Regional Meeting of Parliamentary Committees on Health in East and Southern Africa:

Health Equity and Primary Health Care: Responding to the Challenges and Opportunities
MEETING REPORT

Partners in Population and Development Africa Regional Office (PPD ARO), Regional Network on Equity in Health in East and Southern Africa (EQUINET), African Population and Health Research Centre (APHRC), Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH), United Nations Population Fund (UNFPA), Venture Strategies for Health and Development, German Foundation for World Population (DSW).

Munyonyo Commonwealth Resort, Kampala, Uganda
16-18 September 2008

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Resolutions

Regional Meeting of Parliamentary Committees on Health in East and Southern Africa: Health Equity and Primary Health Care: Responding to the Challenges and Opportunities

Munyonyo, Uganda, September 16-18, 2008

Hosted by: Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH),Partners in Population and Development, Africa Regional Office, Regional Network on Equity in Health in East and Southern Africa (EQUINET), African Population and Health Research Centre (APHRC), United Nations Population Fund (UNFPA), Venture Strategies for Heath and Development, DSW (German Foundation for World Population).

The Regional Meeting of Parliamentary Committees on Health in East and Southern Africa, Munyonyo Uganda September 16-18 2008, 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.

Noting:

- National, regional and international commitments made to protect and advance the right to health and the commitment to equity in health, primary health care and sexual and reproductive heath rights (SRHR) at all levels in East and Southern Africa; the 1999 Southern African Development Community (SADC) Protocol on Health, the 2003 Maseru Declaration on HIV and AIDS, the 2000 African Union Heads of state 'Abuja declaration and plan of action, the East Central and Southern African (ECSA) Regional Health Ministers Conference resolutions, the Maputo Plan of Action, the NEPAD Health Strategy and 2007 African Union Health Strategy 2007-2015 within the framework of the commitments and plans made in relation to the Millennium Development Goals and the International Conference on Population and Development (ICPD);
- That reducing socio-economic and health inequality is essential to achieving the Millennium Development Goals (MDGs) and to reducing absolute poverty;
- The key role of Primary Health Care oriented and public sector systems in addressing health equity, as expressed in the April 2008 Ouagadougou declaration on "Primary health care and health systems in Africa: achieving better health for Africa in the new millennium"
- The importance of implementing the Maputo Plan of Action to enhance SRHR to enable governments to achieve population goals to provide the necessary conditions for economic and social empowerment and development;
- That parliaments have a central role in health in ensuring ratification of treaties and in overseeing implementation of agreements, enactment of laws, oversight and promotion of rights, policies and programmes and ensuring resources and budget allocations to priorities; in association with other arms of central and local government, civil society, communities, university and research institutions and development partners;

- That regional intergovernmental, parliamentary and civil society forums provide opportunities for building co-ordinated policy, law and action and for exchange of experience;

Resolve to:

- Raise the profile of health in all our parliaments, and strengthen our own leadership, roles, capacities in and evidence for promoting, monitoring and advancing equity in health and health care;
- Promote implementation of the Abuja commitment and fair financing in health through progressive tax funding, social health insurance, and abolition of user fees;
- Fight corruption at all levels;
- Promote and ensure the allocation of resources for the empowerment and awareness of communities at all levels, for communities to know and demand their entitlements and involvement in health, for resources be allocated to their health needs;
- Mobilize political will at highest level on issues of SRHR and for adequate resources to implement the Maputo Plan of Action and country roadmaps to provide comprehensive SRHR services;
- Ensure that such comprehensive SRHR services include Reproductive Health supplies (for commodity security), government funding for antiretrovirals (ARV) for adults and children, community mobilization on SRHR that involves men, especially in vulnerable communities and for adolescents and youth and education of girl children.
- Protect policy space, government authorities and indigenous resources, knowledge and medicines within global trade, and promote investment in community knowledge and in local production of medicines, including traditional medicines;
- Protect health in trade agreements, including the Economic Partnership agreements, ensure our laws include all Trade Related Aspects of Intellectual Property Rights (TRIPs) flexibilities, and resist committing our health services within the World Trade Organisation General Agreement on Trade in Services (GATS);
- Advocate for the Executive branch to include members of parliament (MPs) in delegations to meetings on treaties and to report to parliaments on the outcomes of these meetings;
- Encourage public debate on and inclusion in law of provisions addressing stigma and discrimination and the rights of people living with HIV - including to HIV education and information, equality and non-discrimination, ethical and accessible HIV testing, disclosure and partner notification – and on attention to women, children, youth and other vulnerable groups and their access to appropriate prevention, treatment, care and support.

Commit ourselves to:

Work together as organisations within the region towards advancing these resolutions, including:

Within the next two months to:

i. Report back on the deliberations and resolutions of the meeting to relevant parliament and executive committees and partners;

ii. Move a motion on Primary Health Care (PHC) in our parliaments in September - noting the 30 year anniversary of the Alma Ata Declaration on PHC endorsed on 12 September 1978 - and raise public awareness on PHC, particularly in relation to its role in addressing equity in health, in strengthening community empowerment and SRHR, and the need for establishment, support and resourcing of competent health workers and of Community Health Workers (CHWs) and available, accessible and affordable health care services.

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iii. Raise the option of establishing a parliamentary committee or task force to look into, monitor and oversee action on socio-economic inequalities, including inequality in health and access to health care;

iv. Sensitise fellow members of parliament (MPs) and communicate with the Ministers of Health and Finance on implementation of the Abuja commitment; and thereafter as relevant, move a motion for the Executive to report to parliament on progress made in attaining the Abuja commitment to 15% government domestic funding to health, supported in addition by debt cancellation and overseas development aid;

Delegates, Source: PPD ARO 2008

v. Establish and enact in law – where this does not exist - a process whereby health committees are involved early in the budget process and in the planning within the Medium Term Expenditure Framework.

vi. Ensure that all key documents on international and regional commitments and national laws relevant to health, including SRHR, are provided to the health committee;

vii. Petition the Minister to inform the committee on the status of public health laws, including those that are outdated, and those that need review, and take up the identified gaps with the Attorney General and the Law review committee of parliament;

viii. Set up a workplan for parliamentary clerks, co-operating with researchers in and outside parliament, to produce information briefs to make issues more accessible to committees;

Within the coming year, to:

i. Obtain and publicly disseminate key documents, including the Abuja declaration and the Maputo Plan of Action

ii. Monitor progress in health equity and primary health care at country level and regional level through an 'equity watch' in co-operation with technical and civil society partners.

iii. Ensure committee workplans include actions to promote and engage with mechanisms for community empowerment in health, in partnership with CBOs and CSOs, including through constituency meetings, to provide information to communities on health policies, laws and budget resources, and for community input to budget priorities;

iv. Ensure the Executive branch reports to the committee on the level of and distribution of spending on the health budget, and monitor the impact on health and health care performance associated with the increased spending on health, where the Abuja commitment of 15% government spending on health is achieved;

v. Prepare and make budget submissions that

- Promote equity in the allocation of health resources (ie allocations to health needs; district distributions using allocation formulae that integrate equity)
- Ensure adequate budgets for PHC outreach to all, including vulnerable groups;
- Promote removal of user fees
- Include necessary resource allocations for SRHR and for RH supplies (for commodity security);
- Provide for incentives for rural health workers and for community health workers.
- Balance allocations to infrastructure, personnel and services

vi. Promote and oversee the mainstreaming of community health workers in the formal health system, with support for their training

vii. Obtain national population and reproductive health policies and national action plans and request report on progress in their funding and implementation

SEAPACOH

viii. Propose a review of the commitments related to health that government is signatory to and their application in law, including trade agreements, audit their protection of public health to raise gaps, promote public awareness and establish a procedure for effective parliamentary involvement in negotiation of and report back on international engagements and commitments related to health;

ix. Initiate a process for review, update and harmonisation of public health related laws, to take into account international commitments, policies for equity in health and health care, PHC and SRHR, regulation of public- private roles and outlaw of negative cultural practices affecting health;

x. Strengthen the capacities and effectiveness of parliamentary committees nationally through

- Increasing research capacities/staff
- Building consistent partnerships with CSOs, universities and research institutions/ networks and development agencies.
- District outreach and MP involvement in finance committees of their districts

xi. Strengthen regional networking of parliamentary committees on health in East and Southern Africa through

- Monitoring, reporting on and reviewing progress in implementing these resolutions and commitments.
- Building SEAPACOH, its database of membership of parliaments, sharing of relevant reports for tabling in select committees and national parliaments.
- Building South-South cooperation to share good practices and experiences within the region, including with regional partners.

Call on the international community including parliaments to:

Recognise and support these commitments, rights to health and health care and national and regional roles, responsibilities and initiatives through

- Joining our call for a reduction of global inequality in health; for debt cancellation; and fair trade;
- Recognising and engaging parliaments in the development of treaties and conventions;
- Ensuring ethical human resource policies at international level, backed by investments to redress regressive south-north subsidies incurred through health personnel migration;
- Matching our efforts to meet the commitment to 15% of government domestic financing to health by meeting their commitments to debt cancellation and to the official development aid (ODA) target of 0.7 per cent of gross national product (GNP);
- Aligning their financial and technical assistance and cooperation plans to national policies and plans, and to meet international obligations and commitments in health, PHC, HIV and AIDS and SRHR.
- Promoting transparency and accountability, including to parliaments, in this support;
- Taking up these resolutions through international and regional parliamentary forums, including the African Union Parliamentary Forum, The Association of European Parliamentarians for Africa (AWEPA), the Commonwealth Parliamentary Forum, the East African Legislative Assembly and the Southern African Development Community Parliamentary Forum.

Cite as: SEAPACOH, PPD ARO, EQUINET, APHRC, UNFPA, DSW, Venture Strategies (2008) Resolutions: Regional meeting of parliamentary committees on health in East and Southern Africa: Health Equity and Primary health care: Responding to the challenges and opportunities, Munyonyo, Uganda, September 2008, EQUINET/PPD ARO, South Africa

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 carried out field visits to local governments at districts and lower levels to appraise themselves with the prevailing health needs, and mobilised and sensitised leaders at local government levels, in civil society and in communities on health and reproductive health issues. At regional level, parliamentary committees on health have met to review health issues, including through meetings held by EQUINET, the Global Equity Gauge Alliance and the Southern African Development Community Parliamentary Forum (SADC-PF) in 2003 and 2005.

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/ AIDS, TB, Malaria and other diseases important to the region. While SEAPACOH had networked through various interactions since 2005, the network was keen to hold a regional meeting to update on new developments in health and to review the collaboration of the Parliamentary Committees on Health in the region.

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, and the **African Population Health Research Centre (APHRC)**, a non-profit, non-governmental, international organization that is committed to conducting policy-relevant research on population, health and development issues in sub-Saharan Africa, joined with SEAPACOH in early 2007 to plan the regional meeting. The interim committee of SEAPACOH set priorities that they sought to address through such a meeting.

EQUINET supports and carries out research, dialogue, capacity building, exchange of information and experience and critical analysis to build knowledge, shape strategies and inform policy and practice on health equity (See *www.equinetafrica.org). *APHRC facilitates the use of research evidence in policy and practice, in addition to strengthening the research capacity of African scholars and institutions to enhance skills in generating credible scientific evidence. (See www.aphrc.org*)*

EQUINET and APHRC joined with Partners in Population and Development Africa Regional Office (PPD ARO), a southern-led, southern-run inter-governmental organization of 13 African countries that promotes South-South cooperation in reproductive health and population and development. **The Partners in Population and Development Africa Regional Office (PPD ARO)** based in Kampala, Uganda, locally hosted and administered the arrangements for the meeting. PPD ARO aims to provide a platform for the promotion of and resource mobilization for Reproductive Health, Population and Development in Africa through policy dialogue, networking and building strategic partnerships in the region and sharing of experience and good practices. More information is available online at: www.ppdafrica.org.

These African organisations agreed on a theme for the meeting as "Health Equity and Primary Health Care: Responding to the Challenges and Opportunities", noting the 30 year anniversary of Primary Health Care, the renewed focus on equity in health and the commitments made to promoting sexual and reproductive health. They were joined by three international organisations,

- **Venture Strategies for Health and Development**, a nonprofit organization created to improve the health of low income people in resource-poor settings, by making use of local market forces around the world, such as through improving availability of high quality, low cost, off-patent pharmaceutical products available to people (see www.venturestrategies.org*).*
- **Deutsche Stiftung Weltbevölkerung, the German Foundation for World Population (DSW),** working with Population Action International, International Planned Parenthood Federation and the Reproductive Health (RH) Supplies Coalition working group, to develop a comprehensive evidence-based advocacy toolkit and guide to improving reproductive health commodity security(see http://www.dsw-online.de/)
- **The United Nations Population Fund (UNFPA),** an international development agency that promotes rights to health and equal opportunity to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect (See www.unfpa.org*).*

The co-operating organisations all contributed technically and financially to the meeting, locally hosted by PPD ARO.

The objectives of the meeting were to:

- Review the health equity situation assessment in the region in relation to regional goals (e.g. Maputo Plan of Action, Abuja Declaration) as well as international frameworks (e.g. ICPD PoA, and the MDGs)
- Review and discuss sexual and reproductive health, RH commodity security, HIV and AIDS, integration of RH and HIV/AIDS; as well as population policies, legislation and budgets
- Hear evidence on and discuss options for fair and adequate health care financing and for promoting equitable resource allocation, particularly in relation to budget processes.
- Explore the application of international and regional treaties and conventions on the right to health
- Update on current health and trade issues, including patenting laws and the EPA negotiations and more generally legal frameworks for ensuring protection of public health in trade agreements.
- Discuss developments in primary health care and essential health care entitlements
- Review and make proposals to strengthen SEAPACOH regional networking and organization.

The meeting, held at Munyonyo Uganda September 16-18 2008, 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. The programme is shown in Appendix 1, and the delegate list in Appendix 2. The meeting was rapporteured by PPD ARO and this report has been produced by EQUINET (TARSC) and PPD ARO.

2. The opening

Chaired by Dr. Jotham Musinguzi, Regional Director of the Partners in Population and Development Africa Regional Office (PPD ARO).

The meeting opened with welcome to and introductions of all participants.

Dr. Musinguzi outlined the work of PPD ARO and the purpose of the meeting. PPD's Vision for Africa is of a continent that meets its reproductive health needs, promotes the population and development agenda and thereby addresses poverty, through South-South Cooperation. Dr. Musinguzi stressed that PPD ARO has identified lack of strong political leadership from policy makers for Reproductive Health, Family Planning, Population and Development in the region as the major challenge. While there are many challenges to this, there are also enabling Policy frameworks such as the Abuja Declaration, the NEPAD, Accra Agenda for Action on Aid Effectiveness, the Maputo Plan of Action and country roadmaps for maternal and child health, supportive regional networks and strategic partnerships and global resources.

Dr. Rene Loewenson, Director of Training and Research Support Centre (TARSC) and Programme Co-ordinator of Regional Network for Equity in Health in East and Southern Africa (EQUINET) welcomed delegates. She drew attention to the positive achievements since the first Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa in 2003, including increased allocations of national budgets to health. With differences in life expectancy of 30 years across countries in the region, and poor children having up to three times the risk of dying than rich children, addressing inequality in health is a priority. Africa has 25% of the world disease burden, yet only has 1% of the world's spending on health. These are substantial challenges, but we also have the means to address them, if we move from commitments to action. In this 30th anniversary year of the World Health Organization (WHO) Alma Ata Conference that adopted primary health care (PHC), evidence shows that primary health care continues to be a key approach to ensuring that health systems direct resources towards priority health needs, particularly in disadvantaged communities. Parliaments have a vital role in PHC, and this meeting offers an important opportunity to identify ways of exchanging experience and identifying ways of supporting parliamentary action in health.

"We cannot have social justice in health without people, and we cannot have the people without the parliaments."

Dr Rene Loewenson, EQUINET

Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre **(**APHRC) pointed out that research has an important role in informing effective policies and programs aimed at improving the wellbeing of Africans and health outcomes in Africa. He observed that evidence-based policies are a must if Africa is to make solid progress towards attaining the Millennium Development Goals. Rather than just focusing on highlighting problems in Africa, research should be more focused on demonstrating cost-effective solutions for addressing the many health challenges that the continent is facing. He called on members of Parliament to ensure that there is ample local investment in strengthening higher level education and research capacity. Governments also need to pay particular attention to the rapid growth of the African population, given that the continent as limited resources. While mortality is generally declining in Africa, there are still places, such as Kenya, where child mortality is increasing. While fertility has declined in wealthy households, the much larger number of children in poor families is in part due to health systems which fail to make contraception available to low income communities. While large populations are an asset in China and India, these countries are able to educate and provide people with health services. In Burkina Faso, in contrast, 50% of youth 15-19 years of age have never been to school. For populations to have a role in development they need to have the necessary skills. These issues demand action from within Africa. MPs have a critical role in ensuring that

the existing policies are implemented, ensuring resources are allocated to implement these policies, and mobilizing communities to demand the services they need.

Hon. Austin Mtukula, the Deputy Chair of the Southern and East African Parliamentary Alliance of Committees of Health (SEAPACOH), representing Hon. Blessing Chebundo, the Chair of SEAPACOH, pointed out that the issues prioritised by parliamentarians cut across human rights and health. Members of parliament need to learn from each other, working through regional, national, and international networks, and exchanging practices and experiences. Members of parliaments have a number of essential roles: representative, legislative, facilitative, budgeting and oversight. They do this through committees who make recommendations to improve the lives of their people. Parliamentarians can advocate for the increased resources needed for continental and international policy frameworks such as the Millennium Development Goals (MDGs), the Maputo Plan of Action and the Abuja Declaration. Since the August 2003 meeting, SEAPACOH objectives have been to provide cohesive oversight on health at regional level, to facilitate the sharing of best practices, to strengthen linkages, to improve respect of human rights and public health and ensure and oversee effective policies. SEAPACOH recognizes the need for collective action for this at regional and international levels with parliamentary committees responsible for health.

Ms. Janet Jackson, UNFPA Representative, Uganda, pointed to a "positive shift in the policy environment" around the 1994 International Conference on Population and Development (ICPD) as evidenced by new bills and policies in support of sexual and reproductive health, gender, young people, and population and development. She reminded participants that more action is needed to attain the MDGs on time, particularly indicators of health systems functioning such as the maternal mortality ratio (MMR). National Road Maps for Maternal and Neonatal Heath have yet to be fully endorsed, funded, or put into action and Parliaments need to mobilize the necessary resources for this and strengthen leadership in health in national development processes.

"Parliaments need to popularize the Maputo Plan of Action, as it is Africa's own designed framework for attaining universal access to sexual and reproductive health rights in Africa."

Ms. Janet Jackson, UNFPA Representative, Uganda

Mr. Harry Jooseery, the Executive Director of Partners in Population and Development (PPD), urged delegates to focus on reproductive health and population issues, as they are often neglected in development. He called for promotion of South-South partnerships for this, for countries of the South which have similar backgrounds to cluster and utilize their respective comparative advantages and to promote health for all. South-South Collaboration recognizes potentials in the South, and provides a means for nations in the developing world to join hands together to address a common goal.

"Until we deal with the population problem, stabilize population and produce [a] quality population, we are not going to solve any of our problems. The well-being of a nation depends on how much the country has invested in health and education."

Mr. Harry Jooseery, Executive Director PPD

Dr. Jotham Musinguzi, introduced Hon. Dr. Stephen Mallinga, Minister of Health, Uganda. He commended Hon. Dr. Mallinga for the recent approval of a drug called misoprostal making it available to Uganda women who suffer from post-partum haemorrhage (bleeding after delivery), as is also being done in Ethiopia, Ghana, Nigeria, Sudan, Tanzania and Zambia. He further commended the Uganda Roadmap for the Reduction of Maternal Mortality and Morbidity and called on members of parliament in Uganda to follow the roadmap through to budgetary appropriation.

Hon. Dr. Stephen Mallinga, Minister of Health, Uganda opened the meeting on behalf of Hon. Mrs. Janet Museveni, Uganda's First Lady and MP for Ruhaama. He noted that

poor health, particularly for women and children, is a challenge that must be fought on multiple fronts. He too noted that differences in health, such as in maternal and child mortality, are not only experienced between the developed and developing world, but also between the rich and poor in Africa. He pointed out that these differences can be significantly reduced through access to health care, such as prenatal care, skilled attendance at births, and emergency obstetric care for maternal health. Reproductive health has, in recent years, not received the importance and priority it deserves, yet it is very central to poverty eradication.

"*Redressing inequality in health must be a core concern for African countries. Equity is not only a [political and moral imperative, it is essential to improving health outcomes in our countries."*

Hon. Dr. Stephen Mallinga, Minister of Health, Uganda

Yet, according to Hon. Dr. Mallinga, the situation is not bleak. Public health successes in developing countries such as Sri Lanka have improved the health of women; maternal mortality decreased more than twenty-fold, from 486 maternal deaths per 100,000 livebirths to 24 per 100,000 over four decades. The Village Health Team programme in Uganda was promising in its ability to make health care available in remote areas of the country. He thus called for Parliamentarians to make greater investments in primary and preventative health care, making clean water and sanitation more widely available, and building on the commendable immunization programmes in the region. He also called upon African Heads of State to uphold their commitments to allocate 15% of national budgets to health made in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001). With these words the meeting was officially opened.

"Members of Parliament must remain vigilant to demand that policies are in place and funds are allocated and expended in line with the commitments made by leaders".

Hon. Dr. Stephen Mallinga, Minister of Health, Uganda

3. Health equity in ESA and the International and Regional Health and Development Frameworks

Chaired by Dr. Eliya Zulu, APHRC.

Mr. Jyoti Singh, PPD Permanent Observer to the UN, spoke about the ICPD and the MDGs. He noted that the progress towards achieving many of the ICPD goals also has been mixed. While gains have been made in reduction of infant and child mortality, maternal mortality has not improved. Mr. Singh said that there are strong linkages between the achievement of the Millennium Development Goals and universal access to reproductive health services in the ICPD Programme of Action (1994). He called for increased investment in women's empowerment, in education (particularly for young girls) and in provision of reproductive health services, including family planning, to reduce extreme poverty and accelerate the process of sustainable development. He concluded by making four recommendations: 1) to update the goals and objectives of the ICPD Programme of Action for the emergence of new issues (particularly for resource requirements, adolescent health, HIV/AIDS, commodity security and violence against women); 2) strengthen South-South cooperation to help accelerate the implementation of ICPD goals; improve support to regional and sub-regional cooperation based on the initiatives taken by the countries of various regions and sub-regions (such as the Abuja Declaration) in the areas of health, HIV/AIDS, and commodity security; and 4) fully recognize the importance of the new partnerships (among governments, international agencies, foundations and the private sector) that are contributing to sectoral or thematic goals (Global Fund, Gates Foundation, H-8 and others).

Dr. Chi-Chi Undie, APHRC, reviewed the Maputo Plan of Action and the Abuja Declaration. She noted that both documents reflect commitments towards equity in health and take a multi-sectoral approach. There is an assumption that all stakeholders are familiar with and use the plans to shape their work. However this may not be the case. The Maputo Plan of Action is not adequately specific in some areas making it difficult to evaluate progress over time. In the Abuja Declaration, the tasks detailed assume that civil society, parliament and state relate effectively in policy engagement but this too may not always be the case. Dr. Undie thus made a number of recommendations for parliamentarians to consider: 1) for members of parliament (MPs) to serve as a link to build accountability between government and citizens; 2) for MPs to review proposals for legislation so they are in line with the principles of the Maputo POA and the Abuja Declaration, and 3) for MPs to review and report on the performance of the executive and draw attention to lapses. As a starting point Parliamentarians should access and popularize the documents among relevant stakeholders.

Dr. Rene Loewenson, TARSC/EQUINET, presented a synopsis of the trends and situation in relation to health equity in the region, drawing on the EQUINET book "Reclaiming Resources for Health: Progress and Challenges to Health Equity in Eastern and Southern Africa." (Copies of the book were made available to committees). While countries in the region have longstanding policy commitments to health equity, and have made some progress in aggregate economic growth, overall growth has not always translated into improvements in human development, and social, economic and health inequalities are a brake to poverty reduction, even where there is growth. Inequalities in health persist across geographical areas, across income groups and across social groups. She also presented evidence of how those with poorest health status also have worse access to health care, through a chain of disadvantage in access to health interventions. One measure to address this is through ensuring that resources for health (food, skills, indigenous seed, plants and medicines, raw materials) do not drain out of communities and countries in the region with poor returns. Acting on these issues is a matter of political choice, and MPs have a key role in giving leadership to and encouraging public debate on these choices. The health system also has a key role in closing inequalities. She gave examples of how this has been done in the region, through redistributing resources to primary health care (PHC) levels used by the poorest households, through adequately financing district services when user fees are lifted, through using resource allocation formulae that include measures of health need and through empowering communities. This calls for public health leadership, including from MPs. EQUINET is encouraging countries to monitor equity through an equity watch and she invited parliaments to take leadership in this. This is also important to ensure that national and regional needs and priorities are promoted when engaging at global level, such as with global funds for health or in global trade negotiations. She concluded by inviting participants to the September 23-25, 2009 EQUINET Regional Conference on equity in health in east and southern Africa to be held in Uganda.

Parliament experiences and discussion

In the discussion the MP's observed that many MPs have not seen the Abuja and Maputo documents, and that the proliferation of apparently parallel meetings and declarations – ICDP, MDGs, Abuja- can be confusing. They argued for greater coherence across these processes.

The public health approach was appreciated, as this would address wide inequalities, such as in access to safe deliveries. The MPs concurred that the health budget should reach the 15% commitment made in Abuja. The Tanzania experience was shared, where each household pays an equivalent of $5 US per year, enabling households to access healthcare freely.

Parliaments were noted in the discussion to be a good forum for taking up these issues, if adequately informed and supported. The MP from Namibia noted that there is

evidence of delivery on commitments, such as in Namibia's education for all program, but also commented that parliamentarians are not told or involved when these commitments are made. One MP observed that when ministers sign protocols, MPs do not witness the signing, noting that unless they call ministers for briefings, they may not be given this information. Experiences raised from Kenya, such as on the social health insurance scheme, for example, have shown that MPs must push ministers to fulfil their promises.

A number of MPs raised other issues that undermine parliamentary action: The links with civil society are still weak in many countries. High turnovers of MPs after elections can undermine continuity. As health committees may need to have consistent pressure over more than parliament to realize the goals in the declarations, specific measures are needed to ensure continuity in the work of the committees. For example, clerks to parliamentary committees could improve the institutional memory of parliaments, making sure new MPs are properly briefed when they enter parliament.

Taking up international commitments in the Uganda Parliament: Many social groups are represented in the Uganda Parliament. The parliament has set up a Forum on Food Security, Population and Development, which engages the executive on the budget allocation to different sectors. The parliament has built good relationships with the Population Secretariat, PPD ARO and civil society. The Parliament is encouraging these development partners to articulate health and development concerns, but notes that civil society engagement with parliament is still weak, as citizens often do not understand how the Parliament functions.

It was raised in the discussion that the declarations are not legally binding in themselves, that plans such as the Maputo Plan of Action are flexible to allow countries to adapt them to their conditions, and that government, parliament and civil society need to argue for the adoption of their provisions in national law and policies and for their implementation. UNFPA is, for example, currently assessing how far countries are taking on the roadmap and similar monitoring is there for the MDGs and the ICPD. This monitoring needs to go beyond policies to practice —many countries now have policies, programmes, and plans, but are not implementing them. In future meetings it would be beneficial to hear presentations from the MPs on how they are adopting international commitments into policies and programmes.

4. Sexual and Reproductive Health Challenges and Responses

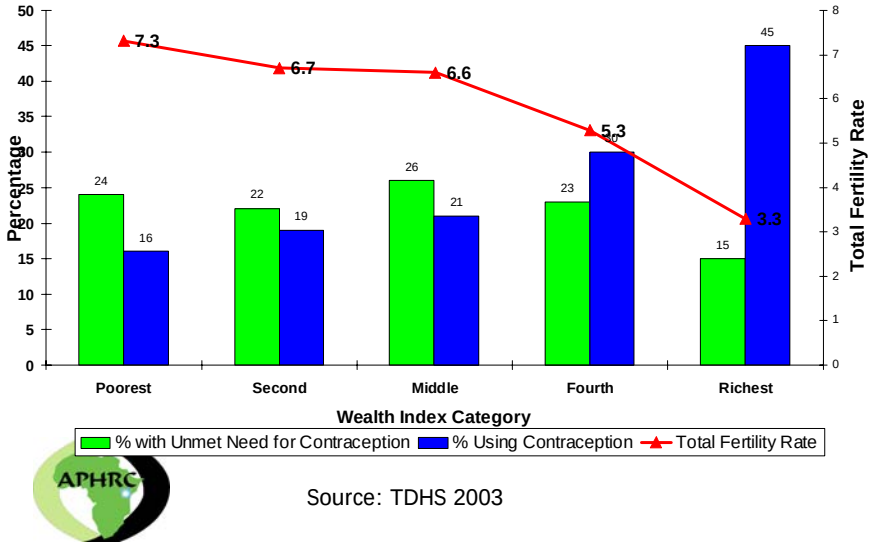
Chaired by Hon. Austin Mtukula, the Deputy Chair, SEAPACOH.

Dr. Eliya Zulu, APHRC, presented on "Population and Reproductive Health in Africa: Key Challenges in Eastern and Southern Africa. He noted that the high population growth in Africa remained a major development challenge that government should not lose sight of. Although Southern Africa has lower population growth rates and fertility rates than in East Africa, these rates are still very high for many of the countries, given their sluggish economic growth. For example, Rwanda, Malawi, Uganda and Burundi have total fertility rates of over six. It is important to examine whether women want the children they are having—births can be either mistimed or unwanted. For example, in Tanzania, the total fertility rate (TFR) for poorest is much higher than richer groups and other indicators show similar differentials, such as in life expectancy, immunization, delivery in a hospital, sex education for adolescents, or service access for populations living in low income areas such as slums.

He argued that the fact that these statistics are not consistently improving shows that we need to recommit ourselves to addressing inequities. “It is not enough to grow economies, we must pay attention to the most vulnerable. It is the only way to improve health outcomes and reduce poverty.”

The technologies and measures to improve these areas of health are known, the policies are there, but what is lacking is the action. He urged MPs to advocate for existing policies to be implemented—to ensure focus on community-based reproductive health issues, promotion of gender equity and comprehensive education.

What’s driving the high fertility of the poor? – Case of Tanzania



Source: TDHS 2003

A presentation on “Family Planning and Equity – Freedom Bridges the Gap” was made by Dr. Martha Campbell, Venture Strategies for Health and Development, on behalf of herself and Prof. Malcolm Potts, School of Public Health, University of California, Berkeley, USA. Dr. Campbell argued that population is only one factor in development, but a critical one. She said that the silencing of voices on the population factor has been unfortunate.

“There is a widespread belief that reducing family size requires limiting people’s rights, and that implies coercion” but “when people, and women in particular, have access to safe family planning backed up with correct information on their use, then they tend to want to have fewer children.”

Dr. Martha Campbell, Venture Strategies for Health and Development

She gave examples from Bangladesh, Ethiopia, and Iran, where demand for family planning was addressed within a human rights framework. “One important factor affecting the worsening inequity between regions of the world is that the total fertility rate” “is much higher in sub-Saharan Africa than the rest of the world. We cannot find any country, other than a few oil rich states . . . that has lifted itself out of poverty while maintaining high birth rates.”

Dr. Campbell concluded by offering four suggestions: 1) to put population and voluntary family planning back on the domestic and international agenda; 2) document and remove unnecessary barriers to family planning; 3) fill the gaps in the supply chain for contraceptive commodities; and 4) empower local communities to help themselves, particularly as concerning primary health care, maternal health and contraception.

Mr. Deogratias Egidio, SADC PF spoke about the "Drafting of a Regional Law on HIV and AIDS." The SADC model law was developed within a human rights-based, gender-sensitive approach, involving people living with HIV. It builds on best practices. The model law aims to protect people affected and infected by HIV/AIDS from discrimination, to guarantee access to health and social services (including prevention), to provide a legal framework for national legislation, to promote implementation of strategies and programmes, to ensure the protection of human rights, to ensure resource provision, and to serve as an advocacy tool for mobilizing resources. Extensive consultations and meetings have been conducted at global, regional and national levels involving various stakeholders. The model law addresses the following key issues: HIV and AIDS-related information, education and communication (IEC); non-discriminating response; HIV testing and counselling; rights of people living with HIV; protection of children, women and other vulnerable groups; and access to treatment, care and support.

"A good HIV specific law should create environment to empower people with knowledge and social support, and to protect infected and affected people from discrimination. It can help to promote behaviour change and access to HIV prevention, treatment and care".

Mr. Deogratias Egidio, SADC PF

He noted that once adopted by the plenary assembly of SADC PF in November 2008, the model law will have the value of a declaration and benefit from the authority and legitimacy of SADC PF as the regional organisation of SADC Parliaments. Of debate he noted was the potentially harmful impact of criminalization of HIV transmission. He identified the next steps for the model law as advocating for the law as a reference document for policy and legislative reform or review; engaging national policymakers; and continuing lobbying the SADC PF political organs for the adoption of a rights-based model law.

Discussion on this session was referred to the working groups.

5. Social empowerment for Primary Health Care

Chaired by Hon. Austin Mtukula, the Deputy Chair, SEAPACOH.

Mr. Itai Rusike, Community Working Group on Health and EQUINET Steering Committee, pointed out that according to the Alma Ata Declaration (1978) "Essential health care is based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self determination." He outlined the central role that social empowerment plays in equitable health systems and PHC, but observed that it is not always formally recognised in law or resourced. Parliamentarians have an important role in this, and there are numerous positive examples from the region. He presented some of the experiences from Zimbabwe in promoting social participation in health through mechanisms such as health advisory boards and health centre committees and noted the key role of the Parliamentary Portfolio Committees. MPs can facilitate wider public participation in the budget processes; promote the 'expert patient' concept; call for global relations that promote equity and public interests; and ensure resources to support joint health service-community actions at the local level. He also proposed a shift from the "medical paradigm" to a "health paradigm" which is more geared to promotion of health

and well-being. The evidence of a health paradigm would for example be an increase in the budgets for preventive services; stronger state and civil society alliances, including in policy dialogue; budget processes that allocate adequate resources to local levels with public involvement in the processes at local and national levels; and improved capacities for district health managers and community representatives in decentralisation programmes. The draft law was distributed and is available from the SADC PF.

Discussion on this session was referred to the working groups.

6. Working Groups on health equity, international commitments, reproductive health and social empowerment

The participants split into three Working Groups to discuss resolutions and areas for short and medium follow up action within the areas of

a. health equity and the international and regional development frameworks
b. sexual and reproductive health and rights (SRHR)
c. social empowerment for Primary Health Care oriented systems

These discussions were consolidated into the resolutions discussed and adopted in the final session and presented as the beginning of this report. Information in the resolutions is thus not repeated here, and this section provides additional points raised in the discussion.

6.1: Health Equity and the International and Regional Development Frameworks

On health equity:

- MPs can make clear that addressing poverty calls for action on equity (rather than equality) as most populations in Africa are under supplied in the distribution of resources.
- Parliaments can identify the current policies and programmes for advancing health equity, to assess how far they are being implemented and facilitate their implementation.
- MPs can monitor the implementation of equity policies and programmes by establishing an equity watch to track health equity issues at country levels and regionally with SEAPACOHs and development partners (eg EQUINET).
- MPs should consult their constituents during the prioritisation of health needs, to make sure that development of infrastructures proceeds together with resources for personnel and medical supplies.
- Health committees should influence the budget allocation before it is tabled in Parliament.
- Neglected areas like reproductive health should receive a reasonable budget line.
- MPs should promote the establishment of and participation in social health insurance schemes to ensure that everyone can access health care
- Promoting health equity calls for strong local government, that are able to achieve a shift in control of resources from national, central level and able to manage planning and procurement of personnel and supplies. Parliaments and local government both need to be stronger and more mutually supportive, and there is need for local government level funding to promote equity. Members of Parliament should be members of the finance committees of their districts.

On treaties and declarations relevant to health equity:

- MPs should be part of the delegation at signing of declaration and that the executive should educate Parliaments on the existing declarations.
- The significantly greater power of the executive can suppress the parliament role in ratifying and domesticating treaties. It was suggested that the East African Parliaments', powers to make laws should also be established in the SADC region.

- MPs should oversee that governments fulfil their commitment to development partners, such as in releasing funding for projects such as the Millennium Villages.

Generally:
- It was recommended that the SEAPACOH secretariat update the membership database on the parliaments and keep periodical reports. These reports should be shared during meetings and tabled in national parliaments, starting with the select committees.

6.2: Sexual and Reproductive Health and Rights (SRHR) challenges and responses, including Population and HIV/AIDS
- As funding for RH is still low, and overall funding for health is below 15% of government spending, technocrats should analyse the finding that goes to different sectors for their health impact and propose a substantial budget for reproductive health, including ARVs
- MPs and development partners (eg PPD ARO) should explore how reproductive health s funded in different countries in the region and engage governments and top leadership to attain improved funding to implement specific roadmaps.
- To address the information gap of MPs, partnerships between MPs, CSOs and development agencies need to be strengthened and capacity built for MPs, including provision of treaties, commitments and research results; and making larger documents more user friendly and accessible to MPS, eg through policy briefs. MPs themselves should also report on their work and be more transparent in their operations.
- To address specific RH concerns such as high teenage pregnancies, low education levels among women, high fertility and negative cultural practices, MPs must increase awareness at the community and policy level, engage local leaders, advocate for integration of sex education in the syllabus, demystify negative myths & misconceptions, lobby for laws to outlaw negative practices and promote social dialogue, such as to empower both men and women to demand and access family planning.

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6.3 Social Empowerment for Primary Health Care

Immediate actions
- Raise awareness in the communities about PHC and the role of community health workers.
- Advocate on the availability, accessibility and affordability of facilities and the role, training and resourcing of community health workers (CHWs).
- Establish CHWs in areas where they are not found.

Medium-term actions
- Advocating for and overseeing the skills training, outreach, and renumeration of community health workers and mainstreaming them into the formal health system; Ensuring structures and mechanisms are put in place and functioning to inform communities about health policies and to bring community voice into decisions on national budgets and decentralised funds; and on oversight of primary health care;
- Build and strengthen partnerships of parliamentarians with CBOs and CSOs, particularly to enhance the community voice for primary health care**.**
- Advocate for increased incentives for rural health workers in terms of career advancement, housing, salaries and allowances.
- Oversee the performance of the health system to make sure PHC policies are prioritised and implemented.

7. Parliament budget roles: Fair financing for equitable health systems

Chaired by Mr. Harry Jooseery, the Executive Director, PPD

Mr. Jooseery opened the session by noting that in 2007, overseas development aid reached only 0.28% of high income country gross national product, not the 0.7% promised. In the past three years, most ODA went to Asia, particularly with funding for Afghanistan and Iraq. With low levels of domestic resource mobilisation, many African countries are dependant on external aid for health financing. Equitable health financing is a priority concern if health needs are to be adequately and fairly met.

Ms. Charlotte M. Zikusooka, Healthnet consult Uganda and from the EQUINET fair financing theme group, outlined the "Options for Fair Mobilisation of Finances for Health." She outlined the key components of a health care financing system as revenue collection, pooling of funds and purchasing. The 2005 World Health Assembly adopted a resolution stating that "health care financing should promote universal coverage," defined as "all citizens having access to adequate health care at an affordable cost." EQUINET expands this definition to state that health care financing should improve cross-subsidies in the overall health system.

"People should contribute to the funding of health services according to their ability to pay and benefit from health services according to their need for care".

C Zikusooka, HNC/EQUINET

In the eastern and southern region of Africa, there is a heavy dependency on donor and household funding, with individual households, including the poor, making high levels of out-of-pocket payments. Many people are not covered by health insurance in the ESA region—and there is a great deal of fragmentation and holes—promoting inefficiencies and inequity. Options for health care financing include domestic funding from government tax-based funding, out-of-pocket (private) spending by households, firms/employers, and multiple forms of health Insurance and pre-payment mechanisms (voluntary private health insurance, mandatory health insurance, and community-based insurance). External (donor) funding includes budget support/basket funding and project support. According to an equity analysis, out-of-pocket expenditure by households is very inequitable, while tax-based and donor funding can be relatively equitable, but often uncoordinated and inadequate. Social health insurance (SHI) is compulsory contributions into a health fund, by employers and employees, in return for a benefit package covering them and their dependants. If social or national health insurance is well managed, it should be one of the most equitable options for funding health care. But national health insurance is complex to design, implement, manage and monitor.

She contrasted the current situation (shown in Figure 1) with the situation we should be aiming for (Figure 2), where tax and insurance funding are the primary sources of funding, supported by ODA, with less in out of pocket and small private insurance schemes, and greater co-ordination of different funding pools within one framework. She questioned why countries have failed to implement social health insurance despite its attributes, and called for debate on how best countries can integrate existing financing mechanisms and use donor funding more effectively.

Figure 1: Current health financing situation in ESA countries

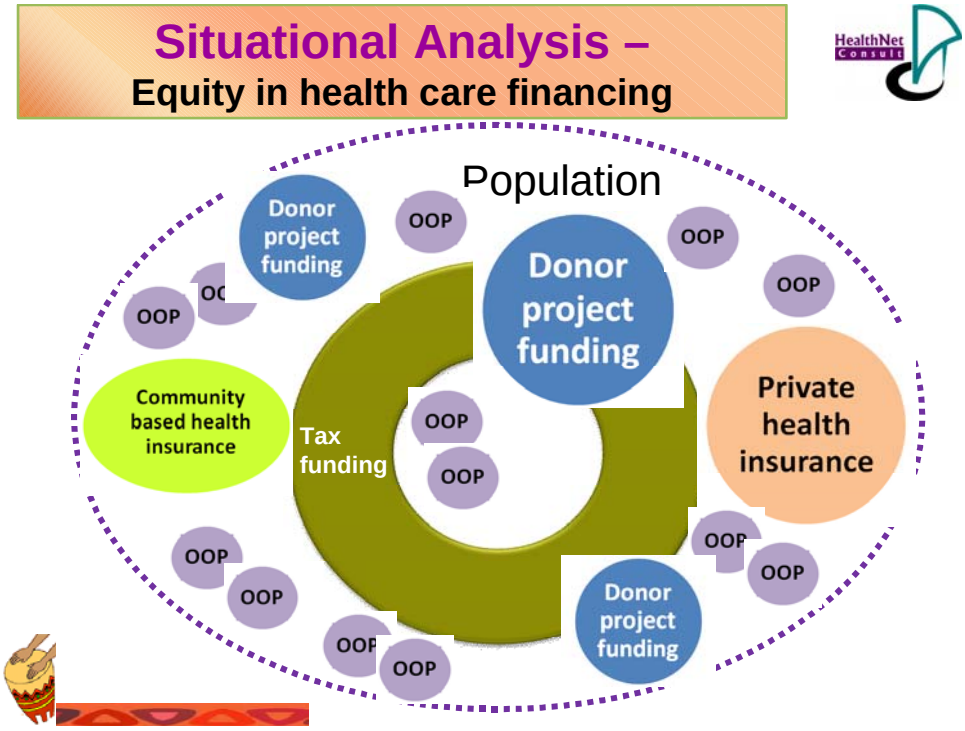
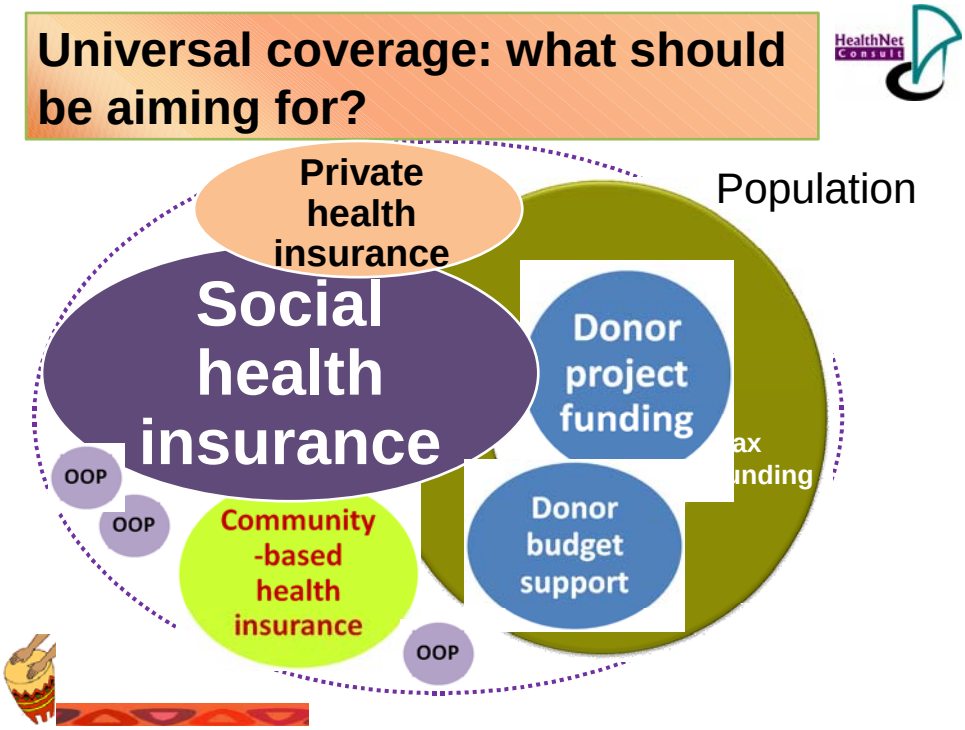


Figure 2: What we should aim for in health financing in ESA to promote equity



Following this presentation, Dr Rene Loewenson, TARSC/ EQUINET presented options on improving equity in the allocation of resources for health drawing on work from the fair financing theme co-ordinated in EQUINET by University of Cape Town Health Economics Unit. Experience from the region indicates that allocations to PHC and low income communities is often compromised when financing is not adequate. There are three components of the commitment made in Abuja 2001- for 15% domestic spending

on health, for ODA to meet commitments of 0.8% GNP and for debt cancellation with resources released to be allocated to health. She urged MPs to advocate for all three elements to be met, as some countries are struggling to adequately fund health due to debt servicing levels. The minimum costs estimated by WHO to deliver health systems are around US$38 / capita for priority disease interventions and US$60-80 / capita for a functioning health system. Meeting the health and HIV/AIDS MDGs demands a further US $9.40/capita by 2002 and $22 / capita by 2015. At least 15% of overall government spending needs to go to health to move towards the level of funding needed to make improvements in health, and to demonstrate prioritisation of health given its poverty reducing impacts. She proposed that MPs monitor this level of government spending, separating domestic and donor spending, as the 15% should be domestic funds, and should not include external funds. She further outlined how countries can ensure that the budgets for health are more equitably allocated, through using a resource allocation formula that integrates poverty and health needs in the allocations made to different districts or areas. This formula is currently being used in various countries in the region, and the experience of Zambia was presented where its use has begun to lead to a more equitable allocation of resources across districts. Policy briefs on the Abuja commitment and equitable allocation of resources were distributed and are available on the EQUINET website (www.equinetafrica.org).

Parliament experiences and discussion

Experiences from Botswana: One of the MPs from Botswana shared information about the country's experiences in equitable health financing. Botswana has many health programmes and 16% of government spending went to health in the last budget. The local government provides primary health care, and the central government is mainly responsible for the curative services. Health care is free in Botswana and available in every district. If medical treatment has to be referred to services outside Botswana, the government covers all costs. It was noted in the discussion that it would be useful to track the impact of this level of adequacy of financing on health outcomes. The Hon MP also noted that Botswana participates in all international conferences but encounters problems in domesticating treaties. The committees in the Botswana Parliament make recommendations to the Parliament, but these are not enforceable by government. Botswana is now addressing the role of traditional medicine: "We cannot run away from the truth that some of our traditional medicines do work and most people seek services from these practitioners." Traditional medical practices thus need to be factored into our analysis of health systems.

In the discussion one MP noted that in Tanzania, inequality is associated with poor social services in some areas and equitable distribution of resources for health is important and needs to guide planners to locate where services are most needed. He advocated inclusion of equity in the allocation of resources in Tanzania. The need to move from the historic allocation of funds and to move towards need-based allocation was endorsed by a number of MPs.

Aid dependency was noted to be a problem in some countries, such as from the Global Fund to procure HIV drugs. This has to some extent suppressed domestic financing from Government. Other examples were given, such as Namibia, where global funding has been partnered by resources from the state. Parliaments thus need to pressure for the application of the Abuja commitment. In the Malawi Parliament, a group has tried to domesticate the Abuja commitment. If the Executive branch of government cannot come up with bills to domesticate commitments like Abuja, then Parliamentarians must draft private bills.

It was also noted in the discussion that the definition of donors often used is one that classifies only OECD countries as donors, including Western donors, Japan, New Zealand and Australia. But new donors have emerged over the past five years, such as

China and India. They make contributions several times larger than some OECD donors and they do not want to be included in the OECD figures, posing a data challenge that needs to be addressed.

An MP from Kenya said that donor fragmentation is a difficult issue to overcome to improve access to health. Some funding from donors is for commodities or services that may not be needed. Beyond donors it was also noted by Ms. Zikusooka that there are alot of private sector resources in the health sector, and that it is important for Parliamentarians to put in place the policies and laws to ensure that these resources contribute to priority areas.

8. Parliament legislative roles: Ensuring rights, laws and agreements that promote health equity

Chaired by Mr. Harry Jooseery, the Executive Director, PPD

Professor Nomafrench Mbombo, University of the Western Cape, South Africa and EQUINET Health & Human Rights Theme Coordinator, presented on "The Right to Health & Application of Treaties in ESA" on behalf of herself, Professor London Leslie and Ms. Jacky Thomas, University of Cape Town, South Africa. According to international agreements, "health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest standard of health conducive to living a life in dignity." States are obliged to promote, respect, protect and fulfil the right to health through a number of international and regional commitments on the right to health, ranging from the Universal Declaration of Human Rights (UDHR) (1948) to the UN International conference documents on Fourth World Conference on Women held in Beijing (1995, Plus), the African Charter on Human and Peoples' Rights (1981), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000); to the African Charter on the Rights and Welfare of the Child, (1990). Parliaments have major roles to play to invoke the right to health by: holding the government to account on meeting its national obligations towards meeting the right to health; reviewing and revising the laws and policies to ensure consistency with human rights obligations; critically examining the international agreements, such as trade agreements, for their impact on the right to health; formulating dialogue and participation with civil society to maximize access to health through public hearings and establishing a monitoring system with appropriate indicators to track increased access to health care and the conditions needed for health. She noted that if government has not ratified relevant health treaties, Parliaments can raise questions on whether government intends to sign; request evidence and information from state officials, civil society and academic institutions on the costs and benefits to the country of signing up to the treaties & the costs to health of not signing and use parliamentary procedures to determine the reasons for not signing, and if the health impacts are positive encourage the executive to start the signing and ratification process without delay. Parliament briefs on the treaties and rights were distributed and are available on the EQUINET website.

In a review of public health laws in East Africa, Mr Mulumba Moses, Makerere University Uganda / EQUINET presented evidence from a study covering laws in Uganda, Kenya and Tanzania (Kasambizi, Mulumba and Loewenson (2008) at www.equinetafrica.org). There has been a shift in health laws from eradicating and treating diseases to wider regulation of social and environmental factors, including cross border issues, e.g. global pandemics, trade, bioterrorism, and the movement of hazardous substances. The review showed that there are still many old laws, and that five areas need to be attended to: 1) harmonizing national laws with national policies; 2) harmonizing national laws with international obligations; 3) harmonization across the different national laws; 4) harmonization of the laws across countries; and 5) enforcing and putting the laws into practice. Parliaments can commission an audit of the law with these issues in mind, and ensure that gaps are addressed. There is also need to widen public information, awareness on the laws to support participation and accountability in health services.

Underlying this there is need for constitutional provisions to set a fundamental platform of rights, obligations and responsibilities for health and access to health care.

Ms. Aulline Mabika, SEATINI/EQUINET explored how MPs can protect rights to health in trade agreements. She described how liberalisation of trade decreases the role of the state and increases the role of market in the health sector. But health services provided for profit on market basis can exclude those who cannot pay, who are often those poorest groups with highest health needs, and so undermine access and equity. Governments thus regulate markets in health. Trade policy is now encroaching into health care services and World Trade Organisation regulates issues such as tobacco control, access to essential drugs, information technology, and traditional knowledge. These agreements can affect poor and vulnerable people. Parliament ratifies trade agreements, and can in principle refuse to ratify a trade agreement, although this has not been tested in practice. This role needs to be strengthened to ensure multilateral and bilateral trade agreements respect public health and to ensure that international law promoting public health is translated into national law. She proposed that Parliaments ensure state obligations to protect the right to health is found in all trade agreements together with the principle that implementation must not cause harm to public health (with audits done where harm is suspected). Relevant agreements should include respect for state obligations to regulate and ensure access to essential health care. No bilateral negotiations, like the EU-ESA Economic Partnership Agreement, should go beyond WTO commitments, should not commit health services under GATS and should ensure all flexibilities in the Trade Related Intellectual Property Rights (TRIPS) agreement are integrated in national law. Agreements should also include obligations for reporting, information sharing and consultation.

Parliament experiences and discussion

In the discussion it was observed that governments are trying to come up with ways to preserve traditional knowledge. For example, traditional birth attendants (TBAs) have been supported and trained in some countries. However many active ingredients from traditional medicines have been patented by international drug companies. There is need for measures to protect these indigenous resources and prevent their exploitation through regional testing, patenting and marketing.

It was noted that international treaties are not enforceable, as they are essentially policy commitments made by respective countries. Future meetings should hear from MPs on how they are adopting international commitments into policies and programmes.

Kenya's parliament experience in trade issues: Kenya is signatory to WTO agreements and has been engaged in discussions looking at TRIPS flexibilities to ensure provision of drugs that are available and affordable; Kenya does not want to be a dumping ground for drugs and wants to ensure that the kind of commodities delivered in the country are of high quality. In Kenya, parliamentarians with other partners are working on a bill in Parliament to discuss counterfeits in the market. The MPs feel that it is important that generic drugs are available and cheap, and that no barriers to generics are created in this bill.

Zimbabwe has taken advantage of flexible advantages for compulsory licensing and parallel importation. In 2001, the cost for ARVs was $300 US for one month. In 2002, the same drugs cost US $30. It was recommended that other countries learn from the Zimbabwe experience to make dugs more available. In Zimbabwe, there are three levels of negation for treaties and agreements: the policy level, expert level, and ministerial level (adoption). Parliament is only involved after Ministry has adopted the treaty, with MPs unable to consult with the Ministry before the treaty is ratified, due to lack of adequate information and the complexity of the laws and protocols.

The issue of medicines was actively discussed. It was noted that PPD is facilitating the distribution of generic drugs in member states and creating a platform for manufacturers to meet WHO standards. It was noted by some MPs that drugs expire and more have to be purchased before the stock was used, while some substandard drugs have been distributed, which can cause side effects. The issue of corruption was also felt to affect drug access and procurement of substandard supplies and MPs could share experiences of how to fight it.

The presentation of liberalization in the health sector as negative was queried, given its common projection as positive. Further clarification was requested on this. In response Ms Mabika commented that while liberalization in all sectors brings both opportunities and risks that we need to weigh up in the health sector apart from rising costs to consumers, cited earlier, liberalization leads to removal of subsidies and cuts in government spending, which undermines already weak health systems. Liberalization measures undermine government controls in the health sector, like price and markup controls, with negative effects on poor people.

9. Working Groups on health financing, health rights and law and trade and health

The participants split into three Working Groups to discuss resolutions and areas for short and medium term follow up action within the areas of

a. Mobilization and allocation of resources and fair financing;
b. the right to health in the application of treaties and public health laws;
c. promoting health in trade agreements.

These discussions were consolidated into the resolutions discussed and adopted in the final session and presented as the beginning of this report. Information in the resolutions is thus not repeated here, and this section provides additional points raised in the discussion.

9.1: Mobilization and allocation of resources and fair financing

- MP's have a role to play in promoting implementation of the Abuja commitment and fair financing in health, in fighting corruption at all levels and ensuring that communities to know and demand their entitlements and involvement in health;
- Towards this MPs need to sensitise fellow members of parliament (MPs) and communicate with the Ministers of Health and Finance on implementation of the Abuja commitment; and thereafter as relevant, move a motion for the Executive to report to parliament on progress made in attaining the Abuja commitment to 15% government domestic funding to health, supported in addition by debt cancellation and overseas development aid;
- It would be important to establish and enact in law – where this does not exist - a process whereby health committees are involved early in the budget process and in the planning within the Medium Term Expenditure Framework.
- The Executive branch should report to the parliament committee on health on the level of and distribution of spending on the health budget, and monitor the impact on health and health care performance associated with the increased spending on health, where the Abuja commitment of 15% government spending on health is achieved;
- The budget submissions made by parliaments should promote equity in the allocation of health resources (ie allocations to health needs; district distributions using allocation formulae that integrate equity) and ensure adequate budgets for PHC outreach to all, including vulnerable groups;

9.2: The right to health in the application of treaties and public health laws

- To address old or outdated laws, MPs should petition Ministers on the status and shortfalls in particular laws in the short term, and review these laws thereafter.
- Committees of Health should take up the identified legal gaps with the Attorney General to promote legal review, including to develop laws to manage the private sector.
- MPs can move private members bills and motions in Parliament on specific rights issues or legal gaps, monitor the progress of existing policies and laws and engage the public in such monitoring.
- Parliaments can establish cross sectoral equal opportunities committees to address inequality.
- To address the lack of capacity of Health Committees, usable and understandable summaries of laws, policies and treaties should be provided, with capacity building and adequate staffing and research assistants for committees.
- A "committees of treaties" could be established in Parliaments to improve the engagement of MPs with international treaties, in partnership with civil society.

9.3: Promoting health in trade agreements

- Committees can propose checks and balances in tender proceedings to avoid corruption and mismanagement of funds in the health sector; and take hearings from country specific regulatory authorities to check standards and balances for quality control.
- Governments should not subsidise the private for profit sector (hospitals etc) as they do not promote equity. The Parliament committee can request information on the subsidies, grants and incentives currently being applied to the private for profit sector to explore their impact and fairness and make relevant proposals.
- MPs should ensure that patent laws contain TRIPS flexibilities, enact laws to protect and strengthen the African regional indigenous knowledge systems and promote networking in testing, registering and patenting local medicines. It was suggested that an African Trade Organization be set up to protect local knowledge. Governments should facilitate the use and packaging of traditional medical resources and that MPs can promote laws to develop their own local/ traditional medicines; and allocate more budget resources to encourage research on local medicines.
- MPs can oversee that countries not commit health services to GATS, avoid signing of agreements that undermine public health and ensure that protection of public health is present as a clause in trade agreements.

10. Reproductive health commodity security

Chaired by Mr. James Kotzsch, Country Director, DSW Uganda.

The chair observed that MPs have reported problems of drugs expiring in national medical stores and waste of supplies due to improper storage. Recalling the opening remarks of Hon. Dr. Mallinga about the significant number of women in Uganda dying due to pregnancy or childbirth, he pointed to the direct link between poor health outcomes for mothers and children and the security of reproductive health supplies.

Dr. Kechi F. Ogbuagu, Advisor, Reproductive Health, Logistics, UNFPA gave an overview of reproductive health commodity security. She gave the story of a girl named "Mere" who could be from any of the countries represented.

"Mere entered into an early marriage and because she was young and could not afford to go to a clinic for delivery. She died due to complications during delivery. Globally, over 500,000 women die from complications of pregnancy; 4.3 million infants die. Every minute in the world, 380 women become pregnant and 190 of these women did not want

to become pregnant. Africa, although it has only of 17% of global total of births, has 70% of the mortality due to pregnancy".

Dr. Ogbuagu, UNFPA

She pointed to the tragedy in that we know what to do. The key factors in maternal death are the delays in seeking care; delays in reaching a treatment facility; and delays in receiving adequate treatment at the facility due to a lack of manpower, equipment, and drugs. Reproductive health commodity security (RHCS) is essential, because without commodities, there cannot be an effective program. If Coca Cola and cigarettes can be accessible everywhere, so too can reproductive health commodities be accessible to all. However resources are insufficient. While a few countries such as Kenya, Tanzania have invested government funds, RHCS is still largely donor driven and the significant resources for AIDS could be used more effectively for reproductive health. Parliamentarians need to be able to monitor these resources and availability of commodities and raise commitment for community level action on delays in deliveries.

Ms. Terri Bartlett, Independent Consultant on behalf of DSW/IPPF/PRMA introduced MPs to the Advocacy Guide and Toolkit on Reproductive Health. She noted that all people have the right to choose, access and use quality affordable reproductive health supplies when they need them. This calls for financial resources to ensure that RH supplies meet current and future need; capacities in national health systems to deliver RH supplies and avoid shortages; and policies and programs to ensure internationally-agreed rights of all individuals to access RH supplies. She shared a number of resources for evidence-based advocacy, including the RH Supplies Data Base and Advocacy Tool Kit, which details five global scenarios: high unmet need for family planning, high HIV prevalence, donor phase-out, health sector decentralization, and high rates of abortion and low fertility rates.

Parliament Experiences and Discussion

In the discussion, the Uganda experience was raised. MPs have taken up the fight for reproductive health and family planning, and developed a plan for increased reproductive health supplies. With input from technical personnel they explored the current gaps, including in implementing the roadmap for the reduction of maternal mortality. An advocacy group was set up in Parliament through the social services committee to enact through relevant laws and to bring together the Ministry of Finance and Ministry of Health to implement and fund the roadmap. Soon, they will begin meetings on the roadmap with district leaders and holding press briefings to discuss RH supply issues. The Uganda parliament group has advocated around issues such as inclusion of improvement of maternal health in loans being negotiated and raised the urgency and the need to address maternal health issues with the public and the executive. At health center level, health workers may not have the skills to plan and requisition stocks and to ensure that supplies do not expire at the lower level. Some health workers requisition for drugs and exclude reproductive health supplies. Health centres may thus lack supplies even though the budget line at the national medical stores is unused.

In the discussion it was raised that members of Parliament need to engage district leaders and health workers to ensure they do the right thing. The unmet need for family planning commodities was felt to be a matter for concern, and one where there is lack of awareness at district levels, even when commodities are available. This was felt to need both national and international advocacy.

It was also noted by MPs that parliamentarians need to examine if policies are implemented, ensure that there is a budget line for reproductive health and ensure that systems are improved, such as by including members of the parliamentary committees of health in country coordinating teams.

The session presenters (Ms. Terri Bartlett and Dr. Kechi F. Ogbuagu) noted that the experiences show that advocacy is not only about supplies, but also about information, awareness, and education that also have to go along with the supplies. Funding for supplies also has to include IEC costs, service delivery costs, and the delivery (infrastructure) costs. When supplies are available, attention is needed on actions to ensure that people know about and are empowered to demand and use the services.

11. Parliament experiences in budget, legislative and oversight roles

Three working groups shared Parliament experiences in legislative, budget, oversight and promotion roles. The groups discussed the lessons learned and how to strengthen the communication between committees and with other institutional partners on the actions they are taking in health. As the discussions did not divide discreetly into these different roles but showed great overlap across roles, the report of the discussion is divided into (i) the experiences within different countries (ii) the lessons learned from the experiences and (iii) the proposals for strengthening communication.

These discussions were consolidated into the resolutions discussed and adopted in the final session and presented as the beginning of this report. Information in the resolutions is thus not repeated here, and this section provides additional points raised in the discussion.

11.1: Parliament Experiences in implementing budget, legislative and oversight roles

In Tanzania, MPs are also councillors in their constituencies and attend committees in their constituencies and four sessions of Parliament. At constituency level MPs receive reports on health from technical personnel and follow up progress in health, education and other sectoral interventions. The issues arising from this are discussed in the budget together with audit reports from different parastatals, where audit queries can be raised and followed up. MPs work with CSOs through exhibitions at Parliament ground to ensure that MPs get information on what is happening. There are public hearings for all bills before they are passed to encourage consensus on the issues covered.
In Uganda, the Parliament has a budget office. MPs are provided with information and make committee input on issues that have budget implications. For example the social services committee has made input on measures for recruitment of health workers. When a bill is read for the first time; the committee summons relevant partners and they discuss it. It is then read for the second time for public hearing. MPs in Uganda are also lobbying government to allocate funds for the implementation of specific plans committed to SRHR programmes, such as the roadmap on SRHR. There is also a new standing order in Uganda clearly stating that the media will be allowed in to attend all sessions of Parliament.

In Kenya, technocrats prepare budget proposals from their various health facilities at district level which are then brought to the national level. MPs make comments on whether budgets are too high or low. However, they are changing the standing orders to ensure that MPs can be involved in the whole budget processes. All bills are discussed after the first reading in Parliament by the committee on health and amendments are made by MPs before it is shared for the second reading, which involves a discussion for the whole house. What has been noted is that implementation of laws is often poor and needs further oversight. Also in Kenya, the Parliament has committees to work with allies on specific target health issues. For example work on housing cuts across six sectors and six ministers report on this.

In Namibia, Zambia and Kenya Parliamentarian constituency offices are facilitated to carry out through health research and monitoring within their constituency.

In Malawi there has been significant improvement in meeting the Abuja commitment. Currently health receives the second highest vote after agriculture. The Botswana parliamentarians also reported significant progress on equity through free health for all, very decentralised system, very good infrastructure, and sound primary health care, but noted problems in monitoring progress of implementation.

11.2: Lessons learned from Parliament experiences
From the sharing of experience, some common lessons emerged:

On **legislative roles,** it is important to involve the top leadership in developing bills if they are to be implemented. Public consultation is also important. Private members bills have also been used to raise new areas of legal reform. There is thus need for advocacy for government funding of these processes. After enactment of laws more attention needs to be given to ensuring that laws are implemented.

Budget roles were seen to be very dependent on good information. Parliamentarians need to have a research desk and staff, and constituency offices should be facilitated to carry out health research and monitoring within their constituency, such as in Kenya, Namibia and Zambia. Committees can also link with established research organisations and influence their research agenda to have informative reports for Parliamentarians on health issues. It was noted that MPs need to give more high profile attention to how funds are devolved to community and PHC level in budget debates, and explore setting up constituency development funds to promote health equity within constituencies.

Oversight, promotion and monitoring roles were identified as very important in a number of areas, such as in securing support for reproductive health interventions. MPs should work closely with local governments to obtain the information needed for their monitoring and oversight role. At district level MPs should be members of the district council, not ex officio. Civil society organisations should be encouraged to avail information from the grassroots level to support motions and act as bridges between Parliament and the communities.

Taking up health issues often calls for collaboration across committees. The Kenya experience of cross sectoral forums provides one way of targeting specific health issues and engaging more widely across sectors and constituencies on these issues.

11.3: Improving communication across Parliamentary committees and between Parliaments and partners
The discussions all pointed to a need for a higher level of exchange of experience among parliamentary committees on health, population and development within and across countries in the region, to enable transfer of practices, expertise and technologies within and outside countries.

Within countries, MPs can work with civil society to inform proactive parliament agendas, and work with media to improve coverage of these issues. Parliamentarian fora on specific health issues can raise the profile of these issues and promote information flow around them.

Across countries, Parliaments need to learn best practices and ways of overcoming challenges from each other. SEAPACOH can support this by updating their databases of committees and their activities, and regularly share experiences through emailed reporting and through using regional meetings. During the meeting a questionnaire implemented by UCT/UWC through EQUINET and SEAPACOH gathered information

from all committees on their work and identified issues and a report on this will be compiled and sent to all the committees.

12. SEAPACOH business meeting

Chaired by Hon. Austin Mtukula, National Assembly of Malawi.

A SEAPACOH business meeting was held on the second day to take forward the networking of parliamentary committees on health. This was a business meeting specifically for the Parliamentary committees and the minutes are separately reported by SEAPACOH.

13. Resolutions and closing of the meeting

Chaired by Hon. Dr Chris Baryomunsi, Parliament of Uganda.

Draft resolutions were developed by a working group from Hon MPs and technical institutions in the meeting, drawing from the working group sessions. The draft resolutions were provided to delegates at the end of the second day for further input, and discussed in detail in a session on the third day. The resolutions as finalised are shown in the beginning of the report. Hon Baryomunsi drew attention to the regional conference on equity in health being held by EQUINET with SEAPACOH involvement in Uganda in September 2009, as an opportunity for MPs to meet a year from this meeting to review progress in implementing the resolutions and their impact.

The closing session commenced with the arrival of the Speaker of the Uganda Parliament, Rt. Hon. Edward Ssekandi.

Dr. Jotham Musinguzi, PPD ARO, opened the closing session with an overview of the meeting's work and the information, advocacy skills and issues exchanged to enhance the Parliaments legislative, oversight, and budgetary roles.

Hon. Dr. Chris Baryomunsi, MP Uganda, noted that the meeting had highlighted that meeting agreed targets for health and development needed a lot more work to address the gaps. Contributing to this, MPs must be proactive in introducing laws on health issues, as well as giving oversight, appropriating budgets to be sure that adequate resources are available and distributed according to need, for the range of actions planned in health, including for RH commodities and supplies. He noted that meetings such as the ones held greatly enhanced parliamentarians' advocacy on health issues.

"The voices of MPs will be much louder on these issues because of the information given at the meeting. In 2001, our governments committed ourselves that we raise the proportion of our national budgets to health to at least 15%, excluding the donor resources. Unfortunately, most of our countries are not doing well on this target. The amount to health in Uganda, is only 8.2%, including donor resources. This is an issue that we will be raising in parliament."

Hon. Dr. Chris Baryomunsi, Parliament of Uganda

He commended Rt. Hon. Edward Ssekandi who, while a distinguished lawyer, has been highly concerned with issues of health, and has been the patron for the Parliamentary Forum on Food Security, Population and Development and regularly meets with them. Having such understanding and support from the speaker of Parliament adds weight and momentum to these issues.

Hon. Prof. Aluse Mytola, MP Tanzania spoke on behalf of the delegates. He congratulated the organizers and commended the knowledge and new thinking on approaches to health problems and interventions in different countries. He observed that all the papers were well-attended and well-discussed and invited the presenters to visit the different countries to reach a greater audience.

"The whole of East and Southern Africa is together fighting health inequities. This war will continue, but the Parliaments this time will hear speeches which are stronger and more focused on health equity".

Hon. Prof. Idris Ali Mtulia, Parliament of Tanzania

He concluded by thanking the Speaker of Uganda for meeting with the group representing different countries.

Hon. Blessing Chebundo, Chair SEAPACOH Committee, thanked the Honourable Speaker, organizers and partners, including PPD ARO, EQUINET, APHRC, DSW, Venture Strategies, and SEAPACOH itself, and the resource people and facilitators for their presence and support, which he noted shows commitment to health issues. He called for participants to commit themselves to working on the issues and actions agreed and resolved upon their return. He reminded MPs to work on budgets; use model laws, such as developed by the SADC Parliamentary Forum on HIV/AIDS; and identify issues and create action plans on what needs to be done in each Parliament. He asked MPs to ensure that this takes centre stage, to create motions, committees, and raise questions for ministers. He called upon technical partners and experts to improve knowledge of MPs so that they can do more for people of Africa. The SEAPACOH business meeting enabled members to take forward these issues as a group and Hon. Dr. Blessing Chebundo called upon partners to assist the group in moving forward as a strong network.

"Parliamentary committees on health are the technical organs of parliament. We should use this opportunity to produce and obtain the information we need and design and implement our agreed action plans to forge forward for health"

Hon. Blessing Chebundo, Chair SEAPACOH Committee

Mr. Harry Jooseery, Executive Director, PPD, on behalf of all organisations hosting the meeting (PPD ARO, EQUINET, APHRC, SEAPACOH, UNFPA, Venture Strategies for Heath and Development and DSW), thanked the speakers and the meeting supporters and participants for their support to this important work. He noted the evidence and insights into current issues raised at the meeting, and noted that all partners will continue updating parliamentarians on relevant issues.

" I have been personally involved with the celebration of the World Population Day, on 11th July 2008 in Uganda, and I would like to commend the enthusiasm, dynamism and very active participation of Ugandan Parliamentarians shown on that day in Mbarara on population issues."

Mr. Harry Jooseery, Executive Director, PPD

He said that PPD will work with a network of Parliaments and update parliamentarians on health-related issues.

Rt. Hon. Edward Ssekandi, Speaker of the Parliament of Uganda, made the Official Closing for the meeting. He conveyed the blessings and good wishes from the 8th Parliament of Uganda. He commended the efforts of the organizers, the information shared, exchanges made, programs debated and lessons learned. He noted that members of Parliament in Uganda always talk about health, and suggested that South-South collaboration be strengthened beyond these regions and involve the entire continent through the AU structure.

"I understand that participants are leaving with a sense of how to better play our roles; and with this expertise, to be better equipped to translate knowledge into capacity and well-directed action to improved service delivery and improved quality for our people."

Rt. Hon. Edward Ssekandi, Speaker of the Parliament of Uganda

He congratulated the participants for coming up with concrete resolutions for the meeting, and asked for MPs to follow up on the international commitments discussed, such as the Maputo Plan of Action, the Abuja Commitment, and the African Health Strategy. He called for countries to report on their progress in implementation and asked for the commitment of all participants to the ICPD and MDGs, as well.

"We are now able to talk about the health equity and primary health care situations in the different countries attending this meeting. We are able to talk about the reproductive health frameworks and the level of commitment and accountability our countries have shown. We are able talk about how we stand in terms of allocating and expending resources for health equitably. We are able to talk about how we are addressing the challenges of population and reproductive health, and in more specific terms, ensuring reproductive health commodities security. In a nut shell, we are able to talk about people, their communities and the challenges facing them in a manner that puts faces to numbers".

Rt. Hon. Edward Ssekandi, Speaker of the Parliament of Uganda

Hon. Rosemay Seninde Nansubuga, Parliament of Uganda, led the passage of a vote of thanks to the Hon Speaker, Rt. Hon. Edward Ssekandi, for sparing his time to close the workshop and for his support to MPs in promoting health. She called for colleagues from all countries to take up the issues and actions as agreed, and report back to the group on their challenges and experiences.

The meeting then closed.

Delegates to the meeting at the opening session

Appendix 1: Meeting programme

Day One: Tuesday, September 16, 2008		
Time	**Session**	**Chair / Presenters**
0800-0900	Registration	Mr. Patrick Mugirwa and Mr. Francis Katushabe (PPD ARO)
0900-1030	**Official Opening Session**	
	Introductions	Dr. Jotham Musinguzi, Regional Director, PPD ARO
	Opening Remarks	Dr. Rene Loewenson, EQUINET Dr. Eliya Zulu, Deputy Executive Director and Director of Research, APHRC Ms. Janet Jackson, UNFPA Representative, Uganda Hon. Austin Mtukula, Dep Chair SEAPACOH Mr. Harry Jooseery, Executive Director, PPD
	Official Opening	Hon. Dr. Stephen Mallinga, Minister of Health, Uganda
1030-1100	Tea/Coffee Break	
1100-1300	**Session One**	**Dr. Eliya Zulu, APHRC**
Health Equity in ESA and the International and Regional Health and Development Frameworks		
1100-1125	International –ICPD and MDGs	Mr. Jyoti Singh, PPD Permanent Observer to the UN
1125-1150	Reflections on the Maputo Plan of Action and the Abuja Declaration	Dr. Chi-Chi Undie, APHRC
1150-1215	Reclaiming Resources for Health: Progress and Challenges to Health Equity in East and Southern Africa	Dr. Rene Loewenson, Director TARSC/ EQUINET programme manager
1215-1300	Parliament experiences and discussion	*Lead in on discussion from Hon MP Uganda*
1300-1400	Lunch	
Parliamentary Oversight Roles: Policies for Promoting Health Equity and PHC		
1400-1630	**Session Two**	**Hon A Mtukula Dep Chair, SEAPACOH**
Sexual and Reproductive Health Challenges and Responses		
1400-1420	Population and Reproductive Health Challenges in Eastern and Southern Africa: Policy and Program Implications	Dr. Eliya Zulu, APHRC
1420-1440	Family Planning and Equity – Freedom Bridges the Gap	Martha Campbell, Venture Strategies, and Dr Prof. Malcolm Potts, School of Public Health, University of California, Berkeley, USA
1440-1500	Drafting of a Regional Law on HIV and AIDS	Mr. Deogratias Egidio, SADC PF
1500-1530	Discussion	*Lead in on discussion from Hon MP from Tanzania*
1530-1545	Tea/Coffee Break	
1545-1605	Social Empowerment for Primary Health Care	Mr. Itai Rusike, Community Working Group on Health and EQUINET SC
1605-1630	Parliament experiences and discussion	
1630-1730	**Working Groups:** Resolutions and areas for follow up	
1800-2030	Dinner and Cultural Entertainment Hosts: UNFPA and Parliament of Uganda	

Day Two: Wednesday, September 17, 2008		
0800-0830	Administration and Logistics	Mr. Patrick Mugirwa and Mr. Francis Katushabe (PPD ARO)
0830-1300	**Session Three**	**Mr. Harry Jooseery, Executive Director, PPD**
Parliamentary Budget Roles: Fair Financing for Equitable Health Systems		
0830-0850	Fair Financing for Health: Options for Fair Mobilisation of Finances for Health	Ms. Charlotte Zikusooka, Healthnetconsult/EQUINET
0850-0910	Meeting Abuja and Global Commitments on Fair Financing and Equitable Resource Allocation	Dr. Rene Loewenson, TARSC/EQUINET
0910-0940	Parliament experiences and discussion	*Lead in on discussion from Hon MP from Malawi*
Parliamentary Legislative Roles: Ensuring Rights, Laws and Agreements that Promote Health Equity		
0940-1000	Rights to Health and Application of Treaties	Nomafrench Mbombo, J. Thomas UWC/UCT/EQUINET
1000-1020	Key Areas for Review of Public Health Laws	Mulumba Moses, HEPS/Makerere/ EQUINET
1020-1050	Parliament experiences and discussion	*Lead in on discussion from Hon MP from Botswana*
1050-1110	Tea/Coffee Break	
1110-1130	How can MPs Protect Rights to Health in Trade Agreements?	Ms. Aulline Mabika, SEATINI/EQUINET
1130-1200	Parliament experiences and discussion	*Lead in on discussion from Hon MPs from Kenya*
1200-1300	**Working Groups:** Resolutions and areas for follow up	
1300-1400	Lunch	
1400-1600	**Session Four**	
Parliament Experiences and Draft Resolutions		
1400-1545	**Group Discussions:** Parliament Work and Lessons Learned	
1545-1600	Tea/Coffee Break	
SEAPACOH Business Meeting		
1600-1800	SEAPACOH Business meeting	
1830-2030	Dinner hosted by PPD ARO and EQUINET	

Day Three: Thursday, September 18, 2008		
0800-0830	Administration	Mr. Patrick Mugirwa and Mr. Francis Katushabe (PPD ARO)
0830-1100	**Session Five**	**Mr. James Kotzsch, Country Director, DSW Uganda**
Reproductive Health Commodity Security		
0830 - 9000	Overview of Reproductive Health Commodity Security: Challenges and Recommendations	Dr. Kechi F. Ogbuagu, Advisor, Reproductive Health, Logistics, UNFPA
9000 - 1100	Reproductive Health Commodity Security	Ms. Terri Bartlett, Independent Consultant on behalf of DSW/IPPF/PRMA
1100 - 1130	Tea/Coffee Break	
1130 - 1315	**Session Six**	**Hon. Dr Chris Baryomunsi, Parliament of Uganda**
Resolutions		
1130 - 1245	Munyonyo Resolutions: Presentation and Adoption of Resolutions	
Official Closing Session		
1245 - 1315	Closing Remarks	Dr. Jotham Musinguzi, Regional Director, PPD ARO Dr Blessing Chebundo, Chair SEAPACOH Committee Mr. Harry Jooseery, Executive Director, PPD
	Official Closing	Rt. Hon. Edward Ssekandi, Speaker, Parliament of Uganda
1315 - 1430	Lunch	

Appendix 2: Meeting Participants

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