Volume 4, Number 1
Spring 2002

DHS+ Dimensions

A semiannual newsletter of the Demographic and Health Surveys project

HIV testing was conducted in conjuction with a DHS survey for the first time during the 2001 Mali DHS.

MEASURE *DHS*+
www.measuredhs.com

Contents

MEASURE *DHS*+ Expands HIV/AIDS Data Collection Efforts

As it becomes clearer how extensively the AIDS pandemic is affecting global development and stability, the need to enhance efforts at collecting data on AIDS becomes even more intense. MEASURE *DHS*+ has responded to the increase in demand for AIDS data with a number of projects designed to improve the availability and use of AIDS-related data.

One of the most exciting new developments to come from MEASURE *DHS*+ in the area of HIV/AIDS data is the creation of the *DHS*+ HIV/AIDS Survey Indicator Database. The database compiles knowledge, attitude and behavioral indicators from several sources, including DHS surveys, UNICEF Multiple Indicator Cluster Surveys, CDC Reproductive Health Surveys, MEASURE Evaluation Sexual Behavior Surveys, and FHI Behavioral Surveillance Surveys. The Web-accessible database will contain dozens of HIV/AIDS indicators that have been compiled from a list of standard indicators defined in *UNAIDS National AIDS Programmes: A Guide to Monitoring and Evaluation*. As with the MEASURE *DHS*+ STATcompiler, users will be able to create their own tables compiling a variety of indicators from different countries. The database, which can be found at http://www.measuredhs.com/hivdata/, will be operational with a limited number of data sets in May 2002. The majority of country data is expected to be available by September.

Continued on page 2

HIV/AIDS, *continued from page 1*

Collecting AIDS data is a vital part of the MEASURE *DHS+* program. Previously the DHS model questionnaire included only a limited number of questions on AIDS-related knowledge and attitudes. However, owing to an increased demand for AIDS-related data, the DHS core survey questionnaire has been expanded now to include a wider range of questions designed to assess knowledge, behavior, and attitudes surrounding AIDS and other sexually transmitted infections. Information is obtained on knowledge of AIDS and means of avoiding HIV infection, misconceptions about HIV/AIDS, knowledge of vertical transmission of HIV, social stigma surrounding people with AIDS, and interspousal communication about AIDS. In addition, a more comprehensive AIDS module is available for use in countries with a high seroprevalence. The expanded AIDS module includes questions regarding HIV testing, discussion of AIDS in the media, and the prevalence of other sexually transmitted infections.

Recently, MEASURE *DHS+* expanded the scope of its biomarker collection efforts to include HIV testing. The 2001 Mali DHS was the first time HIV testing had been conducted in conjunction with a DHS survey. Nationwide, the HIV prevalence rate in Mali was found to be 1.7 percent. Testing for both HIV and syphilis has also been incorporated into the ongoing 2001-2002 Zambia DHS. A number of other countries have expressed interest in conducting HIV testing as part of upcoming DHS surveys.

Nationwide, the HIV prevalence rate in Mali was found to be 1.7 percent.

In addition to these survey data initiatives, several qualitative studies on HIV/AIDS either have been completed or are under way. A study was recently completed on the use of the HIV testing informed consent statement in the Mali DHS.

Population Services International (PSI)
Cover photo: A. Alisalad

Workshop on 'Analysis of DHS Data from a Gender Perspective' a Resounding Success

For most of the decade of the 1990s—especially after the International Conference on Population and Development in 1994—population, health and development organizations were increasingly challenged to integrate gender concerns into their activities, often with the aim of increasing gender equity. However, there has been little guidance on what it means to integrate gender into population and health-related activities, how to measure success or failure in the endeavor, and how to obtain the data to guide the efforts.

The term 'gender' is more often than not equated with women, women's issues, or women's concerns alone. Another common misconception is that gender is something that needs to be *added on* to a project. Few understand that integrating gender is *an approach*: an approach based on gender analysis. Gender analysis refers to the socioeconomic methodologies that identify and interpret the consequences of gender relations and inequities for achieving development objectives and provide an understanding of the environment in which development policies, programs, and projects operate. Specifically, gender analysis examines the disparities in roles, activities, needs, constraints, opportunities, and power associated with being male or female in a given context and looks at how those attributes affect and are affected by interventions and policies.[1]

In recognition of the conceptual and data-related hurdles

Continued on page 3

Gender-related data and other activities in the DHS

The Demographic and Health Surveys have always contained questions that yield widely used indicators of women's status such as education, employment, media exposure, and age at first marriage. In addition,

- Data are now available on women's empowerment as measured by their participation in household decisionmaking and beliefs about specific types of gender roles in most surveys conducted since 1999
- Data on domestic violence including sexual violence, women's status, and female genital cutting are available for selected countries
- Several gender-sensitive qualitative studies are available on topics including FGC and contraceptive discontinuation
- A comparative analytical report on domestic violence is under preparation.

[1]This definition of gender analysis is adapted from a manual for integrating gender into PHN programs being prepared under the aegis of the USAID Interagency Gender Working Group.

Gender, *continued from page 2*

in integrating gender in the field of reproductive health, MEASURE *DHS+* decided to offer a workshop to help build capacity in gender and in the use of gender-related data. The specific goal of the workshop was to provide guidance for conducting gender analysis and for analyzing DHS data within a framework that explicitly accounts for gender roles, needs, and relations. With its in-house capacity for conducting gender analysis, defining and using gender-related indicators, and having an in-depth knowledge of the collection and analysis of DHS data, MEASURE *DHS+* brought unique qualifications to conduct such a workshop. The challenge was to design a curriculum that would be simultaneously relevant to researchers, policy makers, and program managers.

Despite some hurdles (mostly associated with the almost crippling effects on international travel of the attack on the United States on September 11) MEASURE *DHS+* successfully conducted a 3-week workshop entitled "Analysis of DHS Data from a Gender Perspective" from October 8 to October 26, 2001. The workshop was held at the offices of ORC Macro in Calverton, Maryland, and was attended by eight women and one man from seven countries (Eritrea, India, Indonesia, Nepal, Nigeria, Uganda, and the United States). Although the participants were mainly professionals in the fields of demography and health, they came into the workshop with greatly varying levels of exposure to and understanding of gender and its linkages to demographic and health outcomes.

G. Bicego

The 3-week curriculum of the workshop was loosely divided into three parts. During the first few days of the workshop, participants were immersed in reading, discussions, and interactive exercises on the meaning of gender, the need for gender analysis, how to conduct gender analyses in different developmental contexts, and associated data needs. Those activities were followed by hands-on sessions in which participants learned about different types of DHS data as well as how to access and use the data and received in-depth training of all the types of gender data available from the DHS questionnaires and modules. Discussions were also held on what defines a valid indicator, examples of gender indicators, and indicators that can be defined by using DHS data. In addition, participants were exposed to how qualitative methodologies can be used to examine gender and its linkages with demographic and health outcomes. An illustrative session on plotting and interpreting gender-related indicators by using geographical information systems (GIS) helped expose the participants to new ways of looking at familiar indicators. In the third part of the workshop, DHS and invited experts in the areas of HIV / AIDs, gender preferences for children, reproductive health, nutrition, and fertility and family planning helped to explore how integrating gender informs and affects our understanding of outcomes in each of those areas.

Sessions at the ORC Macro offices were interspersed with field visits to the World Bank, the Population Reference Bureau, and the International Center for Research on Women. During the visits, participants were provided with insights into the different ways in which organizations are integrating gender into their work. The USAID Interagency Gender Working Group organized a half-day session to expose participants to the relevance of male involvement in reproductive health. An expert from the Census Bureau held a session on effective ways of presenting gender indicators. Participants watched documentaries that highlighted gender norms around the world.

Participants were required to develop a gender profile based on DHS data for their country and then use it to develop a presentation on how integrating gender affected a demographic or health outcome of interest to them. Presentations were made on the last day of the workshop. Topics chosen by participants ranged from the need for gender sensitivity in training health providers for the prevention of female genital cutting in Eritrea to understanding male involvement in reproductive health in Indonesia. Most participants were able to go home with the groundwork done on research projects in their area of interest.

Despite the intense pace of the workshop, most participants rated the workshop very highly and said that if it were to be held again they would strongly encourage people they knew to attend it. An even more important measure of success than the workshop evaluations, however, is the fact that DHS has received feedback from individual participants on how they are using what they learned at the workshop. A few weeks after the workshop, one participant wrote, "the best thing is that I am actually doing gender analysis of any and every data as a matter of routine."

MEASURE *DHS+* assists countries worldwide in the collection and use of data to monitor and evaluate population, health, and nutrition programs. Funded by the U.S. Agency for International Development (USAID), MEASURE *DHS+* is implemented by Macro International Inc., an Opinion Research Corporation company (ORC Macro), in Calverton, Maryland, with the Population Council and the East-West Center. *DHS+ Dimensions* is published twice a year to provide information about the program and the status of *DHS+* surveys. Send correspondence to MEASURE *DHS+*, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (tel.: 301-572-0200; fax: 301-572-0999; www.measuredhs.com). Project Director: Martin Vaessen.

Haiti: High Levels of Anemia Found in Most Recent DHS

Findings from the 2000 Haiti DHS—or *Enquête Mortalité, Morbidité et Utilisation des Services, EMMUS III*—were presented in a national seminar held on February 5, 2002 in Petionville, Haiti. More than 50 people attended the opening ceremony and participated in the seminar, which received extensive coverage by the media. The 2000 DHS, the third such survey conducted in Haiti in the last 13 years, provides detailed information on socioeconomic, demographic, and health indicators as well as data on the use of health services. Of the numerous indicators reported on during the national seminar, selected findings are highlighted below.

Anemia

Anemia prevalence—measured by the level of hemoglobin concentration in the blood—is used as an indicator of iron deficiency, the most common form of malnutrition in the world. At particular risk for iron deficiency are infants and young children; in children, anemia is associated with impaired mental and physical development. Anemia can also be particularly serious for pregnant women, leading to premature delivery and low birth weight. To assess hemoglobin levels, the DHS survey employs the HemoCue system, in which a drop of blood is taken from a respondent's fingertip or heel and drawn into a microcuvette. The hemoglobin level in the blood is analyzed and the result is displayed in a digital register.

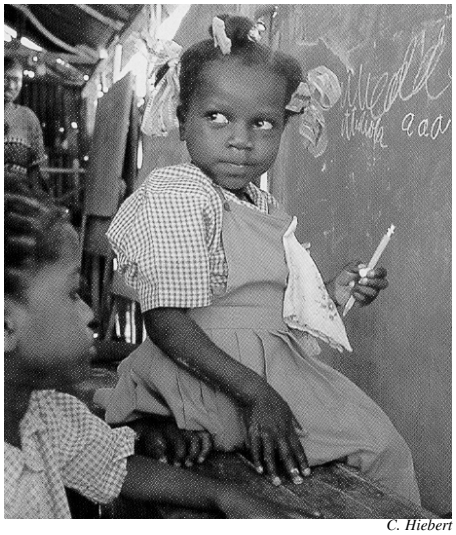
K. Seifert, JHU/CCP

Anemia levels were found to be very high in both women and children. In all, more than half of women were found to have some level of anemia. However, only 19 percent of women were found to be either moderately or severely anemic (less than 10.0 g/dl). Anemia rates in pregnant women were especially elevated; 63 percent of pregnant women suffered from some level of anemia, with one-third being either moderately or severely anemic. Among children 6-59 months old, 65 percent were found to have some level of anemia, with 35 percent being either moderately or severely so. Children under 20 months of age were found to be especially prone to anemia; the prevalence of anemia among children 6-19 months old was found to be over 80 percent.

Literacy

Another striking finding of the 2000 Haiti DHS was the discrepancy between the percentage of people who had never attended school and levels of literacy. All respondents were asked about their level of schooling. Those who reported having had either no education or only primary-level schooling were asked to read from a card to determine rates of adult literacy. Respondents who were asked to read from the card (which contained a simple phrase in French and Creole) were judged as being able to read the entire phrase, part of the phrase, or none of the phrase. Those who could not read any of the phrase were considered illiterate.

It is expected that the percentage of the population that has never attended school will correlate closely with the percentage of people who are illiterate in a population. However, in the 2000 Haiti DHS, it was found that illiteracy rates were in fact much higher than would have been expected, given the levels of education in the population. Twenty-nine percent of women and 19 percent of men had not attended school at any level. However, fully 41 percent of women and 30 percent of men were found to be unable to read at all.


C. Hiebert

Use of Health Services

To better plan for and provide health services, it is essential to identify a population's behavior patterns when health problems arise. At what type of health facility do people seek assistance? To what degree are those facilities accessible to the public? Why is one facility chosen over another? Questions about the use of health services were also included in the 2000 Haiti DHS.

In 32 percent of the households surveyed, at least one person had been seriously sick or injured during the 12 months prior to the survey. Among the households in which someone was sick or hurt, the individual was not brought to any health facility in 16 percent of cases. The reason most often offered as to why the person was not taken to a health facility was the high cost of medicine (41 percent). In 21 percent of the cases in which the person was not brought to a health facility, a traditional healer was consulted instead. In addition, in the majority of cases in which a sick person was brought to a health facility, there was actually another health facility closer to the household than the one visited. People explained their decision to visit the more distant facility as being related to better equipment (59 percent), more competent staff (47 percent) and less-expensive services (17 percent).

Findings From First Cambodia DHS Shed Light on State of the Nation

Interesting findings include numbers on accidental deaths and injuries

There was much anticipation preceding the results of the 2000 Cambodia Demographic and Health Survey (CDHS), the first nationally representative demographic and health survey to be carried out in Cambodia since previous surveys had excluded certain regions because of dangerous conditions. A national seminar to publicize the data was held in Phnom Penh in October 2001. The welcoming speech was made by the Minister of Planning in the presence of ambassadors and officials from several international organizations. After the minister's speech, Samdech Hun Sen, the Cambodian Prime Minister, delivered an address pointing to the crucial need to further use the results of the 2000 CDHS. Below are several of the more interesting findings presented at the seminar.

Accidental Death or Injury and Impairment

In the CDHS, respondents were asked whether any household member had suffered accidental injury or death in the past 12 months. If anyone was injured, the cause of injury was reported. If the victim was dead, the respondent was asked whether the accident was the cause of death. Around 1 percent of the Cambodian population was injured or had died in an accident in the prior year. Among those involved in accidents, one-third had been involved in a roadside accident, 13 percent had fallen from a tree or a building, 5 percent had been harmed by gunshots, and 3 percent had been injured by landmines.

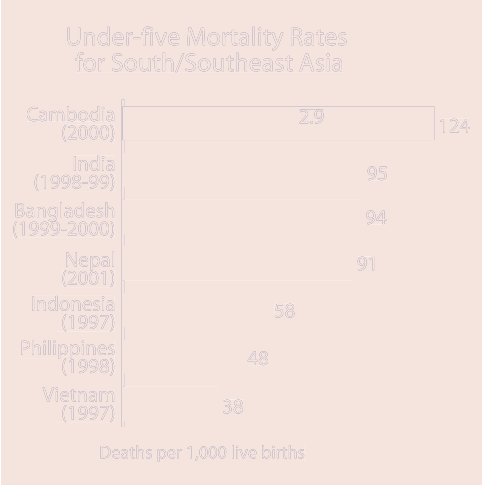
Two percent of the Cambodian population was found to be suffering from some form of physical impairment. Although 37 percent of physical impairments resulted from disease (most commonly poliomyelitis), a large percentage of physical impairments stem from violence and war; 14 percent of impairments were caused by landmines, and 11 percent were caused by guns. As would be expected, landmines and guns have most profoundly affected those in the age groups 20-39 and 40-59; they were the ones most likely to have lived through the period of active conflict and its immediate aftermath.

Infant and Child Mortality

Infant and child mortality rates are high in Cambodia; almost one in 10 babies born in Cambodia does not live to the age of one. Under-five mortality rates are also high, at 124 deaths per 1,000 live births. The rates are among the highest in Asia. Although mortality rates in Cambodia have been declining over the past 25 years, survey results indicate a slight increase in both infant and under-five mortality for the most recent period. Infant mortality rates have increased from 79 per 1,000 births in the period 10-14 years before the survey to 95 per 1,000 births 0-4 years before the survey. Under-five mortality has likewise increased, from 115 to 124 deaths per 1,000 live births during the same period.

Domestic Violence

In Cambodia and elsewhere, the culture of silence that surrounds the topic of violence against women in general, and domestic violence in particular, often makes it difficult to assess the extent of the problem. The 2000 CDHS included a full module of questions designed to provide information on the extent of violence and forms of mistreatment that women in Cambodia suffered at the hands of their spouses and others.



It was found that 23 percent of ever-married women had experienced violence at any time following their fifteenth birthday, with 15 percent having experienced some form of violence within the prior 12 months. These rates were twice as high for women who were divorced or separated as for women who were currently married.

Interspousal violence—or violence against ever-married women by their current or former husbands—was categorized by type as either emotional violence, physical violence, or sexual violence. Sixteen percent of ever-married women had suffered physical violence at the hands of their husbands, 18 percent had suffered emotional violence, and 4 percent had suffered sexual violence. Seventeen percent of women had suffered either physical or sexual violence at the hands of their husbands and one-fourth had suffered from emotional, physical, or sexual violence.

Harvey Nelson

Summary of Demographic and Health Surveys

COUNTRY SURVEY	IMPLEMENTING ORGANIZATION
CENTRAL ASIA	
Kazakhstan 1999	National Institute of Nutrition
1995	Inst. of Obst. & Ped., MOH
Kyrgyz Republic 1997	Settlmt. and Land Rec. Dep., Min. of Agr.
Turkmenistan 2000	MCH/MOH and MIT
Uzbekistan 2002	Min. of Macroeconomics/MOH
1996	Inst. of Obst. & Gynec., MOH
LATIN AMERICA & CARIBBEAN	
Bolivia 1998	Instituto Nacional de Estadística
1994	Instituto Nacional de Estadística
1989	Instituto Nacional de Estadística
Brazil 1996	Soc. Civil Bem-Estar Familiar no Brasil
1991 (NE)	Soc. Civil Bem-Estar Familiar no Brasil
1986	Soc. Civil Bem-Estar Familiar no Brasil
Colombia 2000	PROFAMILIA
1995	PROFAMILIA
1990	PROFAMILIA
1986	Corp. Cen. Reg. de Pob./Min. de Salud
Dominican Rep. 1999	CESDEM
1996	CESDEM/PROFAMILIA
1991	PROFAMILIA
1986	Consejo Nacional de Población y Familia
1986 (Exp.)	Consejo Nacional de Población y Familia
Ecuador 1987	Cen. de Estud. de Pob. y Paternidad Res.
El Salvador 1985	Asociación Demográfica Salvadoreña
Guatemala 1999 (Interim)	Instituto Nacional de Estadística
1997 (In-Depth 1)*	Instituto Nacional de Estadística
1997 (In-Depth 2)*	Inst. de Nutrición de Cent. y Panamá
1995	Instituto Nacional de Estadística
1987	Inst. de Nutrición de Cent. y Panamá
Haiti 2000	Institut Haïtien de l'Enfance
1994	Institut Haïtien de l'Enfance
Mexico 1987	Dir. Gen. de Plan. Fam., Sec. de Salud
Nicaragua 1997	Instituto Nacional de Estadísticas y Censos
Paraguay 1990	Centro Paraguayo de Estudios de Pob.
Peru 2000	Instituto Nacional de Estadística
1996	Instituto Nacional de Estadística
1992	Instituto Nacional de Estadística
1986	Instituto Nacional de Estadística
1986 (Exp.)	Instituto Nacional de Estadística
Trinidad & Tobago 1987	Family Planning Assoc. of Trinidad/Tobago

COUNTRY SURVEY	IMPLEMENTING ORGANIZATION
SOUTH/SOUTHEAST ASIA	
Bangladesh 2001	Mitra & Associates/ACPR/NIPORT
2000	Mitra & Associates/NIPORT
1997	Mitra & Associates/NIPORT
1994	Mitra & Associates/NIPORT
Cambodia 2000	National Institute of Statistics/MOH
1998	SAWA Cam./Nat. Inst. of Public Health
India 1998-2000*	Various organizations
1999	International Inst. for Population Sciences
1993	International Inst. for Population Sciences
Indonesia 2002	Central Bureau of Statistics/NFPCB/MOH
1997	Central Bureau of Statistics/NFPCB/MOH
1994	Central Bureau of Statistics/NFPCB/MOH
1991	Central Bureau of Statistics/NFPCB/MOH
1987	Central Bureau of Statistics/NFPCB
Myanmar 1996	Academy of Preventive Medicine
Nepal 2001	New ERA
1996	Ministry of Health/New ERA
1987 (In-Depth)	New ERA
Pakistan 1991	National Institute of Population Studies
Philippines 2003	National Statistics Office/Dept. of Health
1998	National Statistics Office/Dept. of Health
1993	National Statistics Office
Sri Lanka 1987	Dept. of Cen. & Stat., Min. of Plan Impl.
Thailand 1987	Inst. of Pop. Studies, Chulalongkorn U.
Vietnam 1997	Nat. Comm. on Pop. and Fam. Planning
NORTH AFRICA/WEST ASIA/EUROPE	
Armenia 2000	Nat. Stat. Service/MOH
Egypt 2000	Ministry of Health and Pop./Nat. Pop. Council
1998 (Interim)	El-Zanaty & Associates
1997 (Interim)	El-Zanaty & Associates
1997 (In-depth)*	National Population Council
1995	National Population Council
1992	National Population Council
1988	National Population Council
Jordan 2002	Department of Statistics
1997	Department of Statistics
1990	Department of Statistics
Morocco 2002	SEIS-Ministry of Health
1995 (Panel)	Ministère de la Santé Publique
1992	Ministère de la Santé Publique
1987	Ministère de la Santé Publique
Mauritania 2000-01	Office Nat. de la Statistique

P. Govindasamy

Reproductive Health Association of Cambodia (RHAC)

COUNTRY SURVEY	IMPLEMENTING ORGANIZATION
Tunisia 1988	Office Nat. de la Fam. et de la Population
Turkey 1998	Hacettepe Inst. of Population Studies
1993	Hacettepe Inst. of Population Studies/MOH
Yemen 1997	Central Statistical Organization
1991	Central Statistical Organization

SUB-SAHARAN AFRICA

Benin 2001	Inst. Nat. de la Stat. et de l'Ana Econ.
1996	Institut National de la Statistique
Botswana 1988	Ministry of Health
Burkina Faso 1999	Inst. Nat. de la Statistique et la Démo.
1992	Inst. Nat. de la Statistique et la Démo.
Burundi 1987	Dép. de la Pop., Min. de l'Intérier
Cameroon 1998	Bur. Cen. Recensements et Études de Pop.
1991	Min. du Plan et de l'Amén. du Terr.
Central African Rep. 1994	Dir. des Stat. Dém. et Sociales
Chad 2002	Dir. De la Stat., des Etu. Econ. et DTm.
1997	Bureau Central du Recensement
Comoros 1996	Centre National de Doc. et de Rech. Sci.
Côte d'Ivoire 1998-99	Inst. National de la Statistique
1994	Inst. National de la Statistique
Eritrea 1995	National Statistics Office
Ethiopia 2000	Central Statistical Authority
Gabon 2000	Direction Générale de la Stat
Ghana 1998	Ghana Statistical Service
1993	Ghana Statistical Service
1988	Ghana Statistical Service
Guinea/Conakry 1999	Direction Nationale de la Statistique
Kenya 2003	Central Bureau of Statistics
1999 (SPA)*	National Council for Population and Dev.
1998	National Council for Population and Dev.
1993	National Council for Population and Dev.
1989	National Council for Population and Dev.
Liberia 1986	Min. of Planning & Economic Affairs
Madagascar 2002	DDSS-Institut National de la Statistique
1997	DDSS-Institut National de la Statistique
1992	Centre Nat. de Recherches sur l'Env.
Malawi 2000	National Statistical Office
1996 (KAP)	National Statistical Office
1992	National Statistical Office
Mali 2001	CPS/MSSPA et DNSI
1996	CPS/MSSPA et DNSI
1987	Inst. de Sahel: USED/CERPOD
Mozambique 2003	Instituto Nacional de Estatística
1997	Instituto Nacional de Estatística
Namibia 1992	Min. of Health and Social Services
Niger 1998	Care International
1992	Dir. de la Stat. et des Comptes Nat.
Nigeria 2003	Nat. Pop. Commission
1990	Federal Office of Statistics
Ondo State, Nigeria 1986	Ministry of Health, Ondo State
Rwanda 2001 (SPA)	Office National de la Population
2000	Office National de la Population
1992	Office National de la Population
Senegal 1999	SERDHA
1997 (Interim)	Min. de l'Economie et des Finances
1993	Dir. de la Prévision et de la Stat.
1986	Min. de l'Economie et des Finances
South Africa 1998	Dept. of Health/Med. Research Council
Sudan 1990	Dept. of Stat., Min. of Fin. & Econ. Plan.
Tanzania 1999	National Bureau of Statistics
1996	Bureau of Statistics, Planning Comm.
1995 (In-Depth)*	Bureau of Statistics, Planning Comm.
1994 (KAP)	Bureau of Statistics, Planning Comm.
1992	Bureau of Statistics, Planning Comm.
Togo 1998	Direction de la Statistique
1988	Unité de Recherche Dém., U. du Benin
Uganda 2000-2001	Uganda Bureau of Statistics
1995 (In-Depth)*	Inst. Stat. & Applied Econ., Makerere U.
1995	Dept. of Stat., Min. Fin. & Econ. Plan.
1988	Ministry of Health
Zambia 2001	Central Statistical Office
1996	Central Statistical Office
1992	University of Zambia
Zimbabwe 1999	Central Statistical Office
1994	Central Statistical Office
1988	Central Statistical Office

***Bangladesh:**	Maternal Health Services and Maternal Mortality Survey
***Guatemala 1:**	Health Expenditure Survey
***Guatemala 2:**	Health Provider Survey
***India:**	12 Uttar Pradesh Benchmark Surveys
***Egypt:**	Reasons for Nonuse in Upper Egypt
***Kenya:**	Service Provision Assessment
***Tanzania:**	Estimation of Adult and Childhood Mortality in a High HIV/AIDS Population
***Uganda:**	Negotiating Reproductive Outcomes
***Uzbekistan:**	Health Examination Survey


S. Poedjastoeti


M. Seroussi

Update on Service Provision Assessment

Progress continues to be made on the facility-based Service Provision Assessment (SPA) surveys. The SPA is a survey of health facilities that was formulated to provide information on the general functioning of outpatient services related to basic maternal, child, and reproductive health. It is designed to provide information on the strengths and weaknesses in the service delivery environment via a representative sample of private and/or public facilities. The SPA covers four priority health services, namely, child health, family planning, maternal health, and sexually transmitted infections, including HIV/AIDS.

Building on experiences from the 1999 Kenya SPA, the core SPA questionnaires have been refined to ensure that they reflect specific indicators for maternal, child, and reproductive health services and that they focus on "best practice" standards. Field instruments and guidelines for the implementation of the Service Provision Assessment were finalized and made available in January 2002. The SPA data collection instruments have now also been translated into French.

In 2001, a SPA was conducted in Rwanda. In total, 223 facilities were included in the survey, which was designed to be representative of both government and nongovernment managed facilities across all 12 regions. Data collection was completed in October 2001, and analysis is ongoing. In addition, the pretest for a SPA in Ghana was completed in November 2001, and fieldwork began in April 2002. The Ghana SPA is being implemented by the Ghana Ministry of Health and Ghana Statistical Service. The survey will include approximately 450 facilities, representative of both public and private facilities throughout the country.

India Benchmark Surveys Measure Performance

MEASURE *DHS+* has been conducting a series of surveys in Uttar Pradesh, India, to measure the success of the Innovations in Family Planning Services (IFPS) Project, which is funded by USAID. The objectives of the IFPS project are to increase access to family planning services, improve the quality of family planning services, and promote family planning knowledge and utilization in the largest state in India. The project is driven by a performance-based disbursement system in which USAID disburses funds to the implementing agency according to whether certain standards of performance—or benchmarks—have been met. Many of the benchmarks are measured by independent surveys carried out by MEASURE *DHS+*.

In the most recent surveys, which were completed in March 2002, interviews were conducted with 8,000 women and 700 practitioners of Indian Systems of Medicine (ISM) in nine districts of Uttar Pradesh. The surveys are narrowly defined (to measure multiple indicators of the specified benchmarks), and they provide quick feedback to USAID about the progress of the IFPS project. The fieldwork for the recent surveys was conducted in a single 2-week period in late February, and the final results were available less than 2 weeks after the end of the fieldwork. The surveys measured the number of ISM practitioners recently trained in family planning and providing family planning advice and quality services, the contraceptive prevalence rate for modern methods among currently married women, and the percentage of women who are using modern spacing methods provided by private practitioners and who received counseling during their most recent visit to a private practitioner. Earlier surveys assessed the functioning of the community-based distribution program, which provides pills and condoms at the local level, and family planning programs conducted by dairy cooperatives, among other topics.

DHS STATcompiler Attracts New Users

Many users are already familiar with the free and simple way to create customized tables of Demographic and Health Survey data. In fact, statistics from the DHS website show a 40 percent rise in the number of users over the last 6 months to over 12,000 visitors in the last month. The increase is largely attributed to the increase in popularity of the DHS STATcompiler.

By accessing the DHS STATcompiler's online database of population, health and nutrition indicators, users can select from more than 600 indicators in more than 60 countries to create specific combinations of data for analysis. Topics include Characteristics of Households, Fertility, Family Planning, Other Proximate Determinants of Fertility, Fertility Preferences, Early Childhood Mortality, Maternal and Child Health, Maternal and Child Nutrition, and AIDS and other STDs.

Users may compare a given indicator over many countries or view trends within a country over time. Other features of the STATcompiler include access to regional and national-level data, English and French translations, and export to Microsoft Excel or other graphing software. Also available is the STATcompiler Express which allows users to select from the 30 most requested indicators across the most recent surveys available.

To access the STATcompiler, go to the MEASURE *DHS+* website (www.measuredhs.com) or simply log on to **www.statcompiler.com** and begin building your customized table.

www.statcompiler.com

	Teenage pregnancy and motherhood by background characteristics			
	Highest educational level			Total
	No education	Primary	Secondary or higher	Total
	Teenage pregnancy			
	Percentage who had children or is currently pregnant			
Sub-Saharan Africa				
Ethiopia 2000	20.8	8.9	9.5	16.3
Gabon 2000	35.4	37.8	29.7	32.7
Guinea 1999	45.5	24.1	10.1	37.2
Kenya 1998	41.4	23.7	9.2	20.9
Madagascar 1997	53.5	37.0	17.7	35.7
Zimbabwe 1999	36.8	30.8	15.5	20.5
North Africa/West Asia/Europe				
Egypt 2000	17.2	17.5	4.8	8.5
Jordan 1997	10.4	12.7	5.2	5.7
Central Asia				
Kazakhstan 1999	0.0	0.0	6.7	6.7
Kyrgyz Republic 1997	0.0	34.3	9.4	9.4

Malawi: Adult Mortality Rises While Child Mortality Drops

The number of deaths among men and women increased sharply in Malawi during the 1990s, according to findings from the 2000 Malawi Demographic and Health Survey (MDHS). The 76 percent increase in mortality among men and 74 percent increase in mortality among women since the last survey conducted in 1992 has been attributed to the spread of HIV/AIDS. In contrast to the adult mortality pattern, the survey found a small decline in child mortality.

The link between rising adult death rates and the AIDS epidemic is apparent from the age patterns of mortality. The largest change in mortality from all causes for men occurs at age 30 and older, whereas for women, an earlier impact is observed at age 20 and older. The age pattern of mortality in Malawi is consistent with the pattern observed in HIV-infection and AIDS-related deaths in sub-Saharan Africa.

Survey findings also reveal an increase in maternal mortality from 620 maternal deaths per 100,000 live births estimated from the 1992 MDHS for the period 1986-1992 to 1,120 estimated in 2000 for the period 1994-2000.

Mortality of children under age 5 has declined since the early 1990s. During the period 1988-1992, the under-five mortality rate was 234 deaths per 1,000 live births, compared with 189 per 1,000 between 1996-2000. Although this change represents important progress, the rate of the downward trend is modest and child mortality remains at a very high level

One factor contributing to the decline in childhood mortality may be the improved access to clean drinking water in the country. Overall, 65 percent of Malawian households have access to clean water sources (piped water, protected wells, or boreholes), which represents a substantial increase since the 1992 survey, when only 47 percent had access to water from such sources.

Although sanitation did improve, there was a setback in the fight against vaccine-preventable diseases in Malawi after the early 1990s. The 2000 survey reveals that full vaccination coverage fell from 82 percent in 1992 to 70 percent in 2000. Full vaccination coverage includes the BCG and measles vaccine and at least three doses of both DPT and polio vaccine among children 12-23 months of age.

G. Bicego

DHS Qualitative Research Update

MEASURE *DHS+* supports qualitative research to produce informed answers to questions that lie outside the purview of a standard survey approach for understanding issues in health, population, and nutrition. Below follows a list of recently published studies, on-going studies, and planned studies.

Recently published studies:

- Introducing Complementary Foods to Infants in Central Mali. Castle, Yoder, and Konaté. ORC Macro, Calverton, MD, October 2001.

Looks at complementary feeding patterns of infants 3-12 months old, specifically examining the interaction between mother (or other caretaker) and infant with comparisons between mothers of well-nourished infants and those of malnourished infants.

Studies in process:

- Complementary feeding of infants in Kumasi, Ghana (due June 2002)

Focuses on the interaction between mother (or caretaker) and infant, comparing the actions of mothers of well-nourished infants with those of malnourished infants.

- Abortion among adolescents in Accra, Ghana (due July 2002)

Examines the experiences of 30 single girls who recently decided to have an abortion or carry their pregnancy in order to understand what factors affect these decisions.

- Signs of illness and treatment actions for childhood illness among the Maninka in Central Guinea (due July 2002)

Covers field workers who made daily visits to homes to check on the status of children under 5 years of age to understand what signs of illness mothers and fathers recognize as significant.

- Use of an informed-consent form to draw blood for an HIV test as part of the DHS in Mali (due August 2002)

Assesses the informed consent process by observing its administration and interviewing respondents after they had given blood.

Planned studies:

- Stigma and AIDS in Mexico

Will provide information about how stigma manifests itself in different social situations. This study will be used to modify a survey questionnaire on stigma and AIDS in three states in Mexico.

- Public interest in HIV testing in Malawi

Will examine how HIV testing currently occurs, with and without counseling, to identify terms and concepts relevant to a survey instrument that measures public demand for HIV testing.

- Maternal mortality and cause of female deaths in Malawi

Will study how medical records of female deaths are produced, accompanied by the use of verbal autopsies in local populations, which will serve to identify the terms and concepts required to formulate a survey instrument to classify female deaths.

MEASURE *DHS+* Visitors and Events

July 2001

■ Dr. Clara Fayorsay and Ms. Sawudatu Zchariah from the University of Legon in Ghana visited ORC Macro to work on a qualitative study analysis.

■ Ms. Karine Saribekyam and Mr. Levon Eolian from the Ministry of Health and Mr. Hrachya Petrosyan and Ms. Julietta Maglachants from the National Statistical Service in Armenia visited ORC Macro for the writing of the 2000 Armenia Demographic and Health Survey final report.

August 2001

■ Mr. Andrew Mukulu from the Uganda Bureau of Statistics visited ORC Macro to work on the final report for the 2000-2001 Uganda Demographic and Health Survey.

■ MEASURE DHS+ participated in the 17th International Congress of Nutrition in Vienna, Austria. Altrena Mukuria presented a paper entitled Using National Health and Nutrition Surveys for Policy and Programs: Experiences from DHS.

■ MEASURE DHS+ participated in the XXIVth General Population Conference of the International Union for the Scientific Study of Population (IUSSP), held in Salvador, Brazil on August18-24, 2001. Mary Mahy presented a paper on Reproductive health behavior and fertility among adolescents in sub-Saharan Africa. Stanley Yoder gave a paper on methodological issues in conducting qualitative research. Rebecca Henry presented a poster session on the Philippine's contraceptive discontinuation study. Neeru Gupta presented a paper on Sexual initiation among adolescent women and men: Trends and differentials in sub-Saharan Africa. Guillermo Rojas conducted two workshops on DHS data files & Calculation of important DHS statistics.

September 2001

■ The National Dissemination Seminar for the 2000 Malawi Demographic and Health Survey was held on September 6 in Lilongwe, Malawi.

■ MEASURE DHS+ conducted a Data Users' Workshop for the NFHS-2 at the International Institute for Population Sciences (IIPS) in Mumbai, India, on September 17-18, 2001.

October 2001

■ Ms. Apolline Mukanyonga and Ms. Athanasie Kabagwira from the Office National de la Population in Rwanda visited ORC Macro to work on the final report of the 2000 Rwanda DHS.

■ Dr. Ibrahim-Sorie Yansaneh from the National Statistical Office, United Nations visited ORC Macro for a sampling training session.

■ MEASURE DHS+ participated in the annual meeting of the American Public Health Association (APHA) held in Atlanta, Georgia, October 21-25.

■ MEASURE DHS+ conducted a workshop on Analyzing DHS Data from a Gender Perspective at ORC Macro, October 8-26, 2001. Ms. Helen Nviiri from the Uganda Burea of Statistics; Ms. Anjushree Pradhan from New Era, Ltd. (Nepal); Ms. Liane Adams from USAID / Nigeria; Mr. Muhammed Dawam and Ms. Rahmadewi from the National Family Planning Coordinating Board / BKKBN (Indonesia); Ms. Sherrine Eid from The Futures Group / Washington; Ms. B. Bhamathi from UNFPA / New Delhi; Dr. Sulabha Parasuraman from the International Institute for Popluation Sciences (IIPS), Mumbai; and Ms. Terhas Mehreteab from the Eritrean Ministry of Health attended the workshop. For more details, see related article on page 2.

November 2001

■ Mr. Lucien Kouassi from Institut National de la Statistique, Côte d'Ivoire visited ORC Macro to work on the final report of the 1998-99 Côte d'Ivoire DHS.

■ Mr. Bharat Ban from New Era, Ltd. (Nepal), visited ORC Macro to finalize the final report of the 2001 Nepal Demographic and Health Survey.

■ Mr. Ahmed Ould Isselmon, Mr. Mohamed Lemine Salem Ould Moujtaba, and Mr. Mohamed Aly Ould Ekeibed from the Office National de la Statistique in Mauritania visited ORC Macro to work on the final report of the 2000-2001 Mauritania DHS.

■ The National Seminar for the 2000 Turkmenistan Demographic and Health Survey was held in Ashgabat, Turkmenistan on November 29, 2001.

December 2001

■ MEASURE DHS+ conducted a Data Users' Workshop for the 2000 Peru DHS at the National Statistical Office in Lima, Peru on December 17-21.

What's New in Print?

Country Reports

Armenia	2000 Final Report (English)
Cambodia	2000 Final Report (English) 2000 Key Findings (English)
Côte d'Ivoire	1998-99 Final Report (French)
Mauritania	2000-01 Final Report (French) 2000-01 Summary Report (French)
Rwanda	2000 Final Report (French) 2000 Key Findings (French)
South Africa	1998 Final Report (English)
Turkmenistan	2000 Final Report (English)
Uganda	2000-01 Final Report (English) 2000-01 Key Findings (English)

Analytical Studies

Mahy, Mary and Neeru Gupta. 2002. Trends and Differentials in Adolescent Reproductive Behavior in Sub-Saharan Africa

Comparative Reports

Westoff, Charles and Akinrinola Bankole. 2002. Reproductive Preferences in Developing Countries at the Turn of the Century

Nutrition Publications

Rwanda Nutrition Chartbook
Uganda Nutrition Chartbook
Zambia Nutrition Report
Castle, Sarah, et al. 2001. Introducing Complementary Foods to Infants in Central Mali

Other Publications

Grandia, Liza, et al. 2001. Salud, Migración y Recursos Naturales en Petén (Spanish)

Instituto Nacional de Estadística (INE). 1999. Guatemala: Salud Materno Infantil en los Departmentos del Altiplano (Spanish)

Laguna, Elma, et al. 2000. Contraceptive Use Dynamics in the Philippines

Lamberte, Exaltacion, et al. 2000. Family Planning Service Utilization and Market Segmentation in the Philippines

National Institute of Population Research and Training (NIPORT) 2002. Bangladesh Maternal Health Services and Maternal Mortality Survey 2001: Preliminary Report

Thiam, Mamadou and Alfredo Aliaga. 2001. Estimating Sampling Errors of Means, Total Fertility, and Childhood Mortality Rates Using SAS (English/French)

MEASURE *DHS+* Basic Documentation

3 – Interviewer's Manual for Use with Model "A" Questionnaire for High Contraceptive Prevalence Countries
4 – Interviewer's Manual for Use with Model "B" Questionnaire for Low Contraceptive Prevalence Countries
5 – Supervisor's and Editor's Manual for Use with Model "A" and "B" Questionnaires

Look for these survey publications coming soon!

Benin
Mali
Namibia
Nepal

Selected Statistics From Recent DHS Surveys

REGION/ SURVEY COUNTRY	VITAL RATES: Total Fertility Rate[a]	VITAL RATES: Total Wanted Fertility Rate[a]	VITAL RATES: IMR/ Under-five Mortality[b]	USE OF CONTRACEPTION (Currently Married Women 15-49): % Currently Using Any Method[c]	USE OF CONTRACEPTION (Currently Married Women 15-49): % Currently Using Any Modern Method[d]	MATERNAL CARE (Births in Last 5 Yrs.): % Women Receiving Antenatal Care[e]	MATERNAL CARE (Births in Last 5 Yrs.): % Women Receiving Assistance at Delivery From Professional[e]	CHILD HEALTH INDICATORS: Median Duration (Months) of Breast-feeding[f]	CHILD HEALTH INDICATORS: % Children 0-59 Months Stunted[g]	CHILD HEALTH INDICATORS: % Children Fully Immunized[h]
CENTRAL ASIA										
Kazakhstan 1999	2.1	1.9	62/71	66	53	94	99	7[l]	10	81
Kyrgyz Rep. 1997	3.4	3.1	61/72	60	49	97[i]	98[i]	17	25[m]	82
Turkmenistan 2000	2.9	2.7	74/94	62	53	98[i]	97	18	22	90
LATIN AMERICA/CARIBBEAN										
Bolivia 1998	4.2	2.5	67/92	48	25	65	57	18	26[n]	26
Colombia 2000	2.6	1.8	21/25	77	64	91[i]	86	13	14	52[o]
Guatemala 1999	5.0	4.1	45/59	38	31	60	41	20	46	60
Haiti 2000	4.7[b]	2.7[b]	80/119	28	22	79	24	19	23	34
Nicaragua 1998	3.9[b]	2.5	40/50	60	57	82	65	12	25	73
Peru 2000	2.9	1.8	33/47	69	50	84[i]	59	22	25	66[p]
NORTH AFRICA/WEST ASIA/EUROPE										
Armenia 2000	1.7	1.5	36/39	61	22	92[i]	97	9	13	76
Egypt 2000	3.5	2.9	54/44	56	54	53	61	18	19	92
Jordan 1997	4.4	2.9	29/34	53	38	96	97	12	8	21
Turkey 1998	2.6	1.9	43/52	64	38	68	81	12	16	46
Yemen 1997	6.5	4.6	75/105	21	10	34	22	18	52	28
SOUTH/SOUTHEAST ASIA										
Bangladesh 2000	3.3	2.2	66/94	54	43	33[i]	12	31[k]	45	60
Cambodia 2000	4.0[b]	3.1[b]	95/124	24	19	38[i]	32	24	45	40
India 1999	2.9	2.1	68/95	48	43	65[j]	42[j]	25	47[m]	42
Indonesia 1997	2.8	2.4	46/58	57	55	89	43	24	†	55
Nepal 2001	4.1	2.5	64/91	39	35	49	13	33	51	66
Philippines 1998	3.7	2.7	35/48	47	28	86	56	13	†	73
Vietnam 1997	2.7[b]	†	28/38	75	56	71[i]	77[i]	17	†	57
SUB-SAHARAN AFRICA										
Burkina Faso 1999	6.8[b]	6.0[b]	105/219	21	5	61	31	28	37	29
Cameroon 1998	5.2	4.6	77/151	19	7	79[i]	58[i]	18	29	36
Chad 1997	6.6[b]	6.3[b]	103/194	4	1	32	24	21	40	11
Côte d'Ivoire 1999	5.2	4.5	112/181	15	7	84	47	21	25	51
Ethiopia 2000	5.9[b]	4.9[b]	97/166	8	6	27[i]	6	25	52	14
Gabon 2000	4.3[b]	3.5[b]	57/89	33	12	95[i]	87	12	21	17
Ghana 1998	4.6[b]	3.7[b]	57/108	22	13	89	44	22	26	62
Guinea 1999	5.5	5.0	98/177	6	4	71	35	22	26	32
Kenya 1998	4.7	3.5	74/112	39	32	92[j]	42[j]	21	33	65
Madagascar 1997	6.0	5.2	96/159	19	10	77[j]	47[j]	21	48[m]	36
Malawi 2000	6.3	5.2	104/189	31	26	91[i]	56	24[j]	49	70
Mali 2001	6.8	‡	113/229	8	6	57[j]	42	‡	‡	29
Mauritania 2001	4.7	4.3	74/116	8	5	65[j]	57	21	35	32
Mozambique 1997	5.2	4.7	135/201	6	5	71[j]	44[j]	22	36[m]	47
Niger 1998	7.5	7.2	123/274	8	5	40[j]	44[j]	21	41[m]	18
Rwanda 2000	5.8	4.7	107/196	13	4	92[j]	31	33[j]	43	76
Senegal 1997	5.7	4.6	68/139	13	8	82	47	21	†	†
South Africa 1998	2.9	2.3	45/59	56	55	94	84	16	†	63
Tanzania 1999	5.6	4.8	99/147	25	17	49[j]	36	21	44	68
Togo 1998	5.2	4.2	80/146	24	7	82[j]	51[j]	24	22	31
Uganda 2001	6.9	5.3	88/152	23	18	92[j]	39	22[j]	39	37
Zimbabwe 1999	4.0[b]	3.4[b]	65/102	54	50	93[j]	73	19	27	75

† = Not available from survey data
‡ = Not available until publication of final report
a Based on 3 years preceding survey (women 15-49)
b Based on 5 years preceding survey
c Excludes prolonged abstinence
d Excludes periodic/prolonged abstinence, withdrawal, "other"
e Care provided by medically trained personnel
f Children <3 years old (any breastfeeding)
g Height-for-age z-score is below -2 SD based on the NCHS/CDC/WHO reference population
h Children 12-23 months vaccinated (BCG, measles, 3 doses each DPT/polio) at any time before survey
i Based on last birth
j Based on births in the preceding 3 years
k Based on births in the preceding 4 years
l Children 0-59 months old
m Children 0-35 months old
n Children 3-35 months old
o Excludes measles
p Children 18-29 months old

For more indicators, and to build custom tables with DHS data, visit the STATcompiler at www.measuredhs.com