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For democracy. For everyone.

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Standing Committee on  
Democracy and Human Rights

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## Parliamentary actions to promote the health of women and children

### Background paper for the IPU's Standing Committee on Democracy and Human Rights in follow-up to the 2012 resolution

24 March 2015

#### 1. Introduction

At the 126<sup>th</sup> Assembly of the Inter-Parliamentary Union (IPU), held in April 2012, IPU Member Parliaments unanimously adopted a landmark resolution, "Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children". The resolution highlights the human rights, political and socioeconomic imperatives for parliamentary action in support of women's and children's health.

At the 132<sup>nd</sup> IPU Assembly, to be held in Hanoi, the IPU Standing Committee on Democracy and Human Rights will organize a debate to review the progress of the resolution's implementation and highlight the challenges and good practices that have been identified through parliamentary efforts to promote women's and children's health<sup>1</sup>.

To inform that debate, this paper provides examples of how parliaments in four countries have responded to the resolution's commitments, how their attention to women's and children's health has increased, and how that increased attention has been translated into action. For each of the countries information is provided on the status of selected indicators of women's and children's health, national achievements with respect to accountability (where identified), and the proportion of women in national parliament, a factor identified as essential to the success of countries currently on track to meet the health-related Millennium Development Goals (MDGs). Information on the actions taken, based on document reviews and input from the IPU and national partners, is presented by parliamentary function: legislation, oversight/accountability, budgeting, and advocacy.

This work has been developed in the context of the IPU's ongoing collaboration with technical partners specialized in reproductive, maternal, newborn, and child health, including the World Health Organization (WHO) and the Partnership for Maternal, Newborn and Child Health (PMNCH). Both organizations are members of the IPU's advisory group on HIV/MNCH.

<sup>1</sup> This Background paper was prepared by WHO and IPU as a contribution to the debate on "Implementation of the 2012 IPU resolution on Access to health as a basic right: the role of parliaments in addressing key challenges to securing the health of women and children" at the 132nd IPU Assembly (Hanoi, Viet Nam, 28 March – 1 April 2015)

The eight Millennium Development Goals (MDGs) – which range from halving extreme poverty, to halting the spread of HIV/AIDS, to providing universal primary education, all by 2015 – form a blueprint agreed to by all the world’s countries and leading development institutions. They have galvanized unprecedented efforts to meet the needs of the world’s poorest inhabitants. Two MDGs relate to women’s and children’s health. MDG4 aims to reduce the global rate of under-five mortality by two-thirds; MDG5 to reduce the maternal mortality rate by three quarters and achieve universal access to reproductive health services. The baseline for these reductions is 1990.

**2. Background: The IPU Resolution commits parliamentarians to action**

The 2012 resolution calls for Member Parliaments to take all possible measures to achieve MDGs 4 and 5 by 2015<sup>2</sup>. It also complements the objectives of the UN Secretary-General’s Global Strategy for Women’s and Children’s Health (2010-2015), and of the Every Woman Every Child movement, which has mobilized political action and funding to save the lives of 16 million women and children.

The resolution establishes an ambitious framework for parliamentary action, calling upon parliamentarians and the IPU to generate and sustain the political will and resources needed to achieve MDGs 4 and 5 by 2015<sup>3</sup>.

The resolution recognizes with deep concern that maternal and child mortality rates remain unacceptably high overall and that many countries are not on track to achieve MDGs 4 and 5. It recognizes that lack of access to quality sexual and reproductive health services and supplies, including family planning, safe abortion, and adolescent-oriented services, is a major

contributing factor to maternal mortality. It also highlights the important role played by health systems, noting that ineffective, poorly-resourced, and inaccessible health care facilities, and a lack of qualified human resources in particular, are key impediments to improved health outcomes.

The resolution also notes that young people remain disproportionately affected by HIV/AIDS, and that women between the ages of 15 and 19 – subject to gender inequality, sexual violence, early marriage, intergenerational relationships, and more limited access to education – are particularly vulnerable.

Uniquely placed within their communities, parliamentarians represent the voices of women and children and are critical to driving national and global efforts to improve women’s and children’s health.

It highlights the importance of providing information, education, and services geared to people’s needs at all stages of life, including comprehensive sex education that is age-appropriate, gender-sensitive, and evidence-based.

The resolution encourages parliamentarians to build and strengthen partnerships with relevant stakeholders to achieve the health-related MDGs, working closely with governments, civil society, local communities, health care professionals, academic and research institutions, multilateral organizations, global funds and foundations, the media, and the private sector.

It encourages parliamentarians to develop tools to help assess accountability for better results. This creates a commitment for parliamentarians to: a) renew their political support for reproductive, maternal, newborn, and child health (RMNCH); b) make resources available to support RMNCH-related needs in their countries; c) ensure the availability and accessibility of essential, integrated health services for women and children; and d) collaborate more closely with key national and global partners towards the achievement of MDGs 4 and 5.

Robust reviews of budget allocation and expenditure, combined with legislative review and effective advocacy, are essential to protecting and promoting the health of women and children. The resolution commits parliamentarians to establishing transparent domestic accountability mechanisms for maternal and child health, taking the form, for example, of a multi-stakeholder national commission that reports to parliament. It requests the IPU to develop an accountability mechanism, based on the 2011 report of the Commission on Information and Accountability for Women’s and Children’s Health (CoIA)<sup>4</sup>, to monitor the progress of Member Parliaments in implementing the resolution and to publish the results of that review annually.

Since the resolution was adopted, parliaments in countries most affected by maternal and child deaths have engaged strongly on the issue, with support from IPU, WHO, PMNCH, and other partners. Parliamentary actions have included raising awareness, ensuring budgets for health, establishing maternal and child health parliamentary caucuses, defining new legislation and strengthening oversight.

<sup>2</sup> For the period between 1990 and 2015, MDG 4 aims to reduce child deaths around the world by two-thirds, while MDG 5 aims to reduce the maternal mortality ratio by three-quarters.

<sup>3</sup> At the global level the mandate of the IPU Advisory Group on HIV/AIDS was expanded to include maternal, newborn and child health. This has further intensified the IPU’s commitment to tackling these issues and has also strengthened the collaboration between IPU and global health partners, including the World Health Organization.

<sup>4</sup> The CoIA published ten recommendations, grouped under the headings of Better information, Better tracking of resources, and Better oversight ([http://www.who.int/woman\\_child\\_accountability/about/coia/en/index5.html](http://www.who.int/woman_child_accountability/about/coia/en/index5.html))

Progress in reducing child and maternal deaths in recent years has been accelerated by the UN Secretary-General's Global Strategy for Women's and Children's Health, called for a process to ensure global reporting, oversight and accountability. This led to the creation of the Commission on Information and Accountability for Women's and Children's Health (CoIA) in 2011, co-chaired by President Jakaya Kikwete of the United Republic of Tanzania and Prime Minister Stephen Harper of Canada. The Commission put forward ten ambitious yet practical recommendations to strengthen accountability in this area.

### 3. The post-2015 agenda

This review examines how parliamentarians have worked towards MDGs 4 and 5 in the past and what they can do to influence the global health agenda beyond 2015. The international community is currently working to define Sustainable Development Goals (SDGs), setting development targets to carry on from the MDGs after 2015. The SDGs form a universal and transformative agenda for sustainable development, underpinned by rights and centred on people and the planet. There has been much discussion on how parliamentarians can best engage in framing the global development agenda while simultaneously designing strategies, overseeing government actions, and aligning budgets for sustainable development at national level. Parliamentarians are called upon to rally public support around national development goals and to use the post-2015 agenda as an opportunity to increase their participation in United Nations hearings and consultations.

Five years after the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health, now lauded as a success, MDGs 4 and 5 represent continuing, unfinished business. The global health community has unanimously agreed to update the Global

Strategy for 2016-2030 to align with and complement the SDGs and to include adolescent health. The renewed Global Strategy will be launched in September 2015 at the time of the UN General Assembly. It foresees a more integrated post-2015 development framework supporting the efforts of all countries to attain and sustain their health goals, moving beyond reductions in mortality to a vision of health for all throughout life and across the continuum of care. In this light, the Global Strategy will address issues of financing, policy, and improved services for the most vulnerable, and provide a road map for the goal of ending all preventable deaths and improving the overall health and well-being of women, children, and adolescents by 2030.

### 4. How parliamentarians make a difference for women's and children's health: experiences in four countries

The following pages describe how parliaments in Bangladesh, Chile, Rwanda and Uganda have responded to the commitments set out in the 2012 IPU resolution, how their attention to women's and children's health has increased, and how that increased attention has been translated into parliamentary action, in four categories: legislation, oversight/accountability, budgeting, and advocacy.

Inasmuch as the resolution calls on the IPU to 'facilitate collaboration and exchanges among its Member Parliaments' and to engage with other agencies and networks to help parliaments and parliamentarians improve the health of women and children, examples of collaboration in these four countries with partners outside of parliament are also briefly described.

*"As a male legislator I am aware of my responsibilities to improve women's and children's health. Providing education and information on reproductive health from a young age and involving men and boys into awareness-raising campaigns fosters positive changes to the health and wellbeing of communities." (Habibe Millat, MP, Bangladesh)*

## 5. BANGLADESH

### 5.1 Women's and children's health in Bangladesh

The statistics for Bangladesh are good news: child mortality decreased from 144 deaths per 1,000 live births in 1990, to 41 in 2012<sup>5</sup>, beating the country's target of 48. More than half of these deaths took place during the first month of life. Vaccination coverage is high: around 89%<sup>6</sup> of children having been vaccinated against measles by their first birthday. Maternal mortality decreased by two-thirds, from 574 deaths per 100,000 live births in 1990 to 170 in 2012, approaching the country's target of 143. Antenatal care coverage remains low, however, with 59% of women having seen a skilled health worker at least once during pregnancy and 44% of births attended by skilled health personnel<sup>7</sup>.

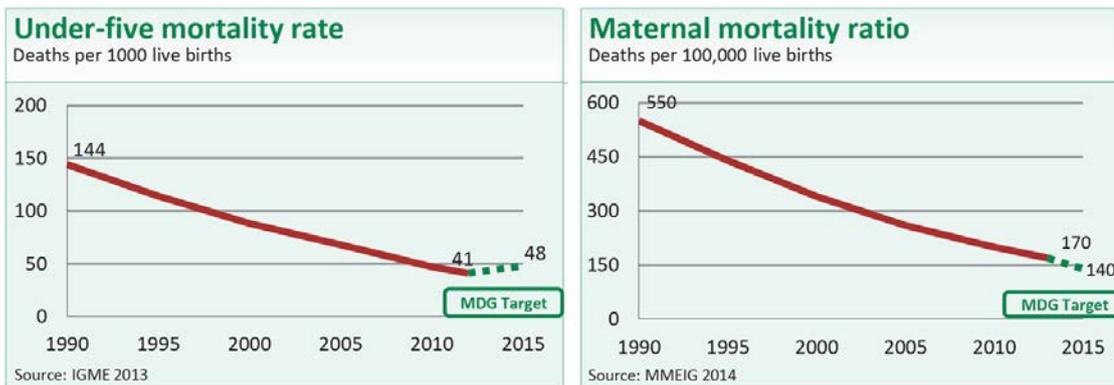
These national level figures mask differences within the country: among the poorest 20% of the population only about 12% of all births are attended by skilled personnel, and only around 30% are preceded by antenatal care<sup>8</sup>.

<sup>5</sup> Fulfilling the health agenda for women and children. 2014 Countdown report.

<sup>6</sup> Bangladesh EPI Coverage Evaluation Survey 2013

<sup>7</sup> Multiple Indicators Cluster Survey 2012-13 (UNICEF-BBS)

<sup>8</sup> Bangladesh Demographic & Health Survey 2011



MDG targets calculated by Countdown to 2015

## 5.2 Accountability achievements and challenges

In response to the recommendations of the United Nations Commission on Information and Accountability for Women's and Children's Health, Bangladesh developed and is implementing a Country Accountability Framework (CAF) that highlights the engagement of parliament through discussion forums on maternal and child health. A recent review of progress on the CAF concluded that implementation has been broad-based and inclusive and has resulted in unprecedented cross-sectorial collaboration. For example, the experience of developing a civil registration and vital statistics system (CRVS) has been highlighted as a success story in improving women's and children's health. Although discussions on the development of a national population register predate the accountability framework, the framework has had a major impact on its progress. The top level of government has been involved, and the cabinet secretary has taken personal interest and leadership, heading a 15-member steering committee on CRVS. The committee comprises secretaries from key ministries and agencies, including Health, Education, Local Government, Election Commission, Planning, Statistics and Informatics, as well as the Prime Minister's office. The country has conducted a CRVS case study<sup>9</sup> and developed a CRVS investment plan, an important step in ensuring that individuals have a legal identity and improving their access to health, education, and social services. The Parliamentary Standing Committee on Health also discusses progress in the field of maternal and child health.

## 5.3 Parliamentary actions

In addition to the Standing Committee of the Ministry of Health and Family Welfare, a Sub-committee on improving maternal health and ensuring safe delivery is active under the Bangladesh Association of Parliamentarians on Population and Development. Among other actions, this committee has approved a Midwifery Strategy and overseen its implementation.

Specific parliamentary actions are listed below.

### Legislation

Five legislative acts related to MNCH have been passed by the Bangladesh Parliament since 2010:

1. The Children Act, 2013 (Act No. 24 of 2013).
2. Breast-Milk Substitutes, Baby Food, Commercially Prepared Baby Food and the Use of its Equipment (Regulation of Marketing) Act, 2013 (Act No. 35 of 2013).
3. The Protection and Rights of Autistic Person Act, 2013 (Act No. 39 of 2013).
4. The Safe Food Act, 2013 (Act No.43 of 2013).
5. The Protection of Neuro-Developmental Disabled Persons Trust Act, 2013 (Act No. 52 of 2013).

### Oversight/accountability

The Parliamentary Standing Committee on Health promotes universal health coverage. An informal caucus on reproductive, maternal, newborn and child health issues has also been established in collaboration with IPU.

With assistance from IPU, a group of the country's parliamentarians visited Sweden in 2013 to identify means of taking more effective action on MNCH. This visit provided important background information for the establishment of the MNCH caucus and subsequent advocacy work by parliamentarians on women's and children's health. There are converse plans for a visit to Bangladesh by Swedish MPs knowledgeable about sexual and reproductive health.

The national health sector programme includes a system for reporting to parliament and strengthening accountability for MNCH, featuring a strong mechanism for reviewing the MNCH situation, both within the Ministry of Health (MOH) and among stakeholders. MPs are encouraged to raise issues with, or request information from, the Minister of Health during sessions of parliament.

<sup>9</sup> Registering millions: celebrating the success and potential of Bangladesh's Civil Registration and Vital Statistics System. Canadian Department of Foreign Affairs, Trade and Development, and the World Health Organization

### Budgeting

A group of parliamentarians recently raised the issue of earmarking funds for a health budget for MNCH. Two programmes included in the MOH's sector-wide approach (SWAp) for 2011-16 are directly devoted to MNCH and enjoy the ministry's largest development budget. Half of the remaining programmes also contribute directly or indirectly to MNCH.

The Sub-committee on improving maternal health and ensuring safe delivery sees to it that 10% of the MOH's budget is spent on maternal health. Activities to promote maternal health include training for health care personnel, strengthening institutional capacity for safe delivery, and increasing community skilled birth attendance.

### Advocacy

The country's MPs engage with civil society organizations such as the White Ribbon Alliance as one means to strengthen advocacy about health care for women and children in their constituencies. This Alliance has provided media training for MPs to strengthen their effectiveness in public hearings and other forums.

Media reporting on health is increasing, with several journalists in the country reporting regularly on health-related issues. There is a coalition of health reporters (Health Reporters Union), and the White Ribbon Alliance has a journalist of its own. Health issues are regularly covered in the media, and the Bangladesh CoA secretariat liaises with the Health Reporters Union. The MOH encourages reporters to participate in health events so that they can bring critical health issues to the forefront and keep citizens informed about them.

### **5.4 Collaborating partners outside parliament**

The Government of Bangladesh is the country's largest provider of primary health care through its extensive, equitably-distributed network of frontline health workers, community clinics, and referral hospitals. Civil society organizations (CSOs) also play an important collaborative role in providing both primary health care and MNCH services. The MOH, together with development partners and CSOs in Bangladesh, takes a joint, multi-sectorial approach to planning, implementing and reviewing the health, population and nutrition programme. The list of partners and CSOs includes WHO, UNICEF, UNFPA, UNAIDS, the US Agency for International Development (USAID), the UK Department of International Development (UKAID), the Japan International Cooperation Agency (JICA), BRAC (a Bangladesh-based development organization), the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), Save the Children, and Plan International. The CoA tracking system has enabled these organizations to use a unified electronic data collection system provided by the MOH. The Government of Germany provided technical assistance to the MOH to develop the software infrastructure, while ICDDR,B provided support to strengthen routine health information systems.

There is a ministry and a strong civil society coalition on women's affairs in Bangladesh, but few member organizations of the coalition address health as a priority issue. Other relevant CSO coalitions include the Health Rights Movement Bangladesh, Bangladesh Base of People's Health Movement, Bangladesh Health Watch, and the White Ribbon Alliance Bangladesh.

## **6. CHILE**<sup>10</sup>

### **6.1 Women's and children's health in Chile**

Chile has the lowest child mortality rate in all of Latin America; a stable 9 deaths per 1,000 live births over the last 5 - 10 years (as of 2012). Maternal mortality is 22 per 100,000 live births (2013)<sup>11,12</sup>. Protection for children born with disabilities is provided through a presidential commission. The care provided to them through the health system has stabilized their mortality rate.

### **6.2 Parliamentary actions**

According to the documentation reviewed, Chile's government addresses the promotion of sexual and reproductive health and rights and has policies to strengthen women's rights, while the parliament gives priority to promoting and protecting MNCH.

Specific actions taken by parliament are presented below.

### Legislation

An important issue now being considered by parliament is the decriminalization of abortion. The Council Vice-Chair of the Inter-American Parliamentary Group on Population and Development is leading the discussions. The government intends to pass legislation that will allow abortion when a woman's life is at risk, in cases of rape, or when the foetus is not viable<sup>13,14</sup>.

<sup>10</sup> Because the Chilean parliament was on summer recess, the information presented for Chile was extracted from documentation and websites, and from a fruitful discussion with government representatives. Further research would be required to gain a fuller picture of the situation.

<sup>11</sup> Maternal mortality in 1990-2013, WHO, UNICEF, UNFPA, the World Bank, and the United Nations Population Division Maternal Mortality Estimation Inter-Agency Group

<sup>12</sup> MMR decreased between 1990 and 2013 by 60%. MMR was 55 per 100,000 live births.

<sup>13</sup> ICPP web page <http://www.ipci2014.org/en/node/102>

Recognizing that gender norms and inequalities can restrict a woman’s movement and ability to earn and control resources, and thus negatively affect her health and that of her children, Chile has worked to develop policies to strengthen women’s equality and rights. The Chilean parliament has established a Ministry for Women and Gender Equity with authority to design, coordinate and evaluate gender empowerment policies. The government is designing a national plan, for implementation in 2015, to tackle gender violence. Proposals are also under consideration for legislation to ensure parental co-responsibility.

According to Chilean law on quotas and gender parity, 40% of government leaders must be female. The current proportion of women parliamentarians is 15.8% in the lower house and 18.4% in the upper house<sup>15</sup>.

Recent legislation also protects the rights of pregnant adolescent girls to remain in school and continue their studies.

Advocacy

The government has adopted the Stockholm Statement of Commitment on the Implementation of ICPD Beyond 2014<sup>16</sup>.

**6.3 Collaborating partners outside parliament**

The Parliament of Chile participates in all the relevant regional and global associations, including the *Parlamento Latinoamericana* (Latin American Parliament). Lobbying is regulated by law to ensure a transparent parliamentary agenda.

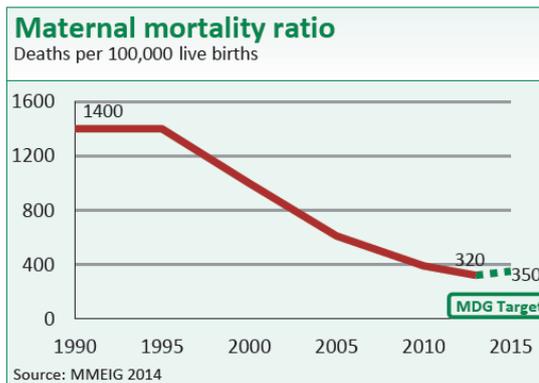
**7. RWANDA**

**7.1 Women’s and children’s health in Rwanda**

Among the 75 countries recording high rates of child and maternal mortality, Rwanda has reported the fastest progress in reducing its mortality rates: from 182 deaths per 1,000 live births in 2000 to 55 in 2012<sup>17</sup>, just short of the country’s MDG target of 50. Around 97% of Rwanda’s children are vaccinated for measles. Between 1990 and 2013, maternal mortality decreased from 1,400 to 268 deaths per 100,000 live births, surpassing the MDG target of 320; 98% of Rwandan women receive antenatal care.<sup>18</sup>

Reductions in child mortality are associated with both improved coverage of effective interventions – full child immunization coverage increased from 69.8% to 90.1%; exclusive breastfeeding increased to 85% – and improvements in socioeconomic conditions<sup>19</sup>.

Disparities between the indicators for the poorest and richest populations in Rwanda, unlike those in many other countries, are relatively small: skilled attendance at delivery ranges from around 60% to over 80% (69% overall). The greatest difference is in care-seeking for child pneumonia, which ranges from 40% to nearly 80%.



MDG targets calculated by Countdown to 2015

**7.2 Parliamentary actions**

A memorandum of understanding (MOU) on RMNCH was signed by Rwanda’s parliament and IPU in 2014. The activities covered are in line with Rwanda’s Five-Year Health Sector Strategic Plan 2013-2018.

Activities were completed in December 2014 to strengthen the coordination of parliamentary activities, improve communication, support capacity building for parliamentarians to deal with RMNCH issues, extend parliamentary

<sup>14</sup> [http://www.senado.cl/derecho-de-alimentacion-de-los-hijos-y-permiso-por-matrimonio-de-trabajador-dan-visto-bueno-a-ambos-proyectos/prontus\\_senado/2014-04-10/161526.html](http://www.senado.cl/derecho-de-alimentacion-de-los-hijos-y-permiso-por-matrimonio-de-trabajador-dan-visto-bueno-a-ambos-proyectos/prontus_senado/2014-04-10/161526.html)

<sup>15</sup> IPU web page Women in National Parliaments <http://www.ipu.org/wmn-e/classif.htm>

<sup>16</sup> [http://www.ipci2014.org/sites/ipci2014.org/files/stockholm\\_outcome\\_final\\_final\\_8\\_may.pdf](http://www.ipci2014.org/sites/ipci2014.org/files/stockholm_outcome_final_final_8_may.pdf)

<sup>17</sup> Fulfilling the health agenda for women and children. The 2014 Countdown report.

<sup>18</sup> idem

<sup>19</sup> Success Factors for Women’s and Children’s Health, 2014 report.

activities to child health, and better involve civil society and the private sector through meetings with parliamentarians<sup>20,21</sup>. Parliamentarians were briefed on RMNCH issues and conducted field visits to 15 of the 30 districts to assess the progress of services at community level. Recommendations from these visits were discussed during a plenary session of parliament, and some have been addressed to the government for implementation.

A national gender policy has been put in place to facilitate equal opportunities for women and men, boys and girls in every sector and to guide planning processes across sectors. Since the adoption of the IPU resolution, additional policy documents have been put in place: Moving to the Maternal Death Surveillance and Response (MDSR) approach (2013); the National Strategic Plan to Accelerate Progress towards Reducing Maternal and Neonatal Morbidity and Mortality 2013-2018, and the National Child Survival Strategic Plan 2013-2018.

The Rwandan Parliamentarians' Network on Population and Development (RPRPD) is affiliated with the country's parliament. Since its creation in 2003, RPRPD has been an advocate for the MDGs and for implementation of the Plan of Action adopted by the International Conference on Population and Development (ICPD), with emphasis on family planning, RMNCH, youth sexual and reproductive health, and HIV/AIDS control. This network implemented the activities contained in the MOU between the IPU and the Government of Rwanda.

Both chambers of parliament (the Chamber of Deputies and Senate) have standing committee on social affairs with responsibility for issues relating to welfare, demographics, hygiene, and health.

As part of its role in overseeing government action, parliament receives civil registration and vital statistics data when finalized. Maternal death surveillance and response data are reported to parliament by means of regular RPRPD briefings to inform members on progress with RMNCH issues.

Here are some specific actions taken by Rwanda's parliament:

#### Legislation

The introduction of affordable health insurance has expanded access to health care, to as high as 90% according to some estimates. Legislation has been introduced to provide free health care for children under six.

Other laws to improve health care, and maternal care in particular, include:

- Organic Law N° 01/2012/OL of 02/05/2012 instituting the Penal Code, with important provisions to promote maternal and child health by punishing acts that would endanger the lives of mothers or children;
- Organic Law N° 03/2013/OL of 16/06/2013 repealing Organic Law N° 08/2005 of 14/07/2005 determining the use and management of land in Rwanda, containing provisions to ensure equal land rights for men and women; and
- Organic Law N° 12/2013/OL of 12/09/2013 on State Finances and Property, with provisions instituting gender responsive budgeting.

#### Oversight/accountability

Parliament has established transparent accountability mechanisms for RMNCH, including a multi-stakeholder commission that reports to parliament. Multi-stakeholder review meetings are held annually to review health sector performance.

#### Budgeting

Parliamentarians ensure that the budget is gender-sensitive.

#### Advocacy

A group of Rwandan parliamentarians visited Sweden to acquire and improve their knowledge and skills related to RMNCH. Many of the implications for parliamentarians resulting from this visit were already being implemented through government development programmes prior to the Stockholm Call for Action<sup>22</sup>.

Parliament organizes public forums for information-sharing and discussion on RMNCH issues.

The Rwanda Women Parliamentarian Forum (FFRP) strongly advocates policies to improve the welfare of women.

Plans have been developed to improve partnerships with civil society and the private sector by providing regular information, holding meetings of parliamentarians, civil society and the private sector, strengthening media coordination, and other means. A joint Government of Rwanda / IPU project was implemented in the last quarter of

<sup>20</sup> Project concept note: Government of Rwanda / IPU to strengthen parliamentary representation and oversight functions in relation to sexual reproductive health and rights.

<sup>21</sup> Country accountability framework progress summary, October 2014

<sup>22</sup> [http://www.ipci2014.org/sites/ipci2014.org/files/stockholm\\_outcome\\_final\\_final\\_8\\_may.pdf](http://www.ipci2014.org/sites/ipci2014.org/files/stockholm_outcome_final_final_8_may.pdf)

2014 to strengthen parliamentary representation and oversight functions in relation to sexual reproductive health and rights. A draft report describes three main activities:

- an orientation/induction seminar for parliamentarians on broader RMNCH issues;
- capacity building for MPs on family planning and its link to sustainable development; and
- hearings of community and local organizations involved in family planning, reproductive health and MNCH activities in hard-to-reach areas.

In accordance with the outcomes expected of this project, parliamentarians have committed to mobilizing families, communities, and religious leaders; advocating more investment in maternal health facilities and human resources; and urging the government to initiate policies to improve access to health services, including investment in other sectors.

**7.3 Collaborating partners outside parliament**

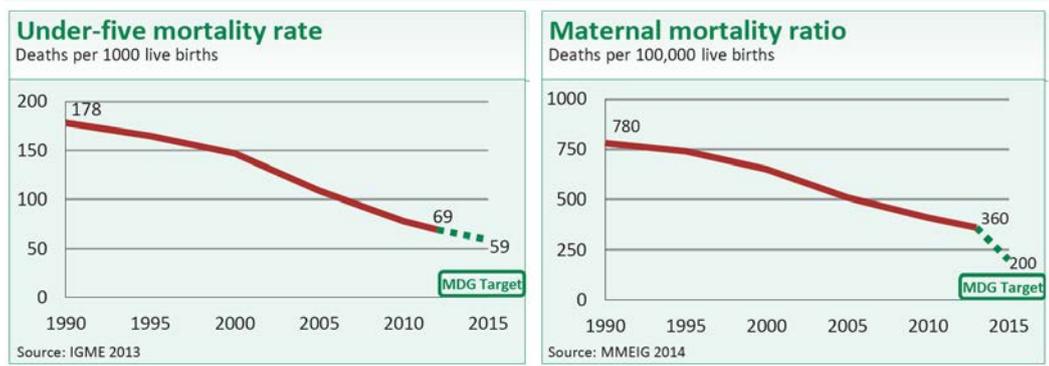
Numerous development partners and civil society organizations are active in RMNCH in Rwanda. Governmental support for care provided by community health workers, whether governmental or CSO-linked, is vital to the extension of health services closer to the population.

In 2013-2014, consultative meetings were held with religious leaders and civil society organizations on their role in promoting family planning and MNCH. These meetings specifically targeted members of the Rwanda Inter-Faith Network on Health Promotion in the Southern Province, the Rwanda NGO Forum on Health Promotion, Fishermen/women cooperatives and their clients, leaders of the Catholic Church, and the Reproductive Health and Rights Consortium led by the Rwanda Women’s Network.

**8. UGANDA**

**8.1 Women’s and children’s health in Uganda**

The reduction of child mortality in Uganda has been impressive, from 178 per 1,000 live births in 1990 to 69 in 2012, approaching the country’s MDG target of 59. Eighty-two per cent of Uganda’s children are vaccinated against measles, and maternal mortality has been halved, from 780 per 100,000 live births in 1990 to 360 in 2013. This is good progress, but still far from the MDG target of 200. The presence of a skilled attendant at childbirth remained stable at around 40% until 2011, when it shot up to 57%. This overall figure hides disparities between rich and poor: only about 40% of Uganda’s poorest citizens had a skilled attendant, compared to around 90% for the richest.<sup>23</sup>



MDG targets calculated by Countdown to 2015

**8.2 Accountability achievements**

A stakeholder workshop held in June 2012 increased awareness about the resolution’s recommendations and Uganda’s Country Accountability Framework and identified priority actions and budget needs.

**8.3 Parliamentary actions**

For some aspects of the resolution, the parliament signed a Memorandum of Understanding with the IPU that outlines an improved legislative environment for MNCH, the promotion of a civil registration and vital statistics system, improved awareness among citizens of MNCH issues, and increased capacity of parliamentary bodies on budget processes. Much of the collaboration between the parliament and IPU centred on briefings and planning meetings to support the parliament’s development of an advocacy strategy on MNCH and implementation of the national Road Map.

A compact also exists between the Government of Uganda and development partners for the implementation of the health sector strategic and investment plan, 2010/11 – 2014/15, but a self-assessment of progress concluded that adherence to this compact is poor.

<sup>23</sup> Fulfilling the health agenda for women and children. The 2014 Countdown report.

The parliament has created a standing committee on health separate from the social services committee. There is also an informal committee, the Network of Women Ministers and Parliamentarians, that is specific to women's and reproductive health and that oversees accountability.

The government has developed plans to systematically involve women's organizations in programme and implementation review processes, revise the terms of reference of the multi-sectoral task force on MNCH (which should report to the parliamentary sessional committee on social services or the parliamentary committee on health), build the capacity of parliamentarians, and develop an all-inclusive CSO coordination framework for MNCH.

Specific actions taken by Uganda's parliament are presented below.

*"In Uganda the IPU resolution was instrumental in creating political momentum on MNCH. Much has been accomplished in the last few years, especially in the reduction of child mortality, and the resolution remains a relevant instrument for parliamentary action." (Sylvia Ssinabulya, MP, Uganda)*

#### Legislation

With IPU's support, a bill on RMNCH has been drafted and lawyers and doctors have been consulted for their input. It has been agreed that national statistics will be examined and consultative meetings will be held with health workers and community leaders before finalizing the bill.

The Ministry of Health has drafted a bill on national health insurance that has been reviewed by stakeholders involved in maternal and child health advocacy and by members of parliament. Ugandan parliamentarians consulted with their colleagues in Ghana, South Africa, and Israel on how the Health Insurance for All programme functions, and made useful recommendations for the reduction of unwanted pregnancies and for maternal and newborn care. The revised bill was subsequently submitted to and accepted by the Ministry of Finance, Planning and Economic Development.

Discussion on the bill included numerous questions for the Minister of Health on the floor of parliament. One example concerned the recruitment of health workers, in particular midwives, to ensure safe deliveries. More than 6,000 health workers have been recruited for FY2013/14, and another 3,000 for FY2014/15.

#### Oversight/accountability

From October 2013 to April 2014 the Ministry of Health engaged with members of parliament in an activity called "National Ward Rounds", involving visits to various hospitals to better understand issues of staffing, equipment, and patient welfare.

For the purposes of accountability, members of parliament were trained in budget tracking and analysis, with an emphasis on the maternal and child health budget. Parliamentarians have been equipped with the knowledge and skills required to hold government offices in their constituencies accountable for health sector funding, equipment, and staffing.

Under the current system, CRVS data are reported to the Ministry of Justice, which then reports to parliament through the appropriate committees. Similarly, data on maternal death surveillance are reported to the Ministry of Health through the MNCH cluster.

#### Budgeting

Ugandan parliamentarians participated in an inter-country workshop<sup>24</sup> to build their own capacity for budget advocacy, and that of multi-stakeholder country teams, to improve women's and children's health. They also discussed ways to foster greater collaboration among the different constituencies that influence budget processes and develop budget advocacy strategies that build on those of existing RMNCH or health society coalitions.

Parliamentarians are the voices of women and children

Although Uganda committed to allocating 15% of the national budget to health, the real number oscillates between 7% and 11%. A CSO coalition lobbying parliament for increased allocations to the health budget engaged with the Parliamentary Health Committee, identified champion MPs, and presented a petition to the Speaker of National Parliament. This advocacy resulted in a budget increase to recruit more than 10,000 health workers, as per staffing norms.

<sup>24</sup> Workshop on Enhancing Capacity for Budget Analysis and Advocacy for Women's and Children's Health, Nairobi, Kenya, August 2013. Conveners : WHO, IPU, UNICEF, Save the Children, World Vision, Mamaye, White Ribbon Alliance, Jumjiya ya Afrika Mashariki, the Partnership for Maternal, Newborn and Child Health

### Advocacy

The IPU has supported the parliament's efforts to implement selected activities under the MOU, including drafting and tabling the bill on maternal, newborn, and child health (see above) and fast-tracking the national health insurance bill. Radio programmes have enabled parliamentarians to hear the views of their constituents on the status of health in their areas. Communities are now demanding accountability from their leaders.

### **8.4 Collaborating partners outside Parliament**

The civil society organizations working on RMNCH in Uganda are numerous. A CSO coalition has been active and successful in lobbying parliament for increased budget allocations to health, and for human resources in particular.

### **9. Conclusions**

In 2011, the Commission on Information and Accountability made ten recommendations for accelerating progress toward MDGs 4 and 5, including measures to increase the engagement of political leaders with RMNCH; the 2012 IPU resolution is one of the principal means of achieving this engagement.

Following the resolution's adoption a dedicated project was launched to assist IPU Member Parliaments with its implementation. The examples presented in this paper underscore the importance of focusing on parliament through advocacy, capacity building, and other types of targeted assistance. The success achieved by a number of IPU Member Parliaments would not have been possible without strong political will in the IPU governing bodies and collaboration with partner organizations.

This paper has provided a small selection of examples of what parliamentarians in various countries have achieved in the areas of legislation, oversight/accountability, budgeting, and advocacy: legislating to ensure universal health coverage, negotiating budgets to make such care possible, and working with civil society to reach the widest possible population.

The four case studies presented reveal certain commonalities: parliaments and their members have created (or are creating) formal and informal parliamentary bodies to ensure sustained attention to RMNCH. Some of these bodies also oversee the development of laws and policies, as well as budgeting. All together, they have helped to raise the profile of MNCH in parliament.

The IPU resolution adopted in 2012, as described above, has helped to make parliamentarians in all four countries more aware about the situation of women's and children's health in their constituencies and the international commitments their governments have made in that connection.

The media is paying more attention to, and parliamentarians are being held more accountable for, promises to improve executive branch accountability in this regard.

Legislation supporting MNCH has recently been passed in Bangladesh, Chile, and Rwanda, and is being considered in Uganda. In Bangladesh and Rwanda, budgeting for health has become a more transparent process. IPU has supported such action in some countries, which underscores the importance of an organization taking on its members' commitments. Key partners, including the WHO and PMNCH, have provided technical advice and support for advocacy activities and budget tracking.

As September 2015 approaches, the landscape for global health and development is evolving. The United Nations Secretary-General's Global Strategy on Women's and Children's Health will be revised and renewed for the period beginning 2016; the world will sign on to a new set of Sustainable Development Goals; and improved mechanisms are being developed to measure and ensure global and country accountability. There is a clear need to further strengthen parliaments' role in holding governments accountable for promises made, including those on women's and children's health. The provisions of the IPU resolution remain as valid as ever and should continue to guide the IPU and its Member Parliaments in the important work of improving accountability for the health of women and children.