

REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE FIRST SESSION OF THE ELEVENTH NATIONAL ASSEMBLY APPOINTED ON 21ST OCTOBER 2011

Consisting of:

Brig. Gen Dr B Chituwo, MP, (Chairperson); Ms C Namugala, MP; Mr M Simfukwe, MP; Mr C Mweetwa, MP; Mr O Chisala, MP; Mr P Mucheleka, MP; Mr L Mufalali, MP; and Mr R Chitotela, MP.

The composition of the Committee changed when Mr I Banda, MP was appointed as Deputy Minister and Col G A Chanda, MP and Mr R Mwewa, MP, as Provincial Ministers who were replaced by Mr M Simfukwe, MP; Mr O Chisala, MP and Mr R Chitotela, MP.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir

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

Functions of the Committee

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

- (i) study, report and make recommendations to the Government through the House, on the mandate, management and operations of the Ministries of Health, and Community Development, Mother and Child Health, departments and/or agencies under their portfolios;
- (ii) carry out detailed scrutiny of certain activities being undertaken by the Government ministries of Health and Community Development, Mother and Child Health, departments and/or agencies under their portfolios and make appropriate recommendations to the House for ultimate consideration by the Government;
- (iii) make, if considered necessary, recommendations to the Government on the need to review certain policies and certain existing legislation relating to the Ministries of Health and Community Development Mother and Child Health;
- (iv) examine annual reports of the Ministries of Health, Community Development Mother and Child Health, departments under their portfolios in the context of the autonomy and efficiency of Government ministries and departments and determine whether the affairs of the said bodies are being managed according to relevant Acts of Parliament, established regulations, rules and general orders; and
- (v) consider any Bills that may be referred to it by the House.

Meetings of the Committee

3.0 Your Committee held thirteen meetings during the period under review. Your Committee's report is divided into three parts. Part I considers the topical issues on which

your Committee undertook a detailed study; Part II is on the Foreign Tour; and Part III considers the outstanding issues from the Action-Taken Report on your Committee's Report for the Fifth Session of the Tenth National Assembly.

Committee's Programme of Work

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

- (a) consideration of the Action-Taken Report for the Fifth Session of the Tenth National Assembly;
- (b) consideration of Maternal Health in Zambia;
- (c) consideration of Social Protection for the Aged in Zambia;
- (d) foreign tour to the Republic of Mauritius in order to learn best practices and share experiences with regard to maternal health and social protection for the aged; and
- (e) consideration and adoption of minutes and Draft Report.

Procedure adopted by the Committee

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

PART I

CONSIDERATION OF TOPICAL ISSUES

TOPIC ONE

MATERNAL HEALTH IN ZAMBIA

6.0 Your Committee recognised that although Zambia had done well to reduce on the previous levels of maternal, neonatal and child mortality rates, the magnitude of the problem was still unacceptably high and well off the set Millennium Development Goal Number 5 (MDG5) whose main targets were to:

- a) reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and
- b) achieve, by 2015, universal access to reproductive health.

It was in this vein that your Committee resolved to undertake a study on Maternal Health in Zambia with intent to identify the major challenges being faced in the provision of quality Maternal Health in order to recommend the way forward.

In order to gain insight into the topic, your Committee invited the following witnesses who represented the views of the major stakeholders, being the Government and Non-Governmental Organisations:

- a) Ministry of Health;
- b) Marie Stopes International;
- c) Alliance Zambia;
- d) Planned Parenthood Association of Zambia (PPAZ);
- e) Churches Health Association of Zambia (CHAZ);

- f) Zambia White Ribbon Alliance for Safe Motherhood;
- g) United Nations Children’s Fund (UNICEF);
- h) United Nations Populations Fund (UNFPA);
- i) Midwives Association of Zambia;
- j) Society for Family Health; and
- k) Johns Hopkins Programme in International Education for Gynaecology and Obstetrics (JHPIEGO)

CONSOLIDATED SUMMARY OF SUBMISSIONS

6.1 Your Committee was informed that Maternal Health referred to the health of women during pregnancy, childbirth and the post partum period. Maternal death on the other hand, was defined as the death of a woman while pregnant or within forty-two days of the termination of pregnancy, regardless of the site or duration of the pregnancy from any cause related to or aggravated by the pregnancy or its management.

Your Committee learnt that the state of maternal health in a nation, Zambia inclusive, was characterised by numerous factors, such as Maternal Mortality and Morbidity Rates, Maternal nutrition status, as well as process indicators of service availability and use.

These indicators included the following:

- i) levels of Antenatal and Postnatal Care;
- ii) Contraceptive Prevalence Rate (CPR);
- iii) coverage of Tetanus Toxoid (TT) vaccination;
- iv) proportion of deliveries conducted in health facilities by trained birth attendants; and
- v) proportion of unwanted pregnancies.

Unfortunately, according to many of these measures, the maternal health situation in Zambia has been poor.

Zambia’s Progress towards the Attainment of Millennium Development Goal Number 5 (MDG5)

6.2 According to the Zambia Demographic and Health Survey (ZDHS) carried out in 2007, the maternal mortality ratio in Zambia reduced from 729 deaths per 100,000 live births in 2002, to 591 deaths per 100,000 live births in 2007. Therefore, in order to attain the Millennium Development Goal target, Zambia had to reduce its Maternal Mortality Ratio (MMR) to approximately 162 deaths per 100,000 live births. This meant that a further reduction of 429 deaths per 100,000 live births had to be achieved by the year 2015.

Your Committee learnt that despite recognising that there was a reduction in the maternal mortality ratios from 729 deaths to 591 deaths, these ratios were still unacceptably high.

Zambia’s Maternal Health Situation

6.3 The stakeholders submitted that the maternal health situation in Zambia was among the worst in Southern Africa and had not improved substantially in most areas of the country.

The stakeholders highlighted the issues set out below as some of the indicators that showed that Zambia was still far from attaining the MDG5.

a) Zambia's Total Fertility Rate

According to the 2007 ZDHS, Zambia's total fertility rate has increased from 5.9% in the year 2002, to 6.2%, making it one of the highest fertility rates in the world. The stakeholders submitted that fertility varied with a mother's education and economic status. It was, further, revealed that uneducated women had more children than educated women. In addition, poorest women had more than twice as many children as women who lived in the wealthiest households. This reflected the trend that poor women generally had the widest gap between total fertility and ideal family size.

b) Antenatal Care

Your Committee learnt that antenatal care coverage was an important indicator of access to reproductive health services. This was because antenatal care enabled trained midwives monitor the pregnancies and identify patients who would develop problems so that appropriate treatment could be instituted. The stakeholders submitted that while ninety four percent (94%) of pregnant women attended at least one antenatal care visit, only sixty percent (60%) attended four or more visits. This was the number of visits recommended by the Zambian Government and World Health Organisation (WHO) guidelines respectively.

Regrettably, your Committee learnt that women living in rural areas were often poor and uneducated. It was submitted that these women were less likely to attend four or more antenatal care visits because of various challenges that they faced. As a result, they sought antenatal care services late. This resulted in their receiving poor quality antenatal care services such as tests, drug supplies and information on the danger signs of the pregnancy. This scenario further prevented them from accessing proper services for the Prevention of Mother to Child Transmission (PMTCT) services for Human Immuno Virus (HIV) positive pregnant women, a service which was supposed to be initiated at fourteen weeks of the pregnancy.

c) Maternal Nutrition

According to the ZDHS 2007, maternal nutrition manifested as being either underweight, Body Mass Index (BMI) $<18.5 \text{ kg/m}^2$ (9.6%), or overweight/obese - BMI $> 30 \text{ kg/m}^2$ (19%). Underweight in women was also associated with nutrient deficiencies (iron, folic acid, Vitamin A), taking the form of anaemia (47% among pregnant women and 29% among non-pregnant women) and Vitamin A deficiency.

Your Committee learnt that the prevalence rate of anaemia among pregnant women was high at 46.9%, resulting from a combination of nutrient deficiencies (iron, folic acid, vitamin A), as well as malaria and HIV infections. It was submitted that anaemia was a predisposing factor to maternal deaths resulting from post-partum haemorrhage and sepsis and that overweight and obesity were risk factors for nutrition-related, non-communicable diseases such as diabetes type II, cancer and heart disease.

Your Committee was informed that good nutrition was important for maternal health. The lack of essential nutrition often contributed to indices of neonatal morbidity and mortality including stillbirths, neonatal deaths and other adverse clinical outcomes.

d) Child Deliveries

Your Committee learnt that another important health intervention useful in the reduction of maternal mortality was to have mothers delivered by a skilled birth attendant. However, less than half (47%) of the births were attended to by a skilled provider, with most of the non-attended births occurring at home (52%). This heightened the likelihood of maternal and neonatal mortality and morbidity in the event of delivery-related complications.

e) Postnatal Care

Your Committee was informed that despite the postnatal period being one of the most dangerous periods for occurrence of life threatening complications, postnatal care in Zambia was quite low. The proportion of mothers seeking postnatal care from professionally trained personnel was low in both rural and urban areas of Zambia. The 2007 ZDHS revealed that 50% of women received no care at all.

f) The Contraceptive Prevalence Rate

Your Committee was informed that Zambia has a contraceptive prevalence rate of thirty three percent (33%) with the 2007 ZDHS revealing that twenty seven percent (27%) of married women have an unmet need for family planning, seventeen percent (17%) for spacing and nine percent (9%) for limiting. The unmet need was highest in rural areas among the least educated and poorest women.

Further, your Committee was informed that with the unmet need for family planning, Zambia also has an unparalleled record of unplanned pregnancies. Statistics in the 2007 ZDHS showed that 42% of pregnancies were unintended while 16% of these were unwanted. Statistics further showed that 26% of the pregnancies were mistimed or only wanted at a later period.

Causes of Maternal Deaths

6.4 Your Committee also learnt that there were both direct and indirect causes of maternal deaths. Despite these causes being preventable, many women continued to die from these preventable complications of pregnancy and child birth.

Direct Causes of Maternal Deaths

6.4.1 The principal direct determinants of maternal deaths were due to five major complications. These complications include:

- haemorrhage (34%) which was bleeding related to the pregnancy;
- sepsis/infection (13%);
- obstructed labour (8%);
- hypertensive conditions (5%); and
- unsafe abortions (4%).

The stakeholders submitted that these complications could occur at any time during pregnancy and child birth, often without forewarning and requiring immediate access to emergency obstetric care for their management.

Indirect causes of maternal deaths

6.4.2 The stakeholders defined indirect determinants as pre-existing diseases/conditions that developed during pregnancy (not related to direct obstetric determinants) and were aggravated by the physiological effects of pregnancy. Conditions such as anemia, diabetes, malaria, sexually transmitted infections (STIs) including HIV and Aids and others could also increase a woman's risk for complications during pregnancy and child birth. It was submitted that HIV-positive women were more likely to die in pregnancy or childbirth than women without the virus. This was because suppressed immunity resulting from HIV infections caused higher risks of prenatal and childbirth complications

Factors Contributing to Maternal Mortality in Zambia

6.5 Your Committee was informed that, in order to improve women's overall health and mortality outcomes visualised by the MDGs, they must have access to comprehensive healthcare. Therefore, ideal and comprehensive healthcare required health systems that made high quality services accessible, available and affordable at both primary care and referral levels. However, this was not the case in Zambia due to the constraints in the current health system.

a. Quality Healthcare

The stakeholders informed your Committee that poor quality healthcare and unacceptable services were common reasons that women and their families gave for not using available health services. In addition, the deplorable state of various health centres and medical equipment in the country compromised the quality of healthcare received by the women. Further, the inadequate number of midwives in facilities especially in rural health centres also compromised the quality of service delivery. It was submitted that most rural health centres were manned by health providers who were not midwives and did not have midwifery skills. As a result, women resorted to having unskilled traditional birth attendants and relatives deliver them because most health centres did not have qualified health professionals to provide the desired service.

b. Accessibility

Your Committee also learnt that distances to health facilities contributed to the high maternal mortality rates. The stakeholders submitted that women were not able to access antenatal care services, deliveries and postnatal care services provided by skilled health workers because of the geographic barriers especially in rural areas. It was submitted that rough terrain and far distances between communities and health centers further made care seeking difficult.

Your Committee was informed that poor road infrastructure, lack of reliable public transport or access to emergency transportation (ambulances) complicated the situation. These challenges of distance and transportation hindered the referral of patients from level one health centers to referral hospitals for curative services, including comprehensive emergency obstetric and neonatal care. Your Committee learnt that Zambia had a limited number of ambulances in each district to meet the needs of all communities in a timely manner. As a result, women were compelled to seek healthcare services from traditional birth attendants who were more accessible, but were neither competent nor equipped to deal with pregnancy complications. This resulted into deaths that could have been prevented.

c. Availability

Your Committee was further informed that when women arrived at a health center, they were unable to receive the healthcare services they required as most public facilities, especially those serving poor and geographically remote areas, commonly faced limited human resource and a shortage of skilled health providers to provide emergency obstetric care. In addition, there was unreliable supply of health commodities such as drugs and delivery equipment. Furthermore, due to the reported lack of essential supplies, most health centers requested expectant mothers to bring their own supplies for delivery, which included disinfectants, gloves and cotton wool. Despite services at level one public health facilities being free of charge in Zambia, there still remained unaccountable costs to the client.

d. Affordability

Your Committee was informed that in terms of affordability, there was a low level of public expenditure on health regarding maternal health services in particular. It was submitted that pressure to achieve financial sustainability of health services often translated into increased household financial burden through user fees and out of pocket payments among others. Families that were already too poor to pay for normal childbirth procedures were overwhelmed and suffered financial

consequences as they tried to support the cost of emergency medical care. In addition to fees for services, there were other informal or hidden costs that arose when women were asked to buy clinical essentials such as gloves, pegs and drugs.

The stakeholders also submitted the following as factors that further contribute to maternal mortality rate.

e. Cultural Practices

Your Committee was informed that negative cultural and traditional practices such as early marriages further contributed to maternal deaths. It was submitted that early marriages were a serious concern in rural areas where young girls were married off as soon as they became of age. When these young girls became pregnant, they were prone to a number of medical complications such as obstructed labour and obstetric fistula because their reproductive organs were not fully developed.

The stakeholders also submitted that traditionally, women were expected to be attended to by fellow women. However, because some health facilities have male midwives, a number of women shunned away from such health facilities.

f. Lack of Decision Making Power

Your Committee learnt that most women lived in social environments that did not recognise them as equal to men. This limited their autonomy and participation in decision making and constrained their control of assets and participation in the economy. These constraints extended to decision making about health, especially around sexual and reproductive health. The limited decision making abilities by women often meant that a man decided when his wife could get pregnant; when a mother attended antenatal services; when to take up family planning; when to use a condom or even when to have sex.

Government Programmes aimed at Improving Maternal Health

6.6 Your Committee was informed that the Government has shown commitment towards the reduction of maternal mortality by ensuring that the necessary policies and strategic plans were put in place. These policies and plans included:

- National Reproductive Health Policy;
- Maternal Newborn and Child Health Roadmap;
- Countdown Recommendations for Zambia;
- Maternal Neonatal & Child Health communication Strategy;
- Comprehensive Abortion Care guidelines;
- Safe-motherhood Guidelines;
- Family Planning Guidelines;
- Sexual and Gender Based Violence guidelines; and
- Mainstreaming of the Maputo Plan of Action.

In addition, there were plans and policies awaiting printing. These included the following:

- i) Adolescent Health Strategic Plan;
- ii) Reproductive Health Commodities security strategy;
- iii) Sexual and Gender Based Violence Policy; and
- iv) Management of Cancer of the cervix guidelines.

Other Concerns raised by Stakeholders

i) The need for a comprehensive roadmap and plan for maternal, newborn and child health services

6.7 The stakeholders submitted that despite the Government's Commitment of proclaiming priority and support for maternal health, Zambia was yet to see substantial improvements. This was because the current level of mortality and morbidity in women and children was unacceptably high. Therefore, concerns were raised that at the pace the Government was moving, it was unlikely that the MDG5 target would be attained. The stakeholders argued that the target could only be attained once a comprehensive roadmap and plan for maternal, newborn and child health services was implemented. In this regard, they proposed that the Government should draw up a roadmap in collaboration with the Civil Society, the Private sector as well as bi-lateral and multilateral partners.

ii) The need to increase budgetary allocation to the maternal sector

The stakeholders also strongly recommended that the Government through the national budget should increase funding for maternal, neonatal and child health. They argued that the 1% budget allocated to maternal health and delivery on existing commitments and policies had made an insignificant progress in the implementation of maternal health programmes. Therefore, increased investment in health infrastructure was needed to ensure that women in far flung areas accessed facilities and services as well as Safe Motherhood Shelters where they could stay as they waited to be delivered.

iii) Un-Safe Abortion

Your Committee was also informed that unsafe abortion was a major cause of maternal mortality in Zambia.

The stakeholders were of the view that, despite having a relatively strong legal framework regarding access to safe termination of pregnancy compared to other countries within the region, access to safe abortion remained limited. *The 1972 Termination of Pregnancy Act* allowed access to safe abortion on medical and social grounds. The Act further states that three physicians should approve the procedure, which should be performed by a doctor at a hospital (level 1 and above). While the Act is liberal in intention, it was immensely challenging in implementation, especially given the well documented extreme shortfall in human resources for health and inequitable distribution of physicians.

iv) Limited access to youth friendly Sexual and Reproductive Health information and services

Your Committee was informed that Zambia has limited access to youth friendly Sexual and Reproductive Health information and services despite experiencing the largest youth population ever in its history entering their childbearing years. The 2010 Population Census Report revealed that almost half of Zambia's population was under the age of fifteen, with adolescents constituting more than one quarter of the total population. The Report further revealed that many adolescents were sexually active and vulnerable to sexual abuse, pregnancy and sexually transmitted infections because of lack of adequate information about sex, reproductive health and relationships.

Your Committee was informed that an escalating youth population meant that there was need for sexual and reproductive health services. Furthermore, considering the established vulnerabilities and extremely low consistent contraceptive use among adolescents, it was only logical to project that maternal mortality resulting from unsafe abortion would rise with the increasingly young demographics unless targeted interventions were urgently introduced.

v) Lack of Male involvement in Reproductive Health

Some stakeholders were of the view that lack of male involvement in reproductive health further contributed to maternal mortality. This was because most male partners did not support pregnant women and at times impeded women's decisions to seek healthcare.

They argued that the absence of male involvement led to their minimal involvement in the Prevention of Mother-to-Child transmission, Voluntary Counseling and Testing and other women centered health services.

vi) Failure to Publicise the National Reproductive Health Policy

Most stakeholders submitted that the National Reproductive Health Policy aimed at achieving the highest possible level of integrated reproductive health had not yet been disseminated to all stakeholders. They argued that this was the framework upon which the Government could strive to provide the highest level of quality integrated reproductive health for all Zambians.

vii) Lack of Integrated Reproductive, Maternal and HIV Services

The stakeholders further submitted that the lack of integrated reproductive, maternal and HIV services in Zambia was a significant barrier to the appropriate provision of care to women. Alliance Zambia's Baseline Survey revealed that some community members preferred integrated sexual and reproductive health and HIV services. Therefore, a *one-stop shop* for all their sexual and reproductive health needs would save time and travel costs.

Committee's Observations and Recommendations

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

- (i) the maternal health sector continues to be underfunded as evidenced by the inadequate supply of health commodities such as drugs and delivery equipment;
- (ii) the Reproductive Health Policy, which should serve as a major source of guidance for standards in service delivery has not been widely publicised;
- (iii) there is a high unmet need for family planning;
- (iv) the deplorable state of various health centers and medical equipment in the country continues to compromise the quality of health care received by the women;
- (v) the number of health workers in rural health centres is inadequate because trained health workers are concentrated in urban areas which further compromises the quality of service delivery;
- (vi) women in rural areas who are more at risk of maternal deaths due to their low levels of education and social economic status are poorly targeted and underserved with regard to quality health services;
- (vii) there is limited access to youth friendly sexual and reproductive health information and services despite adolescents being the most vulnerable to unwanted pregnancies, abortions and sexually transmitted diseases;

- (viii) most men have not been taken on board with regard to maternal and reproductive health services;
- (ix) the grounds and access to safe abortion should be broadened ; and
- (x) the 1972 Termination of Pregnancy Act is immensely challenging in implementation especially given the extreme shortfall of human resource in the Health Sector and the unbalanced distribution of physicians nationally.

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

- (i) the Ministry of Health must engage Ministry of Finance and National Planning to increase funding towards the maternal health sector;
- (ii) in order to achieve the highest possible level of integrated reproductive health, the Government should immediately disseminate the Reproductive Health Policy to all stakeholders;
- (iii) the Government should scale-up access to family planning especially targeting poorer and less educated segments of the population. The increase in the contraceptive prevalence rate will not only reduce the number of unplanned pregnancies, but also reduce the number of induced abortions. Furthermore, the Government should provide for improved family planning methods, choice and mix, especially the uptake of long-term reversible and permanent methods of family planning. This will also provide for a more sustainable contraceptive prevalence across families and communities;
- (iv) the Government should invest more in developing new infrastructure where it does not exist and refurbish infrastructure that is not functional. The availability of good infrastructure will enable Government provide health services in the most underserved areas of the country;
- (v) the Government should enforce strict measures to ensure that as soon as an individual graduates from a public or private health training institution, it is mandatory for them to serve a year in a rural posting. The failure to serve in these rural postings should be accompanied by a penalty;
- (vi) the Government should develop effective outreach services in order to ensure that underserved women in rural areas have access to quality reproductive health information and services;
- (vii) the Government should develop comprehensive youth friendly sexual and reproductive health services including the full range of contraceptives in order to reduce the increasing number of unwanted pregnancies, abortions and sexually transmitted diseases. Further, the Government should develop a package of care for them covering sexuality education which should be advocated from the family, school and church;
- (viii) the Government should develop programmes aimed at encouraging men to assume increased responsibility for their sexual behavior in order to protect the health and well being of their partners, existing and potential offspring's and the family as a whole;
- (ix) the grounds for legal abortion should be broadened and its access implemented under criteria permitted by existing laws. Furthermore, there is need to ensure

expanded coverage of comprehensive safe abortion care services and popularise the Termination of Pregnancy Act to the general public; and

- (x) the regulations around the Termination of Pregnancy Act should be updated in line with evolving technologies that provide for more safe options and negate the need for three doctors to sign off, given the extreme shortfall of human resources in the Health Sector and the unbalanced distribution of physicians nationally.

SOCIAL PROTECTION FOR THE AGED IN ZAMBIA

Background

7.0 Zambia's older population of sixty years and above was estimated at 2.6% of the total national population. The majority of these people lived in rural areas with no predictable income. They were among the most vulnerable groups and their vulnerability was a great challenge to the Government of the Republic of Zambia and the communities in which they lived. Therefore, social protection had been recognised as a tool that could be used to reduce high levels of poverty and vulnerability among the aged. However, there was growing concern that little was being done to ensure the social protection for the aged in Zambia. It was against this background that your Committee resolved to undertake a study on Social Protection for the Aged in Zambia.

The overall objective of the study was to identify the major challenges in the provision of social protection for the aged in order to recommend the way forward.

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

- i) Ministry of Community Development, Mother and Child Health;
- ii) Divine Providence Home;
- iii) Zambia Episcopal Conference (ZEC);
- iv) Senior Citizens Association of Zambia; and
- v) Platform for Social Protection Zambia.

CONSOLIDATED SUMMARY OF SUBMISSIONS

7.1 Your Committee was informed that social protection referred to policies and practices that protected and promoted the well-being of people suffering from critical levels of poverty and deprivation and/or were vulnerable to risks and shocks. Social protection was also defined as an investment in people that promoted economic growth, social equity and human rights. It reflected the traditional (Zambian) concern for the dignity and well-being of the incapacitated, low-capacity households, children and the elderly in our society as a nation.

Your Committee learnt that, the Zambian social security system concentrated on the formal sector. As such, it left out the majority of people in the informal sector with no social security or protection. Currently, only 65,000 elderly people were receiving a contributory pension that was not sustainable. Therefore, for those who had never been employed, venturing into income generating activities had been difficult, especially for those who settled in rural areas and had limited sources of assistance. This situation contributed to the high old age poverty in Zambia which stood at 80% (Living Conditions Monitoring Household Survey of 2006).

Factors that necessitate Social Protection for the Aged

7.1 Your Committee heard that various factors necessitated the need for social protection for the aged. For instance, social protection for older persons in the traditional society was provided by the community anchored on the extended family. This system, however, had

disintegrated. The situation had been compounded by the impact of the HIV and AIDS pandemic which led to the increased number of orphans, who in most cases were left in the custody of the aged, who had no steady income to support themselves and their dependants. This, further, contributed to the high poverty levels among the aged.

Government's Role in Promoting Social Protection for the Aged

7.2 Your Committee was informed that the Government had put in very little measures in as far as ensuring that social protection for the aged was achieved. This was because social protection spending was viewed as consumption spending rather than an investment.

Your Committee learnt that social protection for the aged in Zambia was currently managed by the Ministry of Community Development, Mother and Child Health. Although the Ministry was largely responsible for addressing the needs of the vulnerable in society, the needs for older persons had not been adequately addressed. This was because the Ministry was inadequately funded.

Your Committee was informed that the Ministry in collaboration with stakeholders developed a draft National Policy on Ageing. This was a reflection of the Government's intentions to protect and promote the rights of older persons and also prepare persons below the age of 60, for old age. However, the policy had not yet been adopted by Cabinet.

The Ministry of Community Development, Mother and Child Health, submitted that they would start developing the multi-sectoral National Social Protection Policy in 2012. The National Policy on Ageing would be harmonised with the National Social Protection Policy to ensure a holistic and well coordinated social protection system for older persons in Zambia.

Your Committee heard that although the Government did not have a specific policy on the protection of older persons, there were various policies that were aimed at protecting the welfare of older persons. These policies included, the National Social Welfare, Disability, Social Security and Gender Policies.

In addition, the Government also developed programmes that brought specific benefits to the livelihood of most elderly people; however, various stakeholders were of the view that these policies and programmes were nowhere near adequate to tackle the problems that were being faced by the aged.

Your Committee was informed that the following social protection programmes were aimed at promoting the welfare of the aged in Zambia.

a) Social Cash Transfer Scheme

Your Committee learnt that the Social Cash Transfer Scheme in Katete District was a universal pension scheme which targeted older persons (60 and above) and provided them with cash transfers. Currently, 5,758 beneficiaries were on the scheme.

In addition, the Ministry of Community Development, Mother and Child Health implemented the inclusive model of cash transfer where the incapacitated and extremely poor households were targeted regardless of their age. Areas such as Kalomo, Monze, Kazungula and Chipata districts where the Inclusive Model was implemented, 60% of the beneficiaries were older persons.

Furthermore in Serenje and Luwingu Districts where the multiple categorical targeting was being implemented, most of the beneficiaries were older persons who provided care to orphans and vulnerable children and apart from being out of employment, had limited self help potential.

In addition, the Child Grant Scheme, which was being implemented in Kalabo, Shangombo and Kaputa Districts targeted older persons keeping orphans and vulnerable children under the age of five years.

However, the biggest challenge with the Social Cash Transfer Scheme was that it was not a national programme. As a result, it was not benefiting many elderly people. Furthermore, the Scheme was highly donor dependent with the Government contributing only about 10% of the total budget.

b) Public Welfare Assistance Scheme

Your Committee was informed that the Public Welfare Assistance Scheme (PWAS) also categorised older persons as being vulnerable, especially in rural communities. It targeted them for assistance in form of food, health care, social assistance and educational support for their grandchildren. The Scheme was being implemented throughout the country and was being administered with the help of Community Welfare Assistant Committees (CWACs) who were responsible for identifying clients, prioritising and delivering the assistance. This Scheme did not directly target the aged, they only benefited from it by virtue of being vulnerable.

c) Homes for older people

These were submitted as institutions of care that looked after older persons in an event that they had no relative or support from the family system. Your Committee was informed that there were nine (9) old people's homes across the country. Two (2) were being run by the Ministry of Community Development, Mother and Child Health while the remaining homes were under the auspices of Faith Based Organisations (FBOs). These homes received grants from the Ministry. However, there were various concerns that these grants were unreliable, making it difficult for the homes to budget.

The following list of old people's homes in Zambia was submitted to your Committee.

| No. | Home | Location | Run By | Capacity |
|------------|-------------------|-----------------|---|-----------------|
| 1. | Maramba | Livingstone | Department of Social Welfare. | 45 |
| 2. | Chibolya | Mufulira | Department of Social Welfare | 35 |
| 3. | Divine Providence | Lusaka | Catholic Nuns | 50 |
| 4. | Mwandi | Sesheke | United Church of Zambia | 20 |
| 5. | Mitanda | Ndola | Salvation Army | 25 |
| 6. | Chibote | Luanshya | Catholic Nuns | 20 |
| 7. | St-Thresa | Ndola | Catholic Nuns | 20 |
| 8. | Likulwe | Senanga | Roman Catholic Church | 15 |
| 9. | Nkhulumazhiba | Solwezi | Peace Embassy International (Pentecostal Church) | 15 |

Your Committee further learnt that the conditions in these homes were deplorable, under financed and in most instances overcrowded. In addition, these old aged homes were very limited in number and could not carter for all the old people that needed care.

d) **Food Security Pack Programme**

Your Committee was informed that the Food Security Pack (FSP) Programme is aimed at empowering the targeted low capacity or vulnerable but viable farming households. The programme provides these households with agricultural inputs in order to ensure that they became self sustained through improved productivity and household food security.

Your Committee learnt that the selection matrix for beneficiaries under FSP had “the aged” as one of its categories, hence the programme captures a number of elderly persons especially in the rural areas where most of them had settled and had limited sources of assistance. In addition, most elderly persons were also benefiting from the programme under the category “households keeping orphans” as most of these orphans and vulnerable children were being looked after by their grandparents, having lost their parents mostly from HIV/AIDS. Apart from increasing food and nutritional security at household level for elderly persons, the programme further enhances their household income through the sale of surplus agricultural related produce and services. This in turn helps address the various financial needs of their families.

However, various stakeholders observed that this programme at times did not reach the right targeted clients, because it offers policies that favoured those that could afford, at the expense of the deserving poor, therefore, defeating the whole purpose.

e) **Health Exemption Policy**

Your Committee was informed that under the Ministry of Health, older persons (65 and above) were exempted from paying user fees. This exemption, however, only allowed older persons to access primary health care services. Furthermore, older persons were prone to chronic diseases associated with old age such as diabetes, hypertension, poor eye-sight, memory lapses and arthritis which required adequately equipped and trained medical personnel in health centres. However, due to most health centres being poorly equipped, older persons were forced to procure or seek medical services from other sources which required payment.

Partnership between the Government and the community on issues of social protection for the aged

7.4 Your Committee was informed that there was existing partnership between the community and the Ministry of Community Development, Mother and Child Health on issues of social protection for older persons. For instance, under the PWAS and the Social Cash Transfer Schemes, it was the communities that identified the beneficiaries on the programmes since they lived within the communities and were, therefore, better placed to identify those in need. In most cases, many older persons were found to be poor and vulnerable.

Your Committee was informed that Associations and Community Based Organisations such as the Senior Citizens Association of Zambia, the Zambia Aged People's Association and the Retirees Welfare Bureau of Zambia who dealt with issues of older persons in communities also partnered with Government.

Despite there being a few partnerships between the Government and community based organisations, many stakeholders were of the view that the Government had to provide a conducive environment for other actors to come on board. With the right policies put in place, there was need for social protection to be a shared responsibility between the Government and cooperating partners with the Government taking the lead. These cooperating partners would complement the Government efforts by ensuring social protection, transparency, accountability in the administration and management of the programmes and schemes for the aged.

Committee's Observations and Recommendations

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

- (i) the Government views social protection spending as consumption spending rather than an investment as evidenced by the Government's inability to ensure that social protection for the aged is achieved;
- (ii) Zambia has no clear policy framework to implement Social Protection. Thus, the implementation of activities on the welfare of older persons, the role of the Government and stakeholders lack clarity and proper coordination;
- (iii) there is no national policy on aging in Zambia, making it difficult to implement coordinated efforts to address the plight of the aged; further, your Committee notes with regret that the draft national policy on aging that has been before Cabinet for some time now has not been approved;
- (iv) the Ministry of Community Development Mother and Child Health, which is responsible for the delivery of social protection programmes in Zambia has continued to receive low levels of funding, making it difficult to implement programmes effectively;
- (v) old age Homes lack adequate funding, are very limited in number and cannot cater for all the old people that need care;
- (vi) the social cash transfer scheme is highly dependent on donor funding from the cooperating partners supporting social protection in Zambia;
- (vii) the Social Cash Transfer which is effective in reducing poverty in the lives of the beneficiaries is not a national programme and, therefore, not many elderly people are benefiting from it;
- (viii) there is insufficient research on issues affecting older persons in the communities to help guide the implementation of programmes that aim at addressing the dynamic needs facing their challenges; and
- (ix) elderly persons in Zambia are not highly involved in planning interventions surrounding their welfare in most sectors.

In view of the foregoing, the Committee makes the following recommendations:

- (i) there is need for a shift in political will in order for the Government to view social protection expenditure as an investment spending and not as consumption;
- (ii) your Committee finds Zambia's inability to have a clear policy framework to implement a Social Protection Policy unacceptable as it fails to guarantee equity in service delivery; and thus, your Committee urges the Government, as a matter of urgency, to formulate a broader social protection policy encompassing both social security and social assistance;
- (iii) the draft policy should be approved and implemented without further delay;

- (iv) the Government through the Ministry of Finance should prioritise funding to the Ministry of Community Development, Mother and Child Health so that social protection programmes can be adequately funded and implemented;
- (v) the Government through the Ministry of Community Development, Mother and Child Health should come up with a robust programme to provide Old People's Homes in all parts of the country; furthermore, incentives should be considered to attract private companies to sponsor Old People's Homes;
- (vi) the Government should devise other ways of raising finances to finance the scheme. Increased Government funding to the scheme will ensure Government ownership which is critical to sustain the programme;
- (vii) the Government should extend the Social Cash Transfer to all parts of the country;
- (viii) the needs and challenges facing old people are diverse and dynamic and thus, the Government is urged, as a matter of urgency, to promote extensive research on older persons in Zambia in order to improve and guide programming; and
- (ix) the participation of vulnerable persons in matters that involve their plight is cardinal for the formulation of effective policy interventions and thus, the Government is urged through the Ministry of Community Development, Mother and Child Health, to work closely with stakeholders to devise measures that will promote the active participation of old people in matters that concern them instead of being passive recipients of handouts.

PART II

FOREIGN TOUR TO THE REPUBLIC OF MAURITIUS

OBJECTIVE

8.0 Your Committee undertook a foreign tour to the Republic of Mauritius, which is one of the countries that has recorded low levels of maternal mortality and has a good social protection programme for its aging population.

The objective of the tour was for your Committee to learn best practices and share experiences with regard to improving maternal mortality in an effort to attain the millennium Development Goal No. 5. In addition, your Committee further wanted to learn from the Republic of Mauritius the best practices for ensuring quality social protection for the aged in Zambia.

In line with the objective of the tour, your Committee:

- a) paid courtesy calls on the Speaker and Clerk of the National Assembly of Mauritius; the Minister of Health and Quality of Life; the Minister of Social Security National Solidarity and Reforms Institutions and the Minister of Social Integration and Economic Empowerment;
- b) had working sessions with officers from the Ministry of Health and Quality of Life; the Ministry of Social security National Solidarity and Reforms Institutions and the Ministry of Social Integration and Economic Empowerment;
- c) interacted with officers from the Mauritius Family Planning and welfare Association and the Corporate Social Responsibility Committee, Housing and Community Development Programme of the National Empowerment foundation; and

- d) visited Le Hochet Community Health Centre and Fire Trochieta Residential care Home for Elderly Persons.

Maternal Health

8.1 Pertaining to maternal health, your Committee visited the institutions set out below.

a) Committee's visit to the National Assembly of Mauritius

Your Committee visited the National Assembly of the Republic of Mauritius and had the privilege of meeting the Clerk of the National Assembly, Mr. R R Dowlutta and also paid a courtesy call on Hon Rajkeswur Purryag, GCSK, GOSK, Speaker of the National Assembly.

The Hon Mr Speaker welcomed your Committee and informed the Members that the Republic of Mauritius gained its independence in 1969. During that time, the country was under-developed with 97% of its Gross Domestic Product (GDP) coming from the production of sugar. Because of the concern of rapid population and resource limitations in its island nation, the Government adopted the family planning programme whose objective was to slow the reproductive rate in the country. Therefore, the country emphasised on contraceptive use and treated the access to health as the fundamental human right it is. As a result, health services were widely accessible through the extensive network of hospitals, clinics and community health centres.

The Hon Mr Speaker also informed your Committee that maternal health in Mauritius was considered an investment and not a huge consumption. In view of this, Governments expenditure on maternal health was increased. This expenditure was allocated in such a way that the money was allocated where the greatest need for interventions across the maternal and reproductive health care was. In addition, there was accountability in the activity based budget to ensure that money allocated to a specific programme was utilised for the intended purpose and not misapplied.

Further, the Government showed commitment and consistency in programmes aimed at improving reproductive health. This guaranteed the continuous delivery of better health services to the people and the Governments achievement of the desired results. In addition, the Government had developed its own local networking across the reproductive and maternal health continuum of care in order to avoid heavy reliance on foreign aid and other donor based initiatives. This ensured the continuous and holistic programming in maternal health.

The Hon Mr Speaker further emphasised on the need to fight corruption in order to reduce poverty. He explained that many countries worldwide, failed to address key areas of concern in their economies because of corruption. Therefore, corruption had to be eliminated completely.

b) Committee's courtesy call on the Minister of Health and Quality of Life, and the working session with officers from the Ministry

Your Committee further paid a courtesy call on Hon Lormus Bundhoo, Minister of Health and Quality of Life and interacted with officers from the Ministry. Hon Bundhoo pointed out to your Committee that the greatest asset that the Republic of Mauritius had was the education of its people. He said the Government had made education not only compulsory but also free from primary to tertiary. Therefore, every parent was compelled to take their children to school.

Your Committee learnt that because of the high levels of literacy, most women were able to make the best decisions concerning their health. They understood the importance of delivering from health institutions under skilled personnel and moved away from traditional practices of giving birth in their homes under unsafe conditions where they were prone to maternal complications such as obstructed labour and haemorrhage.

Further, your Committee was informed that the Republic of Mauritius has succeeded in the reduction of maternal mortality because most projects regarding reproductive health were Government driven. The Government was ardent in providing family health services free of charge irrespective of the populations' social economic status. As a result, the Government has shown commitment and consistency in programmes aimed at improving reproductive health. The commitment, therefore, guaranteed the Governments continuous delivery of better health services to the people.

Further, the Government through the Ministry of Health and Quality of Life has decentralised community health centres, area health centres and regional health centres in every district of the country. This brought health services closer to the people. As a result, women were not subjected to walking long distances in search of health services.

In addition, the Government of Mauritius has invested a lot of money in infrastructure development. The availability of good infrastructure enabled the Government to provide health services in the most underserved areas of the country.

Your Committee was further informed that apart from strengthening health care systems in Mauritius, one of the most effective interventions for the attainment of the highest level of reproductive health, was the promotion of family planning. Contraceptive use did not only reduce the number of unplanned pregnancies but also the number of induced abortions. In addition, some contraceptive methods prevented sexually transmitted infections, including HIV. Owing to this fact, various methods of contraceptives were widely accessible in all health centres and these methods were free of charge.

Your Committee further learnt that the Government was now targeting adolescents who constituted the most vulnerable group of the Mauritian society given the increasing number of unwanted pregnancies, abortions, AIDS/STDs among others. In this regard, the Government was constantly developing new strategies and programmes aimed at responding to the changing realities of young people's lives and involving them in the designing of such programmes. Further, the Government through the Ministry conducts door to door campaigns, holds community talks on the benefits of family planning targeting both girls and boys of adolescent age and buys air play on both radio and television.

Your Committee was informed that Mauritius attributes its success to the fact that apart from international indicators, the country has developed its own indicators across the reproductive and maternal health continuum of care. This enabled the country to monitor its own indicators and follow the progress that they were making regarding their reproductive health. It was these indicators that has helped the Government identify where the greatest need for intervention was.

Further, the Government ensures consistency in the maternal death reviews from the community to the national level. The consistency in these statistics helps to identify the gaps in the maternal health continuum of care. These gaps also help the Government to make recommendations for future programmes and policies.

Your committee learnt that when a maternal death occurred, the Government put up an inquiry in order to identify the cause of death. This was done in order to reduce the risk of reoccurrence as well as guarantee the continuous delivery of better health services.

Further, Hon Bundhoo emphasised on the need to exercise good governance at all stages of development because the quality of Governance plays a vital role in the economic development of a country. One of the attributes of good governance was for the Government to have unified views with other political parties in the service delivery of the country, regardless of different political interests.

c) Le Hochet Community Health Centre

Your Committee visited Le Hochet Community Health Centre in Terre Rouge where they were welcomed and briefed by the Principal Midwife, Ms Naslini Parasram.

Ms Parasram informed Your Committee that the health status of the Mauritian population enjoyed sustained and significant improvements. This was because the Government was dedicated to providing quality health care in the country.

Your Committee was also informed that the Government provided universal access to reproductive health services through a network of accessible health care delivery institutions (community health centres, area health care centres and regional hospitals) spread across the country. These institutions were well equipped with the necessary equipment and skilled manpower.

Further, your Committee was informed that every pregnancy in Mauritius was considered a risk and it was for this reason that Government strengthened access to antenatal care services, deliveries and postnatal care services.

Your Committee was informed that in 1960, women in Mauritius had no supervision during the pregnancy and were seen for the first time by untrained labour attendants when they went into labour. The outcome was often disastrous with high rates of complications sometimes resulting in the death of the mother and/or baby. This increased the rate of maternal and infant mortality.

Your Committee learnt that routine antenatal care services and the availability of trained midwives has dramatically changed this situation for the better. This was because antenatal visits enabled trained midwives monitor the pregnancy and identify patients who would develop problems so that appropriate treatment could be instituted.

Pregnant women were made to fill in an obstetric sheet at their first antenatal visit. The obstetric sheet enabled midwives learn more about the patient and her pregnancy. The information obtained from the obstetric sheet enlightened midwives on the patients present medical condition, surgical history if any, genetic history, allergies the patient might have, the type of contraceptives being used and whether the patient was or had suffered any complications during her previous pregnancies among others.

In addition, physical tests such as the measurement of the mother's blood pressure, weight and height measurements, dental check-ups urine and blood tests were carried out in antenatal clinics at every community health centre. Further, pregnant women were given iron and calcium tablets and were vaccinated against tetanus 14-16 weeks of their pregnancy.

Your Committee was further informed that women were routinely tested for HIV as part of their antenatal blood tests. However, the testing was only taken with the patients' consent. Before the testing, the patients underwent pre-testing counseling and post-testing counseling when results were positive. A woman who was HIV positive could transmit the virus to her baby either through the placenta, during childbirth or through breast milk. Therefore, it was important for the baby's health that the mothers HIV status was known because steps could be taken to reduce the chance of transmission to the baby.

Furthermore, midwives conducted health education where pregnant women were taught the basics of hygiene, nutrition and the dangers of smoking and alcohol consumption during their pregnancy.

Your Committee was informed that the highest level of authority at community health centres was a registered medical officer. Therefore, when the community health centre had a complicated pregnancy they could not handle, they referred their patients to area health centres that were more equipped and had gynecologists. If the complication was difficult to compound at the community health centre, the patients were transferred to the biggest hospitals in the region where all deliveries were made.

Once the pregnancy was safely delivered, mothers were offered post natal care services to ensure that no complications had developed with the woman after childbirth. Further, women were educated on the elements of child care, the need for family planning and the importance of birth spacing.

Your Committee was further informed that in an effort to encourage mothers to have their babies vaccinated, the Government introduced a cash gift savings scheme where 200 rupees was paid to each child that was vaccinated. A voucher was given to mothers in the name of the child and the child could only access the money once they were 18 years of age.

d) Committees Interaction with Officers from the Mauritius Family Planning and Welfare Association

Your Committee was informed that Mauritius Family Planning and Welfare Association (MFPWA) was a non-governmental, non-profit reproductive health organisation. The organisation was specialised in the provision of quality sexual and reproductive health care to all segments of the Mauritian society through various strategies including education and counseling, networking, research, training, advocacy, demonstration of practices and the provision of clinical services.

Your Committee was informed that the Republic of Mauritius in the late 1940's had a population growth of 3%. During this period, the country was under developed with limited resources to cater for the requirements of the population. Because of the concern with rapid population growth and resource limitations in the country, a grass root movement was started by the Association in 1957. The objective of the movement was to slow the crude reproduction rate. Therefore, the first family planning clinic was started on a voluntary basis.

Your Committee was informed that the Association had met considerable opposition, especially from religious groups in the years following its formation. Despite opposition, the grass root movement widely campaigned for the use of contraceptives through public meetings, press campaigns, road shows, plays and sketches throughout the country sensitising the public on the importance of family planning and birth control. Further, a lot of advocacy was done through policy makers to introduce family planning and birth control programmes and policies in the development agenda of the country.

As the programme was successful, there were changes in the mentalities of religious views and the Government began to fund the Association in 1965. As a result, there was a creation of centres and branches throughout the country and this saw an impressive decrease in the population growth from 3% to 1.3%.

Your Committee was informed that in looking at the success of the Association and the benefits women and men had, the Government integrated all family planning programmes in the Government health services. Further, the Republic of Mauritius was awarded the United Nations Population award for its population and growth control programme in 1990.

The Republic of Mauritius had, therefore, been cited as one of the success stories in the African region. The Country had been quoted as one of the countries with the highest contraceptive prevalence rate of 79.5 percent. Further, the country had also been quoted as one of the countries with the lowest total fertility rate of 1.4 in the African region due to its strong emphasis on contraceptive use.

MFPWA through the Government also strived to ensure that every individual enjoyed full sexual and reproductive health rights. Further, sexual and reproductive health services had been made available, accessible and affordable to all, irrespective of the sex, age and creed.

The Committee learnt that outreach services have been provided in hard to reach parts of the country in order for underserved women to have equal access to sexual and reproductive health information and services. Furthermore, the Association had encouraged male involvement in family planning so they could become part of the sexual and reproductive health programmes and services.

In addition, your Committee was informed that the country attributed its success in reproductive health due to the receptiveness of the community to the programmes developed by the Government. Community

participation motivated the Government to devise and initiate more strategies in the sexual and reproductive health services of the country.

Further, MFPWA through the Government has integrated HIV prevention interventions, such as voluntary counseling and testing for HIV into sexual and reproductive health services including the provision of mother to child transmission services for HIV infected pregnant women.

In addition, action has been taken to confront and address gender based violence and to provide protection and support to victims of violence.

Your Committee was further informed that programmes in the sexual and reproductive health sector has been designed in such a way that they targeted the needs of specific stakeholders as opposed to a blanket programme that strived to address the needs of various stake holders.

Most importantly, the Mauritian Government strives to ensure that most programmes undertaken in sexual and reproductive health are research based. A well-conducted research was vital to the success of health endeavors because research enabled Government to pursue an in-depth original study about a topic of interest.

It came to the attention of your Committee that pursuing research on these programmes was challenging but rewarding because research gave the Government hard data on which they could base their decisions.

Committee's Observations

8.1.1 In view of the foregoing, the Committee observes that:

- (i) the Mauritian Government considers maternal health as an investment and has since increased its budget allocation on maternal health in order to address the maternal health problems;
- (ii) the Republic of Mauritius has developed its own local networking across the reproductive and maternal health sector in order to avoid heavy reliance on foreign aid and other donor based initiatives;
- (iii) the Mauritian Government has invested a lot in infrastructure development;
- (iv) the Government of Mauritius highly emphasises on contraceptive use regardless of age, gender and creed;
- (v) the Mauritian Government has shown commitment and consistency in designing programmes aimed at improving reproductive health;
- (vi) the Mauritian Government has strived to ensure that most programmes undertaken in sexual and reproductive health are research based;
- (vii) the Government of Mauritius develops new strategies and programmes aimed at responding to the changing realities of young people's lives and involves them in the designing of such programmes;
- (viii) sexual and reproductive health services in the Republic of Mauritius has been made available, accessible and affordable; and
- (ix) the Government of Mauritius ensures consistency in the maternal death reviews from the community to the national level;

Committee's Recommendations

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

- (i) the Zambian Government should demonstrate political will by increasing expenditure on maternal health in order to promote continuous and holistic programming;
- (ii) the Zambian Government should emulate the Republic of Mauritius by developing its own locally grown indicators across the reproductive and maternal health continuum of care to be able to monitor its own indicators and follow the progress being made regarding reproductive health; these indicators will also help the Government to identify where the need for intervention will be great;
- (iii) the Government of Zambia should also invest in infrastructural development as this will take health services closer to the people. The availability of good infrastructure such as good roads and modern health centres will enable expectant mothers access quality health services in the most underserved parts of the country;
- (iv) the Government of Zambia should strongly emphasise on contraceptives use regardless of age, gender and creed especially in rural areas where access to contraceptives is limited;
- (v) the Zambian Government should demonstrate commitment and consistency in programmes aimed at improving reproductive health in order to guarantee the continuous delivery of better health services to the people;
- (vi) the Government should invest heavily in sexual and reproductive health research upon which concise decisions will be made based on empirical data;
- (vii) the Government should prioritise adolescents' and young women's needs by creating policies, programs and guidelines to reduce on the impact of unsafe abortion; the Government should further provide comprehensive sexual education and sexual and reproductive health services for young people and should involve them in the implementation process;
- (viii) the Government should ensure that sexual and reproductive health services are made accessible, available and affordable at both primary care and referral levels in order to improve women's overall health and mortality outcomes visualised by the MDGs;
- (ix) the Government should take significant steps to establish a registration system for the number of maternal live births to deaths and the causes of death; the consistency in these statistics will help the Government identify gaps that need immediate attention;
- (x) the Government should consider involving the private sector as key partners in planning, decision-making and resource mobilisation in matters related to maternal, newborn and child health; and
- (xi) the Government should further ensure a regulatory framework to guarantee within the private sector, quality of maternal neonatal and child health services, training of private health care workers and availability of commodities for family planning and reproductive health.

Social Protection for the Aged

8.2 Pertaining to the social protection for the aged, your Committee interacted with officers in the ministries set out below.

e) Committee's Courtesy Call on the Minister of Social Security National Solidarity and Reforms Institutions and had a working Session with Officers from the Ministry

Your Committee was informed that senior citizens in Mauritius were considered to be citizens who attained the aged of sixty. These approximately constituted 11-12% of the total national population of 1,303,717.

Your Committee was informed that the Government of Mauritius had developed a National policy on aging. The main objective of the policy was enhancing the quality of life of the elderly. This policy was frequently updated in order to define new programmes and strategies concerning the welfare of the aged.

Your Committee was informed that the National Pensions Act provided an extensive social security for elderly persons. Elderly persons aged sixty years and above were provided with a Basic Retirement Pension on a universal basis. This pension varied according to age. The older the individual, the more money he/she was paid. Further, upon receiving this pension, elderly persons were issued with bus passes for free rides on public transport. This facilitated their mobility.

In addition, the Contributory Retirement Pension of a Social Insurance Scheme ensured a reasonable standard of living after the retirement of employees in the private sector at the age of sixty-five. There was also a category of elderly persons who were severely disabled and bed ridden. These needed helpers to take care of them. Therefore, the National Pensions Act provided for a Care-givers Allowance for such vulnerable individuals to enable them employ trained care-givers to look after them. However, this pension was decided by the Medical Board at the Ministry of Social security National Solidarity and Reforms Institutions following certain criteria.

Your Committee was further informed that the Social Aid Act provided social assistance on a means tested basis to the elderly. For instance, there was a category of elder persons who received a Basic Retirement Pension that were leaving alone, paying rent and had no other sources of revenue. Such categories were entitled to a rent allowance. Further, Food Aid in the form of rice and flour was also provided to the needy and elder persons.

In addition, elderly persons were issued with free wheelchairs, free spectacles, free hearing aids, and free dentures and were vaccinated against influenza at the beginning of each winter season.

Your Committee was informed that the Republic of Mauritius has ninety-six centenarians the oldest being 110 years old. The Ministry of Social Security National Solidarity and Reforms Institutions policy on Centenarians was aimed to provide added protection and welfare to the Centenarians. On the occasion of their 100th birthday, the ministry not only celebrated their birthday but also gave them cash gifts. In addition, a Centenarians club has been set up for them.

Your Committee was further informed that the Ministry of Social security National Solidarity and Reforms Institutions was also funding twenty-one Homes for elderly persons. Among these Homes was the Centre for Severely Disabled Elderly Persons. This centre caters for thirty-two severely disabled elderly persons who were bed ridden. The Ministry ensured strict control over these institutions with a view to ensuring that legal norms and standards were respected. Further Private Residential Care Homes were provided under the Residential Care Homes Act 2003. It was mandatory under the appropriate regulations of the Act to have a license to run a Home registered by the ministry. These Residential Care Homes were strictly monitored in order to ensure that they abided to the respected standards. If the standards were not met, immediate closure was recommended by the Ministry.

The Ministry also has a special medical unit with trained medical personal that provided special additional healthcare for elderly persons apart from the universal free healthcare in the country. Elderly persons aged ninety years and above were provided with free monthly medical visits by medical personnel from the medical unit of the Ministry. Medical visits on request were further provided for disabled elderly persons aged seventy-five years and above. In addition, the Prime Minister was dedicated to set up a special hospital for the elderly.

Your Committee was further informed that Government offers training in Gerontology. This course was not only extended to people currently working with the elderly but also those wishing to pursue in such a career. Further, Government through the ministry ensured that people working with elderly persons in care Homes were trained care givers.

Mauritius in addition has a *Protection of Elderly Persons Act* that is aimed at protecting elderly persons from all types of abuse; physical, emotional and social. This Act was enforced with the help of the social security offices widely spread across the island.

Furthermore, there was community participation through Committees such as the Monitoring Committee for the Elderly, the Welfare and Elderly Persons' Protection Unit and twenty Elderly Watch Committees spread across the country who reported cases of abuse to the ministry. In addition, civil society further assists Government in the management of some of the Homes.

Your Committee was further informed that the Republic of Mauritius has a Senior Citizens Counsel whose main objective was to provide for the social, cultural, recreational needs and the general welfare of the elderly to compliment the financial benefits already provided to them by the ministry. The ministry in collaboration with the Senior Citizens Council has set up 600 Senior Citizens Associations throughout the country, therefore, they highly advocated for themselves. These associations' organised seminars, workshops and talks on ageing issues, held courses in Information Technology, talks on Healthcare, Protection of Elderly Persons and helped in the creation of new Associations among other functions.

In addition, your Committee was further informed that the Island of Mauritius has two recreational residential centres with a bed capacity of 100, where elderly persons came in through associations. In addition, eleven day care centres have been set up throughout the country where the elderly could stay during the daytime while their children were at work and their grand children at school. These elderly persons were kept busy in the company of their peers by engaging in leisure and recreational activities under the supervision of trained care-givers.

f) Committee's Visit to Fire Trochieta Residential Care Home for Elderly Persons

Your Committee also visited Fire Trochieta Residential Care Home for severely old people above the age of sixty. These elderly people were severely disabled and were bed ridden. They were admitted to this home because their families were unable to take care of them due to their fragile state.

Your Committee learnt that admission to the home was through applications written by relatives to the local social security offices which were approved by a Board at the Ministry of Social Security, National Solidarity and Reforms Institutions.

The main objective of the Home was to develop the autonomy of the orderly persons by giving them all the specialised medical and social care.

Your Committee was informed that the centre has two living units, one for men and the other for women with a bed capacity of thirty-two.

Further, the management of this Residential Care Home was, through partnerships with the Government, the Ministry of Social Security, National Solidarity and Reforms Institutions and Non-Governmental Organisations (NGO). The NGOs supplement Government by managing the day-to-day running of the

home while the Ministry provides the expertise of dedicated trained staff sent from the medical unit of the Ministry.

Your Committee was informed that the Home has a physiotherapy room where physically disabled children from special schools in need of physiotherapy have sessions. These children were referred to the Home by the disability unit from the Ministry of Social Security, National Solidarity and Reforms Institutions.

g) Courtesy call on the Minister of Social Integration and Economic Empowerment

Your Committee further paid a courtesy call on Hon Surendra Dayal, Minister of Social Integration and Economic Empowerment. Hon Dayal, informed your Committee that the Ministry of Social Integration and Economic Empowerment was a new Ministry that was created in 2010 and its vision is to eradicate absolute poverty. The Ministry has been restructured along four pillars, namely:

- a) Child and Family Development;
- b) Placement and Training;
- c) Social Housing; and
- d) Community Empowerment.

a) Child and Family Development

The Programmes under the Child and Family Development pillar has been strengthened to provide maximum support to ensure the welfare of vulnerable children and their families.

This programme was developed to ensure that every Mauritian child coming from families whose combined monthly income was less than 6,200 Rupees (600) had the right to education. In view of this, the Ministry has a series of support for school children. For instance, the Ministry adopts children as early as three months old and educates them from kindergarten to primary and upper primary for a period of five years. These children are supported with educational materials and school uniforms because they believed education empowered a child and would alleviate poverty. Furthermore, children under this programme were provided with life skill training such as the need to respect the family, the community and protect the environment.

b) Placement and Training

Your Committee was informed that among the beneficiaries of this programme were individuals who were trained but not employed. Therefore, the ministry searched for employment for such individuals by virtue of inviting potential employers to consult the foundation when in need of human resource. Further, the foundation paid employers to provide on the job training for the beneficiaries in a formal recognised course for a period of six months on half pay. After six months, the employer was required to take on board at least 60% of the trained personnel for another period of seven months. This training enabled the beneficiaries acquire at least 13 months of formal training recognised and approved by the Mauritian Qualifications Authority. Following the training, one was able to put themselves in a more employable state than before.

Furthermore, among the beneficiaries of this programme were also individuals who were not trained. Therefore, the foundation outsourced them mainly to private training institutions that were formally accredited by the Mauritian qualifications authority in order to facilitate their employment.

c) Social Housing

Your Committee learnt that this programme applies to vulnerable groups in the community whose monthly income was less than 6,200 Rupees (US\$200) and could not afford to buy land or own a

house. Such families were identified by social workers from the Ministry and different types of houses were built for them depending on their levels of vulnerability.

d) Community Empowerment

Under this programme, your Committee was informed that the Government built infrastructure such as drainages, roads, electricity and water supply in deprived regions of Mauritius. Further, the Government under this programme also maintained the already existing infrastructure.

Your Committee was informed that the above mentioned programmes were a holistic approach to get rid of absolute poverty and eliminating all sorts of discrimination so that people under the poverty line feel part and parcel of the development process of Mauritius.

h) Committees' Interaction with Officers from the Corporate Social Responsibility Committee, Housing and Community Development Programme of the National Empowerment Foundation

Your Committee further interacted with officers from the Corporate Social Responsibility Committee; Housing and Community Development Programme of the National Empowerment Foundation.

Your Committee learnt that the National Empowerment Foundation was a non-profit making Government-owned company that operated under the guidance of the Ministry of Social Integration & Economic Empowerment. The Foundation was fully funded by the Government with 30 million dollars allocated to it through the national budget, and the parent ministry disbursed the money to the Foundations cash flow requirements; projects under the Foundation and servicing the beneficiaries.

Your Committee was informed that the Foundation did not have specific programmes targeting old people; however, other programmes indirectly targeted them.

The Foundation's mandate was to reduce poverty through socio-economic empowerment of vulnerable families with a view of ensuring their integration in the mainstream of society.

In this respect, the Foundation provides services to:

- i) promote child and family development through integrated community development programmes;
- ii) improve the living conditions of vulnerable Mauritian families through the provision of social housing and community development; and
- iii) enhance employment through placement and training of the unemployed.

i) The Corporate Social Responsibility

Your Committee was informed that the Corporate Social Responsibility was a concept whereby the Government of Mauritius has established a policy with the overall objective of mandating registered profitable companies to pay 2% of their book profit towards programmes that contribute to the social and environmental development of the country. These Companies were mainly global entities.

The main advantage of this concept was that it was tax charged by the Government, left in the hands of the private sector and managed by the company under the guidance of the Corporate Social Responsibility (CSR) Committee set up by the Ministry of Finance. The CSR Committee comprises three main actors. These actors include representatives from the private sector, civil society and the public sector.

Your Committee was informed that these companies were mandated to remit their profits into a CSR fund. However, some big players were authorised to bank the money with the National Empowerment Foundation who ran programmes, approved by the companies, and aimed at eradicating poverty in Mauritius. The specific objectives of the Fund are to:

- a) encourage companies to manage their own programmes, impacting the intersection of economic with social and environmental development;
- b) facilitate the contribution of companies to support existing approved National Programmes implemented by Companies, national agencies or NGOs; and
- c) promote a functional community on NGOs with complementary work plans that were relevant to the national development programme.

Your Committee was informed that companies use the Corporate Social Responsibility Fund in the following ways:

- (i) implement an approved programme by the Company;
- (ii) finance the project of an approved NGO;
- (iii) implement an approved programme under the National Empowerment Foundation; and
- (iv) implement projects in collaboration with public sector organisations.

In addition, your Committee was informed that the approved programmes should fall in one of the following areas of intervention:

- a) social housing;
- b) absolute poverty and community empowerment;
- c) welfare of children from vulnerable groups; and
- d) prevention of non-communicable diseases.

Further, your Committee was informed that private sector companies and public sector organisations, including Government ministries and departments and parastatal bodies, would pool their financial and human resources to carry out projects approved under the CSR guidelines and which were funded partly under CSR and partly by public (NEF) funds.

ii) Housing and Community Development Programme

The housing and community development programme was one of the three pillars of the National Empowerment Foundation. Under this programme, social workers under the Foundation identified families living below the poverty line in need of houses.

Your Committee was informed that there were some families who did not have money to buy land for the construction of their own houses, but had relatives who owned land. Such families asked their relatives to build temporal structures on their land for a period of five years in order to enable them have a roof over their head. For such families, the Foundation constructed twenty-two meter square coregated iron sheet houses that cost sixty five thousand Rupees per unit. These houses were free of charge with no refund required.

Further, there were families who owned land, but could not afford to construct a more permanent structure. For such families, the Foundation built twenty five meter square concrete houses that cost one hundred and sixty five thousand (165,000) Rupees for each unit. Your Committee was informed that families under this programme were required to refund the Foundation an amount of thirty

thousand (30,000) Rupees at a rate of five hundred (500) Rupees a month over a period of five years. These housing units were funded with the input of the CSR. The CSR contributed 90,000 Rupees towards the construction of these houses with another 75,000 Rupees coming from the National Empowerment Foundation.

Your Committee was further informed that the Foundation have cases where families were squatting on state and private land because they had no land. For such cases, the Government identifies State land where an integrated village is set up with full concrete housing units. Further, the Government provides all the necessary infrastructure such as drainages, roads electricity plants and water supplies, schools, daycare and recreational centres among others. Beneficiaries of these villages are required to repay one third of the total amount spent to construct these integrated villages. The two hundred and fifty thousand Rupees has to be paid over a period of twenty years. These integrated villages were fully funded by the National Empowerment Foundation.

In addition, there were some families living within a particular area living below the poverty datum line. Such areas were devoid of infrastructure such as roads, drainages, safe drinking water, electricity plants and recreation centres. Therefore, the Foundation identifies the need for infrastructure development in such pockets of poverty in order to reduce the vulnerability of the families living in such areas.

Your Committee was informed that beneficiaries of these housing units were required to sign social contracts in which they were mandated to take their children to school, have regard for the environment and live in harmony with the community.

Committee's Observation

8.2.1 In view of the above, your Committee observes that:

- (i) the largest portion of the Mauritian National Budget (16%) is allocated to the Ministry of Social Security, National Solidarity and Reforms Institution to enable it implement policies and programmes targeting different vulnerable groups among them being the aged;
- (ii) the Government of Mauritius has developed a national policy on aging;
- (iii) the Government of Mauritius has created a special medical unit under the Ministry of Social Security, National Solidarity and Reforms Institutions with trained medical personal that provides special additional healthcare for elderly persons apart from the universal free healthcare in the country;
- (iv) the private sector in Mauritius has complemented Government efforts in the running of homes for the elderly persons; and
- (v) the Government of Mauritius offers training in gerontology (a scientific study of old age).

Committee's Recommendations

8.2.2 In view of the foregoing, the Committee recommends that:

- (i) the Government should increase the budget allocation for the Ministry of Community Development Mother and Child Health in order to facilitate the implementation of various programmes and policies;
- (ii) the National Policy on Ageing in Zambia should immediately be approved by the Cabinet in order to implement coordinated efforts to address the plight of the aged. This policy should be frequently updated in order to define new programmes and strategies

concerning the welfare of the aged;

- (iii) the Government should emulate the Republic of Mauritius by creating a medical unit at the Ministry of Community Development, Mother and Child Health;
- (iv) social protection for the aged in Zambia should be a shared responsibility between the Government and cooperating partners with the Government taking the lead. The private sector should be allowed to run old age homes under the guidance of the Ministry of Community Development, Mother and Child Health. These homes should be managed by trained care givers and frequently monitored by the Ministry ; and
- (v) the Government should offer training in Gerontology and ensure that people working with elderly persons in old age homes are trained carers;

PART III

CONSIDERATION OF THE ACTION TAKEN REPORT ON THE REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE FIFTH SESSION OF THE TENTH NATIONAL ASSEMBLY

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

The Status of Mental Health Services in Zambia

9.1 Your previous Committee had recommended that the Mental Health Policy should be reviewed and implemented in order to improve service provision in the sector. In reviewing the policy, your Committee urged the Government to consider removing the restrictions on the mental health drugs for prescription in order for them to become readily available in health facilities at all levels of health care.

It was reported in the Action-Taken Report that the Government had taken note of the recommendation by your Committee to review the National Mental Health Policy for Zambia developed in 2005, in order to bring mental health services in tandem with the changing political, social and economic environment at global, regional and local levels. Furthermore, in order to address this concern, a Technical Working Group had already been appointed and was studying the Policy on Mental Health in order to make recommendations to Government on the areas requiring review.

With regards to removing restrictions on mental health drugs prescription in order to improve availability in health facilities, the Government had requested your Committee to note the following, as they related to access to the basic psychotropic medication:

- (i) although all psychotropic drugs were under the Dangerous Drugs Act and their prescription by law was restricted to specialised practitioners such as Psychiatrists, Clinical Officers, Psychiatry and Registered Mental Health Nurses, the practice on the ground was that all health care providers with authority to prescribe drugs were doing so. These included Medical Officers, Clinical Officers, General and Registered Nurses.
- (ii) in view of the fore-going, the policy direction as articulated in the Mental Health Policy of 2005 was that "Government shall ensure the availability of cost-effective drugs for Mental Health Services throughout the health care system" and this was what was being implemented.

Recommendations

Your Committee requests a progress report on the findings of the Technical Working Group.

9.1.1 Your previous Committee had urged the Government to urgently enact a law that would be acceptable to all stakeholders. The law had to provide for minimum standards of mental health infrastructure in order to ensure that persons with mental disorders were treated with dignity as human beings. This would be a solution to the current situation where certain mental institutions were like prisons.

It was reported in the Action-Taken Report that the Ministry of Health (MoH) had considered the recommendation to enact a law that provided for the individual rights and privileges of people with mental illness, mental disability and mental impairment as an absolute emergency. To this effect, the Ministry of Health in 2008 had embarked on the process to review and amend the *Mental Disorders Act Cap 305 of 1951*. In this regard there was now a draft *Mental Health Bill (2011)* undergoing editing for submission to the Ministry of Justice. The drafting process had received maximum input from stakeholders and this had been done in a consultative manner drawing consensus at every level of the development process. The New *Mental Health Bill* would be presented to Parliament in its forth coming session.

Recommendations

Your Committee requests to know when the New Mental Health Bill will be presented to Parliament.

9.1.2 Your previous Committee had recommended that funding to the health sector and mental health sector in particular should be increased.

It was reported in the Action-Taken Report that the Government had noted the observation of your Committee on the funding for mental health services as being relatively low. The Ministry of Health in its next planning cycle for the year 2012-2014 and beyond had earmarked an increased budget allocation to Mental Health Services as one of the key considerations.

Recommendations

Your Committee requests detailed information on the comparative analysis of the 2011 and 2012 mental health sector budget in order to confirm that the funding was considered in the planning cycle.

9.1.3 Your previous Committee had recommended that the Government should develop adequate infrastructure for the provision of mental health services and renovate the existing dilapidated infrastructure. In addition, the Government should establish at least one rehabilitation centre in each province and ensure that mental health services were integrated into primary health care in order for them to be easily accessed by all those who required them.

It was reported in the Action-Taken Report that the Government was constructing district hospitals in all districts that did not have such a facility. The new redesigned district hospitals had purposely included a mental health unit. Furthermore, the Ministry had commenced rehabilitation of infrastructure for the delivery of mental health services country wide starting with the National Referral Hospital at Chainama in Lusaka. The programme would be rolled out to other provinces in the 2011-2015 Medium Term Expenditure Framework.

Furthermore, the Ministry had taken the following measures with regard to the integration of Mental Health at primary Health Care Level:

- (i) production and dissemination of a policy brief to stakeholders on the integration of Mental Health Services in Primary Health Care (April, 2011);
- (ii) provisions of annual training on management of mental disorders in primary care. The first training was done in August, 2010 and was supposed to be followed up with a review of its implementation status in August, 2011. Though this activity was planned for August, it was necessary to reschedule it to 28th November, 2011 as it was coinciding with another programme. The assessment would cover all provinces where the training was provided;
- (iii) training of Health Care providers in the management of patients with alcohol and drug abuse. The target was to train over one thousand health care providers by the end of October, 2011; and
- (iv) developing of guidelines in Mental Health diagnosis and treatment for general Health Care workers. A draft document had so far been prepared awaiting stakeholders input when funds were available for the exercise.

Recommendations

Your Committee requests a progress report on the rolling out of the rehabilitation of infrastructure to other provinces and the establishment of rehabilitation centers.

9.1.4 Your previous Committee had recommended that the Government should put measures in place in order to train and retain mental health workers, especially psychiatrists, social workers, occupational therapists, clinical officers and nurses.

It was reported in the Action-Taken Report that the Ministry of Health had been following a methodical approach to human resource development for Mental Health. In 2005, the Ministry started direct entry training for Clinical Officers in Psychiatry and had Registered Mental Health Nurses as opposed to upgrading the existing nurses and clinical officers to psychiatry. This programme was aimed at increasing the number of Clinical Officer Psychiatry in a short time. These categories were expected to provide the necessary backstopping for the provision of Mental Health Services in Health Centers at first and second level referral hospitals. So far, more than Two Hundred had been trained and posted to health facilities country wide.

The Ministry had further commenced the Post graduate training programming for Medical Officers for Masters in Medicine (Psychiatry) at the University Of Zambia School Of Medicine. Currently, there were six students in training. The programme implied that the Government would be producing locally trained Psychiatrists. The vision was to have post Provincial Psychiatrists in all the nine provinces of Zambia by the year 2015.

Furthermore, the Ministry had further sponsored Registered Mental Health Nurses and Clinical Officers psychiatry to pursue a Bachelor of Science Training in Mental Health Nursing and Clinical psychiatry in Malawi. Currently, there were ten of these categories of staff in the country. These represented the middle level management staff who were expected to provide leadership in mental health at provincial and district level.

Worth noting was the fact that the Government did not have an institution that trained Occupational Therapists. This still remained a challenge as the cost of training outside the country was high, considering the need for competing resources required for the health sector. However, the Ministry had plans to localise the training of this category of staff in order to fill in the gap.

Recommendations

Your Committee requests information on measures that have been put in place to retain the two hundred (200) mental health workers that have been trained and posted to health facilities country wide.

9.1.5 Your Previous Committee had recommended that the Ministry of Health should come up with a deliberate policy to protect the mental health workers and patients in psychiatric wards from violent and dangerous patients.

It was reported in the Action-Taken Report that under the current Legal Framework, the mental Health and Psychiatric Services were adequately covered and included issues to do with the security of those providing services or those in care of other patients in the wards and those patients who would potentially harm themselves as criminally insane. Therefore, Chainama East was one such example of a measure provided by Law to protect the criminally insane from harming others.

Government, however, recognised the validity of the recommendation in that the design of most current facilities either did not reflect the current practice in the care of mental health patients or was inadequate in terms of providing for seclusionary rooms. The MoH, therefore, was committed to re-design the structures in order to guarantee security and safety of Clinical Staff, in ward patients and the criminally insane themselves. It was with the same understanding that the Ministry had planned to undertake a study tour to England to learn the practice of modern Psychiatry including the design of Infrastructure.

Recommendations

Your Committee requests a progress report on the re-designing of the facilities.

Provision of Education to the Deaf in Zambia

9.2. Your previous Committee had recommended that the Government should develop a specific policy to address the challenges related to the provision of education to the deaf.

It was reported in the Action-Taken Report that although the provisions of the current policy that is "Educating our Future" did not specifically address the needs of the deaf, they were, however, broad enough to allow the implementers of the policy to adapt them to suit specific disability groups.

Furthermore, the Ministry of Education was currently reviewing the existing policy which would address such concerns. Indeed, there was need to review the Education Policy with a view to incorporate specific provisions for such disabilities such as blindness, hearing impairment and physical disability.

Recommendations

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

9.2.1. Your previous Committee had recommended that there was need for the Government to urgently consider revising the training curriculum for teachers of special education needs in order to ensure that there was specialisation biased towards various major disabilities such as blindness, physical disability and hearing impairment. Teachers for the deaf had to be appropriately trained for them to communicate and teach effectively using sign language, especially at high school and tertiary levels.

It was reported in the Action-Taken Report that the course outline at Nkrumah College of Education had sign language and braille courses as mandatory (core) courses for all students. This would ensure

that all graduating students were conversant in sign language and braille for communication with the deaf and blind respectively.

The curriculum further provided for those who wished to specialise in special education. The Ministry of Education, through the Curriculum Development Centre, was currently reviewing the curriculum for pre-service colleges of education and such concerns would be addressed.

Recommendations

Your Committee requests further information on what is being done on the revision of the training curriculum for other training institutions such as the University of Zambia and the Copperbelt Secondary Teachers' College (COTSECO).

9.2.2. Your previous Committee had recommended that the Government should address the shortage of teachers to teach the deaf learners by increasing the number of training institutions and trainees. The Government should further ensure that the teachers trained were able to communicate in sign language effectively.

It was reported in the Action-Taken Report that the shortage of teachers for the deaf learners had indeed been of great concern. The Government, through the Ministry of Education, was therefore planning to build resource centers for the professional development of teachers in all schools which would include training of teachers in sign language. Therefore, the Zambia Institute for Special Education was being expanded to increase teacher output in this area.

Furthermore, the infrastructure development currently going on at Zambia Institute of Special Education would increase trained teacher output in special education from 100 to 300 annually. The friendly training programmes at Nkrumah would also contribute significantly towards increased teacher output competent to use sign language in schools.

Recommendations

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

9.2.3. Your previous Committee had recommended that there was need to recognise and develop one official sign language. Alternatively, the American Sign Language could be adopted and made official. However, such a policy decision had to be arrived at with proper consultation with the deaf community and other relevant stakeholders.

It was reported in the Action-Taken Report that the Education Act of 2011, provided for sign language as one of the languages to be recognised in the school curriculum.

This would enable the deaf to have access to information as well as promote the linguistic identity of the deaf community as enshrined in Article 24, of the United Nations Convention on the Rights of Persons with Disabilities. In addition, the current Zambian sign language dictionary would be improved upon to champion this agenda.

In an effort to have one official sign language, Zambia National Association of the deaf had developed the Zambian sign language dictionary.

Recommendations

Your Committee requests the Government to state clearly whether an official sign language has been adopted and whether its adoption was arrived at through wider consultations with stakeholders.

9.2.4. Your previous Committee had recommended that the Government should build more deaf units and boarding schools at both basic and high school level. Each province should have at least one boarding basic school and one boarding high school for the deaf. The availability of many deaf schools and units would solve the problem of learners covering long distances to reach a school. Furthermore, there was need to develop and provide sufficient and suitable teaching and learning materials in all schools and units for the deaf.

It was reported in the Action-Taken Report that the Ministry of Education had plans to build special boarding schools in all provinces that would not only cater for the deaf but other disabilities too. These would be in addition to the Centre of Excellence whose construction was due to start last year (2011) in Munali.

As regards educational materials for learners with disabilities, Government had an annual budget of 4.5 billion kwacha. The procurement of these materials included those for the deaf.

Recommendations

Your Committee requests a progress report on the construction of the special boarding schools in all provinces as well as the Center of Excellence.

9.2.5. Your previous Committee had recommended that Government should develop a curriculum for deaf learners which was focused on the acquisition of practical skills.

It was reported in the Action-Taken Report that the school and college curriculum under review had provided for such consideration under alternative syllabus. Therefore, the observation regarding the development of a curriculum for deaf learners which was focused on the acquisition of practical skills was noted.

Recommendations

Your Committee requests the Government to provide more information on the status of the review of the curriculum.

9.2.6. Your Previous Committee had recommended that the Government should come up with a system for universal hearing testing and ensure that all children entering school were tested and placed in the right education institutions.

It was reported in the Action-Taken Report that the Ministry of Education had a decentralised policy of identification and assessment system for Learners with Special Educational Needs. District assessment teams were established for this purpose. In order to aid their operations, each District Teachers Resource Centre was given an assessment instrument for hearing (audiometer).

The process of establishing special education assessment centers in all provinces starting with Lusaka, Copperbelt and Northern provinces was underway. For example, such a facility had been established at Senanga High School in Senanga District.

Recommendations

Your Committee notes the response but will await a progress report regarding the provinces in which the special education centres have been established.

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

The Role of the Department of Community Development in Poverty Reduction

10.0 Your previous Committee had observed that the office of the Registrar for NGOs had not yet become operational and would therefore; await a progress report on the matter.

It was reported in the Action-Taken Report that this had reached an advanced stage and the Statutory Instruments on forms and Fees to be used for registration had been issued. Secondly, nominations of the NGO board members had also been completed and the Registrar and his staff had been recruited. Once they had reached a common definition and measure of poverty in Zambia, the Committee would be informed accordingly.

Recommendations

Your Committee requests a progress report on the implementation of the office of the Registrar for NGO's.

10.1 Your previous Committee had requested for a progress report from the Ministry of Community Development and social services on the recruitment of staff and provision of reliable transport to the Department of Community Development.

It was reported in the Action-Taken Report that the recruitment of staff was an on-going exercise and most districts had a Community Development Officer manning the District. However, there were still some challenges of resignations and requests for transfers. On the aspect of transportation, the Department of Community Development had commenced procuring vehicles for district offices to assist in the monitoring of programmes. So far, nineteen vehicles had been procured to be distributed to nineteen districts. The exercise was on-going and would cover the entire nation. At the sub-centre level fifty motorbikes had been procured and distributed to fifty sub-centres.

Recommendations

Your Committee requests an update on how many districts the recruitment process and the procurement of vehicles has been done and when the recruitment process and procurement of reliable transport will cover the rest of the country.

10.1.2. Your previous Committee had requested for a progress report on the process of developing a comprehensive monitoring and evaluation system that would monitor progress in the implementation of the programmes that were implemented by the department of Community Development.

It was reported in the Action-Taken Report that the Ministry through their cooperating partners had engaged the American Institute for Research (AIR) to help develop the Management, Information, Monitoring and Evaluation systems in order to strengthen programming and progress tracking in the Ministerial programmes. As a starting point this system would commence with the Social Cash Transfer scheme and then extend to other Ministerial programmes. It was envisaged that by 2012 all programmes would be covered by this system.

Recommendations

Your Committee requests a progress report on the implementation of the Management, Information, Monitoring and Evaluation systems.

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

10.2. Your previous Committee had requested for a progress report on the Zambia Environmental Management Authority's (ZEMA) assessment of the compliance levels for 2011. It further requested for a progress report on the recruitment of environmental health staff at all health facilities in line with the approved Ministry of Health establishment structure.

It was reported in the Action-Taken Report that, under the current law no functions had been delegated to the Local Authorities.

Recommendations

Your Committee requests further clarification on the Zambia Environmental Management Authority's (ZEMA) assessment of the compliance levels for 2011, as it has not been addressed. Your Committee further requests a progress report on the recruitment of environmental health staff at all health facilities in line with the approved Ministry of Health establishment structure.

10.2.1. Your previous Committee had requested for a time frame within which incinerators would be provided to all Government hospitals. In addition, your Committee requested for a progress report on the sourcing of funds from cooperating partners for the implementation of the National Health Care Waste Management Plan and the purchase of incinerators. Your Committee further wished to know how much Government had allocated towards the procurement of incinerators and the implementation of the National Health Care Waste Management Plan in the 2011 health sector budget.

It was reported in the Action-Taken Report that the Ministry of Health through its partners (UNICEF, WHO) had during the period 2008/2010 purchased 33 macro-burns incinerators and installed them at several District and General Hospitals. In December 2010 and January 2011 with similar support from WHO, the Ministry carried out an assessment of twenty-two of the incinerators country wide in order to determine their operational efficiency.

Following the assessment, the World Health Organisation, organised a training workshop for all Provincial Environmental Health Officers, from which a detailed action plan in Health Care Waste Management for 2011 was drawn. This action plan included among other interventions carrying out repairs of the non-functional incinerators before more of them could be purchased. The action plan had since been submitted to WHO and World Bank for consideration and for subsequent more funding for the second phase in the procurement and installation of incinerators to other remaining health institutions.

These activities had further been enshrined in the 2011/2012 Ministry's Action Plan while proposals had been made to both UNICEF and the WHO as key partners in Health Care Waste Management.

Furthermore, the cost of purchasing and installing a single macro-burn incinerator was very high. Considering this fact and the fact that the budget allocation to the health sector was already constrained, the Ministry had not included in its budget, the purchase of the incinerators. Instead the Ministry had included among other interventions, capacity building in HCWM biased towards monitoring the running of the incinerators, repairing simple defects, servicing and timely reporting to higher authorities as may be necessary.

Recommendations

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

10.2.2. Your previous Committee had requested for a progress report on the review of the Public Health Act.

It was reported in the Action-Taken Report that the review of the Public Health Act was within the calendar of activities for the Ministry of Health for the year 2011. The Ministry had since constituted a Technical Working Group comprising of all key stakeholders from both Government and Civil Society Organisations in order to spearhead the process.

Recommendations

Your Committee requests a progress report on the findings of the Technical Working Group.

10.2.3. Your previous Committee had requested for a progress report on the development of the National Health Policy and the time frame within which the process would be completed in order to pave way for implementation.

It was reported in the Action-Taken Report that the Ministry of Health had made tremendous progress towards the development of the National Health Policy. The draft Policy document was presented to the National Health Policy Steering Committee for comments and the comments were now already incorporated.

The National Health Policy document had a chapter on Environmental Health and had outlined policy measures to be taken for the management of Health Care Waste. The National Consensus meeting on the draft was scheduled to take place in the month of August, 2011 after which the document would be submitted to the Cabinet Office for consideration by the Cabinet. The process would be completed by December, 2011.

The Ministry of Health had also put in place a five year Strategic Plan for the Health Care Waste Management. The plan was enshrined in the main Ministry of Health Strategic Plan under Public Health.

Recommendations

Your Committee requests a progress report on the development of the National Health Policy and whether the policy has been submitted to Cabinet office for approval.

Foreign Tour (Maputo, Mozambique)

10.3. Your previous Committee had requested for a progress report on the draft report by the Rural Net Associates Limited on the issue of Policies regarding access to credit facilities by vulnerable Groups.

It was reported in the Action-Taken Report that Government through the Ministry of Finance and National Planning had engaged Rural Net Associates Limited, a Consultancy firm to conduct a study to identify key issues regarding rural financing. The purpose of engaging Rural Net Associates Limited was to come up with a report that was going to feed into the development of Rural Finance Strategy and Policy. The final report was submitted by the firm to the Rural Finance Programme under the Ministry of Finance and National Planning.

Following the submission of the final Rural Net Associates Limited report it was agreed in September, 2010 under the Financial Sector Development Plan that; because of inadequate local capacity, the preparation of the Draft Rural Finance Policy (RFP) and Strategy be done by a group of international senior consultants with widest possible exposure of similar work elsewhere, supported by local experts. The Terms of Reference for the consultants were approved in January 2011. The request for the expression of interest was published in March 2011 and a total number of seventeen firms responded. Three firms were shortlisted and evaluated by the Evaluation Committee appointed by the Ministry of Finance and

National Planning. One firm was eventually selected and a no objection was obtained from the International Fund for Agriculture Development. Negotiations were currently being conducted by RFP and the consultants on the pricing for the assignment.

The Terms of Reference for the consultants were as follows:

1. To develop an effective and coherent strategic framework in order to enhance provision of both broader and deeper financial services across all parts of the country;
2. To develop a national policy on rural finance which would create a conducive environment for accommodating commercial banks, microfinance institutions, out-grower schemes and marketing companies, saving and credit co-operatives and small scale informal operators; and
3. Identify and map out strategic options. The consulting firm was expected to undertake and complete the assignment within three and half months from the commencement date. The commencement date would be no other than one month from the signature of the contract.

Recommendations

Your Committee requests a progress report on the matter.

10.3.1. Your previous Committee had requested for information on what measures the then Ministry of Community Development and Social Services had put in place to strengthen the provision of extension and veterinary services in communities where they were not readily available.

It was reported in the Action-Taken Report that Government had started the process of establishing livestock extension service centres in all parts of the country in order to strengthen the provision of extension and veterinary services. These would be one stop centres that would offer services such as livestock extension, dipping, spraying, vaccinations, artificial insemination, embryo transfer, de-worming, branding, castration, de-horning, training of farmers through demonstrations on feed formulation, pasture and range management and registration of farmers. Depending on the level of the centre, some centres would also be offering marketing facilities and training through demonstrations on better animal husbandry practices. Other service providers would also have an opportunity to offer their services at the centres. These centres were being established with the full involvement of local communities through their respective chiefs and village headmen.

The then Ministry of Livestock and Fisheries Development had started the process of filling the structure to have in place the extension officers for both the Livestock Development and the Veterinary Services. In addition, the Ministry had purchased veterinary and postmortem kits for use by their field officers. To broaden farmer outreach, the Ministry had also purchased motor vehicles and motorcycles for use by the field staff.

Recommendations

Your Committee requests a progress report regarding the areas in which the Government has established livestock extension service centres.

10.3.2 The previous Committee had requested for a progress report on the issue of establishing ready markets where farmers under the Food Security Pack Programme could sell their produce.

It was reported in the Action-Taken Report that the Ministry had been sensitising farmers that had surplus, to sell their produce. Where farmers had excess produce, the Ministry had been able to link them to Food Reserve Agency where they were able to sell their produce.

As a follow up action the Ministry had resolved to consult the then Ministry of Agriculture and Cooperatives with the intention of developing a Memorandum of Understanding on ensuring that small projects implemented in localised areas such as the Agricultural Development Support project which had a marketing component could be used as additional possible markets for the farmers under the Food Security Pack Programme.

Recommendations

Your Committee requests progress report on this issue.

10.3.3 Your previous Committee had observed that the implementation of the National Decentralisation Policy had stalled. Therefore, it urged the Ministry of Community Development and Social Services to decentralise the grants system without waiting for the implementation of the National Decentralisation Policy.

It was reported in the Action-Taken Report that the Ministry was looking into decentralising the grants systems as was done with other programmes in the Ministry such as the Public Welfare Assistance and Social Cash Transfer Schemes. This exercise was ear-marked for this year (2012).

Recommendations

Your Committee requests a progress report on the decentralisation of the grants system.

Other Outstanding Issues

10.4. Your previous Committee had requested for a progress report on the overhauling of the sewer system at Choma General Hospital.

It was reported in the Action-Taken Report that Choma General Hospital was being constructed in two phases due to budget constraints. The first phase which involved the construction of the hospital was near completion now. The overhauling of the sewer system and the dilapidated buildings would be done under the second phase. The Ministry of Works and Supply Buildings Department was currently designing the new sewer system and the Ministry expected to commence procurement of the works within the fourth quarter of 2011.

Recommendations

Your Committee requests a progress report on this matter.

10.4.1 Your previous Committee had requested a progress report on the recovery of the funds from Zubala Enterprises amounting to K64, 362, 500.00 and urged the Government to procure a mortuary fridge for Namwala District Hospital. The Government had to further recruit the remaining clinical officers for Namwala District since the positions were funded.

It was reported in the Action-Taken Report that the recovery of funds from Zubala Enterprises was an issue that had since been handled by Anti-Corruption Commission and further taken up by the Attorney General. The Ministry of Health still awaited the outcome on the matter from the Attorney-Generals Chambers.

The Ministry of Health had plans to recruit officers for Namwala District once they graduated before the end of the year 2011. The Government had provided for Treasury Authority for the employment of various health professionals which included Clinical Officers who would be posted to different locations country wide according to the needs. However, Namwala District had received one more Clinical Officer bringing the total number to 9 in the District.

Regarding the purchase of a Mortuary Unit for Namwala District Hospital, the Hospital had a fully functioning mortuary unit which was procured by the Provincial Office following Zubala Enterprises failure to deliver the Unit and while still awaiting investigations by Anti-Corruption Commission. Though the capacity of the fridge was six trays, the Hospital had never had difficulties with storage of bodies as people in the area did not take long to bury their dead. Only upon the completion of construction of the new hospital and when deemed necessary, the Ministry would then consider buying a new mortuary unit for Namwala District Hospital.

Recommendations

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

10.4.2 Your previous Committee wished to find out whether the purchased equipment for the general use in hospitals had arrived.

It was reported in the Action-Taken Report that the full contract (Contract No. 051) amount for the supply of general hospital equipment was US\$2,937,586.88. The Ministry of Health paid TECFAB Inter-Medical of India an advance of US\$1,999,718.19. This left a balance of US\$583,000 outstanding to date to be cleared with the supplier.

To this effect, some equipment had been delivered comprising of mortuary equipment, Intensive Care Unit equipment and Theater equipment. The kitchen equipment had not been delivered as the supplier was awaiting payment of the balance. This equipment was being distributed to various health institutions country wide.

Recommendations

Your Committee requests an update on whether the supplier has been paid and whether the equipment has been delivered.

CONCLUSION

11.0 Your Committee is grateful to you, Mr Speaker, for appointing them to serve on your Committee on Health, Community Development and Social Welfare and for the support rendered to them throughout the year.

They are indebted to all the stakeholders who appeared before them for their co-operation in providing the necessary memoranda and briefs.

Your Committee is very hopeful that the observations and recommendations contained in this report will go a long way in improving maternal health in Zambia and ensuring that issues of social protection for the aged are well taken care of by the Government.

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

APPENDIX I

List of Officials

National Assembly

Mr S M Kateule, Principal Clerk of Committees

Mr G Lungu, Deputy Principal Clerk of Committees

Ms M K Sampa, Committee Clerk (Financial Committees)

Mr S C Kawimbe, Committee Clerk (Social Committees)

Ms Malowa, Assistant Committee Clerk

Ms S Kayawa, Typist

Mr R Mumba, Committee Assistant

Mr C Bulaya, Committee Assistant