Parliamentary Functions and Reforms and their application in promoting Health Equity in Southern Africa

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

In response to demands by the public represented by Civil Society Organization, Parliaments have been called upon to be more effective in carrying out their functions or representation, oversight and legislating.

Beginning with the Parliament of South Africa in 1994 there has thus been a wave of Parliamentary reforms in the region with different levels of success. Parliaments have instituted changes in their committee systems and in the legislative process to allow greater participations from the public.

In seeking to promote health equity and public health, legislatures, through their committees have sought ways to engage with relevant stakeholders, and other organizations in order to broaden their knowledge base.

The work of the Portfolio Committees responsible for Health in the Parliaments of South Africa and Zimbabwe illustrates the effectiveness of committees with the Portfolio Committees era. The portfolio Committees have managed to carryout the oversight function through their investigations and have influenced the legislative process. Committees have been given powers to study the bills, conduct public hearings and engage experts on any subject matter under investigation and to support amendments to bills in order to promote health equity. To this end the South African National Assembly portfolio Committee on Health has effected amendments to such bills like the ***Occupational Diseases in Mines and Works Amendment Bill 2002.***

There is evidence that involving the Portfolio Committees in the budget process has been beneficial to both the electorate and the Executive. Public hearings that are held with stakeholders take stock of what progress has been made and help in setting up new priority areas.

During the era of reforms parliaments and their committees have established good working relationships with the public, among NGOs and other organizations. This interaction has enhanced cross-fertilization of ideas and built stronger legislatures.

Such interaction is very crucial in tackling the HIV/AIDS pandemic. The efforts of the Botswana Parliament's HIV/AIDS Committee exemplify this positive role. The Committee sensitizes the public , promote and leads campaigns against the spread of HIV/AIDS in partnership with the National AIDS Council. Members of Parliament, as representatives of the people, make use of other tools such as motions, and questions to ensure that constituents' needs are addressed.

It is also the duty of Parliamentarians to ensure that international treaties serve the interests of the people. In South Africa, the practice is that requests for approval of treaties are referred to Portfolio Committees who carry out investigations before reporting to the House.

In conclusion, a number of opportunities for parliaments to promote health equity have been identified. Firstly, Parliaments are in charge of their rules which they can revise to become more efficient and effective when they commit themselves to reforms. Secondly, in the region there is a vibrant civil society that raises questions and compels Parliaments to address issues.

Parliaments now offer space for stakeholder input through the use of public hearings, Parliament constituency centres and on site visits.

Parliaments provide an opportunity pro equity legislative analysis by allowing participation by stakeholders in bill analysis during committee scrutiny.

Networking, both nationally and internationally, between Parliaments and with NGOs provides useful information and technical advice which Parliaments can use to carry out its functions effectively.

Constraints have also been identified. These include the economic situation, lack of information on the part of Parliament, limitation in public participation and the fact that recommendations made by Parliament are not binding on the executive and are not always implemented.

1. INTRODUCTION:

The emergence of strong Civil Society Organizations in Southern Africa over the past decade has meant that National Parliaments or Legislatures have been compelled to become more receptive to and responsive in handling the needs and demands of the electorate. Increasing public awareness of their rights and entitlements have placed responsibility on elected representatives i.e. Parliamentarians to be more effective in their multiple functions of *representation, oversight and legislating on behalf of their constituents.*

In seeking to be efficient and effective, many Parliaments in the SADC Region have embarked on, or are planning to undertake reforms in their procedures, practices and systems. These reforms are meant to provide opportunities for parliaments to increase their capacity and expertise in dealing with the challenges posed by different stakeholder groups within the population. Reform programmes have been used to identify deficiencies in parliament and to implement appropriate responses.

Many of the SADC region's national parliaments have set up committee systems to oversee the activities of the Executive and its bureaucrats in the various departments and other agencies of State. These committees meet and following their deliberations table reports and recommendations in Parliament. Portfolio committees have been set up to track the activities of government departments in such sectors as health, education and agriculture among others. Their meetings offer an opportunity to scrutinize and report on the activities of the State.

Reforms have been often accompanied by specialist professional support and specific budgets for the work of the committees. Increasingly many Parliamentary committees are holding their hearings in public and seeking public input in the gathering of relevant evidence for their consideration. A number of Parliaments are also sharing experiences and information on best practices through interaction with such organizations as the SADC Parliamentary Forum (SADC PF), The East African Assembly (EAA) and the Commonwealth Parliamentary Association (CPA). Relevant expertise and information is also availed to Parliaments by non-governmental organizations such as Training and Research Support Centre (TARSC), Health Systems Trust (HST) the National Democratic Institute (NDI), the Public Affairs & Parliamentary Support Trust (PAPST) and networks such as Southern African Regional Network on equity in Health (EQUINET) and the Global Equity Gauge Alliance (GEGA).

It is common knowledge that working relations between the State and NGOs are often characterized by *competition for space and influence among constituents.* In some countries the relations are so polarized that

governments have justified the enactment of targeted legislation to control the existence and activities of NGOs. Public access to their elected representatives and state bureaucrats remain a major cause for concern among many NGO and beneficiary stakeholders. This has the effect of minimizing the input of the electorate in matters of policy formulation, enactment and amendment of legislation and resource allocation to name a few.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region**.** Addressing inequities thus calls for policies aimed at redistributing societal and health resources. These policies are themselves a product of the extent to which different groups of people have the opportunity for participation and the power to direct resources towards their health needs. It is in seeking to redress some of these challenges in health equity that the activities of EQUINET, GEGA and TARSC have been focused.

This paper will attempt to provide some insights into the practical challenges faced by Parliaments and Parliamentarians in addressing the issues of equity in health and describe the attempts that have been made to address those challenges. It should be noted that the roles and relationships between the Executive and Legislative branches of States often define the degree of effectiveness of either or both in working towards equity in health. Furthermore, health programmes have tended to attract multilateral agencies such as WHO, UNICEF, SIDA, USAID, NORAD and DFID, to name a few. These bodies have sought to ensure observance of and increase compliance with various international treaties, agreements, conventions and practices.

2. BACKGROUND:

In seeking to appreciate what role, if any, Parliament has in promoting health equity and public health, it is pertinent to understand the role the institution should and can play in maintaining consistency and continuity in the health sector from both the funding and policy development perspectives. It is also critical to appreciate the limitations of the institution in relation to the practical issues of resource allocation from central government as well as the challenges faced by individual members of Parliament as they carry out their various tasks.

In seeking to appreciate the role Parliament has in promoting health equity and public health, it is important to understand the role the institution should and can play in the development of health policy and in health financing.

It should also be borne in mind that whereas ministries have at their bidding considerable expertise in any subject matter that falls under their portfolio, Parliaments normally do not. Parliamentarians are not often elected for possession of any particular skill but rather to represent populations, nor is assignment of a Parliamentarian to a particular Portfolio Committee usually based on expertise. Therefore, when dealing with national issues, Parliaments can find themselves at a disadvantage in relation to carrying out their responsibilities. Government experts take part in conferences and contribute in the crafting of treaties/agreements and conventions and keep abreast of developments, but Parliaments ordinarily lack this knowledge and expertise.

It is against this background that Legislatures have sought ways to engage with relevant stakeholders NGO's and other organisations to enable them access as much information as their counterparts in the Executive. The principle of the separation of powers can provide the requisite checks and balances only when the two organs operate at an equal level.

In the reform process, Parliaments have sought ways to strengthen the functioning of Committees and increase public participation. The main reason for this deliberate emphasis is that it is through committees that Parliament carries out its work without political influence and interference. This has not always been the case in the House. In many countries in the SADC region, the separation of powers and roles between Parliament and the Executive is not always distinct, due to the composition of parliament. There are some Members of Parliament who are also members of the Executive and these will always prioritize their Executive functions above those of Parliament. It is therefore in the committees that Parliament business of detailed review of proposed legislation, oversight of the Executive branch activities, examination of and reporting on policy issues and investigations are carried out.

3. PARLIAMENTARY REFORMS AND THE ROLE OF COMMITTEES

Parliaments are in charge of their own rules of practice and procedure. This autonomy allows Parliaments to change their method of operation in order to be more efficient and effective to suit changing times. Parliaments can institute reforms without reference to any other authority. The current wave of Parliamentary Reforms in the SADC Region has shown this. These Reforms are intended to increase public participation in Parliamentary and related governance processes.

The cases of the Portfolio Committee on Health and Child Welfare in Zimbabwe and the National Assembly Portfolio Committee on Health (NAPCH) in South Africa can be cited as examples of good practice brought

about by the Parliamentary reform process. These cases illustrate how Parliaments, through their Committee systems, can perform the important functions of oversight, legislation and representation, enhancing the involvement of stakeholders in the operations of Parliament.
A number of Parliaments in southern Africa, namely South Africa, Botswana, Zambia and Namibia, operate effective committee systems. The two cases are chosen as they illustrate the potential of the Parliamentary roles when Parliamentary reforms are instituted and embraced whole heartedly by all those involved - parliament, the executive, stakeholders and development partners.

3.1 Establishing Parliamentary Committees On Health

Before the institution of Parliamentary reforms in 1999, the Parliament of Zimbabwe had four departmental Committees:

Service Ministries
Technical Ministries
Security Ministries
Finance, Economic and Development Ministries.

The Reform Committee recommended the introduction of Portfolio Committees with one committee covering each ministry. There are now twelve Portfolio Committees, including the Portfolio Committee on Health and Child Welfare (HCW). Since its appointment in September 2000, this Committee has tabled three reports in Parliament and produced three budget reports and one specialised report. In contrast, the predecessor Departmental Committee on Service Ministries produced only one report on health matters during its five-year term.

One of the landmark recommendations of the Reform Committee was on the opening up of Committees to the public. To this end, the Committee on Health and Child Welfare has held public hearings and seminars on selected topics such as HIV/AIDS. Various experts have been engaged with the assistance of development partners to analyse the budget and other pertinent issues.

The Committee System in South Africa has gone through various stages of transformation. Before the tricameral system came into being in 1983, Portfolio Committees did not play a major role in the legislative process in Parliament, as bills were normally dealt with by the House itself. Apart from four House Committees, there was a Public Accounts Committee, a Committee on State-owned Land, a Committee on Irrigation Matters and a Petitions Committee. Bills were rarely referred to Committees for consideration, and from time to time *ad hoc* Committees were also appointed to deal with matters of public interest.

Between 1983 and April 1994, Committees came to play an important part in the legislative process. Unlike the previous system, where all the stages of bills were debated in the House, there was only one plenary session on a bill—the Second Reading stage—and all bills were referred to Committees for consideration and report before second reading. Thirteen joint standing committees were established, consisting of members of all three Houses. On each committee, there were twenty-three members, including eleven members from the House of Assembly, seven from the House of Representatives and five from the House of Delegates. Ministerial portfolios were combined in a similar way as the departmental committees were combined in Zimbabwe. A Committee could ask for submissions on the subject of its enquiry and hear interested parties, mostly representative bodies rather than individuals. Meetings were closed to the public, unless declared open by the committee.

In 1994, Portfolio Committees were established in South Africa, and since then they have carried out the following functions:

- Oversight of the government on financial matters (e.g. public accounts).
- Internal functions, to ease the work of the House (by rules and disciplinary committees).
- Examination of specific areas of public life or matters of current public interest (e.g. *ad hoc* and joint monitoring committees).
- Consideration of legislation (by portfolio and select committees).
- Monitoring and oversight of government affairs and provinces (by portfolio and select committees).
- Consideration of private members' legislative proposals.
- Consideration of petitions.
- Consideration of international agreements and conventions.

3.2 Committee Implementation Of The Oversight Role

Whereas the Executive's main function is to govern, that of Parliament is to legislate and call the Executive to account. Parliamentarians are representatives of the people, both those groups who voted and those who did not. They are accountable to the people and are therefore expected to ensure that every person is treated fairly and is heard. Parliamentary reforms have been instituted to ensure that as many people as possible participate in the work of legislatures. Parliaments, mainly through their committees, have sought to be more effective in this oversight role.

To conduct its oversight function effectively, the Zimbabwe Committee on HCW enquired into the operations and activities of the country's Health Ministry at all levels, i.e. headquarters, provincial, district and the rural health centres. The Committee reported its findings and presented its recommendations to Parliament in March 2001. One of the findings was that rural health centres were severely short staffed and run by unqualified

personnel. People in the rural areas were exposed to low quality service or no service at all, since highly qualified personnel tend to prefer to work in urban areas, where living conditions are more attractive. In response, the Committee recommended that the training of State Certified Nurses be reintroduced to improve staffing in rural health centers. This category of staff were in previous years noted to provide trained cadres more likely to remain in rural service. This recommendation was accepted by the Ministry, and training has since started at selected Mission Hospitals in the country.

The Zimbabwe Committee has also provided a mechanism for follow up of the recommendations of the Health Sector Reform (HSR) Commission. The HSR Commission was appointed by the President of Zimbabwe in 1997 to address the deterioration of the health delivery system and to develop recommendations to improve the sector. The report, presented to Government in 1997, proposed that the health delivery system be decentralized, including issues such as the welfare and remuneration of employees. These findings were confirmed by later reports, including the Ministry of Health and Child Welfare's decentralisation concept papers, the Public Service Review Commission Report and the Ten-Year National Health Strategy for Zimbabwe.

With funding from a development partner in 2000, the Committee then engaged an expert to research and study the progress of the decentralisation exercise since its implementation in 1998. The Committee, armed with the findings from the experts' report undertook fact-finding visits to selected provinces and tabled a report in Parliament in October 2002. The Committee found that whereas restructuring had been carried out at headquarters, this process had not filtered down effectively to the district level. There were few structures to run support management of individual hospitals, and where structures did exist, the differentiation of roles was not yet clear.

The Committee found that uncertainty about roles had resulted in a state of stagnation. Decisions were not being made and service delivery was affected. Once more, the rural poor were most affected by these poor implementation processes and lack of monitoring, resulting in an additional burden of inequity despite the original explicit intent of the decentralisation process to improve equity for rural areas. The Committee's main recommendation was that the Executive should enact legislation to strengthen implementation of some of the reforms, such as the transfer of responsibility for running institutions from the Ministry to the management boards along with the transfer of assets and staff from central government to the local authority level.

3.3 Promoting Equitable Legislation

Parliament's main function is to legislate, to make good laws. Good laws that not only provide benefit to everybody but laws that are seen to benefiting

everyone. The Executive is often in a hurry to legislate and it is therefore left to Parliament to ensure that stakeholder participation in the law making process is maximised. Parliaments, have through committees reviewed pieces of legislation brought before them to ensure passage of good laws.

In the Parliament of Zimbabwe, for an example, following the intervention of the Portfolio Committee, the Ministry of Health and Child Welfare produced a draft Bill to implement the reforms called the Government Hospitals Management Bill and the Minister asked the Committee to consult further on the Bill. Once more, with assistance from one of Parliament's development partners, a workshop on legislative analysis was held with stakeholders. Both the Bill and the Public Health Act were analyzed. This illustrates a practice that was recommended in the Reforms.

Criteria were set that these laws should foster accessibility, gender equity, participation, user-friendly language, provide elements of regulation, enable quality assurance, provide for involvement of stakeholders, accommodate vulnerable groups and be consistent with existing policies, international standards and best practices from the SADC region.

A committee analysis of the Government Hospitals Management Draft Bill showed that the draft Bill failed the language, facilitation, quality assurance, capacity and gender equity and equality tests. The Bill only passed the regulatory framework test. The Bill recognized some stakeholders while leaving out others. The Bill left a gap in that it did not provide for health to be treated as a basic human right as stated in article 25 of the Universal Declaration of Human Rights.

The Public Health Act was also found to be in need of amendments in line with the changing socio-economic and political circumstances in the country. It was noted that the Act like all other pieces of health legislation need to be reviewed to ensure that it provided for enhanced participation in the health system, promoted health equity, addressed HIV/AIDS and used simpler and clearer language.

Equipped with information from the workshop, the Committee has since held public hearings on the Draft Bill in two provinces and will continue to hold hearings in other provinces, after which it will produce a report for the Ministry. This exercise will afford both the Committee and the public opportunity to make contributions before the final bill is drafted and published in the government gazette. This process does not preclude further input from stakeholders when the Bill is introduced in the House. With the reforms, it is now a requirement that bills be published 14 days before they are introduced in the House and they automatically stand referred to a portfolio committee. Stakeholders have an opportunity to interact and have an input in the legislative process at this stage.

The South African NAPCH has also demonstrated the potential legislative role of parliaments. It has processed and amended three pieces of legislation in 2002, viz: . the *Medicines Control Amendment Bill, Medical Schemes Amendment Bill* and the *Occupational Diseases in Mines and Works Amendment Bill.*

The Medicines Control Amendment Bill
The Committee scheduled hearings on the Medicines and Related Substances Bill with stakeholders and used their recommendations to amend the bill.

Medical Schemes Amendment Bill, 2002
The Medical Scheme Amendment Bill amends the principal Act of 1998, by broadening the definition of a broker and the circumstances for accreditation. The portfolio Committee introduced further amendments after inputs from stakeholders at public hearings.

Occupational Diseases in Mines and Works Amendment Bill, 2002
This bill was also amended subsequent to stakeholder input co-ordinated by the committee. After which it was passed unanimously. amendment allows a person with an occupational disease 24 months after leaving the employ of a company to apply for compensation. The bill provides that the owner of a controlled mine or controlled works has to pay a reasonable cost for medical bills and costs incurred in relation to the disease. It also provides that a community representatives or attorneys may not receive more than 0,5% of the claimant's benefits.

In each of the above cases the committee afforded the option for public input to the bills. In the latter such amendments widened the scope of benefits for largely low income workers, a pro-equity outcome. In the case studies the committees demonstrate the potential for parliament to facilitate public input to legislation, and to use equity oriented criteria (accessibility, policy consistency, inclusion of major health priorities) in review of legislation.

3.4 Committees And The Representative Role

Parliamentarians at times forget and do not consult with or report back to the electorate on matters that are before Parliament. Modern democratic Parliaments have instituted reforms precisely to avoid such problems and to increase transparency and public accountability. Many Parliaments that have embarked on the reform process have emphasized the need of the involvement of civil society in the activities of Parliament, both in the legislative process and in the operations of committees.

One of the most effective ways of giving voice to communities with a direct interest in equity issues is the use of public hearings. Hearings can be held in both urban and rural centres and provide all sections of the public with an opportunity to be heard.

In 2002, the South African NAPCH held public hearings on a number of issues, including the budget, the Choice on Termination of Pregnancy Act and various bills. These hearings provided evidence of disparities between provinces in the quality of health services.

The national and provincial hearings revealed that transformation in the public health system was generally progressing steadily. Notably, access to health services had improved dramatically, and with improvement in accountability and reporting systems, primary health services were being made available universally.

Health Districts had been established and their development was progressing at varying paces depending on capacity. However, the Committee was concerned about the slower progress towards achieving inter-provincial equity as well as underspending on nutrition and HIV/AIDS.

The Committee was especially alarmed at the slow performance of four provinces,particularly in delivery of key services. The National Health Department's lack of authority to provide input on provincial global budgets was seen to be a stumbling block towards the attainment of better health service delivery.

Referral systems in the provinces were not working as well as anticipated, resulting in additional pressure on services. Finally, public-private partnerships remained weak, creating potential for increasing health inequities and low accountability for improvements in access, delivery and quality of services.

The Committee found that negative perceptions remained across provinces about quality of care and concluded that public campaigns needed to be stepped up to improve not only services but also the image of the health sector in general.

The Committee identified the following priorities as requiring further attention and monitoring:

- Mechanisms to improve inter-provincial equity
- An improved human resource strategy to improve representativity and increase the pool of health workers
- Introduction of mechanisms to ensure cheaper medicines
- Strengthening of Primary Health Care (PHC) services and mechanisms to improve referral systems

- Increasing the pace of development in Health Districts
- Urgent clarification on the basket of PHC services to be delivered at the local government level
- Clarity on what the “end point” function of local government is [?]
- Overhaul of TB hospitals
- A cost analysis of mental health services
- The maintenance of good quality in the private sector
- The practical implications of the rationing of care and public buy-in
- The role of Statutory Councils in setting norms and standards with regard to quality of care

Motions and Questions

Besides the legislative process and work in committees, Parliamentarians can make use of motions and questions to debate or seek information relating to both constituency and national issues. All Parliaments in the SADC region make provision in their rules and procedures for some time to consider and respond to questions posed by backbenchers (ordinary Members of Parliament who are not ministers or deputy ministers) to members of cabinet, either with or without notice. Armed with direct responses and replies to questions and motions, parliamentarians are in a better position to inform their constituents of developments or lack of development on local or national issues.

Treaties and Agreements

When governments sign treaties, conventions, protocols, or enter into agreements with other states and or organisations, Parliaments, as representatives of the People, have the power to accept or reject such treaties or agreements by accepting or refusing to ratify them. No treaty or agreement signed by government can come into force in a democratic country without ratification by its Parliament. In South Africa, requests for approval treaties are referred to relevant Portfolio Committees, who conduct exhaustive investigations before reporting to the House.

The question often asked is, what happens after ratification? Many Parliaments have been found wanting in monitoring treaties after their ratification. What is more disturbing is that some protocols and agreements that are signed and relate to trade or other matters have direct relevance to health or provision of health care services, but are not adequately scrutinised by Parliaments.

In Zimbabwe, for instance, it is a requirement that after ratification, provisions of those agreements have to be domesticated, i.e. incorporated into the laws of Zimbabwe. For instance, to give effect to the Agreement on Trade-related Aspects of Intellectual Property Rights of 1994 (TRIPS Agreement) and the Patent Co-operation Treaty of 1970, the government introduced the Patents Amendment Bill in 2001/2002. The Bill

was passed by Parliament without serious scrutiny about the impact or benefit of TRIPS.

Before the Uruguay Round of the WTO, each country was left to determine it's the operational period of patent rights within that country. But with TRIPS, all patents were uniformly ruled to last 20 years, which prevented developing countries that signed on to TRIPS from copying and manufacturing those drugs still under patent for the stipulated 20 years, regardless of the human cost of this highly profit-oriented decision. The effects of this provision were only eased when a provision of compulsory licensing and parallel importation was introduced. TRIPS also now permits local manufacturers to start preparing the manufacture of a product while it is still under patent, affording companies some lead time to prepare for production of drugs early.

Trade-related restrictions have significantly harmed developing countries. Essential drugs are offered at exorbitant costs that the poor cannot afford. Anti-retroviral drugs are a good example: whereas Southern Africa is one of the hardest hit areas by HIV/AIDS, the majority of the people in the region cannot get access to the required drugs. For most, contracting HIV/AIDS in Africa has become a definite death sentence. TRIPS impacts in southern Africa and options for responding to TRIPS have been explored by organisations such as EQUINET and SEATINI.

Related to TRIPS are the provisions of the General Agreement on Trade in Services (GATS), which give countries the choice of which services to liberalise within a broader global framework of liberalising trade services. Trade in health services falls in this category and affects the movement of health professionals and the provision of medical services. Parliaments need to participate to understand what effect liberalisation will have both nationally and regionally and have to be sensitised on these matters. EQUINET work with SEATINI, which will be reported in this meeting, aims to provide a better understanding of these agreements and better networking between trade and health to ensure protection of public health interests. All countries need to carry out a mapping of their trade in health services, such as has been done by Cleary and Thomas (2002) in South Africa and to discuss the implications of trade agreements with stakeholders. [1]

Site Visits

Committees have found it valuable to undertake site visits, not only to verify information and carry out inspections but also as a way of interacting with stakeholders. The South African NAPCH, as an example,

[1] The paper by Susan Cleary and Stephen Thomas of the University of Cape Town was prepared for the Trade and Industrial Policy Strategies 2002 Annual Forum on Mapping Health Services Trade in South Africa

joined the minister, senior departmental officials and others in a fact-finding tour of the Eastern Cape health facilities in 2002. The Committee visited the Stellenbosch wine farms and had the opportunity to interact with the Liquor industry about concerns around the massive misuse of alcohol by farm workers and their families, and the industry's role in terms of social responsibility. As part of its oversight role, the Committee undertook a visit to Guguletu and Khayelitsha Day Hospitals, as well as to the pilot sites on programs for Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT). The Committee urged that Clinic Committees and Hospital Boards be established as a matter of urgency to facilitate improved governance of state health facilities.

Networking

Networking has been found to be an important source of both information and inspiration for Committees. The NACPH had the opportunity to visit Thailand among other countries, where discussions took place with the Health Ministry and other stakeholders on reforms in the public health sector as well as that country's responses to HIV/AIDS. In October 2002, the Health Systems Trust Equity Gauge Project made an insightful presentation on equity in health to assist the Committee in utilizing equity information and to further strengthen the Committee's oversight work. Present at this session were Zambian Parliamentarians who were also interested in advancing the equity agenda and democracy in their country. The Health Systems Trust Equity Gauge Project screened a video on the Eastern Cape's health services, which supplemented understanding of the on-the-ground challenges of achieving health equity in severely underfunded contexts. Swiss Members of Parliament also met with the Committee to discuss the magnitude of South Africa's health reforms as well as the prevalence of HIV/AIDS and its resulting challenges in the country.

The Committee received an intersectoral briefing by the Departments of Health, Agriculture and Environmental Affairs on Genetically Modified Foods (GM foods). The discussion focused on the safety of GM foods, food labelling and national food policy and regulations. The Committee concluded that a follow-up briefing should take place to determine how modern biotechnology could best be used, and how agricultural productivity could be raised without compromising human health and economic stability.

In Zambia the Committee on Health, Community Development and Social welfare was sponsored by the United Nations Children's Fund to undertake a comparative study visit to Senegal on HIV/AIDS. This enabled the Committee to come up with a detailed programme of action on how to deal with the pandemic.

The Committee also took up another dimension in their scrutiny of the Government policy on Health by approaching it from the Equity point of view. The Committee was approached by the Centre for Health, Science and Social Research (CHESSORE), a non-Governmental Organisation which is a member of the Global Equity Gauge Alliance (GEGA). The Committee was introduced to the concept of equity in the health sector and was sponsored to travel to South Africa, where they met South African Members of Parliament who serve on the Health Portfolio Committee and work closely with the Equity Gauge in South Africa.

In 2003, as part of their continued collaboration with CHESSORE and GEGA, the Committee adopted the following programme of activities with the Equity Gauge of Zambia:

- Travel to Chama and Chingola Districts for feedback sessions on district priorities with those respective District Equity Gauges, and to visit district health facilities.
- Zambia Health Budget Analysis meeting. This activity also offered comparisons between the South African and Zambian health budget allocations in terms of equity considerations.
- Holding of a Benchmarks Workshop involving the Cameroonian, Malawian, Zambian and South African Equity Gauges that focused on an approach to monitor improvements in health systems called the Benchmarks of Fairness for Health Reform.
- National Launch of the Equity Gauge of Zambia, to increase sensitisation to equity issues and increase public participation, and including a return visit by South African Parliament Health Committee Members.
- A study tour of Chile and Ecuador, where the Equity Gauges are very active.

4. THE BUDGET PROCESS

Whereas the Budget process falls within the ambit of Parliament's oversight as well as legislative functions, this process deserves special mention. When carrying out investigations on which aspects of Parliament's role in National Budget preparation required reform, the Reform Committee visited the German Bundestag. It is from the practices of the German Parliament that the idea of the Budget and Finance Committee was born.

In Zimbabwe, the Budget and Finance Committee monitors the performance of the budget through quarterly reports produced by the Ministry of Finance. The structure has now been devolved to Portfolio Committees, to give each sector in the process more specific attention. Each Portfolio Committee is expected to carry out the process in coordination with the Ministries that they

shadow. To this end, the Portfolio Committee on Health and Child Welfare carries out the following activities together with key stakeholders:

- January to May – consultation with stakeholders on proposals for the next fiscal year. For example the committee has in the past consulted civil society through medical associations, through the Community Working Group on Health, the different associations of health providers and others.
- May – August – analysis of quarterly Budget performance of the Ministry
- August/September – consider Ministry's bids sent to Treasury to determine the extent to which the Ministry has addressed stakeholder's concerns
- October/November – after Budget presentation in Parliament, evaluate to what extent the Treasury accommodated the Ministry's submissions. Reprioritise activities as per Treasury allocations and report to the House. Participate in the National Budget Workshop.

In the past two years, the Committee has engaged consultants to assist in analysing the budget bids and estimates of expenditure—a strategy used by Parliamentary Committees in other countries as well. There is a need to build in-house capacity to ensure sustainability and continuity, and to improve scheduling and timing of such support, as Committees have complained of the limited time allocated them to analyse the Budget and examine implications. The budget is usually presented at the end of October and has to be passed, and the requisite Acts assented to, by the President by 31st December, which provides insufficient time to study and to make useful contributions and equity implications *vis-à-vis* gender, the poor, rural/urban divides, etc.

Even when support for budget analysis is provided, though, improvements in equitable allocation may be difficult to ensure. The Committee has found it difficult to recommend specific changes in expenditure given the gross under-funding of all required activities. And although studies have shown that the Ministry's allocations have increased nominally by 15% in 2000/1 and by 105% in 2001/2 fiscal years, this increase is insufficient to mitigate the adverse impact of the country's hyperinflationary environment and translates to real reductions across most areas of expenditure.

Given the direct correlation between poverty and poor health, committees can feel powerless in such circumstances. In both rural and urban areas, the poor and marginalized people in society are more likely to seek treatment in public health facilities than in the private sector due to the cost of private services. Therefore, according to principles of equity, the poor should benefit more from government expenditure on public health services than the well-off. But since the majority of poor people live in rural areas, and since health sector budgets

tend to privilege urban areas, the poor are disproportionately and negatively affected by budget allocations in general, and often as well as by cuts in health sector expenditure. Equity concerns also arise in relation to gender issues, since women have greater need for medical facilities than men due to their reproductive role. Further, given that women also comprise the majority of the poor, they suffer gender inequities compounded by the inequities of the poor. When availability of reproductive health services of pre- and post-natal care, clean and safe delivery, essential obstetric care and family planning is limited due either to limited financial access or to underfunding of those services, women in particular are adversely affected, and society in general is affected since women are often caregivers of the family.

Budget cuts also have an adverse effect on various immunisation programs. Insufficient funds have resulted in shortages of essential vaccines within the public system, and at times even when vaccines themselves are available, transport for the staff to administer the vaccines at the correct time may not be available. Children in rural areas are more likely to be deprived of this service, and even when services are fully available, mothers are often unable to walk long distances to a nearest health centre to take advantage of such activities.

Given such constraints, there is work being done in South Africa, Tanzania, Namibia and Zimbabwe to establish resource allocation formulae within the health sector that incorporate indicators of disease burdens, poverty and health service deficits to ensure that scarce budget resources are equitably distributed[2].

In South Africa, working with the South African Equity Gauge Project, the Committee in South Africa has, for example, made recommendations for:

- A stronger equity component in the formula for allocating global budgets to provinces
- Reviewing provincial processes that determine resource allocations for the health sector within provinces
- Measures to reduce inequity between the private and public health sectors
- A national comprehensive human resource strategy
- Training of staff appropriate levels of care
- Redressing urban-rural inequity
- Clarity on the way forward with regard to the impact of HIV/AIDS and ensuring access to affordable medicines
- Seeking opportunities to strengthen public/private partnerships as a vehicle for providing care

[2] Pioneering work carried out in integrating deprivation into resource allocation by the Centre for Health Policy and Health Economics Unit Cape Town through EQUINET is now being tested in Namibia and Tanzania, while the Zimbabwe Equity Gauge has drawn from this and other experiences to carry out work on equity in resource allocation in Zimbabwe.

- Recognising that a response to HIV/AIDS has to be multi-sectoral and include poverty reduction strategies as well as measures designed to improve basic facilities, especially sanitation.

5. HIV/AIDS

It is difficult to overstate the adverse impact of HIV/AIDS in the region. About one-third of those living with HIV/AIDS in southern Africa are between the ages of 15 and 24. The demographic patterns of HIV/AIDS around the world, and in Southern Africa in particular, are changing. The death of those at the productive ages affects socio-economic structures and has devastating effects on Africa's ailing economies.

HIV/AIDS has had a deep impact on health and health equity issues in Southern Africa, imposing challenges in mounting a response to the epidemic that cuts across its economic, social and public health dimensions. Health care systems have been stressed by increased demand for care, while themselves suffering HIV/AIDS-related losses in health personnel. Household and community caring have complemented and sometimes substituted health care inputs. Where these lack adequate support they increase burdens on already poor households. As HIV/AIDS-related mortality rates have fallen with new treatments available in high income countries, treatment access has become a central issue, with campaigns on this in South Africa recently widening through the Pan African HIV/AIDS Treatment Access Movement. EQUINET has identified that equity challenges in HIV/AIDS arise across all areas of economic and social activity. Equity outcomes are affected by how wider public policy around trade, employment, poverty, social welfare and gender equity reduce risk environments and provide access to mitigation and care in poor households and communities. In health, the changes in demand for health care, and access to resources for prevention and care and the role of treatment in mitigation of future impact have made equity in access to treatment a critical issue for prevention, caring and mitigation of impacts of HIV/AIDS .

In response to the challenge of HIV/AIDS, the Regional Workshop on the Role of Parliaments in combating HIV/AIDS, held in Windhoek in February 2002 and organised by the SADC Parliamentary Forum, recognised that HIV/AIDS is a political issue, since decisions on policy formulation and allocation of resources for AIDS involve political choices. At the same time, the imperative to promote the public good and to use a human rights framework suggests that the HIV/AIDS challenge needs to be tackled in a non-partisan manner. Because political parties meet and interact within Parliaments, Parliamentarians were urged to work together with their governments in setting up new priorities for development in the light of the new challenge posed by HIV/AIDS.

The SADC Parliamentary Forum, as the platform for Parliamentarians in the Region, has played a crucial role in HIV/AIDS. Although a Standing Committee on HIV/AIDS was not among the original committees set up by the Forum, such a committee was established to allow dialogue and exchange of ideas on the issue among Parliamentarians. It is important to note that many Parliaments have now embraced the vision of the Forum and established dedicated HIV/AIDS Committees apart from the Health Committees in their legislatures in order to emphasize the special challenges this devastating disease poses for health sector development and for health equity.

At the Regional Workshop held in Windhoek, the Chairperson of the SADC Parliamentary Forum Standing Committee on HIV/AIDS, who is also a Member of the Botswana Parliament's HIV/AIDS Committee, gave an account of the operations of the Committee in Botswana. He outlined the vision of the Committee as "*a catalyst in the effective control and management of HIV/AIDS."* And its mission as
"to sensitise the public, to promote and lead the campaign against the spread of HIV/AIDS in partnership with National Aids Council (NAC)."

The Botswana Committee's Terms of Reference were

- To ensure and foster the highest political engagement and leadership in the multi-sectoral fight against HIV/AIDS across the political spectrum;
- To promote and lead prevention and mitigation efforts of HIV/AIDS by political leadership at both the local and national levels;
    - To guide and closely monitor the implementation of the national expanded response to HIV/AIDS as outlined in the Botswana Second Medium Term Plan II (MTP-II) for HIV/AIDS;
    - To mobilise extra budgetary resources, if need be, to facilitate effective management of the HIV/AIDS epidemic. (To this end, in 2000 the Committee embarked on a 137 kilometre sponsored walk entitled "*A Walk for Hope"* as well as a dinner dance whose proceeds amounting P50 000 were donated to two NGOs, namely the Coping Centre for People Living with HIV/AIDS (COCEPWA) and Botswana Network of People Living with HIV/AIDS (BONEPWA);)
    - To liaise with the National AIDS Council in the development, review and adoption of necessary and critical national policies and laws, and when necessary to ensure effective control and management of the HIV/AIDS.

In most SADC countries, the Health Committee covers HIV/AIDS, and their involvement has been limited to investigations/enquiries on how the Executive and other players are operating. In this they have adjudicated in areas where they have no direct involvement. In contrast, the Botswana committee has built strong and positive cooperation between Parliament, the Executive and all stakeholders. This has transformed the role of parliament ad taken it

beyond the traditional role of scrutiny/oversight on the executive towards a more active catalytic role on AIDS.

The Zambian committee has also played a more active role. The Zambia Committee on Health, Community Development and Social Welfare undertook an analysis in 1999 of the HIV/AIDS situation in Zambia, with the involvement of both Government and non-Government stakeholders. In 2000 the Committee, concerned with the escalating increase in HIV/AIDS infections, undertook a Performance Review of the Government policy on HIV/AIDS, another form of health impact assessment. The Committee was sponsored by the United Nations Children's Fund to undertake comparative study visits to Senegal and Botswana. Senegal was chosen because of its low HIV prevalence rate and active Anti-AIDS campaign, while Botswana was chosen because it had a high HIV prevalence rate, a similar socio-cultural background to Zambia and had delayed the response to the epidemic. The Committee eventually only toured Senegal, due to logistic problems. The Committee report on the study tour was adopted by the National Assembly.

Arising from this the Committee made recommendations that would see greater participation of Members of Parliament in health matters that relate to HIV/AIDS. The recommendations contained in the Committee's report to Parliament in November 2002 included:

- Government, through the National Assembly, should consider facilitating the establishment of reproductive health activities encompassing HIV/AIDS/STD prevention and control in all constituencies
- In order to sensitise the labour force, trade unions, in conjunction with the Zambia Federation of Employers and Chambers of Commerce and Industry, should incorporate HIV/AIDS prevention and control activities in their programmes at work places.
- Religious leaders should openly talk about the HIV/AIDS problem and advocate for fidelity, abstinence and care for the afflicted. Parents should also be encouraged to spend more time with their families.
- In order to sensitise school children on the danger of HIV/AIDS, government should consider introducing sex education encompassing HIV/AIDS information in the school syllabus.
- The Government should regulate social activities which are suspected to promote the spread of HIV, such as the sale of alcohol, and opening and closing times for bars and nightclubs.
- The Government, non-governmental organisations and community-based organisations should work together to set up telephone hotlines, and to provide free information and counselling to the public.
- The Government and all stakeholders should, as a matter of urgency, approach international drug companies and funding agencies to negotiate for a significant reduction in the cost of anti-retroviral drugs to improve accessibility among those in need.

- Regulations that prohibit the distribution of condoms in prisons should be removed, as there does not seem to be any other feasible way of halting the spread of the disease in prisons. Similarly, female condoms should be made available since females are better able to ensure their use and thus protect themselves from HIV infection.
- Members of Parliament and other decision-makers should strengthen their knowledge about the HIV/AIDS situation in Zambia, including awareness of main opportunities and challenges faced by the country.
- Members of Parliament should increase their active participation in regional networks of Parliamentarians in general, but particularly in the Forum for African and Arab Parliamentarian on Population and Development (FAAPPD). Such active membership would increase sharing of experiences and networking, as well as advocacy and lobbying of governments on matters related to HIV/AIDS. In addition, follow-up to various regional meetings should be strengthened.
- Members of Parliament and other decision-makers would benefit from workshops on Gender, HIV and Human Rights. Such training would provide these representatives and lawmakers with essential information on the challenges of the HIV epidemic and its gender concerns, and would equip them with the skills to address HIV/AIDS using a Human Rights approach. The training manual jointly developed by UNIFEM, UNFPA and UNAIDS would constitute a good tool for such training.
- A short information booklet that summarises the key Human Rights challenges in the fight against HIV/AIDS should be developed to inform a wide decision-maker audience.
- Government should consider hiring experts to look at the existing laws in Zambia and to develop laws that would address gaps in protection of the Rights of PLWHAs, dealing with wilful transmission of HIV, prevention of HIV transmission, that prohibit cultural practices that facilitate the transmission of HIV/AIDS (i.e. sexual cleansing); and establish a national system for monitoring the progressive development of HIV/AIDS-related legislation.

The Committee followed the more active approach taken by the Botswana parliament, viz that of establishing a consensus-building forum of all stakeholders to identify the roles of every sector, harmonise the working relationship of all stakeholders and to reduce suspicion.

These positive examples have more recently been consolidated by a SADC PF workshop communiqué on the role of Parliaments in Combating HIV/AIDS. *(see annex A).* In this all Parliaments in the region were urged to establish Parliamentary Committees on HIV/AIDS, get involved in national activities and review legislation related to HIV/AIDS. The Forum was tasked to be an information centre for Parliaments on HIV/AIDS among other matters. The SADC PF has since then developed guidelines for gender

mainstreaming on HIV/AIDS and has defined the role of Members of Parliament in the process.

6. CONCLUSIONS

This paper highlights the effectiveness of the Committee system in strengthening the parliamentary role in the health sector, even over the very limited time in which they have been functional. In particular the committee system has provided a vehicle for involving stakeholders in parliamentary oversight, legislative and representational roles and in drawing technical and financial resources to support more in depth work by parliament.

This last section summarises some of the major opportunities and constraints for parliaments to further develop this role.

6.1 Opportunities

Parliaments are in charge of their own rules of procedure and most Parliaments have used this opportunity to transform themselves into more effective institutions. The new wave of Parliamentary reforms in the region has created parliaments that are more responsive to the needs of the people. Public hearings, on site visits and the opening of new Parliamentary Constituency Centres offer space for stakeholder inputs.

The work of Committees highlighted in this paper demonstrate what can be achieved when Parliaments work with various stakeholders in civil society and with other development partners.

The new legislative processes such as those described in South Africa and Zimbabwe give opportunity for more thorough analysis of bills before they are passed by Parliament, with participation and input by stakeholders during committee discussions. 'Fast tracking' of bills could at times hinder this process, but there are now mechanisms in place to ensure a pro equity legal review process and this is a good start. This process becomes even more beneficial when Parliament through its committees is afforded the opportunity to analyse the bill in its draft form.

Parliaments can and should review international treaties before they are signed and can tap the resources of civil society and academic institutions towards this.

They can also improve the monitoring and oversight of the implementation of treaties, laws and commissions through gathering evidence on their application, through methods described in this paper such as site visits and hearings.

The experience of the Botswana parliament on HIV/AIDS and of the Zambian and South African parliaments demonstrates that Parliaments will be more motivated towards equity issues when they are exposed to grassroots experiences. The paper indicates a number of vehicles for parliaments to use for obtaining such experience and enhancing the voice of the poor in parliamentary processes, including hearings, site visits, study tours and surveys.

Such processes have motivated parliaments to investigate key health sector issues and advocate for improvements. There is evidence in this paper of parliaments taking up equity issues in relation to inter-provincial inequities, referral systems, establishment of management boards and committees, in allocation formulas; in human resource strategies and in HIV/AIDS.

Parliaments also need information and inspiration. There are numerous examples of parliaments obtaining this through networking nationally and internationally, such as in the Zambian experience after visiting Senegal and South Africa. These visits helped the Zambian parliament to come up with a detailed plan of action. The Parliament of Zimbabwe came up with the re-engineered budget process after studying the work of the German Bundestag. This input has been recognised by the SADC PF in setting up regional co-ordination and information support to parliaments on HIV/AIDS.

6.2 Constraints

While there are clear opportunities for such work, there are also significant constraints.

The economic environment in the region operate is very challenging Parliaments are confronting equity issues at a time when health resources are diminishing, the challenges to equity are growing and when their own technical and financial resources are extremely limited. The challenge of HIV/AIDS is an enormous one that covers all sectors, not simply health. The proactive work of the SADC PF to mobilise and co-ordinate the political response to that challenge in parliament indicates the value of regional networking to support national action.

The Executive and officials in the state often do not share information with the Legislature at planning stage. For example, parliaments may only be informed of international treaties and agreements after they have been signed and brought to Parliament for ratification. It then becomes difficult for the legislature to embarrass its government by refusing to ratify, impeding adequate assessment of such treaties.

It must also be borne in mind that Parliament is in essence a political institution and its composition comes about through contestation in elections.

It would thus be very difficult for a member of a ruling party to defeat what his/her government would have agreed upon. This is felt in discussing the national budget or bills. It is therefore important that information be provided and discussions held *before* finalisation, as is happening in the re-engineered budget process in Zimbabwe.

Parliament's role is not to govern, that is the function of the Executive. The Legislature can recommend but it is up to the Executive to accept or reject such recommendations. Where relationships between Parliament and the Executive are good, the Executive will give reasons why it cannot implement particular recommendations. In other instances the Executive may use the political party machinery to secure support and compliance from its members.

Although Parliaments have become more open to public participation, this participation is generally not equitably distributed. It is often those people living in urban centres who have the opportunity and means to engage parliaments. Public hearings are ordinarily held in urban centres and this deprives rural people of the opportunity to participate in the legislative process. In the health delivery sector, it is the poor who are most affected by policies yet they have least opportunity to input in the policy making process. This also applies to the urban poor or particular social groups such as youth and women who may lack the resources, time, information or social networking to participate in parliamentary processes.

While some of these constraints are formal and relate to the parliamentary role, others can be overcome. Widening the application of current mechanisms emerging from parliamentary reforms would spread current good practice in the region. Improved networking with technical institutions, with civil society and between parliaments will strengthen the information and technical support of parliaments and inform political choices. Equity reflects the social value assigned to inequalities that are perceived to be unfair and avoidable. This paper demonstrates that parliaments can play an important role in giving voice to that social value, promoting and monitoring its application.

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