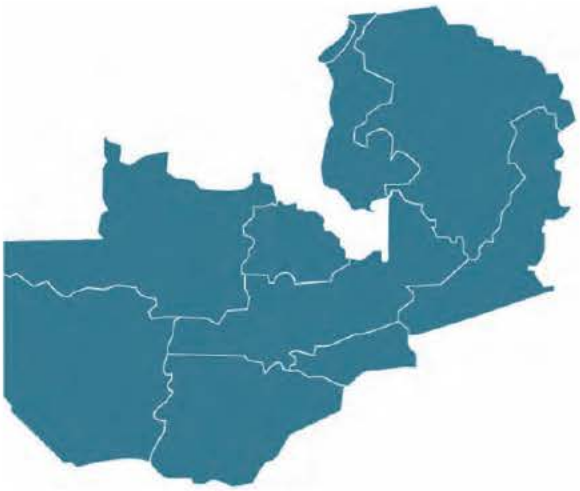
MCHIP Country Brief: Zambia



Selected Health and Demographic Data for Zambia	
Maternal mortality ratio (deaths/100,000 live births)	591
Neonatal mortality rate (deaths/1,000 live births)	34
Under-5 mortality rate (deaths/1,000 live births)	119
Infant mortality rate (deaths/1,000 live births)	70
Contraceptive prevalence rate	32.7
Total fertility rate	6.2
Skilled birth attendant coverage	82.6%
Antenatal care,4+ visits	60.3%
Sources: Zambia International Monetary Fund, Zambia 2010 Census of Population and Housing Preliminary Results, 2007 Demographic and Health Survey.	

Health Areas:

- Newborn Health
- Child Health
- Maternal Health
- Family Planning

Program Dates	October 1, 2011–June 30, 2014					
Total Mission Funding	Redacted					
Geographic Coverage	**No. (%) of provinces**	30%	**No. of districts**	7	**No. of facilities**	244
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INTRODUCTION

Although significant achievements in maternal, newborn and child health (MNCH) have been realized in Zambia, there is still much room for improvement. Currently Zambia ranks 156 out of 180 countries for maternal deaths globally with an estimated 2,600 maternal and 20,400 newborn deaths each year. Currently, 47% of deliveries are attended by a skilled birth attendant and only 48% take place in health facilities. While the maternal mortality ratio has decreased from 729 to an estimated 440 per 100,000 live births from 2001 to 2010, the lifetime risk of maternal death stands at 1 in 37. However, these deaths can be avoided. Of the complications that lead to death, 90% can be averted when women in need have access to quality prevention, diagnostic, and treatment services.

In an effort to achieve Zambia's Millennium Development Goal (MDG) targets of a 162/100,000 maternal mortality ratio and 35/1,000 infant mortality ratio by 2015, the Zambia Ministry of Health (MOH) and Ministry of Community Development, Mother and Child Health (MCDMCH) strategized to increase access to skilled delivery services at health facilities. Through the U.S. Government (USG)-led *Saving Mothers, Giving Life* (SMGL) endeavor, Zambia was selected as a pilot country to examine the effects that concentrated investments in demand creation and health facility improvement can have on maternal survival. Through its public-private partnership, SMGL set the aspirational goal of reducing maternal mortality by 50% in target districts in one year by increasing the availability and use of high-impact maternal health services, particularly in the labor/delivery and immediate postpartum periods.

Under SMGL, MCHIP is designated as the main clinical implementing partner for Mansa and Samfya districts, where MCHIP is working to improve the delivery of high-impact maternal and newborn health services in 62 target facilities. MCHIP is also designated as the *Helping Babies Breathe* (HBB) clinical implementing partner for Chipata, Choma, Kalomo, Lundazi, and Nyimba districts, where the project reaches a total of 179 target facilities.

In order to achieve the goal of 50% reduction in maternal mortality in Mansa and Samfya districts, reduce neonatal mortality in all seven districts and improve postpartum family planning, MCHIP is guided by three main objectives:

1. Increase the quality of labor/delivery and postpartum/postnatal care services in MOH/MCDMCH facilities in SMGL target districts
2. Build capacity of MOH/MCDMCH facilities in Mansa District to increase uterotonic coverage through use of active management of the third stage of labor (AMTSL) in facilities and through distribution of misoprostol for home birth
3. Expand the availability of quality postpartum family planning services in MOH/MCDMCH facilities in Mansa District

MCHIP's approach to reaching these goals and objectives was to work closely across national, district, and community levels to revise and standardize national training packages, implement activities to improve the quality of clinical care and generate demand for maternal health services.

Key interventions included:

- Scaling up emergency obstetric and neonatal care (EmONC) services by training, equipping, and mentoring health care providers at all MOH and MCDMCH facilities that provide labor and delivery services

- Scaling up the *Helping Babies Breathe* (HBB) newborn resuscitation approach by integrating it with the national in-service EmONC curriculum, the National Newborn Framework and the Essential Newborn Care Guidelines, training HBB district trainers and providers, and providing target facilities with resuscitation equipment
- Assisting MCDMCH in the scale-up of misoprostol for postpartum hemorrhage (PPH) prevention by developing a standardized approach based on national policy and developing a three-day PPH prevention refresher training package for health care providers and a five-day safe motherhood action group (SMAG) training package focusing on community education
- Strengthening long-acting reversible contraception (LARC) and postpartum family planning (PPFP) services by training providers with a combined LARC/postpartum intrauterine contraceptive device (PPIUCD) training package and equipping facilities
- Developing a district clinical mentorship program that trained teams in mentorship, coaching, and clinical simulations. Teams were deployed on a monthly basis to all health facilities providing labor and delivery and LARC/PPFP services in Mansa and Samfya districts.

MCHIP has been recognized for its successful implementation of these key interventions and its accomplishments have had a wide reach across each objective.

KEY ACHIEVEMENTS

Objective 1: Increase the quality of labor/delivery and postpartum/postnatal care services in MOH/MCDMCH facilities in SMGL target districts

MCHIP supported trainings for over 90% of labor/delivery providers (N=141) in Mansa District. As a result, 31 out of 32[1] facilities that provide delivery services in Mansa have at least one trained EmONC/HBB provider who is able to apply his/her skills and bring lifesaving services closer to the community and the home. During its first six months of implementation, 34% (N=122) of labor/delivery providers in Samfya District were trained. In Mansa, the overall case fatality rate dropped from 3.4% to 2.7%. The proportion of women receiving care according to national standards increased for PPH (87.5% to 94.7%), pre-eclampsia (PE) (50% to 100%), and eclampsia (75% to 100%).

"After my training in EmONC and HBB, I developed confidence in handling obstetric emergencies. The labor ward has become one of my favorite places to work."

Aloysius Mulenga Kakungu, Clinical Officer, Senama UHC

MCHIP spearheaded the inclusion of HBB into the National Newborn Framework, bringing into focus gaps in neonatal resuscitation, especially misclassification of asphyxiated babies

[1] One additional rural health center that provides labor and delivery services was established in Mansa District as MCHIP came to a close and thus did not benefit from MCHIP-supported interventions.

as stillbirths and incorrect resuscitation technique. Overall, MCHIP trained 346 providers in HBB across the seven districts. With HBB included in the national EmONC curriculum, a greater number of providers will be reached, more cost-effectively.

Finally, MCHIP worked in close collaboration with the Mansa and Samfya district community medical offices (DCMOs) to develop district clinical mentorship programs. The program adapted the evidence-based "low dose, high frequency" training method and obligated mentors and providers to approach quality improvement as a team, rather than as adversaries. Mentorship promoted retention of skills, especially in facilities with infrequent need to perform many basic emergency obstetric and newborn care (BEmONC) functions. Mentorship also promoted adherence to clinical guidelines. Over the life of the project, 85.4% of PE cases were treated according to clinical guidelines and 91% of PPH cases were treated according to clinical guidelines. And in Mansa District, from baseline to Y6 Q2, use of the partograph increased from 6.1% to 44.3%, with 77.1% of partographs appropriately filled out and used for clinical decision-making. At the close of the MCHIP project, Mansa District was continuing to fund the mentorship program in order to continually improve adherence to clinical guidelines and the quality of services delivered.

Objective 2: Build capacity of MOH/MCDMCH facilities in Mansa District to increase uterotonic coverage through use of AMTSL in facilities and through distribution of misoprostol for home birth

MCHIP collaborated with Population Services International (PSI) to develop standard training curriculums in PPH to accompany the misoprostol national guidelines. The collaboration resulted in two draft national training packages: one to train health care providers responsible for distributing misoprostol to women at the first antenatal visit and one to train SMAGs to educate communities about misoprostol and the benefits of facility deliveries. These curriculums can ensure a standard training methodology regardless of the implementing partner and situate misoprostol within a comprehensive approach to PPH prevention, which includes facility delivery and AMTSL as the foremost interventions.

Using this package, MCHIP worked in partnership with the Mansa DCMO and trained 20 providers at high-volume health facilities in PPH prevention, including the distribution and tracking of misoprostol for home deliveries. Due to an unexpected national-level stock-out of misoprostol after this activity was undertaken, no further trainings incorporating misoprostol were conducted under MCHIP. Funds were instead utilized to support capacity development through additional EmONC training. Trainings and implementation of the improved curriculum should commence once misoprostol is back in stock.

Objective 3: Expand the availability of quality postpartum family planning services in MOH/MCDMCH facilities in Mansa District

MCHIP and the Mansa DCMO rolled out LARC and PPFP, including the intrauterine contraceptive device (IUCD) and PPIUCD to seven high-volume facilities in the district. MCHIP trained district clinical mentors in LARC/PPFP for incorporation into monthly mentorship visits and an additional 26 providers from the target facilities in the district and provided them with necessary supplies. Despite slow initial uptake, in Y6 Q2, the number of women receiving an insertion of Jadelle® contraceptive implants increased from 0 at the baseline to 634 for all facilities and from 0 to 552 in MCHIP FP target facilities. Uptake in PPIUCD has been slower to increase; the proportion of women delivering at a facility receiving an PPIUCD insertion prior to discharge increased from 0 at baseline to 0.8% in all facilities and from 0 to 1.2% in MCHIP FP target facilities during Y6 Q2, but providers and SMAGs are currently working to further sensitize communities. Providers and SMAGs are demonstrating that effective training and

mentorship can overcome provider resistance to these methods and that when competent, confident providers are available, women will access LARC and PPFP, including the IUCD. MCHIP promoted community awareness and acceptance of the PPIUCD by training SMAGs at target health facilities. SMAGS learned about messaging that focuses on the benefits and availability of family planning and addresses common misconceptions about LARC. Since SMAGs were trained and began activities in their communities, increases have been seen in the uptake of Jadelle implants and PPIUCD.

WAY FORWARD

During its three years of SMGL implementation, MCHIP saw promising results leading toward achievement of its goals and objectives. However, as with any project, lessons were learned and recommendations were made for improvement moving forward.

- *Intensive investment in limited geographic/administrative areas can produce quick and potentially sustainable results*
  Rather than spreading efforts widely across many districts or provinces, concentration in a specific location enables partners to focus resources and form strong partnerships with buy-in from local governments.

- *Collaboration among implementing partners is best achieved when partners share common, key priorities*
  The common SMGL goal of achieving a 50% reduction in maternal mortality aligned partner interventions and encouraged active cooperation. The lesser focus on neonatal mortality reduction did, however, result in less collaboration and a more challenging rollout of HBB outside of Mansa and Samfya districts.

- *Mentorship is a low-cost, high-impact intervention that can effectively build upon and sustain the benefits of higher cost interventions in training and site strengthening*
  At a cost of a few thousand dollars a month, MCHIP and the DCMOs were able to provide on-site clinical support to every health facility in the districts on a monthly basis. Practice with a mentor ensured consistent delivery of high-quality EmONC services and created a collaborative relationship between providers and mentors.

- *New health interventions are most likely to succeed when the community is actively engaged in their implementation*
  By engaging SMAGs to educate communities about the use of LARC, MCHIP was able to debunk common myths and misconceptions and build trust between health care providers and patients to increase uptake of the interventions.