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WOMEN'S LIVES AND EXPERIENCES: CHANGES IN THE PAST TEN YEARS

RESEARCH FINDINGS FROM THE DEMOGRAPHIC AND HEALTH SURVEYS

June 2006

This publication was produced for review by the United States Agency for International Development. It was prepared by Daniel Vadnais, Adrienne Kols, and Noureddine Abderrahim of ORC Macro.

WOMEN'S LIVES AND EXPERIENCES: CHANGES IN THE PAST TEN YEARS

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The Demographic and Health Surveys (DHS) program assists countries worldwide in conducting national surveys on fertility, family planning, maternal and child health, nutrition, and HIV/AIDS. Data from DHS surveys enable policymakers in developing countries to make crucial decisions about how to allocate resources and provide health services to those most in need. DHS surveys are funded primarily by the United States Agency for International Development under the MEASURE DHS project, which is administered by ORC Macro.

In addition to helping individual countries with their data needs, the DHS program provides an unparalleled body of comparative data for use by researchers around the world. This comparative report on "Women's Lives and Experiences" is the result of an analysis of DHS data on women in many countries. Further information about the DHS program and the MEASURE DHS project can be obtained by contacting:

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DHS publications and DHS data sets are available at no cost on the MEASURE DHS website (www.measuredhs.com). In addition, tools on the website allow users to access and compare DHS data directly. The STATcompiler and the HIV/AIDS Survey Indicators Database are two on-line databases that allow users to build specific tables from DHS surveys and indicators. The STATmapper is an interactive mapping tool that allows users to create maps quickly from a DHS database of findings from more than 75 countries.

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PREFACE

PRESIDENT ELLEN JOHNSON SIRLEAF

Mrs. Ellen Johnson Sirleaf's election victory was formally announced by the Liberian elections commission on November 23, 2005. On Monday 16 January, 2006, she officially became the first democratically-elected female Head of State in the history of the African continent.

I am a woman, a mother of four, a grandmother of eight. I look to the day when women of Liberia, women of Africa and women throughout the world have equal access, rights and opportunities to education, health and employment. I look to the day when they can wake up in the morning and feel safe, free, healthy and equal citizens.

I strongly believe that women have the skills, abilities and instinct to make our world a better place to live, if only given the chance. Throughout my career, and now as President, I have worked to improve the lives of women throughout Liberia and Africa. It is through them that our societies will grow; it is through them that our communities will move forward; and it is through them that our families will nurture both the very young and the very old.

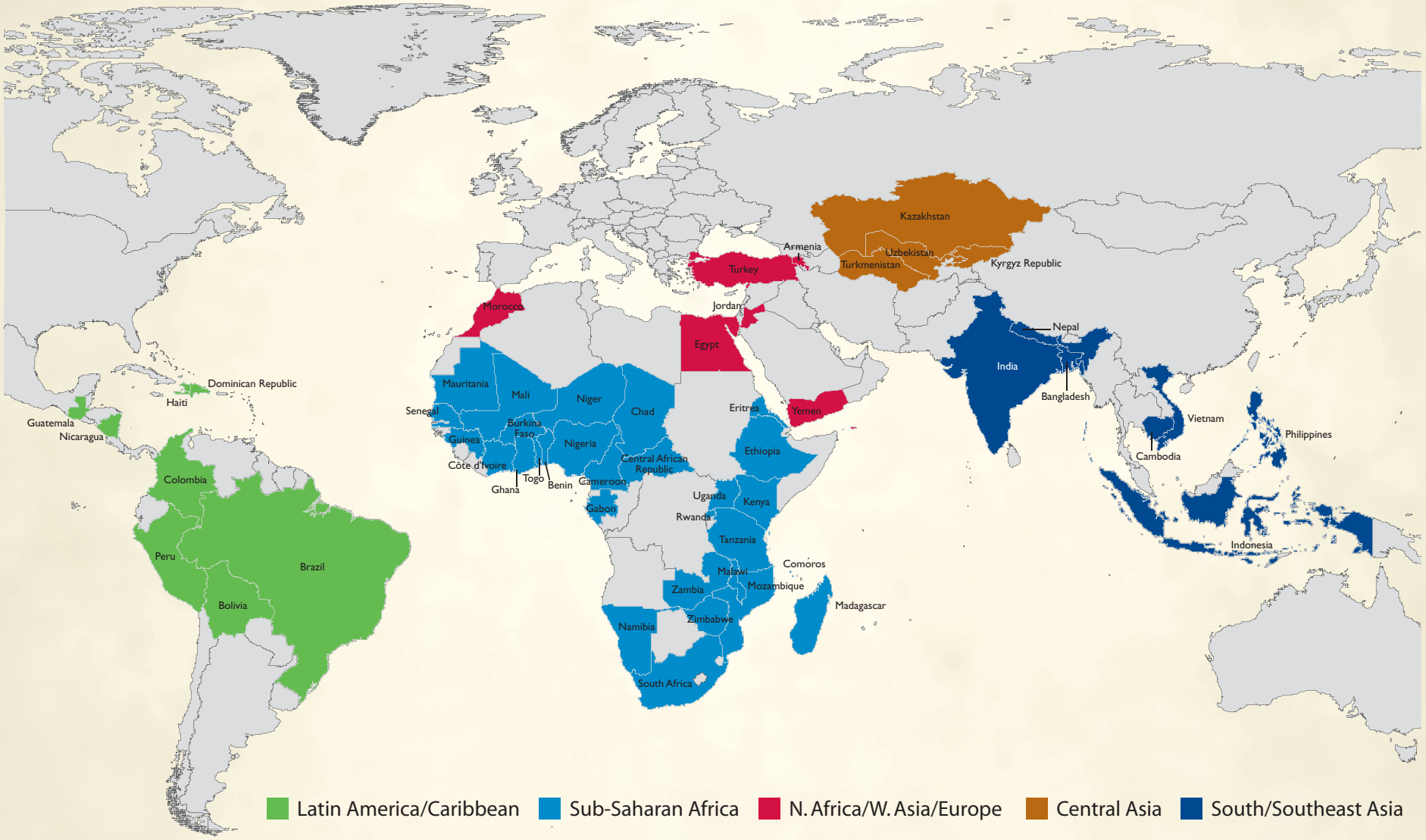
It is time for women everywhere to make their voices heard. And it is time for everyone to listen to what they have to say. While change is slow, progress is undeniable. Around the world, more women are learning how to read and more are finishing primary school. Still, most women do not have the chance to go to secondary school. Still only a small number attend university. The loss of so much potential is a tragedy for Africa and for the world.

The Demographic and Health Surveys (DHS) program helps us track women's progress and gives us the data to demand that more be done. Many years ago, too long ago to be included in this report, the women of Liberia were the first women of Africa, and among the first in the world, to participate in the DHS program. Now, two decades later, after much turmoil, Liberia is again hosting another DHS. This survey will serve as a baseline for the new Liberia and for all the work that lies ahead.

Women's Lives and Experience: Changes in the Past Ten Years provides information about women from 54 countries around the world. It also shows us how much work, commitment, and focus is needed to enable more women to become equal partners to better face the challenges of the twenty-first century.

All in all I am glad I am a women and I think in Liberia today as well as in Africa and in the rest of the world, it is time for women to show what they can do.

COUNTRIES INCLUDED IN THIS REPORT



OVERVIEW

In 1994, delegates to the International Conference on Population and Development in Cairo laid out an ambitious twenty-year plan to transform women's lives around the world by advancing women's reproductive and sexual health and rights. They hoped to reshape every aspect of women's experiences in the process: to encourage women's participation in every sphere of life, to further gender equality, and to maximize women's physical, emotional, and social well-being. One year later, nations around the world reaffirmed their commitment to improving the status of women at the Fourth World Conference on Women in Beijing.

Over a decade later, where do women stand? To what extent have global efforts to advance women's health and rights transformed women's everyday experiences—at home and in the larger community—and the events that shape their lives, such as marriage and birth?

To answer these questions, we turn to one of the world's largest sources of information on women, the Demographic and Health Surveys (DHS) program. Since 1984 DHS surveys have provided a statistical portrait of women's lives and experiences in about 80 developing countries. The results of these nationally representative surveys are a vital resource for decision-makers worldwide who seek to understand the challenges that women face and to improve their health and well-being. The surveys also provide information on basic national indicators of social progress, such as fertility, maternal and child health, and educational attainment.

This report on *Women's Lives & Experiences* summarizes findings from DHS surveys in 54 countries. While the largest group of countries comes from Sub-Saharan Africa, every region of the developing world is represented. Many aspects of women's lives and experiences are examined, including access to education, marriage, childbearing, nutrition, domestic violence, HIV/AIDS, health care, and home life. Charts, maps, and tables display findings from the survey conducted most recently in each country; these range from 1994 to 2005.

The report also examines trends for some indicators. This information comes from 41 countries that have hosted two or more DHS surveys since 1991. For the most part, these surveys are spaced 4 to 6 years apart and cover the period from 1995 to 2005, so the changes documented are both recent and short-term. In 6 countries, however, the interval between surveys is longer, ranging from 7 to 11 years, which should be taken into consideration when comparing progress between countries.

KEY FINDINGS

DHS data show that conditions have improved for women in most countries and in many different ways. However, the pace of change varies widely between and within regions, and in some countries recent trends are actually detrimental to women's health and well-being. Much has already been accomplished, and much remains to be done. Key findings include:

- **Education:** Although women's access to primary education has increased, in 17 countries more than one-third of young women ages 15 to 24 have never attended school. Higher education remains out of reach for the great majority of women in the developing world: in 40 countries less than one-quarter of reproductive age women have completed secondary school.
- **Relationships:** Early marriage remains common in some countries even though the median age at first marriage has generally increased. The median age at first sexual intercourse is earlier than the median age at first marriage in all but 7 of 45 countries surveyed: clearly many women begin having sex before marriage.
- **Childbearing experiences:** Several trends have combined to reduce the proportion of high-risk births: in most countries teenage pregnancy rates are declining, the intervals between births are growing wider, and both desired and actual family size are shrinking. However, maternal mortality remains a pressing problem: in 22 countries more than 500 women die from pregnancy-related causes for every 100,000 live births.
- **Childbearing choices:** Increased use of modern contraceptives has contributed to a decline in unplanned pregnancies in most countries. Still more than one-third of recent births were unplanned in 24 countries; less than one-fifth of women use modern methods in 24 countries; and more than one-fifth of women have an unmet need for contraception in 29 countries.
- **Health status:** Overnutrition is more common than undernutrition in three-quarters of the 50 countries surveyed. Domestic violence is widespread, with one-fifth to one-half of married women reporting that their husbands or partners have physically or sexually abused them in the 12 surveys that probed this issue.
- **HIV/AIDS:** The prevalence of HIV is higher among women than men in nearly all countries surveyed, but most women are not familiar with three basic strategies to avoid being infected. Less than half of married women have discussed AIDS prevention with their husbands in 20 countries. In 14 countries, over one-quarter of young women ages 15 to 24 had higher risk sex in the past year—usually without a condom.
- **Access to health care:** During their most recent pregnancy, less than half of women received adequate antenatal care in 32 countries, and less than half were attended by a skilled provider at childbirth in 30 countries. Access to these services has declined in about one-third of the countries surveyed.
- **Household environment:** Lack of household amenities, especially piped water, adds to women's chores while also posing health risks. Indoor air pollution caused by cooking with biomass fuels also threatens the health of many women.
- **Home life:** A majority of women regularly participate in most household decisions in over half of countries surveyed, but women have little or no influence on those decisions in 8 countries. In 29 countries over half of all reproductive age women work outside the home, often for cash. Over half of women regularly listen to the radio, watch television, or read a newspaper or magazine in 43 countries.

NOTES ON THE DATA

DHS data are not available for every indicator in every country despite the fact that DHS surveys employ standard questionnaires throughout the world. Sometimes countries decide not to ask questions for which they have recent and reliable data. Also, certain practices, such as female genital cutting, are common only in some parts of the world. Therefore this report lists the number of countries surveyed for each indicator—that is, the number of countries for which data have been collected for that specific indicator.

Because most of the graphs in this report present rounded numbers, they sometimes obscure small increases or decreases in an indicator. For example, in India the percentage of unwanted births increased from 8.8 percent in 1992-93 to 9.4 percent in 1998-99. The graph rounds both numbers to 9 percent. The discussion of trends in the accompanying text, however, counts this as an increase.

This report presents complete country data for most indicators in charts, maps, or tables. However, space limitations preclude presenting the country data for every indicator discussed in the text. In these cases, the text notes that the data are not shown.

Because data were specially analyzed for this report, data presented here may differ from other DHS publications or from data generated by the STATcompiler. In some cases, the reference period or another element in an indicator's definition has been changed to ensure that data collected from different countries over many years is comparable. In other cases, indicators have been redefined to shed greater light on key issues facing women.

EDUCATION

Half or more of women have never attended school in 17 of 54 countries surveyed

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In 40 of 53 countries surveyed, less than one-quarter of women have completed secondary school or gone on to higher education.

ACCESS TO EDUCATION AND LITERACY

Education affects almost every aspect of a woman's life, from health and employment to marriage and fertility. Education can expand women's opportunities in life and equip them to take better care of their families. More educated women generally enjoy better health themselves, have healthier children, and live in healthier environments.

According to UNESCO, girls make up 55 percent of all children not enrolled in primary school worldwide, indicating the continued existence of a gender gap in education.[1] However, the situation varies widely by region, and many nations, even in the developing world, have achieved gender parity in primary education.

DHS data show that access to education remains limited for women in many countries. In 17 of 54 countries surveyed, half or more of women ages 15 to 49 have never attended school.

Women in Central Asia and Latin America and the Caribbean are the most likely to have some education. At least 7 out of 10 women have attended school in every country in these regions. Education is virtually universal for women in Kazakhstan, the Kyrgyz Republic, Turkmenistan, and Uzbekistan.

In other regions women's access to education varies widely. In Sub-Saharan Africa, for example, about 80 percent of reproductive age women in Burkina Faso, Guinea, Mali, and Niger have never been to school. In contrast, less than 10 percent of women in Gabon, Namibia, South Africa, and Zimbabwe lack education.

Literacy is one of the most important benefits of education. But having attended school does not always guarantee that women can read. In 41 of 49 countries surveyed, the percentage of women ages 15 to 49 who cannot read exceeds the percentage with no education (data on literacy are not shown). The gap is widest in Sub-Saharan Africa. For example, 38 percent of women in Zambia cannot read although only 12 percent have never been to school. Likewise, in Mozambique 62 percent of women cannot read but only 41 percent lack schooling.

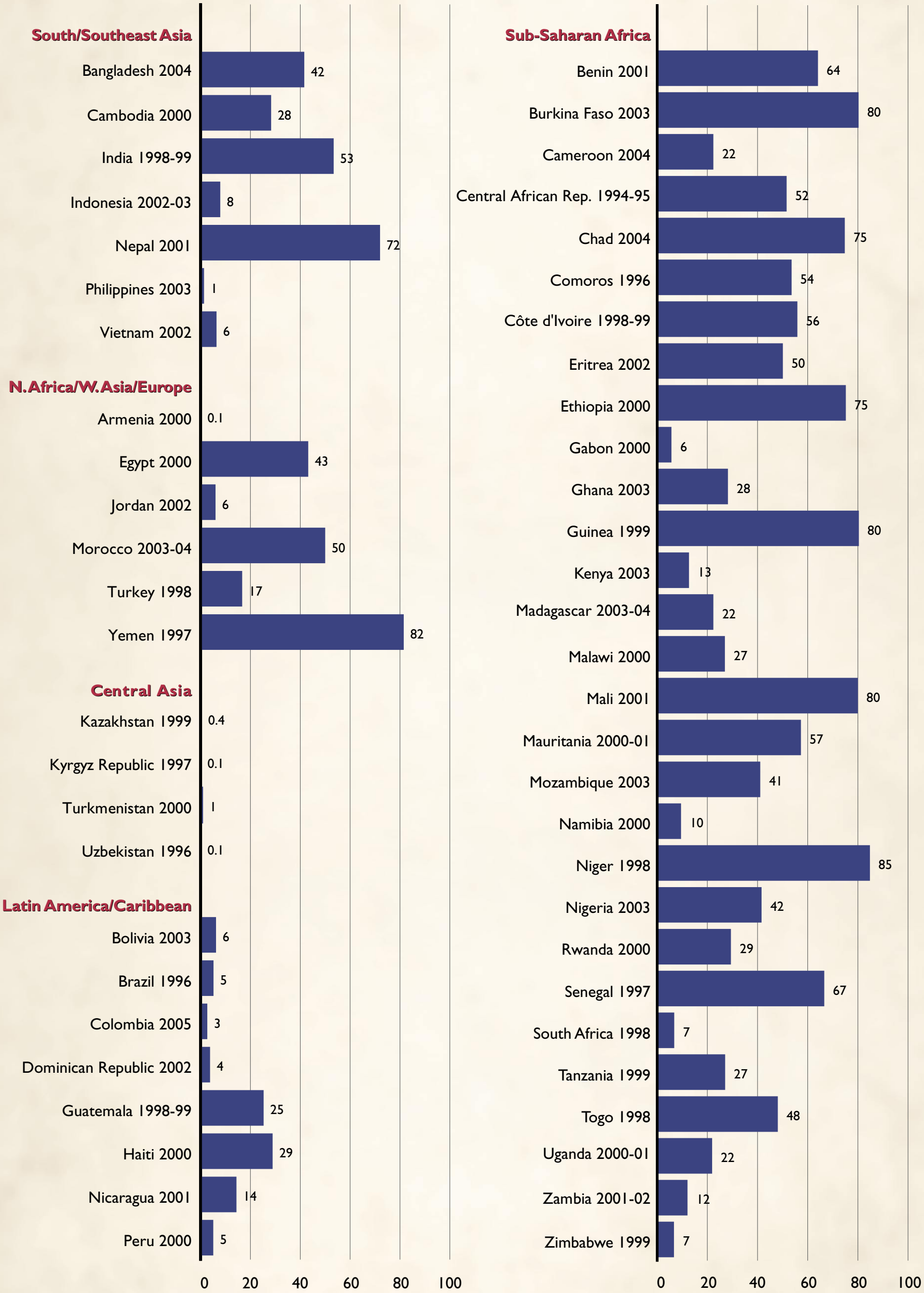
Women are most likely to be able to read in Central Asia and Latin America and the Caribbean: at least 85 percent of women can read in every country in these regions, with the exception of Guatemala and Haiti. Elsewhere literacy rates for women are lower. In 19 of 49 countries surveyed, mostly in South/Southeast Asia and Sub-Saharan Africa, over half of women cannot read. Female literacy rates are lowest in Burkina Faso, Chad, Guinea, Mali, Niger, and Yemen, where more than 80 percent of women cannot read.

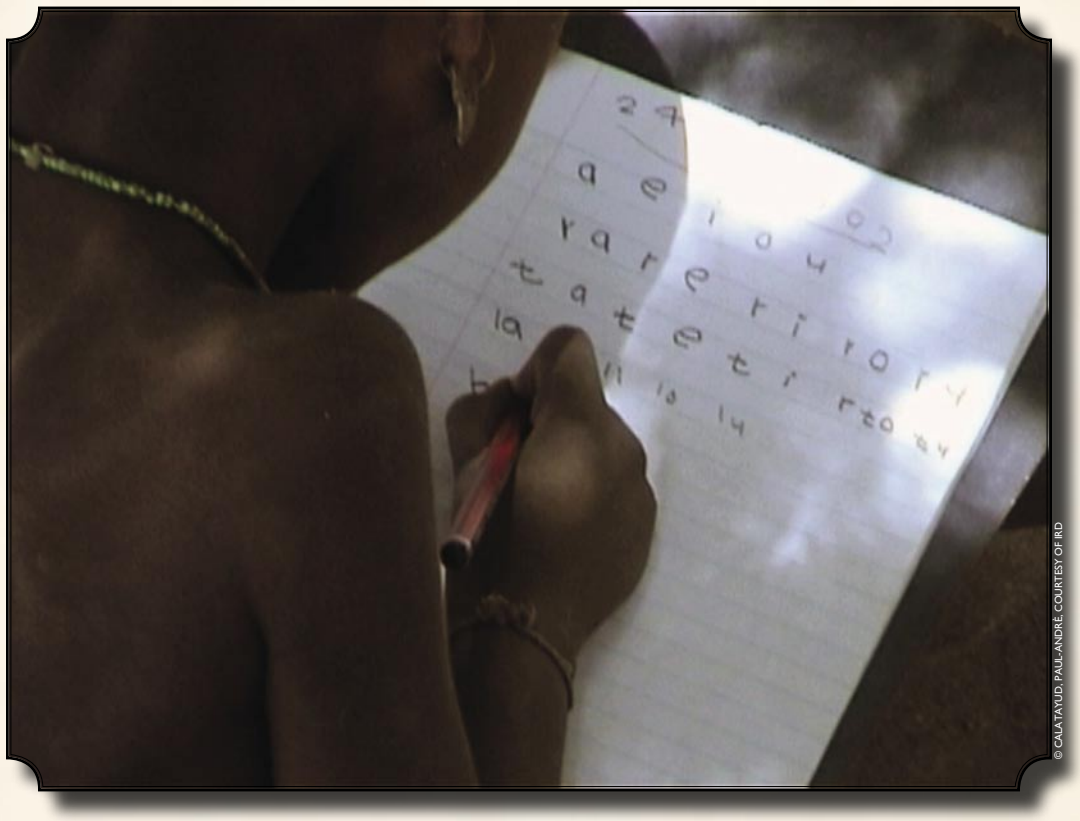
[1] UNESCO. *Literacy for Life: 2006 Education for All Global Monitoring Report.* Paris: UNESCO, 2005.

Defining access to education: Women are considered to have had access to education if they ever attended school.

Defining literacy: Since 1997 DHS surveys have assessed literacy by asking women to read a simple sentence. Women are considered literate if they can read part or all of the sentence. Women with secondary or higher schooling are automatically considered literate. Earlier DHS surveys assessed literacy by asking women if they could read and understand a letter or newspaper. Women are considered literate if they responded "easily" or "with difficulty."

Percentage of Women 15 to 49 Who Have Never Attended School





TRENDS IN YOUNG WOMEN'S EDUCATION

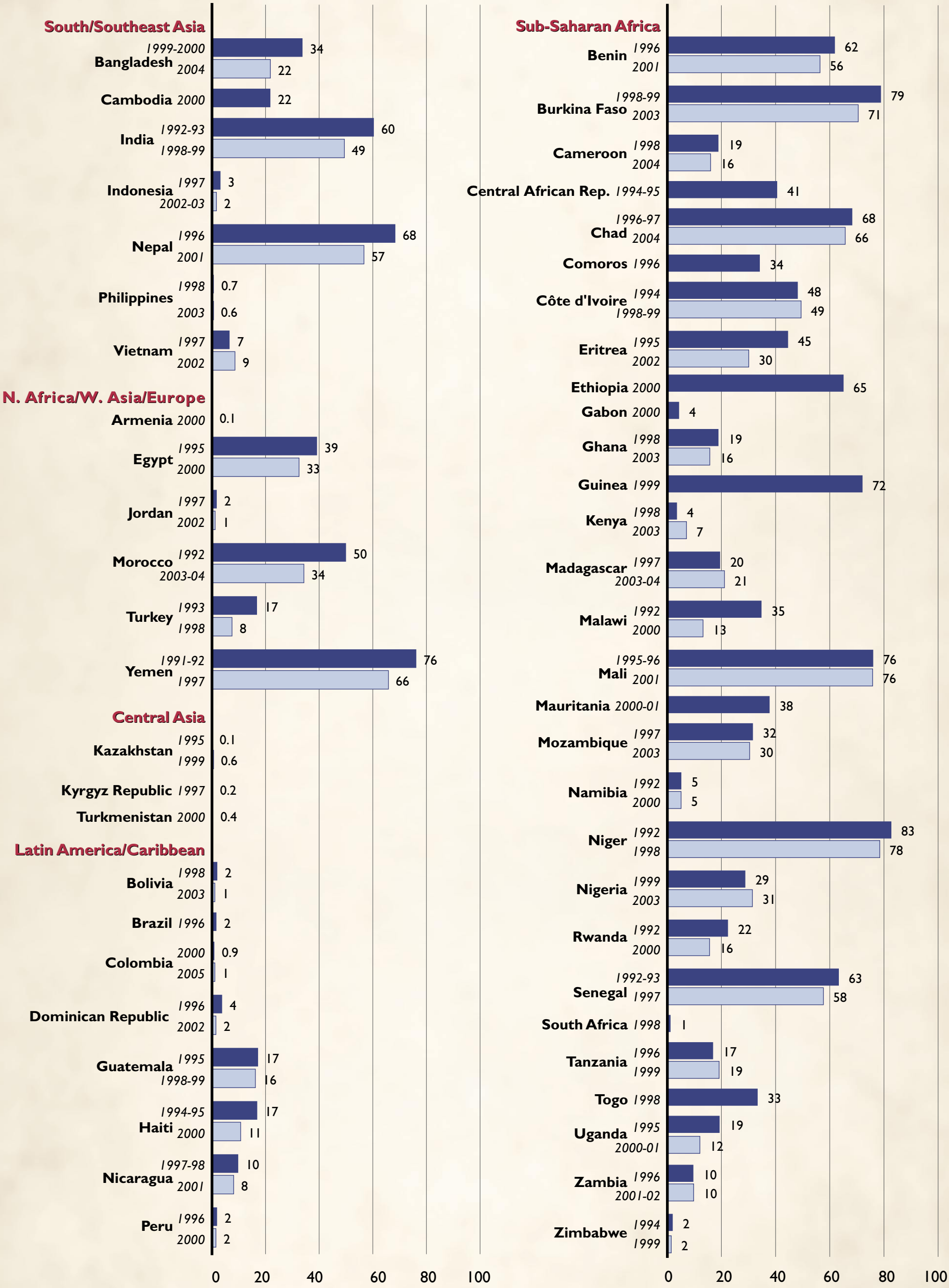
Women's access to education has increased over time. Younger women are more likely than older women to have attended school.

In 29 of 53 countries surveyed—including all of those in Central Asia and Latin America and the Caribbean—over 80 percent of women ages 15 to 24 have some education. However, access to education remains limited for women in some countries. More than half of young women have never attended school in Nepal, Yemen, and 8 of 29 countries surveyed in Sub-Saharan Africa. There is considerable variation within regions. For example, more than three-fourths of young women in Mali and Niger have no education, compared with less than 5 percent in Gabon, South Africa, and Zimbabwe.

Trends. In 32 of 40 countries with two recent surveys, the percentage of young women who have never been to school has declined over time. Advances in women's education have been most consistent in South/Southeast Asia, North Africa/West Asia/Europe, and Latin America and the Caribbean. In these regions, countries with the lowest levels of female education have made some of the greatest gains. In Bangladesh, India, Morocco, Nepal, and Yemen, for example, the proportion of women ages 15 to 24 with no schooling fell by more than 10 percentage points between surveys.

Progress has been uneven in Sub-Saharan Africa. In 6 of 21 countries with two surveys, the percentage of young women who have never attended school has increased over time. Many other countries have experienced only small decreases in the percentage of young women without schooling. Notable exceptions are Eritrea, where the proportion of young women without education fell from 45 percent in 1995 to 30 percent in 2002, and Malawi, where the proportion fell from 35 percent in 1992 to 13 percent in 2000.

Percentage of Women 15 to 24 Who Have Never Attended School



HIGHER EDUCATION

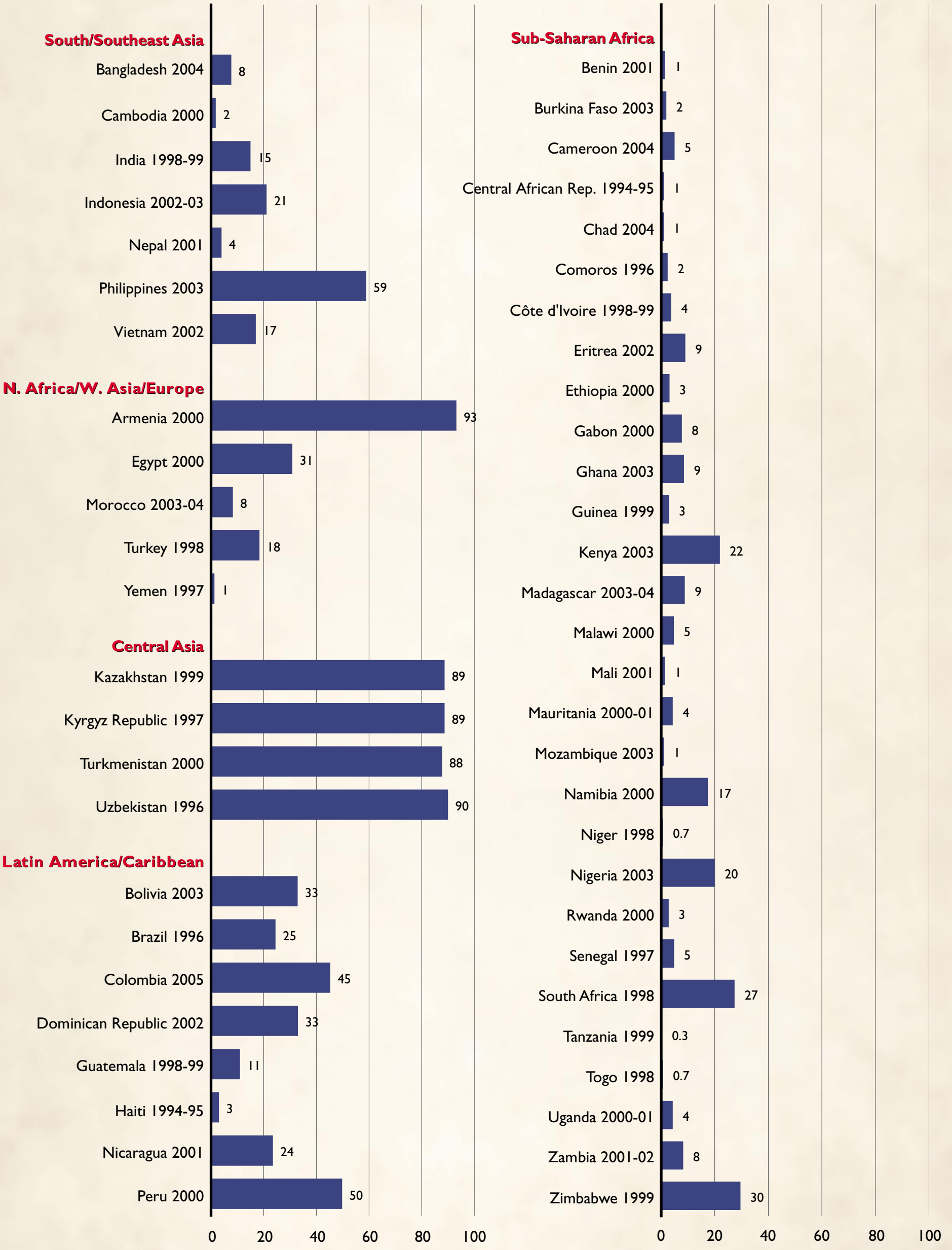
While increasing numbers of girls attend primary school, few complete secondary school or go on for further education. This is consistent with the continued emphasis on domestic roles for girls and women, teenage marriages, and early childbearing.

In 40 of 53 countries surveyed, less than one-quarter of women ages 20 to 49 have a secondary or higher education. In 30 countries, less than one-tenth of women have achieved this level of education. Conspicuous exceptions are countries from the former Soviet Union: in Armenia, Kazakhstan, the Kyrgyz Republic, Turkmenistan, and Uzbekistan, about 9 in 10 women have a secondary or higher education. Peru and the Philippines are the only other countries surveyed where half or more of women have achieved this level of education.

Women are least likely to go beyond a primary education in Sub-Saharan Africa. In 18 of 29 countries surveyed there, less than 5 percent of women have completed secondary school or have more than a secondary education. In this region South Africa and Zimbabwe stand out, because more than one-fourth of women there have a secondary or higher education.

Defining higher education: Information on higher education is collected by questions on the highest level of school attended (primary, secondary, or higher) and the highest grade or form completed at that level. Higher education is defined as completing the last year of secondary school or attending a school at a higher level, for example, a college, university, or technical training institute.

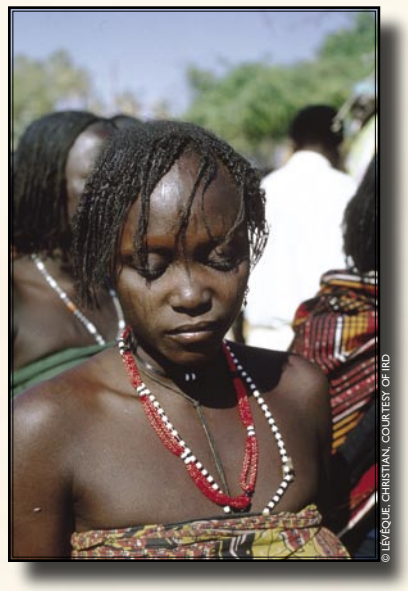
Percentage of Women 20 to 49 Who Have Completed Secondary Education or Have More Than Secondary Education



RELATIONSHIPS

Among 53 countries surveyed, the median age at first marriage ranges from about 15 years in Bangladesh to 27 years in South Africa.

In 22 of 46 countries surveyed, most women have had sex by age 18.



AGE AT FIRST SEXUAL INTERCOURSE

Most women first engage in sexual intercourse as teenagers, often before they marry. Social norms in many countries limit unmarried teenagers' access to family planning services, thus placing them at increased risk of unintended pregnancy, sexually transmitted infections, and school dropout.

In 40 of 46 countries surveyed, the median age at first intercourse for women—that is, the age by which half of women have had sex but half have not—is less than 20 years. Women start having sex at a younger age in Sub-Saharan Africa than in other parts of the world. In 12 of 29 countries surveyed in this region, at least half of young women became sexually active before age 17. The median age at first intercourse is lowest in Niger, at 15.3 years.

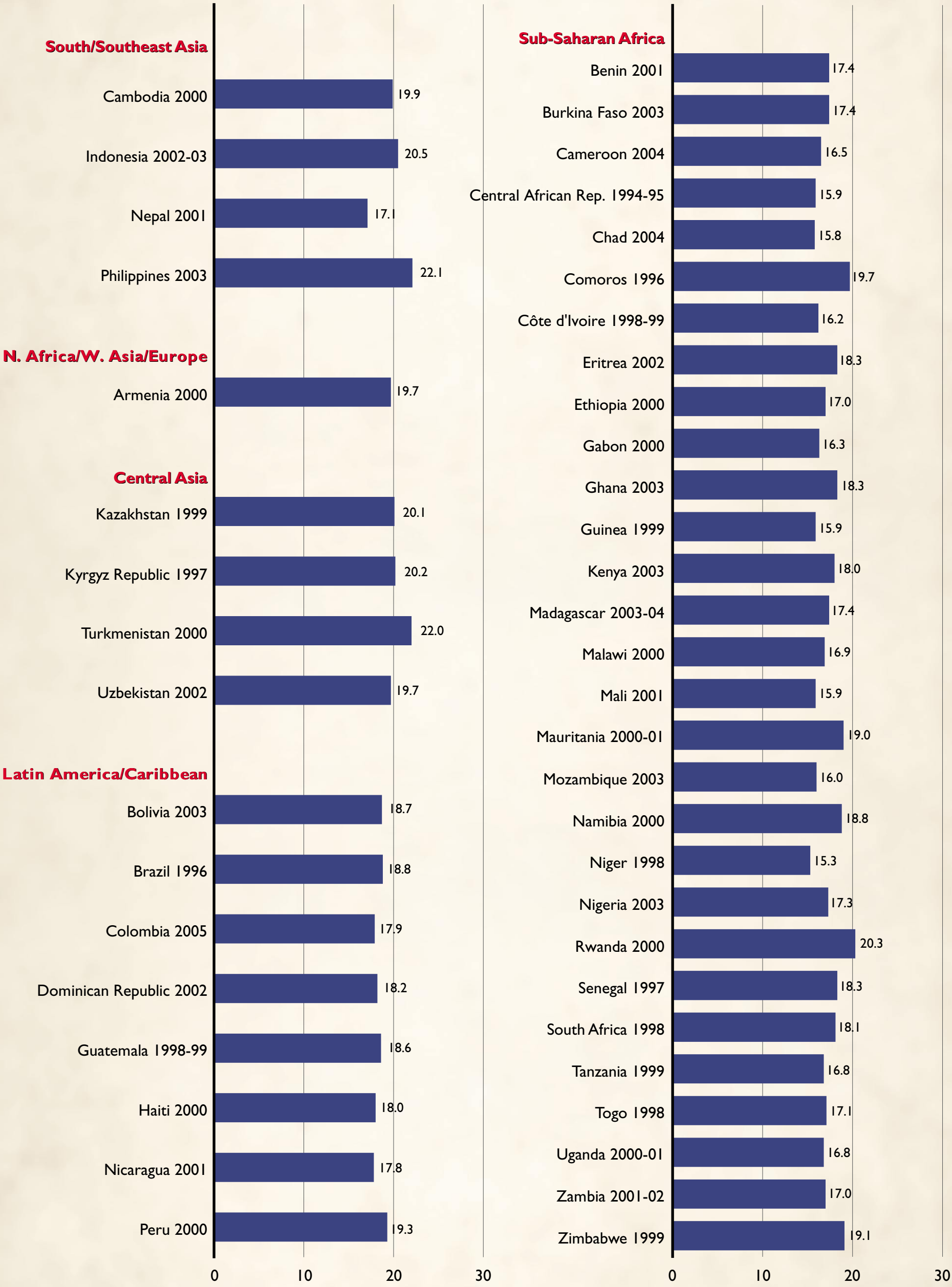
Women tend to be older when they first have sexual intercourse in South/Southeast Asia, North Africa/West Asia/Europe, and Central Asia. With the exception of Nepal, the median age at first intercourse in these three regions is at least 19 years. In Turkmenistan and the Philippines women do not begin having sex until age 22, on average.

Data indicate that many women start having sex before they get married. The median age at first sexual intercourse is lower than the median age at first marriage (see "When women marry," page 15) in all but 7 of 45 countries surveyed.

While little or no time elapses, on average, between sexual initiation and marriage in South/Southeast Asia and Central Asia, the opposite is true in Latin America and the Caribbean and Sub-Saharan Africa. In these two regions, there is at least a one-year difference between the median age at first intercourse and the median age at first marriage in 21 of 36 countries surveyed. In 10 of these countries the difference is two years or more, and in South Africa it is almost nine years.

Measuring age at first sexual intercourse: Young unmarried women tend to underreport sexual experience if asked whether they have ever had sexual intercourse. Instead, DHS surveys directly ask all women how old they were when they had sexual intercourse for the first time.

Median Age at First Sexual Intercourse Among Women 25 to 29



WHEN WOMEN MARRY

When women engage in sexual intercourse, marry, and begin bearing children at an early age—often during adolescence—it becomes more difficult for them to pursue further education and acquire the skills needed for better work opportunities and for self-empowerment. Early marriage also adds to the number of children a woman eventually bears over the course of her lifetime.

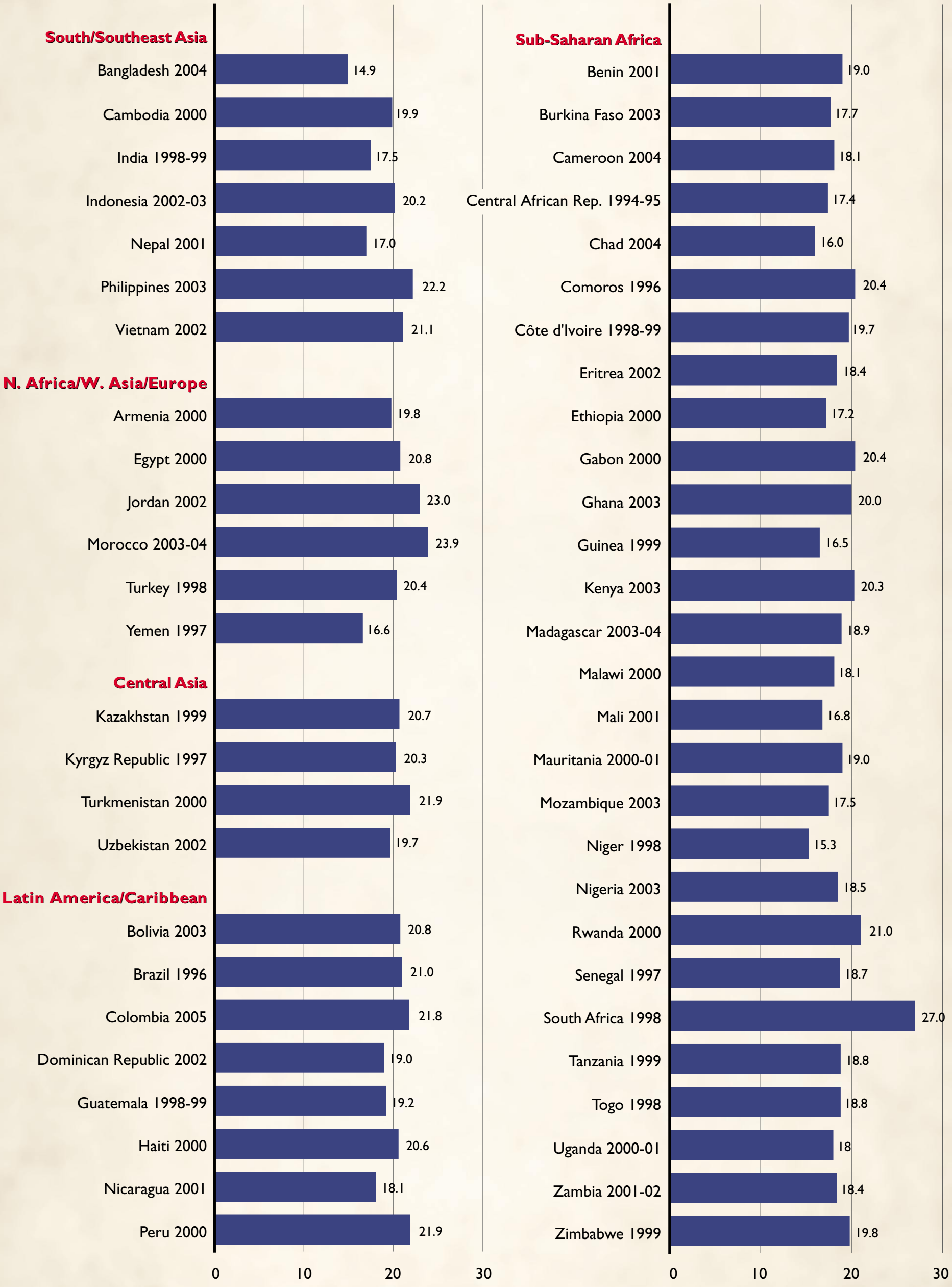
The median age at first marriage—that is, the age by which half of women have married but half have not—varies widely between countries and within regions. Among 53 countries surveyed, the median age of marriage ranges from about 15 years in Bangladesh to 27 years in South Africa.

Many women go directly from teenage life to married life. In 12 countries, at least half of women ages 25 to 29 married before age 18. Women are more likely to marry at a young age in Sub-Saharan Africa and, to a lesser extent, in South/Southeast Asia. These two regions include 5 of the 6 countries where the median age at marriage is less than 17 years: Bangladesh, Chad, Guinea, Mali, Niger, and Yemen.

Women in North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean tend to marry later in life. In 12 of 18 countries surveyed in these three regions, the median age at first marriage is 20 years or older. However, the country where women delay marriage the longest—South Africa—is outside these regions.

Defining marriage: Throughout this publication, marriage refers to both formal and informal unions, that is, living together with a man as if married. Age at first marriage is derived from the date of a woman's first union or, if she does not remember the year, her age when she first began living with a partner.

Median Age at First Marriage Among Women 25 to 29



TEENAGE MARRIAGE

When women marry at a young age, they cut their schooling short and increase the risk of bearing children before they are physically ready. Yet more than one-third of women ages 20 to 24 married before age 18 in 30 of 54 countries surveyed.

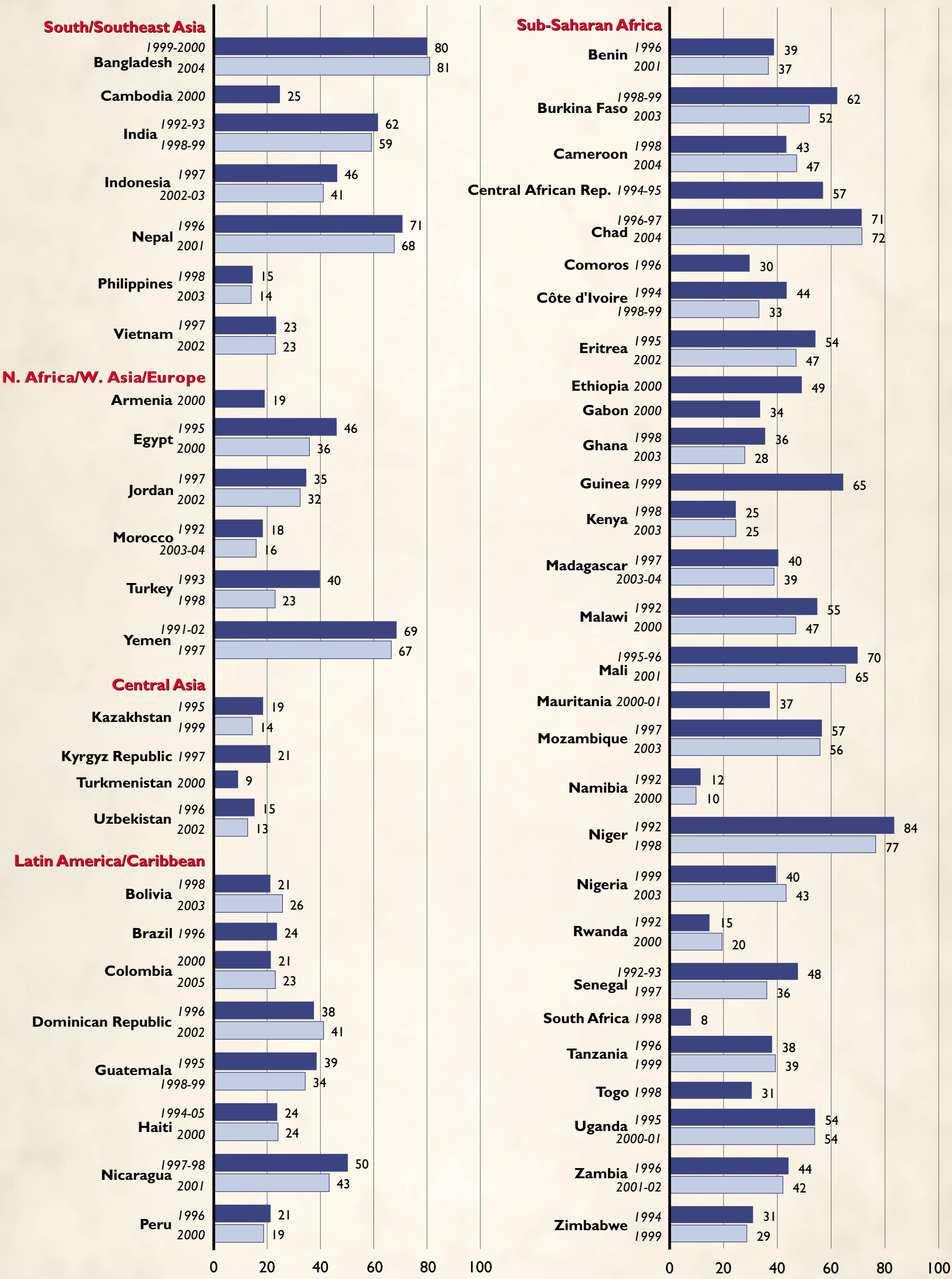
Women tend to marry early in many countries in South/Southeast Asia and Sub-Saharan Africa. These two regions include 11 of the 12 countries where more than half of young women married before age 18 (Yemen is the other). In 2 of these countries, Bangladesh and Niger, more than three-quarters of young women married before their eighteenth birthday.

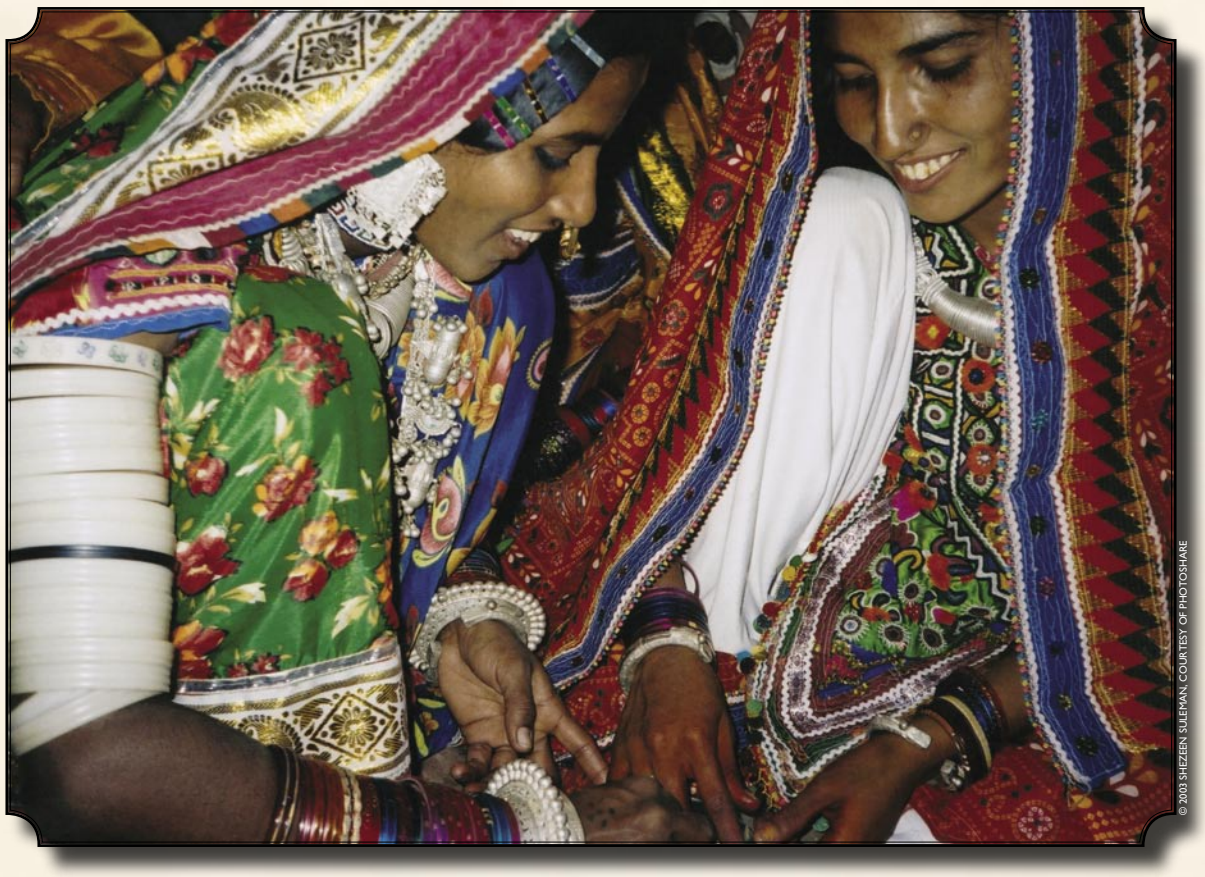
Women are least likely to marry early in Namibia, South Africa, and Turkmenistan; in these countries less than 1 in 10 women married before age 18. Early marriage is also relatively uncommon in Central Asia, where only around 1 or 2 women in 10 marry before age 18.

Trends. Early marriage is becoming less common in most countries, although the pace of change is often slow. In 30 of 41 countries with two recent surveys, the percentage of young women who married before age 18 has decreased over time. In 15 of those countries, however, the drop was less than 3 percentage points. Five countries have experienced declines of more than 10 percentage points: Burkina Faso, Côte d'Ivoire, Egypt, Senegal, and Turkey. The most dramatic change has occurred in Turkey, where the proportion of young women marrying before age 18 fell from 40 percent in 1993 to 23 percent in 1998.

Early marriages have become more, rather than less, common in 4 of the 7 Latin American and Caribbean countries surveyed. The same is true in Bangladesh and 5 countries in Sub-Saharan Africa. In Bolivia, for example, the proportion of young women marrying before age 18 rose from 21 percent in 1998 to 26 percent in 2003.

Percentage of Women 20 to 24 Who Were Married by Age 18





MARITAL STATUS AND POLYGYNY

Few women remain single in the developing world. In 34 of 54 countries surveyed, over 70 percent of reproductive age women are now or have previously been married (data on marital status are not shown). Three countries are notable for high proportions of single women: 54 percent of women in Namibia, 48 percent of women in South Africa, and 46 percent of women in Jordan have never married.

South/Southeast Asia and Sub-Saharan Africa are home to the highest marriage rates. In Guinea, Mali, and Niger, for example, over 80 percent of women are currently married, and less than 15 percent have never married.

Relatively few women ages 15 to 49 are widowed, divorced, or separated. In 35 of 54 countries surveyed, less than 10 percent of women fall into these categories. Women are more likely to be widowed, divorced, or separated in parts of Latin America and the Caribbean and Sub-Saharan Africa. Rwanda has the highest proportion of widowed, divorced, and separated women, at 18 percent, followed closely by Nicaragua, the Dominican Republic, and Colombia.

Some married women are in polygynous unions, that is, marriages in which the husband has more than one wife. The practice of polygyny can affect many aspects of women's lives, including their exposure to sexually transmitted infections and what resources are available for themselves and their children.

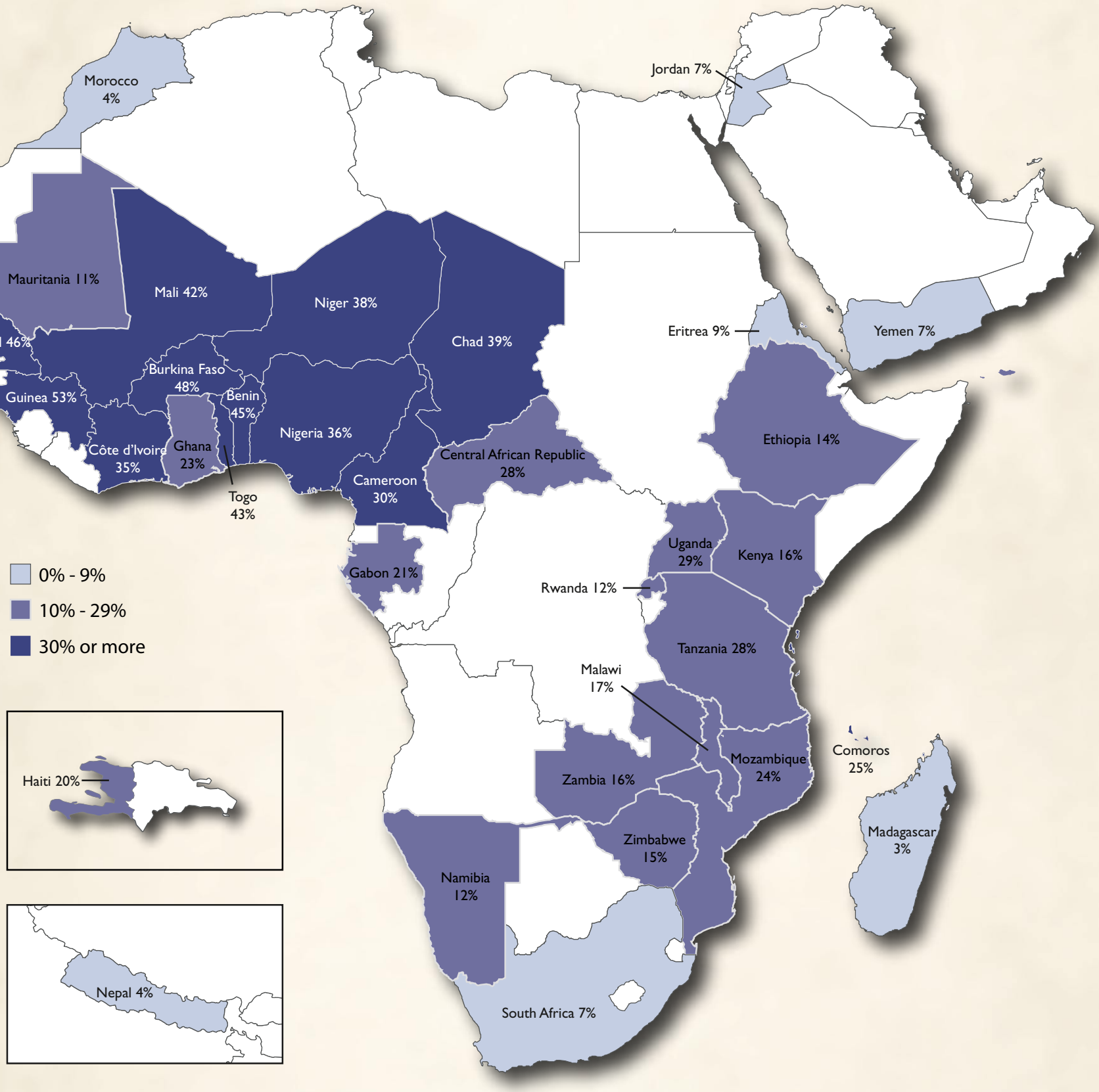
Polygyny is widespread in parts of Sub-Saharan Africa. In 26 of 29 countries surveyed in that region, more than 10 percent of women are married to men who have other wives. In 11 of these countries, primarily in West Africa, over 30 percent of women are in polygynous unions. The practice is most common in Guinea, where 53 percent of women are in polygynous unions.

Polygyny also occurs, although to a lesser extent, in some countries outside of Sub-Saharan Africa. In Jordan, Morocco, Nepal, and Yemen, up to 7 percent of women are in polygynous unions.

Married men in Haiti also frequently have regular, recognized partners in addition to their wives, although they are not formally married to more than one woman. While not strictly polygyny, this practice has many of the same implications for women. In the 2000 survey, 1 in 5 women in Haiti reported that their husbands had another regular partner.

Defining polygyny: As with all subjects involving marriage, both formal and informal unions are included here. Thus DHS surveys ask whether a woman's husband or partner has other wives or whether he lives with other women as if married.

Percentage of Currently Married Women 15 to 49 in a Polygynous Union



DATA TABLE

	Percent
South/Southeast Asia	
Nepal 2001	4
N. Africa/W. Asia/Europe	
Jordan 2002	7
Morocco 2003-04	4
Yemen 1997	7
Latin America/Caribbean	
Haiti 2000	20
Sub-Saharan Africa	
Benin 2001	45
Burkina Faso 2003	48
Cameroon 2004	30
Central African Rep. 1994-95	28

	Percent
Sub-Saharan Africa	
Chad 2004	39
Comoros 1996	25
Côte d'Ivoire 1998-99	35
Eritrea 2002	9
Ethiopia 2000	14
Gabon 2000	21
Ghana 2003	23
Guinea 1999	53
Kenya 2003	16
Madagascar 2003-04	3
Malawi 2000	17
Mali 2001	42
Mauritania 2000-01	11

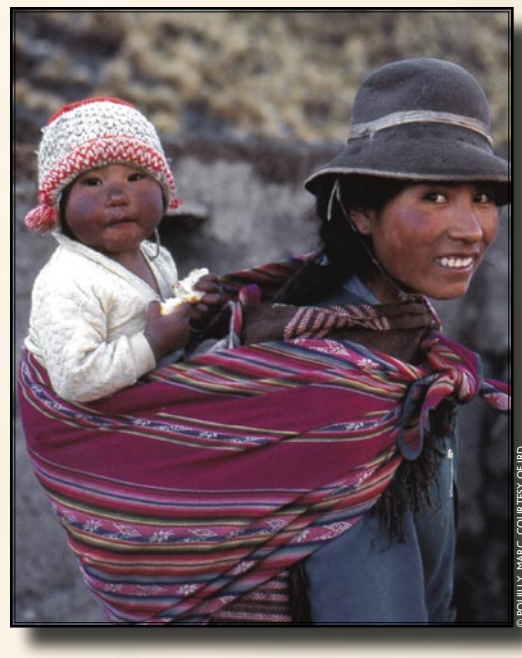
	Percent
Sub-Saharan Africa *(continued)*	
Mozambique 2003	24
Namibia 2000	12
Niger 1998	38
Nigeria 2003	36
Rwanda 2000	12
Senegal 1997	46
South Africa 1998	7
Tanzania 1996	28
Togo 1998	43
Uganda 2000-01	29
Zambia 2001-02	16
Zimbabwe 1999	15

CHILDBEARING EXPERIENCES

The average number of children a woman has ranges widely, from less than 2 in Armenia and Vietnam to more than 7 in Niger.

More than 500 women die from the complications of pregnancy and childbirth for every 100,000 births in 19 of 27 countries surveyed in Sub-Saharan Africa.

Over 40 percent of teenagers in the Central African Republic, Mali, Mozambique, and Niger have a child, are currently pregnant, or have been pregnant.



WHEN WOMEN BECOME MOTHERS

Later childbearing benefits women and their children. Women who postpone motherhood until after the teen years are likely to stay in school longer than their peers and to have fewer and healthier children. Yet many women begin bearing children at an early age.

In 25 of 54 countries surveyed, the median age at first birth—that is, the age by which half have had a child but half have not—is less than 20 years. Women are most likely to begin bearing children as teenagers in South Asia and Sub-Saharan Africa. Indeed, half of women in Bangladesh and Niger have their first child before their eighteenth birthday. Notable exceptions are the Philippines and Vietnam, where the median age at first birth is around 23 years.

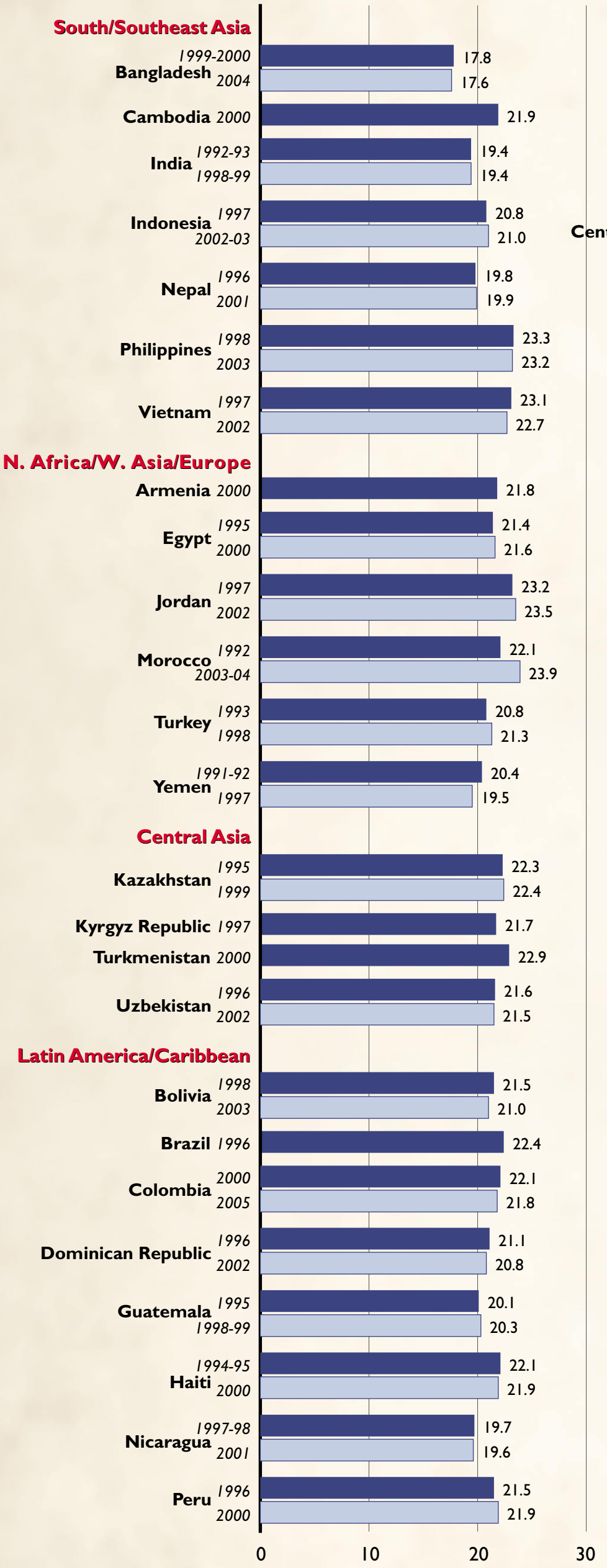
Women in North Africa/West Asia/Europe and Central Asia generally wait longer before bearing a child: the median age at first birth is at least 21 years in every country in these regions except Yemen. Half of women in Jordan and Morocco do not give birth until they are at least 23 years old.

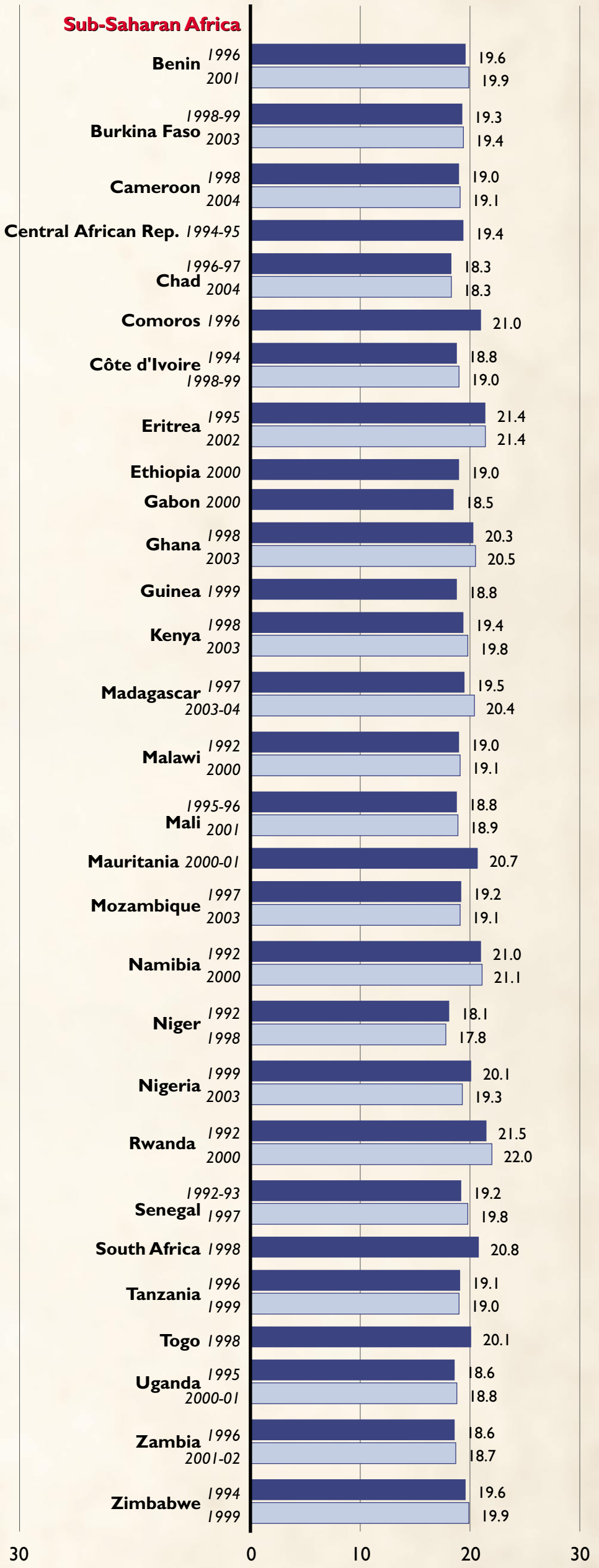
Trends. Women are waiting longer to have children in most countries. Among 41 countries with two recent surveys, 24 countries show an upward trend in median age at first birth, 14 countries show a downward trend, and 3 countries show no change. Most countries in North Africa/West Asia/Europe and Sub-Saharan Africa have experienced increases in the median age at first birth, while decreases are more likely in Latin America and the Caribbean.

Most changes in the median age at first birth—whether increases or decreases—have been small, amounting to 0.3 years (about four months) or less. Morocco has witnessed the greatest increase, with the median age at first birth rising from 22.1 years in 1992 to 23.9 years in 2003-04. Nigeria and Yemen have experienced the greatest declines, with the median age at first birth falling by almost one year between surveys.

Measuring age at first birth: Information on women's childbearing experiences, including age at first birth, comes from a detailed history of all the births a woman has ever had, regardless of whether the children are still alive. Interviewers probe for events that women often fail to report, such as children who die soon after delivery.

Median Age at First Birth Among Women 25 to 49





TEENAGE PREGNANCY

Teenage pregnancy poses a threat to the health of both mother and child, often forces girls to drop out of school, and ultimately narrows women's opportunities in life. Yet teen pregnancy rates remain high in a large number of countries.

In 27 of 54 countries surveyed, more than one-fifth of women ages 15 to 19 have a child, are currently pregnant, or have been pregnant. In 11 countries, that figure rises to one-third of teenagers.

Teenagers in North Africa/West Asia/Europe and Central Asia are least likely to become pregnant. Less than 10 percent of 15- to 19-year olds in 8 of 10 countries surveyed in these regions have ever been pregnant. The exceptions are Turkey and Yemen.

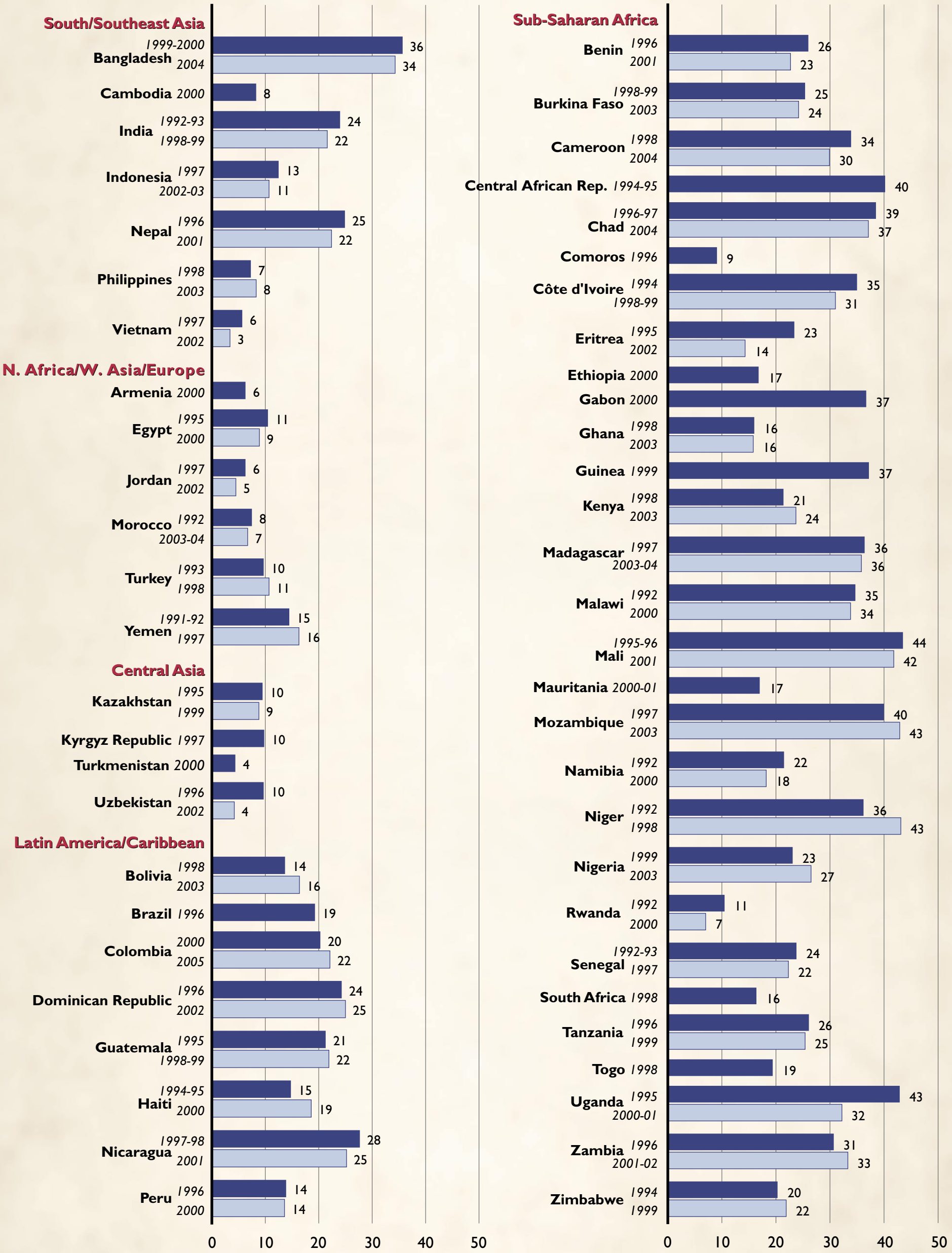
The highest teenage pregnancy rates are found in parts of Sub-Saharan Africa. Over 40 percent of 15- to 19-year olds in the Central African Republic, Mali, Mozambique, and Niger have ever been pregnant. Elsewhere in the region, however, teenage pregnancy rates are much lower. Less than 10 percent of teens in Comoros and Rwanda have ever been pregnant.

Trends. In 27 of 41 countries with two recent surveys, teenage pregnancies have become less common. The biggest declines have taken place in Eritrea, where the teenage pregnancy rate fell from 23 percent in 1995 to 14 percent in 2002, and in Uganda, where it fell from 43 percent in 1995 to 32 percent in 2000-01.

In Latin America and the Caribbean, unlike other regions, teenage pregnancy rates have edged higher in recent years in most countries surveyed. It is Niger, however, that has witnessed the greatest increase in teen pregnancy, with the proportion of teenagers who have ever been pregnant rising from 36 percent in 1992 to 43 percent in 1998.

Measuring teenage pregnancy: Information on teen pregnancy comes from women's birth histories. Teenage pregnancy rates include women ages 15 to 19 who have a child, who are currently pregnant, or who have ever been pregnant.

Percentage of Women 15 to 19 Who Have a Child, are Currently Pregnant, or Have Ever Been Pregnant



SHORT BIRTH INTERVALS

Spacing births too closely can increase infant and child mortality and malnutrition and also heighten the risk of maternal morbidities associated with complications of pregnancy and delivery. After giving birth, experts recommend that women wait at least 24 months before trying to become pregnant again. This is roughly equivalent to a 36-month interval between births, when several months to conceive and 9 months of pregnancy are added to the 24-month waiting period.

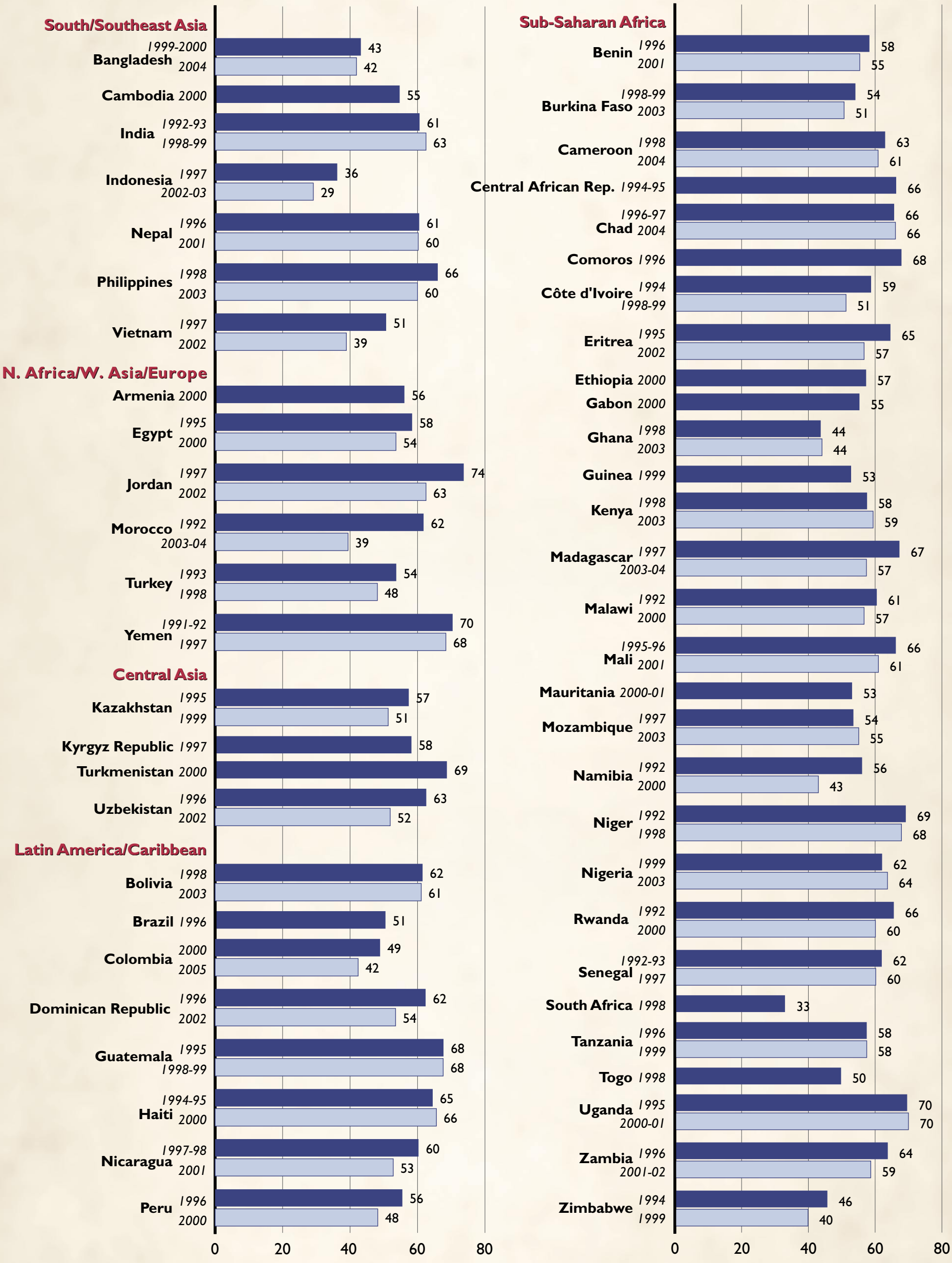
Yet birth intervals shorter than 36 months are common in every region of the world. In 42 of 54 countries surveyed, over half of all recent births followed a birth interval that was less than the recommended 36 months. Women are most likely to space children too closely in Uganda, where 70 percent of birth intervals are less than 36 months, and least likely to do so in Indonesia, where only 29 percent of birth intervals are that short.

Trends. In most countries, the trend is towards wider birth spacing. In four regions of the world—South/Southeast Asia, North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean—the proportion of births following short intervals fell in all but 2 of 20 countries with two recent surveys; the exceptions are Haiti and India. Short birth intervals also became less common in 14 of 21 countries with two recent surveys in Sub-Saharan Africa.

The most dramatic change has taken place in Morocco: the proportion of births occurring within 36 months of a previous birth fell from 62 percent in 1992 to 40 percent in 2003-04. Four other countries have experienced drops of more than 10 percentage points: Jordan, Namibia, Vietnam, and Uzbekistan.

Defining birth intervals: The birth interval is defined as the length of time between the birth dates of two siblings. It is calculated from information collected in women's birth histories. The interviewer asks women to list all of live births they have ever had, including the child's name, date of birth, sex, whether the birth was single or multiple, and whether the child is still alive.

Percentage of Births in the Five Years Preceding the Survey That Occurred Within 36 Months of a Previous Birth



FERTILITY AND FAMILY SIZE

Fertility rates vary widely around the world but are decreasing in most countries. Among 54 countries surveyed, the total fertility rate (TFR) ranged from less than 2 children per woman in Armenia and Vietnam to a high of 7.2 children in Niger.

Women have 2 or 3 children, on average, in most countries outside of Sub-Saharan Africa. Notable exceptions are Guatemala, Haiti, and Yemen, where women have an average of around 5 to 7 children.

Women in Sub-Saharan Africa tend to have large families—an average of 4 or more children in every country surveyed except South Africa. Women in Chad, Malawi, Mali, Niger, and Uganda have 6 or 7 children, on average.

Trends. Outside of Sub-Saharan Africa, fertility has declined over time in all 20 countries with two recent surveys with the exception of Turkey. The biggest drops occurred in Morocco, where the TFR fell from 4 to 2.5 children per woman over an eleven-year period (from 1992 to 2003-04), and Yemen, where it fell from 7.7 to 6.5 children over a six-year period (from 1991-92 to 1997).

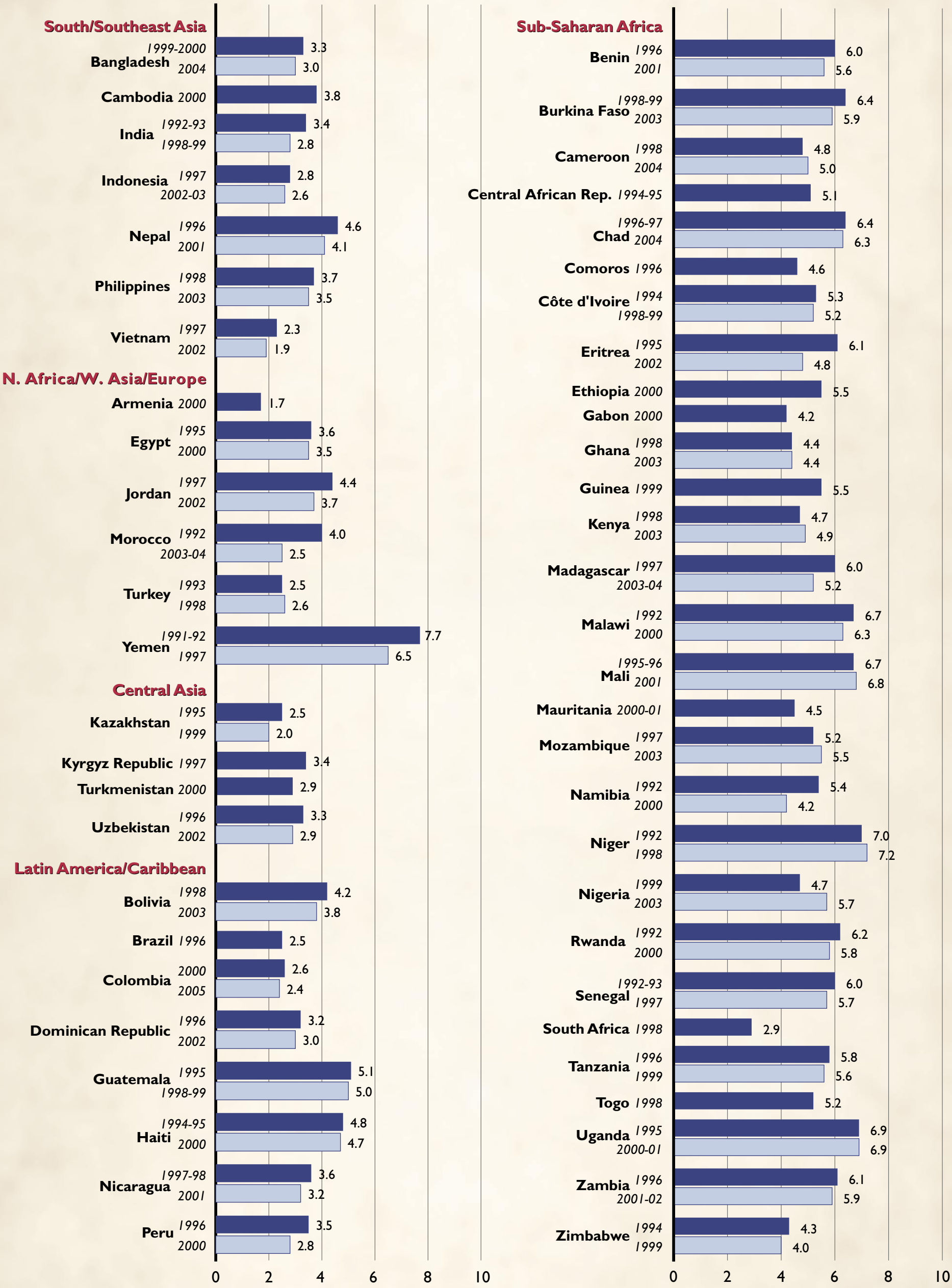
Trends are less consistent in Sub-Saharan Africa. Among 21 countries with two recent surveys, fertility declined in 13 countries, remained stable in 2, and increased in 6. The largest drops occurred in Eritrea, where the TFR fell from 6.1 to 4.8 children over a seven-year period (from 1995 to 2002), and in Namibia, where the TFR fell from 5.4 to 4.2 children over an eight-year period (from 1992 to 2000). The greatest increase occurred in Nigeria, where the TFR rose from 4.7 children in 1999 to 5.7 children in 2003.

Despite recent declines in the fertility rate, most women in developing countries still have larger families than those in the more developed countries of Europe, North America, Australia, Japan, and New Zealand. As a group, these countries have an estimated TFR of 1.6 children per woman.[1]

[1] Population Reference Bureau (PRB). *2005 World Population Data Sheet of the Population Reference Bureau.* Washington, DC: PRB, 2005.

Defining the total fertility rate (TFR):
The TFR represents the number of children the average woman would bear in her lifetime, assuming she experienced the currently observed age-specific fertility rates throughout her reproductive years. Data from women's birth histories are used to calculate age-specific fertility rates which, in turn, are used to calculate each country's TFR.

Average Number of Children Per Woman (Total Fertility Rate)



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WOMEN AND CHILDREN AT RISK IN CHILDBEARING

Complications related to pregnancy and delivery pose some of the greatest hazards for women's health and well-being during their childbearing years. Births pose an especially high risk when the mother:

- Is under age 18 at the time of the birth,
- Is over age 34 at the time of the birth,
- Gives birth within 36 months of a previous birth, or
- Has already had three or more live births.

These risk factors increase the likelihood of serious illness and premature death among infants and young children as well as their mothers.

Among 54 countries surveyed, the proportion of women whose most recent birth fell into one or more of these four high-risk categories ranges from a low of 32 percent in Vietnam to a high of 84 percent in Niger. There are only 8 countries, scattered across every region, where less than half of births fall into some high-risk category. Births are most likely to be at risk in Sub-Saharan Africa. In 19 of 29 countries surveyed in this region, over 70 percent of births fall into a high-risk category. Births are least likely to be at risk in Central Asia.

Trends. In 34 of 41 countries with two recent surveys, the proportion of women whose last birth was at high risk has decreased in recent years. This reflects trends toward an older age at first birth (see page 21), longer birth intervals (see page 25), and smaller family size (see page 27). All 7 countries where the proportion of high-risk births has increased are located in Sub-Saharan Africa. They are Chad, Ghana, Kenya, Mozambique, Niger, Nigeria, and Uganda.

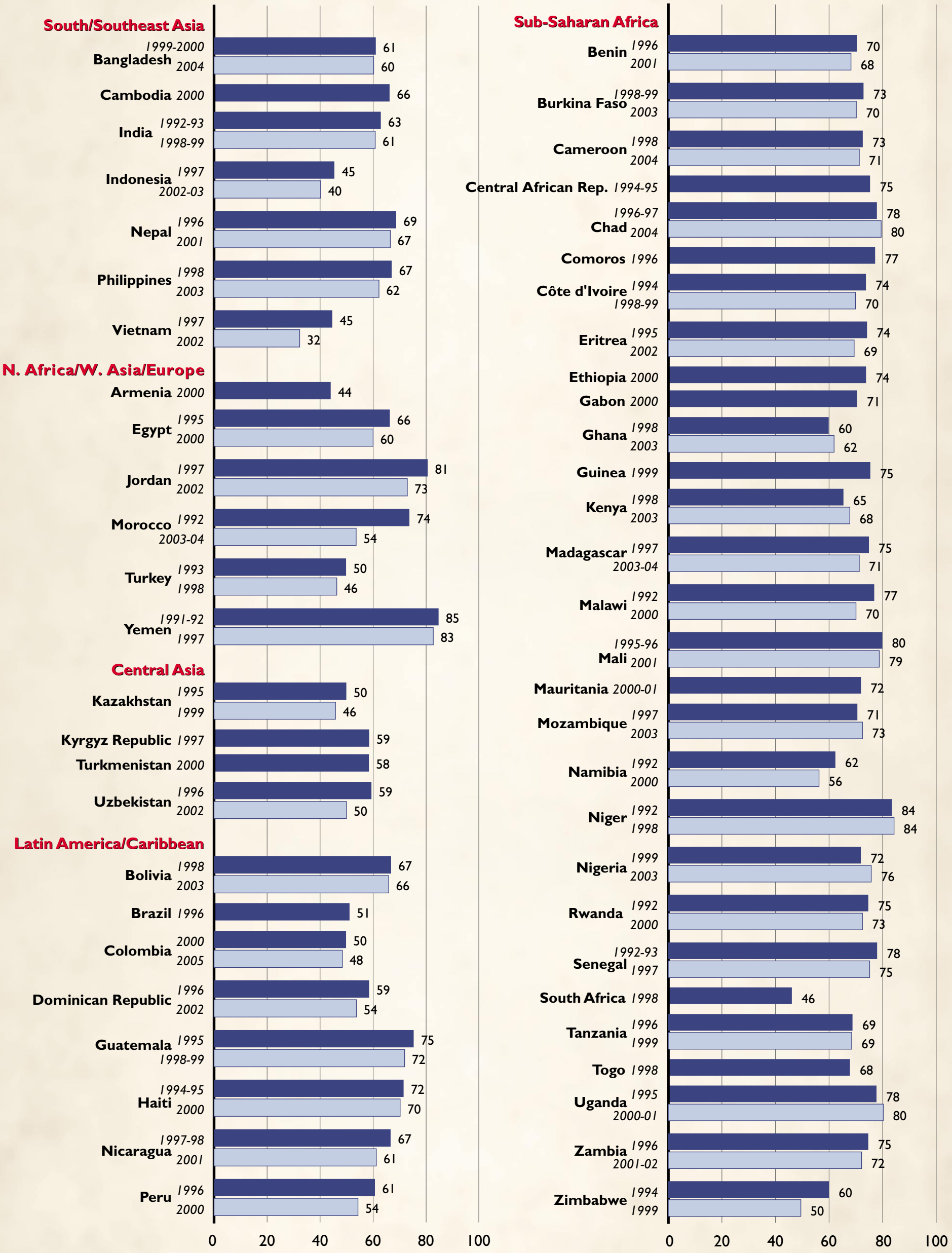
In 23 of 34 countries experiencing a decline in high-risk births, the decrease was less than 5 percentage points. Morocco, Vietnam, and Zimbabwe have experienced the greatest drops, with the percentage of high-risk births falling by 20, 12, and 11 percentage points, respectively. In every country where the percentage of high-risk births has increased, the rise has been limited to less than 4 percentage points.

The Effect of Long Birth Intervals. Preliminary research findings suggest that overly long birth intervals, of 60 months or more, also may increase the risk of complications during pregnancy and perinatal mortality. International experts are reviewing whether official recommendations should warn against overly long birth intervals and advise taking additional precautionary measures for such pregnancies.

Extending the definition of high-risk births to include overly long birth intervals increases the proportion of births considered to be at high risk by at least 5 percentage points in 25 of 54 countries surveyed and by at least 10 percentage points in 8 countries (data on the extended definition of high-risk births are not shown). Adding long birth intervals to the other four risk categories has the greatest impact in Indonesia and Vietnam, where it raises the proportion of high-risk births by 18 and 17 percentage points, respectively. Including long birth intervals as a risk factor generally has less impact in Sub-Saharan Africa, where it raises the proportion of high-risk births by 5 percentage points or more in 8 of 29 countries surveyed. Overall, the proportion of women whose last birth fell into at least one of the five high-risk categories ranges from 49 percent in Vietnam to 85 percent in Niger.

Defining high-risk births: Information collected in a woman's birth history (see box, page 33) is used to calculate her age and parity at the time a child was born and the length of the preceding birth interval. (The birth interval is defined as the length of time from one birth to the next.) Births are defined as high risk if the mother was under age 18 or over age 34, already had three or more children, or gave birth less than 36 months after a previous live birth. An extended definition of high-risk births adds a fifth risk factor: giving birth more than 60 months after a previous live birth. Only women who gave birth during the three years preceding the survey are included in the analysis.

Percentage of Women 15 to 49 Whose Last Birth During the Previous Three Years Was at High Risk due to Mother's Age, Parity, or Birth Interval



MATERNAL MORTALITY

Women in many developing countries cannot take for granted that they will survive a pregnancy. In 22 of 42 countries surveyed, more than 500 women die per 100,000 live births.

Maternal mortality poses the greatest challenge in Sub-Saharan Africa, where there are more than 500 pregnancy-related deaths per 100,000 births in 19 of 27 countries surveyed. In 5 countries in this region, maternal mortality ratios exceed 1,000 deaths per 100,000 births. Maternal deaths are most common in Rwanda, where 1,558 mothers die per 100,000 births.

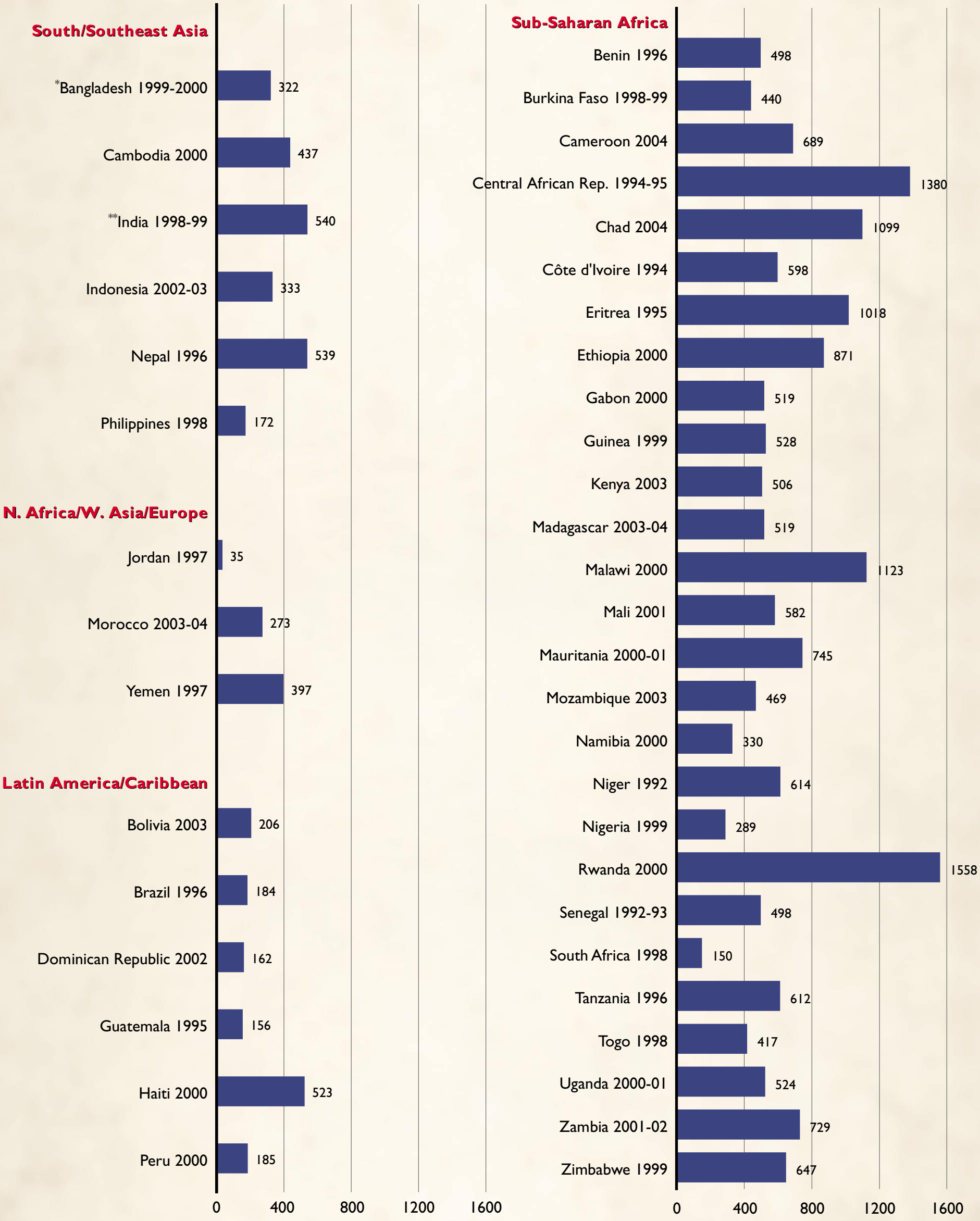
Women are less likely to die from pregnancy-related causes in Latin America and the Caribbean, where maternal mortality ratios in 5 of 6 countries surveyed lay in a narrow range of 156 to 206 deaths per 100,000 births. Haiti stands out in this region with a maternal mortality ratio exceeding 500 deaths per 100,000 live births. Maternal mortality ratios in the Philippines and South Africa fall within the range observed in Latin America and the Caribbean.

Jordan is notable for recording the lowest level of pregnancy-related deaths among all of the countries surveyed. Its maternal mortality ratio of 35 deaths per 100,000 births is comparable to that for women in the more developed countries of Europe, North America, Australia, Japan, and New Zealand. As a group, these countries have an estimated 20 pregnancy-related deaths per 100,000 live births, although the maternal mortality ratio in some is less than 5 deaths per 100,000 births.[1]

[1] Population Reference Bureau (PRB). *2005 Women of Our World.* Washington, DC: PRB, 2005.

Defining maternal mortality: Maternal mortality ratios presented here are a direct estimate of the risk of dying from maternal causes. The ratios are calculated from information collected in a sibling history. The interviewer asks each woman to list all of the children born to her mother, the current age of living siblings, and the age at death and years since death for deceased siblings. Whenever a woman has a sister who died at age 10 or older, the interviewer asks additional questions to determine whether the death was maternity-related. Maternal deaths are defined as any death that occurred during pregnancy, childbirth, or within two months after the birth or termination of a pregnancy. Because the number of female deaths occuring during pregnancy, at delivery, or within two months of delivery is small, maternal mortality ratios are associated with larger sampling errors than other frequently used DHS indicators.

Maternal Deaths per 100,000 Live Births



* For the 3 years preceding the survey; data from the 2001 Maternal Mortality and Maternal Health Services survey
** For the 2 years preceding the survey

DEATH OF A CHILD

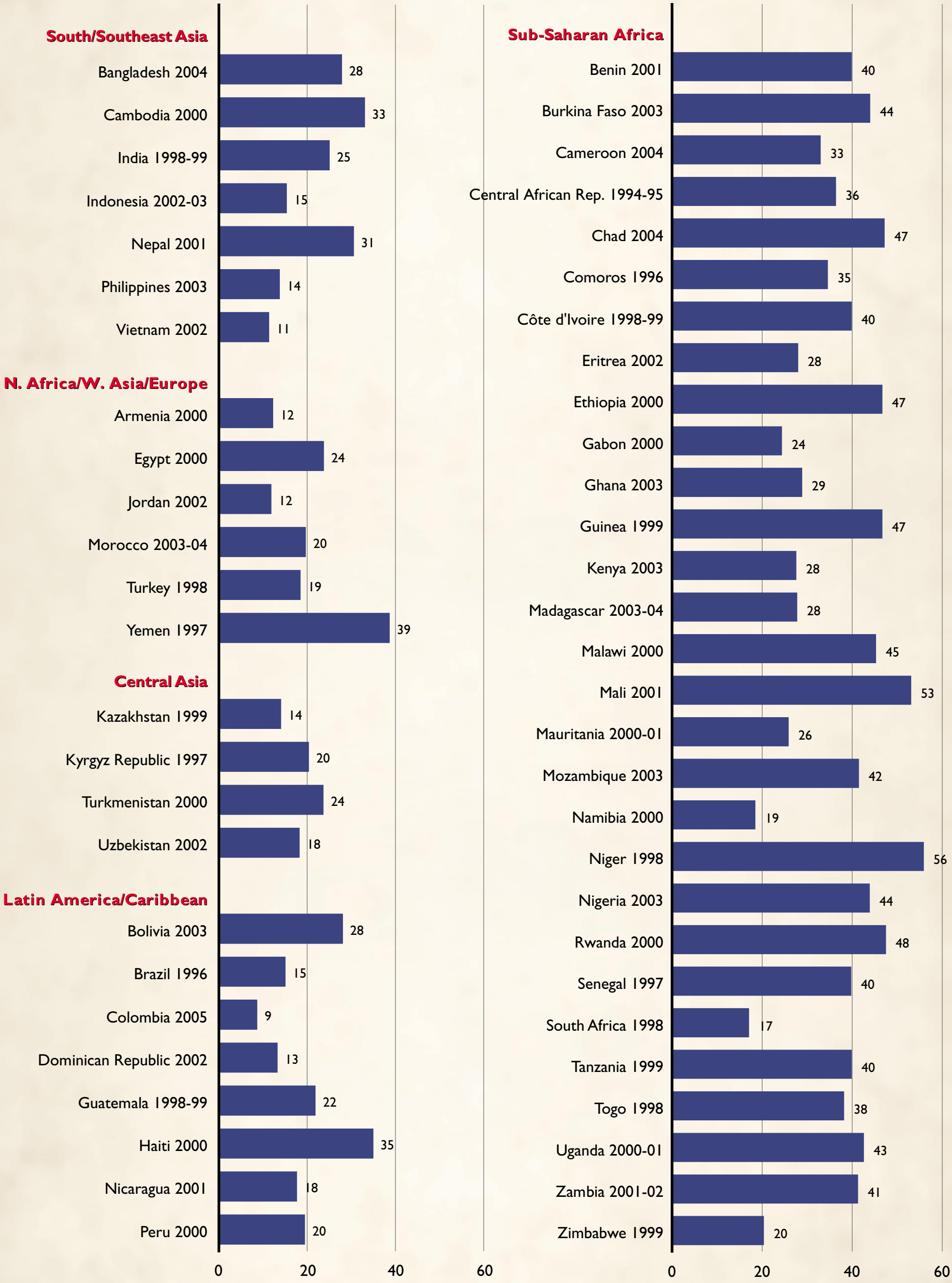
Many women and their families throughout the world have experienced the personal tragedy of losing a child. The death of a child may prompt some women to undergo more pregnancies to ensure that some of their children will survive.

In 32 of 54 countries surveyed, one-fourth or more of ever-married women ages 15 to 49 have lost at least one child. Colombia is the only country where less than 1 in 10 married women have experienced the death of a child.

Women in Sub-Saharan Africa are more likely than women living in other regions to experience the death of a child. In 12 of 29 countries surveyed there, over 40 percent of married women have lost a child. In Mali and Niger, over half of married women have lost a child.

Assessing the death of a child: Information from a woman's birth history is used to determine whether any of her children are dead. The interviewer asks women to list all live births they have ever had, including the child's name, date of birth, sex, whether the birth was single or multiple, whether the child is still alive, and, if dead, the age at death. This analysis includes deaths at any age, so these figures do not represent infant or child mortality.

Percentage of Ever-married Women 15 to 49 Who Have Had at Least One Child Die



CHILDBEARING CHOICES

In all but one Sub-Saharan African country, the average married woman wants to have more than 4 children; elsewhere most women want smaller families.

Modern contraceptive use ranges from 2 percent of married women in Chad to 70 percent in Brazil and has increased over time in all but 3 of 41 countries.

In 29 of 54 countries surveyed, over one-fifth of married women would like to prevent or postpone their next birth but are not using family planning.

IDEAL FAMILY SIZE

The number of children women want varies widely around the world, but ideal family size is declining in most countries.

In 24 of 54 countries surveyed, currently married women ages 15 to 49 want families of less than 4 children, on average. These include all of the countries surveyed in South/Southeast Asia, Central Asia, and Latin America and the Caribbean. Ideal family size is lowest in Bangladesh, Colombia, and Vietnam, at 2.4 children.

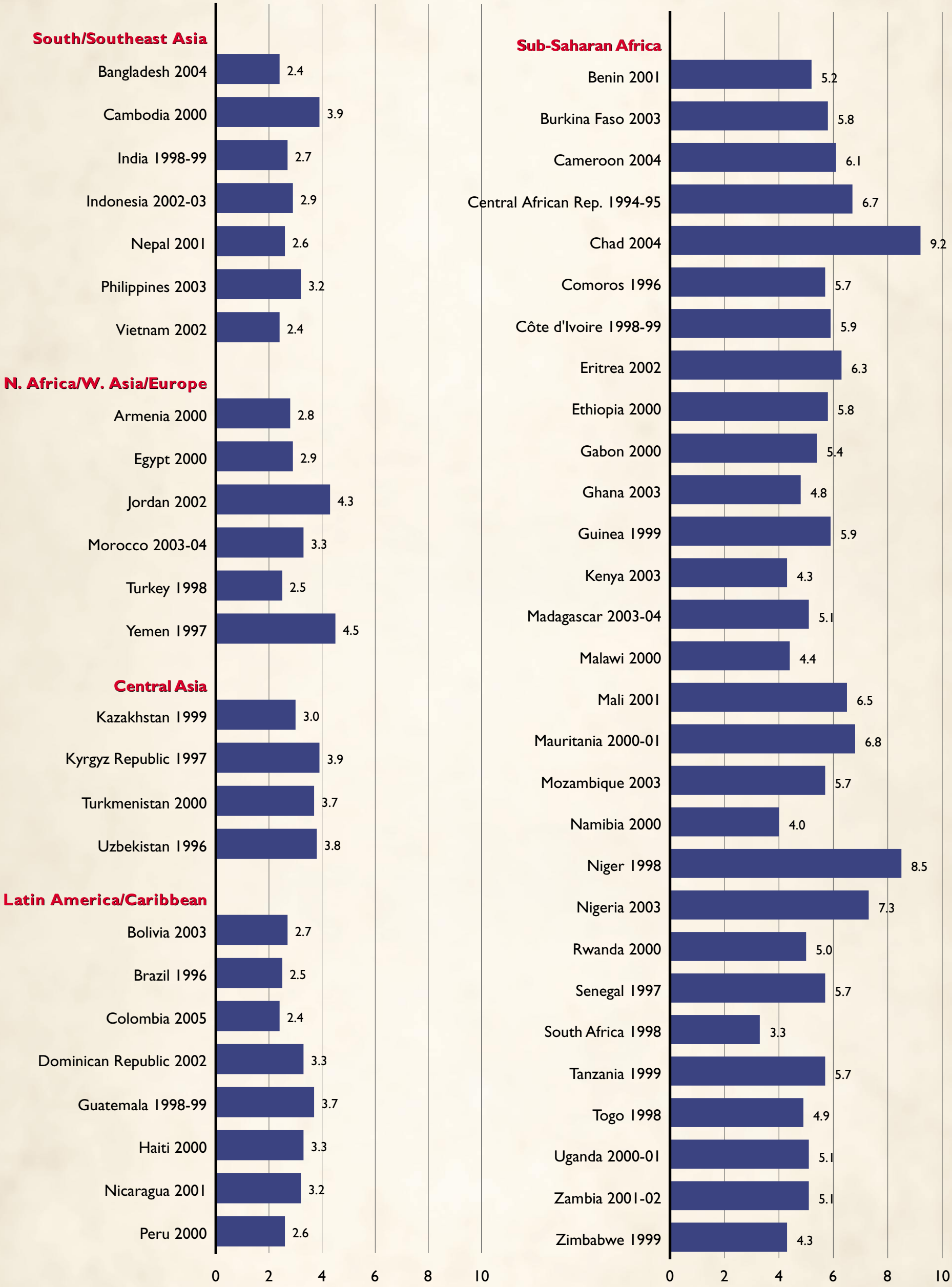
In contrast, married women throughout Sub-Saharan Africa want larger families of at least 4 children, except in South Africa. In 8 of 29 countries surveyed in this region, married women want an average of 6 or more children. Desired family size is largest in Chad and Niger, at 9.2 and 8.5 children, respectively.

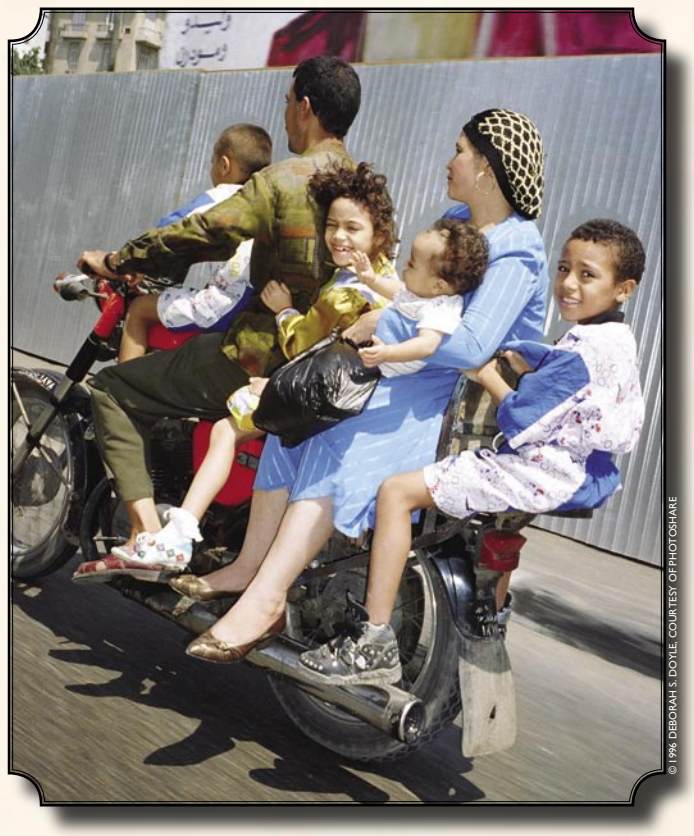
Trends. Women generally want fewer children now than in the past (data on trends in ideal family size are not shown). Ideal family size has decreased in 29 of 40 countries with two recent surveys, remained unchanged in 2 countries, and increased in 9 countries. Desired family size has decreased most consistently in South/Southeast Asia and Latin America and the Caribbean, although the decline is small, only 0.3 children or less.

Trends are mixed in North Africa/West Asia/Europe and Sub-Saharan Africa. Desired family size has dropped substantially in some countries, changed little in others, and increased noticeably in still others. The number of children married women want has declined the most in Namibia—from an average of 5.7 children in 1992 to 4.0 children in 2000—followed by Malawi and Yemen. Chad has registered the greatest increase, with desired family size rising from an average of 8.5 children in 1996-97 to 9.2 children in 2004.

Defining ideal family size: Ideal family size is defined as the number of children women would have over the course of a lifetime if they were able to choose the exact number. Women with children are asked to think back to the time before they had any children before answering this question.

Average Desired Number of Children Among Currently Married Women 15 to 49





UNPLANNED PREGNANCY

Many women have more children than they want or have children sooner than they want.

Women are least likely to have an unplanned pregnancy in Central Asia. In Turkmenistan and Uzbekistan, less than 5 percent of recent pregnancies were mistimed or unwanted. Women are most likely to have an unplanned pregnancy in Latin America and the Caribbean, where over half of all recent pregnancies were either mistimed or unwanted in four countries. Levels of unplanned pregnancies vary widely within other regions.

In 42 of 54 countries surveyed, women are more likely to report that a pregnancy was mistimed than unwanted. This pattern is most striking in Sub-Saharan Africa, where women are interested in spacing births but want large families. According to women in Gabon, for example, 38 percent of recent pregnancies were mistimed but only 7 percent were unwanted.

The opposite pattern, in which women are more likely to consider a pregnancy unwanted than mistimed, is most common in Latin America and the Caribbean. In Bolivia, for example, women said 39 percent of recent pregnancies were unwanted while 23 percent were mistimed.

Trends. Over time, the percentage of unplanned pregnancies has decreased in 23 of 39 countries with two recent surveys. This does not necessarily reflect a drop in both mistimed and unwanted pregnancies, however: only 12 countries show declines in both. Overall, the percentage of mistimed births has decreased in 25 countries, and the percentage of unwanted births has decreased in 17 countries.

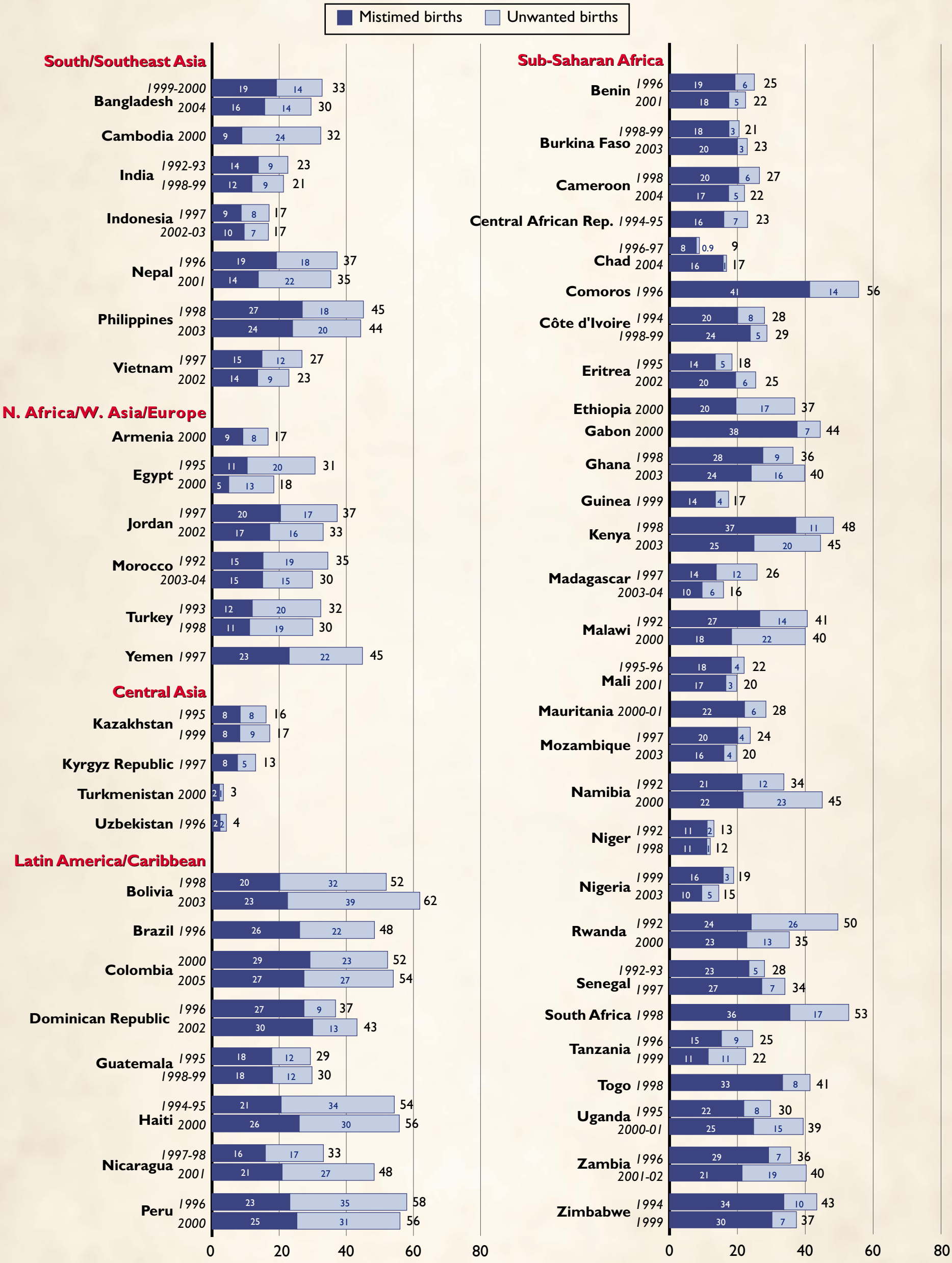
Unplanned pregnancies have declined throughout South/Southeast Asia and North Africa/West Asia/Europe. Egypt has experienced the biggest drop: in the 1995 DHS survey women reported that 31 percent of recent pregnancies were unplanned, compared with only 18 percent in the 2000 survey.

In Latin America and the Caribbean, unplanned pregnancies have increased over time in every country but Peru. The sharpest rise took place in Nicaragua, where the proportion of unplanned pregnancies climbed from 33 percent in 1997-98 to 48 percent in 2001.

Trends in Sub-Saharan Africa have been inconsistent, with wide variation in both the magnitude and direction of change. For example, the proportion of unplanned pregnancies fell from 50 percent to 35 percent in Rwanda over an eight-year period, while it almost doubled from 9 percent to 17 percent in Chad over a seven-year period. Other countries in the region have registered much smaller changes: for example, both the increase in Malawi and decrease in Côte d'Ivoire were less than 1 percentage point.

Defining unplanned pregnancies:
Unplanned pregnancies include both mistimed and unwanted pregnancies. For each child born during the last five years and for current pregnancies, women are asked whether they wanted to become pregnant at that time (defined as a wanted pregnancy), wanted to wait until later (defined as a mistimed pregnancy), or did not want to have any more children at all (defined as an unwanted pregnancy).

Percentage of Births in the Five Years Preceding the Survey That Were Mistimed or Unwanted



CONTRACEPTIVE KNOWLEDGE AND USE

Contraception gives women the means to control when they have children. More women than ever before are using family planning to space births or to stop childbearing altogether.

Contraceptive knowledge is generally high. In 33 of the 54 countries surveyed, over 90 percent of currently married women ages 15 to 49 know of two or more modern contraceptive methods, as do 80 to 90 percent of women in another 8 countries (data on contraceptive knowledge are not shown).

However, contraceptive knowledge remains low in some countries. Less than four-fifths of women know of two or more modern methods in Guatemala, Yemen, and 11 countries in Sub-Saharan Africa. Knowledge is lowest in Chad where only 36 percent of women can name at least two methods.

More women know about family planning than use a method. Modern contraceptive use ranges from 2 percent of currently married women in Chad to 70 percent in Brazil. Over half of married women use modern family planning methods in 14 countries scattered across every region. Less than one-fifth of married women use modern methods in 24 countries, all but 2 of which (Cambodia and Yemen) are located in Sub-Saharan Africa. Levels of contraceptive use in the remaining 16 countries range between 20 percent and 50 percent.

The use of modern methods outweighs traditional methods—usually by a large margin—in all but 8 of 54 countries surveyed. Less than 1 in 10 women rely on a traditional method in 37 of 54 countries surveyed. Only in Armenia, Bolivia, Turkey, and Vietnam do more than 2 in 10 women use traditional methods of contraception.

Trends. Modern contraceptive use has increased over time in all but 3 of 41 countries with two surveys. Modern use has declined in Nigeria and especially in Rwanda, while remaining at the same level in Kenya. Big gains have occurred both in countries where contraceptive use is relatively low and where it is relatively high. In both Malawi and Morocco, for example, modern contraceptive use has increased 19 percentage points, rising in Malawi from 7 percent in 1992 to 26 percent in 2000 and in Morocco from 36 percent in 1992 to 55 percent in 2003-04.

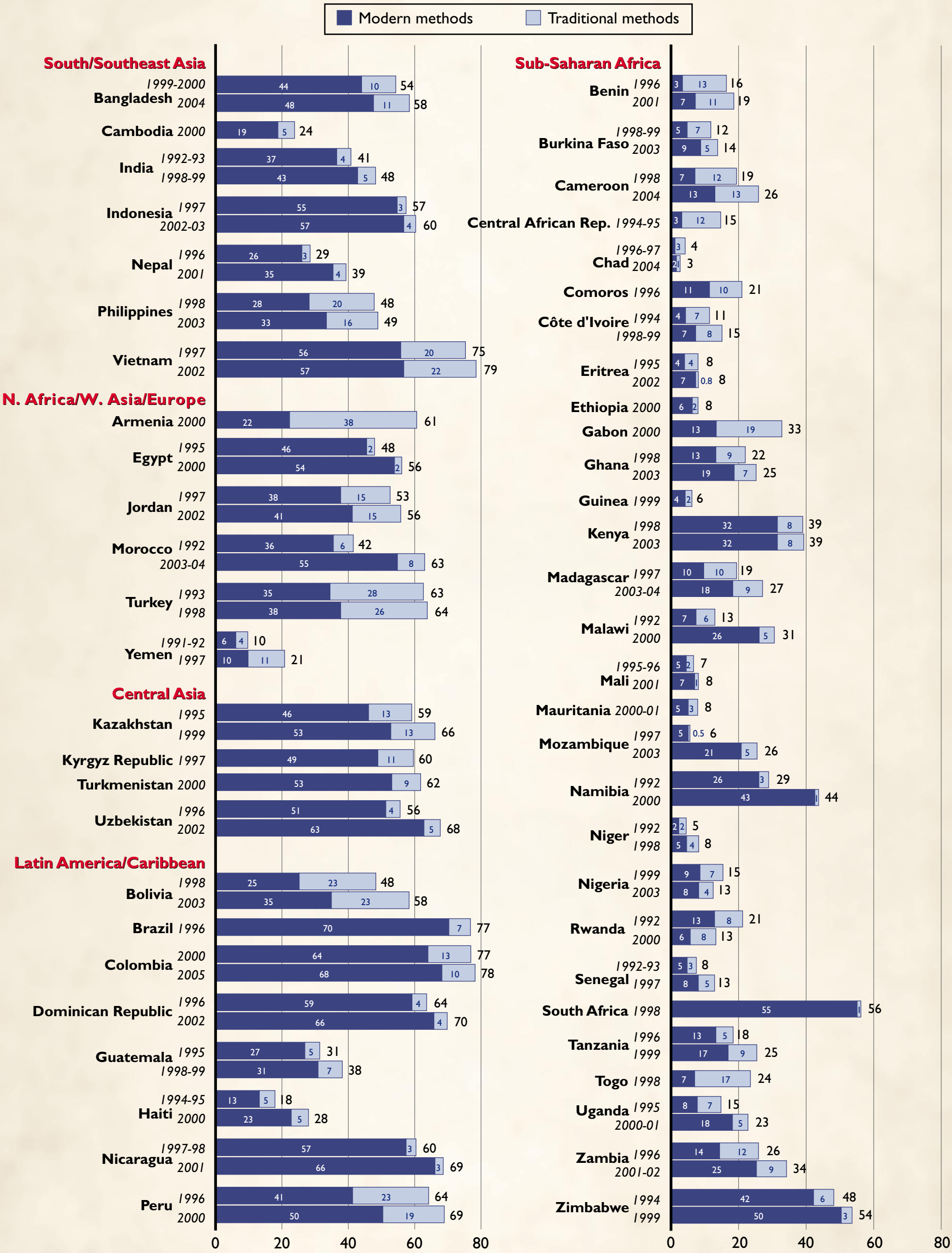
Trends in traditional contraceptive use are mixed. Use of traditional methods has increased in 19 countries, including all but one of those surveyed in South/Southeast and Central Asia; the exception is the Philippines. Use of traditional methods has decreased in 22 countries, largely in Sub-Saharan Africa.

Defining contraceptive knowledge: Information on contraceptive knowledge is collected by an open-ended question on what methods women have heard of, followed by prompting with the names of each method not mentioned spontaneously. Contraceptive knowledge is defined here as either the spontaneous or prompted knowledge of at least two modern methods.

Defining modern and traditional methods: Modern methods include female and male sterilization, oral contraceptives (combined and progestin-only), IUD, injectables, implants, male condom, female condom, diaphragm, and—with the exception of some older surveys—LAM (lactational amenorrhea method). Traditional methods include withdrawal and periodic abstinence.

Defining contraceptive use: A woman is considered to be a current contraceptive user if she is doing something or using any method with the intent of delaying or avoiding pregnancy—even if her method is ineffective.

Percentage of Currently Married Women 15 to 49 Who Are Currently Using Modern and Traditional Contraceptive Methods



CONTRACEPTIVE DISCONTINUATION

Women may decide to stop using a contraceptive method for many reasons, including the desire to have another child. Some decisions to discontinue a method may reflect the weakness of family planning counseling and follow-up services, for example, when a woman becomes pregnant because she has been using a method improperly or when methods are not available. When many women discontinue soon after starting a method, it may indicate a need to strengthen family planning services.

In 13 of 18 countries surveyed, total first-year discontinuation rates range from 33 percent to 44 percent of women using a modern contraceptive method. Rates are exceptionally low in Indonesia, Vietnam, and Zimbabwe, where only 20 to 22 percent of women stop using a modern method during the first year. Bangladesh has the highest discontinuation rate, 50 percent, among the countries surveyed.

Method failure accounts for only a small portion of the first-year discontinuation rate: no more than 6 percent of women became pregnant while using a modern method in every country surveyed except Armenia. The number of women who stopped using a modern method because they wanted to become pregnant is also small, with the highest levels of 8 percent to 9 percent found in Bangladesh and Morocco.

Women are more likely to discontinue because they want to switch methods. From 5 percent of women using a modern method in Vietnam and Zimbabwe to 19 percent in Bangladesh switched methods during the first year of use. Switching is relatively more common in Latin America and the Caribbean.

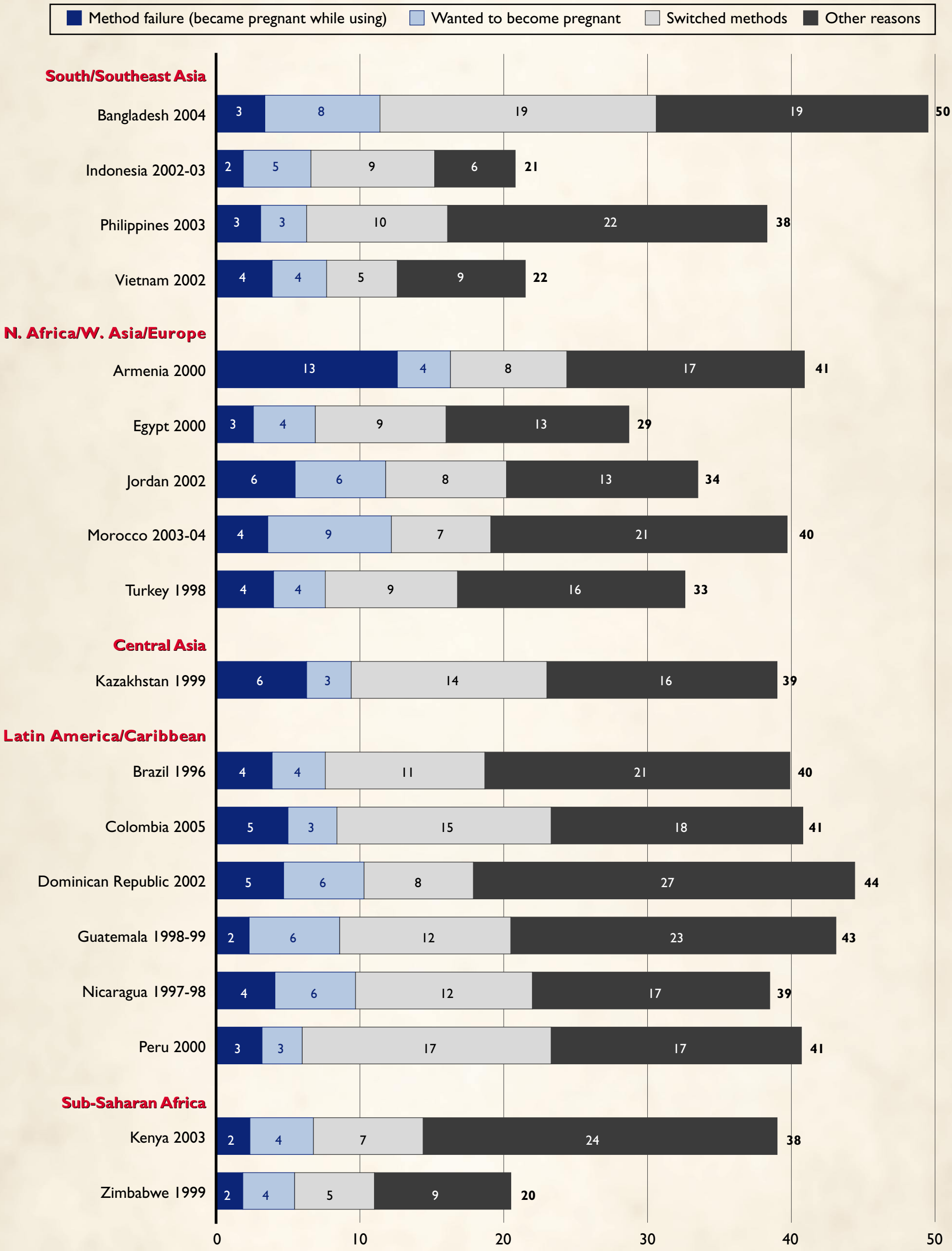
In all but 2 of 18 countries surveyed, the largest group of women who discontinued a modern method during the first year of use did so for "other" reasons. To identify these other reasons, we must turn to data on all discontinuations of a modern method during the five years prior to the survey—including women who discontinued a method after using it for more than one year.

The most commonly mentioned "other" reason for discontinuing a modern method is side effects. In 12 of the 18 countries surveyed more than 20 percent of women cited side effects, with the highest proportions, around 38 percent, in Egypt and Peru. Armenia and Morocco are the only countries where fewer than 10 percent of women mentioned side effects as a reason for discontinuing a method (data on reasons for discontinuation during the five years preceding the survey are not shown).

Many women also cited health concerns. From 10 to 20 percent of women in 7 countries said they discontinued a method because of health concerns; less than 10 percent did so in the remaining 11 countries. Reasons other than side effects and health concerns were generally less important, with the exception of a few countries. For example, 16 percent of women in Kazakhstan said they wanted a more effective method, while 16 percent of women in Morocco explained that they were having sex infrequently or their husbands were away.

Defining contraceptive discontinuation:
Information on contraceptive discontinuation comes from the calendar section of the Woman's Questionnaire, which is used to record all births, pregnancies, pregnancy terminations, and episodes of contraceptive use. For each month over the past five years, the interviewer notes whether a woman was pregnant or using a contraceptive method—and, if using family planning, the type and source of the method. The interviewer also records the reason each time a woman discontinues a method. Discontinuations are defined as any time a woman stops using a method, whether she ceases using contraception entirely or switches to another method. Only modern methods are considered in the analysis presented here.

Among Women Using a Modern Method of Contraception, Percentage Who Discontinued That Method During the First Year of Use, by Reason for Discontinuation



UNMET NEED FOR CONTRACEPTION

In every country surveyed, a sizeable percentage of women say that they would like to stop having children or wait at least two years before having their next child. Many of these women are not currently using contraception and thus are considered as having an unmet need for family planning services.

In 29 of 54 countries surveyed, more than 20 percent of currently married women ages 15 to 49 are potentially in need of contraception. The level of unmet need ranges from 5 percent of women in Vietnam to 40 percent in Haiti.

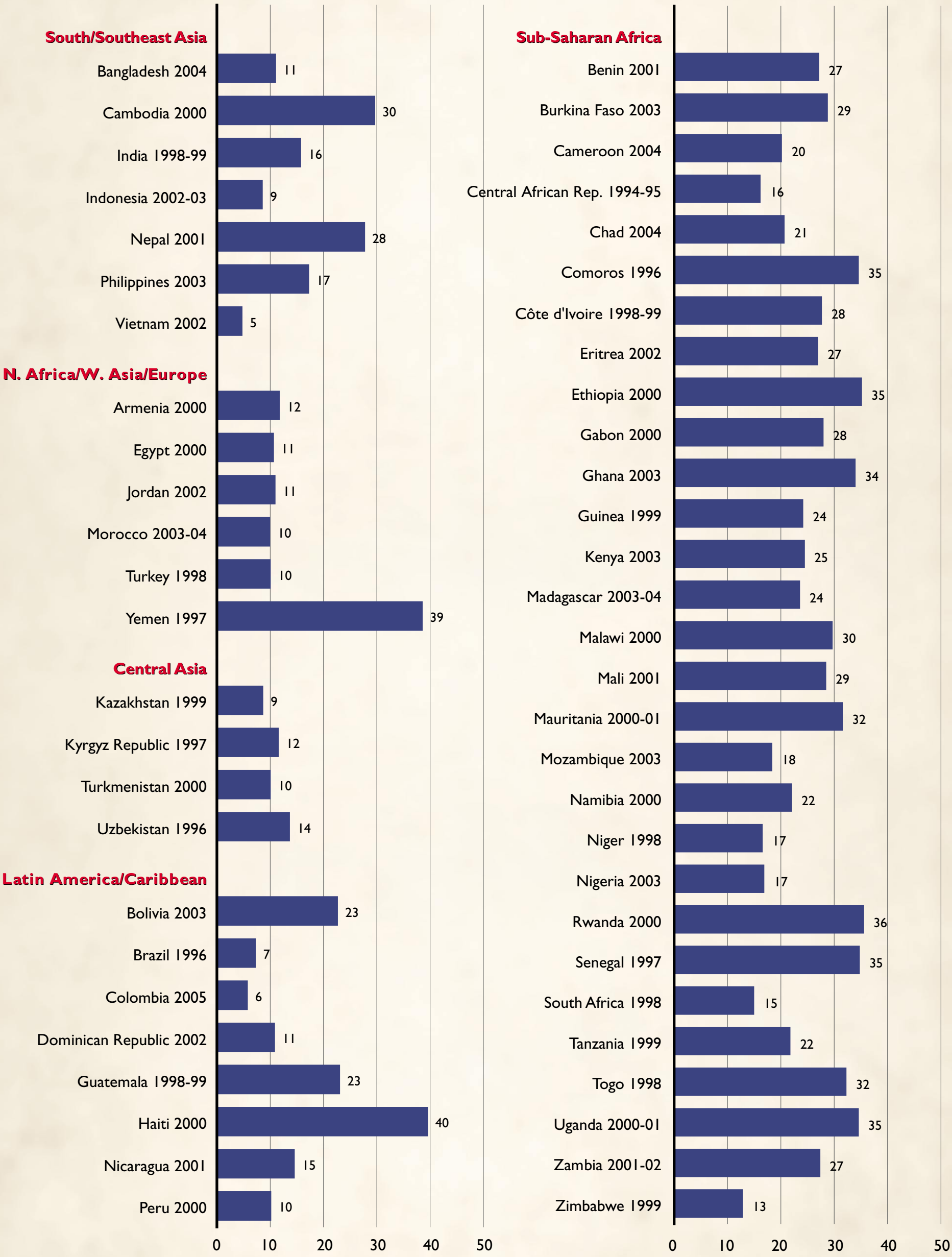
In every country surveyed in North Africa/West Asia/Europe and Central Asia, with the exception of Yemen, less than 15 percent of women have an unmet need for contraception. Elsewhere unmet need for contraception is quite variable but tends to be higher in Sub-Saharan Africa. In 8 of 29 countries surveyed in that region, over 30 percent of married women are potentially in need of contraception.

As contraceptive use grows, women are more likely to have their need for contraception met. As a result, unmet need tends to be lower in countries where contraceptive use is high. For example, in Brazil, Colombia, Indonesia, Kazakhstan, and Vietnam, where over half of married women use modern methods, less than 10 percent of married women have an unmet need for contraception. In contrast, in Mauritania, Rwanda, and Senegal, where only 5 to 8 percent of married women currently use a modern method, over 30 percent of married women have an unmet need for contraception.

Yet, in societies where contraceptive use is limited but women want large families, unmet need also may be relatively low. In Niger, for example, only 17 percent of married women have an unmet need for family planning even though just 8 percent use contraception of any kind. However, women in Niger want 8 or 9 children, on average.

Defining unmet need: Unmet need is defined as the percentage of all currently married women who are in need of contraception but are not currently using a method. It is derived from information on women's fertility preferences and current contraceptive use. Women who say they do not want any more children or want to wait at least two years before having another child, but are not currently using a contraceptive method, are considered to have an unmet need for contraception.

Percentage of Currently Married Women 15 to 49 Who Are Potentially in Need of Contraception



HEALTH STATUS

Overnutrition is more common than undernutrition in three-quarters of the 50 countries surveyed.

From 18 percent of ever-married women in Bangladesh to 54 percent in Bolivia report suffering physical and/or sexual violence at the hands of their partners.

Female genital cutting poses a serious health risk for women and their infants; in seven countries in northeast and west Africa, over 70 percent of women 15 to 49 are cut.

NUTRITIONAL STATUS

Undernutrition has long posed a health problem in developing countries. It can increase the risk of illness and death, threaten pregnancy outcomes, and even reduce cognitive development. More recently, overnutrition has emerged as a health problem for adult women in the developing world, following a pattern first observed in Western societies. Being overweight or obese can increase the risk of developing chronic diseases such as hypertension, coronary heart disease, diabetes, stroke, and some forms of cancer.

At least one-fifth of women ages 15 to 49 are undernourished in 10 of 50 countries surveyed, and at least one-fifth are overnourished in 25 countries. In 13 countries more women suffer from undernutrition than overnutrition; the opposite is true in the remaining 37 countries.

Undernutrition remains the leading dietary challenge for women in parts of South/Southeast Asia and Sub-Saharan Africa. More than one-third of women are undernourished in the three most affected countries: Bangladesh, India, and Eritrea.

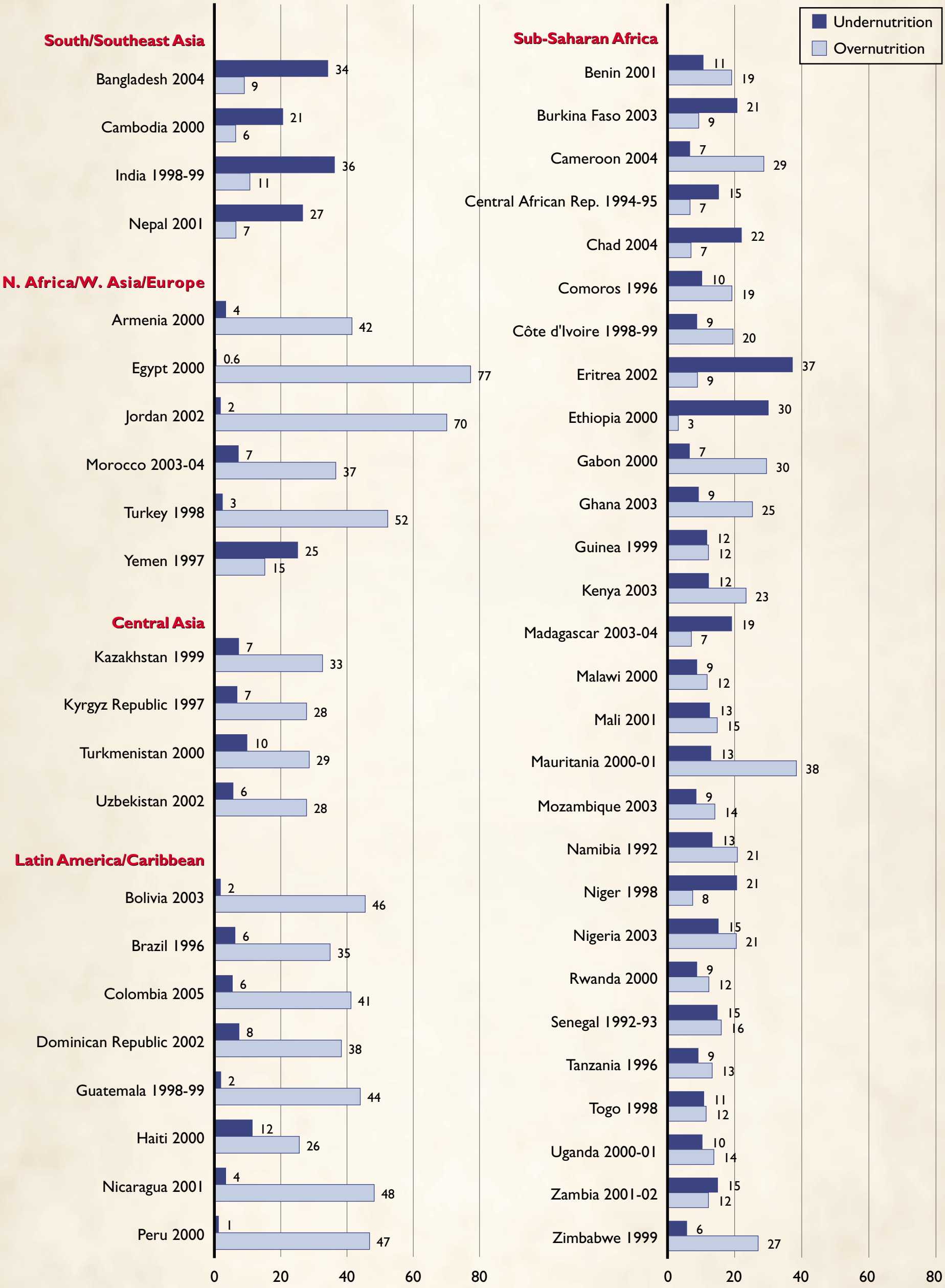
In contrast, overnutrition has become the principal dietary challenge in North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean. With the exception of Yemen, more than one-fourth of women in every country in these regions are overweight or obese. Seventy percent or more are overnourished in the two most affected countries: Egypt and Jordan.

Both under- and overnutrition exist side by side in Sub-Saharan Africa. Undernutrition is common in Burkina Faso, Chad, Eritrea, Ethiopia, and Niger, affecting more than one-fifth of women. Overnutrition affects more than one-fifth of women in Cameroon, Gabon, Ghana, Kenya, Mauritania, Namibia, Nigeria, and Zimbabwe. In countries such as Guinea, Senegal, and Togo, virtually equal proportions of women are under- and overnourished.

The highest level of overnutrition in Sub-Saharan Africa, 38 percent, is found in Mauritania due in large part to the practice of *gavage*, or force-feeding, which was documented in the 2000-01 DHS survey. This practice, which is found almost exclusively in Mauritania, forces young girls—often through brutal means—to absorb huge quantities of food so they will become "big" women who are ready for marriage. Many of these big women have difficulty moving, are unable to work, and are at increased risk of developing chronic diseases.

Defining under- and overnutrition:
Nutritional status is defined by the body mass index (BMI), which is a woman's weight in kilograms divided by the square of her height in meters (kg/m^2). Undernutrition is defined as a BMI of less than 18.5. Overnutrition is divided into two categories: overweight is defined as a BMI of 25-29.9, while obese is defined as a BMI of 30 or more

Percentage of Women 15 to 49 Who Are Undernourished or Overnourished



IRON-DEFICIENCY ANEMIA

Iron-deficiency anemia is the most common micronutrient deficiency in the world. In young women, the growth spurt at puberty and onset of menstruation may exhaust the body's iron supplies and exacerbate or trigger anemia. Anemia is associated with a host of health problems in women, especially pregnant and breastfeeding women. These include poor pregnancy outcomes, lower resistance to infection, decreased work capacity, and poor cognitive development.

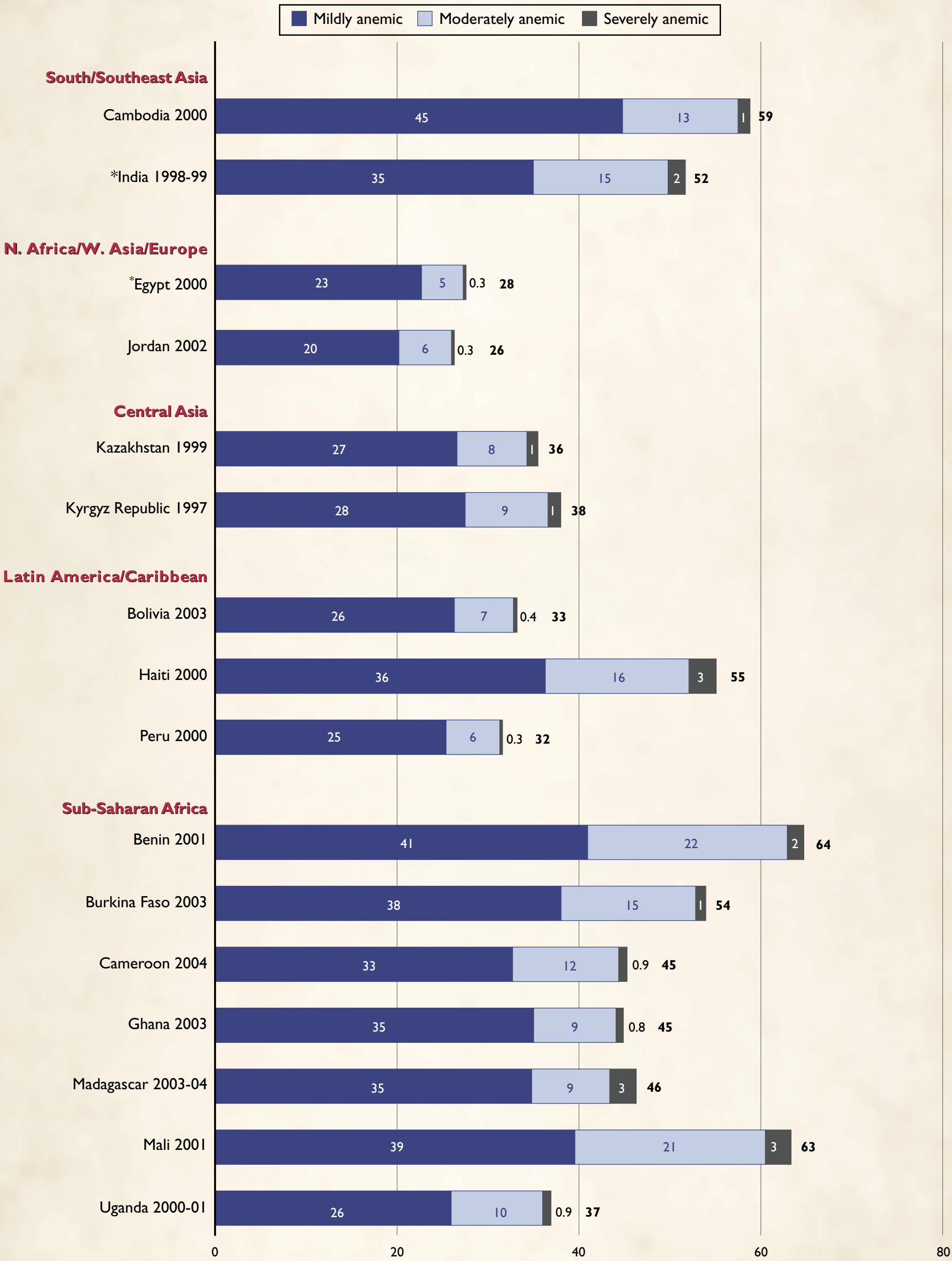
To assess the prevalence of anemia, DHS surveys measure hemoglobin levels among a subsample of women. So far, data have been collected from 16 countries from every region in the world.

Although the number of countries surveyed is limited, the data suggest that no region is spared from anemia. At least one-quarter of women ages 15 to 49 are affected by anemia in every one of the 16 countries surveyed, although most are only mildly anemic. Over half of all women in Benin, Burkina Faso, Cambodia, Haiti, India, and Mali are anemic, with 14 percent to 24 percent of women in these countries experiencing moderate to severe anemia.

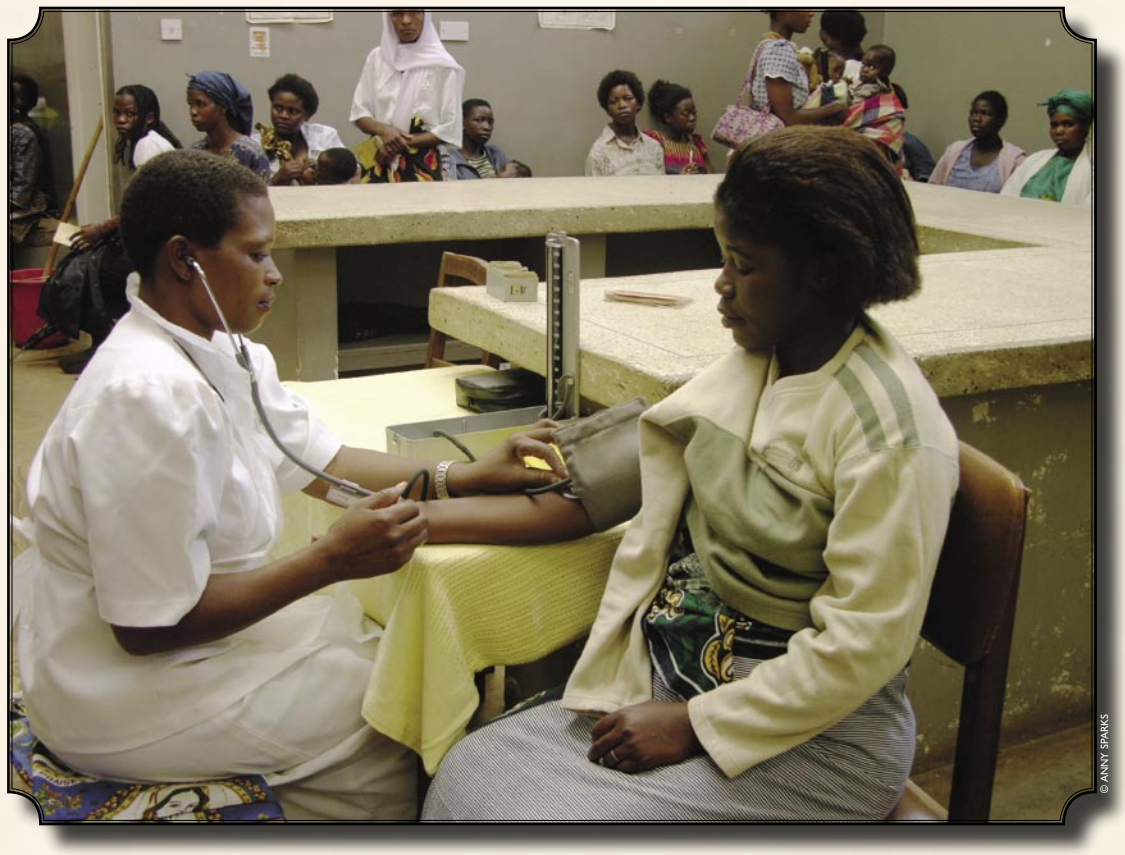
Defining anemia: Severe anemia is defined as a hemoglobin level of less than 7 grams per deciliter, and moderate anemia as hemoglobin levels between 7 and 9.9. The definition of mild anemia depends on whether a woman is pregnant: it is defined as levels of 10 to 10.9 in pregnant women and 10 to 11.9 in non-pregnant women.

Hemoglobin testing in DHS surveys: Fieldworkers read women a consent statement that describes the purpose of the blood test and explains that the results will be made available immediately. When a woman agrees to the test, the fieldworker pricks her finger, collects a drop of blood, and places it in a machine which displays the hemoglobin level.

Percentage of Women 15 to 49 Who Are Affected by Anemia



* For ever-married women



FEMALE GENITAL CUTTING

Female genital cutting (FGC) refers to "the cutting and removal of tissues of genitalia of young girls to conform to social expectations".[1] The World Health Organization (WHO) speaks of injury to or removal of the female genitalia "for cultural or any other non-therapeutic reason".[2] FGC is a common practice in many societies in the northern half of sub-Saharan Africa as well as in Egypt and Yemen. Nearly universal in a few countries, it is practiced by various groups in many African countries and in immigrant populations in Europe and North America. In a few societies, the procedure is routinely carried out when a girl is a few weeks or a few months old (for example, Eritrea and Yemen), while in most others, it occurs later in childhood or adolescence.

The practice of FGC not only violates internationally recognized human rights, but also poses health risk for those cut. In the short term, FGC exposes girls to the risk of hemorrhage, shock and infection. Later in life, the practice increases the risk of serious complications during childbirth.[3] The more extensive and severe the procedure, the more likely are women to experience adverse obstetric outcome.

DHS surveys in 18 African countries and Yemen have collected information about FGC. The prevalence of the practice ranges widely. In 7 countries in northeast and west Africa, over 70 percent of women ages 15 to 49 are cut, and the practice is almost universal in Egypt and Guinea. The prevalence of FGC is lowest in Cameroon, Ghana, and Niger, where 5 percent or less of women are cut.

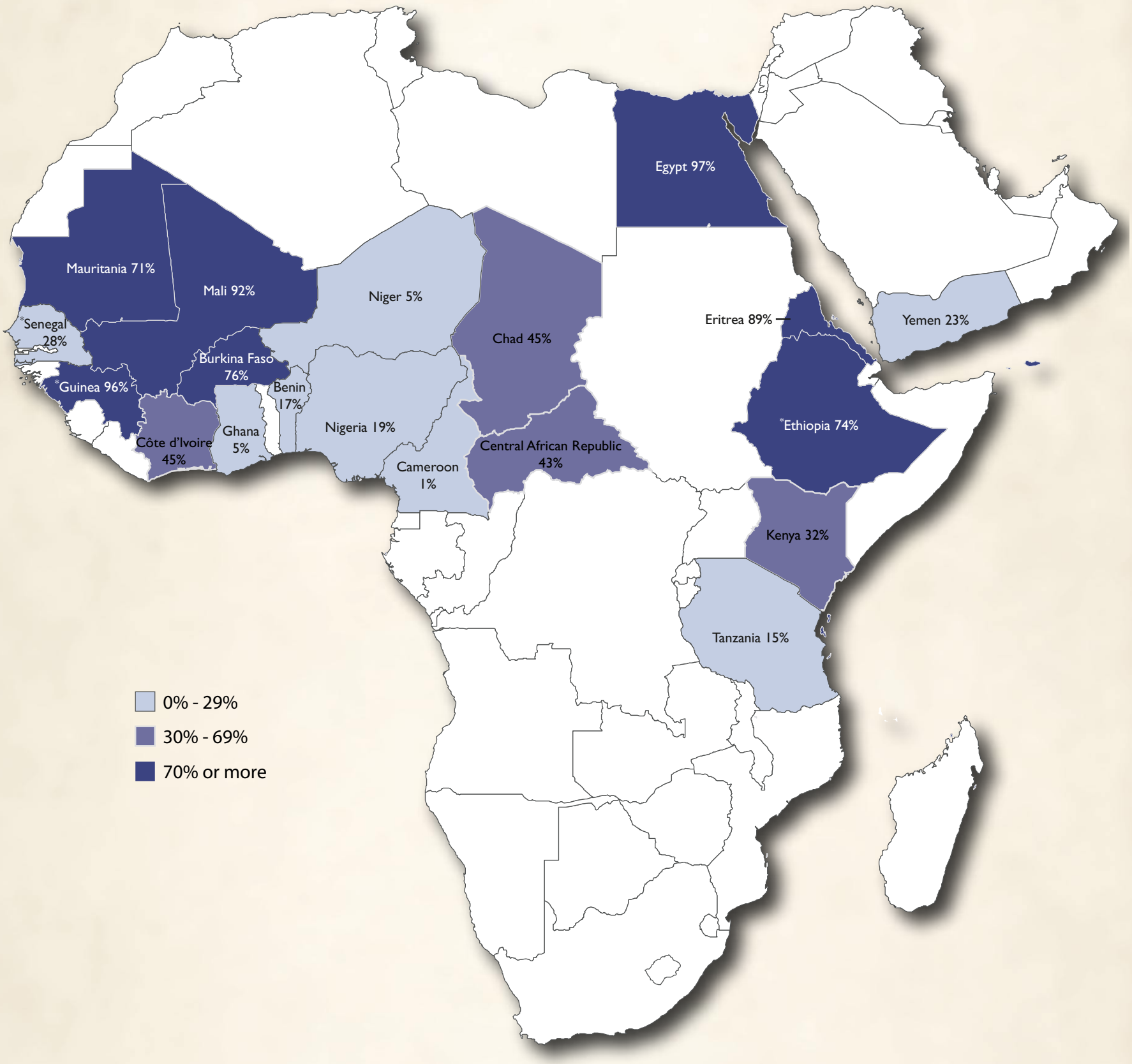
Defining female genital cutting (FGC):
DHS surveys rely on self-reporting by women rather than physical examinations to collect information about the prevalence of FGC. Interviewers employ local languages and locally recognized terms for the practice. Data collected encompass a range of procedures, including partial or complete removal of the clitoris, labia minora, and/or external genitalia, with or without stitching or narrowing of the vaginal opening.

[1] Gruenbaum, E. *The female circumcision controversy: An anthropological perspective.* Philadelphia, Pennsylvania: University of Pennsylvania Press, 2001.

[2] World Health Organization (WHO). F*emale genital mutilation: An overview.* Geneva: WHO, 1998.

[3] WHO study group on female genital mutilation and obstetric outcome. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet* 367:1835-41, 2006.

Percentage of Women 15 to 49 Who Have Experienced Female Genital Cutting



DATA TABLE

	Prevalence of FGC (in percent)
N. Africa/W. Asia/Europe	
Egypt 2000	97
Yemen 1997	23
Sub-Saharan Africa	
Benin 2001	17
Burkina Faso 2003	76
Cameroon 2004	1
Central African Rep. 1994-95	43
Chad 2004	45
Côte d'Ivoire 1998-99	45
Eritrea 2002	89

	Prevalence of FGC (in percent)
Sub-Saharan Africa *(continued)*	
Ethiopia 2005	74*
Ghana 2003	5
Guinea 2005	96*
Kenya 2003	32
Mali 2001	92
Mauritania 2000	71
Niger 1998	5
Nigeria 2003	19
Senegal 2005	28*
Tanzania 2005	15

* Based on preliminary findings.

VIOLENCE AGAINST WOMEN

Many women experience physical, psychological, emotional, and sexual violence in what should be a secure environment—their own homes. Indeed, in many societies women are socialized to accept and tolerate domestic abuse.

In addition to causing physical injuries and psychological problems, violence against women may limit their ability to negotiate safe sex practices, thus increasing their risk of HIV and other sexually transmitted infections. Also, sexual abuse during childhood and adolescence increases the likelihood that women will engage in high-risk sexual behaviors as adults.

DHS surveys in 12 countries around the world have asked women about their experience of violence. A substantial number of women ages 15 to 49 in all countries, ranging from about one-fifth in India to almost three-fifths in Bolivia and Zambia, report that they have experienced physical and/or sexual violence at some point during their lives.

Much of this violence is perpetrated by women's husbands and domestic partners. From 18 percent of ever-married women in Bangladesh to 54 percent in Bolivia report that they have at some time suffered physical and/or sexual violence at the hands of their partners. Such violence is a current concern for the 10 percent to 28 percent of married women who reported violent acts by their partners within the past year.

Defining violence against women: To assess domestic violence, DHS surveys inquire about a series of specific acts. Data presented in this report include physical and sexual violence. Physical violence includes being pushed, shaken, hit, slapped, bitten, kicked, dragged, strangled, threatened with a weapon, attacked with a weapon or having an arm twisted; also included is when a woman has an object thrown at her. Sexual violence is defined as being threatened or physically forced to have unwanted sexual intercourse or to perform unwanted sexual acts. Not every survey includes every item in these lists.

Percentage of Women 15 to 49 Who Have Ever Experienced Physical or Sexual Violence

	Percentage of all women 15-49 who have ever experienced violence by anyone	Percentage of ever-married women 15-49 who have ever experienced violence by husband or partner	Percentage of ever-married women 15-49 who have experienced violence by husband or partner in the 12 months before survey
South/Southeast Asia			
Cambodia 2000	23[1]	18	15
India 1998-99	21[1]	19[2]	10[2]
N. Africa/W. Asia/Europe			
Egypt 1995	35[3]	34[2]	13[2]
Latin America/Caribbean			
Bolivia 2003	58[1]	54	na
Colombia 2005	40	43	22
Dominican Republic 2002	24	22	11
Haiti 2000	35	29	21
Nicaragua 1997-98	33[1]	30	13
Peru 2000	47	42[2]	na
Sub-Saharan Africa			
Cameroon 2004	53	42	28[3]
Kenya 2003	49	43	28[4]
Zambia 2001-02	59	48	27

[1] For ever-married women only
[2] Physical violence only
[3] For currently married women
[4] Excludes widows
na: Not available

HIV/AIDS AND OTHER STIs

When asked how people can avoid getting HIV, over 60 percent of women in 10 countries do not mention any of the three basic prevention strategies: using condoms, limiting partners, or abstaining from sex.

In 20 of 33 countries surveyed, most currently married women have never discussed AIDS prevention with their husbands or partners.

The last time women ages 15 to 24 had sexual intercourse with a higher risk partner, less than 30 percent used a condom in 15 of 27 countries surveyed.

KNOWLEDGE OF HIV/AIDS

Before women can take action to protect themselves from HIV infection, they must be aware of the threat posed by the virus and understand how it is spread. Yet women are often less well informed about HIV/AIDS than men because of lower literacy rates, limited access to print and mass media, and sociocultural norms that discourage them from discussing sexual behaviors, including condom use. AIDS information campaigns and open discussion of HIV in the media can promote overall knowledge of HIV/AIDS in the population, but these vary widely between countries.

In 36 of 49 countries surveyed, over 90 percent of women have heard of AIDS (data on general knowledge of AIDS are not shown). However, knowledge is limited in some parts of South/Southeast Asia: only 40 percent to 60 percent of women in Bangladesh, India, Indonesia, and Nepal have heard of AIDS. Women's knowledge is also exceptionally low in Niger, where just 55 percent of women have heard of AIDS.

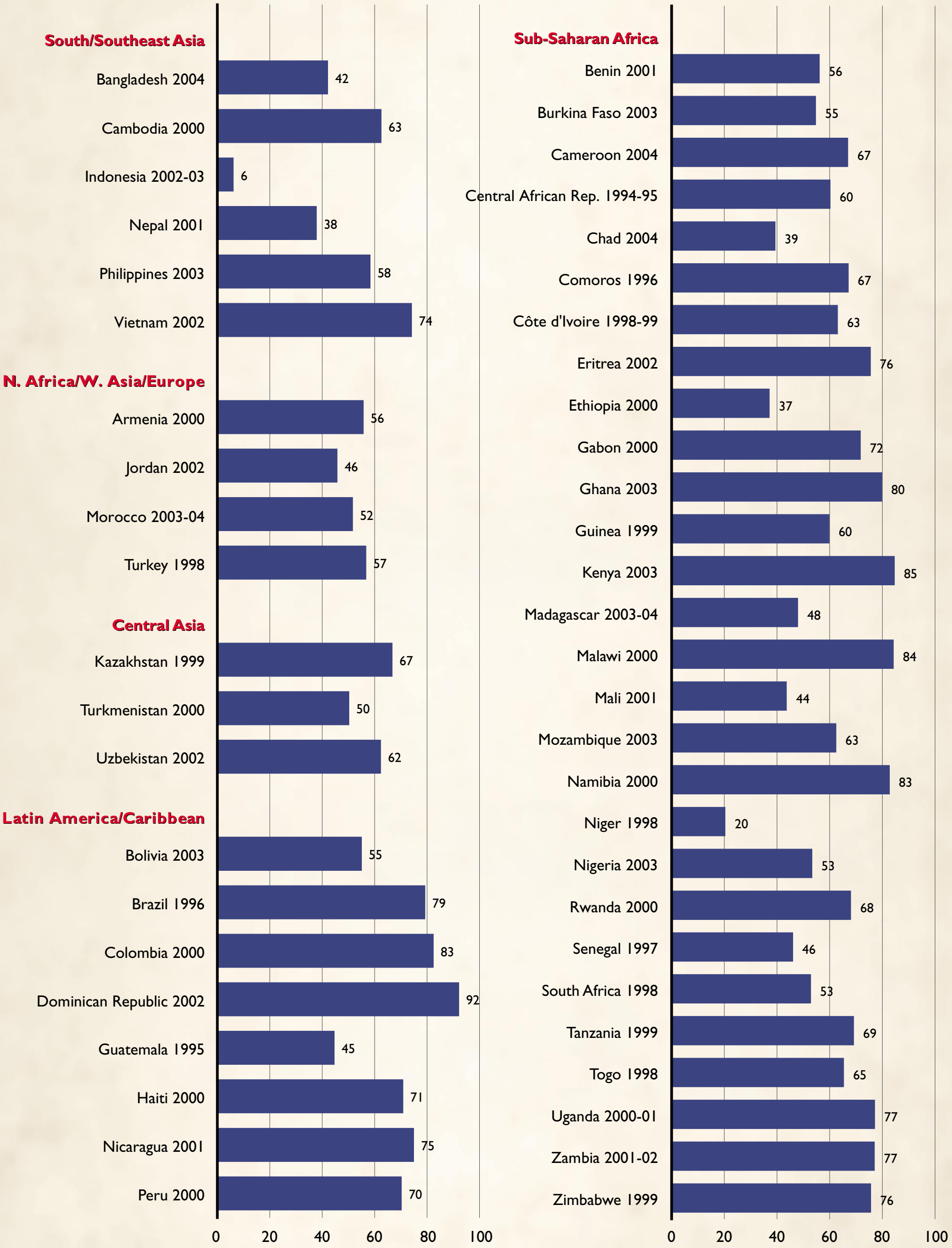
Many women mistakenly believe that they can judge whether people have HIV based on their appearance. Misconceptions like this increase women's vulnerability to infection by leading them to underestimate the risks of unprotected sex and reducing their motivation to protect themselves from infection.

In 11 of 49 countries surveyed, less than half of women ages 15 to 49 realize that a healthy-looking person can have HIV. This misunderstanding is most pervasive in Indonesia, where only 6 percent of women know that people can look healthy and still be infected with HIV.

Women are most likely to have correct information in Latin America and the Caribbean and Sub-Saharan Africa. In these regions, at least three-quarters of women in 12 countries understand that a healthy-looking person can have HIV. That knowledge is nearly universal in the Dominican Republic, where 92 percent of women realize that a person's physical appearance does not necessarily reflect their HIV status.

Measuring HIV/AIDS knowledge: DHS surveys ask women whether they have ever heard of an illness called AIDS and whether it is possible for a healthy-looking person to have the AIDS virus.

Percentage of Women 15 to 49 Who Know That a Healthy Looking Person Can Have the AIDS Virus



KNOWLEDGE OF AIDS PREVENTION

DHS surveys explore women's knowledge of three basic strategies to avoid AIDS: using condoms, limiting oneself to a single faithful and uninfected sex partner, and abstaining from sex.

Awareness of these prevention strategies is low, especially outside of Sub-Saharan Africa. When asked "Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?", less than half of women ages 15 to 49 spontaneously mentioned using condoms in 38 of 50 countries surveyed. Women are even less familiar with the other two ways to protect themselves: less than half spontaneously mentioned limiting partners in 41 countries and abstaining from sex in 47 countries.

In 10 of 49 countries surveyed, over 60 percent of women do not spontaneously mention any of these three prevention strategies. Knowledge is lowest in South/Southeast Asia. In Indonesia, 4 out of 5 women could not name any of the three strategies.

Spontaneous knowledge is highest in Sub-Saharan Africa: more than three-quarters of women in 12 of 27 countries surveyed in this region can name at least one prevention strategy without prompting. In other words, less than one-quarter of women do not know any of the three prevention strategies. Chad and Niger are noteworthy for the lowest levels of knowledge in the region; 58 percent and 75 percent of women, respectively, in these countries could not name any of the three prevention strategies.

In Central Asia and most countries of North Africa/West Asia/Europe, women are more likely to mention limiting the number of sex partners than the other prevention strategies. In contrast, women in Latin America and the Caribbean most often mention using condoms. The pattern is mixed in South/Southeast Asia and Sub-Saharan Africa. In these two regions, limiting partners is the strategy most often mentioned in 20 countries, using condoms in 12 countries, and abstaining from sex in 2 countries (Malawi and Rwanda).

Prompting women with specific questions about each prevention strategy generally elicits higher levels of knowledge (data on prompted knowledge are not shown). The extent to which knowledge increases with prompting varies widely between countries and among strategies. For example, in Mozambique prompting increases the proportion of women who recognize that abstaining from sex can prevent AIDS from 9 percent to 46 percent. Prompting makes much less impact on knowledge of other strategies, which increase from 49 percent to 53 percent for using condoms and from 41 percent to 53 percent for limiting partners.

Defining knowledge of AIDS prevention:
Spontaneous knowledge of AIDS prevention strategies is assessed by a question that asks what a person can do to avoid getting AIDS or the AIDS virus. The question is open-ended, that is, it allows women to respond in their own words, and no answers are suggested. While there are many possible answers, this publication only presents data on abstaining from sex, using condoms, and limiting oneself to a single faithful and uninfected partner. Prompted knowledge of AIDS prevention strategies is assessed by a series of three questions asking women directly whether each strategy can reduce the chances of a person getting the AIDS virus.

Percentage of Women 15 to 49 Who Spontaneously Name Basic AIDS Prevention Strategies

	Percentage of women 15-49 who, when asked about what a person can do to avoid AIDS, spontaneously answer:			
	Using condoms	Limiting oneself to a single faithful and uninfected patner	Abstaining from sex	None of these three strategies
South/Southeast Asia				
Bangladesh 2004	22	3	7	73
Cambodia 2000	66	36	23	30
India 1998-99	8	16	3	79
Indonesia 2002-03	5	14	1	82
Nepal 2001	21	13	5	72
Philippines 2003	12	36	19	46
Vietnam 2002	45	57	4	25
N. Africa/W. Asia/Europe				
Armenia 2000	27	23	24	45
Jordan 2002	0.8	39	15	48
Morocco 2003-04	15	25	9	63
Turkey 1998	13	14	5	71
Central Asia				
Kazakhstan 1999	36	48	14	31
Turkmenistan 2000	16	22	16	62
Uzbekistan 2002	13	29	24	48
Latin America/Caribbean				
Bolivia 2003	39	33	14	43
Brazil 1996	80	9	3	15
Colombia 2005	76	18	8	18
Dominican Republic 2002	73	43	19	10
Guatemala 1995	21	16	10	64
Haiti 2000	39	32	11	42
Nicaragua 2001	19	17	13	65
Peru 2000	33	28	11	44
Sub-Saharan Africa				
Benin 2001	36	40	4	45
Burkina Faso 2003	39	43	24	32
Cameroon 2004	46	44	44	24
Central African Rep. 1994-95	29	46	15	32
Chad 2004	5	27	25	58
Comoros 1996	35	35	1	47
Côte d'Ivoire 1998-99	45	66	12	9
Eritrea 2002	54	72	47	13
Ethiopia 2000	17	53	11	39
Gabon 2000	64	23	17	27
Ghana 2003	23	35	29	38
Guinea 1999	22	65	27	23
Kenya 2003	41	57	43	16
Madagascar 2003-04	38	50	11	37
Malawi 2000	55	24	67	10
Mali 2001	31	27	16	48
Mozambique 2003	49	41	9	37
Namibia 2000	81	31	35	13
Niger 1998	12	13	7	75
Nigeria 2003	12	33	17	49
Rwanda 2000	37	21	76	12
Senegal 1997	26	35	24	43
South Africa 1998	85	na	na	na
Tanzania 1999	56	47	28	23
Togo 1998	33	37	8	36
Uganda 2000-01	54	49	50	14
Zambia 2001-02	48	46	44	17
Zimbabwe 1999	66	58	17	19

na: Not available

KNOWLEDGE OF STI SYMPTOMS

Sexually transmitted infections (STIs) can lead to a host of health problems for women and their unborn children, including pelvic inflammatory disease, infertility, chronic pelvic pain, stillbirth, and low birth weight. STIs, especially those that cause ulcers in the genital area, also increase the risk of acquiring and transmitting HIV.

Unless women recognize the symptoms of STIs, they may not realize that they or their partners need treatment. However, most women have little knowledge of STI symptoms (data on knowledge of STI symptoms are not shown). In 22 of 30 countries surveyed, less than half of ever-married women can name even one symptom either for an STI in a woman or for an STI in a man.

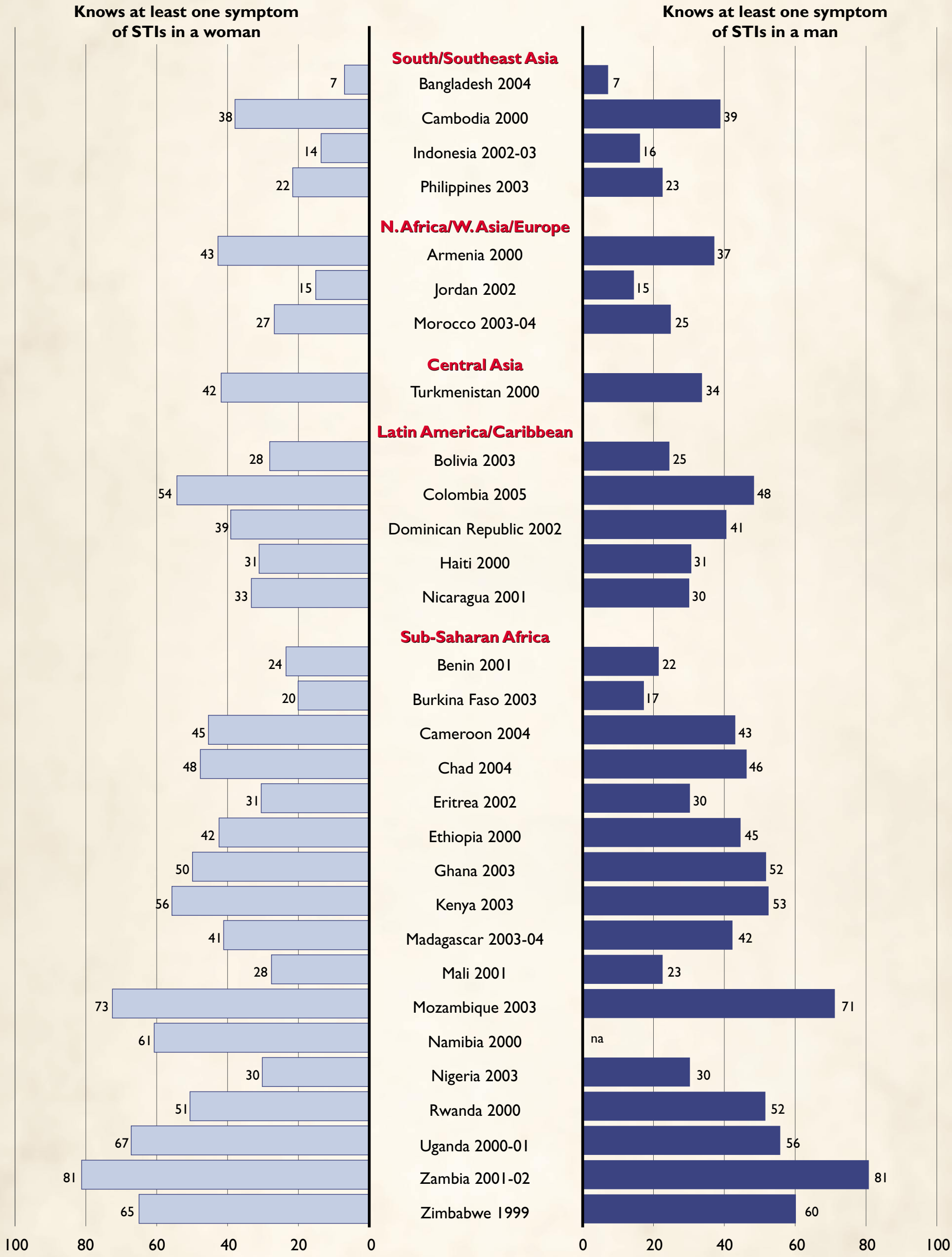
Women are less familiar with STI symptoms in South/Southeast Asia, North Africa/West Asia/Europe, and Central Asia. Knowledge is lowest in Bangladesh, Indonesia, and Jordan, where less than 20 percent of women can name at least one female and one male STI symptom.

Women are most knowledgeable in parts of Sub-Saharan Africa. This region includes all 7 countries where over half of women can name at least one female and one male STI symptom. Knowledge is greatest in Mozambique and Zambia, where about 70 percent and 80 percent of women, respectively, can name at least one male and one female STI symptom.

Differences in women's knowledge of female and male STI symptoms are relatively small in most countries. Women are more likely to know of a female than a male symptom in 19 of 29 countries surveyed, but generally by only a small margin. Knowledge of a female symptom exceeds knowledge of a male symptom by at least 5 percentage points only in Armenia, Colombia, Mali, Turkmenistan, and Uganda. The countries where women are more likely to know of a male than a female STI symptom are largely clustered in South/Southeast Asia and parts of Sub-Saharan Africa, but they also include the Dominican Republic.

Defining knowledge of STI symptoms:
Only spontaneous knowledge of STI symptoms is assessed. Open-ended questions ask what symptoms a man with a STI might have and a woman with a STI might have. There are many acceptable answers for each sex, including abdominal pain, genital discharge, burning pain on urination, and genital sores and ulcers.

Percentage of Ever-married Women 15 to 49 Who Know of STI Symptoms



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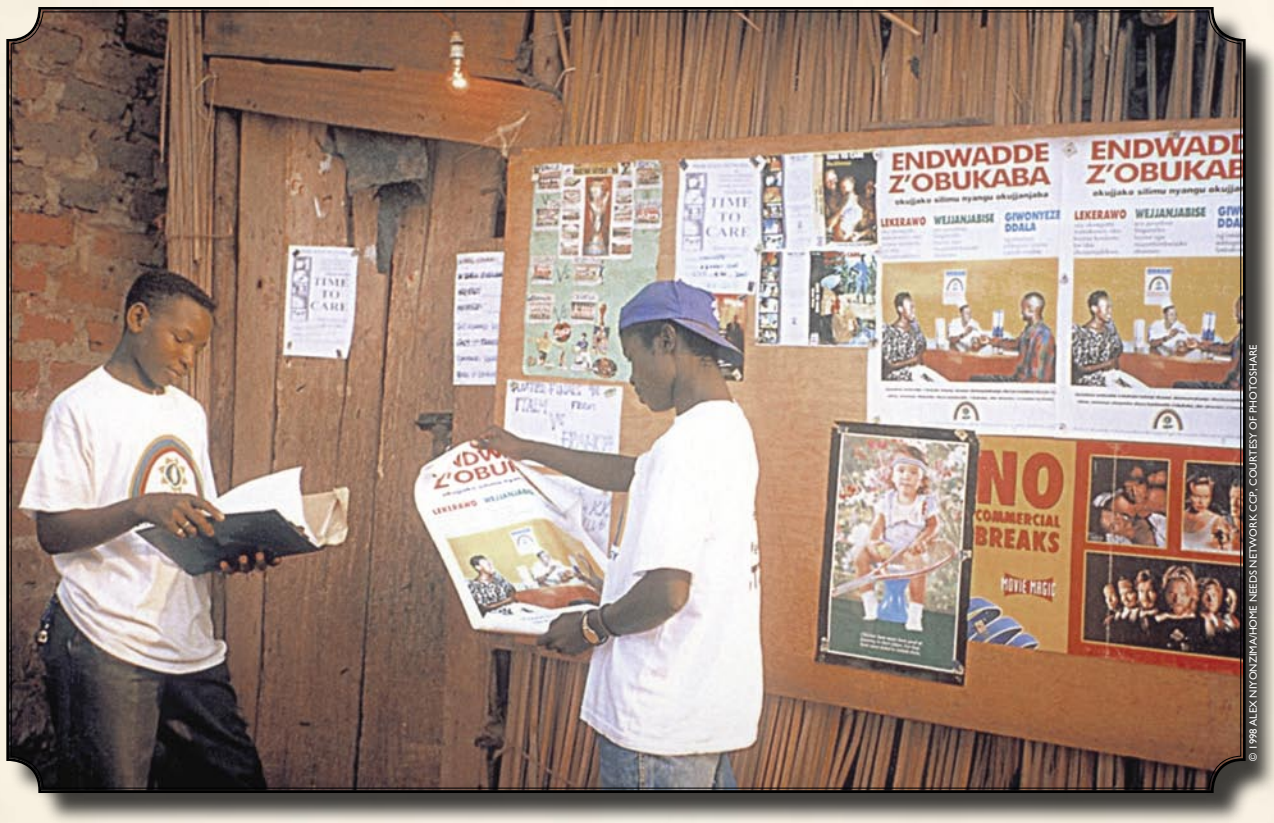


DISCUSSION OF HIV/AIDS WITH PARTNER

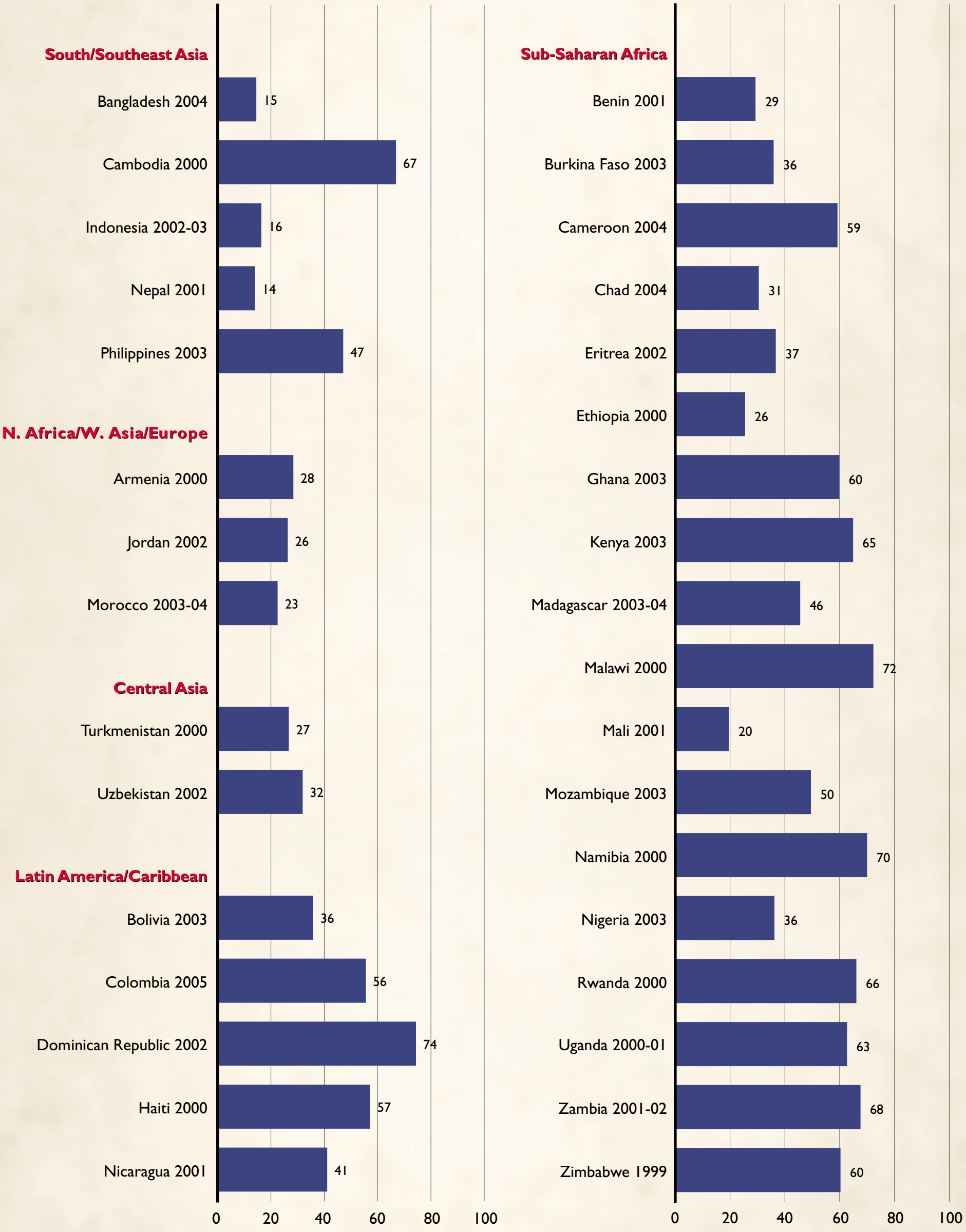
Since many married women contract HIV from their husbands, it is important that couples discuss AIDS prevention. However, many women have not had this conversation. In 20 out of 33 countries surveyed, less than half of currently married women say they have ever discussed AIDS prevention with their husbands or partners.

Couples are least likely to have talked about AIDS prevention in South/Southeast Asia, North Africa/West Asia/Europe, and Central Asia. Less than 30 percent of women report discussing the subject with their husbands or partners in 7 out of 10 countries surveyed in these regions. A noteworthy exception is Cambodia, where two-thirds of married women and their husbands have discussed AIDS prevention.

Couples are most likely to have talked about AIDS prevention in Latin America and the Caribbean and Sub-Saharan Africa. In 12 of 23 countries surveyed in these two regions, over half of married women report discussing the subject with their husbands or partners. These conversations are most common in the Dominican Republic, Malawi, and Namibia, where about 70 percent of married women have ever discussed AIDS prevention with their husbands or partners.

Defining couple discussion of HIV/AIDS:
Each currently married women is asked whether she has ever talked with her husband or the man she is living with about ways to prevent getting the virus that causes AIDS.

Among Women 15 to 49 Who Are Currently Married or Living With a Partner, Percentage Who Have Ever Discussed AIDS Prevention With Their Husband or Partner



HIGHER RISK SEX AMONG YOUTH

Women increase the risk of contracting HIV or another sexually transmitted infection when they engage in sexual intercourse with someone other than a husband or partner who lives with them.

Few young women take such risks in South/Southeast Asia, North Africa/West Asia/Europe, and Central Asia. In the 5 countries surveyed in these regions, less than 6 percent of women ages 15 to 24 report having sex with a non-marital, non-cohabiting partner during the past 12 months.

Young women in Latin America and the Caribbean and Sub-Saharan Africa are much more likely to engage in this type of risky sexual behavior. Within these regions, however, levels of higher risk sex vary widely, ranging from less than 10 percent in Chad, Ethiopia, and Rwanda to 80 percent in Namibia. In 14 of 23 countries surveyed in these two regions, over one-quarter of young women report having sex with a higher risk partner during the past 12 months.

Most young women do not use condoms during these risky sexual encounters. In 15 of 27 countries surveyed, less than 30 percent of women who engaged in this kind of risky sex reported using a condom the last time they had intercourse with a higher risk partner. Only in 2 countries, Burkina Faso and Uzbekistan, did more than half of young women use condoms with higher risk partners.

Defining higher risk sex: Information on a woman's last three sexual partners during the past 12 months is used to assess her exposure to higher risk sex. Higher risk sex is defined as sexual intercourse with a non-marital, non-cohabiting partner. Condom use is assessed for the last time a woman had sexual intercourse with a higher risk partner.

Higher Risk Sex and Condom Use Among Women 15 to 24

	Among women 15-24 who have had sex in the past 12 months, percentage who have had higher risk sex	Among women 15-24 who have had higher risk sex in the past 12 months, percentage who used a condom at last higher risk sex
South/Southeast Asia		
Cambodia 2000	0.7	41
Philippines 2003	6	11
N. Africa/W. Asia/Europe		
Armenia 2000	0.4	50
Central Asia		
Turkmenistan 2000	2	na
Uzbekistan 2002	1	54
Latin America/Caribbean		
Bolivia 2003	32	20
Colombia 2005	52	36
Dominican Republic 2002	29	29
Haiti 2000	58	20
Nicaragua 2001	14	17
Peru 2000	29	19
Sub-Saharan Africa		
Benin 2001	36	19
Burkina Faso 2003	23	54
Cameroon 2004	44	47
Chad 2004	7	17
Ethiopia 2000	7	17
Ghana 2003	50	33
Kenya 2003	30	25
Madagascar 2003-04	31	5
Malawi 2000	18	32
Mali 2001	18	14
Mozambique 2003	37	29
Namibia 2000	80	48
Nigeria 2003	29	24
Rwanda 2000	10	23
Uganda 2000-01	22	44
Zambia 2001-02	30	33
Zimbabwe 1999	20	42

na: Not available

HIV PREVALENCE

DHS surveys have collected data on the prevalence of HIV in 14 countries, all but one in Sub-Saharan Africa. The prevalence of HIV in women ages 15 to 49 ranges from less than 1 percent in the Dominican Republic and Senegal to 26 percent in Lesotho. HIV prevalence is higher among women than men in every country surveyed except for Burkina Faso and the Dominican Republic.

In Sub-Saharan Africa women living in urban areas are much more likely to be infected than rural women. In some countries the gap is wide: HIV prevalence in women is more than twice as high in urban than rural areas of Burkina Faso, Tanzania, and Zambia. In contrast, rural women are slightly more likely to be HIV positive than urban women in the Dominican Republic.

In 8 of 9 countries with data on HIV prevalence by marital status, single women are less likely to be infected with HIV than married women; the exception is Burkina Faso. Among married women, those who are currently married are much less likely to be HIV-positive than those who are widowed, divorced, or separated—perhaps reflecting the fact that HIV/AIDS often causes death, divorce, and separation.

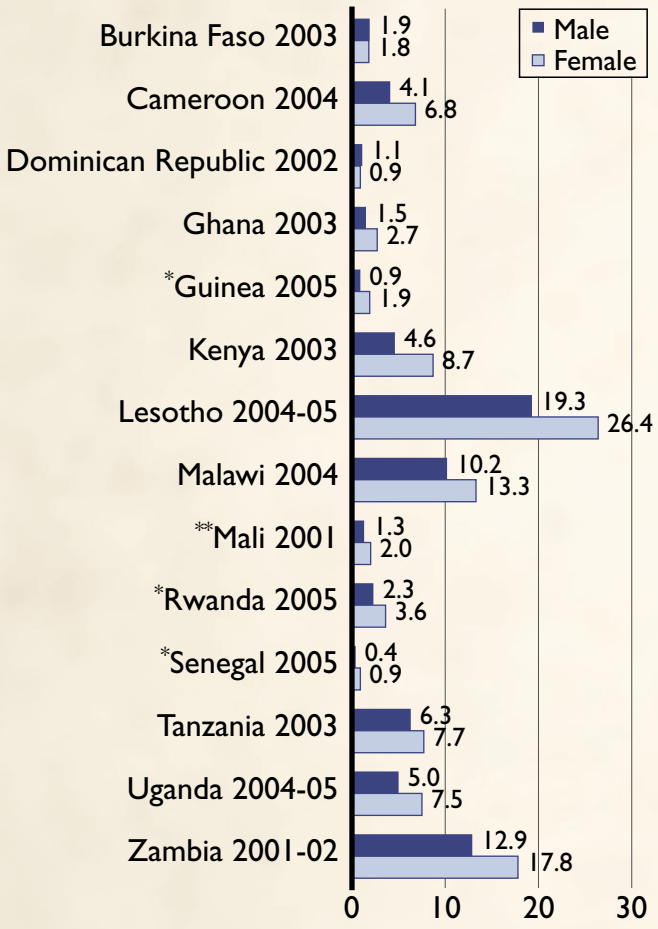
In Ghana, Kenya, Malawi, and Tanzania, women in polygynous unions are more likely to be infected with HIV than women in monogamous unions. The opposite is true in Burkina Faso, Cameroon, and Uganda.

In all 10 Sub-Saharan African countries with data on HIV infection by woman's age, the prevalence of HIV consistently rises with age. In contrast, HIV prevalence in the Dominican Republic rises from the teenage years to the early twenties and then declines slightly, although the numbers are extremely low.

Women's behavior can affect their vulnerability to infection. The prevalence of HIV generally rises with the number of higher risk sexual partners a woman reports having during the previous 12 months. In Tanzania, for example, 8 percent of women who have not had any higher risk partners are HIV positive, compared with 11 percent of women who have had one higher risk partner and over 17 percent of women who have had two or more higher risk partners.

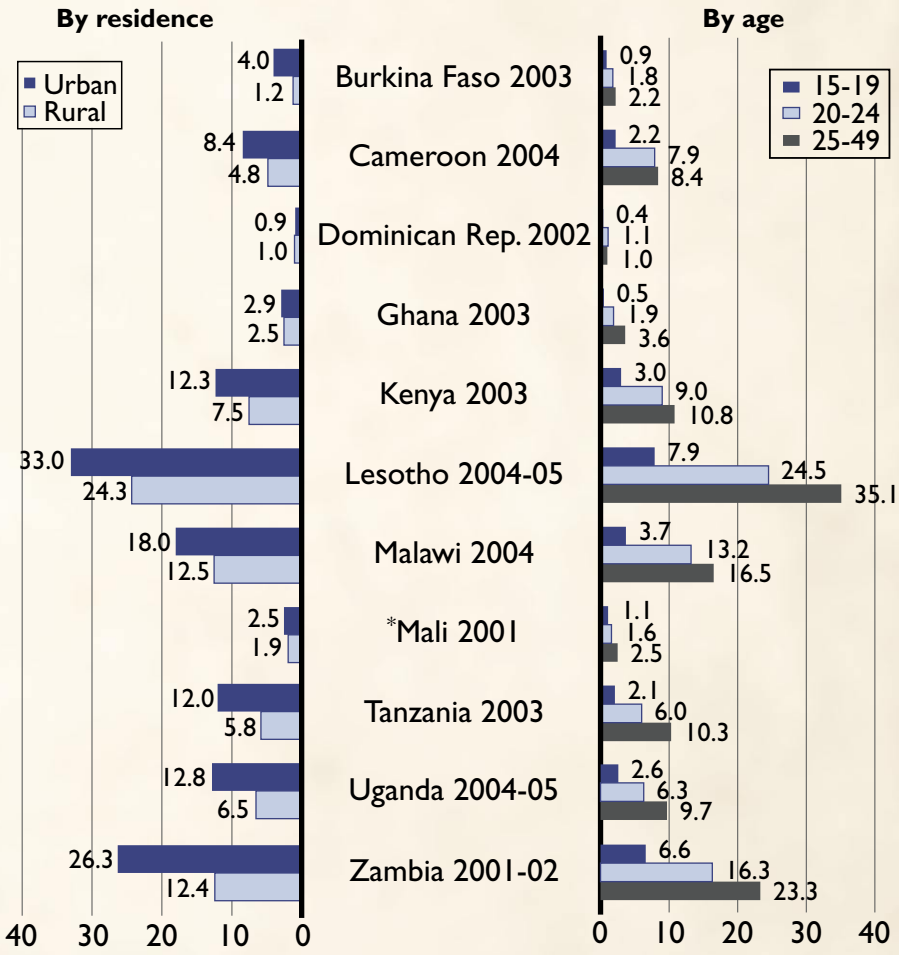
Measuring HIV prevalence: All women and men ages 15 to 49 are eligible for HIV testing during DHS surveys. Fieldworkers read them a consent statement that describes the purpose of the blood test and explains that it will be conducted anonymously. Fieldworkers collect several droplets of blood from women and men who consent to the test. Participants do not receive the results. Instead they are generally given a card that allows them to get more information, counseling, and an HIV test at the nearest facility offering such tests.

HIV Prevalence Among the Population 15 to 49, by Gender (Percent)



*Based on preliminary findings
**Prevalence based on those who answered the individual questionnaire

HIV Prevalence Among Women 15 to 49 (Percent)



* Prevalence based on those who answered the individual questionnaire

HIV Prevalence Among Women 15 to 49, by Marital Status (Percent)

	Never in union	Currently married/ in union	Formerly married	In polygynous union	Not in polygynous union
Burkina Faso 2003	2.2	1.6	6.3*	1.2	2.0
Cameroon 2004	3.5	6.2	18.5	5.5	6.6**
Dominican Republic 2002	0.9	1.0	na	na	na
Ghana 2003	1.1	2.9	6.3	3.3	2.8
Kenya 2003* **	4.7	8.0	23.6	11.4	7.2
Lesotho 2004-05	14.9	26.9	50.9	na	na
Malawi 2004	5.3	12.5	29.1	16.4	11.6
Tanzania 2003	3.8	6.9	19.8	9.9	6.6
Uganda 2004-05	2.7	5.9	22.5	5.7	6.0

*Widowed women only
** In a monogamous union
*** Includes some women who are considered formerly married because they lived with a man in the past
na: Not available

HIV Prevalence Among Women 15 to 49, by Number of Higher Risk Partners in the Past 12 Months (Percent)

	0	1	2+
Burkina Faso 2003	na	4.4	7.7
Cameroon 2004	6.4	10.4	10.5
Ghana 2003	na	3.4	10.6
Kenya 2003	na	15.7	34.0
Lesotho 2004-05	27.4	37.7	34.9
Malawi 2004	13.9	19.6	na
Tanzania 2003	7.9	10.5	17.4
Uganda 2004-05	7.5	15.1	18.6

na: Not available

ACCESS TO HEALTH CARE

Women are more likely to say money poses a big problem in accessing health care than geographic access or concerns related to their roles and status in 20 of 27 countries surveyed.

In 26 of 40 countries surveyed, the percentage of pregnant women making at least four antenatal care visits to a trained provider has increased over time, sometimes substantially.

BARRIERS TO ACCESSING HEALTH CARE

When women get sick, they may face many obstacles in accessing health care, including lack of money, difficulty in reaching a health facility, and cultural barriers.

In 16 of 27 countries surveyed, over half of ever-married women ages 15 to 49 consider money to be a big problem in getting health care. This may reflect not only poverty but also gender differences in control over household resources. Money is the obstacle married women cite most frequently in 20 countries. Women are most likely to cite money in Armenia, Cambodia, Haiti, and Rwanda, where at least three-quarters of married women consider lack of funds an obstacle.

Geographic access to health care, which involves distance to the health facility and lack of transportation, poses a big problem for more than half of married women in 8 countries. These concerns are especially common in the mountainous countries of Bolivia and Nepal. In Namibia and Zimbabwe, married women cite geographic access more often than other obstacles to accessing health care.

Over half of married women in 6 countries (Armenia, Bolivia, Cambodia, Nicaragua, Nepal, and Peru) say that cultural concerns related to women's roles and status pose a big problem in accessing health care. For example, women may need a spouse's permission to go for treatment, may not be able to travel alone to a health facility, or may not feel comfortable consulting a male provider. Cultural concerns are the obstacle that married women cite most frequently in 5 countries. With the exception of Mali, married women in Sub-Saharan Africa are less likely than women in other regions to say that cultural concerns pose a big problem in accessing health care.

Measuring access to health care: Women are asked whether specific obstacles pose a big problem in getting medical advice or treatment when they are sick. Financial concerns are defined as getting the money needed for treatment. Geographic concerns are defined as the distance to the health facility and/or having to take transport. Cultural concerns are defined as needing to get permission to go, not wanting to go alone, and/or concern that there may not be a female health provider.

Percentage of Ever-married Women 15 to 49 Who Report Big Problems in Accessing Health Care for Themselves When They Are Sick

	Money	Geographic access	Cultural concerns
South/Southeast Asia			
Bangladesh 2004	14	14	23
Cambodia 2000	88	48	55
Indonesia 2002-03	24	14	14
Nepal 2001	66	60	70
Philippines 2003	67	32	38
N. Africa/W. Asia/Europe			
Armenia 2000	79	40	51
Egypt 2000	27	18	43
Jordan 2002	30	35	44
Morocco 2003-04	43	36	37
Latin America/Caribbean			
Bolivia 2003	69	59	69
Haiti 2000	75	40	33
Nicaragua 2001	68	50	52
Peru 2000	65	38	57
Sub-Saharan Africa			
Benin 2001	36	24	21
Burkina Faso 2003	63	53	40
Cameroon 2004	66	44	36
Eritrea 2002	47	47	36
Ghana 2003	55	40	30
Madagascar 2003-04	46	44	30
Mali 2001	51	45	44
Mozambique 2003	57	57	26
Namibia 2000	37	55	14
Nigeria 2003	30	28	25
Rwanda 2000	76	48	20
Uganda 2000-01	63	51	34
Zambia 2001-02	66	53	4
Zimbabwe 1999	34	35	18

ANTENATAL CARE

Childbearing takes its heaviest toll on women with the least access to maternity services. Antenatal care, which ranges from nutrition education to monitoring for potential complications, is a key part of these services because it gives providers an opportunity to detect, treat, and/or prevent potentially dangerous conditions.

While national policies concerning antenatal care vary, the World Health Organization (WHO) recommends four antenatal care visits with a trained doctor, nurse, or midwife during normal pregnancies. However, many women still do not receive this level of care, even though most countries are making progress in offering adequate antenatal care to pregnant women.

In 32 of 53 countries surveyed, less than half of women who gave birth during the preceding three years had at least four antenatal care visits with a trained provider. In 11 countries, that percentage was less than one-fifth of pregnant women.

Women are most likely to receive adequate antenatal care in Latin America and the Caribbean and particularly in Central Asia. Over 80 percent of pregnant women in Colombia, Jordan, the Kyrgyz Republic, and Turkmenistan had at least four antenatal care visits with a trained provider.

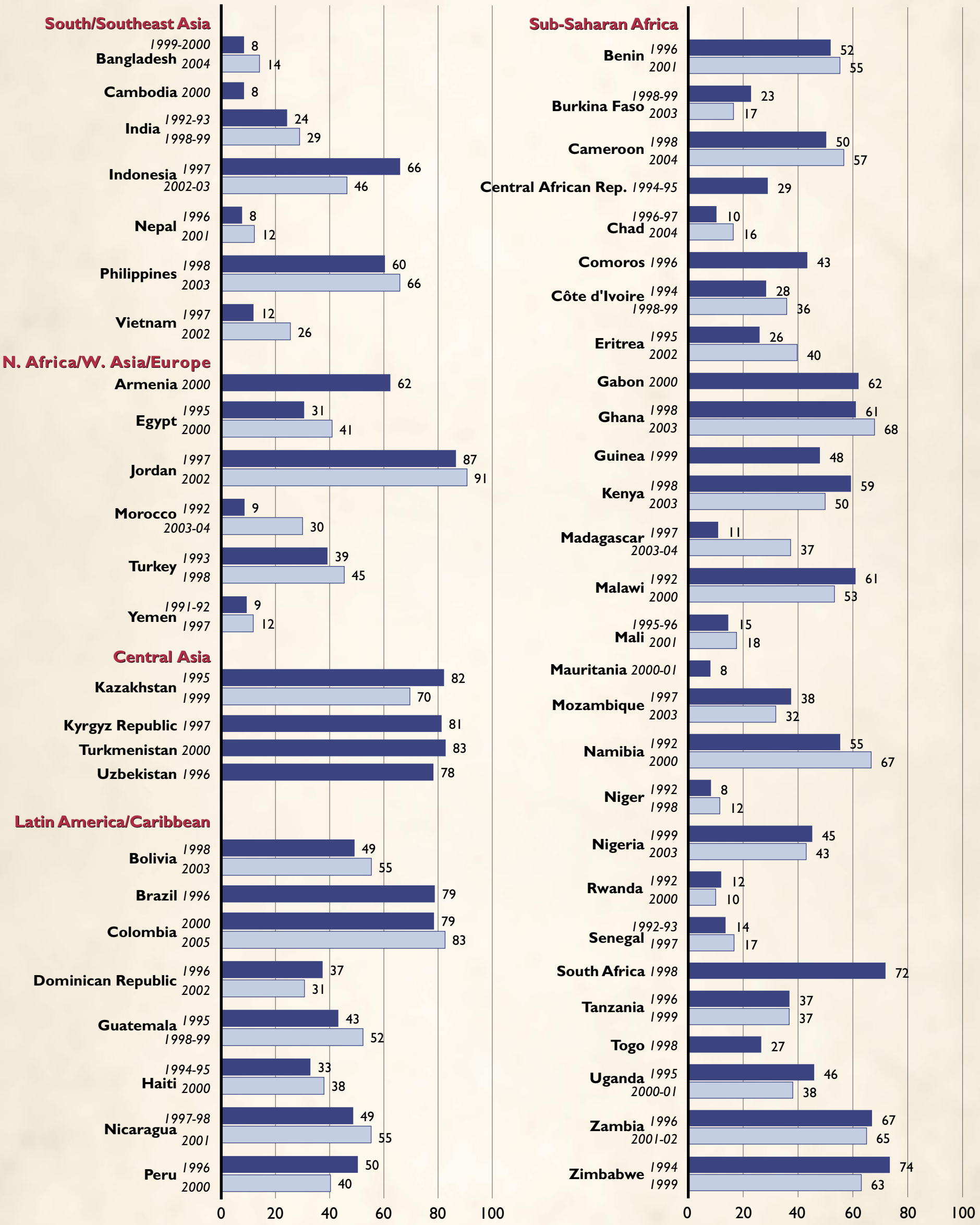
Women are least likely to receive adequate antenatal care in South/Southeast Asia and Sub-Saharan Africa, but there are huge disparities within these two regions. Adequate antenatal care is scarcest in Cambodia and Mauritania, where only about 8 percent of pregnant women visited a trained provider at least four times. In contrast, 66 percent of pregnant women in the Philippines and 72 percent in South Africa received this level of antenatal care.

Trends. In 26 of 40 countries with two recent surveys, the percentage of pregnant women making at least four antenatal care visits to a trained provider has increased over time, sometimes substantially. Trends in three regions—South/Southeast Asia, North Africa/West Asia/Europe, and Latin America and the Caribbean—have been overwhelmingly positive. Madagascar, Morocco, and Vietnam stand out for the great strides made in providing antenatal care to pregnant women. The percentage of pregnant women who made at least four visits to a trained provider more than tripled in Madagascar (from 11 percent to 37 percent) and Morocco (from 9 percent to 30 percent) and more than doubled in Vietnam (from 12 percent to 26 percent).

However, the percentage of pregnant women receiving adequate antenatal care has declined over time in 14 countries, largely in Sub-Saharan Africa. In that region countries are as likely to have experienced a decrease as an increase in the percentage of pregnant women visiting a trained provider at least four times. Indonesia has experienced the greatest decline, with the proportion of women receiving adequate antenatal care dropping from 66 percent in 1997 to 46 percent in 2002-03. In Kazakhstan, Peru, and Zimbabwe, the proportion fell by 10 to 12 percentage points over four or five years.

Defining adequate antenatal care: Based on WHO recommendations, adequate antenatal care is defined as at least four visits with a trained doctor, nurse, or midwife. Only the most recent pregnancy of women who had a live birth during the past three years is included in the calculations.

Among Women 15 to 49 Who Had a Live Birth in the Three Years Preceding the Survey, Percentage Who Had at Least Four Antenatal Care Visits With a Trained Doctor, Nurse, or Midwife During the Most Recent Pregnancy



VACCINATING AGAINST TETANUS

Neonatal tetanus, an almost universally fatal disease, can be prevented by vaccinating pregnant women against the disease. The mother's immunity is transferred to the fetus. Pregnant women who have never previously been vaccinated against tetanus require two doses for full protection. However, a woman who has been vaccinated previously may require just one booster dose during her current pregnancy or, if she has received multiple doses over the course of her lifetime, may not require any further injections.

Tetanus vaccination is the most common antenatal care service provided to pregnant women. In 42 of 48 countries surveyed, pregnant women are more likely to receive a tetanus toxoid injection than four antenatal care visits with a trained provider. In 38 of 48 countries, they are more likely to receive this injection than skilled assistance at childbirth.

Over half of pregnant women received at least one tetanus toxoid injection in 39 of 49 countries surveyed. In 13 of these countries, more than three-quarters of pregnant women were vaccinated. Pregnant women were most likely to receive a tetanus toxoid injection in South/Southeast Asia and Latin America and the Caribbean. They were least likely to receive it in North Africa/West Asia/Europe.

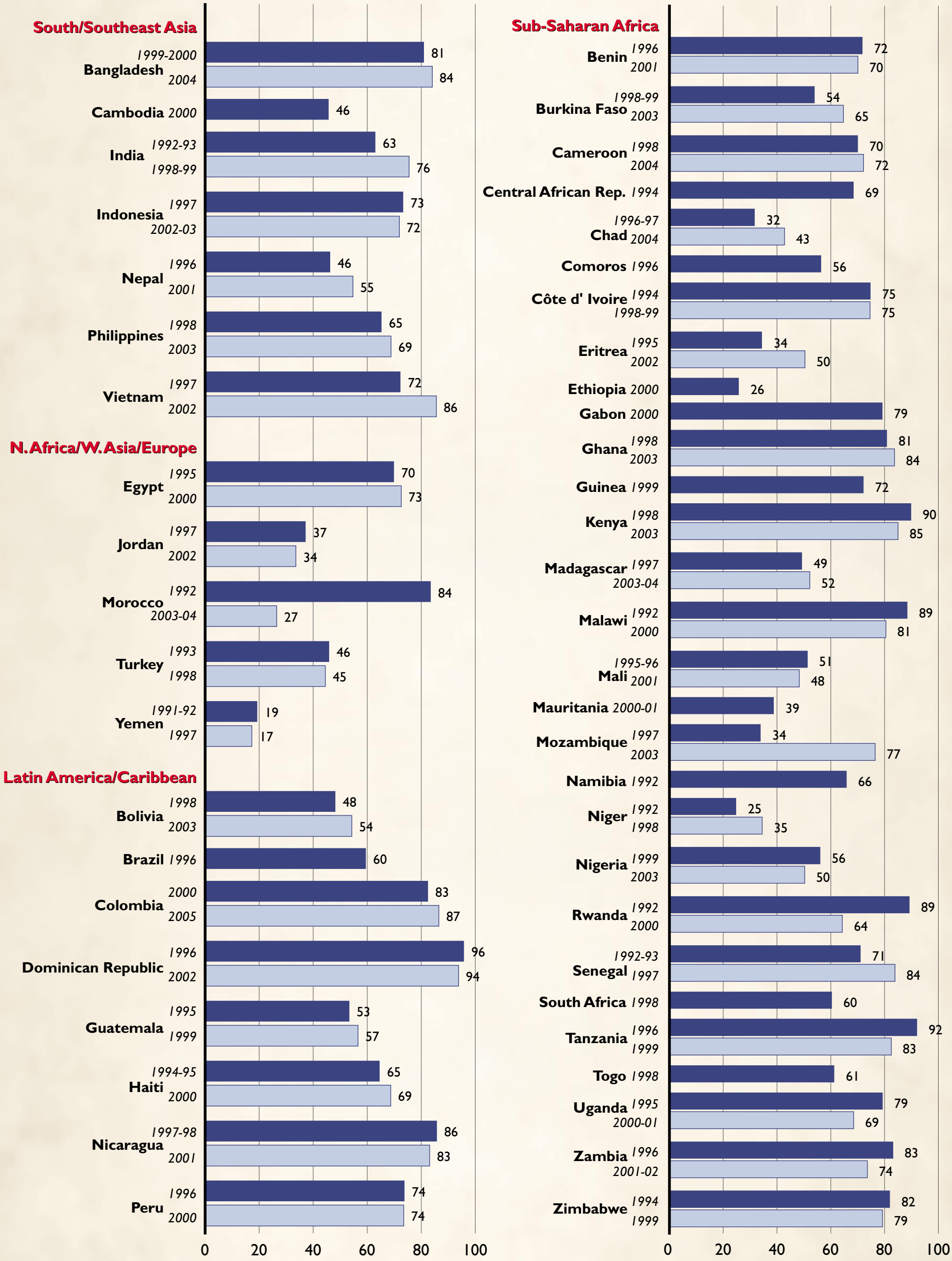
Trends. Recent trends in tetanus vaccination are mixed. Injection rates have increased in 19 of 38 countries with two surveys, with the largest gains seen in South/Southeast Asia and Sub-Saharan Africa. In Mozambique the percentage of pregnant women vaccinated rose from 34 percent in 1997 to 77 percent in 2003.

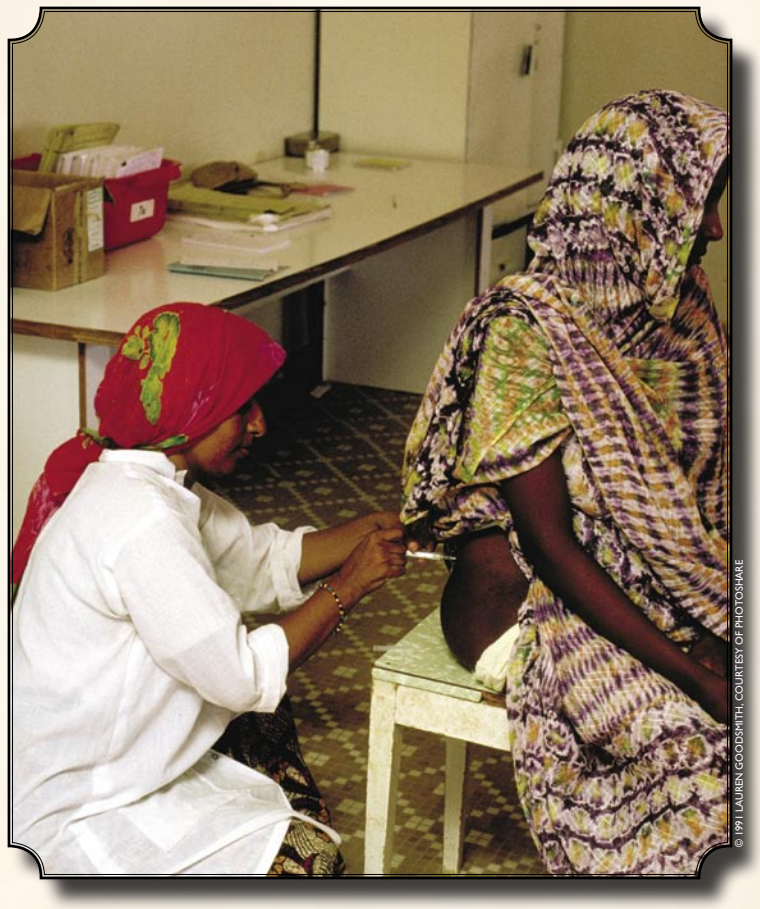
However, injection rates have declined over time in the other 19 countries with two surveys, including all of those surveyed in North Africa/West Asia/Europe, with the exception of Egypt. Morocco and Rwanda have experienced the greatest drops, of 57 and 25 percentage points, respectively. These declines do not necessarily reflect diminishing levels of care, however. For example, many pregnant Moroccan women already have lifetime protection against tetanus because of injections administered at school or by mobile teams who visit rural areas; others have been fully vaccinated during previous pregnancies.

Assessing tetanus vaccinations: The DHS surveys presented here asked women how many tetanus toxoid injections they received during the most recent pregnancy. Since tetanus immunization programs have been in place for some years, it is assumed that many pregnant women may have received injections previously and thus might only need a single booster dose. Therefore, tetanus vaccination is defined as receiving at least one injection during the most recent pregnancy. Previously unvaccinated women who only receive one injection during a pregnancy are not completely protected against tetanus, but it is impossible to identify such women from existing DHS data. It is likewise impossible to identify those pregnant women who do not require any tetanus injections because of prior vaccinations. Only women who had a live birth during the past three years are included in the calculations.

DHS has recently started to collect information on how many doses of tetanus toxoid a woman has received over the course of her lifetime and when those doses were administered, in keeping with UNICEF recommendations. Collecting data this way is the most accurate way to assess protection against neonatal tetanus, which can be achieved by various injection histories. For example, women may be protected by two doses administered during the last pregnancy; four doses, if the last injection occurred within the past 10 years; or five doses received over the course of a lifetime.

Among Women 15 to 49 Who Had a Live Birth in the Three Years Preceding the Survey, Percentage Who Received at Least One Tetanus Toxoid Injection During Their Most Recent Pregnancy





SKILLED ASSISTANCE AT CHILDBIRTH

Skilled assistance at childbirth can reduce the risk of complications to mothers and infants due to problems such as hemorrage, obstructed labor, and puerperal infection. Many women, however, give birth without the assistance of a trained health care provider.

In 30 of 53 countries surveyed, less than half of women were attended by a trained doctor, nurse, or midwife during recent deliveries. Women are most likely to have a skilled attendant at childbirth in Central Asia and North Africa/West Asia/Europe, with the exception of Yemen. All 6 countries where more than 95 percent of women have a skilled attendant during childbirth are located in these two regions; they are Armenia, Jordan, Kazakhstan, the Kyrgyz Republic, Turkmenistan, and Uzbekistan.

Women are least likely to have a skilled attendant at childbirth in South/Southeast Asia and Sub-Saharan Africa. This kind of assistance is especially scarce in Bangladesh, Chad, Nepal, Niger, and Uganda, where less than one-fifth of women are attended by a doctor, nurse, or midwife when they deliver their babies.

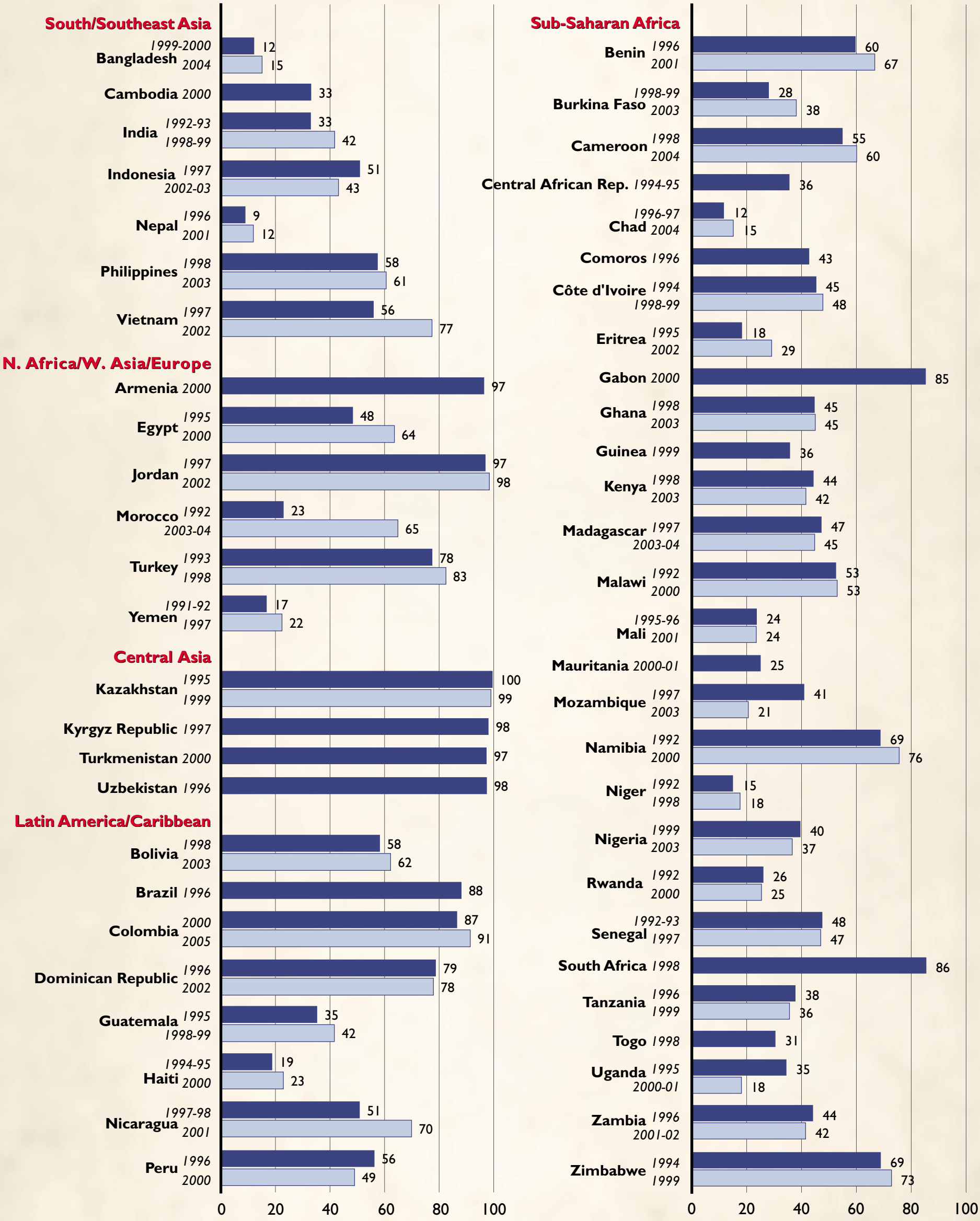
Trends. Skilled assistance at childbirth is increasing in most, but not all, countries. The percentage of deliveries attended by a trained professional rose in 26 of 40 countries with two surveys, including nearly all of the countries surveyed in South/Southeast Asia, North Africa/West Asia/Europe, and Latin America and the Caribbean. Delivery care increased most dramatically in Morocco, rising from 23 percent of births in 1992 to 65 percent in 2003. Five other countries experienced gains of 10 percentage points or more: Burkina Faso, Egypt, Eritrea, Nicaragua, and Vietnam.

In the remaining 14 countries, mostly in Sub-Saharan Africa, skilled assistance at childbirth has decreased over time. The greatest declines occurred in Mozambique, where the proportion of births attended by a trained professional fell from 41 percent in 1997 to 21 percent in 2003, and in Uganda, where delivery care fell from 35 percent in 1995 to 18 percent in 2000-01.

There are 38 countries with complete data on trends in antenatal care, tetanus vaccinations, and skilled attendance at delivery. All three indicators rose over time in 15 countries and fell in 9 countries. Trends were mixed in the remaining 14 countries, although the most common pattern (observed in 7 countries) was a combination of increased antenatal care and delivery attendance and decreased tetanus vaccination.

Defining assistance during childbirth:
Skilled assistance at childbirth is defined as being attended by a trained doctor, nurse, or midwife. Only the most recent birth of women who had a live birth during the past three years is included in the calculations.

Among Women 15 to 49 Who Had a Live Birth in the Three Years Preceding the Survey, Percentage Who Received Assistance From a Trained Doctor, Nurse, or Midwife During the Most Recent Delivery



HOME LIFE

Of three basic amenities—toilet facilities, electricity, and piped water—piped water is the one that households most often lack in every region of the world with the exception of Sub-Saharan Africa.

In 29 of 53 countries surveyed, over half of women work outside the home, often for cash.

In 25 of 35 countries, the percentage of women who regularly watch television has increased over time—by 10 percentage points or more in 10 countries.

HOUSEHOLD ENVIRONMENT

Women bear most of the responsibility for cooking, cleaning, fetching wood and water, and childrearing. Household amenities, including piped water, toilet facilities, and electricity, can ease the burden of these domestic responsibilities and also promote the health of the family.

Of these three amenities, women are most likely to have access to toilet facilities, which can reduce the risk of dysentery, diarrhea, and other illnesses. Access to toilet facilities ranges from just over 20 percent in Ethiopia and Niger to virtually universal access in Armenia, Comoros, Jordan, Kazakhstan, the Kyrgyz Republic, Turkmenistan, and Uzbekistan. Over 70 percent of women live in households with toilets in 37 of 54 countries surveyed. In 11 countries in South/Southeast Asia and Sub-Saharan Africa, however, less than half of women live in households with toilet facilities.

The second most widely available amenity is electricity, which is an important indicator of the general standard of living. It shapes women's access to labor-saving and health-enhancing possessions as well as their potential exposure to mass media such as radio and television. Access to electricity ranges from a low of 5 percent in Chad to a high of 99 percent in Armenia, Jordan, the Kyrgyz Republic, Turkmenistan, and Uzbekistan. In 28 of 53 countries surveyed, mostly in Sub-Saharan Africa, over half of women live in households without electricity. Women are more likely to have access to electricity in North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean. These three regions include 15 of the 19 countries where at least 70 percent of women live in households with electricity.

Households are least likely to have access to piped water. Piped water has many advantages over water from rivers and lakes. Not only is it safer, it is also more accessible. Women spend less time fetching it, making more water available for cleaning and personal hygiene. Access to piped water ranges from less than 10 percent in Bangladesh and Cambodia to 92 percent in Armenia. In 32 of 54 countries surveyed, mostly in South/Southeast Asia and Sub-Saharan Africa, less than half of women have access to piped water at home. Women are more likely to live in households with access to piped water in North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean. In 11 of 18 countries in these three regions, over 70 percent of women have access to piped water at home.

Piped water is the least available amenity in every region of the world with the exception of Sub-Saharan Africa. In that region, electricity is even less widely available than piped water.

Cooking fuels are also an important element of the household environment. Indoor air pollution caused by burning unprocessed biomass fuels, such as wood, animal dung, and crop residues, poses a health threat to all family members. Smoke from biomass fuels has been linked with many health problems, including chronic bronchitis, asthma, tuberculosis, and blindness in adults; acute respiratory infections and chronic nutritional deficiencies in young children; and adverse pregnancy outcomes.

In 22 of 33 countries surveyed, over half of households rely on unprocessed biomass fuels for cooking. While the use of biomass fuels is most widespread in Sub-Saharan Africa, the problem is not confined to that region. The 6 countries where more than 90 percent of households burn biomass fuels are scattered across several regions; they are Bangladesh, Burkina Faso, Ethiopia, Malawi, Morocco, and Nepal.

Defining household amenities: DHS surveys collect information on the household's usual toilet facility, main source of drinking water, main fuel used for cooking, and the presence of electricity in the home. Toilet facilities are defined as a flush toilet, pit latrine, composting toilet, bucket toilet, or hanging toilet, which may be private or shared with other households. Access to piped water is defined as water piped into the dwelling, piped into the yard, or available from a public standpipe. Unprocessed biomass fuels include firewood, straw, dung, and charcoal.

Percentage of Women 15 to 49 Living in Households Without Electricity, Piped Water, and Toilet Facilities, and Where Biomass Cooking Fuels Are Used

	No access to electricity	No access to piped water	No access to toilet facilities	Uses biomass cooking fuels
South/Southeast Asia				
Bangladesh 2004	58	93	13	92
Cambodia 2000	79	92	75	87
India 1998-99	40	63	64	na
Indonesia 2002-03	9	83	23	42
Nepal 2001	76	67	70	91
Philippines 2003	19	46	8	na
Vietnam 2002	11	80	18	na
N. Africa/W. Asia/Europe				
Armenia 2000	0.8	8	0	23
Egypt 2000	2	14	2	2
Jordan 2002	0.4	14	0	0
Morocco 2003-04	21	30	15	91
Turkey 1998	na	44	2	na
Yemen 1997	54	60	30	na
Central Asia				
Kazakhstan 1999	3	36	0.5	na
Kyrgyz Republic 1997	0.2	27	0.1	na
Turkmenistan 2000	0.2	40	0.6	0.2
Uzbekistan 2002	0.3	25	0	16
Latin America/Caribbean				
Bolivia 2003	23	20	29	29
Brazil 1996	5	26	9	na
Colombia 2005	3	14	6	0.6
Dominican Republic 2002	5	73	4	7
Guatemala 1998-99	27	38	12	na
Haiti 2000	57	41	34	47
Nicaragua 2001	24	28	13	58
Peru 2000	25	24	19	33
Sub-Saharan Africa				
Benin 2001	74	53	63	81
Burkina Faso 2003	87	78	66	93
Cameroon 2004	48	56	6	75
Central African Rep. 1994	95	78	26	na
Chad 2004	95	89	72	na
Comoros 1996	66	51	0.2	na
Côte d'Ivoire 1998-99	45	46	31	na
Eritrea 2002	63	60	70	61
Ethiopia 2000	85	81	79	93
Gabon 2000	19	21	2	na
Ghana 2003	49	58	21	58
Guinea 1999	79	77	33	na
Kenya 2003	82	68	15	68
Madagascar 2003-04	76	72	41	69
Malawi 2000	93	75	16	92
Mali 2001	84	68	20	88
Mauritania 2000-01	74	53	47	na
Mozambique 2003	87	73	45	78
Namibia 2000	63	35	50	59
Niger 1998	91	81	78	na
Nigeria 2003	47	83	23	74
Rwanda 2000	91	63	3	87
Senegal 1997	62	47	28	na
South Africa 1998	33	18	11	na
Tanzania 1999	90	62	12	na
Togo 1998	80	59	58	na
Uganda 2000-01	89	88	14	79
Zambia 2001-02	77	62	26	54
Zimbabwe 1999	60	53	24	60

na: Not available

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PARTICIPATION IN HOUSEHOLD DECISIONS

Women's participation in decisions that affect their lives reflects gender roles and responsibilities. Married women who help make household decisions, either alone or jointly with their husbands, tend to have greater control over their own lives and their immediate environment. Four kinds of everyday decisions are considered here: decisions regarding a woman's own health care, major household purchases, purchases for daily household needs, and timing of visits to friends or relatives.

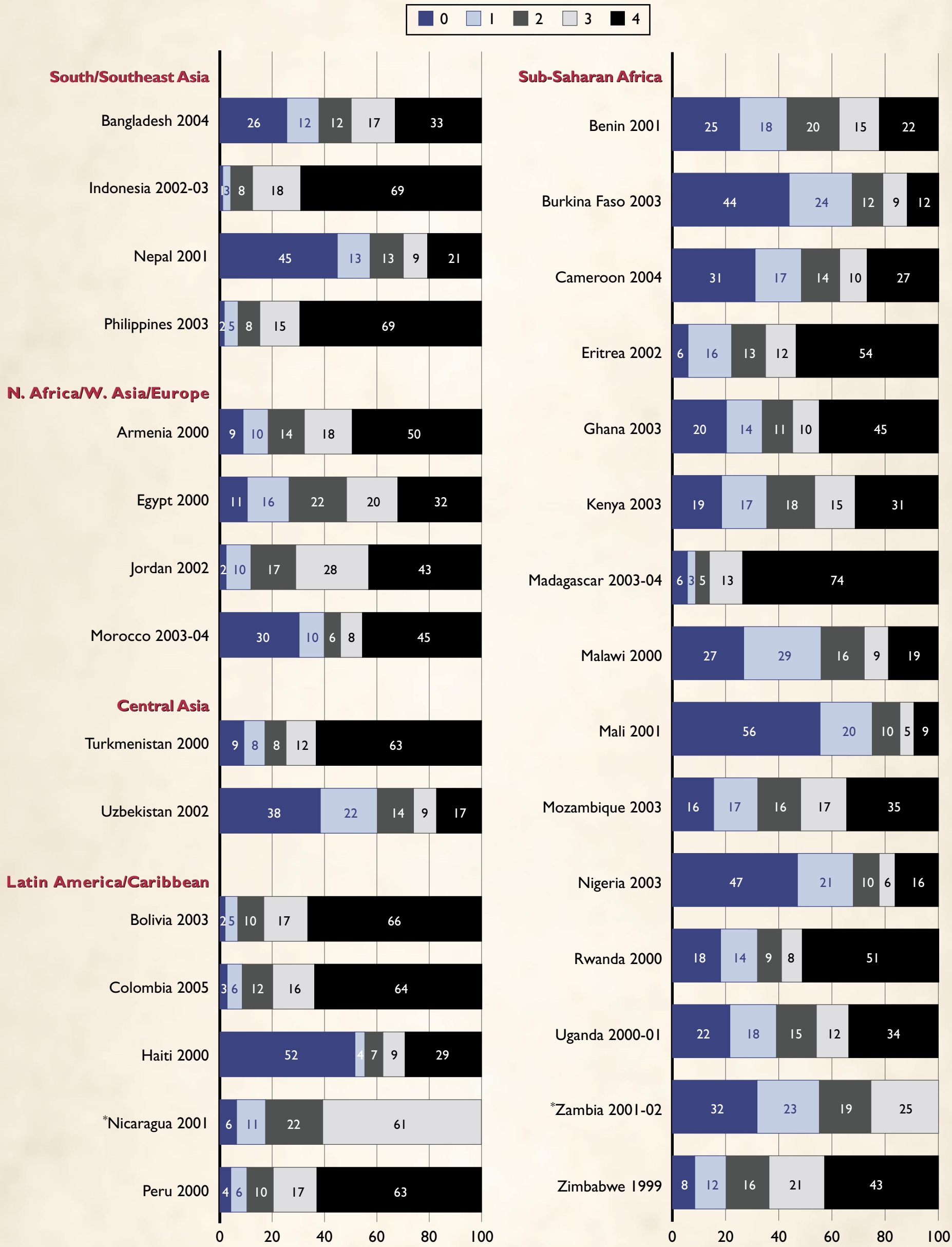
In 17 of 30 countries surveyed, at least half of women usually have a say in three or four household decisions, either making the decision themselves or jointly with their partners.

Women tend to play a larger role in household decision-making in North Africa/West Asia/Europe and Latin America and the Caribbean. With the exception of Haiti, most married women in these countries regularly participate in three or four household decisions. However, women have the strongest involvement in household decision-making in a country in Sub-Saharan Africa: in Madagascar, nearly three-quarters of married women usually have a say in all four household decisions. Bolivia, Indonesia, and the Philippines are also noteworthy for high levels of female involvement in household decisions; more than four-fifths of married women in these countries have a say in at least three decisions.

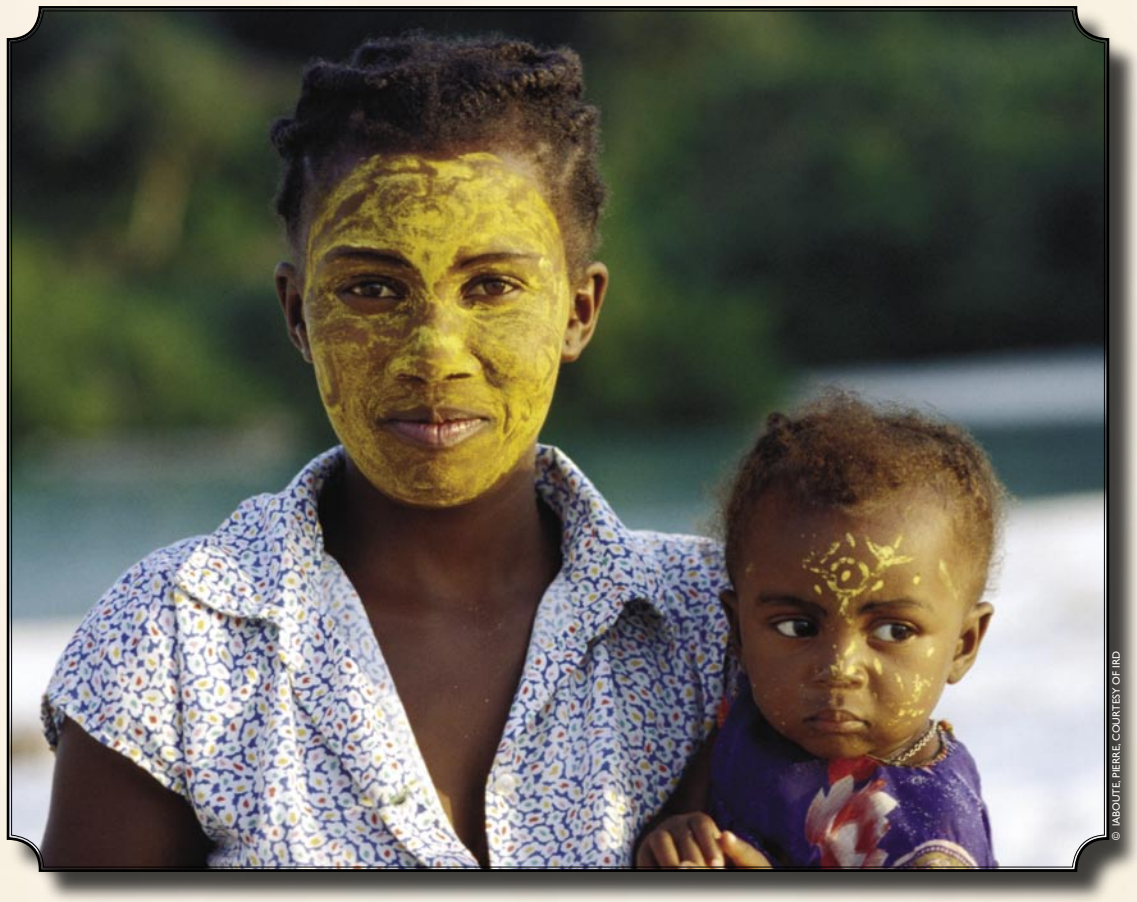
In some countries, husbands dominate household decision-making. More than half of married women in 8 countries, mostly in Sub-Saharan Africa, usually do not participate in any household decisions or take part in only one. Women's decision-making roles are weakest in Burkina Faso and Mali, where 68 and 75 percent of married women, respectively, do not have a say in any household decisions or only in one.

Measuring household decision-making:
Women are asked who usually has the final say in making specific household decisions, namely decisions regarding a woman's own health care, major household purchases, purchases for daily household needs, and timing of visits to friends or relatives. Women's participation is defined as either the woman having the final say herself or the woman making the decision jointly with her partner.

Percent Distribution of Ever-married Women 15 to 49 by the Number of Household Decisions in Which They Participate



*In these two countries, data are available for only three of the four household decision considered here.



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WORK AND EARNING MONEY

Women around the world contribute to the survival of their families by working on family farms, selling food or other goods, doing domestic work for others, running small businesses, or holding other types of jobs. Employment can be a source of empowerment for women, especially if it puts them in control of income and/or exposes them to the outside world.

In 29 of 53 countries surveyed, more than half of all reproductive age women engage in some kind of work beyond their regular household chores. In 12 countries, more than three-quarters of women work outside the home.

Women are most likely to work in South/Southeast Asia and Sub-Saharan Africa. Benin, Burkina Faso, Nepal, and Vietnam are notable because more than 80 percent of women work in these countries.

Women are least likely to work in North Africa/West Asia/Europe. Employment rates are especially low in Jordan, Egypt, and Morocco where one-fifth or fewer women work.

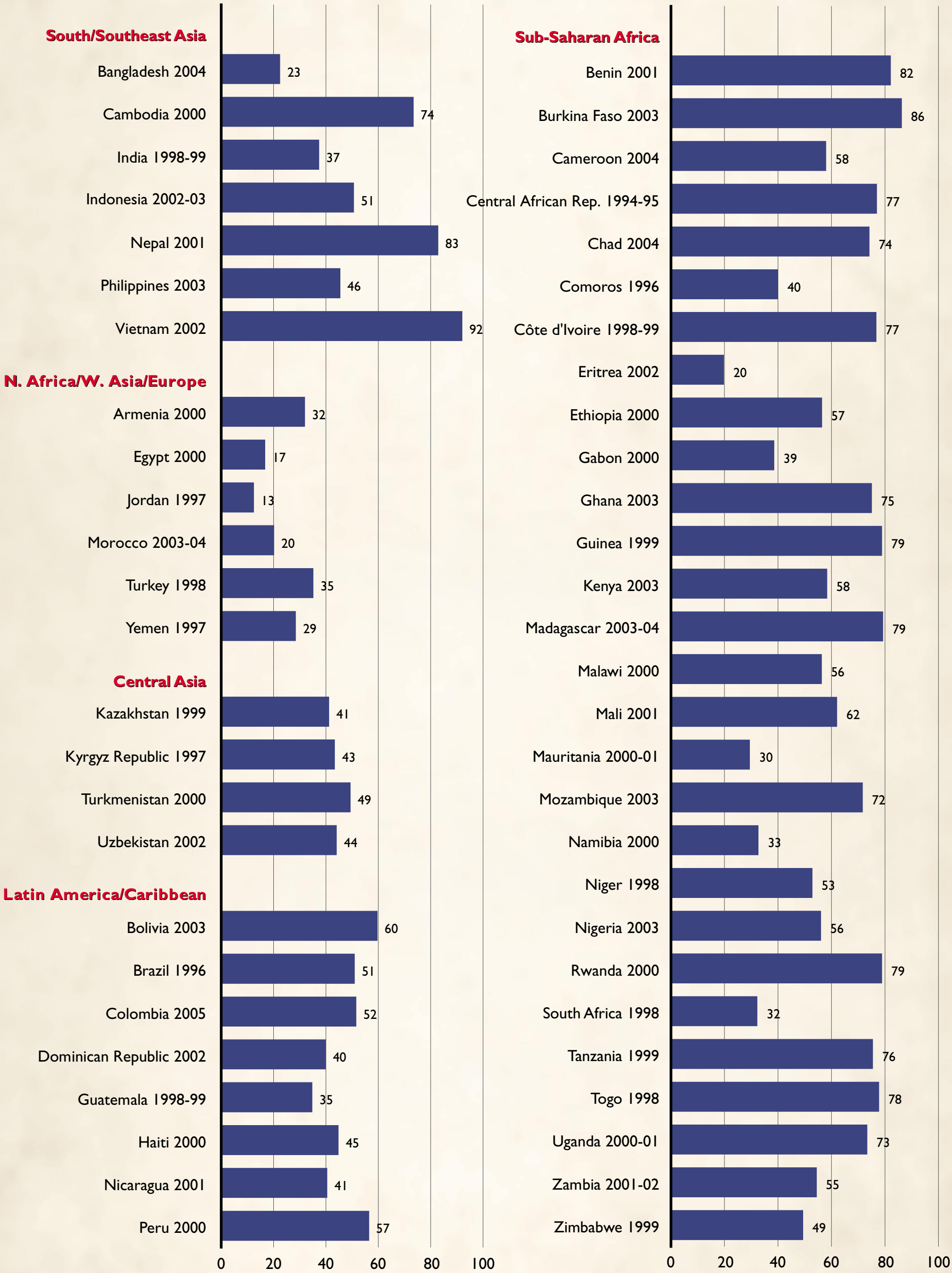
Many working women earn cash, although others are paid in kind or not at all. In 22 of 34 countries surveyed, more than half of working women are paid entirely in cash (data on earning money are not shown). Working women are most likely to be paid solely in cash in Latin America and the Caribbean and Central Asia. Around 70 percent or more of working women in all 8 countries surveyed in these two regions earn money. The Dominican Republic and Turkmenistan are notable because over 90 percent of working women are paid in cash.

Working women are less likely to be paid in cash in parts of South/Southeast Asia and Sub-Saharan Africa. It is worth noting that in the two countries where working women are least likely to be paid in cash—Nepal and Rwanda—rates of female employment are extremely high. Around four-fifths of women in both countries work, but less than 1 in 10 is paid in cash.

Women's overall participation in the cash economy depends on two factors: how many work and what proportion of them are paid in cash. Six countries stand out because 40 percent to 50 percent of all women ages 15 to 49 participate in the cash economy. These are Benin, Bolivia, Colombia, Ghana, Nigeria, and Turkmenistan.

Defining work and pay: Information is collected on a woman's employment status at the time of the survey, specifically whether she does any work aside from her own housework. Data on women who are paid in cash exclude women whose earnings are a mix of cash and in-kind payments; only women paid entirely in cash are included.

Percentage of Women 15 to 49 Who Were Working at the Time of the Survey



EXPOSURE TO MASS MEDIA

The mass media have proven to be an effective way to broaden women's perspectives beyond the community and to disseminate new ideas and information on topics ranging from health and family planning to agriculture and local and international politics. Radio and television, in particular, have the ability to reach women who are illiterate or live in isolated settings. Behavior change campaigns have successfully harnessed the media's ability to inform and persuade in pursuit of health goals.

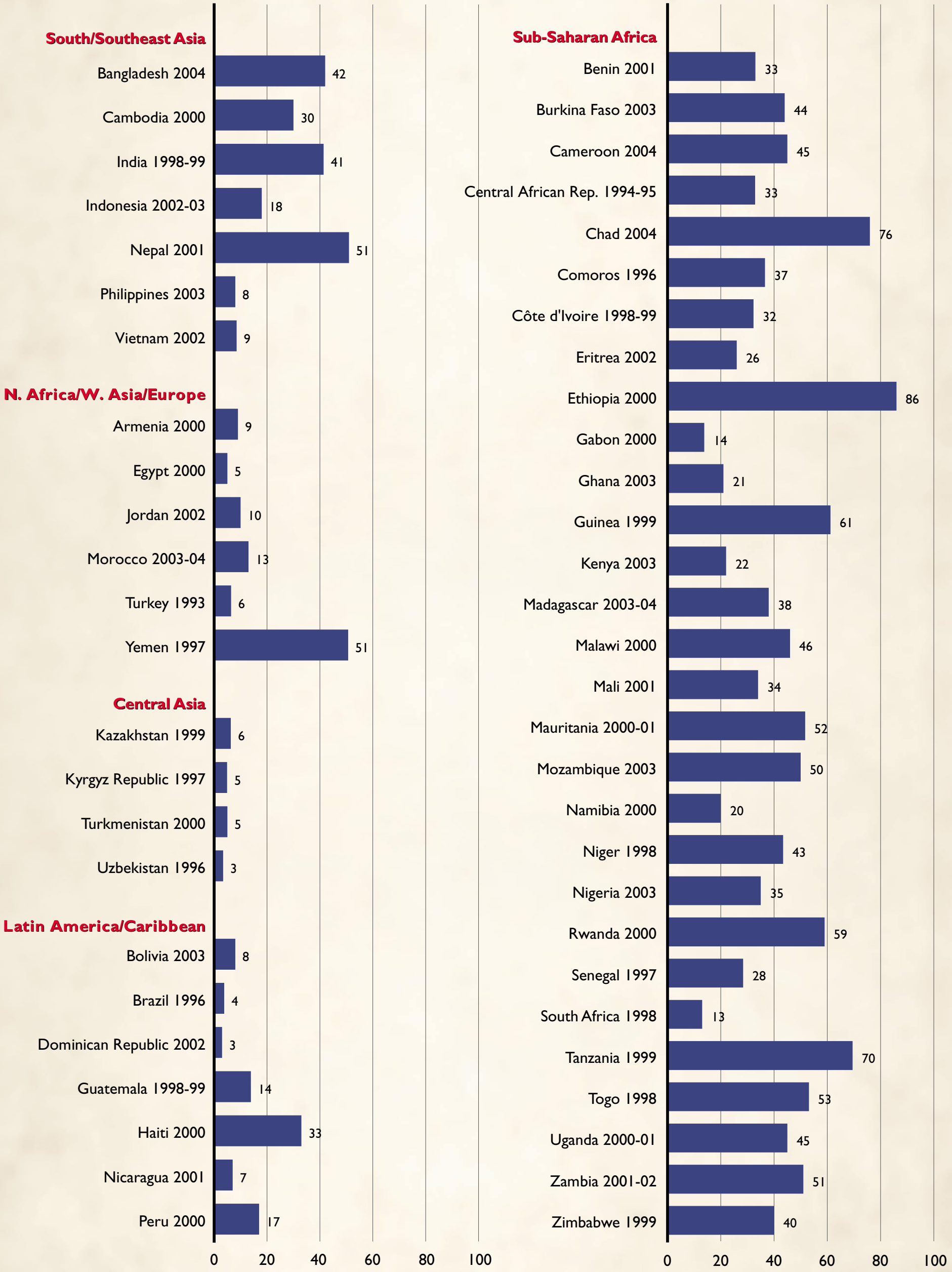
Most women regularly listen to the radio, watch television, or read a newspaper or magazine. In 43 of 53 countries surveyed, half or more of women ages 15 to 49 are exposed to at least one of these three media each week—with radio having the greatest reach in most countries.

Media exposure is highest in North Africa/West Asia/Europe, Central Asia, and Latin America and the Caribbean. At least 80 percent of women in 15 of 17 countries surveyed in these three regions tune in to radio or television or read a newspaper or magazine on a weekly basis; the exceptions are Haiti and Yemen. Media exposure is 95 percent or greater in 6 countries: Brazil, the Dominican Republic, Egypt, the Kyrgyz Republic, Turkmenistan, and Uzbekistan.

Women are least likely to be exposed to the mass media in Sub-Saharan Africa. In 9 of 29 countries surveyed in that region, half or fewer women listen to the radio, watch television, or read a newspaper or magazine each week. In Chad and Ethiopia, less than one-quarter of women routinely see or hear any of these three mass media. However, media exposure is high in some other sub-Saharan African countries, especially in Gabon and South Africa where over 85 percent of women regularly listen to the radio, watch television, or read a magazine or newspaper.

Defining media exposure: DHS survey questions on media exposure have changed over time. To ensure comparability of the data, regular exposure to the mass media is defined here as: usually listening to the radio at least once a week, usually reading a magazine or newspaper at least once a week, or usually watching television at least once a week.

Percentage of Women 15 to 49 Who Have No Regular Exposure to Mass Media



TRENDS IN TELEVISION EXPOSURE

While radio may reach more women than other mass media, the television audience is growing quickly in many countries. In 22 of the 53 countries surveyed, over half of women ages 15 to 49 watch television weekly, and more than three-quarters are regular viewers in 14 countries.

Women are most likely to be regular television viewers in North Africa/West Asia/Europe and in Central Asia. Over 80 percent of women in 9 of 10 countries surveyed in these two regions reported watching television at least once a week. Yemen is a conspicuous exception: only 34 percent of women there see television weekly.

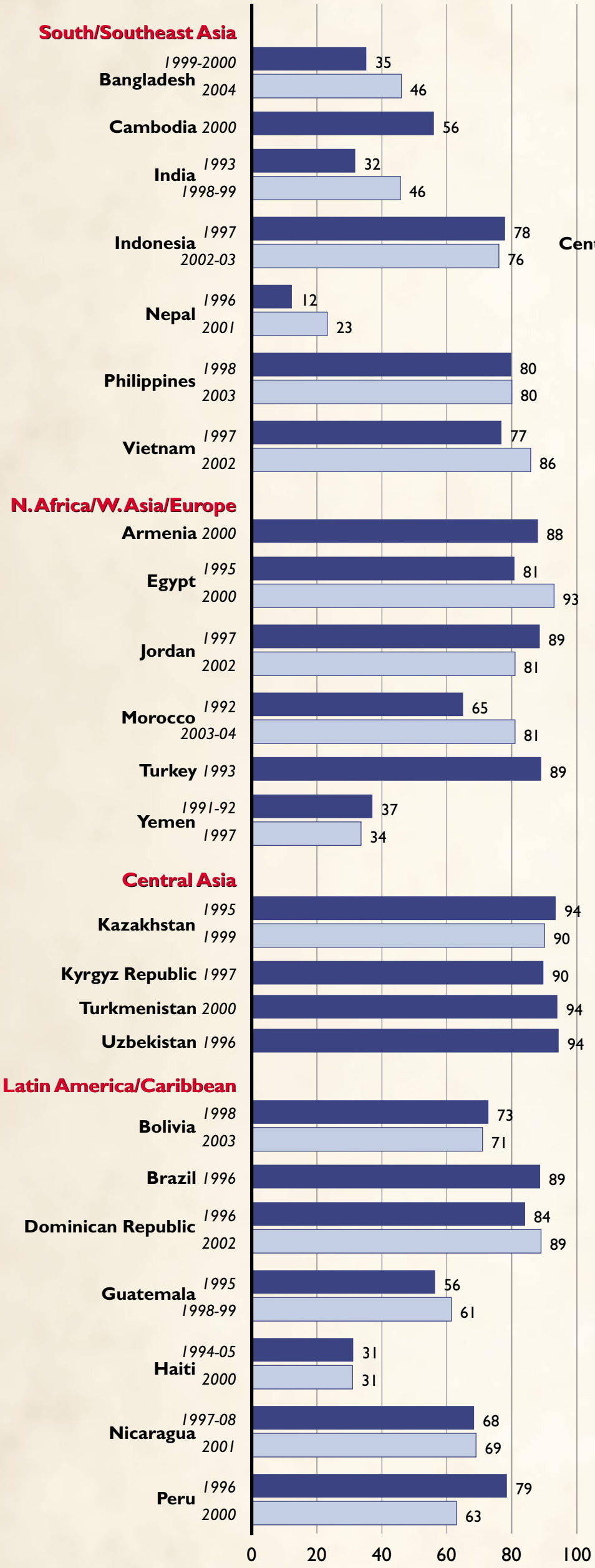
Women are least likely to watch television in Sub-Saharan Africa. Less than one-third of women are regular viewers in 20 of 29 countries surveyed in this region. In 5 countries, only 6 percent or fewer women watch television weekly. Exceptions to this pattern are Côte d'Ivoire, Gabon, and South Africa, where more than half of women watch television weekly.

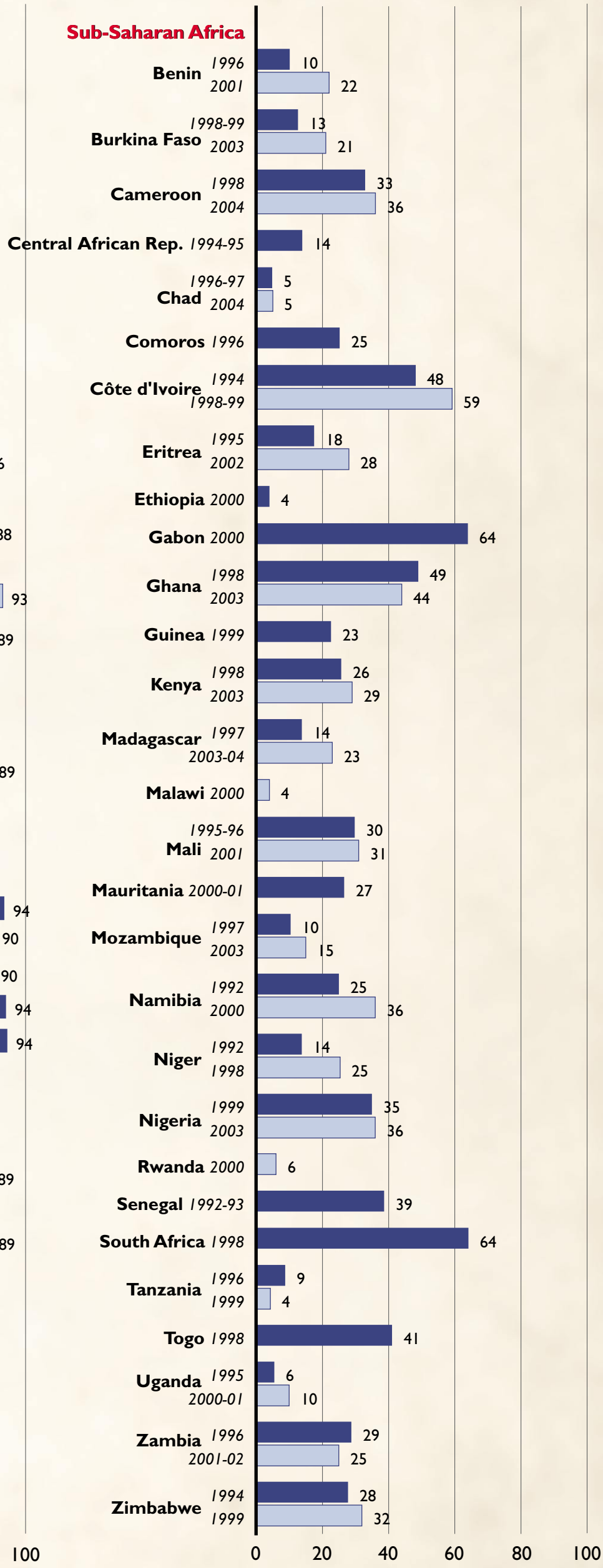
Trends. In 25 of 35 countries with two recent surveys, the percentage of women who regularly watch television has increased over time—by 10 percentage points or more in 10 countries. Although television viewership has increased most dramatically in Benin, from 10 percent of women in 1996 to 22 percent in 2001, the highest proportions of women who watch television regularly are found in Egypt and Uzbekistan.

The percentage of women who regularly watch television has declined in 10 countries across every region of the world. Television viewership has fallen by half in Tanzania, from almost 9 percent in 1996 to less than 5 percent in 1999. Among countries with high viewership, Peru has experienced the greatest drop, with the proportion of women who usually watch television each week falling from 79 percent in 1996 to 63 percent in 2000.

Defining television exposure: To permit comparison of data over time and the analysis of trends, exposure to television is defined here as usually watching television at least once a week.

Percentage of Women 15 to 49 Who Watch Television at Least Once a Week





Data Sources: Characteristics of DHS Surveys and Their Female Respondents

Country/Year	Date of Fieldwork	Implementing Agency	Respondents	Age	Sample Size
South/Southeast Asia					
Bangladesh 1999-2000[1]	10/1999-03/2000	Mitra & Associates	Ever-married women	10-49	10,544
Bangladesh 2004[1]	01/2004-06/2004	Mitra & Associates	Ever-married women	10-49	11,440
Cambodia 2000	02/2000-06/2000	National Institute of Statistics/Ministry of Health	All women	15-49	15,351
India 1992-93[2]	04/1992-09/1993	International Institute for Population Sciences	Ever-married women	13-49	89,777
India 1998-99	11/1998-07/2000	International Institute for Population Sciences	Ever-married women	15-49	90,303
Indonesia 1997	09/1997-12/1997	Central Bureau of Statistics/State Ministry of Population/ National Family Coordinating Board/Ministry of Health	Ever-married women	15-49	28,210
Indonesia 2002-2003	10/2002-04/2003	Central Bureau of Statistics/State Ministry of Population/ National Family Coordinating Board/Ministry of Health	Ever-married women	15-49	29,483
Nepal 1996	01/1996-06/1996	Ministry of Health/New ERA	Ever-married women	15-49	8,429
Nepal 2001	01/2001-06/2001	Ministry of Health/New ERA	Ever-married women	15-49	8,726
Philippines 1998	02/1998-04/1998	National Statistics Office, Department of Health	All women	15-49	13,983
Philippines 2003	06/2003-09/2003	National Statistics Office	All women	15-49	13,633
Vietnam 1997	07/1997-10/1997	National Committee for Population and Family Planning	Ever-married women	15-49	5,664
Vietnam 2002	10/2002-12/2002	General Statistical Office	Ever-married women	15-49	5,665
N. Africa/W. Asia/Europe					
Armenia 2000	10/2000-12/2000	National Statistical Service/Ministry of Health	All women	15-59	6,430
Egypt 1995	11/1995-01/1996	National Population Council	Ever-married women	15-49	14,779
Egypt 2000	03/2000-05/2000	National Population Council	Ever-married women	15-49	15,573
Jordan 1997	06/1997-10/1997	Department of Statistics	Ever-married women	15-49	5,548
Jordan 2002	07/2002-09/2002	Department of Statistics	Ever-married women	15-49	6,006
Morocco 1992	01/1992-04/1992	Ministère de la Santé Publique	All women	15-49	9,256
Morocco 2003-04	10/2003-01/2004	Service des Études et de l'Information Sanitaire/ Ministère de la Santé	All women	15-49	16,798
Turkey 1993[3]	08/1998-11/1998	Hacettape University Institute of Population Studies/ Ministry of Health	Ever-married women	12-49	6,519
Turkey 1998	08/1998-11/1998	Hacettape University Institute of Population Studies	Ever-married women	15-49	8,756
Yemen 1991-92	11/1991-01/1992	Central Statistical Organization	Ever-married women	15-49	5,687
Yemen 1997	10/1997-12/1997	Central Statistical Organization	Ever-married women	15-49	10,414
Central Asia					
Kazakhstan 1995	05/1995-08/1995	National Institute of Nutrition	All women	15-49	3,771
Kazakhstan 1999	07/1999-09/1999	Academy of Preventive Medicine	All women	15-49	4,800
Kyrgyz Republic 1997	08/1997-11/1997	Institute of Obstetrics & Pediatrics/Ministry of Health	All women	15-49	3,848
Turkmenistan 2000	07/2000-10/2000	Gurbansoltan Eje Clinical Research Center for Maternal and Child Health/Ministry of Health and Medical Industry	All women	15-49	7,919
Uzbekistan 1996	06/1996-10/1996	Institute of Obstetrics & Pediatrics/Ministry of Health	All women	15-49	4,415
Uzbekistan 2002	09/2002-12/2002	Analytical and Information Center of the Ministry of Health of Uzbekistan and National Department of Statistics of Uzbekistan	All women	15-49	5,463
Latin America/Caribbean					
Bolivia 1998	03/1998-09/1998	Instituto Nacional de Estadística	All women	15-49	11,187
Bolivia 2003	07/2003-09/2004	Instituto Nacional de Estadística	All women	15-49	17,654
Brazil 1996	03/1996-06/1996	Sociedade Civil Bem-Estar Familiar no Brasil	All women	15-49	12,612
Colombia 2000	03/2000-07/2000	Profamilia	All women	15-49	11,585
Colombia 2005[2]	10/2004-05/2005	Profamilia	All women	13-49	41,344
Dominican Republic 1996	09/1996-12/1996	Centro de Estudios Sociales y Demográficos	All women	15-49	8,422
Dominican Republic 2002	06/2002-10/2002	Centro de Estudios Sociales y Demográficos	All women	15-49	23,384
Guatemala 1995	06/1995-12/1995	Instituto Nacional de Estadística	All women	15-49	12,403
Guatemala 1998-99	11/1998-04/1999	Instituto Nacional de Estadística	All women	15-49	6,021
Haiti 1994-95	07/1994-01/1995	Institut Haïtien de l'Enfance	All women	15-49	5,356
Haiti 2000	03/2000-07/2000	Institut Haïtien de l'Enfance	All women	15-49	10,159
Nicaragua 1997-98	12/1997-05/1998	Instituto Nacional De Estadísticas Y Censos	All women	15-49	13,634
Nicaragua 2001	09/2001-12/2001	Instituto Nacional De Estadísticas Y Censos	All women	15-49	13,060
Peru 1996	08/1996-11/1996	Instituto Nacional de Estadística e Informática	All women	15-49	28,951
Peru 2000	07/2000-11/2000	Instituto Nacional de Estadística e Informática	All women	15-49	27,843
Sub-Saharan Africa					
Benin 1996	06/1996-08/1996	Institut National de la Statistique	All women	15-49	5,491
Benin 2001	08/2001-10/2001	Institut National de la Statistique	All women	15-49	6,219
Burkina Faso 1998-99	12/1998-03/1999	Institut National de la Statistique et de la Démographie	All women	15-49	6,445
Burkina Faso 2003	06/2003-11/2003	Institut National de la Statistique et de la Démographie	All women	15-49	12,000

DATA SOURCES

Country/Year	Date of Fieldwork	Implementing Agency	Respondents	Age	Sample Size
Cameroon 1998	02/1998-06/1998	Bureau Central des Recensements et des Études de Population	All women	15-49	5,501
Cameroon 2004	02/2004-07/2004	Institut National de la Statistique	All women	15-49	10,656
Central African Republic 1994-95	09/1994-03/1995	Direction des Statistiques Démographiques et Sociales	All women	15-49	5,884
Chad 1996-97	12/1996-07/1997	Bureau Central du Resensement	All women	15-49	7,454
Chad 2004	08/2004-12/2005	Institut National de la Statistique, des Études Économiques et Démographiques	All women	15-49	6,085
Comoros 1996	03/1996-05/1996	Centre National de Documentation et de Recherche Scientifque	All women	15-49	3,050
Côte d'Ivoire 1994	06/1994-11/1994	Institut National de la Statistique	All women	15-49	8,099
Côte d'Ivoire 1998-99	09/1998-03/1999	Institut National de la Statistique	All women	15-49	3,040
Eritrea 1995	09/1995-01/1996	National Statistics Office	All women	15-49	5,054
Eritrea 2002	03/2002-07/2002	National Statistics and Evaluation Office	All women	15-49	8,754
Ethiopia 2000	02/2000-05/2001	Central Statistical Authority	All women	15-49	15,367
Gabon 2000	10/2000-12/2000	Direction Générale de la Statistique et des Études Économiques	All women	15-49	6,183
Ghana 1998	11/1998-02/1999	Ghana Statistical Service	All women	15-49	4,843
Ghana 2003	07/2003-10/2003	Ghana Statistical Service	All women	15-49	5,691
Guinea 1999	05/1999-06/1999	Direction Nationale de la Statistique et de l'Information	All women	15-49	6,753
Kenya 1998	02/1998-07/1998	National Council for Population and Development/ Ministry of Health	All women	15-49	7,881
Kenya 2003	04/2003-09/2003	Central Bureau of Statistics	All women	15-49	8,195
Madagascar 1997	09/1997-12/1997	Direction de la Démographie et des Statistiques Sociales, Institut National de la Statistique	All women	15-49	7,060
Madagascar 2003-04	11/2003-03/2004	Institut National de la Statistique	All women	15-49	9,000
Malawi 1992	09/1992-11/1992	National Statistics Office	All women	15-49	4,850
Malawi 2000	07/2000-11/2000	National Statistics Office	All women	15-49	13,220
Mali 1995-96	11/1995-04/1996	Cellule de Planification et de Statistique du Ministère de la Santé, de la Solidarité et des Personnes Âgées, Direction Nationale de la Statistique et de l'Informatique	All women	15-49	9,704

Country/Year	Date of Fieldwork	Implementing Agency	Respondents	Age	Sample Size
Mali 2001	01/2001-05/2001	Cellule de Planification et de Statistique du Ministère de la Santé, Direction Nationale de la Statistique et de l'Informatique	All women	15-49	12,817
Mauritania 2000-01	10/2000-04/2001	Office National de la Statistique	All women	15-49	7,728
Mozambique 1997	03/1997-06/1997	Instituto Nacional de Estatística	All women	15-49	8,779
Mozambique 2003	07/2003-09/2004	Instituto Nacional de Estatística	All women	15-49	12,193
Namibia 1992	07/1992-11/1992	Ministry of Health and Social Services	All women	15-49	5,421
Namibia 2000	09/2000-12/2000	Ministry of Health and Social Services	All women	15-49	6,755
Niger 1992	03/1992-06/1992	Ministère des Finances et du Plan, Direction de la Statistique et des Comptes Nationaux	All women	15-49	6,503
Niger 1998	03/1998-07/1998	Care International/Niger	All women	15-49	7,577
Nigeria 1999[1]	03/1999-05/1999	National Population Commission	All women	10-49	9,810
Nigeria 2003	03/2003-08/2003	National Population Commission	All women	15-49	7,620
Rwanda 1992	06/1992-10/1992	Office National de la Population	All women	15-49	6,551
Rwanda 2000	06/2000-08/2000	Office National de la Population	All women	15-49	10,421
Senegal 1992-93	11/1992-08/1993	Direction de la Prévision et de la Statistique	All women	15-49	6,310
Senegal 1997	01/1997-04/1997	Direction de la Prévision et de la Statistique	All women	15-49	8,593
South Africa 1998	02/1998-09/1998	Department of Health/Medical Research Council	All women	15-49	11,735
Tanzania 1996	07/1996-11/1996	Bureau of Statistics, Planning Commission	All women	15-49	8,120
Tanzania 1999	09/1999-11/1999	Bureau of Statistics, Planning Commission	All women	15-49	4,029
Togo 1998	02/1998-05/1998	Direction de la Statistique	All women	15-49	8,569
Uganda 1995	03/1995-08/2005	Department of Statistics/Ministry of Finance & Economic Planning	All women	15-49	7,070
Uganda 2000-01	09/2000-02/2001	Uganda Bureau of Statistics	All women	15-49	7,246
Zambia 1996	07/1996-01/1997	Central Statistical Office	All women	15-49	8,021
Zambia 2001-02	11/2001-05/2002	Central Statistical Office	All women	15-49	7,658
Zimbabwe 1994	07/1994-11/1994	Central Statistical Office	All women	15-49	6,128
Zimbabwe 1999	09/1999-12/1999	Central Statistical Office	All women	15-49	5,907

[1] Data collected for women 10-49, indicators calculated for women 15-49
[2] Data collected for women 13-49, indicators calculated for women 15-49
[3] Data collected for women 12-49, indicators calculated for women 15-49

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