



**Southern African Regional Network on Equity  
in Health (EQUINET)**  
**Global Equity Gauge Alliance (GEGA)**  
in co-operation  
with the

**Southern African Development Community (SADC)  
Parliamentary Forum**



## **MEETING REPORT**

### **PARLIAMENTARY ALLIANCES FOR EQUITY IN HEALTH IN SOUTHERN AFRICA**

**20-22 August 2003  
Gauteng, South Africa**

**With support from IDRC, Rockefeller, SIDA and NDI**



Southern African Regional Network on Equity in Health (EQUINET)  
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## **RESOLUTIONS OF THE MEETING ON PARLIAMENTARY ALLIANCES FOR EQUITY IN HEALTH IN SOUTHERN AFRICA**

**20-22 August 2003 Gauteng, South Africa**

A meeting of representatives of parliamentary committees on health, health professionals, civil society and co-operating organisations from Kenya, Malawi, South Africa, Tanzania, Zambia, Zimbabwe and SADC Parliamentary Forum, hosted by EQUINET and GEGA in co-operation with the SADC Parliamentary Forum confirmed the policy commitment in the region to equity in health and acknowledged the ongoing work towards implementing health equity policies. The meeting urged that greater effort be made to deal with differences in health status and access to health care that are unnecessary, avoidable and unfair.

The meeting noted that achieving health equity in the region demands that countries address economic, governance, food security, HIV/AIDS and other major challenges to health and for countries to create and protect sustainable, equitable and participatory health systems that are provided with adequate material and human resources.

Achieving health equity calls for countries to allocate more resources towards those with greater health needs, and depends on the extent to which different groups of people have the opportunity for participation and the power to direct resources towards their health needs. To this end, the meeting agreed that parliamentary committees on health promote health equity in the budget process.

The meeting noted that parliaments have an important role in promoting health equity through their representation, legislative and oversight roles. Parliaments can build alliances with the Executive branch of government, across political parties, between different portfolio committees and with civil society, health sector and other agencies at national and regional level in support of these roles.

The meeting observed with concern that some multilateral trade agreements do not fully address the health and development interests of our countries and region and, affirming the position of African Trade Ministers in Mauritius in June



2003 on the upcoming World Trade Organisation (WTO) 5<sup>th</sup> Ministerial Conference in Cancun, Mexico resolved to recommend that

- Countries protect their government authority in all trade agreements to safeguard public health and regulate services in the interests of public health;
- Government trade negotiators consult health ministries, parliamentary health committees and civil society on positions to be taken to trade negotiations for their public health implications;
- Governments assert their rights under the Doha Declaration on Trade Related Aspects of Intellectual Property Rights (TRIPs) and Public Health to define what constitutes a public health problem;
- Governments strengthen their efforts to take full advantage of the flexibilities and policy measures allowed in TRIPs to access cheaper medicines and protect indigenous knowledge systems;
- Governments ensure that national laws and regional policies provide for compulsory licensing, parallel importation, 'government use', and production of generic drugs;
- Given the central role of nutrition and food security in public health, countries retain the right to raise tariffs and demand elimination of subsidies on exports to protect food sovereignty in agricultural production;
- Governments not make any commitments under the General Agreement on Trade in Services (GATS) in health or health related services that compromise their right to regulate according to national policy objectives;
- Countries conduct a comprehensive 'health check' on GATS commitments made or proposed so far, with the active involvement of health ministries, parliamentary health committees and civil society;
- Countries call for a change to GATS rules that restrict them from retracting in commitments already made under GATS.

In line with the above, the meeting proposed that parliamentary committees on health request Trade Ministers to report to them on the negotiating positions to be taken to the 5<sup>th</sup> WTO Ministerial Conference in Cancun, Mexico, refrain from making commitments that conflict with the above provisions and report to parliament on the outcome after the WTO meeting.

The meeting recognised the importance of regional networking, policy and alliances within SADC and COMESA to defend and protect public health and health equity interests in Africa in the face of these challenges. The meeting proposed that health equity and trade and health issues be formally raised as an agenda item in the forthcoming SADC Parliamentary Forum meeting.

## REPORT OF A

**Regional meeting on  
PARLIAMENTARY ALLIANCES FOR  
EQUITY IN HEALTH IN SOUTHERN AFRICA**

**EQUINET, GEGA, SADC PARLIAMENTARY Forum  
Gauteng, August 2003**

## **1. Background**

Periods of significant gains in health in southern Africa have been a product of social action, directed resource investment and technical inputs. Despite these efforts, inequities in health inputs, in provision of and access to health care resources, and in health outcomes persist. While there are a variety of strategies to reduce inequities, legislatures (parliaments) are in a key position to enhance processes and decision-making to support the development of equity-sensitive policies and to monitor the implementation and effects of those policies. Parliaments have a range of representative, legislative, and oversight roles that have an impact on equity in health. There is evidence from existing experience that where parliamentarians are given the information and the requisite technical support, they are able to effectively carry out these responsibilities, with positive impact. Despite this, professionals and civic organizations working on health equity often do not sufficiently understand parliamentary processes to effectively support or work with them and parliaments may not be adequately linked with professional and civic networks working on health equity. Strengthening the processes of policy making, implementation, and monitoring would strengthen health equity initiatives.

There are already initiatives taking place in Malawi, South Africa, Zambia and Zimbabwe to build linkages between professionals, civic groups, and state officials working on equity in health with parliamentarians and parliamentary processes. Parliamentary reforms in the SADC region and the presence of a SADC Parliamentary Forum have strengthened the role of parliament in policy, law, and budget processes, and make these links even more important for implementing national pro-equity policies. Parliamentarians have sought support in terms of information, evidence, and capacities to strengthen their role, while civic and professional organizations have sought to link with the representative, legal, and budgetary authority of parliament.

The Regional Network for Equity in Health in Southern Africa (EQUINET) and the Global Equity Gauge Alliance (GEA) are both networks carrying out work to support pro-equity policies through evidence, engagement, and advocacy. EQUINET covers southern Africa and has formal links with SADC in relation to this work, while GEA works to support pro-equity capacity development and action within portfolio committees on health in several countries (see [www.equinetafrica.org](http://www.equinetafrica.org) and [www.gega.org.za](http://www.gega.org.za)). EQUINET has active work within eight SADC countries. There are Equity Gauges affiliated to GEA in developing countries around the world, including four in the SADC region. EQUINET and GEA have begun a programme of work that seeks to

- strengthen and provide information and resource inputs for the partnership between parliament, professionals, and civil society to work towards building a common platform for health equity
- support networking of parliamentarians through their Portfolio Committees on Health, the secretaries/clerks to these Portfolio Committees, with technical

- and civil society personnel to enhance common work on health equity at the national level in several countries
- Provide information and technical support to national parliaments and to the SADC Parliamentary Forum on international protocols and agreements that have relevance to health in order to strengthen parliamentary responses and promote health equity within SADC positions on these policies.

To initiate this [programme](#), in co-operation with the SADC Parliamentary Forum, EQUINET and GEGA held a regional meeting in East Rand, South Africa on 20-22 August 2003. The meeting included delegates from parliamentary committees on health and their technical staff, resource personnel with experience in health equity and parliamentary technical support institutions from countries within the SADC region and from the SADC Parliamentary Forum and [HIV/AIDS Programme](#). The delegates list is shown in Appendix 1. [Unfortunately, subsequent to the dates for the meeting having been finalised, the long awaited South African National Health Bill was tabled. The Bill was being processed by Parliament during August, making it impossible for members of the South African National Assembly portfolio committee on health to attend the meeting.. They sent their apologies.](#)

The meeting aimed to

- Review current work and health priorities of parliamentary committees on health,
- Review current research and programme work on health equity that could be a potential resource base for parliaments,
- Review international trade protocols and agreements for their health equity implications at national and regional level
- Discuss possible areas of follow up work and co-operation between parliaments and professional and civic resources working in health.

The programme for the meeting is shown in Appendix 2.

The meeting was supported by IDRC (Canada), SIDA (Sweden), Rockefeller, [and the National Democratic Institute \(Malawi\)](#). State University of New York (SUNY) self-funded their delegates. The report outlines the main issues presented and arising in the meeting. Rapporteur at the meeting was through GEGA and EQUINET and the report has been compiled by TARSC. The full papers presented are being produced as separate discussion papers.

## **2. Welcome, opening and introductions**

The delegates were welcomed to the meeting by GEGA and EQUINET at an opening dinner. Both GEGA and EQUINET expressed the importance of the link between the legislators and the wider community in civil society and government working on equity in health. These opportunities made this meeting an important step in forging these links, and both organisations were committed to supporting follow up activities. The objectives of the meeting were introduced (stated above). EQUINET and GEGA were also happy to have in the meeting, in addition to the many people from civil society and other institutions working on health equity, representatives of institutions that have provided support to parliaments in the region (NDI, SUNY, IDASA). The apologies of Dr Mutukwa of the Southern Africa Development community (SADC) Parliamentary Forum were given by Mike Mataure, PAPST, noting the important commitment in Zambia that he was undertaking. He welcomed the delegates and wished them success in their deliberations, noting the critical role played by parliaments in the region. A traditional theatre/dance group, The Talented Boys, provided a stirring conclusion to the opening.

## **3. Equity in Health: National and Regional Priorities**

In the session the following morning, the objectives and programme were discussed and delegates introduced themselves and their areas of work. Dr Rene Loewenson presented a short brief on promoting equity in health in southern Africa.

*'The top three billionaires in the world own more than the combined GNP of all the least developed countries and their 600 million people' (UNDP 1999)*

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. To achieve equity, she noted that resources should be allocated preferentially to those with the worst health status; and that higher income groups should contribute proportionately more than those with fewer resources.

Dr. Loewenson noted that health status varies widely across countries of the SADC region, and within countries between rich and poor. Economic growth alone has not mitigated poverty, and global trade, investment and financing patterns have not facilitated the distribution of societal resources towards addressing basic health issues. Health status has thus been affected by the poor quality and insecurity of employment, by falling real incomes, and by reduced social protection. These negative outcomes have been exacerbated by the impact of a severe HIV/AIDS epidemic in the region. Health services have become more costly and less accessible, particularly for poor communities in the region.

Public policy can, however, make a difference in these circumstances. Evidence of positive health outcomes in countries with low per capita GNPs who have directed resources towards primary health care and district health services indicate that it is not only *how much*, but *how* resources are spent that influence health outcomes. This makes public policy important for equity, particularly in how resources are allocated to and within health, the mix of public – private services, health personnel policies, policies for ensuring treatment access, and ensuring that trade and economic policies protect public health.

Experience in the region and multi-country research carried out by EQUINET indicates that health systems can improve health status in high risk groups and reduce health inequalities by

- redistributing budgets towards prevention;
- improving access to and quality of rural, informal urban and primary care infrastructures and services;
- deploying and orienting health personnel towards major health care problems;
- supporting personnel with adequate resource inputs;
- ensuring fairer distribution of resources between the public and private sector providers;
- investing in community based health care;
- encouraging effective use of services, by improving dissemination of information on prevention and early management of illness; and
- removing cost barriers to primary care services at point of use.

Despite these findings, health resource distribution continues to be uneven, with significant shares going to higher income users of private services, to richer districts and to urban services. Research shows that new resources for AIDS treatment could intensify these existing inequalities, including gender inequalities, if they are not also used to strengthen the personnel, diagnostic services, forms of care and district health systems used by the majority of the population.

Underlying these problems, the diminishing resource flows from the global community to southern Africa, both in aid and as returns from trade, indicate the deeper need for southern African countries to advance and protect their health rights and systems within an increasingly hostile and predatory global environment.

After the presentation the delegates divided into country groups (two countries per group) and a regional group to discuss the priorities of parliamentary agendas generally and in health, the impact that they are having and the areas where they seek to have more impact. These views were then discussed in the plenary.

**Priorities of parliaments generally and in health** are shown in the table below

| COUNTRY      | GENERAL PRIORITIES   | HEALTH PRIORITIES   |
|--------------|--|---|
| KENYA        | Fighting corruption, Poverty reduction, Wealth creation, national security, Education, HIV/AIDS, Constitutional review | Resource allocation to health; HIV/AIDS /TB / Malaria control; Health sector reforms particularly financing; Resource allocation; Reduce donor dependence |
| MALAWI       | HIV, Economic stability; Agriculture and food security; Education; governance  | HIV; Health systems; Material resources and Human resources   |
| SOUTH AFRICA | Economy, welfare, education, security  | HIV/AIDS, District health system, decentralization, Human resources   |
| TANZANIA     | Agriculture, especially for food security and to overcome adverse trade conditions, education and infrastructure       | Fairness, decentralization, National Health Policy HIV/AIDS, Malaria multi-sectoral approach, Food security and agriculture; Education.                   |
| ZAMBIA       | HIV/AIDS, Agriculture and Food security; Governance ;  | HIV/AIDS; Health systems especially the Material and human resources;   |

|          |  |   |
|----------|--|---|
|          | Reform of health systems   | Geographical and financial access to care   |
| ZIMBABWE | Political stability, Economic growth/ food security/ poverty, HIV/AIDS, Constitutional review, Fighting corruption   | USD23 per capita to health; More public funding; resource allocation; enhance preventive and promotive services; human resource provision; quality, access to care and essential drugs and ART, malnutrition  |
| REGIONAL | Economic issues (poverty trade and globalization); Governance issues (legitimacy of the outcome of the elections, conflicts and peace) HIV/AIDS and declining health delivery system | Disease control<br>Strengthening health systems; Human resources; Standards and protocols; Sexual and reproductive health including HIV/AIDS; Access to drugs (procurement, production and pricing); Food security and nutrition; commodification of health |

It was noted that the wider economic and social priorities have direct links to the health priorities:

- Economic policy influences job creation, incomes and thus health
- Economic growth can only be built on a health population
- The welfare system has a direct link to poverty alleviation and managing HIV/AIDS
- Education is critical for promoting health and for channelling programmes like supplementary feeding through schools
- Fair agricultural trade influences food security
- Good governance is linked with improved social delivery, including health
- Governments whose governance or credibility is weak have difficulty engaging communities on health issues.

HIV/AIDS is a commonly shared priority across the region, as are economic development, governance and security issues. Within health, dealing with HIV/AIDS, Malaria and TB are prioritised. It is recognised however that wider economic and political action is required, in addition to health care reforms and revised health financing policies, if poor communities are to access a reasonable quality of care.

### **Areas where parliaments are having an impact in relation to health:**

| COUNTRY      | AREAS OF IMPACT  | AREAS WHERE MORE IMPACT IS SOUGHT  |
|--------------|--|--|
| KENYA        | Advocating for appropriate policies and increased resources to health.                       | Stronger role in monitoring the delivery of health services and policies. Need to strengthen capacity and technical support  |
| MALAWI       | Monitoring and oversight   |  |
| SOUTH AFRICA | Budget oversight, especially to ensure equity  | Overcoming party politics for a more effective response to AIDS; dealing with unfair aspects of the private-public mix so markets do not undermine health              |
| TANZANIA     | More attention now being given to rural areas, especially in budgets and to pro poor budgets | To strengthen community participation in formulation of policies, ensure effective communication with constituencies and have improved information to argue their case |
| ZAMBIA       | Budget oversight, advocating for appropriate policies  |  |

|          |   |   |
|----------|---|---|
| ZIMBABWE | Advocating for appropriate policies and increased resources to health.  | Legislation formalising health centre committees; Stronger role in monitoring the delivery of health services and policies. Need to strengthen capacity and technical support. Overcome resistance from the executive.  |
| REGIONAL | SADC parliaments established standards of good governance, defined roles of parliament; identified areas of common interest (HIV/AIDS, budget and elections) and established an informal peer review process. | Regional drug bulk purchasing; Sharing best practices; acting as watch dogs; Set health care and financing standards; Need to overcome the lack of a clear mechanism for enforcing regional decisions and limited appreciation of regional agreements and co-operation. |

In general, parliaments are having an impact through their oversight and budget roles and in drawing attention to the needs of underserved communities. The feedback from delegates indicated a desire to strengthen their monitoring and oversight roles in health to strengthen health systems and to ensure that the interests of poor communities are met. Parliaments were also seen to have a role in setting and monitoring standards of financing and health care provision. For this they need better information and technical support. They also need to overcome resistance from the Executive to their roles. National parliamentary roles can be complemented by regional support on standards, but equally need support for their enforcement.

#### 4. Parliamentary roles in Health

Mike Mataure (PAPST) presented a background paper on 'Parliamentary Functions and Reforms and their application in promoting Health Equity in Southern Africa'. The paper, commissioned by TARSC for EQUINET/GEGA is presented as a separate discussion paper.

Mataure noted that Parliaments have been called upon to be more effective in carrying out their functions of 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 participation 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 potential valuable role of these committees in health. The Portfolio Committees have managed to carryout the oversight function through their investigations and have influenced the process of review and enactment of health related laws. 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 reforms of the last decade, parliaments and their committees have established good working relationships with the public, 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 and promotes 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.

A number of opportunities for parliaments to promote health equity have been identified. Parliaments are in charge of their rules, which they can revise to become more efficient and effective when they commit themselves to reforms. Secondly, the vibrant civil society in the region continually 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 for pro-equity legislative analysis by allowing participation by stakeholders in bill analysis during committee scrutiny.

Mataure also identified constraints. These included 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. In response to such constraints, he proposed that parliaments negotiate the political space to function effectively through strengthening their links with constituencies and the public, and through managing their relations with executives in a non-confrontational manner. He noted the value in some parliaments of directly seconded experts and the critical role that parliaments can play through public hearings and their public interface in shaping social attitudes, including those that advance health equity.

In the working groups, delegates explored how these roles could be effectively used to respond to the priority health issues raised in the earlier session. Kenya and Tanzania discussed HIV/AIDS, Malawi and Zimbabwe discussed Health sector Reforms and Health budget and resource allocation, and South Africa and Zambia discussed food security and nutrition.

**On HIV/AIDS**, the group stated the major equity goals to be access to ARVs, to quality services and to information for effective use of services. They noted the need for improved multi-sectoral capacity and action in responding to the crisis. Most importantly, they identified the need to move beyond rhetoric to real commitment of national public resources.

In taking up such priorities parliaments were identified as having a role in

- Making sure that laws protected access to generic drugs and their local manufacture
- Disseminating information and mobilising public support for action on AIDS
- Mobilising resource allocation for relevant AIDS and health care interventions.

To support these roles, MPs should create inter-party parliamentary alliances that can reach out to NGOs, religious organizations, civil society, media and others, for which parliaments will need financial resources, human resources, technical input and communications and advocacy strategies.

On **Health sector Reforms and Health budget and resource allocation**, the group noted the major equity goals to be

- Improving public participation and accountability in health systems
- Improving access to and quality of health care
- Raising new sources of financing, including community contributions and through health insurance
- Giving greater power to districts and health institutions (hospitals) to manage their affairs

Parliaments were seen to have a role to play in promoting the achievement of these goals through

- Creating a platform for public information and input (e.g. through hearings, consultative budget processes)
- Budget oversight and monitoring
- Ensuring the establishment of mechanisms for public participation from national to community level, including in health reforms and health financing policies

To support these roles, parliaments would need to build alliances with both **civil society** and **the Executive** including forming links with government ministries and tapping into civil society expertise. Opportunities were also identified to create regional linkages and to work with both the private sector and health professional associations. It was also noted that taking up issues of health financing and health systems demands linkages across parliamentary committees in different sectors, which requires increased capacity and resources within the parliamentary committees, technical expertise, research resources and capacity building to support MPs.

On **food security and nutrition**, the group highlighted equity priorities including the need to address HIV-food security links, both through making treatment available and through ensuring that those on treatment with ARVs have good nutrition. They noted the need to address food security at household level, through improved production and incomes, and at national level through improved process for agricultural commodities.

Parliaments can play a role in this by

- ensuring that laws protect food safety and security and by monitoring law enforcement.
- promoting health in public attitudes and in policy measures for food security in relation to the pattern of crops produced, the land allocation systems, and the trade agreements entered into by the executive, amongst other inputs.

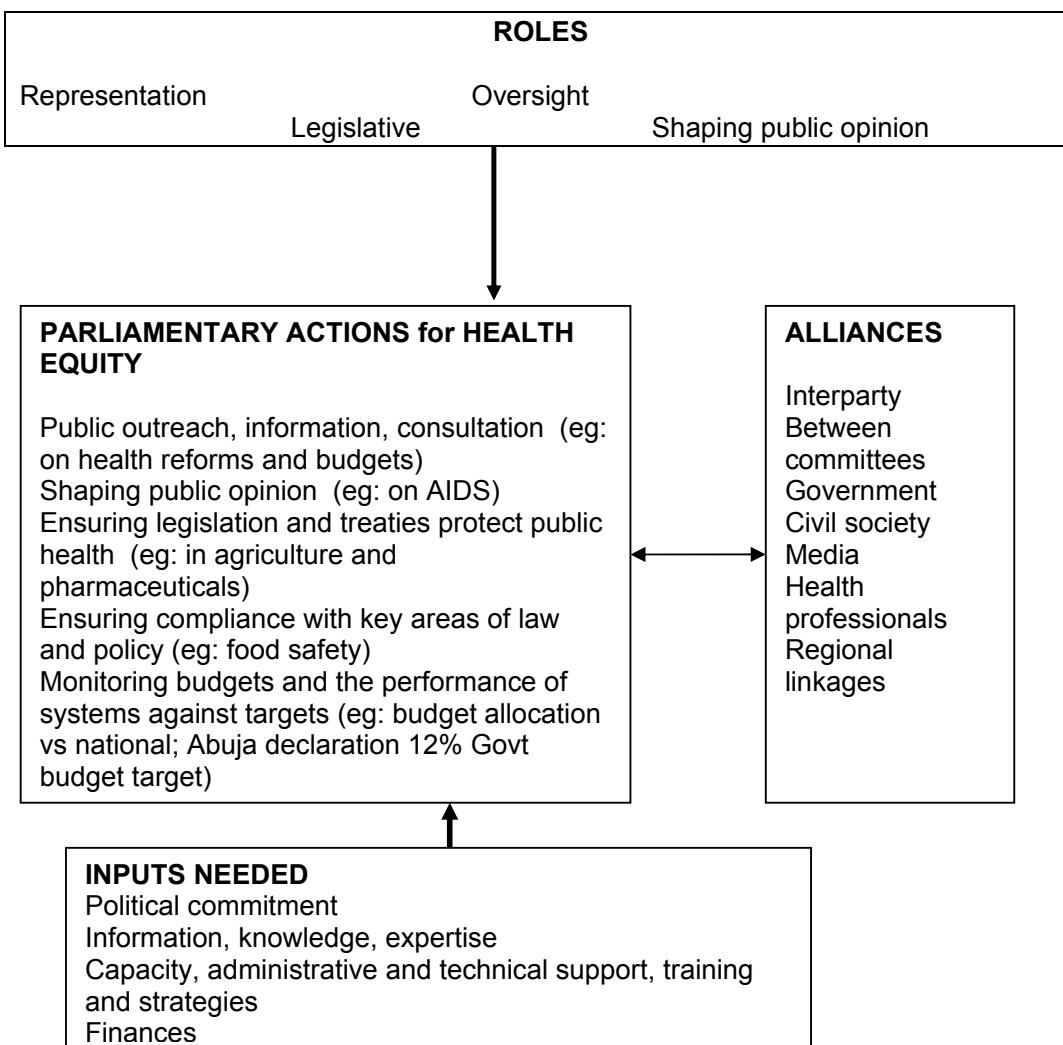
Fulfilling these roles demands information and cross-sector collaboration. It was noted that parliaments are sometimes given very short notice to review international

agreements before ratifying them and that this can undermine their role in ensuring that national policies are followed and public inputs are obtained.

In order for such long-term issues to be addressed, the groups mentioned the need for increased stability in parliaments, for effective technical and administrative support of parliamentary committees, and for a clear policy framework to be developed to enable parliaments to sift through the significant volume of information they are given in order to identify the issues and responses that best promote health public policy.

The figure overleaf summarises the critical roles that parliaments have, the way that these can be used for supporting health equity, and the inputs and alliances needed for this.

**FIGURE 1: PARLIAMENTARY ROLES IN HEALTH EQUITY**



## 5. Promoting health equity in regional and global trade agreements

Yash Tandon and Riaz Tayob (SEATINI) presented a background paper on Trade protocols and Health: Issues for Health Equity in Southern Africa. The paper, commissioned in an EQUINET/SEATINI programme, is being produced as a separate EQUINET discussion paper.

The presentation addressed why health services are being liberalised, noting that the crisis of profitability and demand for access to resources in the North has intensified the pressure to open new markets, including for trade in services. While in theory these changes in the global trade environment are supposed to be reached through consensus, in practice African countries have significantly more limited negotiating power at platforms like the WTO, particularly if they try to deal with issues individually.

In the coming WTO Ministerial conference in September 2003 in Mexico, a number of issues will arise that the presenters reviewed, including

- market access and subsidies for agricultural commodities
- protection of the ground gained at Doha to protect public health in the agreement on Trade Related Intellectual Property Rights (TRIPS) for developing countries to parallel import or compulsory license drugs needed for public health
- dealing with trade in services under the General Agreement on Trade in Services (GATS), and particularly ensuring that commitments made do not undermine government ability to regulate health services
- non-agricultural market access and
- opening to new trade issues while commitments made to resolve bias in the current WTO system remain unaddressed.

The presenters highlighted the components and issues related to health and health equity issues particularly in the TRIPS and GATS agreement, and the options that countries had in each to protect health. Options raised included:

- Preventing/reducing any further international trade commitments that will limit policy flexibility, specifically:
  - New or further GATS commitments;
  - Agreements on the “New Issues” – Competition, Transparency in Government Procurement, Trade Facilitation and Investment.
- Legislating and using the maximum allowable exceptions under the TRIPs agreement, i.e. for compulsory licensing, domestic production, parallel importation of drugs
- Legislating independent intellectual property rights regimes to protect local innovation, e.g. in traditional medicines
- Liaising with Departments of Agriculture and International trade and making inputs that promote food sovereignty
- Seeking the elimination of agricultural subsidies and resisting the demand for a reduction in agricultural tariffs
- Establishing and supporting local SPS and standards generating bodies and developing regional SPS standards
- Seeking a declaration from the WTO Ministerial conferences that prevents the patenting of life forms
- Prioritising the SADC-stipulated 12,5% minimum budget distribution to health.

The presenters tabled the positions reached by the 15 African Trade Ministers in Mauritius and noted the importance of the executives not committing to issues at WTO that diminish the sovereignty or rights of people without first coming back to the people. This was important if the balance needed for health was to be achieved in the imperial, governance and social factors influencing health in the region. Finally, it was noted that the region would be stronger in pursuing such negotiations and in building a development path more suited to the needs of its people if it co-operates and engages as a regional block and if it strengthens its internal economic interaction.

The discussions that followed the presentation explored the actions that countries and parliaments can take to protect health equity in the current global environment. The groups felt that the meeting needed to make a clear resolution on the matters discussed to take back to national and regional level on health issues and ways forward on trade-health issues.

## **Actions to protect public health under globalisation**

### **1: Information and debate:**

Parliamentary committees should

- Engage the Ministries of Foreign Affairs to create rapport and access trade agreements, protocols and treaties (this information can then be used in discussion with the relevant government authorities)
- Stimulate debate on the nature and implications of TRIPS and GATS in parliament and more widely
- Draft a summary from this meeting of issues, costs and benefits of the trade agreements for health that need to be discussed with relevant stakeholders
- Strengthen information dissemination to and capacity of all parties in parliament to review trade-health issues, e.g. through joint half-day seminars of health and trade/finance committees
- Build national and regional consensus on positions to be taken to global forums
- Identify technical groups (e.g. SEATINI, EQUINET and GEGA) who can support capacity input and information in this area
- Provide supporting information accessible across the region (e.g. available drugs (patented or generic) production, capacity, price, delivery systems)
- Promote solidarity campaigns to create momentum in resisting/opposing policies that promote inequity

### **2: Oversight:**

- Present a motion/question in parliament to trade ministers on the concerns on TRIPS and GATS and request information before and after the WTO meeting
- Request ministers to report back to the House on the content, outcome and impact of decisions taken at the 2003 WTO meeting in Cancun Mexico And future WTO meetings
- Categorise trade agreements, protocols and treaties to determine which require Cabinet decisions, parliamentary sanction or general public consultation
- Aim to improve the representation of health in the delegates that attend future WTO meetings
- Ensure rights to reverse commitments that harm public health
- Ensure proposals on agreements are tabled/ discussed in parliament at strategic times
- Monitor the implementation of existing agreements.

### **3. Policy, legislation, and regional action**

- Strengthen regional blocs as a basis for global engagement
- Organise regional bulk purchases of drugs to push down the prices
- Share information on disease management and treatment guidelines between countries of the region
- Ensure policies are formulated to curtail the brain drain, increase the number of health personnel in public service and encourage those who have left the public sector and region to return
- Promote at regional level legislation to protect indigenous knowledge
- Set standards regionally in health related areas.

## **6. Follow up actions**

The session on follow-up actions was initiated by country discussions on how they would take up one particular cross-cutting issue, that of budget review. The discussion on this was used to identify common areas of action and support for a follow-up programme of work and the resources that would be necessary for such work.

A resolution from the workshop developed by a drafting group representing countries and different types of participants was tabled in plenary, discussed and adopted.

Finally EQUINET and GEGA presented their areas of work (available at [www.equinetafrica.org](http://www.equinetafrica.org) and [www.gega.org.za](http://www.gega.org.za)) and the ways in which the networks would follow up from the meeting.

### **Country work on equity oriented health budget oversight:**

The proposals made by the countries are shown in brief below.

#### **6.1 MALAWI**

The Malawi team proposed that they would

- Brief other members of the health committee, stake holders, etc. on the deliberations of the meeting and revise the parliamentary health work plan to include follow up issues arising from the meeting
- Review the budget recently passed to identify equity concerns
- Monitor through the health committee the monthly treasury allocation to the Ministry of Health and the implementation of health services targets
- Meet to brief and discuss with the Ministry of Trade and Industry the trade-health issues identified at the meeting
- Ensure that projects important for health equity (e.g. drug procurement) are implemented

#### **6.2 ZIMBABWE**

- Ensure all relevant civic organizations and stakeholders are formally included in the budget process
- Review the budget from an equity framework, with supporting information and data, particularly in terms of pro-poor policies and outcomes
- Ensure that the equity analysis covers poverty; gender; HIV/AIDS; disability; and the elderly, and include submissions from interest groups for these areas backed by supporting statistics
- Apply an equity analysis to both capital and recurrent budget areas, and to specific areas like tax and subsidy policies
- Work to overcome government fear of negative statistics
- Proactively invite support from and learn from other countries experiences and build regional alliances, e.g. through SADC, EQUINET and GEGA.

#### **6.3 ZAMBIA**

- Build on the existing work by the Zambia Parliamentary Committee on Health Community Development and Social Welfare towards including equity in the budget process
- Work with CHESSORE at the time of budget process to look at the inequalities inherent in the budget
- Hold periodic meetings to review the budget process
- Maintain alliances with GEGA and EQUINET at regional level

- Make alliances with other committees that deal with sectors like Education, Water and Sanitation, Commonwealth, Agriculture, etc., which are factors that affect equity of access to health services
- Make alliances with NGOs dealing with HIV/AIDS and the National AIDS Council to ensure equitable distribution and allocation of Anti-Retroviral drugs and resources to combat HIV/AIDS
- Engage the Ministry of Health before the budget is presented to make suggestions on how to address the equity aspects in the budget
- Monitor use of the medical levy of 1 percent on interest earned on all savings accounts as a cross-subsidy to the health sector.

#### **6.4 KENYA**

- Create opportunities for awareness raising and advocacy by GEGA/EQUINET and other stakeholders with respective Ministries of Health/Treasury on inequities in health
- Enhance the capacity of parliament and particularly committees in fulfilling their respective mandates
- Build partnerships between the various interest groups with the health committee in analyzing and understanding the budget (e.g. through a workshop on budget analysis)
- Introduce a private members bill to empower members to make contributions regarding equity not only in health but also in education and other areas
- Provide policy briefs to members to assist them to understand the issues involved in the achievement of equity.

#### **6.5 TANZANIA**

- Carry out an inventory of ongoing work on resource allocation taking into an account equity issues (thereby establishing a baseline for such work)
- Collect experiences in Tanzania and other countries
- Disseminate information on equity issues to different stakeholders who will be involved in developing a resource allocation formula and encourage the development of a resource allocation formula involving all stakeholders
- Seek support from EQUINET/GEGA to provide information on experiences from different countries and capacity building
- Invite input from Civil Society Organizations involved in budget analysis and advocates for equity issues (e.g. ESRF, Tanzania Public Health Association (TPHA); Tanzania Essential Health Intervention Project (TEHIP))
- Co-ordinate with other parliamentary Committees and with relevant ministries to promote health equity.

#### **6.6 REGIONAL**

EQUINET AND GEGA noted that to support this work they would

- Provide report back from the meeting that can be used by delegates for national and regional feedback
- Circulate the resolutions of the meeting
- Through EQUINET provide research, training, policy briefs and information support through the theme work on trade and health, regional data bases, the work on HIV/AIDS, governance, resource allocation and health personnel, through the monthly EQUINET newsletter, etc. and involve representatives of parliament in the regional activities such as the EQUINET June 2004 conference and regional meetings on AIDS, Health Personnel, Governance etc.
- Through GEGA support country level Equity Gauges with capacity building, information, networking and technical activities; and through the Secretariat provide ongoing information on strategies, activities, and opportunities to

- support health equity monitoring and assessment as well as advocacy and support for community empowerment
- Jointly develop information leaflets to support promoting equity in budget analysis and in other areas of parliamentary roles and mobilise resources for exchange visits and exchange of information on good practice
- Co-ordinate these activities with the SADC Parliamentary Forum, the East African parliamentary Forum and other regional organisations (SEATINI, PAPST, SAfAIDS etc)

The resolutions of the meeting were formally adopted by motion of the delegates and are shown in the front of the report.

## **7. Closing**

The organisers thanked the delegates, the facilitators and the secretariat for their important input to the meeting and wished the delegates safe journeys.

Innocent Modioastile of the SADC AIDS programme gave the closing remarks. He commended the organizers and facilitators for the meeting, noting that delegates would be leaving with a different view taking greater account of health equity in development. He thanked the Honourable members of parliament and commended them for the vital role they have to play in taking forward equity and making a vital link in this between the people and government. He noted that we live in a region characterized by great and often unfair inequalities. The meeting raised the priorities to deal with, and provided some analysis, techniques and approaches to acting on these priorities. SADC objectives include promoting poverty alleviation and equity. The action items proposed at this meeting thus have relevance to SADC and will be reported back to the secretariat. The meeting had opened a number of challenges: In the short term, how to intervene in the meetings to take place nationally and globally at WTO in relation to trade agreements, and in the long term, how to translate the commitment to and knowledge of health equity issues within our countries and communities.

## APPENDIX 1: *Delegates list<sup>1</sup>*

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<sup>1</sup> Also invited but not able to attend : Dr Mutukwa, SADC Parliamentary Forum, Dr E Malekia, SADC Health Desk, Hon. James Ngculu, Chair of the National Assembly Portfolio Committee on Health South Africa, Hon Mrs Baloyi, Member of the National Assembly Portfolio Committee on Health South Africa, D McIntyre, UCT (Equinet theme co-ordinator resource allocation), D Owuor, Equity Gauge Kenya

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## APPENDIX 3:Programme

|                  |  |  |
|------------------|--|--|
| <b>Aug 19</b>    |  |  |
| 19:00            | Dinner and Welcome<br>Traditional Dance presentation   | Ms A Ntuli, GEGA<br>Dr R Loewenson EQUINET<br>Dr Mutukwa SADC<br>Parliamantary Forum (*) |
| <b>Aug 20</b>    |  |  |
| <b>Session 1</b> |  |  |
| 08:30-09:30      | <b>Intro to the Meeting,<br/>Equity in health in Southern Africa<br/>Intro to the small group work</b>                                 | Chair: Parl Cttee Zambia<br>Facilitator<br>R Loewenson                                   |
| 09:30-10:30      | <b>Working group discussions:</b> Issues and priorities on the agenda of Parliaments   |  |
| 10:30-11:00      | Tea break  |  |
| 11:00-12:30      | <b>Working group feedback</b>  |  |
| 12:30-14:00      | Lunch  |  |
| <b>Session 2</b> |  |  |
| 14:00-15:15      | <b>National experiences of parliamentary work in health: Plenary Paper and Discussion</b><br>Parliamentary processes for health equity | Chair: Parl Cttee Malawi<br>Presenter: M Mataure, PAPST                                  |
| 15:15-15.45      | Tea break  |  |
| <b>Session 3</b> |  |  |
| 15:45-16:30      | <b>Working groups:</b> Parliamentary actions to respond to health priorities   | Chair: Parl Cttee Malawi<br>continued<br>Facilitator: L Bambas                           |
| <b>Aug 21</b>    |  |  |
| <b>Session 4</b> |  |  |
| 08:30-09:30      | <b>Feedback on group discussions</b>   |  |
| 09:30-10:00      | Tea break  |  |
| <b>Session 5</b> |  |  |
| 10:00-1:00       | <b>Regional and global trade and health issues</b><br>Presentation and discussion  | Session chair: Parliament SA<br><b>Presenter: Y Tandon, R Tayob SEATINI</b>              |
| 13:00-14:15      | Lunch  |  |
| <b>Session 6</b> |  |  |
| 14:15-15:15      | <b>Working groups:</b> Responses to regional trade and health issues   | Chair: Parliament Tanzania<br>Facilitator: A Muula                                       |
| 15:15-15:45      | Tea break  |  |
| <b>Session 7</b> |  |  |
| 15:45-16:45      | <b>Plenary feedback of working groups</b>  |  |
| 16:45-17.45      | <b>Drafting session / Free time</b>  |  |
| <b>Aug 22</b>    |  |  |
| <b>Session 8</b> |  |  |
| 09:00-11:30      | <b>Way Forward: Next steps and future work</b> Summary of resolutions, follow up work, roles and outcomes to be achieved               | Chair: Parliament cttee Zimbabwe<br>Facilitator: A Ntuli                                 |
| 11:30-12:00      | <b>Closing</b>   | SADC AIDS Desk, EQUINET/ GEGA  |

(\*) This welcome was done by M Mataure who also gave Dr Mutukwa's apologies