

MULTIPLE INDICATOR CLUSTER SURVEY

Mongolia, 2005-2006

Key Findings



Mongolia

**Multiple Indicator Cluster Survey
(Child and Development Survey)**

2005-2006

Key Findings



**National Statistical Office
of Mongolia**



**UNITED NATIONS
CHILDREN'S FUND**

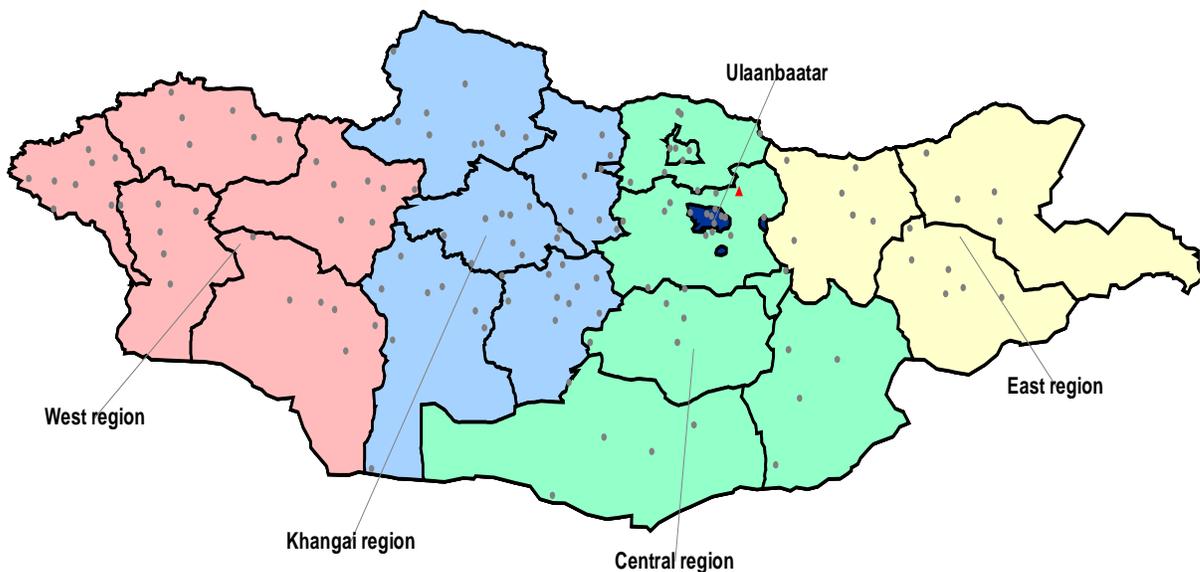
About Mongolia MICS 2005-2006

Multiple Indicator Cluster Surveys (MICS) is an international household survey initiative developed by UNICEF to assist countries in filling data gaps for monitoring human development in general and the situation of children and women in particular.

MICS Mongolia was designed to provide statistically sound and internationally comparable data for monitoring the situation of women and children in Mongolia. Among the social indicators used in the MICS Mongolia are those required for monitoring the goals and targets of the Millennium Declaration, the World Fit for Children Declaration and Plan of Action and the goals of the United Nations General Assembly Special Session on HIV/AIDS. Mongolia conducted the first and the second rounds of MICS in 1996 and 2000.

Information was collected during November and December 2005 from 129 soums representing all 21 Aimags (provinces) and 80 khoroos representing eight districts in the capital city of Ulaanbaatar.

Map 1: Sites where data was collected



What information is included in MICS Mongolia 2005-2006?

At the Household Level: age, sex, orphanhood of children, schooling of all household members, use of iodised salt, access to water and sanitation. The survey also included questions on child labour, child discipline and child disability.

From Women: women's education and literacy, child survival, maternal and newborn health, marriage, contraception including unmet need, HIV/AIDS knowledge and attitude, as well as on attitudes to domestic violence.

On Children under five: birth registration, breastfeeding, vitamin A, care of illness, immunization and anthropometry, early learning education, as well as on child development.

The survey results provide information at the national level, for rural and urban areas, as well as for each of the five regions. Findings are also broken down by other important background characteristics which are known to influence the health and development of children, in particular the education level of the mother, the level of wealth of the household and the type of location (capital city of Ulaanbaatar, Aimag centres, Soum centres or remote rural areas).

Who conducted the survey?

MICS Mongolia has been carried out by the National Statistical Office in partnership with UNICEF throughout 2005-2006. The National Authority for Children, Ministry of Health, Ministry of Education, Culture and Science, Ministry of Social Welfare and Labour, Ministry of Finance, Public Health Institute, General Police Department and local authorities and statistical department/division of capital city/aimag governors office contributed to the survey by providing technical assistance and facilitating the implementation of the survey. Funds to the survey were provided by the Government of Mongolia and UNICEF Mongolia.

For information concerning the MICS Mongolia, contact the Population and Social Statistics Division of the National Statistical Office. Tel: (976) 11-321292; e-mail: nso@magicnet.mn. Report is also electronically available at www.nso.mn.

Additional information on MICS and results from other countries that have implemented the survey programme are available at www.childinfo.org.

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Recommended citation:

National Statistical Office of Mongolia, 2007, Mongolia Multiple Indicator Cluster Survey 2005-2006, Key Findings, Ulaanbaatar, Mongolia.

Date of publication: February 2007

Multiple Indicator Cluster Survey 2005-2006 Mongolia

Key Findings

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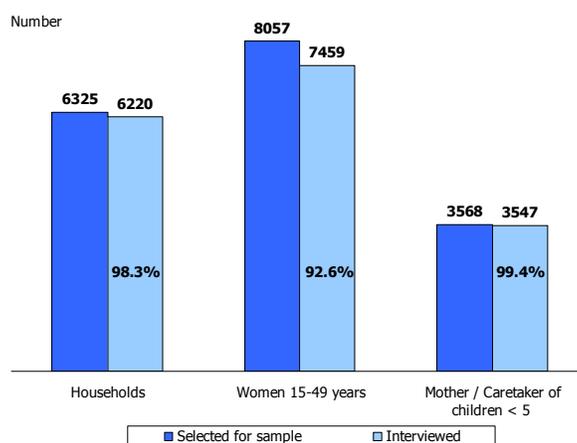
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Sample Coverage and Characteristics of Households and Respondents

Survey sample

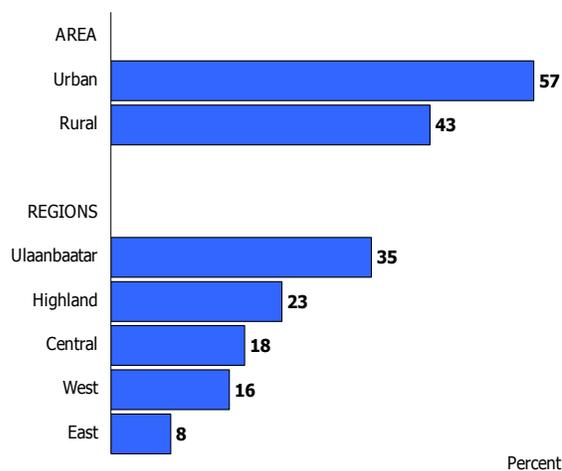
The survey findings are based on interviews with 6220 households, 7459 women aged 15-49 years, and 3547 interviews with mothers or caretakers of children aged less than five years old (see Figure 1).

Figure 1: Survey sample, MICS 2005



Spatial distribution of the population

Figure 2: Distribution of population surveyed in MICS by regions and rural / urban location, Mongolia, 2005



More than half of the households were based in urban areas, 35% living in the capital city and 23% in Aimag centres. Forty three percent were based in rural areas, 10% in Soum centres (small settlements) and 32% in the countryside, mostly leading a nomadic life migrating with their herds in accordance with seasonal changes. One in three households was located in Ulaanbaatar, with the other four regions making up between 23% of the population in Highland down to 8% of the population in East (see Figure 2).

Demographics

The average household size was 4.29 persons. Forty-three percent of the sample was made up by children under the age of 18, 13% of them under the age of 5. Close to half of

all households had one or more children under the age of five and close to nine out ten households had at least one child under the age of 18.

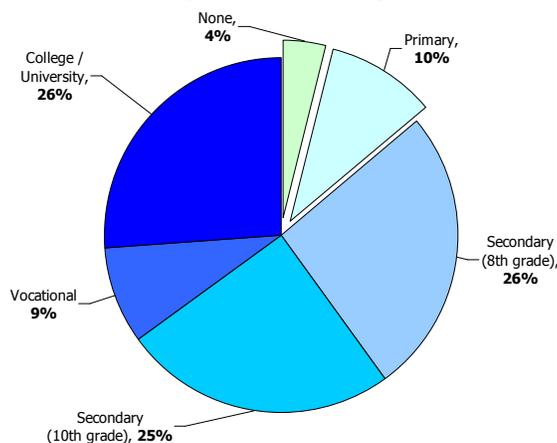
Of the women interviewed for the study three out of ten had never been married or in a union and 25% had never given birth. The number of women in each age group interviewed for the survey starts to decline slowly from age 30 and onwards, with 18% of the female sample being aged 25-29 years old and 9% being aged 45-49 years old.

Education level

One in seven of the women interviewed had little or no education. The education level of the mother is often the most important factor affecting the survival, health and development of a child. Generally, the more educated the mother, the less the risk of child mortality, malnutrition, disease, and child labour and the higher the level of antenatal care, immunization, school attendance and reproductive health knowledge, just to mention some of the areas where education plays a key role.

The education level of the adult population in Mongolia is generally high for women and men alike, with one in four women in the survey having completed tertiary education. Despite the high levels of education 14% of mothers were poorly educated with either no education (4%) or only primary education (see Figure 3).

Figure 3: Education level of women aged 15-49, Mongolia, 2005



Wealth status

Economic status is another key factor when analysing findings. Traditionally economic status is measured through the income or consumption level of a household. This information is, however, time consuming and difficult to collect, and therefore not feasible for a survey already covering so many different issues. In stead, households were divided into five quintiles of wealth categories ranging from the poorest 20% to the richest 20%. The wealth quintiles were based on a wealth index created for the survey, which focuses on the assets a household has accumulated over time.

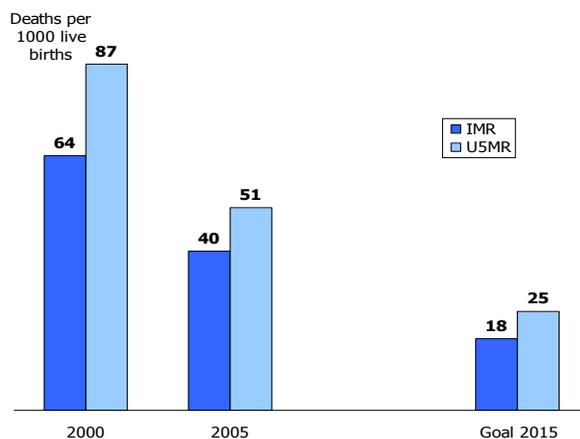
Child Mortality

Infant and child mortality are one of the key indicators of the wellbeing of a society. Identifying children with the highest risk of dying enables policy makers and planners to better channel the efforts to improve child survival and lower the exposure to risk.

Infant mortality and under five mortality (the risk of dying before the age of one and five) has continued to decrease rapidly over the past five years. Currently, one in 20 children in Mongolia do not live to his or her fifth birthday compared with one in every thirteen children five years ago.

This decline is illustrated in Figure 4 with under five mortality decreasing from 87 to 51 deaths per 1000 live births between 2000 and 2005, a decline of 41%. During the same period, infant mortality has declined from 64 to an estimated 41 deaths, a decline of 36%. If this impressive trend can be sustained, it might just be possible to reach the recently revised and very ambitious Millennium Development Goal (MDG) for Mongolia in this area.

Figure 4: Trends in infant and under five mortality rates, Mongolia, 2000 and 2005, versus national goal 2015



The trend of rapid decline in infant and under five mortality rates is consistent with data collected through the Reproductive Health Surveys in 1998 and 2003, as well as with routine data collected by the Ministry of Health. While the **actual** mortality levels found in surveys are considerably higher than the mortality levels reported by the Ministry of Health, the sources all agree on the same positive **trend** of rapid and consistent decline in infant and under five mortality rates over the past 15-20 years (see Figure 5).

Millennium Development Goal 4:

Reduce Child Mortality

Reduce by two thirds, between 1990 and 2015 the under-five mortality rate.

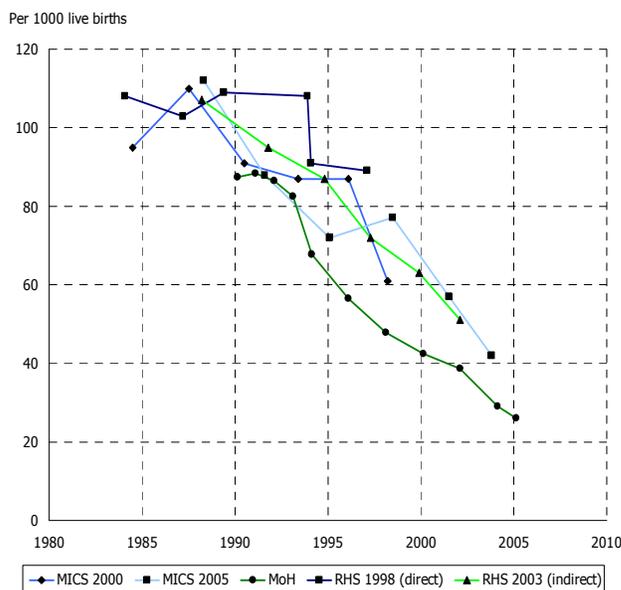
Indicators available in MICS3:

- Under-five mortality rate
- Infant mortality rate
- Proportion of 1-year old children immunized against measles (see section on child health).

National MDG targets:

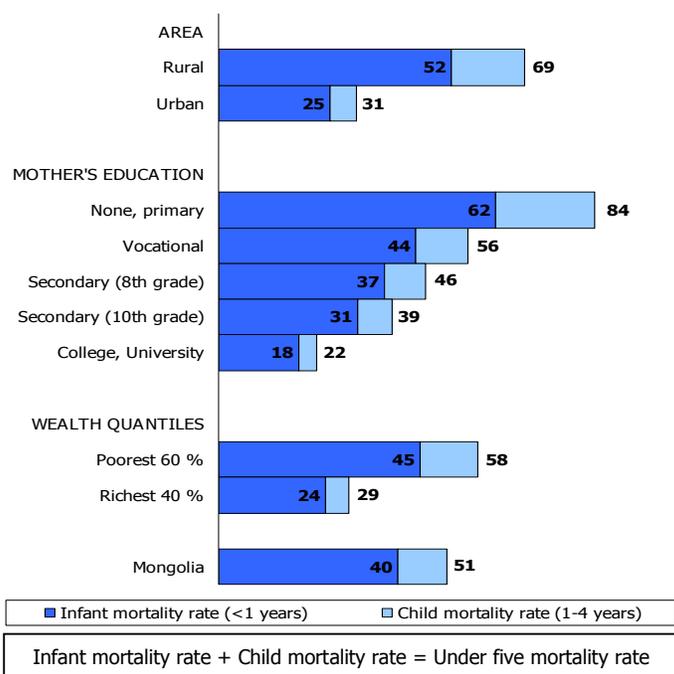
- Reduce under five mortality rate to 25 and infant mortality rate to 18 per 1000 live births by 2015.
- Increase proportion of children immunized against measles to 96%.

Figure 5: Under five mortality rates by different sources, Mongolia, 1984-2005



Some of the possible explanations behind the mortality decline include high and increasing immunization rates, declining malnutrition rates, significant improvements in the coverage of iodised salt and the supplementation of vitamin A. Declining fertility rates between 1990-2000 also play an important role as lower fertility is linked to larger spacing between births which results in lower incidence of: low birth weight, early weaning, malnutrition and disease, and in a lower number of overall children, all of them factors which reduce the risk of dying.

Figure 6: Infant and under-5 mortality rates by background characteristics, Mongolia, 2005



A child's risk of dying varies considerably depending on where in Mongolia the child lives (see Figure 6). Mortality is twice as high in rural areas as in urban areas and is particularly low in the capital city.

Under five mortality rates are particularly high among children born to mothers with no or little education (86 and 81 per 1000 live births). This is almost four times as high as among children born to mothers with college or university education (22 per 1000) and 70% higher than the national average. By far the lowest under five mortality levels are found among children born to mothers belonging to the wealthiest 20% of the population (6 per 1000).

Infant deaths make up an increasing share of the under five deaths, This is common when mortality rates decline, as infant deaths, particularly those happening soon after birth, are commonly caused by prenatal causes such as the mothers health status, congenital defects, birth trauma etc., which are harder to prevent, than deaths taking place later and more often related to environmental factors such as diseases, malnutrition and accidents.

Nutrition

Children's nutritional status is a reflection of their overall health. For young children the lack of healthy food retards their physical and mental development and threatens their survival. Malnutrition is not only caused by inadequate food intake and lack of micronutrients such as iodine, iron, Vitamin A and Vitamin D but also due to disease and lack of care.

Millennium Development Goal 1:

Eradicate extreme poverty and hunger
Reduce by half between 1990 and 2015 the proportion of people who suffer from hunger.

Indicators available in MICS3:

- Prevalence of underweight children under five years of age

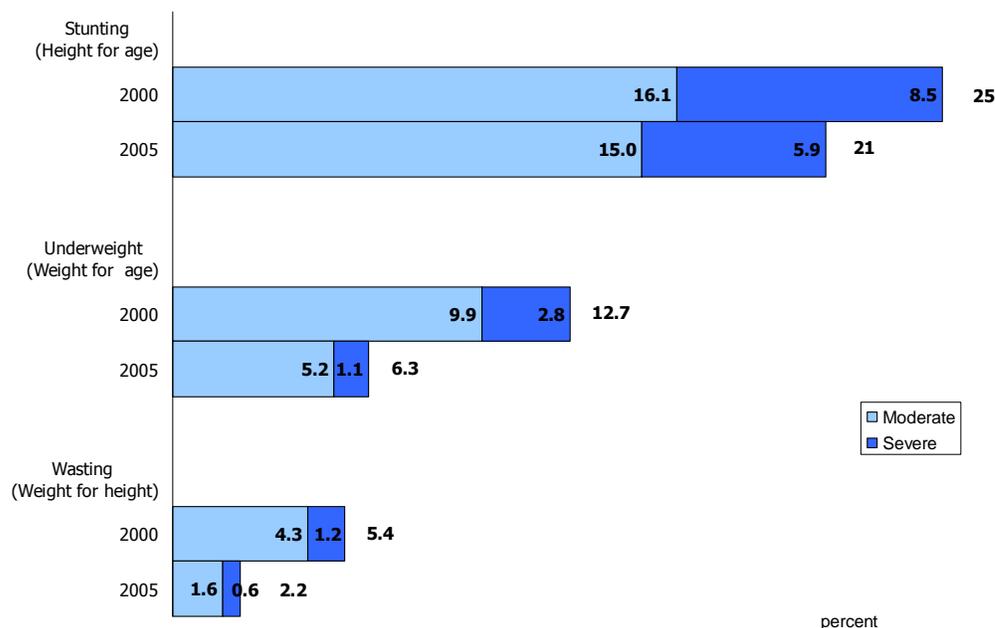
National MDG target:

- Eradicate the prevalence of underweight among children under five years of age.

Nutritional status

Malnutrition among children under the age of five has decreased significantly over the past five years (see Figure 7).

Figure 7: Declining malnutrition rates - stunting, underweight and wasting (moderate and severe), Mongolia, 2000 and 2005



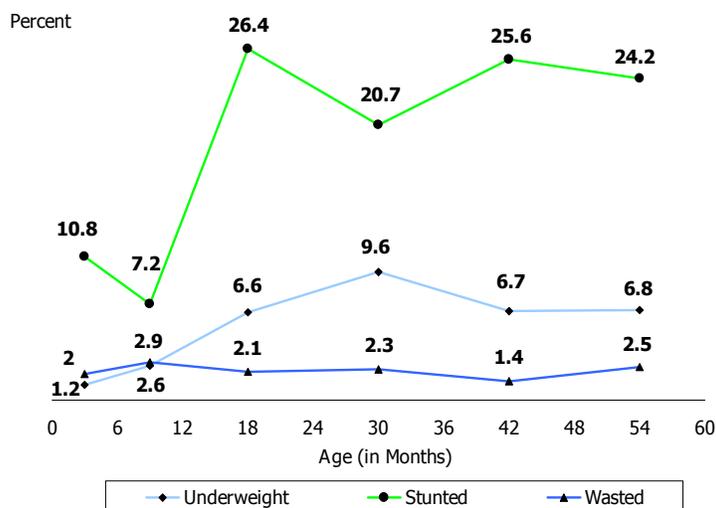
Most impressive has been the reduction in children who are underweight, which has been halved since 2000. One in sixteen children (6.3%) under the age of five is now underweight (too light for their age) compared with one in eight children (12.7%) five years ago. As underweight is a measure of both acute and chronic (long term) malnutrition it is the best way of describing the overall level of malnutrition in a population and the best way of assessing changes over time.

Stunting has been reduced from 25% to 21% over the past five years but remains the most prevalent form of malnutrition in Mongolia affecting one in five children under the age of five. It is particularly high in West (28%) and East (27%) regions. Severe stunting affects

roughly 6 percent of children under five. Stunting, (children who are too low for their age), reflects a chronic situation where repeated disease or long term malnutrition has resulted in poor growth over time.

Wasting, reflecting a recent and chronic situation is the least prevalent form of malnutrition. It has been more than halved over the past five years from 5.5% to 2.2% of children under the age of five who are wasted or too thin for their height.

Figure 8: Malnutrition by age among children under five, Mongolia, 2005



Malnutrition is less among young children still being breastfed, but increases as other foods are introduced into the diet peaking around the age of 24-36 months (see Figure 8).

Children of mothers with no education are twice as likely to be stunted and three times as likely to be underweight or wasted compared with children born to well educated mothers.

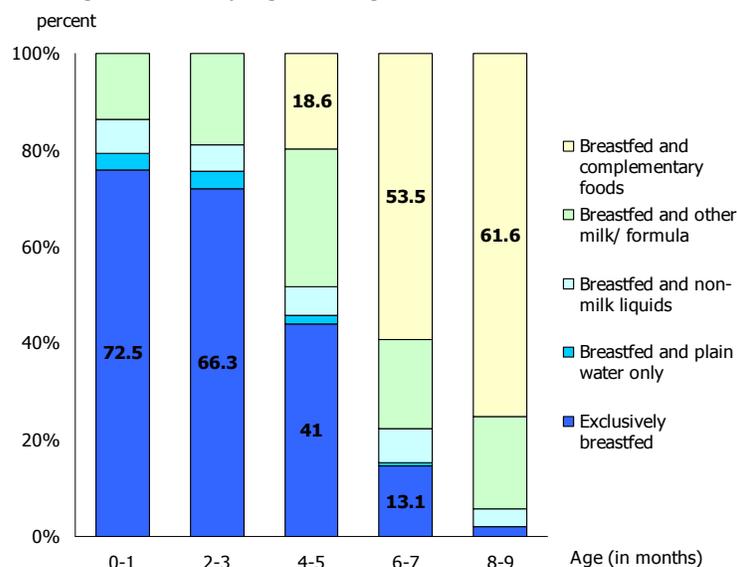
Breastfeeding

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients and is economical and safe. An ideally breastfed child is one who is breastfed within an hour of birth, is then exclusively breastfed for the first six months of life, has appropriate food introduced into it's diet at the age of six months, gradually increases the intake of nutritious food while still continuing to be breastfed till at least two years of age.

In Mongolia nine out of ten women start breastfeeding within a day of birth, 78% within the first hour as recommended in order for the child to get maximum benefit of the colostrums in the early breast milk.

Breastfeeding has increased by 5-8% among all age groups of young children since 2000. Overall 57% of children under the age of six months are exclusively breastfed, more so in rural areas (60%) than in urban areas (55%). Exclusive breastfeeding is more common during the first four months of life but then drops to 41% of children aged 4-5 months. The drop is partly due to an increased use of milk formula for that age group (26%) and partly due to an early introduction of solid food (19%) (see Figure 9).

Figure 9: Infant feeding patterns by age, Mongolia, 2005

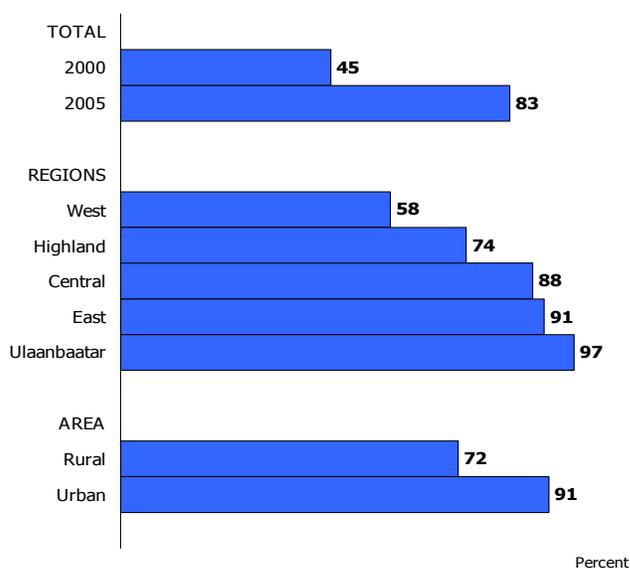


More than eight out of ten children continue to be breastfed at the age of 12-15 months and 65% at the age of 20-23 months. Breastfeeding declines with wealth and income and tends to be particularly low in Aimag centres.

Salt iodisation

There has been an impressive increase in the proportion of households using iodised salt from 45% in 2000 to 83% in 2005 (see Figure 10). This coincides with the Mongolian Law on Universal Salt Iodisation and Prevention of Iodine Deficiency Disorders passed in 2003.

Figure 10: Households consuming adequately iodised salt, Mongolia, 2000 and 2005



The result is palpable. During the same period the incidence of goitre among 8-12 year old children has decreased from 21% to 14%¹.

The use of iodised salt varies considerably across regions from the lowest level of 58% in West region and the highest levels in Central (88%), East (91%) and particularly Ulaanbaatar (97%). The low consumption in the West region is due to the many natural salt deposits and salty lakes, used locally for salt consumption.

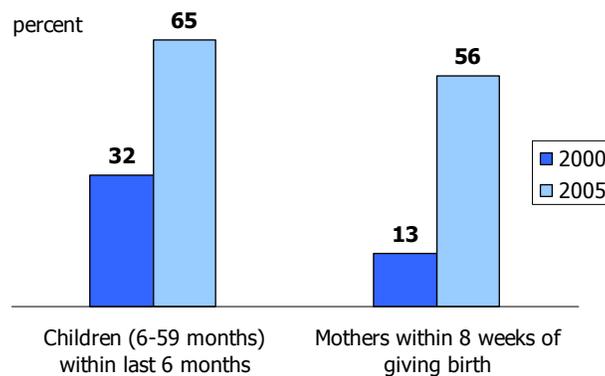
¹ Nutrition Status of Mongolian Children and Women, 2004-2006, 3rd Nutrition Survey Report

Vitamin A supplements

Vitamin A is essential for eye sight and proper functioning of the immune system. In countries with vitamin A deficiency problems the international recommendation is to provide young children aged six to 59 months with two high dose vitamin A capsules a year as a safe, cost-effective and efficient strategy for eliminating Vitamin A deficiency. Vitamin A supplementation of young children was introduced in Mongolia in 1998 and is linked to the immunization services. Starting in 2003, vitamin A supplements have also been given to mothers within the first 2 months after childbirth.

The proportion of children aged 6-59 month who received a Vitamin A dose within the last 6 months doubled from 32% in 2000 to 65% in 2005. Even more impressive is the increase in the proportion of mothers who received a high dose Vitamin A supplement within 8 weeks of giving birth. This has quadrupled from 13% in 2000 to 56% five years later. Supplementation is highest in Ulaanbaatar and lowest in the West region.

Figure 11: Increase in vitamin A supplementation of children and mothers, Mongolia, 2000 and 2005



Low birth weight

Low birth weight is a good indicator not only of a mother's health and nutrition status but also the newborn's chance of survival, growth, long term health and development.

The proportion of babies being weighed at birth has increased from 95% to 98%. However, the proportion of babies who weigh less than 2500 gram at birth has remained unchanged at 5.5%. The risk of being born underweight varies from 4.9% in urban areas to 6.1 in rural areas but is by far the highest among children born to mothers with no education (10%).

Child Health

Immunization coverage for the major vaccine-preventable diseases, along with early diagnostics and treatment, can prevent a high proportion of childhood deaths. Ministry of Health has instituted an Expanded Program on Immunization (EPI)

Immunization

Two out of three children (68%) have received all of the immunizations and all the doses of vaccine in the Expanded Immunization Programme (EPI) by the age of one. Immunization rates are highest for immunizations due early in life such as BCG (97.6) due at birth, DPT1, 2 and 3 (ranging between 92 and 93%) and Polio 1, 2 and 3 (97%, 95% and 93%) due at the ages of 2, 3 and 4 months. Immunization coverage drops for measles due at nine months of age. This is mainly due to a delay in measles vaccination with 76% of children being immunized against measles before the age of one, and another 15% delaying it till after the age of one.

Millennium Development Goal 4 and 6

Reduce child mortality

Reduce by two thirds, between 1990 and 2015 the under-five mortality rate.

Combat HIV/AIDS and other diseases

Halt and begin to reverse the incidence of other major diseases.

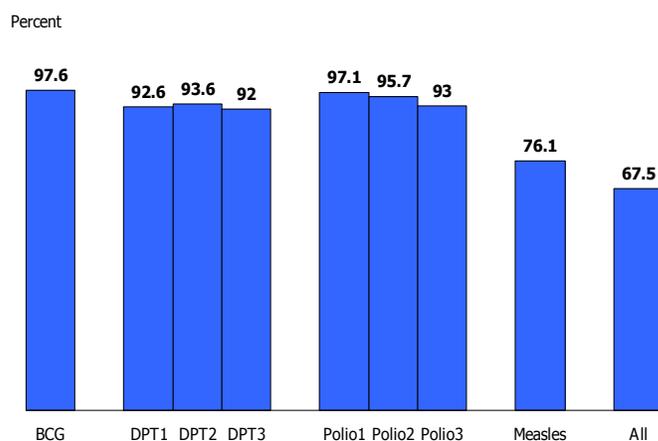
Indicators available in MICS3:

- Proportion of population using solid fuels
- Proportion of 1-year old children immunized against measles

National MDG target:

- Increase proportion of children immunized against measles to 96%

Figure 12: Children aged 12-23 months who received the recommended vaccinations by 12 months of age, Mongolia, 2005



The delay may partly be explained by a nationwide stock out period with no measles vaccine available nationwide four months prior to the survey and may therefore not reflect a typical situation. If including all 12-23 months old children in the survey who had received a measles vaccination, regardless of when it took place, the measles coverage rate rises to 88% and the proportion of children who are fully immunized with all antigens to 82%.

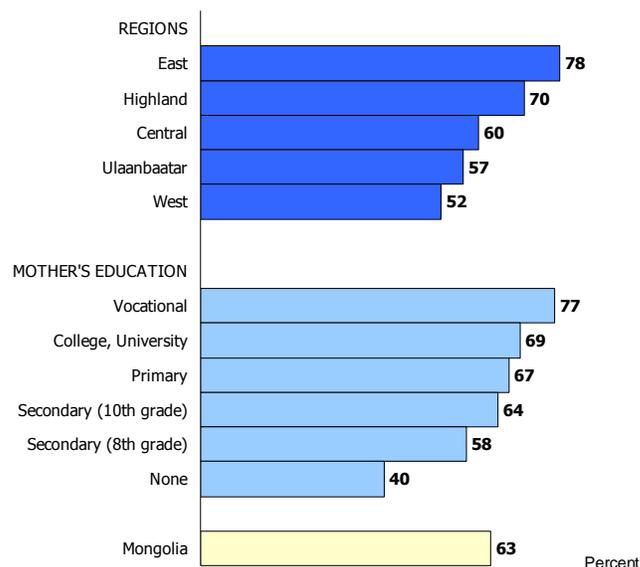
The biggest variation in immunization coverage is found at the regional level. Full immunization coverage is highest in Central region (90%) and lowest in East (70%). The proportion of children who were fully immunized only varies 4% by education level, 6% between rural and urban areas, and 8% by wealth.

Oral rehydration treatment

Diarrhoea is the second leading cause of death among children aged 1-4 years old in Mongolia. Most diarrhoea-related deaths in children are due to dehydration. Management of diarrhoea – either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths.

One in sixteen children (6.6%) had diarrhoea in the two weeks preceding the survey. Children aged 6-23 months are the most vulnerable age group. The incidence of diarrhoea was almost twice as high among children living in rural areas (8.4%) as among urban based children (4.9%). Two in three children were given oral rehydration treatment, either rehydration salts (38%) or a recommended homemade fluid (30%). Boys are less likely to be given treatment (58%) than girls (69%) and urban children less likely (58%) than rural children (66%).

Figure 13: Children aged 0-59 months with diarrhea who received oral dehydration treatment, Mongolia, 2005



Other important strategies for managing diarrhoea are to prevent dehydration and malnutrition by increasing fluid intake and continuing to feed the child (home management of diarrhoea). While 33% of children with diarrhoea increased their intake of fluids and 72% continued feeding, only 21% did both.

Care seeking and antibiotic treatment of pneumonia

Pneumonia is the leading cause of death in children worldwide and the use of antibiotics in under-5s with suspected pneumonia is a key intervention. One in eleven children aged 0-59 months (8.8%) showed symptoms of pneumonia during the two weeks preceding the survey. Of these children, 63% were taken to an appropriate provider and 71% treated with antibiotics. Anti-biotic treatment was highest in West (83%) and lowest in neighbouring Highland (63%). Anti-biotic treatment rises as the living standard increases. The poorer the household the more children go untreated, partly due to the likelihood of treatment being lower, and partly due to higher incidence of pneumonia in these households.

Only 8% of mothers and caretakers were able to recognize the two danger signs of pneumonia (fast or difficult breathing). While 86% of mothers and caretakers would seek immediate medical care for a child with fever, only 21% would do so for a child with fast breathing and 23% for a child with difficulty breathing.



Photo courtesy of UNICEF Mongolia

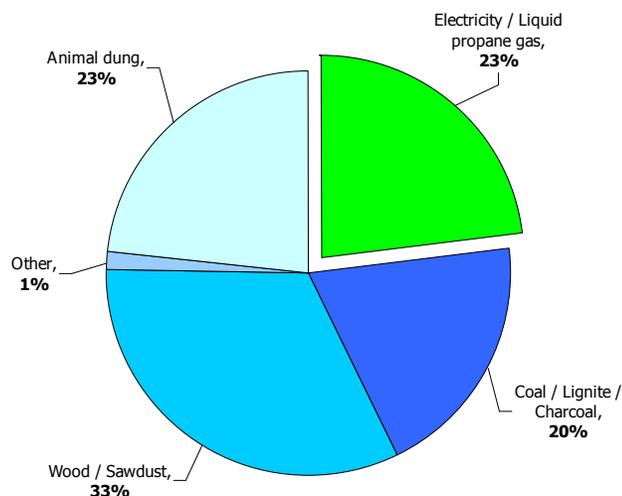
Solid fuel use

Cooking with solid fuels (biomass and coal) leads to high levels of indoor pollution and is a major cause of acute respiratory illness.

Use of solid fuel for cooking is high in Mongolia (77%), even in urban areas (61%) and virtually universal in rural areas (98%).

The types of fuel used are mostly wood (33%), animal dung (23%) and coal (20%). Only amongst the highest educated and the wealthiest households do a significant proportion of households use electricity for cooking (56% and 82% respectively).

Figure 14: Types of fuel used for cooking, solid fuel versus non-solid fuel, Mongolia, 2005



Environment

Improving access to water, hygiene and sanitation is a crucial element in the reduction of under-five mortality and morbidity, particularly in rural and peri-urban areas.

Water

The gap between rural and urban areas in Mongolia becomes very clear when looking at access to clean drinking water and improved sanitation. While the government of Mongolia has been successful in ensuring universal access to education and health services, ensuring access to environmental infrastructure has proved more challenging.

Millennium Development Goal 7

Ensure environmental sustainability

Reduce by half the proportion of people without access to safe drinking water and basic sanitation by 2015.

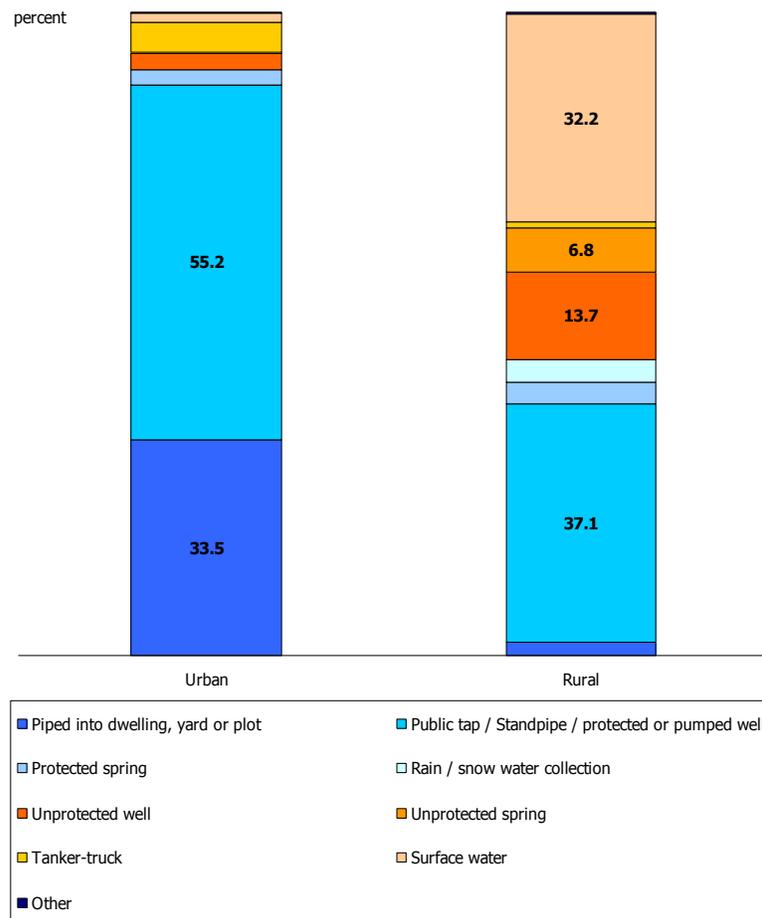
Indicators available in MICS3

- Proportion of population with sustainable access to an improved water source, urban and rural
- Proportion of population with access to improved sanitation, urban and rural

National MDG target:

- Increase the proportion of population using an improved water source to 70%.

Figure 15: Source of drinking water, rural versus urban areas, Mongolia, 2005



Access to clean water has risen by 12% over the past five years, an improvement which has entirely taken place in the rural areas. Clean water now reaches 72% of the Mongolian population – nine out of ten in urban areas (91%) but still less than half the population in rural areas (46%) (See Figure 16). Access to clean water is considerably lower in the West (52%) and Highland (54%) regions than in Central (65%), East (78%) and Ulaanbaatar (95%).

The most common source of drinking water in all areas is water from a public tap/standpipe / protected or pumped well which covers close to half the population, followed by piped water reaching one in five people (See Figure 15).

The source of drinking water varies strongly according to where people live. Only 2% of the rural population benefit from piped water compared with 34% of the urban population. Similarly surface water, which is the most common type of unimproved water, is drunk by one in three people in rural areas compared with 1.4% in urban areas.

Drinking water is not always easily accessible. Ten percent of households have to spend an hour or more and 20% spend between 30-60 minutes every time they have to fetch water.

Sanitation

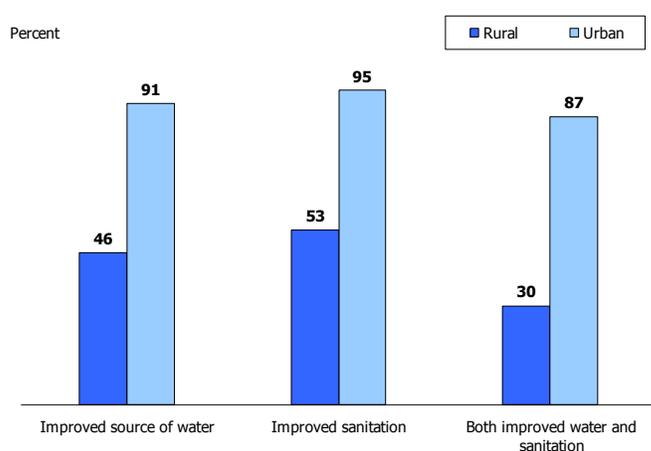
A similar picture to that of water applies on the issue of sanitation. Improved sanitation facilities are available to 77% of the population, nine and a half out of ten in urban areas, but only little over half in rural areas (See Figure 16). Pit latrines with a slab is the most common form of improved sanitation facility in all areas, covering 50% of the population followed by flush toilets covering one in five people, mostly in Ulaanbaatar (35%). The use of both clean water and sanitation is strongly correlated with wealth.

One in eight people have no facility at all (13%). This is particularly the case in the poorest households (48%), among herders living in the countryside (38%), and among households in the regions of West (26%) and Highland (21%).

The risk of lower hygiene and disease can increase where there are many people using the same sanitation facility. Of households with an improved sanitation facility, 3.6% share the facility between four or more households.

Both water and sanitation

Figure 16: Population with access to improved source of water AND improved sanitation, rural versus urban areas, Mongolia, 2005



The differences in use of water and sanitation become even more pronounced when looking at who has access to both clean water AND improved sanitation. Two in three people have access to both, three times as many in urban areas (87%) as in rural areas (30%) (See Figure 16). The wealth gap is bigger again. Eleven percent of the poorest households have access to both clean water and improved sanitation compared with virtually

everyone (99.4%) in the wealthiest 20% of the population.

Reproductive Health

Healthy children need healthy mothers. Complications during pregnancy and at childbirth are a leading cause of death and disability among women of reproductive ages in developing countries.

Antenatal Care

Antenatal care is an important intervention to improve both maternal and newborn health. Virtually all births taking place in the past two years were preceded by at least one antenatal care visit (99.1%). The few women not receiving antenatal care are found among the youngest age group (15-19 years) and among the oldest age groups (40-49 years) of women.

The majority of pregnant women received antenatal care from a doctor (83%) regardless of where they live. Women living in the countryside were those least likely to see a doctor (69%) and most likely to see a 'feldsher' / auxiliary midwife (27%).

The quality of antenatal care varies between regions. While almost all pregnant women had their blood pressure taken (98%) 11% did not have a blood sample or urine specimen taken. This was particularly the case in West region where only two out of three women had these samples taken compared with over 90% in East, Central and Ulaanbaatar.

Assistance at Delivery

Most maternal deaths occur during delivery and the immediate post-partum period. The most critical single intervention for safe motherhood is to ensure a competent health worker with midwifery skills is present at every birth, and transport available for a referral facility for obstetric care in case of an emergency.

The already high use of health facilities and skilled health personnel for deliveries has continued to rise over the past five years. Nearly all births in the two years preceding the survey took place in a health facility (98.6%) thanks to the common practice of pregnant women living in remote areas, moving into a maternity house a couple of weeks before the birth is due. As a result virtually all births took place with the assistance of skilled health personnel (99.2%) either a doctor (70%), a nurse or midwife (10%) or a feldsher (auxiliary midwife) (19%). Women least likely to receive skilled support were women with no education (4.3%).

Millennium Development Goal 5 and 6

Improve maternal health

Reduce the maternal mortality ratio by three quarters by 2015.

Combat HIV/AIDS and other diseases

By 2015 halt and begin to reverse the spread of HIV/AIDS and other major diseases.

Indicators available in MICS3:

- Proportion of births attended by skilled health personnel
- Contraceptive prevalence rate
-

National target:

- Increase proportion of births attended by skilled health personnel to 99.8%

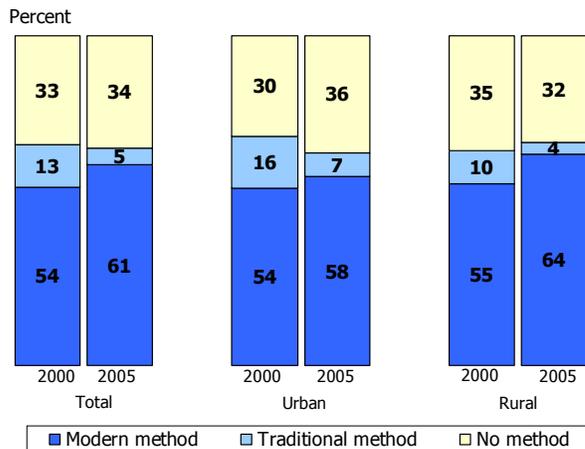
Contraception

Appropriate family planning is important to the health of women and children by 1) preventing pregnancies that are too early or too late; 2) extending the period between births, and 3) limiting the number of children.

Two out of three women who are currently married or in union use contraception. While there has been little change in the overall use of contraception over the past five years, there has been a shift towards the use of modern contraception, which has increased from 54% to 61% and away from the use of traditional methods, which have declined from 13% to 5%.

Women least likely to use modern contraception are women with no children (20%) and women aged 45-49 years old (31%). Otherwise the use of contraception varies relatively little across background characteristics.

Figure 17: Use of contraception (modern and traditional) by women married or in union, Mongolia, 2005



The most popular type of modern contraception is the IUD (29%) followed by the pill and injections (both 11%). Wealthier and more educated women are more likely to use the pill, whereas poorer and less educated women are more likely to use injection. IUD remains the most commonly used form across all groups but more so among the poorest.

The main form of traditional contraceptive methods is periodic abstinence, used by 4.7% of women. Surprisingly this method increases with the education level and economic well being of women, possibly due to better knowledge about the reproductive cycle and how to use this knowledge for birth control.

Unmet Need for Contraception

Among women currently married or in a union, 14% wish to postpone the next birth or wish to stop childbearing altogether, but are not currently using any kind of contraception. This unmet need for contraception increases with age and is highest for women aged 40-49 (17% and 22%) and among women with no or primary education (19%). At the regional level the unmet need varies from 11.6% in Highland to 16% in West.

Education

Universal access to basic education is one of the most important goals of the Millennium Development Goals. Education is a vital prerequisite for combating poverty, empowering women, protecting children, promoting human rights and democracy, protecting the environment and influencing population growth.

Pre-school attendance and school readiness

Attendance in pre-school education is important to foster school readiness of a child.

Children aged 3-4 years old are more likely to attend early childhood education now than five years ago. Attendance in early childhood education has gone up from 21% to 37% - and now stands at 25% in rural areas and twice that (50%) in urban areas (see Figure 18). The increase has been particularly pronounced among children in Aimag centres, Soum centres and remote rural areas.

Millennium Development Goal 2 and 3

Achieve universal primary education

Ensure that all boys and girls complete a full course of primary schooling by 2015.

Promote gender equality and empower women

Eliminate gender disparity in primary and secondary education by 2005, and in all levels of education by 2015.

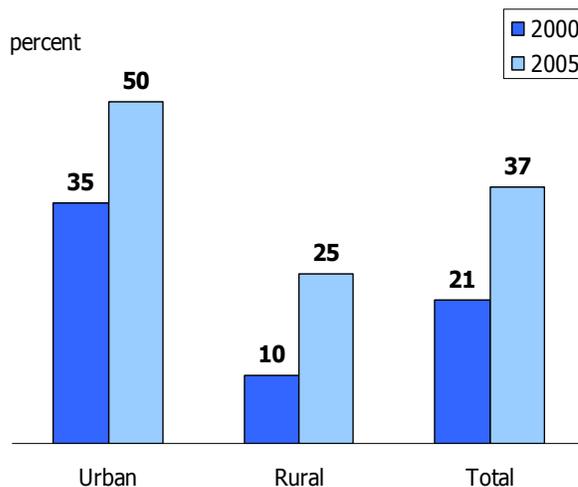
Indicators available in MICS3:

- Net attendance ratio in primary education
- Proportion of pupils starting grade 1 who reach grade 5
- Primary school completion rate
- Ratio of girls to boys in primary and secondary education

National target:

- Increase proportion of pupils starting grade 1 who reach grade 5 to 100%
- Increase Youth literacy rate among 15-24 year olds to 100%

Figure 18: Children aged 36-59 months attending early childhood education, Mongolia, 2000 and 2005



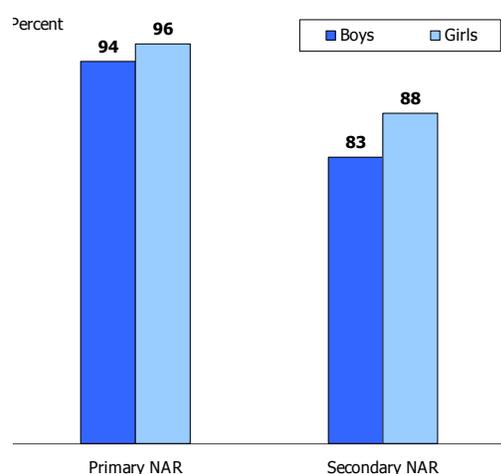
Enrolment is most strongly related to the level of wealth of the family. Eleven percent of the poorest children attend early childhood education rising to 73% of children in the wealthiest households.

Once children reach pre-school age their involvement in pre-school activities go up. Among children in grade one, 80% had attended a pre-school program at some stage during the previous year. Pre-school attendance varies from 67% among the poorest children to 90% among the richest.

Primary and secondary attendance

The net attendance rate of school is 95% for children of primary school age and 85% for children of secondary school age. At the regional level attendance rates vary from 98% in Central to 92% in West for primary schooling. At secondary level attendance rates vary from 90% in Ulaanbaatar to 79% in East region.

Figure 19: Net attendance rate in primary and secondary schooling, by gender, Mongolia, 2005



Attendance at both primary and secondary level is most strongly related to the education level of the mother, a relationship which becomes more pronounced the higher the level of education. At primary level school attendance varies from 85% to 98%, and at secondary level from 61% to 95% depending on the education of the mother. The second most important factor is the financial situation of the household. The third most important factor is the type of location the child lives in. Children in remote rural areas are more likely to be out of school than children elsewhere in the country, particularly boys who are commonly withdrawn to assist with the herding of animals. At secondary level 72% of boys in remote areas attend school compared with 81% of girls.

One in sixteen children drop out of primary school. Of those who enter first grade, 96% reach grade 5 and 94% complete grade five and thus the full five years of primary schooling. Those least likely to complete are children from the West region (89%).

Gender parity index

Mongolia has more girls in school than boys, a gap which increases with the level of education. For every 100 boys attending primary school there are 102 girls or a gender parity index of 1.02. This rises to 106 girls for every 100 boys at the secondary level or a gender parity index of 1.06. The disadvantage of boys at secondary level is most pronounced among boys living in remote rural areas (1.12), in West and East (1.10), among the poorest households (1.10) and in particular among boys of mothers with only primary education (1.21).

Adult literacy

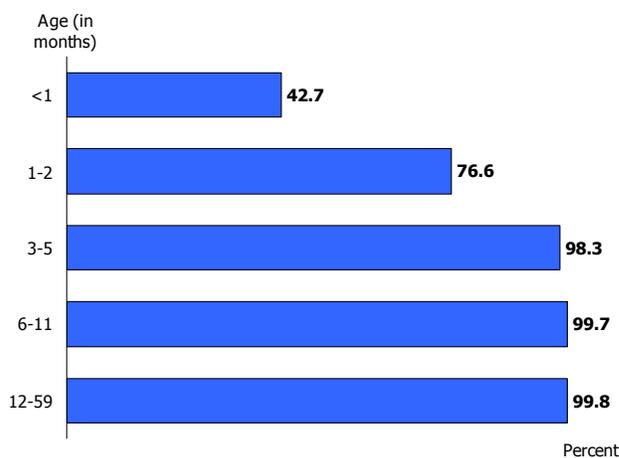
Literacy among young women aged 15-24 years is 94.5%. The majority of illiterate women are found among women in remote rural areas where 16% of the interviewed women could not read, compared with 3% in Soum or Aimag centres and 1% in Ulaanbaatar. Literacy was defined by either school attendance or for those who did not have much schooling the ability to read out a short statement.

Child Protection

Protecting children from violence, exploitation and abuse is essential to guarantee that their rights to survival, growth and development are met.

Birth Registration

Figure 20: Birth registration by age of child, Mongolia, 2005



Birth registration is a fundamental way of ensuring a child's right to a name, a nationality and an identity. Knowing the number of children of different age groups also provides crucial information for planning, implementing and monitoring any kind of service delivery.

Birth registration is virtually universal for children over the age of 6 months (between 99.7-99.8%). Before that age, birth registration increases rapidly from

43% among babies less than a months old, to 77% among babies 1-2 months old and 98.3% among the 3-5 months old (See Figure 20).

Child Labour

Child labour poses a risk of economic exploitation, exposure to hazardous work, interference with a child's education, and potentially harmful effect on the child's development. Project and programmes to eliminate child labour have been implemented in Mongolia since 1999 when Mongolia became involved in the International Program of Elimination of Child Labour.

A child was considered to be involved in child labour activities when one of the follow conditions applied in the week preceding the survey (see box text):

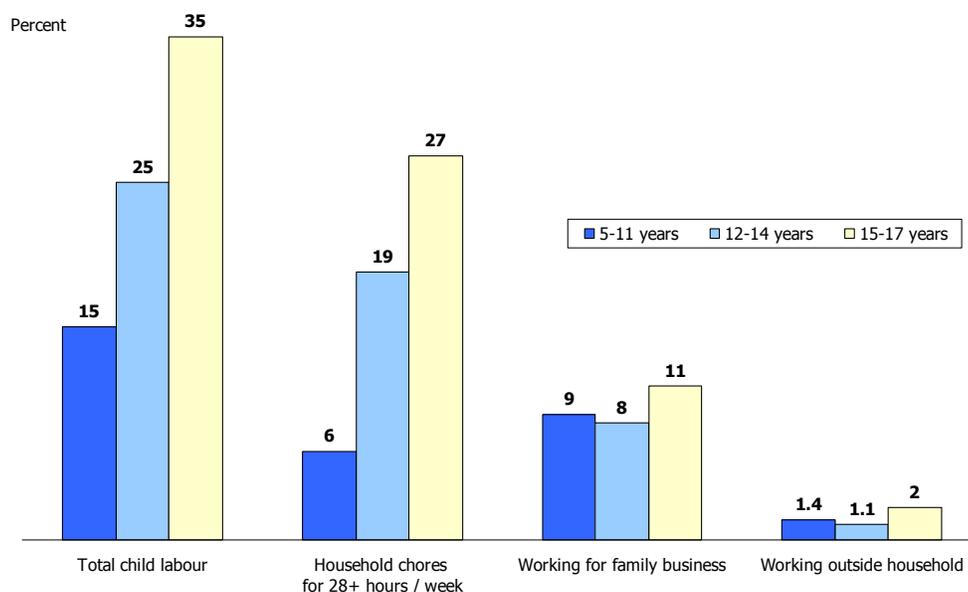
Children aged 5-11 years	Children aged 12-17 years
At least one hour of economic work or	At least 14 hours of economic work or
28 hours of domestic work	

Overall 23% of children age 5-17 were involved in child labour. This varied from 15% among the youngest age group (5-11 years), 25% among the 12-14 year olds, to 35% among the oldest age group (15-17 years).

The most common type of child labour was children doing household chores for more than 28 hours a week affecting 14% of children aged 5-17 years. Another 9% were

involved in the family business. Only a tiny proportion of children were working outside the household (1.6%). This implies that most of the child labour taking place in Mongolia happens within the boundaries of the household.

Figure 21: Child labour by type and age group, Mongolia, 2005



Child labour among the 5-17 year olds is twice as prevalent in rural areas (31%) as in urban areas (15%) mostly due to a much higher involvement of children in the family business, typically herding. Girls are more likely to be involved in an excessive amount of household chores and boys more likely to be working for the family business.

Out of the 23% of children classified as child labourers the majority of them (86%) are also attending school.



Photo courtesy of UNICEF Mongolia

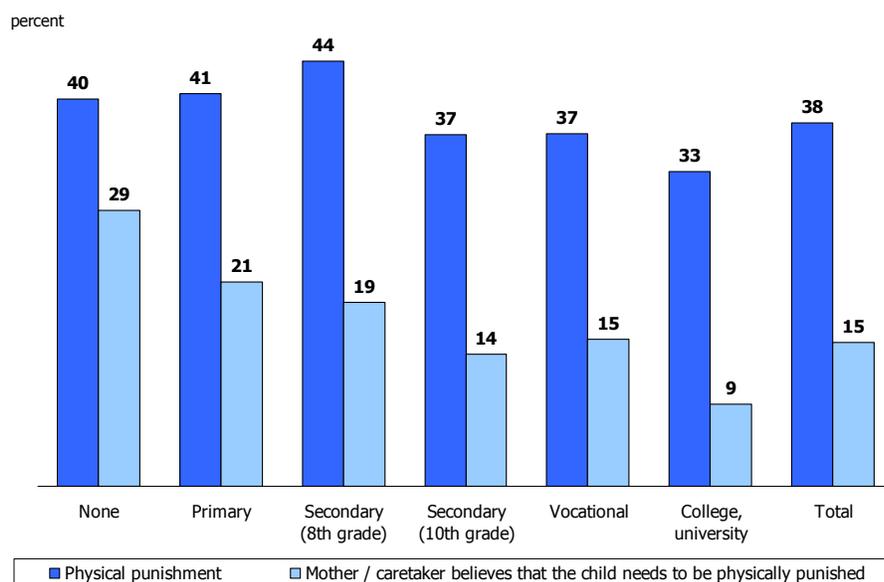
Child Discipline

Mothers and caretakers of children were asked a series of questions on how they tend to discipline their children, when they misbehave. The most common form of discipline experienced by 78% of children was psychological punishment such as yelling /screaming at a child or calling him/her dumb, lazy or another degrading name. Physical punishment, including any kind of minor to severe physical punishment, was experienced by 38% of children. Finally, 17% of the children were disciplined using only non-violent discipline, such as explaining why the behaviour was wrong or giving the child something else to do.

The type of discipline children receive changes somewhat with age. Only non-violent discipline is more likely to be used among the youngest children aged 2-4 while severe physical punishment is less likely to be used with the eldest children aged 10-14. Boys are more likely than girls to be beaten up (42% versus 34%) and girls more likely to be disciplined using only non-violent methods (19% versus 15%).

There is a dilemma between the attitude of mothers and caretakers towards physical punishment on one hand versus what they actually practice on the other. While 15% of mothers /caretakers believe that a child needs to be physically punished, more than twice that number – 38% of children received severe physical punishment. This difference between attitude and practice becomes more pronounced the higher educated women are.

Figure 22: Attitude versus practice regarding physical punishment of children, by education level, Mongolia, 2005



HIV/AIDS

One of the most important prerequisites for reducing the risk of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission.

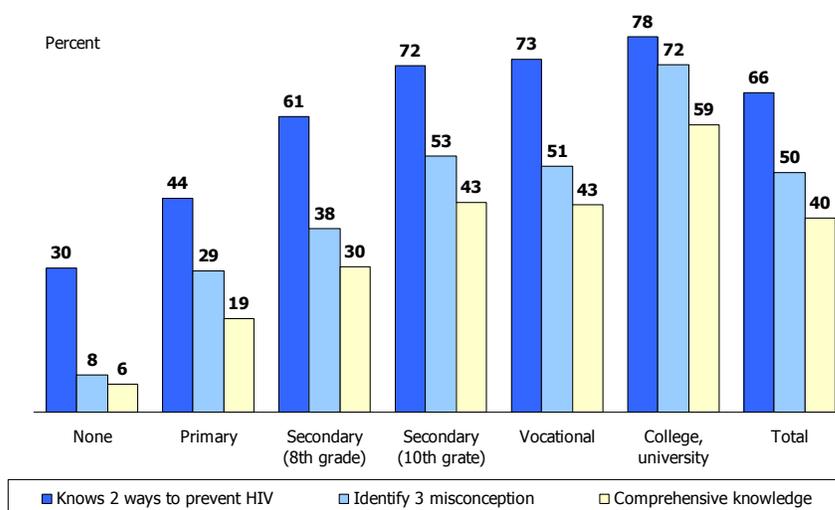
Knowledge of HIV Transmission

Most of the women interviewed (88%) have heard about AIDS - varying from 45% among women with no education to 97% among women with college or university education.

Two out of three women were able to identify the two main means of prevention of HIV/AIDS - use of condom (75%) and having sexual intercourse with only one faithful partner who is not infected (74%). Half of the women (50%) could correctly identify the three misconceptions most relevant to Mongolia - accepting that a healthy-looking person can have AIDS (75%), knowing that HIV/AIDS cannot be transmitted by sharing food (57%) and acknowledging that HIV can be transmitted by sharing needles (85%). Only around 40% had comprehensive knowledge of HIV/AIDS defined as women who could identify both the two main means of prevention as well as the three most common misconceptions.

Women living in the capital city, living in the 40% wealthiest households and with the highest education are those most likely to have corrected HIV/AIDS information. Not surprisingly education is the most important predictor of knowledge. Comprehensive knowledge falls gradually from 60% among women with college or university education to 6% among women with no education (See Figure 23).

Figure 23: Women with comprehensive knowledge of HIV/AIDS transmission, Mongolia, 2005



Four out of five women know that AIDS can be transmitted from mother to child, either during pregnancy (72%), during delivery (64%) or through breast milk (60%). Half of the interviewed women (49%) were aware of all three types of possible transmission.

Millennium Development Goal 6

Combat HIV/AIDS and other diseases

By 2015 halt and begin to reverse the spread of HIV/AIDS and other major diseases.

Indicators available in MICS3:

- Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
- Contraceptive prevalence rate (see section on Reproductive Health)

Tables

Key Indicators

INFORMATION ON HOUSEHOLDS	National		Residence		Regions				
	2000	2005	Urban	Rural	West	High-land	Central	East	UB
MORTALITY									
Under-five mortality rate (deaths per 1000 live births)	87	51	31	69	-	-	-	-	-
Infant mortality rate (deaths per 1000 live births)	64	41	25	52	-	-	-	-	-
NUTRITION									
Children <5 who are underweight (%)	13	6.3	5.6	7	8	6.8	4.9	6.5	5.4
Children <5 who are stunted (%)	25	21	18	24	28	20	16	27	18
Children <5 who are wasted (%)	5.5	2.2	2.2	2.1	2.1	2.2	2	1.5	2.5
Children breastfed within a hour of birth (%)	-	78	72	81	74	85	83	78	72
Children (<6 mths) exclusive breastfed (%)	-	57	55	60	55	59	52	56	60
Continued breastfeeding rate at 12-15 months (%)	75	82	77	89	90	91	76	82	77
Continued breastfeeding rate at 20-23 months (%)	57	65	65	65	56	64	61	72	69
Households using Iodized salt (%)	45	83	91	72	58	74	88	91	97
Vitamin A supplementation of children <5 (%)	32	65	70	60	55	61	71	57	73
Vitamin A supplementation of post-partum mothers (%)	13	56	58	54	51	57	55	53	60
Low birth weight infants (%)	5.5	5.5	4.9	6.1	7.3	4.6	5.9	4.8	5.1
Infants weighed at birth (%)	95	98.3	99.4	97	92.9	99.1	100	98.2	99.8
CHILD HEALTH									
Tuberculosis immunization coverage before age 1(%)	-	97.6	-	-	-	-	-	-	-
Polio immunization coverage before age 1 (%)	-	93	-	-	-	-	-	-	-
DPT immunization coverage before age 1 (%)	-	92	-	-	-	-	-	-	-
Measles immunization coverage before age 1 (%)	-	76.1	-	-	-	-	-	-	-
Fully immunized children before age 1 (%)	-	67.5	-	-	-	-	-	-	-
Use of oral rehydration therapy (ORT) (%)	-	63	58	66	52	70	60	78	57
Home management of diarrhoea (increased fluids + continued feeding) (%)	32	21	18	23	20	18	30	15	23
Children <5 with suspected pneumonia taken to appropriate health provider (%)	78	63	70	55	61	60	58	49	73
Children <5 with suspected pneumonia given antibiotic treatment (%)	-	71	72	71	83	63	75	68	72
Households using solid fuel (%)	-	77	61	98	93	90	80	81	57
ENVIRONMENT									
Households using improved source of drinking water (%)	61	72	91	46	52	54	65	78	95

Mean time to source of drinking water (return trip in minutes)	-	31	21	39	36	31	34	34	24
Households using improved sanitation facilities (%)	74	77	95	53	57	63	79	76	96
Households using improved water AND improved sanitation	-	63	87	30	40	41	56	63	92
REPRODUCTIVE HEALTH (among women aged 15-49 years)									
Contraceptive prevalence any method (%)	67	66	65	68	61	70	72	68	62
modern methods (%)	54	61	58	64	58	67	62	65	55
Unmet need for family planning (%)	-	14	14	14	16	12	13	15	14
Antenatal care (%)	97	98.9	98.9	98.8	97.3	99.7	99.2	97	99.6
Content of antenatal care									
Blood sample taken (%)	-	89	98	79	66	88	95	90	99
Urine specimen taken (%)	-	89	98	79	67	88	94	91	99
Skilled attendant at delivery (%)	97	99.2	99.5	98.9	98.4	99.1	100	99.4	99.4
Institutional deliveries (%)	-	98.6	99	98	96.9	99.1	99.2	98.2	98.9
EDUCATION									
Early Childhood Education among children aged 36-59 months (%)	21	37	50	25	32	32	33	40	48
Pre-school attendance previous year among children in grade 1 (%)	-	80	84	77	75	72	86	83	88
Net school attendance rate									
Primary school age (%)	-	95	96.3	94.2	92	95.2	97.6	95.1	96.2
Secondary school age (%)	-	85	89	81	84	83	85	79	90
Children reaching grade five (%)	95	96.4	99.4	94.2	98.6	93.7	94.5	96.6	100
Primary completion rate (%)	-	93.6	93.1	94.1	88.7	94.4	97.3	92.5	93.9
Gender parity index									
primary school	-	1.02	1.03	1.02	1.01	1.04	1.00	1.03	1.03
secondary school	-	1.06	1.04	1.09	1.10	1.03	1.07	1.10	1.04
Female adult literacy rate 15-24 years (%)	-	*94.5	98	88	92	91	93	89	99
CHILD PROTECTION									
Birth registration of children <5 (%)	97.6	98.3	98	98.7	98.2	98.8	98.5	98.7	97.8
Child labour (age 5-17) (%)	-	23	15	31	30	37	25	15	12
Children 5-17 doing child labour who are also in school (%)	-	87	95	83	83	86	88	89	95
Child discipline (age 2-14 years)									
Psychological punishment (%)	-	78	78	78	74	80	81	84	76
Severe physical punishment (%)	-	38	35	41	33	45	38	47	32
Only non-violent punishment (%)	-	17	17	17	21	15	16	11	19
HIV/AIDS knowledge (women aged 15-49 years)									
Knows two main ways of preventing HIV transmission (%)	75	66	71	59	51	63	71	59	74
Comprehensive knowledge about HIV prevention (%)	-	40	49	27	25	34	41	26	53
Knowledge of mother- to-child transmission of HIV (all three ways fo transmission) (%)	27	49	53	43	37	45	51	49	55

A dash (-) refers to indicators where no information was collected in MICS 2000 or the information is not directly comparable with MICS 2005.

Millennium Development Goal Indicators, Mongolia 2005-2006

Goal	Indicator	Value		
		Male	Female	Total
1. Eradicate extreme poverty and hunger	Prevalence of underweight children under age 5 (severe and moderate) (%)	(5.9)	(6.6)	6.3
	Prevalence of underweight children under age 5 (severe) (%)	(1.2)	(1)	1.1
2. Achieve universal primary education	*Net attendance rate in primary education (%)	94.2	96.3	95.2
	Proportion of pupils starting grade 1 who reach grade 5 (%)	96.7	96	96.4
	Primary completion rate (%)	92.4	94.6	93.6
	Literacy rate of 15-24 year olds (%)	-	94.5	-
3. Promote gender equality and empower women	*Gender parity index (GPI) in primary level attendance	-	-	1.02
	*Gender parity index (GPI) in secondary level attendance	-	-	1.06
4. Reduce child mortality	Under-five mortality rate (deaths per 1,000 live births)	(45)	(36)	40
	Infant mortality rate (deaths per 1,000 live births)	(55)	(46)	51
	1 year-old children immunized against measles (%)	-	-	76
5. Improve maternal health	Proportion of births attended by skilled health personnel (%)	-	-	99.2
6. Combat HIV/AIDS and other diseases	Contraceptive prevalence rate - any method (%)	-	66	-
	Contraceptive prevalence rate - modern methods (%)	-	61	-
	Contraceptive prevalence rate - condoms (%)	-	5.3	-
	Population 15-24 years old who know condom can prevent HIV (%)	-	75	-
	Population 15-24 years old who know a healthy looking person can transmit HIV (%)	-	75	-
	Population 15-24 years old with comprehensive correct knowledge of HIV/AIDS (%)	-	40	-
7. Ensure environmental sustainability	Population with sustainable access to an improved water source (%)	Rural 46	Urban 91	Total 72
	Population with access to improved sanitation (%)	53	95	77
	Population using solid fuels (%)	(98)	(61)	77

*) MICS provides information on school ATTENDANCE rates whereas the global MDG list refers to school ENROLMENT rates. () Figures in brackets are not part of the global list of MDG Indicators.