

Eritrea Demographic and Health Survey 1995

Preliminary Report

**National Statistics Office
Department of Macro Policy and
International Economic Cooperation
Office of the President**

**Demographic and Health Surveys
Macro International Inc.**



The Demographic and Health Surveys Program (DHS) is assisting government and private agencies with the implementation of 59 surveys in developing countries. Funded primarily by the United States Agency for International Development (USAID), DHS is implemented by Macro International Inc. in Columbia, Maryland. The main objectives of the project are: (1) to provide decisionmakers in survey countries with database and analyses useful for informed policy choices, (2) to expand the international population and health database, (3) to advance survey methodology, and (4) to develop in participating countries skills and resources necessary to conduct high-quality demographic and health surveys.

Eritrea

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Calverton, Maryland USA**

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I. INTRODUCTION

The Eritrea Demographic and Health Survey (EDHS) was conducted by the National Statistics Office (NSO) of the Department of Macro Policy and International Economic Cooperation, Office of the President, from September 1995 to January 1996. Macro International Inc. furnished technical assistance as well as funding to the project through the Demographic and Health Surveys (DHS) program, a USAID-funded project providing support and technical assistance in the implementation of population and health surveys in developing countries. The UNFPA and UNICEF also provided some financial assistance in conducting the household listing for the survey.

The primary objectives of the EDHS project are to provide up-to-date information on: fertility levels, nuptiality, sexual activity, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutritional status of mothers and young children, early childhood mortality and maternal mortality, maternal and child health, female circumcision, and awareness and behavior regarding AIDS and other sexually transmitted diseases.

This preliminary report provides a first look at findings from the 1995 EDHS. Only some of the topics mentioned above are addressed in this report. A more extensive analysis of the data will be published in a final report in late 1996. While considered provisional, the results presented here are not expected to differ significantly from those presented in the final report.

II. SURVEY IMPLEMENTATION

A. Questionnaires

Four types of questionnaires were used in the Eritrea Demographic and Health Survey: the Household Questionnaire, the Women's Questionnaire, the Men's Questionnaire, and the Service Availability Questionnaire (SAQ). The SAQ was based on the model questionnaire used in many recent DHS surveys, while the other questionnaires are based on the DHS Model B Questionnaire for low contraceptive prevalence countries. After a meeting with data users (representatives of various ministries and the Planned Parenthood Association of Eritrea) and a meeting with representatives of international donor organizations in Eritrea, all the questionnaires were modified slightly to adapt them to the situation in Eritrea.

The Household Questionnaire was used to list all usual members and visitors of the selected households. The main purpose of the Household Questionnaire was to identify women and men who were eligible for the individual interview. Some basic information was collected on the characteristics of each person listed, including age, sex, education, marital status, labor force participation, and relationship to the head of the household. In addition, the household questionnaire collected information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facilities, material used for the floor of the house, and ownership of various durable goods. The Household Questionnaire also collected information on mortality in the household in the two years preceding the survey.

The Women's Questionnaire was used to collect information on all women age 15-49. These women were asked questions on the following topics:

- Background characteristics (residential history, education, etc.)
- Reproductive history
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal care and delivery care
- Breastfeeding and weaning practices
- Vaccinations and health status of children under age three
- Marriage and sexual activity
- Female circumcision
- Woman's status and husband's occupation
- Awareness and behavior regarding AIDS
- Maternal mortality
- Maternal and child nutrition.

The Men's Questionnaire was administered to all men age 15-59 living in every third household in the EDHS sample. The Men's Questionnaire collected much of the same information as the Women's Questionnaire, but was shorter because it did not cover reproductive history and maternal and child health, although it covered the topic of AIDS in much more detail.

The Service Availability Questionnaire (SAQ) was administered to community leaders during the household listing operation in February-June 1995, before the main survey. One questionnaire was completed for each sample point selected for the EDHS. Any gaps in the SAQ were filled in during the main survey fieldwork. Community level information was collected on the nearest health and family planning services available to residents of each of 208 clusters of households included in the EDHS sample.

B. Training and Fieldwork

All questionnaires were translated and printed in Tigrigna. In addition, the Women's and Men's Questionnaires were translated and printed in three local languages: Tigre, Kunama, and Afar. Pretest training and field testing took place in April 1995. During a three-week period, 7 female and 2 male interviewers were trained to carry out the pretest. The pretest fieldwork was conducted over a three-week period during which approximately 250 interviews were completed. Debriefing sessions were held with the pretest field staff and necessary modifications to questionnaires were made based on the experience of the pretest exercise.

Training of the field staff for the main survey was conducted during a one-month period in August, 1995. The training course consisted of instructions regarding interviewing techniques and field procedures, a detailed review of items on the questionnaires, instruction and practice in weighing and measuring children and women and mock interviews with men and women of eligible age in areas outside the EDHS sample points. Within the constraint of ensuring that there was an adequate number of interviewers for each of the four local languages, interviewers were selected on the basis of overall performance in class, scores on the tests given in class, and performance during practice field interviews. From among those selected, candidates suitable as field editors and supervisors were selected. The supervisors, field editors, and male interviewers/team leaders were given additional training in coordination of fieldwork, methods of field editing, and data quality control procedures.

The EDHS fieldwork was carried out by eight teams, each consisting of one male interviewer/team leader, one female supervisor, one female field editor, four female interviewers, and a driver. Five field survey coordinators, three permanent professional staff from the NSO, and two persons selected from among the trainees were assigned to oversee the teams, facilitate fieldwork activities, and monitor data quality. Data collection took place over a four-month period from September 1995 to January 1996. For cases in which none of the interviewers spoke the respondent's language, interpreters were hired to translate the questions into a language the respondent could understand.

C. Data Processing

All questionnaires for the EDHS were returned to the National Statistics Office for data processing, which consisted of office editing, coding of open-ended questions, data entry, and secondary editing (editing computer-identified errors). The data were processed by a team consisting of four data entry clerks, one data editor and one data entry supervisor. The head of the data processing unit at the NSO provided overall supervision. Data entry and editing were accomplished using the computer program ISSA (Integrated System for Survey Analysis).

D. Sample Design and Implementation

The EDHS employed a nationally representative, multi-stage probability sample of women between the ages of 15 and 49. The five main reporting domains are: the country as a whole, all urban areas, the capital Asmara, other urban areas outside Asmara, and rural areas. Estimates of selected variables were also produced for each of the six administrative zones in the country.

Since there was no national census, the sampling frame used for the survey was constructed from a combination of data sources. In rural areas, the sampling frame consisted of a list of villages with population figures collected by the Ministry of Local Government and the sampling units were villages. In urban areas, data on *zobas* and *mimihidars* collected by the NSO between August 1994 and January 1995 were used in the selection of *mimihidars* as sampling units. In the capital, Asmara, the sampling units were also

mimihidars; however, since reliable data on population size did not exist for these *mimihidars*, the measure of size used for sample selection was the number of registered voters. From this, the number of households and the population size were estimated. A mapping and household listing operation was implemented to update the population size of the sampling units prior to selecting the households for the survey.

The sample for the EDHS was selected in two stages. First, 108 villages and 100 *mimihidars* were selected with probability proportional to size. When villages and *mimihidars* were very large (in population size), they were segmented and only one segment was selected for the survey so that each cluster corresponded generally to a village, a *mimihidar*, or part of a village or *mimihidar*. A complete listing of the households residing in the selected clusters was carried out. The list of households obtained was used as the frame for second-stage sampling, the selection of households to be visited by the EDHS survey teams during the main fieldwork. Women between the ages of 15 and 49 were identified in these households and interviewed. In one-third of the households selected for the survey men between the ages of 15 and 59 were also interviewed.

On average, 25 households were selected in each urban cluster and 35 in each rural cluster. It was expected that the sample would yield interviews with approximately 5,000 women age 15 to 49 and 1,400 men age 15 to 59. Because of the non-proportional distribution of the sample in the 10 *provinces* that existed at the time of the sample design, sampling weights were applied to the data in this report.

III. RESULTS

A. Response Rates

Table 1 shows response rates for the EDHS. A total of 6,258 households were selected in the sample, of which 5,642 were occupied. The shortfall was largely due to cases in which all household members were absent when the team visited the sampled cluster, or the household no longer existed in the sampled cluster at the time of the interview. Of the existing 5,642 households, 5,469 were interviewed, yielding a household response rate of 97 percent.

In the interviewed households, 5,250 eligible women were identified and of these, 5,054 were interviewed, yielding a response rate of 96 percent. In the subsample of households identified for the men's survey, 1,267 eligible men were identified, of which 1,114 were successfully interviewed (88 percent response). The main reason for non-response among both eligible men and women was the failure to find them at home despite repeated visits to the household. This occurred because the fieldwork was implemented during harvest season and many men and women were away from home performing agricultural tasks. The lower response rate for men was due to their more frequent and longer absences from the household. The refusal rate in the EDHS was very low (0.2 and 0.5 percent for women and men, respectively).

B. Characteristics of the Respondents

Table 2 shows the distribution of women age 15 to 49 and men age 15 to 59 surveyed in the EDHS by selected background characteristics. The distribution by age shows a sharp decline in numbers of men and women at increasing ages. About one-third of women and men live in urban areas, and one-fifth in the capital Asmara.

About two-thirds of women and a little less than half of men have never been to school. Besides higher attendance at school, males also tend to reach higher levels of education than females; one-fifth of men attended secondary school or higher, compared with one-tenth of women.

The findings presented in the rest of this report are mainly based on data obtained from interviews with eligible women with some comparative findings from the male survey. A complete analysis of the data obtained from the male survey will be presented in the final report.

Table 1 Household and individual sample results, Eritrea 1995

Number of households, eligible women, and eligible men by results of the interviews, and response rates, Eritrea 1995

	Number	Percent
Selected households		
Households selected	6,258	100.0
Completed	5,469	87.4
Household present but no competent respondent		
at home	71	1.1
Household absent	422	6.7
Refused	2	0.0
Dwelling vacant/no dwelling	141	2.3
Dwelling destroyed	35	0.6
Dwelling not found	100	1.6
Other	18	0.3
Households occupied	5,642	100.0
Households interviewed	5,469	96.9
Households not interviewed	173	3.1
Household response rate	-	96.9
Eligible women	5,250	100.0
Completed	5,054	96.3
Not at home	107	2.0
Refused	9	0.2
Partly completed	5	0.1
Incapacitated	61	1.2
Other	14	0.3
Eligible woman response rate	-	96.3
Eligible men	1,267	100.0
Completed	1,114	87.9
Not at home	105	8.3
Refused	6	0.5
Partly completed	1	0.1
Incapacitated	34	2.7
Other	7	0.6
Eligible man response rate	-	87.9

Table 2 Background characteristics of respondents

Percent distribution of women and men by selected background characteristics, Eritrea 1995

Background characteristic	Women			Men		
	Weighted percent	Number of women		Weighted percent	Number of men	
		Weighted	Un-weighted		Weighted	Un-weighted
Age						
15-19	22.3	1,129	1,137	21.3	237	251
20-24	16.3	823	844	12.7	142	140
25-29	15.5	782	773	11.4	127	136
30-34	12.6	638	652	9.2	102	99
35-39	11.1	562	576	11.2	125	111
40-44	11.9	603	592	10.5	117	114
45-49	10.2	518	480	10.2	113	110
50-54	NA	NA	NA	6.9	77	84
55-59	NA	NA	NA	6.6	73	69
Residence						
Urban	32.6	1,648	2,520	31.9	356	562
Asmara	20.9	1,059	1,446	20.5	229	316
Other town	11.7	589	1,074	11.4	127	246
Rural	67.4	3,406	2,534	68.1	758	552
Zone						
Southern Red Sea	2.8	139	273	3.5	39	72
Northern Red Sea	11.0	556	803	9.9	110	164
Anseba	12.7	642	559	12.0	133	114
Gash-Barka	18.9	957	834	20.9	233	187
Southern	27.5	1,392	852	25.6	286	186
Central	27.1	1,368	1,733	28.0	312	391
Education						
No education	65.9	3,332	2,924	46.7	520	429
Primary incomplete	15.6	786	861	21.9	243	220
Primary complete	8.6	435	566	12.2	136	154
Secondary+	9.9	501	703	19.3	215	311
Total	100.0	5,054	5,054	100.0	1,114	1,114

NA = Not applicable

C. Fertility

All women who were interviewed in the EDHS were asked to report the total number of sons and daughters to whom they had ever given birth in their lifetime. To encourage complete reporting, women were asked separately about children still living at home, children living away from home, and those who had died. A complete birth history was then obtained; this included sex, date of birth, and survival status of each child. For dead children, age at death was recorded.

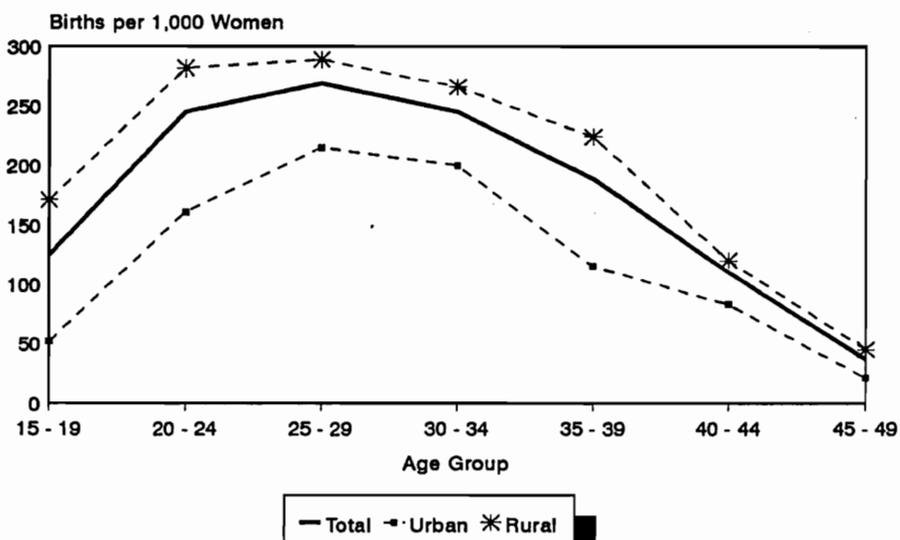
Age-specific and total fertility rates for the three-year period before the survey, for all of Eritrea, and for urban and rural areas are shown in Table 3 and Figure 1. The total fertility rate (TFR), which is five times the sum of the age-specific fertility rates, is a useful means of summarizing the level of fertility. The TFR can be interpreted as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the currently observed age-specific rates. If fertility were to remain constant at current levels, the average Eritrean woman would bear 6.1 children in her lifetime.

Table 3 Current fertility

Age-specific fertility rates and total fertility rates (TFR) for the three-year period prior to the survey, and mean number of children ever born, by age of woman and residence, Eritrea 1995

Age	Urban			Rural			Total		
	Fertility rate	Children ever born	Number of women	Fertility rate	Children ever born	Number of women	Fertility rate	Children ever born	Number of women
15-19	0.052	0.068	448	0.171	0.315	680	0.125	0.217	1,129
20-24	0.161	0.705	282	0.282	1.367	541	0.245	1.140	823
25-29	0.215	1.838	223	0.290	2.633	559	0.269	2.406	782
30-34	0.200	3.163	177	0.267	3.941	460	0.245	3.724	638
35-39	0.115	4.430	180	0.224	5.178	381	0.189	4.938	562
40-44	0.083	4.923	181	0.121	6.462	422	0.110	6.000	603
45-49	0.021	5.906	156	0.045	6.754	362	0.037	6.499	518
TFR 15-49	4.23	2.31	1,648	6.99	3.34	3,406	6.10	3.01	5,054
TFR 15-44	4.12	1.94	1,492	6.77	2.94	3,044	5.91	2.61	4,536

**Figure 1
Age-Specific Fertility Rates by Residence**



EDHS 1995

Table 3 also shows the mean number of children ever born to women by five-year age group. On average, women have given birth to almost 2.5 children by their late twenties, and to around 5 children by their late thirties. By age 45-49, the average Eritrean woman has had 6.5 children. The current fertility level of 6.1 is only slightly lower than the number of children born to women in their late forties.

The TFR in urban areas is 4.2 children. The average number of children ever born to urban women age 40-44 (almost 5 children) and 45-49 (almost 6 children) is much higher than the TFR, indicating that fertility has declined considerably in urban areas. The TFR of 7.0 children in rural areas is much higher than the TFR in urban areas and is slightly higher than the number of children born to women 40-49 in rural areas.

D. Family Planning

The survey collected information on knowledge and use of family planning methods. Respondents were first asked to mention any methods of family planning of which they had heard. For methods not mentioned spontaneously, the interviewer read a brief description of the method and asked if the respondent had ever heard of it. Then, for each method that the respondent reported knowledge of, she was asked if she had ever used that method. Finally, respondents were asked if they were currently using any family planning method, and if so, which one, and where they obtained that. In this report, family planning methods are classified into three categories: modern methods (pill, IUD, injectables, diaphragm/foam/jelly, condom, and female and male sterilization), traditional methods (withdrawal, periodic abstinence, and breastfeeding), and folk methods.

Knowledge of Family Planning

Table 4 shows that knowledge of methods of contraception is not high; only about two-thirds of women age 15-49 know of any method. The most commonly recognized modern methods in Eritrea are pills and injectables. Knowledge of condoms and female sterilization is somewhat lower and is lowest for diaphragm/foam/jelly and male sterilization.

Traditional methods are also not well known. Only one-third of currently married women have heard of at least one traditional method. Less than one-fifth know about periodic abstinence (rhythm method) and the same proportion mentioned breastfeeding as a family planning method, although breastfeeding was not included in the list of methods in the questionnaire. Less than one-tenth of women know of withdrawal. Knowledge of all methods except breastfeeding was higher among all women than among currently married women. The difference in knowledge was substantial for condoms and less than three percentage points for other methods.

Knowledge of all methods is higher among men than among women. Four-fifths of men know at least one method. The difference in knowledge between men and women is especially notable for periodic abstinence: 65 percent among currently married men compared with 18 percent among currently married women.

Ever Use of Family Planning

Only 15 percent of currently married women age 15-49 have used a method of family planning at some time in their lives (see Table 4). Nine percent of married women have used one or more modern methods and 9 percent have experience with traditional methods. The pill is the most popular—7 percent of women have used it; 6 percent of women said that they have used breastfeeding as a contraceptive method, 2 percent have used the IUD, and the same proportion have used condoms. Ever use of injectables is reported by 1 percent of women; use of other methods is negligible.

Table 4 Knowledge of methods, ever use of methods, and current use of methods

Percentage of all women and currently married women and of all men and currently married men who know a contraceptive method, who have ever used a method, and who are currently using a method, by specific methods, Eritrea 1995

Contraceptive method	Women						Men					
	Percent who know a method		Percent who ever used a method		Percent currently using a method		Percent who know a method		Percent who ever used a method		Percent currently using a method	
	All	Currently married	All	Currently married	All	Currently married	All	Currently married	All	Currently married	All	Currently married
Any method	68.0	63.9	12.0	15.2	5.9	8.0	81.7	81.7	22.0	26.9	15.0	19.8
Any modern method	66.3	62.0	6.9	8.5	3.1	4.0	78.9	78.1	14.4	14.7	6.8	7.2
Pill	62.7	59.9	5.7	7.1	1.5	2.0	71.5	73.3	5.5	7.6	2.2	3.3
IUD	18.2	16.7	1.4	1.8	0.4	0.6	25.0	25.6	1.3	2.1	0.6	0.8
Injectables	51.9	51.3	1.0	1.3	0.6	0.8	60.0	62.3	1.1	1.8	0.6	1.1
Diaphragm/foam/jelly	7.5	6.5	0.1	0.1	0.0	0.0	11.5	9.1	0.0	0.0	0.0	0.0
Condom	43.1	34.9	1.7	1.7	0.3	0.3	71.3	68.3	11.2	9.6	3.0	1.3
Female sterilization	24.8	24.0	0.2	0.3	0.2	0.3	29.8	29.9	0.3	0.5	0.3	0.5
Male sterilization	6.5	5.6	0.0	0.0	0.0	0.0	7.6	7.3	0.1	0.1	0.1	0.1
Any traditional method	34.0	33.4	7.2	9.3	2.8	4.0	60.2	65.8	14.0	20.1	8.2	12.7
Periodic abstinence	20.5	17.8	2.6	3.2	0.6	0.8	58.7	64.6	12.9	18.7	7.7	11.9
Withdrawal	7.8	7.0	0.7	0.9	0.1	0.2	26.2	26.1	3.2	4.7	0.3	0.5
Breastfeeding	16.0	18.2	4.5	5.9	2.1	3.0	1.0	1.4	0.4	0.6	0.2	0.3
Any folk method	0.2	0.1	0.0	0.0	0.0	0.0	1.0	1.2	0.0	0.0	0.0	0.0
Any traditional or folk method	34.0	33.4	7.2	9.3	2.8	4.0	60.4	66.1	14.0	20.1	8.2	12.7
Number of persons	5,054	3,371	5,054	3,371	5,054	3,371	1,114	675	1,114	675	1,114	675

The proportion of currently married men who have ever used a method is substantially higher than for married women—27 percent. Although the proportion of currently married men who have ever used each method is greater than among currently married women, the difference is most notable for rhythm or periodic abstinence (19 percent among currently married men vs. 3 percent among married women), implying that there is some misunderstanding of this method by men. The difference in ever use cannot be attributed to wording of the questions because the questions to collect information on contraceptive knowledge and use were identical in the Women's and the Men's Questionnaires.

Current Use of Family Planning

Overall, only 8 percent of currently married women (6 percent of all women) reported that they were currently using a method of family planning; half using a modern and half using a traditional method (4 percent). The most popular methods are breastfeeding (3 percent) and the pill (2 percent). Less than 1 percent of women use any of the other methods.

One-fifth of currently married men reported using a method. The major source of difference in contraceptive prevalence reported by men and women is due to the extremely high reported use of periodic abstinence by men. Twelve percent of currently married men, compared with less than 1 percent of currently married women, reported using the method.

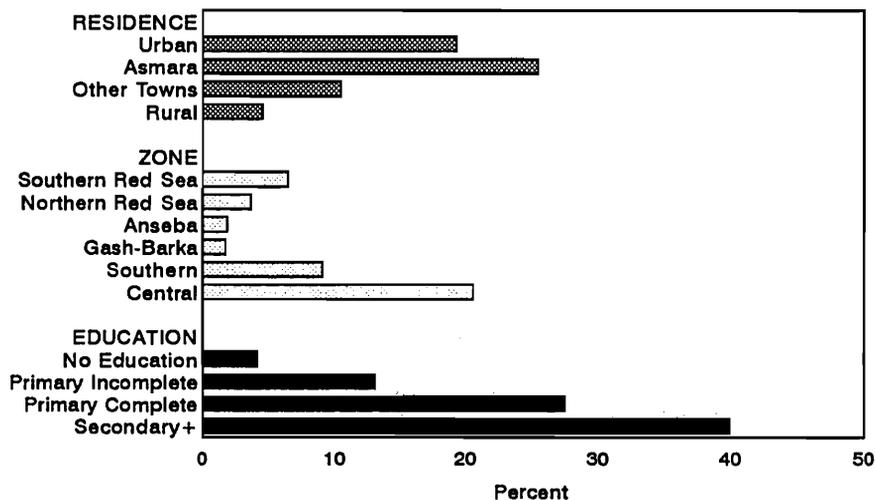
Some married women are more likely to be using contraception than others (see Table 5 and Figure 2). The use of contraception is very low among women 15-19 and women 45-49 (3 percent each), and varies from 9 to 11 percent among other age groups. Urban women are much more likely to be using a method than rural women: 26 percent in Asmara, 11 percent in other towns, and only 5 percent in rural areas. There are large differences in the level of contraceptive use by zone. One-fifth of currently married women in the Central Zone are contraceptive users, compared with one-tenth of women in the Southern Zone and just 2-6 percent of women in the other four zones.

Table 5 Current use of contraception by background characteristics

Percent distribution of currently married women by contraceptive method currently used, according to selected background characteristics, Eritrea 1995

Background characteristic	Modern contraceptive method								Traditional method				Total	Number of women	
	Any method	Any modern method	Pill	IUD	Injectables	Diaphragm foam/jelly	Condom	Female sterilization	Any trad. method	Periodic abstinence	Withdrawal	Breast feeding			Not using any method
Age															
15-19	3.3	0.6	0.4	0.0	0.2	0.0	0.0	0.0	2.7	0.0	0.2	2.5	96.7	100.0	366
20-24	9.5	4.2	2.4	0.7	0.6	0.0	0.4	0.0	5.3	1.3	0.0	4.0	90.5	100.0	571
25-29	8.9	4.1	2.4	0.7	0.7	0.0	0.3	0.0	4.8	0.6	0.2	3.9	91.1	100.0	637
30-34	8.7	4.0	1.5	0.6	1.1	0.0	0.7	0.1	4.7	1.4	0.4	2.9	91.3	100.0	513
35-39	10.5	6.6	2.8	1.1	1.7	0.2	0.2	0.7	3.9	0.6	0.3	2.9	89.5	100.0	450
40-44	9.1	5.3	2.9	0.8	0.6	0.0	0.0	0.9	3.8	0.9	0.1	2.8	90.9	100.0	472
45-49	3.0	1.8	0.4	0.2	0.6	0.0	0.0	0.6	1.1	0.4	0.0	0.7	97.0	100.0	362
Residence															
Urban	19.3	14.5	6.6	2.8	2.8	0.1	1.0	1.1	4.8	3.0	0.8	1.0	80.7	100.0	768
Asmara	25.5	19.6	7.8	4.2	4.4	0.2	1.5	1.6	5.8	3.6	1.1	1.1	74.5	100.0	451
Other town	10.5	7.2	5.0	0.8	0.5	0.0	0.4	0.5	3.3	2.2	0.3	0.8	89.5	100.0	317
Rural	4.6	0.9	0.6	0.0	0.2	0.0	0.0	0.0	3.7	0.1	0.0	3.6	95.4	100.0	2,604
Zone															
Southern Red Sea	6.2	5.1	4.0	0.6	0.0	0.0	0.6	0.0	1.1	1.1	0.0	0.0	93.8	100.0	87
Northern Red Sea	3.7	1.4	1.2	0.0	0.2	0.0	0.0	0.0	2.3	0.3	0.0	2.0	96.3	100.0	447
Anseba	1.9	1.2	0.7	0.2	0.2	0.0	0.0	0.2	0.6	0.6	0.0	0.0	98.1	100.0	441
Gash-Barka	1.8	0.7	0.4	0.1	0.2	0.0	0.0	0.1	1.1	0.5	0.0	0.5	98.2	100.0	735
Southern	9.1	1.4	1.0	0.1	0.1	0.0	0.1	0.1	7.7	0.1	0.1	7.5	90.9	100.0	1,025
Central	20.6	15.4	6.4	3.0	3.6	0.1	1.2	1.2	5.2	2.7	0.8	1.7	79.4	100.0	636
Education															
No education	4.2	1.0	0.6	0.1	0.2	0.0	0.1	0.0	3.2	0.2	0.0	3.0	95.8	100.0	2,636
Primary incomplete	13.1	7.9	3.8	0.9	2.2	0.0	0.3	0.8	5.2	1.8	0.5	2.9	86.9	100.0	445
Primary complete	27.5	20.5	11.1	2.1	3.8	0.0	1.9	1.6	6.9	4.2	0.8	2.0	72.5	100.0	136
Secondary+	39.9	29.6	11.7	8.1	4.8	0.5	2.4	2.1	10.3	5.7	1.4	3.1	60.1	100.0	154
No. of children															
0	1.2	1.0	0.6	0.0	0.2	0.0	0.0	0.2	0.3	0.3	0.0	0.0	98.8	100.0	453
1	7.1	3.1	1.4	0.8	0.5	0.0	0.4	0.1	4.0	1.5	0.3	2.2	92.9	100.0	543
2	11.4	5.1	3.1	0.6	1.1	0.0	0.3	0.0	6.3	1.2	0.3	4.8	88.6	100.0	539
3	8.8	3.7	1.4	0.9	0.7	0.0	0.6	0.0	5.1	0.2	0.2	4.8	91.2	100.0	465
4	7.4	3.3	2.0	0.5	0.4	0.0	0.4	0.0	4.0	0.5	0.0	3.5	92.6	100.0	405
5	7.7	3.9	1.8	0.7	0.8	0.2	0.0	0.2	3.8	0.9	0.2	2.7	92.3	100.0	300
6+	10.4	6.6	2.9	0.8	1.6	0.0	0.1	1.1	3.8	0.8	0.3	2.8	89.6	100.0	666
Total	8.0	4.0	2.0	0.6	0.8	0.0	0.3	0.3	4.0	0.8	0.2	3.0	92.0	100.0	3,371

Figure 2
Current Use of Contraception Use Among Currently Married Women by Background Characteristics



EDHS 1995

Large differentials in current use are also found across educational levels. The current use of family planning methods rises dramatically with level of education. Only 4 percent of women with no education use contraception, compared with 13 percent of women who have some primary education, and more than one-fourth (28 percent) of women who have completed the primary level of education. The highest level of use (40 percent) is among women with secondary or higher education. There is no consistent relationship between current use and the number of living children (see Table 5).

There are substantial differences in the types of methods women use. For example, urban women rely heavily on modern methods, especially the pill, while rural women use breastfeeding almost exclusively. Similarly, while women with no education tend to rely on breastfeeding only, those with some education increasingly use modern methods such as the pill and the IUD.

Source of Methods

Women who reported using a method of contraception at the time of the survey were asked where they last obtained their method. Table 6 and Figure 3 show that 78 percent of current users obtain their method from public sources. Private medical sources were reported by 17 percent of users; other private sources accounted for the remaining 5 percent of current users.

Table 6 Source of supply for specific modern methods

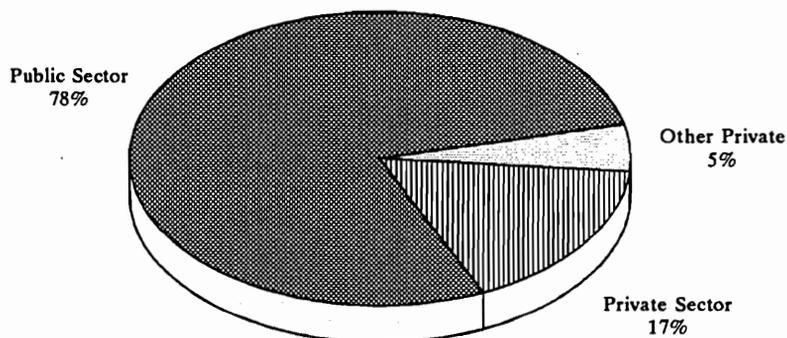
Percent distribution of current users of modern contraceptive methods by last source of supply, according to specific methods, Eritrea 1995

Source of method	Contraceptive method			All modern methods ¹
	Pill	IUD	Inject-ables	
Public	73.0	(93.2)	(91.5)	78.4
Government hospital	18.2	(20.3)	(23.9)	23.6
Government health center	19.7	(10.1)	(9.4)	15.1
Family planning clinic	35.1	(62.8)	(58.2)	39.7
Private medical	18.3	(6.8)	(8.5)	16.5
Private hospital/clinic	5.3	(3.4)	(2.4)	4.0
Pharmacy	11.1	(3.4)	(6.0)	11.6
Private doctor	1.9	(0.0)	(0.0)	0.9
Other private	8.7	(0.0)	(0.0)	5.0
Shop	0.0	(0.0)	(0.0)	0.3
Friends/relatives	6.2	(0.0)	(0.0)	3.0
Other	2.5	(0.0)	(0.0)	1.2
Missing	0.0	(0.0)	(0.0)	0.5
Total	100.0	100.0	100.0	100.0
Number of users	75	22	30	154

Note: Figures in parentheses are based on 25-49 cases.

¹ Includes one woman using vaginal methods, 20 women using condoms and 17 women using female sterilization

Figure 3
Sources of Family Planning Supply Among Current Users of Modern Methods



EDHS 1995

The Planned Parenthood Association of Eritrea clinic in Asmara is the predominant source of contraceptives in Eritrea, providing methods to 40 percent of current users of all modern methods; it supplies the majority of users of IUDs and injectables, and is the leading source for pill users (35 percent). Government hospitals and health clinics are also an important source of supply for modern methods users.

E. Fertility Preferences

Future fertility preferences of currently married respondents were determined by asking whether or not they wanted another child and, if so, how soon. While 73 percent of currently married women age 15-49 would like to have another child, only 21 percent want one within two years (see Table 7 and Figure 4). More than 50 percent would prefer to wait two or more years before having the next child. Eighteen percent say that they want no more children in the future. Thus, almost 7 in 10 currently married women want either to space their next birth or to end childbearing altogether. These women are potentially in need of some method of family planning.

Table 7 shows that the desire to limit births (want no more) is low among women below age 30 and then increases rapidly with age, from 15 percent among currently married women age 30-34 to 47 percent among the oldest women. The wish to have another child declines with age, but the proportion who wish to space the next birth plus the proportion who desire to limit family size is at least 65 percent among women under age 45, and 55 percent among the oldest cohort.

Among currently married men 15-59, the fertility preferences are in general very similar to the fertility preferences of women 15-49. A notable difference is the higher proportion of women than men who want no more children (18 percent vs 14 percent).

Table 7 Reproductive preferences by age

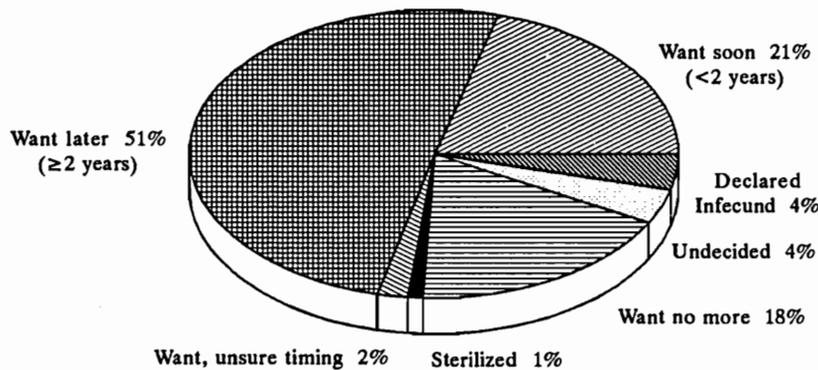
Percent distribution of currently married women and of currently married men by desire for more children, according to age, Eritrea 1995

Desire for children	Age of woman								Age of man								
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	Total
Want another																	
Within 2 years	21.2	20.6	20.2	23.8	21.5	20.2	15.9	20.6	(23.5)	27.4	25.4	33.1	14.6	20.8	21.9	17.8	23.4
After 2 years	69.5	69.5	69.7	53.6	40.7	29.1	8.1	51.0	(70.1)	67.2	67.2	55.7	67.6	40.7	27.8	20.4	52.3
Unsure when	1.1	2.1	1.7	2.4	1.7	0.6	0.3	1.5	(0.0)	1.7	0.0	0.0	1.9	1.4	0.6	0.0	0.8
Undecided^a	3.0	3.3	2.7	4.3	8.2	5.7	1.9	4.1	(6.4)	2.3	0.0	5.0	6.0	5.1	8.9	2.9	4.6
Want no more	3.7	3.8	5.6	14.8	24.8	36.5	47.4	17.9	(0.0)	1.5	7.4	5.6	8.5	30.0	29.8	28.4	14.1
Sterilized	1.3	0.2	0.0	0.3	0.7	0.9	0.6	0.5	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Woman infecund	0.2	0.1	0.2	0.3	1.8	6.9	25.9	4.1	(0.0)	0.0	0.0	0.0	0.7	1.4	11.0	28.3	4.3
Man infecund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	0.6	0.7	0.7	0.0	2.2	0.5
Missing	0.0	0.5	0.0	0.4	0.7	0.0	0.0	0.2	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	366	571	637	513	450	472	362	3,371	43	77	86	116	104	107	70	68	675

Note: Total for men includes 3 currently married men age 15-19. Figures in parentheses are based on 25-49 men.

^a Undecided whether want another child

Figure 4
Fertility Preferences of Currently
Married Women Age 15-49



EDHS 1995

F. Maternity Care

Proper care during pregnancy and delivery are important for the health of both the mother and the baby. In the EDHS, women who had given birth in the three years preceding the survey were asked a number of questions about maternal and child health care. For each birth in that period, the mothers were asked whether they had received tetanus toxoid injections while pregnant, whether they had obtained antenatal care during the pregnancy, and who assisted at the subsequent delivery. Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of death among infants in many developing countries.

Table 8 indicates that for one-third of births, the mothers received a tetanus toxoid injection during pregnancy. There are practically no differences by age of mother but mothers who live in urban areas are three times more likely to receive tetanus toxoid injections than those who live in rural areas. Striking differentials in protection against tetanus also exist by level of education and zone. Women with no schooling are much less likely to obtain a tetanus toxoid injection than women who have completed primary school (24 vs 80 percent). Mothers in the Central Zone are most likely to receive a tetanus toxoid injection, while those in the Southern Red Sea Zone are least likely. First births are more likely to benefit from tetanus toxoid injections, but differences between later births are small.

Table 8 Tetanus toxoid vaccination, antenatal care, and assistance at delivery

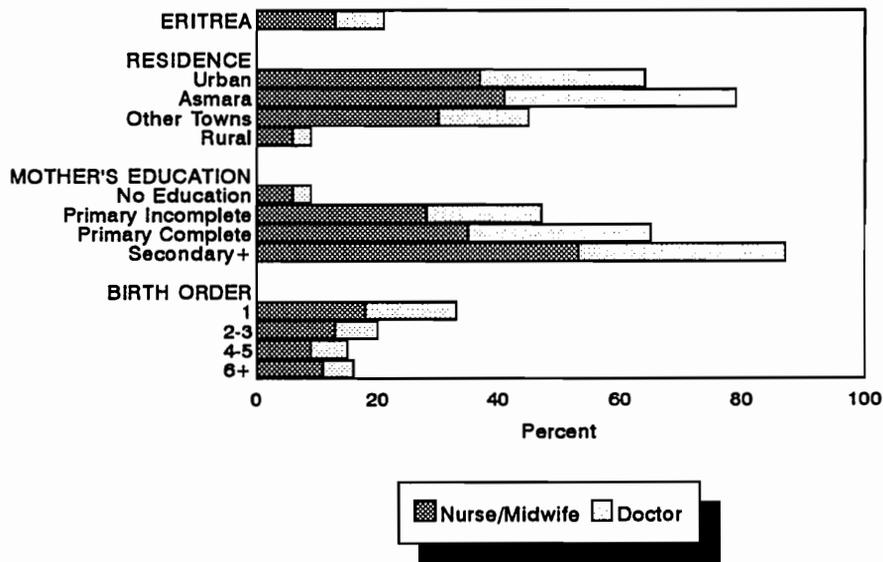
Among births in the three years preceding the survey, the percentage for which mothers received at least one tetanus toxoid injection during pregnancy, antenatal care from a doctor or trained nurse/midwife, and assistance at delivery from a doctor or trained nurse/midwife, by selected background characteristics, Eritrea 1995

Background characteristic	Received tetanus toxoid	Received antenatal care from:		Received assistance at delivery from:		Number of births
		Doctor	Nurse or midwife	Doctor	Nurse or midwife	
Mother's age at birth						
<20	35.9	22.9	23.3	9.6	13.2	417
20-34	33.7	25.6	24.5	8.2	13.2	1,622
35+	32.3	24.8	22.4	5.6	10.8	541
Residence						
Urban	71.1	40.9	44.4	26.9	36.5	542
Asmara	72.4	45.7	43.1	37.5	41.8	287
Other town	69.6	35.6	45.8	15.0	30.4	255
Rural	23.9	20.7	18.4	2.9	6.4	2,037
Zone						
Southern Red Sea	18.3	25.9	2.2	1.5	21.3	68
Northern Red Sea	23.2	14.7	23.1	3.0	10.6	341
Anseba	27.5	23.5	23.2	2.1	12.0	330
Gash-Barka	22.5	22.6	15.2	3.0	8.1	499
Southern	29.3	21.6	21.1	5.8	6.2	882
Central	69.4	42.6	42.9	26.0	31.1	459
Mother's education						
No education	23.9	20.4	18.7	3.2	6.3	1,987
Primary incomplete	58.8	34.8	39.4	18.6	27.9	359
Primary complete	79.5	51.4	39.2	29.5	34.7	119
Secondary+	79.7	46.9	49.3	33.6	53.0	115
Birth order						
1	40.3	26.7	26.2	14.8	18.1	584
2-3	33.7	26.6	22.2	7.0	12.9	790
4-5	32.0	21.6	23.3	5.7	8.5	562
6+	29.6	24.4	24.3	4.6	11.2	644
Total	33.8	25.0	23.9	7.9	12.7	2,580

For half of births in the three years before the survey, the mother reported that she received some antenatal care from a trained health worker; 25 percent from a doctor and 24 percent from a trained midwife (see Table 8). Differentials in obtaining antenatal care are similar to the differentials in tetanus toxoid injection coverage. For example, antenatal care was obtained for more than 9 in 10 births to mothers who had completed primary school or had higher education, compared with only 4 in 10 births to mothers with no education.

One in five births occurring in the same period was assisted at delivery by trained medical personnel: 8 percent by a doctor and 13 percent by a trained nurse or midwife (see Table 8 and Figure 5). As with the tetanus protection and the antenatal care coverage, medical assistance at delivery, especially by doctors, is higher for first births and births to urban women, educated women, and women living in the Central Zone.

Figure 5
Percentage of Births in the Three Years Preceding the Survey for
Which Mothers Received Assistance at Delivery from Medical Personnel



EDHS 1995

G. Vaccination of Children

In order to assist in the evaluation of the Expanded Program of Immunization (EPI), the EDHS collected information on vaccination coverage for all children born during the three years preceding the survey. The EPI considers a child fully vaccinated if she or he has received one dose of BCG vaccine, three doses each of DPT and polio vaccine, and one dose of measles vaccine.

Information on vaccination coverage was collected in two ways: from child vaccination cards shown to the interviewer and from mothers' verbal reports. If a mother was able to present a child's vaccination card, the interviewer recorded vaccination dates directly from the card. If all vaccinations were not recorded on the card or if no card was shown, the interviewer asked the mother to recall whether or not the child had received each vaccine. For DPT and polio antigens, the number of doses the child received was also asked.

Table 9 presents information on children one year of age (12-23 months), the age by which they should be fully vaccinated. Based on the information collected from vaccination cards and mothers' reports, 41 percent of children have received all the recommended vaccinations; almost the same proportion have not received any vaccinations (38 percent). With the exception of the newly introduced dose of polio vaccine at birth (polio 0), each type of antigen was received by approximately half of the children age 12-23 months. The EPI's goal was for 40 percent of children in the country as a whole to be fully vaccinated by 1995. Thus, the EPI met its goal for 1995.

Table 9 Vaccinations by background characteristics

Percentage of children 12-23 months who had received specific vaccines by the time of the survey (according to the vaccination card or the mother's report) and the percentage with a vaccination card, by selected background characteristics, Eritrea 1995

Background characteristic	Percentage of children who received:										Percent- age with a card	Number of children	
	BCG	DPT1	DPT2	DPT3	Polio0	Polio1	Polio2	Polio3	Measles	All ^a			None
Sex of child													
Male	61.5	61.7	55.2	48.9	21.2	61.3	55.6	46.7	52.4	41.6	37.0	50.3	371
Female	59.8	60.0	55.5	48.7	16.9	59.8	56.2	48.7	49.5	41.2	38.5	50.4	354
Residence													
Urban	94.7	94.4	91.3	87.1	55.3	94.7	92.3	84.5	87.0	79.0	3.9	80.1	161
Asmara	97.5	98.3	95.8	91.6	78.2	98.3	97.5	91.6	93.3	87.4	0.8	89.1	87
Other town	91.5	89.7	86.1	81.8	28.4	90.5	86.1	76.1	79.5	69.1	7.5	69.4	74
Rural	51.0	51.3	45.1	37.9	8.8	50.8	45.5	37.1	40.7	30.6	47.4	41.8	564
Zone													
Southern Red Sea	(21.7)	(21.7)	(21.7)	(21.7)	(17.9)	(21.7)	(21.7)	(21.7)	(21.7)	(21.7)	(78.3)	(17.9)	14
Northern Red Sea	32.0	31.8	27.6	23.7	7.1	30.3	28.8	24.2	27.8	20.2	65.7	15.8	103
Anseba	59.5	56.4	44.0	36.4	20.5	58.7	46.3	25.3	53.5	24.5	40.5	51.5	82
Gash-Barka	30.1	30.4	21.4	15.3	3.9	31.7	23.0	16.3	19.7	10.3	67.9	22.5	137
Southern	71.0	72.2	68.6	59.7	12.9	71.0	67.4	59.3	55.9	49.0	27.0	58.8	248
Central	97.7	98.2	95.1	90.2	52.9	97.4	96.2	90.2	91.3	85.3	1.3	90.2	141
Mother's education													
No education	50.8	51.1	45.2	38.5	10.6	51.0	46.0	37.7	41.9	32.3	47.4	42.4	550
Primary incomplete	91.7	90.7	84.6	75.9	35.6	89.2	83.0	73.3	74.9	62.2	8.3	73.4	103
Primary complete	(88.6)	(90.9)	(90.9)	(86.4)	(53.5)	(90.9)	(90.9)	(80.8)	(77.0)	(72.6)	(9.1)	(75.3)	33
Secondary+	(94.6)	(94.6)	(90.8)	(90.8)	(66.4)	(94.6)	(94.6)	(92.7)	(94.6)	(88.9)	(3.5)	(79.7)	39
Total	60.7	60.9	55.3	48.8	19.1	60.6	55.9	47.7	51.0	41.4	37.7	50.3	725

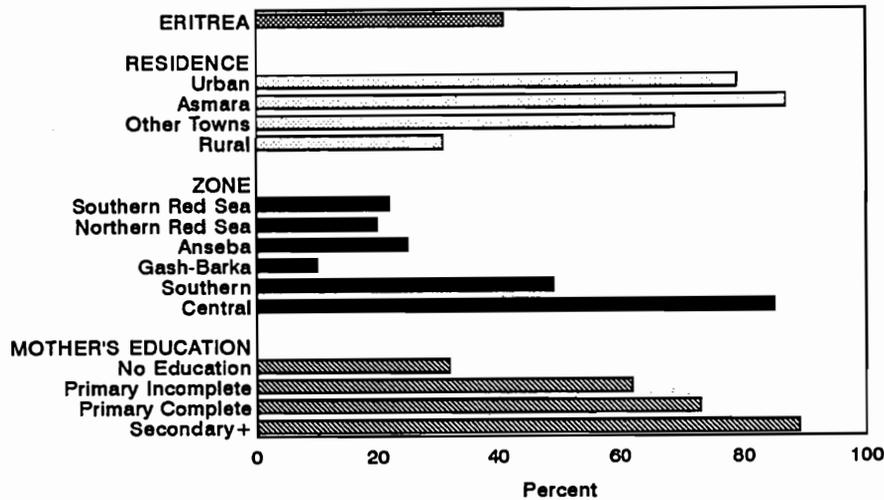
Note: Figures in parentheses are based on 25-49 cases.

^a Children who are fully vaccinated (i.e., those who have received BCG, measles and three doses of DPT and polio)

The vaccination program is highly successful in Asmara, where almost all children received some vaccination and 87 percent have been fully vaccinated. In other towns in Eritrea, only 8 percent of children have not received any vaccination and 69 percent have received all of the recommended vaccines. In rural areas, only 31 percent of children are fully vaccinated.

Male and female children are equally likely to be fully vaccinated, but vaccination coverage varies greatly by zone. Ten percent of children age 12-23 months are fully vaccinated in Gash-Barka, compared with 49 percent in the Southern Zone and 85 percent in the Central Zone (which includes Asmara) (see Figure 6). Immunization coverage improves substantially as the mother's level of education increases. Full immunization of children of women with no education is only 32 percent, compared with 62 percent and 89 percent for children whose mothers had some primary school or attended secondary school, respectively.

Figure 6
Percentage of Children Age 12-23 Months
Who Have Received All Vaccinations



EDHS 1995

H. Childhood Diarrhea

It is well known that diarrhea is one of the major causes of mortality among young children. A simple and effective response to dehydration caused by the disease is a prompt increase in fluid intake, i.e., oral rehydration therapy (ORT).

In the EDHS, for each living child born in the last three years, the mother was asked whether the child had had a bout of diarrhea in the last two weeks and whether the child was given any ORT to combat dehydration. Table 10 shows the prevalence of diarrhea in children under three years of age, and the percentage of children with diarrhea who were given some form of ORT. About one-fourth of children had diarrhea during the two-week reference period. Diarrheal prevalence is higher among children over six months of age and highest among those 6-11 months old. Boys and girls are equally likely to suffer.

Table 10 Prevalence of diarrhea and use of oral rehydration therapy

Among children under three years of age, the percentage reported by the mother to have had diarrhea in the past two weeks, and of those with diarrhea the percentage who were treated with ORS packets or recommended home fluids (RHF), by selected background characteristics, Eritrea 1995

Background characteristic	Diarrhea in past 2 weeks	Use of oral rehydration therapy			Number of children
		ORS packets	RHF	ORS or RHF	
Age of child					
< 6 months	12.5	11.7	12.7	21.1	448
6-11 months	34.2	31.5	7.9	34.3	430
12-23 months	27.1	45.8	14.9	50.5	725
24-35 months	21.0	26.0	8.8	31.0	821
Sex of child					
Male	22.7	33.0	13.7	37.9	1,242
Female	24.5	32.6	8.5	37.2	1,182
Residence					
Urban	17.8	68.2	13.2	70.9	500
Asmara	15.9	74.1	15.5	75.9	266
Other town	19.9	62.7	11.1	66.3	233
Rural	25.1	26.3	10.6	31.4	1,925
Zone					
Southern Red Sea	39.1	40.7	18.3	45.3	59
Northern Red Sea	23.4	40.6	7.8	42.8	317
Anseba	15.0	26.8	6.9	26.8	314
Gash-Barka	29.7	26.7	20.7	38.0	461
Southern	26.1	25.3	4.8	28.5	841
Central	16.3	61.5	15.5	64.1	432
Mother's education					
No education	25.4	27.6	10.8	33.3	1,868
Primary incomplete	17.3	53.4	12.0	53.4	338
Primary complete	19.0	63.6	4.4	63.6	111
Secondary+	15.4	71.4	22.3	71.4	107
Total	23.6	32.8	11.0	37.6	2,424

ORS = Oral rehydration salts

RHF = Recommended home fluids (i.e., sugar-salt-water solution)

The prevalence of diarrhea is higher among rural than urban children. The highest prevalence of the disease is reported in the Southern Red Sea Zone (39 percent) and the lowest in Anseba and Central Zones (15-16 percent). Children of women with no education are reported to experience higher rates of diarrhea than children of women with some education.

Thirty-three percent of children with diarrhea were treated with a solution prepared from oral rehydration packets and 11 percent received recommended homemade fluids (RHF), i.e., a homemade sugar-salt-water solution. Sixty-two percent of children with diarrhea were not given any ORT.

Treatment of diarrhea differs slightly by the sex of the child but young infants are less likely to be treated with ORS packets than those age 6-23 months. Urban children (71 percent), children in the Central Zone (64 percent), and children of mothers with primary complete or higher education (64-71 percent) are most likely to be treated with ORT. About 4 in 10 children with diarrhea in the Southern Red Sea, Northern Red Sea and Gash-Barka Zones are likely to receive rehydration treatment. Less than 3 in 10 children with diarrhea in the Anseba and Southern Zones are treated with either ORS packets or RHF.

I. Infant Feeding Practices

Breast milk is an essential source of nutrition and provides immunological protection for infants and young children. All of the nutrients that a baby requires in the early months of life can usually be provided by breast milk alone. At a later stage of the baby's development, breast milk should be supplemented by other liquids and eventually by solid or mushy food to provide adequate nourishment.

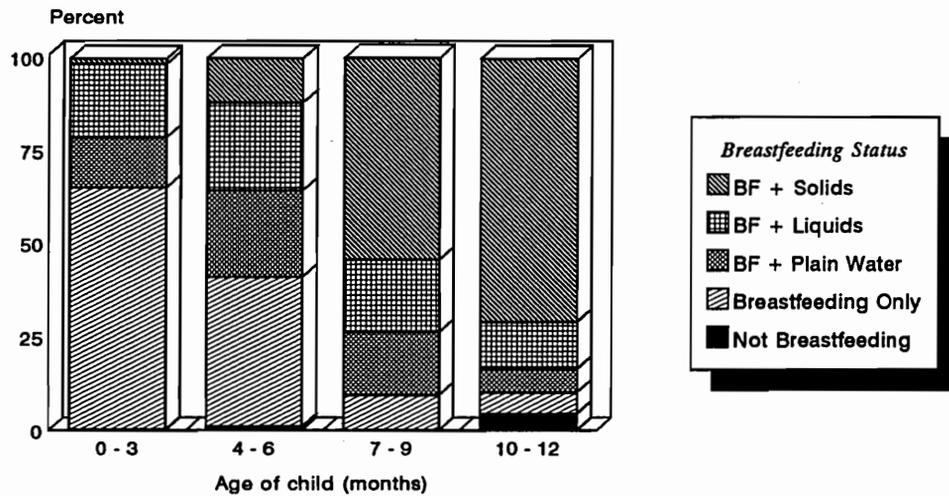
The EDHS collected data on infant feeding for all children born in the three years preceding the survey. As shown in Table 11 and Figure 7, almost all mothers breastfeed their children through the first 12 months of life. Among infants 0-3 months, more than two-thirds are exclusively breastfed; however, sometimes breast milk is supplemented with plain water (14 percent) or with other liquids (20 percent). By age 7-9 months, more than half of children are given solid or mushy food. Three in ten children age 10-12 months who are breastfed are not given solid or mushy food. Only 4 percent of infants are fed using a bottle with a nipple.

Table 11 Breastfeeding and supplementation

Percent distribution of children age 0-12 months by current breastfeeding status, food supplementation, and use of a bottle with a nipple, according to age, Eritrea 1995

Age	Not currently breastfeeding	Breast milk only	Breast milk and:			Total	Use a bottle with a nipple	Number of children
			Plain water only	Other liquid	Solid/mushy food			
0-3 months	0.2	65.0	13.5	19.7	1.5	100.0	2.9	313
4-6 months	1.2	40.2	23.2	23.6	11.9	100.0	4.6	214
7-9 months	0.0	9.5	17.0	19.4	54.2	100.0	3.4	213
10-12 months	4.5	5.7	6.3	12.7	70.7	100.0	4.8	200
0-12 months	1.3	34.2	15.0	19.0	30.5	100.0	3.8	940

Figure 7
Percent Distribution of Infants by Breastfeeding Status, According to Age of Child



EDHS 1995

J. Knowledge of AIDS

Acquired immune deficiency syndrome (AIDS) is a disease that has become a serious public health concern in many countries. To investigate the general level of knowledge of AIDS, all respondents in the EDHS were asked a series of questions about awareness of the disease, sources of information about AIDS, and knowledge of ways to avoid AIDS.

Knowledge of AIDS is widespread but not universal among Eritrean women; 72 percent know about AIDS (see Table 12.1). Knowledge of AIDS is higher among young women (below age 25) than among older women and higher among those currently not married than those currently married. Knowledge is almost universal among urban women and also among educated women, while only about 60 percent of rural women and those with no education have heard of AIDS. Only 4 in 10 women in Gash-Barka, 6 in 10 in Southern Red Sea, Northern Red Sea, and Anseba know about AIDS, while 8 in 10 in the Southern Zone and almost all women in the Central Zone have heard of AIDS.

Among women who know about AIDS, only 5 percent reported that there was no way to avoid the disease. Almost half of the female respondents (47 percent) believe that limiting partners prevents the spread of the disease and one-fifth (22 percent) think that AIDS can be avoided by abstaining from sex. Overall, one-third of women reported that condom use can prevent AIDS and about one-fourth each said that avoiding sex with prostitutes and avoiding injections can prevent acquiring the AIDS virus.

Table 12.1 Knowledge of AIDS and knowledge of ways to avoid AIDS: women

Percentage of women who have heard of AIDS and among those who know about AIDS the percentage mentioning specific ways to avoid AIDS and the percentage with misinformation, by background characteristics, Eritrea 1995

Background characteristic	Know about AIDS	Ways to avoid AIDS								Percent- age with any misin- formation ¹	Number of women
		No way to avoid AIDS	Abstain from sex	Use condoms	Have only one sexual partner	Avoid sex with prostitutes	Avoid sex with homo- sexuals	Avoid trans- fusions	Avoid injec- tions		
Age											
15-19	82.1	4.6	21.9	40.4	46.8	23.6	1.4	17.5	26.4	4.4	1,129
20-24	76.5	4.3	23.4	45.3	50.4	21.9	1.0	15.8	25.9	2.6	823
25-29	69.4	5.7	21.9	37.7	49.0	25.0	1.4	11.9	21.6	1.8	782
30-34	65.9	3.4	19.1	33.2	49.1	23.9	0.7	14.9	24.9	2.6	638
35-39	69.8	4.4	24.6	28.7	48.2	20.9	1.1	13.8	23.1	2.1	562
40-44	66.3	4.5	25.1	22.4	43.7	27.4	0.7	11.8	20.6	1.5	603
45-49	65.4	6.9	20.8	16.6	41.1	22.3	0.4	13.1	21.2	1.5	518
Marital status											
Never married	86.6	3.0	28.9	51.0	48.5	22.4	1.2	17.8	28.3	5.5	1,009
Currently married	66.3	5.8	18.9	27.8	46.8	23.9	0.9	14.5	23.1	1.7	3,371
Formerly married	80.3	3.5	26.0	35.9	47.5	23.9	1.4	10.0	20.4	2.1	674
Residence											
Urban	97.2	1.3	34.2	51.6	47.9	20.7	1.5	18.0	29.3	4.2	1,648
Asmara	98.7	0.9	37.2	53.3	48.6	19.3	1.8	19.9	32.7	5.2	1,059
Other town	94.5	2.0	28.6	48.4	46.6	23.4	0.9	14.5	23.0	2.2	589
Rural	60.1	7.5	13.1	21.3	46.8	25.8	0.7	12.0	19.8	1.5	3,406
Zone											
Southern Red Sea	61.7	10.9	44.5	47.5	16.1	5.3	0.6	2.3	4.7	3.5	139
Northern Red Sea	57.3	5.9	24.5	22.4	28.3	20.0	1.0	5.3	11.7	1.8	556
Anseba	62.9	2.8	16.9	20.1	48.6	9.6	0.2	8.4	10.4	1.6	642
Gash-Barka	41.0	7.4	18.7	30.0	44.3	26.4	0.2	11.2	22.0	1.3	957
Southern	79.7	8.4	10.5	27.6	48.8	33.6	1.0	19.3	29.7	1.9	1,392
Central	98.0	1.0	33.0	48.1	53.0	20.6	1.7	16.6	28.0	4.1	1,368
Education											
No education	58.9	7.7	16.2	16.1	40.1	23.6	0.4	11.5	19.3	1.3	3,332
Primary incomplete	96.0	2.5	25.4	45.3	54.8	26.2	1.6	14.1	25.5	2.6	786
Primary complete	99.3	0.5	29.7	60.8	55.5	22.1	0.9	18.7	28.8	4.4	435
Secondary+	99.9	0.1	35.5	67.9	56.8	20.6	2.9	24.3	35.5	6.3	501
Total	72.2	4.8	22.4	34.6	47.3	23.5	1.1	14.6	24.0	2.6	5,054

¹ Includes avoiding mosquito bites and kissing; seeking protection from a traditional healer.

Knowledge of AIDS is higher among male respondents (89 percent) than female respondents. Differentials by age, residence, zone, and education are similar to those for female respondents, but not as pronounced (see Table 12.2).

The same proportion of male and female respondents mentioned use of condoms as a way to avoid getting AIDS. However, a smaller proportion of men (41 percent) than women believe having one sexual partner is a way to avoid AIDS, while a larger proportion of men than women mentioned abstaining from sex (28 percent), avoiding sex with prostitutes (27 percent), and avoiding blood transfusions (25 percent).

Table 12.2 Knowledge of AIDS and knowledge of ways to avoid AIDS: men

Percentage of men who have heard of AIDS and among those who know about AIDS the percentage mentioning specific ways to avoid AIDS and the percentage with misinformation, by background characteristics, Eritrea 1995

Background characteristic	Know about AIDS	Ways to avoid AIDS							Percent- age with any misin- formation ¹	Number of women	
		No way to avoid AIDS	Abstain from sex	Use condoms	Have only one sexual partner	Avoid sex with prosti- tutes	Avoid sex with homo- sexuals	Avoid trans- fusions			Avoid injec- tions
Age											
15-19	89.4	2.5	25.4	45.9	39.8	17.7	1.9	23.3	33.0	4.7	237
20-24	93.2	2.1	36.4	55.0	48.5	22.1	5.2	28.6	36.4	6.5	142
25-29	94.7	0.6	29.7	43.4	41.6	31.8	3.6	29.4	35.0	4.3	127
30-34	86.6	0.0	29.1	29.1	43.3	32.9	1.6	33.7	49.9	7.6	102
35-39	88.2	0.0	34.3	32.4	44.8	23.1	1.1	30.2	38.0	1.8	125
40-44	84.0	0.9	22.3	25.2	27.7	37.3	0.7	21.1	31.3	7.2	117
45-49	89.2	4.1	22.5	28.6	39.8	25.4	1.3	20.2	33.5	6.7	113
50-54	83.8	0.0	27.8	14.9	47.1	44.5	3.9	19.9	31.7	3.3	77
55-59	81.7	3.0	24.5	12.6	29.9	33.0	1.2	17.0	27.6	4.2	73
Marital status											
Never married	91.7	1.7	29.6	52.1	44.7	21.4	3.3	26.7	36.1	4.6	390
Currently married	87.0	1.6	27.1	25.8	39.8	29.6	1.9	23.7	34.8	5.8	675
Formerly married	(86.4)	(0.0)	(31.3)	(39.6)	(21.3)	(47.1)	(1.7)	(34.6)	(34.2)	(1.7)	50
Residence											
Urban	99.1	0.4	31.1	53.6	51.4	25.6	3.0	35.9	41.6	6.4	356
Asmara	100.0	0.6	31.0	53.5	53.8	24.1	3.5	39.9	44.6	7.3	229
Other town	97.3	0.0	31.4	53.8	47.0	28.5	2.0	28.5	36.1	4.8	127
Rural	83.7	2.2	26.6	26.1	34.8	28.4	2.0	19.4	31.7	4.5	758
Zone											
Southern Red Sea	92.8	0.0	64.5	50.5	16.4	1.3	1.3	3.0	2.7	0.0	39
Northern Red Sea	89.4	0.9	13.2	25.8	42.7	42.0	0.0	19.0	35.5	3.1	110
Anseba	89.7	1.5	14.2	30.5	37.6	62.1	7.7	32.7	54.3	16.7	133
Gash-Barka	67.2	1.8	26.9	13.8	19.3	29.5	0.0	31.9	42.9	2.5	233
Southern	92.3	3.3	36.6	31.3	36.7	6.5	0.0	3.5	4.9	0.7	286
Central	100.0	0.5	27.7	54.5	58.3	29.0	4.3	42.1	53.4	7.1	312
Education											
No education	83.4	2.0	28.0	27.9	33.7	27.1	1.5	18.6	28.4	4.4	746
Primary incomplete	98.8	2.0	28.6	46.3	47.3	26.4	3.0	34.5	47.7	5.6	173
Primary complete	100.0	0.0	26.9	52.0	52.4	32.0	5.3	41.2	50.9	5.7	95
Secondary+	99.3	0.0	29.8	52.9	62.7	26.6	3.7	36.0	41.3	8.7	100
Total	88.6	1.6	28.2	35.9	40.7	27.4	2.4	25.3	35.2	5.2	1,114

¹ Includes avoiding mosquito bites and kissing; seeking protection from a traditional healer.

Preliminary Reports Demographic and Health Surveys

DHS-II

Paraguay	October	1990	(Spanish)
Colombia	October	1990	(Spanish)
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Indonesia	November	1991	(English)
Dominican Republic	December	1991	(Spanish)
Peru	April	1992	(Spanish)
Zambia	July	1992	(English)
Tanzania	September	1992	(English)
Yemen	September	1992	(English)
Morocco	September	1992	(French)
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Rwanda	February	1993	(French)
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DHS-III

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