

# **Namibia Demographic and Health Survey 2013**

## **Main Findings**

**Ministry of Health and Social Services  
Windhoek, Namibia**

**Namibia Statistics Agency  
Windhoek, Namibia**

**National Institute of Pathology  
Windhoek, Namibia**

**The DHS Program  
ICF International  
Rockville, Maryland USA**



**REPUBLIC OF NAMIBIA**

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ICF International  
Rockville, Maryland, U.S.A.**

**June 2014**



The 2013 Namibia Demographic and Health Survey (NDHS) was implemented by the Ministry of Health and Social Services (MoHSS) in collaboration with the Namibia Statistics Agency (NSA) and the National Institute of Pathology (NIP). Technical support was provided by ICF International with financial support from the Government of Namibia, the United States Agency for International Development (USAID) and the Global Fund (GFATM).

Information about the 2013 NDHS may be obtained from the Ministry of Health and Social Services (MoHSS), Private Bag 13198, Windhoek, Namibia; Telephone: (264-61) 203-2500/2; Fax: (264-61) 222-558; Email: [pro@mhss.gov.na](mailto:pro@mhss.gov.na); Internet: [www.mhss.gov.na](http://www.mhss.gov.na).

The 2013 NDHS is part of the worldwide DHS Program which is funded by the United States Agency for International Development (USAID). Additional information about the DHS Program may be obtained from ICF International, 530 Gaither Road, Suite 500, Rockville, Maryland 20850-5971, USA; Telephone: +1-301-407-6500; Fax: +1-301-407-6501; Email: [reports@dhsprogram.com](mailto:reports@dhsprogram.com); Internet: [www.dhsprogram.com](http://www.dhsprogram.com).

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## FOREWORD

The 2013 Namibia Demographic and Health Survey (NDHS) is conducted as a periodic update of the demographic and health situation in Namibia. This is the fourth comprehensive national level population and health survey conducted in Namibia as part of the global Demographic and Health Surveys (DHS) Program.

The 2013 NDHS was implemented by the Ministry of Health and Social Services (MoHSS) in collaboration with the Namibia Statistics Agency (NSA) and the National Institute of Pathology (NIP). Technical support was provided by ICF International with financial support from the Government of Namibia, the United States Agency for International Development (USAID), and the Global Fund (GFATM).

The purpose of this study is to generate recent and reliable information on fertility, family planning, infant and child mortality, maternal and child health, nutrition, domestic violence, knowledge and prevalence of HIV and AIDS, and other non-communicable diseases, which allows monitoring progress through time and addressing these issues. The study was initiated in April 2012 and data collection was carried out from May-September 2013.

Information provided in this report will help to assess the current health- and population-related policies and programs. It will also be useful to formulate new population and health policies and programs. This are the main findings of the 2013 NDHS. The final report containing more detailed information and indicators will be published by September 2014.

The Ministry of Health and Social Services would like to extend our appreciation to all development partners for their input to the survey, to ICF International for providing technical support, and most importantly, to the respondents who provided the information on which this report is based.

ANDREW NDISHISHI  
PERMANENT SECRETARY

# MILLENNIUM DEVELOPMENT GOAL INDICATORS

## Millennium Development Goal Indicators

Namibia 2013

Indicator	Sex		Total
	Male	Female	
<b>1. Eradicate extreme poverty and hunger</b>			
1.8 Prevalence of underweight children under 5 years of age	15.3	11.4	13.3
<b>2. Achieve universal primary education</b>			
2.1 Net attendance ratio in primary education <sup>1</sup>	90.4	91.9	91.2
2.3 Literacy rate of 15-24 year olds <sup>2</sup>	92.8 <sup>a</sup>	95.9	94.4 <sup>b</sup>
<b>3. Promote gender equality and empower women</b>			
3.1 Ratio of girls to boys in primary, secondary and tertiary education			
3.1a Ratio of girls to boys in primary education <sup>3</sup>	na	na	1.0
3.1b Ratio of girls to boys in secondary education <sup>3</sup>	na	na	1.2
3.1c Ratio of girls to boys in tertiary education <sup>3</sup>	na	na	1.5
<b>4. Reduce child mortality</b>			
4.1 Under-five mortality rate <sup>4</sup>	64	54	54
4.2 Infant mortality rate <sup>4</sup>	44	37	39
4.3 Proportion of 1 year-old children immunized against measles	91.4	87.8	89.5
<b>5. Improve maternal health</b>			
5.1 Maternal mortality ratio <sup>5</sup>	na	na	358
5.2 Percentage of births attended by skilled health personnel <sup>6</sup>	na	na	88.2
5.3 Contraceptive prevalence rate <sup>7</sup>	na	56.1	na
5.4 Adolescent birth rate <sup>8</sup>	na	82.3	na
5.5a Antenatal care coverage: at least one visit <sup>9</sup>	na	96.6	na
5.5b Antenatal care coverage: four or more visits <sup>10</sup>	na	62.5	na
5.6 Unmet need for family planning	na	17.5	na
<b>6. Combat HIV/AIDS, malaria and other diseases</b>			
6.2 Condom use at last high-risk sex <sup>11</sup>	82.0	67.5	74.7
6.3 Percentage of the population age 15-24 years with comprehensive correct knowledge of HIV/AIDS <sup>12</sup>	51.1	61.6	56.3
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	1.02	1.01	1.02
6.7 Percentage of children under 5 sleeping under insecticide treated bednets	5.9	5.2	5.6
6.8 Percentage of children under 5 with fever who are treated with appropriate antimalarial drugs <sup>13</sup>	8.8	8.1	8.4
	Rural	Urban	Total
<b>7. Ensure environmental sustainability</b>			
7.8 Percentage of population using an improved drinking water source <sup>14</sup>	71.9	97.8	84.0
7.9 Percentage of population with access to improved sanitation <sup>15</sup>	16.7	53.2	33.8

na = Not applicable

<sup>1</sup> The ratio is based on reported attendance, not enrollment, in primary education among primary school age children (6-10 year-olds). The rate also includes children of primary school age enrolled in secondary education. This is a proxy for MDG indicator 2.1, Net enrollment ratio.

<sup>2</sup> Refers to respondents who attended secondary school or higher or who could read a whole sentence or part of a sentence

<sup>3</sup> Based on reported net attendance, not gross enrollment, among 6-12 year-olds for primary, 13-17 year-olds for secondary and 18-22 year-olds for tertiary education

<sup>4</sup> Expressed in terms of deaths per 1,000 live births. Mortality by sex refers to a 10-year reference period preceding the survey. Mortality rates for males and females combined refer to the 5-year period preceding the survey.

<sup>5</sup> Expressed in terms of maternal deaths per 100,000 live births in the 7-year period preceding the survey

<sup>6</sup> Among births in the five years preceding the survey

<sup>7</sup> Percentage of currently married women age 15-49 using any method of contraception

<sup>8</sup> Equivalent to the age-specific fertility rate for women age 15-19 for the 3-year preceding the survey, expressed in terms of births per 1,000 women age 15-19

<sup>9</sup> With a skill provider

<sup>10</sup> With any healthcare provider

<sup>11</sup> Higher-risk sex refers to sexual intercourse with a non-marital, non-cohabitating partner. Expressed as a percentage of men and women age 15-24 who had higher-risk sex in the past 12 months.

<sup>12</sup> Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about transmission or prevention of the AIDS virus.

<sup>13</sup> Measured as the percentage of children age 0-59 months who were ill with a fever in the two weeks preceding the interview and received any anti-malarial drug

<sup>14</sup> Percentage of de jure population whose main source of drinking water is a household connection (piped), public tap or standpipe, tubewell or borehole, protected dug well, protected spring, rainwater collection, or bottled water.

<sup>15</sup> Percentage of de jure population whose household has a flush toilet, ventilated improved pit latrine, pit latrine with a slab, or composting toilet and does not share its facility with other households.

<sup>a</sup> Restricted to men in sub-sample of households selected for the male interview

<sup>b</sup> The total is calculated as the simple arithmetic mean of the percentages in the columns for male and females

## **1 INTRODUCTION**

The 2013 Namibia Demographic and Health Survey (NDHS) is the fourth nationally representative comprehensive survey conducted as part of the worldwide Demographic and Health Surveys (DHS) project in the country. The 2013 NDHS was implemented by the Ministry of Health and Social Services (MoHSS) in collaboration with the Namibia Statistics Agency (NSA) and the National Institute of Pathology (NIP). Technical support was provided by ICF International with financial support from the Government of Namibia, the United States Agency for International Development (USAID), and the Global Fund (GFATM).

The overall objective of the survey is to provide demographic, socio-economic and health data necessary for policymaking, planning, monitoring, and evaluation at national and regional levels. In addition, the survey will measure the prevalence of anaemia, HIV, high blood glucose, and high blood pressure among women and men age 35-64, and anaemia for children 6-59 months, and collect anthropometric data to assess the nutritional status of women, men, and children.

A long-term objective of the survey is to strengthen the technical capacity of local organisations to plan, conduct, process, and analyze data from complex national population and health surveys. Moreover, the 2013 NDHS is comparable to similar surveys conducted in other developing countries and therefore affords a national and international comparison. The 2013 NDHS also adds to the vast and growing international database on demographic and health-related variables.

The 2013 NDHS collected demographic and health information from a nationally representative sample of 9,849 households, which yielded completed interviews with 9,176 women age 15-49 in all selected households, and 842 women age 50-64 and 4,481 men age 15-64 in half of the selected households.

This report presents the main findings from the 2013 NDHS on a number of key topics of interest to program managers and policy makers. These findings are intended to facilitate an early evaluation of existing programs and assist in designing new strategies for improving population and health programs in Namibia. A more detailed final report will be published by September 2014.



## **2 SURVEY IMPLEMENTATION**

### **2.1 Sample Design**

The primary focus of the 2013 NDHS was to provide estimates of key population and health indicators, including fertility and mortality rates, for the country as a whole and for urban and rural areas separately. In addition, the sample was designed to provide estimates of most key variables for the 13 administrative regions.

Administratively, Namibia is divided into 13 regions and each region is sub-divided into a number of constituencies, with a total number of 107 constituencies. Each constituency is further sub-divided into lower level administrative units. An enumeration area (EA) is the smallest identifiable entity without administrative specification, numbered sequentially within each constituency. Each EA is totally classified as urban or rural.

The sampling frame used for NDHS 2013 is the preliminary frame of the Namibia Population and Housing Census conducted in 2011 (NPHC 2011), with partial updating provided by the Namibia Statistics Agency (NSA). The sampling frame is a complete list of all EAs covering the whole country. Each EA is a geographical area covering an adequate number of households and serves as a counting unit for the population census. In the rural area, an EA is either a natural village, or a part of a large village, or a group of small villages; in the urban area, an EA is usually a city block. The NPHC 2011 also produced digitised map for each of the EAs which is the primary material for EA identification.

The sample for the NDHS 2013 is a stratified sample selected in two stages. In the first stage, 554 EAs—269 in urban areas and 285 in rural areas—were selected with a stratified probability proportional to size selection from the sampling frame. The EA size is the number of households residing in the EA recorded in the NPHC 2011. Stratification is achieved by separating every region into urban and rural areas. Therefore the 13 regions were stratified into 26 sampling strata—13 rural strata and 13 urban strata. Samples were selected independently in every stratum, with a predetermined number of EAs selected. A complete household listing and mapping was carried out in all selected clusters. In the second stage, a fixed number of 20 households were selected in every urban and rural cluster, by an equal probability systematic sampling.

Due to the non-proportional allocation of the sample to the different regions and the possible differences in response rates, sampling weights are required for any analysis using NDHS 2013 data to ensure the actual representativeness of the survey results at the national level and as well as at the regional level. Since the NDHS 2013 sample is a two-stage stratified cluster sample, sampling probabilities are calculated separately for each sampling stage and for each cluster.

### **2.2 Questionnaires**

Three questionnaires were administered in the 2013 NDHS: the Household Questionnaire, the Woman's Questionnaire, and the Man's Questionnaire. These questionnaires were adapted from the standard DHS6 core questionnaires to reflect the population and health issues relevant to Namibia at a series of meetings with various stakeholders from government ministries and agencies, non-governmental organisations, and international donors. The final draft of each questionnaire was discussed at a questionnaire design workshop organised by the Ministry of Health and Social Services from September 25-28, 2012 in Windhoek. These questionnaires were then translated from English into the six main local languages—Afrikaans, Rukwangali, Oshiwambo, Damara>Nama, Otjiherero, and Silozi and back translated into English. The questionnaires were finalised after the pretest, which was held from February 11–25, 2013.

The Household Questionnaire was used to list all the usual members and visitors in the selected households. Some basic information was collected on the characteristics of each person listed, including age, sex, education, and relationship to the head of the household. For children under age 18, survival status of the parents was determined. In addition, the Household Questionnaire included questions on knowledge of malaria and use of mosquito nets by household members and questions on health expenditure. The Household Questionnaire was used to identify women and men who were eligible for the individual interview and interview on domestic violence. The Household Questionnaire also collected information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facilities, materials used for the floor of the house and ownership of various durable goods. The result of the salt test for iodine was also recorded in the Household Questionnaire. In half of the selected households, the Household Questionnaire was also used to record information on biomarker data collected from eligible respondents.

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

- Background characteristics (education, residential history, media exposure, etc.)
- Birth history and childhood mortality
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal, delivery, and postnatal care
- Breastfeeding and infant feeding practices
- Vaccinations and childhood illnesses
- Marriage and sexual activity
- Woman's work and husband's background characteristics
- Awareness and behaviour regarding AIDS and other sexually transmitted infections (STIs)
- Other health issues including questions on: knowledge of tuberculosis; tobacco use; alcohol consumption; physical activity; water, fruits, and vegetables consumed; knowledge of and testing for breast cancer; and mental health
- Maternal mortality
- Domestic violence

The Women's Questionnaire was also used to record information from women age 50-64 living in half the selected households on: marriage and sexual activity; women's work and husband's background; awareness and behaviour regarding AIDS and other STIs; and other health issues.

The Man's Questionnaire was administered to all men age 15-64 living in half the selected households. The Man's Questionnaire collected much of the same information found in the Woman's Questionnaire but was shorter because it did not contain a detailed reproductive history or questions on maternal and child health or nutrition.

For biomarker collection, in 50 percent of selected households:

- All eligible women and men (age 15-64 years) were measured, weighed, and tested for anaemia and HIV
- All eligible women and men (age 35-64 years) had their blood pressure and blood glucose measured
- All children age 0 to 59 months were measured and weighed
- All children age 6 to 59 months were tested for anaemia

To test eligible respondents for HIV, blood samples in the form of dry blood spots (DBS) were collected onto filter paper cards, on which a unique barcode label was fixed for identification purposes. Matching barcode labels were fixed on the Household Questionnaires on the spaces corresponding with the individuals being tested. These samples were transmitted to the National Institute of Pathology in Windhoek for testing. Because of ethical considerations, the testing of DBS samples only started after all the questionnaires were keyed-in and the identifiers scrambled, so the results of these tests will be presented in a separate report.

A HemoCue machine (HemoCue Glucose 201 RT; HemoCue AB) was used to read fasting plasma glucose values in mmol/l using blood from a finger prick.

To measure blood pressure, the survey interviewers were provided with a fully automatic, digital device with automatic upper-arm inflation and automatic pressure release. Interviewers were trained in the use of this device according to the manufacturer's recommended protocol.

### **2.3 Training of Field Staff**

The main training for the 2013 Namibia Demographic and Health Survey (NDHS) was conducted from April 22-May 18, 2013. A total of 250 participants were recruited, including 31 nurses who served as health technicians. The interviewers were split into five classrooms. The first three weeks primarily covered classroom instruction, expert presentations on select topics, mock interviews, and quizzes. At the end of the classroom training, each interviewer was assessed with a final exam and a structured, scored mock interview and their performance during field practice. In addition to training on the basic content of the questionnaires, a separate training was conducted for health technicians from May 6-22 on height and weight measurements, blood pressure and blood glucose measurements, anaemia testing, combined anaemia testing and dried blood spot (DBS) preparation for HIV testing, and packing of DBS and blood glucose measurement. A separate training was held for regional supervisors, team supervisors, and editors on their roles and responsibilities, emphasizing the importance of field editing and data quality.

### **2.4 Fieldwork**

Data collection was carried out by 28 data collection teams. Each team consisted of a supervisor, a field editor, three female interviewers, one male interviewer, and a health technician. Fieldwork started on May 26, 2013 with all teams initially deployed to complete one selected cluster each in Windhoek to enable intense supervision and technical backstopping. After satisfactory completion of these clusters, the teams were deployed to their respective regions to continue fieldwork. Fieldwork was completed on September 30, 2013.

Fieldwork supervision was done by a total of seven regional supervisors. Additionally, six national level supervisors from the MoHSS monitored the overall data quality. Close contact between the MoHSS

central office and the teams was maintained through field visits by senior staff, ICF International staff and USAID/Namibia. Regular communication was maintained through cell phones.

## **2.5 Data Processing**

A total of 29 data processing personnel, including 17 data entry operators, 1 questionnaire administrator, 2 office editors, 3 secondary editors, 2 network technicians, 2 data processing supervisors, and 1 coordinator were recruited and trained on questionnaire reception and coding, data entry and verification, correcting the questionnaires and providing feedback, and secondary editing. NDHS data processing was formally launched during the week of June 22, 2013 at the National Statistics Agency in Windhoek. The concurrent processing of the data was an advantage because field check tables to monitor various data quality parameters could be generated almost instantly and sent to the teams to improve their performance. The data entry and editing phase of the survey was completed by the end of January 2014.

### 3 PRELIMINARY FINDINGS

#### 3.1 Response Rates

Table 1 shows household and individual response rates for the 2013 NDHS. A total of 11,004 households were selected for the sample, of which 10,165 were found to be occupied during data collection. Of these existing households, 9,849 were successfully interviewed, giving a household response rate of 97 percent.

In these households, 10,280 women age 15-49 were identified as eligible for the individual interview. Interviews were completed with 9,176 women, yielding a response rate of 89 percent. In addition, in half these households, 842 women age 50-64 were successfully interviewed, yielding a response rate of 88 percent. Of the 5,271 eligible men identified in the selected sub-sample of households, 4,481 or 85 percent were successfully interviewed. Response rates were higher in rural than in urban areas, with the rural-urban difference in response rates more marked among men than among women. The preliminary tabulations in the next section summarise the main demographic and health findings from interviews with these eligible women and men.

Throughout this report, numbers in the tables reflect weighted numbers unless indicated otherwise. To ensure statistical reliability, percentages based on fewer than 25 unweighted cases are not shown in the tables, and percentages based on 25-49 unweighted cases are shown within parentheses.

<b>Table 1 Results of the household and individual interviews</b>			
Number of households, number of interviews, and response rates, according to residence (unweighted), Namibia 2013			
Result	Residence		Total
	Urban	Rural	
<b>Household interviews</b>			
Households selected	5,343	5,661	11,004
Households occupied	4,975	5,190	10,165
Households interviewed	4,766	5,083	9,849
Household response rate <sup>1</sup>	95.8	97.9	96.9
<b>Interviews with women age 15-49</b>			
Number of eligible women	5,507	4,773	10,280
Number of eligible women interviewed	4,843	4,333	9,176
Eligible women response rate <sup>2</sup>	87.9	90.8	89.3
<b>Interviews with women age 50-64<sup>a</sup></b>			
Number of eligible women	376	582	958
Number of eligible women interviewed	320	522	842
Eligible women response rate <sup>2</sup>	85.1	89.7	87.9
<b>Interviews with men age 15-64<sup>a</sup></b>			
Number of eligible men	2,722	2,549	5,271
Number of eligible men interviewed	2,224	2,257	4,481
Eligible men response rate <sup>2</sup>	81.7	88.5	85.0

<sup>1</sup> Households interviewed/households occupied.  
<sup>2</sup> Respondents interviewed/eligible respondents.  
<sup>a</sup> In 50 percent of selected households.

#### 3.2 Characteristics of Respondents

The distribution of women and men age 15-49 by background characteristics is shown in Table 2. More than half of women (57 percent) and men (59 percent) are below age 30, reflecting the young age structure of the Namibian population.

**Table 2 Background characteristics of respondents**

Percent distribution of women and men age 15-49 by selected background characteristics, Namibia 2013

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
<b>Age</b>						
15-19	20.8	1,906	1,857	22.9	922	883
20-24	19.5	1,786	1,720	20.1	808	771
25-29	16.2	1,489	1,495	16.4	658	613
30-34	13.7	1,260	1,262	12.9	520	516
35-39	12.1	1,110	1,146	11.1	448	454
40-44	10.0	917	942	9.3	376	404
45-49	7.7	708	754	7.2	289	309
<b>Religion</b>						
Roman Catholic	19.6	1,802	1,892	25.9	1,041	1,031
Protestant/Anglican	21.2	1,947	2,049	12.7	511	511
Elcin	44.0	4,035	3,783	43.4	1,745	1,571
Seventh-day Adventist	4.8	436	522	4.0	161	192
No religion	1.1	105	129	1.8	72	100
Other	9.0	827	779	12.0	483	537
Missing	0.3	23	22	0.2	9	8
<b>Language</b>						
Afrikaans	8.3	763	935	10.1	407	514
Damara>Nama	10.7	986	1,382	13.4	541	757
English	2.2	202	147	2.6	106	72
Herero	7.8	718	855	8.5	343	428
Kwangali	9.0	824	796	9.3	375	365
Lozi	4.9	448	613	5.7	228	299
Oshiwambo	52.9	4,850	4,068	56.0	2,253	1,824
Other	0.7	66	95	1.1	43	70
Missing	0.1	6	5	0.1	6	4
<b>Marital status</b>						
Never married	59.5	5,458	5,188	68.3	2,745	2,577
Married	17.9	1,644	1,779	15.1	609	657
Living together	16.1	1,476	1,587	13.7	551	587
Divorced/separated	4.4	408	429	2.6	106	118
Widowed	2.1	189	193	0.2	10	11
<b>Residence</b>						
Urban	56.6	5,190	4,843	56.8	2,282	1,998
Rural	43.4	3,986	4,333	43.2	1,739	1,952
<b>Region</b>						
Zambezi	5.0	457	647	5.4	218	291
Erongo	8.4	771	858	9.3	372	421
Hardap	3.3	304	595	3.8	152	299
//Karas	3.7	343	782	3.8	151	333
Kavango	9.1	835	743	7.9	316	281
Khomas	24.0	2,202	986	25.4	1,023	415
Kunene	2.8	258	584	2.6	104	252
Ohangwena	9.7	894	695	8.2	328	255
Omaheke	2.5	225	535	2.6	103	256
Omusati	9.6	884	725	8.5	342	262
Oshana	8.2	755	671	8.3	335	274
Oshikoto	7.7	707	656	8.3	335	302
Otjozondjupa	5.9	540	699	6.0	241	309
<b>Education</b>						
No education	4.6	419	551	7.7	310	379
Primary	19.6	1,798	1,914	23.5	944	978
Secondary	65.7	6,029	6,019	59.7	2,400	2,307
More than secondary	10.1	930	692	9.1	368	286
Total 15-49	100.0	9,176	9,176	100.0	4,021	3,950
50-64	na	797	842 <sup>a</sup>	na	460	531
Total 15-64	na	9,973	10,018 <sup>a</sup>	na	4,481	4,481

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.

<sup>a</sup> Includes only women from the subsample (50 percent) of households selected for the male survey, and for anthropometric measurements and biomarker testing.

na = Not applicable

The vast majority of women and men belong to the Evangelical Lutheran Church of Namibia or Elcin (44 and 43 percent, respectively), 21 percent of women and 13 percent of men are Protestant/Anglican, and 20 percent of women and 26 percent of men are Roman Catholic.

The majority (53 percent women and 56 percent men) of respondents speak Oshiwambo, 11 percent of women and 13 percent of men speak Damara>Nama while, while about one in ten women and men each speak Afrikaans, Herero, or Kwangali.

Three in five women (60 percent) and two in three men (68 percent) have never been married. Eighteen percent of women are currently married compared with 15 percent of men. In addition, 16 percent of women and 14 percent of men are living together. Twice as many women as men are divorced or separated. Women are 10 times more likely than men to be widowed.

The majority of women and men live in urban areas (57 percent each). One in four women and men each, live in Khomas.

Women are slightly more likely to be educated than men. Sixty-six percent of women and 60 percent of men have attended secondary school, one in ten women and men have received higher than secondary education, while 5 percent of women and 8 percent of men have never been to school.

### 3.3 Fertility

Female respondents age 15-49 were asked about their reproductive histories in the 2013 NDHS. Each woman was first asked to report on the number of sons and daughters living with her, the number living elsewhere, the number who had died. For each pregnancy ending in a live birth, the mother was asked to report on the child's name, sex, age (if alive) or age at death (if deceased) and whether the child was living with her. These data are used to calculate two of the most widely used measures of current fertility, the total fertility rate (TFR) and its component, age-specific fertility rates. The TFR, which is the sum of the age-specific fertility rates, is interpreted as the number of children the average woman would bear in her lifetime if she experienced the currently observed age-specific fertility rates throughout her reproductive years.

According to the results of the 2013 NDHS, the TFR calculated for the three years preceding the survey is 3.6 births per woman age 15-49 (Table 3). Urban-rural differentials in Namibia are obvious with rural women (4.7 births) having an average of nearly two children more than urban women (2.9 births).

The overall age pattern of fertility as reflected in the age-specific fertility rates (ASFR) indicates that childbearing begins early. Fertility is low among adolescents and increases to a peak of 168 births per 1,000 among women age 20-29 and then decreases thereafter.

The TFR from the 2013 NDHS can be compared with the TFR estimated from earlier DHS surveys in the country. A comparison of the three-year rate shows that although fertility declined substantially during the

**Table 3 Current Fertility**

Age-specific rates and total fertility rate, the general fertility rate, and the crude birth rate for the three years preceding the survey, by residence, Namibia 2013

Age group	Residence		Total
	Urban	Rural	
15-19	66	101	82
20-24	134	226	168
25-29	144	207	168
30-34	122	187	149
35-39	84	144	110
40-44	29	59	42
45-49	8	12	10
TFR (15-49)	2.9	4.7	3.6
GFR	103	155	125
CBR	30.0	29.3	29.5

Notes: Age-specific fertility rates are per 1,000 women. Rates for age group 45-49 may be slightly biased due to truncation. Rates are for the period 1-36 months prior to interview.

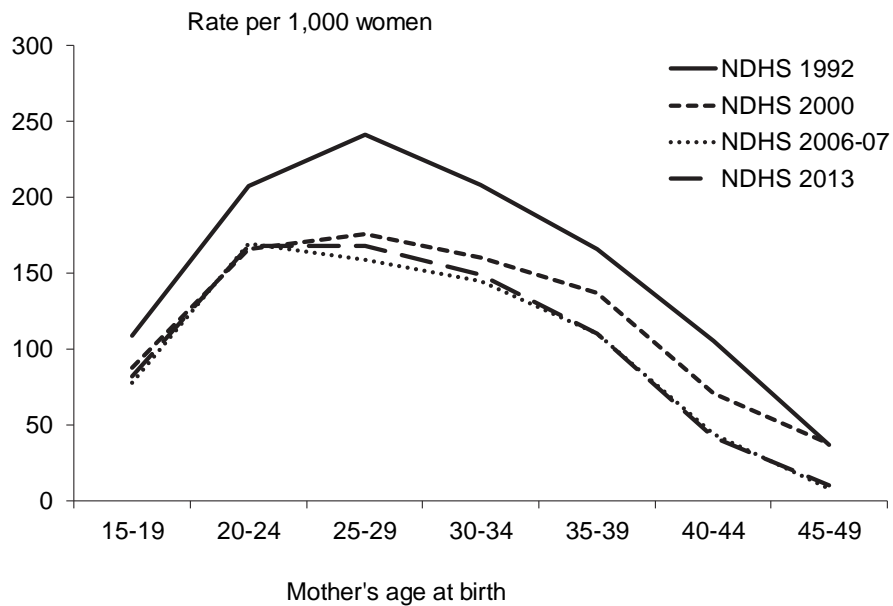
TFR: Total fertility rate expressed per woman

GFR: General fertility rate expressed per 1,000 women age 15-44

CBR: Crude birth rate, expressed per 1,000 population

period 1989-1991 (MoHSS and Macro International Inc., 1993) and 2003-04 to 2005-06 (MoHSS and Macro International Inc., 2008) there has been no change in fertility in the last 6 years (Figure 1). The total fertility rate fell from 5.4 children per woman in the three years preceding the 1992 NDHS to 3.6 children per woman in the three years preceding the 2006-07 NDHS. However, the TFR has stagnated at 3.6 children per woman for the last six years.

**Figure 1 Trends in fertility**



### 3.4 Fertility Preferences

Several questions were asked in the survey concerning a woman's fertility preferences. These questions included: a) whether the respondent wanted another child and b) if so, when she would like to have the next child. The answers to these questions allow an estimation of the potential demand for family planning services either to limit or to space births.

Table 4 indicates that 72 percent of married women say that they either want to delay the birth of their next child or want no more children (including those sterilised). This is only slightly higher than that reported in the 2006-07 NDHS (69 percent). Fertility preferences are closely related to the number of living children a woman has. In general, as the number of living children increases, the desire to want another child decreases. For example, 78 percent of currently married women with 5 living children say they want to have no more children or have been sterilised, compared with 8 percent of women with no children.



**Table 4 Fertility preferences by number of living children**

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, Namibia 2013

Desire for children	Number of living children							Total
	0	1	2	3	4	5	6+	
Have another soon	51.7	28.3	14.8	11.1	6.3	6.1	3.9	16.1
Have another later	17.8	36.7	24.7	16.6	15.6	6.7	5.0	20.3
Have another, undecided when	12.8	7.2	3.4	3.4	1.7	0.4	0.5	4.0
Undecided	2.4	3.2	4.1	4.9	4.6	5.5	7.4	4.5
Want no more	7.7	21.6	43.1	48.6	60.2	67.6	76.6	45.3
Sterilised	0.6	0.5	6.5	12.2	9.6	10.1	4.8	6.7
Declare infecund	6.6	1.9	2.6	2.2	1.4	1.9	1.2	2.3
Missing	0.5	0.6	0.8	1.1	0.7	1.7	0.6	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	207	562	775	633	407	214	321	3,121

<sup>1</sup> The number of living children includes current pregnancy.

<sup>2</sup> Wants next birth within 2 years.

<sup>3</sup> Wants to delay next birth for 2 or more years.

<sup>4</sup> Includes both female and male sterilisation.

### 3.5 Family Planning

Information about knowledge and use of contraceptive methods was collected from female respondents by asking them to mention any ways or methods by which a couple can delay or avoid a pregnancy. The interviewer described each method and then asked if the respondent knew it. Women were asked if they (or their partner) were currently using a method. For analytical purposes, contraceptive methods are grouped into two types in the table: modern and traditional. Modern methods include female and male sterilisation, IUD, pill, contraceptive patch, injectables, implants, male and female condom, diaphragm, and LAM. Traditional methods include rhythm method, withdrawal, and other traditional methods.

Fifty-six percent of currently married women age 15-49 are using a method of contraception (Table 5). The vast majority of users (55 percent) rely on a modern method. Injectables (27 percent) are the most commonly used modern method of family planning followed by male condom (12 percent), pill (7 percent), and female sterilisation (6 percent).

Use of modern contraceptive methods increases from 32 percent among women 15-19 years to 53 percent among women 20-24 years and plateaus at around 57-58 percent among women 25-44 years and then falls slightly to 51 percent among women in the oldest age group.

Contraceptive use varies by residence. For example, use of modern methods among urban women is 26 percent higher than among rural women. Use of modern contraceptive methods is highest in Oshana (68 percent) and //Karas (67 percent).

There is a direct relationship between contraceptive use and education, with use of modern methods of contraception increasing from 35 percent among women with no education to 61 percent among women with more than secondary education.

Table 5. Current use of contraception by background characteristics

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to background characteristics, Namibia DHS 2013

Background characteristic	Modern method										Any traditional method				Total	Number of women				
	Any modern method	Female sterilisation	Male sterilisation	IUD	Pill	Contraceptive patch	Injectables	Implants	Male condom	Female condom	Dia-phragm	LAM	Other	Any traditional method			Rhythm	Withdrawal	Other	Not currently using
<b>Age</b>																				
15-19	37.2	32.2	0.0	0.0	3.1	0.0	23.3	0.0	5.8	0.0	0.0	0.0	0.0	5.0	0.0	0.0	5.0	62.8	100.0	103
20-24	53.7	53.2	0.0	1.0	4.7	1.7	35.5	0.0	10.3	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	46.3	100.0	349
25-29	58.5	58.0	0.2	0.1	7.6	1.3	35.8	0.2	11.9	0.0	0.0	0.0	0.4	0.5	0.0	0.1	0.4	41.5	100.0	558
30-34	58.4	57.6	3.4	0.1	9.3	1.0	30.0	0.2	11.2	0.0	0.0	0.3	0.2	0.8	0.3	0.6	0.0	41.6	100.0	634
35-39	57.3	56.9	8.4	0.4	7.3	0.3	24.5	0.2	14.3	0.4	0.0	0.1	0.0	0.4	0.0	0.1	0.3	42.7	100.0	593
40-44	57.5	56.9	11.3	0.7	6.1	0.7	24.2	0.2	12.1	0.3	0.0	0.1	0.1	0.5	0.3	0.0	0.2	42.5	100.0	497
45-49	52.6	50.9	18.4	0.2	5.7	0.5	8.8	0.1	13.5	1.2	0.3	0.0	0.1	1.7	0.3	0.9	0.5	47.4	100.0	386
<b>Residence</b>																				
Urban	61.1	60.5	8.6	0.4	8.0	1.4	27.0	0.2	12.5	0.4	0.0	0.2	0.1	0.6	0.2	0.3	0.1	38.9	100.0	1,819
Rural	49.2	48.0	3.3	0.1	0.6	0.1	26.7	0.1	11.4	0.1	0.1	0.0	0.1	1.2	0.2	0.2	0.8	50.8	100.0	1,301
<b>Region</b>																				
Zambezi	50.4	49.8	0.0	0.0	5.1	0.4	41.0	0.0	3.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	49.6	100.0	204
Erongo	63.2	62.2	9.0	0.8	9.0	0.0	29.6	1.0	11.2	0.0	0.0	0.6	0.0	1.1	0.5	0.4	0.2	36.8	100.0	305
Hardap	57.8	57.8	14.5	0.4	0.7	9.4	26.8	0.7	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	42.2	100.0	131
//Karas	67.9	67.0	13.8	0.5	6.2	0.3	33.2	0.0	11.7	0.0	0.0	0.3	0.3	0.9	0.5	0.4	0.1	32.1	100.0	133
Kavango	44.2	41.7	1.4	0.0	0.3	4.5	33.6	0.0	2.0	0.0	0.0	0.0	0.0	2.4	0.0	0.0	2.4	55.8	100.0	429
Khomas	61.0	60.5	9.0	0.3	7.1	2.8	22.1	0.0	15.3	0.7	0.0	0.0	0.0	0.6	0.0	0.6	0.0	39.0	100.0	727
Kunene	51.9	51.6	1.0	0.4	0.5	0.0	27.4	0.0	14.9	0.0	0.0	0.0	0.0	0.4	0.0	0.4	0.0	48.1	100.0	108
Oshana	50.3	50.3	3.4	0.0	5.5	0.0	22.1	0.0	18.1	0.0	0.0	0.0	1.1	0.0	0.0	0.0	0.0	49.7	100.0	184
Oshanaheke	57.0	57.0	9.1	0.7	6.8	0.6	25.6	1.0	12.1	0.0	0.0	0.2	0.5	0.0	0.0	0.0	0.0	43.0	100.0	110
Omusati	43.0	42.3	2.3	0.0	1.4	2.9	20.1	0.0	15.1	0.0	0.6	0.0	0.0	0.7	0.7	0.0	0.0	57.0	100.0	187
Oshana	69.3	68.1	10.3	0.0	9.8	1.0	21.0	0.0	25.2	0.8	0.0	0.0	0.0	1.1	0.6	0.0	0.6	30.7	100.0	164
Oshikoto	53.8	53.8	4.1	0.0	8.3	1.3	20.4	0.0	16.8	0.4	0.0	0.0	0.5	0.0	0.0	0.0	0.0	46.2	100.0	208
Ojozondjupa	60.3	59.1	7.5	0.3	9.9	0.0	28.7	0.0	11.8	0.3	0.0	0.4	0.0	1.2	0.3	0.9	0.0	39.7	100.0	231
<b>Education</b>																				
No education	37.0	35.2	3.5	0.0	1.8	0.0	21.3	0.0	8.4	0.0	0.0	0.1	0.0	1.8	0.0	0.7	1.1	63.0	100.0	233
Primary	48.9	48.2	5.1	0.0	4.4	0.0	28.8	0.1	9.8	0.0	0.0	0.1	0.0	0.8	0.0	0.0	0.8	51.1	100.0	718
Secondary	60.2	59.5	6.1	0.2	7.3	0.6	29.7	0.2	13.7	0.4	0.0	0.0	0.1	0.7	0.2	0.3	0.2	39.8	100.0	1,808
More than secondary	62.4	61.3	12.6	1.3	13.6	4.2	12.3	0.3	10.7	0.6	0.3	0.5	0.9	1.1	0.5	0.5	0.0	37.6	100.0	362
<b>Number of living children</b>																				
0	30.2	30.0	0.3	0.2	6.2	0.6	8.4	0.4	12.4	0.9	0.0	0.0	0.0	0.2	0.0	0.2	0.1	69.8	100.0	255
1-2	57.5	56.9	3.4	0.5	8.2	1.4	28.3	0.2	13.2	0.0	0.0	0.1	0.3	0.6	0.1	0.1	0.4	42.5	100.0	1,347
3-4	64.2	63.0	11.6	0.1	7.1	0.4	30.2	0.0	11.1	0.5	0.1	0.2	0.0	1.2	0.4	0.4	0.4	35.8	100.0	999
5+	49.5	48.6	7.1	0.0	3.7	0.4	25.8	0.1	10.8	0.3	0.0	0.0	0.0	1.0	0.1	0.2	0.6	50.5	100.0	520
Total	56.1	55.3	6.4	0.3	7.0	0.9	26.8	0.2	12.0	0.3	0.0	0.1	0.1	0.8	0.2	0.3	0.4	43.9	100.0	3,121

Note: If more than one method is used, only the most effective method is considered in this tabulation.

LAM = Lactational amenorrhoea method

Use of modern contraception increases with the number of living children, from 30 percent among women with no children to 63 percent among women with 3-4 children, and then falls to 49 percent among women with 5 or more children.

### **Trend in contraceptive use**

Data from the four Demographic and Health surveys conducted in Namibia over the past 20 years show that current use of modern contraception doubled from 26 percent in 1992 to 53 percent in 2006-07 but increased only marginally to 55 percent in 2013 (Table 6). The increase in the use of contraceptives can be largely attributed to the increase in the use of injectables from 8 percent in 1992 to 27 percent in 2013. There has also been a noticeable increase in the use of male condoms from less than 1 percent in 1992 to 12 percent in 2013. During the same period there was a relatively smaller decline in the use of the pill and female sterilisation.

Methods	1992 NDHS <sup>1</sup>	2000 NDHS <sup>2</sup>	2006-07 NDHS <sup>3</sup>	2013 NDHS
<b>Any modern method</b>	26.0 <sup>a</sup>	42.6 <sup>b</sup>	53.4 <sup>c</sup>	55.3 <sup>d</sup>
Injectables	7.7	18.7	21.8	26.8
Pill	8.3	8.2	8.6	7.0
Female sterilisation	7.4	8.5	10.3	6.4
IUD	2.1	1.2	1.4	1.2
Male condom	0.3	5.2	10.6	12.0
<b>Any traditional method</b>	2.9	1.1	1.6	0.8
Number	2,259	2,480	3,451	8,121

Sources:  
<sup>1</sup> MoHSS and Macro International Inc., 1993  
<sup>2</sup> MoHSS, 2003  
<sup>3</sup> MoHSS and Macro International Inc., 2008  
<sup>a</sup> Includes users diaphragm/foam/jelly and male sterilisation  
<sup>b</sup> Includes female condom, diaphragm/foam/jelly, and male sterilisation  
<sup>c</sup> Includes female condom, male sterilisation, and implants  
<sup>d</sup> Includes female condom, male sterilisation, implants, and LAM

### **3.6 Early Childhood Mortality**

Information on infant and child mortality is important for the improvement of child survival programs and for identifying those segments of the child population that are most vulnerable. Caution should be exercised in interpreting mortality information, however, since its reliability depends on the quality of information collected in the birth history section of the Woman's Questionnaire. Because women are generally reluctant to talk about their dead children, it is subject to a greater degree of misreporting. Mortality data are also generally subject to large sampling errors. The issue of data quality will be examined in greater depth in the NDHS final report.

Neonatal, postneonatal, infant, child, and under-five mortality rates are shown in Table 7 for cohorts of children born in three consecutive five-year periods before the survey. Under-five mortality for the most recent period (0-4 years before the survey or 2008–2012) is 55 deaths per 1,000 live births. This means that one in 18 children born in Namibia dies before their fifth birthday. Seventy-one percent of deaths among children under five occur during the first year of life: infant mortality is 39 deaths per 1,000 live births. During infancy, the risk of neonatal deaths and postneonatal deaths is 20 and 19 deaths per 1,000 live births, respectively.

Data from the 2013 NDHS indicate that there has been a decrease in childhood mortality. For example, infant mortality declined from 48 deaths per 1,000 live births in the 10-14 years preceding the survey to 42 deaths in the 5-9 year period preceding the survey and to 39 deaths in the most recent five-year period. However, the declining trend in childhood mortality is not consistent for neonatal and postneonatal mortality.

**Table 7 Early childhood mortality rates**

Neonatal, postneonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Namibia 2013

Years preceding the survey	Neonatal mortality (NN)	Post-neonatal mortality (PNN) <sup>1</sup>	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
0-4	20	19	39	16	55
5-9	17	25	42	23	64
10-14	25	23	48	18	65

<sup>1</sup> Computed as the difference between the infant and neonatal mortality rates.

Comparison of mortality data from the past three Namibia DHS surveys indicates there has been a decline in mortality in the most recent six-year period between the 2006-07 survey and the 2013 survey. However when mortality is compared over the 12-year period between the 2000 and 2013 surveys, there has not been much change in childhood mortality.

### 3.7 Maternal Care

Proper care during pregnancy and delivery are important for the health of both the mother and the baby. In the 2013 NDHS, women who had given birth in the five years preceding the survey were asked a number of questions about maternal health care. For the last live birth in that period, mothers were asked whether they had obtained antenatal care during the pregnancy and whether they had received tetanus toxoid injections or iron supplements during pregnancy. For each birth in the same period, the mothers were also asked what type of assistance they received at the time of delivery and where the delivery took place. Similarly, they were asked about postnatal care, and whether they received vitamin A capsules and iron supplements postpartum. Table 8 presents information on some key maternal care indicators.

#### ***Antenatal care***

Antenatal care from a trained provider is important in order to monitor the risks associated with pregnancy and delivery for the mother and her child. According to the 2013 NDHS, 97 percent of women who gave birth in the 5 years preceding the survey received antenatal care at least once for the last live birth from a health professional, that is, a doctor, or nurse/midwife (Table 8). This is a two percentage point increase from that reported in the 2006-07 NDHS, when the percentage of women receiving antenatal care from a doctor, or nurse/midwife was 95 percent (MoHSS and Macro International Inc., 2008).

Due to the very high percentage of women who received antenatal care from a skilled health provider, there are relatively smaller differences by background characteristics. Skilled antenatal care is lowest in Omaheke (89 percent). Skilled care varies from a low of 88 percent among women with no education to 98 percent among women with secondary education.

**Table 8 Maternal care indicators**

Among women age 15-49 who had a live birth in the five years preceding the survey, percentage who received antenatal care from a skilled provider for the last live birth and percentage whose last live birth was protected against neonatal tetanus, and among all live births in the five years before the survey, percentage delivered by a skilled provider and percentage delivered in a health facility, by background characteristics, Namibia 2013

Background characteristic	Percentage with antenatal care from a skilled provider	Percentage whose last live birth was protected against neonatal tetanus	Number of women	Percentage delivered by a skilled provider	Percentage delivered in a health facility	Number of births
<b>Mother's age at birth</b>						
<20	95.2	70.2	592	87.3	86.9	765
20-34	97.1	65.9	2,619	89.9	89.0	3,317
35+	95.9	61.7	630	81.1	80.2	722
<b>Residence</b>						
Urban	96.7	65.5	1,970	94.9	94.7	2,347
Rural	96.5	66.3	1,871	81.7	80.4	2,457
<b>Region</b>						
Zambezi	97.1	83.4	239	86.1	85.2	297
Erongo	98.6	57.5	285	97.9	97.6	334
Hardap	96.8	80.7	133	95.3	94.0	173
//Karas	97.1	77.6	136	93.3	91.8	165
Kavango	96.3	61.2	448	75.0	72.8	577
Khomas	95.7	62.2	771	96.2	95.2	887
Kunene	95.2	77.0	133	74.0	72.4	179
Ohangwena	98.1	60.3	440	85.9	85.9	598
Omaheke	88.8	74.1	107	76.2	75.6	149
Omusati	99.2	64.0	350	87.0	85.8	454
Oshana	98.7	57.1	261	94.8	94.5	310
Oshikoto	97.4	69.8	290	89.7	89.8	373
Otjozondjupa	91.7	71.8	248	86.1	86.0	308
<b>Mother's education</b>						
No education	87.7	61.2	218	59.4	58.0	298
Primary	95.2	63.8	836	75.4	73.8	1,125
Secondary	97.8	68.9	2,517	94.5	94.0	3,073
More than secondary	97.4	48.4	271	99.2	98.5	307
Total	96.6	65.9	3,842	88.2	87.4	4,804

<sup>1</sup> Skilled provider includes doctor, nurse, midwife, or auxiliary midwife.

<sup>2</sup> Includes mothers with two injections during the pregnancy of her last live birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last live birth), or four or more injections (the last within ten years of the last live birth), or five or more injections at any time prior to the last live birth.

## **Tetanus toxoid**

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, an important cause of infant deaths.

Table 8 indicates that 66 percent of women had their last live birth protected against neonatal tetanus. This is an increase from the 57 percent reported in the 2006-07 NDHS. Women age 35 and over are least likely to have their last birth protected against neonatal tetanus (62 percent). Tetanus toxoid coverage ranges from a low of 57 percent in Oshana to a high of 83 percent in Zambezi. Surprisingly, highly educated mothers are least likely to have their last birth protected against neonatal tetanus (48 percent), compared with mothers in the other educational categories.

## **Delivery care**

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the baby. Eighty-eight percent of

mothers received delivery care from a skilled provider for births in the last five years, and 87 percent of babies were delivered at a health facility (Table 8). This is an improvement since 2006-07 when 81 percent of babies received skilled care and a similar percentage were delivered in a health facility (MoHSS and Macro International Inc., 2008).

Skilled health care at delivery are noticeably higher in urban (95 percent) than in rural areas (82 percent). Women in Kunene were least likely (74 percent) to receive skilled delivery care and women in Erongo the most likely (98 percent). Skilled care rises from 59 percent among live births to women with no education to 99 percent among births to women with more than secondary education.

### **3.8 Child Health**

The 2013 NDHS obtained information on a number of key child health indicators, including childhood mortality rates, immunisation of young children, and treatment practices when a child is ill.

#### ***Vaccination of children***

According to the World Health Organization, a child is considered fully immunised if he or she has received a BCG vaccination against tuberculosis; three doses of the DPT vaccine to prevent diphtheria, pertussis, and tetanus; at least three doses of the polio vaccine; and one dose of the measles vaccine. These vaccinations should be received during the first year of life. The 2013 NDHS collected information on the coverage of these vaccinations for all children under age five, including the receipt of 3 doses of the pentavalent vaccination in place of the DPT vaccine. The pentavalent vaccine is a combination of five vaccines in one: diphtheria, tetanus, whooping cough, hepatitis B and Haemophilus influenza type b (the bacteria that causes meningitis, pneumonia, and otitis).

Information on vaccination coverage was obtained in two ways—from health cards and from mothers' verbal reports. All mothers were asked to show the interviewer the vaccination cards on which the child(ren)'s immunisation status was recorded. If the card was available, the interviewer copied the dates on which each vaccination was received. If a vaccination was not recorded on the health card, the mother was asked to recall whether that particular vaccination had been given. If the mother was not able to present a health card for her child, she was asked to recall whether the child had received BCG, polio, pentavalent, and measles. If she indicated that the child had received the polio or pentavalent vaccines, she was asked about the number of doses of each that the child had received.

Table 9 presents information on vaccination coverage for children 12-23 months, who should have been fully immunised against the major preventable childhood illnesses. Nearly seven in ten children (68 percent) were fully immunised and 90 percent of the children or more received BCG, pentavalent 1, polio 1, and the measles vaccine. The proportion of children receiving the third dose of pentavalent and polio is much lower (84 percent and 74 percent, respectively).

There are only slight variations in children fully immunised by gender. Children in urban areas are much less likely to be fully immunised than children in the rural areas (58 percent compared with 79 percent). Full immunisation coverage in Khomas, which is the most urban region, is lowest (40 percent) among all regions. Coverage is highest in Hardap (88 percent).

Full immunisation coverage is lowest (49 percent) among children of mothers with higher than secondary education and highest (75 percent) among children of mothers with primary education.

Full immunisation coverage has not changed in the last six years. It was 69 percent in the 2006-07 NDHS.

Table 9 Vaccinations by background characteristics

Percentage of children age 12-23 months who received specific vaccines at any time before the survey by source of information (vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, Namibia 2013

Background characteristic	Percentage with a vaccination card												
	BCG	Pentavalent 1	Pentavalent 2	Pentavalent 3	Polio 0	Polio 1	Polio 2	Polio 3	Measles	All basic vaccinations	No vaccinations	Percentage with a vaccination card	Number of children
<b>Sex</b>													
Male	95.1	94.4	91.4	85.9	91.2	93.5	88.7	74.5	91.4	69.0	3.1	69.6	440
Female	93.4	91.1	87.0	81.4	88.8	91.8	86.7	74.2	87.8	67.9	5.6	69.5	498
<b>Residence</b>													
Urban	91.8	89.1	84.0	78.3	87.0	89.6	83.8	66.4	85.7	58.1	6.4	59.5	467
Rural	96.5	96.2	94.0	88.6	92.8	95.6	91.4	82.1	93.2	78.6	2.5	79.4	471
<b>Region</b>													
Zambezi	100.0	98.3	95.9	88.8	92.4	98.9	89.3	81.7	91.7	78.3	0.0	74.1	57
Erongo	91.6	91.1	87.1	80.4	90.3	94.0	93.0	71.9	93.3	65.7	6.0	60.9	70
Hardap	98.7	97.5	97.5	97.5	96.7	97.1	97.1	87.8	97.5	87.8	1.3	82.8	35
//Karas	97.2	97.7	94.1	81.4	96.0	95.5	87.3	68.7	91.8	65.0	1.3	66.4	33
Kavango	94.7	94.7	89.4	80.6	90.9	91.8	88.3	78.0	89.0	73.4	5.3	77.8	108
Khomas	83.4	77.3	72.0	64.4	76.8	81.6	73.3	52.6	75.1	39.6	13.9	46.6	165
Kunene	91.6	91.9	89.3	78.7	85.2	94.2	88.1	60.7	88.2	56.0	3.5	52.9	32
Ohangwena	97.0	99.0	95.0	92.6	95.6	95.7	93.5	79.1	95.7	74.7	1.0	74.1	123
Omaheke	94.4	93.5	92.6	87.9	91.1	93.5	88.9	78.2	87.3	73.8	4.7	69.3	27
Omusati	98.8	97.4	95.8	93.0	94.5	98.8	96.0	91.8	91.7	84.7	1.2	90.4	89
Oshana	94.2	89.1	85.5	80.9	85.7	87.9	79.3	66.5	89.8	62.2	4.3	63.3	60
Oshikoto	98.7	98.7	95.4	90.8	97.5	95.8	89.5	83.8	98.7	82.5	0.0	81.3	78
Ojizondjupa	99.1	97.8	94.5	93.5	92.0	96.4	93.2	83.5	90.9	77.6	0.9	76.9	63
<b>Education</b>													
No education	92.3	93.4	88.6	72.8	83.4	93.7	87.1	70.4	83.8	59.0	5.0	69.6	55
Primary	94.9	92.9	92.0	85.9	90.4	92.0	90.0	79.6	89.2	74.6	5.1	76.2	211
Secondary	94.7	94.1	89.6	85.7	91.2	93.4	87.6	73.9	91.3	68.7	3.5	68.2	621
More than secondary	87.4	73.0	70.6	58.4	79.3	84.1	79.6	61.5	75.2	49.3	12.6	57.6	50
Total	94.2	92.7	89.0	83.5	89.9	92.6	87.6	74.3	89.5	68.4	4.4	69.5	938

<sup>1</sup> Polio 0 is the polio vaccination given at birth.

<sup>2</sup> BCG, measles and three doses each of pentavalent, and polio vaccine excluding polio vaccine given at birth.

## **Childhood illnesses**

Acute respiratory illness (ARI) and dehydration from severe diarrhoea are major causes of childhood mortality. Prompt medical attention for children experiencing symptoms of these illnesses is, therefore, crucial in reducing child deaths. To obtain information on how childhood illnesses are treated, for each child under five years, mothers were asked if the child had experienced cough with short, rapid breathing (symptoms of ARI), fever, and diarrhoea in the two weeks before the survey.

Results from the 2013 NDHS show that 6 percent of children under five years had symptoms of ARI, 24 percent had fever, and 17 percent had diarrhoea in the two weeks preceding the survey (data not shown).

Table 10 shows that 68 percent of the children with symptoms of ARI, 59 percent of those with fever and 64 percent of the children with diarrhoea, were taken to a health facility or provider for treatment. With regard to ARI, children age 6-11 months and those in urban areas are more likely than other children to be treated for their illness. With regard to fever, children age 12-23 months, those in rural areas, children in Omusati, and children whose mothers have secondary or higher education are more likely than other children to be taken to a facility or provider for treatment.

For children with diarrhoea, mothers were asked what had been done to treat the diarrhoea. The administration of oral rehydration therapy (ORT) is a simple means of counteracting the effect of dehydration. ORT includes a solution either prepared by mixing water with the powder in a commercially prepared oral rehydration packet (ORS), or homemade fluid, or by increasing the amount of fluids given to children with diarrhoea. Table 10 shows treatment practices for children who had diarrhoea in the two weeks preceding the survey. More than seven in ten (72 percent) of children with diarrhoea were given a solution prepared from an ORS packet. Overall, 78 percent of children were given ORT.

Diarrhoea treatment practices vary by background characteristics. Children under six months are less likely to be given ORT for diarrhoea than older children. This is probably due to the fact that older children are more susceptible to food contamination than very young children, who are more likely to be breastfed. Urban children are more likely than rural children to be given ORT. Percentage of children given ORT for diarrhoea is highest in Omaheke (87 percent). ORT treatment among children with diarrhoea increases with mother's education.



**Table 10 Treatment for acute respiratory infection, fever, and diarrhoea**

Among children under five years who had symptoms of acute respiratory infection (ARI) or were sick with fever in the two weeks preceding the survey, percentage for whom treatment was sought from a health facility or provider, and among children under five years who were sick with diarrhoea during the two weeks preceding the survey, percentage for whom treatment was sought from a health facility or provider, percentage given a solution made from oral rehydration salt (ORS) packets or given prepackaged ORS liquids, and percentage given any oral rehydration therapy (ORT) by background characteristics, Namibia 2013

Background characteristic	Children with symptoms of ARI		Children with fever		Children with diarrhoea			
	Percentage for whom treatment was sought from a health facility/provider	Number of children with ARI	Percentage for whom treatment was sought from a health facility/provider	Number of children with fever	Percentage for whom treatment was sought from a health facility/provider	Percentage given solution from ORS packet	Percentage given any ORT	Number of children with diarrhoea
<b>Age in months</b>								
<6	*	19	57.1	116	61.8	49.4	49.4	61
6-11	(75.5)	41	61.1	194	65.5	68.5	79.5	155
12-23	73.7	61	70.1	260	65.8	75.8	79.9	263
24-35	60.6	70	49.5	223	60.2	75.9	82.2	190
36-47	(67.5)	42	57.3	186	63.5	73.4	77.0	81
48-59	(59.1)	31	51.0	128	63.1	67.3	75.7	51
<b>Sex</b>								
Male	68.3	147	59.5	559	66.6	71.5	78.6	422
Female	66.8	116	57.7	547	60.5	71.7	76.2	378
<b>Residence</b>								
Urban	75.8	121	56.6	567	63.8	75.4	82.0	330
Rural	60.7	143	60.8	538	63.7	69.0	74.3	471
<b>Region</b>								
Zambezi	(77.1)	34	62.5	140	63.4	69.7	80.3	90
Erongo	*	24	62.3	72	(63.5)	(69.3)	(84.4)	32
Hardap	*	4	(51.1)	26	*	*	*	12
//Karas	*	6	55.5	33	(55.9)	(75.9)	(75.9)	15
Kavango	(69.0)	30	62.8	196	72.0	78.3	81.2	172
Khomas	*	45	43.6	225	56.5	75.5	83.6	141
Kunene	*	5	50.5	23	53.1	59.4	65.6	21
Ohangwena	*	22	66.1	105	67.7	66.5	66.5	84
Omaheke	*	5	57.5	33	53.4	82.3	86.8	21
Omusati	*	31	78.7	64	70.2	67.1	76.8	85
Oshana	*	15	(76.4)	53	(64.0)	(78.3)	(78.3)	31
Oshikoto	(54.6)	27	57.2	85	(56.7)	(64.4)	(72.4)	52
Otjozondjupa	(62.2)	17	47.2	50	57.6	62.7	64.9	44
<b>Mother's education</b>								
No education	*	13	44.3	44	53.1	61.6	68.4	40
Primary	56.2	70	55.0	280	67.6	70.8	75.6	241
Secondary	71.3	164	60.6	707	63.1	73.7	80.1	485
More than secondary	*	17	62.1	75	*	*	*	35
<b>Total</b>	<b>67.7</b>	<b>263</b>	<b>58.6</b>	<b>1,106</b>	<b>63.7</b>	<b>71.6</b>	<b>77.5</b>	<b>800</b>

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

<sup>1</sup> Symptoms of ARI (cough accompanied by short, rapid breathing which was chest-related and/or by difficult breathing which was chest-related) is considered a proxy for pneumonia.

<sup>2</sup> Excludes pharmacy, shop, and traditional practitioner.

<sup>3</sup> Includes ORS from packets and prepackaged ORS liquids.

<sup>4</sup> Includes ORS from packets, prepackaged ORS liquids, and recommended home fluid.

## **4 NUTRITION**

### **4.1 Breastfeeding**

Breast milk is the optimal source of nutrients for infants. Exclusive breastfeeding is recommended during the first 6 months of a child's life because it limits exposure to diseases as well as provides all of the nutrients that a baby requires.

Table 11 shows that 72 percent of children less than two months of age are exclusively breastfed and this percentage drops sharply at subsequent ages. Overall, less than one in two children (49 percent) under six months are exclusively breastfed. Nevertheless, this is a remarkable improvement since 2006-07, when only 24 percent of children of the same age were exclusively breastfed.

Bottle-feeding is common in Namibia, however, there has been a decline in the practice from 38 percent in 2006-07 to 26 percent in 2013 among children 0-5 months. Bottle-feeding peaks at 50 percent among children age 9-11 months.

Table 11 Breastfeeding status by age

Percent distribution of youngest children under two years who are living with their mother, by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under two years using a bottle with a nipple, according to age in months, Namibia 2013

Age in months	Percent distribution of youngest children under two living with their mother by breastfeeding status										Number of youngest children under two years	Percentage currently breastfeeding	Number of children under two years using a bottle with a nipple	Percentage of all children under two years
	Not breastfeeding	Exclusively breastfed	Breast-feeding and consuming plain water only	Breast-feeding and consuming non-milk liquids <sup>1</sup>	Breast-feeding and consuming other milk	Breast-feeding and complementary foods	Total							
0-1	2.3	72.0	12.5	1.7	10.7	0.7	100.0	97.7	128	15.4	132			
2-3	5.9	52.7	17.3	5.2	11.2	7.6	100.0	94.1	184	22.9	190			
4-5	14.4	26.8	16.7	3.8	10.2	28.1	100.0	85.6	175	37.0	179			
6-8	19.6	2.4	8.8	3.9	2.8	62.5	100.0	80.4	267	49.3	279			
9-11	25.4	1.8	2.6	0.0	3.0	67.2	100.0	74.6	214	50.0	232			
12-17	40.7	0.8	1.7	1.3	0.0	55.5	100.0	59.3	429	34.8	496			
18-23	70.2	0.5	1.3	0.3	0.4	27.3	100.0	29.8	324	26.3	442			
0-3	4.4	60.6	15.3	3.8	11.0	4.8	100.0	95.6	312	19.9	321			
0-5	8.0	48.5	15.8	3.8	10.7	13.2	100.0	92.0	487	26.0	500			
6-9	21.6	2.4	7.2	3.1	3.3	62.4	100.0	78.4	341	49.8	357			
12-15	35.6	1.2	2.2	1.5	0.0	59.6	100.0	64.4	293	36.4	329			
12-23	53.4	0.7	1.6	0.9	0.2	43.4	100.0	46.6	753	30.8	938			
20-23	79.0	0.2	1.7	0.4	0.0	18.6	100.0	21.0	216	22.6	304			

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, non-milk liquids/juice, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

<sup>1</sup> Non-milk liquids include juice, juice drinks, clear broth or other liquids.

## 4.2 Nutritional Status of Children

Under nutrition places children at an increased risk of morbidity and mortality and is also associated with impaired mental development. Anthropometry provides one of the most important indicators of children's nutritional status. Height and weight measurements were obtained for all children born in the five years before the survey in the sub-sample of households selected for the male survey. The height and weight data are used to compute three summary indices of nutritional status: height-for-age; weight-for-height; and weight-for-age. These three indices are expressed as standard deviation units from the median for the international reference population recommended by the World Health Organization. Children who fall more than two standard deviations (-2 SD) below the reference median are regarded as undernourished, while those who fall more than three standard deviations (-3 SD) below the reference median are considered severely undernourished.

Children whose height-for-age is below minus two standard deviations from the median of the reference population are considered stunted or short for their age. Stunting is the outcome of failure to receive adequate nutrition over an extended period and is also affected by recurrent or chronic illness. Table 12 shows that 24 percent of children under five are short for their age, and 8 percent are severely stunted.

Children whose weight-for-height is below minus two standard deviations from the median of the reference population are considered wasted or thin. Wasting represents the failure to receive adequate nutrition in the period immediately before the survey, and typically is the result of recent illness episodes, especially diarrhoea, or of a rapid deterioration in food supplies. In Namibia, 6 percent of children are wasted and 2 percent are severely wasted (Table 12).

Children whose weight-for-age is below minus two standard deviations from the median of the reference population are considered underweight. The measure reflects the effects of both acute and chronic undernutrition. Thirteen percent of children are underweight and 3 percent are severely underweight.

Table 12 shows that nutritional status among children deteriorates after age 9-11 months, when breastfeeding declines sharply as seen in Table 11. Male children are much more likely to be nutritionally disadvantaged than female children. Differences in nutritional status are especially striking by place of residence and mother's education. For example, in terms of all three measures, rural children are much more likely to be nutritionally disadvantaged than urban children. Children in Oshikoto are more than twice as likely to be underweight than children in Otjozondjupa, Oshana, Karas, and Erongo. Children of mothers with no education (23 percent) are about four times as likely as children of mothers with more than secondary education (6 percent) to be underweight.

Anthropometric measurements also provide information on obesity. Obesity not appear to be a major problem in Namibia. According to the 2013 NDHS, less than 1 percent of children under age five are more than 2 standard deviations above the norm.

Table 12. Nutritional status of children

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Namibia DHS 2013

Background characteristic	Height-for-age <sup>1</sup>			Weight-for-height			Weight-for-age			Number of children
	Percentage below -3 SD	Percentage below -2 SD <sup>2</sup>	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD <sup>2</sup>	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD <sup>2</sup>	Percentage above +2 SD	
<b>Age in months</b>										
<6	(0.0)	(0.0)	(0.9)	(8.3)	(17.2)	(3.2)	(0.0)	(3.3)	(4.8)	(0.1)
6-8	0.0	1.3	0.4	2.5	11.7	0.0	0.0	5.5	1.4	(0.2)
9-11	2.1	5.4	0.9	8.6	18.7	3.9	2.5	12.2	1.9	(0.5)
12-17	5.1	19.8	0.0	3.8	9.7	3.0	3.1	12.7	2.4	(0.6)
18-23	11.8	29.8	(1.2)	2.6	11.8	3.1	2.7	13.0	0.8	(0.8)
24-35	13.5	34.7	(1.5)	1.4	3.4	5.1	3.3	15.0	0.0	(0.8)
36-47	8.6	25.0	(1.3)	0.7	2.4	3.8	2.7	13.0	1.1	(0.9)
48-59	5.3	20.5	(1.2)	0.5	3.1	2.1	2.3	15.3	0.2	(1.0)
<b>Sex</b>										
Male	9.0	26.5	(1.2)	3.1	8.6	3.1	2.9	15.3	0.9	(0.8)
Female	7.3	20.9	(1.0)	0.9	3.9	3.7	2.3	11.4	0.9	(0.7)
<b>Residence</b>										
Urban	5.2	16.7	(0.8)	1.6	5.0	4.1	1.4	9.0	1.5	(0.5)
Rural	9.9	27.8	(1.2)	2.2	7.0	3.0	3.3	15.9	0.5	(0.9)
<b>Region</b>										
Zambezi	5.4	18.6	(1.0)	2.1	5.7	2.0	0.9	10.5	1.3	(0.7)
Erongo	4.4	15.2	(0.7)	4.6	8.1	6.5	0.9	9.9	2.0	(0.3)
Hardap	10.8	29.1	(1.1)	2.6	8.2	3.7	5.7	17.8	0.8	(0.8)
//Karas	9.8	27.0	(1.1)	1.4	5.6	3.2	1.5	12.1	1.5	(0.7)
Kavango	8.9	23.9	(1.1)	1.4	8.5	1.7	2.3	15.0	0.4	(0.9)
Khomas	5.2	12.8	(0.8)	0.7	3.5	3.6	0.0	9.0	0.9	(0.5)
Kunene	5.0	19.3	(0.9)	1.0	6.1	4.3	2.4	11.9	2.9	(0.7)
Oshana	13.9	36.5	(1.5)	1.8	5.4	2.3	4.3	16.3	0.0	(1.1)
Oshanaheke	7.7	26.8	(1.2)	3.3	10.4	5.3	5.2	18.0	1.6	(0.9)
Omusati	8.8	24.2	(1.3)	2.4	6.0	2.4	1.9	14.6	0.5	(1.0)
Oshanaheke	5.6	19.7	(0.9)	2.1	4.5	7.4	1.3	8.1	1.1	(0.5)
Oshikoto	7.6	26.3	(1.1)	3.8	8.5	1.7	5.2	20.7	0.6	(1.1)
Ojizondjupa	6.2	20.1	(0.9)	0.5	4.3	5.7	1.5	6.5	1.7	(0.4)
<b>Mother's education<sup>3</sup></b>										
No education	9.0	33.5	(1.4)	6.9	14.8	1.6	6.1	22.6	1.4	(1.2)
Primary	11.2	29.0	(1.3)	2.6	7.9	2.8	4.9	18.3	0.3	(1.0)
Secondary	6.0	18.8	(0.9)	1.6	6.9	3.4	1.6	10.9	1.0	(0.6)
More than secondary	4.1	8.5	(0.5)	0.4	0.4	6.5	0.6	5.5	0.7	(0.1)
<b>Mother's interview status</b>										
Mother interviewed	7.5	22.0	(1.0)	2.2	7.7	3.5	2.8	13.7	0.9	(0.8)
Mother not interviewed, but in household	4.3	16.8	(0.9)	2.1	2.1	1.3	0.0	6.2	0.0	(0.6)
Mother not interviewed, not in household <sup>4</sup>	10.2	28.7	(1.3)	1.6	3.5	3.6	2.5	13.6	0.9	(0.9)
Total	8.2	23.7	(1.1)	2.0	6.2	3.4	2.6	13.3	0.9	(0.8)

Note: Table is based on children who spent the night before the interview in the household. Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards adopted in 2006. The indices in this table are NOT comparable to those based on the previously used 1977 NCHS/CDC/WHO Reference. Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight. Total includes 1 child missing information on mother's education and 6 children missing information on mother's interview status. Figures in parentheses are based on 25-49 unweighted cases.

<sup>1</sup> Recumbent length is measured for children under age 2 and less than 85 cm; standing height is measured for all other children.

<sup>2</sup> Includes children who are below -3 standard deviations (SD) from the WHO Growth Standards population median.

<sup>3</sup> For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

<sup>4</sup> Includes children whose mothers are deceased.

In general, the nutritional status of children in Namibia has improved over the last six years. The percent of children stunted has declined from 29 percent in 2006-07 to 26 percent in 2013. Similarly, the percent of children who were underweight and wasted declined from 9 percent and 17 percent, respectively, to 6 and 13 percent, respectively in 2013.

## Anaemia

Anaemia is characterised by decreased concentration of haemoglobin in the blood. To measure the level of haemoglobin, capillary blood was taken in the field from a finger using sterile, one-time use lancets that allowed a relatively painless puncture. The concentration of haemoglobin in the blood was measured using the HemoCue system. Each team had a health technician who was specifically trained to conduct this procedure. Each respondent and her parent or guardian, in the case of an unmarried minor, was asked for their consent to participate in the anaemia testing. Levels of anaemia were classified as severe, moderate, or mild according to criteria developed by the World Health Organization (DeMaeyer et.al., 1989).

Table 13 presents anaemia levels for children age 6-59 months and for women age 15-64. Overall, 48 percent of children ages 6-59 months are anaemic. The majority of children who suffer from anaemia are classified as having mild or moderate anaemia (25 and 22 percent, respectively) while less than 1 percent are severely anaemic. Anaemia is relatively less common among women; 21 percent show evidence of anaemia, and the majority is mildly anaemic (17 percent). Anaemia among both children and women is slightly higher in rural than urban areas. Across regions, children and women from Kavango are most likely to be anaemic than those in other regions.

Table 13 Anaemia among children and women

Percentage of children age 6-59 months and women age 15-64 years classified as having anaemia, by background characteristics, Namibia 2013

Background characteristic	Any anaemia	Percentage with anaemia			Number
		Mild anaemia	Moderate anaemia	Severe anaemia	
<b>CHILDREN</b>					
<b>Residence</b>					
Urban	46.6	22.6	23.2	0.8	840
Rural	48.0	26.2	21.0	0.8	1,458
<b>Region</b>					
Zambezi	56.6	29.1	27.4	0.0	149
Erongo	46.1	26.6	17.2	2.4	116
Hardap	39.4	17.0	21.2	1.1	87
//Karas	57.4	28.5	29.0	0.0	71
Kavango	62.9	33.1	27.2	2.6	247
Khomas	42.7	20.0	21.9	0.8	269
Kunene	61.2	28.1	31.6	1.4	89
Ohangwena	35.1	19.9	14.8	0.3	360
Omaheke	37.7	20.4	17.4	0.0	79
Omusati	46.7	27.5	19.2	0.0	295
Oshana	42.1	24.1	18.0	0.0	165
Oshikoto	49.1	26.4	22.2	0.5	212
Otjozondjupa	53.8	23.5	29.0	1.3	159
Total	47.5	24.9	21.8	0.8	2,297
<b>WOMEN</b>					
<b>Residence</b>					
Urban	19.1	15.6	3.0	0.6	2,303
Rural	22.3	17.7	4.3	0.4	1,938
<b>Region</b>					
Zambezi	26.3	19.9	6.2	0.3	219
Erongo	21.1	15.6	5.1	0.4	356
Hardap	14.6	13.3	1.1	0.2	159
//Karas	20.9	17.6	3.1	0.2	167
Kavango	32.6	22.9	7.8	1.8	377
Khomas	15.8	13.7	1.7	0.4	889
Kunene	15.2	12.5	2.7	0.0	120
Ohangwena	16.5	12.8	3.4	0.2	469
Omaheke	20.0	17.1	2.5	0.4	114
Omusati	25.4	21.6	3.8	0.0	409
Oshana	20.8	17.1	2.7	1.0	382
Oshikoto	21.2	17.4	3.3	0.5	330
Otjozondjupa	19.1	15.6	3.6	0.0	249
Total	20.6	16.6	3.6	0.5	4,242

Note: Table is based on children and women who stayed in the household the night before the interview. Prevalence of anaemia, based on haemoglobin levels, is adjusted for altitude (for children and women) and smoking (for women) using CDC formulas (CDC, 1998). Women and children with <7.0 g/dl of haemoglobin have severe anaemia, women and children with 7.0-9.9 g/dl have moderate anaemia, and non-pregnant women with 10.0-11.9 g/dl and children and pregnant women with 10.0-10.9 g/dl have mild anaemia.

### **4.3 Malaria**

Malaria is one of the leading causes of death in malaria-endemic countries. The 2013 NDHS collected data on measures to prevent malaria including the use of mosquito nets among women and children, prophylactic use of antimalarial drugs, and prompt treatment among children. The survey also captured information on utilisation of insecticide-treated mosquito nets (ITNs), indoor residual spraying (IRS), use of intermittent preventive treatment (IPT) during pregnancy, and treatment of children under age 5 with malaria symptoms.

#### ***Ownership and use of mosquito nets***

Insecticide-treated mosquito nets are nets soaked and impregnated with insecticide after purchase, pretreated nets impregnated after manufacturing (ITNs), or long-lasting insecticide treated nets (LLINs), whose threads were treated during the manufacturing process so that they do not require additional treatment. Insecticide-treated nets are considered effective if they were obtained in the last 12 months or had been re-impregnated in the 12 months preceding the survey. Similarly, common mosquito nets soaked in insecticide after purchase are considered ITNs only if they were impregnated in the 12 months preceding the survey. The Household Questionnaire included a series of questions on net type and brand. Interviewers were also instructed to observe the nets, if the respondent allowed. The observation and information obtained from respondents are used to classify mosquito nets as treated or untreated. Table 14 shows that 24 percent of all households own at least one ITN. Ownership of an ITN is more than twice as high in rural (34 percent) than urban (15 percent) areas.

Table 14 shows that 6 percent of children under age 5 slept under an ITN the night before the survey, with small differences between urban and rural areas. An even smaller (4 percent) percentage of pregnant women age 15-49 slept under an ITN the night before the survey. Pregnant women in rural areas were seven times more likely to sleep under an ITN than women in urban areas.

#### ***Indoor residual spraying***

Indoor residual spraying (IRS) is the spraying of the walls inside dwellings with insecticide, which reduces transmission of malaria by killing the female adult mosquitoes when they rest on the walls after feeding. Sixteen percent of households in Namibia were sprayed with IRS in the 12 months preceding the survey. IRS was much higher in rural areas (29 percent) than in urban areas (3 percent). Overall, 26 percent of children age under 5 and 19 percent of pregnant women were protected from mosquitoes because the night before the interview they slept under an ITN or in a household sprayed with IRS in the past 12 months.

#### ***Preventive malaria treatment during pregnancy***

Prophylactic treatment with sulfadoxine/pyrimethamine (SP) can significantly diminish the symptoms and the consequences of malaria among pregnant women who become infected. Information on the use of intermittent preventive treatment (IPT) was obtained by asking women who had given birth in the two years preceding the survey if they had taken preventive antimalarial medication during the last pregnancy. Women who reported taking SP/Fansidar at least once during an antenatal visit were considered to have received IPT. Table 14 shows that only 5 percent of women who gave birth in the two-year period preceding the survey received IPT. The results also show that 26 percent of women who gave birth in the past two years took preventive malarial medication, either SP/Fansidar or other types of antimalarials.

**Table 14 Malaria indicators**

Possession and use of mosquito nets, preventive malaria treatment during pregnancy, and treatment of children with fever using antimalarial drugs, by urban-rural residence, Namibia 2013

Malaria indicators	Residence				Percentage	Number of children
	Urban		Rural			
	Percentage	Number	Percentage	Number		
<b>Mosquito nets</b>						
Percentage of households with at least one mosquito net (treated or untreated)	25.0	5,121	45.1	4,728	34.7	9,849
Percentage of households with at least one Insecticide Treated Net (ITN) <sup>1</sup>	15.2	5,121	34.3	4,728	24.4	9,849
Percentage of children under 5 who slept under a mosquito net the night before the survey	6.9	2,237	8.1	3,474	7.7	5,711
Percentage of children under 5 who slept under an Insecticide Treated Net (ITN) the night before the interview <sup>1</sup>	4.5	2,237	6.2	3,474	5.6	5,711
Percentage of children under 5 who slept under an Insecticide Treated Net (ITN) the night before the interview in a HH with ITNs <sup>1</sup>	22.5	444	16.3	1,335	17.8	1,778
Percentage of pregnant women age 15-49 who slept under a mosquito net the night before the interview	1.6	364	8.2	276	4.4	640
Percentage of pregnant women age 15-49 who slept under an Insecticide Treated Net (ITN) the night before the interview <sup>1</sup>	1.1	364	6.9	276	3.6	640
Percentage of pregnant women age 15-49 who slept under an Insecticide Treated Net (ITN) the night before the interview in a HH with ITNs <sup>1</sup>	6.2	62	18.7	101	14.0	163
<b>Indoor Residual Spraying (IRS)</b>						
Proportion of surveyed households sprayed with a residual insecticide in the last 12 months	3.0	5,121	29.0	4,728	15.5	9,849
Proportion of children under 5 who slept under an ITN or in household sprayed with IRS last 12 months <sup>1</sup>	8.8	2,237	37.8	3,474	26.4	5,711
Proportion of pregnant women who slept under an ITN the previous night or in household sprayed with IRS in the last 12 months <sup>1</sup>	5.0	364	37.9	276	19.1	640
<b>Preventive malaria treatment during pregnancy</b>						
Percentage of last birth in the 2 years preceding the survey for which the mother took antimalarial drugs for prevention during the pregnancy	19.9	925	31.0	1,022	25.7	1,947
Percentage of last birth in the 2 years preceding the survey for which the mother got Intermittent Preventive Treatment (IPT) during an antenatal visit <sup>2</sup>	5.1	925	4.8	1,022	4.9	1,947
<b>Treatment of fever</b>						
Proportion of children under 5 with fever in the two weeks preceding the survey	25.2	2,249	23.0	2,340	24.1	4,588
<b>Among children under age 5 with fever in the two weeks preceding the survey, percentage who took antimalarial drugs</b>						
Any antimalarial drug	7.9	567	9.0	538	8.4	1,106
Quinine	1.8	567	2.5	538	2.1	1,106
Combination with artemisinin	2.9	567	4.7	538	3.8	1,106
Other antimalarial	4.3	567	3.8	538	4.1	1,106
<b>Among children under age 5 with fever in the two weeks preceding the survey, percentage who took antimalarial drugs the same day/next day after developing fever</b>						
Any antimalarial drug	7.7	567	7.5	538	7.6	1,106
Quinine	1.3	567	1.5	538	1.4	1,106
Combination with artemisinin	2.4	567	4.1	538	3.2	1,106
Other antimalarial	5.1	567	4.3	538	4.7	1,106

<sup>1</sup> An Insecticide Treated Net (ITN) is a permanent net that does not require any treatment, a pretreated net obtained within the last 12 months or a net that has been soaked with insecticide within the past 12 months.

<sup>2</sup> Intermittent Preventive Treatment is preventive treatment with at least two doses of SP/Fansidar during antenatal visit.

### **Malaria treatment for children with fever**

Fever is the main symptom of malaria among children under age 5, even though its occurrence may be related to other illnesses. Delays in treating children can have serious consequences, especially in cases of severe infection, so it is recommended that children be treated with antimalarials within the first 24 hours of the onset of fever. Therapies that combine artemisinin with another antimalarial drug—known as artemisinin



combination therapy (ACT)—are the preferred treatment for malaria because they are both effective and well tolerated in patients. The results show that 8 percent of children who had fever in the two weeks preceding the survey received an antimalarial drug. Regarding the recommended ACT treatment, only 4 percent received ACT therapy. The data also show that 2 percent of children in urban areas and 4 percent in rural areas received ACT the same day or the next day after the onset of fever, as recommended.

#### 4.4 HIV/AIDS

The 2013 NDHS included a series of questions that addressed women’s and men’s awareness about the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). These questions sought information on respondents’ source of knowledge, knowledge of ways to avoid the disease, and knowledge and use of condoms for the prevention of sexually transmitted diseases (STDs).

##### *Heard of HIV/AIDS*

Table 15 shows that awareness of HIV/AIDS in Namibia is nearly universal among both women and men and as such there are minimal differences by background characteristics.

<b>Table 15 Knowledge of AIDS</b>				
Percentage of women and men who have heard of AIDS, by background characteristics, Namibia 2013				
Background characteristic	Women		Men	
	Have heard of AIDS	Number of women	Have heard of AIDS	Number of men
<b>Age</b>				
15-24	99.4	3,691	99.0	1,730
15-19	99.3	1,906	98.4	922
20-24	99.5	1,786	99.7	808
25-29	99.8	1,489	98.7	658
30-39	99.3	2,370	99.4	968
40-49	99.5	1,625	99.3	665
<b>Marital status</b>				
Never married	99.6	5,458	99.0	2,745
Ever had sex	99.8	4,155	99.2	2,134
Never had sex	99.0	1,304	98.2	611
Married/living together	99.3	3,121	99.7	1,160
Divorced/separated/widowed	99.6	597	96.4	116
<b>Residence</b>				
Urban	99.7	5,190	99.2	2,282
Rural	99.2	3,986	99.0	1,739
<b>Region</b>				
Zambezi	99.1	457	100.0	218
Erongo	99.8	771	99.0	372
Hardap	98.6	304	99.2	152
//Karas	99.7	343	96.9	151
Kavango	99.4	835	99.1	316
Khomas	99.7	2,202	99.2	1,023
Kunene	98.4	258	97.9	104
Ohangwena	99.7	894	99.6	328
Omaheke	98.8	225	99.0	103
Omusati	99.7	884	99.3	342
Oshana	99.7	755	100.0	335
Oshikoto	99.6	707	99.6	335
Otjozondjupa	98.5	540	96.9	241
<b>Education</b>				
No education	95.9	419	97.8	310
Primary	99.2	1,798	98.7	944
Secondary	99.9	6,029	99.4	2,400
More than secondary	99.3	930	99.2	368
Total 15-49	99.5	9,176	99.1	4,021

### Knowledge of HIV/AIDS prevention

HIV/AIDS prevention programs that target the general population promote monogamy and condom use as the primary ways of avoiding HIV infection among sexually active men and women. To gauge whether programs have effectively communicated these messages, the 2013 NDHS respondents were asked specific questions about whether it is possible to reduce the chance of getting the AIDS virus by having just one uninfected sexual partner and using a condom at every sexual encounter.

Table 16 shows that a very high (88 percent) proportion of women age 15-49 are aware of how to prevent HIV transmission. The percentage of men who are aware of the various prevention methods is marginally higher (90 percent) than women. Knowledge of HIV prevention methods is lowest among women and men age 15-19 and among those respondents who have never had sexual intercourse. Knowledge is also lower in rural than urban areas.

Women in Omusati and men in //Karas are least likely to know about HIV prevention methods. Education impacts knowledge of HIV prevention methods positively. As education levels rise the proportion of women and men with knowledge of HIV prevention methods also rises. For example, knowledge of both prevention methods rises from 69 percent among women age 15-49 with no education to 92 percent among those with higher than secondary education.

Table 16 Knowledge of HIV prevention methods

Percentage of women and men age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting the AIDS virus by using condoms every time they have sexual intercourse and by having one partner who is not infected and has no other partners, by background characteristics, Namibia 2013

Background characteristic	Percentage of women who say HIV can be prevented by:				Percentage of men who say HIV can be prevented by:			
	Using condoms <sup>1</sup>	Limiting sexual intercourse to one uninfected partner <sup>2</sup>	Using condoms and limiting sexual intercourse to one uninfected partner <sup>1,2</sup>	Number of women	Using condoms <sup>1</sup>	Limiting sexual intercourse to one uninfected partner <sup>2</sup>	Using condoms and limiting sexual intercourse to one uninfected partner <sup>1,2</sup>	Number of men
<b>Age</b>								
15-24	85.8	90.3	81.3	3,691	89.0	90.0	83.0	1,730
15-19	82.1	87.5	76.7	1,906	87.5	87.9	80.6	922
20-24	89.6	93.3	86.3	1,786	90.7	92.3	85.6	808
25-29	88.6	93.4	85.2	1,489	91.9	93.6	88.5	658
30-39	89.6	92.7	86.0	2,370	91.7	94.5	88.3	968
40-49	89.2	93.7	86.6	1,625	89.3	93.3	86.1	665
<b>Marital status</b>								
Never married	87.2	91.5	83.1	5,458	90.3	91.0	84.9	2,745
Ever had sex	89.4	93.1	85.7	4,155	91.7	92.8	87.0	2,134
Never had sex	80.1	86.3	74.8	1,304	85.4	84.9	77.5	611
Married/living together	88.4	92.4	85.0	3,121	90.4	95.3	88.1	1,160
Divorced/separated/widowed	90.6	94.7	88.4	597	84.5	88.7	79.3	116
<b>Residence</b>								
Urban	90.8	93.4	86.7	5,190	91.3	93.6	87.8	2,282
Rural	84.0	90.3	80.7	3,986	88.7	90.3	82.9	1,739
<b>Region</b>								
Zambezi	87.9	89.6	81.8	457	85.6	95.4	83.1	218
Erongo	93.1	94.9	89.8	771	90.2	94.3	86.6	372
Hardap	86.5	91.5	83.0	304	89.4	86.3	78.9	152
Karas	92.0	94.9	88.8	343	76.2	82.6	71.3	151
Kavango	87.5	89.9	83.7	835	88.0	88.5	81.8	316
Khomas	90.8	92.4	85.7	2,202	94.0	94.3	91.1	1,023
Kunene	88.6	93.5	86.2	258	90.8	92.5	88.3	104
Oshana	89.0	94.1	86.2	894	95.3	94.4	91.1	328
Omaheke	84.5	90.1	80.7	225	91.5	94.2	88.1	103
Omusati	76.6	86.5	74.3	884	89.5	92.6	84.6	342
Oshana	87.0	92.8	83.8	755	89.1	92.2	83.8	335
Oshikoto	84.6	93.8	81.4	707	85.7	87.6	76.0	335
Otjozondjupa	89.6	92.7	86.7	540	90.8	93.3	89.8	241
<b>Education</b>								
No education	76.1	78.3	68.8	419	85.3	89.2	80.4	310
Primary	82.8	87.4	77.7	1,798	86.2	88.5	80.7	944
Secondary	89.2	93.8	85.9	6,029	91.9	93.3	87.4	2,400
More than secondary	94.1	95.6	91.6	930	92.8	97.1	91.4	368
Total 15-49	87.8	92.0	84.1	9,176	90.2	92.2	85.7	4,021
50-64	81.3	86.7	76.0	797	83.1	90.2	79.0	460

<sup>1</sup> Using condoms every time they have sexual intercourse.

<sup>2</sup> Partner who has no other partners.

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### ***Multiple sexual partners and high-risk sexual behaviour***

Potentially risky sexual activities relate to men and women who have multiple sexual partners, and the failure to use condoms particularly if they have more than one sexual partner. Tables 17.1 and 17.2 present information collected from women and men who had ever had intercourse, on the number of sexual partners they had had during the 12 months before the survey and over their lifetime, and condom use at last sex among women and men reporting more than one sexual partner in the past 12 months.

As Tables 17.1 and 17.2 show, it is much less common among women (2 percent) in Namibia to have multiple sexual partners than men (10 percent).

Among women, multiple sexual partners is most common among those age 20-24, divorced/separated/widowed women, those living in urban areas, women living in Kunene, and uneducated women. Whereas among men multiple sexual partners is more common among those age 25-29, never married men, men living in rural areas, those living in Oshana and among men with higher than secondary education.

Among women and men who had more than one sexual partner in the past 12 months, 68 and 72 percent, respectively, reported using a condom during the last sexual intercourse. Among women, condom use is highest among those age 30-39, never married women, urban residents, and those living in Omusati. Among men, those age 20-24, men who have never been married, those living in urban areas, and those who live in Ohangwene are more likely to report using condom during the last sexual intercourse. Use of condoms is also higher among women and men with higher than secondary education than those with lower levels of education.

Women reported an average of 2.6 lifetime sexual partners whereas men reported an average of 7.4 lifetime partners. The differences by background characteristics are similar to that discussed under partners in the past 12 months.

**Table 17.1 Multiple sexual partners in the past 12 months: Women**

Among all women age 15-49, the percentage who had sexual intercourse with more than one sexual partner in the past 12 months; among those having more than one partner in the past 12 months, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during her lifetime for women who ever had sexual intercourse, by background characteristics, Namibia 2013

Background characteristic	All women:		Among women who had 2+ partners in the past 12 months:		Among women who ever had sexual intercourse:	
	Percent- age who had 2+ partners in the past 12 months	Number of women	Percent- age who reported using a condom during last sexual inter- course	Number of women	Mean number of sexual partners in lifetime <sup>1</sup>	Number of women
<b>Age</b>						
15-24	2.8	3,691	67.8	105	2.0	2,452
15-19	2.1	1,906	61.4	40	1.7	852
20-24	3.6	1,786	71.8	65	2.2	1,600
25-29	2.7	1,489	63.5	40	2.6	1,443
30-39	1.6	2,370	73.3	38	2.9	2,274
40-49	1.2	1,625	68.5	20	2.9	1,561
<b>Marital status</b>						
Never married	2.5	5,458	73.8	136	2.5	4,104
Married/living together	1.2	3,121	26.2	36	2.5	3,040
Divorced/separated/widowed	5.3	597	91.9	31	3.4	586
<b>Residence</b>						
Urban	2.9	5,190	72.0	151	2.7	4,423
Rural	1.3	3,986	56.7	52	2.3	3,307
<b>Region</b>						
Zambezi	1.1	457	73.4	5	2.4	414
Erongo	3.5	771	57.4	27	3.2	673
Hardap	1.7	304	32.3	5	2.9	259
//Karas	1.4	343	80.5	5	2.9	300
Kavango	0.5	835	48.8	4	2.0	765
Khomas	3.7	2,202	77.0	82	2.7	1,844
Kunene	7.2	258	46.3	19	3.5	246
Ohangwena	0.8	894	43.5	7	2.2	710
Omaheke	5.2	225	62.8	12	4.0	203
Omusati	0.5	884	100.0	4	2.0	670
Oshana	0.9	755	85.2	7	2.3	627
Oshikoto	2.1	707	63.3	15	2.2	574
Otjozondjupa	2.1	540	87.5	11	3.0	446
<b>Education</b>						
No education	3.7	419	29.1	16	2.9	395
Primary	1.3	1,798	40.9	24	2.5	1,506
Secondary	2.3	6,029	75.1	141	2.6	5,027
More than secondary	2.4	930	80.3	22	2.6	801
Total 15-49	2.2	9,176	68.1	203	2.6	7,731
50-64	0.2	797	0.0	1	2.5	769

<sup>1</sup> Means are calculated excluding respondents who gave non-numeric responses.

**Table 17.2 Multiple sexual partners in the past 12 months: Men**

Among all men age 15-49, the percentage who had sexual intercourse with more than one sexual partner; among those having more than one partner in the past 12 months, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during his lifetime for men who ever had sexual intercourse, by background characteristics, Namibia 2013

Background characteristic	All men:		Among men who had 2+ partners in the past 12 months:		Among men who ever had sexual intercourse:	
	Percentage who had 2+ partners in the past 12 months	Number of men	Percentage who reported using a condom during last sexual intercourse	Number of men	Mean number of sexual partners in lifetime <sup>1</sup>	Number of men
<b>Age</b>						
15-24	9.2	1,730	79.4	160	4.3	1,124
15-19	4.9	922	75.1	46	3.0	396
20-24	14.1	808	81.1	114	5.0	728
25-29	15.5	658	77.5	102	7.9	602
30-39	11.0	968	58.6	106	8.9	882
40-49	7.7	665	67.2	51	10.6	569
<b>Marital status</b>						
Never married	12.0	2,745	81.0	331	6.5	2,013
Married/living together	6.7	1,160	35.9	78	8.8	1,066
Divorced/separated/widowed	9.8	116	62.7	11	10.1	98
<b>Residence</b>						
Urban	9.8	2,282	73.6	223	7.6	1,864
Rural	11.3	1,739	70.6	197	7.1	1,314
<b>Region</b>						
Zambezi	12.0	218	42.9	26	5.9	197
Erongo	6.5	372	59.9	24	8.6	297
Hardap	7.7	152	62.8	12	8.0	126
//Karas	6.8	151	73.8	10	7.5	110
Kavango	9.6	316	45.0	30	7.2	269
Khomas	10.5	1,023	77.8	108	7.2	838
Kunene	12.9	104	74.7	13	11.9	93
Ohangwena	11.9	328	82.7	39	6.9	246
Omaheke	5.6	103	43.9	6	8.9	89
Omusati	11.9	342	81.4	41	6.8	191
Oshana	15.6	335	79.9	52	8.2	263
Oshikoto	14.1	335	77.6	47	5.5	262
Otjozondjupa	4.6	241	77.5	11	7.3	196
<b>Education</b>						
No education	7.9	310	63.7	24	7.4	275
Primary	8.6	944	72.8	81	7.3	694
Secondary	10.7	2,400	71.0	256	7.2	1,895
More than secondary	16.0	368	80.1	59	8.6	313
Total 15-49	10.4	4,021	72.2	420	7.4	3,177
50-64	6.5	460	38.6	30	11.8	380

<sup>1</sup> Means are calculated excluding respondents who gave non-numeric responses.

### ***Coverage of prior HIV testing***

Knowledge of HIV status helps HIV negative individuals make specific decisions to reduce risk and increase safer sex practices so that they can remain free of disease. For those who are infected with HIV, knowledge of their status allows them to take action to protect their sexual partners, to seek treatment, and to plan for the future. To assess awareness of HIV testing services and the coverage of those services, the 2013 NDHS asked respondents whether they had ever been tested for HIV. If they said that they had been, they were asked whether they had received the results of their last test. If they had never been tested, they were asked if they knew a place where they could go to be tested.

Tables 18.1 and 18.2 show that 97 percent of women and 94 percent of men age 15-49 know where to get an HIV test. The level of this knowledge is slightly higher among urban respondents (98 percent of women and 97 percent of men) than among rural respondents (96 percent of women and 91 percent of men). Women and men age 15-19, those who have never ever had sex, men who live in Kavango, and women and men with no education, are less likely to know where to get an HIV test.

Results show that 79 percent of women and 61 percent of men 15-49 have ever been tested for HIV and received their test results. Respondents least likely to have ever been tested for HIV and received their test results are those age 15-19 (42 percent of women and 25 percent of men), those who have never had sex (28 and 18 percent, respectively), respondents living in rural areas (78 percent of women and 51 percent of men), men in Kavango and Omusati (46 percent each) and women in Hardap and Omusati (76 percent each), and respondents with no or with primary education (73-75 percent of women and 51-54 percent of men).

Overall, 19 percent of women and 37 percent of men 15-49 have never been tested. Forty-nine percent of women and 38 percent of men 15-49 were tested for HIV in the year preceding the survey and received their results.

**Table 18.1 Coverage of prior HIV testing: Women**

Percentage of women age 15-49 who know where to get an HIV test, percent distribution of women age 15-49 by testing status and by whether they received the results of the last test, the percentage of women ever tested, and the percentage of women age 15-49 who were tested in the past 12 months and received the results of the last test, according to background characteristics, Namibia 2013

Background characteristic	Percent distribution of women/men by testing status and by whether they received the results of the last test				Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of women
	Percentage who know where to get an HIV test	Ever tested and received results	Ever tested, did not receive results	Never tested <sup>1</sup>				
<b>Age</b>								
15-24	95.4	62.0	1.9	36.1	100.0	63.9	43.4	3,691
15-19	93.2	41.7	1.7	56.6	100.0	43.4	28.5	1,906
20-24	97.7	83.6	2.1	14.3	100.0	85.7	59.3	1,786
25-29	98.5	93.4	2.2	4.4	100.0	95.6	61.9	1,489
30-39	98.7	91.5	2.4	6.1	100.0	93.9	54.6	2,370
40-49	98.6	87.6	2.5	9.8	100.0	90.2	42.5	1,625
<b>Marital status</b>								
Never married	96.8	72.4	1.7	25.9	100.0	74.1	47.6	5,458
Ever had sex	98.6	86.3	1.9	11.8	100.0	88.2	57.5	4,155
Never had sex	91.0	28.1	1.1	70.8	100.0	29.2	16.1	1,304
Married/living together	98.0	89.0	2.9	8.1	100.0	91.9	51.4	3,121
Divorced/separated/widowed	99.1	90.8	2.7	6.5	100.0	93.5	51.1	597
<b>Residence</b>								
Urban	98.3	80.5	2.0	17.4	100.0	82.6	49.7	5,190
Rural	96.1	77.6	2.4	20.0	100.0	80.0	48.4	3,986
<b>Region</b>								
Zambezi	96.7	78.6	4.7	16.7	100.0	83.3	49.2	457
Erongo	98.3	82.7	1.2	16.1	100.0	83.9	50.2	771
Hardap	97.7	74.2	2.0	23.8	100.0	76.2	41.3	304
//Karas	99.2	80.7	2.8	16.5	100.0	83.5	49.8	343
Kavango	96.1	79.7	4.5	15.9	100.0	84.1	52.9	835
Khomas	98.2	79.2	1.9	18.9	100.0	81.1	47.7	2,202
Kunene	94.8	79.9	1.8	18.3	100.0	81.7	49.8	258
Oshana	96.1	79.6	1.7	18.6	100.0	81.4	53.1	894
Omaheke	95.3	81.6	2.1	16.3	100.0	83.7	50.3	225
Omusati	96.9	74.2	0.7	25.1	100.0	74.9	46.3	884
Oshana	98.9	84.9	1.3	13.8	100.0	86.2	51.4	755
Oshikoto	98.0	79.6	2.5	17.8	100.0	82.2	50.4	707
Otjozondjupa	95.3	74.5	2.8	22.6	100.0	77.4	44.3	540
<b>Education</b>								
No education	88.8	73.3	4.1	22.6	100.0	77.4	40.0	419
Primary	94.4	75.0	2.8	22.2	100.0	77.8	42.6	1,798
Secondary	98.6	80.2	1.9	17.9	100.0	82.1	51.0	6,029
More than secondary	98.7	83.9	2.3	13.8	100.0	86.2	53.9	930
Total 15-49	97.3	79.2	2.2	18.6	100.0	81.4	49.1	9,176
50-64	95.0	67.0	1.3	31.7	100.0	68.3	26.8	797

<sup>1</sup> Includes 'Don't know/missing'.

**Table 18.2 Coverage of prior HIV testing: Men**

Percentage of men age 15-49 who know where to get an HIV test, percent distribution of men age 15-49 by testing status and by whether they received the results of the last test, the percentage of men ever tested, and the percentage of men age 15-49 who were tested in the past 12 months and received the results of the last test, according to background characteristics, Namibia DHS 2013

Background characteristic	Percent distribution of women/men by testing status and by whether they received the results of the last test				Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of men
	Percentage who know where to get an HIV test	Ever tested and received results	Ever tested, did not receive results	Never tested <sup>1</sup>				
<b>Age</b>								
15-24	90.9	39.9	1.3	58.8	100.0	41.2	26.1	1,730
15-19	86.9	24.6	1.2	74.2	100.0	25.8	13.9	922
20-24	95.5	57.3	1.5	41.2	100.0	58.8	40.0	808
25-29	96.3	75.1	2.7	22.2	100.0	77.8	47.5	658
30-39	97.1	79.3	2.1	18.6	100.0	81.4	50.9	968
40-49	97.3	76.5	3.1	20.5	100.0	79.5	41.7	665
<b>Marital status</b>								
Never married	93.3	53.2	1.8	45.0	100.0	55.0	34.3	2,745
Ever had sex	96.4	63.7	1.8	34.5	100.0	65.5	42.0	2,122
Never had sex	82.7	17.7	1.7	80.6	100.0	19.4	8.1	623
Married/living together	97.1	79.1	2.8	18.1	100.0	81.9	46.5	1,160
Divorced/separated/widowed	91.6	69.8	0.3	29.8	100.0	70.2	45.7	116
<b>Residence</b>								
Urban	97.2	69.0	1.9	29.0	100.0	71.0	44.3	2,282
Rural	90.6	50.9	2.2	46.9	100.0	53.1	30.0	1,739
<b>Region</b>								
Zambezi	98.1	59.6	2.1	38.3	100.0	61.7	31.0	218
Erongo	97.3	71.2	2.7	26.0	100.0	74.0	46.7	372
Hardap	97.5	66.4	2.5	31.1	100.0	68.9	32.0	152
//Karas	91.8	52.8	3.9	43.3	100.0	56.7	33.7	151
Kavango	85.9	46.2	2.9	50.9	100.0	49.1	31.4	316
Khomas	97.9	72.4	1.9	25.7	100.0	74.3	47.0	1,023
Kunene	91.2	54.4	0.7	44.9	100.0	55.1	30.3	104
Ohangwena	92.2	57.2	0.8	42.0	100.0	58.0	36.0	328
Omaheke	94.7	64.9	2.8	32.3	100.0	67.7	44.1	103
Omusati	91.0	45.7	1.7	52.6	100.0	47.4	26.2	342
Oshana	97.0	62.8	1.2	35.9	100.0	64.1	38.9	335
Oshikoto	90.8	49.9	2.5	47.6	100.0	52.4	30.2	335
Otjozondjupa	92.3	63.4	1.6	35.0	100.0	65.0	39.9	241
<b>Education</b>								
No education	84.2	54.4	2.1	43.5	100.0	56.5	36.5	310
Primary	89.4	51.1	2.3	46.6	100.0	53.4	29.4	944
Secondary	96.9	62.8	1.7	35.5	100.0	64.5	39.9	2,400
More than secondary	98.8	82.2	3.6	14.2	100.0	85.8	50.2	368
Total 15-49	94.3	61.2	2.0	36.8	100.0	63.2	38.1	4,021
50-64	93.5	67.9	3.0	29.1	100.0	70.9	31.1	460

<sup>1</sup> Includes 'Don't know/missing'.



## 4.5 Prevalence of High Blood Pressure

The 2013 NDHS respondents age 35-64 were asked questions to determine if they had been diagnosed as hypertensive and if they were taking medication to control blood pressure. Respondents were also asked if their blood pressure could be measured as part of the survey. Blood pressure was measured by a fully automatic, digital device with automatic upper-arm inflation and automatic pressure release. Blood pressure measurements were taken by the interviewers who were trained on the use of the device according to the manufacturer's recommended protocol. Three measurements of systolic and diastolic blood pressure (measured in millimeters of mercury [mmHg]) were taken during the survey interview, with an interval of at least 10 minutes between measurements. The average of the second and third measurements was used to classify individuals with respect to hypertension, following internationally recommended categories (WHO, 1999). Individuals were classified as hypertensive if their systolic blood pressure exceeded 140 mmHg or if their diastolic blood pressure exceeded 90 mmHg. Elevated blood pressure was classified as mild, moderate, or severe according to the cut-off points recommended by the World Health Organization and the National Institutes of Health (WHO, 1999; NIH, 1997).

<b>Blood pressure status</b>	<b>Systolic (mmHg)</b>	<b>Diastolic (mmHg)</b>
Optimal	<120	<80
Normal	120-129	80-84
High normal	130-139	85-89
<b>Level of hypertension</b>		
Grade 1, mild	140-159	90-99
Grade 2, moderate	160-179	100-109
Grade 3, severe	180+	110+

Following internationally recommended guidelines, individuals were considered hypertensive if they had a normal average blood pressure reading but were taking antihypertensive medication.

Tables 19.1 and 19.2 show the prevalence of hypertension among survey respondents 35-64. Forty-four percent of women and 45 percent of men 35-64 are classified as hypertensive (i.e., they have systolic blood pressure (SBP)  $\geq 140$  mmHg or diastolic blood pressure (DBP)  $\geq 90$  mmHg at time of survey or they are currently taking antihypertensive medication to control their blood pressure). The term hypertension as used in this report is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey.

Table 19.1. Blood pressure status: Women

Among women age 35-64, prevalence of hypertension, percent distribution of blood pressure values, and percentage having normal blood pressure and taking medication, by background characteristics, Namibia 2013

Background characteristic	Prevalence of hypertension <sup>1</sup>	Classification of blood pressure							Total	Normal blood pressure and taking medicine	Number of women
		Normal			Elevated						
		Optimal <120/80 mmHg	Normal 120-129/80-84 mmHg	High normal 130-139/85-89 mmHg	Mildly elevated (Grade 1) 140-159/90-99 mmHg	Moderately elevated (Grade 2) 160-179/100-109 mmHg	Severely elevated (Grade 3) 180+/110+ mmHg				
<b>Age</b>											
35-39	26.7	40.9	18.7	17.2	17.0	5.5	0.7	100.0	3.6	518	
40-44	40.6	34.3	18.8	13.2	23.1	8.2	2.4	100.0	6.9	413	
45-49	48.8	27.1	12.4	18.0	27.9	9.6	4.9	100.0	6.4	354	
50-54	51.4	23.7	14.5	19.7	24.1	13.2	4.8	100.0	9.3	363	
55-59	62.3	20.5	14.5	14.9	29.7	16.1	4.2	100.0	12.3	211	
60-64	55.8	25.9	12.8	23.1	22.6	10.0	5.6	100.0	17.6	198	
<b>Residence</b>											
Urban	50.6	26.7	14.4	18.3	25.1	12.5	2.9	100.0	9.9	955	
Rural	38.5	34.1	17.2	16.4	21.5	7.1	3.6	100.0	6.3	1,101	
<b>Region</b>											
Zambezi	39.0	31.7	19.2	20.0	20.2	7.9	1.0	100.0	9.9	97	
Erongo	48.3	31.2	11.2	24.0	21.4	7.4	4.8	100.0	14.7	157	
Hardap	52.1	21.9	14.6	19.1	27.2	14.7	2.6	100.0	7.7	91	
//Karas	45.9	27.8	16.7	18.9	22.6	10.6	3.4	100.0	9.3	97	
Kavango	38.1	41.7	14.8	12.8	18.7	9.9	2.2	100.0	7.3	174	
Khomas	57.3	25.2	13.2	13.6	26.6	18.3	3.2	100.0	9.3	319	
Kunene	41.9	30.3	23.6	14.6	18.4	9.0	4.2	100.0	10.3	74	
Ohangwena	35.5	30.9	20.2	19.5	20.9	5.6	2.8	100.0	6.2	222	
Omahenge	51.8	22.3	22.6	15.5	28.8	6.8	3.9	100.0	12.3	67	
Omusati	39.6	32.2	12.6	20.4	22.5	7.0	5.3	100.0	4.8	272	
Oshana	32.6	35.5	17.5	15.9	19.9	8.2	3.1	100.0	1.4	182	
Oshikoto	41.0	36.6	18.9	11.3	26.3	4.8	2.2	100.0	7.8	161	
Otjozondjupa	52.2	23.6	13.5	21.6	28.0	10.3	3.1	100.0	10.8	145	
<b>Education</b>											
No education	53.0	26.1	14.5	12.8	26.2	14.4	6.0	100.0	6.4	263	
Primary	43.7	29.0	16.4	18.0	23.7	9.0	3.9	100.0	7.1	714	
Secondary	41.2	34.0	15.5	17.4	22.2	8.4	2.5	100.0	8.1	915	
More than secondary	47.3	26.9	18.4	21.4	20.4	11.8	1.2	100.0	13.9	163	
50-64	55.8	25.9	12.8	23.1	22.6	10.0	5.6	100.0	17.6	198	
Total 35-64	44.1	30.7	15.9	17.3	23.2	9.6	3.3	100.0	8.0	2,057	

<sup>1</sup> An individual is classified as having hypertension if he/she has blood pressure (BP) levels  $\geq 140$  mmHg SBP or  $\geq 90$  mmHg DBP at time of survey, or he/she is currently taking antihypertensive medication to control their blood pressure. The term hypertension as used in this table is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey

Table 19.2. Prevalence of hypertension by socioeconomic characteristics: Men

Among men age 35-64, prevalence of hypertension, percent distribution of blood pressure values, and percentage having normal blood pressure and taking medication, by background characteristics, Namibia 2013

Background characteristic	Prevalence of hypertension <sup>1</sup>	Classification of blood pressure							Total	Normal blood pressure and taking medicine	Number of men
		Optimal <120/80 mmHg	Normal 120-129/80-84 mmHg	High normal 130-139/85-89 mmHg	Mildly elevated (Grade 1) 140-159/90-99 mmHg	Moderately elevated (Grade 2) 160-179/100-109 mmHg	Severely elevated (Grade 3) 180+/110+ mmHg				
<b>Age</b>											
35-39	30.8	32.8	24.1	14.5	18.8	8.0	1.9	100.0	2.2	367	
40-44	40.1	28.8	19.4	15.7	22.8	9.4	3.8	100.0	4.0	313	
45-49	41.5	31.4	17.9	13.0	21.9	12.3	3.4	100.0	3.9	253	
50-54	51.9	22.2	16.3	16.0	29.6	12.0	3.9	100.0	6.3	184	
55-59	63.9	25.7	9.0	13.9	29.8	15.9	5.7	100.0	12.4	154	
60-64	64.9	19.5	13.3	17.3	25.1	11.2	13.7	100.0	15.0	141	
<b>Residence</b>											
Urban	50.8	23.5	18.7	14.5	25.7	12.2	5.4	100.0	7.6	734	
Rural	37.8	33.2	17.7	15.3	21.1	9.3	3.4	100.0	3.9	679	
<b>Region</b>											
Zambezi	46.9	19.9	24.3	15.2	30.6	7.4	2.6	100.0	6.2	62	
Erongo	52.9	18.4	22.5	18.8	22.9	11.2	6.1	100.0	12.6	159	
Hardap	42.8	27.3	19.2	15.9	21.9	11.7	4.2	100.0	5.1	79	
//Karas	46.5	26.0	16.9	15.1	27.8	11.0	3.2	100.0	4.5	76	
Kavango	30.4	42.7	17.2	12.8	21.4	5.1	0.8	100.0	3.1	121	
Khomas	56.5	21.6	16.8	13.9	25.8	14.8	7.1	100.0	8.8	253	
Kunene	39.0	28.4	16.6	21.2	20.2	9.7	3.9	100.0	5.2	51	
Oshana-Nambo	43.6	30.9	19.2	9.1	22.0	16.2	2.5	100.0	2.8	84	
Omaheke	45.4	24.9	17.1	16.5	24.5	12.8	4.2	100.0	3.9	69	
Omusati	42.5	30.5	16.5	12.8	25.0	9.5	5.6	100.0	2.3	119	
Oshana	35.0	34.4	22.8	11.6	21.6	8.6	1.1	100.0	3.8	102	
Oshikoto	33.4	41.2	13.8	16.7	16.3	7.9	4.1	100.0	5.0	111	
Ojizondjupa	44.3	26.9	16.3	16.5	24.6	9.8	5.9	100.0	4.0	127	
<b>Education</b>											
No education	40.9	35.0	14.4	14.7	22.3	9.5	4.1	100.0	5.0	226	
Primary	44.2	30.9	16.3	14.5	22.7	11.7	3.8	100.0	5.8	448	
Secondary	44.2	24.9	20.8	15.0	23.2	11.0	5.1	100.0	4.9	594	
More than secondary	53.5	22.9	19.8	14.8	29.4	9.0	4.0	100.0	11.1	142	
50-64	64.9	19.5	13.3	17.3	25.1	11.2	13.7	100.0	15.0	141	
Total 35-64	44.5	28.2	18.2	14.9	23.5	10.8	4.4	100.0	5.8	1,412	

<sup>1</sup> An individual is classified as having hypertension if he/she has blood pressure (BP) levels  $\geq 140$  mmHg SBP or  $\geq 90$  mmHg DBP at time of survey, or he/she is currently taking antihypertensive medication to control their blood pressure. The term hypertension as used in this table is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey

As expected, the prevalence of hypertension is associated with age; it is lowest among respondents 35-39 and highest among those 55-64. Fifty-one percent of urban women and men are considered hypertensive, compared with 9 and 38 percent, respectively, among rural respondents. The prevalence of hypertension is highest among women and men living in Khomas (57 percent each) and respondents with more than secondary education (47 percent of women and 54 percent of men).

#### 4.6 Prevalence of Diabetes

Women and men age 35-64 in half of the households selected for the male survey were eligible to have their fasting plasma glucose levels tested. The 2013 NDHS uses WHO cut-off points for measuring fasting plasma glucose (WHO, 2006). The cut-off points correspond to the clinical classification for normal fasting plasma glucose levels, prediabetes, and diabetes. Fasting plasma glucose values considered to be normal are 3.9-6.0 mmol/L. A fasting plasma glucose value of 6.1-6.9 mmol/L is classified as prediabetes, and values greater than or equal to 7.0 mmol/L are considered to be diabetes. The chart below summarises the fasting plasma glucose values as they relate to diabetes classification.

Classification	Level in mmol/L
Normal	3.9-6.0
Prediabetes	6.1-6.9
Diabetes	≥7.0

*Source: WHO, 2006.*

Tables 20.1 and 20.2 show that 6 percent of women and 7 of men 35-64 have diabetes (i.e., either they have fasting plasma glucose (FPG) values of 7 mmol/L or higher or they reported that they are currently taking diabetes medication). Similar to ‘hypertension’, the term ‘diabetes’ in this report is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey.

Data show that prevalence of diabetes is lowest among women and men age 35-39 when compared with older age groups. Urban women and men (8 percent each) have a higher prevalence of diabetes than their rural counterparts (4 percent of women and 5 percent of men). Prevalence of diabetes is highest among respondents in Hardap (19 percent of women and 14 percent of men) and among those with more than secondary education (8 percent of women and 13 percent of men).

**Table 20.1 Prevalence of diabetes by socioeconomic characteristics: Women**

Among women age 35-64, prevalence of diabetes, percent distribution by fasting plasma glucose (FPG) values, and percentage with normal fasting plasma glucose level and taking medication, by background characteristics, Namibia 2013

Background characteristic	Prevalence of diabetes <sup>1</sup>	Fasting plasma glucose values				Total	Normal FPG and taking medicine	Number of women
		<3.9 mmol/L (Below normal)	3.9-6.0 mmol/L (Normal)	6.1-6.9 mmol/L (Prediabetic)	≥7 mmol/L (Elevated FPG)			
<b>Age</b>								
35-39	2.9	5.9	85.5	5.8	2.7	100.0	0.1	465
40-44	6.5	1.7	87.5	4.8	6.1	100.0	0.1	370
45-49	6.7	3.4	82.7	8.2	5.8	100.0	0.9	321
50-54	5.5	4.3	84.0	7.6	4.1	100.0	1.0	337
55-59	7.6	2.4	82.3	9.3	6.0	100.0	0.5	192
60-64	7.2	8.1	75.7	10.3	5.8	100.0	1.2	187
<b>Residence</b>								
Urban	8.0	4.7	82.2	6.5	6.6	100.0	1.0	839
Rural	3.7	3.8	85.2	7.7	3.3	100.0	0.2	1,034
<b>Region</b>								
Zambezi	5.7	1.8	89.2	4.9	4.2	100.0	0.6	88
Erongo	4.7	2.7	86.5	7.5	3.4	100.0	0.6	143
Hardap	19.4	5.9	71.6	8.3	14.2	100.0	4.4	86
//Karas	9.5	5.8	82.9	3.6	7.6	100.0	1.5	89
Kavango	0.7	4.4	84.3	10.6	0.7	100.0	0.0	159
Khomas	6.3	6.4	82.5	5.4	5.7	100.0	0.6	261
Kunene	11.0	6.7	81.3	4.4	7.7	100.0	1.9	68
Ohangwena	6.6	3.1	83.0	7.4	6.6	100.0	0.0	207
Omaheke	2.9	6.2	81.0	10.6	2.1	100.0	0.7	63
Omusati	2.6	5.1	85.5	7.3	2.1	100.0	0.0	265
Oshana	6.5	1.7	83.4	8.5	6.5	100.0	0.0	147
Oshikoto	3.1	3.6	88.6	4.7	3.1	100.0	0.0	161
Otjozondjupa	4.9	2.5	83.3	9.8	4.3	100.0	0.6	135
<b>Education</b>								
No education	3.9	5.3	82.0	8.9	3.7	100.0	0.0	244
Primary	5.8	4.4	83.9	6.5	5.2	100.0	0.6	674
Secondary	5.4	3.9	84.9	6.8	4.4	100.0	0.8	814
More than secondary	7.8	3.2	81.4	9.7	5.7	100.0	0.4	139
50-64	7.2	8.1	75.7	10.3	5.8	100.0	1.2	187
Total 35-64	5.6	4.2	83.8	7.1	4.8	100.0	0.6	1,873

Note: An individual is classified as having diabetes if he/she has fasting plasma glucose  $\geq 7$ mmol/L at time of survey, or he/she is currently taking medication to manage diabetes. The term diabetes as used in this table is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey

**Table 20.2 Prevalence of diabetes by socioeconomic characteristics: Men**

Among men age 35-64, prevalence of diabetes, percent distribution by fasting plasma glucose (FPG) values, and percentage with normal fasting plasma glucose level and taking medication, by background characteristics, Namibia 2013

Background characteristic	Prevalence of diabetes <sup>1</sup>	Fasting plasma glucose values				Total	Normal FPG and taking medicine	Number of men
		<3.9 mmol/L (Below normal)	3.9-6.0 mmol/L (Normal)	6.1-6.9 mmol/L (Prediabetic)	≥7 mmol/L (Elevated FPG)			
<b>Age</b>								
35-39	4.2	9.0	83.2	3.6	4.2	100.0	0.0	308
40-44	5.2	10.2	80.1	5.5	4.3	100.0	0.9	269
45-49	2.9	6.2	83.5	8.1	2.3	100.0	0.1	214
50-54	12.3	8.2	72.2	8.9	10.8	100.0	0.4	163
55-59	8.1	14.2	72.4	9.5	3.9	100.0	1.0	136
60-64	13.3	7.7	77.3	4.9	10.1	100.0	1.9	131
<b>Residence</b>								
Urban	8.4	9.3	78.0	6.3	6.3	100.0	0.7	608
Rural	4.9	8.9	80.5	6.2	4.4	100.0	0.5	613
<b>Region</b>								
Zambezi	4.4	13.2	80.5	5.3	1.1	100.0	2.3	52
Erongo	8.2	6.2	82.0	6.2	5.6	100.0	0.6	146
Hardap	14.4	12.0	71.6	6.5	9.9	100.0	3.6	76
//Karas	7.0	5.3	81.2	7.2	6.3	100.0	0.7	68
Kavango	3.1	5.8	84.8	6.3	3.1	100.0	0.0	103
Khomas	7.5	11.2	75.1	8.2	5.5	100.0	0.0	187
Kunene	6.7	10.9	75.9	7.3	5.9	100.0	0.8	45
Ohangwena	4.6	7.6	78.5	9.3	4.6	100.0	0.0	73
Omaheke	3.5	6.5	83.4	7.0	3.2	100.0	0.4	64
Omusati	6.1	11.3	79.9	3.8	5.0	100.0	1.1	110
Oshana	4.0	11.3	79.0	7.2	2.4	100.0	0.0	75
Oshikoto	8.7	7.0	79.0	5.3	8.7	100.0	0.0	102
Otjozondjupa	5.9	10.8	80.2	3.1	5.9	100.0	0.0	120
<b>Education</b>								
No education	1.8	7.4	86.0	4.8	1.8	100.0	0.0	203
Primary	4.7	11.5	77.3	7.1	4.0	100.0	0.5	399
Secondary	8.7	8.5	79.4	5.3	6.7	100.0	0.7	499
More than secondary	12.7	6.2	73.9	9.9	9.9	100.0	1.4	120
50-64	13.3	7.7	77.3	4.9	10.1	100.0	1.9	131
Total 35-64	6.7	9.1	79.3	6.3	5.3	100.0	0.6	1,221

Note: An individual is classified as having diabetes if he/she has fasting plasma glucose  $\geq 7$ mmol/L at time of survey, or he/she is currently taking medication to manage diabetes. The term diabetes as used in this table is not meant to be a clinical diagnosis of the disease, but rather to provide an indication of the disease burden in the population at the time of the survey

## 4.7 Domestic Violence

Information on women and men facing different types of domestic violence was collected for the first time in the 2013 Namibia DHS. For ethical reasons and to ensure confidentiality, only one woman per household, in the sub-sample of households *not* selected for the male survey, was selected to be interviewed with the domestic violence module. In the case of men, one man per household in the sub-sample of households selected for the male survey was administered the module. This ensured that no man or woman in the same household was asked questions on domestic violence. In this report the discussion of domestic violence is restricted to women only.

Table 21 shows that nearly one in three (32 percent) women age 15-49 years has ever experienced physical violence since age 15 years and 14 percent reported experiencing physical violence within the past 12 months. Among women who experienced physical violence in the past 12 months, 3 percent reported that the physical violence occurred often, while 11 percent experienced physical violence sometimes.

Women age 15-19 are more likely to have ever faced physical violence. Currently married as well as ever-married women are victims of more recent physical violence compared with single women, indicating some degree of intimate partner violence. Women who have 5 or more children and women who are not employed are more likely than their counterparts in the other categories to report physical violence in the past 12 months.

Violence is highest in Kavango, where one in three women reported recent physical violence. On the other hand, women in Omusati are least likely (5 percent) to report being physically abused in the past 12 months.

The proportion of women who have ever experienced physical violence in the recent past is highest among women with no education (25 percent). As women attain higher levels of education their experience of physical violence declines; 10 percent of women with higher than secondary education reported physical violence in the past 12 months.

**Table 21 Experience of physical violence**

Percentage of women age 15-49 who have ever experienced physical violence since age 15 and percentage who have experienced violence during the 12 months preceding the survey, by background characteristics, Namibia 2013

Background characteristic	Percentage who have ever experienced physical violence since age 15 <sup>1</sup>	Percentage who have experienced physical violence in the past 12 months			Number of women
		Often	Sometimes	Often or sometimes <sup>2</sup>	
<b>Age</b>					
15-19	31.5	1.9	14.0	16.0	426
20-24	35.3	3.5	10.2	13.7	401
25-29	28.5	4.3	8.8	13.1	365
30-39	31.9	2.9	10.8	13.7	605
40-49	30.1	3.1	9.1	12.3	429
<b>Residence</b>					
Urban	31.0	3.7	9.8	13.6	1,223
Rural	32.2	2.4	11.6	14.1	1,003
<b>Region</b>					
Zambezi	27.5	4.7	8.5	13.6	146
Erongo	27.0	1.8	11.5	13.3	266
Hardap	26.3	10.3	4.2	14.5	62
//Karas	41.0	3.5	14.4	17.8	80
Kavango	49.3	6.1	28.6	34.7	174
Khomas	32.7	4.7	8.7	13.4	450
Kunene	36.0	3.2	9.2	12.3	64
Ohangwena	30.5	1.6	5.3	6.9	207
Omaheke	42.4	3.5	19.4	22.9	50
Omusati	19.4	0.3	5.0	5.4	228
Oshana	28.2	1.9	9.0	10.9	187
Oshikoto	32.8	0.4	11.1	11.5	178
Otjozondjupa	33.5	3.4	12.3	15.7	134
<b>Marital status</b>					
Never married	26.3	1.4	6.9	8.4	1,263
Married/living together	36.6	4.8	15.7	20.6	841
Divorced/separated/widowed	50.3	8.9	13.9	23.2	122
<b>Number of living children</b>					
0	29.3	2.9	10.2	13.1	653
1-2	30.4	2.9	9.9	12.8	930
3-4	34.9	3.6	10.7	14.4	455
5+	36.6	3.6	15.7	19.3	188
<b>Employment</b>					
Employed for cash	31.3	3.4	9.0	12.4	982
Employed not for cash	34.0	0.6	8.8	9.4	81
Not employed	31.6	3.1	12.2	15.3	1,161
<b>Education</b>					
No education	42.8	6.8	18.2	25.0	92
Primary	34.0	3.9	14.3	18.2	456
Secondary	29.6	2.8	9.5	12.3	1,458
More than secondary	34.6	1.8	7.9	9.9	220
Total 15-49	31.5	3.1	10.6	13.8	2,226

<sup>1</sup> Includes violence in the past 12 months. For women who were married before age 15 and who reported physical violence by a spouse, the violence could have occurred before age 15. Total includes 1 women missing information on employment.

<sup>2</sup> Includes women for whom frequency in the past 12 months is not known.



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