Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa
MEETING REPORT

Partners in Population and Development Africa Regional Office (PPD ARO), Regional Network on Equity in Health in East and Southern Africa (EQUINET), African Population and Health Research Centre (APHRC), Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH)

SEAPACOH
The Alliance of Parliamentary Committees on Health in East and Southern Africa

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

African Population and Health Research Center (APHRC)

Partners in Population and Development Africa Regional Office (PPD ARO)

Speke Resort, Munyonyo, Kampala
21 September 2009

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1. Commitments

SEAPACOH
The Alliance of Parliamentary Committees on Health in East and Southern Africa

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

African Population and Health Research Center (APHRC)

Partners in Population and Development Africa Regional Office (PPD ARO)

Commitments made at the 2009 Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa

Munyonyo, Kampala, Uganda,
21 September 2009

Hosted by: Partners in Population and Development Africa Regional Office (PPD ARO), Regional Network on Equity in Health in East and Southern Africa (EQUINET), African Population and Health Research Centre (APHRC), Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH)

The Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa, held in Munyonyo, Kampala, Uganda, 21 September 2009, gathered members of Parliamentary Committees responsible for health from 12 countries and regional bodies in Eastern and Southern Africa, with technical government and civil society and regional partners to promote information exchange, facilitate policy dialogue and identify key areas of follow up action to advance health equity and sexual and reproductive health in the region. The meeting was held as a follow up to review progress on actions proposed at the September 2008 Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa hosted by the same organisations.

We, the Members of Parliament, participating in the second high level Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH) meeting convened by the Partners in Population and Development Africa Regional Office (PPD ARO), the Regional Network on Equity in Health in East and Southern Africa (EQUINET), African Population and Health Research Centre (APHRC) and SEAPACOH, and representing Parliaments of Ethiopia, Kenya, Malawi, Namibia, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe, the East African Community, the East African Legislative Assembly and the Southern African Development Community Parliamentary Forum, having reviewed our progress on the resolutions made in 2008, agree to the following **Way Forward for the Southern and East African Parliamentary Alliance of Committees On Health (SEAPACOH),** over the next year:

Operationalizing the SEAPACOH Strategic Plan, including to

- Have a better understanding of linkages between reproductive health (RH), family planning (FP), population and development
- Network within the region with parliaments and with key partners
- Undertake resource mobilization activities to support the implementation of the plan

Providing oversight function on

- The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)[1] and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006)[2]
    - Participate in and influence budgetary processes to increase the government budget commitments to health towards meeting the Abuja targets and improving per capita allocations to health
    - Continuously monitor resources to health to ensure value and public health effectiveness for money, equity in resource allocation and that policies promoting population health are resourced and implemented
    - Encourage Public Accounts Committees to incorporate performance auditing)
- The Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for on Sexual and Reproductive Health and Rights 2007-2010 (2006)[3]
- The Accra Agenda for Action (2008) (to accelerate and deepen implementation of the 2005 Paris Declaration on Aid Effectiveness)[4]
- International agreements and commitments
    - Advocate for coordinated country mechanisms that involve parliaments before agreements are reached
    - Have all agreements catalogued and audited by parliament and available for committees
    - Ensure ratification and domestication of those agreements that promote health
    - Monitor implementation and review of agreements to which commitments have been made

Supporting new and innovative programmes to enhance health, reproductive health (RH), family planning (FP), population and development, including effective public health approaches to prevention of health problems such as spraying for DDT according to WHO recommendations[5]

[1] http://www.un.org/ga/aids/pdf/abuja_declaration.pdf
[2] http://www.aumission-ny.org/documents/abuja_call.pdf
[3] http://www.unfpa.org/africa/newdocs/maputo_eng.pdf
[4] http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER-FINAL-16h00.pdf
[5] http://apps.who.int/malaria/docs/IRS/DDT/DDTposition.pdf (The use of DDT in malaria vector control, WHO/GMP position statement, 2007) http://apps.who.int/malaria/docs/DDT/WHOPositiononDDTupdate.pdf (WHO Re-affirms its Position on DDT for Malaria Control, 2009)

2. Background

In East and Southern Africa, access to health care is inadequate and inequitable, posing further challenges to addressing health burdens in the region. Governments in the region have promised to dedicate 15% of their domestic budgets to health, and while progress is being made towards this across many countries in the region, many countries in Africa have yet to met this goal. Our governments have also pledged to ensure universal access to reproductive health services for all people to reduce maternal death and ill-health, yet every year, thousands of women die during pregnancy and in childbirth and family planning services are often unavailable.

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

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

A network of parliamentary committees on health in East and Southern Africa was formed in Lusaka, Zambia in January 2005. The Southern and East African Parliamentary Alliance of Committees of Health (SEAPACOH) aimed to build a more consistent collaboration of the Parliamentary Committees on Health towards achieving national and regional goals of health equity and effective responses to HIV and AIDS. The network aims to strengthen the role of Parliaments in the areas of oversight of budgets, review of legislation, policy and providing leadership for achieving goals of equity in health and effective responses to HIV/ AIDS, TB, Malaria and other diseases important to the region. While SEAPACOH had networked through various interactions since 2005, the network was keen to hold a regional meeting to update on new developments in health and to review the collaboration of the Parliamentary Committees on Health in the region.

In 2008, Members of Parliament from twelve (12) countries in East and Southern Africa pledged to advance health equity and sexual and reproductive health in the region. During the 16-18 September 2008 meeting, important resolutions and commitments were made by Parliamentarians geared at improving health equity and reproductive health situation in the region (PPD ARO, EQUINET, APHRC, SEAPACOH et al 2008).

The follow up meeting in September 2009, provided an opportunity to review progress, share experiences and lessons learnt over the past one year on the implementation of the resolutions of the September 2008 SEAPACOH meeting. The resolutions from the September 2008 meeting are at: http://ppdafrica.org/docs/ParliamentResolutionsSEP08.pdf; the full meeting report and other reports and documents on parliament work in health since 2003 is at http://www.equinetafrica.org.

On 6-9 April 2009, PPD ARO held a workshop for the steering committee members of the Southern and East African Parliamentary Alliance of Committees of Health (SEAPACOH) to develop and adopt its Strategic Plan (2009 – 2013). Through a participatory process, SEAPACOH formulated its strategic direction and articulated the Alliance's priority areas of business focus and strategic interventions during the period 2009-2013. The three main areas of focus identified include: ensuring needs-based resourcing of the health sector; ensuring effective domestication, implementation and compliance with agreed upon commitments in the health sector by governments; and ensuring sustainability of the Alliance. The strategic plan is available online at: http://ppdafrica.org/docs/2009SEAPACOH/SEAPACOHstrategicplan.pdf and at http://www.equinetafrica.org/bibl/docs/SEAPACOH%20STRATEGIC%20PLAN%202009.pdf

As a follow up to the strategic plan and to the 2008 Meeting of Parliamentary Committees on Health in Eastern and Southern Africa which was held in Kampala, Uganda, Partners in Population and Development Africa Regional Office (PPD ARO) in collaboration with the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and African Population and Health Research Centre (APHRC) under the auspices of the Southern and Eastern African Parliamentary Alliance of Committees on Health (SEAPACOH), jointly organized a meeting in Kampala, Uganda on 21 September 2009. The meeting was held prior to the Third EQUINET Regional Conference 23-25 September 2009 that a number of committee representatives also attended and that provided an opportunity to link parliaments with the wider community and resources involved in work on health equity in the region.

During this September 2009 follow up meeting, SEAPACOH met to report back on progress made over the past year, as well as to promote information exchange, facilitate policy dialogue and identify key areas of follow up action to advance health equity and sexual and reproductive health in the region.

The meeting was attended by Parliamentarians drawn from parliamentary committees responsible for health as well as technical, civil society and regional partners.

The objectives of the meeting were to:

- Promote, through country reporting and technical input, exchange of information and good practices on the implementation of the resolutions set at the Sep 2008 SEAPACOH meeting, discuss obstacles and barriers and propose follow up actions;
- Provide an update on the situation in the region in relation to implementation of regional SRHR frameworks including: Maputo Plan of Action; Abuja Declaration; the Ouagadougou Declaration on Primary Health Care (PHC); the Millennium Development Goals (MDGs) and explore the critical gaps that need to be addressed;
- Discuss priority areas of representation, legislation, budget appropriation and oversight roles of parliaments and review and discuss options for support of these roles; and
- Develop recommendations for parliamentarians to use to engage wider policy, technical and research audiences.

The meeting was held at Speke Resort and Conference Center, Munyonyo, Kampala, Uganda on 21 September 2009 and was organized by:

Partners in Population and Development (PPD) is a Southern-led, Southern-run inter-governmental organization of 24 developing countries, encompassing more than half the population of the entire globe. PPD was founded in 1995, to promote South-South cooperation in reproductive health and population and development. The Partners in Population and Development Africa Regional Office (PPD ARO) is based in Kampala, Uganda. The vision of the PPD ARO is “an African continent that meets its Reproductive Health needs, promotes the Population and Development agenda and thereby addresses poverty, through South-South Cooperation.” Its mission is “to provide a platform for the promotion of and resource mobilization for Reproductive Health, Population and Development in Africa through three elements: 1) Policy dialogue 2) Networking and building strategic partnerships in the region and 3) Sharing of experiences and good practices. More information is available online at: www.ppdafrica.org; Email: aro@ppdafrica.org.

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) is a network of academic, professional, civil society, state and parliamentary institutions within east and southern Africa that aims to promote and realise shared values of equity and social justice in health. EQUINET supports and carries out research, dialogue, capacity building, exchange of information and experience and critical analysis to build knowledge, shape strategies and inform policy and practice on health equity. More information is online at: www.equinetafrica.org; Email: admin@equinetafrica.org.

The African Population Health Research Centre (APHRC) is a non-profit, non-governmental, international organization that is committed to conducting policy-relevant research on population, health and development issues in sub-Saharan Africa. The centre also facilitates the use of research evidence in policy and practice, in addition to strengthening the research capacity of African scholars and institutions to enhance skills in generating credible scientific evidence. More information is available at: www.aphrc.org; Email: info@aphrc.org.

The Southern and East African Parliamentary Alliance of Committees of Health (SEAPACOH) is a network of Parliamentary Committees on Health in Southern and Eastern Africa. The objective of the network is to build a more consistent collaboration of the Parliamentary Committees on Health towards achieving individual and regional goals of health equity and effective responses to HIV and AIDS. The network aims to strengthen the role of Parliaments in the areas of oversight of budgets, review of legislation, policy and providing leadership for achieving goals of equity in health and effective responses to HIV/ AIDS, TB, Malaria and other diseases important to the region.

The meeting also received funding from **Deutsche Stiftung Weltbevölkerung, the German Foundation for World Population (DSW)**. DSW supports family planning and sexual and reproductive health projects in Africa and Asia, with a focus on reaching young people. More information is available at: http://www.dsw-online.de/.

The meeting also received support from Swedish International Development Cooperation Agency (SIDA) http://www.sida.se/

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

The meeting programme is shown in Appendix 1, and the list of participants in Appendix 2. The meeting was rapporteured by PPD ARO and this report has been produced by PPD ARO and EQUINET (TARSC).

3. The Opening

Chaired by Hon. Ruth Kavuma Nvumetta, Parliament of Uganda
The meeting opened with welcome to and introductions of all participants.

Dr. Jotham Musinguzi, Regional Director, PPD ARO, outlined the work of PPD ARO and the purpose of the meeting. Like SEAPACOH, PPD was formed as a South-South organization, to help "broker" arrangements for the horizontal transfer of technical and programmatic expertise from one southern country to another.

"PPD ARO sees a great, yet not fully tapped potential of working and collaborating with parliamentarians . . .We believe that by working together with parliamentarians across countries and regions, the benefits of networking, sharing of information, experiences and best practices can be realised."
-- Dr. Jotham Musinguzi, Regional Director, PPD ARO

Dr. Musinguzi reminded participants of PPD ARO's support of the Strategic Plan development meeting for SEAPACOH, which took place in May 2009. Dr. Musinguzi stressed that African countries have good and clear policy frameworks but the overriding problem on our continent remains a lack of political will and commitment to support the implementation of these otherwise good policies. For instance, performance on Abuja Declaration of devoting at least 15 % of the national budgets for health has remained a major challenge. Of all sub Saharan African countries, only one country Malawi, has reached the 15% target. Implementation of the Maputo PoA at country level remains poor and uneven.

While some countries such have formulated national strategies or "Roadmaps", their financing and implementation remains weak. In some countries, the Roadmaps have remained in draft forms due to lack of political commitment. If countries met the goals of the Maputo Plan of Action, then the costs for a number of the MDGs would be greatly reduced (e.g for universal schooling, health care coverage, etc.). Therefore, the PPD ARO sees a lot of hope in Parliamentarians as vanguards to improve the implementation of policies and programmes, as well as resource allocations for health including reproductive health. This is why the PPD ARO is devoted to working with parliamentarians as change agents and central players to the full implementation of international and regional agreements on sexual and reproductive health and rights.[6]

[6] "Opening Remarks," Dr. Jotham Musinguzi, Regional Director, PPD ARO: http://ppdafrica.org/docs/2009SEAPACOH/musinguzi.pdf

"Even in cases where good policies are formulated, they are not successfully implemented because of lack of expertise in transitioning the principles and ideals outlined in policies to practice. . . because of lack of capacity to operationalize the policies or limited local involvement and ownership of the policy development process . . .Without understanding the challenges for the transition from policy to action and analyzing existing policies, it will be difficult for Africa to turn around and break from pervasive poverty and ill health."
-- Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC)

Mr. Moses Mulumba, Steering Committee Member of EQUINET, welcomed delegates. He drew attention to the positive achievements since the first Regional Meeting of Parliamentary Committees on Health in Eastern and Southern Africa in 2003 hosted by EQUINET, Global Equity Gauge Alliance (GEGA) and the Southern African Development Community Parliamentary Forum (SADC PF), and the second and third meetings in 2005 and 2008, including increased allocations of national budgets to health. Mr. Mulumba also reminded participants of their commitments made at the last meeting, to raise the profile of primary health care (PHC) and to realising commitments such as the Abuja Commitment of 15% national budgets.

Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC) stressed that the region's high levels of fertility and population growth rate are key impediments to efforts to fight poverty, illiteracy and the high disease burden on the continent. Big families and a very young population mean both families and national governments are focused on day-to-day survival instead of investing to produce high quality human resources, enhance national productivity, and generate self sustaining economies in future. Dr. Zulu said that issues of fertility, population growth, and reproductive health in general are invisible and poorly understood or articulated in most African countries in part due to the limited evidence to demonstrate the development benefits of addressing population problems such as high fertility and the best practices for doing so.

According to Dr. Zulu, "It is really the home-baked solutions that will change our continent in the long-run. So when Parliamentarians stand up and make a point, when there is research evidence, money is used efficiently." Dr. Zulu emphasized the role of Parliamentarians in the region, to ensure that research is done with the input of end-users, and will be demand-driven. If Africa waits from money from the North—then they will drive the research. Instead, African countries should focus on research that solves problems, and shares the best practices in Africa.[7]

"Parliaments would not be as effective, if they were to walk the journey alone, but through their representative and facilitative role, teaming up, and collaborating with relevant stakeholders, not only will it enhance effectiveness, but will also fulfils the right of citizens to be heard in matters that affect their lives."-- Hon. Blessing Chebundo, Chair, SEAPACOH

[7] "Opening Remarks," Dr. Eliya Zulu, Deputy Executive Director, APHRC:

Hon. Blessing Chebundo, Chair, SEAPACOH, said that the deterioration and potential collapse of health sectors remains one of the greatest challenges facing the nations of sub-Sahara Africa. He said that this will continue to exacerbate the rising mortality and morbidity brought on by HIV/AIDS among the poor and vulnerable sections of the populations in various countries and thus places a major challenge for elected representatives and Parliaments to champion the need for equity in health.

Before concluding, Hon. Chebundo outlined a number of challenges that SEAPACOH has faced since its initiation in 2003 including: Changes in national committee membership due to internal arrangements, elections etc.; non-participation by national committee clerks/officers who could act as "bridging gaps"; lack of support by Presiding Officers and other mattering leadership/designations of parliaments of the member committees; cumbersome/restrictive administrative protocols that some of the committees have to go through to facilitate participation; and financial constraints for SEAPACOH as a network. Hon. Chebundo also emphasized the importance of developing a 'clear cut' way forward on how to successfully use the strategic plan for SEAPACOH to mobilize the needed resources to achieve the plan's objectives.[8]

policy frameworks [e.g. Maputo Plan of Action and the Abuja Declaration]. All these . . . are simply about delivering a better Africa, a better world for the benefit of generations into the future."
-- Hon. Dr. Stephen Mallinga, Minister of Health, Government of the Republic of Uganda

Hon. Dr. Stephen Mallinga, Minister of Health, Government of the Republic of Uganda opening remarks emphasized the collective responsibility of the gathered group to do everything within their power and ability to improve the quality of life of our people in sub-Saharan Africa. Hon. Dr. Mallinga said that the countries represented at this meeting face similar issues, and because the demands on African governments are many, meetings like this one can be used to assist in finding common solutions to some of the problems.

He told a story of how when twins are born in Uganda, the father is entitled to steal food for his family—a thief takes advantage of this situation and takes more than he is entitled to—but in the parallel case of Uganda's Parliament demanding more money for health, Hon. Dr. Mallinga said that he cannot protest.

Hon. Dr. Mallinga stated that policy frameworks such as the Maputo Plan of Action and the Abuja Declaration need to be followed up and implemented within countries. Hon. Dr. Mallinga emphasized that Parliamentarians are key and pertinent stakeholders who

http://ppdafrica.org/docs/2009SEAPACOH/zulu.pdf
[8] "Opening Remarks," Hon. Blessing Chebundo, Chair, SEAPACOH: http://ppdafrica.org/docs/2009SEAPACOH/chebundo.pdf

can through their roles remove legal and administrative barriers to access to high quality health services, influence resource allocation and ensure clear budget lines and expenditures on health and hold national governments to account on commitments they have made as well as ensure that funds from both the national budgets and donors are spent appropriately.[9]

4. Session One

Chaired by Hon. Dr. Desta Delkasso, Parliament of Ethiopia

Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC), spoke on the topic of "Addressing Reproductive Health and Other Health Challenges in Africa." Dr. Eliya Zulu began by giving an overview of fertility in the regions. The total fertility rate remains high in many regions of Africa: in central Africa it is 6.3; West Africa 5.8; East Africa 5.5; while fertility transitions in North and Southern Africa has lowered their fertility rates to 3.2 and 2.9, respectively. This means that when Eastern and Southern Africa are compared in terms of population trends and projections, the population of Eastern Africa will continue to rapidly grow between 2010 and 2030, from almost 325 to up to almost 500 million people, while the population in Southern Africa will remain constant, remaining at approximately 55 million people. This high rate of fertility corresponds with statistics that show that a large proportion of recent births in the region were mistimed or unwanted.

Dr. Eliya Zulu argued that fertility is also highly related to wealth—in Tanzania, the poorest women have, on average 7.3 children while the richest have only 3.3 children per women. The fertility decline in Africa is mostly happening among the rich—this is because the richest women have lower unmet need for contraception and use contraception at a much higher rate than the poor. The richest women and those living in urban areas also desire much smaller families than the poorest women and those living in rural areas. Yet, the demand for contraception is high in Africa—many women would like to stop childbearing.

Dr. Zulu said that there has been a stall in the fertility decline in some African countries—namely, Kenya and Tanzania. This stall will result in a much higher population in these countries. He then spoke about an example of a project of APHRC and partners to improve the fertility decline in Western Kenya through improving the supply of family planning services at community and facility levels and improving the

[9] "Opening Remarks,": Hon. Dr. Stephen Mallinga, Minister of Health, Government of Uganda: http://ppdafrica.org/docs/2009SEAPACOH/mallinga.pdf

"How do we address poor health outcomes among the urban poor? We need to work in partnership—we must put more health workers in the community. We cannot improve anything if the government does not come in to regulate. We need to work as partners."
--Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC)

demand for family planning services through effective outreach and IEC material distribution.

Dr. Zulu also addressed the issues of low life expectancy and high infant mortality in the region. Infant mortality is highly correlated with wealth—the poorest 20% of the population in some countries experience infant mortality at double the rate of the richest 20% of the population. In Kenya, child mortality has been increasing as coverage of preventative health services has been declining.

Dr. Zulu next addressed the specific needs of people living in slums; they have unequal access to social services and livelihood opportunities. In the slum settlements in Nairobi, the infant and under-five mortality rates are much higher than in the rural areas, or for Nairobi as a whole. Urbanization is rapidly increasing in Africa, and thus, the issue of slums must be addressed. He proposed a model for improving health care in slum settlements: strengthening community owenership of health; improve district level management and planning; work with the private sector to achieve common health goals; train the health workforce; and build capacity for operations research, monitoring and evaluation.

Dr. Zulu concluded by outlining how MPs can become involved through: ensuring that the existing policies are implemented; lobbying governments and donor agencies to increase commitment and financial resources to the provision of reproductive health supplies, including contraceptives; support the promotion of gender equity and empowerment of women, especially through education and ensuring comprehensive sexual and reproductive health information and services are available; and mobilizing communities to demand sexual and reproductive health information and services in your constituency.[10]

Dr. Rene Loewenson, Programme Manager of EQUINET and Director of Training and Research Support Centre presented the findings of the Regional Survey of Parliaments carried out by EQUINET (UCT, TARSC, UWC and HEPS) and SEAPACOH in September 2008 and discussed the pmplications for strengthening parliamentary work. The presentation was based on EQUINET Discussion Paper 73, March

[10] "Addressing Reproductive Health and Other Health Challenges in Africa," Dr. Eliya Zulu, APHRC: http://ppdafrica.org/docs/2009SEAPACOH/zulu2.pdf

2009[11]. Dr. Loewenson began by outlining a number of challenges, and argued that the burden of Africa's current growth path is felt greatest at the household level, where economic and health opportunities have been limited by poverty and inequality. Women, over the past two decades, have challenged traditional gender roles, opened new job opportunities, and increased their social autonomy. But women still face longer hours; work in undercapitalised, insecure production activities; have low skill, low paying jobs that are often strenuous with little control over the job pace or content; and there is decreased rest time and increased work related stress. These all contribute to the women's increased burdens of social welfare roles. Also, Africa's current growth path is plagued by poor quality insecure jobs; a migrant, informal economy labour; falling real incomes; falling tax revenue; and declining social protection. She noted that addressing inequality (economic, social, gender) remains a major challenge with opportunities for parliamentary committees on health to play a role in addressing this through their interventions on the budget, legislation and policy oversight.

Dr. Loewenson then reviewed the findings of the survey of ten Parliamentary Committees on Health (19 responses) done in September 2008.

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

On the budget, she noted that at that time, 60% of Parliamentary Committees on Health surveyed were actively monitoring the 15% Abuja commitment (there are likely to be more doing this now). Their priorities included: increased funding, primary health care, maternal and child health, drugs, and health workers.

Actions on budgets taken by MPs included: meeting civil society (90%); information exchange (90%); workshops (80%); public hearings (70%); and constituency visits (50%). Outcomes were reported to be positive in six of the ten countries surveyed, highlighting the influence of parliaments through these means.

She noted that EQUINET would continue to support work by parliaments on fair financing, including allocation of health sector resources, and that this was a major planned area of EQUINET work with SEAPACOH into 2010-2011. However, she also noted the need for parliaments to audit the spending on health by other sectors, as health is an outcome of all policies and committees on health should encourage health promoting spending in all sectors (e.g. water, communications, education, trade, agriculture and so on).

[11] http://www.equinetafrica.org/bibl/docs/DIS73parlgen09.pdf

On laws, 30% of parliaments surveyed had debated or passed laws or policies relating to health in the previous year (2007), including Malawi (HIV AIDS National Policy), Tanzania (HIV and AIDS Bill) and Uganda (Public Health Act). One (Zambia) reported making submissions on the right to health for constitutional reform. Dr. Loewenson said that a clause to protect the right to health is necessary; there needs to be an inherent protection for all people and inclusion of the concept of progressive realisation of health rights despite resource limitations as a barrier to health rights. But parliaments often lack awareness of the concept of progressive realisation as a mechanism to make rationing and priority-setting decision more transparent and defensible within a rights framework. Also, parliamentarians were more likely to be familiar with Trade-related Aspects of Intellectual Property Rights (TRIPS) applications and with the Millennium Development Goals (MDGs) and the provisions of the Abuja Declaration than with the substantive content of the right to health, as contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR), its General Comment 14 or the African Charter on Peoples and Human Rights. All of these conventions, when ratified by states, impose substantial regulatory and programmatic obligations on governments. Dr. Loewenson argued that "important gains could be made if parliamentarians were able to analyse, interpret and integrate international human rights agreements into their parliamentary work." She indicated that we need to be more effective in making conventions available to parliaments for this.

According to Dr. Loewenson, a further means for overseeing the executive is through outreach to constituencies and through questions and motions raised. Nine of the committees reported that the committees had framed and raised health questions to the executive. Examples of this included in Uganda on maternal and child health funding and in Botswana on a rural drug shortage. Outcomes were reported to be positive in five of the ten countries. She called for technical partners to support parliaments with the evidence to support this process, as it is effective in raising awareness and promoting health. However, she noted that there was need for some common platforms across the region so that there could be greater regional exchange for this.

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

Dr. Loewenson concluded by raising a number of questions to the group, including, "Can we identify a shared health outcome, an action in health and a form of parliament action that we focus on and achieve by 2010?" as well as raising specific questions to encourage discussion on how parliaments can share their best practies in information-exchange, outreach and use of motions, budget influence, and effectively using health rights.

Session One Discussion

The first Member of Parliament to speak during the discussion asked about fertility levels in region, “What is the impact of HIV on demographic dynamics?” The second question asked was on commitments made by countries, “How much can we influence before these commitments are made? The commitments are signed, but there is no feedback or monitoring mechanisms?” The third question asked was about the implications in terms of health for the common market protocol in East Africa. The fourth issue raised was about if anyone has looked at the sociological part of moving people from slums to upscale apartments; the MP warned that people may return to the slums and advised that there should be a follow-up investigation on these issues.

Another MP said that she and others needed to hear a stronger case made on the connection between population growth and economic growth.

A technical participant said that Ministries are supposed to deliver services and they have been there for a long time. Thus, it is now time to look at the relationship between the services required and the ministries in place to provide those services. He also said that a research agenda should extend to those areas.

A MP from Kenya, said that there are many teenage pregnancies in Kenya and asked if there was an ability to provision for contraceptives in schools?

Another MP pointed to the difficulties faced by people living in fishing villages. They have poor sanitation and fertility is high. She said that MPs must also address issue of fishing villages. She asked if APHRC has looked into the issues facing fishing villages.

A MP said that the Abuja declaration on health is not being followed by most governments and asked what MPs can do to ensure they are followed, as Africa’s problems center on health. It is possible to reverse the trend, even regarding population growth. If a mother is assured that her two children will reach maturity, she will not bother to get more. But currently, with most children mothers bear, many of the children are dead before the age of five years. MPs should concentrate on ensuring that health services are improved in the country. Fertility rates are low among wealthy people—but there are two kinds of wealthy people—the educated and uneducated. The MP asked if APHRC differentiated between the two types of wealthy people.

Dr. Rene Loewenson, EQUINET, responded to a number of the issues raised. Regarding the issue of commitments; she said that EQUINET had emailed all committees documents including the Abuja commitments, information on the WTO TRIPs agreement and information on other commitments. She noted that every

parliament's clerk should ensure that they contact their legal resources foundations to have a full set of commitments. She urged for health impact assessment to be included in all commitments, as it would ensure that the Ministry of Health is consulted and can widen responsibility for protection of health. She noted that a focus on population numbers does not adequately address the real problem, which is the distribution of resources to people, and particularly the inequality in distribution of resources across the population. The majority of the population does not benefit from economic growth and development in Africa, and thus, we need to look at population, development, and inequality together. Regarding Abuja, Dr. Loewenson said that progress was being made, that we also need to ensure that per capita health levels are adequate and that our ability to reach the Abuja target of 15% is not dependent upon overall wealth in country; rather, it is a political choice. Higher income countries such as South Africa, for example, have not reached the share of government spending on health as lower income countries like Malawi.

"No country has developed with poor quality, high population—with six children [per woman], you cannot develop anything else."
--Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC)

Dr. Eliya Zulu, Deputy Executive Director and Director of Research at the African Population Health Research Centre (APHRC), next responded to the queries raised in the discussion. He said that although Ethiopia was not mentioned as an example in his presentation, it has very high fertility of around six children per women. Regarding the effects of HIV on population, he said that we know this has had a strong effect, particularly in Southern Africa. He then stated that high fertility can be a resource to a country—if people are properly trained and skilled, such as in Asia, you can take advantage of something called the "demographic window." But in Africa, the quality of the population is not as good as in Asia. This is now an issue of how quickly we can address issues of quality. "No country has developed with poor quality high population—with six children [per woman], you cannot develop anything else," he said. Regarding the issues of giving contraceptives in schools, this is complicated, but the population projections take into account youth fertility. Parents, like ourselves, do not want sex contraception in schools. But if schools do good sex education, then children are informed and they can demand contraceptives when they need them. Dr. Zulu said that the example of slums, was just one example of a vulnerable area and population; fishing villages are very vulnerable and research has shown they have HIV rates that are higher.

"Our ability to reach the Abuja target of 15% is not dependent upon overall wealth in country; rather, it is a political choice."
-- Dr. Rene Loewenson, EQUINET

Hon. Chebundo described one practical solution to a question asked. At the 2005 SEAPACOH meeting MPs realized that it was difficult to know the commitments on international agreements made by Ministers. So it was made an agenda item on national committee plans and MPs demanded that the Minister responsible should let parliament know the nature of the agreement and the position to be taken prior to international meetings where the commitment was being discussed. Questions were thus asked about positions that trade delegations were taking at the World Trade Organisation on agreements relevant to health prior to the meetings so that there would not be ratification without the parliament knowing. “As parliamentary committees, we need to know the conventions where our governments have appended signatures.” Doing this gave a form of victory in that the WTO negotiations were now made known to and had input from the health committees.

Dr. Jotham Musinguzi, Regional Director, PPD ARO, spoke about the case of Uganda Parliament’s efforts to move forward regional commitments, including the Maputo Plan of Action. The government of Uganda was not originally supportive of the Maputo Plan of Action, but Members of Parliament, both men and women, worked hard to ensure there is a roadmap for maternal and child health that is now signed by the Ugandan President. This was done because the MPs united and insisted that this must be done. They also worked with Uganda’s First Lady, who is a Member of Parliament. This good work was the result of so much pressure from the Parliament. MPs insisted that they are “looking at the life of mothers.” MPs can do a lot—they can use pressure and persuasion—and this results in progressive change. Dr. Musinguzi then addressed the question of wealthy people who are educated and those who are not educated and fertility rates According to Dr. Musinguzi, there are not very many people who can be rich without education. There is a research study that shows that when people are wealthy a long time, they do have more children—but they have three rather than two children. What we know, is that more education results in fewer children.

5. Session Two: Presentations on Country Achievements and Challenges since September 2008

Chaired by Hon. Dr. Victor Munyaka, Parliament of Kenya

“This burden [of poor reproductive health] is for women. Most health burdens are on women. This means that it is mostly a women’s issue. Let us make alliance with women parliamentarian to develop capacity and skills so we can have good outcomes.”
-- Hon. Dr. Desta Delkasso, Parliament of Ethiopia

Hon. Blessing Chebundo, Chairperson, SEAPACOH, made the first presentation of the session on "Review of SEAPACOH activities, challenges and way forward." Hon. Chebundo began by giving an overview of the history of SEAPACOH since 2003. Due to reforms in the region that allowed Parliaments to have oversight over the Executive implementation of public programs, take part in budgeting processes, and increase involvement with civil society organization, "specific organs of parliaments . . are able to connect and work together, collectively concentrating on pertinent issues of the specific areas such as on international and regional agreements and treaties by governments and the impact of these agreements on health in the countries of the region, on issues of HIV and AIDS, etc."

"In the face of catastrophic health developments, it is clear that ending the loss of life of the current experienced scales goes beyond individual institutional responsibility, but must be on a comprehensive collective institutional and public effort. It is no exaggeration to state that failure by governments and institutions to act swiftly will be seen by future generations as genocide by inaction."
-- Hon. Blessing Chebundo, Chairperson, SEAPACOH

Hon. Chebundo then gave examples of some of the work done in Parliaments:

- In Kenya, the Parliamentary Portfolio committee responsible for health worked closely with APHRC to analyze the population bill of 2004.
- The Zambian Portfolio Committee on Health, Community Development and Social Welfare has worked closely, and benefitted technically from the work of other stakeholders to analyze issues to come up with a sound national HIV and AIDS policy and specific recommendations for national programs.
- The National Assembly Parliamentary Committee on Health for South Africa has received technical assistance so it could make inputs into the "equity formula" for health resource allocation for provincial government budgets.
- The portfolio Committee on Health in Zimbabwe worked with partners in the Health Equity Gauge project, as well as in the budget formulation and monitoring process, legislative analysis, and conducting joint fact finding visits.
- The Committee on Health in Malawi has collaborated with partners to identify priority areas for health, on budgeting, and in conducting advocacy for people's rights to health services. The Committee on Health in Malawi has also benefitted from capacity-building workshops and international exchange visits.

There are a number of lessons to be learnt from SEAPACOH, according to Hon. Chebundo. Regional networking has the added advantage of allowing Parliamentarians to articulate a point of view which has not been "cast in stone" by individual governments. The network also allows for a greater focus on common issues affecting the region, as countries share similar histories, ecologies, health and cultural challenges, and similar contributing factors to health challenges.

"SEAPACOH has also provided a platform for MPs to understand diverse health issues—as we come into being committees of health, not all [of us] come from background of health. Without SEAPACOH, we would not be as effective as we are today. . . [SEAPACOH is a] platform to exchange concerns and knowledge"-- Hon. Blessing Chebundo, Chairperson, SEAPACOH

Hon. Chebundo argued that Parliamentary Committees on Health are aligned with Ministers of Health, but not Ministers of Trade. Yet Ministers of Trade also negotiate on issues that impact on health. Thus, if the Ministers of Trade goes to the World Trade Organization (WTO), there is no formal process of consultation with the Parliamentary Committees on Health.

Hon. Chebundo concluded by stating that SEAPACOH needs practical resolutions for the next meeting. SEAPACOH needs a policy platform and to take stock, to move forward with SEAPACOH with this momentum, need practical way for next meeting—Accra platform (need the practical part of it documented and agreed). He called upon participants to work on the public health crisis in Africa today.[12]

The next presentations by Members of Parliaments addressed country progress, achievements and challenges regarding: Implementation of the September 2008 Munyonyo Parliament Meeting Resolutions; the ICPD PoA; the Maputo Plan of Action; the Abuja Declaration; and the Ouagadougou Declaration on Primary Health Care (PHC).

Hon. Dr. Chris Baryomunsi, MP Uganda, made the first presentation to the group. Hon. Dr. Baryomunsi began by outlining statistics on Uganda. Uganda's total Population is 31 million and the population growth rate is 3.3%. Life expectancy at birth is 51 years. 41% of births are attended by skilled personnel. The maternal mortality ratio is 435/100,000. Contraceptive prevalence stands at 23% and the unmet need for family planning at 41%, resulting in a total fertility rate of 6.7 children per woman. The infant mortality rate is 76/1000 and enrolment in primary education stands at 7.5 million children. The percentage of the government's budget to health is 10.2% (including donors). He said that this week, the Parliament expects an answer as to why health spending is at 10.2%, not 15%. He said they have been engaging the Executive and that MPs are are always reasonable as we advance the cause of RH: "We must meet the Abuja target and go beyond it. Reproductive health must remain a priority."

[12] "Review of SEAPACOH activities, challenges and way forward," Hon. Blessing Chebundo, Chairperson, SEAPACOH: http://ppdafrica.org/docs/2009SEAPACOH/chebundo2.pdf

Since September 2008, Ugandan Parliamentarians have engaged Ministries of Health and Finance and the media on the need to fund sexual and reproductive health issues. They have also raised questions for oral answer on issues of reproductive health on the floor of Parliament.

Specifically, they have

- Recommended policy changes in the management and administration of the budget for drugs including RH commodities;
- Allocated additional resources for RH including HIV/AIDS. Uganda's HIV/AIDS program has been largely funded by donors; domestic contribution was 2%, MPs have now raised this amount to 6%, with the government now contributing 60 billion Uganda shillings for ARVs.
- Successfully advocated for a budget line of 200 million Uganda shillings for activities to address female genital mutilation (FGM);
- Prepared and presented a private member's bill entitled "The Prohibition of Female Genital Mutilation Bill, 2009;
- Drafted the HIV/AIDS Control Bill 2009, which is to be tabled as a private member's bill. Motion to introduce the Bill has already been moved;
- Strengthened collaboration with NGOs – DSW Uganda, Reproductive Health Uganda, etc.;
- Held capacity building activities for Members of Parliament on RH issues such RH Commodity security;
- Held advocacy meetings with leaders at constituency level on Population and RH issues in some districts;
- Undertook oversight and monitoring visits to different parts of the country;
- Established and operationalised Constituency AIDS Task Forces in a number of constituencies; and
- Strengthened the Parliamentary HIV/AIDS Resource Centre with materials.

"We must meet the Abuja target and go beyond it. Reproductive health must remain a priority."
-- Hon. Dr. Chris Baryomunsi, MP Uganda,

Yet, according to Hon. Dr. Baryomunsi, challenges to the Ugandan MPs' work remain. These challenges include: poor funding for population and health programmes; need for capacity building for local governments to deliver sexual and reproductive health services (improved human resource for health); and parliament needs continuing support in order to play its meaningful role.[13]

Hon. Austin Mtukula, Parliament of Malawi, made the second country progress report. He highlighted that over the past year, not a lot of progress was made due to political factors, e.g. the Parliament wanted to impeach the current President. Malawi started domestication of international agreements about three years ago. Malawi has reached the 15% country-financing for health target, as agreed to in the Abuja Declaration.

[13] Hon. Dr. Chris Baryomunsi, MP Uganda: http://ppdafrica.org/docs/2009SEAPACOH/baryomunsi.pdf

Malawi's Committee on Health and HIV/AIDS has a task force to examine the impact of the 15%. They found that the Malawi government was unable to fund biomedical research, and thus, 15% alone is not enough. This means that medical research activities are funded by outsiders, and the government could not control what was happening in research activities. For example, for research on microbicides, many people have gotten HIV during the trial, but they were not being compensated. Hon. Mtukula said that the government needs to fund activities in health sector, so that we can control them and have oversight. With research on HIV and pregnant mothers; the women receive treatment while pregnant, but after they give birth, they are no longer given treatment in the research program. Thus, in Malawi, Parliamentarians have moved a motion to persuade the government to come up with legislation to govern research activities. Also, there are still not enough drugs in Malawi—many people are unable to access basic drugs. The parliament has made a recommendation to overhaul government central medical stores, but this exercise has been delayed.[14]

Session Two Discussion

A comment was made from a representative from Healthnet Consult, an EQUINET member in Uganda. She noted that there needs to be clarity on funding of the health sector regarding the percentage from government and the percentage from donors. She argued that in order to hold the government accountable, the source of funding must be clear.

An MP from Uganda, said that MPs are not adequately funded to do monitoring. He said that MPs do not go to the field because there is no money to pay for the visit. Thus, MPs need to advocate for money do their work. There is also an issue of accountability; the Ministry of Health has inadequate money, but how frugally is it being used? He and his colleagues were shocked to find that funds meant for the purchase of drugs in the Ministry of Health in the last financial year were used to travel abroad. MPs are currently insisting on getting a list of these travels and whom they were taken by. He said that MPs need to emphasize accountability, as there are little funds, but they must properly used by bureaucrats.

Another MP from Uganda said that a recently-published survey in a newspaper found that health workers were reporting late to work, and that they are sluggish. He said that accountability needs to be improved. He also stated that the issue of national health insurance schemes needs to be further considered. In Rwanda, people are currently in jail due to corruption in Rwanda on the insurance scheme. Thus, services need to be improved and efficient.

[14] "Malawi's progress, achievements and challenges," Hon. Austin Mtukula, Parliament of Malawi: http://ppdafrica.org/docs/2009SEAPACOH/mtukula.pdf

A MP asked if Malawi wants to overhauled national medical stores because of shortage, if so, why is there short supply of drugs? Is it due to finance or other factors?

An MP from Uganda said that a percentage of donor funds is hidden in Uganda in the budgetary allocation to health. He called on MPs to insist on transparency in the budget process through the end. “If you insist, you can move.” He said that figures speak louder than words, so you need more than words to make a case, you need figures.

Another representative from a Ugandan civil society organization said that it is very difficult to get the figures you need for advocacy, which makes it difficult to follow the delivery chain down to the ground. She suggested that this can be done in partnership, it would be a good partnership if MPs can get the necessary figures from the Ministry of health (which civil society has difficulty in getting), and then the civil society has partners on the ground, who can visit and check the functioning of health centers—including LC1 to 3 to 4.

Hon. Austin Mtukula, Parliament of Malawi, responded by stating that the Central Medical Stores are controlled by the Ministry of Health.
Hon. Dr. Chris Baryomunsi, MP Uganda, remarked that Parliaments have the power for allocation, which they must follow up on.

Hon. Blessing Chebundo, Chairperson, SEAPACOH, said that there are multiple stages in the budget allocation process: the formulation stage (Parliament is often not involved in this stage), the allocation stage, and finally, the checking and monitoring stage.

6. Session Three: Presentations on Country Achievements and Challenges since September 2008

Chaired by Hon. Lydia Wanyoto Mutende, East Africa Legislative Assembly

Hon. Hansima Christian, Parliament of Namibia, made the first presentation for the third session. She said that the total population of Namibia as of 2001 was 1, 830, 330; population growth is 2.6%. Life expectancy at birth is 50 for females and 48 for males. The total fertility rate is 4.1%. The infant mortality rate is 40-49%/1,000 births (2000-2006). The maternal mortality ratio is 449/100,000 births (2006) and 81% of births are attended by skilled health personnel. Contraceptive prevalence increased from 26% in 1992 to 46% in 2007. Unmeet need for family planning stands at 7%, and the enrolment in primary education (boys and girls) is 92%. Health is 13% of the overall annual government budget; this figure excludes donor resources.

Since September 2008, the SEAPACOH September report was discussed by the Namibia's Health Committee and was tabled in Parliament during November 2008.

Namibia's Committee on Human Resources, Social and Community Development undertook field visits to two regions in March 2009 to assess the implementation of government policies and programmes with regard to health and education issues. With the support from UNFPA in Namibia, the Committee Members were trained in gender based violence, reproductive health and HIV/AIDS in July 2009. And Namibia's Health Committee partnered with UN agencies and government ministries to interact with communities and service providers on gender based violence, reproductive health and HIV/AIDS, in August 2009.

To move forward the ICPD Programme of Action, Namibia developed a national road map that outlines strategies and guidelines for improving maternal and child health as well as acceralating the reduction morbidity and mortality. This roadmap was revised and costed in 2009. A Committee on restructuring of the Health Systems has been established by the MOHSS in May 2009, to restructure the whole ministry setup. Namibia's MOHSS carried out a Health and Social Services Review, looking at the successes and challenges in the Namibian Public Health Sector since independence, as a result, a Health Strategic Plan for the period 2009 to 2013 was developed.

To make progress on the Abuja Declaration, Nambia's budget for health stands at 13% of the overall budget of the country. To address the shortage of skilled health workers, there has also been work on revising and expanding the current scope of practice in health personnel training and recruitment.

Hon. Hansima Christian said that the challenges in Namibia include: long distances to travel to deliver in hospitals and rural health facilities coupled with bad roads; low male involment in reproductive health issues; lack of follow up of PMTCT mother baby pair; lack of essential equipment at some rural health facilities, including transport; and a shortage of skilled workforce (doctors, midwives and nurses). The way forward to address these issues includes: mobilising adequate resources to build and expand health facilities so that reproductive health services are fully intergrated and rendered satisfactory; strengthen PNC (post neonatal care) for the mother and newborn within 1-2 hours and 1-7 days; establish a strong referral system between community and the nearest health facility on maternal and newborn; strengthen male involvement in reproductive health programmes; and establish and promote adolescent friendly health services at all levels of health care system including at community level.[15]

Hon. Nonhlanhla Dlamini, Parliament of Swaziland, began her presentation by giving an overview of statistics on the country. The total population is 929,718 and population growth is at 2.9%. Life expectancy is 31 yrs. The percentage of births attended by skilled health personnel is 74.1% and contraceptive prevalence is at 48%. Unmet need

[15] "Namibia's progress, achievements and challenges," Hon. Hansima Christian, Parliament of Namibia: http://ppdafrica.org/docs/2009SEAPACOH/hansima.pdf

for family planning is 32%. And Swaziland spends 10% of its total annual budget on health—this is an increase over 8% previously. This number does not include donor funds—but it reaches 15% when donor funds are included.

To implement the 2008 resolutions, the Parliament of Swaziland has done activities at both the national and community level. At the national level, there has been capacity building on sexual and reproductive health for members; members have moved several motions, including accessibility of health services, investigations on increase of abortions among young people, and investigation on the late increase on maternal mortality rates. At the community level, they have pushed forward issues such as the training of rural health motivators and the provision of commodities to home base carers. In Swaziland, progress on the ICPD PoA and the Maputo PoA includes institutional changes such as establishing youth friendly clinics and creating an integrated SRH strategic plan for 2008-2015. SRH services in public facilities are free and SRH services in the private sector are subsidised. There has also been work on empowerment of women and gender issues, and while the national constitution calls for 30% representation of women in Parliament, the current representation of women is 22%. Collaboration with NGOs has also increased, as they are the majority implementers of HIV/AIDS programmes and SRH services, including family planning, home based care programmes, and rural health motivators

"This time around next year, we want to have the 15% [for health from the government budget]."
--Hon. Nonhlanhla Dlamini, MP Swaziland

Challenges in Swaziland include HIV and AIDS, and a resultant increase in orphans; poverty which leads to less power to negotiate for safe sex; poor infrastructure creating long trips to health facilities; and crime, such as hijacking of ambulances. To address these challenges, Hon. Nonhlanhla Dlamini outlined a way forward including: advocating for an increase of the government health budget to 15%; meeting with the finance committee during budget preparation; strengthening adolescent sexual and reproductive health services through using available youth centres; strengthening the integration of SRH information in schools and churches; and general community education on sexual and reproductive health.[16]

Hon. Prof. Idris Ali Mtulia, Parliament of Tanzania began by giving an overview of the country's statistics. Tanzania's population stands at 40 million and life expectancy is 45 years. Issues in the country include a heavy disease burden; inadequate coverage of health services; unsatisfactory quality of health services; and limited resources (health

[16] "Swaziland's progress, achievements and challenges," Hon. Nonhlanhla Dlamini, Parliament of Swaziland: http://ppdafrica.org/docs/2009SEAPACOH/dlamini.pdf

is now at 11% of government's annual budget). According to Hon. Prof. Mtulia, the human resource for health has a deficit of 68% of its workforce of various cadres, as there are only 126 training centers and 6 medical universities.

"Most of these causes which kill our mothers are largely preventable if pregnant women can have early access to skilled attendance at births and provision of emergency caesarian (operations) sections. Tanzania is on record that antenatal clinics attendance is up to 94% but only 47% deliver in health facilities with skilled birth attendants."
--Hon. Prof. Idris Ali Mtulia, Parliament of Tanzania

The causes of high maternal mortality (578/100,000) in Tanzania include: haemorrhages; obstructed labour; pregnancy-induced hypertension; sepsis; abortion complications; and HIV/AIDS complications.

Barriers to health care in Tanzania include: long distances to health facilities; lack of transport; unsatisfactory services; lack of functioning referral systems; inadequate capacities of health facilities (i.e. space, skilled attendants, equipment and effect of traditional beliefs); and gender inequalities and access to family resources at household level. Fortunately, the HIV/AIDS pandemic in Tanzania is showing early signs of subsiding: in 1999 the prevalence was at 12%; in 2004 the prevalence was at 7%; and in 2008 the prevalence was 5.8%. Over 2 million people in Tanzania live with HIV/AIDS. There are 1027 VCT sites in Tanzania and each district has at least 3 VCT sites. There are 1400 community home based providers, STI services and PMTCT now has provided services to 255,913 mothers.

Hon. Prof. Idris Ali Mtulia stated that Tanzania's development programme 2007-2017 seeks to address maternal mortality and under-5 child mortality. Maternal mortality should reduce from the present 578/100,000 live births to 175/100,000 live births and under-5 child mortality should reduce from 112 per 1000 live births to 45 per 1000 live births. This decrease demands increasing the coverage of birth attendance up to 88% from the present 46%, as well as scaling up family planning, nutrition, immunization, training 15000 youth peer educators; and provide communications to all 114 districts to improve and strengthen the referral system.[17]

Hon. Dr. Ekwee Ethuro, Parliament of Kenya, began by stating that SEAPACOH has been a useful resource to the Kenya parliament's work—for example, they have referred to Uganda as a case and make sure that Kenya is not left behind when progress is made, e.g. for indoor spraying of DDT for mosquitoes to prevent malaria. Hon. Dr. Ethuro next gave Kenya's background information as follows: population: 38 million (census August 2009); population growth 2.5%; area: 585,000 square kilometres; poverty level: 47%; there is currently a government of national coalition.

[17] "Tanzania's progress, achievements and challenges," Hon. Prof. Idris Ali Mtulia, Parliament of Tanzania: http://ppdafrica.org/docs/2009SEAPACOH/mtulia.pdf

The budget for health in Kenya is now 5.4% of the annual budget. There are now two ministries dealing with health in Kenya: the Ministry of Medical Services and Public Health and Sanitation. New standing orders in Kenya's Parliament mean that the Health Committee now only deals with health; some of its previous workload was offloaded to new labour and social services committees. Hon. Dr. Ethuro said that the Parliament is focusing on proper scrutiny of the Executive budget through interrogating line ministries' budgets. Overall country gains in Kenya include a recent economic stimulus package, which provisions for the constitution of model health centers across the country and the hiring of 20 nurses per constituency.

Hon. Dr. Ethuro also reported back on Kenya's progress on the concrete commitments made at the last meeting in September 2008. Kenya's Parliament has reported back on the deliberations and resolutions of the meeting to Parliament and partners; established a parliamentary taskforce to look into, monitor and oversee action on the socio-economic inequalities, including inequality in health and access to health care; sensitized fellow MPs and communicated with Ministers of Health and Finance; enacted a law involving the Health Committee in the budget process; ensured key docs on international and regional commitments and national laws relevant to health are provided. The Kenya parliament has yet to move a motion on primary health care or petition the Minister to inform the committee on the status of public health laws.[18]

Hon. Munji Habeenzu, Parliament of Zambia, began by stating that although he did not bring statistics to discuss, Zambian MPs are committed to equity in health and the fight against HIV and AIDS. Previously, in Zambia, there was no political will. But more recently, MPs have come together and seen that fight involves everyone. A number of issues are developing in Zambia—for instance, they are now taking circumcision very seriously. Parliament is currently working on a law that mandates circumcision for all male MPs in Zambia.

In Zambia, this is discussed under the theme of "closing the tap." Hon. Habeenzu then told the story of how when a woman went to the market, she accidentally left the tap in the house open. This is during a time when there is water shortage in Zambia, but when the woman returned, the house was filled with water. Thus, in Zambia, the theme is "closing the tap." Zambia will first start with leaders, then go to the community. The plan to close the tap includes male circumcision and improved financing. Previously, there was misuse of funds in the Ministry of Health—this affected the operations in the health sector, which were largely funded by donors. Zambia is also plagued by a shortage of human resource in the health sector. Hon. Habeenzu said that these issues need to be changed.

[18] "Kenya's progress, achievements and challenges," Hon. Dr. Ekwee Ethuro, Parliament of Kenya: http://ppdafrica.org/docs/2009SEAPACOH/ethuro.pdf

Hon. Dr. David Parirenyatwa, Parliament of Zimbabwe, began by giving expressing his appreciation for PPD and for the regional office in Africa; "PPD was raised with Bangladesh, China, and North Africa. But they fought for it to be here, because the needs are greatest in Africa." He then recognized the passion that Hon. Blessing Chebundo has for SEAPACOH . Hon. Dr. David Parirenyatwa then gave an overview of statistics on Zimbabwe. Zimbabwe has an inclusive government. The total population is 11.6 million. The under-five mortality currently at 82 per 1000 live births and the total fertility rate is 3.8. The percentage of births attended by skilled health personnel-decreased to 80% after having been once at 83% over the past 4 years. The contraceptive prevalence rate has increased steadily to 60%, with most women using modern methods of contraception (58%). The most popular methods are the pill (43%) and injection (10%).

"There are three strategies in the fight against HIV/AIDS--prevention, prevention, and prevention."
--Hon. Dr. David Parirenyatwa, Parliament of Zimbabwe

Hon. Dr. Parirenyatwa then said that because health is very broad, there is so much to talk about, so in the end you get lost. But he emphasized that there are five areas that must always be looked at: 1) human resources for health; 2) drugs and medicines; 3) infrastructure; 4) transport, including ambulances; and 5) disease burden. He then spoke about Africa's fight against malaria. "We decided that the best way to fight it in Africa is to spray with DDT. Europe did it. So we are now using indoor residual spray in Africa."

According to Hon. Dr. David Parirenyatwa, "There are three strategies in the fight against HIV and AIDS--prevention, prevention, and prevention." Circumcision is only one small part of the package. With circumcision, you can still catch HIV. He said that the inclusive government in Zimbabwe was done well. They have contributed 15.6% of the budget towards health. It is important to mobilize internal resources. He said that Africa needs donors, but cannot rely on them. Donor money should be controlled by government. All money must go into a transparent basket. It is difficult to know when NGOs receive donor money. All funds coming into the country should be going into one transparent basket and the government itself must also operate transparently. You need "three things—one of each—one [shared] strategy, coordination, and one monitoring and evaluation system."

Hon. Dr. Parirenyatwa also stressed that user fees for the poor should be removed. "Those who can pay, should pay, but if not, there should be no fees."

There have been a number of activities undertaken by the Zimbabwe parliament to implement the September 2008 resolutions at national and community levels, including:

- Tabled motion on the need to link sexual and reproductive health and HIV programmes and policies that address vulnerabilities of women and children;
- Currently participating in the crafting of policy on male circumcision as one of the added strategies to reduce HIV infection;
- Engaged Civic Society (CSOs) in out outreach programmes in constituencies

targeting women and young people;
- Lobbied for the provision of appropriate, affordable, accessible and friendly adolescent and reproductive health services;
- Participated in the review of the country's road map;
- Received feedback from the established Maputo Plan of Action Monitoring taskforce for the country; and
- Conducted research in 2008-2009: 2008-A Rapid Assessment of ASRH Services in Zimbabwe; 2007-9-The Zimbabwe Maternal and Perinatal Mortality Study; 2009-An Assessment of Obstetric Fistula in Zimbabwe; 2009-An Assessment of Waiting Mothers' Shelters in Zimbabwe.

According to Hon. Dr. Parirenyatwa, challenges to Zimbabwe's progress include:
- Weak health systems performance;
- Resource allocation;
- Limited scaling up of integrated interventions;
- Poor intersectoral coordination and collaboration;
- Program monitoring activities hampered by transport shortage;
- Shrinking human resources base;
- Hyperinflationary environment (past 3-4 years) made it difficult to implement planned activities due to loss of value of funds; and
- Previously, an unstable political environment and inconclusive processes.

To address these challenges, Zimbabwe will work towards
- Implementation of the continental policy including universal access to sexual and reproductive health by 2015;
- Strengthen African and South-South co-operation for the attainment of ICPD and MDG goals;
- Increase domestic resources for sexual and reproductive health and rights including the addressing of the human resource crisis;
- Foster community involvement and participation;
- Strengthen sexual and reproductive health commodity security with emphasis on family planning and emergency obstetric care and referral;
- Put in place operational research for evidence based action and effective monitoring tools to track progress made on the implementation of this Plan of Action;
- Avail more resources (internal and external) for SRH to achieve ICPD and MDG goals;
- Increase multi-lateral and bilateral collaboration to exploit comparative advantages;
- Improve working conditions for staff; and
- Address the supply-side factors of health delivery and create demand.

Hon. Dr. Parirenyatwa concluded by stating that Zimbabwe, like a number of African countries (DRC, Nigeria, South Africa) have rich internal resources, and could finance their population health if the resources are held and used to this purpose.[19]

[19] "Zimbabwe's progress, achievements and challenges," Hon. Dr. David Parirenyatwa, Parliament of Zimbabwe:

Hon. Lydia Wanyoto Mutende, East Africa Legislative Assembly, and the Chair of this session, next took the opportunity to report back on the work done over the past year in the East Africa Legislative Assembly. They have developed two model laws: a HIV/AIDS model law and one on international universities. They have a strategic plan on reproductive health and reproductive rights, working under common markets. There is a model law on status, access and to drugs on HIV/AIDS and a model law on FGM. They are working to develop pool procurement of drug, medical supplies and medical equipment. The East Africa Legislative Assembly has an inter-parliamentary forum on health, population and development and has joint training (exchange programs), research and specialization. They are also working on health insurance schemes, following the experiences of Rwanda and Ghana. The East Africa Legislative Assembly is also looking at exploring contracted health workers as opposed to salaried payroll, as part of a larger focus on examining value for money.

Session Three Discussion

One MP opened the discussion by asking about increased breast cancer risk with lower fertility rates. She requested an answer on this issue from a doctor. Another said that he was happy to hear what the East Africa Legislative Assembly (EALA) is doing, and asked what the EALA is doing for health worker standardization. A delegate asked about the work of the EALA to arrange for access to antiretroviral treatment for people when they move across borders, so they can continue their drug regimes. There was also a query on how Swaziland was able to make such good progress on dealing with malaria.

Hon. Nonhlanhla Dlamini, MP Swaziland, said that malaria was a very serious problem in the country. They received Global Fund money and did a full intervention in partnership with three countries that addressed malaria together. Swaziland had to do significant education, and used spraying and nets. It was based on diagnosis and early treatment. They ensured that they did not run out of malaria drugs at any point. They also sprayed DDT indoors.

The question of breast cancer and lower fertility was discussed. It was noted that there is no direct relation between breast cancer and lower fertility. But there is a strong link between human papillomaviruses (HPV) infection and cervical cancer. Thus, we should insist on vaccination for HPV to prevent cervical cancer. There are other cancers related to plastics, as cooking oil, and water are stored in plastic containers that contain lead and cadmium.

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http://ppdafrica.org/docs/2009SEAPACOH/parirenyatwa.pdf

Another MP said that they need to better understand research, and requested that organizations, including the EALA, send research reports and studies to the Parliamentary Committees in each country.

Hon. Lydia Wanyoto Mutende, East Africa Legislative Assembly, said that there is currently research in progress on how people are being trained based through a Ugandan university, but trained through UK universities—as a type of e-training. This needs to be better understood—this is operating at both private and public universities.

A MP said that there is a need for regional harmonization. For example, truck-drivers travel across borders. There needs to be a clear model law for ARVs covering status, access, and treatment so that people can cross borders. The inter-parliamentary health committee should harmonize this at the parliamentary level.

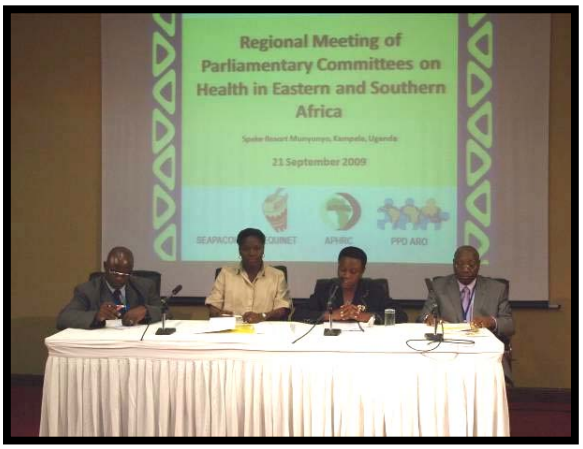
7. Session Four: Follow Up Actions and Resolutions

This session was chaired by Hon. Munji Habeenzu, Parliament of Zambia.

Hon. Austin Mtukula, Vice Chairperson, SEAPACOH, guided participants through a proposed "Way Forward for SEAPACOH," drawn from delegates' presentations and the discussions. The short document was edited and agreed to in plenary and the final document is contained in this report under "1. Commitments."

8. The Closing

The Closing Session was chaired by Hon. Munji Habeenzu, Parliament of Zambia.



Dr. Jotham Musinguzi, Regional Director, PPD ARO, encouraged MPs to become involved from the start of the budgeting process, to ensure that they will be involved in allocating enough funding to health. He said that the record of SEAPACOH over the past two to three years shows that we are on the right track. Dr. Musinguzi concluded by stating that "The voices of parliament in the region are being heard. You must continue to make sure that your voices are being heard. At the Partners in Population and Development Africa Regional Office, we stand ready to continue working with you."

Hon. Blessing Chebundo, Chair, SEAPACOH, spoke next. He began by saying, "As we come to the end of this important meeting, let me say that this is not the end, but that this has been an accelerated action towards addressing health challenges in the region, especially maternal and reproductive health and child mortality." He noted that

due to globalization and increased collaboration with different partners, there has been a great level of capacity building for legislatures as evidenced by progress reports tabled here and displayed by partners. Therefore, the onus is on MPs to take home the resolution messages arising from this meeting. “At the next meeting we need to table reports in Parliament, make relevant motions, ask relevant questions and even commission studies.” He emphasized that the agenda of sexual and reproductive health needs to be scaled up, especially at the primary care level. Hon. Chebundo said that in Africa, people sit on regional commitments and do nothing, but as Committees of Parliaments of Health, MPs gathered at this meeting cannot sit on resolutions, but rather, must move the issues forward. He concluded by commending all participants on the high and productive debate and wished everyone safe travels home.

Hon. Rebecca Kadaga, Deputy Speaker, Parliament of Uganda, made the closing remarks for the meeting. She began by noting that she wanted to discuss a few broad issues that she came with and others that arose from the discussions she has heard at the meeting. She was recently at a meeting in Botswana, where participants were urged to quickly ratify a charter on democracy, but the participants had not been fully informed on the relevant previous protocols, so could not make an informed decision. She then asked participants how they could catalogue and domesticate protocols such as Maputo, Abuja, if they were not familiar with.

She noted that over the past ten years, the Ugandan government signs agreements on water, roads, the environment, etc. Recently, the Parliament was able to get list of treaties signed by the government and the list was three pages long of the treaties and protocols signed since 1996. But none of these documents during this time had been brought in full to Parliament.

She queried participants, “How can you domesticate [a treaty] if you do not know [it]? Our governments should have a Ministries for Protocols and Treaties. There should also be a committee in parliament in charge of treaties. This should not be mixed with foreign affairs.”

She thanked the participants for coming together. She also expressed her hope that this information from the meeting is shared in the larger parliament and is not just for the Health Committee. She stated, “This is an opportunity for you to bring it [to the full parliament] and then the house could appreciate them and put ears of the Ministry of Health on these issues.”

Another issue which came to Hon. Kadaga's attention was the discussion about cancer and vaccination for HPV. She said that the country must start with screening for cervical cancer, but there are not enough facilities, as there are five for the whole country of Uganda. Her speech was briefly interrupted with a correction from a MP in Uganda that there are eight regional hospitals in the country that can do cervical cancer screening. Hon. Rebecca Kadaga continued by stating that eight regional hospitals in the whole country does not satisfy her. A woman must travel for screening; she has to find transport, a hotel. "It is nonsense. We should be advocating for minimum at every sub-country at HL3. That is what we have been advocating for. The Cancer Association of Namibia has a more comprehensive program of screening, they are busy, doing screening every week. So people can ascertain their situation and then get help. We need to get machinery and get the budget for medicine."

She said that this is the first time she has heard about SEAPACOH, so she hopes that its influence will grow and that this that regional body will be seen, heard, and will be effective. In closing, she wished the participants well, but asked them to "please just go home and work."

The meeting then closed.

Appendix 1: Meeting Programme

Sunday, September 20, 2009		
- Arrival of delegates		
Day One: Monday, September 21, 2009		
0800-0900	Registration	• Ms. Charity Birungi and Ms. Diana Nambatya, PPD ARO
OPENING SESSION		
0900-1000	**Opening Session**	**Session Chair:** Hon. Ruth Kavuma Nvumetta, Parliament of Uganda
0900-1000	Opening Remarks Official Opening	• Dr. Jotham Musinguzi, Regional Director, PPD ARO • Mr Moses Mulumba, EQUINET • Dr. Eliya Zulu, Deputy Executive Director, APHRC • Hon. Blessing Chebundo, Chair, SEAPACOH • Hon. Dr. Stephen Mallinga, Minister of Health, Government of Uganda
1000-1015	**Tea/Coffee Break** Group Photograph, Press Conference	
1015-1100	**Session One: Presentations**	**Session Chair** Hon. Dr. Desta Delkasso, Parliament of Ethiopia
1015-1030 1030-1045 1045-1100	Overview of RH, Population and Development Challenges in the Region Findings of the Regional Survey of Parliaments and Implications for Strengthening Parliamentary Work Discussion	• Dr. Eliya Zulu, Deputy Executive Director, APHRC • Dr Rene Loewenson EQUINET
1100-1300	**Session Two: Presentations on Country Achievements and Challenges since September 2008**	**Session Chair:** Hon. Dr. Victor Munyaka, Parliament of Kenya
1100 - 1120	Review of SEAPACOH activities, challenges and way forward	• Hon Blessing Chebundo Chairperson, SEAPACOH

1120-1240 1240-1300	Country progress, achievements and challenges regarding: - Implementation of the September 2008 Munyonyo Parliament Meeting Resolutions; - ICPD PoA; Maputo Plan of Action; - The Abuja Declaration; and - The Ouagadougou Declaration on Primary Health Care (PHC) Discussion	• Hon. Chris Baryomunsi, Parliament of Uganda • Hon Austin Mtukula, Parliament of Malawi
1300-1400	**Lunch**	
1400-1620	**Session Three: Presentations on Country Achievements and Challenges since September 2008** (cont'd)	**Session Chair:** Hon. Lydia Wanyoto Mutende, East Africa Legislative Assembly
1400-1600 1600-1620	*Presentations continue…* Discussion	• Hon. Hansima Christian, Parliament of Namibia • Hon. Nonhlanhla Dlamini, Parliament of Swaziland • Hon. Prof. Idris Ali Mtulia, Parliament of Tanzania • Hon. Dr Ekwee Ethuro, Parliament of Kenya • Hon. Munji Habeenzu, Parliament of Zambia • Hon. Dr. David Parirenyatwa Parliament of Zimbabwe
1620-1635	**Tea/Coffee Break**	
1635-1720	**Session Three: Follow Up Actions and Resolutions**	**Session Chair:** Hon. Munji Habeenzu, Parliament of Zambia
1635-1720	Presentation of the summary of priority issues; Discussion and adoption of Munyonyo 2009 Resolutions	• Hon. Austin Mtukula, Vice Chairperson, SEAPACOH
1720-1800	**Closing Session**	**Session Chair:** Hon. Rose Seninde, Parliament of Uganda
	Closing Remarks Official Closing	• Dr. Jotham Musinguzi, Regional Director, PPD ARO • Hon. Blessing Chebundo, Chair, SEAPACOH • Hon. Rebecca Kadaga, Deputy Speaker, Parliament of Uganda

Appendix 2: List of Participants

	Name	Organization	Country	Email address
1	Mr. Bharam Namanya	EAC	Tanzania	bharam_namanya@yahoo.com
2	Hon. Lydia Wanyoto Mutende	East Africa Legislative Assembly	Tanzania	imwanyoto@yahoo.co.uk
3	Ms. Elizabeth Barinda	East Africa Legislative Assembly	Tanzania	barinda@eachq.org,ebarinda@yahoo.com
4	Mr. Deogratias Egidio	SADC Parliamentary Forum	Namibia	degidio@sadcpf.org
5	Dr. Desta Delkasso	Ethiopian Parliament	Ethiopia	eyosias13@yahoo.com
6	Hon. Dr. Victor Munyaka	Parliament of Kenya	Kenya	drvmunyaka@gmail.com;
7	Hon. Kennedy Otsola	Parliament of Kenya	Kenya	kotsola@aphrc.org, kotsola@gmail.com
8	Hon. Eseli Simiyu	Parliament of Kenya	Kenya	kimitili@parliament.go.ke, eselidol@africaonline.co.ke
9	Hon. Ekwee Ethuro	Parliament of Kenya	Kenya	dethuro@yahoo.com
10	Hon. Austin Mtukula	Malawi Parliament	Malawi	mbutao@poly.ac.mw
11	Ms. Agnes Mukono	Parliament of Namibia	Namibia	a.mukono@parliament.gov.na
12	Hon. Elia George Kaiyamo	Parliament of Namibia	Namibia	e.kayamo@parliament.gov.na; kayamo@yahoo.com
13	Hon. Christian Hansina	Parliament of Namibia	Namibia	h.christian@parliament.gov.na
14	Hon. Dlamini Nonhlanhla	Parliament of Swaziland	Swaziland	mbalis@swazi.net
15	Hon. Thandi Shongwe	Parliament of Swaziland	Swaziland	nhladla@yahoo.com; admiparl@swazi.net
16	Prof. Idris Ali Mtulia	Parliament of Tanzania	Tanzania	Idrismtulia@yahoo.com
17	Hon. Dr. Chris Baryomunsi	Parliament of Uganda	Uganda	cbaryomunsi@parliament.go.ug; cbaryomunsi@yahoo.com
18	Hon. Alex Byarugaba	Parliament of Uganda	Uganda	alexbakunda@yahoo.com
19	Hon. Sylvia Ssinabulya	Parliament of Uganda	Uganda	
20	Hon. Beatrice Magoola	Parliament of Uganda	Uganda	

21	Hon. Winfred Masiko	Parliament of Uganda	Uganda	wmasiko@parliament.go.ug; wmasiko@yahoo.co.uk
22	Hon. Beatrice Rwakimari	Parliament of Uganda	Uganda	brwakimari@parliament.go.ug
23	Hon. Alex Byarugaba	Parliament of Uganda	Uganda	alexbakunda@yahoo.com
24	Hon. Prof. W.W. Anokbonggo	Parliament of Uganda	Uganda	wabonggo@parliament.go.ug
25	Hon. Ruth Kavuma	Parliament of Uganda	Uganda	rkavuma@parliament.go.ug; sseseis@hotmail.com
26	Mr. Wamala Buyungo Musa	Parliament of Uganda	Uganda	Umwamala@yahoo.com;
27	Hon. Mathias Kasamba	Parliament of Uganda	Uganda	mkasamba@parliament.go.ug
28	Hon. James Kubeketerya	Parliament of Uganda	Uganda	nsnyombi@parliament.go.ug
29	Hon. Mariam Nalubega	Parliament of Uganda	Uganda	jkubek@parliament.go.ug
30	Hon. Rosemary Seninde Nansubuga	Parliament of Uganda	Uganda	mnalubega@parliament.go.ug
31	Hon. Florence Nayiga Ssekabira	Parliament of Uganda	Uganda	rseninde@parliament.go.ug; seninderose@yahoo.com
32	Hon. Wangwa Rutangye	Parliament of Uganda	Uganda	fnayiga@parliament.go.ug
33	Hon. Kabuusu Moses Wagaba	Parliament of Uganda	Uganda	erutangye@parliament.go.ug; mrrwfpu@yahoo.com
34	Hon. Moses M. Mukose	Parliament of Uganda	Uganda	mkabuusu@parliament.go.ug; moseskabuusu2004@yahoo.com
35	Hon. Grace Namara	Parliament of Uganda	Uganda	mmutabaali@parliament.go.ug
36	Hon. Isaac Sejjoba	Parliament of Uganda	Uganda	gnamara@parliament.go.ug; gnamara@yahoo.com
37	Hon. Norman Ibrahim Muwulize	Parliament of Uganda	Uganda	isejjoba@parliament.go.ug
38	Hon. Grace Kyomugisha	Parliament of Uganda	Uganda	nmuwulize@parliament.go.ug
39	Hon. Milton Muwuma	Parliament of Uganda	Uganda	
40	Hon. Anne Auru	Parliament of Uganda	Uganda	mkmuwuma@parliament.go.ug
41	Hon. P. Claver Mutuluuza	Parliament of Uganda	Uganda	
42	Ms. Sarah Tukahirwa	Parliament of Uganda	Uganda	

43	Mr. Musa Buyungo	Parliament of Uganda	Uganda	
44	Ms. Lilian Angela Nabatanzi	Parliament of Uganda	Uganda	
45	Hon. Munji Habeenzu	Parliament of Zambia	Zambia	mhabeenzu@parliament.gov.zm; mhabeenzu@yahoo.com
46	Ms. Aillet Mukono	Parliament of Zimbabwe, SEAPACOH	Zimbabwe	ailletm@yahoo.com
47	Hon. Blessing Chebundo	Parliament of Zimbabwe	Zimbabwe	chebundob@yahoo.com; garaibmc@gmail.com
48	Hon. David Parirenyatwa	Parliament of Zimbabwe	Zimbabwe	dparirenyatwa@yahoo.com
49	Dr. Eliya Zulu	APHRC	Kenya	ezulu@aphrc.org
50	Ms. Rose Oronje	APHRC	Kenya	roronje@aphrc.org, rndakala@yahoo.com
51	Dr. Rene Loewenson	TARSC/EQUINET	Zimbabwe	rene@tarsc.org
52	Dr. Chalotte Muheki Zikusooka	Healthnet Consult/ EQUINET	Uganda	charlotte@healthnetconsult.com
53	Mr. Moses Mulumba	HEPS Uganda/ EQUINET	Uganda	mulumba_moses@yahoo.com
54	Ms. Rebecca Pointer	TARSC/ EQUINET	South Africa	rebecca@tarsc.org
55	Dr. Jotham Musinguzi	PPD ARO	Uganda	jmusinguzi@pppdsec.org
56	Mr. Abdelyah Lakssir	PPD ARO	Uganda	alakssir@ppdsec.org
57	Ms. Nichole Zlatunich	PPD ARO	Uganda	nzlautunich@gmail.com
58	Mr. Patrick Mugirwa	PPD ARO	Uganda	pmugirwa@ppdsec.org
59	Ms. Diana Nambatya	PPD ARO	Uganda	dnambatya@ppdsec.org
60	Ms. Charity Birungi	PPD ARO	Uganda	
61	Mr. Francis Matovu	PPD ARO	Uganda	
62	Mr. Charles Zirarema	Uganda Population Secretariat	Uganda	charles.zirarema@popsec.org
63	Mr. Hannington Burunde	Uganda Population Secretariat	Uganda	hburunde2004@yahoo.com
64	Ms. Edith Kangabe	Uganda Population Secretariat	Uganda	kangabe_edith@yahoo.ie

65	Ms. Hope Nzeire	Uganda Population Secretariat	Uganda	
66	Ms. Barbara Kyomugisha	Uganda Population Secretariat	Uganda	
67	Ms. Christine Nakibuuka	Uganda Population Secretariat	Uganda	nakibuukac@yahoo.com
68	Mr. Anthony Bugembe	Uganda Population Secretariat	Uganda	bantda@yahoo.com
69	Ms. Alice Birungi	Uganda Population Secretariat	Uganda	birualice@hotmail.com
70	Mr. Sudarshan Rajasundaram	Uganda Population Secretariat	Uganda	suda_raj@yahoo.com
71	Ms. Eva Nakimuli	Uganda Population Secretariat	Uganda	naeva2002200@yahoo.com
72	Ms. Noelyn Kaddu	Uganda Population Secretariat	Uganda	noelkadd@yahoo.com
73	Mr. Matte Rodgers	Uganda Population Secretariat	Uganda	rogersmatte@yahoo.co.uk
74	Mr. Livingstone Kigozi	Uganda Population Secretariat	Uganda	
75	Dr. Abeja Apunyo	Pathfinder International	Uganda	
76	Canon Job Mbukure	URHAN	Uganda	
77	Mr. James Kotzsch	DSW	Uganda	