

Uganda

Demographic and Health Survey 2000-2001
Key Findings



This report highlights the findings of the 2000-2001 Uganda Demographic and Health Survey (UDHS), a nationally representative survey of households and of women age 15-49 and men age 15-54. Interviews were successfully conducted with 7,246 women age 15-49 and 1,962 men age 15-54. Information was also collected about children born to the women surveyed. Detailed questions about vaccination, breastfeeding, food supplementation, and illnesses were asked about children born in the 5 years before the survey.

The primary objective of the survey is to provide policymakers and programme managers with detailed information on fertility, family planning, childhood and adult mortality, maternal and child health, and nutrition, as well as knowledge and attitudes about HIV/AIDS.

The survey was fielded between September 28, 2000, and March 3, 2001. Survey results are presented at the national level; by urban and rural residence, and for each of four regions of the country. Results of this survey can be compared with those of the two previous Uganda DHS surveys, the 1988-89 UDHS and the 1995 UDHS. However, caution needs to be exercised in analysing trends on the basis of the three data sets, because of differences in their geographic coverage. In the 2000-2001 UDHS, all but four of Uganda's 45 districts¹ were included in the survey. The excluded districts were Bundibugyo, Gulu, Kasese and Kitgum.

The 2000-2001 Uganda Demographic and Health Survey (UDHS) was conducted by the Uganda Bureau of Statistics. Funding for the survey was provided by the U.S. Agency for International Development (USAID), the Department for International Development (DFID/Uganda), UNICEF/Uganda, and UNFPA/Uganda. The UDHS is part of the world wide Demographic and Health Surveys (DHS) project, which was designed to collect, analyse, and disseminate data on fertility, family planning, maternal and child health and HIV/AIDS.

Additional information about the survey may be obtained from the Uganda Bureau of Statistics (UBOS), P.O. Box 13, Entebbe, Uganda; telephone (256-41) 320-741; fax (256-41) 320-147; e-mail ubos@infocom.co.ug. Additional information about the DHS programme may be obtained by writing to MEASURE DHS+, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA; telephone 301-572-0200; fax 301-572-0999; e-mail: reports@macroint.com.

¹ The number of districts has since increased to 56. The newly formed districts are Kayunga and Wakiso in the Central Region; Kaberamaido, Mayuge, and Sironko in the Eastern Region; Pader, Nakapiripirit, and Yumbe in the Northern Region; and Kanungu, Kamwenge, and Kyenjojo in the Western Region.

2000-2001 DEMOGRAPHIC AND HEALTH SURVEY

KEY FINDINGS

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S. Poedjastoeti

How does fertility in Uganda compare to that in other countries?

According to findings from the 2000-2001 UDHS and data available from other DHS surveys, Uganda has the highest TFR of any nation in eastern and southern Africa.

Country/Year	TFR
Uganda 2000-2001	6.9
Malawi 2000	6.3
Zambia 1996	6.1
Eritrea 1995	6.1
Ethiopia 2000	5.9
Rwanda 2000	5.8
Tanzania 1999	5.6
Zimbabwe 1999	4.0
South Africa 1998	2.9

In comparison to countries outside this region for which comparable data are available, Uganda's level of fertility found in the recent survey is only lower than that of Niger 1998 (7.5 births per woman) and slightly higher than that of Burkina Faso 1999 (6.8), Mali 1996 (6.7), Chad (6.6), and Yemen 1997 (6.5).

FERTILITY

The 2000-2001 UDHS collected information on various fertility measures, which are presented to show the levels, patterns, and trends of current and completed fertility. Data were also collected on birth intervals and on the age at which women initiate marriage and childbearing. Information on current and completed fertility is useful in monitoring and evaluating the impact of the population programme in Uganda.

Levels and trends

On average, a Ugandan woman would have 6.9 children by the end of her reproductive years if the current fertility pattern prevailed. The UDHS results show that fertility in Uganda has remained stable over the past decade. Although the total fertility rate (TFR) declined from 7.3 births per woman in 1986-88 to 6.9 births in 1993-1995, the TFR has remained at the same level since then.

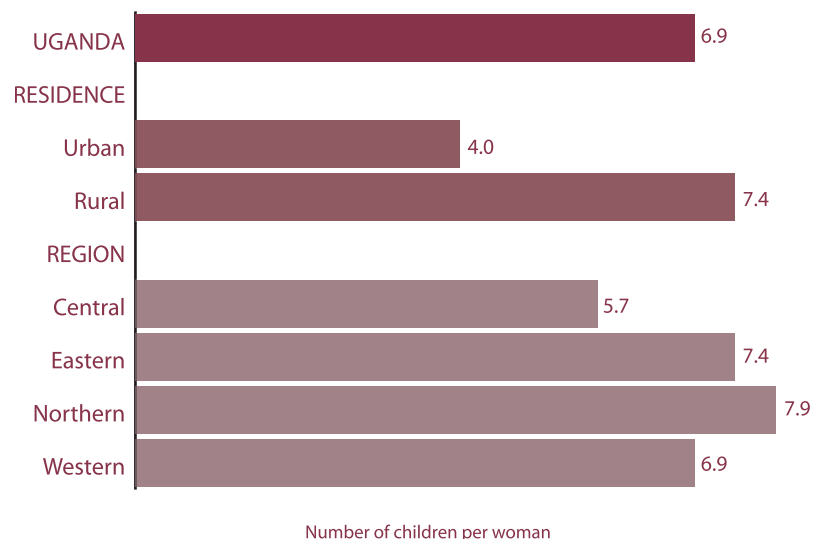
Fertility by background characteristics

Fertility levels vary according to residence and education. Rural women have much higher fertility than urban women (7.4 children compared with 4.0 children per woman). Total fertility rates are lowest in the Central Region (5.7 children per woman) and highest in the Northern Region (7.9 children per woman). Women who have received some secondary education have about four children fewer than women with no education (3.9 children compared with 7.8 children per woman). Sharper variations in the total fertility rate are shown by women's wealth. Whereas total fertility rate for women in the lowest quintile is 8.5 births per woman, for the highest quintile it is only 4.1 births per woman.

Adolescent fertility

Teenage pregnancy and motherhood have constituted a major health and social concern in Uganda, both because they are associ-

How does fertility vary by residence?



ated with higher morbidity and mortality for both the mother and the child and because teenage pregnancy often ends the education of the mother. Overall, 31 percent of teenagers have begun childbearing, with 26 percent being mothers and 6 percent being pregnant with their first child. That represents a notable decline from the 43 percent of teenagers who had begun childbearing observed in the 1995 UDHS.

Factors influencing fertility level

Besides the use of contraception, the fertility level is influenced by marriage, sexual activity, return of menstruation after childbirth, and sexual abstinence. Although the median age at first marriage for women age 25-49 is 17.8, the median age at first sexual intercourse for these women is 16.6, indicating that women generally start having sex about 1 year before they marry. Data from the 2000-2001 UDHS indicate no change in the pattern of initiation of sexual activity in the recent past.

In the absence of contraception, the exposure to the risk of pregnancy in the period after birth is determined by two major factors: the length of absence of menstruation after childbirth (postpartum amenorrhoea) which is highly dependent upon the extent of breastfeeding, and sexual abstinence. The 2000-2001 UDHS results show that the median duration of postpartum insusceptibility to pregnancy is 12 months, the same level as shown in the 1995 UDHS.

Polygynous unions

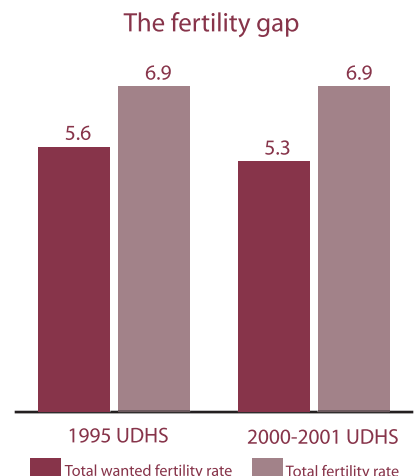
Overall, 32 percent of married women in Uganda are in a polygynous relationship. The percentage is slightly higher than that recorded in the 1995 UDHS (30 percent). In the 2000-2001 UDHS, two out of three women in polygamous unions had only one cowife (22 percent). As expected, older women are more likely to be in a polygynous marriage than younger women.



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Fertility Preferences

The desire to stop childbearing has doubled since 1988; the percentage of women saying that they wanted no more children or have been sterilised rose from 19 percent in 1988-1989 to 38 percent in 2000-2001. The total wanted fertility rate (a rate representing the level of fertility that would have prevailed in the three years preceding the survey if all unwanted births had been prevented) is 5.3 births per woman, a slight decline from 5.6 births in 1995. That finding means that if the desired fertility level were realised, the total fertility rate in Uganda would be 5.3 births per woman, 1.6 fewer births than the observed level. Yet another measure indicates a smaller desired family size in Uganda: the ideal family size among women declined from 5.3 children in 1995 to 4.8 children in 2000-2001. However, the continuing high level of fertility shows that many couples are not having success in achieving their desired family size.



How does family planning use in Uganda compare to that in other countries?

Comparing Uganda's CPR to the rates in selected countries in east and southern Africa for which DHS data are available shows Uganda's rate is only higher than that of Eritrea 1995 (8 percent), Ethiopia 2000 (8 percent) and Rwanda 2000 (13 percent). The CPR in Uganda is also higher than that found in Ghana 1998 (22 percent), Yemen 1997 (21 percent), the Comoros Islands 1996 (21 percent), Cameroon 1998 (19 percent), and Madagascar 1997 (19 percent).

Country/Year	CPR
South Africa 1998	56
Zimbabwe 1999	54
Tanzania 1999	25
Malawi 2000	31
Zambia 1996	26
Uganda 2000-2001	23
Rwanda 2000	13
Eritrea 1995	8
Ethiopia 2000	8



K. Stewart

FERTILITY REGULATION

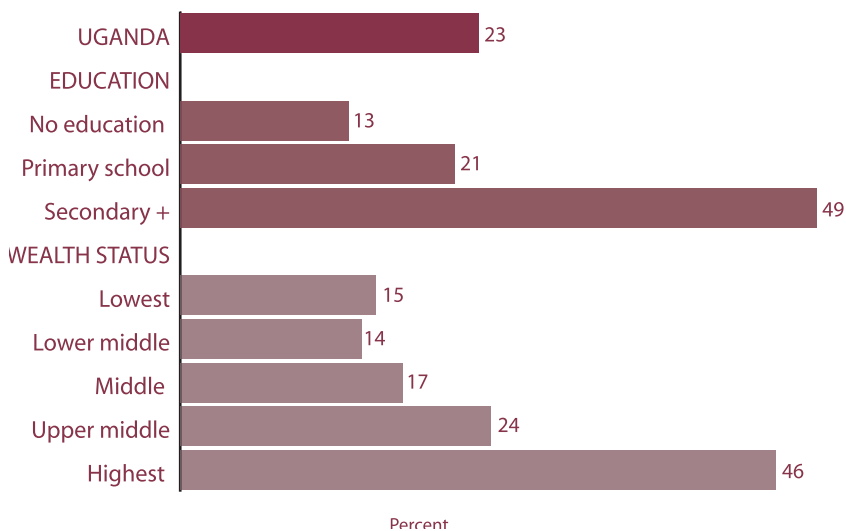
Data on various aspects of contraceptive knowledge, attitudes and behaviour of women and men are essential in assessing the progress of national policies on family planning. Finding out what steps couples have taken to control fertility will provide insights into how successful couples are in realising their reproductive goals.

Levels and trends

Knowledge of contraceptive methods in Uganda is nearly universal. The findings show that 96 percent of women age 15-49 and 98 percent of men age 15-54 knowing of at least one method of contraception.

The contraceptive prevalence rate (CPR) among currently married women age 15-49 has increased steadily from 5 percent in 1988-1989 to 15 percent in 1995 and 23 percent in 2000-2001. In 2000-2001, the majority of users (18 percent of currently married women) were using a modern method. There has been a shift in the contraceptive method mix since 1995: whereas in 1995 the most widely used methods were periodic abstinence, the pill, and injectables, in 2000-2001 the most commonly used methods were injectables (6 percent), lactational amenorrhoea (4 percent), and the pill (3 percent).

Use of contraception by education and wealth status



Family planning use by background characteristics

The survey found large differentials in contraceptive use by urban/rural residence and by region. Currently married urban women are much more likely to be using a contraceptive method than rural women (46 percent compared to 19 percent). Whereas 37 percent of currently married women in the Central Region use contraception, the percentage in the other regions ranges between 15 percent and 21 percent.

Use of family planning increases with a woman's education—from 13 percent among women with no formal education to 21 percent

among women with primary education to 49 percent among women with some secondary education. The wealth index is created using factor analysis to identify the most important variables to divide households in quintiles by socioeconomic status. Contraceptive use is positively associated with a woman's socioeconomic status; the rate of use is between 14 percent and 17 percent among women in the three lowest quintiles and 46 percent among women in the highest quintile.

Source of family planning services

Thirty-six percent of modern method users obtain their methods from a public (government) source, whereas private medical sources are reported by almost half of current users (46 percent). Other private sources supply 16 percent of modern contraceptive users. Within the public sector, hospitals and health centres are the most common sources (15 percent and 13 percent, respectively).



S. Poedjastoeti

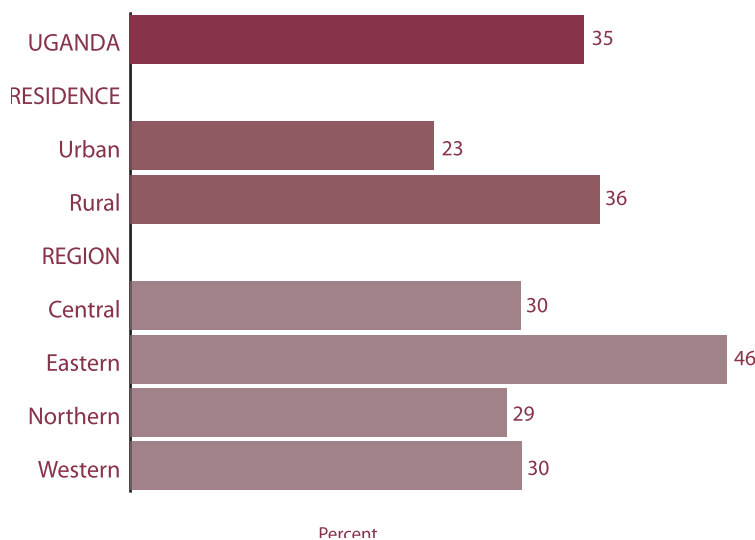
There has been a significant shift in sources of family planning supplies from those recorded in the 1995 UDHS; public sources declined from 47 percent to 36 percent, while private medical sources increased from 42 percent to 46 percent. Based on the 2000-2001 UDHS, more than half of condom users obtain their supply from a non-medical source such as a shop and friends or relatives, an increase from the 40 percent recorded in 1995. On the other hand, whereas 24 percent of condom users obtained condoms from the public sector in 1995, the corresponding proportion in 2000-2001 is only 9 percent.

Unmet need for family planning

Among currently married women, 35 percent have an unmet need for family planning services

(21 percent for spacing births and 14 percent for limiting them). If all the unmet need were satisfied, the contraceptive prevalence rate would rise from 23 percent to 57 percent of married women.

How does unmet need for family planning vary by residence?



Younger women are more likely to need family planning services for spacing than limiting children. On the other hand, older women are in need of family planning more for limiting than for spacing purposes. The level of unmet need for family planning is much higher in rural areas than in urban areas (36 percent and 23 percent, respectively). The unmet need for family planning services is highest in the Eastern Region (46 percent) and lowest in the Northern Region (29 percent). Better-educated women have the lowest level of unmet need.

MATERNAL AND CHILD HEALTH

Findings from the UDHS provide the basis for evaluating the utilisation of services and the implementation of appropriate strategies in improving the health of mothers and children. In particular, the UDHS provides information for gauging the success of the Ministry of Health's recommendations on antenatal care and postnatal care practices.



UNICEF

Antenatal care

Antenatal care is nearly universal in Uganda. Most women receive care from a medical professional: 83 percent from a nurse or a midwife and 9 percent from a doctor. The role of the traditional birth attendant in providing antenatal care is negligible (1 percent). The coverage of antenatal care from a trained provider (91 percent) has hardly changed since 1995.

Mothers in urban areas are three and a half times more likely than rural mothers to receive antenatal care from a doctor (26 percent and 7 percent, respectively). On the other hand, rural women are more likely than urban women

to receive antenatal care from a nurse or a midwife (85 percent and 71 percent, respectively). Seven out of 10 mothers used a public facility for antenatal care. The most commonly used facilities are government health centres (38 percent) and government hospitals (28 percent).

Delivery characteristics

The majority of births in Uganda were delivered at home (62 percent). Births to younger women and low-order births are more likely to be delivered in a health facility than births to older women and higher-order births. Delivery in a health facility is more common in urban than in rural areas (79 percent compared to 32 percent). Mothers with secondary education are more than three times as likely to deliver at a health facility than women with no education (72 percent 21 percent, respectively).

Seven out of 10 babies are not weighed at the time of birth. Among the babies weighed, 89 percent had a normal birth weight (2.5 kilograms or more).

Postnatal care

Postnatal care is important to the health of both the mother and her infant, particularly in the first 6 weeks after delivery (puerperium). The Ministry of Health recommends that mothers receive postnatal care when they bring their infants for immunisation. Although the Sexual and Reproductive Health Minimum Package recommends that mothers attend postnatal care during the first 6 weeks after delivery, the UDHS data show that postnatal care in Uganda for births which were delivered outside of a health facility is poor, with more than nine out of 10 women not receiving postnatal care. Among the mothers who do receive postnatal care, the majority receive care within 2 days of delivery.

The UDHS data shows that postnatal care for births which were delivered outside a health facility in Uganda is poor, with more than nine in ten women not receiving postnatal care.

Urban women, better-educated women, and women living in the Central and Eastern regions are more likely to receive postnatal care than other women.

Immunisation of children

The 2000-2001 UDHS data show only 37 percent of children age 12-23 months as having been fully immunised at any time before the survey. That represents a decline from the 47 percent recorded in 1995. The current survey shows that 29 percent of children are fully immunised by 12 months of age, as recommended.

Immunisation coverage is highest in the Western region; children in the Central region have the lowest coverage. Mother's education is associated with the chances of children being fully immunised. More than half (51 percent) of the children of mothers with secondary education have been fully immunised, compared to only 28 percent of the children of mothers with no education.



UNICEF/G. Pirozzi

Treatment of childhood diseases

Twenty-three percent of children under the age of 5 are reported to have had symptoms of acute respiratory infection (ARI) in the 2 weeks preceding the survey. The highest prevalence of ARI was found among children age 6-11 months (33 percent). The prevalence of ARI decreases with age to 14 percent among children age 48-59 months. Two out of three of children with symptoms of ARI were taken to a health facility for treatment.

Twenty percent of children less than 5 years old had had diarrhoea in the 2 weeks preceding the survey. The prevalence of diarrhoea was highest among children age 6-11 months (38 percent). The risk of diarrhoea decreases as a child grows— diarrhoea prevalence is lowest among children 48-59 months (8 percent). Fewer than half of children who had had diarrhoea in the 2 weeks preceding the survey were taken to a health facility for treatment (45 percent). More than half of children with diarrhoea (53 percent) were treated with either oral rehydration solution (ORS), recommended home fluid, or increased fluid in general.

The 2000-2001 UDHS data show that feeding practices of children with diarrhoea in Uganda are inconsistent with recommended interventions. Only 28 percent of children with diarrhoea were given more fluid than usual, whereas 31 percent were given the same amount of fluid as usual. Furthermore, four out of 10 children with diarrhoea were given either a lower amount of fluids or none at all.

NUTRITIONAL STATUS

The 2000-2001 UDHS looks at several key indicators of the nutritional status of children, women, and men, including patterns of infant feeding practices, anthropometric measurements, prevalence of anaemia, vitamin-A deficiency and supplementation, and iodisation of salt.

Infant feeding practices

Breastfeeding in Uganda is almost universal, with 98 percent of children having been breastfed at some time. The proportion is high across all residential areas, and it varies little by subgroups of children.

In Uganda, infant feeding supplementation starts late, which is consistent with World Health Organisation (WHO) recommendations. Only one out of four children age 2-3 months receives anything other than breast milk and water-based liquids, and two out of three children younger than 6 months of age are exclusively breastfed.

Micronutrients

The government of Uganda set a goal of reaching 90 percent coverage of households having iodised salt by the year 2000. To evaluate this program, UDHS interviewers tested salt from each household for its iodine content. The tests indicate that the goal has been met and passed, with 95 percent of households for which the salt test was performed using adequately iodised salt (15 or more parts per million).

Overall, 58 percent of children under 3 years of age were reported to have received vitamin-A-rich foods in the 7 days preceding the survey. Consumption of vitamin-A-rich foods is highest in the Eastern Region and lowest in the Western Region.

Children's nutritional status

In the UDHS, two kinds of anthropometric measurements were taken for children under 5 years of age. They are weight and height (for children age 24 months and older) or recumbent length (for children under 24 months of age). Physical growth indices, height-for-age, weight-for-height and weight-for-age, are calculated to describe children's nutritional status in comparison to a standard schedule developed by the U.S. National Center for Health Statistics (NCHS). Children whose height-for-age is more than two standard deviations below (-2 SD) the median of the NCHS reference population are considered short for their age, or "stunted." Children whose weight-for-age is below (-2 SD) the median of the reference population are considered "wasted" or too thin for their height. Children whose weight-for-age is below (-2SD) the median of the reference population are classified as "underweight."

In Uganda, four out of 10 children below 5 years of age are stunted. Stunting is higher among children in the rural areas, in the Western Region, and among children whose mothers have had no education. Wasting affects 4 percent of children under 5 years of age. Twenty-three percent of children under the age of 5 are underweight, which reflects either stunting or wasting or a combination of the two. The figures show that there has been little reduction in the levels of malnutrition since 1995.



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Women's nutritional status

In the 2000-2001 UDHS, mother's nutritional status is measured using two indices, height and body mass index (BMI). The mean height of mothers measured in the 2000-2001 UDHS was 158 centimetres, with only 2 percent of women shorter than 145 centimetres.

BMI is derived by dividing the weight in kilograms (kg) by a person's squared height in metres (m²). A cut-off point of 18.5 kg/m² has been recommended for defining chronic undernutrition. The mean BMI among nonpregnant mothers in Uganda is 21.9, which lies within the normal range (18.5 to 24.9). One out of 10 women in Uganda has a BMI below the recommended level of 18.5 and may be regarded as having a chronic nutritional deficit.

Prevalence of anaemia

The level of haemoglobin concentration in the blood is used as an indicator of the prevalence of anaemia. Levels of anaemia can be classified as severe, moderate, or mild, depending on the haemoglobin concentration in the blood and according to criteria developed by the WHO. Severe anaemia is diagnosed when the haemoglobin concentration is less than 7.0 grams per decilitre (g/dl); moderate anaemia is diagnosed when the haemoglobin concentration is 7.0-9.9 g/dl; mild anaemia is diagnosed when the haemoglobin concentration is 10.0-11.9 g/dl (10.0-10.9 g/dl for pregnant women).

In the 2000-2001 UDHS, the level of haemoglobin was measured by means of the HemoCue photometer machine. The test results show that 64 percent of children all under age 5 are anaemic and 7 percent are severely anaemic. Anaemia is common among children 6-15 months old, rural children, children in the Eastern and Northern regions, children of women with no education, and children in the lowest quintile in terms of wealth status.

Three out of 10 women age 15-49 are anaemic. Twenty-two percent have mild anaemia, 8 percent have moderate anaemia, and less than one percent are severely anaemic. Anaemia is more prevalent among women living in rural areas, women who have given birth, women with no education, and women living in the Eastern Region.

The criterion used to classify the prevalence of anaemia in men is different from that used to classify women and children. A man is considered to be anaemic if the haemoglobin level in his blood is less than 13 grams per decilitre. In general, men are much less likely to suffer from anaemia than women or children. The overall level of anaemia among men is 18 percent. As is the case with women and children, urban men and better-educated men are less likely to be anaemic than other men. Variations across regions are slight.

Vitamin-A Deficiency

For the 2000-2001 UDHS, blood samples were taken from women 15-49 and from children under 5 years of age to be tested for level of vitamin A level. The data show that 28 percent of Ugandan children age 6-59 months suffer from vitamin-A deficiency (VAD). At this level of VAD, Uganda can be said to have a severe public health problem.

VAD is lower among children 6-11 months of age, who are still benefiting from the positive effect of breastfeeding. The highest VAD is found among children 12-23 months (32 percent). VAD is more likely to be found among high-order births, people living in rural areas, and residents of the Northern Region.

More than half of the women in Uganda suffer from VAD. The deficiency level varies according to women's characteristics, but not as much as it does among young children.



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MORTALITY

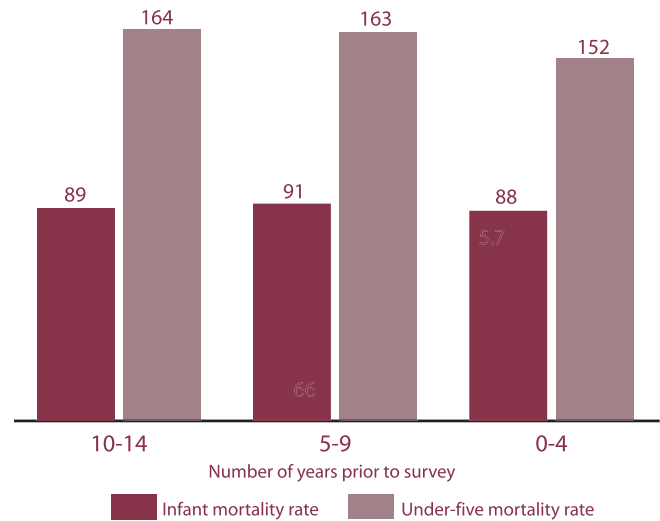
Identifying subgroups of children most vulnerable to mortality risks is necessary for improving their chances of survival and lowering young children's exposure to risks. Information on adult mortality risks over time is helpful for assessing the health condition of the population as a whole.

Infant and child mortality

For the period between 1996 and 2000, the under-5 mortality rate is estimated at 152 deaths per 1,000 live births; the infant mortality rate was 88 deaths per 1,000 live births.

The mortality level of children in urban areas is considerably lower than that of rural children; under-5 mortality was 101 deaths per 1,000 live births in the urban areas but 163 in the rural areas. Children in the Central and Eastern regions have a lower mortality level than those in the other regions—135 to 147 deaths per 1,000 live births compared to 176 or more deaths per 1,000 live births. Children born to mothers with secondary education have the lowest mortality. Children whose mothers have had no education have twice as high a risk of dying before age 5 as those whose mothers have secondary education (187 and 93 deaths per 1,000 live births, respectively).

Trend in infant and under-five mortality



S. Poedjastoeti

Adult mortality

During the period 0 to 9 years before the survey, females had the same mortality risk as males (nine deaths per 1,000 population, for both). Comparison with the estimate from the 1995 UDHS reveals that the situation has not improved in the past 5 years.

Maternal mortality

Maternal mortality represents a fraction of adult female mortality and was defined in the survey as female deaths either during pregnancy, during childbirth, or within 2 months of giving birth. The overall maternal mortality rate for the period 0 to 9 years before the survey was found to be 120 per

100,000 woman-years of exposure. The maternal mortality ratio (MMR) estimated from the 2000-2001 UDHS is 505 deaths per 100,000 live births. There has been no improvement since the 1995 UDHS.

HIV/AIDS AWARENESS AND PRACTICE

In Uganda, HIV/AIDS has been termed a “household disease,” because nearly every household has lost a relative or friend to the disease. In response to the epidemic, a network of collaboration among governmental agencies, development partners, non-government organisations (NGOs), religious groups, individuals, cultural groups, community groups, research institutions, and networks of persons infected and affected by HIV/AIDS has been developed.

HIV/AIDS awareness and practices

Although knowledge of AIDS is universal in Uganda, the level of awareness about the disease is not matched by knowledge of ways to avoid contracting the virus. About half of the female respondents cited the use of condoms, abstaining from sexual relations, and having only one sexual partner. Men are more likely to cite using condom and abstaining from sexual relations but less likely to mention limiting the number of sexual partners.

Most men and women in Uganda know that HIV can be transmitted from mother to child. However, only 58 percent of women know that HIV can be transmitted during pregnancy, 69 percent know about transmission during delivery, and 46 percent know about transmission during breastfeeding.

Prevalence of sexually transmitted infections

Eight percent of women and 3 percent of men report having had a sexually transmitted infection (STI) in the 12 months preceding the survey. However, 17 percent of women and 6 percent of men report having had either an STI and/or symptoms of STIs such as an abnormal discharge and genital sore or ulcer. Given the low level of knowledge about symptoms of STIs, many people may have STIs without knowing it. Therefore, the true level of prevalence of STIs may be higher than the reported one. The rate for women in 2000-2001 is higher than in 1995 (4 percent), but the rate for men is lower than in 1995 (6 percent).

HIV/AIDS testing

Eight percent of women and 12 percent of men reported having been tested for HIV. Women in their 20s and men age 25-39 are the most likely to have had the test. Respondents living in urban areas, in the Central Region, and in Kampala district, and respondents with secondary education, are much more likely to have undergone HIV testing.

A desire to be tested is high among both women and men in Uganda. One-quarter of women and one-fifth of men say they would like an HIV test. With small differences across subgroups of women and men, nine out of 10 of people who were tested knew their HIV status.



S. Poedjastoeti

FACT SHEET

2000 Population Data (Projection)

Total population (thousands)	2,210
Urban population (percent)	16
Annual natural increase (percent)	2.5
Population doubling time (years)	27.6
Crude birth rate (per 1,000 population)	52
Crude death rate (per 1,000 population)	17
Life expectancy at birth male (years)	45.7
Life expectancy at birth female (years)	50.5

2000-2001 Uganda Demographic and Health Survey

Sample Population

Women age 15-49	7,246
Men age 15-54	1,962

Background Characteristics of Women

Percent urban	17
Percent with no education	22
Percent attended secondary or higher	18

Fertility

Total fertility rate ¹	6.9
Mean number of children ever born to women age 40-49	7.1

Use of Family Planning

Percent of currently married women using:	
- Any method	23
- Any modern method	18
- Traditional and folk methods	5

Mortality

Infant mortality rate ²	88
Under-five mortality rate ²	152
Adult mortality ²	
Male	9
Female	8
Maternal mortality ratio ³	505

Health

Percent of last births ⁴ whose mothers:	
- Received antenatal care from a medical professional	92

- Received 2 or more tetanus toxoid injections	42
Percent of births whose mothers were assisted at delivery by:	
- medical provider	39
- non-medical provider	46
- no one	15
Percent of children 0-5 months who are exclusively breastfed	63
Percent of children 12-23 months who received ⁵	
- BCG	79
- DPT (three doses)	46
- Polio (three doses)	54
- Measles	57
- All vaccinations	37
Percent of children under 5 years who in the two weeks preceding the survey:	
- had diarrhoea	20
- had a cough accompanied by rapid breathing	23
- had fever	44

Nutrition

Percent of children under 5 years who:	
- are stunted	39
- are wasted	4
- are anaemic	64
Percent of women 15-49 who:	
- are shorter than 145 cm	2
- have a BMI ⁶ less than 18.5	10
- are anaemic	30
Vitamin A deficiency among:	
- children 6-59 months	28
- women 15-49	52

¹ Based on births to women 15-49 years during the period 0-2 years preceding the survey

² Rates are per 1,000 live births, and for the period 0-4 years preceding the survey (1996 to 2000)

³ Rate is per 100,000 live births, and for the period 0-9 preceding the survey (1990 to 2000)

⁴ Figure includes births in the period 1-59 months preceding the survey

⁵ Based on information from vaccination records and mothers' reports

⁶ BMI is derived by dividing the weight in kilograms (kg) by the square height in metres (m²)

