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# **Multiple Indicator Cluster Survey**

## **Preliminary Report**

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## **Acknowledgements**

Currently, Mongolia is experiencing the transition to the market economy from the centralized planning economy. During the transition period, social protection system has been completely changed from that of the previous system. The problems that occurred in this period are also affecting women and children situation tremendously. More than 40 per cents of the population in the country is constituted by youth under 16 years of age. In this situation, the survey conducted on women and children with the financial and technical support of UNICEF was extremely important event to assess the government effort to improve the status of women and children in the country in the past 10 years.

Government of Mongolia is expressing its deep gratitude and appreciation to the UNICEF Mongolia for its financial and technical support in conducting the Second MICS Survey on the situation of women and children of the country.

The gratitude goes also to all the consultants and staff of UNICEF at EAPRO, Area Office and country office.

The government of Mongolia also thanks also the Ministry of Education, Science and Technology and Culture, the Ministry of Health and Social Welfare, the State Police Department and the National Children Center as well as the Mongolian Child Right Center (NGO) for their active participation in the organization and the review of questionnaire for MICS2.

Special thanks goes to the National Statistical Office and its staff for their tremendous work, their dedication and commitment for conducting overall MICS2 survey in the country and report writing during the whole period of the study.

## **I. Background**

### ***Introduction***

At the World Summit for Children held in New York in 1990, the government of Mongolia committed itself to a Declaration and Plan of Action for Children. Subsequently, a National Programme of Action for Children was developed and approved in 1993. In order to improve the coordination of the activities for children and implement the National Program of Action(NPA), the government of Mongolia established the Working Committee that represent all the sectoral Ministries and NGOs working in child related matters.

To promote the implementation of the NPA and raise the awareness of the government, public the year of 1995 was declared as the “Year of Children” at the initiative of the President of Mongolia.

By the decision of the Parliament, The First National Assembly on “Child Development and Protection” was convened in 1995. The was an important event to define the government policy and create favorable environment for children’s survival, growth, development.

The law on “Protection of Child Rights” was adopted by the Mongolian Parliament in May 1996.

The present Law defines the legal norms for the protection of the rights of the child in line with the socio-economic new system in Mongolia.

National Program for Advancement of Women has been formulated and approved by the Parliament in 1995.

The Plan of Action also called for the establishment of mechanisms for monitoring progress toward the goals and objectives set for the year 2000. Toward this end, UNICEF, in collaboration with WHO, UNESCO and others, has developed a core set of 75 indicators of specific aspects of the situation of children. The 2000 Mongolia MICS survey has been conducted in order to provide end-decade information on many of these indicators.

The Mongolia MICS was conducted by the National Statistics Office. Funding was provided by the UNICEF Mongolian office.

This preliminary report presents selected results on some of the principal topics covered in the survey and on a subset of indicators. A comprehensive full report is scheduled for publication in the first half of December 2000.

### ***Survey Objectives***

The 2000 Mongolia Multiple Indicator Cluster Survey has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in Mongolia at the end of the decade and for looking forward to the next decade;
- To furnish data needed for monitoring progress toward goals established at the World Summit for Children and as a basis for future action;
- To contribute to the improvement of data and monitoring systems in Mongolia 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 Mongolia Multiple Indicator Cluster Survey (MICS) was designed to provide estimates of health indicators at the national level, for urban and rural areas, and for six regions: West, South, North, East, Central-1 and Central-2. The sample was selected in two stages. At the first stage, 300 census enumeration areas were selected with probability proportional to size. After a household listing was carried out within the selected enumeration areas, a systematic sample of 6000 households was drawn. Because the sample was stratified by region, it is self-weighting. For reporting the national level results, sample weights have not been used.

### ***Questionnaires***

In addition to a household questionnaire, questionnaires were administered in each household for women aged 15-49 and children under age five. The questionnaires are based on the MICS model questionnaire with the inclusion of the child disability module. From the MICS model English version, the questionnaires were translated into Mongolian. Questionnaires were

translated back in to English from the Mongolian version. The questionnaires were pretested during Apr. 2000. Based on the results of the pretest, modifications were made to the wording and translation of the questionnaires.

### ***Fieldwork and Processing***

The field staff was trained for 10 days (for interviewers 5 days and for editors and supervisors 10 days) in early May. 2000. The data were collected by eight teams; each was comprised of six interviewers, two editors, one driver, and a supervisor. The MICS Coordinator provided overall supervision. The field work began in May 20, 2000 and completed in early August 2000.

Data were entered in five microcomputers using the ISSA software. For the data entry computer operators have been hired and they were involved in 4 day training, before the beginning the data entry process. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed. The data processing supervisors attended the training in Bangkok in Apr. 2000. They have received excellent grasp of the questionnaires and got good programming skills in the data entry package and SPSS. Procedures and standard programs have been developed under MICS 2 and have been adopted according to the Mongolian specificity the questionnaires were used throughout. Data entry, checking and processing began in July 2000 and finished in August 2000. During the data entry, checking and processing work MICS 2 working group had close cooperation with the resource people from the USAID by mail. The data processing has been organized by based on the guide of the survey. The MICS survey was conducted in two data processing stages: primary and secondary. The goal of primary data processing was to produce clean, edited data files by the following steps.

- Data entry
- Structure check
- Verification
- Secondary editing
- Backup of data .

The goal of secondary data processing was to produce data files to be used for analysis, including tabulations. The secondary data processing comprises the following steps

- Recording of variables
- Tabulation.

NSO staff who were responsible for data entry, checking and data processing worked hard. As the result of their committed work, data processing has been completed within short period of time. After the data processing the statisticians completed statistical analysis on the output tables and prepared some working papers the comparing of the main indicators with the data from other sources.

### ***Sample Coverage***

Of the 6000 households selected for the sample, 6000 were found to be occupied. Of these, 6000 were successfully interviewed for a household response rate of 100 percent. In the interviewed households, 8606 eligible women (age 15-49) were identified. Of these, 8257 were successfully interviewed, yielding a response rate of 95.9 percent. In addition, 6199 children under age five were listed in the household questionnaire. Of these, questionnaires were completed for 6184 for a response rate of 99.8 percent.

### ***Characteristics of the Respondents***

Table 1 presents the percent distribution of households in the sample by background characteristics. About 48.8 percent of the households (2925 households) are urban and 51.2

percent (3075 households) are rural. The Central-2 region comprises the largest of the six regions with 27.4 percent of households while North is next largest with 22.5 percent. The remaining regions each contain between 7.3 and 18.2 percent of households. Most of the households have between four and five members. Seventy-nine point three percent of the households contain at least one child under age five and 99 percent contain at least one woman age 15-49.

Women age 20-24 comprise the greatest percentage of the sample at 21.6 percent (Table 2). This percentage declines steadily across age groups until age 45-49 where it is 4.7 percent. This pattern is typical of countries in the region. Approximately 60 percent of women in the sample are married and 76.4 percent have ever had a birth. The majority of women have had at least some completed secondary education while only 1.1 percent has had no education.

Table 3 shows the characteristics of children under age five. Fifty point nine percent of the children are male and 49.1 percent are female. Approximately 1 percent of mothers of children under age five have no education, a percentage that is almost same the percentage of women with no education in the sample.

## **II. Results**

### ***Primary School Attendance***

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the World Summit for Children. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labor and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth. The primary school age in Mongolia is between 8-12 years. However, in the current survey we used the ages between 7-12 years, which may show to reduced number of children in school compare to the actual situation.

Overall, 75.6 percent of children of primary school age in Mongolia are attending primary school (Table 4). In urban areas, 81.3 percent of children attend school while in rural areas 71.5 percent attend. School attendance in the North is significantly lower than in the rest of the country at 69.7 percent. At the national level, there is virtually no difference between male and female primary school attendance. But about 70 percent boys in urban and girls in rural are attend at school.

*More than 94 percent of children who enter the first grade of primary school eventually reach grade five (Tables 5). However, there are large regional and urban-rural disparities in the achievement of grade five. About 94 percent of urban and 91.3 percent of rural children who enter grade one reach grade five compared to slightly more than half of children in rural areas. In the West, North, South and Central regions 100 percent of those who enter grade one reach grade five while in the East, the comparable percentage is 22.4. (22.4% still checking data) Nationally, probability of reaching the fifth grade of secondary schools among girls who entered the first grade of primary schools is almost 100 per cent. However, this percentage among boys is 93.9 per cent.*

### ***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 cholera and typhoid. Drinking water can also be tainted with chemical, physical and radiological contaminants with harmful effects on human health. 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 overall population by source of drinking water is shown in Figure 1. Over 20 percent of the population uses drinking water from that of piped into their dwelling and 18.1 percent used water from public tap. Protected dug well, pond, rainwater and streams are also important sources of drinking water.

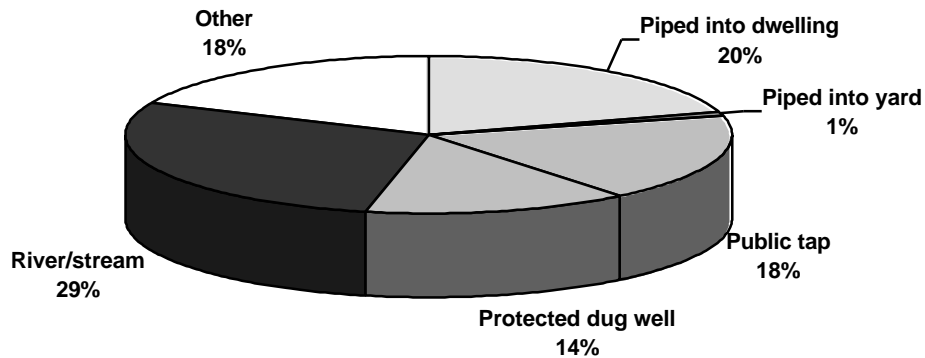
The source of drinking water for the population varies strongly by region (Table 6). In the Central-2 region, 49.2 percent, Central-1 about 27.2 percent, and in the East region 15.5 of the population uses drinking water that is piped into their dwelling. In the Central –2 regions- 38.1 percent, South-23.8 percent and Central-1 regions 19.8 percent respectively use from public tap. In the North, the most important source of drinking water is pond, river or stream well while in the South, more than 38.4 percent use protected dug well.

The population using *safe drinking water* sources is those who use any of the following types of supply: piped water, public tap, borehole/tubewell, protected well, protected spring or rainwater. Overall, 60.5 percent of the population has access to safe drink water – 90.8 percent in urban areas and 34.4 percent in rural areas. The situation in the North is considerably worse than in other regions; only 22.6 percent of the population in this region get its drinking water from a safe source. About 68 percent of the population in the North region get its drinking water from pond river or stream but the situation of the pond river or stream is clean.

During the recent past the number of protected wells has been decreased. Particularly as the biggest rivers and lakes are located in the central, north and east regions of the country, the populations in these regions mostly use the river and spring water. In contrast, aimags in south and gobi regions still using the water from the protected wells established before 1990. Due to the methodology used in this survey, safe drinking water supply in south region is much higher than in the west and east regions.

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhea diseases and polio. *Sanitary means of excreta disposal* include: flush toilets connected to sewage systems or septic tanks, other flush toilets, improved pit latrines, and traditional pit latrines. Seventy three percent of the population of Mongolia is living in households with sanitary means of excreta disposal (Table 7). This percentage is 96.9 in urban areas and 54.1 percent in rural areas. Residents of the South and North are much less likely than others to use sanitary means of excreta disposal. Most of this population uses traditional pit latrine. In contrast, the most common facilities in urban areas of the country are flush toilets with connection to a sewage system or traditional pit latrine.

**Figure 1: Percent distribution of the population by source of drinking water**



### ***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. Undernourishment in a population can be gauged by comparing children to this standard distribution. The standard or reference population used here is the NCHS standard, which is recommended for use by UNICEF and the World Health Organization. Each of the three nutritional status indicators is expressed in standard deviation units (z-scores) from the median of this reference population.

Weight for age is 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*.

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 and recurrent or chronic illness.

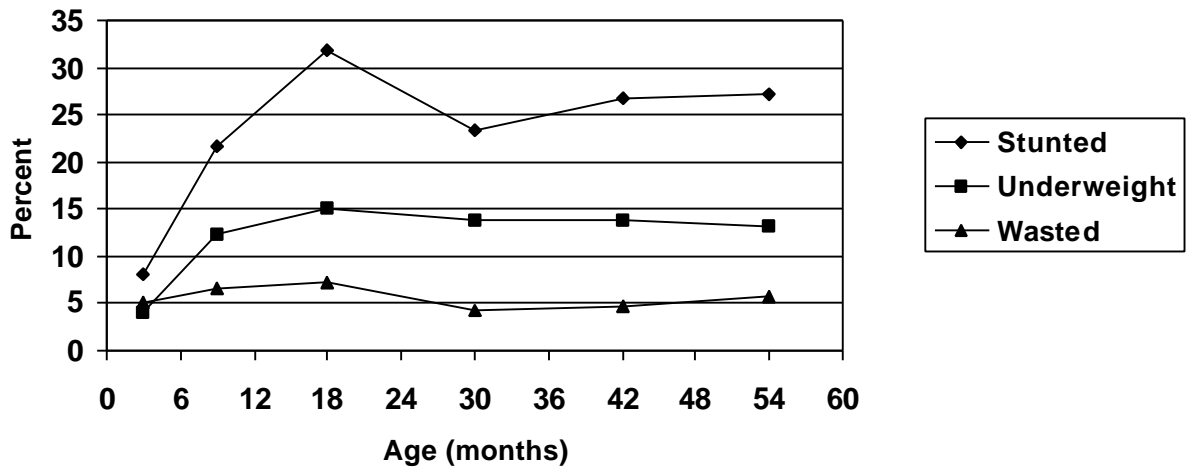
Finally, children whose weight for height is more than two standard deviations below the median of the reference population are classified as *moderately or severely wasted*, while those who fall more than three standard deviations below the median are *severely wasted*. Wasting is usually the result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

In Table 8, children who were not weighed and measured (approximately 4.1 percent of children) and those whose measurements are outside a plausible range are excluded. In addition, a small number of children whose birth dates are not known are excluded.

Almost three in ten children under age five in Mongolia are underweight (2.8%) and eight percent are classified as severely underweight (Table 8). Twenty four point six percent of children are stunted or too short for their age and 5.5 percent are wasted or too thin for their height.

Children in the East are more likely to be underweight and stunted than other children. In contrast, the percentage wasted is highest in the East region. Those whose mothers have none or primary education is the least likely to be underweight and stunted compared to children of mothers with education. The age pattern shows that a higher percentage of children aged 12-23 months are undernourished according to all three indices in comparison to children who are younger and older (Figure 2).

**Figure 2: Percentage of under-five children who are undernourished**



### **Breastfeeding**

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. However, many mothers stop breastfeeding too soon, and there are often pressures to switch to infant formula, which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. The World Summit for Children goal states that children should be exclusively breastfed for four to six months, that breastfeeding should be complemented with appropriate foods from the age of around six months, and that children continue to be breastfed for two or more years.

In Table 9, breastfeeding status is based on women’s reports of children’s consumption in the 24 hours prior to the interview. *Exclusive breastfeeding* refers to children who receive only breast milk and vitamins, mineral supplements, or medicine. *Complementary feeding* refers to children who receive breast milk and solid or semi-solid food. The last two columns of the table include children who are continuing to be breastfed at one and at two years of age. Percentages according to region and mother’s education are not shown due to small sample sizes. For the same reason, the sex and urban-rural residence breakdowns should be interpreted with caution.

Approximately 64percent of children aged less than four months are exclusively breastfed, a level considerably lower than recommended. At age 6-9 months, 54.5 percent of children are receiving breast milk and solid or semi-solid foods. By age 12-15 months, 75.2 percent of children are still being breastfed and by age 20-23 months, 56.9 percent are still breastfed. Boys were more likely to be exclusively breastfed than girls, while girls had higher levels than boys for timely complementary feeding.

### ***Vitamin A Supplementation***

Vitamin A deficiency (VAD) impairs children's immune systems, increasing their chances of dying of common childhood diseases and undermines the health of pregnant and lactating women. It can also cause eye damage and blindness in children. Yet it can be easily prevented by vitamin A supplementation or food fortification. UNICEF and WHO recommend that all countries with an under five mortality rate exceeding 70 per 1000 live births, or where vitamin A deficiency is a public health problem, should put in place a programme for control of vitamin A deficiency. Based on UNICEF/WHO guidelines, the Mongolia Ministry of Health recommends that children aged 6-12 months be given one dose Vitamin A capsule of 100,000 IU every six months, and children older than one year be given one high dose of 200,000 IU every six months.

Within the six months prior to the MICS, 31.6 percent of children aged 6-59 months received the high dose Vitamin A supplement (Table 10). Approximately 53.6 percent did not receive the supplement in the last 6 months but did receive one prior to that time. Fewer than 3.1 percent of children received a Vitamin A supplement at some time in the past but their mother/caretaker was unable to specify when.

The age pattern of Vitamin A supplementation shows that supplementation in the last six months rises from 30.1percent among children aged 6-11 months to 35.9 percent among children aged 12-23 months and then declines steadily with age to 27.7 percent among the oldest children.

The mother's level of education is also related to the likelihood of Vitamin A supplementation. The percentage receiving a supplement in the last six months decreases from 30 percent among children whose mothers have no education to 22.3 percent of those whose mothers have primary education and 30.3-33.5 percent among children of mothers with secondary or higher education.

### ***Salt Iodization***

Deficiency of iodine in the diet is the world's single greatest cause of preventable mental retardation and can lower the average intelligence quotient (IQ) of a population by as much as thirteen points. Salt iodization is an effective, low-cost way of preventing iodine deficiency disorders (IDD). *Adequately iodized salt* contains 15 ppm (parts per million) of iodine or more. In MICS, interviewers tested household salt for iodine levels by means of a testing kit.

Approximately 99.3 percent of households had salt, which was tested during the MICS (Table 11). Among households in which salt was tested, 44.9 percent had adequately iodized salt. The percentage of households with adequately iodized salt ranges from 3 percent in the West to 5.8 percent in the North region. 30.4 percent of urban households had adequately iodized salt compared to 14.5 percent of rural households.

### ***Immunization Coverage***

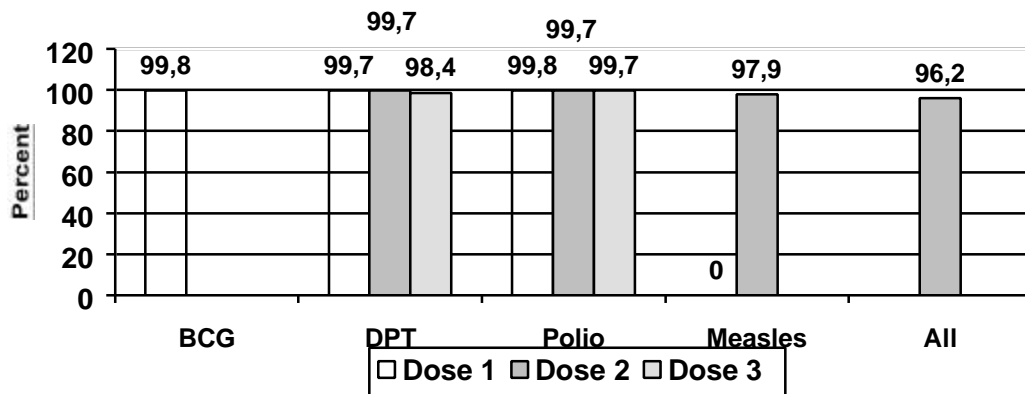
According to UNICEF and WHO guidelines, a child should receive a BCG vaccination to protect against tuberculosis, three doses of DPT to protect against diphtheria, pertussis, and tetanus, three doses of polio vaccine, and a measles vaccination by the age of 12 months. In MICS, mothers

were asked to provide vaccination cards for children under the age of five. Interviewers copied vaccination information from the cards onto the MICS questionnaire. Overall, 86,9 percent of children had health cards. If the child did not have a card, the mother was asked to recall whether or not the child had received each of the vaccinations and, for DPT and Polio, how many times.

Table 12 shows the percentage of children aged 12 to 23 months who received each of the vaccinations. The denominator for the table is comprised of children aged 12-23 months so 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 before 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 the first birthday is assumed to be the same as for children with vaccination cards.

Approximately 99.8 percent of children aged 12-23 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 99.7percent. The percentage declines for subsequent doses of Polio to 99 percent for the third dose. (Figure 3) The coverage for measles vaccine by 12 months is lower than for the other vaccines at 97,9 percent. As a result, the percentage of children who had all recommended vaccinations by their first birthday is at 96.2 percent.

**Figure 3: Percentage of children 12-23 months who received immunizations by age 12 months**



### ***Knowledge of HIV/AIDS Transmission***

One of the most important strategies for reducing the rate of HIV/AIDS infection is the promotion of accurate knowledge of how AIDS is transmitted and how to prevent transmission. Among women aged 15-49 in Mongolia, 94.1 percent have ever heard of AIDS (Table 13). This percentage is very high in urban areas (97.5 percent) and somewhat lower in rural areas (90.9 percent).

Women in the MICS were read several statements about means of HIV/AIDS transmission and asked to state whether they believed the statements were true. Eighty two and two percent believe that having only one uninfected sex partner can prevent HIV transmission. 80.4 percent believe

that using a condom every time one has sex can prevent HIV transmission and 45 percent agreed that abstaining from sex prevents HIV transmission. Overall, 38.3 percent knew all three ways and 88.4 percent were aware of at least one of the means of preventing transmission.

Accurate knowledge of the means of HIV/AIDS transmission is substantially less among women in the North, South, and East than among other women. Also, education is a very important factor in AIDS knowledge. The percentage who know all three means of preventing transmission is more than two times greater among women with secondary or more education compared to women with no education. Differences across age groups are not particularly large; the percentage of women who know all three means ranges from 33.6 percent among 40-44 year olds to 42.4 percent among 35-39 year olds.

Seventy-six and four percent of women correctly stated that AIDS can't be transmitted by supernatural means while 58.2 percent stated that AIDS can't be spread by mosquito bites (Table 14). More than 55.9 percent women correctly believe that a healthy looking person can be infected. Women in the South are more likely to believe misconceptions about AIDS transmission than other women. Women in the Central-1 region are most likely to recognize all three misconceptions. Still, only 43.4 percent of these women correctly identified all three misconceptions.

### ***Assistance at Delivery***

The provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and children by the use of technically appropriate procedures, and accurate and speedy diagnosis and treatment of complications. *Skilled assistance at delivery* is defined as assistance provided by a doctor, nurse, or midwife. Skilled personnel (Table 15) delivered about 96.6 percent of births occurring in the year prior to the MICS survey. This percentage is highest in the East region at 100 percent and lowest in the West at 93.9 percent. The more educated a woman is, the more likely she is to have delivered with the assistance of a skilled person.

Only one percent of the births in the year prior to the MICS survey were delivered with assistance by a midwife. Doctors assisted with the delivery of 58.8 percent of births and nurses assisted with 36.7 percent.

About 58.8 percent women aged between 15-49 years has assistance by doctor, 36.7 percent by nurse and midwife. If the mother's education level is increase same time they have more assistance by doctor. The percentage who have assistance by doctor is more than two times greater among woman with secondary or more education compared to women with uneducated.

### ***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. The births of 97.6 percent of children under five years in Mongolia have been registered (Table 16). There are no significant variations in birth registration across sex, age, or education categories and regions.

**Table 1: Percent distribution of households by background characteristics, Country, Year**

	Area		Total
	Urban	Rural	
Central	74.3	0.0	41.5
South Central	17.1	27.9	21.9
West	8.6	24.8	15.7
East	0.0	26.1	11.5
South	.0.0	21.2	9.4
Number of HH members			
1	9.8	10.5	10.1
2-3	35.6	33.0	34.4
4-5	36.5	34.2	35.5
6-7	12.8	15.1	13.8
8-9	4.0	5.2	4.5
10+	1.4	2.1	1.7
Total	100.0	100.0	100.0
At least one child age < 15	60.9	66.1	63.2
At least one child age < 5	34.7	39.8	37.0
At least one woman age 15-49	78.9	79.5	79.2
Number	2395	1890	4285
Unweighted	2307	1978	4285

**Table 2: Percent distribution of women 15-49 by background characteristics, Country, Year**

	Area		Total
	Urban	Rural	
Central	72.2	0.0	40.0
South Central	19.0	30.3	24.0
West	8.8	24.6	15.8
East	0.0	24.7	11.0
South	0.0	20.4	9.1
Age			
15-19	18.2	23.6	20.6
20-24	16.4	15.3	15.9
25-29	15.0	14.9	15.0
30-34	15.4	14.7	15.1
35-39	13.9	12.8	13.4
40-44	11.9	10.1	11.1
45-49	9.1	8.5	8.8
Marital status			
Currently married	62.3	66.5	64.2
Not currently married	37.7	33.5	35.8
Ever given birth			
Yes	66.2	67.9	67.0
No	33.8	32.1	33.0
Education level			
None	2.3	12.2	6.7
Primary	19.2	35.5	26.5
Secondary +	78.5	52.3	66.8
Total	100.0	100.0	100.0
Number	2196	1769	3965
Unweighted	2060	1905	3965

**Table 3: Percent distribution of children under 5 by background characteristics, Country, Year**

	Area		Total
	Urban	Rural	
Male	52.2	53.8	53.0
Female	47.8	46.2	47.0
Central	74.0	.0	36.2
South Central	17.4	22.9	20.2
West	8.6	20.6	14.8
East	0.0	23.4	11.9
South	0.0	33.1	16.9
Age			
< 6 months	12.2	11.4	11.8
6-11 months	8.1	9.1	8.6
12-23 months	19.1	21.0	20.0
24-35 months	25.1	21.2	23.1
36-47 months	18.7	19.0	18.9
48-59 months	16.8	18.3	17.6
Mother's education			
None	5.5	20.2	13.0
Primary	16.9	36.9	27.1
Secondary +	77.6	42.9	59.9
Total	100.0	100.0	100.0
Number	896	934	1830
Unweighted	857	974	1831

**Table 4: Percentage of children of primary school age attending primary school, Country, Year**

	Male		Female		Total	
	Attending Number	Attending Number	Attending Number	Attending Number	Attending Number	Attending Number
Central	96.5	504	97.3	456	96.9	959
South Central	92.5	324	96.1	296	94.2	620
West	89.7	201	91.1	211	90.4	412
East	93.0	203	87.0	169	90.3	373
South	50.6	172	53.6	159	52.0	331
Urban	95.4	702	96.7	627	96.0	1329
Rural	81.5	702	82.3	663	81.9	1365
Age						
5	83.7	154	81.9	157	82.8	311
6	83.8	176	86.4	158	85.1	334
7	87.8	193	89.2	160	88.4	353
8	91.1	173	92.8	147	91.9	320
9	88.7	180	91.8	175	90.2	355
10	92.0	195	91.6	172	91.8	366
11	90.1	156	90.5	172	90.3	328
12	89.7	177	89.6	150	89.7	327
Total	88.5	1404	89.3	1290	88.9	2694

**Table 5: Percentage of children entering first grade of primary school who eventually reach grade 5, Country, Year**

	Percent attending 2 <sup>nd</sup> grade were in 1 <sup>st</sup> grade last year	Percent attending 3 <sup>rd</sup> grade were in 2 <sup>nd</sup> grade last year	Percent attending 4 <sup>th</sup> grade were in 3 <sup>rd</sup> grade last year	Percent attending 5 <sup>th</sup> grade were in 4 <sup>th</sup> grade last year	Percent who reach grade 5 of those who enter grade 1
Male	86.0	92.4	93.2	93.2	69.1
Female	86.1	92.8	95.2	89.5	68.1
Central	98.2	.	96.9	96.3	.
South Central	93.5	94.5	93.9	96.1	79.7
West	82.5	90.1	93.6	83.4	58.0
East	86.6	92.9	95.4	89.6	68.7
South	51.8	76.4	80.6	72.4	23.1
Urban	95.4	98.7	96.8	96.0	87.4
Rural	78.8	87.4	91.6	86.1	54.3
Total	86.1	92.6	94.2	91.4	68.6

**Table 6: Percentage of the population using improved drinking water sources, Country, Year**

	Main source of water														Total	with safe water	No. of drinking persons	
	Piped into dwelling	Piped into yard or plot	Public tap	Tube-well/ Bore-hole with pump	Pro- tected spring	Pro- tected dug well	Rain- water collec- tion	Bottled water	Unpro- tected spring	Unpro- tected dug well	River or stream	Tanker or truck vendor	Cut official pipe	Other				Don't know
Central	79.8	14.0	0.7	0.0	0.1	0.0	4.3	0.1	0.0	0.0	0.0	0.0	0.0	0.5	0.4	100.0	98.9	6778
South Central	44.3	24.8	0.4	1.3	1.7	0.4	21.9	0.0	0.3	0.0	0.0	0.0	2.2	2.5	0.2	100.0	94.8	3873
West	49.9	31.9	0.6	0.2	0.0	0.1	5.7	0.3	0.0	0.2	0.8	0.9	6.6	1.7	1.1	100.0	88.4	2716
East	32.9	20.9	1.0	1.3	2.8	0.2	28.8	0.3	2.0	0.0	7.5	0.0	1.0	1.1	0.0	100.0	87.9	2077
South	0.0	7.4	2.1	0.0	0.0	0.0	21.3	0.0	0.0	0.5	68.5	0.0	0.0	0.0	0.3	100.0	30.8	1518
Urban	74.4	16.2	0.5	0.5	0.6	0.2	5.5	0.1	0.2	0.0	0.0	0.1	0.1	1.1	0.5	100.0	97.9	9312
Rural	29.2	23.7	1.1	0.5	0.9	0.1	22.3	0.1	0.5	0.2	15.9	0.2	3.6	1.3	0.4	100.0	77.8	7651
Total	54.0	19.6	0.8	0.5	0.8	0.1	13.1	0.1	0.3	0.1	7.2	0.1	1.7	1.2	0.4	100.0	88.9	16963

**Table 7: Percentage of the population using sanitary means of excreta disposal, Country, Year**

	Type of toilet facility									Total	Total with sanitary means of excreta disposal	No. of persons
	Flush to sewage system/ septic tank	Pour flush latrine	Improved pit latrine	Traditional pit latrine	River	Open pit	Other	No facilities/ bush/field	Missing			
Central	87.5	11.5	0.2	0.0	0.0	0.0	0.5	0.0	0.4	100.0	99.2	6778
South Central	73.7	25.7	0.0	0.2	0.0	0.1	0.1	0.1	0.0	100.0	99.6	3873
West	71.0	24.3	1.5	1.0	0.0	0.6	0.6	0.2	0.7	100.0	97.8	2716
East	50.9	44.3	0.5	1.0	0.0	1.7	1.2	0.4	0.0	100.0	96.7	2077
South	.8	17.4	0.0	0.6	28.6	1.1	0.0	50.8	0.6	100.0	18.9	1518
Urban	84.3	14.6	0.1	0.0	0.0	0.0	0.5	0.0	0.4	100.0	99.1	9312
Rural	51.5	29.5	0.7	0.8	5.7	0.9	0.4	10.3	0.2	100.0	82.4	7651
Total	69.5	21.3	0.4	0.4	2.6	0.4	0.5	4.7	0.3	100.0	91.6	16963

**Table 8: Percentage of under-five children who are severely or moderately undernourished, Country, Year**

	Weight for age		Height for age		Weight for height		Number of children
	Percent below – 2 SD	Percent below –3 SD	Percent below – 2 SD	Percent below –3 SD	Percent below –2 SD	Percent below –3 SD	
Male	10.8	2.7	14.2	2.5	3.9	0.8	887
Female	7.1	1.9	11.6	1.3	2.6	0.6	779
Central	5.8	1.4	10.8	1.9	3.3	0.8	609
South Central	8.7	2.5	16.6	1.6	4.6	1.1	350
West	6.1	1.7	11.1	.8	3.9	0.2	228
East	7.4	.5	6.9	.9	1.0	0.2	207
South	20.4	6.0	19.4	3.9	2.9	0.7	272
Urban	6.2	1.3	10.8	1.4	3.3	0.6	816
Rural	11.9	3.3	15.1	2.4	3.3	0.8	849
< 6 months	2.5	.5	3.6	1.0	0.5	0.3	196
6-11 months	8.4	2.9	11.0	3.4	4.3	2.1	141
12-23 months	13.1	4.2	16.8	2.3	5.2	0.7	346
24-35 months	8.6	1.6	12.4	1.6	3.4	0.3	378
36-47 months	9.5	2.5	14.3	1.6	2.9	1.0	315
48-59 months	8.8	1.7	14.8	2.0	2.8	0.7	288
Mother's education							
None	15.5	4.5	15.1	3.7	3.3	0.9	211
Primary	13.2	2.4	16.2	2.2	3.2	0.7	444
Secondary +	5.9	1.8	11.2	1.4	3.4	0.7	1010
Total	9.1	2.3	13.0	1.9	3.3	0.7	1665

**Table 9: Percent of living children by breastfeeding status, Country, Year**

	Percent of children 0-3 months exclusively breastfed		Percent of children 6-9 months receiving breastmilk and solid/semi-solid food		Percent of children 12-15 months breastfed		Percent of children 20-23 months breastfed	
	Number of children	Percent of children	Number of children	Percent of children	Number of children	Percent of children	Number of children	Percent of children
Male	77	14.5	59	18.6	66	39.5	48	10.9
Female	69	9.9	49	32.6	72	36.9	52	13.4
Urban	72	13.0	48	23.9	64	31.1	46	18.2
Rural	74	11.7	59	25.8	74	44.2	54	7.1
Total	146	12.4	108	25.0	138	38.1	100	12.2

**Table 10: Percent distribution of children aged 6-59 months by whether they have received a high dose Vitamin A supplement in the last 6 months, Country, Year**

	Percent of children who received Vitamin A:				Not sure if received	Never received	Total	Number of children
	Within last 6 months	Prior to last 6 months	Not when	sure				
Male	12.2	6.1	0.2		2.2	79.3	100.0	855
Female	15.6	6.6	0.1		1.3	76.4	100.0	757
Central	14.2	8.5	0.3		2.1	74.8	100.0	576
South Central	14.2	5.4	0.0		1.5	78.9	100.0	331
West	17.1	8.9	0.4		1.6	72.0	100.0	246
East	15.1	5.5	0.0		1.5	77.9	100.0	199
South	8.1	0.8	0.0		1.9	89.2	100.0	260
Urban	15.9	8.0	0.3		2.2	73.8	100.0	786
Rural	11.7	4.7	0.1		1.5	82.0	100.0	826
6-11 months	17.1	1.3	0.0		0.6	81.0	100.0	158
12-23 months	21.0	5.2	0.3		1.1	72.4	100.0	366
24-35 months	13.7	9.7	0.0		0.5	76.3	100.0	422
36-47 months	9.6	5.2	0.0		3.2	82.0	100.0	345
48-59 months	8.4	6.9	0.6		3.4	80.7	100.0	321
Mother's education								
None	6.3	3.9	0.5		1.9	87.4	100.0	207
Primary	13.8	7.3	0.5		1.9	76.5	100.0	426
Secondary +	15.3	6.4	0.0		1.7	76.5	100.0	979
Total	13.8	6.3	0.2		1.8	77.9	100.0	1612

**Table 11: Percentage of households consuming adequately iodized salt, Country, Year**

	Percent of households with no salt	Percent of households in which salt was tested	Percent of households with salt testing		Number of households interviewed
			< 15 PPM	15+ PPM	
Central	0.3	99.6	10.6	89.4	1778
South Central	0.8	98.9	30.9	69.1	938
West	0.7	99.3	26.6	73.4	673
East	1.0	96.8	22.9	77.1	493
South	5.0	89.3	42.9	57.1	403
Urban	0.9	99.5	18.6	81.4	2395
Rural	1.1	96.4	26.3	73.7	1890
Total	1.0	98.1	22.0	78.0	4285

**Note: Adequately iodized salt is salt testing 15 PPM (parts per million) or more.**

**Table 12: Percentage of children age 12-23 months immunized against childhood diseases at any time before the survey and before the first birthday, Country, Year**

<b>Percentage of children who received:</b>											
	<b>BCG</b>	<b>DPT1</b>	<b>DPT2</b>	<b>DPT3</b>	<b>Polio 1</b>	<b>Polio2</b>	<b>Polio3</b>	<b>Measles</b>	<b>All</b>	<b>None</b>	<b>No. of children</b>
Vaccinated at any time before the survey											
According to:											
Vaccination card	85.2	80.5	78.6	74.3	84.7	81.8	77.8	56.2	51.7	1.1	314
Mother's report	3.7	5.0	3.0	3.0	3.3	3.3	2.5	4.4	0.8	2.7	52
Either	88.9	85.5	81.6	77.3	88.0	85.1	80.3	60.6	52.5	3.8	366
Vaccinated by 12 months of age	87.1	84.0	79.4	74.5	86.9	83.1	77.2	24.0	19.3	-	366

Table 13: Percentage of women aged 15-49 who know the main ways of preventing HIV transmission, Country, Year

	Percent who know transmission can be prevented by:							
	Heard of AIDS	one uninfected sex partner	only faithful condom every time	Using a condom	Abstaining from sex	Knows all three ways	Knows at least one way	Doesn't know any way
Central	97.0	76.3	76.9	53.7	46.8	83.8	16.2	1587
South Central	93.1	63.3	63.5	45.4	37.3	72.1	27.9	953
West	92.7	53.1	46.0	37.5	27.3	60.8	39.2	627
East	91.1	61.6	59.4	43.3	36.3	66.7	33.3	437
South	82.7	25.0	22.2	20.9	14.9	29.4	70.6	360
Urban	96.5	73.9	73.4	52.1	45.0	81.5	18.5	2196
Rural	89.6	50.0	47.6	36.2	28.0	56.9	43.1	1769
15-19	92.0	58.5	57.1	42.9	33.8	66.4	33.6	818
20-24	94.3	60.8	63.1	42.5	33.4	71.6	28.4	631
25-29	94.2	66.5	63.9	46.1	39.4	72.6	27.4	593
30-34	95.1	69.0	64.4	47.4	41.1	73.6	26.4	599
35-39	94.4	66.9	66.1	48.8	42.2	74.3	25.7	531
40-44	93.6	65.8	63.8	47.3	39.4	72.8	27.2	441
45-49	89.2	54.6	54.5	39.8	33.2	60.6	39.4	351
Education								
None	80.7	17.3	14.9	10.8	6.4	21.6	78.4	266
Primary	87.7	40.4	38.1	29.8	22.0	47.4	52.6	1050
Secondary +	97.0	76.9	76.1	54.5	46.6	84.6	15.4	2649
Total	93.4	63.2	61.9	45.0	37.4	70.5	29.5	3965

Table 14: Percentage of women aged 15-49 who correctly identify misconceptions about HIV/AIDS, Country, Year

	Percent who know that:								Number of women
	Heard AIDS	of Supernatural means	Mosquito bites	A healthy person can be infected	Knows three misconceptions	all Knows least misconception	Doesn't at correctly identify any misconception		
Central	97.0	71.9	63.2	82.7	52.0	90.8	9.2	1587	
South Central	93.1	59.7	48.9	71.7	36.2	82.4	17.6	953	
West	92.7	49.3	38.8	68.0	28.9	78.2	21.8	627	
East	91.1	52.9	45.6	63.3	29.3	77.5	22.5	437	
South	82.7	26.3	18.0	46.1	13.4	53.9	46.1	360	
Urban	96.5	68.8	59.6	80.9	48.3	89.2	10.8	2196	
Rural	89.6	47.1	37.8	61.5	26.4	73.0	27.0	1769	
15-19	92.0	55.9	46.3	68.8	32.2	81.2	18.8	818	
20-24	94.3	60.0	49.4	74.4	39.1	83.6	16.4	631	
25-29	94.2	62.6	55.6	74.8	44.0	83.2	16.8	593	
30-34	95.1	62.7	52.6	73.6	41.2	84.0	16.0	599	
35-39	94.4	63.6	54.4	72.7	43.7	82.5	17.5	531	
40-44	93.6	55.8	47.8	73.7	37.4	81.9	18.1	441	
45-49	89.2	51.0	40.7	67.3	31.8	74.7	25.3	351	
Education									
None	80.7	17.1	11.2	37.3	7.7	45.1	54.9	266	
Primary	87.7	35.0	26.7	53.9	15.8	65.3	34.7	1050	
Secondary +	97.0	73.0	63.0	83.0	50.6	92.3	7.7	2649	
Total	93.4	59.2	49.9	72.2	38.5	82.0	18.0	3965	

**Table 15: Percent distribution of women aged 15-49 with a birth in the last year by type of personnel assisting at delivery, Country, Year**

	Person assisting at delivery						Total	Any skilled personnel	Number of women
	Doctor	Nurse	Midwife	Health assistant	Traditional birth attendant	Other/missing			
Central	33.1	16.9	42.6	0.0	0.0	7.4	100.0	92.6	145
South Central	29.8	20.4	48.5	0.0	0.0	1.2	100.0	98.8	75
West	32.3	9.1	41.6	0.0	2.0	15.0	100.0	83.0	45
East	29.3	9.8	48.8	0.0	2.4	9.8	100.0	87.8	38
South	7.8	3.3	10.0	46.7	26.7	5.6	100.0	21.1	84
Urban	31.7	16.4	45.4	0.0	0.0	6.6	100.0	93.4	195
Rural	21.3	9.7	29.0	20.3	12.6	7.2	100.0	59.9	192
Education									
None	15.2	2.3	16.9	28.5	28.5	8.5	100.0	34.4	46
Primary	19.8	17.5	28.5	20.3	8.1	5.8	100.0	65.7	114
Secondary +	32.2	13.0	45.7	1.2	0.8	7.1	100.0	90.8	227
Total	26.5	13.1	37.2	10.1	6.2	6.9	100.0	76.8	387

**Table 16: Percent distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, Country, Year**

	Birth registered	isDK if birth registered	Costs much	Birth is not registered because:					Reason DK Missing	or Total	No. of children
				Must tootrail toofar	Didn't know tooshould be registered	Doesn't know where to register	to Other				
Male	93.8	4.3	0.1	0.3	0.1	0.1	0.7	0.5	100.0	970	
Female	94.7	4.0	0.0	0.1	0.2	0.1	0.3	0.5	100.0	860	
Central	95.1	2.7	0.2	0.2	0.3	0.2	0.6	0.8	100.0	663	
South Central	94.9	3.2	0.0	0.6	0.0	0.3	1.1	0.0	100.0	370	
West	85.6	13.3	0.0	0.0	0.4	0.0	0.0	0.7	100.0	270	
East	96.5	2.2	0.0	0.4	0.0	0.0	0.9	0.0	100.0	219	
South	97.5	1.9	0.0	0.0	0.0	0.0	0.0	0.6	100.0	309	
Urban	93.5	4.2	0.1	0.4	0.2	0.2	0.7	0.7	100.0	896	
Rural	95.0	4.1	0.0	0.1	0.1	0.0	0.4	0.3	100.0	934	
< 6 months	90.7	4.6	0.0	0.9	0.0	0.0	2.3	1.4	100.0	215	
6-11 months	96.7	2.0	0.0	0.0	0.0	0.0	0.6	0.7	100.0	158	
12-23 months	95.6	2.7	0.0	0.3	0.3	0.0	0.8	0.3	100.0	366	
24-35 months	93.3	5.4	0.2	0.0	0.2	0.0	0.2	0.5	100.0	422	
36-47 months	93.6	4.7	0.0	0.3	0.3	0.6	0.0	0.6	100.0	345	
48-59 months	95.7	4.3	0.0	0.0	0.0	0.0	0.0	0.0	100.0	321	
Mother's education											
None	92.0	2.9	0.0	0.8	0.9	0.9	1.3	1.2	100.0	238	
Primary	92.6	5.6	0.2	0.4	0.2	0.0	0.8	0.2	100.0	496	
Secondary +	95.5	3.8	0.0	0.0	0.0	0.0	0.3	0.5	100.0	1096	
<b>Total</b>	<b>94.2</b>	<b>4.2</b>	<b>0.1</b>	<b>0.2</b>	<b>0.2</b>	<b>0.1</b>	<b>0.6</b>	<b>0.5</b>	<b>100.0</b>	<b>1830</b>	