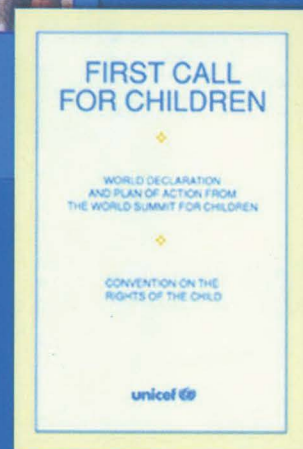
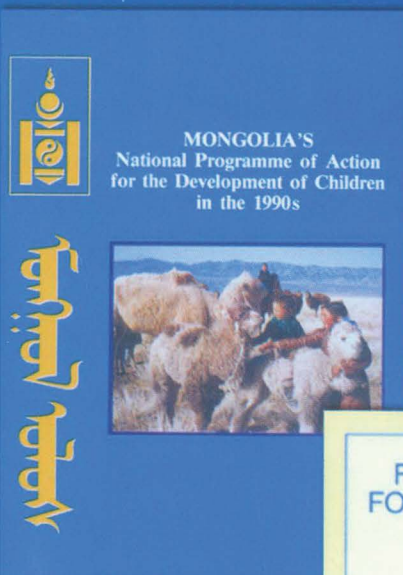




MONGOLIA

CHILD and DEVELOPMENT
survey-2000 (MICS-2)

NATIONAL REPORT



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MONGOLIA

CHILD and DEVELOPMENT survey-2000

(Multiple Indicator Cluster Survey-2)

NATIONAL REPORT

2001

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CHILD AND DEVELOPMENT SURVEY-2000 (MICS-2)

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Foreword

The Child and Development Survey - 2000, which is the Mongolian title of the second Multi Indicator Cluster Survey (MICS-2) to have been conducted in Mongolia, has been implemented by the National Statistical Office of Mongolia with support from UNICEF. It has been a truly collaborative effort involving both international and national agencies. In the organisation of this Multiple Indicator Cluster Survey-2, and in the processing and analysis of the data collected, we have collaborated with the Ministry of Education, Science and Technology and Culture, the Ministry of Health, the State Police Department and the National Children's Centre, now known as the National Committee for Children, as well as the Mongolian Child Rights Center.

The project also benefited from four MICS-2 workshops, one in the capital city of Ulaanbaatar and three regional workshops in the East Asian Pacific region, two of which were held in Bangkok and one in Yangon. These workshops were organized by UNICEF as part of the global MICS-2 effort associated with the end-decade assessment of the goals of the World Summit for Children, and were especially designed for the key organisations involved in the survey and their staff.

Although the sample size of the survey was large, it has been very efficiently executed, in a short period of time, due to an effective consultative process, a strong team of interviewers, good technical and financial support and the special focus that was given to the data processing, report writing and analysis. The data processing and analysis was prepared within seven months of the completion of the fieldwork. In December 2000, a consultant was invited from the UNICEF regional office for East Asia and the Pacific to help in the analysis of the findings and to write the first draft of the report, and the resulting report, in both the Mongolian and English versions, and is now being distributed to the public. The report gives a profile of the current health and education situation of children and women in Mongolia, by region, by mother's education level and by mother's and child's age group. This report provides accurate and systematic information for the evaluation of the National Programme of Action for Children 1990-2000 and base-line data for the new National Programme of Action for Children 2001-2010.

The survey makes available a rich information data-bank and analyses the factors that effect the situation and access to basic services of women and children in Mongolia. Moreover the survey provides data concerning the situation of children in need of special protection, such as children engaged in hazardous labor.

The results of this report and the attached tables will be useful for development researchers whose interests focus on the situation of children, adolescents and

women. Many areas deserve a far greater in-depth focus and further studies. We hope that this survey will be useful for policy makers and planners, who work in the areas of social policy reform, and for those who will conceive, design and plan the National Programme of Action for Children for the next decade.

This report is dedicated to our dear friend and colleague, Matthew Girvin, who was tragically killed in a helicopter crash in January 2001, while on a United Nations Disaster Assistance Mission. Matthew's dedicated work in the last four years, as UNICEF's Programme Officer, has laid much of the foundation for the work that will be conducted in service of children in the years to come.

We hope you find this report useful.



Ch. Davaasuren

Chair person

NSO Mongolia



Gabriella De. Vita

Assistant Representative

UNICEF, Mongolia

Acknowledgements


This Child and Development Survey-2000 is Mongolia's second multiple indicator cluster survey (MICS 2), which has been conducted, with the financial and technical support of UNICEF, among households, women of reproductive age and children. The purpose of this survey is to establish comprehensive statistical data to evaluate the impact of Mongolia's National Program of Action for Children in the 1990s, and to aid future planning and the organisation of a new National Programme of Action for Children 2001-2010. This survey complements and completes the first Multiple Indicator Cluster Survey which was conducted in 1996. Overall, the findings of the Child and Development Survey -2000 (MICS-2) will be a valuable source of information in analysing the current situation of infants, children and women in Mongolia and the factors which impact their situation. It will also be extremely helpful in assessing the impact of the transition period on the status of women and children during the past ten years.

Both National Statistical Office and UNICEF staff have dedicated a great deal of time and effort towards the successful completion of this project, both during the conducting of the survey and in the preparation of this report.

First of all, I would like to express my deep appreciation to UNICEF, Mongolia, for its financial support for this second Multiple Indicator Cluster Survey on the situation of Mongolian women and children, and for the technical assistance provided by UNICEF consultants and staff from the Regional Office for East Asia and the Pacific, the Area Office for China and Mongolia and as well as the Country Office in Mongolia. Also, I wish to give my thanks to the Ministry of Education, Science and Technology and Culture, the Ministry of Health, the State Police Department and the National Children's Centre, now known as the National Committee for Children, as well as the Mongolian Child Rights Center (a non-governmental organization) for their invaluable contribution towards the organization and review of the questionnaire for this second Multiple Indicator Cluster Survey.

I would also like to express my special gratitude to the staff of the National Statistical Office of Mongolia for their tremendous work, their dedication and commitment as the leading agency in the conduct of the survey and the writing of the report during the entire period of the project. It is hoped that the NSO staff, especially the statisticians and programmers have improved their professional knowledge and skills using the combined special software employed in the Multiple Indicator Cluster Survey Two.

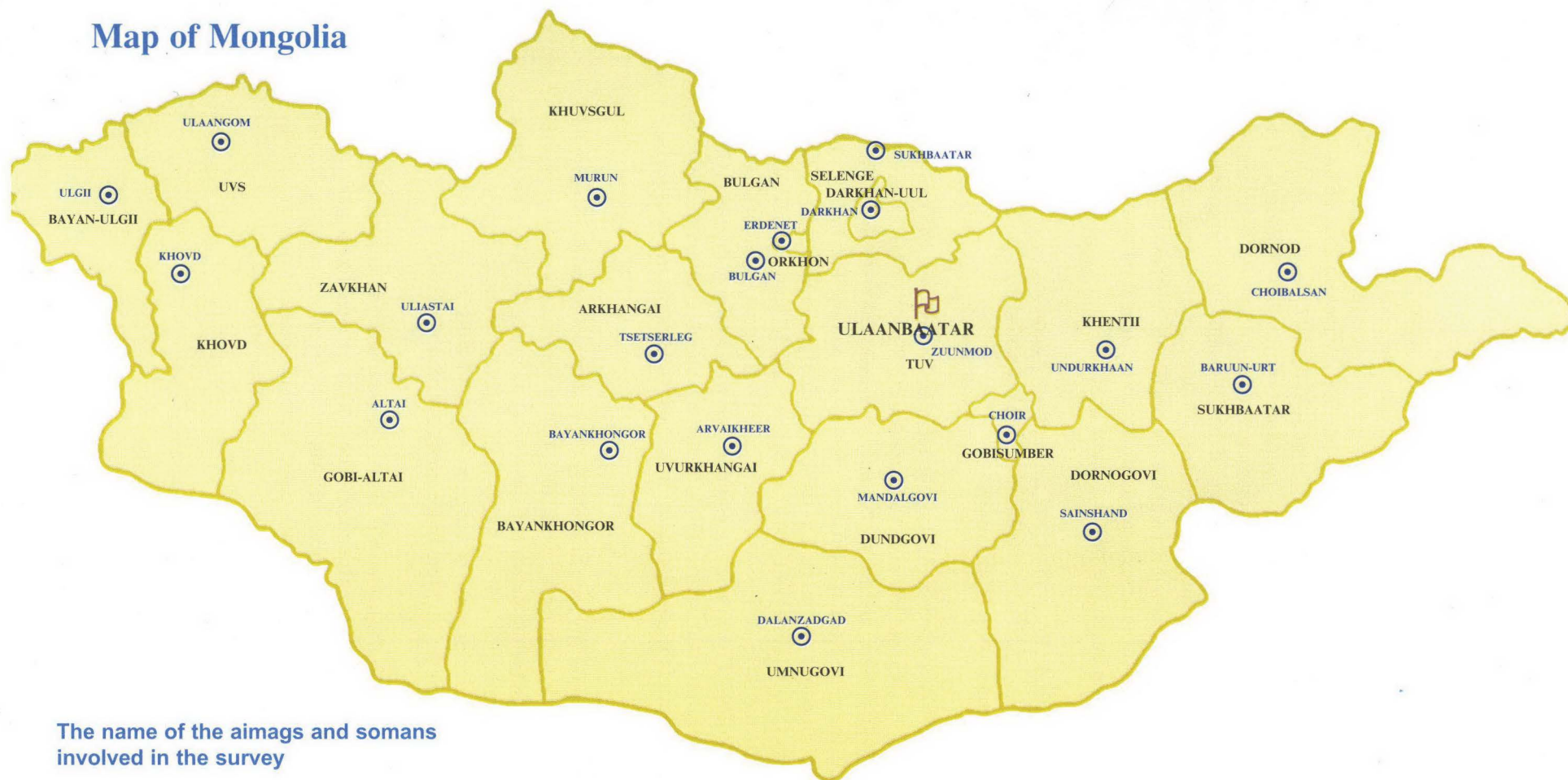
Special thanks are due to the leadership of both government and non-government agencies of Mongolia and UNICEF in Mongolia. Above all, we would like to pay tribute to the work of UNICEF's Programme Officer, Mr. Matthew Girvin, who was the driving force of the project from the outset. Matthew's tragic death has meant the loss of a strong voice for Mongolia's children and we all continue to feel his absence deeply.



B. Batmunkh

Project manager of MICS-2.

Map of Mongolia



The name of the aimags and somans involved in the survey

<i>Name of Aimags</i>	<i>Name of Somans</i>	<i>Name of Aimags</i>	<i>Name of Somans</i>
1. Arkhangai	Battsengel, Tsenkher, Tuvshruuleh, Eredenebulgan, Khotont, Ikh tamir, Under-Ulaan, Tariat	10. Sukhbaatar	Baruun-Urt, Khalzan, Munkhkhaan, Dariganga, Asgat, Sukhbaatar
2. Bayankhogor	Bayankhongor, Hureemaryl, Galuut, Bumbogor, Buutsagaan, Zag, Erdenetsogt	11. Selenge	Sukhbaatar, Tsagaannuur, Altanbulag, Orkhon, Shaamar, Eroo
3. Gobi-Altai	Darvi, Sharga, Esonbulag, Biger, Delger	12. Tov	Bayanjargalan, Bayan, Bayantsagaan, Sergelen, Zuunmod, Jargalant, Bayanchandmani, Altanbulag, Bayankhangai
4. Dornogovi	Urgen, Saikhan-Uul, Altanshree, Dalanjargalan	13. Uvs	Tarialan, Sagil, Ulaangom, Tes, Naranbulag, Zuungovi
5. Dornod	Kherlen, Sergelen, Bayan-Uul, Matad	14. Khovsgol	Moron, Ulaan-Uul, Khatgal, Chandmani-Under, Tarialan, Ikh-Uul
6. Dundgovi	Adaatsag, Erdenedalai, Saikhan-Ovoo, Gurvansaikhan, Mandalgovi	15. Khentii	Norovlin, Bayan-Adarga, Dadal, Binder, Batshireet
7. Zavkhan	Tsagaankhairkhan, Uliastai, Yaruu, Nomrog, Tosontsengel, Ikh-Uul	16. Darkhan-Uul	Orkhon, Darkhan, Shariin-Gol
8. Uverkhangai	Uyanga, Taragt, Nariinteel, Zuunbayan-Ulaan, Kharkhorin, Esonzuil, Ulziit, Arvaikheer, Khairkhandulaan, Baruunbayan-Ulaan	17. Ulaanbaatar	Songinokhairkhan, Khan-Uul, Bayangol, Chingeltei, Bayanzurkh, Baganuur, Gachuurt, Bagakhangai
9. Umnogovi	Dalanzadgad, Nomgon, Bayandalai, Khankhongor		

The Multiple Indicator Cluster Survey (MICS) was prepared for monitoring progress towards the mid decade goals of the World Summit for Children 1990. It was expanded and revised to reflect all the end decade goals and to incorporate the experience gained in conducting some 60 multiple indicator cluster surveys between 1995 and 1996. It also addresses specific challenges identified in the evaluation of multiple indicator cluster surveys conducted in 1997 and it takes us an important step closer to measuring progress in the implementation of Children's Rights.

The Child and Development Survey - 2000 Mongolia, is the second nationally representative multiple indicator cluster survey (MICS-2) of households, women and children. The main objectives of the survey were to assess the implementation of the National Programme for Action for the Children and the main goals established at the World Summit for Children and to develop a basis for future action.

Infant and Under Five Mortality

- Mortality estimates were obtained using the United Nations QFIVE computer program. For Mongolia, the West model life table was considered to be the most appropriate choice. According to the current survey's indirect estimates, using WHO and international statistical methods, the infant mortality rate was 64 (per 1,000) and the under-five mortality rate 87 (per 1,000) for the year 1996.

Education

- Only 21 per cent of the children between the ages of 36 and 59 months are presently attending an organized learning or early childhood education program (Table 9).

- In Mongolia the official primary school age is 8-11 years. However, to allow international comparability data from the MICS-2 survey are tabulated for children 7-12 years. As Table 10 shows almost 76 per cent of children aged 7-12 years group are attending school. If tabulated for children in the 8-11 age group the attendance rate increases to 84.5 per cent. The attendance rate at primary school is about 10 percent higher in urban areas than in rural areas.

- About 94.7 per cent of children who enter grade 1 reach grade 5 (Table 11). In urban areas, 97 per cent of children eventually reach the fifth grade, whereas in rural areas the figure is 4 percent lower, at 93.2 percent.

- The survey found that, overall, 98 per cent of the population over 15 years old, are literate. The differential between men and women, and urban and rural areas is very small (98.6 % for men, 98.5 % for women). The MICS-2 findings correspond closely with figures from the 2000 population census, which found 97.8 per cent literacy in the total population aged 15 years and above, 98 per cent for men and 97.5 per cent for women (Table 12).

Water and Sanitation

- According to the survey results, 60.5 per cent of the Mongolian population is supplied with clean and safe drinking water. Clean drinking water reaches 90.8 per cent of the population in urban centers but only 34.4 per cent in rural areas (Table 13). There are also major variations between the geographic regions.

- Survey data indicate that 73.9 per cent of the population has access to improved sanitary facilities, which include flush toilets connected to sewage systems or septic tanks,

other flush toilets, improved pit latrines, traditional pit latrines. If this is disaggregated according to location, 96.9 per cent of the urban population uses improved sanitary facilities, compared to only 54.1 per cent in the countryside (Table 14).

The supply of drinking water source and type of sanitary facilities used in Mongolia is closely associated with the type of housing and the location.

Child Nutritional Status

- One out of ten surveyed children under the age of 5 were found to be moderately or severely underweight, one in four (of the same age group) were stunted and one in 20 children were found to be wasting (Table 15).

- The cases of underweight, stunting and wasting in children under five in rural areas are twice as numerous as those in urban areas.

- The MICS-2 indicates that there is a clear correlation between malnutrition in young children and mother's education. Children whose mothers had only primary schooling or less, are 3 times as likely to be stunted than those whose mothers had university education.

Breastfeeding

- About 64 per cent of babies under 4 months were breastfed exclusively, lower than the recommended 100 per cent but significantly higher than the average in many regions of the world (Table 16). Approximately 54 per cent of children aged 6-9 months were breastfed along with complementary feeding, 75 per cent aged 12-15 months and 57 per cent of children aged 20-23 months were also still being breastfed.

Salt Iodization

- Overall, 45 per cent of the surveyed households had adequately iodized salt, but there was found to be a very wide variability from region to region (Table 17).

Vitamin A Supplementation

- Within six months prior to the Child and Development Survey - 2000, about 32 per cent of children aged 6-59 months had been given the high dose vitamin A supplement. An additional 11 per cent had received the supplement more than 6 months ago, and 54 per cent are reported never to have received it (Table 18).

- From all 6 regions, a total of 13 per cent of children had received high dose vitamin "A" supplementation within 8 weeks after birth (Table 19).

Low Birth weight

- The survey found 5 per cent of newborns had low birth weight (Table 20).

Immunization Coverage

- About 96 per cent of surveyed children in the 12-23 month age group had been vaccinated for all six major antigens within the first 12 months after birth.

- Measles still has the lowest coverage of all the vaccines, at 86 per cent (Table 21).

Diarrhea

- More than 60 per cent of children with diarrhea were fed breast milk and 56 per cent were given packaged ORS. (N.B. Multiple answers were accepted so percentages do not add up to 100) (Table 23).

- About 98 per cent of the diarrhea cases received one or more recommended forms of treatment.

- The most appropriate treatment - increased fluids and continued eating - was reported in only 32 per cent of the cases (Table 24).

Acute Respiratory Infection

- During the period of the survey, from May to August 2000, about 2 per cent of the children under five were found to have ARI.

- About 78 per cent of these cases taken for treatment to a health provider, in most instances a hospital or health center.

- One out of ten children, aged 6-23 months, have ARI and the numbers decrease as the age of the child increases (Table 25).

Integrated Management of Childhood Illness Initiative

- About 15 per cent of children under five years in the sample were reported to have diarrhea or some other illness in the two weeks prior to the survey, and 44 per cent of these were aged between 6-23 months, indicating that this age group is more vulnerable to sickness (Table 26).

- 39 per cent of children were given more than usual to drink and 57 per cent were given the same or less.

- 78 per cent of children were fed the same as usual and less than 20 per cent of children under 6 months old were given more than usual to drink, whereas the percentage among older children ranges from 35-50 per cent.

- The number of women with knowledge of when it is appropriate to seek medical care is increasing. One out of 3 mothers or caretakers in the survey were able to properly

identify two appropriate symptoms that indicate a sick child should be taken for professional treatment.

- The most common response, given by 58 per cent of mothers and caretakers, was that a fever would be sufficient cause to take a child for professional treatment. Forty seven per cent of mothers said they would take a child for professional treatment if it they became increasingly sick (Table 27).

HIV/AIDS

- Three out of four women were able to identify two effective ways of preventing HIV infection (Table 30a).

- One out of 3 women of reproductive age were able to correctly identify 3 misconceptions about AIDS transmission (Table 31).

- In Mongolia, more than half of the women surveyed (54 per cent) know where they can be tested for AIDS, and 14 per cent have actually been tested. Of those tested, a large majority have collected the results (Table 35).

Contraception

- Current use of some kind of contraception was reported by 67 per cent of the surveyed women who are married or living with a partner.

- By far the most popular method is IUD, used by 33 per cent of these women.

- About 54 per cent of women used a modern contraceptive method (Table 36).

Prenatal Care

- About 97 per cent of the women of reproductive age who gave birth in the year prior to the survey received prenatal care

from professional medical practitioners and 60 per cent of these had deliveries assisted by a doctor (Table 38/39).

Child Rights and Children in Difficult Circumstances

Birth Registration

- About 98 per cent of children aged 0-59 months have been registered. However, a significant proportion are not registered at or soon after birth, and only 85 per cent of children under 6 months of age were found to have been registered (See Table 40).

Living Arrangements of Children, including Orphans

- About 80 per cent of children are living with both biological parents, and less than 2 per cent do not live with a biological parent.
- In the case of nearly 17 per cent of

children, who live with only one parent, it is much more likely that this parent will be the mother.

- Twelve per cent of children are living with their mother only, even though their father is still alive, and 0.3 per cent of children are living with their father only, even though their mother is still alive.

- The survey found that 0.3 per cent of children under five, are orphans, with both of the parents deceased.

Child Labor

- More than 30 percent of children aged 5-14 are likely to be working for more than 4 hours per day. Of those who work for 4 or more hours a day, 20 per cent are working at home

- According to the survey findings, about 1.4 per cent of children are engaged in paid work for someone other than a household member.

Summary Indicators

World Summit for Children Indicators		
Under-five mortality rate	Probability of dying before reaching age five	87 per 1000
Infant mortality rate	Probability of dying before reaching age one	64 per 1000
Underweight prevalence	Proportion of under-fives who are too thin for their age	13 percent
Stunting prevalence	Proportion of under-fives who are too short for their age	25 percent
Wasting prevalence	Proportion of under fives who are too thin for their height	5 percent
Use of safe drinking water	Proportion of population who use a safe drinking water source	60 percent
Use of sanitary means of excreta disposal	Proportion of population who use a sanitary means of excreta disposal	74 percent
Children reaching grade five	Proportion of children entering first grade of primary school who eventually reach grade five	95 percent
Net primary school attendance rate	Proportion of children of primary school age attending primary school	76 ¹⁾ percent
Literacy rate	Proportion of population aged 15+ years who are able to read a letter or newspaper	98 percent
Antenatal care	Proportion of women aged 15-49 attended at least once during pregnancy by skilled personnel	97 percent
Contraceptive prevalence	Proportion of married women aged 15-49 who are using a contraceptive method	67 percent
Childbirth care	Proportion of births attended by skilled health personnel	97 percent
Birth weight below 2.5 kg.	Proportion of live births that weigh below 2500 grams	5 percent
Iodized salt consumption	Proportion of households consuming adequately iodized salt	45 percent
Children receiving Vitamin A supplementation	Proportion of children aged 6-59 months who have received a Vitamin A supplement in the last 6 months	32 percent
Mothers receiving Vitamin A supplementation	Proportion of mothers who received a Vitamin A supplement before infant was 8 weeks old	13 percent
Exclusive breastfeeding rate	Proportion of infants aged less than 4 months who are exclusively breastfed	64 percent
Timely complementary feeding rate	Proportion of infants aged 6-9 months who are receiving breast milk and complementary food	54 percent
Continued breastfeeding rate	Proportion of children aged 12-15 months and 20-23 months who are breastfeeding	75 percent (12-15) 57 percent (20-23)
DPT immunization coverage	Proportion of children immunized against diphtheria, pertussis and tetanus by age one	99 percent
Measles immunization coverage	Proportion of children immunized against measles by age one	98 percent
Polio immunization coverage	Proportion of children immunized against polio by age one	99 percent
Tuberculosis immunization coverage	Proportion of children immunized against tuberculosis by age one	99 percent
ORT use	Proportion of under-five children who had diarrhea in the last 2 weeks who were treated with oral rehydration salts or an appropriate household solution	56 percent
Home management of diarrhea	Proportion of under-five children who had diarrhea in the last 2 weeks and received increased fluids and continued feeding during the episode	32 percent
Care seeking for acute respiratory infections	Proportion of under-five children who had ARI in the last 2 weeks and were taken to an appropriate health provider	78 percent

¹⁾ For the context See page 19

Summary Indicators

Preschool development	Proportion of children aged 36-59 months who are attending some form of organized early childhood education program	21 percent
Indicators for Monitoring Children's Rights		
Birth registration	Proportion of under-five children whose births are reported registered	98 percent
Children's living arrangements	Proportion of children aged 0-14 years in households not living with a biological parent	20 percent
Orphans in household	Proportion of children aged 0-14 years who are orphans living in households	0.3 percent (both parents) 5.6 percent (one parent)
Child labor	Proportion of children aged 5-14 years who are currently working	1.4 percent
Indicators for Monitoring IMCI		
Home management of illness	Proportion of under-five children reported ill during the last 2 weeks who received increased fluids and continued feeding	30 percent
Care seeking knowledge	Proportion of caretakers of under-five children who know at least 2 signs for seeking care immediately	38 percent
Indicators for Monitoring HIV/AIDS		
Knowledge of preventing HIV/AIDS	Proportion of women who correctly state the 3 main ways of avoiding HIV infection	38 percent
Knowledge of misconceptions of HIV/AIDS	Proportion of women who correctly identify 3 misconceptions about HIV/AIDS	36 percent
Knowledge of mother to child transmission	Proportion of women who correctly identify means of transmission of HIV from mother to child	27 percent
Attitude to people with HIV/AIDS	Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS	57 percent
Women who know where to be tested for HIV	Proportion of women who know where to get a HIV test	54 percent
Women who have been tested for HIV	Proportion of women who have been tested for HIV	14 percent

I. INTRODUCTION

Background for the survey

At the World Summit for Children, held in New York in late 1990, the Government of Mongolia committed itself to the Summit Declaration and Plan of Action for Children. In addition to the establishment of goals and objectives for the decade of the 1990s, the Plan of Action also called for the establishment of mechanisms for monitoring progress toward these goals. One of the concrete steps taken by the Mongolian Government was a Child Development Survey /Multiple Indicator Cluster Survey (MICS), carried out in 1996 to measure progress at mid-decade.

To facilitate a broader and more thorough assessment at the end of the decade, UNICEF, in collaboration with WHO, UNESCO and others developed a core set of 75 indicators of specific aspects of the situation of children. The 2000 Mongolia MICS survey, formally designated the "Child and Development Survey -2000" Mongolia, was carried out to provide end-decade information on many of these indicators and to expand and improve the stock of relevant and reliable data on children's and women's issues. More specifically, the Multiple Indicator Cluster Survey Two, has as its main objectives:

- To monitor and evaluate the implementation of Mongolia's National Program of Action for the Development of Children in the 1990s (NPA).
- To furnish data for monitoring progress toward goals established at the World Summit for Children, and as a basis for further action in the first decade of the 21st century.
- To contribute to the improvement of data and monitoring systems in Mongolia,

to enhance technical expertise in the design and implementation of these systems, and to strengthen the capacity for analysis and use of their findings.

Planning and preparation for the Child and Development Survey - 2000 (MICS) began in the last quarter of 1999. One of the first concrete steps was a workshop organized by UNICEF and held at Terelj outside Ulaanbaatar in October 1999, where issues related to sampling, questionnaire content and design, logistics and other key survey issues were considered. Participants included UNICEF staff from country, area and regional offices, and representatives of key government ministries and the National Statistical Office (NSO). Subsequently a Steering Committee and Working group, with members from NSO, MOSTEC, MOH, NCC, MCRC and the Police Department, was set up to provide coordination and overall guidance for the survey design, questionnaire development and field implementation. A Working Group, consisting of representatives from relevant sectional ministries and agencies, was also established to provide technical backup and support. The National Statistical Office was given the responsibility for the survey implementation. UNICEF Mongolia provided funding and additional technical assistance.

The project also benefited from 3 regional MICS workshops, two held in Bangkok in Sept, 1999 and April 2000, and one in Yangon in August 2000. These workshops were organized by UNICEF as part of the global MICS effort associated with the end-decade assessment of World Summit for Children goals. International experts in sampling and survey design, questionnaire construction, interview techniques, data processing and management, analysis and report preparation were used as

resource persons. Participants were government and UNICEF staff expected to play key roles in MICS exercises to be carried out in their respective countries. The workshops were scheduled to correspond as closely as possible to the phases of country-level preparation and implementation.

A 10-day training program for interviewers and other field personnel was carried out in early May 2000 in Ulaanbaatar. The program included training on the survey objectives and the guidance on the interviewing process from UNICEF. Trainers were those who had participated in the regional MICS-2 workshops in Bangkok. At the local training there were around 100 participants, including those who would work as interviewers, editors and supervisors. During the training the participants gained knowledge of the survey objectives and the questionnaire, and the manual for the filling out the questionnaire. All participants studied how to interview, how to fill out the questionnaire and how to make contact with the interviewees. Participants practiced having interviews and learnt how to measure the weight and height of child under 5 years old, and the iodization of table salt used by the surveyed households.

Background of Mongolia

Mongolia is situated in the center of Asia, between the Russian Federation to the north and the People's Republic of China to the east, south and west. Mongolia has an extreme continental dry climate and four seasons. The winter is extremely cold, with temperatures falling to

minus 50-55 degrees centigrade and in summer, especially June, increasing to +30 degrees centigrade. Mongolia is a landlocked country of 1565 thousand square kilometres and is located 1580 metres above sea level with a variety of terrain that includes mountains, forests, steppe and Gobi desert zones. According to the findings of the Population and Housing Census for the year 2000, the population of Mongolia is 2.4 million with a population density of 1.5 person per square kilometre. According to the Census 2000, 32.5 per cent of the total population live in the capital city of Ulaanbaatar. In the last few years there has been increasing urbanization and 58.6 per cent of the population are now living in urban areas, with 41.4 per cent in rural areas²⁾.

The average life expectancy of Mongolians is 64 years. Mongolia is still included among those countries where there is a high fertility rate³⁾ and it is a youthful country with 46.6 per cent of the population being children and adolescents under 19 years old. Young people between the age of 19 and 24 represent 12.1 per cent. Almost 35.2 per cent of women are less than 15 years old and 54.1 per cent are of reproductive age, between 15 and 49.

Around 96 per cent of the population are Mongolian. There are Kazakhs and a Turkish-speaking population who live in the western part of the country. There are also a small number of ethnic Chinese and Russian, most of whom live in Ulaanbaatar. The official language is Mongolian, which has its own unique alphabet, but the Cyrillic alphabet is used in official documents, books, newspapers and magazines.

2) *Population and Housing Census: 2000*

3) *Reproductive Health Survey, NSO/ UNFPA Ulaanbaatar 1999*

Buddhism is the predominant religion. In the last few years, other religions have been coming to Mongolia and the Kazakh populations who live in the west of the country practice Islam.

Mongolia is currently in transition from a centrally planned economy to a market economy. According to the World Bank Statistical Year Book (1999) in which Mongolia is still included as a developing country, the GDP per person was US\$ 380 in 1998. Mongolia's GDP decreased by 3.9 and its industrial output by 30.9 per cent in 1999, at constant prices, from the equivalent in 1989. During this last decade the average income per person decreased by 16 per cent due to the increasing population of Mongolia. Mongolia has implemented a program of economic and structural changes with the support of international financial and development agencies.

The social and economic systems and patterns established during 70 years of socialism have broken down and social protection systems have been completely transformed during this transition period, giving rise to many new problems that significantly affect the situation of women and children. The poverty level was unregistered in 1990 and was thought to a minimum level at that time by the nature of the centrally planned economic system. The 1995 Living Standards Measurement Survey found that the 36.5 per cent of the population fell below the poverty line, and inequality had risen significantly⁴⁾. In 1998, a second Living Standards Measurement Survey⁵⁾, found that the number of poor had remained stable over the past three years at around 35.6 per cent.

Moreover, it is clear from the 1998 Living Standards Measurement Survey, that the level of poverty is deepening. There are a number of alarming adverse phenomenon which are emerging. For example, a number of school aged children from poor households are dropping out of school in order to earn money by working in conditions that are often hazardous to their health, including a number of young girls who are engaging in prostitution.

Due to the economic difficulties, the share of government budget devoted to the social sector has been diminishing significantly and investment in health and education sectors has been decreasing over time. As a result these sectors have been facing considerable difficulties and the availability and the quality of services have been deteriorating. In the past ten years, there has been almost no investment in the building of schools and hospitals. For example, almost no kindergartens were built and only one or two new schools have been built. In rural areas, due to the small number of schools and the relatively few places available, children aged 7 are not able to attend school and children who have graduated from the 8th grade, are not able to continue their education.

One of the concerns of today's society is the fact that the number of children who live on the street has been increasing in Mongolia. In most cases, these children are living in the ducts of heating systems or in tunnels underneath buildings and are living by stealing coal, polishing shoes, and portering products or begging. Poverty, and violence and abuse within their families, often from a stepfather or stepmother, are the major reason that these children choose to live on the street.

4) Living Standards Measurement Survey 1995. (NSO/UNDP), Ulaanbaatar 1995

5) Living Standards Measurement Survey 1998. (NSO/UNDP), Ulaanbaatar 1999

While the Government's commitment to children remains firm, it faces many obstacles and constraints as it attempts to cope with this wide array of social, economic and environmental problems despite seriously limited resources, including budgetary and technical resources. In certain areas, such as those related to exploitative child labor, street children, HIV/AIDS, disabled and homeless children, a serious challenge is the lack of reliable data for assessing and monitoring the magnitude, distribution and severity of the problem as a basis for formulating corrective policies and programs. The MICS-2 survey provides limited information on the current situation in some of these areas, such as knowledge and attitudes about HIV/AIDS, child labor and the living situation of orphans. Though much remains to be done, the findings of this survey may provide a baseline for monitoring trends over time and identifying certain aspects requiring more specific follow-up investigation.

The government of Mongolia has committed itself to a Declaration and Plan of Action for Children. Subsequently, a National Program of Action for Children was developed and approved in 1993, and the National Program

for Advancement of Women was formulated and approved by the Parliament in 1995. In order to improve the coordination of the activities for children and to implement the National Program of Action, the Government of Mongolia, in 1996, established a Working Committee that represents all the Ministries and government and non-governmental organisations working in child related matters.

To promote the implementation of the NPA and raise the awareness of the government and the public, the President of Mongolia took the initiative to declare the year of 1995 as the "Year of the Child". The First National Assembly on "Child Development and Protection" was convened, by the decision of Parliament, in 1995. This was an important event to define government policy and create a favorable environment for children's survival, growth and development.

The Law on the 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 new socio-economic system in Mongolia.



Photo by Giacomo Pirozzi



Photo by Giacomo Pirozzi

II. SURVEY METHODOLOGY

The questionnaire design, manual and methodologies of the first Child and Development Survey (MICS-1) conducted in 1996 were improved and used for the development of related materials for the current survey. The methodology used in this survey was developed using the manual for conducting multi indicator cluster surveys and the methodological guidelines developed by South East Asian Regional Organizations of UNICEF. However the methodology also reflects the unique features of the country. The survey was conducted in close collaboration with the Regional Office of UNICEF, which provided support in determining the sample size, selecting possible methods of sampling, developing the general design of the questionnaire and provided the survey team with common data processing methods, software and guidelines. All classifications, concepts and definitions of indicators and methods of estimation used in this survey are based on internationally accepted standard indicators and methods. MACROS International conducted a training workshop for the survey team in April 2000 in Bangkok, and also prepared the software programmes ISSA and IMPS which were used in the MICS-2 for the data entry and data processing.

2.1. Survey population and survey reference period

Survey population: According to the survey objectives, the current survey subjects were women aged 15-49, children under 5 or of pre-school age, (which in Mongolia includes children up to the age of 8) and of basic education

age (8-15) and disabled children under 18 years in the households of the interviewees.

Survey Coverage: We selected 6000 households for the survey which were representative of all Mongolian households by regional, urban and rural stratification. They were taken from 16 aimags and the capital city.

Reference period: This survey is not an annual survey. It covers only the year preceding the survey - the one-year period from June 1999 to June 2000. Some indicators applied statistics only from the end of 1999 and the maternal births were surveyed only from the last time birth was given.

2.2. Sampling

2.2.1. Sample design: The sample for the survey was designed to provide national estimates for the main indicators covered by the survey, with a margin of error of ± 5 percentage points at a 95 per cent level of confidence.

As Mongolia is a large country encompassing a wide variety of social, economic and geographic conditions, the survey was also designed to produce separate estimates for 6 regions(Western, Northern, Eastern, Southern, Central-1 and Central-2) as well as for urban and rural areas. The survey covered the capital city and 16 aimags, with between three and six soums surveyed in each aimag. These sub-national estimates are of course subject to somewhat wider margins of error than applies at national level.

6) The technical manual, Monitoring Progress toward the Goals of the World Summit for Children, and other documentation related to the Multiple Indicator Cluster Survey can be found at www.childinfo.org. A detailed discussion of MICS sampling procedures, including the formula for determining the required sample size, is presented in Appendix 7 of the manual.

The sample size necessary to achieve the desired level of precision was calculated according to the formula described in the MICS-2 manual⁶⁾. Since the MICS-2 survey was intended to provide information on a variety of indicators and several specific target groups, the required sample size is based on the number of households needed to yield valid results with the desired level of precision for the “rarest” key indicator-target group combination. This ensures that findings on the less “rare” combinations will also be valid at the chosen level of precision or better. For the Mongolian survey the key indicator for calculating the required sample size was the measles immunization rate in the target group of children aged 12-23 months. Using the formula from the MICS-2 manual it was determined that a sample of 6000 households would be needed to obtain data on all survey indicators with a margin of error not greater than +/-5 percentage points at national level with a 95 per cent confidence level (See Appendix A, Estimation of Sample Size for MICS-2 in Mongolia, 2000).

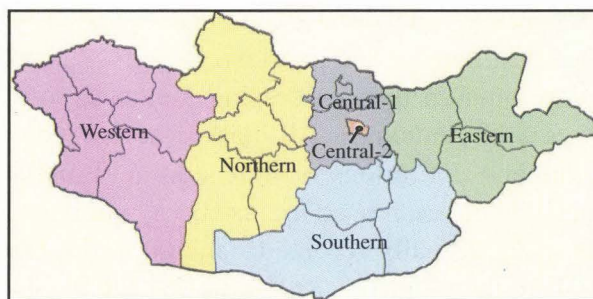
The MICS-2 planners estimated that, on average, each interview team could cover about 20 households per day. Thus it was determined that in order to reach the required total of 6000 households, 300 clusters averaging 20 households each would be needed.

Sample selection was done in two stages. First, using the sampling frame developed for the Population and Housing Census-2000, enumeration areas (EA) were listed according to urban, rural and regional categories and within these categories by aimag, soum and bag. From this listing 300 EA's were selected on the principle of probability proportional to size (pps)⁷⁾. In stage 2, selected EAs were divided into segments of approximately 20 households

each; one of which was selected randomly as a survey cluster. During the fieldwork phase of the survey, every household in each of the selected clusters was interviewed.

2.2.2 Sampling stratification: In the survey, sampling used 2 different stratifications:

1. By region: Most tables in this report are broken down into 6 regions: Western, Northern, Eastern, Southern, Central 1 and Central 2. This is an official government classification based on petrol prices. Specifically, this regional delineation is as follows:



- 1 Western (Uvs, Zavkhan, Gobi-Altai, Bayan-Ulgii, and Khovd aimags)
- 2 Northern (Arhangai, Hovsgol, Bayankhongor, Uverhkangai and Bulgan aimags)
- 3 Eastern (Dornod, Hentii and Suhkbaatar aimags)
- 4 Southern (Omnogovi, Dundgovi, Dornogovi and Govisumber aimags)
- 5 “Central-1” (Tuv, Selenge, Darhkan-Uul and Orkhon aimags)
- 6 “Central-2” (Ulaanbaatar- capital city)

2. By urban and rural: The attached tables in this report are classified into urban and rural. “Urban” population and households are defined as those located in the capital city

7) See Chapter 4 and Appendix 7 of the MICS manual for a detailed explanation of pps and its application in MICS sampling.

of Ulaanbaatar and any aimag centers.

- **“Rural”** - The rest of the population and all other households are classified as rural.

2.2.3 Sample unit: The sample unit is a household. A household is a single person or group of people residing in one dwelling, with common housekeeping arrangements.

2.3. Questionnaires

The questionnaire used in the Mongolian Child and Development Survey-2000 (MICS-2) closely followed the content and format of the model MICS-2 questionnaire recommended by UNICEF⁸⁾, with some revisions and adjustments to suit specific local circumstances. The MICS model actually consists of three sections; each designed to collect information on specific topics and distinct target groups.

2.3.1. Sample survey questionnaires

2.3.1.1. Household Questionnaire collected information such as the construction of the housing; the sex, age, literacy, marital and orphanhood status of the household members. Also included in this questionnaire were questions on education, child labor, supply of water and sanitation, and the use of iodized salt.

2.3.1.2. Women’s Questionnaire (women of reproductive age, 15-49) included modules on:

- Information about women
- Child mortality
- Maternal and infant health
- Contraceptive use
- HIV/AIDS.
- Vitamin “D” deficiency

2.3.1.3. Questionnaire for children under age 5, includes:

- Birth registration
- Early childhood learning
- Vitamin A supplementation
- Breastfeeding
- Care for childhood illness
- Hepatitis
- Child immunization
- Anthropometry (measurement of height and weight)

Modifications of the model questionnaire were carried out with the guidance of and co-ordination by the Steering Committee. The original English version was translated into Mongolian, and circulated among relevant government and non-governmental agencies for comments and suggestions, which were incorporated in subsequent drafts. The MICS-2 Working Group ensured that the substantial inputs from the sectional ministries and other organizations were appropriately worded and consistent with the overall structure and format of the questionnaire. Before finalization, the questionnaires were pre-tested in two separate locations. This field-testing helped to identify and correct problems with physical and logical sequencing and to detect specific questions where changes in wording were needed to make the meaning clear to respondents. In addition, it yielded an estimated average duration of each household interview (about 90 minutes) and provided a basis for planning the number of interviewers required, the approximate workload of each and the probable duration of the entire survey exercise. Following the correction of problems identified by the pre-testing exercise, the questionnaires, along with the revised instruction manual for interviewers

8) The model questionnaire is included in the MICS manual at the end of Chapter 3.

and supervisors, were given a final review and approval by the Steering Committee and the NSO.

2.4. Fieldwork and Data processing

2.4.1 Data collection: The official agreement on conducting Child and Development Survey - 2000 (MICS-2) was established in May 2000 between National Statistics Office of Mongolia and the Resident Representative of UNICEF.

The interviewers for the survey were selected by the Steering Committee and Working Group with the guidance of UNICEF. All the selected interviewers and editors participated at the MICS-2 training, after which eight data collection teams were established, each team consisting of a team leader, 2 editors, 4 interviewers and 2 drivers. As agreed by the Steering Committee and under the direct supervision of the Working Group, supervisors provided team members with plans of action and editors received and checked materials and information daily. Any errors, lack of clarity or omissions in the materials were immediately detected and edited in the field.

One of the supervisors of each team was a staff member from the local statistical office. By agreement with the local authority, these staff were given one month's unpaid leave in order to serve on the MICS team. The participation of these local staff was very positive and made a significant contribution towards facilitating fieldwork, helping to reduce non-sampling error and improving data quality.

It should be noted that the Parliamentary Election Campaign was going on at the same time

as the survey and may have had an adverse effect on the process of implementing the survey.

Household interviews began at the end of May and concluded in early August 2000. Four monitoring units composed of Steering Committee and Working Group members were set up to provide overall supervision of field work progress and interviewers' and supervisors' performance in 10 aimags and Ulaanbaatar, reporting on shortcomings and successes and taking timely action as necessary to ensure continued smooth implementation. The data collection procedures were divided into 3 stages. After each team completed its work in one site and submitted the data to the working group in Ulaanbaatar, which was responsible for receiving and entering data, it was given permission to move to the next site. Each team worked in two aimags and the third stage of fieldwork was in Ulaanbaatar.

2.4.2. Data Processing: ISSA computer software was used for data entry preparation and data collected was keyed into 5 microcomputers. Computer operators for data entry were hired and trained for 4 days. The data processing team had the responsibility of checking the completeness of all received raw data, pre-entry data quality control and preparation for entry, data entry processing, testing and running controlling software, producing data error report, re-entry data correction, converting software provided by the UNICEF Resident Representative's Office in Ulaanbaatar and processing data according to the instructions. In order to ensure the quality of received data, a double entry method, comparing results was used for each questionnaire. The Team Leader and the computer programmer attended a Data Processing training course held in Bangkok in April 2000, during which the trainees received the necessary knowledge and skills to apply in

the case of this particular survey. These skills included questionnaire computer design, data entry, quality control, correction and process, as well as the utilization of the commonly used software package, SPSS, for data integration and analysis for this survey. Some additional software work was carried out and applied to ensure consistency of the software to be used and country-specific questionnaires were designed for the Child and Development Survey-2000.

Data pre-entry preparation, quality control and data entry was carried out in July-August 2000 at a highly professional level and in a shorter time than expected. At this stage of the survey, the working group stayed in close contact with the survey regional office and some questions raised concerning software and mathematical methodology were solved very efficiently.

Survey data were processed using software based on the given designed questionnaire. The data processing was carried out in two stages. The goal of the first stage was to obtain a complete file of raw data according to the processing technology order and to ensure the quality of the data. This included following:

- 1.1 Data entry
- 1.2 Structure checks
- 1.3 Verification
- 1.4 Secondary editing
- 1.5 Production of verified and confirmed data set

The second stage aimed to produce cross tables enabling further analysis to be carried out. This included the following:

- 2.1 Entry of a variety of options and

simulations

- 2.2 Production of output tables

After the completion of the data processing of the survey materials, statisticians analyzed particular indicators, checked consistency with other data sources, reviewed results, edited errors, and reviewed concepts and definitions of unclear indicators. Finally, based on these, they developed a working document, which would be useful for the next survey, and wrote the survey report. The other data sources used for analysis and consistency checks were other official statistics compiled by the National Statistical Office, the Statistical Year Book (NSO)⁹⁾, and the Mongolian government's Population and Housing Census - 2000.

Within the context of the Child and Development Survey-2000 (MICS-2), another survey concerning Children Living in Difficult Circumstances was conducted, by attaching a further questionnaire (Child and Development Survey-2 or CDS-2) to the main survey, and collecting the data at the same time. This required each local government authority to provide information through questionnaire CDS-2, which was completed in August-September, 2000. Data from this second questionnaire was collected and processed, using similar pre-data preparation, quality control and software processing, and in addition, sets of handbooks and instruction were designed for this specific survey and approved by the working group. Children surviving in difficult circumstances were disaggregated by aimag and a database was established.

All related original raw inputs were delivered to the archive after the data process was completed. A working report on the survey organization will be submitted separately.

9) *National Statistical Year Book 1999. National Statistical Office of Mongolia. Ulaanbaatar, Mongolia*



Photo by Giacomo Pirozzi



Photo by Giacomo Pirozzi



Photo by Giacomo Pirozzi

III. SAMPLE CHARACTERISTICS AND QUALITY OF INFORMATION

3.1. Response Rate

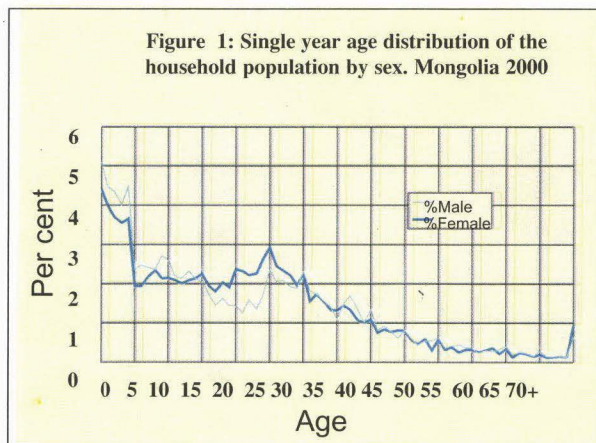
The selected 6000 households for the “Child and Development Survey -2000 (MICS-2) completed the interview (Table 1). About 8606 women aged between 15-49, identified as the select group, were eligible for the women’s questionnaire. Out of these, 8257 were interviewed successfully, with a response rate of 95.9 per cent. In addition, 6199 children under the age of 5 were found to be living in the selected households. Children’s questionnaires were completed for 6184 of these, yielding a response rate of 99.8 per cent.

3.2. Missing data and age distribution:

3.2.1. Quality of information

As a basic check on the quality of the survey data, the percentage of cases missing information on selected questions is shown in Table 3. 8.3 percent of household members (1764 persons) have missing information on their level of education but 0.1 per cent (12 persons) have missing data on the year of education.

Among female respondents, 0.1 per cent did not report a complete birth date (i.e., month and year). Of women who gave birth in the 12 months prior to the survey, 0.1 per cent did not report any data on AIDS testing.



A small number of children under 5 years old and between 6 and 8 years old, gave incomplete answers for the question on children with diarrhea in the last two weeks.

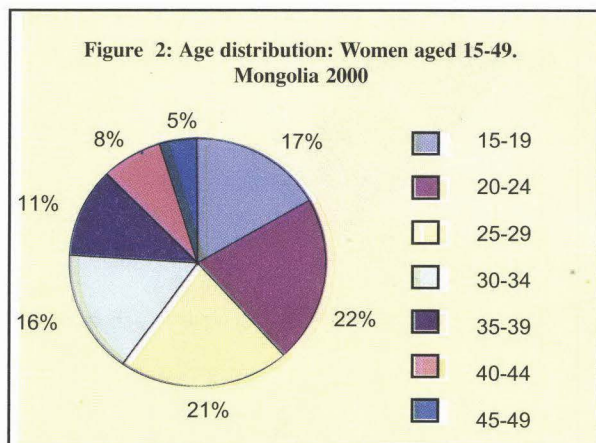
The data on weight and height is missing in the case of approximately four percent of surveyed children under 5 years old, which may be the result of the child not being present, refusal, or other reasons. Data on weight and height is the most likely information to be missing, but, by international standards, the above percentage of missing information is relatively low in comparison to other surveys in which anthropometric measurements have been taken (Sommerfelt and Boerma, 1994).

3.2.2. Age distribution of survey population

Gender and age distribution among the survey population (the sample households) is more or less equal to the gender and age distribution in the total population, except in the under 5 age group and the 16-25 age group where there are slightly more males than in the general population of these age groups.

3.2.3. Demographic characteristics of the survey household

Information on the demographic characteristics of the household population and the survey respondents is provided to assist in the interpretation of the survey findings and to serve



as a basic check on the sample implementation.

By region: The number of households involved in the sampling is shown in Table 4 by region; 49 per cent (2925) of the respondent households are urban, 51 per cent (3075) rural. The Central-2 region (Ulaanbaatar) accounts for the largest share of sample households among the 6 regions, while the Southern, which is comprised of the sparsely populated aimags of Omnogovi, Dundgovi and Dornogovi, contributed only 7 per cent.

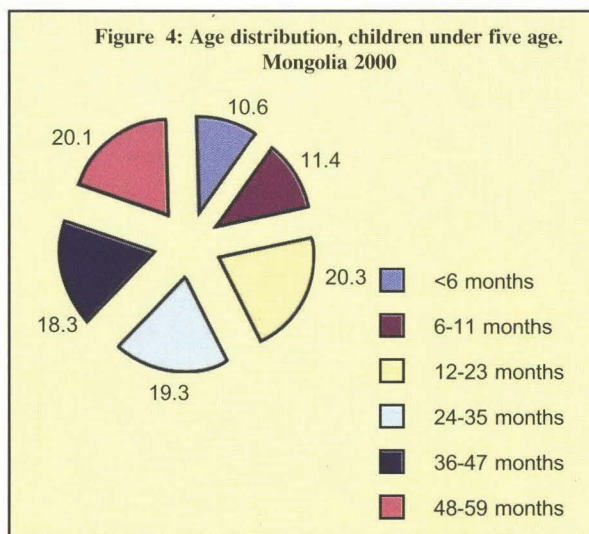
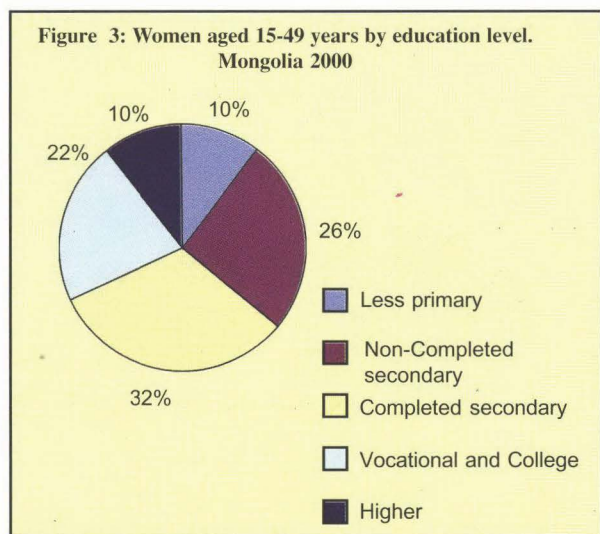
By family size: In terms of family size, most of the households (48 per cent) have 4-5 members, and 22 per cent have 6-7 members, only 0.1 per cent have a single member and about 10 per cent have 8 or more members. The survey results show that nearly 79 per cent of households have at least one child under age 5, and nearly all (99 per cent) have one or more women aged 15-49.

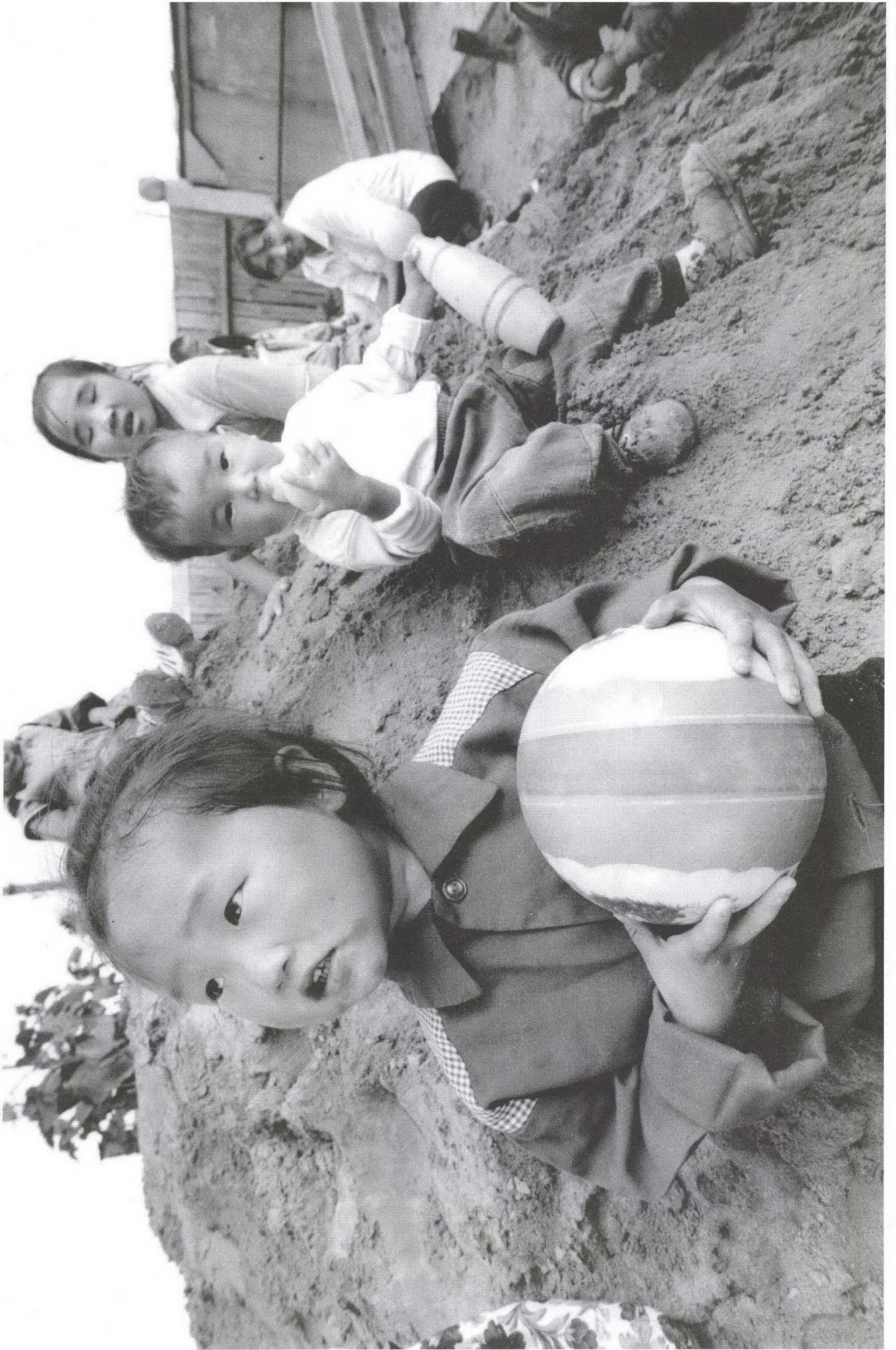
By women's age composition: About 22 per cent of the surveyed women were aged between 20-24 and 21 per cent between 25-29, and these constitute the largest proportion of the sample (Table 5). The proportion of older women in the sample is much smaller than in any of the other age groups, women between 45-49 representing only 5 per cent of the sample.

By women's marital status and education level: About 60 per cent of the sampled women were married or live with partners, and 76 per cent had given birth at least once. About 10 per cent of women in the sample have completed primary education, 25 per cent have completed or have lower secondary education, and over 50 per cent had graduated from completed secondary schools, vocational institutions and colleges, and 10 per cent have graduated from university (Table 5).

Children under 5: Table 6 shows the distribution of children under the age of 5 in terms of gender, place of residence, age group and mother's education. Of the children included in the study, about 11 per cent were less than 6 months or between 6-11 months old, and between 18 and 20 per cent of children are 2,3,4 and 5 years old respectively.

Slightly over half (51 per cent) are boys and 49 per cent are girls. Less than 1 per cent of the mothers with children under 5 years have no formal education, and a mere 5 per cent have completed only primary school, 27 per cent have lower secondary education, 33 per cent have completed secondary education, and over 30 per cent have graduated from vocational institutions and college or university.





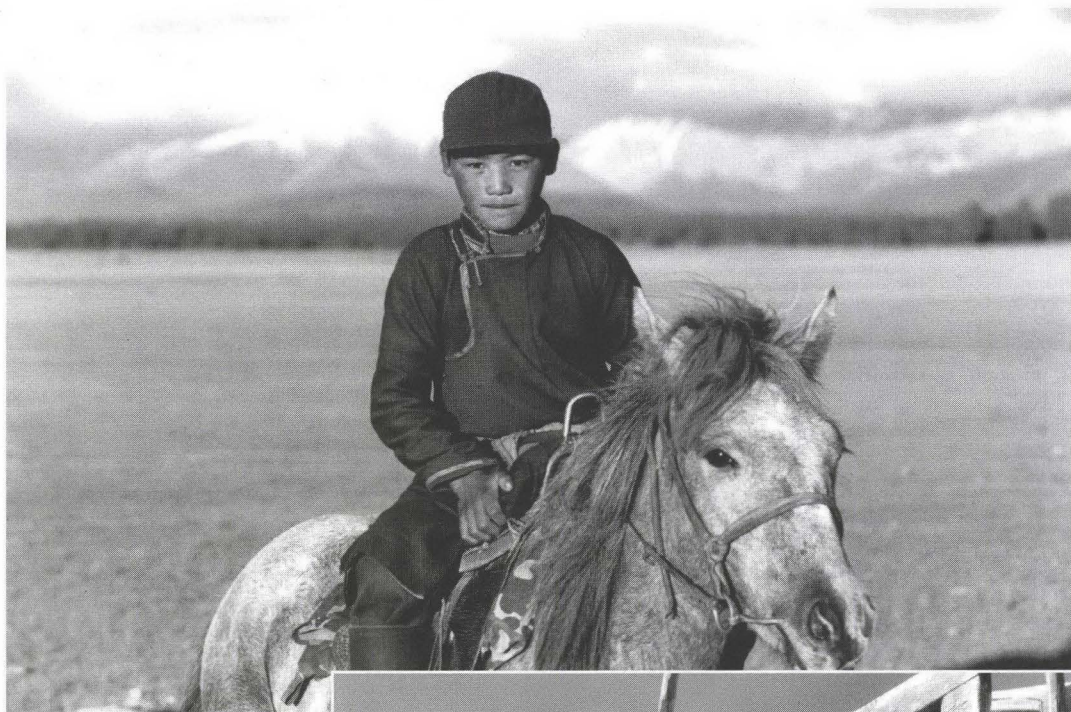


Photo by Giacomo Pirozzi

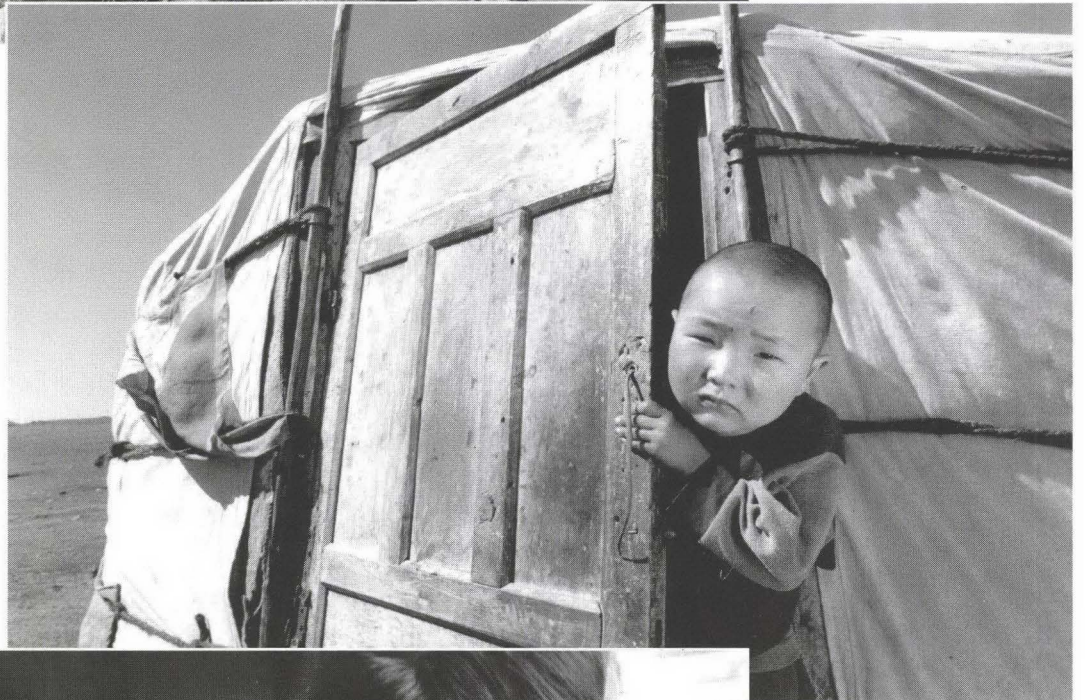


Photo by Giacomo Pirozzi



Photo by Giacomo Pirozzi

IV. THE RESULTS OF THE SURVEY

A. Infant and U5 Mortality

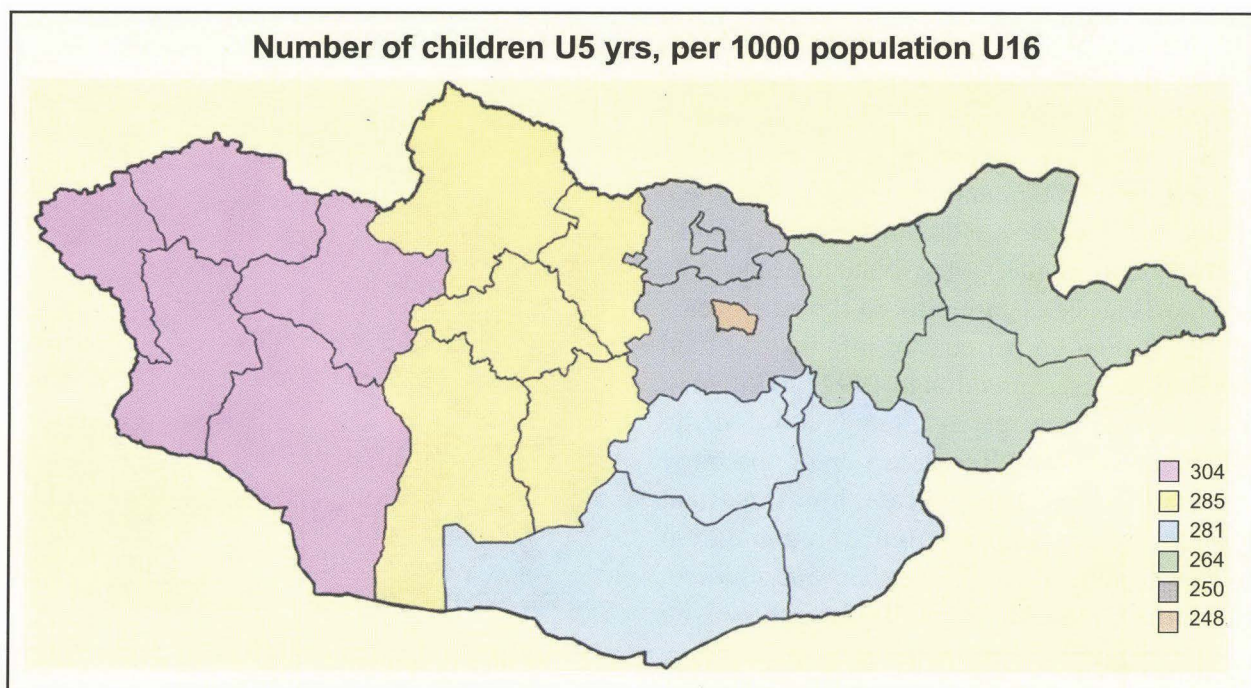
Goals. *Global:* Reduction of IMR and U5MR by one third, or to a level of 70 per 1000 live births. *National:* Reduction of IMR to 49 and U5 MR to 61.

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. These rates are often expressed in terms of the number of deaths per thousand live births. In MICS, infant and under-five mortality have been calculated using an indirect estimation technique (the Brass method). The data used in the estimation are: the mean number of children born for each five-year age group of women aged 15-49 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 the length of their exposure to the risk of dying.

The data used for mortality estimation are shown in the Table 7. The mean number of children born rises from .128 for women of 15-19 years old to 5.325 for women aged 45-49, as would be expected. The steady increase in the proportion of children dead, from .022 among 15-19 year old mothers to .130 among mothers in the 40-44 age group, is also plausible, though it is not immediately clear why the proportion of children dead among women aged 45-49 should be smaller than the proportion among the younger mothers in the 40-44 age group. The highest rate of fertility is among women aged between 25-34.

Mortality estimates were obtained using the United Nations QFIVE computer program. For Mongolia, the West model life table was considered to be the most appropriate choice. By indirect estimates the infant mortality rate was 64 per 1,000 and the under-five mortality



rate 87 per 1,000 according to MICS, for the year 1996. According to MICS, the infant and under-five mortality rate increased in both indicators between 1985 and 1988, and there was a sharp decline from 1988 to 1991 (estimates for 1985 and 1988 are based on reports from women aged 45-49 and 40-44, respectively). There was a leveling off between 1994 and 1996 and after 1996 the mortality rate appears to decline sharply once again. Compared to other sources, the MICS infant and under 5 mortality estimates are somewhat higher than official statistics based on administrative reports, but remarkably similar to the findings of the 1998 Reproductive Health Survey data for 1994-1998.

Infant and under five mortality has been declining as a result of the improved legal environment for the protection of the rights of children and mothers, and as a result of measures undertaken by government and government agencies, and by international organizations and by other countries. However, the level remains high in comparison to the level in other countries. According to the results of a survey on "Mortality in Children Under Five ... Causes and Influencing Factors"¹⁰, conducted in 2000, by the Ministry of Health and Social Welfare with the support of UNICEF, acute respiratory infection and pneumonia, diarrhea, early infant diseases and cerebral and neurological disorders were found to be the most common causes of mortality in the early years of life. About 95 per cent of infants who died because of sepsis infection in 1999 (30 infants), died in care centres in Ulaanbaatar, in the Maternal and Child Research Center and other maternity homes. This indicates how important it is to concentrate on improving medical assistance and services for mothers and children. Of all the children covered by the survey who

died at home, about 30 per cent died because of poor standards of parental care, 27 per cent died because the household was a great distance from medical assistance and 4 per cent died because of inappropriate treatment by doctors. Of the children covered by this survey who died at home, 22 per cent died before receiving medical assistance.

B. Education

Goals. Global: Universal access to basic education. Reduction of adult illiteracy rate 50 % of 1990 levels. National: 98 % of population aged between 8-15, will have completed secondary school education.

Universal access to basic education and the completion of primary school education by all the world's children is one of the most important goals of the World Summit for children. Education is a fundamental condition for democracy, human rights, environmental protection, gender equity and the protection of children from hard and harmful labor.

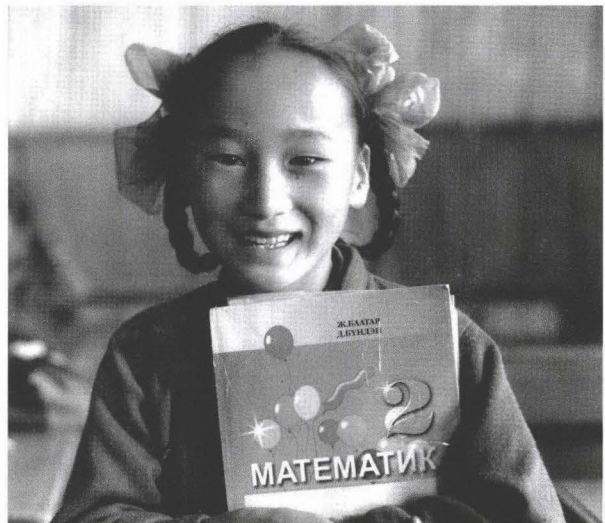


Photo by Giacomo Pirozzi

10) *Mortality in Children Under Five: Causes and Influencing Factors: (MOHSW/UNICEF) Ulaanbaatar 2000 (See page 1 and Table 2-39)*

B.1. Early Childhood Education

Findings from the current MICS-2 survey show that only 21 per cent of children between the ages of 36 and 59 months (or 3-5 years) are presently attending an organized learning or early childhood education program (Table 9). There is almost no differentiation by gender, but there are wide gaps between urban and rural children and among different regions. Thirty-five per cent of urban children are participating in some form of education program, compared with only 10 per cent in the countryside. In Central-2 region (Ulaanbaatar) 41 per cent of this age group are participating in pre-school education programs, while in the North the participation rate is only 7 per cent. Analysis by household location shows a similar pattern. Whereas 41 per cent of children in the capital city are attending some kind of pre-school education program, this percentage declines steadily in smaller settlements; 26 per cent in aimag centers, about 18 per cent in soum centers and a mere 6 per cent in other rural areas. Clearly, children living in the larger cities and towns have a great advantage over those who live in the countryside.

A strong relationship between pre-school attendance and the mother's education is evi-

dent. Children whose mothers have a university education are much more likely to be enrolled in a pre-school education program than those whose mothers have only primary schooling or less. Every increase in the mother's educational level is associated with an increase in the proportion of their children attending some kind of organized pre-school program.

B.2. Basic Education

In Mongolia the official primary school age is from 8-11 years. However, to allow international comparability, data from the MICS-2 survey were collected for children aged 7-12 years (Table 10). As the table shows, almost 76 per cent of children in this age group are attending school. If disaggregated for children in the 8-11 age group, the attendance rate increases to 84 per cent. (The MICS-2 was conducted at the end of the academic year 1999-2000, in May/June. The children who had begun the academic year in the 8-11 age group, by June 2000 were then in the 9-12 age group, for which the attendance rate at primary school was 92 per cent). The survey shows, however, that a significant number (26 per cent) of children are attending school at age 7. At the official starting school age of 8, only 63 per cent of children are in school, and the maximum attendance rate is 95 per cent at the age of 10. This

Figure 5: Percentage of children aged 36-59 months who are attending at Early childhood program. Mongolia 2000

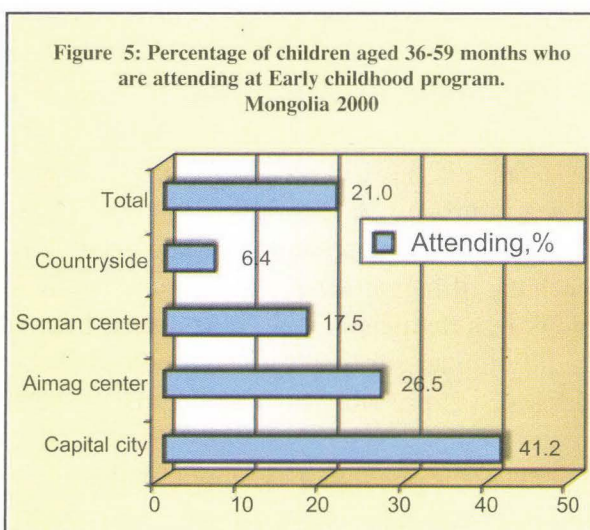
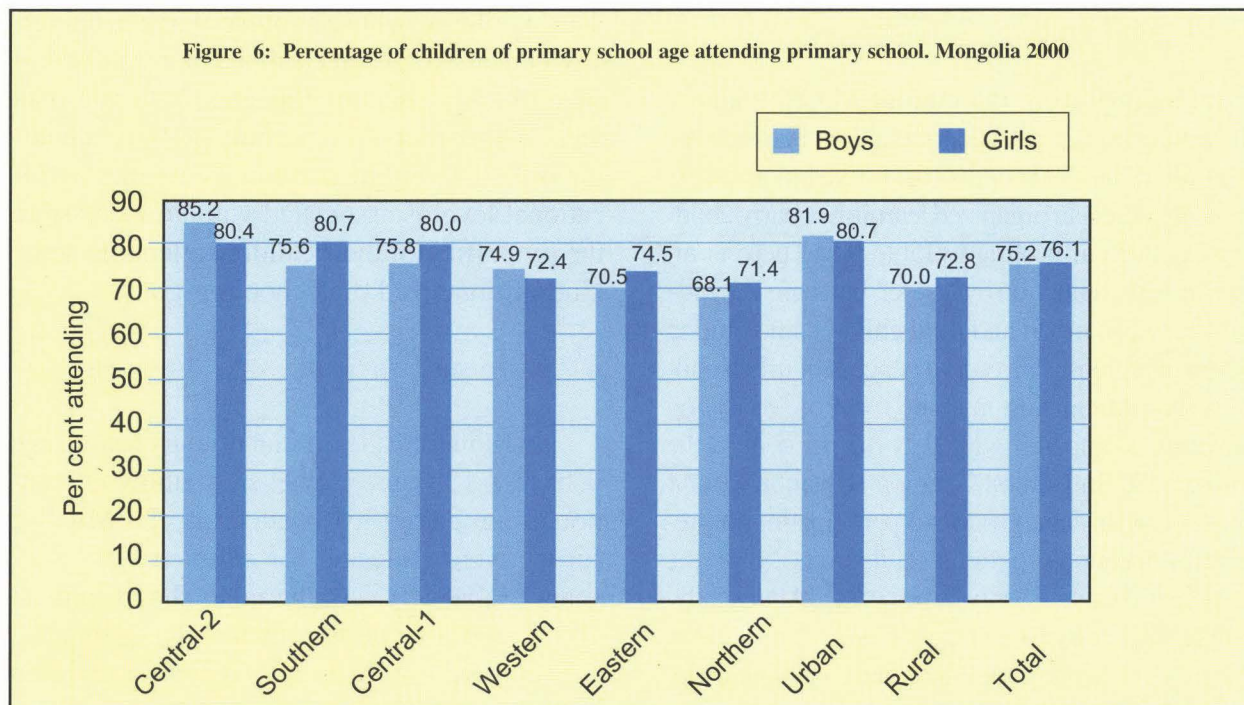


Photo by Giacomo Pirozzi

Figure 6: Percentage of children of primary school age attending primary school. Mongolia 2000



seems to indicate that many parents prefer to start their children's schooling at a relatively late age.

The attendance rate at primary school is about 10 per cent higher in urban areas than in rural areas. There is also a wide differentiation between regions, varying from 70 per cent in the Northern region to 83 per cent in Ulaanbaatar. Overall, girls' attendance is slightly higher than that for boys, but this pattern is not uniform throughout the country. In urban areas and in the Western and Central-2 regions, enrolment of boys is higher than enrolment among girls.

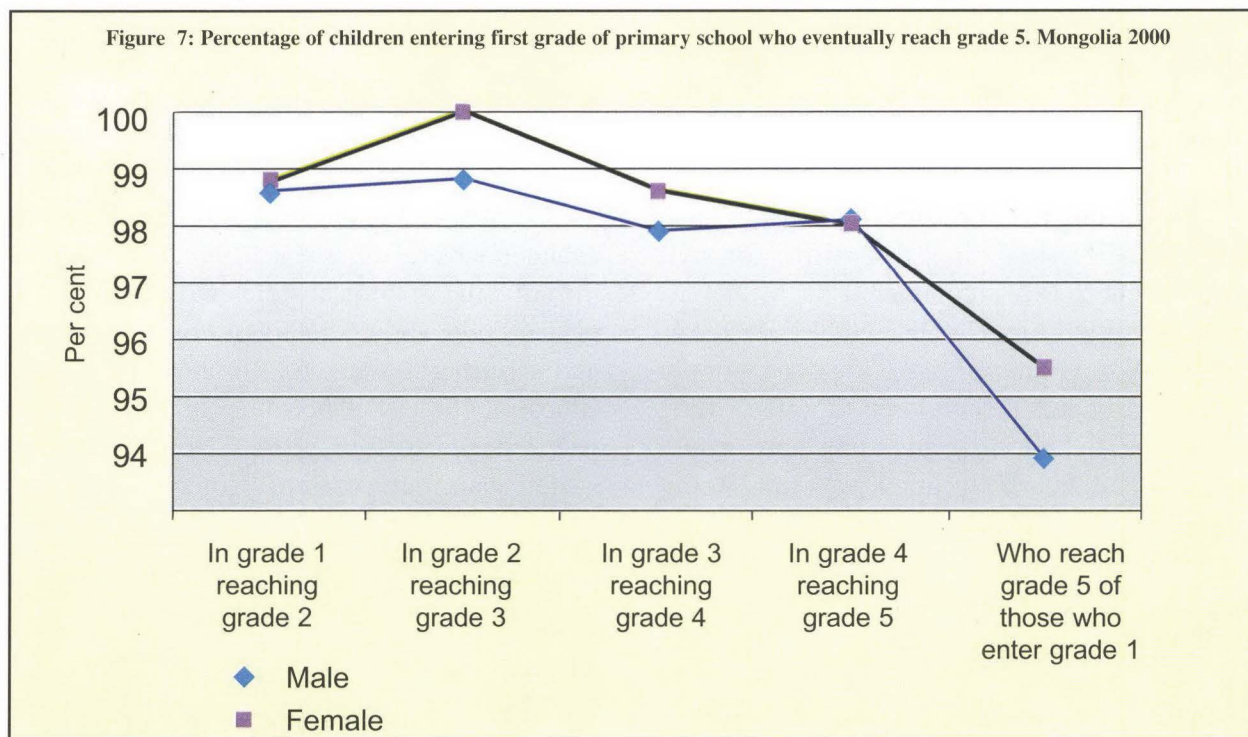
The data show a drop in school attendance after the age of 10, especially for boys. The decline in attendance for male children is 5 percentage points between the ages 10 to 12, while the attendance rate of girls only drops by 2.5 percentage points, or only half as much.

Table 11 shows the survey findings on the proportion of children who enter the first grade of

primary school and eventually reach grade 5. This information was obtained by the interviewer asking whether each child in the appropriate age group was attending school that year, and if so in what level and grade. A second set of questions was asked about the child's attendance and grade the previous year. This information allowed the construction of a flow diagram showing the progress of children from one grade to the next and made possible a calculation of the survival rate at grade 5.

The overall figure from the Child and Development Survey -2000 (MICS-2) is about 95 per cent, and there is relatively little variation by sex or urban-rural residence. In urban areas, for example, 97 per cent of children eventually reach the fifth grade, whereas the rural percentage is less than 4 per cent lower. Girls have a slightly higher survival rate than boys, but the difference is probably not significant.

There is one major exception to this fairly uniform picture, however, in the Eastern region,



where just under 70 per cent of children ultimately reach grade 5, as compared with more than 90 per cent in all the other regions. The survey data show that at every step from grade 1 to grade 5 the transition rates in the Eastern are lower than in any other region. The difference is particularly marked at the earliest stage, where it appears that 15 per cent of the children who enroll in the first grade do not reach grade 2. With further attrition in succeeding years, the end result is that about 3 out of every 10 children who enroll in primary school do not complete four full years of education, the amount generally considered to be the necessary minimum to achieve a sustainable level of literacy.

According to the Population and Housing Census - 2000 statistics, the attendance rate at primary school at age 7 is 29.4 per cent, 84.8 per cent at age 8 and 93.3 per cent at the age of 9. Between the ages of 10-19, 69.4 per cent of the age group are attending school.

B.3. Literacy

The literacy rate is very high in Mongolia. The survey found that, overall, 98 per cent of the population above 15 years of age are literate. The difference between men and women is very small (98.6 % for men, 98.5 % for women), and there is only about 1 per cent difference between urban and rural areas. The only significant differences to emerge were between the population under age 55 and people aged 55 and over, especially those aged 65 and above (See Table 12).

The MICS-2 survey findings correspond closely with those of the Population and Housing Census -2000, which found 97.8 per cent literacy among the total population aged 15 years and over, 98 per cent for men and 97.5 per cent for women.

In 1995 the Mongolian Government approved a national program of Pre-school education which aimed to maintain the level of progress and development that had already been

achieved in the field and to further develop pre-school education during the period of transition. The Government's policies and strategies for the future are reflected in this document.

According to the results of the Mongolian National Report on Education for All Assessment 2000¹¹⁾, conducted by MOSTEC with the support of UNDP, UNICEF, UNFPA, and the World Bank, about 30.6 per cent of pre school age (aged 3-7) children (256924) were, at the time of the survey, attending a pre-school or early childhood education program. About 48.7 per cent of children in this age group in Ulaanbaatar, 43.2 per cent in other urban areas and 15.9 per cent in rural areas are attending an early childhood education program (By 2000, only 4.6 per cent of 7 year olds (or 12,059) were attending primary school). From 1990 to 2000, the number of kindergartens fell by 28.4 per cent, now totalling 650, and the attendance rate fell by 23.9 per cent.

Children who live either in herding families or poor households and disabled children have limited or no chance to attend an early childhood education program. Almost 99 per cent of rural administrative units do not have any early childhood education programs.

According to the survey by MOSTEC, from the beginning of the transition period, the school dropout rate has increased considerably and this phenomenon is more prevalent in rural areas. One of the main causes of children dropping out of school is the structural changes that have taken place in the socio-economic system and the subsequent lowering of the overall living standard of the population. Of children aged 8-15, about 19.6 per cent in 1992, 17.9 per cent

in 1994, 14.1 per cent in 1996, and 12.8 per cent in 1998, were not enrolled in school. The survey highlighted several main reasons for dropping out of school. These were:

1. School System: The school system has changed several times since 1990. For example, initially the school system had six years of primary education, 2 years of lower secondary and a further 2 years for complete secondary education (6+2+2). Then the primary education was reduced to four years. Now the school system has four years of primary education,



Photo by Giacomo Pirozzi

four years of lower secondary and two years of complete secondary (4+4+2). These attempts to change the educational structure have had a negative impact on the normal activities of schools and the quality of training

2. Privatization: One of the negative consequences of the privatization that has taken place during transition has been an increase in the utilization of child labor. Due to privatization of livestock, the number of livestock has been growing, which has had a positive effect on the living standards of households and, consequently, on the economic

11) Mongolian National Report on Education for All Assessment 2000 (MOSTEC, UNDP, UNESCO, UNICEF, WORLD BANK) January 2000

growth of the country. However, the number of cases of children, from herding households, dropping out of school in order to help with the livestock is increasing in rural areas.

3. Dormitory Facilities in Schools: One of the important provisions which enabled children of Mongolian nomadic cattle breeders to attend school was dormitory facilities in schools. Since 1990, due to the economic environment and financial constraints, dormitory facilities have started to deteriorate, and have not been maintained. As a result, the number of schools with dormitory facilities decreased significantly, with a consequent decrease in the number of children from herding families attending school.

4. Deterioration of household living standard: During the transition period, the price of consumer goods and services has been increasing, and consequently, the cost of living has increased. Thus the gap between rich and poor has been increasing. Similarly, as a result of social-economic structural change, unemployment has become widespread. However, not everybody has been able to take advantage of social security and this has resulted in wide spread school drop out rate among children from vulnerable households.

3. Migration: As a result of a lack of planning and implementation of regional development policies, there has been a steady stream of population migration towards to urban settlements, particularly to Ulaanbaatar city. Newly arrived children to the city are more likely to dropout of school.

6. Capability of school teachers and their discipline: Because of a failure to predict problems and difficulties which were likely to occur during the implementation of a new educational system and to undertake appropriate measures that would ensure protection from unex-

pected difficulties, a significant number of knowledgeable and capable teachers left school, resulting in a deterioration in the overall knowledge, capability and discipline of teachers. In turn, this has had a bad affect on the children.

C. Water and Sanitation

C.1. Use of safe drinking water

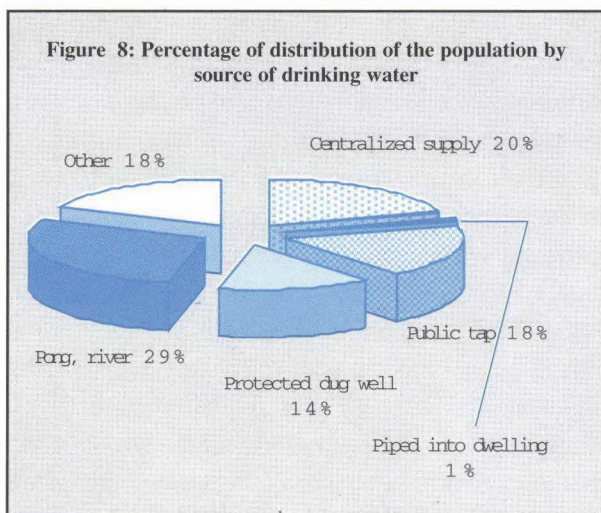
Goals. *Global:* Universal access to safe drinking water. *National:* 85 % of population with access to safe drinking water.

Clean drinking water is fundamental for human health. Polluted water is a carrier of many infectious diseases, including cholera and typhoid. Pollution may also be caused by chemical, physical and radioactive contaminants, which can be harmful to human health. In addition to health considerations, access to safe drinking water may be particularly important for children and women, especially in rural areas, because they often bear primary responsibility for carrying water from the source to the home.

There are many well-known problems associated with assessments of "clean" or "safe" drinking water. Obviously, water quality varies from place to place, and even modern piped systems do not always provide water that is completely clean and safe. Nevertheless, it is known that water quality from some types of sources is generally better than that from other types. Therefore, reasonably accurate estimates of safe water coverage based on the type of source can be obtained through household surveys. In line with UNICEF recommendations and in order to maintain international comparability the following sources of drinking water were classified in the MICS-2 survey as safe:

(1) piped water to the household or yard, (2) public standpipe or tap, (3) tubewell or borehole with pump, (4) protected dug well, (5) protected spring and (6) rainwater. Figure 8, shows the results from the MICS about the sources of drinking water used by the survey households.

According to the current survey results, 60 per cent of the Mongolian population is supplied with clean and safe drinking water (Table 13). However, there are big differences between city water supplies and those in the countryside. Clean drinking water reaches 91 per cent of the population in urban areas but only 34 per cent in rural areas. There is also major variation among regions. Only about 22-32 per cent of the population in Northern and Western regions have access to safe drinking water, while in Central-1 and Central-2 regions the proportions are 84 and 97 per cent, respectively.



Nationally, the survey finds that 20 per cent of the population uses water piped directly into the dwelling, and a further 18 per cent are supplied from public taps. The situation is more diverse in the Southern and Eastern regions, where people obtain drinking water from a wider variety of sources.

There is some concern that the water quality classification used in the Child and Development Survey - 2000, is not wholly appropriate for the Mongolian situation. In particular, it is widely believed that the lakes, streams and rivers that supply much of the drinking water in the Western and Northern regions are in fact a safe source and should be classified accordingly. It is argued that these areas are sparsely settled, with very little industry or modern agriculture of the sort that becomes a major source of water pollution elsewhere. The protected well is one major source of clean drinking water. In the last few years the number of protected wells has reduced slightly. On the other hand, there is some debate as to whether the protected wells that supply 14 per cent of the drinking water nation-wide and are especially important in the Southern region, should actually be classified as safe sources, considering that many of these facilities were installed before 1990 and have not been well maintained since.

According to the results of the "Living Standards Measurement Survey 1998"¹²⁾ about 50 per cent of the total urban population and 72 per cent of the residents of Ulaanbaatar had access to a central supply system of safe drinking water. In the countryside, 27-30 per cent of the rural population have access to safe drinking water from unprotected wells. However,



Photo by Giacomo Pirozzi

12) Living Standards Measurement Survey 1998 (NSO/UNDP) Ulaanbaatar, Mongolia 1999

the percentage of the urban population who have access to a central supply system for safe drinking water has been decreasing in the last 3 years, 67.5 per cent in 1995 to 52.0 per cent in 1998.

C.2. Use of sanitation

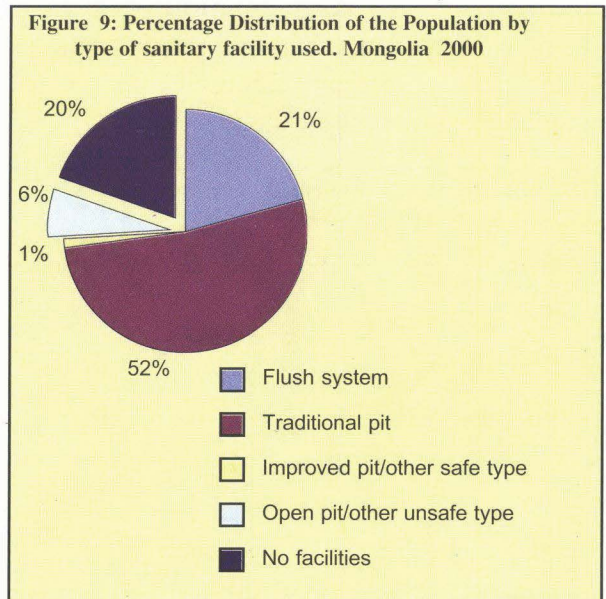
Goals. Global: Universal access to sanitary means of excreta disposal. National: 75 % with flush toilets or latrines that meet sanitary standards.

Inadequate or improper disposal of human excreta and poor personal hygienic are associated with a range of diseases, including diarrhea and polio. In the Child and Development Survey - 2000 sanitary facilities include: (1) flush toilets connected to sewage systems or septic tanks, (2) other flush toilets, (3) improved pit latrines and (4) traditional pit latrines.

The data in the survey indicate that 74 per cent of the population has access to improved sanitary facilities (Table 14). However, as with improved sanitary facilities supply, the situation is very different in urban centers and rural areas and there is considerable variation among regions. More specifically, 97 per cent of the urban population uses improved sanitary facilities, compared to only 54 per cent in the countryside. In the capital city (Central-2 region) less than 5 per cent of the population *do not* have access to adequate sanitary facilities, while in Northern and Southern regions nearly half of the population has no access.

Data from the MICS-2 survey indicate that 21 per cent of the whole population use flush toilets. Among regions, this percentage ranges from nearly zero in the Northern region and less than 10 per cent in the Southern and Western, to almost half the population in

Central-2. The urban-rural difference is very striking. Only about 2 per cent of the rural population use a flush toilet, whereas in urban areas the figure rises to 42 per cent.

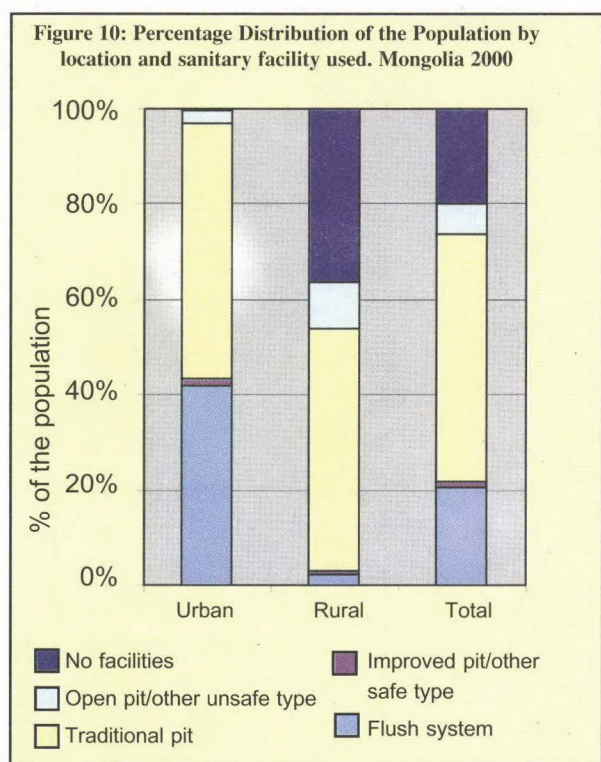


The type of sanitary facilities used is closely associated with housing type and more general living conditions. For example, for urban dwellers who live in apartments or other permanent dwellings with centralized heating, flush toilets are a practical and convenient solution to sanitation needs. For those living in ordinary gers (yurts) or houses, and especially nomadic people who move with their herds two or three times a year, flush toilets are not a



Photo by Giacomo Pirozzi

practical alternative. These population groups commonly use pit latrines. Overall, there is relatively little geographical variation in the use of pit latrines. This type of facility is used by just over half of the population, with little difference between urban and rural locations. Even in the capital city almost of half of the population uses a pit latrine.



It is most common in the Eastern region, where it accounts for about 63 per cent of the total, and least common in the South, where it is used by only 44 per cent. Even in the capital city almost of half of the population uses a pit latrine.

The MICS-2 data show that over one third of the rural population have no toilet facility.

According to the "Living Standard Measurement Survey" in 1998 (NSO/UNDP), about 72 per cent of households in the cities and urban areas live in apartment buildings and houses, while around 22 per cent of the households live

in gers. Also, 51 percent of the households living in the apartment buildings and houses have a connection to a sewage system of such houses is located in Ulaanbaatar and have flush toilets inside their houses. The majority. Eighty percent of the total households have garbage disposal areas and about 50 per cent have sewage pits. About 60 percent of the households have pit latrines. The majority of poor households in the cities and urban areas use pit latrines outside the houses while households with better living standards have more improved sanitation facilities. The availability of adequate garbage disposal is an important necessity to maintain a healthy environment, which will contribute to the health of the population. Poor households, particularly those living in urban settlements, do not have adequate facilities that meet the sanitation requirements.

It is important for city municipalities, aimag and local administrations to plan and implement a set of policies aiming to provide the population with safe drinking water and facilities that meet the sanitation requirements.

D. Child Food and Nutrition

D.1. Nutritional status

Goals. *Global:* Reduction of severe and moderate malnutrition by half of 1990 levels. *National:* Reduction in severe and moderate malnutrition among children under 5 by half of 1990 levels.

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

illnesses, they are able to achieve their growth potential and are considered to be well nourished. Nutritional status is conventionally assessed by comparison with a standard distribution of height and weight for children under the age of 5. For the Child and Development Survey - 2000 (MICS-2), measurements of height and weight were taken for children under 5 in the survey households. These measurements were used to compute 3 standard indicators of nutritional status for each child, from which the proportion of malnourished children in the sample was calculated. The 3 standard indicators of nutritional status are as follows:

- **Underweight (weight for age)** is the best indicator for describing the overall level of malnutrition in a population and for assessing changes over time. Underweight reflects aspects of both stunting and wasting. 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.

- **Stunting (height for age)** means that a child is relatively short compared with the

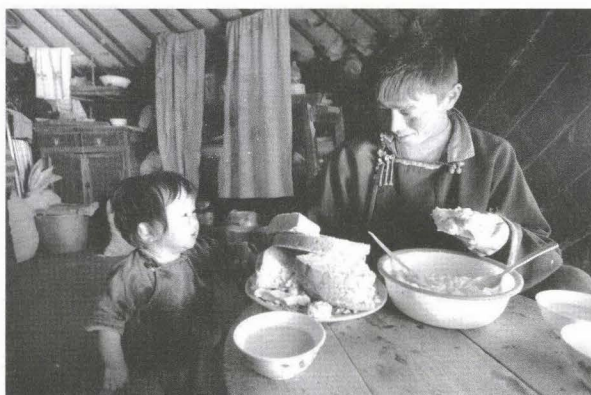


Photo by Giacomo Pirozzi

reference population. Stunting is an indicator of poor growth over time, and is usually associated with chronically insufficient dietary intake, frequent illness and poor feeding practices over a long period. 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 in whom height for age is more than three standard deviations below the median are classified as severely stunted.

- **Wasting (weight for height)** is usually caused by recent nutritional deficiency, and therefore may show significant periodic variation associate with seasonal availability of food or disease prevalence. 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 below the median are severely wasted

The U.S. National Center for Health Statistics (NCHS) standard, recommended by UNICEF and WHO, was used as the reference for determining the nutritional status of children covered by the survey. Two standard deviations below the median value in the NCHS reference population for a given indicator (underweight, stunting or wasting) is defined as moderate malnutrition as measured by that indicator. At 3 standard deviations below the reference median a child is classified as severely malnourished.

Children who were not weighed and measured for height (approximately 4.1 per cent) and whose measurements were outside the plausible range are not included in the calculations. In addition, a small number of children whose birth dates are unknown were excluded.

As shown in Table 15, nearly 13 per cent of the surveyed children under the age of 5 were found to be moderately or severely underweight. The underweight prevalence in rural areas, at 16 per cent, is considerably higher than in urban areas, where the rate is 9 per cent. Among the regions, the underweight prevalence in the Eastern region (21 per cent), is close to twice the national rate, while the lowest levels are found in Central-2 and the Southern regions, with 7 per cent, and 8 per cent respectively. There is no difference in underweight prevalence between boys and girls. The regional pattern varies somewhat for the other 2 indicators, though all types of malnutrition tend to be relatively high in the Eastern, Northern and Western region and lowest in the Southern region and Central-2.

There is a clear correlation between malnutrition in young children and the mother's education. The relationship is especially pronounced with stunting, which is most closely associated with chronic dietary deficiencies and poor feeding practices over a long period. Children whose mothers had only primary schooling or less are 3 times as likely to be stunted

than those whose mothers had university education. The same general pattern holds for underweight and wasting as well. The prevalence of malnutrition also varies with the specific age of the child (Figure 11). In general, malnutrition is at its lowest level in the early months of life, when most children are still being breastfed, and reaches a maximum during the 12-23 month period. Stunting drops sharply in the third year then rises again at the age of 4 and 5. Underweight declines only very gradually after the age of 2, while no particular trend is evident for wasting over the entire 5 years.

D.2. Breastfeeding

Goals. *Global and National:* Empowerment of women to exclusively breastfeed their children for 4-6 months after birth, and continue breastfeeding, with complementary foods, well into the child's second year.

Breastfeeding in the first few years of life protects babies from infection, provides an ideal source of nutrition, and is economically optimal and safe. Nevertheless, many mothers stop

Figure 11: Percentage of Under 5 children who are undernourished. Mongolia 2000

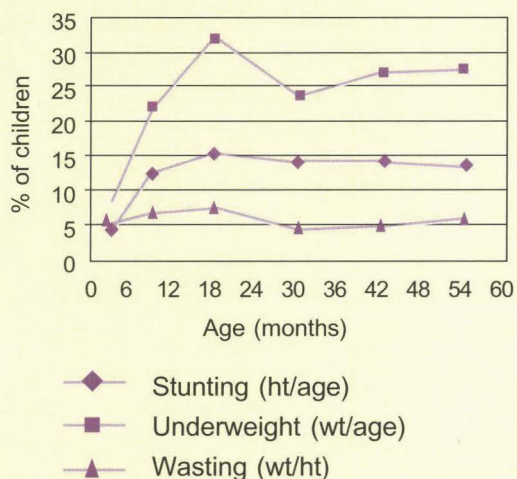
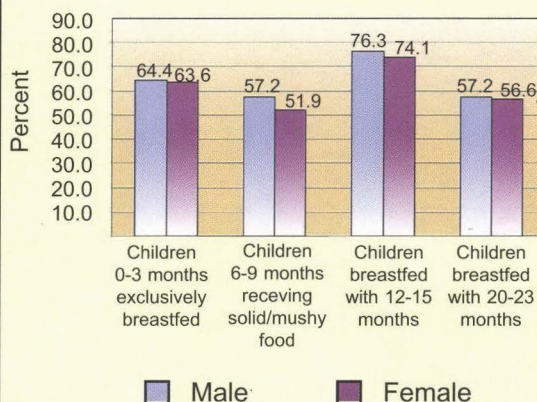


Figure 12: Percent distribution of living children by breastfeeding status. Mongolia 2000



breastfeeding too soon, and this often has a negative influence on the child's health and nutritional status. Bottle feeding with infant formula may be particularly risky if clean drinking water is not readily available. The goal of the World Summit for Children recommends that children should receive only breast milk in their first 4-6 months, and that breastfeeding should continue, along with appropriate complementary foods, well into the second year.

The data in Table 16 are based on information provided by mothers in the survey interviews on children's consumption during the preceding 24 hours. *Exclusive breastfeeding* means that the child has received only breast milk (and possibly vitamins or medicine). *Complementary feeding* refers to children who are given solid or semi-solid food in addition to breast milk. The last 2

columns of Table 16 show the proportion of children who are still being breastfed at the age of 1 and 2 years. Breakdowns by region and mother's educational background are not shown due to the small sample size. For the same reason, the figures on sex and urban-rural residence should be interpreted more cautiously.

Approximately 64 per cent of babies under 4 months were breastfed exclusively, lower than the recommended 100 per cent but significantly higher than the average in many regions of the world. There appears to be little difference between boys and girls, though the rate in rural areas is about 10 points higher than in urban areas. About 54 per cent of children aged 6-9 months were breastfed along with complementary feeding, 75 per cent aged 12-15 months and 57 per cent of children aged 20-23 months were also still being breastfed.

D.3. Salt iodization

Goals. Global: Virtual elimination of iodine deficiency disorders. National: By 1995, carry out prevalence survey of iodine deficiency disorders among the population and initiate corrective action.

A deficiency of dietary iodine is the world's greatest single cause of preventable mental retardation and can cause a reduction in the average intelligence quotient (IQ) in a population of 13 points. Salt iodization is an effective and low-cost way of preventing iodine deficiency disorders (IDD). Adequately iodized salt contains 15 ppm (parts per million) of iodine or more. In the current MICS, interviewers tested household salt for iodine level by means of a testing kit. In more than 99 per cent of households salt was available for testing. The results are shown in Table 17. Overall, 45 per cent of the survey households had adequately iodized salt, but very wide variability was found

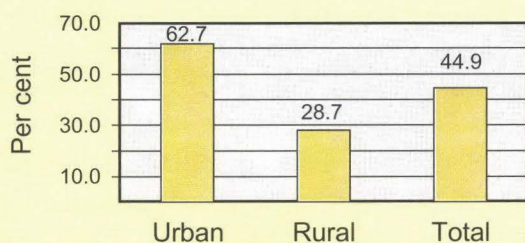




Photo by Giacomo Pirozzi

among regions. In nearly 83 per cent of households in Ulaanbaatar (Central-2) the salt was found to be adequately iodized, but in the Western region this figure was only 17 per cent. Among the other regions the iodization rate ranged between 26 per cent in the Northern region to 63 per cent in the Southern region (Table 17a). For all urban areas the iodization level was about 63 per cent, in comparison to 29 per cent in rural areas.

Figure 13: The consumption level of adequately iodized salt, Mongolia 2000



D.4. Vitamin A supplementation

Goals. *Global:* Virtual elimination of vitamin A deficiency and consequences, including blindness. *National:* By 1995, define prevalence of vitamin A among children under 5, and initiate corrective action as necessary.

Vitamin A deficiency (VAD) impairs a child's immune system, increasing its' chance of dying of common childhood diseases, and can cause eye damage and even blindness in children. It also impairs the health of pregnant and lactating women. Yet VAD can be easily prevented by vitamin "A" supplementation or food fortification. UNICEF and WHO recommend that all countries with an under-five mortality rate greater than 70 per 1000 live births, or where vitamin "A" deficiency is widespread in the population, should establish programs to bring the problem under control. In accordance with recommendations by UNICEF and WHO, the Mongolian Ministry of Health suggests that children aged 6-12 months be given one vitamin A capsule of 100,000 IU every 6 months, and children older than 1 year should get one high dose capsule of 200,000 IU every 6 months.

Within the six months prior to the Child and Development Survey-2000 (MICS-2), about 32 per cent of children aged 6-59 months had been given the high dose vitamin "A" supplement (Table 18). Approximately 10 per cent of others in the age group had received the supplement, but more than 6 months previously, and 54 per cent of children of this age were reported never to have received the supplement. For 3 per cent of the surveyed children, mothers or caretakers reported that the child had received a vitamin "A" supplement at some time in the past, but were not able to give a specific date.

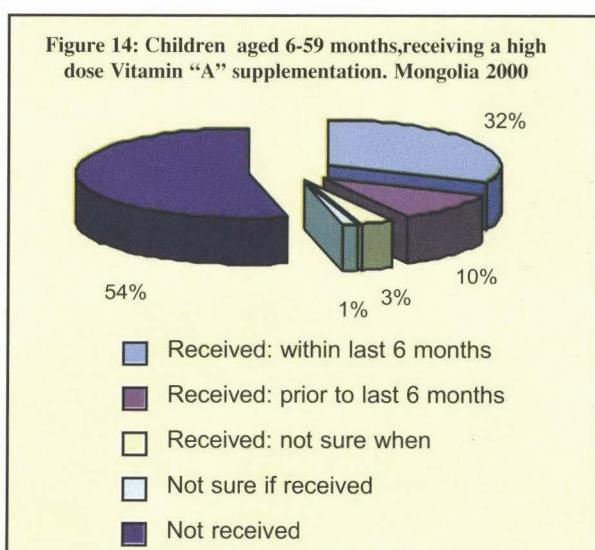
The survey found very little variation among regions in the percentage of children receiving the high dose supplement in the last 6 months, through the rate is significantly higher in the city (37 per cent) than in the countryside (27 per cent). Similarly, 45 per cent of urban children were reported to have received no supplement, while in rural areas this figure was much higher, at about 60 per cent. Regional differences in the propor-

tion of children who had never received a vitamin "A" supplement were also small relatively small. The only exception is the Southern region, where only 46 per cent of children had never received the supplement, compared to between 52 and 56 per cent in other regions.

Survey findings show that about 30 per cent of children aged 6-11 months had received vitamin "A" supplementation in the previous 6 months. This percentage increases to 36 per cent in the second year, then begins to decline, reaching 28 per cent in the fourth and fifth year. There is no clear trend in supplementation associated with the mother or caretaker's education. While the lowest rate (22 per cent) is for women with only a primary education, the supplementation level for all other educational categories shows little variation, from 31 to 34 per cent.

It is interesting to note that in aimag centers every second child received vitamin "A" supplementation, more than in Ulaanbaatar. In Ulaanbaatar and soum centers the vitamin supplementation coverage is 25-28 per cent.

The percentage of children receiving a high



dose of vitamin "A" supplementation within 8 weeks after birth is 13 per cent nation-wide and highest among aimag centre mothers. The percentage of children aged less than 56 days in the twelve months preceding the survey receiving a high dose of vitamin "A" supplementation was 22 per cent in the Central-1 region and in the aimag centers which was the highest rate among the regions. The lowest rate was in the Western region, at 5.6 per cent (Table 19).

D.5. Low Birth Weight

Goals. *Global:* Reduction of the rate of low birth weights (less than 2.5kg) to less than 10%. ***National:*** Reduce the rate of low birth weight from 2% in 2000. And Reduce prevalence of vitamin D deficiency (rickets) 50 % by the year 2000.

Infants who weigh less than 2500 grams (2.5 kg) at birth are classified as low birth weight babies. In order to identify the proportion of low birth weights in the survey sample, two types of information were requested and obtained in interviews with mothers or caretakers. If a health card showing the child's weight at birth was available, or if the mother or caretaker could recall the child's birth weight, this information was recorded. In addition, mothers or caretakers were asked to assess whether the child had been very small, smaller than average, average, larger than average or very large. For children who were weighed at birth, these weights were cross-tabulated with the mother's/caretaker's size assessment to obtain the proportion of births in each size category that were actually recorded as less than 2500 grams. Applying these proportions to the number of unweight children in each size category yielded an estimate of the number of low birth weights among those babies who had not been weighed at birth. This estimate was then added to the

number of babies whose recorded weight was less than 2500 grams to obtain the total number of low birth weight children in the sample, and from this total the percentage of children with low birth weight was calculated.

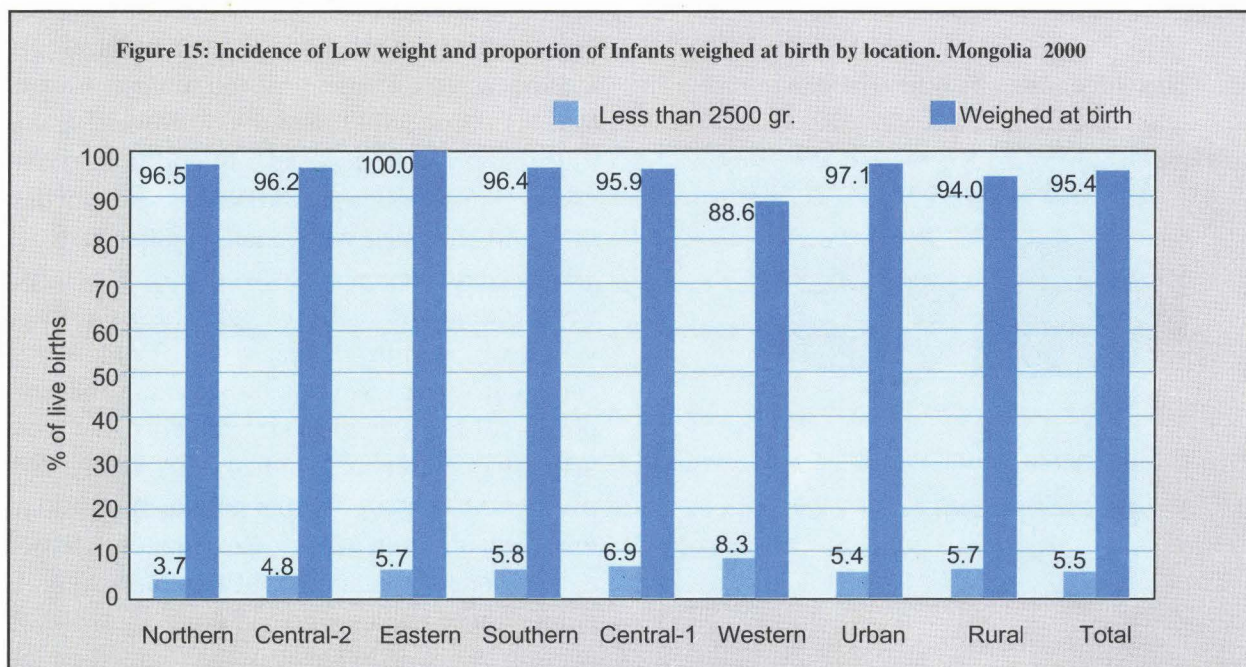
In fact, according to the findings of the survey, more than 95 per cent of the 1515 children born within the 12 months preceding this survey had been weighed at birth, so the estimation procedure described above was actually needed for only a small fraction of the total.

In all, the survey found 5 per cent of newborns with low birth weight (Table 20). There was less than 1 per cent difference between urban and rural, though variations among regions were quite substantial. The Western region shows the highest incidence of low birth weight, at over 8 per cent. The lowest incidence of low birth weight, at 4 per cent, was

found in the Northern region. There is no clear linear pattern according to mother's education level, though mothers with complete secondary school or less are more likely to have a low birth weight baby than better educated women. The number of births on which these statistics are based is relatively small, so caution should be used when interpreting these findings.

In the last few years the living standard of the population has gone down and access to good quality food, that meets health requirements, has been reduced. Poor quality of food and nutrition negatively affects the health of mothers and children. Micronutrient deficiency, particularly a deficiency of vitamin "A" and "D", or iron and iodine deficiency, still remains a most acute health problem in Mongolia. It is important to improve the system of procurement of essential vitamins for mothers and children in the country and to strengthen the control over the implementation.

Figure 15: Incidence of Low weight and proportion of Infants weighed at birth by location. Mongolia 2000



E. Child Health

E.1. Immunization coverage

Goals. Global: Maintenance of high level of immunization coverage (at least 90 % children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, polio-militias, tuberculosis and against tetanus for women of childbearing age. **National:** Achieve 95 % coverage of infants for all antigens.

According to recommendations by UNICEF and WHO, every child should receive first dose of BCG vaccination, within the first 12 months of life, as protection against tuberculosis, 3 doses of DPT vaccine as protection against diphtheria, pertussis (whooping cough) and tetanus, 3 doses of polio vaccine and a measles vaccination. In the current MICS-2 survey, vaccination cards for children under 5 years of age were checked, and information on the type and date of immunizations received was recorded on the questionnaire form. If no vaccination card was available, mothers were asked to provide this information from memory, if possible. Cards were available for about 81 per cent of the children surveyed.

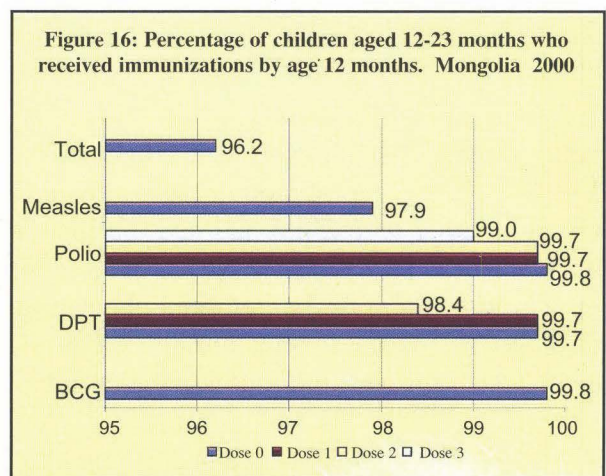
The figures in Table 21 are computed for children aged 12-23 months so only those children who are old enough to be fully vaccinated are counted. The table shows 2 coverage figures for each type of immunization, one based only on information obtained from vaccination cards and the other based on information from cards plus mother's reports in those instances when no card was available.

According to information recorded on

vaccination cards, coverage among surveyed children in the 12-23 month age group was high and very uniform for all vaccines. The figure is 87 per cent for all doses of DPT. BCG coverage was slightly higher, at 90 per cent, and measles was significantly lower than the average, at 82 per cent.

Using information provided by mothers or caretakers in addition to that from vaccination cards, coverage figures rise by 3-5 points for most vaccines. By this calculation the percentages are less uniform across different vaccines, probably indicating that mother's recall is a less reliable source of information than vaccination cards. Measles still has the lowest coverage, at 86 per cent (See Table 21), Polio 3 and DPT 3 are both a little below 90 per cent, and BCG is highest with 96 per cent. Dropout rates, as indicated by declining rates between the first and third doses of DPT and Polio, are very low, considerably less than 1 percentage point according to data from the vaccination cards (Table 22).

We can see from Figure 16 that 96 per cent of children aged 12-23 months had been vaccinated by the first 12 months, within the period recommended by UNICEF and WHO.



In order to cover all children fully by vaccination the Ministry of Health has been organizing a “National Vaccination Day” and, as a result, the coverage of all types of vaccination has been increasing year by year. Moreover, special attention has been given to storage, protection, transportation and provision and appropriate measures were taken in these areas. As a result Mongolia has become one of the countries where child illness has been declining and no cases of polio have been reported. There are no significant differences in the level of coverage of any vaccination from region to region or according to residence. Similarly, there is no significant difference by mother’s educational level.

E.2. Diarrhea

Goals. Global: Reduction by 50% in deaths due to diarrhea, and 25 % reduction of the diarrhea incidence rate, in children under 5 years. National: Reduce incidence by 50%.

Dehydration caused by diarrhea is still a major cause of mortality among children in Mongolia. Home management of diarrhea - either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - could prevent many of these deaths. Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhea. In the MICS-2 questionnaire, mothers were asked to report whether their child had had diarrhea in the two weeks prior to the survey. If so, a series of additional questions were asked about what the child had to eat and drink during the episode and whether this was more or less than usual.

Overall, 8 per cent of the under-5 children

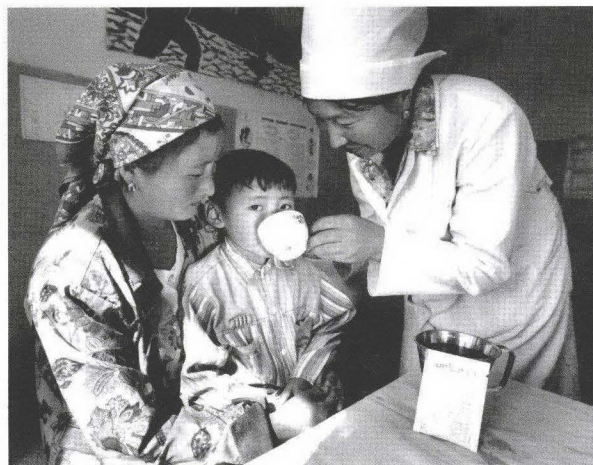


Photo by Giacomo Pirozzi

covered by the survey had diarrhea in the 2 weeks prior to the survey (Table 23). The highest incidence, about 14 per cent, occurred among children aged 12-23 months. This is a common pattern, as this is normally the age at which children are weaned. Among regions, the Northern region had a much lower incidence of childhood diarrhea, at just under 4 per cent, than any other, while the highest incidence was found in Western (nearly 12 per cent) and Southern region (10 per cent). Urban areas had a somewhat higher rate than rural areas, at 9 per cent and 7 per cent, respectively.

Table 23 also shows the percentage of children receiving various kinds of home treatment during the diarrhea episode. Note that multiple answers were accepted, so percentages do not add to 100. In addition, the number of diarrhea cases in many of these categories is quite small, and should be interpreted cautiously. Overall, 98 per cent of the diarrhea cases received one or more recommended forms of treatment. More than 60 per cent of children with diarrhea were fed breast milk and 56 per cent were given packaged ORS.

The recommendation to continue feeding during an episode of diarrhea seems to be gen-

erally accepted in Mongolia. Nearly three-quarters of children with diarrhea were fed about the same or more than usual (Table 24). Increasing the child's intake of fluids appears to be a less common practice. Only 41 per cent of mothers reported their child drank more during diarrhea episodes, and 53 per cent said they drank less. The most appropriate treatment, which is to drink increased fluids and to continue eating, was reported in only 32 per cent of the cases.

E.3. Acute Respiratory Infection

*Goals. Global: Reduction by one third in the deaths due to acute respiratory infections in children under 5 years.
National: Reduce by 38%.*

Acute lower respiratory infection (ARI), particularly pneumonia, is one of the leading causes of child deaths in Mongolia. In the MICS-2 questionnaire children with acute respiratory infection were defined as those who were ill with a cough accompanied by rapid or difficult breathing and whose symptoms were due to a problem in the chest, or both the chest and a blocked nose. Survey data show that only 143 cases of ARI were reported to have occurred in the 2 weeks

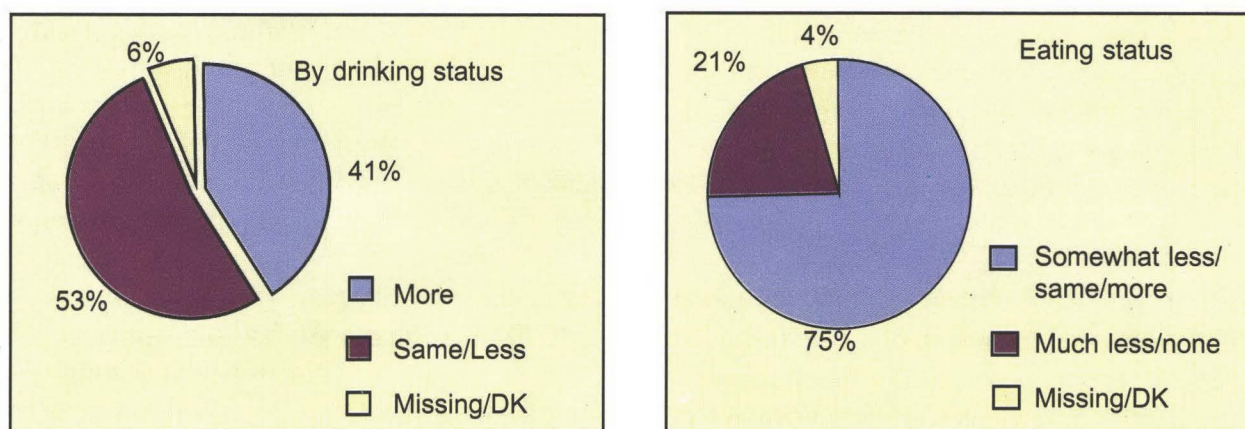
preceding the interview, which represents about 2 per cent of children under five (Table 25). About 78 per cent of these cases were taken for treatment to an appropriate health provider, in most instances a hospital or health center. Given the very small number of cases, more detailed breakdowns by region, mother's education, etc., would not be meaningful.

E.4. Integrated Management of Childhood Illnesses

The Integrated Management of Childhood Illnesses (IMCI) is a program developed by UNICEF and WHO that combines strategies for the control and treatment of the five major killers of children, acute lower respiratory tract infections, diarrhea, malaria, measles and malnutrition. The program focuses on the improvement of family and community practices in the prevention and early management of childhood illnesses. The IMCI approach teaches that appropriate home management of any of these major illnesses includes giving more fluids and continuing to feed sick children as they are normally fed.

Table 26 presents information on the

Figure 17: Percentage of children aged under 5, with diarrhea in the 2 weeks prior to the survey, by drinking and eating status. Mongolia 2000



reported drinking and eating behavior of sick children under the age of 5. About 15 per cent of the under-5 year olds in the sample were reported to have had diarrhea or some other illness in the two weeks prior to the survey. As was noted in the earlier section on diarrhea, children with any kind of illness tend to be fed more or less as usual (about 78 per cent), but the recommended practice of giving additional fluids is much less common (40 per cent). Both eating and drinking during illness vary by age. Less than 20 per cent of children aged less than 6 months old are given more than usual to drink, whereas the percentage among older children ranges from 35 to 50 per cent. On the other hand, a larger percentage of younger children tend to eat more during illness than older children. The IMCI recommendation that sick children should receive increased fluids and continue to eat as usual was followed in only 30 per cent of cases covered in the MICS-2 survey. There is relatively little variation across regions, or between urban-rural locations, and mother's educational level. The most notable exception is for children under the age of 6 months, where the percentage reported to be receiving both more fluids and continued feeding, is only half

of the percentage overall (under 16 per cent and 30 percent respectively). If this is a true reflection of reality it is a matter of considerable concern. However, this finding may be due at least in part to uncertainty about the terms "eating" and "drinking" when infants are being breastfed.

Promoting knowledge among caretakers about when it is appropriate to seek medical care for children who are ill is another important component of the IMCI program. In the Child and Development Survey - 2000 (MICS-2), mothers and other caretakers were asked to name the symptoms that would cause them to take their children to a health facility immediately. The most common response, given by 58 per cent of mothers, was that a fever would be sufficient cause to take a child for professional treatment (Table 27). Another reason for seeking professional treatment, mentioned by 47 per cent of mothers, was if the child became increasingly sick. But while roughly half of the mothers or caretakers in the survey were able to properly identify one appropriate cause for taking a sick child for professional treatment, only 38 per cent were able to name two such

Figure 18: Percentage of children aged under 5, with ARI and treatment by health providers. Mongolia 2000

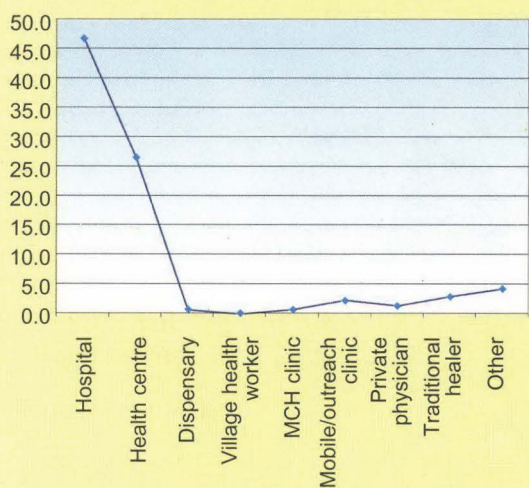
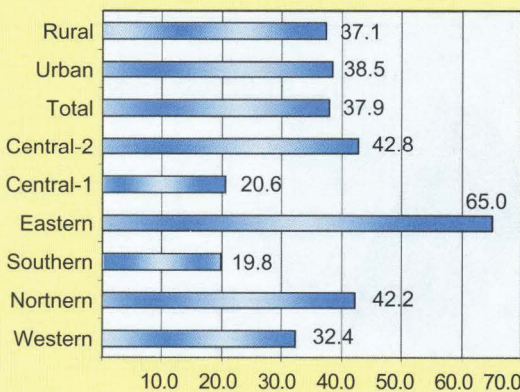
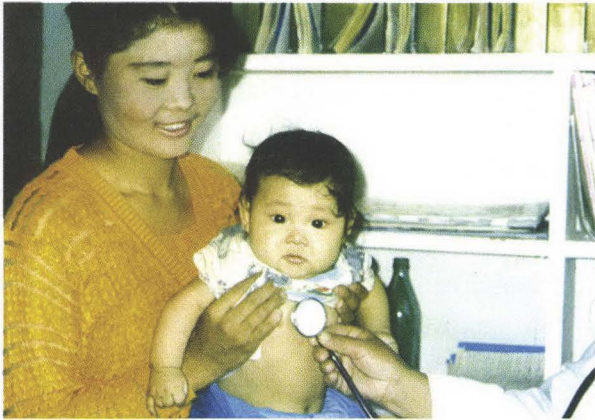


Figure 19: Percentage of caretakers of children under 5 years, who know at least 2 signs for seeking care immediately. Mongolia 2000





causes. This varies somewhat by mother's education, though the association is not as clear or as strong as might be expected. There are very striking differences among regions on this indicator, with about 20 per cent in Southern and Central-1 regions knowing at least 2 symptoms, as compared with more than 40 per cent in Northern and Central-1 regions and 65 per cent in the Eastern region. There is very little difference between urban and rural.

Parents and caretakers do not have sufficient knowledge to take care of sick children at home and their health seeking behavior is low. Not all soums have creches, and 48 per cent of aimags have no day care centers for children. This situation has contributed to the increase of child mortality and child morbidity.

F. HIV/AIDS

F.1. AIDS knowledge

One of the most important strategies for reducing the rate of HIV/AIDS infection is to propagate accurate knowledge of how AIDS is transmitted and how to prevent the spread of HIV infection in the population. The Child and Development Survey - 2000 (MICS-2) found

that 94 per cent of Mongolian women aged 15-49 years have heard about AIDS (Table 30). This proportion represents about 98 per cent in urban centers and just under 91 per cent in rural areas. It varies somewhat among regions, with the lowest level, at 89 per cent, in Northern and Southern regions, and the highest level (99 per cent) in Central-2. Among age categories, the lowest percentage that has ever heard of AIDS is in the group 15-19 years of age, at about 90 per cent.

During the survey all women aged 15-49 were presented with several statements about ways of preventing HIV/AIDS infection and were asked whether they believed them to be true or false. Eighty-two per cent of women believe that having only one uninfected sex partner can prevent HIV infection, while 80 per cent believe that always using a condom during sexual intercourse is an effective prevention measure. Three out of 4 women were able to identify both statements as effective ways of preventing HIV infection (Table 30a). Accurate knowledge about the means of preventing HIV/AIDS transmission is significantly higher among urban women. Women in the youngest age group were the least well informed, with only two-thirds in this group knowing both methods of prevention. There is a fairly consistent increase in knowledge as women's education increases. Between 43-58 per cent of those with only primary education or less, and 70 per cent with lower secondary education, knew both of the main ways of preventing HIV transmission, while among better educated women the percentage ranges between 77 and 86 per cent.

There are many misconceptions about AIDS transmission, and in the survey women were asked to indicate whether or not they believed the following statements:

- AIDS can't be transmitted by supernatural means.

- AIDS can't be transmitted by mosquito bites.
- A healthy-looking person may be infected with AIDS.

Over three-quarters (76 per cent) of the women agreed with statement 1, 58 per cent agreed with statement 2 and 56 per cent agreed with statement 3 (Table 31). The responses show considerable variation across the different regions, between urban and rural residents, and most of all among different educational levels. The proportion able to identify all 3 misconceptions (that is, those who agreed with all of the statements) ranged from 24 per cent in the Southern region to 43 per cent in Central-2, a range of nearly 20 points. The figures for urban and rural women were 43 per cent and 31 per cent, respectively. Those with little or no formal education were much more likely to accept the misconceptions about HIV/AIDS transmission than women with higher levels of education. At the lowest level, (no education or only primary schooling), only 27 per cent correctly identified all 3 misconceptions, as compared with 50 per cent for women with university education. There appears to be little association between age and knowledge about HIV/AIDS, as roughly 36 per cent of all age groups were able to respond correctly concerning all 3 misconceptions.

Table 32 presents data on women's knowledge about AIDS transmission from mother to child. When asked if AIDS can be transmitted from mother to child, 69 per cent of women in the 15-49 age group correctly responded "Yes". Women's education is closely associated with this knowledge, with increasing percentages knowing the correct answer as educational level increases. The percentage knowing that mother-to-child AIDS transmission is possible is about 5 points higher in urban areas than in rural places. The fact that a majority of urban women

know about AIDS transmission and three means of preventing transmission, could be a result of the greater access that urban women have to radio, TV, mass media etc. which provide learning opportunities.

When asked specifically how this transmission can take place, 58 per cent said that transmission during pregnancy was possible, 55 per cent said that transmission at delivery was possible, but only one woman in 3 knew that AIDS could be transmitted from mother to child through breast milk. Only 27 per cent of these women knew all 3 modes of transmission. In general, women aged 30 and above were more likely to know about mother-to-child transmission than younger women, and more education is associated with a greater likelihood of knowing, but in neither case is the relationship very dramatic. At the other end of the spectrum, 34 per cent of the respondents did not know of any specific way in which AIDS could be transmitted from mother to child. On this indicator, the percentage of rural women was significantly higher than for urban women, with 38 and 32 per cent respectively. Nearly half (47 per cent) of young women in the 15-19 age group did not know any mode of transmission, and more than 50 per cent of those with primary education or less did not know. Among regions, the percentage varies between 28 in the Western to 44 in the Northern region.

The MICS-2 survey also attempted to measure discriminatory attitudes towards people living with HIV/AIDS. To this end, respondents were asked whether they agreed with two questions. The first asked whether a teacher who has the HIV virus but is not sick should be allowed to continue teaching in school. The second question asked whether the respondent would buy food from a shopkeeper or food seller whom the respondent knew to be infected with

HIV or AIDS. The results are presented in Table 33. Forty-one per cent of women aged between 15-49 years of age believe that a teacher with HIV/AIDS should not be allowed to work and 14 per cent would not buy food from a person infected with AIDS. Overall 43 per cent of women agree with one or both of the conditions, while 57 per cent agree with neither. The highest percentages of those who believe that a teacher with HIV should not be allowed to work are found in the Central-2 region (53 per cent) and among women with the highest level of education (62 per cent). The same two categories have the highest percentages that would not buy food from a person with AIDS, 22 per cent in Ulaanbaatar (Central-2 region) and 27 per cent for women with a university education. In general, rural dwellers appear to be less prone to discriminatory attitudes than those living in urban areas. Only 46 per cent in the urban category agreed with neither discriminatory statement, while 2 out of 3 in rural areas agreed with neither. Similarly, women with the least education were much more likely to disagree with both discriminatory statements than those who were better educated.

The overall level of knowledge about HIV/AIDS among Mongolian women is reflected in

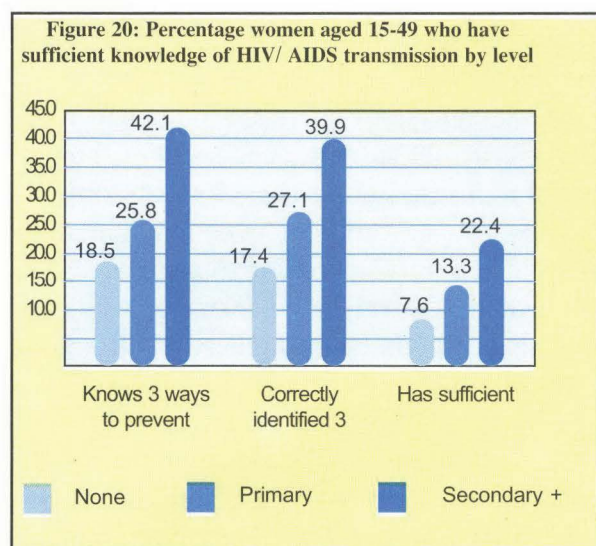


Table 34, which summarizes information from Tables 30 to 31. Table 34 shows that 38 per cent of women of reproductive age know 3 main methods to prevent HIV transmission and 36 per cent can correctly identify 3 misconceptions about AIDS transmission. "Sufficient" knowledge of HIV/AIDS transmission is defined as giving the correct response to all 6 items about prevention and transmission. The proportion of women who responded correctly on all 6 items is only 20 per cent. On this indicator, urban women are twice as likely as rural women to have "sufficient" knowledge, and better educated women are generally more likely to be knowledgeable than those with less education. There are no striking differences among the various age groups but on a regional basis, Central-2 with 28 per cent and the Western region with 20 per cent are places where women are much more likely to be knowledgeable about HIV/AIDS than those living in the Southern region. The knowledge level in each of the other 3 regions is the same for all three, at between 16 and 17 per cent.

F.2. AIDS Testing

Voluntary testing for AIDS, accompanied by counseling, allows those infected to seek health care and to prevent the infection of others. Testing is particularly important for pregnant women who can then take steps to prevent infecting their babies. The indicators shown in Table 35 are designed to monitor whether women are aware of places to get tested for HIV/AIDS, the extent to which they have been tested, and the extent to which those tested have been told the results of the test. In some places, a relatively large proportion of people who are tested do not return to get their results due to fear of having the disease, fear that their privacy will be violated, or other reasons. In Mongolia, more than half of the women surveyed (54 per cent) know where they can be

tested for AIDS, and 14 per cent have actually been tested. Of those tested, a large majority has been given the result. Knowledge of where to be tested is much greater in cities (67 per cent) than in rural places (42 per cent), and much higher among well-educated women (nearly 80 per cent for university women) than among those with less education (roughly 1 in 3 for those with primary school or less). The percentage of women under the age of 20 who know where to be tested for HIV/AIDS, which is about 40 per cent, is substantially lower than the 55-60 per cent figures for older groups.

Women who have actually been tested are much more likely to have at least a completed secondary education and to live in urban areas. Among regions, women living in Central-2 are 5-6 times more likely to have been tested than those living in the Western or Northern region. There is substantial variation in the proportion of those tested who have been given the results, ranging from as high as 91 per cent in Ulaanbaatar to as low as 61 per cent among women with primary schooling.

G. Reproductive Health

G.1. Contraception

Goals. Global: Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many. National: Organize consulting services on sexual life, birth spacing, and family planning. Organize educational courses, intended to reach young girls and all couples in need of guidance, on preventing early and undesired pregnancies; to increase the percentage of women using effective contraception.

One of the key objectives of the Child and Development Survey (MICS-2) was to analyze the reproductive health situation. Questions, related to the use of contraceptives, care during pregnancy, and prenatal care were asked from women of reproductive age who were married or living with a partner.

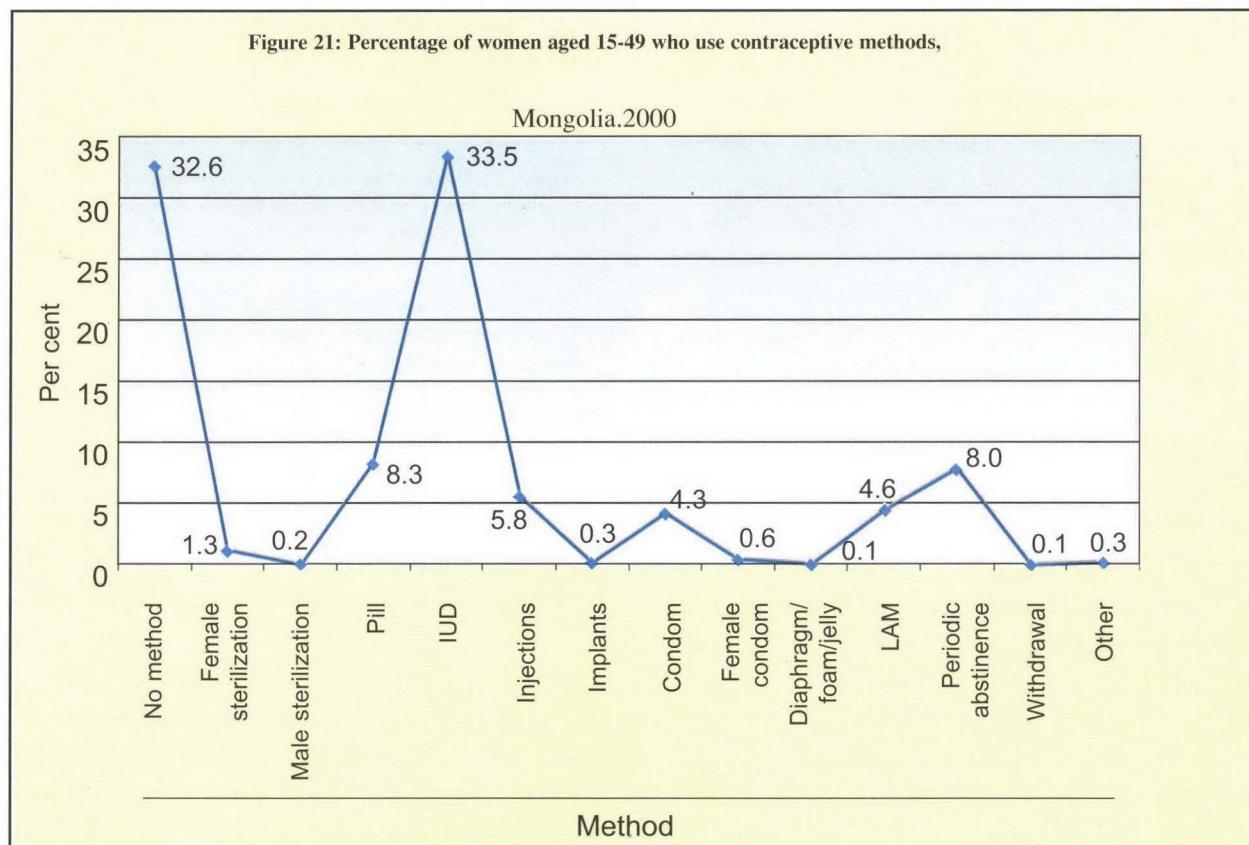
Current use of some kind of contraception was reported by 2 out of 3 of the surveyed women who are married or living with a partner (Table 36). By far the most popular method is IUD used by 34 per cent of these women. The pill was the second most common choice among modern methods, but only at about 8 per cent while injections were reported used by about 6 per cent.

Almost 61 per cent of married women or women in union, aged between 15-49, reported using a contraceptive method of whom 54 per cent had used a modern contraceptive method and 13 per cent had used traditional methods. About 33 per cent of the surveyed women in the above category didn't use any contraceptive method. In rural areas, especially, modern contraceptive methods were not commonly used.

The use of any modern contraceptive method varies relatively little across background categories, the main exceptions being the relatively low percentages in women with the least education. There are much wider differences among groups using traditional methods. Interestingly, the use of any traditional method is significantly more common in urban areas than in rural places, at 16 per cent and 10 per cent respectively, the percentage using traditional methods being highest of all among women with a university education.

According to the Reproductive Health Survey 1998¹³⁾ conducted by the National Statistical Office, covering 6000 households, contra-

Figure 21: Percentage of women aged 15-49 who use contraceptive methods,



ceptive use was highest among married women of reproductive age. The current MICS-2 survey revealed that 84 of reproductive age women use some contraceptive method, and among these 74 percent reported that they use modern contraceptive methods. The most common method was IUD and more than half of women-respondents (56 per cent) said that they use IUD. The next popular method was condoms (29 per cent) and the pill (22 per cent). These two surveys both show that among the most popular methods are IUD and pills, although the figures with reference to condoms are different.

G.2. Prenatal care

Quality prenatal care can contribute to the prevention of maternal mortality by detecting and managing potential complications and risk factors,

including pre-eclampsia, anemia, and sexually transmitted diseases. Prenatal care also provides opportunities for women to learn the danger signs of pregnancy and delivery, to be immunized against tetanus, to learn about infant care, and to be treated for existing conditions, such as anemia.

The MICS-2 survey found that 97 per cent of the 1515 women of reproductive age who gave birth in the year prior to the survey received prenatal care from professional medical practitioners (Table 38). Of these practitioners, 91 per cent were doctors and 5 per cent were fieldshers (community health workers), midwives or nurses. Over all geographic and educational categories, doctors provided prenatal care in 85-95 per cent of pregnancies, and some form of skilled professional assistance was provided in 90 per cent or more of the cases.

G.3. Assistance at delivery

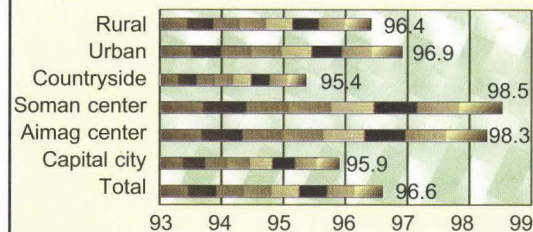
Goals. *Global:* Access by all pregnant women to pre-natal care, trained attendants during child birth and referral facilities for high-risk pregnancies and obstetric emergencies. ***National:*** 75 % of pregnant women with pre-natal care during the first trimester of pregnancy, 100% deliveries supervised by doctors and midwives.

The provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and children through the use of technically appropriate procedures and by accurate and speedy diagnosis and treatment of complications. Table 39 presents the survey's findings on assistance during delivery. Again, the respondents were those women, aged 15-49, who had given birth in the previous 12 months, of whom 97 per cent had antenatal care.

As with antenatal care, the proportion of births assisted by skilled medical personnel is very high. Across virtually all-geographic and educational categories, the figure is 95 per cent or more. The only significant exception is the very small group of women with no formal schooling, with only 80 per cent of deliveries assisted by skilled personnel. However, this educational category includes only 10 births, so the finding may not be significant. Skilled assistance at delivery is assistance provided by a doctor, nurse or midwife. Skilled personnel delivered about 97 per cent of births occurring in the 12 months prior to the MICS-2 survey. There are considerable differences among regions and between urban and rural locations. Two-thirds or more of obstetric cases in Central-1 and Central-2 regions, and roughly half in Western, Northern and Eastern regions, were attended by doctors, but, in the Southern region, doctors provided assistance in only 38 per cent

of the cases. Doctors attend two out of 3 urban deliveries as compared with 53 per cent (just over half) in the countryside.

Figure 22: Percent distribution of women who gave birth in the year prior to the survey by type of personnel assisting at delivery. Mongolia 2000



Accessibility, availability and quality of prenatal and postnatal care are not sufficient in the country, especially in terms of rural health services. Mongolia is still among the countries with high maternal mortality. Causes of maternal mortality are pre-eclampsia, post-pregnancy toxication, other diseases combined with pregnancy, and bleeding, infection etc. The supply of essential drugs is not enough, and the drug management system and the supply and service system do not meet modern requirements.

H. Child Rights and Children in difficult circumstances

Goals. *Global:* Improved protection of children in especially difficult circumstances, ***National:*** Formulate legislation to increase social service coverage for families & children.

H.1. Birth Registration

The Convention on the Rights of the Child emphasizes the right of every child to a name

and a nationality and to the right of protection from being deprived of his or her identity. Birth registration is a fundamental basis for securing these rights. Data from the Child and Development Survey (MICS-2) revealed that about 98 per cent of children aged 0-59 months have been registered (Table 40). There is very little variation across sex, region, urban-rural residence or educational categories. The survey findings do indicate, however, that a significant proportion of children are not registered at or soon after birth. Only 85 per cent of children under 6 months of age were found to be registered. But this delay is not prolonged; for children aged 2 and above, essentially all (99+ per cent) have been registered.

H.2. Orphans and neglected children

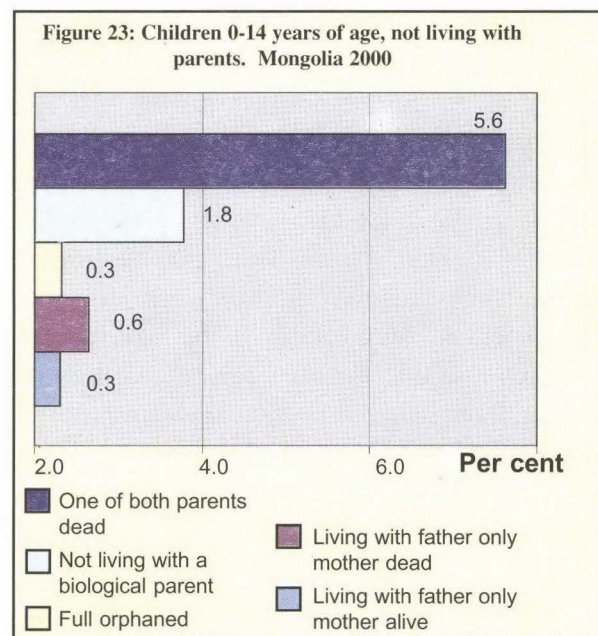
Children who are orphaned or neglected by their parents may be at increased risk of impoverishment, discrimination, denial of property or inheritance rights, or may be subject to various forms of abuse, neglect, and exploitation.



Photo by Giacomo Pirozzi

Monitoring the level of orphanhood and the living arrangements of children assists in identifying those who may be at risk and in tracking changes over time. In Mongolia, of 12,806 children, aged 0-14, who are covered by the survey, 80 per cent are living with both biological parents, and less than 2 per cent do not live with a biological parent (Table 41). In

the case of the 17 per cent of children living with only one parent, it is much more likely that this parent will be the mother. Sixteen per cent of children are living with their mother only. Among these, the fathers of 4 per cent of the children are dead, while the fathers of 12 per cent are still alive. By contrast, the mothers of only 0.3 per cent of the children who are living only with their father, are still alive. The incidence of orphaned children aged 5-9 is 0.1 per cent, rising to about 0.7 per cent for children aged 10-14. According to the findings of the survey, 0.3 per cent of children under 5 years are fully orphaned.



H.3. Child Labor

It is important to monitor the extent to which children work and the type of work they do, for several reasons. Children who are working are less likely to attend school and more likely to drop out. They can be trapped in a cycle of poverty and disadvantage from an early age. Conditions of labor for children are often unregulated, with few safeguards against

potential abuse. In addition, many types of work are hazardous, including jobs involving exposure to chemicals and those requiring the lifting of heavy weights.

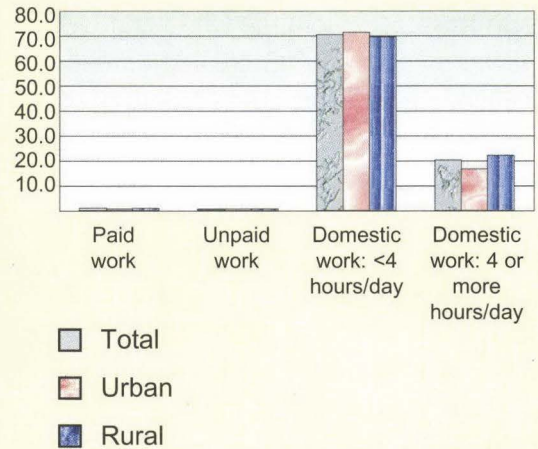


Photo by Giacomo Pirozzi

Data gathered in the current MICS-2 survey on the number of children aged 5-14 who were working, and on some of the characteristics of that work, are presented in Table 42. The survey finds that nearly all children help out with domestic work. However, for 70 per cent of the children, this type of work requires less than 4 hours per day, though for about 20 per cent, domestic work was reported to require 4 or more hours per day.

Overall, the survey estimates that 1.4 per cent of children between 5 and 14 years of age are engaged in paid or unpaid work for someone other than a household member. There are some differences among regions, with paid work for children in the Eastern region and in soum centers nationwide at more than twice the level for the country as a whole. Older children, aged 10-14, are much more likely to be involved in paid work than those in the younger age group. For domestic work requiring less than 4 hours per day there appear to be no major geographical differences, though a greater than average proportion of children in the Southern region are engaged in this category of work, and in the

Figure 24: Percentage of children 5-14 years who are working, Mongolia 2000



Western region the proportion is somewhat lower than average. There is more variability for domestic work of 4 or more hours per day, which involves relatively small percentages of children in the Southern and Central-2 regions and significantly larger than average percentages in the Western and Eastern regions. Children aged 10-14 are much more likely to be working for 4 or more hours per day than are the younger children.

As much as 70 percent of all children doing paid work for someone other than a household member, are in rural areas, out of which 35 per cent work with the livestock and 20 per cent work on the farm.



The estimation of the sample size for MICS, in Mongolia 2000

	Immunization coverage, children aged between 12-23 months				Vitamin "A" supplement	Iodized salt consumption of household	Use of ORT(1) in diarrhoeo, U5 yrs	Percentage of children with low weight. U5 yrs	School enrolment / 5-9 yrs/	Safe water / pop/	Sanitation /pop/
	DPT3	Measles	OPV3	BCG							
Target group, thous	42.5	42.5	42.5	42.5	84.3	535.3		15.0	140		
Percent of population	1.9	1.9	1.9	1.9	3.7	23.4	50.0		6.1	51.9	82.0
Population, thous	2290.8	2290.8	2290.8	2290.8	2290.8	2290.8			2290.8	2290.8	2290.8
<i>Key indicator</i>					0.23			0.92			
Prevalence	0.9	0.9	0.9	0.9	1.75	0.32	0.92	2	0.92	0.92	0.92
Design effect	3	3	3	3	4.3	2	2	4.3	2	2	2
Average household size	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3
Sample size	5985	5985	5985	5985	3463	766	121	404	990	117	74
Total of sample size	5985										

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APPENDIX B

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Table 1: Number of households and women, and response rates, Mongolia, 2000

	By location		Total
	Urban	Rural	
Sampled households	2925	3075	6000
Occupied households	2925	3075	6000
Completed households	2925	3075	6000
Household response rate	100	100	100
Eligible women	4199	4407	8606
Interviewed women	3993	4264	8257
Women response rate	95.1	96.8	95.9
Children under 5	2711	3488	6199
Interviewed children under 5	2703	3481	6184
Child response rate	99.7	99.8	99.8

Table 3: Percentage of cases missing information for selected questions, Mongolia, 2000

	Reference population	Percent missing	Number
Level of education	Household members	8,3	21230
Year of education	Household members	0,1	21230
Number of hours worked	Working child age 15-14	-	146
Complete birth date	Women 15-49	0,1	8257
Ever been tested for HIV	Women 15-49	0,1	7769
Complete birth date	Children under 5	-	6184
Diarrhoea in last 2 weeks	Children under 5	0,1	6184
Weight	Children under 5	4,1	6184
Height	Children under 5	4,1	6184

Table 2: Single year age distribution of household population by sex, Mongolia, 2000

Age					continue				
	Male		Female		Age	Male		Female	
	No	%	No	%		No	%	No	%
0	721	5.1	698	4.4	36	207	1.5	224	1.4
1	629	4.5	629	4.0	37	237	1.7	208	1.3
2	612	4.3	581	3.7	38	190	1.3	164	1.0
3	563	4.0	559	3.5	39	138	1.0	156	1.0
4	630	4.5	576	3.6	40	188	1.3	168	1.1
5	333	2.4	303	1.9	41	113	0.8	117	0.7
6	345	2.4	303	1.9	42	127	0.9	129	0.8
7	340	2.4	340	2.1	43	106	0.8	118	0.7
8	332	2.3	366	2.3	44	82	0.6	125	0.8
9	380	2.7	334	2.1	45	111	0.8	121	0.8
10	365	2.6	337	2.1	46	84	0.6	85	0.5
11	308	2.2	327	2.1	47	60	0.4	68	0.4
12	298	2.1	315	2.0	48	73	0.5	88	0.6
13	325	2.3	326	2.1	49	74	0.5	44	0.3
14	298	2.1	333	2.1	50	86	0.6	88	0.6
15	287	2.0	353	2.2	51	47	0.3	46	0.3
16	244	1.7	305	1.9	52	57	0.4	56	0.4
17	202	1.4	281	1.8	53	59	0.4	37	0.2
18	228	1.6	319	2.0	54	49	0.3	45	0.3
19	200	1.4	297	1.9	55	47	0.3	47	0.3
20	202	1.4	370	2.3	56	31	0.2	37	0.2
21	175	1.2	365	2.3	57	37	0.3	42	0.3
22	221	1.6	348	2.2	58	35	0.2	54	0.3
23	190	1.3	355	2.2	59	42	0.3	31	0.2
24	239	1.7	413	2.6	60	55	0.4	51	0.3
25	331	2.3	459	2.9	61	23	0.2	15	0.1
26	287	2.0	385	2.4	62	33	0.2	32	0.2
27	291	2.1	368	2.3	63	30	0.2	31	0.2
28	269	1.9	346	2.2	64	18	0.1	20	0.1
29	262	1.9	305	1.9	65	37	0.3	28	0.2
30	326	2.3	354	2.2	66	18	0.1	18	0.1
31	253	1.8	240	1.5	67	17	0.1	18	0.1
32	241	1.7	270	1.7	68	19	0.1	20	0.1
33	216	1.5	243	1.5	69	16	0.1	18	0.1
34	197	1.4	209	1.3	70+	89	0.6	151	1.0
35	155	1.1	206	1.3	Total	14130	100	15818	100

Table 4: Percent distribution of households by background characteristics. Mongolia, 2000

		Percent	Number
Region	Western	18,2	1090
	Northern	22,5	1350
	Southern	7,3	435
	Eastern	8,8	530
	Central-1	15,8	950
	Central-2	27,4	1645
Household location	Capital city	27,4	1645
	Aimags center	21,3	1280
	Soman center	17,7	1059
Residence	Countryside	33,6	2016
	Urban	48,8	2925
Number of HH members	Rural	51,2	3075
	1		7
	2-3	20,3	1215
	4-5	47,9	2874
	6-7	21,9	1312
	8-9	7,4	441
	10+	2,5	151
Total		100	6000

Table 4a: Percent distribution of households by background characteristics. Mongolia, 2000.

		Area		Total	
		Urban	Rural	Percent	Number
Region	Western	25,7	74,3	18,2	1090
	Northern	17,4	82,6	22,5	1350
	Southern	27,8	72,2	7,3	435
	Eastern	34,0	66,0	8,8	530
	Central-1	48,8	51,2	15,8	950
	Central-2	100		27,4	1645
Number of HH members	1	48,8	51,2	-	7
	2-3	46,4	53,6	20,3	1215
	4-5	57,9	42,1	47,9	2874
	6-7	47,8	52,2	21,9	1312
	8-9	66,3	33,7	7,4	441
	10+	48,6	51,4	2,5	151
At least one child age < 5		2205	2552	79,3	4757
At least one child age < 15		2730	2976	95,1	5706
At least one woman age 15-49		2887	3054	99,0	5941
Total		2925	3075	100	6000

Table 5: Percent distribution of women 15-49 by background characteristics. Mongolia, 2000

		Percent	Number
Region	Western	17,9	1475
	Northern	21,6	1784
	Southern	6,9	570
	Eastern	9,9	821
	Central-1	16,3	1342
	Central-2	27,4	2265
Household location	Capital city	27,4	2265
	Aimag center	20,9	1728
	Soman center	18,2	1502
Residence	Countryside	33,5	2762
	Urban	48,4	3993
	Rural	51,6	4264
Age group	15-19	16,9	1394
	20-24	21,6	1784
	25-29	21,4	1767
	30-34	16,1	1326
	35-39	11,5	949
	40-44	7,9	649
Marital status	45-49	4,7	388
	Currently married	60,4	4990
	Formerly married	14,1	1161
Ever given birth	Never married	25,5	2106
	Yes	76,4	6309
	No	23,6	1948
Woman's education level	None	1,1	92
	Primary	9,2	759
	Non-Completed	25,4	2099
	Secondary	31,3	2582
	Completed Secondary	31,3	2582
	Vocational	9,2	760
	Vocational training and College	12,2	1008
	Higher	10,3	849
	Missing/DK	1,3	108
Total	100	8257	

Table 6: Percent distribution of children under 5 by background characteristics. Mongolia, 2000

		Percent	Number
Region	Western	19,2	1186
	Northern	25,8	1598
	Southern	7,0	430
	Eastern	9,3	575
	Central-1	14,6	903
	Central-2	24,1	1492
Household location	Capital city	24,1	1492
	Aimag center	19,6	1211
	Soman center	18,6	1152
Residence	Countryside	37,7	2329
	Urban	43,7	2703
	Rural	56,3	3481
Age group	< 6 months	10,6	656
	6-11 months	11,4	708
	12-23 months	20,3	1255
	24-35 months	19,3	1193
	36-47 months	18,3	1131
	48-59 months	20,1	1241
Sex	Male	50,9	3150
	Female	49,1	3034
	None	0,8	48
Mother's education level	Primary	5,1	313
	Non-Completed	26,6	1645
	Secondary	33,4	2064
	Completed Secondary	33,4	2064
	Vocational	10,5	648
	Vocational training and College	13,2	818
	Higher	9,7	599
	Missing/DK	0,8	49
Total	100	6184	

Table 7: Mean number of children ever born (CEB) and proportion dead by mother's age. Mongolia, 2000

By age group	Mean number of CEB	Proportion dead	Number of women
15-19	0.128	0.022	1394
20-24	0.953	0.051	1784
25-29	1.865	0.082	1767
30-34	2.859	0.088	1326
35-39	3.778	0.099	949
40-44	4.855	0.130	649
45-49	5.325	0.123	388
Total	2.152	0.097	8257

Table 7a: Sex ratio at birth by mother's age, Mongolia, 2000

By age group	Total number of		Sex ratio at birth
	boys	girls	
15-19	89	90	0.99
20-24	857	844	1.02
25-29	1762	1533	1.15
30-34	1953	1838	1.06
35-39	1751	1834	0.95
40-44	1490	1661	0.90
45-49	993	1073	0.93

Table 8: Infant and under 5 mortality rate. Mongolia, 2000

Reference period	By model "West"	
	Infant	Under 5
1999-YI	26	31
1998-III	47	61
1996-I	64	87
1993-Y	64	87
1990-YI	66	91
1987-YI	79	110
1984-YI	69	95

Table 9: Percentage of children aged 36-59 months who are attending some from organized early childhood programme, Mongolia, 2000

		Attending programme	
		%	Number of children
Sex	Male	20.9	1216
	Female	21.1	1156
Region	Western	18.0	466
	Northern	7.1	616
	Southern	13.8	160
	Eastern	12.8	211
	Central-1	22.9	315
	Central-2	41.2	604
	Capital city	41.2	604
Household location	Aimag center	26.5	438
	Soman center	17.5	434
	Countryside	6.4	896
Residence	Urban	35.0	1042
	Rural	10.0	1330
Age group	36-47 months	16.2	1131
	48-59 months	25.4	1241
Mother's education level	None	-	16
	Primary	3.4	118
	Non-Completed Secondary	8.6	605
	Completed Secondary	19.0	717
	Vocational	21.2	288
	Vocational training and College	32.8	351
	Higher	49.4	259
	Missing/DK	11.1	18
Total		21.0	2372

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Table 10 : Percentage of children of primary school age attending primary school. Mongolia, 2000

		Sex				Total	
		Male		Female		Attending	Number
		Attending	Number	Attending	Number		
Region	Western	74,9	410	72,4	420	73,6	830
	Northern	68,1	464	71,4	458	69,7	922
	Southern	75,6	160	80,7	150	78,1	310
	Eastern	70,5	207	74,5	192	72,4	399
	Central-1	75,8	376	80,0	431	78,1	807
	Central-2	85,2	406	80,4	368	82,9	774
Household location	Capital city	85,2	406	80,4	368	82,9	774
	Aimag center	79,0	476	80,9	465	79,9	941
	Soman center	73,9	456	77,8	477	75,9	933
Residence	Countryside	67,4	685	69,5	709	68,5	1394
	Urban	81,9	882	80,7	833	81,3	1715
	Rural	70,0	1141	72,8	1186	71,5	2327
Age group	7	25,6	340	26,5	340	26,0	680
	8	62,0	332	63,1	366	62,6	698
	9	87,6	380	87,1	334	87,4	714
	10	94,0	365	95,5	337	94,7	702
	11	93,2	308	94,5	327	93,9	635
	12	88,9	298	93,0	315	91,0	613
Total (by age group)	7-10	68,4	1417	67,8	1377	68,1	2794
	7-11	72,8	1725	72,9	1704	72,9	3429
	7-12	75,2	2023	76,1	2019	75,6	4042
	8-9	75,7	712	74,6	700	75,1	1412
	8-11	84,4	1385	84,5	1364	84,5	2749
	9-12	90,9	1351	92,5	1313	91,7	2664

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Table 11: Percentage of children entering first grade of primary school who eventually reach grade 5. Mongolia, 2000

		Percent in	Percent in	Percent in	Percent in	Percent who reach grade 5 of those who enter grade 1
		grade 1 reaching grade 2	grade 2 reaching grade 3	grade 3 reaching grade 4	grade 4 reaching grade 5	
Sex	Male	98,9	98,8	97,9	98,1	93,9
	Female	98,8	100	98,6	98,0	95,5
Region	Western	98,5	99,2	98,2	98,6	94,7
	Northern	100	99,3	96,3	97,6	93,5
	Southern	97,8	100	100	100	97,8
	Eastern	84,4	95,5	87,3	88,1	69,7
	Central-1	99,5	100	99,0	100	98,5
	Central-2	100	100	100	100	100,0
Residence	Urban	99,4	99,7	99,6	98,3	97,0
	Rural	98,4	99,3	97,4	97,8	93,2
Total		98,9	99,4	98,3	98,1	94,7

Table 12 : Percentage of the population aged 15 years and older that is literate. Mongolia, 2000

		Sex						Total		
		Male			Female			Literate	Not known	Number
		Literate	Not known	Number	Literate	Not known	Number			
Region	Western	99.0	1.0	1370	98.8	1.2	1614	98.9	1.1	2984
	Northern	98.5	1.5	1693	97.4	2.5	2001	97.9	2.1	3694
	Southern	98.0	2.0	538	98.0	1.8	654	98.0	1.9	1192
	Eastern	97.3	2.7	710	98.9	1.1	925	98.2	1.8	1635
	Central-1	98.1	1.9	1236	98.0	2.0	1607	98.1	1.9	2843
	Central-2	99.3	0.7	2104	99.4	0.6	2690	99.4	0.6	4794
Household location	Capital city	99.3	0.7	2104	99.4	0.6	2690	99.4	0.6	4794
	Aimag center	99.1	0.9	1588	98.4	1.6	2030	98.7	1.3	3618
	Soman center	98.3	1.7	1376	99.2	0.8	1682	98.8	1.2	3058
	Countryside	97.9	2.1	2583	97.4	2.5	3089	97.7	2.3	5672
Residence	Urban	99.2	0.8	3692	99.0	1.0	4720	99.1	0.9	8412
	Rural	98.0	2.0	3959	98.1	1.9	4771	98.0	1.9	8730
Age group	15-24	97.6	2.4	2188	99.2	0.7	3406	98.6	1.4	5594
	25-34	99.2	0.8	2673	99.3	0.7	3179	99.2	0.8	5852
	35-44	99.0	1.0	1543	98.8	1.2	1615	98.9	1.1	3158
	45-54	99.1	0.9	700	99.1	0.9	678	99.1	0.9	1378
	55-64	98.6	1.4	351	94.4	5.6	360	96.5	3.5	711
	65+	96.9	3.1	196	81.4	18.6	253	88.2	11.8	449
Total		98.6	1.4	7651	98.5	1.5	9491	98.5	1.4	17142

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Table 13: Percentage of the population using improved drinking water sources. Mongolia, 2000

		Main source of water							
		Piped into dwelling	Piped into yard or plot	Public tap	Tubewell /borehole with pump	Protected dug well	Protected spring	Bottled water	Unprotected dug well
Region	Western	8.1	0.4	2.3	8.5	12.7	0.1	0.1	5.8
	Northern	0.3	0.0	8.4	3.1	10.9	0.0	0.1	6.5
	Southern	5.8	0.0	23.8	12.5	38.4	0.0	0.0	13.9
	Eastern	15.5	0.3	12.0	3.2	22.3	0.0	0.3	18.3
	Central-1	27.2	2.4	19.8	18.6	15.6	0.0	0.1	4.5
	Central-2	49.2	0.1	38.1	1.7	7.9	0.1	0.0	0.4
	Capital city	49.2	0.1	38.1	1.7	7.9	0.1	0.0	0.4
Household location	Aimag center	33.6	1.4	26.4	5.3	16.4	0.1	0.0	2.1
	Soman center	4.2	0.1	12.5	17.1	15.9	0.0	0.3	5.9
	Countryside	0.4	0.6	1.6	6.4	16.8	0.0	0.0	12.9
Residence	Urban	42.1	0.7	32.8	3.3	11.7	0.1	0.0	1.2
	Rural	1.8	0.4	5.5	10.2	16.5	0.0	0.1	10.4
Total		20.4	0.6	18.1	7.0	14.3	0.0	0.1	6.1

World Summit for Children Goal => Number 4

Table 13: Continuation

		Main source of water				Total	Total with safe drinking water	Number of persons
		Unprotected spring	Pond, river or stream	Tanker truck vendor	Other			
Region	Western	0.5	49.5	6.1	5.9	100	32.2	5504
	Northern	0.1	67.9	0.6	2.1	100	22.6	6894
	Southern	0.3	2.6	2.6	0.0	100	80.6	2120
	Eastern	0.1	25.5	1.1	1.4	100	53.3	2848
	Central-1	0.0	5.8	2.6	3.4	100	83.7	5035
	Central-2	0.0	0.0	2.5	0.0	100	97.1	7547
	Capital city	0.0	0.0	2.5	0.0	100	97.1	7547
Household location	Aimag center	0.0	7.0	6.9	0.9	100	83.1	6299
	Soman center	0.0	40.2	1.9	1.8	100	49.8	5722
	Countryside	0.4	55.3	0.6	5.0	100	25.9	10380
Residence	Urban	0.0	3.2	4.5	0.4	100	90.8	13846
	Rural	0.3	49.9	1.0	3.9	100	34.4	16102
Total		0.1	28.3	2.6	2.3	100	60.5	29948

World Summit for Children Goal => Number 4

Table 14: Percentage of the population using sanitary means of excreta disposal. Mongolia, 2000

		Kind of toilet facility							Total	Total with sanitary means of excreta disposal	Number of persons
		Flush to sewage system or septic tank	Pour flush latrine	Improved pit latrine	Traditional pit latrine	Open pit	Other	No facilities or bush or field			
Region	Western	8.0	0.3	0.7	51.7	5.8	0.0	33.4	100	60.8	5504
	Northern	0.2	0.1	0.3	52.1	14.2	0.3	32.7	100	52.8	6894
	Southern	7.5	0.0	0.4	44.4	6.6	0.0	41.1	100	52.4	2120
	Eastern	15.7	0.0	0.3	63.4	5.4	0.0	15.2	100	79.4	2848
	Central-1	28.1	0.3	1.3	59.1	0.7	0.1	10.3	100	88.8	5035
	Central-2	49.1	0.1	1.8	45.7	2.9	0.1	0.2	100	96.8	7547
Household location	Capital city	49.1	0.1	1.8	45.7	2.9	0.1	0.2	100	96.8	7547
	Aimag center	33.6	0.3	0.6	62.5	2.0	0.1	0.9	100	97.0	6299
	Soman center	4.8	0.3	1.1	80.6	7.7	0.1	5.4	100	86.8	5722
Residence	Countryside	0.8	0.0	0.4	34.8	10.3	0.1	53.5	100	36.1	10380
	Urban	42.1	0.2	1.3	53.4	2.5	0.1	0.5	100	96.9	13846
	Rural	2.3	0.1	0.6	51.1	9.4	0.1	36.4	100	54.1	16102
Total		20.7	0.1	0.9	52.1	6.2	0.1	19.8	100	73.9	29948

World Summit for Children Goal => Number 5

Table 15: Percentage of under-five children who are severely or moderately undernourished, Mongolia, 2000

		Weight for age:		Height for age:		Weight for height:		Number of children
		percent below -2SD	percent below -3SD	percent below -2SD	percent below -3SD	percent below -2SD	percent below -3SD	
Sex	Male	12,7	2,6	25,4	8,6	5,6	1,2	2939
	Female	12,7	3,1	23,8	8,5	5,5	1,2	2845
Region	Western	14,3	3,5	29,2	11,8	4,9	1,3	1071
	Northern	16,2	3,7	32,2	11,5	6,4	1,4	1526
	Southern	7,9	1,5	23,2	5,1	4,1	0,3	393
	Eastern	21,3	4,4	27,7	10,0	8,5	1,7	541
	Central-1	10,7	2,0	21,2	6,4	5,8	1,0	859
	Central-2	6,9	1,6	14,1	4,6	4,3	0,9	1394
	Urban	9,0	1,9	18,1	5,8	4,5	1,0	2530
Residence	Rural	15,6	3,5	29,7	10,6	6,4	1,3	3254
Age group	< 6 months	4,0	1,0	8,1	1,9	5,0	0,5	619
	6-11 months	12,3	2,4	21,6	6,2	6,6	1,2	666
	12-23 months	15,1	4,1	31,9	11,7	7,2	1,2	1169
	24-35 months	13,8	2,9	23,4	8,8	4,2	1,1	1131
	36-47 months	13,7	2,9	26,7	9,5	4,7	0,8	1067
	48-59 months	13,2	2,7	27,1	9,2	5,7	1,9	1132
Mother's education level	None	19,6	8,7	34,8	10,9	8,7	2,2	46
	Primary	18,1	4,1	34,8	16,0	7,2	1,0	293
	Non-Completed Secondary	16,7	3,9	31,1	11,5	7,2	1,1	1547
	Completed Secondary	11,2	2,2	23,8	7,5	4,9	1,0	1944
	Vocational	14,2	3,1	23,1	7,9	6,3	2,0	605
	Vocational training and College	9,0	2,1	19,1	5,7	4,2	1,4	759
	Higher	6,1	1,1	10,8	4,0	2,9	0,7	545
	Missing/DK	17,8	8,9	42,2	11,1	6,7	2,2	45
	Total	12,7	2,8	24,6	8,5	5,5	1,2	5784

World Summit for Children Goal => Number 3, 6, 9

Table 16: Percent of living children by breastfeeding status. Mongolia, 2000

		Children 0-3 months exclusively breastfed	Children 6-9 months receiving solid/ mushy food	Children breastfed	
				with 12-15 months	with 20-23 months
Sex	Male	64,4	57,2	76,3	57,2
	Female	63,6	51,9	74,1	56,6
Region	Western	67,1	56,8	83,5	60,2
	Northern	70,8	43,5	74,3	49,4
	Southern	82,1	51,7	92,1	69,0
	Eastern	62,2	53,2	67,9	33,3
	Central-1	60,6	58,2	76,9	55,6
	Central-2	52,9	66,0	67,2	63,9
	Capital city	52,9	66,0	67,2	63,9
Household location	Aimag center	65,3	54,1	84,4	60,7
	Soman center	61,3	46,9	78,7	53,2
	Countryside	71,9	51,4	74,1	52,2
Residence	Urban	58,1	60,3	74,7	62,3
	Rural	68,5	50,0	75,7	52,6
Mother's education level	None	50,0		75,0	100
	Primary	69,6	57,1	53,8	62,5
	Non-Completed Secondary	65,1	48,8	74,8	55,6
	Completed Secondary	67,1	55,8	75,3	56,8
	Vocational	60,9	52,4	86,8	74,3
	Vocational training and College	61,0	52,9	72,9	47,8
	Higher	48,1	68,1	78,9	51,9
	Missing/DK	66,7	50,0	100,0	-
Total		64,0	54,5	75,2	56,9

World Summit for Children Goal => Number 16

Table 17: Percentage of households consuming adequately iodized salt. Mongolia, 2000

	Percent of households with no salt	Percent of households in which salt was tested	Result of test		Number of households interviewed	
			< 15 PPM	15+ PPM		
By region	Western	0.3	99.3	15.2	3.0	1090
	Northern	0.1	99.8	16.8	5.8	1350
	Southern	0.5	98.4	2.7	4.5	435
	Eastern	0.6	99.1	4.6	4.2	530
	Central-1	0.2	98.9	11.0	4.7	950
	Central-2	0.3	99.3	4.8	22.7	1645
Household location	Capital city	0.3	99.3	4.8	22.7	1645
	Aimag center	0.4	99.0	13.5	7.7	1280
	Soman center	0.2	99.2	11.7	5.9	1059
Residence	Countryside	0.2	99.5	25.1	8.5	2016
	Urban	0.3	99.2	18.3	30.4	2925
	Rural	0.2	99.3	36.8	14.5	3075
Total	0.3	99.3	55.1	44.9	6000	

World Summit for Children Goal => Number 14

Table 17a: Incidence of households consuming adequately iodized salt. Mongolia, 2000

	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		
Region	West	0.3	99.3	83.1	16.9	1090
	North	0.1	99.8	74.0	26.0	1350
	South	0.5	98.4	37.2	62.8	435
	East	0.6	99.1	51.9	48.1	530
	Central-2	0.2	98.9	69.3	30.7	950
	Central-3	0.3	99.3	17.2	82.8	1645
Household location	Capital city	0.3	99.3	17.2	82.8	1645
	Aimag center	0.4	99.0	63.0	37.0	1280
	Soman center	0.2	99.2	65.7	34.3	1059
Residence	Countryside	0.2	99.5	74.3	25.7	2016
	Urban	0.3	99.2	37.3	62.7	2925
	Rural	0.2	99.3	71.3	28.7	3075
Total	0.3	99.3	55.1	44.9	6000	

World Summit for Children Goal => Number 14

Table 18: Percent distribution of children aged 6-59 months by whether they received a high dose of Vitamin "A" supplement in the last 6 months. Mongolia, 2000

		Vitamin "A" received			Not sure if received	Not received	Total	
		within last 6 months	prior to last 6 months	not sure when			%	Number of children
Sex	Male	30.6	11.0	3.3	1.2	53.9	100	2820
	Female	32.5	9.9	2.9	1.3	53.4	100	2708
Region	Western	32.4	10.3	2.0	0.7	54.6	100	1076
	Northern	32.5	8.0	2.2	0.4	56.8	100	1429
	Southern	32.4	17.8	2.9	0.5	46.3	100	376
	Eastern	32.4	8.7	3.9	1.2	53.8	100	515
	Central-1	33.6	10.6	2.0	1.6	52.2	100	803
	Central-2	28.0	11.7	5.3	2.6	52.4	100	1329
	Capital city	28.0	11.7	5.3	2.6	52.4	100	1329
Household location	Aimag center	47.9	12.0	2.9	1.5	35.7	100	1086
	Soman center	31.8	11.1	2.0	0.5	54.6	100	1037
	Countryside	25.2	8.6	2.2	0.6	63.4	100	2076
Residence	Urban	36.9	11.8	4.3	2.1	44.9	100	2415
	Rural	27.4	9.4	2.2	0.6	60.5	100	3113
Age group	6-11 months	30.1	1.0	1.1	0.4	67.4	100	708
	12-23 months	35.9	6.1	1.7	0.6	55.7	100	1255
	24-35 months	35.1	10.7	2.8	1.1	50.3	100	1193
	36-47 months	28.2	13.3	5.0	1.7	51.8	100	1131
	48-59 months	27.7	17.4	4.1	2.0	48.8	100	1241
Mother's education level	None	30.0	12.5	-	2.5	55.0	100	40
	Primary	22.3	7.3	2.2	2.6	65.7	100	274
	Non-Completed Secondary	30.7	7.5	2.4	0.9	58.5	100	1478
	Completed Secondary	33.5	9.8	2.9	1.4	52.3	100	1808
	Vocational	32.5	12.7	3.8	1.2	49.7	100	581
	Vocational training and College	31.8	14.0	3.2	0.8	50.2	100	751
	Higher	30.3	15.1	5.3	1.5	47.9	100	551
	Missing/DK	37.8	4.4	-	-	57.8	100	45
Total		31.6	10.5	3.1	1.2	53.7	100	5528

World Summit for Children Goal => Number 15

Table 19: Percentage of women with a birth in the last 12 months by whether they received a high dose of Vitamin A supplement before the infant was 8 weeks old. Mongolia, 2000

		Received Vitamin A supplement	Not sure if received	Number of women
Region	Western	5,7	4,5	245
	Northern	10,2	1,0	403
	Southern	15,5	2,7	110
	Eastern	12,3	0,7	146
	Central-1	21,7	1,4	221
	Central-2	16,2	4,1	390
Household location	Capital city	16,2	4,1	390
	Aimag center	22,0	2,1	291
	Soman center	10,3	0,7	272
Residence	Countryside	8,2	2,5	562
	Urban	18,6	3,2	681
	Rural	8,9	1,9	834
Woman's education level	None	-	-	10
	Primary	6,0	-	84
	Non-Completed	12,8	2,0	391
	Secondary	15,0	1,9	572
	Completed	10,5	1,5	133
	Vocational	11,0	6,4	172
	Vocational training and College	16,5	4,3	139
	Higher	28,6	-	14
Missing/DK				
Total	13,3	2,5	1515	

World Summit for Children Goal => Number 15

Table 20: Percentage of live births in the last 12 months that weighed below 2500 grams at birth, Mongolia, 2000

		Percent of live births below 2500 grams	Percent of live births weighed at birth	Number of live births
Region	Western	8,3	88,6	245
	Northern	3,7	96,5	403
	Southern	5,8	96,4	110
	Eastern	5,7	100	146
	Central-1	6,9	95,9	221
	Central-2	4,8	96,2	390
Household location	Capital city	4,8	96,2	390
	Aimag center	6,1	98,3	291
	Soman center	5,4	97,1	272
Residence	Countryside	5,8	92,5	562
	Urban	5,4	97,1	681
	Rural	5,7	94,0	834
Mother's education level	None	7,0	90,0	10
	Primary	5,3	92,9	84
	Non-Completed	6,1	94,1	391
	Secondary	5,7	97,2	572
	Completed	4,4	96,2	133
	Vocational	5,3	93,6	172
	Vocational training and College	4,6	96,4	139
	Higher	6,4	78,6	14
Missing/DK				
Total	5,5	95,4	1515	

World Summit for Children Goal => Number 12

Table 21. Percentage of children age 12-23 months immunized against childhood diseases at any time before the first birthday, Mongolia, 2000

		BCG	DPT1	DPT2	DPT3	Polio 0	Polio 1	Polio 2	Polio 3	Measles	All vaccinations	No vaccinations	Number of children
	Vaccination Card	89,8	86,9	86,9	86,8	89,8	87,1	87,1	86,9	82,3	80,7	4,2	1128
Vaccinated at any time before the survey according to:	Mother's Report	5,8	5,0	4,0	2,4	4,0	5,2	3,4	2,0	3,3			
	Either	95,6	91,9	90,9	89,2	93,8	92,3	90,5	88,8	85,7	80,7	4,2	1255
	Not vaccinated	4,4	8,1	9,1	10,8	6,2	7,7	9,5	11,2	14,3	17,6	4,2	
Vaccinated by 12 months ago		99,8	99,7	99,7	98,4	99,8	99,7	99,7	99,0	97,9	96,2	3,8	1128

World Summit for Children Goal=>No 22

Table 22: Percentage of children age 12-23 months currently vaccinated against childhood diseases, Mongolia, 2000.

		BCG	DPT 1	DPT 2	DPT 3	Polio 0	Polio 1	Polio 2	Polio 3	Measles	All	None	Percentage children with health card	Number of children
Sex	Male	95.3	92.3	90.7	88.9	93.6	92.4	89.9	88.2	85.8	82.8	4.3	89.5	621
	Female	95.9	91.5	91.2	89.4	94.0	92.1	91.2	89.4	85.5	82.0	4.1	90.5	634
Region	Western	96.9	91.2	91.9	92.3	96.2	90.8	91.5	92.3	87.7	84.6	3.1	96.2	260
	Northern	99.0	93.2	92.5	92.5	98.6	94.9	93.2	92.9	82.4	81.4	1.0	96.9	295
	Southern	100	97.8	97.8	96.7	100	97.8	97.8	96.7	96.7	95.7	-	100	92
	Eastern	89.3	87.5	85.7	83.0	85.7	89.3	84.8	82.1	75.0	71.4	8.9	79.5	112
	Central-1	88.2	84.2	79.8	72.4	82.3	83.7	77.8	70.9	76.4	67.0	11.8	73.4	203
	Central-2	97.3	96.2	95.9	94.5	95.9	96.2	95.6	94.2	94.2	92.2	2.7	90.1	293
	Capital city	97.3	96.2	95.9	94.5	95.9	96.2	95.6	94.2	94.2	92.2	2.7	90.1	293
Household location	Aimag center	89.8	87.9	85.2	80.5	84.0	88.3	84.0	79.7	78.9	73.8	10.2	76.6	256
	Soman center	96.0	92.0	92.4	91.2	95.2	92.4	92.0	91.2	85.3	82.5	3.6	94.4	251
	Countryside	97.6	91.2	90.1	89.5	97.1	91.9	90.1	89.2	84.2	80.9	2.2	95.2	455
Residence	Urban	93.8	92.3	90.9	88.0	90.3	92.5	90.2	87.4	87.1	83.6	6.2	83.8	549
	Rural	97.0	91.5	90.9	90.1	96.5	92.1	90.8	89.9	84.6	81.4	2.7	94.9	706
Mother's education level	None	100.0	87.5	87.5	87.5	100.0	87.5	87.5	87.5	87.5	87.5	-	100	8
	Primary	98.4	82.5	84.1	84.1	95.2	85.7	85.7	84.1	81.0	74.6	1.6	92.1	63
	Non-Completed Secondary	96.2	92.9	91.2	89.6	94.5	92.9	91.0	89.9	84.9	81.9	3.6	92.3	365
	Completed Secondary	94.8	91.5	91.3	89.6	92.9	91.5	90.1	88.7	84.7	81.9	5.2	88.7	425
	Vocational	93.4	87.6	85.1	82.6	91.7	89.3	86.0	82.6	86.0	80.2	5.8	86.8	121
	Vocational training and College	98.6	97.2	95.8	93.1	97.9	97.9	95.1	92.4	89.6	85.4	1.4	91.7	144
	Higher	93.4	92.6	91.8	90.2	90.2	92.6	91.8	90.2	88.5	87.7	6.6	86.9	122
	Missing/DK	100	100	100	100	100	100	100	100	85.7	85.7	-	100.0	7
Total		95.6	91.9	90.9	89.2	93.8	92.3	90.5	88.8	85.7	82.4	4.2	90.0	1255

Table 23: Percentage of under-five children with diarrhea in the last two weeks and treatment with ORS or ORT. Mongolia, 2000

		Had diarrhea in last two weeks	Breast milk	Gruel	Local acceptable	ORS packet	Other milk or infant formula	Water with feeding	Any recommended treatment	No treatment	Number of children with diarrhea
Sex	Male	7.9	62.4	50.8	64.4	57.2	53.2	30.8	98.0	2.0	250
	Female	8.2	59.8	60.6	63.1	54.6	47.4	31.3	98.0	2.0	249
Region	Western	11.9	58.9	51.1	72.3	53.9	55.3	22.0	98.6	1.4	141
	Northern	3.8	67.2	50.8	60.7	37.7	41.0	24.6	93.4	6.6	61
	Southern	10.5	55.6	51.1	42.2	68.9	37.8	17.8	97.8	2.2	45
	Eastern	9.4	55.6	63.0	66.7	59.3	50.0	33.3	100.0	-	54
	Central-1	6.6	68.3	65.0	63.3	63.3	55.0	45.0	100.0	-	60
	Central-2	9.2	61.6	57.2	62.3	57.2	51.4	40.6	97.8	2.2	138
	Capital city	9.2	61.6	57.2	62.3	57.2	51.4	40.6	97.8	2.2	138
Household location	Aimag center	8.6	62.5	56.7	59.6	57.7	43.3	32.7	97.1	2.9	104
	Soman center	8.0	65.2	58.7	60.9	68.5	52.2	27.2	100.0	-	92
	Countryside	7.1	57.6	52.1	69.1	46.7	52.7	24.2	97.6	2.4	165
Residence	Urban	9.0	62.0	57.0	61.2	57.4	47.9	37.2	97.5	2.5	242
	Rural	7.4	60.3	54.5	66.1	54.5	52.5	25.3	98.4	1.6	257
Age group	< 6 months	7.3	85.4	25.0	20.8	31.3	18.8	14.6	95.8	4.2	48
	6-11 months	13.8	85.7	55.1	68.4	58.2	51.0	30.6	100.0	-	98
	12-23 months	14.5	75.3	63.7	68.1	60.4	54.4	33.5	98.4	1.6	182
	24-35 months	6.1	46.6	60.3	69.9	47.9	58.9	32.9	97.3	2.7	73
	36-47 months	4.2	10.6	55.3	68.1	57.4	66.0	34.0	97.9	2.1	47
	48-59 months	4.1	7.8	51.0	66.7	68.6	37.3	33.3	96.1	3.9	51
Mother's education level	None	8.3	25.0	50.0	75.0	100	-	-	100	-	4
	Primary	8.3	53.8	50.0	61.5	46.2	46.2	30.8	100.0	-	26
	Non-Completed Secondary	6.6	58.7	43.1	60.6	51.4	42.2	31.2	96.3	3.7	109
	Completed Secondary	8.4	64.9	54.6	64.9	54.0	48.3	31.0	98.3	1.7	174
	Vocational	7.7	60.0	64.0	60.0	58.0	56.0	24.0	98.0	2.0	50
	Vocational training and College	8.9	63.0	61.6	65.8	64.4	58.9	31.5	98.6	1.4	73
	Higher	9.8	55.9	69.5	66.1	57.6	59.3	37.3	98.3	1.7	59
	Missing/DK	8.2	100	75.0	75.0	75.0	75.0	50.0	100	-	4
Total		8.1	61.1	55.7	63.7	55.9	50.3	31.1	98.0	2.0	499

World Summit for Children Goal => Number 23

Table 24: Percentage of under-five children with diarrhea in the last two weeks who took increased fluids and continued to feed during the episode, Mongolia, 2000

	Had diarrhea in last two weeks	Drinking during diarrhea				Total	Eating during diarrhea			Total	Received increased fluids and continued eating	Number of children with diarrhea
		More	Same/ Less	Missing/ DK	Some what less/ same/ more		Much less/ none	Missing /DK				
Sex	Male	7,9	42,4	51,2	6,4	100	74,8	20,4	4,8	100	33,6	250
	Female	8,2	39,4	55,0	5,6	100	73,9	22,1	4,0	100	29,3	249
Region	Western	11,9	40,4	54,6	5,0	100	68,8	27,0	4,3	100	30,5	141
	Northern	3,8	32,8	60,7	6,6	100	80,3	19,7	0,0	100	27,9	61
	Southern	10,5	46,7	51,1	2,2	100	88,9	8,9	2,2	100	42,2	45
	Eastern	9,4	53,7	42,6	3,7	100	72,2	27,8	0,0	100	33,3	54
	Central-1	6,6	45,0	48,3	6,7	100	71,7	21,7	6,7	100	31,7	60
	Central-2	9,2	36,2	55,1	8,7	100	74,6	17,4	8,0	100	29,7	138
	Capital city	9,2	36,2	55,1	8,7	100	74,6	17,4	8,0	100	29,7	138
Household location	Aimag center	8,6	33,7	58,7	7,7	100	76,0	19,2	4,8	100	26,9	104
	Soman center	8,0	45,7	52,2	2,2	100	79,3	19,6	1,1	100	34,8	92
	Countryside	7,1	46,7	48,5	4,8	100	70,3	26,7	3,0	100	33,9	165
Residence	Urban	9,0	35,1	56,6	8,3	100	75,2	18,2	6,6	100	28,5	242
	Rural	7,4	46,3	49,8	3,9	100	73,5	24,1	2,3	100	34,2	257
Age group	< 6 months	7,3	20,8	66,7	12,5	100	79,2	14,6	6,3	100	16,7	48
	6-11 months	13,8	42,9	53,1	4,1	100	77,6	18,4	4,1	100	31,6	98
	12-23 months	14,5	44,5	52,2	3,3	100	76,9	20,3	2,7	100	36,8	182
	24-35 months	6,1	37,0	53,4	9,6	100	64,4	27,4	8,2	100	24,7	73
	36-47 months	4,2	42,6	48,9	8,5	100	74,5	19,1	6,4	100	36,2	47
	48-59 months	4,1	47,1	47,1	5,9	100	68,6	29,4	2,0	100	31,4	51
Woman's education level	None	8,3	50,0	50,0	0,0	100	100	0,0	0,0	100	50,0	4
	Primary	8,3	23,1	76,9	0,0	100	69,2	30,8	0,0	100	11,5	26
	Non-Completed											
	Secondary	6,6	44,0	47,7	8,3	100	66,1	28,4	5,5	100	32,1	109
	Completed											
	Secondary	8,4	39,7	55,7	4,6	100	79,3	17,8	2,9	100	32,8	174
	Vocational	7,7	44,0	52,0	4,0	100	70,0	28,0	2,0	100	32,0	50
Vocational training and College	8,9	45,2	47,9	6,8	100	80,8	13,7	5,5	100	37,0	73	
Higher	9,8	35,6	54,2	10,2	100	69,5	20,3	10,2	100	23,7	59	
Missing/DK	8,2	75,0	25,0	0,0	100	100	0,0	0,0	100	75,0	4	
Total	8,1	40,9	53,1	6,0	100	74,3	21,2	4,4	100	31,5	499	

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Table 25: Percentage of under-five children with acute respiratory infection in the last two weeks and treatment by health providers, Mongolia. 2000

		Had acute respiratory infection	Children with ARI who were taken to:										Number of children with ARI
			Hospital	Health centre	Dispensary	Village health worker	MCH clinic	Mobile/outreach clinic	Private physician	Traditional healer	Other	Any appropriate provider	
Sex	Male	2,3	47,2	26,4	1,4	-	-	1,4	1,4	4,2	4,2	77,8	72
	Female	2,3	46,5	26,8	-	-	1,4	2,8	1,4	1,4	4,2	77,5	71
Region	Western	3,1	56,8	18,9	-	-	-	5,4	-	-	2,7	81,1	37
	Northern	1,2	52,6	10,5	5,3	-	-	-	5,3	10,5	15,8	73,7	19
	Southern	1,4	66,7	33,3	-	-	-	-	16,7	-	-	100	6
	Eastern	4,2	37,5	45,8	-	-	-	4,2	-	-	-	87,5	24
	Central-1	3,3	33,3	26,7	-	-	-	-	-	-	3,3	60,0	30
	Central-2	1,8	48,1	29,6	-	-	3,7	-	-	7,4	3,7	81,5	27
	Capital city	1,8	48,1	29,6	-	-	3,7	-	-	7,4	3,7	81,5	27
Household location	Aimag center	3,0	30,6	44,4	-	-	-	2,8	-	-	2,8	77,8	36
	Soman center	2,9	54,5	21,2	-	-	-	-	3,0	6,1	3,0	75,8	33
	Countryside	2,0	53,2	14,9	2,1	-	-	4,3	2,1	-	6,4	76,6	47
Residence	Urban	2,3	38,1	38,1	-	-	1,6	1,6	-	3,2	3,2	79,4	63
	Rural	2,3	53,8	17,5	1,3	-	-	2,5	2,5	2,5	5,0	76,3	80
Age group	< 6 months	1,4	55,6	11,1	-	-	-	-	-	-	11,1	66,7	9
	6-11 months	4,4	38,7	25,8	-	-	3,2	9,7	3,2	3,2	6,5	80,6	31
	12-23 months	3,7	44,7	29,8	-	-	-	-	-	-	4,3	74,5	47
	24-35 months	1,4	41,2	41,2	-	-	-	-	-	11,8	-	82,4	17
	36-47 months	1,4	62,5	18,8	6,3	-	-	-	6,3	-	6,3	87,5	16
	48-59 months	1,9	52,2	21,7	-	-	-	-	-	4,3	-	73,9	23
Woman's education level	None	6,3	33,3	33,3	-	-	-	-	-	-	-	66,7	3
	Primary	3,5	45,5	18,2	-	-	-	9,1	9,1	-	-	72,7	11
	Non-Completed	2,1	55,9	17,6	2,9	-	-	-	-	-	5,9	76,5	34
	Secondary	2,3	53,2	23,4	-	-	-	2,1	2,1	4,3	4,3	80,9	47
	Completed Secondary	2,0	30,8	30,8	-	-	-	7,7	-	-	-	69,2	13
	Vocational	1,7	64,3	21,4	-	-	-	-	-	-	7,1	85,7	14
	Vocational training and College	1,7	64,3	21,4	-	-	-	-	-	-	7,1	85,7	14
	Higher	2,8	11,8	58,8	-	-	5,9	-	-	11,8	-	76,5	17
	Missing/DK	8,2	50,0	25,0	-	-	-	-	-	-	25,0	75,0	4
Total	2,3	46,9	26,6	0,7	0,0	0,7	2,1	1,4	2,8	4,2	77,6	143	

World Summit for Children Goal => Number 24

Table 26: Percentage of children 0-59 months of age reported ill during the last two weeks who received increased fluids and continued feeding, Mongolia, 2000

		Reported illness in last two weeks	Children with an illness who				Took increased fluids and continued eating	Number of children
			Drank		Ate			
			More	Same or less	Somewhat less, or more	Much less or none		
Sex	Male	14,6	40,7	54,9	78,4	18,3	31,8	459
	Female	14,8	36,7	60,0	77,8	19,8	27,8	450
Region	Western	19,1	38,1	58,0	73,9	23,0	28,3	226
	Northern	7,7	35,0	61,8	82,1	17,9	29,3	123
	Southern	16,5	36,6	62,0	90,1	8,5	32,4	71
	Eastern	18,3	50,5	46,7	74,3	23,8	34,3	105
	Central-1	18,3	37,0	59,4	78,2	18,8	27,9	165
	Central-2	14,7	37,9	56,6	78,1	16,9	30,1	219
	Capital city	14,7	37,9	56,6	78,1	16,9	30,1	219
Household location	Aimag center	18,7	35,7	59,5	78,9	18,1	28,2	227
	Soman center	14,4	40,4	57,8	81,3	16,9	30,7	166
	Countryside	12,8	40,7	56,2	75,8	22,6	30,3	297
Residence	Urban	16,5	36,8	58,1	78,5	17,5	29,1	446
	Rural	13,3	40,6	56,8	77,8	20,5	30,5	463
Age group	< 6 months	14,6	18,8	71,9	83,3	12,5	15,6	96
	6-11 months	22,2	38,2	59,2	82,8	14,6	30,6	157
	12-23 months	21,9	43,6	54,2	79,6	18,5	36,0	275
	24-35 months	12,1	34,7	59,7	73,6	20,8	25,7	144
	36-47 months	10,3	37,9	58,6	74,1	23,3	26,7	116
	48-59 months	9,8	49,6	47,1	73,6	24,8	33,9	121
Woman's education level	None	16,7	37,5	62,5	87,5	12,5	37,5	8
	Primary	12,5	23,1	76,9	76,9	23,1	15,4	39
	Non-Completed Secondary	11,3	40,9	53,8	71,5	24,7	30,1	186
	Completed Secondary	15,3	35,4	62,0	82,3	16,1	28,5	316
	Vocational	16,4	43,4	53,8	77,4	19,8	32,1	106
	Vocational training and College	16,7	42,3	51,8	80,3	16,1	35,0	137
	Higher	18,4	39,1	55,5	73,6	20,9	26,4	110
Missing/DK	14,3	71,4	28,6	100	-	71,4	7	
	Total	14,7	38,7	57,4	78,1	19,0	29,8	909

Monitoring IMCI

**Table 27: Percentage of caretakers of children 0-59 months who know at least 2 signs for seeking care immediately, .
Mongolia. 2000**

		Not able to drink /breastfeed	Becomes sicker	Develops a fever	Has fast breathing	Has difficult breathing	Has blood in stool	Is drinking poorly	Knows at least two signs	Number of caretakers
Region	Western	0.6	41.7	57.5	10.1	6.9	2.4	0.8	32.4	1186
	Northern	11.0	50.1	57.9	13.5	19.8	11.3	1.4	42.2	1598
	Southern	4.7	47.2	52.8	10.0	8.1	10.7	1.4	19.8	430
	Eastern	14.3	47.8	61.7	23.1	18.1	10.6	2.3	65.0	575
	Central-1	1.8	32.3	61.5	7.2	6.8	2.2	2.0	20.6	903
	Central-2	5.5	55.1	56.4	14.4	13.5	6.0	1.7	42.8	1492
Household location	Capital city	5.5	55.1	56.4	14.4	13.5	6.0	1.7	42.8	1492
	Aimag center	6.1	42.8	55.9	14.9	13.6	7.3	1.7	33.2	1211
	Soman center	6.7	42.4	58.9	13.0	10.5	6.3	1.7	36.8	1152
	Countryside	6.4	45.5	59.6	10.6	13.4	7.5	1.2	37.7	2329
Residence	Urban	5.8	49.6	56.2	14.6	13.5	6.6	1.7	38.5	2703
	Rural	6.5	44.5	59.4	11.4	12.4	7.1	1.4	37.4	3481
Woman's education level	None	10.4	43.8	56.3	6.3	12.5	6.3	4.2	25.0	48
	Primary	4.5	44.4	59.1	9.6	8.9	4.5	1.6	29.7	313
	Non-Completed Secondary	7.2	46.1	58.1	12.6	13.6	7.6	1.3	37.6	1645
	Completed Secondary	7.2	46.4	58.0	12.1	13.7	7.6	1.3	39.6	2064
	Vocational	2.9	47.1	56.2	12.5	10.2	3.9	1.9	33.6	648
	Vocational training and College	4.4	47.4	60.0	15.3	12.6	6.7	1.3	40.1	818
	Higher	6.0	50.1	57.8	14.0	13.7	7.0	2.5	39.6	599
	Missing/DK	10.2	38.8	38.8	24.5	16.3	8.2	-	34.7	49
Total		6.2	46.7	58.0	12.8	12.9	6.9	1.5	37.9	6184

Monitoring IMCI and Malaria Indicator

Table 30: Percentage of women aged 15-49 who know the main ways of preventing HIV transmission. Mongolia, 2000

		Heard of AIDS	Have only one faithful uninfected sex partner	Using a condom every time	Abstaining from sex	Knows all three ways	Knows at least one way	Doesn't know any way	Number of women
Region	Western	94.9	81.6	78.0	44.1	37.9	87.6	12.4	1475
	Northern	89.1	75.9	76.1	35.8	29.0	83.0	17.0	1784
	Southern	88.8	79.3	78.6	37.2	32.5	84.4	15.6	570
	Eastern	95.9	76.2	80.1	46.2	31.5	89.5	10.5	821
	Central-1	92.9	79.6	77.2	43.3	36.7	86.0	14.0	1342
	Central-2	98.9	91.8	87.9	55.2	50.6	95.1	4.9	2265
	Capital city	98.9	91.8	87.9	55.2	50.6	95.1	4.9	2265
Household location	Aimag center	95.7	82.2	82.6	51.0	40.8	91.1	8.9	1728
	Soman center	94.0	80.6	79.2	40.5	33.7	87.1	12.9	1502
	Countryside	89.2	75.0	73.6	35.2	29.1	81.8	18.2	2762
Residence	Urban	97.5	87.7	85.6	53.4	46.3	93.4	6.6	3993
	Rural	90.9	77.0	75.6	37.1	30.7	83.7	16.3	4264
Age group	15-19	89.7	74.0	72.7	43.1	36.2	81.3	18.7	1394
	20-24	95.0	82.2	80.4	45.4	38.4	88.7	11.3	1784
	25-29	95.5	84.5	83.1	45.5	39.0	90.4	9.6	1767
	30-34	94.9	84.2	83.5	45.2	39.3	90.1	9.9	1326
	35-39	94.4	85.6	82.2	48.9	42.4	90.3	9.7	949
	40-44	94.0	81.2	79.7	42.1	33.6	88.6	11.4	649
	45-49	96.1	87.1	82.5	41.5	35.8	91.8	8.2	388
Woman's education level	None	63.0	47.8	47.8	23.9	18.5	53.3	46.7	92
	Primary	84.2	65.2	65.6	33.1	25.8	73.6	26.4	759
	Non-Completed Secondary	91.7	77.1	76.1	38.1	31.5	83.9	16.1	2099
	Completed Secondary	97.1	86.4	84.4	49.3	42.1	92.7	7.3	2582
	Vocational	96.4	84.7	81.6	44.3	38.0	90.8	9.2	760
	Vocational training and College	99.5	90.9	88.9	50.3	44.3	95.6	4.4	1008
	Higher	98.9	92.8	89.0	59.0	52.2	97.2	2.8	849
Missing/DK	61.1	44.4	45.4	20.4	17.6	49.1	50.9	108	
Total		94.1	82.2	80.4	45.0	38.3	88.4	11.6	8257

Monitoring HIV/AIDS Indicator

Table 30a: Percentage of women aged 15-49 who know the main ways of preventing HIV transmission, Mongolia, 2000

		Heard of AIDS	Have only one faithful uninfected sex partner	Using a condom every time	Knows all two ways	Knows at least one way	Doesn't know any way	Number of women
Region	Western	94.9	81.6	78.0	73.5	86.1	13.9	1475
	Northern	89.1	75.9	76.1	69.5	82.5	17.5	1784
	Southern	88.8	79.3	78.6	74.6	83.3	16.7	570
	Eastern	95.9	76.2	80.1	67.6	88.8	11.2	821
	Central-1	92.9	79.6	77.2	72.4	84.4	15.6	1342
	Central-2	98.9	91.8	87.9	85.2	94.5	5.5	2265
Residence	Urban	97.5	87.7	85.6	80.8	92.5	7.5	3993
	Rural	90.9	77.0	75.6	69.9	82.7	17.3	4264
Age group	15-19	89.7	74.0	72.7	66.5	80.2	19.8	1394
	20-24	95.0	82.2	80.4	74.9	87.6	12.4	1784
	25-29	95.5	84.5	83.1	77.9	89.7	10.3	1767
	30-34	94.9	84.2	83.5	78.4	89.3	10.7	1326
	35-39	94.4	85.6	82.2	78.1	89.7	10.3	949
	40-44	94.0	81.2	79.7	73.3	87.5	12.5	649
	45-49	96.1	87.1	82.5	79.1	90.5	9.5	388
Woman's education level	None	63.0	47.8	47.8	43.5	52.2	47.8	92
	Primary	84.2	65.2	65.6	58.6	72.2	27.8	759
	Non-Completed Secondary	91.7	77.1	76.1	70.1	83.1	16.9	2099
	Completed Secondary	97.1	86.4	84.4	79.0	91.8	8.2	2582
	Vocational	96.4	84.7	81.6	76.6	89.7	10.3	760
	Vocational training and College	99.5	90.9	88.9	84.7	95.0	5.0	1008
	Higher	98.9	92.8	89.0	85.7	96.1	3.9	849
	Missing/DK	61.1	44.4	45.4	40.7	49.1	50.9	108
	Total	94.1	82.2	80.4	75.1	87.4	12.6	8257

Table 31: Percentage of women aged 15-49 who correctly identify misconceptions about HIV/AIDS. Mongolia, 2000

		Heard of AIDS	AIDS can't be transmitted by supernatural means	AIDS can't be transmitted by mosquito bites	A healthy looking person can be infected	Knows all three misconcep- tions	Knows at least one misconcep- tion	Doesn't correctly identify any misconception	Number of women
Region	Western	94.9	72.8	56.6	49.2	31.0	85.1	14.9	1475
	Northern	89.1	72.5	62.3	55.3	41.1	81.3	18.7	1784
	Southern	88.8	68.4	48.2	44.9	24.0	79.8	20.2	570
	Eastern	95.9	78.8	59.1	50.7	36.5	88.2	11.8	821
	Central-1	92.9	71.5	52.4	51.9	29.7	83.8	16.2	1342
	Central-2	98.9	85.9	61.5	67.7	43.4	93.4	6.6	2265
Household location	Capital city	98.9	85.9	61.5	67.7	43.4	93.4	6.6	2265
	Aimag center	95.7	81.8	61.2	60.9	41.6	90.3	9.7	1728
	Soman center	94.0	73.7	57.5	52.9	34.5	84.6	15.4	1502
Residence	Countryside	89.2	66.7	53.9	44.7	28.6	78.8	21.2	2762
	Urban	97.5	84.1	61.4	64.7	42.6	92.1	7.9	3993
	Rural	90.9	69.2	55.2	47.6	30.7	80.9	19.1	4264
Age group	15-19	89.7	69.9	56.4	54.3	35.9	80.8	19.2	1394
	20-24	95.0	77.6	59.9	58.5	38.5	88.3	11.7	1784
	25-29	95.5	79.3	59.8	55.7	36.8	87.7	12.3	1767
	30-34	94.9	76.2	59.3	54.1	35.4	86.3	13.7	1326
	35-39	94.4	77.8	56.5	57.9	35.7	88.1	11.9	949
	40-44	94.0	75.8	54.5	53.0	35.1	84.6	15.4	649
	45-49	96.1	79.1	55.7	56.2	35.1	88.4	11.6	388
Woman's education level	None	63.0	38.0	34.8	33.7	17.4	53.3	46.7	92
	Primary	84.2	58.2	48.9	43.1	27.1	71.1	28.9	759
	Non-Completed	91.7	68.7	55.6	50.6	32.1	81.4	18.6	2099
	Secondary	97.1	82.2	60.7	59.3	39.9	90.2	9.8	2582
	Completed Secondary	96.4	74.6	53.9	52.8	29.2	87.9	12.1	760
	Vocational	99.5	88.4	64.8	61.7	41.7	95.1	4.9	1008
	Vocational training and College	98.9	90.2	66.9	72.1	49.9	96.5	3.5	849
	Higher	61.1	40.7	33.3	25.9	17.6	48.1	51.9	108
	Missing/DK	94.1	76.4	58.2	55.9	36.4	86.3	13.7	8257
Total									

Monitoring HIV/AIDS Indicator

Table 32: Percentage of women aged 15-49 who correctly identify means of HIV transmission from mother to child, Mongolia, 2000

		Know AIDS can be transmitted from mother to child	Transmission during pregnancy possible	Transmission at delivery possible	Transmission through breastmilk possible	Knows all three	Did not know any specific way	Number of women
Region	Western	74.9	68.1	62.6	42.7	37.3	27.7	1475
	Northern	61.4	43.3	43.9	24.1	18.8	43.6	1784
	Southern	64.9	56.1	52.5	34.7	26.3	37.4	570
	Eastern	75.6	53.6	62.2	30.7	24.8	28.6	821
	Central-1	66.6	57.0	50.8	37.7	29.6	36.4	1342
	Central-2	71.3	64.2	58.3	29.7	24.9	31.1	2265
Household location	Capital city	71.3	64.2	58.3	29.7	24.9	31.1	2265
	Aimag center	71.8	57.5	56.0	33.7	28.1	32.3	1728
	Soman center	69.6	57.3	54.2	33.3	26.5	34.4	1502
Residence	Countryside	65.1	52.5	51.3	33.8	27.3	38.0	2762
	Urban	71.5	61.3	57.3	31.4	26.2	31.6	3993
	Rural	66.7	54.2	52.3	33.6	27.0	36.7	4264
Age group	15-19	57.2	44.8	44.5	24.5	19.5	46.6	1394
	20-24	67.9	54.3	53.7	30.3	24.6	36.0	1784
	25-29	72.6	61.3	57.8	34.2	27.7	30.2	1767
	30-34	74.7	64.0	59.6	37.2	31.1	28.4	1326
	35-39	72.0	63.5	57.5	35.8	29.8	30.7	949
	40-44	70.4	60.4	55.2	35.4	28.8	32.8	649
	45-49	71.4	60.6	58.0	35.6	30.4	31.4	388
Woman's education level	None	41.3	31.5	30.4	25.0	20.7	62.0	92
	Primary	52.8	41.2	41.0	26.9	20.3	51.0	759
	Non-Completed	64.7	50.9	51.0	32.3	25.8	38.7	2099
	Secondary	71.3	58.6	56.6	33.3	27.8	32.5	2582
	Completed Secondary	74.5	65.3	58.0	40.0	31.4	28.2	760
	Vocational	79.8	72.1	66.6	34.8	30.4	22.5	1008
	Vocational training and College	76.7	67.6	59.7	29.2	24.1	26.4	849
	Higher	38.0	32.4	26.9	18.5	15.7	63.9	108
	Missing/DK							
	Total	69.0	57.6	54.7	32.6	26.6	34.2	8257

Monitoring HIV/AIDS Indicator

Table 33: Percentage of women aged 15-49 who express a discriminatory attitude towards people with HIV/AIDS, Mongolia, 2000

		Believe that a teacher with HIV should not be allowed to work	Would not buy food from a person with HIV/AIDS	Agree with at least one discriminatory statement	Agree with neither discriminatory statement	Number of women
Region	Western	35,2	12,8	36,9	63,1	1475
	Northern	40,2	7,0	42,1	57,9	1784
	Southern	25,4	10,7	27,0	73,0	570
	Eastern	38,5	6,7	40,1	59,9	821
	Central-1	38,9	15,9	41,0	59,0	1342
	Central-2	52,9	21,9	54,6	45,4	2265
Household location	Capital city	52,9	21,9	54,6	45,4	2265
	Aimag center	49,8	16,8	52,1	47,9	1728
	Soman center	37,1	10,9	38,6	61,4	1502
Residence	Countryside	29,0	6,8	30,7	69,3	2762
	Urban	51,6	19,7	53,5	46,5	3993
Age group	Rural	31,9	8,3	33,5	66,5	4264
	15-19	42,3	14,6	44,0	56,0	1394
	20-24	44,3	14,2	46,4	53,6	1784
	25-29	41,4	14,2	42,8	57,2	1767
	30-34	38,8	12,9	40,7	59,3	1326
	35-39	39,5	14,1	41,5	58,5	949
	40-44	40,5	11,7	41,9	58,1	649
Woman's education level	45-49	39,7	13,1	41,2	58,8	388
	None	28,3	3,3	29,3	70,7	92
	Primary	31,4	9,6	33,5	66,5	759
	Non-Completed Secondary	34,7	9,6	36,5	63,5	2099
	Completed Secondary	44,5	15,1	46,0	54,0	2582
	Vocational	33,8	10,9	35,9	64,1	760
	Vocational training and College	46,7	15,6	48,2	51,8	1008
	Higher	62,1	26,7	64,3	35,7	849
Missing/DK	20,4	4,6	21,3	78,7	108	
Total		41,4	13,8	43,2	56,8	8257

Monitoring HIV/AIDS Indicator

Table 34: Percentage of women aged 15-49 who have sufficient knowledge of HIV/AIDS transmission, Mongolia, 2000

		Heard of AIDS	Know 3 ways to prevent HIV transmission	Correctly identify 3 misconceptions about HIV transmission	Have sufficient knowledge	Number of women
Region	Western	94.9	37.9	31.0	20.1	1475
	Northern	89.1	29.0	41.1	16.9	1784
	Southern	88.8	32.5	24.0	10.5	570
	Eastern	95.9	31.5	36.5	16.7	821
	Central-1	92.9	36.7	29.7	16.3	1342
	Central-2	98.9	50.6	43.4	27.7	2265
Household location	Capital city	98.9	50.6	43.4	27.7	2265
	Aimag center	95.7	40.8	41.6	23.0	1728
	Soman center	94.0	33.7	34.5	16.9	1502
	Countryside	89.2	29.1	28.6	13.1	2762
Residence	Urban	97.5	46.3	42.6	25.7	3993
	Rural	90.9	30.7	30.7	14.5	4264
Age group	15-19	89.7	36.2	35.9	20.7	1394
	20-24	95.0	38.4	38.5	20.7	1784
	25-29	95.5	39.0	36.8	18.8	1767
	30-34	94.9	39.3	35.4	20.1	1326
	35-39	94.4	42.4	35.7	21.0	949
	40-44	94.0	33.6	35.1	17.6	649
	45-49	96.1	35.8	35.1	18.6	388
Woman's education level	None	63.0	18.5	17.4	7.6	92
	Primary	84.2	25.8	27.1	13.3	759
	Non-Completed Secondary	91.7	31.5	32.1	16.1	2099
	Completed Secondary	97.1	42.1	39.9	22.4	2582
	Vocational	96.4	38.0	29.2	15.5	760
	Vocational training and College	99.5	44.3	41.7	23.1	1008
	Higher	98.9	52.2	49.9	30.9	849
	Missing/DK	61.1	17.6	17.6	4.6	108
	Total	94.1	38.3	36.4	19.9	8257

Monitoring HIV/AIDS Indicator

**Table 35: Percentage of women aged 15-49 who know where to get an AIDS test and who have been tested.
Mongolia, 2000**

		Know a place to get tested	Have been tested	If tested, have been told result	Number of women
Region	Western	46,6	4,5	73,1	1475
	Northern	49,4	5,2	76,1	1784
	Southern	44,9	14,9	70,6	570
	Eastern	56,6	10,7	87,5	821
	Central-1	46,3	17,0	76,8	1342
	Central-2	69,4	27,2	90,7	2265
Household location	Capital city	69,4	27,2	90,7	2265
	Aimag center	63,5	19,0	83,8	1728
	Soman center	49,6	6,5	72,2	1502
	Countryside	38,7	4,9	63,7	2762
Residence	Urban	66,9	23,6	88,3	3993
	Rural	42,5	5,4	67,2	4264
Age group	15-19	39,9	5,5	64,9	1394
	20-24	54,9	15,1	85,2	1784
	25-29	57,8	15,7	87,4	1767
	30-34	59,8	19,5	83,8	1326
	35-39	58,6	17,4	86,1	949
	40-44	56,1	13,7	83,1	649
	45-49	55,4	9,8	89,5	388
Woman's education level	None	26,1	5,4	100	92
	Primary	34,4	3,7	60,7	759
	Non-Completed Secondary	44,4	8,1	72,8	2099
	Completed Secondary	57,4	16,2	84,4	2582
	Vocational	52,4	14,2	83,3	760
	Vocational training and College	68,7	19,5	90,4	1008
	Higher	78,8	28,9	89,8	849
	Missing/DK	25,9	5,6	66,7	108
	Total	54,3	14,2	84,2	8257

Monitoring HIV/AIDS Indicator

Table 36: Percentage of married or in union women aged 15-49 who are using (or whose partner is using) a contraceptive method, Mongolia, 2000

		No method	Current method							Female condom
			Female sterilization	Male sterilization	Pill	IUD	Injections	Implants	Condom	
Region	Western	27,7	0,4	-	5,4	36,2	7,4	0,1	4,1	0,5
	Northern	41,1	1,4	0,4	5,8	35,7	6,8	0,2	2,7	0,9
	Southern	32,2	2,0	-	13,4	37,0	4,5	0,6	4,5	-
	Eastern	37,0	1,6	-	6,1	34,8	5,4	0,7	4,3	1,1
	Central-1	25,3	1,7	-	13,4	31,8	6,5	0,4	2,8	0,1
	Central-2	31,8	1,3	0,4	9,0	29,4	3,7	0,2	6,7	0,5
Household location	Capital city	31,8	1,3	0,4	9,0	29,4	3,7	0,2	6,7	0,5
	Aimag center	28,4	1,3	-	8,5	34,7	6,7	0,6	3,6	0,6
	Soman center	28,8	1,0	0,1	9,4	33,4	8,1	0,1	4,8	0,7
Residence	Countryside	37,8	1,5	0,2	7,1	36,1	5,5	0,2	2,7	0,5
	Urban	30,3	1,3	0,2	8,8	31,7	5,0	0,4	5,4	0,5
	Rural	34,7	1,3	0,2	7,9	35,2	6,4	0,2	3,4	0,6
Age group	15-19	64,8	-	-	4,5	15,9	4,5	-	5,7	1,1
	20-24	37,3	0,1	0,1	8,0	32,7	6,6	0,1	5,0	0,1
	25-49	30,9	1,6	0,2	8,5	34,1	5,6	0,3	4,1	0,6
Woman's education level	None	58,6	-	-	-	31,0	3,4	-	3,4	-
	Primary	48,2	2,2	-	1,8	32,6	5,8	0,4	1,3	-
	Non-Completed Secondary	39,9	1,4	0,3	5,4	36,3	4,7	0,4	3,2	0,3
	Completed Secondary	32,3	1,1	0,1	8,9	33,6	6,4	0,1	3,0	0,7
	Vocational	29,9	1,8	0,4	8,8	35,6	7,0	-	3,0	0,2
	Vocational training and College	27,8	1,8	0,1	9,9	33,5	5,4	0,2	5,6	0,9
	Higher	21,0	0,3	0,2	12,8	27,3	4,7	0,8	10,6	0,8
	Missing/DK	51,7	-	-	-	20,7	20,7	-	-	-
	Total	32,6	1,3	0,2	8,3	33,5	5,8	0,3	4,3	0,6

World Summit for Children Goal => Number 10

Table 38: Percent distribution of women aged 15-49 with a birth in the last year by type of personnel delivering antenatal care, Mongolia, 2000

		Person delivering antenatal care					Total	Any skilled personnel	Number of women
		Doctor	Nurse/ midwife	Auxiliary midwife	Other/ missing	No antenatal care received			
Region	Western	84.9	9.8	-	3.7	1.6	100	94.7	245
	Northern	93.1	5.2	0.2	0.5	1.0	100	98.5	403
	Southern	89.1	8.2	-	2.7	-	100	97.3	110
	Eastern	91.1	8.2	-	-	0.7	100	99.3	146
	Central-1	93.7	2.7	-	1.8	1.8	100	96.4	221
	Central-2	93.1	2.1	-	1.3	3.6	100	95.1	390
Household location	Capital city	93.1	2.1	-	1.3	3.6	100	95.1	390
	Aimag center	96.2	1.7	-	1.4	0.7	100	97.9	291
	Soman center	93.4	4.8	0.4	0.7	0.7	100	98.5	272
	Countryside	86.7	9.6	-	2.1	1.6	100	96.3	562
Residence	Urban	94.4	1.9	-	1.3	2.3	100	96.3	681
	Rural	88.8	8.0	0.1	1.7	1.3	100	97.0	834
Woman's education level	None	90.0	-	-	-	10.0	100	90.0	10
	Primary	96.4	1.2	-	-	2.4	100	97.6	84
	Non-Completed	89.3	7.4	0.3	1.5	1.5	100	96.9	391
	Secondary	92.5	4.7	-	1.2	1.6	100	97.2	572
	Completed Secondary	90.2	6.0	-	2.3	1.5	100	96.2	133
	Vocational	88.4	5.8	-	3.5	2.3	100	94.2	172
	Vocational training and College	95.0	2.2	-	0.7	2.2	100	97.1	139
	Higher	85.7	14.3	-	-	-	100	100.0	14
Missing/DK	85.7	14.3	-	-	-	100	100.0	14	
Total		91.4	5.3	0.1	1.5	1.8	100	96.7	1515

World Summit for Children Goals => Numbers 9, 11

Table: 36, Continuation

		Current method					Total	Any modern method	Any traditional method	Any method	Number of currently married women
		Diaphragm/foam/jelly	LAM	Periodic abstinence	Withdrawal	Other					
By region	Western	-	10.8	7.0	0.5	-	100	54.1	18.3	72.3	962
	Northern	0.1	-	4.8	-	0.1	100	54.0	4.9	58.9	1131
	Southern	-	-	5.9	-	-	100	61.9	5.9	67.8	357
	Eastern	0.2	2.2	6.3	-	0.4	100	54.0	9.0	63.0	446
	Central-1	0.1	8.5	8.4	-	0.9	100	56.9	17.8	74.7	754
	Central-2	0.1	4.0	12.3	0.1	0.3	100	51.5	16.7	68.2	1340
Household location	Capital city	0.1	4.0	12.3	0.1	0.3	100	51.5	16.7	68.2	1340
	Aimag center	0.3	4.8	10.0	0.1	0.5	100	56.2	15.4	71.6	1026
	Soman center	-	6.3	6.9	0.3	0.2	100	57.5	13.7	71.2	905
Residence	Countryside	-	4.2	4.0	0.1	0.2	100	53.8	8.4	62.2	1719
	Urban	0.2	4.4	11.3	0.1	0.4	100	53.6	16.1	69.7	2366
	Rural	-	4.9	5.0	0.2	0.2	100	55.1	10.2	65.3	2624
Age group	15-19	-	2.3	1.1	-	-	100	31.8	3.4	35.2	88
	20-24	-	6.6	3.1	-	0.1	100	52.8	9.8	62.7	895
	25-49	0.1	4.3	9.2	0.1	0.3	100	55.2	14.0	69.1	4007
Woman's education level	None	-	3.4	-	-	-	100	37.9	3.4	41.4	29
	Primary	-	5.4	1.8	-	0.4	100	44.2	7.6	51.8	224
	Non-Completed Secondary	0.1	4.3	3.2	0.3	0.2	100	52.2	7.9	60.1	1161
	Completed Secondary	-	5.8	7.7	0.1	0.2	100	54.0	13.7	67.7	1543
	Vocational	0.2	5.3	7.5	0.2	0.4	100	56.7	13.3	70.1	571
	Vocational training and College	0.1	3.3	10.9	0.1	0.4	100	57.6	14.7	72.2	818
	Higher	0.3	3.6	17.1	-	0.5	100	57.9	21.1	79.0	615
	Missing/DK	-	3.4	3.4	-	-	100	41.4	6.9	48.3	29
	Total	0.1	4.6	8.0	0.1	0.3	100	54.3	13.0	67.4	4990

**Table 39: Percent distribution of women aged 15-49 with a birth in the last year by type of personnel assisting at delivery.
Mongolia, 2000**

		Person assisting at delivery						Total	Any skilled personnel	Number of women	
		Doctor	Nurse/ midwife	Auxiliary midwife	Traditional birth attendant	Relative/ friend	Other/ missing				No assistance received
Region	Western	50.6	42.0	1.2	-	2.0	4.1	-	100	93.9	245
	Northern	50.9	46.2	0.7	-	0.7	1.0	0.5	100	97.8	403
	Southern	38.2	57.3	0.9	-	0.9	2.7	-	100	96.4	110
	Eastern	57.5	37.7	4.8	-	-	-	-	100	100	146
	Central-1	66.5	29.9	0.5	0.5	0.5	2.3	-	100	96.8	221
	Central-2	74.1	21.3	0.5	-	-	1.3	2.8	100	95.9	390
Household location	Capital city	74.1	21.3	0.5	-	-	1.3	2.8	100	95.9	390
	Aimag center	55.7	41.2	1.4	-	0.3	1.4	-	100	98.3	291
	Soman center	60.7	37.1	0.7	0.4	0.4	0.7	-	100	98.5	272
Residence	Countryside	48.9	44.8	1.6	-	1.4	2.8	0.4	100	95.4	562
	Urban	66.2	29.8	0.9	-	0.1	1.3	1.6	100	96.9	681
	Rural	52.8	42.3	1.3	0.1	1.1	2.2	0.2	100	96.4	834
Woman's education level	None	30.0	50.0	-	-	20.0	-	-	100	80.0	10
	Primary	58.3	39.3	-	-	-	1.2	1.2	100	97.6	84
	Non-Completed	53.7	40.2	2.0	0.3	1.5	2.0	0.3	100	95.9	391
	Secondary	62.2	34.8	0.9	-	-	1.4	0.7	100	97.9	572
	Completed Secondary	63.2	33.8	0.8	-	-	2.3	-	100	97.7	133
	Vocational	54.1	39.5	0.6	-	-	3.5	2.3	100	94.2	172
	Vocational training and College	65.5	30.2	1.4	-	-	0.7	2.2	100	97.1	139
	Higher	35.7	50.0	-	-	14.3	-	-	100	85.7	14
Missing/DK											
Total		58.8	36.7	1.1	0.1	0.7	1.8	0.9	100	96.6	1515

World Summit for Children Goal => Numbers 11

Table 40: Percent distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, Mongolia, 2000

		Registration status								Total	Number of children
		Birth registered	DK if birth registered	Must travel too far	Didn't know it should be registered	Late & didn't want to pay fine	Doesn't know where to register	Other	Reason DK or Missing		
Sex	Male	97.2	0.5	0.3	-	0.0	0.0	1.9	-	100	3150
	Female	98.0	0.1	0.2	0.0	0.1	0.0	1.5	0.1	100	3034
Region	Western	97.1	0.3	0.2	-	-	-	2.3	0.2	100	1186
	Northern	98.3	0.3	0.1	0.1	-	0.1	1.3	-	100	1598
	Southern	97.0	0.2	0.2	-	-	-	2.6	-	100	430
	Eastern	97.7	-	0.5	-	0.2	-	1.6	-	100	575
	Central-1	96.9	0.6	0.3	-	-	-	2.2	-	100	903
	Central-2	97.9	0.3	0.3	-	0.1	0.1	1.3	-	100	1492
	Capital city	97.9	0.3	0.3	-	0.1	0.1	1.3	-	100	1492
Household location	Aimag center	98.2	0.1	0.4	-	0.1	-	1.2	0.1	100	1211
	Soman center	98.0	0.3	0.1	-	-	-	1.5	0.1	100	1152
	Countryside	97.0	0.3	0.2	0.0	-	0.0	2.4	-	100	2329
Residence	Urban	98.0	0.2	0.3	-	0.1	0.0	1.3	0.0	100	2703
	Rural	97.3	0.3	0.1	0.0	-	0.0	2.1	0.0	100	3481
Age group	< 6 months	84.8	0.6	1.7	0.2	-	0.3	12.2	0.3	100	656
	6-11 months	97.9	0.3	-	-	0.1	-	1.7	-	100	708
	12-23 months	98.9	0.2	0.1	-	0.1	-	0.8	-	100	1255
	24-35 months	99.3	0.2	0.2	-	-	-	0.3	-	100	1193
	36-47 months	99.6	0.2	-	-	0.1	-	0.1	-	100	1131
	48-59 months	99.5	0.5	-	-	-	-	0.0	-	100	1241
Woman's education level	None	97.9	-	-	-	-	-	2.1	-	100	48
	Primary	94.9	0.6	0.3	-	-	-	4.2	-	100	313
	Non-Completed	97.3	0.4	0.2	0.1	0.1	-	1.9	-	100	1645
	Secondary	97.8	0.4	0.3	-	-	-	1.5	-	100	2064
	Completed Secondary	96.8	0.2	-	-	-	0.2	2.8	0.2	100	648
	Vocational	98.7	0.1	0.4	-	-	-	0.9	-	100	818
	Vocational training and College	99.0	-	-	-	0.2	-	0.7	0.2	100	599
	Higher	95.9	-	-	-	-	2.0	2.0	-	100	49
Missing/DK	95.9	-	-	-	-	2.0	2.0	-	100	49	
Total		97.6	0.3	0.2	0.0	0.0	0.0	1.7	0.0	100	6184

Table 41: Percentage of children 0-14 years of age in households not living with a biological parent. Mongolia, 2000

		Living arrangement					Living with mother only:		Living with father only:		Total	Not living with a biological parent	One of parents dead	Number of children
	Living with both parents	Living with father only: mother alive	Living with father only: mother dead	Both are alive	Both are dead	Father alive	Father dead	Mother alive	Mother dead					
Sex	Male	80.1	0.1	0.1	1.2	0.3	12.3	4.5	0.4	0.6	100	1.7	5.7	6479
	Female	80.8	0.2	0.2	1.2	0.2	11.9	4.3	0.2	0.7	100	1.8	5.6	6327
Region	Western	90.0	0.0	0.1	0.8	0.2	4.4	3.9	0.0	0.5	100	1.1	4.6	2520
	Northern	81.3	0.3	0.1	1.0	0.4	11.6	4.0	0.2	0.8	100	1.8	5.6	3200
	Southern	80.3	0.0	0.3	1.3	0.4	13.4	3.4	0.4	0.2	100	2.0	4.4	928
	Eastern	77.1	0.2	0.0	1.5	0.3	12.7	6.8	0.5	0.6	100	2.0	7.9	1213
	Central-1	74.8	0.2	0.3	1.7	0.1	15.7	5.5	0.2	0.7	100	2.3	6.8	2192
	Central-2	76.8	0.2	0.1	1.3	0.3	16.0	3.7	0.7	0.7	100	1.9	5.0	2753
	Capital city	76.8	0.2	0.1	1.3	0.3	16.0	3.7	0.7	0.7	100	1.9	5.0	2753
Household location	Aimag center	77.7	0.3	0.3	1.7	0.3	13.2	5.2	0.3	0.7	100	2.6	6.8	2681
	Soman center	82.2	0.1	0.0	0.7	0.2	11.0	4.9	0.2	0.5	100	1.0	5.6	2664
	Countryside	83.2	0.1	0.1	1.2	0.3	9.7	4.1	0.1	0.7	100	1.7	5.3	4708
Residence	Urban	77.2	0.2	0.2	1.5	0.3	14.6	4.5	0.5	0.7	100	2.2	5.9	5434
	Rural	82.9	0.1	0.1	1.0	0.2	10.2	4.4	0.2	0.6	100	1.5	5.4	7372
Age group	0-4 years	80.8	0.1	0.1	1.0	0.2	14.5	2.7	0.2	0.2	100	1.4	3.3	6198
	5-9 years	83.4	0.2	0.1	1.2	0.1	9.6	4.1	0.4	0.6	100	1.6	5.2	3376
	10-14 years	76.8	0.2	0.2	1.6	0.7	10.0	7.9	0.4	1.5	100	2.7	10.5	3232
Total		80.5	0.2	0.1	1.2	0.3	12.1	4.4	0.3	0.6	100	1.8	5.6	12806

Monitoring Children's Rights Indicator

Table 42: Percentage of children 5-14 years of age who are currently working, Mongolia, 2000

		Paid work	Unpaid work	Domestic work:		Currently working	Number of children
				< 4 hours per day	4 or more hours per day		
Sex	Male	0.9	0.6	71.5	18.4	1.5	3324
	Female	0.7	0.5	69.4	22.0	1.3	3284
Region	Western	0.8	0.5	66.7	26.4	1.3	1332
	Northern	1.1	0.6	68.0	20.3	1.7	1601
	Southern	0.2	0.4	80.3	11.1	0.6	497
	Eastern	1.9	1.4	68.1	25.0	3.3	637
	Central-1	0.6	0.7	70.4	20.2	1.3	1285
	Central-2	0.3	0.2	74.7	14.5	0.5	1256
Household location	Capital city	0.3	0.2	74.7	14.5	0.5	1256
	Aimag center	0.7	1.0	68.8	19.1	1.7	1467
	Soman center	1.7	0.9	72.6	18.8	2.6	1509
Residence	Countryside	0.5	0.4	67.7	24.7	0.9	2376
	Urban	0.6	0.6	71.5	17.0	1.1	2723
Age group	Rural	1.0	0.6	69.6	22.4	1.5	3885
	5-9 years	0.4	0.4	74.2	11.6	0.7	3376
	10-14 years	1.2	0.8	66.5	29.1	2.0	3232
Total		0.8	0.6	70.4	20.2	1.4	6608

Monitoring Children's Rights Indicator

Approved by National Statistical Office, Mongolia
2000. Order No

Form: CD1

SURVEY OF "CHILD AND DEVELOPMENT"

THE PURPOSE OF THIS SURVEY IS TO ANALYZE THE WOMEN'S AND CHILDREN'S HEALTH, EDUCATION AND THEIR LIVING CONDITIONS. BY STATISTICAL LAW YOUR FAMILY AND PERSONAL SECRETS WILL RELIABLY BE KEPT BY THE OFFICIALS WHO ARE CONDUCTING THIS SURVEY.

HI . Household questionnaire

1. IDENTIFICATION		
1.	Cluster number	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2.	Household number	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.	Data of interview: ddmmyyy	/ / /2000
4.	Identification code interview	<input type="checkbox"/> <input type="checkbox"/>
5.	Name of household head:	
6.	Household location : Capital-1 ; Aimag center-2 Soman center-3; Rural- 4	<input type="checkbox"/>
7.	Name of province /code/:	
HOUSING CONDITION		
8.	A Type of house: Apartment-1; hostel-2; dormitory-3 Ger-4; Other/..... /-5	<input type="checkbox"/>
	B Type of ownership: Government-1; Private-2; Other/..... /-5	<input type="checkbox"/>
	C Living area, by square meter:	m ²
	D Main construction material of walls: Brick-01; reinforced-02; stone-03; wood-04; straw-05; earth clay-06; Panel of GER: Single-07; Double-08; DK-99	<input type="checkbox"/> <input type="checkbox"/>
	E Main construction material of floor: Brick-01; reinforced-02; stone-03; wood-04; straw-05; earth clay-06; Cement-07	<input type="checkbox"/> <input type="checkbox"/>
	F Number of room:	
	H Number of walls of GER:	
	9	A Type of heating : Centralized-1; uncentralized-2; Simple-3
B Type of fuel use for cooking: Electricity-01; Charcoal-06; Firefood-07; Dung-08; Other/..... /-09 DK-99		<input type="checkbox"/> <input type="checkbox"/>

9	C	Does your household have: Electricity - 1 Radio - 2 Television - 3 Refrigerator - 4 ;	Yes 1 2 3 4
	D	Does any member of your household own: Bicycle - 1 Motorcycle or scooter - 2 Car or truck - 3	Yes 1 2 3
	E	Does your household owns farm livestock: Number: U50 - 1 51-100 - 2 101-200 - 3 201< - 4 ; No one - 0	<input type="checkbox"/>
	F	Does your household owns farm land: Size: U lga - 1 1- 3 - 2 3< - 3 ; No one - 0	<input type="checkbox"/>
	H	Consumption per person /months thous.tog	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
INTERVIEWER CHECKLIST			
10		Result of household interview: Completed-1; Refused-2; Not at home-3; Household not found-4; Other/..... /-5	<input type="checkbox"/>
11		Number of women eligible for interview:	---
12		Of which completed:	---
13		Number of child under 5 ages:	---
14		Of which completed:	---
15		Number of disability child between 0 and 18	---
16		Of which completed:	---
17		Number of household members	---

MICS-2. MONGOLIA.

Cluster no.

Household no.

HL . HOUSEHOLD ROSTER

FIRST, PLEASE TELL ME THE NAME OF EACH PERSON WHO USUALLY LIVES HERE, STARTING WITH THE HEAD OF THE HH.

(Use survey definition of HH member). List the first name in line 01. List adult HH members first, then list children. Then ask: ARE THERE ANY OTHERS WHO LIVE HERE, EVEN IF THEY ARE NOT AT HOME NOW? (THESE MAY INCLUDE CHILDREN IN SCHOOL OR AT WORK). If yes, complete listing. Then, ask and record answers to questions as described in Instructions for Interviewers.

Add a continuation sheet if there is not enough room on this page. Tick here if continuation sheet used

					Eligible for:			For persons age 15 or over ask Qs. 8 and 9				For children Under age 17 years Ask Qs. 10-13										
					WOMEN'S MODULES	CHILD LABOUR MODULE	CHILD HEALTH MODULES															
1. Line No.	2. Name	2A RELATION SHIP TO HEAD HH*	3. IS (name) MALE OR FEMALE ?		4. HOW OLD IS (name)? HOW OLD WAS (name) ON HIS/HER LAST BIRTHDAY? Record in Completed years 99=DK*	5. Circle Line no. if woman is age 15-49	6. For each Child age 5-14: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. of mother/ caretaker	7. For each child under 5: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. of mother/ caretaker	8. CAN HE/SHE READ A LETTER OR NEWSPAPER EASILY, WITH DIFFICULTY OR NOT AT ALL? 1 EASILY 2 DIFFICULT 3 NOT AT ALL 9 DK	9. WHAT IS THE MARITAL STATUS OF (name)?** 1 CURRENTLY MARRIED/ IN UNION 2 WIDOWED 3 DIVORCED 4 SEPARATED 5 NEVER MARRIED	10. IS (name's) NATURAL MOTHER ALIVE? 1 YES 2 NO 9 DK	11. If alive: DOES (name's) NATURAL MOTHER LIVE IN THIS HOUSE- HOLD? 1 YES 2 NO			12. IS (name's) NATURAL FATHER ALIVE? 1 YES 2 NO 9 DK			13. If alive: DOES (name's) NATURAL FATHER LIVE IN THIS HOUSE- HOLD? 1 YES 2 NO				
LINE	NAME	R	M	F	AGE	15-49	MOTHER	MOTHER	E	D	N	DK	Y	N	DK	Y	N	Y	N	DK	Y	N
01		1	1	2		01			1	2	3	9	1	2	9	1	2	1	2	9	1	2
02			1	2		02			1	2	3	9	1	2	9	1	2	1	2	9	1	2
03			1	2		03			1	2	3	9	1	2	9	1	2	1	2	9	1	2
04			1	2		04			1	2	3	9	1	2	9	1	2	1	2	9	1	2
05			1	2		05			1	2	3	9	1	2	9	1	2	1	2	9	1	2
06			1	2		06			1	2	3	9	1	2	9	1	2	1	2	9	1	2
07			1	2		07			1	2	3	9	1	2	9	1	2	1	2	9	1	2
08			1	2		08			1	2	3	9	1	2	9	1	2	1	2	9	1	2
09			1	2		09			1	2	3	9	1	2	9	1	2	1	2	9	1	2
10			1	2		10			1	2	3	9	1	2	9	1	2	1	2	9	1	2
11			1	2		11			1	2	3	9	1	2	9	1	2	1	2	9	1	2
12			1	2		12			1	2	3	9	1	2	9	1	2	1	2	9	1	2
13			1	2		13			1	2	3	9	1	2	9	1	2	1	2	9	1	2
14			1	2		14			1	2	3	9	1	2	9	1	2	1	2	9	1	2
15			1	2		15			1	2	3	9	1	2	9	1	2	1	2	9	1	2

* HEAD-1, SPOUSE-2, CHILD-3, PARENTS-4, PARENT-IN-LAW -5, BROTHER & SISTERS-6, GRANDCHILD-7, GRANDMOTHER & FATHER-8, NEPHEW / NIECE -9, OTHER FAMILY-10, NON RELATED-11

MICS-2. MONGOLIA.

Cluster no. _____ Household no. _____

ED . EDUCATION MODULE																												
If interview takes place between two school years, use alternative wording found in Appendix 1.																												
For persons age 5 or over ask Qs. 15 and 16					For children age 5 through 18 years, continue on, asking Qs. 17-22																							
14. Line no.	15. HAS (name) EVER ATTENDED SCHOOL?	16. WHAT IS THE HIGHEST LEVEL OF SCHOOL (name) ATTENDED? WHAT IS THE HIGHEST GRADE (name) COMPLETED AT THIS LEVEL? LEVEL: 2. PRIMARY 3. SECONDARY 4. HIGHER 5. OTHER 9. DK GRADE: 99. DK <i>If less than 1 grade, enter 00.</i>					17. Is (name) CURRENTLY ATTENDING SCHOOL?		18. DURING THE CURRENT SCHOOL YEAR, DID (name) ATTEND SCHOOL AT ANY TIME?		19. SINCE LAST (day of the week), HOW MANY DAYS DID (name) ATTEND SCHOOL?	20. WHICH LEVEL AND GRADE IS/WAS (name) ATTENDING? LEVEL: 1. PRESCHOOL 2. PRIMARY 3. SECONDARY 5. OTHER 9. DK GRADE: 99. DK			21. DID (name) ATTEND SCHOOL LAST YEAR? 1. YES 2. NO ↗ NEXT LINE 9. DK ↗ NEXT LINE			22. WHICH LEVEL AND GRADE DID (name) ATTEND LAST YEAR? LEVEL: 1. PRESCHOOL 2. PRIMARY 3. SECONDARY 5. OTHER 9. DK GRADE: 99. DK										
LINE	Y	NO	LEVEL					GRADE	YES	NO	YES	NO	DAYS	LEVEL			GRADE	Y	N	DK	LEVEL					GRADE		
01	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
02	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
03	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
04	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
05	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
06	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
07	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
08	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
09	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
10	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
11	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
12	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
13	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
14	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____
15	1	2	2	3	4	5	9	_____	1	2	1	2	_____	1	2	3	5	9	_____	1	2	9	1	2	3	5	9	_____

MICS-2. MONGOLIA.

Cluster no. _____

Household no. _____

CL . CHILD LABOUR MODULE																									
To be administered to caretaker of each child resident in the household age 5 through 17 years.																									
Copy line number of each eligible child from household listing.																									
Now I would like to ask about any work children in this household may do.																									
1. Line no.	2. Name	3. DURING THE PAST WEEK DID (name) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HH ? <i>If yes: FOR PAY?</i>			3 A <i>If yes:</i> WHAT KIND WORK DID HE/ SHE DO? ESTABLISHMENT - 1 LIVESTOCK-2 FARM-3 MARKET-4 IN THE STREET-5 RESTAURANT-6 HOUSE WORKER-7 OTHER-8 DK-99			4. <i>If yes:</i> SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? <i>If more than one job, include all hours at all jobs.</i> <i>Record response then ⇒ Q.6</i>			5. AT ANY TIME DURING THE PAST YEAR, DID (name) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? <i>If yes: FOR PAY?</i>			5 A <i>If yes:</i> WHAT KIND WORK DID HE/ SHE DO? ESTABLISHMENT - 1 LIVESTOCK-2 FARM-3 MARKET-4 IN THE STREET-5 RESTAURANT-6 HOUSE WORKER-7 OTHER-8 DK-99			6. DURING THE PAST WEEK, DID (name) HELP WITH HOUSEKEEPING CHORES SUCH AS COOKING, SHOPPING, CLEANING, WASHING CLOTHES, FETCHING WATER, OR CARING FOR CHILDREN? 1 YES 2 NO ⇒ Q.8		7. <i>If yes:</i> SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE SPEND DOING THESE CHORES?		8. DURING THE PAST WEEK, DID (name) DO ANY OTHER FAMILY WORK (ON THE FARM OR IN A BUSINESS)? 1 YES 2 NO ⇒ NEXT LINE		9. <i>If yes:</i> SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK?		10. <i>If yes:</i> WHAT KIND WORK DID HE/ SHE DO? ESTABLISHMENT-1 LIVESTOCK-2 FARM-3 TRADE, MARKET-4 SERVICE-10 OTHER- 8 DK-99
LINE NO.	NAME	YES			NO. HOURS	YES			YES	NO	NO. HOURS	YES	NO	NO. HOURS											
		PAID	UNPAID	NO		PAID	UNPAID	NO																	
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											
—		1	2	3	—	1	2	3	1	2	—	1	2	—											

MICS-2. MONGOLIA.

MM . OPTIONAL MATERNAL MORTALITY MODULE									
<i>Administer to each adult household member. Copy name and line number of each adult (age 15 or over) in the household. If one of these adults is not at home, another adult may respond for him/her. Indicate this by placing a '1' in column 3, and insert line number of proxy respondent in column 4</i>									
1.LINE NO (FROM HH LIST)	2.NAME	3. IS THIS A PROXY REPORT?		4. LINE NO. OF PROXY RESPONDENT	5. HOW MANY SISTERS (BORN TO SAME MOTHER) HAVE YOU EVER HAD?	6. HOW MANY OF THESE SISTERS EVER REACHED AGE 15**?	7. HOW MANY OF THESE SISTERS (WHO ARE AT LEAST 15 YEARS OLD) ARE ALIVE NOW?	8. HOW MANY OF THESE SISTERS WHO REACHED AGE 15 OR MORE HAVE DIED?	9. HOW MANY OF THESE DEAD SISTERS DIED WHILE PREGNANT, OR DURING CHILDBIRTH, OR DURING THE SIX WEEKS AFTER THE END OF PREGNANCY?*
		1- YES							
		2-NO ⇒ Q. 5			99-DK ⇒GOTO NEXT	99-DK	99-DK	99-DK	99-DK
LINE NO	NAME	YES	NO	LINE NO					
---		1	2						
---		1	2						
---		1	2						
---		1	2						
---		1	2						
---		1	2						
---		1	2						
---		1	2						
---		1	2						

WHEN ALL CHILDREN IN THE AGE RANGE HAVE BEEN COVERED, *go to water and sanitation module* ⇒

MICS-2. MONGOLIA.

Cluster no. _____

Household no. _____

DM . DISABILITY CHILD MODULE																									
To be administered to caretaker of each child resident in the household age under 18. Copy line number of each eligible child from household listing.																									
1. LINE NO	2. NAME	3. DOES HE/SHE... HAVE ANY SERIOUS DELAY? 1-YES 2-NO ⇒ GOTO NEXT		4. DOES HE/SHE... HAVE SERIUOS DELAY IN SITTING, STANDING OR WALKING & MOVING 1-YES 2-NO		5. DOES HE/SHE... HAVE DEFICULTY SEEING, EITHER IN THE DAYTIME, AT NIGHT? IF YES : 1- BAD SIGHTED 2- BLIND 3-NO			6. DOES HE/SHE... HAVE DEFICULT Y HEARING ? IF YES : 1- USES HEARING AID 2- HEARS WITH DEFFICULT Y 3-COMPLETLY DEAF 4-NO				7. DOES HE/SHE HAVE MIND PROBLEM ? 1-YES 2-NO		8. DOES HI/SHE SOMETIMES HAVE FITS, BECOME RIGED OR LOSS CONSCIOUSNESS ? 1-YES 2-NO		9. HAVE YOU EVER HAD A TREATMENT ? 1-YES 2-NO		10. HAVE YOU ANY RESULT / EFFECTIVE ? 1-GOOD 2-FAIR 3-NO			11. CAN YOU LIVE WITHOUT ANY SUPPORT OR BODY IN THE FUTHER? 1-YES 2-NO		12. HAVE YOU USE ANY AIDS? 1-YES 2-NO	
LINE NO	NAME	YES	NO	YES	NO	BA	BL	NO	U	H	C	N	YES	NO	YES	NO	YES	NO	G	F	NO	YES	NO	YES	NO
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2
		1	2	1	2	1	2	3	1	2	3	4	1	2	1	2	1	2	1	2	3	1	2	1	2

MICS-2. MONGOLIA.

Cluster no. _____

Household no. _____

WS . WATER AND SANITATION MODULE	
<p><i>This module is to be administered once for each household visited. Record only one response for each question. If more than one response is given, record the most usual source or facility.</i></p>	
<p>1. WHAT IS THE MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD?</p> <ul style="list-style-type: none"> • With centralized water supply system 01 • Piped into yard or plot 02 • Public tap 03 • Tubewell / borehole with pump 04 • Protected dug well 05 • Protected spring 06 • Rainwater collection 07 • Bottled water 08 • Unprotected dug well 09 • Unprotected spring 10 • Pond, river or stream 11 • Tanker-truck, vendor 12 • Other (specify) _____ 13 • NO ANSWER OR DK 99 	<p>4. IS THIS FACILITY LOCATED WITHIN YOUR DWELLING, OR YARD OR COMPOUND?*</p> <p>Yes, in dwelling/yard/compound 1 No, outside dwelling/yard/compound 2 DK 9</p>
<p>2. HOW LONG DOES IT TAKE TO GO THERE, GET WATER, AND COME BACK?</p> <ul style="list-style-type: none"> • No. of minutes _____ • Water on premises 888 • DK 999 	<p>5. WHAT HAPPENS WITH THE STOOLS OF YOUNG CHILDREN (0-3 YEARS) WHEN THEY DO NOT USE THE LATRINE OR TOILET FACILITY?</p> <ul style="list-style-type: none"> • Children always use toilet or latrine 1 • Thrown into toilet or latrine 2 • Thrown outside the yard 3 • Buried in the yard 4 • Not disposed of or left on the ground 5 • Other (specify) _____ 6 • No young children in household. 8
<p>3. WHAT KIND OF TOILET FACILITY DOES YOUR HOUSEHOLD USE?</p> <ul style="list-style-type: none"> • Flush to sewage system or septic tank 01 • Pour flush latrine (water seal type) 02 • Improved pit latrine (e.g., VIP) 03 • Traditional pit latrine 04 • Open pit 05 • Bucket 06 • Other (specify) _____ 07 • NO FACILITIES OR BUSH OR FIELD. 08 ⇒Q.5 • DK 09 	<p>SI . SALT IODIZATION MODULE</p> <p>1. WE WOULD LIKE TO CHECK WHETHER THE SALT USED IN YOUR HOUSEHOLD IS IODIZED. MAY I SEE A SAMPLE OF THE SALT USED TO COOK THE MAIN MEAL EATEN BY MEMBERS OF YOUR HOUSEHOLD LAST NIGHT? Once you have examined the salt, circle number that corresponds to test outcome.</p> <ul style="list-style-type: none"> • Not iodized 0 PPM (no colour) 1 • Less than 15 PPM (weak colour) 2 • 15 PPM or more (strong colour) 3 • No salt in home 8 • Salt not tested 9
<p>go to women's questionnaire ⇨</p>	
<p><i>Now for each woman age 15-49 years, write her name and line number at the top of each page in the Women's Questionnaire. For each child under age 5, write his/her name and line number AND the line number of his/her mother or caretaker at the top of each page in the Children's Questionnaire. You should now have a separate questionnaire for each eligible woman and child in the household.</i></p>	

QUESTIONNAIRE FOR INDIVIDUAL WOMEN

Cluster no. _____ Household no. _____ Women line no _____

WI . WOMEN'S INFORMATION PANEL		
This module is to be administered to all women age 15 through 49 (see column 5 of HH listing). Fill in one form for each eligible woman.		
1	Women's line number	<input type="text"/> <input type="text"/>
2	2. Name	
3	A IN WHAT MONTH AND YEAR WERE YOU BORN? Date of birth : Month/Year	____/____/____ 999999
	OR: B HOW OLD WERE YOU AT YOUR LAST BIRTHDAY? Age (in completed years)	<input type="text"/> <input type="text"/>
CM . CHILD MORTALITY MODULE		
This module is to be administered to all women age 15-49. All questions refer only to LIVE births. Follow instructions as provided in training. See Instructions for Interviewers		
1	NOW I WOULD LIKE TO ASK ABOUT ALL THE BIRTHS YOU HAVE HAD DURING YOUR LIFE. HAVE YOU EVER GIVEN BIRTH? 1-YES 2-NO ⇒ CONTRACEPTIVEUSE MODULE If "NO" probe by asking: I MEAN, TO A CHILD WHO EVER BREATHED OR CRIED OR SHOWED OTHER SIGNS OF LIFE – EVEN IF HE OR SHE LIVED ONLY A FEW MINUTES OR HOURS?	<input type="checkbox"/>
2	A If "NO" probe by asking: I MEAN, TO A CHILD WHO EVER BREATHED OR CRIED OR SHOWED OTHER SIGNS OF LIFE – EVEN IF HE OR SHE LIVED ONLY A FEW MINUTES OR HOURS? Date of first birth ddmmyyyy	____/____/____ 99999999
	DK DATE OF FIRST BIRTH ⇒ 2.B	
3	DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE NOW LIVING WITH YOU? 1-Yes 2- NO ⇒ Q5	<input type="checkbox"/>
4	HOW MANY SONS & DAUGHTERS LIVE WITH YOU? 1. SONS 2. DAUGHTERS	1. ____ 2. ____
5	DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE ALIVE BUT DO NOT LIVE WITH YOU? 1-YES 2-NO ⇒ Q7	<input type="checkbox"/>
6	HOW MANY SONS & DAUGHTERS ARE ALIVE BUT DO NOT LIVE WITH YOU? 1. SONS ELSEWHERE 2. DAUGHTERS ELSEWHERE	1. ____ 2. ____
7	HAVE YOU EVER GIVEN BIRTH TO A BOY OR GIRL WHO WAS BORN ALIVE BUT LATER DIED? 1-YES 2-NO ⇒ Q9	<input type="checkbox"/>
8	HOW MANY BOYS & GIRLS HAVE DIED? 1. Boys dead 2. Girls dead	____
9	SUM ANSWERS TO Q. 4, 6, AND 8 SUM	<input type="text"/> <input type="text"/>
10	JUST TO MAKE SURE THAT I HAVE THIS RIGHT, YOU HAVE HAD IN TOTAL (total number) BIRTHS DURING YOUR LIFE. IS THIS CORRECT? 1- Yes ⇒ Go to Q.11 2- No ⇒ Check responses and make corrections before proceeding to Q.11	<input type="checkbox"/>
11	OF THESE (total number) BIRTHS YOU HAVE HAD, WHEN DID YOU DELIVER THE LAST ONE (EVEN IF HE OR SHE HAS DIED)? Date of last birth /Day/Month/Year /	____/____/____
Did the woman's last birth occur within the last year, that is, since (insert date)? <input type="checkbox"/> Yes, live birth in last year. ⇒ GO TO TETANUS TOXOID MODULE <input type="checkbox"/> No live birth in last 2 year. ⇒ GO TO CONTRACEPTIVE USE MODULE		

Cluster no. _____ Household no. _____ Women line no _____

TT . Tetanus toxoid (tt) module			or B	How many years ago did you receive the last dose? Years ago	<input type="text"/> <input type="text"/>
This module is to be administered to all women with a live birth in the year preceding date of interview.					
1	Do YOU HAVE A CARD OR OTHER DOCUMENT WITH YOUR OWN IMMUNIZATIONS LISTED? <i>If a card is presented, use it to assist with answers to the following questions.</i> 1- Yes (card seen) 2- Yes (card not seen) 3-No 9-DK	<input type="checkbox"/>	7	Add responses to Q.3 and Q.5 to obtain total number of doses in lifetime. <i>Total no. of doses</i>	<input type="text"/> <input type="text"/>
MN . MATERNAL AND NEWBORN HEALTH MODULE					
This module is to be administered to all women with a live birth in the year preceding date of interview. Use Q.7 and Q.8 only in countries where a local term for night blindness exists.					
2	When you were pregnant with your last child, did you receive any injection to prevent him or her from getting convulsions after birth (an anti-tetanus shot, an injection at the top of the arm or shoulder)? 1-Yes 2-No 9-DK } ⇒Q.4	<input type="checkbox"/>	1	In the first two months after your last birth, did you receive a vitamin A dose like this? <i>Show 200,000 IU capsule or dispenser.</i> 1 – Yes 2 – No 9 – DK	
3	<i>IF YES:</i> How many doses of tetanus toxoid (anti-tetanus injections) did you receive during your last pregnancy? <i>No. of doses</i> 99 -DK	<input type="text"/> <input type="text"/>	2	DID YOU SEE ANYONE FOR ANTENATAL CARE FOR THIS PREGNANCY? <i>If yes: WHOM DID YOU SEE?</i> <u>Health professional:</u> 1-Doctor, 2-Nurse/midwife 3-Auxiliary midwife <u>Other person</u> 4-Traditional birth attendant 6-Other (specify) 0- No one Anyone else?	1 2 3 4 6 0
<i>How many TT doses were reported during last pregnancy in Q.3?</i> <input type="checkbox"/> <i>At least two TT injections during last pregnancy. ⇒ GO TO MATERNAL AND NEWBORN HEALTH MODULE</i> <input type="checkbox"/> <i>Fewer than two TT injections during last pregnancy. ⇒ CONTINUE WITH Q.4</i>					
4	Did you receive any tetanus toxoid injection (ADDITIONAL PROBES) at any time before your last pregnancy, including during a previous pregnancy or between pregnancies? 1-Yes 2-No 9-DK } ⇒Q.7	<input type="checkbox"/>	3	Who assisted with the delivery of your last child (OR NAME)? <i>IF YES:</i> <u>Health professional:</u> 1-Doctor 2-Nurse/midwife 3-Auxiliary midwife <u>Other person</u> 4-Traditional birth attendant 5-Relative/friend 6-Other (specify) 0-No one Anyone else?	1 2 3 4 5 6 0
5	<i>IF YES:</i> How many doses did you receive? <i>No. of doses</i>	<input type="text"/> <input type="text"/>			
6	A When was the last dose received? <i>Date of last dose /Month/Year /</i> <i>DK date ⇒Q.6B</i>	<input type="text"/> / <input type="text"/> <input type="text"/>			

		Cluster no. _____	Household no. _____	Women line no. _____
4	When your last child (<i>NAME</i>) was born, was he/she very large, larger than average, average, smaller than average, or very small? <i>Very large-1, Larger than average -2, Average - 3, Smaller than average - 4, Very small - 5, DK - 9</i>	<input type="checkbox"/>		
5	Was (<i>NAME</i>) weighed at birth? 1-Yes 2-No } ⇒A.7 9-DK	<input type="checkbox"/>		
6	HOW MUCH DID (<i>name</i>) WEIGH? RECORD WEIGHT FROM HEALTH CARD, IF AVAILABLE. 1 - From card 2 - From recall 99999 - DK	1. _____ gr 2. _____ gr 99999		
7	When you were pregnant with your last child, did you have difficulty with your vision during the daylight? 1-Yes 2-No 9-DK	<input type="checkbox"/>		
8	During that pregnancy, did you suffer from night blindness (<i>INSERT LOCAL TERM</i>)? 1-Yes 2-No 9-DK	<input type="checkbox"/>		
CU . CONTRACEPTIVE USA MODULE				
Ask Q.1 for all women age 15-49 and then follow the skip instruction carefully. Questions on pregnancy and contraception are to be asked only of women who are currently married or in union				
1	Are you currently married or living with a man? 1-Yes 2-No, widowed, divorced, separated } NEXT MODULE 3-No, never married	<input type="checkbox"/>		
2	Now i am going to change topics. I would like to talk with you about another subject – family planning – and your reproductive health. I know this is a difficult subject to talk about, but it is important that we obtain			
	this information. Of course, all the information you supply will remain strictly confidential. You will never be identified with the answers to these questions. Are you pregnant now? 1-Yes, currently pregnant ⇒ next module 2-No 3-Unsure or DK			<input type="checkbox"/>
3	Some couples use various ways or methods to delay or avoid a pregnancy. Are you currently doing something or using any method to delay or avoid getting pregnant? 1- Yes 2- No ⇒ next module			<input type="checkbox"/>
4	WHICH METHOD ARE YOU USING? 01-Female sterilization 02-Male sterilization 03-Pill 04-IUD 05-Injections 06-Implants 07-Condom 08-Female condom 09-Diaphragm 10-Foam/jelly 11-Lactational amenorrhoea method (LAM) 12-Periodic abstinence 13-Withdrawal 14-Other (specify)			01 02 03 04 05 06 07 08 09 10 11 12 13 14
HA . HIV/AIDS MODULE				
This module is to be administered to all women age 15-49. See Instructions for Interviewers for further discussion of these questions.				
1	Now I would like to talk with you about what you know about serious illness, in particular, about HIV and AIDS. Have you ever heard of the virus HIV or an illness called AIDS? 1-Yes 2-No ⇒Q.18			<input type="checkbox"/>

			Cluster no. _____	Household no. _____	Women line no. _____
2	Is there anything a person can do to avoid getting HIV, the virus that causes AIDS? 1-Yes 2-No 9-DK	<input type="checkbox"/>	9	Can the AIDS virus be transmitted from a mother to a child? 1-Yes 2-No 9-DK } Q. 13	<input type="checkbox"/>
3	Now I will read some questions about how people can protect themselves from the AIDS virus. Can people protect themselves from getting infected with the AIDS virus by having one uninfected sex partner who also has no other partners? 1-Yes 2-No 9-DK	<input type="checkbox"/>	10	Can the AIDS virus be transmitted from a mother to a child during pregnancy? 1-Yes 2-No 9-DK	<input type="checkbox"/>
4	Do you think a person can get infected with the AIDS virus through supernatural means?*** 1-Yes 2-No 9-DK	<input type="checkbox"/>	11	Can the AIDS virus be transmitted from a mother to a child at delivery? 1-Yes 2-No 9-DK	<input type="checkbox"/>
5	Can people protect themselves from the AIDS virus by using a condom correctly every time they have sex? 1-Yes 2-No 9-DK	<input type="checkbox"/>	12	Can the AIDS virus be transmitted from a mother to a child through breast milk? 1-Yes 2-No 9-DK	<input type="checkbox"/>
6	Can a person get the AIDS virus from mosquito bites? 1-Yes 2-No 9-DK	<input type="checkbox"/>	13	If a teacher has the AIDS virus but is not sick, should he or she be allowed to continue teaching in school? 1-Yes 2-No 9-DK	<input type="checkbox"/>
7	Can people protect themselves from getting infected with the AIDS virus by not having sex at all? 1-Yes 2-No 9-DK	<input type="checkbox"/>	14	If you knew that a shopkeeper or food seller had AIDS or the virus that causes it, would you buy food from him or her? 1-Yes 2-No 9-DK	<input type="checkbox"/>
8	Is it possible for a healthy-looking person to have the AIDS virus? 1-Yes 2-No 9-DK	<input type="checkbox"/>	15	I am not going to ask you about your HIV status (USE TERM UNDERSTOOD LOCALLY), but we are interested to know how much demand there is in your community for HIV testing and counselling. So, I would like to ask you: I do not want to know the results, but have you ever been tested to see if you have HIV, the virus that causes AIDS? 1-Yes 2-No ⇒ Q.17	<input type="checkbox"/>

16	I do not want you to tell me the results of the test, but have you been told the results? 1-Yes 2-No	<input type="checkbox"/>	4	Have you taken vitamin D from 2 months age? 1-Yes 2-No 9-DK	<input type="checkbox"/>
17	At this time, do you know of a place where you can go to get such a test to see if you have the AIDS virus? 1-Yes 2-No	<input type="checkbox"/>	5	Did your child sleep badly or wince? (Q5-Q12 will ask mother/ caretaker who had child under 3 years) 1-Yes 2-No 9-DK	<input type="checkbox"/>
18	Is the woman a caretaker of any children under five years of age? <input type="checkbox"/> Yes. ⇒ GO TO QUESTIONNAIRE FOR CHILDREN UNDER FIVE and administer one questionnaire for each child under five for whom she is the caretaker. <input type="checkbox"/> No. ⇒ CONTINUE WITH Q.19		6	Is the babies fontanel big & adage soft? 1-Yes 2-No 9-DK	<input type="checkbox"/>
19	Does another eligible woman reside in the household? <input type="checkbox"/> Yes. ⇒ End the current interview by thanking the woman for her cooperation and GO TO QUESTIONNAIRE FOR INDIVIDUAL WOMEN to administer the questionnaire to the next eligible woman. <input type="checkbox"/> No. ⇒ End the interview with this woman by thanking her for her cooperation. Gather together all questionnaires for this household and tally the number of interviews completed on the cover page		7	Have the teeth appeared in time? 1-Yes 2-No 9-DK	<input type="checkbox"/>
VD . DEFICIENCY 'D' VITAMIN MODULE			8	Is the baby bandy legged? 1-Yes 2-No 9-DK	<input type="checkbox"/>
This module is to be administered to all women who had delivered in last two years See Instructions for Interviewers for further discussion of these questions.			9	Is the baby got narrow chest? 1-Yes 2-No 9-DK	<input type="checkbox"/>
1	Did you have a deficiency vitamin "D"? 1-Yes 2-No 9-DK	<input type="checkbox"/>	10	Is the baby's back curved? 1-Yes 2-No 9-DK	<input type="checkbox"/>
2	Did you got vitamin D during the pregnant period? 1-Yes 2-No 9-DK	<input type="checkbox"/>	11	Is baby stomach enlarged? 1-Yes 2-No 9-DK	<input type="checkbox"/>
3	Did you delivered before the time 1-Yes 2-No 9-DK	<input type="checkbox"/>	12	Is baby head sweated ? 1-Yes 2-No 9-DK	<input type="checkbox"/>

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

This questionnaire is to be administered to all women who care for a child that lives with them. And is under the age of 5 years (see Q.4 of the HH listing). A separate form should be used for each eligible child. Questions should be administered to the mother or caretaker of the eligible child (see Q.7 of the HH listing). Fill in the line number of each child, the line number of the child's mother or caretaker, And the household and cluster numbers in the space at the top of each page.

Cluster no. _____ Household no. _____ Caretaker Line no. _____ Child Line no. _____

BR . BRITH REGISTRATION AND EARLY LEARNING MODULE			VA . VITAMIN "A" MODULE		
1	Child's name.	7	Do you know how to register your child's birth? 1-Yes 2-No 8-No answer	<input type="checkbox"/>
2	Child's age (copy from Q.4 of HH listing). Age (in completed years)	<input type="checkbox"/> <input type="checkbox"/>	8	CHECK AGE. IF CHILD IS 3 YEARS OLD OR MORE, ASK: Does (NAME) attend any organized learning or early childhood education programme, such as a private or government facility, including kindergarten or community child care? 1-Yes 2-No 9-DK } ⇒NEXT MODULE	<input type="checkbox"/>
3	NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF EACH CHILD UNDER THE AGE OF 5 IN YOUR CARE, WHO LIVES WITH YOU NOW. NOW I WANT TO ASK YOU ABOUT (name). IN WHAT MONTH AND YEAR WAS (name) BORN? Probe: WHAT IS HIS/HER BIRTHDAY? If the mother knows the exact birth date, also enter the day; otherwise, enter 99 for day. Date of birth / Day/Month/Year /	/ /	9	Within the last seven days, about how many hours did (NAME) attend? Number of hours	_____
4	DOES (name) HAVE A BIRTH CERTIFICATE? MAY I SEE IT? If certificate is presented, verify reported birth date. If no birth certificate is presented, try to verify date using another document (health card, etc.). Correct stated age, if necessary. 1-Yes, seen ⇒Q.8 2-Yes, not seen 3-No 9-DK	<input type="checkbox"/>	1	HAS (name) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? Show capsule or dispenser. 1-Yes 2-No 9-DK } ⇒NEXT MODULE	<input type="checkbox"/>
5	IF NO BIRTH CERTIFICATE IS SHOWN, ASK: Has (NAME'S) birth been registered? 1-Yes ⇒Q.8 2-No 9-DK ⇒Q.7	<input type="checkbox"/>	2	How many months ago did (NAME) take the last dose? Months ago DK-99	<input type="checkbox"/> <input type="checkbox"/>
6	Why is (NAME'S) birth not registered? Costs too much**-1, Must travel too far-2, Did not know it should be registered-3, Late, and did not want to pay fine-4 Does not know where to register-5, Other (specify) _____ 6 DK-9	<input type="checkbox"/>	3	WHERE DID (name) GET THIS LAST DOSE? On routine visit to health centre-1, Sick child visit to health centre-2, National Immunization Day campaign -3, Other (specify). 4, DK-9	<input type="checkbox"/>
			4	DOES YOUR CHILD HAVE ANY PROBLEM SEEING IN THE DAYTIME? 1-Yes 2-No 9-DK	<input type="checkbox"/>

Cluster no. ___ Household no. ___ Caretaker no. ___ Child no. ___

5	DOES YOUR CHILD HAVE ANY PROBLEM SEEING IN THE NIGHTTIME? 1-Yes 2-No 9-DK } → Q.7	<input type="checkbox"/>
6	Is this problem different from other children in your community? 1-Yes 2-No 9-DK	<input type="checkbox"/>
7	DOES YOUR CHILD HAVE NIGHT BLINDNESS? (Use local term for night blindness.) 1-Yes 2-No 9-DK	<input type="checkbox"/>
BF . BREASTFEEDING MODULE		
1	HAS (name) EVER BEEN BREASTFED? 1-Yes 2-No 9-DK } → Q.4	<input type="checkbox"/>
2	Is he/she still being breastfed? 1-Yes 2-No 9-DK } → Q.4	<input type="checkbox"/>
SINCE THIS TIME YESTERDAY, DID HE/SHE RECEIVE ANY OF THE FOLLOWING: Read each item aloud and record response before proceeding to the next item.		
3	A VITAMIN, MINERAL SUPPLEMENTS OR MEDICINE? Vitamin supplements: 1-Yes, 2-No, 9-DK	<input type="checkbox"/>
	B Plain water? Plain water: 1-Yes, 2-No, 9-DK	<input type="checkbox"/>
	C Sweetened, flavoured water or fruit juice or tea or infusion? Sweetened water or juice: 1-Yes, 2-No, 9-DK	<input type="checkbox"/>
	D Oral rehydration solution (ORS)? ORS: 1-Yes, 2-No, 9-DK	<input type="checkbox"/>
	E Tinned, powdered or fresh milk or infant formula? Milk: 1-Yes, 2-No, 9-DK	<input type="checkbox"/>

	F Any other liquids? Other liquids (specify):1-Yes, 2-No, 9-DK	<input type="checkbox"/>
	G Solid or semi-solid (mushy) food? Mushy food:1-Yes, 2-No, 9-DK	<input type="checkbox"/>
4	SINCE THIS TIME YESTERDAY, HAS (name) BEEN GIVEN ANYTHING TO DRINK FROM A BOTTLE WITH A NIPPLE OR TEAT? 1-Yes 2-No 9-DK	<input type="checkbox"/>
CI . CARE OF ILLNESS MODULE		
1	HAS (name) HAD DIARRHOEA IN THE LAST TWO WEEKS, THAT IS, SINCE (day of the week) OF THE WEEK BEFORE LAST? 1-Yes → Q.3 2-No 9-DK	<input type="checkbox"/>
2	IN THE LAST TWO WEEKS, HAS (name) HAD ANY OTHER ILLNESS, SUCH AS COUGH OR FEVER, OR ANY OTHER HEALTH PROBLEM? 1-Yes → Q.4 2-No 9-DK } → Q.11	<input type="checkbox"/>
DURING THIS LAST EPISODE OF DIARRHOEA, DID (name) DRINK ANY OF THE FOLLOWING: Read each item aloud and record response before proceeding to the next item.		
3	A BREAST MILK? BREAST MILK: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>
	B CEREAL-BASED GRUEL OR GRUEL MADE FROM ROOTS OR SOUP? GRUEL: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>
	C yogurt drink OTHER ACCEPTABLE: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>
	D ORS PACKET SOLUTION? ORS PACKET: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>
	E OTHER MILK OR INFANT FORMULA? OTHER MILK: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>
	F WATER WITH FEEDING DURING SOME PART OF THE DAY? WATER WITH FEEDING: 1-YES, 2-NO, 9-DK	<input type="checkbox"/>

Cluster no. ___ Household no. ___ Caretaker Line no. ___ Child Line no. ___

	G	WATER ALONE? WATER ALONE : 1-YES, 2-No, 9-DK	<input type="checkbox"/>	10	FROM WHERE DID YOU SEEK CARE?	01	
	H	defined "unacceptable" fluids (e.g., cola, etc. (insert local names)) UNACCEPTABLE FLUIDS: 1-YES, 2-No, 9-DK	<input type="checkbox"/>		01-Hospital	02	
	I	NOTHING NOTHING: 1-YES, 2-No, 9-DK ⇒ Q.5	<input type="checkbox"/>		02-Health center	03	
4	DURING (name's) ILLNESS, DID HE/SHE DRINK MUCH LESS, ABOUT THE SAME, OR MORE THAN USUAL? MUCH LESS OR NONE-1, ABOUT THE SAME (OR SOMEWHAT LESS)-2, MORE-3, DK-9		<input type="checkbox"/>		03-Dispensary	04	
	DURING (name's) ILLNESS, DID HE/SHE EAT LESS, ABOUT THE SAME, OR MORE FOOD THAN USUAL? If "less", probe: MUCH LESS OR A LITTLE LESS? NONE-1, MUCH LESS-2, SOMEWHAT LESS-3, ABOUT THE SAME-4, MORE-5, DK-9		<input type="checkbox"/>		04-Village health worker	05	
6	HAS (name) HAD AN ILLNESS WITH A COUGH AT ANY TIME IN THE LAST TWO WEEKS, THAT IS, SINCE (day of the week) OF THE WEEK BEFORE LAST? 1-Yes 2-No 9-DK } Q.11		<input type="checkbox"/>		05-MCH clinic	06	
	WHEN (name) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, QUICK BREATHS OR HAVE DIFFICULTY BREATHING? 1-Yes 2-No 9-DK } Q.11		<input type="checkbox"/>		06-Mobile/outreach clinic	07	
8	WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE? Problem in chest-2, Both-3 Blocked nose-1 Other (specify) _____ 4 } Q.11 DK-9		<input type="checkbox"/>		07-Private physician	08	
	DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME? 1-Yes 2-No 9-DK } Q.11		<input type="checkbox"/>		08-Traditional healer	09	
					11	11-OTHER (SPECIFY)	10
					11	ANY WHERE ELSE?	11
				11	Ask this question (Q.11) only once for each caretaker. Sometimes children have severe illnesses and should be taken immediately to a health facility. What types of symptoms would cause you to take your child to a health facility right away? Keep asking for more signs or symptoms until the caretaker cannot recall any additional symptoms. Circle all symptoms mentioned, but do NOT prompt with any suggestions.	01	
				11	01-Child not able to drink or breastfeed	02	
				11	02-Child becomes sicker	03	
				11	03-Child develops a fever	04	
				11	04-Child has fast breathing	05	
				11	05-Child has difficult breathing	06	
				11	06-Child has blood in stool	07	
				11	07-Child is drinking poorly	08	
				11	08-Other (specify) _____	09	
				11	09-Other (specify) _____	10	
				11	10- OTHER (SPECIFY)		
HB . HEPATITE "B" MODULE							
1	DID YOUR BOY/ GIRLS SICK OR HAD A HIPATET? 1-Yes 2-No 9-DK } ⇒ next module		<input type="checkbox"/>				
	2	IF YES, HOW MANY YEARS AGO ? HOW MANY YEARS AGO.		<input type="checkbox"/>	<input type="checkbox"/>		

Cluster no. ___ Household no. ___ Caretaker Line no. ___ Child Line no. ___

III.6 (IM) . IMMUNIZATION MODULE				
If an immunization card is available, copy the dates in Qs.2-5 for each type of immunization recorded on the card. Qs.7-15 is for recording vaccinations that are not recorded on the card. Qs.7-15 will only be asked when a card is not available.				
1	1. Is there a vaccination record for (NAME)? 1-Yes, seen 2-Yes, not seen 9-DK } => A.7			<input type="checkbox"/>
(a) Copy dates of all vaccinations from the card.		Date of Immunisation		
(b) Write '44' in day column if card shows that vaccination was given but no date recorded		DAY	MONTH	YEAR
2	A BCG	___	___	___
3	A OPV0	___	___	___
	B OPV1	___	___	___
	C OPV2	___	___	___
4	D OPV3	___	___	___
	A DPT1	___	___	___
	B DPT2	___	___	___
5	C DPT3	___	___	___
	A Measles	___	___	___
	B Hepatite	___	___	___
6	IN ADDITION TO THE VACCINATIONS SHOWN ON THIS CARD, DID (name) RECEIVE ANY OTHER VACCINATIONS - INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY? Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, and/or Measles vaccine(s). Go to Q.15 after you finish (Probe for vaccinations and write '66' in the corresponding day column on Q. 2 to Q. 5.)			<input type="checkbox"/>
7	Has (NAME) ever received any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign 1-Yes 2-No 9-Dk } => A.15			<input type="checkbox"/>
8	Has (NAME) ever been given a BCG vaccination against tuberculosis – that is, an injection in the left shoulder that caused a scar? 1-Yes 2-No 9-Dk			<input type="checkbox"/>
9	Has (NAME) ever been given any “vaccination drops in the mouth” to protect him/her from getting diseases – that is, polio? 1-Yes 2-No 9-Dk } => A.12			<input type="checkbox"/>
10	How old was he/she when the first dose was given – just after birth or later? 1-Just after birth 2- later			<input type="checkbox"/>
11	How many times has he/she been given these drops? No. of times			<input type="checkbox"/> <input type="checkbox"/>
12	Has (name) ever been given a DPT vaccination – that is, an injection in the thigh or buttocks – to prevent him/her from getting tetanus, whooping cough, and diphtheria? (sometimes given at the same time as polio) 1-Yes 2-No 9-Dk } => A.14			<input type="checkbox"/>
13	How many times? No. of times			<input type="checkbox"/>

Cluster no. ___ Household no. ___ Caretaker Line no. ___ Child Line no. ___

14	Has (name) ever been given "vaccination injections" – that is, a shot in the arm at the age of 9 months or older - to prevent him/her from getting measles?	<input type="checkbox"/>	4	Result. Measured-1 Not present-2 Refused-3 Other (specify) _____ -4	<input type="checkbox"/>
15	Please tell me if (name) has participated in any of the following national immunization days:		5	Is there another child in the household who is eligible for measurement? <input type="checkbox"/> Yes. ⇨ Record measurements for next child. <input type="checkbox"/> No. ⇨ End the interview with this household by thanking all participants for their cooperation.	
	A DATE/TYPE OF CAMPAIGN A: 1-yes, 2-no, 9-DK	<input type="checkbox"/>			
	B DATE/TYPE OF CAMPAIGN B: 1-yes, 2-no, 9-DK	<input type="checkbox"/>			
	C DATE/TYPE OF CAMPAIGN C: 1-yes, 2-no, 9-DK	<input type="checkbox"/>			
III.7 (AN) ANTHROPOMETRY MODULE					
After questionnaires for all children are complete, the measurer weighs and measures each child. Record weight and length/height below, taking care to record the measurements on the correct questionnaire for each child. Check the child's name and line number on the HH listing before recording measurements.					
1	Child's weight. (kg)	<input type="text"/> <input type="text"/> <input type="text"/>			
2	Child's length or height. Length (cm) Lying down Height (cm) Standing up	_____. _____.			
3	Measurer's identification code.	<input type="text"/> <input type="text"/> <input type="text"/>			

