Democratic Republic of São Tomé e Príncipe

NATIONAL STATISTICS INSTITUTE
Ministry of Planning and Finance

UNICEF
United Nations Children's Fund

2006 Multiple Indicator Cluster Survey

INSTITUTO NACIONAL DE ESTATÍSTICA
REPÚBLICA DEMOCRÁTICA DE S.TOMÉ E PRÍNCIPE

MICS

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The Institute of National Statistics, in collaboration with the United Nations Children's Fund (UNICEF) whose financial and technical support was considerable, conducted the 2006 Multiple Indicator Cluster Survey (MICS3) for São Tomé e Príncipe. Our appreciation is also extended to the varied ministries, UN and other development partners that worked with the UNICEF Sao Tome team and the Minsitry of Planning and Finance to produce the MICS 3 report.

The survey is part of the framework series of MICS surveys undertaken between 2005 and 2006 in more than 50 countries in the world, following those of 1995 and 2000. The survey instruments to evaluate the situation of children and women in the world are based on model types elaborated by the Coordinator of the Global MICS Project at UNICEF Headquarters in New York. Complementary information on the project is available at www.childinfo.org.

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Combined results table
2006 São Tomé e Príncipe Multiple Indicator Cluster Survey (MICS) and
Millennium Development Goals (MDGs) Indicators

Topic	MICS Indicator Number	MDG Indicator Number	Indicator		Value
CHILD MORTALITY					
Mortality	1	13	Under five mortality rate	66	Per thousand
	2	14	Child mortality rate	45	Per thousand
NUTRITION					
Nutritional status	6	4	Moderate weighted insufficiency prevalence	9.2	Percent
	6	4	Low birth weight prevalence	1.2	Percent
	7		Stunting prevalence	10.1	Percent
	8		Wasting prevalence	1.4	Percent
Breastfeeding	45		Timely initiation of breastfeeding	35.3	Percent
	15		Exclusive breastfeeding rate < 0-3 months	70.2	Percent
	15		Exclusive breastfeeding rate < 6 months	60.4	Percent
	16		Continued breastfeeding rate to 12-15 months to 20-23 months	88.2 18.4	Percent Percent
	17		Timely complementary feeding rate	60.0	Percent
	18		Frequency of complementary feeding	44.3	Percent
	19		Adequately-fed children	52.6	Percent
Salt iodisation	41		Iodised salt consumption	36.6	Percent
Vitamin A	42		Vitamin A supplemented (under 5s)	33.4	Percent
	43		Vitamin A supplemented (postpartum mothers)	63.1	Percent
Weighted insufficiency at birth	9		Low birth weight newborns	7.8	Percent
	10		Newborns weighed at birth	82.4	Percent
CHILD HEALTH					
Vaccination	25		Tuberculosis vaccination coverage	98.1	Percent
	26		DPT vaccination coverage (3)	91.4	Percent
	27		Polio vaccination coverage (3)	87.4	Percent
	28	15	Measles vaccination coverage	83.4	Percent
	31		Children completely vaccinated	76.0	Percent
	29		Hepatitis B vaccination coverage	82.9	Percent
	30		Yellow fever vaccination coverage	76.9	Percent
Tetanus toxoid	32		Protection against neonatal tetanus	87.3	Percent
Illnesses care	33		Utilisation of oral rehydration therapy (ORT)	47.1	Percent
	34		Home care in the case of diarrhoea	49.2	Percent
	35		ORT received with increase of fluid, followed by feeding	62.9	Percent
	23		Care sought for presumed pneumonia	71.3	Percent
	22		Antibiotic treatment for presumed pneumonia	56.0	Percent
Solid fuels use	24	29	Solid fuels	75.5	Percent
Malaria	36		Availability of impregnated mosquito nets (IMN), by household	36.0	Percent
	37	22	Under fives sleeping under an IMN	41.7	Percent
	38		Under fives sleeping under a mosquito net	52.8	Percent

Topic	MICS Indicator Number	MDG Indicator Number	Indicator		Value	
	39	22	Anti-malarial treatment (under five)		17.0	Percent
	40		Intermittent preventive anti-malarial treatment (pregnant women)		0.0	Percent
Supply source and cost	96		Supply source (public sources)			
				Impregnated mosquito nets	57.6	Percent
				Anti-malarials	38.8	Percent
				Antibiotics	64.5	Percent
				Oral rehydration salts	95.9	Percent
	97		Supply cost (average)			
			Impregnated mosquito nets			
				Public sources	27000	[STD]
				Private sources	27000	[STD]
			Anti-malarials			
				Public sources	5000	[STD]
				Private sources	15064	[STD]
			Antibiotics			
				Public sources	5000	[STD]
				Private sources	3000	[STD]
			Oral rehydration salts			
				Public sources	3000	[STD]
				Private sources	5000	[STD]
ENVIRONMENT						
Water and sanitation	11	30	Use of improved potable water sources		86.2	Percent
	13		Water treatment		13.7	Percent
	12	31	Use of improved sanitation facilities		28.0	Percent
	14		Disposal of child faeces		19.0	Percent
Security of tenure and housing durability	93		Security of tenure		NA	Percent
	94		House durability		NA	Percent
	95	32	Slum household		NA	Percent
REPRODUCTIVE HEALTH						
Contraception needs	21	19c	Prevalence of contraceptives		30.3	Percent
	98		Family planning needs		15.2	Percent
	99		Family planning needs covered		65.8	Percent
Maternal and neo-natal health	20		Pre-natal care		97.3	Percent
	44		Pre-natal care package		98.5	Percent
	4	17	Care by qualified staff		80.7	Percent
	5		Births in specialised clinics		77.8	Percent
Maternal mortality	3	16	Maternal mortality rate		267	Per 100,000
CHILD DEVELOPMENT						
Child development	46		Study support		NA	Percent
	47		Father's support towards learning		NA	Percent
	48		Study support : children's books		NA	Percent
	49		Study support : other books		NA	Percent
	50		Study support : teaching materials		NA	Percent
	51		Non adult tutor		NA	Percent

Topic	MICS Indicator Number	MDG Indicator Number	Indicator		Value
EDUCATION					
Education	52		Pre-school attendance	27.4	Percent
	53		School readiness	81.7	Percent
	54		Net intake in primary education	74.0	Percent
	55	6	Net primary school attendance rate	94.1	Percent
	56		Net secondary school attendance rate	35.4	Percent
	57	7	Children reaching grade 5	87.2	Percent
	58		Transition rate to secondary school	77.7	Percent
	59	7b	Primary school completion rate	31.9	Percent
	61	9	Gender parity index		
			Primary school	1.00	Ratio
			Secondary school	1.00	ratio
Literacy	60	8	Adult literacy rate	69.9	Percent
CHILD PROTECTION					
Birth registration	62		Registration at birth	68.7	Percent
Child labour	71		Child labour	7.5	Percent
	72		Labourer students	7.5	Percent
	73		Student labourers	81.7	Percent
Child punishment	74		Child punishment	NA	Percent
			Any, psychological or physical		
Early marriage and polygamy	67		Marriage before 15 years	3.3	Percent
			Marriage before 18 years	35.9	Percent
	68		Young women 15-19 married/in union	18.5	Percent
	70		Polygamy	NA	Percent
	69		Age difference in couples (women 15-19)	17.0	Percent
			Age difference in couples (women 20-24)	16.2	Percent
Excision / female genital mutilation / cutting (E/FGM)	66		Approval for E/FGM	NA	Percent
	63		Prevalence of E/FGM	NA	Percent
	64		Prevalence of extreme E/FGM	NA	Percent
	65		Prevalence of E/FGM in girls	NA	Percent
Domestic violence	100		Domestic violence attitudes	32.0	Percent
Handicap	101		Handicapped children	15.7	Percent
HIV/AIDS, SEXUAL BEHAVIOUR, ORPHANED AND VULNERABLE CHILDREN					
Knowledge and behaviours related to HIV/AIDS	82	19b	General knowledge on HIV prevention among the young	39.3	Percent
	89		Knowledge on maternal-infant HIV transmission	76.4	Percent
	86		Attitude towards HIV/AIDS infected people	23.8	Percent
	87		Women aware of HIV testing centres	69.0	Percent
	88		Women voluntarily tested for HIV	36.6	Percent
	90		Psychological care for the prevention of mother-to-child transmission	70.5	Percent
	91		Preventive mother-to-child HIV testing	53.8	Percent

Topic	MICS Indicator Number	MDG Indicator Number	Indicator		Value
Sexual behaviour	84		Age of first sexual relation among the young (15-19)	8.9	Percent
	92		Age mixing among sexual partners	12.4	Percent
	83	19a	Condom use by non-regular partners	56.3	Percent
	85		High risk sexual relations during the past year	33.5	Percent
Support to orphaned and vulnerable children	75		Prevalence of orphans	6.2	Percent
	78		Children's living arrangements	15.5	Percent
	76		Prevalence of vulnerable children	5.2	Percent
	77	20	School attendance orphans/non-orphans	1.09	Ratio
	81		External support to orphaned children or vulnerable children with HIV/AIDS	4.3	Percent
	79		Malnutrition among orphaned and made vulnerable children by HIV/AIDS**	0.95	Ratio
	80		Early sex among children orphaned and made vulnerable by HIV/AIDS	0.89	Ratio

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AIDS	Acquired Immune Deficient Syndrome	NAR	Net Attendance Rate
BCG	Bacille-Calmette-Guérin (Tuberculosis)	NCHS	National Centre for Health Statistics (United States)
CCA	Common Country Assessment	NSI	National Statistics Institute (STP)
CD	Census District	NY	New York
CEDAW	Convention on all Forms of Discrimination against Women	ORS	Oral Rehydration Salts
CO	Carbon	ORT	Oral Rehydration Treatment
CRC	Convention on the Rights of Children	OVC	Orphan and Vulnerable Children
DPT	Diphtheria Pertussis Tetanus	PNC	Pre-natal Consultations
EVP	Extended Vaccination Programme	PNLP	National Plan for the Fight against Malaria Plan
GPI	Gender Parity Index	PPM	Parts per million
HB	Hepatitis B	SO^2	Dioxide azote
HIV	Human Immunodeficiency Virus	SPSS	Statistical Package for Social Sciences (software)
IDD	Iodine Deficiency Disorders	UNAIDS	United Nations Programme on HIV/AIDS
IMN	Impregnated Mosquito Net(s)	UNDAF	United Nations Development Assistance Framework
INE	Institute of National Statistics	UNDP	United Nations Development Programme
IPT	Intermittent Preventive Treatment	UNGASS	United Nations General Assembly Special Session for HIV/AIDS
IUD	Intrauterine Device		
LAM	Lactational Amenorrhea Method	UNICEF	United Nations Children's Fund
MDG	Millennium Development Goals	WFFC	World Fit for Children
MICS	Multiple Indicator Cluster Survey	WHO	World Health Organisation
MoH	Ministry of Health		

Acknowledgements

The Multiple Indicators Cluster Survey (MICS 3), carried out in 2006 by the Institute of National Statistics, has provided invaluable information and pertinent indicators on the situation of children and women in São Tomé e Príncipe.

The result is the present report, which also responds, in large part, to follow-up requirements for project implemented towards the achievement of objectives and goals included in international agreements such as the Millennium Development Declaration, the Plan of Action of a World Fit for Children as well as the Poverty Reduction Strategic Plan.

The success of the MICS3, demonstrated by this report's publication, was possible thanks to the collaboration and support from the Institute of National Statistics, Ministry of Planning and Finance and the UNICEF Sao Tome and UNICEF Area Office (Gabon) teams.

Co-ordination by the New York UNICEF Headquarters and the Dakar UNICEF Regional Bureau technical teams has equally contributed to the project's success. The highly technical input has resulted in scientifically assured results of the survey presented in this final report. We sincerely thank all our external partners!

Our thanks also go to the various ministries who, at a crucial moment, were able to contribute in an important manner towards the validation of the questionnaire.

We address our thanks as well to all administrative and local authorities for their timely assistance to the survey, to the women and men who responded to the survey, for their availability, their collaboration and the quality of information provided to the survey.

Finally, to the children, who endured our manipulation during the anthropometric (weight and height) measurements in the field, we send our apologies and wish them a wonderful and radiant future is likely to be guaranteed through the good use of survey results.

Analytical Summary

The Multiple Indicator Cluster Survey (MICS 2006) for São Tomé e Príncipe is the second series of its kind, after that of 1995, to which the country did not participate, and that of 2000. This survey is within the framework of co-operation between São Tomé e Príncipe and UNICEF, the follow-up of progress achieved towards the attainment of the internationally agreed objectives and goals such as the Millennium Development Declaration adopted by the Member States of the United Nations in September 2000 and the Plan of Action for a World Fit for Children adopted in May 2002, and based on promises made by the international community during the Global Children's Summit of 1990.

The main intention of the 2006 MICS (MICS3) is to make available to the State and its development partners pertinent data, disaggregated according to some social categories of interest that can assist it in the definition and implementation of actions in benefit of the population, of children and women in particular. The survey also intends to strengthen national and institutional capacities to improve monitoring and evaluation in the targeted sectors through the collection, treatment and analysis of data.

MICS3 is a national probing survey based on the global sample of 5600 households representative of households throughout the country. Specifically, its objective is to estimate a great number of indicators relative to the situation of children and women nationally and in particular that of some sub-populations (women between 15 and 49, children under five).

MICS3 was carried out between 12 May and 12 June 2006. The collection of data for MICS3 has allowed the measurement and updating of indicators with regard to child mortality, nutrition and health of the child, the environment, reproductive health, the development of the child, education, child protection and HIV/AIDS, in particular with regard to sexual behaviour among orphaned children and those made vulnerable by AIDS.

Principal Survey Results

Infantile mortality

Child mortality is relative compared to sub-regional levels, with differences in the rates between social categories. At the national level, 45 of 1000 children die before reaching one year and 66 of 1000 die before reaching 5 years.

Probability of death prior to one year is slightly higher among boys while infant-juvenile mortality is slightly less for boys (65 of 1000 against 66 to 1000). The difference between districts is greater, with rates lower in Mé-zochi and Lobata (35 and 39 of 1000, respectively). The infant-

juvenile mortality rates follow the same tendency. Whatever the mortality type, the risks of death are lower with the education of the mother while they remain insensitive to the household's level of life.

Nutrition

Close to one child under five out of 10 (9.2%) suffers from moderate weighted insufficiency while 1.2% suffer from sever weighted insufficiency. Close to one child of every four (23%) suffer from moderate growth retardation and one child out of 10 (10.1%) is too short in relation to age. About 6.0% of children are moderately emaciated and 1.4% is too thin for their height. More than one child out of ten suffers from excessive weight.

More than one third (35.3%) of women have begun exclusive breastfeeding their children within the hour following birth, and more than eight out of ten (81.0%) less than a day following birth.

Exclusive breastfeeding is reasonably widespread : 70.2% of children between 0-3 months are exclusively breastfed and 60.4% of those less than six months. Between 6-9 months, six children out of ten are breastfed as well as fed solids, semi-solids while 88.2% and 18.4% of children from 12-15 months, and 20-23 months, respectively, continue to be breastfed.

More than six children out of ten, aged 0-5 months, benefit from adequate nutrition or exclusive breastfeeding considered adequate according to the recommendations, while four children out of ten are not correctly nourished. Under half (44.3%) of children between 6-11 months have access to maternal milk and complementary food at the minimum recommended daily times.

The use of adequately iodised salt is not widespread enough in São Tomé e Príncipe : less than one household out of four (36.6%) utilise correctly iodised salt (i.e., containing >15 ppm), which means that the great majority of households consume inadequately iodised salt. Following legal dispositions based on the conclusions of the National Technical Commission for Salt Iodisation in São Tomé e Príncipe, the body that sets the level of iodine at 60 ppm or more, the percentage of households consuming iodised salt at an adequate level falls to 17.7%, or twice less than the percentage calculated against the standard of >15 ppm.

One third of children 6-59 months received a high dose of Vitamin A supplements during the six months preceding the survey. This support in Vitamin A is more frequent in the districts of Príncipe and Lembá (63.4% and 42.4%, respectively), among the youngest children (0-23 months) with 44.0% and among newborn with more educated mothers (37.0%). It is less widespread in the districts of Água Grande (25.4%) and Cantagalo (25.4%) and among children with uneducated mothers (21.0%) and among older children (20% for those aged 48-59 months).

About 63.0% of women having given birth during the two years preceding, the survey received Vitamin A supplements prior to the eighth month following birth. This proportion is higher in the districts of Príncipe (84.0%) and Lembá (71.0%) and among women with more education (73.0%).

More than eight children out of ten born within the two years preceding the survey were weighed at birth. Less than 8.0% among them weighed less than the standard birth weight of 2500 grams. At whatever the level of analysis, weak birth weights vary very lightly in relation to the context's social categories (6.0% to 9.0%).

Health of the Child

In São Tomé e Príncipe practically all children (98.0%) are vaccinated against BCG before the age of 12 months, 91.4% received the 3 doses of DPT, 87.0% the Polio (Polio3) doses and 83.0% the measles vaccine. In general, three quarters (76.0%) of children were vaccinated against the principle childhood illnesses. About 83.0% and 77.0% are completely vaccinated against Hepatitis B and Yellow Fever, respectively, before the age of one.

Altogether, close to eight out of ten children aged 12-23 months have been vaccinated against childhood illnesses at one moment or another. Nevertheless, vaccine coverage against childhood illnesses varies depending upon the context. The percentage of vaccinated children against all illnesses is higher for boys (84.0%) in the Districts of Mé-Zochi (92.0%), Caué and Príncipe (86.0%) and among children with educated mothers and among the well-off (85.0%, respectively). It is lower in the Districts of Cantagalo and Lobata (66.0% respectively) and among children of women without education (62.0%).

Close to nine women out of ten (87.0%) are protected against tetanus of which two thirds have received at least two doses during pregnancy, one woman out of five at least two doses in the three preceding years. Women with education are better protected against maternal tetanus : 95.0% of women with secondary level education against 86.0% of women with primary level education ad 81.0% of women without education.

During the two weeks preceding the survey, 13.0% of children under five contracted diarrhoea. Of 7.0% of children aged 6 months, this prevalence becomes 19.0% among those aged 6-11 months and 24.0% among those aged 12-23 months, before falling to 14.0% among those aged 24-35 months to only 6.0% among children aged 48-59 months. Prevalence peaks (6-11 and 12-23 months) coincide with weaning, period during which the risk in contamination of food and the environment are the highest.

Less than half of children (47.0%) having had diarrhoea have used whatever method of ORT. Among these, 31.0% received fluids prepared with ORT packets, 2.0% of pre-conditioned ORT fluids and 17.0% of recommended fluids prepared at home. For those who purchased their own ORT, the average cost is 3,000 dobras (0.16 Euros) in public outlets and 5,000 dobras (0.27 Euros) in private outlets.

Among children who have had diarrhoea, more than six out of ten (61.4%) drank more than usual, while 38.0% drank as much or less. Close to 81.0% continued to eat, although eating a little less, as much or more than usual while 19.0% ate much less than usual or nearly nothing. Close to half of children (49.0%) received an increase in fluids while continuing to eat.

Only 4.0% of children presented symptoms of acute pneumonia during the two weeks preceding the survey. Among these children, 71.0% consulted an appropriate health care provider : 10.0% in a public hospital, 23.0% in a public health centre, 17.0% in a public health post while 7.0% consulted a private clinic and 4.0% consulted a private doctor. Among these, 56.0% received an antibiotic (50.0% in an urban setting and 63.0% in a rural setting). For those who purchased their antibiotics, the average cost is 5,000 dobras (0.27 Euros) at a public outlet and 3,000 dobras (0.16 Euros) at a private outlet.

About 37.0% of mothers /caretakers (48.0% in an urban setting and 30.0% in a rural setting) know two pneumonia danger signs, that is : "difficulty in breathing" and "rapid breathing". The most currently cited symptoms necessitated the child being immediately taken to a health service, are by order of importance, "when the child developed fever" (82.0%), "when the child became more ill" (52.0%) and "when the child experienced difficulty in breathing" (49.0%).

Altogether, more than three quarters (76.0%) of households utilise solid fuels for cooking although the frequency of the utilisation of fuel varies according to the considered socio-economic category. Recourse to solid fuels is less spread in the District of Água Grande, which is the most urbanised (52.0%), and in households where the head of the household has at lease a secondary level education (49.0%) and the richer households (31.0%). This percentage is higher in the Districts of Príncipe and Lembá (respectively, 97.0% and 95.0% of households) and the poorest households who utilise solid fuels exclusively. More than two thirds of households utilise wood to cook their meals and 23.0% have recourse to benzene while less than 9.0% charcoal. In São Tomé and Príncipe, only one household out of two (3 out of 4 among the well off) utilise closed ovens with exhausts to cook their meals.

Less than half of households (49.0%) own a mosquito net of which only 36.0% at least an impregnated mosquito net. The households in the District of Água Grande, those better off and those whose head of household has at least a secondary level of education are favoured : respectively 50.0%, 53.0% and 48.0% of households own at least one impregnated mosquito net. More than half of children (53.0%) slept under

a mosquito net the night preceding the survey and 42.0% slept under an impregnated mosquito net. For those who bought their treated mosquito net, the average cost is 27,000 dobras (1.5 Euros) at a public outlet and 27,000 dobras (1.5 Euros) at a private outlet.

The prevalence of fever during the two weeks preceding the survey is 18.0% with a peak in children aged 12-23 months (23.0%) and in the District of Lembá (one quarter of children). One fevered child out of four was treated with an "appropriate" anti-malarial drug and 17.0% received anti-malarial drugs within 24 hours after symptoms appeared : 12.0% received armodiaquine, 2.0% received chloroquine, 1.0% SP/Fansidar while three quarters (75%) received other medication such as Paracetamol/Panadol/Acetaminophen. For those who bought their anti-malarial drugs, the average cost is 5,000 dobras (0.27 Euro) at a public outlet and 15,000 dobras (0.83%) at a private outlet.

In terms of intermittent preventive anti-malarial treatment, 90.0% of women aged 15-49 gave birth during the two years preceding the survey received anti-malarial medication during their pregnancy. Among them, no one received 2 or more doses of SP/Fansidar and 10.0% received chloroquine.

Water and Sanitation

About 86.0% of the population utilise an improved potable water source (88.0% in urban settings and 83.0% in rural settings). The inhabitants of Lobata (97.0%), the most well off (95.0%) and households where its head has had at least a secondary level education (92.0%) are those better equipped. The principal sources of potable water are the public fountains (53.0% of the population), household connection to the network (22.0%) and protected wells (7.0%).

More than one quarter of households (26.9%) enjoy a source of drinkable water *in situ*, that is, in the home. This type of access is more widespread in the District of Água Grande (41.0%), in urban areas (32.0%), in the most well off households (74.0%) and in those directed by a person with at least a secondary level of education (46.0%). For those households who have to obtain their water outside the home, the average time is 16 minutes, although 43.0% obtain their water in less than 15 minutes and 14.0% dedicate 30 minutes or longer to this task.

In more than two thirds of households (67.0%), an adult female is generally responsible for the collection of drinking water, when the source is located away from the home. An adult male does not accomplish this task except in one case out of five.

Only 28.0% of the population live in households enjoying toilets for the removal of human excrement. Toilets have a higher utilisation rate in richer households (80.0%), where the head of the household has had at least a secondary level education (49.0%) and among residents of Água Grande (42.0%) than among the poorest households (1.0%) for whom the safe removal of human excrements is a real public health problem.

Less than 7.0% of households utilise toilets linked to a sewer system, 13.0% linked to a sceptic tank or a latrine, while only 1.0% enjoy improved self-aerated latrines and 7.0% compost toilets.

The proportion of children aged between 0 to 2 years who enjoy the safe removal of their excrements is estimated at 19.0%, nationally (24.0% in urban areas and 12.0% in rural areas). This proportion, 33.0% in the District of Água Grande, varies from between less than 6.0% in Principe to 15.0% in Lobata. The richest households and those where the head of the household has received at least a secondary level education are relatively more numerous in terms of safe removal of their children's excrements (respectively 60.0% and 41.0%).

Few households benefit from good coverage of improved water provision and improved means of excrement removal : respectively 86.0% and 28.0%, while 26.0% only have access to both at the same time. In the urban setting, 31.0% have access to two sources while the percentage is only 20.0% in the rural setting. The residents of Água Grande, those where the head of the household has had at least secondary education and the better-off households all have greater access (respectively, 40.0%, 48.0% and 76.0%). Less than 1.0% of the poor enjoy the same privilege.

Reproductive Health

Among married women or those with partners, 30.0% currently utilise essentially modern contraception. Prevalence of contraception is higher in the District of Príncipe (44.0% of women) and among women aged 30-34 years (39.0%). About 16.0% of female users have recourse to the pill 10.0% to the IUD and 2.0% the condom.

Currently, 16.0% of total contraception needs are unsatisfied. The demand for satisfied contraception is estimated at 66.0%, with little variation among categories.

Nearly all women between 15 and 49 years (99.0%) have received pre-natal care provided by a qualified person (doctor, nurse or mid-wife), at least one during their pregnancy. Close to 95.0% of women consulted a nurse or mid-wife, and 3.9.0% consulted a doctor.

Close to 83.0% of women have had a blood test, of which 96.0% have had their blood pressure tested, 83.0% their urine, and 97.0% were weighed as well.

During the 10-14 year period preceding the survey, the maternal mortality rate was estimated at 148 maternal deaths for each 100,000 live births.

Education

Slightly more than one in five children aged 36 to 59 months (27.0%) attends a pre-school education programme. Among children in their first primary school year, 82.0% attended a pre-school programme the preceding year. The chances for a child to attend pre-school are higher if the child reaches 48 to 59 months (36.0%), live in the better-off households (51.0%) or when the mother has had at least a secondary education (39.0%).

Among children at the official primary school entry age (7 years), 74.0% are presently enrolled in the first year of primary school. Whatever their housing environment or the sex of the child, 94.0% of children at the primary school age (7-12 years) attend school.

The net attendance rate of secondary school or beyond aged 13-17 years is 35.0% for boys as well as for girls. Nevertheless, the children from well-off households and those whose mother has had a minimum of a secondary level education have a real advantage over their less-advantaged peers (respectively, 62.0% and 68.0%).

Among children in their first year, 87.0% reach fifth grade. There is practically no difference in terms of age. On the other hand, the better-off children and those with mothers having had a secondary education or more perform better (respectively, 98.0% and 92.0% against 76.0% respectively for the poorest children and those with uneducated mothers.

Only 32.0% of children at the age of primary school completion (12) attended school in the last year of primary level education. This rate of achievement is higher among the better-off households and among children whose mother has a secondary level education or more : 66.0% and 58.0% respectively against less than 17.0% respectively for the poorest children and those whose mother is uneducated. More than three quarters (78.0%) of children in the last primary school year during the preceding year are currently attending secondary school. Contrary to the rate of achievement for primary education, this secondary transition rate is nearly the same throughout the social groups. Globally, gender parity is as perfect in primary as it is in secondary.

Seven out of ten women aged 15-24 years know how to read and write. This percentage is more prevalent among the rich (90.0% against 50.0% amongst the poorest), among urban women (73.0% against 65.0% of rural women), and among female residents of the District of Água Grande (79.0% against 46.0% for those in Caué).

Child protection

Close to seven out of ten children (69.0%) under five years of age have been registered. If there is no difference between boy and girl registration or type of housing, the disparities are noteworthy when linked to districtal residence (between 79.0% and 65.0%), and to the quality of household life and to educated mothers : 78.0% and 79.0%, respectively, of children from better off households and those with the most educated mothers are registered while percentages for children from the poorest families or with uneducated mothers are at 63.0% and 70.0% respectively. Registration depends, essentially, on the age of the child : those registered at less than one year (30.0%) against 98.0% for children reaching 48-59 months.

During the week preceding the survey, less than 8.0% of children aged 5-14 years were working, whatever their sex. The percentage increases with the age of the child (6.0% of those aged 5 to 11 and 10.0% of those aged 12 to 14 years) and is slightly higher in rural areas than in urban ones (10.0% against 6.0%) as well as in Príncipe (17.0% against 3.0% in Água Grande). Among these children, close to three quarters (74.0%) work in family business and less than 3.0% are involved in domestic activities for more than 28 hours per week. Work outside the home affects less than 3.0% of children of which only 1.0% are remunerated. Close to 82.0% of child labourers also attend school and close to 8.0% of students are also involved in child labour.

Generally, 3.0% of women currently married had done so before the age of 15 and 36.0% before the age of 18. Only marriage before 18 years increases with the age of women (33.0% of those aged 20 to 24 against 40.0% of those aged 40-44). Insofar as the survey is concerned, polygamy is unknown in São Tomé e Príncipe. More than half of women aged 15 to 19 have an older husband/partner by 5 to 9 years and only 17% are ten years younger than their husband/partner is. On the other hand, 36.0% of women between 20 and 24 have an older husband/partner by 5 to 9 years, and 16.0% are ten years younger than their husband/partner, attesting to the fact that age does not favour age differences among couples.

Less than one third (32.0%) find that their husband/partner beats them for any one of the targeted reasons, especially "neglecting the children" (20.0%), "contradicting him in a discussion" (17.0%), "going out without advising him" (15.0%), "burning the meal", and " refusing sexual relations". The attitude among women towards domestic violence varies according to the context, with women more favourable to it in the Districts of Caué (more than half of all women), Lembá and Lobata (44.0% and 42.0% respectively) than those in Mé-Zochi (29.0%) and Água Grande (26.0%). Rural women are more receptive than their urban counterparts (35.0% against 30.0%) are. Paradoxically, the youngest women seem more receptive to this type of violence (33.0% of those aged 15 to 19 against 29.0% for those aged 45 to 49 years), while the most well-off women and those more educated are noteworthy for their disagreement : only 20.0 to 21.0% believe that a husband may beat his wife while twice that rate (40.0 to 42.0%) is prevalent amount the poorest women and those without education.

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Less than 16.0% of children aged 2 to 9 years have an officially declared handicapped. Among these, 18.0% "cannot express themselves normally" and 13.0% among those aged 3 to 9 years are "incapable of naming at least one object".

HIV/AIDS, sexual behaviour, orphans and vulnerable children

Nearly all women (97.0%) have heard of AIDS yet 46.0% know only the three main types of prevention of HIV transmission, in particular "having a loyal and non-infected partner", "utilising a condom for each sexual relation" and "abstaining".

More than half (close to 53.0%) reject the two most widespread misconceptions and that a seemingly healthy person can be infected. 87.0% know that HIV/AIDS cannot be transmitted by supernatural means and 75.0% know that HIV/AIDS cannot be transmitted by mosquito bites. Close to one woman in four has complete knowledge of HIV/AIDS transmission prevention methods.

Generally, 91.0% of women know that AIDS can be transmitted from the mother to the child and more than three quarters (76.0%) know all three mother-to-child methods of transmission, while 5.0% are ignorant of any specific means of transmission.

Close to one quarter of women aged 15-49 years do not agree with discriminatory attitudes vis-à-vis persons living with AIDS. Three women out of ten did not care for a household member infected with AIDS, 44.0% prefer keeping secret the fact that a household member has AIDS, close to 25.0% believe that a teacher should not be allowed to teach and 46.0% would not buy vegetables from an infected seller. More than three quarters (76.0%) agree with at least one discriminatory attitude.

Close to seven women out of ten (69.0%) know of a voluntary testing centre for HIV/AIDS, while 37.0% have actually taken the test. Among the latter, 91.0% have received their test results.

At the national level, 9.0% of women aged 15 to 19 years had sexual relations before reaching 15, and 53.0% aged 20 to 24 before the age of 18. About 12.0% of women aged 15 to 24 had sexual relations during the twelve months preceding the survey with men ten years or more their senior. One third of women between 15 and 24 (34.0%) admitted to having had sexual relations with a non-regular partner during the 12 months preceding the survey. Of the latter, only 56.0% utilised a condom during high-risk relations.

Among children aged 0 to 17 years living with only one parent, 51.0% have both parents living and 0.2% have both parents living and 0.2% have both parents living and 0.2% have both parents, 1.6% have only a father, while 0,8% have only a mother.

Of 100 children aged 0 to 17, 5.0% are vulnerable, 6.0% have at least one deceased parent and close to 11.0% are orphans or vulnerable. The percentage of orphaned or vulnerable children is slightly higher in households with children aged 10 to 14 (13.0%) and those with children aged 15-17 years against 6 to 10.0% among younger children.

Only 4.0% of orphaned children received support. Among households with orphaned children, 1.0% received medical support in the last 12 months, and 2.0% school attendance support. During the last three months, 1.0% received psychological or emotional support and 2.0% material/social support.

With regard to malnutrition for the under fives and for girls aged 15-17 exposed to HIV/AIDS risks, orphan or vulnerable children do not suffer more than other children do.

I. Introduction

Context

This report is based on the Multiple Indicator Cluster Survey carried out in São Tomé e Príncipe in 2006 by UNICEF and by the Government of São Tomé e Príncipe, through its National Statistics Institute. This survey provides invaluable information on the situation of children and women in São Tomé e Príncipe and is based largely on the need to monitor the objectives and targets set in recent international agreements such as the Millennium Declaration, adopted by all 191 Member States of the United Nations in September of 2000, and the Plan of Action of the World Fit for Children, adopted by 189 Member States during a special session on children of the United Nations General Assembly, in May of 2002. These two commitments are based on promises made by the international community during the 1990 Global Children's Summit.

By signing these international agreements, the governments have committed themselves to improve the condition of their children and to monitor progress in this direction. UNICEF has been charged with a support role within this framework (see table below).

A Commitment to Action : National and International Reporting Responsibilities

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

"We shall monitor regularly at the national 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-focussed research. We will enhance international co-operation to support of statistical capacity-building efforts and build community capacity for monitoring, assessment and planning". (**A World Fit for Children,** paragraph 60.)

"...We will conduct periodic progress reviews at the national and sub-national 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 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 specialised 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 ".

STP has adopted the Convention on the Rights of Children (CRC) and has subscribed to different commitments arising since the Global Children's Summit (GCS) in New York in September of 1990, with the participation of 158 Heads of State or of Governments. Respect of these commitments and to those which followed afterward (MDG, WFFC, etc.) has lead to the implementation of different types of programmes favouring children and women. Thus, from 1991 to 1996, with the co-operation framework between the government and UNCIEF, these programmes were developed and implemented in maternal and child health, potable water provision, sanitation, pre-school and primary education, community development and social insertion of street children. The objectives sought were to reduce the maternal and infant rates and improve the quality of life for children, in particular their nutrition and their education[1]. During the following programming period (1997 – 2001), the same domains were targeted, with renewed vigour to improve considerably coverage, provision and quality of basic social services, in particular in terms of health, basic education and water and sanitation. The programme sought also to strengthen capacities at all levels in the domains of health, basic education, water and sanitation as well as monitoring and evaluation to ensure sustainability of the services provided. Improved protection and assistance to vulnerable children as well as the strengthening of community capacities in the management of basic service were the objectives sought during this period[2].

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1   *Vide* the National Co-operation Programme 1997-2001, p.8
2   *Vide* the National Co-operation Programme 1997-2001, p.11

The combined effect of these programmes has produced non-negligible qualitative changes in the lives of Saotomeans; thanks to the two previous MICS of the mid-1990s and in 2000, these changes have been noted. In effect, since 1990, one notes, like in other developing countries, a positive evolution of health, nutrition, child development, and education and child protection indicators. The infant-juvenile mortality rate has decreased from 138 per thousand in 1994 to 97 per thousand in 2000 (MICS II Report for 2000). Thus, between 1998 and 2002, the net attendance rate for primary level education reached 100% among boys and 94% among girls. Equally, the gross attendance rate for primary level education tends to be higher during the period between 1991 and 2005 : 131% in 1991, 47.2% in 2001 and 149.3% in 2005.

Malnutrition has decreased countrywide, together with a decrease in the proportion of children suffering from moderate and severe low birth weight (13.0% in 2002 against 11.0% in 2003).

Nevertheless, despite this progress, much remains to be done to improve even more the quality of life for children and women, in particular in the domain of the fight against early mortality and malnutrition that still affect a considerable number of children, and HIV/AIDS and the painful consequences for children. Promotion and of universal basic education should remain a major preoccupation for the country.

This final report presents the results of the indicators and of themes covered by the survey.

Survey objectives

The 2006 Multiple Indicator Cluster Survey in São Tomé e Príncipe has the following principal objectives :
- Provide updated information to enable evaluation of the situation of children and women in São Tomé e Príncipe ;
- Provide necessary data for progress monitoring in relation to the objectives of the Millennium Development Goals, the World Fit for Children and others fixed globally as the basis for future action ;
- Contribute to the improvement of data collection and monitoring systems in São Tomé e Príncipe, and to strengthen technical expertise in terms of conception, implementation and analysis of these systems.

II. Sampling and survey methodology

Sample conception

The survey plan for the São Tomé e Príncipe Multiple Indicator Cluster Survey (MICS) was conceived to provide estimations on a large number of indicators on the situation of children and women, at the national level, in urban and rural zones and for the seven country districts of Água Grande, Mé-Zochi, Caué, Cantagalo, Lembá, Lobata and Príncipe. The districts were identified as the principal domains of the sampling and the sampling was selected in two phases. Among the 149 selected zones, 100 cluster survey zones were selected with a tailored proportional probability. After the establishment of a list of households in the selected survey zones, a systematic sampling of 5645 households was randomly selected. Of these households, it was not possible to visit 20 due to the inaccessibility of some and/or the absence of capable respondents during the collection period. The sampling was stratified by district and was not self-weighted. The table below gives the distribution of the household samplings according by district.

District	Urban	Rural	Total
Água Grande	800	0	800
Mé-Zochi	120	680	800
Cantagalo	540	270	800
Caué	345	460	800
Lembá	540	270	800
Lobata	180	630	800
Príncipe	135	675	800
Total Country	**2660**	**2985**	**5600**

To enable results at the national level, weighted samplings were utilised. A detailed description of the sampling plan is provided in Appendix A.

Questionnaires

Three series of questionnaires were utilised for the survey : 1) a household questionnaire to collect information on all *de facto* household members, on the household itself and on the place of the dwelling; 2) a questionnaire for women, administered in each household to all women aged 15 to 49; and, 3) a child questionnaire, administered to mothers or those responsible for all children under five years of age living in the household. These questionnaires contain the following modules :

The questionnaire for households contains the following modules :

- o List of household members
- o Education
- o Water and sanitation
- o Household characteristics
- o Issues linked to malaria
- o Orphaned and vulnerable children
- o Child labour
- o Handicap
- o Maternal mortality
- o Salt iodisation

The individual questionnaire for women, administered to all women aged between 15 and 4 years living in households, contains the following modules :

- o Infant mortality
- o Tetanus toxoid
- o Maternal and neo-natal health
- o Marriage and union
- o Contraception
- o Attitudes on domestic violence
- o Sexual behaviour
- o Knowledge about HIV

The questionnaire for children less than five years was administered to mothers or to persons responsible for children under five years living in the households. Normally, this questionnaire should be administered to mothers with children under five years but in cases where the mother is not part of the list of household members, that is, if she does not live in the household, the principal person in charge of the child is identified and interviewed. The questionnaire contains the following modules :

- o Official birth registration and early education
- o Vitamin A
- o Breastfeeding
- o Treatment of illnesses
- o Malaria
- o Vaccination
- o Anthropometry

These questionnaires are based on the MICS3 questionnaire model[3]. The São Tomé e Príncipe MICS survey questionnaires are therefore based on the Portuguese version, translated from the French, of this model. Preliminary mock testing of the questionnaires was then conducted in the Saotomean capital during 15 days in May of 2006. Based on the results of the preliminary test, modifications were then made to the formulation and the initial translation of the questionnaires. A copy of the São Tomé e Príncipe MICS questionnaires can be found in Appendix F.

Apart from the administration of questionnaires, the fieldwork teams tested the iodine in kitchen salt utilised by households and measured the weight and height of children under five years of age. The details and conclusions of these measurements are provided in the respective chapters of this report.

Training and field work

Training for data collectors was carried out during 20 days in April of 2006. This training consisted in courses on survey techniques and the content of questionnaires, as well as mock interviews between trainees to familiarise them in interviewing techniques, that is, to conduct interviews correctly.

Towards the end of the training period, trainees spent five days doing fieldwork in the District of Água Grande to exercise their new skills, that is, they undertook household practice interviews.

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[3] The model for the MICS3 questionnaire can be found in www.childinfo.org, or in the UNICEF website, 2006.

Seven teams undertook the collection of data; each team was composed of 35 interviewers, 1 driver, 1 monitor, 1 anthropometrician and 1 supervisor. Fieldwork began on 17 May 2006 and ended on 20 June 2006.

Data treatment

The data was entered utilising the CSPro software installed on 8 microcomputers by 16 data entry operators and 3 data entry supervisors. To ensure quality control, all the questionnaires were entered twice and later submitted to internal consistency controls. During the entire process, standard procedures and programmes developed for the global MICS3 project and adapted for São Tomé e Príncipe specificities were utilised during the entire process. Data processing began on 15 June 2006 and ended 20 September 2006. The data was analysed utilising the Statistical Package for Social Sciences (SPSS), Version 14, and the model syntax and tabulation plans developed by UNICEF for this task.

III. Sample representativity and characteristics of surveyed households and individuals

Sample representativity

Of the 5646 households selected for the sampling, 5645 were occupied, and 5625 facilitated the interview, achieving a rate of response of 99.6%. In the surveyed households, 4744 women aged 15 to 49 were identified. Of these women, 4612 were interviewed successfully, with a response rate of 97.2%. As well, 3170 children under five were included in the household questionnaires, of which 3140 questionnaires were completed for these children, indicating a response rate of 99.1%. The global rate of response has been calculated as 96.9% and 98.7% respectively with regard to the interviews of women and children under five (Table HH.1).

According to the results shown in Table HH.1, the rate of response is quite high, which demonstrates good representivity of the sampling. The differences in the response rate between residential zones and districts are nearly negligible. With regard to the response rate for households, it is identical whether in urban or rural settings (99.7% and 99.6%) and varies very little between the districts (98.3% in Príncipe and 100% for Água Grande, Mé-Zochi, Cantagalo and Lembá. The global response rate for women aged 15 to 49 is slightly less in rural areas (95.7%) than in urban areas (98.0%) most likely linked to women's activities outside the home. It is weaker in Príncipe (87.8) yet varies weakly between districts (99.2% for Água Grande and 95.7% for Cantagalo). The global rate of response for children under five is more homogenous between residential zones (between 99.7% in Água Grande and 96.6% in Príncipe). The response rate is relatively weaker in Príncipe can be explained by the work hours imposed on the data collection teams and work conditions that did not facilitate interviews.

Household characteristics

The distribution by age and sex of the surveyed population is supplied in Table HH.1. In the 5625 households interviewed successfully during the survey, 22728 household members were recorded. Of these household members, 11477 are men and 11251 women. Based on these figures, the survey estimated the average size of households as 4.0 individuals.

Table HH.2 shows an age pyramid relatively larger at the base, which indicates that the population is still very young : close to 42.0% are under 15, close to half (48.4%) are between 0 and 17 years of age and about 52.0% are older than 18. Those aged 65 or older are estimated at 5.0%. The

population able to work or the essentially active population (15-64 years) is estimated at 53.1%. From this age structure, it is clear that there is relatively strong dependence. The missing age groups represent a feeble percentage (2.0 per thousand).

The age structure presents some irregularities affecting the analysis of particularly large specific groups, in particular the age groups 0-4 years, 15-19 years, and 45-49 years. The direct effect of mortality being to reduce progressively the numbers in the oldest age groups, in absence of strong migration, the size of the 0-4 population should be less than that of the 5-9. Survey data shows an inverse tendency, which may have two possible explanations : on the one hand, the effect of the attraction for rounded figures like "0" or "5" in surveys, and on the other, the behaviour of the interviewers more concerned with reducing their workload than with collecting exact data. In the latter case, it should be noted that each child aged 0 – 4 listed among household members are included in a specific mother/person in charge questionnaire, in other words, an additional task. Some interviewers are thus tempted to estimate some children's ages as older than 0 – 4. Either situation implies a population transfer of the youngest to the oldest. The youngest (0 – 4 years) represent 13.1%of the total population and the older (5 – 9 year olds) 14.8%. There is no difference between sexes among these age groups.

A similar problem can be seen with those of the population aged 15 – 19 years, although with differences in relation to the sex of the person interviewed. Males aged between 15-19 account for 12.5% of the male population while females account for only 9.7% of the female population. The most plausible explanation would be a « conscientious » omission or an « error in categorising » by the interviewers of young girls aged 15 – 19 amongst the lower-aged groups, by not having completed a women's questionnaire given that all women aged 15 to 49 were eligible to this questionnaire. The fact that boys of the same age were not affected by this phenomenon supports this hypothesis.

The phenomenon of age transfer to an older (50 – 54) age group is also observed for those aged 45 – 49. In this case, as well, only the females were affected. In fact, women 45 – 49 represent merely 2.6% of the female population while men of the same age represent 3.2% of the male population. On the other hand, men aged 50 – 54% represent a mere 2.7% of their group while women of the same age represent 4.5% of the female population. A deliberate action on the part of the interviewers to make women ineligible who would otherwise be interviewed (women aged 15-49) for the women's questionnaire is suspected.

By comparing the numbers of the MICS to those of the General Population and Habitat Census (GPHC) of 2001, there are slight differences. According to the GPHC, the population of those under 15 years represent 42% of the total population, while MICS 3 estimates this same population at 42.4% in 2006. The population aged 15 – 49 represents 48% for the GPHC and 45.7% for MICS3. Concerning those aged over 50, the GPHC gives 10% while the MICS3 is 12.7%. If the GPHC results are correct, MICS3 may have under-estimated the under-15 population as well as that aged 15 – 49.

Figure 1: HH1 Distribution (percentage) of household population, by sex and age

Table HH.3 provides basic information on households. It contains details on each household, such as the sex of the household head, the residential districts, that urban/rural status and the number of household members. These basic characteristics are equally utilised in all tables in this report; the figures of this table are also intended to present the number of observations according to the report's principle analytical categories.

The household weighed and non-weighted numbers are equal, given that sampling weights were normalised. (see Appendix A). This table also indicates that the household proportions where at least one child under 18 years, at least one under five and at least one eligible female aged between 15 and 49 years were found. Table HH3 shows that the majority of households (56.7%) are in urban settings. It also shows that more than six households out of ten (61.9%) are headed by a male. The majority of households (63.3%) are localised in the Districts of Água Grande, with more than one third (35.5%) and Mé-Zochi with more than one quarter (27.8%). The Districts of Caué (5.0%) and Príncipe (5.4%) are those with the weakest representation. The majority of households are composed of 2 to 5 people : more than one household out of four (26.4%) are made up of 2 or 3 persons and more than one household out of three (30.8%) are made up of 4 or 5 persons. A little less than one fifth of the total (18.6%) households composed of one person or people living alone are fairly well represented in the sample.

In 71.4% of households a child under 18 resides, and in 41.3% of households a child under 5. In more than 67.0% of households one finds a female between 15 and 49 years.

Characteristics of people surveyed

Tables HH.4 and HH.5 provide information on basic characteristics of women surveyed who age is between 15 and 49 years and with children under 5. In these two tables, the total number of weighted and non-weighted observations is equal, given that sample weights were normalised (standardised). Apart from useful information on the basic characteristics of women and children, these tables provide as well the number of observations in each of the base categories. These categories are utilised in the different tabulations in this report.

Table HH4 provides base characteristics on women interviewed aged between 15 and 49. It contains information on the distribution of women by districts, type of urban/rural residence, age, family situation, the mother's status, education[4], the quintiles[5] and the health index. Globally,

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[4]   Unless otherwise stated, the term "education" refers to the level of instruction achieved by the respondent of those questioned throughout this report when it is used as a background variable.

[5]   Principal components analysis was performed by using information on the ownership of household goods and amenities (assets) to assign weights to each household asset and to obtain wealth scores for each sampled household (the asets used in these calculations were the following : electricty, radio,

the number of weighted and non-weighted observations was identical (4611 and 4610, respectively). However, it is useful to point out notable differences according to certain particular categories because of an over- or under-sampling. The range of differences is particularly important for the districts, in particular that of Água Grande (1796 and 777, respectively, Mé-Zochi (1238 and 665, respectively), Caué 209 and 674 respectively) and Príncipe (196 and 514, respectively). These differences were equally noteworthy according to the environment, in particular the urban environment (2818 and 3410, respectively against 1791 and 2201 respectively in rural environments). With regard to the other categories, the observed differences are relatively weak.

Of all interviewed women, 61.2% live in an urban setting and 38.8% in a rural setting. Nearly 60.0% of these women are under 30 years of age, of which 21.7% are between 15 and 24 years, 20.9% are aged from 30 to 24 years, while 19.1% are aged 25 to 29 years. Women aged 45 to 49 make up the smallest age group, representing only 5.8%. Close to six out of ten (59.2%) of these women are married or live in union, while single women in this age group represent 26.0%. Those separated divorced or widowed account for less than 15.0% of all women in their reproductive years.

The great majority of these women have already given birth to one child : close to 72.0% have given birth to at least one child and only 28% have never had a child. Most women are educated : more than 60% have a primary level education and 29% secondary level education or more. A small number of women (less than 6.0%) have never been to school.

Certain basic characteristics for children under five years are presented in Table HH.5 which gives the distribution of these children according to several attributes, such as sex, residential district, age in months and the mother's or the person in charge's education level and health.. In relation to the number of weighted and non-weighted observations, the same can be said for women between 15-49 years of age with regard to the range of differences and the concerned categories (district and residential environment).
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Close to one third of children (32.7%) live in the District of Água Grande and more than one quarter (26.4%) in that of Mé-zochi while those of Caué and Príncipe account for relatively a small amount of children (less than 6.0%). In terms of the sex of the child, boys and girls are nearly equal (50.2% and 49.8 respectively). In relation to the residential environment, the urban has more representation than the rural (56.9% and

53.1% respectively. As can be expected, the weight of age groups lowers with age because of mortality. The under 13 month old children represent 22.5% of children under five 11.6% and 10.9% respectively for those under six months and those between six and eleven months). This percentage falls to 21.5% for children aged 12 to 23 months, to 19.7% for those aged 24-35 months and to 19.9% for those aged between 48 to 59 months. In a practically inexistent migratory context, the quality of data on age rather than to another factor such as a higher mortality rate for the concerned categories results in the relatively weak weight of the last group and the fact that the percentage of children aged 24 and 35 months is lower than for those aged 36 to 47 months. The table also shows that for 72% of children, the mother or person in charge has a primary school level education and for 19.8% a secondary school education or more. The under fives are unequally distributed between the wealth index quintiles : they are somewhat represented in the richest quintile (16.0%) and very much represented in the poor and poorest quintiles (close to 22.0% respectively), which can be explained by various factors such as the small size and lower rate of reproduction of the wealthiest categories.

IV. Child mortality

One of the overarching goals of the Millennium Development Goals (MDGs) and the WFFC is to reduce infant and under-5 mortality. Specifically, the MDGs call for a reduction in under-5 mortality by two-thirds between 1990 and 2015. Monitoring progress towards this goal is an important but difficult objective. Measuring childhood mortality may seem easy, but attempts using direct questions, such as "Has anyone in this household died in the last year?" give inaccurate results. Using direct measures of child mortality from birth histories is time consuming, more expensive, and requires greater attention to training and supervision. Alternatively, indirect methods developed to measure child mortality produce robust estimates that are comparable with the ones obtained from other sources. Indirect methods minimize the pitfalls of memory lapses, inexact or misinterpreted definitions and poor interviewing technique.
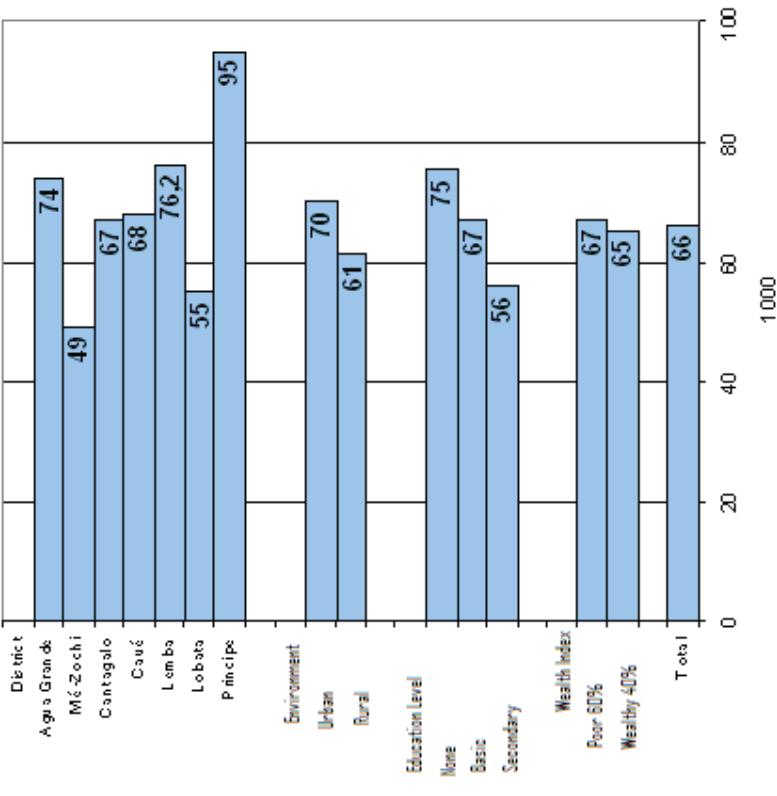
Infant mortality rate is the probability of dying before the first birthday. Under-5 mortality rate is the probability of dying before the fifth birthday. In MIC surveys, infant and under-5 mortality rates are calculated based on an indirect estimation technique known as the Brass method (United Nations, 1983; 1990a; 1990b). The data used in the estimation are the mean number of children ever born for 5-year age groups of women aged 15 to 49, and the proportion of these children who are dead, also for 5-year age groups of women. The technique converts these data into probabilities of dying by taking into account both the mortality risks to which children are exposed and their length of exposure to the risk of dying, assuming a particular model age pattern of mortality. Based on previous information on mortality in São Tomé e Príncipe, the north model life table was selected as most appropriate.

Table CM.1 provides estimates of child mortality by various background characteristics, while Table CM.2 provides the basic data used in the calculation of the mortality rates for the national total. The infant mortality rate is estimated at 45 per thousand, while the probability of dying at the under-5 mortality rate (U5MR) is around 66 per thousand. These estimates have been calculated by averaging mortality estimates obtained from women aged 25-29 and 30-34, and refer to mid-2003. Differences exist in mortality probability between some social categories. These differences are however small between boys and girls : **male child mortality is only two points higher than for girls (46 per thousand against 48 per thousand) while the male under five mortality rate is one point lower than that for girls (65 per thousand against 66 per thousand)**. On the other hand, differences between districts are clearer. Child mortality rates are lowest in the Districts of Mé-zochi (35 per thousand) and Lobata (39 per thousand) and he highest

in those of Príncipe (62 per thousand) and Lembá (56 per thousand). The lowest rate is 77.0% higher than the highest rate. The tendency is the same for the under five mortality rates : the highest rate is Príncipe's (95 per thousand), close to twice (1.96) higher than the lowest (in Mé-zochi, with 49 per thousand). Mortality rates are also higher in rural environments than in urban ones : 47 per thousand in urban areas against 43 per thousand in rural areas, with the under five mortality rates at 70 per thousand against 61 per thousand.

The child and under five mortality rates lower in relation to the mother's level of education. The rates are higher among children whose mother does not have any education (respectively 50 and 75 per thousand) and lower among children with mothers with at least a secondary education (respectively 39 and 56 per thousand), or, a decrease of 28% and 34% respectively. On the other hand, the influence of the level of quality of life seems negligible on mortality : the child mortality rate is estimated at 46 per thousand in the poorest 60% of households, and 45 per thousand in the 40% wealthier households. The probability of dying in the under fives follows this tendency (respectively 67 and 65 per thousand).

Figure CM.1 : Mortality rate for the under fives, by socio-economic groupings. São Tomé, 2006

Figure 2: CM1 Mortality rate for the under fives, by socio-economic groupings

Figure CM.2 presents a series of estimations of under five mortality rates, based on responses from women from different age groups, and for different points in time, indicating thus the estimated tendency of mortality rates for the under fives from the survey data. MICS estimations globally indicate a decrease in mortality during the last 15 years. A study on the Mother and Child Health indicators by the Ministry of Health and undertaken in 1996 by Drs António Lima and Lázaro Sousa, indicated that the under fives mortality rates passed from 76 per thousand between 1991 -- 1994 to 66 per thousand for the period 1997 -- 2000, in other words a decrease of 15%. The most recent MICS3 estimation (66 deaths per 1000 live births) for 2000 -- 2006 seems to indicate some stagnation in the mortality rates against an expected decrease following the tendency indicated by the above-mentioned study. Nevertheless, compared to the 2001 General Population and Habitat Census (GPHC) results, with 72 deaths per 1000 live births, this estimation indicates a decrease of about 9% between 2001 and 2003. With regard to child mortality, the same tendency between the GPHC and the MICS3 is observable. The most recent MICS3 estimation in child mortality (45 deaths per 1000 live births) is about 17.0% lower than that of the GPHC in 2001 (54 deaths per 12000 live births). Globally, these results indicate a decreasing tendency in child mortality, whatever the source, even if comparison of data quality cannot be definitively established. A more profound evaluation of these apparent decreases and differences, as well as their determinants, should be undertaken by an independent and substantive analysis.

Figure 3: CM2 Mortality rate tendency for the under fives

V. Nutrition

Nutritional status

Children's nutritional status is a reflection of their overall health. When children have access to an adequate food supply, lower exposure to repeated illness, and well cared for, they are considered as well nourished and able to reach their growth potential.

Under-nutrition is associated with more than half of all child deaths worldwide. Undernourished children are more likely to die from common childhood ailments, and those who survive have recurring sicknesses and faltering growth. Three quarters of the children who die from causes related to malnutrition were only mildly or moderately malnourished - showing no outward sign of their vulnerability. The MDGs target is to reduce by half the proportion of people who suffer from hunger between 1990 and 2015. The WFFC goal is to reduce the prevalence of malnutrition among under-5 children by at least one third between 2000 and 2010, with special attention to children under 2 years of age. A reduction in the prevalence of malnutrition will assist in the goal to reduce child mortality.

In a well-nourished population, there is a reference distribution of height and weight for under-5 children. Under-nourishment in a population can be gauged by comparing children to a reference population. The reference population used in this report is the WHO/CDC/NCHS reference, which was recommended for use by UNICEF and the World Health Organization (WHO) at the time the survey was implemented.

Each of the three nutritional status indicators can be expressed in standard deviation units (z-scores) from the median of the 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.

Finally, 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.
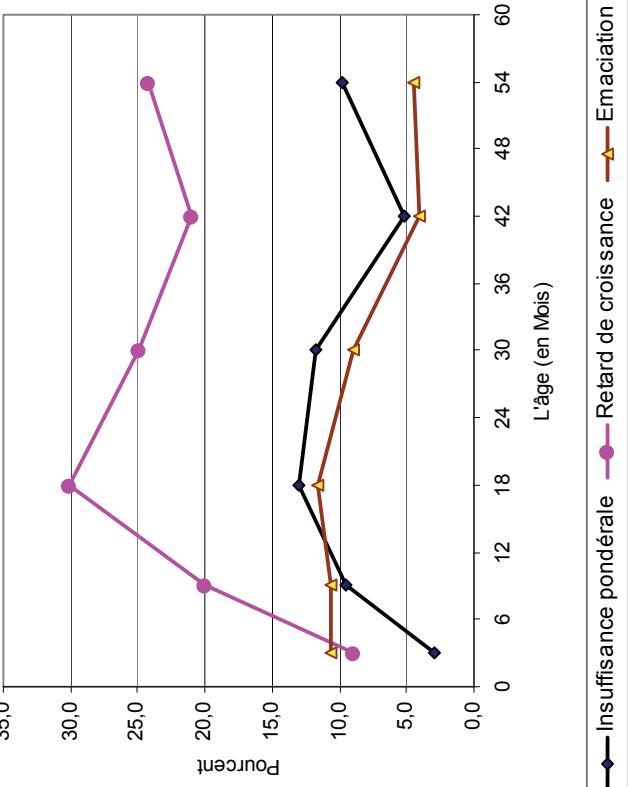
In the MICS III, weights and heights of all under-5 children were measured using anthropometric equipment recommended by UNICEF (UNICEF, 2006). The findings in this section are based on the results of these measurements.

Table NU.1 shows the percentages of children classified into each of these categories, based on the anthropometric measurements that were taken during fieldwork. Additionally, the table includes the percentage of children who are overweight, which takes into account those children whose weight for height is above two standard deviations from the median of the reference population.

In Table NU.1, children whose dates of birth are not known are not taken into account. For the specific case of São Tomé e Príncipe, all children selected are weighed. Close to 9.0% were excluded from the analysis for one of the following reasons : they were not weighed or measured, their measurements are above two standard deviations from the median of the reference population, or their date of birth is not known. Exclusion cases are more frequent in the District of Príncipe (15.2%), among children under 6 months and between 6 – 11 months (21.5% and 14.4% respectively).

Table NU.1 shows about 9.2% of children under five in São Tomé e Prínicpe suffer from moderate underweight and 1.2% are considered as suffering from severe underweight. Close to one child out of four (23.0%) of children suffer from moderate stunting or are too short for their age and one childe out of ten suffer from sever stunting. About 8.0% either is wasting moderately or is too thin for their height while 1.4% is wasting severely. More than one child out of ten (10.7%) are overweight.

Figure NU.1: Pourcentage de malnutrition chez les moins de 5 ans,São Tomé et Príncipe, 2006

Legend: Insuffisance pondérale — Retard de croissance — Emaciation

Axis: Pourcent / L'âge (en Mois)

Figure 4: NU.1 Percentage of malnutrition in under fives

According to these indicators, differences may be established between the nutritional status of girls and boys. The greatest difference for girls relates to severe underweight (0.8% against 1.6%), moderate or severe stunting (21.6% against 24.3% while overweight is in detriment to them 11.8% against 9.7%). Rural children have a greater risk of suffering from moderate or severe underweight (11.4% against 7.5%) and severe 1.1%against 0.4%), moderate or severe stunting (28.2% against 19.0% and severe stunting (12.2% against 8.5%) and wasting 12.2% against 8.5% than urban children.

The tendency is the same for overweight (11.9% against 9.9%). Moderate or severe underweight is more frequent in the Districts of Lembá (11.2%) and Caué (10.8%), among children aged 12 – 23 months (13.1%), children whose mother is not educated 12.6%) and the poorest households 12.7%); it is weaker in the District of Príncipe (0.4%) and among those aged less than 6 months and the wealthier who ignore this sort of malnutrition. Moderate or sever stunting is more frequent among children whose mothers did not go to school (respectively 25.1% and 11.1% against respectively 18.2% and 8.8% for those children whose mother has had a secondary level or more of education). It is also widespread among children in the poorest households (respectively 30.6% and 14.5% against respectively 12.2% and 5.0% for children from wealthier households). Overweight is particularly frequent in Príncipe (23.7% against a national average of 10.7%), among children under 6 months (22.4%) and those from six to 11 months (14.9%).

It is interesting to underline that from the point of view of the structure by age and according to the three malnutrition indices, children from 12 to 23 months are more affected than those younger or older (Figure NU.1). This situation is normal because at that age many children are being weaned from breastfeeding and are thus contaminated through water, food and the environment.

Breastfeeding

Breastfeeding for the first few 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. There are often pressures to switch to an infant formula, which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. The WFFC goal states that children should be exclusively breastfed for six months and continue to be breastfed for two years of age and beyond, and introduced to safe, appropriate and adequate complementary feeding at six months.

The WHO/UNICEF have the following feeding recommendations:
• Exclusive breastfeeding for the first six months
• Continued breastfeeding for two years or more
• Safe, appropriate and adequate complementary foods beginning at six months
• Frequency of complementary feeding: at least twice per day for 6-8-month-olds; at least three times per day for 9-11 month olds
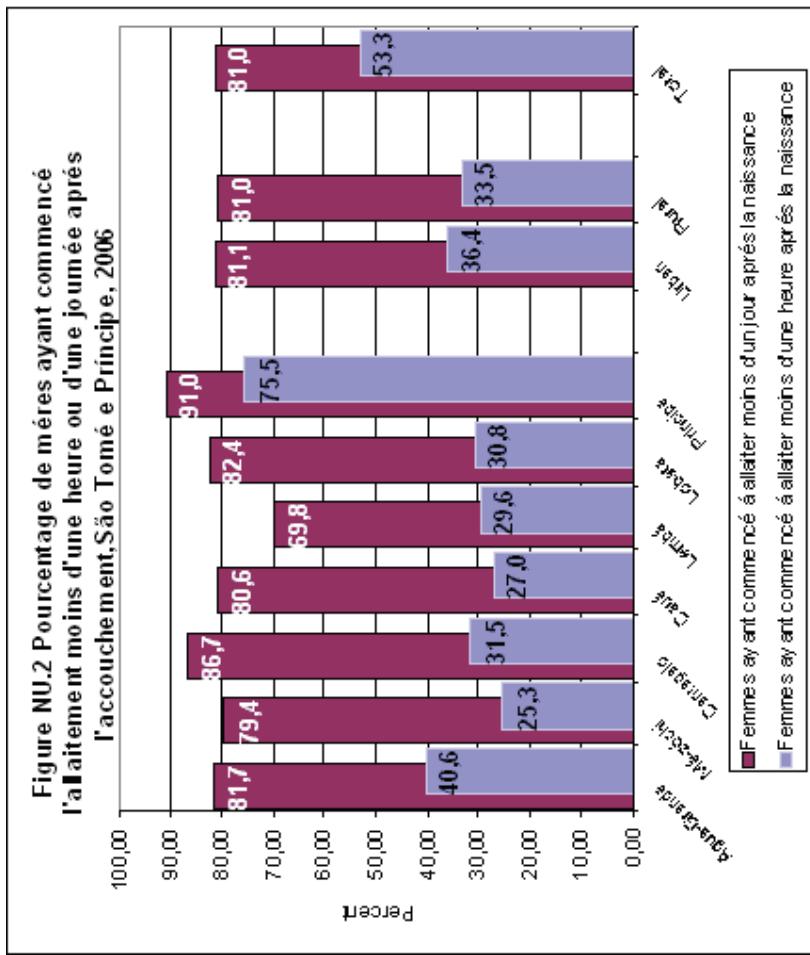
It is also recommended that breastfeeding should be initiated within one hour of birth.

The indicators of recommended child feeding practices are as follows:
• Exclusive breastfeeding rate (< 6 months & < 4 months)

- Timely complementary feeding rate (6-9 months)
- Continued breastfeeding rate (12-15 & 20-23 months)
- Timely initiation of breastfeeding (within 1 hour of birth)
- Frequency of complementary feeding (6-11 months)
- Adequately fed infants (0-11 months)

Table NU.2 presents the proportion of women who began breastfeeding their newborns within the hour following birth and women who began breastfeeding within the day following the birth (this includes those who began breastfeeding within the hour). More than one third of women 35.3%) began breastfeeding less than one hour after the birth and 81.0% less than one day after the birth. Breastfeeding within the hour following birth is more frequent in the District of Príncipe (75.5%) and Água Grande (40.6%), in urban areas (36.4%), among children between 12 and 23 months (39.2%), among children whose mothers have a secondary level or more of education (36.1%). This practice is less widespread in the District of Mé-zochi (25.3%), in rural areas (34.5%), among children 6-111 months (25.6%), and children whose mother has not been to school (32.5%).

Figure NU.2 Pourcentage de mères ayant commencé l'allaitement moins d'une heure ou d'une journée après l'accouchement, São Tomé e Príncipe, 2006

Figure 5: NU2 Percentage of mothers having initiated breastfeeding less than one hour or one day after giving birth
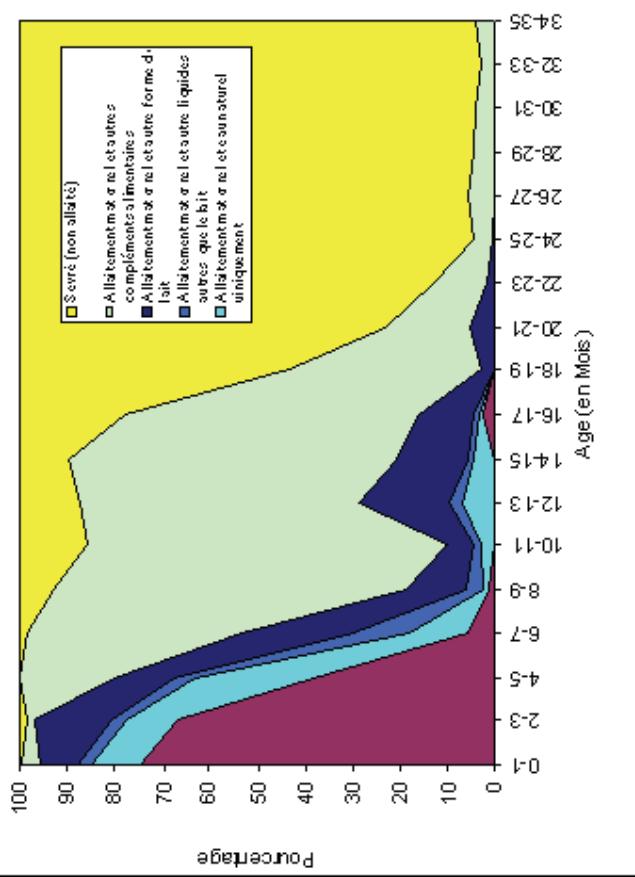
In Table NU.3, the breastfeeding status is based on reports by mothers/care-givers about infant consumption of solids and liquids the 24 hours preceding the interview. Infants receiving nothing other than maternal milk define exclusive breastfeeding. This table presents exclusive

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breastfeeding of infants during the first six months of their lives (apart from those 0 – 3 months and those aged 0 – 5 month), as well as complementary breastfeeding of infants 6 to 9 months and continued breastfeeding of children aged 12 to 15 months and from 20 to 23 months.

Close to seven children out of ten aged under three months are breastfed exclusively and 60.4% of those under six months are exclusively breastfed. 60.0% of children aged 6 to 9 months are breastfed and receive solid and semi-solid foods at the same time. 88% of children aged 12 and 15 months continue to be breastfed while only 18.0% continue to be breastfed from 20 to 23 months. Exclusive breastfeeding is generally more frequent in boys under 6 months than in girls of the same age (63.9% against 57.3%). It is also more widespread in urban areas (61.7% against 58.0%). Children from wealthier households are more frequently exclusively breastfed than others (64.3%, against 56.5% among the poorest). On the other hand, between 6 to 9 months, girls are more likely to be breastfed at the same time as solid and semi-solid foods (61.3% against 58.6%). Urban children have greater tendency to follow this practice than rural children (68.8% against 48.0%) do. Breastfed boys are relatively more numerous than breastfed girls aged 12 to 15 months (90.0% against 86.8%). This practice is mirrored in rural settings (93.6% against 84.9%).

Figure NU.3 presents the detailed breastfeeding status, by age of the child in months. Even at the earliest months, the majority of children receive fluids or foods other than maternal milk. At the end of the six months, the percentage of exclusively breastfeed children is approximately 10 per cent. Only about 18 per cent of children continue to be breastfed after their second year.

Figure NU.3 Modes d'alimentation des nourrissons par âge: Répartition (en pourcentage) des enfants de moins de 3 ans par mode d'alimentation et par groupe d'âges, São Tomé et Príncipe, 2006

Figure 6: NU.3 Distribution (or percentage) of children under three, by feeding method and by age

The adequacy of infant feeding in children less than 12 months is provided in Table NU.4. Different criteria of adequate feeding are used, depending on the age of the child. For infants aged 0-5 months, exclusive breastfeeding is considered as adequate feeding. Infants aged 6-8 months are considered to be adequately fed if they receive breast milk and complementary food at least twice a day, while infants aged 9-11 months are considered to be adequately fed if they receive breast milk and eating complementary food at least three times a day.

About 60.4% of children from 0 to 5 months (63.9% of boys and 57.3% of girls) were exclusively breastfed. Among children from 6 to 8 months, 49.4% (59.3% in urban areas and 32.0% in rural areas) received maternal milk and complementary foods at least twice per 24 hours. Among children 9 – 11 months, 38.9% were adequately nourished by receiving maternal milk and complementary foods at least three times per 24 hours. For children aged 6 to 11 months, 44.3% (44.5% in boys and 44.2% in girls) were adequately nourished by maternal milk and complementary foods at least the recommended times per 24 hours. The proportion adequately nourished children is higher in the District of Água Grande (63.4), in urban settings (56.4%) and among children whose mothers have a secondary or higher level of education (67.8%). The proportion is lower in the District of Caué (29.0%) and in rural areas (28.3%). Globally, only half (53.6%) of children aged 0 to 11 months have received adequate nourishment. Children from the District of Água Grande (66.2%), urban children (59.3%) and those from the wealthiest households (59.0%) are the best nourished. Children living in the District of Cantagalo (38.7%), rural children (42.3%) and those from the wealthiest and poorest (respectively 50.5% and 47.4%) are the least well nourished.

Salt iodisation

Iodine Deficiency Disorders (IDD) is the world's leading cause of preventable mental retardation and impaired psychomotor development in young children. In its extremes forms, iodine deficiency causes cretinism. It also increases the risks of stillbirth and miscarriage in pregnant women. Iodine deficiency is most commonly and visibly associated with goitre.

IDD takes its greatest toll in impaired mental growth and development, contributing in turn to poor school performance, reduced intellectual ability and impaired work performance. The international goal is to achieve sustainable elimination of iodine deficiency by 2005. The indicator is the percentage of households consuming adequately iodized salt (≥15 parts per million).

Following the National Technical Commission's recommendations on salt iodisation, the National Assembly voted in favour of a law fixing the amount of iodine in salt to be consumed by households to 60 parts per million (pm) or more. This law confirms the results of a study indicating that goitre risk was particularly high amongst the population, and that only such a measure would help in lowering this risk for the population, leading to an iodine content adapted to the country's needs.

In São Tomé e Príncipe, the government, with UNICEF's technical assistance, has promulgated a law stipulating the salt produced, imported and sold in the country must be iodised. Customs procedures have been established to allow the verification of imported salt is up to the standards as defined by law. If salt is generally iodised, the amount of iodine is not sufficiently high to compensate the level of deficiency amongst the Saotomean population.

Cooking salt was tested in 83.6% of households to determine their iodine content by utilising salt testing kits evaluating the presence of potassium iodate. Table NU.5 indicates that in a small proportion of households (15.1%), there was no salt. In 36.6% of households, the tested salt contained 15 ppm or more of iodine. The use of iodised salt is less widespread among households in the District of Caué (16.2%) and more widespread in that of Príncipe (60.4%). In urban settings nearly four households out of ten (39.7%) had available enough iodised salt and in rural areas iodised salt was available in less than one third of households (32.5%). Adequate consumption of iodised salt is also unequal according to the level of household life : a little less than half (46.8%) of wealthier households consume sufficient iodised salt while one out of three poorest households (29.5%) have this type of salt available.

Only 17.7% of households consume iodised salt adequately under the terms of the law of November 1996, still in effect, and which stipulates that the required content of iodine for household consumption should be 60 ppm or more and consequently the salt sold in the country must be up to this standard. The utilisation of iodised salt in households is less widespread in the District of Caué (5.4%) and more widespread in those of Príncipe (23.4%) and Água Grande (22.8%). In urban areas, close to one household out of five (19.9%) have enough iodised salt available while in the rural areas, only 14.8% of households own this type of salt. Correct consumption of iodised salt is also unequal according to the household level of life : more than one quarter (26.0%) of the wealthiest households consume iodised salt adequately while amongst the poorest only 12.3%, or less than half, have available this type of salt.

Figure NU.4 Pourcentage de ménages consommant du sel correctement iodé,São Tomé et Principe, 2006
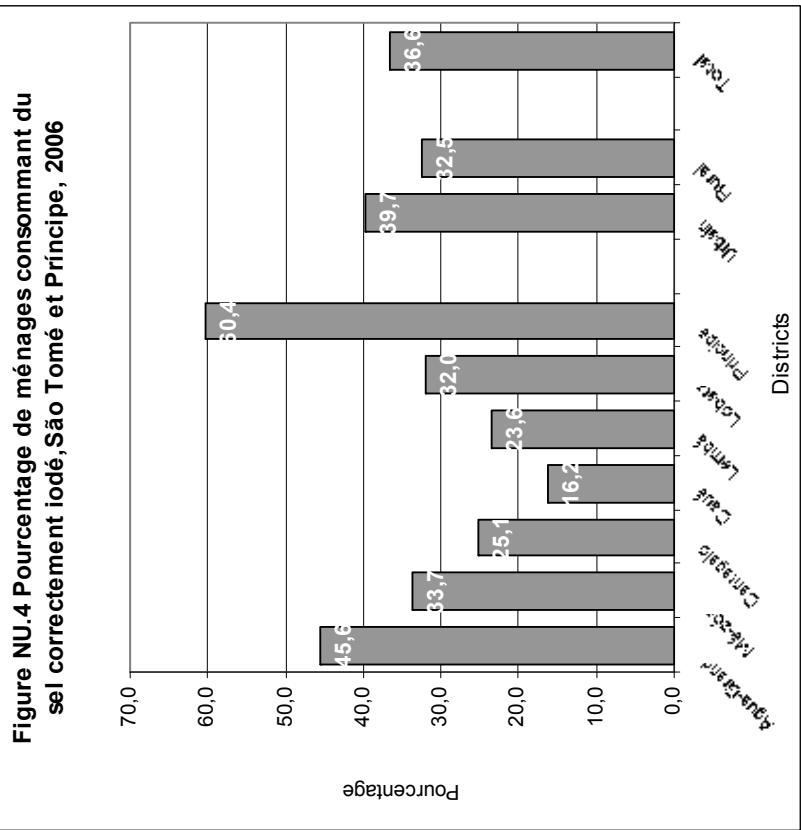
Figure 7: NU.4 Percentage of households correctly consuming iodised salt

Vitamin A Supplementation

Vitamin A is essential for eye health and proper functioning of the immune system. It is found in foods such as milk, liver, eggs, red or orange fruits, red palm oil and green leafy vegetables, although the amount of Vitamin A readily available to the body from these sources varies widely. In the developing areas of the world, where Vitamin A is largely consumed in the form of fruits and vegetables, daily per capita intake is often insufficient to meet dietary requirements. Inadequate intakes are further compromised by increased requirements for the Vitamin as children grow or during periods of illness, as well as increased losses during common childhood infections. As a result, Vitamin A deficiency is quite prevalent in the developing world and particularly in countries with the highest burden of under-5 deaths

The 1990 World Summit for Children set the goal of virtual elimination of Vitamin A deficiency and its consequences, including blindness, by 2000. This goal was also endorsed at the Policy Conference on Ending Hidden Hunger in 1991, the 1992 International Conference on Nutrition, and the UN General Assembly Special Session on Children in 2002. The critical role of Vitamin A for child health and immune function also makes control of the deficiency a primary component of child survival efforts, and therefore is critical to the achievement of the fourth MDG: a two-thirds reduction in under-5 mortality by 2015.

For countries with Vitamin A deficiency problems, current international recommendations call for high-dose Vitamin A supplementation every four to six months, targeting all children between the ages of 6-59 months living in the affected areas. Providing young children with two high-dose Vitamin A capsules a year (at six-monthly intervals) is a safe, cost-effective, efficient strategy for eliminating Vitamin A deficiency and improving child survival. Giving Vitamin A to new mothers who are breastfeeding helps protect their children during the first months of life and helps to replenish the mother's stores of Vitamin A, which are depleted during pregnancy and lactation. For countries with Vitamin A supplementation programmes, the definition of the indicator is the percentage of children 6-59 months of age receiving at least one high dose of Vitamin A supplement in the last six months.

In 1992, studies on micronutrient deficiencies, such as Vitamin A, indicated that the retinol rate in the under fives was very weak (less than 100 mcg/l). Thus, UNICEF and the Ministry of Health implemented the « Vitamin A Capsule Programme » destined to post-partum mothers and children aged 6 to 59 months.

Based on UNICEF/WHO directives, the São Tomé e Príncipe Ministry of Health recommends that children aged 6 to 59 months and 29 days receive a Vitamin A capsule every six months, until their fifth birthday. In certain parts of the country, the Vitamin A capsules are associated with vaccination services and are given when the child comes into contact with these services after reaching 6 months. It is equally

recommended that their mothers take Vitamin A supplementation eight weeks prior to labour given the increase in Vitamin A needs during pregnancy and breastfeeding.

During the six months preceding MICS3, 33.4% of children aged 6 – 59 months received a high dose of Vitamin A supplements during the last six months while 27.0% at some time or another prior to the last six months. Vitamin A supplementation is slightly more widespread in urban settings (36.5% than in rural areas (32.0%), and more amongst girls (34.5%) than boys (32.0%) are. The differences between districts are greater : 63.4% in Príncipe and only 25.4% in Água Grande and 27.5% in Cantagalo. Vitamin A supplementation lowers considerably with the age of children, with the youngest representing greater numbers : 43.8% respectively for those aged 6 – 11 months and 12 – 23 months against 34.2% for those aged 24 – 35 months and 20.2% for those aged 48 – 59 months. The mother's or the caretaker's level of instruction influences positively supplementation of Vitamin A (36.8% when the mother has a secondary or higher level of education against only 20.9% if she has not been to school) while the level of household life has a contrary effect (36.0% amongst the poorest against 30.0% amongst the wealthier).

Post-partum Vitamin A supplementation of mothers seems more widespread than for children. Table NU.7 indicates that more than six out of ten (63.1%) of mothers who have given birth during the two years preceding MICS received Vitamin A supplement eight weeks before the birth of their child. This percentage is slightly higher in rural women (65.0%) than in urban women (61.8%). The most favoured districts are those of Príncipe (84.2%) and Lembá (71.1%) while the District of Cantagalo is the least (55.8% of mothers). Vitamin A supplementation coverage increases with the level of education of the mother (57.9% for those who have not gone to school and 64.7% for those with a secondary level or higher of education) and the level of household life (60.7% of mothers living in the poorest households and 72.9% of those in the wealthiest).

Low birth weight

Weight at birth is a good indicator not only of a mother's health and nutritional status but also of the newborn's chances of survival, growth, long-term health and psychosocial development. Low birth weight (less than 2,500 grams) carries a range of grave health risks for children. Babies who were undernourished in the womb face an increased risk of dying during their early months and years. Those who survive have an impaired immune function and increased risk of disease; they are likely to remain undernourished, with reduced muscle strength, throughout their lives, and suffer a higher incidence of diabetes and heart disease in later life. Children born underweight also tend to have a lower intelligence quotient (IQ) and cognitive disabilities, affecting their performance in school and their job opportunities as adults.

In the developing world, low birth weight stems primarily from the mother's poor health and nutrition. Three factors have the most impact : the mother's poor nutritional status before conception, short stature (due mostly to under-nutrition and infections during her childhood) and poor nutrition during pregnancy. Inadequate weight gain during pregnancy is particularly important, since it accounts for a large proportion

of foetal growth retardation. Moreover, diseases such as diarrhoea and malaria, which are common in many developing countries, can significantly impair foetal growth if the mother becomes infected while pregnant.

In the industrialized world, cigarette smoking during pregnancy is the leading cause of low birth weight. In developed and developing countries alike, teenagers who give birth when their own bodies have yet to finish growing run the risk of bearing underweight babies.
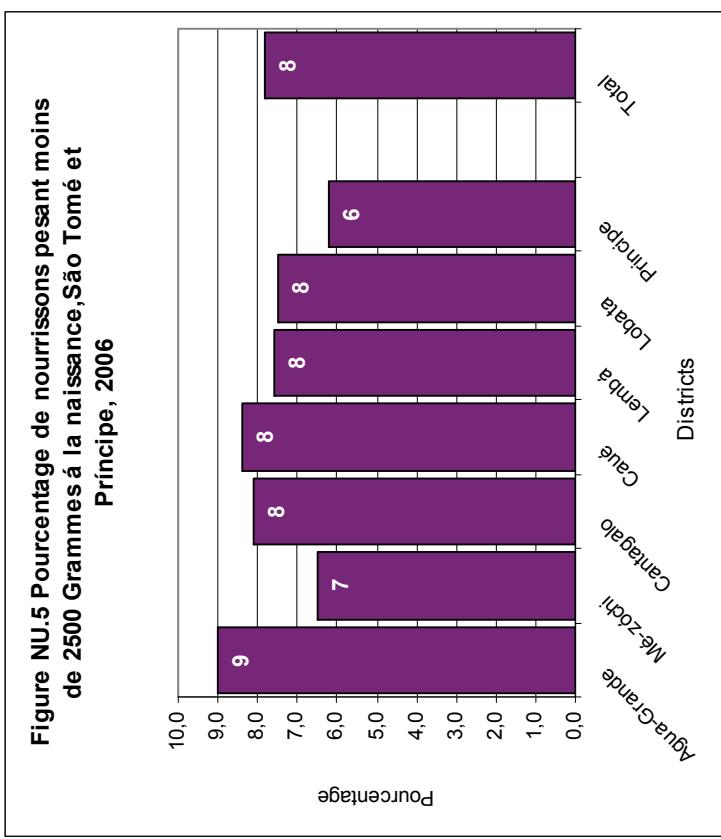
One of the major challenges is in measuring the incidence of low birth weight is the fact that more than half of infants in the developing world are not weighed. In the past, most estimates of low birth weight for developing countries were based on data compiled from health facilities. However, these estimates are biased for most developing countries because the majority of newborns are not delivered in facilities, and those who are, represent only a small sample of all births.

Since many infants are not weighed at birth, the weights of those who are weighed may bias the sample of all births. The reported birth weights usually cannot be used to estimate the prevalence of low birth weight among all children. Therefore, the percentage of births weighing below 2,500 grams is estimated from two items in the questionnaire: the mother's assessment of the child's size at birth (i.e. very small, smaller than average, average, larger than average, very large) and the mother's recall of the child's weight or the weight as recorded on a health card if the child was weighed at birth.[6]

Table NU.8 indicates that, altogether, 82.4% of newborns were weighed at birth and 7.8% weighed less than 2500 gr. at birth. There is not important variation with regard to low birth weight according to social categories, especially between urban and rural settings (respectively 8.5% and 6.9%). The most important variation is observed between the districts and the wealth quintiles : from 6.2% in the District of Príncipe, the percentage of low birth weight rises to 9.0/ in that of Água Grande. The disparity is the same between children from the wealthier households to the poorest ones. Low birth weight is invariable whether the mother has been to school or not.

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[6] For a detailed description of this methodology, see Boerma, Weinstein, Rutstein and Sommerfelt, 1996.

Figure NU.5 Pourcentage de nourrissons pesant moins de 2500 Grammes á la naissance,São Tomé et Principe, 2006

Figure : NU.5 Percentage of newborns weighing less than 2500 gr. at birth

VI. Health of the child

Immunization

MDG 4 aims to reduce child mortality by two thirds between 1990 and 2015. Immunization plays a key part in this goal. Immunization has saved the lives of millions of children in the three decades since the launch of the Expanded Programme on Immunization (EPI) in 1979. Worldwide, there are still 27 million children overlooked by routine immunization and, as a result, vaccine-preventable diseases cause more than two million deaths every year.

A WFFC goal is to ensure full immunization of children under one year of age at 90 per cent nationally, with at least 80 percent coverage in every district or equivalent administrative unit.

São Tomé e Príncipe, like all other WHO member countries, subscribes to global initiatives such as eradication of polio, elimination of neo-natal tetanus and measles. Thus, since 1979, the country has initiated an enlarged vaccination programme (EVP) targeting children under one and women in reproductive age. The strategies and activities developed globally by this programme have been applied, with remarkable results at the regional level.
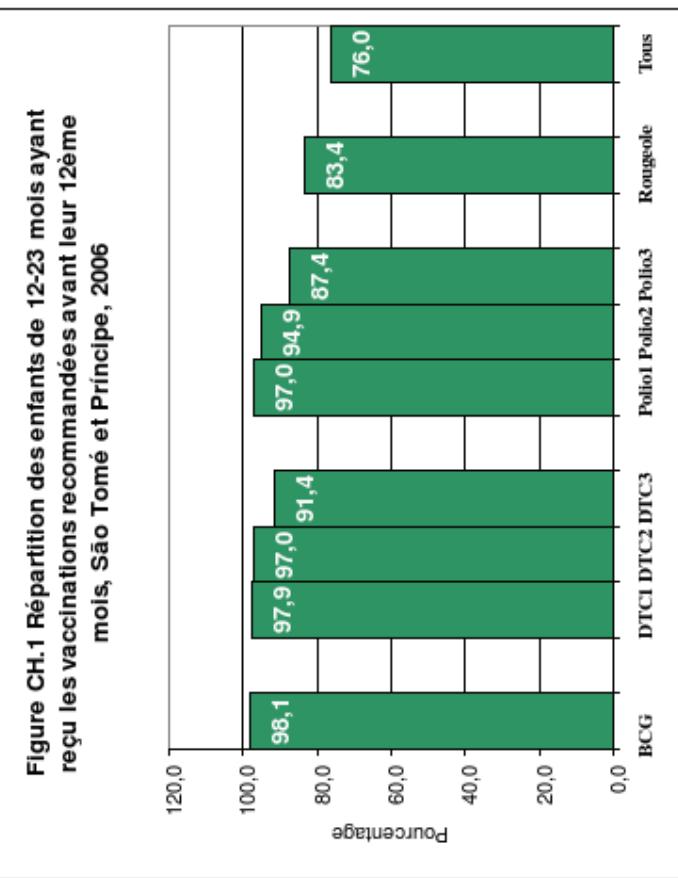
According to the UNICEF WHO guidelines, children should receive a BCG vaccination to protect them against tuberculosis, three doses of DPT to protect them against diphtheria, pertussis and tetanus, three doses of polio vaccine, and a measles vaccination by the age of 12 months. Mothers were asked to provide vaccination cards for the under-fives. Interviewers copied vaccination information from the cards on to the MICS questionnaire.

Within the EVP framework in São Tomé e Príncipe, a vaccination calendar for children less than one year has been established. Thus, from their birth, the child must receive BCG and polio vaccines. The first DPT and polio doses are administered during the first six weeks in the infant's life. The second dose DPT2 and Polio2) is taken after the 10th week and the third dose (DPT3 and Polio3) at the 14th week. The measles vaccine is given to the child nine months after birth. To strengthen the child's protection against polio and DPT, the EVP recommends the administration of a new dose one year after the third dose.

Table CH.1 indicates that, altogether, 79.0% of children have a health card. In lieu of the health card, the interviewer requested the mother to recall whether each vaccination was given to her child or not. With regard to DPT and polio, the mothers were requested to provide the number of times the child received them. This table, which also indicates the percentage of children having received each vaccination, children

aged 12 to 23 months constitute the denominator so that only those children with sufficient age to be completely vaccinated are taken into account. In the upper part of the table, all children who were vaccinated at one time or another prior to the survey are registered according to their vaccination card or information provided by their mother. In the lower part only those children vaccinated before their first birthday are included, as recommended. For children without vaccination cards, the proportion of vaccinations given before the first birthday is supposed to be the same as for those children with a vaccination card.

About 8.1% of children aged 12 to 23 months were given the BCG vaccine at the age of 12 months and their first DPT dose was administered at the rate of 97.9%. For the following DPT doses, the percentage is lower : 97.0% for the second dose and 91.4% for the (Figure NU.4). Equally, 97.4% of children were given polio 0 at the age of 12 months although this percentage falls gradually to 87.4% for Polio 3. The rate of coverage against measles at the age of 12 months is established at 83.4%, which is lower than for other vaccines. Globally, more than three children aged 12 –23 months out of ten (76.0%) were given all the recommended vaccines by their first birthday.

Figure CH.1 Répartition des enfants de 12-23 mois ayant reçu les vaccinations recommandées avant leur 12ème mois, São Tomé et Príncipe, 2006

Figure 8: CH.1 Percentage of children aged 12-23 months having received recommended vaccinations before their 12th month

In São Tomé e Príncipe the vaccination framework calendar recommends three doses of Hepatitis B and one yellow fever vaccination, both of which were introduced in 2003. Hepatitis B1 is given at the sixth week of age, Hepatitis B2 one month afterwards (at the tenth week) and Hepatitis B3 by the 14th week. The yellow fever vaccine is given to the child nine months after birth.

Table CH.1c indicates that Hepatitis B vaccine coverage is at 87.6% for the first dose, 82.9% for the third dose, while yellow fever vaccine coverage is estimated at 76.9%.

Tables CH.2 and CH.2c present the rates of vaccine coverage for children between 12 and 23 months, according to context characteristics. The numbers indicate the percentage of children who were vaccinated at one moment or another before the survey and are based on information drawn from the health cards and from information provided by the mothers/caregivers. Vaccine coverage for BCG is very strong whatever the category under consideration : the lowest rate of coverage is found among children from the wealthier households (93.5%) and those from the District of Lobata (95.3%) while it is as high as 100% in the Districts of Príncipe, Cantagalo and Mé-Zochi, among the poor and in rural areas. With a few rare exceptions, this tendency is nearly the same for the other vaccines. Considering all vaccinations, boys are better protected : 84.3% of all boys were given the recommended vaccines, against 75.0% for girls. Globally, the Districts of Mé-zochi (91.1%), Caué (86.4%) and Príncipe (86.3%) have the best coverage, while those of Lobata (66.2%) and Lembá (73.7%) have relatively poor coverage. In the same manner, rural children have a better immunization rate than urban children (83.0% against 77.0%). There is also a strong positive correlation between the mother's level of education and vaccination coverage for children : the rate of global coverage rises from 61.7% in cases where the mother has not been to school, to 79.9% when she has been to primary school, to 84.7% when the mother has a level of secondary or higher level of education. The level of household life seems to have a positive effect on vaccination coverage, rising from 79.6% for children from the poorest households to 85.1% among the wealthiest households. ~

Tetanus toxoid

One of the MDGs consists in reducing by three quarters the rate of maternal mortality, with a strategy designed to eliminate maternal tetanus. Another objective is the reduction of neo-natal mortality to not more than one case per 1000 live births in each district. A WFFC objective is to eliminate maternal land neo-natal tetanus by 2015.

Prevention of maternal and neo-natal tetanus consists in ensuring that all pregnant women receive at least two doses of tetanus toxoid. Nevertheless, if women have not be given two doses of this vaccine during their pregnancy, they and their newborn are considered as protected if the following conditions are present :

- They have received at least two doses of tetanus toxoid, that last during the preceding three years
- They have received at least three doses of tetanus toxoid, the last during the preceding five years
- They have received at least four doses, the last during the preceding ten years
- They have received at least five doses, giving them lifelong protection

Table CH.3 presents the status of protection against tetanus in women with a live birth during the last twelve months. Figure CH.2 indicates the protection status of women in terms of neo-natal tetanus according to contextual characteristics.

Close to two women out of three (65.7%) have received at least 2 doses of tetanus toxoid during their pregnancy, and close to one woman out of five (19.7%) were given at least two doses during the last three years. Protection against neo-natal tetanus is better in urban areas : close to seven urban women out of ten were given two doses of tetanus toxoid against six rural women. At the district level, the proportion of women having received at least two doses during their pregnancy is higher in Lembá (73.6%) and lower in Príncipe (only 47.3%). Altogether, 87.3% of women are protected against neo-natal tetanus, with light variations according to contextual categories. The proportion of women protected is stronger in the District of Mé-zochi (89.4%) and lower in that of Caué (80.2%). The disparity between urban and rural areas is negligible (1 percentage point). On the other hand, the age of the women seems to negatively influence against neo-natal coverage : the proportion of vaccinated women decreases from 92.3% for women aged 15 to 19, to 83.8% for those aged between 30 and 34, down to 76.4% for those aged 45 to 49. The level of education is also indicative : the coverage rate increases from 80.9% for women who have never been to school, to 85.7% for those with a primary level education, and again, to 95.0% for those women with a secondary or higher level of education. The impact of the level of household life remains ambiguous.

Figure CH.2 Pourcentage de femmes ayant accouché d'un enfant vivant au cours des 12 dernièrs mois qui sont protégées contre le tétanos néonatal,São Tomé et Príncipe, 2006
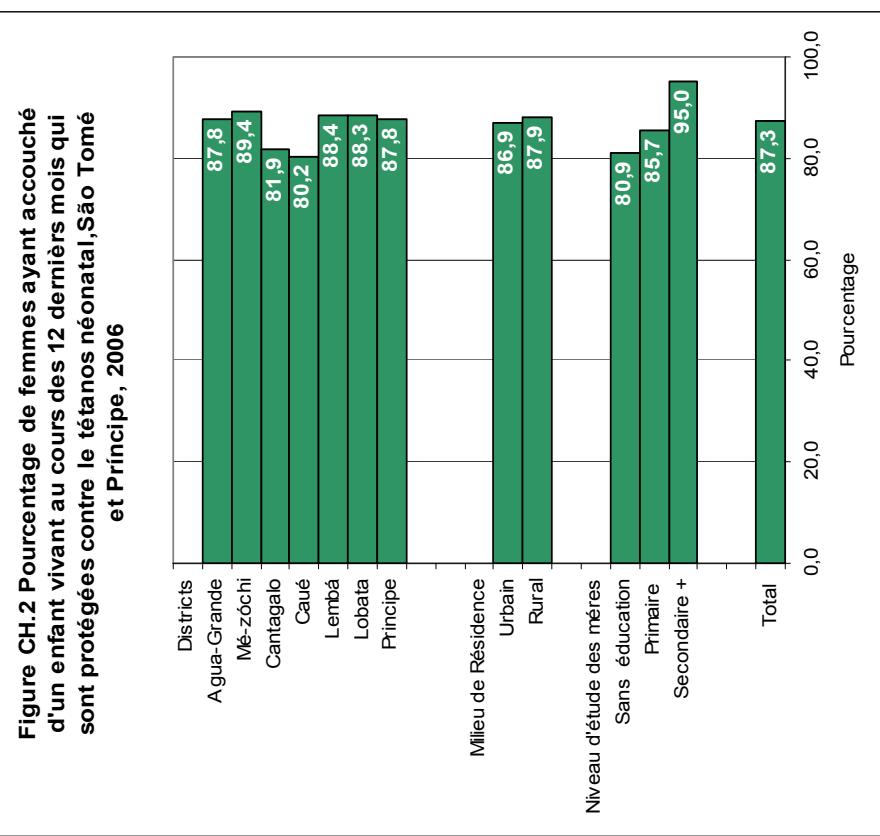
Figure 9: CH.2 Percentage of women having given birth to a live child during the preceeding 12 months protected from neo-natal tetanus

Oral Rehydration Treatment

Diarrhoea is the second leading cause of death among under-5 children worldwide. Most diarrhoea-related deaths in children are due to dehydration from loss of large quantities of water and electrolytes from the body in liquid stools. Management of diarrhoea - either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhoea.

The goals are to reduce by one-half deaths due to diarrhoea among under-5 children by 2010 compared to 2000 (WFFC) (2) and to reduce by two thirds the mortality rate among under-5 children by 2015 compared to 1990 (MDGs). In addition, the WFFC calls for a reduction in the incidence of diarrhoea by 25 per cent.
The indicators are:

- Prevalence of diarrhoea
- Oral rehydration therapy
- Home management of diarrhoea
- ORT or increased fluids and continued feeding

In the MICS questionnaire, mothers (or caretakers) were asked to report whether their child had had diarrhoea in the two weeks prior to the survey. If so, the mother was asked a series of questions about what the child had to drink and eat during the episode and whether this was more, or less, than the child usually ate and drank.

Table CH.4 indicates that 13.1% of children under five had diarrhoea during the two weeks preceding the survey. This prevalence for diarrhoea is particularly high in the District of Lembá (23.0%) in relation to other districts, which vary between 10.3% in Lobata and 13.5% in Água Grande. The age of the child also influences the level of diarrhoea prevalence, which increases by one point during weaning : 18.9% for those aged 6 to 11 months, and 24.3% for those aged between 12 and 23 months while amongst children younger or older, less than 7.0% had diarrhoea during the last two weeks.

Table CH.4 presents, as well, the percentage of children receiving different types of recommended fluids during the diarrhoea episode. Given that their mothers were able to cite a type of fluid, the total of these percentages is not necessarily equal to 100. About 31.4% of children were given fluids prepared from ORT packets; only 1.7% was given pre-conditioned ORT fluids, and 17.1% was given recommended homemade fluids. About 47.1% of children with diarrhoea were given one or more recommended home treatments (That is, they were treated with ORT or recommended homemade fluids), which signifies that the majority (52.9%) did not receive treatment. Girls had more chance of being treated

than boys (51.3% against 42.9%). Equally, rural children receive more treatment than urban children (53.1% against 43.3%) do. In addition, the youngest receive more treatment than older children do : respectively 58.0% of children aged 0 – 6 months and those aged 6 to 11 months received ORT treatment while the proportion varies between 41.0% and 48.0% amongst older children. The relation between ORT on the one hand, and the level of the mother's education and the level of household life on the other remains ambiguous, even if children from the more educated and wealthier households seem to be more favourable (respectively, 58.0% and 67.0%) than those from the less educated and poorer households (respectively 51.3% and 47.0%).

Figure CH.3 Pourcentage d'enfants de 0-59 mois atteints de diarrhée durant les 2 semaines et ayant reçu un traitement RVO, São Tomé et Príncipe, 2006
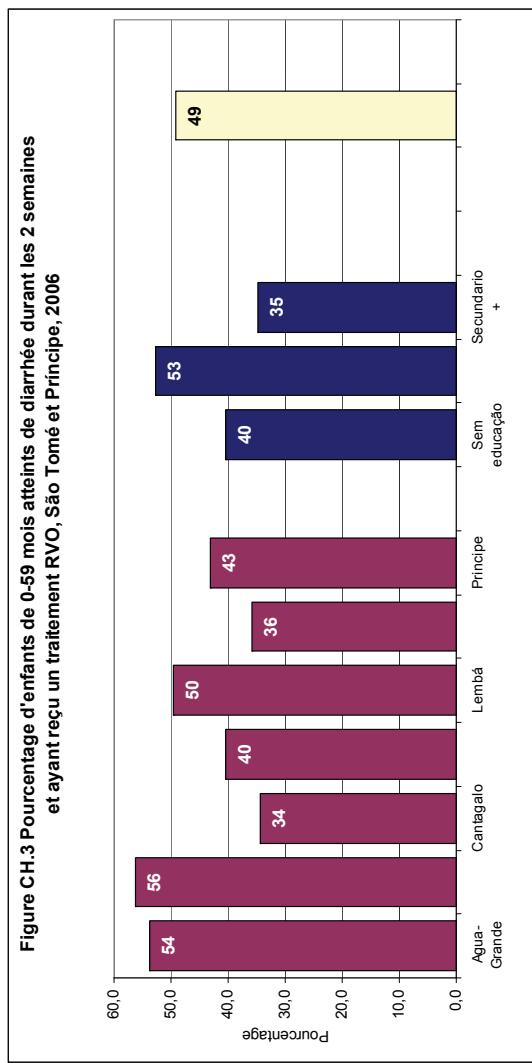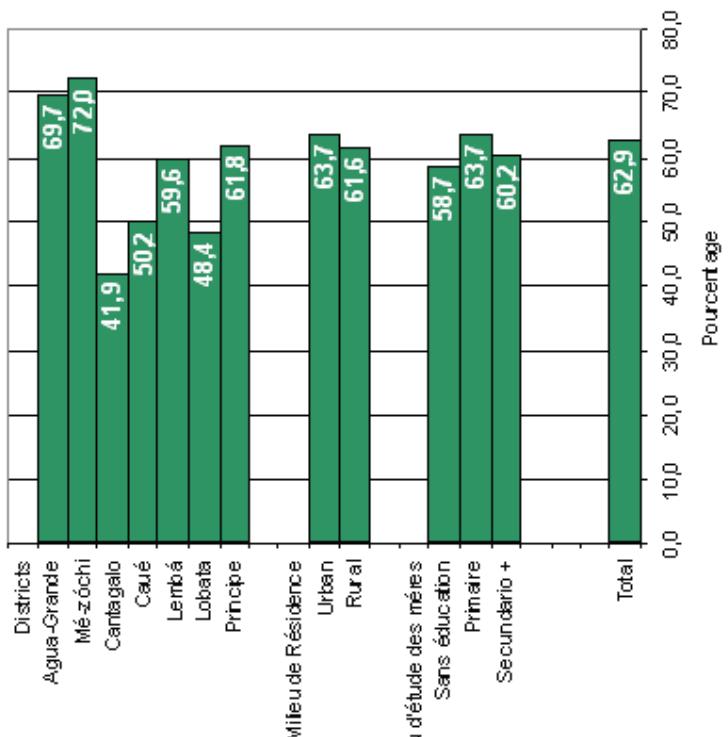
Figure 10: CH.3 Percentage of children between 0 – 59 months with diarrhoea during the last two weeks who received ORT treatment

Table CH.5 indicates that close to two thirds (61.4%) of children under five with diarrhoea during the last two weeks have increased their intake of fluids, while 37.9% have the same or less intake of fluids. Nearly 81.0% have continued their intake of food, eating less, the same or more than usual, while for 18.9% ate considerably less than usual or have hardly eaten. Close to 63.0% of children received more fluids than usual while continuing to eat. Close to one-half of children with diarrhoea during the last two weeks were attended to in their home.

There are important differences in home management of diarrhoea according to contextual characteristics. In the District of Mé-zochi, 72.0% of children received an ORT or more fluids than usual while continuing to eat, while those in Cantagalo less than 42.0% of children benefited from the same type of treatment. The differences are very minor between girls and boys, on the one hand, and between urban and rural areas on the other (respectively 64.1% against 61.6%, and 63.7% against 61.6%). Children aged 24 – 35 months seem to receive better treatment than others (74.5% against 53 to 68.0% for the others). Differences in home management of diarrhoea are very small between rural and urban areas (respectively 50.7% and 48.2%), and is lower in the District of Cantagalo (34.4%) and higher in Mé-zochi (56.3%). Home management is lower for children 0 to 11 months (29.2% against more than half among older children).

Figure CH.4 Pourcentage d'enfants de 0-59 mois atteints de diarrhée dans les 2 dernières semaines et ayant reçu un traitement RVO ou des portions accrues d'aliments fluides et poursuivi l'alimentation,São Tomé et Príncipe, 2006

Figure 11: CH.4 Percentage of children between 0 – 59 months with diarrhoea during the last two weeks who received ORT treatment or increased amounts of fluids followed by food.

Care seeking and antibiotic treatment of 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. A WFFC goal is to reduce by one-third the deaths due to acute respiratory infections.

Children with suspected pneumonia are those who had an illness with a cough accompanied by rapid or difficult breathing and whose symptoms were not due to a problem in the chest and a blocked nose.

The indicators are:
• Prevalence of suspected pneumonia
• Care seeking for suspected pneumonia
• Antibiotic treatment for suspected pneumonia
• Knowledge of the danger signs of pneumonia

Table CH.6 presents the prevalence for presumed pneumonia and, if care has been sought outside the home, the location of the care centre. . About 4.3% of children aged 0 to 59 months were found to have symptoms of pneumonia during the two weeks preceding the survey. These cases of suspected pneumonia are slightly more frequent among children aged 24 – 35 months (6.4%) and in the Districts of Mé-zochi (5.5%) and Lembá (5.3%), while they are relatively rare in the Districts of Cantagalo (2.9%) and Príncipe (1.5%) and among children 0 to 11 months (2.8%). Of these children, 71.3% were seen at an appropriate health facility. Recourse to an appropriate health facility is more widespread in the District of Cantagalo (90.1% of children), among children aged 0 to 23 months (80.0%) and among children whose mother has not been to school (86.0%). Among the appropriate facilities, public facilities are the most sought after, with more than half of children (23.3%) seeking attention in health centres, 16.6% in health posts and 10.0% in hospitals. Recourse to an appropriate facility varies according to the district : in the District of Lembá, 57.1% of children have more recourse to health centres, while in that of Cantagalo, 70.7% of children seek care in health posts. The wealthier children also seek public health centres (41.9% against an average of 23.3%).

Table CH.7 presents the utilisation of antibiotics in the treatment of presumed pneumonia in children under five, by sex, age, place of residence, and socio-economic factors. In São Tomé e Príncipe, 56.0% of children under five suffering from suspected pneumonia received an antibiotic during the two weeks preceding the survey. This percentage is greater in rural (62.7%) than in urban (50.1%) areas, and lower among girls (54.7% against 57.3%). Although important disparities are noted in other categories, their values are too low to reflect significant differences. Concernant les autres catégories, bien des écarts importants sont notés, les effectifs sont très faibles pour refléter des différences significatives.

Indications of danger signs for pneumonia are presented in Table CH.7A. It is clear that the level of the mother's knowledge on danger signs is an important indicator with regard to seeking treatment. Overall, 37.3% of women are familiar with two danger signs for pneumonia : difficult and rapid breathing. The most widely known identified symptom to take a child to a health facility is fever (81.6% of mothers). More than 44.0% of mothers identified rapid breathing and 48.9% difficult breathing as danger signs leading to an immediate transfer of the child to a health facility. The percentage of women familiar with two danger signs for pneumonia is higher in rural (47.6%) than in urban (29.5%) areas. The level of familiarity of the two danger signs also depends on the residential district : the percentage is thus greater in the District of Príncipe (48.4%) and lower in those of Lembá (27.0%) and Água Grande (23.0%).

Utilisation of solid fuels

More than 3 billion people around the world rely on solid fuel (biomass and coal) for their basic energy needs, including cooking and heating. Cooking and heating with solid fuel lead to high levels of indoor smoke, a complex mix of health-damaging pollutants. The main problem with the use of solid fuel is products of incomplete combustion, including CO, polyaromatic hydrocarbons, SO2, and other toxic elements. Use of solid fuel increases the risks of acute respiratory illness, pneumonia, chronic obstructive lung disease, cancer, and possibly tuberculosis, low birth weight, cataracts and asthma. The primary indicator is the proportion of the population using solid fuel as the primary source of domestic energy for cooking.

Table CH.8 indicates that overall, 75.5% of São Tomé e Príncipe households utilise sold fuel for cooking. Utilisation of solid fuels is least in urban areas (65.8%) and stronger in rural areas where close to 9 households out of 10 (88.2%) utilise this type of fuel. Household behaviour with regard to the utilisation of solid fuels varies also according to district of residence : 96.9% of Príncipe households, while in Mé-zochi 81.1% use solid fuels and 52.2% in Água Grande. The effects on the level of household life and the level of education of the head of household with regard to the continued utilisation of solid fuels are particularly important. The percentage of households utilising these fuels ranges from 93.0% when the head of the household is uneducated to 80.9% when a primary level education has been attained, to only 49.1% when the head of household has had a minimum of a secondary level of education. Equally, this percentage ranges from nearly 100% amongst the poorest, to 94.5% among the poor, to 79.3% among the less poor, to 62.9% among the wealthy decreasing to 31.25 AMONG THE WEALTHIEST. This table also clearly indicates that the high use of solid fuels by a greater use of wood for cooking (close to 67.0%) and a lesser use of charcoal (23.1%). Less than 9.0% utilise charcoal and less than 1.0% have access to gas and electricity.

Utilisation of solid fuel causes pollution, in varying degrees, of the interiors, given that the concentration of pollutants varies according to the type of fuel used in the different types of stoves. Utilisation of closed stoves with chimneys reduces internal pollution, while an open stove/fire

without chimney or hood indicates that there is not protection against the dangers of solid fuels. The types of stoves utilised with solid fuel is presented in Table CH.9.

Nationally, about half of all households utilise a closed stove with chimney and the other half an open stove/fire without chimney. The former are more widespread in rural households (54.5%), in the district of Caué (70.6%) and Lembá (57.5%) and less frequent in urban households (45.5%) and in the District of Água Grande (40.5%). Differences according to the household's level of life are significant : the percentages range from 36.5% amongst the poorest to 55.4% amongst the less poor, to 64.5% among the wealthy, and to more than 75.0% among the wealthiest.

Malaria

In São Tomé e Príncipe, malaria is one of the principal causes of child mortality for the under fives. It contributes, equally, to anaemia in children and causes significant absences at school. Prevention measures, in particular with impregnated mosquito nets, may significantly reduce child mortality rates. In regions where malaria is endemic, international recommendations suggest the treatment of any fever in the child as malaria and to immediately administer a complete treatment of recommended anti-malarials. Children presenting symptoms of severe malaria, such as fever or convulsions, should be taken to a health facility. Equally, children convalescing from malaria should receive supplementary fluids and food and the youngest should continue to be breastfed.

The questionnaire is composed of questions on the availability and utilisation of mosquito nets both in households and by children under five as well as malaria treatment and intermittent prophylaxis. Table CH.10 indicates that in São Tomé e Príncipe, 49.2% of households own at least one mosquito net (58.4% in urban settings and only 37.3% in rural areas). The rate of mosquito ownership varies according to the district : two households out of three in Água Grande and less than half in Mé-zochi. It increases as well with the household's head's level of education and the level of household life, ranging from 31.5% among the poorest, to 69.9% among the wealthiest and 37.3% when the head of the household has never been to school, to 62.8% when she/he has had a higher level or more.

Overall, 36.0% of households own at least one mosquito net treated with insecticide. Differences between social categories are maintained. The rate of ownership of at least one impregnated mosquito net is higher in urban areas (44.1%), in the District of Água Grande (more than half of households), among the more educated heads of households (48.4%) and the richest households (53.4%); it is lower in rural areas (25.4%, in the District of Mé-zochi (21.3%, among uneducated heads of households (20.8%) and among the poorest households (21.9%).

Survey results indicate that 52.8% of children under five have slept under a mosquito net the night preceding the survey and that 41.7% have slept under an impregnated mosquito net (Table CH.11). There are no significant disparities between the under fives, whether girls or boys, in relation to the use of impregnated mosquito nets. On the other hand, differences in certain other categories are significant, whether the mosquito nets are treated or not. In the District of Água Grande, 62.2% of children have slept under a treated mosquito net while in those of Mé-zochi and Cantagalo, respectively, only 25.4% and 30.1% slept under treated mosquito nets. Differences are also significant between urban and rural areas (51.1% against 29.2%) and between children from the wealthiest and poorest households (63.0% against 29.4%). Equally, the youngest children have a better chance of sleeping under an impregnated mosquito net (57.5% against 41.0% for the oldest).

Questions on the prevalence and treatment of fever were asked for all children under five. About 18.0% of them were ill with fever during the two weeks preceding the survey (Table CH.12). Fever prevalence decreases with age, to 23.4%, in children aged 11 to 23 months. Fever rates are slightly higher in children whose mother has had at least a primary school education, or a secondary or higher level of education (more than 18.0%) than for those whose mother has never been to school (13.7%). If differences in fever prevalence between urban and rural areas is practically zero (18.0% and 17.0%), those between districts are significant (nearly one quarter of Lembá children and 20.3% in Caué against 16.9% in Lobata and only 14.8% in Cantagalo). As well, children from the poorest households are more affected than those from the wealthiest (19.7% against 14.1%). Paradoxically, children whose mother has never been to school are more affected that those whose mother has had a secondary education of more (13.7% against 18.4%).

Mothers were asked to mention all medications administered to their child for the treatment of fever, whether medication given at home or prescribed by or given in a health facility. On the whole, during the last two weeks close to one feverish child out of four (24.7%) were treated by an « appropriate » anti-malarial and 17.0% were given anti-malarials within 24 hours after symptoms appeared.

« Appropriate » anti-malarials are chloroquine, PS, a complex based on Artemisia, etc. In São Tomé e Príncipe, less than 2.0% of feverish children received chloroquine and 1.2% PS/Fansidar. About 6.4% were given Artemisia-based therapy. More than three out of four children were given other medication, including anti-pyretics such as paracetamol, aspirin and ibuprofen.

Girls have more chances of receiving an appropriate treatment (31.0% against 18.9%). Children from the Districts of Caué and Mé-zochi receive better treatment than those in Água Grande (18.3%) and Cantagalo (24.8%). The chances of having an appropriate treatment are higher in rural areas (28.0%) than in urban ones (22.3%). The chances of having an appropriate anti-malarial treatment decreases with the mother's level of education, with 37.7% of children with mothers with no schooling and 17.7% for those whose mother has had a minimum of secondary level of education.

Feverish children taking an anti-malarial within 24 hours after the first symptoms appeared is also varied, depending on social categories, in the same direction yet with slightly lower than taking an appropriate anti-malarial during the last two weeks. Chances are stronger for girls (23.8%), children residing in the District of Caué, for children aged 23 – 35 months and those aged 48 – 59 months (more than 26.0% respectively), children whose mother has not been to school (27.6%) and among children whose household's level of life is middle-income. Chances decrease in the Districts of Lobata (10.5%) and Príncipe (12.8%), and children with the most educated mothers (12.7%).

Pregnant women living in zones were malaria prevalence is strong have four times more chances than other adults of contracting this illness and twice of dying. If infected, pregnant women risk anaemia, premature labour, and giving birth to a stillborn. Their infants risk underweight at birth, which compromises their survival during their first year. For this reason, measures have been taken to protect pregnant women by distributing impregnated mosquito nets and by medicating them during their pre-natal consultations (intermittent preventive treatment or IPT). Within the São Tomé e Príncipe MICS framework, women ere asked to reply to questions related to the medications they received during their last pregnancy during the last two years. The women are considered as having received an intermittent preventive treatment if they received at lease 2 doses of PS/Fansidar during their pregnancy.

Intermittent preventive treatment for malaria among pregnant women having given birth during the two years preceding the survey is presented in Table CH.13. It indicates that 90.2% of pregnant women received intermittent preventive treatment against malaria. Whatever the district, eight women out of ten were given this treatment, although coverage is stronger in Água Grande (94.2%) and Príncipe (93.4%) and relatively lower in Cantagalo (79.8%). The level of education also is a positive factor with regard to intermittent preventive treatment : 83.6% of women with no education, more than 90.0% of women with at least a primary level education. The effect of level of household life remains ambiguous. Close to one woman out of ten were given chloroquine and no woman took two or more doses of Fansidar.

Supply sources and costs

The São Tomé e Príncipe MICS questionnaire included questions on the sources and costs of the four types of provision in respect of impregnated mosquito nets, anti-malarials, antibiotics and oral rehydration salts. This information is very important as hey permit an evaluation of these programmes, based on population and the specific target groups' level of coverage by the programmes. This information is also useful to control provision of free or subsidised material, and to evaluate their cost given that their price may constitute an obstacle to its use. It may also be essential to programme managers who wish to determine the weight of either the public or private sector in the provision of these materials, as well as the relative significance of each of the sources.

The sources and costs f providing impregnated mosquito net (IM) are indicated in Table CH.14. This table gives information on IM acquisition from either public or private sources, the percentage of households who received the IMs at no cost, and the average cot of the IM for those households who paid for them. . All together, 57.6% of households received mosquito nets from a public source, while only 2.2% are from private sources and 40.2% from other sources. The percentage of households having recourse to the public sector for IMs is higher in the Districts of Cantagalo, Caué and Lembá (88.0% to 91.2%, against an average of 58.0%), in rural areas (66.9% against 53.5% in urban areas), among the poorest (78.3% against 38.2% among the wealthiest), and those households where the head of household has never been to school (62.2% against 50.0% when the level of education is at least the secondary). On the other hand, those having greater recourse to sources other than public and private are more frequent in Água Grande (57.1% against an average of 40.2%) and among the wealthiest (60.8%). If the percentage of households obtaining their IMs from the private sector is relatively low, it is however higher in the District of Príncipe (8.0% against an average of 2.2%). For households who bought their treated mosquito nets, the average price is 27,000 dobras (1.5 Euros) from public sources and 27,000 dobras (1.5 Euros) from private sources.

The State, with regard to its Fight against Malaria policy, appears as the primary donor of IMs. To this effect, it is worth noting the numerous sensitisation campaigns against malaria, often involving the free distribution of IMs. Among households having acquired a free IM, 42.0% obtained it from a public facility and 32.5% from a private one. Urban households (58.4%) and the poorest (51.1%) received the most free IMs from State sources. Households in the Districts of Caué (90.1%) and Lembá (100.0%) receive their IMs free from private sources. More rural households receive their IMs free from private sources than urban households (39.2% against 25.1%).

The sources and costs of providing anti-malarials for the under fives are indicated in Table CH.15. Among children with fever during the last 2 weeks who have been treated with anti-malarials, 38.8% benefited from public sources and only 5.3% from private sources. More than half (59.9%) come from other sources. Recourse to public sources for anti-malarial supplies is more frequent in rural areas (44.6% against 34.5% in urban area) and in the District of Mé-zochi (51.0%). More than one child out of four (25.8%) were given free anti-malarial in a public facility while no private facility provided it free. For those having had to pay for their anti-malarials, the average cost is 5,000 dobras (0.27 Euros) from public sources and 15,000 dobras (0.83euros) from private sources.

The sources and costs of providing antibiotics for the treatment of pneumonia in the under fives are indicated in Table CH.16. Close to 65.0% of children are provided with antibiotics for pneumonia in public facilities and 31.3% has recourse to a private source. More urban children have benefited from State sources than those from rural areas. Among children having received antibiotic pneumonia treatment, less than 4.0% received it free in a public facility. No child received its antibiotics free from private sources. For those who bought their antibiotics, the average cost is 5,000 dobras (0.27 Euros) from public sources and 3,000 dobras (0.16 Euros) from private sources.

The sources and costs of providing oral rehydration salts (ORS) for the under fives are indicated in Table CH.17. Close to 96.0% of ORS are from public sources and less than 2.0% from private sources. Hardly one child received ORS free (1.2%). For those who purchased their ORS, the average cost is 3,000 dobras (0.16 Euros) from public sources and 5,000 dobras (0.27 Euros) from private sources.

VII. Environment

Water and sanitation

Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid and schistosomiasis. Drinking water can also be tainted with chemical, physical and radiological contaminants with harmful effects on human health.

In addition to its association with disease, access to drinking water may be particularly important for children and women, especially in the rural areas, where they bear the primary responsibility of carrying water, often for long distances.

The MDG goal is to reduce by half, between 1990 and 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. The WFFC goal calls for a reduction in the proportion of households without access to hygienic sanitation facilities and affordable safe drinking water by at least one third.

The list of indicators used in MICS is as follows:

Water
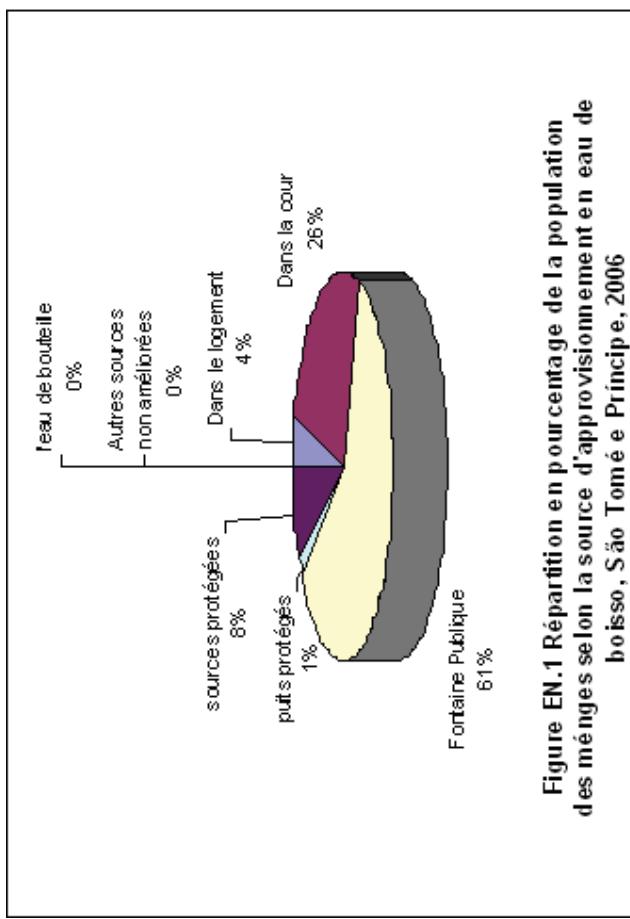
  • Use of improved drinking water sources
  • Use of adequate water treatment methods
  • Time to source of drinking water
  • Person collecting drinking water

Sanitation

  • Use of improved sanitation facilities
  • Sanitary disposal of child's faeces

The distribution of the population by source of drinking water is shown in Table EN.1 and Figure 7.1.

The population using *improved sources of drinking water* are those using any of the following sources of supply: piped water (into dwelling, yard or plot), public tap/standpipe, tubewell/borehole, protected well and rainwater collection. Bottled water is considered as an improved water source only if the household is using an improved water source for other purposes, such as hand washing and cooking.

Figure EN.1 Répartition en pourcentage de la population des ménges selon la source d'approvisionnement en eau de boisso, São Tomé e Principe, 2006

Figure 12: EN.1 Distribution (by percentage) of the household population, by source of drinking water

All together, 86.2% of the population utilises an improved drinking water source -- 88.4% in urban areas and 83.2% in rural areas. Coverage is relatively good in al the districts, in particular those of Lobata and Água Grande where, respectively 96.5 and 90.4% of the population uses an improved source. The District of Caué has the lowest coverage rate, with seven people out of ten having access to improved sources. Members from the wealthiest households have more access than the rest : 94.5% against 78.2% and 79.0% respectively for the poor and for the poorest 87.4% for those with middle incomes and 91.7% for the wealthy. Household heads with a minimum secondary education also have more access : 92.1% against 85.4% where the head of household has not been to school.

Table EN.1 indicates that 22.0% of the population utilises piped potable water located in their household compound; for 52.5% water is accessible from public fountains. Nevertheless, the types of sources of drinking water vary considerably according to some social categories. Provision of piped drinking water located in the household compound is more widespread in the District of Água Grande (37.0% against 8.0% in Cantagalo and Príncipe), among households whose head of household has a minimum of a secondary level of education (36.4% against 12.9% for heads of households with no education), and among the wealthiest (58.1% against 8.4% among the poorest and poor and 13.0% among those with middle income). The public fountain is more frequently utilised in the Districts of Lembá and Lobata (respectively 76.9% and 73.6%, against 38.1% to 46.0% in Príncipe, Água Grande and Mé-zochi) and among the urban poorest (68.9% against 48.0% for the wealthy and 20.2% for the wealthiest). A small part of the population is supplied piped water to their houses (less than 4.0%), even among the more privileged categories living in the wealthiest households (13.5%) and those whose head of household has a minimum of a secondary level of education (8.1%). If less than 10.0% of the entire population utilise an unprotected water source (fountains, rivers and streams), it is worth noting the exceptional case of the District of Príncipe : close to half (43.3%) of its population lives with this very unhealthy situation.

Households were asked about ways they may be treating water at home to make it safer to drink - boiling, adding bleach or chlorine, using a water filter and using solar disinfection were considered as proper treatment of drinking water. Home water treatment is indicated in Table EN.2, which gives percentages for the household members utilising appropriate water treatment methods, separately for all households, for households utilising improved drinking water sources and unimproved. Less than 14.0% of the population utilises a water treatment method considered adequate, for all drinking water sources, whatever their type : 11.3% add bleach or chlorine and 2.3% boil their water. This percentage is higher in the District of Caué (20.2% against 2.7% in that of Príncipe), among the wealthiest households (21.5% against 8.0% among the poorest), and among households whose head of household has a minimum of a secondary level education (19.3% against 10.7% for those with no education). This percentage is practically the same for improved water sources (15.1%) and, paradoxically, it falls to less than 10.0% for unimproved water sources.

The amount of time necessary to obtain water is indicated in Table EN.3 while the person who normally collects the water is indicated in Table EN.4. It should be noted that these results include a round trip from the house to the source of drinking water. Information regarding the number of trips made during one day was not collected.

Table EN.3 indicates that for 25.8% of households, the source of drinking water is at home. Contrarily, 16.0% of households travel less than 30 minutes to reach the water source, collect the water and return, and 10.0% need between 30 and 60 minutes to do the same. The mean time for a round trip to the water source is 16 minutes for households without access to water. This time is necessarily higher in rural areas (17.1

minutes) than in urban areas (15.3 minutes). The inhabitants of the District of Mé-zochi need more time for this task (close to 20 minutes) while those in Lembá need on average only half that time (10 minutes).

Table EN.4 indicates that in the majority of households, it is generally an adult female who is responsible for collecting drinking water when the source of water is away from the household : close to 67.0% of women). Only 20.0% of adult males do collect water, while the rest of the households it is girls and boys under 15 who collect the household's water (respectively 9.3% and 4.2%). More females that are adult collect water in the District of Cantagalo (71.4%), in the households where the head of household has had no education (72.5%) and among the wealthiest (71.9%). On he other hand, it is in rural areas where adult males collect drinking water more frequently (22.7% against 16.6% in urban areas) and in the District of Príncipe (22.8% against 15.2% in that of Lembá).

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases and polio. Improved sanitation facilities for excreta disposal include flush or pour flush to a piped sewerage system, septic tank or latrine; ventilated improved pit latrine, pit latrine with a slab and composting toilet.

Table EN.5 indicates that 28.0% of the São Tomé e Príncipe population live in households with improved sanitary installations. The utilisation of improved sanitary installations varies considerably between social categories. For example, 32.7% of the urban population have access to improved sanitary installations against 21.5% of the rural population. Equally, the utilisation of improved installations varies considerably between the District of Água Grande, the best-equipped (41.9%) and that of Cantagalo, the least equipped (13.6%). The wealthy are clearly better equipped than the poor : respectively one third of wealthy household inhabitants and close to 80.0% of the wealthiest utilise improved installations while respectively less than 1.0% and 8.1% among the poorest and poor have access to these toilets. Similar differences are also observed according to the head of household's education level : where this level is secondary or higher education, close to 50.0% utilise improved toilets while only 18.0% of households whose head of household has no education have access to such a toilet.

Nearly six households out of ten simply do not have access to toilets, with a range of serious lacuna according to districts : 68.0% in rural areas, 74.2% in Cantagalo, 72.2% in that of Mé-zochi and 66.3% in Príncipe. However, flushing sanitary installations linked to a sewage system or to a septic tank are rare in São Tomé e Príncipe (respectively 6.7% and 11.9%) and unequally distributed among its population. These types of toilets are more widespread among the wealthiest (respectively 21.6% and 43.5% against less than 1.0% respectively among the poor and poorest) and among the most educated households (respectively 15.0% and 22.9%).

Safe disposal of child faeces is the disposal or washing off in toilets or latrines of the child's last faeces. Disposal of faeces for children aged 0 to 2 years is indicated in Table EN.6. Safe disposal of child faeces in a sanitary installation is only possible for less than one child out of five

(19.0%). For 15.0% faeces are thrown into latrines/toilets and for less than 2.0% they are buried. Seven out of ten children have their faeces thrown into the bush or into the sea/river (respectively 46.3% and 22.7%).

Table EN.7 indicates the overall picture of percentages in respect of households with improved drinking water sources and means for the safe disposal of faeces .86.2% of all households utilise improved water sources (88.4% in rural areas and 83.2% in rural areas). It is in the District of Água Grande that households are better equipped in improved water sources (90.4%) compared to the Districts of Caué (71.8% and above all, in Príncipe (55.8%). It is also among the wealthiest and most educated households where improved water sources exist. The percentage of people is 86.2% among the wealthiest and only 78.2% among the poorest. This percentage is 92.1% where the head of household has a minimum of a secondary level of education and 85.4% where the head of household has not had any education. With regard to improved methods for the disposal of faeces, only 28.0%, as indicated in the Table, are equipped. The differences between social categories are more favourable in the District of Água Grande (41.9% against 13.6% in Cantagalo, in urban areas (32.7% against 21.5% in rural areas), for the more educated households (48.9% against 17.5% for households whose head of household has not been to school), and for the wealthiest (79.6% against les than 1.0% for the poorest and 8.1% for the poor). Nationally, 26.4% of households utilise both improved water sources and improved systems of faeces disposal. Differences between categories are the same if the water sources and disposal systems are considered separately.

VIII. Reproductive health

Contraception

Appropriate family planning is important for the health of women and children in : 1) the prevention of early or late pregnancies, 2) spacing between births, and 3) limit the number of children. A World Fit for Children objective is the access to information and services permitting the prevention of early pregnancies, un-spaced pregnancies, late pregnancies or too many pregnancies.

Current utilisation of contraception was mentioned by 30.3% of married women or living with a partner (Table RH.1). The most widespread method, utilised by 16.4% of married or union women is the pill, followed by that of injection (10.3%) of married women. A much-reduced proportion of women mentioned the use of the calendar, the IUD, female sterilisation or the condom. Less than 1.0% of women utilise periodic abstinence, withdrawal, male sterilisation, vaginal methods or Lactational amenorrhea methods (LAM).

Prevalence of contraception is slightly higher in rural areas (31.6%) than in urban ones (29.4%). At the district level, Príncipe indicates the highest level of contraception (44.4%) followed by the Districts of Caué (34.5%) and Lembá (32.6%). Contraceptive prevalence increases with age through to 30 to 34 years, decreasing again for those older. Thus among adolescents 15 to 19 married or with partners, only 24.3% currently utilise a contraception method, while 32.9% of women aged 20 to 24 years and 39.1% of women aged 30 to 34 years utilise a contraception method. Contraceptive prevalence falls to 29.5%, to 21.4% for those aged 40 to 44 years and to less than 15.0% for those aged 45 to 49 years.

A correlation exists between the level of education in women and contraception prevalence. The percentage of women utilising one contraception method increases, from 23.8% among those without education to more than 30.0% for those with at least a primary level education. A part from differences in prevalence, the methods vary according to the level of education.

Only about 8.0% of women without education utilise the pill and 13.5% are injected. Among those with at least a primary level of education, 17.5% utilise the pill and 10.9% are injected. On the other hand, 15.3% of women utilising contraceptives with a minimum of a secondary education use the pill and 7.6% are injected.

Contraception needs

Needs to be met[7] in terms of contraception make reference to fecund women who do not utilise any method of contraception but who would like to space their next baby or simply wish to stop having children. The needs to be covered are identified in the MICS framework by utilising a series of questions on preferences and current behaviours in the use of contraceptives, fecundity and fertility.

Women whose needs are not met in terms of birth spacing are women currently married or in unions, fecund (who are actually pregnant or who are planning to be ready to become pregnant), who do not currently utilise contraceptives and who wish to space their babies. Pregnant women are considered to wish to space their babies when they do not want babies at that moment or they have become pregnant. Women who are not pregnant are classed in this category if they wish to have another child but wish this child only after two years or after getting married.

Women whose needs are met in terms of birth spaces are those who are actually married or in union, fecund (are pregnant or currently think they are physically ready to become pregnant), who do not utilise any means of contraception and who wish to limit their babies. This last group is composed of women who are currently pregnant but who did not at all wish this pregnancy and women who are not currently pregnant and who do not wish to have another child.

Needs not met in terms of contraception are simply the sum of needs to be met in terms of spacing and limiting their babies.

By utilising the information on contraception and the needs to be met, the percentage of the satisfied demand is equally estimated from MICS dada. The percentage of the satisfied demand in terms of contraception is defined as the proportion of currently married women or in union who are utilising a contraceptive method, over the total demand for contraceptives. The total demand for contraception concerns women whose demands are currently not met (in terms of spacing and limiting births), as well as those who currently use contraception.

Table RH.2 presents the results of the survey on contraception, the needs to be met and the satisfied demand for contraception. About three women out of ten currently utilise a contraceptive method. Apart from the District of Príncipe, which distinguishes itself by a current contraceptive prevalence of 44.4%, differences between districts (28.0% to 34.6%) and between habitat environments (29.2% and 31.6% are weak. The entire needs in contraceptives are estimated at 15.7%, of which 10.0% for spacing and 5.7% for limiting babies. All together, the

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7   The needs to be met for the MICS3 is slightly different than that utilised for other surveys on households, such as demographic and health surveys (DHS). For a DHS, more detailed information is collected on supplementary variables such as post-partum amenorrhoea and sexual activity. The results of these two types of surveys are not strictly comparable. s.

satisfied demand in contraceptives touches nearly 68.0% of currently married or in union women. There is not difference between rural and urban women. The level of satisfied demand varies slightly between the districts : between 73.4% in Príncipe and 62.2% in Caué. The satisfied demand for contraception varies according to the age of women : lower for adolescents aged 15 to 19 (55.5%), reaching 68.7% for women aged 30 to 34 years, and falling to 62.6% for women aged 45-49. The level of household life also influences on the level of satisfied contraceptive demand : 58.0% among the poorest and 71.2% among the wealthiest.

Pre-natal consultations

The pre-natal period presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. A better understanding of foetal growth and development and its relationship to the mothers health has resulted in increased attention to the potential of pre-natal care as an intervention to improve both maternal and newborn health. For example, if the pre-natal period is used to inform women and families about the danger signs, symptoms and the risks of labour and delivery, it may provide the route for ensuring that pregnant women do, in practice, give birth to babies with the assistance of skilled health care providers. The pre-natal period also provides an opportunity to supply information on birth spacing, which is recognized as an important factor in improving infant survival. Tetanus immunization during pregnancy can be life saving for both the mother and infant. The prevention and treatment of malaria among pregnant women, management of anaemia during pregnancy and treatment of sexually transmitted infections (STIs) can significantly improve foetal outcomes and maternal health. Adverse outcomes such as low birth weight can be reduced through a combination of interventions to improve women's nutritional status and prevent infections, e.g., malaria and sexually transmitted infections during pregnancy. More recently, the potential of the pre-natal period as an entry point for HIV prevention and care, in particular for the prevention of HIV transmission from mother to child, has led to renewed interest in access to, and use of, antenatal services.

WHO recommends a minimum of four pre-natal visits based on a review of the effectiveness of different models of pre-natal care. WHO guidelines are specific on the content on pre-natal care visits, which include:
- Blood pressure measurement
- Urine testing for bateriuria and proteinuria
- Blood testing to detect syphilis and severe anaemia
- Weight/height measurement (optional)

Access to pre-natal care (by a doctor, nurse or mid-wife) is high in São Tomé e Príncipe : 97.3% for women aged 15 to 49 years have received pre-natal care at least one time during their pregnancy. There is no difference in pre-natal care coverage between urban and rural areas but the

rate of access is variable according to the district : it goes from 90.4% in the District of Caué to close to 99.0% in the Districts of Lobata, Água Grande and Príncipe. Women aged 45 to 49 years have a weaker rate of access to pre-natal care (89.0% against 94.0% for the other age groups).

Table RH.3 presents the type of personnel dispensing pre-natal care to women aged 15 to 49 years having given birth during the preceding two years. It indicates that among the 97.3% who have received pre-natal care dispensed by a qualified person, 94.8% consulted a nurse or a mid-wife and 2.5% a doctor. Even though it is globally low, the proportion of women who have consulted a doctor is relatively higher among residents of the District of Cantagalo (5.7%), women aged 20 to 24 years (48%, the most educated (4.3%) and the wealthiest (4.3%).

The types of services given to pregnant women are indicated in Table RH.4. This table indicates that 98.5% of women who have given birth during the last two years received, at least once, pre-natal care during their pregnancy. 82.6% of them have had a blood test, 96.4% have also had their blood pressure taken, 83.4% had their urine tested and 96.9% were weighed. Although the blood pressure and the weighing are fairly widespread, the blood and urine tests are much less frequent among women residing in the Districts of Caué (45.4% and 42.3% respectively), Lembá 66.9% and 69.3% respectively) and Cantagalo 67.6% and 68.6%, among women without education (68.2% and 71.2% respectively) and among the poorest (73.0% and 73.7%) respectively).

Assistance during childbirth

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

A WFFC goal is to ensure that women have ready and affordable access to skilled attendance at delivery. The indicators are the proportion of births with a skilled attendant and proportion of institutional deliveries. The skilled attendant at the delivery indicator is also used to track progress towards the MDGs target of reducing the maternal mortality ratio by three quarters between 1990 and 2015.

The MICS included a number of questions to assess the proportion of births attended by a skilled attendant. A *skilled attendant* includes a doctor, nurse, midwife or auxiliary midwife.

In fact, the more women are educated, the more chances they have to give birth with the assistance of a qualified person : the percentage of assisted births went from 65.3% among women without education to 80.0% among women with a primary education, and to 87.6% among women with a minimum of a secondary level of education. The wealthier household level of life increases in the same way the chances for

women to be assisted by a qualified person. The percentage of assisted births is 70.0% among the poorest women and 88.0% among the wealthy and the wealthiest.

A mid-wife or nurse assisted more than three quarters (77.0%) of births during the year preceding the MICS survey. Only 3.5% of births were attended to by a doctor, and 12.2% by a traditional mid-wife. Even if births assisted by doctors are rare, the wealthiest women and those with the most education have a greater chance of benefiting from this (8.0% against less than 2.0% among the poorest and those who are not education). On the other hand, rural women (16.0%), older women (26.0% of those aged 40 to 44 years), women without education (20.0%) and the poorest (20.0%) have greater tendency to be assisted by a traditional mid-wife.

Close to 78.0% of births are in a health centre. Birth in a health centre is more frequent among younger women (88.0%), the wealthiest (87.0%), the most educated (87.0%) and the residents of Água Grande, the most urban district in the country (85.2%). On the other hand, among the oldest women, the poorest, those without education and the residents of the Districts of Cantagalo and Caué (the least urbanised districts), about 50.0% and two thirds of births take place in a health facility.

Maternal mortality

Pregnancy and labour complications are the principal causes of death and illness among women in their reproductive years in developing countries. It is estimated that globally about 529,000 women die each year following labour. In addition, for each woman who dies, nearly 20 suffer from lesions and invalidities during pregnancy or labour. This means that at least 10 million women undergo this type of complication each year.

The most common fatal complication is post-partum haemorrhaging. Septicaemia, complications arising from abortions carried out in unhealthy conditions or a long or blocked labour and high blood pressure during pregnancy, eclampsia in particular, provoke supplementary deaths. These complications, which may occur at any moment during pregnancy and labour, need rapid access to quality obstetric services, equipped to administer vital medication, antibiotics and transfusions, and to carry out cesaerian and other surgical interventions to prevent deaths caused by labour blockages, eclampsia and obstinate haemorrhage. One of the MDGs is to reduce by three quarters between 1990 and 2015, the rate of maternal deaths.

Maternal mortality is defined as the death of a woman from causes linked to pregnancy, during pregnancy or within 42 days after pregnancy. The rate of maternal mortality is the number of deaths per 100,000 live births. In the MICS framework, the maternal mortality rate is estimated by utilising the indirect sister method. To enable the collection of necessary information for the calculation of this method of estimation, a few

questions are asked of adult household member concerning the survival of their sisters and the moment of death due to pregnancy, labour and post-partum complications for their deceased sisters. The collected information is then converted to maternal mortality life risks and to maternal mortality quotients[8].

The results of the survey on maternal mortality are presented in Table RH.6. It should be noted that these estimates cover close to 10 and 14 years preceding the survey and are only applicable at the national level as the maternal mortality quotients generally carry very large sampling errors.

Thus, the rate of maternal mortality in São Tomé e Príncipe is estimated at 148 maternal deaths per 100,000 live births during the period of 10 to 14 years preceding the survey.

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[8] For more information on the indirect sister method, see WHO and UNICEF, 1997.

IX. Education

Pre-School Attendance and School Readiness

Attendance of pre-school education in an organized learning or child education programme is important for the readiness of children to school. One of the WFFC goals is the promotion of early childhood education.
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According to Table ED.1, only 27.4% of children from 36 to 59 attend pre-school. The disparities between residential environments and districts are important. In urban areas, three out of ten go to pre-school while in rural areas only one out of four children have this opportunity. Equally, the percentage of children aged 36 to 59 months attending pre-school is higher in the districts of Caué (43.8%) and Príncipe (41.3%) and lower in the Districts of Mé-zochi (17.2%) and Cantagalo (18.2%). The disparities linked to gender are negligible : 2.8% of boys against 25.9% of girls attend a pre-school. On the other hand, disparities according to socio-economic status are important : 50.9% of children living in wealthy households are at pre-school, while this rate decreases to 17.5% in the poor households. Thus, 20.2% of children aged 36 to 47 months and 36.3% of older children aged 48 to 59 months attend pre-school.

Table ED.1 indicates, as well, the proportion of children in their first year of primary school who attended pre-school the preceding year, an important indicator to school readiness. Overall, 51.2% of children aged seven and who are currently in their first year of primary school attended a pre-school the preceding year. This proportion is higher for girls (55.3%) than for boys (48.3%). The difference observed between urban and rural children is even greater in favour of rural children : 59.4% against 43.8%. With regard to the effects on school readiness of residential district, the level of the mother's education and the socio-economic status of households, the expected tendencies are visible yet as the numbers for certain categories are too low, the only certainty is the gap for these disparities.

Primary and secondary 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 MDGs and WFFC. 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.

The indicators for primary and secondary school attendance include :
  • Net intake rate in primary education

- Net primary school attendance rate
- Net secondary school attendance rate
- Net primary school attendance rate of children of secondary school age
- Female to male education ratio (GPI)

The indicators of school progression include:
- Survival rate to Grade 5
- Transition rate to secondary school
- Net primary completion rate

Table ED.2 indicates that among children at primary school entry age (7 years) in São Tomé e Príncipe, 74.0% are enrolled in their first year of primary school. There are slight (6 percentage points) disparities in gender : 76.7% are boys while 71.1% are girls, and between urban (72.5%) and rural (75.8%) children. On the other hand, there are strong districtal differences. The District of Príncipe appears to have the best coverage, with nearly 80.0% of children enrolled in their first year of primary school, while the District of Lembá's enrolment rate is weaker, with only 68.8% of children enrolled. School attendance deteriorates also in terms of the child's age. Close to 80.0% of seven year olds are enrolled, falling to 68.7% for eight year olds, indicating that the older the child is, the less chances there are to start school. The data reveals a paradox, or a negative correlation between school attendance for children at primary school entry age on the one hand, and on the other the mother's level of education and the socio-economic status of the child's household : among primary school aged children whose mother has a minimum of a secondary school level education, only 58.2% are enrolled in their first year against 72.0% to 78.0% when the mother has achieved a primary school level education or none at all. The same paradox is noted in relation to the level of the child's household life : 67.3% of the wealthiest children against 76.9% of the poorest children.

Table ED.3 presents the percentage of primary school aged children who attend primary or secondary school. The majority of primary school aged children are at school (93.9%), indicating that at least 6.0% of school aged children are not at school. No difference is noted between urban and rural environments or between genders. The rate of school attendance is higher in the Districts of Água Grande (96.7%) and Príncipe (96.0%) and lower in that of Lembá (87.3%). With regard to age, there exists an increasing tendency between 7 and 9 years (from 87.1% to 98.9%) prior to a slight decrease to 90.9% at 12 years of age. Equally, the rate increases with the level of the mother's education : 97.0% when she has had a minimum of a secondary education, 94.6% when her education is only at the primary level and only 89.5% when she has had no education. The same tendency exists, as well as gaps of equal size, according to the child's household level of life (from 98.5% among the wealthiest to 89.5% among the poorest).

The net school attendance rate is presented in Table ED.4. Only 6.0% of children at the primary school age do not attend school, while at the secondary level only 35.4% of secondary school age attend school. Although no differences exist between boys and girls, a slight difference can be detected in relation to their residential environments (33.1% in rural areas and 37.2% in urban areas). At the district level, Água Grande and Mé-zochi have the best rates (42.2% and 38.9% respectively) while those of Caué and Lembá have the lowest rates (19.2% and 20.7% respectively). The level of the mother's education has a positive significant influence, with a double rate from one category to another (67.7% against, respectively, 33.9% and 17.8% when the mother has had a primary level education and when she has had no education). Tendencies according to the household level of life are similar (from 62.4% for the wealthiest to 15.7% for the poorest.

The net primary school attendance rate of secondary-aged children is presented in Table ED.4W. About one secondary-aged child out of three (35.0%) are still at primary rather than school. Given that the preceding table indicates that 35.0% of those attend secondary school, the remaining 30.0% are not in school at all. The percentage of children attending primary school among those at the secondary school age is nearly the same for boys and girls while it is lower with age : from 69.1% for children aged 13, falling steadily and establishing itself to less than 5.0% for those 17 years old. With regard to the districts, Lobata and Lembá have the highest levels (44.0% and 38.2% respectively) and the lowest are Mé-zochi and Príncipe (less than 32.0%). There is a positive correlation between this phenomenon and the mother's level of education. The percentage of secondary school aged children still in primary school is higher among mothers without education (42.4% against 25.8% for others with a minimum of a secondary education). Differences exist also according to the child's level of household life (more than 36.0% for the poorest and less than 27.0% for the wealthiest). It should be underlined that this rate is only 15.2% among children living in households without their mother.

The percentage of children entering primary and reaching fifth grade is presented in Table ED.5. Out of all children entering first grade, the majority (87.2%) reach fifth grade. It should be underlined that this figure includes children who repeat grades and end up by passing their fourth grade. No difference was noted in relation to residential environment. It is in the Districts of Lobata and Água Grande that the proportion of children having reached firth grade is the strongest (92.2% and 90.7% respectively). Equally, this proportion increases with the mother's level of education : 100.0% for those children whose mother had had a minimum of a secondary level education, 92.4% among those whose mother has had a primary level of education and only 76.2% for children whose mother has had no education. The tendency is the same according to the level of life (97.5% for the wealthiest and 75.9% for the poorest).

The net primary level completion and that of passing into the secondary level is presented in Table ED.6. At the time of the survey, only 31.9% of children at the age of primary level completion (11 years) were in their last primary school year. This rate should be distinguished from the gross primary level completion rate that includes children of all ages in the last primary grade. This level is higher among girls (35.5% against 28.5% for boys), in urban areas (37.7% against 24.2% in rural areas) among children whose mothers are more educated (58.2% against 31.4% and

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16.7% respectively for those whose mother has only a secondary level education and those whose mother has no education. The tendency is the same with regard to the household level of life (65.5% for the wealthiest to 15.0% for the poorest). There are also differences between districts, where Água Grande is higher (46.7%) than Lembá (12.8%), Lobata (15.3%) and Caué (16.3%).

Nearly eight children out of ten (78.0%) who have successfully completed their last primary school grade are in their first secondary school grade at the time of the survey. For this indicator, there are hardly any differences linked to gender, residential environment, mother's level of education or household level of life. Nevertheless, the rate of transition is higher among children whose mother is not a member of the household.

The rate for girls and the rate for boys in school at the primary and secondary levels are provided in Table ED.7. These rates are better known by the label of « gender parity index » (GPI).The latter provide a mistaken description of the GPI, in particular because in the majority of cases, most older children still attending primary school are boys. The Table indicates that the GPI in terms of primary school is 1, which indicates that there is not difference between boys and girls with regard to school attendance. The gaps in schooling are generally in favour of girls, in particular in the district of Príncipe (1.04) and Cantagalo (1.03), among children whose mother is not educated (1.06). With respect to the secondary net rate (SNR), the global GPI is also very close to 1, indicating the absence of disparities between boys and girls. Nevertheless, huge disparities are noted relative to social context characteristics. These disparities favour girls, particularly in the districts of Príncipe (1.78), Lobata (1.22) and Água Grande (1.04), when the mother is educated (1.08) and in the poorest households (1.19) or poor households (1.21). They are unfavourable to girls essentially in the Districts of Caué (0.68 and Cantagalo (0.82) and when the child's mother is not educated (0.75.)

Adult literacy

One of the WFFC goals is to assure adult literacy, which is also an MDG indicator, relating to both men and women. In the MICS, since only a women's questionnaire was administered, the results are based only on females aged 15-24. Literacy was assessed on the ability of women to read a short simple statement or on school attendance. The literacy percentage is presented in Table ED.8.

Overall, close to 70.0% of women are illiterate. Only women having attended school are literate but the rate is very low (54.9%) among those with only a primary school education, indicating that more than half of them quit school very early or have lost their capacity to read and write. The proportion of literate women is higher in urban areas (72.7%) than in rural areas (65.4%). It is also higher in the District of Água Grande (78.9%) and lowest in those of Caué (46.0%), Lembá (50.9%) and Cantagalo (54.4%). The proportion of literate women decreases with age (75.4% among women aged 15 to 19, and 64.2% among those aged 20 to 24 years) and the household level of life (90.1% in the wealthier households, to 50.2% in the poorest).

X. Child protection

Birth registration

The Convention on the Rights of the Child states that every child has the right to a name and a nationality and the right to being deprived of his or her identity. Birth registration is a fundamental means of securing these rights for children. The WFFC states the goal to develop systems to ensure the registration of every child at or shortly after birth, and fulfil his or her right to acquire a name and a nationality, in accordance with national laws and relevant international instruments. The indicator is the percentage of under-5 children whose birth is registered.

For 68.7% of children under five in São Tomé e Príncipe are registered at birth (Table CP.1). There is no disparity linked to birth registration linked to gender or residential environment. On the other hand, important differences according to age, the level of the mother's education and the household level of life. The percentage of children registered at birth is steadily increasing, going from 29.3% for those aged 0 – 11 months, to 79.6% for those aged 24 to 35 months to 98.2% for those aged48 to 59 months. This percentage is also high for children whose mother has a minimum of a secondary level education compared to those whose mother is not educated (79.0% against 70.0%). The level of household life influences the probability for a child to be registered at birth : the proportion of children registered is 62.5% in the poorest households and 77.6% in the wealthiest.

Children residing in different districts do not have the same registration opportunities. Those residing in the Districts of Cantagalo and Príncipe have more opportunity (79.3% and 78.4% respectively) than those from Lobata and Mé-zochi 62.9% and 65.2% respectively).

It is estimated that for the less than 10.0% of those not registered at birth, the reasons are due to the cost, the distance and ignorance, 78.0% state other reasons and 13.0% do not know the reason.

Child Labour

Article 32 of the Convention on the Rights of the Child states: "States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development..." The WFFC mentions seven strategies to combat child labour and the

Millennium Declaration calls for the protection of children against exploitation. In the MICS questionnaire, a number of questions addressed the issue of child labour, that is, children aged 5-14 involved in labour activities.

A child is considered to be involved in child labour activities at the time of the survey if during the week preceding the survey:

- Ages 5-11: did at least one hour of economic work or 28 hours of domestic work per week
- Ages 12-14: did at least 14 hours of economic work or 28 hours of domestic work per week.

This definition allows differentiation between child labour and child work to identify the type of work that should be eliminated. As such, the estimate provided here is a minimum of the prevalence of child labour since some children may be involved in hazardous labour activities for a number of hours that could be less than the numbers specified in the criteria explained above.

Table CP.2 presents the results on child labour, by type. Following the definition above, child labour can be considered as non-existent in São Tomé e Príncipe : overall, it affects less than 8.0% of children. Of these, 3.2% work in a family business and 2.5% carry out domestic tasks during at least 28 hours per week. The table also indicates that some children work outside the household but this proportion is insignificant (1.8% for remunerated labour and the same for non-remunerated labour).

Table CP.3 presents the percentage of children considered as student labourers or labourer students. The student labourers are children who go to school who also held remunerated jobs during the time of the survey. Nationally, 80.9% of children aged 5 to 14 years go to school and 7.5% have a remunerated job. On the other hand, of the 7.5% of children considered child labourers, the majority (81.7%) of these also go to school.

Child labour is more widespread in rural areas than in urban (9.7% against 5.7%) and among children aged 12 to 14 (10.0% against 6.4%), among those aged 5 to 11 and in the Districts of Príncipe (17.0%) and Lobata (14.2%). It is less frequent in the District of Água Grande (3.3%) and among the wealthiest (3.9%).

Child labourers who go to school are more frequent in rural areas than in urban (84.7% against 77.8%), among the wealthiest and the wealthy (more than 93.0% against 72 to 76.0% for the poorest and poor), those whose mother has a minimum of a secondary level school level (96.2% against 74.6% for children whose mother is uneducated), and among children from 5 to 11 years (88.1% against 71.9% for those aged 12 to 14). The phenomenon is rarer in the District of Cantagalo (73.1%).

Student workers can be found more frequently in rural areas (10.1% against 5.5% in urban areas) and in the districts of Príncipe (17.6%) and Lobata (14.8%). It is rarer in the District of Água Grande (3.1%) and among children from the wealthiest households (4.0% against 8.2% in the poorest households).

Marriage and Union

Marriage before the age of 18 is a reality for many young girls. According to UNICEF's worldwide estimates, over 60 million women aged 20-24 were married/in union before the age of 18. Factors that influence child marriage rates include : the state of the country's civil registration system, which provides proof of age for children, the existence of an adequate legislative framework with an accompanying enforcement mechanism to address cases of child marriage, the existence of customary or religious laws that condone the practice.

In many parts of the world parents encourage the marriage of their daughters while they are still children in hopes that the marriage will benefit them both financially and socially. In fact, 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. The right to a 'free and full' consent to a marriage is recognized in the Universal Declaration of Human Rights - with the recognition that consent cannot be 'free and full' when one of the parties involved is not sufficiently mature to make an informed decision about a life partner. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) mentions the right to protection from child marriage in article 16, which states: "The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage..." While marriage is not considered directly in the Convention on the Rights of the Child, child marriage is linked to other rights - such as the right to express their views freely, the right to protection from all forms of abuse; and the right to be protected from harmful traditional practices - and is frequently addressed by the Convention on the Rights of the Child. Other international agreements related to child marriage are the Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages and the African Charter on the Rights and Welfare of the Child and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Child marriage is also identified by the Pan-African Forum against the Sexual Exploitation of Children as a type of commercial sexual exploitation of children.

Young married girls are a unique, though often invisible, group. Required to perform heavy amounts of domestic work, under pressure to demonstrate fertility and responsible for raising children while still children themselves, married girls and child mothers face constrained decision-making and reduced life choices. Boys are also affected by child marriage but the issue impacts girls in far larger numbers and with more intensity. Cohabitation - when a couple lives together as if married - raises the same human rights concerns as marriage. Where a girl lives with a man and takes on the role of caretaker for him, the assumption is often that she has become an adult woman, even if she has not yet

reached the age of 18. Additional concerns due to the informality of the relationship - for example, inheritance, citizenship and social recognition - might make girls in informal unions vulnerable in different ways than those who are in formally recognized marriages.

Research suggests that many factors interact to place a child at risk of marriage. Poverty, protection of girls, family honour and the provision of stability during unstable social periods are considered as significant factors in determining a girl's risk of becoming married while still a child. Women who married at a younger age are more likely to believe that it is sometimes acceptable for a husband to beat his wife and are more likely to experience domestic violence themselves. The age gap between partners is thought to contribute to these abusive power dynamics and to increase the risk of untimely widowhood.

Closely related to the issue of child marriage is the age at which girls become sexually active. Women who are married before the age of 18 tend to have more children than those who marry later in life. Pregnancy-related deaths are known to be a leading cause of mortality for both married and unmarried girls between the ages of 15 and 19, particularly among the youngest of this cohort. There is evidence to suggest that girls who marry at a young age are more likely to marry older men, which puts them at an increased risk of HIV infection. Parents seek to marry off their girls to protect their honour, and men often seek younger women as wives as a means to avoid choosing a wife who might already be infected.

Two indicators used to determine early marriage among females are the percentage of women married before 15 years of age and the percentage married before 18 years of age. Table ED. indicates that only 3.3% of women are married before their 15th year, which leads to the conclusion that early marriage is practically non-existent. While early marriage is rare in São Tomé e Príncipe, it is more widespread among young girls with no education (7.3% against 0.7% among women with a minimum of a secondary school education), those aged to 30 to 34 years (4.9%) and those who live in the Districts of Caué (7.1%), Príncipe (6.3%), Lembá (5.6%) and Cantagalo (5.3%). For women married before the age of 18, the proportion is 35.9% (39.5% in rural areas and 33.6% in urban areas). In the District of Caué, they are more numerous (51.6% against 29.3% in Água Grande and 33.8% in Mé-zochi). This proportion increases with the age of women, going from 33.4% for those aged 20 to 24. Marriage before 18 is also more widespread among women from the poorest households (46.0% against 20.3% among the wealthiest).

At the moment of the survey, 18.5% of women aged 15 to 19 years were married or living in union. This proportion is stronger in the Districts of Príncipe and Lembá (more than 24.0%), among the less educated (more than 22.0%) and weaker in the District of Mé-zochi (14.3%) and among more educated women (11.0%) and the wealthiest (3.8%). The São Tomé e Príncipe population is essentially Christian; polygamy does not exist.

Another element is the difference in age within the couple where the indicator is the percentage of married women or those in union with an age difference of 10 years of more with their current partner. Table CP.6 presents the result of age differences between husband and wife. Two categories of women were studied to indicate this difference, women aged 15 to 19 currently married/in union and women between 20 to 24 currently married/in union. The table indicates that 17.0% of women aged 15 to 19 years currently married/in union are 10 years younger than their spouses, 51.1% have a husband 5 to 9 years older and only 31.2% have spouses 4 years older than their husbands/partners. With regard to women 20 to 24, 16.2% have a husband/partner 10 years older, 36.4% are 5 to 9 years older and 44.1% are only 4 years apart. The difference in age of five years or more affects women aged 15 to 19 more (68.1%) than those aged 20 to 24 years (52.6%).

Domestic violence

A number of questions were asked of women aged 15-49 to assess their attitudes towards whether husbands are justified to hit or beat their wives/partners for a variety of scenarios. These questions were asked to have an indication of cultural beliefs that tend to be associated with the prevalence of violence against women by their husbands/partners. The main assumption here is that women who agree with the statements indicating that their husbands/partners are justified to beat their wives/partners under the situations described in reality tend to be abused by their own husbands/partners.

The responses to these questions are tabulated in Table CP.9.

Overall, 32.0% of women declared that a husband has the right to beat his wife for various reasons. This proportion varies according to some social categories. Rural women have a greater tendency to share this point of view than urban women (35.1% against 30.1%) do. This proportion is also higher in the Districts of Caué (51.1%), Lembá (42.4%) than in that of Água Grande (26.3%). It is lower also according to age (from 34.0% for those 15 to 19 years of age, to 28.9% for those aged 45 to 49), indicating, paradoxically, that younger women are more likely to approve the fact that the husband may have reason to beat his wife. The reasons for men to beat their wives are divers. One women out of five think that the husband has the right to beat his wife when she neglects their children, about 14.7% when she goes out without previously informing him, 17.4% when she stands up to him in a discussion, and 7.6% when she burns the meal.

Handicapped children

One of the World Fit for Children objectives is to protect children against abuse, exploitation and violence, as well as the elimination of discrimination against handicapped children. For children aged 2 to 9 years, a series of questions were asked to evaluate a number of illnesses/troubles, such as sight, deafness and difficulty in speaking. This approach is based on the concept of functional handicap as

developed by WHO and seeks to identify the implications of all infirmities or troubles on the development of the child (that is, related to its health, nutrition, education, etc.).

Table CP.10 presents the results of these questions and gives the percentage of children aged 2 to 9 with a declared handicap according to the nature of the handicap. Overall, of a total of 15.7% of children aged 2 to 9 have declared at least one handicap. The handicap frequency in children of this age is stronger among the youngest (21.8% for the 2 to 4 year olds against 12.5% for the 7 to 9 year olds), in the Districts of Caué (22.9%) and Lembá (19.8%). Among children aged 2, 13.2% are "incapable of naming at least one object" and among 3 to 9 year olds, 17.7% "do not speak normally".

XI. HIV/AIDS, Sexual behaviour and orphans and vulnerable children

Knowledge on HIV transmission and condom use

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 towards raising awareness and giving young people the tools to protect them from infection. Misconceptions of 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 (for example that sharing food can transmit HIV or mosquito bites can transmit HIV). The UN General Assembly Special Session on HIV/AIDS (UNGASS) called on governments to improve the knowledge and skills of young people to protect them from HIV. The indicators to measure this goal as well as the MDG of reducing HIV infections by half include improving the level of knowledge of HIV and its prevention, and changing behaviour to prevent further spread of the disease.

The HIV module was administered to women aged 15-49. One indicator, which is both an MDG and UNGASS indicator, is the percentage of young women who have comprehensive and correct knowledge of HIV prevention and transmission. Women were asked whether they knew of the three main ways of preventing HIV transmission - having only one faithful uninfected partner, using a condom every time, and abstaining from sex. The results are presented in Table HA.1.

In São Tomé e Príncipe, nearly all interviewed women (96.7%) had heard about AIDS, 87.3% knew of at least one way to prevent AIDS, and 12.7% did not know of any one of the three methods. More than 74.0% of women know that it is necessary to have a faithful and uninfected sexual partner, 75.3% know that a condom must be used every time, and 55.9% now about abstaining from sex as a method in the prevention of HIV transmission. Less than half of women (46.4% know the three principle methods of preventing HIV transmission.
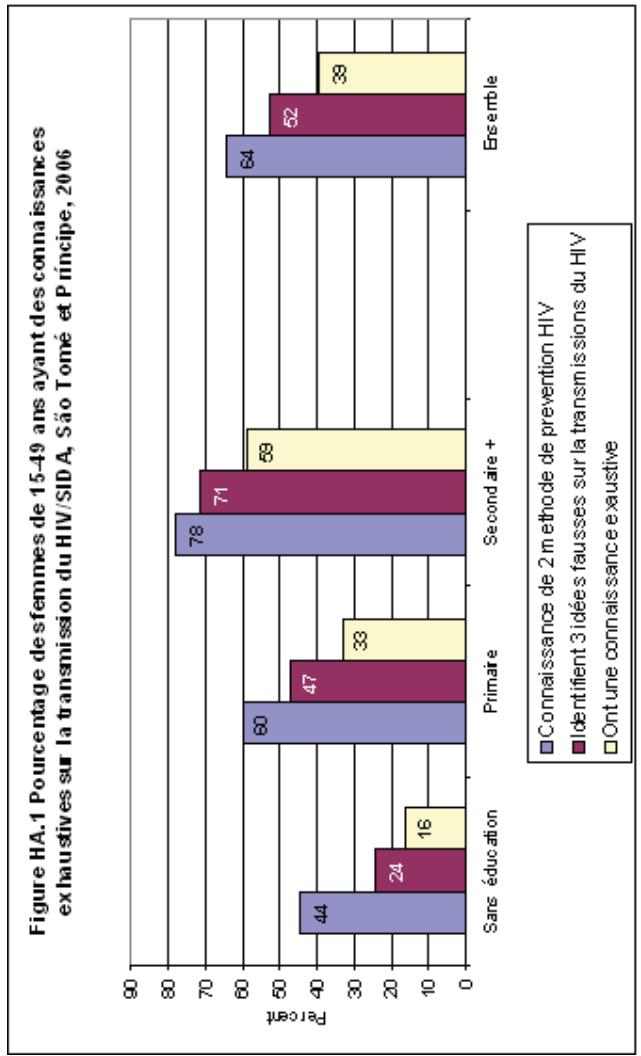
The proportion of women with knowledge on the three principle methods of preventing HIV transmission is greater in urban areas (50.2%) than in rural areas (40.5%), in the District of Água Grande (55.0%) than in those of Lembá (33.8%, Cantagalo and Caué (35.0% respectively). Women aged 20 to 24 are relatively better informed on the methods of preventing transmission : 52.6% know of three methods, against 47.9% for women aged 15 to 19 and less than 46.0% for older women. The level of life influences positively on awareness of methods to prevent HIV transmission. From 58.0% of women living in the wealthiest families, the proportion of women with knowledge on the three principle methods of preventing HIV transmission falls steadily to 34.1% for those who live in the poorest households, of which one women out of five does not know of any method of HIV prevention. The effect of the woman's level of education seems to have greater importance towards good

knowledge of the principal methods of HIV prevention : the proportion of women with knowledge of the three methods goes from 30.0% for women without education to 42.6% for those with a primary level education and 58.4% for those with a minimum of a secondary level education. Among uneducated women, close to 31.0% doe not know of any preventive method. The results below indicate the necessity and pertinence of sensitisation campaigns carried out in the framework of the fight against AIDS, but above all the choice of targets with particular attention to rural women, women residing in the Districts of Lembá, Caué and Cantagalo, women aged more than 25, women without education and the poorest women. In some of these categories, more than one quarter do not know of any means of preventing AIDS.

Table HA.2 presents the percentage of women able to correctly identify misconceptions about HIV. The indicator is based on the two most widespread misconceptions in São Tomé e Príncipe : VIH can be transmitted by supernatural means and by mosquito bites. This table also provides information on whether women's awareness that HIV cannot be transmitted by sharing food but that it can be transmitted by sharing needles. 52.5% of women interviewed reject the two most widespread misconceptions and know that a person who seems health may be infected. Close to 87.0% of women know that AIDS cannot be transmitted by supernatural means, and 75.1% know that mosquito bites cannot transmit HIV, while close to three women out of four know that a person seemingly in good health can be infected. In addition, 77.1% of women know that HIV cannot be transmitted by sharing food, and 81.2% know that it can be transmitted by sharing needles. Women rejecting the two most widespread misconceptions and know that a healthy –looking person can be infected are relatively more numerous in urban areas (56.1%) than in rural areas (46.7%). The Districts of Água Grande, Mé-zochi, Príncipe and Lobata are those where this proportion is strongest (84.0% to 91.2% against 75.0% to 78.0% elsewhere). This profile is also more widespread among women aged 20 to 24 (57.0%) and rarer among older women (43.9% for the 45 to 49 year olds). The wealthiest women and those with a minimum of a secondary level education are generally better informed : 69.8% and 71.1% respectively against 36.7% and 23.7% respectively for the women without education and the poorest.

Table HA.3 summarises the information in Tables HA.1 and HA.2, and presents the percentage of women who know two methods of preventing HIV transmission and reject the three widespread misconceptions. Close to two-thirds (64.1%) of women declare their knowledge on at least two methods of preventing HIV transmission and 52.5% identified three misconceptions on HIV/AIDS transmission. Nevertheless, global knowledge of methods of HIV prevention and transmission is still, on the whole, fairly weak (39.3% of women), even with differentiation according to some social categories. 43.9% of urban women have complete knowledge while only 32.2% of rural women are at the same level. With 49.8% of women, the District of Água Grande seems to the best informed on the principle methods of prevention and on misconceptions than other Districts such as Lembá (25.8%) and Cantagalo (26.8%). Differences also exist in relation to women's age : 44.7% of women aged 20 to 24, falling to 27.7% for those aged 45 to 49. As indicated in Figure HA.1, the percentage of women with complete awareness increases with the level of their education : 58.5% for the most educated women, and 27.7% for those without education. Table HA.3 also indicates that 58.5% of the most educated women can identify the two principle prevention methods and the three misconceptions while this proportion falls to 32.8% among women with a primary level education and again to 16.3% for women with no education. The level of

household life also tends to influence positively with regard to complete awareness on the prevention of HIV/AIDS transmission : from 55.7% among the wealthiest women, falling steadily to 25.9% among the poorest.

Figure HA.1 Pourcentage des femmes de 15-49 ans ayant des connaissances exhaustives sur la transmission du HIV/SIDA, São Tomé et Principe, 2006

Figure 13: HA.1 Percentage of women 15-49 with complete knowledge on HIV/AIDS transmission

Knowledge of mother-to-child transmission of HIV is also an important first step for women to avoid infection in the baby. Women should know that HIV could be transmitted during pregnancy, delivery and breastfeeding. The level of knowledge among women aged 15-49 concerning mother-to-child transmission is presented in Table HA.4. Globally, 91.3% of women know that AIDS can be transmitted from mother to child yet only 76.4% of women know of the three principle methods of transmitting the virus from mother to child, while only 5.4% do not know of any particular means of transmission. Close to nine women out of ten (88.0%) declare that HIV can be transmitted during pregnancy, 82.7% during labour, and 83.2% by breastfeeding. Knowledge of all three mother-to-child transmission methods varies according to the context. It is more generalised in the District of Água Grande (81.8%) and weaker in those of Caué and Lembá (less than 68.0%) while the household environment and the age of the women have only a negligible influence. On the other hand, the proportion of women with knowledge on the three methods increases with the woman's level of education and the level of household life : from more than 83.0% for the most educated and wealthiest, it falls to 55.6% and 71.0% respectively among women without education and the poorest.

The indicators on attitude towards people living with HIV measure stigma and discrimination in the community. Stigma and discrimination are low if respondents report a favourable attitude on the following four statements: • would care for family member sick with AIDS • would buy fresh vegetables from a vendor who was HIV positive • thinks that a teacher who is HIV positive should be allowed to teach in school • would not want to keep the HIV status of a family member a secret. Table HA.5 presents the attitudes of women towards people living with HIV/AIDS. Close to three women out of four (76.2%) approve of at least one discriminatory attitude against AIDS while 23.8% disapprove of all discriminatory attitudes. Among the various forms of discrimination, 45.5% of women declare that they will not buy fresh vegetables from a seropositive vendor, 44.3% that they would not wish to maintain secret the fact that a family member has HIV, 30.0% would not take care of a family member with AIDS and 24.5% think that a seropositive teacher should not be allowed to teach. The women who disapprove of all forms of discrimination are relatively more numerous among the most educated and the wealthiest (more than 31.0%) and the residents in the District of Água Grande (28.6%), and less numerous among women with no education and the poorest (15.0%) and residents in the Districts of Caué (12.9%), Lembá (17.3%) and Cantagalo (18.8%).

Another important indicator is the knowledge of where to be tested for HIV and use of such services. Questions related to knowledge among women of a facility for HIV testing and whether they have ever been tested is presented in Table HA.6. Close to seven women out of ten (69.0%) know where to be tested and 36.6% have taken the test. Of those who have been tested, a large proportion (close to 91.0%) has received their test results. The proportion of women who know a testing centre varies according to district, the housing environment, age, education and the level of life. The proportion is higher in the Districts of Água Grande and Príncipe (81.4% and 76.4% respectively), in urban areas (72.6%), in women aged 20 – 24 (78.3%), the most educated (88.1%) and the wealthiest (85.4%). It is lower in the Districts of Caué and Lembá (less than 44.0%), in rural areas (63.3%), among older women (59.5%), the poorest (53.3%) and in particular among women with no education

(32.1%). With regard to women who have already taken the test, the same disparities exist. The proportion is higher in Água Grande (50.4%), urban areas (40.8%), among women aged 20 to 24 (50.0%), the most educated women (45.9%) and the wealthiest (48.4%). In the lower socio-economic categories, the proportion of women having had the test varies between 15 and 30.0%.

Among women who had given birth within the two years preceding the survey, the proportion who received counselling and HIV testing during antenatal care is presented in Table HA.7. While 97.3% women have received pre-natal care from a health worker during their pregnancy, 70.5% have received advice about HIV prevention during a visit to the health centre. The proportion of women having received counselling varies on the district, level of education and household level of life. It is higher in the District of Água Grande (77.3% against 60.0% in that of Lembá), among the most educated (83.9% against 44.2% for uneducated women), and among the wealthiest (79.4% against 60.3%). The tendency is the same for the proportion of women who have received their test results, except in relation to their residential environment (six out of ten urban women have received their test results against four out of ten rural women only).

Sexual behaviour linked to HIV transmission

Promoting safer sexual behaviour is critical for reducing HIV prevalence. The use of condoms during sex, especially with non-regular partners, is especially important for reducing the spread of the virus. In most countries, over half of new HIV infections are among young people aged 15-24. Thus, a change in behaviour among this age group will be especially important to reduce new infections. A module of questions was administered to women aged 15-24 to assess their exposure to the risk of HIV infection. Risk factors for HIV include sex at an early age, sex with older men, sex with a non-marital non-cohabitating partner and failure to use a condom. The frequency of sexual behaviours that increase the risk of HIV infection in women is presented in Table HA.8 and Figure HA.2. About 9.0% of women aged 15 to 19 have had sex before their 15th birthday while 53.4% of those aged 20 to 24 have had their first sexual relations before 18, suggesting that São Tomé e Príncipe is distinguished by a tendency to early sexuality. Early sexual relations is more widespread in the District of Cantagalo where 18.6% of women aged 15 to 19 have had sex before 15 (against 4.9% in Mé-zochi) and among the poorest and poor women (11.5 to 13.0% against 4.5% among the wealthiest). About 12.4% of women have had sex in the last 12 months before the survey with a man 10 years older. This practice is common to nearly all social categories under consideration.

Figure HA.2 Comportement sexuel favorisant le risque d'infection á HIV, São Tomé et Príncipe, 2006

Femmes de 15-19 ayant eu des rapports sexuels avant 15 ans
Femmes de 20-24 ans ayant eu des rapports sexuels 18 ans
Femmes ayant eu des rapports sexuels dans les 12 mois avec un homme de 10 + agées qu'elles
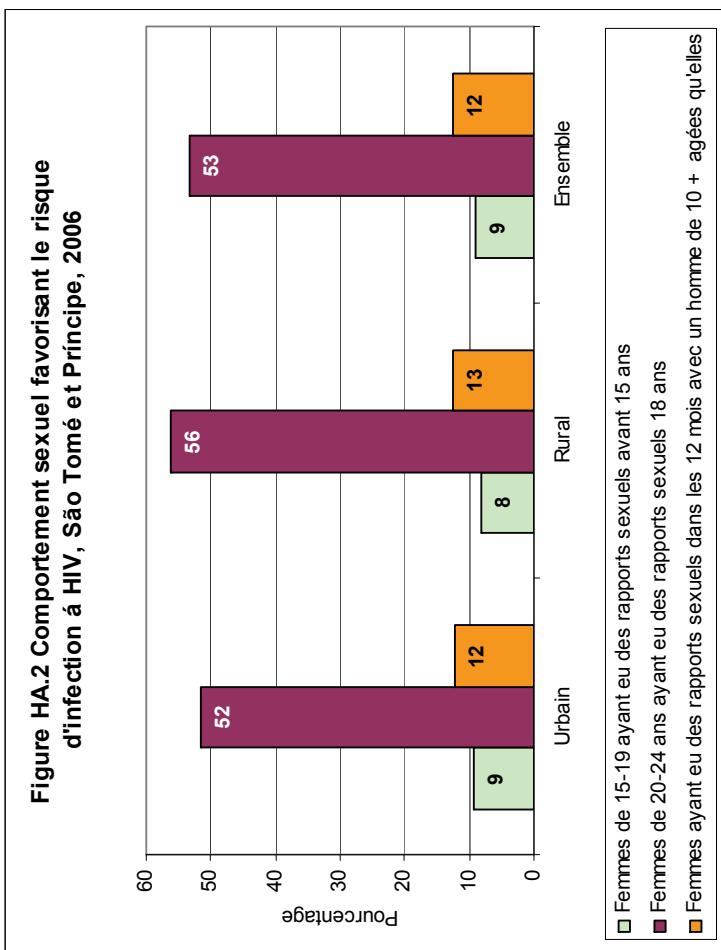
Figure 14: HA.2 Sexual behaviour favouring the risk of HIV infection

Condom use for sex with men other than their husbands or partners was evaluated among women 15 to 24 who have had this type of partner during the preceding year (Table HA.9). Close to one out of three women aged 15 to 24 (33.5%) declared having a casual sex partner during the 12 months preceding the survey. This type of sexual relation is more frequent in urban areas (38.4%) and in the District of Água Grande (42.4%) and rarer in rural areas (26.0%) and in the District of Lembá (17.6%). The levels of education and of household life favour casual sex outside the marriage/union. More than half of women with a secondary level of education or higher have had this type of sex (against 24.0% among those with only a primary education level). This percentage is higher among the wealthiest women (58.2% against less than 29.0% for the poorest). Among women having casual sex outside the marriage/union, 56.3% did not use a condom during the last time they had sex with a high-risk partner. The proportion that did not use a condom during their last sexual contact is higher in the District of Mé-zochi (64.0%, in rural areas (61.0%) and, paradoxically, among the most educated women (62.3%against 50.0% among those with only a primary education) and among he wealthiest (59.0% against 45.0% among the poorest). More than two out of three women aged 15 to 24 (67.0%) declare that they have never had sexual relations.

Orphans and vulnerable children

As the HIV/AIDS pandemic progresses, more and more children are becoming orphaned and vulnerable. Children who are orphaned or in vulnerable households may be at an increased risk of neglect or exploitation, if the parents are not available to assist them. Monitoring the variations in different outcomes for orphans and vulnerable children and comparing them to their peers gives us a measure of how well communities and governments are responding to their needs. To monitor these variations, a measurable definition of orphaned and vulnerable children needed to be created. The UNAIDS Monitoring and Evaluation Reference Group developed a proxy definition of children who have been affected by adult morbidity and mortality. This should capture many of the children affected by AIDS in countries where a significant proportion of the adults are HIV infected. This definition classifies children as orphaned and vulnerable if they have experienced the death of either parent, if either parent is chronically ill, or if an adult (aged 18-59) in the household either died (after being chronically ill) or was chronically ill in the year prior to the survey.

The average number of children living with only one parent, with either their mother or their father, is presented in Table HA.10. Half (50.6%) of children live with their two parents. Among children living with neither parent, 13.0% of them have both their parents alive. Close to 16.0% of children do not live with their biological parents, and 6.2% of children have either one or both parents dead.

Table HA.11 indicates the percentage of orphans and vulnerable children aged 0 to 17. On the whole, 5.2% of children aged 0 to 17 are vulnerable, 6.2% are orphans with either one or both parents dead and 10.5% are orphans and vulnerable. The percentage of orphans is higher in the District of Lembá and among the poorest households (8.0%) while the orphans are equally distributed among different social categories,

except in terms of the child's age. In fact, the percentage of orphans increases with the age of the child, going from 1.8% for 0 to 4 year olds to 5.8% for those aged 5 to 9, to 8.6% for those aged 10 to 14 and close to 11.0% for those aged 15 to 17.

One of the measures developed for the assessment of the status of orphaned and vulnerable children relative to their peers looks at the school attendance of children 10-14 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). If children whose parents have died do not have the same access to school as their peers, then families and schools are not ensuring that these children's rights are being met.

In São Tomé e Príncipe, 13.2% of children aged 10 to 14 are orphans or have become vulnerable due to AIDS, 0.4% have lost both parents (Table HA.12). They all go to school. Among children aged 10 to 14 who have not lost a parent and who live with at least one parent (90.5%), go to school. From school attendance, it can be seen that double orphans have a higher rate of attendance in comparison to non-orphans.

In many countries, few services are available to families who have taken in orphaned or vulnerable children. Community-based organizations and governments need to be sure that families are supported to care for these children. The level and types of support provided to households caring for orphaned and children made vulnerable by AIDS are presented in Table HA.13. Among orphans or children made vulnerable by AIDS aged 0 to 17, 95.7% did not received any external assistance during the last 12 months, as did only 4.3%. Although overall very few children benefit from support, those residing in the Districts of Lembá and Caué seem to be better off (11.4% and 8.6% respectively) while those in Água Grande enjoy less external assistance (1.5%). The most frequent type of assistance is social or material assistance (2.3% of children), followed by school assistance (1.2%).

The prevalence of malnutrition among orphans and vulnerable children under five years of age is presented in Table HA.14. Close to one orphan or vulnerable child aged 0 to 4 out of ten (9.90%) are underweight in relation to age, 26.0% are stunted and 7.6% are underweight in relation to height. For the first two indicators, the percentages are smaller among non-orphans or non-vulnerable children (respectively 9.1% and 22.7%), proof that the first are at a disadvantage. The ratio between the two groups (orphans and vulnerable children, and non-orphans and non-vulnerable children) is estimated, respectively, at 1.09, 1.14 and 0.95.

Research suggests that in some areas children who were orphaned are more likely to have worse sexual and reproductive health outcomes than other children are. Table HA.15 presents information on the sexual behaviour of orphaned and vulnerable women aged 15-17. The percentage of children aged 15 to 17 who have had sex before 15 is slightly lower in orphans and vulnerable children than in others. The ration between percentages is estimated 0.9.

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MICS 3 STP Tables

Table HH.1: Household and individual survey results

Number of households, women and children under 5 by results of the household, women's and under-5's interviews, and household, women's and under-5's response rates, São Tomé e Príncipe, 2006

	Residence		Region								Total
	Urban	Rural	Água-Grande	Mé-zochi	Cantagalo	Caué	Lembá	Lobata	Príncipe		Total
Number of households											
Selected	2660	2985	800	800	810	805	810	810	810		5645
Occupied	2660	2985	800	800	810	805	810	810	810		5645
Interviewed	2652	2973	800	800	810	802	810	807	796		5625
Rate of response	99.7	99.6	100.0	100.0	100.0	99.6	100.0	99.6	98.3		99.6
Number of women											
Eligible	2452	2292	783	674	667	642	721	682	575		4744
Interviewed	2410	2202	777	666	638	627	716	674	514		4612
Rate of response	98.3	96.1	99.2	98.8	95.7	97.7	99.3	98,8	89.4		97.2
Global rate of response	98.0	95.7	99.2	98.8	95.7	97.3	99.3	98.5	87.8		96.9
Number of under fives											
Eligible	1554	1616	381	399	481	478	526	458	447		3170
Mothers / Caregivers	1541	1599	380	395	473	471	525	457	439		3140
Rate of response	99.2	98.9	99.7	99.0	98.3	98.5	99.8	99.8	98.2		99.1
Global rate of response	98.9	98.6	99.7	99.0	98.3	98.2	99.8	99.4	96.5		98.7

Table« HH.2: Distribution of household members by age and sex

Percentage distribution of the household population by five-year age groups and dependency age groups, and number of children aged 0-17 years, by sex, São Tomé e Príncipe, 2006

	Male		Female		Both	
	Number	Percentage	Number	Percentage	Number	Percentage
Age						
0-4	1503	13.1	1490	13.2	2992	13.2
5-9	1713	14.9	1660	14.8	3372	14.8
10-14	1586	13.8	1553	13.8	3138	13.8
15-19	1432	12.5	1088	9.7	2519	11.1
20-24	1140	9.9	1037	9.2	2176	9.6
25-29	830	7.2	852	7.6	1682	7.4
30-34	633	5.5	638	5.7	1272	5.6
35-39	546	4.8	549	4.9	1095	4.8
40-44	446	3.9	528	4.7	974	4.3
45-49	372	3.2	290	2.6	662	2.9
50-54	309	2.7	501	4.5	810	3.6
55-59	230	2.0	224	2.0	454	2.0
60-64	191	1.7	228	2.0	419	1.8
65-69	201	1.8	212	1.9	413	1.8
70+	307	2.7	388	3.4	694	3.1
Does not know	40	.3	13	.1	53	.2
Dependent age groups						
< 15	4801	41.8	4702	41.8	9503	41.8
15-64	6128	53.4	5935	52.8	12064	53.1
65 +	508	4.4	600	5.3	1108	4.9
Does not know	40	.3	13	.1	53	.2
Children aged 0-17	5633	49.1	5360	47.6	10993	48.4
Adults aged 18+ Does not know	5844	50.9	5891	52.4	11735	51.6
Total	11477	100.0	11251	100.0	22728	100.0

Table HH.3: Household composition

Percentage distribution of households by selected characteristics, São Tomé e Príncipe, 2006

	Weighted percentage	Number of household members	
		Weighted	Non weighted
Sex of head of household			
Male	61.9	3484	3767
Female	38.1	2141	1858
Region			
Agua-Grande	35.5	1999	800
Mé-zochi	27.8	1565	800
Cantagalo	10.2	573	810
Caué	5.0	283	802
Lembá	7.3	408	810
Lobata	8.8	495	807
Príncipe	5.4	302	796
Residence			
Urban	56.7	3189	2652
Rural	43.3	2436	2973
Size of household			
1	18.6	1044	1086
2-3	26.4	1483	1401
4-5	30.8	1730	1699
6-7	15.7	883	937
8-9	5.9	331	356
10+	2.7	154	146
Total	100.0	5625	5625

Table HH.4: Women's background characteristics

Percentage distribution of women aged 15-49 by background characteristics, São Tomé e Príncipe, 2006

	Weighted percentage	Weighted	Non weighted
Region			
Agua-Grande	39.0	1796	777
Mé-zochi	26.9	1238	665
Cantagalo	9.5	439	638
Caué	4.5	206	627
Lembá	7.3	337	716
Lobata	8.6	397	674
Príncipe	4.3	196	514
Residence			
Urban	61.2	2819	2410
Rural	38.8	1791	2201
Age			
15-19	21.7	1000	986
20-24	20.9	964	914
25-29	17.1	790	761
30-34	12.8	588	640
35-39	11.1	511	545
40-44	10.6	489	488
45-49	5.8	268	277
Marital status			
Currently married/in union	59.2	2727	2847
Separated/Divorced/Widowed	14.9	688	693
Single	25.9	1194	1071
Mother's status			
Already pregnant	71.9	3315	3453
Never pregnant	28.1	1295	1158
Education			
None	5.9	271	388
Primary	64.8	2988	3208
Secondary +	29.0	1339	990
Informal programme	.3	12	25
Wealth index quintiles			
Very poor	17.4	804	947
Poor	17.9	826	1082
Middle income	19.6	906	986
Wealthy	21.4	987	878
Very wealthy	23.6	1088	718
Total	100.0	4610	4611

Table HH.5: Children's background characteristics
Percentage distribution of children under 5 by background characteristics, São Tomé e Príncipe, 2006

	Weighted percentage	Number of children under five	
		Weighted	Non weighted
Sex			
Male	50.2	1569	1565
Female	49.8	1556	1564
Region			
Agua-Grande	32.7	1023	378
Mé-zochi	26.4	825	393
Cantagalo	11.3	353	473
Caué	5.6	176	471
Lembá	8.9	279	525
Lobata	9.3	290	450
Príncipe	5.8	180	439
Residence			
Urban	56.9	1779	1537
Rural	43.1	1346	1592
AGE			
< 6 months	11.6	363	360
6-11 months	10.9	342	308
12-23 months	21.5	673	655
24-35 months	19.7	616	636
36-47 months	19.9	623	620
48-59 months	16.3	509	550
Mother's education level			
None	7.7	241	301
Primary	72.4	2261	2386
Secondary +	19.8	618	430
Informal programme	.2	5	12
Wealth index quintiles			
Very poor	21.7	678	764
Poor	21.6	675	862
Middle income	20.2	631	675
Wealthy	20.5	641	523
Very wealthy	16.0	500	305
Total	100.0	3125	3129

Table CM.1: Child mortality
Infant and under-5 mortality rates, São Tomé e Príncipe, 2006

	Child mortality rate	Under 5 mortality rate
Sex		
Male	51	73
Female	49	75
Region		
Agua-Grande	50	74
Mé-zochi	35	49
Cantagalo	46	67
Caué	46	68
Lembá	56	84
Lobata	39	55
Príncipe	62	95
Residence		
Urban	47	70
Rural	43	61
Mother's education level		
None	50	75
Primary	46	67
Secondary +	39	56
Informal programme	50	75
Wealth index quintiles		
Very poor	41	58
Poor	48	71
Middle income	47	69
Wealthy	47	69
Very wealthy	41	58
Total	45	66

* MICS indicator n. 2; MDG indicator n. 14
** MICS indicator n. 1; MDG indicator n. 13

Table CM.2: Children ever born and proportion dead
Mean number of children ever born and proportion dead by age of women, São Tomé e Príncipe, 2006

	Mean number of children ever born	Mean number of children survivors	Proportion of deceased children	Number of women
Age				
15-19	.200	.193	.038	1000
20-24	1.157	1.119	.033	964
25-29	2.146	2.015	.061	790
30-34	3.549	3.294	.072	588
35-39	4.574	4.230	.075	511
40-44	5.445	4.985	.084	489
45-49	5.817	5.199	.106	268
Total	2.528	2.341	.074	4610

Table NU.1: Child malnourishment
Percentage of children aged 0-59 who is severely or moderately malnourished, São Tomé e Príncipe, 2006

	Weight relative to age		Height relative to age		Weight relative to height			Number of children aged 0-59 months
	% above -2 SD*	% above -3 SD*	% above -2 SD**	% above -3 SD**	% above -2 SD***	% above -3 SD***	% above +2 SD	
Sex								
Male	9.1	1.6	24.3	10.9	8.1	1.2	9.7	1429
Female	9.3	.8	21.6	9.3	7.9	1.7	11.8	1418
Region								
Agua-Grande	7.0	1.4	15.5	8.3	8.7	1.6	10.8	935
Mé-zochi	10.8	.9	27.5	12.1	8.8	1.6	10.5	753
Cantagalo	9.6	2.2	28.6	11.8	6.3	1.6	11.3	316
Caué	10.8	.9	29.5	13.2	5.6	.7	12.0	161
Lembá	11.2	1.3	23.2	8.3	7.4	1.6	8.1	261
Lobata	9.5	1.4	20.5	5.4	9.9	.8	5.0	269
Príncipe	7.7	.4	31.6	15.6	3.5	1.1	23.7	153
Residence								
Urban	7.5	1.1	19.0	8.5	7.4	1.5	9.9	1623
Rural	11.4	1.5	28.2	12.2	8.7	1.4	11.9	1224
Age								
< 6 months	3.0	.0	9,0	1.1	10.6	1.2	22.4	285
6-11 months	9.6	1.5	20.0	7.2	10.6	3.8	14.9	293
12-23 months	13.1	2.7	30.2	14.9	11.6	2.4	12.7	587
24-35 months	11.8	1.9	24.9	13.6	9.0	1.3	7.2	582
36-47 months	5.2	.3	21.1	8.3	4.0	.5	7.0	603
48-59 months	9.8	.5	24.2	9.3	4.4	.4	7.9	498
Mother's level of education								
None	12.6	.9	25.1	11.1	6.6	1.0	10.5	213
Primary	9.8	1.4	24.0	10.3	8.5	1.6	10.8	2057
Secondary +	6.0	.9	18.2	8.8	7.0	1.1	10.4	573
Informal programme	.0	.0	38.2	15.9	.0	.0	39.4	5
Wealth index quintiles								
Very poor	12.7	1.7	30.6	14.5	8.5	1.2	12.1	615
Poor	8.6	1.4	24.6	11.2	8.8	2.3	9.1	629
Middle income	10.7	1.2	24.3	9.9	6.5	1.2	10.1	567
Wealthy	8.1	1.7	20.2	8.4	8.7	1.4	9.4	581
Very wealthy	4.8	.0	12.2	5.0	7.2	.9	13.7	456
Total	9.2	1.2	23.0	10.1	8.0	1.4	10.7	2848

* MICS indicator 6; MDG indicator 4   ** MICS indicator 7   *** MICS indicator 8

Table NU.2: Initial breastfeeding
Percentage of women aged 15-49 with a birth in the two years preceding the survey who breastfed their baby within one hour of birth and within one day of birth, São Tomé e Príncipe, 2006

	Percentage of women starting breastfeeding within 1 hour after birth*	Percentage of women starting breastfeeding within 1 day after birth **	Number of women with a live born birth during the 2 years preceding the survey
Region			
Agua-Grande	40.6	81.7	454
Mé-zochi	25.3	79.4	297
Cantagalo	31.5	86.7	127
Caué	27.0	80.6	63
Lembá	29.6	69.8	116
Lobata	30.8	82.4	108
Príncipe	75.5	91.0	66
Residence			
Urban	36.4	81.1	740
Rural	33.5	81.0	491
Number of months since birth			
< 6 months	37.1	81.5	331
6-11 months	25.6	77.9	304
12-23 months			
Mother's level of education			
None	32.5	82.0	76
Primary	35.2	82.0	892
Secondary +	36.1	77.6	261
Informal programme	47.7	47.7	1
Wealth index quintiles			
Very poor	31.0	77.7	271
Poor	37.8	84.1	260
Middle income	32.5	84.9	236
Wealthy	38.0	79.1	260
Very wealthy	37.3	79.5	205
Total	35.3	81.0	1230

* MICS indicator no 45

Table NU.3: Breastfeeding Percentage of living children according to breastfeeding status at each age group, São Tomé e Príncipe, 2006

	Children 0-3 months		Children 0-5 months		Children 6-9 months		Children 12-15 months		Children 20-23 months	
	Percentage exclusive breastfeeding*	Number of children	Percentage exclusive breastfeeding *	Number of children	Percentage of children breastfeeding and eating solid and semi-solid foods (mash)**	Number of children	Percentage of breastfeeding ***	Number of children	Percentage of breastfeeding***	Number of children
Sex										
Male	77.0	114	63.9	169	58.6	116	90.0	112	12.9	117
Female	64.6	137	57.3	194	61.3	125	86.8	140	25.5	91
Region										
Agua-Grande	78.2	102	68.5	148	72.3	85	84.8	102	7.3	61
Mé-zochi	74.7	43	58.7	68	57.4	71	96.0	52	14.1	63
Cantagalo	56.7	22	46.3	33	54.8	30	94.1	25	19.8	26
Caué	62.2	17	60.6	23	23.3	5	91.5	18	66.1	11
Lembá	59.6	22	47.7	31	63.8	19	89.1	20	22.9	20
Lobata	61.6	32	57.9	39	51.6	21	71.0	24	19.1	17
Príncipe	64.7	13	53.9	21	18.1	10	100.0	12	48.0	10
Residence										
Urban	72.3	159	61.7	231	68.8	139	84.9	156	15.8	108
Rural	66.4	92	58.0	132	48.0	102	93.6	96	21.3	99
Mother's level of education										
None	90.8	15	79.7	19	33.3	14	72.0	14	15.2	17
Primary	68.5	179	59.1	259	54.5	176	90.4	184	20.3	151
Secondary +	69.7	56	59.7	85	86.7	50	84.8	53	12.6	40
Informal programme	100.0	1	100.0	1	.	0	.	0	.	0
Wealth index quintiles										
Very poor	68.9	55	56.5	83	57.7	51	93.2	52	35.5	43
Poor	75.3	44	65.1	74	47.5	48	87.3	57	25.6	55
Middle income	69.9	49	61.6	64	59.3	50	94.6	43	20.5	41
Wealthy	68.2	45	54.9	71	65.8	65	85.1	50	.8	45
Very wealthy	69.3	57	64.3	70	74.3	27	81.7	50	.0	24
Total	70.2	251	60.4	363	60.0	241	88.2	252	18.4	208

*MICS indicator no 15; ** MICS indicator no 17; *** MICS indicator no 16

Table NU.3w. Different feeding methods for children, by age

Percentage distribution of children aged less than 3 years according to type of food and age, São Tomé e Príncipe, 2006

Age (months)	Different feeding methods						Total	Number of children
	Exclusively breastfeeding	Exclusively breastfeeding and drinking natural water	Breastfeeding and liquids other than milk	Breastfeeding and another type of milk	Breastfeeding and other complementary foods	Weaned (no breastfeeding)		
0-1	74.6	10.4	2.8	7.6	4.1	.5	100.0	107
2-3	66.9	10.3	3.5	15.7	1.6	2.0	100.0	143
4-5	38.4	24.4	4.5	12.5	20.2	.0	100.0	112
6-7	6.0	11.5	12.1	23.3	45.3	1.7	100.0	116
8-9	1.1	1.1	4.2	12.5	73.6	7.6	100.0	125
10-11	.0	3.2	1.1	5.8	75.7	14.3	100.0	101
12-13	.0	6.8	2.7	19.6	58.1	12.7	100.0	141
14-15	.5	4.2	.8	15.4	68.6	10.6	100.0	111
16-17	2.3	1.1	.9	11.7	61.7	22.3	100.0	105
18-19	.0	.5	.0	2.0	40.6	56.8	100.0	108
20-21	.0	.0	.4	4.8	17.8	77.0	100.0	113
22-23	.0	.0	.0	1.9	11.0	87.1	100.0	95
24-25	.0	.0	.0	.9	3.7	95.3	100.0	99
26-27	.0	.0	.0	.0	6.0	94.0	100.0	141
28-29	.0	.0	.0	.5	3.8	95.7	100.0	97
30-31	.0	.0	.0	.0	3.8	96.2	100.0	105
32-33	.0	.0	.0	.6	2.5	97.0	100.0	81
34-35	.0	.0	.0	.0	3.9	96.1	100.0	93
Total	11.6	4.4	2.0	8.1	28.7	45.2	100.0	1994

Table NU.4: Adequately fed infants
**Percentage of infants under 6 months of age exclusively breastfed, percentage
of infants 6-11 months who are breastfed and who ate solid/semi-solid food at least
the minimum recommended number of times yesterday and percentage of infants
adequately fed, São Tomé e Príncipe, 2006**

	Percentage of children					
	0-5 months exclusively breastfed	6-8 months breastfed and eating complementary food at least twice per day during the last 24 hours	9-11 months breastfeeding and eating complementary food at least 3 times per day during the last 24 hours	6-11 months breastfeeding and eating complementary food the minimum recommended number of times per day *	0-11 months adequately fed **	Number of children aged 0 -11 months
Sex						
Male	63.9	44.2	44.8	44.5	54.3	335
Female	57.3	54.3	33.4	44.2	51.1	370
Region						
Agua-Grande	68.5	66.2	59.3	63.4	66.2	267
Mé-zochi	58.7	37.5	30.4	33.6	43.8	167
Cantagalo	46.3	36.2	26.3	31.8	38.7	70
Caué	60.6	21.9	32.7	29.0	52.2	32
Lembá	47.7	45.9	46.0	45.9	46.8	62
Lobata	57.9	44.1	27.7	35.4	47.8	70
Príncipe	53.9	24.7	19.2	21.2	39.6	37
Residence						
Urban	61.7	59.3	52.4	56.4	59.3	426
Rural	58.0	32.0	25.3	28.3	42.3	279
Mother's level of education						
None	79.7	32.6	68.1	46.6	61.8	41
Primary	59.1	42.7	31.5	37.3	48.4	506
Secondary +	59.7	78.8	56.6	67.8	63.4	158
Informal programme	100.0	.	.	.	100.0	1
Wealth index quintiles						
Very poor	56.5	56.0	34.2	43.8	50.5	159
Poor	65.1	28.4	24.2	26.4	47.4	136
Middle income	61.6	46.9	37.7	42.3	51.5	135
Wealthy	54.9	48.4	68.1	55.5	55.2	155
Very wealthy	64.3	75.2	32.0	51.7	59.0	121
Total	60.4	49.4	38.9	44.3	52.6	705

* MICS indicator no 18
** MICS indicator no 19

Table NU.5: Iodized salt consumption
Percentage of households consuming adequately iodized salt, São Tomé e Príncipe, 2006

	Percentage of households where salt was tested	Number of households surveyed	Percentage of households with test results			Total	Number of households where salt was tested or there was no salt
			No salt	< 15 PPM	>15 PPM*		
Region							
Agua-Grande	85.7	1999	13.0	41.4	45.6	100.0	1969
Mé-zochi	81.7	1565	17.7	48.6	33.7	100.0	1554
Cantagalo	85.0	573	14.2	60.7	25.1	100.0	568
Caué	82.9	283	16.7	67.1	16.2	100.0	281
Lembá	80.9	408	18.3	58.1	23.6	100.0	404
Lobata	82.9	495	15.8	52.3	32.0	100.0	487
Príncipe	82.7	302	9.6	30.0	60.4	100.0	276
Residence							
Urban	84.9	3189	13.9	46.4	39.7	100.0	3145
Rural	81.9	2436	16.7	50.8	32.5	100.0	2395
Wealth index quintiles							
Very poor	75.8	1265	23.1	47.3	29.5	100.0	1248
Poor	82.2	1177	16.8	51.3	31.9	100.0	1162
Middle income	82.6	1145	15.7	48.4	35.8	100.0	1122
Wealthy	88.8	1038	9.9	48.5	41.6	100.0	1023
Very wealthy	91.0	1000	7.6	45.6	46.8	100.0	986
Total	83.6	5625	15.1	48.3	36.6	100.0	5540

 * MICS indicator no 41

Table NU.6: Children's Vitamin A supplementation
Percentage distribution of children aged 6-59 months by whether they have received
a high dose of Vitamin A supplement in the last 6 months,
São Tomé e Príncipe, 2006

	Percent of children who were given' vitamin A :						
	During the last 6 months*	Prior to the last six months	Does not know when	Is not sure if the child was given vitamin A	Was never given vitamin A	Total	Number of children aged de 6-59 months
Sex							
Male	32.0	27.1	9.6	2.8	28.4	100.0	1400
Female	34.9	27.0	9.7	2.2	26.2	100.0	1362
Region							
Agua-Grande	25.4	27.5	9.7	2.8	34.6	100.0	875
Mé-zochi	36.0	34.4	7.0	2.3	20.3	100.0	757
Cantagalo	27.5	20.0	11.2	2.6	38.8	100.0	320
Caué	31.4	30.4	13.3	2.7	22.2	100.0	153
Lembá	42.4	24.1	8.2	3.1	22.2	100.0	248
Lobata	34.7	21.1	11.5	2.6	30.1	100.0	251
Príncipe	63.4	14.1	14.6	1.0	6.9	100.0	159
Residence							
Urban	31.0	25.4	9.8	2.5	31.3	100.0	1548
Rural	36.5	29.2	9.5	2.5	22.3	100.0	1214
Age							
6-11 months	43.8	4.9	3.4	1.0	46.9	100.0	342
12-23 months	43.8	25.6	8.0	2.0	20.5	100.0	673
24-35 months	34.2	35.5	11.3	1.2	17.8	100.0	616
36-47 months	26.6	31.5	11.1	3.9	26.8	100.0	623
48-59 months	20.2	28.1	12.2	4.1	35.4	100.0	509
Mother's level of education							
None	20.9	14.8	14.0	5.5	44.8	100.0	222
Primary	33.9	28.1	9.0	2.1	26.9	100.0	2003
Secondary +	36.8	28.3	10.2	3.0	21.8	100.0	533
Informal programme	57.5	.0	.0	.0	42.5	100.0	4
Wealth index quintiles							
Very poor	35.6	29.2	8.9	2.7	23.7	100.0	594
Poor	36.2	25.7	8.1	2.3	27.7	100.0	602
Middle income	34.8	25.2	10.1	2.0	28.0	100.0	567
Wealthy	29.4	26.9	8.9	3.2	31.5	100.0	570
Very wealthy	30.1	28.6	13.3	2.4	25.6	100.0	430
Total	33.4	27.0	9.6	2.5	27.4	100.0	2762

* MICS indicator no 42

Table NU.7: Post-partum mothers' Vitamin A supplementation
Percentage of women aged 15-49 with a live birth in the two years preceding the survey by whether they received a high dose of Vitamin A supplement before the infant was eight weeks old,
São Tomé e Príncipe, 2006

	Has been given vitamin A supplement	Not sure of having been given vitamin A	Number of women aged 15-49
Region			
Agua-Grande	60.4	2.6	454
Mé-zochi	64.3	3.6	297
Cantagalo	55.8	4.2	127
Caué	64.1	1.5	63
Lembá	71.1	2.8	116
Lobata	57.5	1.4	108
Príncipe	84.2	6.9	66
Residence			
Urban	61.8	2.5	740
Rural	65.0	4.0	491
Mother's level of education			
None	57.9	2.7	76
Primary	63.0	2.7	892
Secondary +	64.7	4.3	261
Informal programme	52.3	47.7	1
Wealth index quintiles			
Very poor	60.7	4.1	271
Poor	57.7	2.9	260
Middle income	65.6	1.4	236
Wealthy	60.9	3.7	260
Very wealthy	72.9	3.1	205
Total	63.1	3.1	1230

* MICS indicator no 43

Table NU.8: Low birth weight infants
Percentage of live births in the two years preceding the survey that weighed
below 2500 grams at birth,
São Tomé e Príncipe, 2006

	Percentage of live births :		Total number of live births
	Less than 2500 gr.*	Weighed at birth**	
Region			
Agua-Grande	9.0	91.9	454
Mé-zochi	6.5	77.8	297
Cantagalo	8.1	73.6	127
Caué	8.4	75.7	63
Lembá	7.6	77.7	116
Lobata	7.5	79.8	108
Príncipe	6.2	73.7	66
Residence			
Urban	8.5	87.7	740
Rural	6.9	74.4	491
Mother's level of education			
None	7.9	70.0	76
Primary	7.8	81.4	892
Secondary +	8.0	89.6	261
Informal programme	3.4	52.3	1
Wealth index quintiles			
Very poor	9.1	72.4	271
Poor	7.6	81.2	260
Middle income	8.7	82.2	236
Wealthy	7.3	89.7	260
Very wealthy	6.2	88.2	205
Total	7.8	82.4	1230

* MICS indicator no 9
** MICS indicator no 10

Table CH.1: 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, São Tomé e Príncipe, 2006

	BCG*	DPT1	DPT2	DPT3**	Polio0	Polio1	Polio2	Polio3***	Measles****	All****	None	Number of children 12-23 months
Vaccinated at one moment or another preceding the survey												
According to :												
Vaccination card	90.8	90.8	90.4	87.5	90.6	90.9	90.6	87.5	80.0	79.0	,0	673
Information given by mother	7.5	7.2	6.9	4.7	6.9	6.2	4.7	.6	6.8	.6	1,8	673
Both	98.2	97.9	97.4	92.1	97.5	97.1	95.3	88.1	86.9	79.6	1,8	673
Vaccination at 12 months	98.1	97.9	97.0	91.4	97.4	97.0	94.9	87.4	83.4	76.0	1,8	673

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

Table CH.1c: Vaccinations in first year of life (continued)

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

	HepB1	HepB2	HepB3*	Yellow fever**	Number of children 12-23 months
Vaccinated at one month or another preceding the survey					
According to :					
Vaccination card	88.0	86.6	83.2	73.9	673
Information given by mother	.0	.0	.0	5.4	673
Both	88.0	86.6	83.2	79.3	673
Vaccination at 12 months	87.6	86.6	82.9	76.9	673

*MICS indicator 29
**MICS indicator 30

Table CH.2: Vaccinations by background characteristics
Percentage of children aged 12-23 months currently vaccinated against childhood diseases,
São Tomé e Príncipe, 2006

	Percentage of children who were given :											Percentage with a vaccination card	Number of children 12-23 months
	BCG	DPT1	DPT2	DPT3	Polio0	Polio1	Polio2	Polio3	Measles	All	None		
Sex													
Male	99.2	99.0	98.8	91.2	98.5	98.0	95.5	85.3	85.5	75.0	.8	88.1	337
Female	97.2	96.8	95.9	93.1	96.6	96.2	95.1	90.9	88.2	84.3	2.8	93.4	336
Region													
Agua-Grande	96.7	96.7	96.7	91.4	95.9	95.9	93.4	83.0	86.9	76.8	3.3	84.8	241
Mé-zochi	100.0	100.0	100.0	94.8	100.0	98.6	98.6	95.9	94.4	91.9	.0	97.4	177
Cantagalo	100.0	100.0	98.3	89.6	97.8	98.4	95.2	85.0	77.8	66.3	.0	90.6	65
Caué	98.7	98.7	98.7	97.1	98.7	98.7	98.0	96.0	89.1	86.4	1.3	97.0	38
Lembá	98.2	97.1	95.3	92.3	96.5	97.1	95.0	89.1	78.5	73.7	1.8	92.7	66
Lobata	95.3	95.3	93.6	86.5	95.3	95.3	92.6	80.0	77.1	66.2	4.7	86.1	52
Príncipe	100.0	96.7	95.3	91.1	100.0	96.7	93.7	91.1	93.8	86.3	.0	95.1	34
Residence													
Urban	97.6	97.3	96.4	90.6	96.6	95.9	93.3	84.8	86.8	77.2	2.4	87.4	391
Rural	99.1	98.9	98.7	94.2	98.9	98.9	98.1	92.7	86.9	83.0	.9	95.4	282
Mother's level of education													
None	98.9	98.9	97.7	81.2	98.9	96.5	95.3	77.8	72.0	61.7	1.1	93.0	43
Primary	98.2	97.9	97.2	93.0	97.5	97.0	95.5	88.6	86.7	79.9	1.8	90.6	498
Secondary +	97.9	97.9	97.9	92.6	97.1	97.9	94.5	89.7	92.5	84.7	2.1	90.8	132
Wealth index quintiles													
Very poor	99.4	98.9	97.5	93.3	99.4	97.3	94.8	91.5	85.0	79.6	.6	93.1	151
Poor	100.0	100.0	99.0	94.4	99.6	99.5	98.6	88.3	88.4	79.4	.0	92.8	157
Middle income	99.4	98.5	98.5	89.7	97.0	98.5	96.1	86.6	83.7	77.4	.6	93.5	122
Wealthy	97.4	97.4	97.4	90.2	97.4	95.6	92.7	85.7	87.1	77.9	2.6	85.6	140
Very wealthy	93.5	93.5	93.5	92.5	92.5	93.5	93.5	88.0	90.5	85.1	6.5	88.0	102
Total	98.2	97.9	97.4	92.1	97.5	97.1	95.3	88.1	86.9	79.6	1.8	90.8	673

Table CH.2c: Vaccinations by background characteristics (continued)
Percentage of children aged 12-23 months currently vaccinated against childhood diseases,
São Tomé e Príncipe, 2006

	Percentage of children who were given :				Percentage with a vaccination card	Number of children 12-23 months
	HepB1	HepB2	HepB3	Yellow fever		
Sex						
Male	84.4	82.4	79.5	75.0	88.1	337
Female	91.6	90.9	86.9	83.6	93.4	336
Region						
Agua-Grande	80.6	80.6	77.8	81.7	84.8	241
Mé-zochi	95.9	93.8	91.2	78.8	97.4	177
Cantagalo	90.0	86.8	82.8	75.0	90.6	65
Caué	96.3	94.3	93.3	89.4	97.0	38
Lembá	88.5	86.7	81.3	71.0	92.7	66
Lobata	86.1	86.1	77.0	70.2	86.1	52
Príncipe	88.1	84.1	82.4	91.8	95.1	34
Residence						
Urban	84.4	83.4	80.0	80.1	87.4	391
Rural	93.0	91.2	87.5	78.1	95.4	282
Mother's level of education						
None	80.3	75.9	70.0	57.1	93.0	43
Primary	88.1	87.6	83.7	78.1	90.6	498
Secondary +	90.1	86.6	85.4	91.2	90.8	132
Total	88.0	86.6	83.2	79.3	90.8	673

Table CH.3: Neo-natal tetanus protection
Percentage of mothers with a birth in the last 24 months protected against neo-natal tetanus,
São Tomé e Príncipe, 2006

	Percentage of mothers having birth a live birth during the last 12 months and who :						Number of mothers
	Has received at least 2 doses during pregnancy	Has received at least 2 doses during the 3 preceding years	Has received at least 3 doses during the last 5 years	Has received at least 4 doses in the 10 preceding years	Has received at least five doses since birth	Protected against tetanus toxoid*	
Region							
Agua-Grande	69.2	18.3	.4	.0	.0	87.8	454
Mé-zochi	60.8	23.4	.8	4.5	.0	89.4	297
Cantagalo	67.2	13.8	.3	.6	.0	81.9	127
Caué	60.1	18.4	.7	1.0	.0	80.2	63
Lembá	73.6	14.3	.0	.4	.0	88.4	116
Lobata	69.2	18.3	.0	.7	.0	88.3	108
Príncipe	47.3	36.7	2.9	.8	.0	87.8	66
Residence							
Urban	69.6	16.2	.7	.4	.0	86.9	740
Rural	59.9	24.9	.4	2.7	.0	87.9	491
Age							
15-19	83.2	9.1	.0	.0	.0	92.3	151
20-24	72.1	19.3	.5	.0	.0	91.9	399
25-29	61.4	22.5	.0	.4	.0	84.3	289
30-34	55.3	22.9	1.5	4.2	.0	83.8	178
35-39	58.9	18.3	1.6	5.7	.0	84.6	139
40-44	48.8	28.8	.0	.0	.0	77.6	69
45-49	69.9	6.5	.0	.0	.0	76.4	7
Mother's level of education							
None	60.4	20.5	.0	.0	.0	80.9	76
Primary	64.6	19.4	.6	1.1	.0	85.7	892
Secondary +	71.5	20.4	.7	2.4	.0	95.0	261
Informal programme	.0	.0	.0	.0	.0	.0	1
Wealth index quintiles							
Very poor	68.0	19.8	.4	.4	.0	88.7	271
Poor	61.8	21.4	.0	.6	.0	83.7	260
Middle income	67.5	15.7	.3	.6	.0	84.1	236
Wealthy	65.3	19.8	.9	2.6	.0	88.6	260
Very wealthy	66.2	21.7	1.3	2.8	.0	92.0	205
Total	65.7	19.7	.6	1.3	.0	87.3	1230

* MICS indicator 32

Table CH.4: Oral rehydration treatment
Percentage of children aged 0-59 months with diarrhoea in the last two weeks and treatment with oral rehydration solution (ORS) or other oral rehydration treatment (ORT),
São Tomé e Príncipe, 2006

	Has had diarrhoea during the last 2 weeks	Number of children 0-59 months	Children with diarrhoea who were given :				Rate of use of other orally rehydration *	Number of children 0-59 months with diarrhoea
			Packet of liquid ORT	Recommended homemade liquid	Packaged liquid	No treatment		
Sex								
Boy	13,0	1569	29.0	15.1	1.9	57.1	42.9	204
Girl	13,2	1556	33.8	19.1	1.5	48.7	51.3	206
Region								
Agua-Grande	13,5	1023	23.0	16.1	.0	62.6	37.4	138
Mé-zochi	11,4	825	33.3	20.7	.0	51.1	48.9	94
Cantagalo	11,0	353	40.1	18.3	1.5	43.3	56.7	39
Caué	14,8	176	37.7	12.1	4.1	47.5	52.5	26
Lembá	23,0	279	38.2	10.7	4.9	50.0	50.0	64
Lobata	10,3	290	24.9	22.1	1.7	53.0	47.0	30
Príncipe	10,8	180	44.0	25.0	7.7	27.7	72.3	19
Residence								
Urban	14,1	1779	30.4	14.8	1.2	56.7	43.3	251
Rural	11,8	1346	33.1	20.7	2.5	46.9	53.1	159
Age								
< 6 months	6,8	363	43.2	14.3	.0	42.4	57.6	25
6-11 months	18,9	342	41.8	20.3	3.6	41.9	58.1	65
12-23 months	24,3	673	31.7	13.1	.8	56.8	43.2	163
24-35 months	13,6	616	26.0	21.1	3.0	53.9	46.1	84
36-47 months	7,1	623	20.7	20.7	.8	59.0	41.0	44
48-59 months	5,6	509	28.4	18.6	1.2	51.7	48.3	29
Mother's level of education								
None	10,1	241	32.0	14.4	6.3	48.7	51.3	24
Primary	14,1	2261	28.4	18.3	1.7	55.4	44.6	318
Secondary +	10,7	618	45.9	12.4	.0	42.1	57.9	66
Informal programme	11,2	5	.0	.0	.0	100.0	.0	1
Wealth index quintiles								
Very poor	15,6	678	28.3	17.3	2.9	53.0	47.0	106
Poor	14,3	675	26.8	17.4	2.2	57.3	42.7	97
Middle income	15,8	631	35.9	16.9	1.6	50.3	49.7	100
Wealthy	11,5	641	26.0	14.7	.0	59.3	40.7	74
Very wealthy	6,7	500	53.2	21.6	.0	33.3	66.7	34
Total	13,1	3125	31.4	17.1	1.7	52.9	47.1	410

* MICS indicator 33

Table CH.5: 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, São Tomé e Príncipe, 2006

	Has had diarrhoea during the last 2 weeks	Number of children 0-59 months	Children with diarrhoea who:				Home management of diarrhoea*	Has been given ORT or has increased fluid intake AND eaten**	Number of children 0-59 months with diarrhoea
			Has drunk more	Has drunk the same or less	Has eaten less, the same or more	Has eaten much less or nothing			
Sex									
Boy	13.0	1569	61.5	38.1	79.5	20.0	48.4	61.6	204
Girl	13.2	1556	61.3	37.7	81.9	17.9	50.0	64.1	206
Region									
Agua-Grande	13.5	1023	58.6	41.4	90.5	9.5	53.8	69.7	138
Mé-zochi	11.4	825	69.3	30.7	85.2	14.8	56.3	72.0	94
Cantagalo	11.0	353	56.0	44.0	54.1	43.3	34.4	41.9	39
Caué	14.8	176	52.8	45.5	77.8	20.5	40.4	50.2	26
Lembá	23.0	279	69.7	27.1	76.1	23.9	49.5	59.6	64
Lobata	10.3	290	47.6	50.7	77.7	22.3	35.8	48.4	30
Príncipe	10.8	180	59.6	40.4	66.6	33.4	43.0	61.8	19
Residence									
Urban	14.1	1779	57.6	41.2	83.9	15.5	48.2	63.7	251
Rural	11.8	1346	67.4	32.6	75.6	24.4	50.7	61.6	159
Age									
0-11 months	12.7	705	42.1	57.9	78.4	21.6	29.2	53.3	90
12-23 months	24.3	673	68.8	30.9	79.2	19.9	56.2	62.3	163
24-35 months	13.6	616	65.0	33.2	85.0	15.0	53.6	74.5	84
36-47 months	7.1	623	65.7	32.0	80.3	19.7	52.6	58.8	44
48-59 months	5.6	509	62.4	37.6	84.5	15.5	53.6	68.0	29
Mother's level of education									
None	10.1	241	49.1	50.9	74.4	25.6	40.4	58.7	24
Primary	14.1	2261	64.8	34.5	80.8	18.7	52.8	63.7	318
Secondary	10.7	618	49.4	49.8	82.3	17.7	34.8	60.2	66
Higher	11.2	5	100.0	.0	100.0	.0	100.0	100.0	1
Wealth index quintiles									
Poorest	15.6		62.8	36.7	79.6	19.4	49.2	66.3	106
Second	14.3		63.3	35.2	79.5	20.5	49.9	61.3	97
Middle	15.8		64.6	35.0	77.1	22.9	51.8	60.6	100
Fourth	11.5		60.2	39.8	83.9	15.5	46.6	62.7	74
Richest	6.7		44.8	53.7	91.4	8.6	44.8	63.5	34
Total	13.1	3125	61.4	37.9	80.7	18.9	49.2	62.9	410

* MICS indicator 34
** MICS indicator 35

Table CH.6: Care seeking for suspected pneumonia. Percentage of children aged 0-59 months with suspected pneumonia in the last two weeks taken to a health provider, São Tomé e Príncipe, 2006

| | Has had a serious respiratory infection | Children with suspected pneumonia who were treated by : | | | | | | | | | | | | | | | Number of children 0-59 months with suspected pneumonia |
| | | Public facilities | | | | | | Private facilities | | | | | Other | | | Other* | |
		Hospital	Health centre	Health post	Village health worker	Mobile clinic	Other public facilities	Private hospital / clinic	Private doctor	Pharmacy	Mobile clinic	Other private facilities	Parents or friends	Shop	Traditional practioner		
Sex																	
Boy	4.2	19.7	18.5	13.1	1.6	0.0	0.8	5.2	1.1	0.0	0.0	9.7	8.7	0.0	2.5	68.6	66
Girl	4.4	0.7	27.9	20.0	0.0	0.0	0.0	7.7	7.1	0.0	0.0	10.4	0.0	0.0	3.9	73.8	69
Region																	
Agua-Grande	4.7	16.6	19.8	9.4	0.0	0.0	0.0	11.1	0.0	0.0	0.0	10.2	4.9	0.0	3.5	67.1	48
Mé-zochi	5.5	5.3	22.8	14.9	0.0	0.0	0.0	6.0	10.8	0.0	0.0	17.4	5.6	0.0	6.0	77.3	45
Cantagalo	2.9	10.5	8.9	70.7	6.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	90.1	10
Caué	3.8	12.5	34.8	16.1	5.3	0.0	0.0	0.0	0.0	0.0	0.0	4.6	0.0	0.0	0.0	73.2	7
Lembá	5.3	0.0	57.1	16.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.5	15
Lobata	2.6	9.4	0.0	6.8	0.0	0.0	0.0	10.0	0.0	0.0	0.0	7.1	11.7	0.0	0.0	43.2	7
Príncipe	1.5	17.0	0.0	0.0	0.0	0.0	19.4	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	36.5	3
Residence																	
Urban	4.1	12.4	25.8	15.2	1.0	0.0	0.0	7.3	0.0	0.0	0.0	7.5	6.7	0.0	2.3	68.3	73
Rural	4.6	7.1	20.4	18.2	0.6	0.0	0.8	5.5	9.0	0.0	0.0	13.1	1.4	0.0	4.3	74.8	62
Age																	
0-11 months	2.8	16.7	30.2	10.1	0.0	0.0	0.0	0.0	3.8	0.0	0.0	19.4	0.0	0.0	0.0	80.1	20
12-23 months	3.4	17.9	26.3	10.2	3.0	0.0	0.0	23.1	0.0	0.0	0.0	2.3	0.0	0.0	7.2	79.9	23
24-35 months	6.4	12.9	21.8	21.7	0.9	0.0	0.0	6.9	7.9	0.0	0.0	0.0	12.4	0.0	0.0	72.2	39
36-47 months	4.6	1.6	28.6	9.9	0.0	0.0	1.8	2.6	6.2	0.0	0.0	7.3	3.0	0.0	0.0	57.9	29
48-59 months	4.8	2.0	10.9	27.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.6	0.0	0.0	11.2	70.3	24
Mother's level of education																	
None	3.3	0.0	21.9	31.4	4.4	0.0	0.0	0.0	0.0	0.0	0.0	27.5	0.0	0.0	0.0	85.2	8
Primary	4.6	10.8	22.1	16.9	0.7	0.0	0.5	5.1	3.9	0.0	0.0	8.5	5.5	0.0	4.2	67.9	104
Secondary +	3.7	9.7	29.3	10.2	0.0	0.0	0.0	14.9	6.7	0.0	0.0	10.9	0.0	0.0	0.0	81.7	23
Informal programme	0.0	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	0
Wealth index quintiles																	
Very poor	4.7	10.9	22.7	15.5	1.1	0.0	0.0	2.3	0.0	0.0	0.0	15.3	2.7	0.0	0.0	67.8	32
Poor	2.8	2.5	35.9	31.8	0.0	0.0	2.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.0	19
Middle income	5.6	14.0	7.8	15.2	2.0	0.0	0.0	7.6	2.1	0.0	0.0	17.5	7.1	0.0	0.0	64.2	35
Wealthy	4.4	7.9	21.6	19.8	0.0	0.0	0.0	18.8	11.8	0.0	0.0	0.0	0.0	0.0	9.6	79.9	28
Very wealthy	4.1	11.1	41.9	2.6	0.0	0.0	0.0	0.0	7.5	0.0	0.0	12.3	11.3	0.0	8.1	75.5	21
Total	4.3	10.0	23.3	16.6	0.8	0.0	0.4	6.5	4.2	0.0	0.0	10.1	4.3	0.0	3.2	71.3	135

Table CH.7: Antibiotic treatment of pneumonia
Percentage of children aged 0-59 months with suspected pneumonia who received antibiotic treatment,
São Tomé e Príncipe, 2006

	Percentage of children aged 0-59 months with suspected pneumonia and received antibiotic treatment during the last 2 weeks *	Number of children aged 0-59 months who was suspected of pneumonia during the 2 weeks preceding the survey
Sex		
Boy	57.3	66
Girl	54.7	69
Region		
Agua-Grande	55.6	48
Mé-zochi	67.7	45
Cantagalo	52.8	10
Caué	61.9	7
Lembá	46.0	15
Lobata	16.2	7
Príncipe	27.9	3
Residence		
Urban	50.1	73
Rural	62.7	62
Age		
0-11 months	54.1	20
12-23 months	54.6	23
24-35 months	57.8	39
36-47 months	51.2	29
48-59 months	61.6	24
Mother's level of education		
None	72.4	9
Primary	53.7	103
Secondary +	60.2	23
Informal programme	72.4	9
Wealth index quintiles		
Very poor	68.4	32
Poor	53.4	19
Middle income	50.8	36
Wealthy	40.9	28
Very wealthy	68.6	21
Total	56.0	135

* MICS indicator 22

Table CH.7A: Knowledge of the two danger signs of pneumonia

Percentage of mothers/caretakers of children aged 0-59 months by knowledge of types of symptoms for taking a child immediately to a health facility, and percentage of mothers/caretakers who recognize fast and difficult breathing as signs for seeking care immediately, São Tomé e Príncipe, 2006

	Percentage mothers(caretakers of children under 5 who believe that a child should be immediately taken to a health facility if s/he :								Mothers/caretakers who know how to recognise the two danger signals of pneumonia*	Number of mothers/caretakers looking after children under 5
	Cannot either eat or drink	Becomes increasingly ill	Fever	Rapid breathing	Difficult breathing	Blood in faeces	Drinks with difficulty	Other symptoms		
Region										
Agua-Grande	17.8	38.6	78.0	35.6	35.9	31.4	17.9	71.6	27.9	1023
Mé-zochi	30.1	54.3	83.4	48.6	56.3	48.5	25.5	65.5	45.0	825
Cantagalo	25.5	65.8	79.7	53.4	60.8	46.4	25.1	68.9	45.8	353
Caué	25.8	66.4	81.0	48.7	56.8	54.0	23.5	61.6	39.9	176
Lembá	18.7	57.5	87.4	31.6	42.2	32.8	16.6	77.7	23.0	279
Lobata	23.0	57.5	85.7	55.2	52.1	48.6	27.4	58.9	42.9	290
Príncipe	36.4	60.2	83.1	56.1	62.1	48.4	34.8	28.9	48.4	180
Residence										
Urban	20.3	48.0	80.0	37.8	41.2	34.9	20.0	68.9	29.5	1779
Rural	28.8	57.4	83.7	53.2	59.0	50.5	26.4	62.2	47.6	1346
Mother's level of education										
None	21.1	55.9	81.2	41.7	48.2	41.9	20.5	62.6	33.5	241
Primary	23.4	52.1	81.1	44.8	49.2	42.1	21.6	66.8	37.3	2261
Secondary +	27.4	50.4	83.5	44.3	48.1	39.3	28.1	64.4	38.8	618
Informal programme	.0	73.0	88.8	44.7	33.5	60.6	.0	73.0	22.3	5
Wealth index quintiles										
Very poor	25.4	53.6	82.2	46.6	50.3	45.7	24.2	63.0	40.4	678
Poor	24.0	55.4	77.9	44.5	52.7	38.1	21.2	64.6	38.6	675
Middle income	23.3	52.3	85.2	42.5	50.5	46.4	20.0	67.2	35.2	631
Wealthy	24.7	52.8	84.2	48.9	47.9	41.3	23.1	69.2	38.7	641
Very wealthy	21.9	44.3	78.2	38.2	41.0	35.1	25.9	66.5	31.9	500
Total	24.0	52.1	81.6	44.4	48.9	41.6	22.8	66.0	37.3	3125

Table CH.8: Solid fuel use

Percentage distribution of households according to type of cooking fuel, and percentage of households using solid fuel for cooking, São Tomé e Príncipe, 2006

	Percentage of households using :								Solid cooking fuels*	Number of households
	Electricity	Kerosene	Gas	Charcoal	Wood	Carroço	Other	Total		
Region										
Agua-Grande	.1	2.0	45.1	12.4	39.8	.0	.6	100.0	52.2	1999
Mé-zochi	.0	.1	18.4	3.3	77.7	.1	.5	100.0	81.1	1565
Cantagalo	.0	.0	5.0	4.5	89.6	.0	.9	100.0	94.0	573
Caué	.1	.0	6.5	4.1	89.0	.2	.0	100.0	93.3	283
Lembá	.0	.0	3.9	12.9	81.8	.2	1.2	100.0	94.9	408
Lobata	.2	.1	7.6	9.5	82.0	.0	.6	100.0	91.5	495
Príncipe	.1	.0	2.7	21.3	75.6	.0	.3	100.0	96.9	302
Residence										
Urban	.1	1.3	32.1	11.7	54.1	.0	.8	100.0	65.8	3189
Rural	.0	.1	11.3	5.2	82.9	.1	.4	100.0	88.2	2436
Head of houseold's level of education										
None	.0	.0	6.1	7.4	85.4	.2	.8	100.0	93.0	890
Primary	.0	.1	18.4	9.0	71.9	.0	.5	100.0	80.9	3347
Secondary +	.1	3.0	47.2	9.6	39.5	.0	.7	100.0	49.1	1306
Informal programme	.0	.0	1.3	9.6	89.1	.0	.0	100.0	98.7	18
DK	3.7	.0	14.9	7.8	73.6	.0	.0	100.0	81.4	64
Wealth index quintiles										
Very poor	.0	.0	.0	.0	99.6	.2	.2	100.0	99.8	1265
Poor	.0	.0	4.5	6.9	87.6	.0	1.0	100.0	94.5	1177
Middle income	.0	.0	20.0	12.5	66.7	.0	.6	100.0	79.3	1145
Wealthy	.0	.0	36.7	14.8	48.1	.0	.4	100.0	62.9	1038
Very wealthy	.3	4.3	63.4	12.1	19.1	.0	.8	100.0	31.2	1000
Total	.1	.8	23.1	8.9	66.6	.1	.6	100.0	75.5	5625

Table CH.9: Solid fuel use by type of stove or fire
Percentage of households using solid fuel for cooking by type of stove or fire,
São Tomé e Príncipe, 2006

	Percentage of household utilising solid fuels for cooking :					Number of household utilising solid fuels for cooking
	Stove with chimney	Open stove or fire with chimney or hood	Open stove or fire without chimney or hood	Other type of stove	Total	
Region						
Agua-Grande	40.5	.2	59.3	.0	100.0	1043
Mé-zochi	48.9	.0	50.8	.3	100.0	1269
Cantagalo	52.1	.2	47.5	.2	100.0	539
Caué	70.6	.4	28.7	.3	100.0	264
Lembá	57.5	.1	41.9	.5	100.0	388
Lobata	51.2	.3	48.2	.3	100.0	453
Príncipe	55.6	.4	43.8	.2	100.0	293
Residence						
Urban	45.5	.3	54.0	.2	100.0	2098
Rural	54.5	.1	45.2	.3	100.0	2150
Head of househol's level of education						
None	48.9	.3	50.2	.6	100.0	828
Primary	49.4	.2	50.3	.2	100.0	2709
Secondary +	53.9	.0	45.9	.1	100.0	641
Informal programme	54.5	.0	45.5	.0	100.0	17
DK	55.8	.0	44.2	.0	100.0	52
Wealth index quintiles						
Very poor	36.5	.3	62.6	.5	100.0	1262
Poor	45.6	.2	54.1	.2	100.0	1112
Middle income	55.4	.0	44.4	.2	100.0	908
Wealthy	64.5	.1	35.4	.1	100.0	653
Very wealthy	75.1	.1	24.8	.0	100.0	312
Total	50.1	.2	49.5	.2	100.0	4248

Table CH.10: Availability of insecticide treated nets
Percentage of households with at least one insecticide treated net (ITN),
São Tomé e Príncipe, 2006

	Percentage of households with at least one mosquito net	Percentage of households with at least one ITN*	Number of households
Region			
Agua-Grande	65.5	50.2	1999
Mé-zochi	31.2	21.3	1565
Cantagalo	41.5	28.0	573
Caué	51.1	38.0	283
Lembá	45.8	32.5	408
Lobata	49.0	37.1	495
Príncipe	53.1	34.8	302
Residence			
Urban	58.4	44.1	3189
Rural	37.3	25.4	2436
Head of household's level of education			
None	34.1	20.8	890
Primary	48.1	35.5	3347
Secondary +	62.8	48.4	1306
Informal programme	35.7	28.8	18
DK	45.8	27.6	64
Wealth index quintiles			
Very poor	31.5	21.9	1265
Poor	39.4	26.8	1177
Middle income	49.8	36.2	1145
Wealthy	61.5	46.6	1038
Very wealthy	69.8	53.4	1000
Total	49.2	36.0	5625

* MICS indicator 36

Table CH.11: Children sleeping under bed nets
Percentage of children aged 0-59 months who slept under an insecticide treated
net during the previous night,
São Tomé e Príncipe, 2006

	Percentage of children who :						
	Slept under a bed net*	Slept under an ITN**	Slept under an untreated bed net	Has slept under a bed net but does not know if it is treated	Does not know if sleep was under a bed net	Have not slept under a bed net	Number of children 0-59 months
Sex							
Male	52.5	41.7	9.4	1.4	.3	47.2	1569
Female	53.1	41.6	10.2	1.3	.2	46.7	1556
Region							
Agua-Grande	73.2	62.2	10.3	.7	.3	26.4	1023
Mé-zochi	37.1	25.4	10.4	1.4	.2	62.7	825
Cantagalo	42.7	30.1	10.1	2.5	.0	57.3	353
Caué	48.3	41.4	6.5	.4	.4	51.2	176
Lembá	45.7	34.4	10.2	1.1	.2	54.1	279
Lobata	54.4	42.1	11.0	1.2	.4	45.2	290
Príncipe	41.1	32.7	3.7	4.7	.5	58.4	180
Residence							
Urban	61.8	51.1	9.6	1.1	.2	38.0	1779
Rural	41.0	29.2	10.0	1.7	.3	58.7	1346
Age							
0-11 months	70.9	57.5	12.2	1.2	.0	29.1	705
12-23 months	53.1	40.8	11.0	1.4	.0	46.9	673
24-35 months	46.2	35.7	8.6	1.9	.3	53.5	616
36-47 months	40.5	31.4	8.5	.6	.2	59.3	623
48-59 months	50.2	40.6	7.8	1.8	1.0	48.8	509
Wealth index quintiles							
Very poor	38.7	29.4	8.0	1.4	.1	61.2	678
Poor	41.8	32.7	7.6	1.5	.3	57.9	675
Middle income	49.6	36.0	12.3	1.4	.5	49.9	631
Wealthy	65.4	53.0	11.5	.9	.1	34.5	641
Very wealthy	74.6	63.0	9.7	1.9	.3	25.1	500
Total	52.8	41.7	9.8	1.4	.3	46.9	3125

* MICS indicator 38
** MICS indicator 37; MDG indicator 22

Table CH.12: Treatment of children with anti-malarial drugs. Percentage of children aged 0-59 months who were ill with fever in the last two weeks who received anti-malarial drugs, São Tomé e Príncipe, 2006

Percentage children under 5 ill with fever during the last 2 weeks and who were given anti-malarials

	Has had fever during the last 2 weeks	Number of under-5s	Anti-malarials: SP/Fansidar	Chloroquine	Armodiaquine	Quinine	Artemisia combinations	Other anti-malarials	Any appropriate anti-malarial	Paracet-amol/ Panadol/ Acetamin-ophen	Other medications: Aspirin	Ibuprofen	Other	Does not know	Based on symptoms, any appropriate anti-malarials during the last 24 hours *	Number of children with fever during the last 2 weeks
Sex																
Boy	18.7	1569	1.1	.9	11.7	2.4	4.0	.8	18.9	76.4	4.7	1.6	10.5	.0	10.8	293
Girl	17.1	1556	1.3	2.8	12.9	3.2	9.1	2.1	31.0	74.1	4.3	1.9	8.8	1.1	23.8	267
Region																
Agua-Grande	19.1	1023	.0	1.4	10.1	1.1	4.2	2.4	18.3	79.8	4.5	.0	9.4	.0	14.5	195
Mé-zochi	16.4	825	2.4	.0	17.4	1.5	9.3	1.3	30.1	65.3	1.1	3.1	13.5	.0	19.5	136
Cantagalo	14.8	353	3.3	.0	5.7	9.6	5.1	1.1	24.8	81.3	2.2	1.1	7.9	.0	13.8	52
Caué	20.3	176	.9	3.9	15.2	3.2	13.9	.0	36.5	69.5	13.7	.0	4.2	.8	27.5	36
Lembá	24.9	279	2.0	5.6	13.1	5.0	5.5	.0	27.8	80.2	5.7	.8	10.7	1.4	22.1	70
Lobata	16.9	290	.0	1.8	14.4	1.8	6.6	.0	24.6	81.9	9.3	6.9	6.2	1.5	10.5	49
Príncipe	12.5	180	.0	4.5	4.1	3.9	2.1	4.2	18.8	61.6	2.1	4.5	6.0	3.9	12.8	23
Residence																
Urban	18.4	1779	.6	2.3	10.0	2.5	6.6	1.6	22.3	79.3	5.5	.4	9.7	.5	17.4	327
Rural	17.3	1346	2.0	1.0	15.5	3.1	6.2	1.2	28.0	69.7	3.1	3.5	9.7	.5	16.4	233
Age																
0-11 months	18.0	705	1.3	.0	2.8	2.1	5.0	.0	10.8	82.9	4.9	4.5	11.7	.0	5.8	127
12-23 months	23.4	673	.6	3.3	13.9	1.4	5.4	.4	24.6	72.8	5.9	1.7	9.5	.5	18.6	157
24-35 months	17.0	616	2.5	2.5	18.2	3.5	7.8	.9	34.8	73.5	1.2	.0	9.8	1.3	26.3	105
36-47 months	13.7	623	.4	.0	13.3	2.3	6.1	5.6	22.5	69.2	2.7	.0	7.9	.0	10.0	85
48-59 months	16.9	509	1.3	2.6	15.0	5.8	9.0	2.0	35.1	76.7	7.0	1.5	8.5	.9	26.4	86
Mother's level of education																
None	13.7	241	4.1	6.3	14.3	4.5	8.5	.0	37.7	82.7	4.1	.0	10.0	.8	27.6	33
Primary	18.3	2261	.9	1.9	13.3	2.7	6.5	1.9	25.5	72.5	4.5	2.2	7.9	.6	17.4	413
Secondary +	18.4	618	1.4	.0	8.0	2.7	5.6	.0	17.7	83.1	4.7	.5	16.1	.0	12.7	114
Informal programme	.0	5	.	.	.	.	.	.	.	.	.	.	.	.	.	0
Wealth index quintiles																
Very poor	19.7	678	2.9	1.8	16.6	2.2	4.8	2.9	30.5	69.0	6.3	1.8	7.3	.9	17.5	134
Poor	19.0	675	.7	1.3	11.8	4.2	1.1	.5	19.6	83.8	2.9	.7	8.7	.0	13.6	128
Middle income	18.1	631	.3	2.9	14.5	5.0	12.5	1.5	33.5	65.9	3.9	.0	4.5	.7	26.9	114
Wealthy	17.7	641	1.4	2.3	6.4	.9	8.6	.0	19.3	79.8	6.7	2.6	14.4	.8	13.0	113
Very wealthy	14.1	500	.0	.0	10.5	.8	6.0	2.7	17.3	79.8	1.3	4.9	16.7	.0	12.7	70
Total		3125														560

Table CH.13: Intermittent preventive treatment for malaria
Percentage of women aged 15-49 who gave birth during the two years preceding the survey and who received intermittent preventive therapy (IPT) for malaria during pregnancy,
São Tomé e Príncipe, 2006

	Percentage of pregnant women who took :							Number of women aged 15-49 who have given birth during the 2 years preceding the survey
	One anti-malarial during their pregnancy	SP/Fansidar once only	SP/Fansidar twice or more *	SP/Fansidar, unknown times*	Chloroquine	Other medication	Does not know	
Region								
Agua-Grande	94.2	.0	.0	.0	7.6	1.1	1.4	454
Mé-zochi	89.8	.0	.0	.0	11.1	2.1	.5	297
Cantagalo	79.8	.0	.0	.0	11.3	1.4	3.2	127
Caué	87.1	.0	.0	.0	12.9	1.0	2.2	63
Lembá	86.2	.0	.0	.0	9.6	2.4	1.4	116
Lobata	91.2	.0	.0	.0	9.1	1.1	.4	108
Príncipe	93.4	.0	.0	.0	14.7	1.1	.0	66
Residence								
Urban	90.4	.0	.0	.0	9.1	1.1	1.5	740
Rural	90.0	.0	.0	.0	10.8	2.1	.9	491
Mother's level of education								
None	83.6	.0	.0	.0	13.0	.0	2.0	76
Primary	90.6	.0	.0	.0	10.0	1.7	1.4	892
Secondary +	91.2	.0	.0	.0	8.2	1.2	.7	261
Informal programme	.0	.0	.0	.0	.0	.0	.0	1
Wealth index quintiles								
Very poor	89.4	.0	.0	.0	10.0	.9	4.4	271
Poor	86.9	.0	.0	.0	11.4	2.3	1.0	260
Middle income	89.2	.0	.0	.0	13.0	.6	.4	236
Wealthy	92.1	.0	.0	.0	6.5	3.4	.0	260
Very wealthy	94.5	.0	.0	.0	8.1	.0	.0	205
	90.2	.0	.0	.0	9.8	1.5	1.3	1230
Total	89.4	.0	.0	.0	10.0	.9	4.4	271

* MICS indicator 40

Table CH.14: Source and cost of supplies of ITNs

Percentage distribution of households, percentage of households in which ITNs were obtained for free, and median cost of ITNs for those paying for ITNs,
São Tomé e Príncipe, 2006

	Source of ITN				Number of households with at least 1 ITN	Percentage free		Average cost for those not receiving a free ITN	
	Public*	Private	Other	Total		Public*	Private	Public**	Private**
Region									
Agua-Grande	41.2	1.7	57.1	100.0	1004	45.1	29.2	27000.0	27000.0
Mé-zochi	58.6	4.1	37.3	100.0	333	46.9	43.5	27000.0	27000.0
Cantagalo	91.2	.3	8.6	100.0	160	44.8	.0	25000.0	25000.0
Caué	87.7	3.1	9.2	100.0	107	20.2	90.1	25000.0	25000.0
Lembá	87.6	.5	11.9	100.0	133	44.0	100.0	27000.0	
Lobata	73.4	.7	25.9	100.0	184	27.4	.0	25000.0	50000.0
Príncipe	63.7	8.0	28.3	100.0	105	58.6	.0	25098.2	27000.0
Residence									
Urban	53.5	1.5	45.0	100.0	1407	42.3	25.1	26917.1	27000.0
Rural	66.9	3.8	29.3	100.0	619	41.4	39.2	27000.0	27000.0
Mother's level of education									
None	62.2	3.4	34.4	100.0	185	38.3	.0	25000.0	25887.0
Primary	61.2	2.4	36.4	100.0	1187	43.8	44.5	25000.0	27000.0
Secondary +	50.0	1.5	48.5	100.0	632	38.7	17.8	27000.0	27207.3
Informal programme	37.9	.0	62.1	100.0	5	25.6	.	143605.6	.
Wealth index quintiles									
Very poor	78.4	2.1	19.5	100.0	277	51.5	11.0	25000.0	25449.4
Poor	76.6	2.1	21.3	100.0	316	47.8	29.0	25000.0	28000.0
Middle income	60.0	2.9	37.2	100.0	414	41.0	24.9	27000.0	25000.0
Wealthy	52.7	3.2	44.1	100.0	484	42.3	57.2	27000.0	27000.0
Very wealthy	38.2	1.0	60.8	100.0	534	25.7	4.9	27000.0	32898.6
Total	57.6	2.2	40.2	100.0	2026	42.0	32.5	27000.0	27000.0

* MICS indicator 96

Table CH.15: Source and cost of supplies for antimalarials

Percentage distribution of children with fever aged 0-59 months who took antimalarials in the two weeks preceding the survey by source of antimalarials, percentage of children for whom antimalarials were obtained for free, and median cost of antimalarials for those paying for antimalarials, São Tomé e Príncipe, 2006

	Source of anti-malarials				Number of children with a fever during the last two weeks treated with anti-malarials	Percentage having received Free anti-malarials		Average cost for those who have not received free anti-malarials	
	Public*	Private	Other	Total		Public*	Private	Public**	Private**
Sex									
Male	33.0	4.8	62.1	100.0	168	35.1	.0	5000.0	24127.6
Female	44.8	5.8	49.3	100.0	159	18.6	.0	5000.0	15000.0
Region									
Agua-Grande	25.9	6.8	67.3	100.0	115	23.0	.0	5000.0	32370.0
Mé-zochi	51.0	10.3	38.7	100.0	84	19.8	.0	3000.0	1713.0
Cantagalo	33.7	2.8	63.5	100.0	35	35.2	.0	6677.0	3000.0
Caué	61.3	.0	38.7	100.0	20	33.4	.	1923.8	.
Lembá	46.8	.0	53.2	100.0	33	25.6	.	5094.2	.
Lobata	34.4	.0	65.6	100.0	29	28.9	.	7322.7	.
Príncipe	41.3	.0	58.7	100.0	11	50.2	.	1889.1	.
Residence									
Urban	34.5	4.1	61.4	100.0	189	25.8	.0	5000.0	32370.0
Rural	44.6	7.0	48.4	100.0	138	25.9	.0	2931.8	2102.0
Mother's level of education									
None	44.2	13.3	42.5	100.0	22	42.0	.0	3750.5	14271.7
Primary	41.5	5.0	53.5	100.0	228	28.4	.0	5000.0	28000.0
Secondary +	29.2	3.9	66.9	100.0	77	8.3	.0	5000.0	24303.1
Wealth index quintiles									
Very poor	51.4	6.7	42.0	100.0	71	27.5	.0	5000.0	1000.0
Poor	46.0	1.3	52.6	100.0	75	31.6	.0	5996.6	3000.0
Middle income	53.5	.0	46.5	100.0	65	23.0	.	5000.0	.
Wealthy	22.9	12.3	64.8	100.0	67	24.7	.0	5871.8	60000.0
Very wealthy	11.4	6.9	81.7	100.0	49	.0	.0	2000.0	30104.0
Total	38.8	5.3	55.9	100.0	327	25.8	.0	5000.0	15063.9

* MICS indicator 96
** MICS indicator 97

Table CH.16: Source and cost of supplies for antibiotics

Percentage distribution of children aged 0-59 months with suspected pneumonia during the two weeks preceding the survey by source of antibiotics for treatment of pneumonia, percentage of children aged 0-59 months with suspected pneumonia during the two weeks preceding the survey for whom antibiotics were obtained for free, and median cost of antibiotics for those paying for the antibiotics, by type of source of antibiotics,
São Tomé e Príncipe, 2006

	Source of antibiotics				Number of children with a respiratory illness during the last 2 weeks who were given antibiotics	Percentage having received free anti-malarials		Average cost for those who have not received free anti-malarials	
	Public*	Private	Other	Total		Public*	Private	Public**	Private**
Sex									
Male	58.3	34.6	7.1	100.0	38	8.7	.0	5000.0	5000.0
Female	70.8	28.0	1.2	100.0	38	.0	.0	2092.1	3000.0
Region									
Agua-Grande	62.5	31.3	6.2	100.0	27	.0	.0	.	.
Mé-zochi	51.3	48.7	.0	100.0	31	9.3	.0	3500.0	3000.0
Cantagalo	100.0	.0	.0	100.0	5	.0	.	5000.0	.
Caué	92.6	7.4	.0	100.0	4	12.2	.0	5000.0	3000.0
Lembá	79.1	.0	20.9	100.0	7	.0	.	5000.0	.
Lobata	100.0	.0	.0	100.0	1	.0	.	5000.0	.
Príncipe	61.1	38.9	.0	100.0	1	.0	.0	3000.0	5000.0
Residence									
Urban	70.0	22.6	7.4	100.0	37	.0	.0	5000.0	5000.0
Rural	59.3	39.6	1.2	100.0	39	8.3	.0	5000.0	3000.0
Mother's level of education									
None	63.6	36.4	.0	100.0	6	.0	.0	5000.0	.
Primary	63.3	31.0	5.7	100.0	56	5.5	.0	4534.9	3000.0
Secondary +	69.5	30.5	.0	100.0	14	.0	.0	.	.
Wealth index quintiles									
Very poor	92.4	3.0	4.6	100.0	10	.0	.0	.	5000.0
Poor	33.4	60.8	5.8	100.0	19	7.7	.0	5000.0	3000.0
Middle income	73.9	26.1	.0	100.0	12	17.0	.0	.	.
Wealthy	73.3	14.9	11.7	100.0	14	.0	.0	.	.
Very wealthy	64.5	31.3	4.2	100.0	76	3.9	.0	5000.0	3000.0
Total	92.4	3.0	4.6	100.0	10	.0	.0	.	5000.0

* MICS indicator 96
** MICS indicator 97

Table CH.17: Source and cost of supplies for oral rehydration salts

Percentage distribution of children aged 0-59 months with diarrhoea during the two weeks preceding the survey by source of oral rehydration salts for treatment of diarrhoea, percentage of children aged 0-59 months with diarrhoea during the two weeks preceding the survey for whom oral rehydration salts were obtained for free, and median cost of oral rehydration salts for those paying for the oral rehydration salts, by type of source of oral rehydration salts,
São Tomé e Príncipe, 2006

	Source ORSs				Number of children with diarrhoea during the last 2 weeks who were given ORSs	Percentage having received free ORSs		Average cost for those who have not received free ORSs	
	Public*	Private	Other	Total		Public*	Private	Public**	Private**
Sex									
Male	94.0	2.4	3.5	100.0	59	2.6	.0	4750.1	5000.0
Female	97.5	1.0	1.5	100.0	70	.0	.0	3000.0	.
Region									
Agua-Grande	100.0	.0	.0	100.0	32	.0	.	5000.0	.
Mé-zochi	90.3	3.0	6.7	100.0	31	5.2	.0	3000.0	5000.0
Cantagalo	93.5	.0	6.5	100.0	16	.0	.	1609.8	.
Caué	100.0	.0	.0	100.0	10	.0	.	1500.0	.
Lembá	97.9	2.1	.0	100.0	25	.0	.0	3444.8	.
Lobata	100.0	.0	.0	100.0	7	.0	.	2000.0	.
Príncipe	91.7	8.3	.0	100.0	9	.0	.0	.	.
Residence									
Urban	94.7	1.2	4.1	100.0	76	.0	.0	5000.0	.
Rural	97.7	2.3	.0	100.0	53	2.8	.0	2716.1	5000.0
Mother's level of education									
None	100.0	.0	.0	100.0	8	.0	.	4987.9	.
Primary	96.1	1.6	2.3	100.0	90	1.7	.0	3000.0	5000.0
Secondary +	94.4	2.3	3.3	100.0	31	.0	.0	4956.7	.
Wealth index quintiles									
Very poor	96.9	3.1	.0	100.0	30	.0	.0	3000.0	5000.0
Poor	90.0	2.0	8.1	100.0	26	.0	.0	4451.7	.
Middle income	100.0	.0	.0	100.0	36	.0	.	2452.1	.
Wealthy	96.3	3.7	.0	100.0	19	7.9	.0	2228.9	.
Very wealthy	94.3	.0	5.7	100.0	18	.0	.	5000.0	.
Total	95.9	1.7	2.4	100.0	129	1.2	.0	3000.0	5000.0

* MICS indicator 96
** MICS indicator 97

Table EN.1: Use of improved water sources

Percentage distribution of household population according to main source of drinking water and percentage of household members using improved drinking water sources, São Tomé e Príncipe, 2006

	Principal drinking water supply sources														
	Source supplied from :								Source not supplied from :					Improved drinking water source *	Humber of household members
	Water tap in the house	Tap water in the compound	Public fountain	Protected well	Protected source	Bottled water	Non protected well	Non-protected source	River	Rain-water	Bottled water	Other	Total		
Region															
Agua-Grande	5.0	37.0	46.1	1.0	1.2	.1	.0	3.8	.3	.0	.2	5.3	100.0	90.4	7890
Mé-zochi	3.3	17.0	46.1	1.9	17.7	.1	5.8	.0	6.1	.0	.0	2.1	100.0	86.1	6385
Cantagalo	.7	7.0	63.5	1.5	9.3	.0	3.2	.0	13.4	.1	.0	1.4	100.0	82.0	2302
Caué	5.0	14.0	47.1	2.3	3.3	.0	6.8	.0	21.0	.0	.1	.3	100.0	71.8	1210
Lembá	1.4	10.7	76.9	.3	.1	.0	.5	.0	9.7	.0	.0	.3	100.0	89.4	1767
Lobata	1.2	19.5	73.6	.5	1.8	.0	.1	.0	2.5	.0	.1	.8	100.0	96.5	2093
Príncipe	5.7	7.5	38.1	.3	4.3	.0	23.3	.0	20.0	.0	.0	.8	100.0	55.8	1081
Residence															
Urban	3.7	28.0	50.8	1.1	4.7	.1	1.2	2.3	4.1	.0	.1	3.9	100.0	88.4	13065
Rural	3.2	14.0	54.7	1.4	9.9	.0	6.5	.0	9.1	.0	.0	1.1	100.0	83.2	9663
Head of household's level of education															
None	.6	12.9	62.1	2.4	7.3	.0	2.6	.7	8.3	.0	.0	3.0	100.0	85.4	3393
Primary	2.4	18.9	54.3	.9	7.8	.0	4.2	1.5	7.2	.0	.1	2.6	100.0	84.4	13760
Secondary +	8.1	36.4	42.1	1.4	3.9	.3	2.1	1.4	2.2	.0	.1	2.1	100.0	92.1	5238
Informal programme	1.4	1.3	79.8	4.1	.0	.0	1.7	.0	11.9	.0	.0	.0	100.0	86.4	52
DK	3.8	21.1	32.2	.0	15.0	.0	3.9	.0	8.1	.0	.0	15.8	100.0	72.2	286
Wealth index quintiles															
Very poor	.0	.0	68.9	.7	8.6	.0	6.2	.7	13.1	.0	.3	1.5	100.0	78.2	4523
Poor	.0	8.4	61.9	2.4	6.2	.0	6.1	1.9	9.7	.0	.0	3.3	100.0	79.0	4562
Middle income	.9	13.0	63.4	.8	9.2	.0	3.1	1.0	6.2	.0	.0	2.2	100.0	87.4	4543
Wealthy	3.0	30.6	48.0	1.6	8.4	.0	1.2	2.2	1.8	.0	.0	3.0	100.0	91.7	4555
Very wealthy	13.5	58.1	20.2	.6	1.9	.3	.8	.9	.3	.0	.1	3.5	100.0	94.5	4545
Total	3.5	22.0	52.5	1.2	6.9	.1	3.5	1.3	6.2	.0	.1	2.7	100.0	86.2	22728

* MICS indicator no 11; MDG indicator no 30

Table EN.2: Household water treatment. Percentage distribution of household population according to drinking water treatment method used in the household, and percentage of household population that applied an appropriate water treatment method, São Tomé e Príncipe, 2006

	Home treatment methods of water treatment								All drinking water sources		Improved drinking water sources		Unimproved drinking water sources	
	None	Boiled	Add bleach	Filter through cloth	Utilise a filter	Let rest	Other	Does not know	Appropriate water treatment method*	Number of households	Appropriate water treatment method*	Number of households	Appropriate water treatment method*	Number of households
Region														
Agua-Grande	84.2	4.5	10.5	.5	.3	.0	.0	.0	15.2	7890	15.6	7123	11.8	767
Mé-zochi	85.4	1.5	13.0	.0	.0	.1	.0	.0	14.5	6385	13.4	5489	21.0	897
Cantagalo	88.3	1.0	9.5	1.1	.0	.1	.0	.0	10.5	2302	10.0	1887	12.5	416
Caué	79.3	.2	20.0	.4	.0	.1	.0	.0	20.2	1210	18.7	869	24.0	342
Lembá	87.9	.1	8.5	2.1	.0	1.1	.0	.3	8.6	1767	8.8	1579	7.5	187
Lobata	84.1	2.7	12.5	.2	.0	.6	.0	.0	15.2	2093	15.3	2021	12.5	72
Príncipe	96.6	.3	2.4	.7	.0	.0	.0	.0	2.7	1081	1.7	603	4.0	477
Residence														
Urban	85.5	3.2	10.4	.7	.2	.1	.0	.0	13.7	13065	13.7	11534	13.3	1531
Rural	85.6	1.3	12.5	.3	.0	.3	.0	.0	13.7	9663	13.4	8036	15.4	1627
Head of household's level of education														
None	88.7	1.1	9.7	.3	.0	.3	.0	.0	10.7	3393	11.4	2897	6.9	496
Primary	87.3	2.0	10.1	.4	.0	.2	.0	.0	12.1	13760	11.4	11610	15.6	2150
Secondary +	79.6	4.3	14.7	.9	.4	.1	.0	.1	19.3	5238	20.1	4813	10.4	425
Informal programme	55.4	.0	40.3	4.3	.0	.0	.0	.0	40.3	52	37.0	45	60.9	7
DK	79.2	.0	19.1	1.7	.0	.0	.0	.0	19.1	286	8.9	206	45.6	79
Wealth index quintiles														
Very poor	91.7	1.0	7.0	.0	.0	.2	.0	.1	8.0	4523	7.3	3538	10.7	985
Poor	88.5	1.2	9.6	.3	.0	.3	.0	.0	10.8	4562	9.4	3603	16.3	959
Middle income	86.1	2.1	11.4	.2	.0	.2	.0	.0	13.5	4543	13.6	3970	12.3	572
Wealthy	84.3	1.1	13.6	.8	.0	.1	.0	.0	14.7	4555	15.1	4177	9.8	378
Very wealthy	77.2	6.3	14.7	1.2	.5	.0	.0	.1	21.5	4545	20.8	4282	32.8	263
Total	85.6	2.3	11.3	.5	.1	.2	.0	.0	13.7	22728	13.6	19570	14.4	3158

* MICS indicator no 13

Table EN.3: Time to source of water
Percentage distribution of households according to time to go to source of drinking water, get water and return, and mean time to source of drinking water, São Tomé e Príncipe, 2006

	Time to source of drinking water							Mean time to access drinking water source	Number of households
	Water at home	Less than 15 minutes	From 15 to 30 minutes	From 30 minutes to less than1 hour	1 hour or more	Does not know	Total		
Region									
Agua-Grande	41.4	30.9	15.2	8.5	2.4	1.6	100.0	16.7	1999
Mé-zochi	19.8	41.0	15.9	14.2	7.5	1.5	100.0	19.7	1565
Cantagalo	7.9	58.5	17.3	13.0	1.6	1.7	100.0	14.3	573
Caué	20.6	48.1	16.0	10.8	3.0	1.5	100.0	15.7	283
Lembá	16.6	64.8	9.4	3.8	.8	4.5	100.0	10.0	408
Lobata	19.3	55.3	17.1	5.6	1.4	1.3	100.0	12.4	495
Príncipe	14.6	52.4	22.2	7.9	2.4	.5	100.0	14.8	302
Residence									
Urban	31.9	39.4	15.6	9.3	1.9	1.9	100.0	15.3	3189
Rural	17.7	48.1	16.0	10.9	5.8	1.5	100.0	17.1	2436
Head of household's level of education									
None	13.4	48.7	19.5	10.7	4.8	2.9	100.0	16.8	890
Primary	21.2	45.6	16.3	11.3	3.9	1.6	100.0	16.3	3347
Secondary +	46.1	32.7	12.1	6.6	1.5	1.1	100.0	15.0	1306
Informal programme	7.8	53.7	29.8	8.6	.0	.0	100.0	12.2	18
DK	26.6	49.4	8.4	.8	12.2	2.6	100.0	17.3	64
Wealth index quintiles									
Very poor	1.8	55.0	18.5	16.4	5.8	2.4	100.0	17.6	1265
Poor	11.5	53.4	17.2	10.7	4.4	2.8	100.0	15.6	1177
Middle income	16.0	50.1	18.8	9.6	3.7	1.8	100.0	15.6	1145
Wealthy	35.4	36.5	18.6	6.8	2.0	.8	100.0	15.0	1038
Very wealthy	74.0	15.1	4.3	4.9	1.3	.4	100.0	17.0	1000
Total	25.8	43.2	15.8	10.0	3.6	1.7	100.0	16.2	5625

Table EN.4: Person collecting water
Percentage distribution of households according to the person collecting drinking water used in the household,
São Tomé e Príncipe, 2006

	Person collecting drinking water :						Number of households
	Adult female	Adult male	Girl younger than 15	Boy younger than 15	Does not know	Total	
Region							
Agua-Grande	69.4	17.3	9.3	3.8	.3	100.0	1211
Mé-zochi	65.5	22.1	8.1	4.2	.0	100.0	1314
Cantagalo	71.4	18.3	7.6	2.6	.0	100.0	538
Caué	66.5	19.5	11.3	2.7	.0	100.0	236
Lembá	68.8	15.2	11.4	4.3	.2	100.0	359
Lobata	58.6	21.3	12.5	7.4	.2	100.0	418
Príncipe	63.0	22.8	8.4	5.8	.0	100.0	270
Residence							
Urban	69.5	16.6	10.2	3.6	.2	100.0	2248
Rural	64.0	22.7	8.3	4.9	.0	100.0	2097
Head of household's level of education							
None	72.5	13.7	9.1	4.5	.1	100.0	796
Primary	65.1	21.3	8.9	4.5	.2	100.0	2753
Secondary +	66.7	20.0	10.2	3.1	.0	100.0	730
Informal programme	50.7	41.2	8.2	.0	.0	100.0	16
DK	72.5	13.7	9.1	4.5	.1	100.0	796
Wealth index quintiles							
Very poor	66.6	21.4	7.4	4.5	.1	100.0	1242
Poor	64.9	20.1	10.5	4.2	.3	100.0	1089
Middle income	67.5	20.9	7.7	3.9	.1	100.0	1009
Wealthy	67.2	15.0	13.4	4.4	.0	100.0	717
Very wealthy	71.9	16.0	8.0	4.1	.0	100.0	288
Total	66.8	19.5	9.3	4.2	.1	100.0	4345

Table EN.5: Use of sanitary means of excreta disposal

Percentage distribution of household members according to type of toilet facility used by the household, and the percentage of household members using sanitary means of excreta disposal, São Tomé e Príncipe, 2006

	Improved sanitation facilities						Un-improved sanitation facilities				Total	Percentage of population utilising safe excreta disposal facilities *	Number of household members
	Sewage system	Septic tank	Latrine	Improved self-airing latrine	Covered latrine	Composting toilet	Water tank toilet linked to mains	Open pit latrine t	No sanitation facilities : bush	Other			
Region													
Agua-Grande	9.3	20.4	1.5	2.1	8.6	.0	.7	8.6	44.4	4.4	100.0	41.9	7890
Mé-zochi	6.3	8.2	.2	.4	5.7	.3	.5	3.8	72.2	2.4	100.0	20.9	6385
Cantagalo	4.7	2.7	.2	.7	5.3	.0	.1	6.3	74.2	5.8	100.0	13.6	2302
Caué	7.1	7.0	.3	1.3	4.6	.1	.0	4.3	64.3	11.0	100.0	20.3	1210
Lembá	5.3	10.3	2.6	2.2	5.6	.0	.1	9.8	51.0	13.1	100.0	26.1	1767
Lobata	2.8	8.3	2.1	2.0	9.9	.0	.0	9.1	61.4	4.3	100.0	25.1	2093
Príncipe	3.7	6.3	.5	.0	4.4	.7	12.7	3.9	66.3	1.3	100.0	15.1	1081
Residence													
Urban	7.1	14.4	1.4	1.8	8.0	.0	.7	7.8	53.2	5.5	100.0	32.7	13065
Rural	6.2	8.6	.5	.7	5.5	.2	1.4	5.1	67.8	4.0	100.0	21.5	9663
Head of household's level of education													
None	5.2	5.4	.6	.6	5.5	.0	.5	7.6	66.4	8.0	100.0	17.5	3393
Primary	4.2	9.5	.9	1.4	6.7	.2	1.1	6.6	64.3	5.1	100.0	22.7	13760
Secondary +	14.6	22.9	1.6	1.5	8.3	.0	1.0	6.5	41.7	1.8	100.0	48.9	5238
Informal programme	.0	36.9	.0	.0	.9	.0	.0	.0	56.2	6.0	100.0	37.8	52
DK	1.7	3.8	.0	3.8	9.6	.0	2.3	3.2	64.6	11.0	100.0	18.8	286
Wealth index quintiles													
Very poor	.0	.0	.1	.0	.4	.0	.5	.8	93.5	4.7	100.0	.5	4523
Poor	1.0	.8	.4	.8	5.0	.0	2.3	5.6	76.0	8.0	100.0	8.1	4562
Middle income	3.5	4.8	1.1	.7	8.3	.6	1.3	6.4	66.7	6.7	100.0	18.4	4543
Wealthy	7.4	10.5	2.3	2.8	10.1	.0	.7	12.4	49.8	3.9	100.0	33.1	4555
Very wealthy	21.6	43.5	1.2	2.3	10.9	.0	.1	8.2	11.1	1.0	100.0	79.6	4545
Total	6.7	11.9	1.0	1.3	6.9	.1	1.0	6.7	59.4	4.9	100.0	28.0	22728

Type of sanitation facility utilised by household

* MICS indicator no 12; MDG indicator no 31

Table EN.5w: Common use of improved sanitation facilities. Percentage Distribution of household members utilising improved sanitation facilities, by number of households using these facilities. São Tomé e Príncipe, 2006

	Number of household members utilising the facilities*												Number of household members utilising improved facilities
	1**	2	3	4	5	6	7	8	9	10 or more	DK	Total	
Type of sanitation facility													
Linked to sewer system	85.2	1.1	.3	.9	.2	.3	.1	2.2	.2	9.2	.3	100.0	1527
Linked to septic tank	82.9	5.3	2.5	.7	.6	.4	.2	.1	.0	6.5	.8	100.0	2713
Latrine	85.3	3.8	1.1	1.9	.0	2.0	2.9	.0	.0	3.0	.0	100.0	233
Improved self-airing latrine	93.9	4.8	.4	.0	.5	.0	.0	.0	.0	.4	.0	100.0	305
Covered latrine	85.2	1.1	.3	.9	.2	.3	.1	2.2	.2	9.2	.3	100.0	1527
Region	87.3	6.0	2.8	1.0	0.9	0.5	0.4	0.7	0.0	0.2	0.3	100.0	3309
Agua-Grande	87.3	6.0	2.8	1.0	.9	.5	.4	.7	.0	.2	.3	100.0	3309
Mé-zochi	87.2	4.4	4.0	.8	.0	.0	.0	.2	.0	3.5	.0	100.0	1335
Cantagalo	78.1	4.3	1.9	.0	.0	.0	.5	.0	.0	13.9	1.3	100.0	314
Caué	89.3	4.7	.6	1.3	.0	.0	.0	.0	.0	3.3	.9	100.0	245
Lembá	61.5	2.8	.0	.0	.3	.0	.0	.0	.6	32.2	2.7	100.0	460
Lobata	81.1	3.5	1.6	.0	.0	.2	.0	.0	.0	13.6	.0	100.0	526
Príncipe	78.2	2.9	1.2	2.2	.5	3.3	.0	6.6	.0	4.5	.7	100.0	163
Residence													
Urban	87.8	5.7	2.5	.8	.7	.4	.3	.6	.0	.7	.5	100.0	4278
Rural	77.1	3.5	2.7	.8	.0	.2	.1	.5	.1	14.5	.4	100.0	2075
Head of household's level of education													
None	85.4	2.6	0.0	0.0	0.0	0.0	0.0	0.2	0.0	11.4	0.5	100.0	591
Primary	79.9	6.0	4.0	1.0	0.7	0.0	0.2	0.5	0.0	6.8	0.9	100.0	3127
Secondary +	88.9	4.4	1.6	0.7	0.4	0.8	0.3	0.8	0.1	2.0	0.0	100.0	2560
Informal programme	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	20
DK	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	54
Wealth index quintiles													
Very poor	100.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	100.0	23
Poor	70.6	11.2	3.5	.0	.0	.3	.0	.0	.0	12.6	1.8	100.0	369
Middle income	68.8	4.2	1.4	3.4	1.1	.0	.0	.0	.3	19.8	1.0	100.0	838
Wealthy	81.9	6.4	2.3	1.2	.1	.8	.3	.0	.0	6.2	.9	100.0	1507
Very wealthy	90.2	4.0	2.9	.1	.6	.3	.3	1.0	.0	.7	.0	100.0	3617
Total	84.3	5.0	2.6	.8	.5	.3	.2	.6	.0	5.2	.5	100.0	6353

Table EN.6: Disposal of child's faeces. Percentage distribution of children aged 0-2 years according to place of disposal of child's faeces, and the percentage of children aged 0-2 years whose stools are disposed of safely, São Tomé e Príncipe, 2006

| | Place of child excreta disposal | | | | | | | | | Proportion of children whose excreta is disposed of safely | Number of children aged 0-2 |
	Child uses sanitation facilities	Excreta is disposed of in toilets / latrine	Excreta is disposed in a sewer	Excreta is disposed in waste bins with household waste	Excreta is buried	Excreta is left out in the open	Other	DK	Total		
Region											
Agua-Grande	7.5	25.7	2.8	2.0	3.5	33.2	5.7	.2	100.0	33.2	700
Mé-zochi	2.1	10.2	.0	2.3	.7	56.1	2.9	1.2	100.0	12.3	530
Cantagalo	2.2	8.3	.0	3.1	1.3	62.7	2.5	.0	100.0	10.6	209
Caué	3.0	10.3	5.7	6.6	1.7	41.6	6.4	.4	100.0	13.3	110
Lembá	1.1	8.0	2.6	5.8	.4	42.9	2.9	.0	100.0	9.2	186
Lobata	3.8	11.3	.3	2.5	1.3	51.5	6.8	1.2	100.0	15.1	180
Príncipe	.0	5.6	3.0	16.3	.5	53.3	2.2	.0	100.0	5.6	105
Residence											
Urban	5.3	18.7	2.1	3.2	2.4	39.8	4.5	.4	100.0	23.9	1167
Rural	2.2	10.1	1.2	4.1	.9	55.1	4.1	.7	100.0	12.3	851
Head of household's level of education											
None	1.6	3.3	.3	1.7	2.8	64.8	1.4	.0	100.0	4.9	132
Primary	2.2	11.6	1.4	4.1	1.9	49.6	3.8	.7	100.0	13.8	1456
Secondary +	10.9	30.4	3.1	2.3	1.1	29.1	7.2	.0	100.0	41.3	428
Informal programme	.0	.0	.0	41.3	.0	17.4	.0	.0	100.0	.0	1
Wealth index quintiles											
Very poor	.1	1.0	.0	4.7	1.4	58.6	1.5	1.1	100.0	1.1	440
Poor	1.2	7.1	.4	6.6	1.4	50.7	3.6	.3	100.0	8.3	419
Middle income	3.0	8.5	1.2	3.0	3.5	56.5	5.2	.2	100.0	11.5	393
Wealthy	2.5	21.4	2.5	2.1	2.4	42.5	4.2	.5	100.0	23.8	441
Very wealthy	16.1	43.7	5.2	1.2	.0	16.5	8.2	.5	100.0	59.8	325
Total	4.0	15.0	1.7	3.6	1.8	46.3	4.4	.5	100.0	19.0	2018

* MICS indicator no 14

Table EN.7: Use of improved water sources and improved sanitation
Percentage of household population using both improved drinking water sources
and sanitary means of excreta disposal,
São Tomé e Príncipe, 2006

	Percentage of household members			
	Utilisation improved water sources*	Utilisation of improved excreta disposal methods**	Utilisation improved water sources and utilisation of improved excreta disposal methods ***	Number of household members
Region				
Agua-Grande	90.4	41.9	40.2	7890
Mé-zochi	86.1	20.9	19.6	6385
Cantagalo	82.0	13.6	12.7	2302
Caué	71.8	20.3	19.7	1210
Lembá	89.4	26.1	24.9	1767
Lobata	96.5	25.1	23.9	2093
Príncipe	55.8	15.1	10.7	1081
Residence				
Urban	88.4	32.7	31.3	13065
Rural	83.2	21.5	19.8	9663
Mother's level of education				
None	85.4	17.5	16.3	3393
Primary	84.4	22.7	21.0	13760
Secondary +	92.1	48.9	47.7	5238
Informal programme	86.4	37.8	37.8	52
DK	72.2	18.8	15.1	286
Wealth index quintiles				
Very poor	78.2	.5	.4	4523
Poor	79.0	8.1	7.1	4562
Middle income	87.4	18.4	17.0	4543
Wealthy	91.7	33.1	31.7	4555
Very wealthy	94.5	79.6	76.0	4545
Total	86.2	28.0	26.4	22728

* MICS indicator no 11; MDG indicator no 30
** MICS indicator no 12; MDG indicator no 31

Table EN.10: Slum housing

Percentage of households and household members in the urban areas *(or in capital city)* that are considered as living in slum housing, by background characteristics, São Tomé e Príncipe, 2006

	The housing is considered durable	Absence of housing security	Crowded housing : more than 3 persons in one room	Absence of improved water source	Absence of improved sanitation facilities	Percentage of household considered as living in precarious housing *	Number of households	Percentage of persons considered as living in precarious housing	Total number of persons
Head of household's level of education									
None	.0	100.0	13.9	14.5	84.6	100.0	480	100.0	1945
Primary	.0	100.0	18.9	15.3	77.8	100.0	1799	100.0	7603
Secondary +	.0	100.0	11.8	7.4	46.9	100.0	875	100.0	3382
Informal programme	.0	100.0	16.2	44.5	100.0	100.0	3	100.0	10
Wealth index quintiles									
Very poor	.0	100.0	22.1	20.4	99.5	100.0	567	100.0	2001
Poor	.0	100.0	25.9	20.0	93.0	100.0	537	100.0	2246
Middle income	.0	100.0	18.5	12.4	87.4	100.0	596	100.0	2327
Wealthy	.0	100.0	15.7	10.4	71.0	100.0	687	100.0	2978
Very wealthy	.0	100.0	3.9	6.3	20.5	100.0	801	100.0	3514
Total	.0	100.0	16.1	13.1	70.2	100.0	3189	100.0	13065

* MICS indicator no 95; MDG indicator no 32

Table RH.1: Contraceptive use
Percentage of women aged 15–59 currently married or in union who utilise (or whose partner uses) a contraceptive method, São Tomé e Príncipe, 2006

		Female sterilisa-tion	Male sterilisa-tion	Pill	IUD	Injections	Condom	Female condom	Diaphragm/ foam /gel	Condom	LAM	Periodic abstinence	Retreat	Calendar	All modern methods	All traditional methods	All methods*	
Region																		
Agua-Grande	71.5	.0	.0	14.2	2.0	8.5	3.0	.4	.0	.0	.2	.1	.0	2.8	0.0	0.0	0.0	1026
Mé-zochi	71.1	.5	.0	18.8	.0	7.9	.9	.0	.3	.0	.0	.0	.5	1.9	0.0	0.0	0.0	696
Cantagalo	69.3	.5	.3	16.4	.3	10.7	.5	.0	.0	.2	1.4	.0	.3	0.2	0.0	0.0	0.0	274
Caué	65.4	.2	.0	13.5	.2	19.5	.2	.0	.0	.0	1.0	.0	.0	0.5	0.0	0.0	0.0	139
Lembá	67.4	.0	.0	11.8	.3	18.6	.9	.2	.0	.0	.7	.1	.0	1.7	0.0	0.0	0.0	224
Lobata	70.3	.2	.0	21.0	.4	7.0	1.1	.0	.0	.0	.0	.0	.0	1.4	0.0	0.0	0.0	247
Príncipe	55.6	.0	.0	23.7	.0	19.8	.9	.0	.0	.0	.0	.0	.0	1.3	0.0	0.0	0.0	122
Residence																		
Urban	68.6	0.0	0.1	14.7	1.3	10.2	0.3	0.3	0.1	0.0	0.4	0.1	.1	2.0	0.0	0.0	0.0	1625
Rural	66.6	0.6	0.0	19.3	0.2	10.1	0.0	0.0	0.0	0.0	0.2	0.0	.3	1.9	0.0	0.0	0.0	1077
Age																		
15-19	75.3	0.0	0.0	13.8	1.1	3.9	0.0	0.0	1.2	0.0	0.4	0.0	.0	0.7	0.0	0.0	0.0	185
20-24	66.7	0.0	0.0	20.1	0.2	9.3	0.8	0.8	0.0	0.0	0.2	0.1	.1	0.3	0.0	0.0	0.0	563
25-29	65.3	0.0	0.0	18.6	0.5	12.0	0.0	0.0	0.0	0.0	0.5	0.0	.0	1.2	0.0	0.0	0.0	572
30-34	57.2	0.1	0.0	21.2	1.5	14.1	0.0	0.0	0.0	0.0	0.2	0.0	.5	3.7	0.0	0.0	0.0	463
35-39	67.8	0.2	0.0	14.9	2.4	11.2	0.0	0.0	0.0	0.1	0.1	0.0	.2	2.8	0.0	0.0	0.0	413
40-44	75.9	0.2	0.3	8.4	0.0	9.5	0.0	0.0	0.0	0.0	0.8	0.4	.0	2.6	0.0	0.0	0.0	346
45-49	82.9	2.3	0.0	7.4	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	.0	2.4	0.0	0.0	0.0	185
Mother's level of education																		
None	74.5	1.2	0.0	8.4	0.0	13.7	0.0	0.0	0.0	0.0	0.8	0.0	.0	1.3	0.0	0.0	0.0	196
Primary	68	0.2	0.0	17.5	0.5	10.9	0.1	0.1	0.1	0.0	0.3	0.0	.2	1.1	0.0	0.0	0.0	1929
Secondary +	64.9	0.0	0.0	15.2	2.4	7.6	0.3	0.3	0.0	0.0	0.2	0.2	.0	4.7	0.0	0.0	0.0	594
Informal programme	63.6	0.0	0.0	22.5	0.0	5.3	0.0	0.0	0.0	0.0	0.0	0.0	.0	0.0	0.0	0.0	0.0	8
Wealth index quintiles																		
Very poor	72.9	0.3	0.0	13.1	0.1	10.8	0.0	0.0	0.5	0.0	0.3	0.0	.0	1.7	0.0	0.0	0.0	469
Poor	66.6	0.1	0.0	17.1	1.0	13.3	0.1	0.1	0.0	0.0	0.5	0.1	.0	0.6	0.0	0.0	0.0	543
Middle income	69.0	0.2	0.2	18.7	0.1	10.6	0.0	0.0	0.0	0.0	0.2	0.0	.0	0.3	0.0	0.0	0.0	576
Wealthy	65.8	0.0	0.0	19.7	0.5	9.8	0.4	0.4	0.0	0.1	0.5	0.0	.6	1.4	0.0	0.0	0.0	563
Very wealthy	65.5	0.6	0.0	13.0	2.3	7.5	0.4	0.4	0.0	0.0	0.2	0.3	.1	5.3	0.0	0.0	0.0	576
Total	67.8	0.2	0.0	16.4	0.8	10.3	0.2	0.2	0.1	0.0	0.3	0.1	.2	1.9	0.0	0.0	0.0	2727

* MICS indicator no 21; MDG indicator no 19C

Table RH.2: Unsatisfied contraceptive needs

Percentage of women aged 15–49 currently married or in union whose family planning needs are unsatisfied, and percentage of satisfied contraceptive demand, São Tomé e Príncipe, 2006

	Currently uses contraception*	Unsatisfied contraceptive needs			Number of women currently married or in union	Percentage of satisfied contraceptive demand*****	Number of women currently married or in union needing contraception
		To space births**	To limit births***	Total****			
Region							
Agua-Grande	28.5	9.6	4.7	14.3	1027	66.6	439
Mé-zochi	28.9	10.3	6.0	16.2	696	64.1	314
Cantagalo	30.7	10.9	7.3	18.1	274	62.8	134
Caué	34.6	13.8	7.2	21.1	139	62.2	77
Lembá	32.6	11.7	4.1	15.8	224	67.4	108
Lobata	29.7	9.5	5.0	14.5	247	67.2	109
Príncipe	44.4	5.4	10.7	16.1	122	73.4	74
Residence							
Urban	29.4	10.6	4.8	15.4	1650	65.6	741
Rural	31.6	9.3	6.9	16.2	1077	66.1	515
Age							
15-19	24.3	18.6	.9	19.5	185	55.5	81
20-24	32.9	15.9	1.2	17.1	564	65.8	282
25-29	33.5	12.7	3.3	16.0	572	67.7	283
30-34	39.1	8.8	9.1	17.8	462	68.7	263
35-39	29.3	5.5	11.3	16.7	413	63.7	190
40-44	21.4	2.2	8.5	10.7	346	66.6	111
45-49	14.9	3.8	5.2	8.9	185	62.6	44
Mother's level of education							
None	23.8	6.9	7.4	14.3	196	62.5	75
Primary	30.9	10.1	5.6	15.7	1931	66.3	899
Secondary +	30.5	11.2	5.3	16.5	593	64.9	279
Informal programme	32.6	.0	.0	.0	7	100.0	2
Wealth index quintiles							
Very poor	25.4	12.3	6.2	18.4	469	58.0	206
Poor	32.8	9.8	5.7	15.5	543	67.9	262
Middle income	30.6	9.0	6.0	15.0	576	67.1	262
Wealthy	32.7	12.0	6.5	18.5	564	63.9	289
Very wealthy	29.1	7.6	4.2	11.8	576	71.2	236
Total	30.3	10.1	5.7	15.7	2727	65.8	1255

* MICS indicator 21; MDG indicator 19C
**** MICS indicator 98
***** MICS indicator 99

Table RH.3: Pre-natal care provider

Percentage distribution of women aged 15-49 who gave birth in the two years preceding the survey by type of personnel providing pre-natal care,

São Tomé e Príncipe, 2006

	Pre-natal care giver**					Did not receive pre-natal care	Total	All qualified personnel *	Number of women having given birth during the last two years
	Doctor	Nurse/ Midwife	Assistant midwife	Traditional midwife	Other				
Region									
Agua-Grande	2.0	96.6	.0	.0	.0	1.4	100.0	98.6	454
Mé-zochi	3.1	94.5	.0	2.0	.0	.5	100.0	97.5	297
Cantagalo	5.7	87.6	.5	1.4	.8	4.0	100.0	93.3	127
Caué	3.3	87.1	1.0	2.0	1.7	4.9	100.0	90.4	63
Lembá	1.1	96.6	1.1	.0	.0	1.2	100.0	97.7	116
Lobata	1.2	97.6	.0	.0	.0	1.2	100.0	98.8	108
Príncipe	.8	97.8	.7	.0	.0	.7	100.0	98.6	66
Residence									
Urban	2.6	94.9	.1	.5	.2	1.6	100.0	97.5	740
Rural	2.2	94.7	.4	1.1	.2	1.4	100.0	97.0	491
Age									
15-19	1.1	96.6	.4	.0	.9	1.0	100.0	97.7	151
20-24	4.8	93.4	.2	1.1	.0	.5	100.0	98.2	399
25-29	2.1	95.6	.3	.5	.1	1.4	100.0	97.7	289
30-34	1.1	93.7	.3	1.7	.2	3.1	100.0	94.8	178
35-39	1.3	97.5	.0	.0	.0	1.2	100.0	98.8	139
40-44	.0	94.2	.5	.0	.0	5.4	100.0	94.2	69
45-49	.0	88.9	.0	4.6	.0	6.5	100.0	88.9	7
Mother's level of education									
None	.0	95.2	.4	.4	.0	4.0	100.0	95.2	76
Primary	2.2	94.8	.3	.9	.2	1.6	100.0	97.0	892
Secondary +	4.3	95.1	.0	.2	.2	.4	100.0	99.3	261
Informal programme	.0	.0	.0	.0	.0	100.0	100.0	.0	1
Wealth index quintiles									
Very poor	2.6	94.9	.0	1.5	.0	1.0	100.0	97.5	271
Poor	2.3	90.9	.5	1.4	.8	4.1	100.0	93.2	260
Middle income	1.4	96.0	.6	.6	.0	1.5	100.0	97.4	236
Wealthy	2.2	96.9	.1	.0	.0	.8	100.0	99.1	260
Very wealthy	4.3	95.7	.0	.0	.0	.0	100.0	100.0	205
Total	2.5	94.8	.2	.7	.2	1.5	100.0	97.3	1230

* MICS indicator 20

Table RH.4: Pre-natal care. Percentage of pregnant women receiving pre-natal care among women aged 15-49 who gave birth in two years preceding the survey and percentage of pregnant women receiving specific care as part of the pre-natal care received, São Tomé e Príncipe, 2006

	Percentage of pregnant women receiving pre-natal care at least once during their pregnancy	Percentage of women who :				Number of women having given birth during the last two years
		Tested their blood*	Tested their blood pressure *	Tested their urine*	Took their weight*	
Region						
Agua-Grande	98.6	95.4	97.7	94.3	98.1	454
Mé-zochi	99.5	82.8	97.0	86.8	97.0	297
Cantagalo	96.0	67.6	92.0	68.8	93.1	127
Caué	95.1	45.4	94.2	42.3	93.4	63
Lembá	98.8	66.9	95.8	69.3	97.1	116
Lobata	98.8	76.5	95.6	76.2	97.6	108
Príncipe	99.3	94.8	97.7	95.5	97.7	66
Residence						
Urban	98.4	85.2	96.6	84.2	97.0	740
Rural	98.6	78.7	96.1	82.1	96.9	491
Age						
15-19	99.0	82.7	96.5	82.7	98.3	151
20-24	99.5	86.0	98.2	86.6	99.0	399
25-29	98.6	829	96.5	83.9	96.4	289
30-34	96.9	75.5	94.5	78.1	94.8	178
35-39	98.8	83.2	95.6	82.4	96.2	139
40-44	94.6	78.4	92.4	79.5	91.9	69
45-49	93.5	77.6	93.5	81.7	93.5	7
Mother's level of education						
None	96.0	68.2	94.6	71.2	94.3	76
Primary	98.4	80.7	95.7	81.5	96.5	892
Secondary +	99.6	93.4	99.6	93.4	99.6	261
Informal programme	.0	.0	.0	.0	.0	1
Wealth index quintiles						
Very poor	99.0	73.3	95.1	73.7	95.4	271
Poor	95.9	73.0	93.5	75.8	94.7	260
Middle income	98.5	82.5	96.1	83.8	97.0	236
Wealthy	99.2	92.4	98.1	91.2	98.4	260
Very wealthy	100.0	94.6	100.0	95.2	100.0	205
Total	98.5	82.6	96.4	83.4	96.9	1230

* MICS indicator no 44

Table RH.4w: Composition of pre-natal care. Percentage of pregnant women receiving specific care as an integral health care approach for pregnant women aged 15-49 who gave birth during the 2 years preceding the survey, São Tomé e Príncipe, 2006

	Percentage of women who :				Number of women having given birth during the last two years
	Tested their blood*	Tested their blood pressure *	Tested their blood*	Took their weight*	
Region					
Agua-Grande	96.8	99.1	95.7	99.5	448
Mé-zochi	83.2	97.4	87.2	97.5	295
Cantagalo	70.4	95.8	71.7	97.0	122
Caué	47.7	99.0	44.5	98.2	60
Lembá	67.7	96.9	70.1	98.3	115
Lobata	77.5	96.8	77.2	98.8	107
Príncipe	95.4	98.4	96.2	98.4	65
Residence					
Urban	86.6	98.2	85.6	98.6	727
Rural	79.8	97.4	83.2	98.2	484
Age					
15-19	83.6	97.5	83.6	99.3	150
20-24	86.5	98.7	87.0	99.5	397
25-29	84.1	97.9	85.1	97.7	285
30-34	77.9	97.5	80.6	97.8	172
35-39	84.2	96.8	83.4	97.4	137
40-44	82.8	97.6	84.0	97.1	65
45-49	83.0	100.0	87.4	100.0	6
Mother's level of education					
None	71.0	98.5	74.1	98.2	73
Primary	82.0	97.2	82.8	98.0	878
Secondary +	93.8	100.0	93.7	100.0	260
Informal programme	71.0	98.5	74.1	98.2	73
Wealth index quintiles					
Very poor	74.1	96.1	74.5	96.4	268
Poor	76.2	97.5	79.1	98.7	249
Middle income	83.7	97.5	85.0	98.4	232
Wealthy	93.1	98.9	91.9	99.2	257
Very wealthy	94.6	100.0	95.2	100.0	205
Total	83.9	97.9	84.7	98.5	1211

Table ED.1: Early childhood education
Percentage of children aged 36-59 months who are attending some form of organized early childhood education programme and percentage of first graders who attended pre-school, São Tomé e Príncipe, 2006

	Percentage of children aged 36-59 months who go to a pre-school *	Number of children aged 36-59 months	Percentage of children admitted to first grade of primary school who also attended a pre-school **	Number of children admitted to first grade of primary level
Sex				
Male	28.8	590	75.1	93
Female	25.9	541	86.5	131
Region				
Agua-Grande	33.1	333	77.9	71
Mé-zochi	17.2	303	87.4	90
Cantagalo	18.2	147	76.5	10
Caué	43.8	68	82.7	14
Lembá	31.7	94	81.2	13
Lobata	27.6	110	80.3	13
Príncipe	41.3	76	68.5	13
Residence				
Urban	29.6	628	82.4	106
Rural	24.8	504	81.2	118
Child's age				
36-47months	20.2	623	.	0
48-59 months	36.3	509	.	0
6 years***	.	0	81.7	225
Mother's level of education				
None	18.5	112	97.9	21
Primary	25.8	819	78.8	153
Secondary +	39.2	197	84.5	50
Informal programme	33.0	4	.0	0
Wealth index quintiles				
Very poor	17.5	239	77.9	41
Poor	21.5	260	81.9	52
Middle income	20.6	243	94.1	43
Wealthy	33.8	209	76.8	50
Very wealthy	50.9	180	78.4	39
Total	27.4	1132	81.7	225

* MICS indicator 52
** MICS indicator 53

Table ED.2: Primary school entry
Percentage of children of primary school entry age attending Grade 1,
São Tomé e Príncipe, 2006

	Percentage of children at the primary school entrance age currently enrolled in first grade *	Total number of children at the primary school entrance age **
Sex		
Male	76.7	646
Female	71.1	594
Region		
Agua-Grande	70.7	365
Mé-zochi	75.5	355
Cantagalo	77.2	147
Caué	77.6	88
Lembá	68.8	110
Lobata	75.2	113
Príncipe	79.6	63
Residence		
Urban	72.5	676
Rural	75.8	564
Child's age (years)		
7 ***	79.3	625
8	68.7	615
Mother's level of education		
None	72.6	188
Primary	77.6	868
Secondary +	58.2	177
Informal programme	61.3	7
DK	100.0	0
Wealth index quintiles		
Very poor	76.9	270
Poor	73.9	278
Middle income	80.3	230
Wealthy	71.3	234
Very wealthy	67.3	228
Total	74.0	1240

* MICS indicator 54

Table ED.3: Primary school net attendance ratio
Percentage of children of primary school age** attending primary or secondary school (NAR),
São Tomé e Príncipe, 2006

	Male		Female		Both	
	Net attendance ration (NAR)	Number of children	Net attendance ration (NAR)	Number of children	Net attendance ration (NAR)	Number of children
Region						
Agua-Grande	96.4	611	97.0	567	96.7	1179
Mé-zochi	95.2	551	94.1	511	94.7	1062
Cantagalo	90.1	205	93.2	188	91.6	393
Caué	91.7	137	89.7	116	90.8	254
Lembá	86.6	160	88.0	152	87.3	312
Lobata	94.1	184	94.1	174	94.1	358
Príncipe	94.1	102	98.3	86	96.0	188
Residence						
Urban	94.2	1078	94.2	995	94.2	2073
Rural	93.6	872	94.5	800	94.0	1672
Age**						
7	88.0	343	86.0	282	87.1	625
8	95.8	304	97.4	311	96.6	615
9	98.8	327	99.0	304	98.9	631
10	95.1	347	98.5	272	96.6	618
11	96.0	292	93.7	306	94.8	598
12	90.5	338	91.3	320	90.9	658
Mother's level of education						
None	87.0	332	92.2	320	89.5	652
Primary	95.2	1333	94.1	1188	94.6	2521
Secondary +	96.2	272	97.8	274	97.0	546
Informal programme	94.6	10	96.8	11	95.8	21
DK	100.0	4	100.0	0	100.0	4
Wealth index quintiles						
Very poor	90.9	414	87.9	362	89.5	776
Poor	90.4	406	92.8	362	91.6	769
Middle income	94.9	401	95.0	300	95.0	701
Wealthy	95.1	388	97.5	375	96.3	763
Very wealthy	99.2	341	97.9	395	98.5	736
Total	93.9	1950	94.3	1795	94.1	3745

* MICS indicator 55; MDG indicator 6

Table ED.4: Secondary school net attendance ratio
Percentage of children of secondary school age** attending secondary school or higher (NAR),
São Tomé e Príncipe, 2006

	Male		Female		Both	
	Net attendance ration (NAR)	Number of children	Net attendance ration (NAR)	Number of children	Net attendance ration (NAR)	Number of children
Region						
Agua-Grande	41.5	433	42.9	467	42.2	900
Mé-zochi	41.1	449	36.3	374	38.9	823
Cantagalo	32.0	144	26.1	109	29.4	252
Caué	22.7	74	15.5	68	19.2	141
Lembá	22.1	117	19.2	110	20.7	227
Lobata	26.3	154	32.0	135	29.0	289
Príncipe	27.0	71	48.0	51	35.7	122
Residence						
Urban	37.8	791	36.5	795	37.2	1586
Rural	32.8	650	33.5	518	33.1	1168
Age**						
13	17.8	312	19.7	280	18.7	592
14	28.4	297	36.3	375	32.8	672
15	42.3	286	42.6	232	42.4	518
16	45.2	305	47.2	206	46.0	510
17	47.1	241	34.9	221	41.3	462
Mother's level of education						
None	20.2	282	15.1	236	17.8	518
Primary	32.5	776	35.3	730	33.9	1506
Secondary +	65.1	142	70.5	134	67.7	276
Informal programme	40.6	9	38.3	4	39.9	14
Mother not living in the household	46.0	232	35.9	207	41.2	439
DK	.0	0	25.2	2	21.5	2
Wealth index quintiles						
Very poor	14.3	253	17.0	252	15.7	505
Poor	18.9	296	22.8	231	20.6	528
Middle income	37.1	293	31.8	258	34.7	551
Wealthy	40.3	315	38.4	267	39.5	582
Very wealthy	64.8	284	60.2	304	62.4	588
Total	35.5	1441	35.3	1313	35.4	2754

* MICS indicator no 56

Table ED. 4W: Secondary school age children attending primary school
Percentage of children of secondary school age** attending primary school,
São Tomé e Príncipe, 2006

	Male		Female		Both	
	Percentage attending primary school	Number of children	Percentage attending primary school	Number of children	Percentage attending primary school	Number of children
Region						
Agua-Grande	34.7	433	35.9	467	35.3	900
Mé-zochi	29.2	449	34.7	374	31.7	823
Cantagalo	30.9	144	36.3	109	33.2	252
Caué	38.9	74	30.7	68	35.0	141
Lembá	38.0	117	38.4	110	38.2	227
Lobata	45.4	154	42.4	135	44.0	289
Príncipe	36.6	71	24.5	51	31.6	122
Residence						
Urban	34.3	791	36.5	795	35.4	1586
Rural	34.3	650	34.7	518	34.5	1168
Age**						
13	67.8	312	70.4	280	69.0	592
14	52.5	297	43.3	376	47.3	672
15	27.4	286	33.1	233	30.0	519
16	12.8	305	10.2	203	11.7	508
17	4.1	241	5.4	223	4.7	464
Mother's level of education						
None	39.3	282	46.1	236	42.4	518
Primary	40.0	776	40.3	730	40.1	1506
Secondary +	27.8	142	23.7	134	25.8	276
Informal programme	11.8	9	23.4	4	15.4	14
Mother not living in the household	14.4	232	16.2	207	15.2	439
DK	.0	0	25.2	2	21.5	2
Wealth index quintiles						
Very poor	36.1	253	36.2	252	36.2	505
Poor	37.2	296	43.4	231	39.9	528
Middle income	33.6	293	35.2	258	34.3	551
Wealthy	37.6	315	42.5	267	39.8	582
Very wealthy	26.9	284	24.3	304	25.6	588
Total	34.3	1441	35.8	1313	35.0	2754

Table ED.5: Children reaching Grade 5
Percentage of children entering first grade of primary school who eventually reach Grade 5, São Tomé e Príncipe, 2006

	Percentage of students in 2nd grade the preceding year	Percentage of students in 3rd grade were in 2nd grade last year	Percentage of students in 4th grade were in 3rd grade last year	Percentage of students in 5th grade were in 4th grade last year	Percent age of students who reach 5th grade of those who enter 1st grade*
Sex					
Male	99.5	98.5	96.6	91.7	86.8
Female	98.3	99.4	97.8	91.8	87.7
Region					
Agua-Grande	98.8	100.0	96.6	95.0	90.7
Mé-zochi	100.0	98.4	98.1	90.8	87.7
Cantagalo	96.9	99.2	99.1	89.2	85.0
Caué	98.2	98.7	95.1	76.4	70.4
Lembá	98.6	96.0	97.8	93.4	86.5
Lobata	100.0	99.1	97.2	95.8	92.2
Príncipe	97.7	100.0	94.8	93.8	86.8
Residence					
Urban	98.4	99.6	96.5	93.5	88.4
Rural	99.4	98.3	98.2	89.6	86.0
Mother's level of education					
None	98.7	97.8	95.6	82.6	76.2
Primary	98.9	99.0	98.3	96.0	92.4
Secondary +	100.0	100.0	100.0	100.0	100.0
Informal programme	100.0	100.0	100.0	100.0	100.0
Mother not living in the household	.	100.0	97.2	56.4	.
DK	100.0	100.0	100.0	100.0	100.0
Wealth index quintiles					
Very poor	98.3	98.3	96.4	81.4	75.9
Poor	98.9	97.4	95.9	92.4	85.4
Middle income	98.8	99.6	96.3	90.0	85.3
Wealthy	99.3	99.6	97.3	95.8	92.2
Very wealthy	99.5	100.0	100.0	98.0	97.5
Total	98.9	98.9	97.2	91.7	87.2

* MICS indicator 57; MDG indicator 7

**Table ED.6: Primary school completion and transition
to secondary education Primary school completion rate and transition rate to secondary
education,
São Tomé e Príncipe, 2006**

	Net 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	28.5	338	76.9	377
Female	35.5	320	78.6	307
Region				
Agua-Grande	46.7	226	74.1	275
Mé-zochi	31.9	175	82.5	207
Cantagalo	26.4	60	79.3	50
Caué	16.3	39	82.7	20
Lembá	12.8	53	77.1	39
Lobata	15.3	72	75.2	65
Príncipe	25.9	33	77.2	28
Residence				
Urban	37.7	376	76.8	401
Rural	24.2	282	78.9	283
Mother's level of education				
None	16.7	123	72.7	55
Primary	31.4	443	80.7	346
Secondary +	58.2	86	74.9	131
Informal programme	.0	4	100.0	1
Mother is not a household member	.	0	85.4	60
DK	.0	2	.	0
Wealth index quintiles				
Very poor	14.6	108	75.7	72
Poor	23.6	162	72.6	88
Middle income	29.1	111	78.7	122
Wealthy	25.6	148	75.0	170
Very wealthy	65.6	129	77.4	214
Total	31.8	658	76.2	666

* MICS indicator no 59; MDG indicator no 7b

Table ED.7: Education gender parity
Ratio of girls to boys attending primary education and ratio of girls to boys attending secondary education,
SãoTomé e Príncipe, 2006

	Net school attendance (NAR), girls	Net school attendance (NAR), boys	Gender parity index (GPI) for the primary NAR*	Net secondary school attendance (NAR) girls	Net secondary school attendance (NAR) boys	Gender parity index (GPI) for the secondary NAR*
Sex						
Male	na	93.9	na	na	35.5	na
Female	94.3	na	na	35.3	na	na
Region						
Agua-Grande	97.0	96.4	1.01	42.9	41.5	1.04
Mé-zochi	94.1	95.2	.99	36.3	41.1	.88
Cantagalo	93.2	90.1	1.03	26.1	32.0	.82
Caué	89.7	91.7	.98	15.5	22.7	.68
Lembá	88.0	86.6	1.02	19.2	22.1	.87
Lobata	94.1	94.1	1.00	32.0	26.3	1.22
Príncipe	98.3	94.1	1.04	48.0	27.0	1.78
Residence						
Urban	94.2	94.2	1.00	36.5	37.8	.97
Rural	94.5	93.6	1.01	33.5	32.8	1.02
Mother's level of education						
None	92.2	87.0	1.06	15.1	20.2	.75
Primary	94.1	95.2	.99	35.3	32.5	1.08
Secondary +	97.8	96.2	1.02	70.5	65.1	1.08
Informal programme	96.8	94.6	1.02	38.3	40.6	.94
Mother is not a household member	.	.	.	35.9	46.0	.78
DK	100.0	100.0	1.00	25.2	.0	.
Wealth index quintiles						
Very poor	87.9	90.9	.97	17.0	14.3	1.19
Poor	92.8	90.4	1.03	22.8	18.9	1.21
Middle income	95.0	94.9	1.00	31.8	37.1	.86
Wealthy	97.5	95.1	1.03	38.4	40.3	.95
Very wealthy	97.9	99.2	.99	60.2	64.8	.93
Total	94.3	93.9	1.00	35.3	35.5	.99

 * MICS indicator 61; MDG indicator 9

Table ED.8: Adult literacy
Percentage of women aged 15-24 who are literate*,
São Tomé e Príncipe, 2006

	Percentage literate*	Percentage unknown**	Number of women aged 15-24
Region			
Agua-Grande	78.9	.0	808
Mé-zochi	72.6	.0	517
Cantagalo	54.4	.0	173
Caué	46.0	.0	78
Lembá	50.9	.0	141
Lobata	65.9	.0	163
Príncipe	61.2	.0	85
Residence			
Urban	72.7	.0	1226
Rural	65.4	.0	738
Mother's level of education			
None	.0	.0	45
Primary	54.9	.0	1202
Secondary +	100.0	.0	714
Informal programme	.0	.0	3
Age			
15-19	75.4	.0	1000
20-24	64.2	.0	964
Wealth index quintiles			
Very poor	50.2	.0	334
Poor	59.3	.0	320
Middle income	61.0	.0	398
Wealthy	78.9	.0	436
Very wealthy	90.1	.0	477
Total	69.9	.0	1964

 * MICS indicator o 60; MDG indicator no 8

Table CP.1: Birth registration

Percentage distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, São Tomé e Príncipe, 2006

	Registered birth*	Does not know if registered	Number of children under 5	Birth registration was not done because :								Total	Number of unregistered under fives
				High cost	Too far	Does not know that the child needs to be registered	It was late and did not want to pay the penalty	Does not know where to register	Other	DK			
Sex													
Male	69.5	.3	1569	5.1	2.8	.1	.5	.1	78.4	13.0	100.0	473
Female	67.8	.4	1556	4.8	4.8	.2	.1	.0	77.8	12.2	100.0	494
Region													
Agua-Grande	67.0	.7	1023	3.0	1.5	.0	.0	.0	85.9	9.7	100.0	330
Mé-zochi	65.2	.3	825	6.7	2.6	.0	.6	.0	67.4	22.7	100.0	284
Cantagalo	79.3	.0	353	6.7	2.4	1.4	.9	.0	82.4	6.2	100.0	73
Caué	73.2	.0	176	11.5	15.8	.0	1.0	.7	71.0	.0	100.0	47
Lembá	68.1	.2	279	6.5	6.3	.0	.0	.0	74.7	12.5	100.0	88
Lobata	62.9	.4	290	2.2	3.6	.6	.0	.0	86.2	7.4	100.0	106
Príncipe	78.4	.0	180	2.0	15.6	.0	.0	.0	77.0	5.3	100.0	39
Residence													
Urban	69.8	.4	1779	3.9	2.4	.0	.1	.0	84.5	8.9	100.0	529
Rural	67.1	.3	1346	6.1	5.5	.4	.5	.1	70.4	17.0	100.0	439
Age													
0-11 months	29.3	.9	705	4.4	3.2	.1	.0	.1	80.4	11.8	100.0	492
12-23 months	54.7	.7	673	6.4	4.8	.3	.2	.0	73.2	15.1	100.0	300
24-35 months	79.6	.0	616	4.6	4.1	.0	2.0	.0	78.4	10.9	100.0	126
36-47 months	93.3	.1	623	1.0	2.7	.0	.0	.0	84.5	11.9	100.0	41
48-59 months	98.2	.0	509	9.6	5.5	.0	.0	.0	80.2	4.7	100.0	9
Mother's level of education													
None	70.0	.2	241	12.9	3.6	.0	.0	.0	77.7	5.8	100.0	72
Primary	65.7	.3	2261	4.7	4.2	.2	.4	.0	77.9	12.6	100.0	769
Secondary +	78.7	.8	618	1.9	1.9	.0	.0	.0	79.7	16.5	100.0	126
Informal programme	77.7	.0	5	.0	.0	.0	.0	.0	100.0	.0	100.0	1
Wealth index quintiles													
Very poor	62.5	.5	678	5.4	4.7	.0	.7	.0	73.9	15.3	100.0	251
Poor	66.8	.1	675	6.4	6.0	.0	.3	.1	79.9	7.3	100.0	224
Middle income	68.1	.0	631	6.4	2.5	.5	.2	.0	79.6	10.7	100.0	201
Wealthy	70.7	.4	641	3.6	2.5	.3	.0	.0	76.8	16.8	100.0	185
Very wealthy	77.6	1.0	500	.3	1.9	.0	.0	.0	83.9	13.8	100.0	107
Total	68.7	.4	3125	4.9	3.8	.2	.3	.0	78.1	12.6	100.0	968

* MICS indicator 62

Table CP.2: Child labour
Percentage of children aged 5-14 who are involved in child labour activities by type of work,
São Tomé e Príncipe, 2006

	Work outside the home		Domestic work, minimum 28 hours weekly	Work in the family business	All together, child labour	Number of children aged 5-14
	Remunerated	Non-remunerated				
Sex						
Male	1.4	1.4	2.2	3.5	7.7	3298
Female	1.1	1.2	2.7	2.9	7.2	3212
Region						
Agua-Grande	.4	1.0	2.0	3.1	6.3	1902
Mé-zochi	2.0	1.4	2.6	2.9	8.4	659
Cantagalo	2.9	2.1	2.2	5.8	11.4	406
Caué	1.6	1.3	3.9	4.4	10.2	537
Lembá	2.9	1.6	5.4	6.6	14.2	619
Lobata	1.9	5.2	6.8	7.3	17.0	303
Príncipe	.4	1.0	2.0	3.1	6.3	1902
Residence						
Urban	1.1	1.1	2.1	2.0	5.7	3642
Rural	1.4	1.6	3.0	4.7	9.7	2869
Age (years)						
5-11	1.2	1.5	1.2	3.1	6.4	4588
12-14	1.4	.8	5.4	3.4	10.0	1922
Goes to school						
Yes	1.2	1.4	2.4	3.4	7.5	5268
No	1.4	1.0	2.9	2.4	7.1	1243
Mother's level of education						
None	1.8	1.5	3.1	2.1	7.9	1137
Primary	1.3	1.3	2.4	3.4	7.5	4393
Secondary +	.5	1.0	1.7	3.3	6.3	947
Informal programme	.0	2.3	5.5	14.9	14.9	29
DK	.0	.0	9.3	5.7	14.9	5
Wealth index quintiles						
Very poor	1.6	1.6	2.9	3.0	8.3	1345
Poor	2.5	1.4	2.8	3.7	9.4	1333
Middle income	1.2	1.4	2.8	4.1	8.8	1255
Wealthy	.6	1.4	2.4	3.0	6.7	1347
Very wealthy	.1	.7	1.3	2.1	3.9	1230
Total	1.2	1.3	2.5	3.2	7.5	6511

 * MICS indicator 71

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Table CP.2w: Child labour. Percentage of children aged 5-14 currently working and percentage of children involved in eliminable child labour, by type of activity, São Tomé e Príncipe, 2006

	Work outside the home				Domestic work		Family business work		All child labour		Number of children aged 5-14
	Remunerated work		Unremunerated work								
	All child labour	Child labour (to eliminate)	All child labour	Child labour (to eliminate)	All domestic work	More than 28 hours per week	All child labour	Child labour (to eliminate)	All child labour	Child labour (to eliminate) / total child labour	
Sex											
Male	2.2	1.4	1.9	1.4	71.5	2.2	5.0	3.5	10.2	7.7	3298
Female	1.5	1.1	1.8	1.2	77.0	2.7	4.4	2.9	9.3	7.2	3212
Region											
Agua-Grande	1.3	.8	1.0	.7	72.1	1.0	1.8	1.0	5.0	3.3	2086
Mé-zochi	.8	.4	1.7	1.0	76.8	2.0	4.3	3.1	8.3	6.3	1902
Cantagalo	2.4	2.0	1.7	1.4	66.9	2.6	4.3	2.9	9.8	8.4	659
Caué	3.7	2.9	2.7	2.1	71.2	2.2	7.5	5.8	14.1	11.4	406
Lembá	2.2	1.6	1.7	1.3	76.6	3.9	6.2	4.4	12.6	10.2	537
Lobata	3.7	2.9	2.1	1.6	82.5	5.4	9.5	6.6	17.6	14.2	619
Príncipe	4.1	1.9	7.1	5.2	71.0	6.8	12.1	7.3	24.3	17.0	303
Residence											
Urban	1.7	1.1	1.5	1.1	72.0	2.1	3.0	2.0	7.5	5.7	3642
Rural	2.0	1.4	2.2	1.6	77.0	3.0	6.8	4.7	12.6	9.7	2869
Age (years)											
5-11	1.2	1.2	1.5	1.5	66.9	1.2	3.1	3.1	6.4	6.4	4588
12-14	3.4	1.4	2.5	.8	91.7	5.4	8.5	3.4	17.8	10.0	1922
Goes to school											
Yes	1.7	1.2	1.9	1.4	79.4	2.4	5.0	3.4	9.9	7.5	5268
No	2.5	1.4	1.6	1.0	52.3	2.9	3.2	2.4	9.1	7.1	1243
Mother's level of education											
None	2.4	1.8	1.9	1.5	76.5	3.1	3.7	2.1	10.2	7.9	1137
Primary	1.9	1.3	1.9	1.3	75.1	2.4	4.9	3.4	9.9	7.5	4393
Secondary +	.9	.5	1.1	1.0	66.9	1.7	4.4	3.3	77	6.3	947
Informal programme	.0	.0	4.6	2.3	83.6	5.5	33.3	14.9	33.3	14.9	29
NS	24.4	.0	.0	.0	100.0	9.3	5.7	5.7	39.3	14.9	5
Wealth index quintiles											
Very poor	2.7	1.6	2.5	1.6	77.5	2.9	4.6	3.0	11.6	8.3	1345
Poor	2.9	2.5	2.1	1.4	74.3	2.8	5.5	3.7	11.7	9.4	1333
Middle income	2.0	1.2	2.1	1.4	72.9	2.8	6.0	4.1	11.6	8.8	1255
Wealthy	1.0	.6	1.6	1.4	76.5	2.4	4.2	3.0	8.1	6.7	1347
Very wealthy	.4	.1	.9	.7	69.3	1.3	3.3	2.1	5.5	3.9	1230
Total	1.8	1.2	1.8	1.3	74.2	2.5	4.7	3.2	9.7	7.5	6511

* MICS indicator 71

Table CP.3: Labourer students and student labourers
Percentage of children aged 5-14 who are labourer students and student labourers,
São Tomé e Príncipe, 2006

	Percentage of children who work*	Percentage of students***	Number of children aged 5-14	Percentage of children who work while attending school**	Number of children aged 5-14 who work	Percentage of students who also work****	Number of students aged 5-14
Sex							
Male	7.7	80.6	3298	81.7	253	7.8	2658
Female	7.2	81.2	3212	81.7	232	7.3	2610
Region							
Agua-Grande	3.3	83.5	2086	77.7	69	3.1	1742
Mé-zochi	6.3	81.2	1902	84.9	120	6.6	1544
Cantagalo	8.4	73.5	659	73.1	55	8.3	484
Caué	11.4	78.2	406	80.6	46	11.8	317
Lembá	10.2	77.1	537	77.5	55	10.3	414
Lobata	14.2	82.1	619	85.4	88	14.8	508
Príncipe	17.0	85.5	303	88.4	51	17.6	259
Residence							
Urban	5.7	80.9	3642	77.8	207	5.5	2946
Rural	9.7	80.9	2869	84.7	278	10.1	2322
Age (years)							
5-9	6.4	78.7	4588	88.1	293	7.2	3611
10-14	10.0	86.2	1922	71.9	192	8.3	1657
Mother's level of education							
None	7.9	75.0	1137	74.6	90	7.9	853
Primary	7.5	80.6	4393	81.2	330	7.6	3541
Secondary +	6.3	89.3	947	96.2	60	6.8	845
Informal programme	14.9	86.2	29	63.0	4	10.9	25
DK	14.9	84.0	5	100.0	1	17.8	4
Wealth index quintiles							
Very poor	8.3	72.7	1345	72.1	112	8.2	977
Poor	9.4	76.4	1333	75.8	125	9.3	1018
Middle income	8.8	78.6	1255	82.7	110	9.2	987
Wealthy	6.7	86.0	1347	94.4	90	7.3	1159
Very wealthy	3.9	91.6	1230	93.5	48	4.0	1127
Total	7.5	80.9	6511	81.7	485	7.5	5268

** MICS indicator 72
**** MICS indicator 73

Table CP.5: Early marriage and polygamy

Percentage of women aged 15-49 in marriage or union before their 15th birthday, percentage of women aged 20-49 in marriage or union before their 18th birthday, percentage of women aged 15-19 currently married or in union, and the percentage of married or in union women in a polygamous marriage or union, São Tomé e Príncipe, 2006

	Percentage of women married before 15*	Number of women aged 15-49	Percentage of women married before 18 *	Number of women aged 20-49	Percentage of women aged 15-19 married/in union**	Number of women aged 15-19	Percentage of women aged15-49 in polygamous marriage/union***	Number of women aged 15-49 married/in union
Region								
Agua-Grande	2.1	1796	29.3	1387	18.6	409	.0	1027
Mé-zochi	2.5	1238	33.8	979	14.3	259	.0	696
Cantagalo	5.3	439	44.4	350	23.5	89	.0	274
Caué	7.1	206	51.6	159	19.1	47	.0	139
Lembá	5.6	337	46.2	264	24.3	74	.0	224
Lobata	3.2	397	39.0	312	17.1	85	.0	247
Principe	6.3	196	49.7	158	24.5	38	.0	122
Residence								
Urban	2.9	2819	33.6	2186	18.1	633	.0	1650
Rural	3.9	1791	39.5	1424	19.3	367	.0	1077
Age								
15-19	2.5	1000	.	0	18.5	1000	.0	185
20-24	3.1	964	33.4	964	.	0	.0	564
25-29	2.9	790	33.0	790	.	0	.0	572
30-34	4.9	588	37.1	588	.	0	.0	462
35-39	4.4	511	39.7	511	.	0	.0	413
40-44	3.4	489	40.2	489	.	0	.0	346
45-49	2.4	268	36.3	268	.	0	.0	185
Mother's level of education								
None	7.3	271	50.9	257	22.4	14	.0	196
Primary	4.0	2988	42.3	2389	23.1	599	.0	1931
Secondary +	.8	1339	15.5	953	11.0	386	.0	593
Informal programme	8.8	12	74.7	11	46.8	2	.0	7
Wealth index quintiles								
Very poor	4.5	804	46.0	645	20.3	159	.0	469
Poor	4.5	826	41.5	658	26.9	167	.0	543
Middle income	5.3	906	44.4	708	31.1	198	.0	576
Wealthy	2.7	987	31.5	779	17.4	208	.0	564
Very wealthy	.5	1088	20.3	819	3.8	268	.0	576
Total	3.3	4610	35.9	3610	18.5	1000	.0	2727

* MICS indicator 67   ** MICS indicator 68   *** MICS indicator 70

Table CP.6: Spousal age difference
Percentage distribution of currently married/in union women aged 15-19 and 20-24 according to the age difference with their husband or partner,
São Tomé e Príncipe, 2006

	Percentage of women currently married/in union aged 15-19 whose husband is :						Number of women aged 15-19 currently married/ in union	Percentage of women currently married/in union aged 20-24 whose husband is :						Number of women aged 20-24 currently married/ in union
	Younger	0-4 older	5-9 older	10+ older*	Spouse age unknown	Total		Younger	0-4 older	5-9 older	10+ older*	Spouse age unknown	Total	
Region														
Agua-Grande		25.3	51.1	23.6	.0	100.0	76	4.8	38.6	39.4	17.2	.0	100.0	208
Mé-zochi		32.8	48.3	18.9	.0	100.0	37	.0	48.6	30.2	21.2	.0	100.0	155
Cantagalo		45.1	54.9	.0	.0	100.0	21	1.0	48.7	42.6	6.7	1.0	100.0	49
Caué		33.4	41.7	20.2	4.7	100.0	9	.0	44.6	36.5	17.4	1.6	100.0	22
Lembá		34.5	55.5	4.9	5.1	100.0	18	.6	47.9	35.0	14.8	1.7	100.0	50
Lobata		42.8	41.0	16.2	.0	100.0	15	2.0	42.3	36.8	14.0	5.0	100.0	43
Príncipe		15.5	69.9	14.6	.0	100.0	9	3.1	46.6	38.2	6.1	6.1	100.0	36
Residence														
Urban		30.7	51.5	17.4	.4	100.0	114	3.4	42.2	38.4	15.6	.5	100.0	321
Rural		32.2	50.4	16.3	1.2	100.0	71	.8	46.6	33.7	17.1	1.8	100.0	243
Age														
15-19		30.9	51.0	17.4	0.7	100.0	185	0.0	0.0	0.0	0.0	0.0	0.0	0
20-24	na	0.0	0.0	0.0	0.0	0.0	0	2.3	44.2	36.4	16.1	1.1	100.0	563
Mother's level of education														
None		26.4	44.3	29.2	.0	100.0	3	17.1	43.1	22.8	15.0	1.9	100.0	22
Primary		34.3	46.5	18.3	1.0	100.0	139	1.1	45.5	35.9	16.1	1.3	100.0	419
Secondary +		22.1	66.7	11.2	.0	100.0	42	3.6	39.6	39.9	17.0	.0	100.0	122
Informal programme		.0	43.8	56.2	.0	100.0	1	.0	.0	100.0	.0	.0	100.0	1
Wealth index quintiles														
Very poor		41.3	44.7	13.9	.0	100.0	32	2.3	45.5	36.8	13.8	1.7	100.0	119
Poor		36.5	50.0	10.6	3.0	100.0	45	.8	49.7	37.4	11.0	1.1	100.0	102
Middle income		28.9	49.0	22.1	.0	100.0	61	3.9	40.8	39.0	14.4	1.8	100.0	134
Wealthy		24.9	63.0	12.1	.0	100.0	36	3.0	47.6	29.1	19.9	.3	100.0	130
Very wealthy		12.4	45.8	41.8	.0	100.0	10	.0	34.4	41.8	23.7	.0	100.0	79
Total		31.2	51.1	17.0	.7	100.0	185	2.3	44.1	36.4	16.2	1.1	100.0	564

* MICS indicator 100

Table CP.9: Attitudes towards domestic violence. Percentage of women aged 15-49 who believe a husband is justified in beating his wife/partner in various circumstances, São Tomé e Príncipe, 2006

	Percentage of women aged 15-19 who believe a husband is justified in beating his partner when :						Number of women 15-49
	She goes out without letting him know	She neglects the children	She stands up to him in a discussion	She refuses sexual relations	She burns the meal	For all these reasons*	
Region							
Agua-Grande	9.1	16.1	13.8	3.6	6.8	26.3	1796
Mé-zochi	14.2	17.2	14.7	2.6	5.0	29.1	1238
Cantagalo	18.2	23.8	19.6	5.1	7.2	34.6	439
Caué	30.1	33.7	32.5	9.5	13.6	51.1	206
Lembá	23.4	29.8	26.6	9.5	11.1	43.7	337
Lobata	19.8	25.1	24.9	7.5	12.5	42.4	397
Principe	19.4	28.0	16.1	6.1	11.2	36.6	196
Residence							
Urban	12.3	19.3	16.4	4.8	7.6	30.1	2819
Rural	18.3	21.8	19.0	4.3	7.8	35.1	1791
Age							
15-19	15.0	23.4	18.0	4.9	8.9	34.0	1000
20-24	16.2	21.2	18.2	4.1	6.3	33.4	964
25-29	11.6	16.3	16.4	4.5	7.6	30.7	790
30-34	15.5	21.1	17.0	3.5	7.7	32.5	588
35-39	15.0	19.1	17.7	5.5	7.7	31.8	511
40-44	14.1	19.5	16.6	5.5	8.0	29.1	489
45-49	15.9	17.9	16.9	4.6	7.4	28.9	268
Family status							
Curently married/in union	15.6	20.7	18.5	4.8	8.5	34.1	2727
Separated/Divorced/Widowed	15.8	20.5	17.9	5.0	5.8	31.9	688
Single	11.8	19.0	14.6	3.9	6.7	27.4	1194
Mother's level of education							
None	25.5	25.8	25.8	8.2	11.9	41.8	271
Primary	16.8	23.2	20.6	5.5	8.5	36.2	2988
Secondary +	7.6	12.5	8.5	1.9	4.9	20.7	1339
Informal programme	20.6	12.3	26.0	.0	7.4	50.3	12
Wealth index quintiles							
Very poor	20.8	23.5	23.4	6.7	9.4	39.6	804
Poor	22.3	27.7	22.6	7.7	9.0	39.8	826
Middle income	15.8	20.8	19.0	3.6	8.1	33.7	906
Wealthy	11.7	21.0	18.1	3.1	6.3	31.6	987
Very wealthy	6.1	11.0	7.1	2.9	6.2	19.7	1088
Total	14.7	20.2	17.4	4.6	7.6	32.0	4610

* MICS indicator 100

Table CP.10: Child handicaps
Percentage of children 2-9 declared as handicapped by their mother/caretaker, by the nature of the handicap, São Tomé e Príncipe, 2006

	Percentage of children 2-9 declared as handicapped, by nature of the handicap											3-9 years		2 years	
	Late sitting, standing, walking	Day or night vision impaired	Seems to have difficulty in hearing	Does not understand instructions	Difficulty in walking, moving arms, weakness or stiffness	Has crises, stiffens, loses faints	Does not learn like other same aged children	Does not talk or cannot be understood	Appears mentally retarded, dull, or slow	Percentage of children 2-9 with at least 1 handicap	Number of children aged 2-9	Locution is not normal	Number of children 3-9	Incapable of naming at least 1 object	Number of children aged 2
Region															
Agua-Grande	1.3	.8	2.7	4.1	3.7	2.2	3.3	7.0	1.9	15.6	1573	22.9	1394	7.2	179
Mé-zochi	3.3	1.9	2.3	2.0	1.6	.6	1.2	6.2	1.4	12.8	1449	14.6	1273	11.3	176
Cantagalo	2.0	1.6	2.4	4.5	3.1	1.7	2.6	6.9	1.7	16.7	581	17.9	512	22.7	69
Caué	4.8	1.0	3.2	7.2	4.1	2.6	2.1	8.7	2.2	22.9	316	15.7	279	17.0	37
Lembá	4.9	1.3	4.0	4.9	2.5	2.1	2.4	7.6	1.9	19.8	419	12.0	366	15.6	53
Lobata	1.8	1.5	2.7	3.9	3.6	1.5	1.6	6.2	2.9	16.4	447	14.0	393	12.8	54
Príncipe	2.2	1.6	2.0	3.1	3.9	1.3	2.5	7.5	1.8	14.5	256	21.2	224	28.9	32
Residence															
Urban	2.7	1.2	2.8	4.3	3.7	1.9	2.7	7.1	1.8	17.2	2787	19.5	2461	12.0	327
Rural	2.4	1.6	2.5	3.0	2.1	1.2	1.7	6.6	1.9	13.9	2253	15.5	1980	14.6	273
Child's age (years)															
2-4	3.5	1.5	1.7	5.3	3.7	1.4	2.0	13.9	1.9	21.8	1668	3.5	1,5	1.7	5,3
5-6	1.9	1.0	3.4	3.7	2.7	1.9	2.7	4.3	1.4	13.1	1502	1.9	1,0	3.4	3,7
7-9	2.3	1.5	3.0	2.3	2.6	1.5	2.1	2.7	2.1	12.5	1871	2.3	1,5	3.0	2,3
Mother's level of education															
None	2.4	1.0	2.8	1.9	2.0	1.9	2.1	5.7	1.6	13.5	643	13.8	597	11.2	46
Primary	2.7	1.4	2.9	4.1	3.2	1.7	2.1	6.9	1.8	16.3	3544	18.1	3121	13.4	423
Secondary +	2.0	1.5	1.7	3.8	2.7	.9	3.1	7.7	2.0	15.3	838	19.3	708	12.4	130
Informal programme	3.6	.0	3.6	.0	.0	2.3	3.6	3.6	3.6	5.9	15	9.7	14	100.0	1
DK	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	0	.0	0	.	0
Wealth index quintiles															
Very poor	3.0	1.5	3.6	4.3	1.9	2.0	1.6	7.3	1.7	16.1	1083	14.5	962	18.7	122
Poor	2.3	.8	2.1	3.6	3.1	1.0	2.6	6.5	1.7	14.6	1076	18.5	958	15.3	118
Middle income	3.4	1.3	3.0	3.4	3.2	.9	2.2	7.4	1.7	17.3	1021	15.0	892	10.8	128
Wealthy	2.7	1.4	2.9	4.8	3.0	2.6	3.2	6.9	2.7	16.2	1000	22.8	863	13.6	138
Very wealthy	1.1	1.9	1.5	2.3	3.9	1.5	1.7	6.3	1.4	14.2	860	18.2	766	5.9	94
Total	2.5	1.4	2.7	3.7	3.0	1.6	2.3	6.9	1.8	15.7	5040	17.7	4440	13.2	600

* MICS indicator 101

Table HA.1: Knowledge of preventing HIV transmission

Percentage of women aged 15–49 who know the main ways of preventing HIV transmission, São Tomé e Príncipe, 2006

	Already heard talk of AIDS	Percentage of women who know transmission can be avoided by:			Know 3 ways of prevention	Know at least 1 way of transmission	Does not know any way	Number of women
		Have a single uninfected partner	Always use a condom	Abstain from sexual relations				
Region								
Agua-Grande	99.4	81.2	82.5	64.4	55.0	92.9	7.1	1796
Mé-zochi	97.1	73.7	75.4	52.9	42.4	89.4	10.6	1238
Cantagalo	91.7	62.7	63.7	42.8	35.2	75.5	24.5	439
Caué	90.7	67.0	63.7	44.9	35.1	78.3	21.7	206
Lembá	90.1	61.6	61.1	42.6	33.8	74.6	254	337
Lobata	97.4	75.2	74.1	58.2	47.2	87.0	13.0	397
Príncipe	97.3	69.3	73.2	57.0	50.1	80.4	19.6	196
Residence								
Urban	96.9	76.9	77.3	59.4	50.2	88.5	11.5	2819
Rural	96.4	70.3	72.1	50.5	40.5	85.3	14.7	1791
Age								
15-19	97.3	73.7	78.1	56.0	47.9	87.2	12.8	1000
20-24	97.8	77.6	79.9	59.2	52.6	90.0	10.0	964
25-29	97.7	76.3	75.3	56.5	45.6	90.0	10.0	790
30-34	96.8	74.8	74.1	56.0	45.2	86.7	13.3	588
35-39	96.8	67.1	70.9	52.9	40.8	83.0	17.0	511
40-44	94.4	73.1	72.7	50.8	42.2	84.3	15.7	489
45-49	91.3	73.9	63.0	57.4	41.8	84.6	15.4	268
Mother's level of education								
None	83.2	59.3	51.2	41.9	29.6	69.1	30.9	271
Primary	96.7	71.2	72.3	53.1	42.6	85.5	14.5	2988
Secondary +	99.4	84.7	86.8	65.3	58.4	94.9	5.1	1339
Informal programme	94.8	54.0	62.7	38.7	36.8	75.8	24.2	12
Wealth index quintiles								
Very poor	94.3	66.3	64.4	44.3	34.1	80.4	19.6	804
Poor	94.4	71.6	66.2	48.9	38.2	82.6	17.4	826
Middle income	97.5	71.9	75.5	56.4	46.7	86.6	13.4	906
Wealthy	97.4	75.9	79.2	58.1	50.3	89.1	10.9	987
Very wealthy	99.0	82.9	86.3	67.6	58.0	94.8	5.2	1088
Total	96.7	74.3	75.3	55.9	46.4	87.3	12.7	4610

Table HA.2: Identifying misconceptions about HIV/AIDS. Percentage of women aged 15-49 who correctly identify misconceptions about HIV/AIDS, São Tomé e Príncipe, 2006

	Percentage who know that:			Reject two most common misconceptions and know a healthy-looking person can be infected	Percentage who know that:		Number of women
	HIV cannot be transmitted by:		A healthy looking person can be infected		Option 3: Not by sharing food	Option 4: By sharing needles	
	Option 1: By supernatural means	Option2: By mosquito bites					
Region							
Agua-Grande	81,0	81,0	84,7	62,1	91,2	94,9	1796
Mé-zochi	79,4	75,1	71,1	50,4	88,2	92,5	1238
Cantagalo	68,7	63,1	67,9	40,9	77,6	85,9	439
Caué	63,7	66,4	63,2	39,5	75,2	81,6	206
Lembá	67,4	65,8	63,6	42,4	76,2	80,7	337
Lobata	74,2	73,9	66,9	46,1	84,5	90,5	397
Príncipe	82,6	75,2	66,4	47,5	88,2	91,6	196
Residence							
Urban	77,3	76,7	78,6	56,1	87,4	91,4	2819
Rural	76,8	72,6	68,4	46,7	85,3	91,0	1791
Age							
15-19	77,9	81,6	72,3	54,1	86,2	91,4	1000
20-24	81,1	78,5	76,9	57,0	89,1	93,1	964
25-29	78,9	77,0	77,8	53,6	90,2	92,1	790
30-34	77,3	75,4	75,7	52,7	89,9	93,3	588
35-39	76,5	68,6	70,2	48,6	87,1	89,3	511
40-44	72,3	65,5	73,9	47,1	76,6	87,4	489
45-49	63,6	62,2	73,3	43,9	78,0	87,1	268
Mother's level of education							
None	48.3	47.8	52.7	23.7	63.2	70.1	271
Primary	75.8	71.1	69.9	46.8	85.8	90.3	2988
Secondary +	85.8	89.8	89.7	71.2	93.1	97.5	1339
Informal programme	75.5	54.9	53.0	39.6	69.8	92.0	12
Wealth index quintiles							
Very poor	68.6	64.6	57.8	36.7	78.4	85.6	804
Poor	71.6	67.3	66.5	43.2	84.1	87.2	826
Middle income	76.8	73.2	74.0	47.9	89.0	91.3	906
Wealthy	78.7	79.0	80.9	58.2	86.6	93.2	987
Very wealthy	86.5	86.8	88.1	69.8	92.4	96.6	1088
Total	77.1	75.1	74.6	52.5	86.6	91.2	4610

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Table HA.3: Comprehensive knowledge of HIV/AIDS transmission
Percentage of women aged 15-49 who have comprehensive knowledge of HIV/AIDS transmission,
São Tomé e Príncipe, 2006

	Knowledge of at least 2 ways of transmitting HIV/AIDS	Identifies 3 ways of preventing HIV/AIDS transmission	Knowledge and understanding (identifies 2 preventive ways and 3 misconceptions *	Number of women
Region				
Agua-Grande	72.6	62.1	49.8	1796
Mé-zochi	61.1	50.4	36.5	1238
Cantagalo	53.1	40.9	26.8	439
Caué	55.8	39.5	28.8	206
Lembá	50.3	42.4	25.8	337
Lobata	64.2	46.1	35.3	397
Príncipe	63.4	47.5	30.4	196
Residence				
Urban	67.4	56.1	43.8	2819
Rural	59.0	46.7	32.2	1791
Age				
15-19	66.3	54.1	42.6	1000
20-24	68.7	57.0	44.7	964
25-29	67.5	55.5	43.6	1964
30-34	63.8	53.6	38.0	790
35-39	65.2	52.7	38.4	588
40-44	57.3	48.6	34.1	511
45-49	62.4	47.1	36.7	489
Mother's level of education				
None	44.0	23.7	16.3	271
Primary	60.1	46.8	32.8	2988
Secondary +	77.5	71.2	58.5	1339
Informal programme	428	39.6	25.2	12
Wealth index quintiles				
Very poor	53.0	36.7	25.9	804
Poor	56.9	43.2	28.9	826
Middle income	62.7	47.9	35.5	906
Wealthy	67.5	58.2	44.2	987
Very wealthy	76.1	69.8	55.7	1088
Total	64.1	52.5	39.3	4610

* MICS indicator 82; MDG indicator 19b

Table HA.4: Knowledge of mother-to-child HIV transmission
**Percentage of women aged 15-49 who correctly identify means of HIV transmission
from mother to child,
São Tomé e Príncipe, 2006**

	Know that AIDS can be transmitted from mother to child	Percentage who know that AIDS can be transmitted:				Does not know of a specific way	Number of women
		During pregnancy	During labour	By breastfeeding	The 3 ways*		
Region							
Agua-Grande	95.8	92.1	88.0	88.7	81.8	3.6	1796
Mé-zochi	91.3	88.4	82.5	81.4	75.4	5.8	1238
Cantagalo	85.1	80.9	75.5	77.2	69.4	6.7	439
Caué	80.9	78.6	70.7	73.1	67.1	9.8	206
Lembá	80.3	78.4	71.8	74.0	67.5	9.7	337
Lobata	92.2	88.4	82.2	82.5	74.5	5.1	397
Príncipe	91.3	85.9	85.1	86.9	79.2	6.1	196
Residence							
Urban	92.3	88.9	83.9	84.9	77.8	4.6	2819
Rural	89.7	86.2	80.8	80.6	74.3	6.7	1791
Age							
15-19	94.1	89.9	81.8	85.3	75.7	3.2	1000
20-24	93.1	89.4	85.1	85.6	78.8	4.7	964
25-29	91.2	87.6	83.7	83.0	77.1	6.6	790
30-34	91.5	89.4	83.2	85.0	78.6	5.3	588
35-39	88.1	84.7	80.1	77.3	72.1	8.7	511
40-44	87.6	85.6	83.0	80.7	76.9	6.8	489
45-49	86.5	81.7	78.1	79.7	71.8	4.7	268
Mother's level of education							
None	68.8	66.9	61.1	61.5	55.6	14.4	271
Primary	90.3	86.9	81.5	81.8	75.2	6.5	2988
Secondary +	98.2	94.6	90.3	91.0	83.7	1.2	1339
Informal programme	75.2	51.6	39.8	75.2	39.8	19.6	12
Wealth index quintiles							
Very poor	85.9	82.0	77.4	76.9	71.0	8.4	804
Poor	85.2	82.8	76.7	78.4	72.7	9.2	826
Middle income	91.1	87.8	83.0	80.9	74.3	6.4	906
Wealthy	93.6	89.4	84.4	86.6	78.7	3.8	987
Very wealthy	97.9	94.6	89.6	90.5	83.1	1.1	1088
Total	91.3	87.8	82.7	83.2	76.4	5.4	4610

* MICS indicator 89

Table HA.5: Attitudes towards people living with HIV/AIDS
Percentage of women aged 15-49 who have heard of AIDS and who express a
discriminatory attitude towards people living with HIV/AIDS,
São Tomé e Príncipe, 2006

	Percentage of women who :						
	Does not provide care for an AIDS-infected family member	Secrecy regarding a family member with HIV	An AIDS infected school teacher should not teach	Vegetables should not be bought from an AIDS infected vendor	Agree with at least one discriminatory view	Does not agree with at least one discriminatory view*	Number of women who have heard of AIDS
Region							
Agua-Grande	24.9	46.2	17.7	41.0	71.4	28.6	1785
Mé-zochi	29.6	46.9	24.8	43.6	77.8	22.2	1202
Cantagalo	35.5	42.9	34.2	51.8	81.2	18.8	403
Caué	47.1	48.1	35.6	58.5	87.1	12.9	187
Lembá	41.0	38.6	32.9	55.1	82.7	17.3	304
Lobata	34.2	37.6	31.8	52.5	78.4	21.6	386
Príncipe	24.3	32.7	26.8	44.6	74.1	25.9	191
Residence							
Urban	28.8	46.6	22.2	45.1	75.7	24.3	2731
Rural	31.8	40.8	28.1	46.2	76.9	23.1	1727
Age							
15-19	27.5	47.6	19.7	43.5	74.1	25.9	974
20-24	29.8	46.4	23.0	44.0	76.6	23.4	942
25-29	28.7	47.8	22.7	42.2	77.0	23.0	772
30-34	33.4	40.9	27.3	50.4	81.0	19.0	569
35-39	31.6	39.5	29.5	48.4	76.4	23.6	495
40-44	28.8	41.2	28.5	46.7	74.2	25.8	461
45-49	35.4	36.1	30.9	50.6	72.8	27.2	244
Mother's level of education							
None	47.3	38.3	42.7	60.2	85.1	14.9	225
Primary	34.7	41.6	29.9	51.0	78.8	21.2	2890
Secondary +	16.9	51.2	9.7	30.9	68.9	31.1	1331
Informal programme	17.3	41.8	37.5	76.9	89.2	10.8	12
Wealth index quintiles							
Very poor	42.5	42.2	36.0	58.3	84.7	15.3	758
Poor	38.4	42.5	33.5	54.4	79.9	20.1	779
Middle income	33.8	40.9	29.8	47.3	75.0	25.0	883
Wealthy	25.7	45.7	19.9	43.8	76.0	24.0	961
Very wealthy	15.8	48.7	9.7	30.3	68.6	31.4	1077
Total	30.0	44.3	24.5	45.5	76.2	23.8	4458

* MICS indicator 86

Table HA.6: Knowledge of a facility for HIV testing
Percentage of women aged 15-49 who know where to get an HIV test, percentage of
women who have been tested and of those tested the percentage who have been told
the result,
São Tomé e Príncipe, 2006

	Knowledge of a testing facility*	Has already been tested**	Number of women	Has been tested and knows the result	Number of women who have been tested
Region					
Agua-Grande	81.4	50.4	1796	94.7	906
Mé-zochi	66.9	30.2	1238	96.1	373
Cantagalo	58.0	28.8	439	82.5	126
Caué	42.1	15.1	206	73.3	31
Lembá	43.9	18.5	337	77.4	63
Lobata	63.0	29.6	397	88.9	117
Príncipe	76.4	36.5	196	50.3	72
Residence					
Urban	72.6	40.8	2819	92.0	1150
Rural	63.3	30.0	1791	88.3	538
Age					
15-19	63.2	19.3	1000	93.1	193
20-24	78.3	50.0	964	88.4	482
25-29	74.6	47.0	790	91.8	372
30-34	67.6	41.6	588	91.0	245
35-39	65.3	37.0	511	88.4	189
40-44	64.2	31.1	489	94.6	152
45-49	59.5	20.6	268	93.7	55
Mother's level of education					
None	32.1	15.5	271	75.5	42
Primary	63.8	34.3	2988	89.7	1026
Secondary +	88.1	45.9	1339	94.0	614
Informal programme	60.8	47.4	12	57.2	6
Wealth index quintiles					
Very poor	53.3	25.4	804	84.0	204
Poor	58.7	30.5	826	84.7	252
Middle income	65.8	33.3	906	89.5	301
Wealthy	75.2	40.9	987	91.0	404
Very wealthy	85.4	48.4	1088	97.0	527
Total	69.0	36.6	4610	90.8	1688

* MICS indicator 87
** MICS indicator 88

Table HA.7: HIV testing and counselling coverage during pre-natal care
Percentage of women aged 15-49 who gave birth in the two years preceding the
survey and who were offered HIV testing and counselling with their pre-natal care,
São Tomé e Príncipe, 2006

	Percentage of women who :				
	Have received pre-natal care during their last pregnancy	Have received information on HIV prevention during their visit to the health centre	Were tested during a visit to a health centre	Received the result of their HIV test during a visit to the health centre **	Number of women who gave birth during the last 2 years before the survey
Region					
Agua-Grande	98.6	77.3	83.5	80.9	454
Mé-zochi	97.5	70.8	53.1	50.7	297
Cantagalo	93.3	60.8	42.4	36.1	127
Caué	90.4	63.8	31.4	21.5	63
Lembá	97.7	60.0	27.5	21.5	116
Lobata	98.8	72.6	51.4	45.0	108
Príncipe	98.6	62.4	57.1	18.2	66
Residence					
Urban	97.5	72.1	66.4	61.3	740
Rural	97.0	68.1	49.7	42.5	491
Age					
15-19	97.7	61.7	64.8	59.7	151
20-24	98.2	74.4	61.3	54.4	399
25-29	97.7	67.9	59.1	53.9	289
30-34	94.8	70.1	54.8	51.1	178
35-39	97.0	73.2	58.5	50.7	214
Mother's level of education					
None	95.2	44.2	33.2	22.5	76
Primary	97.0	68.9	55.2	49.3	892
Secondary +	99.3	83.9	83.2	78.6	261
Informal programme	.0	.0	.0	.0	1
Wealth index quintiles					
Very poor	97.5	60.3	44.2	36.7	271
Poor	93.2	61.4	46.2	39.8	260
Middle income	97.4	70.9	53.5	48.3	236
Wealthy	99.1	82.9	75.5	68.7	260
Very wealthy	100.0	79.4	84.9	81.7	205
Total	97.3	70.5	59.8	53.8	1230

* MICS indicator 90
** MICS indicator 91

Table HA.8: Sexual behaviour that increases risk of HIV infection
Percentage of young women aged 15-19 who had sex before age 15, percentage of young women aged 20-24 who had sex before age 18, and percentage of young women aged 15-24 who had sex with a man 10 or more years older, São Tomé e Príncipe, 2006

	Percentage of women aged 15-19 who have had sexual relations before 15*	Number of women 15-19	Percentage of women aged 20-24 who have had sexual relations before 18**	Number of women 20-24	Percentage who had sex in the 12 months preceding the survey with a man 10 or more years older**	Number of women who had sex in the 12 months preceding the survey
Region						
Agua-Grande	8.2	409	48.9	399	14.4	507
Mé-zochi	4.9	259	52.6	258	13.4	325
Cantagalo	18.6	89	66.0	84	4.5	108
Caué	11.5	47	53.2	31	16.5	42
Lembá	11.0	74	64.7	67	10.2	90
Lobata	10.8	85	46.3	78	10.8	96
Príncipe	9.4	38	68.1	47	7.3	60
Residence						
Urban	9.3	633	51.5	592	12.3	742
Rural	8.3	367	56.3	371	12.6	486
Age						
15-19	8.9	1000	.	0	9.0	402
20-24	.	0	53.4	964	14.1	826
Mother's level of education						
None	15.9	14	66.1	32	18.7	30
Primary	11.3	599	60.7	603	12.4	788
Secondary +	5.1	386	38.4	328	11.8	408
Informal programme	.0	2	100.0	2	60.0	2
Wealth index quintiles						
Very poor	11.5	159	61.3	175	10.7	227
Poor	12.8	167	59.0	153	8.8	210
Middle income	11.3	198	59.1	200	13.0	274
Wealthy	7.3	208	48.7	227	16.1	273
Very wealthy	4.5	268	42.1	208	12.2	244
Total	8.9	1000	53.4	964	12.4	1228

* MICS indicator 84
** MICS indicator 92

Table HA.9: Condom use at last high-risk sex

Percentage of young women aged 15-24 who had high-risk sex in the previous year and who used a condom at last high-risk sex, São Tomé e Príncipe, 2006

	Never had sex	Has had sex during the last 12 months	Has sex with more than 1 partner during the last 12 months	Number of women 15-24	Percentage of those who had sex in last 12 months, with non-marital, non-cohabiting partner in the last 12 months*	Number of women 15-24 who had sex in the last 12 months	Percentage of women who had a non-marital, non-cohabiting partner in the last 12 months, who used a condom at last sex with such a partner****	Number of women 15-24 who had sex in the last 12 months with a non-marital, non-cohabiting partner*
Region								
Agua-Grande	67.5	62.7	2.5	808	42.4	507	53.5	215
Mé-zochi	66.7	62.9	.2	517	30.6	325	63.9	100
Cantagalo	67.8	62.1	1.5	173	25.4	108	43.7	27
Caué	60.4	54.4	.9	78	22.4	42	49.4	9
Lembá	67.9	63.7	2.3	141	17.6	90	46.2	16
Lobata	63.5	58.9	.7	163	34.5	96	65.7	33
Principe	73.6	71.5	2.5	85	18.3	60	64.0	11
Residence								
Urban	65.3	60.5	2.2	1226	38.4	742	54.3	285
Rural	69.8	65.8	.7	738	26.0	486	60.8	126
Age								
15-19	43.3	40.1	1.1	1000	46.5	401	53.4	225
20-24	91.7	85.8	2.2	963	27.2	826	58.6	187
Mother's level of education								
None	69.9	65.4	2.8	45	15.9	30	34.6	5
Primary	69.9	65.6	1.2	1202	23.8	788	49.9	188
Secondary +	61.8	57.2	2.1	714	53.5	408	62.3	218
Informal programme	80.8	47.9	.0	3	31.4	2	.0	0
Wealth index quintiles								
Very poor	75.5	68.1	1.2	334	28.4	227	45.0	65
Poor	71.2	65.5	2.2	320	20.1	210	58.3	42
Middle income	73.2	68.8	1.2	398	25.2	274	58.4	69
Wealthy	65.1	62.6	2.0	436	34.1	273	57.3	93
Very wealthy	54.8	51.3	1.5	477	58.2	244	59.1	142
Total	67.0	62.5	1.6	1964	33.5	1228	56.3	411

* MICS indicator 85   ** MICS indicator 83; MDG indicator 19a

Table HA.10: Children's living arrangements and orphanhood

Percentage distribution of children aged 0-17 years according to living arrangements, percentage of children aged 0-17 in households not living with a biological parent and percentage of children who are orphans, São Tomé e Príncipe, 2006

	Living with both parents	Children living without any parent				Living with their mother only		Living with their father only		Not possible to determine	Total	Does not live with biological parents*	One of two parents is dead**	Number of children
		Only the father is alive	Only the mother is alive	Both parents alive	Both parents dead	Father living	Father dead	Mother living	Mother dead					
Sex														
Male	50.5	1.5	.8	12.7	.2	26.7	3.3	3.6	.5	.1	100.0	15.3	6.4	5633
Female	50.8	1.6	.7	13.3	.2	27.1	2.9	2.6	.4	.3	100.0	15.8	6.0	5360
Region														
Agua-Grande	46.1	1.8	1.0	15.6	.2	29.2	2.8	2.8	.1	.4	100.0	18.6	6.0	3561
Mé-zochi	47.4	2.2	.2	13.2	.0	30.2	2.7	3.2	.6	.2	100.0	15.7	5.8	3123
Cantagalo	56.6	.2	.7	10.9	.6	23.1	4.0	2.9	.7	.2	100.0	12.4	6.2	1140
Caué	65.2	.8	1.2	10.4	.1	15.0	3.7	3.0	.4	.2	100.0	12.5	6.2	648
Lembá	58.5	1.0	1.1	10.3	.5	21.3	4.1	2.7	.4	.0	100.0	13.0	7.2	927
Lobata	54.7	1.3	1.3	10.1	.4	24.2	3.0	4.1	.9	.1	100.0	13.0	6.8	1048
Príncipe	47.5	1.0	.9	11.7	.3	29.2	3.9	4.6	.7	.2	100.0	13.9	6.8	547
Residence														
Urban	50.0	1.6	.9	13.4	.3	26.7	3.2	3.2	.4	.3	100.0	16.3	6.4	6214
Rural	51.4	1.5	.6	12.3	.2	27.1	3.1	3.1	.6	.2	100.0	14.6	5.9	4780
Age														
0-4	65.9	.5	.1	3.2	.0	28.1	1.1	.8	.1	.2	100.0	3.7	1.8	2992
5-9	50.6	1.6	.6	13.9	.3	26.0	2.8	3.7	.5	.1	100.0	16.4	5.8	3372
10-14	42.2	2.2	1.2	17.9	.4	26.7	4.1	4.3	.7	.3	100.0	21.7	8.6	3138
15-17	37.8	2.2	1.5	20.1	.4	26.9	5.8	4.0	.7	.6	100.0	24.2	10.8	1490
Wealth index quintiles														
Very poor	42.7	1.1	.8	11.4	.1	36.7	3.9	2.3	.9	.2	100.0	13.3	6.7	2266
Poor	53.3	1.4	.4	10.1	.2	28.7	2.6	3.1	.3	.1	100.0	12.0	4.8	2254
Middle income	52.4	1.3	.6	11.9	.5	24.3	3.7	4.5	.4	.4	100.0	14.3	6.5	2172
Wealthy	51.3	2.1	.7	14.3	.3	25.0	3.2	2.2	.6	.3	100.0	17.4	6.9	2251
Very wealthy	53.8	1.9	1.4	17.5	.2	18.9	2.3	3.7	.2	.1	100.0	21.0	5.9	2050

* MICS indicator 78
** MICS indicator 75

Table HA.11: Prevalence of orphanhood and vulnerability among children
Percentage of children aged 0-17 who are orphaned or vulnerable due to AIDS,
São Tomé e Príncipe, 2006

	Parents very ill	1 family adult is dead	Adult with chronic illness in the household	Vulnerable children*	One of 2 parents dead**	Orphans and vulnerable children	Number of children aged 0-17
Sex							
Male	1.0	1.2	3.1	5.2	6.4	10.6	5633
Female	1.0	1.2	3.1	5.2	6.0	10.3	5360
Region							
Agua-Grande	2.1	1.7	2.4	6.1	6.0	11.1	3561
Mé-zochi	.4	.2	2.1	2.8	5.8	8.2	3123
Cantagalo	.3	1.9	4.1	5.9	6.2	11.2	1140
Caué	.5	1.8	4.7	6.9	6.2	11.7	648
Lembá	.4	2.1	5.9	8.1	7.2	13.3	927
Lobata	.9	1.0	2.9	4.7	6.8	10.5	1048
Príncipe	.7	.1	4.9	5.7	6.8	11.2	547
Residence							
Urban	1.5	1.7	3.3	6.3	6.4	11.7	6214
Rural	.4	.6	2.8	3.7	5.9	8.9	4780
Age							
0-4	.6	.9	3.2	4.6	1.8	6.1	2992
5-9	1.0	1.6	2.9	5.3	5.8	10.0	3372
10-14	1.5	1.0	3.3	5.7	8.6	13.2	3138
15-17	1.0	1.2	2.9	5.1	10.8	14.6	1490
Wealth index quintiles							
Very poor	1.1	1.8	5.3	8.0	6.7	13.3	2266
Poor	.4	.6	3.1	3.8	4.8	8.0	2254
Middle income	.9	1.3	2.4	4.6	6.5	9.9	2172
Wealthy	1.3	1.1	2.5	4.9	6.9	11.2	2251
Very wealthy	1.4	1.2	2.2	4.7	5.9	9.9	2050
Total	1.0	1.2	3.1	5.2	6.2	10.5	10993

* MICS indicator 76
** MICS indicator 75

Table HA.12: School attendance, orphaned and vulnerable children

School attendance by orphaned and vulnerable status among children aged 10-14,

São Tomé e Príncipe, 2006

	Percentage of children whose parents are dead	School attendance rate for children whose parents are dead	Percentage of children whose parents are alive and the child is living with at least one of them	School attendance rate for children whose parents are alive and the child is living with at least one of them	School attendance rate for orphans and vulnerable children *	Percentage of orphans and vulnerable children	School attendance rate for orphans and vulnerable children	Percentage of children who are neither orphans nor vulnerable	School attendance rate children who are neither orphans nor vulnerable	School attendance rate for orphans/ vulnerable children, and for non orphans/ vulnerable	Total number of children aged 10-14
Sex											
Male	.3	100.0	73.3	90.6	1.10	13.2	84.4	86.8	90.6	.93	1586
Female	.5	100.0	73.1	90.1	1.11	13.2	82.8	86.8	91.1	.91	1553
Region											
Agua-Grande	.5	100.0	68.1	95.6	1.05	13.6	88.2	86.4	95.3	.92	1006
Mé-zochi	.2	100.0	74.1	88.2	1.13	11.8	75.7	88.2	89.3	.85	914
Cantagalo	.5	100.0	77.6	87.1	1.15	14.6	81.9	85.4	87.7	.93	284
Caué	.0	.	77.2	84.5	.	12.9	79.8	87.1	84.4	.95	190
Lembá	.3	100.0	75.6	83.1	1.20	15.6	76.9	84.4	84.6	.91	260
Lobata	1.1	100.0	76.6	92.3	1.08	13.8	92.0	86.2	91.8	1.00	334
Principe	.5	100.0	76.8	92.9	1.08	11.1	100.0	88.9	92.7	1.08	151
Residence											
Urban	.5	100.0	68.1	95.6	1.05	13.6	88.2	86.4	95.3	.92	1006
Rural	.2	100.0	74.1	88.2	1.13	11.8	75.7	88.2	89.3	.85	914
Wealth index quintiles											
Very poor	.0	.	73.2	83.8	.	18.3	73.0	81.7	84.1	.87	616
Poor	.4	100.0	80.3	85.5	1.17	8.0	77.4	92.0	85.8	.90	620
Middle income	.5	100.0	76.4	90.8	1.10	12.4	80.5	87.6	91.4	.88	590
Wealthy	.4	100.0	70.6	93.7	1.07	12.8	90.6	87.2	94.4	.96	676
Very wealthy	.6	100.0	66.0	98.7	1.01	14.5	95.8	85.5	98.0	.98	636
Total	.4	100.0	73.3	90.5	1.09	13.2	83.5	86.8	90.7	.92	3138

* MICS indicator 77; MDG indicator 20

Table HA.13: Support to AIDS orphans and children made vulnerable by AIDS

Percentage of children aged 0-17 orphaned or made vulnerable by AIDS whose households have received outside support, São Tomé e Príncipe, 2006

	Percentage of orphans and vulnerable children whose household is a recipient of aid :							Number of orphans and vulnerable children 1-17
	Medical assistance during the last 12 months	Emotional and psychological assistance during the last 3 months	Material/school assistance during the last 3 months	Educational assistance during the last 12 months	One type of assistance*	All	None	
Sex								
Male	1.6	.6	1.9	1.2	3.8	.1	96.2	599
Female	1.0	1.5	2.7	1.8	5.0	.1	95.0	551
Region								
Água-Grande	.0	1.5	.0	.0	1.5	.0	98.5	395
Mé-zochi	.0	.0	2.8	2.3	2.8	.0	97.2	257
Cantagalo	1.5	.5	2.5	.8	4.8	.0	95.2	128
Caué	7.3	1.7	3.7	2.2	8.6	1.1	91.4	76
Lembá	.4	2.0	6.4	5.8	11.4	.0	88.6	123
Lobata	3.1	1.8	1.6	.9	5.6	.0	94.4	110
Príncipe	6.6	.0	5.2	1.1	6.6	.0	93.4	61
Residence								
Urban	1.0	1.4	1.4	1.5	4.0	.1	96.0	724
Rural	1.9	.5	3.7	1.5	5.0	.0	95.0	426
Age								
0-4	2.4	.6	1.1	.0	2.6	.2	97.4	182
5-9	1.2	2.4	3.3	2.4	6.2	.0	93.8	337
10-14	1.3	.7	2.0	1.5	3.9	.0	96.1	415
15-17	.7	.2	2.1	1.4	3.8	.2	96.2	217
Wealth index quintiles								
Very poor	.7	.8	1.4	1.6	3.3	.0	96.7	300
Poor	4.5	1.1	2.1	.0	5.5	.0	94.5	181
Middle income	1.6	.6	3.8	1.8	4.7	.4	95.3	215
Wealthy	.6	.3	2.1	1.9	3.8	.0	96.2	252
Very wealthy	.0	.9	2.3	1.9	5.2	.0	94.8	202
Total	1.3	1.1	2.3	1.5	4.3	.1	95.7	1150

* MICS Indicator 81

Table HA.14: Malnutrition among orphans and vulnerable children
Percentage of children aged 0-4 years that are moderately or severely underweight, stunted or wasted by orphanhood and vulnerability due to AIDS,
São Tomé e Príncipe, 2006

	Percentage of children 0-4 who are moderately or severely :			Number of children 0-4
	Underweight	Stunted	Wasted	
Status				
Orphans	11.21	33.48	11.92	54
Vulnerable	8.67	22.40	5.28	127
Orphans or vulnerable	9.90	26.01	7.63	173
Neither orphans nor vulnerable	9.15	22.75	8.03	2675
	9.19	22.95	8.00	2848
Total	1.08	1.14	.95	.

*MICS Indicator 79

Table HA.15: Sexual behaviour among young women by orphanhood and vulnerability status due to AIDS
Percentage of young women aged 15-17 who had sex before age 15 by vulnerability status and survival status of parents,
São Tomé e Príncipe, 2006

	Percentage of women aged 15-17 who had sexual relations before 15	Number of women aged 15-17
Status		
Orphan	7.78	66
Vulnerable	9.04	38
Orphan or vulnerable	8.16	93
Neither orphan nor vulnerable	9.18	512
	9.02	605
Total	7.78	66
		.
Ratio OVC to non-OVC*	.89	.

APPENDIX D: DATA QUALITY TABLES

		Male		Female	
		Effective	%	Effective	%
Age	0	327.71	2.86	363.11	3.23
	1	319.29	2.78	314.50	2.80
	2	292.34	2.55	307.36	2.73
	3	318.99	2.78	270.19	2.40
	4	244.28	2.13	234.44	2.08
	5	392.16	3.42	393.51	3.50
	6	347.14	3.02	368.72	3.28
	7	342.74	2.99	282.17	2.51
	8	303.59	2.65	311.41	2.77
	9	327.09	2.85	303.88	2.70
	10	346.91	3.02	271.52	2.41
	11	291.75	2.54	305.77	2.72
	12	338.05	2.95	320.13	2.85
	13	312.40	2.72	279.70	2.49
	14	296.60	2.58	375.48	3.34
	15	286.21	2.49	231.51	2.06
	16	304.64	2.65	205.69	1.83
	17	241.47	2.10	220.79	1.96
	18	329.79	2.87	237.68	2.11
	19	269.57	2.35	192.08	1.71
	20	293.28	2.56	215.63	1.92
	21	199.27	1.74	219.67	1.95
	22	270.32	2.36	211.62	1.88
	23	216.13	1.88	196.48	1.75
	24	160.70	1.40	193.29	1.72
	25	193.20	1.68	215.87	1.92
	26	150.35	1.31	186.47	1.66
	27	175.63	1.53	153.11	1.36
	28	132.96	1.16	159.53	1.42
	29	177.47	1.55	137.40	1.22
	30	162.85	1.42	158.02	1.40
	31	104.86	0.91	121.90	1.08
	32	136.08	1.19	114.80	1.02
	33	107.47	0.94	110.27	0.98
	34	121.86	1.06	133.42	1.19
	35	135.00	1.18	114.44	1.02
	36	119.85	1.04	110.46	0.98
	37	104.17	0.91	101.80	0.90
	38	89.37	0.78	114.03	1.01
	39	97.62	0.85	108.48	0.96
	40	120.72	1.05	116.57	1.04
	41	69.70	0.61	88.09	0.78
	42	106.83	0.93	126.34	1.12

Table DQ.1:Age distribution of household population
Single-year age distribution of household population by sex (weighted), São Tomé e Príncipe, 2006

	43	81.72	0.71	111.10	0.99
	44	67.40	0.59	85.46	0.76
	45	87.27	0.76	67.19	0.60
	46	67.98	0.59	66.68	0.59
	47	66.76	0.58	69.20	0.62
	48	80.33	0.70	54.77	0.49
	49	69.60	0.61	32.12	0.29
	50	94.75	0.83	152.02	1.35
	51	44.05	0.38	90.52	0.80
	52	69.97	0.61	89.58	0.80
	53	65.53	0.57	67.50	0.60
	54	34.49	0.30	101.88	0.91
	55	57.01	0.50	58.45	0.52
	56	63.12	0.55	26.50	0.24
	57	32.16	0.28	46.06	0.41
	58	49.49	0.43	38.04	0.34
	59	28.00	0.24	54.95	0.49
	60	53.67	0.47	60.55	0.54
	61	25.53	0.22	35.48	0.32
	62	51.99	0.45	58.48	0.52
	63	44.67	0.39	38.42	0.34
	64	15.32	0.13	35.06	0.31
	65	30.39	0.26	53.94	0.48
	66	39.77	0.35	33.36	0.30
	67	44.54	0.39	36.61	0.33
	68	45.06	0.39	44.43	0.39
	69	41.61	0.36	43.72	0.39
	70	33.16	0.29	39.73	0.35
	71	14.58	0.13	25.96	0.23
	72	33.89	0.30	39.27	0.35
	73	40.96	0.36	36.83	0.33
	74	23.25	0.20	17.79	0.16
	75	22.27	0.19	30.23	0.27
	76	17.33	0.15	24.05	0.21
	77	15.15	0.13	16.99	0.15
	78	12.50	0.11	27.32	0.24
	79	7.94	0.07	9.70	0.09
	80+	85.62	0.75	119.98	1.07
	DK	40.08	0.35	13.33	0.12
Total		**11477.28**	**100.00**	**11250.61**	**100.00**

Table DQ.2:Age distribution of eligible and interviewed women						
Household population of women age 10-54, interviewed women age 15-49, and percentage of eligible women who were interviewed (weighted), by five-year age group, São Tomé e Príncipe, 2006						
		Female household population aged 10-54	Women 15-49 surveyed		Percentage of affected women surveyed	
		Effective	Effective	%		
Age	10-14	1552.61	.	.	.	
	15-19	1087.75	1000.47	21.70	91.98	
	20-24	1036.69	963.52	20.90	92.94	
	25-29	85238	790.21	17.14	92.71	
	30-34	638,40	588.12	12.76	92.12	
	35-39	549,.22	511.30	11.09	93.10	
	40-44	527.56	488.61	10.60	92.62	
	45-49	289.97	267.79	5.81	92.35	
	50-54	501.50	.	.	.	
15-49		**4981.97**	**4610.02**	**100.00**	**92.53**	

Table DQ.3:Age distribution of eligible and interviewed under-5s				
Household population of children aged 0-4, children whose mothers/caretakers were interviewed, and percentage of under-5 children whose mothers/caretakers were interviewed (weighted), by five-year age group, São Tomé e Príncipe, 2006				
		Percentage of affected children surveyed	Questionnaires for children 0-4		Percentage of affected children surveyed
		Effective	Effective	%
Age	0	690.82	689.47	23.32	99,80
	1	633.80	627.21	21.21	98,96
	2	599.70	592.85	20.05	98,86
	3	589.18	577.62	19.54	98,04
	4	478.72	469.32	15.87	98,04
	5	785.67	.	.	.
	6	715.87	.	.	.
	7	624.91	.	.	.
0-4		2992.22	2956.47	100.00	98,81

Table DQ.4:Age distribution of under-5 children Age distribution of under-5 children by 3-month groups (weighted), São Tomé e Príncipe, 2006							
		Male		Female		Total	
		Effective	%	Effective	%	Effective	%
Age in months	0-2	81.07	5.17	92.06	5.92	173.13	5.54
	3-5	87.91	5.60	101.78	6.54	189.68	6.07
	6-8	86.89	5.54	90.27	5.80	177.16	5.67
	9-11	79.57	5.07	85.42	5.49	164.99	5.28
	12-14	97.71	6.23	118.28	7.60	215.99	6.91
	15-17	72.42	4.61	68.32	4.39	140.74	4.50
	18-20	71.50	4.56	89.11	5.73	160.61	5.14
	21-23	95.17	6.06	60.08	3.86	155.25	4.97
	24-26	81.46	5.19	85.37	5.49	166.83	5.34
	27-29	98.58	6.28	72.08	4.63	170.66	5.46
	30-32	73.68	4.69	77.48	4.98	151.16	4.84
	33-35	53.01	3.38	74.33	4.78	127.34	4.07
	36-38	99.74	6.36	103.34	6.64	203.09	6.50
	39-41	63.39	4.04	58.87	3.78	122.26	3.91
	42-44	74.46	4.74	64.92	4.17	139.38	4.46
	45-47	92.70	5.91	65.27	4.20	157.98	5.06
	48-50	78.21	4.98	80.92	5.20	159.13	5.09
	51-53	66.63	4.25	65.72	4.22	132.35	4.24
	54-56	62.25	3.97	39.55	2.54	101.80	3.26
	57-59	53.07	3.38	62.46	4.02	115.53	3.70
Total		1569.42	100.00	1555.64	100.00	3125.06	100.00

Table DQ.5: Heaping on ages and periods
Age and period ratios at boundaries of eligibility by type of information collected (weighted), São Tomé e Príncipe, 2006

	Age and period ratios*			Limit of eligibility(lower-upper)	Module or questionnaire			
	Males	Females	Total					
Age in administered household questionnaire								
1	1.02	0.96	0.99					
2	0.94	1.03	0.99	Lower	Child discipline and handicapped children			
3	1.12	1.00	1.06					
4	0.77	0.78	0.77	Upper	Under 5 questionnaire			
5	1.20	1.18	1.19	Lower	Child labour and education			
6	0.96	1.06	1.01					
8	0.94	1.04	0.99					
9	100	1.03	1.02	Upper	Handicapped children			
10	1.08	0.92	1.00					
13	0.99	0.86	0.92					
14	0.99	1.27	1.13	Upper	Child labour and discipline			
15	0.97	0.85	0.91	Lower	Women's questionnaire			
16	1.10	0.94	1.03					
17	0.83	1.00	0.90	Upper	Orphans and vulnerable children			
18	0.86	1.02	0.93					
23	1.00	0.98	0.99					
24	0.85	0.96	0.90	Upper	Education			
25	1.15	1.09	1.12					
	.	.	.					
48	1.11	1.05	1.09					
49	0.85	0.40	0.63	Upper	Women's questionnaire			
50	1.36	1.66	1.53					
Age in women's questionnaire								
23	Na	1.00	Na					
24	na	0.95	Na	Upper	Sexual behaviour			
25	na	1.10	Na					
Months since last birth in women's questionnaire								
6-11	na	0.96	Na					
12-17	na	1.08	Na					
18-23	na	0.94	Na	Upper	Tetanus toxoid and mother's and child health			
24-29	na	1.11	Na					
30-35	na	0.85	Na					

* The age or period ratios are calculated according to the formula $x / ((x_{n-1} + x_n + x_{n+1}) / 3)$, x being the age or the period

Table DQ.6: Completeness of reporting
Percentage of observations missing information for selected questions and indicators (weighted),
São Tomé e Príncipe, 2006

Questionnaire and number	Reference group	Percentage of missing information*	Number of cases
Household			
Salt test	All households surveyed	0.00	5625
Women			
Date of birth	All married women aged 15-49		
Month only		0,00	
Missing month and year		0.64	4610
Date of first childbirth	All married women aged 15-49 with at least one live birth		
Month only		1.29	3315
Missing month and year		6.71	3315
Number of years after first childbirth	All married women aged 15-49 with at least one live birth	0.00	242
Date of last childbirth	All married women aged 15-49 with at least one live birth		
Month only		1.01	3315
Missing month and year		0.64	3315
Date of first marriage/in union	All married women aged 15-49		
Month only		3.74	3416
Missing month and year		62.93	3416
Age of first marriage/in union	All married women aged 15-49	0.44	3416
Age of first sexual relation	All women aged 15-24 who have already had a sexual relation	0.00	1964
Time since last sexual relation	All women aged 15-24 who have already had a sexual relation	0.00	1316
Under-5			
Date of birth	All children under 5 surveyed		
Month only		0.11	3125
Missing month and year		0.07	3125
Anthropometry	All children under 5 surveyed		
Height		0.00	3125
Weight		0.00	3125
Height or weight		0.00	3125

* Includes responses of « does not know »

	Table DQ.7: Presence of mother in the household and the person interviewed for the under-5 questionnaire Distribution of children under five by whether the mother lives in the same household, and the person interviewed for the under-5 questionnaire (weighted), São Tomé e Príncipe, 2006									
	Mother living in the same household					**Mother not living in the same household**				
	Mother surveyed	Father surveyed	Other adult female surveyed	Other adult male surveyed		Father surveyed	Other adult female surveyed	Other adult male surveyed	Total	Number of children 0-4
Age										
0	99.19	0.00				0.00	0.81	0.00	100	691
1	97.57	0.44				0.11	1.88	0.00	100	634
2	95.46	0.00				0.66	3.89	0.00	100	600
3	90.00	0.00				1.09	8.29	0.62	100	589
4	92.33	0.00				0.52	7.15	0.00	100	479
Total	95.19	0.09				0.45	4.14	0.12	100	2992

Table DQ.8: School attendance by single age
Distribution of household population aged 5-24 by educational level and grade attended in the current year (weighted),
São Tomé e Príncipe, 2006

Age	Primary							Secondary						University	Informal programme	NS	Does not go to school	Total	Effective
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	11.00	12.00						
5	34.65	1.92	0.00	0.00	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	63.35	100	786
6	18.71	31.39	4.27	0.92	0.00	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.14	44.51	100	716
7	1.74	53.32	25.98	4.43	0.86	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.92	100	625
8	0.55	24.50	44.18	24.13	2.42	0.67	0.00	0.12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.43	100	615
9	0.00	7.75	27.14	45.48	16.96	1.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.10	100	631
10	0.00	2.43	18.14	31.55	29.47	13.16	1.68	0.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.44	100	618
11	0.00	0.26	6.80	19.83	30.38	23.12	12.93	1.35	0.08	0.07	0.00	0.00	0.00	0.00	0.00	0.00	5.16	100	598
12	0.00	0.05	5.11	11.65	19.73	20.68	26.94	6.64	0.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.82	100	658
13	0.00	1.02	1.81	9.81	11.88	21.59	23.00	14.63	3.92	0.16	0.00	0.00	0.00	0.00	0.00	0.00	12.19	100	592
14	0.00	0.08	0.56	2.18	8.89	14.00	21.64	18.45	11.32	3.03	0.00	0.00	0.00	0.00	0.00	0.00	19.87	100	672
15	0.00	0.00	0.00	1.05	4.05	6.44	18.48	21.07	14.02	4.74	2.27	0.29	0.00	0.00	0.00	0.00	27.57	100	518
16	0.00	0.06	0.10	0.00	0.84	2.71	7.96	15.66	16.84	9.87	3.12	0.48	0.00	0.00	0.12	0.00	42.23	100	510
17	0.00	0.00	0.00	0.18	0.95	0.59	3.11	7.17	15.74	12.16	5.01	1.18	0.00	0.00	0.00	0.00	53.91	100	462
18	0.00	0.05	0.05	0.38	0.38	1.74	2.59	6.26	8.25	13.73	6.48	3.80	0.27	0.33	0.29	0.00	55.40	100	567
19	0.00	0.00	0.08	0.10	0.24	0.39	1.63	1.79	4.11	12.73	3.46	3.85	0.00	0.00	0.29	0.00	71.35	100	462
20	0.00	0.07	0.07	0.50	0.58	1.38	1.45	1.67	3.57	5.05	2.44	8.91	0.21	0.37	0.00	0.00	73.73	100	509
21	0.00	0.00	0.00	0.22	0.33	0.96	1.66	1.63	4.02	3.27	2.41	5.99	1.06	0.00	0.00	0.11	78.36	100	419
22	0.00	0.15	0.00	0.00	0.47	1.26	1.48	1.54	0.69	3.61	0.72	3.86	0.00	0.00	0.22	0.00	86.00	100	482
23	0.00	0.00	0.00	0.00	1.09	0.20	2.65	0.71	4.88	3.60	1.48	3.22	0.21	0.21	0.21	0.00	81.55	100	413
24	0.00	0.00	0.00	0.00	0.00	0.42	0.79	2.42	2.01	2.65	1.14	1.88	0.16	0.00	0.00	0.00	88.52	100	354
Total	3.75	7.12	7.48	8.43	7.10	6.00	6.73	5.03	4.19	3.31	1.25	1.41	0.08	0.04	0.05	0.01	38.02	100	11207

Table DQ.9: Sex ratio at birth among children ever born and living
Sex ratio at birth among children ever born, children living, and deceased children, by age of women (weighted),
São Tomé e Príncipe, 2006

		Number of boys born	Number of girls born	Sex ratio	Number of boys living	Number of girls living	Sex ratio	Sex ratio	Number of girls deceased	Sex ratio	Number of women
Age	15-19	88.09	112.26	0.78	84.45	108.33	0.78	3.65	3.94	0.93	
	20-24	565.66	548.87	1.03	545.97	532.28	1.03	19.69	16.59	1.19	964
	25-29	845.83	849.95	1.00	792.59	799.73	0.99	53.24	50.23	1.06	790
	30-34	1045.94	1041.36	1.00	972.33	965.19	1.01	73.61	76.17	0.97	588
	35-39	1199.63	1139.28	1.05	1115.23	1047.70	1.06	84.40	91.57	0.92	511
	40-44	1363.58	1296.90	1.05	1236.04	1199.69	1.03	127.54	97.22	1.31	489
	45-49	803.36	754.42	1.06	704.20	688.12	1.02	99.16	66.30	1.50	268
Total		5912.09	5743.05	1.03	5450.81	5341.04	1.02	461.29	402.01	1.15	4610

Note : The sex ratio is calculated taking into account the Number of boys/Number of girls

Table DQ.10: Distribution of women by time since last birth
Distribution of women aged 15 - 49 with at least one live birth by months since last (weighted), São Tomé e Príncipe, 2006

		Number	Percent
Number of months after first live birth	0	37	2.22
	1	68	4.09
	2	58	3.48
	3	71	4.27
	4	55	3.31
	5	41	2.45
	6	63	3.79
	7	44	2.64
	8	58	3.50
	9	53	3.20
	10	43	2.56
	11	42	2.51
	12	64	3.85
	13	64	3.82
	14	66	3.92
	15	31	1.86
	16	42	2.49
	17	53	3.16
	18	43	2.55
	19	47	2.81
	20	44	2.64
	21	58	3.45
	22	29	1.76
	23	46	2.73
	24	33	1.95
	25	50	3.02
	26	55	3.28
	27	57	3.40
	28	31	1.83
	29	41	2.44
	30	37	2.20
	31	35	2.12
	32	31	1.83
	33	22	1.34
	34	35	2.08
	35	24	1.46
Total		1671	100.00

ANNEX E. MICS Indicators : enumerators and denominators

	INDICATOR	ENUMÉRATOR	DÉNOMINATOR
1	Under-5 mortality rate	Probability of dying by exact age 5 years	
2	Infant mortality rate	Probability of dying by exact age 1 year	
3	Maternal mortality rate	Number of pregnancy deaths in women during a specific year	Number of live births during the year (expressed as per100,000 births)
4	Skilled attendant at delivery	Number of women aged 15-49 with a birth in the 2 years preceding the survey who were attended during childbirth by skilled health personnel	Total number of women surveyed aged 15-49 with a live birth in the 2 years preceding the survey
5	Child birth in a specialised facility	Number of women aged 15-49 with a birth in the 2 years preceding the survey who gave birth in a specialised facility	Total number of women surveyed aged 15-49 with a live birth in the 2 years preceding the survey
6	Underweight prevalence	Number of children under age five who fall below minus two standard deviations from the median height for age of the NCHS/WHO standard (moderate and severe); number that fall below minus three standard deviations (severe)	Total number of under fives who were underweight
7	Stunting prevalence	Number of children under age five who fall below minus two standard deviations from the median height for age of the NCHS/WHO standard (moderate and severe); number that fall below minus three standard deviations (severe)	Total number of children under age five measured -
8	Wasting prevalence	Number of children under age five who fall below minus two standard deviations from the median weight for height of the NCHS/WHO standard (moderate and severe); number that fall below minus three standard deviations (severe)	Total number of children under age five weighed and measured
9	Low-birth weight infants	Number of last live births in the 2 years preceding the survey weighing below 2,500 grams	Total number of last live births in the 2 years preceding the survey
10	Infants weighed at birth	Number of last live births in the 2 years preceding the survey who were weighed at birth	Total number of last live births in the 2 years preceding the survey
11	Use of improved drinking water sources	Number of household members living in households using improved sources of drinking water	Total number of household members in households surveyed
12	Use of improved sanitation facilities	Number of household members using improved sanitation facilities	Total number of household members in households surveyed
13	Water treatment	Number of household members using water that has been treated	Total number of household members in households surveyed
14	Disposal of child's faeces	Number of children under age three whose (last) stools were disposed of safely	Total number of children under age three surveyed
15	Exclusive breastfeeding rate	Number of infants aged 0-5 months who are exclusively breastfed	Total number of infants aged 0-5 months surveyed
16	Continued breastfeeding rate	Number of infants aged 12-15 and 20-23 months currently breastfed	Total number of infants 12-15 and 20-23 months surveyed
17	Complementary food started on time	Number of infants aged 6-9 months breastfed receiving complementary foods	Total number of infants 6-9 months surveyed
18	Frequency of complementary feeding	Number of infants aged 6-11 months breastfed receiving complementary foods at least the minimum number of recommended times per day (twice per day for those aged 6-8 months and three times per day for those aged 9-11 months)	Total number of infants 6-11 months surveyed
19	Adequately fed infants	Number of infants aged 0-11 months who are appropriately fed: infants aged 0-5 months that are exclusively breastfed and infants aged 6-11 months that are breastfed and ate solid or semi-solid foods the appropriate number of times (see above) yesterday	Total number of infants aged 0-11 months surveyed
20	Pre-natal care	Number of women aged 15-49 who were attended to at least once during pregnancy in the 2 years preceding the survey by skilled health personnel	Total number of women surveyed aged 15-49years with a birth in the 2 years preceding the survey
21	Contraceptive prevalence	Number of women aged 15-49 married or in union utilising (or whose partner utilises) a contraceptive method (modern or traditional)	Total number of women aged 15-49 married or in union
22	Antibiotic treatment of suspected pneumonia	Number of children aged 0-59 months with suspected pneumonia in the previous 2 weeks receiving antibiotics	Total number of children aged 0-59 months with suspected pneumonia in the previous 2 weeks
23	Care-seeking for suspected pneumonia	Number of children aged 0-59 months with suspected pneumonia in the previous 2 weeks who are taken to an appropriate health provider	Total number of children aged 0-59 months with suspected pneumonia in the previous 2 weeks
24	Solid fuel	Number of residents in households who use solid fuel (wood, charcoal, crop residues and dung) as the primary source of domestic energy to cook	Total number of residents in households surveyed
25	Tuberculosis immunization coverage	Number of children aged 12-23 months receiving BCG vaccine before their first birthday	Total number of children aged 12-23 months surveyed
26	Polio immunization coverage	Number of children aged 12-23 months receiving OPV3 vaccine before their first birthday	Total number of children aged 12-23 months surveyed
27	Immunization coverage for diphtheria, pertussis and tetanus (DPT)	Number of children aged 12-23 months receiving DPT3 vaccine before their first birthday	Total number of children aged 12-23 months surveyed
28	Measles immunization coverage	Number of children aged 12-23 months receiving measles vaccine before their first birthday	Total number of children aged 12-23 months surveyed

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29	Hepatitis B immunization coverage	Number of children aged 12-23 months immunized against yellow fever before their first birthday	Total number of children aged 12-23 months surveyed
30	Yellow fever immunization coverage	Number of children aged 12-23 months immunized against yellow fever before their first birthday	Total number of children aged 12-23 months surveyed
31	Fully immunized children	Number of children aged 12-23 months receiving DPT1-3, OPV-1-3, BCG and measles vaccines before their first birthday	Total number of children aged 12-23 months surveyed
32	Neonatal tetanus protection	Number of mothers with live births in the previous year who were given at least two doses of tetanus toxoid (TT) vaccine within the appropriate interval prior to giving birth	Total number of women surveyed aged 15-49 years with a birth in the year preceding the survey
33	Use of oral rehydration therapy (ORT)	Number of children aged 0-59 months with diarrhoea in the previous 2 weeks that received oral rehydration salts and/or an appropriate house-hold solution	Total number of children aged 0-59 months with diarrhoea in the previous 2 weeks
34	Home management of diarrhoea	Number of children aged 0-59 months with diarrhoea in the previous 2 weeks who received more fluids AND continued eating somewhat less, the same or more food	Total number of children aged 0-59 months with diarrhoea in the previous 2 weeks
35	Received ORT or increased fluids and continued feeding	Number of children aged 0-59 months with diarrhoea who received ORT (oral rehydration salts or an appropriate household solution) or received more fluids AND continued eating somewhat less, the same or more food	Total number of children aged 0-59 months with diarrhoea in the previous 2 weeks
36	Household availability of insecticide-treated nets (ITNs	Number of households with at least one mosquito net, either permanently treated or treated within the previous year	Total number of households surveyed
37	Under-5s sleeping under insecticide-treated nets	Number of children aged 0-59 months who slept under an insecticide-treated mosquito net the previous night	Total number of children aged 0-59 months surveyed
38	Under-5s sleeping under mosquito nets	Number of children aged 0-59 months who slept under an insecticide-treated mosquito net the previous night	Total number of children aged 0-59 months surveyed
39	Antimalarial treatment (under- 5)	Number of children aged 0-59 months reported to have had fever in the previous 2 weeks who were treated with an appropriate antimalarial within 24 hours of onset	Total number of children aged 0-59 months reported to have had fever in the previous 2 weeks
40	Intermittent preventive malaria treatment (pregnant women)	Number of women receiving appropriate intermittent medication to prevent malaria (defined as at least 2 doses of SP/Fansidar) during the last pregnancy, leading to a live birth within the 2 years preceding the survey	Total number of women who have had a live birth within the 2 years preceding the survey
41	Iodized salt consumption	Number of households with salt testing 15 parts per million or more of iodine/iodate	Total number of households surveyed
42	Vitamin A supplementation (Under-5s)	Number of children aged 6-59 months receiving at least one high-dose Vitamin A supplement in the previous 6 months	Total number of children aged 6-59 months surveyed
43	Vitamin A supplementation (post-partum mothers)	Number of women with a live birth in the 2 years preceding the survey who received a high-dose Vitamin A supplement within 8 weeks after birth	Total number of women who had a live birth in the 2 years preceding the survey
44	Content of pre-natal care	Number of women with a live birth in the 2 years preceding the survey who received pre-natal care during the last pregnancy	Total number of women with a live birth in the 2 years preceding the survey
45	Timely initiation of breastfeeding	Number of women with a live birth in the 2 years preceding the survey who put the newborn infant to the breast within 1 hour of birth	Total number of women with a live birth in the 2 years preceding the survey
46	Support for learning	Number of children aged 0-59 months living in households in which an adult has engaged in four or more activities to promote learning and school readiness in the past 3 days	Total number of children aged 0-59 months surveyed
47	Father's support for learning	Number of children aged 0-59 months whose father has engaged in one or more activities to promote learning and school readiness in the past 3 days	Total number of children aged 0-59 months
48	Support for learning: children's books	Number of households with three or more children's books	Total number of households surveyed
49	Support for learning: non-children's books	Number of households with three or more non-children's books	Total number of households surveyed
50	Support for learning: materials for play	Number of households with three or more materials intended for play	Total number of households surveyed
51	Non-adult care	Number of children aged 0-59 months left alone or in the care of another child younger than 10 years of age in the past week	Total number of children aged 0-59 months surveyed
52	School readiness	Number of children aged 36-59 months who attend some form of early childhood education programme	Total number of children aged 36-59 months surveyed
53	School readiness	Number of children in first grade who attended some form of pre-school the previous year	Total number of children in the first grade surveyed
54	Net intake rate in primary education	Number of children of school entry age who are currently attending first grade	Total number of children of primary school entry age surveyed
55	Net primary school attendance rate	Number of children of primary school age currently attending primary or secondary school	Total number of children of primary school age surveyed
56	Net secondary school attendance rate	Number of children of secondary school age currently attending secondary school or higher	Total number of children of primary school age surveyed
57	Children reaching Grade 5	Proportion of children entering the first grade of primary school who eventually reach grade five	Total number of children of primary school age surveyed
58	Transition rate to secondary school	of children who were in the last grade of primary school during the previous school year who attend secondary school	Total number of children of secondary school age surveyed
59	Primary completion rate	Number of children (of any age) attending the last grade of primary school (excluding repeaters)	Total number of children that were in the last grade of primary school during the previous school year surveyed

60	Adult literacy rate	Number of women aged 15-24 who are able to read a short simple statement about everyday life	Total number of women aged 15-24 surveyed
61	Gender parity index	Proportion of girls in primary and secondary education	Proportion of boys in primary and secondary education
62	Birth registration	Number of children aged 0-59 months whose births are reported registered	Total number of children aged 0-59 months surveyed
63	Prevalence of female genital mutilation/cutting (FGM/C)	Number of women aged 15-49 who reported undergoing any form of genital mutilation/cutting	Total number of women aged 15-49 surveyed
64	Prevalence of extreme form of FGM/C	Number of women aged 15-49 who reported undergoing an extreme form of genital mutilation/cutting (such as infibulations)	Total number of women aged 15-49 surveyed
65	Prevalence of FGM/C among daughters	Number of women aged 15-49 who reported that at least one daughter had undergone female genital mutilation/cutting	Total number of women aged 15-49 surveyed who have at least one living daughter
66	Approval for FGM/C	Number of women aged 15-49 favouring the continuation of female genital mutilation/cutting	Total number of women aged 15-49 surveyed
67	Marriage before age 15 and age 18	Number of women who were first married or in union by the exact age of 15 and the exact age of 18, by age groups	Total number of women aged 15-49 and 20-49 surveyed, by age groups
68	Young women aged 15-19 currently married or in union	Number of women aged 15-19 years currently married or in union	Total number of women aged 15-19 surveyed
69	Spousal age difference	Number of women married/in union aged 15-19 years and 20-24 years with a difference in age of 10 or more years between them and their current spouse	Total number of women aged 15-19 and 20-24 years surveyed that are currently married or in union
70	Polygamy	Number of women in a polygamous union	Total number of women aged 15-49 surveyed who are currently married or in union
71	Child labour	Number of children aged 5-14 who are involved in child labour	Total number of children aged 5-14 surveyed
72	Labourer students	Number of children aged 5-14 involved in child labour activities who attend school	Total number of children aged 5-14 involved in child labour activities
73	Student labourers	Number of children aged 5-14 attending school who are involved in child labour activities	Total number of children aged 5-14 attending School
74	Child discipline	Number of children aged 2-14 who (1) experience only non-violent aggression, (2) experience psychological aggression as punishment, (3) experience minor physical punishment, (4) experience severe physical punishment	Total number of children aged 2-14 selected and surveyed
75	Prevalence of orphans	Number of children under age 18 with at least one dead parent	Total number of children under age 18 surveyed
76	Prevalence of vulnerable children	Number of children under age 18 who have a chronically ill parent, who live in a household where an adult aged 18-59 has died in the past year, or who live in a household where an adult aged 18-59 has been chronically ill in the past year	Total number of children under age 18 surveyed
77	School attendance of orphans versus non-orphans	Proportion of double orphans (both mother and father dead) aged 10-14 attending school	Proportion of children aged 10-14, both of whose parents are alive, who are living with at least one parent and are attending school
78	Children's living arrangements	Number of children aged 0-17 not living with a biological parent	Total number of children aged 0-17 surveyed
79	Malnutrition among children orphaned and made vulnerable by HIV/AIDS	Proportion of orphaned or vulnerable children under age five who are moderately or severely underweight, of all orphaned and vulnerable children under age five who are weighed	Proportion of children not classified as orphaned or vulnerable under age five who are moderately or severely underweight, of all children not classified as orphaned or vulnerable under age five who are weighed
80	Early sex among children orphaned and made vulnerable by HIV/AIDS	Proportion of orphaned and vulnerable children aged 15-17 who had sex before age 15, of all orphaned and vulnerable children aged 15-17 surveyed	Proportion of children not classified as orphaned or vulnerable aged 15-17 who had sex before age 15, of all children not classified as orphaned or vulnerable aged 15-17 surveyed
81	External support to children orphaned and made vulnerable by HIV/AIDS	Number of orphaned and vulnerable children under age 18 whose households received free basic external support in caring for the child	Number of orphaned and vulnerable children under age 18 surveyed
82	Comprehensive knowledge of HIV prevention among young people	Number of women aged 15-24 who correctly identify two ways of avoiding HIV infection and reject three common misconceptions of HIV transmission	Total number of women aged 15-24 years surveyed
83	Condom use with non-regular partners	Number of women aged 15-24 years reporting the use of a condom during sexual intercourse with their last non-marital, non-cohabiting sex partner in the previous 12 months	Total number of women aged 15-24 surveyed who had a non-marital, non-cohabiting partner in the previous 12 months
84	Age at first sex among young people	Number of women aged 15-24 who have had sex before age 15	Total number of women aged 15-24 surveyed
85	Higher risk sex in the last year	Number of sexually active women aged 15-24 who have had sex with a non-marital, non-cohabitating partner in the previous 12 months	Total number of women aged 15-24 who were sexually active in the previous 12 months

86	Attitude towards people with HIV/AIDS	Number of women expressing acceptance on all four questions about people with HIV or AIDS	Total number of women surveyed
87	Women who know where to be tested for HIV	Number of women who state knowledge of a place to be tested	Total number of women surveyed
88	Women who have been tested for HIV	Number of women who report being tested for HIV	Total number of women surveyed
89	Knowledge of mother-to-child transmission of HIV	Number of women who correctly identify all three means of vertical transmission	Total number of women surveyed
90	Counselling coverage for the prevention of mother-to-child transmission of HIV	Number of women who gave birth in the previous 24 months and received antenatal care reporting that they received counselling on HIV/AIDS during this care	Total number of women who gave birth in the previous 24 months surveyed
91	Testing coverage for the prevention of mother-to-child transmission of HIV	Number of women who gave birth in the previous 24 months and received antenatal care reporting that they received the results of an HIV test during this care	Total number of women who gave birth in the previous 24 months surveyed
92	Age-mixing among sexual partners	Number of women aged 15-24 who had sex in the past 12 months with a partner who was 10 or more years older than they were	Total number of sexually active women aged 15-24 surveyed
93	Security of tenure	Number of household members living in urban households who lack formal documentation for their residence or who feel at risk of eviction	Number of urban household members in households surveyed
94	Durability of housing	Number of household members living in urban dwellings that are not considered durable	Number of urban household members in households surveyed
95	Slum household	Number of household members living in urban slums	Number of urban household members in households surveyed
96	Source of supplies	Number of children (or households) for whom supplies were obtained from public providers, presented separately for each type of supply: insecticide-treated mosquito nets, oral rehydration salts, antibiotics and antimalarials	Total number of children (or households) for whom supplies were obtained
97	Cost of supplies	Median cost of supplies obtained, presented separately for each type of supply and whether sourced from public or private providers: insecticide treated mosquito nets, oral rehydration salts, antibiotics and antimalarials.	Total number of children (or households) for whom supplies were obtained
98	Needs to be met in family planning	Number of fecund women married or in union desirous of spacing or limiting their children and who do not practice contraception	Total number of women married or in union surveyed
99	Demand for family planning coverage	Number of women married or in union practicing contraception	Number of women married or in union whose demand in contraception is not covered, or who practice contraception
100	Attitudes towards domestic violence	Number of women who consider that a husband/partner is justified in hitting or beating his wife in at least one of the following circumstances :(1) she goes out without telling him, (2) she neglects the children, (3) she argues with him, (4) she refuses sex with him, (5) she burns the food	Total number of women surveyed
101	Handicapped children	Number of children aged 2-9 suffering from at least one of the nine handicaps indicated : (1) late sitting position, standing or walking ;(2)day or night vision impaired; (3) seems to have a hearing problem;(4) difficulty in understanding instructions; (5) difficulty in walking or moving arms or weakness/stiffness in arms; (6) undergoes crises, stiffens, loses consciousness; (7) does not learn things as other children of the same age; (8) does not know how to speak or speaks unintelligibly; (9) seems to be weak or slow mentally.	Total Number of children aged 2-9 surveyed

QUESTIONNAIRES

MICS

HOUSEHOLD QUESTIONNAIRE

WE ARE FROM THE **NATIONAL STATISTICS INSTITUTE (NSI).** WE ARE WORKING ON A PROJECT CONCERNING FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT (number) MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. DURING THIS TIME, I WILL LIKE TO SPEAK WITH ALL MOTHERS OR OTHERS WHO TAKE CARE OF CHILDREN IN THE HOUSEHOLD. MAY I START NOW? *If permission is given, begin the interview.*

HOUSEHOLD INFORMATION PANEL	HH
HH1. Enumeration Area Number : ___ ___ ___	HH2. Household Number : ___ ___ ___
HH3. Interviewer Name and Number : Name_____ ___ ___	HH4. Supervisor name and Number : Name_____ ___ ___
HH5. Day/Month/Year of Interview	___ ___ / ___ ___ / ___ ___ ___ ___
HH6. Area : Urban .... 1 Rural... 2	HH7. Region: *Region 1*.. 1 *Region 2*.. 2 *Region 3*.. 3 *Region 4*.. 4
HH 8. Name of the Head of Household : _____	

After all questionnaires on the household have been completed, complete the following information :

HH9. Household interview result : Completed .... 1 Not at home.. 2 Refused .... 3 House not found/destroyed.................... 4 Other (*specify*) _____ 6	HH10. Name of Respondent: Name:_____ Line no. : ___ ___
	HH11. Total number of household members : ___ ___
HH12. Number of eligible women : ___ ___	HH13. Number of women questionnaires completed: ___ ___
HH14. Number of under fives : ___ ___	HH15. Number of under five questionnaires completed : ___ ___

Interviewer/Supervisor notes : *Use this space to record notes about the interview with this household, such as call-back times, incomplete individual interview, number of attempts to revisit, etc.*

HH16. Data Entry clerk Number : ___ ___

HOUSEHOLD LISTING FORM

FIRST TELL ME THE NAME OF EACH PERSON WHO USUALLY LIVES HERE, STARTING WITH THE HEAD OF THE HOUSEHOLD. *Indicate the head of household in Line 01. Indicate all other household members (HL2), their relation to the head of the household (HL3), their sex (HL4). Next questions : ARE THERE ANY OTHER PERSONS LIVING HERE, EVEN IF THEY ARE NOT PRESENT NOW? (Including children who are AT SCHOOL OR AT WORK) If yes, complete the list. Then, begin questioning, starting by HL5, each person. Add another sheet if there are more than 12 household members. Indicate here if another sheet is being utilised.* ☐

						Eligible for :		For children aged **0-17** Make the following questions in HL9-HL12			
					WOMEN'S QUESTIONNAIRE	CHILD LABOUR MODULE	CHILDREN UNDER FIVE QUESTIONNAIRE				
HL1. Line No.	HL2. *Name*	HL3. What is the relationship of (NAME) to the head of THE HOUSEHOLD?	HL4. Is (NAME) Male or female? 1 MALE 2 FEM.	HL5. HOW OLD IS (name)? HOW OLD WAS (name) ON HIS/HER LAST BIRTHDAY? Record in completed years 98= DK*	HL6. Circle Line no. *If woman is age15-49*	HL7. For each child age 5-14: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. *of mother/ caretaker*	HL8. For each child under 5: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. *of mother/ caretaker*	HL9. IS (name's) NATURAL MOTHER ALIVE? 1 YES 2 NO HL11 8 DK HL11	HL10. *If alive:* DOES (NAME)S NATURAL MOTHER LIVE IN THIS HOUSE-HOLD? Record Line no. *of mother or 00 for 'no'*	HL11. IS (name's) NATURAL FATHER ALIVE? 1 YES 2 NO NEXT LINE 8 DK NEXT LINE	HL12. *If alive:* DOES (NAME)S NATURAL FATHER LIVE IN THIS HOUSEHOLD? Record Line no. of father or 00 for 'no'
LINE	NAME	REL.	M F	YEARS	15–49	MOTHER	MOTHER	Y N DK	MOTHER	Y N DK	FATHER
01		0 1	1 2	__ __	01	__ __	__ __	1 2 8	__ __	1 2 8	__ __
02		__ __	1 2	__ __	02	__ __	__ __	1 2 8	__ __	1 2 8	__ __
03		__ __	1 2	__ __	03	__ __	__ __	1 2 8	__ __	1 2 8	__ __
04		__ __	1 2	__ __	04	__ __	__ __	1 2 8	__ __	1 2 8	__ __
05		__ __	1 2	__ __	05	__ __	__ __	1 2 8	__ __	1 2 8	__ __
06		__ __	1 2	__ __	06	__ __	__ __	1 2 8	__ __	1 2 8	__ __
07		__ __	1 2	__ __	07	__ __	__ __	1 2 8	__ __	1 2 8	__ __
08		__ __	1 2	__ __	08	__ __	__ __	1 2 8	__ __	1 2 8	__ __
09		__ __	1 2	__ __	09	__ __	__ __	1 2 8	__ __	1 2 8	__ __

HH.200

HL1. Line No.	HL2. Name	HL3. What is the relationship of (NAME) to the head of THE HOUSEHOLD?	HL4. Is (NAME) Male or female? 1 MALE 2 FEM.		HL5. HOW OLD IS (name)? HOW OLD WAS (name) ON HIS/HER LAST BIRTHDAY? Record in completed years 98= DK*	HL6. Circle Line no. *If woman is age15-49*	HL7. For each child age 5-14: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. of mother/ caretaker	HL8. For each child under 5: WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? Record Line no. of mother/ caretaker	HL9. IS (name's) NATURAL MOTHER ALIVE? 1 YES 2 NO HL11 8 DK HL11	HL10. *If alive:* DOES (NAME)S NATURAL MOTHER LIVE IN THIS HOUSE-HOLD? *Record Line no. of mother or 00 for 'no'*	HL11. IS (name's) NATURAL FATHER ALIVE? 1 YES 2 NO NEXT LINE 8 DK NEXT LINE	HL12. *If alive:* (NAME)S NATURAL FATHER LIVE IN THIS HOUSEHOLD? *Record Line no. of father or 00 for 'no'*
LINE	NAME	REL.	M	F	YEARS	15-49	MOTHER	MOTHER	Y N DK	MOTHER	Y N DK	FATHER
10		— —	1	2	— —	10	— —	— —	1 2 8	— —	1 2 8	— —
11		— —	1	2	— —	11	— —	— —	1 2 8	— —	1 2 8	— —
12		— —	1	2	— —	12	— —	— —	1 2 8	— —	1 2 8	— —

DO OTHER CHILDREN LIVE HERE EVEN IF THEY ARE NOT FAMILY MEMBERS OR DO NOT HAVE PARENTS LIVING IN THE HOUSEHOLD, INCLUDING CHILDREN AT SCHOOL OR AT WORK= IF YES, INDICATE THE NAME OF THE CHILD AND COMPLETE THE HOUSEHOLD SHEED. AFTER THIS, COMPLETE BELOW
.

	Women 15-49	Children 5-14	Under 5
Total	— —	— —	— —

*See instructions. To be utilised only if in the household there are also elderly living in it (that is, the code "do not know/older than 50 years").
Now for each women aged 15 -49, write her name and the line number and other identification information in the sheed Women's Questionnaire Information.
For each child under 5, write the name and line number. And the line number of the mother /caregiver, in the sheet Under Five's Questionnaire Information. The interviewer should now have a separate questionnaire foe each eligible women and for each child under five living in the household

* Code for : relationship with head of household :

01 = Head of household
02 =Spouse
03 = Son/Daughter
04 =Son or Daughter in law
05 = Grandchild

06 =Father or Mother
07 =Parent in law
08 = Brother/Sister
09 = Brother/Sister in law
10 = Uncle/Aunt

11 = Blood Nephew/Niece
12 = Marriage Nephew/Niece
13 = Other relative
14 = Adopted child
15 = No parentage

98 = Does not know

4 July 2005

HH.201

EDUCATION MODULE

For household members age 5 and above | **For household members age 5 – 24**

ED1. Line No.	ED1A. Name	ED2. HAS (name) EVER ATTENDED SCHOOL OR PRESCHOOL? 1 YES ED3 2 NO NEXT LINE	ED3. WHAT IS THE HIGHEST LEVEL OF SCHOOL (name) ATTENDED? WHAT IS THE HIGHEST GRADE (name) COMPLETED AT THIS LEVEL? LEVEL: 0 PRE-SCHOOL 1 PRIMARY 2 SECONDARY 3 HIGHER 6 INFORMAL PROGRAMME 98 DK GRADE: 98 DK *IF LESS THAN 1 GRADE, ENTER 00*	ED4. DURING THE (2005-2006) SCHOOL YEAR, DID (name) ATTEND SCHOOL OR PRESCHOOL AT ANY TIME? 1 YES 2 NO ED6	ED5. SINCE LAST (day of the week), HOW MANY DAYS DID (name) ATTEND SCHOOL? *Insert number of days in space*	ED6. DURING THIS SCHOOL YEAR, WHICH LEVEL AND GRADE IS (name) ATTENDING? LEVEL: 0 PRE-SCHOOL 1 PRIMARY 2 SECONDARY (3 HIGHER 6 INFORMAL PROGRAMME 98 DK GRADE: 98 DK	ED7. DID (name) ATTEND SCHOOL OR PRESCHOOL AT ANY TIME DURING THE PREVIOUS SCHOOL YEAR, THAT IS (2004-2005)? 1 YES ED8 2 NO ED8 NEXT LINE⤵ 8 DK NEXT LINE ⤵	ED8. DURING THAT PREVIOUS SCHOOL YEAR, WHICH LEVEL AND GRADE DID (name) ATTEND? LEVEL: 0 PRE-SCHOOL 1 PRIMARY 2 SECONDARY 3 HIGHER 6 INFORMAL PROGRAMME 98 DK GRADE: 98 DK
LINE		Yes No	LEVEL | GRADE	Yes | No	DAYS	LEVEL | GRADE	Y | N | DK	LEVEL | GRADE
01		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
02		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
03		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
04		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
05		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
06		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
07		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
08		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
09		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
10		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
11		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __
12		1 2⇨ NEXT LINE	0 1 2 3 6 8 | __ __	1 | 2	__	0 1 2 3 6 8 | __ __	1 | 2 | 8	0 1 2 3 6 8 | __ __

WATER AND SANITATION MODULE

WS1. WHAT IS THE MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD?	Piped water Piped into dwelling Piped into yard or plot Public tap/standpipe	 11 12 13	11⇨WS5 12⇨WS5
	Dug well Protected well. Unprotected well	 31 32	
	Fountain water Protected fountain Unprotected fountain	 41 42	⇨WS3
	Tanker-truck	61	
	River/Stream. Rainwater	81 82	
	Bottled water	**91**	
	Other *(specify)*	96	96⇨WS3
WS2. WHAT IS THE MAIN SOURCE OF WATER USED BY YOUR HOUSEHOLD FOR OTHER PURPOSES SUCH AS COOKING AND HANDWASHING?	Piped water Piped into dwelling Piped into yard or plot Public tap/standpipe	 11 12 13	11⇨WS5 12⇨WS5
	Dug well Protected well. Unprotected well	 31 32	
	Fountain water Protected fountain Unprotected fountain	 41 42	
	Tanker-truck	61	
	River/Stream. Rainwater	81 82	
	Other *(specify)*	96	
WS3. HOW LONG DOES IT TAKE TO GO THERE, GET WATER, AND COME BACK?	No. of minutes.. Water on premises. DK	__ __ __ 995 998	995⇨WS5
WS4. WHO USUALLY GOES TO THIS SOURCE TO FETCH THE WATER FOR YOUR HOUSEHOLD? *Probe:* IS THIS PERSON UNDER AGE 15? WHAT SEX? Circle code that best describes this person	Adult woman Adult man Female child (under 15) Male child (under 15) DK	1 2 3 4 8	
WS5. DO YOU TREAT YOUR WATER IN ANY WAY TO MAKE IT SAFER TO DRINK	Yes .... 1 No... 2 DK.. 8		2⇨WS7 8⇨WS7
WS6. WHAT DO YOU USUALLY DO TO THE WATER TO MAKE IT SAFER TO DRINK? ANYTHING ELSE? *RECORD ALL ITEMS MENTIONED.*	Add bleach/chlorine Strain it through a cloth Use water filter (ceramic, sand, composite, etc.) Let it stand and settle	B C D F	
	Other (specify)	X	
	DK	Z	
WS7. WHAT KIND OF TOILET FACILITY DO MEMBERS OF YOUR HOUSEHOLD USUALLY USE?	Toilet Flush to piped sewer system. Flush to septic tank	 11 12	

If "flush" or "pour flush", probe: WHERE DOES IT FLUSH TO? *If necessary, ask permission to observe* the facility	Flush to pit (latrine). Flush to somewhere else Flush to unknown place/not sure/DK where. Ventilated Improved Pit latrine (VIP) Pit latrine with slab Pit latrine without slab / open pit Bucket No facilities or bush or field Other *(specify)*	13 14 15 21 22 23 .41 95 96	95⇨NEXT MODULE
WS8. DO YOU SHARE YOUR TOILET FACILITY WITH OTHER HOUSEHOLDS?	Yes .... 1 No 2		2⇨ NEXT MODULE
WS9. HOW MANY HOUSEHOLDS IN TOTAL USE THIS TOILET FACILITY?	No. of households (if less than 10). Ten or more households DK	0 ___ 10 98	

HOUSEHOLD CHARACTERISTICS MODULE		
HC2. HOW MANY ROOMS IN THIS HOUSEHOLD ARE USED FOR SLEEPING?	No. of rooms..__ __	
HC3. Main material of the dwelling floor. Record observation.	Natural floor Earth/sand 11 Rudimentary floor Wood planks. 21 Palm/bamboo 22 Finished floor Parquet or polished wood. 31 Ceramic tiles 33 Cement. 34 Carpet. 35 Mixed 36 Rug 37 Other *(specify)* 96	
HC4. Main material of the roof. Record observation.	Natural roofing Thatch/palm leaf. 12 Rudimentary Roofing Palm/bamboo 22 Wood planks 23 Finished roofing Metal/corrugated iron 31 Wood 32 Zinc 33 Ceramic tiles 34 Cement 5 Other (specify) _____ 96	
HC5. Main material of the walls. Record observation.	Natural walls Thatch/palm leaf 12 Rudimentary walls Plywood. 24 Reused wood 26 Finished walls Cement 31 Stone with cement 32 Bricks 33 Cement blocks 34 Wood 36 Other *(specify)* 96	
HC6. WHAT TYPE OF FUEL DOES YOUR HOUSEHOLD MAINLY USE FOR COOKING?	Electricity 01 Liquid Propane Gas (LPG) 02 Kerosene. 05 Charcoal. 07 Wood. 08 Straw/shrubs/grass. . 09 Wood chips 12 Other *(specify)* 96	01⇨HC8 02⇨HC8 03⇨HC8 04⇨HC8
HC7. IN THIS HOUSEHOLD, IS FOOD COOKED ON AN OPEN FIRE, AN OPEN STOVE OR A CLOSED STOVE? Probe for type.	Open fire 1 Open stove 2 Closed stove. 3 Other *(specify)* 6	3⇨HC8 6⇨HC8
HC7A. DOES THE FIRE/STOVE HAVE A CHIMNEY OR A HOOD?	Yes 1 No 2	

HC8. IS THE COOKING USUALLY DONE IN THE HOUSE, IN A SEPARATE BUILDING, OR OUTDOORS?	In the house 1 In a separate building 2 Outdoors 3 Other *(specify)* *6*	
HC9. DOES YOUR HOUSEHOLD HAVE: ELECTRICITY? A RADIO? A TELEVISION? A MOBILE TELEPHONE? A NON-MOBILE TELEPHONE? A REFRIGERATOR?	Yes No Électricity ....1 2 Radio ....1 2 Television...1 2 Mobile telephone ....1 2 Non-mobile telephone......................1 2 Refrigerator......................................1 2	
HC10. DOES ANY MEMBER OF YOUR HOUSEHOLD OWN: A WATCH? A BICYCLE? A MOTORCYCLE OR SCOOTER? A CAR OR TRUCK? A BOAT WITH A MOTOR?	Yes No Watch ....1 2 Bicycle ....1 2 Motorcycle ....1 2 Car or truck......................................1 2 Boat with motor................................1 2	

CHLID LABOUR MODULE   **CL**

The questions of this module must be asked to the mother/caretaker for each child in the household aged 5-14. For household members under 5 or more than 14, leave the line blank.

NOW I WOULD LIKE TO ASK YOU A QUESTION ABOUT THE TYPE OF WORK THAT THE CHILDREN LIVING IN THIS HOUSEHOLD ARE CAPABLE OF ACCOMPLISHING

CL1. LINE NO.	CL2. Name	CL3. DURING THE PAST WEEK, DID (NAME) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? IF YES: FOR PAY IN CASH OR KIND? 1 YES, FOR PAY (CASH OR KIND) 2 YES, UNPAID 3 NO TO CL5	CL4. If yes: SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? If more than one job, include all hours at all jobs. Record response then CL.6	CL5. AT ANY TIME DURING THE PAST YEAR, DID (name) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? If yes: FOR PAY IN CASH OR KIND? 1 YES, FOR PAY (CASH OR KIND) 2 YES, UNPAID 3 NO	CL6. DURING THE PAST WEEK, DID (name) HELP WITH HOUSEHOLD CHORES SUCH AS SHOPPING, COLLECTING FIREWOOD, COOKING, WASHING, CLEANING, FETCHING WATER, OR CARING FOR CHILDREN? 1 YES 2 NO TO CL8	CL7. If yes:SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE SPEND DOING THESE CHORES?	CL8. DURING THE PAST WEEK, DID (name) DO ANY OTHER FAMILY WORK (ON THE FARM OR IN A BUSINESS OR SELLING GOODS IN THE STREET, COOKING OR LAUNDRY? 1 YES 2 NO NEXT LINE	CL9. If yes: SINCE LAST (day of the week), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK?

LINE	NAME	PAID	N. PAID	No	NO. HOURS	PAID	N. PAID	No	NO. HOURS	YES	No	NO. HOURS	YES	No	NO. HOURS
01		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
02		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
03		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
04		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
05		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
06		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
07		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
08		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
09		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
10		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
11		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___
12		1	2	3	___ ___	1	2	3		1	2	___ ___	1	2	___ ___

SALT IODISATION MODULE		SI
SI1. WE WOULD LIKE TO CHECK WHETHER THE SALT USED IN YOUR HOUSEHOLD IS IODIZED. MAY I SEE A SAMPLE OF THE SALT USED TO COOK THE MAIN MEAL EATEN BY MEMBERS OF YOUR HOUSEHOLD YESTERDAY? *Once you have examined the salt, circle number that corresponds to test outcome*	Not iodized 0 PPM.. 1 Less than 15 PPM... 2 15 PPM or more...3 No salt in home..6 Salt not tested..7	

SI2. *Does any eligible woman age 15-49 reside in the household? Check household listing, column HL6.You should have a questionnaire with the Information Panel filled in for each eligible woman.*

.☐ *Yes. Go to QUESTIONNAIRE FOR INDIVIDUAL WOMEN to administer the questionnaire to the first eligible woman.*

▱No. Continue

SI3. *Does any child under the age of 5 reside in the household? Check household listing, column HL8. You should have a questionnaire with the Information Panel filled in for each eligible child.*

☐ *Yes. Go to QUESTIONNAIRE FOR CHILDREN UNDER FIVE to administer the questionnaire to caretaker of the first eligible child.*

☐ *No. End the interview by thanking the respondent for his/her cooperation. Gather all questionnaires for this household and tally the number of interviews completed on the cover page.*

MICS

QUESTIONNAIRE FOR INDIVIDUAL WOMEN

WOMEN'S INFORMATION PANEL	WM

This module is to be administered to all women age 15 through 49 (see column HL6 of HH listing).
Fill in one form for each eligible woman Fill in the EA and household number, and the name and line number of the woman in the space below.
Fill in your name, number and the date.

WM1. Enumeration Area Number:: ___ ___ ___	WM2. Household number: ___ ___ ___
WM3. Woman's Name::	WM4. Woman's Line Number: ___ ___
WM5. Interviewer name and number:: ___ ___	WM6. Day/Month/Year of interview:: ___ ___ / ___ ___ / ___ ___ ___ ___

WM7. Result of women's interview:	Completed	1
	Not at home	2
	Refused	3
	Partly completed	4
	Incapacitated	5
	Other (specify)	6

Repeat greeting if not already read to this woman: WE ARE FROM THE **NATIONAL STATISTICS INSTITUTE (NSI).** WE ARE WORKING ON A PROJECT CONCERNED WITH FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT 45 MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. IN ADDITION, YOU ARE NOT OBLIGED TO ANSWER ANY QUESTION YOU DO NOT WANT TO, AND YOU MAY WITHDRAW FROM THE INTERVIEW AT ANY TIME. MAY I START NOW?

If permission is given, begin the interview. If the woman does not agree to continue, thank her, complete WM7, and go to the next interview. Discuss this result with your supervisor for a future revisit

WM8. IN WHAT MONTH AND YEAR WERE YOU BORN?	Date of first birth	
	Day...___ ___	
	DK day...98	
	Month.. ___ ___	
	DK month...98	
	Year ....___ ___ ___ ___	
	DK year..9998	
WM9. HOW OLD WERE YOU AT YOUR LAST BIRTHDAY?	Age in completed years.......................................___ ___	
WM10. HAVE YOU EVER ATTENDED SCHOOL?	Yes... 1 No 2	2⇨WM14
WM11. WHAT IS THE HIGHEST LEVEL OF SCHOOL YOU ATTENDED: PRIMARY, SECONDARY, OR HIGHER?	PRIMARY 1 SECONDARY 2 HIGHER 3 INTERMEDIATE 4 B.A 5 INFORMAL PROGRAMME 6	
WM12.WHAT IS THE HIGHEST GRADE YOU	Grade .... ___ ___	

COMPLETED AT THAT LEVEL		

WM13. *Check WM11:*

☐ *Secondary or higher. Go to Next Module*

☐ *Primary or non-standard curriculum. Continue with WM14*

| WM14. NOW I WOULD LIKE YOU TO READ THIS SENTENCE TO ME. *Show sentences to respondent. If respondent cannot read whole sentence, probe:* CAN YOU READ PART OF THE SENTENCE TO ME? Example sentences for literacy test: *1. The child is reading a book.* *2. The rains came late this year.* *3. Parents must care for their children.* *4. Farming is hard work.* | Cannot read at all   1 Able to read only parts of sentence..............................2 Able to read whole sentence   .3 Blind/mute, visually/speech impaired   5 | |

CHILD MORTALITY MODULE

This module is to be administered to all women age 15-49.
All questions refer only to LIVE births.

CM1. NOW I WOULD LIKE TO ASK ABOUT ALL THE BIRTHS YOU HAVE HAD DURING YOUR LIFE. HAVE YOU EVER GIVEN BIRTH? If "No" probe by asking: I MEAN, TO A CHILD WHO EVER BREATHED OR CRIED OR SHOWED OTHER SIGNS OF LIFE - EVEN IF HE OR SHE LIVED ONLY A FEW MINUTES OR HOURS?	Yes.. 1 No 2	2⇨ MODULO UNIAO/C ASAMENT O
CM2A. WHAT WAS THE DATE OF YOUR FIRST BIRTH? I MEAN THE VERY FIRST TIME YOU GAVE BIRTH, EVEN IF THE CHILD IS NO LONGER LIVING, OR WHOSE FATHER IS NOT YOUR CURRENT PARTNER. ***Skip to CM3 only if year of first birth is given. Otherwise, continue with***	Date of first birth Day...___ ___ DK day...98 Month.. ___ ___ DK month..98 Year ....___ ___ ___ ___ DK year...9998	⇨CM3 ⇩CM2B
CM2B. HOW MANY YEARS AGO DID YOU HAVE YOUR FIRST BIRTH?	Completed years since first birth.....................___ ___	
CM3. DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE NOW LIVING WITH YOU?	Yes.. 1 No 2	2⇨CM5
CM4. HOW MANY SONS LIVE WITH YOU? HOW MANY DAUGHTERS LIVE WITH YOU?	Sons at home..___ ___ Daughters at home... __ __	
CM5. DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE ALIVE BUT DO NOT LIVE WITH YOU?	Yes.. 1 No 2	2⇨CM7
CM6. HOW MANY SONS ARE ALIVE BUT DO NOT LIVE WITH YOU? HOW MANY DAUGHTERS ARE ALIVE BUT DO NOT LIVE WITH YOU?	Sons elsewhere... __ __ Daughters elsewhere... __ __	
CM7. HAVE YOU EVER GIVEN BIRTH TO A BOY OR GIRL WHO WAS BORN ALIVE BUT LATER DIED?	Yes.. 1 No 2	2⇨CM9
CM8. HOW MANY BOYS HAVE DIED? HOW MANY GIRLS HAVE DIED?	Boys dead... __ __ Girls dead. .... __ __	
CM9. Sum answers to CM4, CM6, and CM8.	Total... __ __	

CM10. JUST TO MAKE SURE THAT I HAVE THIS RIGHT, YOU HAVE HAD IN TOTAL (total number) BIRTHS DURING YOUR LIFE. IS THIS CORRECT?

☐ *Yes. Go to CM11*

☐ *No. Check responses and make corrections before proceeding to CM11*

CM11. OF THESE (total number) BIRTHS YOU HAVE HAD, WHEN DID YOU DELIVER THE LAST ONE (EVEN IF HE OR SHE HAS DIED)? If day is not known, enter '98' in space for day.	Date of last birth Day/Month/Year...................... __ __/__ __/__ __ __ __	

CM12. *Check CM11: Did the woman's last birth occur within the last 2 years, that is, since (day and month of interview in 2005)?*

If child has died, take special care when referring to this child by name in the following modules.

☐ *No live birth in last 2 years. Go to MARRIAGE/UNION module.*

☐ *Yes, live birth in last 2 years. Continue with CM13*

Name of child_____

CM13. AT THE TIME YOU BECAME PREGNANT WITH (name), DID YOU WANT TO BECOME PREGNANT THEN, DID YOU WANT TO WAIT UNTIL LATER, OR DID YOU NOT WANT MORE CHILDREN AT ALL?	Then..1 Later.. 2 No more.. 3	

TETANUS TOXOID MODULE   TT

This module is to be administered to all women with a live birth in the 2 years preceding date of interview.

TT1. DO YOU HAVE A CARD OR OTHER DOCUMENT WITH YOUR OWN IMMUNIZATIONS LISTED? If a card is presented, use it to assist with answers to the following questions.	Yes (card seen)... 1 Yes (card not seen) .... 2 No .... 3 DK 8	
TT2. WHEN YOU WERE PREGNANT WITH YOUR LAST CHILD, DID YOU RECEIVE ANY INJECTION TO PREVENT HIM OR HER FROM GETTING TETANUS, THAT IS CONVULSIONS AFTER BIRTH (AN ANTI-TETANUS SHOT, AN INJECTION AT THE TOP OF THE ARM OR SHOULDER)?	Yes... 1 No .... 2 DK 8	2⇨TT5 8⇨TT5
TT3. If yes: HOW MANY TIMES DID YOU RECEIVE THIS ANTI-TETANUS INJECTION DURING YOUR LAST PREGNANCY?	Many times... __ __ DK 98	98⇨TT5

TT4. How many TT doses during last pregnancy were reported in TT3?

☐ *At least two TT injections during last pregnancy. Go to Next Module*

▱ **Fewer than two TT injections during last pregnancy. Continue with TT5**

TT5. DID YOU RECEIVE ANY TETANUS TOXOID INJECTION AT ANY TIME BEFORE YOUR LAST PREGNANCY?	Yes... 1 No .... 2 DK 8	2⇨NEXT MODULEE 8⇨NEXT MODULE
TT6. HOW MANY TIMES DID YOU RECEIVE IT?	Many times... __ __	
TT7. IN WHAT MONTH AND YEAR DID YOU RECEIVE THE LAST ANTI-TETANUS INJECTION BEFORE THAT LAST PREGNANCY? *Skip to next module only if year of injection is given. Otherwise, continue with TT8.*	Month .... __ __ DK month .... 98 Year .... __ __ __ __ DK year 9998	⇨MODULE ⇩TT8
TT8. HOW MANY YEARS AGO DID YOU RECEIVE THE LAST ANTI-TETANUS INJECTION BEFORE THAT LAST PREGNANCY?	Years...................................... __ __	

MATERNAL AND NEWBORN HEALTH PANEL — MN

This module is to be administered to all women with a live birth in the 2 years preceding date of interview.
Check child mortality module CM12 and record name of last-born child here _____.
Use this child's name in the following questions, where indicated.

MN1. IN THE FIRST TWO MONTHS AFTER YOUR LAST BIRTH [THE BIRTH OF NAME], DID YOU RECEIVE A VITAMIN A DOSE LIKE THIS? ***Show 200,000 IU capsule or bottle/jar***	Yes... 1 No .... 2 DK.. 8	
MN2. DID YOU SEE ANYONE FOR ANTENATAL CARE FOR THIS PREGNANCY? If yes: WHOM DID YOU SEE? ANYONE ELSE? *Probe for the type of person seen and circle all answers given.*	Health worker Doctor ....A Nurse/midwife...B Other person Traditional midwife ....F Community health agent........................ G Other((specify) _____X No-one ....Y	Y⇨MN7
MN3. AS PART OF YOUR ANTENATAL CARE, WERE ANY OF THE FOLLOWING DONE AT LEAST ONCE? MN3A. WERE YOU WEIGHED? MN3B. WAS YOUR BLOOD PRESSURE MEASURED? MN3C. DID YOU GIVE A URINE SAMPLE? MN3D. DID YOU GIVE A BLOOD SAMPLE?	Yes No Weight..1 2 Blood pressure ....1 2 Urine ....1 2 Blood..1 2	
MN4. DURING ANY OF THE ANTENATAL VISITS FOR THE PREGNANCY, WERE YOU GIVEN ANY INFORMATION OR COUNSELED ABOUT AIDS OR THE AIDS VIRUS?	Yes... 1 No .... 2 DK.. 8	
MN5. I DON'T WANT TO KNOW THE RESULTS, BUT WERE YOU TESTED FOR HIV/AIDS AS PART OF YOUR PRE-NATAL CARE?	Yes... 1 No .... 2 DK.. 8	2⇨MN7 8⇨MN7
MN6. I DON'T WANT TO KNOW THE RESULTS, BUT DID YOU GET THE RESULTS OF THE TEST?	Yes... 1 No .... 2 DK.. 8	
MN7. WHO ASSISTED WITH THE DELIVERY OF YOUR LAST CHILD *(or name)*? ANYONE ELSE? *Probe for the type of person assisting and circle all answers given.*	Health worker Doctor ....A Nurse/midwife...B Other person Traditional midwife ....F Community health agent........................ G Other((specify) _____X No-one ....Y	

MN8. WHERE DID YOU GIVE BIRTH TO *(name)*? *If source is hospital, health centre, or clinic, write the name of the place below. Probe to identify the type of source and circle the appropriate code.*	Residence
	   Your residence 11
	   Another residence…………………………12
	
	Public sector
	   Hospital /Maternity............................... 21	

_____
(Name of place)
	Health centre. 22
	Other public facility ((specify) _____ 26
	
	Private sector
	   Private clinic 32
	   Other private facility ((specify) _____ 36
	
	Other (specify)_____ 96	

MN9. WHEN YOUR LAST CHILD (name) WAS BORN, WAS HE/SHE VERY LARGE, LARGER THAN AVERAGE, AVERAGE, SMALLER THAN AVERAGE, OR VERY SMALL?	Very large.. 1 Larger than average .... 2 Normal. .... 3 Smaller than average .... 4 Very small .... 5 NS 8	
MN10. WAS (NAME) WEIGHED AT BIRTH?	Yes.. 1 No .... 2 DK 88	2⇨MN12 8⇨MN12
MN11. HOW MUCH DID (name) WEIGH? *Record weight from health card, if available.*	From the card.....1 (kilograms) __ . __ __ __ From memory..2 (kilograms) __ . __ __ __ DK... 99998	
MN12. DID YOU EVER BREASTFEED (name)?	Yes.. 1 No .... 2 DK 8	2⇨NEXT MODULE.
MN13. HOW LONG AFTER BIRTH DID YOU FIRST PUT (name) TO THE BREAST? *If less than 1 hour, record '00' hours.* *If less than 24 hours, record hours.* Otherwise, record days.	Immediately... 000 Hours .... 1 __ __ *or* Days.. 2 __ __ DK/Does not remember.......................... 998	

- All children with more than **3 kg** are considered **normal** while those with more than 3 kg are considered larger than normal and those with less are considered as smaller than average. All children with 3 kg are considered normal.

MARRIAGE/UNION MODULE		MA
MA1. ARE YOU CURRENTLY MARRIED OR LIVING TOGETHER WITH A MAN AS IF MARRIED?	Yes, currently married .... 1 Yes, I live with a man .... 2 No, I don't live with anyone 3	3⇨MA3
MA2. HOW OLD WAS YOUR HUSBAND/PARTNER ON HIS LAST BIRTHDAY?	Completed years .... __ __ DK 98	⇨MA5 98⇨MA5
MA3. HAVE YOU EVER BEEN MARRIED OR LIVED TOGETHER WITH A MAN?	Yes, I was already married .... 1 Yes, I already lived with a man .... 2 No 3	3⇨NEXT MODULE.
MA4. WHAT IS YOUR MARITAL STATUS NOW: ARE YOU WIDOWED, DIVORCED OR SEPARATED?	Widow .... 1 Divorced .... 2 Separated 3	
MA5. HAVE YOU BEEN MARRIED OR LIVED WITH A MAN ONLY ONCE OR MORE THAN ONCE?	Once .... 1 More than once 2	
MA6. IN WHAT MONTH AND YEAR DID YOU FIRST MARRY OR START LIVING WITH A MAN AS IF MARRIED?	Month .... __ __ DK month .... 98 Year .... __ __ __ __ DK year 9998	
MA7. Check MA6: ☐ *Both month and year of marriage/union known? Go to Next Module* ▱ **Either month or year of marriage/union not known? Continue with MA8**		
MA8. HOW OLD WERE YOU WHEN YOU STARTED LIVING WITH YOUR FIRST HUSBAND/PARTNER?	Completed years .... __ __	

CONTRACEPTION MODULE		CP
CP1. I WOULD LIKE TO TALK WITH YOU ABOUT SOMETHING ELSE – FAMILY PLANNING – AND YOUR REPRODUCTIVE HEALTH ARE CURRENTLY PREGNANT?	Yes, currently pregnant .... 1 No .... 2 Not sure or DK 8	1⇨NEXT MODULE.
CP2. SOME COUPLES USE DIFFERENT WAYS OR METHODS OF AVOIDING PREGNANCY. ARE YOU NOW UTILISING OR DOING SOMETHING TO AVOID PREGNANCY?	Yes.. 1 No 2	2⇨NEXT MODULE.
CP3. WHAT IS THE METHOD YOU USE? *Do not suggest : If more than one method is mentioned, circle codes for all the methods mentioned*	Female sterilisation ....A Male sterilisation ....B Pill ....C IUD...D Injections ....E Implants ....F Condom .... G Female condom ....H Diaphragm...I Foam/gel .... J Breastfeeding method Amenorrhea method (MAMA).......................K Periodic abstinence .... L Coitus Interruptus....................................... M Calendar.. .N Ovulation... .O Other(*specify*)_____X	

HIV/AIDS MODULE		HA
HA1. NOW I WOULD LIKE TO TALK WITH YOU ABOUT SOMETHING ELSE. HAVE YOU EVER HEARD OF THE VIRUS HIV OR AN ILLNESS CALLED AIDS?	Yes ……………………………………………1 No..2	2⇨NEXT MODULE
HA2. CAN PEOPLE PROTECT THEMSELVES FROM GETTING INFECTED WITH THE AIDS VIRUS BY HAVING ONE SEX PARTNER WHO IS NOT INFECTED AND ALSO HAS NO OTHER PARTNERS?	Yes ....1 No...2 DK 8	
HA3. CAN PEOPLE GET INFECTED WITH THE AIDS VIRUS BECAUSE OF WITCHCRAFT OR OTHER SUPERNATURAL MEANS?	Yes ....1 No...2 DK 8	
HA4. CAN PEOPLE REDUCE THEIR CHANCE OF GETTING THE AIDS VIRUS BY USING A CONDOM EVERY TIME THEY HAVE SEX?	Yes ....1 No...2 DK 8	
HA5. CAN PEOPLE GET THE AIDS VIRUS FROM MOSQUITO BITES?	Yes ....1 No...2 DK 8	
HA6. CAN PEOPLE REDUCE THEIR CHANCE OF GETTING INFECTED WITH THE AIDS VIRUS BY NOT HAVING SEX AT ALL?	Yes ....1 No...2 DK 8	
HA7. CAN PEOPLE GET THE AIDS VIRUS BY SHARING FOOD WITH A PERSON WHO HAS AIDS?	Yes ....1 No...2 DK 8	
HA7A. CAN PEOPLE GET THE AIDS VIRUS BY GETTING INJECTIONS WITH A NEEDLE THAT WAS ALREADY USED BY SOMEONE ELSE?	Yes ....1 No...2 DK 8	
HA8. IS IT POSSIBLE FOR A HEALTHYLOOKING PERSON TO HAVE THE AIDS VIRUS?	Yes ....1 No...2 DK 8	

HA9. CAN THE AIDS VIRUS BE TRANSMITTED FROM A MOTHER TO A BABY?

	Yes	No	DK
HA9A. DURING PREGNANCY?	During pregnancy 1	2	8
HA9B. DURING DELIVERY?	During labour 1	2	8
HA9C. BY BREASTFEEDING?	While breastfeeding 1	2	8

HA10. IF A TEACHER HAS THE AIDS VIRUS BUT IS NOT SICK, SHOULD HE/SHE BE ALLOWED TO CONTINUE TEACHING IN SCHOOL?	Yes ....1 No...2 DK /Is not sure/Depends.............................8	
HA11. WOULD YOU BUY FRESH VEGETABLES FROM A SHOPKEEPER OR VENDOR IF YOU KNEW THAT THIS PERSON HAD THE AIDS VIRUS?	Yes ....1 No...2 DK /Is not sure/Depends.............................8	
HA12. IF A MEMBER OF YOUR FAMILY BECOMES INFECTED WITH THE AIDS VIRUS, WOULD YOU WANT IT TO REMAIN A SECRET?	Yes ....1 No...2 DK /Is not sure/Depends.............................8	
HA13. IF A MEMBER OF YOUR FAMILY BECAME SICK	Yes 1	

WITH THE AIDS VIRUS, WOULD YOU BE WILLING TO CARE FOR HIM OR HER IN YOUR HOUSEHOLD?	No...2 DK /Is not sure/Depends............................8	
HA14. *Check MN5: Tested for HIV during antenatal care?* ☐ ***Yes. Go to HA18A*** ▱ **No. Continue with HA15**		
HA15. I DO NOT WANT TO KNOW THE RESULTS, BUT HAVE YOU EVER BEEN TESTED TO SEE IF YOU HAVE HIV, THE VIRUS THAT CAUSES AIDS?	Yes.. 1 No 2	2⇨HA18
HA16. I DO NOT WANT YOU TO TELL ME THE RESULTS OF THE TEST, BUT HAVE YOU BEEN TOLD THE RESULTS?	Yes.. 1 No 2	
HA17. DID YOU, YOURSELF, ASK FOR THE TEST, WAS IT OFFERED TO YOU AND YOU ACCEPTED, OR WAS IT REQUIRED?	Ask for the Test.. 1 Accepted a proposal .... 2 Required 3	1 END INTERVIEW 2 END INTERVIWE 3 END INTERVIEW.
HA18. AT THIS TIME, DO YOU KNOW OF A PLACE WHERE YOU CAN GO TO GET SUCH A TEST TO SEE IF YOU HAVE THE AIDS VIRUS? HA18A. If tested for HIV during pre-natal care: OTHER THAN AT THE PRE-NATAL CLINIC, DO YOU KNOW OF A PLACE WHERE YOU CAN GO TO GET A TEST TO SEE IF YOU HAVE THE AIDS VIRUS?	Yes.. 1 No 2	

FOLLOW INSTRUCTIONS IN YOUR INTERVIEWER'S MANUAL

MICS

CHILDREN'S QUESTIONNAIRE

INFORMATION PANEL ON CHILDREND UNDER FIVE	UF

This questionnaire is to be administered to all mothers or caretakers (see household listing, column HL8) who care for a child that lives with them and is under the age of 5 years (see household listing, column HL5).
A separate questionnaire should be used for each eligible child.
Fill in the cluster and household number, and names and line numbers of the child and the mother/caretaker in the space below. Insert your own name and number, and the date.

UF1. Enumeration Area Number:: ___ ___ ___	UF2. Household number: ___ ___ ___
UF3. Child's Name::	UF4. Child's Line Number: ___ ___
UF5 Mother's/Caretaker's Name::	UF6. Mother's/Caregiver's Number:: ___ ___
UF7. Interviewer name and number:: ___ ___	UF8. Day/Month/Year of interview: ___ ___ / ___ ___ / ___ ___ ___ ___

UF9. Result of interview for children under 5 (Codes refer to mother/caretaker.)	Completed	1
	Not at home	2
	Refused	3
	Partly completed	4
	Incapacitated	5
	Other (specify)	6

Repeat greeting if not already read to this respondent:
WE ARE FROM VARIOUS GOVERNMENT DEPARTMENTS (CENTRAL STATISTICS DEPT., DOSH, ETC.). WE ARE WORKING ON A PROJECT CONCERNED WITH FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT 45 MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. IN ADDITION, YOU ARE NOT OBLIGED TO ANSWER ANY QUESTION YOU DO NOT WANT TO, AND YOU MAY WITHDRAW FROM THE INTERVIEW AT ANY TIME. MAY I START NOW?

If permission is given, begin the interview. If the respondent does not agree to continue, thank him/her and go to the next interview. Discuss this result with your supervisor for a future revisit.

UF10. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF EACH CHILD UNDER THE AGE OF 5 IN YOUR CARE, WHO LIVES WITH YOU NOW. NOW I WANT TO ASK YOU ABOUT (name). IN WHAT MONTH AND YEAR WAS (name) BORN? *Probe:* WHAT IS HIS/HER BIRTHDAY? If the mother/caretaker knows the exact birth date, also enter the day; otherwise, circle 98 for day.	Date of birth : Day ....__ __ DK Day ....98 Month..__ __ Year ....__ __ __ __	
UF11. HOW OLD WAS (name) AT HIS/HER LAST BIRTHDAY? Record age in completed years.	Complete age ....__	

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BIRTH REGISTRATION AND EARLY LEARNING MODULE			BR
BR1. (*Name*) DO YOU HAVE THE BIRTH CERTIFICATE? MAY I SEE IT?	Yes, I saw it Yes, I did not see it No DK	1 2 3 8	1⇨BR5
BR2. WAS (*name*) REGISTERED IN THE NOTARY PUBLIC?	Yes No DK	1 2 8	1⇨BR5 8⇨BR4
BR3. WHY WAS (*name*) NOT REGISTERED?	It's very expensive It's very far away Didn't know it was necessary to register a child It not want to pay the fine Did not know where to register Other (*specify*) DK	1 2 3 4 5 6 8	
BR4. DO YOU KNOW WHAT IS NECESSARY TO REGISTER YOUR CHILD?	Yes No	1 2	

BR5. *Verify the age of the child in question UF11 : child aged 3 or 4 years*

▢ *Yes. ⇨ Continue with BR6*

▢ *No. ⇨ Go to BR8*

BR6. DOES *(Name)* GO TO PRE-SCHOOL , PUBLIC OR PRIVATE, KINDERGARTEN, COMMUNITY CENTRE OR SOME OTHER PROGRAMME OUTSIDE THE HOUSE ?	Yes.. 1 No .... 2 DK 8		 2⇨BR8 8⇨BR8
BR7. DURING THE PAST SEVEN DAYS, HOW MANY HOURS HAS (*name*) PASSED IN THIS PLACE?	Number of hours .... __ __		

BR8. DURING THE LAST 3 DAYS, DID YOU OR ANOTHER HOUSEHOLD MEMBER OLDER THAN 15 CARRY OUT WITH (*name*) SOME OF THE FOLLOWING ACTIVITIES :

If "yes", ask : WHO PARTICIPATED IN THIS ACTIVITY WITH THE CHILD : MOTHER, FATHER OR ANOTHER ADULT HOUSEHOLD MEMBER, INCLUDING THE PERSON SURVEY)?
Circle all replies.

		Mother	Father	Other	Nobody
BR8A. READ BOOKS OR LOOK AT PICTURE BOOKS WITH (*name*)?	Books	A	B	X	Y
BR8B. STORYTELLING WITH (*name*)?	Stories	A	B	X	Y
BR8C. SINGING WITH (*name*)?	Music	A	B	X	Y
BR8D. GO OUT WITH (*name*) OUTSIDE THE HOUSE, RESIDENCE, YARD?	Go out	A	B	X	Y
BR8E. PLAYING WITH (*name*)?	Play with	A	B	X	Y
BR8F. SPENDING TIME WITH (*name*) STORYTELLING AND/OR DRAWING?	Spend time	A	B	X	Y

VITAMIN A MODULE		VA
VA1. Has (*Name*) received one Vitamin A capsule (supplement) like this? *Show the capsule or bottle for different* *doses :* 100 000 UI for children 6-11 months, 200 000 UI for children 12-59 months	Yes... 1 No .... 2 DK... 8	2⇨Foll. Module 8⇨ Foll. Module
VA2. How many months has it been since (*name*) took the last dose?	Number of months............................... __ __ DK... 98	
VA3. Where did (*name*) receive the last dose?	In a health centre during the last routine visit1 In a health centre when the child was ill 2 National vaccination day .... 3 Other (*specify*) _____ 6 DK... 8	

BREASTFEEDING MODULE		BF
BF1. BREASTFEEDING (*name*)?	Yes.. 1	
	No 2	2⇨BF3
	DK ……………………………………………….. 8	8⇨BF3
BF2. STILL BREASTFEEDING (*name*) ?	Yes.. 1	
	No 2	
	DK... 8	
BF3. SINCE YESTERDAY AT THE SAME HOUR AS TODAY, DID YOU RECEIVE ONE OF THE FOLLOWING FOOD SUPPLEMENTS? Read out loud the name of each item and note down the reply before going to the next item. BF3A.VITAMIN AND MINERAL SUPPLEMENTATION? BF3B. WATER? BF3C. SUGARED WATER, FRUIT JUICES, TEA OR INFUSIONS? BF3D.ORAL REHYDRATION SALTS (ORS)? BF3E. PREPARED BABY FOODS SOLD COMMERCIALLY? BF3F. POWDERED MILK PACKETS OR FRESH MIILK? BF3G. OTHER LIQUIDS? BF3H.SOLID OR SEMI-SOLID (MASH) FOOD ?	 Y N DK A. Vitamin supplementation.............. 1 2 8 B. Water .... 1 2 8 C. Sugared water or juice................. 1 2 8 D. ORS... 1 2 8 E. Prepared foods .... 1 2 8 F. Milk .... 1 2 8 G. Other liquids .... 1 2 8 H. Solid or semi-solid foods.............. 1 2 8	
BF4. Verify BF3H : The child receives solid or semi-solid (mash) foods? ☐ Yes. ⇨ Continue with BF5 *☐ No or DK. ⇨ Go to the Following Module*		
BF5. SINCE YESTERDAY AT THE SAME HOUR AS TODAY, HOW MANY TIMES DID (*name*) EAT SOLID OR SEMI-SOLID FOODS OR MASHED, OTHER NON-LIQUID FOODS? If 7 times or more, enter '7'.	Number of times...................................... ___ DK... 8	

ILLNESS MANAGEMENT MODULE		CA
CA1. HAS (name) HAD DIARRHOEA IN THE LAST TWO WEEKS, THAT IS, SINCE (day of the week) OF THE WEEK BEFORE LAST? Diarrhoea is determined as perceived by mother or caretaker, or as three or more loose or watery stools per day, or blood in stool.	Yes... 1 No .... 2 DK.. 8	2⇨CA5 8⇨CA5
CA2. DURING THIS LAST EPISODE OF DIARRHOEA, DID (name) DRINK ANY OF THE FOLLOWING: Read each item aloud and record response before proceeding to the next item. CA2A. A FLUID MADE FROM A SPECIAL PACKET CALLED (local name for ORS packet solution)? CA2B. GOVERNMENT-RECOMMENDED HOMEMADE FLUID? CA2C. A PRE-PACKAGED ORS FLUID FOR DIARRHOEA?	Y N DK A. Fluid from ORS packet .... 1 2 8 B. Recommended homemade fluid .. 1 2 8 C. Pre-packaged ORS fluid 1 2 8	
CA3. DURING DIARRHOEA DID (name) DRINK LESS THAN USUAL, THE SAME AMOUNT OR MORE THAN USUAL?	Much less or nothing .... 1 The same quantity (or slightly less) .... 2 More .... 3 DK.. 8	
CA4. DURING DIARRHOEA DID (name) EAT LESS THAN USUAL, THE SAME QUANTITY OR MORE THAN USUAL? If "less", insist : MUCH LESS OR A LITTLE LESS?	Nothing…………………………………………1 Much less... 2 Slightly less .... 3 More or less the same quantity .... 4 More... 5 DK.. 8	
CA5. IN THE LAST FOUR WEEKS, DID (name) COUGH?	Yes... 1 No .... 2 DK.. 8	2⇨CA12 8⇨CA12
CA6. WHEN (name) COUGHED WAS BREATHING MORE RAPID THAN USUAL WITH SHORT AND FAST BREATHS OR WITH BREATHING DIFFICULTIES?	Yes... 1 No .... 2 DK.. 8	2⇨CA12 8⇨CA12
CA7. SYMPTOMS ARE DUE TO A PROBLEM IN A RIB OR THE NOSE IS OBSTRUCTED?	Problem in a rib .... 1 Nose obstructed .... 2 Both .... 3 Other (specify) _____ 6 DK.. 8	2⇨CA12 6⇨CA12
CA8. DID YOU SEEK MEDICAL ADVICE OR WERE YOU TREATED OUTSIDE THE HOME?	Yes... 1 No .... 2 DK.. 8	2⇨CA10 8⇨CA10

CA9. WHERE DID YOU SEEK ADVICE OR TREATMENT??
 	
 IN ONE OF THESE PLACES
 	
 Circle all providers mentioned but do Not give suggestions.
 	
 If it is a hospital, a health centre or a clinic, write the name of the facility. Insist so that the type of source is determined, and circle the appropriate code.
 	
 ————————————————
 (Name of facility)
	Public Sector
	    Central Hospital.......................................A
	    Health centre ....B
	    Health post C
	    Community health agent.........................D
	    Another public facility (*specify*) ....H
	
	 Private medical practice
	    Private hospital/clinic................................I
	    Private doctors ....J
	    Private pharmacy ....K
	    Private other (*specify*)........................... O
	
	 Other sources
	    Family or Friend(s) ....P
	    Magazines/books .... Q
	    Traditional practioner ....R
	
	 Other (*specify*) _____ X	

CA10.O (*name*) DID YOU TAKE MEDICATION TO CURE THIS ILLNESS?	Yes.. 1 No .... 2 DK... 8	2⇨CA12 8⇨CA12
CA11. WHAT MEDICATION WAS IT QUAL FOI O MEDICAMENTOS QUE O (*name medication*)? Circle all mentioned medications.	Antibiotic treatment ....A Paracetamol/Panadol/Acetaminophen ....P Aspirin .... Q Ibuprofen..R Other ((*specify*)_____X DK...Z	
CA12. VERIFY UF11: Is the child under three? ☐ Yes⇨ Continue with a CA13 ☐ No⇨ Go to CA14		
CA13. THE LAST TIME YOU HAD A BOWEL MOVEMENT, WHERE DID YOU PLACE YOUR FAECES?	The child The child used a toilet/latrine 01 Placed it in the toilet/latrine 02 Placed it in a hole 03 Placed it in the garbage 04 Buried it 05 Left in an open place/bush 06 Sea/River 07 Other (*specify*) 96 DK 98	

Put the following question (CA14) to the child's mother or caregiver, only once. CA14. SOMETIMES CHILDREN SUFFER FROM SEVERE ILLNESSES AND SHOULD BE TAKEN IMMEDIATELY TO A HEALTH FACILITY. WHAT TIME OF SYMPTOM WOULD LEAD YOU TO IMMEDIATELY TAKE YOUR CHILD TO A HEALTH FACILITY? Continue to query for more signs or symptoms until the person is no longer able to respond. Circle all mentioned symptoms. But do Not make suggestions.	The child cannot drink, or suck at the breast or bottle A The child worsened B The child has fever C The child has rapid breathing D The child has difficulty breathing E The child's faeces has blood F The child drinks with difficulty G Other (*specify*) X Other (*specify*) Y Other (*specify*) Z	

IMMUNIZATION MODULE					IM

If an immunization card is available, copy the dates in IM2-IM8 for each type of immunization or vitamins dose recorded on the card. IM10-IM18 are for recording vaccinations that are not recorded on the card. IM10-IM18 will only be asked when a card is not available.

IM1. IS THERE A VACCINATION CARD FOR (*name*)?	Yes, seen ....1 Yes, not seen...2 No...3	2⇨IM10 3⇨IM10

(a) Copy dates for each vaccination from the card. (b) Write '44' in day column if card shows that vaccination was given but no date recorded.	Date or Immunization			
	DAY	MONTH	YEAR	

IM2. BCG	BCG									
IM3A. POLIO AT BIRTH	OVP0									
IM3B. POLIO1	OVP1									
IM3C. POLIO2	OVP2									
IM3D. POLIO3	OVP3									
IM4A. DPT1	DPT1									
IM4B. DPT2	DPT2									
IM4C. DPT3	DPT3									
IM5A. HEPB1 (OR DPTHB1)	(DPT)H1									
IM5B. HEPB2 (OR DPT HB2)	(DPT)H2									
IM5C. HEPB3 (OR DPT HB3)	(DPT)H3									
IM6. MEASLES (OR MMR)	MEASLES									
IM7. YELLOW FEVER	YF									
IM8A. VITAMIN A (1)	VITA1									
IM8B. VITAMIN A (2)	VITA2									

IM9. IN ADDITION TO THE VACCINATIONS AND VITAMIN A CAPSULES SHOWN ON THIS CARD, DID (name) RECEIVE ANY OTHER VACCINATIONS - INCLUDING VACCINATIONS RECEIVED IN CAMPAIGNS OR IMMUNIZATION DAYS? Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, Hepatitis B 1-3, Measles, Yellow Fever vaccine(s), or Vitamin A supplements.	Yes ....1 (Probe for type of vaccine and write '66' in the corresponding day column on IM2 to IM8B). No...2 DK 8	1⇨IM19 2⇨IM19 8⇨IM19
IM10. HAS (name) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES, INCLUDING VACCINATIONS	Yes ....1 No...2	 2⇨IM19

RECEIVED IN A CAMPAIGN OR IMMUNIZATION DAY?	DK 8	8⇨IM19

IM11. HAS (name) EVER BEEN GIVEN A BCG VACCINATION AGAINST TUBERCULOSIS - THAT IS, AN INJECTION IN THE ARM OR SHOULDER THAT CAUSED A SCAR?	Yes ....1 No..2 DK 8	
IM12. HAS (name) EVER BEEN GIVEN ANY "VACCINATION DROPS IN THE MOUTH" TO PROTECT HIM/HER FROM GETTING DISEASES – THAT IS, POLIO?	Yes ....1 No..2 DK 8	2⇨IM15 8⇨IM15
IM13. HOW OLD WAS HE/SHE WHEN THE FIRST DOSE WAS GIVEN – JUST AFTER BIRTH (WITHIN TWO WEEKS) OR LATER?	Just after birth (within 2 weeks) ....1 Later 2	
IM14. HOW MANY TIMES HAS HE/SHE BEEN GIVEN THESE DROPS?	Number of times ....__ __	
IM15. HAS (name) EVER BEEN GIVEN "DPT VACCINATION INJECTIONS" - THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS - TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, DIPHTHERIA? (SOMETIMES GIVEN AT THE SAME TIME AS POLIO)	Yes ....1 No..2 DK 8	2⇨IM17 8⇨IM17
IM16. HOW MANY TIMES?	Number of times ....__ __	
IM17.HAS (name) EVER BEEN GIVEN "MEASLES VACCINATION INJECTIONS" OR MMR - THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES?	Yes ....1 No..2 DK 8	
IM18. HAS (name) EVER BEEN GIVEN "YELLOW FEVER VACCINATION INJECTIONS" - THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING YELLOW FEVER? (SOMETIMES GIVEN AT THE SAME TIME AS MEASLES)	Yes ....1 No..2 DK 8	
IM19. PLEASE TELL ME IF (name) HAS PARTICIPATED IN ANY OF THE FOLLOWING CAMPAIGNS, NATIONAL IMMUNIZATION DAYS AND/OR VITAMIN A OR CHILD HEALTH DAYS: IM19A. *DATE/TYPE OF CAMPAIGN A* IM19B. *DATE/TYPE OF CAMPAIGN B* IM19C. *DATE/TYPE OF CAMPAIGN C*	Y N DK Campaign A.................................1 2 8 Campaign B.................................1 2 8 Campaign C.................................1 2 8	

IM20. *Does another eligible child reside in the household for whom this respondent is mother/caretaker? Check household listing, column HL8.*

☐ *Yes. End the current questionnaire and then Go to QUESTIONNAIRE FOR CHILDREN UNDER FIVE to administer the questionnaire for the next eligible child.*

☐ *No. End the interview with this respondent by thanking him/her for his/her cooperation. If this is the last eligible child in the household, go on to ANTHROPOMETRY MODULE.*

ANTHROPOMETRY MODULE		AN
After questionnaires for all children are complete, the measurer weighs and measures each child. Record weight and length/height, taking care to record the measurements on the correct questionnaire for each child. Check the child's name and line number on the household listing before recording measurements.		
AN1. CHILD'S WEIGHT.	Kilograms (kg) .... __ __ . __	

AN2. CHILD'S LENGTH OR HEIGHT on the household listing verify child's age in UF11:
 	
 ☐ Child under 2. ⇨ Measure length (lying down).
 	
 ☐ Child over 2. ⇨ Measure height (standing).
	Length (cm)
	    Lying down .... 1 __ __ __ . __
	
	 Height (cm)
	    Standing .... 2 __ __ __ . __	

AN3. MEASURER'S IDENTIFICATION CODE.	Code Number .... __ __	
AN4. RESULT OF MEASUREMENT	Measured .... 1 Absent .... 2 Refused... 3 Other (*specify*)_____ 6	

AN5. IS THERE ANOTHER CHILD IN THE HOUSEHOLD ELIGIBLE FOR ANTHROPOMETRIC MEASUREMENT?

☐ *Yes.* ⇨ *Record measurements for next child.*

☐ *No.* ⇨ *End of interview in this household. Thank all participants for their collaboration.*
Gather together all questionnaires for this household and check that all identification numbers are inserted on each page. Tally on the Household Information Panel the number of interviews completed.