Namibia

2006-07 Demographic and Health Survey

Key Findings

This report summarizes the findings of the 2006-07 Namibia Demographic and Health Survey (NDHS), carried out by the Ministry of Health and Social Services (MoHSS). Macro International Inc. (Macro) provided technical assistance in the design, implementation, and analysis of the survey as part of the Demographic and Health Surveys project (MEASURE DHS). Funding for the survey was provided by the Government of Namibia, with additional assistance from the Global Fund, UNICEF, and DFID through a SADC project. USAID and the President's Emergency Plan for AIDS Relief (PEPFAR) also provided funds for the implementation of the survey and technical assistance through Macro.

This publication was made possible through support provided by the U.S. Agency for International Development. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

Additional information about the 2006-07 NDHS may be obtained from the Ministry of Health and Social Services (MoHSS), Private Bag 13198, Windhoek, Namibia, Telephone: (264-61) 203-2544/5; Fax: (264-61) 272-286; Email: doccentre@mhss.gov.na; Internet: www.healthnet.org.na.

Additional information about the DHS project may be obtained from Macro International, Inc., 11785 Beltsville Drive, Calverton, MD 20705, USA; Telephone: 301-572-0200, Fax: 301-572-0999, Internet: www.measuredhs.com.

Recommended citation:

Ministry of Health and Social Services (MoHSS) [Namibia] and Macro International, Inc. 2008. *Namibia Demographic and Health Survey 2006-07: Key Findings*. Calverton, Maryland, USA: MoHSS and Macro.

USAID
FROM THE AMERICAN PEOPLE

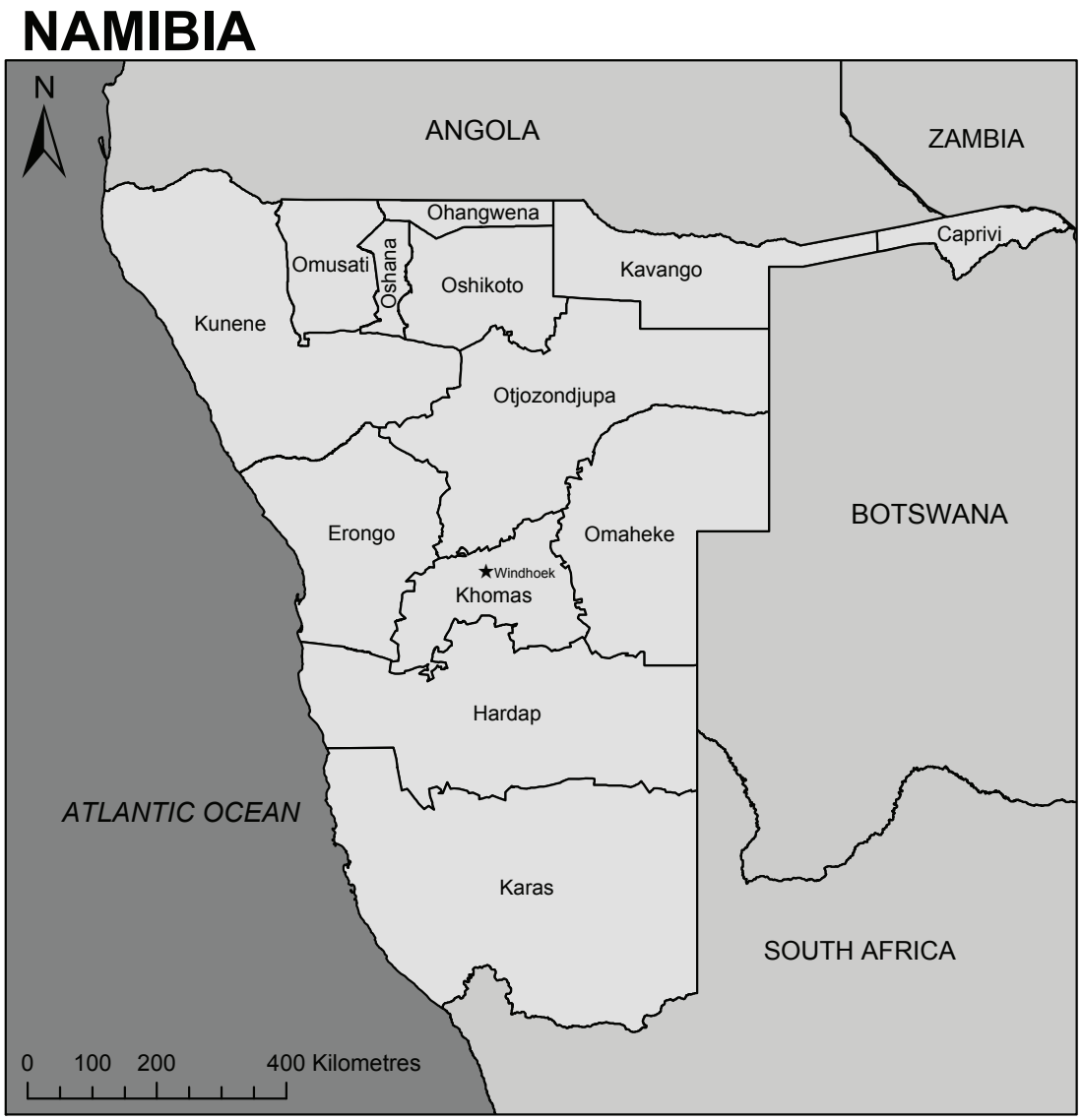
The Global Fund- To Fight AIDS, Tuberculosis, and Malaria

About the 2006-07 NDHS

The 2006-07 Namibia Demographic and Health Survey (NDHS) was designed to provide data for monitoring the population and health situation in Namibia. The 2006-07 NDHS is the third Demographic and Health Survey conducted in Namibia. The objective of the survey is to provide up-to-date information on fertility, family planning, childhood mortality, infant and child feeding practices, maternal and child health, maternal mortality, and HIV/AIDS-related knowledge and behavior.

Who participated in the survey?

A nationally representative sample of 9,804 women age 15-49 and 3,915 men age 15-49 were interviewed. This represents a response rate of 95 percent for women and 88 percent for men. This sample provides estimates for Namibia as a whole, for urban and rural areas, and, for most indicators, an estimate for each of the thirteen regions.



Ownership of Goods

Currently three-quarters of Namibian households own a radio and about one-third own a television. Half of households own a mobile phone, and 40 percent have a refrigerator.

More than a third of urban households own a car or truck, compared to 15 percent of rural households. Rural households, however, are far more likely than urban households to own agricultural land or farm animals.

(c) UNICEF Namibia photo library/ Tony Figuera

Household Characteristics

Household Composition

Namibian households consist of an average of 4.5 persons. Almost half (44 percent) of households in Namibia are headed by a woman.

Housing Conditions

Housing conditions vary greatly based on residence. More than three in four urban households have electricity, compared with only 15 percent of households in rural areas.

Almost 90 percent of households have access to an improved water source, and more than half have drinking water on the premises. Most urban households have water piped into their dwelling or yard (80 percent), while only 26 percent of rural households have directly piped water. Rural households also rely on public taps/standpipes (32 percent), tubewells/boreholes (17 percent) and surface water (11 percent) for their drinking water. Overall, only 16 percent of households are more than 15 minutes from their drinking water supply.

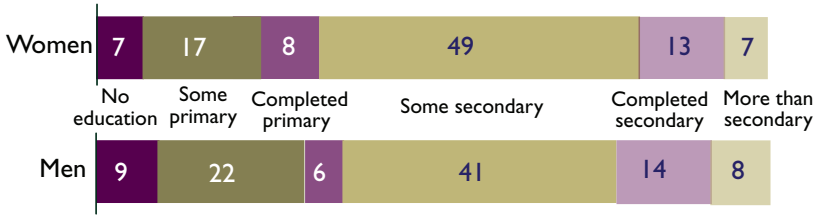
One-third of households nationwide have an improved (and not shared) toilet facility. More than three-in four rural households have no toilet facility.

Education of Survey Respondents

The majority of Namibians have received some education, and more than half have at least started secondary school. Only about 8 percent of men and women age 15-49 have had no education at all. Urban residents are more educated than rural residents. Education is highest in Khomas and lowest in Kunene, where 28 percent of women 32 percent of men have had no education.

Education

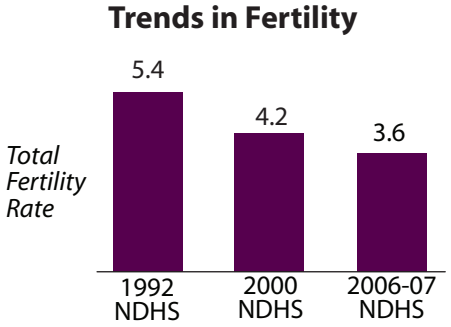
Percent distribution of women and men age 15-49 by highest level of education



Fertility and its Determinants

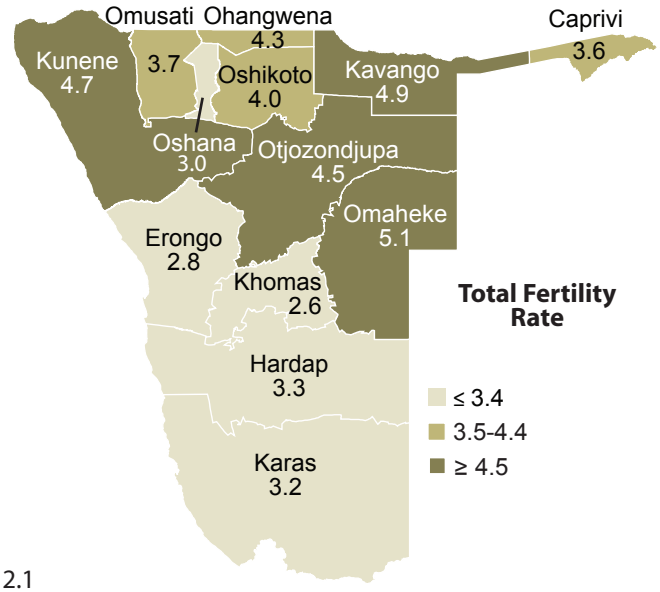
Total Fertility Rate (TFR)

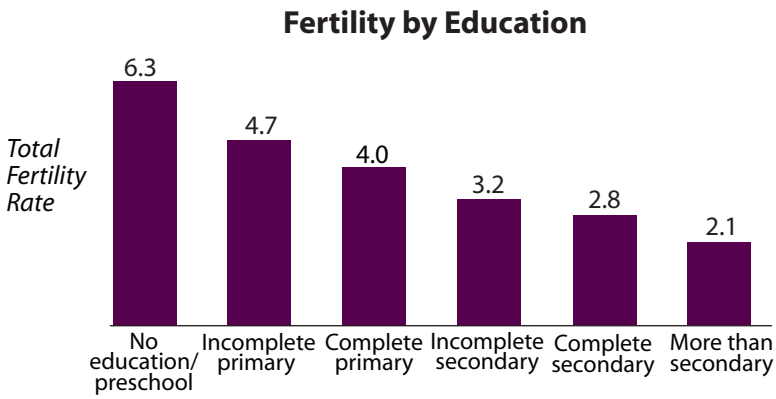
Fertility in Namibia has decreased dramatically since 1992 according to past Demographic and Health Surveys. Currently, women in Namibia have an average of 3.6 children, down from 4.2 in 2000 and 5.4 in 1992.



Fertility varies by residence and by region. Women in urban areas have 2.8 children on average, compared with 4.3 children per woman in rural areas. Fertility is highest in Omaheke (5.1 children per woman) and Kavango (4.9 children per woman) and lowest in Khomas, where women have an average of 2.6 children.

Fertility also varies with mother's education and economic status. Women with no education have three times as many children as those who have more than secondary education. Fertility increases as the wealth of the respondent's household* decreases. The poorest women, in general, have twice as many children as women who live in the wealthiest households (5.1 versus 2.4 children per woman).





* Wealth of families is calculated through household assets collected from DHS surveys—i.e., type of flooring; source of water; availability of electricity; possession of durable consumer goods. These are combined into a single wealth index. They are then divided into five groups of equal size, or quintiles, based on individuals' relative standing on the household index.

Desired Family Size

Namibian women report a mean ideal family size of 3.1 children. Ideal family size is slightly higher among women in rural areas than urban areas (3.3 versus 2.8). Ideal family size decreases dramatically as women's education increases: women with no education would like 4.5 children compared to only 2.8 among those with more than secondary education.

(c) 2003 Harvey Nelson, Courtesy of Photoshare

Age at First Marriage

In Namibia, many women bear children without entering a stable union. Marriage comes at a relatively late age in Namibia. Only 17 percent of women age 20-49 were married by their twentieth birthday. The median age at first marriage among women age 30-49 is 28.2, while men marry even later, at about age 35. Women in urban areas tend to marry later (median age of 29.1) than their counterparts in rural areas (median age of 27.4). Age at marriage is relatively high across all education and wealth groups.

Age at First Sexual Intercourse

More than one-third of women and half of men (age 20-49) were sexually active by the age of 18. Five percent of women and 12 percent of men had had sex by the age of 15. Half of women age 25-49 had their first sexual intercourse by age 19.3, while men had their first sex earlier, at a median age of 18.2. While there is little difference in age at first sex between urban and rural areas, there is a wide range by region: age at first sex for women 25-49 ranges from 17.5 in Kavango to 21.0 in Omusati. Women with more than secondary education wait three years longer to initiate sexual activity than those with no education (median age at first sex of 21.1 versus 18.1).

Age at First Birth

In Namibia, half of women age 20-49 have their first birth by age 21.5. Only 17 percent of women had their first birth by age 18. Urban women age 25-49 have their first birth at a slightly older age than rural women—21.8 years versus 21.0 years. Women with more education wait much longer to have their first birth. Women who have completed secondary education have their first birth at a median age of 24.2 years, compared to only 19.5 among those who have not completed primary school. Age at first birth also varies by region, ranging from 19.5 years in Kunene to 22.9 years in Omusati.

Teenage Fertility

One in seven young women age 15-19 have already begun childbearing: 13 percent are mothers and an additional 3 percent are pregnant with their first child. Young motherhood is more common in rural areas than in urban areas, and young women with no education are almost ten times as likely to have started childbearing by age 19 than those who have completed secondary school (58 versus 6 percent).

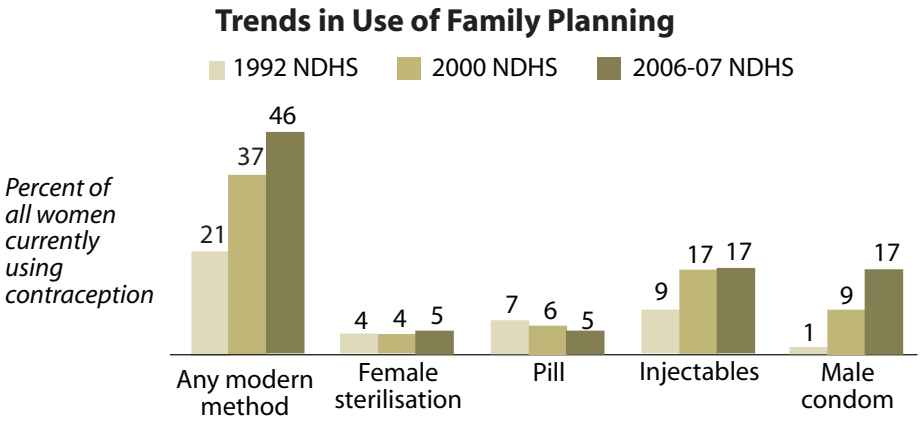
Family Planning

Knowledge of Family Planning

Knowledge of family planning methods in Namibia is universal: 98 percent of all women age 15-49 know at least one modern method of family planning. The most commonly known methods are the male condom (95 percent), injectables (93 percent), and the pill (90 percent).

Trends in Use of Family Planning

Use of modern methods of family planning has more than doubled since 1992, from 21 percent of all women, to 37 percent in 2000 and 46 percent in 2006-07. Injectable use doubled between 1992 and 2000, and use of male condoms doubled between 2000 and 2006-07.



Current Use of Family Planning

Almost half of all women (46 percent) currently use a modern method of family planning. Injectables (17 percent), male condoms (17 percent), and pill (5 percent) are the most commonly used. Five percent of all women are sterilized. Currently married women are more likely to use family planning than all women (53 percent versus 46 percent), but unmarried, sexually active women are most likely to use family planning—two-thirds (66 percent) are using a modern method, with 24 percent using injectables and 23 percent using the male condom.

Use of modern family planning varies by residence and region. Modern methods are used by 74 percent of sexually active women in urban areas, compared with 55 percent in rural areas. Modern contraceptive use ranges from a low of 47 percent of sexually active women in Kavango to a high of 79 percent in Erongo.

Modern contraceptive use increases dramatically with women's education. Sexually active women with more than secondary education are twice as likely to use a modern method as those with no education (76 percent versus 37 percent). Use of modern methods also increases with wealth—78 percent of sexually active women in the wealthiest households use a modern method compared to only 43 percent of sexually active women in the poorest households.

Source of Family Planning Methods

Public sources such as government hospitals, health centres, and clinics currently provide contraceptives to about 75 percent of current users, while private hospitals and clinics provide methods to only 10 percent of users. Pills and injectables are most frequently obtained from public sources, while IUDs are usually obtained through private medical facilities and condoms are obtained through both public and other private sources, such as shops.

NEED FOR FAMILY PLANNING

Intention to Use Family Planning

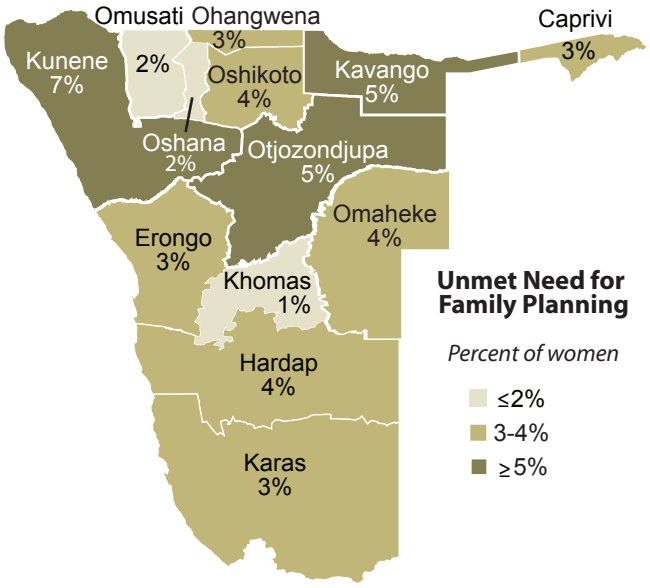
Six in ten (62 percent) non-users intend to use family planning in the future. Injectables, condoms, and pills are the most popular methods for future use among all women, while married women are also interested in sterilization.

Desire to Delay or Stop Childbearing

Almost half (49 percent) of Namibian women want no more children, and 11 percent are already sterilized. Another 16 percent want to wait at least two years before their next birth. These women are potential users of family planning.

Unmet Need for Family Planning

Unmet need for family planning is defined as the percentage of women who want to space their next birth or stop childbearing entirely but are not using contraception. The 2006-07 NDHS reveals that only 3 percent of women have an unmet need for family planning—2 percent for spacing and 3 percent for limiting. Unmet need is highest among women age 30-34, among those with little or education, and among those in the poorest households.



Missed Opportunities

Almost 40 percent of women and one-third of men had not been exposed to any messages about family planning on the radio, television, or newspapers/ magazines in the six months before the survey. Women and men in rural areas are less likely to see or hear these messages.

Among all women who are not currently using family planning, only 7 percent were visited by a field worker who discussed family planning, and only 7 percent of women who visited a health facility discussed family planning with a health worker. Overall, almost 9 in 10 non-users did not discuss family planning with any health worker.

Informed Choice

Family planning clients should be informed about the side effects of the method used, what to do if they experience side effects, and told about other methods that could be used. Unfortunately, about half of Namibian women did not get this information the last time they began using a new method of contraception. Only 53 percent were informed about possible side effects of their method, and 58 percent were informed about other methods that could be used.

Infant and Child Mortality

Levels and Trends

Childhood mortality has remained relatively stable in Namibia over the last 15 years. Currently, one in every 14 children in Namibia dies before his or her fifth birthday.

(c) 2003 Harvey Nelson, Courtesy of Photoshare

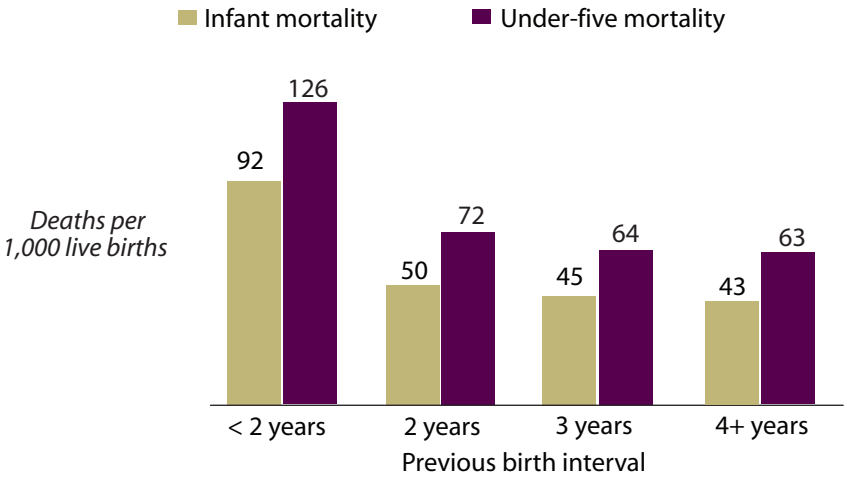
The infant mortality rate for the five years before the survey (2002-2006) is 46 deaths per 1,000 live births and the under-five mortality rate is 69 deaths per 1,000 live births. For the period 1997-2001, infant mortality was 51 and under-five mortality was 69, almost identical to the rates for 2002-2006.

Mortality rates are slightly higher in rural than urban areas, but they differ markedly by region. Infant mortality ranges from 27 deaths per 1,000 live births in Kunene to 78 deaths per 1,000 live births in Caprivi. Mortality is lowest among children whose mothers have more than secondary education (19 infant deaths per 1,000 live births) and among those in the wealthiest households (23 infant deaths per 1,000 live births).

Birth Intervals

Spacing children at least 36 months apart reduces risk of infant death. In Namibia, the average birth interval is relatively long—42 months. Infants born less than two years after a previous birth have particularly high infant mortality rates (92 deaths per 1,000 live births compared to only 45 deaths per 1,000 live births for infants born three years after the previous birth). One in eight infants in Namibia is born less than two years after a previous birth. These infants are at particularly high risk of death.

Childhood Mortality by Previous Birth Interval

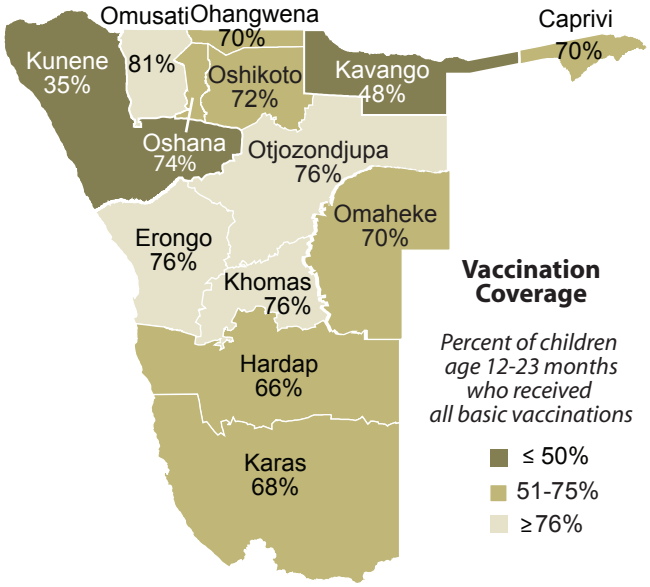


CHILD HEALTH

Vaccination Coverage

According to the 2006-07 NDHS, 69 percent of Namibian children age 12–23 months had received all recommended vaccines—one dose of BCG, three doses each of DPT and polio, and one dose of measles. More than 90 percent of children received BCG, DPT 1, and Polio 1, while fewer received the subsequent doses of DPT or Polio, and only 84 percent received the measles vaccine. Only 2 percent of children had not received any of the recommended vaccines.

Vaccination coverage is slightly higher in urban areas than rural areas (72 versus 67 percent). There is marked variation in vaccination coverage by region, ranging from only 35 percent fully vaccinated in Kunene to 81 percent in Omusati. As expected, coverage increases with mother's education and household wealth.



Childhood Illnesses

In the two weeks before the survey, 4 percent of children under five had symptoms of an acute respiratory infection (ARI), and 17 percent had a fever. Among those with fever, more than half (56 percent) were taken to a health provider. Ten percent of children with fever took antimalarial drugs, and 15 percent took antibiotics.

During the two weeks before the survey, 12 percent of Namibian children under five had diarrhoea. The rate was highest (20 percent) among children 12-23 months old. Sixty percent of children with diarrhoea were taken to a health provider. Children with diarrhoea should drink more fluids, particularly through oral rehydration salts (ORS). Almost all (91 percent) mothers with children born in the last five years know about ORS packets, and in the two weeks before the survey, 63 percent of children with diarrhoea were treated with ORS. One in six children with diarrhoea was offered increased fluids. Almost three in four children with diarrhoea were treated with some type of oral rehydration therapy or increased fluids. Many children, however, went without any treatment (17 percent).

(c) UNICEF Namibia photo library/Tony Figuera

Feeding Practices and the Nutritional Status of Women and Children

Breastfeeding and the Introduction of Complementary Foods

Breastfeeding is very common in Namibia, with 94 percent of children ever breastfed. WHO recommends that children receive nothing but breastmilk (exclusive breastfeeding) for the first six months of life. About one-quarter of children under six months of age in Namibia are exclusively breastfed. On average, children breastfeed until the age of 17 months, but exclusively breastfeed for less than one month. Infants should *not* be given water, juices, other milks, or complementary foods until six months of age, yet almost one-third of Namibian children under six months receive these.

(c) 2003 Henrica A.F.M. Jansen, Courtesy of Photoshare

Complementary foods *should* be introduced when a child is six months old to reduce the risk of malnutrition. In Namibia, 72 percent of children ages 6–9 months are eating complementary foods.

The Infant and Young Child Feeding (IYCF) practices recommend that breastfed children age 6-23 months also be fed three or more other food groups. Almost two-thirds of breastfed children in Namibia meet this recommendation, but only half are fed at least the minimum number of times recommended. Non-breastfed children should be fed milk or milk products, and four or more food groups. Sixty-three percent of non-breastfed Namibian children receive milk or milk products, and 60 percent were fed four or more food groups. Only 25 percent, however, were fed four or more times, as recommended. Overall, among all children age 6-23 months, only 26 percent were fed according to all three IYCF practices.

Vitamin A and Iron Supplementation

Micronutrients are essential vitamins and minerals required for good health.

Vitamin A, which prevents blindness and infection, is particularly important for children and new mothers. In the 24 hours before the survey, 76 percent of children age 6-35 months ate fruits and vegetables rich in vitamin A. Sixty-three percent ate foods rich in iron. Half of children age 6–59 months received a vitamin A supplement in the six months prior to the survey, but only 12 percent received an iron supplement in the week before the survey.

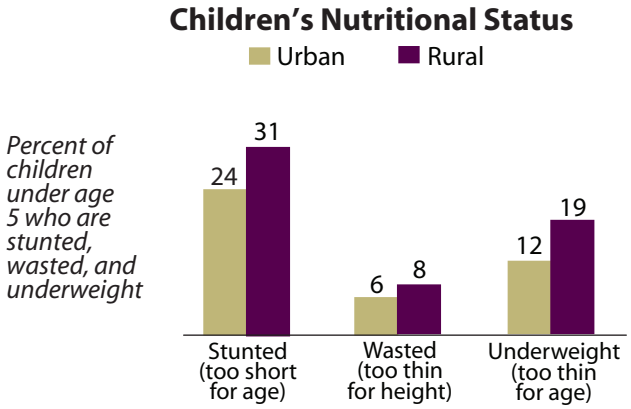
Pregnant women should take iron tablets or syrup for at least 90 days during pregnancy to prevent anemia and other complications. Only one-third of women took iron tablets or syrup for at least 90 days during their last pregnancy. In addition, only 51 percent of women received a vitamin A supplement postpartum.

Children's Nutritional Status

The NDHS measures children's nutritional status by comparing height and weight measurements against an international reference standard. According to the 2006-07 NDHS, 29 percent of children under five are stunted, or too short for their age. This indicates chronic malnutrition. Stunting is more common in rural areas (31 percent) than urban areas (24 percent). Stunting ranges from 22 percent in Erongo and Omaheke to 39 percent in Kavango. Eight percent of children are wasted (thin for height), and 17 percent of children are underweight.

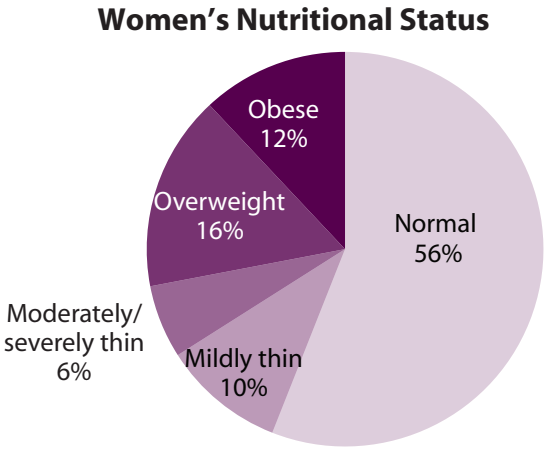
Nutritional status has remained the same since 2000.

(c) 2003 Harvey Nelson, Courtesy of Photoshare



Women's Nutritional Status

Namibian women also face nutritional challenges. However, overweight and obesity are more common than underweight. More than half of Namibian women have normal body mass index (BMI). About 16 percent of Namibian women are thin (BMI <18.5), while 6 percent of Namibian women are moderately and severely thin. More than one in four, however, is overweight or obese (BMI ≥ 25.0). Overweight is most common among women living in urban areas (37 percent), and among the most educated (52 percent) and wealthiest (43 percent).



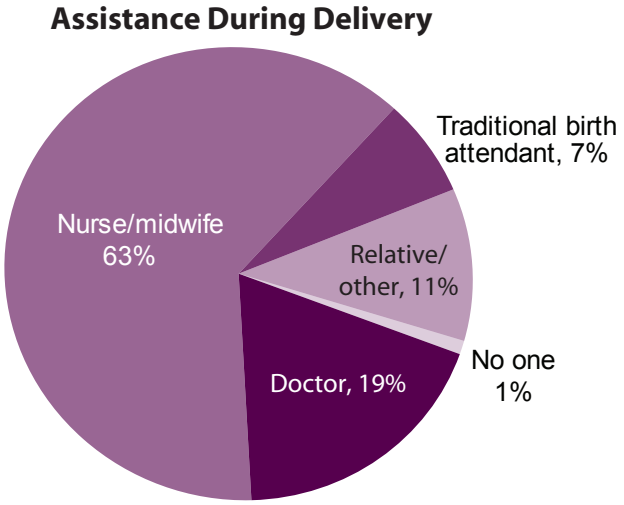
Maternal Health

Antenatal Care

Almost all (95 percent) Namibian women receive some antenatal care from a medical professional, most commonly from a nurse/midwife (79 percent). Only one-third of women, however, had an antenatal care visit by their fourth month of pregnancy, as recommended. Although almost all Namibian women receive some antenatal care, they may not be receiving all the recommended components of care. According to the 2006-07 NDHS, only 58 percent of women were informed of signs of pregnancy complications during antenatal care. Eighty percent took iron tablets or syrup. Almost all women who received antenatal care were weighed and had their blood pressure measured. Only 57 percent of women's most recent births was protected against neonatal tetanus.

Delivery and Postnatal Care

Four-fifths of Namibia's births occur in health facilities—76 percent in the public sector and 5 percent in private sector facilities. One-fifth of births occur at home. Home births are more common in rural areas (28 percent) than urban areas (6 percent). Eighty-one percent of births are assisted by a skilled provider (doctor, or nurse/midwife). Another 7 percent are assisted by a traditional birth attendant and 11 percent by untrained relatives or friends.



Postnatal care helps prevent complications after childbirth. Almost four in five women had a postnatal checkup. Only one-third, however, had a check up within four hours of birth, as recommended.

Maternal Mortality

The NHDS asked women about deaths of their sisters to determine maternal mortality—deaths associated with pregnancy and childbearing. The 2006-07 maternal mortality rate for the ten years prior to the survey is 449. This is higher than the maternal mortality rate reported in the 2000 NDHS of 271.

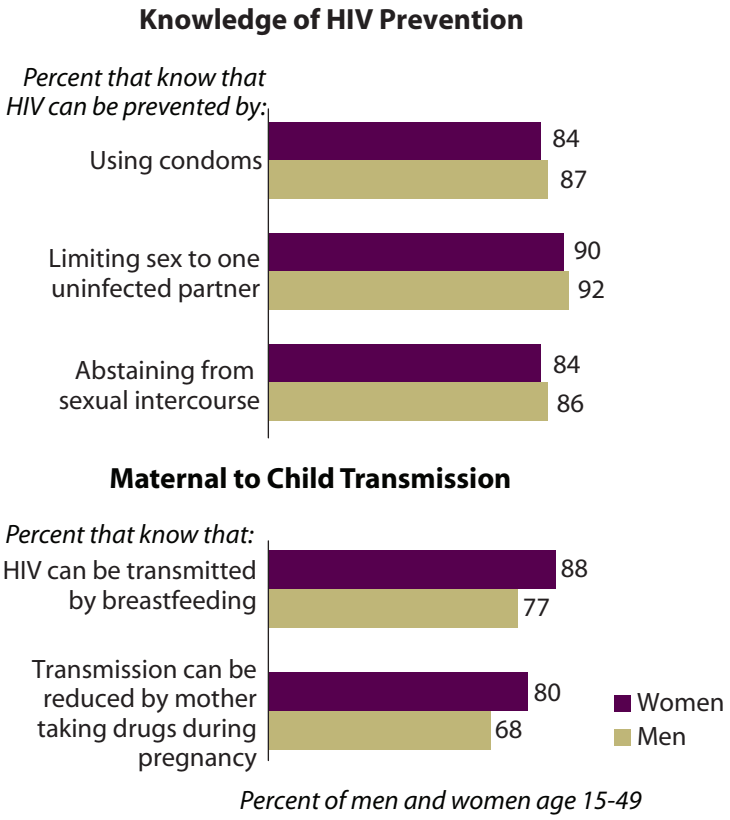
HIV/AIDS Knowledge and Attitudes

Knowledge

According to the 2006-07 NDHS, almost all Namibian adults have heard of AIDS, but many have no knowledge of HIV prevention measures. For example, only 84 percent of women and 87 percent of men age 15-49 know that the risk of getting HIV can be reduced by using condoms. Prevention knowledge varies by region. Only 64 percent of women in Omaheke know that using condoms can prevent HIV, compared to 90 percent of women in Khomas.

Most men and women know that HIV can be transmitted by breastfeeding, and about three-quarters know that the risk of mother-to-child transmission can be reduced by taking drugs during pregnancy.

Many Namibians still have misconceptions about HIV/AIDS. Only eight in ten women and seven in ten men, for example, know that AIDS cannot be transmitted by mosquito bites.



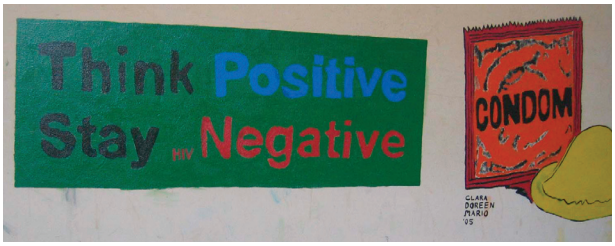
Attitudes

There is still a lot of stigma associated with HIV in Namibia. While most men and women say they are willing to take care of a family member with the AIDS virus, only about 55 percent say that they would not want to keep secret that a family member got infected with the AIDS virus. Three in four say that they would buy fresh vegetables from a shopkeeper who has the AIDS virus.

The majority of Namibian adults (about 85 percent) agree that children age 12-14 should be taught about using a condom to avoid AIDS.

Negotiating Safer Sex

Most men and women say that women can negotiate with their husbands to have safer sex. Eighty-six percent of women and 89 percent of men believe that women can refuse sex if the husband has a sexually transmitted infection (STI).

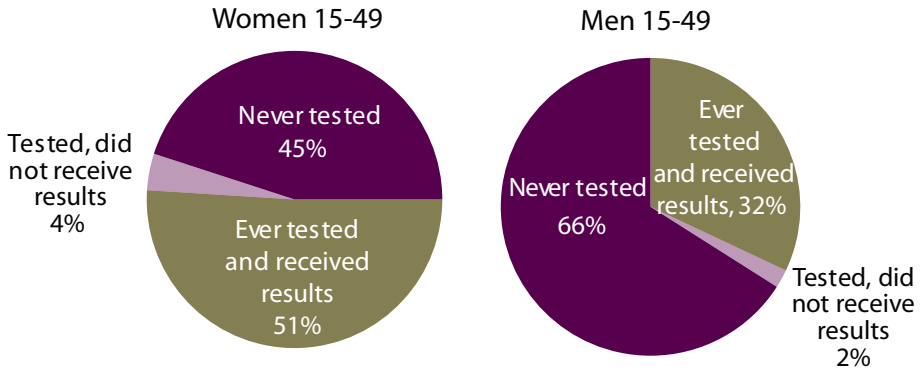


HIV/AIDS-Related Behavior

HIV Testing

Most Namibians (around 90 percent) know where to get an HIV test. Women are far more likely to have been tested for HIV—51 percent of women have ever been tested and received results compared to only 32 percent of men. Testing is more common in urban areas than rural areas, and is most common among men and women with higher levels of education and those from the wealthier households. In the 12 months before the survey, 29 percent of women and 18 percent of men had taken an HIV test and received the results. Sixty-two percent of women who were pregnant in the two years before the survey were offered and received HIV testing during antenatal care. HIV testing during antenatal care ranges from only 37 percent of women in Omaheke to 80 percent of women in Oshana.

Prior HIV Testing

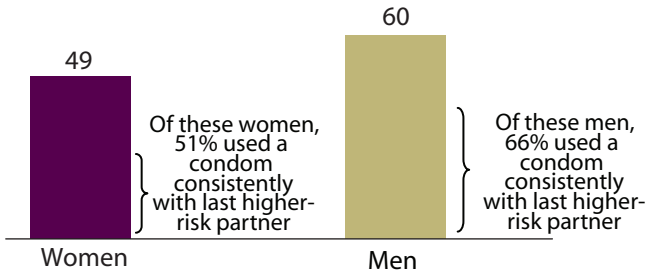


Higher Risk Sex and Condom Use

In the 2006-07 NDHS, higher-risk sex is defined as sex with a partner who is neither a spouse or lived with the respondent in the 12 months preceding the survey. Overall, 49 percent of women and 60 percent of men engaged in higher-risk sex in the year before the survey. About half of these women and two-thirds of these men reported using a condom consistently with their last higher-risk partner.

Higher Sex and Condom Use

Percent of women and men (age 15-49) who had sex with a nonmarital, noncohabiting partner in the 12 months before the survey



Youth and HIV/AIDS

Almost two-thirds of youth (age 15-24) have comprehensive knowledge of HIV/AIDS. That is, they know that use of condoms during sex and having just one uninfected partner can reduce the change of getting AIDS, know that a healthy-looking person can have AIDS, and reject the two most common local misconceptions about AIDS. Nine in ten young people know a place to get condoms. More than half of young women and men have sex before marriage. Among these sexually active youth, 64 percent of young women and 81 percent of young men report that they used a condom the last time they had sex.

Malaria

Ownership and Use of Mosquito nets

Overall, one-quarter of households have at least one mosquito net, and most of these households (20 percent) have an insecticide-treated net (ITN). Ownership of nets varies by region, ranging from only 2 percent in Erongo to 65 percent in Caprivi. Nationwide, 11 percent of children under age five slept under an ITN the night before the survey. Use of mosquito nets is high in Caprivi, where 41 percent of children slept under an ITN the night before the survey.

(c) UNICEF Namibia photo library/Tony Figuera

Pregnant women are also especially vulnerable to malaria. Nine percent of pregnant women slept under an ITN the night before the survey, compared to 7 percent of all women. Again, use of mosquito nets is highest in Caprivi and lowest in Erongo.

Management of Malaria in Children

In the two weeks before the survey, 17 percent of children under age five had fever, the primary symptom of malaria. Of these children, 10 percent took an antimalarial drug.

Antimalarial Drug Use During Pregnancy

Malaria during pregnancy contributes to low birth weight, infant mortality, and other complications. At the time of the survey, it was recommended that pregnant women receive two doses of the antimalarial drug SP/Fansidar as intermittent preventive treatment (IPT). Thirty percent of pregnant woman took any antimalarial drug during their last pregnancy, and most of these took SP/Fansidar. Only 11 percent of pregnant women, however, took two or more doses of SP/Fansidar, and only 10 percent took two doses, including one during an ANC visit.

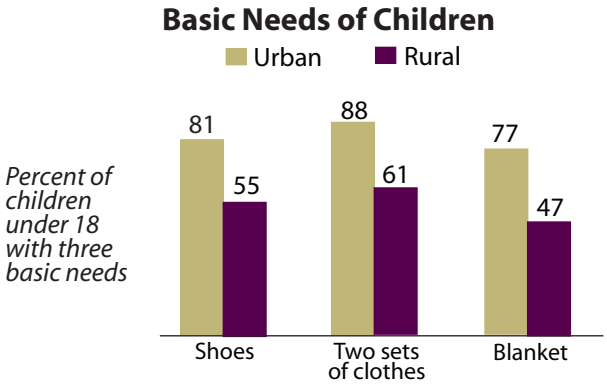
Malaria Knowledge

Almost all men and women know that malaria is caused by mosquito bites, and one-half to two-thirds of women and men know the common symptoms of malaria: headache and high temperature. More than 90 percent of women and men say that they would go to a health facility if malaria was suspected. Mosquito nets are the most commonly reported method of malaria prevention, followed by house spraying, using repellents, and using mosquito coils.

Orphanhood

In Namibia, only one-quarter of children under 18 lives with both of their parents. One-third of children under 18 are not living with either biological parent. Seventeen percent of children have one or both parents dead (considered an orphan), while an additional 14 percent have had a very sick parent or live in a household with a sick adult (considered vulnerable). In all, 28 percent of children under 18 are considered orphans and/or vulnerable. More than half of orphans are not living with all of his or her siblings.

Orphans and vulnerable children (OVC) are less likely than non-OVC to possess the three basic needs—a pair of shoes, two sets of clothes, and at least one meal per day. Only 41 percent of OVC have these basic needs, compared to 54 percent of non-OVC. OVC are also slightly more likely to be underweight than their non-OVC peers.



Few households with sick persons received external assistance during the year before the survey. Assistance to orphans is also rare—11 percent of households with OVC received social or material support in the three months before the survey, but 84 percent of OVC's households received no external support at all.

Caregivers of children should plan for succession in case of illness. Almost half (49 percent) of caregivers have made succession arrangements.

Women's Empowerment

Employment

More than half of women age 15-49 interviewed in the NDHS are employed compared to 69 percent of men. Among those who are employed, men are more likely to earn cash, while women are more likely than men to be unpaid. Women who earn cash generally earn less than their husbands.

(c) UNICEF Namibia Photo Library

Participation in Household Decisions

Namibian women contribute to many household decisions. More than three-quarters of women report that they participate in decisions regarding their own health care, making daily and major household purchases, and visits to her family or friends. Sixty-four percent report that they participate in all four of these decisions. Nine percent of women do not participate at all in any of the four decisions.

Attitudes Towards Wife Beating and Refusing Sex

More than one-third of women and 41 percent of men agree that a husband is justified in beating his wife for at least one reason, such as neglecting the children or going out without telling him. About 85 percent of women and men agree that a woman is justified in refusing sexual intercourse with her husband if she knows he has a sexually transmitted infection, if she knows her husband has sex with other women, or if she is tired or not in the mood. About a quarter of men, however, believe that if a woman refuses to have sex with her husband, the husband has the right to get angry and reprimand her. Another 16 percent believe the husband has the right to have sex with another woman.

(c) UNICEF Namibia

Women's Empowerment and Health Outcomes

Empowered women often have better health outcomes than women who are less empowered. For example, women who participate in more household decisions and those who find no reasons to justify wife beating are more likely to use modern methods of contraception. Women who participate in more household decisions are also more likely to receive antenatal care and assistance from health personnel during delivery than those who have no say in decision making. For example, 84 percent of women who participate in three or four household decisions received assistance from health personnel during delivery compared to only 64 percent of those who participated in no decisions.

Adult Health

Health Insurance

Four-fifths of Namibians age 15-49 report that they have no health insurance coverage. Nine percent of women and 11 percent of men have employer-based insurance, and another 5 percent have social security.

Tuberculosis

Almost all women and men have heard of tuberculosis (TB). Three-quarters know that TB is spread through the air by coughing. More than 90 percent know that TB can be cured. There is little stigma reported concerning TB: less than 20 percent of women and men would want their family member's TB to be kept secret.

(c) 2004 HCP Namibia, Courtesy of Photoshare

Use of Tobacco

Eight percent of women and 24 percent of men use tobacco, usually through smoking cigarettes. Among the cigarette smokers, 31 percent of women and 26 percent of men smoke ten or more cigarettes per day.

Access to Government Health Facilities

Two-thirds of households report that the closest government health facility is a clinic, while one-fifth are closest to a hospital. More than three in five households access their nearest government health facility by walking, 18 percent take a bus or taxi, and 17 percent take a car or motorcycle. When households need to access a hospital, 63 percent would take a bus or taxi.

On average, households are about 74 minutes from a government health facility. Urban households are much closer to a government health facility than rural households (25 minutes versus 114 minutes).

Key Indicators

		Residence			
Fertility	Total	Urban	Rural	Caprivi	Erongo
Total fertility rate (births per woman)	3.6	2.8	4.3	3.6	2.8
Women age 15–19 who are mothers or now pregnant (%)	15	12	18	30	15
Median age at first marriage for women age 30-49 (years)	28.2	29.1	27.4	21.9	26.2
Median age at first intercourse for women age 25-49 (years)	19.3	19.2	19.4	18.0	18.9
Median age at first birth for women age 25-49 (years)	21.4	21.8	21.0	19.9	21.3
Married women (age 15–49) wanting no more children (%)	60	62	58	37	72
Family Planning					
Current use of any modern method (sexually active women 15-49) (%)	66	74	55	51	79
Women with an unmet need for family planning[1] (%)	3	2	4	3	3
Maternal and Child Health					
Maternity care					
Women giving birth in last 5 years who received antenatal care from a health professional (%)	95	96	93	94	93
Births in last 5 years assisted by a health professional (%)	81	94	73	80	93
Births in last 5 years delivered in a health facility (%)	81	94	72	78	92
Child immunization					
Children 12–23 months fully vaccinated[2] (%)	69	72	67	70	76
Nutrition					
Children under 5 years who are stunted (moderate or severe) (%)	29	24	31	26	22
Children under 5 years who are wasted (moderate or severe) (%)	8	6	8	5	3
Children under 5 years who are underweight (%)	17	12	19	14	7
Median duration of any breastfeeding (months)	16.8	9.8	18.8	20.0	6.4
Median duration of exclusive breastfeeding (months)	0.7	0.7	0.9	2.0	1.7
Women 15-49 who are overweight or obese (%)	28	37	19	24	45
Childhood Mortality					
(Figures are for the ten-year period before the survey, except for the national rate, in italics, which represents the five-year period before the survey)					
Number of deaths per 1,000 births:					
Infant mortality (between birth and first birthday)	*46*	43	52	78	48
Under-five mortality (between birth and fifth birthday)	*69*	60	76	93	65
Malaria					
Households with at least one insecticide-treated net (ITN) (%)	20	10	29	54	1
Children <5 who slept under an ITN the night before the survey (%)	11	7	12	41	<1
AIDS-related Knowledge					
Knows ways to avoid AIDS:					
-Having one sex partner (women 15–49/men 15-49) (%)	90/92	90/93	89/90	88/94	84/88
-Using condoms (women 15–49/ men 15-49) (%)	84/87	86/90	83/85	86/96	78/89
Knows HIV can be transmitted by breastfeeding (women 15–49/ men 15-49) (%)	88/77	89/81	87/73	82/82	81/79
Knows risk of MTCT can be reduced by mother taking special drugs during pregnancy (women 15–49/ men 15-49) (%)	80/68	83/73	78/63	69/61	79/69

[1] Currently married women who do not want any more children or want to wait at least 2 years before their next birth but are not currently using a method of family planning. [2] Fully vaccinated includes BCG, measles, and three doses each of DPT and polio)

Region										
Hardap	Karas	Kavango	Khomas	Kunene	Ohangwena	Omaheke	Omusati	Oshana	Oshikoto	Otjozondjupa
3.3	3.2	4.9	2.6	4.7	4.3	5.1	3.7	3.0	4.0	4.5
19	13	34	6	31	10	27	9	9	14	27
27.0	27.1	22.1	29.9	23.0	29.1	28.0	a	a	a	24.8
19.0	19.9	17.5	19.5	17.6	20.2	18.6	21.0	20.2	19.6	18.2
20.6	21.4	19.7	22.5	19.5	21.7	20.3	22.9	22.5	21.3	20.2
71	72	47	59	52	55	76	57	69	63	64
63	68	47	78	56	53	58	66	68	61	67
4	3	5	1	7	3	4	2	2	4	5
96	99	92	97	81	96	92	97	99	95	93
91	94	64	95	54	71	76	88	89	79	80
90	92	63	95	54	71	77	88	89	78	80
66	68*	48	76	35	70	70	81	74	72	76
30	30	39	23	27	34	22	28	28	32	27
11	8	7	5	5	7	6	10	10	11	9
20	16	19	11	13	20	14	18	21	22	15
13.1	8.1	20.6	8.9	16.0	18.6	13.6	17.2	15.8	18.0	16.9
0.6	0.7	0.5	0.6	0.7	1.8	0.5	1.5	0.9	1.4	0.7
35	44	16	38	36	13	39	17	24	18	41
48	45	49	40	27	62	37	49	49	48	49
73	59	67	52	49	95	63	76	74	64	67
4	3	32	4	11	38	21	27	38	30	14
1	1	19	2	4	10	7	10	21	8	7
87/95	92/96	83/97	92/95	74/84	95/84	73/86	94/94	93/87	94/94	86/88
82/96	86/94	75/89	90/91	71/87	90/88	64/78	86/95	87/70	87/78	84/81
85/87	88/70	89/89	90/80	79/81	89/57	73/65	91/87	91/60	93/81	87/77
71/73	75/53	67/62	86/74	61/71	86/54	63/54	89/87	90/65	86/72	71/61

a- omitted because less than 50 percent of the women married for the first time before reaching age 30
*- based on only 25-49 unweighted cases