REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES FOR THE THIRD SESSION OF THE ELEVENTH NATIONAL ASSEMBLY APPOINTED ON THURSDAY 26TH SEPTEMBER, 2013

Consisting of:

Brig Gen Dr B Chituwo, MP (Chairperson); Mr C J Antonio, MP; Mr M Habeenzu, MP; Mr C Matafwali, MP; Mr L Mufalali, MP; Mrs I M Mphande, MP; Mr E C Musonda, MP; and Mr M Simfukwe, MP.

Following the appointment of Mrs I M Mphande, MP as Deputy Minister, the membership of the Committee was reduced to seven (7).

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir

Your Committee has the honour to present its Report for the Third 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 to-

a) 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 portfolio;

b) carry out detailed scrutiny of certain activities being undertaken by Ministries of Health and Community Development, Mother and Child Health, departments and/or agencies under their portfolio and make appropriate recommendations to the House for ultimate consideration by the Government;

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

d) examine annual reports of Government ministries and departments under their portfolio 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

e) consider any Bills that may be referred to it by the House.

Programme of Work and Meetings of the Committee

3.0 Your Committee carried out the following activities in line with its programme of work for the period under review:

a) consideration of topical issues:

(i) the Health Insurance System in Zambia; and
(ii) Availability and Uptake of Family Planning Services in Zambia;

b) foreign study tour of Ghana;

c) consideration of the Action-Taken Report on the Report of the Committee for the Second Session of the Eleventh National Assembly; and

d) consideration of the Committee's Report for the Third Session of the Eleventh National Assembly.

In this regard, your Committee held seventeen meetings to execute its programme of work besides undertaking a foreign tour of Ghana.

Procedure adopted by the Committee

4.0 Your Committee requested detailed written memoranda on the topics under consideration from relevant stakeholders. The stakeholders also appeared before your Committee and made oral submissions.

Report of the Committee

5.0 Your Committee's Report is in three parts. Part I highlights the findings of your Committee on the Health Insurance System in Zambia and the Operations of Ghana's Public Health Insurance System. Part II presents your Committee's findings on the Availability and Uptake of Family Planning Services in Zambia while Part III reviews the Action-Taken Report on the Report of your Committee for the Second Session of the Eleventh National Assembly.

PART I

THE HEALTH INSURANCE SYSTEM IN ZAMBIA

6.0 Health insurance is insurance against medical expenses and loss of earnings due to accident or illness. This may cover individuals only or extended to their dependants. Health insurance schemes may be compulsory or voluntary, and their cost may fall on individuals or on their employers[1].

Health insurance has been associated with some benefits to the citizenry and society as a whole. The benefits include, among others, improved accessibility of healthcare services and providing a more sustainable way of financing health care services. Health insurance can be provided by both the private and public sectors.

In Zambia, provision of health insurance has largely been left in the hands of private health insurers. However, concern has been raised that private health insurance providers are not properly regulated to ensure adherence to minimum standards. In addition, there seems to be no clear policy and legislation governing the provision of health insurance in Zambia.

In order to appreciate these concerns and identify areas needing policy intervention, your Committee resolved to undertake a study on the Health Insurance System in Zambia whose objectives were to:

a) ascertain the policy, legal and regulatory environment governing the provision of health insurance in Zambia;

[1] Oxford Dictionary of Economics, 1997

b) appreciate the current system of public and private health insurance in Zambia;

c) appreciate the operations and constraints affecting the effective provision of public and private health insurance in the country;

d) understand the effect of health insurance, or lack thereof, on access to health facilities by the individual citizens;

e) understand the impact that an effective health insurance system, or lack thereof, can have on the Zambian society as a whole; and

f) make recommendations on possible improvements to the health insurance system in the country.

The following institutions made both written and oral submissions on the subject:

a) Ministry of Health;
b) Ministry of Community Development, Mother and Child Health;
c) Pensions and Insurance Authority;
d) Madison Health Solutions;
e) Promed Health Insurance;
f) Lusaka Trust Hospital;
g) Fairview Hospital;
h) Sancare Health Insurance Scheme;
i) Zambia Federation of Employers (ZFE);
j) Workers' Compensation Fund Control Board;
k) Treatment, Advocacy and Literacy Campaign (TALC); and
l) Competition and Consumer Protection Commission.

CONSOLIDATED SUMMARY OF STAKEHOLDERS' SUBMISSIONS

The Policy, Legal and Regulatory Environment Governing the Provision of Health Insurance in Zambia

6.1 Your Committee was informed that Zambia does not have a stand-alone policy on health insurance and there is no explicit reference to health insurance in the current law, the *Insurance Act, No. 27 of 1997*. The Pensions and Insurance Authority (PIA), which is the regulatory authority, categorises health insurance as long-term insurance. Thus, it is treated as such even for purposes of regulation.

Stakeholders further informed your Committee that the inadequate provisions for health insurance in the law had negatively affected the sector in terms of compliance and quality of service. Some health insurance providers were not registered and therefore were not regulated by the Pensions and Insurance Authority. On the other hand, some insurers were not offering the minimum standard package of benefits.

The Current System of Public and Private Health Insurance in Zambia

6.2 Stakeholders submitted to your Committee that public health insurance does not exist in Zambia. However, your Committee learnt that there were plans by the Executive to establish a National Social Health Insurance Scheme. In this regard, significant steps had been taken to develop the social health insurance component within the overall health care financing strategy. It was further planned that a National Social Health Insurance Management Authority would be established to manage the Scheme and provide comprehensive health care benefits aimed at reaching universal coverage.

Your Committee was also informed that the Government had consulted widely with various stakeholders on the establishment of the National Social Health Insurance Scheme. Further, an actuarial assessment was conducted in 2012, that showed that the National Social Health Insurance Scheme would be financially viable and sustainable. In this regard, a *National Social Health Insurance Bill* had been drafted and discussed at provincial level consultative meetings.

On the other hand, private health insurance schemes existed, but they were costly and concentrated along the line of rail. Only those who could afford to pay took out private health insurance policies.

Your Committee learnt that the uncertainty created by the absence of specific reference to health insurance in the law had been exploited. This has led to the establishment of a health insurance market which was poorly coordinated and virtually unregulated leading to frequent entry and exit of private insurance schemes in the market.

The Constraints Affecting the Effective Provision of Public and Private Health Insurance in the Country

6.3 Your Committee was informed that there were a number of constraints that could affect the effective provision of public and private health insurance in the country. These are detailed below.

a) Poor data management systems by both insurers and healthcare providers. This leads to difficulties in carrying out reconciliations and ultimately delays the settlement of claims. Related to this constraint was the lack of Information and Communication Technology (ICT) systems that could improve data management and allow interface between insurers and health service providers. Such systems were said to be so expensive that both health insurers and healthcare providers were reluctant to procure them.

b) Poor health insurance market regulation. This had led to the emergence of unlicensed insurers who engaged in unfair business competition with licensed insurers.

c) Fraud, sometimes involving both staff and policy holders. The use of a manual claims system by some insurers further complicated the situation by making it difficult to notice on time when insured persons overshot their limit.

d) Lack of public confidence in health insurance which was mainly attributed to insurance firms that had undergone liquidation.

e) Inadequate qualified health personnel. The public health sector in Zambia has been experiencing a human resource crisis for a number of years. As a result, the country operated with only about 50 per cent of the required quality health personnel. This situation had been exacerbated by brain drain in the health sector.

f) Reluctance by public health care providers to enter into effective contracts with health insurance companies. This affected effective provision of health insurance by the health insurance companies.

g) Lack of accurate locally researched actuarial data which would enable insurance companies to charge appropriate premiums for corresponding benefits.

h) The non-availability and inaccessibility of quality health care services and facilities particularly in rural areas where such services might not always be available for various reasons. If they were available, accessibility was sometimes hampered by long distances to health facilities.

i) The low awareness about the concept of health insurance among the general public. This affected the uptake of health insurance policies by the general public.

j) The large size of the informal sector which could make resource mobilisation a challenge.

The Effect of Health Insurance, or Lack Thereof, on Access to Health Facilities by the Individual Citizens and on the Zambian Society as a whole

6.4 Your Committee was informed that the high income earners who could afford health insurance and those employed by organisations that had medical schemes were generally able to access health facilities. A number of employers had medical schemes as part of the conditions of service for their employees. In this context, the existence of health insurance had a positive effect on access to health facilities.

Your Committee further heard that health insurance, through corporate schemes, had a positive impact on the well-being of employees and their families. The organisations which subscribed to corporate schemes aimed at both prevention and cure of diseases, which ultimately reduced absenteeism from work. Thus, both the individuals and society as a whole benefited through improved health outcomes and increased productivity.

Your Committee also learnt that there were positive effects associated specifically with public health insurance on both individuals and society as a whole. Stakeholders stated that the introduction of public health insurance would ensure equity of access to healthcare. Availability of public health insurance would pool the risks of health care and share the health care costs for a patient amongst a group of people. For that reason, the rich would subsidise the poor while the employed would subsidise the unemployed. The low risk groups would further subsidise high risk groups. In addition, the income generated by the Scheme would help improve public health facilities in Zambia.

The positive effects notwithstanding, some stakeholders were concerned that many citizens could not afford to pay for health insurance because a large portion of the Zambian population was unemployed and poor. Private health insurance was said to be expensive. Therefore, its existence had a negative effect on accessibility of health facilities as only a few privileged people could afford it.

Your Committee learnt too that lack of health insurance has some negative effects on individuals' access to health facilities. The absence of health insurance further has negative effects on society as a whole. Some of the effects are highlighted below.

a) Potential increase in mortality and morbidity: Productive individuals die from curable illnesses due to lack of resources to cover essential medical costs and access health services. This loss of human capital impacts negatively on economic development.

b) Increased dependence on out-of-pocket payments for health care by individuals. Out-of-pocket payments places the full burden of paying for health services on the individual. This is one of the major barriers to accessing health services especially by the poor. It also reduces resources for investment and savings by those affected. In this regard, out-of-pocket payments have adverse effects on both the individual and society as a whole.

c) Inequity in access to health services as only the privileged few have disproportionate access to health services. As an example, the Zambia Demographic and Health Survey of 2007 estimated that 91 percent of the richest quintile had births delivered by skilled birth attendants when compared with only 27 percent in the poorest quintile. Furthermore, only about 1 percent of the population was covered by private health insurance.

d) Low quality of public health care**.** The quality of public health care services has continued to deteriorate as a result of underfunding to the health sector in Zambia. The public often

complain about staff shortages and inappropriate work attitude for those that are available, drug stock outs and lack of comprehensive laboratory, radiology and diagnostic services.

e) Low utilisation of health care services. The utilisation of health care services by the general population in Zambia was considered to be low. Health indicators, such as under five child mortality and maternal mortality ratio did not suggest that the applicable health related Millennium Development Goals would be achieved. This situation reflected unmet healthcare needs of the population and untimely poor health outcomes.

Stakeholders' Recommendations on Possible Improvements to the Health Insurance System in Zambia

6.5 Stakeholders suggested the recommendations presented hereunder.

i) Zambia should establish a public insurance scheme which should be administered by a government agency. The agency should be mandated to collect the funds for the scheme.

ii) Zambia should consider other efficient and equitable ways of raising additional revenue for health such as a proportion of Value Added Tax (VAT) to the health sector.

iii) More time should be allocated for public consultations on the proposals to introduce social health insurance, including carrying out a full cost-benefit analysis.

iv) There is need to enact specific health insurance legislation that should clearly define what health insurance is.

v) Health insurance should be declared as Value Added Tax (VAT) exempt.

FOREIGN TOUR OF THE REPUBLIC OF GHANA

6.6 In accordance with its programme of work for the Third Session of the Eleventh National Assembly, your Committee undertook a study visit to Ghana from 31st May to 8th June, 2014. The main objective of the tour was to understand and appreciate the operations of Ghana's health insurance system. The tour further provided an opportunity for your Committee to appreciate the management of a public health insurance scheme and the regulation of private health insurance schemes.

Whilst in Ghana, your Committee visited and interacted with the following institutions in order to gather information on Ghana's health insurance system:

(i) the Ministry of Health;
(ii) the National Health Insurance Authority;
(iii) the Nationwide Mutual Healthcare;
(iv) Ridge Regional Hospital - Out Patients Department;
(v) Family Health Hospital;
(vi) Ghana Parliamentary Committee on Health; and
(vii) Ghana Parliamentary Committee on Local Government.

The findings of your Committee are set out below.

a) Ghana has a comprehensive health insurance system despite facing some challenges. The system comprises three types of schemes namely; the national health insurance scheme; private commercial health insurance schemes; and private mutual health insurance schemes.

The National Health Insurance Scheme is a public scheme established by law in 2003. It is a mandatory scheme for all residents of Ghana. On the other hand, private commercial health insurance schemes operate as business ventures and any person can enrol to become a member. However, membership is not mandatory as is the case with the National Health Insurance Scheme.

Private mutual health insurance schemes are set up by a group of persons and registered as companies limited by guarantee. The schemes enrol members who make contributions to the scheme. The scheme provides health benefits to the members and is not for profit making.

b) Ghana established the National Health Insurance Authority by an Act of Parliament. The objective of the Authority is to attain universal health insurance coverage to persons resident in Ghana and those visiting the country. Furthermore, the Authority seeks to provide access to healthcare services to persons covered by the National Health Insurance Scheme. It is, therefore, the implementer of the National Health Insurance Policy.

The Authority is also the manager of a National Health Insurance Fund established by an Act of Parliament. The purpose of the Fund is to pay for the cost of health care services for the members of the National Health Insurance Scheme.

c) The sources of funding for the National Health Insurance Scheme include, among others, the National Health Insurance Levy which is 2.5 per cent of Ghana's Value Added Tax (VAT); 2.5 per cent of basic national social security contributions for each person; and moneys that may be approved by Parliament.

d) Private health insurance schemes are registered and supervised by the National Health Insurance Authority. In this regard, the Authority is the regulator of private health insurance schemes.

e) A network of accredited public and private health care providers provide health care to members of the National Health Insurance Scheme. Accreditation is done by the National Health Insurance Authority.

f) There is a clearly defined benefit package for members of the National Health Insurance Scheme.

g) The Government of Ghana undertook comprehensive consultations with stakeholders on the National Health Insurance Policy in order to build consensus. In addition, there was bi-partisan political commitment to the establishment of the National Health Insurance Scheme.

h) The membership of the Scheme was currently about 38 per cent of the total population eligible to be members of the Scheme.

Your Committee also learnt that the Scheme faces some challenges which include:

i. the long-term financial sustainability;
ii. lack of human resource capacity;
iii. ensuring the coverage of poor and vulnerable populations;
iv. inadequate ICT systems;
v. sub-standard quality of health care provided in some facilities; and
vi. a weak pharmaceutical supply chain.

From the point of view of the providers of healthcare, the challenges include:

i) inadequate staff and infrastructure;
ii) cumbersome claims system;
iii) delayed reimbursement of healthcare providers;
iv) low medicine and service tariffs that do not match the prices of drugs and the cost of provision of services such as laboratory services; and
v) lack of a uniform information management system among health care providers.

COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

6.7 Having analysed the situation of Health Insurance in Zambia and taking into consideration the findings from the study tour of Ghana, your Committee's observations and recommendations are set out hereunder.

i. Review of the legal environment

Your Committee observes that Zambia's legal environment governing the provision of health insurance is inadequate in that there are no specific provisions on health insurance in the current insurance law, the *Insurance Act No. 27 of 1997*.

Your Committee also observes that Ghana enacted a specific law that guides and regulates the provision of health insurance and the operations of health insurance schemes, among other things. This strategy has improved coordination and compliance by stakeholders in the health insurance sector in Ghana.

In view of the good performance of Ghana's strategy of enacting a specific law to guide and regulate the provision of health insurance, your Committee is of the view that the Executive should take Ghana's strategy of enacting a specific law to guide and regulate the provision of health insurance as a best practice. It, therefore, recommends that the Executive should introduce the necessary legislation to Parliament for enactment that will clearly define health insurance; and guide and regulate its provision in Zambia. This will improve compliance in terms of adherence to minimum standards.

ii. Create a specific agency to regulate the provision of health insurance

Your Committee observes that the regulation of health insurance providers is inadequate. This is evidenced by the compliance and quality assurance issues said to be affecting the sector. For example, some private health insurance schemes are reportedly not registered with the regulatory authority and therefore, are unregulated. In addition, there has been reported frequent entry and exit of private health insurance schemes in the sector. Further, some healthcare providers operate medical schemes modelled after health insurance schemes but they are not regulated at all.

Furthermore, your Committee observes that Ghana has instituted measures to improve the regulation of health insurance schemes. Ghana's current *National Health Insurance Act, 2012* empowers the National Health Insurance Authority to register and supervise private health insurance schemes in terms of licensing and general compliance with the law; in addition to being the implementer of the national health insurance scheme.

Your Committee recommends that the Executive should establish an agency that will be mandated to specifically regulate health insurance schemes in Zambia. This will boost compliance with the provisions of the proposed national social health insurance legislation once enacted.

iii. *Expedite the process of establishing a national social health insurance scheme*

Your Committee bemoans the absence of a public health insurance scheme in Zambia while noting the success story of Ghana's National Health Insurance Scheme. Ghana's National Health Insurance

Scheme has increased the percentage of its population that has health insurance cover from 6 per cent in 2005 to the current 38 percent of Ghana's population.

Your Committee being fully aware that the Executive has plans of establishing a national social health insurance scheme and considering the success story of Ghana, urges the Executive to expedite the process of establishing the National Social Health Insurance Scheme in Zambia. It is anticipated that the Scheme will ensure that a larger percentage of the Zambian population has health insurance cover and is able to afford health care whenever it is needed. It is further anticipated that the National Social Health Insurance Scheme will improve utilisation of health care services and attain universal health coverage.

iv. ***Provide tax relief for the procurement of Information and Communication Technology (ICT) systems and introduce a biometric card system***

Your Committee observes that health insurers and healthcare providers lack ICT systems that can improve data management and speed up the claims settlement process because such systems are very expensive to procure. Lack of ICT systems has also contributed to increased fraud by both insurers and policy holders. For example, policy holders may facilitate the illegal utilisation of their insurance cover by their uninsured relatives.

Your Committee further observes that Ghana has not been spared by these challenges brought about by the lack of ICT systems. It is aware that Ghana is currently rolling out a biometric card system after a successful pilot of the system to overcome some of the challenges such as card management, fraud and abuse in claims payment.

Therefore, in order to overcome some of the challenges brought about by the lack of ICT systems, your Committee recommends that the Executive should consider giving tax relief to insurers and healthcare providers who invest in appropriate ICT systems.

In addition, the Executive should draw lessons from Ghana and consider introducing a biometric card system once the proposed National Social Health Insurance Scheme becomes a reality. The biometric card system will help Zambia circumvent some of the challenges experienced by the Ghanaian system prior to the introduction of a biometric card system.

v. Identify reliable and sustainable sources of financing for the proposed Scheme

Your Committee observes that Ghana's National Health Insurance Scheme is financed through various sources of funding apart from the contributions made by members of the Scheme. These include a National Health Insurance Levy of 2.5 per cent of Value Added Tax and 2.5 per cent of each person's monthly mandatory social security contribution.

Your Committee recommends that the Executive should seriously consider identifying reliable and sustainable sources of financing the proposed Social Health Insurance Scheme before it becomes operational. It is your Committee's considered view that the Executive should borrow some ideas from Ghana on how to finance the Scheme, which can be adapted to the Zambian situation.

vi. Need for extensive stakeholder consultation, political commitment and leadership

Your Committee observes that Ghana's process of establishing the National Health Insurance Scheme involved extensive consultations with stakeholders in order to solicit their support. Furthermore, there was bi-partisan political commitment and leadership by political leaders and the Government, respectively. This has been sustained to date and has contributed to the successful implementation of the National Health Insurance Scheme.

Therefore, your Committee recommends that the Executive should undertake further extensive consultations on the establishment of the proposed National Social Health Insurance Scheme with all relevant stakeholders in order to build consensus and ensure their support during implementation. It further implores both the political leadership and the Executive to show political commitment and leadership, respectively to ensure the successful establishment and implementation of the proposed Social Health Insurance Scheme.

vii. Accreditation of healthcare providers

Your Committee observes that in Ghana, a network of public and private health care providers who are accredited by the National Health Insurance Authority provide health care services to members of the National Health Insurance Scheme. This helps to guarantee quality health care to members of the Scheme.

In this regard, your Committee recommends that the Zambian Government should adopt a similar measure where only accredited providers should provide health care services to members of the Scheme once it becomes operational. This will serve as a quality control measure. Your Committee further recommends that private providers should be included in the provision of health care services to members of the Scheme because public providers or facilities may not cope with increased utilisation of health care services.

viii. Devise strategies to ensure availability of trained health workers

Your Committee observes that there is inadequate health personnel in the country. This might negatively affect the provision of quality health care services due to the anticipated increase in the uptake of healthcare services once the social health insurance scheme is operational.

Therefore, it is recommended that the Executive should devise strategies to ensure the availability of trained health workers to provide quality health care services in all facilities that will be accredited as healthcare providers under the National Social Health Insurance Scheme.

ix. Educate and sensitise the public on health insurance

Your Committee is concerned that the level of understanding of health insurance among the citizens is low.

In this regard, it recommends that the Executive should conduct education and sensitisation campaigns about health insurance and its benefits in order to improve the uptake of health insurance policies. Furthermore, individuals' roles and responsibilities once they take out health insurance policies should be explained. This could stem some of the fraudulent activities reported to be happening in the sector.

x. Institute measures to reduce the cost of doing business in Zambia

Your Committee notes that the cost of doing business in Zambia is high. This has also affected the private health insurers who pass on the cost to the consumers resulting in private health insurance being expensive and unaffordable to many citizens.

Your Committee is of the view that the Executive should institute measures to reduce the cost of doing business in Zambia in order to promote private health insurance and make it affordable. It recommends that the Executive should consider reviewing the tax structure pertaining to insurance.

xi*. *Promote the provision of study programmes in actuarial sciences and underwriting

Your Committee bemoans the shortage of skilled human resources in actuarial sciences and underwriting. This has resulted in health insurance providers lacking accurate actuarial data to enable them determine appropriate premiums for specific benefits.

Therefore, your Committee recommends that the Executive should encourage and promote the provision of study programmes in actuarial sciences and underwriting in public and private universities and colleges. This measure is meant to make the Country have enough qualified actuaries.

PART II

THE AVAILABILITY AND UPTAKE OF FAMILY PLANNING SERVICES IN ZAMBIA

7.0 Family planning is the planning of when or whether to have children and the use of birth control and other techniques to implement such plans. The purpose of family planning is to make sure that any couple, man, or woman who has the desire to have a child has the resources that are needed to complete this goal. Family planning services, therefore, enable individuals to determine freely the number and spacing of their children and to select the means by which this may be achieved. Contraception can help to avoid unwanted pregnancies and space births; protect against sexually transmitted infections, including HIV/AIDS; and provide other health benefits.

According to the Ministry of Community Development, Mother and Child Health's Costed Eight-Year Integrated Family Planning Scale-up Plan (2013–2020), the uptake of family planning services in Zambia is relatively low. The Plan indicates that the Contraceptive Prevalence Rate (CPR) is at 40 per cent for all methods and the unmet need for family planning is currently estimated at 27 per cent.

In the light of the foregoing, your Committee undertook a study on the Availability and Uptake of Family Planning Services in Zambia. The objective of the study was to fully appreciate the factors behind the failure by the Zambian Government to achieve universal provision of family planning services, and also the factors behind the low uptake of family planning services by the Zambian public.

To help it study the topic, your Committee requested written submissions from the following stakeholders:

i) Ministry of Education, Science, Vocational Training and Early Education;
ii) Ministry of Health;
iii) Ministry of Community Development, Mother and Child Health;
iv) Churches Health Association of Zambia (CHAZ);
v) Planned Parenthood Association of Zambia (PPAZ);
vi) Society For Family Health;
vii) United Nations Population Fund **(**UNFPA);
viii) Youth Alive Zambia;
ix) Population Council; and
x) Traditional Healers and Practitioners Association of Zambia (THPAZ).

CONSOLIDATED SUMMARY OF STAKEHOLDERS' SUBMISSIONS

Government's Policy on Family Planning

7.1 Your Committee was informed that there was no stand-alone policy on family planning. Instead guidelines and provisions were highlighted mainly in the *National Reproductive Health Policy 2008*, and the recently launched Integrated Family Planning Scale-up Plan 2013-2020. It was

explained to your Committee that family planning is a cross-cutting issue that required a multi-sector response. For that reason, family planning policy guidelines were also found in the following policy documents:

a) National Health Policy 2013;
b) National Health Strategic Plan 2011-2015;
c) HIV Policy 2005;
d) National AIDS Strategic Framework 2011-2015; and
e) Termination of Pregnancy Act of 1972.

Your Committee learnt that the Government's intention on family planning was to increase access to quality family planning services through:

(i) enhancing capacity to ensure eligibility of families and individuals accessing family planning services;
(ii) integrating with other reproductive health services;
(iii) ensuring availability of adequate skilled staff;
(iv) ensuring commodity security;
(v) ensuring availability of information, education and communication materials;
(vi) public-private partnerships;
(vii) ensuring women access family planning without hindrance; and
(viii) encouraging child spacing.

In order to address some of the challenges associated with provision of family planning services, the Government has developed a plan called the Eight-Year Integrated Family Planning Scale-Up Plan (2013–2020). The Plan focuses on six strategic priorities as detailed below.

a) Family planning demand generation and behavior change communication. This aimed at strengthening demand for family planning services by repositioning family planning as a key driver in development, and providing targeted, easily accessible and accurate information to the population.

b) Targeting adolescents and the youth with quality accessible sexual and reproductive health information and services in and out-of-school.

c) Staff and training strategy aimed at building the capabilities of providers and increase capacity to deliver high quality contraceptive services, including Long-Acting Reversible Contraception (LARC).

d) Targeting rural and underserved areas' access to family planning services by increasing coverage and access to quality integrated family planning services available to those living in these areas.

e) Managing stock-outs at service delivery points by improving the distribution, availability and security of family planning commodities from the central level to service delivery points, including both contraceptives and consumables.

f) Improving the family planning governance structure and programme coordination by strengthening the central, provincial and district-level family planning structures to better coordinate and monitor government and partner activities, in order to deliver services efficiently.

The Relevance of Zambia's Current Family Planning Policy

7.2 Stakeholders were of the view that the current framework is still relevant. Your Committee learnt that the Policy has contributed to the reduction of maternal mortality and morbidity through

scaling up the provision of quality integrated family planning services in Zambia. Further, the Policy serves as a guide to the Government to drive the family planning programme agenda forward and provide strategic direction for partner support.

However, concern was raised that the guidelines in the Reproductive Health Policy may be inadequate to contribute to effective implementation of an integrated family planning policy.

The Efficacy of the Government's Implementation Strategy of the Policy on Family Planning

7.3 Your Committee learnt that the Government's implementation strategy was an evidence-based method that had worked very well for other health programmes such as counselling and testing for HIV and cervical cancer screening. The Government was targeting to reach 58 per cent of contraceptive use by 2015. Therefore, it was committing specific budget lines for family planning programming and commodity security.

However, some stakeholders raised concern about the efficacy of the Government's implementation strategy of the policy on family planning, specifically referring to the Scale-up Plan. They were specifically concerned at some of the challenges that hinder effective implementation. These include inadequate human and financial resources, inadequate infrastructure, the issues of poor coordination between the Ministry of Health and the Ministry of Community Development, Mother and Child Health and over-dependence on donor aid to implement family planning programmes. Stakeholders urged the Government to address these issues in order to improve the efficacy of the Strategy.

The Factors, if any, Leading to Failure by the Government to Achieve Universal Coverage in Terms of Provision of Family Planning Services

7.4 Stakeholders submitted that there were various factors they considered to be contributing to the failure by the Government to achieve universal coverage in the provision of family planning services. It was clear to your Committee that the human resource crisis that the health sector was experiencing was everyone's concern. Stakeholders bemoaned the shortage of skilled staff especially in the rural areas. Your Committee was also informed that the shortage was the major reason for limited provision of long term family planning methods, especially in rural areas. Staff shortage was also associated with conflicting or competing priorities and excessive workloads for available staff. This led to failure by staff to perform non-urgent and relatively time-consuming tasks such as providing LARC services.

Other factors identified by stakeholders include:

i) inadequate and unsuitable infrastructure: in some instances, there was no infrastructure for provision of family planning while at times the available infrastructure did not provide for privacy for provision of family planning methods such as Intrauterine Contraceptive Devices (IUDs) and implants;

ii) low acceptability of family planning services due to various issues such as cultural and religious beliefs;

iii) the affordability of family planning services especially in rural areas; though services were free, it was costly to access them due to the long distances to health facilities and the use of short term family planning methods that required frequent visits to health facilities; and

iv) accessibility of the services depended on the availability of commodities and skilled service providers.

Reasons for the Low Uptake of Family Planning Services Even Where These are Accessible

7.5 Your Committee learnt that there were various reasons for the low uptake of family planning services as elaborated below.

(i) The existence of myths and misconceptions about family planning that discouraged those who needed family planning. For example, some people believed that implants and IUDs could travel around the body. Some people further believed that fertility would not return after one stopped using a LARC method.

(ii) Misinformation on the various family planning methods. This was made worse by the low education among women.

(iii) Fear of spousal disapproval by women because some husbands did not approve of women seeking family planning services.

(iv) The existence of cultural and religious beliefs that did not support any other family planning method except the natural method. Furthermore, some Zambian health care providers had negative beliefs about IUDs in particular as they believed that IUDs caused infections. As a result, they were biased against IUDs and could not give them to women who had no surviving children. Besides, they exhibited negative attitudes towards provision of contraceptives to adolescents and young persons.

The Challenges Affecting the Effective Implementation of the Government Policy on Family Planning

7.6 Stakeholders submitted that there were a number of challenges that affects the effective implementation of the Government policy on family planning. They highlighted various challenges that include the following:

a) inadequate human resources to provide the various family planning services;

b) inadequate funding for family planning programs;

c) shortages and stock-outs of family planning commodities;

d) inaccessibility of services due to long distances to the few health facilities or delivery points especially in rural areas;

e) socio-cultural factors such as social stigma prevents some women from seeking family planning service; unmarried women were reluctant to seek services for fear of stigma and embarrassment;

f) religious beliefs had an effect on policy decisions surrounding family planning; this resulted in funding restrictions on sexual and reproductive health services and promotion of narrow sex education programmes for young people;

g) low and inappropriate integration of family planning services with other services such as HIV care and maternal and child health;

h) regulations on who distributes family planning commodities; for instance, drug stores are currently not allowed to stock and dispense oral contraceptives; and

i) lack of a specific policy framework on family planning.

Possible Solutions to the Constraints Identified

7.7 Stakeholders suggested a number of interventions as outlined below.

i. There is need to ensure availability and accessibility of family planning services and commodities, especially in rural and hard to reach remote areas.

ii. Community involvement and outreach should be prioritised. This might include engaging community leaders including traditional and religious leaders, community health workers to assist in disseminating information on family planning and the distribution of family planning commodities at community level.

iii. Basic systems for service delivery should be in place.

iv. There is need for of effective integration of family planning services with other services such as HIV care and treatment.

v. The participation of the private sector in family planning service provision should be encouraged.

vi. The Government should support the implementation of the national supply chain strategy which seeks to decentralise the distribution of commodities by creating regional hubs for the Medical Stores Limited. This would improve the last mile distribution of contraceptives especially for the rural and underserved populations.

vii. The Government should introduce a separate budget line for family planning commodities in the health budgetary allocation. The Government should then increase/double budgetary allocation for family planning commodities as pledged at the London Family Planning Summit in 2012.

viii. There is need for a specific policy on family planning.

ix. Improving financing of family planning programmes through adequate and timely funding.

x. Availing family planning services to the reproductive age group of between 15-49 years regardless of one's marital status.

xi. Ensuring competent skilled staff were placed at all levels.

xii. Investing in girl's education, which in the long term will reduce unwanted pregnancies and increase the age at marriage.

COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

7.8 Your Committee's observations and recommendations are set out hereunder.

i. ***Improve the availability and accessibility of family planning services in rural areas***

Your Committee bemoans the challenges of accessing family planning services in rural areas. Some women have to travel long distances to health facilities to access family planning services. Women are further subjected to short term family planning methods such as oral contraceptives when there are long acting contraception methods available. Short-term methods entail frequent visits to access family planning services.

Your Committee urges the Ministry of Community Development, Mother and Child Health and the Ministry of Health to improve the provision of family planning services to rural areas by ensuring that services are accessible and available. Furthermore, long acting and reversible contraceptive methods

should be made available to rural women. This will make family planning service provision more efficient and effective by reducing the number of visits to health facilities that women have to make to access short term family planning methods.

ii. Incentives for Community Based Distributors (CBDs)

Your Committee welcomes the use of Community Based Distributors (CBDs) to assist in the distribution of family planning commodities, in the absence of adequate qualified health personnel. However, your Committee considers this policy unsustainable in the absence of monetary incentives to attract and retain the volunteers.

Therefore, your Committee recommends that the Executive should consider combining both non-monetary and monetary incentives to motivate the volunteers and ensure this is espoused in a care givers policy once formulated.

iii. Adequate funding for the implementation of family planning programmes and service provision

Your Committee observes that the implementation and provision of family planning programmes and services respectively are inadequately funded. It is aware that the Executive has come up with a Costed Integrated Family Planning Scale-up Plan 2013-2020 to address the gaps in the provision of family planning services.

For that reason, your Committee recommends that the Executive should adequately fund the Family Planning Scale-up Plan and other related programmes for effective implementation of all family planning activities.

iv. Train and retrain health workers

Your Committee is concerned about the unprofessional conduct of some health workers towards the youth and unmarried women who seek family planning services.

In order to stem this unprofessional conduct by some staff, your Committee recommends that the Ministry of Health and the Ministry of Community Development, Mother and Child Health should train and retrain health workers in handling the affected clients and emphasise the clients' rights to information on family planning.

v. Conduct public education and sensitisation on family planning services

Your Committee observes that uptake of family planning services in Zambia is low despite the reported high awareness of family planning. In addition, there is concern about the lack of information on the roles of the Ministry of Health and the Ministry of Community Development, Mother and Child Health with regard to the implementation of family planning programmes.

In this regard, your Committee recommends that the Executive should conduct public education and sensitisation programmes on the benefits of family planning services. However, the messages, content and mode of communication should be culturally sensitive and promote healthy behaviour. This will ensure that the public does not reject the messages. In addition, the Executive should inform the public and its partners in family planning service provision on the specific roles of the Ministry of Health and the Ministry of Community Development, Mother and Child Health. This will clear the uncertainties on which Ministry is responsible for what aspects of the family planning policy implementation.

vi. Strategies to address the shortage of trained staff in the health sector

Your Committee observes that there is shortage of trained staff in the health sector. It is concerned that this problem has persisted for too long and that it undermines the goal of universal coverage in terms of provision of family planning services.

Your Committee, therefore, recommends that the Executive should come up with strategies to address the shortage of trained staff in the health sector.

vii. Policy guidelines on the distribution of family planning commodities

Your Committee observes that drug stores are not allowed to distribute some family planning commodities despite being patronised by many potential clients.

Your Committee recommends that the Executive should reconsider its position on the issue of drug stores vis-à-vis distribution of family planning commodities. It is your Committee's considered view that in the interest of taking family planning services beyond the health facility, distribution by drug stores should be piloted.

viii. Integrate family planning services with other healthcare services

Your Committee observes that family planning services are not integrated with other services that are popular, with a higher uptake such as voluntary counselling and testing and under 5 clinic.

In order to improve the uptake of family planning services, your Committee recommends that the Executive should identify appropriate programmes and services that can be integrated with family planning services.

PART III

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

8.0 Your Committee noted the responses by the Executive to the recommendations made in the previous report. While noting the responses, your Committee resolved to follow-up the issues presented below.

Breast and Cervical Cancer in Zambia

8.1 Your previous Committee had recommended that 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.

It was reported in the Action-Taken Report that in order to ensure equitable access for all women to quality services for breast and cervical cancer prevention, the Government through the Ministry of Health was developing a National Cancer Control Plan which will be a framework to address the issues of equity of access to quality services.

Committee's Observations and Recommendations

Your Committee observes that no time-frame has been provided for the completion of the development of the National Cancer Control Plan. Therefore, your Committee requests the Executive to provide a time-frame for the development of the National Cancer Control Plan.

8.2 Your previous Committee had recommended that the Government ought to upgrade the National Cancer Registry to international standards in order to provide critical and on-going surveillance information.

It was reported in the Action-Taken Report that the Government was aware of the need to upgrade the National Cancer Registry to international standards and the process of grading had already started. In addition, the Government intended to recruit a registrar to ensure that the National Cancer Registry was operating according to international standards.

Committee's Observations and Recommendations

Your Committee observes that no time-frame has been provided within which the registrar will be engaged and when the upgrade of the National Cancer Registry will be completed. It therefore requests the Executive to provide a time-frame.

8.3 Your previous Committee had recommended that the Government ought to engage other stakeholders for the development and dissemination of breast and cervical cancer guidelines to all health facilities in the country.

It was reported in the Action-Taken Report that the process of developing guidelines had started and other stakeholders were involved in the development of draft guidelines. The process of finalising and disseminating these guidelines would also involve other stakeholders.

Committee's Observations and Recommendations

Your Committee awaits a progress report on the development and dissemination of the guidelines.

8.4 Your previous Committee had recommended that the Government should engage the private sector on the construction of transit homes such as the ones Breakthrough Cancer Trust was constructing for the under-privileged patients who 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 Diseases Hospital.

It was reported in the Action-Taken Report that the Government had taken note of this important recommendation and would study the recommendation to determine the feasibility and modalities on how it could be done. Mechanisms were already in place to assist patients who were in need through the Social Welfare Department under the Ministry of Community Development, Mother and Child Health.

Committee's Observations and Recommendations

Your Committee acknowledges that it is aware of the facility for the patients in need provided under the Social Welfare Department. However, it is concerned about the lack of transit homes for people who travel from far places to take care of the patients.

Therefore, it reiterates its earlier recommendation that the Executive should engage the private sector on the construction of transit homes for people who travel from far places to take care of the patients.

8.5 Your previous Committee had recommended that the Government ought to, as a matter of urgency, investigate why most mammography machines being procured and installed were defective.

It was reported in the Action-Taken Report that the Government had called the suppliers to verify the state of the equipment and replace the defective ones. According to the terms and conditions of the contract, the equipment was covered by a global warranty which was used for replacement of the

defective equipment. In this regard, the Ministry of Health invoked the warranty provisions of the contract.

Committee's Observations and Recommendations

Your Committee observes that this response is misplaced as the question is why faulty machinery was bought in the first place. It therefore, requests the Executive to provide a more appropriate response.

8.6 Your previous Committee had recommended that the Government should decentralise cancer units in every province which will be supervised by the Cancer Diseases Hospital.

It was reported in the Action-Taken Report that the decentralisation of cancer units in every province to be supervised by the Cancer Diseases Hospital (CDH) had been planned for by Government through the Ministry of Health in the CDH Phase III Project which was meant to help cancer patients a lot if the services were decentralised. The smooth implementation of this project would depend on the availability of funds**.**

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

8.7 Your previous Committee had recommended that the Government must urgently present the *Traditional Health Practitioners Bill* to Parliament.

It was reported in the Action-Taken Report that through the Ministry of Health, it had been working closely with stakeholders to develop the proposed *Traditional Health Practitioners Bill* which should guide the product, practice and traditional practitioners in terms of regulatory framework. The aim was to enhance the capacity of the country to effectively deal with traditional medicines to manage, prevent and treat diseases that were of major concern to public health in the country. However, the efficacy of the traditional medicines had to be evaluated in an integrated manner. The layman's draft Bill was in place and consultations with relevant stakeholders were progressing well. It was expected that the consensus building process on the proposed legislation would be completed by the end of 2013. Thereafter, the legislative approval and drafting processes would commence prior to introducing the Bill in Parliament.

Committee's Observations and Recommendations

Noting that the 2013 deadline for the completion of the consensus building process on the proposed *Traditional Health Practitioners Bill* has already passed, your Committee awaits an up-date on the drafting process.

Local Tours/ Public Hearing

8.8 Your previous Committee had recommended that the Government ought to formulate a care givers policy in partnership with Civil Society Organisations and Non-Governmental Organisations. This would guide and motivate thousands of volunteers in the health system.

It was reported in the Action-Taken Report that the Government with support from Civil Society Organisations (CSO) was undertaking a study on volunteerism in Zambia for Health and Social development with a view to harmonising incentives and ensuring that these incentives were sustainable. Once the recommendations from the study were ready, the Government would work out modalities on the application.

Committee's Observations and Recommendations

Your Committee awaits a progress report on the matter.

8.9 Your previous Committee had recommended that the Government should extend sensitisation on the benefits of circumcision to the rural parts of the country in an effort to curb the escalating number of non-communicable diseases such as cervical cancer.

It was reported in the Action-Taken Report that the Human Papilloma-Virus (HPV) is a virus from the papillomaviruses family that was capable of infecting humans. Like all papillomaviruses, HPVs established productive infections only in keratinocytes of the skin. Therefore, there had been misunderstanding on the benefits of circumcision in curbing the escalating number of non-communicable diseases such as cervical cancer. Circumcision did not prevent transmission of HPV let alone cervical cancer because the virus resided in the skin where ever it was.

Committee's Observations and Recommendations

Your Committee is concerned about the response given by the Ministry of Health particularly that a lot of sensitisation programmes on male circumcision vis-à-vis cervical cancer have been allowed to go on, both on radio and the print media. Furthermore, Your Committee is worried that the general public might have been misled which might lead to serious consequences. Therefore, your Committee resolves to ask for a comprehensive statement from the Ministry of Health on the benefits of male circumcision and the relationship between male circumcision and prevention of cervical cancer.

Outstanding Issues on Social Protection for the Aged in Zambia

8.10 Your previous Committee had requested a progress report on the development of the multi-sectoral Social Protection Policy.

It was reported in the Action-Taken Report that the process to develop a multi-sectoral social protection policy had reached an advanced stage, with the consultant being engaged and provincial consultations having been undertaken. The process also involved looking at how the social programmes would be coordinated and work in this area was being spearheaded with guidance from Cabinet Office. The Consultant was currently developing the Zero Draft for approval by the Technical Working Group.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter which should be submitted by the end of 2014.

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

It was reported in the Action-Taken Report that the Government had developed a Zero Draft on the Minimum Standards Guidelines for Old People Homes. However, the Ministry of Health had not been able to finalise the guidelines due to financial constraints as the document must be subjected to scrutiny by other stakeholders such as Old People's Homes. The private sector had been involved in providing support such as financial and material. In addition to the homes that were run by faith based organisations, one more had been set up which was privately owned.

Committee's Observations and Recommendations

Your Committee awaits an update on the finalisation of the guidelines.

Provision of Education to the Deaf in Zambia

8.12 Your previous Committee requested a progress report on the review of the Education Policy in order to address the concerns raised on provision of education to the deaf.

It was reported in the Action-Taken Report that the Policy was still under review as consultations were still going on to also incorporate emerging issues.

Committee's Observations and Recommendations

Your Committee awaits a progress report on the matter.

8.13 Your previous Committee had requested 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 no provincial resource centres had been built and phase two of the infrastructure development at the Zambia Institute of Special Education had also not commenced due to financial challenges.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

8.14 Your previous Committee had requested an update on the construction of special boarding schools in various provinces and the progress made on other the construction works that had already commenced.

It was reported in the Action-Taken Report that there was no progress made on the issue due to financial constraints.

Committee's Observations and Recommendations

Your Committee awaits an updated progress report on the matter.

The Role of the Department of Community Development in Poverty Reduction

8.15 Your previous Committee had requested a progress report on the rolling out of the Management, Information, Monitoring and Evaluation Systems to other ministerial programmes other than the Social Cash Transfer Programme.

It was reported in the Action-Taken Report that the Management Information, Monitoring and Evaluation System had not been rolled out. However, the training module had been done and the users had been trained.

Committee's Observations and Recommendations

Your Committee awaits a progress report on the matter.

Outstanding Issues on the Report of the Auditor-General on Medical Waste Management in Zambia

8.16 Your previous Committee had requested information on the second phase of the procurement and installation of incinerators in health institutions that had not earlier been provided with incinerators.

It was reported in the Action-Taken Report that the second phase of the procurement and installation of incinerators had not been implemented as the World Bank and World Health Organisation had not released funding.

Committee's Observations and Recommendations

Your Committee resolves to await an update on the procurement and installation of incinerators.

8.17 Your previous Committee had requested information on when the *Public Health (Amendment) Bill* would be presented before Parliament.

It was reported in the Action-Taken Report that consultations on the review of the *Public Health (Amendment) Bill* were progressing well and were expected to be completed before the end of the year and thereafter the drafting process would commence. However, it was difficult to give an exact date when the Bill would be presented to Parliament.

Committee's Observations and Recommendations

Your Committee awaits an update on the completion of the drafting process of the *Public Health (Amendment) Bill*. It further asks the Executive to indicate when the Bill is likely to be presented before Parliament.

CONCLUSION

9.0 Your Members are grateful to you, Mr Speaker for granting them the opportunity to serve on your Committee. Your Committee is also grateful to the office of the Clerk of the National Assembly for the support rendered to it throughout this session. Your Committee is further indebted to all witnesses that submitted memoranda and appeared before it.

Finally, your Committee remains hopeful that its observations and recommendations will be considered by the Executive and go a long way in addressing some of the challenges facing the health sector in Zambia.

June, 2014 Brig Gen Dr B Chituwo, MP
LUSAKA **CHAIRPERSON**

APPENDIX I

List of Officials

Mr S C Kawimbe, Acting Principal Clerk of Committees
Ms M K Sampa, Acting Deputy Principal Clerk of Committees
Mr M F Kateshi, Acting Committee Clerk (SC)
Mrs A M Banda, Assistant Committee Clerk
Ms K Chisenga, Typist
Mr R Mumba, Committee Assistant
Mr C Bulaya, Committee Assistant