

THE FIRST REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE FOURTH SESSION OF THE TENTH NATIONAL ASSEMBLY APPOINTED ON 25 SEPTEMBER 2009

Consisting of:

Mrs J Kapata, MP, (Chairperson), Mr M Habeezu, MP, Mr B Imenda, MP; Dr J Katema, MP; Col G A Chanda, MP; Mr N P Magande, MP; Mr G G Nkombo, MP; and Dr S Musonda, MP

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir, following the guidance that your Committee should table the Report of the previous Committee for the Third Session of the Tenth National Assembly, your Committee studied the Report in detail and, on Thursday 8th October 2009, adopted it.

Your Committee, Mr Speaker, now, have the honour to present the Report.

Mrs J Kapata, MP
CHAIRPERSON

September 2009
LUSAKA

REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE THIRD SESSION OF THE TENTH NATIONAL ASSEMBLY APPOINTED ON THURSDAY, 17 JANUARY, 2009

Consisting of:

Mr M Habeenzu, MP (Chairperson); Mr B Imenda, MP; Mrs J Kapata, MP; Dr J Katema, MP; Col. G A Chanda, MP; Mr N P Magande, MP; Mr L Chibombamilimo, MP and Mr G Chazangwe, MP.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir

Your Committee have the honour to present their Report for 2009.

Functions of the Committee

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

- (i) study, report and make recommendations to the Government through the House, on the mandate, management and operations of the Ministries of Health and Community Development and Social Services, Departments and/or agencies under their portfolios;
- (ii) carry out detailed scrutiny of certain activities being undertaken by the Government ministries of Health and Community Development and Social Services, departments and/or agencies under their portfolios 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; and
- (v) consider any Bills that may be referred to them by the House.

Meetings of the Committee

3. Your Committee held sixteen meetings during the period under review.

Committee's Programme of Work

4. Your Committee considered and adopted the following programme of work:

- (a) consideration of the outstanding issues from the Action-Taken Report on the Committee's Report for 2008;
- (b) consideration of the following topical issues: -
 - (i) Regional and International Health-related instruments that Zambia has committed herself to, with specific focus on the Abuja

- Declaration and the Maputo Plan of Action on Sexual and Reproductive health and Rights;
- (ii) the operations of the National Trust for the Disabled; and
 - (iii) tours of selected health institutions.

Procedure adopted by the Committee

5. Your Committee requested detailed memoranda from the relevant Government ministries, parastatal bodies, non-Government Organisations and interested individuals and then invited their Chief Executives to appear before them to make oral submissions and clarifications on issues concerning their submissions.

PART I

CONSIDERATION OF TOPICAL ISSUES

TOPIC ONE

REGIONAL AND INTERNATIONAL HEALTH- RELATED INSTRUMENTS TO WHICH ZAMBIA IS A SIGNATORY WITH SPECIFIC FOCUS ON THE ABUJA DECLARATION AND THE MAPUTO PLAN OF ACTION

6. Your Committee recognise that there are a number of regional and international instruments that the Zambian Government has committed itself to, such as the Abuja Declaration and the Maputo Plan of Action on Sexual and Reproductive Health and Rights. These instruments are on key health issues such as primary health care and reproductive health rights.

They observe, however, that Members of Parliament have little or no information on these commitments because the Executive delegations to the conferences and meetings where such commitments are made do not inform Parliament upon their return. Your Committee note the important role that Parliament plays in overseeing Government actions, hence the need to be fully equipped with such vital information in order to monitor the implementation of health-related programmes by the Government. Against this background, your Committee resolved to undertake a study on this important topic in order for them to have an appreciation of these Instruments.

In order to help them in their study, your Committee invited the following witnesses: -

- a) Ministry of Health;
- b) Ministry of Justice;
- c) Ministry of Foreign Affairs;
- d) Zambia White Ribbon Alliance for Safe Motherhood; and
- e) United Nations Population Fund.

HIGHLIGHTS OF THE SUBMISSIONS BY THE GOVERNMENT

Your Committee were informed that the word “*treaty*” covered a broad range of concepts that included contracts, covenants, agreements, settlements and international agreements between states. Treaties were a means by which subjects of international law undertook binding obligations under international law towards one another. Such obligations may be declaratory of international customary law or the general principles of law recognised by civilised nations. They could also be considered as international legislation in the sense that they regulate states.

Regional treaties are treaties entered into by states within a geographical framework such as a continent or a region within a continent. For example, Southern Africa Development Community (SADC) treaties are regional and apply to certain countries within the Southern Africa region. The Common Market for Eastern and Southern Africa (COMESA) is a regional organisation which has treaties and agreements that apply to Eastern and Southern African countries. West Africa has treaties for the Economic Community for West African states. On the other hand, international treaties apply to more than one continent or to members of all the five continents of the World. An example of international treaties is the United Nations Charter and treaties established under the United Nations (UN) such as the Convention on the Rights of Persons with Disabilities or the Convention on the Rights of the Child.

Your Committee heard that international agreements were frequently described as treaties concluded by two or more states or other entities with international personality such as international organisations, if the agreements were intended to have international legal effect. Other terms used to describe bilateral or multilateral agreements include convention, pact, accord, protocol, general act and final declaration. The agreements may also be letters of agreements, letters of intent, various types of memoranda and mutual recognition agreements. These are general bilateral or multilateral agreements between government organisations in different states with the purpose or intent to achieve defined objectives.

A country could be a party to a commitment, agreement or treaty by way of signing, ratifying or acceding. The signing of a treaty implied confirmation of an international consensual engagement or intent to be bound. It was normally the act by means of which the will of the contracting parties was expressed. Signature served the purpose of signifying the binding character of a consensual engagement or willingness to be bound through appending of a signature, while ratification was to confirm the expression of the common will of the parties as signified by their signatories for the purpose of giving it binding force. If a treaty required ratification that acted as an indispensable condition for bringing the treaty into operation, the act of ratification established the binding character of a treaty. It signified the willingness of the state to be bound by a treaty, the international procedure whereby a treaty entered into force, the formal exchange or deposit of the instruments of ratification.

In the case of accession, this was a process by which a state accepted the offer or the opportunity of becoming a party to a treaty signed for and ratified by other states. The difference between accession, on the one hand, and signature or ratification, on the other, was that the acceding state did not take part in the negotiations that produced the treaty, but was invited by the negotiating states to accede to it. Accession was possible only if it was provided for in the treaty, or if all the parties to the treaty agreed that the acceding state should be allowed to accede. Accession has the same effects as signature and ratification combined. An accession becomes effective only when it is deposited or communicated with the appropriate authority specified in the instrument which is being acceded to.

Your Committee were informed that in terms of importance, all subjects of international law, that are the states, must take their commitments seriously and must endeavour to meet their obligations. The legal implications, once consent to be bound had been made by a state, were that the rights and duties created under a treaty begin to have effect. In Zambia, however, before a treaty could have the force of law, the provisions of that treaty must be included in the Zambian laws. This process is known as domestication. A treaty obligation was not a mere moral obligation but was an obligation by which the parties to the treaty are bound to one another. None of the contracting parties was entitled to frustrate or impair the treaty by means of unilateral decision. The interpretation and application of treaties depended on reasonableness and good faith. The reciprocity of rights and duties between states in treaty relations were the hallmarks of the rights that formed the law of treaties.

Your Committee heard that the Ministry of Justice had developed a database of the international agreements that Zambia had signed. The database was updated regularly. However, the Ministry of Justice relied on the Ministry which was responsible for the subject matter to notify the Ministry of Justice when they signed and ratified the agreements. So far, implementation of treaties and agreements had been left to the respective Ministries who were better placed to access the benefits of each treaty. This was because Zambia had inherited a dual legal system whereby a treaty needed to be domesticated after it had been ratified for it to have legal effect. This process of domestication, as alluded to earlier, would involve a process by which the provisions of the treaty were incorporated into the laws of Zambia.

Your Committee also learnt that the process of implementation of treaties took long because a lot of consultations needed to be carried out, especially, by the affected ministry to make sure that all aspects of the legal framework were harmonised before implementation. It was explained that in cases where a country did not domesticate a treaty that they were a party to, there were no penalties levelled against such a country because each nation was a sovereign state. An example was the Abuja Declaration where not all countries who were party to it had acted in accordance to the agreement, saying countries had varying levels of economic development and, therefore, the targets that were set were merely to persuade countries to meet them rather than compelling them.

Your Committee were informed that as a member of SADC, COMESA and the African Union (AU), Zambia had increasingly recognised the need to adopt a holistic approach towards human development in its integration agenda. As part of the various clusters in the above bodies, health had been prioritised. This was due to the realisation that close cooperation in health is essential in addressing the health problems of the people of the African region efficiently and effectively. It is believed that the daunting health problems and challenges facing member states could only be effectively addressed through regional interventions and co-operation.

Henceforth, it is generally expected that the ratification of various regional and international instruments/protocols/commitments would lead to Zambia integrating more in health issues within the region and the world. Through collaboration with other member states, it was hoped that Zambia would reach the objective of “health for all” as adopted by the World Health Organisation (WHO), with priority given to the delivery of primary health care. In addition, Zambia would move closer towards realising its vision of ‘making health care accessible to all Zambians as close to their families as possible’.

Regional and International Instruments/Commitments

Some of the commitments to achieving better health that had been signed by Zambia are as set out below.

- i. Abuja Declaration on HIV/AIDS, Tuberculosis, and other related Infectious Diseases.** This was signed by the Heads of State and Government of the Organisation of African Unity (OAU) that met in Abuja, Nigeria in 2001, at a Special Summit devoted specifically to address the exceptional challenges of HIV/AIDS, Tuberculosis and other related Infectious Diseases.
- ii. Maputo Plan of Action on Sexual and Reproductive Health and Rights.**
- iii. SADC Protocol on Health.** Zambia is a signatory to the SADC Protocol on Health that was adopted by the SADC Heads of State and Government on 18th August 1999. The SADC Protocol on Health has 40 Articles that aspire to offer a full range of cost-effective and quality integrated health services through regional cooperation.

iv. International Health Partnerships and related initiatives (IHP+).

Zambia was one of the signatories to the Global Compact on the IHP+ which has now been signed by twelve (12) developing countries (Burundi, Cambodia, Ethiopia, Kenya, Mali, Madagascar, Mozambique, Nepal, Nigeria, Uganda, Rwanda, Zambia), eleven (11) bilateral donors (UK, Norway, France, Germany, Portugal, Italy, Netherlands, Canada, Sweden, Finland, and Australia), six (6) UN agencies (WHO, UNICEF, UNAIDS, UNFPA, UNDP, and ILO), and 6 other international organizations (EC, World Bank, African Development Bank, Bill et Melinda Gates Foundation, GAVI, and the Global Fund). The IHP+ aims at catalyzing the implementation of the Paris Declaration on aid effectiveness and attainment of health related MDGs.

The Global Compact on the IHP+ was signed on 5th September 2007 in London by the Minister of Health. Ratification of the IHP+ commits all signatories to strengthening country partnerships in line with the Paris Declaration on Aid Effectiveness and in a way that: *"reflects the unique situation in each country, channels support into country owned health plans, and secures fair and sustainable financing of health systems"*.

The Abuja Declaration

Your Committee were informed that the Heads of State and Government of the Organisation of African Unity (OAU) met in Abuja, Nigeria, from 26-27 April 2001, at a Special Summit devoted specifically to address the exceptional challenges of HIV/AIDS, Tuberculosis and other related infectious diseases. The leaders were deeply concerned about the rapid spread of HIV infection in Africa and the millions of deaths caused by AIDS, Tuberculosis and other related infectious diseases, in spite of the serious efforts being made to control these diseases. They undertook a critical review and assessment of the situation and made the Declaration set out hereunder.

- a) Consider AIDS as a State of Emergency on the continent. All tariff and economic barriers to accessing funding for AIDS-related activities should be lifted.
- b) To place the fight against HIV/AIDS at the forefront and as the highest priority issue in national development plans. Foundations for the prevention and control of the scourge of HIV/AIDS, tuberculosis and other related infectious diseases should be consolidated through a comprehensive multi-sectoral strategy which involves all appropriate development sectors of African governments as well as a broad mobilisation of societies at all levels, including community level organisations, civil society, NGOs, the private sector, trade unions, the media, religious organisations, schools, youth organisations, women organisations, people living with HIV/AIDS organizations and individuals who care for, support and sensitise populations to the threat of HIV/AIDS and associated opportunistic infections and also to protect those not yet infected, particularly the women, children and youth, through appropriate and effective prevention programmes.
- c) Commitment to personal responsibility and leadership for the activities of the National AIDS Commissions/Councils. African Governments to lead from the front, the battle against HIV/AIDS, Tuberculosis and other related Infectious Diseases by ensuring that National AIDS Commissions/Councils were properly convened in mobilizing societies as a whole and providing focus for unified national policy-making and programme implementation, ensuring coordination of all sectors at all levels with a gender perspective and respect for human rights, particularly to ensure equal rights for People Living with HIV/AIDS (PLWHA).

- d) Commitment to take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition, the African leaders pledged to set a target of allocating at Least 15% of annual budgets to the improvement of the health sector. Further, it was pledged that all the necessary resources would be made available for the improvement of the comprehensive multi-sectoral response, and that an appropriate and adequate portion of this amount would be put at the disposal of the National Commissions/Councils for the fight against HIV/AIDS, Tuberculosis and other related Infectious Diseases.
- e) Requested the OAU Secretariat to assist Member States in formulating a continental-wide policy for an international assistance strategy for the mobilisation of additional financial resources in collaboration with ADB, ECA, and all other partner institutions, especially WHO and UNAIDS.
- f) Donor countries to complement national resources mobilization efforts to fight the scourge of HIV/AIDS, Tuberculosis and other related Infectious Diseases, bearing in mind that Africa cannot, from its weak resource base, provide the huge financial resources needed. In this regard, donors were requested to, among others, fulfil the target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries.
- g) Undertake to mobilize all the human material and financial resources required to provide care and support and quality treatment to populations infected with HIV/AIDS, tuberculosis and other related infections, and to organize meetings to evaluate the status of implementation of the objective of access to care.
- h) Support the development of effective affordable, accessible HIV vaccine relevant to Africa including support to “The Africa; AIDS Vaccine Programme” (AAVP), its collaborative partners, international partners and institutions committed to the facilitation of HIV vaccine research and testing in Africa.
- i) Commitment to scaling up the role of education and information in the fight against HIV/AIDS in recognition of the essential role education, in its widest sense, plays as a cost-effective tool for reaching the largest number of people.

The Maputo Plan of Action on Sexual and Reproductive Health and Rights

Your Committee were informed that in recognising the fact that African countries were not likely to achieve the Millennium Development Goals (MDGs) without significant improvements in the sexual and reproductive health of its people, the Second Ordinary Session of the Conference of African Ministers of Health, meeting in Gaborone, Botswana, in October 2005, adopted the Continental Policy Framework on Sexual and Reproductive health and Rights. The policy framework was endorsed by the African Union Heads of State in January 2006. This policy framework addressed Africa’s key sexual and reproductive health and rights challenges and calls for an increase in resource allocation to health, in order to improve access to services.

Given the urgency of this matter, in September 2006, the African Union Ministers of Health adopted the *Maputo Plan of Action* for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework during its Special Session held in Maputo. The Continental policy framework on sexual and reproductive health and rights addresses the reproductive health and rights challenges faced by Africa. It also calls for strengthening the health sector component by increasing resource allocation to health in order to improve access to services.

Importance and legal implications of the Abuja Declaration and the Maputo Plan of Action

Your Committee were informed that the Abuja and Maputo Declarations are not legally binding, but are commitments by the Heads of State to holistically address the high burden of diseases and, henceforth, extremely important to Zambia. If Zambia was not a signatory to the above declarations, it would have reflected badly on Zambia's commitment to deeper integration in the region. Zambia also stands to lose a great deal in terms of long-term investment in the health sector, which can contribute to sustainable economic growth. It is generally acknowledged that good health contributes to sustainable economic growth. In addition, Zambia would not benefit from economies of scale in areas such as bulk procurement of drugs and medical supplies, and sharing of expensive medical technology, which can be realized from collaboration, and sharing of resources among member states.

Progress made and challenges towards the implementation of the Abuja Declaration and the Maputo Plan of Action

Your Committee heard that in response to the Abuja and Maputo Declarations, the HIV/AIDS epidemic had been highly prioritized in Zambia and a lot of political support is provided. Zambia had made significant progress in the development of AIDS strategies and policies, particularly, in the areas of strategic planning, prevention, treatment and civil society participation. The measures set out below have been put in place.

- (i) From 2000 the Government embarked on the multi-sectoral response to HIV/AIDS. In 2001, the draft HIV/AIDS/STI/TB policy was finalised and the HIV/AIDS/STI/TB Act was enacted in Parliament in 2002. This established the National AIDS Council and gave the Council a legal mandate to co-ordinate a multi-sectoral response against HIV/AIDS.
- (ii) The National AIDS Council established to coordinate the multisectoral response under the National HIV/AIDS/STI/TB Council Act has achieved the following:
 - Compliance with the "Three Ones Principle"
 - Development of the National HIV/AIDS Strategic Frameworks (2002-2005, 2006-2010) and the Monitoring Evaluation Plan 2006-2010
 - Four Joint Annual Programme Reviews
 - Establishment of Districts AIDS Task Forces
- (iii) A number of hospices have been opened up to care for the AIDS patients. The Government also encourages home based care support in order to decongest the hospitals.
- (iv) Through collaboration with various multilateral and bilateral have Cooperating Partners (CPs), a lot of financial and material been resources mobilized to fight the HIV/AIDS pandemic.
- (v) The provision of free Anti-Retroviral Therapy (ART) in order to improve access to HIV/AIDS drugs.
- (vi) The promotion of human rights is explicitly mentioned in the National AIDS Policy and strategy. Zambia has a policy to ensure equal access for women and men to prevention, treatment, care and support. There are some laws that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations such as the laws on homosexuality, prostitution and injection drug use. The National AIDS Policy also prohibits HIV screening for general employment purposes.

Challenges in the implementation of the Abuja and Maputo Plan of Action

Your Committee were informed that as a signatory to the Abuja Declaration, Zambia is required to spend 15% of its domestic discretionary budget on health. However, the Abuja target had not been attained in Zambia since the Declaration was made in 2001. The Government health budget declined from an average of 6.4% in the early 1980s to 5.7% in 1991 and then increased to 13.4% in 1994 and further to 14.4% in 1998. The Government health budget then started declining and in 2004, the Government only allocated 9.4% of its budget to health. Since 2005, there had been a steady nominal increase in the annual Government health budget which increased from 9.7% in 2005 to 10.3% in 2006, 10.5% in 2007, 11.3% in 2008 and 11.4% in 2009. This trend puts the country (Zambia) in good standing to meet the Abuja target although much more has to be done.

Your Committee were informed that the percentage of households' expenditure on HIV/AIDS has been declining since 2003, but was higher than Government expenditure on HIV/AIDS throughout the period 2003 to 2006. This suggests that the financial burden on the poor households is still high despite government's provision of free ARVs since mid-2005. The free ARVs policy might not have fully reduced the frequency of opportunistic infections among HIV/AIDS patients and likelihood of incurring catastrophic health expenditures. Other indirect costs (travel and time costs, food and accommodation for in-patients and relatives) and non health costs (quality, information, and cultural), makes poor people to bear the financial burden more.

Financial Implications of the Maputo Plan of Action and the Abuja Declaration for Zambia

Your Committee were informed that the Ministry of Finance and National Planning's understanding of the financial implications of the Maputo plan of action and the Abuja declaration was twofold. Firstly, the health sector played a pivotal role in economic development of the country as health and development were inter-related. When the Government scaled up the budget allocation to health, the underlying understanding was that such a move would improve the health status of the general population. Better health contributed to economic development by increasing worker productivity and lengthening the life expectancy of the population and particularly the labour force. In the same way, better child health and nutrition promoted future productivity growth by helping children develop into future, healthier and more productive adults. Better health could also reduce the amount of money spent on curative care thereby freeing up resources for other developmental programmes or needs.

On the other hand, increasing the budget allocation of the health sector to 15 percent of the national budget was a medium to long term target. This was because immediate implementation would displace resources from other vital sectors of the economy especially in view of the constrained resource envelope. Other priority areas such as education, infrastructure, public order and safety, water and sanitation and agriculture would be affected. In view of the above, Government strategy was to allow the economy grow over time so that the extra resources raised could be devoted to the Health and other equally important sectors without negatively affecting others.

How Parliament can be kept informed of the commitments and the measures that the Government should put in place to implement the commitments

Your Committee heard that Parliament could be kept informed of the progress being made towards the attainment of the Abuja Declaration and Maputo Plan of Action by requesting for periodic updates from the Ministry of Health specifically towards the implementation of the above. Alternatively, Parliament can rely on routine reports that

are produced by the Ministry of Health and donors such as the Financial Reports, the Ministry of Health Joint Annual Review and/or Annual Reports, and the Annual Health Statistical Bulletins. In addition, every year the Minister of Health issues a policy statement during the approval of budget estimates for the Ministry of Health. This statement includes highlights on the achievements and challenges faced towards fulfilling the Abuja targets.

Parliament can assist the Ministry of Health by advocating and ensuring that the Abuja target of 15% funding to the health sector is attained while there should be more concerted efforts towards the alleviation of the human resources for health crisis.

THE VIEWS OF THE NON-GOVERNMENT STAKEHOLDERS

Your Committee sought the views of the Zambia White Ribbon Alliance for Safe Motherhood and United Nations Population Fund (UNFPA) on the Maputo Plan of Action on Sexual and Reproductive Health and Rights as the stakeholders were believed to have valued information on the commitment. Generally, the two stakeholders were in agreement that regional and international commitments were important as they could bring about closer collaboration among countries on ways to mitigate the impact of the diseases. They were of the view that:

- the Maputo Plan of Action Commitment is very important because it is a yardstick for a country's performance in health service delivery which is key in meeting the Millennium Development Goals (MDGs);
- the Maputo Plan of Action is an important commitment especially that women were at the centre of it; and
- one way to determine a country's level of development was to examine the number of women who die due to pregnancy related complications.

Concerns

The stakeholders are, however, concerned with:

- the statistics of women who attended antenatal sessions and those who were assisted with delivery was not impressive because only 48% of deliveries were supervised in the country;
- the lack of financial and material capacity by communities to provide for the requisites demanded at clinics, the long distances to the health centres; and
- the inadequate number of skilled staff to attend to pregnant women.

Committee's Observations and Recommendations

Observations

Your Committee observe as follows: -

- a) there is inadequate dissemination of information to Parliament and the general public on the international agreements entered into by the Government;
- b) the signing of agreements and their implementation by the same wing of Government makes it difficult to evaluate and account for the successes and failures recorded;
- c) the discretionary manner and the lack of legal effect to enforce the agreements leaves room for countries not to abide by the agreements;
- d) it is difficult for a country to implement international agreements if the sources of funds are from donors;

- e) it is difficult for countries to enforce agreements uniformly due to differences in levels of economic development; and
- f) the appending of signatures to international agreements or commitments that cannot be implemented in time was a worrying phenomenon.

Recommendations

Your Committee, therefore, recommend as follows: -

- a) the executive delegations to conferences where commitments are made should include Members of Parliament, such as, Chairpersons of Portfolio Committees;
- b) Members of Parliament should closely monitor the implementation and status of the agreements so that they are in a position to inform the public through their constituencies;
- c) there is need for the agreements to have legal effect so that all countries that are party to the agreements implement them to the letter in order to forge ahead;
- d) international agreements should be tailored on the basis of a country's development so that the set benchmarks are achievable;
- e) Zambia should only enter into agreements which will be implemented in time in order for the general public to benefit;
- f) there is need for the Minister of Health to inform Parliament whenever health-related regional and international commitments are made; and
- g) special programmes for the implementation of regional and international commitments should be domestically financed.

TOPIC TWO

THE OPERATIONS OF THE NATIONAL TRUST FOR THE DISABLED

7. The National Trust for the Disabled (NTD) is a grant-aided institution that has been tasked to provide specialised services and loans on behalf of the Ministry of Community Development and Social Services to persons with disabilities.

Your Committee observed that there were complaints that the NTD had failed to carry out its mandate because persons with disabilities could no longer access the services for various reasons. Your Committee, therefore, resolved to undertake a study of the operations of the NTD and ascertain its capacity to carry out its mandate so as to advise the Government accordingly. In order to help them carry out their study, your Committee invited the following witnesses: -

Ministry of Community Development and Social Services;
 Zambia National Federation of the Disabled;
 Zambia National Federation of the Blind;
 National Trust for the Disabled;
 Kanyama Savings and Credit Union;
 George Madalitso Cooperative;
 Zambia Deaf Division; and
 Chipata Cooperative.

Highlights of the Submissions by the Ministry of Community Development and Social Services/ National Trust for the Disabled

Your Committee were informed that the National Trust Fund was a credit facility that was created in the Ministry of Community Development and Social Services in 1994; and the aim was to empower unemployed persons with disabilities through micro-credit and entrepreneur skills for sustainable self employment as a means of equalising of opportunities for Zambians.

To apply for a loan, one had to be a Zambian, disabled, unemployed, aged between eighteen (18) and sixty (60) years and registered with the Zambia Agency for Persons with Disabilities. The types of loans fell into categories of whether one was a first, a second or a third time applicant. The amounts ranged from five hundred thousand Kwacha (K500,000) to one million Kwacha (K1,000,000,000) for a first applicant, one million five hundred thousand Kwacha (K1,500,000) to three million Kwacha (K3,000,000) for a second applicant and three million Kwacha (K3,000,000) to five million Kwacha (K5,000,000) for third applicants.

Your Committee heard that the implementation of the Fund loans was done with the assistance of the Ministry of Community Development and Social Services. This arrangement had resulted in most recipients perceiving the loans as grants from the Government, resulting in poor loan recoveries. There was, therefore, need for the Ministry to partner with NTD and sensitize the targeted people on the operations of the Fund. The NTD had recently launched an income generating programme and had acquired twenty-five (25) hectares of land in Makeni area for crops and livestock production. To that effect, a loan application of K2.8 billion had been forwarded to the Citizens Economic Empowerment Commission.

THE VIEWS OF THE NON- GOVERNMENT STAKEHOLDERS

Your Committee also sought the views of the following institutions:

- Zambia Federation of Disability Organisations;
- Zambia National Federation of the Blind;
- Kanyama savings and credit union, Lusaka;
- George Madalitso Cooperative, Lusaka;
- Zambia Deaf Vision, Lusaka; and
- Chipata Cooperative, Lusaka.

Your Committee heard that for the past fifteen (15) years that the loan facility has been in existence, it was difficult to measure its impact on the lives of persons with disabilities. In all these years, the institution had only reached about 255 out of the estimated 1,300,000 persons with disabilities. The number reached was less than 0.02 percent of disabled persons. This clearly showed the reason why disabled persons still continued to be among the poor of the poorest. Further to that, the loan units were very small to the extent that they could not change anything. For example, if one was to go into farming, one bag of fertilizer was fetching between ZMK250,000 and ZMK300,000. Therefore, to have one Lima, one needed four bags of fertilizer. This meant one NTD loanee would manage to get fertilizer without a bag of seed. In other words, there was no serious impact one could point at.

It was observed generally that the micro-credit had not improved the welfare of disabled persons. It had instead burdened them with excess stress when it came to repayment. Some of the complaints regarding the micro-credit facility that needed to be addressed included:

- high interest rates on the loans that is 12% for a period of six months and 25% for a period of one year;
- the loan amounts were small to allow someone to start a meaningful business venture. The amounts ranged from K1,000,000 to K5,000,000 depending on whether one was a first time or second time applicant; and

- the period within which the loans were supposed to be paid back was short.

It was further observed that there was inadequate funding by the Government in 2009. The funding had been reduced from K600,000,000 in 2008 to K550,000,000 in 2009. Out of this amount, only K40,000,000 would be disbursed as loans while the rest would go into administrative and project costs.

Your Committee were informed that political pronouncements were made that explicitly seemed to include disabled persons yet they ended up being a hoax. There were basically two vivid examples that could attest to this. The 5th National Development Plan, Chapter 21, clearly states what issues Government intended to do in order to address disability issues. But, up to now, nothing tangible could be pointed at as an achievement.

Another example was the Citizen Economic Empowerment Fund. Disabled people are well spelt out in the guidelines, yet the collateral needed for one to access the funds was beyond disabled persons' reach. The empowerment programme should have a window through which to lend to socially excluded groupings like the disabled and provide the loans at affordable collateral. As a way forward, therefore, the approach NTD used for the micro-credit loans needed to be overhauled in order to respond to the current disability needs. For instance, the Micro Bankers Trust that falls within the same Ministry as NTD had a straight forward loan interest of ten (10) percent on all loans for a period of one year and the recoveries are very effective. Furthermore, the NTD could do more by using some models like the Grameen Micro-Finance Banking Model where there was a mixture of men and women per group and also the ratification of the United Nations Convention on the Rights of Persons with Disabilities by the Government so that it could be easy to mobilise foreign resources.

On the status of the recovery rates, it was stated that the rates had improved tremendously from 5% when there was individual lending to 59% under the current group lending scheme.

As regards the possibility of accessing the loans from Banks instead of NTD, in view of the fact that NTD's amounts were very small (i.e, K400,000) for any meaning business ventures, it was explained that the difficulty with banks was their insistence on collateral which the disabled persons could not provide. Your Committee noted with concern that the larger portion of the amount (more than 90%) was spent on administering the fund and only about 8% went to the actual provision of loans.

Committee's Observations and Recommendations

Observations

Based on their careful consideration of the views from various stakeholders, your Committee observe that:

- (i) borrowers do not fully understand the objectives of the loan scheme;
- (ii) loans have been restricted only to persons with disabilities;
- (iii) administrative structures of the loan scheme are weak, leading to very low recovery rates;
- (iv) loan amounts involved are very small to start a meaningful business venture;
- (v) interest rates are very high for the kind of beneficiaries involved;
- (vi) conditions set by the Citizens Economic Empowerment Commission may not be met by the disabled persons for them to access the funds; and
- (vii) out of the total allocation of the fund, 90% went to administering the scheme and only about 8% went to the actual provision of the loans.

Recommendations

In view of the foregoing, your Committee recommend as follows: -

- (i) there is need to carry out a sensitization programme on the purpose and objectives of the loan scheme;
- (ii) the scheme should be extended to include the able bodied, but vulnerable in society;
- (iii) there is need to streamline and strengthen the administrative structure of the loan scheme so as to increase on the number of beneficiaries and also improve on the recovery rate;
- (iv) there is need to increase on the amounts to be lent out and also reduce the interest rates to lessen the burden of paying back; and
- (v) the Citizens Economic Empowerment Commission should set deliberate conditions that will enable disabled persons have access to the Fund as a way of complimenting the assistance from the Ministry of Community Development and Social Services.

PART II

TOURS

Your Committee undertook tours of selected health institutions in Southern, Central and Copperbelt Provinces so as to acquaint themselves with the status of health facilities in the country.

(i) MONZE DISTRICT

Your Committee were informed that Monze District was 61,875 square kilometres with a population of 225,660 people. It had a total of twenty-six (26) health facilities, out of which three (3) were health posts and one (1) was a General Hospital as well as a Mission Hospital. The District mainly provided primary health care services, while Monze (Mission) General Hospital provided first and second level health services, with a catchment area extending to Choma, Gwembe, Mazabuka and Sinazongwe districts.

All the twenty six (26) health facilities (including the hospital) were Tuberculosis (TB) treatment centres. The District had two (2) diagnostic centres, namely: Chikuni Health Centre and Monze Mission Hospital. In addition to the two (2) diagnostic centres, the District had four (4) microscopic sites. In 2008, the District diagnosed a total of 1,072 TB patients. The number of cancer positive patients was one hundred and eighty-four (184) compared to one hundred and thirty-two (132) in 2007. However, in general, the total number of new TB cases had been relatively stable between 980 to 1,100 cases per year for the past three (3) years.

Your Committee heard that all the twenty-six (26) health facilities in the District offered Voluntary Counselling and Testing (VCT) and Diagnostic Counselling and Testing (DCT) services. In 2008, a total of 8,944 HIV tests were done and 2,647 were reactive (29.5%). The Anti Retrol Viral Therapy (ART) sites were done at Monze Mission Hospital and Chikuni clinic. A mobile ART was about to start in the District.

General State of Health Facilities

Your Committee were informed that out of twenty six (26), only four (4) health facilities were in bad state of repair, and these were: Bwengwa, Hakunkula, Moongwe and Siatontola. The rest needed minor works such as solar system, incinerator, painting and replacement of defective materials.

New Health Facilities under Construction

Name of Health Facility	Funded by	Level of Progress
Nadongo	Matantala	Completed the Clinic Staff house on foundation level
		-Staff and patients toilet not started
Nteme	GRZ (K282,000,000.00)	- Clinic building and the staff house on painting level.
Banakaila	-Community Support up front materials GRZ funded (K100,000,000.00)	Health Post building completed remaining with 3 toilets and staff house not yet started.
Makonka	-CDF -Community Support	-Foundation level with 800 blocks molded.
Nalutanda	-CDF/Community Support	-Foundation level.
Chuongwa Malembe	-Community Support	Application approved with available upfront materials. Still looking for a neutral site.
St Mary's	-CDF -Community Support	-Foundation level with available upfront material.
Mabumbu	-CDF -community Support	-Application approved -Already supported with materials by CDF is cement, reinforcement and door frames.
Kayuni	-Community Support	-Application approved
Bbwantu	- Mantantala	-Application
Mulongawalwiili	-Community Support	-Application made for construction of Health Facility.
Kalundu	-Community Support	-Application made for the construction of the Health Facility. Community advised to acquire permanent independent site.

(ii) MONZE MISSION HOSPITAL

Your Committee were informed that Monze Mission Hospital was a level two (2) hospital with a catchment area extending to Choma, Gwembe, Mazabuka, Namwala and Sinazongwe districts. However, patients did not only come from the said districts but also from other towns in the province and even from outside the province because of the expertise that the hospital had in gynaecology, especially fistula repair.

The hospital also had a fully operational laboratory which was able to handle most of the laboratory procedures. With the advent of HIV/AIDS, the laboratory had been equipped with bio-chemistry and CD4 Count machines to help with the initiation of patients on antiretroviral (ARV) drugs.

Infrastructure Development

Your Committee heard that the hospital was opened in 1964 and, since then, it had undergone tremendous expansion to the current 274 bed capacity. There were extensions being made to include ten (10) beds in the eye ward and ten (10) new beds in Intensive Care Unit (ICU). There was also an ART building coming up which was funded by the Aids Health Care Foundation (AHF).

Your Committee were informed that since 1964, the school of nursing had been training students in nursing and midwifery. The Ministry of Health had since noted that the rate of student uptake and graduation of nurses would not meet the human resource needs of the country. Through funding from the Clinton Foundation, expansion of existing nursing and midwifery schools had been undertaken at a cost of K1.3 billion.

Committee's Observations and Recommendations

Observations

Your Committee observe that:

- i. Chikuni Hospital was playing a big role in the provision of Health Services in the District; and
- ii. building of staff houses has been slow at some sites and non existence in many places where the projects have been approved.

Recommendations

Your Committee therefore, recommend that:

- i. Chikuni Hospital should be recognised by the Government so that it is also funded just like other Mission hospitals; and
- ii. the Ministry of Health should take the issue of staff housing in rural areas seriously by ensuring that building of the houses is started and completed where the projects have been approved.

(iii) GWEMBE DISTRICT HOSPITAL

Your Committee were informed that the Hospital was built between 1959 and 1962 as a Leprosarium and later converted into a District Hospital. It was explained that the hospital was operating without a Doctor or a Clinical Officer. In times of need, the Director of Health from Monze was available to attend to patients. Currently, the hospital had twelve (12) nurses, two (2) radiologists, one (1) laboratory technician, fourteen (14) general workers and one (1) hospital administrator. It was stated that the Clinical Officer from the Out-patient Department did the rounds and also was on call when the Director of Health was not available, adding that most of the work at the hospital was done by nurses.

Your Committee heard that although the hospital was well stocked with drugs, there were several challenges that needed attention such as the following:

- a) the laboratory was not suitable to culture specimen;
- b) the CD4 Count machine was constantly breaking down;

- c) the hospital had no theatre;
- d) the toilet facilities were located away from the wards making them not user friendly to patients;
- e) the VCT and ART rooms needed to be closer in order to facilitate the smooth flow of work;
- f) the mortuary fridge was constantly breaking down; and
- g) there was need for a brick wall fence to serve the hospital facilities.

On the staff housing construction project and the status of funding levels, the hospital administration told your Committee that out of a grant of K84 million, 30% went to hospital administration. Your Committee further heard that a rehabilitation exercise was carried out in 2005 and staff houses had been worked on by fixing new doors and air vents, and a total sum of K100 million was spent on the exercise. It was, however, mentioned that over K400 million meant for the construction of houses had not been used and was in the bank.

Committee's Observations and Recommendations

Observations

Your Committee make the following observations:

- (i) there are serious weaknesses in the management of the hospital;
- (ii) there has been no building of staff houses; instead old housing units were renovated at a suspicious cost of K100 million;
- (iii) the hospital is incapacitated by lack of transport;
- (iv) there is a risk of the hospital being vandalised;
- (v) the design of the hospital is not user friendly to the patients; and
- (vi) the hospital has no reliable CD4 Count machine and has no operating theatre.

Recommendations

In view of the above, your Committee recommend as follows:

- (i) there is need for effective management of the hospital;
- (ii) the Government should immediately provide an ambulance to the hospital;
- (iii) the refrigeration capacity at the hospital mortuary should be increased;
- (iv) there is need to build a new hospital for the District;
- (v) there is need to build capacity in the laboratory by acquiring a new CD4 Count machine;
- (vi) the Government should build an operating theatre at the hospital; and
- (vii) the reported K400 million that was in the bank needs to be utilised to build more staff houses.

(iv) CHOMA GENERAL HOSPITAL

Your Committee were informed that Choma Hospital was the largest Government health facility in the District. Although the buildings were old and not designed for that purpose, it had continued to provide satisfactory health care to the people in the District, whose population stood at 245,000. The hospital had bed capacity of two hundred and eight (208). It had all the departments/sections and wards but had no intensive care unit (ICU).

Your Committee heard that there were plans for the construction of a new hospital. The new hospital would be a prototype of a District Hospital with a bed capacity of one hundred (100). It was, however, not known what would happen to the old structures, particularly the departments that were recently refurbished with modern equipment since the sizes of the rooms of the departments were smaller on the new hospital plan.

Your Committee were informed that the hospital would continue to provide health services through the old hospital buildings since it might take long for the new hospital to be operational. It was explained that the hospital had recently undertaken some projects, among them, electrification of staff houses, renovations of the laundry and some wards, improvements on the drainage system and repairs on the Tata truck. The Hospital Management was also in support of the recommendations and proposals by the Environmental Council of Zambia and the Provincial Environmental Health Specialist concerning the rehabilitation of the hospital sewer system. The estimated cost of rehabilitating the sewer system was K240 million.

Your Committee heard that the funding for the hospital had reduced from K307 million to K122 million and for the District hospital from one hundred and ten million kwacha (K110 million) to sixty nine million kwacha (K69 million). There was very good support from non-governmental organisations, well wishers and the business communities at large. The hospital was receiving assistance of various forms, ranging from construction works, equipment and building materials. Some of the institutions and individuals that were assisting the hospital were as follows:

- Aids Health Foundation (AHF)
- Sight Savers International
- Steinfeld Marketing
- Lahoo Investments
- Choma my Home Town (MHT)
- The Rotary Club
- The Lions Club of Choma
- World Vision Zambia
- Centre for Infectious Disease Research in Zambia (CIDRZ)
- Spar of Choma
- Centre for Disease Control (CDC)

When asked on the patient to doctor ratio, it was stated that on average, one doctor had about thirty (30) patients to attend to, adding that out of fifteen (15) doctors on the establishment, only five (5) were actually available, and out of eighty nine (89) nurses, sixty six (66) were available.

Committee's Observations and Recommendations

Observations

Your Committee observe that:

- the hospital sewer system is a health hazard to the surrounding communities;
- there is an ever increasing number of social and economic activities in the district requiring a corresponding increase in the provision of health services; and
- the reduction in the funding levels are negatively impacting on the operations of the hospital.

Recommendations

In view of the foregoing, your Committee recommend that:

- the Government should release the 240 million kwacha for over-hauling the sewer system at the hospital;
- there is need to build a big hospital with bed capacity of not less than 208 to cater for the increasing demand for health services in the District; and

- there is need to restore the funding levels to what it was at the beginning of the year.

(v) **NAMWALA**

Your Committee were informed that there were only two (2) ART centres in the District because of inadequate staff. According to the 5th National Development Plan, five (5) health posts were supposed to be opened, but due to lack of staff, only one (1) post was opened. There had, however, been a vigorous campaign on the sensitisation of communities on HIV/AIDS since 2005. To that effect, an ART centre called Namwala District Youth Friendly Centre was constructed for the purpose of disseminating information on HIV/AIDS to the youth in the District.

Your Committee also learnt that the Zambia Social Investment Fund (ZAMSIF) provided funds for the theatre, while Danida donated the CD4 Count machine. The CD4 Count machine was, however, not reading the specimen from children and pregnant women correctly.

In the mortuary, only one of the two fridges was working. Your Committee heard that the money which was allocated to buy equipment for the mortuary was misappropriated and investigations had been instituted.

The kitchen had one stove with one plate functioning while the recovery ward for patients who came from the theatre was substandard and not cleaned. It had a lot of cob webs in the roof and the walls were dirty. The storeroom had an assortment of goods all mixed up with drugs. Some expired drugs were found among the drugs that still had shelf life. Your Committee advised that the store room be rearranged to particularly separate the expired drugs from the rest of the drugs.

On the establishment, the District as a whole was operating at 54% capacity. Three quarters of the clinics were run by nurses because there was a critical shortage of clinical officers.

Committee's Observations and Recommendations

Observations

Your Committee wish to make the following observations:

- a) there is a critical shortage of clinical officers in the District;
- b) there is lack of effective management at the hospital; and
- c) your Committee are dismayed at the misappropriation of funds meant for mortuary equipment.

Recommendations

Your Committee, therefore, recommend as follows

- a) the Government should send more clinical officers to the District;
- b) there is need to strengthen management at the institution; and
- c) there is need to follow up the issue of the mortuary fridge which was paid for but not delivered.

(vi) **MUMBWA DISTRICT HOSPITAL**

Your Committee were informed that Mumbwa District Hospital was originally a farm and that the buildings now being used as wards were piggery units. The buildings were later used to isolate and screen people who were suspected to be suffering from sleeping sickness before

it was turned into a small clinic. Currently, Mumbwa had two first referral hospitals (Mumbwa District Hospital and Nangoma Mission Hospital). In addition to the two hospitals, there were twenty three (23) health centres and three health posts, bringing the total to twenty eight (28).

The District hospital operated with three hundred and twenty eight (328) staff, both medical and non-medical, as opposed to an establishment of five hundred and sixty seven (567). The main shortfall was on the medical staff who operated at 39%. The major reasons for the shortage of staff were the non-availability of accommodation coupled with unrealistic housing allowance that were not meeting the demand for house rent. In most cases, staff were forced to share accommodation so that they could pull resources together and afford to pay their rentals.

Your Committee heard that the District had embarked on infrastructure development with a new district hospital being constructed. Two (2) health centres are under construction, with one (1) health post just completed, and two (2) proposed health posts had just been funded. These would bring the total number of health facilities in the District to thirty three (33).

The District hospital structure which started in 2006 is in phase III and would provide for female and children's wards, ten (10) staff houses, drainage and landscaping. So far, phase I and phase II were receiving final touches. Phase II had the kitchen, laundry, Out Patient Department (OPD) block, administration, Male ward, Mortuary and Incinerator.

Committee's Observations and Recommendations

Observations

Your Committee observe as follows:

- a) the building of infrastructure for the new hospital has been slow; and
- b) there is shortage of skilled personnel.

Recommendations

Your Committee, therefore, recommend that:

- a) the Government should ensure expeditious completion of the new hospital so that it is opened before 2011; and
- b) the Government should employ the doctors and nurses needed at the hospital.

(vii) MKUSHI DISTRICT HOSPITAL

Your Committee were informed that Mkushi District Hospital was a residential house which later was donated to the Government and turned into a hospital. There had been a lot of modifications done to try and make it suitable for a hospital, but this was a futile exercise. For example, the registry was housed in a container placed close to the building. The kitchen and the laundry were also not properly located. That was why it became imperative that a new site be found where a good structure could be constructed.

Your Committee heard that there was a critical shortage of staff at the hospital such that one nursing staff could work the whole day and another the whole night. In view of the problem, management had taken the initiative of re-engaging retirees at various health centres. However, the recruited staff were not being put on the payroll and, therefore, stretching the budget of the District office.

Committee's Observations and Recommendations

Observations

Your Committee wish to make the following observations:

- i.** the method of paying staff who are not on the payroll is susceptible to abuse;
- ii.** there is very little effort being made to put the workers on the payroll;
- iii.** work on the new site had not started yet except for one semi-detached house for staff;
and
- iv.** there is a tendency of spreading resources thinly at the expense of completing projects

Recommendations

Your Committee recommend as follows:

- i.** there is need to urgently put all the workers on the payroll;
- ii.** there is need to release enough funds to enable completion of projects that have been initiated; and
- iii.** there is need to build enough staff houses to attract staff to the hospital.

(viii) LUFWANYAMA DISTRICT

Your Committee were informed that Shimukunami Health Centre was built by the Government of Zambia with funds from the World Bank in 1996. The centre was being run by a Sister-in-Charge. Currently, there was an interim establishment which showed vacancies for the positions of a Clinical Officer, a laboratory technician and a stores officer. The laboratory was being run by a classified daily employee who had been trained at Chikankata for two (2) months. She, therefore, had limited knowledge in conducting complicated examinations to the extent that the CD4 Count machine was not being used until such a time that a trained person will be found.

Your Committee heard that the health centre did not have a back-up system for their registry as they had not yet input information in the computers. The Committee noted that it was not safe to maintain records in the manual state as there was a risk of losing them through fire and reminded the staff on the risks involved.

Your Committee were informed that there was construction work going on for a District hospital located near the Boma. However, the Committee observed that the construction project for the District hospital did not include the component of staff houses.

As regards the number of health centres that were offering ART services in the District, the District had fourteen (14) health centres, but due to lack of adequate trained personnel, only four (4) were providing the services.

On the issue of funding, the Director stated that there was a decline in the funding pattern, adding that, last year, K1.6 billion was budgeted for and released while this year only 10% of the budgeted K1.8 billion had been released.

Committee's Observations and Recommendations

Observations

Your Committee observe that:

- the new hospital is being built without the component of staff houses; and

- the District plan does not harmonise the location of the various Government institutions.

Recommendations

Your Committee recommend that:

- the Government should include staff houses in the project for the new hospital; and
- the Government should redesign the plan for the new District headquarters so as to harmonise the location of the various institutions like schools and residential houses.

TOURS RELATED TO THE OPERATIONS OF THE NATIONAL TRUST FOR THE DISABLED

Your Committee visited the following institutions as projects for persons with disabilities who had acquired loans from the National Trust for the Disabled:

- Kanyama Savings and Credit Union;
- Chipata Savings and Credit Union; and
- Buyantanshi Cooperative Society.

Committee's Observations and Recommendations

Observations

Your Committee observe generally that:

- i. some projects can not succeed as the agents who act as advisors lack capacity to administer loans on behalf of the National Trust for the Disabled;
- ii. there is the tendency by persons with disabilities to regard the loans as grants and, therefore, are reluctant to pay back; and
- iii. loanees have problems with paying back especially that they have to start paying back immediately they access the loan.

Recommendations

Your Committee, therefore, wish to recommend as follows:

- i. the National Trust for the Disabled should build capacity in all the loan agents before they engage them;
- ii. there is need to sensitise the persons with disabilities on the importance of repaying the loans; and
- iii. those who access the loans need to be given a grace period for projects to take off before they could start paying back the loan.

PART III

CONSIDERATION OF THE ACTION-TAKEN REPORT FOR 2008

From the Action-Taken Report, your Committee noted the responses to the issues raised in the previous Report. However, the following issues set out below were of particular concern to your Committee.

1. Health-Related Issues

Your Committee request a progress report from the Government on the following: -

- a) lack of appropriate accommodation for health workers in the country;

- b) lack of proper guidelines on the qualification and administration of the retention scheme to the health personnel;
- c) the slow pace of placing staff on the pay roll;
- d) the continuous existence of ghost workers in the Ministry;
- e) the continuous lack of good kitchen and laundry equipment in rural hospitals;
- f) the inability to dispose of expired drugs in a prompt and efficient manner;
- g) the lack of harmonisation of the construction of new hospitals with the increase in the staff establishment to ensure that all health facilities have human resource to run them; and
- h) the lack of policy guidelines on the procurement of uniforms for health personnel.

2. Zambia Agency for Persons with Disabilities/Petition by Persons with Disabilities

Your Committee wish to receive a progress report on the following issues:

- a) appointment of disability focal point persons in all the ministries;
- b) completion of the compilation of a disability database;
- c) phase one (1) of the rehabilitation of the sixteen (16) farm centres throughout the country;
- d) procurement of a vehicle for Chitila farms; and
- e) payment of separation packages to the retired workers.

CONCLUSION

10. Your Committee are indebted to you, Mr Speaker, for appointing them to this Committee and the guidance given to them throughout their deliberations. They further wish to express their gratitude to all the witnesses that submitted memoranda and appeared before them.

Your Committee also wish to express their appreciation to the Office of the Clerk of the National Assembly for the services rendered throughout their deliberations and tours.

August, 2009
LUSAKA

M Habeenzu, MP
CHAIRPERSON