



REPUBLIC OF ZAMBIA

REPORT

OF THE

COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES

FOR THE

**FIRST SESSION OF THE TWELFTH NATIONAL ASSEMBLY APPOINTED ON THURSDAY 6TH
OCTOBER, 2016**

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REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES FOR THE FIRST SESSION OF THE TWELFTH NATIONAL ASSEMBLY APPOINTED ON THURSDAY 6TH OCTOBER, 2016

Consisting of:

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

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir,

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

Functions of the Committee

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

- i) study, report and make appropriate recommendations to the Government through the House on the mandate, management and operations of the Government ministries, departments and agencies under their portfolio;
- ii) carry out detailed scrutiny of certain activities being undertaken by the Government ministries, departments and agencies under their portfolio and make appropriate recommendations to the House for ultimate consideration by the Government;
- iii) make, if considered necessary, recommendations to the Government on the need to review certain policies and certain existing legislation;
- iv) examine annual reports of Government ministries and departments under their portfolios in the context of the autonomy and efficiency of Government ministries and departments and determine whether the affairs of the said bodies are being managed according to relevant Acts of Parliament, established regulations, rules and general orders;
- v) consider any Bills that may be referred to it by the House;
- vi) consider International Agreements and Treaties in accordance with Article 63 of the Constitution;

- vii) consider special audit reports referred to it by the Speaker or an order of the House;
- viii) where appropriate, hold public hearings on a matter under its consideration; and
- ix) consider any matter referred to it by the Speaker or an order of the House.

Meetings of the Committee

3.0 Your Committee held twelve meetings during the period under review. Your Committee's report is divided into four parts. Part I is on the topical issue on which your Committee undertook a detailed study, while Part II is on the Local Tour and Part III is on the Foreign Tour. Part IV consists of the Action-Taken Report on your Committee's Report for the Fifth Session of the Eleventh National Assembly.

Committee's Programme of Work

4.0 At the commencement of the First Session of the Twelfth National Assembly, your Committee considered and adopted the following programme of work:

- a) consideration of the Action-Taken Report on the report of the Committee for the Fifth Session of the Eleventh National Assembly;
- b) consideration of Zambia's preparedness for the implementation of the Sustainable Development Goal on Health with special focus on Sexual Reproductive Health Rights;
- c) foreign tour to Rwanda on best practices and sharing of experiences with regard to sexual and reproductive health; and
- d) consideration and adoption of minutes of the Committee's meetings and draft report.

PART I

CONSIDERATION OF THE TOPICAL ISSUE

ZAMBIA'S PREPAREDNESS FOR THE IMPLEMENTATION OF THE SUSTAINABLE DEVELOPMENT GOAL ON HEALTH WITH SPECIAL FOCUS ON SEXUAL REPRODUCTIVE HEALTH RIGHTS

5.0 Your Committee recognised that in 2015, the Millennium Development Goals (MDGs) era came to an end and a post-2015 agenda was adopted by 191 United Nations Member countries. Considerable efforts had been made during the MDGs implementation to reduce maternal mortality, cervical cancer and unwanted pregnancies, among many others. As the country is now implementing the Sustainable Development Goals (SDGs), it was imperative to ensure that the unfinished agenda of the MDGs was not abandoned and that the experiences, challenges and lessons learnt therefrom were taken into account in the implementation of the SDGs, particularly SDG 3 and Target 3.7, which states that:

"By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes".

SDG 3, particularly Target 3.7, has a focus on Sexual Reproductive Health Rights (SRHR) with the following proposed indicators:

- i) 3.7.1 - Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods; and
- ii) 3.7.2 - Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group .

It was in this vein that your Committee resolved to undertake a study on Zambia's preparedness for the implementation of the SDG on Health with special focus on Sexual Reproductive Health Rights.

Procedure adopted by the Committee

6.0 Your Committee sought both written and oral submissions from relevant Government ministries, non-governmental organisations and interested individuals. The following major stakeholders presented their views:

- a) Ministry of Health;
- b) Ministry of National Development Planning;
- c) Ministry of General Education;
- d) Ministry of Higher Education;
- e) Churches Health Association of Zambia (CHAZ);
- f) United Nations System in Zambia;
- g) Society for Family Health (SFH);
- h) The Non Governmental Organisations' Coordinating Council (NGOCC);
- i) IPAS Zambia;

- j) Marie Stopes International;
- k) University of Zambia – School of Public Health;
- l) Planned Parenthood Association of Zambia (PPAZ);
- m) National HIV/AIDS/STI/TB Council(NAC);
- n) Zambia Medical Association (ZMA);
- o) Center for Reproductive Health and Education (CRHE) ;
- p) Restless Development; and
- q) Zambia National Traditional Counsellors Association (ZNTCA).

CONSOLIDATED SUMMARY OF SUBMISSIONS

6.1 Your Committee was informed that Zambia was committed to achieving Sustainable Development Goals, including Goal 3 whose aim is to “*Ensure healthy lives and promote well-being for all at all ages*” with the associated targets. The Committee learnt that Sexual Reproductive Health and Rights (SRH&R) is a health, human rights and development issue, which allows people to be able to make reproductive choices, and to be empowered to attain a state of complete physical, mental and social well-being in all matters relating to the reproductive processes, functions and systems during a person’s life course.

The extent to which sexual and reproductive health is a public health problem in Zambia

a) Maternal Mortality

Your Committee was informed that although maternal death had reduced by 54% from 1990 to 2014, it was still very high in Zambia as it stood at 398 for every 100,000 live births recorded by women. In health facilities, the main causes of maternal death included excessive bleeding after delivery (34%), sepsis (13%), abortion complications (13.3%), obstructed labour (8%), and eclampsia (5%), among many others.

b) Fertility Rate

Your Committee learnt that Zambia had one of the highest fertility rates in the world. The National Total Fertility Rate (TFR) had dropped from 6.2 births per woman in 2007, to 5.3 births per woman in 2013. However, rural TFR remained high at 6.6 births per woman compared to 3.7 births per woman in urban areas.

c) Unmet Need for Family Planning

According to the 2013/2014 Zambia Demographic Health Survey (ZDHS), unmet need for family planning was highest among women aged 15-19 years (25%). Geographically, unmet need was higher in rural areas (24%) than in urban areas (17%). 25% of Zambian married women had an expressed unmet need for family planning, including the need for birth limiting family planning. This was even higher in the rural areas.

d) Unsafe Abortions

The actual burden of unsafe abortions in Zambia could not be estimated due to the increasing number of illegal provision of the service especially to adolescents and older women. Unsafe and poorly performed abortions were a major cause of maternal mortality and morbidity. Despite the availability of legal safe abortion, available data and clinical impressions pointed to a high and perhaps increasing prevalence of illegally induced abortions with up to 30% of pregnancy-related deaths resulting from unsafe abortion.

e) Limited Access to SRHR Information by Adolescents

Your Committee was informed that current data indicated that continued limited access to sexual and reproductive health information and services among young people, had contributed to low condom use, where only 40% of the girls and 49% of boys aged 15-24 years used a condom during their last sexual intercourse; high rates of teenage pregnancy at 29%; high HIV prevalence rates where 8% of girls aged 15-19 years were infected compared to 5% of boys; low contraceptive use with only 28% of married adolescent girls using contraception despite their need to space births; and low school retention where 58% and 44% of girls dropped out of school by 9th and 12th grades respectively, mainly due to pregnancy and child marriage.

f) Teenage Pregnancy

According to the 2013/2014 ZDHS, 28.5% of women aged between 15-19 years had either been pregnant or had a live birth. The Ministry of General Education (MoGE) had recorded that between 2007 and 2014, a total of 120,024 in-school girls got pregnant and dropped out of school. The majority, 103,621 were in primary school when they got pregnant as compared to 16,403 who were in secondary school.

Regarding school dropouts due to pregnancy, recent statistics from the MoGE Statistical Bulletin 2015, revealed the trends as shown in the table below.

YEAR	BASIC SCHOOL	HIGH SCHOOL	TOTAL
2007	13,403	1,223	14,626
2008	12,370	1,566	13,936
2009	13,634	1,863	15,497
2010	13,769	1,817	15,586
2011	13,929	1,778	15,707
2012	12,753	2,096	14,849
2013	12,500	3,428	14,928
2014	13,275	3,103	16,378
2015	11,989	3,136	15,125

Source: Ministry of General Education

Trends in Financing of SRH Services by Ministry of Health

6.2 Your Committee was informed that the trend in financing of SRH programmes as a proportion of the total budget for programmes in the Ministry of Health for the past 7 years had not been consistent as outlined in the table below.

Year	SRHR Allocation	Total Programmes Budget	Proportion of Moh Budget For SRH (%)
2010	24,415,785	694,490,767	3.5
2011	24,670,116	797,285,585	3.1
2012	42,670,645	1,703,152,171	2.5
2013	26,976,403	1,444,208,499	1.9
2014	44,495,895	1,773,145,746	2.5
2015	42,783,632	1,830,065,6	2.3
2016	40,081,560	1,690,938,007	2.4

Source: Ministry of Health

Major strategies put in place to successfully implement Target 3.7

6.3 Your Committee was informed that successful implementation of SDGs relied upon setting up a strong policy and legal environment which would enhance access to SRHR for all women and foster the development of supportive social transformation in support of women's rights.

To ensure achievement of the national vision, the Government of the Republic of Zambia was in the process of domesticating the SDGs through the Seventh National Development Plan, and had put in place several policies and interventions that included the Health Policy, the Youth Policy, the HIV Policy and the Reproductive Health Policy. To sustain implementation of these policies, the Government was developing the successor National Health Strategic Plan (NHSP) and the National AIDS Strategic Framework (NASF) for the period 2017 - 2021. Both strategic frameworks would reflect high impact and cost effective strategies to scale up quality service delivery, improve demand for integrated services by beneficiaries, ensure availability of health commodities and medicines at points of use, secure domestic resources for health, improve availability of health, information to guide decision -making, ensure availability of skilled human resource for health; and ensure national ownership, coordination and accountability for results, to mention a few.

Zambia's National Vision 2030 placed SRHR as a key development factor that would contribute to Zambia becoming a prosperous middle income nation by 2030. This would

call for an acceleration of efforts to advance SRHR as not only a public health strategy, but also as a catalyst that underpins inclusive social and economic development.

Sexual Reproductive Health Rights /HIV/Gender Based Violence linkages guidelines had been developed and these were ensuring that most service points were able to offer all the needed SRH services. Furthermore, your Committee was informed that the Ministry of Health had repositioned Adolescent Health. The National Health Policy, the National Health Strategic Plan, the Reproductive, Maternal, Neonatal and Child Health Roadmap and the Adolescent Health Strategic Plan had given the country a very favourable environment for all stakeholders to implement adolescent health programmes.

In addition, the Family Planning 2020 (FP2020) scale up plan had been developed to respond to the pledges made at the 2012 London summit. This strategic cost document was used to mobilise funds to implement strategies which will increase family planning service providers in long acting reversible contraceptives and also FP providers in the community.

Your Committee also learnt that the Ministry of General Education had integrated SRH in the relevant subjects of the school curriculum as part of Comprehensive Sexuality Education (CSE) from Grade 5 to 12 and also developed age appropriate teaching and learning materials for CSE to be used in schools with the support from UNESCO.

Indicators of sexual and reproductive health and rights put in place

6.4 Your Committee was informed of the recommended SRH indicators for the achievement of Target 3.7 as set out below.

i) Contraception

The proportion of family planning demand met with modern contraception.

ii) SRH Service Availability

- The Proportion of health facilities that provide essential SRH services.
- The proportion of health facilities that provide postpartum, post abortion and/or HIV services that also provide clients who use those services with contraceptive information and care.

iii) Knowledge about Sexual and Reproductive Health Rights

Proportion of young men and women aged 15-24 with basic knowledge about sexual and reproductive health and rights.

iv) Adolescent Fertility

- The adolescent birth rate; and
- The proportion of births to women younger than 20 that were unplanned.

v) Quality of Care, including Respect for Rights

- The proportion of women using contraceptives who are informed about possible side effects of their method and how to deal with them, who are informed about other family planning methods and who participate in the decision to use contraceptives.
- The proportion of family planning service sites with at least five modern methods available.
- Whether universal access to contraceptive and other SRHR information and service is included in the National Policy.
- An indicator reflective of respectful care and human rights in provision of SRHR information and services.

vi) Prevention of Sexually Transmitted Infections

- The proportion of females who have received the recommended number of doses of Human Papillomavirus (HPV) vaccine prior to age 15.
- Country includes HPV vaccination in its vaccination programme.

vii) Abortion

The proportion of health facilities that provide care for complications related to unsafe abortion or where it is not against the law, that provide safe abortion.

Coordination Mechanism among major players in the Implementation of Target 3.7 at National, Sector, Province and District Level

6.5 Your Committee learnt that Zambia had shown leadership in the way it coordinated partners in the health sector being the first African country to implement the Sector Wide Approach (SWAp). The SWAp structures that included the Sector Advisory Group (SAG), Technical Working Groups (TWGs), Policy Meetings and Annual Consultative Meetings (ACM) were set up and operational.

This approach ensured greater efficiency and equity in the distribution of resources, decreased duplication and transaction costs while ensuring sustainability and continuity in policy development and implementation.

Regrettably, other stakeholders were of the view that the coordination mechanisms

were inadequate and depended on the strength of the stakeholders in that area. Further, HIV/AIDS was the only aspect of SRHR that had a strong coordination mechanism which was multisectoral and decentralized in nature. The Stakeholders recommended that the Government should develop similar energies, coordination mechanisms and support in order for target 3.7 to be achieved.

Measures put in place to monitor implementation and attainment of the Target 3.7

6.6 Your Committee learnt that the Ministry of Health had a robust Health Information System that had since been revised to include indicators that would make it easier to monitor the programmes in Reproductive, Maternal, Newborn and Child Health (RMNCH) including integrated programmes like SRH/HIV and FP/HIV. Registers have been revised and data disaggregated by age and sex.

Lessons Learnt in the Implementation of the MDGs

6.7 The stakeholders submitted that a number of lessons were learnt through the implementation of the MDGs which should be carried on through the SDGs. Some of the lessons are as set out below.

a) HIV Prevalence Rate

Your Committee learnt that at the inception of the MDGs, the HIV prevalence for Zambia for the population aged 15-49 years was 16%. The HIV prevalence target that was set was 15.6% or less. Zambia met this target by 2007, when the Zambia Demographic and Health Survey (ZDHS) was undertaken with the country recording a prevalence rate of 14.3%. HIV prevalence had continued to decline to 13.3% in 2013/14 and 12.3% in 2016. However, it had been noted that prevalence was not the most sensitive indicator to monitor the HIV epidemic due to the successful scale-up of Anti-Retroviral Therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT). To this effect, the focus should be on HIV incidence which was still high with approximately 41,000 new infections per year mostly occurring in young people aged 15-24 years

b) Partner Coordination

Your Committee learnt that the Inter-sectoral meetings provided platforms for updates and sharing of information such as best practices and lessons learnt. However, there was need for the Government to strengthen partnerships with Civil Society Organisations to complement each other's effort in service provision.

c) Gender Inequality

Your Committee was informed that according to the gender analysis of the MDGs, it

was observed that the MDGs on health were not gender sensitive. While the goals had a specific goal aimed at attaining gender equality and empowerment of women and girls, gender was not adequately mainstreamed across all the goals. Based on this observation, it was safe to conclude that it was possible that the implementation of the MDGs led to the widening of the gender gap in Zambia as opposed to reducing it.

d) Management of Donor Funds

Your Committee learnt that while donor funded activities were assisting the country in the attainment of the goals, the MOH needed to take up ownership of the programmes and ensure sustainability even after the donors had ended their programmes.

e) Commodity Shortages

Shortages of commodities for family planning were a huge setback especially in areas where Community Based Distributors had been trained to bring family planning services into the community.

However, other stakeholders submitted that the MDG lessons had not been properly documented and thus urged the Government to hold a lesson learning process to feed into the implementation of Target 3.7 at the national level.

Other concerns raised by stakeholders

i) The need for Sustainable Financing

To achieve universal access, it was essential that SRH services were affordable even for the poorest people in society. In many instances, this would mean that services must be free.

ii) Child Marriage and Gender Based Violence

Your Committee was informed that just like teenage pregnancy, child marriage in Zambia was an abusive practice that prevented adolescents' ability to enjoy their SRHR and from fulfilling their development potential. Although progress had been made in reducing child marriage from 42% in 2002 to 31.4% in 2014, it still remained among the highest in the world as it affected both boys and girls. However, girls were more affected than boys. According to the ZDHS 2013/2014, among 15-19 year olds, 16.5% females reported being currently married as compared to 1% of males. Similarly, among 20-24 year olds, only 2.2% males are reported having married when they were younger than 18 as compared to 31.4% of females.

iii) Empowering Women

Your Committee learnt that achieving Target 3.7 and Zambia's Vision 2030 would be difficult if women were not empowered to enjoy their sexual reproductive rights which enabled positive decision making and effective participation in national development and democratic processes. Women's empowerment included ensuring women had access to education, health and employment opportunities and particularly ensuring timely access to family planning services, freedom from gender based violence and all forms of discrimination and violence. It also included ensuring that women did not die while giving life. Currently, women in Zambia still face many challenges.

iv) Domesticating of SDGs

Your Committee heard that Zambia would domesticate the SDGs in the National Development Plan and the National Health Strategic Plan. Meanwhile most of the expected interventions were already being implemented. However, despite Zambia having various of policies and legislation, little had been done to ensure their actual implementation. This had also been exacerbated by the failure to meet the commitment to the Abuja Declaration of allocating 15% of the national budget to the health sector.

v) Barriers to accessing SRH Services

Your Committee learnt that the barriers affecting access to SRHR in Zambia were complex and multiple. This indicated that some of the barriers were linked to a combination of, but not limited to:

- a) limited resource allocation (human and financial);
- b) unsupportive legal environment for adolescents and young people to access SRH services;
- c) inadequate information on SRH Services;
- d) cultural norms; and
- e) gender inequality.

vi) Targeting Marginalised Groups

Your Committee heard that many people were unable to access mainstream SRH services or programmes for reasons such as poverty, language, disability and geographical inaccessibility or were denied access because of stigma, discrimination or restrictive laws and policies. Overcoming inequalities in access required that the SRH needs of marginalised people should be identified, and interventions targeted towards meeting their needs in a culturally considerate manner. Mobile health facilities which link services directly to people is one method of addressing physical barriers to access the most isolated and often the poorest populations. Mobile health units were also being used to deliver free condoms, STI testing and treatment, and prenatal care to sex workers peer educators, who were themselves sex-workers and undertook a variety of

activities including raising awareness about HIV and AIDS and assisting people in accessing medical care.

vii) Conflicting of existing Legislation

The stakeholders informed your Committee that Article 7(d) of the Constitution of Zambia (Amendment) Act No. 2 of 2016 recognised customary law practices as long as they were not in conflict with the Constitution. Although the Constitution defined a child as a person below the age of 18 and an adult as a person above the age of 18, customary law which is recognised by the Constitution does not define age in numeric terms. In many customs in Zambia, when a child reaches puberty regardless of their age, they are deemed to be an adult and are eligible to marry. The *Marriage Act Chapter 50 of the Laws of Zambia* sets the age for marriage at 21 years old. However, it allows child marriage according to customs and permits a judge to authorise child marriage if that was not against public interest.

Further, Zambia had not fully domesticated the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. Given the demographics of the Zambia population, it was very important that children's rights were safeguarded so that they could participate fully in national development. There was, therefore, need to enact child laws to enshrine the rights of children and adolescents to protect them from harmful practices and ensure the realisation of their full potential. The Act should, among other things, address children's sexual and reproductive health and rights based on the evolving capacities of the child.

Committee's Observations and Recommendations

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

- i. the National Health Strategic Plan and the National Adolescent Health Strategic Plan have not enshrined Target 3.7 and the respective indicators are outdated;
- ii. SRH programmes have not been properly decentralised;
- iii. the unmet need for modern family planning which is still high especially among women aged 15-19 years in rural areas;
- iv. customary Law and Statutory Law are not harmonised;
- v. Zambia has not fully domesticated the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child;
- vi. the presence of most NGOs and other Government partners is mostly in urban areas neglecting the rural areas;
- vii. there is still limited access to SRH by adolescents and young people due

to stigma by the society;

- viii. there are limited trained people as well as learners' material to roll out the Comprehensive Sexuality Education curriculum in and out of school;
- ix. there are negative attitudes by health care providers towards young women and adolescents seeking contraception and other SRHR information and services;
- x. some stakeholders were focussing on abortion as a method of eliminating unwanted or unplanned pregnancies and not the primary prevention of pregnancy through the use of family planning methods; and
- xi. there is weak stakeholder coordination among various players in the implementation of target 3.7.

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

- i. the Government should expedite the revision of the National Health Strategic Plan and the National Adolescent Health Strategic Plan and widely publicise them;
- ii. the Decentralisation Policy Implementation Plan should be properly operationalised in order to bring authorities and resources closer to the people;
- iii. the Government should consider providing affordable access to reproductive health commodities for poor and marginalised women and girls. The commodity supply chain should also be strengthened and decentralised so that drugs and commodities are readily available as and when needed;
- iv. the Government should ensure the domestication of regional and international conventions and treaties that Zambia has committed to as well as harmonise the legal framework on age of consent which would make it easy for adolescents and young people to access sexual and reproductive health services;
- v. the Government should expedite enactment of the *Children's Act* to enshrine the sexual and reproductive health and rights of children and adolescents and to protect them from harmful practices and ensure the realisation of their full potential;
- vi. the Government and Civil Society must prioritise rural areas in the provision of SRH services;
- vii. there is need to increase access and utilisation of integrated HIV and SRH services to prevent pregnancies and HIV by young people;

- viii. the Government should increase funding towards training teachers in CSE and developing learners materials;
- ix. the Government should strengthen its awareness strategies and be robust in advocating for primary prevention of unwanted pregnancies through uptake of family planning and not abortion; and
- x. there is need to ensure a coordinated multi-stakeholder accountability framework that will not only be intra governmental but also include cooperating partners, the private sector, civil society, the media and representatives of communities. This will enable tracking of SRHR indicators beyond medical indicators to include human rights and development components.

PART II

LOCAL TOUR FOR THE FIRST SESSION OF THE TWELFTH NATIONAL ASSEMBLY

TOUR OF SELECTED HEALTH INSTITUTIONS AND PUBLIC HEARINGS

6.8 Your Committee undertook a tour of selected health institutions in Lusaka, Central, Copperbelt, Muchinga and Northern Provinces based on its study of the topic “Zambia’s preparedness for the implementation of Sustainable Development Goal on Health with special focus on Sexual Reproductive Health Rights”. Your Committee also conducted two public hearings in Kabwe District, Central Province, and Masaiti District, Copperbelt Province.

The following institutions were visited:

- i. University Teaching Hospital;
- ii. Kanyama Hospital;
- iii. Ministry of General Education;
- iv. Society for Family Health;
- v. Kabwe General Hospital;
- vi. Ngungu Clinic;
- vii. Ndola Teaching Hospital;
- viii. Masala Clinic;
- ix. Michael Chilufya Sata Hospital; and
- x. Kasama General Hospital.

UNIVERSITY TEACHING HOSPITAL

6.8.1 Your Committee specifically visited the Women and Newborn Hospital (WNH) wing and learnt that the WNH is a tertiary institution providing specialised services for women and the newborn adhering to the life cycle approach. One of the core functions is to provide specialised sexual reproductive health care. The Hospital has a bed capacity of over 357 with 13 wards, 90 cot beds and 21 incubators. The Hospital also has 3 labour wards and four theatres and is being supported by a 24 hour pharmacy and a laboratory stationed in D block.

Sexual and Reproductive Health Services

The hospital offered the services set out below.

- i) Antenatal, delivery and postnatal care services.
- ii) PMTCT - Option B+.
- iii) Family planning.
- iv) General gynecology (reproductive health services).
- v) Emergency gynecology services.
- vi) Cancer screening and treatment.

- vii) Menopause.
- viii) Adolescent services.

Antenatal and Postnatal

Statistics revealed that there was an upward increase in both antenatal and postnatal clients in the first quarter of 2017, compared to the first quarter of 2016. Your Committee was also informed that there was a downward trend in the number of patients counseled and tested for HIV in the 1st quarter of 2017, compared to 2016. The percentage of those that tested HIV positive was between 3 and 4 percent. The provision of antenatal and postnatal services was also extended to adolescents.

Family Planning

The Hospital provided both long and short term family planning services. The statistics revealed a slight decrease in the first quarter of 2017, compared to 2016.

Gynecology Services

The Hospital also provided gynecology services. The most common conditions seen were menstrual disorders, fibroids, pelvic inflammatory disease (PID), cancers (cervical cancer being common), among others. There had been a downward trend in the new patients observed from the first quarter of 2017. The Hospital also had a gynecological emergency ward open 24 hours. It had a small theatre from which treatment for the various types of abortions were done. These included threatened abortions, incomplete and complete abortions, septic abortions and Manual Vacuum Aspiration (surgical procedure), among many others.

The Sexual Gender based Violence One Stop Centre

The University Teaching Hospital – HIV/AIDS Programme (UTH-HAP) with financial support from Centre for Disease Control provides care and support for survivors of child and sexual assault through a one stop centre. The one stop centre became operational on 20th March, 2017.

Maternal Delivery Services

The WNH offered specialist delivery maternity and neonatal services and received patients not only from Lusaka City, but also from other districts. The number of deliveries in 2016 was 23,264 with a caesarean section rate of about 18%. The main causes of maternal deaths included pregnancies with abortive outcome, hypertensive disorders in pregnancy, childbirth obstetric hemorrhage and pregnancy-related infection, among others.

Challenges

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

- a) The Hospital has limited infrastructure to accommodate the pool of patients.
- b) The Hospital is understaffed, hence compromising on quality of service delivery.
- c) The Hospital has limited funding as most of the funding is internally generated.
- d) There were weak referral system from the clinics and other District Hospitals that are supposed to provide primary health care.
- e) The court cases at the one stop Sexual Gender Based Violence (SGBV) Centre took too long leading to case withdrawals especially for cases relating to incest.
- f) The Hospital has no link with the Ministry of General Education to ensure that adolescents got back to school after delivery.
- g) The hospital has no infection rails in the corridors and wards.

In view of the challenges, the Hospital administration stated that the challenges could be addressed through the following, among others:

- i. speed up infrastructure rehabilitation and development as the Hospital needs a major facelift;
- ii. ensure that nursing assistants are quickly deployed to the wards to perform minor procedures and take care of patients;
- iii. the new Hospitals to be supported to develop their Strategic and Action Plans to ensure they have approved budget lines for the year 2018;
- iv. strengthening of the referral system to ensure that patients are accessing primary care services in their localities. To this effect, Information Education and Communication (IEC) should be implemented for the public at large;
- v. provision of an effective fast track court for victims of sexual violence and rape to ensure that cases are dealt with within the shortest possible time;
- vi. the MoH to have an MoU with MoGE on linking girls who drop out of school due to pregnancy, to facilitate the re-entry policy for such girls; and

vii. urgently put in place infection rails in the corridors and the wards.

KANYAMA HOSPITAL

6.8.2 Your Committee learnt that Kanyama Hospital situated west of Lusaka Central Business District is a 1st level Hospital. The Hospital offers primary, first and second care services, to a high density and low income population with a catchment area of more than 200,000 people. The Hospital has one of the highest client base with an average of 2,000 clients per day. Kanyama Hospital also has a limited bed capacity of 40 of which 20 are for the adult medical patients and the remaining for the labour ward. The Hospital does not have a Surgical and Children's ward.

The facility offers a wide range of reproductive health services which include the following, among others:

- i. Family Planning;
- ii. Comprehensive Abortion Care;
- iii. Antenatal;
- iv. Postnatal;
- v. Cervical Cancer Screening; and
- vi. Voluntary Medical Male Circumcision (VMC).

Family Planning

The facility provided voluntary, informed and free family planning services which include short term, long term and permanent methods. An average of 200 clients accessed family planning services per day.

Cervical Cancer Screening

The Hospital provided cervical cancer screening and referred patients for Loop Electrosurgical Excision Procedure (LEEP) service to UTH. As of April, 2017, the Hospital had screened a total of 20,342 new clients. In 2016, a total of 3,099 clients were screened.

Voluntary Medical Male Circumcision

This service was offered in partnership with the Centre for Infectious Diseases Research in Zambia (CIDRZ). Clients were also offered voluntary counselling and testing for HIV.

Antenatal Care

This included couple counselling and HIV testing. The first antenatal care visit indicator was at 90% and the highest in the district. However, the total number of mothers at first antenatal against antenatal visits before 14 weeks was very low.

Postnatal Care

This service was offered to mothers after delivery. HIV counselling and testing was offered to all clients. Those found HIV reactive were initiated on ART and their babies given Niverapine suspension. Health education concerning the care of the new born and mother was given to all mothers before discharge.

Maternal Deliveries

The labour ward had one obstetrician and 24 midwives conducting an average of 35 deliveries per day. The Hospital had the highest deliveries in 2016 having a total number of 8,300 deliveries.

Comprehensive Abortion Care (CAC)

The services offered include prevention of pregnancy and management of complications associated with termination of pregnancy. The Hospital also offered Manual Vacuum Aspiration (MVA).

Challenges

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

- i. the Hospital was heavily congested and had limited infrastructure;
- ii. the Hospital had low staffing levels but servicing a large catchment area of more than 200,000;
- iii. the Hospital had many deliveries of 35-40 babies per day with limited midwives and only seven delivery beds;
- iv. low funding by the Government hence compromising quality of service delivery;
- v. lack of an ambulance for referrals in case of an emergency;
- vi. the Hospital had no mother's shelter for pregnant women and those seeking postnatal services were made to sit outside while waiting to be attended by medical personnel; and

vii. lack of radiology equipment.

The Hospital recommended the following, among others:

- i. MoH must support and fund the initiative by the Hospital to demolish the old staff houses in order to expand the Hospital space;
- ii. the clinics in Kanyama should be upgraded to offer maternal delivery services and ART in order to decongest Kanyama Hospital;
- iii. urgent deployment of more specialised health personnel to the facility to reduce waiting time by the patients at the hospital;
- iv. urgent procurement of hospital beds especially in the maternity wing;
- v. MoH to increase the facility's budget to improve operations of the facility;
- vi. urgent procurement of an ambulance for emergency cases;
- vii. construction of mothers' shelters; and
- viii. urgent procurement of radiology equipment.

MINISTRY OF GENERAL EDUCATION (MoGE)

6.83 Your Committee was informed that the Ministry of General Education through the Curriculum Development Centre (CDC) was in the third year of implementing the Revised School Curriculum which was launched in January, 2014. The Revised Curriculum highlighted changes at all levels and one worth noting was the integration of Comprehensive Sexuality Education (CSE) in the relevant carrier subjects. CSE emphasised a holistic approach to human development and sexuality.

Comprehensive Sexuality Education (CSE)

The inclusion of the CSE in the school curriculum had been done to meet the needs of an individual, the community and nation. The revision was also an opportunity for integration of CSE for the in and out of school population. The integration had been extended to in-service and pre-service teacher curriculum.

Implementation of Comprehensive Sexuality Education (CSE)

CSE had been integrated in specific carrier subjects such as Integrated Science, Social Studies, Home economics, Biology, among others. It was also offered as a course in the pre-service curriculum for teachers.

Benefits of Comprehensive Sexuality Education (CSE)

It provided structured opportunities for young people to gain knowledge, skills and positive attitudes which would help them apply life skills in addressing challenges regarding their sexuality. It also equipped learners with correct knowledge to make responsible decisions about their sexual relationships thereby leading to delayed sexual debut, reduced teenage pregnancies and unsafe sex or abortions, among others.

Re-entry Policy

The policy had been in existence since 1997, in order to provide opportunities to girls who dropped out of school as a result of pregnancy to be able to go back to school after delivery. Guidelines were developed in 2004 by the Ministry of General Education in collaboration with partners. However, trends showed that more cases of pregnancies were recorded in rural areas than in urban schools.

Challenges

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

- i. Inadequate materials to cater for teachers and learners.
- ii. Delays in the release of funds to complete the development of CSE materials.
- iii. Lack of understanding of the Re-entry Policy by parents and pupils.
- iv. Social stigma against girls that return to school after delivery.

The MoGE was of the view that there was need to:

- i. expedite the provision and distribution of learners' materials;
- ii. urgently complete development of CSE materials;
- iii. increase community awareness on the right of a girl child to continue with school during pregnancy and after delivery; and
- iv. sensitise the communities on the Re-entry Policy.

SOCIETY FOR FAMILY HEALTH

6.84 Your Committee was informed that Society for Family Health (SFH) was supporting the Ministry of Health to deliver services in the areas of Reproductive Health (RH) and Family Planning, HIV prevention (condom social marketing, voluntary medical male circumcision, social and behaviour change communication) and research, among others.

Achievements

The following were some of the achievements:

- i. more than eighty-eight health facilities have been supported with mentorship and supervision;
- ii. about 481,673 women of reproductive age have received FP services;
- iii. five hundred and thirty two Community Based Distributors have been have been trained to provide FP services and attached to facilities;
- iv. five hundred and thirty two (532) Community Based Distributors have been trained to provide family planning services including injectable Depo Provera;
- v. HIV-self test kits have been distributed across 16 sites; and
- vi. sixty-five health providers have been trained in clinical male circumcision skills.

Challenges

There was low involvement of men in antenatal and family planning.

Recommendations

There was need to strengthen awareness strategies among men.

KABWE GENERAL HOSPITAL

6.85 Your Committee learnt that the Hospital is a Second Level Hospital with a bed capacity of 430. Out of the eleven districts in Central Province, the hospital provided second level healthcare services to nine districts. Kabwe General Hospital and Kabwe Mine Hospital also provided first level services for Kabwe District which did not have a 1st level Hospital although the latter is completely fee paying.

Family Planning

The Hospital provided full components of family planning methods from reversible to permanent methods including Long Term Reversible Contraceptive methods (LARCs). Available methods included oral contraceptive pills, injectable contraception, implants, Intrauterine Contraceptive Devices (IUCDs) and sterilization procedures for women who had completed their family.

Cervical Cancer Screening

The Hospital was offering routine cervical cancer screening using Visual Inspection with Acetic (VIA) and Pap Smear. It also houses the Loop Electrosurgical Excision Procedure (LEEP) clinic which is open Monday to Friday and is the referral centre for patients from screening sites in Kabwe and other districts that require further diagnostic services which include biopsies and histological confirmation. Advanced cervical cancer patients are referred to Cancer Diseases Hospital in Lusaka for chemotherapy and radiotherapy.

Antenatal Clinic

A specialised antenatal clinic is run every week day. The clinic is dedicated to all pregnant women from within and around Kabwe who come with complicated pregnancies. However, women with normal pregnancies are also provided with antenatal service.

General Gynaecology Clinic

Your Committee learnt that a general gynaecology clinic was operational twice every week following the antenatal clinic. Conditions such as uterine fibroids, ovarian cyst, and pelvic Infections, menstrual disorders, child birth injuries and infertility issues are commonly seen in this clinic. Others included structural genital anomalies, cervical cancers and ovarian cancers. About 2,000 women were seen at gynaecology clinic for various reasons in 2016.

Maternity Ward

The Hospital conducted an average of 35-40 deliveries per day. Common conditions for admission to this ward included High Blood Pressure in pregnancy, Malaria, anaemia, previous operative delivery and bleeding during pregnancy. Other conditions included heart disease, sickle cell disease, asthma and twining pregnancy, among others. About 4,345 women were admitted to this ward between January and December, 2016, out of which 896 (21%) had operative deliveries (caesarean sections) while 79% had normal deliveries.

Operating Theatre

Kabwe General Hospital main theatre has dedicated two elective operating days per week during which women requiring operative diagnostic or therapeutic procedures are

attended to. Common indications for operations included uterine fibroids, ovarian cysts, sterilization procedures, perineal tear repairs, Vesico-Vaginal Fistula (VVF) repairs and occasionally tubal surgery for infertility. Hysterectomies for early stage cancer and cancer reduction surgeries for ovarian cancer were also conducted in the theatre.

Male Circumcision

A walk-in daily Voluntary Male Medical Circumcision Service is offered to contribute to healthy families by reducing transmission of deadly viruses such as Human Papilloma Virus and HIV.

HIV Counselling, Testing and Treatment

Women of reproductive age and everyone else were offered free counselling and testing services for HIV at all points of service. Those found infected received treatment for elimination of Mother to Child Transmission of HIV and partner treatment for discordant couples.

Challenges

Your Committee was informed of the following challenges:

- i. the Hospital was heavily congested and providing first and second level care;
- ii. the Hospital had limited infrastructure and could not meet the current demand;
- iii. the Hospital had no CT- Scan in the Trauma Centre despite having a well established operating room;
- iv. there were inadequate bed spaces leading to increased waiting time by patients at the Hospital and ultimately compromising on service delivery. At peak times, women were forced to share bed spaces which was unhealthy, but could not be avoided as the situation stood;
- v. there was limited human resource. The General Hospital currently had only one Obstetrician and Gynaecologist assisted by three General Medical Officers; and
- vi. the Hospital had no paralegal officer at the One Stop GBV Centre.

Recommendations

The Hospital administration made the recommendations as set out below.

- i. The MoH should expedite the establishment of a district hospital to reduce the congestion at the General Hospital.
- ii. The MoH to increase funding to the Hospital in order to run a comprehensive outreach programme for second level reproductive health services such as emergency obstetric care and cervical cancer screening.
- iii. The hospital urgently needed hospital beds.
- iv. The MoH should urgently deploy specialised personnel such as Obstetricians, Gynaecologists and General Medical Officers.
- v. There was urgent need to procure a CT- Scan for the trauma centre.
- vi. A permanent paralegal officer should be deployed to the One Stop GBV Centre at the Hospital.

NGUNGU CLINIC

6.86 Your Committee was informed that Ngungu Clinic located in the outskirts of Kabwe was servicing a population of 17,018 and a proportion of 3,487 were women in their child bearing age. Ngungu was currently undergoing renovations and thus not offering maternal delivery, abortion and post abortion care.

Family Planning

The Clinic provides all forms of family planning. There was a significant decrease in the number of women accessing family planning services in 2015, compared to 2016.

Cervical Cancer Screening

Cervical cancer screening at Ngungu Clinic started on the 3rd July, 2012. By the end of the 1st Quarter, 2017, a total of 12, 080 women had been screened. (Of the 12,080 screened, 28% were HIV positive.)

Antenatal

Your Committee was informed that a large number of women were accessing antenatal service with 51% percent of men being involved. However, antenatal attendance at less than 14 weeks of pregnancy was still very low which could be attributed to various reasons such as cultural misconceptions on early booking.

Challenges

The Clinic faced the following challenges:

- i. inadequate space in the screening room;
- ii. non-functional incinerator for disposal of waste;
- iii. the Clinic is currently not providing abortion and post abortion services due to the transfer of the only staff who was trained in the delivery of the services;
- iv. Ngungu Clinic was the only clinic currently providing cervical cancer screening services in Kabwe;
- v. lack of radiology equipment; and
- vi. inadequate transport.

Recommendations

The Clinic administration made the recommendations set out below.

- i. There was need to expand the screening room with the possibility of creation of a storeroom.
- ii. There was urgent need to procure an incinerator at Ngungu Clinic.
- iii. There was need for training of the majority of staff at Ngungu Clinic in the provision of abortion and post abortion care.
- iv. There was need for all districts in Central Province to have at least one screening clinic.
- v. There was need to intensify linkage of cervical cancer screening clinic to HIV services.
- vi. There was urgent need to procure radiology equipment.
- vii. There was need to increase provision of ambulances and utility vehicles in Central Province.

NDOLA TEACHING HOSPITAL

6.87 Your Committee was informed that Ndola Teaching Hospital is the second largest health facility in Zambia and has twenty-seven wards with a capacity of 851 beds and ninety-seven baby cots. The catchment area of the Hospital was serviced by other public and private clinics and hospitals which included nineteen clinics and health posts being run by Ndola District Health Office (DHO), three (3) Zambia Army clinics and

one hospital, one Zambia Flying Doctors Services (ZFDS) clinic and twenty-two clinics run by various private and parastatal companies. Additionally, the facility received referrals from other health facilities on the Copperbelt, Northern, Luapula, Muchinga, Central and North-Western Provinces. The Hospital offers primary, secondary and tertiary care services to adults and children.

Gynaecology Services

Your Committee was informed that on average, close to 400 patients were admitted per month with various conditions like cervical cancer, genital tract infections, and early pregnancy complications. Victims of sexual violence (defilement and rape) were also attended to in the same ward. Comprehensive abortion care was also offered in line with the existing legal framework.

Antenatal Services

Your Committee heard that antenatal wards admitted women who were more than twenty-six weeks pregnant with various obstetric and medical conditions such as hypertension, heart disease, and haemorrhage. However, most patients were admitted in labour either in latent phase or active phase. Women planned for elective caesarean section were prepared from these wards.

Maternal Delivery

On average, the Hospital conducted about five hundred deliveries per month out of which more than 120 were caesarean sections. Women admitted in labour were either self-referrals or referred by the health centres in Ndola and other districts. The Hospital recorded twenty-six maternal deaths in 2016. The major causes of deaths were haemorrhage, complications of hypertension and chronic illnesses like HIV/AIDS and Sepsis, among others. Erratic supply of blood for transfusion contributed to some of the deaths from haemorrhage.

Challenges

The following were some of the challenges being faced by the Hospital:

- i. human resource shortages in almost all the wards;
- ii. inadequate surgical equipment (trays, receivers, trolleys, bowls and drip stands) in the wards;
- iii. inadequate surgical instruments and sets for caesarean sections and hysterectomies in the operating theatre;
- iv. lack of an emergency operating theatre for obstetric emergencies;

- v. erratic supply of stationery (partographs, fluid balance charts and drug charts) in labour ward and other wards;
- vi. inadequate linen for patients especially bed sheets;
- vii. broken ceiling boards, floor tiles, windows and doors in the operating theatre; and
- viii. the cervical cancer screening clinic has only one digital camera which results in closure of the clinic each time there is an outreach activity.

Recommendations

The Hospital made the following recommendations:

- i. urgent procurement and supply of:
 - autoclave machine;
 - beddings;
 - digital cameras to be used in cancer clinic; and
 - stationery and improvement on the timely supply of surgical instruments and equipment in the operating theatre;
- ii. improvement of the infrastructure in the operation theatre;
- iii. facilitate funding for the establishment of emergency operating theatre for obstetric emergencies at the identified space;
- iv. the staffing levels at the Hospital need to be increased;
- v. the operating theatre needs to be renovated; and
- vi. the hospital management should have records of localised statistics of HIV prevalence in adults and adolescents.

MASALA CLINIC

6.88 Your Committee was informed that Masala Clinic was a modern 24 hours operating clinic with twenty delivery beds and served a total population of 45,721 people.

Maternal deliveries

Your Committee was informed that the Hospital provided the service to both women and adolescents. An average of 284 deliveries was undertaken on a monthly basis. Maternal service was provided to a large catchment area against twelve midwives.

Antenatal Care and Postnatal Care

With regard to antenatal care, the statistics at the Clinic revealed that 95% of the pregnant women attended at least four antenatal visits as required by WHO and 82% received postnatal care within six days in the first quarter of 2016.

Family Planning

The Clinic provided short term, long term and permanent family planning services. Masala Clinic also had a community outreach programme to educate women on the different forms of family planning and the advantages of being on family planning.

HIV/AIDS Services

The services offered include HIV counselling and testing and ART.

Challenges

Your Committee was informed of some of the major challenges as follows:

- i. inadequate infrastructure for safe motherhood services;
- ii. inadequate human resources leading to multi-tasking of midwives;
- iii. lack of a medical doctor; and
- iv. lack of a mothers' shelter.

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

- i. expand the Clinic to improve service delivery and reduce waiting time at the clinic;
- ii. deploy medical doctors and other medical personnel to the clinic; and
- iii. establish a mothers' shelter to accommodate women when they visit the clinic for antenatal care.

MICHAEL SATA HOSPITAL

6.89 Your Committee was informed that Michael Chilufya Sata Hospital located in Mpika District 10km away from Mpika Boma offered 1st level services to the Northern zone of the District. The Hospital offers free health services to the population it serves. Specialised services provided at the Hospital include Voluntary Medical Male Circumcision (VMMC), ART/VCT, PMTCT, cervical cancer screening, theatre and GBV survivor support services.

Maternal Health

The Hospital has an average of eighty seven monthly deliveries. The Hospital offers spontaneous vaginal delivery (SVD), instrumental delivery (Vacuum) and caesarean section. The main complications during delivery include sepsis, obstructed labour, eclampsia and ruptured uterus, among others.

Family Planning

The Hospital provides limited family planning services. Only condoms and BTL were being offered. The bulk of the service was being offered at the old District Hospital.

Cervical Cancer Screening

A total number of 1,679 clients had been screened since the Hospital was opened in May, 2015. Clients with Loop Electrosurgical Excision Procedure (LEEP) were referred to Chinsali General Hospital for further investigations.

Termination of Pregnancy

The Hospital was currently not offering abortion services. However, Manual Vacuum Aspirations (MVAs) were being offered in case of incomplete and unsafe abortions. About 171 had been done so far.

Voluntary Medical Male Circumcision

The Hospital conducted both mobile and static VMMC services. There were currently twelve trained providers of the service at the Hospital.

Challenges

The Hospital submitted the following challenges:

- i. there was no utility vehicle permanently stationed at the hospital;
- ii. existence of fractured services compromised service provision;
- iii. the Hospital was being underutilised;

- iv. the Hospital was not complete and most of the space had been improvised thus services provision was being compromised; and
- v. lack of transport (staff bus) for members of staff.

Recommendations

The Hospital management made the recommendations set out below.

- i. MoH should expedite the procurement of a utility vehicle and an ambulance for the Hospital.
- ii. MoH should fund the completion of the remaining phase of the Hospital infrastructure.
- iii. MoH should deploy more specialised medical personnel to enable the Hospital be utilised fully.
- iv. There was need to procure a staff bus for members of staff to ease their movements.

KASAMA GENERAL HOSPITAL

6.810 Your Committee was informed that Kasama General Hospital had a bed capacity of 400 and estimated to have between 800-900 bed spaces once completed. It operates as a 1st level referral hospital for Kasama and Mungwi Districts and a second level hospital for Muchinga and Northern Provinces.

Family Planning

The Hospital offers all family planning methods including Long Term Reversible Contraceptive methods (LARCs). The service was accessed by both women and adolescents.

Cervical Cancer Screening

The Hospital did not have a specialist to diagnose cervical cancer. However, all specimens were sent to UTH for diagnosis.

Antenatal Clinic

There was specialised antenatal clinic at the Hospital. The service was mostly dedicated to all pregnant women with complicated pregnancies.

Maternity Health

The Hospital attended to pregnant women who had complicated pregnancies. The Hospital had twelve (12) midwives, seven (7) delivery beds and an average of 250 deliveries per month. Most complications during delivery were characterised by High Blood Pressure, bleeding during and after delivery and Sepsis, among others.

Male Circumcision

Voluntary Male Medical Circumcision Service was offered to boys and men.

HIV Counselling, Testing and Treatment.

The Hospital offered this service to the general public. However, HIV testing was offered to all pregnant women and some of their partners during pregnancy and after delivery to prevent and eliminate PMTC. Those found infected were immediately put on treatment.

Challenges

The Hospital faced the following challenges:

- i. the Hospital was incomplete and dilapidated;
- ii. the Government owed staff a total amount of K4,015,215.07 in various categories of allowances;
- iii. theatre equipment was inadequate;
- iv. non-functional renal unit;
- v. there was no cold room for storage purposes;
- vi. the Hospital had no reliable utility vehicle and ambulance;
- vii. inadequate Doctors and Anaesthetists; and
- viii. lack of a qualified staff to operate the CT-Scan.

Way Forward

The Hospital management made the following recommendations:

- i. there was need to complete the hospital construction and conduct a full rehabilitation;

- ii. there was need to quickly settle the debt for personnel in order to have a highly motivated staff;
- iii. there was need to urgently procure theatre equipment;
- iv. there was need to urgently set up a renal unit;
- v. there was need to procure at least two utility vehicles, ambulances and a light truck; and
- vi. there was need to deploy specialised staff to improve service delivery.

PUBLIC HEARINGS

7.0 Your Committee held two public hearings in Kabwe District, Central Province and Masaiti District, Copperbelt Province, sponsored by the Southern African Development Community Parliamentary Forum (SADC-PF) and Irish Aid. The public hearings were attended by 255 people.

Objective of the Public Hearings

The public hearings were aimed at information collection to be used in prioritising sexual reproductive health challenges, developing human rights friendly policies, reforming legislation, deploying resources and subsequently measuring success.

The findings of your Committee's public hearings are set out below.

Contraception

Unmarried women and girls were not comfortable to access family planning because they feared being judged by the community. The women were also avoiding taking family planning because of the myths and misconceptions that it caused cancer. Further, some religious leaders did not allow their members to take family planning medicines.

Maternal Health

Your Committee learnt from the members of the public as set out below.

- i) traditional medicines were still being used to induce labour for pregnant women who were almost due.

- ii) women were travelling long distances to get to the nearest health facilities to access maternal services. However, most of the available health facilities did not have mothers' shelters and maternity waiting homes.
- iii) Masaiti was a new District and health facilities were limited and spaced thus, most women ended up delivering in homes.
- iv) the trained Safe Motherhood Action Groups (SMAGs) lacked motivation and were not provided with bicycles to assist them in community health service.

Abuse of Alcohol

- i) The members of the public informed your Committee that there was too much abuse of alcohol by young people who were under age. In addition, the owners of the bars did not follow the stipulated operating hours.
- ii) Your Committee was informed that the abuse of alcohol by the youths, especially the girl child, led to many of them getting into prostitution and indulging in sex transactions.

Early Marriages

- i) Your Committee was informed that most families could not afford to pay school fees for their children and dependants at secondary school level, thus the young people dropped out of school to get married.
- ii) The members of the public informed your Committee that Masaiti District had insufficient secondary schools. As a result, most pupils opted to access secondary schools in Luanshya and lived in rented houses. However, the members of the public expressed concern that the pupils engaged in pre-marital sex and dropped out of school due to pregnancies.

General concerns

- i) The entire District of Kabwe only had two ambulances.
- ii) Members of the public submitted that some marriage traditional counsellors had continued to give young women entering marriage traditional medicine to insert into their reproductive organs for various reasons.

Committee's Observations and Recommendations

7.1 Taking into consideration the findings from the local tour and the public hearings, your Committee makes the observations and recommendations set out below.

i) Increase in Unsafe Abortions

Your Committee observes that the unmet need for family planning is still high and there is an increase in the number of unsafe and incomplete abortion cases in health facilities.

Your Committee recommends that the Government should be aggressive in implementing family planning awareness strategies as the primary method of avoiding unwanted pregnancies which led to unsafe abortions.

ii) Inadequate data capturing

Your Committee observes that the available data in most health facilities is not disaggregated to reflect the age of the mother at delivery and uptake of family planning by adolescents and women in different age groups, making it difficult to measure and monitor targets 3.7.1 and 3.7.2, adolescent birth rate (among age groups 10–14, 15–17, 18–19 years) per 1,000 and the percentage of women of reproductive age (15–49 years) who have their need for Family planning satisfied with modern methods respectively.

Your Committee recommends that the Ministry of Health should strengthen the data collection system and ensure that there is standardisation in the collection of data for monitoring purposes of the two indicators.

iii) Myths and Misconceptions

Your Committee observes that women shun using modern contraceptives because of the misconceptions and the myths that they cause cancer.

Your Committee recommends that the Government should immediately engage and target traditional leaders, religious leaders and other key players in sensitising communities on the benefits of using modern contraception methods.

iv) Inadequate Cervical Cancer Screening Services

Your Committee observes that there are limited health facilities providing cervical cancer screening services especially in rural areas.

Your Committee recommends that as a matter of urgency, the Government should heavily invest in increasing cervical cancer services throughout the country and intensify the linkage of cervical cancer screening clinics to HIV services.

v) Inadequate Skilled Human Resource

Your Committee observes that most health facilities are understaffed which leads to congestion and ultimately long waiting hours by the patients.

Your Committee, therefore, strongly recommends that the Ministry of Health should deploy health workers based on equity and output of the respective health facilities.

vi) Lack of Emergency Operating Theatres and Equipment

Your Committee observes that most health facilities lack emergency operating theatres for obstetric emergencies. Your Committee also observes that there are inadequate surgical instruments and equipment in the existing theatres.

Your Committee recommends that the Government should invest more in developing new theatres for emergency cases and refurbish the non-functional ones to avoid maternal deaths during operations. Your Committee further recommends that the Ministry of Health should urgently restock operating theatres with the required surgical instruments and equipment.

vii) Delayed Commencement of Antenatal Care

Your Committee observes that antenatal attendance at less than 14 weeks of pregnancy is still very low especially in rural areas.

Your Committee recommends that the Ministry of Health should actively scale up strategies to aggressively raise awareness on early commencement of antenatal care.

viii) Alcohol Abuse by Young People

Your Committee observes that there is an increase in the abuse of alcohol by adolescents leading to the increase in transactional sex and prostitution.

Your Committee recommends that the Government should enforce strict measures and ensure that all alcohol drinking places adhere to the stipulated operating hours. Your Committee further recommends that stringent measures be put in place to disallow the under age youths in bars and to close down bars allowing youths who are under age to patronise bars.

ix) Centralised Medical Stores

Your Committee observes that there is an increase in stock of family planning commodities in the country.

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

x) Weak Referral System

Your Committee observes that patients not necessarily requiring specialised services are still being attended to at tertiary hospitals thereby causing congestion.

Your Committee recommends that the Ministry of Health should actively raise awareness in the communities at large on the need to use local primary facilities.

xi) One Stop GBV Centres

Your Committee observes that court cases for the perpetrators of GBV take too long leading to cases of incest being withdrawn.

Your Committee, therefore, recommends that a fast track court system for victims of sexual violence and rape should be created to ensure that cases are dealt with within the shortest possible time. Your Committee further recommends that a paralegal officer be assigned to every One Stop GBV Centre.

xii) Inadequate Equipment

Your Committee observes that most health facilities have inadequate beds leading patients to share beds in some instances.

Your Committee recommends that the Ministry of Health should, as a matter of urgency, procure adequate beds and beddings for the health facilities lacking these facilities.

PART III

FOREIGN TOUR TO THE PARLIAMENT OF RWANDA

OBJECTIVE

8.0 Your Committee undertook a foreign tour to Rwanda , which is one of the nineteen countries that met the United Nations Millennium Development Goal (MDG 5) of reducing the number of women who die during pregnancy, or shortly after giving birth, by three-quarters.

The objective of the tour was to learn best practices in the implementation of the Sustainable Development Goal (SDG) on Health with special focus on sexual and reproductive health.

In line with the objective of the tour, your Committee interacted with the following institutions:

a) MINISTRY OF HEALTH

Your Committee was informed that tackling conditions ranging from obstructed labour to chronic infectious diseases required modern health infrastructure and well-trained staff. Rwanda's health facilities were currently staffed by 625 physicians, 8,273 nurses, and 240 nurse midwives, heavily concentrated in urban areas. In Rwanda, 80% of the disease burden was being addressed at community level. Further, the country had 499 Health Centres, thirty six (36) District Hospitals and five (5) Referral Hospitals. However, Rwanda faced one of the greatest shortages of human resources for health in the world with a very high turnover. Thus, the Rwandan Government took the initiative to utilise Community Health Workers (CHW) in strengthening its health system.

Your Committee learnt that a cadre of 45,000 community Health Workers performed many tasks over the past decade. After being elected by their communities, CHW were trained to diagnose and provide empirical treatment for numerous health conditions and contributed to health promotion. The CHW had no fixed salary but depended on incentives.

As it was well defined in the Policy of Community-Based Provision (CBP) of FP services, the CHWs were authorised to re-supply to current users of short time methods of Family Planning. These included injections, oral contraceptive pills, standard days method and condoms.

Since 2005, maternal health indicators had improved. Antenatal care by skilled providers increased from 94% in 2005, to 99% in 2014-15. Skilled assistance during delivery had increased from 39% in 2005, to 91% in 2014-15. Facility-based deliveries also greatly increased from 28% to 91% in 2014-15.

Regarding antenatal care, just over half of women made their 1st antenatal care visit during the 1st trimester of pregnancy. 44% of pregnant women made 4 or more Antenatal clinic visits during their pregnancy.

Your Committee learnt that 91% of births in Rwanda took place in a health facility; and 8% took place at home. Currently, the Contraceptive Prevalence Rate (CPR) for Rwanda is 53% with 48% of married women using modern methods of contraception and 6% using traditional methods of contraception. Among married women, injectables, implants, and the pill were the most popular.

Your Committee learnt that the Rwandan Government had taken a lead in using home grown solutions in the implementation of SRHR programmes and any other policies and programmes in general. Some of which are outlined below:

i. Performance Contracts with districts (Imihigo)

The contract consists of indicators which reflect the goals in the national agenda and each district had its own indicators assigned for the key indicators of the development including health.

ii. Audit of the maternal and child deaths

The monitoring system of the maternal deaths was in place in order to provide the information and to identify correct measurements necessary to prevent the similar deaths.

iii. Rapid SMS for alert

The alert system tracks the maternal and neonatal life cycle, ensuring that critical points in the cycle were documented and sent electronically.

iv. Umuganda

Each village held community work, every last Saturday of the month to encourage partnership at community level.

The family planning strategies and interventions that the Rwandan Government has put in place include:

- a) improving family planning within the maternal and child health subsector;
- b) increasing availability and use of FP services (by choice) in public and private sectors;
- c) increasing knowledge, acceptability and use of the full range of FP methods in the community;

- d) sustaining a FP programming and funding mechanisms developed; and
- e) promoting and use operation research from national and international FP programs.

b) RWAMAGANA DISTRICT HOSPITAL

Your Committee was informed that Rwamagana Provincial Hospital was a public institution located in Eastern Province, Rwamagana District, 60 km from Kigali. It was founded in 1949, as a dispensary for people who worked in mines. In 1952, it became a Public District Hospital. It served a population of 344,717 and fourteen (14) health centres, nine (9) health posts, two (2) private clinics and 1 Prison dispensary.

Your Committee learnt that the District Hospital provided emergency and ambulances services, Internal Medicine, Pediatrics Gyneco- Obstetrics and Surgery. Other services included HIV Clinical Services, TB, Family Planning, Isange One Stop Center and Nutrition.

Your Committee was also informed that family planning activities were integrated in all services provided at the Hospital. Family Planning was also continuous even after a woman had delivered. Rwamagana Hospital also had a high level commitment to deliver information, education, and communication/Behavioral Change Communication (IEC/BCC). Further, both short and long term methods of family planning were being provided. The Hospital was also involved in the mentorship of Community Health Workers in the District.

c) KIMISAGARA ONE STOP YOUTH CENTER

Your Committee was informed that Kimisagara One Stop Youth Centre was committed to promoting decent youth empowerment using an integrated approach. The Youth Centre had the initiative of empowering the youths economically and keeping them away from engaging in sexual activities as a result of poverty. A number of activities were being integrated including Information and Communication Technology Program, Talent Development Programme, Health, Sport and Culture Program, Good Governance, Civic Education and Volunteerism Programme, among others.

Your Committee learnt that from 2012, 19,940 youths had undergone training and among these, 19,932 undertook HIV testing. The 459 youths that were diagnosed with HIV/AIDS were counselled and were receiving treatment. In addition, 1,918 boys and young men undertook circumcision and over 175,000 thousands condoms had been distributed.

After undergoing various training, Kimisagara One Stop Youth Centre in partnership with Kigali Employment Service Centre (KESC) linked the youths that had undergone various training to potential employers. Officially launched on 30th May, 2013, KESC was a

unique first public job centre in the Sub-Saharan Africa and worked under the City of Kigali. It worked in partnership with the Ministry of Youth, Information, Communication and Technology (MYICT).

Your Committee heard that KESC had about 2,663 registered job seekers and forty-seven (47) MoU's signed with employers including public and private institutions. So far, 841 job seekers got employed or internship and four (4) job fairs had been conducted. 3,900 job seekers and 156 employers attended.

d) RWANDA SOCIAL SECURITY BOARD

Your Committee was informed that as per the relevant Law (No 62/2007), it was mandatory for all residents in Rwanda to have some form of health insurance. A fine was applicable for failure to comply with the Law. In the formal sector Medical Scheme, it was mandatory for the Government and public institutions (voluntary for private institutions) and retirees to contribute a rate of 15% equally shared by the employer and employee.

Your Committee learnt that the Government of Rwanda had made universal health coverage one of its key objectives, as a means to reduce poverty, as laid out in the Economic Development and Poverty Reduction Strategy (EDPRS); and to meet the health targets under the Millennium Development Goals (MDGs). Moreover, universal health protection had contributed considerably in meeting the health targets under the (MDGs). The Mutuelle de Santé / Community Based Health Insurance (CBHI) was developed to meet the needs of those Rwandans outside the formal sector where access to and utilisation of healthcare services had been historically very low. Other Government programmes were developed in parallel which would impact the CBHI.

Your Committee was informed that the CBHI offered its beneficiaries a very substantial benefit package that included both outpatient (OPD) and inpatient (IPD) care. Basic health care was provided at the health centre level, with more routine procedures and advanced cases being treated at the district hospitals, and sophisticated tertiary care at the referral hospitals. There were no limits of the amount of care available, either for the individual or the family. However, the health centre served as a referral point for all services beyond basic care with a nurse.

e) Ministry of Social Affairs

Your Committee was informed that Article 14 of the Rwandan Constitution stated: *"The State shall, within the limits of its capacity, take special measures for the welfare of the survivors of genocide, the disabled, the indigent, the elderly and other vulnerable groups"*.

Your Committee learnt that the Ministry of Social Affairs was also an important aspect in the Medical Insurance Scheme, particularly, the CBHI. The Ministry was responsible

for managing the Ubudehe, a community programme in which village residents were engaged in participatory planning process to shape their own destiny.

Your Committee learnt that the CBHI started in 1999, aiming at making health services more accessible to the poor and the Government started the testing of pre-payment community based mutual insurance schemes. The poverty rate at the time was beyond 60 percent. This particular type of insurance was aimed at protecting indigenous people against the cost of illness and improving access to quality health services for citizens who were excluded from formal insurance.

In 2001, Ubudehe was reintroduced into Rwanda as a way to better involve communities in their development by setting up participatory problem-solving mechanisms. Building on traditional Rwandan culture, the system functioned at the level of the decentralised administrative entity nearest to the recipients, at the cell or village level. One of its most important aspects was assigning all Rwandan households into one of the four categories, based on income and assets. Currently, four categories existed with Category I comprising the poorest households which were fully subsidised by the Government regarding health insurance. The CBHI was organised at three levels: national, district and local, with enrolment tracked for each.

Your Committee learnt that Community-Based Health Insurance (CBHI) was an emerging concept for providing financial protection against the cost of illness and improving access to quality health services for citizens who were excluded from formal insurance. The role of the District in CBHI was to mobilise the populations in order to get them to subscribe to CBHI through different channels.

Committee's Observations

8.1 Arising from its tour of Rwanda, your Committee observes that:

- i. the Rwandan Government has a mandatory Health Insurance Scheme run by Rwanda Social Security Board;
- ii. the Rwandan Government has embraced decentralisation up to village level as a tool in the implementation of all SRH programmes and policies and all other programmes in the country with the district as the implementing organ;
- iii. Rwanda uses ICT to register all women of reproductive age and pregnant women, track pregnancies and pregnancies which are due as well as the danger signs, if any, in the community using Rapid SMS alert;
- iv. the Government of Rwanda has put up robust strategies to ensure that all maternal deliveries occur at a health facility;
- v. Rwanda continuously invests in infrastructure development of health

- facilities in both rural and urban areas;
- vi. Rwanda has a strong health referral system from village level up to tertiary level;
 - vii. the Government of Rwanda has a well established performance based approach system and performance contracts for public workers that reflect all the development plans, targets and indicators;
 - viii. Rwanda has aggressive maternal and child health implementation strategies;
 - ix. the Government of Rwanda has a high level commitment to support Community Health Workers and provides a conducive and sustainable environment for them;
 - x. the Rwandan Government has developed home grown solutions in implementing SRH and all other programmes in the Country to suit every situation as opposed to implementing general strategies from other Countries;
 - xi. all health centres in Rwanda provide comprehensive ART programmes and prescription is also done by nurses; and
 - xii. it is mandatory for each district to have a one stop GBV Centre. These Centres are integrated with other economic, health and social activities.

Committee's Recommendations

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

- i. the Government should as a matter of urgency take the lead in promoting a sustainable universal health access system by introducing the Social Health Insurance Bill to Parliament which should clearly stipulate which Government entity or institution will manage the Scheme;
- ii. the Ministry of Health should as a matter of urgency decentralise the implementation of policies and programmes to the districts as the main implementing agents in order to increase efficiency in operations and service delivery;
- iii. the Government should strengthen the health information through the use of ICT to register maternal deaths and other vital events by all health facilities and these health facilities must be linked to the central health system;
- iv. the Zambia Government should scale up the Community Health Workers

- (CHW) programme and standardise the incentives and/or packages for the CHW to increase;
- v. the Zambian Government should expedite the construction of health facilities especially in rural districts in order to reduce the distance to the health facilities;
 - vi. the Government of Zambia should strengthen the referral system in the health sector at all levels to increase efficiency;
 - vii. the Government should develop performance contracts for the public service at all levels which should reflect the targets in the national agenda;
 - viii. the Government should invest heavily and scale up in family planning awareness programmes especially in rural areas;
 - ix. the Government should consistently demonstrate commitment and consistency in aligning all Donor and International Partners' agenda to the national agenda to avoid duplication of efforts and resources;
 - x. the Government should invest heavily in sexual and reproductive health research upon which concise decisions will be made based on empirical data;
 - xi. the Ministry of Health should invest in task sharing and train nurses and other medical personnel in prescribing ART. Your Committee further recommends that more ART centres must be operationalised to increase the uptake of ART; and
 - xii. the Government should ensure that all health facilities have a one stop GBV centre integrated with other SRHR activities and strengthen the national capacity to deliver integrated SRH/HIV/GBV.

PART IV

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

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

The Implementation and Coordination of Zambia's Food and Nutrition Policy and Interventions

9.1 Your previous Committee had recommended that the Government should expedite the review process and present the Bill in Parliament as soon as possible. The Government should further review the *National Food and Nutrition Policy* to bring it in line with current nutrition developments. The World Health Organisation recommends that health related legislation and policies should be reviewed every ten and five years, respectively.

It was reported in the Action-Taken Report that the process to review the *National Food and Nutrition Commission Act* had reached an advanced stage. Stakeholders' consultative meetings on the revision of the Act were held in 2015. The Ministry of Health had since submitted drafting instructions to the Ministry of Justice to facilitate drafting of the Bill. The process to review the policy had also commenced. A road map had been developed and the process was expected to be completed in 2017.

Committee's Observations and Recommendations

Your Committee requests an update on the review of the *National Food and Nutrition Commission Act*.

9.2 Your previous Committee had recommended that the Government should fund the nutrition sector adequately by way of honouring the pledges it made at the Nutrition for Growth Summit in London in 2013, one of which was to increase the nutrition budgets by 20 percent per year over a period of ten years.

It was reported in the Action-Taken Report that the Government had started honouring its pledges by increasing funding for direct nutrition interventions across all sectors. It was further reported that the Government was defining a framework for nutrition sensitive interventions through the National Food and Nutrition Commission. This framework would guide the Government on priority nutrition interventions in Agriculture, Social Protection, Education, Health and Water and Sanitation. The framework would also serve as a basis for nutrition investments.

Committee's Observations and Recommendations

Your Committee notes the response and requests a progress report on the funding for direct nutrition interventions across all sectors and an update on the framework for nutrition sensitive interventions.

9.3 Your previous Committee had bemoaned the inadequate human resource in the nutrition sector to undertake effective implementation of nutrition programmes and activities across all sectors. Therefore, your Committee had recommended that the Government should invest in human resource development for the nutrition sector, if implementation-level challenges were to be addressed in the sector.

It was reported in the Action-Taken Report the Government through the Ministry of Health had prioritised training of nutrition cadres. In the 2016 training plan, ten slots had been allocated for Bachelor of Science in Nutrition at the University of Zambia.

Committee's Observations and Recommendations

Your Committee notes the response and requests an update on the training of ten nutrition cadres.

9.4 Your previous Committee had urged the Government to develop a comprehensive and clear accountability framework to ensure that all line ministries implement their policy measures on nutrition.

The Government responded through the Action-Taken Report that a comprehensive and clear accountability framework to ensure that all line ministries implemented their policy measures on nutrition would only be possible after the enactment of a new *Food and Nutrition Commission Act* as these would be enshrined in the Act. The process to review the Act had already commenced.

Committee's Observations and Recommendations

Your Committee notes the response and requests an update on the review of the *National Food and Nutrition Commission Act*.

9.5 Your previous Committee had recommended that the Government should strengthen nutrition governance ensuring that the NFNC has an appropriate mandate, structure and institutional home to effectively execute its coordination mandate. The Government could consider placing the NFNC in a neutral institution which is above the line ministries.

It was reported in the Action-Taken Report that that the Government was in the process of reviewing the *National Food and Nutrition Commission Act*. The Review of the Act

would pave way for the restructuring and repositioning of the NFNC. The draft Bill had been submitted to Ministry of Justice for drafting before submitting it to Parliament.

Committee's Observations and Recommendations

The Committee requests an update on the review of the *National Food and Nutrition Commission Act*.

9.6 Your previous Committee had recommended that there was need for the Government to establish and fund the coordination structures at all levels in order to improve the implementation of nutrition programmes/interventions

It was reported in the Action-Taken Report that the Government had commenced the restructuring process that would comprehensively relook at the various structures in the sector country-wide and recommend for responsive structures to the local needs. To that effect, an Institutional Assessment had been done and a draft Strategic Plan had been submitted to Cabinet Office for approval. The Strategic Plan forms the basis for restructuring which was hoped to address some of the structural inadequacies. Through this process, nutrition shall be mainstreamed in the work of the Ministry.

Committee's Observations and Recommendations

Your Committee requests an update on the status of the Institutional Assessment and the Strategic Plan.

9.7 Your previous Committee had recommended that the Government should consider authorising all sector ministries to upgrade nutrition positions in their establishments to higher levels, possibly at directorate level.

It was reported in the Action-Taken Report that the Government had taken note of the recommendation and that the issue had been brought to the attention of the relevant departments for further action.

Committee's Observations and Recommendations

Your Committee requests an update on the upgrade of nutrition positions in sector ministries.

9.8 Your previous Committee had recommended that the Government through the Ministry of Health should consider modernising and restructuring the NFNC to align its structures with its coordinating role.

It was reported in the Action-Taken Report that modernisation of the National Food and Nutrition Commission was based on the amendment of the Act. The Government had already commenced the process to amend the Act which would eventually lead to the restructuring and modernisation of the Commission.

Committee's Observations and Recommendations

Your Committee requested an update on the amendment of the *National Food and Nutrition Commission Act*.

The Sustainability of Zambia's National HIV/AIDS Response

9.9 Your previous Committee had recommended that the Government should seriously consider owning the National HIV/AIDS Response by ensuring that it begins to fund it more from locally mobilised resources.

It was reported in the Action-Taken Report that the National HIV/AIDS response was owned by the Government, through provision of policy direction, and human resources, infrastructure and other non-financial contributions. The Government spends substantial amounts of money every year in support of various programmes related to HIV from local resources.

Committee's Observations and Recommendations

Your Committee notes the response and requests an update on the progress report on the Government funding to National AIDS Council.

9.10 Your previous Committee had bemoaned the Government's delay to establish the national social health insurance scheme. It urged the Government to expedite the establishment of the National Social Health Insurance Scheme as one alternative source of financing for HIV/AIDS programmes.

It was reported in the Action-Taken Report that Government was committed to establishing sustainable ways of financing Health Care in the country and the Social Health Insurance Scheme was one such measure. The proposed Social Health Insurance Scheme Bill had been merged with the Social Protection Bill which the Government intended to present to Parliament.

Committee's Observations and Recommendations

Your Committee requests an update on the Social Protection Bill.

9.11 Your previous Committee observed that despite the law providing for the establishment of the HIV/AIDS Fund, Zambia had not yet established one. Your Committee recommended that the Ministry of Health should consider beginning the process of establishing the HIV/AIDS Fund as provided for under the law.

It was reported in the Action-Taken Report that the Government was rethinking the establishment of an HIV/AIDS Fund. The Government would like to take an integrated approach to financing health care and in this regard the Government was working on establishing the Social Health Insurance Scheme which would be all inclusive.

Committee's Observations and Recommendations

Your Committee requests an update on the Social Health Insurance Scheme.

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

Committee's Observations and Recommendations

10. Your previous Committee had recommended that 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 the Members of Parliament in sensitising communities on important health issues such as family planning and immunisation services and engage religious groupings on the issue of some religious leaders advising their members not to take ARVs.

It was reported through the Action-Taken Report as follows:

- (i) safe motherhood community groups were being trained and each district had the groups which sensitised mothers and took records of the mothers who needed to visit the facilities. This strategy had improved the delivery at health facilities and antenatal care services attendance in most districts;
- (ii) community radio programmes were ongoing in each province on maternal health and Safe motherhood services;
- (iii) chiefs and community leaders had been oriented in each province and district to participate in the maternal health services. There were also champions such as a Chieftainess and a Chief who advocated for these services in their communities. The Government was further exploring the possibility of working with Members of Parliament in sensitising communities on important health issues; and

- (iv) outreach services in the community, health education and counselling was conducted at the clinics every day during antenatal and postnatal.

It was further reported in the latest Action-Taken Report that the Government had taken note of the recommendation and wished to advise that the partnership with the Members of Parliament was on-going through the Committee on Health and the various seminars that the Ministry had been organising with the Members of Parliament.

Committee's Observations and Recommendations

Your Committee requests an update on the engagement of religious leaders in the distribution of ARVs. Your Committee further requests for a progress report on the delivery of women at health facilities.

10.1 Your previous Committee had recommended that the Ministry of Health should devise measures to reduce the reported unsafe abortions. Your Committee was 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 was 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.

It was reported in the Action-Taken Report that the Government was concerned with the high number of reported unwanted pregnancies and unsafe abortions. In this regard, the Ministry of Health in consultation with other relevant stakeholders developed and launched guidelines for reducing unsafe abortions. In addition, the Government had commenced the process to review the *Termination of Pregnancy Act, 1972*, with a view to reducing the bottlenecks in accessing such services by those in need of them. Family planning was provided free of charge in all public health facilities and the Government would continue to sensitise the public on the availability of these services.

It was further reported in the latest Action-Taken Report that the process of reviewing the *Termination of Pregnancy Act, 1972* was progressing well. The Government through the Ministry of Health together with partners engaged a consultant in December, 2015, to undertake a Regulatory Impact Assessment (RIA) of the Legal and Policy framework on the *Termination of Pregnancy Act* in order to address the challenges of access to comprehensive abortion care services in Zambia. It was hoped that after the Regulatory Impact Assessment is completed, it shall inform the next steps on the review of the Act.

Committee's Recommendation

Your Committee while noting the response, requests an update on the Regulatory Impact Assessment (RIA) of the Legal and Policy framework on the *Termination of Pregnancy Act of 1972*.

10.2 Your previous Committee had recommended that 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 had remained unemployed since 2014. The Ministry of Health should also expedite the construction and opening of the Chainama Training Institute which was expected to be training various cadres of health personnel.

It was reported in the Action-Taken Report that the Government had continued to address the shortage of health workers in the health sector from primary to secondary and tertiary health facilities country-wide through increasing out puts from the training institutions and continued recruitment of the health personnel at all levels.

In this vein, the Government through the Ministry of Finance had set aside K270, 751,950.00 for net recruitment in the Medium Term Expenditure Framework (MTEF) Plan for the three year period running from 2015 to 2017. In the 2015 national budget, the Government had set aside K52,500,000.00 while K 113, 190, 000.00 and K 105,061,950.00 had been projected for 2016 and 2017, respectively. Given the various needs at various levels of health care service provision, the Government had prioritised the funding of critical positions ranging from medical doctors, clinical officers, nurses, midwives, community health workers and a few administrative positions. Further, the Government through the Ministry of Health had embarked on the construction of a National Health Training Institute at Levy Mwanawasa General Hospital which would have an approximate capacity to train three thousand students. The works on the facility which commenced in March, 2015, were at 55 percent in terms of completion and were progressing well. The works to the facility were scheduled to be completed in 2016.

Your Committee had noted the response from the Government and made a further request on the figures and categories of the health personnel recruited in 2015, and progress report on the construction of a National Health Training Institute at Levy Mwanawasa General Hospital Health.

It was further reported in the latest Action-Taken Report that the following numbers and categories of the health personnel were recruited in 2015.

Summary of net recruitment as at December, 2015

SN	CATEGORY	TOTAL
1	Administrative	82
2	Clinical Officer	2
3	Doctor	144
4	Environmental	4
5	Laboratory	23
6	Midwives	57
7	Nurse	203
8	Nutrition	4

9	Pharmacy	38
10	Physiotherapy	2
11	Radiography	29
12	Teaching	26
TOTAL		614

Regarding the construction of the National Training Institute at Levy Mwanawasa Hospital, the Government reported that the construction of the school commenced in March, 2014. The works were currently being undertaken by four contractors and were expected to be completed in 2017. To date construction works had reached 65 percent.

Committee's Observations and Recommendations

Your Committee notes the response and awaits a progress report on the construction of the National Training Institute at Levy Mwanawasa General Hospital. Your Committee further requests an update on why eighty two (82) Administrative Officers were recruited as opposed to recruiting medical personnel.

10.3 Your previous Committee had recommended that 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.

It was reported in the Action-Taken Report that the Government through the Ministry of Health commenced the exercise to establish power back up systems for health facilities in order to sustain service delivery in critical areas of health care such as intensive care units, laboratories, cold chain and others in 2008. In phase one, twenty-three generators were procured and installed in various facilities across the country. In the second phase, the Ministry had procured eighteen generator sets which were expected in the country before the end of 2015. In phase three, the Ministry planned to procure an additional sixty-nine generators to be distributed to the remaining hospitals and training institutions. Forty-seven hospitals and twenty-two training institutions would benefit from phase three which was planned for the 2016-2018 Medium Term Expenditure Framework.

It was further reported in the latest Action-Taken Report that eighteen Generators had been procured and delivery and installations had commenced. The first Generator was installed at Levy Mwanawasa General Hospital and the exercise was expected to be completed by the end of the third quarter of 2016.

Committee's Observations and Recommendations

Your Committee notes the response and awaits a progress report on the delivery and installations of the procured generators.

Zambia's preparedness against a possible outbreak of the Ebola Virus Disease

10.4 Your previous Committee had recommended that the Ministry of Health should ensure that there was adequate 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.

The Government reported through the Action-Taken Report that the Ministry of Health had posted and stationed health officials at all ports of entry who worked in shifts. These officers had been trained and equipped with the necessary skills and equipment. The Ministry in conjunction with the Japanese Government was in the process of procuring fourteen additional state of the art industrial thermo scanners to be placed in the major points of entry in order to avoid overcrowding.

It was further reported in the latest Action-Taken Report that the fourteen industrial scanners were being procured with the assistance of the Japanese Government through JICA. The request had been approved by the Japanese Government and the Ministry of Health was in the process of signing the contract with the identified supplier.

Committee's Observations and Recommendations

Your Committee notes the response and still awaits an update on the procurement of fourteen additional state of the art industrial thermo scanners.

Breast and Cervical Cancer In Zambia

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

Government's Response

The Government reported through 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. Further explanation was provided by the Government that the Cancer Diseases Hospital Phase III project proposal had been developed and submitted to the Ministry of Finance for approval and funding.

The Government further reported that the Cancer Diseases Hospital Phase III project proposal to, among others, establish cancer screening centres in provincial hospitals had reached appraisal stage. The proposal was submitted by Ministry of Finance to various partners for funding. Your Committee had noted the response from the Government and requested for an update on the matter.

Following a request for an update on the matter by your Committee, it was reported in the latest Action-Taken Report that the Government was still awaiting the outcome on the proposals submitted to partners on the roll out of Cancer Screening Centres in Provincial Hospitals.

Committee's Observations and Recommendations

Your Committee awaits an update on the outcome on the proposals submitted to partners on the roll out of Cancer Screening Centres in Provincial Hospitals.

Outstanding Issues on Social Protection for the Aged in Zambia

10.6 It was reported in the Action-Taken Report that the Government had developed a Zero Draft on the minimum standards and 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 support. 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.

In the last Action-Taken Report, the Government stated that through the Ministry of Community Development and Social Welfare, it had managed to secure resources from cooperating partners in particular, the Government of Finland to review social protection programmes. These programmes included guidelines for operating and establishing old people's homes. Furthermore, a consultative workshop for this purpose had been planned for the fourth quarter of 2015, after which the guidelines would be expected to be finalised and become operational.

Following a request for an update on the matter by your Committee, it was reported in the latest Action-Taken Report that the Ministry was awaiting funding from their cooperating partners to support the process of finalising the guidelines. The budget request of K400, 000.00 was submitted to the cooperating partners who were yet to avail the resources to the Ministry. However, this activity was earmarked to take place before the end of the year (2016). The finalisation of guidelines involved the holding of stakeholder consultations, actual printing and dissemination of the guidelines.

Committee's Observations and Recommendations

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

10.7 Your previous Committee had recommended that 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.

It was reported in the Action-Taken Report that the provision of health facilities with adequate and appropriate transport was an on-going exercise and every year the two ministries budgeted for the procurement of motorised transport. For example, in 2015, some districts had been provided with land cruisers and motor cycles for outreach activities. Further, under the 2015 Ministerial Budget, an allocation of K 5,582,372.00 had been reserved for purchase of motor vehicles and motor bikes for the districts.

Your previous Committee requested for information on the districts that had received the vehicles and which districts had benefitted from the 2015 budget allocation of K5, 582,372.00 reserved for the purchase of motor vehicles and motor bikes for the districts.

It was further reported in the latest Action-Taken Report that fifteen (15) vehicles were distributed as follows:

	MAKE	INSTITUTION
1.	Toyota Landcruiser	Kasama PMO
2.	Toyota Hilux	Mongu PMO
3.	Toyota GX	Chiengi DMO
4.	Toyota GX	Nsama DMO
5.	Isuzu KB	Chipata PMO
6.	Mitsubishi Spotero	Mkushi DMO
7.	Nissan Hard Body	Luano DMO
8.	Nissan Hard body	Mansa PMO
9.	Nissan Hard body	Ndola PMO
10.	Nissan Navara	Chilubula Mission Hospital
11.	Ford Ranger	Livingstone Central Hospital
12.	Toyota Prado	Chilonga Mission Hospital
13.	Toyota L/Cruiser	Kasama PMO
14.	Nissan Navara	Renal Unit (UTH)
15.	Nissan Navara	Kalulushi DMO

Committee's Observations and Recommendations

Your Committee notes the update and requests an update on when the Ministry would complete procuring vehicles for all health facilities in need.

CONCLUSION

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

Your Committee is hopeful that the observations and recommendations contained in this Report will be favourably considered by the Government for implementation by the concerned Ministries and Departments in the interest of the development of Zambia.

Dr J K Chanda, MP
CHAIRPERSON

June, 2017
LUSAKA

APPENDIX I
LIST OF OFFICIALS

National Assembly

Mr S C Kawimbe, Principal Clerk of Committees

Ms M K Sampa, Deputy Principal Clerk of Committees

Ms C Musonda, Senior Committee Clerk (FC)

Mr F Nabulyato, Senior Committee Clerk (SC)

Mrs E K Zgambo, Committee Clerk

Mrs S Mensah, Personal Secretary II

Mr C Bulaya, Committee Assistant

Mr M Chikome, Committee Assistant

Mr D Lupiya, Parliamentary Messenger