Monitoring the Situation of Children and Women

Findings from the Iraq Multiple Indicator Cluster Survey 2006

PRELIMINARY REPORT

March 2007

Implementing agencies:
Central Organization for Statistics & Information Technology (COSIT)
Kurdistan Regional Statistics Office (KRSO)
Suleimaniyah Statistical Directorate (SSD)
Partner:
Ministry of Health (MOH)

UNITED NATIONS CHILDREN'S FUND

Summary Table of Findings
MICS and MDG Indicators, Iraq, 2006

TOPIC	INDICATOR NUMBER		INDICATOR	VALUE		UNIT
	MICS-3	MDG		NATIONAL	KURDISTAN REGION	
Child Mortality	1	13	Under-five mortality rate	41	39	Per 1,000
	2	14	Infant mortality rate	34	32	Per 1,000
Nutrition	6	4	Underweight prevalence: (moderate and severe)	7.6	7.9	Percent
			(severe)	1.4	1.6	Percent
	7		Stunting prevalence (moderate and severe)	21.4	13.1	Percent
			(severe)	7.5	3.9	Percent
	8		Wasting prevalence (moderate and severe)	4.8	4.9	Percent
			(severe)	1.2	1.2	Percent
	15		Exclusive breastfeeding rate	25.1	23.5	Percent
	16		Continued breastfeeding rate (infants 12-15 months)	67.6	68.3	Percent
	16		(infants 20-23 months)	35.7	36.2	Percent
	17		Timely complementary feeding rate	51.0	49.3	Percent
Child health	25		Tuberculosis immunization coverage	90.6	96.3	Percent
	26		Polio immunization coverage	58.0	72.2	Percent
	27		DPT immunization coverage	54.9	65.7	Percent
	28	15	Measles immunization coverage	54.0	65.8	Percent
	31		Fully immunized children	35.4	52.6	Percent
	33		Use of oral rehydration therapy (ORT)	30.7	30.1	Percent
	34		Home management of diarrhoea	15.3	14.8	Percent
	35		Received ORT or increased fluids and continued feeding	63.8	66.0	Percent
	22		Antibiotic treatment of suspected pneumonia	82.0	73.8	Percent
	24	29	Solid fuels	4.6	5.9	Percent
Environment	11	30	Use of improved drinking water sources	79.2	96.9	Percent
	12	31	Use of improved sanitation facilities	92.3	97.7	Percent
Reproductive health	21	19c	Contraceptive prevalence	49.8	58.2	Percent
	4	17	Skilled attendant at delivery	88.5	88.1	Percent
	5		Institutional deliveries	62.6	67.8	Percent
Education	55	6	Net primary school attendance rate	83.1	88.2	Percent
	61	9	Gender parity index for primary school	0.91	0.97	None
			Gender parity index for secondary school	0.79	0.99	None
	59	2	Primary completion rate	78.9	114.1	Percent
Child protection	62		Birth registration	95.0	98.5	Percent
	67		Marriage (before age 15)	5.4	6.8	Percent
			(before age 18)	22.6	26.1	Percent
	71		Child labour	10.7	6.4	Percent
	68		Young women aged 15-19 currently married	19.0	10.0	Percent
HIV/AIDS, and orphaned children	82	19b	Comprehensive knowledge about HIV prevention among young women	2.1	0.7	Percent
	77	20	School attendance of orphans versus non-orphans	0.84	1.10	None

CONTENTS

TABLES

FIGURES

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacillis-Cereus-Geuerin (Tuberculosis)
CDC	Center for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COSIT	Central Organization for Statistics and Information Technology
CRC	Convention on the Rights of the Child
CSPro	Census and Survey Processing System
DHS	Demographic and Health surveys
DPT	Diptheria, Pertussis, and Tetanus
GPI	Gender Parity Index
Hep B	Hepatitis B
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
KRSO	Kurdistan Regional Statistics Office
LAM	Lactational Amenorrhea Method
LAS	League of Arab States
MDG	Millennium Development Goals
MENA	Middle East and North Africa
MICS	Multiple Indicator Cluster Survey
MICS-2	The second round of the Multiple Indicator Cluster Survey
MICS-3	The third round of the Multiple Indicator Cluster Survey
MMR	Measles, Mumps, and Rubella
MOH	Ministry of Health
NA	Not applicable
NAR	Net Attendance Ratio
NCHS	National Center for Health Statistics (USA)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAPFAM	Pan Arab Project for Family Health
PPS	Probability Proportional to Size
PSU	Primary Sampling Unit
RHF	Recommended Home Fluid
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
SSD	Suleimaniyah Statistical Directorate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WFFC	World Fit For Children
WHO	World Health Organization

PREFACE

With due acknowledgement of the huge joint effort rendered by all partners, we are pleased to present the preliminary findings of the Multiple Indicator Cluster Survey (MICS) on key social indicators related to the situation of children and women in Iraq.

This survey represents the third round of the Multiple Indicator Cluster Survey (MICS-3) in Iraq. The first MICS was undertaken in 1996, and MICS-2 was completed in 2000. This preliminary report for MICS-3 presents the main findings at the national level for the 18 governorates of Iraq on some of the main topics covered in the overall survey. Further analysis and disaggregated estimates for indicators at the governorate level will be included in the final report.

The primary implementers of MICS-3 are Iraq's Central Organization for Statistics and Information Technology and the statistical offices in Kurdistan Region, in collaboration with the Ministry of Health. The survey was completed with the much appreciated technical and financial support from UNICEF, and complied with the standard methodologies recommended by UNICEF throughout the various stages of preparation, field work and production of results.

MICS is a large-scale and truly representative survey, with a sample size of 18,144 households randomly selected from all governorates of Iraq, including the Kurdistan Region.

Iraq is one of the first countries in the Middle East and North African region to release its MICS-3 survey findings, despite the huge technical, financial and operational difficulties involved in carrying out such a task during this difficult period of time. That Iraq is able to undertake data collection in this way is indeed an outstanding achievement and testifies to the great spirit of resilience and dedication shared by all partners in the MICS-3 process.

It is hoped that the MICS-3 findings will positively contribute to monitoring progress towards implementing major international commitments and goals, including the World Fit for Children (WFFC) goals and the Millennium Development Goals (MDGs). This critical information will enable the Government of Iraq and all its partners to improve policy development for basic services, and prioritize efforts to protect and promote the wellbeing of Iraqi children and women.

Ali Ghaleb Baban
Minister of Planning and Development Cooperation

ACKNOWLEDGEMENTS

Our children are our flowerbuds of today and our treasure for tomorrow. They are our greatest assets and the Multiple Indicators Cluster Survey (MICS) is an indispensable means of establishing scientific approaches to address the many possible problems facing children and to establish reliable approaches to improve their conditions.

We in the Central Organization for Statistics and Information Technology (COSIT) and Kurdistan Regional Statistics Office (KRSO) are both committed to full and active participation in any noble activity on these lines and extend our appreciation to all those who contributed directly or indirectly to the preparation, implementation and the delivery of the findings of the MICS-3.

The Iraq Country Office, Headquarters and MENA Regional Office of the United Nations Children's Fund (UNICEF) and their staff should be acknowledged for their efforts in realising this and spending time and energy for advocating, realising and capacity building in this respect.

Our sincere thanks and appreciation go to all the employees in the various departments of the COSIT and KRSO who played a major coordinating role throughout the survey. Their contribution has culminated in the successful completion of this important survey and production of reliable results despite the immense difficulties facing our beloved country.

We would also like to acknowledge our fruitful partnership with WHO and UNFPA and the valuable technical support of Measure DHS/ ORC Macro and PAPFAM/LAS and their constructive comments and advice provided throughout the various stages of the survey.

Dr. Mehdi Alalak **and** **Dr Jamal Ameen**
Head of COSIT **Head of KRSO**

Higher National Steering Committee supervising the implementation of the Multiple Indicator Cluster Survey (MICS-3):

- Dr. Mehdi Al-Alalak – Director of Central Organization for Statistics and Information Technology (COSIT) – Chairperson
- Dr. Mohammed Shuaib – Directorate of Public health and primary Health Care-member
- Mr. Loay Haqi Rasheed – Director General of Technical Affairs Directorate / COSIT – member
- Ms. Siham Mohammad AbdelHamid – Expert and Manager of Social and Educational Statistics / COSIT - member
- Ms. Huda Hadawi Mohammed – Director of Environment Statistics/ COSIT – member
- Ms. Eman AbdelWahab- Chief of Statisticians / Directorate of Social and Education Statistics / COSIT – member and decision maker.
- Dr. Mohamed Jabr – Deputy Director General of Public Health and Primary Health Care Directorate / Ministry of Health (MOH) – member
- Dr. Nagham Mohsen Al-Khafagi – Director of Biostatistics Department / MOH - member
- Dr. Hanan Hashem Hasan – Director of Maternal & Child Care Unit / MOH - member
- Dr. Thaker Wa'dallah – Specialized doctor / Maternal & Child Care Unit / MOH – member
- Mr. Hasan Karim Abbas – Chief Engineer / Ministry of Municipalities and Public Works (MMPW) – member
- Mr. Anmar Rashed – Research Director of Planning, Studies & Statistics Dept / Ministry of Labour and Social affairs (MOLSA) – member
- Mr. Ali Makki – Director of Education Statistics / Ministry of Education (MOE) – member.

IT Committee

- Ms. Fawziah Ibrahim – Chief of System Analysis / COSIT – member
- Ms. Huda Ajaj – Chief Senior Programmer / COSIT – member
- Ms. Suhad Hassan – Assistant Chief Programmer / MOH
- Ms. Donya Ibrahim – Engineer / MOH

Higher Steering Committee / Kurdistan Region:

- Dr. Sahib Qaraman, Head of Regional Statistics Office
- Mr. Zirar Haji Merkhan, Director General of Regional Statistics Office
- Mr. Mahmud Othman Ma'aruf, Director of Suleimanyah Statistics Office
- Dr. Najmuddin Hassan, Director General of Health and Environmental Prevention Affairs, Directorate of Health Suleimanyah

United Nations Children's Fund UNICEF

- Staff members from UNICEF Headquarters, Regional Office for Middle East and North Africa region, and Country Office for Iraq

International MICS-3 Consultant

- Dr. Manar El Sheikh Abdel-Rahman

I. BACKGROUND AND OBJECTIVES

INTRODUCTION

This preliminary report is based on the Iraq Multiple Indicator Cluster Survey (MICS-3), conducted in 2006 by the Central Organization for Statistics and Information Technology (COSIT), the Kurdistan Regional Statistics Office (KRSO) and Suleimaniyah Statistical Directorate (SSD), in partnership with the Ministry of Health (MOH). The survey was based, in large part, on the need to monitor progress towards attainment of goals and targets emanating from the recent international agreements: the Millennium Declaration, adopted by all 191 United Nations Member States in September 2000, and the Plan of Action of 'A World Fit For Children', adopted by 189 Member States at the United Nations Special Session on Children in May 2002. Both of these commitments build upon promises made by the international community at the 1990 World Summit for Children.

In signing these international agreements, governments committed themselves to improving conditions for their children and to monitoring progress towards the same. UNICEF was assigned a supporting role in this task (see Table 1.1).

Table 1.1
A Commitment to Action: National and International Reporting Responsibilities

The governments that signed the Millennium Declaration and the World Fit for Children Declaration and Plan of Action also committed themselves to monitoring progress towards the goals and objectives they contained:

"We will monitor regularly at the national level and, where appropriate, at the regional level and assess progress towards the goals and targets of the present Plan of Action at the national, regional and global levels. Accordingly, we will strengthen our national statistical capacity to collect, analyse and disaggregate data, including by sex, age and other relevant factors that may lead to disparities, and support a wide range of child-focused research. We will enhance international cooperation to support statistical capacity-building efforts and build community capacity for monitoring, assessment and planning." (**A World Fit for Children**, paragraph 60)

"…We will conduct periodic reviews at the national and subnational levels of progress in order to address obstacles more effectively and accelerate actions.…" (**A World Fit for Children**, paragraph 61)

The Plan of Action (paragraph 61) also calls for the specific involvement of UNICEF in the preparation of periodic progress reports:

"… As the world's lead agency for children, the United Nations Children's Fund is requested to continue to prepare and disseminate, in close collaboration with Governments, relevant funds, programmes and the specialized agencies of the United Nations system, and all other relevant actors, as appropriate, information on the progress made in the implementation of the Declaration and the Plan of Action."

Similarly, the **Millennium Declaration** (paragraph 31) calls for periodic reporting on progress:

"…We request the General Assembly to review on a regular basis the progress made in implementing the provisions of this Declaration, and ask the Secretary-General to issue periodic reports for consideration by the General Assembly and as a basis for further action."

As a follow up to the second round of the Multiple Indicator Cluster Survey (MICS2) that was conducted in Iraq in year 2000, UNICEF, in close collaboration with its partners, has supported the conduct of the third round of Multiple Indicator Cluster Surveys (MICS-3).

MICS is one of the key tools that Governments, UNICEF and its development partners use to monitor ongoing progress towards the realization of children and women's rights as enunciated in the Convention on the Rights of the Child (CRC) and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The data on the indicators covered by MICS are used to measure and report on progress - at the national, regional and global levels - towards the achievement of the goals as enunciated in the 'World Fit for Children Goals' (WFFC) and, Millennium Development Goals (MDGs) declarations. Results of Iraq's MICS-3 will also provide the necessary data and information for the report that the Government of Iraq plans to submit to the UN General Assembly's Commemorative Session, scheduled in 2007. The national report will cover progress made in Iraq with regards to the implementation of the WFFC goals, whose targets are also milestones to achieving the MDGs.

The value of this survey goes beyond the mere generation of data and international reporting purposes. While this preliminary report specifically includes estimates at the national level, the final report will provide disaggregated estimates at subnational levels. The 2006 MICS-3 results should eventually gain special prominence in the development and updating of Iraq's National Development Strategy and will significantly contribute to the ongoing efforts of the Ministry of Planning and Development Cooperation and the Ministry of Planning in Kurdistan Region, as well as other Iraqi ministries, in formulating effective programmes, plans of actions and policies for children and women that are directed towards expanding inclusion and the reduction of inequalities and poverty.

Finally, it is hoped that the MICS-3 findings will contribute significantly towards enriching the deliberations of the planned COMPACT, Donor Conferences, and in ultimately influencing the priorities and resource allocations of the Government, UN agencies, donors and other development partners in Iraq.

This preliminary report presents selected results on some of the principal topics covered in the survey and on a subset of indicators[1]. The results in this report are preliminary and are subject to change, although major changes are not expected. A comprehensive full report is scheduled for publication shortly.

SURVEY OBJECTIVES

The 2006 Iraq Multiple Indicator Cluster Survey has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in Iraq;
- To furnish data needed for monitoring progress toward goals established by the Millennium Development Goals and the goals of A World Fit For Children (WFFC) as a basis for future action;
- To contribute to the improvement of data and monitoring systems in Iraq and to strengthen technical expertise in the design, implementation and analysis of such systems.

[1] For more information on the definitions, numerators, denominators and algorithms of Multiple Indicator Cluster Surveys (MICS) and Millennium Development Goals (MDG) indicators covered in the survey: see Chapter 1, Appendix 1 and Appendix 7 of the MICS Manual – *Multiple Indicator Cluster Survey Manual 2005: Monitoring the Situation of Children and Women*, also available at www.childinfo.org.

II. SAMPLE AND SURVEY METHODOLOGY

SAMPLE DESIGN

The sample for the Iraq Multiple Indicator Cluster Survey was designed to provide estimates on a large number of indicators on the situation of children and women at the *national* level; for *areas of residence* of Iraq represented by rural and urban (metropolitan and other urban) areas; for the18 *governorates* of Iraq; and also for metropolitan, other urban, and rural areas for each governorate. Thus, in total, the sample consists of *56 different sampling domains*, that includes 3 sampling domains in each of the 17 governorates outside the capital city Baghdad (namely, a "metropolitan area domain" representing the governorate city centre, an "other urban area domain" representing the urban area outside the governorate city centre, and a "rural area domain") and 5 sampling domains in Baghdad (namely, 3 metropolitan areas representing "Sadir City", "Resafa side", and "Kurkh side", an other urban area sampling domain representing the urban area outside the three Baghdad governorate city centres, and a sampling domain comprising the rural area of Baghdad).

The sample frame for the MICS-3 survey is divided into two separate parts. The first is derived from the 1997 census of Iraq, and covers the 15 Southern governorates. The other one is based on information provided by the Statistical Offices in the Kurdistan Region. Primary sampling units (PSUs) were constructed by merging the majalas/ blocks or villages which comprise the lowest area unit in the frames in urban and rural areas respectively. Nomads, who consist of 0.09 of the total population, were omitted in the frames.

The sample was selected in two stages. Within each of the 56 sampling domains, 54 PSUs were selected with linear systematic probability proportional to size (PPS). In some cases it was necessary to segment PSUs using a specified splitting rule. In such cases the size of the segments (number of households) was quick-counted and the selection of segments was done using PPS.

After mapping and listing of households were carried out within the selected PSU or segment of the PSU, linear systematic samples of six households were drawn. Cluster sizes of 6 households were selected to accommodate the current security conditions in the country to allow the surveys team to complete a full cluster in a minimal time. The total sample size for the survey is 18144 households. The sample is not self-weighting. For reporting national level results, sample weights are used.

QUESTIONNAIRES

Three questionnaires were used in the survey. In addition to the household questionnaire which was used to collect information on all household members, an individual woman questionnaire was administered in each household to all women aged 15-49. Mothers or caretakers of under 5 children were identified in each household, and these persons were interviewed using the questionnaire for children under 5. The questionnaires included the following modules:

- Household Questionnaire
  - Household Listing
  - Education
  - Water and Sanitation
  - Household Characteristics
  - Child Labour
  - Child Discipline
  - Disability

- Salt Iodization

- Questionnaire for Individual Women
  - Marriage
  - Child Mortality
  - Birth History
  - Tetanus Toxoid
  - Maternal and Newborn Health
  - Contraception and Unmet Need
  - Attitude Towards Domestic Violence
  - HIV/AIDS

- Questionnaire for Children Under Five
  - Birth Registration and Early Learning
  - Vitamin A
  - Breastfeeding
  - Care of Illness
  - Immunization
  - Anthropometry

The questionnaires were based on the third round of the Multiple Indicator Cluster survey model questionnaires. From the MICS-3 model English version, the questionnaires were revised and customized to suit local conditions and translated into Arabic and Kurdish languages. The Arabic language version of the questionnaire was pre-tested during January 2006 while the Kurdish language version was pre-tested during March 2006. Based on the results of the pre-test, modifications were made to the wording and translation of the questionnaires.

FIELDWORK AND PROCESSING

Fieldwork, training, and data processing were conducted at consecutive dates for the 15 South/Centre governorates of Iraq and for the Kurdistan Region.

All supervisors (from COSIT, KRSO, SSD and MOH) were trained for 14 days in a training of trainers' workshop in December 2005 in Amman by experts from Measures DHS/ ORC Macro and PAPFAM. These supervisors in turn, trained the interviewers for 10 days in January and February 2006 for Iraq South/Centre governorates and Kurdistan Region respectively. Refresher trainings were carried out prior to start of fieldwork in Kurdistan Region. The data were collected by 167 teams; each was comprised of two interviewers (one female from MOH and one male from COSIT, KRSO, or SSD) except for Baghdad and Al-Anbar governorates which had larger teams. In general, in the South/Centre governorates, groups of three teams were supervised by a local supervisor from the statistical office of each governorate. A central supervisor from the steering committee members and MOH was assigned to each governorate. In Kurdistan Region, groups of three teams were supervised by two local supervisors (one from KRSO/SSD and one from MOH). Two central supervisors from KRSO/SSD and MOH were also assigned to each governorate. A high committee, consisting of members from KRSO/SSD and MOH was also assigned for overall supervision of the survey in Kurdistan.

Fieldwork began in the South/Centre governorates of Iraq in February 2006 and concluded in March 2006. In the Kurdistan Region, fieldwork began in Suleimaniyah governorate in April 2006 and was completed in April 2006 while fieldwork was initiated in May 2006 in Erbil/Dohuk governorates and concluded in June 2006.

Questionnaires were edited simultaneously with fieldwork and data were entered on 88 microcomputers (70 in South/Centre governorates and 18 in Kurdistan Region) using the Census and Survey Processing System (CSPro) software. In order to ensure quality control, all questionnaires were entered twice and internal consistency checks were performed. Procedures and standard programs developed under the global MICS-3 project and adapted to Iraq questionnaires were used. Data processing in the South/Centre parts of Iraq began simultaneously with data collection in March 2006 and finished in April 2006. Similarly, in Kurdistan Region, data processing began on April 2006 and finished in June 2006. Data were analysed using the Statistical Package for Social Sciences (SPSS) software program customizing the model syntax and tabulation plans developed for this purpose.

SAMPLE COVERAGE

One cluster of the 3024 clusters selected was not completed. Of the 18144 households selected for the sample, 18123 were found to be occupied. Of these, 17873 were successfully interviewed for a household response rate of 98.6 percent. In the interviewed households, 27564 women (age 15-49) were identified. Of these, 27186 were successfully interviewed, yielding a response rate of 98.6 percent. In addition, 16570 children under age five were listed in the household questionnaire. Of these, questionnaires were completed for 16469 which correspond to a response rate of 99.4 percent. Overall response rates of 97.3 and 98.0 are calculated for the women's and under-5's interviews respectively (Table 1).

The Iraq MICS-3 sampled all women of reproductive age. Of the 27186 successfully interviewed women, 15875 women (58 percent) were currently married, 958 women (4 percent) were formerly married, and 10353 women (38 percent) were never married.

III. RESULTS

CHILD MORTALITY

One of the overarching goals of the MDGs and the World Fit for Children is to reduce infant and under-five mortality. Monitoring progress towards this goal is an important but difficult objective.

The *infant mortality rate* is the probability of dying before the first birthday. The *under five mortality rate* is the probability of dying before the fifth birthday. These rates are expressed per 1,000 live births. In this report, infant and under five mortality rates are directly calculated by using information collected from the birth history module of the questionnaire administered to individual women. For all births of the respondent the module collect information on sex, month and year of birth, survivorship status and current age, or, if the child had died, age at death.

The under-5 mortality rate for the most recent five-year period (which corresponds to the years 2001-2006) is estimated at 41 deaths per 1,000 births (Table 2). This means that around one in twenty-four children born in Iraq die before reaching the fifth birthday. Eighty five percent of deaths under age five occur in the first year of life; the infant mortality rate is 34 deaths per 1,000 births.

The results of the survey show that, as expected, male children are more likely to die in infancy than female children. Differences exist in under-5 mortality and infant mortality by education of the mother. Children born to mothers with no education experience a 32 percent increased risk of dying before their fifth birthday than children born to mothers who had secondary or higher education (49 vs. 37 per 1,000 live births, respectively). This educational advantage is also observed for infant mortality rates with 42 deaths per 1,000 live births to women with no education, compared to only 33 deaths per 1,000 to women with secondary or higher education.

Work is in progress to finalize analysis on mortality estimates and more detailed results from the survey will be presented in the final report.

NUTRITIONAL STATUS

Children's nutritional status is a reflection of their overall health. Children, who have access to adequate food supply and good nutrition, are less prone to develop infections that lead to repeated illness like diarrhoeal diseases and respiratory infections. These children reach their growth potential and are considered well nourished.

In a well-nourished population, there is a standard distribution of height and weight for children under age five. Undernourishment in a population can be gauged by comparing children to this reference distribution. The reference population used here is the World Health Organization / Center for Disease Control / National Center for Health Statistics (WHO/CDC/NCHS) reference, which is recommended for use by UNICEF and the World Health Organization. Each of the three nutritional status indicators can be expressed in standard deviation units (z-scores) from the median of this reference population.

Weight for age is a measure of both acute and chronic malnutrition. Children whose weight for age is more than two standard deviations below the median of the reference population are considered *moderately or severely underweight* while those whose weight for age is more than three standard deviations below the median are classified as *severely underweight.*

Height for age is a measure of linear growth. Children whose height for age is more than two standard deviations below the median of the reference population are considered short for their age and are classified as *moderately or severely stunted.* Those whose height for age is more than three standard deviations below the median are classified as *severely stunted.* Stunting is a reflection of chronic malnutrition as a result of failure to receive adequate nutrition over a long period and recurrent or chronic illness.

Children whose weight for height is more than two standard deviations below the median of the reference population are classified as *moderately or severely wasted,* while those who fall more than three standard deviations below the median are *severely wasted*. Wasting is usually the result of a recent nutritional deficiency. The indicator may exhibit significant seasonal shifts associated with changes in the availability of food or disease prevalence.

Finally, children whose weight for height is more than two standard deviations above the median of the reference population are classified as *overweight*. Overweight or obesity is a chronic condition that increases the risk of many diseases and health conditions. Individual behaviours, environmental factors and genetics all contribute to the complexity of being overweight.

Table 3 shows percentages of children classified into each of these categories, based on the anthropometric measurements that were taken during fieldwork. In Table 3, children who were not weighed and measured and those whose measurements are outside a plausible range are excluded (7 percent).

Eight percent of children under age five in Iraq are moderately or severely underweight and one percent are classified as severely underweight (Table 3). Over one-fifth (21 percent) of children are severely or moderately stunted (or too short for their age) and eight percent are severely stunted. Five percent of children are severely or moderately wasted (or too thin for their height) and one percent are severely wasted.

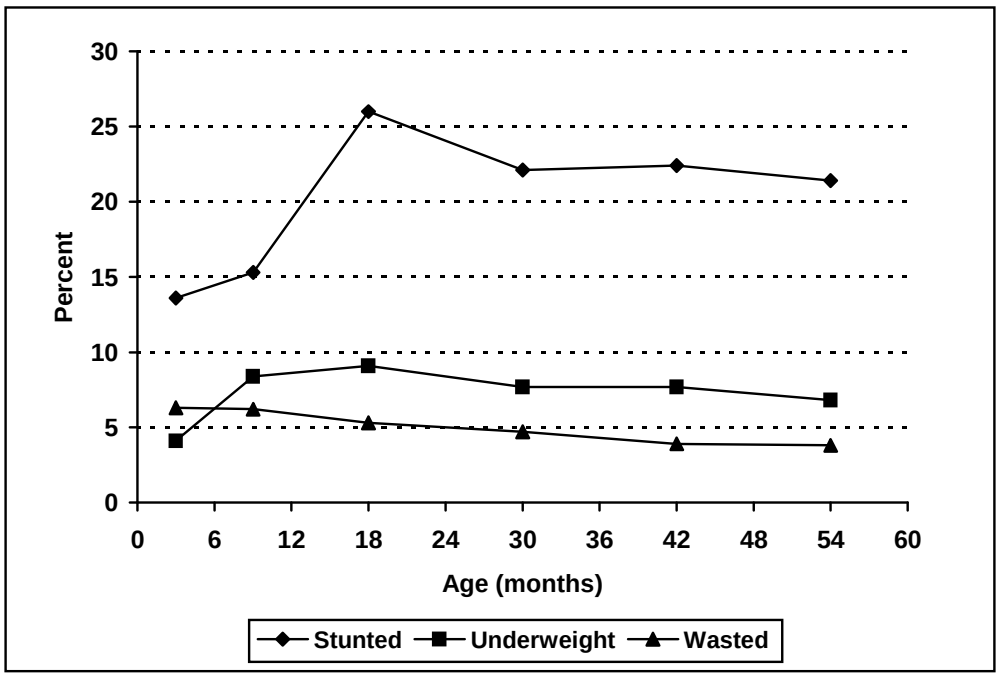

Figure 1: Percentage of children aged 0-59 months who are undernourished, Iraq, 2006

Children in rural areas are more likely to be stunted than other children. Children who live in metropolitan areas are better nourished than those who live in other areas. Looking at educational differentials, as expected those children whose mothers have secondary or higher education are the least likely to be underweight and stunted. Gender differentials are very small. The age pattern shows that a higher percentage of children aged 12-23 months are stunted in comparison to children who are younger and older (Figure 1).

Overall, about nine percent of children in Iraq are overweight.

BREASTFEEDING

Breastfeeding for the first three years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. However, many mothers stop breastfeeding too soon and there are often pressures to switch to infant formula, which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. The World Fit for Children goal states that children should be exclusively breastfed for 6 months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to 2 years of age and beyond.

In Table 4, breastfeeding status is based on the reports of mothers/caretakers of children's consumption of food and fluids in the 24 hours prior to the interview. *Exclusively breastfed* refers to infants who received only breast milk and vitamins, mineral supplements, or medicine. The table shows exclusive breastfeeding of infants during the first six months of life (separately for 0-3 months and 0-5 months), as well as complementary feeding (receiving breast milk and solid/ mushy food) of children 6-9 months and continued breastfeeding of children at 12-15 and 20-23 months of age.

Only one in four children aged less than six months are exclusively breastfed (25 percent), At age 6-9 months, half of the children are breastfed together with receiving solid or semi-solid foods (51 percent). By age 12-15 months, 68 percent of children are still being breastfed and by age 20-23 months, 36 percent continue breastfeeding.

Girls are slightly more likely to be exclusively breastfed and have timely complementary feeding than boys, while boys breastfed slightly longer than girls. Slightly more children living in rural areas (27 percent) are exclusively breastfed compared to urban areas (24 percent).

IMMUNIZATION

According to national immunization schedule by a first birthday each child in Iraq should receive through routine immunization - a BCG vaccination to protect against tuberculosis, three doses of DPT to protect against Diphtheria, Pertussis, and Tetanus, four doses of polio vaccine, three doses of Hepatitis B (Hep B) and a measles vaccination at the age of 9 months. In addition, a Measles, Mumps, and Rubella (MMR) vaccination is given to children at 15 months of age as part of the second opportunity for measles vaccination to protect against measles, as well as against mumps and rubella.

Following the World Health Organization (WHO) guidelines (recommendation) children are considered fully immunized if they receive DPT (1-3 doses), polio (1-3 doses), BCG, and measles vaccines by 12 months of age. For the estimation of fully immunized children, children age 12-23 are considered in this report. Full vaccination indicators incorporating the MMR and Hep B will be included in the final report.

Mothers were asked to provide vaccination cards for children under the age of five. Interviewers copied vaccination information from the cards onto the MICS-3 questionnaire. If

the child did not have a card, the mother was asked to recall whether or not the child had received each of the vaccinations and, for DPT and Polio, how many times.

Overall, 61 percent of children aged 12-23 months had health cards that were seen by interviewers. A further 24 percent indicated that they had health cards, but were not seen at the time of interview. The percentages of children aged 12 to 23 months who received a BCG and each of three DPT and polio vaccinations, measles vaccinations, and were fully immunized are shown in Table 5.

The denominator for the percentages in the table consists of children aged 12-23 months so that only children who were old enough to be fully vaccinated were counted. 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 panels, only those who were vaccinated before their first birthday were included. For children without vaccination cards, the proportion of vaccinations given before 12 months was assumed to be the same as for children with vaccination cards.

Approximately 91 percent of children aged 12-23 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 81 percent. The percentage declines for subsequent doses of DPT to 71 percent for the second dose, and 55 percent for the third dose (Figure 2). Similarly, 86 percent of children received Polio 1 by age 12 months and this percentage declines to 58 percent by the third dose. The coverage for measles vaccine by 12 months is at 54 percent. The percentage of children who had all recommended vaccinations (full vaccination) by age 12 months is 35 percent.

The Ministry of Health launched two rounds of national polio campaigns in Iraq during June and July of 2005. The campaigns targeted children 0-59 months of age. Therefore, only children in the MICS-3 sample who were 7 months or more in South/Centre Iraq and children 11 months or more in Kurdistan were exposed to this campaign.

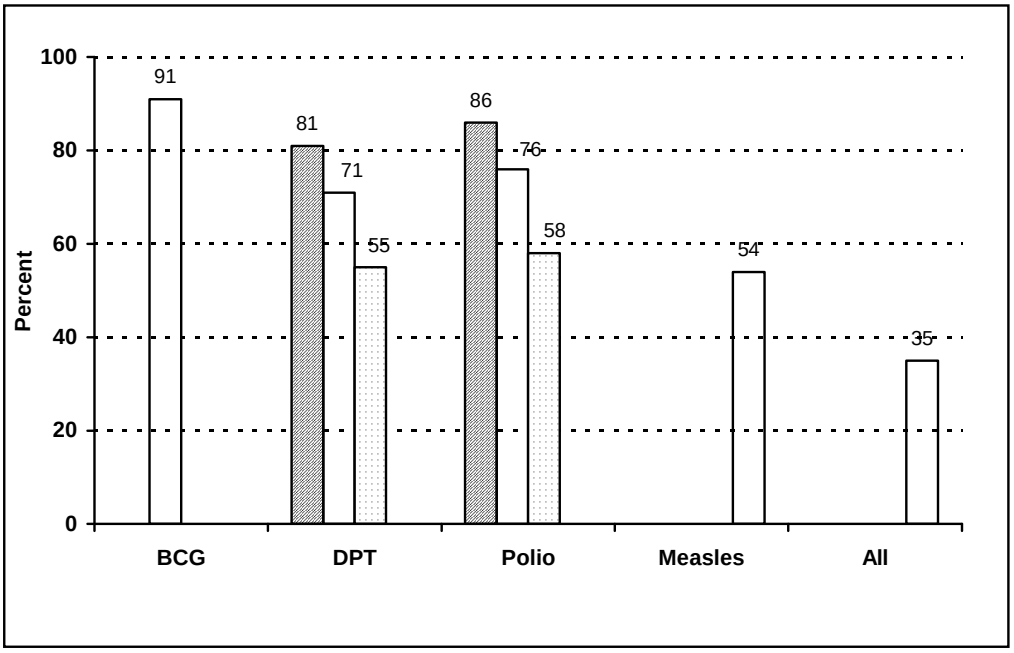

Figure 2: Percentage of children 12-23 months who received immunizations by age 12 months, Iraq, 2006

Table 6 presents results for children vaccinated in each round and in both rounds of the campaign in South/Centre Iraq and in Kurdistan Region. Overall, 84 percent of children in South/Centre Iraq exposed to the campaign received polio vaccinations at both rounds of campaigns. This percentage is the same for Kurdistan Region. The coverage was more or less similar in urban and rural areas and increased by mother's educational level.

An MMR campaign was also launched in April/May 2005 in Iraq South/Centre governorates and in May of the same year in Kurdistan Region. The MMR campaign targeted children aged 12-60 months born from May 2000 to May 2004 for South/Centre of Iraq and children born from June 2000 to June 2004 for Kurdistan. Thus, only children in the MICS-3 sample currently 20 months or more for South/Centre governorates of Iraq and 23 months or more for Kurdistan were exposed to this MMR campaign. Results of the MMR campaign are presented separately for these two groups of children in Table 7. In South/Centre governorates of Iraq, 68 percent of the children exposed to MMR campaign received an MMR vaccination. The MMR campaign mostly covered children born between 2001 and 2003. Similar to the polio campaigns above, the coverage did not vary by urban and rural areas and increased by mother's education. A generally similar picture is seen for Kurdistan Region with an overall coverage percentage of 67, although the coverage varied by area of residence with a higher percentage in urban areas (70 percent) compared to rural areas (59 percent).

The large proportions of immunized children at these campaigns clearly contribute to the overall protection of these children against these diseases.

ORAL REHYDRATION THERAPY

Dehydration caused by diarrhoea is a major cause of mortality and morbidity among Iraqi children. Dehydration is caused by loss of large quantities of water and electrolytes from the body in liquid stools. Oral rehydration therapy (ORT) – either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. RHF are fluids which have electrolytes usually made from sugar, salt and water.

Mothers or caretakers were asked to report whether their child had diarrhoea in the two weeks prior to the survey. If so, the mother was asked a series of questions about what the child drank and ate during the episode. In this survey questions were asked about the following oral homemade treatments: drinking water, rice water, vegetable soup, yogurt drink and fruit juice. None of these homemade treatments is considered as RHF and thus the ORT indicator is based on use of ORS only.

Overall, 13 percent of children under-five years of age had diarrhoea in the two weeks preceding the survey (Table 8). The peak diarrhoea prevalence occurred among children aged 6-11 months.

Table 8 also shows the percentage of children receiving various types of liquids during episodes of diarrhoea. Since mothers were able to name more than one type of liquid, the percentages do not necessarily add up to 100. Drinking water (84 percent) was the most commonly cited fluid, followed by yoghurt drinks (46 percent) and fruit juice (42 percent). Almost one third of the children (31 percent) received ORS (i.e. ORT) while they had diarrhoea. This percentage did not vary much by sex or area of residence. Use of ORS did not vary steadily with age of child (Figure 3). The age group 6-11 months had the highest percentage of ORS use.

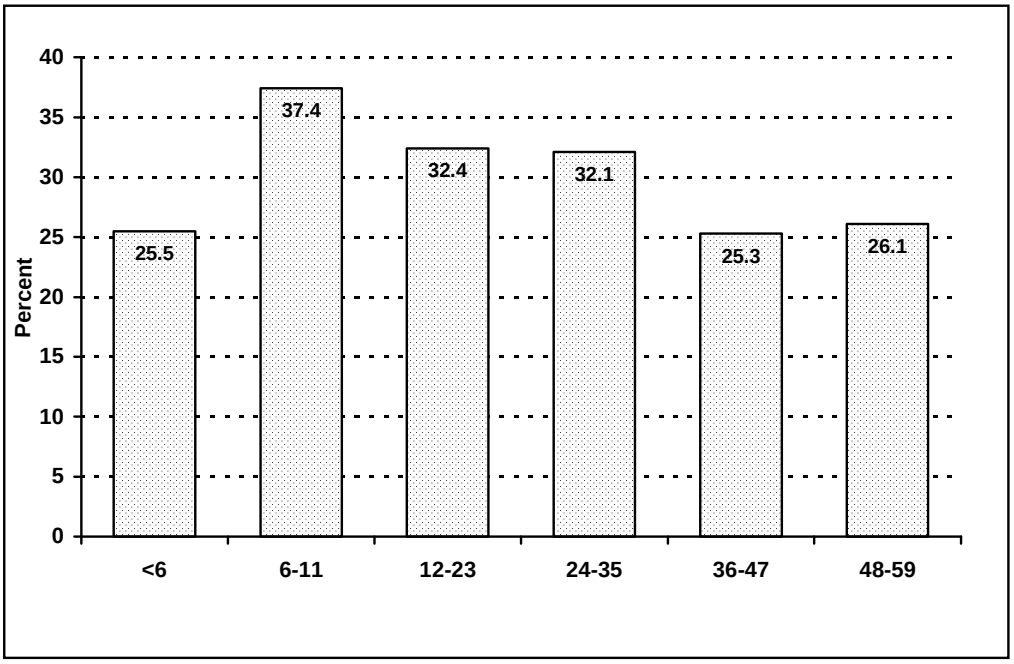

Figure 3: Percentage of children aged 0-59 months with diarrhoea who received the recommended oral rehydration therapy, Iraq, 2006

HOME MANAGEMENT OF DIARRHOEA

Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are important strategies for managing diarrhoea.

About one quarter (23 percent) of under-five children with diarrhoea drank more than usual while 76 percent drank the same or less (Table 9). Sixty seven percent ate somewhat less, same or more (continued feeding), but 32 percent ate much less or ate almost none. Given these figures, only 15 percent children received increased fluids and at the same time continued feeding. Combining the information in Table 9 with those in Table 8 on oral rehydration therapy, it is observed that 64 percent of children either received ORT or fluid intake was increased, and at the same time, feeding was continued, as is the recommendation.

The home management of diarrhoea varies by sex, where males were more likely to receive or increased fluids and continued feeding (66 percent) than females (61 percent). In rural areas 67 percent of children received ORT or increased fluids and continued feeding compared to 62 percent in urban areas. Within urban areas, the percentage of children in metropolitan areas who received ORT or increased fluids and continued feeding (57 percent) is less than children in other urban areas (69 percent). The home management of diarrhoea varied by age of the child, with the highest percentage observed for the 24-35 months age group (75 percent) and the lowest percentage observed for the 0-11 months age group (54 percent). Differentials by mother's educational level varied, with children of mothers with secondary or higher education receiving the least percentage of receiving ORT or increased fluids and continued feeding.

ANTIBIOTIC THERAPY OF CHILDREN WITH SUSPECTED PNEUMONIA

Pneumonia is the leading cause of death in children and the use of antibiotics in under-5s with suspected pneumonia is a key intervention. Children with suspected pneumonia are 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 and not solely a blocked nose. Information was collected for children who had suspected pneumonia as to whether or not they had received an antibiotic within the previous two weeks.

Table 10 presents the percentage of children aged 0-59 months with suspected pneumonia in the last two weeks before the survey and the use of antibiotics for the therapy of this pneumonia by sex, age, residence, age, mother's education. In Iraq, 13 percent of the children surveyed had suspected pneumonia. Although this percentage did not vary in urban and rural areas, Metropolitan areas had a higher percentage of suspected pneumonia (15 percent) compared to other urban areas (12 percent). The prevalence of suspected pneumonia varied by age of the child, with the highest percentage observed for the 12-23 months age group (16 percent).

Overall, 82 percent of under-5 children with suspected pneumonia had received an antibiotic during the two weeks prior to the survey. The table also shows that antibiotic therapy of suspected pneumonia is lower among children from rural households and children whose mothers/caretakers have no education than among other children. The use of antibiotics is more or less similar for different age groups of the child, with the least use of antibiotics observed for older children aged 48-59 months (79 percent).

SOLID FUEL USE

Cooking with solid fuels (biomass and coal) leads to high levels of indoor pollution and is a major cause of ill-health in the world, particularly among under-5 children, in the form of acute respiratory illness.

Table 11 shows that overall, only about five percent of all households in Iraq are using solid fuels for cooking. Use of solid fuels is negligible in urban areas (0.6 percent), but increases in rural areas, with 13 percent of the households using solid fuels. Differentials with respect to educational level of the household head are significant – nine percent for no education, five percent for primary education, and two percent for secondary education or higher. The table also shows that about half households use of solid fuel comes from the use of wood for cooking purposes.

WATER AND SANITATION

Safe drinking water is a basic necessity for good health and also a human right. Unsafe drinking water can be a significant carrier of diseases such as cholera, typhoid, and diarrhoeal diseases such as amoebic and bacillary dysentery. Drinking water can also be contaminated with chemical, physical and radiological contaminants with potentially 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, who bear the primary responsibility for carrying water, often for long distances.

The distribution of the population by source of drinking water is shown in Table 12 and Figure 4. The population using improved drinking water sources are those who use any of the following types of supply: piped water, public tap, borehole/ tube well, protected well, protected spring or rainwater. Overall, 79 percent of the population has access to improved drinking water sources – 92 percent in urban areas and only 57 percent in rural areas. The

above figures do not reflect the condition and reliability of the main drinking water sources. Based on a question in the survey about the reliability of the drinking water source, results show that nearly half (48%) of those who have access to improved drinking water sources indicated problems with the condition of services. Twenty one percent of the respondents reported problems on a daily basis, while 19 percent, and nine percent indicated less than weekly and weekly problems respectively (Table not shown).

Two-thirds of the households have water piped into their dwellings (65 percent). Water supply sources from surface water and tanker truck are the main unimproved sources of drinking water, mostly occurring in rural areas.

The source of drinking water for the population varies strongly by area of residence (Table 12). In the rural areas, only 47 percent of the population uses drinking water that is piped into their dwelling or into their yard or plot. In the metropolitan areas and other urban areas, 90 and 89 percent, respectively, use piped water.

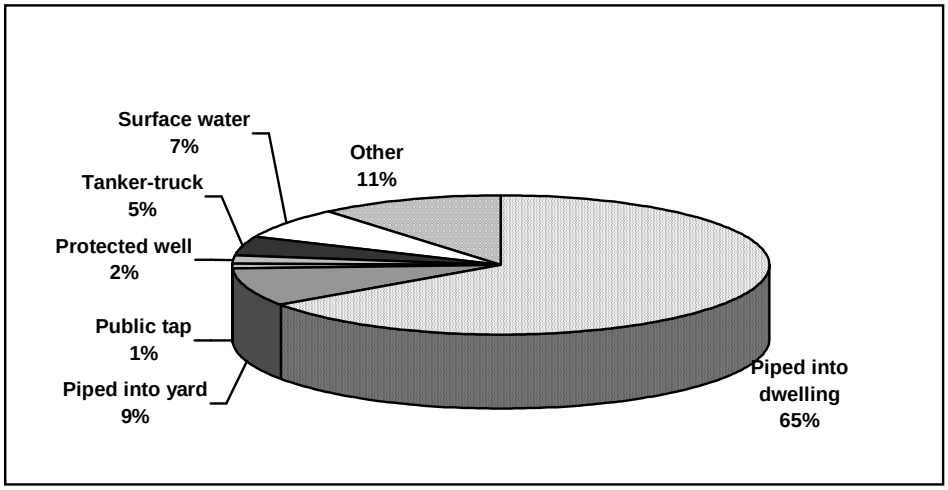

Figure 4: Percent distribution of the population by source of drinking water, Iraq, 2006

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases and polio. Improved sanitation facilities include: flush toilets connected to sewerage systems or septic tanks or pit latrines, ventilated improved pit latrines and pit latrines with slabs, and composting toilets. Respondents in Iraq MICS-3 using flush toilets connected to sewerage systems or septic tanks or pit latrines were asked about the functionality of the sewerage systems around their house by indicating whether they have no problems, occasional, weekly, or daily problems.

Overall, 92 percent of the population of Iraq is living in households using improved sanitation facilities (Table 13) with 87 percent of the population using flush toilets connected to sewerage systems or septic tanks or pit latrines. The percentage of households using improved sanitation facilities is 98 percent in urban areas and 82 percent in rural areas. The above figures do not reveal the situation on the ground, as 40 percent of the respondents indicated problems with the functionality of the sewage system around their house (Table not shown).

The use of improved sanitation is similar at metropolitan areas and other urban areas. The most common improved sanitation facility in urban areas is flush toilet connected to septic tank (43 percent), while toilets flushed to pit (latrine) are most common in rural areas (36 percent).

CONTRACEPTION

Current use of contraception of currently married women or husbands of these women was reported by half the women (50 percent) (Table 14). Of these, 33 percent are using modern methods and 17 percent are using traditional methods. The most popular method is the pill which is used by 15 percent of married women in Iraq. The next most popular method is Intrauterine Device (IUD), which accounts for 12 percent of married women. Eight and seven percent of women reported use of the withdrawal method and the lactational amenorrhea method (LAM) respectively. Between two and three percent of women reported use of female sterilization, periodic abstinence and injectables. Condom use is very rare; only one percent of married women reported using it as a method of contraception.

Younger women are less likely to use contraception than older women. Only about 21 percent of married women aged 15-19 currently use a method of contraception compared to 36 percent of 20-24 years old and 64 percent of 40-44 years old women. The use of any contraceptive method is negligible when the woman has no living children (one percent). The greater the number of living children a woman has the more likely she is to use contraceptives - the contraceptive use rate rises from 34 percent for women with one living child to 65 percent for women with four or more living children (Figure 5).

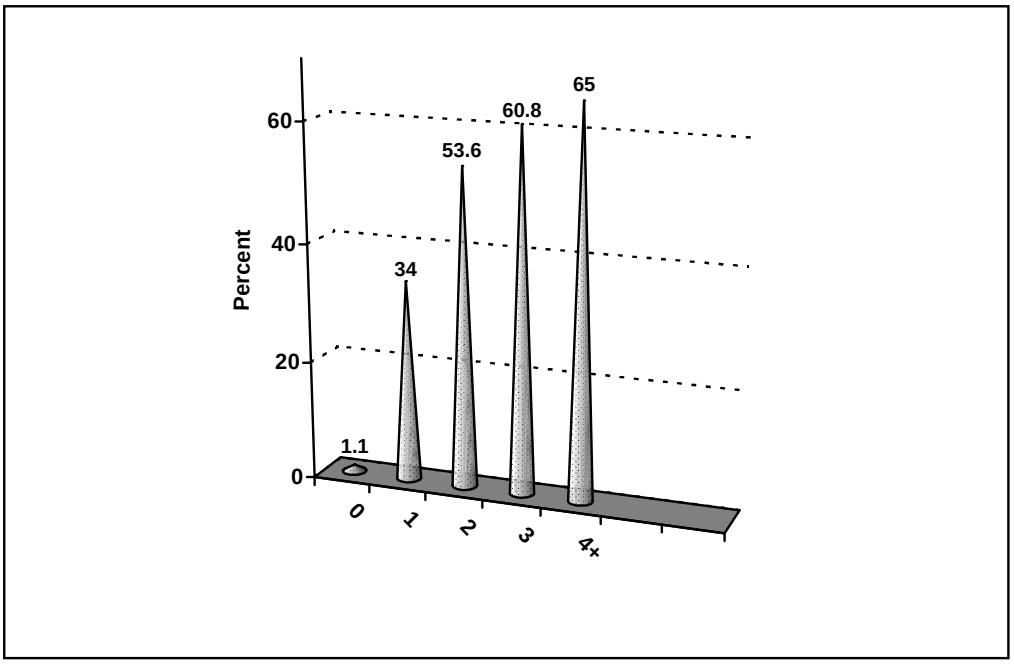

Figure 5: Percentage of women aged 15-49 years currently married who are using (or whose husband is using) a contraceptive method by number of living children, Iraq, 2006

Women's education level is associated with contraceptive prevalence. The percentage of women using any method of contraception rises from 45 percent among those with no education to 48 percent among women with primary education, and to 55 percent among women with secondary or higher education. A small number of women had a non-standard curriculum educational level (i.e. went to schools that did not teach a full standard school curriculum) with a 47 percent of them using any method of contraception. The method mix varies by education. Contraceptive users with secondary or higher education are more likely

to use the pill and IUD (32 percent) compared with those with no or primary education users (23 and 25 percent, respectively).

ASSISTANCE AT DELIVERY

The provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and infants by the use of technically appropriate procedures and accurate and speedy diagnosis and therapy of complications. Skilled assistance at delivery is defined as assistance provided by a doctor, nurse, or certified midwife.

Eighty-nine percent of births occurring in the two years prior to the Iraq MICS-3 survey were delivered by skilled personnel (Table 15). This percentage is more in urban areas (95 percent) than rural areas (78 percent). The more educated a woman is the more likely she is to have delivered with the assistance of a skilled person.

More than half of births (55 percent) in the two years prior to the Iraq MICS-3 survey were delivered with assistance of a doctor. Certified midwifes assisted with the delivery of a quarter of births (25 percent), uncertified midwifes assisted with five percent of the births, nurses assisted with nine percent of the births, and traditional birth attendants referred to as "gida" in Iraq assisted with six percent of births. Younger women were more assisted by doctors than older women. In contrast, older women were more assisted by midwifes than younger women.

DELIVERY IN A HEALTH FACILITY

Overall, approximately 2 out of 3 births occurring in the two years prior to the Iraq MICS-3 survey were delivered in a health facility (63 percent) (Table 15). More births are delivered in health facilities in urban areas (68 percent) than in rural areas (54 percent). Very young and older women were more to deliver their births in a health facility compared to women in the middle age group 30-39. Delivery in a health facility increases with a woman's educational level – only about half of the uneducated women delivered in a health facility (52 percent), compared with 61 percent for women with primary education and 72 percent for women with secondary or higher education.

PRIMARY SCHOOL ATTENDANCE

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 Millennium Development Goals and A World Fit for Children. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Overall, 5 in 6 children of primary school age in Iraq are attending primary school or secondary school (83 percent) (Table 16). In urban areas, 89 percent of children attend school while in rural areas 75 percent attend. The school attendance increases with mother's education – 92 percent for mothers with secondary or higher education, 84 percent for mothers with primary education, and 72 percent for mothers with no education. Males have a higher school attendance (87 percent) when compared to females (79 percent).

The ratio of girls to boys attending primary and secondary education is provided in Table 17. The table shows that gender parity for primary school is 0.91, indicating that more boys attend primary school compared to girls. The indicator drops to 0.79 for secondary education indicating that for every 100 boys attending secondary school 79 girls attend. The

disadvantage of girls is particularly pronounced in the rural areas where the gender parity for primary school is 0.83 and gender parity for secondary school is 0.44. Gender parity in metropolitan areas was slightly higher than that of other urban areas. Also gender parity increased with mother's education.

PRIMARY SCHOOL COMPLETION AND TRANSITION TO SECONDARY EDUCATION

Improvements of the education system coverage and students educational attainment are regarded as important aspects of the national progress towards the Millennium Development Goal of universal primary completion.

Table 18 presents the primary completion rate and the net primary completion rate. The primary completion rate considers the number of children of *all ages* who are completing the final year of primary education, as a percentage of the population of the official primary school graduation age. The net rate is calculated as the number of children of *primary school completion age* who are completing the final year of primary education as a percentage of the population of the official primary school graduation age. In Iraq the primary school cycle spans 6 years with children officially entering primary school at 6 years and officially graduating at 11 years.

Results show that the primary completion rate is 79 percent. The primary completion rate varies within sex and area of residence. Boys have a higher rate (90 percent) than girls (68 percent) and urban areas have a higher rate (88 percent) than rural areas (65 percent). This indicates attendants of more boys of all ages than girls and more children of all ages in urban areas than in rural areas at the 6th grade. The primary completion rate also increases with mothers' education.

About 30 percent of Iraqi children of primary graduation age (11 years) are attending the 6th grade at age 11 years. There is no difference in the rate between boys (30 percent) and girls (30 percent) and the difference observed in the primary completion rate is due to the fact that the majority of children over age 11 years at the time of the survey attending the 6th grade of primary school are boys. The net completion rate is greater in urban areas (36 percent) compared to rural areas (21 percent) and the rate increases markedly with mothers' education.

Comparing the primary completion rate (79 percent) with the net completion rate (30 percent) indicates the presence of children who are over age 11 years at the time of the survey at the 6th grade.

The transition rate to secondary education is also shown in Table 18. In Iraq, 78 percent of children who were in the 6th grade of primary school last year attended the first grade of secondary school this year. The percentage is higher for girls (82 percent) than boys (76 percent) and for urban areas (82 percent) than rural areas (70 percent). The rate is associated positively with mothers' education.

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 95 percent of children under-five years in Iraq have been registered (Table 19). There are no significant variations in birth registration across sex or mother's education categories. Older children are more likely to have been registered than younger children.

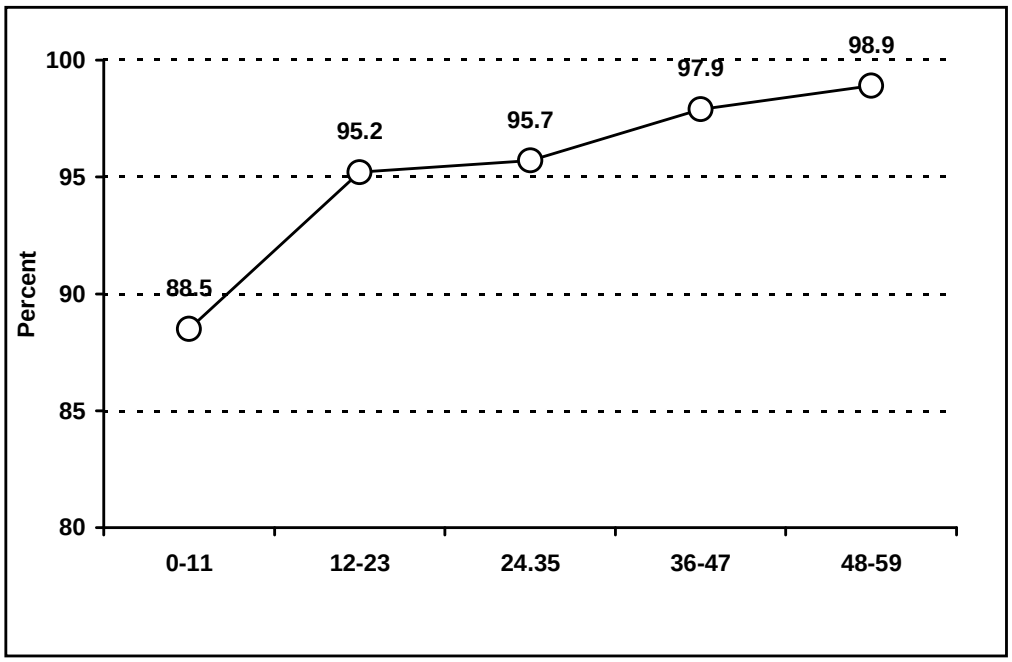

Figure 6: Percent distribution of children aged 0-59 months where birth is registered, Iraq, 2006

CHILD LABOUR

The Convention on the Rights of the Child calls for protections of children against abuse, exploitation and violence. 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. In addition, work can expose them to health, mental, or social development problems. In addition to exploiting children and contributing to long term poverty and further disadvantage, child labour increases the risk of exposure to sexual abuse, physical violence and abuse accidents which lead to permanent disabilities.

The child labour module asks a series of questions to the mother/caretaker of each child in the household 5-14 years of age about the kind of work a child does and for how many hours. Data is also collected on economic activities and domestic work. Economic activities include paid or unpaid work for someone who is not a member of the household and work for a family farm or business. Domestic work includes household chores like collecting firewood, fetching water, cooking, cleaning, looking after animals/livestock, or caring for children.

Child labour is defined as work that exceeds a minimum number of hours, depending on the age of a child and on the type of work. For ages 5-11, children are considered to be involved in child labour if during the week preceding the survey did at least one hour of economic activity or at least 28 hours of domestic chores. For ages 12-14, this involves at least 14 hours of economic activity or at least 28 hours of domestic chores.

In Iraq, the MICS-3 survey estimates that about 1 in 9 children aged 5-14 years work (11 percent) (Table 20). A higher percentage of children work in the rural areas (18 percent) compared to the urban areas (6 percent). Boys (12 percent) work more than girls (9 percent). Child labour rates are slightly higher among the age group 12-14 (12 percent) when compared to the younger age group 5-11 years (10 percent). The results also show that

children who work are less likely to participate in schools – 10 percent participate in school and 14 percent do not.

Table 20 also shows that only one percent of children 5-14 years engage in paid work. Two percent of these children participate in unpaid work for someone other than a household member, an equal percentage of children do household chores for 28 hours or more per week, while a higher percentage of children work for family business (7 percent). Involvement of Iraqi children decreases as mother's education increases (Figure 7).

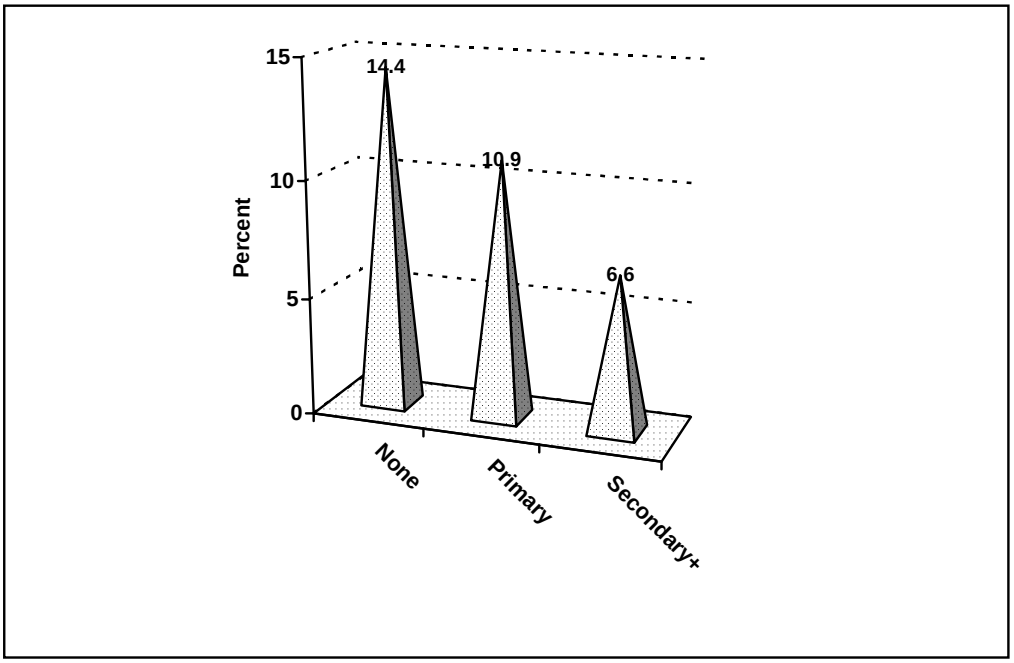

Figure 7: Percentage of children aged 5-14 years who are involved in child labour activities by mother's education, Iraq, 2006

EARLY MARRIAGE

Child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty. Women married at younger ages are more likely to dropout of school, experience higher levels of fertility, domestic violence and maternal mortality.

The percentage of women married at various ages is provided in Table 21. About one in five young women aged 15-19 years is currently married (19 percent). This proportion does not vary much between urban (19 percent) and rural areas (20 percent), but is strongly related to the mother's education.

Five percent of women aged 15-49 years were married before age 15 while 23 percent of women aged 20-49 years were married before age 18. Examining the age pattern for women aged 20-49 years, it is clear that the prevalence of early marriage age has declined over time; for example, 34 percent of women age 45-49 were married before their 18th birthday compared to 17 percent of women age 20-24.

KNOWLEDGE OF HIV/AIDS TRANSMISSION

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step toward raising awareness and giving young people the tools to protect them from infection. Misconceptions about HIV are common and can confuse young people and hinder prevention efforts. Different regions are likely to have variations in misconceptions although some appear to be universal. The survey results showed that the most common misconceptions in the country are (1) sharing food can transmit HIV and (2) people can get the aids virus from mosquito bites.

Table 22 presents the percentage of women 15-49 years who know 2 ways of preventing HIV transmission. Knowledge of HIV prevention methods is very low although there are large differences by area of residence. Overall, only 1 in 8 women report knowing two prevention methods (13 percent). In urban areas 17 percent of women identified two methods compared to only six percent in rural areas. Knowledge of HIV prevention methods is more in metropolitan areas (18 percent) than other urban areas (14 percent). As expected, the percentage of women who know two prevention methods significantly increases with women's education level.

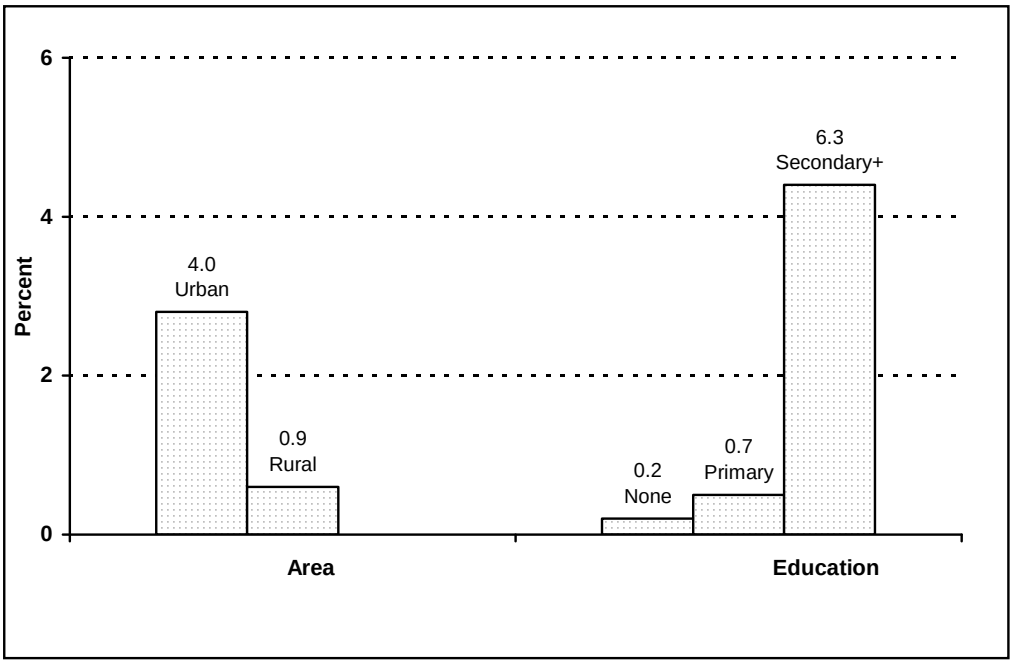

Figure 8: Percentage of women aged 15-24 years who have comprehensive knowledge of HIV/AIDS transmission, Iraq, 2006

A key indicator used to measure countries' responses to the HIV epidemic is the proportion of young women 15-24 years who have comprehensive knowledge of HIV i.e. know two methods of preventing HIV, reject two common misconceptions and know that a healthy looking person can have HIV. Table 23 presents the percentage of women who have comprehensive knowledge of HIV for the age group 15-24 years. Only two percent of young women have comprehensive correct knowledge of HIV. Area of residence is highly associated with comprehensive knowledge of HIV among women of this age group, with greater knowledge for urban women (3 percent) compared to rural women (less than one percent) (Figure 8). Level of education is also positively associated with comprehensive

knowledge with a four percent comprehensive knowledge of HIV for women with secondary or higher education compared to less than one percent for women with primary or no education.

ORPHANS SCHOOL ATTENDANCE

Due to the increase of violence and displacement in Iraq, more and more children are becoming orphaned. Children who are orphaned or living away from their parents may be at increased risk of neglect or exploitation if their parents are not available to assist and protect them. Monitoring the variations in educational outcomes for children who have lost both parents (double orphans) versus children whose parents are alive (and who live with at least one of these parents) is one way to ensure that children's rights are being met even after their parents have died or are no longer able to care for them.

In Iraq, about eight percent of children aged 10-14 are orphans who have lost one parent (Table 24). The percentage of orphans is greater in urban areas (8 percent) than in rural areas (7 percent). One percent of children aged 10-14 have lost both parents. Among those only 64 percent are currently attending school. Among the children aged 10-14 who have not lost a parent and who live with at least one parent, 76 percent are attending school. This would suggest that the double orphans have a disadvantage to the non-orphaned children with a ratio of orphans to non-orphans school attendance ratio of 0.84.

Table 1: Results of household and individual interviews

Number of households, women, and children under 5 by results of the household, women's and under-five's interviews, and household, women's and under-five's response rates, Iraq, 2006

	Residence				
		Urban			
	Urban	Metropolitan	Other Urban	Rural	Total
Number of households					
Sampled	12312	6480	5832	5832	18144
Occupied	12300	6472	5828	5823	18123
Interviewed	12113	6356	5757	5760	17873
Response rate	98.5	98.2	98.8	98.9	98.6
Number of women					
Eligible	18626	9840	8786	8938	27564
Interviewed	18381	9709	8672	8805	27186
Response rate	98.7	98.7	98.7	98.5	98.6
Overall response rate	97.2	96.9	97.5	97.4	97.3
Number of children under 5					
Eligible	10203	5132	5071	6367	16570
Mother/Caretaker interviewed	10131	5097	5034	6338	16469
Response rate	99.3	99.3	99.3	99.5	99.4
Overall response rate	97.8	97.5	98.1	98.5	98.0

Table 2: Child mortality

Infant and under-five mortality rates for the 5 year period preceding the survey, Iraq, 2006

	Under-five mortality rate (per thousand)*	Infant mortality rate (per thousand)**
Sex		
Male	44	37
Female	37	32
Residence		
Urban	41	34
Metropolitan	37	31
Other urban	46	38
Rural	41	34
Mother's education		
None	49	42
Primary	40	32
Secondary +	37	33
Total	41	34

*** MICS indicator 1; MDG indicator 13**

**** MICS indicator 2; MDG indicator 14**

Table 3: Child malnourishment

Percentage of children aged 0-59 months who are severely or moderately malnourished, Iraq 2006

	Weight for age		Height for age		Weight for height			Number of children aged 0-59 months
	% below - 2 SD*	% below - 3 SD*	% below - 2 SD**	% below - 3 SD**	% below - 2 SD***	% below - 3 SD***	% above + 2 SD	
Sex								
Male	7.9	1.4	22.1	8.0	5.4	1.2	8.5	7782
Female	7.3	1.4	20.6	7.0	4.1	1.2	10.3	7533
Residence								
Urban	7.1	1.2	19.4	6.4	4.8	1.1	8.5	9216
Metropolitan	6.0	.9	17.3	5.4	4.1	1.0	7.6	5306
Other urban	8.6	1.5	22.3	7.8	5.7	1.3	9.7	3911
Rural	8.4	1.8	24.4	9.2	4.8	1.3	10.7	6100
Age								
< 6 months	4.1	.5	13.6	3.6	6.3	1.6	17.1	1330
6-11 months	8.4	2.1	15.3	5.2	6.2	1.6	11.6	1633
12-23 months	9.1	2.0	26.0	10.1	5.3	1.7	10.3	3255
24-35 months	7.7	1.6	22.1	8.1	4.7	1.0	7.4	3090
36-47 months	7.7	1.2	22.4	7.7	3.9	.7	8.2	3056
48-59 months	6.8	.8	21.4	6.8	3.8	1.0	7.0	2952
Mother's education §								
None	9.4	1.8	24.0	8.9	5.3	1.3	8.6	2975
Primary	7.7	1.4	22.3	7.4	4.7	1.3	9.7	7446
Secondary +	6.2	1.2	18.0	6.8	4.6	1.0	9.5	4776
Non-standard curriculum	15.0	2.7	28.9	6.4	6.6	2.0	7.1	117
Total	7.6	1.4	21.4	7.5	4.8	1.2	9.4	15316

*** MICS indicator 6; MDG indicator 4**

**** MICS indicator 7**

***** MICS indicator 8**

§ 2 un-weighted cases with "missing/ don't know mother's education" not shown

Table 4: Breastfeeding

Percentage of living children according to breastfeeding status at each age group, Iraq, 2006

	Children 0-3 months		Children 0-5 months		Children 6-9 months		Children 12-15 months		Children 20-23 months	
	Percent exclusively breastfed	Number of children	Percent exclusively breastfed*	Number of children	Percent receiving breast milk and solid/ mushy food**	Number of children	Percent breastfed***	Number of children	Percent breastfed***	Number of children
Sex										
Male	30.8	556	23.5	808	49.3	557	68.3	682	36.2	586
Female	37.3	523	26.7	820	52.6	614	66.8	597	35.2	536
Residence										
Urban	32.5	664	23.7	1028	51.1	723	63.7	733	36.0	669
Metropolitan	33.8	407	25.5	608	49.4	427	59.4	393	34.7	399
Other urban	30.3	257	21.2	420	53.5	296	68.6	340	38.0	270
Rural	36.3	415	27.4	600	50.9	448	72.9	545	35.2	453
Mother's education §										
None	36.1	183	25.4	289	47.0	190	65.1	259	43.6	208
Primary	34.2	563	25.2	853	53.3	582	69.1	625	32.8	549
Secondary +	32.1	329	24.3	481	49.4	394	66.5	389	35.7	361
Total	33.9	1080	25.1	1628	51.0	1171	67.6	1278	35.7	1122

*** MICS indicator 15**

**** MICS indicator 17**

***** MICS indicator 16**

§ 5-8 un-weighted cases with "non-standard curriculum" not shown

Table 5: Vaccinations in first year of life

Percentage of children aged 12-23 months immunized against childhood diseases at any time before the survey and before the first birthday, Iraq, 2006

	Percentage of children who received:											
		DPT			Polio							
	BCG *	1	2	3 **	0	1	2	3 ***	Measles ****	All	None *****	Number of children aged 12-23 months
Vaccinated at any time before the survey												
According to:												
Vaccination card	60.0	54.6	47.4	40.9	60.0	54.9	47.2	40.6	38.2	36.6	0.2	3560
Mother's report	31.1	27.9	25.8	18.8	23.8	33.2	30.9	22.3	21.8	9.3	5.4	3560
Either	91.1	82.6	73.2	59.7	83.7	88.1	78.1	62.9	60.0	45.8	5.7	3560
Vaccinated by 12 months of age	90.6	81.0	70.9	54.9	83.3	86.4	75.7	58.0	54.0	35.4	5.7	3560

*** MICS indicator 25**
**** MICS indicator 27**
***** MICS indicator 26**
****** MICS indicator 28; MDG indicator 15**

******* MICS indicator 31**

Table 6: Vaccinations under Polio national campaign

Percentage of children who were exposed to Polio campaign rounds and were vaccinated against Polio during vaccination campaign, South/Centre Iraq and Kurdistan Region, 2006

	Polio campaign round in June	Polio campaign round in July	Both polio campaign rounds	Number of children	Polio campaign round in June	Polio campaign round in July	Both polio campaign rounds	Number of children
	children age 7-59 months, South/Centre Iraq				children age 11-59 months, Kurdistan Region			
Residence								
Urban	86.1	86.8	84.7	7427	87.1	85.3	84.1	1135
Metropolitan	87.5	88.1	86.0	4418	86.6	83.1	82.7	485
Urban-other	84.1	84.8	82.7	3010	87.4	87.0	85.2	650
Rural	85.1	85.0	83.4	5444	85.8	86.5	84.7	424
Mother's education §§								
None	83.7	83.1	81.2	2215	83.7	83.9	83.1	665
Primary	85.9	86.6	84.6	6366	87.4	84.7	82.9	629
Secondary +	86.2	86.4	84.8	4189	92.8	91.9	90.3	252
Non-standard curriculum	97.8	97.8	97.8	99	§	§	§	14
Age								
7-11 months	47.3	58.5	45.6	1336	NA	NA	NA	NA
12-23 months	83.9	82.7	81.3	3146	76.2*	75.6*	72.2*	462*
24-35 months	91.2	90.4	90.0	2841	90.6	89.9	88.9	373
36-47 months	92.5	91.7	91.4	2808	91.8	89.8	89.7	374
48-59 months	93.9	92.9	92.8	2740	91.0	89.9	89.5	351
Total	85.7	86.0	84.1	12872	86.7	85.6	84.3	1560

* Age group 11-23 months

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

§§ 2 un-weighted cases of children in South/Centre Iraq with "missing/ don't know mother's education" not shown

Table 7: Vaccinations under MMR (Measles- Mumps-Rubella) national campaign

Percentage of children who were exposed to MMR campaign and were vaccinated against MMR during vaccination campaign, South/Centre Iraq and Kurdistan Region, 2006

	MMR	Number of children exposed to MMR campaign		MMR	Number of children exposed to MMR campaign
South/Centre Iraq			**Kurdistan Region**		
Residence			**Residence**		
Urban	67.8	5222	Urban	69.8	824
Metropolitan	67.0	3111	Metropolitan	67.3	351
Other urban	69.1	2110	Urban-other	71.7	473
Rural	67.2	3862	Rural	58.5	306
Mother's education §§			**Mother's education**		
None	64.3	1591	None	65.2	483
Primary	66.9	4472	Primary	67.7	447
Secondary +	69.9	2937	Secondary +	68.2	188
Non-standard curriculum	81.8	82	Non-standard curriculum	§	12
Age cohorts			**Age cohorts**		
2/2001 - 1/2002	74.3	2416	6/2001 - 5/2002	73.5	345
2/2002 - 1/2003	71.1	2790	6/2002 - 5/2003	66.9	379
2/2003 - 1/2004	65.3	2841	6/2003 - 6/2004	60.9	407
2/2004 - 5/2004	48.6	1037			
Total	67.6	9084	**Total**	66.7	1131

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

§§ 2 un-weighted cases of children in South/Centre Iraq with "missing/ don't know mother's education" not shown

Table 8: Oral rehydration therapy

Percentage of children aged 0-59 months with diarrhoea in the last two weeks and treatment with oral rehydration solution (ORS) or other oral treatments, Iraq, 2006

	Had diarrhoea in last two weeks	Number of children aged 0-59 months	Children with diarrhoea who received: Fluid from ORS packet	Drinking water	Rice water	Vegetable soup	Yogurt drink	Fruit juice	No treatment	ORT Use Rate *	Number of children aged 0-59 months with diarrhoea
Sex											
Male	13.7	8359	30.1	84.7	35.4	29.5	45.8	43.0	6.3	30.1	1146
Female	12.3	8110	31.4	83.4	34.4	29.0	47.4	40.8	7.1	31.4	996
Residence											
Urban	13.3	9865	29.8	86.1	33.6	28.2	42.3	45.5	7.7	29.8	1315
Metropolitan	13.2	5661	25.5	86.8	28.9	28.8	42.9	48.6	7.2	25.5	748
Other urban	13.5	4204	35.6	85.0	39.9	27.5	41.5	41.4	8.5	35.6	567
Rural	12.5	6604	32.0	80.9	37.0	30.8	53.4	36.3	5.0	32.0	827
Age											
< 6 months	14.8	1628	25.5	67.9	17.0	5.3	8.8	17.9	20.3	25.5	241
6-11 months	20.2	1794	37.4	85.0	42.0	31.4	40.1	34.8	6.1	37.4	363
12-23 months	16.9	3560	32.4	87.1	37.3	35.7	52.0	47.2	4.5	32.4	601
24-35 months	12.4	3214	32.1	86.0	33.9	29.9	61.1	44.4	3.9	32.1	398
36-47 months	10.0	3182	25.3	82.1	35.6	28.6	48.7	47.6	7.5	25.3	317
48-59 months	7.2	3092	26.1	91.6	37.5	34.2	54.2	53.3	2.4	26.1	223
Mother's education §§											
None	15.2	3245	28.9	78.7	35.5	26.6	50.9	31.3	9.8	28.9	492
Primary	13.6	8051	33.0	83.9	32.3	27.6	46.1	41.3	5.8	33.0	1091
Secondary +	10.9	5051	27.5	89.2	39.7	34.9	43.9	52.8	5.5	27.5	550
Non-standard curriculum	7.5	120	§	§	§	§	§	§	§	§	9
Total	13.0	16469	30.7	84.1	34.9	29.3	46.6	42.0	6.7	30.7	2142

*** MICS indicator 33**

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

§§ 2 un-weighted cases of children 0-59 months with "missing/ don't know mother's education" not shown

Table 9: Home management of diarrhoea

Percentage of children aged 0-59 months with diarrhoea in the last two weeks who took increased fluids and continued to feed during the episode, Iraq, 2006

			Children with diarrhoea who:						
	Had diarrhoea in last two weeks	Number of children aged 0-59 months	Drank more	Drank the same or less	Ate somewhat less, same or more	Ate much less or none	Home manage-ment of diarrhoea*	Received ORT or increased fluids AND continued feeding**	Number of children aged 0-59 months with diarrhoea
Sex									
Male	13.7	8359	21.4	77.6	68.8	30.1	14.8	66.0	1146
Female	12.3	8110	23.8	74.8	64.6	34.3	15.8	61.4	996
Residence									
Urban	13.3	9865	22.2	76.4	65.7	33.0	15.1	62.0	1315
Metropolitan	13.2	5661	24.3	74.9	61.0	38.0	15.6	56.8	748
Other urban	13.5	4204	19.5	78.4	72.0	26.5	14.5	68.9	567
Rural	12.5	6604	23.0	76.0	68.6	30.5	15.6	66.8	827
Age									
0-11 months	17.6	3422	17.9	81.0	59.6	38.6	11.3	53.5	603
12-23 months	16.9	3560	28.2	71.0	62.9	36.7	17.0	61.8	601
24-35 months	12.4	3214	20.5	78.7	76.4	23.2	17.1	74.7	398
36-47 months	10.0	3182	24.3	73.7	72.8	25.6	18.4	68.5	317
48-59 months	7.2	3092	20.5	77.1	71.4	26.7	13.9	71.1	223
Mother's education §§									
None	15.2	3245	28.7	69.8	71.2	26.9	19.0	66.4	492
Primary	13.6	8051	21.0	77.8	68.5	30.4	15.4	66.1	1091
Secondary +	10.9	5051	20.0	79.2	59.6	39.9	11.8	56.9	550
Non-standard curriculum	7.5	120	§	§	§	§	§	§	9
Total	13.0	16469	22.5	76.3	66.8	32.0	15.3	63.8	2142

*** MICS indicator 34**

**** MICS indicator 35**

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

§§ 2 un-weighted cases of children 0-59 months with "missing/ don't know mother's education" not shown

Table 10: Antibiotic therapy of suspected pneumonia

Percentage of children aged 0-59 months with suspected pneumonia who received antibiotic treatment, Iraq, 2006

	Had suspected pneumonia in the last two weeks	Number of children aged 0-59 months	Percentage of children aged 0-59 months with suspected pneumonia who received antibiotics in the last two weeks*	Number of children aged 0-59 months with suspected pneumonia in the two weeks prior to the survey
Sex				
Male	14.4	8359	80.9	1206
Female	12.4	8110	83.2	1006
Residence				
Urban	13.5	6604	84.5	1323
Metropolitan	14.5	5661	83.3	822
Other urban	11.9	4204	86.6	501
Rural	13.5	6604	78.2	890
Age				
0-11 months	15.5	3422	83.0	530
12-23 months	16.0	3560	81.1	570
24-35 months	13.2	3214	84.2	423
36-47 months	12.5	3182	81.8	399
48-59 months	9.4	3092	78.9	291
Mother's education §§				
None	12.0	3245	75.9	389
Primary	13.8	8051	83.2	1114
Secondary +	13.7	5051	83.7	694
Non-standard curriculum	12.6	120	§	15
Total	13.4	16469	82.0	2213

*** MICS indicator 22**

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

§§ 2 un-weighted cases of children 0-59 months with "missing/ don't know mother's education" not shown

Table 11: Solid fuel use

Percent distribution of households according to type of cooking fuel, and percentage of households using solid fuels for cooking, Iraq, 2006

	Percentage of households using:										
	Electricity	Liquefied Petroleum Gas (LPG)	Kerosene	Coal, lignite	Wood	Straw, shrubs, grass	Animal dung /Agricultural crop residue	Other source	Total	Solid fuels for cooking*	Number of households
Residence											
Urban	0.2	92.2	7.0	0.0	0.3	0.2	0.0	0.0	100.0	0.6	12048
Metropolitan	0.3	93.0	6.6	0.0	0.1	0.1	0.0	0.0	100.0	0.2	7284
Other urban	0.2	90.9	7.7	0.0	0.7	0.5	0.0	0.0	100.0	1.2	4764
Rural	0.2	74.1	12.8	0.3	5.9	4.6	2.1	0.1	100.0	12.9	5825
Education of household head §											
None	0.2	79.0	11.5	0.2	4.6	3.0	1.4	0.0	100.0	9.3	4161
Primary	0.1	83.7	10.9	0.1	2.3	2.0	0.8	0.0	100.0	5.2	5503
Secondary +	0.3	91.7	6.2	0.0	0.8	0.8	0.3	0.0	100.0	1.8	8205
Total	0.2	86.3	8.9	0.1	2.1	1.7	0.7	0.0	100.0	4.6	17873

*** MICS indicator 24; MDG Indicator 29**

§ 5 un-weighted cases with "missing/ don't know household head education" not shown

Table 12: Use of improved water sources

Percent distribution of household population according to main source of drinking water and percentage of household population using improved drinking water sources, Iraq, 2006

	Main source of drinking water																	
	Improved sources								Unimproved sources									
	Piped into dwelling	Piped into yard/ plot	Public tap/ stand-pipe	Tube-well/ bore-hole	Pro-tected well	Pro-tected spring	Rain-water	Bottled water[1]	Unpro-tected well	Unpro-tected spring	Tanker truck	Cart with tank/ drum	Surface water	Bottled water[1]	Other	Total	Improved source of drinking water*	Number of household members
Residence																		
Urban	83.2	6.6	0.2	0.3	0.5	0.0	0.0	1.1	0.0	0.0	0.4	0.1	0.1	0.1	7.4	100	91.9	71765
Metropolitan	86.7	3.6	0.1	0.1	0.1	0.0	0.0	1.6	0.0	0.0	0.1	0.1	0.1	0.1	7.5	100	92.2	41881
Other urban	78.3	10.9	0.3	0.5	0.9	0.0	0.1	0.4	0.1	0.1	0.9	0.1	0.2	0.1	7.2	100	91.5	29884
Rural	33.8	13.1	3.1	1.0	4.1	0.4	1.4	0.2	1.2	1.0	11.7	2.6	19.9	0.1	6.3	100	57.0	41091
Education of household head																		
None	55.4	12.7	1.8	0.9	2.1	0.3	0.8	0.1	1.0	1.0	6.9	1.6	11.0	0.0	4.4	100	74.0	27404
Primary	62.9	10.1	1.4	0.6	2.4	0.1	0.6	0.5	0.5	0.3	4.9	1.2	7.6	0.0	6.8	100	78.5	35262
Secondary +	72.3	6.2	0.9	0.3	1.1	0.1	0.4	1.3	0.2	0.1	2.9	0.5	5.1	0.1	8.5	100	82.5	50166
Missing/Don't know	(44.3)	(13.9)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(10.5)	(0.0)	(0.0)	(31.2)	(0.0)	(0.0)	(0.0)	(100.0)	(58.3)	24
Total	65.2	9.0	1.2	0.5	1.8	0.2	0.5	0.8	0.5	0.4	4.5	1.0	7.3	0.1	7.0[2]	100	79.2[3]	112856

*** MICS indicator 11; MDG indicator 30**

[1] For households using bottled water as the main source of drinking water, the source used for other purposes such as cooking and hand washing is used to determine whether to classify the source as improved.

[2] More than 90% of the cases in the category "other" corresponds to "Reverse osmosis" category in Basra governorate

Figures in parentheses are based on 25-49 un-weighted cases

[3] All figures do not reflect the condition and reliability of the sources. Nearly half (48%) of the survey respondents with access to improved sources of drinking water reported problems with services at least once a week

.

Table 13: Use of sanitary means of excreta disposal

Percent distribution of household population according to type of toilet facility used by the household, and the percentage of household population using sanitary means of excreta disposal, Iraq, 2006

	Type of toilet facility used by household											Percentage of population using sanitary means of excreta disposal*	Number of household members
	Improved sanitation facility						Unimproved sanitation facility						
	Flush/pour flush to:												
	Piped sewer system	Septic tank	Pit latrine	Ventilated improved pit latrine	Pit latrine with slab	Compos-ting toilet	Flush/ pour flush to some-where else	Pit latrine without slab/ open pit	No facilities / bush / field	Other	Total		
Residence													
Urban	34.6	47.1	13.8	1.3	1.4	0.1	1.3	0.2	0.0	0.2	100.0	98.2	71765
Metropolitan	47.5	39.9	10.9	0.2	0.3	0.0	1.0	0.1	0.0	0.1	100.0	98.7	41881
Other urban	16.5	57.3	17.9	2.8	2.9	0.1	1.8	0.3	0.0	0.4	100.0	97.5	29884
Rural	1.9	35.1	36.1	2.8	5.7	0.2	5.1	6.0	6.9	0.2	100.0	81.9	41091
Education of household head													
None	16.2	35.4	28.9	2.2	4.0	0.1	4.0	3.2	5.7	0.4	100.0	86.7	27404
Primary	21.5	41.7	24.2	1.2	2.7	0.2	2.8	2.8	2.5	0.2	100.0	91.7	35262
Secondary +	27.1	47.5	16.5	2.1	2.5	0.1	1.9	1.4	0.8	0.2	100.0	95.7	50166
Missing/Don't know	(0.0)	(0.0)	(67.8)	(0.0)	(21.6)	(0.0)	(0.0)	(0.0)	(0.0)	(10.5)	(100.0)	89.5	24
Total	22.7	42.8	21.9	1.8	2.9	0.1	2.7	2.3	2.5	0.2	100.0	92.3	112856

*** MICS indicator 12; MDG indicator 31**

Figures in parentheses are based on 25-49 un-weighted cases

Table 14: Use of contraception

Percentage of women aged 15-49 years currently married who are using (or whose husband is using) a contraceptive method, Iraq, 2006

		Percent of currently married women who are using:														Number of women currently married
	Not using any method	Female sterili-zation	Male sterili-zation	Pill	IUD	Injections	Condom	Diaph-ragm/ foam/ jelly	LAM	Periodic abstin-ence	With-drawal	Other	Any modern method	Any tradi-tional method	Any method*	
Residence																
Urban	46.8	2.9	0.0	15.7	13.3	2.2	1.5	0.3	5.6	2.3	9.0	0.5	35.9	17.4	53.2	10369
Metropolitan	45.2	2.7	0.0	15.5	14.2	2.6	2.0	0.3	4.9	2.1	10.0	0.4	37.3	17.4	54.8	6121
Other urban	49.0	3.1	0.0	16.0	12.0	1.5	0.8	0.3	6.7	2.5	7.6	0.5	33.7	17.3	51.0	4248
Rural	56.5	2.1	0.0	12.4	10.3	1.8	0.4	0.1	9.6	1.7	4.6	0.4	27.2	16.3	43.5	5506
Age																
15-19	79.5	0.1	0.1	6.2	2.3	0.7	0.7	0.0	8.3	0.4	1.8	0.1	10.0	10.6	20.5	1214
20-24	64.5	0.1	0.0	11.5	6.4	1.3	1.0	0.1	9.0	0.9	5.1	0.0	20.5	15.0	35.5	2620
25-29	51.4	0.3	0.0	16.1	11.0	2.1	1.0	0.3	9.2	1.9	6.8	0.0	30.8	17.9	48.6	3092
30-34	43.4	1.1	0.0	16.9	15.4	2.7	1.5	0.3	8.1	1.6	8.5	0.4	38.0	18.6	56.6	3032
35-39	39.1	3.6	0.0	17.9	16.8	3.2	1.0	0.3	6.1	2.8	8.7	0.6	42.8	18.1	60.9	2584
40-44	35.6	8.7	0.1	15.6	17.6	2.3	1.1	0.5	3.7	3.8	9.5	1.5	45.9	18.5	64.4	2053
45-49	51.6	7.5	0.1	11.0	11.6	0.5	1.0	0.2	0.6	3.9	11.3	0.8	31.8	16.5	48.4	1280
Number of living children																
0	98.9	0.1	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0	0.6	0.5	1.1	2081
1	66.0	0.2	0.1	9.8	2.8	1.2	1.7	0.3	10.6	1.1	6.1	0.1	16.1	17.9	34.0	2366
2	46.4	0.1	0.0	16.1	13.9	2.0	1.6	0.2	9.0	1.6	8.8	0.3	33.9	19.7	53.6	2212
3	39.2	1.0	0.0	19.1	15.3	2.3	1.1	0.2	8.4	2.8	10.3	0.2	39.0	21.8	60.8	2047
4+	35.0	5.3	0.1	18.4	17.5	2.9	1.1	0.3	6.8	3.0	8.8	0.8	45.7	19.3	65.0	7170
Education §																
None	55.2	3.8	0.1	11.9	10.9	1.8	0.4	0.2	7.1	2.2	5.8	0.6	29.1	15.7	44.8	3199
Primary	51.9	2.4	0.0	13.5	11.1	2.4	0.8	0.2	8.5	1.9	7.0	0.4	30.3	17.8	48.1	7168
Secondary +	44.7	2.1	0.0	17.6	14.7	1.8	2.0	0.4	4.9	2.3	9.2	0.3	38.6	16.7	55.3	5354
Non-standard curriculum	53.6	4.5	0.0	13.1	7.8	2.0	0.0	0.0	8.3	2.6	6.1	2.0	27.4	19.0	46.4	153
Total	50.2	2.6	0.0	14.6	12.2	2.0	1.1	0.2	7.0	2.1	7.5	0.5	32.9	17.0	49.8	15875

*** MICS indicator 21; MDG indicator 19C**

§ 1 un-weighted case with "missing/ don't know education" not shown

Table 15: Assistance during delivery

Percent distribution of women aged 15-49 with a birth in two years preceding the survey by type of personnel assisting at delivery, Iraq, 2006

	Person assisting at delivery											
	Doctor: gover. or private	Nurse	Midwife: certified	Midwife: not certified	Traditional birth attendant: Gida	Relative/Friend	Other/missing	No attendant	Total	Any skilled personnel*	Delivered in health facility**	Number of women who gave birth in preceding two years
Region												
Urban	59.8	8.9	26.4	2.2	2.3	0.4	0.1	0.0	100.0	95.0	67.9	4042
Metropolitan	63.7	7.6	25.1	1.3	2.0	0.3	0.1	0.0	100.0	96.4	70.9	2335
Other urban	54.4	10.7	28.1	3.4	2.8	0.5	0.0	0.1	100.0	93.2	63.8	1707
Rural	46.0	9.1	23.0	8.7	10.6	2.0	0.4	0.2	100.0	78.1	54.1	2510
Age												
15-19	60.8	9.8	20.5	2.6	6.0	0.1	0.1	0.0	100.0	91.1	70.3	578
20-24	54.8	10.4	24.1	4.0	5.9	0.7	0.2	0.0	100.0	89.3	64.1	1623
25-29	54.0	9.7	25.1	4.9	5.0	1.2	0.2	0.0	100.0	88.8	63.0	1745
30-34	52.4	8.2	26.8	5.1	5.8	1.5	0.1	0.1	100.0	87.4	59.7	1376
35-39	54.0	6.0	28.0	5.6	5.5	0.4	0.3	0.2	100.0	88.0	58.9	848
40-44	55.7	6.7	23.1	6.2	4.5	2.6	0.5	0.6	100.0	85.5	61.5	344
45-49	49.2	15.1	24.8	3.8	7.1	0.0	0.0	0.0	100.0	89.1	63.4	37
Education												
None	45.2	8.5	25.3	7.7	11.0	2.0	0.2	0.2	100.0	78.9	52.0	1194
Primary	53.0	8.6	25.6	5.5	6.1	0.9	0.2	0.1	100.0	87.1	60.8	3229
Secondary +	62.2	9.9	24.2	1.6	1.5	0.5	0.1	0.0	100.0	96.3	71.5	2103
Non-standard curriculum	(49.1)	(3.8)	(27.8)	(10.3)	(9.0)	(0.0)	(0.0)	(0.0)	(100.0)	(80.7)	(52.8)	25
Total	54.5	9.0	25.1	4.7	5.5	1.0	0.2	0.1	100.0	88.5	62.6	6551

*** MICS indicator 4; MDG indicator 17**

**** MICS indicator 5**

* Skilled health personnel includes doctors, nurses, and certified midwives

Figures in parentheses are based on 25-49 un-weighted cases

Table 16: Primary school net attendance ratio

Percentage of children of primary school age 6-11 years attending primary or secondary school (NAR), Iraq, 2006

	Male		Female		Total	
	Net attendance ratio	Number of children	Net attendance ratio	Number of children	Net attendance ratio*	Number of children
Residence						
Urban	90.3	5382	86.9	5052	88.6	10433
Metropolitan	90.5	3033	87.7	2782	89.2	5816
Other Urban	89.9	2348	85.8	2270	87.9	4618
Rural	82.5	3816	68.2	3688	75.5	7505
Age						
6	64.5	1625	62.6	1549	63.6	3174
7	89.2	1569	83.4	1462	86.4	3031
8	92.8	1504	86.0	1447	89.5	2951
9	93.7	1538	85.2	1402	89.7	2940
10	92.8	1462	82.2	1442	87.6	2904
11	90.8	1501	75.8	1439	83.4	2940
Mother's education §						
None	79.4	2473	65.0	2487	72.2	4960
Primary	87.4	3949	80.4	3702	84.0	7651
Secondary +	93.3	2775	90.5	2550	92.0	5325
Total	87.0	9198	79.0	8740	83.1	17938

*** MICS indicator 55; MDG indicator 6**

§ 4 un-weighted cases with "missing/ don't know mother's education" not shown

Table 17: Education gender parity

Ratio of girls to boys attending primary education and ratio of girls to boys attending secondary education, Iraq, 2006

	Primary school net attendance ratio (NAR), girls	Primary school net attendance ratio (NAR), boys	Gender parity index (GPI) for primary school NAR*	Secondary school net attendance ratio (NAR), girls	Secondary school net attendance ratio (NAR), boys	Gender parity index (GPI) for secondary school NAR*
Residence						
Urban	86.9	90.3	0.96	44.8	49.6	0.90
Metropolitan	87.7	90.5	0.97	45.8	51.0	0.90
Other Urban	85.8	89.9	0.95	43.3	47.6	0.91
Rural	68.2	82.5	0.83	13.6	30.7	0.44
Mother's education						
None	65.0	79.4	0.82	21.6	30.1	0.72
Primary	80.4	87.4	0.92	31.9	38.9	0.82
Secondary +	90.5	93.3	0.97	62.6	65.7	0.95
Total	79.0	87.0	0.91	33.5	42.5	0.79

*** MICS indicator 61; MDG indicator 9**

Table 18: Primary school completion and transition to secondary education

Primary school completion rate and transition rate to secondary education, Iraq, 2006

	Net primary school completion rate*	Gross primary school completion rate	Number of children of primary school completion age	Transition rate to secondary education**	Number of children who were in the last grade of primary school the previous year
Sex					
Male	29.6	89.5	1501	75.7	957
Female	30.3	68.0	1439	81.9	694
Residence					
Urban	36.0	88.2	1750	81.5	1191
Metropolitan	36.6	89.6	962	84.5	667
Other Urban	35.3	86.5	788	77.8	524
Rural	21.0	65.3	1190	70.0	459
Mother's education					
None	15.8	68.1	907	74.7	470
Primary	25.2	73.9	1204	76.2	553
Secondary +	52.1	94.0	829	84.5	588
Mother not in household	-	-	-	§	9
Missing/DK	§	§	1	-	-
Total	29.9	78.9	2940	78.3	1651

*** MICS indicator 59; MDG indicator 7b**

**** MICS indicator 58**

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

Table 19: Birth registration

Percent distribution of children aged 0-59 months by whether birth is registered , Iraq, 2006

	Birth is registered*	Number of children aged 0-59 months
Sex		
Male	95.2	8359
Female	94.9	8110
Residence		
Urban	94.7	9865
Metropolitan	93.2	5661
Other urban	96.6	4204
Rural	95.6	6604
Age		
0-11 months	88.5	3422
12-23 months	95.2	3560
24-35 months	95.7	3214
36-47 months	97.3	3182
48-59 months	98.9	3092
Mother's education §		
None	94.8	3245
Primary	94.7	8051
Secondary +	95.6	5051
Non-standard curriculum	95.8	120
Total	95.0	16469

*** MICS indicator 62**

§ 2 un-weighted cases with "missing/ don't know mother's education" not shown

Table 20: Child labour

Percentage of children aged 5-14 years who are involved in child labour activities by type of work, Iraq, 2006

	Working outside household		Household chores for 28+ hours/ week	Working for family business	Total child labour*	Number of children aged 5-14 years
	Paid work	Unpaid work				
Sex						
Male	1.6	2.1	1.0	8.4	12.1	15180
Female	0.1	1.4	2.7	5.9	9.2	14629
Residence						
Urban	0.9	1.6	0.8	2.5	5.5	17594
Metropolitan	1.1	1.8	0.8	2.2	5.7	9881
Other urban	0.7	1.3	0.7	2.8	5.3	7713
Rural	0.8	2.0	3.4	13.9	18.1	12214
Age						
5-11 years	0.5	2.2	0.9	7.6	10.3	21458
12-14 years	1.8	0.6	4.2	5.9	11.7	8350
School participation						
Yes	0.5	1.9	1.0	6.8	9.5	20739
No	1.8	1.5	3.7	8.1	13.5	9069
Mother's education §						
None	1.1	1.4	3.0	10.5	14.4	8750
Primary	1.0	1.9	1.8	7.1	10.9	12398
Secondary +	0.5	1.9	0.7	3.9	6.6	8658
Total	0.9	1.8	1.8	7.2	10.7	29808

*** MICS indicator 71**

§ 4 un-weighted cases with "missing/ don't know mother's education" not shown

Table 21: Early marriage

Percentage of women aged 15-49 years in marriage before their 15th birthday, percentage of women aged 20-49 years in marriage before their 18th birthday, percentage of women aged 15-19 years currently married, Iraq, 2006

	Percentage married before age 15*	Number of women aged 15-49 years	Percentage married before age 18*	Number of women aged 20-49 years	Percentage of women 15-19 married**	Number of women aged 15-19 years
Residence						
Urban	5.1	18028	21.5	13790	18.7	4239
Metropolitan	4.9	10677	20.5	8232	19.3	2445
Other urban	5.4	7351	22.9	5558	17.8	1793
Rural	6.0	9158	24.8	7011	19.7	2147
Age						
15-19	3.8	6386	na	na	19.0	6386
20-24	3.4	5277	17.0	5277	na	na
25-29	4.8	4390	19.1	4390	na	na
30-34	5.8	3918	23.4	3918	na	na
35-39	6.6	3176	24.7	3176	na	na
40-44	9.3	2478	29.8	2478	na	na
45-49	11.0	1561	33.7	1561	na	na
Education						
None	10.3	4971	33.4	4046	26.3	926
Primary	6.4	11390	26.8	8689	25.9	2701
Secondary +	1.9	10632	12.0	7875	9.8	2757
Non-standard curriculum	14.5	192	41.3	190	§	2
Missing/Don't know	§	1	§	1	-	-
Total	5.4	27186	22.6	20800	19.0	6386

*** MICS indicator 67**

**** MICS indicator 68**

§ Figure is based on fewer than 25 un-weighted cases and has been suppressed

Table 22: Comprehensive knowledge of HIV/AIDS transmission for women aged 15-49 years

Percentage of women aged 15-49 years who have comprehensive knowledge of HIV/AIDS transmission, Iraq, 2006

	Know 2 ways to prevent HIV transmission	Correctly identify 3 misconceptions about HIV transmission	Have comprehensive knowledge (identify 2 prevention methods and 3 misconceptions)	Number of women
Residence				
Urban	16.5	12.4	5.1	18028
Metropolitan	18.3	14.3	5.8	10677
Other urban	13.9	9.6	4.1	7351
Rural	5.7	4.1	1.5	9158
Age				
15-19	8.0	6.0	1.6	6386
20-24	12.3	6.6	2.6	5277
15-24	9.9	6.3	2.1	11662
25-29	15.0	6.3	2.7	4390
30-34	16.0	7.2	3.6	3918
35-39	15.9	6.5	3.1	3176
40-44	13.5	6.6	3.2	2478
45-49	14.0	6.5	2.7	1561
Education §				
None	2.3	0.6	0.1	4971
Primary	6.8	2.6	0.7	11390
Secondary +	24.4	13.5	5.9	10632
Non-standard curriculum	7.5	1.3	0.3	192
Total	12.9	6.5	2.7	27186

*** MICS indicator 82; MDG indicator 19b**

§ 1 un-weighted cases with "missing/ don't know education" not shown

Table 23: Comprehensive knowledge of HIV/AIDS transmission for women aged 15-24 years

Percentage of women aged 15-24 years who have comprehensive knowledge of HIV/AIDS transmission, Iraq, 2006

	Know 2 ways to prevent HIV transmission	Correctly identify 3 misconceptions about HIV transmission	Have comprehensive knowledge (identify 2 prevention methods and 3 misconceptions)*	Number of women
Region				
Urban	13.0	8.4	2.8	7690
Metropolitan	14.9	9.3	2.7	4472
Other urban	10.3	7.2	3.0	3218
Rural	4.1	2.1	0.6	3972
Age				
15-19	8.0	6.0	1.6	6386
20-24	12.3	6.6	2.6	5277
15-24	9.9	6.3	2.1	11662
Education §				
None	1.5	0.5	0.2	1724
Primary	4.6	2.5	0.5	5127
Secondary +	18.6	12.3	4.4	4810
Total	9.9	6.3	2.1	11662

*** MICS indicator 82; MDG indicator 19b**

§ 4 un-weighted cases with "non-standard curriculum" not shown

Table 24: School attendance of orphaned children

School attendance of children aged 10-14 years by orphanhood, Iraq, 2006

	Percent of children whose mother and father have died	School attendance rate of children whose mother and father have died	Percent of children of whom both parents are alive and child is living with at least one parent	School attendance rate of children of whom both parents are alive and child is living with at least one parent	Double orphans to non-orphans school attendance ratio*	Percent of children who are orphaned	School attendance of children who are orphaned	Percent of children who are not orphaned	School attendance of children who are not orphaned	OC vs non-OC school attendance ratio	Total number of children aged 10-14 years
Sex											
Male	0.9	78.6	92.3	84.9	0.93	7.3	77.6	92.7	85.0	0.91	7151
Female	1.1	52.4	91.4	66.7	0.79	7.8	57.0	92.2	66.5	0.86	7042
Residence											
Urban	0.9	70.2	91.3	83.7	0.84	8.1	74.1	91.9	83.5	0.89	8570
Metropolitan	1.0	(67.5)	90.6	83.7	0.81	8.6	72.7	91.4	83.5	0.87	4797
Urban-other	0.8	74.6	92.2	83.6	0.89	7.5	76.0	92.5	83.6	0.91	3773
Rural	1.1	56.4	92.7	64.3	0.88	6.8	54.3	93.2	64.2	0.85	5623
Total	1.0	64.1	91.9	75.9	0.84	7.6	67.1	92.4	75.8	0.88	14194

*** MICS indicator 77; MDG indicator 20**

Figure in parentheses is based on 25-49 un-weighted cases