

## Instructions on How to Customize the Model Preliminary Report

The primary objectives of the preliminary report are to convey the main results of the survey quickly and to stimulate interest in the current situation among government agencies, non-governmental organizations, other multilateral donors, the press and the general public. More detailed information on the uses and contents of the preliminary report are provided in Chapter 8 (Analysis, Reporting and Dissemination) of the MICS3 manual.

More specifically, the preliminary report should be used to *publicize some of the key results* from the MICS3 surveys soon after the data collection is completed; should be made available as widely as possible *to stir interest* in the topics covered, and *stimulate the provision of feedback* from all interested parties. The results of the preliminary should not, however, be presented as the final results of the survey; it should be made clear that the final results will be available with the production of the full technical report, and work should continue to evaluate the results and on drafting the full technical report.

The model preliminary report is provided to facilitate the production of preliminary reports by countries participating in MICS3, and to ensure the production of comparable reports that can be used easily to draw comparisons between countries. Countries are expected to use the model report as a starting point for their national preliminary reports, and customize it in accordance with the contents of their surveys.

UNICEF recommends the adoption of the following basic guidelines in the customization of the preliminary reports:

- The preliminary report should be drafted by the implementing agency/government, with assistance from the country and regional offices of UNICEF, as well as UNICEF Headquarters, as needed.
- The front cover of the report should explicitly display the name and logo of the implementing agency, and other national agencies/governmental organizations participating in the survey. UNICEF's name and logo may also be included, although this is not absolutely necessary. However, it is strongly recommended that the MICS3 logo is included on the front cover.
- Countries are invited to keep the cover design as precisely as possible. This is of symbolic as well as practical importance – reports with similar designs from countries around the world are expected to enhance the visibility of MICS3, and emphasize the fact that MICS3 is an international survey.
- Countries will customize the model preliminary report in accordance with the contents of their surveys, adding or deleting tables and sections as needed. It is recommended that countries avoid the inclusion of many additional topics and tables. The text of the preliminary report should preferably not exceed 15-20 pages – analysis of the remaining MICS3 topics and tables should be left to the full technical report.
- Table numbers refer to the numbers used in the general tabulation plan, which includes all MICS3 tables (see Appendix 7 of the MICS3 Manual, “Tabulation Guidelines”). Countries are required to re-number the tables from 1 to X, depending on which tables are included.
- For proportions or percentages, the recommended minimum size of the denominator is 25 unweighted cases. A percentage with an unweighted denominator less than 25 cases

should not be shown in the table, while a percentage based on less than 50 cases should be shown in parentheses. In the latter case, you might keep the line for the denominator in the table, and put '\*' for any proportions/percentages based on the denominator. Alternatively, you might exclude the line altogether from the table, but insert a footnote from the variable, indicating that there were X number of cases (which should be less than 25) in category Y which is not shown in the table. If your sample requires the use of weights, then you will have to run the tabulations both weighted and unweighted in order to determine whether the unweighted denominators are below 50 cases.

- Missing cases and 'don't know' responses are not shown in the tables, with the exception of those tables that include percentage distributions of responses to a question where 'Don't know' responses were explicitly allowed in the questionnaire; in such cases, 'Don't know' categories are shown. In general, however, missing cases and 'don't know' responses should be included in the actual tabulations as separate categories. If the total of 'missing' and 'don't know' is less than 5 percent, these two categories should be combined into a single category and denoted as 'Don't Know/Missing'. For cases when the combination of these two categories is more than 5 percent, then each should be shown on separate columns, and caution should be exercised in the interpretation of the results.

*Monitoring the Situation of  
Children and Women*

Findings from the  
[Country]  
Multiple Indicator Cluster Survey  
2006

PRELIMINARY REPORT

[Month] 2006

[PLACE NAME AND LOGO  
OF IMPLEMENTING AGENCY HERE]

[PLACE NAME AND LOGO  
OF IMPLEMENTING AGENCY HERE]



**Summary Table of Findings**  
**MICS and MDG Indicators, [Country], [Year]**

TOPIC	MICS3 INDICATOR NUMBER	MDG INDICATOR NUMBER	INDICATOR	VALUE	UNIT
Child Mortality	1	13	Under-five mortality rate (MDG		
	2	14	Infant mortality rate		
Nutrition	6	4	Underweight prevalence		
	7		Stunting prevalence		
	8		Wasting prevalence		
	15		Exclusive breastfeeding rate		
	16		Continued breastfeeding rate		
	17		Timely complementary feeding rate		
Child health	25	15	Tuberculosis immunization coverage		
	26		Polio immunization coverage		
	27		DPT immunization coverage		
	28		Measles immunization coverage		
	31		Fully immunized children		
	22	29	Antibiotic treatment of suspected pneumonia		
	24		Solid fuels		
	37		Under-fives sleeping under insecticide-treated nets		
	38		Under-fives sleeping under mosquito nets		
39	22	Antimalarial treatment (under-fives)			
Environment	11	30	Use of improved drinking water sources		
	12	31	Use of improved sanitation facilities		
Reproductive health	21	19c	Contraceptive prevalence		
	4	17	Skilled attendant at delivery		
	5		Institutional deliveries		
Education	55	6	Net primary school attendance rate		
	61	9	Gender parity index		
Child protection	62		Birth registration		
	67		Marriage before age 15, before age 18		
	68		Young women aged 15-19 currently married/in union		
	70		Polygyny		
HIV/AIDS, Sexual behaviour, and orphaned and vulnerable children	82	19b	Comprehensive knowledge about HIV prevention among young people		
	83	19a	Condom use with non-regular partners		
	85		Higher risk sex in the last year		
	77	20	School attendance of orphans versus non-orphans		

# Contents

<b>ACKNOWLEDGEMENTS</b> .....	7
<b>I. BACKGROUND</b> .....	8
INTRODUCTION.....	8
SURVEY OBJECTIVES .....	9
<b>II. SAMPLE AND SURVEY METHODOLOGY</b> .....	9
SAMPLE DESIGN.....	9
QUESTIONNAIRES.....	10
FIELDWORK AND PROCESSING.....	10
SAMPLE COVERAGE.....	11
<b>III. RESULTS</b> .....	12
CHILD MORTALITY .....	12
NUTRITIONAL STATUS .....	12
BREASTFEEDING.....	14
IMMUNIZATION COVERAGE .....	15
ANTIBIOTIC TREATMENT OF CHILDREN WITH SUSPECTED PNEUMONIA.....	16
SOLID FUEL USE.....	16
MALARIA.....	17
WATER AND SANITATION .....	18
CONTRACEPTION.....	19
ASSISTANCE AT DELIVERY .....	20
PRIMARY SCHOOL ATTENDANCE.....	20
BIRTH REGISTRATION .....	21
EARLY MARRIAGE AND POLYGYNY .....	21
KNOWLEDGE OF HIV/AIDS TRANSMISSION AND CONDOM USE .....	21
ORPHANS AND VULNERABLE CHILDREN SCHOOL ATTENDANCE .....	22

## Tables

Table HH.1:	Results of household and individual interviews .....
Table CM.1:	Child mortality .....
Table NU.1:	Child malnourishment .....
Table NU.3:	Breastfeeding .....
Table CH.1:	Vaccinations in first year of life .....
Table CH.7:	Antibiotic treatment of pneumonia .....
Table CH.8:	Solid fuel use.....
Table CH.11:	Children sleeping under bednets .....
Table CH.12:	Treatment of children with anti-malarial drugs.....
Table EN.1:	Use of improved water sources .....
Table EN.5:	Use of sanitary means of excreta .....
Table RH.1:	Use of contraception .....
Table RH.5:	Assistance during delivery .....
Table ED.3:	Primary school net attendance ratio .....
Table ED.7:	Education gender parity .....
Table CP.1:	Birth registration .....
Table CP.5:	Early marriage and polygyny .....
Table HA.3:	Comprehensive knowledge of HIV/AIDS transmission.....
Table HA.9:	Condom use at last high-risk sex.....
Table HA.12:	Orphaned and vulnerable children school attendance .....

## **ACKNOWLEDGEMENTS**

*[Provide a listing of organizations involved in the implementation of the survey. Include information on funding sources and individuals/organizations that have played an important role in the completion of the survey].*

## I. BACKGROUND AND OBJECTIVES

### INTRODUCTION

This preliminary report is based on the [*name of country*] Multiple Indicator Cluster Survey, conducted in [2006] by the [*list national agencies involved in the survey*]. The survey was based, in large part, on the needs 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, 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 Table 1.1).

**Table 1.1**  
**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.”



*[Briefly mention national efforts to accomplish the above goals, including how MICS3 findings fit into an overall plan to assess the situation in the country. In this context, you may consider mentioning national development strategies, poverty reduction strategies, national action plans for children, the Millennium Development Goals, the World Fit for Children goals, the UNICEF Country Programme, UN Development Assistance Framework, and reporting on the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women]*

This preliminary report presents selected results on some of the principal topics covered in the survey and on a subset of indicators<sup>1</sup>. 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 *[provide date of full survey report publication]*.

## **SURVEY OBJECTIVES**

The *[2006]* *[Country]* Multiple Indicator Cluster Survey has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in *[Country]*;
- To furnish data needed for monitoring progress toward goals established by the Millennium Development Goals 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 *[Country]* 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 *[Country]* 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 urban and rural areas, and for *[insert number of regions]* regions: *[provide listing of the strata]*. Regions were identified as the main sampling domains and the sample was selected in two stages. Within each region, *[insert number of clusters]* 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 *[insert number of households]* households was drawn. *[Insert number of enumeration areas that could not be visited]* of the selected enumeration areas were not visited because they were inaccessible during the fieldwork period.

---

<sup>1</sup> For more information on the definitions, numerators, denominators and algorithms of Multiple Indicator Cluster Surveys (MICS) and Millennium Development Goals (MDG) 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](http://www.childinfo.org).

The sample was stratified by region and is not self-weighting. For reporting national level results, sample weights are used.

## QUESTIONNAIRES

Three questionnaires were used in the survey. In addition to a household questionnaire which was used to collect information on all household members, the household, and the dwelling, questionnaires were administered in each household to women aged 15-49 – mothers or caretakers of under 5 children were identified in each household, and these person were interviewed on children under 5. The questionnaires included the following modules:

*[Delete the questionnaires/modules not used in your survey, or add any additional modules/questionnaires that you may have used. The list only includes core modules of the MICS3 model questionnaires]*

- Household Questionnaire
  - Household listing
  - Education
  - Water and Sanitation
  - Household characteristics
  - Child Labour
  - Salt Iodization
- Questionnaire for Individual Women
  - Child Mortality
  - Tetanus Toxoid
  - Maternal and Newborn Health
  - Marriage/Union
  - Contraception
  - HIV/AIDS
- Questionnaire for Children Under Five
  - Birth Registration and Early Learning
  - Vitamin A
  - Breastfeeding
  - Care of Illness
  - Immunization
  - Anthropometry

The questionnaires are based on the MICS3 model questionnaire. From the MICS3 model English version, the questionnaires were translated into *[insert languages]* and were pre-tested during *[insert month/year of pre test]*. Based on the results of the pre-test, modifications were made to the wording and translation of the questionnaires.

## FIELDWORK AND PROCESSING

The field staff was trained for 12 days in early *[insert month/year of training]*. The data were collected by *[insert number of teams]* teams; each was comprised of *[insert number of interviewers]* interviewers, one driver, one editor/measurer and a supervisor. Fieldwork began in

*[insert month/year of initiation of fieldwork]* and concluded in *[insert month/year of completion of fieldwork]*.

Data were entered on four microcomputers using the CSPro software. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed. Procedures and standard programs developed under the global MICS3 project and adapted to the *[Country]* questionnaire were used throughout. Data processing began simultaneously with data collection in *[insert month/year of initiation of data processing]* and finished in *[insert month/year of completion of data processing]*. Data were analysed using the SPSS software program and the model syntax and tabulation plans developed for this purpose.

## **SAMPLE COVERAGE**

Of the *[insert number of households selected for sample]* households selected for the sample, *[insert number of households occupied – must be lower than number selected]* were found to be occupied. Of these, *[insert number of households successfully interviewed]* were successfully interviewed for a household response rate of *[insert response percent]* percent. In the interviewed households, *[insert number of eligible women 15-49]* women (age 15-49) were identified. Of these, *[insert number of women successfully interviewed]* were successfully interviewed, yielding a response rate of *[insert percent interviewed]* percent. In addition, *[insert number of children under 5 listed in HH questionnaire]* children under age five were listed in the household questionnaire. Of these, questionnaires were completed for *[insert number of completed questionnaires for children under 5]* which corresponds to a response rate of *[insert response percent]* percent. Overall response rates of *[insert overall response rate for women's questionnaire]* and *[insert overall response rate for under-5 questionnaire]* are calculated for the women's and under-5's interviews respectively (Table HH.1).

### III. RESULTS

#### CHILD MORTALITY

One of the overarching goals of the MDGs and the World Fit for Children is to reduce infant and under-five mortality. Monitoring progress towards this goal is an important but difficult objective. Measuring childhood mortality may seem easy, but attempts using direct questions, such as “Has anyone in this household died in the last year?” give inaccurate results. On the other hand, using direct measures of child mortality from birth histories is time consuming and complicated. Demographers have therefore had to devise ways to measure childhood mortality indirectly. These ‘indirect methods’ minimize the pitfalls of memory lapses, inexact or misinterpreted definitions, and poor interviewing technique.

The *infant mortality rate* is the probability of dying before the first birthday. The *under five mortality rate* is the probability of dying before the fifth birthday. In MICS3, infant and under five mortality rates are calculated based on an indirect estimation technique; the so-called Brass method. The data used in the estimation are: the mean number of children ever born for five year age groups of women from age 15 to 49, and the proportion of these children who are dead, also for five year age groups of women. The technique converts these data into probabilities of dying by taking account of both the mortality risks to which children are exposed and their length of exposure to the risk of dying.

Table CM.1 provides estimates of child mortality by various background characteristics [Provide a description of the mortality based on Table CM.1]. The infant mortality rate is estimated at 43 per thousand, while the probability of dying under-5 mortality rate is around 52 per thousand. There is almost no difference between the probabilities of dying among males and females. Infant and under-5 mortality rates are lowest in the West, while the figures for the East are almost twice as much that of the West. There are also significant differences in mortality in terms of educational levels, wealth, and ethnicity. In particular, probabilities of dying among infants and under-5s living in the richest households is almost a third of the national average.

#### 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 a reference distribution. The reference population used here is the WHO/CDC/NCHS reference, which is recommended for use by UNICEF and the World Health Organization. Each of the three nutritional status indicators can be 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.

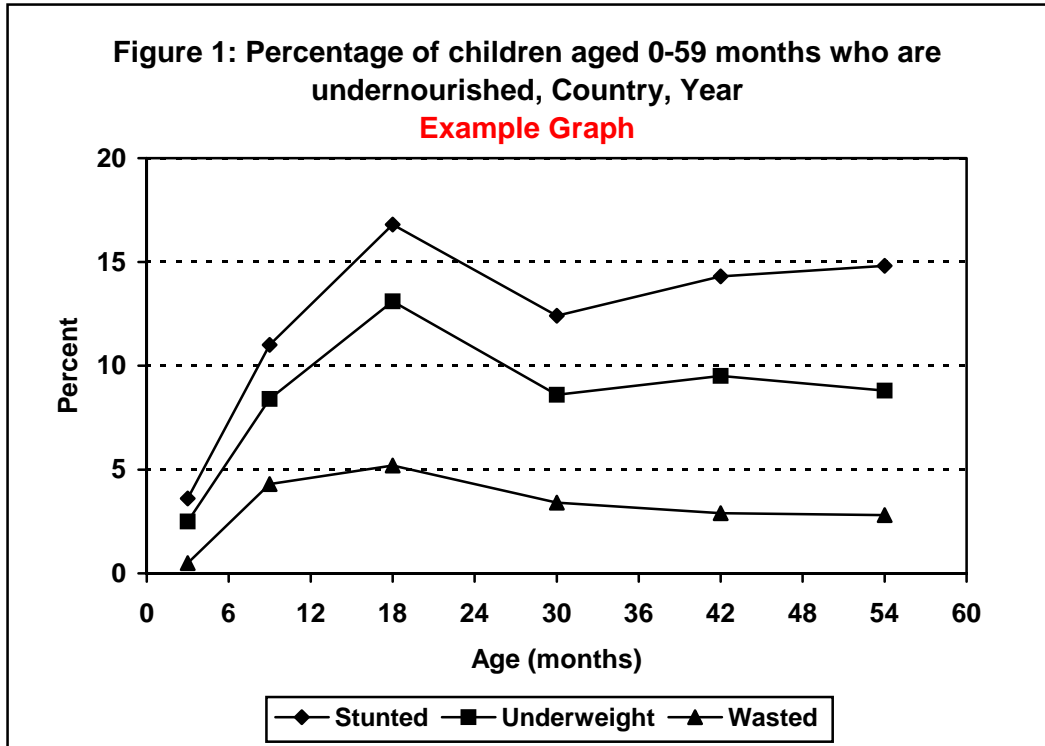
Table NU.1 shows percentages of children classified into each of these categories, based on the anthropometric measurements that were taken during fieldwork. Additionally, the table includes the percentage of children who are overweight, which takes into account those children whose weight for height is above 2 standard deviations from the median of the reference population.

In Table NU.1, children who were not weighed and measured (approximately [*insert percent of children not measured as shown in the working table associated with Table NU.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 [*This should normally not exist in MICS3 surveys*].

[*Below is an example of how Table NU.1 could be described.*]

Almost one in ten children under age five in [*Country*] are moderately underweight (9%) and two percent are classified as severely underweight (Table NU.1). Thirteen percent of children are stunted or too short for their age and three percent are wasted or too thin for their height.

Children in the South are more likely to be underweight and stunted than other children. In contrast, the percentage wasted is highest in the Central region. Those children whose mothers have secondary or higher education are the least likely to be underweight and stunted compared to children of mothers with no education. Boys appear to be slightly more likely to be underweight, stunted, and wasted than girls. 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). This pattern is expected and is related to the age at which many children cease to be breastfed and are exposed to contamination in water, food, and environment.



## 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 Fit for Children goal states that children should be exclusively breastfed for 6 months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to 2 years of age and beyond.

In Table NU.3, breastfeeding status is based on the reports of mothers/caretakers of children's consumption of food and fluids in the 24 hours prior to the interview. *Exclusively breastfed* refers to infants who received only breast milk and vitamins, mineral supplements, or medicine. The table shows exclusive breastfeeding of infants during the first six months of life (separately for 0-3 months and 0-5 months), as well as complementary feeding of children 6-9 months and continued breastfeeding of children at 12-15 and 20-23 months of age.

[Example of text that could accompany a description of Table NU.3]

Approximately 12 percent of children aged less than six months are exclusively breastfed, a level considerably lower than recommended. At age 6-9 months, 25 percent of children are receiving breast milk and solid or semi-solid foods. By age 12-15 months, 38 percent of children are still being breastfed and by age 20-23 months, 12 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.

## IMMUNIZATION

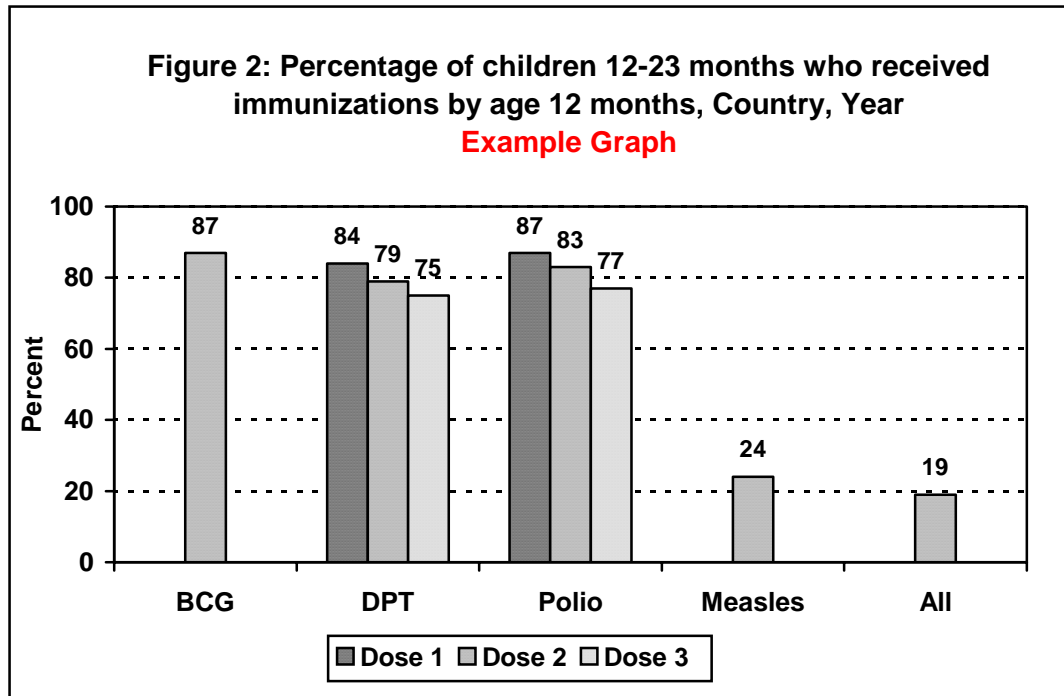
[Note: please be sure to specify which vaccinations children should receive by 12 months of age in your country – this can vary from country to country – below is just an example.]

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. Mothers were asked to provide vaccination cards for children under the age of five. Interviewers copied vaccination information from the cards onto the MICS3 questionnaire.

[Example of text on describing Table CH.1.]

Overall, 86 percent of children had health cards (Table CH.1). 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. The percentage of children aged 12 to 23 months who received each of the vaccinations is shown in Table CH.1. 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 87 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 84 percent. The percentage declines for subsequent doses of DPT to 79 percent for the second dose, and 75 percent for the third dose (Figure 3). Similarly, 87 percent of children received Polio 1 by age 12 months and this declines to 77 percent by the third dose. The coverage for measles vaccine by 12 months is lower than for the other vaccines at 24 percent. This is primarily because, although 61 percent of children received the vaccine, only around 40 percent received it by their first birthday. As a result, the percentage of children who had all eight recommended vaccinations by their first birthday is low at only 19 percent.



## ANTIBIOTIC TREATMENT OF CHILDREN WITH SUSPECTED PNEUMONIA

Pneumonia is the leading cause of death in children and the use of antibiotics in under-5s 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 and a blocked nose. 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 the previous two weeks.

### [Example of text on describing Table CH.7.]

Table CH.7 presents the use of antibiotics for the treatment of suspected pneumonia in under-5s by sex, age, region, residence, age, and socioeconomic factors. In [Country], 41 percent of under-5 children with suspected pneumonia had received an antibiotic during the two weeks prior to the survey. The percentage was considerably higher in the capital city, while the percentage declines to only 15 percent in the South. The table also shows that antibiotic treatment of suspected pneumonia is very low among the poorest households, and among children whose mothers/caretakers have at least secondary education. The use of antibiotics rises with the age of the child.

## 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 under-5 children, in the form of acute respiratory illness.



[Example of text on describing Table CH.8.]

Overall, more than a third (35 percent) of all households in [*Country*] are using solid fuels for cooking. Use of solid fuels is very low in urban areas (6 percent), but very high in rural areas, where almost half of the households (48 percent) are using solid fuels. Differentials with respect to household wealth and the educational level of the household head are also significant. The table clearly shows that the percentage is high due to high level of use wood for cooking purposes.

## **MALARIA**

Malaria is a leading cause of death of children under age five in [*Country*]. It also contributes to anemia in children and is a common cause of school absenteeism. Preventive measures, especially the use of mosquito nets treated with insecticide (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 anti-malarial tablets. Children with severe malaria symptoms, such as fever or convulsions, should be taken to a health facility. Also, children recovering from malaria should be given extra liquids and food and should continue breastfeeding.

[An example description is provided below.]

The MICS3 questionnaire incorporates questions on the use of bednets, both at household level and among children under five years of age, as well as anti-malarial treatment, and intermittent preventive therapy for malaria. In [*Country*] the MICS3 results indicate that household availability of insecticide treated nets is 12 percent. Most of the mosquito nets (9 percent) used at household level were treated with insecticide and 3 percent were long lasting nets.

Results indicate that 27 percent of children under the age of five slept under any mosquito net the night prior to the survey and 20 percent slept under an insecticide treated net (Table CH.11). ITN use among children under five declines steadily with age and there were no significant gender disparities in ITN use among children under five.

Questions on the prevalence and treatment of fever were asked for all children under age five. Slightly more than one in three (36 percent) of under five children were ill with fever in the two weeks prior to the MICS3 (Table CH.12). Fever prevalence declined with age and peaked at 11-23 months (39 percent). Fever is less common among children whose mothers have secondary or higher education than among children of less educated mothers. Regional differences in fever prevalence are not large, ranging from 34 to 38 percent across the five regions.

Mothers were asked to report all of the medicines given to a child to treat the fever, including both any medicine given at home and medicines given or prescribed at a health facility. Overall, 66 percent of children with fever in the last two weeks were treated with an “appropriate” anti-malarial drug and 42 percent received anti-malarial drugs within 24 hours of onset of symptoms.

“Appropriate” anti-malarial drugs include chloroquin, SP, artemisine combination drugs, etc.. In [Country], 42 percent of children with fever were given chloroquine, and 18 percent were given SP. Only 2 percent received artemisinin combination therapy. A large percentage of children (32 percent) were given other types of medicines that are not anti-malarials, including anti-pyretics such as paracetamol, aspirine or ibuprofen.

Overall, children with fever in the South, where malaria is probably most prevalent, are the most likely to have received an appropriate anti-malarial drug while those in the Central region are the least likely to receive an appropriate drug. Urban children are more likely than rural children to be treated appropriately as are the children of mothers with secondary or higher education. Little difference was noted between boys and girls receiving appropriate anti-malarial drugs.

## 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 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.

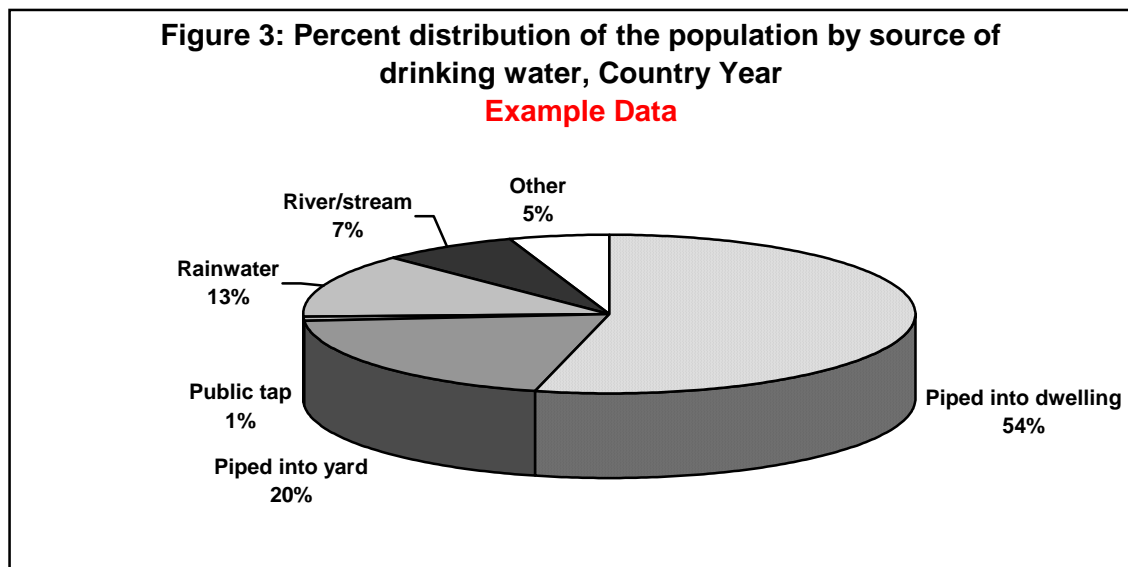
*[An example description if provided below.]*

The distribution of the population by source of drinking water is shown in Table EN.1. 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 has access to improved drinking water sources – 93 percent in urban areas and 61 percent in rural areas. The situation in the South is considerably worse than in other regions; only 47 percent of the population in this region gets its drinking water from an improved source.

The source of drinking water for the population varies strongly by region (Table EN.1). In the Central region, 94 percent of the population uses drinking water that is piped into their dwelling or into their yard or plot. In the South Central and West regions, 69 and 82 percent respectively use piped water. In contrast, only about 54 percent of those residing in the East and less than 10 percent of those in the South have piped water. In the East, the second most important source of drinking water is rainwater collection while in the South, more than two thirds use river or stream water (an unsafe source) and most of the remainder use collected rainwater.

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases and polio. *Improved sanitation facilities* include: flush toilets connected to sewage systems, septic tanks or pit latrines, ventilated improved pit latrines and pit latrines with slabs, and composting toilets. Ninety two percent of the population of [Country] is living in households using improved sanitation facilities (Table EN.5). This percentage is 96 in urban areas and 90 percent in rural areas. Residents of the South are much less likely than others to use improved facilities. Most of this population uses rivers, bush, fields, or has no facilities.

In contrast, the most common facilities in other areas of the country are flush toilets with connection to a sewage system or septic tank.



## CONTRACEPTION

*[Example explanation provided below.]*

Current use of contraception was reported by 45 percent of women currently married or in union (Table RH.1). The most popular method is the pill which is used by one in four married women in [Country]. The next most popular method is female sterilization, which accounts for 10 percent of married women. Between two and three percent of women reported use of the IUD, injectables, and the condom. Less than one percent use periodic abstinence, withdrawal, male sterilization, vaginal methods, or the lactational amenorrhea method (LAM).

Contraceptive prevalence is highest in the Central region at 53 percent and almost as high in the West region at 51 percent. Forty four percent of married women in the South Central region and 39 percent in the East use a method of contraception. In the South, contraceptive use is rare; only six percent of married women reported using any method. Adolescents are far less likely to use contraception than older women. Only about 26 percent of married or in union women aged 15-19 currently use a method of contraception compared to 43 percent of 20-24 year olds and 47 percent of older women.

Women's education level is strongly associated with contraceptive prevalence. The percentage of women using any method of contraception rises from 11 percent among those with no education to 35 percent among women with primary education, and to 53 percent among women with secondary or higher education. In addition to differences in prevalence, the method mix varies by education. About half of contraceptive users with no or primary education use the pill and 31-39 percent are sterilized. In contrast, 63 percent of contraceptive users with secondary or higher education use the pill and 20 percent are sterilized.

## ASSISTANCE AT DELIVERY

The provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and infants 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, midwife or auxiliary midwife.

*[Example description provided below.]*

About 77 percent of births occurring in the year prior to the MICS survey were delivered by skilled personnel (Table RH.5). This percentage is highest in the South Central region at 99 percent and lowest in the South at 21 percent. The more educated a woman is, the more likely she is to have delivered with the assistance of a skilled person.

More than one in three of the births (34 percent) in the year prior to the MICS survey were delivered with assistance by a midwife. Doctors assisted with the delivery of 27 percent of births and nurses assisted with 13 percent. Overall, about 10 percent of births were delivered by health assistants, but these births occurred only among women in the South where the type of personnel providing delivery assistance is noticeably different than in other regions. In the South, about 47 percent of births are delivered by health assistants and 27 percent by traditional birth attendants. In the other regions, between 42 and 49 percent of births are delivered with the assistance of a midwife while 29-33 percent are delivered by a doctor.

## 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 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.

*[Example description provided below.]*

Overall, 89 percent of children of primary school age in [Country] are attending primary school or secondary school (Table ED.3). In urban areas, 96 percent of children attend school while in rural areas 82 percent attend. School attendance in the South is significantly lower than in the rest of the country at 52 percent. At the national level, there is virtually no difference between male and female primary school attendance.

The ratio of girls to boys attending primary and secondary education is provided in Table ED.7. 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 South region, as well as among children living in the poorest households and rural areas.

## **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.

*[Example description provided below.]*

The births of 94 percent of children under five years in [*Country*] have been registered (Table CP.1). There are no significant variations in birth registration across sex, age, or education categories. Children in the West are somewhat less likely to have their births registered than other children but this appears to be due primarily to a relatively large proportion of mothers who do not know if their child's birth was registered. Among those whose births are not registered, cost, travel distance, and lack of knowledge do not appear to be the main reasons.

## **EARLY MARRIAGE AND POLYGYNY**

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 younger ages 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 CP.5. *[Provide further description of the table.]*

## **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. 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 can transmit HIV or mosquito bites can transmit HIV).

*[Example description is provided below.]*

Table HA.3 presents the percentage of women 15-49 years who know 2 ways of preventing HIV transmission. Knowledge of HIV prevention methods is still fairly low although there are differences by residence. Overall, 58 per cent of women report knowing two prevention methods while in urban areas 66 percent of women identified both methods. As expected, the percent of women who know two prevention methods increases with the woman's education level.

A key indicator used to measure countries' responses to the HIV epidemic is the proportion of young people 15-24 years who know two methods of preventing HIV, reject two misconceptions and know that a healthy looking person can have HIV. Less than 50 per cent of young women

have comprehensive correct knowledge of HIV. Level of education and residence are highly associated with knowledge of HIV.

Promoting safer sexual behaviour is critical for reducing HIV prevalence. The use of condoms during sex, especially with non-regular partners is especially important for reducing the spread of HIV. Over half of new HIV infections are among young people 15-24 years thus a change in behaviour among this age group will be especially important to reduce new infections.

Condom use during sex with men other than husbands or live-in partners (non-marital, non-cohabiting) was assessed in women 15-24 years of age who had sex with such a partner in the previous year (Table HA.9). Over 30 percent of women 15-24 years report having sex with a non-regular partner in the 12 months prior to the MICS. Of those women, only one-quarter report using a condom when they had sex with the high risk partner. Nineteen percent of women with incomplete primary education used a condom during higher risk sex in the year before the MICS while 37 percent of women with secondary or more education used a condom with such a partner.

#### **ORPHANS AND VULNERABLE CHILDREN SCHOOL ATTENDANCE**

As the HIV epidemic progresses more and more children are becoming orphaned and vulnerable due to HIV and AIDS. Children who are orphaned or living away from their parents may be at increased risk of neglect or exploitation if the parents are not available to assist them. Monitoring the variations in educational outcomes for children who have lost both parents (double orphans) versus children whose parents are alive (and who live with at least one of these parents) is one way to ensure that children's rights are being met even after their parents have died or are no longer able to care for them.

*[Example description below.]*

In [*Country*], 3 percent of children aged 10-14 have lost both parents (Table HA.12). Among those only 88 per cent are currently attending school. Among the children ages 10-14 who have not lost a parent and who live with at least one parent, 92 percent are attending school. This would suggest that the double orphans have a disadvantage to the non-orphaned children.

**Table HH.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, Country, Year

	<b>Residence</b>		<b>Region</b>			<b>Total</b>
	Urban	Rural	Region 1	Region 2	Region 3	
<b>Number of households</b>						
Sampled						
Occupied						
Interviewed						
Response rate						
<b>Number of women</b>						
Eligible						
Interviewed						
Response rate						
Overall response rate						
<b>Number of children under 5</b>						
Eligible						
Mother/Caretaker interviewed						
Response rate						
Overall response rate						

**Table CM.1: Child mortality**

Infant and under-five mortality rates, Country, Year

	Infant mortality rate*	Under-five mortality rate**
<b>Sex</b>		
Male		
Female		
<b>Region</b>		
Region 1		
Region 2		
Region 3		
<b>Residence</b>		
Urban		
Rural		
<b>Women's education</b>		
None		
Primary		
Secondary +		
<b>Wealth index quintiles</b>		
Poorest		
Second		
Middle		
Fourth		
Richest		
<b>Ethnicity/Language/Religion</b>		
Group 1		
Group 2		
Group 3		
Total		

\* MICS indicator 2; MDG indicator 14

\*\* MICS indicator 1; MDG indicator 13



**Table NU.1: Child malnourishment**

Percentage of children aged 0-59 months who are severely or moderately malnourished, Country, Year

	Weight for age		Height for age		Weight for height			Number of children aged 0-59 months
	% below - 2 SD*	% below - 3 SD*	% below - 2 SD**	% below - 3 SD**	% below - 2 SD***	% below - 3 SD***	% above + 2 SD	
<b>Sex</b>								
Male								
Female								
<b>Region</b>								
Region 1								
Region 2								
Region 3								
<b>Residence</b>								
Urban								
Rural								
<b>Age</b>								
< 6 months								
6-11 months								
12-23 months								
24-35 months								
36-47 months								
48-59 months								
<b>Mother's education</b>								
None								
Primary								
Secondary +								
<b>Wealth index quintiles</b>								
Poorest								
Second								
Middle								
Fourth								
Richest								
<b>Ethnicity/Language/Religion</b>								
Group 1								
Group 2								
Group 3								
Total								

\* MICS indicator 6; MDG indicator 4

\*\* MICS indicator 7

\*\*\* MICS indicator 8

**Table NU.3: Breastfeeding**

Percentage of living children according to breastfeeding status at each age group, Country, Year

	<u>Children 0-3 months</u>		<u>Children 0-5 months</u>		<u>Children 6-9 months</u>		<u>Children 12-15 months</u>		<u>Children 20-23 months</u>	
	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
<b>Sex</b>										
Male										
Female										
<b>Region</b>										
Region 1										
Region 2										
Region 3										
<b>Residence</b>										
Urban										
Rural										
<b>Mother's education</b>										
None										
Primary										
Secondary +										
<b>Wealth index quintiles</b>										
Poorest										
Second										
Middle										
Fourth										
Richest										
<b>Ethnicity/Language/Religion</b>										
Group 1										
Group 2										
Group 3										
Total										

\* MICS indicator 15

\*\* MICS indicator 17

\*\*\* MICS indicator 16

**Table CH.1: Vaccinations in first year of life**

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

	Percentage of children who received:											Number of children aged 12-23 months
	BCG*	DPT1	DPT2	DPT3**	Polio0	Polio1	Polio2	Polio3***	Measles****	All*****	None	
<b>Vaccinated at any time before the survey</b>												
<i>According to:</i>												
Vaccination card												
Mother's report												
Either												
Vaccinated by 12 months of age												

\* MICS indicator 25

\*\* MICS indicator 27

\*\*\* MICS indicator 26

\*\*\*\* MICS indicator 28; MDG indicator 15

\*\*\*\*\* MICS indicator 31

**Table CH.7: Antibiotic treatment of pneumonia**

Percentage of children aged 0-59 months with suspected pneumonia who received antibiotic treatment, Country, Year

---

	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
<b>Sex</b>		
Male		
Female		
<b>Region</b>		
Region 1		
Region 2		
Region 3		
<b>Residence</b>		
Urban		
Rural		
<b>Age</b>		
0-11 months		
12-23 months		
24-35 months		
36-47 months		
48-59 months		
<b>Mother's education</b>		
None		
Primary		
Secondary +		
<b>Wealth index quintiles</b>		
Poorest		
Second		
Middle		
Fourth		
Richest		
<b>Ethnicity/Language/Religion</b>		
Group 1		
Group 2		
Group 3		
Total		

---

\* MICS indicator 22

**Table CH.8: Solid fuel use**

Percent distribution of households according to type of cooking fuel, and percentage of households using solid fuels for cooking, Country, Year

	Percentage of households using:											Total	Solid fuels for cooking*	Number of households	
	Electricity	Liquified Petroleum Gas (LPG)	Natural Gas	Biogas	Kerosene	Coal, lignite	Charcoal	Wood	Straw, shrubs, grass	Animal dung	Agricultural crop residue				Other source
<b>Region</b>															
Region 1													100.0		
Region 2													100.0		
Region 3													100.0		
<b>Residence</b>															
Urban													100.0		
Rural													100.0		
<b>Education of household head</b>															
None													100.0		
Primary													100.0		
Secondary +													100.0		
<b>Wealth index quintiles</b>															
Poorest													100.0		
Second													100.0		
Middle													100.0		
Fourth													100.0		
Richest													100.0		
<b>Ethnicity/Language/Religion</b>															
Group 1													100.0		
Group 2													100.0		
Group 3													100.0		
Total													100.0		

\* MICS indicator 24; MDG Indicator 29

**Table CH.11: Children sleeping under bednets**

Percentage of children aged 0-59 months who slept under an insecticide treated net during the previous night, Country, Year

	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	
<b>Sex</b>							
Male							
Female							
<b>Region</b>							
Region 1							
Region 2							
Region 3							
<b>Residence</b>							
Urban							
Rural							
<b>Age</b>							
0-11 months							
12-23 months							
24-35 months							
36-47 months							
48-59 months							
<b>Wealth index quintiles</b>							
Poorest							
Second							
Middle							
Fourth							
Richest							
<b>Ethnicity/Language/Religion</b>							
Group 1							
Group 2							
Group 3							
Total							

\* MICS indicator 38

\*\* MICS indicator 37; MDG indicator 22

**Table CH.12: Treatment of children with anti-malarial drugs**

Percentage of children aged 0-59 months who were ill with fever in the last two weeks who received anti-malarial drugs, Country, Year

	Children with a fever in the last two weeks who were treated with:											Don't know	Any appropriate anti-malarial drug within 24 hours of onset of symptoms*	Number of children with fever in last two weeks		
	Anti-malarials:						Other medications:									
Had a fever in last two weeks	Number of children aged 0-59 months	SP/ Fansidar	Chloroquine	Amodia- quine	Quinine	Artemisinin based combin- ations	Other anti- malarial	Any appropriate anti-malarial drug	Paracetamol/ Panadol/ Acetamin- ophen	Aspirin	Ibuprofen	Other				
<b>Sex</b>																
Male																
Female																
<b>Region</b>																
Region 1																
Region 2																
Region 3																
<b>Residence</b>																
Urban																
Rural																
<b>Age</b>																
0-11 months																
12-23 months																
24-35 months																
36-47 months																
48-59 months																
<b>Mother's education</b>																
None																
Primary																
Secondary +																
<b>Wealth index quintiles</b>																
Poorest																
Second																
Middle																
Fourth																
Richest																
<b>Ethnicity/Language/Religion</b>																
Group 1																
Group 2																
Group 3																
Total																

\* MICS indicator 39; MDG indicator 22

**Table EN.1: 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, Country, Year

	Main source of drinking water															Improved source of drinking water*	Number of household members	
	Improved sources								Unimproved sources									
	Piped into dwelling	Piped into yard/plot	Public tap/stand-pipe	Tube-well/bore-hole	Protected well	Protected spring	Rain-water	Bottled water <sup>1</sup>	Unprotected well	Unprotected spring	Tanker truck	Cart with tank/drum	Surface water	Bottled water <sup>1</sup>	Other			Total
<b>Region</b>																		
Region 1																		100.0
Region 2																		100.0
Region 3																		100.0
<b>Residence</b>																		
Urban																		100.0
Rural																		100.0
<b>Education of household head</b>																		
None																		100.0
Primary																		100.0
Secondary +																		100.0
<b>Wealth index quintiles</b>																		
Poorest																		100.0
Second																		100.0
Middle																		100.0
Fourth																		100.0
Richest																		100.0
<b>Ethnicity/Language/Religion</b>																		
Group 1																		100.0
Group 2																		100.0
Group 3																		100.0
Total																		100.0

\* MICS indicator 11; MDG indicator 30



**Table EN.5: 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, Country, Year

	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									
	Flush/pour flush to:						Flush/pour flush to somewhere else	Flush/pour flush to unknown place/not sure/don't know	Pit latrine without slab/open pit	Bucket	Hanging toilet/hanging latrine	Other	No facilities / bush / field			
Piped sewer system	Septic tank	Pit latrine	Ventilated improved pit latrine	Pit latrine with slab	Composting toilet									Total		
<b>Region</b>																
Region 1															100.0	
Region 2															100.0	
Region 3															100.0	
<b>Residence</b>																
Urban															100.0	
Rural															100.0	
<b>Education of household head</b>																
None															100.0	
Primary															100.0	
Secondary +															100.0	
<b>Wealth index quintiles</b>																
Poorest															100.0	
Second															100.0	
Middle															100.0	
Fourth															100.0	
Richest															100.0	
<b>Ethnicity/Language/Religion</b>																
Group 1															100.0	
Group 2															100.0	
Group 3															100.0	
Total															100.0	

\* MICS indicator 12; MDG indicator 31

**Table RH.1: 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, Country, Year

	Percent of women (currently married or in union) who are using:																Number of women currently married or in union	
	Not using any method	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*
<b>Region</b>																		
Region 1																		
Region 2																		
Region 3																		
<b>Residence</b>																		
Urban																		
Rural																		
<b>Age</b>																		
15-19																		
20-24																		
25-29																		
30-34																		
35-39																		
40-44																		
45-49																		
<b>Number of living children**</b>																		
0																		
1																		
2																		
3																		
4+																		
<b>Education</b>																		
None																		
Primary																		
Secondary +																		
<b>Wealth index quintiles</b>																		
Poorest																		
Second																		
Middle																		
Fourth																		
Richest																		
<b>Ethnicity/Language/Religion</b>																		
Group 1																		
Group 2																		
Group 3																		
Total																		

\* MICS indicator 21; MDG indicator 19C

**Table RH.5: 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, Country, Year

	Person assisting at delivery						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	No attendant				
<b>Region</b>										
Region 1							100.0			
Region 2							100.0			
Region 3							100.0			
<b>Residence</b>										
Urban							100.0			
Rural							100.0			
<b>Age</b>										
15-19							100.0			
20-24							100.0			
25-29							100.0			
30-34							100.0			
35-39							100.0			
40-44							100.0			
45-49							100.0			
<b>Education</b>										
None							100.0			
Primary							100.0			
Secondary +							100.0			
<b>Wealth index quintiles</b>										
Poorest							100.0			
Second							100.0			
Middle							100.0			
Fourth							100.0			
Richest							100.0			
<b>Ethnicity/Language/Religion</b>										
Group 1							100.0			
Group 2							100.0			
Group 3							100.0			
Total							100.0			

\* MICS indicator 4; MDG indicator 17

\*\* MICS indicator 5

**Table ED.3: Primary school net attendance ratio**

Percentage of children of primary school age\*\* attending primary or secondary school (NAR), Country, Year

	Male		Female		Total	
	Net attendance ratio	Number of children	Net attendance ratio	Number of children	Net attendance ratio*	Number of children
<b>Region</b>						
Region 1						
Region 2						
Region 3						
<b>Residence</b>						
Urban						
Rural						
<b>Age**</b>						
5						
6						
7						
8						
9						
10						
11						
12						
>12						
<b>Mother's education</b>						
None						
Primary						
Secondary +						
<b>Wealth index quintiles</b>						
Poorest						
Second						
Middle						
Fourth						
Richest						
<b>Ethnicity/Language/Religion</b>						
Group 1						
Group 2						
Group 3						
Total						

\* MICS indicator 55; MDG indicator 6

**Table ED.7: Education gender parity**

Ratio of girls to boys attending primary education and ratio of girls to boys attending secondary education, Country, Year

	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*
<b>Sex</b>						
Male	na		na	na		na
Female		na	na		na	na
<b>Region</b>						
Region 1						
Region 2						
Region 3						
<b>Residence</b>						
Urban						
Rural						
<b>Mother's education</b>						
None						
Primary						
Secondary +						
<b>Wealth index quintiles</b>						
Poorest						
Second						
Middle						
Fourth						
Richest						
<b>Ethnicity/Language/Religion</b>						
Group 1						
Group 2						
Group 3						
Total						

\* MICS indicator 61; MDG indicator 9

**Table CP.1: Birth registration**

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

	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	Other	Don't know		
<b>Sex</b>											
Male										100.0	
Female										100.0	
<b>Region</b>											
Region 1										100.0	
Region 2										100.0	
Region 3										100.0	
<b>Residence</b>											
Urban										100.0	
Rural										100.0	
<b>Age</b>											
0-11 months										100.0	
12-23 months										100.0	
24-35 months										100.0	
36-47 months										100.0	
48-59 months										100.0	
<b>Mother's education</b>											
None										100.0	
Primary										100.0	
Secondary +										100.0	
<b>Wealth index quintiles</b>											
Poorest										100.0	
Second										100.0	
Middle										100.0	
Fourth										100.0	
Richest										100.0	
<b>Ethnicity/Language/Religion</b>											
Group 1										100.0	
Group 2										100.0	
Group 3										100.0	
Total										100.0	

\* MICS indicator 62

**Table CP.5: Early marriage and polygyny**

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, percentage of women aged 15-19 years currently married or in union, and the percentage of married or in union women in a polygynous marriage or union, Country, Year

	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/in union**	Number of women aged 15-19 years	Percentage of women aged 15-49 years in polygynous marriage/union***	Number of women aged 15-49 years currently married/in union
<b>Region</b>								
Region 1								
Region 2								
Region 3								
<b>Residence</b>								
Urban								
Rural								
<b>Age</b>								
15-19			na	na				
20-24					na	na		
25-29					na	na		
30-34					na	na		
35-39					na	na		
40-44					na	na		
45-49					na	na		
<b>Education</b>								
None								
Primary								
Secondary +								
<b>Wealth index quintiles</b>								
Poorest								
Second								
Middle								
Fourth								
Richest								
<b>Ethnicity/Language/Religion</b>								
Group 1								
Group 2								
Group 3								
Total								

\* MICS indicator 67

\*\* MICS indicator 68

\*\*\* MICS indicator 70

**Table HA.3: Comprehensive knowledge of HIV/AIDS transmission**

Percentage of women aged 15-49 years who have comprehensive knowledge of HIV/AIDS transmission, Country, Year

	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
<b>Region</b>				
Region 1				
Region 2				
Region 3				
<b>Residence</b>				
Urban				
Rural				
<b>Age</b>				
15-19				
20-24				
15-24				
25-29				
30-34				
35-39				
40-44				
45-49				
<b>Education</b>				
None				
Primary				
Secondary +				
<b>Wealth index quintiles</b>				
Poorest				
Second				
Middle				
Fourth				
Richest				
<b>Ethnicity/Language/Religion</b>				
Group 1				
Group 2				
Group 3				
Total				

\* MICS indicator 82; MDG indicator 19b



**Table HA.9: Condom use at last high-risk sex**

Percentage of young women aged 15-24 years who had high risk sex in the previous year and who used a condom at last high risk sex, Country, Year

---

	Ever had sex	Had sex in the last 12 months	Had sex with more than one partner in last 12 months	Number of women aged 15-24 years	Percent who had sex with non-marital, non-cohabiting partner*	Number of women aged 15-24 years who had sex in last 12 months	Percent who used a condom at last sex with a non-marital, non-cohabiting partner**	Number of women aged 15-24 years who had sex in last 12 months with a non-marital, non-cohabiting partner
<b>Region</b>								
Region 1								
Region 2								
Region 3								
<b>Residence</b>								
Urban								
Rural								
<b>Age</b>								
15-19								
20-24								
<b>Education</b>								
None								
Primary								
Secondary +								
<b>Wealth index quintiles</b>								
Poorest								
Second								
Middle								
Fourth								
Richest								
<b>Ethnicity/Language/Religion</b>								
Group 1								
Group 2								
Group 3								
Total								

---

\* MICS indicator 85

\*\* MICS indicator 83; MDG indicator 19a

**Table HA.12: School attendance of orphaned and vulnerable children**

School attendance of children aged 10-14 years by orphanhood and vulnerability due to AIDS, Country, Year

	Percent of children whose mother <u>and</u> father have died	School attendance rate of children whose mother <u>and</u> father have died	Percent of children whom both parents are alive and child is living with at least one parent	School attendance rate of children of whom both parents are alive and child is living with at least one parent	Double orphans to non-orphans school attendance ratio*	Percent of children who are orphaned or vulnerable	School attendance of children who are orphaned or vulnerable	Percent of children who are <u>not</u> orphaned or vulnerable	School attendance of children who are <u>not</u> orphaned or vulnerable	OVC vs non-OVC school attendance ratio	Total number of children aged 10-14 years
<b>Sex</b>											
Male											
Female											
<b>Region</b>											
Region 1											
Region 2											
Region 3											
<b>Residence</b>											
Urban											
Rural											
<b>Wealth index quintiles</b>											
Poorest											
Second											
Middle											
Fourth											
Richest											
Total											

\* MICS indicator 77; MDG indicator 20