

DHS+ Dimensions

A semiannual newsletter of the Demographic and Health Surveys project

*The DHS
STATcompiler
builds
customized
tables from
DHS data
from
anywhere
in the
world.*



Contents

Improved Child Survival in Bangladesh	3
Kenya Service Provision Assessment	4
Release of CSPro Software	5
Summary of DHS Surveys	6
Abortion Rates Fall in Kazakhstan	8
Burkina Faso: Little Improvement in Health	9
DHS+ Visitors and Events	10
Publications Update	11
Selected DHS Statistics	12

Access DHS Data Instantly and Easily With New Internet Tool

Researchers, policymakers, members of academic institutions and general users from around the world have long realized the value of their well-worn final reports in giving them access to data from the Demographic and Health Surveys (DHS). Users can now benefit from a new tool that provides easy, unlimited, and instant access to DHS data from country reports.

The DHS STATcompiler is an innovative on-line database tool that allows users to select from numerous countries and hundreds of indicators and to create customized tables to serve their specific data needs. The flexible and easy to use tool is certain to save data users time, money and papercuts as they build tables by means of just a few simple clicks of the mouse.

What kind of information does the STATcompiler contain?

Virtually all of the population and health indicators that are published in DHS final reports can be viewed on-line. The available indicators are grouped under the following topics:

- Characteristics of households
- Fertility
- Fertility regulation
- Other proximate determinants of fertility
- Fertility preferences
- Early childhood mortality

Continued on page 2

- Maternal and child health
- Maternal and child nutrition
- AIDS and other STIs.

What does the STATcompiler offer?

- **Worldwide access.** Because it is an on-line tool, the DHS STATcompiler is accessible from anywhere in the world. No longer do you need to search through volumes of DHS survey reports to find the data you need.
- **Immediate results.** Access to more than 600 indicators from more than 60 countries allows users to retrieve up-to-date statistics on population and health instantly.
- **Flexibility.** Customized tables can be exported to Microsoft Excel for direct inclusion in reports or for editing.

How much does it cost to use the STATcompiler?

Nothing. Use of the DHS STATcompiler is free to anyone with access to the World Wide Web. You simply log on to www.measuredhs.com, select STATcompiler from the home page, and begin building a customized table.

Is the STATcompiler difficult to use?

Not at all. The STATcompiler was designed to be accessible to even the most technically challenged user. Customized tables can be created in just three easy steps (see sidebar).

What are examples of practical applications of the tool?

A simple example of the use of the STATcompiler would be to obtain quick figures on the prevalence of family planning in West Africa. If you wanted to use the STATcompiler to find out how many women with no education are using a modern method of family planning in all the West African countries where DHS has conducted surveys, you would select all of the countries from the West African region and choose “current use of contraception by background characteristics” as an indicator. A table would be built in less than a minute. To compare those figures with the percentage of women using traditional methods, you could simply add that indicator to the table.

You might also use the STATcompiler to view trends within a country in terms of a single indicator across time. For example, you could examine trends in infant mortality for the three most recent Indonesia DHS surveys by first selecting Southeast Asia from the Select Surveys drop-down list and then choosing the 1991, 1994, and 1997 Indonesia DHS surveys. Next, you would click on “Select Indicators” and choose “Early Childhood Mortality” from the list of topics. Then you would select “Infant and Child Mortality by background characteristics” and check the Infant mortality box. Finally, you would add the items to the table and click on “Build Table.” In a matter of seconds, the table would be ready for you to print, save, or export into another file format.

3 easy steps for building custom tables with the STATcompiler

Step 1:

If you know the country you want to search for, choose “Select Surveys.” If you know the specific indicators you wish to identify, choose “Select Indicators.”



Opening screen invites a search by selecting a survey country or indicator

Step 2:

Continue selecting topics until you come to a list of variables with boxes to check. Select at least one variable from each group. Groups are identified by those items separated by the word “by.” For your convenience, key indicators are preselected. Click on “Add Items to Table.” Repeat step 2 for all desired surveys and indicators.



Childhood mortality indicators are selected to be added to a table with four surveys

Step 3:

After you have finished selecting and saving your desired items, click on **Build Table** at the bottom of the “Custom Table Selection” box.



The specific indicators for infant and under-five mortality by residence are selected



Table is generated and ready for printing or export to other program

Survival Chances Increase for Children in Bangladesh

Recent preliminary findings from the 1999-2000 Bangladesh Demographic and Health Survey (BDHS) show that child survival has improved dramatically in the past 15 years. Under-five mortality has declined 19 percent, from 116 deaths per 1,000 live births for the period 1992-96 to 94 deaths for the period 1995-99.

Contributing most to the overall decline in under-five mortality was the reduction in infant mortality—the probability of a child’s dying before reaching his or her first birthday. The infant mortality rate declined from 82 to 66 deaths per 1,000 live births between the two periods. This encouraging trend in childhood mortality raises the question, “What factors are contributing to this dramatic decline?” Improvements in childhood nutrition and an increase in immunization coverage may, in part, provide an answer.

Childhood nutrition

Although the overall nutritional status of Bangladeshi children has improved considerably since 1996, the twin goals of ending poverty and malnutrition remain among the most important challenges to the health and welfare of infants and young children in Bangladesh. Undernourishment influences both the physical and the mental development of children. It not only exposes them to an increased risk of illness but also puts them at risk for a reduction in cognitive development, which may result in lower educational attainment.

Significant progress has recently been made in fighting childhood undernutrition in Bangladesh. Although the 1999-2000 BDHS shows that 45 percent of children under five are too short for their age (stunted) and 10 percent are underweight for their height (wasted), those figures represent a significant improvement since the 1996-1997 BDHS, in which

55 percent of children were identified as stunted and 18 percent were wasted.

Bangladeshi infant feeding practices have also improved in recent years. Many studies have shown the beneficial effects

An improvement in childhood nutrition and an increase in immunization coverage may be factors contributing to the encouraging downward trend in childhood mortality.

of breastfeeding on infants’ nutritional status, morbidity, and mortality. In Bangladesh, the overall duration of breastfeeding is among the longest in the world.

However, many mothers do not follow the recommended practice of giving infants breast milk *exclusively* during the first 4 to 6 months of life. Only half of infants from birth to 3 months old are exclusively breastfed, while the others receive water, other liquids, or solid/mushy foods. These practices have important implications for a child’s health and nutritional status because a child is placed at an increased risk of developing an infection, diarrhea or other illness.

Later in life, it is the lack of proper supplementation that endangers children’s health. Among children 10 to 12 months old, 14 percent receive only breast milk or breast milk and water. At that age, however, children should be receiving supplementary foods.

Childhood illness

An important means of improving the survival of young children consists of immunizing them against the principal childhood diseases: tuberculosis; diphtheria, pertussis, and tetanus (DPT); polio; and measles. Overall, 60 percent of Bangladeshi children age 12-23 months receive all the vaccinations recommended by the Extended Programme on Immunisation, an increase from the level in the 1996-1997 BDHS (54 percent). Most children received the first dose of polio vaccine (94 percent), although only 72 percent received the third dose as required for complete immunization.

In the 2 weeks before the survey, 6 percent of children under five years of age had diarrhea. More than 60 percent of those children were treated with a solution prepared from packets of oral rehydration salts (ORS) packet or *khabar*, while one-quarter were given a home-made solution of *labon gur*.

Vitamin A deficiency is a leading cause of preventable childhood blindness, as well as being a major contributing factor to the severity of several other causes of childhood morbidity and mortality. Data from the 1999-2000 BDHS show that vitamin A supplementation increased from 67 percent of children under ages in 1996-1997 to 73 percent in 1999-2000.



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

Survey Looks at Service Delivery in Kenya's Health Facilities

Results from the 1999 Kenya Service Provision Assessment (KSPA) provide a comprehensive picture of the reproductive and child health care services in the country. The KSPA focuses on the supply side of the health care situation, and complements the information on health status and health care needs collected in the 1998 Kenya Demographic and Health Survey (KDHS).

The KSPA, the first national-level facility-based survey to be conducted in Kenya, specifically examined the availability and quality of services for clients seeking services for family planning, sexually transmitted infections (STIs) or maternal and child health. Data for the KSPA were collected through community interviews, visits to health facilities and observations of consultations.

Family Planning Services

Since the launching of Kenya's family planning program, the use of contraceptive methods in the country has expanded. Findings from the 1998 KDHS indicated a contraceptive prevalence rate of almost 40 percent among currently married women, an increase from the findings of the 1993 survey. However, the survey also found a considerable unmet need for family planning among married and unmarried women.

Information collected in the KSPA covers the delivery of family planning services at Kenyan health facilities, the suppliers of modern contraceptive methods to 85 percent of current users. The results indicate that access to family

planning services is available at most facilities and that most clients are offered a choice of methods, although clinical methods are not as readily available as supply methods such as the pill, condom, and injection. More than a quarter of facilities offer adolescents special family planning counseling. Most facilities performed well in the areas of contraceptive storage and record keeping and relatively few reported stockouts.

An area of concern for Kenya's family planning services was poor compliance with infection control procedures, including sterilization of equipment and disposal of needles. Providers have also not always been discussing the full range of options with their clients: in about a quarter of new client consultations only one method was discussed. Although virtually all providers give out information on how to use contraceptive methods, fewer discuss the health risks, benefits and side effects. Finally, of particular concern is the fact that too often health workers fail to take the opportunity of counseling sessions to discuss STIs or HIV/AIDS prevention with new family planning clients.

STI/HIV/AIDS Services

The high prevalence of STIs and HIV/AIDS poses a major problem for Kenya's future development. It is compounded by a large sexually active youth population and inadequate knowledge and education about the problem. The government of Kenya faces the challenges of educating the population about

the means of preventing the diseases and promoting behavioral changes, including the use of condoms. The KSPA assesses how well prepared health facilities are to meet the challenges and to deal with STI sufferers.

More than 90 percent of facilities offer STI treatment services, and slightly more than half offer testing. Less than 60 percent of Kenyan facilities offer HIV/AIDS services. Stockouts of the primary drugs used to treat the most common STIs are a major problem among all types of health facilities in Kenya. Another major concern is the lack of training among health providers. Only about half of health providers providing STI services have had basic training in HIV/AIDS.

During observations of STI consultations, it was noted that a high percentage of clients were asked questions important for proper diagnosis. Laboratory tests were performed for around a third of clients. Most health workers were observed either giving medicine to clients for a diagnosed STI or giving a prescription for the drugs. Few workers, however, were observed mentioning to their clients the risk factors for acquiring HIV/AIDS and only slightly over a third promoted condoms.

Maternal and Newborn Health Services

Complications related to pregnancy and childbirth are among the leading causes of morbidity and mortality among Kenyan women. Data collected in the KSPA are intended to help the Ministry of

Health evaluate its efforts to promote safe motherhood through the National Reproductive Health Strategy.

Antenatal care is provided by 86 percent of facilities, while delivery care is provided in one-third of all facilities, mainly in hospitals, maternities and health centers. To provide comprehensive and high quality maternal care for women, health facilities need to have available appropriate equipment, supplies, and medicines. Although most facilities are well equipped to deal with normal deliveries and offer antenatal care, they are not prepared for managing obstetric complications or transferring women in emergency situations. Furthermore, training of maternal and newborn care providers is lacking, particularly in the areas of managing complications and counseling. Many facilities lack essential equipment, including items needed for neonatal resuscitation.

Relatively few facilities have the capacity to provide women with assisted vaginal delivery (AVD) when progress in labor is slow. Just over a quarter of delivery services can perform caesarean section, including the majority of hospitals, half of all maternities, and a quarter of clinics. Availability of blood transfusion services and post-abortion care is limited.

Child Health Services

The KSPA looked at a number of aspects of child health service, including the provision of immunization services and the treatment of common illnesses.

continued on page 5

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More than 85 percent of health facilities in Kenya offer immunization services and treatment for common childhood illnesses. Among those facilities, immunization services are offered an average of 4 days a week. However, only two-thirds of facilities that offer immunizations have all the necessary elements of the cold chain system. On the day of the survey, most facilities had five out of the six essential drugs used to treat common childhood illnesses in stock.

The standards of care used to assess the quality of sick-child consultations were based on the Ministry of Health guidelines and WHO/UNICEF's Integrated Management of Childhood Illness (IMCI). The observations of consultations for children with fever, diarrhea, and cough or difficult breathing, indicated that providers are not taking the appropriate steps during history taking and are not paying attention to danger signs. For example, less than half of the children with diarrhea were checked for dehydration.

Medications are being delivered inappropriately—too many children with simple cough or cold are being given antibiotics and too few children with fever are being given antimalarials. Furthermore, health workers need to explain procedures, such as treatment of diarrhea at home, to caretakers of children. The lack of training among providers of child health services is again a major factor.

Release of CPro Promises Increased Flexibility

New census and survey processing software has expanded capabilities

Just hours after the first version of the Census and Survey Processing (CPro) system was made available to the public in May, users from around the world were downloading the new software. During the first week, more than 100 users from 20 countries downloaded CPro to use in universities, government organizations and the private sector.

CPro is an integrated system for census and survey data processing designed to meet the needs of data producing organizations worldwide. It is a Windows-based system that provides for entry and tabulation of census and survey data, including the creation of data entry systems, secondary editing, tabulation and analysis, and dissemination of data files. The software was created for increased user-friendliness and flexibility and it combines the capabilities of the Integrated System for Survey Analysis (ISSA) and the Integrated Microcomputer Processing Systems (IMPS). The product is the result of a joint development effort among MEASURE *DHS+*, MEASURE partner, the International Program Center (IPC) at the U.S. Bureau of the Census (BUCEN), and a team of programming consultants at SerPro Ltda.

The first release of the software contains the CPro Designer, where dictionaries and applications are created, the Data Entry Module, and the Quick Tabulation Module. The Map Viewer, Text Viewer, and Table Viewer tools, add-on utilities that allow for different table formats, are included with the release. Future versions of the system will offer the Batch Processing Module, the Full Tabulation Module, and the Sampling Errors Module, as well as improvements and extensions to the existing modules.

New Features of CPro

- The new Data Entry Module allows users to design Windows-based data entry forms (screens) and applications for both form and field level processing, which include both pre- and post-entry logic. The processing language, based on the extremely powerful ISSA language, includes all of the functionality that you would expect from a full-featured programming language. The data entry system will allow interactive verification of data as well as the separate comparison of data
- The Quick Tabulation Module allows users to tabulate variables quickly by means of an interactive graphical interface. You can drag-and-drop variables from a list onto a table grid to design table layouts, then simply hit a button to tabulate the data. The Quick Tabulation Module allows you to generate quick tables whose rows and columns allow for nesting, thus permitting 4 dimensions of tabulation.
- In the near future, a Full Tabulation Module will allow for multiple row, column, and layer variables, with nesting on each dimension. This module will also give you complete control over the tabulation process, and allow tallying to individual cells, multiple tallies per case, and post processing of tabulations. Users will be able to define the type of statistic to present in each row or column of the table or to calculate their own statistics.
- The Sampling Errors Module will permit users to calculate sampling errors for various types of indicators (including complicated statistics such as fertility and mortality rates) by means of several techniques.
- Finally, the Batch-Processing Module will permit the processing of multiple questionnaires or cases at a time. It can be used for editing data, recoding data, producing reports, or other forms of secondary processing. An export module will allow you to export data to use with SPSS, SAS, Stata, or other statistical packages.

An advantage for users accustomed to ISSA is that they can convert ISSA dictionaries into CPro by using the dictionary converter. Since CPro uses the ISSA language, ISSA applications only require minor modifications to function with CPro.

The current version of CPro is updated each week. The next major release is planned for Fall 2000. Look for the new releases of CPro on the *DHS+* web site at http://www.measuredhs.com/about/survey_processing.cfm

Summary of Demographic and Health Surveys

COUNTRY SURVEY

IMPLEMENTING ORGANIZATION

ASIA

Bangladesh 2000	Mitra & Associates/NIPORT
1997	Mitra & Associates/NIPORT
1994	Mitra & Associates/NIPORT
Cambodia 2000	National Institute of Statistics/MOH
1998 ¹	SAWA Cam./Nat. Inst. of Public Health
India 1998-2000*	Various organizations
1999	International Inst. for Population Sciences
1993	International Inst. for Population Sciences
Indonesia 1997	Central Bureau of Statistics/NFPCB/MOH
1994	Central Bureau of Statistics/NFPCB/MOH
1991	Central Bureau of Statistics/NFPCB/MOH
1987	Central Bureau of Statistics/NFPCB
Kazakhstan 1999	Academy of Preventive Medicine
1995	National Institute of Nutrition
Kyrgyz Republic 1997	Inst. of Obst. & Ped., MOH
Myanmar 1996²	Settltmt. and Land Rec. Dep., Min. of Agr.
Nepal 1996	Ministry of Health/New ERA
1987 (In-Depth)	New ERA
Pakistan 1991	National Institute of Population Studies
Philippines 1998	National Statistics Office/Dept. of Health
1993	National Statistics Office
Sri Lanka 1987	Dept. of Cen. & Stat., Min. of Plan Impl.
Thailand 1987	Inst. of Pop. Studies, Chulalongkorn U.
Turkmenistan 2000	MCH/MOH and MIT
Uzbekistan 1996	Inst. of Obst. & Gynec., MOH
Vietnam 1997³	Nat. Comm. on Pop. and Fam. Planning

LATINAMERICA & CARIBBEAN

Bolivia 1998	Instituto Nacional de Estadística
1994	Instituto Nacional de Estadística
1989	Instituto Nacional de Estadística
Brazil 1996	Soc. Civil Bem-Estar Familiar no Brasil
1991(NE)	Soc. Civil Bem-Estar Familiar no Brasil
1986	Soc. Civil Bem-Estar Familiar no Brasil
Colombia 2000	PROFAMILIA
1995	PROFAMILIA
1990	PROFAMILIA
1986	Corp. Cen. Reg. de Pob./Min. de Salud
Dominican Rep. 1999	CESEM
1996	CESEM/PROFAMILIA
1991	PROFAMILIA

COUNTRY SURVEY

IMPLEMENTING ORGANIZATION

LATINAMERICA & CARIBBEAN

1986	Consejo Nacional de Población y Familia
1986 (Exp.)	Consejo Nacional de Población y Familia
Ecuador 1987	Cen. de Estud. de Pob. y Paternidad Responsable
El Salvador 1985	Asociación Demográfica Salvadoreña
Guatemala 1999 (Interim)	Instituto Nacional de Estadística
1997 (In-Depth 1)*	Instituto Nacional de Estadística
1997 (In-Depth 2)*	Instituto Nacional de Estadística
1995	Instituto Nacional de Estadística
1987	Inst. de Nutrición de Cent. y Panamá
Haiti 2000	Institut Haïtien de l'Enfance
1994	Institut Haïtien de l'Enfance
Mexico 1987	Dir. Gen. de Plan. Fam., Sec. de Salud
Nicaragua 1997	Instituto Nacional de Estadísticas y Censos
Paraguay 1990	Centro Paraguayo de Estudios de Población
Peru 2000	Instituto Nacional de Estadística
1996	Instituto Nacional de Estadística
1992	Instituto Nacional de Estadística
1986	Instituto Nacional de Estadística
1986 (Exp.)	Instituto Nacional de Estadística
Trinidad & Tobago 1987	Family Planning Association of Trinidad/Tobago

NEAR EAST/NORTHAFRICA/EUROPE

Armenia 2000	Nat. Stat. Service/MOH
Egypt 2000	National Population Council
1998 (Interim)	El-Zanaty & Associates
1997 (Interim)	El-Zanaty & Associates
1997 (In-Depth)*	National Population Council
1995	National Population Council
1992	National Population Council
1988	National Population Council
Jordan 1997	Department of Statistics
1990	Department of Statistics
Morocco 1995 (Panel)	Ministère de la Santé Publique
1992	Ministère de la Santé Publique
1987	Ministère de la Santé Publique
Mauritania 2000	Office Nat. de la Statistique
Tunisia 1988	Office Nat. de la Fam. et de la Population
Turkey 1998	Hacettepe Inst. of Population Studies
1993	Hacettepe Inst. of Population Studies/MOH
Yemen 1997	Central Statistical Organization
1991	Central Statistical Organization



COUNTRY SURVEY

IMPLEMENTING ORGANIZATION

SUB-SAHARANAFRICA

Benin 1996	Institut National de la Statistique
Botswana 1988	Ministry of Health
Burkina Faso 1999 1992	Inst. Nat. de la Statistique et la Démo. Inst. Nat. de la Statistique et la Démo.
Burundi 1987	Dép. de la Pop., Min. de l'Intérieur
Cameroon 1998 1991	Bur. Cen. Recensements et Études de Pop. Min. du Plan et de l'Amén. du Terr.
Central African Rep. 1994	Dir. des Stat. Dém. et Sociales
Chad 1997^{3,4}	Bureau Central du Recensement
Comoros 1996⁴	Centre National de Doc. et de Rech. Sci.
Côte d'Ivoire 1994	Inst. National de la Statistique
Eritrea 1995	National Statistics Office
Ethiopia 2000	Central Statistical Authority
Gabon 2000	Direction Générale de la Stat
Ghana 1998 1993 1988	Ghana Statistical Service Ghana Statistical Service Ghana Statistical Service
Guinea/Conakry 1999	Direction Nationale de la Statistique
Kenya 1999 (SPA)* 1998 1993 1989	National Council for Population and Dev. National Council for Population and Dev. National Council for Population and Dev. National Council for Population and Dev.
Liberia 1986	Min. of Planning & Economic Affairs
Madagascar 1997⁴ 1992	Dir. de la Dem. et de la Statistique Sociale Centre Nat. de Recherches sur l'Env.
Malawi 2000 1996 (KAP) 1992	National Statistical Office National Statistical Office National Statistical Office
Mali 2000 1996 ⁵ 1987	CPS/MSSPA et DNSI CPS/MSSPA et DNSI Inst. de Sahel: USED/CERPOD
Mauritania 2000^{3,4}	Office Nat. de la Statistique
Mozambique 1997	Instituto Nacional de Estatística
Namibia 1992³	Min. of Health and Social Services
Niger 1998 1992	Care International Dir. de la Stat. et des Comptes Nat.
Nigeria 1999⁶ 1990	Nat. Pop. Commission Federal Office of Statistics
Ondo State, Nigeria 1986	Ministry of Health, Ondo State
Rwanda 2000 1992	Office National de la Population Office National de la Population

COUNTRY SURVEY

IMPLEMENTING ORGANIZATION

SUB-SAHARANAFRICA

Senegal 1999 1997 (Interim) 1993 1986	SERDHA Min. de l'Economie et des Finances Dir. de la Prévision et de la Stat. Min. de l'Economie et des Finances
South Africa 1998	Dept. of Health/Med. Research Council
Sudan 1990	Dept. of Stat., Min. of Fin. & Econ. Plan.
Tanzania 1999 1996 1995 (In-Depth)* 1994 (KAP) 1992	National Bureau of Statistics Bureau of Statistics, Planning Comm. Bureau of Statistics, Planning Comm. Bureau of Statistics, Planning Comm.
Togo 1998 1988	Direction de la Statistique Unité de Recherche Dém., U. du Benin
Uganda 2000 1995 (In-Depth)* 1995 1988	Uganda Bureau of Statistics Inst. Stat. & Applied Econ., Makerere U. Dept. of Stat., Min. Fin. & Econ. Plan. Ministry of Health
Zambia 1996 1992	Central Statistical Office University of Zambia
Zimbabwe 1999 1994 1988	Central Statistical Office Central Statistical Office Central Statistical Office

- 1 Funded by ADB and the World Bank
- 2 Funded by UNDP
- 3 Funded by the World Bank
- 4 Funded by UNFPA
- 5 Funded directly by USAID/Mali
- 6 Limited technical assistance

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

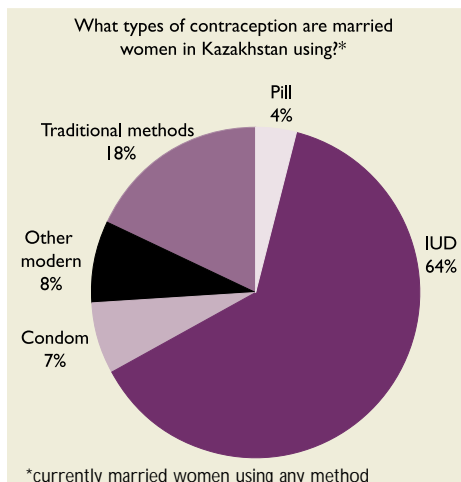


Increased Use of Contraception in Kazakhstan Contributes to Abortion Decline

Women in Kazakhstan are having fewer induced abortions now than 5 years ago and are choosing new methods of family planning to limit births, according to the findings of the 1999 Kazakhstan Demographic and Health Survey (KDHS). Induced abortion, which has long been used as a means of fertility control in the republics of the former Soviet Union, can adversely affect a woman's health, reduce her chances for further childbearing, and contribute to maternal and perinatal mortality.

In Kazakhstan, induced abortion accounts for 37 percent of all pregnancy outcomes. Although women in all demographic groups use induced abortion to control fertility, the extent of the practice varies widely. For example, urban women terminate 46 percent of pregnancies, while rural women terminate 28 percent. Women of Russian ethnicity are almost twice as likely to terminate a pregnancy (49 percent) as Kazakh women (27 percent).

Data collected in the survey were used to calculate the total abortion rate (TAR), which is interpreted as the number of abortions a woman would have in her lifetime if she observed the current rate during her childbearing years. The TAR is 1.4 abortions per woman, although that rate varies by residence and ethnicity. The data show that the TAR for Russian women (1.7 abortions per woman) exceeds the TAR for Kazakh women (1.1) by about 55 percent.



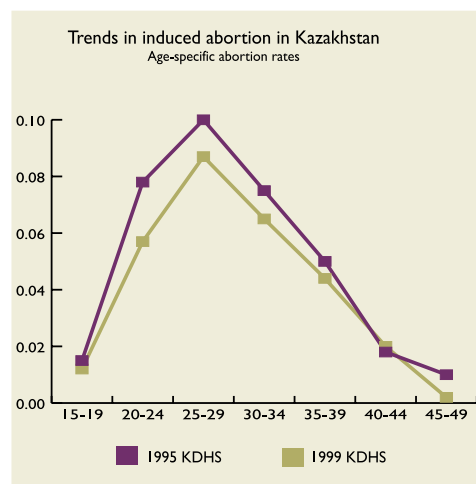
A comparison of the 1999 KDHS and the 1995 KDHS indicates a decline of 22 percent in the total abortion rate, from 1.8 to 1.4 abortions per woman. The decline occurred across all regions and education groupings. Whereas the TAR among Russians declined 37 percent from 2.7 to 1.7, the TAR among Kazakhs remained stable at 1.1.

More than half of the induced abortions that took place during the 3 years before the survey were preceded by contraceptive failure. It appears that the availability of more reliable methods might further reduce the incidence of induced abortion. In an effort to limit the practice of abortion, the Ministry of

Induced abortion, long used as a means of fertility control in the republics of the former Soviet Union, may affect women's health adversely.

Health in Kazakhstan has for the past decade been committed to making safe, effective contraceptive methods widely available to the population. As part of this effort, family planning offices have been opened around the country in both cities and villages. These offices provide women with professional advice about family planning as well as supplies of various contraceptive methods. Results from the 1999 KDHS indicate there has been an increase in the use of modern contraceptive methods over the past 5 years.

Among married women in Kazakhstan, two-thirds are using a method of contraception. Most of these women are using a modern method (53 percent). The IUD is by far the most widely used modern method of contraception, chosen by 42 percent of currently married women, followed by the condom.



Overall use of family planning has increased since 1995. In particular, the country has witnessed an increase in the use of modern methods from 46 percent in 1995 to 53 percent in 1999. While the use of modern contraceptive methods has increased, the use of traditional methods such as periodic abstinence and withdrawal has declined.

Accompanying the rise in the use of modern contraceptive methods has been a decline in total fertility in Kazakhstan. Data from the 1999 KDHS indicate that the total fertility rate is 2.1 children per woman, although the rate varies according to the background characteristics of the respondents. As expected, fertility rates are higher both in rural areas and among women with less education. Additionally, the total fertility rate is highest among Kazakh women (2.5 children per woman), compared with 1.4 for Russian women and 1.7 among other ethnic groups.

During the decade between the 1989 census and the 1999 KDHS, fertility declined by 28 percent, or almost one child per woman. Total fertility has decreased from 2.9 children per woman during the period 1988-1989 (Darsky and Dworak 1993) to 2.5 for the period 1992-1995 (1995 KDHS) to 2.1 for the period 1996-1999. Fertility declines took place not only among ethnic Kazakh and Russian women, but also among rural and urban women, among women in all regions of Kazakhstan, and among all education levels.

Health Conditions in Burkina Faso Show Little Improvement

On July 13-14, 2000, a National Dissemination Seminar was held in Ouagadougou, the capital of Burkina Faso, to officially release the results of the second DHS survey in the country—the *Enquête Démographique et de Santé au Burkina Faso, 1998-1999* (EDSBF-II), which was carried out under MEASURE DHS+. The results of the EDSBF-II indicate that there has been little improvement in the health and well being of women and children since the last DHS survey conducted in 1993. In some areas, health conditions have even worsened.

Adequate care during pregnancy and childbirth can reduce the risks of illness and death for both mothers and children. Antenatal care has been proven to be most effective when it is received from early in the pregnancy through delivery. Women who are at risk of future complications during pregnancy or at the time of delivery can be identified and monitored during routine antenatal care visits. For four in 10 births in Burkina Faso mothers received no antenatal care, which is the same proportion as in 1993.

An important component of antenatal care is protecting pregnant women and children against tetanus, a principal cause of death among infants. In Burkina Faso, data show that for almost half of all births (45 percent) no tetanus toxoid injections were given. The figure was 36 percent in 1993.

Furthermore, only three in 10 births were to mothers who received assistance at delivery. The low level of delivery assistance, however, was not surprising to some seminar participants. They held that the widespread prevalence of home deliveries (67 percent) highlights the need to ensure that *matrones* (traditional birth attendants) who assist 42 percent of home deliveries are trained to refer pregnant women with serious complications to medical facilities. In 1993, 56 percent of births occurred at home.

Immunization against the major preventable diseases of childhood (tuberculosis; diphtheria, pertussis, and tetanus; polio; measles) also increases the chances of child survival. EDSBF-II data show a decrease in total immunization coverage: only 29 percent of children were immunized in 1999, compared with 35 percent in 1993. The administration of BCG vaccine, which protects children against tuberculosis, and the measles vaccine dropped the most since the last survey, from 85 percent to 72 percent and 60 percent to 46 percent, respectively.

In the 2 weeks before the survey one in five children under the age of five was ill with diarrhea. Respondents' knowledge and use of commercially packaged oral rehydration salts (ORS) to treat dehydration caused by severe diarrhea improved slightly since 1993 (from 49 percent to 52 percent and 12 percent to 15 percent, respectively). However, a smaller proportion of children received increased fluids (a decrease from 43 percent to 37 percent) when they had diarrhea.

The stagnation in the health improvement of Burkinabe children and mothers is unfortunately coupled with feeding practices that put children at increased risk of infection. Many studies have demonstrated that breast milk is the best source of the nutrients and fluids that infants need early in their lives.

Only about 5 percent of infants in Burkina Faso are exclusively breastfed during the first 6 months of life.

The introduction of liquids and solid foods earlier than the recommended age of about six months puts infants at a greater risk of diarrheal disease. Consumption of liquids and solid foods also decreases an infant's intake of breast milk, which in turn reduces the mother's supply of milk. Solid foods should be introduced to infants after they have reached the age of six months because then breast milk alone is no longer sufficient to maintain a child's optimal growth. In Burkina Faso, one in two children age 6 to 9 months old is not being properly fed.

It is estimated that around 37 percent of all deaths that occur before the age of five in Burkina Faso are related to malnutrition, especially through the weakening of a child's immune system. Continued high levels of fertility in the country (6.8 children per woman) translate into fewer household resources for each child and may increase the chances that a mother may not be able to breastfeed or care for her children adequately. EDSBF-II data also show that the proportion of children under 5 years old who are stunted (or chronically malnourished) has increased since 1993—from 29 percent to 37 percent—and that those who are underweight increased from 30 percent to 34 percent.

Mortality trends presented on the second day of the National Dissemination Seminar indicated a decline in child survival since the 1993 survey. Based on data from 0-4 years before the survey, it is estimated that more than one in 10 children (105 per 1,000 births) will die before their first birthday compared with 94 per 1,000 in 1993. The increase is wholly due to a higher risk of dying between the first and 12th month (from 51 to 65 per 1,000), while the risk of dying during the first month has actually decreased slightly (from 43 to 41 per 1,000). More than one in five children in Burkina Faso will not live to see their fifth birthday. This rate is among the highest in sub-Saharan Africa.



After the age of 6 months, solid foods should be introduced to children as a supplement to breast milk. In Burkina Faso, half of children 6 to 9 months old are not being fed properly and malnutrition is a big concern.

MEASURE *DHS+* Visitors and Events

January 2000

■ **Ms. Lourdes Fidalgo** and **Ms. Carina Ismael** from Mozambique visited ORC Macro to finalize the draft of the Mozambique In-Depth Nutrition Report.

■ The Zonal Dissemination Seminars for the 1998 Ghana Demographic and Health Survey were held in Tamale, Kumasi, and Sogakope from January 11 to January 17.



USAID Ghana representative Mr. Lawrence Aduonum-Darko addresses the participants at the Northern Zone 1998 GDHS Dissemination Seminar, held in Tamale on January 11. The seminar received generous media coverage, including a segment on national television.

February 2000

■ **Ms. Ana Vega** from Colombia visited ORC Macro to work on converting the standard data entry and data management programs for the MEASURE *DHS+* survey in Colombia.

March 2000

■ **Mr. Tinga Sinaré** and **Mr. François Ilboudo** from Burkina Faso visited ORC Macro to draft the final report for the 1998-99 Burkina Faso DHS survey.

■ **Mr. Mamadou Badian Diallo**, **Mr. Ibrahima Diallo**, and **Ms. Marie-Anne Doualamou** from Guinea visited ORC Macro to complete the draft of the final report for the 1999 Guinea DHS survey.

April 2000

■ *DHS+* conducted a 2-week workshop on Disseminating DHS Results at the National Seminar held from April 10 to 21 in Calverton, Maryland. The workshop covered: selecting and targeting audiences, preparing computerized presentations of results, working with the media, speaker rehearsals, and tips on designing printed dissemination materials. **Mr. Julius Atula** and **Ms. Ebere Iheanacho** from Nigeria, **Mr. Irenius Ruyobya** from Tanzania, **Mr. Peter Katambarare** from Zim-

babwe, **Mr. Mario Gutierrez** from Bolivia, and **Mr. Tinga Sinaré** from Burkina Faso participated in the workshop.

■ **Dr. Paul Kizito** and **Dr. Margaret Mukumi** from Kenya visited ORC Macro to draft the final report for the 1999 Kenya Service Provision Assessment.

■ **Mr. Joseph Maturufa** from Zimbabwe visited ORC Macro to work on the final report for the 1999 Zimbabwe DHS survey.

May 2000

■ *DHS+* held a 1-week workshop on Preparing Materials for the National Seminar in Conakry, Guinea May 8-12. **Ms. M'Ballou Béréte**, **Ms. Salématou Diallo**, **Mr. Mamadou Chérif Bah**, **Mr. Ibrahima Diallo**, **Ms. Marie-Anne Doualamou**, **Mr. Mamadou Badian Diallo**, **Mr. Lansana Fofana**, **Mr. Ousmane Balole**, **Mr. Lansana Chérif**, and **Mr. Abdoulaye Diallo** attended the workshop.

■ **Mr. Bedel Sarbaev**, **Dr. Adil Katarbaev**, **Dr. Turqeldy Sharmanov**, and **Dr. Akkumys Salkhanova** from Kazakhstan visited ORC Macro to finalize the final report for the 1999 Kazakhstan DHS survey.

June 2000

■ The Bangladesh National Dissemination Seminar was held in Dhaka, Bangladesh, on June 22.

■ **Mr. Emmanuel Boadi** and **Mr. Steve Grey** from Ghana spent time at ORC Macro to work on the further analysis of the 1998 Ghana DHS survey.

■ *DHS+* participated in the annual meeting of the **Global Health Council**, held June 13-16 in Crystal City, Virginia.

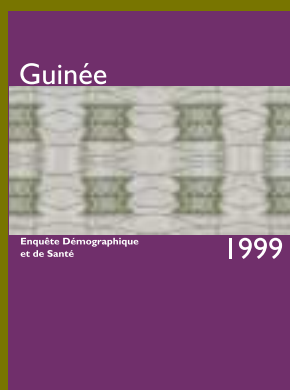


Participants in the *DHS+* workshop on Preparing Materials for the National Seminar held in Guinea this May pose with their certificates of completion and *DHS* staff member Daniel Vadrnais.

Fresh Look for DHS Publications

DHS recently unveiled a new look for several publications that are guaranteed to brighten any bookshelf. The covers of the final report, summary report, chartbooks, and other publications now feature colorful designs from survey countries. The motifs are chosen in collaboration with survey implementing organizations and include local textile patterns, artwork, and symbols. Other survey publications, such as wall charts, fact sheets, and calendars, also incorporate the designs to create a uniform appearance.

The formatting of the final report content has also been updated for easier reference and greater visual appeal. A redesigned summary report is intended to better target policymakers and program managers with more informative sections and eye-catching graphics.



New Final Report



New Summary Report

How to order DHS publications

DHS publications are listed on the DHS web site and may be ordered directly. Requests can also be sent to the Publications Clerk at the address below. To receive a publications catalogue or the newsletter (*DHS+ Dimensions*), contact

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E-mail: reports@macroint.com
Web: www.measuredhs.com

What's New in Print?

Country Reports

Burkina Faso	1998-99 Final Report (French) 1998-99 Summary Report (French)
Guinea	1999 Final Report (French) 1999 Summary Report (French)
Kazakhstan	1999 Final Report (English)
Tanzania	1999 Final Report (English)

Further Analysis Reports

Govindasamy, P. and E. Boadi. 2000. A Decade of Unmet Need for Contraception in Ghana: Programmatic and Policy Implications. (English)

Blanc, A. K. and S. Gray. 2000. Greater than Expected Fertility Decline in Ghana: An Examination of the Evidence. (English)

Other Publications

Burkina Faso Nutrition Chartbook (French/English)
Guinea Nutrition Chartbook (French/English)

Dissemination Materials

1998 South Africa Fact Sheet (English)
1999 Guinea Fact Sheet (French)
1999 Guinea Wall Chart (French)
1999 Burkina Faso Wall Chart (French)
1999 Burkina Faso Fact Sheet (French)

Look for these publications coming soon!

Bangladesh 1999-2000 Final Report (English)
Colombia 2000 Final Report (Spanish)
Kenya 1999 SPA Final Report (English)
Nigeria 1999 Final Report (English)
Senegal 1999 Final Report (French)
Zimbabwe 1999 Final Report (English)

Espeut, D., et al. 2000. Nutrition and Health Status of Young Children and Their Mothers in Mozambique. (English and Portuguese)

Rafalimanana, H. and C. Westoff. 2000. Gap Between Preferred and Actual Birth Intervals in Sub-Saharan Africa. (English)

REGION/ SURVEY COUNTRY	VITAL RATES			USE OF CONTRACEPTION (Currently Married Women 15-49)		MATERNAL CARE (Births in Last 5 Yrs.)		CHILD HEALTH INDICATORS		
	Total Fertility Rate ^a	Total Wanted Fertility Rate ^a	IMR/ Under-5 Mortality ^b	% Currently Using Any Method ^c	% Currently Using Any Modern Method ^d	% Women Receiving Antenatal Care ^e	% Women Receiving Assistance at Delivery From Professional ^e	Median Duration (Months) of Breast- feeding ^f	% Children 0-35 Months Stunted ^g	% Children Fully Immunized ^h
ASIA										
Bangladesh 2000	3.3	††	66/94	54	43	33	13	††	45	60
Indonesia 1997	2.8	2.4	46/58	57	55	82	43	24	†	55
Kazakhstan 1999	2.1	1.9	62/71	66	53	94	99	7	10 ⁱ	81
Kyrgyz Republic 1997	3.4	3.7	61/72	60	49	97	98	17	25	82
Nepal 1996	4.6	2.9	79/118	29	26	39 ^j	10 ^j	31	48	43
Philippines 1998	3.7	2.7	35/48	47	28	86	56	13	†	73
Uzbekistan 1996	3.3	3.1	49/59	56	51	95 ^j	98 ^j	17	31	85
Vietnam 1997	2.7 ^b	2.4	28/38	75	56	71	77	17	†	57
LATIN AMERICA/CARIBBEAN										
Bolivia 1998	4.2	2.5	67/92	48	25	65 ^j	57 ^j	18	26 ^k	26
Brazil 1996	2.5	1.8	39/49	77	70	81 ^l	78 ^l	7	11 ^l	73
Colombia 1995	3.0	2.2	28/36	72	59	83	85	11	13	66
Dominican Republic 1996	3.2	2.5	47/57	64	59	98	96	8	11 ^l	39
Guatemala 1999	5.0	4.1	45/59	38	31	60	41	20	42	60
Haiti 1994	4.8	3.0	74/131	18	13	68	46	18	27	30
Nicaragua 1997	3.9	2.8	40/50	60	57	82	65	12	25	73
Peru 1996	3.5	2.2	43/59	64	41	66	55	20	26 ⁱ	63
NEAR EAST/NORTH AFRICA										
Egypt 2000	3.5	††	56/69	56	54	53	61	††	††	92
Jordan 1997	4.4	2.9	29/32	53	38	96	97	12	8	21
Morocco 1995	3.3	2.2	62/80	50	42	45	40	15	21 ^m	85
Turkey 1998	2.6	1.9	43/52	64	38	68	81	†	†	46
Yemen 1997	6.5	4.5	90/121	21	10	34	22	18	52 ⁱ	28
SUB-SAHARAN AFRICA										
Benin 1996	6.3 ^b	5.0 ^b	94/167	16	3	80 ^j	64 ^j	23	25	56
Burkina Faso 1999	6.8	6.0	105/219	12	5	61	31	27	37 ⁱ	29
Cameroon 1998	5.2	4.6	77/151	19	7	79	58	18	29	36
Chad 1997	6.6	6.3	103/194	4	1	32	24	21	40 ^m	11
Comoros 1996	5.1 ^b	3.7 ^b	77/104	21	11	85 ^j	52 ^j	20	34	55
Eritrea 1995	6.1	5.7	66/136	8	4	49 ^j	21 ^j	22	38	41
Ghana 1998	4.5 ^b	4.2 ^b	56/107	22	13	81	39	22	26	51
Guinea 1999	5.5	5.0	98/177	6	4	71	35	22	26 ⁱ	32
Kenya 1998	4.7	3.5	74/112	39	31	92	44	21	33	65
Madagascar 1997	6.0	5.2	96/159	19	10	78	47	21	48	36
Mali 1996	6.7	6.0	123/238	7	5	47 ^j	40 ^j	22	30	32
Mozambique 1997	5.6	5.9	135/201	6	5	71	44	22	36	47
Niger 1998	7.5	7.2	123/274	8	5	40	44	21	41	18
Senegal 1997	5.7	4.6	68/139	13	8	82	47	21	†	†
South Africa 1998	2.9	††	45/59	62	61	94	84	††	††	63
Tanzania 1999	5.6	4.8	99/147	25	17	49	36	21	44	68
Togo 1998	5.4	4.2	80/146	24	7	82	59	24	22 ⁱ	31
Uganda 1995	6.9	5.6	81/147	15	8	91 ⁿ	38 ⁿ	20	38	47
Zambia 1996	6.1	5.3	109/197	26	14	96	47	20	42 ⁱ	67
Zimbabwe 1999	4.0	††	††	54	50	93	83	††	††	75

† = Not available from survey data.

†† = Not available until publication of final report.

a Based on 3 years preceding survey (women 15-49).

b Based on 5 years preceding survey.

c Excludes prolonged abstinence.

d Excludes periodic/prolonged abstinence, withdrawal, "other."

e Care provided by medically trained personnel.

f Children <3 years old (any breastfeeding).

g Height-for-age z-score is below -2 SD based

on the NCHS/CDC/WHO reference population.

h Children 12-23 months (BCG, measles, 3 doses each DPT/polio).

i Children 0-59 months old.

j Based on births in the preceding 3 years.

k Children 3-35 months old.

l Care provided by doctor.

m From 1992 ENPS-II.

n Based on births during the preceding 4 years.