Tajikistan

2012 Demographic and Health Survey

Key Findings

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.

Additional information about the survey can be obtained from the Statistical Agency under the President of the Republic of Tajikistan: 17 Bokhtar Street, Dushanbe, Tajikistan; Telephone: 992-372-23-02-45, Fax: 992-372-21-43-75, email: stat@tojikiston.com

Additional information about the DHS programme may be obtained from MEASURE DHS, ICF International, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, U.S.A. (Telephone: 1.301.572.0200; Fax: 1.301.572.0999; e-mail: info@measuredhs.com).

Recommended citation:
Statistical Agency, Republic of Tajikistan, and ICF International, 2013. *2012 Tajikistan Demographic and Health Survey: Key Findings*. Dushanbe, Tajikistan and Calverton, Maryland, USA: Statistical Agency (Tajikistan), and ICF International.

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About the 2012 TjDHS

The 2012 Tajikistan Demographic and Health Survey (TjDHS) is designed to provide data for monitoring the population and health situation in Tajikistan. The 2012 TjDHS is the first Demographic and Health Survey conducted in Tajikistan. The objective of the survey was to provide up-to-date information on 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.

Who participated in the survey?

A nationally representative sample of 9,656 women age 15–49 in all selected households. This represents a response rate of 99%. This sample provides estimates for Tajikistan as a whole, for urban and rural areas, and, for most indicators, an estimate for each of the five regions.

Household Characteristics

Household composition

Tajik households are large, consisting of an average of 6.3 people. Thirty-eight percent of the household members are children under age 15.

Housing conditions

Housing conditions are relatively good throughout Tajikistan. Almost all households (99%) have electricity and over three-quarters of households have access to an improved water source. Household access to an improved water source does vary by residence - 95% of urban households have an improved water source, most commonly piped water into the dwelling or yard, compared to only 71% of rural households. Water access has improved since 2000, when only 57% of the household population had an improved water source compared to 76% of the population in 2012. (UNICEF MICS). More than 90% of households use an improved toilet facility. In urban areas, flush/pour toilets to piped sewer systems are most common, while in rural areas, the majority of households have a pit latrine with slab.

Ownership of goods

Currently, 96% of Tajik households own a television and 93% have a mobile phone; only 24% of households have a radio. Ownership of these assets does not differ substantially between urban and rural areas.

One quarter of households own a bicycle and 31% own a car or truck. Almost three-quarters of households own agricultural land.

Education of survey respondents

The majority of Tajik women have some education, although the majority do not go to school beyond the general secondary level. Only 13% of women age 15-49 have attended professional primary, middle, or higher education. Women in urban areas are much more likely to achieve higher levels of education.

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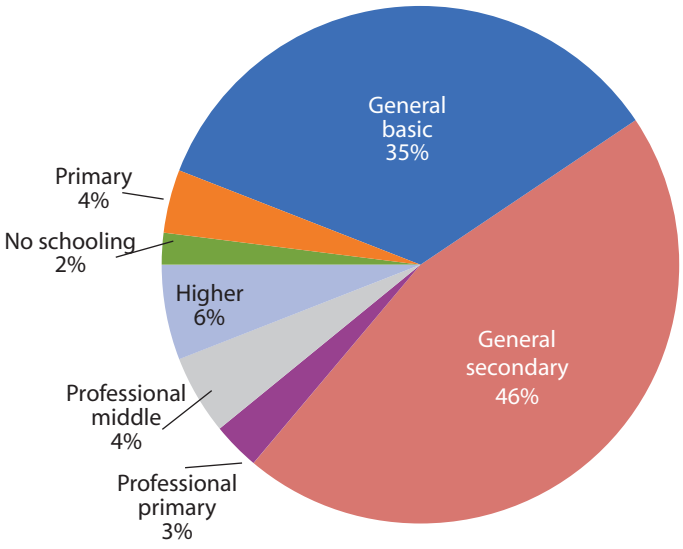
Education

Percent distribution of women age 15–49 by highest level of education



Fertility and its Determinants

Total Fertility Rate (TFR)

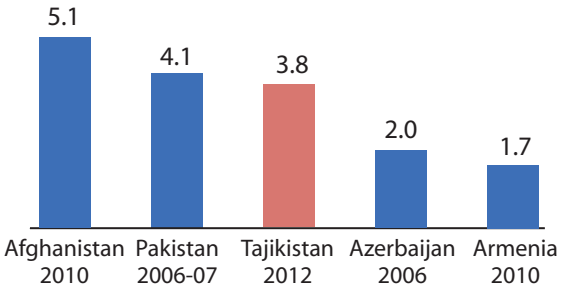
Currently, women in Tajikistan have an average of 3.8 children. This is comparable to other countries in South Asia, like Pakistan, but higher than neighboring countries to the west, like Azerbaijan and Armenia.

Fertility varies by residence and by region. Women in urban areas have 3.3 children on average, compared with 3.9 children per woman in rural areas. Fertility is highest in Khatlon, where women have an average of 4.2 children, and lowest in GBAO and Sughd where women have an average of 3.3 children.

Fertility also varies with mother's education and economic status. Women who have higher education have an average of 2.7 children, while women with no schooling or only primary schooling have an average of 4.2 children. Fertility increases as the wealth of the respondent's household* decreases. The poorest women, in general, have one child more than women who live in the wealthiest households (4.1 versus 3.2 children per woman).

Fertility in Central and Southern Asia

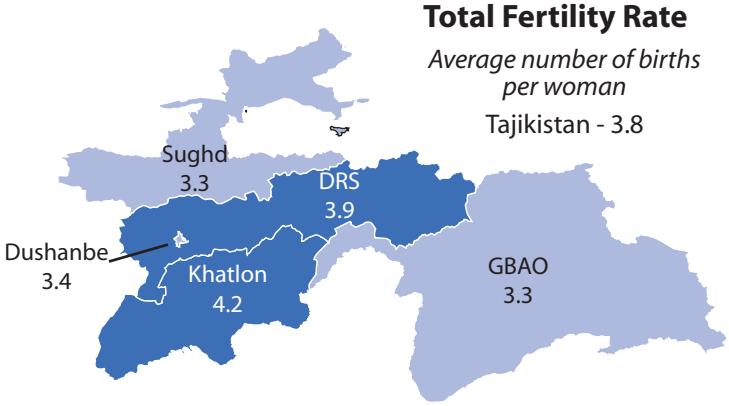
Average number of births per woman



Total Fertility Rate

Average number of births per woman

Tajikistan - 3.8



Age at first birth

Very few women in Tajikistan have their first birth before age 18 - only 3%. The median age at first birth for all women age 25–49 is 21.8. Women in GBAO wait to a median age of 24.1, the latest in the country. On average, women with lower levels of education have their first birth one to two years earlier than women with higher education (median age of 23.5).

Age at first marriage

Twelve percent of 20-24 year old women in Tajikistan were married by age 18; 44% were married by age 20. The median age at first marriage is 20.2 for women age 25–49. Median age at first marriage is highest in GBAO and among women with higher education.

* Wealth of families is calculated through household assets collected from DHS surveys—i.e., type of flooring; source of water; availability of electricity; possession of durable consumer goods. These are combined into a single wealth index. They are then divided into five groups of equal size, or quintiles, based on individuals' relative standing on the household wealth index.

Age at first sexual intercourse

In general, Tajik women initiate sexual intercourse about the same time as their first marriage. Only 11% of women age 20-24 had their first sexual intercourse by the age of 18. The median age at first intercourse is 20.3.

Desired family size

Tajik women want between three and four children, on average. Ideal family size is highest in Khatlon (3.9) and lowest in GBAO and Sughd (3.2 each).

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Abortion

Frequency of abortion

Ten percent of women age 15-49 in Tajikistan report having ever had an abortion Among women who have had an abortion, about one-third have had two or more.

Abortions are more common among women with many children and among older women (those age 35-44). Abortions are also more common among educated women and those from wealthier households

Use of contraception before abortion

Among pregnancies that resulted in abortion, 83% occurred after no contraceptive method was used. Thirteen percent of abortions occurred after using a modern method, and 4% of abortions occurred after use of a traditional method.

Family Planning

Knowledge of family planning

Knowledge of family planning methods in Tajikistan is not universal. Eighty-three percent of all women know a modern method of contraception. Married women are more likely to know a method (95%). The most commonly known methods among all women are the IUD (81%) and the pill (71%).

Current use of family planning

One-quarter of married women (26%) currently use a modern method of family planning. Another 2% are using a traditional method (primarily withdrawal). The IUD is the most popular method, used by 19% of married women. Two percent each of married women use the male condom, injectables, or pills.

Use of modern family planning methods varies by region. Modern contraceptive use ranges from a low of 22% in DRS to a high of 35% of married women in GBAO. Use of traditional methods is highest in Sughd (5%) and Dushanbe (3%), while less than 1% of married women in the other regions report using a traditional method.

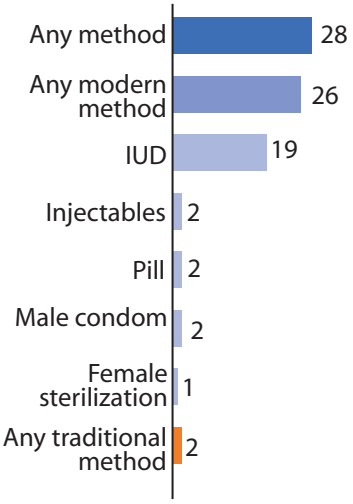
Modern contraceptive use increases with a woman's education. Married women with higher education are almost twice as likely to use a modern method as women with no/primary education (37% versus 20%). Modern method use is also highest among women from the wealthiest households (33%).

Source of family planning methods

Public sources, such as government hospitals, health centres, and polyclinics currently provide contraceptives to 89% of current users, while the private medical sector provides methods to 10% of users. Female sterilization, the pill, IUDs, injectables, and implants are most commonly accessed at public facilities, while male condoms come primarily from the private sector.

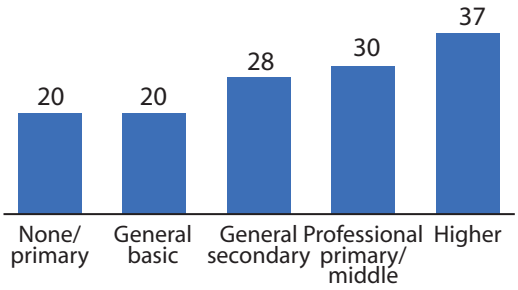
Family Planning

Percent of married women age 15–49 using family planning



Modern Method Use by Education

Percent of married women 15–49 using a modern method



Need for Family Planning

Intention to use family planning

One in four currently married nonusers (26%) intend to use family planning in the future.

Desire to delay or stop childbearing

Two in five (43%) currently married Tajik women want no more children. Another 19% want to wait at least two years before their next birth. These women are potential users of family planning.

Unmet need for family planning

Unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception. The 2012 TjDHS reveals that 23% of married women have an unmet need for family planning—12% for spacing and 11% for limiting. Unmet need is highest among women from the DRS region, and among the poorest and less educated women.

Missed opportunities

Overall, half of women were exposed to a family planning message on the radio, TV, or in the newspaper. Television is the most common source of family planning messages in the media.

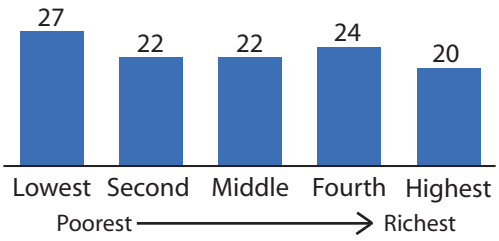
Among all women who are *not* currently using family planning, only 18% were visited by a field worker who discussed family planning, and only 18% of women visited a health facility where they discussed family planning. Overall, 75% of nonusers did not discuss family planning with any health worker.

Informed choice

Family planning clients should be informed about the side effects of the method used and given options about other available methods. About three-quarters of Tajik users of modern methods were informed about side effects and told what to do if they experienced side effects. Seventy percent were informed of other methods that could be used.

Unmet Need by Wealth Quintile

Percent of married women 15–49 with unmet need for family planning



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Infant and Child Mortality

Currently, the infant mortality rate in Tajikistan is 34 deaths per 1,000 live births for the five year period before the survey. Under-five mortality (death before the 5th birthday) is 43 per 1,000 live births.

Childhood mortality decreases with mother's education and, more dramatically, wealth. For example, there are 58 under-five deaths per 1,000 live births from the poorest households compared to 38 under-five deaths per 1,000 live births from the richest households.

Mortality rates are slightly higher in rural than urban areas. Under-5 mortality, for example, is 50 deaths per 1,000 live births in rural areas compared to 42 in urban areas.

Mortality also differs by region. Under-5 mortality ranges from only 29 deaths per 1,000 live births in Dushanbe to 61 deaths per 1,000 live births in Khatlon.

Spacing children at least 36 months apart reduces risk of infant death. In Tajikistan, the median birth interval is fairly long—31 months. Infants born less than two years after a previous birth are more than twice as likely to die before age five (71 deaths per 1,000 live births) as infants born four years or more after the previous birth (30 deaths per 1,000 live births). One-third of infants in Tajikistan are born less than two years after a previous birth.

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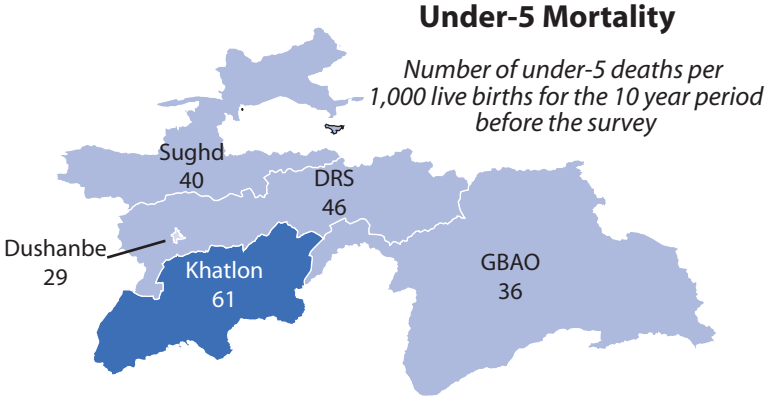
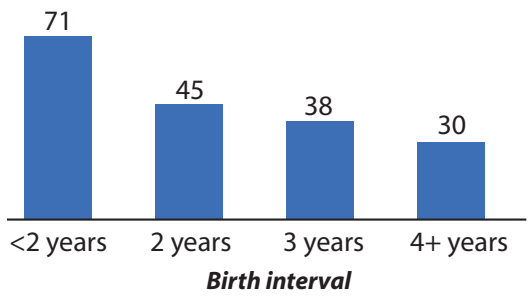
Under-5 Mortality

Number of under-5 deaths per 1,000 live births for the 10 year period before the survey



Under-5 Mortality by Birth Interval

Number of under-5 deaths per 1,000 live births for the 10 year period before the survey



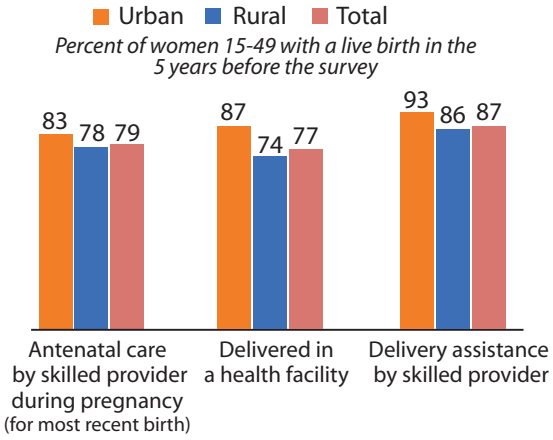
Maternal Health

Antenatal care

Four in five Tajik women received some antenatal care (ANC) from a skilled provider, most commonly from a doctor (64%). One in five women had no antenatal care at all. ANC coverage varies by region. Only two-thirds of women in Khatlon received ANC from a skilled provider compared to more than 80% in Dushanbe and GBAO and 94% in Sughd.

The timing and quality of ANC are also important. Only 52% of women with a recent birth had an antenatal care visit by their fourth month of pregnancy, as recommended. Just over half (53%) of women received the recommended four or more visits.

Maternal Health Care by Residence



Only one-third of women took iron supplements during pregnancy; the large majority (more than 90%) of women had their blood pressure measured, and urine and blood samples taken. Three-quarters of women (76%) were informed of signs of pregnancy complications during an ANC visit. Eleven percent of women were admitted to a health facility during their pregnancy. More than 6 in 10 women had social support during ANC from a partner or family member.

Delivery and postnatal care

Three-quarters (77%) of births in Tajikistan occur in health facilities, almost entirely in the public sector. Facility-based births are most common in Sughd (93%) and Dushanbe (88%). Twenty-three percent of births occur at home. Home births are more common in rural areas (26%) than urban areas (12%). Home deliveries are especially rare in Sughd (6%).

Almost nine in ten (87%) of births are assisted by a skilled provider (doctor, nurse, midwife, or feldsher). Another 9% are assisted by a traditional birth attendant. Skilled assistance at birth is almost universal in Dushanbe and Sughd (96% and 95%, respectively) and least common in DRS (80%). Women with more education and those from wealthier families are most likely to have their births attended by a skilled provider.

Postnatal care helps prevent complications after childbirth. Eighty percent of women received a postnatal checkup within two days of delivery. However, 13% of women did not have a postnatal checkup within 41 days of delivery.

A postnatal checkup for the newborn is less common: only 54% of births were followed up by a postnatal checkup within 2 days.

Child Health

Vaccination coverage

According to the 2012 TjDHS, 89% of Tajik children age 18-29 months have received all recommended vaccines—one dose each of BCG and measles or MR and three doses each of DPT/pentavalent and polio. Only 1% of children did not receive any of the recommended vaccines.

Vaccination coverage is above 80% in all regions, but is highest in Sughd (93%) and Khatlon (91%). Vaccination coverage is lowest (77%) among children of women with higher education.

Childhood illnesses

In the two weeks before the survey, 1% of children under five had symptoms of an acute respiratory infection (ARI). Nine percent of children had a fever in the two weeks before survey. Of these children, 57% received treatment from a facility or provider and 50% took antibiotics.

During the two weeks before the survey, 15% of Tajik children under five had diarrhea. The rate was highest (24%) among children 12-23 months old and those 6-11 months old (23%). More than half (54%) of children with diarrhea were taken to a health provider. Children with diarrhea should drink more fluids, particularly through oral rehydration therapy (ORT). Four in five (82%) children with diarrhea were treated with ORT or increased fluids.

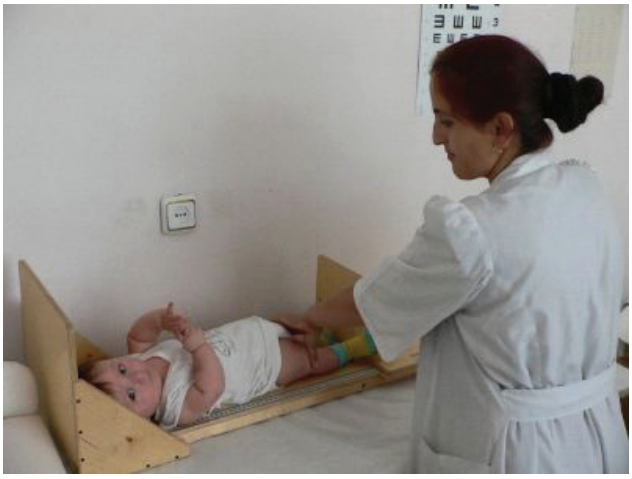
Feeding Practices and the Nutritional Status of Women and Children

Breastfeeding and the introduction of complementary foods

Breastfeeding is very common in Tajikistan, with 98% of children ever breastfed. WHO recommends that children receive nothing but breast milk (exclusive breastfeeding) for the first six months of life. One-third (34%) of children under six months in Tajikistan are being exclusively breastfed. On average, children 0-35 months breastfeed until the age of 19 months and are exclusively breastfed for an average of 1.5 months.

Complementary foods should be introduced when a child is six months old to reduce the risk of malnutrition. In Tajikistan, 46% of children ages 6–9 months are breastfeeding and eating complementary foods.

The Infant and Young Child Feeding (IYCF) practices recommend that breastfed children age 6–23 months also be fed four or more other food groups. Only 17% of breastfed children in Tajikistan meet this recommendation. It is also recommended that nonbreastfed children be fed milk or milk products, and four or more food groups. However, only 58% of nonbreastfed Tajik children receive milk or milk products, and only 60% were fed four or more food groups.



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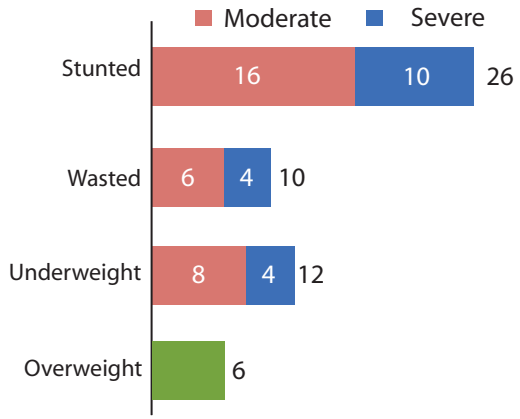
Children's nutritional status

The TjDHS measures children's nutritional status by comparing height and weight measurements against an international reference standard. According to the 2012 survey, 26% of children under five are stunted, or too short for their age; 10% are severely stunted. This indicates chronic malnutrition. Stunting is more common in rural areas (27%) than urban areas (21%). Stunting is least common among children of more educated mothers and those from wealthier families. Stunting ranges from 19% in Dushanbe to 27% in Sughd and Khatlon.

Wasting (too thin for height), which is a sign of acute malnutrition, is far less common (10%). In addition, 12% of Tajik children are underweight, or too thin for age. Six percent of Tajik children are overweight or obese.

Children's Nutritional Status

Percent of children under age 5, based on WHO Child Growth Standards



Women's nutritional status

The 2012 TjDHS also took weight and height measurements of women age 15–49. Just over 10% Tajikistan women are too thin, while 30% are overweight or obese. Overweight and obesity are higher in urban areas than in rural areas (38% compared with 27%) and increase with age and wealth.

Vitamin A and iron supplementation

Vitamin A, which prevents blindness and infection, is particularly important for children and new mothers. In the 24 hours before the survey, 52% of children age 6–23 months ate fruits and vegetables rich in vitamin A. Almost eight in ten (77%) children age 6–59 months received a vitamin A supplement in the six months prior to the survey. Only 27% of women received a vitamin A supplement postpartum. Less than half of children (43%) ate iron-rich foods the day before the survey, but only 20% were given iron supplements in the week before the survey.

Pregnant women should take iron tablets or syrup for at least 90 days during pregnancy to prevent anaemia and other complications. While 35% of women took some iron during pregnancy, only 1% took iron tablets or syrup for at least 90 days during their last pregnancy.

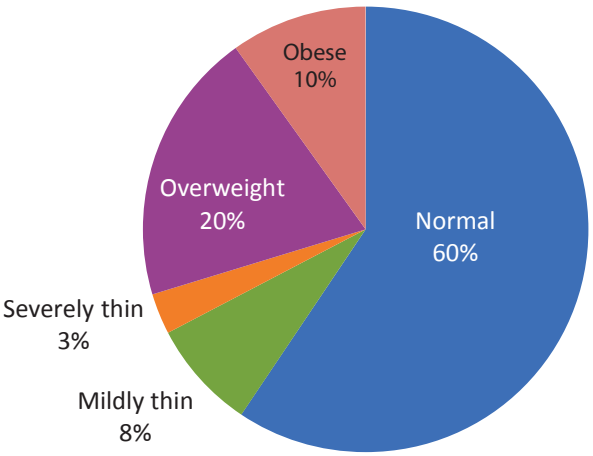
Use of Iodized Salt

Iodine is an important micronutrient for brain development, and maternal and child health. Iodine is commonly ingested through iodization of household salt.

More than 8 in 10 households in Tajikistan have iodized salt, but iodization levels were adequate in only 39% of households. Adequately iodized salt is more commonly found in urban (50%) than rural households (34%).

Women's Nutritional Status

Percent of women age 15-49, by BMI level



Women's Empowerment

Employment

Only one-third of married women age 15–49 interviewed in the TjHS are employed. About half of these women earn cash only, 21% earn cash and in-kind and 8% earn in-kind payments only. One in five employed women are not paid. Among the women who earn cash, three-quarters report that their cash earnings are less than their husband's.

Ownership of assets

Almost half of Tajik women do not own a house and 71% do not own land. The majority of women who do own a house or land own these items jointly.

Participation in household decisions

Not all Tajik women have power to make decisions. Just over half of women report that they have sole or joint decisionmaking power over their own health care, making major household purchases, and visits to their family or relatives. One-third of women do not participate at all in any of the three decisions asked about in the TjDHS; 43% report that they participate in all three decisions.

Women who are employed for cash are most likely to participate in all three decisions. Women's decisionmaking also varies by region. Less than 40% of women in Sughd and Khatlon participate in all three decisions compared to more than half of women in GBAO (58%) and DRS (54%). Lastly, 58% of women with higher education participate in all three decisions compared to 31% of women with no education.

Gender Based Violence

Experience of violence

About one in five women in Tajikistan report that they have suffered from physical violence at some point since age 15. Thirteen percent of women suffered from acts of violence during the past 12 months. This proportion is substantially higher for divorced/separated/widowed women (21%) than married women (15%) or never married women (5%). More than four-fifths of women who have ever experienced physical violence report that the perpetrator of the violence was a current or former husband/partner.

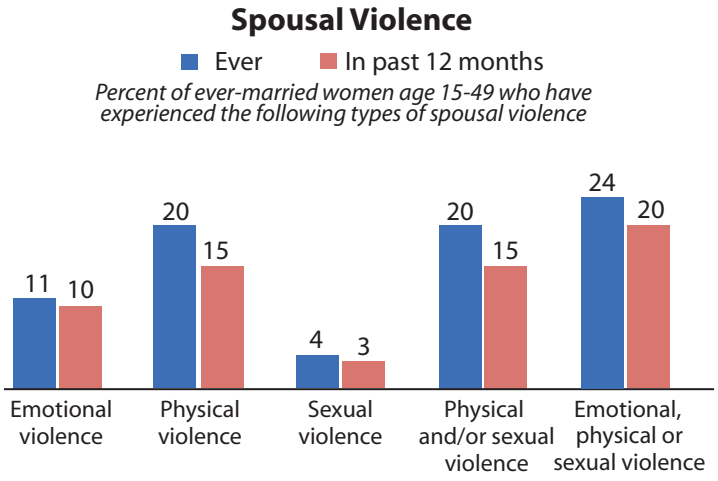
Four percent of women have ever experienced sexual violence. In more than 90% of cases, sexual violence is perpetrated by current or former husbands or partners.

Spousal violence

One-quarter of ever-married women have suffered from spousal or partner abuse at some point in time, whether physical, emotional, or sexual. Fifteen percent of ever-married women report having experienced some form of physical or sexual violence by their husband/partner in the past year.

Spousal violence is most common in Sughd and Khatlon, where more than 20% of ever-married women have ever experienced physical or sexual violence by a partner compared to 12% in DRS.

Wife beating continues to be accepted by some women. According to the TjDHS, 60% of women believe that wife beating is justified in certain circumstances, such as arguing with her husband, neglecting the children, or going out without telling her husband.



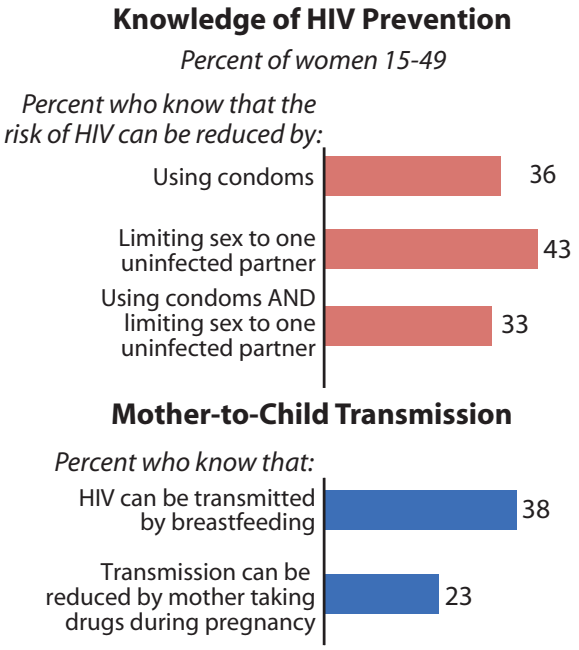
HIV/AIDS Knowledge and Behavior

Knowledge

According to the 2012 TjDHS, knowledge of HIV is not yet universal in Tajikistan. Only 62% of women have ever heard of AIDS. Knowledge of HIV prevention measures is much lower. Only one-third of women know that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful, uninfected partner. Prevention knowledge increases quickly with education: 63% of women with higher education know these two prevention methods compared to only 17% of women with no education/primary education.

Just over one-third of women know that HIV can be transmitted by breastfeeding. Fewer (23%) know that the risk of mother-to-child transmission can be reduced by taking drugs during pregnancy.

HIV-related misconceptions are very common in Tajikistan. Only 30% of women know that a healthy-looking person can have HIV, and only 32% of women know that HIV/AIDS cannot be transmitted by mosquito bites.



Attitudes

Tajik women are not yet accepting of people living with HIV/AIDS. Only 27% report that they would buy fresh vegetables from a shopkeeper living with the AIDS virus, and 42% would be willing to care for a family member with AIDS in their home.

Just over half (57%) of Tajik women believe that women are justified in refusing to have sex with their husbands if she knows he has sex with other women. The same percentage believe they can ask the husbands to wear a condom if he has a sexually transmitted infection.

Prior HIV testing

Three in ten Tajik women know where to get an HIV test. Only 13% of women have ever been tested and received the results, and only 5% have been tested in the last year. Recent testing is most common in urban areas (8%), in Dushanbe (8%), and among those with higher education (14%).

One-quarter of women received counseling on HIV during antenatal care; 16% received counseling and an HIV test, as well as the results.

Other Women's Health Issues

Tuberculosis

Seven in ten Tajik women have heard of tuberculosis (TB). Among these women, three-quarters know that TB is spread through the air when an infected person coughs, and 81% know that TB can be cured. There is some stigma associated with TB—25% of women would want a family member's TB to be kept a secret.

Among women who have heard of TB, the most commonly identified symptoms were any coughing (85%), coughing with sputum (37%), and weight loss (24%).

While many women know that TB is spread through the air via coughing, myths about transmission persist. More than one-quarter of women who had heard of TB think that TB can be spread through food or sharing utensils.

Knowledge about TB treatment is not universal. Only half of women who have heard of TB reported that appropriate treatment of the sick person prevents spread of TB. Almost half (47%) referred to the DOTS treatment strategy.

Hypertension

Twelve percent of Tajik women 15-49 report that they have been told by a health worker that they have hypertension, or high blood pressure. Three quarters of these women have been told about their high blood pressure two or more times. Among those who have been told they have high blood pressure, 4 in 5 are taking prescribed medication, while 46% are cutting down the salt in their diet. Some are controlling or losing weight (39%), and some hypertensive women are exercising (29%).

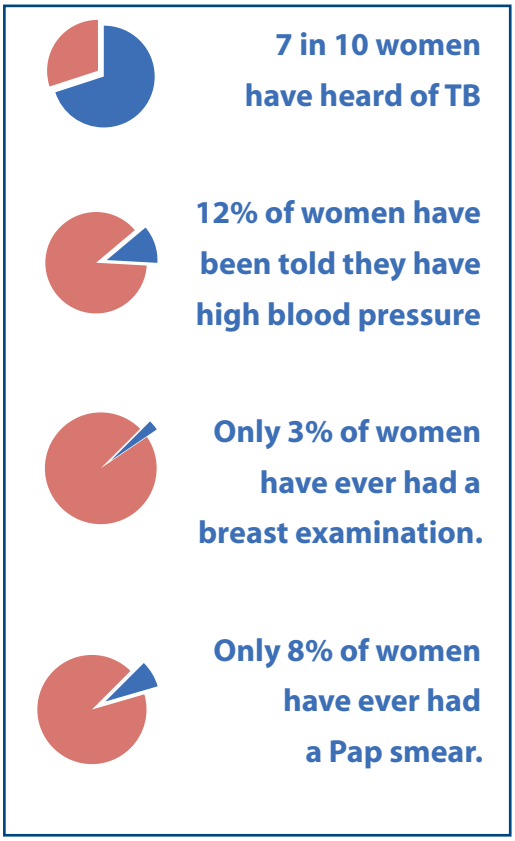
Breast cancer

Less than half of Tajik women have heard of breast cancer. Among these women, only 43% listed a lump in the breasts as a symptom. Women in Dushanbe are most aware of breast cancer and its symptoms.

Screening for breast cancer is very rare in Tajikistan. Only 3% of women 15-49 report that they have ever had a breast examination given by a health professional. Six percent say that they know how to give a self-exam.

Cervical cancer

Two in five Tajik women age 15-49 have heard of cervical cancer. Only 8% have ever been given a Pap smear test.



Key Indicators

Fertility	Total
Total fertility rate (number of children per woman)	3.8
Women age 15–19 who are mothers or currently pregnant (%)	7
Median age at first marriage for women age 25–49 (years)	20.2
Median age at first intercourse for women age 25–49 (years)	20.3
Median age at first birth for women age 25–49 (years)	21.8
Married women age 15–49 who want no more children or are sterilized (%)	44
Total abortion rate (total induced abortion rate for the 3 years before the survey)	0.5
Family Planning (married women, age 15–49)	
Current use	
Any method (%)	28
Any modern method (%)	26
Currently married women with an unmet need for family planning[1] (%)	23
Maternal and Child Health	
Maternity care	
Pregnant women who received antenatal care from a skilled provider[2] (%)	79
Births assisted by a skilled provider[2] (%)	87
Births delivered in a health facility (%)	77
Child vaccination	
Children 18-29 months fully vaccinated[3] (%)	89
Nutrition	
Children under 5 years who are stunted (moderate or severe) (%)	26
Children under 5 years who are wasted (moderate or severe) (%)	10
Children under 5 years who are underweight (%)	12
Women 15-49 who are overweight or obese (%)	30
Childhood Mortality	
Infant mortality (between birth and first birthday)[4]	*34*
Under-five mortality (between birth and fifth birthday)[4]	*43*
HIV/AIDS-related Knowledge	
Knows ways to avoid HIV (women age 15–49):	
Having one sexual partner (%)	43
Using condoms (%)	36
Knows HIV can be transmitted by breastfeeding and that the risk of MTCT can be reduced by mother taking special drugs during pregnancy (%)	18
Tested for HIV in the past 12 months and received result of the test (%)	5
Women's Experience of Violence (women age 15–49)	
Ever experienced physical violence since age 15 (%)	19
Ever experienced physical or sexual violence committed by a husband/partner[5] (%)	20

[1] Currently married women who do not want any more children or want to wait at least two years before their next birth but are not currently using a method of family planning.
[2] Skilled provider includes doctor, nurse, midwife, and feldsher
[3] Fully vaccinated includes BCG, measles, three doses of DPT and three doses of polio (excluding Polio 0 and Polio 4)
[4] Number of deaths per 1,000 births; figures are for the ten-year period before the survey except for the national rate, in italics, which represents the five-year period before the survey.
[5] Ever-married women age 15-49

Residence		Region				
Urban	Rural	Dushanbe	GBAO	Sughd	DRS	Khatlon
3.3	3.9	3.4	3.3	3.3	3.9	4.2
7	8	7	3	6	9	8
20.5	20.1	20.5	22.6	20.1	20.1	20.2
20.6	20.2	20.6	22.9	20.2	20.2	20.3
22.0	21.7	22.2	24.1	21.7	21.6	21.9
43	45	40	47	46	41	46
0.6	0.4	0.7	0.4	0.4	0.5	0.5
32	27	32	35	35	22	24
29	25	29	35	31	22	23
21	23	24	23	20	28	22
83	78	81	85	94	79	67
93	86	96	93	95	80	85
87	74	88	65	93	70	67
88	89	83	83	93	83	91
21	27	19	24	27	26	27
10	10	10	8	8	10	11
11	13	9	13	10	13	14
38	27	40	22	26	33	29
35	39	22	29	31	38	48
42	50	29	36	40	46	61
50	41	43	68	52	33	41
42	35	37	47	45	28	34
22	17	15	20	25	18	12
8	4	8	7	7	3	3
21	18	15	14	22	13	21
22	20	15	15	25	12	23