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## SUMMARY RECORDS

ON THE PANEL DISCUSSION HELD DURING THE 125<sup>th</sup> ASSEMBLY IN BERN  
(OCTOBER 2011)

on the subject item

**"Access to health as a basic right: The role of parliaments in addressing  
key challenges to securing the health of women and children"**

Chosen for debate by the Third Standing Committee  
*(Democracy and Human Rights)*

during the 126<sup>th</sup> Assembly in April 2012 in Kampala (Uganda)

## **Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children**

### Item 3(c) of the agenda

*Panel discussion on the subject chosen for debate by the Third Standing Committee on Democracy and Human Rights during the 126<sup>th</sup> Assembly in April 2012*

### **Sitting of Tuesday, 18 October**

(Morning)

*The meeting was called to order at 9.15 a.m. with the President of the Third Standing Committee, Mr. O. Kyei-Mensah-Bonsu (Ghana) in the Chair.*

The MODERATOR explained that the comments made during the meeting would be used by the co-Rapporteurs to edit and finalize their report before it was presented to the Third Standing Committee for discussion at the 126<sup>th</sup> IPU Assembly. In addition, a draft resolution would be formulated following the present debate to accompany the finalized report and to also be adopted at the next Assembly.

Ms. S. ATAULLAHJAN (Canada), *co-Rapporteur*, said that the report comprised an evaluation of progress towards the achievement of Millennium Development Goals (MDGs) 4 and 5 (on reducing child mortality and improving maternal health), a description of the key challenges – including the need to strengthen health systems and address the inequities faced by vulnerable groups of women and children – and a summary of relevant international human rights frameworks. The report described the lack of accountability that existed in some countries that had not introduced policies or made resources available to enhance maternal and child health services.

While progress still needed to be made to achieve the MDGs by 2015 and to ensure transparency in national health expenditure, there were already a number of successes at the country level that the international community could build upon. The concluding section of the report focused on the role that all parliamentarians could play to ensure that the necessary improvements were made to women's and children's health services globally. The report also recognized that women and children played a key role in all areas of development.

Ms. P. TURYAHIKAYO (Uganda), *co-Rapporteur*, said that it was the responsibility of States to ensure that the right to health was fulfilled through appropriate legislative, administrative, budgetary and judicial measures. To that end, parliamentarians needed to take appropriate actions in line with their responsibilities for raising awareness among the public, drafting legislation, ensuring financial oversight, transparency and accountability, and reporting on, monitoring and evaluating national programmes.

Parliamentarians first needed to raise awareness through parliamentary debates and sensitize the public of key issues affecting the health of women and children. Next, they needed to ensure that relevant legislation was introduced or amended to ensure respect for the right to health and to guarantee equality of access to health care for all. They also needed to ensure that legislation conformed to relevant international legal obligations of each country.

As part of budgetary processes, parliamentarians had to work to secure the adequate allocation of financial resources to reproductive, maternal and child health services, and to ensure access to those services for the most vulnerable women and children.

Transparency and accountability were vital in the health sector; parliamentarians needed to hold consultations with stakeholders prior to drafting budgets. Furthermore, donor country parliamentarians should request adequate reporting on the proportion of their governments' international assistance that targeted maternal and child health to ensure the most vulnerable communities were able to benefit. Monitoring government spending was a prerequisite to ensure that countries honoured pledges they had made, as part of the UN Secretary-General's Global Strategy for Women's and Children's Health and other international instruments.

Parliamentarians also needed to oversee all government action on maternal, child and newborn health, both in policy development and programme implementation. Such oversight would help prevent discrimination in health service delivery and determine whether programmes were harnessing new technologies and exploring all possible financing mechanisms. To facilitate their monitoring role, parliamentarians needed to establish robust national accountability frameworks, such as commissions, that could report on government action and monitor progress towards achievement of the MDGs.

Mr. F. SARDINHA (India), *co-Rapporteur*, said that lack of access to equitable health care was still a serious global issue, and one that contributed greatly to high maternal and infant mortality rates that still persisted in developing regions, notably sub-Saharan Africa and South Asia. The international community therefore needed to expedite its work to achieve the MDGs and reduce those high mortality rates. To do so, the issue of financial constraints would need to be addressed, with governments paying greater attention to appropriate gender-sensitive budgeting approaches. Parliamentarians needed to take responsibility for the oversight and coordination of government action to improve maternal and child health, including the development and implementation of relevant policies and programmes. Achieving the goal of healthy mothers and children would pave the way for development in all areas and parliamentarians thus needed to take all the legislative, administrative and budgetary measures needed to ensure the right to health for all.

To that end, his country was steadily working towards the provision of free health care for all and had raised the allocation of funds to the health sector in recent years. A national rural health mission had also been launched in 2005 to help provide accessible, affordable and quality health services to the poorest communities in the most remote regions; the mission's aim was to establish fully functional, community-owned, decentralized delivery systems. In addition, mobile medical units had been made operational in nearly 400 districts.

Ms. F. BUSTREO, *Assistant Director General, Family, Women's and Children's Health, World Health Organization (WHO), Panellist*, welcomed the growing attention that had been given by IPU in recent years to promote the health and rights of women and children. She was particularly pleased to see that IPU Member Parliaments intended to adopt a relevant resolution at its 126<sup>th</sup> Assembly.

There were a number of legislative actions that parliaments could take to ensure better programmes for women's and children's health. Many countries that collectively accounted for 98 per cent of maternal and child deaths had not yet ratified and enacted international instruments such as the Maternity Protection Convention of the International Labour Organization (ILO) and the International Code of Marketing of Breast-milk Substitutes issued by the World Health Organization (WHO). The principles of enabling mothers to spend time with their newborn babies while retaining their jobs, and of underscoring the importance of nutrition for women and children were essential in promoting maternal and child health and should be implemented in countries as a matter of priority.

Parliamentarians were also able to introduce or amend legislation to ensure health-care services also reached the most vulnerable and disadvantaged communities and those with the highest burden of maternal and child mortality. Crucially, many countries did not have

legislation for the provision of midwives, who could administer life-saving treatment. Without that provision, many women, in particular young women and adolescents who delivered at home or far from health facilities, were unable to receive the vital care they needed.

A key area of concern was the high proportion of girls who married before the age of 18. The Elders, an independent group of eminent global leaders brought together by Nelson Mandela, had launched a campaign called "Girls Not Brides", which campaigned for the establishment of a legal age for marriage, not least because girls were five times more likely to die during pregnancy or childbirth if they were under the age of 15.

The UN Human Rights Council had recently passed a resolution on preventable maternal mortality and morbidity and human rights. It had requested the Office of the High Commissioner for Human Rights to report on best practices and the approaches that countries had implemented to address the burden of maternal mortality. Establishing a link between that and IPU work done through its Third Standing Committee was essential; parliamentarians needed to ensure accountability of government action to reduce mortality rates. Many countries had committed to the Global Strategy for Women's and Children's Health, but efforts should be maintained in order to meet the goal of securing that objective. To that end, WHO had established a Commission on Information and Accountability for Women's and Children's Health. The Commission presented, in September 2010, 10 key recommendations to the UN Secretary-General, which included: establishing adequate civil registration systems in countries so that every woman and child could be counted; providing disaggregated data in national budgets on how much was invested in women's and children's health from both domestic resources and development assistance; and establishing an independent expert review group to report to the Secretary-General every year to 2015 on progress in implementing the Global Strategy and its recommendations.

Ms. C. PRESERN, *Director, Partnership for Maternal, Newborn and Child Health (PMNCH), World Health Organization, Panellist*, said that she had previous experience of working in a country where legislation to promote women's and children's right to health did not exist, governance was weak, and basic resources not available. However, several years later, that country had enshrined women's reproductive rights in its constitution, implemented a regulatory framework, and established outreach schemes for remote regions, and made available basic equipment. It was true that many countries faced severe financial constraints and had difficult choices to make in establishing systems to promote and improve access to women's and children's health, but there was much that parliamentarians, in their role as legislators, could do to help. The *World Health Report 2010*, issued by the World Health Organization, called for the abolishment of direct user fees, which often led to financial hardship for many people who were simply in need of essential health care. The Report also encouraged countries to ensure that official development assistance was used in accordance with their own nationally defined priorities. Parliamentarians could play a key role in determining the terms on which that assistance was provided.

Other measures that should be implemented included gender-sensitive budgeting, securing funds specifically for maternal, newborn and child health, and addressing the challenges faced in remote regions, such as appropriate allocation of resources and the need for transport.

Good examples of other actions and programmes could be seen in some countries: a coalition of civil society organizations had been established in United Republic of Tanzania to engage with parliaments and review allocations and expenditure regarding maternal, newborn and child health; Viet Nam had set up a health-care fund for the poor, which provided free care and had helped to dramatically reduce mortality; and research in Mexico, which assessed whether appropriate policies were in place and that right choices were being made, showed that much focus was placed on care during the neonatal period, but not during birth.

Many countries provided public hearings and grievance redressal systems, which were crucial for ensuring that the views of constituents and stakeholders were heard. Parliamentarians had a central role to play in ensuring that legislation was informed by those views and the situation on the ground. They also had responsibility to oversee and report on implementation of legislation and programmes for health and ensuring accountability. They needed to verify that every action taken to promote women's and children's health represented good value for money and made best use of available funds.

She looked forward to the resolution that would come out of the debate and draft report and urged Member Parliaments to continue making progress towards securing women's and children's health and achieving MDGs 4 and 5.

### **Debate**

Ms. H.-H. JEON (Republic of Korea) said that despite the adoption of the United Nations Millennium Declaration in 2000 and other international commitments that required countries to secure the right to health for women and children, a lack of accountability in some regions undermined that objective. The draft report was therefore a timely reminder to parliamentarians to play a more active role in enhancing human rights and health for women and children through national legislative, budgetary and oversight mechanisms, for which they had responsibility.

Local communities should also work to ensure women's and children's health and parliamentarians should facilitate that by increasing efforts to eradicate poverty, which hampered health and hindered participation of community members.

Mr. M. YUNOKI (Japan) said that the right to give birth safely and raise healthy children should be afforded to all women, regardless of where they lived. To counter the slow progress of achieving MDG 5, Japan believed that, first, women's right to sexual and reproductive health and access to health services must be ensured. Women needed to have adequate knowledge about sexual health and family planning matters and access to the relevant services at an affordable cost, including appropriate methods of contraception, health care during pregnancy, and availability of experienced midwives during childbirth.

Second, health-care systems needed to be strengthened in local communities. Japan had worked for many years to ensure that women and children had access to health care within their communities through a number of nationwide policies and programmes, such as the provision of mother and child health diaries. Globally, countries needed to work to increase the number of community health workers and medical staff who worked locally, and ensure that their professional standards and working conditions were raised.

Finally, action needed to be strengthened globally to combat infectious diseases that affected women and children.

Mrs. S. KOUKOUMA KOUTRA (Cyprus) said that while the highest attainable standard of health had been recognized as a right for several decades, there were still many countries where it was not guaranteed, particularly in sub-Saharan Africa and Southern Asia. The right to physical and mental health was vital to both women's and children's lives and legislators needed to safeguard the right of women to control all aspects of their health, including their fertility. Contrary to that objective was the fact that 19 million abortions occurred globally each year in non-secure conditions, with many women dying or having their health impaired from complications. Parliamentarians should use all the legislative tools at their disposal to protect and promote the right to health for women and children and ensure its integration into national laws and policies. Increased access was needed to proper, affordable and quality health care, as well as food, nutrition and safe drinking water in order to help eliminate leading

diseases, particularly those affecting infants. Currently there were too many obstacles that kept countries from attaining the MDGs and other goals and she urged parliamentarians to review their health systems and enact comprehensive reforms so that those systems were sufficiently flexible to adapt to each country's ever-changing health needs.

Mr. G. SILVA (Portugal) said that although the international community currently faced grave financial difficulties, health must still be considered a priority and promoted as a fundamental right. Parliaments and governments needed to work to guarantee universal access to health care, including preventive and curative treatments, screening programmes for women, and expanded mandatory vaccination coverage. Women's and children's health could also be enhanced through removing any socio-economic barriers to access to health for children and through promoting good health practices among young people.

Many countries were struggling with allocation of financial resources to avoid overspending; nevertheless, parliaments needed to prioritize the provision of health care and health education, including campaigns to raise public awareness. They also had a central role to play in policy development and ensuring adequate budgetary allocations to health systems.

Mr. K.S. WEE (Malaysia) said that several measures had been taken in his country to ensure health care was affordable and accessible to all women and children, including health clinics that provided health services to women in all stages of life, with an emphasis on prevention. All people had a right to health care regardless of age, gender and race and the international community needed to adopt measures to ensure that vulnerable groups, particularly women and children, were not discriminated against in terms of accessing health care. Health laws and policies needed to be disaggregated and tailored to those groups most in need of assistance.

Malaysia wished to encourage regional cooperation to combat pandemics and emerging infectious diseases, particularly where women and children were at high risk, and looked forward to working with other countries to improve capacities for pandemic preparedness. At the global level, countries needed to share experiences and best practices in order to build capacity and enhance research and development. Transborder patterns of infectious diseases needed to be identified and measured effectively.

Ms. MA LI (China) said that her country viewed maternal and child health as a fundamental right and essential for population well-being. China had therefore done much work to ensure legislation that provided for the protection of children and their interests and had also given prominence to women's and children's health in its socio-economic development plans. Through those and other measures, the health of women and children in China had improved considerably in recent years and the country was making good progress towards achieving MDGs 4 and 5. The government had also invested in strengthening rural health systems and detecting cervical cancer and HIV/AIDS. Maternal, neonatal and child mortality rates had dropped significantly since 2000.

China had engaged in information-sharing with other developing countries to improve maternal and child health and wished to continue working with the international community to strengthen cooperation and implement further measures and legislation.

Ms. A. TJONGARERO (Namibia) said that while progress had been made in improving women's and children's health in Africa, it was clear that many countries were still lagging behind in terms of achieving MDGs 4 and 5. Maternal mortality had risen rather than dropped in her country for a variety of reasons, including lack of proper nutrition, long distances between villages and health centres, HIV/AIDS and lack of trained personnel. To address those issues, a number of strategies and programmes had been established and some new health

centres had been built in communities where they were lacking. The Namibian Government was working to improve access to health care for women and children but parliamentarians had a duty to ensure, through oversight and outreach visits, that nationally approved health budget resources actually reached communities.

Mr. H. HASSANI (Islamic Republic of Iran) said that health was at the centre of comprehensive and sustainable development and, as such, his country's Constitution ensured universal access to health care services free of charge. Health care was an area in which parliamentarians should play an effective role, particularly in the allocation of resources to health systems to ensure that all people were covered by health insurance and had access to primary health care.

It was regrettable that a number of countries were not on track to meet the health-related MDGs by 2015. All parliaments needed to continue to work to reverse that trend and ensure that those goals were achieved. His country was set to meet the MDGs by the target date and worked to steadily reduce the maternal and under-five mortality rates as well as to increase the number of mother- and child-friendly hospitals, family planning services, child vaccination and health insurance coverage.

Developed countries needed to do more to assist developing countries in poverty eradication, health promotion and debt relief, if those countries were to attain the MDGs. In addition, the international community as a whole needed to consider what action should be taken in the post-MDG period in order to pursue assistance to those countries in need.

Mr. T. GÜNTNER (Romania) said that access to health services for women and children was not just a fundamental right but also a critical element of eradicating poverty and inequality, and essential to achieving the MDGs.

One of the priorities of the parliamentary Subcommittee on Population and Development in Romania was the implementation of a national programme for women's and children's health. The Subcommittee also had responsibility for informing and raising awareness among parliament, media and the public about key issues related to women's and children's health. Given Romania's new status as a donor country, those activities took on an international dimension. The Subcommittee sought full stakeholder participation to identify main national goals for women's and children's health, and the action to be taken.

Another Subcommittee responsibility was to link any Romanian parliamentary actions with those of other parliaments, relevant bodies and the United Nations.

He urged all parliaments to establish similar structures to prioritize and promote women's and children's health both in parliamentary and public life.

Ms. G. DE VENECIA (Philippines) said that his country had made considerable progress towards achieving the MDGs; it had also reduced under-five mortality, increased access to safe drinking water and reduced the incidence of malaria. Much more needed to be done though to achieve health-related MDGs, particularly reducing maternal mortality. Programmes had been implemented in the Philippines to reduce maternal mortality and strengthen health systems and services; to that end, the government had passed several laws for improving health care. Through affirmative action, the Philippines had been recognized as one of 10 countries making the boldest efforts to achieve the MDGs.

Ms. M.d.F. MUNHICA ANTÓNIO (Angola) said that governments had responsibility for promoting health as a human right in all social and political arenas and implementing appropriate health policies. She welcomed the significant progress that had been made in recent years through increased focus on health access for all, leading to a rise in new or adapted practices that responded to health needs across all social sectors. In that regard the

MDGs had enabled greater cooperation and coordination between countries and had also helped to enhance capacity and planning. Parliaments, through their legislative functions, needed to continue to monitor programme design and implementation and ensure that governments made the best use of available funds to ensure equal access to quality and affordable health care.

Mrs. J. AL NASSIF (Bahrain) said that women and children were always the first to suffer in many conflicts around the world, with children especially at risk of exploitation. Little consideration was given to their physical or mental well-being, meaning that such exploitation was a great threat to their health.

With regard to improving women's and children's health in Bahrain, the State guaranteed the provision of free health-care services and allocated about 30 per cent of the national budget to health and education. As a result of those and other measures, the maternal and infant mortality rates in Bahrain were very low compared with other countries in the region.

Mrs. P. TAMTHAI (Thailand) said that the Thai Government had taken a number of steps in recent years to provide basic health services for citizens at minimal or no cost, including a health volunteer programme in every village aimed at preventing illnesses and promoting basic health care for families. Such measures had done much to improve access to health care for women and children, but some challenges remained: breast, cervical and uterine cancer were still the leading causes of death among women in Thailand; women and children belonged to vulnerable and disadvantaged groups that lacked proper health services access; mortality rates in certain areas of the country were worrisome; and issues of teenage pregnancy, poor reproductive health and domestic violence needed to be addressed.

The parliament had worked to ensure that appropriate legislative measures were in place and a number of bills had been introduced that sought to promote health and gender equality. All parliamentarians needed to oversee adoption of appropriate administrative, budgetary and other measures to monitor government policies and to implement parliamentary mechanisms such as women's caucuses. They should also support local government in training health volunteers and ensuring adequate financial support for local level health promotion.

Mrs. E. AYELECH (Ethiopia) said that, as elected representatives, parliamentarians were ultimately responsible for ensuring policy development and service delivery across all sectors, ensuring in particular that women and children had access to the necessary health-care services. The Ethiopian Parliament had been working towards universal health-care access and had established a standing committee to review and evaluate the reports of relevant government ministries. A community-based health programme had been implemented that focused in particular on women and children in rural areas and sought to prevent and control communicable diseases. In addition, several thousand health workers had been trained and primary health-care coverage was due to reach 100 per cent by 2014. Ethiopia was set to achieve the MDGs by 2015 and had seen a significant reduction in maternal and child mortality rates.

Developed countries had a responsibility to see that their commitments and support to developing countries were fully met, as the latter continued to need support from development partners in attaining MDGs. She encouraged parliamentarians to agree a robust resolution on universal access to health care.

Mr. U. SINGH (India) said that, globally, the lack of transparency and accountability in health schemes and projects was often more problematic than the actual issue of scarce resources. The IPU should therefore formulate a model legislative framework that could be used by countries to determine what improvements could be made to their own national frameworks and to ensure that projects truly benefited the intended recipients.

Donor countries and the IPU should monitor where and how funds were utilized at national levels; systems should be established to facilitate sharing of best practices.

Ms. U. KARLSSON (Sweden) said that the number of women who died each year during pregnancy or in childbirth was appalling, not least because the majority of them were wholly preventable. It was unacceptable that so many women still lacked access to adequate prenatal care and trained midwives during childbirth, while many others were denied the right to contraception and safe abortions. Religious, traditional or cultural norms frequently led to the restriction of women's rights, particularly in the poorest countries and communities.

All national and international stakeholders should participate in efforts to improve maternal health. Young people needed better access to family planning, counselling and sex education, as well as contraception and safe abortions. In some cases, countries had made much progress to ensure those services, but they were only made available to married women, thus discriminating against many young unwed women. Parliamentarians needed to act urgently to overcome such discrimination and ensure women's rights were respected insofar as early marriages and sexual violence against them were concerned.

Dr. A.F. PECHUHO (Pakistan) said that several sectors in her country had been devolved to the provincial level, which had served to improve ownership, priority-setting and better oversight and implementation of legislation, particularly with regard to health. Devolution had considerably helped efforts towards universal health care in Pakistan.

Social and economic disparity and a lack of education were impediments to health attainment, but progress was being made and legislation was in the pipeline to help promote reproductive health and introduce premarital blood screening and tests for HIV/AIDS.

Parliamentarians needed to push for longer secondary education and a higher school-leaving age in many countries to encourage girls to stay in school and not marry young. Such action would have a positive impact on their health, human rights and future life prospects.

Mr. A.M. MPONTSHANE (South Africa) said that access to health as a basic right had been enshrined in his country's Constitution, while the legal framework promoted that right among women and children in particular. Pregnant women had free access to health care and the government had abolished user fees for primary health care. Legislation was also in place allowing women the choice to terminate pregnancy under safe conditions

Cross-party women's caucuses had been established and given responsibility for overseeing the achievement of the MDGs from a gender perspective and particularly to ensure that maternal, infant and neonatal mortality rates improved.

Parliament alone could not successfully realize those objectives and for that reason, South Africa encouraged the participation of civil society, notably in campaigns to improve health and treatment actions.

Mr. A.A.C. WIJAYA (Indonesia) said that in recent decades, his country had been able to achieve significant reductions in maternal and under-five mortality rates, owing to the active promotion of women's and children's health through a national integrated health office. Despite that progress, however, Indonesia was still far from meeting MDG 5 target rate for maternal mortality by 2015; to rectify that, the country was striving to improve access to and quality of drugs and health-care facilities through an increased health budget and by enhancing community participation.

Other challenges remained in overcoming disparity in birth assistance by skilled health personnel and ensuring the same level of access to quality health-care facilities in all regions. As a result, the government had introduced a number of bills to address those challenges.

Mrs. C. BOURRAGUE (France) said that France's development policy recognized the need for strategies to mainstream gender equality and combat maternal and infant mortality. Her country had worked recently with nine African countries to scale up efforts to promote family planning, reproductive health and education for young people. Gender equality had been integrated into development aid and projects in a number of countries, which was essential for ensuring the health of mothers and children. In addition to those efforts, France had donated considerable funds to help finance vaccination campaigns and the structures needed to support them.

She underscored the need for a vote by parliamentarians on the legal age for marriage, as marrying at a very young age had a negative impact on girls' health, particularly if they also gave birth while still young.

Ms. M. VAN EETVELDE (Belgium) said that the clear and concise nature of the co-Rapporteurs' report and the way it addressed key issues should serve as an example for the types of reports needed in future for debates by the Standing Committees.

It was evident that both donor and developing countries needed to enhance efforts to achieve MDGs 4 and 5. Crucially, achieving results mattered more than reporting them, but certain practical steps were needed to ensure the goals were met. She therefore welcomed the co-Rapporteurs' emphasis on differentiating at country level and identifying groups of women and children for whom targets were most lagging behind. Efforts and resources should be concentrated where most needed.

Ms. N. MAZAI (Belarus) said that her country had produced a 2010 report on the extent to which MDGs had been achieved; Belarus had already halved infant mortality and had achieved the target for maternal mortality. Measures to improve mothers' and children's health had been integrated into national programmes, which also included prevention of HIV/AIDS. The country's legal framework ensured free access to basic health care, while medical care and assistance were provided to women during pregnancy, birth and for newborns. The parliament was continuing to fine-tune national policies on other family issues.

The final report and future IPU resolution should underscore the need for parliaments to use all measures available to them to ensure that the MDGs were achieved.

Ms. T. BACKMAN (Iceland) proposed that the final report should also address the issue of surrogacy, as the growing number of surrogate mothers, particularly in developing countries, had implications for both the health and rights of women. The business of paying one woman to bear a child for another also touched on issues of morality, legality, science and globalization and should be addressed as a matter of priority.

Ms. M. LOHELA (Finland) said that the international community had overcome many challenges to the health and rights of women and children; much more still had to be done. Affirmative action was no longer needed in some countries: in a number of others it should be used only as a starting point for achieving that objective, and not as a permanent practice.

Female genital mutilation was a sensitive issue but one that was a major obstacle to improving women's and children's health and rights; she asked why the draft report had not addressed that matter.

Mrs. I. YAMEOGO (Burkina Faso) said that particular attention needed to be paid to reproductive health, which contributed greatly to the overall health status of women and could help to significantly improve maternal and child health. Parliamentarians needed to propose legislation to strengthen national efforts and follow up actions taken to promote maternal and

child health and achieve MDGs 4 and 5 and other relevant international and regional agreements. They should work to ensure that resources allocated to women's and children's health were indeed used for that purpose. Parliamentary inquiries were an excellent mechanism to oversee government action and verify honouring of international commitments.

Ms. I. AL-WAZIR (Palestine) said that Palestinian authorities paid much attention to the adequate care of women; all government and non-governmental agencies worked to ensure that health services and facilities were provided through all stages of a woman's life, particularly during pregnancy and childbirth. Legislation ensured that there was no discrimination between men and women with regard to health care and that also entitled children to comprehensive care.

Women living in the Occupied Territories faced a number of health-related challenges. Several had been prevented from reaching hospitals when giving birth, greatly increasing risks to their health during delivery. An embargo on some medicines and vaccines also posed a threat to children's health and well-being. The authorities were working to find ways to improve care despite those difficult circumstances and strengthen both infrastructure and resources.

Mr. W. MADZIMURE (Zimbabwe) said that while most countries had a great number of legislative and other measures to secure the health of women and children, necessary budget allocations were not always provided. Parliamentarians therefore needed to advocate for adequate funding of health services; he encouraged the creation of parliamentary committees to focus on such action.

In Zimbabwe, free health services were provided for children aged five and under, and other mechanisms and partnerships existed to promote nutrition and feeding schemes. Such schemes were not always sustainable; action was needed to build capacity in local communities so as to take ownership of those programmes.

Mr. T. WICKHOLM (Norway) said that although progress for achieving MDGs 4 and 5 had been lagging behind in some countries, global mobilization efforts and measures such as legal frameworks would help to achieve those goals. Negative attitudes and harmful traditions such as female genital mutilation also needed to be opposed and overcome.

The global financial crisis meant that access to necessary funds would be more difficult in coming years. It was imperative that donor countries found ways to maintain or increase their contributions.

Mr. R. PEZ FERRO (Cuba) recalled the principles contained in the Universal Declaration of Human Rights, which stated that each person had the right to health, clothing, housing, medical care and necessary social services. However, despite its 1948 adoption, many of its objectives were still far from being achieved. All countries therefore needed to scale up their efforts to achieve the MDGs.

Cuba provided free health care for the whole population and there were several national programmes aimed specifically at improving the health of women and children. There was considerable cooperation in the provision of health care between the government, doctors and nurses and the country had achieved significant reductions in infant mortality.

Mrs. G. REQUENA (Venezuela) said that new social policies in her country over the last decade sought to promote the attainment of the MDGs and to sustain and increase investment in health care, particularly for women and children. Venezuela currently had a paediatric cardiology hospital and a number of programmes on food and nutrition, disease prevention and screening. Investments had also been made to ensure the provision of safe drinking water and sewage systems.

A standing committee had responsibility for the oversight of health measures and the approval of policies that sought to implement international conventions and agreements to which Venezuela was a party.

Mr. R. AL-AZZAWI (Iraq) said that all Member Parliaments were no doubt aware of the importance of ensuring women's and children's health, not just for them as individuals, but for the overall well-being of the population. Parliaments therefore needed to ensure that appropriate legislative measures were in place to achieve that objective. The Iraqi Parliament had established special committees to address matters relating to the family, women and children. It also followed up on programmes to ensure that they were being implemented in a timely manner and allocated the budget for the continued restoration of the health-care system.

Ms. S. ČRNUGELJ (Slovenia) said that universal medical care was provided in her country by law, and also covered asylum-seekers and refugees. Special attention was paid to vulnerable groups, including women and children. Among other measures taken to enhance women's health care were that all women had direct and free access to gynaecologists, programmes had been established to promote reproductive health and reduce the risks of diseases related to reproduction, screening was carried out for both cervical and breast cancer and early terminations of pregnancy were covered by health insurance. All children were guaranteed quality primary health care in Slovenia and a comprehensive government programme had been introduced in recent years to promote children's health.

Mrs. A. AL-AWADHI (Kuwait) stressed the importance of women's and children's health in ensuring the overall ability of a country to develop. The health-care system in Kuwait needed further development but care was provided to all citizens free of charge and at a low cost for non-citizens. There were many countries where the provision of free services was not possible owing to a lack of resources; as such, developed countries needed to increase their financial and moral support to developing countries. Laws also needed to be developed that provided health care for all without distinction, particularly for low-income earners. Public campaigns should be launched to raise awareness of the importance of maternal and child health.

Mr. J.M. GALÁN (Colombia) said that the issues of mental, sexual and reproductive health and violence against women were indissociable from the wider discussion on women's and children's health. Many women had suffered from psychological, sexual or other types of violence; such issues transcended borders and social class. Taking action on those issues would contribute greatly to improving women's rights and health.

Many countries' policies were insufficient to address mental health and the consumption of addictive substances, such as alcohol as a means of coping with problems.

All countries needed to strengthen legislation on sexual and reproductive health and ensure adequate education at all levels.

Mr. J.A. COLOMA (Chile) said that a chief impediment to improving family health care was the little time working mothers were able to spend with their children. Chile had recognized that the less time women were able to spend with their children, the more likely it was that health- and care-related problems would arise in families. It also recognized that many could not afford to take time away from work and had therefore enacted legislation that extended post-natal maternity leave to six months and provided extra funds to be paid to mothers for each month of leave during that period.

Mrs. M. XAVIER (Uruguay) said that Latin America, while not the poorest region, had the worst distribution of wealth, which negatively impacted on many public policies, including health. Despite that, Uruguay had in recent years adapted its health-care system to guarantee universal, equal and open primary health care. All countries needed to promote accessibility to medicines; many people suffered from chronic disease but parliaments were not always in a position to negotiate the availability of medicines to all.

As legislators, parliaments needed to promote diversity and ensure that religious and cultural differences did not interfere with access to health as a right.

Mrs. Z. BENAROUS (Algeria) said that Algeria attached great importance to disease prevention, more so than treatment and had ensured that women had access to free health care. The principle of free health care was particularly important for mothers and children; it could have very positive results in improving their health, family planning and conditions for pregnancy and delivery.

Ms. E. BAZAÏBA (Democratic Republic of the Congo) said that parliamentarians not only had a duty to the population as legislators, but also as social stakeholders; through their work they needed to ensure that health facilities in all communities were able to provide the necessary services and quality medicines. Parliamentarians were able to have direct contact with the population in a way that governments could not, and therefore had a duty to recommend to governments necessary actions for improving maternal and child health.

Mr. E. OKUPA (Uganda) said that his country was taking all measures at its disposal to achieve the MDGs by 2015; there were, however, clear challenges, particularly as budgetary allocations did not currently prioritize maternal and child health. Female genital mutilation was still performed on many girls in Uganda but the Government had passed a number of laws and policies to prohibit the practice and much progress had been made.

All parliaments needed to continue to promote family planning as a way to improve women's health and reduce their mortality rates as many women died each year. Measures also needed to be put in place to ensure that young girls stayed in school and did not marry and begin to have children until they were more mature.

Mr. C. GANYA (Kenya) said that the worrying statistics on women's and children's health, as documented *inter alia* in annual UNICEF reports, were a stark reality in her country. Sub-Saharan Africa had the worst rates of maternal mortality in the world, due in part to the considerable size of many constituencies and an appalling lack of hospitals, health services and personnel, and the consequent inability of the population to travel the necessary distances to reach those that were available in more urban areas.

At current rates, MDGs 4 and 5 were unlikely to be achieved in sub-Saharan Africa by 2015; the region desperately needed scaled up support for its health-care systems from the IPU and parliaments and investment by development partners.

Ms. N. MOTSAMAI (Lesotho) said that, as a representative of a rural constituency in a least-developed country, she had experienced many of the problems and challenges articulated in the draft report. She therefore welcomed the opportunity provided by the IPU to learn of the good practices in other countries that faced similar issues. Of particular value was the description by the co-Rapporteurs of activities in India to improve health services in rural areas.

Mr. C.A. AVOKA (Ghana) said that the concepts of democracy and human rights necessitated the provision of key facilities, including health care, to all citizens and particularly for women and children, but to achieve that, countries needed to ensure that the appropriate legislative measures were in place and the necessary institutions were established. Parliaments alone could not achieve that objective, but needed support from the executive, civil society organizations and development partners.

Ghana's Constitution enshrined the provision of health care for women and children as a basic right and had established the necessary structures to safeguard that right. Through a law on national health insurance, medical care was provided free of charge to all pregnant women and minors.

Female genital mutilation and diseases such as malaria, still had a detrimental effect on women's and children's health in the country but it was hoped that collaborative global action would help address those and other challenges.

Ms. B. BOUPHA (Lao People's Democratic Republic) said that her country's parliamentarians were committed to strengthening existing policies and legislative tools in the area of health and to advocating for enhanced administration tools needed to carry out health-related programmes and research. A maternal, newborn and child health strategy had been developed and implemented in some regions and was expected to be scaled-up nationwide in the near future. Through such action her country hoped to address the key challenges to women's and children's health and achieve the health-related MDGs by 2015.

Ms. L.S. LYIMO (United Republic of Tanzania) said that maternal and infant mortality rates had fallen considerably in recent years, primarily through measures to control malaria, acute respiratory infections and diarrhoea and to improve personal and environmental hygiene and sanitation. Tanzania also provided preventive and curative treatment through its health services. The management of childhood diseases was integrated into services in all districts and vaccination coverage had also been improved. Despite those efforts, challenges remained in terms of insufficient human resources and underfunding, which hampered the improvement of the necessary physical structures and the procurement of equipment.

Ms. F. AKHTER (Bangladesh) said that the Constitution of Bangladesh recognized access to health as a basic right for all citizens. The country was on track to reach MDGs 4 and 5 but still faced a number of challenges, as did many other developing countries, in securing the health of women and children. Parliaments could play a vital role in addressing those challenges by drafting legislation, formulating national policies, ensuring adequate budgetary allocations for projects and programmes to promote health, monitoring the implementation of those programmes, and overseeing the ratification and implementation of international health-related instruments and conventions at the national level.

Mrs. L. MENCHACA CASTELLANOS (Mexico) said that investing in prevention programmes and ensuring appropriate legislative frameworks were vital in improving women's and children's health. Legislation was currently being drafted to ensure reproductive health services, family planning, treatment of sexually transmitted diseases, and prenatal care, as well as access to necessary information.

Women and children under five were now covered by social security and had access to health care. Family planning services were provided for women in rural areas and communities with small populations

Certain regions in Mexico had noticeably higher rates of infant mortality and the authorities were looking at why that was so. The primary challenge to improving women's and children's health in Mexico remained inadequate budgetary allocations.

Ms. A. HAYDEN (Ireland) said that, in view of the statements by the UN Committee on the Elimination of Discrimination against Women that all States needed to give special attention to the health needs of women belonging to vulnerable and disadvantaged groups, as well as that parliaments needed to provide enabling legislation to criminalize the abuse of women and children, Ireland had in recent years addressed the issue of female genital mutilation in its legislation. The practice had increased in prevalence in recent years in Ireland owing to increases in refugee and migrant populations and the legislation that was enacted made it an offence both to perform female genital mutilation on any woman or girl living in or visiting Ireland and to remove or attempt to remove any woman or girl from Ireland for the purposes of carrying out the practice elsewhere. It was hoped that the legislation would be a powerful deterrent, and other steps were being taken to empower communities in Ireland with a tradition of female genital mutilation to resist pressure from their countries of origin to perpetuate the practice.

Mrs. S. MOULENGUI-MOUELE (Gabon) said that more emphasis should be placed on the need for parliamentary oversight of the distribution of medicines to rural areas, as unfair distribution impacted negatively on the most vulnerable sections of society.

Ms. M.d.L ROCHA MONTEIRO (Cape Verde) said that her country had several programmes in place to protect women's and children's health. Infant mortality was under control, vaccines were provided universally, folic acid and vitamins were provided to pregnant women, family planning services were available and there were cancer screening programmes for women. In addition, Cape Verde had established the first milk bank in West Africa. The country continued to promote access to quality universal health care and the training of health professionals.

The delegate of UGANDA said that countries needed to report on progress made in improving women's and children's health. Such reports would allow other countries to draw lessons on what they could do to improve their own national situation and emulate successful practices. Uganda would be willing to provide such a report to the IPU 126<sup>th</sup> Assembly. It could also be useful to establish benchmarks for donor funding, to help drive the process forward and better gauge progress.

Mr. K. DOUMBIA (Mali) suggested that the IPU should work to facilitate the exchange of information and cooperation between countries on health measures, as the draft report had already provided a basis for such action.

There was legislation in Mali on reproductive health and the provision of telemedicine and health insurance plans were mandatory. Several measures had been taken to enhance women's and children's health including provision of free caesarean sections, free anti-malarial treatments for children up to age five, as well as free antiretroviral drugs and distribution of insecticide-treated mosquito nets to pregnant women. A parliamentary health committee had responsibility for visiting national hospitals regularly.

Ms. S. ABDALLA (Kenya) said that parliamentarians needed to take certain key action as part of efforts to secure access to health as a fundamental right. They needed to use all tools available to them, such as establish committees; request transparent figures on all planned and actual domestic expenditure in the health sector; track resources pledged for maternal and child health; request regular and transparent reports on the use of all international assistance intended for the health system; and gather the input of a range of stakeholders in advance of preparing budgets.

Mr. U. NILSSON (Sweden) said that all countries should ensure that health care was not denied to any person because of any prejudice or traditional practice, including unequal rights for men and women. To that end, strategies should be drawn up to ensure that there was no obstruction to health care for women and children. There was also a need to ensure basic security for the poorest.

Mr. M.-S. PARK (Republic of Korea) said that development assistance had not done enough to strengthen health-care infrastructure or the training of medical staff. In order to address such challenges, his country had announced a plan to facilitate the achievement of the health-related MDGs, which included projects to build primary health-care systems, the sharing experiences in reducing maternal and infant mortality and providing training for medical professionals.

Mr. G. VARNAVA (Cyprus) said that parliaments played a pivotal role in securing the health of women and children and needed to provide legislation to ensure that the competent authorities, service providers and health care professionals followed strict rules and standards. Weaknesses in health systems and administrative discrepancies could be addressed through the exchange of knowledge and best practices between countries, while campaigns to raise awareness and promote cooperation between the various actors would foster constructive dialogue on the outcomes of and levels of satisfaction with health services. He stressed that the level and quality of health care in any country depended on its democracy and human rights record.

Ms. F. BUSTREO, *Assistant Director General, Family, Women's and Children's Health, World Health Organization (WHO), Panellist*, noting that many delegates had spoken of specific causes of maternal and child mortality, said that they underscored the recommendations made by the Commission on Information and Accountability for Women's and Children's Health that all countries should establish a maternal death audit system. The causes of maternal mortality varied by country and region and such a system, whereby all cases of maternal deaths were documented, allowed individual governments to identify the conditions that were prevalent in their countries and to target their actions accordingly. Several countries had already established such a system and had improved their ability to provide the necessary services for women's health in a targeted and timely manner.

Many speakers had commented on the need for prevention, a concept that was at the heart of WHO's philosophy and action. Also important was the recognition of the need for relevant information to be provided, particularly to young people, on fertility and their right to access care.

Ms. C. PRESERN, *Director, Partnership for Maternal, Newborn and Child Health (PMNCH), World Health Organization, Panellist*, said that reports would be produced each year to 2015 on progress towards the MDGs and would include country-specific information on problems and solutions, enabling countries to share and emulate successful activities, as had been mentioned by some speakers.

She welcomed the attention drawn by some speakers to legislative difficulties in securing women's and children's health, as well as the issues relating to harmful practices. Those issues needed to be discussed openly and national parliaments were encouraged to find ways to overcome them.

Those donors who had continued to provide high levels of assistance during the difficult financial climate were to be praised. It was important that donors and developing countries continued to work together to maximize the resources available and ensure appropriate budget allocations to health systems.

Ms. S. ATAULLAHJAN (Canada), *co-Rapporteur*, welcomed all the comments that had been made on the content of the draft report and said that the scope of the report was intended to be international, not focusing on country-specific situations, so as to be relevant to as many IPU Member Parliaments as possible.

Many comments had been made on reproductive health and family planning and she noted that the report's aim was to draw on existing international norms and commitments in that area and encourage countries to ensure that men and women had equal access to health care, including family planning services. Particular attention should be paid to promoting access to health care among vulnerable groups, and the Convention on the Elimination of All Forms of Discrimination against Women specifically included the right of women in rural areas to health care facilities, including counselling and services in family planning.

The subject of surrogacy, raised by the delegate of Iceland, was of concern, as it raised important issues for the health and rights of both women and children. Many of those issues were, however, specific to surrogacy and therefore beyond the scope of the draft report. The subject could benefit from a more in-depth discussion by IPU Members in the future.

Ms. P. TURIAHIKAYO (Uganda), *co-Rapporteur*, responding to the particular points raised regarding infrastructure, said that a more centralized approach was needed which encompassed ministries of education, health and transport, to ensure that the necessary infrastructure was in place to strengthen health systems and to reduce maternal, neonatal and infant mortality rates. Partnerships between the public and private sectors could also make a valuable contribution to that objective.

The challenges to securing women's and children's health were well-known, as were the solutions. Now was an opportune moment for parliamentarians to use their functions as legislators, overseers of government action and representatives of the people to scale up efforts to overcome those challenges, securing health for all and attaining the MDGs by 2015.

Mr. F. SARDINHA (India), *co-Rapporteur*, reiterated the fact that the report was designed to have as broad a scope as possible and was not intended to focus on country-specific practices, particularly those deemed to be controversial, or to infringe upon national rights. As a result, there were some topics that were not covered in the report and which would be better suited to discussions by other committees, such as those on human rights.

Mr. M. CHUNGONG, *Secretary of the Third Standing Committee*, said that the co-Rapporteurs had noted all the comment that had been made, which in the coming weeks would be incorporated in a draft revised version of the report. That revised report would be used to inform the drafting of a resolution and both documents would be submitted to IPU Member States in due course for comments and suggestions. A second debate on the topic of securing women's and children's health would be held at the 126<sup>th</sup> Assembly, where the resolution would be put forward for adoption.

*The meeting rose at 1 p.m.*