REPUBLIC OF ZAMBIA

REPORT

OF THE

COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT

AND SOCIAL SERVICES

ON THE

OPERATIONS OF THE NATIONAL HEALTH INSURANCE

MANAGEMENT AUTHORITY

FOR THE

FOURTH SESSION OF THE THIRTEENTH NATIONAL ASSEMBLY

Printed by the National Assembly of Zambia

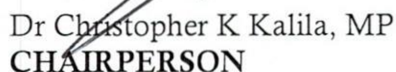
FOREWORD

Honourable Madam Speaker, the Committee on Health, Community Development and Social Services has the honour to present its report on the ***Operations of the National Health Insurance Management Authority***, for the Fourth Session of the Thirteenth National Assembly. The Committee undertook its functions as set out in Standing Orders 206 (e) and 207 of the National Assembly Standing Orders, 2024.

In accordance with its programme of work, the Committee held twelve meetings to interact with stakeholders on the topical issue. The Committee requested detailed memoranda from various stakeholders, who were also invited to appear before it to clarify any issues arising therefrom. The list of stakeholders is at Appendix II. To augment the findings, the Committee undertook a ten-day local tour of selected NHIMA offices and accredited health facilities in Central, Luapula, Muchinga, Northern, and Lusaka provinces.

The Committee's Report is arranged in two parts: Part I presents a summary of submissions from stakeholders on the topical issue, the findings of the Committee from local tours and the Committee's observations and recommendations. Part II highlights the Committee's observations and recommendations based on the Executive's responses in the Action-Taken Report from previous Sessions.

The Committee is grateful to the stakeholders who provided both written and oral submissions. It also extends its thanks to Madam Speaker for the opportunity to fulfill its objectives. The Committee also appreciates the Clerk of the National Assembly for the support and guidance rendered throughout its work.



Dr Christopher K Kalila, MP — July, 2025
CHAIRPERSON — **LUSAKA**

ACRONYMS

DS	Decentralisation Secretariat
8NDP	Eighth National Development Plan
HCPs	Health Care Providers
HFS	Health Financing Strategy, 2017-2027
LA	Local Authority
MoH	Ministry of Health
NHIMA	National Health Insurance Management Authority
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NHSP	National Health Strategic Plan, 2022–2026
OOP	Out-of-Pocket Payment
PHC	Primary Health Care
PwD	Persons with Disability
SCT	Social Cash Transfer
UHC	Universal Health Coverage
UN	United Nations

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1.0 MEMBERSHIP OF THE COMMITTEE

The Committee consisted of Dr Christopher K Kalila, MP, (Chairperson); Mrs Marjorie Nakaponda, MP (Vice-Chairperson); Mr Paul Chala, MP; Mr Alex Katakwe, MP; Mr Heartson Mabeta, MP; Mr Monty Chinkuli, MP; Mr Joseph S Munsanje, MP; Mr Leevan Chibombwe, MP; Mr Masautso Tembo, MP; and Mr Miles B E Sampa, MP.

PART I

CONSIDERATION OF THE TOPICAL ISSUE

2.0 OPERATIONS OF THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

2.1. Zambia's Epidemiological Profile

Zambia's epidemiological profile faced the dual disease burden broadly categorised as Communicable Diseases (CDs) and Non-Communicable Diseases (NCDs). Malaria, HIV/AIDS, and Tuberculosis were prominent CDs that contributed to substantial morbidity and mortality rates. The country also experienced a surge in NCDs with noticeable illnesses such as hypertension, diabetes, and cancer. Maternal and child health added to the health burden with maternal mortality ratio estimated at 195 per 100,000 live births. The disease burden underscored the urgent need for Universal Health Coverage (UHC) to address inequalities, reduce financial adversities, and improve health outcomes.

2.2. Background

Zambia, alongside other member States of the United Nations (UN) committed to achieving UHC by 2030, as outlined in SDG 3. The goal aimed to ensure that all individuals would access health services without financial hardship, with Target 3.8 focusing on financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Globally, UHC was commonly described using the three dimensions comprising, *service coverage*, *proportion of the costs covered*, and *population coverage*, as illustrated by the cube in Figure 1 below.

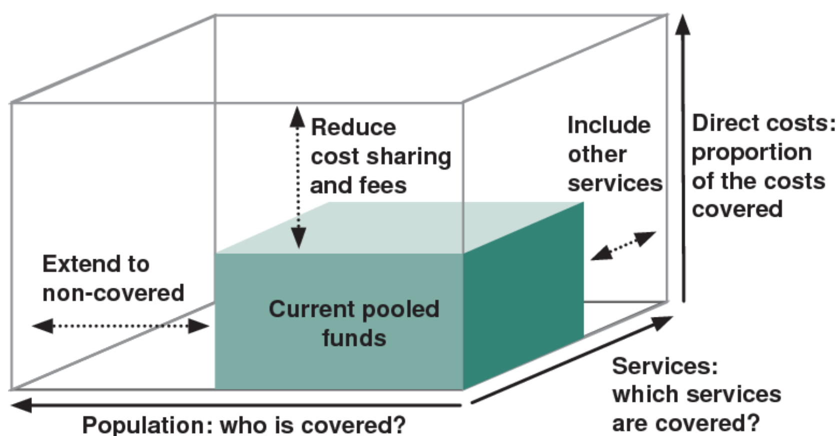


Figure 1: Three dimensions to consider when moving towards universal coverage

The three dimensions of health coverage *depth*, *breadth*, and *direct costs* were key in evaluating the effectiveness of pooled health financing as described below:

(i) depth referred to the range of services available, including prevention, treatment, rehabilitation, and palliative care;
(ii) breadth related to the proportion of the population covered, distinguishing between those eligible, entitled, and actually receiving services; and
(iii) direct costs highlighted the financial risk under the prevailing coverage, emphasising the need to reduce out-of-pocket (OOP) expenses, which could increase financial hardship and result in negative economic and social consequences for individuals and families.

To realise UHC, the Zambian Government established the National Health Insurance Management Authority (NHIMA) in 2018 to manage the National Health Insurance Scheme (NHIS). Based on a solidarity model, NHIMA pooled resources to share financial risk among members. Its operations began in October 2019 with a few accredited public and private Health Care Providers (HCPs) serving eligible beneficiaries.
NHIMA followed a unified financing model where membership was mandatory for the formal sector; voluntary for the informal sector; and free for retirees, those above 65 years, mentally or physically disabled persons who were incapable of working, and poor and vulnerable people. This model significantly reduced reliance on OOP, which historically limited access to healthcare for low-income populations.

NHIMA operated a scheme which transformed healthcare financing in Zambia by shifting from input-based funding to a demand-driven and results-based financing model. This approach incentivised HCPs to prioritise patient satisfaction and service quality. Over time, NHIMA had utilised pooled revenues to reduce financial inequities, extended healthcare access to underserved areas, and promoted a more sustainable healthcare system. In this regard, NHIMA played a critical role in advancing UHC, particularly in less privileged areas.

In just five years of operation, NHIMA faced, among other challenges, the threat of insolvency due to unsustainable income flows, a growing number of beneficiaries, and fraudulent claims. In light of the foregoing, the Committee undertook a study to review the operations of NHIMA in order to appreciate its operations, as well as its role in contributing to the realisation of UHC for all Zambians.

2.3. Objectives of the Study

The objectives of the study were to appreciate:
(i) adequacy of the policy and legal framework promoting UHC in Zambia;
(ii) mandate and operations of NHIMA in advancing UHC in less privileged areas;
(iii) strategies used to register the poor and vulnerable people, including those in the informal sector; and

(iv) identify challenges, if any, faced by NHIMA and accredited health service providers; and make recommendations on the way forward.

2.4. Summary of Submissions by Stakeholders

In line with the objectives of the study, stakeholders who appeared before the Committee made the submissions summarised below.

2.4.1. Adequacy of the Policy and Legal Framework Promoting Universal Health Coverage in Zambia

a. Policy Framework

Stakeholders submitted that the key policy documents guiding the operations of NHIMA were as set out below:

i) **The Vision 2030** was Zambia's long-term development plan which envisioned equitable access to quality healthcare services without financial hardship for all citizens;

ii) **The Eighth National Development Plan (8NDP)** was a short to medium term national plan which, among other interventions, recognised NHIMA as a strategic vehicle to provide affordable healthcare, and expand financing mechanisms to underserved populations;

iii) **The National Health Strategic Plan (NHSP), 2022–2026** outlined a comprehensive and strategic approach to advancing National Health Insurance in Zambia, emphasising healthcare infrastructure, and ensuring access to quality healthcare services in rural and underserved areas; and

iv) **The Health Financing Strategy (HFS), 2017-2027** supported sustainable mechanisms to finance quality healthcare in Zambia, and fostered the establishment of a social health insurance to reduce financial hardships.

b. Legal Framework

The legal framework regulating in the operations of NHIMA were as set out below:

i) ***The National Health Insurance Act, No. 2 of 2018*** established NHIMA to provide universal access to quality insured health care services and reduce OOP. The Act mandated the registration of all eligible individuals and specified the accreditation of healthcare providers. Further, it provided for different types of funds raised through member contributions, appropriations by Parliament, loans, grants or donations, as well as interests arising from investments.

ii) **National Health Insurance (General) Regulations, Statutory Instrument No. 63 of 2019** operationalised the National Health Insurance Scheme (NHIS) and defined key administrative guidelines, such as the registration of members, contribution rates, benefit package, criteria for accreditation, and fees. The scheme aimed at ensuring sound and reliable healthcare financing for all Zambian citizens and legal residents.

Given the broad legislative and policy framework for health insurance in Zambia, stakeholders expressed general satisfaction with the provisions, citing the well-articulated foundational documents that established and operationalised NHIMA. However, they identified the need to harmonise the *National Health Insurance Act, No. 2 of 2018* with Section 18 (3) (c) of the *Zambia Medicines and Medical Supplies Agency Act, No. 9 of 2019*. The latter required NHIMA to remit funds to the Medicines and Medical Supplies Fund to support the procurement of essential medicines and supplies for public health facilities. Due to the absence of specific regulations, NHIMA had no legal obligation to make such remittances.

Additionally, stakeholders raised concerns about overlapping roles between NHIMA and the Health Professions Council of Zambia (HPCZ), particularly regarding the accreditation of health facilities. They noted inconsistencies between accreditation provisions outlined in PART IV of the *National Health Insurance Act, No. 2 of 2018* and PART VII of the *Health Professional Council of Zambia Act, No.17 of 2024*, highlighting the need for legislative alignment to streamline responsibilities.

2.4.2. Mandate and Operations of NHIMA in Advancing Universal Health Coverage in Less Privileged Areas

The stakeholders submitted that NHIMA's mandate was derived from Section 5 of the *National Health Insurance Act, No. 2 of 2018.* The Act empowered the Authority to undertake activities set out below:

i) implement, operate and manage the NHIS and advise the Ministry of Health (MoH) on health insurance policy formulation;
ii) manage the National Health Insurance Fund and undertake programmes for the sustainability of the NHIS;
iii) accredit HCPs and receive, process, and pay out claims for the services rendered;
iv) develop a comprehensive benefit package to be accessed by the NHIS members and effectively monitor the provision of health services under the package; and
v) register and issue membership cards to members and facilitate access of health care for the poor and vulnerable and to ensure protection of the poor and vulnerable against deprivation of health services.

Arising from its mandate, some of NHIMA's key operations included the following:

i) Developing a Comprehensive Benefit Package

NHIMA operated a benefit package outlined in the Fourth Schedule of the National Health Insurance (General) Regulations, Statutory Instrument No. 63 of 2019. The package includes the following services:

- Medical Care: consultations, examinations, diagnostic services (hemodialysis, kidneys transplants, radiology and laboratory), nursing care and intensive care unit;
- Surgery: General surgery, anesthetics, orthopedics, pediatric surgery, and Ear, Nose and Throat (ENT);
- Maternity and neonatal care: Antenatal care, delivery (normal or assisted), caesarean section and postnatal care;
- Selected eye care services;

- Selected oral health services;
- Pharmaceutical drugs and supplies: Prescription of generic drugs on the essential drugs list prescribed by an accredited HCP and approved or used under the scheme, medical supplies, and blood products; and
- Selected physiotherapy services.

ii) Registration of Members

As of 30th November, 2024, NHIMA had registered a total of 4,928,739 members, comprising 3,471,351 principal members and 1,457,388 beneficiaries. Membership from the formal sector accounted for 40 per cent of total enrolment, while the informal sector made up 47 per cent. However, the informal sector exhibited a low compliance rate of just 3 per cent. The exempted category represented 13 per cent, equating to 2.1 per cent of Zambia's total population.

Despite these efforts, NHIMA had only managed to cover 23 per cent of the national population by the same date. Consequently, 77 per cent of Zambians remained reliant on private insurance, free public healthcare services, and in some cases OOP.

Figure 2: Membership Distribution by Type and Sector

Membership by type	No of Members	% Distribution
Principal Members	3,471,351	70
Beneficiaries	1,457,388	30
Total Members	**4,928,739**	**100**
Principal members by sector	**No of Members**	**% Distribution**
Formal sector	1,400,056	40
Informal Sector	1,621,866	47
Exempted category	449,429	13
Total Principal	**3,471,351**	**100**
Beneficiaries by Sector	**No of Members**	**% Distribution**
Formal	1,213,144	83
Informal	177,982	12
Exempted	66,262	5
Total	**1,457,388**	**100**

Source: NHIMA, January, 2025

Section 5 of the Act mandated NHIMA to facilitate access to quality healthcare for the poor and vulnerable and to ensure protection of the poor and vulnerable against deprivation of health services. Further, Section 16 of the Act exempted the poor and vulnerable population from making contributions, meaning that they had to be registered at no cost.

NHIMA contributions were the lowest health insurance schemes in Zambia, averaging only K50 monthly contribution for up to seven family members. With this minimal contribution, most of the rural poor, who were also in the informal sector, were eligible to access all the services they needed under the NHIS.

However, NHIMA needed to explore structured mechanisms to register and maintain the informal sector. This could be done through collaborating with strategic stakeholders such as aggregators and mobile service providers, for easier registration and payment of monthly contributions.

iii) Accreditation of Health Care Providers

As of 30th November, 2024, NHIMA had 452 HCPs, broken down as follows:

- Public HCPs – Level 1, 2 and 3 – 114;
- Public HCPs – Mini Hospitals – 61;
- Faith Based HCPs – 39; and
- Private HCPs (including diagnostic facilities, pharmacies, and specialised hospitals) – 238.

Stakeholders noted that only 33.6 per cent (approximately one-third) of the accredited facilities were public HCPs, while 66.4 per cent (two-thirds) were private. This disproportionate allocation to high-cost private providers exposed NHIMA to accelerated resource depletion, posing a significant risk of insolvency. In view of this, NHIMA halted the accreditation of private HCPs in urban areas in 2024, shifting its focus to accrediting rural-based public HCPs, except in special cases where accreditation for private HCPs was sought in underserved rural regions.

iv) Processing Claims

NHIMA's claims processing operations involved the systematic verification, assessment, and reimbursement of claims for services rendered to insured beneficiaries. Upon receipt, claims underwent rigorous checks for accuracy, eligibility, and compliance with guidelines to prevent fraud and errors.

v) Clinical Audits

NHIMA conducted regular audits to ensure compliance with ethical standards and to identify any irregularities. This meant that healthcare facilities found guilty of fraudulent practices, such as billing for services not rendered faced the risk of deaccreditation. This intervention reinforced accountability mechanisms within the scheme. At the time of interaction with the Committee, NHIMAs Anti-Fraud unit was handling 27 cases involving suspicious and confirmed fraudulent activities by HCPs, some of whom were found wanting and faced appropriate sanctions for their misconduct.

2.4.3. Strategies to Register the Informal Sector, and Poor and Vulnerable People

The Committee was informed that NHIMA faced challenges in registering and maintaining the informal sector, particularly underserved and vulnerable populations. To address this,

NHIMA implemented various strategies aimed at extending healthcare services to these target groups. The strategies included:

i) Leveraging Aggregators and Associations in the Informal Economy

NHIMA utilised institutions in markets, bus stations, and other public places as registration points, recognising that it was more efficient to register the informal sector collectively rather than individually. However, challenges arose due to the sector's lack of structured income systems and employer oversight. Additionally, the absence of a centralised, reliable database to track informal sector establishments hindered equitable coverage. Vulnerable populations in remote areas faced further barriers, including limited awareness and logistical difficulties in accessing registration points, leading to low enrollment rates and reduced access to healthcare benefits.

ii) Leveraging Technology

NHIMA deployed digital platforms for registration. However, some HCPs faced challenges in the implementation of the digital platforms deployed by NHIMA ranging from connectivity, service disruptions from server hosts and gadget malfunctions, among others.

iii) Marketing Appeals

The informal sector was sensitised through mainstream channels like television and radio adverts. Additionally, NHIMA conducted roadshows and outreach programs in public places to engage and register informal sector participants.

iv) Targeting Beneficiaries of the Social Cash Transfer Programme

NHIMA collaborated with the Ministry of Community Development and Social Services (MCDSS) to identify and register a fraction of the eligible individuals through the Global Fund pilot project that was expected to run for three years, from 2024 to 2026. The project targeted the poor and vulnerable populations living with HIV/AIDS, Tuberculosis (TB) and Persons with Disabilities (PwD), in high HIV/AIDS and TB districts and those without contributory capacity.

NHIMA was granted UD$1.5 m to cover 16,000, out of 1,311,101 eligible households registered under the Social Cash Transfer (SCT) Programme. The Global Fund paid K50 per month, amounting to K600 annual payments, per household with each household allowed to register up to 7 members. A total of 40,414 actual members were registered on the NHIS. In view of this, NHIMA would receive monthly premiums of K800,000 per month for the registered households. The preliminary effect of the project triggered a high demand from the remaining SCT beneficiaries, implying the unmet need for access to healthcare services under the NHIS.

v) Needs-Based Accreditation of Healthcare Providers

Stakeholders noted a significant disparity in healthcare utilisation between urban and rural populations. Urban areas experienced higher NHIMA membership and access to superior health facilities, resulting in better health outcomes. In contrast, rural areas faced low enrollment and fewer accredited providers, widening the healthcare gap and contributing to poorer health indicators. This meant that rural members, living in poverty estimated at

78.8%, were effectively subsidising services for urban members, whose poverty rate was much higher at 31.9%. To address this imbalance, NHIMA launched a rural-focused initiative in June, 2023, accrediting 52 mini-hospitals in underserved districts.

2.4.4. Challenges faced by NHIMA

Stakeholders submitted that despite considerable progress, the operations of NHIMA presented a number of challenges as set out below:

i) Disparities in Access and Utilisation Between Urban and Rural Facilities

Most rural areas were surrounded by facilities offering primary health care, whereas the scheme only accredited level 1 facilities or higher, including mini hospitals. Further, most health facilities in rural areas failed to meet NHIMA's accreditation criteria and standard in staffing, infrastructure, and service delivery. This resulted in rural populations having to travel long distances to seek health care in urban facilities, thereby incurring significant OOP. The unequal distribution of health facilities resulted in low accreditation of HCPs in rural areas which consequentially affected disease management and prevention, thereby, exposing rural populations to unsafe traditional medicines or unregulated HCPs.

ii) Strengthening Capacity and Referral Systems in Public HCPs

Public HCPs were largely perceived as unprepared to deliver the service independently, without support from private health providers. Additionally, the scheme had adversely affected the referral system, as many patients were bypassing primary health care facilities and directly seeking services at first-level hospitals, leading to congestion. In light of this, stakeholders recommended that the Government reinforce the referral system and consider introducing deterrent measures, such as applying additional charges to patient accounts for bypassing appropriate levels of care.

iii) Disparities in services and charges between the public and private HCPs

Stakeholders submitted that, the scheme provided patients with a broad choice to select which accredited health facility they wanted to visit. Their decisions were mainly driven by the quality of service offered, in terms of waiting time, access to drugs, diagnosis services and many other amenities. This meant that when the public sector failed to meet patient expectations, the patients often turned to private facilities, which partly explained why private HCPs had more claims.

Regarding charges, stakeholders informed the Committee that, public service charges were usually much lower due to subsidised overhead costs on emoluments, drugs and consumables, while their counterparts in the private sector provided cost reflected services.

iv) Low and Unsustainable Premium Contributions

The contributions to the NHIS from the formal economy were set at 2 per cent of basic pay for both employers and employees, while the Actuarial Valuation Reports of 2012, 2020, and 2022 recommended a rate of 5 per cent of gross income. This was by far lower than what other African countries charged their citizens. For instance, Tanzania and Kenya were at 5 per cent and Rwanda at 7 per cent of gross income. The lower rate jeopardised

NHIMA's financial viability which was further burdened by the on-boarding of non-contributing members.

While deductions from the formal sector were relatively stable, due to payroll systems, collecting premiums from the informal workers presented significant challenges.

v) Higher Claims Versus Member Contributions

NHIMA also processed claims from accredited HCPs. From 2019 to 2022, the scheme consistently recorded a positive variance in claims. However, in 2023 and 2024, a surge in claim volumes led to loss ratios of 143 per cent and 135 per cent, respectively. This translated to unpaid claims amounting to over K508m in 2023 and K453m in 2024, highlighting growing financial pressure on the scheme.

vi) High Administrative Costs

NHIMA relied on 10 per cent of total collections to undertake substantial operations, in accreditation, management, and monitoring healthcare facilities. These costs were amplified by the need to ensure that health facilities met quality standards, especially in underserved areas where infrastructure investments were necessary. The high expenses reduced the funds available for direct healthcare provision and member benefits.

In view of this, NHIMA sought the partnership of ZSIC General Insurance for an initial contract of 5 years on a Build, Operate and Transfer basis. The Committee also learnt that the contract was worth K790m, out of which ZISC was being paid K158m annually, or K13m monthly. The contract was expected to terminate in March, 2025 but would be extended for a further year as NHIMA sought cabinet approval to increase the administrative cost from 10 per cent to 25 per cent from the contributions. Furthermore, to mitigate the high administrative costs, NHIMA invested in Government bonds which yielded them K250m income.

vii) Delayed Reimbursements From NHIMA

Many accredited HCPs faced delays in receiving reimbursements for services rendered to insured patients. The delays often disrupted cash flows, making it difficult for health facilities to procure medical supplies, pay staff salaries, and meet other financial obligations. The financial strain often resulted in reduced service quality and in some cases reluctance among HCPs to accept NHIMA patients.

viii) Inadequate Training of Health Personnel

Staff in some health facilities often lacked adequate training on prescription modalities, billing, reporting, and reimbursement systems, leading to errors in claims submissions, and further delaying the reimbursement process. The lack of standardised training for healthcare providers created inefficiencies and reduced the scheme's overall effectiveness.

ix) Delays in NHIMA Remittance Reports

According to NHIMA policy, remittance reports were to be shared within 15 days of fund receipt. However, delays in issuing these critical reports hindered HCPs from promptly

identifying the reasons for claim rejections, thereby limiting their ability to rectify and appeal the claims in a timely manner.

x) Lack of Service Transparency

A major impediment to the success of NHIMA was the lack of adequate transparence during service delivery. For instance, clients were only shown their medical bills when they requested, signifying that the billing system lacked transparency and could easily be exploited by HCPs. In view of the identified weakness, stakeholders proposed that the system could be re-designed to enable clients' access their bills and other information in real time.

xi) Unrevised Tariffs

The tariffs had not been revised since 2019 despite the cost of services increasing due to high inflation of medical commodities. For instance, tariffs for procedures like prostate biopsy and deep vein thrombosis were a fraction of the actual cost. On the other hand, simple procedures like ear syringing were overpriced at K1,800. As a result of the disparities, some facilities were selective in conducting procedures or declined unprofitable services altogether.

xii) Unfair Losses due to Duplication, Shopping and Double Entry

Some HCPs forfeited consultation fees because the NHIMA system did not accept double payment for a client who visited more than one facility in a day. This practice was deemed unfair because while the system allowed patients to seek treatment for more than one medical condition in one day, it did not accept multiple consultation fees.

xiii) Lack of Treasury Support

As of 2024, the Government did not appropriate public funds from the treasury to support NHIMA's operations, in terms of capital injection and funds to cover the medical costs for the exempt population. However, though not adequate, a budget line of K1.5m was initialised in the 2025 national budget to ensure inclusion of this critical need. Stakeholders informed the Committee that NHIMA required K230m capital injection for it to operate effectively.

xiv) Inadequate Marketing and Public Relations Strategy

A major challenge for NHIMA's success was inadequate marketing and public engagement, especially among the informal sector, illiterate populations, culturally sensitive groups, and PwD. Many Zambians, particularly in rural and informal areas, lacked understanding of NHIS benefits. Public sensitisation efforts were often limited by cultural and geographical barriers. NHIMAs reliance on mass media such as television and the internet excluded remote populations, who struggled to connect with these modern communication methods. The absence of targeted, traditional outreach strategies for the informal sector further contributed to low enrollment rates, hindering NHIMAs ability to reach vulnerable and underserved communities effectively.

xv) Absence of Socioeconomic Data Systems

Zambia's socioeconomic data systems were fragmented and outdated, complicating efforts to identify and support poor and vulnerable households. Without a unified national registry, many eligible individuals risked being excluded from the NHIS. In response, NHIMA developed an in-house database, however, inaccuracies in patient records persisted. These errors led to claim rejections, such as a caesarean section claims being denied because the patients' gender was incorrectly recorded as male, highlighting the need for improved data accuracy.

xvi) Registration of Exempt Populations

The *National Health Insurance Act, No. 2 of 2018* commendably included provisions for exempt groups, demonstrating the Government's commitment to social protection and its obligation to subsidise premiums for these groups. However, Zambia lacked a unified, reliable data system to target vulnerable groups effectively. Further, NHIMA faced logistical challenges in reaching remote communities where poverty levels were often highest.
Additionally, limited access to registration points, coupled with low public awareness, reduced the scheme's effectiveness. Therefore, clear operational guidelines were necessary to bridge these gaps and strengthen collaboration with Local Authorities (LAs) and Civil Society Organisations (CSOs), who could provide data and outreach to identify eligible individuals. Without such measures, the registration of vulnerable populations risked being a theoretical rather than practical achievement.

xvii) Unpredictability of the Informal Sector

The informal sector constituted a large proportion of Zambia's workforce, mostly characterised by unpredictable income, leading to irregular contributions. NHIMA could not accurately estimate their income levels when assessing the desirable premiums. In view of this, many informal workers perceived the contributions as an additional financial burden, further discouraging their participation. Further, the lack of innovative payment systems tailored to the needs of informal workers exacerbated the issue, leaving a significant revenue gap, thereby threatening NHIMA's financial sustainability.

xviii) Pre-Authorisation Concerns

The delay in processing the pre-authorisation requests came with considerable cost implications to both the HCPs and NHIMA. The worst was faced during weekends and holidays which resulted in patients staying longer in wards which resulted in more expenses. In some cases, patients discharged themselves before logging out of the system, resulting in facilities not being paid. When faced with this challenge, HCP were obliged to take up the responsibility of treating patients, regardless.

Additionally, pre-authorisation was not ideal for emergency situations where the HCP was required to commence treatment or perform a surgical procedure. The health facilities were unsure who would settle the bill in case authorisation was not granted within 24 hours as per requirement.

xix) Exclusion of the Private Sector from Providing Dental and Optical Services

In the 2024 revised package, private HCPs were excluded from providing dental and optical services, restricting the services to public HCPs. The stakeholders expressed concern that such a decision would overwhelm public facilities as well as deny the private sector commercial opportunities. Additionally, they submitted that 2 per cent (400,000) of Zambia's population, were blind, out of which 50 per cent (200,000) were cataract patients, a reversible condition. Therefore, excluding private health facilities would negatively impact cataract patients, a situation which could approximately take 55 years to clear the backlog.

xx) Unrealistic Expectations

Some stakeholders portrayed NHIMA as the main health financier, accusing them for inadequate investments in areas such as infrastructure, medicines, medical equipment and supplies. This led to a misunderstanding of NHIMA's mandate and inappropriate apportioning of health sector challenges on the Authority.

3.0 Local Tour

To consolidate its findings, the Committee conducted a tour of selected districts across Central, Luapula, Northern, Muchinga and Lusaka provinces. During their tour, the Committee held stakeholder meetings, visited both public and private HCPs, and engaged with beneficiaries of the NHIS.

In Central Province, the Committee toured Serenje District Hospital and Aidmed Pharmacy.
In Luapula Province, the Committee toured several HCPs, including Lubwe Mission Hospital, Samfya District Hospital, Mansa General Hospital, Home of Compassion, and Sanket Diagnostic Centre. Additionally, the Committee held a meeting with the NHIMA Luapula Provincial Office.

During its visit to the Northern Province, the Committee conducted a joint meeting with Cooperate Medical Clinic & Laboratory Services and the NHIMA Northern Provincial Office. The Committee concluded its tour of the Province by visiting Snowy Hub Dental Clinic.

In Muchinga Province, the Committee toured Nakonde District Hospital and Chinsali General Hospital.

In Lusaka Province, the Committee held a joint meeting with the six Teaching Hospitals and concluded its tour with a visit to Kafue General Hospital.

The key outcomes of the tour are summarised below:

3.1. Positive Impact of NHIMA on Healthcare Delivery

Stakeholders commended the Government for implementing the NHIS nationwide, citing life-saving interventions, reduced OOP, financial stability, improved service delivery, and increased innovation as key benefits of the Scheme. Since the hospital's accreditation in 2020, the scheme has been well received in the districts that the Committee toured.

3.2. Limited Capacity of Accredited Public Healthcare Providers

Stakeholders expressed concern over the limited access to NHIMA services and the poor conditions and distribution of accredited HCPs in remote areas. Compounding the issue was the lack of essential and specialised services, as well as critical medical equipment in many of the facilities toured. Further, NHIMA's effectiveness was impacted by low staffing levels in public health facilities, where healthcare workers were overwhelmed by high patient demand and competing responsibilities. This gap in service provision often resulted in financial losses to the benefit of private providers. However, some districts did not have NHIMA-accredited pharmacies available. Consequently, patients were forced to travel long distances, ranging from 90 to 200 kilometers, to access the necessary healthcare services. The situation was exacerbated by NHIMA's policy restrictions, which prevented pharmacies from operating in neighboring communities under the same trading name.

3.3. Discrepancies in Drug Availability Despite Adequate Stock Levels

The Committee was informed that most public HCPs maintained adequate stocks of essential medicines, with availability ranging between 60 and 90 per cent. This helped to reduce NHIMA's reliance on private pharmacies. However, the nature of NHIMA's collaboration with the Zambia Medicines and Medical Supplies Agency (ZAMMSA) to ensure sustained drug availability remained unclear, particularly given that public HCPs received medical supplies at no direct cost as they were funded through the public purse.

Despite generally sufficient stock levels of essential medicines, some patients reported not receiving the prescribed drugs or suitable substitutes. This was attributed to instances where certain public hospitals claimed the medications were unavailable when, in fact, they were in stock. This raised concerns about internal inefficiencies, possible miscommunication, or poor stock management within the facilities.

3.4. Accreditation of separate units in public HCPs

Public HCPs appealed to NHIMA to allow them to separately accredit standalone units within their facilities, similar to the arrangement with the Cancer Diseases Hospital (CDH). They advocated for the accreditation of laboratory and pharmacy services. This proposal was based on the recognition that some public pharmacies and laboratories offered competitive services and already held national and regional accreditation. Moreover, the Committee was informed that the original intent behind private pharmacy accreditation was to serve as a stop-gap measure to address the critical shortage of medicines. In light of this, there was need to re-assess the state of affairs.

3.5. Higher Rejection rates in rural areas

The Committee observed high claim rejection rates among most rural HCPs visited, with some facilities experiencing rejection rates as high as 50 per cent. In contrast, urban HCPs recorded significantly lower rejection rates, with the lowest being just 1% at the Cancer Diseases Hospital. These disparities were largely attributed to errors made during the claim processing stage. In many cases, facilities lacked the necessary knowledge to properly complete claims, leading to frequent mistakes, mis-postings, and a general misunderstanding of the claims system. This lack of capacity contributed significantly to the

high volume of rejected claims in rural areas. As a result, users required periodic refresher training to operate the system effectively.

3.6. Delayment of Claim Payments

The Committee learnt that, at the inception of the scheme, NHIMA processed claim payments on a bi-monthly basis. However, in recent times, claim payments were delayed for up to six months, significantly affecting coverage and service delivery. This delay was primarily attributed to NHIMA's financial challenges, which were characterised by a growing number of claims against a backdrop of declining income, a trend already highlighted in the Actuarial Reports.

The resulting erratic payment schedule undermined the scheme's sustainability, with large sums of money tied up during extended waiting periods. These irregular payments have had a serious impact on hospital operations, disrupting cash flow, procurement processes, and overall service delivery.

3.7. Procurement of medical and non-medical equipment

Stakeholders expressed satisfaction that, since the introduction of the NHIMA scheme, HCPs were able to procure high-end diagnostic and support equipment using claim refunds. Some facilities acquired essential medical tools such as X-ray machines, hormonal profiling machines, suction machines, and oxygen cylinders. They also procured non-medical equipment such as heaters and generators. Further, some HCPs directed the funds to improve infrastructure such as, constructing and rehabilitating patient wards. At the UTH Adult Hospital, K1.8 m was used to repair a lift and convert a boiler room.

However, in cases where the Government supplied equipment, some facilities were unable to fully benefit from the investment. For example, Chinsali General Hospital was equipped with state-of-the-art laboratory equipment but lacked the necessary reagents to operate them. Additionally, even when diagnostic tests were performed, results were often delayed for several months due to restrictions on image interpretation services. Since these services could not be conducted in-house, facilities were forced to outsource them, further contributing to delays and limiting the overall effectiveness of service delivery.

3.8. Limited knowledge on the usage of funds generated from NHIMA

Most stakeholders demonstrated uncertainty in the utilisation of NHIMA generated funds, with several expressing mixed views. While a few adhered to the intended purpose of the funds, others deviated from established guidelines. NHIMA guidelines stipulated that 80 per cent of the funds should be used to enhance patient care, such as purchasing medical equipment, medicines, and improving service delivery and employing casual workers. The remaining 20 per cent was allocated for administrative support. Though there was sufficient guidance, the Committee learnt that some HCPs used the funds for purchasing groceries and food supplies for staff. This inconsistency highlighted the need for stricter enforcement of Government guidelines on the utilisation of externally generated resources.

3.9. Lack of awareness on the operations of NHIMA

The Committee noted that some key stakeholders in the health sector, particularly Provincial Health Departments (PHDs) lacked adequate understanding of NHIMA's operations. This information gap was attributed to insufficient engagement among provincial and district-level structures, and disinterest on the part of provincial authorities. This absence likely contributed to inconsistencies in the implementation and oversight at sub-national levels. Therefore, strengthening engagement and fostering active participation was essential to ensuring effective rollout and sustainability of the scheme across all regions, especially in rural areas.

3.10. Slow Response Time to Queries from HCPs

Stakeholders expressed concern over NHIMA's frequent delays in responding to queries raised by HCPs. These delays created unnecessary suspicions and hindered the timely resolution of operational challenges, particularly those related to claims processing, reimbursements, and service delivery. This often left HCPs uncertain about procedural requirements and corrective actions, negatively impacting efficiency and service quality. Stakeholders emphasised the need for NHIMA to establish a more responsive and structured communication mechanism to support effective engagement with HCPs.

3.11. Limitations in System Functionality and Reliability

Most HCPs submitted that the NHIMA system frequently experienced technical failures on its portal, leading to delays in service delivery and patient care. Internet connectivity challenges further compounded the problem, often preventing patients from logging out of the system. As a result, patients were not recorded as successfully attended to, leading to losses on corresponding claims. Additionally, the system lacked flexibility to accommodate patient referrals, making it difficult for clients to switch HCPs. Additionally, billing limitations where the system only allowed one patient visit per day restricted access to multiple services when needed.

3.12. Segregation of NHIMA and General Patients

The Committee was informed that some HCPs were separating NHIMA patients from general patients in an effort to provide premium services aligned with their entitlements. While this differentiation was served as a motivator for informal sector enrollment, it often posed logistical challenges in public HCPs. Further, many public facilities lacked adequate ward space to implement this separation effectively, resulting in overcrowding and reduced patient satisfaction. Moreover, the emphasis on NHIMA patients sometimes led to imbalanced service delivery, with general patients receiving less attention.

3.13. Expanding NHIMA Access for the Informal Sector and Vulnerable Groups

Most HCPs noted that they primarily received patients from the formal sector, citing high poverty levels and lack of awareness among the informal sector, who could not manage monthly payments due to irregular income. To address this, stakeholders proposed that NHIMA should consider allowing contributors to extend their payment schedules, instead of requiring monthly payments. Additionally, the scheme should be flexible enough to accept non-monetary contributions, allowing beneficiaries, particularly in rural areas, to pay in-kind, such as through livestock or harvested goods. Stakeholders also suggested that

NHIMA would collaborate with Faith-Based Organisations to raise awareness about the benefits of joining NHIMA, particularly among the informal sector. The Committee was also informed that, prior to referral to the CDH, patients were required to be registered under NHIMA.

3.14. Removal of Dental and Optical Services

Private HCPs expressed concerns about the restriction of dental and optical services to public health facilities, arguing that this decision particularly impacted underprivileged patients. The limitation also resulted in significant income loss for some private HCPs. For example, one facility reported a daily loss of income ranging from K50,000 to K100,000, which eventually decreased to K2,500 daily due to the reduced patient flow.

3.15. Admission of Ineligible Patients

Stakeholders reported that the NHIMA system allowed ineligible patients to access benefit packages. However, when claims were submitted, NHIMA rejected them based on patient ineligibility. HCPs considered this unfair, as it meant they had to provide services without guaranteed compensation. A notable example involved beneficiaries from LAs who accessed services despite having significant unpaid arrears. NHIMA could only cut off these beneficiaries after four months of non-payment, further exacerbating concerns of HCPs.

3.16. Pricing Concerns in the NHIMA Scheme

The Committee was informed that NHIMA last revised the scheme package in 2022. However, the package was considered unprofitable, as not all drugs were reimbursed at market prices. NHIMA's pricing for selected drugs was too low, which led some healthcare facilities to subsidise costs through corporate social responsibility initiatives to continue serving their patients. Alternatively, facilities hoped for large sales volumes to generate marginal profits, in addition to the challenge of dealing with perishable commodities.

3.17. Prioritise Public HCPs

The Committee was informed that NHIMA should be restricted to public HCPs, with private facilities engaged only in exceptional cases, such as when public facilities were unable to address specific medical needs. This approach would prioritise the strengthening and optimal utilisation of public healthcare services. Furthermore, it was suggested that this action could temporarily help stabilise NHIMA financially, given the substantial financial burden from claims submitted by private HCPs.

4.0 COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

Having carefully reviewed the submissions from various stakeholders and the findings from the local tour, the Committee notes that NHIMA requires immediate interventions to support its role in contributing to the realisation of UHC. In view of this, the Committee makes the observations and recommendations prescribed below.

4.1. Harmonise Legislation

The Committee observes challenges in the enforcement, inconsistency and vagueness of legislation regulating NHIMA, ZAMMSA and HPCZ. Therefore, the Committee recommends the following:

i) harmonise the *National Health Insurance Act, No. 2 of 2018* with Section 18 (3) (c) of the *Zambia Medicines and Medical Supplies Agency Act, No. 9 of 2019* to clarify NHIMA's obligation to remit funds to the Medicines and Medical Supplies Fund; and
ii) amend legislation in PART IV of the *National Health Insurance Act, No. 2 of 2018* and PART VII of *The Health Professions Council of Zambia Act No.17 of 2024* to differentiate similar roles performed by NHIMA and HPCZ on the accreditation of health facilities.

4.2. Revise Tariffs

The Committee notes that, tariff revisions are overdue, owing to the rising cost of medical commodities. Therefore, the Committee recommends revision of National Health Insurance General Regulations, SI No. 63 of 2019 to ensure cost reflective tariffs.

4.3. Treasury Support for Exempted Groups

The Committee observes that while the Government has appropriated K1.5m in the 2025 National Budget, the funds are not adequate to meet NHIMA's operations. In this regard, the Committee recommends that the Government should allocate a minimum of K230 million as capital injection to make initial investments and offset medical costs for the exempt category.

4.4. Change the Contributory Base from Basic to Gross Income

The Committee in agreeing with the 2019, 2020, 2022 and 2024 Actuarial findings observes that the 2 per cent contribution rate is not sustainable. Therefore, the Committee recommends the following:

i) 2 - 5 per cent contribution to NHIMA be progressively adjusted overtime from basic to gross income;
iii) allocation of 1 - 2 per cent of each Constituency Development Fund and a portion of the Social Cash Transfer to NHIMA, helping to subsidise the substantial costs associated with exempt populations; and
iii) impose 'sin tax' on commodities that are detrimental to good health including; cigarettes, alcoholic beverages, sugar and any other items of a similar nature.

4.5. Restructure the Benefits Package

The Committee observes that the benefits package is unsustainable due to unlimited access to health services. Therefore, it recommends:

i) Introducing a tiered benefits package with clearly defined premium contributions and corresponding services;
ii) Implementing a co-payment mechanism to reduce high claims while ensuring equitable access; and
ii) Setting a maximum limit on the benefits package to promote responsible use of the scheme.

4.6. Disproportional Accreditation of Health Care Providers in Rural Areas

The Committee notes limited access to NHIMA services in rural areas and recommends the following:

i) establish a tiered accreditation system for Zonal Health Facilities, enabling HCPs with basic infrastructure and staffing to receive limited NHIMA support while progressing toward full accreditation;
ii) promote Public-Private Partnerships in rural HCPs to enhance access to quality and essential service; and
iii) encourage separate accreditation of pharmacies and laboratories within public HCPs, restricting earnings to essential drug purchases in coordination with ZAMMSA.

4.7. Lack of Transparency in The Billing System

The Committee expresses concern over fraudulent claims by accredited HCPs and recommends installing an electronic invoicing and receipting system that sends clients text messages upon billing. Additionally, the Committee advises developing a personalised app to allow clients to access e-statements of all NHIS-related transactions for enhanced transparency and accountability.

4.8. Enrollment of Students

The Committee notes that tertiary institutions enroll large numbers of students and charge them medical fees. To ensure adequate medical coverage for this significant population, the Committee recommends amending the National Health Insurance Act, No. 2 of 2018, to require tertiary institutions to enroll students and pay their NHIS contributions.

4.9. Strengthen NHIMA's Audit Mechanisms

The Committee observes that NHIMA lacks sufficient mechanisms to detect and prevent fraud and to monitor its contribution toward UHC. Therefore, it recommends the following:

i) NHIMA to strengthen its fraud detection, prevention, and claims verification mechanisms; and
ii) the Ministry of Health to develop a structured Monitoring and Evaluation framework using 14 tracer indicators for routine data collection, analysis, and reporting on service coverage, financial protection, and equitable access to healthcare.
iii)

4.10. Scale Up Collaborations

The Committee in agreeing with stakeholders, observes the low informal sector registration and contributions. In this regard, the Committee recommends that NHIMA should enhance partnerships with telecommunications companies, Local Authorities (LAs), informal sector associations, community-based organisations, and traditional leaders, to improve the identification, registration and contributions of the informal sector.

4.11. Pre-Authorisation

The Committee observes that, although pre-authorisation has its merits, its current structure is inadequate for emergency situations. Therefore, the Committee recommends the

introduction of round the clock support services and automated systems for emergency pre-authorisation approvals to prevent delays in critical and life-threatening cases.

4.12. Utilisation of NHIMA funds by public HCPs

The Committee expresses concern over the apparent lack of clarity regarding the guidelines on the use of funds derived from NHIMA claims. Accordingly, it recommends strict enforcement of regulations governing the utilisation of internally generated resources.

PART II

5.0 CONSIDERATION OF THE ACTION TAKEN REPORT ON THE REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES, FOR THE THIRD SESSION OF THE THIRTEENTH NATIONAL ASSEMBLY

5.1. Topic: Devolution of Primary Health Care Services in Zambia

5.1.1. Adequacy of the Policy and Legal Framework

In the previous Session, the Committee had recommended that the National Health Policy (NHP) should be reviewed in order to provide sector specific policy direction for the devolution of the health sector, in line with the National Decentralisation Policy.

Executive's Response

In its response to the Committee, the Executive submitted that though primary health services had been devolved to LA, the health policy was still the mandate of the MoH, with input from stakeholders such as the Ministry of Local Government and Rural Development at an appropriate time.

Committee's Observations and Recommendations

The Committee in noting the submission, expresses concern that nothing has been done to review the NHP. Therefore, the Committee resolves to await the progress report on the matter.

5.1.2. Harmonisation of Existing Legislation

In the previous Session, the Committee observed that while the constitution and subsidiary pieces of legislation supported the implementation of the National Decentralisation Policy, existing legislation needed to be reviewed and aligned to the Constitution to strengthen the policy implementation. For example, while the Constitution gave the powers to administer the district to the town clerk, the *Planning and Budgeting Act* assigned the administration to the District Commissioner thereby, creating conflict between the two offices.

Executive's Response

In its response to the Committee, the Executive submitted that it was in the process of reviewing all legislation and aligning them with the Constitution in order to strengthen the decentralisation policy implementation. *The National Planning and Budgeting Act, No.1 of 2020*

was under review and had reached cabinet level, and it was envisaged that the review would resolve the district administration conflicts.

Committee's Observations and Recommendations
The Committee in noting the submission urges the Executive to expedite the process of reviewing all subsidiary legislation supporting the implementation of the National Decentralisation Policy, as well as aligning them with the Constitution. The Committee resolves to await progress report on the matter.

5.1.3. Oversight Capacity
In the previous Session, the Committee noted that for enhanced and effective oversight and implementation processes relating to primary health services, there was need to prioritise targeted capacity-building programmes for councillors at local level, especially those in rural areas.

Executive's Response
In response, the Executive affirmed the recommendation of the Committee, stating that it was in line with expectations of the National Decentralisation policy which on page 17 stipulated the functions of the central Government that the roles and responsibilities of the devolved Ministries would be to:

i) provide sector-specific policy direction;
ii) set sector-specific standards for devolved functions;
iii) undertake sector-specific monitoring and evaluation; and
iv) build relevant capacity for LAs, provincial and district departments for devolved service delivery.

The Committee was further informed that at the time of commencing the implementation, there was no structure put in place to implement the stated roles and responsibility, making it difficult for the Ministry to perform the function. However, the Ministry commenced the process on ensuring that the structure at the MoH was revised to include the Directorate to look into the matter.

Committee's Observations and Recommendations
The Committee in noting the submission urges the Executive to ensure that the structure at the MoH is revised to undertake capacity-building activities for councilors. The Committee resolves to await a progress report on the matter.

5.1.4. Health Service Commission
In the previous Session, the Committee noted that the employees who performed devolved functions were attached to the LAs and would continue to draw their salaries from central Government through the Payroll Management and Establishment Control system. The Committee further observed that once devolution was fully implemented, the health workers would be full-time under the Councils.

In view of the foregoing, the Committee recommended for constitutional amendments to establish a Health Service Commission to provide for the administration and conditions of services as well as transfers and promotions of the health personnel.

Executive's Response

In its response, the Executive affirmed the Committee's recommendations to establish a Health Services Commission in line with Article 216 of the Constitution of Zambia. However, considering that the matter bordered on the Constitution, the Ministry of Justice was requested to provide ***guidance.***

Committee's Observations and Recommendations

The Committee in noting the submission urges the Executive to ensure that the establishment of a Health Service Commission is expedited. The Committee resolves to await a progress report on the matter.

5.2. Topic: Review of the Operations of the Zambia Flying Doctor Service

5.2.1. Legal Framework

The Committee in the previous Session resolved to await a progress report on the plans by the Executive to finalise the review of the *Flying Doctor Service Act, Chapter 298 of the Laws of Zambia* by the second quarter of 2024.

Executive's Response

In response, the Executive informed the Committee that the Zambia Flying Doctor Service Board sought approval from the MoH to have the review of the *Flying Doctor Service Act, Chapter 298 of the Laws of Zambia* pushed to Second Quarter of 2025. This was due to the huge budgetary implication the process would have on the finances of the services. Thus the said process was moved to Quarter 2 of 2025.

Committee's Observations and Recommendations

The Committee notes the submission, and urges the Executive to expedite the review of the *Flying Doctor Service Act, Chapter 298 of the Laws of Zambia* by the second quarter of 2025. The Committee awaits a progress report on the matter.

5.2.2. Recapitalisation of the Zambia Flying Doctor Service

The Committee in the previous Session re-emphasised the need for the Executive to ensure that the Zambia Flying Doctor Service was recapitalised to enable it procure the required helicopter, pressurised plane, aero medical equipment, employ the necessary staff and operate effectively to facilitate efficient and effective service delivery in hard to reach areas. The Committee noted that the MoH was exploring options for the recapitalisation of the ZFDS amounting to $ 6, 500,000.00.

Executive's Response

In its response, the Executive submitted that, authority was granted for the Zambia Flying Doctor Service to procure second hand items and the said request was followed by a meeting held at the Ministry of Finance and the request for recapitalising the Zambia Flying

Doctor Service was granted. The Ministry of Health, through the office of the Permanent Secretary-Administration wrote to the ZFDS by letter dated 3rd April, 2024 informing the Service that the Ministry of Finance had granted authority for ZFDS to utilise a total of K167,750,000 on budget line 460737 5532002 310000- Medical Equipment and guided the ZFDS to begin the Procurement process. As at July, 2024, the funds were not yet released to the ZFDS, however, the Ministry pledged to release the funds soon.

Committee's Observations and Recommendations
The Committee notes the progress made so far. However, it recommends that the Executive engages the Treasury for more funds to recapitalise ZFDS. The Committee awaits a progress report on the matter.

5.2.3. Liquidation of Outstanding Statutory Debt
In the previous Session, the Committee learnt that the Executive consistently disbursed the grants to the ZFDS. The Committee however, urged the Executive to ensure that the K13,508,674.12 statutory debt accumulated was liquidated. The Committee resolved to await a progress report on the matter.

Executive's Response
In its response, the Committee was informed that, in the 2024 budget, the Zambia Flying Doctors Services (ZFDS) had been recapitalised with an amount of K167,750,000 million which was yet to be disbursed to them. It was envisaged that the outstanding statutory debt would be cleared within this allocation.

Committee's Observations and Recommendations
The Committee notes the Executive's submission and resolves to await a progress report on the matter.

5.2.4. Limited Operational Airstrips
The Committee in the previous Session noted the progress made by the Executive in the maintenance of district airstrips. However, it expressed concern that the MoH being the end user of the airstrips could not converse with the sister Ministry regarding the maintenance and construction of airstrips countrywide. In view of the foregoing, the Committee reiterated that a comprehensive maintenance and construction of the airstrips countrywide be facilitated by the Government to enable the ZFDS to effectively carry out its mandate and reduce on the operational costs. The Committee resolved to await a progress report on the matter.

Executive's Response
The Executive in its update to the Committee submitted that between 2018 and 2019, the Government devolved the construction and management of district airstrips to LAs with the exception of ten provincial and strategic aerodromes. Further to this, the Government through the Civil Aviation Authority developed standards for the construction and management of district airstrips for use by LAs. As such, the Ministry of Local Government and Rural Development was better placed to develop a comprehensive construction and maintenance plan for district airstrips.

Further to the above, the Committee was informed that the Government had embarked on phased approach to construct and update aviation infrastructure and facilities at various provincial airports in order to improve domestic connectivity. The Government completed the construction of Kasama Runway project on 15th July, 2023. The construction of Kasama Airport was poised to open up the Northern Circuit for tourism and enhance trade and investment for the region.

The Executive further submitted that the Government had prioritised the construction and upgrade of Solwezi, Mongu, Mbala, Mansa, Kasaba Bay and Choma Airports under phase one. The Attorney General had cleared the agreements awarding contracts for the construction and upgrade of Solwezi, Mansa, and Mongu aerodromes awaiting mobilisation by the contractors while Mbala and Kasaba Bay Airports were still at various stages of procurement. Upon completion, the projects would help the Zambia Flying Doctors Service to effectively carry out its mandate of attaining universal health coverage across the country.

Committee's Observations and Recommendations

The Committee notes the progress being made in the upgrading and construction of airports and aerodromes. However, it observes that the works are either undergoing initial phases of construction or are at various stages of procurement. In view of this, the Committee urges the Executive to expedite the maintenance and construction works by sourcing for funds from the Treasury. The Committee resolves to await a progress report on the matter.

5.3. Review of the Operations of the Social Cash Transfer Programme

5.3.1. Policy and Legal Framework

The Committee in noting the submission urged the Executive to ensure that the policy review processes were expedited to facilitate the effective and efficient implementation of the SCT Programme. The Committee resolved to await a progress report on the matter.

Executive's Response

The Executive submitted that the Policy had been finalised and the Ministry was working on the development of its Implementation Plan. To further support the implementation of the Policy which would take a Lifecycle Approach, the Ministry began the processes to facilitate the signing and ratification of the protocol to the African Charter on Human and Peoples' Rights on the Rights of Citizens to Social Protection. This was aimed at ensuring that Social Protection, the SCT was inclusive, accessible, adequate, affordable, and transparent to all citizens in Zambia.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await the development of an explicit legal framework to ring-fence SCT Programmes in the bid to strengthen inclusive development practices in the social protection sector.

5.3.2. Lack of Connectivity

The Committee in the previous Session, had noted the submission that, the Executive should ensure more was done to enhance broadband connectivity, to facilitate the roll out of the electronic payments of cash transfers to beneficiaries through the Zambia Integrated Social Protection Information Management System (ZISPIS) to all parts of the country.

Executive's Response

In its response, the Executive reported that efforts to enhance broadband connectivity were on-going countrywide. The Government was working on several initiatives to improve broadband connectivity, including:

i) Through Starlink's satellite-based internet connectivity services which commenced in October, 2023, and a total number of subscribers was estimated at 4,000;
ii) Issuing four new Network Licenses in International segment for data only whose total investment was USD 52 M. (Bayobab (MTN), Telesonic (Airtel), BCS and Starlink). This resulted in Connectivity of Angola to Zambia through Bayobab;
iii) Issuance of a policy directive to all Mobile Network Operators to commence upgrading their Mobile Communication Towers from 2G to 3G, 4G and 5G in collaboration with Private sector. (Installation of 131 Mobile Communications Towers with minimum 3G Voice and Internet);
iv) Through the Universal Access Service programme, the Government commenced implementation of 31 Mobile Communication Towers with Internet and the project will be completed in Q4 2024;
v) Procurement and distribution of 2000 computers to Government schools in the 10 provinces (200 computers per province);
vi) Commenced connectivity to schools with a target of 1,291 Secondary Schools and 22 schools had functional internet and 78 schools in Phase I would be completed by Q4 of 2024 bringing the total number of Phase I to 100; and
vii) Distributed 500 Starlink low orbit satellite kits to provide internet connectivity to all the 150 Constituency offices, 106 Post Office and 244 will be installed in other designated public institutions (Including schools and health facilities) for an initial 1-year free subscription.

The Committee would be updated on the progress.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the matter.

5.3.3. Graduation of SCT Programme Beneficiaries

The Committee in the previous Session urged the Executive to ensure that a draft proposal for a pilot Exit and Graduation Pathway was worked on without further delay, if the SCT programme was to remain sustainable. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive informed the Committee that the following had been done:

a. Drafted a proposal for a pilot of the Exit and Graduation Pathway

This would include the design of the Pathway and a comprehensive monitoring and evaluation plan that would maximise learning from the pilot stage and could inform future scale ups. This pilot would include:

i) a set of basic interventions and linkages within the purview of MCDSS that could feasibly be implemented in the short-term; and
ii) the establishment of inter-ministerial arrangements (in the first instance a technical working group) for dialogue around a more ambitious approach, with potentially greater transformational potential, requiring inter-ministerial cooperation and institutional change.

b. Set up a small technical working group to help finalise the pilot design and guide its implementation

This working group would consist of director-level technical staff from several agencies, including staff from MCDSS, NHIMA, Ministry of Labour and Social Security, Ministry of Education, and other ministries that attended the workshop. It could also include staff from NGOs and other cooperating partners. This technical working group would aim to generate practical ideas for inter-ministerial collaboration that could then be escalated to more senior levels for approval.

iv) Develop a communication campaign to build buy-in and prevent political backlash

This would need to include sensitisation and awareness raising at all levels, e.g., from the Permanent Secretary for the Ministry and other relevant ministries down to the council at district level. This would also require developing or refining existing grievance and redress mechanisms.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the actual implementation of the draft proposal.

5.3.4. Withdrawal Charges

The Committee in the previous Session observed that despite the payment of service charges being a prerogative of the Government, some beneficiaries of the SCT Programme complained of being charged fifty kwacha as withdrawal charge by mobile money agents. In this regard, the Committee recommended that a follow-up should be made to verify the allegation on the ground. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive reported that it followed up the allegations and established that beneficiaries were being charged K10.00 for those who received K400.00 and K20.00 for those that received K800.00. This was due to a technical issue from one of the service providers who delivered payments using the voucher system. That was not satisfactory as it would expire before beneficiaries could access their fund. That compelled the service provider to change the delivery mode to a wallet which was not zero rated during the time of payment.

The Ministry further engaged the service provider to refund the affected beneficiaries.

Furthermore, the Ministry, in collaboration with the service providers, enhanced sensitisation of beneficiaries on digital payments two weeks before payments were done in order to ensure that beneficiaries understood the digital products within their reach, the associated costs and how the products worked. If the situation re-occurred, service providers were required to refund the affected beneficiary without fail.

Committee's Observations and Recommendations
The Committee notes the submission and resolves to await a progress report on the refund.

5.3.5. Incentives given to Community Welfare Assistance Committees

The Committee in the previous Session urged the Executive to urgently develop guidelines on the provision of incentives to enable Community Welfare Assistance Committees to discharge their mandates efficiently and effectively. The Committee resolved to await a progress report on the matter.

Executive's Response
The Ministry had secured funds to develop the Guidelines to guide the incentivisation of Community Welfare Assistance Committee members and other volunteers in the country. Consultations would be undertaken in all 10 provinces in selected districts and wards before the commencement of the drafting process.

Committee's Observations and Recommendations
The Committee notes the submission and resolves to await progress report on the matter

5.4. Topic: The Pharmaceutical Manufacturing Industry in Zambia: Challenges and Opportunities

5.4.1. Policy Framework

The Committee in the previous Session urged the Executive to ensure that the National Medicines Policy and its Implementation Plan were finalised without further delay. The Committee resolved to await a progress report on the matter.

Executive's Response
In its response, the Executive informed the Committee that the National Medicines policy was advanced and the policy and the implementation plan were being finalised by the end of 2024.

Committee's Observations and Recommendations
The Committee notes the submission, however, it is concerned that despite drafting the National Medicines Policy and the Implementation Plan in 2023, the Executive had not finalised the document. The Committee resolves to await progress on the matter.

5.4.2. Debt Owed to Suppliers

The Committee in the previous Session expressed concern at the rate at which the debt owed to suppliers was being offset and urged the Executive to speedily offset the debt. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive reported that due to fiscal space, the Ministry was offsetting the debt in a phased manner. At the time of reporting, the debt to suppliers was K1,181,826,833.83.

Committee's Observations and Recommendations

The Committee notes the progress on the debt payments, however, the phased approach has deprived the suppliers from realising their earnings. In view of this, the Committee urges the Executive to offset the debt at once. The Committee resolves to await a progress report on the matter.

5.4.3. Pharmaceutical Sector Empowerment Fund

The Committee in the previous Session had resolved to await a progress report on what the Executive intended to do in order to promote low interest bank loans and develop a specific pharmaceutical sector empowerment fund.

Executive's Response

The Committee was informed that the Pharmaceutical Sector Empowerment fund was yet to be established.

Committee's Observations and Recommendations

The Committee in noting the submission resolves to await a progress report on the matter.

5.4.4. Promoting Local Manufacturing

The Committee in the previous Session resolved to await a progress report on the matter.

Executive's Response

The Executive in its update to the Committee submitted that the Zambia Pharma Manufacturing Initiative (ZPMI) Steering Committee working with stakeholders developed a draft Local Pharmaceutical Manufacturing Strategy. The strategy which took into account the local pharmaceutical landscape provided an investment case for the pharmaceutical sector in Zambia including strategies for technology transfer, as well as to strengthen local production of pharmaceutical products for the next five years (2024 – 2028). The strategy was undergoing validation and final approval processes.

Committee's Observations and Recommendations

The Committee in noting the submission reiterates its earlier position of urging the Executive to take urgent steps to venture into the local manufacturing of health supplies through joint ventures as provided for under the *Zambia Medicine and Medical Supplies Agency Act, No. 9 of 2019,* in order to reduce the expenditure on imports and meet the domestic pharmaceutical needs of the country. In this regard, the Committee urges the Executive to

expedite the validation and approval processes to facilitate the implementation of the Local Pharmaceutical Manufacturing Strategy. The Committee resolves to await a progress report on the matter.

5.4.5. Market Access for Locally Manufactured Products

The Committee in the previous Session urged the Executive to expedite the implementation of measures to enhance market access for locally manufactured pharmaceutical products and resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive submitted that the Pharmaceutical Manufacturing Strategy was completed and launched while the Local Content Bill through ZPPA was awaiting cabinet approval.

Committee's Observations and Recommendations

The Committee in noting the submission resolves to await a progress report on the matter.

5.5. Topic: Zambia's Preparedness to Respond to Emerging Epidemics and Pandemics

5.5.1. Review of the *Public Health Act, No. 22 of 1995*

The Committee in the previous Session urged the Executive to expedite the process of reviewing the Bill in line with the policy direction of the new administration. The Committee had resolved to await the progress report on the Amendment of the Public Health Bill and the resubmission to Ministry of Justice and subsequent introduction to Parliament of the Bill.

Executive's Response

In its response, the Executive informed the Committee that the Government through the MoH was finalising the NHP, after which the layman's Bill of the *Public Health Act No,22 of 1995* would be submitted to the Ministry of Justice in the first quarter of 2025.

Committee's Observations and Recommendations

The Committee in noting the submission resolves to await a progress report on the matter.

5.5.2. Increased Funding to the Health Sector in Line with the Abuja Declaration

The Committee, in the previous Session, noted with delight the progress made towards the actualisation of the Abuja Declaration which requires 15 per cent of national budget allocation towards the health sector. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive updated the Committee that though the Abuja Declaration had not yet been actualised, the Government was committed to ensuring that budgetary allocations over the years towards the health sector increased from K9.2 billion in 2021 to K12.4 billion in 2022, K16.1 billion in 2023 and K18.7 billion in 2024. This represented a per centage increase of approximately 34.8% from 2021 to 2022, 29.8% from 2022 to 2023

and 16.1% from 2023 to 2024, highlighting the Government's strong commitment to increasing allocation.

Committee's Observations and Recommendations

The Committee notes the nominal increase of the budget to the health sector, however, it urges the Executive to ensure that the required allocation of 15 per cent of the national budget as per the Abuja Declaration was attained. The Committee resolves to await a progress report on the matter.

5.5.3. Operationalisation of the National Public Health Emergency Fund

The Committee in the previous Session had urged the Executive to expedite the process of finalising the regulations to facilitate for the operationalisation of the National Public Health Emergency Fund. The Committee had resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive informed the Committee that the National Public Health Emergency Fund (NPHEF) was directed to be established through *the Zambia National Public Health Act, No. 19 of 2020*. The NPHEF was meant to be a financial resource that was readily available to be accessed and utilised in order to respond to and manage public health crises. The NPHEF was not yet operationalised. Thus far a draft-zero of the regulations had been jointly developed by stakeholders including, the ZNPHI, Ministry of Health, Ministry of Justice, Ministry of Finance, and other cooperating partners. The draft regulations would be finalised and submitted to Ministry of Justice within the fourth quarter of 2024.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the matter.

5.5.4. Lack of Infrastructure to Manage Highly Infectious Disease such as the COVID - 19 Virus

The Committee in the previous Session expressed concern that due to limited fiscal space, the construction of highly infectious disease isolation facility in Ndola could not be included in the 2024 budget. In this regard, the Committee urged the Executive to ensure that funds were secured for the construction of the facility. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive reported to the Committee that budget allocations towards the Ministry of Health, for infrastructure development had not been adequate. The Treasury was still facing a tight fiscal space especially with the drought faced during the 2023/2024 farming season, which had also exacerbated the situation. Therefore, the MoH re-prioritised their infrastructure development needs within their allocated ceiling, in view of the tight fiscal space.

Committee's Observations and Recommendations

The Committee in noting the submission urges the Executive to re-prioritise the project in the ensuing budget. The Committee resolves to await a progress report on the matter.

5.5.5. Lack of a Formidable Public Health Laboratory System

The Committee in the previous Session resolved to await a progress report on the construction of a bio-safety level 3 laboratory which was still at the preparation stage of the design.

Executive's Response

In its response, the Executive reported that, in line with section (V) of *the Zambia National Public Health Institute Act, No. 19 of 2020*, the ZNPHI had established the Zambia National Public Health Reference Laboratory (ZNPHRL) to provide capabilities to diagnose, confirm and characterize diseases and public health threats. To this effect, a significantly equipped modern laboratory facility had been setup, housed within the Levy Mwanawasa Medical University grounds in Lusaka. This laboratory had capabilities to perform a range of diagnostic and specialised tests, including genomic sequencing. The laboratory had anchored testing services for events of public health concern such as COVID-19, Cholera, Mpox, Marburg, mumps and other emerging and re-emerging threats. To augment this capability, the ZNPHI was implementing the Africa CDC Regional Investment Financing Project (ACDCP) at the core of which was the construction of a purpose-built, modern, high-containment laboratory complex, which would serve as the nation's apex referral laboratory for public health.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the construction of the state-of-the-art high containment bio-safety level 3 (BSL-3) laboratory facility in Lusaka Province.

5.5.6. The Establishment of a Viable Single Surveillance Platform for Reporting Public Health Events

The Committee in the previous Session urged the Executive to speed up the talks riding on the One-Health Strategic Plan to create an integrated platform that would house human, animal and environment health data. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive reported that the Public Health Security Information Management System (PHSIMS) which would link to other data management systems in the one health information system including human health, agriculture, livestock and fisheries, environment, wildlife, plant health, academia and other players was under development. This system was meant to support and manage an integrated one health information platform in order to achieve a one health approach to public health security. A multi-sectoral technical committee to guide development of PHSIMS was created and was functional. The Roadmap for the development of the PHSIMS was in place and the full realisation of the system was targeted by end of the year 2025.

Committee's Observations and Recommendations

The Committee notes the planned intervention, however, it urges the Executive to ensure that the envisaged PHSIMS addresses the Committee's concern of having an Integrated

Disease Surveillance Platform. The Committee resolves to await a progress report on the matter.

5.5.7. Empowerment of the National Bio-safety Authority

The Committee in the previous Session resolved to await a progress report on the Bio-safety and Biotechnology Policy which was submitted to Cabinet for approval.

Executive's Response

In its response, the Executive informed the Committee that, the Ministry of Green Economy and Environment consulted all stakeholders on the Policy as per Government procedure. The Policy was circulated on the e-cabinet platform for comments. Further, the comments were received and analysed and were submitted to Cabinet Office for possible inclusion on the Cabinet Agenda. The Executive awaits Cabinet's approval of the Policy which would be shared with the Committee.

Committee's Observations and Recommendations

The Committee notes the updates, however, it is concerned that the approval of the revised Bio-safety and Biotechnology Policy has dragged inordinately. The Committee urges the Executive to expedite the approval of the Policy and resolves to await a progress report on the matter.

5.5.8. Inadequate Transport

The Committee in the previous Session, resolved to await a progress report on the implementation of the guidelines on the car pooling system.

Executive's Response

In its response, the Executive updated the Committee that Government was still undertaking consultations with Cabinet Office, Ministries, Provinces and other Spending Agencies (MPSA) on the establishment and implementation of a car pooling system.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the implementation of the transport pooling system.

5.6. Topic: The Growing Demand for Specialised Medical Treatment Abroad by Patients: Challenges and Opportunities for Health

5.6.1. The Adequacy of the Policy and Legal Framework Governing Specialised Medical Treatment Abroad

The Committee in the previous Session urged the Executive to ensure the review process of the NHP and its plan was completed as submitted. Further, that the development of the draft National Health Services Bill was commenced as submitted. The Committee resolves to await a progress report on the matter.

Executive's Response

In its response, the Executive updated the Committee that the review process of the NHP and its implementation plan that was expected to be completed by the fourth quarter of 2023

would be completed in the fourth quarter of 2024. The development of the draft National Health Services Bill that was expected to commence in the first quarter of 2024 after the adoption of the NHP by the Government would commence in the first quarter of 2025.

Committee's Observations and Recommendations

The Committee notes the submission and urges the Executive to ensure the review process of the NHP and its plan is completed in the fourth quarter of 2024 as submitted. Further, that the development of the draft National Health Services Bill commences in the first quarter of 2025 as submitted. The Committee resolves to await a progress report on the commitments.

5.7. Topic: The Public Welfare Assistance Scheme and Women Empowerment Programmes

5.7.1. Duplicity of Functions

The Committee in the previous Session urged the Executive to urgently finalise the specified offices contribution pension scheme rules to facilitate the presentation of the Specified Offices Pension Benefit Bill,2024 the National Pension Scheme (Amendment) Bill; and the Workers' Compensation (Amendment) Bill to Parliament. The Committee resolves to await the progress report on the matter.

Executive's Response

The Executive, in its submission reported that following the passing of *the Emoluments Commission Act, No. 1 of 2022* and the appointment of the Commissioners, the country now had a fully functional Emoluments Commission. During the consultative process, the Commission requested for involvement in the whole reform process citing Article 65 (3) of the Constitution, which stated as follows "A Bill that confers emoluments on State officers or Constitutional office holders shall only be introduced in the National Assembly if the emoluments are recommended by the Emoluments Commission". This was understood from the perspective of the definition of emoluments, which included pensions.

The state of affairs culminated into the resolution that there was need for Cabinet approval in principle to ensure a holistic approach to the pension reform process. *The National Pension Scheme Act, No. 7 of 2015* was amended through *the National Pension Scheme (amendment) Act, No. 22 of 2022* in order to reduce the penalty rate from 20 per cent to 10 per cent, to provide for a penalty waiver and to allow for ZNPF beneficiaries to claim their benefits without waiting to the eligibility period. A further amendment was done through *the National Pension Scheme (amendment) Act, No. 1 of 2023* which introduced the pre-retirement pension benefit.

Once the approval in principle was granted, the consultations would resume leading to the enactment of the Specified Offices Pension Benefit Bill of 2024.

Committee's Observations and Recommendations

The Committee appreciates the progress regarding the legislative reforms on the National Pension Scheme (Amendment) Bill. However, it urges the Executive to finalise the Specified Offices Contribution Pension Scheme Rules to facilitate for the presentation of the Specified

Offices Pension Scheme Bill; and the Workers' Compensation (Amendment) Bill to Parliament. The Committee resolves to await the progress report on the matter.

5.8 Service Delivery in Public Health Institutions in Zambia

5.8.1 Refurbishing of Old Health Facilities Countrywide and the Completion of the 650 Health Posts

The Committee in in the previous Session urged the Executive to ensure that funds were secured for the completion of the 650 health posts and rehabilitation of old health facilities as continued delay would lead to the increase in standing cost and the rise in the cost of building materials. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive updated the Committee that the rehabilitation of old health facilities had been budgeted for in the 2024 MoH Infrastructure Operational Plan and works would commence once funds were disbursed by Ministry of Finance for this purpose.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the matter.

5.8.2 Revision of the National Health Plan to define the Role of Non- state Actors in the Delivery of Health Services in the Country

The Committee in the previous Session urged the Executive to ensure that the NHP was completed and the development of the draft National Health Services Bill commenced in the first quarter of 2024 as submitted. The Committee resolved to await a progress report on the matter.

Executive's Response

In its update to the Committee, the Executive submitted that the review process of the NHP and its implementation plan that was expected to be completed by the fourth quarter of 2023 would be completed in the fourth quarter of 2024. The development of the draft National Health Services Bill that was expected to commence in the first quarter of 2024 after the adoption of the NHP by the Government would commence in the first quarter of 2025.

Committee's Observations and Recommendations

The Committee in noting the submission urges the Executive to ensure that the NHP is completed in the fourth quarter of 2024 and the development of the draft National Health Services Bill commences in the first quarter of 2025 as submitted. The Committee resolves to await a progress report on the matter.

5.8.3 Offsetting the Outstanding Debt of K172,797,981.01 for Goods and Services at the University Teaching Hospitals

The Committee in the previous Session urged the Executive to expedite the rate at which it was liquidating the debt for goods and services at the University Teaching Hospitals. The Committee resolved to await a progress report on the matter.

Executive's Response
The Executive in its response, informed the Committee that the outstanding balance as at the time of publication of the report was at K74,715,246.67 (this was for Authur Divison Children's Hospital, Ndola Teaching Hospital, Cancer Diseases Hospital, Women and New Born Hospital University Teaching Hospital Adult Hospital, University Teaching Hospital Children's Hospital and Chainama Hills Hospital). The outstanding debt would be paid once funds were made available.

Committee's Observations and Recommendations
The Committee notes the submission, however, it is concerned that the outstanding debt of K74,715,246.67 owed for goods and services at the University Teaching Hospitals has not been settled. The Committee urges the Executive to expedite the settlement and resolves to await a progress report on the matter

5.9 Topic: The Welfare of Older Persons in Zambia

5.9.1 Construction of Old People's Homes in the Ten Provinces of the Country
The Committee in the previous Session resolved to await a comprehensive progress report on the construction of old People's Homes in the ten provinces of the country.

Executive's Response
The Executive informed the Committee that the Ministry of Infrastructure, Housing, and Urban Development, in collaboration with the Ministry of Community Development and Social Services, had commenced phased construction of old people's homes in the ten (10) provinces of Zambia. The Government had initiated construction in four (4) provincial headquarters, now at various levels of progress. Implementation of the projects began in Choma, Southern Province, Ndola in the Copperbelt Province, Mongu in Western Province, and Chinsali in Muchinga Province. Notably, the contract for the construction of an old people's home in Ndola was terminated due to the contractor's non-performance, however, the project would soon be retendered.

Additionally, the Government updated the Committee on the progress of the construction of social housing units for the vulnerable under the Social Cash Transfer Registry. This initiative was implemented by the Ministry of Infrastructure, Housing, and Urban Development in collaboration with the Ministry of Community Development and Social Services. Under this programme, the government was constructing 200 social housing units across four (4) provinces, namely the Southern, Eastern, Western, and Central Provinces, with 50 housing units allocated per province in the selected districts.

Below is a summary of the progress of the projects highlighted above:

Progress Status for Old People's Home				
S/N	**Project**	**Location (District)**	**Work Per centage Done**	**Intended Completion Date**
1	Construction of Old Peoples Home in Western Province	Mongu District	28 per cent	November 2024
2	Construction of Old People's home Copperbelt	Ndola	15 per cent	TBA

	Province			
3	Construction of Old People's home Southern Province	Choma	65 per cent	August 2024
4	Construction of Old People's Home in Muchinga Province	Chinsali District	45 per cent	August 2024
Progress Status for Social Housing Units for the Vulnerable				
	Project	**Location (District)**	**Work Per centage Done**	**Intended Completion Date**
1	Construction of 50No. low cost houses for the Vulnerable on social cash transfer registry in Eastern Province	Sinda 12 No., Chadiza 13 No., Vubwi 11 No. Mambwe 14 No.	80 per cent	November 2024
2	Construction of 50No. low-cost houses for the Vulnerable on social cash transfer registry in Southern Province	Pemba 10 No., Gwembe 15 No., Sinazongwe 15No. Namwala 10 No.	60 per cent	September 2024
3	Construction of 50 No. Housing Units in Western Province	Kaoma 15, Nkheyema 15, Luampa 10 and Limulunga 10	25 per cent	November 2024
4	Construction of 50No. Housing Units in Central Province	Serenje 12 Ngabwe 13 Mkushi 12 and Luano 13	40 per cent	January 2025

Committee's Observations and Recommendations

The Committee notes the progress and resolves to await a comprehensive progress report on the construction of old People's Homes in the ten provinces of the country.

5.9.2 Domestication of Regional and International Treaties Aimed at Uplifting the Welfare of Older Persons

The Committee in the previous Session observed with concern the time it had taken for the African Charter on Human and People's Rights on the rights of older persons to be ratified. The Committee, therefore, recommended that the process of ratifying the Charter be expedited and resolved to await a progress report on the matter

The Executive's Response

The Executive in its update submitted that the process of the ratification of the African Charter on Human and People's Rights on the Rights of Older Persons would be implemented alongside the review of the Policy Framework for Older Persons. This would ensure alignment to both international standards and conformity to the local context. The processes was ongoing.

Committee's Observations and Recommendations

The Committee notes the submission and resolves to await a progress report on the matter.

5.10 Topic: Zambia's Response Towards Non-Communicable Diseases

5.10.1 Establishment of Prostheses Section in the Rehabilitation Department of Major Health Institutions

The Committee in the previous Session noted the progress and urged the Executive to ensure that all hospitals had functional prosthetic and orthotic services. The Committee resolved to await a progress report on the matter.

Executive's Response

The Executive informed the Committee that Government, through the MoH was still in the process of opening up provincial centres for prosthetics and orthotics. In 2024, K12,000,000.00 was allocated for procurement of prosthetic materials. The process to procure prosthetic materials through the ZAMMSA had commenced. These were intended for four service delivery points at Kitwe Teaching Hospital, Arthur Davison Children Hospital, UTH Adult Hospital and Livingstone Central Hospital. The process had reached an advanced stage and supplies were expected by September month end.

Committee's Observations and Recommendations

The Committee notes the submission and awaits a progress report on the opening up of provincial centres for prosthetics and orthotics, as well as procurement of prosthetic materials in 2025 as submitted.

5.10.2 Warnings Placed on Tobacco Packaging

The Committee in the previous Session observed with concern that the Tobacco Control Bill had not been presented to Parliament a year after the Executive had indicated that the Bill would be brought to Parliament. The Committee, hence urged the Executive to ensure that the Bill was brought to Parliament without further delay. The Committee resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive updated the Committee that, the delay in introducing the Tobacco Control Bill to Parliament was as a result of two contentious clauses in the Bill that were affecting key line Ministries of Agriculture, Commerce Trade and Industry, Finance and National Planning. Following various consultative meetings, stakeholders resolved the contentious clauses. In this regard, the Bill was expected to be introduced in Parliament in the Fourth Session of the Thirteenth National Assembly.

Committee's Observations and Recommendations

The Committee notes the submission and awaits the presentation of the Tobacco Control Bill to Parliament.

5.10.3 Promotion of Medical Tourism

The Committee in the previous Session urged the Executive to ensure that the construction works at the Ndola Cancer Treatment Centre were completed as submitted. Further, the Committee urged the Executive to conclude the procurement process for the construction of

the Livingstone Cancer Treatment Centre. The Committee resolved to await a progress report on the matter.

Executive's Response
The Executive in its response informed the Committee that, the construction of Ndola Cancer Treatment Centre was at 40per cent and was expected to be completed by second quarter of 2025, whereas the Livingstone Cancer Treatment Centre in Livingstone was at tender stage.

Committee's Observations and Recommendations
The Committee notes the submission and awaits the completion of works at the Ndola Cancer Treatment Centre by the second quarter of 2025 as submitted. Further, the Committee urges the Executive to speed up the procurement process for the construction of the Livingstone Cancer Treatment Centre. The Committee resolves to await a progress report on the matter.

5.11 Topic: Progress and Update on the Social Cash Transfer Programme in Zambia

5.11.1 Social Protection Legislation
The Committee in the previous Session urged the Executive to expedite the process of consultation at provincial level for the review of the 2014 National Social Protection Policy to inform the finalisation of the review process. The Committee resolved to await a progress report on the matter.
Executive's Response
In its response, the Executive submitted that Provincial consultations of the National Social Protection Policy were concluded and the Policy was finalised, awaiting the development of its Implementation Plan before submission to Cabinet for clearance.

Committee's Observations and Recommendations
The Committee notes that the National Social Protection Policy has been revised, however, the Committee awaits the development of its Implementation Plan.

5.12 Topic: Zambia's Preparedness for the Implementation of the Sustainable Development Goal on Health with Special Focus on Sexual Reproductive Health Rights

5.12.1 Centralised Medical Stores
The Committee in the previous Session resolved to close the matter on the construction of the Mongu Medical Stores Hub which was completed and operationalised; and resolved to await a progress report on the construction of the Kabompo Medical Stores hub.

Executive's Response
The Executive updated the Committee that funds for the construction of Kabompo Medical Stores hub had been secured through the Global Fund. Procurement Processes to engage a contractor had commenced. The hub was expected to be constructed and completed in 2025.

Committee's Observations and Recommendations
The Committee in noting the submission resolves to await a progress report on the construction of Kabompo Medical Stores hub.

5.12.2 Performance Contracts for the Public Service
The Committee in the previous Session urged the Executive to ensure that the rollout of the performance contracts was implemented within 2024. The Committee resolved to await a progress report on the matter.

Executive's Response
The Executive in its response submitted that, the Committee of Permanent Secretaries and the Local Government Service Commission had meetings to consider the draft performance contracts for principal officers in the LAs and had agreed on the content and format of the contracts. Capacity building in performance contracts for principal officers in the LAs was slated for August, 2024 in readiness for the rollout of the performance contracts in 2025.

Committee's Observations and Recommendations
The Committee in noting the progress, urges the Executive to ensure that the rollout of the performance contracts is implemented in 2025 as submitted. The Committee resolves to await a progress report on the matter.

5.13 Topic: Breast and Cervical Cancer in Zambia
The Committee in the previous Session, resolved to await a comprehensive progress report on the construction of the Livingstone Cancer Treatment Centre and expansion of the Cancer Disease Hospital in Lusaka.

Executive's Response
In its response, the Executive submitted that, the construction works of the King Salman Bin Abdulla Aziz Women and Children Specialist Hospital was in progress and stood at 70 per cent complete and was expected to be completed in March 2025. The extension of time from May, 2024 to March, 2025 was granted to the Contractor due to lack of funds for Value Added Tax (VAT) and Counterpart funds.

Committee's Observations and Recommendations
The Committee notes the submission, and expresses concern on the Executive's delay to operationalise the two radiotherapy centres in Livingstone and Ndola and the expansion of the Cancer Disease Hospital in Lusaka into a centre of excellence.

5.14 Topic: Poor Maintenance of Medicine Inventories

5.14.1 Quality of Storage Facility

Audit Finding
The Auditor General's Report revealed that seven health facilities did not have any air conditioners in the pharmacies, thereby posing a risk to the efficacy of certain drugs which needed to be stored at certain temperatures.

Furthermore, twelve health facilities had pharmacies which stored drugs on the floor due to inadequate space. It was also observed at Chawama Level I Hospital that two store rooms were maintained for storage of medicines, however, the bulk store was poorly maintained as it had a leaking roof causing flooding, which could damage the medicines.

The Committee in the previous Session urged the Executive to ensure that funds for the construction of the Central Province hub were secured. The Committee resolved to await a comprehensive progress report on the construction of the regional hub in Northern Province and mobilisation of funds for the construction of the Central Province hub.

Executive's Response

The Committee was informed that the mobilisation of funds for the construction of the Central Province hub was still underway while the Government had secured land for construction of the Northern Province Hub.

Committee's Observations and Recommendations

The Committee notes the submission, however it awaits a comprehensive progress report on the construction of regional hubs in Central and Northern Provinces.

5.15 General Concerns

5.15.1 Policy, Standards and Guidelines

The Committee in the previous Session observed with concern the failure by the Executive to complete the review of the National Mental Health Policy which was expected to be completed in 2023. In this regard, the Committee recommended that the Executive expedites the processes of reviewing the Policy and resolved to await a progress report on the matter.

Executive's Response

In its response, the Executive submitted that, the process to review the 2005 draft Mental Health Policy commenced with internal consultative meetings held. However, the NHP which was the anchor document for the Mental Health Policy was not finalised. Therefore, the standalone Mental Health Policy would be concluded once the NHP was finalisation and launched.

Committee's Observation and Recommendation

The Committee notes with concern that, in its previous submissions, the Executive committed to revise the National Mental Health Policy in 2024. However, the matter has dragged for too long. In noting the submission, the Committee urges the Executive to expedite the process of reviewing the Policy and resolves to await a progress report on the matter.

5.15.2 Resource Allocation to Mental Health

The Committee in the previous Session urged the Government to ensure that the allocation to mental health was increased as submitted and resolved to await a progress report on the matter.

Executive's Response
In its response, the Executive updated the Committee that the Government would continue to increase allocations towards the health sector, which would consequently translate into increased allocations towards mental health.

Committee's Observation and Recommendation
The Committee notes the submission, however, it is concerned that the Executive has not indicated whether it has fulfilled its intention to increase the allocation for mental health to 10 per cent starting from 2024. The Committee urges the Government to ensure that the intention is fulfilled and resolves to await a progress report on the matter.

5.15.3 Availability of Infrastructure and Equipment
The Committee in the previous Session urged the Executive to ensure that skilled human resource operated mental health facilities. Further, the Committee recommended that mental health units which were to be renovated at Solwezi and Choma General Hospitals met the recommended specifications. The Committee further, urged the Executive to ensure that the other psychiatric units in Mongu, Choma and Kasama were rehabilitated and new psychiatric facility in Solwezi and Ndola were built as well as give a facelift to Chainama Hills Hospital. The Committee resolved to await a comprehensive progress report on the matter.

Executive's Response
The process to review the 2005 draft Mental Health Policy commenced with internal consultative meetings held. However, the NHP which was under finalisation had included a Mental Health section. Therefore, the Stand-alone Mental Health Policy awaited the launch of the NHP.

Committee's Observation and Recommendation
The Committee reiterates its recommendation to the Executive to ensure that skilled human resource to operate mental health facilities are available. Further, the Committee recommends that mental health units which are to be renovated at Solwezi and Choma General Hospitals meet the recommended specifications. The Committee further, urges the Executive to ensure that psychiatric units in Mongu, Choma, Kabwe and Kasama are rehabilitated, and a new psychiatric facility in Solwezi built, as well as give a facelift to Chainama Hills Hospital. The Committee resolves to await a comprehensive progress report on the matter.

5.15.4 Provision of Rehabilitation Services to Users/Patients
The Committee in the previous Session, had expressed concern that nothing had been done to ensure that the three dilapidated rehabilitation centres were renovated. In that regard, the Committee reiterated its previous year's recommendation that the Government should without further delay secure funds to renovate the three centres.

Executive's Response

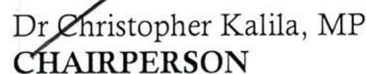
The Executive responded that the issue of rehabilitation centres had been deferred to 2025.

Committee's Observation and Recommendation

The Committee notes the response, however, it reiterated its previous recommendation urging the Government to secure funds for renovating the three dilapidated rehabilitation centres namely; Nsadzu (Chadiza), Kawimbe (Mbala) and Litambya (Senanga). The Committee awaits a progress report on the matter.

6.0 CONCLUSION

The Committee commends the Government of the Republic of Zambia for establishing the NHIMA as a key strategic intervention supporting the realization of UHC and reducing financial barriers to healthcare, especially for the poor and vulnerable. So far, NHIMA has recorded notable successes, including improved domestic resource mobilisation. However, the Committee observes that its establishment was rushed and did not adequately incorporate expert guidance from the Actuarial Reports of 2012, 2022, and 2024. As such, NHIMA faced the risk of insolvency, driven by low contribution levels, high utilisation rates, and an overly ambitious benefits package. Therefore, the Committee urges the Government to assume greater responsibility in resourcing NHIMA, as well as prioritising support for rural healthcare infrastructure, staffing, equipment, and essential medical supplies. It is the Committee's expectation that the observations and recommendations in this report will be acted upon promptly to strengthen and sustain the operations of NHIMA. Further, the Committee hopes the outstanding action on matters from previous Sessions are expedited.



Dr Christopher Kalila, MP
CHAIRPERSON

July, 2025
LUSAKA

APPENDIX I – NATIONAL ASSEMBLY OFFICIALS

Mr Barnabas Bwalya, Director (Social Committees)
Mrs Chitalu Mumba, Deputy Director (Social Committees)
Mr Darius Kunda, Senior Committee Clerk (SC 1)
Mr Aubrey Chilambwe, Senior Budget Analyst
Mr Kelezo Lushako, Committee Clerk
Mr Robson Maamba, Research Officer
Ms Catherine Chibuye, Administrative Assistant II
Mrs Vivian M Banda, Administrative Assistant
Mr Daniel Lupiya, Senior Committee Assistant
Mr Muyembi S Kantumoya, Committee Assistant
Ms Taona Chabinga, Committee Assistant
Ms Rachael K Chileshe, Intern

APPENDIX II - LIST OF WITNESSES

Ministry of Health
Global Fund Programme Coordination Unit
Levy Mwanawasa University Teaching Hospital
Kafue General Hospital
Ministry of Community Development and Social Services
National Health Insurance Management Authority
African Medical Research Foundation
Centre for Reproductive Health and Education
Churches Health Association of Zambia
Diabetes Association of Zambia
Health Professionals Council of Zambia
Healthcare Federation of Zambia
Medicines Research and Access Platform
Pharmaceutical Society of Zambia
Policy Monitoring and Research Centre
UniLabs
Zambia Dental Association
Zambia Institute for Policy Analysis and Research
Zambia Medical Association
Zambia Medicines and Medical Supplies Agency
Zambia Medicines Regulatory Authority
Zambia National Public Health Institute
Dr Dale Mudenda
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