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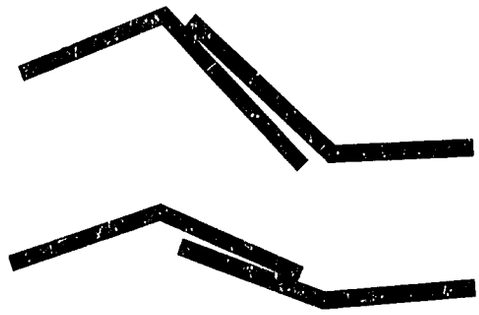
Zimbabwe



Demographic and Health Survey 1994

SUMMARY REPORT

ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994

SUMMARY REPORT

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Central Statistical Office
P.O. Box 8063
Causeway
Harare, Zimbabwe

September 1995

Photographs: George Bicego and Chika Ezeh

This report summarises the findings of the 1994 Zimbabwe Demographic and Health Survey (ZDHS) conducted by the Central Statistical Office (CSO) of the Government of Zimbabwe. Macro International Inc. provided technical assistance. Funding was provided by the U.S. Agency for International Development.

The ZDHS 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 Zimbabwe survey may be obtained from the Central Statistical Office, P.O. Box 8063, Causeway, Harare, Zimbabwe (Telephone: 706-681; Fax: 708-854). Additional information about the DHS programme may be obtained by writing to: DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (Telephone: 301-572-0200; Fax: 301-572-0999).

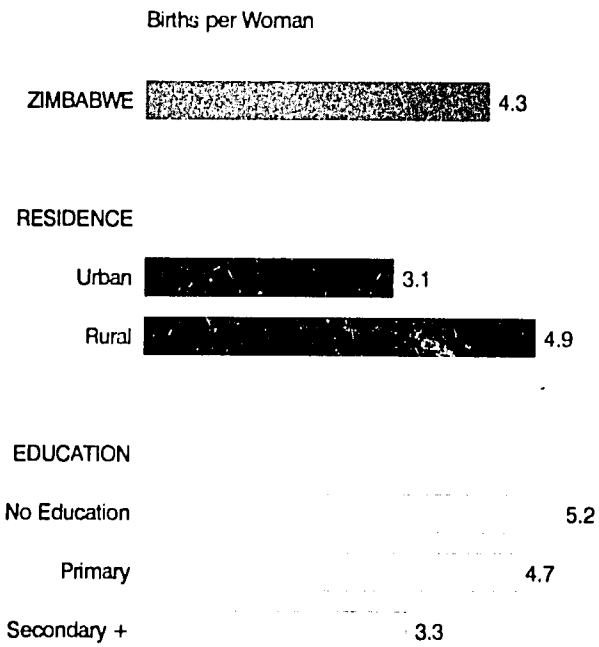
Background

The 1994 Zimbabwe Demographic and Health Survey (ZDHS) is a nationally representative survey of 6,128 women age 15-49 and 2,141 men age 15-54. Fieldwork for the ZDHS took place from July to November 1994.

As with the previous DHS survey in Zimbabwe—the 1988 Zimbabwe Demographic and Health Survey—the 1994 ZDHS was designed to provide information on levels and trends in fertility, family planning knowledge and use, infant and child mortality, and maternal and child health. However, the 1994 ZDHS went further, collecting data on: compliance with contraceptive pill use, knowledge, attitudes and behaviours related to AIDS and other sexually-transmitted diseases, and mortality related to pregnancy and childbearing (i.e., maternal mortality). The ZDHS data are intended for use by programme managers and policymakers to evaluate and improve family planning and health programmes in Zimbabwe.

The 1994 ZDHS was implemented by the Central Statistical Office (CSO), with technical guidance provided by the Ministry of Health and Child Welfare (MOH&CW) and the Zimbabwe National Family Planning Council (ZNFPC). Macro International Inc. (U.S.A.) provided technical assistance throughout the course of the project in the context of the Demographic and Health Surveys (DHS) programme, while financial assistance was provided by the U.S. Agency for International Development (USAID/Harare).

Total Fertility Rates by Background Characteristics (Women 15-49)



Fertility has declined throughout Zimbabwe, but particularly among urban women and women who have attended secondary school or higher.

Fertility

Zimbabwe has witnessed a sustained decline in fertility over the last decade. The findings of the ZDHS indicate that fertility levels in all population subgroups have decreased as women and men utilise contraceptive methods to realise their preferred family size.

Fertility Levels and Trends

The total fertility rate in Zimbabwe has declined from 5.5 births per woman for the period 1986-88 to 4.3 births for the period 1992-94, a drop of 22 percent. This represents a significant decrease in fertility, and facilitates the economic and social development of Zimbabwe by reducing population growth.

There have been substantial decreases in fertility in all geographic and socioeconomic subgroups, although large differences continue to exist. For example, fertility is 58 percent higher in rural areas than in urban areas (4.9 versus 3.1 births per woman); and, on average, a woman with no education will have 5.2 children in her lifetime, compared with 4.7 for a woman who has attended primary school, and 3.3 for a woman who has attended secondary school or higher.

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Age at First Birth

The age at which a woman first gives birth influences the number of children she will have in her lifetime. Women who start childbearing early tend to have more children than those who start later. In Zimbabwe, age at first birth has been rising slowly in recent years. For women currently age 25-29, the median age at first birth is 19.7 years, compared with 19.3 years for women age 30-34. Despite this trend, around half of women still begin childbearing before reaching age 20. This finding is of particular concern because children born to

...on average, a woman with no education will have 5.2 children in her lifetime, compared with 4.7 for a woman who has attended primary school, and 3.3 for a woman who has attended secondary school or higher.

young mothers suffer higher rates of mortality. Further, opportunities for social and economic advancement are often limited when childbearing begins very early in life. Zimbabwean adolescents (women 15-19) who have not attended secondary school are three times as likely to have given birth as those who have attended secondary school.

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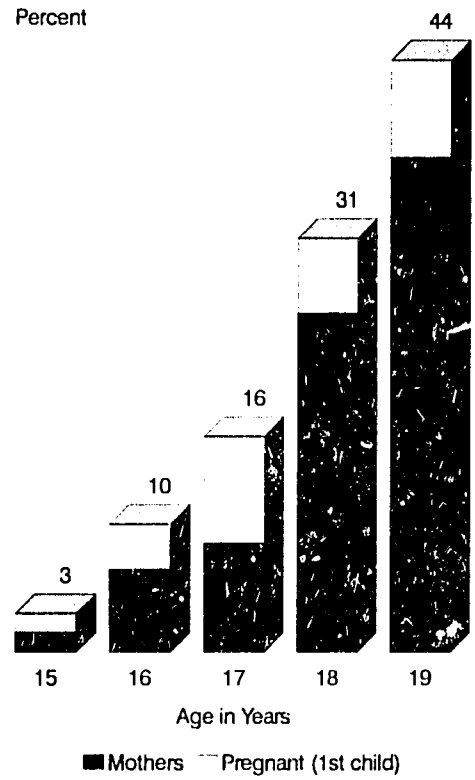
Adolescents Who Are Mothers or Pregnant with the First Child (Women 15-19)



Although median age at first birth is increasing, almost half of women begin childbearing before age 20.

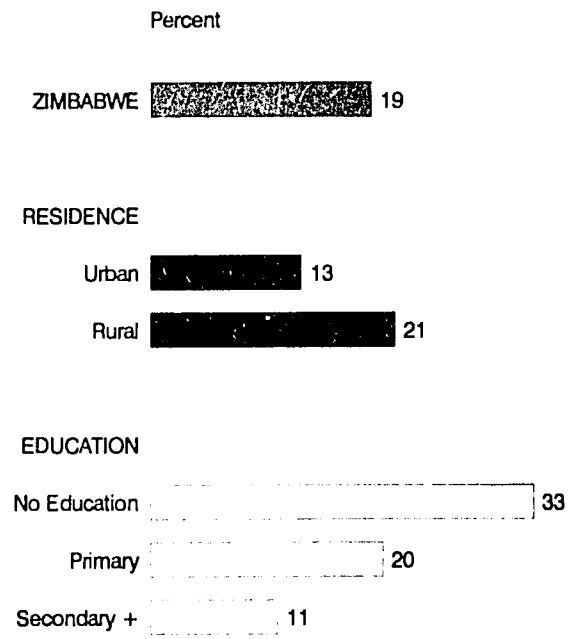
Marriage and Exposure to the Risk of Pregnancy

The age at which women marry has risen from 18.9 years among women 40-49 to 19.8 years among women 20-24. Men marry at a much later age: the median age at first marriage for men is 25 years. Only 11 percent of men are married by age 20, compared with 62 percent of women. Women with a secondary education generally marry three years later than women with no education.

While men first marry an average of six years later than women, women and men become sexually active at about the same age. In the youngest age cohort for which estimates are available (age 20-24), first sex occurs at a median age of 18.8 years for women and 18.7 years for men.

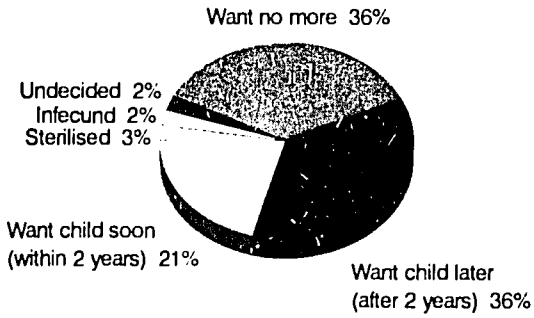
Nineteen percent of currently married women are in polygynous unions (i.e., their husbands have at least one other wife). This represents a small increase in polygyny since the 1988 ZDHS, when 17 percent of married women were in polygynous unions.

Polygynous Unions by Background Characteristics (Currently Married Women 15-49)



Polygyny, which increased slightly between 1988 and 1994, is most common among rural women and women with no education.

Fertility Preferences
(Currently Married Women 15-49)

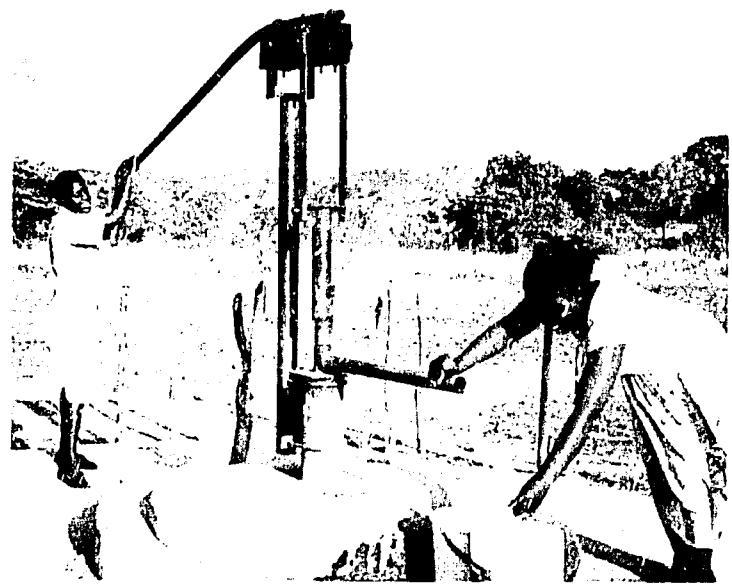


Almost three-quarters of currently married women either want no more children, or want to wait at least two years before having another child.

Fertility Preferences

Fertility levels and the pace of childbearing are influenced by individual fertility preferences. In Zimbabwe, around one-third of both women and men say they want no more children. Another 36 percent of women and 40 percent of men would like to delay their next child for at least two years. Thus, 72 percent of women and 73 percent of men want either to limit or to space their births.

When asked how many children they would like to have if they could live their lives over and choose exactly, both women and men reported an average ideal family size of 4.3 children. In the 1988 ZDHS, the ideal family size was 4.9 children.



Of births in the last three years, 1 in 10 was reported as unwanted and 1 in 3 was mistimed. Measuring the level of unwanted fertility is important for determining the effectiveness of family planning programmes. One way of measuring unwanted fertility is to calculate the difference between the total fertility rate and the *wanted fertility rate*, i.e., what the total fertility rate would be if all unwanted births were avoided. The results of the 1994 ZDHS indicate that if unwanted births were avoided, the total fertility rate in Zimbabwe would be 3.5 births per woman, almost one child less than the actual fertility rate (4.3 births per woman).

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Family Planning

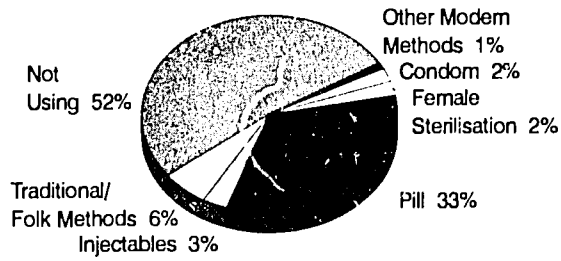
Knowledge and Use of Contraception

Knowledge and use of family planning in Zimbabwe have continued to rise over the last decade. The results of the 1994 ZDHS indicate that virtually all married women (99 percent) and men (100 percent) know at least one modern method of contraception. The pill, condoms, female sterlisation, and injectables are the most widely known methods.

Overall, 48 percent of currently married women are using a method of family planning to achieve their childbearing goals. Use of modern methods has increased from 27 percent in 1984 (the Zimbabwe Reproductive Health Survey), to 36 percent in 1988, to 42 percent in 1994. The pill is the method used by most Zimbabwean couples—78 percent of users of modern methods rely on the pill. There have been small increases in the use of injectables and condoms.

Contraceptive use varies widely among geographic and socioeconomic subgroups. Fifty-eight percent of married women in Harare use a modern method, compared with 28 percent in Manicaland. Use of modern methods is twice as high among women who have attended secondary school (55 percent) as among those with no education (26 percent).

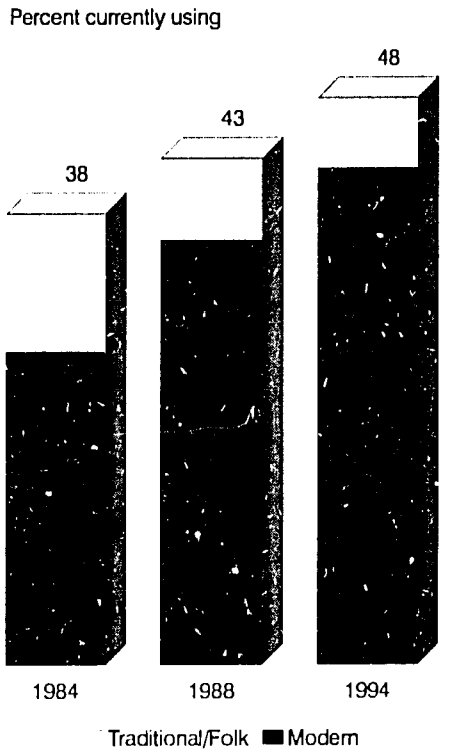
Use of Specific Contraceptive Methods (Currently Married Women 15-49)



Almost half of married women are using a method of family planning. The pill is the most commonly used method.

Use of modern methods has increased from 27 percent in 1984...to 42 percent in 1994.

Trends in Contraceptive Use, 1984-1994 (Currently Married Women 15-49)



While use of modern methods increased substantially between 1984 and 1994, use of traditional/folk methods decreased.

Sources of Contraceptive Methods

Government-sponsored providers remain the chief source of contraceptive methods in Zimbabwe. Around one-third of users obtain their method from rural or municipal clinics, and nearly one-quarter from clinics and community-based distribution (CBD) workers of the Zimbabwe National Family Planning Council (ZNFPC). About 12 percent of modern method users obtain their method through the private sector, up from around 4 percent in the 1988 ZDHS.

Unmet Need for Family Planning

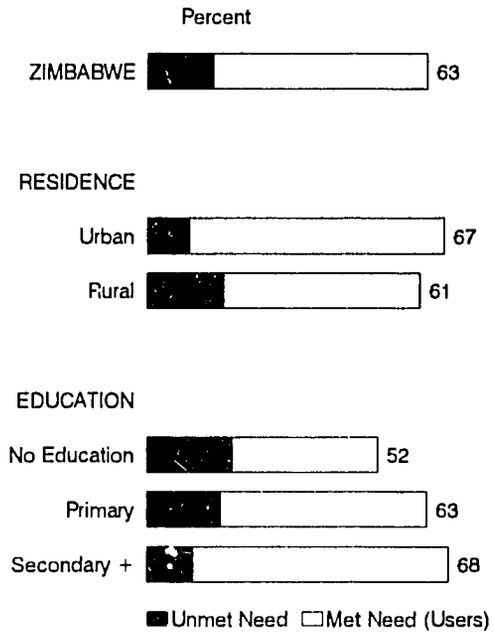
The survey results show that 15 percent of married women have an unmet need for family planning (either for spacing or limiting births). This group comprises married women who are not using a method of family planning but either want to wait at least two years for their next birth (9 percent) or do not want any more children (6 percent).

Unmet need is almost twice as high among rural women as urban women. Among the provinces, Matabeleland North and Matabeleland South have the highest levels of unmet need.

Although total demand for family planning services increases with level of education, women who have attended school are more likely to be using contraception. As a result, unmet need for family planning among women with no education is almost twice as high as among women who have attended secondary school or higher.

Among women who are not currently using a contraceptive method, almost two-thirds say they plan to use a method in the future—most within the next 12 months.

Demand for Family Planning Services (Currently Married Women 15-49)



Unmet need for family planning is high among rural women, women in some provinces, and women with no education.

The survey results show that 15 percent of married women have an unmet need for family planning (either for spacing or limiting births).

Maternal and Child Health

Significant progress has been made in the provision of services intended to improve the health and survival of Zimbabwe's mothers and children. Yet, despite these gains, no improvement in child survival prospects was observed over the last several years and significant segments of the population remain undernourished.

Maternity Services

Utilisation of antenatal care services is high in Zimbabwe: in the three years before the survey, mothers received antenatal care for 93 percent of births. The median number of antenatal visits per pregnancy was 5.8. Most antenatal care is provided by nurses and trained midwives (77 percent), although the percentage provided by doctors (23 percent) has risen in recent years. Still, over one-quarter of women who receive services start during the third trimester of pregnancy—too late to realize the optimum benefits of antenatal care.

Tetanus toxoid is a powerful weapon in the fight against neonatal tetanus, a deadly disease that strikes newborns. Mothers reported receiving at least one tetanus toxoid injection for 82 percent of births in the three years before the survey.

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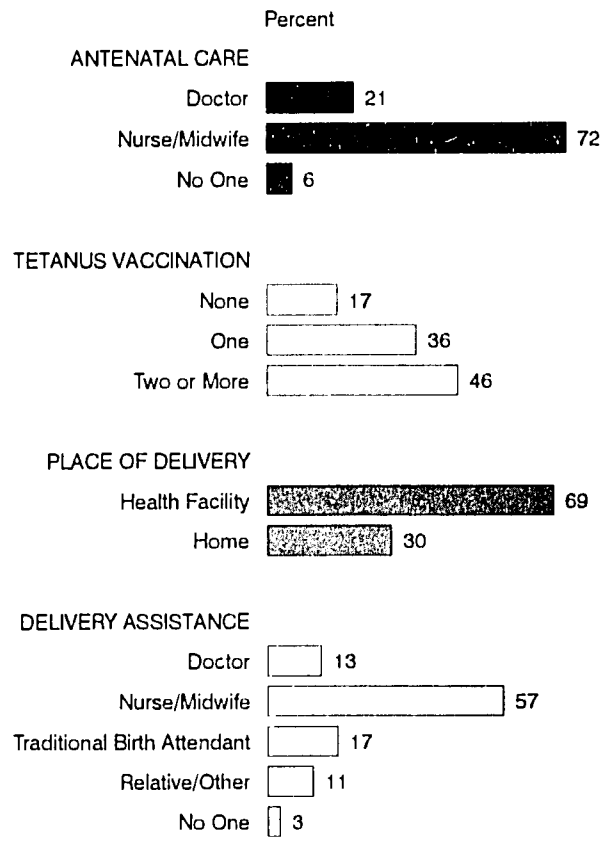
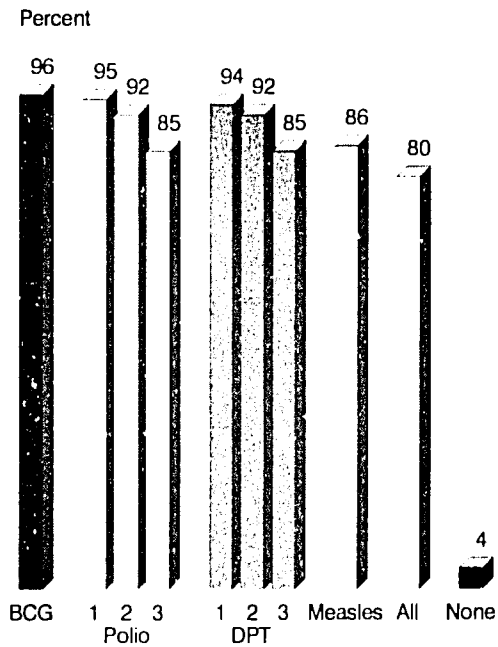
Antenatal Care and Delivery Care (Births in the Preceding 3 Years)



More than two-thirds of women deliver in a health facility and about the same proportion are assisted at delivery by medical personnel.

Vaccination Coverage (Children 12-23 Months)



Note: Based on health card information and mothers' reports.

Eighty percent of children age 12-23 months are fully vaccinated against the major childhood diseases.

About 70 percent of births take place in health facilities; however, this figure varies from around 53 percent in Manicaland and Mashonaland Central to 94 percent in Bulawayo. It is crucial for the health of both the mother and child that trained medical personnel are available in cases of prolonged or obstructed delivery, major causes of maternal morbidity and mortality.

Maternal Mortality

The ZDHS collected information that allows estimation of mortality related to pregnancy and childbearing (i.e., maternal mortality). For the period 0-9 years preceding the survey, the maternal mortality ratio was estimated to be 283 maternal deaths per 100,000 live births. A Zimbabwean woman has a 1 in 59 chance of dying from maternal causes during her lifetime.

Childhood Immunisations

Childhood immusation levels are high in Zimbabwe. The 1994 ZDHS found that 80 percent of children age 12-23 months are fully vaccinated against the major childhood diseases, 67 percent before the first birthday. Only 4 percent of children have received no vaccinations. This level of coverage is virtually the same as that measured in the 1988 ZDHS.

Treatment of Childho Diseases

In the two weeks preceding the survey, 25 percent of children under three years of age experienced symptoms of acute respiratory infection (ARI)—cough with short, rapid breathing. Peak ARI prevalence occurs during age 6-11 months. Around half of children with ARI symptoms were taken to a health facility or doctor for treatment.

Twenty-four percent of children under age three had diarrhoea in the two weeks preceding the survey. The percentage of children with diarrhoea rises sharply with age to a peak at 12-17 months (36 percent), falling thereafter. Diarrhoeal prevalence is substantially higher in rural areas (26 percent) than urban areas (18 percent). Around 30 percent of children with diarrhoea are taken to a health facility for treatment. Nearly 4 of 5 children with diarrhoea receive oral rehydration therapy in the recommended form—sugar-salt-water solution—as a treatment for their diarrhoea.

Infant Feeding

Almost all children (99 percent) are breastfed for some period of time; however, only 40 percent are breastfed within the first hour of life (91 percent within the first day).

The median duration of breastfeeding is 18.5 months; however, the survey findings indicate that supplementary liquids and foods are introduced very early in life. Over half of children under two months of age are given some form of supplementary feeding.

Exclusive breastfeeding (i.e., breast milk only) is recommended until age 4-6 months. In Zimbabwe, only 16 percent of children under four months are exclusively breastfed. Exclusive breastfeeding is important not only because it provides all the nutrients a child needs, but because it reduces exposure to disease agents in the environment.

The median duration of breastfeeding is 18.5 months; however, the survey findings indicate that supplementary liquids and foods are introduced very early in life.

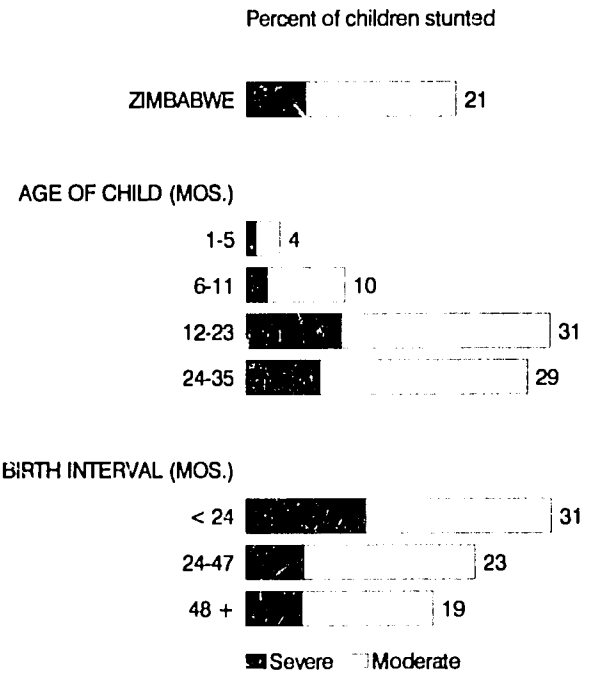
There are wide disparities in the types of food received by children in different geographic and socioeconomic groups. Generally, children living in urban areas (particularly Harare and Bulawayo) and children of more educated women receive protein-rich foods (i.e., meat, eggs, etc.) on a more regular basis than other children.

Nutritional Status of Children under Three

In the ZDHS children under three years of age and their mothers were weighed and measured to obtain data for estimating levels of undernutrition. The results indicate that 21 percent of children under three are *stunted* (i.e., short for their age), a condition reflecting chronic undernutrition; and 6 percent are *wasted* (i.e., thin for their height), a problem indicating acute or short-term food deficit. Children age 12-23 months and children born after a short birth interval are at greater risk of poor nutritional status than other children.

There are substantial variations by province in the nutritional status of children. The prevalence of stunting ranges from 13 percent in Midlands and Bulawayo to more than 25 percent in Mashonaland Central, Matabeleland North, and Matabeleland South. Wasting varies from 2 percent in Mashonaland East and Masvingo to 10 percent in Matabeleland North.

Prevalence of Stunting by Child's Age and Length of Birth Interval (Children under 3 Years)



Stunting, which reflects chronic undernutrition, is highest among children age 12-23 months and children born after a short birth interval.

Maternal Nutrition

Women whose body mass index (BMI)—weight in kilograms divided by height in metres squared—falls below 18.5 are considered undernourished. The data show that 5 percent of mothers of young children in Zimbabwe have a BMI value below 18.5. The percentage of mothers with a low BMI varies from 1 percent in Harare to 11 percent in Matabeleland North province.

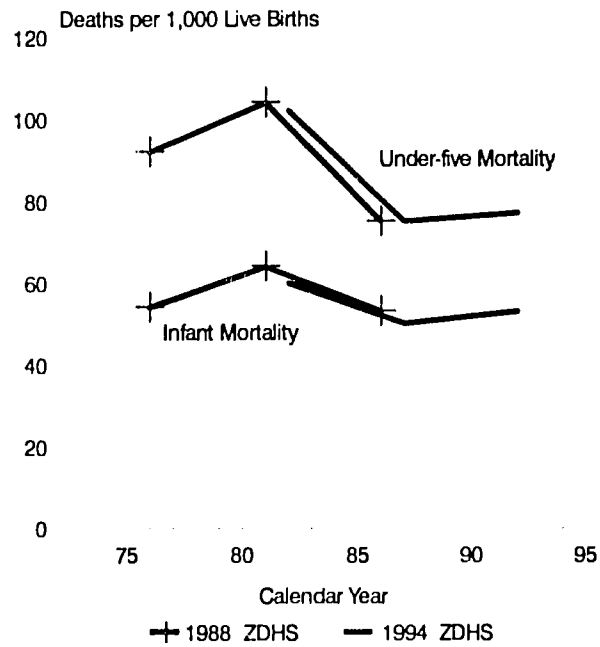
Childhood Mortality

One of the main objectives of the 1994 ZDHS was to obtain information about current levels of mortality among children under age five. The results of the survey indicate that child survival prospects have not improved since the late 1980s.

The results of the 1994 ZDHS indicate that child survival prospects have not improved since the late 1980s.

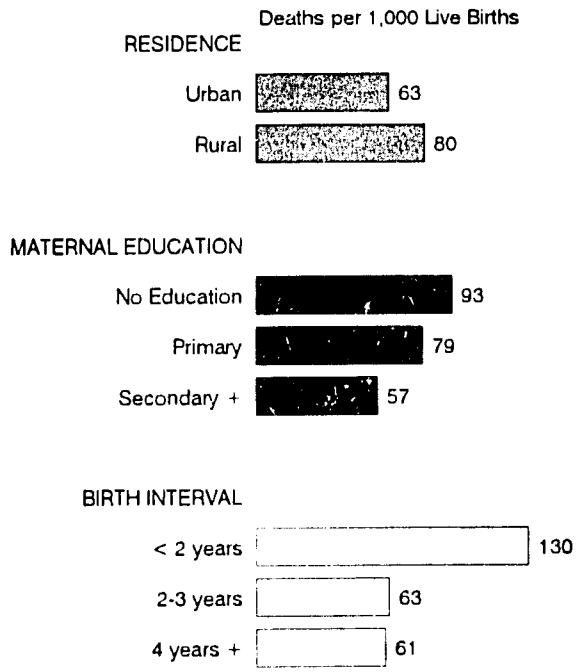
For the most recent five-year period (1990-94), infant mortality was 53 deaths per 1,000 live births and under-five mortality was 77 deaths per 1,000 live births. These are virtually the same mortality levels as those estimated for the preceding five-year period (1985-89), when infant mortality was 50 per 1,000 and under-five mortality was 75 per 1,000. Data from other sources confirm this stagnation in the decline of childhood mortality in Zimbabwe.

Trends in Infant and Under-five Mortality



Infant and under-five mortality rates indicate there has been a stagnation in the decline of childhood mortality in Zimbabwe.

Under-five Mortality by Selected Characteristics



Children born after a short birth interval (less than two years) are twice as likely to die as children born after longer birth intervals.

Survey results show that childhood mortality is especially high when associated with two factors: a short preceding birth interval and a low level of maternal education. The risk of dying for both infants and children under five is doubled when the child is born after an interval of less than 24 months; it is almost two-thirds higher for children of mothers who have no education, compared with those whose mothers attended secondary school or higher.

AIDS-Related Knowledge and Behaviour

All but a fraction of Zimbabwean women and men have heard of AIDS, but the quality of that knowledge is sometimes poor. Over one-quarter of women and 15 percent of men do not believe that a healthy-looking person can carry the AIDS virus. Nearly 1 in 5 women and 1 in 16 men do not know a way to avoid infection with the AIDS virus.

Condom use and limiting the number of sexual partners were cited most frequently by both women and men as ways to avoid transmission of the AIDS virus. Generally, men have greater knowledge of AIDS-related information than women. Radio is the primary source of AIDS-related information for both women and men, but other sources are also commonly cited. Women are more likely to obtain information from health workers and friends or relatives; men are more likely to get information from printed materials, especially newspapers.

Women, more than men, perceive themselves at risk of getting HIV/AIDS. Nearly one-quarter of women, but only 12 percent of men reported that they were at moderate or great risk of getting HIV/AIDS. When asked why they believed themselves to be at high risk, 59 percent of women reported that their spouse had another sexual partner (compared with only 2 percent of men).

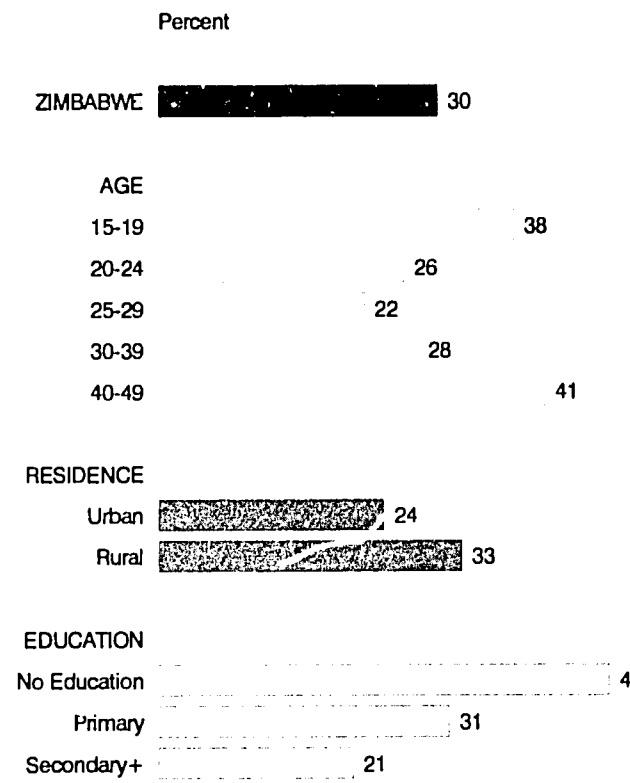
All but a fraction of Zimbabwean women and men have heard of AIDS, but the quality of that knowledge is sometimes poor.

While awareness of condoms is nearly universal, when asked where they could get a condom, 30 percent of women and 20 percent of men could not name a source. About half of women with no education do not know where to obtain condoms. Less than one-third of women but more than two-thirds of men reported that they had used a condom at some time.

Questions were asked about condom use in the last four weeks. Sixty percent of men who had sex with a non-spouse in the last four weeks used condoms at least some of the time; only 12 percent of men used condoms with their spouses. For women, the comparable figures for condom use were 38 percent for non-spousal sex and 7 percent for sex with their husbands.

While awareness of condoms is nearly universal, when asked where they could get a condom, 30 percent of women and 20 percent of men could not name a source.

Women Age 15-49 Who Do Not Know A Source for Condoms



Almost half of women with no education do not know a source for condoms.

Conclusions

Fertility and Family Planning

Zimbabwe is currently in a transition from high to lower fertility levels. This decline has occurred primarily as a result of the increased use of modern contraceptive methods, although other fertility-related factors may be contributing. The sharp increase in contraceptive use over the last decade is a result of changing fertility preferences and changing perceptions of ideal family size. Zimbabwean couples want smaller families and are seeking safe and effective ways to achieve this goal. Despite the government's past success in meeting the reproductive needs of a large proportion of the population, many challenges remain.

The level of unwanted fertility in Zimbabwe is high: 10 percent of recent births were reported as unwanted and one-third were mistimed. A substantial proportion of women have an unmet need for family planning, although this varies among geographic and socioeconomic groups. Programmes may see the greatest success by targeting efforts to groups that have the greatest need for services.

Currently, most couples rely on the pill for family planning; however, a stated goal of the government is to improve the contraceptive method mix by encouraging greater use of long-term and permanent methods. The majority of users of modern methods obtain their methods from the public sector, although the private sector has an increasing role in the delivery of family planning services.

Most women who are not using a method of family planning say that they want to adopt a method in the future. Meeting the reproductive needs of these women will not only improve maternal and child health, but will also support the downward trend in fertility that is necessary to sustain Zimbabwe's continued economic and social development.

Maternal and Child Health

Efforts to provide basic maternal and child health services have been in large part successful. Immunisation levels are high, but could be improved. Most women receive some type of antenatal care, but often it is of uncertain quality and is initiated too late in pregnancy. Significant numbers of women die from causes related to pregnancy and childbearing, a situation that could be ameliorated by improved access to medical care around the time of delivery. A substantial proportion of deliveries occur at home and without the assistance of trained midwives.

Many Zimbabwean children have frequent episodes of common childhood illnesses, including acute respiratory infection (ARI) and diarrhoea. Children age 6-17 months are especially vulnerable to sickness. Around half of children with ARI receive medical attention. The promotion of recommended rehydrating fluids, particularly sugar-salt-water solution, for treatment of diarrhoea has been moderately successful, but requires further efforts to improve the knowledge of parents regarding the importance of increasing fluid intake.

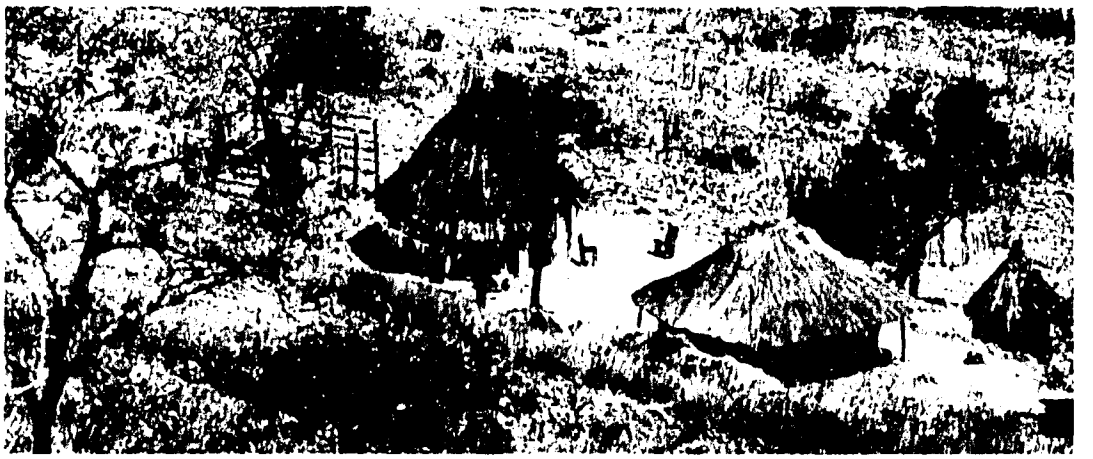
Many of Zimbabwe's young children are not receiving adequate nutrition—levels of both chronic and acute undernutrition are high and efforts should be made to alleviate food shortages and improve nutrition education at the household level. Improving feeding patterns, especially during the first year of life, will aid in proper growth and improved child survival.

Despite noteworthy gains in the delivery of child health services, the survival prospects of Zimbabwean children under five have remained roughly constant since the late 1980s. Analysis of this troubling situation will help policymakers and programme managers develop strategies that will lead to further declines in childhood mortality.

AIDS-Related Knowledge and Behaviour

The AIDS epidemic poses a major threat to the physical, social, and economic health of Zimbabwe. While most people understand the threat and have a general knowledge of HIV/AIDS, large numbers of women and men—especially women living in rural areas—continue to believe there is no way to avoid infection with the AIDS virus. Notable gender differences exist in the ways women and men perceive the risk of HIV/AIDS and in the modifications of behaviour in response to the epidemic.

Condom use is widespread but, for significant segments of the population, access to condom supplies appears limited.



Fact Sheet

1992 Population Data[1]

- Total population (millions) 10.4
- Urban population (percent) 30.6
- Annual intercensal population growth (percent) 3.1
- Population doubling time (years) 23
- Crude birth rate (per 1,000 population) 34.5
- Crude death rate (per 1,000 population) 9.5
- Life expectancy at birth (years) 61.0

Zimbabwe Demographic and Health Survey 1994

Sample Population

- Women age 15-49 6,128
- Men age 15-54 2,141

Background Characteristics of Women Interviewed

- Percent urban 32.2
- Percent with no education 11.1
- Percent attended secondary school or higher 41.6

Marriage and Other Fertility Determinants

- Percent of women 15-49 currently married 61.8
- Percent of women 15-49 ever married 73.1
- Median age at first marriage among women age 20-49 ..... 19.2
- Median duration of breastfeeding (months) 18.5
- Median duration of postpartum amenorrhoea (months) 12.9
- Median duration of postpartum abstinence (months) 3.5

Fertility

- Total fertility rate 4.3
- Mean number of children ever born to women age 40-49 ..... 6.3

Desire for Children

- Percent of currently married women who:
  - Want no more children 35.6
  - Want to delay their next birth at least 2 years 35.8
- Mean ideal number of children among women 15-49[4] 4.3
- Percent of births in the last 3 years that were:
  - Unwanted 9.7
  - Mistimed 33.7

Knowledge and Use of Family Planning

- Percent of currently married women who:
  - Know any method 98.8
  - Know a modern method 98.5
  - Have ever used any method 79.7
  - Are currently using any method 48.1
  - Are currently using a modern method 42.2
- Percent of currently married women currently using:
  - Pill 33.1
  - IUD 1.0
  - Injectables 3.2
  - Condom 2.3
  - Female sterilisation 2.3
  - Male sterilisation 0.2
  - Implant 0.2
  - Periodic abstinence 0.1
  - Withdrawal 4.2
  - Folk methods 1.7

Mortality and Health

- Infant mortality rate[5] 53
- Under-five mortality rate[6] 77
- Maternal mortality ratio[7] 283
- Percent of births[8] to mothers who:
  - Received antenatal care from medical provider 93.1
  - Received 2 or more tetanus toxoid injections[9] 45.8
- Percent of births[8] to mothers who were assisted at delivery by:
  - Doctor 12.5
  - Nurse/Trained midwife 56.7
  - Traditional birth attendant 17.4
  - Relative/Other 10.8
- Percent of children 0-3 month who are breastfeeding 98.7
- Percent of children 10-11 months who are breastfeeding 95.0
- Percent of children 0-3 months who are exclusively breastfeeding 16.1
- Percent of children 12-23 months who received:[10]
  - BCG 95.7
  - DPT (three doses) 85.2
  - Polio (three doses) 85.4
  - Measles 86.3
  - All vaccinations 80.1
- Percent of children under 3 years who:
  - Had diarrhoea in the 2 weeks preceding the survey 23.5
  - Had a cough accompanied by short, rapid breathing in the 2 weeks preceding the survey 25.4
  - Are chronically undernourished (stunted)[11] 21.4
  - Are acutely undernourished (wasted)[11] 5.5

[1] Based on 1992 national census data (Central Statistical Office, 1994. *Census 1992: Zimbabwe National Report*. CSO, Harare)

[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 the 0.7 percent of women who gave a non-numeric response to ideal family size

[5] Rates for the period 0-4 years preceding the survey (roughly 1990 to 1994), expressed as deaths per 1,000 live births

[6] Ratio for the period 0-9 years preceding the survey; expressed as maternal deaths per 100,000 live births

[7] Figure includes births in the period 1-35 months preceding the survey

[8] Refers to injections received during pregnancy

[9] Based on information from vaccination cards and mothers' reports

[10] Stunting assessed by height-for-age, wasting assessed by weight-for-height; the percent undernourished are those below -2 SD from the median of the international reference population, as defined by the U.S. National Centre for Health Statistics, and recommended by the World Health Organisation.