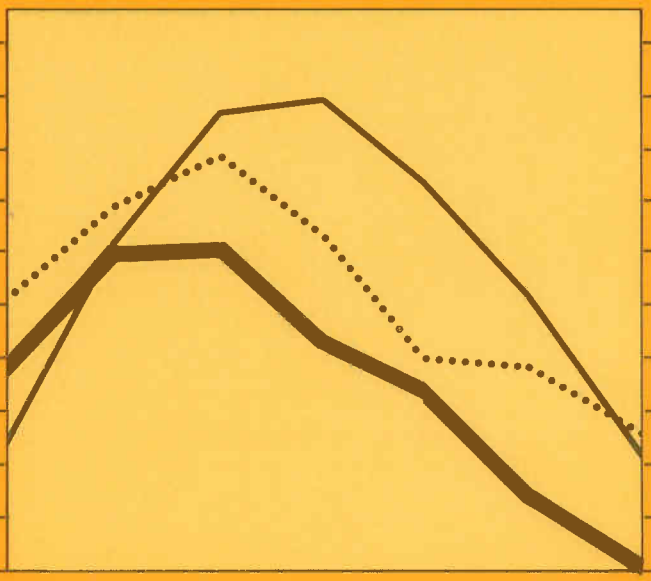
DHS

Namibia

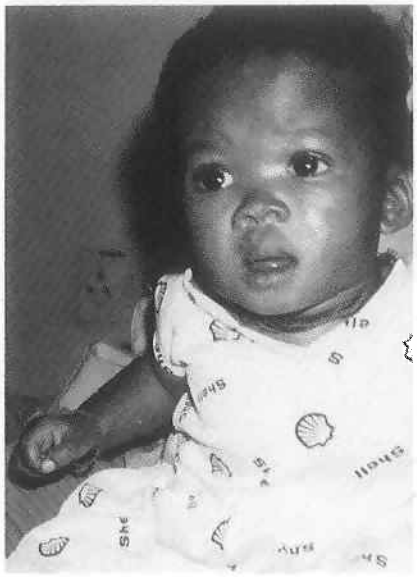


Demographic and Health Survey 1992

SUMMARY REPORT

NAMIBIA DEMOGRAPHIC AND HEALTH SURVEY 1992

SUMMARY REPORT



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Ministry of Health
and Social Services
Epidemiology Unit
Harvey Street
Pr. Bag 13198
Windhoek, Namibia

May 1993

This report summarises the findings of the 1992 Namibia Demographic and Health Survey (NDHS) conducted by the Ministry of Health and Social Services, in collaboration with the Central Statistical Office. Macro International Inc. provided technical assistance. Funding was provided by the World Bank through a grant from the Government of Japan.

The NDHS is part of the worldwide Demographic and Health Surveys (DHS) programme, which is designed to collect data on fertility, family planning and maternal and child health. Additional information about the NDHS may be obtained from the Ministry of Health and Social Services, Epidemiology Unit, Harvey Street, Pr. Bag 13198, Windhoek, Namibia (Telephone (061)2032320/2032307; Fax(061)227607). Additional information about the DHS programme may be obtained by writing to: DHS, Macro International Inc., 8850 Stanford Boulevard, Suite 4000, Columbia, MD 21045, USA (Telephone 410-290-2800; Fax 410-290-2999).

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Background

The Namibia Demographic and Health Survey (NDHS) was a nationally representative sample survey of women age 15-49. The survey was designed to provide information on levels and trends of fertility, infant and child mortality, maternal mortality, family planning, and maternal and child health. The data are intended for use by programme managers and policymakers to evaluate and improve family planning and maternal and child health programmes.

The NDHS was conducted by the Ministry of Health and Social Services, with assistance from the Central Statistical Office. Macro International Inc. provided technical assistance to the project under a contract with the World Bank.

Between July and December 1992, more than 4000 households were visited and 5421 women were interviewed. Information was also collected on the children born to these women. For the 3562 children born in the five years preceding the survey, detailed questions were asked about vaccination status, breastfeeding, food supplementation and recent illness. In addition, anthropometric measurements were collected for both mothers and children in order to assess nutritional status.

Figure 1
Total Fertility Rates in Sub-Saharan Africa
(Selected DHS Surveys)

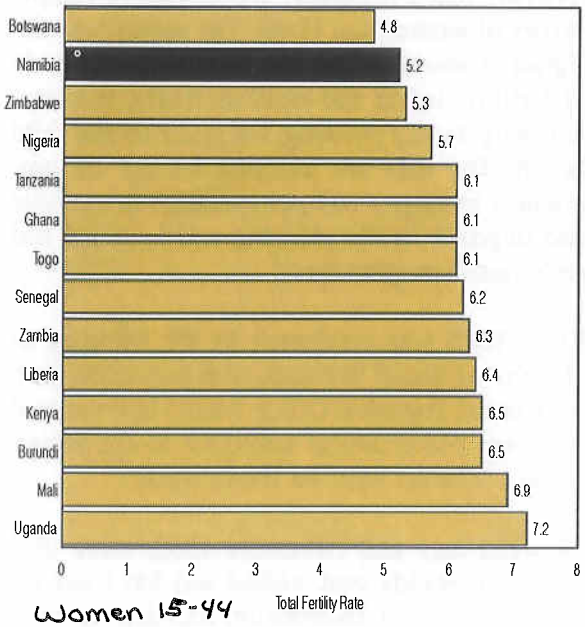
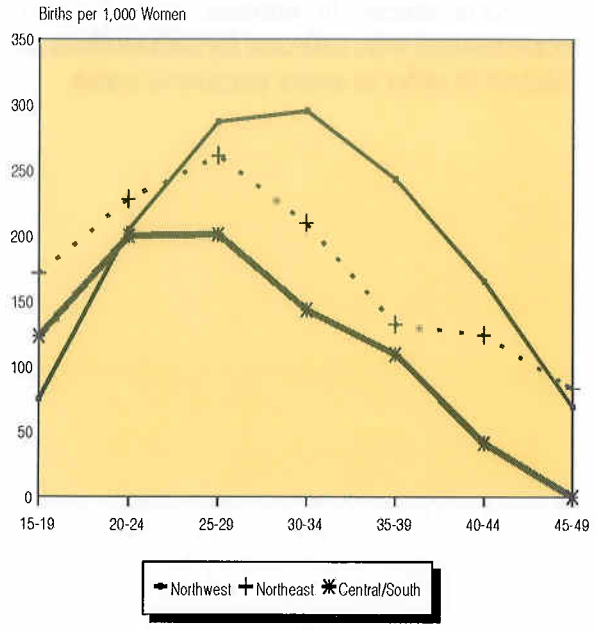


Figure 2
Age-Specific Fertility Rates by Region



Fertility

Levels and Trends

- At current fertility levels, a Namibian woman will have an average of 5.4 children by the end of her reproductive years. This is lower than for most sub-Saharan countries, and it appears that fertility has been declining gradually over the past fifteen years.

At current fertility levels, a Namibian woman will have an average of 5.4 children by the end of her reproductive years.

- Fertility rates are higher in rural areas than in urban areas (6.3 versus 4.0 children per woman). Regional differences are marked as well. Fertility rates are high in the Northwest and Northeast regions (6.7 and 6.0 children, respectively), and much lower in the Central and South regions (4.1 children per woman).
- Fertility decreases as education increases. Women with no education have, on average, two children more than women with secondary and higher education (6.5 versus 4.1 children).

Marriage and Exposure to the Risk of Pregnancy

- Only 42 percent of women 15-49 in Namibia are currently in a union. Most women (51 percent) have never been married. In the 30-34 age group, 64 percent of women are married, and 26 percent have never been married.
- Overall, women are marrying at a later age than they did previously. The median age at first marriage is 25 years. In the Northeast region, however, the average age at marriage is 19 years.

Overall, women are marrying at a later age than they did previously. The median age at first marriage is 25 years.

- Twelve percent of married women say their husbands have other wives. Polygynous unions are relatively common in the Northeast region (25 percent) and rare in the South region (4 percent).

Figure 3
Total Fertility Rates by Selected Characteristics

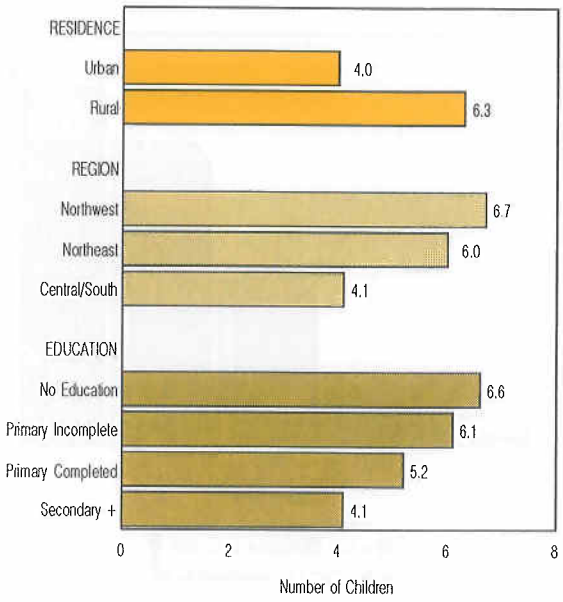


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Figure 4
Teenage Pregnancy and Motherhood

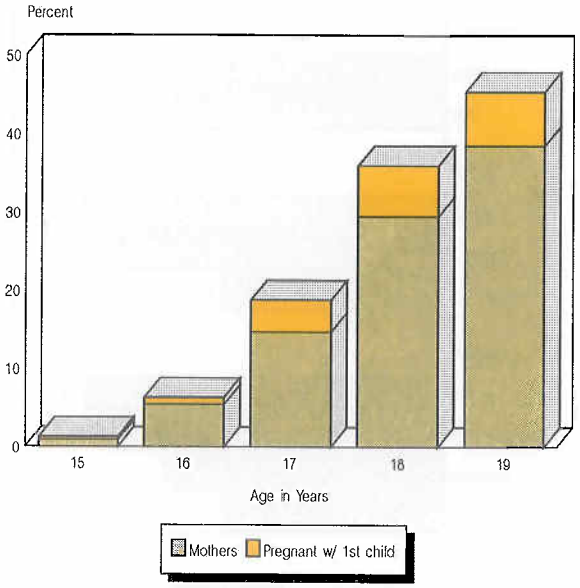
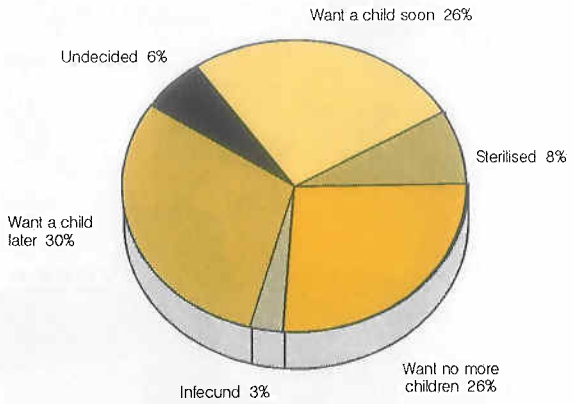


Figure 5
Fertility Preferences
(Currently Married Women 15-49)



- Sexual intercourse starts well before marriage: the median age at first sexual intercourse is 19 years. The average age for women to have their first child is 21. About one in six teenagers (women age 15-19) has borne a child. By the time they reach age 19, 45 percent of Namibian women are either mothers or pregnant with their first child.

The average age for women to have their first child is 21. About one in six teenagers (women age 15-19) has borne a child.

Fertility Preferences

- The vast majority of births in Namibia are wanted. When asked how many children they would like to have if they could live their lives over and choose exactly, women report an average ideal family size of 5.0 children, only slightly lower than the total fertility rate (5.4 children).

- About one-quarter of currently married women do not want to have any more children. An additional 30 percent want to wait at least two years before having another child.

About one-quarter of currently married women do not want to have any more children.

- Results from the NDHS suggest that if all unwanted births were eliminated, the total fertility rate would be 4.8 children per woman.

Figure 6
Total Fertility Rates and Wanted Fertility Rates (Women 15-49)

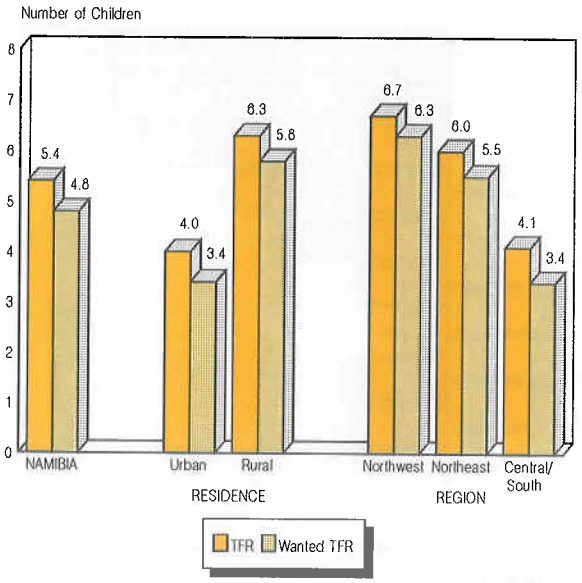


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Figure 7
Knowledge of Contraceptive Methods
(All Women 15-49)

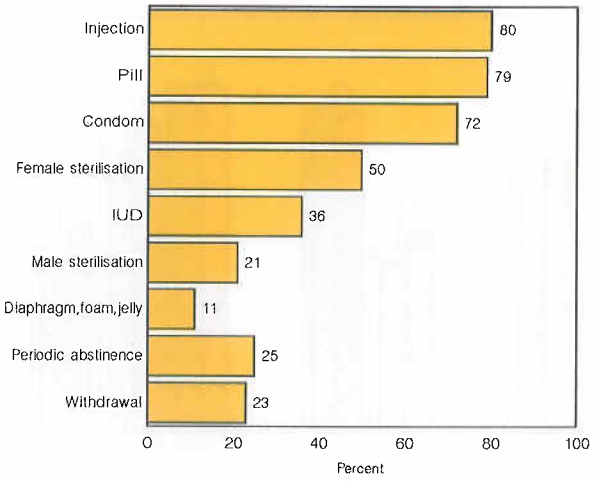
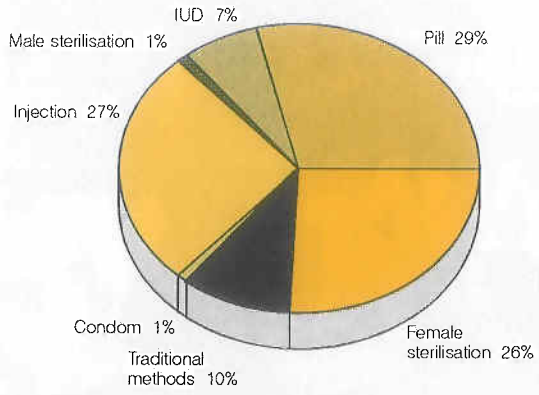


Figure 8
Method Mix among Current Users
(Currently Married Women 15-49)



Family Planning

Knowledge and Use of Contraception

- Contraceptive knowledge is nearly universal; 90 percent of women report knowing about at least one modern contraceptive method. The most widely known methods are the pill, injection, condom and female sterilisation.
- More than half of currently married women and 41 percent of all women have used a contraceptive method at some time, but only 29 percent of married women and 23 percent of all women are currently using any method.
- About one in five women (21 percent) are using modern methods of contraception, whereas 2 percent are using traditional methods. The most popular contraceptive methods are injection (9 percent), the pill (7 percent), and female sterilisation (4 percent). About one in twelve currently married women has been sterilised.

About one in five women (21 percent) are using modern methods of contraception, whereas 2 percent are using traditional methods.

- Use of family planning differs markedly by place of residence and region. Contraceptive use in urban areas is about three times higher than in rural areas. More than half (52 percent) of married women in the South region use a contraceptive method compared to 32 percent in the Central region, 22 percent in the Northeast region, and 9 percent in the Northwest region. Half of the contraceptive users in the Northeast region use traditional methods, mostly herbs.

- Contraceptive use is higher among better educated women, ranging from 17 percent among women with no education to 48 percent among those with at least some secondary education.

Contraceptive use in urban areas is about three times higher than in rural areas.

- The government is the most important provider of family planning services, supplying over 86 percent of the women who use modern methods.

Figure 9
Current Use of Family Planning Methods
(Currently Married Women 15-49)

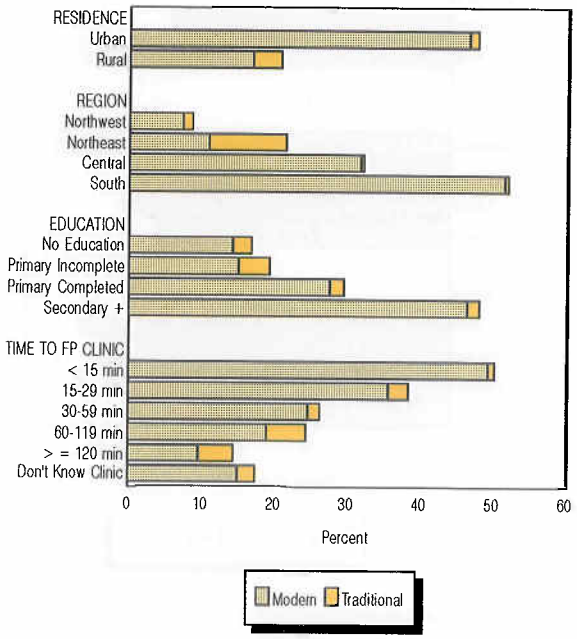


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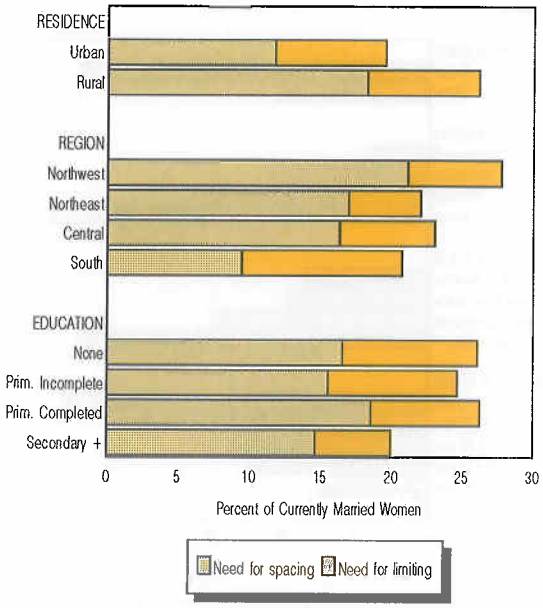
Figure 10
Unmet Need for Family Planning

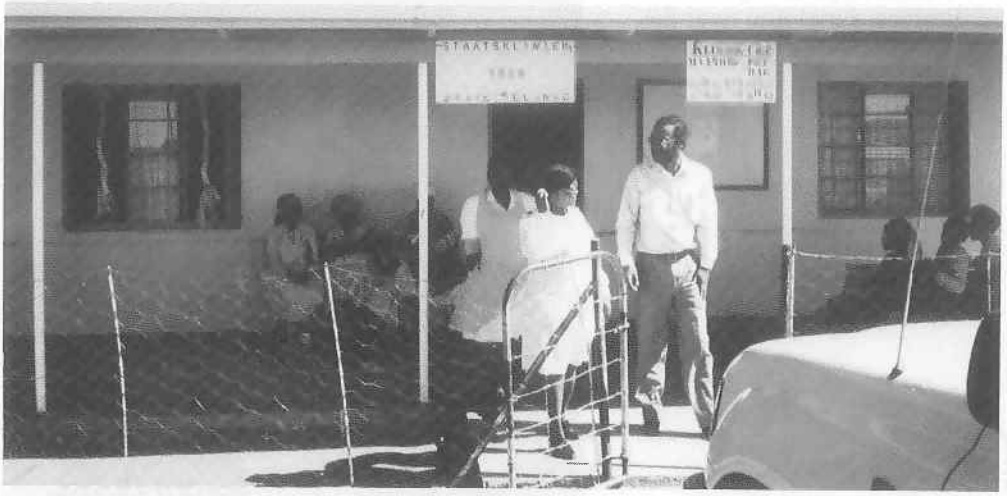


Unmet Need for Family Planning Services

- Twenty-four percent of currently married women in Namibia have an unmet need for family planning services. These include women who are not using any family planning method but want to wait two or more years for their next birth (16 percent) or who do not want more children (8 percent).

Twenty-four percent of currently married women in Namibia have an unmet need for family planning services.

- Combined with 28 percent of married women who are currently using a contraceptive method, the total demand for family planning comprises half of married women.



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Maternal and Child Health

Infant and Child Mortality

- Infant mortality is estimated at 57 per 1,000 live births for the period 1988-92, while one in 12 children dies before reaching age five. Infant and child mortality have been declining during the past decade at a rate of about 1.5 percent per year.
- Infant and child mortality in Namibia are lower than in most other countries in sub-Saharan Africa. Namibia's mortality level is, however, higher than in Botswana and about the same as Zimbabwe.
- There is very little difference in infant and child mortality between the Northwest region and the Central/South regions. However, mortality levels are much higher in the Northeast region: infant mortality is 84 per 1,000 live births and under-five mortality is 135 per 1,000 live births for the decade preceding the survey.
- The length of the preceding birth interval strongly affects infant and child mortality rates. For example, children born less than 2 years after the preceding birth have an infant mortality of 98 per 1,000 live births, compared to 53 per 1,000 live births for children born 2-3 years after the preceding birth.

Figure 11
Childhood Mortality Rates in Sub-Saharan Africa (Selected DHS Surveys)

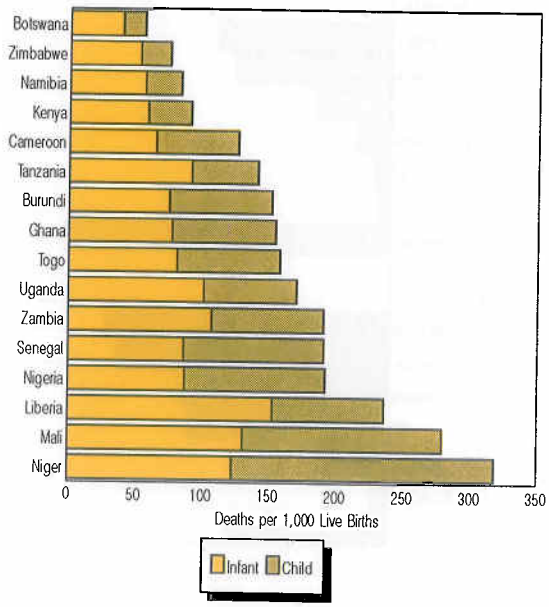


Figure 12
Under-Five Mortality by Background Characteristics

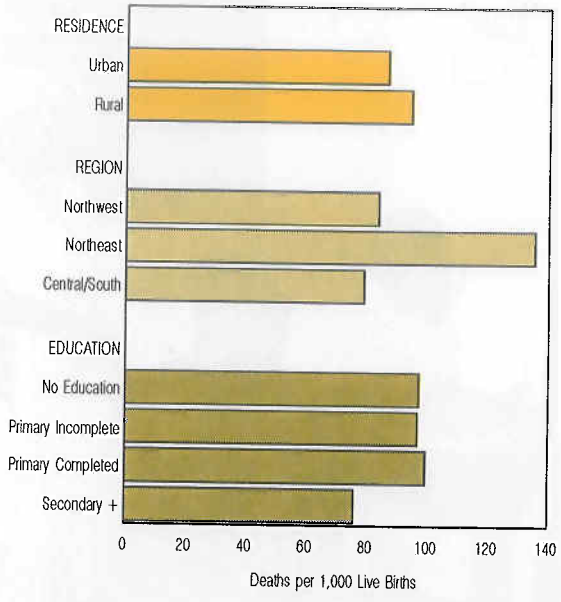
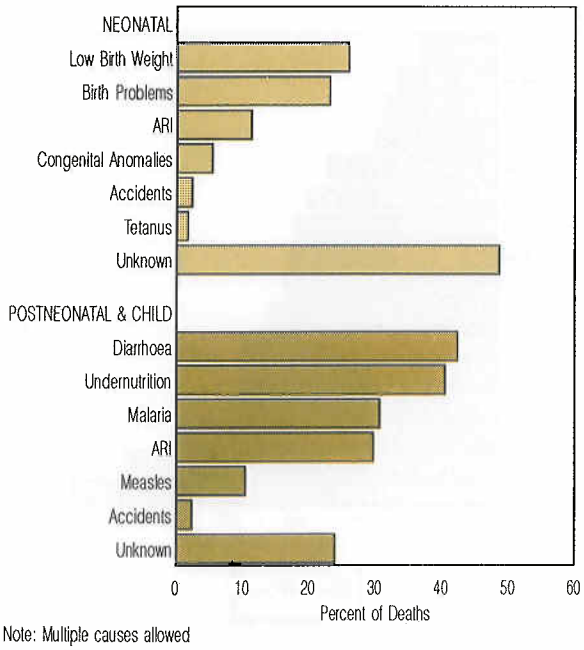
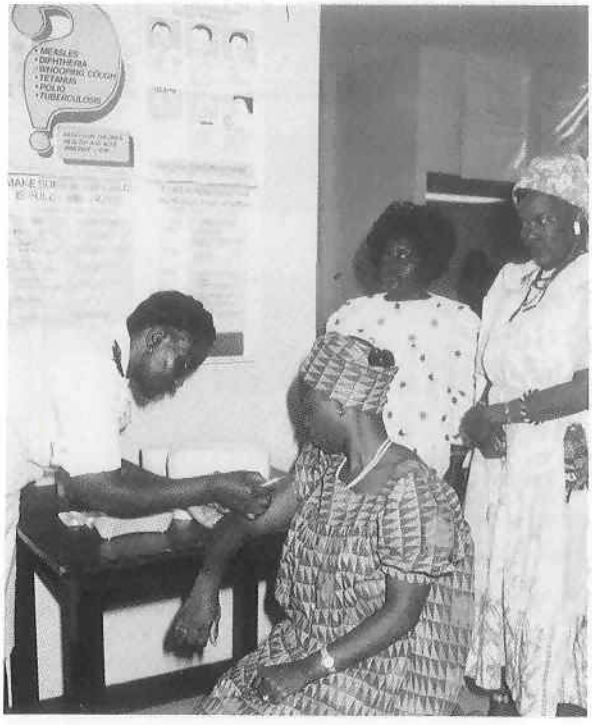


Figure 13
Leading Causes of Death in Childhood



Note: Multiple causes allowed



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- The leading causes of death among young children are diarrhoea, undernutrition, acute respiratory infection (pneumonia), and malaria: each of these conditions was associated with about one-fifth of under-five deaths. Among neonatal deaths low birth weight and birth problems were the leading causes of death. Neonatal tetanus and measles were not found to be major causes of death.

The leading causes of death among young children are diarrhoea, undernutrition, acute respiratory infection (pneumonia), and malaria.

Maternal Mortality

- Maternal mortality was estimated from reports on the survival status of sisters of respondents. In the ten years preceding the survey, maternal mortality was 225 per 100,000 live births. The NDHS data also show considerable excess male mortality at ages 15-49, which may in part be related to the war of independence in the 1980s.

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Antenatal Care and Delivery Assistance

- Utilisation of maternal and child health services is high. Almost 90 percent of mothers received antenatal care, of which 15 percent were seen by doctors. For 61 percent of births, mothers received at least one tetanus toxoid injection during pregnancy.
- Two-thirds of the babies born in Namibia are delivered in health facilities. Nurses or midwives are the most common source of delivery assistance (54 percent of births). Doctors assisted in 14 percent of births, almost one-third of which were caesarean sections. Traditional birth attendants assisted only 6 percent of births.

Two-thirds of the babies born in Namibia are delivered in health facilities.

Immunisation

- Vaccination coverage for young children has increased rapidly since independence. Among children 12-23 months, 91 percent have received a BCG vaccination, 92 percent have received at least one dose of DPT and polio vaccines (70 percent have received three doses of DPT and polio vaccines), and 76 percent have received a measles vaccination.

Figure 14
Antenatal Care, Tetanus Vaccinations, Place of Delivery, and Assistance at Delivery

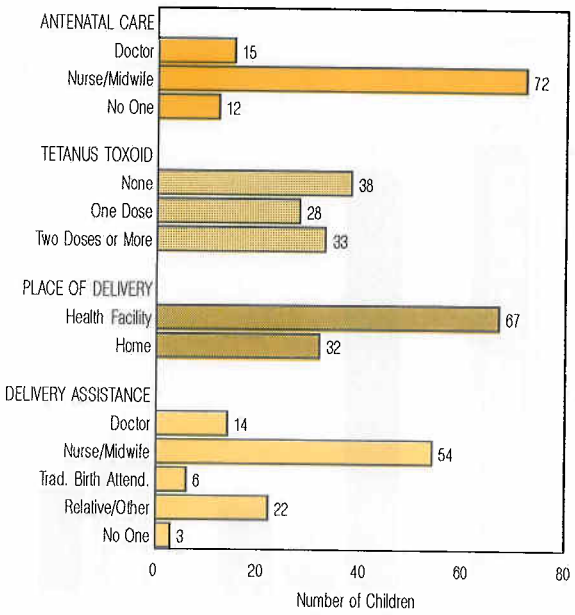


Figure 15
Vaccination Coverage among Children Age 12-23 Months

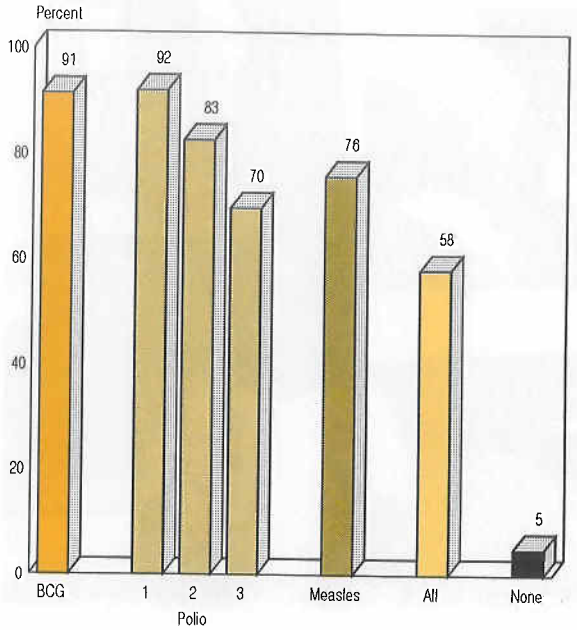
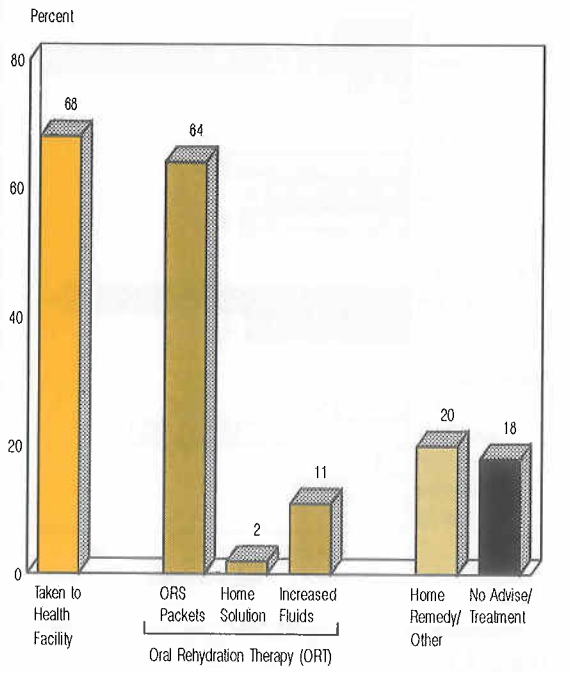
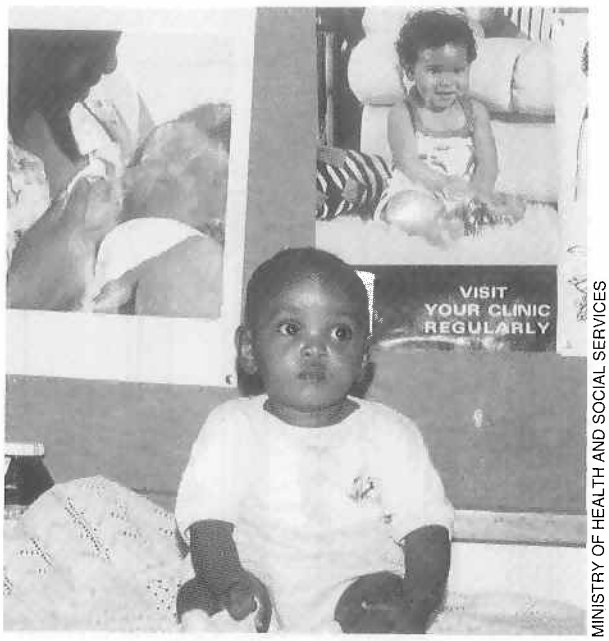


Figure 16
Treatment of Diarrhoea in the Two Weeks Preceding the Survey
(Children under 5 Years)





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Treatment of Childhood Diseases

- Children with symptoms of possible acute respiratory infection (cough with rapid breathing) may have pneumonia and need to be seen by a health worker. Among children with such symptoms in the two weeks preceding the survey two-thirds were taken to a health facility. Children least likely to be taken to a health facility were those whose mothers lived more than 30 km from a facility.
- About one in five children had diarrhoea in the two weeks preceding the survey. Diarrhoea prevalence was very high in the Northeast region, where it affected almost half of the children. A dysentery epidemic in this region contributed to the high figure: diarrhoea with blood was reported for 17 percent of the children under five in the Northeast region.
- Among children with diarrhoea in the last two weeks 68 percent were taken to a health facility, and 64 percent received a solution prepared from ORS packets (oral rehydration therapy). However, only 11 percent of mothers of children with diarrhoea said they increased the amount of fluids given during the episode.

Among children with diarrhoea in the last two weeks 68 percent were taken to a health facility, and 64 percent received a solution prepared from ORS packets (oral rehydration therapy).

Nutrition of Mothers and Children

Breastfeeding Practices

- Nearly all babies are breastfed (95 percent), but only 52 percent are put to the breast immediately. Exclusive breastfeeding is practiced for a very short period and not for the recommended 4-6 months. Most babies are given water, formula, or other supplements in the first four months of life, which both jeopardises their nutritional status and increases the risk of infection. About 30 percent of children under four months were given supplemental feeding in a bottle with a nipple.
- On average, children are breastfed for about 17 months, but large differences exist by region. In the South region children are breastfed for less than a year, in the Northwest region for about one and a half years and in the Northeast region for almost two years.

Birth Weight

- Most babies are weighed at birth, but the actual weight could be recalled for only 44 percent of births. Using these data and data on reported size of the newborn (for all births in the last five years), it was estimated that the mean birth weight in Namibia is 3048 grams, and that 16 percent of babies have a low birth weight (less than 2500 grams).

MINISTRY OF HEALTH AND SOCIAL SERVICES

It was estimated that the mean birth weight in Namibia is 3048 grams, and that 16 percent of babies have a low birth weight (less than 2500 grams).

Figure 17
Nutritional Status of Children Under Five Years in Sub-Saharan Africa
(Selected DHS Surveys)

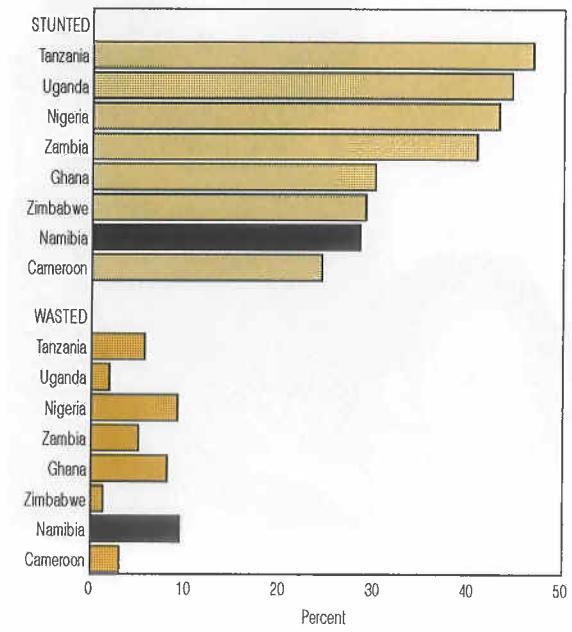
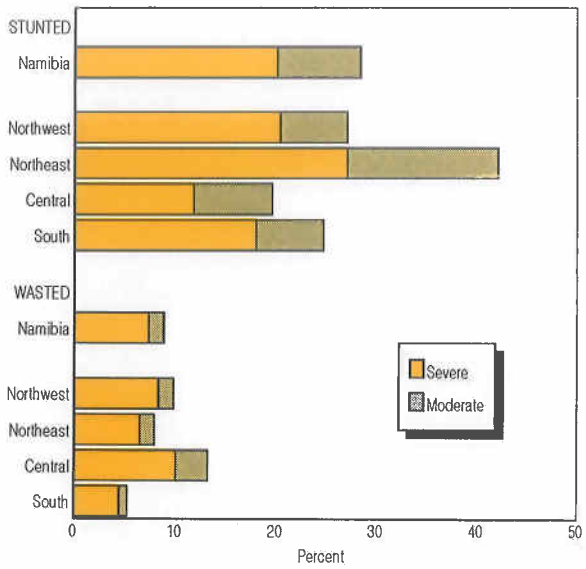


Figure 18
Nutritional Status of Children Under Five Years (Moderate and Severe Undernutrition)



Nutritional Status of Children

- The nutritional status of children deteriorates during the first 18 months of life and then remains relatively unchanged until the fifth birthday.
- Stunting, a sign of chronic undernutrition, is observed for 28 percent of children under five. The prevalence of stunting increases with age, from 13 percent of children under 6 months to 33 percent of two-year-olds. Stunting is much more common in the Northeast region (42 percent) than elsewhere in Namibia.

Stunting, a sign of chronic undernutrition, is observed for 28 percent of children under five.

- Almost 9 percent of children are wasted, an indicator of acute undernutrition. The amount of wasting is higher than expected for Namibia and may have been caused by the drought conditions during 1992. Wasting is highest in the Central region (13 percent).

Nutritional Status of Mothers

- Maternal height is an indicator of nutritional status over generations. The average height of women in Namibia is 160 cm and there is little variation between regions. The Body Mass Index (BMI), defined as weight divided by squared height, is a measure of current nutritional status. The BMI was lower among women in the Northwest and Northeast regions than among women in the South and Central regions.

Availability of Health Services

- On average, women had a health facility available within 40 minutes travel time. Women in the Northwest region, however, had to travel more than one hour to reach the nearest health facility. At a distance of less than 10 km, 56 percent of women had access to antenatal care services, 48 percent to maternity services, 72 percent to immunisation services, and 49 percent to family planning services. Within one hour travel time, 52 percent of women had access to antenatal care services, 48 percent to delivery services, 64 percent to immunisation services, and 49 percent to family planning services. Distance and travel time were greatest in the Northwest region.

On average, women had a health facility available within 40 minutes travel time.

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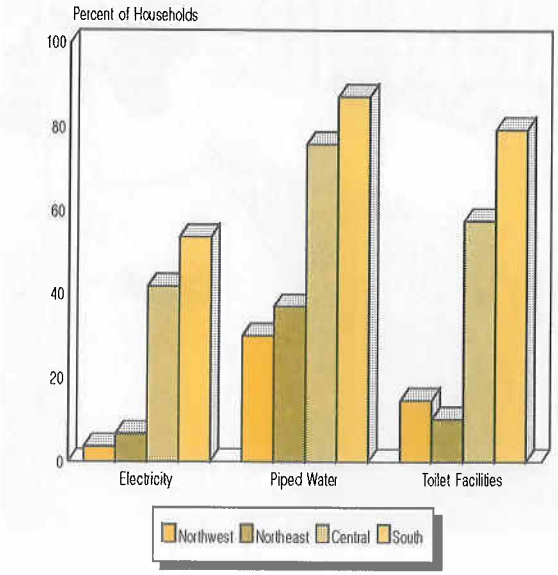
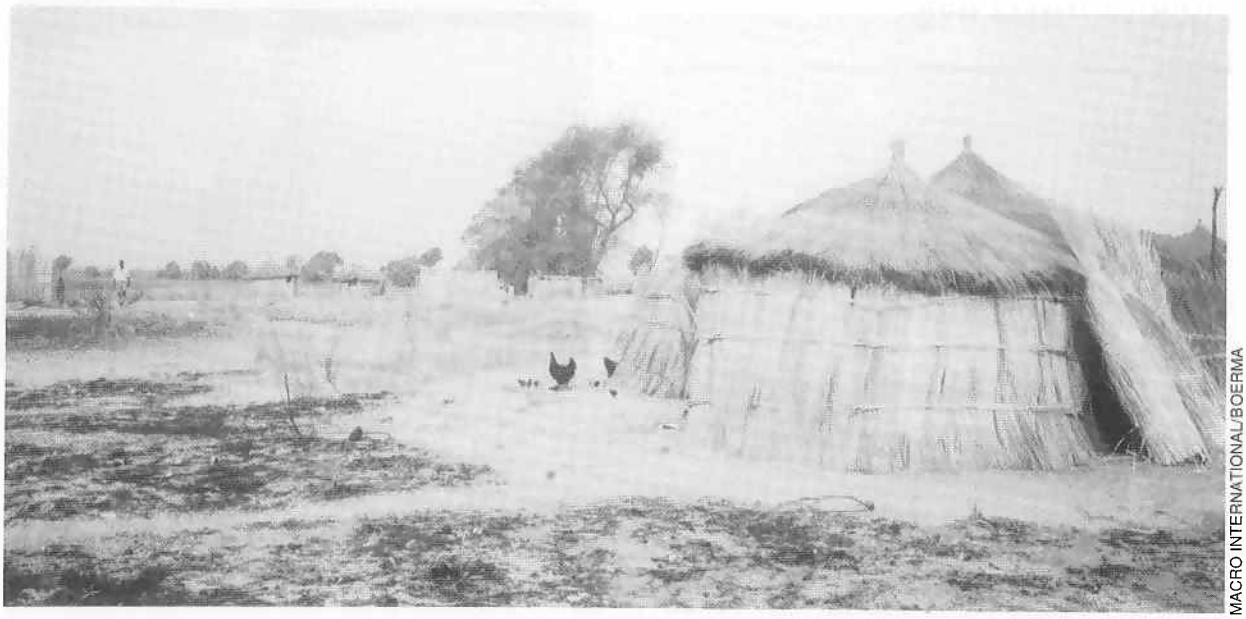
Figure 19
Housing Characteristics by Region



Note: Piped water includes public tap;
toilet facilities include flush, latrine, and bucket.

Housing Characteristics

- Overall, 26 percent of households in Namibia have electricity. These households are primarily in the South and Central regions. Less than 10 percent of households in the Northwest and Northeast regions have electricity.
- Only 38 percent of households have water piped into the residence; another 19 percent use a public tap for drinking water. More than three-quarters of households in the Central and South regions have a piped water supply (private or public) compared to about one-third of households in the Northwest and Northeast regions.
- One in three households in Namibia has a flush toilet, but most have no sanitation facilities at all (58 percent). In the Northwest and Northeast regions, 84 and 90 percent of households, respectively, have no facilities.



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Conclusions

Fertility and Family Planning

Fertility levels in Namibia have been declining gradually for more than a decade; the total fertility rate, 5.4 children per woman, is lower than that of most sub-Saharan countries. Currently, 26 percent of married women use a modern method of family planning and 3 percent use a traditional method. However, unmet need for family planning is high; 24 percent of married women are not using family planning despite the fact that they do not want any more children or they want to space their next birth.

There are marked differences in fertility and family planning by region. Northern Namibia has high fertility with low levels of contraceptive use, while the Central and South regions have much lower fertility and high levels of contraceptive use. Part of this difference is explained by less demand for family planning services in the Northwest and Northeast regions. Equally important, however, is the limited availability of family planning services in the Northwest.

Maternal and Child Health

Child mortality has been declining gradually in Namibia and mortality during the neonatal period has become more prominent. The main causes of neonatal death appear to be low birth weight and birth trauma. Improving maternal health, particularly women's nutritional status may reduce the incidence of low birth weight. In addition, increasing the accessibility of antenatal care and improving the quality of delivery services may reduce the proportion of babies who are born at home. These measures could also reduce the risk of maternal death, which occurs once every 500 deliveries.

After the neonatal period, diarrhoea, pneumonia, and undernutrition are the major causes of death in children. In northern Namibia malaria is also important. Health care utilisation is high for children with symptoms of common illnesses such as diarrhoea and respiratory infections. However, certain aspects of treatment need more emphasis in health education, such as the amount of fluids given to a child with diarrhoea. In addition, the burden of illness may be reduced by improving environmental conditions (e.g., toilet facilities). Vaccination coverage has been increasing rapidly. Further increases could virtually eliminate such diseases as poliomyelitis, measles, and neonatal tetanus.

The nutritional status of children deteriorates during the first 18 months of life and then remains relatively unchanged until the fifth birthday. Although almost all babies are breastfed, many are given supplemental foods and liquids at an early age. This practise is not only unnecessary, but is potentially dangerous to the child's nutritional status and a possible source of infection. Mothers should be taught the proper age at which to introduce supplementary foods to their babies.

Most indicators show that children in the Northeast region are worse off than children elsewhere in Namibia. Not only are the rates for mortality and undernutrition the highest in the country, but also the indicators for utilisation of maternal and child health care are the lowest.

Fact Sheet

1992 Population Data
Central Statistical Office

Total population (millions)	1.4
Urban population (percent)	33
Annual natural increase (percent)[1]	3.0
Population doubling time (years)[1]	24
Crude birth rate (per 1,000 population)[1]	44
Crude death rate (per 1,000 population)[1]	10
Life expectancy at birth (years)[1]	56

Namibia Demographic and Health Survey 1992

Sample Population

Women age 15-49	5,421

Background Characteristics of Women Interviewed

Percent urban	38.3
Percent with no education	14.5
Percent attended secondary or higher	37.1

Marriage and Other Fertility Determinants

Percent of women 15-49 currently married	41.7
Percent of women 15-49 ever married	48.7
Median age at first marriage among women age 25-49	24.8
Median duration of breastfeeding (in months)[2]	17.1
Median duration of postpartum amenorrhoea (in months)[2]	8.3
Median duration of postpartum abstinence (in months)[2]	6.0

Fertility

Total fertility rate[3]	5.4
Mean number of children ever born to women age 40-49	5.7

Desire for Children

Percent of currently married women who:	
Want no more children	25.8
Want to delay their next birth at least 2 years	29.7
Mean ideal number of children among women 15-49[4]	5.0
Percent of women giving a non-numeric response to ideal family size	8.3
Percent of births in the last 5 years which were:	
Unwanted	12.3
Mistimed	21.4

Knowledge and Use of Family Planning

Percent of currently married women:	
Knowing any method	90.4
Knowing a modern method	90.4
Knowing a modern method and knowing a source for the method	81.8
Had ever used any method	51.9
Currently using any method	28.9
Percent of currently married women currently using:	
Pill	8.3
IUD	2.1
Injection	7.7
Diaphragm, foam, jelly	0.1
Condom	0.3
Female sterilisation	7.4
Male sterilisation	0.2
Periodic abstinence	0.7
Withdrawal	0.3
Other traditional	1.9

Mortality and Health

Infant mortality rate[5]	56.6
Under-five mortality rate[5]	83.2
Maternal mortality[6]	225
Percent of births[7] whose mothers:	
Received antenatal care from medical provider	87.2
Received 2 or more tetanus toxoid injections	32.7
Percent of births[7] whose mothers were assisted at delivery by:	
Doctor	14.1
Midwife/Trained nurse	54.1
Traditional birth attendant	5.9
Percent of children 0-1 month who are breastfeeding	97.9
Percent of children 4-5 months who are breastfeeding	86.4
Percent of children 10-11 months who are breastfeeding	81.7
Percent of children 12-23 months who received:[8]	
BCG	91.3
DPT (three doses)	69.6
Polio (three doses)	69.6
Measles	75.7
All vaccinations	57.9
Percent of children under 5 years[9] who:	
Had diarrhoea in the 2 weeks preceding the survey	20.6
Had a cough accompanied by rapid breathing in the 2 weeks preceding the survey	18.0
Had a fever in the 2 weeks preceding the survey	34.2
Are chronically undernourished (stunted)[10]	28.4
Are acutely undernourished (wasted)[10]	8.6
Had low birth weight (<2500 grams)	15.9

[1] Based on 1991 census
[2] Current status estimate based on births during the 36 months preceding the survey
[3] Based on births to women 15-49 years during the period 0-2 years preceding the survey
[4] Excludes women who gave a non-numeric response to ideal family size
[5] Rates are for the period 0-4 years preceding the survey (1988 to 1992)
[6] Per 100,000 live births for the period 1983-92
[7] Figure includes births in the period 1-59 months preceding the survey
[8] Based on information from vaccination cards and mothers' reports
[9] Figures include children born in the period 1-59 months preceding the survey
[10] *Stunted:* percentage of children whose height-for-age z-score is below -2SD based on the NCHS/CDC/WHO reference population; *wasted:* percentage of children whose weight-for-height z-score is below -2SD based on the NCHS/CDC/WHO reference population.