Ministry of Health

ZAMBIA 2008
COUNTDOWN TO 2015
CONFERENCE REPORT

20TH to 21ST AUGUST, 2008

MULUNGUSHI INTERNATIONAL CONFERENCE CENTRE, LUSAKA

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FOREWORD

The Ministry of Health's vision is to provide quality health services as close as possible to the family. Maternal, newborn and child health are high on the government's agenda and strategies to address the common contributors to ill health in this vulnerable population have been clearly defined in the Fifth National Strategic Plan and elaborated in the Fourth National Health Strategic Plan. The burden of disease in Zambia is high with maternal mortality and child mortality indicators being a major concern. Inspite of numerous challenges, the Ministry of Health with its partners in Health Service delivery have together achieved a number of successes in an effort to achieve its goal. Some of our successes have been noted through the Zambia Demographic and Health Survey of 2007 which has shown significant reduction in under five mortality rate from 168 deaths per 1000 live births in 2002 to 119 deaths per 1000 live births. The maternal mortality rate also deceased from 729 deaths per 100,000 live births in 2002 to 591 deaths per 100,000 live births in 2007. Although Zambia has made much progress in reducing the maternal and child mortalities, there is still much effort needed to reverse these trends. A number of high impact interventions have been introduced and implemented to address maternal and child survival and greater effort needs to be made in the area of the newborn health. The high impact interventions that have been introduced over time include family planning, skilled attendance at delivery, emergency obstetric and newborn care, childhood immunizations, improved infant and young child feeding practices, vitamin A supplementation, malaria prevention and treatment, pneumonia and diarrhea treatment and the prevention of mother to child transmission of HIV. The coverage of these interventions differs across the provinces.

Zambia is signatory to the global village that is committed to attaining the Millennium Development Goals on Maternal Health Reducing the maternal mortality rate by three quarters of the 1990 levels by 2015 and Child Health- Reducing under five mortality by two-thirds by 2015 from the 1990 levels. The countdown meeting was first held in London as an initiative to monitor progress being made in attaining these goals. The Zambia countdown meeting was a follow up meeting to the Cape Town meeting held in April 2008 monitoring progress at global, regional and country levels. Zambia has attached great value in tracking its own progress and this meeting was a step in ensuring that measures are put in place for the country to reach its targets. The report highlights coverage of the high impact interventions across the continuum of care, some of the challenges the country is facing in trying to address maternal, newborn and child health and how the various partners in health can contribute towards attaining the MDGs 4 and 5.

Dr. Velepi Mtonga
Permanent Secretary

ACKNOWLEDGEMENTS

The Ministry of Health believes that it is through strong partnerships that we have attained successes in maternal and child survival. The Ministry values such strong partnerships and would like to take this opportunity to thank all partners who have supported the fight for maternal and child survival. Special thanks are extended to the World Health Organisation, UNICEF, USAID, HSSP, ZPCT, JHPIEGO, UNFPA, Clinton Foundation, CHAZ, NATSAVE And Standard Bank for their support in the hosting of the first ever National countdown conference which led to the culmination of this report. The report has gone a step further to include the findings of the Demographic and Health Survey 2007 in order to give a comprehensive picture of progress made towards attainment of the MDG 4 and 5. It is hoped that the report shall inform provinces and district of where further efforts should be made if the MDGs are to be achieved.

Dr. Victor Mukonka
Director Public Health and Research

1. Introduction to the Countdown

The Millennium Development Goals (MDGs) are the world's time bound and quantified targets for dramatically reducing the world's poverty by 2015. Regular monitoring of progress toward the MDGs is an important part of ensuring their achievement. Different mechanisms have been developed for monitoring progress at global, regional and country levels. A major initiative for monitoring progress globally is the Countdown to 2015 which started in 2005 with a conference in London. The Countdown to 2015 is a movement of governments, individuals and institutions that aims to stimulate country action by tracking coverage for interventions needed to attain Millennium Development Goals 4 and 5, together with parts of MDGs 1, 6 and 7.

The *Countdown* aims to build on country-level data, attracting attention and resources for addressing service delivery barriers and to further speed up progress towards the health-related Millennium Development Goals. An output of the process is the Countdown report whose primary purpose is to bring available data on the priority countries together in one place to facilitate evidence-based review and planning efforts designed to accelerate country-level actions in maternal, newborn and child health.

The *Countdown* has explicitly adopted a continuum of care approach and in 2008 the Countdown broadened the scope of analysis by including maternal health and interventions that impinge on maternal survival. Therefore, the 2008 Countdown Report, for the first time tracks coverage across the continuum of care.

Zambia participated in the 2005 and 2008 countdown to 2015 conferences held in London and Cape Town respectively. The country organized a national countdown meeting that aimed to help policy makers and their partners assess progress and prioritise actions to reduce maternal, newborn and child mortality in the country. The meeting aimed to add value to local efforts currently underway in addressing the MDG 4 & 5. The meeting also highlighted not only the progress but the challenges the nation and selected provinces and districts have encountered during the implementation of the identified interventions.

2. Goals of the Countdown Meeting

The main objective of the 2008 national countdown was to organize a high profile, high level stakeholders' meeting for stimulating country action through introduction of coverage results for interventions and complementary system dimensions that will sharpen and reinforce efforts already under way to monitor progress towards meeting health related MDGs.

Specific Objectives were:

- To share proceedings of the Global Countdown meeting held in Cape Town and therefore allow stakeholders take stock of Zambia's current position vis a vis Countdown to 2015 (national and sub-national levels).
- To share MoH and partners' vision of where Zambia should be in the countdown process.
- Identify knowledge gaps that are hindering progress.
- To formulate a way forward and divide roles for specific actions that Zambia needs to undertake to reach MDGs by 2015.
- Agree on a tracking mechanism for the process of the national Countdown.
- Mobilize development partners and the broader community to be accountable for

proposed new actions to achieve the health-related Millennium Development Goals, in particular Millennium Development Goals 4 and 5.

3. Process of the Countdown Meeting

The meeting took place over two days at the Mulungushi Conference Centre in Lusaka.

It was officially opened by the Minister of Health, Honourable Dr. Brian Chituwo, who highlighted the achievements of the sector as follows:

1. Reduction in Maternal Mortality Ratio from 729 per 100,000 live births in 2001/2 to 591 per 100,000 live births in 2007

2. A sustained high Antenatal Care coverage of 93 percent

3. Increase in Contraceptive Prevalence Rate from 34 percent in 2001/2 to 41 percent in 2007

4. Reduction in HIV prevalence from 16 percent in 2001/2 to 14.3 percent in 2007

5. The Under Five Mortality Rate has reduced from 168 per 1,000 live births in 2001/2 to 119 per 1,000 live births in 2007

6. The Infant Mortality Rate reduced from 95 per 1,000 live births in 2001/2 to 70 per 1,000 live births in 2007

He further indicated that although progress had been made, we were still a long way from attaining the desired targets in achieving the MDGs. He went on to give the following directives:

- Permanent Secretary should ensure that the key directions proposed by this conference are disseminated to all health institutions and health workers in the country;
- The Permanent Secretary should ensure that follow-up actions from this conference are implemented through the regular performance assessments and technical support visits to provinces and districts and other monitoring mechanisms.
- All Ministry of Health Directors and Heads of Health Institutions should ensure that their annual plans clearly indicate how they will contribute to the achievement of the health related MDGs, with set annual targets and how they will track progress.
- Quarterly Health Sector Advisory Group Meetings should be given regular updates of progress towards coverage of effective health interventions at provincial level.
- The Annual Consultative meeting of the health sector should culminate in giving well summarized data on where we are at the end of the year and where the gaps are.

The keynote speech was made by Dr. Tigest Ketsela, Director of Reproductive and Family Health, World Health Organisation (WHO), Africa Regional Office (AFRO). In her remarks she noted 10 percent of the world's population lives in Africa and yet Africa accounts for 44 percent of the world's under-five mortality. Africa also accounts for 60 percent of global

maternal mortality. In her speech she noted that from the 2008 Maternal and Child Survival Countdown, a review of 68 countries that contribute to 97 percent of maternal and child deaths was done and we know the following: Only 16 countries (24%) are on track to meet MDG4. Of the 16, only 3 have moved from "not on track" to "on track" since the 2005 Child Survival Countdown. 56 of 68 countries (82%) have high maternal mortality. None of the countries listed as the ten best performers of the 68 reviewed are in Africa south of the Sahara or South Asia. 12 of the 13 countries with the highest Maternal Mortality ratios were in Africa south of the Sahara. Key messages from the 2008 Countdown report included:

- The adoption of clear policies on interventions and delivery mechanisms is a key building block of well functioning health systems
- Few countdown countries had a comprehensive set of policy measures in place that would facilitate increase access to and utilization of Maternal, Newborn and Child Health (MNCH) interventions
- Coupled with formidable challenges in health financing and human resources, lack of policy measures poses a serious threat to rapid scaling-up of effective Maternal, Newborn and Child Health interventions
- The implementation of a systematic framework to assess policy and health system indicators at country and global levels was critical to facilitating action in this area.

Participants were drawn from various key government ministries, cooperating partners, parliamentarians and civil society organizations. There were 25 presentations made in plenary sessions with discussions held after a couple of presentations. The discussions and debate following these presentations highlighted the progress made towards attaining the MDGs 4 and 5, what the challenges were and action points for follow-up.

This report gives synthesis of the key messages, progress, challenges and action points for the various stakeholders in maternal and child health in order for Zambia to attain the MDGs 4 and 5 by 2015

4. Key Messages

Zambia has made progress on MDG 4 and 5 but more was needed if we are to meet the MDG by 2015

Continuum of Care

There was a need to maintain and scale up interventions such as:

- Family Planning services,
- Skilled attendance at delivery and
- Emergency obstetric and newborn care (EmONC)
- Expanded Programme of Immunisation (EPI),
- Integrated Management of Childhood Illnesses (IMCI),
- Infant & Young Child Feeding (IYCF);

develop action plans, mobilize resources and prioritise MDG 4 & 5 interventions above.

Health Systems

The skills, expertise, and enthusiasm of health professionals needs to be harnessed into a collective shared vision on the importance of the MDGs targets. But there was need to:

- Increase production, retention and equitable distribution of HR for Health.
- Identify partners from other sectors and involve them in various MNCH

committees.

- ? Intensify community engagement but ensure sustainability by supporting them with resources.
- ? Review data collection formats at the national, provincial and district level to include MDG 4 & 5 interventions and report quarterly
- ? Regularly report on progress on the MDGs to the Inter-agency Coordinating Committee (ICC), Sector Advisory Group (SAG), Annual Consultative Meeting and the M & E technical group.

Strong partnerships exist within the sector but multi-sectoral collaborations need to be harnessed and increased.

Funding

Even though the financial commitments have increased remarkably for MNCH it was still inadequate to achieve the intended goals

- ? Cooperating Partners (CPs) should commit funding for MNCH interventions through buy-in of existing plans (e.g. National Development Plan (NDP), National Health Strategic Plan (NHSP) and annual action plans).
- ? National, Provincial, and Districts should commit to increase funding for MNCH through existing planning cycles and reviews.

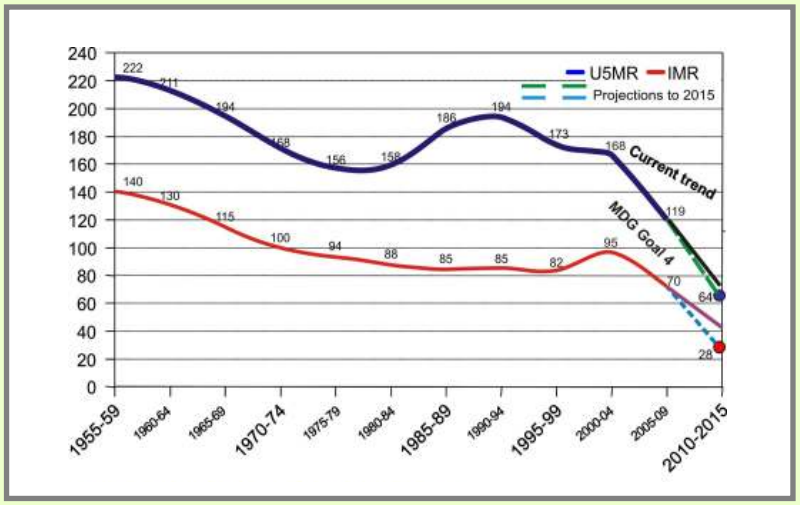
- ? There should be leveraging of resources directed at 'bigger' programmes e.g. Global Funds (GF), Global Alliance of Vaccine Initiative (GAVI), Roll Back Malaria (RBM) Partnership, and World Bank (WB).

5. Countdown to 2015: Where are we -Key MNCH Impact interventions in Zambia?

5.1 Progress Towards MDG4: Cut the Under Five Mortality Rate by Two-thirds by 2015

The figure below (figure 1) shows the trend in the Under 5 and Infant Mortality Rates 1955-2007 and MDG Projection to 2015

Figure 1: Trend in the Under 5 and Infant Mortality Rates 1955-2007 and MDG Projection to 2015



Source: World Health Chart, WHO, ZDHS 2007

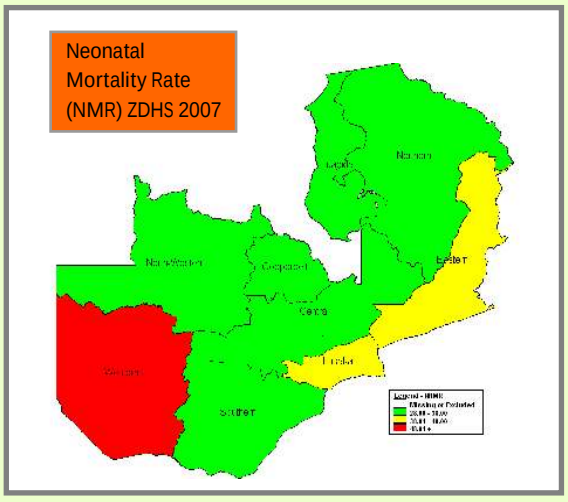
We are still off target to achieving the MDG 4 goal as shown by the projection above. The figure below (figure 2) breaks the child mortality into critical age groups and shows their trends.

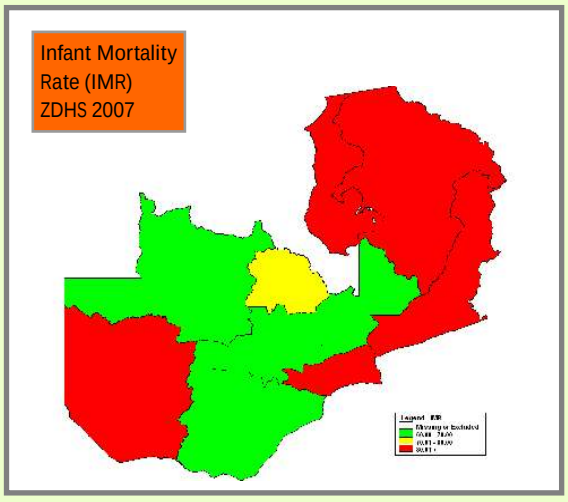
Figure 2: Trends in Child Mortality Rates, ZDHS 1980-2007

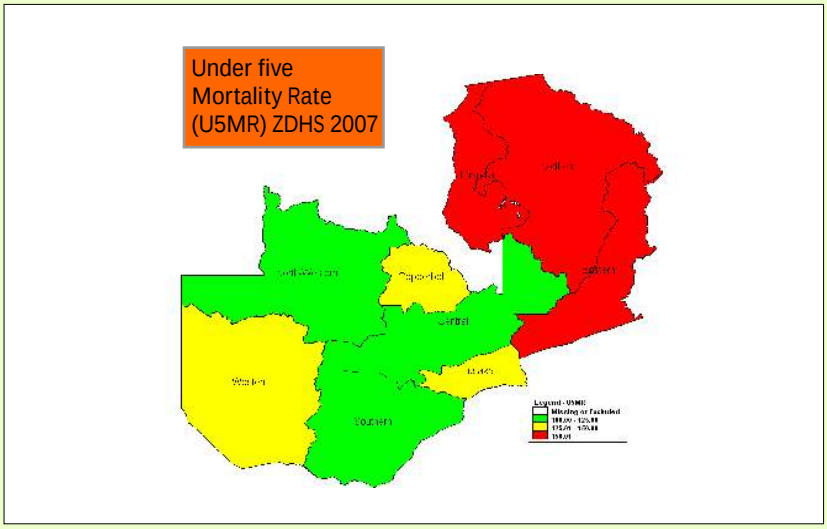
Although Zambia has made progress on MDG 4 much more is needed if we are to meet the MDG by 2015. The neonatal mortality rate has remained stagnated over the years showing the least decline among the child mortality rates. The neonatal mortality rate as a proportion of the under-five mortality rate on the recent ZDHS was 29 percent (ranging from 21% in North Western and Luapula to 36% in Southern province.

Different parts of the country are progressing at different rates as shown in the maps below.

Figure 3: Maps of Zambia showing the NMR, IMR, U5MR (ZDHS 2007)







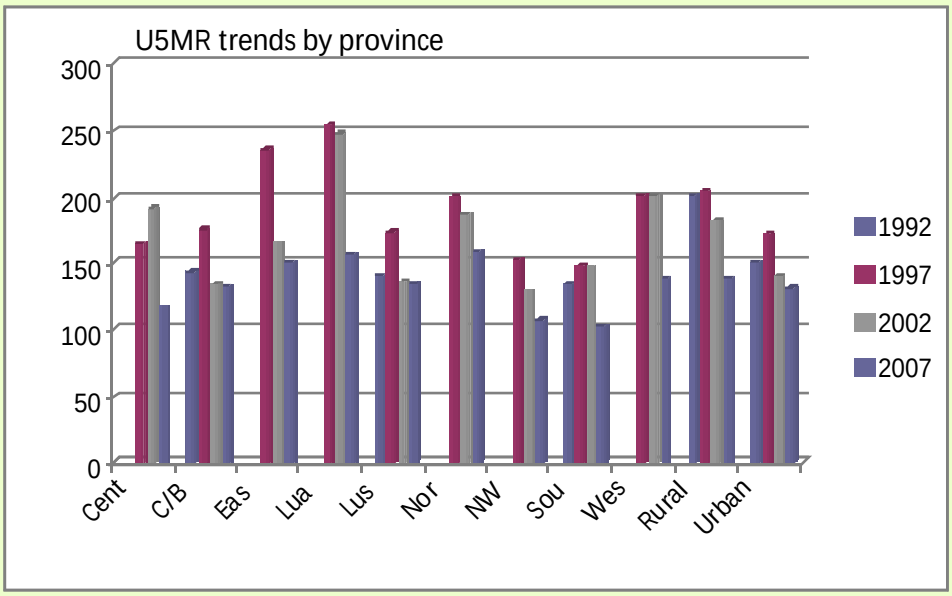
Which Provinces are making progress?

The table below (table 1) indicates that according to ZDHS 2007, three provinces Central, North-Western and Southern if they reduced under-five mortality at a rate of 10 deaths per 1000 live births per year would reach the MDG 4 target of 64 for Zambia by the year 2015. Lusaka, Copperbelt and Western provinces will have to reduce at a rate of at least 12 deaths/1000 live births per year while Eastern and Luapula will have to reduce at a rate of about 15 deaths/1000 live births per year to reach the MDG 4 target by the year 2015.

Table 1: Count down Priority Provinces - Progress Towards MDG 4

Summary of Progress	**Progress towards MDG4**	**Provinces**
No of provinces	3 provinces require to reduce Under five mortality by about 10 deaths /1000LB per year to reach MDG 4 by 2015	Central, North Western, Southern
	3 provinces need to reduce under five mortality rate by 12 deaths /1000LB per years to reach MDG4 by 2015	Copperbelt, Lusaka and Western
	3 provinces need to reduce under five mortality rate by 14 deaths /1000LB per years to reach MDG4 by 2015	Eastern, Luapula and Northern

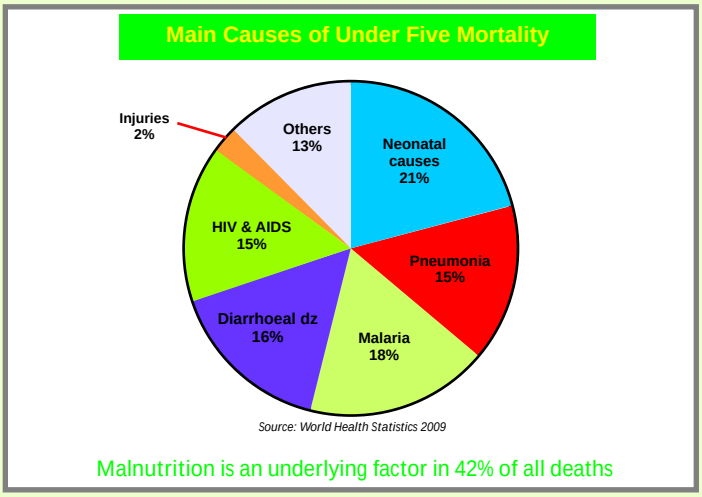
Figure 4: Under Five Mortality Trends by Province



Source: ZDHS 1992- 2007

Zambia's MDG 4 target for 2015 is 64. The various provinces in the country have varied U5MR ranging from 103/1000 live births in Southern Province to 159/1000 live births in Northern Province. Copperbelt and Lusaka Provinces have had no reduction since the previous DHS with rates of 134 to 132/1000LB from 2002 to 2007 for Copperbelt and 137 to 134/1000LB from 2002 to 2007 for Lusaka. The greatest reductions were observed from Luapula, Central and Western provinces with reductions of 91, 74 and 62/1000 live births. There was no consistency observed in the rate of reduction in the five years between the 1997 and 2002 ZDHS survey and the five years between the 2002 and 2007 ZDHS surveys in the all the provinces.

Figure 5: Main Causes of Under Five Mortality

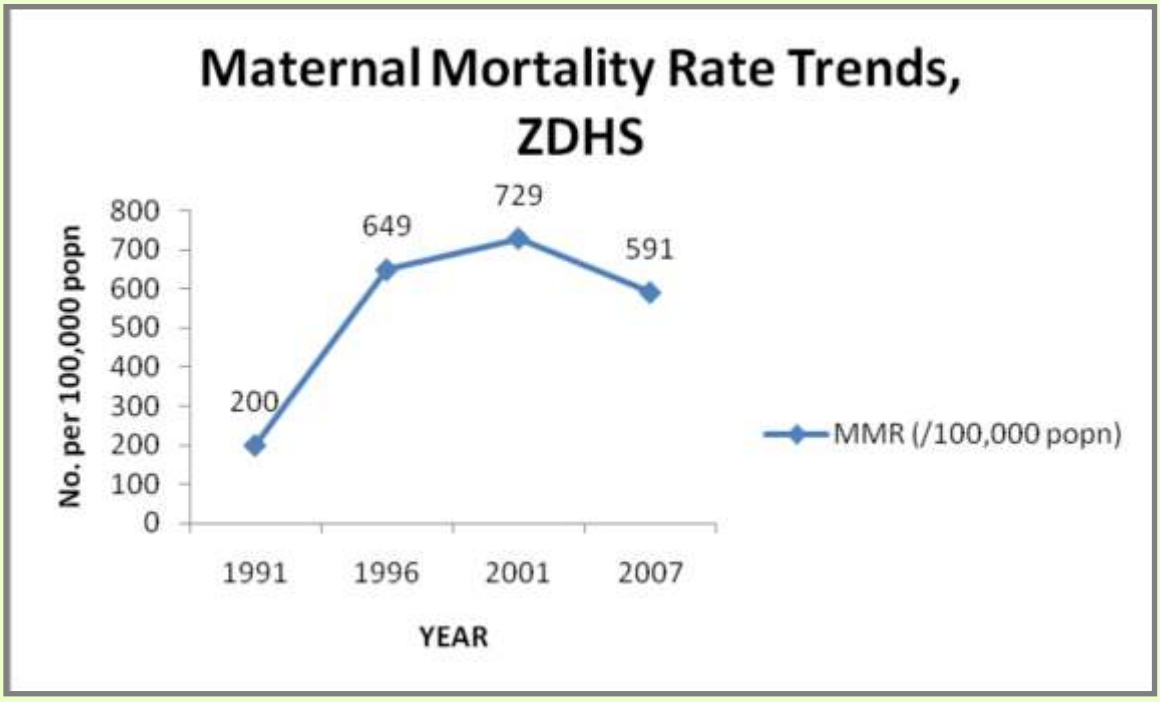


The main causes of death in children less than five years have remained the same over the years as shown in the diagram above.

5.2 Progress Towards MDG 5: cut the Maternal Mortality Rate by Three Quarters and Achieve Universal Access to Reproductive Health by 2015

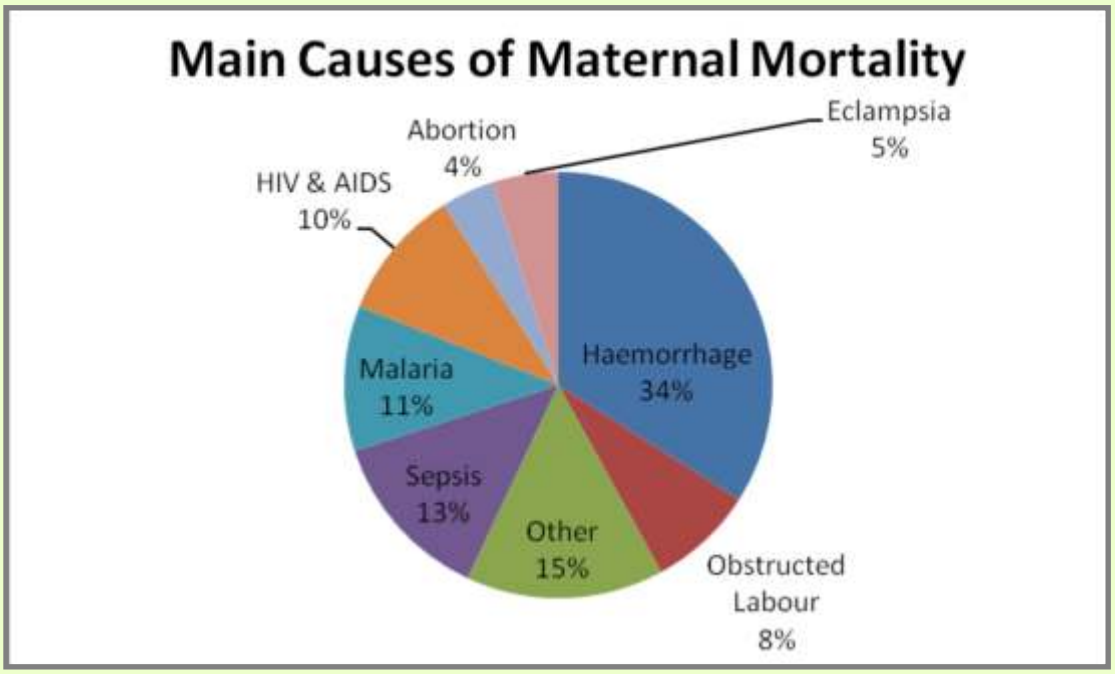
MDG 5 Target for 2015 is 185.The maternal mortality levels have remained moderately high over the three surveys conducted. In 1996 the MMR was 649/100,000 live births, 2001-2002 729/100,000 and 591/100,000. The 2001 ZDHS marks the highest maternal mortality observed (figure 6).

Figure 6: Trends in the Maternal Mortality Rates, ZDHS 1992-2007



The main causes of mortality are; haemorrhage, sepsis and obstructed labour. Malaria and HIV and AIDS are major indirect contributors to maternal mortality (figure 7).

Figure 7: Main Causes of Maternal Mortality



Source: World Health Statistics 2009

6. Tracking Coverage for Life Saving Interventions: Three Steps to Save the Lives of Women and Children

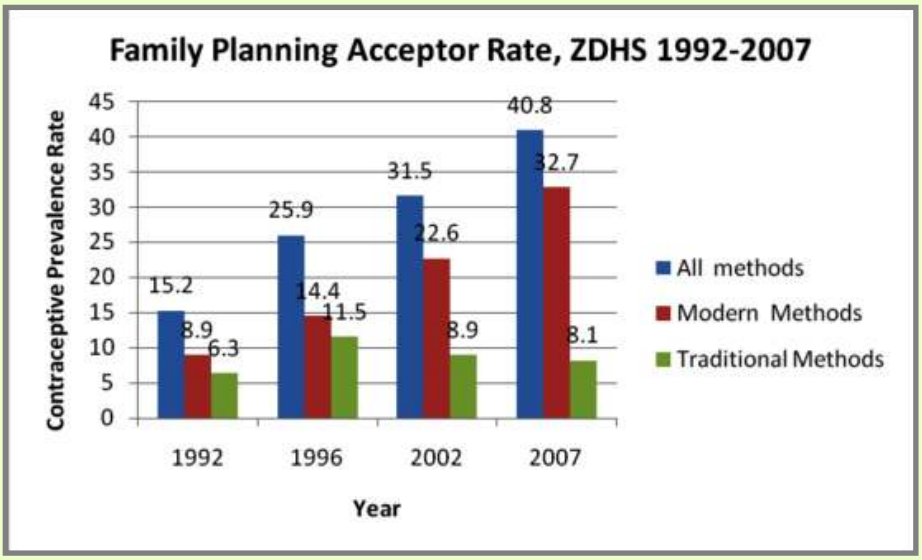
There are a few proven interventions when implemented successfully that improve child survival and maternal health. For improved maternal health: Family Planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC). For child survival these are: Expanded Programme of Immunisation (EPI), Integrated Management of Childhood Illnesses (IMCI) and Infant and Young Child Feeding (IYCF).

Progress in prevention

Most provinces have made progress in coverage of prevention for maternal survival family planning services and antenatal care and prevention of major childhood killers such as measles and malaria. Progress has been made in the following interventions:

Family Planning: There has been a steady increase in the number of women accessing modern family planning services (figure 8).

Figure 8: Trends in Family Planning Acceptor Rate ZDHS 1992-2007



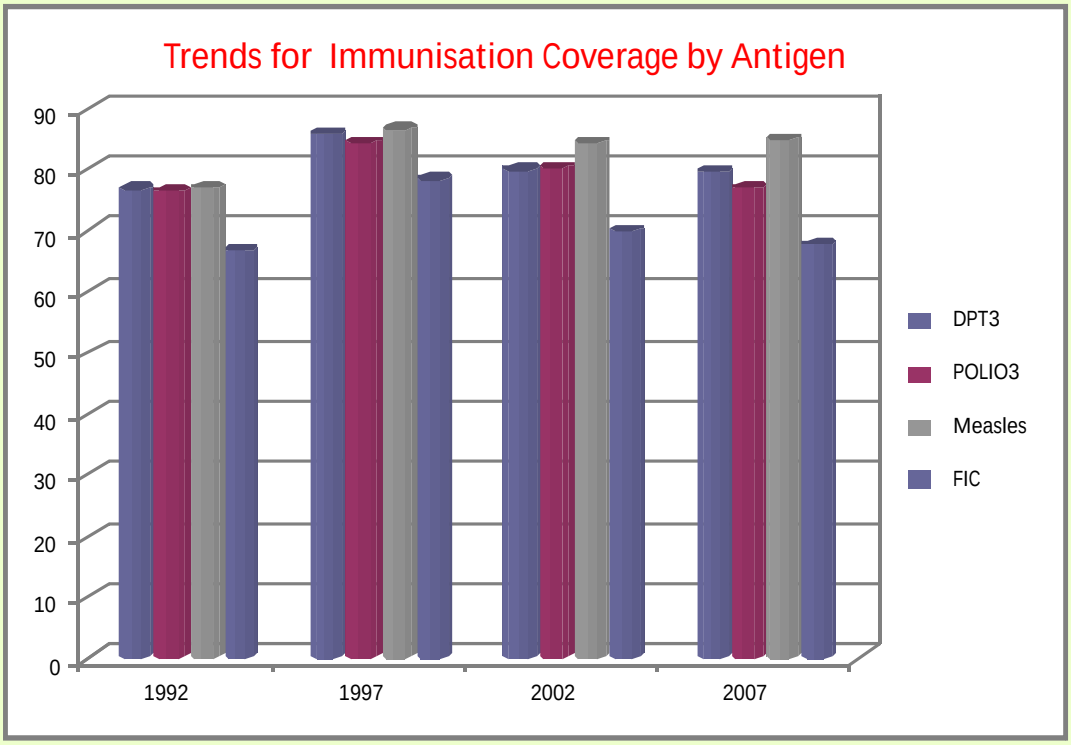
Access to effective family planning methods contributes to maternal health by averting disability and death. There is a significant number of women who are not able to access family planning services. According to the 2007 ZDHS, 27 percent of currently married women had an unmet need for family planning.

Antenatal Care: WHO approach to promoting safe pregnancies recommends that a woman without complications should have at least four ANC visits. This is an updated approach called focused Antenatal Care (FANC) which puts emphasis on quality of care during the visits over the quantity of care. The 2007 ZDHS reported sixty percent of women visited antenatal clinics at least four times during pregnancy and 93 percent of pregnant women had ANC at least once.

The strategy of intermittent preventive treatment (ITP) for prevention of malaria in pregnant women has been implemented since 2003. According to the MIS 2008, 88 percent of mothers reported taking an anti-malarial drug for prevention of malaria during their last pregnancy. Sixty-six percent took the recommended two or more doses for IPT.

Immunisations: Zambia has maintained high levels of immunisation coverage over the years through routine and supplemental immunisation activities (campaigns, child health weeks). Coverage for the four life saving vaccinations are: Hib3 for prevention of meningitis (79.7% coverage), immunisation for neonatal tetanus (81% coverage), DPT3 diphtheria, pertussis, and tetanus (79.7% coverage), and measles immunisation (84.9% coverage). Figure 9 below shows the trends of immunisations over the years.

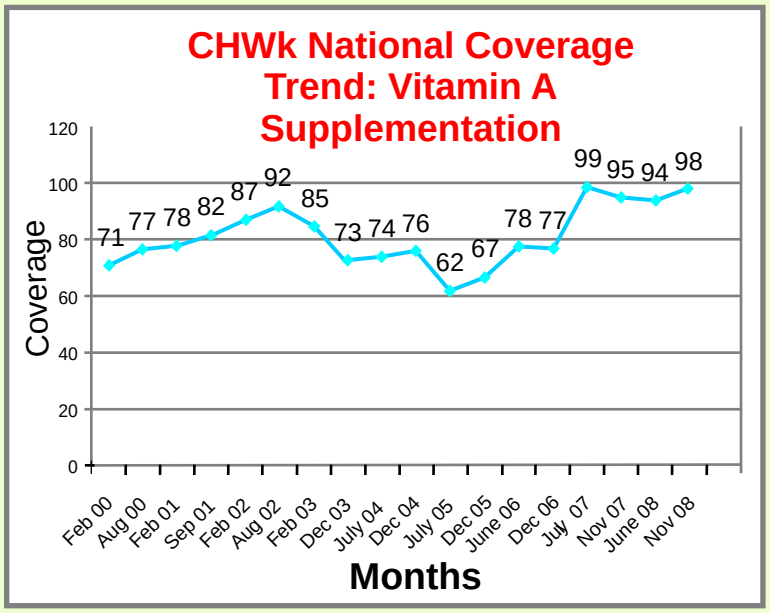
Figure 9: National Immunisation Trends for Different Antigens



Source: ZDHS 1992 2007

Vitamin A Supplementation: The coverage for Vitamin A supplementation during child health week has increased steadily and been maintained at above 90 percent since 2007 (figure 10).

Figure 10: Trends in Vitamin A supplementation During Child Health Weeks



Child health weeks have supplemented the routine service delivery of interventions that improve child survival and increased the coverage of these interventions. The national coverage of Vitamin A supplementation was reported to be 60 percent in the 2007 ZDHS. This is an indication that there is a significant number of children not accessing vitamin A during routine clinic visits and the child health week.

Insecticide Treated Nets: The ownership and use of mosquito nets, both treated and untreated, is the primary prevention strategy for reducing malaria transmission in areas where indoor residual spraying (IRS) is not targeted. According to the 2008 Malaria Indicator Survey (MIS 2008), 71.5 percent of households in Zambia had a mosquito net with 62.5 percent of households in possession of an insecticide treated net (ITN). More than half of the households with a net had more than one net. Rural households had more nets than the urban households although there was no difference in ITN ownership. In addition to owning ITNs, use of ITNs especially among the pregnant women and children is important in reducing the incidence of malaria. In the MIS 2008, 48 percent of children under age of five years were reported to have slept under a mosquito net the night before the survey and 41.1 percent were reported to have slept under an ITN. For pregnant women, 50.3 percent and 43.2 percent reported to have slept under mosquito nets and ITNs respectively.

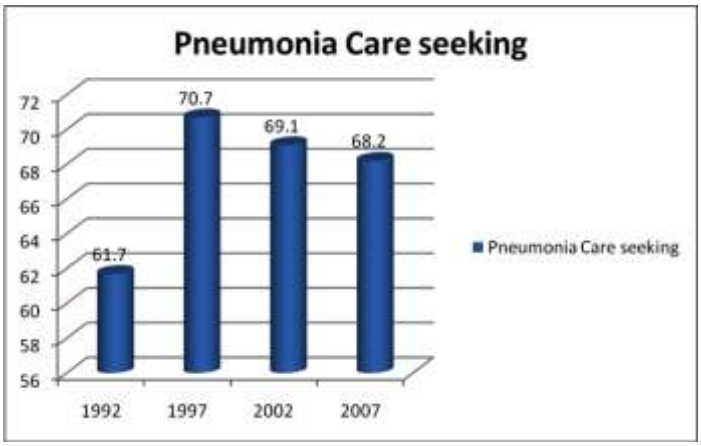
Missed Opportunities To Provide Critical Services And Treatment

The majority of women and children do not access vital health services for potentially fatal illnesses which are dependent on strong health systems that can provide 24- seven care within the community at health facilities through a functional referral system particularly when more serious intervention is necessary.

Post natal care: More than half (52 percent) of all births occur at home without access to skilled care or emergency obstetric and newborn care. This has an implication on the maternal and neonatal mortality as about three quarters of neonatal deaths occur in the first week of life and maternal deaths usually occur during this period as well. Skilled care during pregnancy, child birth and in the post-partum period prevents complications for mother and newborn and allows their early detection and appropriate management. Post natal care is also important to provide the mother with information about self-care and how to look after the baby and this should be within 48 hours. Only 39 percent of mothers had post natal check within the first 48 hours after delivery.

Management of Pneumonia and Diarrhoea: According to the 2007 ZDHS, among children with symptoms of Acute Respiratory Infection symptoms, 68 percent of them were taken to health facility of health care provider for advice or treatment. This has decreased from the previous ZDHS.

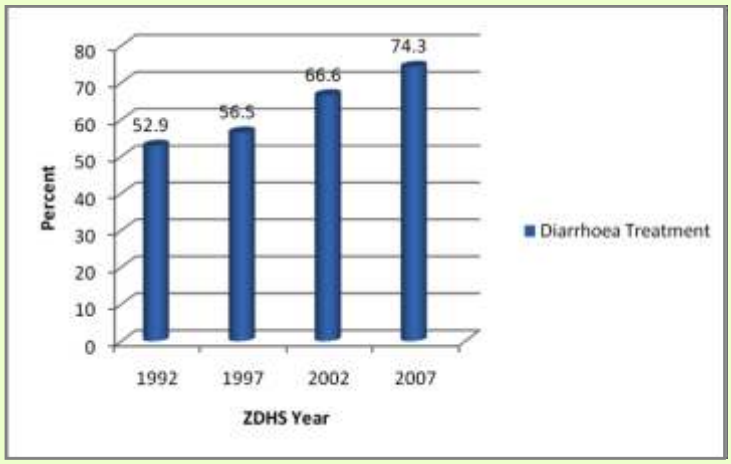
Figure 11: Pneumonia Care Seeking in Under Five Children



Of those who sort treatment 46 percent received antibiotics compared to the 1992 levels of 14 percent.

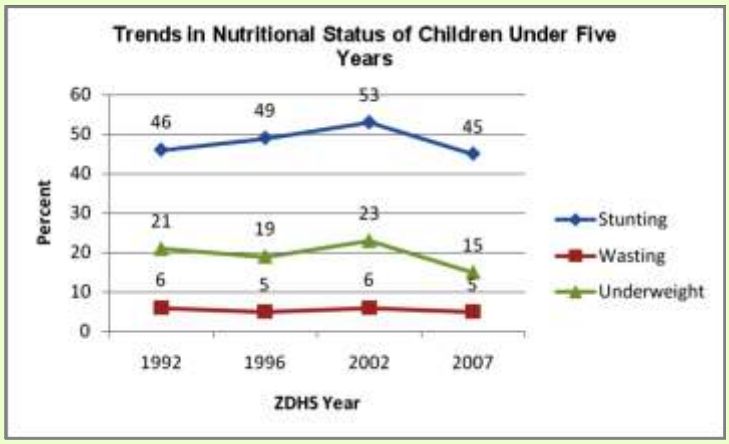
Treatment and advice on diarrhoea are sought more often in rural areas (60%) than in children in urban areas (56%). Overall the treatment of diarrhoea with oral rehydration therapy (ORT) or increase in fluid has improved over the years (figure 12).

Figure 12: Trends in Treatment of Diarrhoea, ZDHS 1992-2007



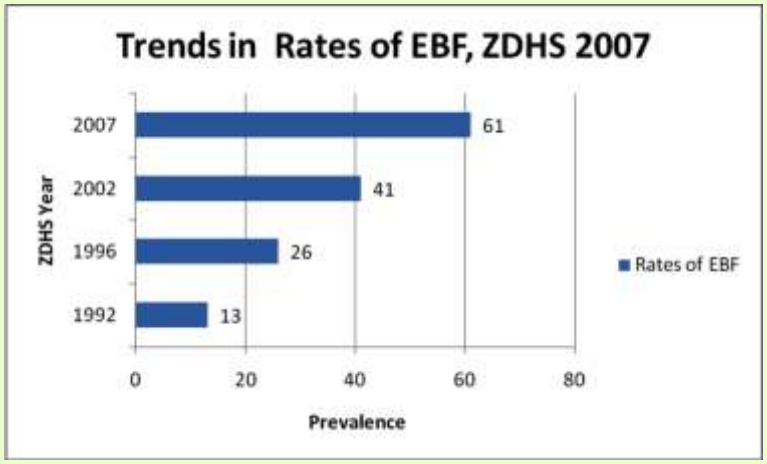
Under-nutrition: Under-nutrition underlies about 42 percent of all under 5 deaths in Zambia. Infant and Young Child Feeding is an important child survival strategy that needs to be promoted and supported at all levels. The malnutrition indicators have improved although they need to improve more if the MDG 4 is to be met. The graph below (figure 13) shows the trends in nutritional status of children under five years of age.

Figure 13: Trends in Nutritional Status of Children Under five Years of Age



Zambia has adopted the WHO recommendation of breastfeeding exclusively for six months and thereafter introduction of adequate and appropriate complementary foods with continued breastfeeding up to two years and beyond. The rates of exclusive breastfeeding have increased from 13 to 61 percent (figure 14.

Figure 14: Trends in the Rates of Exclusive Breastfeeding, ZDHS 1992 2007

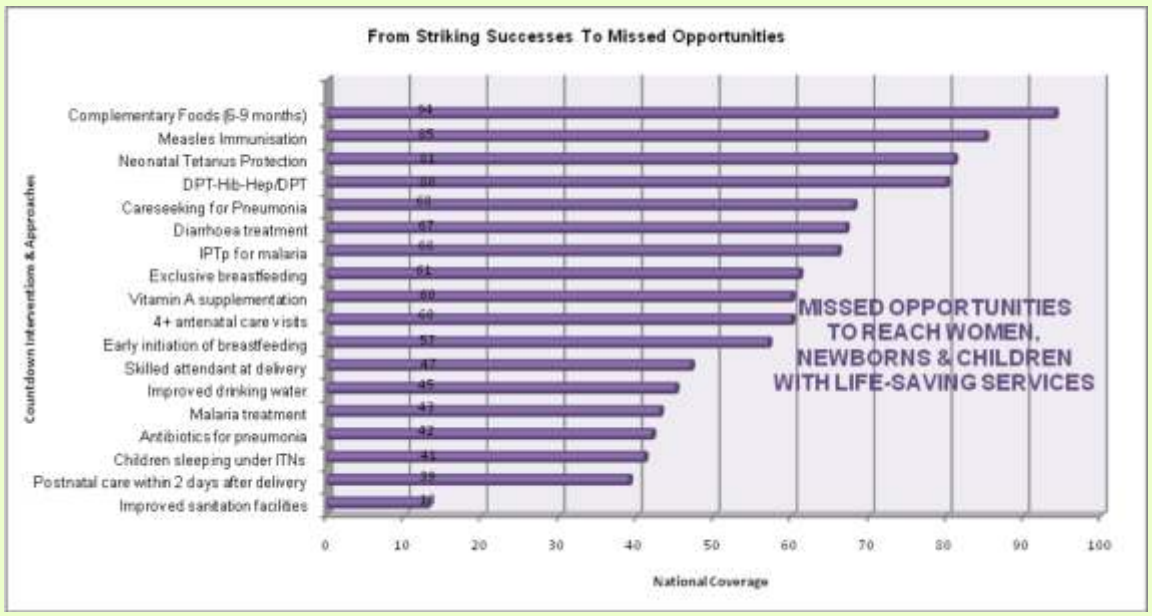


This increase has been attributed to commitment from the government to improve nutrition among children. There has been a number of trainings for health workers and the community on different aspects of infant and young child feeding. In addition, advocacy for IYCF at different levels has been done. More needs to be done as the quantity and quality of the complementary foods that are introduced are usually inadequate leading to malnutrition in the latter half of infancy and beyond.

7. From Striking Success to Missed Opportunities

The chart below shows the average coverage for critical health interventions in Zambia. The empty space in the chart (figure 15) represents women, newborns and children who are missing out on this life saving care.

Figure 15: Striking Successes to Missed Opportunity

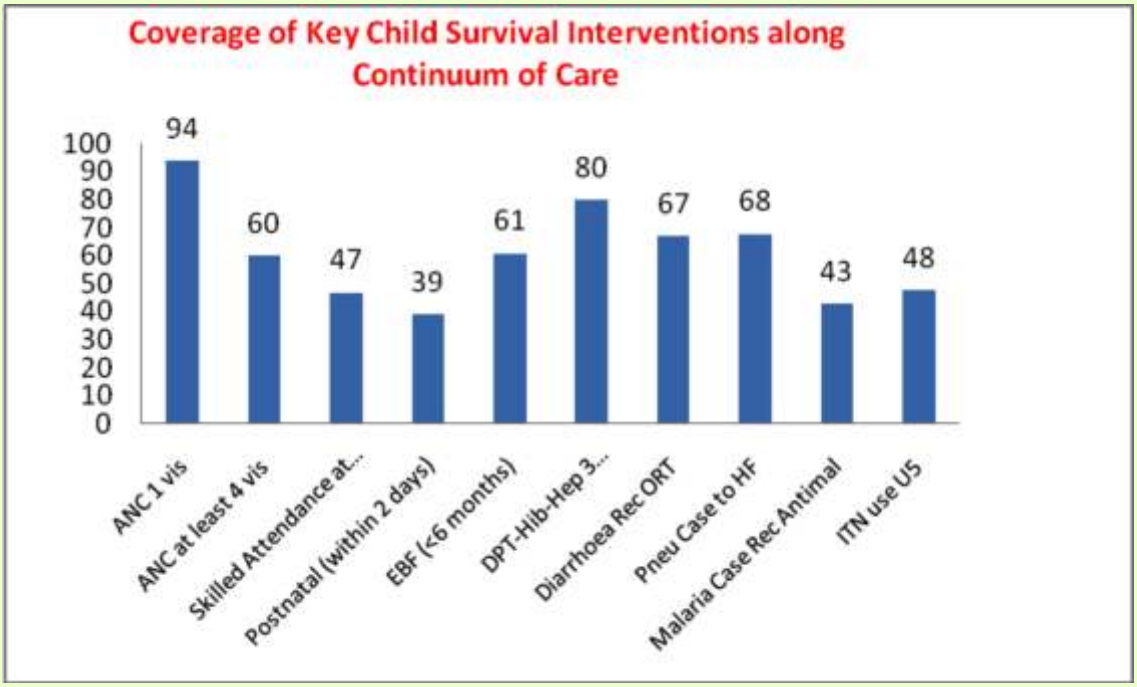


Source: 2007 ZDHS & MIS 2008

8. Coverage across the continuum of Care: Highs and Lows

The figure below shows the coverage of care through key stages (pre pregnancy, pregnancy, birth, postnatal period and childhood) in the lifecycle. Highlighted in figure 16 are the highs and lows of care through out the lifecycle.

Figure 16. Continuum of Care- Highs and Lows throughout the Life Cycle



Source: ZDHS 2007 and MIS 2008

Priority Coverage Gaps Identified in the Continuum Of Care….

Family Planning Services: There has been an increase in the use of modern methods. In 1992 use of modern methods increased from 9 percent, 14 percent in 1996, and 23 percent in 2001-2002 to 33 percent in 2007. This is still inadequate and there is a significant number of women not accessing family planning services even when they want to.

Skilled attendance at delivery: Only 47 percent of births are assisted by a skilled health worker, an increase of 4 percent from 43 percent in 2001-2002. Skilled health care influences birth outcome and health of the mother and infant.

Post natal visit within 2 days: Care for the mother and infant within 2 two days of delivery which is the most critical period is low at 39 percent when more than 50 percent of neonatal deaths occur. A significant number of mothers die due to complications arising from the delivery within the same period of highest neonatal deaths.

Clinical care for sick children: Only forty- six percent of children with pneumonia- a significant killer in children under the age of five years received appropriate treatment.

Infant and Young Child Feeding: Even though the exclusive breastfeeding up to 6 months

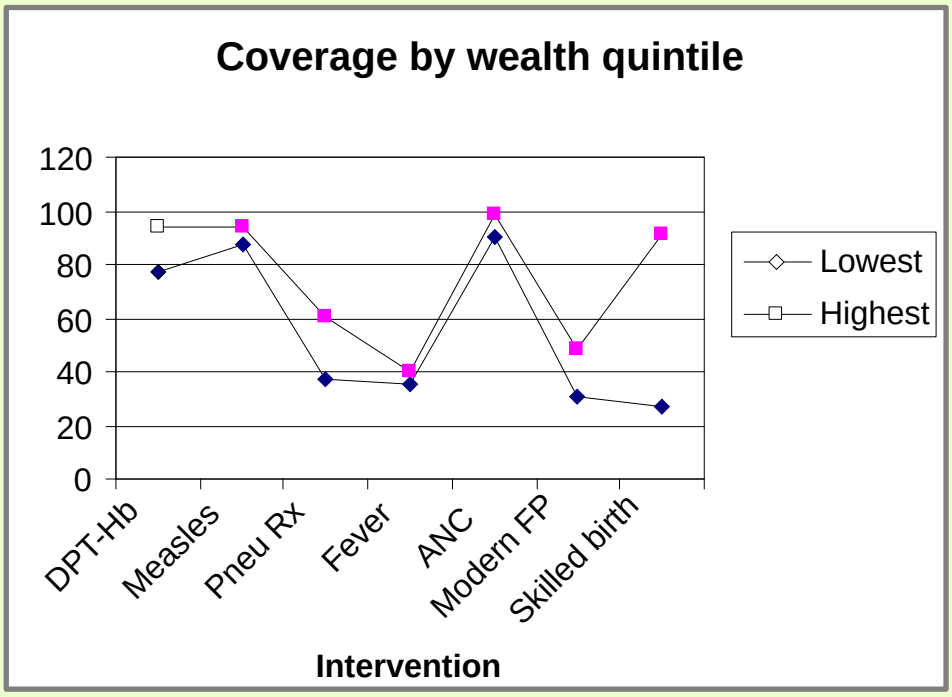
rate has increased from 40 to 61 percent, there is need to continue promoting for universal exclusive breastfeeding as this is a proven intervention that saves lives. Introduction of appropriate and adequately nutritious complementary feeds at 6 months is an important aspect for the continued care of the infant. This is usually a challenge as most of the complementary foods that are introduced at this time are not adequate in quality and quantity.

9. Closing the Gap: Targeting the Poorest

Reduce Inequalities

The coverage gap represents the percentage of target population not receiving critical services for maternal and child survival. This measure raises awareness levels of the magnitude of inequities within the country and generally shows that wealthier populations have greater access to key interventions than poor ones. The figure below shows some inequities in critical interventions for maternal, newborn and child health.

Figure 17: Coverage of Interventions by Wealth Quintile



Source: ZDHS 2007

10. Creating Health Policies for Women and Children

Policies creating enabling environment for provision of effective interventions exists and these include:

- International Code of Marketing Breastmilk Substitutes
- New ORS formular and Zinc management for diarrhoea
- Community treatment for pneumonia partial
- IMCI adapted to include 0-1 week of age
- Costed implementation plans for maternal, newborn and child health available-partial
- Midwives being authorized to administer a core set on life saving interventions-partial
- Maternal Protection 90 days paid leave. Partial implementation. Need to ratify the ILO Maternity Protection Convention 183.
- Specification of maternal deaths Partial. There is need to institutionalize maternal death reviews

The challenge remains in the successful implementation of some of these policies

11. Call to Action: Lead The Change For Women And Children

What can Government do differently?
Actively involve all partners through the process of planning, implementation, monitoring and evaluation of MNCH

Advocacy to parliamentarians on importance of MNCH and importance of improving the maternal and child indicators as a means of assessing progress in country's development
Lobbying to parliamentarians on increased allocation of targeted funds for MNCH

Timely and regular sharing of data
Prioritising in planning, implementation and monitoring of the key MNCH interventions within the continuum of care (pre-pregnancy through 24 months) at all levels in government
Operational research to improve on scaling up of the key interventions especially in the under-served population

What can Parliamentarians do?
Advocate for and increase targeted funding for MNCH and the health sector as a whole
Actively participate in the planning, implementation and monitoring of MNCH programmes in their constituencies

What can donors do?
Cooperating Partners (CPs) should be actively involved in the development and monitoring of national and sector plans: National Development Plan (NDP), National Health Strategic Plan (NHSP), provincial planning and reviews, programme monitoring, mid-term reviews of the national and sector plans.

CPs should commit funding for MNCH through buy in of existing plans
Lobbying for leveraging of resources directed at targeted programmes e. g. GFATM, GAVI, RBM, World Bank

What can civil society organizations do?
Be actively involved in the planning, implementation and monitoring of MNCH at all levels

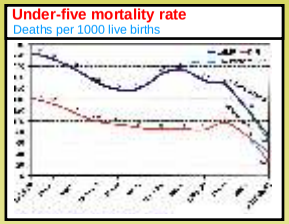
Ministry of Health

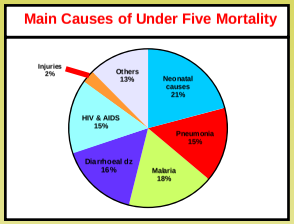
Countdown to 2015 Zambia

Marternal, Newborn & Child Survival

DEMOGRAPHICS

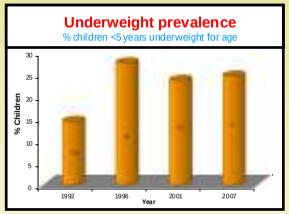
Total Populations	11,696 (2006)
Total under-five population (000)	2,012 (2006)
Birth (000)	470
Birth registration (%)	10
Under-five mortality rate (per 1000 live births)	119
Infant mortality rate (per 1000 live births)	70
Neonatal Mortality rate (per 1000 live birth)	34
Marternal mortality rate (per 100,000 live births)	591

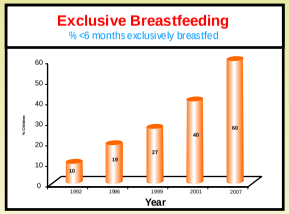


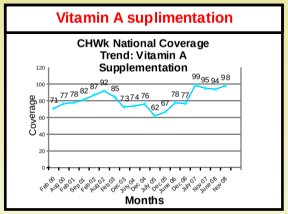


INTERVENTION COVERAGE FOR MOTHERS, NEWBORNS AND CHILDREN

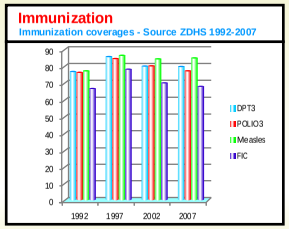
NUTRITION

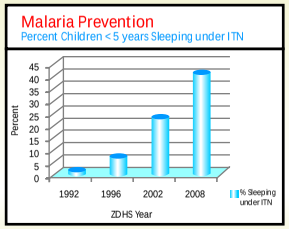


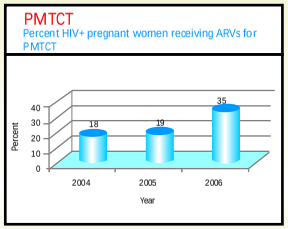


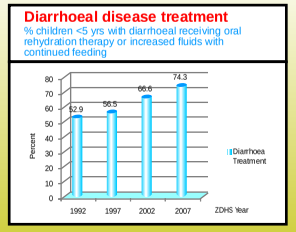


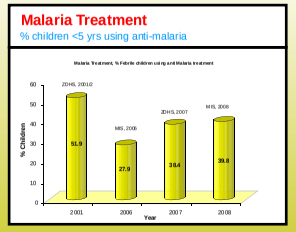
CHILD HEALTH

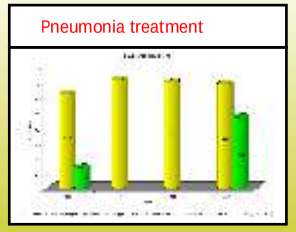






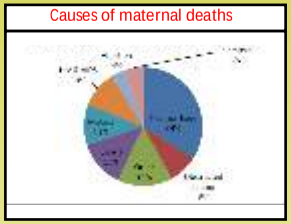


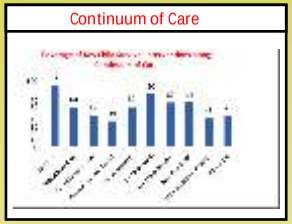


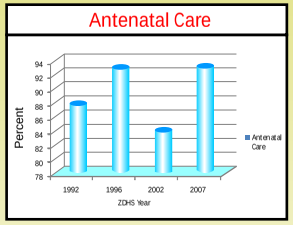


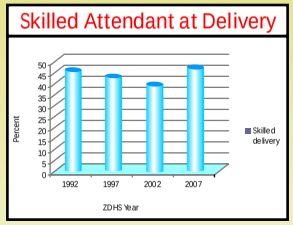
MATERNAL AND NEWBORN HEALTH

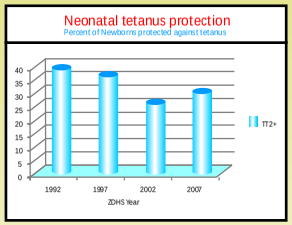
Unmet need for family planning (%)	27 (2007)
Antenatal visits for women (4 or more visit, %)	61 (2007)
Intermittent preventive treatment for malaria, %)	87 (2007)
Early initiation of breastfeeding (within 1 hr of birth, %)	57 (2007)
Postnatal visit for baby (within 2 days, %)	39 (2007)



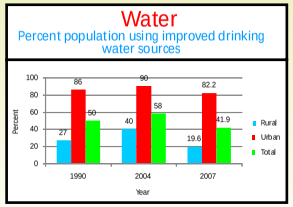


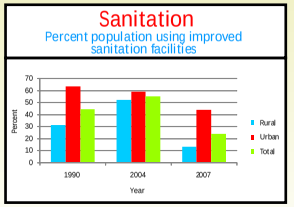




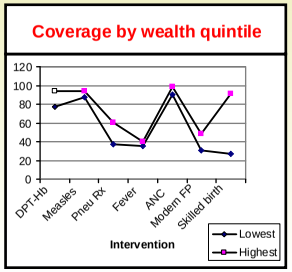


WATER AND SANITATION





EQUITY



POLICIES

International Code of Marketing Breastmilk Substitutes	
New ORS formular and Zinc management for diarrhoea	
Community treatment for pneumonia.	partial
IMCI adapted to include 0-1 week of age	
Costed implementation plans for maternal, newborn and child health available.	partial
Midwives being authorized to administer a core set on life saving interventions.	partial
Maternal Protection 90 days paid leave.	Partial
Specification of maternal deaths.	Partial

Zambia

Countdown to 2015
CONFERENCE REPORT

SPONSORS / PARTNERS

WHO, UNICEF, HSSP, JHPIEGO, UNFPA, STANCHART, CLINTON FOUNDATION, NATSAVE, ZPCT, CHAZ