

REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES FOR THE FOURTH SESSION OF THE ELEVENTH NATIONAL ASSEMBLY APPOINTED ON THURSDAY 25TH SEPTEMBER, 2014

Consisting of:

Mr L M Mufalali, MP; (Chairperson); Brig Gen Dr B Chituwo, MP; Mr C J Antonio, MP; Mr E C Musonda, MP; Mr M Simfukwe, MP; Mrs S T Masebo, MP; Mr M Habeenzu, MP; and Mr L Lingweshi, MP.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir

Your Committee has the honour to present its Report for the Fourth Session of the Eleventh National Assembly.

Functions of the Committee

2.0 The functions of your Committee are as follows:

- 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) Review of the Progress Made by Zambia towards Achieving the Health-Related Millennium Development Goals (MDGs) Number Four, Five and Six; and

- ii) Zambia's Preparedness Against a Possible Outbreak of the Ebola Virus Disease;
- b) local tour of selected health institutions and ports of entry in Lusaka, Eastern, Muchinga and Copperbelt Provinces;
- c) consideration of the Action-Taken Report on the Report of the Committee for the Third Session of the Eleventh National Assembly; and
- d) consideration of the Committee's Report for the Fourth Session of the Eleventh National Assembly.

In this regard, your Committee held fifteen meetings to execute its programme of work besides undertaking a local tour.

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 Review of the Progress Made by Zambia towards Achieving the Health-Related Millennium Development Goals (MDGs) Number Four, Five and Six and the resulting local tour. Part II presents your Committee's findings on Zambia's Preparedness Against a Possible Outbreak of the Ebola Virus Disease and the resulting local tour, while Part III reviews the Action-Taken Report on the Report of your Committee for the Third Session of the Eleventh National Assembly.

PART I

REVIEW OF THE PROGRESS MADE BY ZAMBIA TOWARDS ACHIEVING THE HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS (MDGS) NUMBER FOUR, FIVE AND SIX

6.0 Millennium Development Goals (MDGs) are development related goals that were agreed upon by 189 countries in 2000. There are eight (8) MDGs which are aimed at creating an environment conducive to development and the eradication of extreme poverty. The UN Member States committed themselves to attaining the MDGs by 2015.

Three (3) out of the eight (8) MDGs are health-related. These are MDGs number four (4), five (5) and six (6) as set out below.

- a) MDG Number Four: Reduce Child Mortality;
- b) MDG Number Five: Improve Maternal Health; and
- c) MDG Number Six: Combat HIV and AIDS, Malaria and Other Diseases.

Considering that there were less than one year remaining before the 2015 deadline for achieving MDGs, your Committee found it expedient to undertake a Review of the Progress made by Zambia Towards Achieving the Health-Related MDGs Number Four, Five and Six. The study would provide an opportunity for taking stock of Zambia's achievements and challenges regarding MDGs. It was further anticipated that Members of Parliament would be empowered with information needed to raise debate on health policy issues which are related to MDGs and make appropriate recommendations on the way forward beyond 2015.

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

- i) Ministry of Health;
- ii) Ministry of Community Development, Mother and Child Health;
- iii) Ministry of Education, Science, Vocational Training and Early Education;
- iv) United Nations Systems in Zambia;
- v) Save the Children, Zambia;
- vi) National Food and Nutrition Commission;
- vii) Civil Society Alliance for Scaling Up Nutrition (CSO-SUN);
- viii) Oxfam Zambia;
- ix) Marie Stopes International;
- x) Planned Parenthood Association of Zambia (PPAZ);
- xi) Society for Family Health;
- xii) Churches Health Association of Zambia (CHAZ);
- xiii) Jesuit Centre for Theological Reflection (JCTR);
- xiv) Civil Society for Poverty Reduction;
- xv) Network of Zambian People Living with HIV/AIDS (NZP+);
- xvi) National HIV/AIDS/STI/TB Council;
- xvii) National Malaria Control Centre;
- xviii) The University of Zambia, Department of Development Studies;
- xix) Zambia Medical Association (ZMA);
- xx) Zambia Union of Nurses Organisation (ZUNO);
- xxi) Surgical Society of Zambia;
- xxii) Family Fountain of Hope (FFOH);
- xxiii) Zambia Asthma Association;
- xxiv) Dr Sondashi; and
- xxv) Traditional Healers and Practitioners Association of Zambia (THPAZ).

CONSOLIDATED SUMMARY OF STAKEHOLDERS' SUBMISSIONS

Overview of the situation of Child Health, Maternal Health and HIV/AIDS, Malaria and Tuberculosis in Zambia

6.1 Stakeholders informed your Committee that Zambia had made significant progress towards achieving the health-related Millennium Development Goals (MDGs) number four (4), five (5) and six (6). The stakeholders were, however, quick to point out that Zambia would have to make further efforts to achieve the goals and specific targets.

MDG Number Four (4): Reduce Child Mortality

The target under MDG number four is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Specifically the target is to reduce the under-five mortality rate to 63.6 deaths per 1,000 live births and infant mortality rate to 37.5 deaths per 1,000 live births. Your Committee was informed that data from the 1992 to the 2013-14 Zambia Demographic and Health Surveys (ZDHS) on trends in childhood mortality indicated that there had been a decline in under-five mortality and in infant mortality rate since the 1996 survey.

The under-five mortality rate had decreased from 197 deaths per 1,000 live births in the 1996, ZDHS to 75 deaths per 1,000 live births in the 2013-14, ZDHS. Data from the 2013-14 ZDHS further indicated that the infant mortality rate had declined from 109 deaths per 1,000 live births in 1996, to 45 deaths per 1 000 live births in 2013-2014. However, concern was raised with the minimal decline in neonatal mortality, which had decreased from 29 to 24 deaths per 1,000 live births between 1999 and 2013.

Stakeholders bemoaned the fact that despite the declines in childhood mortality in Zambia, it was still high. Therefore, the MDG number four target, to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate, could not be achieved by 2015.

MDG Number Five (5): Improve Maternal Health

The target under MDG number five was to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio to 162.3 deaths per 100,000 live births. Your Committee was informed that maternal mortality ratio had improved from 649 deaths per 100,000 live births in 1996, to 398 deaths per 100,000 live births in 2013-2014. Your Committee further learnt that 64 percent of births in Zambia were delivered by a skilled health provider. However, stakeholders submitted that maternal mortality was still high. They observed further that thirty-eight (38) women die every month on average during pregnancy and childbirth. This current situation made it impossible to attain MDG number five.

Stakeholders also submitted that unsafe abortions were prevalent in Zambia and contributed to maternal deaths. They stated that many women did not know the law on abortion in Zambia. Stakeholders further argued that it was important to prevent the need for abortion by eliminating unwanted pregnancies.

MDG Number Six (6): Combat HIV/AIDS, Malaria and Other Diseases

Your Committee learnt that the national HIV prevalence rate for Zambia among adults fifteen (15) to forty-nine (49) years declined from 15.6 percent in 2002, to 14.3 percent in 2007. According to the ZDHS of 2013-2014, the HIV prevalence rate for adults in Zambia is 13 percent. Therefore, the national target to keep the prevalence rate at or below 15.6 percent had been met. The ZDHS of 2013-2014, further indicates that women in Zambia had a higher prevalence rate of 15 percent compared to men with 11 percent.

Your Committee was also informed that Zambia had generally performed well in the provision of adult Anti Retroviral Therapy (ART). This was because over 85 percent of the eligible people living with HIV (PLWHIV) were accessing ART services. Furthermore, prevention of mother to child transmission (PMTCT) of HIV had been scaled up to 90 percent. Up take of voluntary counselling and testing (VCT) services had also improved tremendously as over 500,000 people were on ART.

Malaria

Stakeholders informed your Committee that malaria remained a major public health concern in Zambia despite it being both preventable and curable. According to the routine Health Management Information System (HMIS) of 2013, over five (5) million Zambians suffered from malaria in 2013.

Your Committee was also informed that the burden of malaria was highest among children under the age of five (5) years, pregnant women and among the vulnerable and poor in society. The parasite prevalence among children aged six (6) to fifty nine (59) months which acts as a proxy to the general population, had varied over the past four Malaria Indicator Surveys as follows: 22 percent in 2006, 10.2 percent in 2008, 16 percent in 2010 and 14 percent in 2012.

Your Committee was further informed that after some years of success in the anti-malaria campaign, the reduction in resources allocated to the malaria programme resulted in Zambia having an increase in both new cases and deaths from 2009 to 2010. New cases of malaria increased from 255 cases per 1,000 population in 1990, to 336 cases in 2013, which is higher than the MDG target of 250 cases per 1,000 population.

Tuberculosis (TB)

Your Committee was informed that the two targets related to TB are to halt and begin to reverse the incidence of TB by 2015, relative to the 1990 levels; and to reduce the prevalence of, and deaths due to TB by 50 percent, by 2015, compared with the 1990 levels.

Your Committee learnt that in the period 2013-2014, a nationwide TB Prevalence Survey aimed at estimating the TB burden in the country was conducted. This was the first TB prevalence survey in Zambia and the preliminary report was being awaited. However, the World Health Organisation (WHO) estimates for Zambia indicate that the TB prevalence per 100,000 population had been on the decline from 665 cases in 1990, to 512 cases in 2000 and to 388 cases in 2012. The number of TB cases in the country had remained relatively stable over the past decade while the incidence of TB had also declined over the same period.

The TB notification rates in Zambia had decreased in the past five years, from 376 cases per 100,000 population in 2009, to 314 cases per 100,000 population in 2013. The incidence of TB had declined from 716 per 100,000 population in 1990, to 410 cases per 100,000 population in 2013. Furthermore, the TB mortality had reduced from 81 deaths per 100,000 in 1990, to 25 deaths per 100,000 population in 2013. Your Committee was also informed that seventy (70) per cent of people with TB were also HIV-positive and TB was the leading cause of death among people with HIV.

Your Committee was also informed that good nutrition was essential for healthy and active lives, and therefore, contributed to the fight against poverty. In this regard, nutrition was linked to the achievement of health-related MDGs as good and adequate nutrition was important in the fight against illness.

The programmes that the Government has implemented to accelerate the achievement of the Health-Related MDGs

6.2 Your Committee learnt that the Government had implemented a number of programmes and interventions to accelerate the achievement of the health-related MDGs. Some of the programmes and interventions related to specific MDGs are set out below.

Child Health

The following programmes and interventions with regard to child health had been put in place:

- i) scaled up the coverage of the Expanded Programme on Immunisation (EPI);
- ii) strengthened the implementation of the Integrated Management of Child Illnesses (IMCI) strategy;
- iii) scaled up of the infant and young child feeding services, including promotion of breastfeeding and complementary feeding after six months;
- iv) strengthened the School Health and Nutrition (SHN) Programme; and
- v) promoted Integrated Community Case Management of pneumonia, diarrhoea, malaria and malnutrition, new-born care, paediatric HIV and nutrition.

Maternal Health

The following programmes had been put in place with regard to maternal health:

- i) strengthening of safe motherhood services such as family planning, focused antenatal care, post natal and new-born care and emergency obstetrics and new-born care (EmONC);
- ii) strengthening and improving the visibility of adolescent reproductive health services including provision of accessible information;
- iii) scaling up and expanding the coverage for reproductive health services including cervical cancer screening, fistulae, sexual and gender based violence and male reproductive health; and
- iv) strengthening the adolescent health programme and improving its visibility (including adolescent sexual and reproductive health services).

In addition to the above mentioned programmes in child health and reproductive health, interventions were implemented which were aimed at strengthening the response to cross-cutting issues. These included, among others:

- i) strengthening of the maternal, newborn and child health (MNCH) interventions through the Campaign for Accelerated Reduction of Maternal Mortality in Zambia (CARMMAZ) strategy;
- ii) strengthening community involvement in MNCH and nutrition services;
- iii) mainstreaming nutrition in other key health sector interventions, such as maternal and adolescent health, HIV care, TB and non-communicable diseases (NCDs);
- iv) providing comprehensive health promotion services in all programmes; and
- v) strengthening operational research.

HIV/AIDS

The following programmes had been undertaken in relation to HIV/AIDS:

- i) the Social Behavior Change Communication strategy;
- ii) HIV testing and counselling (HTC);
- iii) Prevention/Elimination of Mother to Child Transmission of HIV;
- iv) Voluntary Medical Male Circumcision (VMMC);
- v) screening and prevention of sexually transmitted infections;
- vi) comprehensive condom programming;
- vii) post exposure prophylaxis;
- viii) blood safety;
- ix) ART services;
- x) home based care; and
- xi) support for orphaned and vulnerable children.

Malaria Programmes/Interventions

The measures and programmes set out hereunder had been undertaken in relation to Malaria:

- (a) Integrated Vector Management (IVM): The IVM was an intervention aimed at promoting an integrated approach to the control of malaria vectors. The two main interventions for vector control in Zambia aimed at preventing malaria transmission were the use of insecticide treated nets (ITNs-specifically long-lasting insecticide treated nets- LLINs) and indoor residual

spraying (IRS) of eligible targeted structures. The national vision for the LLIN programme to achieve universal national coverage was meant to ensure that all sleeping spaces in all targeted households were covered by an LLIN. Two main distribution methods used were mass distribution campaigns and routine distribution to pregnant women through antenatal care clinics. Other methods included the equity channel, which targeted vulnerable groups (orphans, aged and chronically ill).

- (b) Prevention of Malaria in Pregnancy: The malaria control programme had developed and was implementing well-defined Malaria in Pregnancy (MIP) Policy. This included the provision of free Intermittent Preventive Treatment during Pregnancy (IPTp) and free prompt diagnosis and treatment of clinical malaria. This package of interventions was implemented as part of routine focused antenatal care. Current national coverage rates for pregnant women with LLINs and IPTp were among the highest in sub-Saharan Africa.
- (c) The curative interventions were enshrined in prompt and effective case management, which focused on providing care for those that suffered from malaria. A key component of this was the use of confirmatory diagnostic tools such as malaria rapid diagnostic tests (RDTs) and microscopy.

Tuberculosis Programmes

Your Committee was informed that the Government had been implementing the TB control strategies that incorporated the six components of the global STOP TB strategy.

The six components are highlighted as follows:

- a) enhancing and expanding high quality Directly Observed Treatment Short Course (DOTS) services in all districts;
- b) addressing and strengthening TB/HIV and Multi Drug Resistant TB activities in all districts;
- c) contributing to health systems strengthening;
- d) improving collaboration between all care providers in TB care;
- e) engaging people with TB and affected communities in TB control; and
- f) promoting and conduct programme-based operational research.

The strategic interventions and programmes that had been implemented to achieve the TB programme objectives include:

- i) securing sustained political commitment to TB control that had resulted in increased funding for TB control activities from both the Government and the development partners;
- ii) training of the critical mass of health care workers countywide including the community;
- iii) ensuring uninterrupted supply of quality assured TB medicine, laboratory reagents and other supplies;
- iv) increasing TB diagnostic centres to the current 364 centres;
- v) increased coordination and collaboration between TB and HIV/AIDS programmes;
- vi) greater involvement of the community in TB control activities;
- vii) strengthened monitoring, evaluation and supervision at all levels;
- viii) increased focus on TB research; and
- ix) the expansion of TB programmes and interventions to prisons.

The adequacy and efficacy of the programmes that the Government has implemented to accelerate the achievement of the Health-Related MDGs

6.3 Your Committee was informed that the programmes that the Government had implemented to accelerate the achievement of the health-related MDGs were adequate as evidenced by the preliminary results from the 2013/2014 Zambia Demographic and Health Survey. Zambia had recorded remarkable improvements on the health-related MDGs.

Preliminary results from the 2013/2014 Zambia Demographic and Health Survey indicated that the infant mortality rate reduced significantly from 107 deaths per 1,000 live births in 1992, to 45 deaths per 1,000 live births in 2013-2014. Similarly, over the same period, the under-five mortality rate reduced from 191 deaths per 1,000 live births in 1992, to 75 deaths per 1,000 live births in 2013/2014.

The country had further recorded a reduction in maternal mortality from 729 deaths per 100,000 live births in 2002, to 398 deaths per 100,000 live births in 2013/2014.

Some stakeholders were of the view that the programmes were adequate and effective if well implemented. They pointed out that it was necessary to address issues of skilled health workers in general and skilled birth attendants in particular, appropriate infrastructure and equipment and appropriate referral systems at all levels to improve the efficiency and effectiveness of the programmes.

The goals and targets that have been attained

6.4 Your Committee was informed that none of the health-related MDGs had been achieved despite the country making remarkable improvements in a number of indicators. Indications were that Zambia was on course in achieving MDG number four while MDG number five was not likely to be achieved. However, few specific targets related to MDG Number six were attained and, therefore, the country was poised to attain MDG number six. The country had achieved its national target of the HIV prevalence rate of 15.6 percent or less as the HIV prevalence rate stood at 14.6 percent, currently. However, concern was with the malaria target which was threatened by the general observed trend of an increase in the incidence of malaria up to 2011.

Your Committee was informed that the country had attained the two targets of reversing the incidence of TB and reducing deaths due to TB well ahead of the year 2015. However, the target on reversing the prevalence of TB had not been achieved yet.

The challenges affecting the effective implementation of the MDGs programmes

6.5 Stakeholders submitted that there were a number of challenges that affected the effective implementation of the MDGs programmes. They highlighted the various challenges that include the following:

- i) a high disease burden that has impacted negatively on the effective implementation of the MDGs programmes;
- ii) limited medical equipment for diagnosis of malaria, tuberculosis and HIV, among other diseases;
- iii) inadequate infrastructure for health services resulting in clients travelling long distances and fewer early infant diagnostic centers, among other things;
- iv) inadequate financial resources allocated to the health sector;
- v) critical shortage of skilled health workers;

- vi) continued dependency on donor support, which often comes with attached conditions;
- vii) high poverty levels in the country resulting in a high income inequity which has had a negative impact on health indicators;
- viii) existence of some social, cultural and religious beliefs that impact negatively on the implementation of the MDGs programmes;
- ix) limited access to safe and clean water and poor sanitation;
- x) inadequate appropriate transport to conduct outreach services;
- xi) sustained retention of community volunteers is difficult due to lack of incentives;
- xii) inadequate cold chain space for vaccines in the immunisation programme;
- xiii) poor supply chain management which leads to stock outs of relevant commodities in health facilities;
- xiv) stigma hinders many from accessing services;
- xv) poor road networks and communication infrastructure; and
- xvi) lack of maternity waiting homes/mother's shelters in some health facilities.

The experiences and lessons learnt from the implementation of MDGs programmes that can inform the Post 2015 Development Agenda

6.6 Stakeholders submitted that they had learnt some lessons through their experiences with the implementation of MDGs that could inform the implementation of the Post 2015 Development Agenda. Some of the experiences and lessons learnt are set out below.

- i) There had been low engagement with all relevant stakeholders such as parliamentarians on the development agenda.
- ii) A multi-sectoral approach was critical in addressing the MDGs as they were cross cutting.
- iii) There was need for more publicity around MDGs as was the case with HIV and AIDS.
- iv) Provision of maternity waiting homes would promote institutional deliveries.
- v) Traditional birth attendants and community health workers were still critical in the delivery of health services especially in rural areas.
- vi) Working with traditional leaders as champions on issues such as teen pregnancies contributed positively to addressing MDGs.
- vii) There seemed to have been a problem of country ownership of MDGs as their implementation had been mostly driven by external support instead of Government funding.
- viii) The attainment of health related MDGs required adequate financial resources and as such it was necessary for the Government to increase the budgetary allocation to the health sector.

- ix) The critical shortage of skilled health workers needed to be addressed if the health- related MDGs were to be attained.
- x) Reliable data was necessary for policy decision-making. The Ministry of Health in collaboration with Central Statistical Office (CSO) and other stakeholders should continue to conduct the National Demographic and Health Surveys regularly to provide an update on a wide range of indicators such as maternal and child health, HIV/AIDS, malaria and other diseases of public health concern. These indicators were needed by the Government and co-operating partners to track progress made towards implementation of various social and economical development policies and programmes and for policy decision-making.
- xi) A silo approach with many vertical health programmes was not sustainable. Therefore, linkages such as sexual and reproductive health/HIV and family planning/sexually transmitted infections should be promoted and supported.
- xii) Young people must be recognised as a crucial resource for realising the Post-2015 Agenda. Over 34 percent of Zambia’s population is aged between ten (10) and twenty four (24) years.
- xiii) The implementation of the MDGs had unraveled the need for clear policies and guidelines for their operationalisation at all levels.

Update on the Post 2015 Development Agenda

6.7 Your Committee was informed that the United Nations Team in Zambia had organised a national consultation on the Post-2015 Development Agenda in 2013. The objective of the “Post 2015 Future We Want Zambia National Dialogues” were to identify priorities and to provide inputs to the global exercise which culminated in the world’s leaders formulating and agreeing to a bold and inspiring development framework owned by all stakeholders. The development framework would take the world beyond the MDGs.

The national dialogues in Zambia were held across all ten (10) provinces. There were discussions on national television and radio, in public town halls and on various social media platforms. Over 2,000 Zambians participated in cross country community consultations in twenty-nine (29) districts. Others were reached through five (5) radio discussions, two (2) television discussions and via SMS. About a thousand young people participated by viewing the dedicated facebook page on a weekly basis. Voices of young children were also heard in school debates in ten (10) districts.

The dialogues underlined the fact that it was imperative to address root causes and not just the symptoms of development challenges. The youth in Zambia endorsed the idea that people’s participation was crucial for driving inclusive human progress and growth. The top five (5) development priorities identified for the Post 2015 Development Agenda were:

- i) provision of quality education with life skills;
- ii) provision of better health care;
- iii) provision of equality of income, gender, access and opportunity;
- iv) provision of better job opportunities and an enabling business environment; and
- v) eradication of poverty.

In this regard, the Seventh National Development Plan was expected to provide guidance on Zambia’s post 2015 development priorities, as it was expected to be informed by the available evidence.

Your Committee was further informed that the Ministry of Health and the Ministry of Community Development, Mother and Child Health had been part of the planning process and consultative meetings on the Post 2015 Development Agenda.

Stakeholders' recommendations on the way forward beyond 2015 to ensure that issues of Child and Maternal Health, HIV/AIDS, Malaria and Tuberculosis are not side-lined as the Sustainable Development goals take centre stage

6.8 Stakeholders suggested the recommendations presented hereunder.

- (a) There was need to promote early antenatal care (ANC) attendance, health facility deliveries and emergency management of neonatal and maternal care (EmONC). Women should deliver at health facilities where they would be assured of skilled attendance at delivery and trained human resource in EmONC.
- (b) Access to clean water and improved sanitation facilities both in homes and schools could accelerate the achievement of some health-related MDGs.
- (c) Women should be empowered to improve child survival. Therefore the Government should support women's education as it would have a direct impact on the lives, health and nutritional status of their children.
- (d) The Government should construct maternity waiting homes in all health facilities so that women were closer to good delivery facilities early in their pregnancy.
- (e) There was need to reduce the high number of unsafe abortions, both by preventing unplanned pregnancies and by tackling barriers that prevent women from accessing safe services. Community interventions could increase awareness about the moral and legal rights of women to access abortions under certain circumstances.
- (f) The Government and its partners should focus on improving access to VCT and VMMC especially in rural areas.
- (g) The prevention of mother-to-child transmission (PMTCT) of HIV during pregnancy, labour, delivery and breastfeeding should be strengthened. It was important that the Government took the ownership of many HIV/AIDS programmes such as ART and ensured that enough resources were available for quality services.
- (h) Policies should be reviewed to provide an enabling environment for the national HIV response.
- (i) The cash transfer scheme should be scaled up to help reduce poverty.
- (j) There was need to strengthen the nutrition interventions and the NFNC by moving it to the Office of the Vice President.
- (k) The Government should employ more health workers that is, nurses, midwives and doctors, among others.
- (l) The Government should fund the health sector adequately and ensure that health facilities received adequate grants which were released and disbursed regularly to health facilities.
- (m) There was need for a robust monitoring system for the drug supply chain to ensure availability of drugs at health facilities.
- (n) Health priorities post-2015 should address the neglected elements of the MDGs such as the social determinants of health, including girls' education, women's literacy, health, equity and gender equality.

- (o) The structure of the MDGs had encouraged the building of silos especially from the donor funding. The next development agenda should have linkages and integration of programmes at different levels whilst observing the required outcomes and indicators.
- (p) The reproductive rights of women must be clearly upheld in the Post-2015 Agenda.
- (q) In order to sustain the gains made in the past decade in the implementation of TB-HIV collaborative activities, there should be increased coordination and collaboration between the TB and HIV and AIDS Programmes at national, provincial, district and health facility level.
- (r) TB control in prisons and mines should be prioritised.
- (s) Community and civil society involvement should be strengthened. The Government should consider allocating a modest budget to motivate hard working community volunteers.

TOUR OF SELECTED HEALTH INSTITUTIONS AND A PUBLIC HEARING CONDUCTED AT ST FRANCIS MISSION HOSPITAL IN KATETE

6.9 Your Committee undertook a tour of selected health institutions in Lusaka, Eastern and Muchinga Provinces on the topic “Progress made by Zambia towards achieving the health-related MDGs number four, five and six”.

The following institutions were visited:

- i) Chongwe District Hospital;
- ii) Minga Mission Hospital;
- iii) St Francis Mission Hospital;
- iv) Chipata General Hospital;
- v) Lundazi District Community Hospital;
- vi) Chama District Hospital; and
- vii) Chinsali District Hospital.

CHONGWE DISTRICT HOSPITAL

6.9.1 Your Committee learnt that Chongwe District Hospital was a 1st level hospital and the only hospital in Chongwe District. It has a bed capacity of 100 and serves a population of approximately 174,000.

The Hospital provides various services including maternal health, child health, HIV/AIDS, malaria and tuberculosis services.

Child Health Services

The Hospital provides immunisations and child counselling services. Hospital admissions in 2014 totalled 1153, mainly due to malaria, pneumonia, diarrhoea anaemia, and malnutrition in that order. In the same year, the Hospital recorded twenty-three (23) deaths, that is 2 percent of the total admissions.

Maternal Health Services

The Hospital provides short term, long term and permanent family planning services. Other services provided include antenatal care, EMTCT, deliveries of normal and complicated/assisted cases, comprehensive abortion care and emergency surgical interventions for ruptured uterus, ruptured ectopic pregnancy and obstructed labour.

HIV/AIDS Services

The services offered include HIV counselling and testing and ART.

Malaria

Your Committee learnt that malaria was very common among the under-five children and pregnant women. Malaria interventions by the Hospital include IRS, and distribution of ITNs to all children and pregnant women on discharge as well as to mothers with new-born babies to encourage institutional deliveries.

Tuberculosis (TB) Services

Your Committee further learnt that the Hospital was one of the three (3) diagnostic centres in the District. In 2014, the Hospital recorded 228 TB cases. The cure rate was 70 percent while seventeen deaths were recorded.

Challenges

Your Committee was informed that the Hospital was facing a number of challenges, which are highlighted hereunder.

- (a) The Hospital has no standby electricity generator.
- (b) There is inadequate medical equipment and furniture (concentrators, infant incubators, suction machines, doppler, ultra sound machines, vacuum extractor sets, baby cots, lockers and chairs).
- (c) The Hospital has inadequate space for malnutrition and burns patients.
- (d) Irregular funding by the Government.
- (e) The Hospital experiences inadequate supplies from Medical Stores Limited (MSL).
- (f) Only 41 percent of the Hospital establishment is funded.
- (g) The Hospital has no incinerator (micro-burn).
- (h) The Hospital has no relatives' shelter.
- (i) There is inadequate space in the laboratory.
- (j) The Hospital has no utility vehicle.

The Hospital administration urged your Committee to lobby the Government on their behalf for the following, among others:

- i) the urgent procurement of a stand by generator;
- ii) the urgent delivery of the hospital equipment;
- iii) provision of a separate malnutrition ward and a laboratory;
- iv) the expansion of the Out Patients Department taking into account cervical cancer and ART services provision;
- v) funding of all positions on the establishment;
- vi) construction of a relatives' shelter;
- vii) provision of a utility vehicle for the hospital;
- viii) regular disbursement of the grant by the Government; and
- ix) MSL to regularly supply basic essentials for quality health care provision.



Members of the Committee with Chongwe District Hospital members of staff



MINGA MISSION HOSPITAL

6.9.2 Your Committee was informed that Minga Mission Hospital located in Petauke District was a 1st level hospital owned and managed by the Catholic Church. It had a bed capacity of 175 and served an estimated population of 112, 365.

Child and Maternal Health Services

The Hospital provides antenatal and postnatal services, elimination of mother to child transmission of HIV (eMTCT), cervical cancer screening, deliveries and family planning (only Bilateral Tubal Ligation-BTL).

The Hospital further provides immunisations and child monitoring services.

HIV/AIDS

The services offered include static and outreach counselling and testing, ART and VMMC.

Malaria Services

The Hospital undertakes case management, provides ITNs, conducts IRS and offers intermittent presumptive treatment in pregnancy services.

TB Services

The Hospital provides in relation to TB services detection and management, follow-ups, contact tracing and information, education and communication, amongst others.

Challenges

The Hospital faces the following challenges:

- (i) inadequate infrastructure for the maternity ward, chest clinic and antenatal clinic;
- (ii) inadequate equipment for EmONC such as incubators, delivery packs and oxygen concentrator.
- (iii) faulty stand by electricity generator;
- (iv) limited staff establishment resulting in critical shortage of skilled health workers;
- (v) inadequate and delayed funding;
- (vi) lack of internet facility; and
- (vii) inadequate transport for outreach services.

The Hospital administration urged your Committee to lobby Government for the following:

- i) a new maternity ward, chest clinic, antenatal clinic and mother's shelter were constructed;
- ii) increased and regular funding on a monthly basis;
- iii) expansion of the hospital establishment;
- iv) provision of reliable transport and internet to the hospital;
- v) provision of back up lighting system for the maternity ward such as solar energy; and
- vi) provision of adequate equipment for EmONC.



Members of the Committee with Minga Mission Hospital members of staff

ST FRANCIS MISSION HOSPITAL

6.9.3 Your Committee was informed that St Francis Mission Hospital located in Katete District is owned by the Zambia Anglican Council, which had mandated the Anglican Diocese of Eastern Province and the Catholic Diocese of Chipata to manage the hospital jointly. (Joint Anglican-Catholic Management Board).

It was founded as a mission hospital by the Anglican Church in 1948. The Hospital has developed into a 2nd level referral hospital in Eastern Province with a 350 bed capacity. As the only hospital in Katete District, it also acts as a 1st level referral hospital for health centres and clinics in neighbouring Mambwe, Chadiza, Sinda and Petauke districts.

St Francis Mission Hospital was totally supported by the Government of Zambia for all its monthly operational costs. Partners such as Churches Health Association of Zambia (CHAZ) and Friends of St Francis, supported specific projects such as renovations of hospital infrastructure and outreach programmes. The Hospital's monthly grant was about 60 percent to 70 percent that of a non-church run health institution.

The Hospital has 405 members of staff including 185 GRZ medical staff and tutors and fifty-nine (59) staff on St Francis Mission Hospital's local payroll.

Child Health Services

The Hospital has an in-patient paediatric ward consisting of eighty (80) beds and a neonatal ward (special care baby unit) with eleven (11) improvised incubators.

The major causes of morbidity in children under-five years in 2014, were malaria, malnutrition, pneumonia and anaemia, in that order. The Hospital also reported increased malnutrition cases in 2014. Two hundred and seventy nine (279) cases of malnutrition were admitted at the Hospital in 2014 while fifty-nine (59) deaths were reported to have been caused by malnutrition in the same year. There had, further, been a marked decline in deaths arising from the major causes of mortality, although malnutrition and malaria had shown an increase in 2014.

In 2014, there were a total of 592 neonatal admissions and 150 deaths. The major causes of morbidity were birth asphyxia (250), prematurity (200) and neonatal sepsis (127). The other fifteen (15) cases were due to other causes. Out of the 150 neonates who died, sixty-one (61) were due to prematurity, fifty-six (56) died from asphyxia, nineteen (19) died from neonatal sepsis and fourteen (14) died from other causes.

Maternal Health Services

The services provided include deliveries and postnatal care, family planning (permanent method), out-patient gynaecology clinic, cervical cancer screening and antenatal to mothers at the 'waiters' shelter. The Hospital has a maternity ward with seventy-one (71) beds for ante natal, post natal and labour ward combined. In addition, there were twenty-two (22) gynaecology beds on a ward shared with general surgery and orthopaedic patients.

In 2014, the Hospital conducted 2,956 deliveries and all of them were attended to by skilled health personnel. Further, 2,428 women were screened for cervical cancer. Out of this number, 2,215 were negative while 213 were positive.

The number of maternal deaths occurring in the institution declined from 0.27 percent in 2013 to 0.17 percent in 2014. Post partum haemorrhage (PPH) accounted for four (4) out of the five (5) maternal deaths in 2014 and one (1) resulted from puerperal sepsis.

HIV/AIDS Services

Your Committee learnt that St Francis' Mission Hospital had one of the largest ART programmes in the country. The Hospital has been conducting static and mobile ART services since 2004. Other HIV related services provided by the Hospital include HIV testing and counselling (HTC), PMTCT/eMTCT as well as VMMC.

Malaria Services

Services provided by the Hospital include out-patient department screening for malaria, in-patient wards for adults and children for treatment of non complicated or severe and complicated malaria. There are also malaria microscopy and rapid diagnostic tests services in the laboratory. Other services were IRS and distribution of ITNs.

TB Services

The TB services provided by the Hospital are laboratory sputum examination, x-ray, biopsy, treatment and follow-up of TB clients. In addition, out patients are seen on a daily basis at the Hospital's TB corner.

Challenges faced by the Hospital

Your Committee was informed of the following challenges:

- i) human resource shortages as the hospital had no paediatrician, TB and HIV specialists and paediatric nurses and midwives were also few;
- ii) inadequate medical equipment such as incubators;
- iii) inconsistent supply of medical supplies such as F100, paediatric ARVs formulations and plump nut from MSL;

- iv) frequent breakdown of the old chemistry and haematology blood testing machines which compromised the quality of care for the clients;
- v) inadequate infrastructure at the clinic for the proper management of clients during counselling, testing, collection of specimens and general examination. There was no dedicated obstetric operating theatre;
- vi) ART services were Cooperating partner dependant and raised sustainability concerns; and
- vii) lack of transport designated for the TB programme.

Way forward

The Hospital recommended that in order for it to operate efficiently, there was need to-

- i) expand the Hospital establishment in order to provide for adequate relevant staff such as midwives, a paediatrician and HIV specialist;
- ii) purchase at least ten (10) incubators, lobby for new high-volume chemistry and haematology machines and decentralise the maintenance of hospital equipment;
- iii) ensure sustainable availability of paediatric ART formulations, nutritional supplements and other supplies at MSL;
- iv) provide funding for the expansion of the Hospital infrastructure including a dedicated obstetric operating theatre;
- v) provide more GRZ budgetary support towards implementation of ART services; and
- vi) purchase a new vehicle (Land-cruiser) for the TB programme.

CHIPATA GENERAL HOSPITAL

6.9.4 Your Committee learnt that Chipata General Hospital was a provincial referral hospital with a bed capacity of 458. The Hospital serves a provincial population of 1,789,650.

Child Health Services

Your Committee was informed that Chipata General Hospital provides diagnostic services, curative care, blood transfusion services and rehabilitative services under child health. Your Committee also learnt that malnutrition was the leading cause of deaths in under-five children on average, followed by pneumonia, severe diarrhoea and malaria, respectively. In 2014, the Hospital admitted five hundred and four (504) cases of malnutrition and recorded fifty nine (59) deaths due to malnutrition.

Maternal Health Services

The Hospital management informed your Committee that the maternal health services offered by the Hospital were diagnostic services (ultra sound scan and laboratory services), delivery services, post abortion care, family planning and cervical cancer screening.

On the trends in maternal health, your Committee learnt that the maternal mortality rate increased from 0.7 percent to 0.9 percent by the end of 2014. The major causes of maternal mortality from the mortality review meetings conducted were identified to be hemorrhage (pre and postnatal) and eclampsia due to delayed referrals and lack of an intensive care unit (ICU) facility.

HIV/AIDS Services

The HIV/AIDS services provided by the Hospital are pre and post-test counselling, HIV testing and viral load checkups.

TB Services

The Hospital provides diagnostic services, that is microscopy and molecular (genexpert), tuberculosis treatment and radiology services.

The number of clients tested against TB had increased from 1 688 in 2013, to 1 981 in 2014, respectively. On the other hand, the positivity rate reduced from 17.3 percent in 2013, to 8.3 percent at the end of 2014.

Malaria

With regard to malaria, Chipata General Hospital offered diagnostic services (rapid diagnostic tests and microscopy), curative services, blood transfusion and provision of ITNs.

The Hospital reported that it had successfully reduced deaths arising from malaria cases in all ages from 68 deaths per 1000 population in 2013, to 46 deaths per 1000 population by December, 2014.

Challenges

Your Committee was informed of a number of challenges the Hospital faces that affected services provision negatively. Notable among them were:

- i) inadequate infrastructure resulting in limited space for provision of services such as maternity and emergency theatre and lack of space for I C U and neonatal unit;
- ii) inadequate equipment such as resuscitative and diagnostic equipment and lack of a renal dialysis unit;
- iii) limited staff establishment which resulted in shortage of relevant staff;
- iv) delayed and inadequate funding;
- v) inadequate skills to maintain the available equipment;
- vi) lack of a backup electricity generator; and
- vii) inadequate and delayed supply of drugs by MSL.

The Hospital management was of the view that there was need to:

- i) construct a maternity theatre;
- ii) provide space for an intensive care unit (ICU), a neonatal unit and procure other necessary equipment such as a renal dialysis unit;
- iii) expand the staff establishment to meet the growing demand;
- iv) release the government grant timely and regularly;
- v) decentralise the management of hospital equipment;
- vi) procure a backup electricity generator in case of a power failure;
- vii) ensure that drugs were available and regularly supplied to the Hospital.



Members of the Committee with Chipata General Hospital members of staff

LUNDAZI DISTRICT HOSPITAL

6.9.5 Your Committee was informed that Lundazi District Hospital was a level one hospital which was built in 1946. Your Committee further heard that the burden of disease in Lundazi was high. However, the Hospital had not been expanded despite serving a current population of 256, 502. Major causes of ill-health include malaria, HIV/AIDS, TB, pneumonia, diarrhoea, maternal and childhood illnesses, road traffic accidents and non communicable diseases.

Maternal Health Services

The Hospital offered antenatal and postnatal care, deliveries including caesarean sections and family planning counselling and provision services. In addition, cervical cancer screening and education was also conducted.

HIV/AIDS

The Hospital provides VMMC and ART services.

Tuberculosis (TB)

In addition to health education on TB and its management, VCT was offered to all TB patients on admission.

Achievements

Your Committee learnt that among the notable achievements of the Hospital were its ability to offer all the 1st level package of health services despite the poor staffing; and the prudent utilisation of all the received resources both in material form and finances.

Challenges

The major challenges faced by the Hospital are as follows:

- i) poor staffing at the hospital;
- ii) delayed Government funding;
- iii) high water bills from Eastern Water and Sewerage Company (EWSC) which ranged from K7,500 to K12,800 per month amid the delayed Government funding;
- iv) inadequate hospital space to separate highly infectious patients and to accommodate all the patients, which sometimes resulted in floor beds especially in the children's ward (paediatrics).



Members of the Committee and some Hospital staff outside Lundazi District Hospital



In the paediatric ward of Lundazi District Hospital

CHAMA DISTRICT COMMUNITY HOSPITAL

6.9.6 Your Committee was informed that the population of Chama District was 131, 514. Your Committee further learnt that Chama District Community Hospital offered the following services to the community:

- i) antenatal care;
- ii) deliveries;
- iii) postnatal care;
- iv) family planning;
- v) TB/STI services;
- vi) VMMC;
- vii) HIV testing and ART; and
- viii) screening of patients/admission.

Child Health Services

The Hospital has recorded an improvement in case management and there was increased community sensitisation on good health seeking practices. However, immunisation programmes were hampered by the District's bad terrain in the rainy season.

Maternal Health Services

Your Committee further learnt that there had been an increase in the number of women delivering from the Hospital and rural health centres (RHCs) due to increased sensitisation and donor support in the last five (5) years. Skilled deliveries had also improved due to an increase in the number of trained midwives at the Hospital and RHCs.

However, maternal deaths had risen in 2013, mainly due to indirect causes such as anaemia in pregnancy and complications of HIV. Many still births were also experienced during the rainy season as most facilities were cut off during the rainy season, thereby making it impossible for patients requiring operative deliveries to reach the hospital in time.

TB

The Hospital conducts active case detection and management and involved the community in TB sensitisation and management. The anti TB drugs were available and were provided to clients as required. This has resulted in a cure rate of 96 percent in the district.

Malaria

Your Committee was informed that malaria was still the leading cause of morbidity and mortality in the district. Despite the interventions in the district, the geographical location was a major hindrance. For example, while ITNs were distributed and accepted by the community, they were rarely used as most areas were a valley and tended to be too hot.

Challenges

The major challenges faced by the Hospital are as follows:

- i) uptake of family planning services was still a challenge due to cultural norms;
- ii) lack of continued support by cooperating partners in HIV/AIDS and TB care from the time Chama became part of Muchinga Province;
- iii) inaccessibility of facilities during the rainy season making it difficult to provide outreach services; and
- iv) irregular flow of the Government grant.

In view of the challenges highlighted above, your Committee learnt that there was need:

- i) to undertake more community sensitisation on the importance of family planning;
- ii) to harness more partners' support such as Centres for Disease Control and Prevention (CDC) and Zambia Prevention, Care and Treatment (ZPCT) as they were able to reach almost every area in the district despite the inaccessibility of some areas; and
- iii) for timely and regular release of the monthly government grant.



Members of the Committee and Chama Hospital members of staff



In the Operating Theatre at Chama Hospital

CHINSALI DISTRICT HOSPITAL

6.9.7 Your Committee learnt that Chinsali District Hospital was a 1st level hospital catering for a total population of 88,031 with a bed capacity of 100. It is currently the referral hospital for the newly created Shiwangandu District which had nine health centres.

Child Health and Maternal Health Services

The Hospital conducts all forms of deliveries, that is, normal deliveries, complicated deliveries, caesarean sections, ventouse/vacuum and forceps (rare). Other services provided were antenatal and postnatal care by a unit called Hospital Affiliated Health Centre (HAHC) at Location Clinic, family planning, PMTCT of HIV and cervical cancer screening.

In addition, immunisations and growth monitoring and promotion services are provided by the Hospital Affiliated Health Centre (HAHC) while the Hospital has a paediatrics ward.

Challenges related to Child and Maternal Health Services Provision

These are:

- i) inadequate midwives at the hospital;
- ii) non-availability of standard delivery beds;
- iii) inadequate resuscitation equipment for the new born;
- iv) few health workers trained in emergency obstetric and neonatal care; and
- v) inadequate transport.

HIV/AIDS Services

The HIV/AIDS services provided are HIV counselling and testing, distribution of condoms, ART services and defaulter tracing.

However, provision of these services was challenged by inadequate transport and the inadequate number of adherence counsellors.

TB Services

The Hospital offers preventive services, curative services, laboratory services and radiological services. The Hospital has one (1) modern x-ray machine and it was the only x-ray facility in the district.

Challenges

The following challenges were faced by the Hospital-

- i) lack of a utility vehicle for routine TB activities;
- ii) inadequate laboratory and clinical staff; and
- iii) there were few partners to support the TB programme.

The Hospital management recommended that there was need for the Hospital to have at least two (2) utility vehicles for effective delivery of health services and to harness more partners to support the TB programmes in the province. It was further recommended that the Ministry of Health should find ways of motivating community TB treatment supporters besides the 10 percent community allocation from the government grant.

Malaria Services

The Hospital provides intermittent presumptive treatment, environmental management and early diagnosis and treatment of malaria.



Members of the Committee and Senior Management at Chinsali District Hospital

PUBLIC HEARING

6.9.8 In addition to touring St Francis Mission Hospital, your Committee further held a public hearing within the precincts of the hospital. The public hearing was attended by 118 people. The findings of your Committee arising from the public hearing are set out below.

Child Health

- i) Mothers complained that the staff at the referral hospital were often rude to them.
- ii) The members of the public were concerned with the referral system in their area. They stated that people living near St Francis Mission Hospital had to look for a clinic elsewhere leaving the hospital nearby as the hospital would not attend to sick children without a referral letter. They argued that the process of looking for a referral letter contributed to parents' delay in taking sick children to the hospital. If parents went to the hospital without referral letters, they were asked to pay a fee in order to be attended to.
- iii) The members of the public observed that children waited for a long time on the queue before being attended to at most health facilities. Besides, parents were told to buy certain medicines that health facilities could not provide.
- iv) The members of the public bemoaned the fact that insecticide treated nets (ITNs) were not equitably distributed. They alleged that ITNs did not reach the villages that were farther away from the district centre.

- v) There was a shortage of skilled health personnel as some health facilities in Katete were being manned by non-skilled personnel. They cited certain health facilities where sick children were being attended to by cleaners.

Maternal Health

- i) The members of the public bemoaned the unprofessional conduct of some nurses. They informed your Committee that some nurses were rude, neglected pregnant women and some of them even insulted patients. Your Committee heard that such nurses were reported to relevant authorities, but no action was taken. Some clinics did not have midwives.
- ii) Women shunned contraceptives due to some beliefs such as the alleged negative effects of contraceptives on a women's fertility.
- iii) Health facilities were too spaced in Katete resulting in women having to travel long distances to access maternal health services. Your Committee was informed about this problem which has resulted in some women delivering on the way to a health facility.

HIV/TB/Malaria

- i) The members of the public informed the Committee that there was a shortage of septrin which is sometimes prescribed for clients on Anti-Retroviral Treatment.
- ii) ART centres sometimes experienced stock outs of ARVs thereby forcing them to give clients drugs for shorter periods. Clients complained that they were forced to make more trips to ART centres to collect ARVs.
- iii) The District Aids Task Force in Katete was not adequately funded to effectively supervise HIV/AIDS activities in the district.
- iv) There was lack of confidentiality by some HIV/AIDS counselors and service providers. As a result, some clients shunned the services for fear of being stigmatised.
- v) Some churches discouraged people from taking ARVs.
- vi) Katete District had insufficient secondary schools. As a result many pupils are weekly boarders. However, concern was raised that pupils in boarding houses engaged in premarital sex and ended up contracting STIs and HIV.
- vii) Many people in Katete suffered from Malaria because there were too many mosquitoes. Some participants observed that Katete was too dirty and suggested that there was need for community sensitisation on the importance of cleanliness. The participants submitted that there was need for the Environmental Health Officers to constantly sensitise the community on better health practices and carry out indoor residual spraying to prevent breeding of mosquitoes and distribute insecticide treated nets equally.

General Concerns

- i) Some health posts opened at 10:00 hours and closed as early as 16:00hours.
- ii) Private sector participation in health services delivery in Katete was limited.
- iii) Katete had no district hospital.



Some of the participants at the public hearing



St Francis Women Choir Welcoming the Committee

COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

6.10 Having reviewed the progress made by Zambia towards achieving the Health-Related Millennium Development Goals (MDGs) Number Four, Five and Six and taking into consideration the findings from the local tour and the public hearing, your Committee's observations and recommendations are set out hereunder.

Observations

- (a) Some religious and cultural beliefs negatively affect the uptake of certain health services such as family planning, child immunisation and ART.
- (b) Maternal mortality remains high in Zambia. Your Committee also observes that maternity waiting homes promote institutional deliveries in areas where women have to travel long distances to access maternal health services.
- (c) The reported cases of unsafe abortions being presented to health facilities are a matter of concern.
- (d) Most HIV/AIDS programmes are donor funded.
- (e) TB is among the leading causes of death among HIV positive people.
- (f) Malaria is still a major public health concern as it is one of the main causes of morbidity and mortality generally.
- (g) The financial resources allocated to the health sector are inadequate considering the many health programmes competing for the same resources. This is evidenced by the net recruitment freeze of 2014, despite the shortage of skilled personnel in the health sector; and the reported inadequate resources for some programmes, which had resulted in the resurgence

of some diseases like malaria. Further, despite the reported increase in Government funding to the National Malaria Control Programme (NMCP) in 2013, it still had a shortfall of 53 percent of its total annual financing needs. The Government funding to NMCP in 2013 was US \$24.8 million against the total annual required budget of US \$52.8 million.

- (h) There is limited medical equipment in health facilities for provision of effective health services such as diagnosis and management of diseases like HIV, TB, Malaria and provision of EmONC services.
- (i) The available medical equipment in health facilities is rarely serviced and maintained leading to frequent breakdowns.
- (j) There is inadequate infrastructure for the provision of certain services in some health facilities. For instance, some facilities have no proper maternity wards, ICU and laboratories.
- (k) The health sector suffers from a critical shortage of skilled health workers such as midwives, paediatricians and HIV and TB specialists who are key in implementing MDGs programmes.
- (l) There seems to be a problem with the supply chain management as evidenced by the reported inconsistent supply of certain drugs such as adult and paediatric ARVs and other essential drugs to health facilities.
- (m) Lack of adequate and appropriate transport has affected the provision of outreach services especially in places with hard to reach areas such as Chama District.
- (n) The existing staff establishments in a number of health facilities are small and not all positions on the current establishments are funded in some health facilities. For example, only 41 percent of the hospital establishment is funded at Chongwe District Hospital while St Francis Mission Hospital, which is a 2nd level hospital, has no paediatrician as that position was frozen.
- (o) There is irregular disbursement of the monthly Government grant to health facilities.
- (p) Many health facilities are in need of standby electricity generators as an alternative source of power in the event of power failures or load shedding.
- (q) There are persistent general complaints about the bad attitude of health workers, especially nurses.
- (r) The referral system seems to disadvantage clients that live very near a referral hospital. This is because they have to leave the health facility near them to look for a clinic elsewhere that can then provide them with a referral letter to seek services at the referral hospital.
- (s) Malnutrition contributes to morbidity and mortality among under-five children. For example, data at St Francis Mission Hospital and Chipata General Hospital indicates that malnutrition is a leading cause of mortality in under-five children.

Recommendations

- (a) The Ministry of Health should embark on massive targeted sensitisation of communities that shun family planning and immunisation services in order to educate them on their importance. The Ministry should explore the possibility of partnering with Members of Parliament in sensitising communities on important health issues such as family planning and immunisation services. The Ministry should further engage religious groupings on the issue of some religious leaders advising their members not to take ARVs.

- (b) In order to sustain the gains in the reduction of maternal mortality and to make progress towards achieving MDG number five, the Government should construct maternity waiting homes or mothers' shelters in health facilities where they are non-existent. The Government should additionally continue sensitising pregnant women on the importance of seeking early ANC services and delivering in health facilities.
- (c) The Ministry of Health should devise measures to reduce the reported unsafe abortions. Your Committee is of the view that unwanted pregnancies should be prevented by ensuring that every woman in need of family planning services accesses them without difficulty. The Government is further urged to undertake consultations on the abortion law in Zambia with all relevant stakeholders to chart the way forward on how best to implement the legal abortion policy in Zambia.
- (d) It is time the Government took ownership of the HIV programmes by ensuring that adequate resources are allocated for the provision of quality HIV/AIDS services.
- (e) There is need to integrate TB and HIV/AIDS services considering the observed relationship between TB and HIV in clients.
- (f) The Ministries of Health and Community Development, Mother and Child Health should continue and intensify the malaria interventions such as distribution of ITNs and IRS in order to contain the malaria situation.
- (g) Adequate resources should be allocated to the health sector for improved service delivery at all levels. Your Committee, therefore, urges the Government to meet the 15 percent Abuja Declaration target that encourages governments to allocate at least 15 percent of their national budget to the health sector.
- (h) The Ministry of Health should procure relevant medical equipment for all health facilities around the country. Notable among the equipment required urgently are haematology and chemistry machines, ultra sound machines and incubators.
- (i) The Ministry of Health should also revisit the current policy on servicing and maintenance of medical equipment to ensure that technical and financial capacity is built at national level and at provincial level through decentralisation of financial resources to provinces. The current situation where some very expensive equipment such as the laundry equipment at Chipata General Hospital is faulty and has remained unused is unacceptable.
- (j) There is need to expand the health infrastructure to meet the growing population and demand for services such as deliveries, ICU and laboratories. The Government should embark on a deliberate expansion and modernisation programme especially for all old health facilities such as 1st level and 2nd level facilities.
- (k) The Government should take seriously, the critical shortage of skilled health workers and begin to address the problem by employing all the health workers that have remained unemployed since 2014. The Ministry of Health should also expedite the construction and opening of the Chainama Training Institute which is expected to be training various cadre of health personnel.
- (l) The Ministry of Health is urged to address the problems associated with the supply chain management to deal with the reported inconsistent supply of certain drugs in health facilities.
- (m) The Government should provide health facilities with adequate and appropriate transport that suits the terrain of each concerned area to enable them conduct outreach services.

- (n) The Ministries of Health and Community Development, Mother and Child Health should review and increase current staff establishments in health facilities to enable health facilities increase their staffing levels to meet the growing demand and required expertise. For instance, some health facilities require specialists such as paediatricians and TB and HIV specialists. However, they are constrained by the limited establishment. Further, all positions on the current staff establishments that are not funded should be funded to allow the concerned facilities to have the required staff.
- (o) The Government should disburse the monthly grant to health facilities regularly and promptly without missing any month.
- (p) The Ministry of Health should expedite the provision of standby electricity generators to all health facilities as an alternative source of power in case of power failures or load shedding.
- (q) The Ministry of Health is urged to ensure that training institutions also teach trainee health workers the need for professional conduct and respect for clients in their performance of duty.
- (r) The Ministry of Health should explore the possibility of allowing clients living very near a referral hospital to access health services at the hospital instead of seeking services elsewhere.
- (s) The Government should adequately fund and scale up high impact interventions that will prevent malnutrition in children. In addition, the Government should train more relevant cadre in nutrition to ensure that nutrition programmes and policies are implemented effectively and efficiently.

PART II

ZAMBIA'S PREPAREDNESS AGAINST A POSSIBLE OUTBREAK OF THE EBOLA VIRUS DISEASE

Background

7.0 Following the outbreak of the Ebola Virus Disease (EVD) in West Africa and the Democratic Republic of Congo (DRC) in 2013 and 2014, respectively, your Committee resolved to undertake a study on Zambia's Preparedness against a Possible Outbreak of the Ebola Virus Disease.

The main objective of the study was to ascertain and appreciate measures that the Government had instituted to prevent a possible outbreak of the Ebola Virus Disease as well as to manage it in the event of an outbreak.

To help it study the topic, your Committee requested written memoranda from the Ministries of Health and Home Affairs, Centres for Disease Control and Prevention (CDC) Zambia and the Zambia Revenue Authority. These stakeholders also made oral submissions before your Committee.

CONSOLIDATED SUMMARY OF STAKEHOLDERS' SUBMISSIONS

7.1 Your Committee was informed that the Ebola Virus Disease is a severe disease in humans, which is caused by the Ebola virus. The virus is transmitted from wild animals to people. Among humans, Ebola is transmitted through direct contact with the blood, secretions, organs or other bodily fluids of infected people, and indirect contact with environments contaminated with such fluids.

Your Committee learnt that the signs and symptoms of Ebola included the sudden onset of fever, intense weakness, muscle pain, headache and sore throat. This was followed by vomiting, diarrhoea, skin rash, poor kidney and liver functioning and in some cases, both internal and external bleeding.

Measures that the country has put in place for the prevention and management of a possible EVD outbreak

7.2 Your Committee was informed that Zambia had taken important steps to prepare for a possible Ebola outbreak, generally. In this regard, the Government through the Ministry of Health had adopted measures related to coordination, surveillance, case management, resources and logistics and information, education and communication. These are detailed below.

i) Coordination

The Disaster Management and Mitigation Unit (DMMU) in the Office of the Vice President had been mandated to coordinate the Ebola response preparedness. A national rapid response team had been constituted comprising all the key stakeholders.

In order to strengthen a Government-wide approach, multi-sectoral meetings, chaired by the Secretary to the Cabinet were held weekly. All Government Ministries were represented at Permanent Secretary level. The Ministry of Health provided updates on the Ebola situation in West Africa while other ministries shared progress on their mandated responsibilities. Similar meetings were also held at provincial and district levels. Furthermore, a comprehensive Ebola Virus Disease Epidemic Preparedness and Response Plan with an estimated budget of K106,142,459.00 had been prepared. The budget covered disease surveillance, port health, case management, community sensitisation, isolation and quarantine facilities as well as building laboratory capacity.

ii) Surveillance

Zambia had intensified surveillance for all notifiable diseases and for Ebola in particular. Consequently, the Minister of Health through the *Public Health Act* issued the *Statutory Instrument No. 49 of 2014*, to add Ebola to the list of notifiable infectious diseases in the country.

Your Committee further learnt that Zambia had in-country capacity to test for Ebola at the University of Zambia, School of Veterinary Medicine. The Ministry of Health was also building the capacity of the Virology Laboratory at the University Teaching Hospital to test specimen for Ebola.

The Ministry was rigorously screening travelers from the Ebola affected countries at all ports of entry to ascertain their level of risk. Therefore, two infra-red thermal scanners had been installed at the Kenneth Kaunda and Simon Mwansa Kapwepwe International Airports. In addition, all the four international airports and Mwami, Kasumbalesa, Nakonde, Mpulungu, Nchelenge and Katima Mulilo border posts had been equipped with hand held thermal scanners.

iii) Case Management

Your Committee was informed that each province had identified isolation facilities to use at the points of entry in the event of an outbreak. However, the Government planned to build appropriate isolation facilities for infectious diseases.

All hospitals in the provinces were holding regular meetings on Ebola to raise awareness among the health care providers. The Ministry of Health had stationed ambulances in the provinces to facilitate the movement of suspected cases to isolation facilities.

iv) Resources and Logistics

Your Committee was informed that the Ministry of Health had procured Personal Protective Equipment (PPE) including ninety-five (95) respirators and tyvec suits which were distributed to the provinces. In addition, the World Health Organisation (WHO) had also donated additional PPE to the Ministry of Health.

v) **Information, Education and Communication**

Your Committee was further informed that the Ministry of Health in collaboration with other stakeholders had been conducting a massive sensitisation campaign on Ebola using electronic and print media and community meetings.

The country's strengths and weaknesses vis-à-vis health systems and disease surveillance

7.3 Your Committee was informed that Zambia's disease surveillance network was fairly well established to serve the country well in the event of an Ebola outbreak. There was also strong political will to ensure that the health system in the country functioned effectively through increased budgetary allocation to the health sector to improve service delivery and human resource, among other things. Additionally, a comprehensive disease surveillance system existed in Zambia through the implementation of the Integrated Disease Surveillance and Response Strategy adapted from the WHO African Region. Further, the capacity to identify and manage Ebola also existed across all levels of health care. However, there were some weaknesses such as inadequate laboratory infrastructure for confirming highly infectious diseases and inadequate PPE for use in the management of highly infectious diseases such as Ebola. Infrastructure for isolation of highly infectious diseases like Ebola did not exist as well while inadequate awareness on Ebola issues at health facilities around the country could lead to failure to recognise Ebola cases early and ultimately failure to prevent a large outbreak.

Challenges affecting the process of preparedness against possible outbreak of the Ebola Virus Disease (EVD)

7.4 Your Committee was informed that the main challenges affecting the process of preparedness against a possible outbreak of Ebola were the inadequate funding for rehabilitation and construction of infectious diseases isolation sites in selected provinces and districts; and the non-availability of a web-based early warning system and communication accessories in the health facilities and ports of entry.

Some Concerns Raised

7.5 While appreciating that Ebola-related trainings had been conducted especially at national level, a concern was raised that there might not have been any trainings conducted at district and facility levels. Concern was also raised over the heavy reliance on thermal scanners when screening travellers from affected countries. It was suggested that travellers with suspected possible exposures should be checked further using a standard thermometer. Concern was further raised over the inadequate health personnel and Ebola screening equipment at points of entry. It was observed that such a situation led to overcrowding as travellers queued for screening which was a recipe for Ebola transmission.

Stakeholders were also concerned at the porousness of some borders as that made it difficult to control the movement of illegal travellers who opted to use illegal points of entry.

Recommendations for enhancing preparedness for possible outbreaks, in particular, Ebola Virus Disease (EVD)

7.6 Stakeholders made the following recommendations:

- i) preparedness for outbreaks should never be an ad-hoc venture, but rather an all-round in-built system within disease surveillance;
- ii) there was need for adequate and regular funding to the health sector to ensure a robust and responsive disease surveillance system;

- iii) Health Emergency Operations Centers must be established and remain functional with or without an outbreak situation; and
- iv) a deliberate policy for constructing infectious disease isolation sites across the country must be put in place including construction of laboratories for confirming highly infectious diseases like EVD.

TOUR OF SELECTED PORTS OF ENTRY

7.7 In order to have first-hand information on what was happening at the ports of entry concerning preparedness against a possible outbreak of Ebola, your Committee toured Mwami and Kasumbalesa border posts. It also toured Kenneth Kaunda International Airport.

At Mwami and Kasumbalesa border posts, your Committee observed a positive situation in terms of preparedness. Both borders had staff from various departments who had been sensitised on Ebola issues. Two (2) health workers were found manning the health desk at each border post and conducting screening of travellers using hand held thermal scanners. Your Committee was also informed that the staff had been supplied with PPE including musks, boots, aprons, gloves and tyvec suits to handle initial cases of Ebola in case of an outbreak .

Notwithstanding the above, the two borders faced the following challenges:

- i) inadequate health personnel to conduct screening of travellers;
- ii) porous border areas at both Mwami and Kasumbalesa border posts which made it difficult to screen some illegal travellers from Malawi and the Democratic Republic of Congo (DRC), respectively; and
- iii) lack of appropriate isolation facilities for the quarantine of Ebola suspects.

At Kenneth Kaunda International Airport (KKIA), your Committee noted the presence of trained port health staff who conducted screening of travellers. Your Committee further inspected the isolation facility as well as the thermal scanner that the Ministry of Health procured from China. Your Committee was informed that the scanner at the Airport was no longer in use as it was faulty. It had only worked for a few months. The situation was the same at Simon Mwansa Kapwepwe Airport in Ndola. These two airports had, however, been provided with hand held scanners which were currently in use. Your Committee was also informed that the hand held scanners were just as effective as the main scanner. However, they were not user friendly to staff who endured several hours of pointing the scanner at travellers.

Your Committee was further informed that some Very Important Persons (VIPs) including ministers and senior government officials had refused to cooperate with port health staff who were conducting screening because they did not want to be screened.



A health worker showing Members of the Committee the PPE at the isolation facility at KKIA



Members of the Committee with Ministry of Health officials and the Airport Management

COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

7.8 Based on its interaction with various stakeholders and its tour of selected points of entry, your Committee's observations and recommendations are set out hereunder.

Observations

- (a) The Government has taken important steps to prepare for a possible Ebola outbreak. However, efforts are being hampered by the inadequate health personnel in the health sector to execute the EVD epidemic preparedness and response plan.
- (b) The outbreak of the EVD in the DRC and West Africa has exposed the Country's inadequacies in relation to preparedness for outbreaks of infectious diseases such as EVD. The country lacks a treatment unit, there are no suitable laboratories and isolation facilities in a number of provinces and districts for quarantine of cases of infectious diseases and there is no dedicated and trained cadre of staff to handle such situations.
- (c) Despite a budget amounting to K106,142,459.00 being dedicated to the Plan, institutions visited complained of irregular and inadequate funding for Ebola activities.
- (d) Some of the country's borders are long and porous thereby making it difficult to control the illegal entry of travellers into Zambia. This poses a great risk of importing Ebola into the country.
- (e) Some of the country's border posts do not have quarantine sites such as Nakonde and Mwami Border posts.

- (f) Port health staff and screening equipment is inadequate at the country's ports of entry such as airports and border posts.
- (g) Your Committee bemoans the purchase of very expensive equipment by the Ministry of Health such as thermal scanners and laundry equipment in some health facilities that only function for a short period. They are of the view that purchase of equipment whose software the local technicians do not understand and whose manuals are in a language other than English is unacceptable.
- (h) The report that some VIPs resist to be screened for Ebola by port health staff is a matter of concern

Recommendations

- (a) The Government should end the employment freeze and begin to employ all health personnel that have graduated in the recent past. This will help alleviate the shortage of the much needed health personnel to improve service delivery and boost preparedness against a possible outbreak of diseases such as Ebola.
- (b) The Ministry of Health should embark on the construction of suitable infrastructure necessary for the management of infectious diseases such as isolation facilities and laboratories for conducting relevant tests. The Government is further urged not to be complacent but instead continue to be vigilant and expedite the construction of the treatment unit at Mwembeshi and train more staff in Ebola issues.
- (c) The Government should release the necessary funding for the Ebola preparedness activities and ensure that the funding is adequate and regular until such a time when the threat will be completely gone.
- (d) The Government should deploy more uniformed men and women to intensify border patrols during times of serious threats and risks such as Ebola. Further, there should be a deliberate policy to ensure national level collaboration with neighbours such as the DRC and Tanzania on issues such as the Ebola threat.
- (e) The Ministry of Health should ensure that all ports of entry have functional quarantine sites to avoid putting staff at risk and minimise transmission of infectious diseases in case of an outbreak.
- (f) The Ministry of Health should ensure that there is adequate port health staff and screening equipment at ports of entry to avoid crowding and queuing for screening as that could lead to rapid transmission of any case of infectious disease including Ebola.
- (g) The Ministry of Health should stop importing substandard equipment that only works for a few months. This has proved expensive as the Ministry has to continue calling experts from outside the country after the expiry of warranties. The Ministry of Health should further decentralise to provinces, the resources needed for contracting services for maintenance of medical equipment.
- (h) The Ministry of Health should sensitise the public including VIPs on the importance of being screened at ports of entry and the need to allow port health staff to perform their duty effectively without fear or favour.

PART III

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

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

The Health Insurance System in Zambia

8.1 Your Previous Committee had recommended that the Government should introduce the necessary legislation to Parliament for enactment that would clearly define health insurance; and guide and regulate its provision in Zambia. This would improve compliance in terms of adherence to minimum standards.

Executive's Response

It was reported in the Action-Taken Report that the Government had undertaken to establish a pro-poor National Social Health Insurance Scheme and this objective had been articulated in various government documents including the National Health Policy, Revised Sixth National Development Plan, National Health Strategic Plan, National Social Protection Policy and the Medium Term Expenditure Framework. The Government was accordingly in the process of undertaking comprehensive social protection reforms, which would include the establishment of a Social Protection System, which included the National Social Health Insurance Scheme. The aim of the Scheme would be to support the goal of achieving universal health coverage for all citizens and legal residents of Zambia.

The Government through the Ministry of Health had proposed draft legislation to cover the establishment and provision of a National Social Health Insurance Scheme which would be managed by a separate quasi government agency that would be established through an Act of Parliament. It was proposed that this legislation would regulate the provision of public health insurance and further stakeholder consultation was still ongoing. The Government through Cabinet Office was harmonising the proposed National Social Health Insurance Bill with other social protection/security reforms so as to achieve policy coherence.

The Government plan was that the reformed Pensions and Insurance Authority (PIA) would provide regulatory oversight over the National Social Health Insurance Scheme, private commercial health insurance, insurance companies and pension schemes.

Private health insurance would be regulated under a revised Insurance Act. Among the objectives of the proposed revised Insurance Act was the establishment of a coordinated, regulated and sustainable private health insurance system. The identified weaknesses in the private health insurance market were anticipated to be dealt with, following the introduction of regulations under the revised Insurance Act. It was further proposed in the revised Insurance Bill that health insurance would be defined under the health insurance regulation. Private health insurance would continue to be regulated under the revised Insurance Act as *long term insurance* and the accompanying regulation would detail its provision.

Committee's Observations and Recommendations

Your Committee awaits a progress report on the matter with a clear time frame on when the proposed legislation to provide for the establishment of a National Social Health Insurance Scheme would be introduced to Parliament.

8.2 Your previous Committee had recommended that the Government should draw lessons from Ghana and consider introducing a biometric card system once the proposed National Social Health Insurance Scheme became a reality. The biometric card system would help Zambia circumvent some of the challenges experienced by the Ghanaian system prior to the introduction of a biometric card system.

Executive's Response

It was reported in the Action-Taken Report that learning from other developing and developed countries' experiences in implementing biometric smart cards such as but not limited to Ghana, India, Israel, Thailand, South Korea, Canada, Germany and Netherlands, the Government favoured the option of a biometric smart card system to ensure the right identification of SHI members at the point of service and limit the risk of frauds.

Based on these country experiences, it was noted that identity verification solutions based on biometric smart card technology could provide identity assurance and authentication while increasing privacy and security. Biometric smart cards also brought operational efficiencies to the healthcare system and health insurance that reduced costs, fraud and increased patient satisfaction.

Building on these various experiences, the proposed National Social Health Insurance Scheme once established would consider issuing beneficiaries with biometric smart cards with capabilities to store member's fingerprints and photographs for authentication and identification purposes. This would be linked to information and communication technology (ICT) systems at health provider level and health insurance providers to facilitate smooth data flow with completely cashless transactions to reduce the risk of fraud and reduce claim processing time.

Biometric smart card technology is used globally for secure identity, access and payment applications. As a standards-based technology, biometric smart card solutions for patient and provider identity management are deployed around the world and are available from numerous vendors. Biometric smart card technology provides a strong foundation for health identity cards, enabling improvement in healthcare processes and in patient and provider identity verification while securing information and protecting privacy.

Therefore, the Government in line with the National ICT policy, would consider different ICT and biometric smart card options for verifying patient and healthcare provider identity taking into account the cost-effectiveness, privacy and security, usability and performance implications in rural and urban environments of the different options available in the market. The selected ICT and biometric smart identity card solution would be built on standards that can be maintained, upgraded and inter-operable across multiple locations within the country.

Furthermore, discussions were on-going within the Government on the coordination of the multiple national initiatives related to ICT development. The Ministry of Health had also engaged with line ministries and institutions such as the National Pension Scheme Authority (biometric card information system), Ministry of Community Development Mother and Child Health (single registry database) and CDC (smart care systems) in order to ensure from the onset that the selected SHI information would be in alignment and compatible with other national databases and technologies currently in use. A major objective is also to avoid duplication of efforts and investments to develop similar databases. This strategy also includes ongoing discussion with the Ministry of Home Affairs on the smart biometric card based National Registration Cards system being developed.

Committee's Observation and Recommendations

Your Committee awaits a progress report on the matter.

8.3 Your previous Committee had recommended that the Zambian Government should adopt a measure where only accredited providers should provide health care services to members of the Scheme once it became operational. This would serve as a quality control measure.

Executive's Response

It was reported in the Action-Taken Report that the Government appreciated your Committee's recommendation where only accredited health care providers should provide health care services to members of the National Health Insurance Scheme.

It was further reported that this provision had been taken into consideration in the draft National Social Health Insurance Bill. One of the key proposed functions of the National Social Health Insurance Management Authority (NSHIMA) was to accredit healthcare providers in collaboration with other regulatory bodies such as Health Professions Council of Zambia (HPCZ), Zambia Medicines Regulatory Authority (ZAMRA) and the General Nursing Council of Zambia (GNCZ).

Further, the proposed National Social Health Insurance Bill had outlined certain important requirements for accreditation to ensure that only healthcare providers who meet accreditation standards as prescribed by the National Social Health Insurance Management Authority (NSHIMA) would be registered for the Scheme and published annually in print and electronic media for general circulation in Zambia.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

8.4 Your previous Committee had recommended that the Government should devise strategies to ensure the availability of trained health workers to provide quality health care services in all facilities that would be accredited as healthcare providers under the National Social Health Insurance Scheme.

Executive's Response

The Government responded in the Action-Taken Report that it was increasing the overall training capacity of various critical health care providers in line with the National Scale-Up Plan for Health Care Workers in Zambia. Zambia's health training institutions had made significant progress since 2011 in increasing the number of students enrolled in and graduating from health care training institutions nationwide.

The Ministry of Health had devised a National Training Operational Plan (NTO) 2013-2016 which is currently being implemented to address the gap between Zambia's current rate of health care workers production and the projected health care workforce needed to meet the expected increase in demand for additional health care workers to serve the total health needs of a fast growing Zambian population.

There had been a 33 percent increase overall in annual number of health worker graduates between 2008 and 2012. However, the NTO 2013-2016 noted that significant shortages still existed for general nurses, midwives, clinical officers, theatre nurses, pharmacists, doctors, environmental health staff and nutritionists. In order to mitigate these shortages, a national health training institute, with a 3000 graduate per year capacity, was being constructed at Chainama College to train various cadres based on need. The training capacity at existing training institutions was being enhanced through construction of additional class rooms, skills laboratories, libraries, student hostels, and refurbishments of the existing infrastructure, procurement of training materials and training of tutors. Furthermore, the Government had created an enabling environment for the private sector to contribute to training health care workers. Private training institutions played important roles in increasing the number of health workers. Eleven (11) private nursing training institutions that had opened since

2008 had contributed a 23 percent increase in the number of students enrolled and a 16 percent increase in the number of graduates from 2008 to 2012. Two (2) private training institutions (Apex and Cavendish Universities) and one (1) Government medical school (Ndola campus) had programmes to train medical doctors to complement the medical school at Ridgeway Campus. The Ministry of Education also offered bursaries to deserving students to study medicine abroad (Poland, Russia, Malaysia, India) and return to complete their internship and rural posting under bonding arrangements provided under these bursaries. The Ministry of Health was working with the regulatory bodies and relevant training institutions to develop new and innovative training programmes that respond to the sector's needs. For example, in response to the need for general medical practitioners, additional anaesthesia and psychiatric specialists, the University of Zambia (UNZA) School of Medicine had introduced degree programmes providing a Master of Medicine in Family Medicine, Psychiatry and Anaesthesia.

In order to retain staff and address imbalances in the distribution of health workers between urban and rural areas, a concerted effort was being made to improve the working conditions and incentives for health workers in the rural areas of the country. These efforts included the implementation of the rural/remote hardship allowance and Zambia Health Workers Retention Scheme in rural and deprived districts of the country. The Government through the Ministry of Health would continue to actively participate in committees working to improve remuneration packages and working conditions to attract and promote retention of health service providers in rural and remote facilities.

There was evidence that students from rural and remote areas were more likely to remain in rural and remote regions. Programmes that promoted rural and remote students such as positive discrimination practices and quota systems were being explored. In this regard, the Community Health Assistant (CHA) training programme was also in place. The idea was to recruit CHA students from rural and remote communities to serve within their community based at health posts and placed on government payroll. Depending on the findings of the evaluation of the CHA pilot, CHA training facilities would be expanded to reach the Ministry of Health's vision of 5,000 CHAs trained by 2017.

Committee's Observations and Recommendations

Your Committee while noting the response, requests further details on the number of doctors, nurses, clinical officers, and midwives currently available and what the shortfall is. It also awaits a progress report on the construction of a training centre at Chainama Training Institute.

8.5 Your previous Committee had recommended that the Government should encourage and promote the provision of study programmes in actuarial sciences and underwriting in public and private universities and colleges. This measure was meant to make the country have enough qualified actuaries.

Executive's Response

It was reported in the Action-Taken Report that the Government had taken note of the recommendation aimed at ensuring the country had enough qualified actuaries. Currently, Zambia does not have the facilities to train Actuaries but would look into the possibility of establishing a course at one of the higher institutions of learning.

Committee's Observations and Recommendations

Your Committee requests an update on the matter.

The availability and uptake of Family Planning Services in Zambia

8.6 Your previous Committee had recommended that in order to stem the unprofessional conduct by some staff, 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.

Executive's Response

It was reported in the Action-Taken Report that there were guidelines and training manuals for family planning in place that emphasised the human rights approach to accessing family planning services. This was being inculcated in the health workers as they were being trained and through mentorship initiatives. The two ministries responsible for health had also engaged the General Nursing Council to help in sensitising the health providers and also discipline the health workers if found wanting.

Committee's Observations and Recommendations

Your Committee urges the two ministries responsible for health to continue sensitising health workers on the need to conduct themselves professionally when providing family planning services.

8.7 Your previous Committee had recommended that the Government 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 would 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. That would clear the uncertainties on which Ministry was responsible for what aspects of the family planning policy implementation.

Executive's Response

It was reported in the Action-Taken Report that the Ministry of Health was responsible for the procurement of family planning commodities and provision of long term training of health workers in family planning. The Ministry of Community Development, Mother and Child Health on the other hand was responsible for in-service training of health workers on how to provide family planning services and also the actual provision of family planning services at the facility level. The Government had also engaged the chiefs and other traditional leaders as champions for information on family planning and was also working with Safe Motherhood Action Groups to deliver this information.

Committee's Observations and Recommendations

Your Committee urges the two concerned ministries to clearly inform the public on the role of each ministry regarding family planning services provision.

Breast and Cervical Cancer in Zambia

8.8 Your previous Committee had noted a response from the Government in the Action-Taken Report that the Government through the Ministry of Health was developing a National Cancer Control Plan which would be a framework to address the issues of equity of access to quality services. In noting the response, your Committee had urged the Executive to provide a time frame for the development of a National Cancer Control Plan.

Executive's Response

It was reported in the Action-Taken Report that Development of the National Cancer Control Plan was expected to be completed by the 4th Quarter of 2014.

Committee's Observations and Recommendations

Your Committee observes that the time frame provided by the Government has elapsed and therefore requests another update on the matter.

8.9 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.

Executive's Response

It was reported in the Action-Taken Report that the development of breast and cervical cancer/Non-Communicable Diseases guidelines was completed. The finalised documents were awaiting printing prior to dissemination.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

8.10 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.

Executive's Response

It was reported in the Action-Taken Report that the Government had taken note of the 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.

The Government reported further that it was still pursuing this recommendation through the Ministry of Community Development, Mother and Child Health and would provide an update on the institutions that would be engaged for the construction of transit homes.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

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

Executive's Response

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 the 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.

It was further reported that the Cancer Diseases Hospital Phase III project proposal had been developed and submitted to Ministry of Finance for approval and funding.

Committee's Observations and Recommendations

Your Committee awaits an update on the matter.

8.12 Your previous Committee had requested the Ministry of Health to issue a comprehensive statement on the benefits of male circumcision and the relationship between male circumcision and prevention of cervical cancer.

Executive's Response

The Executive responded that the Human Papilloma-Virus (HPV) which causes Cervical Cancer commonly infects the foreskin. Therefore, removing the foreskin reduced the prevalence of HPV and indirectly reduced the prevalence of cervical cancer. The Ministry of Health would be requested to provide a comprehensive statement on the matter.

Committee's Observations and Recommendations

Your Committee requests a time frame from the Executive within which the statement would be issued.

Outstanding issues on Social Protection for the Aged in Zambia

8.13 Your previous Committees 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.

Executive's Response

It was reported in the Action-Taken Report that the Government had developed a Zero Draft on the Minimum Standards Guidelines for Old People's 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.

It was further reported that consultations with stakeholders had not taken place due to financial constraints. Nevertheless, the Ministry would endeavour to obtain financial support from cooperating partners to finalise and endorse the guidelines.

Committee's Observations and Recommendations

Your Committee awaits an updated progress report on the matter.

Provision of education to the Deaf in Zambia

8.14 Your previous Committees had requested updates on the review of the Education Policy in order to address the concerns raised on provision of education to the deaf.

Executive's Response

The Government reported in the Action-Taken Report, that the Ministry of Education, Science, Vocational Training and Early Education had been reviewing the education policy 'Educating the Future' to come up with a policy reflective of the merged Ministry of Education, Science, Vocation Training and Early Education. To this effect, a draft policy had been drafted.

In addition, the new Ministry of Education, Science, Vocational Training and Early Education had been harmonising the existing policies through stakeholder engagement. The policy would effectively address concerns on the provision of education for the deaf. The Policy was at final stage of stakeholder consultation.

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

8.15 Your previous Committees had been requesting updates on the second phase of the procurement and installation of incinerators in health institutions that had not earlier been provided with incinerators.

Executive's Response

The Government reported in the Action-Taken Report that the World Bank did not release funds for the second phase as indicated and there had been inadequate funding for health care waste management.

The Government reported further that it was aware of the importance of strengthening the health care waste management in the country. To this effect, it had made sure that all the newly constructed public health facilities have incinerators including the 650 health posts that were being constructed country wide. In addition, the Government through the Ministry of Health had made sure that the proposed Public Health (Amendment) Bill would among other key provisions address the issue of health care waste management in the country.

Committee's Observations and Recommendations

Your Committee notes the response and awaits the enactment of the proposed Public Health (Amendment) Bill.

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 the observations and recommendations contained in this Report will be favourably considered by the Executive and go a long way in improving the health sector and informing the implementation of the new Sustainable Development Goals.

May, 2015
LUSAKA

L M Mufalali, MP
CHAIRPERSON

APPENDIX I
List of Officials

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