

Multiple Indicator Cluster Survey

Republic of Moldova - 2000

Contents

List of Figures	3
Foreword and Acknowledgements	4
Executive Summary.....	5
Summary Indicators	7
I. Introduction	9
Background of the Survey	9
the Republic of Moldova Background	9
Survey Objectives.....	10
II. Survey Methodology	10
Sample Design.....	10
Questionnaires.....	10
Fieldwork and Processing	11
III. Sample Characteristics and Data Quality	12
Response Rates.....	12
Age Distribution and Missing Data	12
Characteristics of the Household Population	13
IV. Results	13
B. Education.....	13
Early childhood education	13
Basic education	14
Literacy.....	14
C. Water and Sanitation.....	15
Use of drinking water	15
Use of sanitation.....	16
D. Child Malnutrition	16
Salt iodization	16
E. Child Health	16
Immunization coverage.....	16
Diarrhea.....	18
Acute respiratory infection	19
IMCI initiative	19
F. HIV/AIDS.....	20
AIDS knowledge.....	20
AIDS testing	22
G. Reproductive Health	22
Contraception.....	22
H. Child Rights.....	23
Birth registration	23
Orphanhood and living arrangements of children	23
Child labor	24
Appendix A: Sample Design	25
Appendix B: List of Personnel Involved in the Republic of Moldova MICS	25
Appendix C: Questionnaires.....	25

List of Figures

Figure 1: Single year age distribution of the household population by sex, Republic of Moldova, 2000	12
Figure 2: Percentage of children of primary school age attending school, Republic of Moldova, Year 2000....	14
Figure 3: Percent distribution of the population by source of drinking water.....	15
Figure 4: Percentage of children 15-26 months who received immunizations by age 12 months	18
Figure 5: Percentage of women aged 15-49 who have sufficient knowledge of HIV/AIDS transmission by level of education, Republic of Moldova, 2000.....	21

Foreword and Acknowledgements

This report contains up-to-date information on the situation of children and women in the Republic of Moldova provided by the Multiple Indicator Cluster Survey. Its main purpose is to provide data for monitoring of progress towards the goals established at the World Summit for Children and defining national policies in the area of the child protection. This report serves as an important tool for the end of decade review process in the country and aims at launching a nation wide policy dialogue for developing a long term strategy for the well-being of children and families.

We address special thanks to the survey team comprised of a large number of people and institutions. We had excellent cooperation between the ministries and the other organizations involved. Over one hundred and fifty people were involved in technical or field work. The survey teams including coordinators, field staff and data entry staff carried out their work diligently. We also would like to thank the 10,380 households, which agreed to participate and be interviewed.

Special thanks go to the team of the Moldovan National Scientific and Practical Center of Preventive Medicine, which ensured timely and high quality of operations during this project. The Steering Committee established under the supervision of the National Council for the Protection of the Rights of the Child made considerable contribution to the coordination between the central and local authorities and ensured efficient implementation at different stages of the survey.

The UNICEF country office, regional office and global MICS team provided invaluable and ongoing support. We hope to continue a fruitful cooperation in the future for improving the situation of children in the Republic of Moldova.

Executive Summary

The 2000 Republic of Moldova Multiple Indicator Cluster Survey (MICS) is a nationally representative survey of households, women, and children. The main objectives of the survey are to provide up-to-date information for assessing the situation of children and women in Republic of Moldova at the end of the decade and to furnish data needed for monitoring progress toward goals established at the World Summit for Children and as a basis for future action.

Education

- Ninety nine percent of children of primary school age in the Republic of Moldova are attending primary school. At the national level, there is virtually no difference between urban and rural, Western and Eastern part, male and female primary school attendance. More than ninety eight percent of children who enter the first grade of primary school eventually reach grade five.
- The vast majority (96 percent) of the population over age 15 years is literate. Literacy substantially declines after the age 65, being more obvious in women (75 percent) than in men (88 percent)

Water and Sanitation

- Ninety two percent of the population has access to safe drinking water – 97 percent in urban areas and 88 percent in rural areas. The situation in the Eastern part is better than in the Western one; 96 percent of the population from the former region compared to 91 percent of the population from the latter one gets its drinking water from a safe source.
- Ninety nine percent of the population of the Republic of Moldova is living in households with sanitary means of excreta disposal.

Salt Iodization

- Only thirty three percent of households in the Republic of Moldova have adequately iodized salt. The percentage of households with adequately iodized salt ranges from 13 percent in the Eastern part to 37 percent in the Western region, and from 30 percent in rural to 38 percent in urban settings.

Immunization Coverage

- Ninety eight percent of children aged 15-26 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 95 percent. The percentage declines for subsequent doses of DPT to 94 percent for the second dose, and 91 percent for the third dose.
- Similarly, 95 percent of children received Polio 1 by age 12 months and this declines to 92 percent by the third dose.
- The same patterns can be observed for Hepatitis B vaccination – 93 percent for first dose and 88 percent for the third
- The coverage for measles and mumps vaccines by 15 months is lower than for the other vaccines. Only 87 and 82 percent of children received measles and mumps immunizations respectively on a timely manner.
- The percentage of children who had all recommended by the World Summit for Children vaccinations by their first birthday is 86 percent.
- Male and female children are vaccinated at roughly the same rate.

Diarrhea

- Ninety five percent of children with diarrhea received one or more of the recommended home treatments (i.e., were treated with ORS or RHF).
- Only 19 percent of children with diarrhea received increased fluids and continued eating as recommended.

Acute Respiratory Infection

- Less than two percent of under five children had an acute respiratory infection in the two weeks prior to the survey. Seventy eight percent of these children were taken to an appropriate health provider.

IMCI Initiative

- Among under five children who were reported to have had diarrhea or some other illness in the two weeks preceding the MICS, 27 percent received increased fluids and continued eating as recommended under the IMCI programmed.
- Seventy three percent of mothers know at least two of the signs that a child should be taken immediately to a health facility.

HIV/AIDS

- Twenty percent of women aged 15-49 know all three of the main ways to prevent HIV transmission – having only one uninfected sex partner, using a condom every time, and abstaining from sex.
- Twenty nine percent of women correctly identified three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected.
- Sixty two percent of women of reproductive age in the Republic of Moldova know a place to get tested for AIDS and about 12 percent have been tested.

Contraception

- Current use of contraception was reported by 62 percent of married or in union women. The most popular method is the IUD, which is used by 35 percent of married women followed by withdrawal, which accounts for 14 percent of married women.

Birth Registration

- The births of 98 percent of children under five years in the Republic of Moldova have been registered. There are no significant variations in birth registration across sex, age, or education categories.

Orphanhood and Living Arrangements of Children

- Overall, 84 percent of children aged 0-14 are living with both parents. Children who are not living with a biological parent comprise 1.7 percent and children who have one or both parents dead amount to 1.6 percent of all children aged 0-14.
- Ten percent live with their mother only although their father is alive and 1.4 percent of children are living with neither parent, although both of them are alive.

Child Labor

- About two percent of children aged 5-14 years engage in paid work. About five times as many – 10 percent – participate in unpaid work for someone other than a household member.
- Seventy one of children engage in domestic tasks, such as cooking, fetching water, and caring for other children, for less than four hours a days while 15 percent spend more than four hours a day on such tasks.

Summary Indicators

World Summit for Children Indicators		
Use of safe drinking water	Proportion of population who use a safe drinking water source	91.6 percent
Use of sanitary means of excreta disposal	Proportion of population who use a sanitary means of excreta disposal	98.7 percent
Children reaching grade five	Proportion of children entering first grade of primary school who eventually reach grade five	98.5 percent
Net primary school attendance rate	Proportion of children of primary school age attending primary school	98.5 percent
Literacy rate	Proportion of population aged 15+ years who are able to read a letter or newspaper	96.2 percent
Contraceptive prevalence	Proportion of married women aged 15-49 who are using a contraceptive method	62.4 percent
Iodized salt consumption	Proportion of households consuming adequately iodized salt	33.1 percent
DPT immunization coverage	Proportion of children immunized against diphtheria, pertussis and tetanus by age one	91.4 percent
Measles immunization coverage	Proportion of children immunized against measles by age one	86.9 percent
Polio immunization coverage	Proportion of children immunized against polio by age one	92.4 percent
Tuberculosis immunization coverage	Proportion of children immunized against tuberculosis by age one	98.1 percent
ORT use	Proportion of under-five children who had diarrhea in the last 2 weeks who were treated with oral rehydration salts or an appropriate household solution	95.0 percent
Home management of diarrhea	Proportion of under-five children who had diarrhea in the last 2 weeks and received increased fluids and continued feeding during the episode	18.7 percent
Care seeking for acute respiratory infections	Proportion of under-five children who had ARI in the last 2 weeks and were taken to an appropriate health provider	78.0 percent
Preschool development	Proportion of children aged 36-59 months who are attending some form of organized early childhood education program	30.4 percent
Indicators for Monitoring Children's Rights		
Birth registration	Proportion of under-five children whose births are reported registered	97.9 percent
Children's living arrangements	Proportion of children aged 0-14 years in households not living with a biological parent	1.7 percent
Orphans in household	Proportion of children aged 0-14 years who are orphans living in households	0.1 percent (both parents dead) 0.2 percent (one parent dead)
Child labor	Proportion of children aged 5-14 years who are currently working	37.1 percent
Indicators for Monitoring IMCI		
Home management of illness	Proportion of under-five children reported ill during the last 2 weeks who received increased fluids and continued feeding	27.4 percent
Care seeking knowledge	Proportion of caretakers of under-five children who know at least 2 signs for seeking care immediately	73.0 percent

Indicators for Monitoring HIV/AIDS		
Knowledge of preventing HIV/AIDS	Proportion of women who correctly state the 3 main ways of avoiding HIV infection	74.1 percent
Knowledge of misconceptions of HIV/AIDS	Proportion of women who correctly identify 3 misconceptions about HIV/AIDS	28.8 percent
Knowledge of mother to child transmission	Proportion of women who correctly identify means of transmission of HIV from mother to child	63.2 percent
Attitude to people with HIV/AIDS	Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS	24.0 percent
Women who know where to be tested for HIV	Proportion of women who know where to get a HIV test	62.1 percent
Women who have been tested for HIV	Proportion of women who have been tested for HIV	35.1 percent

I. Introduction

Background of the Survey

At the World Summit for Children held in New York in 1990, the government of the Republic of Moldova did not committed itself to a Declaration and Plan of Action for Children because it gains its independence after that date, in 1991. Consequently, a National Programme of Action for Children was not developed.

However, the Government recognizes children's rights as a priority and manifests its interest to the establishment of mechanisms for monitoring progress toward the goals and objectives set for the year 2000. Toward this end, UNICEF, in collaboration with WHO, UNESCO and others, has developed a core set of 75 indicators of specific aspects of the situation of children. The 2000 Republic of Moldova MICS survey was conducted in order to provide end-decade information on many of these indicators.

The Republic of Moldova MICS was conducted by the National Center of Preventive Medicine. The UNICEF Moldova office provided funding and technical support.

This preliminary report presents results on some of the principal topics covered in the survey and on a subset of indicators. A comprehensive full report is scheduled for publication at the end of 2000.

This report presents results on the principal topics covered in the survey and on the World Summit indicators.

The Republic of Moldova Background

Children and women of Moldova (1.3 million under 18 years of age) continue to suffer the negative consequences of transition. Moldova is one of the poorest countries in the CEE, CIS and the Baltic States region with a per capita GNP of US\$ 370 (1999), with 35 percent of total population of 4.3 million living below the poverty line. Social development is hampered by unemployment, greater inequality in the distribution of income, and inflation. Reduced budgetary allocations to the social sector led to the worsening of major social indicators and to the deterioration of quality and access to social services.

The poor status of children's health is reflected in infant and under-five mortality rates of 27 and 34 per 1,000 live births respectively. The maternal mortality rate of 28.3 per 100,000 (1999) is mainly caused by pregnancy related pathologies, and puerperal infections. Almost 28 percent of children under five years of age and 20 percent of women in the reproductive age suffer from anaemia. According to the Ministry of Health, 22 percent of school-age children have iodine deficiency disorders.

The HIV/AIDS is spreading rapidly. To date 1,110 of HIV cases have been identified, out of which 27 have developed AIDS. Children and young people aged 15 to 19 years represent 15.4 percent of all HIV cases. The significant increase in sexually transmitted infections, from 7.1 in 1989 to 200.1 per 100,000 people in 1999, is also a cause for concern.

The combined effects of poverty and cuts in social sector investments have weakened family capacity to protect children. The number of children in need of special protection, such as children deprived of parental care and of family life, continues to grow. Public care system responses rely heavily on residential care including for children with disabilities. According to the latest governmental data, 12,344 children reside in institutions.

The quality of basic education has decreased substantially over the past decade due to lack of adequate funding. This adversely affected the conditions of the learning environment, and disparities have also increased. Another problem is the lack of relevance in the curriculum, and children are exiting the system without the basic life skills. Rising costs of education services and supplies have prevented access to basic education amongst the most vulnerable. According to the World Bank, over 15 percent of children of the poorest families do not attend primary school. Pre-school education has been severely affected. In the rural areas, 80 percent of children stay at

home until entering primary school, and have no access to early childhood development opportunities.

Decreasing opportunities for continuing education and development of livelihood related to employment and for meaningful participation and access to organised free time activities, are increasing the risks for adolescents and young people to become exposed to crime, alcohol and drug abuse. Problems affecting young people include the lack of communication and support from family and community, and drop out from the formal school system.

Survey Objectives

The 2000 Republic of Moldova Multiple Indicator Cluster Survey has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in the Republic of Moldova at the end of the decade and for looking forward to the next decade;
- To furnish data needed for monitoring progress toward goals established at the World Summit for Children and as a basis for future action;
- To collect the information that will serve as a sound base for defining national policies in the area of child protection
- To contribute to the improvement of data and monitoring systems in the Republic of Moldova and to strengthen technical expertise in the design and implementation of such systems, and better analysis of available data.

II. Survey Methodology

Sample Design

The sample for the Moldova Multiple Indicator Cluster Survey (MICS) was designed to provide estimates of various indicators at the national level with a margin of error (ME) within 5%. The survey consists of two separate strata sampled separately: Western and Eastern part of Moldova.

Subgroup analysis allows estimates for urban and rural areas, by gender, educational level of mothers and socio-economic status of the households.

The sample was selected in two stages. At the first stage, 322 election areas were selected with probability proportional to size using 1999 election lists provided by the National Election Committee. After a household listing was carried out within the selected election areas, a systematic sample of 11,592 households (36 households per each cluster) was drawn.

Because the sample was stratified by region, it is not self-weighting. For reporting national level results, sample weights are used. The sample weights were adjusted according to the households, women and children response rates.

Full technical details of the sample are included in Appendix A.

Questionnaires

The questionnaires for the Moldova MICS were based on the MICS Model Questionnaire with two additional modules on safe injections and access to health care services.

A household questionnaire was administered in each household, which collected various information on household members including sex, age, literacy, marital status, and orphanhood status. The household questionnaire also includes education, child labor, water and sanitation, and salt iodization modules.

In addition to a household questionnaire, the survey included questionnaires specifically for women age 15-49 and children under age five. For children, the questionnaire was administered to the mother or caretaker of the child.

The questionnaire for women contains modules on contraceptive use and HIV/AIDS.

The questionnaire for children under age five includes modules on:

Birth registration and early learning

Care of Illness: Diarrhea, ARI, IMCI

Immunization.

From the MICS model English version, the questionnaires were translated into two languages: Romanian and Russian. The questionnaires were pre-tested during June 2000. The pre-test was carried out on 240 households and served as a base for final adjustments. Major modifications were made to the sequence of the different modules, the sequence of questions inside some of the modules, as well as to the wording and translation of the questionnaires. The full questionnaires can be seen in Appendix B.

Fieldwork and Processing

The fieldwork was conducted by 24 teams: 16 in the western part and 8 in the eastern part of the country. Each team was comprised of three interviewers, one driver, and a supervisor.

The field staff that worked in the eastern part of the country was trained for five days at the end of June 2000 and participated in a two days pilot-study. The MICS Technical Director and the Fieldwork Coordinator provided the overall supervision of the training and fieldwork. Supervisors were responsible for the fieldwork organization and the quality of data checking. They also had to carry out editor's duties in the field.

The authorities of the eastern part of the country (Transnistria) required having their own teams for fieldwork. As a result, eight new local teams were established and trained for 4 days at the beginning of August, including the organization of a pilot study. At least one member who had participated in the fieldwork in the western part of the country was included in each Transnistria team.

In order to facilitate the logistics organization the cluster size was defined as 36 households and was covered by a team in 2 days.

The fieldwork began on 10th of July 2000 and concluded on 5th of September 2000.

In order to ensure the quality of data, four data editors were involved in checking each questionnaire before entering the data in computer.

Two data entry coordinators guided the data entry process. In order to be carried out simultaneously with data collection, 16 teams of two persons each (32 total) were trained and involved in the data entry process. Data were entered on 16 microcomputers using the ISSA software. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed. Procedures and standard programs developed under MICS and adapted to the Republic of Moldova questionnaire were used throughout. Data processing began on 19th of July 2000 and finished on 8th of September 2000.

Performance of the data collection teams and of individual interviewers was measured and feedback provided to teams on a weekly base by the data editors and data entry coordinators.

SPSS software was used to tabulate indicators and analyze data according to standard formats recommended for MICS reporting.

III. Sample Characteristics and Data Quality

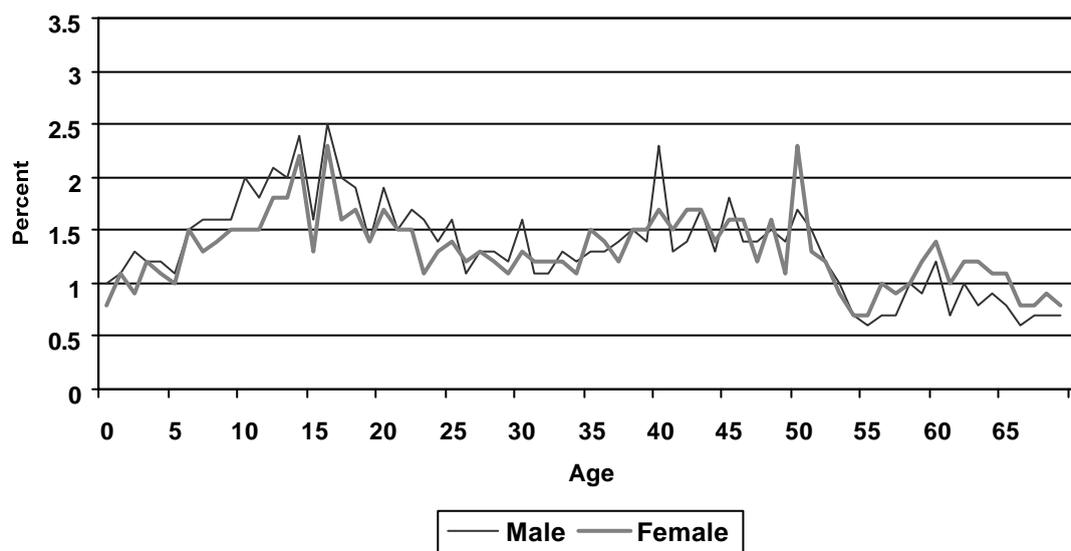
Response Rates

Of the 11,592 households selected for the sample, 11,163 were found to be occupied (Table 1). Of these, 10,380 were successfully interviewed for a household response rate of 93 percent. The household response rate was significantly lower (89 percent) in urban areas compared to rural areas (97 percent). In the interviewed households, 8,414 eligible women aged 15-49 were identified. Of these, 7,871 were successfully interviewed, yielding a response rate of 94 percent. In addition, 1,674 children under age five were listed in the household questionnaire. Of these, questionnaires were completed for 1,661 for a response rate of 99 percent.

Age Distribution and Missing Data

As shown in Table 2 and Figure 1, the single year age distribution of household members by sex exhibits some distortions centered around age 10 and 40 for males and on age 50 for females. There can be observed heaping of men on ages 7-25. The situation changes starting with 55 years, when the proportion of women becomes higher. For both sexes, some digit preference is evident for ages ending in 0, a pattern typical of populations in which precise ages are not always accurately known.

Figure 1: Single year age distribution of the household population by sex, Republic of Moldova, 2000



A puzzling feature of this distribution is the dip at the age of 15. One possible explanation is of this phenomenon is that the time of the survey coincided with admissions to high school when a lot of 14-15 years children were away from home, especially in the rural areas. As a result in some cases, interviewers may not have reported children of this specific age. Another thing would be that interviewers might have avoided reporting the age of 15 because of the cut-off point established by the education and child labor modules at the age of 15.

As a basic check on the quality of the survey data, the percentage of cases missing on selected questions is shown in Table 3. Less than one percent of household members have missing information on their level of education, year of education, number of hours worked, complete birth date and diarrhea in the last two weeks for children under five. Among female respondents, 9.2 percent did not report their complete birth date (i.e., month and year); however all of them reported their age. These low levels of missing data suggest that there were no significant problems with the questions or the fieldwork.

Characteristics of the Household Population

Information on the characteristics of the household population and the survey respondents is provided to assist in the interpretation of the survey findings and to serve as a basic check on the sample implementation.

Table 4 presents the percent distribution of households in the sample by background characteristics. About 42 percent of the households (4,371 households) are urban and 58 percent (6,009 households) are rural. The Western part of Moldova contains 84 percent of households while the Eastern part accounts for 16 percent. Most of the households have between two and five members. Only fourteen percent contain at least one child under age five, while 62 percent contain at least one woman age 15-49.

Table 5 shows the characteristics of female respondents aged 15-49. Percentage of women of different age groups varies from 12 to 17 percent. Women age 40-44 and 15-19 comprise the greatest percentage of the sample at 17 and 16 percent respectively. Women of other age groups account for 12-14 percent of the sample. Approximately 67 percent of women in the sample are married. Almost all of women (99%) have had at least some secondary education. This pattern is typical of countries in the region.

Percentage of women in each wealth quintile varies from 13 percent in the poorest to 24 percent in the richest. Second, third and fourth quintiles include around 21 percent of women each.

Table 6 shows the characteristics of children under age five. Fifty one percent of the children are male and 49 percent are female. Percentage of children under 5 in specified age groups increases slightly with age. This picture reflect a decline in birth rates over time. More children (44 percent) than women (33 percent) are located in the poorest and second wealth quintiles.

IV. Results

A. Education

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the World Summit for Children. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labor and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Early childhood education

Less than one third of children aged 36-59 months are attending an organized early childhood education programme, such as kindergarten or community childcare with organized learning activities (Table 7).

A higher percentage of girls (32 percent) compared to boys (29 percent) are attending these programmes. There are large variations according to region, from 26 percent of children in the Western part of the country to 60 percent in the Eastern region. In addition, children in urban areas are almost three times as likely to attend early learning activities as children in rural areas. Relatively fewer children attend educational programmes at age four (48-59 months) when compared to children at age three (36-47 months). Mother's education appears to be strongly related to the likelihood that a child will attend an early childhood education programme. The percentage of children attending increases from 22 percent to 39 percent as the mother's education increases from gymnasium to lyceum education.

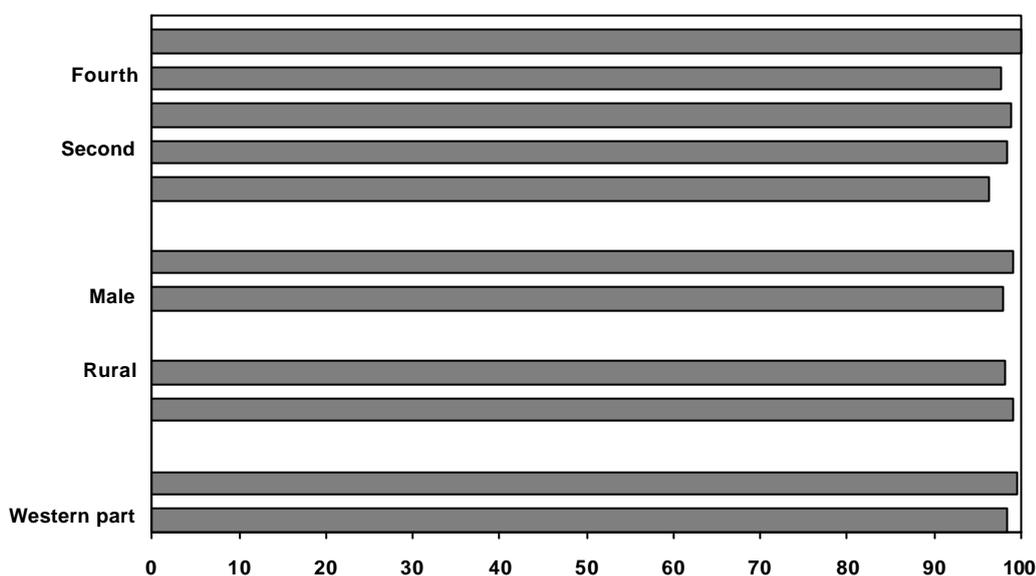
Finally, the attendance of organized early childhood education programme is strongly determined by the socio-economic status of the households. It ranges from 7 percent in the poorest quintile to 58 percent in the richest one.

Basic education

According to Moldova legislation children must enroll in school at the age of seven and are required to complete at least 9 grades. Although the official primary school age is 7-10, a number of children go to school before the age of 7, that is why there is a small percent of children under the formal primary school age in school. By the time these children are 9-10 years, they are already in secondary school. Therefore, the primary school attendance is better reflected by including all children of primary school age who were currently attending school in the school year immediately preceding the survey.

Overall, more than 98 percent of children of primary school age in the Republic of Moldova are attending school (Table 8). At the national level, there is virtually no difference between urban and rural, Western and Eastern parts, or males and females (Figure 2).

Figure 2: Percentage of children of primary school age attending school, Republic of Moldova, Year 2000



Over 98 percent of children who enter the first grade of primary school eventually reach grade five (Table 9). It also can be mentioned that there is virtually no difference between urban and rural, region, or sex in reaching grade five. However, the lowest proportion of children attending primary school can be observed in the poorest wealth quintile.

Literacy

The vast majority of the population (96 percent) over age 15 years in the Republic of Moldova is literate (Table 10). The *literate* population includes those who are reported to read 'easily or with difficulty'. Overall, there are no substantial differences in the literacy rate among the West and East regions, urban and rural areas, as well as male and female.

Literacy substantially declines after the age 65, being more obvious in women than in men. Thus, the percentage literate among the population aged 65 and older constitutes 88 percent in men and 75 percent in women.

The proportion of literate persons varies with the socio-economic status from 91 percent in the poorest wealth quintile to 99 percent in the richest one. Poorer women have less chances of being literate (87 percent) compared to men (95 percent), while in the richest households their chances are the same.

C. Water and Sanitation

Use of drinking water

Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid, and schistosomiasis. Drinking water can also be tainted with chemical, physical and radiological contaminants with harmful effects on human health. In addition to its association with disease, access to drinking water may be particularly important for women and children, particularly in rural areas, because they bear the primary responsibility for carrying water, often for long distances.

Half of the population uses drinking water from protected dug wells and 31 percent used water piped into their dwelling (Figure 3). Water piped into yard, unprotected dug well, tubewell, tanker, protected spring and public tap represent less important sources of drinking water. Rainwater collection and rivers and streams are not used at all as sources of drinking water.

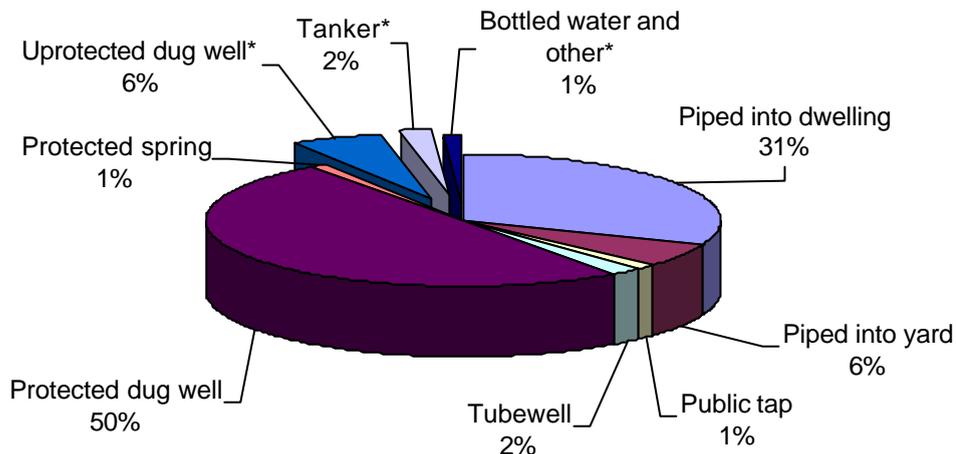


Figure 3: Percent distribution of the population by source of drinking water

The source of drinking water for the population varies strongly by region (Table 11). In the Eastern region (Transnistria), 71 percent of the population uses drinking water that is piped into their dwelling or into their yard or plot while in the Western part of the country only 31 percent use piped water. Protected dug well was reported as the main source of drinking water in the Western part of the country (56 percents). This source of drinking water is mainly used in rural areas, where 74 percent of the population reported to use it. Urban population uses mainly piped water (78 percent) in contrast with rural areas where only 9 percent of those residing have piped water.

The population using *safe drinking water* sources is represented by those who use any of the following types of supply: piped water, public tap, borehole/tubewell, protected well, protected spring or rainwater. Overall, 92 percent of the population has access to safe drinking water – 97 percent in urban areas and 88 percent in rural areas. The situation in the Eastern part is better than in the Western one; 96 percent of the population from the former region compared to 91 percent of the population from the latter one gets its drinking water from a safe source.

Use of sanitation

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrheal diseases and polio. *Sanitary means of excreta disposal* include: flush toilets connected to sewage systems or septic tanks, other flush toilets, improved pit latrines, and traditional pit latrines.

Ninety nine percent of the population of the Republic of Moldova is living in households with sanitary means of excreta disposal (Table 12). This percentage is more than 99 in urban areas and 98 percent in rural areas. About two thirds of the population in Moldova uses traditional pit latrine and other 29 percent uses flush toilets with connection to a sewage system or septic tank. However, the situation is different for rural and urban areas, as well as for western and eastern part of Moldova.

Urban population primarily uses flush toilets with connection to a sewage system (68 percent), while most rural inhabitants use traditional pit latrine (92 percent). The population from the eastern part of Moldova in 47 and 41 percent of cases indicates use of traditional pit latrine and flush toilet with a sewage system respectively. The situation is different in the western part of Moldova, where 69 percent of the population uses traditional pit latrine and flush toilet with sewage system is reported in only 27 percent of cases.

D. Child Malnutrition

Salt iodization

Deficiency of iodine in the diet is the world's single greatest cause of preventable mental retardation and can lower the average intelligence quotient (IQ) of a population by as much as thirteen points. Salt iodization is an effective, cost-effective way of preventing iodine deficiency disorders (IDD). In MICS, interviewers tested household salt for iodine levels by means of two testing kits: with potassium iodate and potassium iodide. *Adequately iodized* was considered salt that contained 15 ppm (parts per million) of iodate or 75 ppm of iodide.

Approximately 98 percent of households had salt, which was tested during the MICS (Table 13). Among households in which salt was tested, only 35 percent had adequately iodized salt. Bigger difference were found between regions, than between urban and rural areas. The percentage of households with adequately iodized salt varied from 13 percent in the East to 38 percent in the West region. Thirty nine percent of urban households had adequately iodized salt compared to 32 percent of rural households. The highest proportion of households with adequately iodized salt was found in the richest quintile (42 percent).

E. Child Health

Immunization coverage

According to UNICEF and WHO guidelines, a child should receive a BCG vaccination to protect against tuberculosis, three doses of DPT to protect against diphtheria, pertussis, and tetanus, three doses of polio vaccine, and a measles vaccination by the age of 12 months. The vaccination schedule followed by the National Immunization Program of the Republic of Moldova provides all vaccinations mentioned above as well as vaccination against Hepatitis B and Mumps. Country immunization schedule for children up to five years of age is provided in the table below:

Age	Antigens
First 24 hours of life	HepB1
First 3-5 days of life	BCG
1 month	HepB2
3 months	DPT1+ OPV1
4.5 months	DPT2+ OPV2
6 months	DPT3+ OPV3+HepB3
12 months	Measles+Mumps
22-24 months	DPT4+ OPV4

The goal of the NIP in Moldova is to achieve 95% coverage for BCG, HepB3, OPV3, and DPT3 before the age of twelve months and with Measles and Mumps immunizations before the age of 24 months.

Taking into consideration that NIP Schedule provides measles and mumps immunization at the age of 12 months, the immunization coverage for all antigens was estimated in the birth cohort 15-26 months of age, allowing a reasonable interval of three months for children to receive vaccinations against Measles and Mumps.

MICS data for coverage were gathered from a variety of sources, including oral report of children's caretakers, home-based and facility-based medical records. A brief description of the record-based data sources from which children's immunization status was assessed is given below.

Form 112. *Form 112* is a standard medical record for children aged fifteen years or less in Moldova. This form is generally kept in primary health care facilities by the family doctor. This form is generally used for making notes on children health status during visits to the family doctor, including the administration of vaccines.

Form 63. *Form 63* is a single sheet of folded paper, which only contains information on a child's immunization status. This medical record is kept in primary health care facility in a single file box.

Form 64. *Form 64* is a registry, which maintains children's immunization records and is held in primary health care facility. It records the same information as the form 63. Form 63 and form 64 are alternative documents and it is up to the health facility what form to use for immunization records. In rural areas (in small health facilities) mainly form 64 is used, while in urban areas the form 63 was widely accepted.

In MICS, mothers were asked to provide any immunization records for children under the age of five kept at home. If immunization records were identified in the household, interviewers copied the information onto the MICS questionnaire. Overall, only 13 percent of children had immunization records at home. It is a normal situation for Moldova, because the NIP does not require an immunization card to be kept at home.

Independently of the fact, whether the child had or did not have an immunization record at home, the mother was asked to recall whether or not the child had received each of the vaccinations and for DPT, Polio, Hepatitis B how many times. Before leaving the household interviewers were instructed to check whether a child had a BCG scar in order to obtain tangible evidence that a child had been successfully immunized against tuberculosis. Ninety eight percent of examined children had a BCG scar, an indication of high vaccination coverage against tuberculosis.

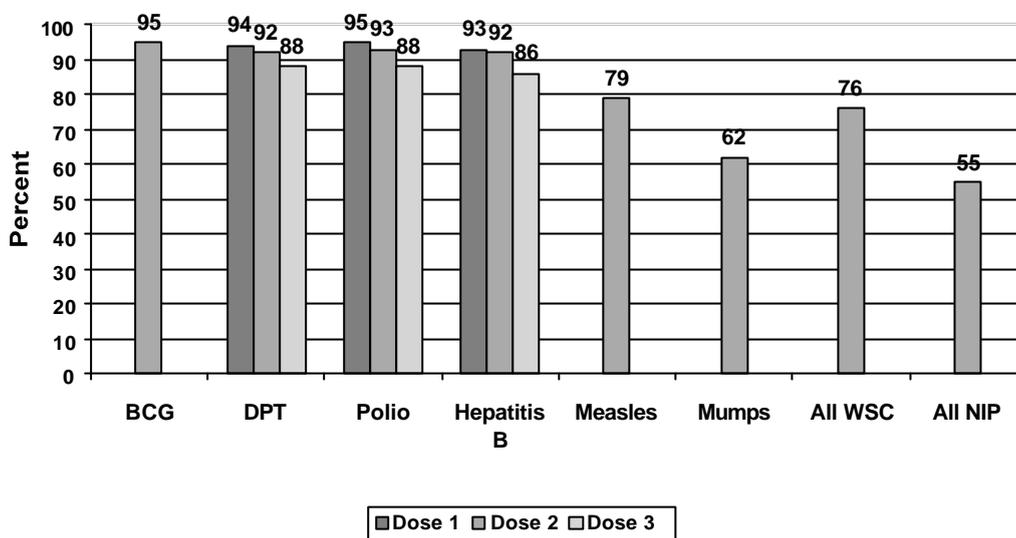
After finishing all interviews in households interviewers were instructed to go to the health facility in order to obtain information on children's immunization status from the medical records. The information from the immunization records was copied into a separate table of the questionnaire. Immunization records were identified at the health facility for 93 percent of sampled children.

Table 14 shows the percentage of children aged 15 to 26 months who received each of the vaccinations. The denominator for the table is the number of children aged 15-26 months so only those children who were old enough to be fully vaccinated at the time of the survey are included. In the top panel, the numerator includes all children who were vaccinated at any time before the survey according to the vaccination card or the mother's report. In the bottom panel, only those who were vaccinated before their first birthday (before 15 months of age for Measles and Mumps) are included. For children without vaccination cards, the proportion of vaccinations given before the first birthday is assumed to be the same as for children with vaccination cards.

Approximately 95 percent of children aged 15-26 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 94 percent. The percentage declines for subsequent doses of DPT to 92 percent for the second dose, and 88 percent for the third dose (Figure 4). Similarly, 95 percent of children

received Polio 1 by age 12 months and this declines to 88 percent by the third dose. The same patterns can be observed for Hepatitis B vaccination – 93 percent for first dose and 86 percent for the third dose.

Figure 4: Percentage of children 15-26 months who received immunizations by age 12 months



*by the age of 15 months for measles and mumps immunizations

The coverage for measles and mumps vaccines by 15 months is lower than for the other vaccines. Only 79 and 62 percent of children received measles and mumps immunizations respectively on a timely manner. There are several possible explanations of this figures, including vaccine shortage, rare immunization sessions due to the use of 10 doses vials and low proportion of the birth cohort etc. As a result, 76 percent of children had eight vaccination recommended by the Expanded Programme of Immunization. At the same time the immunization coverage by all twelve antigens recommended by the National Immunization Programme is low at only 55 percent. It is mainly caused by low vaccination coverage with Hepatitis B, measles and mumps vaccines in the Eastern region of the country.

In Table 15, the percentage of children age 15-26 months currently vaccinated against childhood diseases is shown according to background characteristics. Unlike the previous table, the estimates in this table refer to children who received the vaccinations by the time of the survey, even if they did not occur prior to the age of 12 months.

Male and female children are vaccinated at roughly the same rate. Rural children are more likely to be vaccinated than urban children. Regional breakdowns are based on small numbers of cases and should be viewed with caution, but it appears that the West region has the highest coverage rates for most vaccinations and the highest percentage of children who have received all of the recommended vaccinations. This is in spite the fact that eastern part has the highest percentage of children with health cards at 97 percent.

Diarrhea

Dehydration caused by diarrhea is an important cause of mortality among children in the Republic of Moldova. Home management of diarrhea – either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhea.

In the MICS questionnaire, mothers (or caretakers) were asked to report whether their child had had diarrhea in the two weeks prior to the survey. If so, the mother was asked a series of questions about what the child had to drink and eat during the episode and whether this was more or less than the child usually ate and drank. Overall, 4.2 percent of under five children had diarrhea in the two weeks preceding the survey (Table 16). The peak of diarrhea prevalence occurs in the weaning period, among children age 6-23 months.

Table 16 also shows the percentage of children receiving various types of recommended liquids during the episode of diarrhea. Since mothers were able to name more than one type of liquid, the percentages do not necessarily add to 100. Eighty percent of children received breast milk while they had diarrhea. Children under age 12 months are especially likely to have received breast milk. About 53 percent of children received gruel and less than 8 percent received ORS. There is important difference between regions: while in the west 22 percent of children received breast milk, not a single child in the East did so. It is mainly explained by the universally accepted management of diarrhea by doing hydration pauses in that region. Another peculiarity of the Eastern region is non-administration of ORS, which was promoted only in the Western part of the country through ARI/CDD programme. Approximately 95 percent of children with diarrhea received one or more of the recommended home treatments (i.e., were treated with ORS or RHF).

More than 32 percent of under five children with diarrhea drank more than usual while 57 percent drank the same or less (Table 17). About 70 percent ate somewhat less, the same, or more than usual, while 30 percent ate much less than usual or none. The situation differs substantially by regions. Again, eating somewhat less, the same or more during the diarrhea is much more common for the Western part (75 percent) when compared to the Eastern region (42 percent).

Overall, only 19 percent of children with diarrhea received increased fluids and continued eating as recommended. By regions, children from the Eastern part are four times less likely to follow recommended treatment than children from the Western part of Moldova.

Acute respiratory infection

Acute lower respiratory infections, particularly pneumonia, are one of the leading causes of child deaths in the Republic of Moldova. In the MICS questionnaire, children with acute respiratory infection are defined as those who had an illness with a cough accompanied by rapid or difficult breathing and whose symptoms were due to a problem in the chest, or both a problem in the chest and a blocked nose, or whose mother did not know the source of the problem.

Only 1.4 percent of under five children had an acute respiratory infection in the two weeks prior to the survey according to these criteria (Table 18). Of these, 23 percent were taken to a hospital, and 72 percent were taken to a primary health care facility. Nobody sought care at a private doctor or family member, friend, or neighbor. Five percent were taken to any other type of health provider. Overall, 78 percent of children with ARI were taken to an appropriate health provider (i.e., hospital, PHC facilities or private doctor).

IMCI initiative

The Integrated Management of Childhood Illnesses (IMCI) is a programme developed by UNICEF and WHO that combines strategies for control and treatment of five major killers of children – acute lower respiratory tract infections, diarrheal dehydration, measles, malaria, and malnutrition. The programme focuses on the improvement of case management skills by health workers, improvement of the health system, and improvement of family and community practices in the prevention and early management of childhood illnesses. Appropriate home management of illness is one component of IMCI. The approach teaches mothers that appropriate home management of diarrhea or any other illness requires giving more fluids and continuing to feed sick children as they are normally fed.

Table 19 presents information on the drinking and eating behavior of sick children. Fifteen percent of children were reported to have had diarrhea or some other illness in the two weeks preceding the survey. Of these, 46 percent drank more liquids during the illness and 70 percent continued eating (i.e., ate somewhat less, the same,

or more). Overall, only 27 percent of ill children received increased fluids and continued eating as recommended under the IMCI programmed.

Promoting knowledge among caretakers about when it is appropriate to seek care for ill children is another important component of the IMCI programme. In the Republic of Moldova MICS, mothers or caretakers of children were asked to name all of the symptoms that would cause them to take a child to a health facility right away. The most common response, given by 88 percent of mothers, was that they would take their child to a health facility right away if he/she developed a fever (Table 20). Fifty one percent said that the child becoming sicker would cause them to take the child to a health facility and 39 percent mentioned difficulty breathing. Every fourth mother cited fast breathing and blood in stools as reasons for taking a child to a health facility right away. The less frequently reported signs were inability to breastfeed (16 percent) and drinking poorly (8 percent).

Overall, 73 percent of mothers know at least two signs for seeking care. Mothers with a lower level of education less likely than mothers with higher educational level to know the signs for seeking care immediately. There are no differences between regions, urban-rural and different wealth quintiles.

F. HIV/AIDS

AIDS knowledge

One of the most important strategies for reducing the rate of HIV/AIDS infection is the promotion of accurate knowledge of how AIDS is transmitted and how to prevent transmission. Among women aged 15-49 in the Republic of Moldova, more than 96 percent have ever heard of AIDS (Table 21). This percentage is very high in urban areas (99 percent) and somewhat lower in rural areas (95 percent).

Women in the MICS were read several statements about means of HIV/AIDS transmission and asked to state whether they believed the statements were true. Sixty four percent believe that having only one uninfected sex partner can prevent HIV transmission. Fifty five percent believe that using a condom every time one has sex can prevent HIV transmission and 30 percent agreed that abstaining from sex prevents HIV transmission. Overall, 20 percent knew all three ways and 74 percent were aware of at least one of the means of preventing transmission.

Accurate knowledge of the means of HIV/AIDS transmission is somewhat less among women in rural areas compared to urban ones. Differences across age groups are not particularly large; the percentage of women who know all three means ranges from 17 percent among 45-49 year olds to 22 percent among 25-29 year olds. Women with higher educational level and better socio-economic status were more likely to have accurate knowledge on HIV/AIDS.

Seventy one percent of women correctly stated that AIDS could not be transmitted by supernatural means while 36 percent stated that AIDS could not be spread by mosquito bites (Table 22). Seventy seven percent of women correctly believe that a healthy looking person can be infected. Rural women are more likely to believe misconceptions about AIDS transmission than urban women are. Women with higher educational level are most likely to recognize all three misconceptions. Still, less than one third of these women correctly identified all three misconceptions. Socio-economic status seems to be strongly associated with correct identification of all three misconceptions. While women from the poorest quintile correctly stated all three misconceptions in 18 percent of cases, the richest women did it in 39 percent.

Eighty nine percent of women in the Republic of Moldova know that AIDS can be transmitted from mother to child (Table 23). When asked specifically about the mechanisms through which mother to child transmission can take place, 86 percent said that transmission during pregnancy was possible, 81 percent said that transmission at delivery was possible, and 67 percent agreed that AIDS can be transmitted through breast milk. Sixty three percent of women knew all three modes of transmission. This percentage varies across regions (65

percent in the Western and 50 percent in the Eastern part of the country), but it is almost the same in urban and rural areas.

Again, there is important association between the knowledge of mother to child transmission and socio-economic status of the households. Only 81 percent of women from the poorest quintiles versus 94 percent of the richest women knew that AIDS could be transmitted in this way, and only 58 of the poorest women could correctly identify all three mechanisms of mother to child transmission compared to 63 percent of women from the richest quintile.

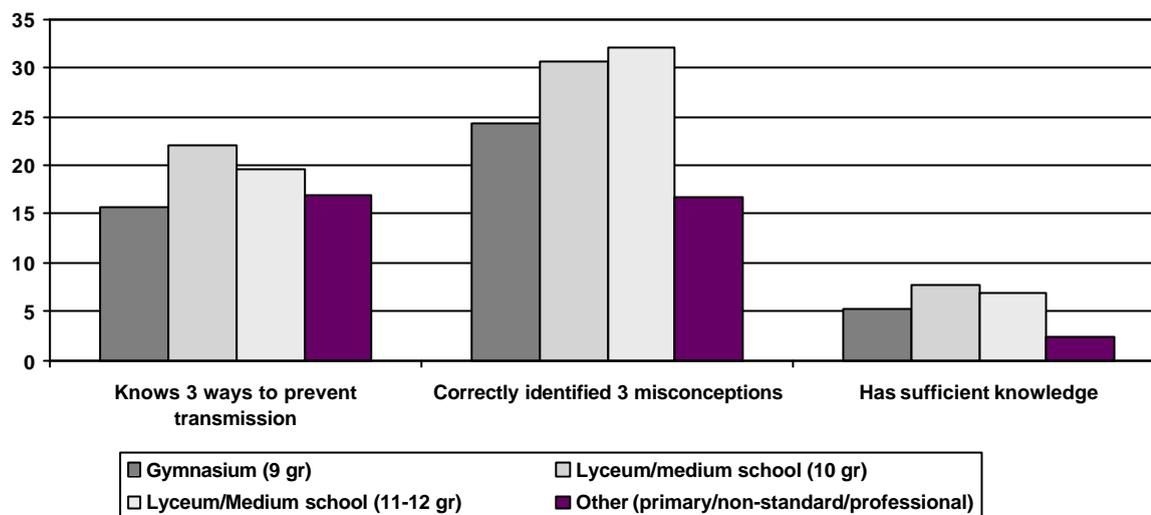
The MICS survey also attempted to measure discriminatory attitudes towards people living with HIV/AIDS. To this end, respondents were asked whether they agreed with two questions. The first asked whether a teacher who has the AIDS virus but is not sick should be allowed to continue teaching in school. The second question asked whether the respondent would buy food from a shopkeeper or food seller who the respondent knew to be infected with AIDS. The results are presented in Table 24.

Twenty three percent of the respondents believe that a teacher with HIV/AIDS should not be allowed to work. This percentage is higher in urban areas. Women in their twenties and those with a higher education are more likely to express this discriminatory attitude than the other women. Eight percent of women would not buy food from a person infected with AIDS. This measure shows the same pattern as the first question. Overall, 24 percent of women agree with at least one of the discriminatory statements. It is worth mentioning, that women from the richest quintile are four times more likely to express a discriminatory attitude.

Table 25 summarizes information from two previous tables on AIDS knowledge (Tables 21 and 22). The second column shows the percentage of women who know all three means of preventing HIV transmission – having one faithful uninfected partner, using a condom every time, and abstaining from sex. Twenty percent of women know all three ways. The third column of the table shows the percentage of women who correctly identified all three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected. Twenty nine percent of women correctly identified these misconceptions. Finally, the fourth column of the table shows the percentage of women who have ‘sufficient knowledge’ of HIV/AIDS transmission. These are women who know all three ways of preventing HIV transmission and correctly identified all three misconceptions. Less than 7 percent of women fall into this category.

Knowledge of HIV/AIDS transmission presents some variations by level of education (Figure 5). Women with lyceum and medium school are more likely to know all three ways to prevent transmission and to identify correctly all three misconceptions than women with gymnasium or other education.

Figure 5: Percentage of women aged 15-49 who have sufficient knowledge of HIV/AIDS transmission by level of education, Republic of Moldova, 2000



AIDS testing

Voluntary testing for AIDS, accompanied by counseling, allows those infected to seek health care and to prevent the infection of others. Testing is particularly important for pregnant women who can then take steps to prevent infecting their babies. The indicators shown in Table 26 are designed to monitor whether women are aware of places to get tested for HIV/AIDS, the extent to which they have been tested, and the extent to which those tested have been told the result of the test. In some places, a relatively large proportion of people who are tested do not return to get their results due to fear of having the disease, fear that their privacy will be violated, or other reasons.

Sixty two percent of women of reproductive age in the Republic of Moldova know a place to get tested for AIDS. Women living in urban area (72 percent) are more likely to know a place compared to those in rural regions (54 percent). Percent of women knowing where to get tested increases with the level of education from 51 percent of women with gymnasium to 69 percent of women with lyceum and medium school. Socio-economic level seems to be an important determinant of the knowledge of the place to get an AIDS test. Women from the poorest quintile are twice less informed (41 percent) compared to women from the richest quintile (77 percent).

Thirty five percent of women have been tested for AIDS. Again, this percentage is higher in urban at 43 percent and lower in rural at 29 percent. Women from 25 to 34 years were tested most frequently, compared to women of other age groups. Again, women from the poorest quintile reported the less number of tests (25 percent).

The vast majority of women who have been tested were told the result (91). There is no important variation across regions, age groups, and education levels, however poorer women less than others reported to have been told the result.

G. Reproductive Health

Contraception

Family planning issues and use of contraception influences the reproductive health status of the women and, consequently, children's health and development.

Current use of contraception was reported by 62 percent of married or in union women (Table 27). The most popular method is the IUD, which is used by 35 percent of married women in the Republic of Moldova. The

next most popular method is withdrawal, which accounts for 14 percent of married women. About four percent use periodic abstinence and condom, and only 3 percent of women use pills. Female sterilization, lactational amenorrhea and vaginal methods were reported in 1 percent of cases or less.

Contraceptive prevalence is lower in adolescents than in older women. Only 42 percent of married or in union women aged 15-19 currently use a method of contraception compared to 64 percent of 20-24 year olds and 62 percent of older women.

Variations in use of contraception are not important in women with different educational level. Age seem to be the most important factor in use of IUD and condom, whereas place of residence is strongly associated with the use of withdrawal and pills. Older women tend to prefer IUD, while condom use is more common at younger ages. Withdrawal is twice as frequent in rural areas as compared with urban places. Use of the pill is more than three times as high in urban areas. Although relatively rare, condom use appears to be more than twice as common among urban women.

Worthwhile mentioning that modern methods of contraception prevails in women from the richest quintile, while traditional methods are more frequent in poorer women.

H. Child Rights

Birth registration

The International Convention on the Rights of the Child states that every child has the right to a name and a nationality and the right to protection from being deprived of his or her identity. Birth registration is a fundamental means of securing these rights for children. The births of 98 percent of children under five years in the Republic of Moldova have been registered (Table 28). There are no significant variations in birth registration across sex, education or socio-economic categories. Children under the age of six months have the lowest birth registration rate at 89 percent, while older children have been registered in more than 98 percent of cases. It is caused by the late registration of children, after the age of 6 months. Among those whose births are not registered, cost, travel distance, and lack of knowledge do not appear to be the main reasons.

Orphanhood and living arrangements of children

Children who are orphaned or living away from their parents may be at increased risk of impoverishment, discrimination, denial of property rights and rights to inheritance, various forms of abuse, neglect, and exploitation of their labor or sexuality. Monitoring the level of orphanhood and the living arrangements of children assists in identifying those who may be at risk and in tracking changes over time.

Overall, 84 percent of children aged 0-14 are living with both parents (Table 29). An important percentage of children - 10 percent – are living with their mother only although their father is alive. This percentage is higher in urban at 14 percent compared to rural at 7 percent. Children who have one or both parents dead amount to 4 percent of all children aged 0-14. Older children (7 percent) are more likely to live away without their biological parents than younger children. One percent of children is living with neither parent although both parents are alive.

The situation of children not living with biological parents does not differ significantly by region and urban-rural. While 1.7 percent of children from the western part are not living with a biological parent, 1.9 percent of children from the eastern region do so. Percentage of children not living with biological parents is higher in urban (1.8 percent) compared to rural area (1.6 percent). Males have slightly more chances not to live with a biological parent (1.8), when compared to female (1.5).

Child labor

It is important to monitor the extent to which children work and the type of work in which they participate for several reasons. Children who are working are less likely to attend school and more likely to drop out. This pattern can trap children in a cycle of poverty and disadvantage. Working conditions for children are often unregulated with few safeguards against potential abuse. In addition, many types of work are intrinsically hazardous and others present less obvious hazards to children, such as exposure to pesticides in agricultural work, carrying heavy weights and scavenging in garbage dumps.

In the Republic of Moldova, the MICS survey estimates that only two percent of children aged 5-14 years engage in paid work (Table 30). About 10 percent – participate in unpaid work for someone other than a household member.

‘Domestic work’ is defined as cooking, shopping, cleaning, washing clothes, fetching water, and caring for children. Seventy one percent of children do these tasks for less than four hours a day while 15 percent spend more than four hours a day on such tasks.

Overall, older children (aged 10-14) are more likely than younger children (aged 5-9 years) to do paid, unpaid, or domestic work more than 4 hours per day. Variations across regions are greatest in the percentage of children who engage in unpaid work for someone other than a household member. This percentage varies from 9 percent in the western region to 17 percent in the eastern part for this indicator.

Children who have done any paid or unpaid work for someone who is not a member of the household or who did more than four hours of housekeeping chores in the household or who did other family work are considered to be ‘currently working’. Overall, 37 percent of children are classified as currently working. There is virtually no difference between boys and girls. Regionally, the percentage of children working is somewhat higher in the eastern part (42 percent) compared to the western part (36 percent). Rural children are twice more likely to work than urban children, especially when it comes to domestic work more than 4 hours per day.

Socio-economic status is strongly associated with the percentage of children who are currently working. Percentage of working children increases substantially from 20 percent of cases in children from the richest quintile to 50 percent of the poorest children. Domestic work more than 4 hours per day is four times greater in children the poorest quintile when compared to children from the richer one.

Appendix A: Sample Design

Appendix B: List of Personnel Involved in the Republic of Moldova MICS

Appendix C: Questionnaires