



Tajikistan State
Committee on Statistics



Findings from Tajikistan

Multiple Indicator Cluster Survey 2005

PRELIMINARY REPORT



Monitoring the Situation of Children and Women
October 2006

Findings from Tajikistan

**Multiple Indicator
Cluster Survey 2005**

PRELIMINARY REPORT

Summary Table of Findings MICS and MDG Indicators, Tajikistan, 2005

TOPIC	MICS3 INDICATOR NUMBER	MDG INDICATOR NUMBER	INDICATOR	VALUE	
Child Mortality	1	13	Under-five mortality rate	79	Per 1000
	2	14	Infant mortality rate	65	Per 1000
Nutrition	6	4	Underweight prevalence	17.3	Percent
	7		Stunting prevalence	26.9	Percent
	8		Wasting prevalence	7.2	Percent
	15		Exclusive breastfeeding rate	25.5	Percent
	16		Continued breastfeeding rate	74.9	Percent
	17		Timely complementary feeding rate	15.3	Percent
	Tajikistan specific		Global acute malnutrition	11.1	Percent
Child health	25		Tuberculosis immunization coverage	95.1	Percent
	26		Polio immunization coverage	79.3	Percent
	27		DPT immunization coverage	82.1	Percent
	28	15	Measles immunization coverage	85.6	Percent
	31		Fully immunized children	69.3	Percent
	29		Hepatitis B immunization coverage	68.5	Percent
	22		Antibiotic treatment of suspected pneumonia	40.6	Percent
	24	29	Solid fuels	35.0	Percent
	37	22	Under-fives sleeping under insecticide-treated nets	1.3	Percent
	38		Under-fives sleeping under bednets	1.7	Percent
	39		Antimalarial treatment (under-fives)	1.2	Percent
	41		Iodized salt consumption	46.4	Percent
Environment	11	30	Use of improved drinking water sources	69.5	Percent
	12	31	Use of improved sanitation facilities	93.7	Percent
Reproductive health	21	19c	Contraceptive prevalence	38.0	Percent
	4	17	Skilled attendant at delivery	83.4	Percent
	5		Institutional deliveries	61.8	Percent
Education	55	6	Net primary school attendance rate	88.6	Percent
	61	9	Female to male education ratio	0.99	Female to Male Ratio
Child protection	62		Birth registration	88.3	Percent
	67		Marriage before age 15, before age 18	0.8	Percent
	68		Young women aged 15-19 currently married or in union	6.4	Percent
HIV/AIDS, Sexual behaviour, and orphaned and vulnerable children	82	19b	Comprehensive knowledge about HIV prevention among young people	2.9	Percent



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Abbreviations used in the text

ACTED	L'Agence d'Aide à la Coopération Technique et au Développement
AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacillus- Cereus- Geuerin
CDC	Centre for Disease Control and Prevention
CIS	Commonwealth of Independent States
DPT	Diphtheria- pertussis-tetanus
DRD	Direct Rule Districts
GAVI	The Global Alliance for Vaccines and Immunization
GBAO	Gorno Badakhshan
GPI	Gender Parity Index
HIV	Human Immunodeficiency Virus
IDD	Iodine Deficiency Disorders
ITN	Insecticide treated Net
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
LSMS	Living Standards Measurement Survey
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NAR	Net Attendance Rate
NCHS	National Centre for Health Statistics
PPM	Parts Per Million
SCS	State Committee on Statistics
SD	Standard Deviation
SP	Sulfadoxine-pyrimethamine
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFC	World Fit for Children
WHO	World Health Organization
WHZ	Weight for Height





Acknowledgements

The 2005 Multiple Indicator Cluster Survey (MICS) provides an excellent picture of the status of children and women in Tajikistan. The MICS was originally developed in 1995 in response to the 'World Summit for Children' in order to measure progress towards an internationally agreed-upon set of mid-decade goals. Tajikistan conducted its first MICS in 2000. The current round of MICS aims to ascertain where Tajikistan stands in achieving the selected goals of 'A World Fit for Children', the Millennium Development Goals (MDGs), as well as other major international commitments. In contrast to the MICS 2000, the MICS 2005 also provides new data on areas such as child discipline, maternal mortality, marriage/union status of women, domestic violence, tuberculosis, vitamin A and nutritional status of children.

The MICS 2005 required months of planning and involved over 160 people, four weeks of trainings, six weeks of fieldwork and four weeks of data entry. It could not have happened without the hard work and dedication of those who participated in this project including; statistical experts, trainers, field coordinators, editors, mappers, listers, supervisors, interviewers, drivers, monitors, data entry clerks, and data processors.

Special thanks must be given to: Bakhtiya Mukhammadieva, First Deputy Director of the State Committee on Statistics (SCS). As technical director of the project he supported the MICS team by providing valuable advice on both overall and technical issues as well as showing great coordination skills. Thanks also go to Kislitsyna Elena, Head of the Demography Department of SCS, for her analytical skills and insights as well as to Kholdorbekov Ikhtier, Head of the Programming Department of SCS, for his technical support in programming and data processing. Thanks also to the supervisors of the field groups in the various regions: Asoev A., Ashurov G., Boymatov K., Stodolya O., Khaitov C., Boboev R., Vorisov A., Shokirov Sh., Shoibragimov A., Zangirbekov D., Kholdorbekov A., Gumaeva R., Mamadkarimova Kh. And finally to those who participated in mapping, field editing, interviewing, including drivers and data entry operators.

For the MICS 2005 a Coordinating Committee was established which included the active participation of many government institutions and international organizations such as: the Ministry of Health, the Ministry of Education, SCS, the Ministry of Labour and Social Protection and the Youth Committee under the Government of Tajikistan provided thoughtful comments and advice at every stage of the implementation. The World Bank was also part of this committee.

Needless to say, the MICS 2005 would not have been accomplished without the financial support and understanding from the Department for International Development in the United Kingdom (DFID), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID). These donors were also part of the steering committee.

Many committee members also contributed to the successful implementation of the MICS 2005 in many diverse ways, such as the World Health Organization (WHO). The Ministry of Health and SCS staff participated in the monitoring of MICS field work in various districts and regions. At training UNFPA gave lectures on contraception and also participated in the monitoring of fieldwork in Sogd. Action Against Hunger provided anthropometric demonstrations for the interviewers as well as the anthropometric fieldwork equipment. L'Agence d'Aide à la Coopération Technique et au Développement (ACTED) carried out the presentations on bed-nets and the Aga Khan Foundation provided the logistical support for fieldwork in GBAO.

The following also provided constant support and guidance: the UNICEF New York staff and the Geneva Regional Office: the UNICEF Tajikistan staff; Yukie Mokuo, the Tajikistan Country Office Representative who coordinated various partners and always guided the team in the right direction: Niloufar Pourzand, former Programme coordinator: Naoko Hosaka, M&E officer: Farhod Khamidov, M&E assistant: and Nukra Sinavbarova, MICS-3 assistant.

Lastly, constant support and guidance was given by Oleg Benes, the consultant who designed the sample, supervised trainings, provided advice on fieldwork, created tabulation plans and drafted this report.

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I. Background and Objectives

Introduction

This preliminary report is based on the Tajikistan Multiple Indicator Cluster Survey (MICS), conducted in 2005 by the State Committee on Statistics (SCS) supported by its regional-level offices as well as the Ministry of Health, Ministry of Education, Ministry of Labour and Social Protection and the Youth Committee under the Government of Tajikistan. The survey was based, in large part, on the need to monitor progress towards goals and targets emanating from recent international agreements: the Millennium Declaration, adopted by all 191 United Nations Member States in September 2000, and the Plan of Action of A World Fit For Children (WFFC), adopted by 189 Member States at the United Nations Special Session on Children in May 2002. Both of these commitments build upon promises made by the international community at the 1990 World Summit for Children.

In signing these international agreements, governments committed themselves to improving conditions for their children and to monitoring progress towards that end. UNICEF was assigned a supporting role in this task (see Box).

A Commitment to Action: National and International Reporting Responsibilities

The governments that signed the Millennium Declaration and the World Fit for Children Declaration and Plan of Action also committed themselves to monitoring progress towards the goals and objectives they contained:

“We will monitor regularly at the national level and, where appropriate, at the regional level and assess progress towards the goals and targets of the present Plan of Action at the national, regional and global levels. Accordingly, we will strengthen our national statistical capacity to collect, analyse and disaggregate data, including by sex, age and other relevant factors that may lead to disparities, and support a wide range of child-focused research. We will enhance international cooperation to support statistical capacity-building efforts and build community capacity for monitoring, assessment and planning.” (A World Fit for Children, paragraph 60)

“...We will conduct periodic reviews at the national and subnational levels of progress in order to address obstacles more effectively and accelerate actions...” (A World Fit for Children, paragraph 61)



The Plan of Action (paragraph 61) also calls for the specific involvement of UNICEF in the preparation of periodic progress reports:

“... As the world’s lead agency for children, the United Nations Children’s Fund is requested to continue to prepare and disseminate, in close collaboration with Governments, relevant funds, programmes and the specialized agencies of the United Nations system, and all other relevant actors, as appropriate, information on the progress made in the implementation of the Declaration and the Plan of Action.”

Similarly, the Millennium Declaration (paragraph 31) calls for periodic reporting on progress:

“...We request the General Assembly to review on a regular basis the progress made in implementing the provisions of this Declaration, and ask the Secretary-General to issue periodic reports for consideration by the General Assembly and as a basis for further action.”

Over the past years, the Tajikistan government has increased their political commitment and capacity in undertaking social reforms in line with the realization of the Millennium Development Goals (MDGs) and the rights of children and women. In 2005 the government made major progress towards the MDG achievements, with the completion of a MDG Needs Assessment and a draft of a National Development Strategy. However, still much remains to be done especially in the areas of access to quality health, education and child protection services. Tajikistan continues to be in dire need of additional international support in order to meet the MDG targets, as well as fulfil its commitment to the realization of children and women’s rights. The completion of the 2005 MICS will complement this strategically related work by providing updated baseline data for future planning and implementation by all stakeholders and duty-bearers. It is expected that the MICS 2005 findings will further enhance the evidence based policy planning and analysis of the Government, thus, contributing to more systematic policy development and its implementation towards the MDGs and a WFFC.

This preliminary report presents selected results on a variety of principal topics covered in the survey and on a subset of indicators¹. As specified, the results in this report are preliminary and are subject to change, although major changes are not expected. A comprehensive full report is scheduled for publication in spring 2007.

Survey Objectives

The 2005 Tajikistan Multiple Indicator Cluster Survey (MICS) has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in Tajikistan;

¹ For more information on the definitions, numerators, denominators and algorithms of Multiple Indicator Cluster Surveys (MICS) and Millennium Development Goals (MDGs) indicators covered in the survey: see Chapter 1, Appendix 1 and Appendix 7 of the MICS Manual – Multiple Indicator Cluster Survey Manual 2005: Monitoring the Situation of Children and Women, also available at www.childinfo.org

- To furnish data needed for monitoring progress toward goals established by the Millennium Development Goals (MDGs) and the goals of A World Fit For Children (WFFC) as a basis for future action;
- To contribute to the improvement of data and monitoring systems in Tajikistan and to strengthen technical expertise in the design, implementation, and analysis of such systems.







II. Sample and Survey Methodology

Sample Design

The sample for the Tajikistan Multiple Indicator Cluster Survey (MICS) was designed to provide estimates on a large number of indicators on the situation of children and women at the national level, for both urban and rural areas, and for five regions: Dushanbe (the capital), Direct Rule Districts (DRD), Sogd, Khatlon and Gorno Badakhshan (GBO). Regions by urban-rural areas were identified as the main sampling domains. The sample followed a two-stage design. At the first stage, 290 primary sampling units were selected with probability proportional to size from a master frame of 17,923 census enumeration areas, produced by a Tajikistan census of the population conducted in 2000. After household listing and mapping was carried out within the selected enumeration areas, a systematic sample of 6,968 households was drawn. All selected enumeration areas were successfully visited. The distribution of clusters between sampling domains is not proportional to the census distribution of population and, consequently neither is the final household distribution. The sample is therefore not a self-weighting household sample. For reporting national level results, sample weights are used.

Questionnaires

Three questionnaires were used in the survey: a Household Questionnaire, a Questionnaire for Individual Women and a Questionnaire for Children Under-Five.

The questionnaires were used to collect data on all household members. Information was collected on all household members to identify and subsequently administer questionnaires to all women aged 15-49 as well as children under-five. For children under-five, the questionnaire was administered to the mother or caretaker of the child. Information on the dwelling of the household was also collected. The content of these questionnaires was based on model MICS questionnaires. Consultations with partners were held in Dushanbe to select the most important topics to be covered by the survey. Following these consultations the model MICS questionnaires were adjusted to reflect issues relevant to Tajikistan regarding population, women and children's health, family planning, domestic violence and other health issues.

The Tajikistan MICS questionnaires had a number of important additions as compared to the model MICS questionnaires. In the household questionnaire a number of questions were included to assess salt acquisition and consumption patterns. The Questionnaire for Individual Women incorporated additional questions on pregnancy outcomes, a larger list of antenatal



health services, knowledge of contraceptives, participation of women in the household decision making and a module on tuberculosis.

The final questionnaires were approved by the Coordinating Committee and included the following modules:

Household Questionnaire

- Household listing
- Education
- Water and Sanitation
- Household characteristics
- Insecticide treated Net (ITN)
- Child Labour
- Child Discipline
- Maternal Mortality
- Salt Iodization

Questionnaire for Individual Women

- Child Mortality
- Maternal and Newborn Health
- Marriage/Union
- Contraception
- Attitudes Toward Domestic Violence
- HIV/AIDS
- Tuberculosis

Questionnaire for Children Under-Five

- Birth Registration and Early Learning
- Child Development
- Vitamin A
- Breastfeeding
- Care of Illness
- Malaria
- Immunization
- Anthropometry

From the MICS3 model English version, the questionnaires were translated into Tajik and Russian. All aspects of MICS data collection were pre-tested during July 2005. Seventeen people, who were expected to act as fieldwork supervisors and editors during the main fieldwork, were trained for four days and then dispatched in order to conduct interviews in both on Tajik and Russian. At this time weight and height measurements were also taken. These fieldwork exercises for the pre-testing period were conducted in one urban and one rural area in a district close to Dushanbe. Participants worked in teams composed of two people allowing the interviewers to both observe and support each other. Each team performed between four and seven household interviews. The lessons learned from these pre-tests were used to finalize the survey instruments and logistical arrangements.



Training

The field staff was trained for nine days in late August 2005. A total of 86 participants were trained as field staff supervisors, editors and interviewers. Only female candidates were selected for the positions of interviewers and field editors. Males were recruited to act mainly as field work supervisors. Training included plenary presentations, demonstrations and discussions. These were supplemented by small group activities such as role playing, mock interviews, discussions and performing anthropometry measurements and iodine tests. Resource people from UNFPA, Action Against Hunger, ACTED and UNICEF made presentations on Tajikistan's programmes on the topics of family planning, anthropometry, insecticide treated nets, maternal and child health, HIV/AIDS and salt iodization. In addition to in-class training, participants practiced their interviewing skills during a two day fieldwork exercise. Once completed, a final session was held to address any lasting concerns or issues that would be faced in the field. Participants selected as field supervisors and editors were given an additional day of training on the topic of how to supervise field work and edit questionnaires.

Fieldwork and Data Processing

The data was collected by 14 teams; each comprised of three to four female interviewers, one driver, one female editor/measurer and one supervisor. Senior staff from the SCS and two national fieldwork coordinators coordinated and supervised the field work activities.

Fieldwork began at the beginning of September 2005 and concluded in mid October 2005

Data was entered on 10 computers using the CSPro software. In order to ensure quality control, all questionnaires were entered twice and consistency checks were performed. Standard programs and procedures, developed under the global MICS3 project and adapted to the Tajikistan questionnaire, were used throughout. An additional set of data control tables was developed by the data collection team and was used on a weekly basis during the data entry period to monitor the quality of incoming data. Data processing began simultaneously with data collection in mid September 2005 and was completed by the end of October 2005. Data was analysed using the SPSS software program and the model syntax and tabulation plans developed for this purpose.

Sample Coverage

Of the 6,968 households selected for the sample, 6,961 were found to be occupied. Of these, 6,684 were successfully interviewed for a household response rate of 96 percent. In the interviewed households, 10,626 women (age 15-49) were identified. Of these, 10,243 were successfully interviewed, yielding a response rate of 96 percent. In addition, 4,370 children under age five were listed in the household questionnaire. Of these, 4,273 questionnaires were completed by mothers or caretakers of the children, yielding a response rate of 98 percent. Overall response rates of 93 and 94 percent were calculated for the Individual Women and Children Under-Five interviews respectively (Table 1).



III. Results

Child Mortality

One of the overarching goals of the Millennium Development Goals (MDGs) and A World Fit for Children (WFFC) is to reduce infant and under-five mortality. Monitoring progress towards this goal is an important but difficult objective. Measuring child mortality rates may seem unproblematic in theory. In practice attempts using direct questions, such as “Has anyone in this household died in the last year?” have proven to provide inaccurate results. At the same time, gaining data concerning child mortality rates from birth histories is both time consuming and complicated. Demographers have therefore been forced to devise ways to measure childhood mortality indirectly. These ‘indirect methods’ minimize the danger of memory lapses, inexact or misinterpreted definitions, and poor interviewing techniques.

The infant mortality rate is the probability of dying between birth and exactly one year of age expressed per 1.000 live births. The under-five mortality rate is the probability of dying between birth and exactly five years of age expressed per 1.000 live births. In the MICS 3, infant and under-five mortality rates were calculated based on an indirect estimation technique; the so-called ‘Brass method’. “The Brass method allows mortality rates to be estimated from aggregate information on the number of children born to women in 5-year age groups (15-19, 20-24 etc), and the proportion of children in each group who die” (Aleshina & Redmond, 2003, 27). The technique converts this data into the probability of dying by taking into account both the mortality risks to which children are exposed as well as the length of their exposure to these risks.

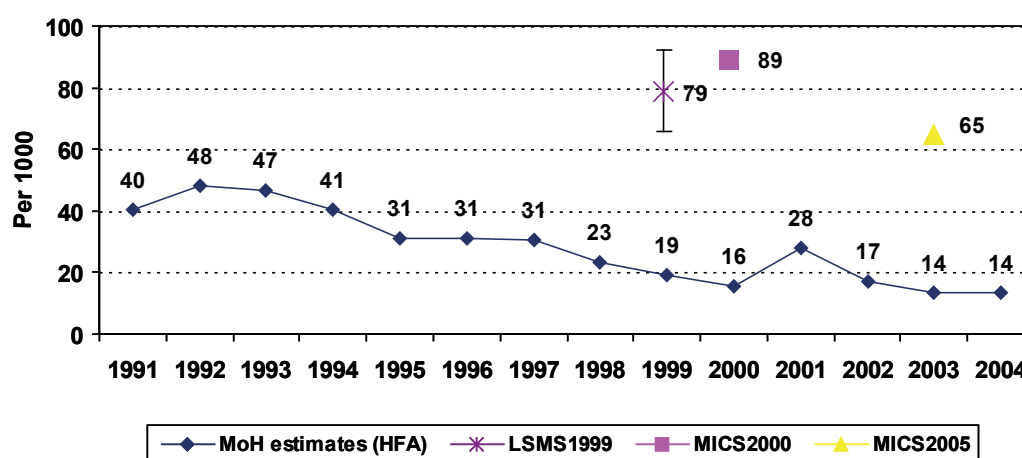
Table 2 provides estimates of child mortality by various background characteristics. The infant mortality rate is estimated at 65 per thousand, while the under-five mortality rate is 79 per thousand. These estimates are based on the year 2003. Excess male mortality during the neonatal period is widespread and substantial in some countries, but sex differentials after the neonatal period are generally very small. In Tajikistan both infant mortality and under-five mortality rates are significantly higher among males than females (75 versus 54 and 92 versus 66 respectively). These findings need further analysis, as the gender difference in the under-five mortality rates is significantly different than expected differentials. By region, results indicate the highest level of under-five mortality rate occurs in Khatlon (102 per thousand) while the lowest are seen in DRD, GBAO and Dushanbe (less than 60 per thousand). There are also significant differences in child mortality rates in terms of educational levels and wealth. Rates are almost five times higher in children born to mothers with little or no secondary education as compared to those with higher levels of education. Children born into the poorer households interviewed are more likely to die during their



first five years of life as compared to those living in wealthier environment. However, both the infant mortality and under-five mortality rates are lower as compared to the MICS 2000 data (89 and 126 per 1000 accordingly).

Adjusting for the known biases in national data (under-reporting of vital statistics), WHO Euro estimated the under-five mortality rate in Tajikistan to be around 86 per 1000 live births in 2001 and 63 per 1000 in 2002. The UNICEF report, 'The State of the World's Children 2006' estimates Tajikistan's infant mortality rate to have been 91 in 2004.

Figure 1: Infant mortality rate estimates, Tajikistan, 2005



The MICS 2005 infant mortality estimates are in line with the findings from the 1999 Tajikistan Living Standards Measurement Survey (LSMS). These estimates were 79 per 1000 live births (95 percent confidence interval 65-92). The 2004 research into the main causes of infant death in Tajikistan (using an adaptation of the standard verbal autopsy protocols of the WHO), suggests infant mortality rates to be varied for four surveyed country regions from 58 (Sogd, DRD) to 103 (Dushanbe, Khatlon) during a period of time covering 1998-2002.

Conversely, infant mortality rates as reported by the Ministry of Health in Tajikistan are significantly lower (27.9 per 1000 in 2001, 17.2 in 2002, and 13.5 in both 2003 and 2004) as compared to survey estimates for the same years. The existing discrepancy between registered infant mortality rates and survey data may be partially explained by the fact that official estimates of infant mortality use protocols established during the Soviet regime, which do not consider newborns less than 999 grams in weight, those born before 28 weeks of pregnancy and those who do not manifest vital signs other than breath, as live births. At the same time, there is a persistent gap in the registration of births particularly for the first six months of a child's life (Aleshina & Redmond: 2003).

Nutritional Status

Children's nutritional status is a reflection of their overall health. When children have access to an adequate food supply, are not exposed to repeated illness and are well cared for, they reach their growth potential and are considered well nourished.



In a well-nourished population there is a standard distribution of height and weight for children under age five. Under-nourishment in a population can be measured by comparing children to this standard distribution. The reference for this population distribution that was in use for this survey was the WHO/Centre for Disease Control and Prevention (CDC)/ National Centre for Health Statistics (NCHS) reference. This reference has been recommended for use by many international organizations such as UNICEF and WHO. Each of the three nutritional status indicators (explained below) can be expressed in standard deviation (SD) units (z-scores) from the median of this reference population.

The first indicator, weight for age, can be used as a measure of both acute and chronic malnutrition. Children whose weight for age is more than two standard deviations below the median of the reference population are considered moderately or severely underweight while those whose weight for age is more than three standard deviations below the median are classified as severely underweight.

The second indicator, height for age is a measure of linear growth. Children whose height for age is more than two standard deviations below the median of the reference population are considered short for their age and are classified as moderately or severely stunted. Those whose height for age is more than three standard deviations below the median are classified as severely stunted. Stunting is a reflection of chronic malnutrition as a result of failure to receive adequate nutrition over a long period of time and/ or recurrent or chronic illness.

Finally, children whose weight for height is more than two standard deviations below the median of the reference population are classified as moderately or severely wasted. Those who fall more than three standard deviations below the median are severely wasted. Wasting is usually the result of a recent nutritional deficiency. The indicator may exhibit significant seasonal shifts associated with changes in the availability of food and/ or disease prevalence.

Table 3 shows the percentages of children in these various categories based on the anthropometric measurements that were taken during fieldwork. The table also includes the percentage of children who are overweight, which takes into account those children whose weight for height is above two standard deviations from the median of the reference population.

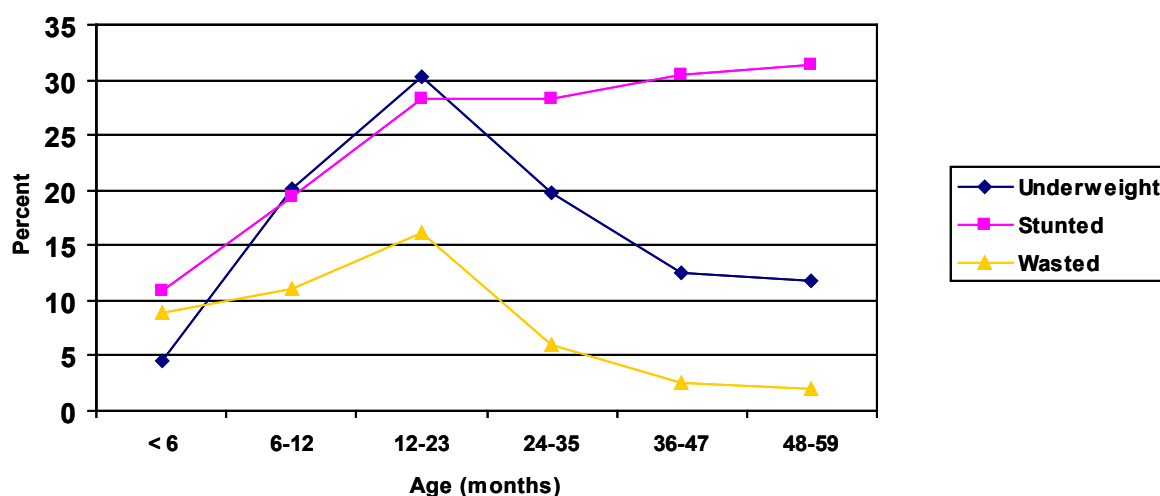
For this survey, children who were not weighed or measured (approximately one percent of children) as well as those whose measurements were outside a plausible range were excluded from the survey results. In addition, a small number of children whose birth dates are not known were excluded.

In Tajikistan, underweight prevalence (moderate and severe) is 17 percent (Table 3). About 4 percent of children under-five are severely underweight. Nearly 27 percent are stunted and 9 percent are severely stunted. Seven percent of those surveyed could be classified as wasted. It is estimated that about 4 percent of children under-five are overweight.

The prevalence rates of underweight children were highest in the Khatlon and GBAO regions, while the lowest rates were found in Dushanbe. A similar pattern was found for the prevalence rates for stunting. Those children whose mothers had higher educational levels were the least likely to be underweight and/ or stunted as compared to children whose mothers had little or no primary or secondary education..

Underweight and wasting levels are roughly equal between boys and girls, whereas boys are somewhat more likely to be stunted than girls. The age pattern shows that a higher percentage of children aged 12-23 months are underweight or wasted as compared to children of other ages (Figure 2). However, for stunting the levels reach a plateau during the second to fifth year of life. This pattern is expected and is related to the age at which many children cease to be breastfed and are continuously exposed to contamination from the water, food and the environment.

Figure 2: Percentage of children aged 0-59 months who are undernourished, Tajikistan, 2005



In addition to the three MICS standard indicators used to assess the nutritional status of children (weight for age, height for age and weight for height) two other indicators were utilized, the mid - upper arm circumference (MUAC) and the presence of oedema. The aim of including these extra indicators was to assess for the presence of Global Acute Malnutrition in children aged 12 to 59 months (as determined by weight for height below $-2SD$, MUAC below 12.5 cm or oedema). Countrywide 11 percent of children aged 12 to 59 months were exposed to Global Acute Malnutrition (Table 4). The highest rate was observed in the Khatlon region (14 percent). The prevalence of Global Acute Malnutrition was higher in children from the poorest quintile (13 percent) as compared to children from the richest quintile (10 percent).

Breastfeeding

Breastfeeding for the first few years of life protects children from infection, provides them with an ideal source of nutrients as well as being economical and safe. However, many mothers stop breastfeeding too soon as there are often pressures for them to switch to infant formula. This early cessation of breastfeeding can contribute to growth faltering, micronutrient malnutrition and is unsafe if clean water is not readily available. One goal of A World Fit for Children states that children should be exclusively breastfed for six months, followed by breastfeeding combined with safe, appropriate and adequate supplementary feeding to two years of age and beyond.

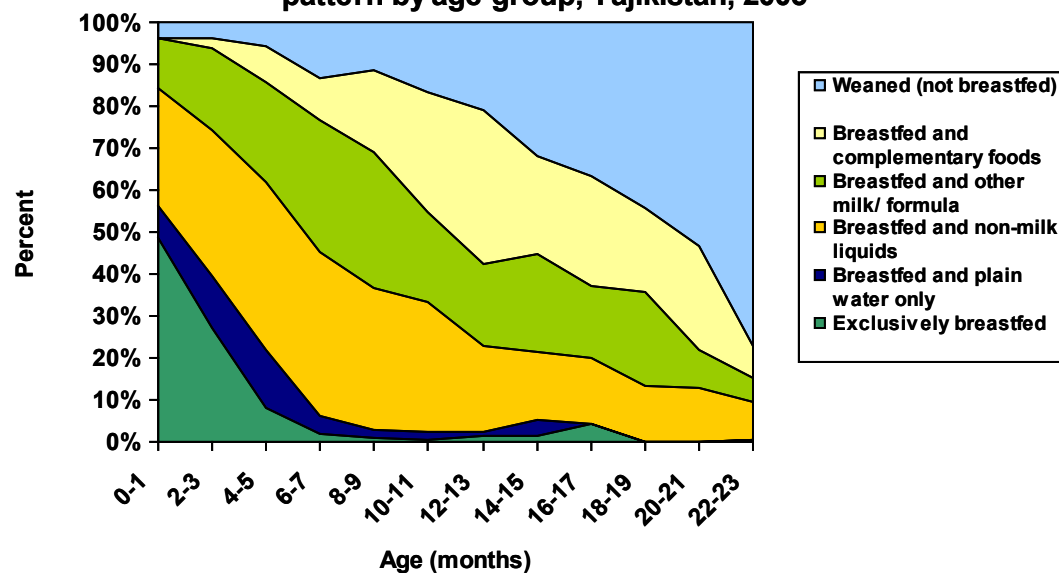


In Table 5, breastfeeding status was based on information from the children's mother or caretaker who reported on the child's consumption of food and/ or fluids in the 24 hours prior to the interview. Exclusively breastfed refers to infants who received only breast milk and vitamins, mineral supplements, and/ or medicine. Breastfed refers to infants who receive breast milk along with water, non-milk liquids and other complementary foods. Table 5 shows exclusive breastfeeding of infants during the first six months of life separated for 0-3 months and 0-5 months. The table also shows complementary feeding of children aged 6-9 months and continued breastfeeding of children at 12-15 and 20-23 months of age.

In Tajikistan, approximately 26 percent of children six months of age or less are exclusively breastfed. The remaining percentage of children is subject to the introduction of water and non-milk liquids in addition to breastfeeding, (Figure 3). This practise can be unsafe for the child's overall health.

At age 6-9 months, 15 percent of children were receiving breast milk as well as solid or semi-solid foods. This practise can also be unsafe as it exposes children to insufficient micronutrients intake needed for their normal grow and development. By age 12-15 months, 75 percent of children were being breastfed, with this number dropping to 34 percent for children aged 20-23 months. Breastfeeding patterns during the first year of life vary significantly by regions as well as by education level of mothers. Boys were more likely to be exclusively breastfed and receive timely complementary foods than were girls. Children from rural areas, the poorest quintile and those whose mothers had not completed secondary or higher education were more likely not to receive complementary feeding during their first year of life.

**Figure 3: Infant feeding patterns by age:
Percent distribution of children aged under 2 years by feeding
pattern by age group, Tajikistan, 2005**



Salt Iodization

Iodine Deficiency Disorders (IDD) is the world's leading cause of preventable mental retar-

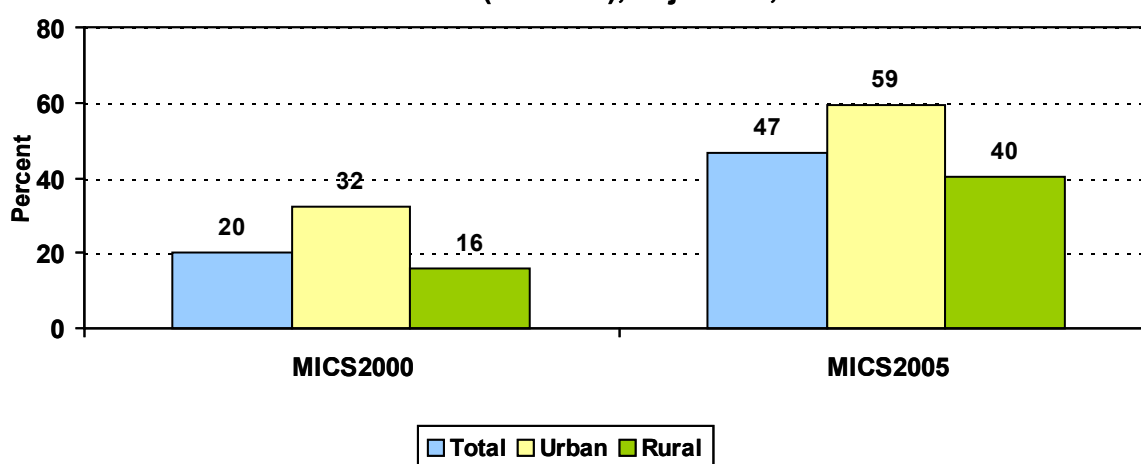
dation and impaired psychomotor development in young children. In its most extreme form, iodine deficiency causes cretinism. It also increases the risks of stillbirth and miscarriage in pregnant women. Iodine deficiency is most commonly associated with visible goitres. IDD also leads to impaired mental growth and development, contributing in turn to poor school performance, reduced intellectual ability, and impaired work performance.

The reported incidence of endemic goiter, as a main marker of IDD, increased in Tajikistan from 1.14 per thousand in 1997 to 2.15 in 2002. Examinations carried out revealed a high percentage of the population is affected by goiters: for the different regions, 45-82 percent among children and 60 percent among women of reproductive age (MoH, 2003).

In Tajikistan joint efforts of the Government and the donor community to address IDD were formulated in the National Programme for Elimination of IDD, developed in 1997. The programme stipulates that all salt must be iodized to 45 parts per million (PPM). The Law № 344 On Salt Iodization, adopted in 2002, regulates the production, distribution and consumption of iodized salt in the country. Development of the national standard for iodized salt and the mobilization of the salt producer community, as well as other concerted actions at the national level, aim to achieve a change in iodine intake. This change is measured by the proportion of the population consuming an adequate amount of iodized salt, which was as low as 20 percent according to MICS conducted in 2000.

In about 99 percent of households, salt used for cooking was tested for iodine content by using salt test kits and testing for the presence of potassium iodate. In a very small proportion of households (less than 1 percent), there was no salt in the household (Table 6). In 46 percent of households, salt was found to contain 15 (PPM) or more of iodine, that reveal an important progress made over the past five years (Figure 4).

Figure 4: Percentage of households consuming adequately iodized salt (15+PPM), Tajikistan, 2005



Use of iodized salt was the highest in Sogd (75 percent) and the lowest in Khatlon (27 percent). Some 59 percent of urban households were found to be using adequately iodized salt as compared to 40 percent in rural areas. Iodised salt consumption was nearly as twice as high among richest quintile of the population (63 percent) as compared to the poorest (31 percent).



Immunization

According to UNICEF and WHO guidelines, a child should receive; a Bacillus-Cereus-Geuerin (BCG) vaccination to protect against tuberculosis, three doses of the Diphtheria-pertussis-tetanus (DPT) vaccination, three doses of the polio vaccine, and a measles vaccination. The vaccination schedule followed by the National Immunization Programme of Tajikistan provides all vaccinations mentioned above as well as vaccinations against hepatitis B (three doses). All vaccinations should be received during the first year of life, with the exception of measles which is given soon after the age of 12 months. Taking into consideration this vaccination schedule, immunization coverage was estimated for the cohort 15-26 months of age, allowing a reasonable interval of three months for children to receive measles vaccine.

The information on vaccination coverage was obtained for all children under five years of age. In Tajikistan, as in many other countries from the Commonwealth of Independent States (CIS), child health records are routinely maintained in the local health facilities. The practice of keeping immunization cards in the possession of the child's parent or guardian has recently started to be implemented with the support from The Global Alliance for Vaccines and Immunization (GAVI). In this survey, data was collected from both these sources as well as from the mother's verbal report. All mothers were asked to provide immunisation cards and if these were available, interviewers copied the vaccination information onto the MICS3 questionnaire. The interviewer then proceeded to ask the mother if the child had received the BCG, polio, DPT, hepatitis B and measles vaccines as well as how many doses. After completing the interview in the household, information about the address of the local health facility where the child's immunization record is kept was collected and interviewers or the supervisors visited that health facility in order to obtain the immunization information.

Vaccination certificates at home were obtained for 9 percent of children while immunization records at the health facility were obtained for 82 percent of children. In some cases both sources of information were used for a child. Overall, 85 percent of children had immunization records either at home or at health facility². The percentage of children aged 15 to 26 months who received each of the vaccinations is shown in Table 7. The denominator for the table is comprised of children aged 15-26 months meaning that only children who are old enough to be fully vaccinated are counted. In the top panel, the numerator includes all children who were vaccinated at any time previous to the survey according to the vaccination card or the mother's report. In the bottom panel, only those who were vaccinated before their first birthday are included. For children without vaccination cards, the proportion of vaccinations given before their first birthday is assumed to be the same as for children with vaccination cards.

Approximately 95 percent of children aged 15-26 months received a BCG vaccination by the age of 12 months. The first dose of DPT was given to 91 percent of these same children with the percentage declining for subsequent doses of DPT to 87 percent for the second dose, and 82 percent for the third dose (Figure 5). Similarly, 92 percent of children received the first dose of Polio vaccine by age 12 months with this declining to 79 percent by the third dose. The coverage for measles vaccine by 15 months is 86 percent. Overall, the percentage of children

² These figures are not included in the attached tables

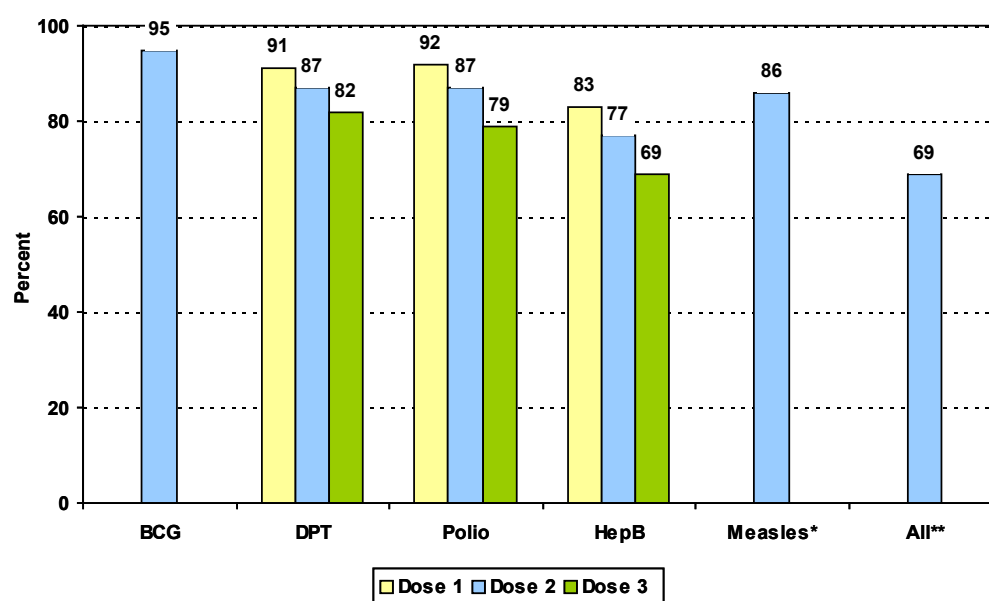


who had all eight recommended vaccinations (three doses of DPT, three doses of Polio (excluding Polio 0), BCG, and Measles vaccine) by their first birthday (in case of measles – by 15 months of age) is low at only 69 percent. It is important to note that 4 percent of the children never received any of the eight doses of vaccines. It is also worth mentioning that none of the latter children had an immunization card available either at home or at the health facility.

Coverage with hepatitis B vaccine is analyzed separately taking into consideration its recent introduction (it was started in 2002 small scale in a few districts as well as the maternity hospital and has scaled up to cover all districts since 2003). Approximately 83 percent of children aged 15-26 months received the first dose of hepatitis B vaccine by the age of 12 months. As in the case of the polio and DPT coverage, the prevalence of subsequent doses of hepatitis B vaccine drops gradually to 77 percent for the second dose and 69 percent for the third dose.

Table 7 also shows the proportions of children who had received the vaccinations at any time before the survey, regardless of the age of the child at the time of vaccination. It includes both timely vaccinations and vaccinations given later than the child's first birthday. These figures are 1-4 percent higher as compared to timely received doses. Even in this final case, accessibility of routine vaccination services to children measured by proportion of children receiving DPT1 is only 93 percent. The decline in coverage levels reflects drop-out rates of 8 percent for DPT, 11 percent for polio and 14 percent for hepatitis B vaccine. The drop-out rate represents the proportion of children who receive the first dose of vaccine but do not finalize the immunization series getting the third dose. Drop-outs higher than 10 percent are usually related to the lack of continuity of immunization services at the health delivery level. Both accessibility of immunization services and their continuity should be thoroughly addressed in Tajikistan in order to achieve timely vaccination coverage over 90 percent for complete immunization series.

Figure 5: Percentage of children 15-26 months who received immunizations by age 12 months, Tajikistan, 2005



* Measles – received by age 15 months

** All = 3 doses of DPT, 3 doses of Polio (excluding Polio 0), BCG, and Measles.



Antibiotic Treatment of Children with Suspected Pneumonia

Pneumonia is the leading cause of death in children and the use of antibiotics in under-five's with suspected pneumonia is a key intervention. Children with suspected pneumonia are those who had an illness with a cough accompanied by rapid or difficult breathing and whose symptoms were due to a problem in the chest. This question was limited to children who had suspected pneumonia within the previous two weeks and whether or not they had received an antibiotic within this time frame.

According to the reports of the Ministry of Health (MoH) and data from the State Committee on Statistics, respiratory system diseases account for 30-40 percent of infant mortality in Tajikistan.

Table 8 represents the use of antibiotics for the treatment of suspected pneumonia in under-fives. Taking into consideration the survey was conducted in September to October, when the spread of respiratory diseases is low, the prevalence of children with suspected pneumonia was rather low at 1.6 percent. The limited number of observations allows further disaggregating data only by sex and area. In Tajikistan, 41 percent of under-five children with suspected pneumonia had received an antibiotic during the two weeks prior to the survey. The percentage was higher among female (46 percent) comparing to male (36 percent) and in urban areas (55 percent) comparing to rural areas (34 percent).

Solid Fuel Use

Cooking with solid fuels (biomass and coal) leads to high levels of indoor pollution and is a major cause of ill-health in the world, particularly among children under-five, in the form of acute respiratory illness.

Overall, more than a third (35 percent) of all households in Tajikistan are using solid fuels for cooking (Table 9). Use of solid fuels is very low in urban areas (8 percent), but very high in rural areas, where almost half of the households (48 percent) are using solid fuels. Differentials with respect to region, household wealth and the educational level of the household head are also significant. The table clearly shows that the percentage is high mainly due to high level of wood usage for cooking purposes.

Malaria

Malaria is a leading cause of death of children under age five in endemic areas. It also contributes to anaemia in children and is a common cause of school absenteeism. Preventive measures, especially the use of insecticide treated nets (ITNs), can dramatically reduce malaria mortality rates among children. In areas where malaria is common, international recommendations suggest treating any fever in children as if it were malaria and immediately giving the child a full course of recommended antimalarial tablets. Children with severe malaria symptoms, such as fever or convulsions, should be taken to a health facility. As well, children recovering from malaria should be given extra liquids and food and/ or should continue breastfeeding.



Malaria re-emerged in Tajikistan in 1992 as a result of the social-economic deterioration linked to armed conflict, mass population movement across zones of intensive transmission of malaria (particularly Afghanistan where malaria is endemic), and the disruption of public health care services as well as vector control activities. Marked changes in agricultural practices, particularly the increase in the cultivation of rice, have led to an increase in vector breeding grounds. The above mentioned activities have led to the formation of standing-water reservoirs and the establishment of an endemic transmission of the disease particularly in the southern part of Tajikistan. The number of malaria cases reported in Tajikistan peaked in 1997, when nearly 30,000 cases were registered. Despite a 92 percent reduction in reported number of cases since this time, the malaria situation in the country remains serious. The resumption of *P. falciparum* cases and the expansion of the territory in which this type of malaria is spread is a matter of particular concern. During the last five years more than three quarters of reported cases of malaria occurred in the Khatlon region, 14 percent in DRD and only 2-4 percent in the remaining three regions.

The residents of the Khatlon Region, an area bordering Afghanistan which is home to 2.2 million people, bear the highest burden of malaria in the WHO European Region. A survey carried out in this region in 2001 indicated that more than 10 percent of the study population were asymptomatic parasite carriers of *P. vivax* and *P. falciparum*. Within the the Khatlon Region, the number of malaria cases was estimated to be as high as 150,000 to 250,000. The total number of malaria cases within the country, including both symptomatic and asymptomatic cases, was estimated to reach up to 300,000-400,000.

Based on information provided by MoH Malaria Centre, selected endemic districts of the Khatlon and Sogd regions (the latter has a population of 0.4 million), have been supplied with almost 115,000 bednets over the last eight years. This has been done with support from ACTED and MERLIN with the aim of reducing the risk of mosquito bites.

The MICS3 questionnaires (Household and Children Under-five) incorporate questions on the use of bednets, antimalarial treatment as well as intermittent preventive therapy for malaria. The MICS3 results in Tajikistan indicate a low rate of bednet use: household availability of bednets is 5 percent and availability of insecticide treated nets is 2 percent. The highest rates were reported in Khatlon (8 percent) and Sogd (6 percent) while in other regions less than 1 percent of households had a bednet³.

Two percent of children under the age of five had slept under a bednet the night prior to the survey and only 1 percent slept under an insecticide treated net (Table 10). ITN use among children under five was only practiced in households from the Khatlon region (3 percent). ITN were not used among children from Dushanbe, Sogd or the GBAO regions.

Questions on the prevalence and treatment of fever were asked for all children under the age of five. Seven percent of children under five were ill with fever in the two weeks prior to the MICS3 fieldwork interview (Table 11). Fever prevalence declined with age and peaked at 12-23 months (10 percent). Fever was less common among children living in households from the richest quintile (6 percent) as compared to those from the poorest quintile (10 percent). There is no significant variation by gender, urban/rural area or level of mother's education.

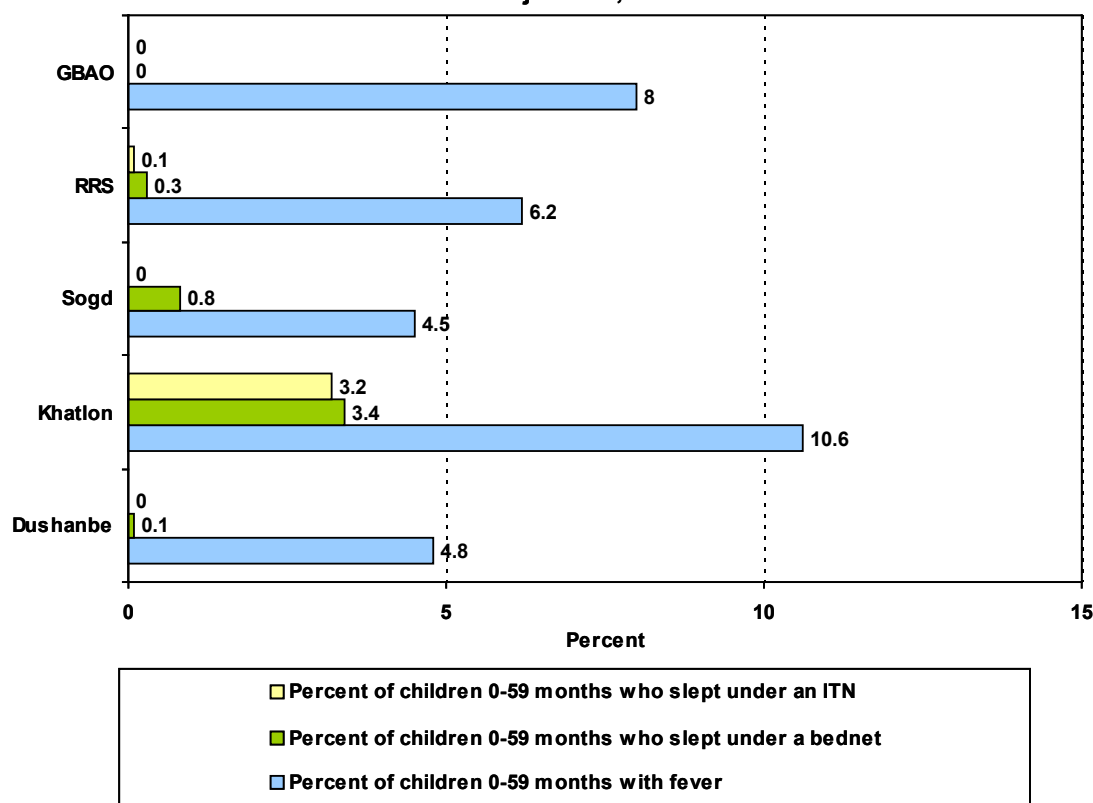
³ The table where these figures came from is not shown in this report, but will be shown in the final report.



Some regional differences in fever prevalence were observed, ranging from 5 percent in Sogd and Dushanbe to 11 percent in Khatlon (Figure 6).

Mothers were asked to report all medicines, both those from home and those given/ prescribed at a health facility, given to a child to treat fever. Overall, 2 percent of children with fever in the two weeks prior to the field visits were treated with an ‘appropriate’ antimalarial drug and 1 percent received antimalarial drugs within 24 hours of the onset of symptoms.

Figure 6: Percentage of children 0-59 months who slept under a bednet previous night and percent of children who had fever, Tajikistan, 2005



‘Appropriate’ antimalarial drugs include: Chloroquine, Sulfadoxine-pyrimethamine (SP), artemisine combination drugs, etc. In Tajikistan, none of children with fever were given Chloroquine, quinine, Armodiaquine and less than 1 percent was given a SP/Fansidar and artemisine combination therapy. A large percentage of children (73 percent) were given other types of medicines that are not antimalarials, including anti-pyretics such as Paracetomal, Aspirin or Ibuprofen.

Girls were more likely to receive appropriate antimalarial drugs as compared to boys. There was no significant variation of appropriate anti-malaria treatment of children with fever by regions, urban/rural areas, mother’s education or wealth of the households. According to the MICS 2000 data, both the percentage of children who slept under a bednet (6 percent) and percentage of children receiving appropriate anti-malaria treatment (69 percent) were higher as compared to recent estimates in Tajikistan.

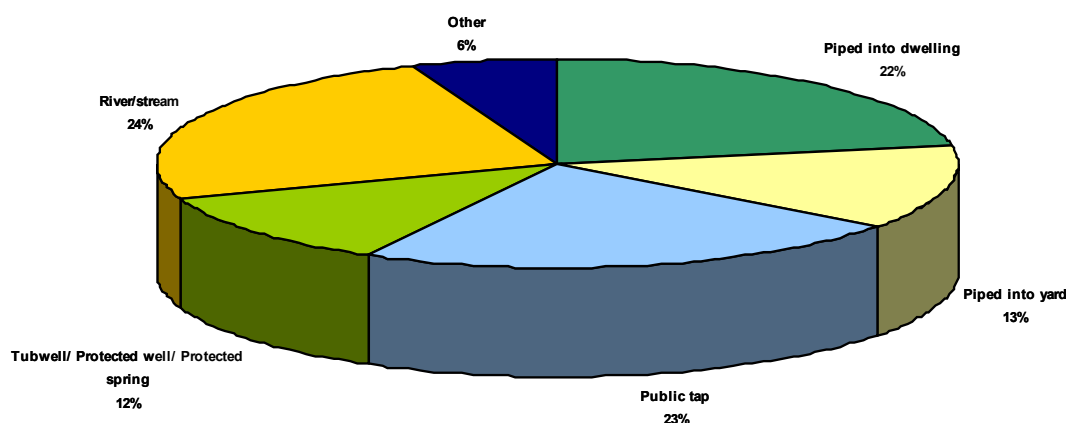
Water and Sanitation

Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid, and schistosomiasis. Drinking water can also be tainted with chemical, physical and radiological contaminants. In addition to its association with disease, access to drinking water may be particularly important for women and children, particularly in rural areas, who bear the primary responsibility for carrying water, often for long distances.

The distribution of the population by source of drinking water is shown in Table 12. According to the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation Assessment, conducted in 2000, the population using improved drinking water sources are those who use any of the following types of supply: piped water, public tap, borehole/ tubewell, protected well, protected spring or rainwater. Overall, 70 percent of the population had access to improved drinking water sources – 93 percent in urban areas and 61 percent in rural areas. The situation in the GBAO and Khatlon regions was considerably worse than in other areas; only 52-55 percent of the population in these regions got its drinking water from an improved source.

The source of drinking water for the population varied strongly by region (Table 12). In Dushanbe, 93 percent of the population used drinking water that was piped into their dwelling or into their yard or plot. The National Report for 2005 done by the Dushanbe Sanitary Epidemiological Station showed that 99 percent of the population used piped water. However, it is worth mentioning that supplied pipe water, particularly that in Dushanbe, comes from surface sources without being exposed to routine cleaning procedures. In DRD 39 percent of population used piped water, while in Sogd and Khatlon that proportion was 27 and 28 percent respectively. In contrast, only about 15 percent of those residing in GBAO had piped water. In Sogd the most important source of drinking water was public taps while in Khatlon and GBAO four out of ten households used river or stream water (an unsafe source).

Figure 7: Percent distribution of the population by source of drinking water, Tajikistan, 2005



The percentage of the population using an improved source of drinking water has increased in comparison to the MICS 2000 when the figure was only 57 percent. Use of



public taps or standpipes has increased from 8 to 23 percent while surface water use has decreased from 33 to 25 percent.

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases, typhoid fever, polio and parasitic invasions. Improved sanitation facilities include: flush toilets connected to a sewage systems septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with slabs, and composting toilets. 94 percent of the population of Tajikistan is living in households using improved sanitation facilities (Table 13). This percentage is 97 in urban areas and 92 percent in rural areas. Residents of GBAO were much less likely than others to use improved facilities. Almost eight percent of household population there used bushes, fields, or had no facilities. In Dushanbe the most common facility were flush toilets with connection to a piped sewer system (73 percent), other areas of the country used pit latrines with slabs (62-86 percent).

Contraception

Information about knowledge and use of contraception methods was collected from female respondents by asking them to mention any ways or methods by which a couple might delay or avoid a pregnancy. Women that were not pregnant at the time of the survey were asked whether or not they were using any method of contraception.

Current use of contraception was reported by 38 percent of women currently married or in union. One third of the women used modern methods that include female/male sterilization, the Pill, intrauterin device (IUD), injections, female/male condom and diaphragm/foam/jelly (Table 14). The most popular method is IUD which is used by one in four married women in Tajikistan. The next most popular methods are the Lactational Amenorrhea Method (LAM), injectables and the Pill that accounts each for 2-3 percent of married women. Use of condom and withdrawal was reported by 1 percent of women and less than 1 percent use periodic abstinence, male/female sterilization, vaginal methods.

Contraceptive prevalence was highest in the Sogd region at 46 percent. In Khatlon, Dushanbe and GBAO from 35 to 39 percent of women used a method of contraception. In the DRD contraceptive use was the lowest, only 29 percent of married women reported using any method.

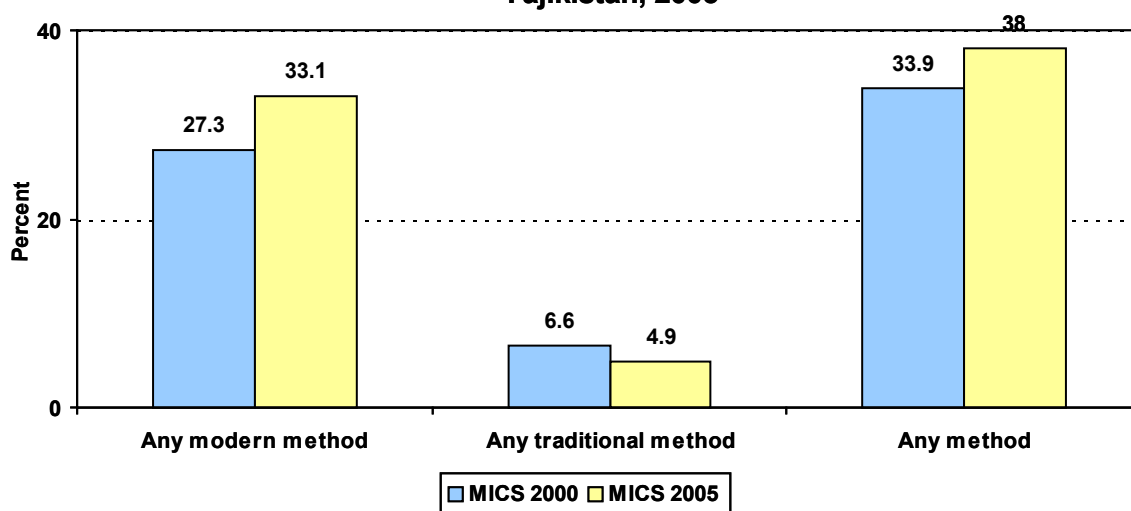
Adolescents are far less likely to use contraception than older women. Only about 9 percent of married or in union women aged 15-19 currently use a method of contraception compared to 25 percent of 20-24 year olds and 50 percent of women 35 to 49 years of age. Use of any contraception method varies significantly by number of living children from less than 1 percent among those with no children to 48 percent among women with 3 living children.

Women's education level is strongly associated with contraceptive prevalence. The percentage of women using any method of contraception rises from 14 percent among those with no education to 25 percent among women with primary education, and to 30 - 51 percent among women with secondary or higher education. In addition to differences in prevalence, the contraception method used varies by education. Less than one out of twenty contraceptive users with no or only primary education use the Pill. The Pill and condoms are used mainly by

women with higher education, such as university (5 and 6 percent). LAM is mainly reported by women with little or no primary education (6-7 percent).

In terms of trends, in the MICS 2000 the proportion of women using any method was somewhat less (34 percent), while the figure for modern methods used was 27 percent (Figure 8).

Figure 8: Percentage of women aged 15-49 years married or in union who are using (or whose partner is using) a contraceptive method, Tajikistan, 2005



Assistance at Delivery

The provision of delivery assistance by skilled attendants can greatly improve the outcomes for mothers and infants with the use of technically appropriate procedures, accurate and speedy diagnosis and treatment of complications. Skilled assistance at delivery is defined as assistance provided by a doctor, nurse, midwife or auxiliary midwife.

About 83 percent of births occurring in the two years prior to the MICS survey were delivered by skilled personnel (Table 15). This percentage was highest in the Sogd region (95 percent) and lowest in the Khatlon (75 percent) and GBAO (77 percent) regions. Skilled attendance was higher in urban areas (89 percent) as compared to rural areas (81 percent).

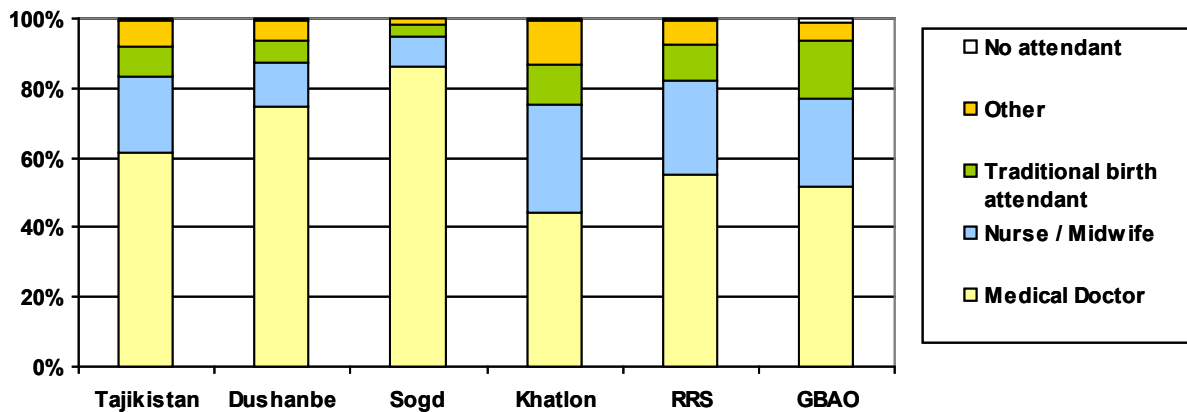
The more educated a woman is, the more likely she is to have delivered with the assistance of a skilled person. Less than two thirds of women with little or primary education had their deliveries assisted by skilled personnel whereas almost all women with higher education benefited from skilled assistance at delivery.

The age of women and wealth of the households were also important factors in skilled assistance at delivery. The numbers decrease gradually from 94 percent of women 15-19 years of age to less than 75 percent of women over 40 years of age. Only 69 percent of women from the poorest quintile had skilled assistance at delivery, while in the richest quintile this number was 91 percent.



Doctors assisted with the delivery of 61 percent of births. One in five of the births were delivered with assistance by a nurse or midwife. Overall, about 9 percent of births were delivered by traditional birth attendants, but these births occurred mainly in GBAO, Khatlon and DRD where the type of personnel providing delivery assistance is noticeably different as compared to the other regions (Figure 9).

Figure 9: Percent distribution of women aged 15-49 with a birth in two years before the survey by type of personnel assisting at delivery, Tajikistan, 2005



In GBAO about 17 percent of births are delivered by traditional birth attendants and 5 percent by other persons, including relatives and friends. In Khatlon each of the above two categories accounts for 12 percent while in DRD those proportions are 10 and 7 percent respectively. Less than one out of a hundred births took place with no one in attendance. Unattended births occurred mainly in women over 35 years of age.

Provision of delivery assistance by skilled attendants has improved when compared to MICS 2000, when 71 percent of births were assisted by skilled personnel. Percentage of deliveries assisted by a doctor has increased over the last five years by almost a third.

Tajikistan has noted an important progress in providing skilled assistance at delivery; however there is still room for further improvement.

Primary School Attendance

Universal access to basic education and the achievement of primary education for the world's children is one of the most important aims of the Millennium Development Goals and A World Fit for Children. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Overall, 89 percent of children of primary school age in Tajikistan are attending primary or secondary school (Table 16). There is no significant variation of the indicator in urban and



rural areas. School attendance in the DRD region is the lowest (81 percent), followed by the Sogd region (86 percent). At the national level, there is virtually no difference between male and female primary school attendance rates.

There is a significant variation of school attendance by the age of the child and mother's education level. School attendance rates increase from 65 percent in 7 year old children to 98 percent in 10 year olds. It also rises gradually from 76 percent in children whose mothers have little or no education to 96 percent in children with mothers having attended a high school.

The ratio of girls to boys attending primary and secondary education is provided in Table 17. The table shows that gender parity for primary school is close to 1.00, indicating no difference in the attendance of girls and boys to primary school. However, the indicator drops to 0.83 for secondary education. The disadvantage of girls is particularly pronounced in the Khatlon, Dushanbe and DRD regions, as well as among children living in the poorest households and those whose mothers did not complete secondary school. In households with the head of household using Tajik as their mother tongue the gender parity index is 0.79. There is no significant difference in the gender parity index by urban/rural area.

Birth Registration

The International Convention on the Rights of the Child states that every child has the right to a name and a nationality and the right to protection from being deprived of his or her identity. Birth registration is a fundamental means of securing these rights for children.

In Tajikistan, the births of 88 percent of children less than five years of age have been registered (Table 18). For this survey, 2 percent of respondents did not know whether the birth of their child was registered. Children in urban areas are somewhat less likely to have their births registered (85 percent) than children in rural areas (90 percent). The lowest birth registration rates are observed in DRD and Dushanbe (81 and 83 percent) (Figure 10). Birth registration rate is lower in children under one (82 percent) and rises above 90 percent in children 24-59 months. Mother's education is also an important determinant of birth registration. There is no significant variation in birth registration by sex.

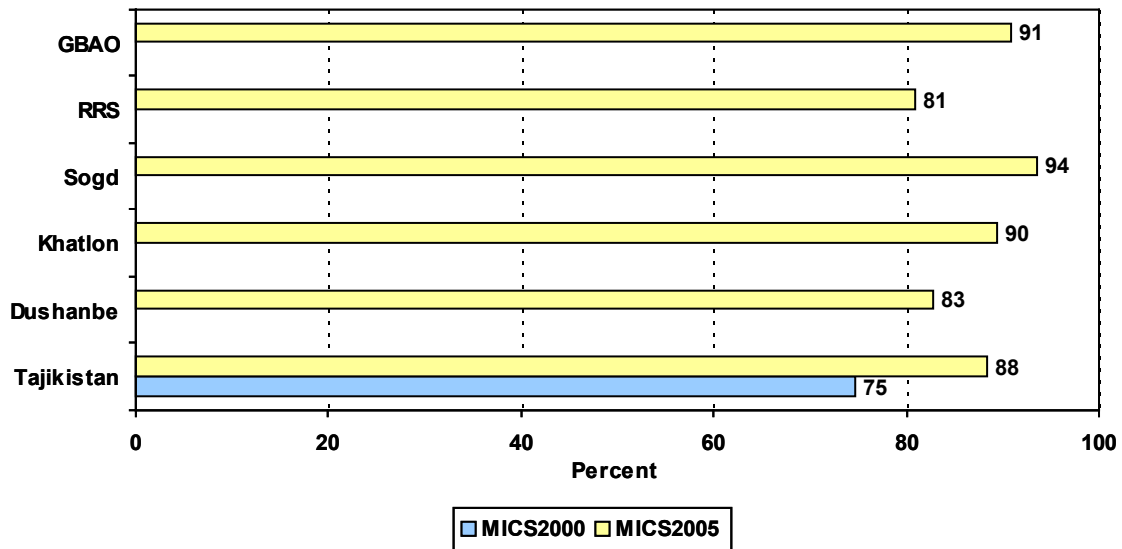
Among those whose children's births are not registered, cost was the main reason accounting for 42 percent of unregistered births while lack of time accounted for 16 percent. Missing other required documents (marriage certificate, passport) for birth registration was stated by 8 percent of respondents. Travel distance as well as lack of knowledge, both the need to register the birth and the place where registration is performed, appeared to explain almost one in ten unregistered births.

Compared to the MICS 2000 data, where 75 percent of under-fives were registered, birth registration seems to have achieved a noticeable progress in recent years. Costs related to birth registration remains the main reported obstacle to getting a birth certificate for their child.

(Figure 10 on next page)



Figure 10: Percentage of children 0-59 months whose birth is registered, Tajikistan, 2005



Early Marriage

Child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty. Women married at a younger age are more likely to dropout of school, experience higher levels of fertility, domestic violence, and maternal mortality

The percentage of women married at various ages is provided in Table 19. In Tajikistan only 1 percent of women reported marriage before the age of 15 years. It is worth mentioning a higher percentage of early marriage (2 percent) among women 25-29. It is also indicative that early marriage is more common to women that have not completed secondary education.

Almost 15 percent of women in Tajikistan reported having been married before the age 18. In the GBAO region this indicator is the lowest (8 percent) and differs significantly from the rest of the country. There is also a significant variation in early marriage by woman according to their educational level. For instance, early marriage is seen in 28 percent of women with primary education and in only 5 percent of women with higher education. As in the case of marriage before 15, the highest prevalence rates of marriage before 18 (23 percent) is observed among women 25-29 years old and differs significantly from other age groups. More than one in five women that have not completed secondary education got married before the age of 18 as compared to one in twenty women with secondary, special or higher education. Women from the poorest quintile of households and Tajik women are also more likely to get married early.

At the time of the survey, 6 percent of women aged 15-19 reported being married or in a



union. The lowest percentage was in GBAO (1 percent) and the highest (7-8 percents) was in Sogd and DRD. Woman's educational level appears to be the most important factor influencing this indicator.

Knowledge of HIV/AIDS Transmission and Condom Use

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step toward raising awareness and giving young people the tools to protect themselves from infection. Abstaining from sex, being faithful to one uninfected partner, and using condoms are important ways to avoid the spread of HIV/AIDS. Misconceptions about HIV are common and can confuse young people and hinder prevention efforts. Different regions are likely to have variations in misconceptions although some appear to be universal (for example that sharing food or mosquito bites or supernatural means such as witchcraft can transmit HIV).

Tajikistan currently is faced with an alarming increase in HIV/AIDS cases; the prevalence rate per 100,000 population is 7.8, which makes the country currently within the stage of a concentrated epidemic (Republican Aids Centre Official Data in 2006). According to the estimation from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the real number of HIV cases in Tajikistan is 10 times higher than the official data. Eighty-four percent of HIV infection cases are young people aged 15-29. (UNICEF 2005 Tajikistan Annual Report).

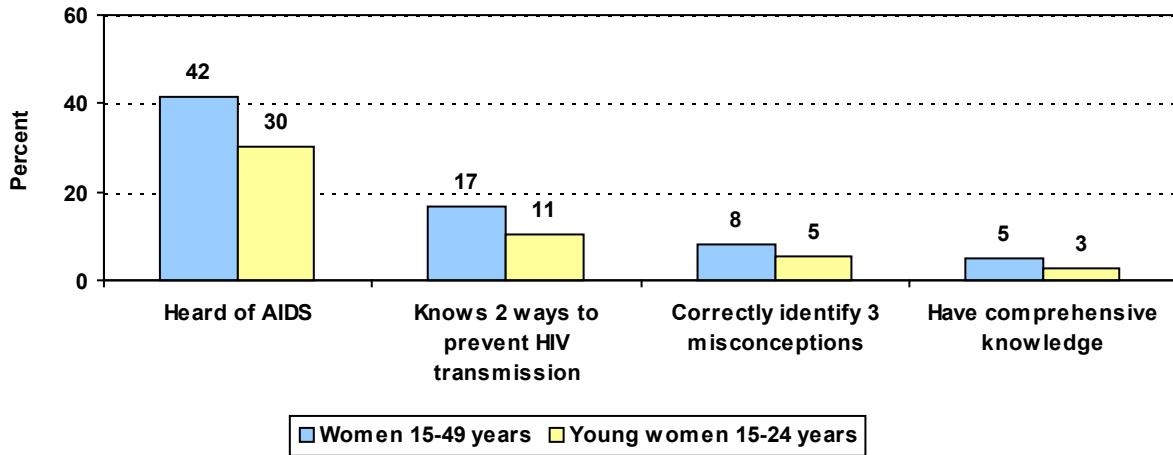
Women were asked whether they had heard of an illness called AIDS. As shown in Table 20, awareness of AIDS is rather low at 42 percent. Up to twofold differences of the indicator can be noticed by age group, residence, region and wealth index. However, there is a noticeable increase in awareness by level of education, with numbers rising from 6 to 84 percent.

Table 20 presents the percentage of women aged 15-49 years who know at least 2 ways of preventing HIV transmission. Knowledge of HIV prevention methods is still fairly low although there are differences by region and area of residence. Overall, 17 percent of women report knowing two prevention methods while in urban areas 27 percent of women identified two methods. In DRD only 12 percent of respondents knew two ways to prevent HIV infection as compared to 23 percent in GBAO and 30 percent in Dushanbe. There is a significant variation in the indicator by age of respondents from those aged 15-19 years (7 percent) to those aged 30-34 years (23 percent). The percent of women who know two prevention methods increased dramatically from 0 to 49 percent as the woman's education level increased. Wealth of the household index and ethnicity appear to be the other determinants of knowledge of HIV prevention techniques.

A key indicator used to measure countries' responses to the HIV epidemic is the propor-



Figure 11: Percentage of women 15-49 years and young women aged 15-24 years who have knowledge of HIV/AIDS transmission



tion of young people 15-24 years of age who know; two methods of preventing HIV, can properly identify two HIV/AIDS misconceptions and are aware of the fact that a healthy looking person can have HIV. Only 3 percent of young women (15-24 years) have comprehensive correct knowledge of HIV. Generally HIV/AIDS awareness and accurate knowledge of how HIV is transmitted is lower among young women comparing to all women of reproductive age (Figure 11 on next page).

Awareness of HIV/AIDS has increased two fold in Tajikistan since the MICS 2000 when the figure was 20 percent, yet the figure still remains low.



References

- Aleshina, Nadezdha & Redmond, Gerry (2003). *How High is Infant Mortality Rate in Central and Eastern Europe and the CIS?*. Innocenti Working Paper No. 95. Florence: UNICEF Innocenti Research Centre.
- Analytical and Information Centre, Ministry of Health of the Republic of Uzbekistan, State Department of Statistics, Ministry of Macroeconomics and Statistics (Uzbekistan) & ORC Macro. (2004) *Uzbekistan Health Examination Survey 2002*. Maryland: Analytical and Information Centre, State Department of Statistics & ORC Macro.
- Division of Reproductive Health/Centres for Disease Control (DRH/CDC) & ORC Macro/DHS. (2003). *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative*.
- Guerra, R., Ferrelli, R., Coclite, D. & Napoletano, A. (2004, October). *Using Verbal Autopsy to Assess the Path to Infant and Maternal Death; A synthesis of two studies conducted in Tajikistan in 2002 and 2003*. Dushanbe, Tajikistan: Ministry of Health: Tajikistan, Istituto Superiore di Sanita & UNICEF Tajikistan.
- <http://www.childinfo.org>
- <http://www.euro.who.int/highlights>
- <http://www.euro.who.int/malaria>
- Ministry of Health of Republic of Tajikistan; Medical Statistics and Information Centre. (2003) *Health of population and health care of Republic of Tajikistan 1990-2002*. Dushanbe, Tajikistan.
- Report*. Atlanta: U.S. Department of Health and Human Services.
- United Nations Children's Fund. (2001). *The status of women and children: Tajikistan, 2000 Multiple Indicator Cluster Survey*. Kazakhstan: UNICEF.
- United Nations Children's Fund & Government of Tajikistan. (2002, November 26). *Report on the Mid-term Review of the Country Programme of Cooperation*. Dushanbe, Tajikistan.
- World Health Organization. (2006) *Highlights on health in Tajikistan 2005*, EUR/05/5046415S.
- (2003, December 1). *National Nutrition and Water and Sanitation Survey 2003, Tajikistan: Preliminary Results*. Dushanbe, Tajikistan.



Appendix one: Tables

Table 1: Results of household and individual interviews

Number of households, women, and children under 5 by results of the household, women's and under-five's interviews, and household, women's and under-five's response rates, Tajikistan, 2005								
	Residence		Region					Total
	Urban	Rural	Dushanbe	Khatlon	Sogd	DRD	GBAO	
Number of households								
Sampled	2,839	4,129	1,711	1,320	1,345	1,296	1,296	6,968
Occupied	2,836	4,125	1,710	1,319	1,342	1,296	1,294	6,961
Interviewed	2,677	4,007	1,594	1,285	1,297	1,269	1,239	6,684
Response rate	94.4	97.1	93.2	97.4	96.6	97.9	95.7	96.0
Number of women								
Eligible	3,750	6,876	2,074	2,297	2,087	2,200	1,968	10,626
Interviewed	3,593	6,650	2,031	2,244	1,999	2,165	1,804	10,243
Response rate	95.8	96.7	97.9	97.7	95.8	98.4	91.7	96.4
Overall response rate	90.4	93.9	91.3	95.2	92.6	96.4	87.8	92.6
Number of children under 5								
Eligible	1,477	2,893	828	1,174	815	924	629	4,370
Mother/Caretaker interviewed	1,437	2,836	814	1,154	794	910	601	4,273
Response rate	97.3	98.0	98.3	98.3	97.4	98.5	95.5	97.8
Overall response rate	91.8	95.2	91.6	95.8	94.2	96.4	91.5	93.9

Table 2: Child mortality

Infant and under-five mortality rates, Tajikistan, 2005		
	Infant mortality rate*	Under-five mortality rate**
Sex		
Male	75	92
Female	54	66
Region		
Dushanbe	50	59
Khatlon	81	102
Sogd	61	73
DRD	47	57
GBAO	46	54
Residence		
Urban	58	70
Rural	68	83
Women's education		
None/Primary	75	95
Incomplete Secondary	73	91
Complete Secondary	63	76
Secondary special	56	67
Higher education	13	14
Wealth index quintiles		
Poorest 60%	78	98
Richest 40%	48	57
Total	65	79
* MICS indicator 2; MDG indicator 14		
** MICS indicator 1; MDG indicator 13		



Table 3: Child malnourishment

Percentage of children aged 0-59 months who are severely or moderately malnourished, Tajikistan, 2005								
	Weight for age		Height for age		Weight for height			Number of children aged 0-59 months
	% below	% below	% below	% below	% below	% below	% above	
	- 2 SD*	- 3 SD*	- 2 SD**	- 3 SD**	- 2 SD***	- 3 SD***	+ 2 SD	
Sex								
Male	17.6	4.2	28.2	10.4	7.1	2.0	3.5	2,053
Female	17.1	3.0	25.6	7.7	7.2	1.1	3.6	1,983
Region								
Dushanbe	13.3	2.7	20.6	8.9	6.8	1.4	5.6	322
Khatlon	20.2	4.8	29.0	10.0	9.2	2.5	3.1	1,613
Sogd	15.3	2.4	28.9	9.7	4.0	0.3	5.9	1,126
DRD	16.1	3.4	22.8	6.4	7.8	1.4	0.8	892
GBAO	20.0	4.5	29.7	11.6	5.2	1.1	3.0	83
Residence								
Urban	17.2	3.2	26.1	9.3	7.4	2.4	4.0	1,064
Rural	17.4	3.8	27.2	9.0	7.1	1.2	3.4	2,972
Age								
< 6 months	4.6	1.1	10.8	1.2	8.8	1.6	8.5	349
6-11 months	20.1	3.4	19.4	4.7	11.1	1.6	2.6	411
12-23 months	30.2	7.8	28.3	11.8	16.1	3.9	3.8	771
24-35 months	19.8	4.9	28.3	9.9	6.0	1.2	3.4	845
36-47 months	12.5	1.8	30.4	9.8	2.6	0.7	3.2	837
48-59 months	11.8	1.3	31.3	10.6	2.0	0.5	2.3	821
Mother's education								
None/Non-standard	[26.8]	-	[27.7]	[12.1]	[7.6]	-	[3.2]	38
Primary	13.4	4.5	27.5	6.6	3.6	1.8	6.3	85
Incomplete Secondary	16.7	3.3	25.6	7.7	7.0	0.7	3.0	1,109
Complete Secondary	18.1	4.3	28.8	10.0	7.7	1.9	3.8	2,296
Secondary special	17.6	1.4	22.6	9.7	6.6	2.9	4.4	289
Higher education	12.4	1.0	19.4	6.3	4.4	0.5	2.4	218
Wealth index quintiles								
Poorest	22.4	4.7	31.9	12.9	7.6	1.4	4.7	837
Second	18.2	4.3	28.2	8.9	7.6	2.4	3.1	770
Middle	18.1	3.5	29.1	7.7	8.6	1.2	2.0	804
Fourth	14.3	3.1	24.7	8.5	6.9	1.4	3.9	818
Richest	13.7	2.5	20.6	7.4	5.1	1.4	4.0	806



Percentage of children aged 0-59 months who are severely or moderately malnourished, Tajikistan, 2005								
	Weight for age		Height for age		Weight for height			Number of children aged 0-59 months
	% below	% below	% below	% below	% below	% below	% above	
	- 2 SD*	- 3 SD*	- 2 SD**	- 3 SD**	- 2 SD***	- 3 SD***	+ 2 SD	
Ethnicity/Language								
Tajik	17.6	4.0	27.5	9.8	8.0	1.8	3.5	2,893
Uzbek	16.9	2.5	25.7	7.5	5.1	0.8	3.7	1,054
Other	14.7	4.1	21.3	6.6	3.9	1.1	4.2	88
Total	17.3	3.6	26.9	9.1	7.2	1.6	3.6	4,036
* MICS indicator 6; MDG indicator 4								
** MICS indicator 7								
*** MICS indicator 8								
[] Figures that are based on 25-49 unweighted cases								



Table 4: Child acute malnutrition*

Percentage of children 12 to 59 months of age exposed to acute severe or moderate malnutrition, Tajikistan, 2005															
	MUAC**				Oedema	Weight for height: (WHZ***)			Global Acute Malnutrition:			Severe Acute Malnutrition:		Number of children	
	% <110 mm	% 110- 119 mm	% 120- 124 mm	% 125- 134 mm		% >=135 mm	% below -2SD	% below -3SD	% above +2SD	% WHZ < -2SD or MUAC<125mm	% WHZ < -2SD or MUAC<125mm or Oedema	% WHZ < -3SD or MUAC<110mm	% WHZ < -3SD or MUAC <110mm or Oedema		
Sex															
Male	0.6	1.6	2.1	9.3	86.4	1.5	6.9	2.2	3.3	9.4	10.7	2.8	4.1	1,688	
Female	1.0	1.4	2.5	9.9	85.2	2.8	6.1	0.9	3.1	9.2	11.6	1.7	4.5	1,587	
Region															
Dushanbe	-	-	1.9	5.2	92.8	2.8	6.4	1.3	5.2	8.1	10.7	1.3	4.1	261	
Khatlon	1.4	2.2	3.1	11.1	82.2	1.9	8.4	2.7	2.5	12.4	13.8	3.9	5.6	1,289	
Sogd	0.7	1.5	1.7	10.7	85.4	2.8	4.2	0.3	5.4	6.9	9.4	1.0	3.7	922	
DRD	0.2	0.9	1.7	6.8	90.4	1.4	6.3	1.2	0.9	7.6	8.9	1.4	2.8	735	
GBAO	0.6	0.7	1.3	13.8	83.6	1.6	4.7	1.2	2.5	6.7	7.9	1.9	3.4	68	
Residence															
Urban	1.5	1.3	2.0	7.7	87.5	2.1	7.3	2.5	3.6	10.9	12.6	4.0	5.9	900	
Rural	0.5	1.6	2.4	10.4	85.2	2.1	6.2	1.2	3.0	8.7	10.5	1.6	3.7	2,375	
Age															
12-23 months	2.5	4.8	5.5	22.5	64.7	3.3	16.1	3.9	3.8	22.7	25.5	6.0	9.3	771	
24-35 months	0.6	1.3	2.7	10.5	84.9	1.9	6.0	1.2	3.4	9.6	11.0	1.8	3.6	845	
36-47 months	-	0.0	1.1	5.0	93.9	1.8	2.6	0.7	3.2	3.6	5.2	0.7	2.6	837	
48-59 months	0.2	0.1	-	1.3	98.3	1.5	2.0	0.5	2.3	2.3	3.7	0.7	2.2	821	
Height															
< 75cm	4.1	9.7	9.9	30.8	45.5	3.6	19.9	3.1	8.0	32.4	35.2	6.5	10.2	300	
>=75cm	0.5	0.7	1.5	7.5	89.9	1.9	5.1	1.4	2.7	7.0	8.7	1.8	3.7	2,975	



Percentage of children 12 to 59 months of age exposed to acute severe or moderate malnutrition, Tajikistan, 2005													
	MUAC ^{**}				Oedema	Weight for height: (WHZ ^{**})			Global Acute Malnutrition:		Severe Acute Malnutrition:		Number of children
	% <110 mm	% 110-119 mm	% 120-124 mm	% 125-134 mm		% >=135 mm	% below -2SD	% below -3SD	% above +2SD	% WHZ < -2SD or MUAC < 125mm	% WHZ < -3SD or MUAC < 110mm	% WHZ < -3SD or MUAC < 110mm or Oedema	
Mother's education													
None/Non-standard	-	-	[4.5]	[21.0]	[74.5]	-	[6.2]	-	[10.7]	[10.7]	-	-	32
Primary	-	2.4	4.3	8.3	85.0	1.2	4.9	2.5	6.2	9.2	10.4	2.5	63
Incomplete Secondary	0.3	1.8	1.6	10.1	86.1	2.8	5.9	0.6	2.7	8.2	10.3	1.0	867
Complete Secondary	0.8	1.5	2.6	9.7	85.4	2.1	7.0	1.9	3.5	9.8	11.6	2.6	1,896
Secondary special	3.0	0.6	1.9	6.7	87.7	1.4	6.2	3.0	2.7	11.3	12.7	6.0	238
Higher education	0.1	1.1	1.6	8.5	88.6	0.6	4.9	0.6	2.5	7.2	7.7	0.7	179
Wealth index quintiles													
Poorest	-	2.1	4.2	14.5	79.2	1.5	7.3	1.4	4.2	11.5	12.7	1.4	663
Second	0.9	1.3	2.1	10.3	85.5	3.0	6.5	2.2	3.4	8.0	10.5	3.0	625
Middle	0.7	2.2	1.4	9.5	86.3	1.9	6.9	1.1	1.8	9.1	10.8	1.7	639
Fourth	1.1	1.3	2.4	8.4	86.7	2.0	7.1	1.5	2.8	10.0	11.4	2.3	663
Richest	1.3	0.6	1.3	5.6	91.2	2.2	4.8	1.5	3.5	7.8	10.0	2.8	685



Percentage of children 12 to 59 months of age exposed to acute severe or moderate malnutrition, Tajikistan, 2005														
	MUAC**				Oedema	Weight for height: (WHZ***)			Global Acute Malnutrition:		Severe Acute Malnutrition:		Number of children	
	% <110 mm	% 110- 119 mm	% 120- 124 mm	% 125- 134 mm		% >=135 mm	% below -2SD	% below -3SD	% above +2SD	% WHZ < -2SD or MUAC<125mm	% WHZ < -3SD or MUAC<110mm or Oedema	% WHZ < -3SD or MUAC <110mm or Oedema		
Ethnicity/ Language														
Tajik	0.9	1.6	2.7	9.4	85.3	2.3	7.4	1.8	3.2	10.7	12.6	2.7	4.9	2,380
Uzbek	0.5	1.2	1.0	10.5	86.8	1.5	4.2	0.9	3.1	5.8	7.1	1.2	2.7	825
Other	0.6	0.2	0.8	7.1	91.3	2.1	4.0	0.9	3.9	5.1	6.7	1.5	3.6	70
Total	0.8	1.5	2.3	9.6	85.8	2.1	6.5	1.6	3.2	9.3	11.1	2.3	4.3	3,275
* Country specific indicators														
** MUAC = Middle upper arm circumference														
***WHZ - Weight for height Z score														
[] Figures that are based on 25-49 unweighted cases														



Table 5: Breastfeeding

Percentage of living children according to breastfeeding status at each age group, Tajikistan, 2005										
	Children 0-3 months		Children 0-5 months		Children 6-9 months		Children 12-15 months		Children 20-23 months	
	Percent exclusively breastfed	Number of children	Percent exclusively breastfed*	Number of children	Percent receiving breastmilk and solid/ mushy food**	Number of children	Percent breastfed***	Number of children	Percent breastfed***	Number of children
Sex										
Male	43.2	119	27.9	192	17.8	161	79.0	159	40.5	137
Female	28.9	126	23.0	201	12.6	147	70.6	149	26.7	116
Region										
Dushanbe	[23.8]	19	17.0	33	17.6	21	58.8	23	[36.4]	19
Khatlon	33.5	89	19.8	170	4.4	146	78.8	100	35.2	110
Sogd	49.5	84	44.5	107	[42.3]	69	78.5	109	[29.0]	71
DRD	19.6	49	12.6	77	10.2	68	67.8	69	38.0	49
GBAO	[61.0]	4	51.1	7	[24.2]	5	[89.1]	7	[39.2]	4
Residence										
Urban	33.3	56	23.8	84	23.5	66	72.7	80	35.3	63
Rural	36.6	189	25.9	310	13.1	243	75.7	228	33.8	190
Mother's education										
None / Primary	*	7	*	18	*	13	*	12	*	3
Incomplete Secondary	36.9	94	26.7	135	9.9	89	73.3	93	26.5	79
Complete Secondary	39.5	110	28.2	192	14.8	171	80.3	173	37.9	146
Secondary special & higher education	[28.0]	34	19.7	49	[31.5]	36	[55.3]	31	[34.5]	26
Wealth index quintiles										
Poorest	[31.1]	59	25.6	95	13.4	70	74.8	71	37.4	62
Second	[38.9]	49	29.4	80	[14.3]	50	[82.3]	59	[40.8]	40
Middle	[49.7]	48	29.9	82	11.3	72	82.6	67	33.8	56
Fourth	22.9	52	15.9	77	18.8	64	67.0	60	[26.5]	42
Richest	39.4	38	26.1	60	20.2	52	66.0	52	32.1	53



Percentage of living children according to breastfeeding status at each age group, Tajikistan, 2005										
	Children 0-3 months		Children 0-5 months		Children 6-9 months		Children 12-15 months		Children 20-23 months	
	Percent exclusively breastfed	Number of children	Percent exclusively breastfed*	Number of children	Percent receiving breastmilk and solid/ mushy food**	Number of children	Percent breastfed***	Number of children	Percent breastfed***	Number of children
Ethnicity/Language										
Tajik	38.7	166	26.3	269	15.1	207	75.1	225	37.7	187
Uzbek	27.9	73	21.8	114	13.1	96	75.2	79	23.5	62
Other	*	6	[43.2]	11	[57.7]	6	*	5	*	4
Total	35.9	245	25.5	393	15.3	309	74.9	308	34.2	253
* MICS indicator 15										
** MICS indicator 17										
*** MICS indicator 16										
* Replaces figures that are based on fewer than 25 unweighted cases.										
[] Figures that are based on 25-49 unweighted cases										



Table 6: Iodized salt consumption

Region	Percentage of households consuming adequately iodized salt, Tajikistan, 2005									
	Percent of households in which salt was tested	Number of households interviewed	No salt	Percent of households with			Total	Number of households in which salt was tested or with no salt		
				0 PPM	< 15 PPM	15+ PPM*				
Dushanbe	98.8	749	0.3	15.5	28.8	55.5	100.0	742		
Khatlon	99.3	2,092	0.2	40.4	32.6	26.8	100.0	2,081		
Sogd	99.3	2,201	0.4	11.2	13.0	75.4	100.0	2,195		
DRD	99.7	1,440	0.3	57.2	16.2	26.3	100.0	1,440		
GBAO	98.0	202	0.8	22.7	32.1	44.4	100.0	200		
Residence										
Urban	99.2	2,198	0.3	18.7	21.7	59.4	100.0	2,187		
Rural	99.3	4,486	0.4	37.1	22.4	40.1	100.0	4,472		
Education of household head										
None	100.0	250	-	38.5	18.2	43.3	100.0	250		
Primary	99.4	337	0.4	37.0	24.1	38.5	100.0	336		
Incomplete Secondary	98.7	832	0.3	38.0	20.8	40.9	100.0	824		
Complete Secondary	99.2	2,708	0.5	30.3	21.5	47.7	100.0	2,700		
Secondary special	99.5	1,155	0.3	32.7	24.9	42.1	100.0	1,153		
Higher education	99.4	1,381	0.2	24.3	22.4	53.1	100.0	1,376		
Non-standard/Missing/DK	*	*	*	*	*	*	*	21		
Wealth index quintiles										
Poorest	99.2	1,149	0.4	42.7	25.8	31.0	100.0	1,145		
Second	99.3	1,229	0.4	40.7	21.0	37.9	100.0	1,227		
Middle	99.4	1,271	0.3	34.3	22.7	42.6	100.0	1,267		
Fourth	99.5	1,293	0.2	29.3	20.3	50.1	100.0	1,290		
Richest	99.2	1,741	0.2	15.4	21.6	62.7	100.0	1,731		
Total	99.3	6,684	0.3	31.1	22.2	46.4	100.0	6,659		
* MICS indicator 41										
Adequately iodized salt is defined as salt that contains at least 15 parts per million of iodine.										
If a household has salt, but it is not tested (SII=7), these households are omitted from the denominator of the indicator.										
* Replaces figures that are based on fewer than 25 unweighted cases.										



Table 7: Vaccinations in first year of life

Percentage of children aged 15-26 months immunized against childhood diseases at any time before the survey and before the first birthday, Tajikistan, 2005																
Percentage of children who received:																
		BCG*	DPT1	DPT2	DPT3**	Polio0	Polio1	Polio2	Polio3***	Measles****	HepB1	HepB2	HepB3*****	All*****	None	Number of children aged 15-26 months
Vaccinated at any time before the survey																
According to:																
Vaccination card	81.6	82.2	81.3	80.6	79.4	81.8	80.9	79.4	72.1	71.9	69.8	66.9	67.4	0.0	789	
Mother's report	13.9	11.0	8.9	5.5	9.7	11.1	8.1	3.0	16.5	12.1	9.1	5.3	9.4	3.7	789	
Either	95.5	93.2	90.1	86.1	89.1	92.9	89.0	82.4	88.6	84.0	78.9	72.3	76.8	3.7	789	
Vaccinated by 12 months of age	95.1	91.4	87.0	82.1	86.6	91.6	86.9	79.3	85.6	83.4	77.0	68.5	69.3	3.7	789	
* MICS indicator 25																
** MICS indicator 27																
*** MICS indicator 26																
**** MICS indicator 28; MDG indicator 15																
***** MICS indicator 29																
***** MICS indicator 31 (Children who received 'all' vaccinations are those who have received 3 doses of DPT, 3 doses of Polio (excluding Polio 0), BCG, and Measles)																



Table 8: Antibiotic treatment of pneumonia

Percentage of children aged 0-59 months with suspected pneumonia who received antibiotic treatment, Tajikistan, 2005		
	Percentage of children aged 0-59 months with suspected pneumonia who received antibiotics in the last two weeks*	Number of children aged 0-59 months with suspected pneumonia in the two weeks prior to the survey
Sex		
Male	[36,3]	38
Female	[46,0]	30
Residence		
Urban	[55,1]	22
Rural	[33,7]	46
Total	40,6	68
* MICS indicator 22		
[] Figures that are based on 25-49 unweighted cases		



Table 9: Solid fuel use

	Percentage of households using:											Total	Solid fuels for cooking*	Number of households			
	Electricity	Liquefied Petroleum Gas (LPG)	Natural Gas	Kerosene	Coal, lignite	Charcoal	Wood	Straw, shrubs, grass	Animal dung	Agricultural crop residue	Other source						
Region																	
Dushanbe	71.7	17.2	10.1	0.0	0.0	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.9	749
Khatlon	66.2	3.5	2.4	0.0	0.7	0.0	7.2	6.0	6.0	8.0	0.1	100.0	27.9	2,092			
Sogd	13.9	0.7	33.7	0.0	1.4	0.0	49.3	0.0	0.8	0.1	0.1	100.0	51.6	2,201			
DRD	56.0	5.9	4.0	0.0	0.2	0.0	30.0	0.2	3.5	0.0	0.0	100.0	34.0	1,440			
GBAO	38.4	0.3	0.0	1.1	0.3	0.0	46.4	6.7	6.6	0.0	0.2	100.0	60.0	202			
Residence																	
Urban	52.0	10.5	29.8	0.0	0.4	0.0	6.5	0.1	0.5	0.0	0.1	100.0	7.5	2,198			
Rural	43.9	1.6	6.0	0.0	0.9	0.0	36.2	3.1	4.4	3.8	0.0	100.0	48.4	4,486			
Education of household head																	
None	42.2	3.3	13.0	0.0	0.0	0.0	32.6	0.7	1.9	6.4	0.0	100.0	41.6	250			
Primary	46.2	0.6	10.7	0.1	0.8	0.0	29.2	3.1	5.1	4.2	0.0	100.0	42.4	337			
Incomplete Secondary	41.4	3.2	11.2	0.2	0.7	0.0	32.8	2.9	5.3	2.3	0.0	100.0	44.0	832			
Complete Secondary	41.8	4.0	14.0	0.0	0.9	0.0	31.9	1.7	2.8	2.8	0.1	100.0	40.1	2,708			
Secondary special	57.1	5.1	12.0	0.0	0.1	0.0	16.5	3.0	3.4	2.6	0.1	100.0	25.6	1,155			
Higher education	51.3	7.1	17.3	0.0	1.2	0.0	18.5	1.8	1.9	1.0	0.0	100.0	24.3	1,381			
Non-standard/Missing/DK	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	21
Wealth index quintiles																	
Poorest	29.3	-	0.1	-	0.9	-	48.9	5.7	9.0	6.1	-	100.0	70.5	1,149			
Second	42.9	0.4	1.8	0.0	1.5	-	41.9	2.7	4.5	4.0	0.1	100.0	54.7	1,229			
Middle	51.9	1.1	6.0	0.0	1.0	-	33.2	2.2	2.2	2.2	0.1	100.0	40.9	1,271			
Fourth	54.5	2.8	18.5	0.1	0.5	-	19.3	1.1	1.5	1.6	0.0	100.0	24.0	1,293			
Richest	50.8	14.2	33.6	0.0	0.2	-	1.2	0.0	0.1	-	-	100.0	1.4	1,741			



Percent distribution of households according to type of cooking fuel, and percentage of households using solid fuels for cooking, Tajikistan, 2005														
Percentage of households using:														
	Electricity	Liquefied Petroleum Gas (LPG)	Natural Gas	Kerosene	Coal, lignite	Charcoal	Wood	Straw, shrubs, grass	Animal dung	Agricultural crop residue	Other source	Total	Solid fuels for cooking*	Number of households
Ethnicity/Language														
Tajik	51.7	5.1	14.2	0.0	0.6	0.0	22.5	1.5	2.5	1.8	0.1	100.0	28.9	4,753
Uzbek	32.4	2.3	11.4	0.0	1.2	0.0	39.4	3.5	4.7	5.1	0.0	100.0	53.9	1,598
Russian	55.0	11.9	33.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	100.0	0.1	160
Kirgiz	22.1	0.0	0.0	3.3	2.8	0.0	21.1	40.4	9.7	0.0	0.6	100.0	73.9	27
Other	32.2	2.8	9.1	1.0	0.4	0.0	45.4	1.5	7.6	0.0	0.1	100.0	54.8	143
Missing	*	*	*	*	*	*	*	*	*	*	*	*	*	3
Total	46.6	4.5	13.8	0.0	0.8	0.0	26.5	2.1	3.1	2.5	0.0	100.0	35.0	6,684

* MICS indicator 24; MDG Indicator 29

* Replaces figures that are based on fewer than 25 unweighted cases.



Table 10: Children sleeping under bednets

Percentage of children aged 0-59 months who slept under an insecticide treated net during the previous night, Tajikistan, 2005							
	Percentage of children who:						Number of children aged 0-59 months
	Slept under a bednet*	Slept under an insecticide treated net**	Slept under an untreated net	Slept under a net but don't know if treated	Don't know if slept under a net	Did not sleep under a bednet	
Sex							
Male	2.1	1.6	0.5	0.0	0.1	97.8	2,168
Female	1.3	1.0	0.2	0.0	0.3	98.4	2,105
Region							
Dushanbe	0.1	0.0	0.1	0.0	0.1	99.8	336
Khatlon	3.4	3.2	0.2	0.0	0.3	96.3	1,714
Sogd	0.8	0.0	0.8	0.0	0.2	99.0	1,205
DRD	0.3	0.1	0.2	0.0	0.1	99.5	928
GBAO	0.0	0.0	0.0	0.0	0.0	100.0	90
Residence							
Urban	0.7	0.1	0.6	0.0	0.4	98.9	1,129
Rural	2.0	1.8	0.3	0.0	0.2	97.8	3,144
Total	1.7	1.3	0.3	0.0	0.2	98.1	4,273
* MICS indicator 38							
** MICS indicator 37; MDG indicator 22							



Table 11: Treatment of children with antimalarial drugs

Percentage of children aged 0-59 months who were ill with fever in the last two weeks who received antimalarial drugs, Tajikistan, 2005		Children with a fever in the last two weeks who were treated with:											Number of children with fever in last two weeks				
Had a fever in last two weeks	Number of children aged 0-59 months	Antimalarials:						Other medications:									
		SP/Fansidar	Chloroquine	Amodiaquine	Quinine	Artemisinin based combinations	Other anti-malarial	Any appropriate antimalarial drug	Paracetamol/Panadol/Acetaminophen	Aspirin	Ibuprofen	Other		Don't know	Any appropriate antimalarial drug within 24 hours of onset of symptoms*		
Sex																	
Male	2,168	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	18.0	0.0	7.9	2.6	0.5	172
Female	2,105	0.1	0.0	0.0	0.0	0.4	3.1	3.5	72.2	12.8	0.1	14.5	4.2	2.0	145		
Region																	
Dushanbe	336	[1.0]	[0.0]	[0.0]	[0.0]	[3.5]	[1.5]	[5.0]	[75.8]	[11.9]	[0.0]	[9.9]	[0.0]	[1.0]	16		
Khatlon	1,714	0.0	0.0	0.0	0.0	2.3	2.3	2.3	69.7	16.8	0.0	6.7	3.8	1.5	182		
Sogd	1,205	[1.7]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[1.7]	[93.4]	[10.8]	[0.0]	[12.6]	[2.9]	[1.7]	54		
DRD	928	0.0	0.0	0.0	0.0	0.0	0.0	0.0	62.8	16.9	0.0	23.8	3.1	0.0	58		
GBAO	90	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[66.8]	[16.9]	[2.4]	[1.9]	[4.0]	[0.0]	7		
Residence																	
Urban	1,129	0.2	0.0	0.0	0.0	0.8	0.3	1.1	80.5	10.1	0.0	10.7	1.5	0.2	76		
Rural	3,144	0.4	0.0	0.0	0.0	1.8	1.8	2.1	70.3	17.3	0.1	10.9	3.9	1.5	241		
Age																	
0-11 months	841	0.2	0.0	0.0	0.0	0.2	0.0	0.2	76.9	9.2	0.2	11.5	5.1	0.2	77		
12-23 months	836	0.0	0.0	0.0	0.0	1.8	1.8	1.8	79.2	7.4	0.0	14.7	4.4	1.5	81		
24-35 months	878	1.3	0.0	0.0	0.0	0.6	2.1	4.0	62.5	20.9	0.0	13.5	0.0	3.4	71		
36-47 months	865	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[66.4]	[22.0]	[0.0]	[2.9]	[2.9]	[0.0]	51		
48-59 months	853	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[4.1]	[4.1]	[78.4]	[27.9]	[0.0]	[7.2]	[4.1]	[0.0]	37		
Mother's education																	
Primary/None/Non-standard	142	*	*	*	*	*	*	*	*	*	*	*	*	*	7		
Incomplete Secondary	1,177	0.0	0.0	0.0	0.0	0.0	3.4	3.4	69.0	14.7	0.0	17.2	1.5	1.4	87		
Complete Secondary	2,429	0.5	0.0	0.0	0.0	0.0	0.8	1.2	70.6	17.4	0.1	8.5	4.8	1.2	193		
Secondary special and higher education	525	[0.5]	[0.0]	[0.0]	[0.0]	[1.9]	[0.0]	[1.9]	[96.9]	[4.3]	[0.0]	[10.7]	[0.0]	[0.5]	30		



Percentage of children aged 0-59 months who were ill with fever in the last two weeks who received antimalarial drugs, Tajikistan, 2005																	
Had a fever in last two weeks	Number of children aged 0-59 months	Children with a fever in the last two weeks who were treated with:												Number of children with fever in last two weeks			
		Antimalarials:						Other medications:									
		SP/Fansidar	Chloroquine	Amodiaquine	Quinine	Artemisinin based combinations	Other anti-malarial	Any appropriate antimalarial drug	Paracetamol/Panadol/Acetaminophen	Aspirin	Ibu-pro-fen	Other	Don't know		Any appropriate antimalarial drug within 24 hours of onset of symptoms*		
Wealth index quintiles																	
Poorest	9.8	911	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.1	0.0	6.8	2.0	3.1	89
Second	8.0	832	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.3	2.3	15.7	0.3	10.4	3.3	0.0	66
Middle	6.3	832	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	18.9	0.0	17.3	5.2	0.0	52
Fourth	7.1	853	1.5	0.0	0.0	0.0	0.0	0.0	0.4	1.9	1.9	14.7	0.0	13.0	6.4	1.5	60
Richest	5.8	845	0.3	0.0	0.0	0.0	0.0	1.2	0.0	1.2	1.2	13.8	0.0	9.6	0.0	0.3	49
Total	7.4	4,273	0.3	0.0	0.0	0.0	0.0	0.2	1.4	1.9	1.9	15.6	0.1	10.9	3.3	1.2	317
* MICS indicator 39; MDG indicator 22. [] Figures that are based on 25-49 unweighted cases												* Replaces figures that are based on fewer than 25 unweighted cases.					



Table 12: Use of improved water sources

		Percent distribution of household population according to main source of drinking water and percentage of household population using improved drinking water sources, Tajikistan, 2005														Number of household members		
		Main source of drinking water																
		Improved sources							Unimproved sources								Total	
	Piped into dwelling	Piped into yard/plot	Public tap/stand-pipe	Tube-well/bore-hole	Protected well	Protected spring	Rain-water	Bottled water ¹	Unprotected well	Unprotected spring	Tanker truck	Cart with tank/drum	Surface water	Bottled water ¹	Other	Improved source of drinking water*		
Region																		
Dushanbe	79.7	13.6	1.3	0.1	0.5	0.6	0.0	0.0	0.0	0.7	0.0	0.1	2.4	0.0	1.0	100.0	95.7	3,414
Khatlon	11.8	16.3	16.7	5.8	2.9	1.0	0.1	0.0	1.9	1.5	1.2	0.3	38.9	0.0	1.5	100.0	54.6	14,684
Sogd	18.3	8.5	42.8	3.5	2.6	2.3	0.0	0.0	0.4	1.9	1.2	0.1	15.5	0.0	2.8	100.0	78.1	12,833
DRD	24.8	14.6	11.4	3.3	3.1	16.3	0.0	0.0	0.4	1.3	1.5	0.0	20.5	0.0	2.7	100.0	73.6	9,615
GBAO	2.9	12.2	24.6	0.0	3.5	8.3	0.0	0.0	0.3	5.2	0.0	0.0	43.1	0.0	0.0	100.0	51.5	1,146
Residence																		
Urban	54.8	21.0	14.0	1.1	1.7	0.4	0.0	0.0	0.0	0.2	1.5	0.1	4.4	0.0	0.7	100.0	93.1	11,301
Rural	10.0	10.2	25.6	4.9	3.1	6.9	0.0	0.0	1.2	2.2	1.0	0.2	32.1	0.0	2.6	100.0	60.7	30,392
Education of household head																		
None	16.0	11.4	22.7	6.7	6.0	3.8	0.0	0.0	0.5	2.2	0.0	0.0	25.4	0.0	5.2	100.0	66.7	1,699
Primary	11.6	15.5	24.6	2.6	1.4	7.2	0.0	0.0	0.0	2.2	0.7	0.3	29.5	0.0	4.4	100.0	62.9	2,333
Incomplete Secondary	18.2	11.5	25.2	4.4	2.3	5.3	0.0	0.0	1.0	3.3	1.1	0.1	25.8	0.0	2.0	100.0	66.8	5,578
Complete Secondary	20.3	11.9	24.9	3.5	2.7	5.9	0.1	0.0	0.6	1.7	1.2	0.0	25.2	0.0	2.0	100.0	69.2	16,556
Secondary special	21.0	15.8	20.6	4.0	2.6	3.8	0.1	0.0	0.9	1.2	1.5	0.5	26.2	0.0	1.8	100.0	67.9	7,295
Higher education	34.1	14.4	16.8	4.0	2.3	4.5	0.0	0.0	1.8	0.5	1.0	0.2	19.3	0.0	1.1	100.0	76.1	8,075
Nonstand./Missing/DK	10.1	2.3	20.2	6.7	23.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	37.2	0.0	0.0	100.0	62.8	157

Percent distribution of household population according to main source of drinking water and percentage of household population using improved drinking water sources, Tajikistan, 2005																			
	Main source of drinking water																		
	Improved sources						Unimproved sources						Total	Improv- ed source of drinking water**	Number of household members				
	Piped into dwelling	Piped into yard/ plot	Public tap/ stand- pipe	Tube- well/ bore- hole	Pro- tected well	Pro- tected spring	Rain- water	Bottled waterl	Unpro- tected well	Unpro- tected spring	Tanker truck	Cart with tank/ drum				Sur- face water	Bottled waterl	Other	
Wealth index quintiles																			
Poorest	0.8	6.7	29.1	1.3	1.7	8.4	0.1	0.8	1.7	3.8	2.0	0.4	43.4	0.0	0.8	100.0	48.0	8,339	
Second	4.7	13.0	28.5	4.0	3.1	8.7	0.0	4.7	1.2	2.1	1.1	0.0	31.5	0.0	2.1	100.0	62.1	8,339	
Middle	10.3	10.3	27.6	7.0	2.9	6.7	0.0	10.3	0.8	1.0	0.7	0.0	29.2	0.0	3.5	100.0	64.8	8,346	
Fourth	22.8	21.0	21.5	5.6	4.3	1.4	0.0	22.8	0.8	0.9	1.3	0.3	16.6	0.0	3.5	100.0	76.6	8,328	
Richest	72.0	14.9	5.7	1.6	1.3	0.3	0.1	72.0	0.0	0.4	0.6	0.1	2.4	0.0	0.4	100.0	96.0	8,343	
Ethnicity/Language																			
Tajik	24.4	13.6	21.2	3.2	2.2	5.6	0.0	0.0	0.9	1.4	1.0	0.2	24.1	0.0	2.2	100.0	70.2	30,212	
Uzbek	14.1	12.7	27.1	6.1	4.2	3.1	0.0	0.0	0.7	2.1	1.6	0.1	26.3	0.0	1.9	100.0	67.3	10,179	
Russian	86.2	4.0	2.0	5.8	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	1.4	0.0	0.0	100.0	98.0	373	
Kirgiz	0.0	0.0	0.0	1.5	23.1	55.1	0.0	0.0	0.4	0.0	0.0	0.0	20.1	0.0	0.0	100.0	79.6	145	
Other	14.3	11.3	26.8	0.0	0.5	5.4	0.0	0.0	0.4	6.3	0.0	0.0	35.1	0.0	0.0	100.0	58.3	755	
Missing	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	29
Total	22.1	13.2	22.5	3.9	2.7	5.1	0.0	0.0	0.9	1.6	1.1	0.2	24.6	0.0	2.1	100.0	69.5	41,693	

* MICS indicator 11; MDG indicator 30

* Replaces figures that are based on fewer than 25 unweighted cases.

Table 13: Use of sanitary means of excreta disposal

		Percent distribution of household population according to type of toilet facility used by the household, and the percentage of household population using sanitary means of excreta disposal, Tajikistan, 2005											Percentage of population using sanitary means of excreta disposal*	Number of household members			
		Type of toilet facility used by household					Unimproved sanitation facility								Total		
		Improved sanitation facility			Type of toilet facility used by household		Pit latrine without slab/open pit	Bucket	Hanging toilet/hanging latrine	No facilities / bush / field	Other						
		Flush/pour flush to:	Septic tank	Pit latrine	Ventilated improved pit latrine	Pit latrine with slab						Composting toilet				Flush/pour to somewhere else	
Piped sewer system																	
Region																	
Dushanbe	73.0	0.2	1.5	0.2	24.3	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.3	100.0	99.2	3,416
Khatlon	6.9	0.1	0.0	0.0	83.7	0.0	0.0	0.0	0.0	8.8	0.0	0.4	0.0	0.0	100.0	90.7	14,689
Sogd	11.3	0.4	0.1	0.0	83.0	0.0	0.0	0.0	0.0	5.2	0.0	0.0	0.0	0.0	100.0	94.8	12,818
DRD	5.6	0.0	3.4	0.4	86.4	0.0	0.0	0.0	0.0	3.7	0.0	0.0	0.3	0.0	100.0	95.8	9,626
GBAO	5.4	15.1	2.7	0.7	62.4	0.0	0.4	0.0	0.0	4.0	0.0	7.8	1.4	100.0	86.3	1,146	
Residence																	
Urban	45.8	0.7	1.1	0.3	49.6	0.0	0.0	0.0	0.0	1.8	0.0	0.1	0.2	100.0	97.4	11,303	
Rural	1.2	0.5	1.0	0.1	89.5	0.0	0.0	0.0	0.0	7.1	0.0	0.5	0.0	100.0	92.3	30,392	
Education of household head																	
None	4.5	0.0	0.7	0.0	87.3	0.0	0.0	0.0	0.0	7.2	0.0	0.1	0.2	100.0	92.5	1,699	
Primary	2.8	0.1	1.6	0.0	89.3	0.0	0.3	0.0	0.0	5.7	0.0	0.1	0.1	100.0	93.8	2,333	
Incomplete Secondary	7.2	0.4	1.2	0.0	85.0	0.0	0.0	0.0	0.0	5.8	0.0	0.2	0.0	100.0	94.0	5,578	
Complete Secondary	11.2	0.3	1.1	0.1	79.1	0.0	0.0	0.0	0.0	7.5	0.0	0.5	0.0	100.0	91.9	16,555	
Secondary special	14.2	1.2	0.8	0.2	76.9	0.0	0.0	0.0	0.0	5.5	0.0	0.6	0.1	100.0	93.4	7,296	
Higher education	25.9	0.9	0.8	0.3	69.8	0.0	0.0	0.0	0.0	1.9	0.0	0.3	0.2	100.0	97.6	8,075	
Non-standard/ Missing/DK	10.1	0.0	0.0	0.0	89.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0	157	



Percent distribution of household population according to type of toilet facility used by the household, and the percentage of household population using sanitary means of excreta disposal, Tajikistan, 2005																
	Type of toilet facility used by household										Percentage of population using sanitary means of excreta disposal*	Number of household members				
	Improved sanitation facility					Unimproved sanitation facility							Total			
	Flush/pour flush to:		Ventilated improved pit latrine	Pit latrine with slab	Composting toilet	Flush/pour to somewhere else	Pit latrine without slab/open pit	Bucket	Hanging toilet/hanging latrine	No facilities / bush / field				Other		
Piped sewer system	Septic tank	Pit latrine														
Wealth index quintiles																
Poorest	0.0	0.3	0.0	0.0	91.2	0.0	0.0	0.0	6.8	0.0	0.0	0.8	0.0	100.0	92.4	8,335
Second	0.0	0.5	0.3	0.0	87.8	0.0	0.0	0.0	10.8	0.0	0.0	0.4	0.0	100.0	88.8	8,343
Middle	0.0	0.6	2.2	0.0	91.6	0.0	0.1	0.0	5.5	0.0	0.0	0.3	0.0	100.0	94.1	8,335
Fourth	0.7	0.5	1.7	0.2	92.0	0.0	0.0	0.0	4.7	0.0	0.0	0.4	0.1	100.0	94.5	8,342
Richest	65.7	0.9	0.8	0.5	30.8	0.0	0.0	0.0	0.6	0.0	0.0	0.2	0.2	100.0	98.6	8,338
Ethnicity/Language																
Tajik	15.0	0.6	1.0	0.1	77.7	0.0	0.0	0.0	4.9	0.0	0.0	0.3	0.0	100.0	94.5	30,216
Uzbek	5.3	0.3	1.1	0.1	84.8	0.0	0.0	0.0	8.2	0.0	0.0	0.2	0.0	100.0	91.5	10,177
Russian	90.8	0.0	1.1	0.0	8.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	100.0	99.9	373
Kirgiz	0.0	0.0	0.0	0.0	70.2	0.0	0.0	0.0	11.7	0.0	0.0	18.1	0.0	100.0	70.2	145
Other	17.6	4.9	0.4	0.4	68.8	0.0	0.0	0.0	3.1	0.0	0.0	2.6	2.1	100.0	92.2	755
Missing	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	29
Total	13.3	0.6	1.0	0.1	78.7	0.0	0.0	0.0	5.7	0.0	0.0	0.4	0.1	100.0	93.7	41,693
* MICS indicator 12; MDG indicator 31													* Replaces figures that are based on fewer than 25 unweighted cases.			



Table 14: Use of contraception

		Percentage of women aged 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method, Tajikistan, 2005														Number of women currently married or in union		
		Percent of women (currently married or in union) who are using:																
Region	Not using any method	Female sterilization	Male sterilization	Pill	IUD	Injections	Implants	Condom	Female Condom	Daphragm/foam/jelly	LAM	Periodic abstinence	Withdrawal	Other	Any modern method	Any traditional method	Any method*	
		Dushanbe	62.3	0.4	0.0	3.5	29.4	0.6	0.0	1.9	0.0	0.0	1.0	0.5	0.2	0.2	35.8	1.9
Khatlon	64.9	0.3	0.0	1.9	24.3	3.8	0.1	0.6	0.0	0.0	3.8	0.0	0.3	0.0	31.0	4.1	35.1	2,048
Sogd	53.7	0.7	1.0	2.4	28.2	2.0	0.0	2.7	0.0	0.0	4.9	0.5	3.7	0.2	36.9	9.4	46.3	2,166
DRD	71.1	0.0	0.0	1.1	24.8	1.6	0.0	0.6	0.1	0.2	0.3	0.3	0.0	0.0	28.3	0.5	28.9	1,365
GBAO	60.8	0.0	0.0	3.4	31.1	3.7	0.0	0.8	0.0	0.3	0.0	0.0	0.0	0.0	39.2	0.0	39.2	154
Residence																		
Urban	57.6	0.6	0.0	2.7	29.8	2.0	0.1	2.7	0.0	0.0	1.7	0.7	1.7	0.3	38.0	4.4	42.4	1,727
Rural	63.7	0.3	0.5	1.8	25.0	2.6	0.0	0.9	0.0	0.1	3.6	0.1	1.3	0.0	31.2	5.1	36.3	4,518
Age																		
15-19	91.4	0.0	0.0	1.0	2.9	0.0	0.0	0.0	0.0	0.0	4.1	0.0	0.6	0.0	3.9	4.7	8.6	155
20-24	75.4	0.3	0.3	0.5	13.3	0.6	0.0	1.1	0.0	0.0	6.8	0.3	1.2	0.2	16.1	8.5	24.6	1,052
25-29	61.4	0.2	0.1	2.6	24.1	2.0	0.0	2.5	0.0	0.1	5.3	0.3	1.4	0.0	31.6	7.0	38.6	1,146
30-34	52.8	0.1	0.4	2.8	33.4	3.6	0.0	1.9	0.0	0.1	3.2	0.3	1.4	0.0	42.2	4.9	47.2	1,128
35-39	50.2	0.8	0.6	3.3	35.3	4.1	0.0	1.8	0.0	0.0	1.5	0.5	1.9	0.0	45.9	3.9	49.8	1,073
40-44	62.3	0.2	0.2	2.1	30.2	2.7	0.0	0.4	0.1	0.0	0.3	0.1	1.5	0.0	35.9	1.9	37.7	1,010
45-49	69.3	1.0	0.7	0.7	24.2	1.6	0.3	0.5	0.0	0.0	0.0	0.2	1.2	0.3	28.9	1.8	30.7	680
Number of living children**																		
0	99.1	0.0	0.0	0.0	0.6	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.9	544
1	79.2	0.3	0.3	1.1	8.2	0.1	0.0	1.1	0.0	0.0	7.9	0.3	1.1	0.3	11.2	9.6	20.8	693
2	57.1	0.5	0.4	2.7	27.8	1.4	0.0	3.0	0.0	0.0	4.4	0.4	2.2	0.2	35.8	7.2	42.9	1,087
3	52.4	0.1	0.2	2.9	32.7	3.0	0.0	2.2	0.0	0.0	3.9	0.6	2.1	0.0	41.1	6.6	47.6	1,302
4+	56.7	0.5	0.5	2.1	32.7	3.7	0.1	0.7	0.0	0.1	1.5	0.2	1.2	0.0	40.5	2.9	43.3	2,617
Education																		
None/ Non-standard	86.5	0.0	0.0	2.0	4.8	0.5	0.0	0.0	0.0	0.0	6.2	0.0	0.0	0.0	7.2	6.2	13.5	66
Primary	75.3	0.0	0.0	0.0	13.2	2.6	0.0	0.0	0.0	0.0	7.1	0.0	1.8	0.0	15.8	8.9	24.7	103



Percentage of women aged 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method, Tajikistan, 2005																		
	Not using any method	Percent of women (currently married or in union) who are using:											Number of women currently married or in union					
		Female sterilization	Male sterilization	Pill	IUD	Injections	Implants	Condom	Female Condom	Diaphragm/foam/jelly	LAM	Periodic abstinence		Withdrawal	Other	Any modern method	Any traditional method	Any method*
Incomplete Secondary	70.1	0.5	0.1	1.7	20.7	1.5	0.0	1.0	0.0	0.1	3.3	0.2	0.6	0.2	25.6	4.3	29.9	1,313
Complete Secondary	61.0	0.3	0.5	1.8	27.6	2.7	0.0	1.2	0.0	0.0	2.9	0.0	1.6	0.0	34.2	4.8	39.0	3,886
Secondary special	53.0	0.8	0.0	2.8	32.8	3.1	0.0	1.0	0.0	0.0	3.6	0.0	2.6	0.0	40.4	6.6	47.0	490
Higher education	49.3	0.6	0.0	5.2	31.8	1.9	0.5	6.0	0.3	0.0	1.5	1.1	1.3	0.6	46.3	4.4	50.7	387
Wealth index quintiles																		
Poorest	66.6	0.3	0.0	2.0	22.4	3.1	0.0	0.4	0.0	0.0	4.5	0.3	0.4	0.0	28.2	5.2	33.4	1,173
Second	64.4	0.2	0.4	2.4	24.5	2.4	0.0	0.5	0.0	0.1	3.7	0.0	1.4	0.0	30.5	5.1	35.6	1,191
Middle	62.6	0.7	0.7	1.6	25.5	2.7	0.0	0.8	0.0	0.0	3.6	0.3	1.3	0.0	32.2	5.2	37.4	1,253
Fourth	61.0	0.4	0.5	1.5	28.3	2.2	0.0	1.5	0.1	0.1	2.4	0.1	1.9	0.0	34.6	4.4	39.0	1,307
Richest	56.4	0.2	0.1	2.9	30.3	1.7	0.2	3.7	0.0	0.0	1.5	0.7	2.0	0.4	39.0	4.5	43.6	1,321
Ethnicity/Language																		
Tajik	63.3	0.3	0.4	2.3	25.1	2.3	0.0	1.5	0.0	0.0	3.0	0.3	1.3	0.1	32.1	4.7	36.7	4,488
Uzbek	59.0	0.6	0.2	1.2	29.5	2.6	0.0	1.1	0.0	0.1	3.6	0.2	1.8	0.0	35.4	5.6	41.0	1,594
Russian	45.0	0.0	0.0	5.0	36.1	0.0	0.0	11.8	0.0	0.0	0.0	1.1	0.0	1.0	53.0	2.0	55.0	42
Kirgiz	[89.9]	[0.0]	[0.0]	[2.9]	[7.3]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[0.0]	[10.1]	[0.0]	[10.1]	17
Other	59.1	0.0	0.0	3.8	27.6	4.1	0.0	0.8	0.0	0.3	2.2	0.0	0.0	2.2	36.5	4.4	40.9	103
Total	62.1	0.4	0.4	2.1	26.3	2.4	0.0	1.4	0.0	0.0	3.1	0.3	1.4	0.1	33.1	4.9	37.9	6,245
* MICS indicator 21; MDG indicator 19C																		
[] Figures that are based on 25-49 unweighted cases																		
* Replaces figures that are based on fewer than 25 unweighted cases.																		



Table 15: Assistance during delivery

Percent distribution of women aged 15-49 with a birth in two years preceding the survey by type of personnel assisting at delivery, Tajikistan, 2005										
	Person assisting at delivery					No attendant	Total	Any skilled personnel*	Delivered in health facility**	Number of women who gave birth in preceding two years
	Medical doctor	Nurse/midwife	Auxiliary midwife	Traditional birth attendant	Other					
Region										
Dushanbe	75.0	12.1	0.3	6.4	5.6	0.6	100.0	87.4	68.9	133
Khatlon	44.4	28.9	2.0	11.6	12.4	0.8	100.0	75.2	42.3	682
Sogd	86.3	8.4	0.0	3.4	1.8	0.0	100.0	94.7	88.5	501
DRD	55.1	26.8	0.2	10.3	7.2	0.3	100.0	82.1	60.3	361
GBAO	51.8	23.5	1.9	16.6	4.8	1.4	100.0	77.2	45.8	34
Residence										
Urban	72.9	15.7	0.8	4.4	6.0	0.2	100.0	89.4	72.1	427
Rural	57.6	22.8	0.9	10.0	8.1	0.6	100.0	81.3	58.3	1,284
Age										
15-19	[68.8]	[20.5]	[4.6]	[5.7]	[0.5]	[0.0]	100.0	[93.8]	[86.6]	57
20-24	68.6	17.0	1.0	7.0	6.1	0.3	100.0	86.6	68.4	605
25-29	59.5	22.8	0.3	9.2	8.1	0.0	100.0	82.7	58.3	499
30-34	55.8	24.4	0.7	9.1	9.9	0.1	100.0	80.9	58.6	334
35-39	55.5	20.9	1.5	11.7	8.7	1.8	100.0	77.9	50.1	170
40-44	47.2	[27.7]	[0.0]	[14.8]	[5.8]	[4.5]	100.0	[74.9]	[49.4]	39
45-49	*	*	*	*	*	*	*	*	*	6
Education										
None/Primary/Non-standard/	[47.9]	[15.1]	[3.4]	[17.8]	[15.8]	[0.0]	[100.0]	[66.4]	[41.6]	55
Incomplete Secondary	57.1	22.0	0.9	12.3	7.4	0.3	100.0	80.0	56.6	529
Complete Secondary	60.6	22.1	0.9	7.4	8.3	0.7	100.0	83.7	61.8	928
Secondary special	73.3	19.5	0.0	3.2	4.0	0.0	100.0	92.8	75.2	116
Higher education	91.4	8.4	0.0	0.2	0.0	0.0	100.0	99.8	88.8	83
Wealth index quintiles										
Poorest	45.8	22.1	1.4	15.7	14.5	0.5	100.0	69.3	43.3	387
Second	56.4	24.6	1.1	9.7	7.9	0.4	100.0	82.1	51.8	338
Middle	59.8	25.2	0.0	7.6	6.3	1.0	100.0	85.0	64.8	335
Fourth	68.8	21.7	1.3	2.8	5.3	0.2	100.0	91.8	72.3	335
Richest	79.7	10.8	0.6	6.2	2.6	0.2	100.0	91.0	80.1	315
Ethnicity/Language										
Tajik	58.9	22.1	0.8	9.8	7.9	0.6	100.0	81.7	58.6	1,225
Uzbek	67.6	18.5	1.3	5.8	6.6	0.2	100.0	87.4	70.1	448
Other	70.8	18.1	0.0	4.1	7.0	0.0	100.0	88.9	64.7	38
Total	61.4	21.0	0.9	8.6	7.6	0.5	100.0	83.4	61.8	1,711
* MICS indicator 4; MDG indicator I7										
** MICS indicator 5										
[] Figures that are based on 25-49 unweighted cases										
* Replaces figures that are based on fewer than 25 unweighted cases.										



Table 16: Primary school net attendance ratio

Percentage of children of primary school age** attending primary or secondary school (NAR), Tajikistan, 2005						
	Male		Female		Total	
	Net attendance ratio	Number of children	Net attendance ratio	Number of children	Net attendance ratio*	Number of children
Region						
Dushanbe	95.9	177	93.8	170	94.9	347
Khatlon	95.1	842	92.9	763	94.1	1,605
Sogd	86.5	621	84.9	622	85.7	1,242
DRD	80.4	551	82.3	460	81.2	1,011
GBAO	93.9	54	90.7	49	92.4	103
Residence						
Urban	87.9	543	90.5	560	89.2	1,104
Rural	89.5	1,702	87.3	1,503	88.5	3,205
Age**						
7	63.3	541	66.2	553	64.8	1,094
8	93.9	586	93.1	528	93.5	1,114
9	99.9	508	98.3	415	99.2	924
10	98.5	609	97.6	568	98.0	1,177
Mother's education						
None/Primary/ Non-standard	80.3	61	[70.6]	56	75.6	117
Incomplete Secondary	88.4	380	85.8	305	87.2	685
Complete Secondary	88.9	1,502	88.7	1,417	88.8	2,919
Secondary special	91.2	181	88.6	175	89.9	356
Higher education	95.6	121	96.5	111	96.0	232
Wealth index quintiles						
Poorest	91.2	497	89.6	437	90.5	934
Second	88.9	494	85.3	447	87.2	942
Middle	86.3	430	83.7	391	85.0	820
Fourth	88.0	401	89.6	380	88.8	782
Richest	90.9	422	92.7	409	91.8	831
Ethnicity/Language						
Tajik	88.1	1,648	87.1	1,529	87.6	3,177
Uzbek	92.1	555	91.1	486	91.6	1,041
Other	90.9	42	91.8	48	91.4	91
Total	89.1	2,245	88.2	2,063	88.7	4,308
* MICS indicator 55; MDG indicator 6						
[] Figures that are based on 25-49 unweighted cases						
* Replaces figures that are based on fewer than 25 unweighted cases.						



Table 17: Education gender parity

Ratio of girls to boys attending primary education and ratio of girls to boys attending secondary education, Tajikistan, 2005						
	Primary school net attendance ratio (NAR), girls	Primary school net attendance ratio (NAR), boys	Gender parity index (GPI) for primary school NAR*	Secondary school net attendance ratio (NAR), girls	Secondary school net attendance ratio (NAR), boys	Gender parity index (GPI) for secondary school NAR*
Sex						
Male	na	89.1	na	na	88.0	na
Female	88.2	na	na	72.7	na	na
Region						
Dushanbe	93.8	95.9	0.98	73.0	92.8	0.79
Khatlon	92.9	95.1	0.98	68.7	90.7	0.76
Sogd	84.9	86.5	0.98	79.5	84.3	0.94
DRD	82.3	80.4	1.02	68.5	86.4	0.79
GBAO	90.7	93.9	0.97	90.2	92.5	0.98
Residence						
Urban	90.5	87.9	1.03	76.1	89.8	0.85
Rural	87.3	89.5	0.97	71.5	87.4	0.82
Mother's education						
None/Primary/Non-standard	66.8	80.4	0.8	46.1	73.3	0.6
Incomplete Secondary	85.8	88.4	0.97	64.6	86.6	0.75
Complete Secondary	88.7	88.9	1.00	74.0	87.8	0.84
Secondary special	88.6	91.2	0.97	72.6	91.4	0.79
Higher education	96.5	95.6	1.01	93.1	96.2	0.97
Wealth index quintiles						
Poorest	89.6	91.2	1.0	68.7	86.0	0.8
Second	85.3	88.9	1.0	67.0	88.2	0.8
Middle	83.7	86.3	1.0	72.0	86.3	0.8
Fourth	89.6	88.0	1.0	76.0	86.9	0.9
Richest	92.7	90.9	1.0	81.5	93.2	0.9
Ethnicity/Language						
Tajik	87.1	88.1	0.99	70.0	88.6	0.79
Uzbek	91.1	92.1	0.99	79.9	85.6	0.93
Other	91.4	83.5	1.1	86.4	92.6	1.0
Total						
Total	88.2	89.1	0.99	72.7	88.0	0.83
* MICS indicator 6I; MDG indicator 9						

Table 18: Birth registration

Percent distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, Tajikistan, 2005													
	Birth is Registered*	Number of children aged 0-59 months	Birth is not registered because:									Total	Number of children aged 0-59 months without birth registration
			Costs too much	Must travel too far	Didn't know child should be Registered	Late, did not want to pay fine	Doesn't know where to register	Lack of time	Missing other documents	Other	Don't know		
Sex													
Male	87.6	2,168	41.8	3.7	4.0	0.3	4.8	18.9	8.7	2.9	15.0	100.0	217
Female	88.9	2,105	41.4	9.0	2.6	1.4	3.0	13.5	8.5	1.5	19.0	100.0	192
Region													
Dushanbe	82.7	336	24.1	1.2	2.4	1.4	5.0	24.1	4.4	5.4	31.8	100.0	54
Khatlon	89.5	1,714	59.3	4.8	6.2	0.0	3.3	9.7	6.6	0.0	10.1	100.0	128
Sogd	93.6	1,205	[18.3]	[21.0]	[3.4]	[2.0]	[0.0]	[28.7]	[19.1]	[1.4]	[6.1]	100.0	62
DRD	80.9	928	42.4	2.9	1.2	0.6	5.9	15.0	7.9	3.1	21.1	100.0	157
GBAO	90.8	90	[41.0]	[14.4]	[4.0]	[4.6]	[0.0]	[2.0]	[2.4]	[5.2]	26.4	100.0	7
Residence													
Urban	84.9	1,129	40.5	0.4	2.4	0.5	4.1	20.8	5.7	2.5	23.1	100.0	151
Rural	89.5	3,144	42.2	9.6	3.8	1.0	3.9	13.8	10.4	2.1	13.2	100.0	257
Age													
0-11 months	82.1	841	25.3	4.9	4.5	0.0	4.7	32.2	7.8	3.4	17.3	100.0	126
12-23 months	86.8	836	47.7	5.1	3.2	1.0	3.6	6.4	11.6	3.6	17.8	100.0	94
24-35 months	90.0	878	40.7	7.7	4.8	1.9	5.1	13.9	7.0	0.3	18.6	100.0	74
36-47 months	90.5	865	58.6	9.3	0.4	1.3	0.0	13.0	8.4	0.0	9.0	100.0	62
48-59 months	91.8	853	51.0	5.4	2.1	0.3	5.9	3.9	8.0	2.4	20.9	100.0	53
Mother's education													
None/ Primary/ Non-standard/	79.7	142	*	*	*	*	*	*	*	*	*	*	20
Incomplete Secondary	83.7	1,177	41.3	6.5	2.5	1.2	5.1	12.2	10.4	3.8	18.1	100.0	148
Complete Secondary	90.1	2,429	41.6	7.5	3.6	0.8	2.7	18.6	6.6	2.3	16.5	100.0	202
Secondary special & higher education	92.4	525	34.3	1.7	3.1	0.0	3.2	25.0	11.8	0.4	20.4	100.0	39
Wealth index quintiles													
Poorest	88.6	911	47.9	19.4	3.7	0.0	0.0	13.8	4.0	0.1	11.1	100.0	76
Second	87.3	832	54.1	8.1	0.0	0.4	0.0	14.0	13.6	0.0	9.8	100.0	87
Middle	88.0	832	50.6	1.7	5.0	1.7	2.7	8.5	8.3	7.2	14.3	100.0	73
Fourth	91.2	853	24.0	2.5	8.3	2.5	13.2	15.9	10.9	0.7	22.1	100.0	69
Richest	86.2	845	32.0	0.6	1.3	0.0	4.9	26.1	6.7	3.2	25.2	100.0	104



Percent distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, Tajikistan, 2005													
	Birth is Registered*	Number of children aged 0-59 months	Birth is not registered because:									Total	Number of children aged 0-59 months without birth registration
			Costs too much	Must travel too far	Didn't know child should be Registered	Late, did not want to pay fine	Doesn't know where to register	Lack of time	Missing other documents	Other	Don't know		
Ethnicity/Language													
Tajik	86.5	3,076	40.9	6.3	3.7	0.6	4.0	15.3	9.8	2.5	16.9	100.0	353
Uzbek	92.7	1,103	48.0	6.5	0.0	2.4	4.0	21.4	1.5	0.0	16.3	100.0	51
Other	95.2	94	*	*	*	*	*	*	*	*	*	*	4
Total	88.3	4,273	41.6	6.2	3.3	0.8	4.0	16.4	8.6	2.2	16.9	100.0	409
* MICS indicator 62													
[] Figures that are based on 25-49 unweighted cases													
* Replaces figures that are based on fewer than 25 unweighted cases.													



Table 19: Early marriage

Percentage of women aged 15-49 years in marriage or union before their 15th birthday, percentage of women aged 20-49 years in marriage or union before their 18th birthday and the percentage of women aged 15-19 years currently married or in union, Tajikistan, 2005							
	Percentage married before age 15*	Number of women aged 15-49 years	Percentage married before age 18*	Number of women aged 20-49 years	Percentage of women 15-19 married or in union**	Number of women aged 15-19 years	Number of women aged 15-49 years currently married or in union
Region							
Dushanbe	0.6	876	14.8	692	4.7	183	512
Khatlon	0.7	3,480	15.9	2,622	5.5	857	2,048
Sogd	0.9	3,246	12.8	2,543	7.6	703	2,166
DRD	0.9	2,344	16.8	1,709	7.1	635	1,365
GBAO	0.5	297	7.8	231	1.0	66	154
Residence							
Urban	0.8	2,891	13.6	2,252	6.7	639	1,727
Rural	0.8	7,352	15.2	5,546	6.2	1,806	4,518
Age							
15-19	0.0	2,445	na	na	6.4	2,445	155
20-24	1.0	1,981	12.7	1,981	na	na	1,052
25-29	2.1	1,428	23.4	1,428	na	na	1,146
30-34	0.7	1,270	16.4	1,270	na	na	1,128
35-39	0.8	1,192	10.6	1,192	na	na	1,073
40-44	0.7	1,137	12.2	1,137	na	na	1,010
45-49	0.6	790	11.5	790	na	na	680
Education							
None/ Non-standard/	0.0	161	13.9	86	9.5	75	66
Primary	2.7	267	27.7	140	12.1	127	103
Incomplete Secondary	1.2	3,145	21.7	1,762	5.2	1,383	1,313
Complete Secondary	0.6	5,334	14.3	4,587	7.5	747	3,886
Secondary special	0.2	704	5.1	660	[8.6]	45	490
Higher education	0.0	632	4.5	563	2.9	68	387
Wealth index quintiles							
Poorest	0.9	1896	17.0	1402	4.6	493	1173
Second	0.8	1995	13.6	1487	5.0	508	1191
Middle	0.8	2075	14.3	1589	6.0	486	1253
Fourth	0.9	2116	14.4	1614	9.7	502	1307
Richest	0.6	2162	14.6	1707	6.4	455	1321
Ethnicity/Language							
Tajik	0.9	7,472	16.2	5,610	6.6	1,862	4,488
Uzbek	0.5	2,440	11.3	1,920	6.2	520	1,594
Russian	0.5	90	8.1	81	*	9	42
Kirgiz	0.8	31	13.1	24	*	8	17
Other	1.5	210	7.9	163	0.0	47	103
Total	0.8	10,243	14.7	7,798	6.4	2,445	6,245
* MICS indicator 67							
** MICS indicator 68							
[] Figures that are based on 25-49 unweighted cases							
* Replaces figures that are based on fewer than 25 unweighted cases.							



Table 20: Comprehensive knowledge of HIV/AIDS transmission

Percentage of women aged 15-49 years who have comprehensive knowledge of HIV/AIDS transmission, Tajikistan, 2005					
	Heard of AIDS	Know 2 ways to prevent HIV transmission	Correctly identify 3 misconceptions about HIV transmission	Have comprehensive knowledge (identify 2 prevention methods and 3 misconceptions)*	Number of women
Region					
Dushanbe	57.1	30.2	19.4	13.7	876
Khatlon	28.5	16.2	6.3	3.7	3,480
Sogd	58.4	16.8	7.1	4.4	3,246
DRD	29.0	11.5	6.1	3.3	2,344
GBAO	65.9	22.8	26.6	11.9	297
Residence					
Urban	55.6	26.8	14.6	9.6	2,891
Rural	36.1	12.7	5.7	3.1	7,352
Age					
15-19	23.5	7.3	3.9	2.2	2,445
20-24	38.9	14.5	7.2	3.8	1,981
15-24	30.4	10.5	5.4	2.9	4,426
25-29	48.3	21.5	10.0	6.5	1,428
30-34	54.1	23.1	11.9	6.7	1,270
35-39	51.5	21.2	11.3	7.1	1,192
40-44	49.1	20.7	9.5	5.3	1,137
45-49	46.9	19.6	8.8	6.2	790
Education					
None/ Non-standard/ Primary	5.1	0.0	0.0	0.0	159
Primary	9.4	3.6	2.9	1.8	267
Incomplete Secondary	26.5	8.5	3.0	1.6	3,145
Complete Secondary	43.8	15.8	6.9	3.6	5,334
Secondary special	75.1	39.8	22.3	14.2	704
Higher education	83.9	48.5	34.2	24.5	632
Wealth index quintiles					
Poorest	36.0	10.2	3.7	1.8	1,896
Second	33.0	12.4	3.7	1.8	1,995
Middle	35.0	12.4	5.5	2.9	2,075
Fourth	44.0	18.6	9.9	5.7	2,116
Richest	58.5	28.6	17.4	11.6	2,162
Ethnicity/Language					
Tajik	40.7	16.6	8.1	4.7	7,472
Uzbek	40.7	14.0	5.7	3.5	2,440
Russian	96.1	59.8	47.1	30.9	90
Kirgiz	18.4	7.8	1.9	1.9	31
Other	66.8	35.1	27.9	17.8	210
Total	41.6	16.7	8.2	4.9	10,243
* MICS indicator 82; MDG indicator 19b					
* Replaces figures that are based on fewer than 25 unweighted cases.					



Appendix two: MICS3 Indicators and Definitions used in the Tajikistan MICS3 Preliminary Report

	MICS 3 INDICATOR	NUMERATOR	DENOMINATOR
1	Under-five mortality Rate	Probability of dying by exact age 5 years	
2	Infant mortality rate	Probability of dying by exact age 1 year	
4	Skilled attendant at delivery	Number of women 15-49 with a birth in the 2 years preceding the survey who were attended during childbirth by skilled health personnel	Total number of women surveyed aged 15-49 years with a birth in 2 years preceding the survey
5	Institutional deliveries	Number of women 15-49 with a birth in the 2 years preceding the survey who were delivered in health facility	Total number of women surveyed aged 15-49 years with a birth in 2 years preceding the survey
6	Underweight prevalence	Number of children under 5 years of age who fall below -2 standard deviations (SDs) from the median weight-for-age of the NCHS/WHO standard (moderate and severe); number who fall below -3 SDs (severe)	Total number of children under five years of age weighed
7	Stunting prevalence	Number of children under 5 years of age who fall below -2 standard deviations (SDs) from the median height-for-age of the NCHS/WHO standard (moderate and severe); number who fall below -3 SDs (severe)	Total number of children under five years of age measured
8	Wasting prevalence	Number of children under 5 years of age who fall below -2 standard deviations (SDs) from the median weight-for-height of the NCHS/WHO standard (moderate and severe); number who fall below -3 SDs (severe)	Total number of children under five years of age weighed and measured and examined
	Global Acute Malnutrition ⁴	Number of children under 5 years of age with weight for height below -2SD, MUAC below 12.5 cm or oedema	Total number of children under five years of age weighed, measured and examined
11	Use of improved drinking water sources	Number of household members living in households using improved sources of drinking water	Total number of household members in households surveyed
12	Use of improved sanitation facilities	Number of household members using improved sanitation facilities	Total number of household members in households surveyed
15	Exclusive breastfeeding rate	Number of infants less than 6 months (and less than 4 months) of age who are exclusively breastfed	Total number of infants 0-5 (and 0-3) months old surveyed
16	Continued breastfeeding rate	Number of infants 12-15 months, and 20-23 months of age who are currently breastfeeding	Total number of children aged 12-15 months; children aged 20-23 months surveyed
17	Timely complementary feeding rate	Number of infants 6-9 months old who are receiving breast milk and complementary foods	Total number of infants 6-9 months old surveyed

⁴ Tajikistan Specific Indicator



	MICS 3 INDICATOR	NUMERATOR	DENOMINATOR
21	Contraceptive prevalence	Number of women currently married or in union aged 15-49 years who are using (or whose partner is using) a contraceptive method (either modern or traditional)	Total number of women aged 15-49 years who are currently married or in union
22	Antibiotic treatment of suspected pneumonia	Number of children 0-59 months old with suspected pneumonia in the previous 2 weeks receiving antibiotics	Total number of children aged 0-59 months old with suspected pneumonia in the previous 2 weeks
24	Solid fuels	Number of residents in households that use solid fuels (wood, charcoal, crop residues and dung) as the primary source of domestic energy to cook	Total number of residents in households surveyed
25	Tuberculosis immunization coverage	Number of 15-26 month-olds receiving BCG vaccine before first birthday	Total number of children aged 15-26 months surveyed
26	Polio immunization coverage	Number of 15-26 -month-olds receiving OPV3 vaccine before first birthday	Total number of children aged 15-26 months surveyed
27	DPT immunization coverage	Number of 15-26 month-olds receiving DPT3 vaccine before first birthday	Total number of children aged 15-26 months surveyed
28	Measles immunization coverage	Number of 15-26 month-olds receiving measles vaccine before first birthday	Total number of children aged 15-26 months surveyed
29	Hepatitis B immunization coverage	Number of children aged 15-26 months immunized against hepatitis B (HepB3) before their first birthday	Total number of children aged 15-26 months surveyed
31	Fully immunized children	Number of 15-26 month-olds receiving DPT1-3, OPV-1-3, BCG and measles before first birthday	Total number of children aged 15-26 months surveyed
37	Under-fives sleeping under insecticide treated nets	Number of children aged 0-59 months who slept under an insecticide treated net the previous night	Total number of children aged 0-59 months surveyed
38	Under-fives sleeping under bednets	Number of children aged 0-59 months who slept under a bednet the previous night	Total number of children aged 0-59 months surveyed
39	Antimalarial treatment (under-fives)	Number of children aged 0-59 months reported to have fever in previous 2 weeks who were treated with an appropriate antimalarial within 24 hours of onset	Total number of children aged 0-59 months reported to have fever in previous two weeks
41	Iodized salt consumption	Number of households with salt testing 15 parts per million or more of iodine/iodate	Total number of households surveyed
55	Net primary school attendance rate	Number of children of primary-school age currently attending primary school	Total number of children of primary school age surveyed.
61	Female to male education ratio	Proportion of girls in primary, secondary, and tertiary education	Proportion of boys in primary, secondary, and tertiary education
62	Birth registration	Number of children aged 0-59 months whose births are reported registered	Total number of children aged 0-59 months surveyed



	MICS 3 INDICATOR	NUMERATOR	DENOMINATOR
67	Marriage before age 15, before age 18	Number of women who were first married or in union by exact age 15, 18 by age groups.	Total number of women aged 15-49, 20-49 surveyed, respectively, by age groups
68	Young women aged 15-19 currently married or in union	Number of women aged 15-19 currently married or in union	Total number of women aged 15-19 surveyed
82	Comprehensive knowledge about HIV prevention among young people	Number of women aged 15-24 who correctly identify 2 ways of avoiding HIV infection and reject 3 common misconceptions	Total number of women aged 15-24 surveyed

