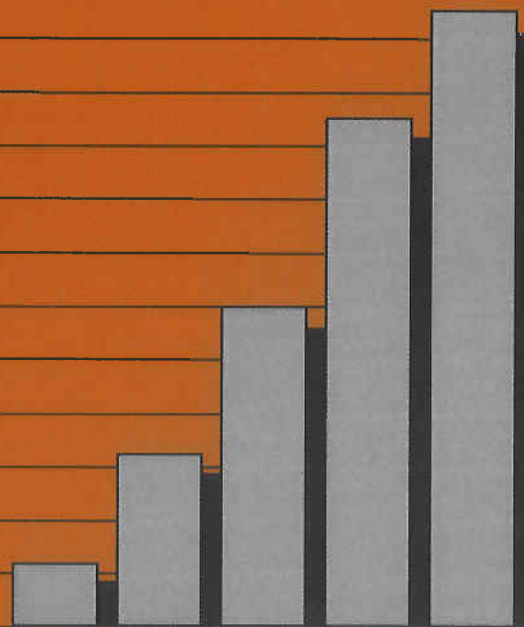


Nepal



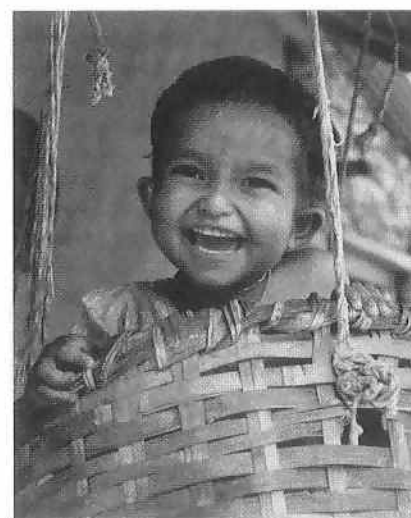
Family Health Survey 1996

SUMMARY REPORT

NEPAL FAMILY HEALTH SURVEY 1996

SUMMARY REPORT

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This report highlights the findings of the 1996 Nepal Family Health Survey (NFHS), conducted under the aegis of the Family Health Division, Department of Health Services, Ministry of Health, and implemented by New ERA, a local research firm. Funding for the survey was provided by the U.S. Agency for International Development (USAID) through its mission in Nepal. Macro International Inc. provided technical assistance under the Demographic and Health Surveys Project.

The 1996 Nepal Family Health Survey (NFHS) is part of the worldwide Demographic and Health Surveys (DHS) project. Information about the NFHS may be obtained from the Family Health Division, Department of Health Services, Ministry of Health, P.O.Box 2936, Teku, Kathmandu, Nepal (Telephone: 213541 or 212051 and Fax: 223142) and New ERA, P.O.Box 722, Maharajgunj, Kathmandu, Nepal (Telephone: 410803 or 413603 and Fax: 419562). Additional information about the DHS project may be obtained from Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (Telephone: 301-572-0200; Fax: 301-572-0999; E-mail: reports@macroint.com; Internet: <http://www.macroint.com/dhs/>).

Photographs: Pavalavalli Govindasamy

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Background

This report summarizes information from the 1996 Nepal Family Health Survey (NFHS). The NFHS is a nationally representative survey of 8,429 ever-married women age 15-49. The survey was fielded between January and June 1996. The NFHS is the fifth in a series of demographic and health surveys conducted in Nepal. The primary objective of the NFHS was to provide policy-makers and planners with detailed information on fertility, family planning, infant and child mortality, and maternal and child health, and nutrition. In addition, the NFHS collected information on women's knowledge of AIDS.

The NFHS was conducted under the aegis of the Family Health Division of the Department of Health Services in the Ministry of Health of His Majesty's Government of Nepal. Financial support came from the U.S. Agency for International Development (USAID) through its mission in Nepal. The survey was implemented by New ERA, a local research firm. Technical assistance was provided by Macro International Inc., through the USAID-funded Demographic and Health Surveys project.



Fertility

Levels and Trends in Fertility

At current fertility levels, a woman in Nepal will have an average of 4.6 children during her childbearing years. This rate represents a significant decline from the level of fertility reported in the mid-1970s when women were having an average of more than six births.

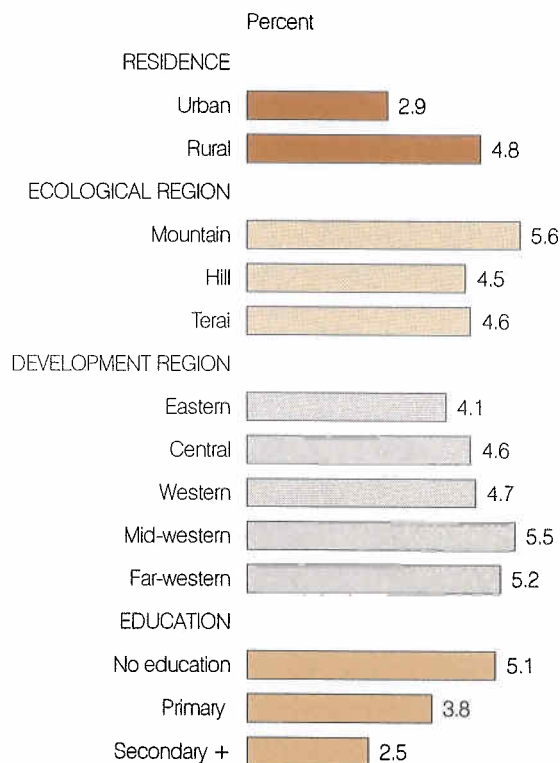
There are substantial differences in fertility among subgroups. Urban women (2.9 births per woman) have about two children less than rural women (4.8 births per woman), and women in the Hills and Terai (4.5 and 4.6 births per woman, respectively) have about one child less than women in the Mountains (5.6 births per woman). Within development regions, the highest fertility is observed in the Mid-western region of Nepal (5.5 births per woman), and the lowest in the Eastern region (4.1 births per woman).



There is a strong relationship between fertility and education. Fertility is lowest among women with some secondary education (2.5 births per woman) and highest among women who have never been to school (5.1 births per woman).

Urban women have about two children less than rural women, and women in the Hills and Terai have about one child less than women in the Mountains.

Figure 1
Total Fertility Rate by Background Characteristics



There are substantial differences in fertility among sub-groups. Women with no education have twice as many children as women with some secondary education.

Age at First Marriage

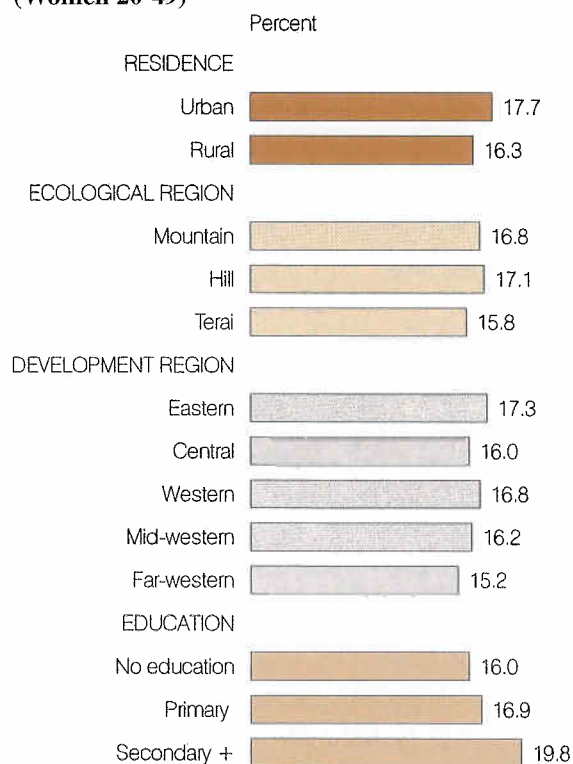
Fertility decline in Nepal has been influenced in part by a steady increase in the age at first marriage over the past 25 years. This trend towards later marriage is supported by the fact that the median age at first marriage has risen from 15.5 years among women age 45-49 to 17.1 years among women age 20-24, and the proportion of women married by age 15 has declined from 41 percent among women age 45-49 to 14 percent among women age 15-19.

Fertility differentials among subgroups are clearly influenced by differences in the average age at marriage. The urban-rural difference in age at marriage is just over one year; however, this difference is more pronounced among younger than older women. Urban women age 20-24 get married on average 2.4 years later than rural women in the same age group. Women from the *Terai* region marry earlier than women from the Hill and Mountain regions, and the Far-western region has the earliest age at marriage (15.2 years) while the Eastern region has the latest (17.3).



Education has a strong influence on the age at marriage. The median age at marriage among women with no formal education is 16.0 years compared with 19.8 years among those with some secondary education.

Figure 2
Median Age at First Marriage
(Women 20-49)



Rural women, women in the Terai, women in the Far-western region, and women with no education get married earlier than other women.

Adolescent Childbearing

Despite the trend towards later marriage, childbearing begins early for many Nepalese women. One in four women age 15-19 is already a mother or pregnant with her first child. Adolescent childbearing is more common among rural women (24 percent) than urban women (20 percent), among women residing in the *Terai* (31 percent) than in the Mountains (20 percent) and Hills (17 percent), and in the Central development region (29 percent) than in the other development regions.

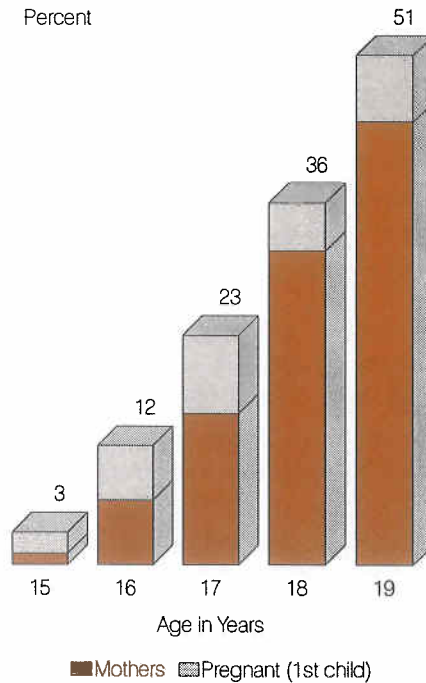
One in four women age 15-19 is already a mother or pregnant with her first child.

Short Birth Intervals

Closely spaced births are common with one in four births occurring within 24 months of a previous birth. The average interval between births varies little by place of residence but is significantly shorter among women age 15-19 and if the previous child died.

Short birth intervals are partly due to the relatively short period of insusceptibility, which averages 14 months, during which women are not exposed to the risk of pregnancy either because they are amenorrhoeic or abstaining. Mothers of the majority of births (57 percent) are susceptible to the risk of pregnancy by 12-13 months after birth.

Figure 3
Adolescents Who Are Mothers or Are Pregnant with Their First Child (Women 15-19)



Twenty-four percent of women in their teens have either given birth or are pregnant with their first child.



Fertility Preferences

Despite the decline in fertility, Nepalese women continue to have more children than they consider ideal. The total wanted fertility rate (2.9 births per woman) is about one and a half children less than the actual total fertility rate (4.6 births per woman).

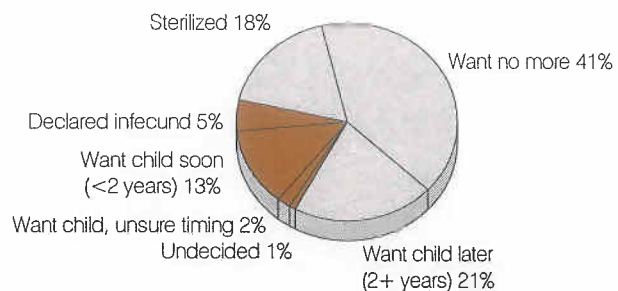
Unplanned and unwanted births are associated with increased mortality risks. More than half of all children born in the five years preceding the survey had an increased risk of dying because the mother was too young (under 18 years) or too old (over 34 years), or the birth was of order 3 and higher, or the birth occurred within 24 months of a previous birth.

Nevertheless, the percentage of women who want to stop childbearing has increased substantially over the last 15 years. Forty-one percent of currently married women age 15-49 state that they do not want any more children and an additional 18 percent are sterilized. Moreover, one in five women want to wait at least two years for their next child and only 13 percent want a child within two years.

The total wanted fertility rate is about one and a half children less than the actual total fertility rate.



Figure 4
Fertility Preferences
(Currently Married Women 15-49)



Four of five currently married women either want no more children or want to wait at least two years before having another child or are sterilized.

Family Planning

Knowledge and Use of Family Planning

Knowledge of family planning among Nepalese women is universal, with 98 percent of currently married women having heard of at least one method. Much of this knowledge comes from media exposure, with more than one of two ever-married women exposed to family planning messages on the radio and/or the television and one of four exposed to family planning messages in the print media. In addition, one of four women has heard at least one of three specific family planning programmes on the radio.

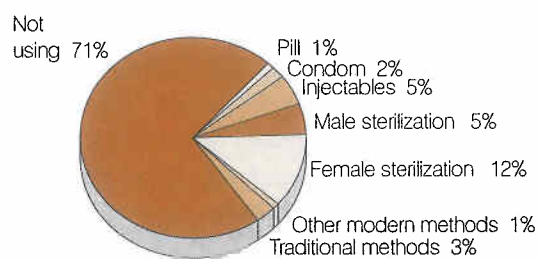
The use of family planning is widely approved in Nepal. Nine in 10 currently married women approve of couples using contraception. In addition, according to women, seven in 10 husbands approve of the use of family planning.

Despite widespread approval of family planning, only one in three (35 percent) currently married women has ever used a modern method of family planning and one in four (26 percent) is currently using a modern method.

The most widely used method is sterilization (18 percent, male and female combined), followed by injectables (5 percent).

Only one in three currently married women has ever used a modern method of family planning and one in four is currently using a modern method.

Figure 5
Current Use of Family Planning by Method
(Currently Married Women 15-49)



Sterilization (male and female) is the most widely used method among women who currently use a modern contraceptive method.



Trends and Differentials in Family Planning Use

Current use of modern contraceptive methods among currently married non-pregnant women rose nine-fold over the past 20 years, from 3 percent in 1976 to 29 percent in 1996. Although the use of modern methods has risen steadily over the last two decades, the percentage increase is lowest in the most recent years (1991-1996).

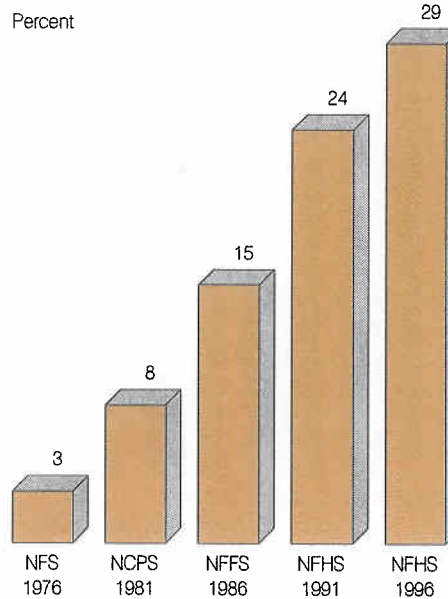
This is partly due to the decrease in the overall use of sterilization, from a high of 86 percent of modern methods in 1986 to 67 percent in 1996. While female sterilization increased by only 3 percent between 1986 and 1996, male sterilization declined by almost 50 percent over the same period. At the same time, the share of temporary methods has risen from 14 percent to 33 percent, with most of the increase attributable to the increased use of injectables.

There are marked differences in the level of family planning use by residence. The level of current use of contraception is nearly twice as high in urban areas (50 percent) as in rural areas (27 percent) and lowest in the Mountains (18 percent), compared with the Hills and Terai (30 percent and 29 percent, respectively).

Use of family planning increases directly with education. Women who have completed their School Leaving Certificate (SLC) are twice as likely to use contraception as women who have no formal education. In general, as women's education rises, so does the likelihood that they will use spacing methods.

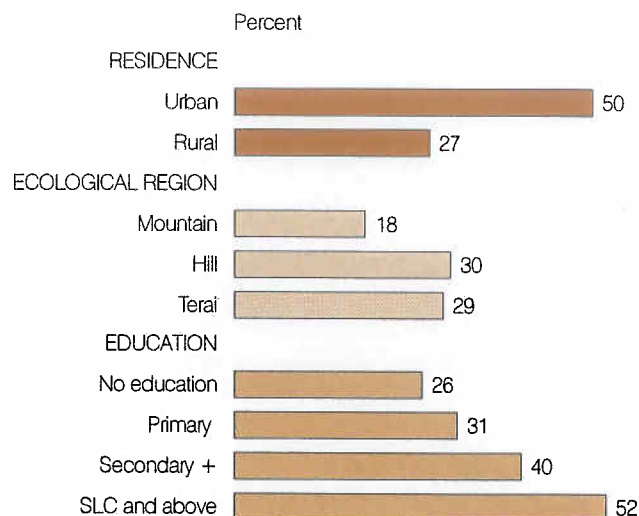
Current use of contraception is nearly twice as high in urban areas as in rural areas.

Figure 6
Current Use of Modern Contraceptive Methods
(Currently Married Non-pregnant Women 15-49)
Nepal, 1976-1996



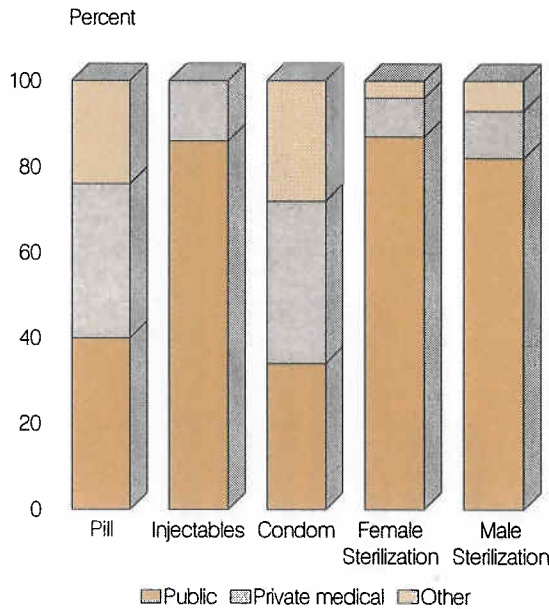
Contraceptive use rose nine-fold between 1976 and 1996; however, the percentage increase between 1991 and 1996 is the smallest.

Figure 7
Current Use of Family Planning by Background Characteristics
(Currently Married Women 15-49)



The highest levels of family planning use are found among urban women and women who have completed secondary school.

Figure 8
Distribution of Current Users of Selected Modern Methods by Source of Supply



Note: "Other" includes "don't know" and "missing"

The public sector is the major source of contraceptives for injectables and male and female sterilization, while the private sector is an important supplier of the pill and condoms.



Sources of Family Planning Services

The public sector is a major source of contraceptives: 79 percent of modern method users obtained their methods from a public source, especially hospitals and district clinics (32 percent) and mobile camps (28 percent). Sterilizations are mostly performed in public hospitals or district clinics, and injectables mostly given in health posts and sub-health posts. Both the public and private medical sectors are equally important sources of the pill and condoms, with pharmacies the leading suppliers.

Unmet Need for Family Planning

There is considerable potential for increased family planning use. One in three currently married Nepalese women has an unmet need for family planning, with 14 percent having an unmet need for spacing and 17 percent an unmet need for limiting. According to the survey, the family planning needs of only one in two women is being met. If all the family planning needs were met, the level of contraceptive use in Nepal would double from 29 percent to 60 percent.

Two of three women who have an unmet need for family planning are below age 35. Rural women, women who live in the Mountains and Hills, women who live in the Western and Far-western regions of Nepal, and women who have some primary education have a greater unmet need than other women.

If all the family planning needs were met, the level of contraceptive use in Nepal would double from 29 percent to 60 percent.

Child Health

Levels and Trends in Childhood Mortality

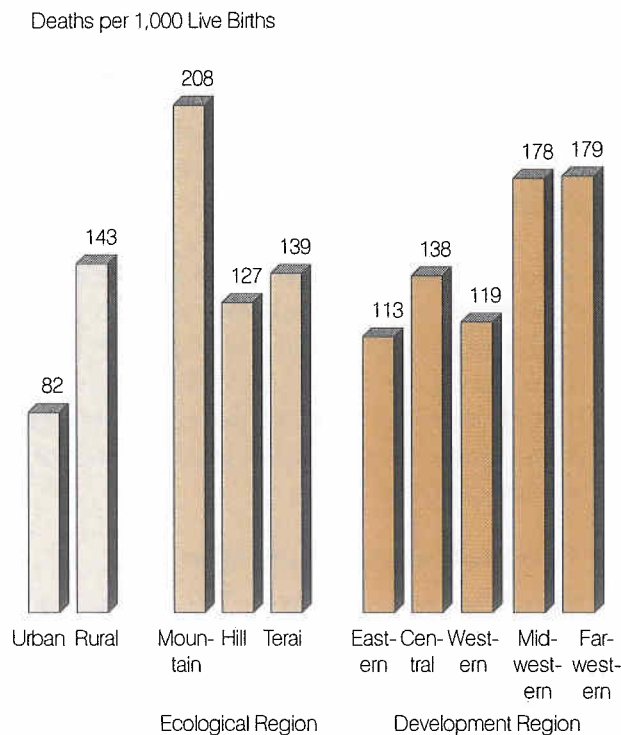
At current mortality levels, one in eight children born in Nepal will die before the fifth birthday, with two of three deaths occurring during the first year of life. Mortality is consistently lower in urban than in rural areas, with children in the Mountains faring worse than children living in the Hills and Terai. Mortality is also higher in the Far-western and Mid-western regions compared with other development regions.

Maternal education is strongly related to a child's risk of dying. Infant mortality is nearly twice as high among children of mothers with no education as among children of mothers with some secondary education. As expected, neonatal mortality is higher among males than females. However, child mortality is 24 percent higher among females than males. Higher mortality is also experienced by first births, higher order births, and births that occur within 24 months of a previous birth.

As indicated by the NFHS data, mortality levels have declined rapidly since the early 1980s. The current under-five mortality is 40 percent lower than it was 10-14 years before the survey. The pace of decline was somewhat faster for child mortality (45 percent) than infant mortality (38 percent).

At current mortality levels, one in eight children born in Nepal will die before the fifth birthday, with two of three deaths occurring during the first year of life.

Figure 9
Under-five Mortality by Place of Residence



Under-five mortality is high in rural areas, in the Mountains, and in the Mid-western and Far-western regions.



Immunization of Children

A primary means of improving child survival is expanding childhood vaccination coverage. Seventy-six percent of Nepalese children age 12-23 months have been vaccinated against tuberculosis, diphtheria, whooping cough and tetanus (DPT), and polio. However, coverage declines after the first dose for DPT and polio, with one in three children who start the series not completing it. Fifty-seven percent of children age 12-23 months are vaccinated against measles. Overall, only two of five children age 12-23 months are fully vaccinated, that is, received all three doses of DPT and polio, and were vaccinated against tuberculosis and measles.

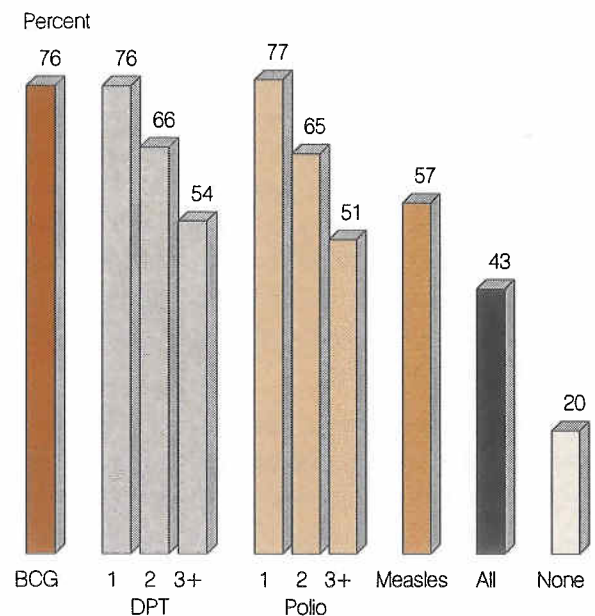
Treatment of Childhood Illnesses

Diarrhoeal and respiratory illnesses are common causes of childhood deaths in Nepal. However, use of a health facility to treat these illnesses is low. During the two weeks preceding the survey 28 percent of children suffered from diarrhoea and 34 percent were ill with a cough accompanied by short, rapid breathing (symptoms of acute respiratory infections or ARI). Only 14 percent of children with diarrhoea and 18 percent of children with symptoms of ARI were taken to a health facility.

Twenty-nine percent of children with diarrhea received oral rehydration therapy: 26 percent were treated with a solution prepared from oral rehydration salts (ORS), 4 percent were given recommended home fluids (RHF) such as breastmilk, and one in three was given increased fluids. Nevertheless, over one-third of children with diarrhoea did not receive any treatment at all.

Overall, only two out of five children age 12-23 months are fully vaccinated.

Figure 10
Vaccination Coverage
(Children 12-23 Months)



Note: Based on health card information and mothers' report

One in five children age 12-23 months has received no vaccinations against the five preventable childhood illnesses.



Breastfeeding

Breastfeeding is nearly universal in Nepal. The length of time children are breastfed is relatively long (an average of 28 months). However, a significant minority (40 percent) of children are not breastfed within one day of birth. Bottle feeding is rare in Nepal with less than 3 percent of children under three years being fed with a bottle with a nipple.

Even though exclusive breastfeeding is recommended until 4-6 months of age, 18 percent of children under four months are not exclusively breastfed. Complementary foods are introduced relatively early and one of three children age 4-5 months receives complementary foods other than plain water.

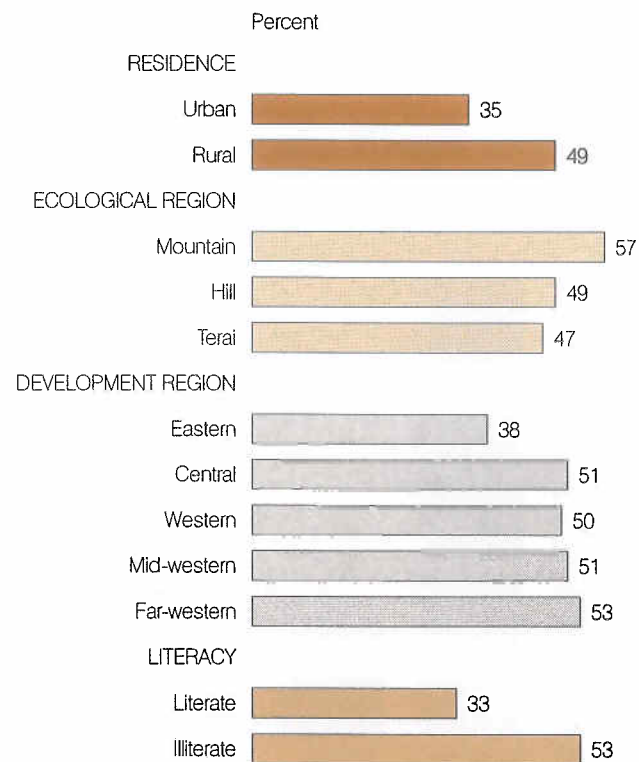
Children's Nutritional Status

The level of malnutrition among children is relatively high, with 48 percent of children under age three stunted, 11 percent wasted, and 47 percent underweight. There is considerable variation in children's nutritional status by place of residence, with rural children, children living in the Mountains, and children living in the Far-western region, more likely to be malnourished than other children.

The level of malnutrition among children is relatively high, with 48 percent of children under age three stunted, 11 percent wasted, and 47 percent underweight.



Figure 11
Prevalence of Stunting by Place of Residence and Literacy
(Children under Three Years)



Stunting, which reflects chronic malnutrition, is highest among rural children, children in the Mountains and the Far-western region, and children of illiterate mothers.

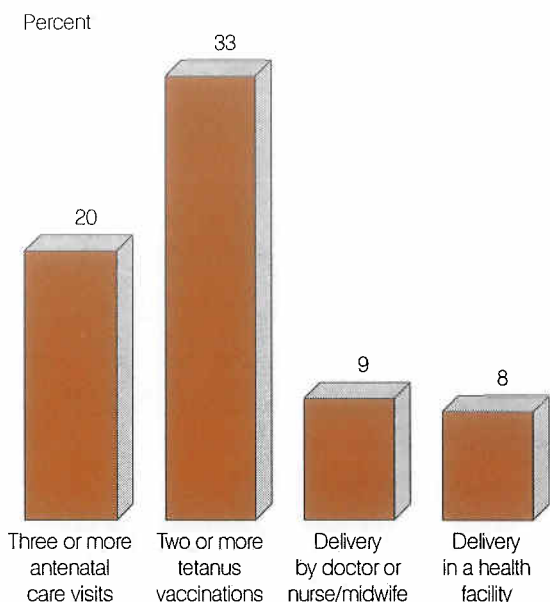
Women's Health and Well-being

Maternity Care Indicators

The care women receive during pregnancy and at delivery reduces the risk of illness or death for both mothers and children. For the majority of births (56 percent) in the three years preceding the survey, mothers did not receive any antenatal care. Antenatal care from a doctor was received for only 13 percent of births, and 11 percent of births received antenatal care from a nurse/midwife.

An important component of antenatal care is protection against tetanus. Mothers received two or more doses of tetanus toxoid for one-third of births in the three years preceding the survey, and one dose for 13 percent of births. Mothers did not receive a single dose for well over half of births.

Figure 12
Antenatal Care, Tetanus Coverage and Delivery Care
(Births in the Preceding Three Years)



Women receive regular antenatal care (three or more visits) for 20 percent of births and delivery care from a doctor or nurse/midwife for only 9 percent of births.

The majority of Nepalese children are born at home without assistance from trained medical personnel. Only 8 percent of births in the three years before the survey were delivered in a health facility and only 9 percent were delivered under the supervision of a doctor or nurse/midwife. Births in urban areas are seven times more likely to be delivered with the assistance of a doctor than births in rural areas, and more educated women and women living in the *Terai* and the Central Hill regions are more likely to have a medically-supervised delivery.

Fifteen percent of Nepalese mothers of children born in the three years before the survey are less than 145 centimetres tall, the height below which a woman is considered to be at nutritional risk. Furthermore, the level of chronic energy deficiency among mothers is high. More than one of four women are below the cutoff of 18.5 for the body mass index, a measure of thinness.



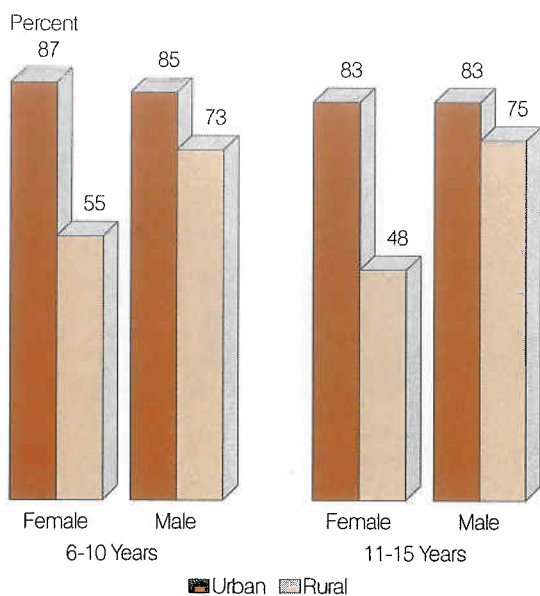
Maternal mortality is high relative to developed countries. Maternal deaths accounted for 27 percent of all deaths to women age 15-49 in the seven years preceding the survey. The maternal mortality ratio, which measures the obstetric risk associated with each live birth, is 5 deaths per 1,000 live births.

For the majority of births (56 percent) in the three years preceding the survey, mothers did not receive any antenatal care.

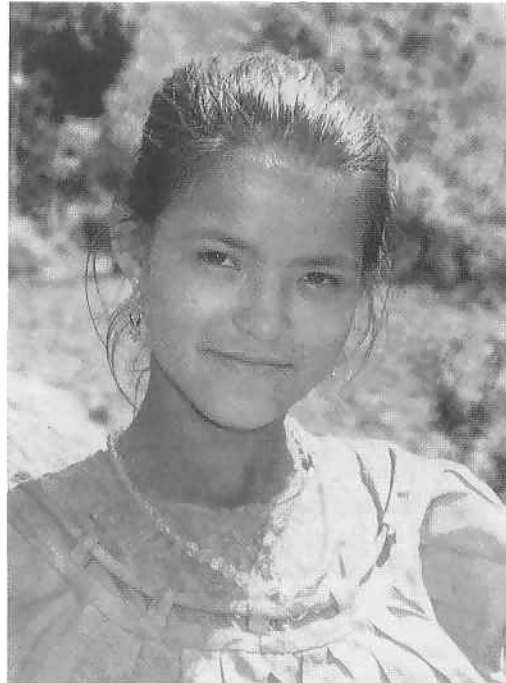
Women's Education

The vast majority (80 percent) of Nepalese women have never been to school. One in nine has attended primary school, 6 percent have some secondary education, and less than 3 percent have passed their SLC. Four of five women are illiterate.

Figure 13
School Enrolment by Sex and Residence
(Children 6-15 Years)



There are large differentials in school enrolment between boys and girls in rural areas.



There is a marked difference in women's educational attainment by place of residence. One in two urban women has no education compared with four in five rural women. Women residing in the Mountains are least likely to have any education compared with women in the Hills and *Terai*. Women living in the Western and Eastern regions are slightly more educated than women residing in the other regions of Nepal.

Nevertheless, there has been an improvement over time in the educational attainment of women. More than one of two girls currently attends school at least through the primary level. The enrolment drops substantially after age 15, to 19 percent at ages 16-20, and 4 percent at ages 21-24. The two principal reasons for leaving school among ever-married women age 15-24 was to get married and help in the family.

There are marked differences in education by urban-rural residence. Eighty-five percent of urban girls age 6-15 years are currently enrolled in school compared with 52 percent of rural girls. Overall, school enrolment is much higher among boys than girls; however, the gender-gap is non-existent in urban areas among children age less than 16.

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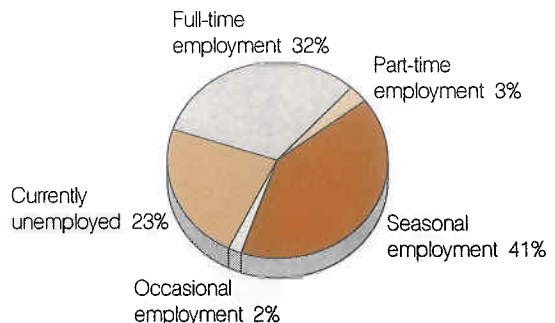
Women's Employment

About one-third of women are employed full-time, that is, working at least five days a week throughout the year. Nearly one-fourth were not employed at the time of the survey, and four in ten women are seasonally employed, reflecting the seriousness of the unemployment and underemployment problem among women in Nepal. Seven percent of women are self-employed, 9 percent work for someone else, and an overwhelming majority (84 percent) work for family members.

Only 13 percent of employed women receive cash earnings. More than 80 percent of women who earned cash reported that they decide how their earnings will be used, either jointly with the husband (42 percent) or alone (39 percent).

Nine of 10 women are engaged in the agricultural sector, with the majority working on their own land. Four percent work in sales or service, 3 percent are skilled manual workers, 2 percent are unskilled manual workers, and 2 percent are engaged in professional, technical, managerial or clerical occupations.

Figure 14
Employment Status
(Women 15-49)



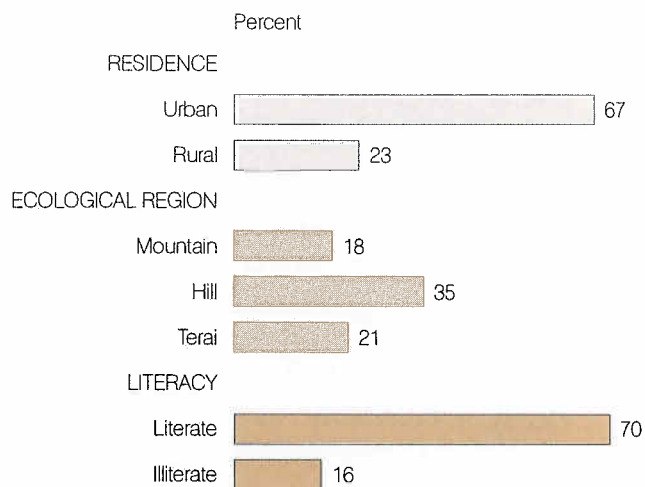
While about one-third of women are employed full-time, four in ten are seasonally employed.

Knowledge of AIDS

Knowledge of AIDS is very limited among ever-married women. Slightly more than one-fourth (27 percent) have heard of AIDS. Knowledge varies markedly by place of residence, with urban women three times more likely to have heard of AIDS than rural women. Thirty-five percent of women in the Hills have heard of AIDS compared with 21 percent of women in the Terai and 18 percent from the Mountains. Women from the Western development region are more knowledgeable about AIDS than women from the other regions, especially women in the Far-western development region. Knowledge also varies by level of education, with nine of ten women who have passed their SLC aware of AIDS compared with 17 percent of women with no education.

The major source of information on AIDS is the radio (79 percent), followed by friends and relatives (45 percent), and television (30 percent).

Figure 15
Knowledge of AIDS
(Women 15-49)



Women who live in urban areas and literate women are most likely to have heard of AIDS.

Half of those women who have heard of AIDS believe that limiting sex to one partner would help prevent the disease. Thirty-six percent and 31 percent believe that avoiding prostitutes, and using condoms during intercourse, respectively, are other ways to avoid the disease. One of five women who has heard of AIDS is unaware of how to avoid the disease, and one in ten has misconceptions about how the disease can be prevented.



Conclusions

Fertility and Family Planning

There has been a significant decline in fertility in Nepal since the mid-1970s. This decline is partly due to an increase in the use of modern contraceptives among currently married non-pregnant women from 3 percent in 1976 to 29 percent in 1996. A rising age at marriage has also contributed to this fertility decline.

Nevertheless, there continue to be serious challenges to maintaining the pace of fertility decline. Nepalese women have about one and a half children more than they consider ideal. Teenage marriage continues to be widespread and early childbearing is common particularly among rural women and women with little or no education. Moreover, the percentage increase in contraceptive use in the most recent period (1991-96) is very low. This is partly attributed to the decline in the use of male sterilization. Despite the increasing use of injectables, the overall use of spacing methods continues to be limited.

Contraceptive use is low in rural areas, in the Mountains and the Far-western region. Current use in rural areas is half that in urban areas. In a country that is predominantly rural, this poses a serious challenge. Fear of side effects appears to be an important reason for nonuse.

Women's and Children's Health

The survey results document improvements in a number of key areas pertaining to women's and children's health. The percentage of births for which mothers received antenatal care from a doctor or nurse/midwife increased from 15 percent in the period 1988-91 to 24 percent in the period 1994-96. Tetanus toxoid coverage has improved since 1991, when mothers received two or more doses for 27 percent of births, compared with 33 percent in 1996. The percentage of children age 12-23 months fully vaccinated increased from 37 percent in 1991 to 43 percent in 1996.



Despite these improvements, there continue to be a number of serious concerns regarding women's and children's health. For the majority of births (56 percent) mothers did not receive any antenatal care, and one of two women who did receive antenatal care had fewer than 3 visits. Likewise, for three of four births, mothers did not receive antenatal care from medical personnel, and for well over half of births mothers did not receive at least one dose of tetanus toxoid. The level of medical assistance received during delivery remains very low—6 percent of births were assisted by a doctor and 3 percent by a nurse/midwife. This is largely due to the fact that the majority of births (92 percent) are delivered at home.

Mortality levels continue to be high. Survey results indicate that one in eight children will die before the fifth birthday, with two of three deaths occurring during the first year of life. Vaccination coverage remains far from the goal of 90 percent coverage by the year 1995, and one of five children age 12-23 months has not received any vaccination at all. Use of a health facility for treating ARI and diarrhoea among children under three years of age is low: four of five children suffering from symptoms of ARI were not taken to a health facility; and one-third of children suffering from diarrhoea were not given any kind of treatment.

Although breastfeeding is universal, many children are given supplements too early. There is considerable chronic malnutrition among Nepalese children. One of two children under age three is stunted or underweight, and one of nine children is wasted.

Children of mothers with little or no education and children living in rural areas, in the Mountains, and in the Far-western region of the country are especially disadvantaged. Additionally, children of very young or older mothers, children of higher birth order, and children born too soon after an earlier birth face increased risk of illness and death.



Fact Sheet

1996 Population Data¹

Total population (millions)	23.2
Crude birth rate (per 1,000 population)	39.0
Crude death rate (per 1,000 population)	12.0

Nepal Family Health Survey 1996

Sample Population

Ever-married women age 15-49	8,429
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Background Characteristics of Women Interviewed

Percent urban	8.4
Percent with no education	80.0
Percent completed secondary school or higher	9.0

Marriage and Other Fertility Determinants

Percent of women 15-49 currently married	79.0
Percent of women 15-49 ever married	83.4
Median age at first marriage among women age 25-49	16.2
Median duration of breastfeeding (months) ²	31.0
Median duration of postpartum amenorrhoea (months) ²	10.3
Median duration of postpartum abstinence (months) ²	3.0

Fertility

Total fertility rate ³	4.6
Mean number of children ever born to women age 40-49	5.7

Desire for Children

Percent of currently married women who:	
Want no more children ⁴	58.8
Want to delay their next birth at least 2 years	20.6
Mean ideal number of children ⁵	2.9
Percent of births in the last 3 years that were:	
Unwanted	18.1
Mistimed	19.2

Knowledge and Use of Family Planning

Percent of currently married women who:	
Know any method	98.4
Know a modern method	98.3
Have ever used any method	38.4
Are currently using any method	28.5
Are currently using a modern method	26.0
Percent of currently married women currently using:	
Female sterilization	12.1
Male sterilization	5.4
Injectables	4.5
Condom	1.9
Pill	1.4
Norplant	0.4
IUD	0.3
Withdrawal	1.4
Periodic abstinence	0.9
Other methods	0.2

Mortality and Health

Infant mortality rate ⁶	79
Under-five mortality rate ⁶	118
Maternal mortality ratio ⁷	5
Percent of births ⁸ to mothers who:	
Received antenatal care from medical provider ⁹	39.3
Received 2 or more tetanus toxoid injections	32.6
Percent of births ⁸ to mothers who were assisted at delivery by:	
Doctor	5.8
Nurse/midwife	3.2
Maternal child health (MCH) worker	0.7
Other health professional ¹⁰	0.4
Traditional birth attendant	22.5
Relative/Other	56.4
Percent of children 0-3 months who are breastfeeding	99.5
Percent of children 10-11 months who are breastfeeding ...	100.0
Percent of children 0-3 months who are exclusively breastfeeding	81.8
Percent of children 12-23 months who received: ¹¹	
BCG	76.0
DPT (three doses)	53.5
Polio (three doses)	50.9
Measles	56.6
All vaccinations	43.3
Percent of children under 3 years:	
With diarrhoea who received oral rehydration therapy ¹²	28.6
With acute respiratory infection who were seen by medical personnel	18.2
Chronically malnourished (stunted) ¹³	48.4
Acutely malnourished (wasted) ¹³	11.2

¹ Source: 1996 World Population Data Sheet. Population Reference Bureau, Washington, D.C.

² Current status estimate based on births during the 36 months preceding the survey

³ Based on births to women 15-49 years during the period 1-36 months preceding the survey

⁴ Includes sterilized women

⁵ Excludes the 3 percent of women who gave a non-numeric response to ideal family size

⁶ Rates for the period 0-4 years preceding the survey (roughly 1992 to 1996); expressed as deaths per 1,000 live births

⁷ Ratio for the period 0-6 years preceding the survey, expressed as maternal deaths per 1,000 live births

⁸ Includes births in the period 0-35 months preceding the survey

⁹ Includes care received from doctor, nurse/midwife, village health worker (VHW), MCH worker, and other health professionals (health assistant, health post staff)

¹⁰ Includes VHW, health assistant and health post staff

¹¹ Based on information from vaccination cards and mothers' reports

¹² Includes use of a solution from commercially produced packets of oral rehydration salts (ORS) and breastfeeding

¹³ *Stunting* assessed by height-for-age, *wasting* assessed by weight-for-height; the percent malnourished are those below -2 SD from the median of the international reference population, as defined by the U.S. National Centre for Health Statistics, and recommended by the World Health Organization.