

Zambia 1999 Multiple Indicator Cluster Survey Report

**Report on the monitoring of the End of
Decade Goals**



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Foreword

Acknowledgements

Executive Summary

The 1999 Zambia Multiple Indicator Cluster Survey (MICS) was a nationally and provincially representative survey of households, women, and children. The main objectives of the survey were to provide up-to-date information for assessing the situation of children and women in Zambia at the end of the decade; and to furnish the necessary data for monitoring progress toward the goals established at the World Summit for Children. This data will form the basis for future action. Below are some of the key findings

Education

- Sixty two per cent of children of primary school age in Zambia were attending primary school. School attendance in Eastern province is significantly lower than in the rest of the country at 44 per cent. At the national level, there was virtually no difference between male and female primary school attendance - 61.6 per cent for boys and 61.5 per cent for girls.
- The vast majority (85 per cent) of children who entered the first grade of primary school reached Grade Five.
- More than two thirds (68 per cent) of the population that is over age 15 years is literate. However, literacy declines from 71 per cent among those aged 15-34 to 57 per cent among the population aged 65 and older.

Water and Sanitation

- Fifty nine per cent of the population has access to safe drinking water – 89 per cent in urban areas and 38 per cent in rural areas. The situation in Luapula province is considerably worse than in other provinces; only 17 per cent of the population in the province gets its drinking water from a safe source.
- Approximately 79 per cent of the population in Zambia was living in households with sanitary means of excreta disposal.

Child Malnutrition

- Twenty five per cent of children under the age of five in Zambia were underweight or too thin for their age. Fifty three per cent of children were stunted or too short for their age and six per cent were wasted or too thin for their height.
- Children whose mothers had secondary or higher education were the least likely to be underweight and stunted compared to children of mothers with less education.

Breastfeeding

Approximately 29 per cent of children aged less than four months were exclusively breastfed, a level considerably lower than recommended.

Salt Iodization

- Approximately 68 per cent of households in Zambia has adequately iodized salt. The percentage of households with adequately iodized salt ranged from 37 per cent in Luapula to 93 per cent in Western province.

Vitamin A Supplementation

- In the six months prior to the MICS, 81 per cent of children aged 6-59 months received a high dose Vitamin A supplement. Approximately 5 per cent did not receive a supplement in the last 6 months but did receive one prior to that time.

- Vitamin A supplementation depends on the mother's level of education. The percentage receiving a supplement in the last six months increased from 79 per cent among children whose mothers had no education to 86 per cent among children of mothers with secondary or higher education.
- Only about 40 per cent of mothers with a birth in the year before the MICS received a Vitamin A supplement within eight weeks of the birth

Low Birth weight

- Approximately 8 per cent of infants were estimated to weigh less than 2500 grams at birth. This percentage is somewhat lower than the average for the Latin America and Caribbean countries (*The State of the World's Children, 2001*, UNICEF).

Immunization Coverage

- Approximately 65 per cent of children aged 12-23 months received a BCG vaccination before the survey and the first dose of DPT was given to 82 per cent. The percentage declines for subsequent doses of DPT to 75 per cent for the second dose, and 64 per cent for the third dose.
- Similarly, 86 per cent of children received Polio 1 before the survey and this declines to 76 per cent by the third dose.
- The coverage for measles vaccine was 74 per cent.
- Slightly over half of children had all eight recommended vaccinations before the survey.
- Male and female children are vaccinated at roughly the same rate.
- Vaccination coverage is highest among children whose mothers have secondary or higher education. The education differences are greatest for the third doses of DPT and Polio, suggesting that drop out rates are higher among children with less educated mothers.

Diarrhoea

- Approximately 19 per cent of under five children had diarrhoea in the two weeks preceding the survey
- About 92 per cent of these children received one or more of the recommended home treatments (i.e., were treated with ORS or RHF).
- Only 8 per cent of children with diarrhoea received increased fluids and continued eating as recommended.

Acute Respiratory Infection

- About 3 per cent of under five children had an acute respiratory infection in the two weeks prior to the survey. Approximately 70 per cent of these children were taken to an appropriate health provider.

IMCI Initiative

- Among under five children who were reported to have had diarrhoea or some other illness in the two weeks preceding the MICS, only 7 per cent received increased fluids and continued eating as recommended under the IMCI programmed.
- Approximately 14 per cent of mothers knew at least two of the signs that a child should be taken immediately to a health facility.

Malaria

- In Zambia only 6 per cent of under five children slept under a bednet the night prior to the survey interview. However, only about 18 per cent of the bednets used were impregnated with insecticide.

- Approximately 60 per cent of children with a fever in the two weeks prior to the MICS interview were given Paracetamol to treat the fever and 38 per cent were given Chloroquine while less than 1 per cent were given other medicines.

HIV/AIDS

- About 44 per cent of women aged 15-49 know that there are three main ways of preventing HIV transmission – having only one uninfected sex partner, using a condom every time, and abstaining from sex.
- Forty one per cent of women correctly identified three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected.
- Fifty nine per cent of women of reproductive age in Zambia know a place to get tested for AIDS and about 5 per cent had been tested.
- The percentage of women who had sufficient knowledge of HIV transmission and the percentage who knew where to get tested for HIV increased dramatically with the level of education.

Contraception

- The use of contraceptives was reported by 22 per cent of married or in union women. The most popular method was the pill that was used by 13 per cent of married women followed by the female injection, which accounts for 3 per cent of married women.

Prenatal Care

- Two out of three women with recent births in Zambia were protected against neonatal tetanus. The vast majority of these women had received two or more doses of tetanus toxoid within the last three years.
- Virtually all women in Zambia have received some type of prenatal care and 83 per cent have received antenatal care from skilled personnel (doctor, nurse, midwife).

Assistance at Delivery

- A doctor, nurse, or midwife delivered about 47.1 per cent of births in the year prior to the MICS survey. This percentage is highest in Lusaka province at 81 per cent and lowest in Southern at 30 per cent.

Birth Registration

- The births of 90 per cent of the children under five years in Zambia have not been registered. There were no significant variations in birth registration across sex, age. But there was a variation by education level.

Orphanhood and Living Arrangements of Children

- Overall, 64 per cent of children aged 0-14 were living with both parents. Children who were not living with a biological parent comprised 10 per cent of all children aged 0-14.
- The situation of children in Western province differs from that of other children. In Western province, only about half of children live with both parents. Sixteen per cent live with their mother only although their father is alive and a relatively large proportion (12 per cent) were living with neither parent.

Child Labour

- Less than 1 per cent of children aged 5-14 years engage in paid work. About 8 per cent participate in unpaid work for someone other than a household member.

- Almost two thirds of children aged 5-14 engage in domestic tasks, such as cooking, fetching water, and caring for other children for less than four hours a days.

Summary Indicators

World Summit for Children Indicators		
Under-five mortality rate	Probability of dying before reaching age five	Not collected
Infant mortality rate	Probability of dying before reaching age one	
Underweight prevalence	Proportion of under-fives who are too thin for their age	25.0 per cent
Stunting prevalence	Proportion of under-fives who are too short for their age	53.0 per cent
Wasting prevalence	Proportion of under fives who are too thin for their height	5.6 per cent
Use of safe drinking water	Proportion of population who use a safe drinking water source	58.6 per cent
Use of sanitary means of excreta disposal	Proportion of population who use a sanitary means of excreta disposal	79.2 per cent
Children reaching grade five	Proportion of children entering first grade of primary school who eventually reach grade five	85.3 per cent
Net primary school attendance rate	Proportion of children of primary school age attending primary school	61.5 per cent
Literacy rate	Proportion of population aged 15+ years who are able to read a letter or newspaper	67.9 per cent
Antenatal care	Proportion of women aged 15-49 attended at least once during pregnancy by skilled personnel	83.1 per cent
Contraceptive prevalence	Proportion of married women aged 15-49 who are using a contraceptive method	22.0 per cent
Childbirth care	Proportion of births attended by skilled health personnel	47.1 per cent
Birth weight below 2.5 kg.	Proportion of live births that weigh below 2500 grams	7.5 per cent
Iodized salt consumption	Proportion of households consuming adequately iodized salt	68.2 per cent
Children receiving Vitamin A supplementation	Proportion of children aged 6-59 months who have received a Vitamin A supplement in the last 6 months	80.9 per cent
Mothers receiving Vitamin A supplementation	Proportion of mothers who received a Vitamin A supplement before infant was 8 weeks old	39.7 per cent
Exclusive breastfeeding rate	Proportion of infants aged less than 4 months who are exclusively breastfed	29.1 per cent
Timely complementary feeding rate	Proportion of infants aged 6-9 months who are receiving breast milk and complementary food	Not collected
Continued breastfeeding rate	Proportion of children aged 12-15 months and 20-23 months who are breastfeeding	Not collected
DPT immunization coverage	Proportion of children immunized against diphtheria, pertussis and tetanus by age one	64.2 per cent
Measles immunization coverage	Proportion of children immunized against measles by age one	74.3 per cent
Polio immunization coverage	Proportion of children immunized against polio by age one	75.8 per cent
Tuberculosis immunization coverage	Proportion of children immunized against tuberculosis by age one	64.6 per cent
Children protected against neonatal tetanus	Proportion of one year old children protected against neonatal tetanus through immunization of their mother	60.3 per cent
ORT use	Proportion of under-five children who had diarrhoea in the last 2 weeks who were treated with oral rehydration salts or an appropriate household solution	92.1 per cent
Home management of diarrhoea	Proportion of under-five children who had diarrhoea in the last 2 weeks and received increased fluids and continued feeding during the episode	8.3 per cent

Care seeking for acute respiratory infections	Proportion of under-five children who had ARI in the last 2 weeks and were taken to an appropriate health provider	70.4 per cent
Preschool development	Proportion of children aged 36-59 months who are attending some form of organized early childhood education programme	6.4 per cent
Indicators for Monitoring Children's Rights		
Birth registration	Proportion of under-five children whose births are reported registered	9.6 per cent
Children's living arrangements	Proportion of children aged 0-14 years in households not living with a biological parent	10.3 per cent
Orphans in household	Proportion of children aged 0-14 years who are orphans living in households	2.2 per cent (Both parents) 2.1 per cent (Maternal) 7.4 per cent (Paternal)
Child labour	Proportion of children aged 5-14 years who are currently working	10.4 per cent
Indicators for Monitoring IMCI and Malaria		
Home management of illness	Proportion of under-five children reported ill during the last 2 weeks who received increased fluids and continued feeding	6.7 per cent
Care seeking knowledge	Proportion of caretakers of under-five children who know at least 2 signs for seeking care immediately	13.8 per cent
Bednets	Proportion of under-five children who sleep under an insecticide impregnated bednet	1.2 per cent
Malaria treatment	Proportion of under five children who were ill with fever in the last 2 weeks who received anti-malarial drugs	37.7 per cent
Indicators for Monitoring HIV/AIDS		
Knowledge of preventing HIV/AIDS	Proportion of women who correctly state the 3 main ways of avoiding HIV infection	43.5 per cent
Knowledge of misconceptions of HIV/AIDS	Proportion of women who correctly identify 3 misconceptions about HIV/AIDS	40.6 per cent
Knowledge of mother to child transmission	Proportion of women who correctly identify means of transmission of HIV from mother to child	68.5 per cent
Attitude to people with HIV/AIDS	Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS	70.3 per cent
Women who know where to be tested for HIV	Proportion of women who know where to get a HIV test	59.0 per cent
Women who have been tested for HIV	Proportion of women who have been tested for HIV	4.9 per cent

I. Introduction

Background of the Survey

In September 1990, the World Summit for Children which was held at the United Nations in New York, the Government of Zambia committed itself to a Declaration on the Survival, Protection and Development of Children and a Plan of Action for Children. These commitments were a renewed effort to put children first in all development interventions. Zambia ratified the United Nations Convention on the Rights of the Child on 6 December 1991.

In August, 1994, Zambia demonstrated her resolve to realize children's rights to the survival, protection and development of the child by adopting the National Child Policy. Subsequently, the National Programme of Action for Children (NPAC) was developed and thus set Zambia on a path towards achieving goals for the survival, protection and development of children by the year 2000. The NPAC provided a focus for specific actions to improve the living conditions of children and to ensure that the programmes of economic and social recovery directly addressed these needs.

The Plan of Action also called for the establishment of mechanisms for monitoring progress toward the goals and objectives set for the year 2000. Toward this end, UNICEF, in collaboration with other international organizations, developed a core set of 75 indicators of specific aspects of the situation of children. A Multiple Indicator Cluster Survey (MICS) was conducted in 1995 to measure progress at mid-decade. The 1999 Zambia MICS survey was implemented to provide end-decade information on many of the indicators. Information on other indicators was derived from the vital registration system and various disease monitoring systems.

The Zambian MICS was jointly conducted by the Food Security, Health and Nutrition Information System (FHANIS) and the Central Statistical Office (CSO) Labour Division. Funding was provided by the UNICEF Zambia country office and the International Labour Organisation (ILO). Where as UNICEF funding was principally focused on obtaining indicators for child protection, survival and development, ILO focused on child labour. As such the survey in Zambia is called the End of Decade Goals and Child Labour Survey (EDGCLS).

This report presents results on the main areas covered in the survey and on the World Summit indicators.

Background on Zambia

Geographically, Zambia has a land area of 752,614 square kilometers and is land locked with eight neighbouring countries. The longest boundary is shared with the Democratic Republic of Congo to the north and northwest, Tanzania to the northeast, Malawi to the east, Mozambique to the southeast, Zimbabwe to the south, Botswana and Namibia to the southwest, and Angola to the west. Zambia derives her name from the Zambezi river.

Administratively, Zambia is divided into nine provinces, namely Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, North-Western, Southern and Western provinces. These provinces are further divided into a total of 72 districts. Lusaka is the capital city of Zambia and the seat of government. The government comprises of central and local government structures.

According to the preliminary report of the 2000 Census of Population and Housing, Zambia's population stood at 10.3 million persons as at 25 October, 2000. Of this total population, 5.1 million were males while 5.2 were females. The Copperbelt Province was the most populated while North Western Province was the least. The average annual growth rate between 1990 and 2000 was 2.9 per cent. In terms of population density, the Copperbelt Province is the most densely populated with 65 persons per square kilometre. North Western Province is the least densely populated with 5 persons per square kilometre.



The demographic and health survey of 1996 estimated infant mortality to be at 109 per 1000 live births while maternal mortality was estimated at 649 per 100,000 live births. Under-five mortality was estimated at 197 per 1000 live births. The total fertility rate was estimated at 6.1.



According to the 1998 Sentinel Surveillance Survey, the estimated adult (15-49 years old) HIV prevalence rate is 19.7 per cent. Current trends show a decline between the period 1994-1998 in terms of HIV positive tests in the age group 15-49 years. However, mother to child transmission of HIV is on the rise. The HIV/AIDS situation accounts for the increase in mortality and morbidity, especially among females and orphaned and vulnerable children. The HIV/AIDS pandemic has eroded Zambia's life expectancy with current prevalence rates estimated at around 37 years. The TB incidence rate increased from 1 per 1,000 to 5 per 1,000 persons. At the same time, the burden of disease caused by malaria, diarrhoea and respiratory tract infections is also a cause of concern.

Zambia is striving to reverse the negative trend in morbidity and mortality. The major thrust for health care provision is to ensure that health care services that focus on primary health care are available, accessible and affordable to the majority of Zambians. In this regard, the Government and its cooperating partners are working out measures that are aimed at ensuring that a basic health care package is made available to most households in Zambia. In addition, the nexus of HIV/AIDS/STD/TB, the rollback malaria programme, child immunization and nutrition supplementation are also being accorded priority.

The management of the Zambian economy is based on free market principles with minimal Government interference under the auspices of the World Bank and International Monetary Fund structural adjustment programme (SAP). The SAP has in recent times shifted focus from macroeconomic stabilization and structural reforms to encompass the emerging issues of HIV/AIDS, the debt burden, gender and the environment among others. These emerging issues are broadly being considered under the complex and diverse phenomenon of poverty. With the current focus on poverty reduction, the government is expected to draw up a broadly consultative, policy and resource consistent poverty reduction strategy paper (PRSP). The PRSP should clearly outline priorities for public action that will have the greatest impact on poverty. The strategy paper is also expected to address the critical and often complex issues related to building capacity, enhancing governance, and supporting transparency in overall policy making. Efforts

should also be made to integrate cross-cutting issues such as population, gender, HIV/AIDS and the environment in developing the PRSP and the national development framework.

Survey Objectives

The 1999 Zambia MICS had as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in Zambia at the end of the decade;
- To furnish the necessary data for monitoring progress towards the goals established at the 1990 World Summit for Children, which will also form the basis for future action;
- To contribute to the improvement of data and monitoring systems in Zambia and to strengthen technical expertise in the design, implementation, and analysis of such systems.

II. Survey Methodology

Sample Design

The Zambia MICS was designed to provide estimates of MICS indicators at the national level, for urban and rural areas, and for nine provinces. The two-stage stratified probability proportional to size (PPS) cluster sampling method was applied in Zambia's MICS survey. Each province was an independent stratum. Each province is stratified by urban and rural strata. The first stage involved the selection of the primary sampling units (Standard Enumeration Areas, SEA) based on the probability proportional to size method in each district. The second stage was the selection of households within the sample SEAs. Three hundred sixty SEAs were selected from total 13,000 SEAs in Zambia. Twenty five households in urban areas and 20 households in rural areas were selected from each sampled SEA by the systematic sampling method. A total of 8,000 households was drawn. Sample weights are used for reporting national and provincial level results. The full technical details of the sample design are included in Appendix A.

The Questionnaire

The questionnaire for the Zambia MICS was based on the MICS Model Questionnaire with some modifications and additions. The questionnaire was administered in each household. As opposed to the MICS Model Questionnaire, the Zambian MICS used one unified questionnaire the comprised the household, women's and child questionnaires. Appropriate instructions guided the enumeration process vis-à-vis which section of the questionnaire applied to what category of respondent. In each household, information was collected on household members including sex, age, literacy, marital status, and orphanhood status. Household level questions also included information on education, household expenditure, household income, labour force, child labour, water and sanitation, and salt iodization modules. The module on child labour was expanded to take into account the needs of the ILO child labour component. The module on education considered all members of the household greater than five years as opposed to the MICS standard of child level questions. In addition to questions at household level, questions were administered

in each household for women age 12-49 and children under age five in contrast to the MICS standard of 15-49 years. For children, the questions were administered to the mother or primary caretaker of the child. All modules in the MICS model questionnaire were used for child level questions with the exception of the child mortality module. The optional modules of maternal mortality and child disability were not implemented in the Zambia MICS. Since the Zambian MICS was prepared ahead of the finalization of the MICS model questionnaire, some questions and their responses may not strictly follow the MICS model.

The section of the questionnaire that focused on women aged 15 – 49 contained the following modules:

Maternal care and tetanus toxoid
Contraceptive use
HIV/AIDS.

The section of the questionnaire for children under age five included modules on:

Birth registration and early learning
Vitamin A
Breastfeeding
Care of Illness
Malaria
Immunization
Anthropometry.

The questionnaire was pre-tested during July 1999. The pre-test was primarily concerned with the flow of questions, translation during interview and the actual wording of the questions. Based on the results of the pretest, modifications were made to the wording and better local language translation formats adopted. The full questionnaire is at Appendix B.

Fieldwork and Processing

The field staff (Supervisors and Enumerators) were trained over a period of five days in early September, 1999. The field staff training was preceded by the training of trainers (Master Trainers) that also took five days. After training, field staff were dispatched to conduct the listing exercise that facilitated second stage sampling of households. After sampling, field allocations and dispatching for enumeration was conducted. In each province, two Master Trainers (except Central, Copperbelt and Luapula provinces which had one Master Trainer), four Supervisors (except for Central, Luapula, North-Western, Southern and Western provinces, which had three Supervisors), and approximately twenty enumerators were allocated. The MICS and child labour coordinators provided joint overall supervision. The fieldwork was conducted in October 1999.

For Eastern, North Western, Luapula and Western provinces, questionnaires were transported to Lusaka for entering the data. In the rest of the provinces, data was entered at provincial level. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed (100 per cent verification). Data entry for the survey was done using a software package called Integrated Microcomputer Process System (IMPS). The cleaning of the data was done using the Statistical Application Software (SAS). The data was then converted from SAS to Software Package for Social Sciences (SPSS) format. Data entry began in

November 1999 and was completed by January 2000. Production of tables was undertaken using SPSS with MICS programmes

III. Sample Characteristics and Data Quality

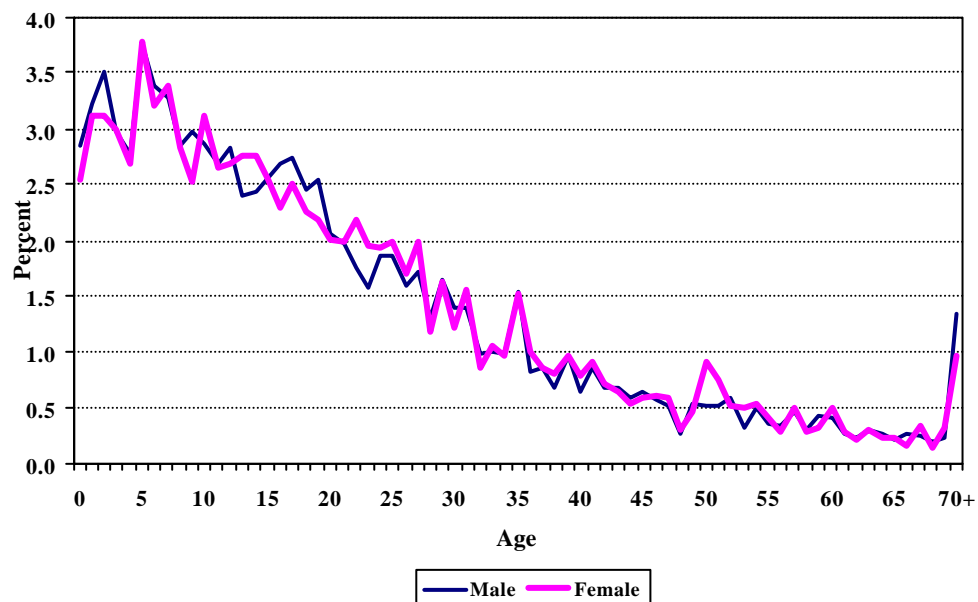
Response Rates

In Zambia, 8,000 households were selected for the MICS sample. When a household refused to be interviewed or could not be found (non-contact), or dwelling could not be found or could not be interviewed due to some other problem, the household was replaced. The replacement was meant to improve the response rate. However, there were cases when even the replacement household could not be interviewed. In the end, a total of 7,915 households were successfully interviewed (see Table 1 of Appendix D) for a household response rate of 98.9 per cent. The response rate was higher in rural areas (99.1 per cent) than in urban areas (98.8 per cent). In the interviewed households, 10,128 eligible women aged 15-49 were identified. Of these, 9,639 were successfully interviewed, yielding a response rate of 95 per cent. In addition, 6,397 children under age five were listed in the household questionnaire. Of these, questionnaires were completed for 6,217 children for a response rate of 97 per cent.

Age Distribution and Missing Data

As shown in Table 2 and Figure 1, the single year age distribution of household members by sex indicates some distortions centred around age 7 for females and on age two for males. There appears to be significant heaping of women on ages 58 and perhaps a slight dearth of women ages 9-10. For both sexes, some digit preference is evident for ages ending in 0 and 5, a pattern typical of populations in which ages are not always known.

Figure 1: Single year age distribution of the household population by sex, Zambia, 1999



As a basic check on the quality of the survey data, the percentage of cases missing information on selected questions is shown in Table 3. A high percentage of about 10 per cent of household members have missing information on their level of education. Under one per cent of all

respondents, did not report a complete birth date (i.e., month and year). These levels of missing data suggest that there were not significant problems with most questions while there were some problem with a few of them. There is a possibility that there were problems with the fieldwork.

The data on weight and height had a higher percentage of missing data in comparison with other questions. In most surveys these data are the most likely among the selected information to be missing. Approximately 20 per cent of children are missing this information, which may be the result of the child not being present, not co-operation, or some other reason.

Characteristics of the Household Population

Information on the characteristics of the household population and the survey respondents is provided to assist in the interpretation of the survey findings and to serve as a basic check on the sample implementation.

Table 4 presents the per cent distribution of households in the sample by background characteristics. About 37 per cent of the households (713,228 households) are urban and 63 per cent (1, 218,420 households) are rural. The Eastern Province comprises the largest of the nine regions with 16 per cent of households while Copperbelt and Lusaka provinces are the next largest with 14 per cent of all households each.

More than one fourth of the households have between four and five members. About 54 per cent of the households contain at least one child under age five and 84 per cent contain at least one woman age 15-49.

Table 5 shows the characteristics of female respondents aged 15-49. Women age 15-19 comprise the greatest percentage of the sample at 24 per cent. This percentage declines steadily across age groups until age 45-49 where it is 5 per cent. This pattern is typical of Zambia. Approximately 70 per cent of women in the sample are married and 71 per cent have ever given a birth. More than two thirds of women have had at least some primary education while only 27 per cent have had at least secondary education.

Table 6 shows the characteristics of children under age five. About 52 per cent of the children are male and 48 per cent are female. The distribution of the children across provinces is not very different from that of the general population (see Table 4). There are slightly more children aged 0-11 months (about 23 per cent), aged 12-23 months (21 per cent) and aged 24-35 months (21 per cent).

IV. Results

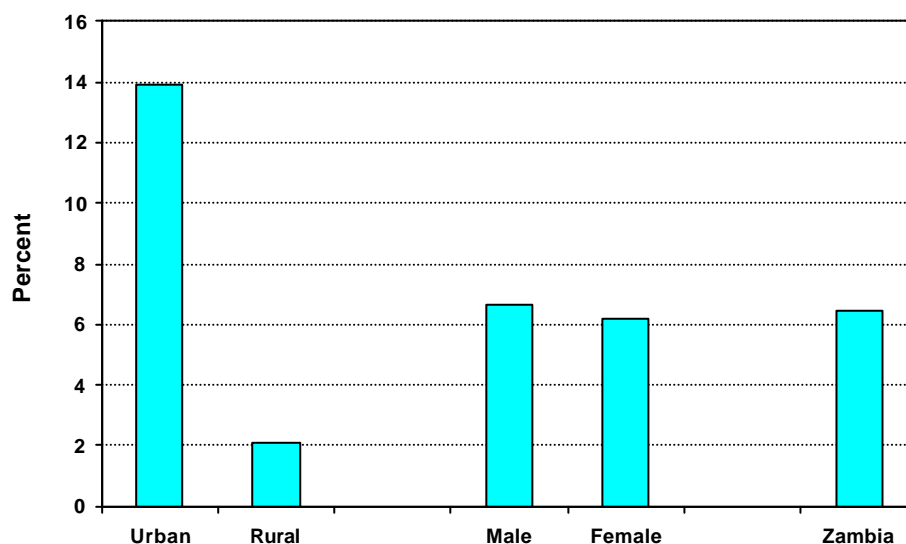
A. Education

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the 1990 World Summit for Children. Zambia recognizes that education is a vital prerequisite for combating poverty, empowering women, and for ultimately promoting human rights and democracy.

Early childhood education

Six in 100 children aged 36-59 months are attending an organized early childhood education programme, such as kindergarten or community childcare with organized learning activities (Table 9). Approximately equal percentages of girls and boys were attending these programmes in 1999. There are large variations according to province ranging from less than 1 per cent of children in Western Province to 19 per cent in Lusaka Province. In addition, children in urban areas are almost seven times as likely to attend early learning activities as children in rural areas (14 per cent urban and 2 per cent rural). Relatively few children attend at age three (36-47 months) while the majority of children attend at age four (48-59 months). Finally, the education of the mother influences whether a child will attend an early childhood education programme. The percentage of children attending increases from 3 per cent to 15 per cent as the mother's education increases from none to secondary or higher education.

Figure 2: Percentage of children aged 36-59 months who are attending some form of organized early childhood education programme, Zambia, 1999

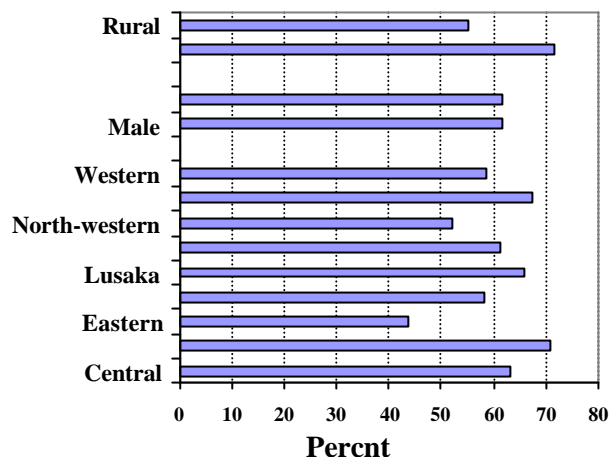


Primary education

Overall, 62 per cent of children of primary school age in Zambia were attending primary school in 1999 (Table 11). In urban areas, 72 per cent of children attend school while in rural areas 55 per cent attend. School attendance in the Eastern Province is significantly lower than in the rest

of Zambia at 43.8 per cent. At the national level, there is virtually no difference between male and female primary school attendance.

Figure 3: Percentage of children of primary school age attending primary school, Zambia, 1999

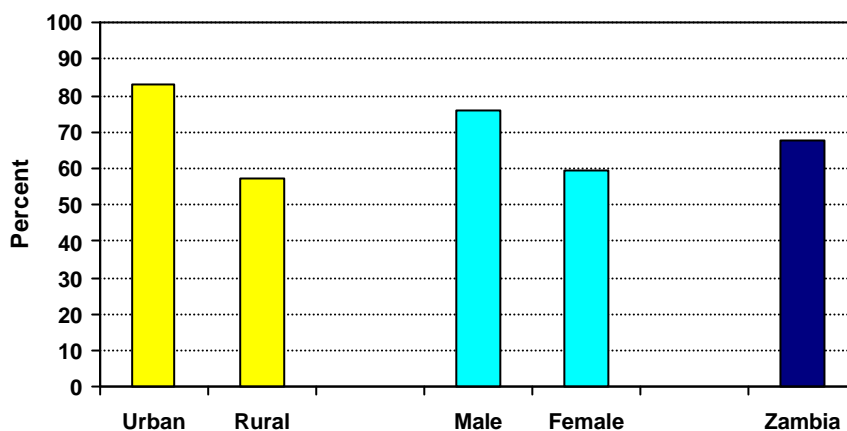


More than four fifth of children in Zambia who enter the First Grade of primary school eventually reach Grade Five (Table 10). However, there are significant provincial and urban-rural disparities in the achievement of Grade Five. Approximately 88 per cent of urban children who enter Grade One reach Grade Five compared to 84 per cent in rural areas. In North-Western Province, 96 per cent of those who enter Grade One reach Grade Five while in Northern Province, the comparable percentage is 78. The main difference between Northern and other provinces is that more children manage to reach the next grade from Grade 1 to Grade 2, Grade 2 to Grade 3, and Grade 3 to Grade 4. But there is a big fall from Grade 4 to Grade 5.

Literacy

The vast majority of the population over age 15 years in Zambia is literate (Table 12). The literate population includes those who are reported to read 'easily or with difficulty' and this figure stands at 68 per cent. Overall, females are less likely than males to be literate at 60 per cent and 76 per cent respectively. The percentage literate is lower in Eastern and North Western Provinces than in Copperbelt and Lusaka Provinces. Literacy is also substantially lower in Eastern province than in other provinces. Literacy tends to increase with increasing age up to a peak in the age group 25–44 and declines thereafter. From a peak of 74 per cent, literacy declines to 39 per cent for the population aged 65 and older.

Figure 4: Percentage of population aged 15 years and older that is literate, Zambia, 1999

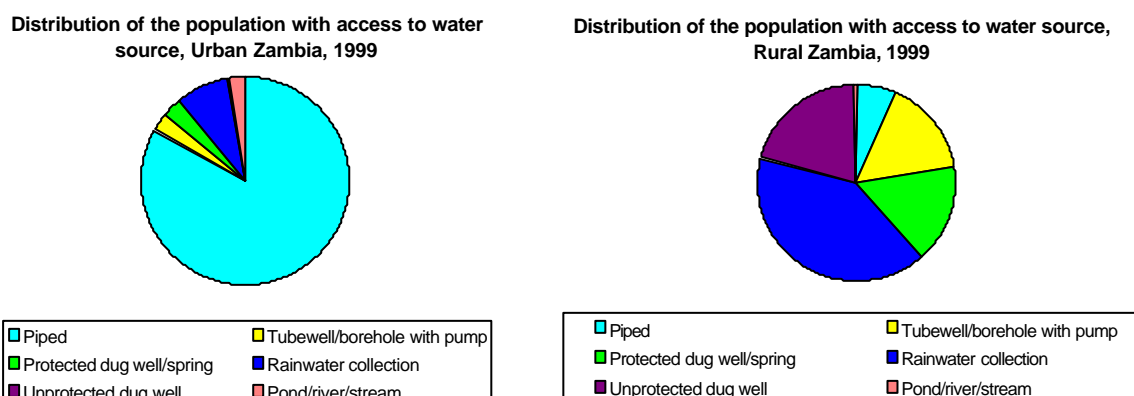


B. Water and Sanitation

Use of drinking water

For any society safe drinking water is a basic necessity for good health. Unsafe drinking water harbours diseases such as trachoma, cholera, typhoid, and schistosomiasis. In some parts of Zambia drinking water is also tainted with chemical, physical and radiological contaminants that have harmful effects on human health. In addition to its association with disease, access to drinking water is particularly important for women and children, especially those in rural areas, who bear the primary responsibility of carrying water, often than not for long distances. Thus the high morbidity from diarrhoeal diseases and parasitic infections are largely as a result of lack of access to safe water sources.

Figure 5: Percentage distribution of the population with access to type of water source by area, Zambia, 1999

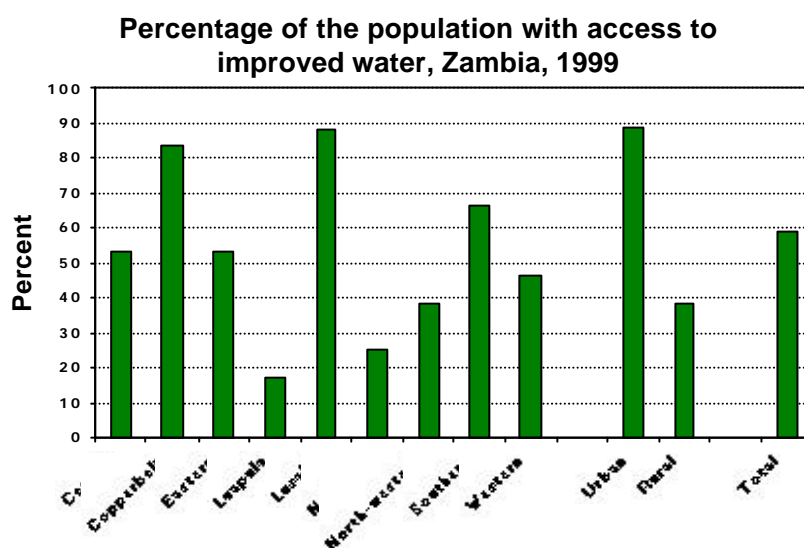


In Zambia, over half of the population use drinking water from a source that is safe and 25 per cent use water piped into their yard or plot. Rainwater collection and rivers and streams are also

important sources of drinking water. As depicted in Table 13 the source of drinking water for the population varied strongly by Province. With regard to piped water, Copperbelt Province has the highest figure with 62 per cent of the population using drinking water that is piped into their dwelling or into their yard or plot. Forty one per cent of the population in Lusaka Province access to piped water. In contrast, only 3 per cent of those residing in the Eastern and 4 per cent of those in Luapula had water piped in their dwelling or yard.

Figure 6: Percentage of the population with access to safe drinking water source, Zambia, 1999

The populations using safe drinking water sources are those who use any of the following types of supply: piped water, public tap, borehole/tubewell, protected well, protected spring or rainwater. Overall, 59 per cent of the population has access to safe drinking water – 89 per cent in



urban areas and 38 per cent in rural areas. The situation in Eastern Province was considerably worse than in other Provinces; only 17 per cent of the population in the Province gets its drinking water from a safe source.

Use of sanitation

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases and polio. *Sanitary means of excreta disposal* include: flush toilets connected to sewage systems or septic tanks, other flush toilets, improved pit latrines, and traditional pit latrines. For the case of Zambia 79 per cent of the population live in households with sanitary means of excreta disposal (Table 14). This percentage is 99 in urban areas and 66 per cent in rural areas. Residents of the Western Province use less sanitary means of excreta disposal than others as most of this population uses rivers, bushes, fields, or has no facilities. The most common facility for sanitary excreta disposal in Zambia is the traditional pit latrine that caters for 56 per cent of the population.

C. Child Malnutrition

Nutritional status

A child's nutritional status is a reflection of overall health. When children have access to adequate food supply and are not frequently exposed to illness, they reach their growth potential.

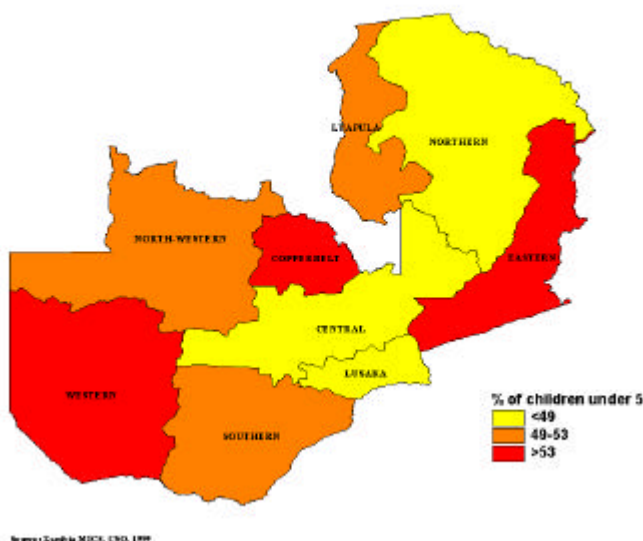
In a well-nourished population, there is a standard distribution of height and weight for children under age five. Undernourishment in a population can be gauged by comparing children to this standard distribution. The standard or reference population used here is the National Centre for Health Statistics (NCHS) standard, which is recommended for use by UNICEF and the World Health Organization. Each of the three nutritional status indicators is expressed in standard deviation units (z-scores) from the median of this reference population.

Weight for age is a measure of both acute and chronic malnutrition. Children whose weight for age is more than two standard deviations below the median of the reference population are considered *moderately or severely underweight* while those whose weight for age is more than three standard deviations below the median are classified as *severely underweight*.

Height for age is a measure of linear growth. Children whose height for age is more than two standard deviations below the median of the reference population are considered short for their age and are classified as *moderately or severely stunted*. Those whose height for age is more than three standard deviations below the median are classified as *severely stunted*. Stunting is a reflection of chronic malnutrition as a result of failure to receive adequate nutrition over a long period and recurrent or chronic illness.

Finally, children whose weight for height is more than two standard deviations below the median of the reference population are classified as *moderately or severely wasted* while those who fall more than three standard deviations below the median are *severely wasted*. Wasting is usually the result of a recent nutritional deficiency. The indicator may exhibit significant seasonal shifts associated with changes in the availability of food or disease prevalence.

Prevalence of Stunting, Zambia, 1999



In Table 15, children who were not weighed and measured (approximately 6 per cent of children) and those whose measurements are outside a plausible range are excluded. In addition, a small number of children whose birth dates are not known are excluded.

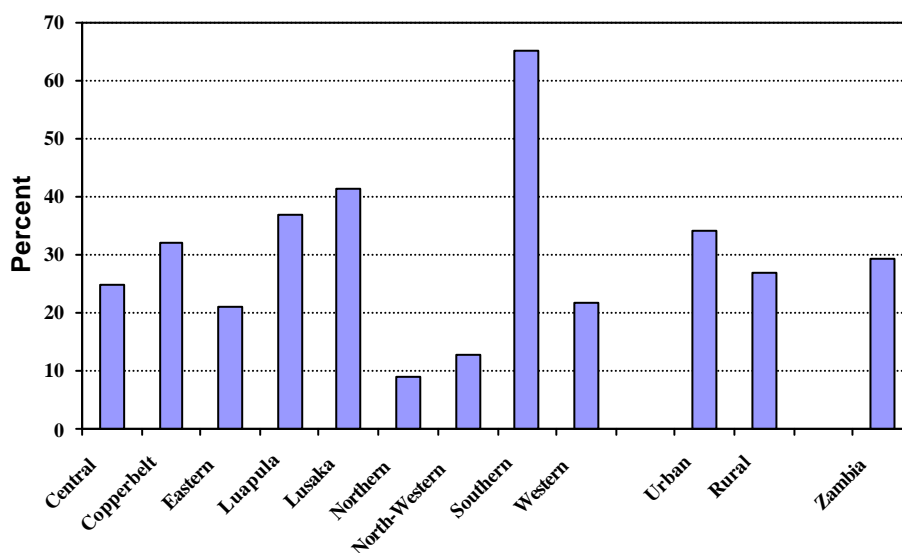
Twenty five per cent of children under age five in Zambia are underweight and 6 per cent are classified as severely underweight (Table 15). Fifty three per cent of children are stunted or too short for their age and 6 per cent are wasted or too thin for their height.

Children in Luapula Province are more likely to be underweight and wasted than other children. In contrast, the percentage of stunted children is highest in Eastern Province. Those whose mothers have secondary or higher education are the least likely to be underweight, wasted or stunted compared to children of mothers with less education. Boys appear to be slightly more likely to be underweight, stunted, and wasted than girls. The age pattern shows that a higher percentage of children aged 12-23 months are undernourished according to all three indices in comparison to children who are younger and older. This pattern is expected and is related to poor weaning practices and the age at which many children cease to be breastfed and are thus exposed to contamination in water, food, and the environment.

Breastfeeding

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. However, many mothers stop breastfeeding too soon, and there are often pressures to switch to infant formula. This can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. The World Summit for Children goal states that children should be exclusively breastfed for four to six months, that breastfeeding should be complemented with appropriate foods from the age of around six months, and that children should be breastfed for two or more years.

Figure 7: Percentage of children 0-3 months who are exclusively breastfeeding, Zambia, 1999



In Table 16, breastfeeding status is based on women's reports of children's consumption in the 24 hours prior to the interview. *Exclusive breastfeeding* refers to children who receive only breast

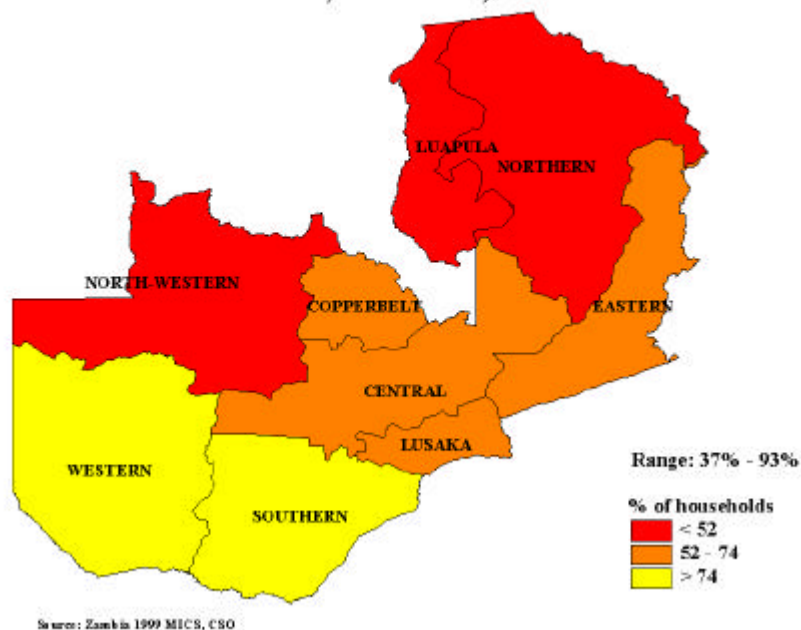
milk and vitamins, mineral supplements, or medicine. Complementary feeding refers to children who receive breast milk and solid or semi-solid food. The last two columns of the table include children who are being breastfed at one and at two years of age. Percentages according to province and mother's education are not shown due to small sample sizes. For the same reason, the sex and urban-rural residence breakdowns should be interpreted with caution.

Approximately 29 per cent of children aged less than four months are exclusively breastfed, a level considerably lower than recommended. Since Zambia's questionnaire is different from the standard MICS questionnaire, indicators on complementary feeding and continued breastfeeding cannot be estimated.

Salt iodization

Deficiency of iodine in the diet slows down mental and physical development. In severe cases, it causes goitre, an enlargement of the thyroid gland, and brain damage before birth or during infancy or childhood. Iodine deficiency is the single greatest cause of preventable mental retardation in the world today. The iodization of salt is a low-cost way of preventing iodine deficiency disorders (IDD). In MICS, interviewers tested household salt for iodine levels by means of a testing kit. According to the *Zambian MICS*, *adequately iodized salt* contains 25 ppm (parts per million) of iodine or more.

Percentage of households consuming adequately iodized salt, Zambia, 1999



Approximately 89 per cent of households had salt that was tested during the MICS (Table 17). Among households in which salt was tested, 68 per cent had adequately iodized salt. The percentage of households with adequately iodized salt ranges from 37 per cent in Luapula Province to 93 per cent in Western Province. Sixty seven per cent of urban households had adequately iodized salt compared to 69 per cent of rural households.

Vitamin A supplementation

Vitamin A deficiency (VAD) can cause eye damage and blindness in children. It also impairs children's immune systems, increasing their chances of dying of common childhood diseases and undermines the health of pregnant and lactating women. Yet it can be easily prevented by vitamin A supplementation, food fortification or dietary changes. Based on UNICEF/WHO guidelines, the Zambian Ministry of Health recommends that children aged 6-11 months be given one high dose Vitamin A capsule a year and children aged older than one year be given two capsules. In some parts of Zambia, Vitamin A capsules are linked to immunization services and are given when the child has contact with these services after six months of age. It is also recommended that mothers take a Vitamin A supplement within eight weeks of giving birth due to increased Vitamin A requirements during pregnancy and lactation.

Within the six months prior to the MICS, 76 per cent of children aged 6-59 months received the high dose Vitamin A supplement (Table 18). Approximately 10 per cent did not receive the supplement in the last 6 months but did receive one prior to that time. About 5 per cent of children received a Vitamin A supplement at some time in the past but their mother/caretaker was unable to specify when. Vitamin A supplementation coverage is highest in the Copperbelt Province and lowest in the North-Western Province.

The age pattern of Vitamin A supplementation shows that supplementation in the last six months rises from 74 per cent among children aged 6-11 months to 78 per cent among children aged 12-23 months and then declines steadily with age to 71.6 per cent among the oldest children.

Vitamin A supplementation also depends on the mother's level of education. The percentage receiving a supplement in the last six months increases from 79 per cent among children whose mothers have no education to 86 per cent among children of mothers with secondary or higher education.

In the year before the MICS, only about 40 per cent of mothers who gave birth received a Vitamin A supplement within eight weeks of the birth (Table 19). This percentage is highest in the North Western Province at 58 per cent and lowest in Southern Province at 29 per cent. Vitamin A coverage increases with the education of the mother from 35 per cent for mothers with no education to 48 per cent for those with secondary or higher education.

Low birth weight

Infants who weigh less than 2500 grams (2.5 kg.) at birth are categorized as low birth weight babies. Since many infants are not weighed at birth and those who are weighed may be a biased sample of all births, reported birth weight cannot be used to estimate the prevalence of low birthweight among all children. Therefore, the percentage of births weighing below 2500 grams is estimated from two items in the questionnaire: the mother's assessment of the child's size at birth (i.e., very small, smaller than average, average, larger than average, very large) and the mother's recall of the child's weight or the weight as recorded on an under five card if the child was weighed at birth. Fifty two per cent of live births in the Zambian MICS were weighed at birth.

First, the two items are cross-tabulated for those children who were weighed at birth to obtain the proportion of births in each category of size who weighed less than 2500 grams. This proportion is then multiplied by the total number of children falling in the size category to obtain the estimated number of children in each size category who were of low birth weight. The numbers

for each size category are summed to obtain the total number of low birth weight children. This number is divided by the total number of live births to obtain the percentage of low birth weight.

In Zambia, approximately 7.5 per cent of infants are estimated to weigh less than 2500 grams at birth (Table 20). This percentage is somewhat lower than the average for the Latin America and Caribbean countries (9 per cent, *The State of the World's Children, 2001*, UNICEF). The prevalence of low birth weight births varies slightly across provinces but does not vary much between urban and rural areas or by mother's education.

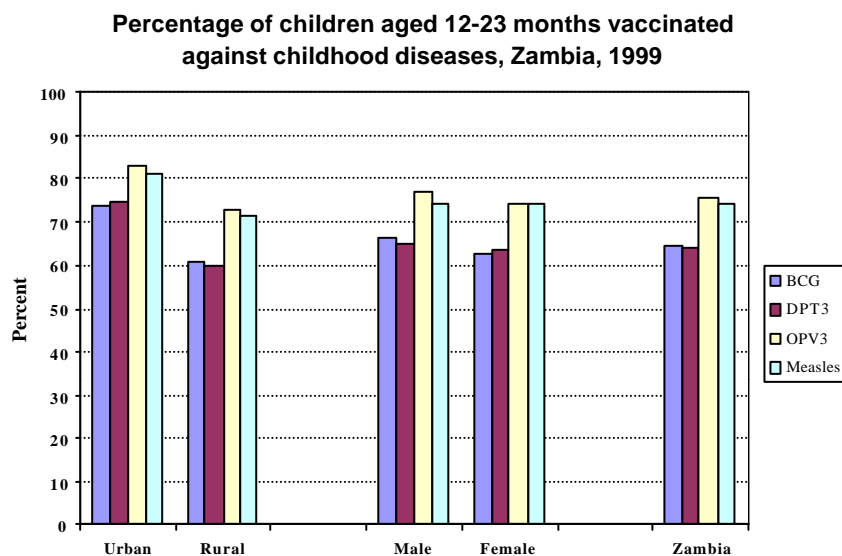
D. Child Health

Immunization coverage

According to UNICEF and WHO guidelines, a child should receive a BCG vaccination to protect it against tuberculosis; three doses of DPT to protect against diphtheria, pertussis, and tetanus; three doses of polio vaccine, and a measles vaccination by the age of 12 months. During the Zambian MICS, mothers were asked to provide vaccination cards for children under the age of five. Interviewers copied vaccination information from the cards onto the MICS questionnaire. Mothers were also probed to report any vaccinations that a child had received that did not appear on the card. Overall, 66.3 per cent of children had health cards. If the child did not have a card, the mother was read a short description of each vaccine and asked to recall whether or not the child had received it and, and how many times.

Table 21 shows the percentage of children aged 12 to 23 months who received each of the vaccinations. The denominator for the table is comprised of children aged 12-23 months so that only children who are old enough to be fully vaccinated are counted. In the top panel, the numerator includes all children who were vaccinated at any time before the survey according to the vaccination card or the mother's report. In the bottom panel, only those who were vaccinated before their first birthday are included. For children without vaccination cards, the proportion of vaccinations given before the first birthday is assumed to be the same as for children with vaccination cards.

Figure 8: Percentage of children aged 12-23 months who received immunizations at any time before the survey, Zambia 1999



Approximately 65 per cent of children aged 12-23 months received a BCG vaccination and the first dose of DPT was given to 82 per cent. The percentage declines for subsequent doses of DPT to 75 per cent for the second dose, and 64 per cent for the third dose (Figure 4). Similarly, 86 per cent of children received polio 1 and this declines to 76 per cent by the third dose. The coverage for measles vaccine is almost the same as for the other vaccines at 74 per cent. In addition, the percentage of children who had all eight recommended vaccinations was low at only 51 per cent.

In Table 22, the percentage of children age 12-23 months currently vaccinated against childhood diseases is shown according to background characteristics. Unlike the previous table, the estimates in this table refer to children who received the vaccinations by the time of the survey, even if they did not occur prior to the age of 12 months.

Male and female children are vaccinated at roughly the same rate at 66 and 63 per cent respectively. Urban children were more likely to be vaccinated than rural children with figures for urban at 74 per cent and 61 per cent for rural children. Provincial breakdowns show that the Copperbelt Province had the highest coverage rates for all vaccinations and the highest percentage of children who had received all of the recommended vaccinations. In contrast, North-Western Province had on average the lowest coverage rates for all vaccinations. The Copperbelt Province also had the highest percentage of children with health cards at 79 per cent. Vaccination coverage was highest among children whose mothers had secondary or higher education. The education differences were greatest for the fully vaccinated, suggesting that the more educated mothers tended to complete the vaccination course.

Diarrhoea

Dehydration caused by diarrhoea is a major cause of mortality among children in Zambia. Home management of diarrhoea – either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhoea.

In the Zambian MICS questionnaire, mothers (or caretakers) were asked to report whether their child had had diarrhea in the two weeks prior to the survey. If so, the mother was asked a series of questions about what the child had had to drink and eat during the episode and whether this was more or less what the child usually ate and drank. Overall, 19 per cent of under five children had diarrhoea in the two weeks preceding the survey (Table 23). The prevalence of diarrhoea was significantly higher in Lusaka Province at 25 per cent than in other Provinces. Diarrhoea tended to occur among children age 6-23 months during the weaning period.

Table 23 also shows the percentage of children receiving various types of recommended liquids during the episode of diarrhoea. Since mothers were able to name more than one type of liquid, the percentages do not necessarily add to 100. Gruel was found to be the most common fluid administered to children during their episodes of Diarrhoea. Children under the age of 12 months are especially likely to have received breast milk. About 63 per cent of children received gruel and 49 per cent received ORS and 40 per cent received locally accepted brews (*Munkoyo*). With regard to rural/urban distributions, rural areas had slightly higher incidence – at 20.4 per cent compared to urban areas –at 18.3 per cent. Furthermore, children of mothers with secondary education appeared to be less likely than other children to have received ORS and breast milk, but more likely to have received gruel.

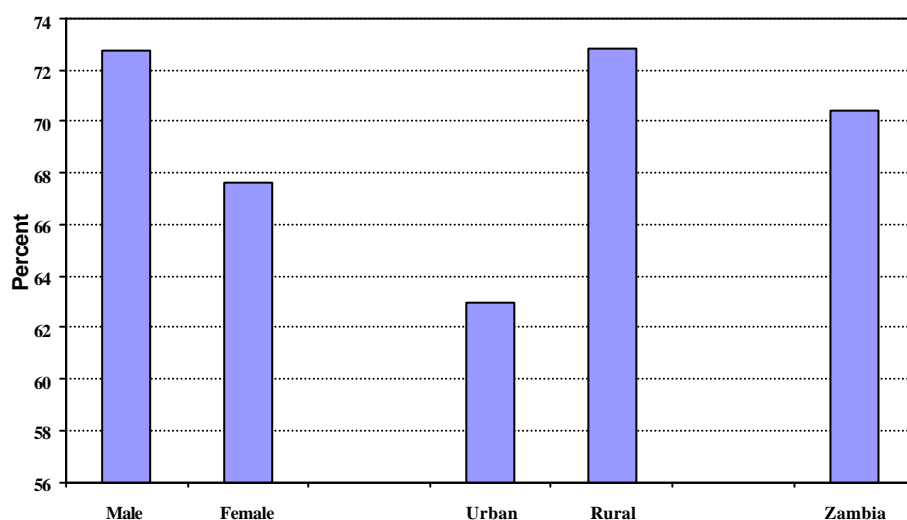
Among under five children with diarrhoea 10 per cent drank more fluids than usual, while 19 per cent drank the same or less (Table 24). About 15 per cent ate somewhat less, the same or more

than usual while 13 per cent ate much less than usual or none. Overall, only 8 per cent of children with diarrhoea received increased fluids and continued eating as recommended.

Acute respiratory infection

Acute lower respiratory infections, particularly pneumonia, are one of the leading causes of child deaths in Zambia. In the MICS questionnaire, children with acute respiratory infection are defined as those who had an illness with a cough accompanied by rapid or difficult breathing and whose symptoms were due to a problem in the chest, or both a problem in the chest and a blocked nose, or whose mother did not know the source of the problem. Only 3 per cent of under five children had an acute respiratory infection in the two weeks prior to the survey according to these criteria (Table 25). Of these, 68 per cent were taken to a hospital for treatment, 5 per cent were taken to a health center and 7 per cent were taken to traditional healers. Overall, almost 70 per cent of children with ARI were taken to an appropriate health provider (i.e., doctor, specialist, hospital, health centre).

Figure 9: Percentage of under-five children with ARI in the last two weeks who had appropriate treatment, Zambia, 1999



IMCI initiative

The Integrated Management of Childhood Illnesses (IMCI) is a programme developed by UNICEF and WHO. IMCI combines strategies for control and treatment of five major killers of children – acute lower respiratory tract infections, diarrhoeal dehydration, measles, malaria, and malnutrition. The programme focuses on the improvement of case management skills by health workers, improvement of the health system, and improvement of family and community practices in the prevention and early management of childhood illnesses. Appropriate home management of illness is one component of IMCI. The approach teaches mothers that appropriate home management of diarrhoea or any other illness requires giving more fluids and continuing to feed sick children as they are normally fed.

Table 26 presents information on the drinking and eating behaviour of sick children. Almost one-third of the children were reported to have had diarrhoea or some other illness in the two weeks

preceding the survey. Of these, 28 per cent drank more liquids during the illness and 34 per cent continued eating (i.e., ate somewhat less, the same, or more). Overall, only 7 per cent of ill children received increased fluids and continued eating as recommended under the IMCI programme.

Promoting knowledge among caretakers about when it is appropriate to seek care for ill children is another important component of the IMCI programme. In the Zambian MICS, mothers or caretakers of children were asked to name all of the symptoms that would cause them to take a child to a health facility right away. The most common response, given by 13 per cent of mothers was that if the child developed a fever this was followed by 11 per cent of mothers who said that they would take their child to a health facility right away if a child developed diarrhoea persistently (Table 27). Another 8 per cent said that if the child 's condition worsened, they would take the child to a health facility and 6 per cent mentioned difficulty in breathing. Between 3 and 7 per cent of mothers cited an inability to breastfeed, fast breathing, blood in stools, and drinking poorly as reasons for taking a child to a health facility right away.

Among the Provinces, mothers in Copperbelt Province were more likely than mothers in other Provinces to recognize the signs for seeking care immediately. Overall, 37 per cent of mothers in Copperbelt Province knew at least two signs for seeking care compared to 15 per cent in Luapula, 15 per cent in Lusaka, 14 per cent in Southern, 11 per cent in Central and 10 per cent or less in the remaining Provinces. Of significance to this is North Western Province that recorded less than 1 per cent of mothers who knew at least two signs for seeking care. These provincial differences were also reflected in the urban-rural and educational differentials.

Malaria

Malaria is one of the leading causes of death in children under five in Zambia. It also contributes to anaemia in children and is a common cause of school absenteeism. Preventive measures, especially the use of mosquito nets treated with insecticide, can dramatically reduce malaria mortality rates among children. In areas where malaria is common, international recommendations suggest treating any fever in children as if it was malaria and immediately giving the child a full course of recommended anti-malarial tablets. Children with severe malaria symptoms, such as fever or convulsions, should be taken to a health facility. In addition, children recovering from malaria should be given extra liquids and food and should continue breastfeeding.

The Zambian MICS questionnaire incorporated questions on the use of bednets among children, namely if the bednets were insecticide impregnated. Only 6 per cent of under five children slept under a bednet the night prior to the survey interview (Table 28). Of these only 18 per cent slept in an insecticide-impregnated bednet while the majority used ordinary bednets. Bednets were found to be more common in urban areas than rural areas at 9 and 5 per cent respectively.

Questions were also posed on the prevalence and treatment of fever for all children under age five. Of all the under five children, 14 per cent were ill with fever in the two weeks prior to the MICS (Table 29). The prevalence of fever was at 12 per cent for all children under 6 months. Children in the 6-11 months age group had 16 per cent which was marginally less than the 12-23 months old children whose prevalence of fever was 17 per cent. The prevalence then declines to 15 per cent for children aged 24-35 months, 14 per cent among children aged 36-47 months and to 12 per cent for those aged 48-59 months. Fever was less common among children whose mothers had secondary or higher education than among children of less educated mothers. There was also a variation in the prevalence of fever between provinces, these ranged from the highest Luapula with 27 per cent and the lowest Copperbelt with 8 per cent.

Mothers were also asked to report all of the medicines given to a child during their illness - any medicine given at home and medicines given or prescribed at a health facility. Approximately 60 per cent of children were given paracetamol and 38 per cent were given chloroquine while less than one per cent were given other medicines. Fifty seven per cent of children with fever in Eastern province received an appropriate anti-malarial drug, while in Luapula Province only 26 per cent received an appropriate drug. Urban children were more likely to receive appropriate treatment than those in rural areas and so were children of mothers with secondary or higher education.

E. HIV/AIDS

AIDS knowledge

One of the most important strategies for reducing the rate of HIV infection is the dissemination of accurate information on how HIV is transmitted and how it can be prevented. Among women aged 15-49, 96 per cent have heard of AIDS (Table 30). This percentage is slightly higher in urban areas, 97 per cent, compared to 96 per cent in rural areas.

Women in the MICS were read several statements about the ways in which HIV is transmitted and asked to state whether they believed the statements were true. Eighty per cent believed that having only one uninfected and faithful sexual partner can prevent HIV transmission. Fifty seven per cent believed that using a condom every time one has sex can prevent HIV transmission and 80 per cent agreed that abstaining from sex prevents HIV transmission. Overall, 44 per cent knew all three ways to prevent HIV transmission and 94 per cent were aware of at least one of the ways of preventing transmission.

Accurate knowledge of how HIV is transmitted is substantially less among women in Northern Province than among other women. Evidently, education is a very important factor in HIV/AIDS knowledge. The percentage who know all three ways of preventing transmission is higher for women with secondary or more education at 48 per cent compared to women with no education at 42 per cent. The differences across age groups are not particularly large between 15-39 years old, range between 44% and 46%. It declines to 33 per cent among 45-49 year olds. The women between 45 and 49 years of age have the least knowledge of all three ways of HIV transmission.

Sixty seven per cent of women correctly stated that HIV cannot be transmitted by witchcraft and 62 per cent stated that HIV cannot be spread by mosquito bites (Table 31). More than seven in ten women correctly believe that a healthy looking person can be infected. Women in Northern Province are more likely to believe misconceptions about AIDS transmission than other women. Women in the Copperbelt Province are most likely to recognize all three misconceptions.

Eighty eight per cent of women in Zambia know that HIV can be transmitted from mother to child (Table 32). When asked specifically about the mechanisms through which mother to child transmission can take place, 84 per cent said that transmission during pregnancy/delivery was possible, and 72 per cent agreed that HIV can be transmitted through breast milk. Sixty nine per cent of women knew all three modes of transmission. This percentage does not vary much across background categories.

The MICS survey also attempted to measure discriminatory attitudes towards people living with HIV/AIDS. To this end, respondents were asked whether they agreed with two questions. The first asked whether a worker who has the HIV virus but is not sick should be allowed to continue

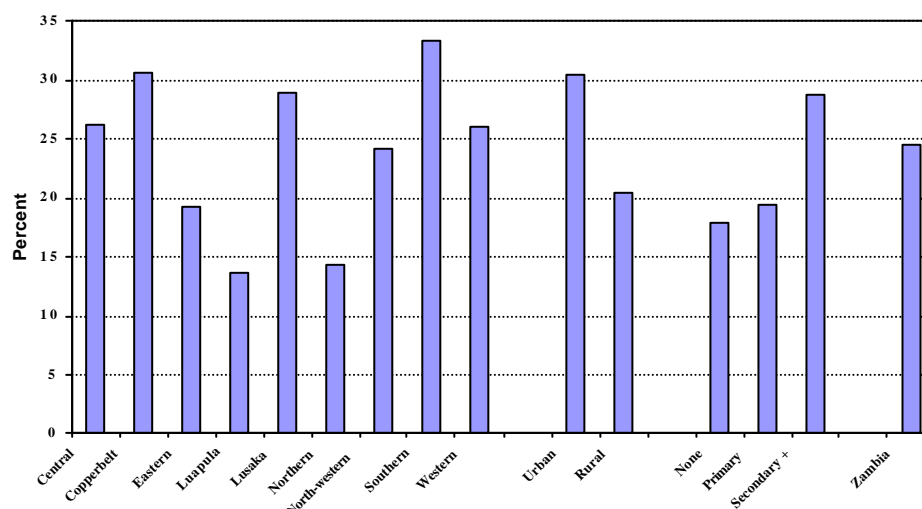
working. The second question asked whether the respondent would buy food from a shopkeeper or food seller who the respondent knew to be infected with HIV. The results are presented in Table 33.

Sixty four per cent of the respondents believed that a worker with HIV/AIDS should not be allowed to work. This percentage is highest in the Copperbelt Province at 72 per cent and lowest in Eastern Province at 55 per cent. Urban women and those with secondary or higher education were more likely to express this discriminatory attitude than rural women and those with no or primary education. Thirty five per cent of women would not buy food from a person infected with AIDS. Interestingly, women in the Copperbelt Province were still more likely to express discriminatory attitudes on the second question. On the whole, 70 per cent of women agreed with at least one of the discriminatory statements.

Table 34 summarizes information from two previous tables on HIV/AIDS knowledge (Tables 30 and 31). The second column shows the percentage of women who know all three ways of preventing HIV transmission – having a faithful uninfected partner, using a condom every time, and abstaining from sex. Forty four per cent of women know all three ways. The third column of the table shows the percentage of women who correctly identified all three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected. Forty one per cent of women correctly identified these misconceptions. Finally, the fourth column of the table shows the percentage of women who have ‘sufficient knowledge’ of HIV/AIDS transmission. These are women who know all three ways of preventing HIV transmission and correctly identified all three misconceptions. Only 22 per cent of women aged 15-49 fall into this category.

Knowledge of HIV/AIDS transmission varies according to level of education. Women with secondary or higher education are more likely to know all three ways of preventing transmission than women with no education. They are also more likely to correctly identify all three misconceptions about AIDS and are more likely to have sufficient knowledge of HIV/AIDS transmission.

Figure 10: Percentage of women aged 15 -49 who have sufficient knowledge of HIV/AIDS transmission, Zambia, 1999



HIV testing

Voluntary testing and counseling for HIV/AIDS allow those infected to seek health care and to prevent the infection of others. Testing is particularly important for pregnant women who can then take steps to prevent mother-to-child-transmission. The indicators shown in Table 35 are designed to monitor whether women are aware of places to get tested for HIV/AIDS, the extent to which they have been tested, and the extent to which those tested have been told the result of the test. In some places, a relatively large proportion of people who are tested do not return to get their results due to fear of having the disease, fear that their privacy will be violated, or for other reasons.

Fifty nine per cent of women of reproductive age in Zambia know a place to get tested for HIV. Women living in Copperbelt Province are most likely to know a place, followed by those in the provinces of Lusaka, North Western, Central, Western, Southern, Northern, Luapula and Eastern respectively. Only 47 per cent of women with no education know of a place to get tested compared to 55 per cent of women with primary school education and 77 per cent of women with secondary or higher education.

With regard to testing, only about 5 per cent of women have been tested for HIV. This percentage is highest in Lusaka Province at 8 per cent, lowest in Western Province at 3 per cent and ranges from 3-6 per cent in the other provinces. The vast majority of women who have been tested were given their results. However, there is some variation across provinces, age groups, and education levels. Among the provinces, women in the Northern Province were least likely to have been told their results. In the case of adolescent girls (age 15-19), they were least likely of any age group to have been tested. While those in the 35-39 age group were the least likely to know their results.

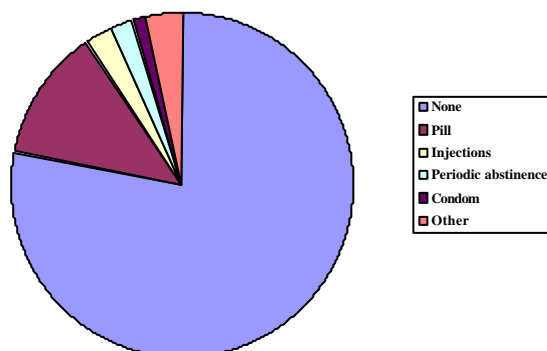
F. Reproductive Health

Contraception

Married and in union women were asked to state their main method of contraception (only one method). Current use of contraception was reported by 22 per cent of married or in union women (Table 36). The most popular method is the pill which is used by 13 per cent of married and in union women in Zambia. The next most popular method is injections, which accounts for 3 per cent of married women. Two per cent of women reported use of periodic abstinence. The least used contraceptive methods are the female condom and diaphragm/foam/jelly.

Figure 11: Percentage of women aged 15-49 years who currently use a contraceptive method, Zambia, 1999

Percentage of women aged 15-49 years who currently use a contraceptive method, Zambia, 1999



The use of contraceptives is highest in the Copperbelt Province at 37 per cent, followed by Lusaka Province at 29 per cent. Twenty three per cent of married women in Central Province and 21 per cent in Luapula Province use a method of contraception. In North Western Province, contraceptive use is rare; only six per cent of married women reported using any method. Adolescents are far less likely to use contraceptives than older women are. Only 13 per cent of married or in union women aged 15-19 currently use a method of contraception compared to 22 per cent of 20-24 year olds and 23 per cent of older women.

A woman's education level very much determines whether she will use a contraceptive. The percentage of women using any method of contraception rises from 12 per cent among those with no education to 22 per cent among women with primary education, and to 33 per cent among women with secondary or higher education. In addition to differences in prevalence, the method mix varies by education. About half of contraceptive users with no education or at least primary education use the pill and 31-39 per cent have undergone tubal ligation. In contrast, 63 per cent of contraceptive users with secondary or higher education use the pill and 20 per cent have undergone tubal ligation.

Prenatal care

Quality prenatal care can contribute to the prevention of maternal mortality by detecting and managing potential complications and risk factors, including pre-eclampsia, anaemia, and sexually-transmitted diseases. Antenatal care also provides opportunities for women to recognize potential complications during pregnancy and delivery, to be immunized against tetanus, to learn about infant care, and to be treated for existing conditions, such as malaria and anaemia.

Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus, a major cause of infant death that is due primarily to unsanitary conditions during childbirth. Two doses of tetanus toxoid during pregnancy offer full protection. However, if a woman was vaccinated during a previous pregnancy, she may only need a booster to give full protection. Five doses of tetanus toxoid are thought to provide lifetime protection.

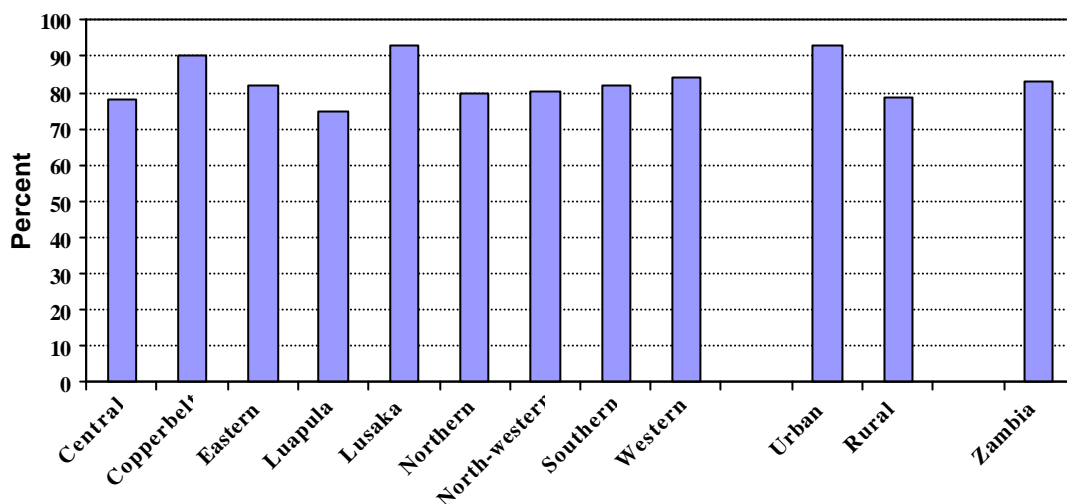
Approximately 60 per cent of women with recent births in Zambia are protected against neonatal tetanus (Table 37). The vast majority of these women have received two or more doses of tetanus toxoid within the last three years. Among the provinces, women living in Lusaka Province are most likely to be protected (70 per cent) while those living in North-Western and Southern Provinces are the least likely to be protected (50 per cent). Note, however, that the provincial estimates are based on small numbers of cases and should be interpreted with caution. Women with secondary or higher education are more likely to be protected against tetanus than those with either no education or primary education.

Female respondents who had had a birth in the year prior to the Zambia MICS were asked whether they had received antenatal care for the birth and, if so, what type of person provided the care. If the woman saw more than one type of provider, all were recorded in the questionnaire. Table 38 presents the per cent distribution of women with a birth in the year prior to the MICS by the type of personnel who delivered antenatal care. If more than one provider was mentioned by the respondent, she is categorized as having seen the most skilled person she mentioned.

The majority of women in Zambia receive some type of prenatal care and 83 per cent receive antenatal care from skilled personnel (doctor, nurse, midwife). Only 9 per cent of women with a birth in the year prior to the survey received antenatal care from a doctor, 68 per cent from a nurse/midwife, and 7 per cent from clinical personnel. Traditional birth attendants (TBAs) provided prenatal care for 5 per cent of women and relatives/friends for 5 per cent. Eight per cent

of women did not receive any antenatal care. In all provinces, nurses/midwives are most likely to provide prenatal care. In cases where doctors are not available, clinical personnel provide prenatal care second to nurses/midwives.

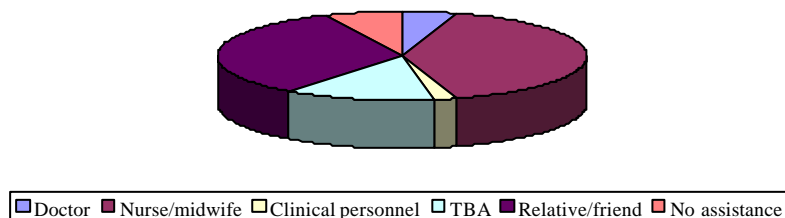
Figure 12: Percentage of women aged 15-49 with a birth in the last year who received antenatal care from skilled health workers, Zambia, 1999



Assistance during delivery

The provision of assistance during delivery by trained attendants can greatly improve outcomes for mothers and children. More so as use technically appropriate procedures, make accurate and speedy diagnosis and treat complications. *Skilled assistance at delivery* is defined as assistance provided by a doctor, nurse, or midwife. About 47 per cent of births that occurred in the year prior to the MICS survey were delivered by skilled personnel (Table 39). This percentage is highest in Lusaka Province at 81 per cent and lowest in Southern Province at 30 per cent. The more educated a woman is, the more likely she is to have delivered with the assistance of a skilled person.

Figure 13: Per cent distribution of women with a birth in the last year by type of personnel assisting at delivery, Zambia, 1999



More than one in three of the births in the year prior to the MICS survey were delivered with the assistance of a nurse/midwife. Doctors assisted with the delivery of only 5 per cent of births. On the whole, clinical personnel delivered about 2 per cent of births, but these births occurred mostly in Luapula, Western and North Western Provinces. In all cases, relatives/friends provided more assistance than the TBAs.

G. Child Rights

Birth registration

The Convention on the Rights of the Child states that every child has a right to a name and a nationality and the right to protection from being deprived of his or her identity. Zambia recognizes that birth registration is fundamental to securing other rights for children. And yet, more than 90 per cent of births of all children under five years in Zambia have not been registered (Table 40). There are no significant variations in birth registration across sex, or age categories. Children born in urban areas were found to be more likely to be registered than those born in rural areas. Northern and North-Western Provinces were the least likely to have had their births registered. But this appears to be primarily due to a relatively large proportion of mothers who do not know that their children's births are supposed to be registered. Among those whose births were not registered, cost and travel distance did not appear to be the main reasons.

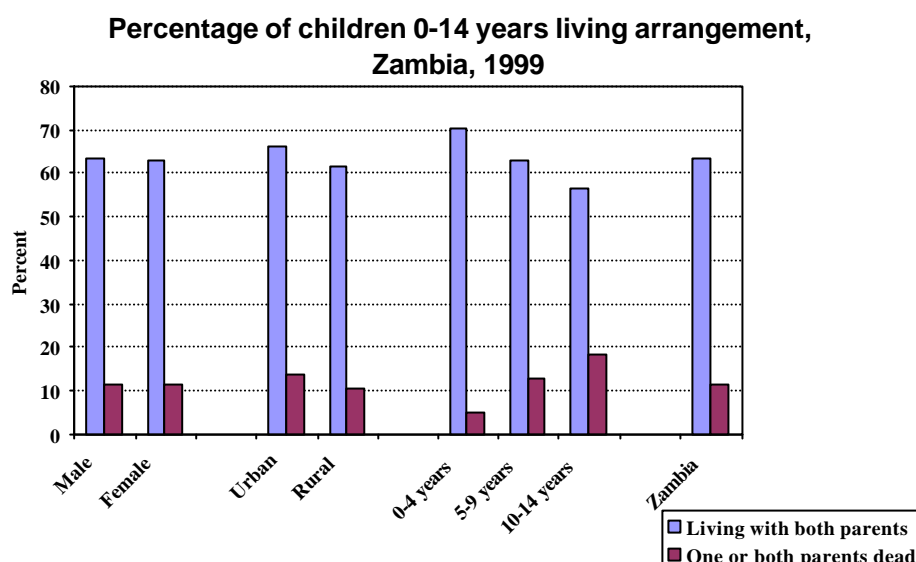
Orphans and living arrangements of children

Children who are orphaned or living away from their parents are usually at increased risk of •impoverishment, •discrimination, •denial of property rights and rights to inheritance, •various forms of abuse and neglect, •exploitation of their labour or sexuality, and •exposure to HIV/AIDS. Monitoring the number of orphans and the living arrangements of these children will help to identify those who may be at risk and in tracking changes over time.

In Zambia, 64 per cent of children aged 0-14 were living with both parents (Table 41). Ten per cent are living with their mother only although their father is alive. A total of 5 per cent were living with neither parent although both parents were alive. Children who were not living with a biological parent comprised 10 per cent of all children aged 0-14. Older children were found to be more likely to live away from their biological parents than younger children. Furthermore, while only 3 per cent of children under age five were not living with a biological parent, 17 per cent of children aged 10-14 were.

The situation of children in Western Province differs from that of other children in Zambia. In this province only about half of the children live with both parents. Sixteen per cent live with their mother only (fathers are alive) and a relatively large proportion, 12 per cent were living with neither parent.

Figure 14: Percentage of children 0-14 years living arrangements, Zambia, 1999



Child labour

It is important to monitor the extent to which children work and the type of work for several reasons. Children who work are less likely to attend school and more likely to drop out. This pattern can trap children in a cycle of poverty. Working conditions for children are often unregulated with few safeguards against potential abuse. In addition, many types of work are intrinsically hazardous and others present less obvious hazards to children, such as exposure to pesticides in agricultural work, carrying heavy weights and scavenging in garbage dumps.

In Zambia, the MICS survey estimated that about 10 per cent of all children aged 5-14 years were employed. These children were directly employed for remuneration or were assisting in a family enterprise. Of the employed children, less than 1 per cent were engaged in paid work (Table 42). The majority, 8 per cent of employed children aged 5-14 years participate in unpaid work for someone other than a household member.

'Domestic work' is defined as cooking, shopping, cleaning, washing clothes, fetching water, and caring for children. More than half of the children, 62 per cent, do these tasks for less than four hours a days while less than one per thousand of children spent more than four hours a day on such tasks. Overall, girls were more involved in domestic work – 65 per cent compared to boys at 59 per cent. Furthermore, older children (aged 10-14) were more likely than younger children (aged 5-9 years) to do domestic work. There are variations across the provinces with the highest percentage of 75 per cent in Luapula and the lowest, 46 per cent in North-Western engaging in less than four hours of domestic work a day.

Children who have done any paid or unpaid work for someone who is not a member of the household or who did more than four hours of housekeeping chores in the household or who did other family work are considered to be 'currently working'. Overall, 10 per cent of children are classified as currently working. There is a marginal difference between boys and girls (11 per cent of boys and 10 per cent of girls). Provincially, the percentage of children working is lowest

in Lusaka Provinces at 2 per cent and highest in Southern at 15 per cent. Rural children were more in the category of the currently working at 15 per cent compared to 3 per cent for urban areas. This differential should be understood in the context of seasonality with respect to the period of the survey.

Appendix A: Sample Design

The Multiple Indicator Cluster Survey, called the End of Decade Goals and Child Labour Survey (EDGCLS) in Zambia, covered both rural and urban areas in all provinces and districts in the Republic of Zambia. The main focus of the sample design for this survey was to draw a representative sample of about 8,000 households distributed proportionally between the rural and urban areas on the basis of population size. Due to the sample size the design allowed for the production of estimates at national and provincial levels.

Administratively, Zambia is divided into nine provinces and 72 districts. The Central Statistical Office further demarcated the country into Census Supervisory Areas (CSA) within a district. The CSA is then divided into Standard Enumeration Areas (SEA). The listing of all CSAs and SEAs was used as the Sampling frame for the survey and SEAs were the sampling points. About 360 SEAs were selected from a total of 13,000. The measure of size for selecting the sample SEAs was based on the number of households in the 1990 Census count. For the purpose of selecting the sample, the provinces were stratified into rural and urban areas. There are a total of eighteen strata.

In the urban areas, the basic sample design for the survey was a two-stage stratified cluster sampling. The first stage involved the selection of the primary sampling units (SEAs) based on the probability proportional to size method. The second stage was the selection of households within the sample SEAs. A listing exercise in which all households in the selected SEAs were listed was conducted prior to the second stage of the sampling. After the listing exercise, the households were stratified into three categories; those with at least one child working for pay or profit, those with at least one child worker but not for pay or profit, and those with no children working at all. The given number of households to be selected per cluster (SEA) was then allocated to the three strata proportionally, to yield a completely self-weighting sample. For urban areas, 25 households were selected from each of the SEAs.

In the rural areas, the selection of households was slightly different to that of the urban areas. Apart from the stratification based on whether the household had any working children, FHANIS required that the households were also stratified on the basis of the scale of their agricultural activity. Fortunately, the agricultural survey had been conducted a few months earlier. A sub-sample of the agricultural survey of rural SEAs was drawn. Therefore, the listing exercise in the rural areas only involved the updating of the listing done in the agricultural survey to determine whether the households had working children or not. Once that had been established, a total of 20 households were selected from each rural cluster (SEA).

Allocation of Households and Clusters

A proportional allocation of the desired number of households in the 18 strata gave a distribution that did not allow for reliable estimates for Luapula, North Western and Western province. For this reason, the survey adopted a disproportionate allocation method, otherwise known as the Kish Square Root Method, to allow for reliable estimates for the three provinces mentioned above. The disproportionate allocation was done as shown in table A1.1 below.

Table A1.1: The allocation of sample households by Province and rural/urban areas

Province	Urban	Rural	Total
Central	400	400	800
Copperbelt	800	300	1100
Eastern	320	580	900
Luapula	330	420	750
Lusaka	930	270	1200
Northern	330	570	900
North Western	270	480	750
Southern	350	500	850
Western	250	500	750
All Zambia	3,980	4,020	8,000

The number of clusters (SEAs) that would yield the sample of household depicted above is shown in table A1.2 below. The number of sample clusters that were selected from each stratum was calculated by dividing the number of households in the stratum by the number of the sample households in the stratum; 25 households in the urban areas and 20 in the rural areas.

Table A1.2: Number of clusters by Province and rural/urban areas according to the given allocation of households.

Province	Urban	Rural	Total
Central	16	20	36
Copperbelt	32	14	46
Eastern	12	28	40
Luapula	14	20	34
Lusaka	38	14	52
Northern	14	28	42
North Western	10	24	34
Southern	14	26	40
Western	10	26	36
All Zambia	160	200	360

Note: For the purpose of calculating sampling errors, in which the first step is to form pairs of homogenous clusters, even numbers are recommended.

Selection of Clusters

A cluster is the primary sampling unit and it is equivalent to a standard enumeration area (SEA).

The procedure of selecting SEAs in each stratum was as follows:

- (i) Calculate the sampling interval (I) of the stratum.
- (ii) Calculate the cumulated size of the cluster (SEA).
- (iii) Calculate the sampling numbers $R, R+I, R+2I, \dots, R+(A-1)I$, where R is the random number between 1 and I .
- (iv) Compare each sampling number with the cumulated sizes

The first SEA with a cumulated size that was greater or equal to the random number was selected.

Selection of Households

During listing, a couple of questions were asked in order to group households into three categories: those with at least one paid child worker, those with at least one child working but not for pay and those with no child working at all. The number of households selected in each category was calculated by allocating the total number of households selected in the cluster proportionally.

For example:

M= the total number of households listed in the SEA

M1=the total number of households listed in category 1

M2=the total number of households listed in category 2

M3=the total number of households listed in category 3

n=the number of households to be selected in the survey

n_i =the number of households to be selected in each category

$i=1,2,3$

- The number of households to be selected from category 1 proportionally was calculated as follows:
 $(M1/M) \times n = n_1$
- The sampling interval was calculated as follows: $M1/n_1=I1$
- The random start (R) was the first number between 1 and I
- The interval was added to R to get the next selection. This was repeated until the desired sample size in the category n_i was reached.

Appendix B: List of Personnel Involved in the Zambia MICS

Central Province

Dorothy Simambo	Provincial Coordinator
Chibwe Lwamba	Master Trainer

Copperbelt Province

Stanley Kamocha	Provincial Coordinator
Shadrach Chakamisha	Master Trainer/Regional Statistician

Eastern Province

Amukusana K. Katundu	Provincial Coordinator
Favour Chiyala	Master Trainer
Patrick Chewe	Master Trainer

Luapula Province

Chola Chabala	Provincial Coordinator
Cobby Nyasulu	Master Trainer

Lusaka Province

Chola H. Mulenga	Provincial Coordinator
John Kabongo	Assistant Provincial Coordinator
Edgar Chani	Master Trainer/Regional Statistician
Phillip Miti	Master Trainer

Northern Province

Batista Chilopa	Provincial Coordinator
Overson Njovu	Master Trainer
Chibola Kaliki	Master Trainer

North Western Province

Lishala C. Situmbeko	Provincial Coordinator
Mate Mate	Master Trainer
Martin Njobvu	Master Trainer

Southern Province

Zahia Khan	Provincial Coordinator
Mukatimui Chabala	Master Trainer
Moses Simwizyi	Master Trainer/Regional Statistician

Western Province

Martin Tolosi
Alfonsius Susiku
Lungowe Mwapela

Provincial Coordinator
Master Trainer
Master Trainer/Regional Statistician

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World Summit Goal Indicators by Table Number

Indicators for 17 of the World Summit Goals can be measured with the MICS model questionnaire and 1 additional indicator can be measured with the Child Disability Module. Summarized below is the table in which the indicators corresponding to Summit Goals can be found.

World Summit for Children Goal	Table Number
1	8
3	15
4	13
5	14
6	10,11
7	12
8	43
9	8, 15, 38
10	36
11	38, 39
12	20
14	17
15	18 19
16	16
22	21, 37
23	23, 24
24	25
26	9, 15

Table 1: Number of households and women, and response rates, Zambia, 1999

	Urban	Rural	Total
Number of women:			
Eligible	5,487	4,641	10,128
Interviewed	5,230	4,409	9,639
Response rate	95.3	95.0	95.2
Number of children < 5	2,984	3,413	6,397
Number completed	2,919	3,298	6,217
Percent completed	97.8	96.6	97.2

Table 2: Single year age distribution of household population by sex, Zambia, 1999

Age	Males		Females	
	Number	%	Number	%
0	149,919	2.8	133,577	2.5
1	170,212	3.2	164,164	3.1
2	185,175	3.5	163,827	3.1
3	156,159	3.0	157,539	3.0
4	146,968	2.8	141,269	2.7
5	197,814	3.7	199,128	3.8
6	178,834	3.4	168,728	3.2
7	172,850	3.3	177,742	3.4
8	150,242	2.8	148,746	2.8
9	156,345	3.0	132,541	2.5
10	150,731	2.9	164,253	3.1
11	141,966	2.7	138,453	2.6
12	149,463	2.8	140,919	2.7
13	126,225	2.4	145,507	2.8
14	128,328	2.4	144,619	2.8
15	134,983	2.6	133,682	2.5
16	142,061	2.7	120,489	2.3
17	143,870	2.7	131,094	2.5
18	129,202	2.4	118,553	2.3
19	134,619	2.6	114,607	2.2
20	108,755	2.1	105,280	2.0
21	103,728	2.0	103,669	2.0
22	92,748	1.8	114,546	2.2
23	83,149	1.6	102,327	1.9
24	97,766	1.9	101,043	1.9
25	98,430	1.9	104,512	2.0
26	83,533	1.6	89,620	1.7
27	90,549	1.7	103,948	2.0
28	69,234	1.3	61,385	1.2
29	86,008	1.6	85,374	1.6
30	73,633	1.4	63,929	1.2
31	73,608	1.4	81,783	1.6
32	52,133	1.0	44,824	0.9
33	52,645	1.0	54,956	1.0
34	52,490	1.0	50,216	1.0
35	80,308	1.5	79,543	1.5
36	43,429	0.8	52,876	1.0
37	45,102	0.9	44,972	0.9
38	35,957	0.7	42,185	0.8
39	51,232	1.0	51,517	1.0
40	34,083	0.6	41,360	0.8
41	44,829	0.8	48,144	0.9
42	36,189	0.7	37,728	0.7
43	35,964	0.7	33,052	0.6
44	31,204	0.6	28,032	0.5
45	34,397	0.7	30,847	0.6
46	29,830	0.6	31,337	0.6
47	27,138	0.5	31,183	0.6
48	13,880	0.3	15,398	0.3
49	28,821	0.5	23,970	0.5
50	26,486	0.5	47,752	0.9

51	28,084	0.5	39,815	0.8
52	31,087	0.6	27,264	0.5
53	17,470	0.3	25,699	0.5
54	26,396	0.5	28,411	0.5
55	18,815	0.4	21,960	0.4
56	17,784	0.3	14,919	0.3
57	24,325	0.5	25,954	0.5
58	16,259	0.3	14,772	0.3
59	23,199	0.4	17,108	0.3
60	22,011	0.4	25,580	0.5
61	13,680	0.3	14,768	0.3
62	12,142	0.2	11,739	0.2
63	15,155	0.3	15,178	0.3
64	14,192	0.3	12,139	0.2
65	11,184	0.2	12,183	0.2
66	13,637	0.3	7,834	0.1
67	13,356	0.3	18,103	0.3
68	10,372	0.2	7,100	0.1
69	12,611	0.2	16,867	0.3
70+	71,217	1.3	50,711	1.0
Zambia	5,276,197	100.0	5,254,846	100.0

Table 3: Cases of missing information for selected questions, Zambia, 1999

Question	Reference population	% missing	Number
Level of education	Household members	29.0	25,686
Number of hours worked	Working children age 5-14	9.5	1,041
Complete birth date	Women 15-49	0.0	9,833
Date of last tetanus toxoid injection	Women with a live birth in the last year	61.5	1,362
Ever been tested for HIV	Women 15-49	3.6	9,833
Complete birth date	Children under 5	0.0	6,142
Diarrhoea in last 2 weeks	Children under 5	7.0	6,142
Weight	Children under 5	21.0	5,418
Height	Children under 5	20.8	5,418

Table 4: Distribution of households by background characteristics, Zambia, 1999

	Percent	Number	Unweighted
Province			
Central	9.1	175,927	783
Copperbelt	14.2	274,539	1,075
Eastern	15.7	303,968	860
Luapula	8.6	166,667	747
Lusaka	14.2	273,400	1,216
Northern	13.7	264,092	892
North-western	5.8	112,620	713
Southern	10.9	211,092	862
Western	7.7	149,343	767
Area			
Urban	36.9	713,228	3,932
Rural	63.1	1,218,420	3,983
Number of household members			
1	5.5	98,427	435
2-3	22.8	410,883	1,694
4-5	29.8	537,617	2,100
6-7	21.6	390,247	1,539
8-9	12.1	218,256	925
10+	8.3	148,995	637
Zambia	100.0	1,804,424	7,330
At least one child age < 15	79.9	1,931,648	7,915
At least one child age < 5	53.6	1,931,648	7,915
At least one woman age 15-49	83.7	1,931,648	7,915

Table 5: Distribution of women 15-49 years by background characteristics, Zambia, 1999

Characteristic	%	Number	Unweighted	Characteristic	Percent	Number	Unweighted
Province				Marital status			
Central	9.8	229,739	1,035	Currently Married	56.6	1,185,879	4,677
Copperbelt	16.2	378,648	1,448	Widowed	4.6	96,891	395
Eastern	14.5	339,372	970	Divorced	5.7	119,349	487
Luapula	7.7	180,204	852	Separated	2.7	56,356	236
Lusaka	14.9	349,666	1,537	Never Married	30.4	638,336	2,813
Northern	12.6	295,295	1,047	Ever given birth			
North-western	5.4	125,886	861	Yes	71.4	1,499,010	6,062
Southern	11.5	269,762	1,124	No	28.6	600,410	2,718
Western	7.3	170,512	959	Educational level			
Area				None	28.4	665,354	2,584
Urban	41.5	971,351	5,368	Primary	43.7	1,022,471	3,967
Rural	58.5	1,367,734	4,465	Secondary +	27.8	651,260	3,282
Age Group				Zambia			
15-19	23.8	557,088	2,424		100.0	2,339,085	9,833
20-24	21.3	498,116	2,088				
25-29	18.4	431,416	1,763				
30-34	12.3	286,788	1,228				
35-39	11.1	260,340	1,078				
40-44	7.8	182,665	758				
45-49	5.2	122,673	494				

Table 6: Distribution of children Under-5 by background characteristics, Zambia, 1999

	%	Number	Unweighted
Sex			
Male	51.8	810,687	3,118
Female	48.2	754,322	3,024
Province			
Central	10.8	169,047	696
Copperbelt	13.9	217,924	838
Eastern	15.3	239,308	670
Luapula	8.5	132,813	572
Lusaka	13.1	204,312	866
Northern	13.7	213,643	720
North-western	4.9	76,603	506
Southern	13.1	205,366	745
Western	6.7	104,259	513
Area			
Urban	34.4	537,640	2,880
Rural	65.6	1,025,635	3,246
Age			
0-5 months	12.2	190,518	724
6-11 months	10.3	160,685	600
12-23 months	20.9	327,497	1,270
24-35 months	21.3	334,008	1,330
36-47 months	18.3	286,571	1,128
48-59 months	17.0	265,732	1,090
Zambia	100.0	1,565,010	6,142

Table 9: Children aged 36-59 months who are attending some form of organized early childhood education programme, Zambia, 1999

	Attending programme	Number of children
Sex		
Male	6.7	280,739
Female	6.2	271,564
Province		
Central	5.9	63,201
Copperbelt	11.3	80,556
Eastern	1.2	71,942
Luapula	4.6	42,393
Lusaka	19.2	77,310
Northern	1.6	80,339
North-western	1.1	26,677
Southern	4.7	70,278
Western	0.5	38,878
Area		
Urban	13.9	203,219
Rural	2.1	348,355
Age		
36-47 months	5.8	286,571
48-59 months	7.1	265,732
Mother's education level		
None	3.1	135,200
Primary	4.1	286,560
Secondary +	14.9	130,543
Zambia	6.4	552,303

Table 10: Children entering first grade of primary school who eventually reach grade 5, Zambia, 1999

	Percent attending 2 nd grade who were in 1 st grade last year	Percent attending 3 rd grade who were in 2 nd grade last year	Percent attending 4 th grade who were in 3 rd grade last year	Percent attending 5 th grade who were in 4 th grade last year	Percent who reach grade 5 of those who enter 1 st grade
Sex					
Male	96.2	95.8	95.4	97.9	86.1
Female	95.3	98.1	95.8	94.4	84.4
Province					
Central	94.4	97.3	93.6	96.0	82.6
Copperbelt	97.2	98.8	97.3	96.9	90.5
Eastern	94.3	97.5	94.5	94.3	81.9
Luapula	91.6	95.6	97.5	99.4	84.9
Lusaka	95.2	96.8	96.3	94.7	84.1
Northern	93.3	96.8	92.8	93.2	78.1
North-western	97.2	100.0	98.5	100.0	95.8
Southern	100.0	94.4	97.4	97.8	89.8
Western	97.1	94.6	93.2	98.3	84.1
Area					
Urban	97.2	97.9	96.8	95.7	88.3
Rural	94.8	96.2	94.8	96.5	83.5
Zambia	95.8	96.9	95.6	96.2	85.3

Table 11: Children of primary school age attending primary school, Zambia, 1999

	Male		Female		Total	
	Attending	Number	Attending	Number	Attending	Number
Province						
Central	62.0	114,287	64.7	111,751	63.3	226,038
Copperbelt	72.2	185,394	69.4	183,414	70.8	368,808
Eastern	42.7	130,362	44.9	132,017	43.8	262,379
Luapula	59.1	78,883	57.1	66,140	58.2	145,023
Lusaka	65.6	142,385	65.7	160,324	65.7	302,709
Northern	63.0	135,638	59.1	123,032	61.1	258,670
North-western	53.5	55,719	51.0	58,367	52.2	114,085
Southern	67.0	130,368	68.0	144,741	67.5	275,109
Western	56.5	74,787	61.1	68,373	58.7	143,160
Area						
Urban	71.9	395,232	71.1	409,634	71.5	804,866
Rural	55.3	652,590	55.3	638,527	55.3	1,291,117
Age						
7	35.8	172,850	39.8	177,742	37.8	350,592
8	59.3	150,242	56.0	148,746	57.6	298,989
9	62.4	156,345	61.9	132,541	62.2	288,886
10	71.7	150,731	69.7	164,253	70.6	314,984
11	67.2	141,966	71.3	138,453	69.2	280,419
12	71.4	149,463	73.0	140,919	72.2	290,382
13	68.5	126,225	63.7	145,507	65.9	271,732
Zambia	61.6	1,047,822	61.5	1,048,161	61.5	2,095,982

Table 12: Population aged 15 years and older that is literate, Zambia, 1999

	Male			Female			Total		
	Literate	Not		Literate	Not		Literate	Not	
		known	Number		known	Number		known	Number
Province									
Central	74.3	0.0	275,381	64.0	0.1	277,914	69.1	0.1	553,296
Copperbelt	90.3	0.0	524,012	78.3	0.0	519,379	84.3	0.0	1,043,391
Eastern	58.5	0.1	360,870	38.8	0.1	378,851	48.4	0.1	739,721
Luapula	74.0	0.3	192,444	53.9	0.3	204,555	63.6	0.3	397,000
Lusaka	83.1	0.2	503,607	70.0	0.1	444,090	76.9	0.1	947,697
Northern	82.0	0.1	335,157	54.8	0.2	365,743	67.8	0.1	700,900
North-western	56.7	0.1	154,654	41.3	0.0	163,419	48.8	0.1	318,073
Southern	75.2	0.2	356,739	62.4	0.1	341,365	69.0	0.1	698,104
Western	65.5	0.7	212,102	49.7	0.8	238,518	57.2	0.8	450,620
Area									
Urban	88.4	0.1	1,245,089	77.4	0.1	1,195,533	83.0	0.1	2,440,621
Rural	67.0	0.2	1,669,878	47.6	0.2	1,738,303	57.1	0.2	3,408,180
Age									
15-24	72.6	0.1	1,170,882	66.1	0.1	1,145,289	69.4	0.1	2,316,171
25-34	81.4	0.2	732,261	67.5	0.1	740,548	74.4	0.2	1,472,810
35-44	84.2	0.1	438,296	65.1	0.3	459,409	74.5	0.2	897,705
45-54	79.6	0.3	263,589	45.7	0.1	301,674	61.5	0.2	565,263
55-64	67.4	0.3	177,563	21.9	0.3	174,117	44.9	0.3	351,680
65+	56.7	0.3	132,376	17.3	0.0	112,797	38.5	0.2	245,173
Zambia	76.1	0.2	2,914,967	59.7	0.2	2,933,835	67.9	0.2	5,848,802

Table 13: Population with access to safe drinking water, Zambia, 1999

	Main source of drinking water											Total with safe drinking water	Number of persons
	Piped into dwelling	Piped into yard or plot	Public tap	Tubewell /borehole with pump	Bottled water	Protected dug well or spring	Unprotected dug well or spring	Rainwater collection	Pond, river or stream	Tanker truck vendor	Other		
Province													
Central	9.1	8.7	7.2	11.8	0.1	16.6	38.5	0.0	7.5	0.0	0.5	53.4	1,039,523
Copperbelt	41.6	20.0	15.7	1.3	0.2	5.2	11.6	0.1	2.7	0.0	1.6	83.9	1,878,593
Eastern	1.0	1.7	4.0	22.7	0.2	23.4	35.6	0.0	11.3	0.0	0.1	53.1	1,339,174
Luapula	2.0	2.0	4.0	0.9	0.1	8.1	57.7	0.4	24.0	0.0	1.0	17.0	718,381
Lusaka	25.0	15.8	38.5	8.7	0.1	0.6	4.9	0.0	2.8	0.0	3.6	88.6	1,624,749
Northern	6.2	3.9	8.3	0.8	0.0	5.8	36.8	0.0	37.3	0.0	1.0	25.0	1,283,270
North-western	6.0	1.6	6.0	0.6	0.3	24.2	49.3	0.0	12.0	0.0	0.0	38.5	564,998
Southern	6.6	11.4	10.4	31.9	0.0	6.3	15.9	0.0	15.0	0.0	2.4	66.7	1,312,004
Western	3.5	2.7	4.9	13.3	0.0	22.0	48.6	0.0	4.8	0.1	0.1	46.3	771,434
Area													
Urban	34.4	21.0	27.8	3.0	0.0	2.7	8.4	0.0	0.2	0.0	2.5	88.7	4,248,491
Rural	1.2	1.6	3.4	16.0	0.2	16.0	40.9	0.1	20.2	0.0	0.6	38.3	6,283,635
Zambia	14.6	9.4	13.2	10.7	0.1	10.6	27.8	0.0	12.1	0.0	1.4	58.6	10,532,125

Table 14: Population with access to sanitary means of excreta disposal, Zambia, 1999

	Type of toilet facility used by household (%)							Total with sanitary means of excreta disposal	Number of persons
	Flush to sewer system/septic tank	Pour flush latrine (Water seal type)	Improved pit latrine (Eg VIP)	Traditional Pit latrine	Aqua Privy	Bucket	Non/Bush/field		
Province									
Central	14.2	2.9	0.8	69.9	0.1	0.1	11.8	87.9	1,039,523
Copperbelt	49.6	8.8	3.0	34.6	0.2	0.1	3.7	95.9	1,878,593
Eastern	1.4	0.0	2.5	55.9	0.0	0.0	40.2	59.8	1,339,174
Luapula	3.9	0.7	1.5	87.2	0.4	0.5	5.8	93.3	718,381
Lusaka	21.6	1.2	11.5	63.1	0.2	0.1	2.4	97.2	1,624,749
Northern	7.1	0.3	0.9	78.4	0.0	0.0	13.3	86.7	1,283,270
North-western	6.2	0.1	0.9	87.6	0.0	0.1	5.0	94.5	564,998
Southern	8.8	2.0	6.4	34.8	0.0	0.5	47.6	52.0	1,312,004
Western	4.1	0.3	1.9	25.3	0.4	0.9	67.1	31.7	771,434
Area									
Urban	38.5	5.8	6.0	48.4	0.1	0.1	1.2	98.5	4,248,491
Rural	1.8	0.1	2.5	61.6	0.1	0.3	33.5	66.1	6,283,635
Zambia	16.6	2.4	3.9	56.3	0.1	0.2	20.5	79.2	10,532,125

Table 15: Under-5 children who are severely or moderately undernourished, Zambia, 1999

	Weight for age		Height for age		Weight for height		Number of children
	Percent below - 2 SD	Percent below - 3 SD	Percent below - 2 SD	Percent below - 3 SD	Percent below - 2 SD	Percent below - 3 SD	
Province							
Central	21.0	5.2	47.9	24.7	3.6	1.2	109,774
Copperbelt	17.3	5.0	49.8	28.3	3.5	0.7	149,925
Eastern	23.0	3.9	61.4	29.7	4.9	1.5	163,659
Luapula	39.7	13.3	57.5	29.5	10.2	4.0	92,202
Lusaka	19.3	3.5	44.3	22.2	8.1	1.6	145,767
Northern	37.5	9.5	58.7	36.9	7.1	0.3	153,738
North-Western	30.1	7.9	58.3	33.2	10.1	3.0	46,959
Southern	21.2	3.4	48.3	21.5	3.0	0.6	158,896
Western	23.1	4.9	54.2	27.2	3.9	0.7	72,869
Area							
Urban	19.2	3.9	48.1	25.4	5.1	1.1	377,653
Rural	28.1	6.9	55.5	29.1	5.9	1.4	716,136
Age							
< 6 months	-	-	-	-	-	-	-
6-11 months	22.8	7.1	36.5	12.8	8.4	2.6	106,722
12-23 months	34.1	9.0	57.9	29.9	8.8	2.0	249,845
24-35 months	24.6	6.2	51.3	26.9	5.8	1.3	287,778
36-47 months	18.0	4.8	53.7	29.3	3.4	0.6	240,304
48-59 months	24.0	2.3	57.0	32.5	2.8	0.5	210,351
Sex							
Male	26.3	6.1	54.6	28.4	6.0	1.0	572,665
Female	23.6	5.6	51.2	27.1	5.2	1.6	522,335
Mother's education level							
None	26.4	6.5	56.9	33.0	6.7	1.3	247,139
Primary	26.7	6.6	55.4	29.0	5.4	1.2	606,194
Secondary +	19.2	3.3	42.8	19.5	5.0	1.3	241,667
Zambia	25.0	5.9	53.0	27.8	5.6	1.3	1,095,000

Table 16: Distribution of living children by breastfeeding status, Zambia, 1999

	Exclusive breastfeeding among children 0-3 months	
	%	Number of children
Sex		
Male	30.1	63,413
Female	28.1	64,269
Area		
Urban	34.0	41,789
Rural	26.8	85,836
Mother's education level		
None	16.5	28,280
Primary	30.2	74,152
Secondary +	40.1	25,250
Zambia	29.1	127,682

Table 17: Households consuming adequately iodized salt, Zambia, 1999

	% of households with no salt	% of households in which salt was tested	% of households with salt testing		Number of households interviewed
			< 25 PPM	25+ PPM	
Province					
Central	8.5	88.9	25.9	74.1	175,927
Copperbelt	6.3	93.1	25.2	74.8	274,539
Eastern	7.9	90.8	41.4	58.6	303,968
Luapula	21.9	77.3	63.3	36.7	166,667
Lusaka	6.3	90.9	40.2	59.8	273,400
Northern	12.6	85.1	58.1	41.9	264,092
North-western	7.9	91.7	47.9	52.1	112,620
Southern	4.7	94.8	21.9	78.1	211,092
Western	15.6	82.8	6.6	93.4	149,343
Area					
Urban	6.9	91.1	33.0	67.0	713,228
Rural	11.1	87.6	31.0	69.0	1,218,420
Zambia	9.6	88.9	31.8	68.2	1,931,648

Table 18: Distribution of children aged 6-59 months by whether they have received a high dose Vitamin A supplement in the last 6 months, Zambia, 1999

	Received: within last 6 months	Received: prior to last 6 months	Received: not sure when	Not sure if received	Not received	Number of children
Sex						
Male	76.6	7.4	4.2	1.4	10.4	657,935
Female	74.3	8.6	4.6	1.8	10.7	606,375
Province						
Central	74.5	9.9	3.9	0.6	11.0	128,878
Copperbelt	90.3	2.2	0.1	1.8	5.7	184,269
Eastern	59.9	14.1	10.6	2.1	13.3	199,011
Luapula	83.6	2.1	2.3	0.9	11.1	100,660
Lusaka	85.4	5.6	2.9	1.1	5.0	163,763
Northern	72.9	7.9	1.7	0.4	17.2	172,806
North-Western	78.2	7.6	4.1	0.7	9.4	58,210
Southern	66.2	14.4	4.0	3.2	12.3	168,639
Western	74.8	2.6	11.4	3.4	7.9	87,379
Area						
Urban	86.3	4.6	2.0	1.2	6.0	441,017
Rural	69.7	9.8	5.7	1.8	13.0	822,597
Age						
6-11 months	73.7	3.4	2.5	1.4	18.9	140,658
12-23 months	77.5	5.3	3.8	0.9	12.5	299,907
24-35 months	76.1	8.0	4.9	1.8	9.1	312,411
36-47 months	77.0	9.6	4.4	1.4	7.7	274,126
48-59 months	71.6	12.0	5.6	2.6	8.2	237,206
Mother's education level						
None	68.0	8.2	7.0	3.5	13.4	290,093
Primary	75.1	8.7	3.9	1.2	11.1	694,975
Secondary +	84.3	6.1	2.9	0.6	6.1	279,241
Zambia	75.5	8.0	4.4	1.6	10.5	1,264,309

Table 19: Women with a birth in the last 12 months by whether they received a high dose Vitamin A supplement before the infant was 8 weeks old, Zambia, 1999

	% of received vitamin A supplement	% of not sure if received	Number of women
Province			
Central	48.8	0.0	28,401
Copperbelt	53.0	0.8	45,535
Eastern	37.0	2.3	63,030
Luapula	35.3	0.0	33,359
Lusaka	39.4	2.5	48,107
Northern	31.5	0.7	58,820
North-western	58.0	2.8	16,035
Southern	28.8	4.2	46,859
Western	47.3	1.1	23,511
Area			
Urban	47.6	0.6	117,347
Rural	36.0	2.2	246,311
Mother's education level			
None	35.4	1.5	94,420
Primary	38.9	1.8	196,746
Secondary +	47.6	1.5	72,491
Zambia	39.7	1.7	363,657

Table 20: Live births in the last 12 months that weighed below 2500 grams at birth, Zambia, 1999

	% of live births:		Number of live births
	Below 2500 grams	Weighed at birth	
Province			
Central	6.9	56.9	28,401
Copperbelt	6.7	68.3	45,535
Eastern	8.5	32.8	63,030
Luapula	6.8	39.4	33,359
Lusaka	7.2	72.0	48,107
Northern	6.4	39.3	58,820
North-western	6.9	78.7	16,035
Southern	10.2	49.1	46,859
Western	6.1	56.4	23,511
Area			
Urban	7.4	74.4	117,347
Rural	7.5	40.7	246,311
Mother's education level			
None	7.7	38.1	94,420
Primary	7.6	48.9	196,746
Secondary +	6.8	76.7	72,491
Zambia	7.5	51.6	363,657

Size at birth	No. of weighed births (1)	No. of weighed births < 2500 g (2)	Proportion of weighed births < 2500 g (2)/ (1) = (3)	Total number of births (4)	Estimated number < 2500 g (3) x (4) = (5)
Very small	28,031	932	0.0	45,606	1,516
Smaller than average	35,183	69	0.0	55,277	108
Average	117,606	8,164	0.1	203,923	14,155
Larger than average	12,103	3,657	0.3	22,061	6,665
Very large	5,872	2,635	0.4	10,437	4,684
Don't know	1,813	0	0.0	6,071	0

Table 21: Children age 12-23 months immunized against childhood diseases at any time before the survey and before the first birthday, Zambia, 1999

	%	BCG	DPT1	DPT2	DPT3	Polio 1	Polio2	Polio3	Measles	All	None	No. of children
Vaccinated at any time before the survey												
According to:												
Vaccination card		51.5	60.9	59.0	56.0	63.7	62.3	58.9	57.2	38.7	0.4	327,497
Mother's report		13.1	20.6	15.6	8.2	21.8	21.7	16.9	17.1	12.2	2.8	
Not vaccinated		35.4	18.5	25.4	35.8	14.5	16.0	24.2	25.7			
Children 12-23 months immunized against childhood diseases before the first birthday, for children who had a complete date on their vaccination card		97.0	95.9	95.2	92.1	95.9	95.4	92.2	88.1	73.3	0.1	

Table 22: Children age 12-23 months currently vaccinated against childhood diseases, Zambia, 1999

	% of children who received:										% with health card	Number of children
	BCG	DPT1	DPT2	DPT3	Polio 1	Polio2	Polio3	Measles	All	None		
Province												
Central	53.8	71.6	71.0	60.7	71.9	73.1	69.1	66.3	45.3	9.9	56.0	34,004
Copperbelt	78.6	96.3	88.8	78.5	98.4	98.0	91.6	91.0	70.2	0.7	78.6	39,444
Eastern	63.5	83.6	78.1	65.5	87.5	85.9	80.7	76.8	54.1	4.6	66.9	57,585
Luapula	65.6	82.0	75.9	69.3	85.8	86.3	80.3	80.9	57.4	6.5	66.9	31,708
Lusaka	71.7	81.9	79.4	74.1	84.6	82.9	76.4	68.8	53.5	3.1	71.7	37,141
Northern	62.7	80.2	67.4	48.2	90.7	86.7	71.2	74.7	37.6	0.7	65.4	47,942
North-western	50.0	72.7	60.3	50.6	69.5	63.0	52.4	58.2	33.9	3.2	52.3	17,037
Southern	65.8	81.0	70.8	63.7	86.4	84.1	72.1	72.9	51.5	1.0	67.6	42,881
Western	58.3	74.3	69.1	63.6	79.7	78.5	73.2	63.9	43.4	3.7	59.0	19,453
Area												
Urban	73.6	88.6	82.8	74.8	89.8	89.1	82.9	81.1	61.3	2.2	74.2	99,900
Rural	60.7	78.5	71.0	59.6	83.8	81.7	72.7	71.4	46.4	4.1	62.9	227,294
Sex												
Male	66.3	81.6	74.9	64.7	86.1	84.7	77.0	74.1	51.3	2.6	67.6	168,297
Female	62.8	81.4	74.2	63.7	85.0	83.1	74.5	74.5	50.5	4.5	65.0	159,200
Mother's education level												
None	58.5	75.2	68.4	56.8	83.1	81.0	70.4	69.9	43.6	4.8	59.6	76,357
Primary	64.2	82.9	75.4	64.0	86.3	84.2	74.8	73.6	49.4	3.7	66.7	181,697
Secondary +	72.4	84.8	78.9	73.1	86.4	86.4	84.2	80.9	63.0	1.6	72.7	69,444
Zambia	64.6	81.5	74.6	64.2	85.6	83.9	75.8	74.3	50.9	3.5	66.3	327,497

Table 23: Under-5 children with diarrhoea in the last two weeks and treated with ORS or ORT, Zambia, 1999

	Had diarrhoea in last two weeks	% of children with diarrhoea who received:							No treatment	Number of children
		Breast milk	Gruel	Locally- defined acceptable home fluid	ORS packet	Other milk or infant formula	Water with feeding	Any recom- mended treatment		
Sex										
Male	19.9	46.4	61.5	40.1	49.6	6.5	49.5	90.9	9.1	810,687
Female	18.0	49.4	65.3	39.5	48.6	6.4	55.6	93.4	6.6	754,322
Province										
Central	10.9	49.4	62.4	39.8	37.0	10.1	41.7	89.4	10.6	169,047
Copperbelt	18.3	50.2	67.1	34.0	55.9	11.8	64.4	91.4	8.6	217,924
Eastern	19.3	52.4	61.0	38.4	43.0	3.7	49.9	92.6	7.4	239,308
Luapula	23.8	51.1	54.0	41.3	47.7	1.0	39.6	89.5	10.5	132,813
Lusaka	24.6	41.5	76.8	49.1	60.7	11.9	61.7	95.5	4.5	204,312
Northern	23.5	48.1	57.9	31.9	39.8	4.2	46.0	90.8	9.2	213,643
North-Western	11.3	37.9	39.5	27.7	49.7	5.8	39.3	82.4	17.6	76,603
Southern	16.8	47.3	69.8	49.9	48.7	4.7	58.0	95.2	4.8	205,366
Western	17.1	44.8	53.3	35.9	58.9	2.0	51.2	92.3	7.7	104,259
Area										
Urban	20.4	45.9	69.4	41.5	56.4	11.8	59.0	92.6	7.4	539,374
Rural	18.3	48.8	59.7	38.8	44.9	3.3	48.3	91.8	8.2	1,025,635
Age										
<6 months	13.0	89.0	54.3	27.8	34.8	9.4	54.6	94.4	5.6	190,518
6-11 months	27.9	80.9	64.2	32.0	47.9	5.8	43.3	93.8	6.2	160,685
12-23 months	30.7	71.4	61.7	36.8	49.1	5.6	51.6	94.0	6.0	327,497
24-35 months	18.0	10.3	62.5	44.3	50.0	5.3	54.6	87.8	12.2	334,008
36-47 months	15.0	8.8	68.3	53.1	54.8	6.8	55.5	93.2	6.8	286,571
48-59 months	9.3	9.0	70.0	43.9	53.8	10.1	57.6	87.1	12.9	265,732
Mother's education level										
None	20.0	46.9	63.8	42.8	41.6	2.7	49.5	91.8	8.2	359,438
Primary	20.0	49.0	62.0	36.6	49.7	6.2	51.7	91.8	8.2	863,921
Secondary +	15.6	45.0	66.3	46.1	57.4	12.1	57.8	93.5	6.5	341,651
Zambia	19.0	47.7	63.2	39.8	49.1	6.4	52.3	92.1	7.9	1,565,010

Table 24: Under-5 children with diarrhoea in the last two weeks who took increased fluids and continued to feed during the episode, Zambia, 1999

	Had diarrhoea in last two weeks	% of children with diarrhoea who received:				Received increased fluids and continued eating	Number of children
		Drank more	Drank the same or less	Ate somewhat less, same or more	Ate much less or none		
Sex							
Male	19.9	9.8	19.1	15.4	13.5	7.2	810,687
Female	18.0	10.0	17.9	14.5	13.0	9.6	754,322
Province							
Central	10.9	4.8	13.9	11.1	8.0	5.3	169,047
Copperbelt	18.3	6.7	18.0	12.9	11.8	10.7	217,924
Eastern	19.3	10.6	20.7	18.4	12.7	4.2	239,308
Luapula	23.8	16.4	23.3	20.6	18.3	10.0	132,813
Lusaka	24.6	13.4	17.4	13.0	17.8	10.8	204,312
Northern	23.5	13.4	23.8	19.4	17.9	9.7	213,643
North-Western	11.3	10.1	11.1	13.4	7.6	13.3	76,603
Southern	16.8	6.5	16.5	11.9	10.7	5.2	205,366
Western	17.1	7.6	16.7	13.1	11.2	5.9	104,259
Area							
Urban	20.4	10.4	18.0	14.0	14.5	10.1	537,640
Rural	18.3	9.6	18.8	15.5	12.7	7.2	1,025,635
Age							
<6 months	13.0	7.5	13.9	11.4	9.3	7.5	190,518
6-11 months	27.9	11.9	26.6	18.5	19.7	5.3	160,685
12-23 months	30.7	14.0	26.0	18.4	21.5	7.7	327,497
24-35 months	18.0	10.9	17.5	16.1	12.3	8.9	334,008
36-47 months	15.0	8.0	14.5	12.7	9.8	10.7	286,571
48-59 months	9.3	6.2	13.2	12.3	7.1	11.1	265,732
Mother's education level							
None	20.0	8.5	17.6	12.7	13.4	5.1	359,438
Primary	20.0	10.5	19.3	15.8	13.7	8.4	863,921
Secondary +	15.6	9.8	17.5	15.4	12.2	12.3	341,651
Zambia	19.0	9.9	18.5	15.0	13.3	8.3	1,565,010

Table 25: Under-5 children with acute respiratory infection in the last two weeks and treated by health providers, Zambia, 1999

	Had acute respiratory infection	% of children with ARI who were taken to						Any appropriate provider	Number of children
		Govt./mission clinic, hospital	Community health worker	Mobile/outreach clinic	Private physician/Clinic	Traditional healer	Other		
Sex									
Male	2.9	71.4	5.1	0.0	2.6	5.6	20.8	72.7	810,687
Female	2.6	64.5	3.8	2.0	3.6	8.4	12.1	67.6	754,322
Province									
Central	1.2	56.7	8.4	0.0	15.2	0.0	8.4	72.0	169,047
Copperbelt	1.4	70.6	0.0	0.0	0.0	0.0	1.4	70.6	217,924
Eastern	3.5	79.2	11.7	0.0	0.0	14.2	26.6	79.2	239,308
Luapula	6.4	65.7	4.0	4.0	4.0	11.3	22.9	65.7	132,813
Lusaka	2.4	52.8	0.0	1.0	10.0	4.7	11.6	57.6	204,312
Northern	3.8	68.8	0.0	0.0	1.5	5.4	25.6	70.3	213,643
North-Western	2.4	57.2	14.1	0.0	3.6	0.0	5.9	71.2	76,603
Southern	2.2	73.5	3.7	0.0	0.0	0.0	0.0	73.5	205,366
Western	1.9	74.9	3.3	0.0	0.0	7.9	7.9	74.9	104,259
Area									
Urban	2.0	60.1	0.6	0.0	6.2	3.7	11.8	62.9	537,640
Rural	3.2	71.0	5.9	1.2	2.0	7.9	18.5	72.9	1,025,635
Age									
< 6 months	1.7	77.3	0.0	0.0	9.3	18.8	11.6	77.3	190,518
6-11 months	4.1	64.5	7.6	5.1	9.7	8.6	14.2	69.1	160,685
12-23 months	4.5	71.1	8.5	0.0	1.2	5.0	22.0	73.2	327,497
24-35 months	2.4	64.8	0.8	0.6	1.5	8.8	18.7	66.9	334,008
36-47 months	2.3	75.8	0.0	0.0	0.0	5.2	10.5	75.8	286,571
48-59 months	1.4	50.7	3.3	0.0	1.7	0.0	12.0	54.1	265,732
Mother's education level									
None	3.2	66.3	2.9	2.9	6.1	15.3	20.6	68.9	359,438
Primary	2.9	72.6	6.2	0.2	1.9	4.8	15.8	74.5	863,921
Secondary +	1.9	55.1	1.0	0.0	1.9	0.0	13.7	57.0	341,651
Zambia	2.8	68.3	4.6	0.9	3.0	6.9	16.8	70.4	1,565,010

Table 26: Children 0-59 months of age reported ill during the last two weeks who received increased fluids and continued feeding, Zambia, 1999

	Reported illness in last two weeks	% of children with an illness who:					Number of children
		Drank more	Drank the same or less	Ate somewhat less, same or more	Ate much less or none	Took increased fluids and continued eating*	
Sex							
Male	31.9	28.6	59.1	35.4	52.6	6.6	810,687
Female	30.4	27.5	61.1	33.2	54.4	6.9	754,322
Province							
Central	20.1	23.2	63.2	34.9	53.7	4.5	169,047
Copperbelt	26.9	25.2	64.2	38.8	50.7	10.4	217,924
Eastern	32.7	20.0	72.4	41.4	50.4	4.1	239,308
Luapula	47.3	37.0	42.4	29.8	47.8	8.4	132,813
Lusaka	33.1	39.1	51.3	27.6	62.9	8.8	204,312
Northern	39.5	30.7	62.4	37.7	55.7	7.5	213,643
North-Western	20.9	33.8	56.4	33.7	55.9	7.2	76,603
Southern	27.4	20.2	62.7	29.2	52.1	3.2	205,366
Western	28.4	21.2	62.8	32.0	52.0	5.0	104,259
Area							
Urban	30.5	33.4	57.4	32.1	59.1	8.5	537,640
Rural	31.6	25.4	61.4	35.5	50.6	5.8	1,025,635
Age							
< 6 months	24.4	19.3	66.4	38.5	44.3	4.8	190,518
6-11 months	41.4	23.5	68.0	28.4	62.4	3.6	160,685
12-23 months	42.7	29.9	59.4	30.2	59.0	6.6	327,497
24-35 months	30.6	31.9	57.1	35.4	53.5	7.5	334,008
36-47 months	25.7	29.2	56.9	35.0	51.1	8.3	286,571
48-59 months	22.2	27.9	56.5	44.9	40.0	8.7	265,732
Mother's education level							
None	29.1	25.4	62.3	32.0	56.0	4.0	359,438
Primary	32.6	28.1	60.1	33.3	53.9	6.8	863,921
Secondary +	29.7	30.9	57.5	39.7	49.5	9.3	341,651
Zambia	31.2	28.1	60.0	34.3	53.4	6.7	1,565,010

Table 27: Caretakers of children 0-59 months who know at least 2 signs for seeking care immediately, Zambia, 1999

	% of know child should be taken to health care facility if child:									Knows at least two signs	Number of caretakers
	Not able to drink/ breastfeed	Becomes sicker	Develops a fever	Has fast breathing	Has difficulty breathing	Has blood in stool	Is drinking poorly	Vomiting constantly	diarrhoea constantly		
Province											
Central	4.1	6.1	9.0	4.9	4.5	2.8	3.0	9.6	8.8	11.2	169,047
Copperbelt	11.9	19.1	33.4	12.4	16.0	15.9	5.4	22.9	29.9	36.5	217,924
Eastern	2.9	2.2	4.0	2.5	2.1	1.6	1.7	3.4	3.8	5.3	239,308
Luapula	6.9	8.7	14.7	5.3	5.9	4.3	3.7	8.0	12.9	15.1	132,813
Lusaka	10.4	11.8	13.6	10.1	10.1	9.3	9.0	13.3	13.6	14.7	204,312
Northern	2.3	2.2	6.6	1.9	4.1	0.7	1.8	3.8	5.0	7.0	213,643
North-Western	0.4	0.4	0.5	0.2	0.2	0.2	0.2	0.6	0.7	0.7	76,603
Southern	2.9	7.6	12.9	3.5	2.4	6.1	2.5	9.9	9.7	13.5	205,366
Western	7.1	8.4	9.3	7.8	7.3	6.9	4.9	7.8	10.1	10.4	104,259
Area											
Urban	8.7	12.4	19.5	8.8	10.3	9.9	5.8	14.5	17.8	21.2	537,640
Rural	4.1	5.4	8.8	4.0	4.1	3.5	2.6	7.0	7.8	9.9	1,025,635
Mother's education level											
None	5.5	7.0	11.1	5.2	6.0	5.3	4.4	9.6	9.7	12.8	359,438
Primary	5.0	7.3	11.7	4.8	5.5	5.1	3.0	8.4	10.5	12.8	863,921
Secondary +	7.7	10.3	16.1	8.4	8.4	7.7	5.2	12.4	15.0	17.5	341,651
Zambia	5.7	7.8	12.5	5.7	6.3	5.7	3.8	9.5	11.3	13.8	1,565,010

Table 28: Children 0-59 months of age who slept under an insecticide-impregnated bednet during the previous night, Zambia, 1999

	Slept under a bednet (%)			Bednet treated (%)			Number of children
	Yes	No	DK/missing	Yes	No	DK/missing	
Sex							
Male	6.1	83.2	10.8	21.6	77.5	0.9	810,687
Female	5.9	82.7	11.3	14.2	84.6	1.2	754,322
Province							
Central	6.3	82.1	11.6	18.6	81.4	0.0	169,047
Copperbelt	7.2	81.9	10.8	28.1	69.6	2.2	217,924
Eastern	3.2	85.8	11.0	21.8	78.2	0.0	239,308
Luapula	9.1	81.5	9.4	30.1	68.6	1.3	132,813
Lusaka	4.0	85.4	10.6	13.8	82.2	4.0	204,312
Northern	9.7	81.1	9.2	4.3	95.7	0.0	213,643
North-Western	2.8	84.4	12.8	40.7	59.3	0.0	76,603
Southern	3.9	82.7	13.3	21.9	78.1	0.0	205,366
Western	8.2	80.1	11.7	5.6	92.8	1.6	104,259
Area							
Urban	8.5	80.8	10.7	19.4	78.9	1.7	537,640
Rural	4.7	84.1	11.2	16.8	82.7	0.4	1,025,635
Age							
< 6 months	7.3	81.7	11.0	18.6	81.4	0.0	190,518
6-11 months	4.5	86.6	8.9	16.8	78.4	4.8	160,685
12-23 months	7.6	82.6	9.8	17.1	81.4	1.5	327,497
24-35 months	5.9	83.7	10.5	19.4	80.0	0.6	334,008
36-47 months	5.7	84.3	10.0	19.3	79.9	0.7	286,571
48-59 months	4.4	79.8	15.7	16.5	83.5	0.0	265,732
Zambia	6.0	83.0	11.0	18.1	80.9	1.0	1,565,010

Table 29: Children 0-59 months of age who were ill with fever in the last two weeks who received anti-malarial drugs, Zambia, 1999

	Had a fever in last two weeks	% of children received anti-malarial drugs						Number of children	
		Paracetamol	Chloroquine	Fansidar	Quinine	Other	Don't know		Any appropriate anti-malarial drug
Sex									
Male	14.4	58.7	35.5	0.0	0.0	0.0	21.2	35.5	116,465
Female	14.4	61.0	40.0	0.0	0.0	0.0	15.0	40.0	108,828
Province									
Central	8.1	44.7	38.6	0.0	0.0	0.0	9.4	38.6	13,683
Copperbelt	7.7	54.8	33.6	0.0	0.0	0.0	25.2	33.6	16,776
Eastern	15.8	77.2	56.5	0.0	0.0	0.0	2.8	56.5	37,705
Luapula	27.0	59.1	26.0	0.0	0.0	0.0	46.2	26.0	35,898
Lusaka	11.6	63.5	48.5	0.0	0.0	0.0	13.0	48.5	23,615
Northern	17.1	53.0	34.8	0.0	0.0	0.0	6.1	34.8	36,479
North-Western	12.9	59.4	28.2	0.0	0.0	0.0	10.0	28.2	9,907
Southern	14.7	59.3	34.2	0.0	0.0	0.0	32.6	34.2	30,109
Western	20.2	52.3	28.6	0.0	0.0	0.0	8.3	28.6	21,038
Area									
Urban	10.7	62.5	42.4	0.0	0.0	0.0	17.5	42.4	57,721
Rural	16.3	58.9	36.1	0.0	0.0	0.0	18.4	36.1	167,490
Age									
< 6 months	11.9	47.5	45.5	0.0	0.0	0.0	26.0	45.5	22,646
6-11 months	16.3	58.2	42.4	0.0	0.0	0.0	10.5	42.4	26,178
12-23 months	16.6	63.8	42.0	0.0	0.0	0.0	13.0	42.0	54,344
24-35 months	15.0	57.1	32.7	0.0	0.0	0.0	25.2	32.7	49,982
36-47 months	14.1	60.8	29.7	0.0	0.0	0.0	15.7	29.7	40,542
48-59 months	11.9	66.2	38.7	0.0	0.0	0.0	19.9	38.7	31,602
Mother's education level									
None	15.4	55.0	40.8	0.0	0.0	0.0	15.4	40.8	55,470
Primary	14.8	59.8	35.1	0.0	0.0	0.0	18.8	35.1	128,105
Secondary +	12.2	66.3	41.4	0.0	0.0	0.0	20.1	41.4	41,719
Zambia	14.4	59.8	37.7	0.0	0.0	0.0	18.2	37.7	225,294

Table 30: Women aged 15-49 years who know the main ways of preventing HIV transmission, Zambia, 1999

	Heard of AIDS	% of know transmission can be prevented by:					Number of women	
		Having only one uninfected sex partner	Using a condom every time	Abstaining from sex	Knows all three ways	Knows at least one way		Doesn't know any way
Province								
Central	95.5	76.6	48.9	77.0	37.0	92.7	7.3	229,739
Copperbelt	97.2	82.6	61.6	82.4	46.9	96.7	3.3	378,648
Eastern	95.7	66.1	49.5	72.8	31.0	89.1	10.9	339,372
Luapula	98.2	80.1	49.9	79.0	36.6	96.3	3.7	180,204
Lusaka	95.4	85.2	63.2	83.5	50.8	95.8	4.2	349,666
Northern	93.9	72.9	41.6	72.7	27.4	88.2	11.8	295,295
North-Western	98.5	83.8	62.2	84.0	51.4	95.2	4.8	125,886
Southern	95.8	87.6	71.5	84.5	59.8	95.9	4.1	269,762
Western	97.7	87.6	71.0	82.5	57.4	96.7	3.3	170,512
Area								
Urban	96.6	82.8	61.0	83.3	48.2	96.2	3.8	971,351
Rural	95.8	77.3	54.6	76.8	40.1	92.1	7.9	1,367,734
Age								
15-19	95.3	75.5	60.2	79.2	44.8	92.3	7.7	557,088
20-24	96.1	81.3	58.0	79.0	43.9	93.9	6.1	498,116
25-29	95.7	80.3	59.8	79.4	44.0	94.3	5.7	431,416
30-34	95.7	80.2	56.0	80.3	43.8	94.2	5.8	286,788
35-39	97.7	83.2	57.2	80.3	45.6	95.1	4.9	260,340
40-44	97.8	81.1	51.5	79.4	40.6	94.8	5.2	182,665
45-49	97.2	77.4	43.9	80.0	32.9	93.3	6.7	122,673
Education level								
None	95.4	78.7	54.6	78.4	41.9	92.8	7.2	665,354
Primary	96.0	78.5	55.8	78.9	41.7	93.4	6.6	1,022,471
Secondary +	97.1	82.2	62.3	81.5	47.7	95.5	4.5	651,260
Zambia	96.1	79.6	57.3	79.5	43.5	93.8	6.2	2,339,085

Table 31 Women aged 15-49 years who correctly identify misconceptions about HIV/AIDS, Zambia, 1999

	Heard of AIDS	% who believe that:					Doesn't correctly identify any mis- conception	Number of women
		AIDS cannot be transmitted by:		A healthy looking person can be infected	Knows all three mis- conceptions*	Knows at least one misconception		
		Supernatural means	Mosquito bites					
Province								
Central	95.5	67.4	62.1	80.2	44.6	91.7	8.3	229,739
Copperbelt	97.2	71.6	68.2	86.7	48.7	95.5	4.5	378,648
Eastern	95.7	68.3	60.4	68.8	36.5	89.9	10.1	339,372
Luapula	98.2	63.8	59.6	71.8	32.2	91.8	8.2	180,204
Lusaka	95.4	68.4	62.8	83.6	45.4	93.0	7.0	349,666
Northern	93.9	63.2	60.6	64.3	30.6	89.5	10.5	295,295
North-Western	98.5	60.9	66.2	68.7	36.5	90.0	10.0	125,886
Southern	95.8	71.5	61.0	83.5	45.2	93.4	6.6	269,762
Western	97.7	59.3	59.2	77.7	38.0	91.5	8.5	170,512
Area								
Urban	96.6	71.2	67.3	83.7	48.6	94.1	5.9	971,351
Rural	95.8	64.2	59.0	72.3	35.0	90.6	9.4	1,367,734
Age								
15-19	95.3	67.4	61.9	73.8	39.4	91.0	9.0	557,088
20-24	96.1	68.8	63.2	77.1	41.5	92.5	7.5	498,116
25-29	95.7	64.8	62.3	79.2	40.4	92.7	7.3	431,416
30-34	95.7	66.5	63.3	77.3	41.6	92.1	7.9	286,788
35-39	97.7	66.0	62.7	81.1	41.3	93.8	6.2	260,340
40-44	97.8	71.4	64.0	76.7	43.4	91.8	8.2	182,665
45-49	97.2	64.1	57.5	75.5	35.6	90.2	9.8	122,673
Education level								
None	95.4	61.3	57.5	70.2	32.8	88.6	11.4	665,354
Primary	96.0	64.9	58.9	76.2	37.0	92.1	7.9	1,022,471
Secondary +	97.1	76.5	73.1	85.4	54.3	95.6	4.4	651,260
Zambia	96.1	67.1	62.4	77.0	40.6	92.1	7.9	2,339,085

Table 32: Women aged 15-49 years who correctly identify means of HIV transmission from mother to child, Zambia, 1999

	Know AIDS can be transmitted from mother to child	% who know AIDS can be transmitted:			Did not know any specific way	Number of women
		During pregnancy/ at delivery	Through breastmilk	All three ways*		
Province						
Central	87.4	84.2	72.6	69.4	12.6	229,739
Copperbelt	86.9	84.5	68.3	66.0	13.1	378,648
Eastern	86.8	83.9	76.8	73.9	13.2	339,372
Luapula	92.7	88.3	78.3	73.8	7.3	180,204
Lusaka	82.0	80.4	68.0	66.4	18.0	349,666
Northern	85.9	81.2	67.0	62.3	14.1	295,295
North-Western	86.8	81.4	76.0	70.6	13.2	125,886
Southern	91.1	85.2	73.0	67.1	8.9	269,762
Western	94.8	89.0	78.3	72.5	5.2	170,512
Area						
Urban	86.4	83.8	69.5	66.8	13.6	971,351
Rural	88.4	84.0	74.1	69.7	11.6	1,367,734
Age						
15-19	83.0	77.9	67.5	62.3	17.0	557,088
20-24	89.3	85.5	73.9	70.0	10.7	498,116
25-29	87.9	85.1	71.8	69.0	12.1	431,416
30-34	90.4	87.1	76.4	73.1	9.6	286,788
35-39	90.1	86.8	73.9	70.5	9.9	260,340
40-44	88.0	85.1	72.9	70.0	12.0	182,665
45-49	87.4	85.4	73.8	71.8	12.6	122,673
Education level						
None	86.2	81.7	73.5	68.9	13.8	665,354
Primary	87.7	83.7	72.8	68.8	12.3	1,022,471
Secondary +	88.7	86.4	70.0	67.6	11.3	651,260
Zambia	87.6	83.9	72.2	68.5	12.4	2,339,085

Table 33: Women age 15-49 years who express a discriminatory attitude toward people with HIV/AIDS, Zambia, 1999

	% of women who:				Number of women
	Believe that a worker with HIV should not be allowed to work	Would not buy food from a person with HIV/AIDS	Agree with at least one discriminatory statement*	Agree with neither discriminatory statement	
Province					
Central	62.6	29.6	67.3	32.7	229,739
Copperbelt	71.6	48.0	79.2	20.8	378,648
Eastern	54.5	26.3	61.1	38.9	339,372
Luapula	64.9	39.6	74.4	25.6	180,204
Lusaka	69.2	42.9	75.0	25.0	349,666
Northern	60.0	25.6	66.9	33.1	295,295
North-Western	58.3	22.9	65.1	34.9	125,886
Southern	65.8	34.4	71.6	28.4	269,762
Western	61.0	31.0	67.3	32.7	170,512
Area					
Urban	71.2	42.8	77.3	22.7	971,351
Rural	58.4	28.8	65.4	34.6	1,367,734
Age					
15-19	63.1	35.6	70.7	29.3	557,088
20-24	66.5	36.1	73.4	26.6	498,116
25-29	61.9	34.3	68.1	31.9	431,416
30-34	63.8	34.5	71.0	29.0	286,788
35-39	65.2	33.7	70.2	29.8	260,340
40-44	62.6	31.1	68.0	32.0	182,665
45-49	60.1	33.1	66.8	33.2	122,673
Education level					
None	57.3	25.7	63.6	36.4	665,354
Primary	60.8	32.0	68.1	31.9	1,022,471
Secondary +	74.9	47.9	80.7	19.3	651,260
Zambia	63.7	34.6	70.3	29.7	2,339,085

Table 34: Women aged 15-49 years who have sufficient knowledge of HIV/AIDS transmission, Zambia, 1999

	Know 3 ways to prevent HIV transmission (%) (1)	Correctly identify 3 misconceptions about HIV transmission (%) (2)	Have sufficient knowledge (%) (Col. 1+2)	Number of women
Province				
Central	37.0	44.6	23.4	229,739
Copperbelt	46.9	48.7	25.8	378,648
Eastern	31.0	36.5	16.1	339,372
Luapula	36.6	32.2	13.1	180,204
Lusaka	50.8	45.4	26.2	349,666
Northern	27.4	30.6	11.6	295,295
North-Western	51.4	36.5	22.6	125,886
Southern	59.8	45.2	30.7	269,762
Western	57.4	38.0	22.0	170,512
Area				
Urban	48.2	48.6	27.2	971,351
Rural	40.1	35.0	17.6	1,367,734
Age				
15-19	44.8	39.4	22.6	557,088
20-24	43.9	41.5	22.3	498,116
25-29	44.0	40.4	21.1	431,416
30-34	43.8	41.6	22.6	286,788
35-39	45.6	41.3	21.5	260,340
40-44	40.6	43.4	19.9	182,665
45-49	32.9	35.6	16.2	122,673
Education level				
None	41.9	32.8	17.9	665,354
Primary	41.7	37.0	19.4	1,022,471
Secondary +	47.7	54.3	28.8	651,260
Zambia	43.5	40.6	21.6	2,339,085

Table 35: Women aged 15-49 years who know where to get an AIDS test and who have been tested, Zambia, 1999

	Know a place to get tested (%)	Have been tested (%)	If tested, have been told result (%)	Number of women
Province				
Central	61.5	4.7	88.4	229,739
Copperbelt	73.5	6.4	73.2	378,648
Eastern	44.2	2.7	86.3	339,372
Luapula	47.1	2.7	89.0	180,204
Lusaka	69.4	8.2	92.0	349,666
Northern	51.9	4.6	65.8	295,295
North-Western	68.2	3.8	70.9	125,886
Southern	54.7	5.1	79.1	269,762
Western	55.8	2.6	91.0	170,512
Area				
Urban	71.2	6.9	83.1	971,351
Rural	50.3	3.4	79.2	1,367,734
Age				
15-19	54.5	2.5	77.0	557,088
20-24	59.7	4.7	80.6	498,116
25-29	62.3	6.9	84.4	431,416
30-34	62.2	6.0	85.2	286,788
35-39	60.8	5.6	74.3	260,340
40-44	55.0	5.2	89.0	182,665
45-49	59.1	4.2	75.4	122,673
Education level				
None	47.0	3.0	82.2	665,354
Primary	55.3	3.9	79.7	1,022,471
Secondary +	77.0	8.2	82.7	651,260
Zambia	59.0	4.9	81.5	2,339,085

Table 36: Married or in union women aged 15-49 years who are using (or whose partner is using) a contraceptive method, Zambia, 1999

	% of women who are using:																Number of women
	Fem. Sterilization	Male sterilization	Pill	IUD	Injections	Implants	Condom	Female condom	Dia-phragm / foam/ jelly	LAM	Periodic abstinence	Withdrawal	Other	Any modern method	Any traditional method	Any method	
Province																	
Central	0.9	0.5	14.1	0.5	1.4	0.1	0.5	0.1	0.0	2.7	1.7	0.2	0.5	18.2	5.0	23.2	110,109
Copperbelt	0.7	0.6	20.4	1.3	5.6	0.1	2.0	0.1	0.0	2.2	2.6	0.5	0.9	30.9	6.2	37.1	194,849
Eastern	0.0	0.0	9.8	0.0	1.2	0.1	1.4	0.0	0.0	0.2	0.8	0.1	0.7	12.4	1.8	14.2	187,390
Luapula	1.1	0.0	9.1	0.0	2.6	0.0	0.8	0.0	0.0	0.7	3.4	1.3	1.4	13.7	6.8	20.5	92,605
Lusaka	0.4	0.0	18.1	1.8	4.7	0.0	1.6	0.1	0.0	0.2	1.1	0.3	0.7	26.6	2.3	28.8	180,515
Northern	0.3	0.0	11.0	0.0	0.8	0.1	1.1	0.1	0.0	1.2	2.4	1.0	1.8	13.3	6.5	19.7	177,695
North-Western	0.0	0.3	2.6	0.0	1.0	0.0	1.3	0.0	0.0	0.0	0.0	-	0.9	5.2	0.9	6.1	55,357
Southern	0.0	0.3	9.1	0.0	1.6	0.8	0.7	0.0	0.0	0.0	5.4	0.2	0.5	12.5	6.1	18.6	145,876
Western	0.3	0.0	5.8	0.1	0.3	0.0	0.4	0.0	0.3	0.9	0.0	-	0.6	7.2	1.5	8.7	71,013
Area																	
Urban	0.6	0.3	19.6	1.3	4.5	0.4	1.6	0.1	0.0	1.0	2.0	0.4	0.7	28.5	4.1	32.6	474,456
Rural	0.2	0.1	8.1	0.0	1.1	0.0	1.0	0.0	0.0	0.9	2.2	0.4	1.1	10.6	4.6	15.2	740,954
Age																	
< 20 years	0.0	0.0	7.8	0.0	1.0	0.0	0.5	0.0	0.0	2.0	0.7	0.5	0.4	9.4	3.6	13.0	99,653
20-24 years	0.0	0.2	12.5	0.3	1.5	0.0	2.0	0.1	0.1	1.4	2.6	0.5	0.6	16.6	5.1	21.7	251,518
25-49 years	0.6	0.2	13.2	0.7	2.9	0.2	1.1	0.0	0.0	0.7	2.2	0.4	1.1	18.8	4.3	23.1	864,239
Education level																	
None	0.0	0.1	5.9	0.2	1.0	0.1	0.5	0.0	0.0	0.7	1.9	0.5	1.2	7.7	4.2	12.0	314,851
Primary	0.4	0.2	12.3	0.4	2.2	0.0	1.4	0.0	0.0	1.2	2.4	0.5	0.9	16.9	5.0	21.9	597,067
Secondary+	0.7	0.4	20.0	1.1	4.6	0.5	1.7	0.2	0.1	0.6	1.8	0.3	0.7	29.2	3.4	32.7	303,492
Zambia	0.4	0.2	12.6	0.5	2.5	0.2	1.2	0.0	0.0	0.9	2.1	0.4	0.9	17.6	4.4	22.0	1,215,410

Table 37: Mothers who have given birth in the last 12 months protected against neonatal tetanus, Zambia, 1999

	% of mothers with a birth in the last 12 months who:				Number of mothers
	Received at least 2 doses, last within 3 years	Received at least 3 doses, last within 10 years	Received at least 5 doses during lifetime	Protected against tetanus	
Province					
Central	55.5	0.0	2.7	58.2	28,401
Copperbelt	64.4	0.0	3.1	67.5	45,535
Eastern	59.6	0.0	1.1	60.6	63,030
Luapula	49.2	0.0	3.8	53.1	33,359
Lusaka	69.2	0.0	0.3	69.6	48,107
Northern	63.8	0.0	1.7	65.5	58,820
North-Western	48.5	0.0	1.1	49.7	16,035
Southern	49.5	0.0	0.3	49.7	46,859
Western	50.5	0.0	4.7	55.2	23,511
Area					
Urban	67.8	0.0	2.2	69.9	117,347
Rural	54.1	0.0	1.7	55.8	246,311
Education level					
None	56.2	0.0	2.3	58.5	94,420
Primary	56.1	0.0	1.5	57.5	196,746
Secondary +	68.1	0.0	2.3	70.4	72,491
Zambia	58.5	0.0	1.8	60.3	363,657

Table 38: Distribution of women age 15-49 years who have delivered in the last year by type of personnel delivering antenatal care, Zambia, 1999

	% of person delivering antenatal care						No antenatal care received	Total	Number of women
	Doctor	Nurse/midwife	Clinical personnel	Traditional birth attendant	Other/missing	Any skilled personnel			
Province									
Central	12.2	60.7	5.0	3.1	7.3	77.9	11.7	100.0	28,401
Copperbelt	10.9	77.9	1.4	0.0	1.3	90.1	8.5	100.0	45,535
Eastern	4.7	71.6	5.5	8.8	5.1	81.8	4.3	100.0	63,030
Luapula	2.3	54.1	18.6	1.8	9.3	74.9	13.9	100.0	33,359
Lusaka	18.3	73.6	0.9	0.0	0.0	92.8	7.2	100.0	48,107
Northern	2.0	67.0	10.6	3.6	8.2	79.6	8.7	100.0	58,820
North-Western	4.3	65.3	10.9	10.3	4.8	80.5	4.4	100.0	16,035
Southern	12.5	68.3	1.1	11.5	2.8	81.9	3.7	100.0	46,859
Western	12.9	53.9	17.4	4.2	3.6	84.2	8.0	100.0	23,511
Area									
Urban	13.1	79.4	0.3	0.0	0.7	92.8	6.5	100.0	117,347
Rural	6.6	62.0	9.9	7.0	6.5	78.5	8.0	100.0	246,311
Education level									
None	7.2	62.6	6.0	6.4	9.6	75.7	8.3	100.0	94,420
Primary	7.5	67.4	8.6	5.4	3.8	83.4	7.4	100.0	196,746
Secondary +	14.1	74.7	3.2	0.6	0.5	92.0	6.9	100.0	72,491
Zambia	8.7	67.6	6.8	4.7	4.6	83.1	7.5	100.0	363,657

Table 39: Distribution of women age 15-49 years who have delivered in the last year by type of personnel assisting at delivery, Zambia, 1999

	% of person assisting at delivery						No assistance received	Total	Number of women
	Doctor	Nurse/ midwife	Clinical personnel	Traditional birth attendant	Relative/ friend	Any skilled personnel			
Province									
Central	8.0	32.0	0.0	12.5	36.7	40.0	10.8	100.0	28,401
Copperbelt	8.4	57.6	1.2	10.6	14.6	67.3	7.5	100.0	45,535
Eastern	3.6	27.0	2.0	25.4	35.3	32.6	6.7	100.0	63,030
Luapula	1.6	23.7	6.5	23.6	36.1	31.7	8.6	100.0	33,359
Lusaka	11.5	68.8	0.5	3.5	12.0	80.8	3.7	100.0	48,107
Northern	0.5	39.8	0.6	10.4	43.4	41.0	5.2	100.0	58,820
North-Western	3.0	48.2	4.9	19.1	20.6	56.1	4.2	100.0	16,035
Southern	3.4	26.9	0.0	7.7	55.4	30.3	6.6	100.0	46,859
Western	2.4	43.0	5.8	8.8	31.7	51.2	8.2	100.0	23,511
Area									
Urban	9.7	66.8	0.6	3.0	14.8	77.1	5.2	100.0	117,347
Rural	2.4	28.0	2.5	18.4	41.4	32.9	7.3	100.0	246,311
Education level									
None	2.5	28.6	1.7	17.2	42.9	32.9	7.0	100.0	94,420
Primary	4.5	37.1	2.3	14.9	34.3	43.9	6.9	100.0	196,746
Secondary +	8.6	65.1	0.8	4.5	15.6	74.5	5.4	100.0	72,491
Zambia	4.8	40.5	1.9	13.4	32.8	47.1	6.6	100.0	363,657

Table 40: Children age 0-59 months by whether birth is registered and reasons for non-registration, Zambia, 1999

	% of birth is registered	% of birth is not registered because:							Total	Number of children
		Costs too much	Must travel too far	Didn't know it should be registered	Late, did not want to pay fine	Doesn't know where to register	Other	Don't know		
Province										
Central	7.1	1.8	5.7	19.7	0.3	9.6	5.5	40.1	100.0	169,047
Copperbelt	16.5	0.9	0.7	19.7	0.5	6.7	4.7	33.1	100.0	217,924
Eastern	6.5	0.8	1.5	20.9	0.1	25.2	2.4	35.5	100.0	239,308
Luapula	5.7	0.5	0.8	28.8	0.9	17.7	2.1	33.7	100.0	132,813
Lusaka	16.8	3.6	1.6	3.5	0.4	15.3	10.7	33.6	100.0	204,312
Northern	3.3	0.9	3.9	25.7	0.1	14.9	5.6	36.5	100.0	213,643
North-Western	3.3	1.7	1.3	26.9	0.5	13.8	3.6	40.3	100.0	76,603
Southern	14.5	0.7	2.3	27.0	0.1	9.1	4.3	31.4	100.0	205,366
Western	4.5	4.0	4.3	21.0	0.6	20.3	2.8	33.6	100.0	104,259
Sex										
Male	9.5	1.5	2.5	21.1	0.4	14.6	4.3	35.1	100.0	810,687
Female	9.6	1.5	2.3	20.5	0.3	14.6	5.6	34.9	100.0	754,322
Area										
Urban	15.5	2.0	1.0	13.9	0.5	9.8	8.4	34.3	100.0	539,374
Rural	6.4	1.3	3.2	24.4	0.3	17.1	3.0	35.4	100.0	1,025,635
Age										
<6 months	-	-	-	-	-	-	-	-	-	-
6-11 months	9.8	1.4	3.0	19.2	0.5	13.2	5.1	39.7	100.0	160,685
12-23 months	9.9	0.5	2.3	25.4	0.1	16.3	5.0	28.8	100.0	327,497
24-35 months	11.0	2.7	2.4	26.3	0.4	18.7	5.4	19.6	100.0	334,008
36-47 months	11.3	1.5	3.0	23.4	0.7	17.2	8.1	22.2	100.0	286,571
48-59 months	12.2	2.5	3.4	21.0	0.3	15.6	4.0	26.5	100.0	265,732
Mother's Education level										
None	4.7	1.6	2.0	21.2	0.1	18.9	3.4	37.5	100.0	359,438
Primary	9.0	1.3	2.5	22.7	0.5	15.1	4.0	34.4	100.0	863,921
Secondary +	16.1	2.0	2.6	15.5	0.3	8.6	8.8	33.7	100.0	341,651
Zambia	9.6	1.5	2.4	20.8	0.3	14.6	4.9	35.0	100.0	1,565,010

Table 41: Children 0-14 years of age in households not living with a biological parent, Zambia, 1999

	% of living with both parents	% of living with neither parent				% of living with mother only		% of living with father only		% of not living with a biological parent*	% of one or both parents dead	Number of children
		Father only alive	Mother only alive	Both are alive	Both are dead	Father alive	Father dead	Mother alive	Mother dead			
Province												
Central	62.3	1.0	1.1	5.4	2.1	7.3	4.6	2.1	1.3	9.6	10.1	486,227
Copperbelt	70.5	1.0	2.1	4.6	2.6	9.4	6.2	1.3	0.8	10.4	12.7	835,202
Eastern	58.3	2.1	1.0	4.4	2.2	14.8	6.0	1.1	0.7	9.7	12.0	599,453
Luapula	61.7	2.1	2.1	4.6	2.6	12.3	7.2	0.7	0.1	11.3	14.1	321,381
Lusaka	64.6	0.9	2.2	4.6	2.9	6.7	6.7	1.5	1.4	10.5	14.0	677,051
Northern	73.5	1.4	1.8	3.9	1.8	10.2	4.8	0.7	0.5	8.7	10.1	582,369
North-Western	54.8	1.0	1.2	5.3	0.8	10.6	2.7	2.1	1.0	8.3	6.8	245,842
Southern	60.9	1.1	2.3	6.0	2.2	10.1	4.4	2.9	0.9	11.5	10.8	613,900
Western	50.5	0.8	2.8	6.8	2.0	15.8	4.9	4.2	1.1	12.3	11.6	320,814
Sex												
Male	63.7	1.3	1.9	4.7	2.0	10.6	5.5	1.9	1.0	9.9	11.8	2,361,230
Female	63.4	1.2	1.8	5.2	2.4	10.1	5.4	1.6	0.8	10.6	11.6	2,321,011
Area												
Urban	66.5	1.0	2.1	4.7	2.8	8.7	6.4	1.7	1.3	10.7	13.6	1,807,695
Rural	61.7	1.4	1.7	5.1	1.9	11.4	4.9	1.8	0.6	10.0	10.4	2,874,546
Age												
0-4 years	70.6	0.4	0.4	2.1	0.3	14.0	3.3	0.7	0.3	3.2	4.7	1,568,809
5-9 years	63.1	1.4	2.1	5.4	2.2	9.2	6.0	2.1	0.9	11.2	12.6	1,682,970
10-14 years	56.4	1.9	3.1	7.5	4.4	7.7	7.3	2.4	1.5	17.0	18.2	1,430,462
Zambia	63.5	1.2	1.9	4.9	2.2	10.4	5.5	1.7	0.9	10.3	11.7	4,682,241

Table 42: Children aged 5-14 years who are currently working, Zambia, 1999

	Paid work	Unpaid work	Domestic work		Family work (farm or business)	Currently working	Number of children
			< 4 hours/day	4 or more hours/day			
Sex							
Male	0.7	8.6	58.9	0.0	9.9	10.7	1,414,114
Female	0.5	8.0	65.4	0.0	9.6	10.1	1,398,080
Age							
5-9 years	0.2	5.6	46.5	0.0	6.8	7.1	1,498,554
10-14 years	1.0	11.4	80.0	0.0	13.1	14.2	1,313,640
Province							
Central	0.2	10.6	67.2	0.0	13.7	13.9	271,932
Copperbelt	0.8	6.5	53.6	0.0	7.5	8.4	543,382
Eastern	0.4	12.4	60.3	0.0	13.6	14.0	351,632
Luapula	0.4	9.1	75.4	0.0	10.5	11.0	189,256
Lusaka	0.4	0.6	52.7	0.0	1.0	1.5	411,562
Northern	1.0	10.0	69.2	0.1	11.9	12.9	368,590
North-Western	1.4	7.6	46.4	0.0	9.1	10.5	130,192
Southern	0.6	12.9	74.1	0.1	14.4	15.1	359,905
Western	0.4	7.1	64.9	0.0	8.9	9.3	185,741
Area							
Urban	0.7	1.8	53.4	0.0	2.4	3.2	1,135,209
Rural	0.5	12.7	68.1	0.0	14.7	15.3	1,676,986
Zambia	0.6	8.3	62.2	0.0	9.7	10.4	2,812,194