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 estimates mortality rates from aggregate information concerning the number of children born to women in five-year age groups as well as the proportion of children in each group who die.

One of the overarching goals of the Millennium Development Goals and A World Fit for Children is to reduce infant and under-five mortality.
Monitoring progress towards this goal is an important but difficult objective.

The MICS3 report was made possible thanks to generous contributions from: DFID, UNDP, UNFPA, UNICEF, USAID

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Photography:
Giacomo Pirozzi

According to the 2005

TAJIKISTAN

Multiple Indicator Cluster Survey
Preliminary Report

CHILDHOOD MORTALITY IS ON THE DECLINE

Infant mortality and under–five mortality rates, Tajikistan 2000 & 2005, per 1000 live births

Survey Year	Infant Mortality Rate	Under–Five Mortality Rate
2000	89	126
2005	65	79

THE INFANT MORTALITY RATE IS...

...estimated at 65 per thousand, while the under-five mortality rate is 79 per thousand. These estimates are centrered on the year 2003.

By region, results indicate the highest level of childhood mortality rates occur in Khatlon (above 80 per thousand) while the lowest are seen in DRD, GBAO and Dushanbe (less than 60 per thousand).

There are also differences in infant and under-five mortality rates in terms of educational levels. 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 almost twice as likely to die during the 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 respectively).

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.

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.

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).

MICS 3 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;

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;

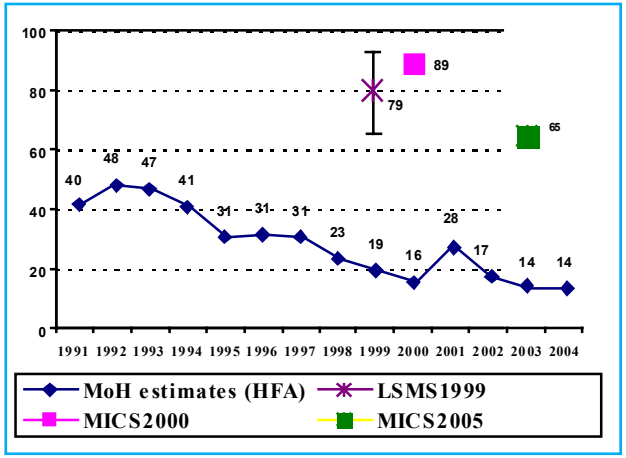
To contribute to the improvement of data and monitoring systems in Tajikistan and to strengthen technical expertise in the design, implementation, and analysis of such systems.

The MICS 3 preliminary report presents selected results on a variety of principal topics covered in the survey and on a subset of indicators. As specified, the results in the 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.

KEY RESULTS:

- Childhood mortality rates are lower as compared to MICS 2000.
- The highest level of under-five mortality occurs in Khatlon (102 per 1000), while the lowest are seen in DRD, GBAO and Dushanbe (less than 60 per 1000).
- Infant and under-five mortality rates are almost five times higher in children born to mothers with little or no education as compared to those with higher education.

Infant mortality rate estimates (per 1000) Tajikistan, 2005



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. Traditional birth attendants are not considered as skilled assistance at delivery.

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

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SKILLED ASSISTANCE AT DELIVERY IS INCREASING

Skilled Attendant at Delivery Tajikistan 2000 & 2005

Survey Year	Skilled attendant at delivery
2000	71%
2005	83%

SKILLED PERSONNEL DELIVERED…

…about 83 percent of births occurring in the two years prior to the MICS3. 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).

Doctors assisted with the delivery of 61 percent of births. Nurses/ midwives accounted for 21 percent of assisted births, with auxiliary midwives assisting with 1 percent of births.

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 was an important factor 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.

Wealth of the household was also a contributing factor. Only 69 percent of women from the poorest quintile had skilled assistance at delivery, while in the richest quintile this number was 91 percent.

Overall, about 9 percent of births were delivered by traditional birth attendants, but these births occurred mainly in GBAO, Khatlon and DRD. Friends and relatives were present at almost 8 percent of deliveries. While less than 1 percent of births occurred with no one in attendance. A majority of these births occurred in women over the age of 35.

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.

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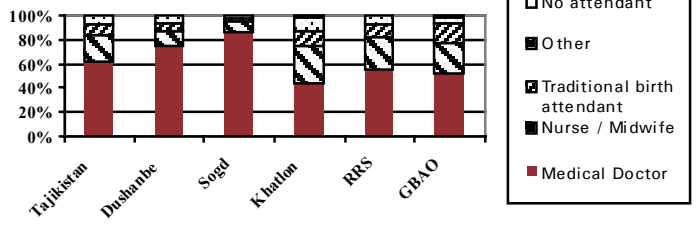
KEY RESULTS:

- The presence of skilled attendants at delivery has increased since MICS 2000.
- Skilled attendance is slightly higher in urban areas as compared to rural areas.
- Educated women are more likely to have delivered with the assistance of a skilled personnel.
- The richest quintile of the population is more likely to have skilled assistance at delivery.

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



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. By determining if children have deviated from this standard distribution, one is able to measure if a child is ***underweight, stunted*** or ***wasted***.

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NUTRITIONAL STATUS OF CHILDREN IS PROBLEMATIC

Child Nutritional Status Prevalence Rates
Tajikistan, 2005

Underweight	17%
Stunting	27%
Wasting	7%
Global Acute Malnutrition	11%

STUNTING IN CHILDREN…

… is the effect of chronic malnutrition as a result of failure to receive adequate nutrition over a long period of time and/ or recurrent or chronic illness. In Tajikistan, around one in four children under-5 (or 27 percent) is stunted… that is to say that they are too short for their age. Of these about 9 percent are severely stunted.

Wasting is usually the result of a recent nutritional deficiency. The indicator may exhibit seasonal shifts associated with changes in the availability of food and/ or disease prevalence. Seven percent of those children surveyed could be classified as wasted.

Finally, the survey found that slightly less than 1 in 5 children under-5 (or 17 percent) are underweight. Children are considered underweight if they weigh too little for their age, a result of being stunted, wasted, or both. About 4 percent of children under-five are severely underweight.

Prevalence rates of underweight and stunted children were highest in the Khatlon and GBAO regions, while the lowest rates were found in Dushanbe. Prevalence rates of wasted children were highest in Khatlon and lowest in Sogd.

Children of educated mothers (those with at least some secondary education) were less likely to be underweight and/or stunted than those whose mothers had no education or just some primary education

Boys and girls prevalence rates for underweight and wasting levels are roughly equal with boys slightly 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. 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.

The mid-upper arm circumference (MUAC) and the presence of oedema were two indicators used to assess for the presence of Global Acute Malnutrition (GAM) in children aged 12 - 59 months. Eleven percent of children fall within the definition of GAM.

The highest rate was observed in Khatlon (14 percent). The prevalence of GAM was also higher in children from the poorest quintile (13 percent) as compared to children from the richest quintile (10 percent).

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KEY RESULTS:

- The highest underweight as well as stunting prevalence rates are in Khatlon and GBAO, while the lowest are found in Dushanbe.
- Children of educated mothers are less likely to be underweight and/or stunted than those whose mothers have little or no education.
- Boys are slightly more likely than girls to be stunted.
- GAM is highest in children from the poorest quintile.

Percentage of children aged 0-59 months who are malnourished, Tajikistan, 2005