



Tajikistan

2012 Demographic and Health Survey

Policy Briefs

This report summarises the findings of the 2012 Tajikistan Demographic and Health Survey (TjDHS) conducted by the Statistical Agency under the President of the Republic of Tajikistan (SA) and the Ministry of Health (MOH) of the Republic of Tajikistan from July 2012 through September 2012. ICF International provided technical assistance for the survey through the USAID-funded MEASURE DHS program, which is designed to assist developing countries to collect data on fertility, family planning, and maternal and child health. Funding for the TjDHS was received from USAID/Tajikistan and the United Nations Population Fund (UNFPA)/Tajikistan. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organizations.

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Ministry of Health of the
Republic of Tajikistan



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Introduction

The 2012 Tajikistan Demographic and Health Survey (2012 TjDHS) was published on November 20, 2013. The first Demographic and Health Survey conducted in Tajikistan, the TjDHS was implemented by the Statistical Agency under the President of the Republic of Tajikistan in collaboration with the Ministry of health and social welfare. The 2012 TjDHS collected information from more than 6,400 households and over 9,600 women age 15–49 nationwide.

	Urban	Rural	Total
Number of Households Interviewed	2,675	3,757	6,432
Number of Women interviewed	3,408	6,248	9,656

The survey provides information for the country as a whole, for urban and rural areas, and for the five major administrative regions.

The 2012 TjDHS was designed to collect national and regional data on current status of household water and sanitation, fertility and contraceptive use, maternal and child health, childhood mortality, domestic violence against women, and knowledge and behavior regarding tuberculosis, HIV infection, and other sexually transmitted infections.

The survey results give information needed to evaluate existing social programs and to design new strategies for improving health and health services for women and children in Tajikistan. In addition, the 2012 TjDHS provides indicators for the government of Tajikistan to report on the country's progress in meeting many of its Millennium Development Goals.

National policies play a critical role in improving national health and welfare. Sound policies lay the foundation for strong health systems, effective programs, and improved outcomes. Policy also contributes to better governance and accountability. But to be effective, policies must be based on accurate information. The 2012 TjDHS provides this information. The four policy briefs in this publication are based largely on the results of the Tajikistan DHS as well as on other national and regional sources of data. They were written by representatives of the Statistical Agency, the Ministry of health and social welfare, and the Ministry of economic development and trade and address essential issues in Tajikistan: water and sanitation, fertility and family planning, infant mortality, and child nutrition. Each brief provides critical policy and program recommendations to the government of Tajikistan and major national stakeholders with the goal of improving living standards for all citizens of Tajikistan.



Emomali Rahmon, President of the Republic of Tajikistan, at the International Summit on the implementation of the International Decade of Water for Life, 2005–2015, Dushanbe, June 8, 2010.

Water and Sanitation

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Executive Summary

More than one-fifth of the population of Tajikistan or about 2 million people do not have access to improved sources of drinking water. In areas where there is not enough water or access to improved sources of water, there are higher rates of infectious and other diseases.

Due to insufficient water and sewage systems, 90% of the population—or more than 7 million people—in Tajikistan do not have flush toilets. This creates a large risk of various infectious diseases such as diarrhea and intestinal worms.

Medical facilities and schools outside cities and regional centers do not have sewage systems. When the facilities are in the planning stages, sewage systems are not included in the essential infrastructure. As the population grows, the situation grows worse.

To improve the situation, it is advisable to ratify a national state program to provide the population with access to clean drinking water and flush toilets with central or autonomous sewage systems by the year 2020. A key part of the program would be to declare the years 2015–2020 a Five Year Plan to provide the population with clean drinking water, autonomous or central sewage systems.

Introduction

Tajikistan is one of the world's most water-rich countries. Every year 64 billion cubic meters of water is produced, with makes up more than 60% of the river water flowing into the Aral Sea. Only about 10 percent of the water flowing in Tajikistan's rivers is used for domestic needs. The rest of the water flows to countries downstream, where it is mostly used to irrigate land (OP RT, 2010).

“Despite our abundance of water resources, more than 40% of the country's population does not have access to safe drinking water, and in some rural areas access to drinking water is a grave problem.”

Solving the problem of water resources is an integral part of the National Development Strategy and the Strategy to Reduce Poverty in Tajikistan 2013–2015, which is implementing a series of measures in education, legislation, investment, city planning and construction and other areas to improve access to clean water.

At present, the republic holds last place in Central Asia in percent of irrigated land and per capita water use (OP RT, 2010). According to a recent expert study, Tajikistan will need about \$1 billion dollars (US) to provide safe drinking water to half of the households which are in need. In order to improve water supplies and achieve Millennium Development Goal Number 7, the government ratified the “Program for Improving the Tajik Population's Access to Clean Drinking Water for 2008 to 2020.” As a result of measures carried out in the past five years, about 1.2 million people have gotten access to improved water supply systems, and more than 600,000 people have gotten access to safe drinking water (OP RT, 2010).

To improve use of water resources, in the last five years the Government of RT ratified more than 15 programs, strategies, and action plans supporting dozens of projects. These activities have cost more than \$500 million dollars (US).



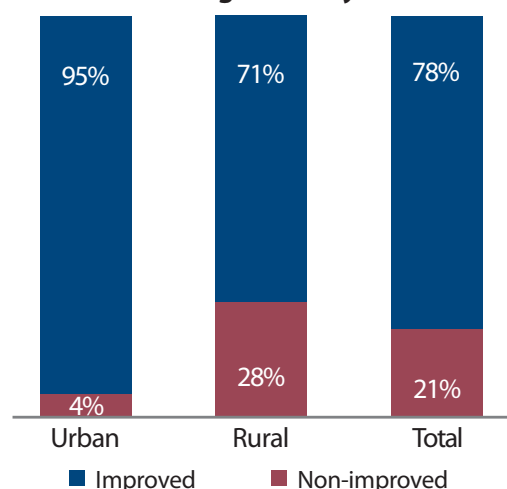
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TjDHS 2012: Current Access to Improved Water and Sanitation

Drinking water: More than three-fourths of households in Tajikistan and 7 in 10 rural households get drinking water from improved sources¹. However, less than half of all households (39%) and less than one-fourth (22%) of rural households has a water pipe inside the house, in the courtyard, or on the property. About 25% of households get water from a public standpipe on the street. A substantial minority of households, 11% nationally and 14% in rural areas, has to travel more than 30 minutes round trip to get water. In addition, 85% of households boil water to be used for drinking.

Urban households have greater access to improved drinking water than rural households, and urban households are more than twice as likely as rural households to have a water source in the house or land than for rural households.

Household Drinking Water by Residence



Access to water varies widely by oblast. Only 59% of households in GBAO and 63% in Khatlon have an improved water source compared to 99% of households in Dushanbe.



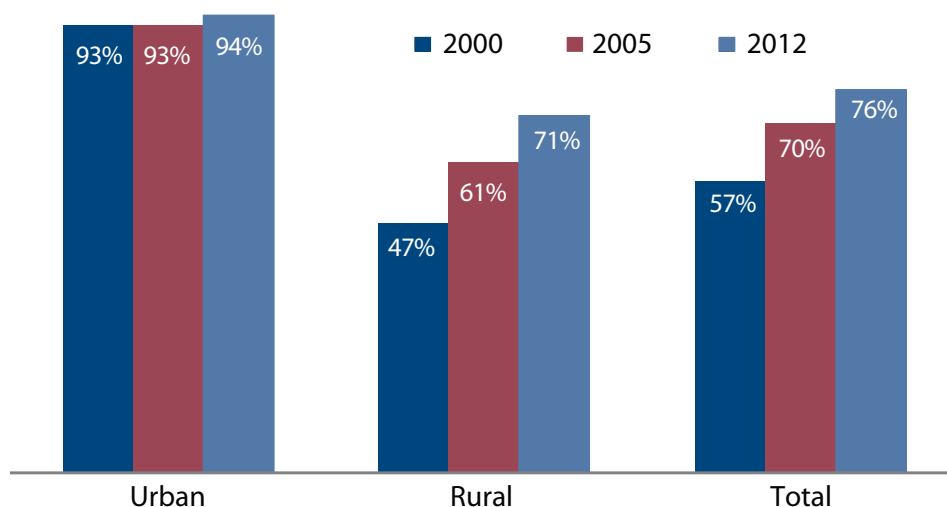
Access to an Improved Water Source:

Overall, more than three-quarters of Tajiks have access to an improved water source, such as piped water in to the dwelling/yard or a public tap. Access to improved water varies by region, from 59% and 63% in GBAO and Khatlon, respectively, to 99% in Dushanbe.

The good news is that access to safer sources of drinking water is improving. The share of the population with access to improved water sources has increased from just 57% in the 2000 Multiple Indicator Cluster Survey (MICS) [UNICEF 2008] to 78% in the 2012 DHS. This increase is especially marked in rural areas, rising from 47 in 2000 to 71% in 2012.

¹ The source of drinking water is an indicator of whether it is suitable for drinking. For the TjDHS, water was classified as from improved or unimproved sources, as recommended by the WHO/UNICEF Joint Program on Monitoring Water Supplies and Sanitation (UNICEF and WHO, 2012).

Change in use of improved sources of drinking water Tajikistan 2000, 2005, and 2012



Despite these recent improvements, Tajikistan still lags behind neighboring countries. Over 90% of households in Armenia, Pakistan, and Ukraine and 88% of households in the Kyrgyz Republic have access to safe drinking water compared to only 78% of households in Tajikistan (NIPS and ICF International, 2013, NSC et al, 2013, NSS et al, 2012, UCSR et al, 2008).

Poor access to improved sources of water leads to higher rates of infectious diseases. According to the Tajikistan Ministry of Health in 2012, the morbidity rate for infectious diseases – such as typhoid fever and acute intestinal infections—were highest in the regions where the lowest percent of households had access to improved sources of water. The rate of typhoid fever was 3.4 per 100 000 in Khatlon region and 18.2 per 100 000 in GBAO. The rate of acute intestinal infections in Khatlon was 2518.9 per 100 000 and 2868.2 per 100 000 in GBAO. In other regions of the country, the rate of typhoid was 25% less, and the rate of acute intestinal infections was half (RCMSI, 2013).

Sanitary facilities: Hygienic toilets² greatly reduce the risk of diarrhea and other infectious diseases. The results of the TjDHS 2012 show that the vast majority of households (97%) use improved sanitary systems, an increase from 94% in the MICS 2005 (SCS, 2007). The majority of households with improved sanitary facilities do not share them. Only about 3% of Tajik families share improved toilet facilities with other households.

A closer look at the TjDHS results, however, shows that most Tajik households use latrines, not flush toilets, which are the norm in developed countries. Even in urban areas, almost 4 in 10 households rely on pit latrines. Only 17% of all Tajik households and less than 1% percent of rural households have a flush toilet.

GBAO has less access to improved sanitary facilities than other oblasts in Tajikistan. Over 90 percent of households in DRS, Dushanbe, Khatlon, and Sughd use improved sanitary facilities compared to only 77% of households in GBAO.



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² The WHO/UNICEF Joint Program on Monitoring Water Supplies and Sanitation defines hygienic toilet facilities as private facilities used only by members of the household and facilities that hygienically separate human excreta from human contact, such as flush toilets connected to a piped sewage system/septic tank/pit latrine; ventilated improved pit latrine; pit latrine with slab; and composting latrine. (UNICEF and WHO, 2012).



Less than half of all households in Tajikistan has a water pipe inside the house, in the courtyard, or on the property.



Conclusions and Recommendations

The government of Tajikistan has done a great deal to provide the population with access to safe drinking water. The country has enough rivers, springs, and aquifers to pipe water to towns and into rural areas. But government programs have not been entirely successful. Greater government commitment, careful oversight of public projects, and support from the private sector are required to ensure that every household can easily obtain safe water.

But unfortunately, at the government level, efficient and sustainable systems for providing the population with improved sanitation through sewage systems have not been developed. The government has still not enacted laws and regulations requiring sewage systems for all cities and towns. While builders are allocated large lots of land and towns are built, there are no laws requiring the installation of water pipes for drinking water, electricity, and sewage systems. Water and sewage systems are not even mandatory or widely available in the outskirts of the capital city of Dushanbe. Installing water and sewage systems immediately will lower the rates of infectious diseases, especially among children, and increase the standard of living for all citizens of Tajikistan. Improving sanitation will also increase much needed tourism revenue and make Tajikistan more attractive to foreign investment.

The following tasks must be carried out:

1. Draw the attention of the government to this problem in order to develop and ratify a national state program to ensure that the entire population has safe drinking water and flush toilets connected to autonomous or centralized sewage systems before 2020.
2. Recommend that when the Ministry of economic development and trade of the Republic of Tajikistan drafts a program of development for a region (oblast, city, district), it must be required to include a plan to provide drinking water and a sewage system.
3. Declare the years 2015–2020 a Five Year Plan for providing the Tajik population with safe drinking water and autonomous and centralized sewage systems. Set the goal of making Tajikistan the first and only country in Central Asia that has entirely switched to flush toilets by the year 2030.
4. Recommend that the government seek financial support from a variety of sources (state budget and grants from donor organizations) and increase oversight to ensure that the funds are spent effectively to provide drinking water and sewage systems.
5. Recommend that the government attract private capital for building and servicing clean drinking water and sewage systems in rural areas. Considering the socially significant nature of this business, recommend that legislation and normative acts be passed to simplify business start-up in this field, provide tax breaks, etc.
6. Recommend that the government ratify legal and normative documents requiring flush toilets and sewage systems to be part of building plans for private houses as well as public buildings. These systems must be either centralized or autonomous, and lead to plants where the biological refuse can be recycled and used as fertilizer.
7. Recommend that the government include the requirement that all hotels, especially in mountainous regions, be fitted out with flush toilets and autonomous sewage systems when developing concept plans, strategies and programs to develop tourism in the country.
8. Recommend that the government fund and conduct a mass media campaign showing the benefits of flush toilets within homes, apartments and public facilities.
9. Recommend that the Ministry of health and social welfare and the Ministry of education and science of the Republic of Tajikistan ratify measures to provide health and educational facilities with flush toilets and autonomous sewage systems if there is no centralized sewage system.

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Child Nutrition

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Executive Summary

Nutrition and diet in the earliest period of a child's life have an enormous impact on his physical, mental and emotional development. Although the government of the Republic of Tajikistan (RT) has instituted several programs and signed into law key legislation to support good nutrition for all children, the 2012 Demographic and Health Survey showed continuing problems. More than one-fourth of children are stunted, and 10% suffer from wasting. While 98% of children are breastfed—an important guarantee of healthy development—only 34% are breastfed according to Ministry of health and social welfare (MOH) recommendations. Programs are in place; now, efforts must be directed to conducting communication campaigns to reach women and their families and encourage them to make use of the resources available to them.

Introduction

The period from birth to two years is especially important for a child's optimal growth, health and development. Women with poor nutritional status (indicated by being underweight, of short stature, with anemia or microelement deficiency) are at higher risk of complications during childbirth. They are also more likely to give birth to an underweight infant or experience fatal postnatal complications, such as hemorrhaging. Meanwhile, breastfeeding and diet are determined by many economic and socio-cultural factors.

In Tajikistan, the government has made solving the problem of children's nutrition a priority. In order to lower morbidity and mortality rates related to poor nutrition, the government passed federal laws "on iodized salt" in 2002 (DG RT, 2002) and "on the protection of natural breastfeeding" in 2006 (DG RT, 2006).

Despite these efforts, every year Tajikistan spends US\$41 million on medical conditions caused by poor or insufficient diets, 43% of which goes to deal with iodine deficiency and 29% goes to preventing stunting (UNICEF and the World Bank, 2012).

TJDHS: Status of Children's Nutrition

The Demographic and Health Survey (DHS) conducted in Tajikistan in 2012 showed that more than one fourth of children under age five (26%) are stunted, that is, they are short for their age. This is a sign of chronic poor nutrition. Stunting in Tajikistan is lower than the rate in some neighboring countries, like Pakistan where it is 45%, but higher than in former Soviet republics of Armenia (19%) and Kyrgyzstan (18%) (NIPS and ICF International, 2013, NSC et al, 2013; NSS [Armenia] et al., 2012)

Wasting—when an individual's weight is two or more standard deviations below the median determined by international standards—affects 10% of all children under 5 and 23% of children younger than 6 months.

Among children under age 5, 12% are underweight. Children born less than 24 months after a previous birth are more likely to be underweight (14%) than children born 48 or more months after a previous birth (10%). Compared to the 2005 Multiple Indicator Cluster Survey (MICS) the percent of children who are stunted has fallen from 27% to 21% in 2012 DHS, but the share of children who suffer from wasting and underweight did not change (UNICEF 2008).



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The practice of breastfeeding plays a key role in establishing an infant's optimal growth and development. Poor breastfeeding and supplemental feeding practices may harm the health and nutritional status of infants, which may then affect their intellectual and physical development. Damage to a child's physical and/or intellectual development due to poor nutrition from conception to age two cannot be reversed. Breastfeeding also helps the mother, usually extending the intervals between



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pregnancies. Immediate post-natal breastfeeding plays an important role in lowering the risk of maternal complications and protecting the newborn from infectious diseases.

Although 98% of Tajik infants are breastfed, only 34% are fed in accordance with World Health Organization (WHO) and MOH recommendations—exclusive breastfeeding for the first six months of life. Water is given to 39% of babies. This is higher than in 2005, when the MICS survey showed 25% received water in addition to breast milk. According to the DHS only 49% percent of children are given complementary solid food from the age of 6–8 months, as recommended.

Deficits of micronutrients (vitamins and microelements) are one of the main causes of child morbidity and mortality. Children can receive micronutrients from food products, fortified food products, and special supplements (pharmaceutical

products). In Tajikistan, 43% of children aged 6 to 23 months consume iron-rich products and 52% consume products rich in Vitamin A. In the 6 months before the DHS, 77% of children aged 6 to 59 months received vitamin A supplements, a great improvement since 2005, when the MICS showed only 47%. Iron supplements were given to 20% percent of children aged 6 to 59 months in the 7 days before the survey.

Using iodized salt in households is the most widespread way of getting sufficient iodine in the diet to prevent iodine-deficit disorders including poor cognitive development in infants. Law Number 344 “On iodizing salt,” passed in 2002, regulates the production, distribution and use of iodized salt in the country (DG RT, 2002). According to the World Health Organization, Tajikistan’s salt iodization program is considered to be successful if iodized salt is used by 97 percent of all households (TjDHS, 2013).

In Tajikistan, 84% of households use any iodized salt, but only 39% of households use adequately iodized salt. This represents a decrease from 46% reported in the 2005 MICS. Half of urban households have adequately iodized salt compared to only 38% of rural households. Less than 30% of households in DRS and Khatlon region have adequately iodized salt.

Several types of intestinal parasites can cause malnutrition. Regular deworming to rid the body of the helminth worm improves micronutrient absorption by children. Nationally, 50% of children aged 6–59 months have received deworming medicines. The percent of children who received these medicines rises with age from 17% at ages 6–8 months to 60% at ages 36–59 months.



Percent of Households with Adequately Iodized Salt



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Conclusions and Recommendations

Although research has shown improvement in many of the indicators for nutrition, the rates of morbidity connected with poor nourishment remain high and point to serious problems. The existing state programs and laws must be carried out more completely and universally. In addition, the public—especially women—must be informed about nutrition and encouraged to follow MOH recommendations.

1. Although exclusive breastfeeding for the first six months has risen to 34%, it is still low. Medical personnel must be trained and pregnant women and women who have just given birth must be informed, helped, and encouraged to breastfeed. Doctors and nurses must promote the Ten Steps to Successful Breastfeeding in medical institutions, and the MOH must make more hospitals “child-friendly.”
2. Since only 49% of children aged 6–8 months are given supplementary food, the mass media—press, healthy lifestyles centers, and Ministry of Health press center—must conduct communication activities to inform women about optimal feeding of babies and encourage them to follow recommendations.
3. Since the pilot project to use micronutrient supplements in the diets of children aged 6 to 24 months proved to be effective, the project should be rolled out to the national level.
4. Since the percent of households using adequately iodized salt is low (39%), the intersectoral work on production, storage, and sale of iodized salt must be improved and the importance of iodized salt should be promoted in a communications campaign in the mass media. The campaign should include the development and printing of brochures, posters, and other print materials, as well as events in schools and medical facilities.
5. Finally, efforts by national and local administrations to eliminate the base causes of poor nutrition must be supported. This includes greater access to safe drinking water and sanitary conditions, general improvement in hygiene practices, and other components of the state program to improve the well-being of the population.

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Neonatal Mortality

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Executive summary

Although the Republic of Tajikistan has made great strides in reducing infant and child mortality rates, neonatal mortality rates are still relatively high. Research has shown the close correlation between the health and behavior of women before and during pregnancy and the risk of neonatal mortality. The risk is especially high for newborns when their mothers give birth at a young age, have children without an interval of at least two years between births, or do not maintain optimal health during pregnancy. Existing national programs provide much of what is needed to ensure lower neonatal mortality rates. But more efforts must be made to ensure that medical personnel are carrying out protocols of care for mother and child, and are working to inform and educate women and their families about the importance of modern family planning methods, antenatal care and micronutrients, and appropriate breastfeeding.

Neonatal mortality rate: the number of children dying within the first month after birth per 1,000 live births

Infant mortality rate: the number of deaths among infants under 12 months per 1,000 live births

Introduction

Since Tajikistan gained independence, the government has made protecting and improving the rights of women and children a priority. Key international documents have been ratified, such as the UN Convention on Children's Rights (1993) and the Convention on the Elimination of all Forms of Discrimination against Women. Programs such as Baby-Friendly Hospitals and promotion of exclusive

breast feeding for the first six months have shown the government's priority for improved health of newborns, babies and children.

As a priority policy of the Republic's government, protecting the health of newborns is reflected in a multitude of laws, strategies and programs. Specialists were trained or received additional training, especially neonatologists. In addition, a series of methodological recommendations and clinical protocols for maternal and child health care issues, including for newborns, has been printed and distributed. In order to lower the neonatal mortality rate, the Republic of Tajikistan has been implementing protocols on antenatal care, childbirth, and care for the new mother and newborn. These protocols are World Health Organization (WHO) recommendations, adapted for conditions in Tajikistan.

Demographic indicators, such as the declining infant mortality rate, show the success of these efforts. According to state statistics (RCMSI, 2013), the infant mortality rate fell from 40.9 in 1990 to 17.2 in 2012. In 2012, the Demographic and Health Survey (DHS) showed an infant mortality rate of 34 deaths per 1000 live births, which is significantly lower than the rates reported in the Multiple Indicator Cluster Surveys (MICS) in previous years.

However, although the infant death rate has decreased nearly three-fold, the current indicator is still relatively high. In 2012, according to official statistics (RCMSI, 2013) 48.6% of the deaths of infants under one year occurred in the early neonatal period (0–6 days), 8.7% in the later neonatal period (7–27 days), and 42.7% in the post-neonatal period (28 days to one year). Thus more than half—57.2%—of the cases of infant death were registered in the neonatal period (0–28 days). Neonatal deaths remain high—18.9 per 1,000 live births, and have increased since the year 2000, when the indicator was 14.6. The neonatal mortality rate in Tajikistan is higher than in neighboring states such as Armenia (13 in 2012) and Ukraine (14 in 2008) (NSS et al 2012, UCSR and Macro International, 2008).

Beyond these statistics are personal tragedies. Every year in Tajikistan about 200,160 babies are born—548 births every day. Of those 548 babies, 10 die every day (RCMSI, 2013).

TjDHS 2012: Neonatal Mortality

Neonatal mortality rates do not vary significantly between urban and rural areas, but there are differences among regions. The neonatal mortality rate in rural areas is only slightly greater than in urban communities (20 and 18, respectively). The mortality rate varies from a low of 11 deaths per 1,000 live births in the capital city of Dushanbe to a high of 23 in Khatlon region. The mother's level of education and economic status do not significantly influence the neonatal mortality rate.

However, the neonatal mortality rate shows a clear correlation to the age of the mother when the child is born. The highest rate is among children born to mothers who are younger than 20 years old (38 per 1000 live births).

The first child born to a woman is at greater risk of neonatal death than the second and third (25 and 16 respectively), but then the mortality rate rises with the fourth and more children (20 deaths per 1000 live births).

Infants are at greater risk when the interval between births is less than two years. In those cases, the neonatal mortality rate is 28, as opposed to 11 when the birth interval is two full years. Another risk factor is the birth size. The neonatal mortality rate for babies whom the mothers characterized as small or very small is 39 per 1000 live births; for babies that the mothers described as average or larger, the rate is much lower—12 deaths per 1000 live births.



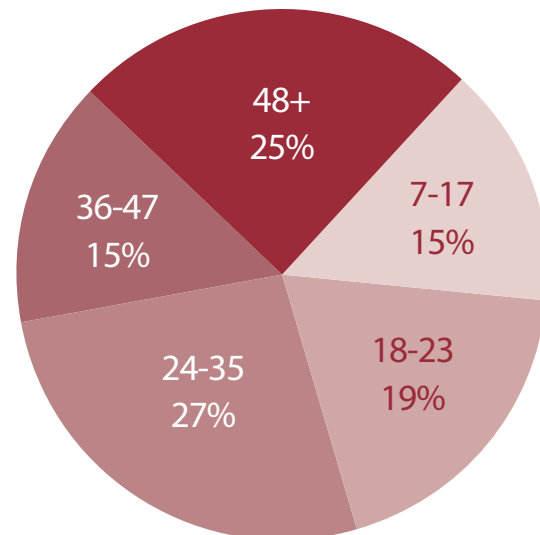
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Research by the WHO and many other health organizations has shown that appropriate breastfeeding (exclusive breastfeeding for the first six months followed by continued breastfeeding up to two years along with complementary foods for children starting at age 6 months) can contribute to better outcomes for the infants. In Tajikistan, only 34% of children are breastfed exclusively

until the age of six months, and only half of children receive complementary foods at the appropriate

Length of Birth Intervals in Months

34% of births occur less than 24 months after the preceding birth, while doctors recommend a birth interval of at least 36 months



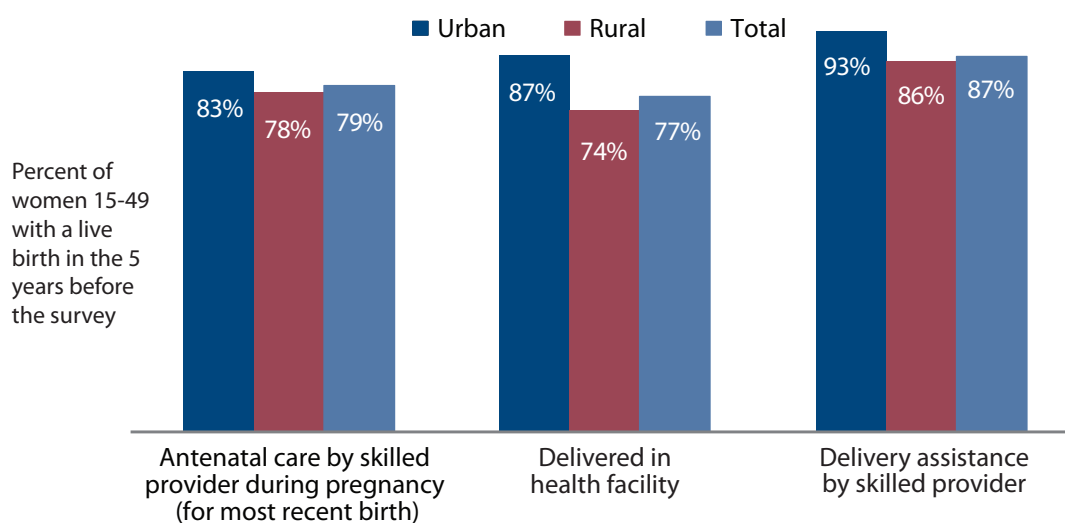
Percent distribution of births in the five years preceding the survey by number of months since preceding births

age. Predominant breastfeeding (breast milk and plain water or juice, clear broth, and other liquids) is prevalent in 55% of babies under six months.

Improved maternal health will result in larger babies, and greater chances for survival. About one of five women is getting no antenatal care, and almost every second woman does not receive the recommended number of visits at the recommended time. According to the TjDHS, just over one-quarter of women received postpartum vitamin A and less than one-third took iron supplements during pregnancy. Almost 17% of women do not have properly iodized salt in their homes. The number of non-pregnant women who are thin (with a BMI of less than 18.5) has increased from 7% in 2009 to 11% in 2012.

Better family planning counselling and contraceptive use will also improve neonatal mortality rates. With family planning, women can avoid unwanted pregnancies when they are very young or old, space their pregnancies, and take care of their overall reproductive health. At present, according to the DHS almost 30% of women aged 20–29 have unmet needs for family planning. Three out of four women did not discuss family planning when visiting a health facility in the year before the survey.

Maternal Health Care by Residence



Conclusions and Recommendations

Despite the many improvements in maternal and child care in recent decades and the generally positive tendencies in infant and child mortality rates, efforts must still be made to lower the rates of neonatal mortality. Current national programs are generally effective and universally implemented throughout the country. However, efforts must be made to continue to raise the qualifications of medical personnel in maternity hospitals, intensive care units for newborns, and children's wards in hospitals where infants are placed. Their work must be monitored more carefully to ensure that all the protocols adapted from WHO recommendations are implemented. We also recommend that the plans to establish at least five perinatal centers be carried out. These centers should be in Dushanbe and oblast capitals and should care for the most seriously ill newborns.

Education and communication efforts must be expanded to ensure that all Tajik women know about the services available and make use of them.

We recommend that efforts be increased within and without the medical community to inform and encourage women to take measures that will ensure better birth outcomes:

1. To increase the number of women asking for and receiving the full recommended antenatal care and taking the recommended micronutrients, messages should be broadcast on television, radio and in the print media to encourage antenatal visits. Medical facilities should have posters, brochures and other materials available.
2. Use of modern methods of contraception must be increased in order to prevent births to very young women and to increase the interval between births to at least two years. Family doctors, gynecologists and other medical providers should be required to discuss family planning with patients. The mass media should be used to convey the message that family planning helps women arrange optimal child spacing and healthier babies. We would also recommend that the Ministry of education and science develop and include both obligatory and elective health courses and lessons into the curriculum for teenagers in state schools.
3. To contribute to lower neonatal and infant mortality rates, practicing exclusive breastfeeding, providing healthy supplemental food for babies, easing the physical and emotional burden on pregnant women and other practices to improve the health of mothers and their children should be promoted in the mass media and in all medical institutions. The number of Baby-Friendly hospitals should be expanded.
4. We recommend inclusion of modern clinical protocols and methodological recommendations on antenatal care, care and intensive care for newborns, pregnant women's and infants' nutrition, family planning etc. into the curriculum at medical schools. We also recommend non-stop professional training for medical personnel.

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“Although the size of a family and number of children is the personal choice of every family, our duty is to tell the bitter truth about the negative consequences of unplanned births, which have an unfavorable effect on the families themselves and on society as a whole.”

Emomali Rahmon, President of the Republic of Tajikistan

“Meeting the needs of families is a reliable indicator of the quality of medical services and the work of the health care system in general.”

World Health Organization

Fertility and Family Planning

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Executive Summary

At present, most families in the Republic of Tajikistan (RT) have 3 or 4 children. About three-fourths of married women would like to stop having children or get pregnant at a later time. At the same time, only one-fourth of married women are using modern contraceptive methods, and the vast majority of them—75% according to the 2012 Tajikistan DHS (TjDHS)—have not discussed family planning with a medical care provider. Immediate efforts are needed by the government of Tajikistan to increase demand for family planning, provide fair and equal access to family planning and counseling services, and to expand the modern contraceptive options available to both men and women.

Introduction

Fertility is one of the main indicators of a nation's health, which is tightly connected with the social and economic conditions in the country. In Tajikistan, continuing population growth is straining government resources and contributing to high rates of unemployment and poverty (GRT, 2004). The government is very concerned about the health of women and children, which is reflected in the implementation of over 10 national programs since 1997. While fertility remains high, modern contraceptive use is declining.

TjDHS: Family Planning and Fertility

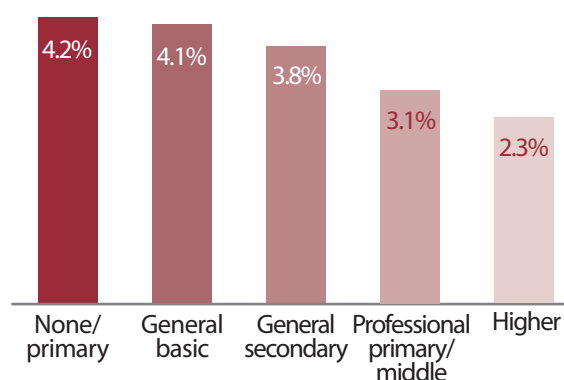
According to the 2012 Tajikistan Demographic and Health Survey, fertility in Tajikistan remains high. The average Tajik woman has three or four children, which is considerably higher than other CIS states including Azerbaijan, Armenia, and Ukraine (NSS et. al., 2012; SSC and Macro International, 2008; UCSR et. al, 2008).

Fertility rates vary according to oblast and residence, ranging from a high of 4.2 children, on average, in Khatlon oblast and 3.9 children in DRS to a low of 3.3 children in GBAO and Sughd. Women living in rural areas have 3.9 children, on average, compared with 3.3 children per women living in urban areas.

The number of children also varies by mother's level of education and material wealth. Women with higher education have only two to three children compared to more than four children (4.2) among women without any education or just primary school. Very poor women have one to two children more than women who live in the most affluent households (4.1 compared to 3.2 children).

Fertility by Mother's Education

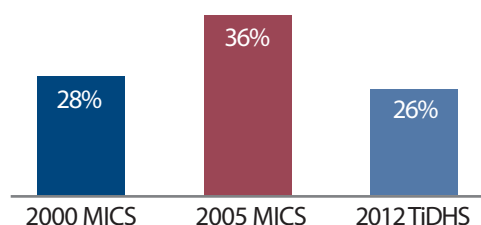
TFR for women age 15-49 for the 3-year period preceding the survey



Tajik women have many unwanted pregnancies. According to the DHS, if women had exactly the number of children they wanted, the national total fertility rate would be 3.3 children per woman. Despite Tajik women's clear preference to control the size of their families, in recent years the percent of married women using modern contraceptive methods declined from 36% in the 2005 Multiple Indicator Cluster Survey (MICS) to 26% in the 2012 DHS (UNICEF 2008).

Trends in Use of Family Planning

Percent of married women age 15-49



Among married women there is a gap between knowledge of modern contraceptives and use of these methods. Almost all married women age 15-49 (95%) know about contraceptives in general and modern methods in particular, but only 26% use modern methods. Far fewer women know

about permanent contraceptive methods; only 30% of currently married women know about female sterilization, and only 12% know about male sterilization (vasectomy).

The most popular modern method is the IUD, which is used by more than 70% of all modern contraceptive users. The pill, condom, and injectables are each used by about 2% of women.

Modern method use varies widely by region and education. Urban women are ahead of rural women in using modern methods (29 and 25% respectively). Among regions, modern method use ranges from a high of 35% of women in GBAO to a low of 23% in Khatlon and 22% in DRS. Highly educated women are almost twice as likely to use modern methods as women with little or no education—37 and 20% respectively. Similarly, contraceptive prevalence is higher among women from the wealthiest households than women from the poorest households.



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Most women are not exposed to information about family planning. In the year before the TjDHS only 18% of women not using contraception talked with a health worker visiting her at home about family planning. Similarly, only 18% of women who visited a health care facility in the year before the survey talked about family planning. The one exception is GBAO where almost half of women interviewed had talked about family planning with a health worker. Not surprisingly, GBAO has the highest use of contraception in Tajikistan.

Family planning is also not widely covered in the mass media. More than half of women have not seen or heard any reference to family planning on television, radio or newspapers in the few months before the survey.

Access to contraception: The overwhelming majority of contraceptive users—nine out of ten—are provided with contraceptives free of charge thanks

to subsidies from donor organizations. Most women obtain their methods from polyclinics and health centers. Over one-third of pill users and one-half of condom users rely on pharmacies for their methods.

Traditionally contraception was handled and discussed with obstetricians/gynecologists (OB/GYNs) in centers for reproductive health. Today an OB-GYN at the local medical facility provides assistance to four family doctors who care for about 3,000 women of child-bearing age. While the OB-GYN is essentially responsible for access to contraception, s/he does not do family visits. Now family planning counselling is supposed to be provided by these family doctors who cover districts with 1,000–1,500 people. In these circumstances, few women report talking to their doctors about contraception. Thus, family doctors are not assuming this new responsibility, either because they don't know that they should provide contraceptive services or because they need additional training in counselling.

In some distant regions of the country there are either few medical practitioners or, if there are enough, they are not qualified to provide counseling or to prescribe contraceptives. According to the DHS, more than half of women have at least one problem accessing health care, most often getting money for treatment. Almost 30% of women say that distance to the health care facility is an obstacle while 17% say they need permission from their husbands to go for treatment.



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Conclusions and Recommendations

The RT government has shown consistent support for programs to preserve the health of mothers and children and family planning. The DHS results will be used to assess the impact of the Strategic Plan of RT on the reproductive health of the population until 2014, the program on ensuring safe motherhood until 2015, and a number of other programs that indirectly affect improvement of reproductive health.

1. Women need more access to contraceptive information and services. While family doctors are now authorized to provide modern contraceptives, it is not clear that they have the skills and motivation to do so. The Ministry of health and social welfare (MOH) needs to understand why doctors are not integrating counselling on modern contraception into their work. Once the reasons are clearly understood, the MOH can take the appropriate actions, for example, providing training to family doctors, to increase counseling and provision of modern method use.
2. Contraceptive use is lowest among women from the poorest households and among women with little education. These women also have larger families than wealthier, more educated women, but they have fewer resources to care for them. The Government of Tajikistan needs to make special efforts to reach these women with information and services. The government also needs to allocate state funding to provide poor and disadvantaged women with contraception and the full range of reproductive health services free of charge.
3. At present, donor organizations provide most contraceptive supplies available in Tajikistan. To ensure long-term access to modern contraceptive methods, the government of Tajikistan must gradually assume costs of importing contraceptive supplies into the country.
4. Research worldwide shows that the most successful family planning programs offer a wide range of contraceptive methods to meet women's needs at every stage of their reproductive lives. In Tajikistan, most women rely on only one method, the IUD. Research is needed to assess the availability of all methods and to understand the attitudes among health practitioners and women regarding other modern methods, particularly, inexpensive and permanent methods like vasectomy and female sterilization that are rarely used in the country.
5. In order to have a multi-sectoral approach to family planning, the number of agencies that are responsible for family planning should be expanded, a system to monitor contraceptive use should be put in place, and there should be a special coordinator in the presidential administration.
6. Modern contraception and birth spacing have significant health benefits for women and babies. Yet one-third of infants born in Tajikistan in the last five years were born less than two years after a previous birth. The government needs to launch an effective public service campaign that would position contraceptive use as a way to space births and improve maternal and child health. The campaign should have a special focus on reaching people living in distant rural areas.

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