NATIONAL ASSEMBLY OF ZAMBIA

REPORT

OF THE

COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES

FOR THE

SECOND SESSION OF THE TWELFTH NATIONAL ASSEMBLY APPOINTED ON
20\textsuperscript{TH} SEPTEMBER, 2017

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REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES FOR THE SECOND SESSION OF THE TWELFTH NATIONAL ASSEMBLY APPOINTED ON WEDNESDAY 20TH SEPTEMBER, 2017

Consisting of:

Dr C Kalila, MP (Chairperson); Ms P Kasune, MP (Vice Chairperson); Dr C Kambwili, MP; Dr J K Chanda, MP; Mr L N Tembo, MP; Mr J Kabamba, MP; Ms A M Chisangano, MP; Mr L Kintu, MP; Mr M Ndalamei, MP; and Mr A Mandumbwa, MP.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir,

Your Committee has the honour to present its Report for the Second Session of the Twelfth National Assembly.

Functions of the Committee
2.0 The functions of your Committee, set out in the National Assembly Standing Orders, are as follows:

i) study, report and make appropriate recommendations to the Government through the House on the mandate, management and operations of the Government ministries, departments and agencies under their portfolio;

ii) carry out detailed scrutiny of certain activities being undertaken by the Government ministries, departments and agencies under their portfolio and make appropriate recommendations to the House for ultimate consideration by the Government;

iii) make, if considered necessary, recommendations to the Government on the need to review certain policies and certain existing legislation;

iv) examine annual reports of Government ministries and departments under their portfolios in the context of the autonomy and efficiency of Government ministries and departments and determine whether the affairs of the said bodies are being managed according to relevant Acts of Parliament, established regulations, rules and general orders;

v) consider any Bills that may be referred to it by the House;

vi) consider international agreements and treaties in accordance with Article 63 of the Constitution;

vii) consider special audit reports referred to it by the Speaker or an Order of the House;

viii) where appropriate, hold public hearings on a matter under its consideration; and

ix) consider any matter referred to it by the Speaker or an Order of the House.
Meetings of the Committee
3.0 Your Committee held thirteen meetings to consider submissions on the topical issues during the period under review.

Committee’s Programme of Work
4.0 At the commencement of the Second Session of the Twelfth National Assembly, your Committee considered and adopted the following programme of work:


b) Consideration of the following topical issues:

i) Zambia’s Response Towards Non-Communicable Diseases;

ii) Progress and Update on the Social Cash Transfer Programme in Zambia;

c) Local tour to Central, Southern and Lusaka provinces; and

d) Consideration and adoption of minutes of the Committee’s meetings and draft report.

Arrangement of the Report
5.0 Your Committee’s Report is in two parts. Part I highlights the findings of your Committee on two topical issues, namely: Zambia’s Response towards Non-Communicable Diseases and Progress and Update on the Social Cash Transfer Programme in Zambia. Part I also covers the local tour undertaken by your Committee while Part II reviews the Action-Taken Report on the Report of your Committee for the First Session of the Twelfth National Assembly.

Procedure adopted by the Committee
6.0 Your Committee sought both written and oral submissions from the relevant Government ministries and institutions, non-Governmental organisations, civil society organisations, the United Nations system in Zambia and interested individuals.

PART I
CONSIDERATION OF THE TOPICAL ISSUES

i) ZAMBIA’S RESPONSE TOWARDS NON-COMMUNICABLE DISEASES
7.0 The spread of non-communicable diseases (NCDs) presents a global crisis and in almost all countries and all income groups, men, women, and children are at risk of these diseases. Low and middle-income countries face the double burden of infectious diseases and NCDs, while in high-income countries the disease burden is mostly NCDs. In Zambia, the substantial gains that have been achieved in economic growth, health, and living standards are being eroded by the NCDs crisis, principally through heart disease, stroke, diabetes, cancers, and chronic respiratory disease.

It was in this vein that your Committee resolved to undertake a study on Zambia’s Response towards Non-Communicable Diseases. The objectives of the study, among others, were to:
i. understand the extent of NCDs as a public health concern in Zambia;
ii. understand the measures in place to reduce exposure to the risk factors for NCDs;
iii. identify the strategies to strengthen health systems and infrastructure for NCDs;
iv. identify the major challenges in the management of NCDs; and
v. make recommendations to the Executive on the way forward.

During its deliberations, your Committee engaged various stakeholders who are listed at appendix II.

Summary of Stakeholders’ Submissions

Overview of Zambia’s Response towards Non-Communicable Diseases

8.0 Your Committee was informed that non-communicable diseases (NCDs) have been traditionally defined as chronic diseases that were non-infectious by nature. There was growing concern over NCDs particularly in low and middle income countries like Zambia as they contributed significantly to mortality and morbidity. In 2014, the World Health Organisation (WHO) estimated that in Zambia, NCDs accounted for 23 percent of all deaths, 80 percent of which were due to the four main diseases, namely cardiovascular disease, diabetes, chronic obstructive pulmonary diseases and cancer. Other important NCDs included epilepsy, mental health conditions, trauma due to accidents and eye diseases.

Your Committee was also informed that recent reports by the World Health Organisation (WHO) showed that in 2016, 33 percent of all deaths for all ages in Zambia were due to NCDs compared to 23 percent in 2014. It was also disturbing for your Committee to learn that NCDs were also affecting the younger population unlike the previous trend where the elderly were mostly affected. These diseases were prevalent in the productive age group of thirty to sixty years and contributed significantly to premature deaths in Zambia. This meant that an adult person in Zambia was, more than ever before, likely to die from an NCD.

Major Risk Factors for NCDs

8.1 Your Committee heard that NCDs of public health concern included, but were not limited to, diabetes mellitus, hypertension, trauma, certain cancers, asthma, obstructive lung diseases which were brought about by occupation and lifestyle such as cigarette smoking. The risk factors for NCDs were highly measurable and in most cases were modifiable. They could be classified as being lifestyle related physiological and biological risk factors.

Stakeholders explained that lifestyle-related risk factors included obesity, mainly caused by unhealthy diets, lack of physical activity, tobacco use, and alcohol and substance abuse, which also contributed to trauma related deaths such as road traffic accidents. The common physiological risk factors included high cholesterol, high blood pressure, and high blood glucose levels while biological risk factors were said to be those with hereditary influence and run through family generations. Physical risk factors were traumas suffered through living and working conditions which included occupational hazards. Physical risk factors included risky conditions in the mining sector and violence and accidents, which included war and road traffic accidents.
Extent of NCDs as a Public Health Concern

8.2 Your Committee learnt that the global burden and threat of NCDs constituted a major public health challenge that undermined social and economic development throughout the world, and had the effect of increasing inequalities between countries and within populations. An estimated 36 million of the 57 million deaths that occurred globally in 2008 were due to NCDs, comprising mainly cardiovascular diseases (48%), cancer (21%), chronic respiratory diseases (12%) and diabetes (3.5%). Of the 36 million deaths from NCDs in 2008, 29 million (80%) occurred in low and middle-income countries, most of these being in the productive ages of thirty to seventy years.

Your Committee further learnt that the Zambian burden of NCDs was equally increasing, and was a major barrier to development and contributed to health inequalities. For example, between 2010 and 2012, Zambia recorded a 22 percent increase in the total number of NCDs. During this same period, cases of out-patient departments’ hypertension cases increased by 39 percent for all age groups. Cancer cases also increased by 43 percent, from 1,282 in 2010 to 1,828 in 2012.

The prevalence of adult hypertension ranged between 25.8 percent and 32.8 percent in rural areas while in urban areas, it was about 34.8 percent. The prevalence of diabetes in the urban area was estimated at 4.6 percent for female adults and 5.35 percent for male adults in Lusaka. Furthermore, NCDs were killing and disabling Zambians at the peak of their productivity. The majority of people who died from largely preventable NCDs were between the ages of thirty and seventy. Therefore, if left unchecked, NCDs had the potential to impact negatively on economic growth in Zambia.

Interventions in Place to Address NCDs

8.3 Your Committee was informed that the interventions listed below had been put in place by the Government to address NCDs.

a) Disease Prevention and Health Promotion
   i. Primary Health Care and Community Health Approach: this was done through the formation of public health teams at sub-district and or health centre levels which were cardinal in the implementation of programmes in respect of prevention, promotion and curative activities for NCDs.

   ii. Vaccination against Human Papilloma Virus (HPV) and Hepatitis B Virus (HPB) which caused cervical and liver cancer respectively.

   iii. Observation of wellness days at places of work and commemoration of the National Wellness Week.

   iv. Launch of the Framework Convention on Tobacco Control (FCTC) in November, 2017, which would be domesticated into comprehensive national legislation.

   v. Policy and legislation to address NCD risk factors, including the development of the final draft National Alcohol Policy which was under review by line ministries; facilitated
the repeal and replacement of the Mental Disorders Act, No. 13 of 1994 and the Mental Health Bill which was approved by Cabinet.

vi. *SI No.163 of 1992-Public Health Tobacco Regulations*, 1992 which prohibits smoking in some places specified in Regulation 5, including hospitals, health centres, nursing homes, kindergartens, cinema halls, theatres, elevators, public transport and schools for adolescents up to 21 years of age.

b) **Early Diagnosis and Control of NCDs through Health Systems Strengthening**
   i. Training of health workers on screening and management of diabetes with the support from Novo Nordisk of Switzerland.

   ii. Collaboration with NGOs in NCD screening.

   iii. Screening for cervical cancer at seventy four facilities across the ten provinces and at ten provincial sites for breast cancer. Two more centres for cervical cancer screening were opened in Mwansabombwe and Nchelenge on 10th February, 2018 during the commemoration of World Cancer Week.

   iv. De-addiction programme for alcoholics and drug addicts currently running at Chainama hospital.

c) **Monitoring, Surveillance and Research**
   The Ministry of Health had undertaken a nationwide NCD survey which would form the basis for monitoring, surveillance, research as well as future planning of services.

d) **Multisectoral Approach on the Determinants of Health**
   This was through the implementation of the Health-in-All-Policies (HiAP) strategy which was approved by Cabinet in May, 2017. HiAP compelled all Government ministries and key stakeholders to align policies with promotion of health. A draft HiAP implementation framework was being developed following a consultative meeting with Government ministries.

**Strategies to Strengthen the Health System and Infrastructure for NCDs**

8.4 Your Committee was informed that the Ministry of Health had made remarkable progress in ensuring availability of infrastructure for prevention and management of NCDs by implementing the measures listed below.

   a) Strengthening of the Tropical Diseases Research Centre in Ndola to include NCDs research.

   b) Setting up of basic infrastructure for prevention and management of NCDs at all levels including seventy four cervical cancer screening sites across the nation and breast cancer screening centres.

   c) Promotion of healthy communities through the healthy city concept/approach which included walk and cycling paths on some roads.
d) Construction and rehabilitation of physiotherapy departments in both old and newly constructed hospitals.

e) Construction of a specialised hospital in Lusaka and expansion of the cancer diseases hospital.

The stakeholders, however, submitted that more strategies could be considered to strengthen the system infrastructure for NCDs as set out below.

i. Development of clinical nutrition and dietary guidelines, and training of health workers in the management of NCDs.

ii. Raising awareness on NCDs through information, education and communication (IEC) materials such as television documentaries, posters and media discussions.

iii. Advocating for healthy lifestyles and introduction of work place interventions for smoking cessation which were found to be effective.

iv. Supporting national coordination towards establishment of centres of excellence and specialised care for NCDs.

Programmes on Community Awareness and Health Promotion

8.5 Stakeholders informed your Committee that to scale up its technical assistance to support countries in implementing the best buys and other recommended interventions, the World Health Organisation (WHO) had developed technical assistance packages to assist in country-level implementation aimed at reducing the demand for tobacco as contained in the WHO Framework Convention on Tobacco Control (FCTC), scale-up cardiovascular disease management in primary health care, reduce population salt intake, integrate essential NCDs interventions into primary health care and to reduce childhood obesity.

Your Committee was further informed that the Ministry of Health had heightened sensitisation through commemoration of international events such as World Health Day, World Mental Health Day, and World Epilepsy Day. It had introduced wellness days at work places and it had trained community volunteers in the prevention, control, care and support as well as importance of regular examination for NCDs.

Measures in place to Achieve Target 3.4 of the Sustainable Development Goals (SDGs)

8.6 Your Committee was informed that target 3.4 recommends the reduction by one third, premature mortality from NCDs by prevention, treatment and promoting mental health and well-being. To this effect, your Committee was informed that the Government through the Ministry of Health was putting in place the measures set out below.

a) Health Promotion and education in communities, schools, churches and workplaces on NCDs and their risk factors.
b) Training of front line health workers and community volunteers in prevention, promotion and control of NCDs as was the response at the height of the HIV pandemic.

c) Scaling up the de-addiction programme for alcoholics and other drug addicts.

d) Providing guidelines for the management of NCDs at all levels of health care.

e) Enforcement of legislation passed to control NCD and related risk factors.

f) Updating the NCD medicines and supplies on the essential medicines list for Zambia to meet the demand.

g) Recruitment and deployment of human resources for health countrywide.

h) Construction and renovation of hospitals and health centres countrywide to manage NCDs.

i) Enhancing the referral system at all levels of health care.

Although these measures had been initiated, they were still non-exhaustive in tackling the NCD burden in Zambia.

**Trend of Financing towards NCD Programmes**

8.7 Your Committee heard that the National NCD Control Programme required optimal and timely financing to NCD programmes and effective allocation, utilisation and tracking of the available resources to achieve high impact and realise value for money. Therefore, the NCD budget line was included in the main Ministry of Health budget. Further, it was learnt that very few partners supported NCDs despite them being crosscutting issues in HIV/AIDS, Tuberculosis (TB), malaria, maternal and child health. However, United Nations Development Programme (UNDP) and WHO had supported components of the NCD plan. Your Committee was also informed that the Government could provide funding for national NCD responses through domestic, bilateral and multilateral channels through the introduction of taxes on health-harming products like tobacco as revenue to finance national SDG responses including NCDs.

**Coordination and Engagement in NCD Interventions**

8.8 Your Committee was informed that the major causes of NCDs were social and environmental and were, therefore, outside the mandate of the health sector. Stakeholders informed your Committee that in order to address NCDs effectively, the National Health Strategic Plan 2017-2021 aimed at strengthening prevention, health promotion and education in the continuum of care using the primary health care approach and promotion of the Health in All Policies (HiAP) framework, ensuring harmonised and strengthened inter-sectoral action on health using the Whole Government and Whole Society approach. Moreover, a multisectoral NCDs steering Committee was to be established and an NCD Alliance created by NGOs and civil society so as to foster the adoption of healthier lifestyles.
Use of Research for the Prevention and Control of NCDs

8.9 Whilst it was agreed by all stakeholders that Research and Development should be the core driver of public health interventions, your Committee learnt that investment in NCD research still remained very low in Zambia. This had contributed to the low demand for NCD research among academics and the civil society in general, as most financial resources were targeted at communicable diseases such as HIV/AIDS, TB and malaria and sexual reproductive health. Furthermore, coordination mechanisms of NCD research efforts to feed into the national policy were still inadequate, which made translation of evidence into practice challenging. A number of institutions such as the University of Zambia, School of Public Health and Medicine had continued to undertake research on NCDs, although that had mostly been funded by cooperating partners like the World Health Organisation (WHO) and National Institute of Health (NIH). Stakeholders emphasised the need for studies to ascertain prevalence levels if successes scored in various interventions put in place were to be measured.

Challenges being faced in the Management of NCDs

8.10 Your Committee learnt that there were a number of challenges being faced in the management of NCDs. These are set out below.

i. Inadequate policies to influence or support a healthy environment for improved nutrition. This was mainly in light of the rise in the availability of processed foods which had led to consumption of energy dense foods that were high in sugar, salt and fat.

ii. Inadequate political will, collaboration and convening of main stakeholders to raise priority given to NCDs in the country and national health agendas demonstrated by the low level priority given and meagre resources allocated to prevention and control of NCDs.

iii. Inadequate promotion of healthy diets, physical activity and promotion of healthy lifestyles as there were no population-wide interventions to guide the general public on the importance of healthy diets, physical activity and healthy lifestyles.

iv. There was no country wide data to adequately influence policy and programming in NCDs.

v. Inadequate partnerships created to enhance response to NCDs given that multisectoral partnerships were appropriate to promote cooperation at all levels among Governmental agencies, inter-Governmental organisations, non-Governmental organisations, civil society and the private sector to strengthen efforts for prevention and control of NCDs.

vi. Inadequate human resources.

vii. Inadequate equipment and medical supplies for diagnostics and treatment.

viii. Inadequate infrastructure to address NCDs.
TOUR REPORT

9.0 In order to consolidate its findings, from oral and written submissions from various stakeholders, your Committee undertook tours to various institutions charged with the responsibility of prevention and management of non communicable diseases in Central, Lusaka and Southern Provinces.

During its tour, your Committee visited the following institutions:

i. University Teaching Hospitals (UTH) - Adult Hospital;
ii. University Teaching Hospitals (UTH) - Eye Hospital;
iii. Chilenje Level One Hospital;
iv. Kabwe General Hospital;
v. Mahatma Ghandi Clinic;
vi. Mazabuka District Medical Office;
vii. Gwembe District Hospital;
viii. Munyumbwe District Hospital;
ix. Livingstone Central Hospital; and
x. Libuyu Clinic, Livingstone.

The findings of your Committee arising from the tours are highlighted hereunder.

UTH ADULT HOSPITAL

9.1 The hospital is the largest of the UTH group of third level referral hospitals. It has a bed capacity of 872 with a provision to accommodate an extra 100, divided into 23 wards. The hospital offers emergency and surgical services and among others, is positioned to perform cardiac surgery, intervention cardiology, renal transplant and spinal surgery between 2018 and 2020.

In terms of NCDs, your Committee was informed that the hospital offered disease prevention, curative, palliative, health promotion and rehabilitative care services, among others. To achieve this, the Adult Hospital had in place dedicated units to address an array of NCD problems such as cardiology and psychiatry. In addition, diagnostic services in radiology, laboratory and pathology were in place. To address NCDs associated with physical inactivity, the hospital had introduced weekly aerobics for its members of staff.

Your Committee also learnt that progress had been made in a number of areas such as infrastructure where renovation of the casualty wing was carried out; had piped pressure oxygen to Intensive Care Unit (ICU); construction of a car park and surgical wards; rehabilitation of the central ventilation and water supply systems; and 24 hour pharmacy services. In terms of medical equipment, basic equipment had been procured such as drip stands, blood pressure machines, suction machines, patient trolleys, bedside lockers, cardiac monitors and ventilators. The hospital had an approved establishment of 1,602 for both medical and support staff. There was also a team for trainings in cardiac surgery and renal transplant.

In terms of challenges, the hospital had inadequate competent staff in most departments across all cadres leading to the high doctor-to-patient ratio, for example. The supply of drugs, medical and surgical consumables from Medical Stores Limited (MSL) was erratic and the hospital still
used mostly paper records. Further, financing from the treasury was inadequate, leading to the hospital accruing debts for goods and services, personal emoluments and utility bills.

In view of the above, the hospital proposed as follows:

i. there was need to invest in capacity building of human resource especially in areas such as cardiac surgery, endocrinology cardiology, pathology, pulmonary, plastic surgery, midwifery, critical care nursing, vascular nursing advanced life support and nephrology;
ii. there was an urgent need for investment in electronic records management;
iii. there was need to promote medical tourism which would bring in foreign exchange in terms of service provision and specialised medical teaching;
iv. the Government should invest in mindset change of staff for them to be more dedicated to providing quality service;
v. there was need to invest in skills transfer and ensure that expatriates transferred skills to local staff; and
vi. there was need to procure more CT scan machines and have the service contracts handled by the Adult Hospital for efficiency.

As a way forward, it was stated that the hospital intended to modernise the business centres, Highland House and the UTH Sports Club and save on accommodation costs for expatriates.

**UTH EYE HOSPITAL**

**9.2** The Eye Hospital was created in December, 2016. Previously, it was a Unit under the department of surgery. Currently, it consisted of two wards, three operating theatres and an Out-Patients Department (OPD) which was separate from the main hospital administration block. The hospital offered premium and fast track services at 14:00 hours every day. For theatres, nothing had changed from the time the facility was just a clinic.

Your Committee learnt that the hospital offered in and outpatient services and operated 24 hours in several sub-specialised departments. The other services were in the laboratory, medical imaging, anaesthesia, pharmacy, oculoprostheses and ocular imaging. However, the laboratory, medical imaging and anaesthesia were being shared with other hospitals.

The most common NCD conditions for outpatient attendance were Cataract, refractive errors, glaucoma, allergic conjunctivitis, trauma, uveitis, pterygium, diabetic retinopathy, corneal ulcers and conjunctival growths. The volume of patients seen by the hospital’s outpatient department showed an increasing trend with 16,200 in 2015, 18,986 in 2016 and in the first quarter of 2017, 6,429 patients were seen.

The hospital performed surgeries on patients with various eye ailments. In the first three quarters of 2016, 1,084 eye surgeries were performed of which 30 percent were cataract. In the same period of 2017, 1,391 surgeries were performed, giving an increase of 28 percent. The types of surgeries performed were cataract, glaucoma, destructive eye, repairs and oculoplastic surgeries. Your Committee was informed that some of the successes scored by the hospital were as outlined below:
i. There was an increased number of surgeries and patients accessing the hospital;

ii. The hospital linked with Frimley Park Hospital, a cooperating partner in the diabetic retinopathy screening programme;

iii. Acquisition of former Mwaiseni Stores and commencement of renovation works for an administration block;

iv. The hospital acquired and secured space for construction;

v. It was a local and international training centre for UNZA and private universities’ for both under and post graduates;

vi. Procurement of a range of state-of-the-art medical equipment in different quantities (some of which were not functional at the time of your Committee’s visit);

vii. The new establishment for the UTH Eye Hospital medical and support staff was approved by Cabinet Office. However, there was need to train sub-specialists like vitreoretina surgeons, cornea transplant surgeons, glaucoma, medical retina and oculoplastic surgeons; and

viii. The hospital had developed documents necessary for running the hospital such as the Action Plan, Procurement Plan and Hospitals Performance Assessment tools and standards.

Your Committee was informed that the hospital was faced with a number of challenges in its operations. Some of these are as set out below.

i. Infrastructure such as the theatres, wards, office space and OPD were inadequate and too far apart. Only one theatre was attending to trauma cases and was shared by all hospitals.

ii. There were too many administrative transfers which were frustrating staff.

iii. The hospital had a number of misplacements of staff as some eye health personnel were working in areas they did not specialise in.

iv. Transport was inadequate as the hospital only had one pool vehicle.

v. Drugs and consumables were inadequate. The hospital was receiving less than 30 percent of required drugs and consumables and ended up using part of the grant to make up the shortfall.

vi. There was lack of adequate sub-specialised personnel and support staff.

**Emerging issues and recommendations**

**9.2.1** Arising from the above challenges, the hospital advanced the following suggestions in order to improve its efficiency:
i. Significant investment in adequate and convenient infrastructure.

ii. There was need to procure adequate Vehicles.

iii. Funding of the establishment would make staff secure and motivated.

iv. Medical Stores Limited should stock adequate consumables for eye health.

v. There should be training of sub-specialised eye surgeons.

vi. In order to motivate staff and increase effectiveness, there should be correct placement of eye health personnel.

vii. The hospital should be supported with basic furniture and computers.

viii. It was also suggested that the hospital diversifies into bifocal, progressive spectacles and contact lenses.

**Other findings**

**9.2.2** In addition to the above, your Committee learnt during the tour that:

i. most of the clinics around Lusaka did not have sufficient space, resulting in staff remaining at UTH while waiting for creation of space.

ii. the Ministry of Health (MOH) sometimes sent staff that were not appropriately qualified. For example, the hospital had requested for an optonometric technologist from MOH but was instead given a clinical officer.

iii. The hospital trains staff in NCDs at primary health care units to handle all cases except the complex ones.

iv. In pursuing a preventive rather than a curative model, the new Department of Health Promotion was spearheading the drive for information dissemination.

v. The current document used to examine Public Service Vehicle (PSV) drivers was inadequate. The form should compel all drivers to be tested at hospitals like UTH which have equipment approved by the World Health Organisation (WHO) which test for video fields in order to curb accidents due to poor eye sight of drivers who are not adequately tested.

**CHILENJE FIRST LEVEL HOSPITAL**

**9.3** Your Committee was informed that Chilenje First Level Hospital was in sub District six of the six sub health districts of Lusaka district. It is the third most populated in the Lusaka District with a total population of 426,437 with a growth rate of 3.8% per year, according to CSO projections of 2010. The sub district six has one first level hospital namely Chilenje First level Hospital, six health centres (Kabwata, Prisons, Civic Centre, State House, State Lodge and Bauleni) and three health posts (Malata, Lubwa and Mahopo).
Your Committee heard that the services offered by Chilenje First Level Hospital were labour and delivery, imaging, eye clinic, counseling and testing, obstetrics and gynecology, cervical cancer, out and inpatient departments, public health, postnatal, physiotherapy, mental health, environmental health and anti retroviral therapy. The district had 307 community volunteers and 559 staff, of which 185 were public health workers.

Further, your Committee was informed that the hospital had recorded a general increase in NCDs; the most common being diabetes, hypertension, asthma, trauma (mainly due to road traffic accidents), epilepsy, dental health and mental health. The table below shows the trend of NDCs recorded at the hospital during the period 2015 to 2017.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NCD</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetes</td>
<td>1163</td>
<td>1018</td>
<td>1386</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>4521</td>
<td>5895</td>
<td>4845</td>
</tr>
<tr>
<td></td>
<td>Trauma</td>
<td>359</td>
<td>333</td>
<td>686</td>
</tr>
<tr>
<td></td>
<td>Epilepsy</td>
<td>1325</td>
<td>1331</td>
<td>769</td>
</tr>
<tr>
<td></td>
<td>Dental Health</td>
<td>8537</td>
<td>7697</td>
<td>9271</td>
</tr>
<tr>
<td></td>
<td>Mental Health.</td>
<td>506</td>
<td>534</td>
<td>405</td>
</tr>
</tbody>
</table>

Trend of NCDs at Chilenje first level hospital, 2015 to 2017

Your Committee was informed that in promoting a preventive rather than a curative approach, the hospital carried out the following health promotion activities:

i. sensitisation in schools, markets, shopping malls, churches and work places;

ii. integrated outreach activities such as medical checkups at shopping malls, offer blood pressure checkups to parents during under five outreach;

iii. educating community members on lifestyle changes such as medical checkups, encourage physical activity and diet changes;

iv. door to door sensitisation of community members;

v. distribution of Information, Education and Communication (IEC) materials including those translated in local languages;
vi. commemoration of various health days as this also helps to create awareness; and

vii. identifying champions for various health programmes for both local community and influential leaders to help drive health programmes.

![Blood Pressure Check-up during Out Reach Programme](image)

Your Committee learnt that the hospital had the following challenges regarding its operations:

i. optimal, regular and close supervision of facilities within the sub district were impaired by the absence of a utility vehicle at Chilenje First Level Hospital;

ii. community health education was not optimal due to limited standardised IEC materials;

iii. long waiting time for patients because the volume of patients going to the hospital had more than tripled since the upgrade compared to the number of staff available;

iv. the supply of essential drugs to the facility was yet to meet the demand of the high flow of patients;

v. though consistent, the grant was still inadequate to meet demands such as community volunteers’ motivation as they undertook sensitisation activities; and

vi. There was need to increase the infrastructure of the hospital in general.

In order to provide better services to the community, the hospital recommended as set out
below.

i. There was need for a new staff establishment to respond to the huge volume of patients so as to improve on waiting time. 12 Medical Officers, 40 Clinical Officers and 100 Midwives were proposed.

ii. Two Land Cruisers with Public address Systems were required.

iii. There was need for support to facilitate the development and printing of specialised IEC Materials and procurement of television (TV) airtime and radio for health promotion.

iv. The grant towards community based activities should be increased as this would motivate the community volunteers in terms of incentives.

v. The bed capacity for in-patients should be increased.

vi. There was need to engage MSL with the new drug consumption rates so that the drug supplies may be increased.

**Kabwe General Hospital**

9.4 Your Committee was informed that Kabwe general hospital was a third level hospital with a 430 bed capacity. The hospital attended to 210 in-patients per day and offered services in four disciplines. Further, your Committee learnt that NCDs accounted for the highest in morbidity and mortality and were costly in terms of man hours and drugs. Of all the NCDs, trauma due to road traffic Accidents constituted the highest number of cases and occupied staff most of the time.

Your Committee learnt that in order to prevent the NCDs, the hospital employed the measures outlined below to reduce risks of NCDs.

i. Used local radio stations to disseminate information to the population.

ii. Undertook mobile outreach services, especially on cancer.

iii. The hospital had a breast clinic for women breast checkups.

iv. The hospital planned to constitute a team from different departments to visit various institutions for wellness programmes.

Your Committee heard that, the hospital had a number of strategies to combat NCDs. These included the following:

i. in instances where the hospital lacked specialised staff, it out sourced from UTH;

ii. the hospital had an active nutrition department; and
iii. the hospital took advantage of open days to interact and screen for NCDs.

Your Committee learnt that the following were some of the challenges that the provincial referral hospital faced in its operations:

i. inconsistent supply of drugs;

ii. lack of vital diagnosis equipment such as CT scan and dialysis machines, leading to referrals to UTH of patients with brain haemorrhages and renal failure;

iii. the hospital did not have sub specialties in different areas such as neurosurgeons and nephrologists;

iv. lack of a mammography screening machine;

v. poor health seeking behaviour leading to patients reporting late for treatment;

vi. the psychiatry ward did not have necessary drugs and these had to be sourced from Chainama Hospital in Lusaka; and

vii. in the trauma centre, digital X-ray and ultra sound machines were not working at the time of the visit.

In view of the above, the hospital management recommended as set out below.

i. The Government should seriously consider putting in place measures that would help to reduce road traffic accidents.

ii. Whenever an opportunity arose, such as during under-five clinics and political gatherings, the occasion should be used to sensitise the population about NCDs.

iii. There was need for increased and reliable supply of drugs by Medical Stores Limited (MSL).

iv. All the requisite equipment such as CT scan, MRI and Renal Units should be urgently procured to reduce on referrals of patients to UTH.

v. Adequate specialised staff should be recruited at all levels to handle the increasing cases of NCDs and expanding hospital activities.

MAHATMA GHANDI CLINIC/KABWE DISTRICT HEALTH OFFICE

9.5 Your Committee visited Mahatma Gandhi Clinic where they also interacted with the District Health Office officials. Your Committee was informed that the District had a population of 227,551 people and it was serviced by forty five health facilities that included thirty two health centres run directly by the District Health Office, four (4) by the Ministry of Defence, three by the Ministry of Home Affairs and six by private practitioners.
Your Committee was informed that from 2014 to 2016, hypertension featured as the top cause of morbidity among people of all ages while most of the mortality for the period was attributed to cardiovascular disease. In 2017 the worst cause of ill health in Kabwe district was hypertension (9,416) followed by asthma (2,133), cardiovascular disease (1,281), diabetes (1,229) and sickle cell anaemia (422). Generally, of all the health centres, Katondo had the highest cases of NCDs while Mahatma Ghandi recorded the least.

Your Committee learnt that some of the successes scored by the district were as follows:

i. equipment to diagnose common NCDs was procured;
ii. health promotion activities on NCDs were being undertaken on radio and in communities;
iii. knowledgeable staff on NCDs (doctors and senior clinical officers) were involved in the management of complicated cases; and
iv. the district had educated community health care givers who were the link between the community and the health facilities.

Your Committee was informed that some of the challenges faced by health facilities in the district were as listed here under.

i. Inadequate knowledge and skills on NCDs by staff.
ii. There was inadequate health infrastructure for NCDs.
iii. Limited equipment for diagnosing NCDs.
iv. Inadequate knowledge on NCDs in the community.

Further, your Committee heard that in order to improve service provision, the following measures were necessary:

i. integration of screening for NCDs with existing programmes like test-and-treat for HIV outreach activities;
ii. sensitisation of communities in churches, markets and the shopping malls;
iii. continued sensitisation programmes on radio;
iv. continued orientation of staff on the management of NCDs; and
v. continued lobbying for the construction of first level hospital in order to decongest Kabwe General Hospital.
Your Committee was informed that Mazabuka District had a total number of forty three health facilities, which included ten health posts, thirty two health centres and one general hospital. Out of the forty three Health facilities, thirty three facilities were Government while ten were private health facilities. The population of the district in 2018 was estimated at 194,832 and it comprised mostly young people.

The major causes of morbidity in the district were hypertension, diabetes, trauma and asthma especially in children. The district had recorded a reduction in trauma, but an increase in hypertension. The table below depicts the prevalence of NDCs in the district during the period 2015 TO 2017.

<table>
<thead>
<tr>
<th>NCDs prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Sickle cell Anemia</td>
</tr>
</tbody>
</table>

Your Committee learnt that asthma and hypertension were the highest causes of illness in all ages between 2015 and 2017, while in the same period, mortality due to cardiovascular diseases were responsible for the highest motilities followed by diabetes and trauma.

The district’s responses to NCDs were at four levels, namely; community, rural health centre or health post, hospital and district health office. These responses included services ranging from sensitisation to screening and curative services. The main activities of the District Health Office in relation to NCDs were as outlined below.

i. Screening of cancers.

ii. Growth monitoring.

iii. Radio programmes on alcohol and tobacco abuse and physical exercises.

iv. Distribution of Information Education and Communication (IEC) materials.

v. Provision of drugs, rehabilitative and palliative care.

vi. Water quality assessment to ensure it is free from contamination with NCD risk factors.

Despite the challenges encountered, the District had scored some successes in service provision as set out here under.

i. The district had secured a free slot on Radio for health promotion programmes.
ii. There was improved drug supply for NCDs.

iii. Funding under Swedish International Development Agency (SIDA) had helped the DHO and Mazabuka Hospital to plan for staff training.

iv. Reduction in trauma cases due to road traffic accidents despite roads being in bad state.

v. Introduction of portable laboratory for water quality assessments necessitated by the contamination of water with fertilisers which could cause NCDs.

vi. Opening up of the food and drug laboratory in the District.

Your Committee was also informed that the district was facing a number of challenges as highlighted below.

i. No staff in the District was trained in cervical cancer (CaCx) screening.

ii. The brewing and abuse of kachasu, an illicit beverage, was rife in the District.

iii. Some people presented late for medical attention and did not take routine check-ups seriously.

iv. The increase in fast food outlets contributed to poor nutrition and the rise in NCDs.

v. Despite the improved drug supply, there are limited alternatives in hypertension drugs from Medical Stores Limited.

vi. The available radio frequency did not cover the whole District.

vii. Mazabuka General Hospital was operating as a district hospital in terms of infrastructure and lacked specialised wards.

viii. Staffing levels were inadequate and of the specialised staff, only surgeons were available there by negatively affecting diagnosis and treatment of NCDs.

ix. There were inadequate IEC materials for distribution.

x. There was inadequate transport to cater for patients especially those referred to UTH.

In view of the above, the DHO made recommendations as set out below.

i. Specialised staff befitting a General Hospital should be posted to the facility.

ii. There was need to speed up the opening of cancers screening centres, as planned, at Mazabuka General and Chivuna Mission Hospitals.

iii. Support should be available to facilitate development of more IEC materials.
iv. There was need for the Government to encourage research into herbal medicines.

GWEMBE DISTRICT HOSPITAL/MEDICAL OFFICE

9.7 Your Committee was informed that Gwembe District had a population of 53,117, the majority of whom were rural-based. The District had eighteen Health facilities categorised as: one district hospital in Munyumbwe, one hospital affiliated Health centre, eight health Centres and seven Health posts. The new district hospital at Munyumbwe was not yet fully operational and therefore, the old hospital still operated as district hospital. To supplement Government efforts, a number of stakeholders helped in provision of health services. In 2017, the District received 92% of the expected Government grant.

Your Committee learnt that the prevalence of NCDs between 2017 and the first quarter of 2018 was as tabulated below.

<table>
<thead>
<tr>
<th>NO.</th>
<th>DISEASES</th>
<th>2017</th>
<th>1st QUARTER OF 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Asthma</td>
<td>1806</td>
<td>431</td>
</tr>
<tr>
<td>2</td>
<td>Hypertension</td>
<td>667</td>
<td>224</td>
</tr>
<tr>
<td>3</td>
<td>Epilepsy</td>
<td>343</td>
<td>61</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes</td>
<td>61</td>
<td>32</td>
</tr>
<tr>
<td>5</td>
<td>Cardio Vascular</td>
<td>61</td>
<td>34</td>
</tr>
<tr>
<td>6</td>
<td>Cancers</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Respiratory conditions</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

The high asthma cases in 2017 and 2018 were attributed to environmental factors such as dust and pollen, especially in the rainy season while the low cancer cases recorded were as a result of lack of screening due to inadequate facilities.

Your Committee was informed that the district had made several achievements including the following:

i. construction of new district hospital in Munyumbwe was at phase II level;

ii. construction of ten health posts had commenced;

iii. construction of a health post, Mothers’ shelter and VCT rooms at Ntanga by Collin Glasco Foundation was underway;

iv. a reasonable number of staff in different specialisations had been posted to the district although that still did not meet the establishment;

v. there was an improvement in immunisation coverage at 83% of fully immunised children;

vi. three ambulances equipped with basic life support equipment had been acquired;

vii. seven motor bikes and two utility vehicles had been received from SIDA; and

viii. less than ten deaths due to NCDs had been recorded per year.
The following were the major challenges faced by the District:

i. inadequate transport and constant breakdown of vehicles due to bad roads;

ii. constant power outages and broken down generator compromised service delivery;

iii. staff houses were in a deplorable state; and

iv. theatre equipment and an X-ray machine (with part missing) had been marooned for two years without installation.

**CHOMA GENERAL HOSPITAL**

9.8 Your Committee heard that Choma General Hospital was a second level hospital in the capital of Southern Province which catered for referrals from surrounding districts.

As regards to NCDs, your Committee learnt that the prevalence of NCDs in 2017 was as tabulated below.

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>3979</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>1165</td>
</tr>
<tr>
<td>Hypertension</td>
<td>829</td>
</tr>
<tr>
<td>Diabetes</td>
<td>583</td>
</tr>
<tr>
<td>Anaemia</td>
<td>547</td>
</tr>
<tr>
<td>Trauma (RTA)</td>
<td>511</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>238</td>
</tr>
<tr>
<td>Nutritional deficiencies</td>
<td>207</td>
</tr>
<tr>
<td>Burns</td>
<td>185</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>125</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>75</td>
</tr>
<tr>
<td>Asthma</td>
<td>48</td>
</tr>
<tr>
<td>Cataracts</td>
<td>23</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>10</td>
</tr>
</tbody>
</table>

stroke  | 8

Prevention of most of these NCDs was being done by the District Health Management Team through its outreach officers and rural health centres. This was done by screening for hypertension and blood sugar mainly during commemoration of national and world health days.

**Measures taken to manage NCDs**

9.8.1 The hospital was mainly preoccupied with curative measures as outlined below.

i. The hospital had specific clinics for diabetes, hypertension and cardiac patients.

ii. The hospital was supported by a functional laboratory for blood sugar tests.

iii. X-ray department had an echo machine for diagnosing heart problems.
iv. The hospital had an eye clinic which also organised public health outreach for the district.

v. The hospital also had a physiotherapy department handling many of the stroke patients.

The following were some of the challenges faced by the hospital:

i. weak law enforcement regarding the consumption and trade of alcoholic beverages. This had resulted in high alcohol consumption levels and consequently a higher rate of trauma;

ii. lack of an ECG machine which was used for diagnosing cardiovascular diseases and CT-scan machine for brain scan and other trauma. The hospital lacked an intensive care unit too,

iii. there were inadequate specialised staff to handle NCDs;

iv. the hospital lacked a trauma centre;

v. there was inadequate bed linen;

vi. the old wing of the hospital was dilapidated; and

vii. inadequate transport because the hospital only had one old utility vehicle.

As a way forward, the hospital management submitted the following proposals:

i. there was need for procurement of an ECG machine to facilitate treatment through enhanced diagnosis;

ii. there was need to procure modern physiotherapy equipment to enhance the quality of service offered;

iii. there was need to expedite the completion of the new hospital to create space for most crucial departments;

iv. the Government should consider entering into partnerships with NGOs on health promotion;

v. there was need to establish a bigger and better equipped rehabilitation centre;

vi. the Government should reduce bias towards recruitment of more nurses and doctors at the expense of other medical specialisations;

LIVINGSTONE CENTRAL HOSPITAL (LCH)
Your Committee heard that Livingstone Central Hospital was a major tertiary referral institution in the southern region of Zambia whose approach to NCDs was mainly curative and rehabilitative. The most common NCDs were cardiovascular diseases, hypertension and diabetes and the hospitals primary response was treatment and prevention of progression. Your Committee was informed that to prevent progression of disease, the following measures were in place:

i. patients were educated on complications arising from common NCDs through morning briefs held on clinic visit days;

ii. clients were taught on healthy lifestyles;

iii. urinalysis, random blood sugar and BMI had been incorporated as part of the vital signs during routine check-up in outpatient department;

iv. cardio vascular clinic day was observed; and

v. encourage staff patient collaboration with a view to motivating patients to seek medical advice.

The hospital management submitted that the institution faced various challenges. These are highlighted below.

i. In many cases, patients presented to hospitals with NCDs quite late, so it was difficult to arrest the progression of the ailments.

ii. screening tools such as glucometers and blood pressure machines were inadequate on account of funding.

iii. There were inadequate medicines.

iv. The renal unit had limited dialysis machines for diabetic patients.

v. A piece of land reserved for the construction of a medical tourism facility had not been utilised for many years.

**Integration of Care**

9.9.1 It was reported that LCH had embarked on integrating Primary Health Care (PHC) within its framework of strengthening health systems with the objective of improving the competencies of the staff providing PHC and enabling them to reach out to the community. However, primary health centres were faced with lack of trained personnel, inadequate staffing and non-availability of screening tools. Therefore, to prevent the development of NCDs, the following measures had been put in place:

i. mentorship visits to local clinics by trained staff were being undertaken;

ii. outreach programmes through radio broadcasts were initiated;
iii. local nurses were oriented on urinalysis, Body Mass Index (BMI), blood pressure and random glucose testing; and

iv. peer groups were formed among clients being seen in the clinics.

In view of the above measures, it was expected that the following outcomes would be attained:

i. all primary health centres to be oriented on screening for risk factors;

ii. all primary health centres to have basic screening tools;

iii. all clients with established NCDs to be aware of the risks and complications of their conditions; and

iv. to have fully fledged community outreach programmes through primary health care.

The hospital management made several suggestions as regards how management and care of patients with NCDs could be improved. These are set out below.

i. Improve staffing levels.

ii. Supply of basic screening tools such as glucostix and glucometers.

iii. Relevant legislation should be put in place for all organisations to be conducting health clinics for their staff.

LIBUYU HEALTH CENTRE

9.10 Your Committee was informed that Libuyu Health Centre was one of the Zonal Health Centres in Livingstone District built in the 1960s and later extended in 2005 due to population growth. It had a catchment population of 19,763 divided into ten zones, six of which were in Libuyu compound and four in the peri-urban. The facility had 38 staff of different specialties and 109 active community health workers. The health centre offered promotive, preventive, curative and rehabilitative services such as health promotion, medical treatment, nutrition assessment, outreach and school health services.

Your Committee learnt that, in 2016, 16 cases of diabetes were recorded and 211 in 2017, while hypertension cases were 464 in 2016 and dropped to 429 in 2017. For the rest of the NCDs, basic assessments were carried out after which patients were referred to the central hospital due to lack of necessary equipment at the clinic. The clinic faced challenges as set out below.

i. The laboratory was too small and inadequately equipped.

ii. It had inadequate blood sugar screening equipment.

iii. Most staff were not trained in the handling of NCDs.

In view of the foregoing, the district and clinic management recommended that more investment be put into training of specialised staff and procurement of basic NCD diagnosis equipment.
Committee’s Observations and Recommendations

10.0 In view of the above findings, your Committee recommends as set out below.

i. Your Committee observes that all health facilities visited did not have adequate transport and tools for checking vital signs on outreach services, thereby compromising service delivery.

Your Committee therefore, implores the Government to acquire adequate transport and equipment for use during outreach services to the community as outreach encourages a preventive rather than a curative approach to NCDs.

ii. Your Committee observes that there is generally poor collaboration between the community and the health institutions.

Your Committee recommends that the Government should allocate resources towards community based activities as this will motivate the community volunteers in terms of incentives and reduce their turnover.

iii. Your Committee observes that there are generally limited specialised medical personnel in non communicable diseases. This was clearly evident when your Committee visited the UTH Adult Hospital which is one of the main referral hospitals in Zambia.

In the light of this, your Committee recommends that the Government should invest as a matter of urgency in capacity building of human resources, especially in areas such as: cardiac surgery, endocrinology, cardiology, pathology, pulmonary, plastic surgery, midwifery, critical care nursing, vascular nurses, advanced life support and nephrology.

iv. Your Committee observes that in almost all the institutions that were visited where new equipment has been acquired there is, regrettably, one or two parts of the equipment that are missing and as such they are not functioning. This is unfortunate considering that huge sums of tax payers’ money have been spent on the equipment, thereby depriving other needy areas.

In this regard, your Committee recommends that the Government should take stock of all the equipment that has been procured especially in the treatment of Non Communicable Diseases and ensure that they are operational.

v. Your Committee observes that generally all institutions have a problem of transport.

Your Committee recommends that the Government should prioritise procurement of transport to ease the challenges of transport.

vi. Your Committee observes that screening for sugar levels is not undertaken as a regular routine as is the case with blood pressure or the Body Mass Index (BMI) leading to people not knowing their sugar level until it is too late.
In view of this, your Committee urges the Government to seriously consider acquiring more glucometers and ensure that screening for sugar levels is among the routine checkups in the outpatient departments of all health facilities.

vii. Your Committee observes that Livingstone Central Hospital is the only hospital with a prosthesis section in the rehabilitation department in the country and has very few trained personnel. Arising from this, your Committee recommends that the Government should establish similar facilities in, at least, all major health institutions in the country in order for the artificial limbs to be easily accessible.

viii. Your Committee observes that the cases of asthma in Mazabuka and Munyumbwe are among the highest of the NCDs in Southern Province.

In view of this, your Committee recommends that the Government undertakes a study to establish the cause of asthma cases in the two districts.

ix. Your Committee expresses concern that despite the fact that the double disease burden of communicable and non-communicable diseases can seriously constrain the country’s social and economic development, NCDs have not been given the due attention in terms of public health awareness.

Your Committee, therefore, urges the Government to prioritise the prevention and control of non-communicable diseases through more robust community sensitisation and awareness.

x. Your Committee is concerned that the primary health system is poorly resourced to effectively control, prevent and manage NCDs in Zambia.

Your Committee, therefore, recommends that the Government should put in place measures to strengthen health systems in the country to help prevent and control NCDs and the underlying social determinants through primary health care and universal health coverage in line with WHO Global NCD Action Plan 2013-2020.

xi. Your Committee expresses concern over the lack of timely data for use by policy makers as most of the data comes from research undertaken in high-income countries.

Your Committee, therefore, strongly urges the Government to put measures in place for the carrying out of more targeted research, using local population samples, in order to inform policy in Zambia.

xii. Your Committee observes that the absence of strong multisectoral partnerships is hampering the promotion of cooperation among Governmental agencies and non-Governmental organisations (NGOs) in strengthening efforts for the prevention and control of non-communicable diseases in Zambia.
Your Committee, therefore, urges the Government to urgently strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate the country’s response for the prevention and control of non-communicable diseases.

xiii. Your Committee observes that the National Health Strategic Plan (2017-21) has prioritised health promotion by creation of a Health Promotion Directorate within the Ministry of Health. While your Committee welcomes the creation of the new department, it is concerned that more attention is still being given to communicable diseases.

Your Committee, therefore, strongly recommends that the Government strengthens and enhances NCD-specific activities, including healthy diets and physical activities by adopting an integrated approach.

xiv. Your Committee observes that record management in all the health institutions that were visited by your Committee are the paper or manual system which is inefficient.

In this regard, your Committee recommends that the Government should immediately invest in an electronic records management system in order to improve record management.

xv. Your Committee urges that most of the equipment in the radiology departments of most of the hospitals visited is non-functional and that contracts for servicing hospital equipment are procured by the Ministry of Health which makes the process of repair and maintenance too long.

Your Committee therefore, strongly urges the Government to procure more equipment and repair the existing machinery taking into account that the service contracts for the equipment should be entered into by the user institutions and not the Ministry’s headquarters. The decentralisation of the service contracts to the user institutions would instill a sense of ownership and reduce the time taken to repair the machines thereby improving service delivery.

xvi. Your Committee expresses concern that the expired NCD Strategic Plan (2013-16) which places more emphasis on health promotion is underutilised as it focuses much on curative efforts at the expense of prevention.

Your Committee urges that the Government to expedite the process of developing a new NCD strategic plan and that in the next plan, the Government should underscore the importance of prevention rather than cure of NCDs. Further, the Government should ensure that NCDs such as epilepsy, injuries and mental health are not overshadowed by the four main NCDs, namely: cardiovascular disease, cancer, chronic respiratory diseases and diabetes.
xvii. Your Committee notes that because of the bias by both Government and partners towards infectious diseases, more resources are also channelled to the infectious diseases at the expense of NCDs.

Your Committee, therefore, urges the Government to urgently increase the health budget to 15 percent of the national budget as per Abuja declaration and ultimately narrow the gap in funding between communicable and non-communicable diseases.

xviii. Your Committee is concerned that the warnings on the harmful effects of cigarette smoking placed on tobacco packaging are usually in too small a print to catch the attention of consumers.

Your Committee, therefore, strongly urges the Government to put in place measures to ensure that the warnings are put in print large enough to be readable. Your Committee further urges the Government to consider making the warnings pictographic and in the major local languages as is the case in Senegal.

xix. Your Committee observes that despite the establishment of a Health Promotions Department in the Ministry of Health, most of the patients still seek medical attention when it is too late due to lack of information or stigma. This can be confirmed by the high ratio of a given population to the number of people who were tested or known to have NCDs.

Your Committee recommends that the Government should carry out a more vigorous sensitisation campaign with messages encouraging people to be screened for NCDs even in the absence of any symptoms and also cause them to understand that NCDs such as mental health are like any other diseases so as to avoid self stigma. Further the committee urges the Government through District Health Management teams to be following people where they are found such as markets, bus stops and churches unlike them always going to the health centres.

xx. Your Committee observes that Zambia and particularly Livingstone is strategically positioned to promote medical tourism. Apart from hosting the mighty Victoria Falls, Livingstone is home to many tourism attractions including the Livingstone Hospital itself which was built in 1918 by the colonial Government and has been declared National Heritage site.

Your Committee is of the view that if properly harnessed, some patients can choose to be treated in Zambia while at the same time taking advantage of the tourist attractions. In the light of the above, your Committee urges that the Government to come up with a robust strategy of promoting medical tourism which will bring in foreign exchange.

xxi. Your Committee observes that the psychiatry departments of some of the health institutions visited did not have the necessary drugs and these had to be sourced from Chainama hospital in Lusaka.
Your Committee recommends that drugs for mental patients be prioritised as those for other NCDs.

xxii Your Committee observes that the existing laws including by-laws on alcohol such as operating hours of bars, noise pollution and age of consumers are not being enforced.

Your Committee urges Government, as a matter of urgency, to enforce the existing laws and that Government should formulate an alcohol policy to augment the existing by-laws so as to curb the production and consumption of alcohol.

xxiii Your Committee is concerned with the hazards of cigarette smoking in public as well as the smoking of motor vehicles which have continued with little or no control.

Your Committee recommends that the Government puts in place strong legislation on the control of public smoking and that through the Ministry of Health collaborating with the Ministry of Transport and Communications, Government should formulate laws to ban smoking vehicles.

iii) PROGRESS AND UPDATE ON THE SOCIAL CASH TRANSFER PROGRAMME IN ZAMBIA

Background
11.0 Many countries were developing social policy frameworks to give greater priority to social protection programmes. With support from development partners, they were formulating social protection policies with strategies including cash transfers for the most vulnerable households. Social Cash Transfer (SCT) programmes were publicly funded social protection schemes designed to mitigate the negative effects of poverty among the poorest in society. According to the 2015 Living Conditions Monitoring Survey (LCMS), out of the estimated population of 15.5 million in Zambia, 54.4 percent were living in poverty while 40 percent lived in extreme poverty. In this regard, the country was making strides in implementing SCT through the Ministry of Community Development and Social Welfare. The households selected as beneficiaries to the SCT needed regular and continuous social assistance to address hunger and food insecurity; school enrolment and attendance needs; health, nutrition and intergenerational poverty. However, there had been concerns about the implementation of the programme such as criteria for targeting beneficiaries and its sustainability.

In view of the above, your Committee resolved to undertake a study to enable it appreciate the progress of the SCT programme and obtain an update on related matters. The objectives of the study were to:

i. assess the sustainability of the programme;

ii. understand the criteria used to select beneficiaries;

iii. assess the effectiveness of the programme;
iv. identify the strengths and weaknesses of the programme; and

v. make recommendations to the Executive on the way forward.

In order to gain insight into the subject under inquiry, your Committee interacted with various stakeholders; a list of which is at appendix II.

Summary of Submissions from Stakeholders

Overview of the Social Cash Transfer (SCT) Programme

12.0 Your Committee was informed that the Social Cash Transfer was one of the many social protection programmes in Zambia. It started as a pilot project in Kalomo, Southern Province, in 2003 and was later extended to Kazungula in 2005 and Monze in 2007, reaching about 1000 beneficiaries. A Memorandum of Understanding was signed by the Government of Zambia and three donors (UNICEF, Irish Aid and DFID) who committed to support the programme. In 2010, the project expanded to Katete District in Eastern Province. Later, in 2017, the Government scaled it up by increasing coverage and monthly payments to each beneficiary household. Further, the number of beneficiary households was increased from 242,000 in 2016 to 590,000 in 2017. In the 2018 national budget, the number of Social Cash Transfer beneficiaries was further increased to 700,000. The main objective of the SCT programme was to reduce extreme poverty, hunger and starvation in the 10 percent most destitute and incapacitated (non-viable) households in the pilot region. The focus lay mainly on households that were headed by the elderly and were caring for orphans and vulnerable children (OVC) because the breadwinners were chronically sick or had passed on due to HIV/AIDS.

Criteria for Selection of Social Cash Transfer Beneficiaries

12.1 Your Committee heard that the aim of the SCT Programme was to contribute towards the reduction of poverty. The programme therefore, targeted the vulnerable and incapacitated beneficiaries who were expected to meet the three criteria of residency, incapacitation and welfare estimation. One of the qualifications to be a beneficiary was that one must have been living in a particular catchment area for at least six months. There must also be proof of incapacitation of a household such as households with persons medically certified with severe disabilities, households with the elderly, child headed households, chronically ill and medically certified persons who were on palliative care and female headed households with three and more children. Thirdly, a household estimated welfare must be below a certain pre-determined threshold based on the Households Living Index in the country.

Process of Graduation of Beneficiaries

12.2 Your Committee was informed that the beneficiaries under the Social Cash Transfer were re-assessed every three years from the time they enrolled on the programme with a view to weaning them off the programme. However, some households, such as those headed by persons with severe disabilities and the elderly who had no one to look after them, needed not graduate. Your Committee was also informed that the Ministry was in the process of coming up with a comprehensive exit strategy to guide the process and a consultant had been engaged for the exercise.
Sustainability of the Programme
12.3 Stakeholders informed your Committee that the sustainability of the Social Cash Transfer depended upon several factors, including; Government ownership, legislative backing, graduation of recipients and the public’s perception of the programme. The Zambian Government had demonstrated political will to sustain funding of the Programme by increasing its contribution overtime and expanding its reach to cover the whole country. Further, the use of public resources as opposed to donor dependency increased the sustainability for the programme.

Your Committee also heard that the absence of a clear legal framework compelling the state to support people living in extreme poverty would render the Social Cash Transfer and other social protection mechanisms an optional programme subject to the inclination and convenience of successive Governments. Such provisions, if existent, would guarantee social protection as a duty for the Government and a right for the poor and vulnerable. Further, the high poverty levels experienced throughout the country meant that large numbers of people qualified as recipients of the Social Cash Transfer. The Government had to invest in a communication strategy to make it clear that some categories of Social Cash Transfer recipients would be graduated to pave way for others. Those would be people proven not to be making efforts at improving their circumstances despite linkages with economic empowerment programmes.

Strengths of the Programme
12.4 Your Committee was informed that the SCT programme had the benefits set out below.

a) SCT increased food security as the number of households eating more than one meal per day and that of households not severely food insecure increased.

b) SCT had helped to reduce the poverty gap and the extreme poverty rate among SCT recipient households. There was also a reduction in the number of households having an outstanding loan.

c) The programme improved living conditions as exhibited by the increased number of SCT recipient-households owning a pit latrine, mosquito nets, with purchased lighting and the number of households with cement floors.

d) It increased productivity and asset ownership as SCT beneficiaries were cultivating more land than their non SCT counterparts, with an 18 percent increase in the size of land cultivated among SCT beneficiaries recorded.

e) SCT improved child wellbeing due to reduced prevalence of diarrhoea in the recipient households while the number of children who had all three material needs met (shoes, second set of clothing, and a blanket) and children attending primary school increased.
Weaknesses of the Programme

12.5 Your Committee was informed that the Social Cash Transfer programme had the weaknesses set out hereunder.

a) lack of a fully-developed nutrition component, which should specifically outline how best the beneficiaries could contribute to their nutrition levels in their food intake.

b) lack of capacity building on the selection criteria which left communities unclear on the qualifications of beneficiaries.

c) social protection had not been appreciated as a fundamental right of every citizen; as a result, the people who were eligible were not fully aware of how to benefit from social protection services being provided by the Government.

d) the selection criteria for persons with disabilities demanded that they must be medically certified as persons with severe disability. This disadvantaged other categories of persons with disabilities such as those with mental and psychosocial disabilities whose disabilities may not be obviously visible.

e) lack of a legislative framework on social protection as a whole meant that continuity of SCT programmes was not guaranteed and there could be gaps in adherence to minimum standards.

f) most beneficiaries on SCT did not graduate from SCT, despite evident improvements in livelihoods, resilience and wellbeing, so as to give chance to others.

g) the transfer value (currently K90.00) was extremely low when compared to national average household income of K1, 801 or the rural areas average of K810 and the K3, 152.00 urban averages.

LOCAL TOUR

13.0 After receiving submissions from witnesses with regard to the SCT, your Committee held a public hearing in Choma, Southern Province. Your Committee also received an update on the subject from the Livingstone Social Welfare Officer on the SCT Programme in the district. Attendance at the public hearing was good with about 250 members of the public in attendance. Some of the findings generated from the public hearing and meeting with the Livingstone District Social Welfare Officer were as outlined below.

a. there was general dissatisfaction over the services provided by the implementers of the SCT particularly, failure by the Department of Social Welfare to adequately respond to complaints or queries in a timely manner;

b. some beneficiaries complained that sometimes they only got a fraction of their entitlement and remained wondering what was happening to the balances;

c. some attendees submitted that there was unfair targeting of beneficiaries as some forms of vulnerability such as widowhood were omitted from the criteria;
d. the public also expressed disappointment that Government had not fully sensitised the masses on the selection process and criteria for qualification which had led to misunderstandings;

e. the grievance procedure to handle complaints advanced by stakeholders was cumbersome and costly therefore, needed review; and

f. the bi-monthly transfer of K180 or K360 was inadequate.

At Livingstone Social Welfare Office, your Committee was given the following update.

a. the programme started in 2013 in which 753 persons with disabilities were targeted. Other categories such as the chronically ill and the child-headed households were included later;

b. in 2017, about 1444 beneficiaries were added bringing the total to 2197 out of which 138 were to be removed on account of death or duplication; and

c. in 2018 the number of beneficiaries would be scaled up by 208 and that the 138 to be removed would be replaced.

Committee’s Observations and Recommendations

14.0 After careful consideration of oral and written submissions from stakeholders, your Committee observes and recommends as set out here under.

i. Your Committee is concerned over delayed funding to the programme which leads to disruptions in implementation of the programme. For example, your Committee observed on its local tour that the payments to beneficiaries were four months behind schedule.

Your Committee, therefore, urges the Government to put in place measures to ensure regularity and predictability of transfers as this is a key feature of SCTs to facilitate planning, consumption smoothing and investment.

ii. Your Committee is concerned with the insufficiency of the transfer amount to beneficiaries as the K 90.00 is too little to meaningfully impact on the livelihoods of the beneficiaries.

Your Committee, therefore, urges the Government to consider increasing the amount by indexing it to inflation or doubling monthly transfers if a meaningful impact is to be achieved.

iii. Your Committee expresses concern that there is no legal framework to guarantee the right to social protection, thereby leaving gaps in the adherence to minimum standards.

To this effect, your Committee strongly urges the Government to expedite the enactment of the necessary legislation such as the Social Protection Bill so that the Social Cash Transfer programme is backed and protected by a legal framework to guarantee the continuation of the programme even across successive Governments.
Legislation would also help to ensure that minimum standards are met in the implementation of the programme.

iv. Your Committee is concerned that the huge demand for Social Cash Transfer is resulting in an over reliance on the programme to the exclusion of other social protection programmes such as Public Welfare Assistance Scheme, Food Security Pack, Women Empowerment Fund, among others.

Your Committee, therefore, urges the Government to sensitise the public on the availability and importance of the other programmes from which they could seek assistance.

v. Your Committee observes that the Community-Based Targeting being used, which selects eligible households by the assessment of a selected team of community members and leaders, is unreliable while risks of selection bias are inevitable and therefore, may undermine the programme’s effectiveness.

Your Committee, therefore, strongly recommends that the Government reviews the targeting method with a view of finding one which is acceptable and cost effective to reduce overhead costs and avoid fears of bias. Further, your Committee recommends that the selection model should take a bottom-up approach, allowing residents to vet themselves as they know each other’s economic status very well.

vi. Your Committee is concerned over the failure by the programme to graduate most beneficiaries on SCT despite evidenced improvements in their livelihoods, resilience and wellbeing. Your Committee notes that this is defeating the essence of the programme.

Your Committee recommends that the Government should urgently establish coherent graduation criteria which will allow others to be considered for selection and also that this would work well if the SCT was made conditional.

vii. Your Committee also observes with disappointment that Government had not fully sensitised the masses on the selection process and criteria for qualification which has led to misunderstandings. For example, during the public hearing, it was observed that by merely registering, people believed that they qualified for the cash transfers.

Your Committee recommends that the Government should, therefore, fully sensitise the masses on the selection process and criteria for qualification to avoid misunderstandings and complaints arising there from.

viii. Your Committee observes that some beneficiaries did not know the exact amounts they were entitled to receive.
In this regard your Committee recommends that the Government should put in place thorough monitoring mechanisms to ensure that beneficiaries who were mostly illiterate were informed about the correct amounts to expect and their rights fully explained.

ix. Your Committee observes that some complaints by stakeholders took too long to be attended to.

Your Committee recommends that Government should put in place a non-cumbersome grievance procedure to handle all complaints and views advanced by stakeholders;

**PART II**

15.0 CONSIDERATION OF THE ACTION TAKEN REPORT ON THE REPORT OF THE COMMITTEE FOR THE FIRST SESSION OF THE TWELTH NATIONAL ASSEMBLY

Zambia’s Preparedness for the Implementation of the Sustainable Development Goal on Health with Special Focus on Sexual Reproductive Health Rights

15.1 Your previous Committee had recommended that the Government should expedite the revision of the National Health Strategic Plan and the National Adolescent Health Strategic Plan and widely publicise them.

**Executive’s Response**

The Executive responded that the Government, through the Ministry of Health, had completed the revision of both the National Health Strategic Plan and the National Adolescent Health Strategic Plan. Both documents were covering 2017 - 2021 and would be launched before the end of 2017 followed by dissemination. The documents were already being used for planning for 2018.

**Committee’s Observations and Recommendations**

Your Committee notes the response and requests an update on the launch and dissemination of the National Adolescent Health Strategic Plan.

**Operationalization of the Decentralisation Implementation Plan**

15.2 Your previous Committee had recommended that the Decentralisation Policy Implementation Plan should be properly operationalised in order to bring authorities and resources closer to the people.

**Executive’s Response**

In response, the Executive submitted that the Government, through the Ministry of Health, had completed the development of the sector devolution plan which would be disseminated for implementation to the districts, councils and relevant stakeholders. In addition, the Ministry of Health had developed the Community Health Strategic Plan, which would strengthen the provision of health services at community level.
Committee’s Observations and Recommendations
Your Committee notes the response and awaits progress on the actual implementation of the Devolution Plan and the Community Health Strategic Plan.

Domestication of Regional and International conventions on age of consent
15.3 Your previous Committee had urged the Government to ensure the domestication of regional and international conventions and treaties that Zambia had committed to as well as harmonise the legal framework on age of consent which would make it easy for adolescents and young people to access sexual and reproductive health services.

Executive’s Response
In response, the Executive explained that the Government had taken note of the recommendation by the Committee and would ensure the domestication of regional and international conventions and treaties that Zambia had committed to and would also ensure that the legal framework was harmonised on the age of consent which would make it easy for adolescents and young people to access sexual and reproductive health services.

Committee’s Observations and Recommendations
Your Committee awaits an update on the timeframe for the domestication of treaties and harmonisation of the legal framework on the age of consent.

Enactment of legislation on child protection
15.4 Your previous Committee’s recommendation was that Government should expedite the enactment legislation on child protection to enshrine the sexual and reproductive health and rights of children and adolescents and to protect them from harmful practices and ensure the realisation of their full potential.

Executive’s Response
In the Action Taken Report, the Government explained that the Ministry of Gender and Ministry of Sport, Youth and Child Development were spearheading the enactment of laws related to children such as the Child Code Bill and the Marriage Bill which were meant to protect children and end child marriage. The Ministry of Health was working closely with the two ministries. On the other hand, the health sector had the Child Health Policy of 2008 which fed into the sector programming.

Committee’s Observations and Recommendations
Your Committee takes note of the response and request the Government to expedite the enactment of the necessary legislation and provide an update on the matter.

Increasing accounts and utilisation of integrated HIV and SRP services.
15.5 Your previous Committee recommended that there is need to increase access and utilisation of integrated HIV and SRH services to prevent pregnancies and HIV by young people.
Executive’s Response
The Government submitted that the Ministry of Health and its partners and stakeholders were promoting integration of HIV and SRH services at various levels. The National Health Strategic Plan 2017-2021 and the Adolescent Health Strategy 2017-2021 had prioritised adolescents and the young people providing strategies on how this should be enhanced. In addition, capacity building for health care workers was being provided. Intra-sectoral and multisectoral collaboration was being promoted to enhance the integration. These interventions were targeting both the in-school and out-of-school adolescents and young people. To be effective, focus was being put on addressing the supply and demand side of the HIV and SRH services targeting young people. The National Guidelines on SRH/HIV/GBV Integration were developed in 2016, and this was followed by the development of SRH/HIV/GBV integration training manuals and job aids to be used in training health providers. The training materials had been piloted and would be finalised by end of September, 2017.

Committee’s Observations and Recommendations
Your Committee awaits an update on the finalisation of the piloting of the training materials.

Increased Funding for Teachers Training in Comprehensive Sexually Education and Development of Teachers Materials
15.6 Your previous Committee had urged the Government to increase funding towards training teachers in CSE and developing learners’ materials.

Executive’s Response
In response, the Government submitted that the Ministry of Health, in conjunction with Ministry of General Education, with support from UNFPA and other partners had been training teachers in CSE since 2015. The learners’ curriculum had since been revised to include CSE from grade 5 to secondary school. This was being rolled out to the out-of-school young people.

Committee’s Observations and Recommendations
Your Committee considers this response inadequate considering that it does not address the question of funding. Your Committee therefore, urges the Government to put specific measures in place to address the issue of funding and provide a progress report.

Coordinated Multi-Stakeholder Accountability Framework
15.7 Your previous Committee had recommended that there was need to ensure a coordinated multi-stakeholder accountability framework that would not only be intra-Governmental but also include cooperating partners, the private sector, civil society, the media and representatives of communities. This would enable tracking of SRHR indicators beyond medical indicators to include human rights and development components.

Executive’s Response
The Government explained that the Ministry of Health was taking integrated multisectoral action on health issues seriously. This was arising from the conviction that most of the determinants of health were outside the purview of the health sector. The National Health Strategic Plan 2017 – 2021 had provided the overarching monitoring and evaluation framework which had then informed the provincial, district and community planning processes. These would be the main
framework to monitor and evaluate progress. The Ministry would strengthen further the existing coordinating mechanisms prescribed in the public sector to include all the key strategic partnerships and facilitate their active participation. The partnerships would include line ministries, the private sector, CSOs, faith based organisations, NGOs, media, academia, research institutions, marriage counselors, traditional and civic leaders. Advantage would be taken of the platforms such as annual consultative meetings, policy meetings, cluster group meetings, technical working groups, joint annual reviews, midterm reviews, perinatal and maternal death surveillance and response activities.

Committee’s Observations and Recommendations
Your Committee awaits an update on the inclusion of all the key strategic partners and the facilitation of their active participation. Your Committee also urges the Government to treat prevention, and not abortion, as a primary health concern.

LOCAL TOUR OF SELECTED HEALTH INSTITUTIONS AND PUBLIC HEARINGS FOR THE FIRST SESSION OF THE TWELFTH NATIONAL ASSEMBLY

Increase in Unsafe Abortions
15.8 Your previous Committee had recommended, after observing that the unmet need for family planning was still high, that the Government should be aggressive in implementing family planning awareness strategies as the primary method of avoiding unwanted pregnancies which led to unsafe abortions.

Executive’s Response
The Government responded that your Committee’s observations and recommendations were well noted. The Ministry of Health was pursuing a transformational agenda that sought to develop personal skills for social behaviour change and enhanced life skills. To this end, a communications unit with skills across both print and electronic media had been created within the newly created Department of Health Promotion, Environment and Social Determinants. The Unit was tasked with empowering individuals, households and communities to attain the highest level of health using media platforms.

Given that most of the unsafe abortions occurred in young people who were not ready to raise children, interventions targeted at this age group had been put in place. To this end, the Government had developed a comprehensive sexuality education package for both in and out of school young people. This was aimed at building capacity for them to understand their personal values and rights and be able to relate these to health, sexuality and gender.

Further to this, the sector had engaged community members to aid their understanding of the reasons that influenced delayed attendance for first antenatal by pregnant women as well as myths and misconceptions around contraception. In response to some of the identified myths and misconceptions, key messages had been developed that were expected to help to dispel these misconceptions. These messages had been dramatised, television and radio spots produced which were then aired on both national and community media platforms. Family planning awareness was being provided at all levels of health service delivery and in the community by Safe Motherhood Action Groups and community based distributors of family planning. At the health
centre level, as part of routine health education, sessions were provided to women attending various health services.

The sector had also introduced community radio listening groups to enhance the value obtained from radio spots and programmes produced on various topical issues including primary care facilities.

Committee’s Observations and Recommendations
Your Committee would like to be availed details or statistics relating to interventions being put in place and specific areas where community radio listening groups have been introduced.

Inadequate Data Capturing
15.9 Your previous Committee had observed that data in most health facilities was not disaggregated to reflect the age of the mother at delivery and uptake of family planning by adolescents and women in different age groups. It had, therefore, recommended that the Ministry of Health should strengthen the data collection system and ensure that there was standardisation in the collection of data for monitoring purposes of targets 3.7.1 and 3.7.2 of the SDGs.

Executive’s Response
In response, the Executive explained that the Government appreciated the recommendation made by your Committee and had planned through the Ministry of Health, to revise the Health Management Information System (HMIS) to include age disaggregation in addition to occupation and disability in its data collection tools.

Committee’s Observations and Recommendations
Your Committee awaits an update on the planned revision of the Health Management Information System (HMIS).

Myths and Misconceptions
15.10 Your previous Committee had recommended that the Government should immediately engage and target traditional leaders, religious leaders and other key players in sensitising communities on the benefits of using modern contraception methods and dispelling misconceptions and myths that they caused cancer.

Executive’s Response
In response, it was reported that while appreciating your Committee’s observations, the Ministry of Health had prioritised integrated multisectoral action on health, particularly in reproductive health. This was arising from the fact that the majority of the determinants of health were outside the purview of the Ministry of Health. Therefore, the newly created Department of Health Promotion, Environment and Social Determinants in the Ministry had been given the mandate to pursue unprecedented coalition building and stakeholder engagement, including line Ministries, private sector, CSOs, faith based organisations, NGOs, media, academia, research institutions, marriage counsellors, traditional and civic leaders to enhance community sensitisation on the benefits of using modern contraception methods. This was being promoted at national, provincial, district and community levels.

Committee’s Observations and Recommendations
While taking note of the response, your Committee seeks clarity on whether the new Department had been operationalised and the specific activities it was doing regarding your Committee’s recommendation.

**Inadequate Skilled Human Resource**

15.11 Your previous Committee had strongly recommended that the Ministry of Health should deploy health workers based on equity and output of the respective health facilities.

**Executive’s Response**

In response, the Government reported that the observation of your Committee was well noted and the World Health Organisation (WHO) recommended optimal staffing (nurses, midwives, doctors) of 2.3 per 1,000 population. Currently, Zambia stood at 1.2 per 1,000. The Ministry of Health was dedicated and committed to deploying health workers evenly based on equity and output of respective health facilities. The Ministry of Health recruited 2,071 health workers in 2016 and 7,400 by end of 1st Quarter 2017. These health care workers were all serving in various parts of the country with priority given to the rural and remote parts of the country. The Ministry intended to recruit more staff in 2017 and in coming years. The staff shortage was being addressed by increasing training institutions and expanding training programmes to match the needs. The shortage of staff was a well-known barrier to the delivery of quality health services and would continue getting due attention. In posting these staff, equity and health facility volumes were some of the key criteria used.

**Committee’s Observations and Recommendations**

Your Committee requests an update on progress made towards meeting the WHO recommendation of an optimal staffing of 2.3 per 1,000 population.

**Centralised Medical Stores**

15.12 Your previous Committee had recommended that, as a matter of urgency, the Government should decentralise Medical Stores to all districts as a way of strengthening the commodity supply chain so that drugs and commodities could be readily available as and when needed.

**Executive’s Response**

In response, the Government reported that Medical Stores Limited (MSL) was mandated to ensure prompt, safe and efficient distribution of health commodities from the central storage facilities to the entire country so that the quality of the products was maintained throughout the process and that commodities were always available and accessible to all in need at all times. The Government was implementing two strategies which were aimed at creating a decentralised medical store as stated below.

1. Regional Hubs had been created in certain parts of the country and these were Mongu, Choma, Chipata and Luanshya. The hubs had dedicated transport for distribution of commodities to the last mile (health facilities) thereby promoting commodity security. Others in the pipeline included Mpika, Kasama, Mansa and Solwezi. Mpika and Mansa sites had been handed over to the contractor and funds had already been paid by the Global Fund through the implementing partner UNDP. The hubs were expected to be
2. The Essential Medicines Logistics Improvement Programme (EMLIP) was employed. This strategy ensured that MSL delivered health commodities up to the hub and district stores for distribution to lower levels. Reproductive health medicines including family planning commodities were part of the essential medicines that ordered using EMLIP whereby service delivery points (health facilities) were required to report on what they had consumed so that they were resupplied based on the demand.

Committee’s Observations and Recommendations
Your Committee notes the response and requests for a progress report on the creation of new distribution hubs in Mpika, Kasama, Mansa and Solwezi.

One Stop GBV Centres
15.13 Your previous Committee had recommended that a fast track court system for victims of sexual violence and rape should be created to ensure that cases were dealt with within the shortest possible time. Your Committee had further recommended that a paralegal officer be assigned to every One Stop GBV Centre.

Executive’s Response
In response, it was reported that the Government agreed with your Committee’s observations and recommendations. There were already two fast track court systems created by the Judiciary, one in Lusaka and the other in Kabwe which were operationalised in the year 2016 as pilot projects in order to address the raised concerns. The courts were assigned with staff to handle various cases assigned to the system.

Committee’s Observations and Recommendations
Your Committee requests an update on the performance of the piloted fast track courts. Furthermore, the Government is urged to urgently scale up the project as it had been observed to have worked well in other jurisdictions. Your Committee is concerned that the question of having a paralegal officer assigned to every One Stop GBV Centre had not been addressed and urges the Government to expeditiously attend to the matter.

Inadequate Equipment
15.14 Your previous the Committee had recommended that the Ministry of Health should, as a matter of urgency, procure adequate beds and beddings for health facilities lacking these facilities.

Executive’s Response
The Government reported that the Ministry of Health had given policy direction that no patient should sleep on the floor or shares a bed with another patient. In this regard, beds and mattresses had been distributed to health facilities that had been lacking countrywide. Furthermore, the Ministry of Health was in the process of procuring hospital linen for all health facilities countrywide. In addition, all health institutions had been directed to strengthen internal controls to prevent pilferage and theft of linen and enhance community sensitisation.
Committee’s Observations and Recommendations
Your Committee notes the response and awaits an update on the procurement of hospital linen and equipment, giving a breakdown of the distribution, for all health facilities countrywide.

FOREIGN TOUR TO THE PARLIAMENT OF RWANDA

Decentralisation of Implementation Policies and Programmes to the Districts

15.15 Your previous Committee had recommended that the Ministry of Health should, as a matter of urgency, decentralise the implementation of policies and programmes to the districts as the main implementing agents in order to increase efficiency in operations and service delivery.

Executive’s Response
The Government responded that the transformation agenda currently being undertaken by the Ministry of Health was focusing on ensuring that decision making and resources, including human, financial and material were further decentralised to the service delivery points. This was already happening and would continue to be improved upon. The Ministry headquarters was focusing more on policy formulation, resource mobilisation, standard setting, monitoring and evaluation and overall oversight provision. Implementation of policies, guidelines and programmes had been taken as the core mandate of service delivery levels in districts and health facilities.

Committee’s Observations and Recommendations
Your Committee notes the response and requests that the question be answered in the context of the overall decentralization process as the Ministry cannot do it on its own without other players like the Ministry of Local Government.

Strengthening Health Information Management

15.16 Your previous Committee had recommended that the Government should strengthen the health information management through the use of ICTs to register maternal deaths and other vital events by all health facilities and these health facilities must be linked to the central health system.

Executive’s Response
In response, the Executive explained that the Government, through Ministry of Health, was cooperating with the Ministry of Home Affairs on the registration of births, deaths and collection of other vital information. This exercise was being piloted in Livingstone at the Central Hospital and Maramba Clinic. The implementation plan for the scale up in the country would be developed in close consultation with all the stakeholders, namely Smart Zambia Institute, Ministry of Home Affairs and Ministry of Local Government.

Committee’s Observations and Recommendations
Your Committee requests for an update on the pilot exercise in Livingstone and progress on scaling it up Country wide. Further, your Committee insists that the Ministry of Health should go straight into scaling up without further piloting as the necessary information was available.
Scaling up the Community Health Workers Programme

15.17 Your previous Committee had recommended that the Zambian Government should scale up the Community Health Workers (CHW) Programme and standardise the incentives and/or packages for the CHW to increase.

The Executive responded that the Government, through the Ministry of Health, had taken the role of the community health workers programme as key to the quest to attain universal health coverage using the primary health care approach. Community health work was being undertaken by Community Health Assistants (CHAs) who had undergone one year training at Mwachisompola in Central Province and Ndola on the Copperbelt. Since this programme started, a total of 2,000 CHAs had been trained and posted to various parts of the country with rural areas as a priority. The CHAs were on Government payroll. The plan was to scale up the training of CHAs by opening up provincial training sites in coming years. The Ministry had just completed the Community Health Strategy 2017-2021 which had provided strategies to address issues of community health workers’ identification, recruitment, training, remuneration and motivation, among other aspects. Standardisation of approaches and interventions had been prioritised. This strategy would be accompanied by an implementation plan and guidelines.

Committee’s Observations and Recommendations

Your Committee requests for progress report on the scaling up of the Community Health Workers (CHW) Programme and the implementation of the Community Health Strategy 2017-2021. In addition, your Committee urges the Government to consider adopting the Rwandan or Ethiopian model of training people hailing from the communities they would be serving after their training to, among other reasons, reduce on staff turnover.

Construction of Health Facilities

15.18 Your previous Committee had recommended that the Zambian Government should expedite the construction of health facilities, especially in rural districts in order to reduce the distance to the health facilities.

Executive’s Response

In response, the Executive stated that the Government, through the Ministry of Health, took infrastructure development as a key pillar to health system strengthening. At planning stage, this area had been receiving high prioritization although the level of investment at times was limited by the resource envelope. Policy direction in the health sector had been provided that focus would be on completing ongoing infrastructural works before embarking on new projects. This had been the focus since 2016. Even with this move, priority was being given to rural areas. In addition, the project constructs to health posts under the 650 Health Posts package had seen 275 completed and in use. The delay had been due to contractual challenges with one of the contractors whose contract was terminated. The remaining health posts would be completed within 2017.

Committee’s Observations and Recommendations

While noting the responses, your Committee requests a progress report on the completion of the remaining 375 health posts.
Performance Contracts for the Public Service

15.19 Your previous Committee had recommended that the Government should develop performance contracts for the public service at all levels, which should reflect the targets in the national agenda.

Executive’s Response
In response, the Government stated that the Performance Based Management System was introduced in the Zambian Public Service in 1998 with the development and implementation of the Performance Management Package (PMP) which encompassed Strategic Planning at institutional level, annual work planning and target setting at both departmental and individual levels, the Annual Staff Performance Appraisal System (APAS) as well as institutional performance assessment.

After the launch of the Performance Based Contract System in the Public Service in 2015 by the Republican President, it was being rolled out across the public service. In 2017, the system was being rolled out to directors and assistant directors in the core public service. The system would be launched and rolled out in all the councils in the third quarter of 2017. The Secretary to the Cabinet had since issued instructions to all ministries and their statutory bodies to ensure that they implemented the performance based contracting system.

During the launch of the Seventh National Development Plan, the President directed that Ministers should also be placed on Performance Based Contracts. The Government was in the process of developing a system to ensure that this directive was implemented as part of the roll out.

Committee’s Observations and Recommendations
Your Committee requests an update on rolling out the Performance Based Contract system to all districts and the placing of Ministers on performance based contracts.

Integrated SRH/HIV/GBV services

15.20 Your previous Committee had recommended that the Government should ensure that all health facilities had a one stop GBV centre integrated with other SRHR activities and strengthen the national capacity to deliver integrated SRH/HIV/GBV services.

Executive’s Response
In response, the Government stated that the Ministry of Health had prioritised this approach in its 2017-2021 National Health Strategic Plan which was informing annual planning and budgeting depending on the resource envelope. The Government, through the Ministry of Health, was taking the activities set out below to ensure that all health facilities had a one stop GBV centre integrated with other SRHR activities.

(a) Scaling up of one stop GBV centres was on going, depending on the availability of resources.
(b) Provinces and districts had been directed to prioritise SRHR as an integrated package.
(c) Guidelines had been developed in 2015 on SRH/HIV/GBV integration and linkages to improve provision of services and currently a training manual for health care providers was being developed.
Committee’s Observations and Recommendations
Your Committee awaits a status report on the roll out of One Stop GBV/HIV/SRH Centres.

16.0 CONSIDERATION OF THE ACTION-TAKEN REPORT ON THE COMMITTEE’S REPORT FOR THE FIFTH SESSION OF THE ELEVENTH NATIONAL ASSEMBLY

Your previous Committee had noted the responses by the Government to the issues raised in its previous report. However, your Committee resolved to follow up the issues set out below.

The Implementation and Coordination of Zambia’s Food and Nutrition Policy and Interventions
16.1 Your previous Committee had requested an update on the review of the National Food and Nutrition Commission Act chapter 308 of the laws of Zambia.

Executive’s Response
In response, the Government stated that Cabinet had already approved in principle the introduction of a Bill in Parliament to repeal and replace the National Food and Nutrition Commission Act, chapter 308 of the laws of Zambia. The Ministry of Health, working closely with stakeholders, had submitted the layman’s draft of the Bill to the Ministry of Justice. The Bill was expected to be introduced in Parliament upon completion of the drafting process and also completion of the necessary legislative approval process.

Committee’s Observations and Recommendations
Your Committee urges the Government to expedite the process of reviewing the Food and Nutrition Commission Act chapter 308 of the laws of Zambia and await a progress report on its enactment.

Funding for Direct Nutrition Interventions and Framework for Nutrition Sensitive Interventions
16.2 Your previous Committee had requested for a progress report on the funding for direct nutrition interventions across all sectors and an update on the framework for nutrition sensitive interventions.

Executive’s Response
The Government reported that direct funding for nutrition interventions was available in various line ministries such as those responsible for health, education, community development and social welfare. Various non-Governmental organisations also received funding from partners for direct nutrition interventions at various levels. It was, however, difficult for the Ministry of Health to quantify overall funding for nutrition across sectors, suffice to state that there had been some noted increase over the years as evidenced by the number of programmes and projects coming on board to directly support nutrition interventions.

At the moment, line budgets for some nutrition interventions were documented in the annual
budget but this did not include all the nutrition support, particularly that from partners financing NGOs. There was need to have an established and comprehensive mechanism for tracking nutrition funding and expenditure. The Ministry was working with partners through the National Food and Nutrition Commission (NFNC) to establish a more robust mechanism for tracking nutrition funding. To strengthen tracking and reporting on nutrition financing, the Government would invest in and integrate financing and budgeting for nutrition directly into the proposed Zambia Nutrition Information Management system, which was under development.

The framework for nutrition sensitive interventions had been developed and shared with the relevant ministries including those responsible for agriculture, community development, water and sanitation, general education, gender, youth and sport. Additionally, staff from these ministries had been trained in the use of the framework for planning. The framework would serve as a useful planning tool during the MTEF planning for 2018-2020, which had been launched.

Committee’s Observations and Recommendations
Your Committee expresses concern that the Ministry of Health was not in a position to track the funding going to nutrition which is problematic for coordinating and monitoring interventions.

Strengthening Nutrition Governance
16.3 Your previous Committee had requested for an update on the recommendation that the Government should strengthen nutrition governance by ensuring that the National Food and Nutrition Commission (NFNC) had an appropriate mandate, structure and institutional home to effectively execute its coordination mandate.

Executive’s Response
The Government reported that Cabinet had already approved in principle the introduction of a Bill in Parliament to repeal and replace the National Food and Nutrition Commission Act chapter 308 of the laws of Zambia. The Ministry of Health, working closely with stakeholders, had submitted the layman’s draft of the Bill to the Ministry of Justice. The Bill was expected to be introduced in Parliament upon completion of the drafting process and also completion of the necessary approval process.

Committee’s Observations and Recommendations
Your Committee urges Government to expedite the repeal of the National Food and Nutrition Commission Act chapter 308 of the laws of Zambia which should incorporate measures to strengthen the NFNC.

Upgrading of Nutrition Positions in line Ministries
16.4 Your previous Committee had requested an update on the upgrading of nutrition positions in sector Ministries.

Executive’s Response
In response, the Government explained that in the Ministry of Health at Headquarters, the Nutrition Unit was headed by a Chief Nutrition Officer who reported to the Assistant Director Child Health & Nutrition. In addition, Nutritionists were placed at Provincial, District and high
volume hospitals. Plans were underway, resources permitting, to have Nutritionists at other health facilities and at community level starting with high volume catchment areas of health.

Committee’s Observations and Recommendations
Your Committee takes note of the response. However, your Committee notices that the issue has not been responded to adequately as it has only addressed an upgrade of nutrition positions in the Ministry of Health and not line Ministries. Your Committee, therefore, awaits a progress report on the matter.

Social Protection Bill
16.5 Your previous Committee had requested an update on the Social Protection Bill.

Executive’s Response
In response, the Government reported that the Social Protection Bill was still in draft form and was at the Ministry of Justice.

Committee’s Observations and Recommendations
Your Committee strongly urges the Government to expedite the enactment of the Social Protection Bill and provide a progress report.

17.0 CONSIDERATION OF THE ACTION-TAKEN REPORT ON THE COMMITTEE’S REPORT FOR THE FOURTH SESSION OF THE ELEVENTH NATIONAL ASSEMBLY

Engagement of Religious Leaders in distribution of ARVs
17.1 Your previous Committee had requested an update on the engagement of religious leaders in the distribution of ARVs. Your Committee had further requested for a progress report on the delivery of women at health facilities.

Executive’s Response
The Government reported that the religious leaders’ engagement in the distribution of ARVs had not yet taken place. However, a meeting on this matter had been scheduled for 10th August, 2017. Facility deliveries had increased from below 50 percent in 2007 to 67 percent in 2014 (ZDHS 2013-14). This could be attributed to strong community structures such as Safe Motherhood Action Groups (SMAGs) and engagement of traditional leaders in safe motherhood.

The comprehensive Abortion Care Standards and Guidelines had been finalised and would be launched soon. Further, the Ministry of Health with the Support of IPAS Zambia had extended comprehensive abortion care services including safe termination of pregnancies and contraceptive services to four provinces, namely Eastern, Luapula, North-Western and Muchinga.

Committee’s Observations and Recommendations
Your Committee resolves to await a progress report on the engagement of religious leaders in the distribution of ARVs.
Delivery and Installation of Generators as a power back up system in health Institutions

17.2 Your previous Committee awaited a progress report on the delivery and installations of the procured generators as a power back up system in health institutions.

Executive’s Response
In response, the Government stated that due to sharp increase in the exchange rate, the contract for the supply of the remaining eighteen generator sets was cancelled after obtaining approval from the Attorney General. The twenty-five percent payment that was made by the Ministry of Health was just enough to cater for only two generators which had since been installed at Levy Mwanawasa General Hospital and Chipata Central Hospital respectively. The procurement and installation of generators would only be undertaken once funds were made available.

Committee’s Observations and Recommendations
Your Committee awaits an update on the status of the procurement and installation of generators as a power back up system in health institutions.

Breast and Cervical Cancer in Zambia

17.3 Your previous Committee had requested an update from the Government on the outcome of the proposals submitted to partners on the roll out of Cancer Screening Centres in Provincial Hospitals.

Executive’s Response
In response, the Government submitted that Cancer Diseases Hospital (CDH) Phase III project was developed to establish radiotherapy centres in each province of Zambia. The Government, through Ministry of Finance, had identified would be funders, namely; Arab Bank for Economic Development in Africa (BADEA) and OPEC Fund for International Development (OFID). Following this, an appraisal mission was done to construct the first two centres; one in Livingstone and the second in Ndola and an upgrade of CDH as a supervising centre. Both BADEA and OFID sent draft loan agreements which were presented to Cabinet in July, 2017. Cabinet had approved these draft loan agreements and the Government, through Ministry of Finance, was now mandated to sign the loan agreement with BADEA and OFID for the Government to start implementation of this project as soon as possible.

Committee’s Observations and Recommendations
Your Committee seeks an update on the signing of the loan agreements between the Government through Ministry of Finance and BADEA and OFID and the start of the implementation of the project.

Outstanding Issues on Social Protection for the Aged in Zambia

17.4 Your previous Committee had requested an update on the finalisation of the guidelines for operating and establishing old people’s homes.

Executive’s Response
The Government stated that the guidelines had been finalised and would be launched soon.
Committee’s Observations and Recommendations
Your Committee notes the response and awaits an update on the launch of the guidelines.

CONCLUSION
18. Your Committee wishes to thank you, Mr Speaker, for the guidance rendered to it throughout the Session. Your Committee also wishes to pay tribute to all the stakeholders who appeared before it and tendered both oral and written submissions. Your Committee further extends its gratitude to the office of the Clerk of the National Assembly for the services rendered to it.

Your Committee is hopeful that the observations and recommendations contained in this Report will be favourably considered in the quest for improvement of the health, community development and social service sectors of Zambia.

Dr C K Kalila, MP
June, 2018
CHAIRPERSON
LUSAKA
APPENDIX I

LIST OF NATIONAL ASSEMBLY OFFICIALS

Ms C Musonda, Principal Clerk of Committees
Mr F Nabulyato, Deputy Principal Clerk of Committees (SC)
Mr S Chiwota, Senior Committee Clerk (SC)
Mr C Bulaya, Committee Clerk
Ms N Mwenda, Intern
Mr M Chikome, Committee Assistant
Mr D Lupiya, Committee Assistant
APPENDIX II
LIST OF WITNESSES

Non Communicable Diseases
i. Ministry of Health.
ii. The Non-Governmental Organisations’ Coordinating Council (NGOCC).
iii. University of Zambia – School of Public Health.
iv. Zambia Medical Association (ZMA).
v. University Teaching Hospital (UTH).
vi. World Health Organisation (WHO).
viii. Zambia Medical Association (ZMA).
x. Centre for Infectious Disease Research in Zambia (CIDRZ).
xi. Breakthrough Cancer Trust.
xii. Tropical Disease Research Centre (TDRC).
xv. Churches Health Association of Zambia.

Social Cash Transfer
i. Ministry of Community Development and Social Welfare;
ii. Caritas Zambia;
iii. Civil Society for Poverty Reduction (CSPR);
iv. Churches Health Association of Zambia (CHAZ);
v. Non-Government Organisations Coordinating Council (NGOCC);
vi. Policy Monitoring and Research Centre (PMRC);
vii. Civil Society Scaling up Nutrition Alliance (CSO-SUN); and
viii. Irish Aid.