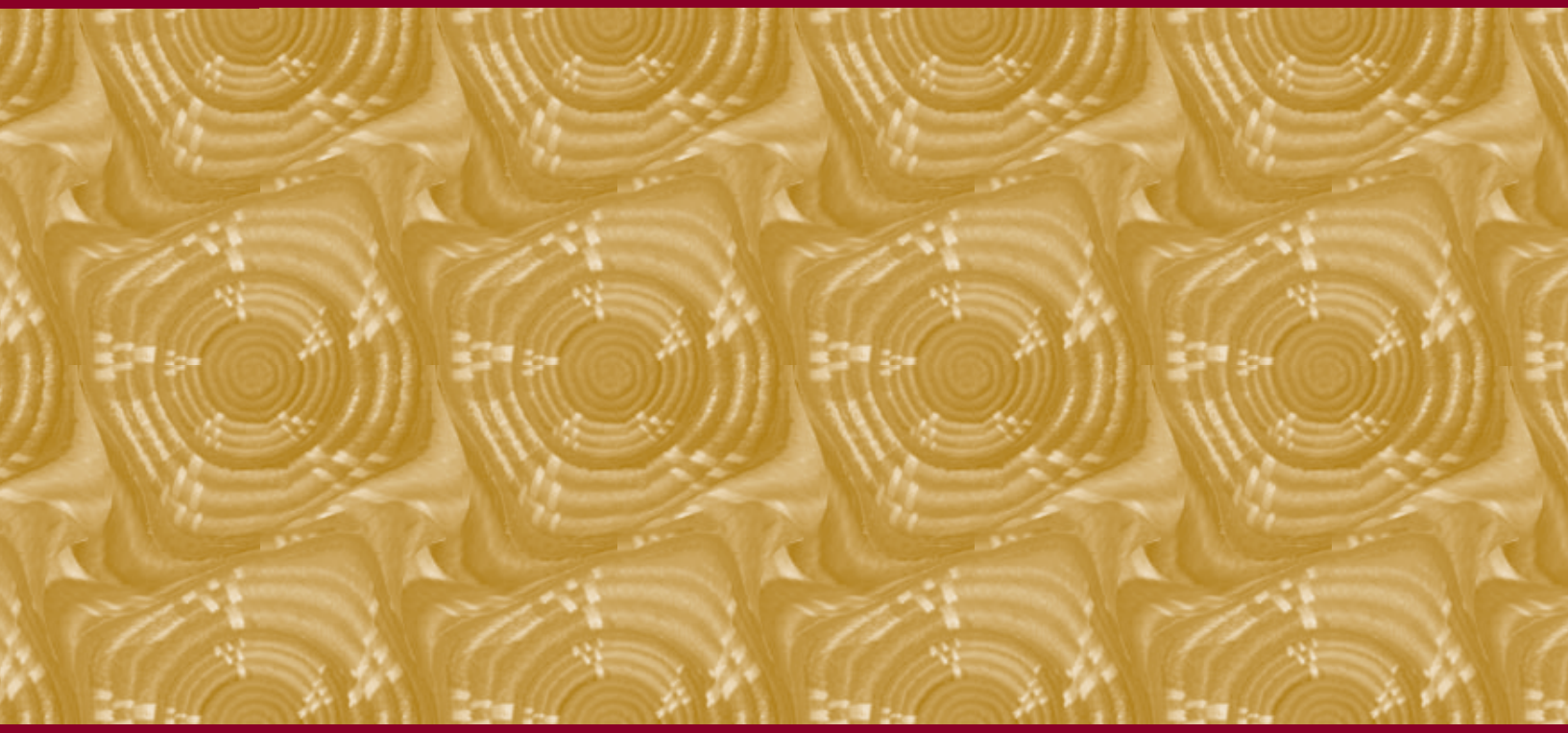
Eritrea



Demographic and Health Survey

2002

World Summit for Children Indicators

World Summit for Children Indicators by zoba, Eritrea 2002

			Zoba					
		Total	Debubawi Keih Bahri	Maekel	Semenawi Keih Bahri	Anseba	Gash-Barka	Debub
Childhood mortality	Infant mortality rate (per 1,000 live births)	48	122	39	77	37	66	58
	Under-five mortality rate (per 1,000 live births)	93	187	60	154	73	123	111
Childhood undernutrition	Percent stunted (children under 5 years)	37.6	37.4	23.0	41.9	40.5	44.8	38.7
	Percent wasted (children under 5 years)	12.6	13.8	6.1	18.0	15.6	16.9	9.8
	Percent underweight (children under 5 years)	39.6	41.1	23.4	51.2	46.7	49.6	34.6
Clean water supply	Percent of households within 15 minutes of safe water supply[1]	67.4	83.7	91.5	62.6	56.3	70.3	51.9
Sanitary excreta disposal	Percent of households with flush toilet, pit toilet/latrine[2]	25.6	56.7	58.4	24.1	19.2	10.3	10.0
Basic education	Proportion entering primary school[3]	14.4	14.4	39.5	9.2	9.5	7.7	9.4
	Net primary school attendance rate[3]	61.2	52.7	87.5	42.7	53.3	40.4	71.1
Children in especially difficult situations	Percent of children who do not live with either biological parent[3]	5.7	6.6	6.6	4.3	5.3	5.4	5.9
	Percent of children with at least one parent dead[3]	9.8	12.0	11.7	9.8	8.1	12.2	8.0
	Percent of children age 10-14 that are working	2.2	9.9	0.8	2.2	1.4	4.3	1.7
Family planning	Contraceptive prevalence rate (any method, currently married women)	8.0	7.1	19.6	5.1	4.4	1.9	7.9
	Contraceptive prevalence rate (any method, all women)	5.8	6.2	10.5	4.0	3.2	1.8	5.7
Antenatal care	Percent of women who received antenatal care from a health professional[4]	70.4	68.0	89.1	74.1	68.6	64.0	62.1
Delivery care	Percent of births in the 5 years preceding the survey attended by a health professional	28.3	41.9	71.9	22.5	15.4	11.0	20.5
Low birth weight	Percent of births in the 5 years preceding the survey at low birth weight[5]	11.3	17.1	9.8	16.4	12.4	7.5	4.8
Iodized salt intake	Percent of households that use iodized salt[6]	68.0	51.0	79.1	48.7	70.2	57.1	75.6
Vitamin A supplements	Percent of children age 6-59 months who received a vitamin A dose in the 6 months preceding the survey	38.0	22.1	51.7	36.0	37.3	32.2	35.8
	Percent of women age 15-49 who received a vitamin A dose in the 2 months after delivery[4]	13.4	10.7	25.8	12.7	12.7	11.4	8.0
Night blindness	Percent of women age 15-49 who suffered from night blindness during pregnancy[4, 7]	11.6	19.2	3.4	11.9	9.9	13.7	15.4
Exclusive breastfeeding	Percent of children under 6 months who are exclusively breastfed	52.0	26.1	55.7	44.9	58.3	48.8	54.4
Continued breastfeeding	Percent of all children age 12-15 months still breastfeeding	91.0	77.3	(85.6)	89.3	90.3	91.6	97.6
	Percent of all children age 20-23 months still breastfeeding	58.0	(28.5)	(58.7)	(54.9)	53.4	(65.2)	60.8

(Continued on inside back cover)

World Summit for Children Indicators (Continued from inside front cover)

			Zoba					
		Total	Debubawi Keih Bahri	Maekel	Semenawi Keih Bahri	Anseba	Gash-Barka	Debub
Timely complementary feeding	Percent of children age 6-9 months receiving breast milk and complementary foods	42.5	28.2	62.5	38.3	39.9	34.4	42.8
Vaccinations	Percent of children whose mothers received at least 2 tetanus toxoid vaccinations[4]	34.6	50.0	40.7	37.1	34.6	32.7	29.3
	Percent of children age 12-23 months with at least 3 DPT vaccinations	82.8	76.5	95.0	78.8	94.8	73.5	75.8
	Percent of children age 12-23 months with at least 3 polio vaccinations	83.3	75.6	91.9	79.8	93.0	75.6	79.0
	Percent of children age 12-23 months with measles vaccination	84.2	70.2	96.1	80.3	93.8	75.7	78.7
	Percent of children age 12-23 months with BCG vaccination	91.4	90.8	97.9	89.1	97.9	87.1	86.8
Diarrhea control	Percent of children with diarrhea in preceding 2 weeks who received ORS or RHF	55.7	47.1	75.8	64.4	51.3	57.7	47.1
Home management of diarrhea	Percent of children age 0-59 months with diarrhea in the past 2 weeks who took more fluids than usual and continued eating somewhat less, the same, or more food	30.4	27.1	41.3	29.4	39.9	42.5	20.1
Treatment of ARI	Percent of children age 0-59 months with acute respiratory infection (ARI) in past 2 weeks who were taken to a health facility or provider	43.6	41.1	61.5	40.3	32.7	57.2	36.0
Malaria control	Percent of children age 0-59 months who slept under an insecticide-treated mosquito net on the previous night[8]	4.2	2.1	0.7	8.1	4.5	3.0	5.4
	Percent of children age 0-59 months with fever in the past 2 weeks who were treated with antimalarial drugs	3.6	0.0	5.8	0.7	4.4	5.6	2.8
HIV/AIDS	Percent of women age 15-49 who correctly state two ways of avoiding HIV infection[9]	51.5	46.3	71.2	29.2	42.4	31.0	61.3
	Percent of women age 15-49 who correctly identify two misconceptions about AIDS[10]	46.3	36.5	72.4	30.8	42.3	24.2	45.9
	Percent of women age 15-49 who believe that AIDS can be transmitted from mother to child during pregnancy, delivery, and breastfeeding	60.2	57.8	63.7	54.1	65.9	44.1	67.7

Note: Figures in parentheses are based on 25-49 unweighted cases.
[1] Piped water or protected well water from covered well or tanker
[2] In household or shared with others
[3] Based on de jure children
[4] For the last live birth in the five years preceding the survey
[5] For children without a reported birth weight, the proportion with low birth weight is assumed to be the same as the proportion with low birth weight in each birth size category among children who have a reported birth weight
[6] 15 parts per million or more
[7] Includes women who report night blindness and difficulty with vision during the day
[8] Mosquito net bought or treated with insecticide within 6 months before the interview
[9] Having sex with only one partner who has no other partners and using a condom every time they have sex
[10] They said that AIDS cannot be transmitted through mosquito bites and that a healthy-looking person can have the AIDS virus

Eritrea
Demographic and Health Survey
2002

National Statistics and Evaluation Office
Asmara, Eritrea

ORC Macro
Calverton, Maryland, USA

May 2003

National Statistics and
Evaluation Office

ORC Macro

This report summarizes the findings of the 2002 Eritrea Demographic and Health Survey (EDHS) carried out by the National Statistics and Evaluation Office. Financial support for the survey was provided by the U.S. Agency for International Development (USAID) and the Ministry of Health through the Technical Assistance and Support Contract (TASC) with John Snow, Inc. ORC Macro provided technical assistance for the survey through the USAID-funded MEASURE *DHS*+ project, which is designed to assist developing countries to collect data on fertility, family planning, and maternal and child health. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

Additional information about the EDHS may be obtained from the National Statistics and Evaluation Office P.O. Box 5838, Asmara, Eritrea (telephone: 291-1-202940/119507; e-mail: seo12@eol.com.er). Additional information about the MEASURE *DHS*+ project may be obtained by contacting: MEASURE *DHS*+, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999; e-mail: reports@orcmacro.com; internet: www.measuredhs.com).

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PREFACE

The 2002 Eritrea Demographic and Health Survey (EDHS) is the second National Demographic and Health Survey (DHS) in the series that started in 1995. The National Statistics and Evaluation Office (NSEO), Office of the President conducted the survey under the aegis of the Ministry of Health (MOH). ORC Macro furnished technical assistance to the survey as part of the MEASURE *DHS*+ program, while funding was provided by the U.S Agency for International Development (USAID). The United Nations Population Fund (UNFPA) and the Canada International Development Agency (CIDA) supported the survey by supplying 20 field vehicles. The fieldwork for the 2002 EDHS was carried out between the last week of March and the first week of July 2002.

The major objective of this survey, similar to the first survey, was to collect and analyze data on fertility, mortality, family planning, and health. Compared with the 1995 EDHS, the present survey was expanded in scope to include a malaria module and questions on gender issues. Moreover, geographic coordinates were taken for the selected sample points to allow analysis based on the geographic information system (GIS). Thus, the 2002 EDHS will not only update the information from the 1995 EDHS, but also will provide findings on some new topics of interest.

The findings of the 2002 EDHS presented in this report provide up-to-date and reliable information on a number of key topics of interest to planners, policymakers, program managers, and researchers that will guide the planning, implementation, monitoring, and evaluation of population and health programs in Eritrea. In addition to the estimates at the national level, estimates for key indicators relating to fertility, mortality, and health are provided for all six zobas and for urban and rural areas.

The 2002 EDHS results present evidence of a decline in fertility and early childhood mortality as well as a substantial increase in the level of child immunization coverage since the 1995 EDHS survey. Knowledge of HIV/AIDS remains high in Eritrea. There is, however, still a wide gap between knowledge and use of family planning.

The National Statistics and Evaluation Office (NSEO) acknowledges the efforts of a number of organizations and individuals who contributed immensely to the successful completion of the 2002 EDHS and the timely publication of this report. NSEO is particularly thankful to USAID for funding the survey, to ORC Macro for providing technical assistance, and to UNFPA and CIDA for supporting field vehicles. The office would like to express its gratitude to the Ministry of Health (MOH) for close cooperation in the whole operation and for their significant technical and logistical inputs. The office is grateful for the endeavors of government officials at all levels of administration that supported the survey. High appreciation and commendation go to all the 2002 EDHS field personnel for commitment to high-quality work in difficult working conditions. We acknowledge with gratitude the NSEO staff, who made the survey successful through commitment and a spirit of team work. Last but not least, special gratitude goes to all of the respondents who generously gave their valuable time to provide information that forms the basis of this report

Dr. Georgis Teclemichael
National Statistics and Evaluation Office (Head)
May 2003

SUMMARY OF FINDINGS

The 2002 Eritrea Demographic and Health Survey (2002 EDHS) is a nationally representative sample survey covering 9,389 households and 8,754 women age 15-49.

The survey provides up-to-date information on fertility, early childhood mortality, fertility preferences, knowledge and use of family planning, maternal and child health and nutrition, awareness and behavior regarding HIV/AIDS and other sexually transmitted infections, malaria control program indicators, and female genital cutting (female circumcision). It was designed as follow-on to the 1995 EDHS survey. As most of the information collected in the two surveys is similar, it is possible to examine trends in the different indicators over the intervening period of six and a half years. The major findings are considered at the national level, by urban-rural residence, and by region (the six zobas).

The National Statistics and Evaluation Office (NSEO) was responsible for implementing the survey. Fourteen survey teams conducted interviews from the last week of March to the first week of July 2002.

FERTILITY

Fertility Trends: Fertility has declined sharply since 1995; the total fertility rate has dropped from 6.1 children per woman to 4.8 children, a decline of 21 percent. Because of this decline, at current fertility levels, the average Eritrean woman will give birth to five children instead of six children by the end of her reproductive years. The decline is more rapid among rural women and younger women (below age 35), and is most notable among adolescents (15-19).

Fertility Differentials: Similar to the pattern that exists in all sub-Saharan countries, fertility among urban women in Eritrea is substantially lower than fertility among rural women. The total fertility rate among rural women is 5.7 children per women, compared with 3.2 children in urban areas. By zoba, fertility ranges from a high of 5.7 children per woman in zoba Debub to a low of 3.4 children in zoba Maekel.

Fertility levels are related to various socioeconomic characteristics of women. Education, for example, has a negative relationship with fertility. The total fertility rate decreases from 5.5 children among women with no education to 3.1 children among women who have at least some secondary education.

Birth Intervals: The length of interval between births influences overall fertility, as well as the health status of mother and child. The interval between births in Eritrea has increased from 31.3 months in 1995 to 33.6 months in 2002. The optimal interval between births is at least 36 months. In Eritrea, 43 percent of births occur with the optimal birth interval, compared with 35 percent in 1995.

Nuptiality: Women's age at marriage has been increasing. For example, the proportion of women age 15-19 still single has increased from 62 percent in1995, to 69 percent in 2002. In 1995, almost six in ten women were married by age 18, compared with less than half in 2002. These results indicate that the rising age at marriage is an important factor in fertility decline in Ertirea. The proportion of never-married women who reported that they had sex in the year before the survey is less than 3 percent.

Childbearing at Young Ages: Fourteen percent of adolescent women (15-19) are either already mothers (11 percent) or are currently pregnant with their first child (3 percent). The rate for adolescent women has declined substantially since 1995 (23 percent). The decline is mainly attributable to lower teenage childbearing among rural women. In 1995, one in three rural teenagers had started childbearing, compared with one in five in 2002, a decline of more than 40 percent.

Unplanned Fertility: The 2002 EDHS data indicate that one-fourth of all births in the five years preceding the survey were unplanned; 6 percent were unwanted and 20 percent were mistimed (wanted later). The proportion of mistimed births has increased from 14 percent in the 1995 EDHS to 20 percent in 2002, while the proportion of unwanted births increased only slightly from 5 percent to 6 percent. If all births associated with unwanted pregnancy were avoided, the total fertility rate in Eritrea would be 4.4 children per woman, which is roughly one-half child lower than the observed total fertility rate.

Ideal Family Size: Eritrean women want to have large families; the mean ideal number of children for all women is 5.8. Overall, only one in ten women wants less than four children, while more than one-fourth want seven or more. One in ten women considers 10 or more children to be the ideal family size.

FAMILY PLANNING

Knowledge of Family Planning Methods: Almost nine in ten women know of at least one modern method of family planning. The pill, male condoms, and injectables are the most widely known modern methods among all subgroups. Knowledge of family planning methods has increased since 1995. The mean number of methods known by all women increased by almost two methods from 2.6 in 1995 to 4.4. in 2002.

Mass media are important sources of information on family planning. A majority of women (55 percent) heard or saw a family planning message on the radio, on television, in a newspaper/ magazine, or on a poster in the 12 months before the survey. Half of all women have heard a family planning message on the radio, which is the major medium for all subgroups. Women's exposure to all other media is much lower. Nineteen percent of women reported seeing a family planning message on television, and the same proportion saw a family planning message on a poster. Only 16 percent saw a family planning message in newspapers or magazines.

Trends in Contraceptive Use: Contraceptive use remains low in Eritrea; there has been no increase since 1995. The 2002 EDHS results show that only 8 percent of currently married women reported using contraception at the time of the survey, with 5 percent depending on modern methods and 3 percent relying on traditional methods. Currently, the most widely used methods among married women are injectables (3 percent), lactational amenorrhea method (LAM) (2 percent), and the pill (1 percent).

Differentials in Family Planning Use: There are marked differences by background characteristics in current use of family planning methods among currently married women. Urban women are more than four times as likely to use a method of contraception as rural women (17 versus 4 percent). Among zobas, use of contraception is highest in zoba Maekel (20 percent) and lowest in zoba Gash-Barka (2 percent). One-fifth of women with some secondary education reported using a method, compared with only 4 percent of women with no education.

Source of Family Planning Methods: The survey results show that public facilities remain the major source for modern contraceptive methods in Eritrea, providing family planning methods to nearly three-fourths (74 percent) of current users. Fifteen percent of users get their methods from private medical sources, and 8 percent get their methods from other private sources (mainly shops).

As in 1995, three-fourth of pill users and more than 90 percent of users of injectables rely on the public sector. The Family Reproductive Health Association of Eritrea (previously the Planned Parenthood Federation of Eritrea) remains the major source for pills, while government hospitals are the predominant source for injectables users.

Unmet Need for Family Planning: Currently married women who either do not want any more children or want to wait two or more years before having another child, and are not using contraception, are considered to have an unmet need for family planning. The total unmet need for family planning in Eritrea is 27 percent — 21 percent for

spacing and 6 percent for limiting births. Because unmet need has remained unchanged since 1995, no progress has been made in satisfying women's need for family planning. Among currently married women, less than one-fourth of the total demand for family planning is being satisfied.

CHILD HEALTH AND SURVIVAL

Early Childhood Mortality: The 2002 EDHS data indicate that early childhood mortality in Eritrea has declined sharply since 1995. The infant mortality rate has declined from 72 per 1000 live births in the 1995 EDHS survey (1991-1995) to 48 in the 2002 EDHS survey (1997-2001). The under-five mortality rate was 136 per 1000 live births in the period 1991-1995, compared with 93 per 1000 for the period 1997-2001. Factors that have contributed to the decline in child mortality are increasing urbanization, major gains in child immunization, improved nutrition and increasing education among women.

Marked differentials in early childhood mortality exist in Eritrea. Infant mortality ranges from a low of 37 deaths per 1,000 live births in zoba Anseba to a high of 122 in zoba Debubawi Keih Bahri. Living in rural areas, low maternal education, and young age of mothers at birth are factors associated with higher infant and childhood mortality.

Vaccination Coverage: The 2002 EDHS results show that three-fourths of children age 12-23 months are fully vacinated. This represents a substantial increase from the 41 percent fully vaccinated in 1995. Although urban children are more likely to be fully vaccinated, the urban-rural gap has narrowed. It is encouraging to note that the proportion of fully vaccinated children among uneducated mothers has doubled since 1995. Zoba Anseba (92 percent) has the highest proportion of children fully immunized and zoba Debubawi Keih Bahri has the lowest (60 percent).

Childhood Illnesses: The survey provides data on some of the more common childhood illnesses and their treatment. One in five children under five had a cough accompanied by short, rapid breathing—signs of acute respiratory infection (ARI)—in the two weeks before the survey. Of these, 44 percent were taken to a health facility for treatment. Thirteen percent of children under age five were reported to had experienced diarrhea some time in the two weeks preceding the survey. Overall, more than two-thirds of these children received some type of oral rehydration therapy, i.e., solution prepared from packets of oral rehydration salts (ORS), homemade sugar-salt water solution, or increased fluids. Although almost all mothers who had a birth in the five years preceding the survey reported knowing about ORS packets, only 45 percent of children with diarrhea received ORS.

Breastfeeding Practices: The 2002 EDHS data indicate that almost all children under one year of age are breastfed. Despite the universal prevalence of breastfeeding of newborns in Eritrea, the majority of infants are not fed in compliance with WHO/UNICEF recommendations. Exclusive breastfeeding is common but not universal in early infancy in Eritrea. The prevalence of exclusive breastfeeding would be higher except for the early supplementation of breast milk with plain water. Overall, the median duration of any breastfeeding is 22 months; the median duration of exclusive breastfeeding is 2.5 months.

Patterns of Feeding in Early Childhood: During the period when complementary foods should be introduced, at age 6-9 months, only 54 percent of Eritrean infants in this age group received solid or semi-solid foods the day and night preceding the survey and the variety of foods given was limited. These children mainly received foods made from grain and milk, (cheese or yogurt), and to a lesser extent received animal products (meats, poultry, fish, or eggs), and fruits and vegetables, and infant formula.

Micronutrient Supplements: The 2002 EDHS data show that only 38 percent of children age 6-59 months received a vitamin A supplement in the six months preceding the survey. The survey also measured the iodine content of salt used in the household. The results show that over two-thirds (68 percent) of children under age five live in households that use adequately iodized salt.

Nutritional Status of Children: Overall, 38 percent of children under age five are chronically

malnourished or stunted (short for their age), 13 percent are wasted (thin for their height), and 40 percent are underweight (low weight-for-age). Rural children are more than one and a half times as likely to be stunted and wasted as urban children. Among zobas, malnutrition is more prevalent in Gash-Barka, Anseba, and Semenawi Keih Bahri than in other zobas. The prevalence of severe malnutrition among children in these zobas is also higher than in other zobas. A comparison of children under three years in 1995 and 2002 indicates a slight improvement in the nutritional status.

WOMEN'S HEALTH

Maternal Health: The 2002 EDHS findings indicate that there has been a substantial improvement in antenatal care coverage since 1995. Seven in ten women with births in the five years before the survey received antenatal care services for the last birth from a health professional (doctor, trained nurse, midwife or auxiliary midwife), compared with only half of mothers in 1995. Forty-one percent of women with a birth in the five years preceding the survey had four or more antenatal care visit, though only 22 percent made the first visit in the first trimester. Half of women who had a live birth in the five years preceding the survey received at least one tetanus toxoid injection during pregnancy for the most recent birth; 32 percent received multivitamin or vitamin C tablets. Four in ten mothers received iron tablets for the last birth in the five years preceding the survey but almost all took the tablets for less than 60 days.

Delivery under hygienic conditions and where medical assistance is available decreases the risk of maternal morbidity and mortality. Overall, one-fourth of births—compared with 17 percent in 1995—occurred in health facilities, almost all of them public facilities. More than nine in ten women with deliveries outside health facilities do not receive any postnatal checkup.

Three percent of births in the five years preceding the survey were delivered by caesarean section (C-section), indicating a slight increase from 1995. A C-section rate below 5 percent is generally thought to be a reflection of limited access to maternal health services and potentially life-saving emergency obstetrical care.

Female Genital Cutting: Results from the 2002 EDHS show that knowledge of female circumcision is universal among Eritrean women, with almost all respondents (99 percent) having heard of female genital cutting. Nine in ten women (89 percent) reported that they had been circumcised, indicating a slight decline in the proportion of women circumcised in 1995 (95 percent). Among circumcised women, 39 percent had their vaginal area sewn closed (the most severe form of circumcision), 4 percent had some flesh removed, and 46 percent were nicked and no flesh was removed. Younger women (age 15-19) are less likely to be circumcised than older women. Sixty-three percent of women with living daughters indicated that at least one daughter was circumcised.

Attitudes of Eritrean women toward female circumcision are evenly divided: the proportion of women who support continuation of the practice is the same as the proportion who want it to be discontinued (49 percent). As expected, women who are not circumcised are more likely to want the practice discontinued (86 percent) than those who are circumcised (44 percent). Seven percent of circumcised women say they have had problems during sexual relations; one in ten reported having problems during delivery and one in twenty-five reported problems during both sexual relations and delivery.

Constraints to Use of Health Services: Many different factors can be barriers to women seeking health care for themselves. Seventy-two percent of women reported at least one issue or circumstance they regarded as a big problem in seeking health care. The major constraints to women's access to health services are lack of money, distance to health facilities, and having to take transportation. Almost four in ten women mentioned the problem of waiting in line at the health facility as a big problem. Eleven percent of women in Eritrea do not know where to go for health care.

Nutritional Status of Women: The 2002 EDHS collected information on the height and weight of

all women age 15-49. Overall, 2 percent of women are shorter than 145 cm, the cutoff point below which a woman is identified as at risk of delivering a baby with low birth weight. The findings also indicate that more than half of women age 15-49 have a body mass index (BMI)—a measure of a woman's weight relative to her height—in the normal range, and 37 percent have a low BMI (less than 18.5), indicating chronic energy deficiency. Rural women and women with no education are more likely to have a low BMI than urban women and women with some education. In addition, 9 percent of Eritrean women are overweight, including 2 percent that are severely overweight or obese.

WOMEN'S CHARACTERISTICS AND STATUS

Residence and Education: Almost six in ten (57 percent) of the survey respondents live in rural areas. Over half of women age six and over have never been to school.

Women's Migration: More than half of women in Eritrea can be considered migrants because they are not living in the area in which they were born.

Women's Status and Empowerment: Only one in five women is currently working. Two-thirds (65 percent) of these women work for cash. Nearly three-fourths (73 percent) of working women who receive cash earnings report that they are solely responsible for decisions on the use of their earnings.

To assess women's attitudes toward wife beating, women interviewed in the EDHS were asked whether a husband would be justified in beating his wife for specific reasons. Seven in ten women believe that a husband is justified in beating his wife for at least one of the reasons.

MALARIA CONTROL PROGRAM INDICATORS

Mosquito nets: The use of insecticide-treated mosquito nets has been proven to reduce malaria transmission. The 2002 EDHS found that 34 percent of households owned at least one mosquito net. Possession of mosquito nets is more common in rural areas (37 percent) than urban areas (28 percent), but it is most common in small towns (45 percent). Mosquito nets are least prevalent in zoba Maekel, where malaria prevalence is low.

Women: Seven percent of all women and pregnant women slept under a mosquito net the night before the interview; however, only 3 percent used an insecticide-treated net. Use of antimalarials by pregnant women is low. Only five percent of women who had at least one birth in the five years preceding the survey reported that they received antimalarial treatment for the last birth.

Children: Twelve percent of children under five slept under a mosquito net the night before the interview. However, only 4 percent of children under five slept under an insecticide-treated net. (Note: the survey was conducted in the dry season, when mosquito net use is lower than average).

Fever is a major manifestation of malaria in children. Thirty percent of children under five had a fever in the two weeks preceding the survey. Fever was most prevalent among children age 6-23 months. Among febrile children, only 4 percent were treated with antimalarial medication, mostly chloroquine.

HIV/AIDS AND OTHER STIs

Knowledge of HIV/AIDS and Prevention Methods: The 2002 EDHS results indicate that awareness of HIV/AIDS is nearly universal among women in Eritrea, with 96 percent of women reporting that they have heard of AIDS. The ways to prevent HIV/AIDS mentioned most frequently by respondents were staying faithful to one partner (72 percent), using condoms (54 percent), and abstaining (47 percent). Almost eight in ten women know two or more programmatically important ways to avoid getting infected with HIV.

Knowledge of ways that HIV can be transmitted is important in preventing the spread of the disease. More than seven in ten women recognize that the HIV virus can be transmitted from mother to child during pregnancy (80 percent),

during delivery (72 percent), and through breastfeeding (70 percent). Three-fourths of women know that a healthy-looking person can have the AIDS virus.

Knowledge of Condoms and Use of Condoms: One of the main objectives of the National HIV/AIDS Control Programme is to encourage consistent and correct use of condoms, especially among high-risk groups. The 2002 EDHS data show that 54 percent of women know a source for condoms. However, use of condoms is negligible, with only 2 percent of women having used condoms during the last sexual intercourse in the past year.

Social Aspects of HIV/AIDS Prevention and Mitigation: Discussion of HIV/AIDS with a with spouse or partner is an important first step in prevention of HIV/AIDS and the control of the epidemic. The 2002 EDHS survey results show that only 37 percent of women have had such discussions with their partners. One-fourth of women say that they would not be willing to take care of a relative who had HIV/AIDS

Knowledge of Signs and Symptoms of Sexually Transmitted Infections (STIs): Sexually transmitted infections (STIs) are believed to be important predisposing factors in HIV/AIDS transmission. Fifty-eight percent of women in Eritrea have no knowledge of STIs other than HIV. Among those who have heard of STIs, one in ten women was unable to mention any symptoms of STIs in a man and a woman.

ERITREA

Note: This is not the official and political map of Eritrea.