REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE SECOND SESSION OF THE ELEVENTH NATIONAL ASSEMBLY APPOINTED ON 27TH SEPTEMBER 2012

Consisting of:

Brig. Gen Dr B Chituwo, MP, (Chairperson); Ms D Siliya, MP; Mr M Simfukwe, MP; Mr C Mweetwa, MP; Mr O Chisala, MP; Mr M Habeenzu, MP; Mr L Mufalali, MP; and Mr C Matafwali, MP. However, the composition of the Committee changed following the appointment of Mr O Chisala, MP as Deputy Minister and replaced with Mr E Musonda, 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 Eleventh National Assembly.

Functions of the Committee

2.0 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, Mother and Child Health, 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, Mother and Child Health, 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 relating to the Ministries of Health and Community Development Mother and Child Health;

(iv) examine annual reports of the Ministries of Health, Community Development Mother and Child Health, 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 it by the House.

Meetings of the Committee

3.0 Your Committee held ten meetings during the period under review. Your Committee's report is divided into three parts. Part I contains the topical issues on which your Committee undertook a detailed study; Part II is on the Local Tour; and Part III contains the outstanding issues from the Action-Taken Report on your Committee's Report for the First Session of the Eleventh National Assembly.

Committee's Programme of Work

4.0 Your Committee considered and adopted the following programme of work:

(a) consideration of the Action-Taken Report for the First Session of the Eleventh National Assembly;

(b) consideration of Breast and Cervical Cancer in Zambia;

(c) consideration of Diabetes in Zambia;

(d) Local tour to Lusaka, Central and Western Provinces; in order to check on the infrastructure and services being provided for the prevention and treatment of Breast, Cervical Cancer and Diabetes in Zambia; and

(e) consideration and adoption of minutes and draft Report.

Procedure adopted by the Committee

5.0 Your Committee sought both written and oral submissions from relevant Government ministries, Non-Governmental Organisations and interested individuals.

PART I

CONSIDERATION OF TOPICAL ISSUES

TOPIC ONE

BREAST AND CERVICAL CANCER IN ZAMBIA

6.0 Your Committee recognised that cancer diseases in Zambia had significantly increased and had become a major public health concern. In the absence of functional cancer registries in most African countries, Zambia inclusive, population based studies were non-existent, thereby, making it difficult to arrive at prevalence rates of breast and cervical cancer.

It was in this regard that your Committee resolved to undertake a study on breast and cervical cancer in Zambia, with intent to identify the major challenges being faced in the prevention and treatment of breast and cervical cancer in order to recommend the way forward.

In order to gain insight into the topic, your Committee invited as witnesses from among stakeholders, the Government, Non-Governmental Organisations and members of the public as follows:

a) Ministry of Health;
b) Center for Infectious Disease Research in Zambia (CIDRZ);
c) Cancer Diseases Hospital;
d) Churches Health Association of Zambia (CHAZ);
e) Breakthrough Cancer Trust;
f) Zambia Cancer Society;
g) Doctors Outreach Care International;
h) Zambia Medical Association;
i) Traditional Health Practitioners Association of Zambia (THPAZ);
j) Africa Directions; and
k) Mr Martin Sampa, a Special Research Fellow from the University of Zambia.

CONSOLIDATED SUMMARY OF SUBMISSIONS

Your Committee was informed that cancer was a group of diseases that caused cells in the body to change and grow out of control. Most types of cancer cells eventually formed a lump or mass called a tumour, and were named after the part of the body where the tumour originated.

Therefore, breast cancer was a disease characterised by the uncontrollable growth of breast cells or cancer that originated in the breast tissue. This was most commonly from the inner lining of milk ducts or the lobules that supplied the ducts with milk. While the overwhelming majority of cases occurred in women, breast cancer could also occur in men.

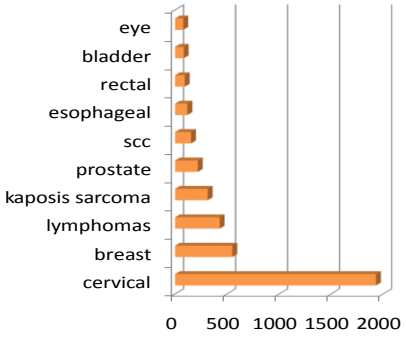
Your Committee learnt that cervical cancer on the other hand, was a cancer of the entrance to the uterus, the cervix, being the narrow part of the lower uterus, often referred to as the neck of the womb.

Overview of Breast and Cervical Cancer in Zambia

Your Committee was informed that the true burden of cancer in Zambia was unknown. However, cervical cancer in Zambia was the commonest cancer seen and contributed thirty to thirty-five percent of all cases presented to the Cancer Diseases Hospital (CDH) and recorded by the Zambian National Cancer Registry. Further, breast cancer was the second most common cancer seen in Zambia after cervical cancer.

CDH Top 10 cancers 2006 -2011

Cancers	No. of Patient	%
cervical	1932	35
breast	551	9
lymphomas	430	7
kaposis sarcoma	315	5
prostate	220	4
scc	155	3
esophageal	120	2
rectal	95	2
bladder	85	2
eye	80	1



Your Committee learnt that the incidence of cervical cancer in Zambia was fifty-two per 100 000 women in the reproductive age group. This was the second highest incidence among Sub-Sahara African Countries as reported by GLOBOCAN in 2008. The mortality rate from cervical cancer in Zambia was forty-four per 100 000 women. This meant that about 1,880 women in Zambia were diagnosed with cervical cancer every year and of these 1,440 would die from the disease.

The age at which cancer patients were presenting in Zambia was between thirty and forty-five years and a second peak was noted after fifty-five years. Your Committee was informed that the two types of cancers were preventable and could be treated or managed if detected at an early stage.

Factors Contributing to Breast and Cervical Cancer

Your Committee was informed that the single most important factor that contributed to breast cancer was the exposure of breast tissue to unopposed oestrogens (excessive oestrogens) over a prolonged period. This could be familial/genetic or acquired. For example, genetic disorders that were passed from mothers to daughters, some familial syndromes that predisposed to increased oestrogen, the use of oral contraceptives, early menarch (early menses), late menopause, having children at an older age or not having children at all.

Your Committee also learnt that obesity, smoking (both primary and secondary), high alcohol intake, diet high in fatty foods, low intake of fruits and vegetables and lack of physical activity were other risk factors for breast cancer.

With regard to cervical cancer, your Committee was informed that the commonest risk factor for developing cancer of the cervix was persistent infection with the Human Papilloma Virus (HPV). This virus resided in the foreskin of uncircumcised men and once sexually transmitted, could cause cancer over a ten to twenty year period of time. Your Committee was also informed that other factors that are attributed to cervical cancer included:

a) severe immune suppression(with the HIV infection, steroids etc);
b) early age at first sexual intercourse;
c) multiple sexual partners;
d) high number of pregnancies;
e) douching;
f) old age;
g) smoking; and
h) low intake of fruits and vegetables.

Stakeholders also submitted that, the lack of cervical and breast cancer screening at any one point in one's life also contributed to increased cancer cases.

Preventive and treatment measures

Your Committee was informed that prevention of breast and cervical cancer was at three levels. These include:

a) primary prevention which was aimed at populations that had not yet been exposed to the disease causing agent; this could be through health education and immunisation with vaccines;

b) secondary prevention was aimed at populations exposed to the disease causing agent, but had not yet developed the disease; for example breast and cervical cancer screening; and

c) tertiary prevention which encompassed early diagnosis and treatment of cases to prevent morbidity and mortality.

Your Committee was further informed that cancer treatment in general include:

a) chemotherapy medicines to kill cancer cells:

b) radiation therapy to destroy cancerous tissue:

c) surgery to remove cancerous tissue; and

d) Human Pappiloma Virus vaccine given to women and is more effective when given before the infection occured.

In view of the foregoing, there were no known vaccines for breast cancer; as a result, self breast examination, breast health education and yearly clinical breast examination were key for early diagnosis in Zambia.

Your Committee was further informed that an analogue mammography machine, which was a special X-Ray examination for breasts, had been installed in the nine provinces of the country. These machines were intended to help in the early diagnosis of breast cancer. Further, in February and

October of every year, the Cancer Diseases Hospital and other cancer associations carried out mass screening for communities at specific locations with lower service delivery staff in order to transfer knowledge. The problem however, was with pathological confirmation of breast cancer from tissues obtained during screening, as the pathology service was still centralised at University Teaching Hospital (UTH), Kitwe Central Hospital, Ndola Central Hospital and Kabwe General Hospital.

Regarding cervical cancer, your Committee was informed that in 2010, the Zambian Government, with support from partners, applied for free Human Papilloma Virus vaccines through the AXIOS sponsored Gardasil Access Program and a school-based Human Pappilloma Virus demonstration project would be rolled out with the goal of vaccinating 50,000 girls aged between nine to thirteen. This would be undertaken under the Ministry of Community Development, Mother and Child Health and was planned for the first quarter of 2013. Once instituted, it would result in a projected seventy percent reduction in the cancer burden within fifteen to twenty years of initiating the vaccine.

With regard to secondary prevention, the Ministry of Health working with supporting partners was offering free cervical cancer screening services in twenty sites and had screened over 90,000 women. The model being used for cervical cancer screening was the 'see and treat' model which was a same day service, also known as Visual Inspection with Acetic Acid (VIA). This model was a low-cost proven methodology in which vinegar was applied to the cervix in order to detect pre-cancerous or cancerous growths.

Accessibility and affordability of treatment

Your Committee was informed that screening services were being provided free of charge at primary health care level so as to reach as many people as possible. Further, mobile hospitals were equipped with screening materials that took the service to remote places. The Ministry of Health was also expanding the treatment of precancerous and cancerous lesions to the provincial health centres so as to reduce the congestion at the Cancer Disease Hospital. In case of invasive cancer, treatment modalities such as chemotherapy and radiotherapy were accessible at the Cancer Disease Hospital. The treatment modalities were, however, accessible for people in urban and peri-urban areas of Lusaka, while patients from other parts of the country had to incur costs to access treatment, in form of travel and living expenses while undergoing treatment.

Regarding breast cancer, screening opportunities were inadequate and treatment was not easily accessible by women who resided in rural areas. Further, modern methods of diagnosis were rare and conservative surgical treatment options (lumpectomy/sentinel lymphnode biopsy) were essentially unavailable within the country, even in urban areas. In addition, operating time was limited in most hospitals together with supplies and consumables needed for surgery.

In addition, each of the nine provinces of the country had one to two general surgeons, but their ability to interpret mammograms and adequately perform mastectomies needed to be verified. Further, Radiographers who were trained to read mammograms were available in the country, but limited job opportunities in Government-operated facilities had not helped the matter. Your Committee also learnt that the country had only one pathologist specialised in breast cancer, that is, the interpretation of fine needle aspirates and core biopsies.

Regarding cervical cancer, stakeholders submitted that the treatment of cervical cancer was accessible through the national referral system that begun from the facility where the patient first presented the case to the highest health institution in the country (UTH) through other second level facilities and subsequently, the Cancer Diseases Hospital. Unfortunately, there was no universal access to screening since screening had started only recently and the roll out currently followed facilities with improved medical services and infrastructure.

Effectiveness of diagnosis and referral systems

Your Committee was informed that infrastructure for the diagnosis and treatment of breast and cervical cancer were heavily overburdened because of the high number of patients against the shortage of specialised physicians. In addition, there were only four to five Clinical Oncologists, one to two formally trained Gynaecologic Oncologists and seven to eight Pathologists in the country. Currently, the country had no surgeons that had received specialised training in breast cancer treatment.

In addition, breast cancer patients who were being screened and found with lumps had difficulties in obtaining histologically confirmed diagnosis since it was this step that was critical for early diagnosis and treatment to attain a cure or long term survivorship. Therefore, patients had to be referred to Central Hospitals in order to have biopsies done and upon confirmation of cancer; they then entered the referral chain to University Teaching Hospital and finally the Cancer Disease Hospital.

Your Committee further heard that the systems of diagnosis and treatment of cervical cancer were fairly robust as they hinged on an already well developed referral infrastructure with the Cancer Diseases Hospital at the top of the referral chain. These systems once integrated, would be able to achieve prevention activities as well as early diagnosis and treatment.

Government Programmes aimed at improving Breast and Cervical Cancer Management

Your Committee was informed that the Cancer Diseases Hospital was instituted to manage cases of cancer locally. Further, Zambian specialists had been trained in the management of cancer diseases and imaging services (Mammograms) had been rolled out to the provincial hospitals.

Furthermore, the Cervical Cancer Prevention Programme in Zambia, in collaboration with the Zambian Government was operating a screening and treatment program for the early detection and treatment of precancerous cervical lesions. To date, over seventy nurses, clinical officers and doctors from around the country had been trained to use VIA (Visual Inspection with Acetic Acid)-based cervical cancer screening.

Your Committee was also informed that the vaccination against cervical cancer was a pilot project that would be implemented in three districts of Lusaka province, involving 50,000 girls in grade four, over a two year period. If the pilot project was successfully completed, Zambia would be eligible to apply for the national roll out of HPV vaccination through Global Alliance for Vaccines and Immunisation (GAVI).

Further, mobile service units had been upgraded with screening equipment to enable women in the most remote places to receive the services. As scaling up the interventions at stationary health facilities was being done, the mobile units would be used to offer these services.

The Ministry of Health was also developing a National Cancer Control Plan were women's cancer prevention and control was one of the main components. The plan would be shared with all stakeholders working in this field in order for activities being done by various partners and stakeholders to complement the Governments effort to ensure that both parties move at the same pace and share common objectives and goals.

In addition, palliative care was an important aspect in the continuum of care and the Ministry of Health was developing guidelines for health centres on palliative care whose main component was pain management.

The Relationship between the Human Papilloma Virus (HPV) and the Human Immunodeficiency Virus (HIV)

Your Committee learnt that about ninety-nine percent of cervical cancer cases were due to infections with the oncogenic Human Papilloma Virus (HPV). This was a sexually transmitted infection that had no symptoms. The HPV persisted in one genital lining for a year and six months and cleared if ones immunity was strong. However, if one continued to have multiple sexual encounters that were unprotected she got re-infected and when clearance was prolonged, this provided ample time to develop cancer at the mouth of the womb. The duration from initial infection with the HPV to the appearance of cancer was between fifteen to twenty years in HIV negative populations. In the presence of HIV, the immunity was weakened and the HPV clearance did not occur, making almost all women with HIV at risk of developing cervical cancer. Further, the duration from the initial infection with the HPV to the appearance of cancer in HIV positive women was five to ten years. In view of the foregoing, HIV infections made ones risk to cervical cancer increase and occur at a much younger age.

Efforts to Raise Awareness on Breast and Cervical Cancer

Your Committee was informed that awareness activities being undertaken included; community sensitisation using community health workers and other volunteers as well as television documentaries. The sensitisation also included other forms of Information Education Communication (IEC) materials such as brochures, posters and drama performances.

Further, your Committee was also informed that awareness campaigns on the risks, symptoms and signs of the cancers were on-going and were intensified during the world cancer days/weeks and the breast cancer month in February and October respectively.

Furthermore, traditional marriage counsellors commonly known as Alangizi/Bana Chimbusa also helped in raising awareness as they were influential and their presence was across the country.

Additionally, civil society and Non Governmental Organisations (NGOs) such as Centre for Infectious Disease Research in Zambia (CIDRZ), Breakthrough Cancer Trust and Zambia Cancer Society, among others, and United Nations agencies such as the World Health Organisation (WHO) and United Nations International Children's Fund (UNICEF) also contributed greatly in advocacy and providing oversight to the country in cancer control activities.

OTHER CONCERNS RAISED BY STAKEHOLDERS

During your Committees interaction with a special research fellow from the University of Zambia, your Committee was informed that soya was linked to breast, cervical cancer and diabetes as it contained phytohormones and other properties which were detrimental to human health and reproduction.

Your Committee was informed that soya had the potential of completely sterilising the entire Zambian population within three generations and was listed in the Poisonous Plant Database where there was over 280 peer reviewed articles appeared warning of its tumourigenesis, carcinogenesis, hormone disruption, and cytotoxic effects.

However, soya was being portrayed as the ultimate health food and had become ubiquitous in the Zambian diet presumably to overcome protein deficiency. It was fed to infants as part of the high energy, high protein supplement (HEPS) in under-five clinics programmes and was also increasingly becoming a standard protein of choice in boarding schools. In addition, soya was found in most foods such as mealie-meal, biscuits, instant soups, margarines, cooking oils and bread. These were made available to every consumer through groceries and supermarkets who were completely unaware of the toxicity in the foods.

Your Committee learnt that the consequences of lax in legislative oversight over the food processing industry were that the nation was experiencing a rapid increase of cases of leukaemia, high blood pressure, diabetes and stroke in addition to high rates of breast and cervical cancer.

In view of the foregoing, your Committee was informed that a policy review, at the highest level, of the continued inclusion of soya in Zambian foods/diet was urgently required.

Committee's Observations and Recommendations

6.1 After consideration of the oral and written submissions from various witnesses, your Committee observes that:

i) Zambia has no National cancer control plan that includes breast and cervical cancer prevention and control;

ii) the ability to expand prevention and treatment services is severely hampered by lack of equipment, human resource and the underdevelopment of the public healthcare infrastructure;

iii) currently, there are few sources of data describing the cancer epidemic in Zambia;

iv) breast and cervical cancer prevention is vertical and not integrated into the existing programmes as was the case with sexual and reproductive health, sexually transmitted infections (STI), oncology, and/or adolescent services;

v) there are no guidelines in the health facilities for the prevention and management of cervical cancer;

vi) awareness on breast and cervical cancer which should serve as a hallmark of prevention is lacking in rural areas;

vii) whereas there is a budget line for cervical cancer treatment by the Government, donor budgets for cervical cancer treatment are tied to HIV/AIDS programmes; and

viii) despite eighty percent of the population seeking traditional medicine initially, the Traditional Health Practitioners Bill which should serve as a tool to implement coordinated efforts in the health service delivery of the citizenry has not yet been presented to Parliament for over eighteen years.

In view of the above observations, your Committee recommends that;

i) the Government should develop a national framework to ensure equitable access for all women to quality services for breast and cervical cancer prevention; further, norms or standards must be developed as the first step for making preventative services available for all women;

ii) the Government must invest in cancer management infrastructure, equipment and human resource country wide for purposes of screening, diagnosis and treatment; furthermore, Government should, as a matter of urgency, monitor the procurement of equipment and supplies both from within and outside the country for the improvement of service delivery and efficiency;

iii) the Government must upgrade the National Cancer Registry to international standards in order to provide critical and on-going surveillance information;

iv) the Government should integrate breast and cervical cancer prevention into the existing Sexual and Reproductive Health, STI, oncology, and/or adolescent services;

v) the Government must engage other stakeholders for the development and dissemination of breast and cervical cancer guidelines to all health facilities in the country;

vi) the Government must ensure that Traditional Birth Attendants who are trained to deliver babies must be educated on breast and cervical cancer as a way of raising awareness in rural areas;

vii) the Government must create a budget line specifically for non-communicable diseases in an effort to address the ever increasing challenges in the management of these diseases; and

viii) the Government must urgently bring to Parliament the Traditional Health Practitioners Bill.

DIABETES IN ZAMBIA

Background

7.0 Diabetes a chronic disease that could cause many serious complications if unattended to, was a public health concern that threatened national health and economic development. Often, it progressed very slowly that by the time many people realised, life threatening complications had occurred. Therefore, in order to be involved and provide leadership at Parliamentary level, your Committee resolved to undertake a study on Diabetes in Zambia.

The overall objective of the study was to identify the major challenges in the management of diabetes in order to recommend the way forward.

In order to ensure that your Committee gathered enough information on this subject, they sought written memoranda and oral submissions from the following stakeholders:

a) Ministry of Health;
b) Center for Infectious Disease Research in Zambia (CIDRZ);
c) Diabetes Association of Zambia;
d) Churches Health Association of Zambia (CHAZ);
e) Doctors Outreach Care International;
f) Zambia Medical Association; and
g) Traditional Health Practitioners Association (THPAZ).

CONSOLIDATED SUMMARY OF SUBMISSIONS

Your committee was informed that diabetes was a condition in which a person had a persistently high blood sugar, either because the pancreas did not produce enough insulin or because cells did not respond to the insulin that was produced. It was a chronic fatal disease and a risk factor for many other conditions such as heart disease, strokes, blindness and amputations.

Your Committee was informed that there was no national prevalence study that had been conducted on diabetes in Zambia. However, according to the Ministry of Health 2008 STEP survey data, the prevalence for impaired glucose level or diabetes was at 4.0 percent; 7.3 percent in urban areas and 2.7 percent in rural areas.

In addition, the International Diabetes Federation 2012, data on diabetes statistics in Zambia was as indicated below.

Table on Diabetes Statistics in Zambia

Prevalence of Diabetes in Adult Population	4.57%
Number of Adults with Diabetes	268,000
Number of Adults with undiagnosed Diabetes	221,390
Number of deaths due to Diabetes	10,535
Mean Health care expenditure per person with Diabetes	USD$ 124.96

Your Committee learnt that the incidence of diabetes was due to rapid urbanisation and westernisation of lifestyle, rapidly decreasing physical activity, changes in dietary habits and ageing of the population among other causes.

Types of Diabetes

Your Committee learnt that there were three main types of diabetes: type one diabetes, type two diabetes and gestational diabetes. The details of the three types of diabetes are reviewed hereunder.

a) Type one diabetes results from insufficient insulin. The body is unable to produce enough insulin for its own needs. Therefore, it requires the person to inject insulin or wear an insulin pump in order to supplement its basic needs. This form of diabetes was previously referred to as "insulin-dependent diabetes mellitus" (IDDM) or "juvenile diabetes".

b) Type two diabetes results from insulin resistance. The body fails to use insulin properly. This condition was sometimes combined with an absolute insulin deficiency. This form was previously referred to as “non insulin-dependent diabetes mellitus” (NIDDM) or "adult-onset diabetes".

c) Gestational diabetes, occurs when pregnant women without a previous diagnosis of diabetes develop a high blood glucose level. This may sometimes precede the development of type two diabetes.

Causes of Diabetes

Your Committee was informed that the causes of diabetes depended on the type. For instance, causes of type One Diabetes was unknown; however, there were associated risk factors, genetic factors and environmental factors. For instance, having a member of a family with type One diabetes increases the chances of developing the condition. In addition, environmental factors such as exposure to viral infections and increased maternal age at delivery were associated with the increased risk of developing type One diabetes.

Your Committee further learnt that several factors associated with the causation of type Two diabetes include: obesity (overweight), low fibre-high fat -salty diet, physical inactivity, increasing age, insulin resistance and family history of diabetes among others.

Regarding Gestational Diabetes, your Committee was informed that this type of diabetes occurs during pregnancy. Pregnant women who were overweight or had a family history of diabetes have increased chances of developing this type of diabetes.

Preventive and treatment measures of Diabetes

Your Committee was informed that Diabetes mellitus was a chronic disease that requires long term management. Management concentrates on keeping blood sugar levels as stable and close to normal (euglycemia) as possible, without causing low blood sugar (hypoglycemia). This could usually be accomplished with lifestyle changes and the use of appropriate medications (insulin in the case of type One diabetes and oral medications with mainly Metformin and Glibenclamide, as well as possibly insulin, in the case of type Two diabetes).

Further, attention has to also be paid to other risk factors that would accelerate the bad effects of diabetes. These include smoking, elevated cholesterol levels, obesity, high blood pressure, and lack of regular exercise.

Accessibility and affordability of treatment

On the issue of the availability and accesibility to treatment, your Committee heard that the 2006 International Diabetes Foundation Report for Zambia found that only seventy-five percent of health facilities in Zambia have a supply of drugs (Insulin) and fifty-four percent of these facilities have testing materials for blood sugar and monitoring facilities. No follow-up has been conducted in the years after 2006, although anecdotally, there had been few changes at the primary and secondary care levels. In addition, your Committee heard that currently, Medical Stores was the only public health sector supplier of both testing kits and drugs.

Your Committee was further informed that access to specialist treatment was only available in some centres. However, specialist clinics usually were not conducted because of the shortage of doctors and health personnel. Additionally, your Committee learnt that Zambia only had one specialised doctor in diabetes, a diabetologist.

Government Programmes aimed at Improving Diabetes in the Country

Your Committee was informed that key programs that the Government had been implementing aimed at combating diabetes were through the Non-Communicable Diseases Programme at the Ministry of Health where issues of the prevention, treatment and control of diabetes were being introduced. In addition, Non-Governmental Organisations and corporate institutions had come on board to screen and treat diabetes as well as its complications (diabetic foot, eye etc.)

Additionally, public awareness campaigns were being initiated as well as the commemoration of the World Diabetes Day. There were also plans to include screening and treatment of diabetes into already existing prevention and treatment programmes aimed at communicable diseases such as HIV/AIDS that had proved to be effective and wide spread in Zambia.

Committee's Observations and Recommendations

7.1 After considering all the submissions, your Committee observes that:

i) the levels of awareness of the diabetes disease among the citizenry is still very low;

ii) lower levels of health care are unable to effectively diagnose and manage diabetes;

iii) there is lack of monitoring and screening supplies of glucometers and glucosticks in most health facilities as well as inadequate supply of medicines;

iv) there are no guidelines in most health facilities for the management of diabetes;

v) there is lack of adequate funding for the implementation of activities directed at the prevention and control of diabetes and other non-communicable diseases;

vi) there are no specialised clinics for diabetes except for tertiary care institutions such as the University Teaching Hospital; and

vii) there are no deliberate policies to promote healthy eating and physical activities in the country.

In view of the above observations, your Committee recommends that:

i) sensitisation programmes on diabetes prevention and healthy lifestyles must be intensified including mobilising of communities to participate in diabetes prevention activities. Further, health education and healthy diet programmes should be introduced in primary and secondary schools in order for it to be part of peoples' lifestyle;

ii) the Government must build the capacity of all health workers on the diagnosis and treatment of diabetes;

iii) Medical Stores Limited must, as a matter of urgency, be supplying institutions with drugs on time, particularly glucometers, glucosticks and other testing reagents; there must also be stronger inventory and tracking systems for these commodities;

iv) the Government must ensure that guidelines and protocols for detection and management of diabetic complications are produced and disseminated;

v) the Government must increase funding for the Non-Communicable Diseases Unit at the Ministry of Health so that interventions and other activities from prevention, care, treatment and research can be conducted;

vi) a concerted effort to ensure that diabetes screening and management is part of primary health services is needed; and

vii) the Government should ensure that physical education in schools is enforced by making it an examinable subject in view of the increase of non-communicable diseases which usually develop as a result of physical inactivity. Further, a deliberate policy must be introduced to have all Government and private institutions meet every afternoon at designated areas for supervised exercise according to age. Furthermore, the Government must establish in its physical planning, community play parks, cycling and walking lanes in cities, towns and residential areas. Your Committee also urges the Government to formulate an awareness campaign on healthy eating habits.

PART II

LOCAL TOUR TO LUSAKA, CENTRAL AND WESTERN PROVINCES

OBJECTIVE

8.0 In its quest to appreciate what was obtaining on the ground, your Committee toured selected health institutions in Lusaka, Central and Western Provinces. The objective of the tour was to assess services being provided for the prevention and treatment of breast, cervical cancer and diabetes in Zambia. Your Committee further held a public hearing at Chieftainess Kabulwebulwe's Chiefdom in Mumbwa District, Central Province.

In line with the objectives of the tour, your Committee toured the following institutions:

(i) Cancer Diseases Hospital, Matero, Kanyama and Chawama Hospitals in Lusaka Province;

(ii) Nangoma Mission Hospital and Mumbwa District Hospital in Central Province; and

(iii) Kaoma District Hospital, Lewanika General Hospital and Senanga District Hospital in Western Province.

a) Breast and Cervical Cancer

8.1 With regard to breast and cervical cancer, your Committee learnt that the level of knowledge on the cancers was very low especially for people in rural areas. Further, the Centre for Infectious Disease Research in Zambia (CIDRZ) was providing free screening services for cervical cancer at the primary health care level. However, there was no universal access to screening except in facilities with improved medical services and infrastructure.

Your Committee further learnt that most institutions visited had inadequate infrastructure to accommodate cervical cancer screening which was conducted using Visual Inspection with Acetic Acid (VIA), a model in which vinegar was applied to the cervix in order to detect pre-cancerous or cancerous growths. Pre cancer lesions that were manageable at clinic level were locally treated using cryotherapy. However, due to lack of medical supplies and equipment such as a specula, head lamp, cameras with enhanced imaging, nitrous gas and lithotomy beds, the ability to perform onsite cryotherapy was difficult. In addition, very few staff were oriented in cervical cancer screening and staffing levels in most health institutions visited were very low.

Your Committee learnt that screening for breast cancer was usually done in Maternal and Child Health Departments during physical examinations of pregnant women, as a routine examination at first antenatal visit. Women were further taught how to conduct breast self examinations during those visits.

The tour by your Committee also revealed that breast cancer patients with lumps had difficulties in getting the diagnosis confirmed. Therefore, patients had to be referred to Central Hospitals in order to have biopsies done. There was also a shortage of pathology laboratories in the country that were adequately equipped to process tissue from biopsy or surgical specimen to confirm cancer.

Your Committee also learnt that patients with invasive cancer were referred to Central Hospitals for further investigations and upon confirmation of the cancers the patients were then entered in the referral chain to the University Teaching Hospital and finally the Cancer Disease Hospital. However, your Committee learnt that the referral system was weak as there was no information flow once a patient was referred from the lower health facility to the higher health facility. The lack of feedback on patients referred to respective higher health facilities deprived staff from lower health facilities from gaining the necessary capacity for improved knowledge and skill.

Your Committee learnt that treatment of the cancers had been centralised in Lusaka and thus access to the services was extremely difficult for most patients because they had to incur a lot of costs to reach the Cancer Disease Hospital. This resulted in the fewer number of referrals from remote areas.

Your Committee also learnt that there were no bed spaces at the Cancer Diseases Hospital which resulted in the Hospital outsourcing a female ward from the University Teaching Hospital. The male patients were scattered in different wards, thereby, overwhelming doctors and nurses during ward rounds. Further, patients on radiotherapy and chemotherapy treatment who did not require ward space incurred huge accommodation costs.

The tour by your Committee also revealed that operational grants to health facilities were inadequate and not received on time. Additionally, limited transportation hampered the referral and outreach programmes. Further, most of the health institutions visited by your Committee did not have a power generator. Those that had were mal-functional, thereby, compromising the operations of the health institutions as well as the quality of health care, given the power outages that the country was currently experiencing.

Other Concerns Raised

Your Committee was informed that despite most health facilities such as Matero, Kanyama and Chawama hospitals having been upgraded to first level hospitals by building theatres and maternity wards, the theatres were of sub-standard. The health facilities had no surgeons, anaesthetics, theatre nurses or surgical wards. Stakeholders, therefore, submitted that consultations were not made with professionals when designing the buildings. In addition, the establishments at the health facilities had not been upgraded despite the transformations, hence, the funded positions were less than the current establishments.

Your Committee acknowledged the Governments good intentions of taking health care as close to the family as possible, however, the creation of more districts would inevitably exacerbate the shortage of health personel unless training of health workers was intensified.

Your Committee also learnt that hospital and health care data was poorly collected and uninformative with regard to non communicable diseases such as breast, cervical cancer and diabetes. Further, information officers at health institutions were not in place to properly collect and manage the data. This impacted negatively on the quality of information that one could draw from health facilities in order to guide decision making and improve service delivery.

The tour by your Committee also revealed that the neighbourhood health committees and other community volunteers greatly assisted health facilities in information dissemination, but the health facilities were unable to give them incentives. This resulted in them being less motivated to provide services.

Some stakeholders were of the view that the issue of user fees be reviewed as the fees enabled health facilities to raise funds that would complement the grants that they were receiving from the Government. Further, the payment of part time health workers was obtained from the fees in order to provide quality health services. Therefore, the absence of the user fees had made the health institutions to fail to attract part time health workers to cushion the inadequate staffing levels. As such, patients were subjected to long waiting lists and poor attendance to their needs due to the shortage of staff. Other stakeholders were, however, of the view that the collection of user fees was in itself not beneficial due to the high poverty levels.

b) Diabetes

8.2 With regard to diabetes, your Committee learnt that the awareness level of the disease was very low in terms of primary, secondary and tertiary prevention and treatment of the disease was not readily available at health facilities except for secondary and tertiary level institutions. Further, most health facilities lacked glucometers and glucosticks for monitoring treatment. In addition, not all health workers in health institutions were properly trained to screen, diagnose and treat the disease. Furthermore, there was an irregular supply of oral diabetic drugs especially oral hypoglycemic medications. The irregular supply of those drugs resulted in some health institutions reducing the right amounts of dosages to be administered. Your Committee further learnt that the irregular supply of those medicines was as a result of the inability of Medical Stores to supply health institutions with drugs on time.

Committee's Observations

8.3 In view of the foregoing, your Committee observes that:

i) follow up mechanisms in the referral system are poorly coordinated and in some places non-existent;

ii) there is poor record keeping in most health facilities thereby compromising the quality and completeness of registered data; in addition, providers charged with the responsibility of handling data are not educated and trained to properly collect and manage data, as well as use it to guide decision-making in order to improve the quality of services;

iii) neighbourhood health committees and other community volunteers who assist health facilities in information dissemination and the general maintenance of health facilities are not given any incentives;

iv) the removal of user fees by the Government from heath facilities has affected the general operations of the health facilities considering the meagre financial allocations from the Government;

v) the removal of the user fees has hampered the health facilities ability to engage part time health workers in an effort of cushioning the inadequate staffing levels being experienced by most health facilities hence affecting the provision of quality health services;

vi) patients from far flung areas who have little resources have to incur costs to travel to and from the Cancer Diseases Hospital for treatment;

vii) there is lack of diagnostic skills among health care workers on breast cancer;

viii) most clinics are being manned by personnel who are not suitably qualified and trained to man the clinics;

ix) mammography machines for screening breast cancer in most provincial centres are defective;

x) the theaters at Kanyama, Matero and Chawama Hospitals are constructed in a sub-standard manner and are currently un-usable;

xi) the coming of the Cancer Disease Hospital has escalated the number of patients being attended to thereby overwhelming the limited health personnel at the hospital; and

xii) the irregular supply of oral diabetic drugs in many primary care facilities particularly in high density areas has resulted in some health institutions reducing the doses of medication to be administered.

Committee's Recommendations

8.4 Based on the above findings, your Committee recommends that:

i) the Government should strengthen referral systems from the lowest health care facility to the higher levels of health care delivery;

ii) existing health information systems and registries must be strengthened in order to ensure effective data collection; further, the Health Information Systems (HMIS) in most health institutions must be upgraded and health information officers positions be created or filled were these exist;

iii) the Government must formulate a care givers policy in partnership with Civil Society Organisations and Non-Governmental Organisations; this will guide and motivate thousands of volunteers in the health system;

iv) the Government must work towards the creation of a health insurance policy mechanism that will cushion citizens who are unable to pay for their health services;

v) the Government must create a fund dedicated for part time workers at health facilities;

vi) the Government should engage the private sector by constructing transit homes like the ones the Breakthrough Cancer Trust was constructing for the under-privileged patients who have to travel to Lusaka with their care givers as well as those who could not occupy hospital beds with acute cancer cases seeking treatment at the Cancer Disease Hospital;

vii) the Government should train health-care workers in breast cancer management and include breast cancer management in the curricula of those in training;

viii) the Government must develop a deliberate policy to ensure that only qualified clinical officers are deployed to man clinics;

ix) the Government must, as a matter of urgency, investigate why most mammography machines being procured and installed are defective;

x) the sub-standard theatres must be redesigned to provide for the barest safety minimum requirements;

xi) the Government should decentralise cancer units in every province which will be supervised by the Cancer Diseases Hospital. Further, in order for this to be effective, the Cancer Diseases Hospital must be transformed into a National Institute for Cancer Diseases under an Act of Parliament; and

xii) the supply chain management system of diabetes medicine and diagnostics must be improved.

Public Hearing

8.5 Your Committee held a public hearing at Chieftainess Kabulwebulwe's Chiefdom in Central Province in order to ascertain the level of awareness on breast, cervical cancer and diabetes and the availability and accessibility of preventive and treatment measures.

About 150 people attended the public hearing and of those, three had suspected cases of cervical cancer while one had suspected breast cancer. Through the public hearing, your Committee learnt that the levels of awareness on breast, cervical cancer and diabetes amongst the rural populace was limited as most people did not know much about the cancers in terms of their signs and symptoms. The participants did not also know where to seek screening and treatment. Further, most local people were not aware of the availability of equipment for the diagnosing of cancer at the Mumbwa District Hospital.

In addition, local people who attended the public hearing thought that cervical cancer only affected the native people of the rural areas, that is, the Ilas and the Kaondes who were not circumcised. It

came to the attention of your Committee that some participants thought that cervical cancer could not be found amongst the older people. Your Committee also learnt that some participants thought that cervical cancer could also be found in men whilst others thought that breast and cervical cancer was caused by contraceptives, particularly injectibles that most women were subjecting their bodies to.

Your Committee learnt that there was some willingness for men to undergo circumcision, however, there were some uncertainties regarding the benefits of circumcision as some men thought that one could die after being circumcised while others were of the view that there was no need for older men to be circumcised.

Through the public hearing, your Committee learnt that Non Governmental Organisations such as Palliative Care Association of Zambia and CIDRZ have conducted some outreach cervical cancer screening and sensitisation. However, these screenings were ineffective as they were not regularly conducted. In addition most women had to travel long distances to acquire the necessary knowledge at the screening sites. Additionally, sensitisation was mainly focused on cervical cancer screening only and women were not educated on the importance of conducting self breast examinations.

Committee's Observations and Recommendations

8.6 Your Committee observes that:

i) the levels of awareness amongst the rural populace with regard to the causes, symptoms and prevention of breast and cervical cancer were very low;

ii) the lack of programmes aimed at sensitising the general public on the dangers of breast and cervical cancer have contributed to the rising cases of the diseases being presented late for treatment;

iii) there is no sensitisation on the importance of women conducting self breast examinations; and

iv) most men did not know the benefits of circumcision.

In view of the foregoing, your Committee recommends that:

i) the Government in collaboration with other organisations involved in the prevention of cancer should as a matter of urgency, scale up the awareness programmes in all the provinces;

ii) the Government should have programmes aimed at sensitising the general public on the dangers of breast and cervical cancer;

iii) concerted efforts in encouraging all women to perform Self Breast Examination (SBE) which could help find abnormal lumps and facilitate early detection of breast cancer while it could still be treated should be strengthened; and

iv) the Government should extend sensitisation on the benefits of circumcision to the rural parts of the country in an effort of curbing the escalating number of non-communicable diseases such as cervical cancer.

PART III

CONSIDERATION OF THE ACTION-TAKEN REPORT ON THE REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE FIRST SESSION OF THE ELEVENTH NATIONAL ASSEMBLY

9.0 Your Committee 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**.**

MATERNAL HEALTH IN ZAMBIA

9.1 Your previous Committee had recommended that the Ministry of Health must engage the Ministry of Finance and National Planning to increase funding towards the maternal health sector.

It was reported in the Action-Taken Report that the Government had taken note of this and also recognised that the creation of the new Ministry of Community Development, Mother and Child Health provided an opportunity to further raise the funding profile for maternal health.

Recommendations

Your Committee requests the Government to explain clearly what activities are being undertaken at the new Ministry to raise the funding profile for maternal health.

9.1.1 Your previous Committee had recommended that in order to achieve the highest possible level of integrated reproductive health, the Government should immediately disseminate the Reproductive Health Policy to all stakeholders.

It was reported in the Action-Taken Report that the Government intended to complete the consensus building process on the Reproductive Health Policy in a timely manner.

Recommendations

Your Committee requests a progress report on the status of the Reproductive Health Policy.

9.1.2 Your previous Committee had recommended that the Government should scale-up access to family planning especially targeting poorer and less educated segments of the population. The increase in the contraceptive prevalence rate would not only reduce the number of unplanned pregnancies, but also reduce the number of induced abortions. Furthermore, the Government should provide for improved family planning methods, choice and mix, especially the uptake of long-term reversible and permanent methods of family planning. This would also provide for a more sustainable contraceptive prevalence across families and communities.

It was reported in the Action-Taken Report that the Government had committed to seeking a doubling of the budgetary allocation intended for family planning in 2013. Strategic planning had been done with the intention of meeting the needs of the underserved population, including rural families, the young and the poorest. The method mix to enhance choice between various methods was being improved with the introduction of more products for long term methods of family planning, as well as building the skills base to perform permanent methods.

Recommendations

The 2013 National Budget indicates that the budgetary allocation towards family planning has reduced significantly from K524,357,874 in 2012 to K132,400,227 in 2013 respectively. Therefore,

your Committee requests the Government to clearly state when it intends to fulfil its previous commitment of doubling the budgetary allocation intended for family planning.

9.1.3 Your previous Committee had recommended that the Government should invest more in developing new infrastructure where it did not exist and refurbish infrastructure that was not functional. The availability of good infrastructure would enable the Government provide quality health services in the most underserved areas of the country.

It was reported in the Action-Taken Report that the Government had taken note of the recommendation as the availability of adequate infrastructure would increase access to health services for families and communities. The Government through the Ministry of Health had developed a detailed infrastructure development plan for 2012 and a total of ZMK180, 191,670,461.73 had been allocated in 2012 towards infrastructure development in the health sector. Further, priority focus on the utilisation of these funds had been made to ensure that facilities were completed and refurbished in order for health services to be administered within a more sustainable environment.

The plan included the rehabilitation and construction of district hospitals in districts without one, as well as the establishment of 650 new health posts countrywide. This plan was intended to mitigate the deficit in health infrastructure in underserved areas of the country.

Recommendations

Your Committee requests a progress report on how many district hospitals have been rehabilitated and constructed and how many of the planned 650 new health posts have been established countrywide.

9.1.4 Your previous Committee had recommended that the Government should enforce strict measures to ensure that as soon as an individual graduated from a public or private health training institution, it was mandatory for them to serve a year in a rural posting. Failure to serve in these rural postings should be accompanied by a penalty.

It was reported in the Action-Taken Report that currently, the Government through the Ministry of Health was enforcing a one year rural posting for medical doctors only. Extending this policy to other professional health workers would be a welcome development as it would greatly help to alleviate the critical shortage of qualified health workers in rural areas.

Recommendations

Your Committee requests a progress report on the extension of the policy to other medical personnel. Your committee further requests the Government to state what it is doing to ensure that the establishment in the health sector is flexible enough to free positions at the point of service delivery specifically for medical personnel who have gone for training for a long period of time.

9.1.5 Your previous Committee had recommended that the Government should develop comprehensive youth friendly sexual and reproductive health services including the full range of contraceptives in order to reduce the increasing number of unwanted pregnancies, abortions and sexually transmitted diseases. Further, the Government should develop a package of care for them covering sexuality education which should be advocated from the family, school and church.

It was reported in the Action-Taken Report that the voluntary nature of work done by youths as peers had proved to be a challenge in ensuring continuity. The Ministry of Health had developed a comprehensive Adolescent Health Policy, and intended to implement it in order to mitigate the reproductive and sexual issues of the youth. The New Ministry of Community Development, Mother and Child Health was also well placed to take up this challenge.

Recommendations

Your Committee requests for a progress report on the implementation of the comprehensive Adolescent Health Policy.

9.1.6 Your previous Committee had recommended that the Government should develop programmes aimed at encouraging men to assume increased responsibility for their sexual behavior in order to protect the health and well being of their partners, existing and potential offspring and the family as a whole.

It was reported in the Action-Taken Report that the Government welcomed the recommendation and that a multi-sectoral approach involving all line ministries to pursue this goal of behavioural change among men had been adopted.

Recommendations

Your Committee requests for a progress report on how many ministries had adopted the multi-sectoral approach.

9.1.7 Your previous Committee had recommended that the regulations under the *Termination of Pregnancy Act* should be updated in line with evolving technologies that provided for more safe options and negated the need for three doctors to sign off, given the extreme shortfall of human resources in the health sector and the unbalanced distribution of physicians nationally.

It was reported in the Action-Taken Report that the Government through the Ministry of Health had already embarked on a process that was aimed at strengthening the legal and regulatory framework in the health sector so as to ensure compatibility with internationally accepted safety standards. The review of the legal and regulatory framework in the health sector was being done in a phased manner. Each year, the Ministry of Health drew up a policy and legislative agenda that identified and prioritised the policies, pieces of legislation and regulations in the health sector that required reviewing, developing, amending and/or repealing.

Recommendations

Your Committee requests for a progress report on whether the regulatory framework under the *Termination of Pregnancy Act* has been updated.

SOCIAL PROTECTION FOR THE AGED IN ZAMBIA

9.2 Your previous Committee had recommended that there was need for a shift in political will in order for the Government to view social protection expenditure as an investment and not as consumption.

It was reported in the Action-Taken Report that the Government was a pro-poor Government that valued social protection as a tool for uplifting the lives of the poor and disadvantaged in society. It was, therefore, viewed as investing in the lives of the Zambian citizens in order to reduce poverty and break its intergenerational transfer.

Recommendations

Your Committee requests the Government to clearly explain the activities that are being undertaken to show that social protection is being treated as an investment and not consumption.

9.2.1 Your previous Committee found Zambia's inability to have a clear policy framework to implement a social protection policy unacceptable as it failed to guarantee equity in service delivery;

and thus, your Committee urged the Government, as a matter of urgency, to formulate a broader social protection policy encompassing both social security and social assistance.

It was reported in the Action-Taken Report that the Government had a policy framework for social protection as espoused in the Sixth National Development Plan which provided direction in the sector. Government was also in the process of developing a multi-sectoral social protection policy with support from the Finnish Government to coordinate all social protection programming in the country.

Recommendations

Your Committee requests for a progress report on the development of the multi-sectoral social protection policy.

9.2.2 Your previous Committee had recommended that the draft National Policy on Aging should be approved and implemented without further delay.

It was reported in the Action-Taken Report that in June, 2012, the Government successfully concluded the stakeholder consultations on finalising the National Policy on Ageing. It was regrettable that it had taken so long to develop, but this was due to a few factors outside the control of the Ministry of Community Development, Mother and Child Health.

Recommendations

Your Committee requests for a progress report on the adoption of the Policy on Ageing.

9.2.3 Your previous Committee had recommended that the Government through the Ministry of Finance should prioritise funding to the Ministry of Community Development, Mother and Child Health so that social protection programmes could be adequately funded and implemented.

It was reported in the Action-Taken Report that with regard to the low levels of funding received by the Ministry of Community Development, Mother and Child Health, poverty reduction had been prioritised by the Government and the Ministry of Finance would be engaged to ensure that adequate resources were provided to the Ministry.

Recommendations

Your Committee requests for a progress report on this matter until concrete steps have been taken.

9.2.4 Your previous Committee had recommended that the Government should devise other ways of raising finances to finance the Social Cash Transfer Scheme. Increased Government funding to the Scheme would ensure Government ownership which was critical to sustain the programme.

It was reported in the Action-Taken Report that the Government under the Ministry of Community Development, Mother and Child Health had created a budget line item for the Social Cash Transfer Scheme. This budget line over the years had been increasing in terms of allocation to match that provided by cooperating partners. Further, there was a joint financing agreement which stipulated how much Government would be contributing to the Scheme so that the Government would be expected to put in more funds than the donor contribution. Furthermore, the Government through the Ministry was also looking at how social protection financing could be financed outside the current funding modalities.

Recommendations

Your Committee requests for detailed information on the comparative analysis of how much the Government and donors are contributing to the Scheme.

9.2.5 Your previous Committee had recommended that the Government should extend the Social Cash Transfer to all parts of the country.

It was reported in the Action-Taken Report that the Committee had observed that the Social Cash Transfer Scheme was donor driven. However, the Government had been making significant efforts in increasing Government funding to the programme. For instance, in 2008 Government's contribution was K0.5 billion and was at K11.5 billion in 2012,with the intention of matching the donor contribution in the coming years as the programme was scaled up to the rest of the country in a phased manner.

Recommendations

Your Committee requests for an update regarding the provinces in which the Social Cash Transfer Scheme has been extended.

9.2.6 Your previous Committee had observed that the needs and challenges facing old people were diverse and dynamic and thus, the Government was urged, as a matter of urgency, to promote extensive research on older persons in Zambia in order to improve and guide programming.

It was reported in the Action-Taken Report that in terms of research on issues affecting older persons, the Government had a wealth of knowledge obtained from HELPAGE International who were the leading organisation in addressing issues of ageing at a global scale. However, local research would be conducted to enrich the one existing at an international level.

Recommendations

Your Committee requests for an update on how many home grown research efforts on the status of aging in Zambia have been undertaken so far.

FOREIGN TOUR TO THE REPUBLIC OF MAURITIUS

9.3 Your previous Committee had recommended that the Zambian Government should demonstrate political will by increasing expenditure on maternal health in order to promote continuous and holistic programming.

It was reported in the Action-Taken Report that the Zambian Government was determined to increase expenditure on maternal health in order to promote continuous and holistic programming.

Recommendations

Your Committee requests the Government to clearly state how expenditure on maternal health will be increased in order to promote continuous and holistic programming.

9.3.1 Your previous Committee had recommended that the Zambian Government should emulate the Republic of Mauritius by developing its own locally grown indicators across the reproductive and maternal health continuum of care in order to monitor its own indictors and follow the progress being made regarding reproductive health. These indicators would also help the Government to identify where the need for intervention would be great.

It was reported in the Action-Taken Report that the Government would undertake a learning visit to the Republic of Mauritius in order to have an appreciation of what was being done in that country on addressing issues of ageing.

Recommendations

Your Committee requests for a progress report on the matter until concrete measures are taken to address your previous Committees concerns.

9.3.2 Your previous Committee had recommended that the Government of Zambia should also invest in infrastructural development as this would take health services closer to the people. The availability of good infrastructure such as good roads and modern health centres would enable expectant mothers' access quality health services in the most underserved parts of the country.

It was reported in the Action-Taken Report that the Government would build 650 health posts with the support of the Indian Government and had continued to build health centres in districts in order to increase access to maternal health. Further, the Government had continued to train and employ health workers who were equipped with skills in emergency obstetric and neo-natal care and had procured equipment for hospitals in fifty districts. Additionally, the Government had embarked on constructing mother's shelters at health centres for women to wait in until they delivered and due to long distances, the Government with cooperating partners had procured bicycle ambulances and motor bike ambulances to transport women in labour to the clinics.

Recommendations

Your Committee requests for an update on which districts the hospital equipment, bicycle and motorbike ambulances have been procured for and mother's shelters constructed.

9.3.3 Your previous Committee had recommended that the Government should invest heavily in sexual and reproductive health research upon which concise decisions would be made based on empirical data.

It was reported in the Action-Taken Report that the Government had taken note of this recommendation on undertaking sexual and reproductive health research. The Government had ear-marked to undertake research with the support from cooperating partners such as UNFPA and WHO focusing on linkages between family planning, reproductive health and HIV/AIDS to mention a few areas of interest.

Recommendations

Your Committee will await an update on whether the research has been undertaken and what the findings are.

9.3.4 Your previous Committee had recommended that the Government should prioritise adolescents' and young women's needs by creating policies, programmes and guidelines to reduce on the impact of unsafe abortion. The Government should further provide comprehensive sexual education and sexual and reproductive health services for young people and should involve them in the implementation process.

It was reported in the Action-Taken Report that in 2008, the Reproductive Health Unit conducted a study in the facilities and communities on the magnitude and consequences of unsafe abortions and this information had been disseminated. Thereafter, the unit went ahead to develop standards and validation guidelines on comprehensive abortion care services. It was important to note that a lot had been done to facilitate safe abortion care in Zambia in comparison to other countries including the provision of a continuum of care. However, the Zambian Law was restrictive on the cadres who could be allowed to provide the Comprehensive Abortion Care. The recommendation from the above mentioned study was that there was need to allow nurses and midwives to be trained in order for them to provide this service as was being done in the post abortion care programme.

Furthermore, in the area of adolescent health services; the adolescent health strategic plan had been developed and some of the initiatives being implemented were:

- revamping or establishment of youth friendly centres where information and services on family planning and other reproductive health issues would be provided;

- strengthening linkages with the Ministry of Education to ensure that the sexual education curriculum was updated and delivered appropriately;

- comprehensive abortion care; guidelines had already been developed and the sensitisation and training of health workers was being done in a phased manner; and

- strengthening collaboration between line ministries such as Ministry of Youth and Sport, Ministry of Health and Ministry of Community Development, Mother and Child Health.

Recommendations

Your Committee will await a progress report on what has been achieved with regard to the above mentioned programmes.

9.3.5 Your previous Committee had recommended that the Government should ensure that sexual and reproductive health services were made accessible, available and affordable at both primary care and referral levels in order to improve women's overall and mortality outcomes visualised by the MDGs.

It was reported in the Action-Taken Report that in order to ensure that sexual and reproductive services were made accessible, available and affordable at both primary care and referral levels, HIV, STI, Malarial and Sexual, Reproductive Health services were integrated into primary health care. Furthermore, the human resource crisis and the increased disease burden created by the HIV/AIDS pandemic had led to an increase in dependence on the community to undertake some of the responsibilities that health workers had been undertaking. The MCDMCH was currently implementing this through Safe Motherhood Action Groups. Communities were being sensitised on the importance of women delivering in health facilities through the Safe Motherhood Action Groups (SMAGS).

In addition, the Government had developed the Campaign to Accelerate Reduction in Maternal Mortality (CARMMA) and follow up activities to sustain life saving interventions. This initiative was meant to allow for a focused approach to mainstream women's survival, and utilize a multi-sectoral approach, with the involvement of the Private Public Partnerships and civil society. However, the Government was aware that in most instances these health centres were not closer to the communities and would endeavor to establish additional centres.

Recommendations

Your Committee requests an update on the establishment of additional health centres.

9.3.6 Your previous Committee had recommended that the Government should take significant steps to establish a registration system for the number of maternal live births to deaths and the causes of death; the consistency in these statistics would help the Government identify gaps that needed immediate attention.

It was reported in the Action-Taken Report that in an effort to establish a registration system for the number of maternal live births to deaths and causes, the Ministry was strengthening Maternal Death Reviews (MDRs) at all levels from community to the referral Hospitals. A maternal death review was

the construction of events that lead to the death of a pregnant woman from the community to the health facilities (hospital or clinic). Thus, factors that led to the death of a pregnant woman were elucidated at community level, health centre level and hospital level. This in turn made interventions more focused.

All the Provinces had Maternal Death Review (MDR) committees set up at provincial, district, health centre and community level. Maternal deaths were in the process of being notifiable just like other diseases such as Tuberculosis (TB) or cholera. Therefore, the Government would have more accurate data on the magnitude of the problem and the progress that was being made in addressing maternal mortality.

Recommendations

Your Committee notes the response, but urges the Government to initiate a legislative framework that will compel the collection of Maternal Death Reviews.

SOCIAL PROTECTION FOR THE AGED

9.4 Your previous Committee had recommended that the Government should increase the budget allocation for the Ministry of Community Development, Mother and Child Health in order to facilitate the implementation of various programmes and policies.

It was reported in the Action-Taken Report that the Ministerial budget over the years had been growing; however, the Government would engage the Ministry of Finance to ensure that the budgetary allocation was based on need rather than on ceilings.

Recommendations

Your Committee requests for a progress report on what has been achieved as a result of the Government and the Ministry's engagement.

9.4.1 Your previous Committee had recommended that the National Policy on Ageing in Zambia should immediately be approved by Cabinet in order to implement coordinated efforts to address the plight of the aged. This policy should be frequently updated in order to define new programmes and strategies concerning the welfare of the aged.

It was reported in the Action-Taken Report that the draft National Ageing Policy would be approved before the end of the year and would be updated after every five years to incorporate emerging issues.

Recommendations

Your Committee requests for a progress report on this matter.

9.4.2 Your previous Committee had recommended that the Government should emulate the Republic of Mauritius by creating a medical unit at the Ministry of Community Development, Mother and Child Health.

It was reported in the Action-Taken Report that discussions were underway on setting up a medical unit at the Ministry. The Government was discussing modalities with the Ministry of Health and the Ministry of Community Development, Mother and Child Health on how the unit could be set up.

Recommendations

Your Committee requests for a progress report on the setting up of the medical unit at the Ministry.

9.4.3 Your previous Committee had recommended that social protection for the aged in Zambia should be a shared responsibility between the Government and cooperating partners with the Government taking the lead. The private sector should be allowed to run old age homes under the guidance of the Ministry of Community Development, Mother and Child Health. These homes should be managed by trained care givers and frequently monitored by the Ministry.

It was reported in the Action-Taken Report that Government was in the process of developing guidelines for institutions running old people's homes. Currently, a number of old people's homes were run by the churches and the Ministry of Community Development, Mother and Child Health supervised the homes and provided them with guidance on how to run the homes. However, the private sector would be engaged to ascertain how they could support the running and setting up of old people's homes.

Recommendations

Your Committee requests for a progress report on the development of the guidelines for institutions running old people's homes and whether the private sector has been engaged in the running and setting up of old people's homes.

9.4.4 Your previous Committee had recommended that the Government should offer training in gerontology and ensure that people working with elderly persons in old age homes were trained carers.

It was reported in the Action-Taken Report that training in gerontology would be offered after consulting the Ministry of Health if the course was offered locally. If it was not then this would be discussed at the learning visit which would be undertaken to Mauritius.

Recommendations

Your Committee requests for a progress report on whether the course is being offered locally.

CONSIDERATION OF THE ACTION-TAKEN REPORT ON THE COMMITTEE'S REPORT FOR THE FIFTH SESSION OF THE TENTH NATIONAL ASSEMBLY

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

The Status of Mental Health Services in Zambia

10.1 Your previous Committee had requested for a progress report on the findings of the Technical Working Group.

It was reported in the Action-Taken Report that instead of having each area in the health sector that required policy intervention to have a specific national policy, the Ministry of Health had opted to develop a comprehensive National Health Policy which would include a chapter on mental health services in the country with specific goals, objectives and policy measures that Government intended to implement in the area of mental health services. The findings of the Technical Working Group had already been noted and had since been incorporated in the overarching National Health Policy that the Ministry of Health had developed. Further, a cabinet memorandum had already been submitted to Cabinet Office to request for approval of the National Health Policy.

Recommendations

Your Committee will await an update on the status of the National Health Policy.

10.1.1 Your previous Committee had requested to know when the New Mental Health Bill would be presented to Parliament.

It was reported in the Action-Taken Report that the processing of the new Mental Health Bill had progressed well and a cabinet memorandum had been submitted to Cabinet to request approval in principle to repeal the Mental Disorders Act and introduce the new Mental Health Bill in Parliament.

It was however, difficult at this stage to indicate the exact date when the Bill would be introduced in Parliament. However, it was the intention of Government to introduce the Bill in Parliament once all the legislative approval procedures had been completed for the Bill to be introduced in Parliament preferably by 2013.

Recommendations

Your Committee will await a progress report on the introduction of the Bill to Parliament

10.1.2 Your previous Committee had requested detailed information on the comparative analysis of the 2011 and 2012 mental health sector budgets in order to confirm that the funding was considered in the planning cycle.

It was reported in the Action-Taken Report that funding to the health sector had increased from ZMK1.8 trillion to ZMK 2.4 trillion in 2011 and 2012 respectively. In terms of mental health and in particular Chainama Hills College Hospital, there had been an increase from ZMK2,899,772, 518 to ZMK 4,301, 967, 716 in 2011 and 2012 respectively. These funds were for the rehabilitation and extension of mental health service delivery.

Recommendations

Your Committee requests for information on how much work has been done with these increments.

10.1.3 Your previous Committee had requested a progress report on the rolling out of the rehabilitation of infrastructure to other provinces and the establishment of rehabilitation centers.

It was reported in the Action-Taken Report that the programme for the rehabilitation of mental health infrastructure would be rolled out to other provinces in the 2012 to 2015 Medium Term Expenditure Framework. The first phase of this programme would include Livingstone General Hospital, Chipata General Hospital and Ndola Central hospital.

The Government through the Ministry of Health had disbursed Zambian ZMK 700,000,000.00 to Ndola Central Hospital and another ZMK 700,000,000.00 to Livingstone General Hospital for the rehabilitation of the mental health units at these two major health facilities.

Further, a mental health unit was being constructed at Solwezi General Hospital at a cost of ZMK 2,000,000,000.00.

Recommendations

Your Committee requests for a progress report on when the rehabilitation of mental health infrastructure will be rolled out to other provinces and the progress made on the rehabilitation of the mental health units at the two major health facilities as well as the construction works at Solwezi General Hospital.

10.1.4 Your previous Committee requested a progress report on the re-designing of the facilities

It was reported in the Action-Taken that the Government through Ministry of Health had re-designed the new district hospitals that were being constructed in some districts countrywide. The new district hospitals would have a mental health unit built in order to improve access to mental health services.

Recommendations

Your Committee requests the Government to state clearly the district hospitals that have been re-designed and whether mental health services have been taken into consideration.

PROVISION OF EDUCATION TO THE DEAF IN ZAMBIA

10.2 Your previous Committee requested a progress report on the review of the policy in order to address the concerns raised.

It was reported in the Action-Taken Report that the Government started the process of reviewing the education policy 'Educating the Future' in August, 2011 and had come up with a draft policy which was ready for consultation with stakeholders. However, shortly before the consultation process was undertaken, the new Government came into office with its manifesto whose aspirations had to be incorporated into the policy. In addition, the Ministry was merged with the former Ministry of Science, Technology and Vocational Training which had two major policies that were also undergoing the review process.

The new Ministry of Education, Science, Vocational Training and Early Education had to start the harmonisation process of the existing policies and the new Government's aspirations which had resulted into a draft policy document which was being considered by senior management before it was subjected to stakeholders for consultations.

Recommendations

Your Committee requests for a progress report on the matter in order to address the concerns raised.

10.2.1 Your previous Committee had requested for further information on what was being done on the revision of the training curriculum for other training institutions such as the University of Zambia and the Copperbelt Secondary Teachers' College (COSETCO).

(a) **The University of Zambia**

It was reported in the Action-Taken Report that the revision of the curriculum for specialisation in Braille and Sign language was underway. The proposed revision had already been approved by the School of Education and had been submitted to the University Senate for ratification.

(b) **COSETCO**

It was reported in the Action-Taken Report that the revision process was yet to commence for COSETCO.

Recommendations

Your Committee requests for an update on the ratification of the proposed revision of the Curriculum by the University of Zambia Senate and the commencement of the revision process of the Curriculum at COSETCO.

10.2.2 Your previous Committee had requested for a progress report on the building of resource centres in all schools and the expansion of the Zambia Institute for Special Education.

It was reported in the Action-Taken Report that the first phase of building the lecture block, library and lecture theatre had been done. Other phases yet to be undertaken will include construction of an ablution block, staff houses, assembly hall, specialised rooms and a tutorial block.

Recommendations

Your Committee requests for a progress report on the specific schools where the infrastructure has been put up as well as the other phases that are yet to be undertaken.

10.2.3 The previous Committee had requested the Government to state clearly whether an official sign language had been adopted and whether its adoption was arrived at through wider consultations with stake holders.

It was reported in the Action-Taken Report that the official sign language had not yet been decided although there was the Zambian Sign Language Dictionary. The Ministry was drafting a sign language syllabus to be used in schools. This would standardise the language. Consultations with relevant disability organisations and other stakeholders would be held soon after completion of the draft syllabus for sign language.

Recommendations

Your Committee requests for a progress report on the status of the syllabus

10.2.4 Your previous Committee had requested for a progress report on the construction of special boarding schools in all provinces as well as the Center of Excellence.

It was reported in the Action-Taken Report that the progress on construction works at Munali Center of Excellence were as follows:

- Classroom Area – Sub-structure works were in progress i.e. from excavations to slab casting.
- Teachers/Ancillary Staff Houses – At lintel level.
- Fencing is at 90% level and about to be completed.

The contract started on 30th December, 2011 and was expected to be completed on 30th June, 2014.

However, the construction of special boarding schools in all provinces was an on-going programme and in Lusaka Province, the construction of Faith Baptist School, (Special Boarding School) had begun and was at foundation footing level. The construction was expected to be completed by 2013. The contract started on 24th October, 2011 and was expected to be completed on 2nd December, 2013.

Recommendations

Your Committee requests for an update on the construction of special boarding schools in the remaining provinces and the progress made on the construction works that have already commenced.

10.2.5 Your previous Committee had requested the Government to provide more information on the status of the review of the curriculum.

It was reported in the Action-Taken Report that orientation of the new syllabi in piloted schools had already started. So far Lusaka and Kafue had been completed while officers were currently in the field in Northern Province.
The sign language syllabus had been developed awaiting testing and approval with a view of implementing it in 2014.

As regards practical skills, there was nothing specifically designed for the deaf. However, the general curriculum provided for adaption to suit learners with disabilities in general and the deaf in particular.

Recommendations

Your Committee requests for a progress report until the syllabus is implemented in 2014.

CONSIDERATION OF THE ACTION-TAKEN REPORT ON THE COMMITTEE'S SECOND REPORT FOR THE FOURTH SESSION OF THE TENTH NATIONAL ASSEMBLY

The Role of the Department of Community Development in Poverty Reduction

11.0 Your previous Committee had requested for an update on how many districts the recruitment process and the procurement of vehicles had been done and when the recruitment process and procurement of reliable transport would cover the rest of the country.

It was reported in the Action-Taken Report that the Government was not in a position to recruit, on account that most vacancies had been frozen by Public Service Management Division. This was due to the high turnover of staff as a result of resignations and transfers. The recruitment process would only be completed once authority to recruit was granted as they were currently frozen. With regard to the procurement of motorised transport, this was being done in phases due to financial constraints. In 2012, under the Department of Community Development, the Ministry budgeted to procure twenty-five additional vehicles, however, treasury authority was being awaited from Ministry of Finance.

Recommendations

Your Committee will await a progress report on the matter in order to address previous concerns raised**.**

11.1 Your previous Committee had requested a progress report on the implementation of the Management, Information, Monitoring and Evaluation Systems.

It was reported in the Action-Taken Report that the Management Information, Monitoring and Evaluation System had been designed and currently its implementation would be piloted on the social cash transfer implementing districts starting with Luwingu, Serenje, Kaputa, Kalabo and shangombo. At the moment the Ministry was preparing training modules for officers who would be using the Management Information, Monitoring and Evaluation System. After the piloting phase it would then be rolled out to other ministerial programmes.

Recommendations

Your Committee requests for a progress report on whether the Management Information, Monitoring and Evaluation System had been rolled out to other ministerial programmes.

CONSIDERATION OF THE REPORT OF THE AUDITOR-GENERAL ON MEDICAL WASTE MANAGEMENT IN ZAMBIA

11.2 Your previous Committee requested further clarification on the ZEMA assessment of the compliance levels for 2011, as it had not been addressed. The Committee further requested a progress report on the recruitment of environmental health staff at all health facilities in line with the approved Ministry of Health establishment structure.

It was reported in the Action-Taken Report that the Zambia Environmental Management Agency (ZEMA) regulated the management of health care waste, namely generation, storage and transportation of health care waste through licensing of health facilities. This was done through issuing of licenses with conditions. These licenses were classified according to the level of pollution being produced. They ranged from Class I, which was the highest polluting class to Class IV which was the lowest polluting class. ZEMA also monitored the operations of the incinerators at all health facilities countrywide.

Air permits were issued for the incinerators and these were classified in four classes (class I to class IV). All health facilities in Zambia fell under Class IV which was the lowest polluting class for generation, storage and transportation of health care waste and air permits. The average for compliance in the year 2011 was forty-one percent. To further enforce the provision of the Statutory Instruments, ZEMA came up with the technical guidelines on the management of health care waste.

Furthermore, the establishment for environmental health personnel was 2,063. In post was 1380 and the gap was 683. In 2011, the Ministry of Health recruited eighty-five Environmental Health Technologists (EHTs) and in 2012, 60 EHTs had been recruited. The need for EHTs in all health facilities was still huge but the capacity to have adequate numbers of EHTs in the health facilities was limited by low outputs from training institutions.

Committee's Observations and Recommendations

Your Committee requests information on why there is low output from training institutions and what the Government is doing to increase the number of staff.

11.2.1 Your previous Committee requested an update on how many provinces and districts where the incinerators were installed and further requested a progress report on the funding of the second phase of the procurement and installation of incinerators in the remaining institutions by the World Bank and World Health Organisation.

The incinerators were installed in all the ten provinces as follows:

S/N	Province	District	Health Facility
01	Southern	Livingstone, Namwala and ItezhiTezhi	Livingstone General Hospital, Batoka Hospital, Namwala and Itezhi Tezhi Hospitals
02	Northern	Kasama	Kasama General Hospital
03	Muchinga	Chinsali	Chhinsali District Hospital
04	Luapula	Mansa, Kawambwa	Mansa General Hospital, Kawambwa District Hospital
05	Western	Sesheke, Mongu, Lukulu, Kaoma, Senanga	Lewanika General Hospital, Sesheke, Lukulu, Kaoma and Senanga District Hospitals
06	Central	Kabwe, Mkushi, Mumbwa and Chibomba	Kabwe General Hospital, Mkushi, Chibombo, Mumbwa Dsitrict Hospitals
07	Lusaka, Luangwa	Lusaka, Luangwa	University Teaching Hospital (02), Levy Mwanawasa General Hospital, Luangwa Boma, Kalingalinga, Mtendere, Kamwala, Chelstone, Chipata, Matero, Kamwala, Chilenje and Chawama Health Centres
08	Copperbelt	Kitwe, Ndola, Chingola	Kitwe Central Hospital, Arthur Davison Children Hospital, Ndola Central Hospital, Chingola North General Hospital
09	Eastern	Chipata, Nyimba, Lundazi, Petauke	Chipata General Hospital, Nyimba, Lundazi, Petauke District hospitals
10	North-Western	Kasempa, Solwezi, Zambezi	Solwezi General Hospital, Mukinge Mission Hospital, Zambezi District Hospital

The funding for the second phase of the procurement and installation of incinerators in the remaining institutions had not been made available by the World Bank and the World Health Organisation.

Recommendations

Your Committee will await a progress report on the status of second phase of the procurement and installation of incinerators in the remaining institutions.

11.2.2 Your previous Committee requested a progress report on the findings of the Technical Working Group.

It was reported in the Action-Taken Report that the Government through Ministry of Health was still undertaking extensive consultations with both internal and external stakeholders on the review of the Public Health Act. The consultations were progressing well as the Ministry of Health was still receiving active support and participation from all key stakeholders.

Further, under the business licensing reforms that the Government was currently implementing, the Public Health (Amendment) Bill, 2012 had been proposed. However, this proposed piece of legislation was still at consultation stage and consensus was yet to be built with all key stakeholders.

Recommendations

Your Committee will await a progress report on the revision of the Bill and when it is expected to be presented before Parliament.

11.2.3 Your previous Committee requested a progress report on the development of the National Health Policy and whether the policy had been submitted to Cabinet Office for approval.

It was reported in the Action-Taken Report that the development of the National Health Policy had been completed and the Draft National Health Policy had been submitted to Cabinet Office for approval. The implementation of the National Health Policy would only commence after Cabinet had approved the draft National Health Policy.

Recommendations

Your Committee will await a progress report on the status of the National Health Policy**.**

FOREIGN TOUR (MAPUTO, MOZAMBIQUE)

11.3 Your previous Committee requested a progress report on the matter.

It was reported in the Action-Taken Report that in June 2012, the draft Rural Finance Policy had been developed by the consultants. However, the Ministry expressed concern that the draft policy did not include or address issues of gender, poverty and other cross-cutting issues. The consultants had assured the Ministry that the cross-cutting issues would be incorporated in the draft policy. A stakeholders meeting had been planned to validate the draft policy before submission to Cabinet Office for approval.

Recommendations

Your Committee will await a progress report on whether the cross-cutting issues have been incorporated in the draft policy and whether the draft policy has been submitted to Cabinet Office for approval.

11.3.1 Your previous Committee requested a progress report regarding the areas in which the Government had established livestock extension service centres.

It was reported in the Action-Taken Report that the Ministry of Community Development, Mother and Child Health continued to receive veterinary and extension services at the livestock extension service centres.

Recommendations

Your Committee will await a progress report on which districts the Government has established livestock extension service centres under the Ministry of Community Development, Mother and Child Health**.**

11.3.2 Your previous Committee requested a progress report on this issue.

It was reported in the Action-Taken Report that the Government had not yet formulated a Memorandum of Understanding between the Ministry of Agriculture and Cooperatives and the Ministry of Community Development, Mother and Child Health on linking farmers to the Food Reserve Agency where they could sell their produce.

Recommendations

Your Committee will await a progress report on whether a Memorandum of Understanding has been made between the two Ministries on linking farmers under the Food Security Pack Programme to Food Reserve Agency.

11.3.3 Your previous Committee requested a progress report on the decentralisation of the grants system.

It was reported in the Action-Taken Report that the Government through the Department of Community Development had commenced the process to decentralise and started with developing guidelines on how the funds would be administered through the provincial and district offices. At the moment, headquarters was receiving feedback from the District and Provincial officers on the guidelines. Once the guidelines had been finalised a training workshop would be held to equip the officers on these new roles that they would be required to perform.

Recommendations

Your Committee will await a progress report on the current status of the decentralisation of the grants system.

OTHER OUTSTANDING ISSUES

11.4 Your previous Committee requested a progress report on this matter.

It was reported in the Action-Taken Report that the construction of phase I of Choma General Hospital was about to be completed. Phase II of the construction of the hospital would encompass the rehabilitation of the mortuary, construction of two wards and an overhaul of the sewer system at the hospital. Phase II which would include overhauling of the sewer system at the hospital was planned for commencement in the year 2013.

Recommendations

Your Committee will await a progress report on the matter.

11.4.1 Your previous Committee requested an update on whether the Ministry of Health had recovered the funds from Zubala Enterprises intended to purchase a mortuary unit at Namwala District Hospital.

It was reported in the Action-Taken Report that the recovery of funds amounting to K64, 362,500.00 from Zubala Enterprises was an issue that was still being handled by the Anti-Corruption Commission; and the Ministry of Health was still awaiting the outcome on the matter from the Attorney-General's Chambers.

Recommendations

Your Committee will await a progress report until the funds are recovered.

11.4.2 Your previous Committee requested an update on whether the supplier had been paid and whether the equipment had been delivered.

It was reported in the Action-Taken Report that the full contract amount as earlier reported for the supply of general hospital equipment was US$ 2,937,586.88. The Ministry of Health paid TECFAB Inter-Medical of India an advance of US$ 1,999, 718.19. The breakdown of equipment to be supplied under this contract was as follows:

(i) Theatre equipment—US$ 1,096,147.74

(ii) Intensive Care Unit—US$ 1,027,551.21

(iii) Kitchen equipment—US$ 313,289.88

(iv) Mortuary equipment—US$ 500,598.05

The supplier was paid for supplying and delivering equipment under (i) and (iv) above in full. The payment for equipment under (ii) above was reduced to US$ 793,947.32 as the supplier did not deliver the Blood gas analysers costing US$ 313,289.88. Further, the Kitchen equipment was not delivered and no payment was made for equipment under (iii) above.

Your Committee noted that the supply and delivery of the blood gas analysers and kitchen equipment had been re-advertised.

Committee's Observations and Recommendations

Your Committee will await a progress report on whether the blood gas analysers and kitchen equipment had been supplied and delivered.

CONCLUSION

12.0 Your Committee is grateful to you, Mr Speaker, for the support rendered to it throughout the year.

It is indebted to all the stakeholders who appeared before it for their co-operation in providing the necessary memoranda and briefs.

Your Committee is very hopeful that the observations and recommendations contained in this report will go a long way in improving the treatment of Breast and Cervical Cancer and Diabetes in Zambia.

Finally Sir, your Committee wishes to express its appreciation to the Office of the Clerk of the National Assembly for the invaluable and tireless assistance rendered throughout its deliberations.

June 2013
LUSAKA

Brig.Gen. Dr. B Chituwo, MP
CHAIRPERSON

APPENDIX

List of Officials

National Assembly
Mr S M Kateule, Principal Clerk of Committees
Mr S C Kawimbe, Deputy Principal Clerk of Committees
Ms M K Sampa, Committee Clerk (SC)
Ms C Malowa, Assistant Committee Clerk
Ms S Kayawa, Typist
Mr R Mumba, Committee Assistant
Mr C Bulaya, Committee Assistant