Iraq Multiple Indicator Cluster Survey 2011

Preliminary Report

April 2012

Central Statistical Organization (CSO)

Kurdistan Regional Statistics Office (KRSO)

Ministry of Health

United Nations Children's Fund

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacillus-Cereus-Geuerin (Tuberculosis)
CDC	Centre of Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Central Organization for Statistics
CRC	Convention on the Rights of the Child
CSPro	Census and Survey Processing System
DPT	Diphtheria, Pertussis, and Tetanus
FGM/C	Female Genital Mutilation/Cutting
GPI	Gender Parity Index
Hep B	Hepatitis B
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
KRSO	Kurdistan Regional Statistics Office
LAM	Lactational Amenorrhea Method
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MICS-4	The Fourth Round of the Multiple Indicator Cluster Survey
MMR	Measles, Mumps, and Rubella
MoH	Ministry of Health
NA	Not applicable
NAR	Net Attendance Ratio
NCHS	National Center for Health Statistics (USA)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PPS	Probability Proportional to Size
PSU	Primary Sampling Unit
RHF	Recommended Home Fluid
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
UNICEF	United Nations Children's Fund
WFFC	World Fit for Children
WHO	World Health Organization

Summary Table of Findings
MICS and MDG Indicators, Iraq, 2011.

Topic	Indicator Number		Indicator	Value		UNIT
	MICS	MDGs		National	Kurdistan Region	
Fertility	-	-	Total Fertility Rate	4.6	3.5	Per woman
Child Mortality	1.1	4.1	Under-five Mortality Rate	37.9	33.9	Per 1000 Live Births
	1.2	4.2	Infant Mortality Rate	32.9	29.8	Per 1000 Live Births
Nutritional Status	2.1a	1.8	Underweight Prevalence (Moderate and Severe)	8.4	6.5	Percentage
	2.1b		(Severe)	3.8	3.4	Percentage
	2.2a		Stunting Prevalence (Moderate and Severe)	22.3	17.1	Percentage
	2.2b		(Severe)	9.6	6.6	Percentage
	2.3a		Wasting Prevalence (Moderate and Severe)	6.9	4.7	Percentage
	2.3b		(Severe)	3.4	2.4	Percentage
	2.6		Exclusive Breastfeeding Rate (0-5 months)	18.6	18.8	Percentage
	2.7		Continued Breastfeeding Rate (at 12-15 months)	52.0	40.9	Percentage
	2.8		(at 20-23 months)	23.7	26.6	Percentage
			Timely Complementary Feeding Rate (6-9 months)	68.5	54.7	Percentage
Child Health						
Immunization (12-23 months)	3.1		Tuberculosis Immunization Coverage at 12 months	91.3	97.2	Percentage
	3.2		Polio Immunization Coverage at 12 months	70.4	76.8	Percentage
	3.3		DPT Immunization Coverage at 12 months	63.5	72.0	Percentage
	3.4	4.3	Measles Immunization Coverage at 12 months	64.2	74.5	Percentage
			Fully Immunized Children at 12 months	45.4	60.7	Percentage
Care of illness			Use of Oral Rehydration Solution (ORS)	24.2	36.1	Percentage
			Use of ORS or increased fluids	33.2	44.1	Percentage
	3.8		Received ORT (ORS or increased fluids) with continued feeding	24.2	28.1	Percentage
	3.10		Antibiotic Treatment of Suspected Pneumonia	69.1	65.1	Percentage
Solid Fuel Use	3.11		Solid Fuel Use	1.5	0.3	Percentage
Healthy Environment	4.1	7.8	Use of improved drinking water sources	89.0	96.4	Percentage
			Use of improved sanitation	95.7	98.5	Percentage
Reproductive Health	5.3	5.3	Contraceptive Prevalence	51.2	61.9	Percentage
	5.7	5.2	Skilled Attendant at Delivery	88.5	91.0	Percentage
	5.8		Institutional Deliveries	74.4	81.2	Percentage
Education	7.4	2.1	Net Primary School Attendance Rate	89.1	94.8	Percentage
	7.9	3.1	Gender Parity Index for Primary School	0.92	0.97	Ratio (female/male)
	7.10	3.1	Gender Parity Index for Secondary School	0.82	0.95	Ratio (female/male)
	7.7		Gross Primary School Completion Rate	81.8	101.1	Percentage
			Net Primary School Completion Rate	43.3	60.7	Percentage
Child Protection	8.1		Birth Registration	99.1	99.4	Percentage
	8.6		Marriage (Before Age 15)	5.7	5.6	Percentage
	8.7		(Before Age 18)	24.2	23.7	Percentage
	8.8		Young women aged 15-19 currently married	18.7	9.1	Percentage
	8.2		Child Labour	6.9	3.2	Percentage
	8.12		Female Genital Mutilation/Cutting	12.1	44.1	Percentage
HIV/AIDS and Orphaned Children	9.2	6.3	Comprehensive Knowledge about HIV (15-24 years)	3.1	3.6	Percentage
			School Attendance of Orphans (double orphanhood) versus Non-Orphans	0.83		Orphans/Non-Orphans school attendance
			School Attendance of Orphans (either parent) versus Non-Orphans	0.93		

Members of the MICS-4 (2011) National Steering Committee

- Dr. Mahdi Muhsen AL-Alak - Head of the Central Statistics Organization (CSO) /Chief
- Miss Thana Abass Salman - General Director for Technical Affairs (CSO)
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Message from the Minister of Planning

The development of a safe and healthy society requires appropriate consideration of the interests and well-being of individuals. Understanding their situation and what has to be done to improve it implies acknowledging the fundamental role of women and children in any sustainable process of community building.

In order to better understand the status of women and children's health and education, nutrition and social protection, UNICEF developed the Multiple Indicator Cluster Survey (MICS) in 1995. MICS produces a wide range of scientifically built and tested indicators to provide a realistic and detailed picture of the situation of women and children in many countries across the world.

Acknowledging the relevance of this tool, the Central Statistics Organization (CSO) conducted the first round of the survey in 1996 interviewing 6,000 households (MICS-1); the second round was conducted in 2000 (MICS-2) and 13,430 households were interviewed. In 2006, 18,144 households were interviewed to conduct the third round (MICS-3).

In 2011, the fourth round was conducted (MICS-4) which doubled the number of households interviewed to36, 580 and information was obtained for all districts in all governorates.

The successive rounds of MICS were conducted by CSO and the Kurdistan Region Statistics Office (KRSO), in close cooperation and coordination with the Ministry of Health, and with financial and technical support from UNICEF.

We are pleased to present the Preliminary Findings Report of MICS-4, 2011, which provides information on indicators of utmost importance on the status of children and women in Iraq, and to measure the progress attained through efforts aiming at achieving the Millennium Development Goals (MDG) and the objectives of a World Fit for Children (WFFC).

We are cognizant that the results of this survey will provide valuable and reliable information to support the national efforts in enhancing the status of children and women in IRAQ.

Professor Dr.Ali Yousif AL-Shukri
Minister of Planning

Message from the Chief of the Central Statistics Organisation

MICS is a primary source of information on women and children as it provides statistical indicators that are critical for human development. MICS is a reputable and high quality source of information for assessing the situation of women and children and for monitoring and evaluating efforts and progress towards the fulfillment of the Millennium Development Goals and the Word Fit for Children framework.

The implementation of MICS-4 has been a success in all its phases. The excellence achieved is confirmed by the robustness of the results and the high quality data, which was confirmed in an international validation workshop held in November 2011 under the guidance and expertise of the UNICEF MICS Global Team from New York.

Iraq is significant in the Middle East and North Africa region because it has implemented all four rounds of MICS surveys. The dissemination of their results has been endorsed and appreciated by governmental bodies, Arab organizations, and other regional and international organizations.

In presenting the Preliminary Findings Report of MICS-4, 2011, we wish to express our gratitude and appreciation for all efforts that have contributed directly or indirectly in designing, conducting the survey, preparing this report and releasing its results, from the workers in CSO and KRSO to MoH, to the members of the National Higher Supervisory Committee of the survey. The contributions made by UNICEF Iraq Country Office, UNICEF Middle East and North Africa Regional Office, and UNICEF Headquarters cannot be overstated. We are also thankful to the Iraq offices of the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

We hope to have succeeded in this important statistical work.

Dr.Mahdi Muhsen Al Alak
Chief of the Central Statistics Organization

1. Background and Objective

Introduction

The 2011 MICS-4 survey was conducted by the Central Statistics Organisation (CSO) and the Kurdistan Regional Statistics Office(KRSO) in coordination with the MoH and provides a detailed understanding of the status of children and women in Iraq today .The survey was implemented largely in response to the need to monitor progress towards the attainment of the goals and targets contained in the international agreements: the Millennium Declaration and Millennium Development Goals(MDGs) adopted by 191 Member States of the United Nations in September 2000, and the Plan of Action of a 'World Fit for Children' (WFFC), which was adopted by 189 United Nations Member States during the meeting of the United Nations Special Session on Children in May 2002. Both of these commitments build upon the pledge of the international community made in 1990 at the World Summit for Children.

Signatories to these international agreements have committed themselves to improve the conditions of children and to monitor progress made towards the same. The United Nations Children's Fund (UNICEF) has been entrusted to play a supportive role in carrying out this task (see box below).

Commitment for Action: National and International Monitoring

The Governments of the signing States to the Millennium Declaration, the Convention on the Rights of the Child and the Plan of Action, have committed themselves to monitor progress towards attainment of the goals and objectives contained in those documents.

"We will regularly monitor at the national and regional levels, wherever possible, and evaluate our progress towards the goals and targets of the plan of operations at the national, regional and international levels. We will support, consequently, our national statistical capacities to collect, analyse and disaggregate data providing indicators by gender, age and other relevant factors that may lead to disparities, as well as to support a wide range of child-focused research. We will strengthen international cooperation to support statistical capacity-building efforts and build community capacity in monitoring, evaluation and planning"(**A World Fit for Children,** paragraph 60)

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

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

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

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

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

The CSO conducted three rounds of MICS in 1996, 2000, and 2006, with UNICEF and its national partners. UNICEF provided financial and technical support to conduct the fourth

round of MICS in 2011.MICS is one of the key data sets used by governments, UNICEF, and its partners to monitor progress towards the achievement of the rights of children and women as defined in the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). MICS-4 indicators are used to measure and document progress made towards the achievement of the goals in the WFFC and the MDGs at the national, regional and international levels. Therefore, the findings in Iraq's MICS-4 provide the necessary data and information to enable the government to prepare national progress reports towards the achievement of the goals of the CRC which are the cornerstone for the attainment of the MDGs.

The value of this survey goes beyond the mere generation of data and international reporting purposes. While this preliminary findings report specifically includes estimates at the national level, the final report will provide disaggregated estimates at subnational levels. The 2011 MICS-4 results will provide useful input towards the development and updating of Iraq's National Development Plan (NDP), the National Poverty Reduction Strategy Paper (PRSP) for Iraq, the National Education Strategy (NED), and will significantly contribute to ongoing government efforts at the central and KRG levels, as well as other national actors, in formulating effective programmes, plans of action and policies for children and women directed towards expanding inclusion and the reduction of inequities and poverty. MICS-4 will also facilitate tracking Iraq's progress towards the MDGs and the National Human Development Report – all of which will provide the United Nations agencies with data to be used in the formulation and prioritization of targets aimed to address current challenges in Iraq.

MICS-4 results are based on credible, detailed and up-to-date indicators and will certainly lead to extensive work in formulating effective goals, assessing, implementing and monitoring development actions for the children and women in which all line ministries join forces .This preliminary report presents selected results on some of the principal topics covered in the survey and on a subset of indicators. The results in this report are preliminary and are subject to change, although major changes are not expected. A comprehensive full report is scheduled for publication shortly.

Survey Objectives

The 2011 MICS-4 primary objectives are to:

- Provide up-to-date information for assessing the situation of children and women in Iraq;
- Furnish data needed for monitoring progress toward goals established by the Millennium Development Goals and the goals of A World Fit for Children (WFFC) as a basis for future action;
- Contribute to the improvement of data and monitoring systems in Iraq and to strengthen technical expertise in the design, implementation and analysis of such systems; and,
- Develop data on the situation of children and women, including the identification of deprived groups, and to identify disparities with a view to enriching policies and interventions.

2. Sample and Survey Methodology

Sample Design

The total sample size for MICS-4 was 36,580 households with 3,658 clusters, where each cluster includes 10 households. The MICS-4 sample provides estimates that are representative at different levels: at the district level with an acceptable margin of error, at governorate level with minimal margin of error, and at national level with a high accuracy and precision margin, and also disaggregated by urban and rural areas.

The survey sample covers all governorates including those of the Kurdistan Region, and thereby all districts in Iraq. For the first time, the CSO designed the sample by applying the modern demographical framework resulting from the Enumeration and Listing Process that was conducted in 2009 in preparation for the Census. Whereas in the past, the MICS sample was derived from the 1997 census data, which is out of date and not commensurate with the demographic changes taking place in Iraq. Hence, based on the application of the sample size formula, the sample size in each district was estimated at 310 households, with each 10 households comprising a cluster, and thereby 31 clusters in each district.

Sample selection was completed in two phases. In the first phase, 31 primary sampling units (PSU) or blocks were selected in each district using the linear systematic probability proportional to size (PPS) method. Blocks were then divided in each district according to urban/rural weights. Blocks are groups of buildings comprising of, or part of, a mahala/village in which the borders are clearly outlined on the ground, mapped, coded/numbered, with easily identifiable landmarks, covering at least 70-100 buildings/infrastructure, and are sequentially numbered within the borders of the mahala/village.

Sample sizes differ between governorates depending on the number of districts in each governorate. Iraq has 118 districts, 85 in Central and Southern Iraq and 33 in the Kurdistan Region.

The total number of clusters selected in urban areas is 2,199 equalling 60.1 per cent of the total, and 1,459 clusters in rural areas amounting to 39.9 per cent of all clusters. At the second stage, ten households from each PSU (block) were selected, randomly from the updated listing exercise which was carried out at the cluster level within the selected PSU (or block). The listing provided information on the locations and numbers of sample households included in the cluster, and latitude/longitude of the cluster centre and maps. Data was normalized during the analysis stage using the weighting based on weights of the PSUs.

The PSUS are weighted to estimate indicators that adequately represent the different geographical areas: districts, governorates, and rural-urban areas.

Questionnaires

Three questionnaires were used to collect information for MICS-4. Firstly, a questionnaire was designed for all household members. The second questionnaire was used for individual women aged 15-49 years in all surveyed households. The third questionnaire related to children under-five and included mothers or caretakers of under-five children in each household. The questionnaires included the following modules:

Household Questionnaire

- Household Information Panel
- Household Listing
- Education
- Water and Sanitation
- Household Characteristics
- Child Labour
- Child Discipline
- Hand washing
- Salt Iodization
- Chlorine Testing

Questionnaire for Individual Women

- Woman Information Panel
- Women Background
- Marriage
- Child Mortality
- Birth History
- Desire for Last Birth
- Maternal and Last Newborn Health
- Illness Symptoms
- Contraception
- Attitudes Towards Domestic Violence
- Female Genital Mutilation/Cutting
- HIV/AIDS

Questionnaire for Children Under-five

- Under-five Child Information Panel
- Age
- Birth Registration
- Early Childhood Development
- Breastfeeding
- Care of Illness
- Immunization
- Anthropometry

The MICS-4 standard questionnaires were revised and customized to local conditions, translated into Arabic and Kurdish languages, and re-translated into English. The Arabic and Kurdish language versions of the questionnaires were pre-tested in December 2011. Based on the results of the pre-test, modifications were made to the questionnaires.

Fieldwork and Data Processing

Each fieldwork team comprised six individuals: two female physicians, one statistician, one anthropometric specialist, one field editor and one field supervisor. The number of field teams

in each governorate was linked to the number of districts per governorate as each field team covered one district.

Fieldwork, training activities, and data processing were conducted sequentially. 22 central supervisors were trained for 10 days at a Training of Trainers workshop held in Amman, Jordan (June 2010) by consultants/experts from UNICEF Regional Office MICS team. The implementation of the survey was postponed due to the conduction of the Census, thus the same group of trainers received a refresher Training of Trainers course in January 2011.

The trainers subsequently trained field interviewers for the Kurdistan Region in January and February 2011 and the field interviewers for Central/Southern Iraq in March 2011. Training was conducted over a period of 13 days in three training centres in the Kurdistan Region (Dohuk, Erbil, and Sulaymaniyah), and in eight training centres in Central/Southern Iraq, as follows:

- Baghdad training centre – covering Baghdad and Diala Governorates
- Kerbala training centre – covering Kerbala, Babil and Najaf Governorates
- Qadissiya training centre – covering Qadissiya, Wassit and Al-Muthana Governorates
- Basra training centre – covering Basra, Thiqar and Missan Governorates
- Al-Anbar training centre – covering Al-Anbar Governorate
- Kirkuk training centre – covering Kirkuk Governorate
- Ninewa training centre – covering Ninewa Governorate
- Salahiddin training centre – covering Salahiddin Governorate

A total of 207 trainees from the Kurdistan Region participated in these trainings and 610 trainees from Central and Southern Iraq, all of whom were members of the field teams, (local supervisors, local editors, and alternates).

Field work in the Kurdistan Region was carried out by 33 field teams from 13 February 2011 until 18 March 2011; in Central/Southern Iraq field work was carried out by 85 field teams from 31 March 2011 until 9 May 2011. A local supervisor from the governorate statistical office was assigned to each governorate, as well as one central supervisor assigned to each governorate from MoH and CSO except for Al-Anbar, Salahaddin, Kirkuk, Baghdad, Sulaymaniyah and Erbil governorates where two central supervisors were assigned to each of these governorates. Overall supervision of the survey was carried out by the National Steering Committee whose members conducted field visits to the governorates and maintained direct oversight on progress of field work.

The filled questionnaires were reviewed by field editors during the field work and a second review was conducted by the central supervisors. The data entry process began using 95 microcomputers (70 in Baghdad and 25 in Kurdistan Region) using the Census and Survey Processing System (CSPro). For quality assurance purposes, data was entered in duplicate and internal consistency checks were performed.

Data entry took place in Baghdad from May until August. In the Kurdistan Region, the entry process began in April and ended in June. Data processing ended in October , and overall data quality was assessed in November (2011). The Statistical Package for Social Sciences (SPSS) was used to analyse the data and to produce the tabulation plan based on MICS-4 standard programs adequately customized for Iraq's questionnaires.

Sample Coverage

The number of households first selected for the MICS-4 sample was 36,580 households, and was increased during the field work by two households - one household in Ninewa and one in Erbil Governorates, to reach a total of 36,582 households. Out of the 36,582 households, 35,818 households were found occupied in the 3,658 clusters selected for the sample. Of these, 35,691 registered households were successfully interviewed with a response rate of 99.6 percent. Response rates in rural areas were slightly higher (99.8 percent) than in urban areas (99.5 percent). Based on household interviews, the identified number of eligible women aged 15-49 years is 56,430. The proportion of women in urban areas is 58.6 percent compared to 41.4 percent in rural areas. Of these, 55,177 women were successfully interviewed yielding a response rate of 97.8 percent. The number of children under-five covered by the survey was 36,596 and data was collected for 36,306 children from their mothers or care givers resulting in a response rate of 99.2 percent. The overall response rate of interviews for women aged 15-49 years is 97.4 percent, whereas the overall response rate for children under-five is 98.9 percent.[1]

The Iraq MICS-4 sampled all eligible married and unmarried women of reproductive age. Of the 55,177 women interviewed, 34,215 (62 percent) were married, 2,111 (4 percent) were formerly married, and 18,851(34 percent) women have never been married.

[1] "Response rates" are different from "overall response rates": for example, the response rate of women 15-49 years is the result of dividing the number of interviewed women by the number of eligible women, times 100; the overall response rate of women 15-49 years is the result of multiplying the response rate of women 15-49 years times the households response rate, times 100.

3. Results

Child Mortality

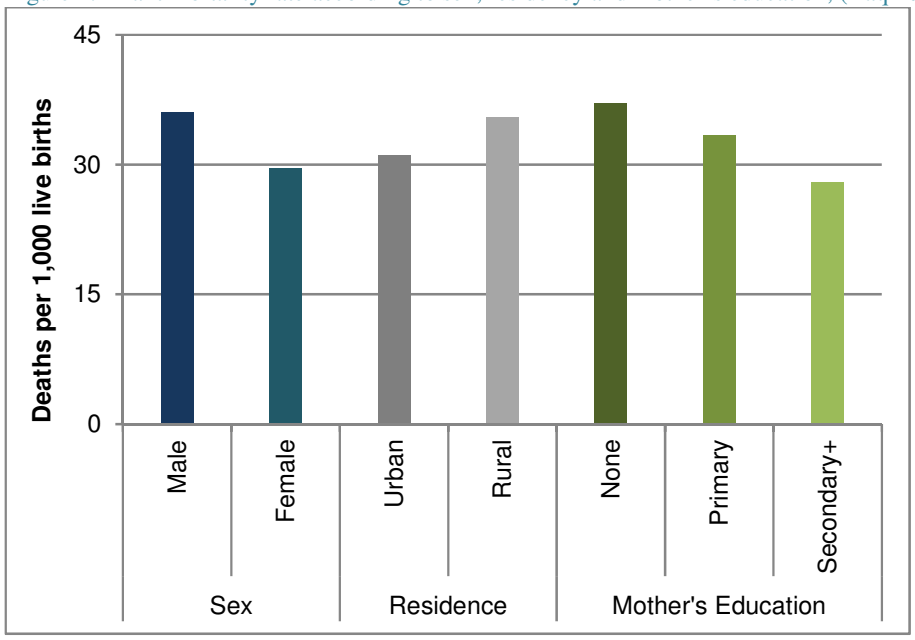
One of the overarching goals of the MDGs and the CRC is to reduce infant and under-five child mortality. Monitoring progress towards this goal is a critical objective yet difficult to implement.

The infant mortality rate represents the probability of death before the first birthday. The under-five mortality is the probability of death before the fifth birthday. These rates are expressed in terms number of deaths per every 1,000 live births. In this report, the two rates were calculated using the 'direct method' based on information gathered from the birth history module of the questionnaire for individual women aged (15-49) years, which included data on the sex of the child, month and year of the birth of each child, the child's survival status and current age, and age at death (if deceased).

Table 2 shows the estimates of the under-five children mortality rates in the five years preceding the date of the survey (corresponding to the years 2007-2011). The under-five mortality rate is estimated at 38 deaths per 1,000 live births. This means that one out of every 26 children born in Iraq dies before reaching age five. It was found that the infant mortality is 33 deaths per 1,000 live births, indicating that 87 per cent of deaths among children under-five occur in the first year of life.

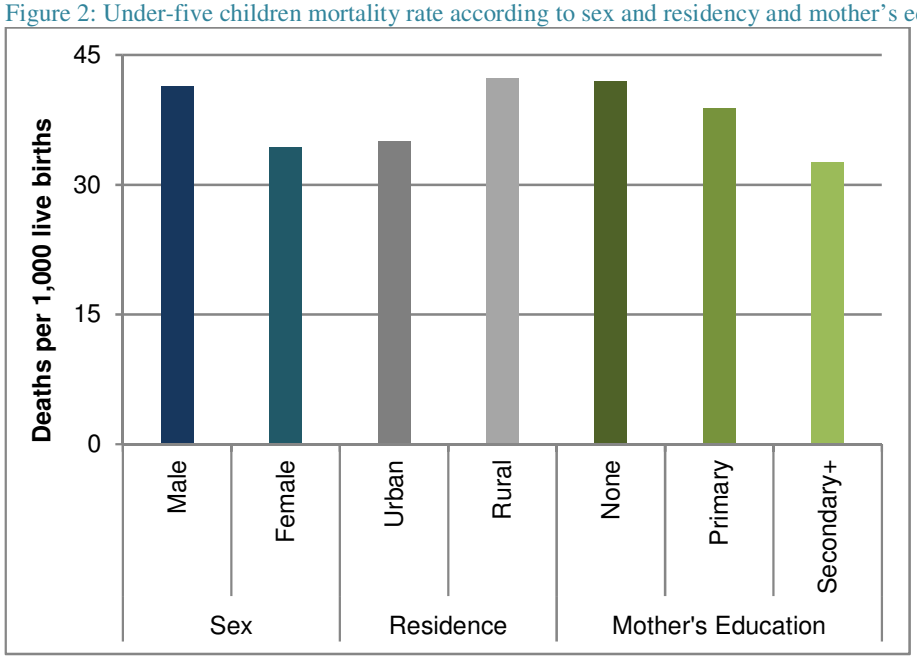
The results of the survey show, as expected, that the infant mortality is higher for males than for females, reaching 36 deaths per 1,000 live births for males against 30 for females. In addition, under-five children in urban areas are less likely to be exposed the risk of dying than children in rural areas before reaching their fifth birthday; 35 versus 42 deaths per 1,000 live births, respectively.

Figure 1: Infant mortality rate according to sex, residency and mother's education, (Iraq 2011)



The infant mortality rate in urban areas is 31 deaths per 1,000 live births, compared to 36 deaths per 1,000 live births in rural areas. The results also indicate that the risks of dying are also related to the level of education of the mother. Children born to mothers with no education face a higher risk of death before their first birthday than those born to mothers who have secondary or higher education (42 versus 33 deaths per 1,000 live births). The level of education of the mother has an impact on infant mortality as well, as the rate reaches 37 deaths per 1,000 live births to mothers with no education, compared to 28 deaths only per 1,000 live births to those mothers with secondary or higher education.

Figure 2: Under-five children mortality rate according to sex and residency and mother's education, (Iraq 2011)



The infant mortality rate increases to 39 deaths per 1,000 live births in the poorest households compared to 32 deaths of infants from the richest households. Similarly, under-five mortality is higher among children in the poorest households with a rate of 45 deaths per 1,000 live births, than among children from richest households where the rate is 37 deaths per 1,000 live births.

Nutritional Status

The nutritional status of children is a reflection of their overall health. Children who have access to an adequate food supply and good nutrition are less prone to develop infections leading to repeated illnesses such as diarrhoeal disorders or respiratory infections. Such children achieve their natural growth potential and are considered well nourished.

A well-nourished population is characterized by the standard distribution of height and weight in children under-five. Malnourishment in a population can be assessed by comparing measurements of the height and weight of children to child growth reference standards. The reference standards used here are those published in 2006 by the World Health Organization (WHO), which replaced the 1977 WHO/National Center for Health Statistics (WHO/NCHS) figures. The 2006 reference standards are recommended by UNICEF and the World Health

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

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

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

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

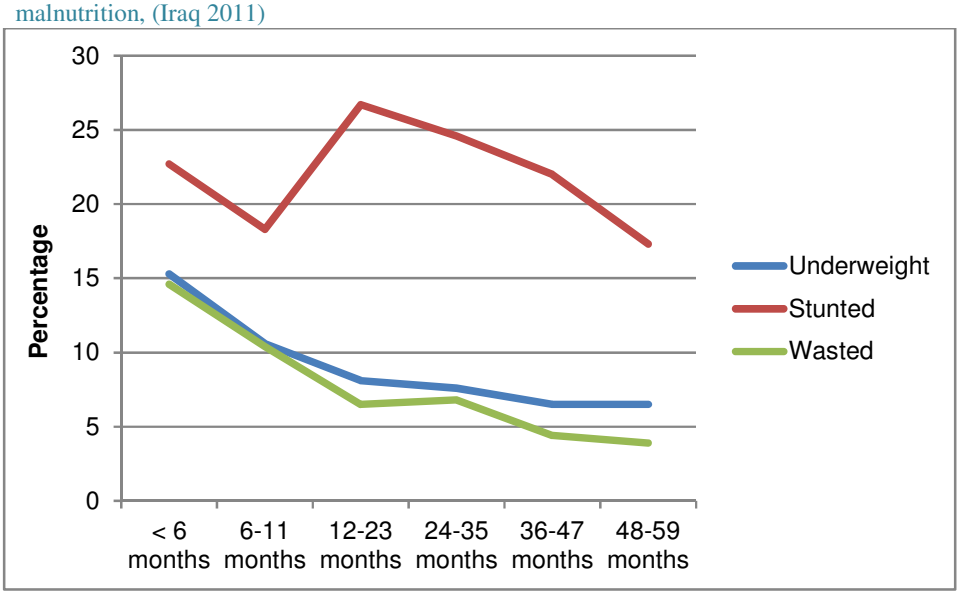
Finally, children whose weight for height is more than two standard deviations above the median of the reference population are classified as *overweight*. Overweight or obesity is a chronic condition that increases the risk of many diseases and health conditions. Individual behaviours, environmental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

Table 3 shows percentages of children classified into each of these categories, based on the anthropometric measurements taken during the fieldwork of the survey. Children who have not been weighed or measured and children whose measurements fell outside the plausible range were excluded from the analysis.

The table shows that 8 per cent of under-five children in Iraq are moderately or severely underweight, and 4 per cent of them are severely underweight. Additionally, more than one fifth (22 per cent) of children are severely or moderately stunted (or too short for their age), with 10 per cent of them severely stunted. Results also indicate that almost 7 per cent of children are wasted (too thin for their height), and 3 per cent of them are severely wasted.

The results revealed that children from rural areas tend to be more stunted than those from urban areas. Regarding mothers' education levels, children whose mothers have secondary or higher education are less likely to be underweight and stunted. Children from richest households are less likely to be stunted than children from poorest households. The sex differentials indicate that males are slightly better nourished than females. The age pattern shows that the highest percentage of stunted children is found among the age group of 12-23 months, compared to children in the preceding or following age groups.

Figure 3: Percentage of children aged (0-59) months who suffer from intermediate and severe malnutrition, (Iraq 2011)



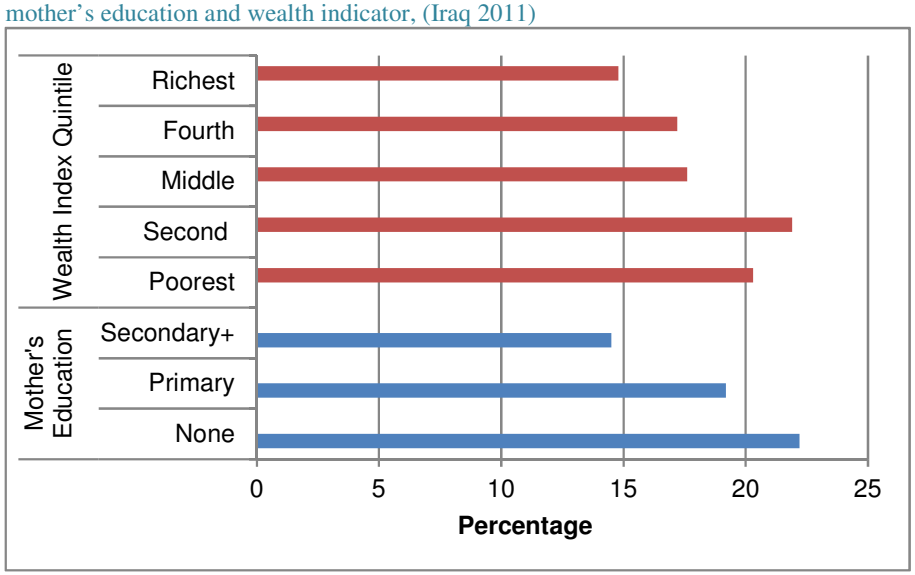
It is worth noting that 11 per cent of children in Iraq are overweight, with children from richest households being more affected (14 per cent) than children from poorest ones (10 per cent).

Breastfeeding

Breastfeeding for the first three years of life protects children from infections, provides them with an ideal source of nutrition, and is also economical and safe. However, some mothers stop breastfeeding too soon and switch to infant formula early on, which may lead to bacteriological contamination and complications resulting in malnutrition, and is unsafe if clean water is not readily available. The WFFC goals state that children should be exclusively breastfed for six months and continued breastfeeding with supplementary feeding up to at least two years of age.

The indicators presented in Table 4 were based on the information given by the mothers/caretakers on children's consumption of foods and fluids during the 24 hours prior to the interview. Exclusive breastfeeding refers to infants who received only breast milk, vitamins and other minerals or medications. The table shows indicators of exclusive breastfeeding during the first six months of life (for children aged 0-3 months, and for children aged 0-5 months), along with indicators of complementary feeding (receiving breast milk and solid/semi-solid food) for children aged 6-9 months and continued breastfeeding for children aged 12-15 months and 20-23 months.

Figure 4: Percentage of exclusively breastfed children aged (0-5) months according to mother's education and wealth indicator, (Iraq 2011)



One out of every five children less than six months of age is exclusively breastfed (19 percent). More than half the children aged 6-9 months (69 percent) are breastfed and are receiving solid and semi-solid food. While 52 percent of children at 12-15 months of age are still breastfed, and 24 percent of children aged 20-23 months continue to be breastfed.

The results also reveal that exclusive breastfeeding is slightly less frequent for females than for males, and male babies tend to be breastfed longer than girls. Slightly more children aged 0-5 months from rural areas (20 percent) are exclusively breastfed than children from urban areas (18 percent). Additionally, children below six months of age that live in the poorest and second wealth quintiles households tend to be more exclusively breastfed (20 percent and 22 percent respectively) than children from fourth and richest wealth quintiles households (15 percent).

Iodized Salt

Iodine deficiency is the world's single greatest cause of preventable mental retardation. It is especially damaging during the early stages of pregnancy and in early childhood. Iodine deficiency is concomitant with goiter, and in its most severe form it is associated with cretinism, stillbirths, miscarriages and infant mortality.

The iodine content in consumable salt was tested in 99.7% of MICS-4 households, as it is shown in Table 5. The results showed that 28% of households consume salt that contains 15Parts Per Million (PPM) of iodine or more. In urban areas iodine fortification was 32% in comparison with 20% in rural areas. Meanwhile, 46% of households in the sample consume non-fortified salt and 27% of households consume salt that contains less than 15 PPM.

Immunization

According to the instructions of the national vaccination campaigns in Iraq, a child during his/her first year of life (that is by the child's first birthday), should be vaccinated through routine immunization with: BCG vaccine for the prevention of tuberculosis; three doses of DPT vaccine for the prevention of diphtheria, pertussis and tetanus; four doses of polio vaccine for the prevention of polio, three doses of Hep-B against Hepatitis-B, and measles vaccine at the age of nine months. The child is also given MMR vaccine upon reaching the age of 15 months - as part of the second round of measles vaccination - for the prevention of measles as well as mumps and rubella.

According to WHO guidelines, children are considered fully immunized if they received three doses of DPT vaccine to protect against diphtheria, pertussis and tetanus; three doses of polio vaccine (OPV 1,2,3), one dose of tuberculosis vaccine (BCG), and one dose of measles vaccine at the age of 12 months.

Mothers or caretakers of children under-five were asked to show the vaccination cards of children, and interviewers copied vaccination information recorded on the cards. If the child had no vaccination card, the mother or caretaker was asked to recall whether her child received the vaccines, and how many times (doses) the child received the vaccine, particularly for DPT and polio.

The results showed that 70 per cent of children aged 12-23 months had health cards that were seen by the interviewers. A further 15 per cent of children have health cards, but were not seen at the time of the interviews. Table 6a shows the vaccination coverage of children aged 12-23 months who received a BCG vaccine, each of the three doses of DPT, polio, Hepatitis-B, and measles and those who were fully vaccinated.

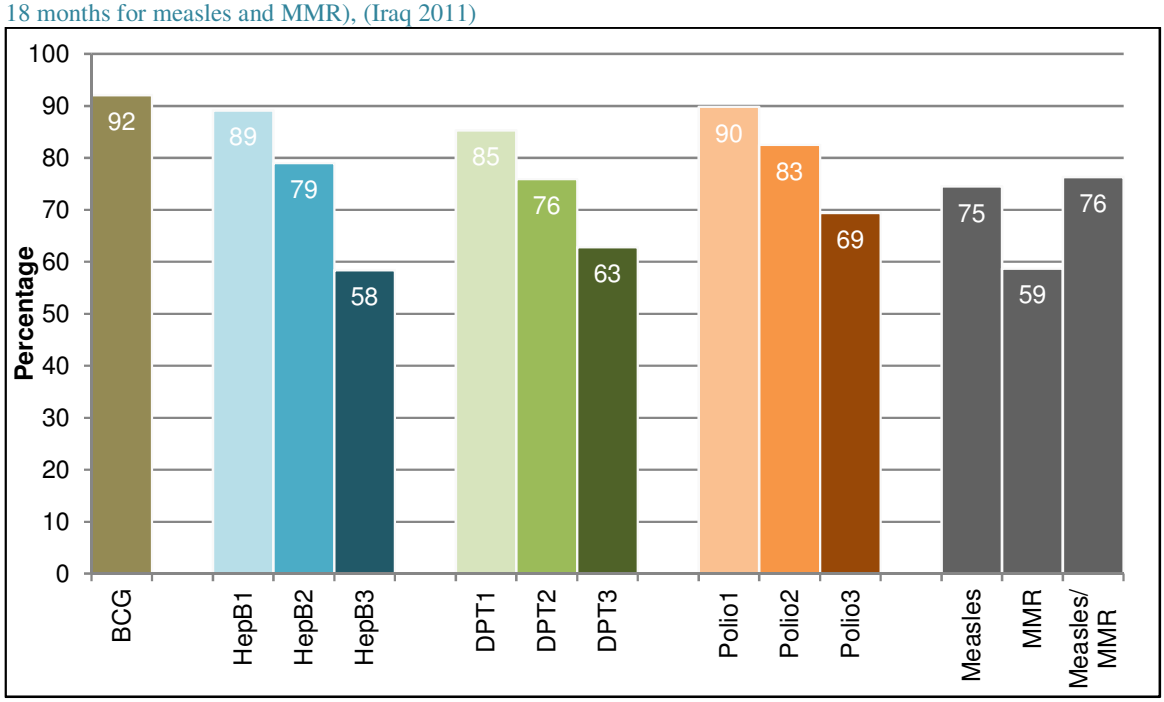
The denominator for the percentages in the table consists of children aged 12-23 months in order to limit the count to those children who ought to have been fully vaccinated. In the first three rows of the table, the numerator includes all children that were vaccinated at any time before the survey according to the vaccination cards, according to mother's reports, or either of the two. The numerator for the figures in the bottom row of the table includes children who were vaccinated before their first birthday.

Approximately 91 per cent of children aged 12 to 23 months received BCG during the first twelve months of age, and about 85 percent received the first dose of DPT. However, the percentage declines for the subsequent doses DPT: 75 percent for the second dose and 64 per cent for the third one. Similarly, 90 per cent of children received the second dose of polio vaccine (polio 1 in Table 6a) at the age of 12 months, and the percentage decreases to 70 per cent for the third dose of polio. The percentage of children who received the first dose of Hepatitis-B vaccine is 89 per cent and the percentage declined to 60 per cent for the third dose. The coverage of measles vaccine at age 12 months reached 64 percent, of the children. The percentage of children who received the full package of vaccinations at the age of 12 months is 45 percent, and 57 per cent at any time before the survey.

Table 6b shows the percentage of children aged 18-29 months who have been immunized against the diseases at any time before survey and before the first birthday: the denominator for

the percentages consists of children aged 18-29 months while the numerator includes all children who have been immunized against the disease at any time before the survey (first three rows of Table 6b) or before their first birthday (18 months of age for measles and MMR). The results show that 75 per cent of children received measles vaccine by their 18 month of age, 59 per cent received MMR vaccine, and 76 per cent received either measles or MMR vaccine. The percentage of children who received all vaccines at the age of 18 months is 49 per cent.

Figure 5: Percentage of children 18-29 months who received recommended vaccinations at age 12 months (and at 18 months for measles and MMR), (Iraq 2011)



Diarrhoea Incidence and Oral Rehydration Therapy

Diarrhoea is a major cause of child mortality and morbidity. Diarrhoea leads to the loss of large quantities of water and nutrients from the body in the form of liquid stools. Treatment through Oral Rehydration Therapy (ORT) - whether through Oral Rehydration Solution (ORS) or a recommended home fluid (RHF) or increased fluids - can prevent many of these deaths. RHF are fluids that contain electrolytes usually made of sugar, salt and water.

Mothers or caretakers were asked to report whether their child had episodes of diarrhoea in the two weeks prior to the survey, and if so, the mother was asked to respond to a series of questions about what the child received during that period in terms of food and fluids, and the amount of intake for each.

Figure 6: Percentage of children aged (0-59) months affected with diarrhoea in the two weeks prior to the survey, (Iraq 2011)

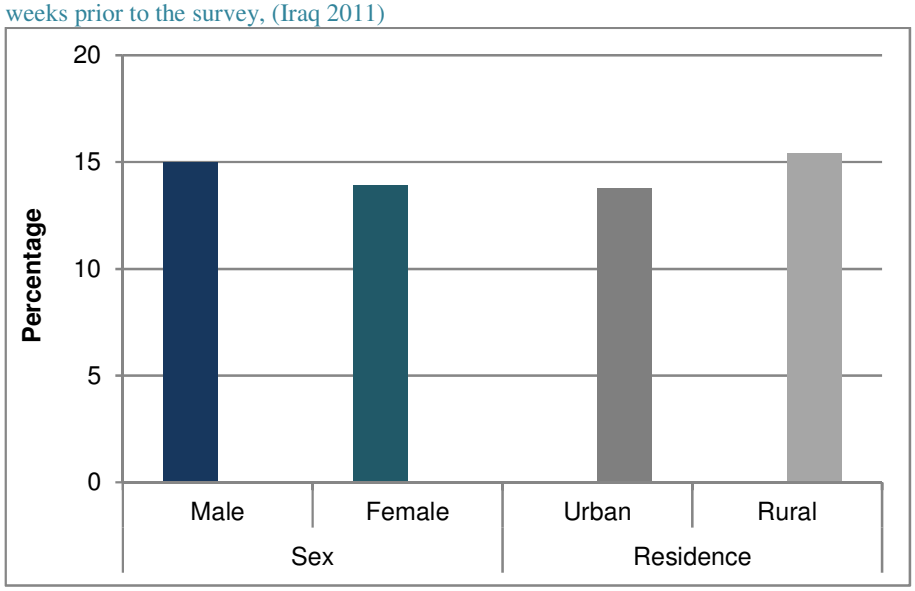
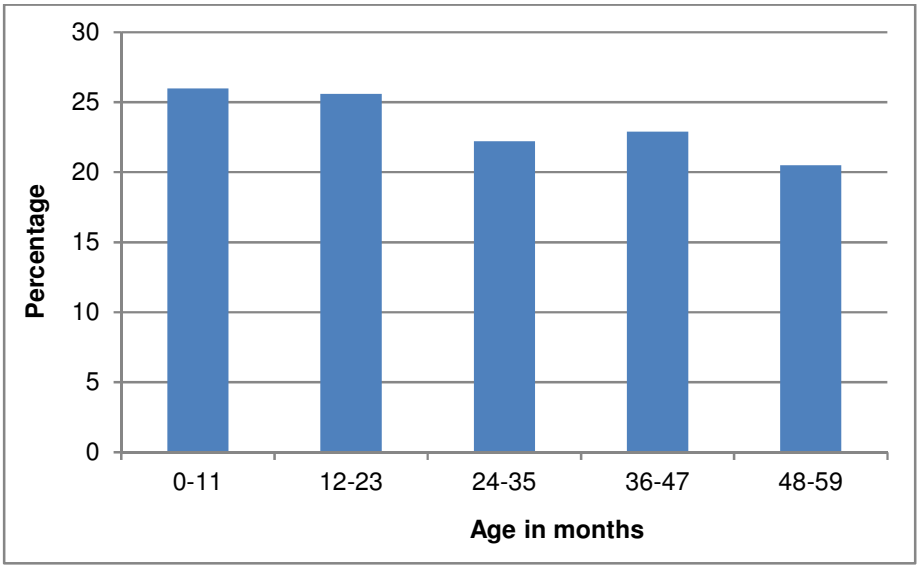


Table 7 shows that the percentage of under-five children who had diarrhoea in the two weeks prior to the survey is approximately 15 per cent. The highest incidence rate of diarrhoea was recorded above 20 percent among children aged 0-11 and 12-23 months.

The table also shows that almost one quarter of children (24 per cent) with diarrhoea received ORT during episodes of diarrhoea. These percentages do not vary much by sex, but vary according to the area of residence, i.e. 27 per cent in urban areas compared to 21 per cent in rural areas. Moreover the highest percentage of ORT use (26 per cent) was among children of the age group of 0-11 months, and the lowest among children aged 48-59 months (21 per cent).

Figure 7: Percentage of children aged (0-59) months affected with diarrhoea who took ORS, (Iraq 2011)



Home Management of Diarrhoea

The treatment of diarrhoea by increasing fluid intake and continuous feeding of the child are important strategies to control malnutrition.

The results in Table 8 indicate that about 12 per cent of under five children drank more quantities of fluids than usual, 38 percent drank similar amounts of fluids, 34 percent had somewhat less quantities of liquids, 13 per cent drank much less fluids and 3 per cent had almost nothing to drink. As for the food, the results showed that 25% of children ate much less than usual or nothing. 75% of children received continued feeding: 71% ate equal or somewhat less than usual, and 4% ate greater quantities than usual. Given these rates, 33 per cent of children received either ORT or drank more than usual.

When considering indicators from Tables 7 and 8, about 24 per cent of the children were treated with ORS or drank more fluids and received continued feeding, as recommended.

The home management of diarrhoea does not vary by the sex of the child, as the results are similar for males and females (24 per cent) who received ORS or received more fluids and continued feeding. However, the results for the same indicator vary by area of residence; 21 per cent in rural areas compared to 27 per cent in urban areas. Home management of diarrhoea varies by age group; the highest percentage of children who received appropriate treatment is found among children 12-23 months age (27 per cent) and the lowest among children of 48-59 months (22 per cent). Differences are evident depending on mothers' education: 22 per cent of children from mothers with no formal education received ORS or increased fluids with continued feeding compared to 29 per cent children of mothers with secondary or higher education levels.

Use of Antibiotics for Children with Suspected Pneumonia

Pneumonia is one of the leading causes of death in children and the use of antibiotics for children under the age of five years with suspected pneumonia is a major therapeutic intervention. Children with suspected pneumonia are those who had a cough accompanied by

rapid or difficult breathing and who have symptoms in the chest, (not solely a blocked nose). Information was collected for children who had suspected pneumonia as to whether or not they had received an antibiotic within the last two weeks.

Table 9 shows the percentages of children aged 0-59 months with suspected pneumonia in the last two weeks prior to the survey, disaggregated by sex, age, area of residence, educational level of the mother and the socio economic factors. In Iraq, 10 per cent of children surveyed had suspected pneumonia. Though this percentage does not vary between urban and rural areas, the prevalence of suspected pneumonia in children varies by age: the highest prevalence rate (12 percent) occurred among children 12-23 months age.

Overall, 69 percent of under five children suffering from symptoms of suspected pneumonia received antibiotics during the last two weeks before the survey. The results show that treatment with antibiotics was slightly less common for children living in rural areas (67 per cent) than for those living in urban areas (71 per cent). Similarly, the use of antibiotic therapy for children with suspected pneumonia does not vary among age groups and mothers' education. Nevertheless the percentage of children from poorest households receiving antibiotics is lower (63 per cent) than from those living in richest households (73 per cent).

Use of Solid Fuel

The use of solid fuel for cooking (biomass and coal) leads to high levels of indoor pollution and is a major cause of illness in the world, particularly for children under 5, in the form of acute respiratory infections.

Table 10 indicates that less than 2 per cent of all household members in Iraq are using solid fuel for cooking .Almost all of them are living in rural areas, where 4 per cent of household members use solid fuel for cooking as opposed to 0.1 percent in urban areas. The use of solid fuel for cooking is affected by the educational level of the household head: 3 percent of population living in households whose head had no education use solid fuels; this percentage decreases to 1 per cent where household heads achieved primary education, and declines to 0.2 per cent where household heads have secondary education. Differentials are also significant with respect to the household wealth where the use of solid fuel is mostly found in poorest households. The table showed that nearly half of these households use wood as solid fuel for cooking.

Water and Sanitation

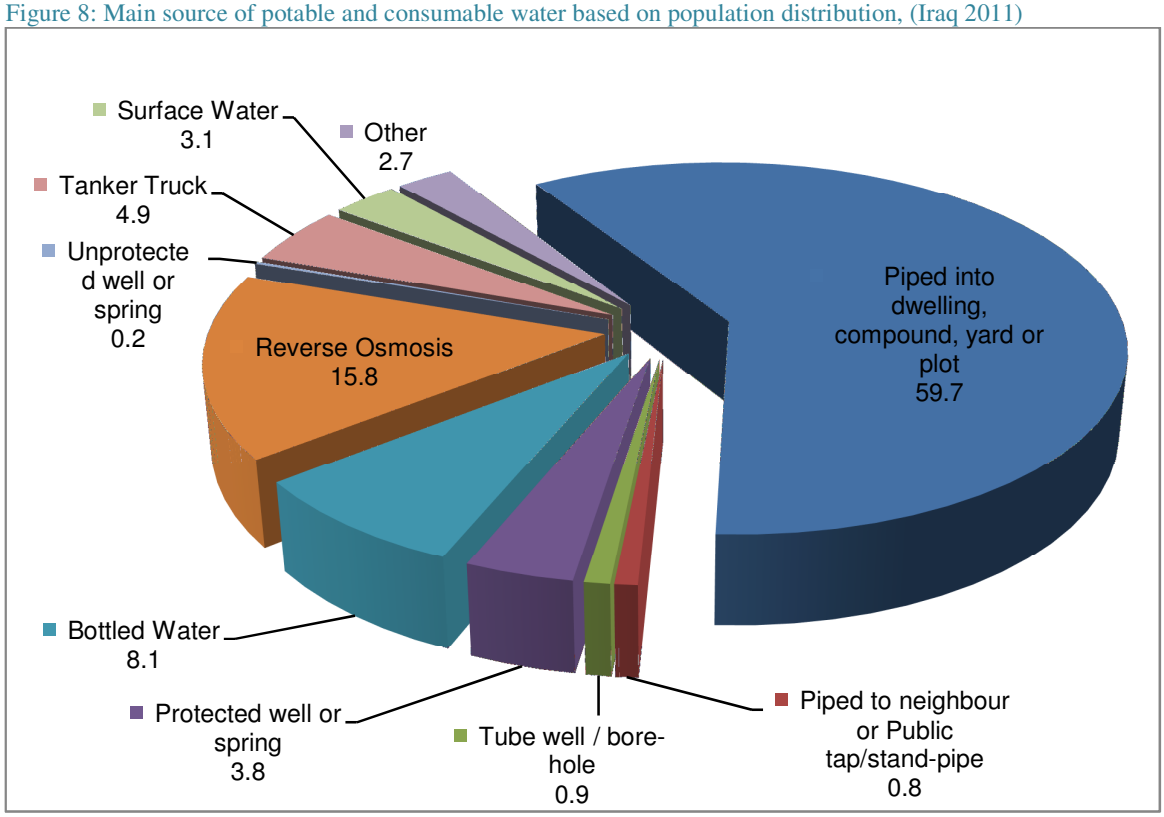
Access to safe drinking water is a basic condition for good health and is also a human right. Unsafe drinking water can be a carrier of serious diseases such as cholera, typhoid, and diarrhoeal diseases such as amoebic and bacillary dysentery. Drinking water can also be contaminated with chemical, biological and radiological contaminants with potentially harmful effects on human health. In addition to its association with diseases, access to drinking water is of great significance, especially in rural areas where children and women bear the burden of carrying water often from far distances.

Table 11 shows the distribution of population by source of drinking water used. The populations using improved drinking water sources are those who use any of the following types for water supply: piped water, public tap/stand-pipe, tube-well/borehole, protected well

or spring, rainwater, water treated with Reverse Osmosis, or bottled water (only if the water source used for cooking and hand washing is an improved one). About 89 per cent of the population has access to improved drinking water - 97 percent in urban areas and 76 per cent in rural areas.

More than half of the population (53 percent) has water piped into their dwellings. Water supply sources from surface and tanker trucks are the main unimproved sources of unsafe drinking water, especially in rural areas. The sources of drinking water vary greatly by area of residence: about 47 per cent of the population uses drinking water piped into their dwellings or to the house courtyard in rural areas, while 67 percent in urban areas have these water sources in urban areas.

Figure 8: Main source of potable and consumable water based on population distribution, (Iraq 2011)



Inadequate disposal of human excreta and personal hygiene are associated with a range of diseases including diarrhoea and polio. Improved sanitation facilities include flush toilets connected to sewerage systems or septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with slabs, and composting toilets.

The results in Table 12 show that about 96 per cent of the population in Iraq is using improved sanitation facilities, and 83 per cent of the population use flush toilets connected to sewerage systems or septic tanks or pit latrines. The percentage of population using improved sanitation facilitates is 99 percent in urban areas and 90 percent in rural areas. However, the percentage of household members using flush toilets connected to a sewerage system decreases to 4 percent in rural areas but is 33 percent in urban areas .The most common improved sanitation facility is the flush toilet connected to a septic tank, which is used by 40 per cent of the population from urban areas and 38 percent from rural areas.

Testing Chlorine Levels in Water

MICS-4 field teams performed free chlorine testing in water for households who were utilizing water transported via pipelines or tap water by utilizing specific testing kits; drinking water was tested for 74 percent of households.

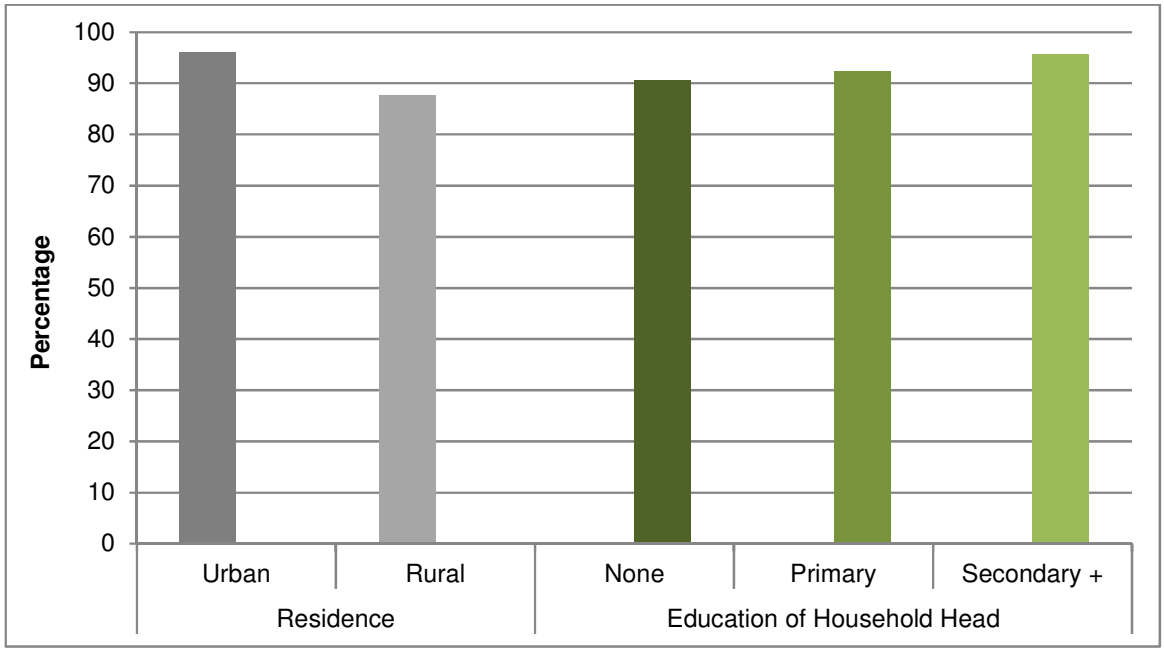
Table 13 indicates that in 46% of households that were tested for chlorine levels, the water contained more than 0.5 PPM which is within the acceptable percentage for sterilization of drinking water, cooking, hand and vegetable and fruit washing: in 15% of households the level ranged from 0.5 - 1 PPM and in 31% of households the level was more than 1 PPM. In 19% of households the level was less than 0.5 PPM. The results indicate that 35% of households had no chlorine at all in the water.

Handwashing

Handwashing with soap and water is the most cost effective hygienic intervention to reduce the incidence of both diarrhoeal diseases and pneumonia among children under-five. Handwashing is most effective when done with soap and water after using the toilet or cleaning a child, before eating or handling food, and before feeding a child. Monitoring correct practices of handwashing among the population is challenging. In MICS-4 this information is collected from interviewers' observation of whether there is a specific place for handwashing; interviewers check whether water and soap (or any other detergent) is available.

The results in Table 14 indicate that 93 percent of households have a designated place for handwashing: 96 per cent in urban areas and 88 percent in rural areas. About 5 percent of the households have no designated place for handwashing; in rural areas the percentage is 11 percent and 2 percent in urban areas. The education level of the head of the household is related to the absence of a designated place for handwashing in the households: 8 percent of households with a head lacking formal education do not have a handwashing place while this percentage is only 2 percent where the head of the household has secondary or higher education.

Figure 9: Percentage of families where a designated place for hand washing was observed according to residency and educational level of the head of household, (Iraq 2011)



Among those households that have a designated place for handwashing water and soap is available in 97 per cent of them, 2 per cent of them have only water available, and 1 per cent have only soap. Nevertheless, soap was available in 94 per cent of households without a designated place for handwashing.

Use of Contraception

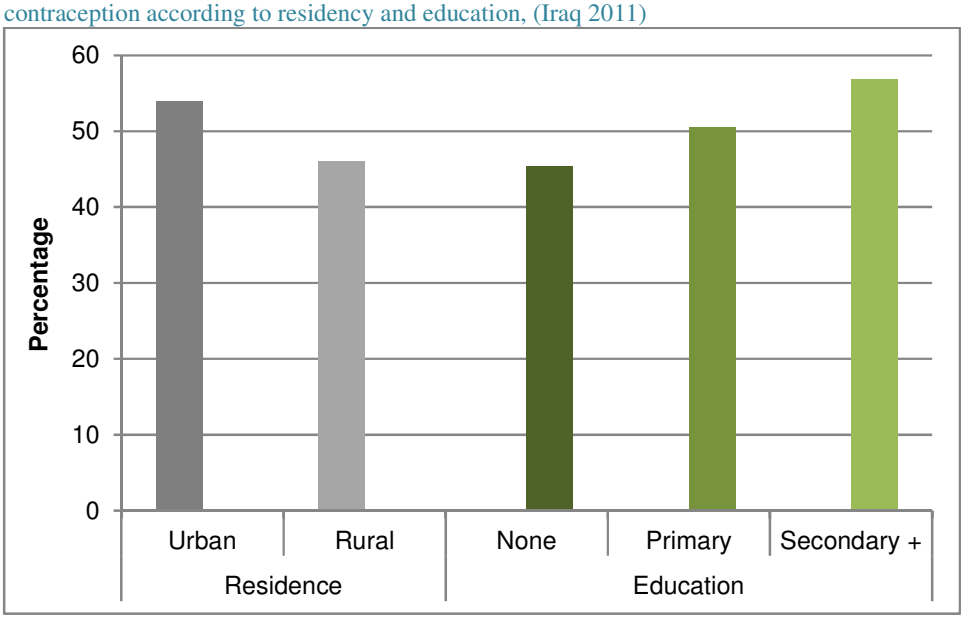
The prevalence of contraceptive use among married women (or their husbands) is about 51 per cent, as shown in Table 15. Modern methods of contraception are practiced by 33 percent of the women, while 18 per cent are using traditional methods. The pill is the most common modern contraceptive used (15 per cent) in Iraq, followed by the Intra-Uterine Device (IUD) used by 10 per cent. Among the traditional methods, the most common contraceptive is withdrawal (14 per cent), and only 2 per cent of women rely on the lactational amenorrhea method (LAM) as a contraceptive. The use of female sterilization, periodic abstinence or injections is used among 1 percent and 3 per cent of women. The use of male or female condoms is limited to about 2 percent of women.

The results showed that younger women are less likely to use contraceptives than older women. Contraceptives are currently used by 21 per cent of married women aged 15-19 years, compared with 39 per cent of women aged 20-24 years and 63 percent of women aged 40-44 years. The use of contraceptives does not exceed 2 percent of women who have no living children. The greater the number of living children for women, the more likely they use contraception: 33 percent of the women that have one living child use some method while 66 percent of women with four or more living children use it.

Women's education level is associated with the use of contraceptives. The percentage of women using any method of contraception rises from 45 per cent among women with no education to 51 per cent among women with primary education and to 57 per cent among

women with secondary or higher education. The method of contraception used is also affected by the women's educational level: women with secondary or higher education are more likely to use pills or withdrawal (35 per cent) than women with no education or with primary education (26 per cent and 29 per cent respectively). The use of contraceptive methods is also associated with wealth as it increases from 42 percent among women from poorest households to 56 per cent among women from richest ones.

Figure 10: Percentage of currently married women aged (15-49) years who had utilized contraception according to residency and education, (Iraq 2011)



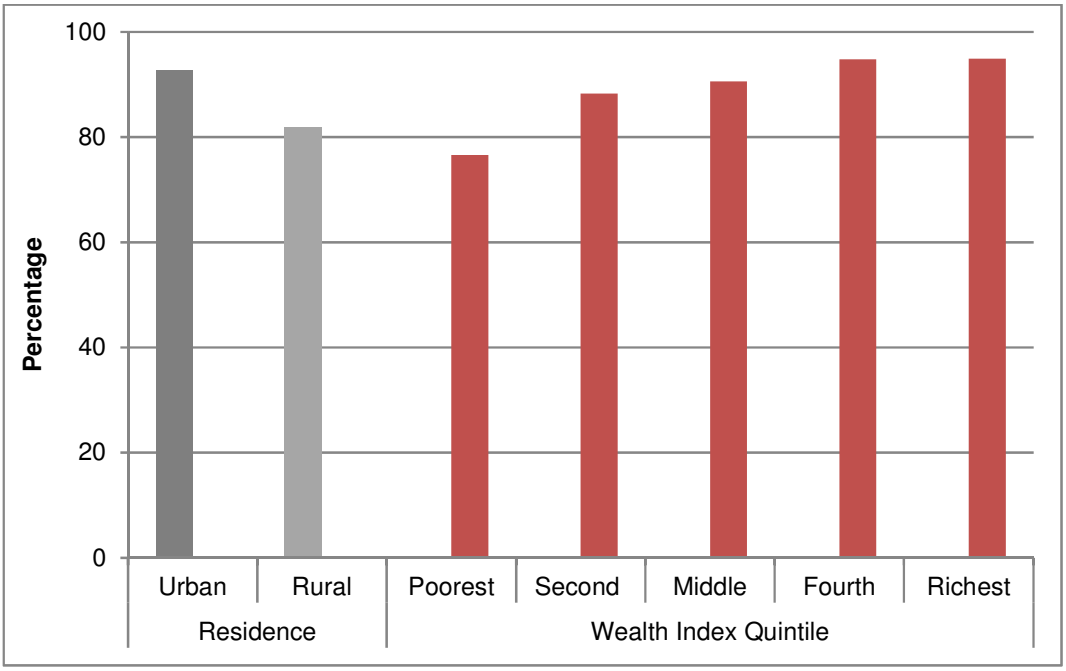
Assistance at Delivery

The provision of assistance at delivery by skilled attendants can greatly improve outcomes for both mothers and infants through early diagnosis and response to potential complications of delivery. Skilled assistance at delivery is defined as assistance provided by a doctor, a nurse or a certified midwife.

The percentage of births attended by skilled personnel in the two years prior to the survey is 89 per cent, as can be seen in Table 16. This percentage is higher in urban areas (93 per cent) than in rural areas (82 per cent). The more educated a woman the more likely her delivery will be attended by skilled personnel: 81 per cent among women with no education compared to 95 per cent for women with secondary or higher education.

Similarly, wealth is also related to skilled delivery attendance: 95 percent of women from richest households have skilled attendance compared to 77 percent of women from the poorest households.

Figure 11: Percentage of deliveries attended by skilled personnel according residency and wealth indicator, (Iraq 2011)



About 60 per cent of the births were assisted by doctors, either public or private, and 28 per cent by nurses or certified midwives. Births assisted by uncertified midwives and traditional birth attendants (Jidda) were 10 per cent. Among young women aged less than 20 years, 64 per cent tend to deliver assisted by doctors compared to 60 percent of older women. Older women rely more on uncertified midwives and traditional birth attendants than do younger women.

Delivery in a Health Centre

Table 16 shows that three out of every four births (74 per cent) occurred in a health centre or a hospital in the two years prior to the survey. The highest percentage of births that took place in hospitals and health centres is found among urban women (79 per cent) compared to rural women (67 per cent).Women aged less than 20 years are more likely to give birth in a hospital or a health centre than aged 20-34 years (74 percent) and older women aged 35-49 years (71percent). The percentage of births in a hospital or health centre increases with the educational level of women; about 66 per cent of women with no education are giving birth in a hospital or a health centre, compared with 74 per cent of women with primary education and 82 per cent of women with secondary and higher education. The percentage of deliveries at hospitals and health centres is also affected by the household wealth, ranging from 62 per cent for women from the poorest households to 82 for women from the richest households.

Primary School Attendance

Universal access to education and completion of primary education for all children of the world is an important goal highlighted in the MDGs and the WFFC. Education is an essential prerequisite for poverty reduction, women empowerment, and protection of children from the harsh effects of child labour and sexual violence. It also supports developing human rights, democracy, and environmental protection, and has an impact on population growth.

The results of the survey indicate that eight out of every nine children of primary school age in Iraq (89 per cent) are attending primary or secondary schools (Table 17). In urban areas, 93 per cent of children attend school compared with 84 per cent in rural areas. Attendance rates increase with the level of the mother's education: school attendance is 97 percent among children whose mothers have secondary or higher education, 91 percent among those whose mothers have primary education and 81 percent when the mother has no education. Males have a higher school attendance rate than females (93 per cent and 85 percent respectively). The school attendance rate of children is higher in richest households; 97 percent of children from richest households attend school and 95 percent of children of rich households, 93 percent of children of intermediate households, compared to 89 percent of children from poor households and 77 percent from poorest households.

Figure 12: Net attendance rate for primary stage according to sex, residency and wealth indicator, (Iraq2011)

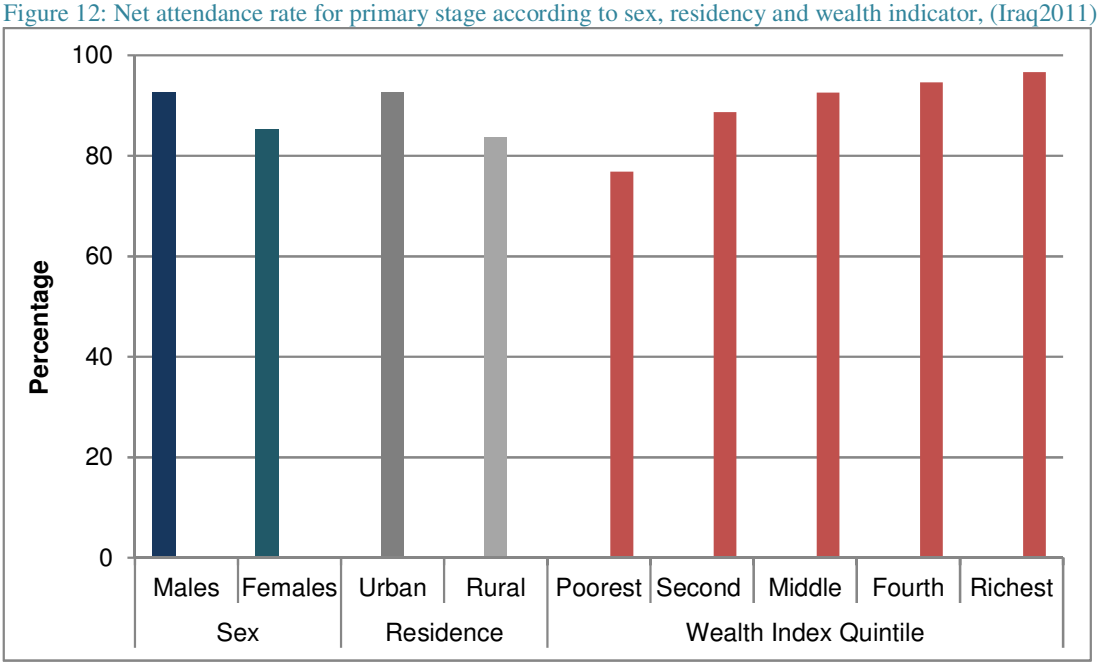


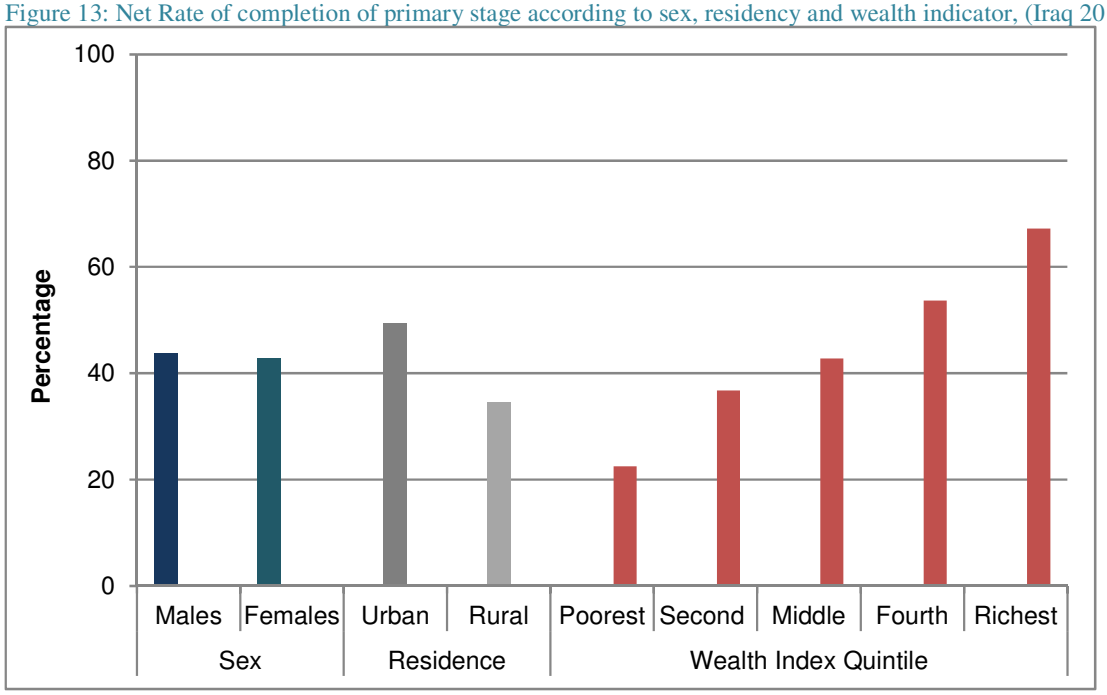
Table 18 refers to the ratio of girls to boys attending primary and secondary education. The table shows that the gender parity for primary education is 0.92, indicating that the number of boys attending primary school is higher than the number of girls. The indicator drops to 0.82 for secondary education, indicating that for every 100 male students attending secondary school there are 82 girl students. The gender disparity increases in rural areas, as the indicator drops to 0.86 for primary education and to 0.57 for secondary education. However, gender parity is much better in urban areas for both primary and secondary education (0.96 for primary education and 0.95 for secondary). Gender equity improves as the education of the mother increases.

Completion of Primary Education and Transition to Secondary Education

The improvement in the level of coverage of the education system and attendance of students in various educational stages are important aspects of national progress towards the attainment of one of the fundamental MDGs, namely "Achieve Universal Primary Education."

Table 19 shows the gross primary school completion rate and the net primary school completion rate. The gross primary school completion rate relates to the number of children *of all ages* who have completed the final grade of primary education, as a percentage to the population of primary school age. The net primary school completion rate is calculated by the number of children *of primary school completion age*, who have completed the final grade of primary education as a percentage to the population of primary school age. In Iraq, the primary school cycle extends to over six years for children officially entering primary school at the age of six years and officially graduating at the age of 11 years.

Figure 13: Net Rate of completion of primary stage according to sex, residency and wealth indicator, (Iraq 2011)



Results indicate that the gross primary school completion rate is 82 per cent and varies by sex and area of residence. Boys have a higher primary school completion rate (92 per cent) than girls (71 per cent). Similarly, primary school attendance rates in urban areas are higher than in rural areas (90 per cent and 70 per cent respectively). This implies that larger numbers of boys of all ages complete their primary education than girls, and that more children of all ages from urban areas complete their primary education than children from rural areas. Primary school completion rates also increase with the advancement of the education of mothers; 94 per cent of children whose mothers have secondary or higher education complete primary school, 80 per cent complete primary school if their mothers have primary education, and 72 per cent of children when mothers have no education. The gross primary school completion rate is also affected by the wealth of the household as it rises to 100 per cent for children from richest households and decreases to 57 per cent for children from poorest households.

About 43 per cent of Iraqi children of primary school graduation age (11 years) are attending the final grade (6^{th}) at the age of 11 years. Net primary school completion rates do not differ between boys and girls as the ratio of boys is 44 per cent and for girls is 43 per cent. The difference in rates observed for the gross primary completion rate among boys and girls is

attributable to the fact that the majority of children over the age of 11 years, at the time of the survey, who were attending the 6th grade of primary school, are boys. The net primary school completion rate is higher in urban areas (49 per cent) than in rural areas (35 per cent). It is also higher among children whose mother has higher education levels, and it is also higher among children living in wealthier households: 67 per cent for children in richest households versus 23 per cent for children of poorest households.

Comparing the gross primary school completion rate (82 per cent) with the net primary school completion rate (43 per cent) indicates the presence of a large number of children, who are over the age of 11 years at the time of the survey, are still in the 6th grade of primary school.

Results in Table 19 show the transition rate to secondary education. In Iraq, 89 per cent of children who were in the 6th grade in primary school in 2010 attended the first grade of secondary school in 2011. The rate is even higher for females (91 per cent) compared to males (87 per cent), as well as for children from urban areas (90 per cent) compared to rural areas (86 per cent). The transition rate increases slightly as mother's education also increases, and also as household wealth increases: the rate is about 92 percent for children living in the richest households and 86 per cent for children from the poorest households.

Birth Registration

The CRC states that children are to be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as much as possible, the right to know and be cared for by his or her parents. Birth registration is a fundamental measure of securing these rights for children. In Iraq, 99 per cent of births of children under-five have been registered (Table 20). There are no statistically significant variations in birth registration between males and females, by the educational level of mothers or according to household socio economic indicators. Birth registration of oldest children under-five is slightly higher than younger children (99.6 per cent and 97.6 per cent respectively), which is not statistically significant.

Child Labour

The CRC calls for the protection of all children from abuse, exploitation and violence. It is necessary to control the employment of children and the type of work they perform for several reasons. Children who work are less inclined to attend school and more likely to drop out of school and working children are more exposed to health, mental or social development problems. In addition to the exploitation of children and contribution to long term poverty and further disadvantages, child labour increases the risk of exposure to sexual abuse, physical violence, and abusive incidents that lead to cases of permanent disability.

The MICS-4 child labour module directs a series of questions to the mother or caretaker based on each child between the ages of 5-14 years on the type of work a child does and for how many hours, which are mainly related to economic activities and domestic work. Economic activities include paid or unpaid work for someone who is not a member of the household as well as work on the family farm or other businesses. Domestic work includes household chores

such as collecting firewood, fetching water, fetching fuel, cooking, cleaning, looking after animals/livestock, and caring for children.

Child labour is defined as work that exceeds a certain number of working hours, depending on the child's age and the type of work. For ages 5-11, children are considered to be involved in child labour if they performed an economic activity for at least one hour in the last week prior to the survey, or if they spent at less than 28 hours in household. As for ages 12-14 years, children are considered involved in child labour if they performed an economic activity for at least 14 hours or spent at least 28 hours in household chores during the last week prior to the survey.

The MICS-4 results estimate that one in 14 children aged 5-14 years works (7 per cent), as shown in Table 21. A higher percentage of child labour exists in rural areas (10 per cent) compared to urban areas (5 per cent). More boys than girls work (8 per cent and 6 per cent respectively). Child labour rates are slightly higher among children of the age group 12-14 years (8 per cent) when compared to the younger children of the age group 5-11 years (6 per cent). The results also show that children who work are less likely to attend school (10 per cent) compared to those who do not work (6 per cent).

Figure 14: Percentage of child labour for ages (5-14) years according to sex, residency and wealth indicator, (Iraq2011)

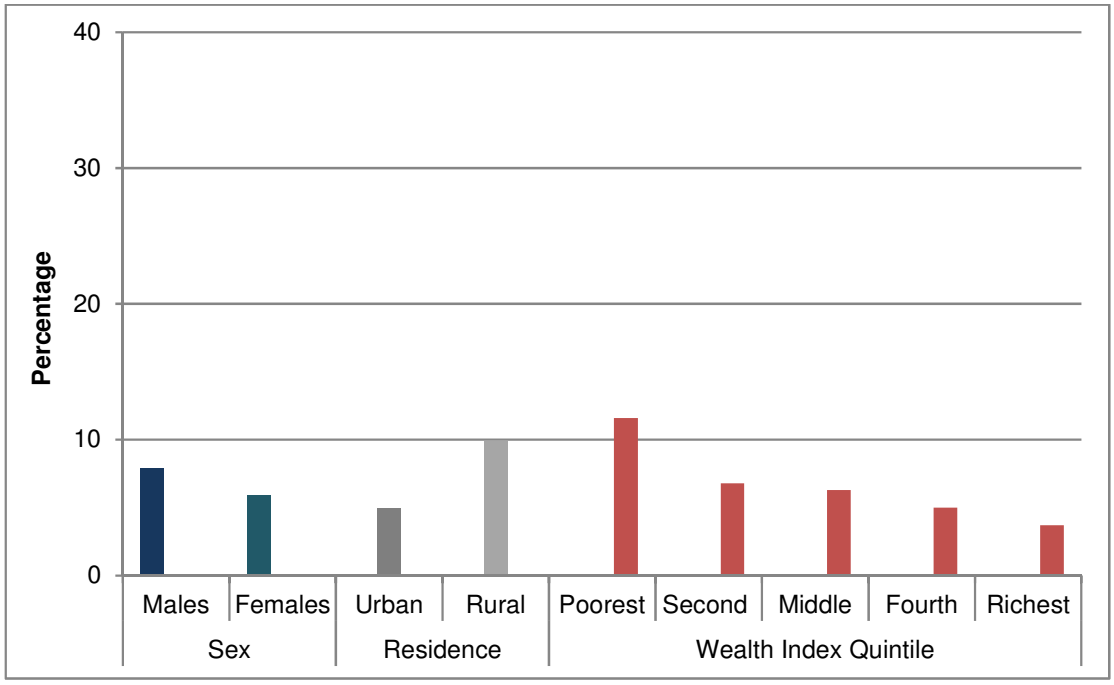


Table 21 also shows that only 0.6 per cent of children aged 5-14 years are engaged in paid work, about 1 percent are engaged in unpaid work for non-family members, and about the same percentage of children do household chores for at least 28 hours a week, whereas higher percentages of children work for family businesses (5 per cent). The involvement of children in child labour decreases as mother's education level increases. Similarly, child labour rates decrease as household wealth increases reaching 4 per cent of children in the richest households compared to 12 percent of children in the poorest households.

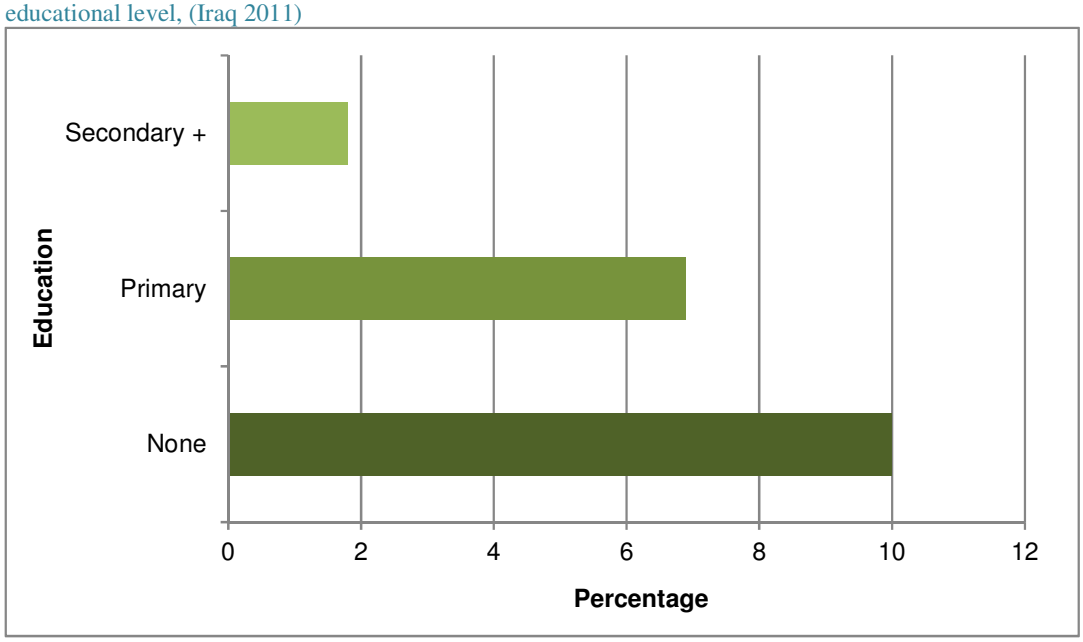
Early Marriage

Child marriage is a violation of human rights, compromising the development of girls often resulting in early pregnancy and social isolation, and the concomitant decline in their education level, which leads to less profitable occupations that reflect the gendered nature of poverty. It is known that women who are married at early ages are more likely to drop out of school, give birth to more children and are more exposed to domestic violence and the risk of maternal mortality.

Table 22 shows the percentage of women married at various ages. One in every five young women aged 15-19 years is currently married (19 per cent). This percentage does not vary much between urban (18 per cent) and rural areas (19 per cent), but it is profoundly influenced by the educational level of the mother, as it reaches 26 percent among women whose mothers have no education, compared to 10 percent among women whose mothers have secondary or higher education. Early marriage is less influenced by the household wealth as it reached 17 per cent among women of the richest households versus 19 percent among women of the poorest households.

Results show that 6 per cent of women aged 15-49 years are married before the age of 15 years, and 24 per cent of women aged 20-49 years are married before the age of 18. When examining the age pattern for early marriage among women 20-49 years it is clear that the prevalence of early marriage has declined over time. For example, 30 per cent of women aged 45-49 years were married before their eighteenth birthday while this percentage has dropped to 23 per cent for women aged 20-24 years.

Figure 15: Percentage of women aged (15-49) years who were married before 15 years of age, according to educational level, (Iraq 2011)



Knowledge of HIV / AIDS Transmission

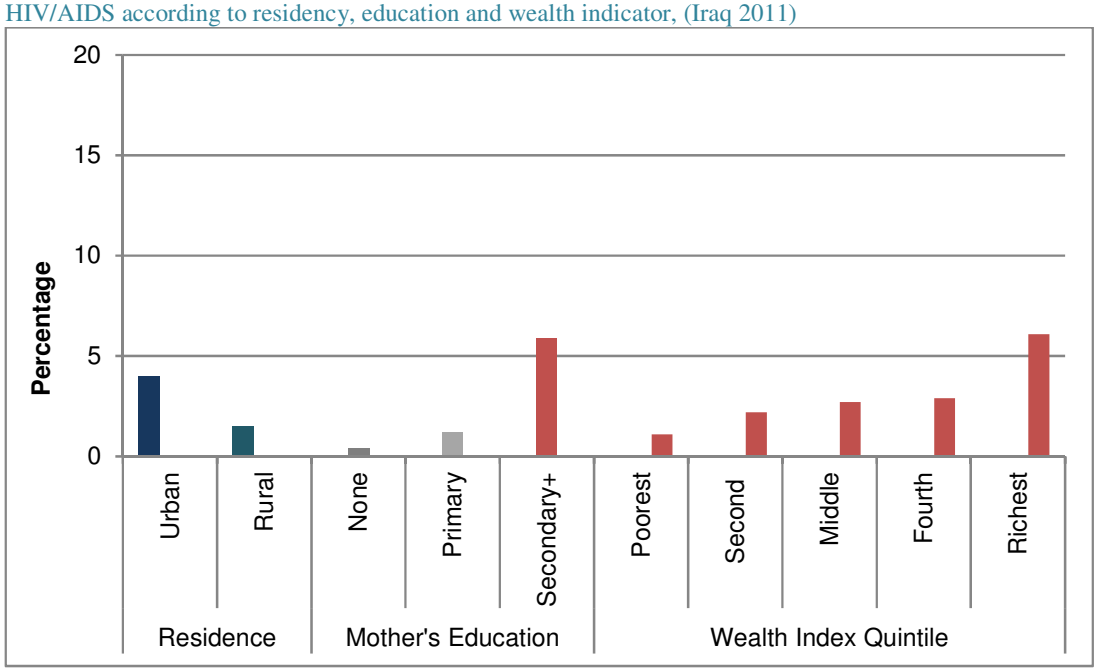
One of the important requirements to reduce the rate of HIV infection is having accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is crucial for awareness raising and equipping young people with the means to protect them from infection. Misconceptions about HIV are common and may confuse young people and hinder protection efforts. The survey examines the three most common ways of preventing HIV transmission. In addition, knowledge on the two most common misconceptions: sharing food or mosquito bites can transmit HIV is also examined for the calculation of the indicator.

Table 23 presents the percentage of women aged 15-49 years who know that having one faithful uninfected sex partner and using a condom every time are two ways of preventing HIV transmission. Knowledge of HIV prevention methods is very low, with significant differences between the urban and rural areas. In general, only one out of every five women has knowledge of the two prevention methods (19 per cent). In urban areas, 22 per cent of women identified two methods of HIV prevention compared to 12 per cent in rural areas. As expected, the percentage of women who know two HIV/AIDS prevention methods increases substantially with the women's education level: 31 per cent for women with secondary or higher education, 14 percent for women with primary education, and 7 per cent for women with no education. The percentage of women aged 15-49 years knowing two prevention methods also increases

with an increased level of household wealth: 30 per cent among women in the richest households, 14 per cent among women in the second wealth quintile and 7 per cent among women in the poorest wealth quintile.

However, the key indicator used to measure the conditions to prevent the HIV/AIDs epidemic is through the proportion of young women aged 15-24 years who have comprehensive knowledge about HIV; i.e. know the two HIV prevention methods and also reject two common misconceptions (HIV cannot be transmitted by sharing food or through mosquito bites), and acknowledge that a healthy looking person may have HIV. Table 24 shows that the percentage of women aged 15-24 years with comprehensive knowledge of HIV is about 3 per cent.

Figure 16: Percentage of women aged (15-24) years who had sufficient knowledge on the transmission of HIV/AIDS according to residency, education and wealth indicator, (Iraq 2011)



Comprehensive knowledge of HIV is associated with the area of residence, with greater knowledge among women living in urban areas (4 per cent) compared to rural women (1.5 per cent). Level of women's education also plays a positive role in increasing the comprehensive knowledge of women with HIV as it reaches 6 per cent for women with at least secondary education, compared to 1 per cent for women with primary education, and almost nobody (0.5 per cent) among women with no education.

The comprehensive knowledge of HIV of women aged 15-24 years is influenced by the household wealth as it reaches 6 per cent for women in the richest households, 2 per cent for women the second wealth quintile, and 1 per cent for women in the poorest quintile.

Attitudes Towards Domestic Violence

A number of questions were directed to women from 15 to 49 years to assess their attitudes towards whether husbands are justified to hit or beat their wives for any of the seven different reasons given in the survey (listed in Table 25). These questions were put forward to

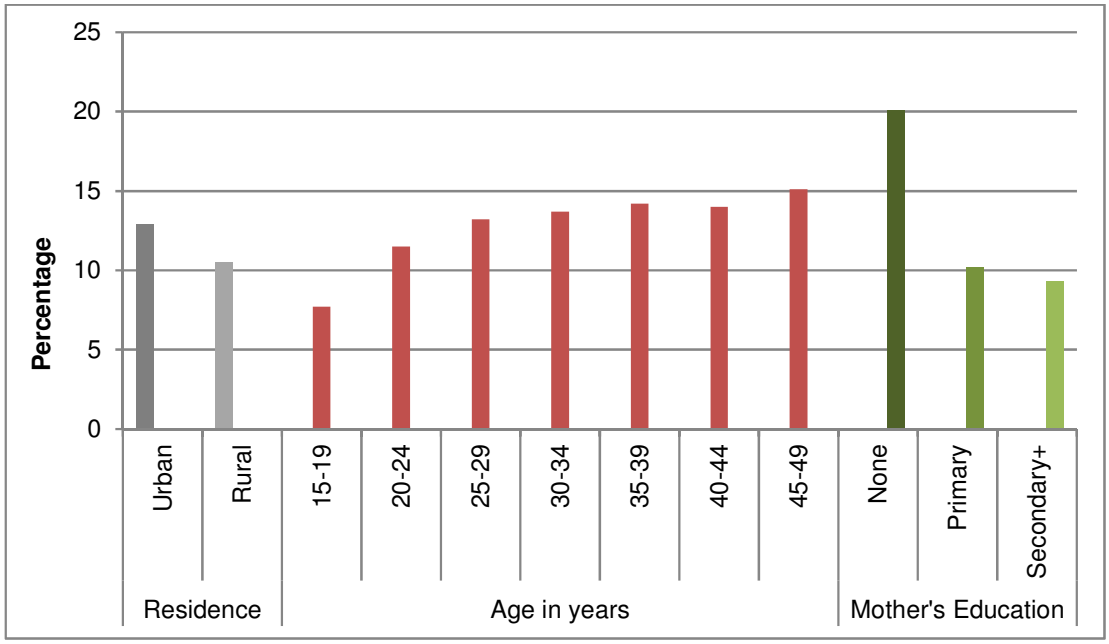
understand the cultural beliefs that are likely to be linked to the widespread practice of violence against women by their husbands.
Responses to the survey questions can be found in Table 25. In general, 58 per cent of women think it is justified that a husband beats his wife for at least one of the seven given reasons. 37 percent of women believe that violence is justified if due to negligence in child care, 41 percent if violence is due to their demonstration of a kind of independence such as leaving the house without husband's knowledge, 37 percent if violence is due to starting an argument with their husband and 48 percent if violence is due to disclosure of family secrets. Acceptance of domestic violence for any of the reasons is more prevalent among women living in poorest households (70 per cent) compared to women living in richest households (49 per cent), and it is also more prevalent among the least educated and the women that are currently married.

Female Genital Mutilation/Cutting (FGM/C)

FGM is the partial or total removal of external female genitalia or any other damage to the female reproductive organs. FGM is a fundamental violation of human rights. In the absence of any sophisticated medical precondition, female genital mutilation of girls and women expose them to health risks, and can have life-threatening, psychological or sexual consequences.

MICS-4 results show the prevalence of female genital mutilation among women, and Table 26 indicates that 12 per cent of women aged 15-49 years have undergone some form of female genital mutilation. The percentage dropped from 20 per cent for women with no education to 9 per cent for women with secondary or higher education. The practice is more common in the Kurdistan Region amounting to 44 per cent compared to approximately 1 per cent in Central and Southern Iraq. It is also higher among women in the second and poorest wealth quintiles (between 14 per cent and 17 per cent) than among those in the richest households (5 per cent). The FGM percentage is 11 per cent in rural areas compared to 13 per cent in urban areas. It is also higher among women aged 45-49 years than among younger women aged 15-19 years (8 percent).

Figure 17: Percentage of women aged (15-49) years exposed to circumcision according to age, residency and mother's education, (Iraq 2011)



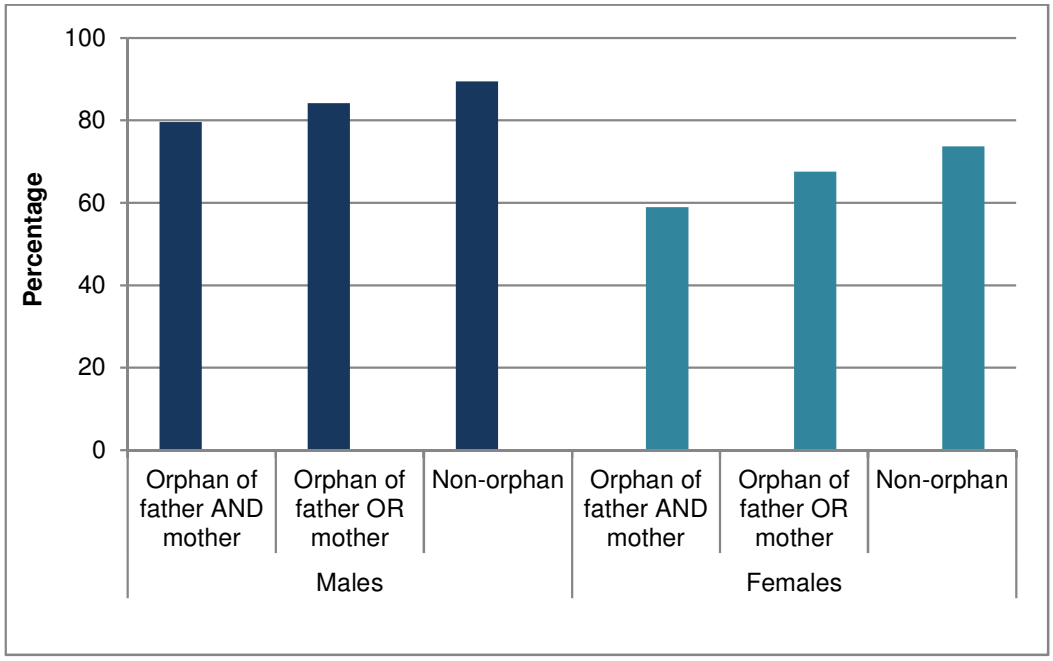
Approximately 50 per cent of women aged 15-49 years have heard of FGM and 8 percent who believe that FGM practice should continue, while 84 per cent believe it should be discontinued. Endorsement of the practice is higher among uneducated women; 19 per cent of women with no education compared to 3 per cent of women with secondary or higher education think that the practice should be continued and is also influenced by household wealth, and is found among 16 per cent of women from the poorest households versus only two per cent of women from the richest households.

School Attendance Among Orphaned Children

The number of orphaned children in Iraq has increased due to violence and displacement. Children who are orphaned or living away from their parents may be subject to further marginalization and exploitation when their parents are not available to help and protect them. Comparing the educational achievements of children who have lost both parents (double orphanhood) with those children who have both parents alive (and are living with at least one parent) is one way to assess whether children's rights are being met even if they lost their parents or they can no longer care for them.

The survey results show that 5 per cent of children aged 0-17 years are orphaned after the death of one parent, and 0.3 per cent of them are orphaned after the death of both parents.

Figure 18: Percentage of children aged (10-14) years according to orphan status and attendance to school and sex (Iraq 2011)



The percentage of orphaned children aged 10-14 years with the loss of one parent (single orphanhood) is 7 per cent (Table 27). The percentage of orphaned children aged 10-14 years with the loss of both parents is 0.4 per cent. There is no difference in the percentage of orphaned children by area of residence or by sex. 68 per cent of double orphaned children are attending school. Among the children aged 10-14 of whom both parents are alive and who live with at least one parent, 82 per cent are attending school. This would suggest that the double orphans have a disadvantage to the non-orphaned children with a ratio of orphans to non-orphans school attendance of 0.83, and a ratio of single orphans to non-orphans school attendance of 0.93.

Table 1: Results of Household and Individual Interviews

Number of households, women and children under-five by results of interviews and response rates, Iraq, 2011.

	Residence		
	Urban	**Rural**	**Total**
Number of Households			
Sampled	21990	14590	36580
Occupied	21499	14319	35818
Interviewed	21396	14295	35691
Response Rate	99.5	99.8	99.6
Number of Women			
Eligible	33042	23388	56430
Interviewed	32278	22901	55179
Response Rate	97.7	97.9	97.8
Overall Response Rate	97.2	97.8	97.4
Number of Children Under-five			
Eligible	19794	16802	36596
Mother/Caretaker Interviewed	19650	16656	36306
Response Rate	99.3	99.1	99.2
Overall Response Rated	98.8	99.0	98.9

Table 2: Child Mortality
Infant and under-five mortality rates for the five year period preceding the survey, Iraq, 2011.

	Infant mortality rate (per thousand) [1]	Under-five mortality rate (per thousand)[2]
Sex		
Male	36.0	41.4
Female	29.5	34.3
Area		
Urban	31.1	35.0
Rural	35.5	42.3
Mother's education		
None	37.1	42.0
Primary	33.4	38.9
Secondary +	28.0	32.6
Wealth Index Quintile		
Poorest	39.2	44.6
Second	29.7	35.7
Middle	32.7	36.2
Fourth	29.6	35.3
Richest	32.1	36.5
Total	32.9	37.9

[1]**MICS indicator 1.2; MDG indicator 4.2**
[2]**MICS indicator 1.1; MDG indicator 4.1**

Table 3: Nutritional Status of Children (WHO standard)

Percentage of children aged 0-59 months who are severely or moderately malnourished, Iraq, 2011.

	Weight for Age			Height for Age			Weight for Height			Number of children
	% below -2SD[1]	% below -3SD[2]	Number of children	% below -2SD[3]	% below -3SD[4]	Number of children	% below -2SD[5]	% below -3SD[6]	% above +2SD	
Sex										
Male	9.2	4.5	18244	23.3	10.6	18112	7.4	3.9	11.7	18067
Female	7.6	3.0	17356	21.4	8.6	17301	6.5	2.9	10.5	17231
Area										
Urban	8.2	3.8	21379	20.8	9.1	21244	6.9	3.3	11.3	21187
Rural	8.7	3.7	14221	24.6	10.4	14169	7.0	3.5	10.9	14112
Age										
< 6 months	15.3	8.0	3827	22.7	11.1	3778	14.6	8.1	15.9	3712
6-11 months	10.6	4.8	3748	18.3	10.0	3718	10.4	4.5	10.7	3734
12-23 months	8.1	4.0	7329	26.7	11.9	7273	6.5	3.2	13.0	7290
24-35 months	7.6	3.5	7160	24.6	11.0	7125	6.8	3.5	11.4	7114
36-47 months	6.5	2.6	7089	22.0	8.2	7071	4.4	2.0	10.0	7041
48-59 months	6.5	1.9	6448	17.3	5.9	6448	3.9	1.5	7.6	6408
Mother's Education										
None	9.8	4.4	8302	25.0	10.9	8241	6.8	3.6	9.8	8207
Primary	8.0	3.4	17652	22.6	9.5	17592	6.6	3.0	11.0	17516
Secondary+	8.1	3.9	9561	19.5	8.8	9495	7.7	3.9	12.6	9490
Non-standard curriculum	5.1	0.8	84	18.9	8.6	84	2.2	2.2	12.5	84
Wealth Indicator										
Poorest	9.3	4.1	8272	25.2	10.5	8235	7.4	3.7	9.7	8199
Second	8.3	3.6	7951	23.5	9.4	7914	6.1	2.8	10.8	7870
Middle	7.7	3.2	7188	20.6	8.7	7154	6.7	3.3	10.6	7143
Fourth	8.1	3.8	6518	20.2	9.2	6474	7.4	3.3	11.4	6469
Richest	8.6	4.3	5670	21.2	10.3	5635	7.2	3.8	14.3	5618
Total	8.4	3.8	35600	22.3	9.6	35413	6.9	3.4	11.1	35299

[1] **MICS indicator 2.1a; MDG indicator 1.8**
[2] **MICS indicator 2.1b**
[3] **MICS indicator 2.2a**
[4] **MICS indicator 2.2b**
[5] **MICS indicator 2.3a**
[6] **MICS indicator 2.3b**

Table 4: Breastfeeding

Percentage of living children according to breastfeeding status at each age group, Iraq, 2011.

	Children 0-3 months		Children 0-5 months		Children 6-9 months		Children 12-15 months		Children 20-23 months	
	Percent Exclusively Breastfed	Number of Children	Percent Exclusively Breastfed[1]	Number of Children	Percent receiving breast milk and solid/mushy food	Number of Children	Percent Breastfed[2]	Number of Children	Percent Breastfed[3]	Number of Children
Sex										
Male	25.3	1367	19.6	2019	69.4	1347	54.5	1418	24.6	1217
Female	22.8	1282	17.6	1877	67.6	1228	49.3	1325	22.7	1113
Area										
Urban	22.3	1606	17.6	2352	66.2	1560	49.5	1663	24.9	1434
Rural	26.9	1043	20.3	1543	72.1	1014	55.8	1081	21.7	895
Mother's Education										
None	28.4	610	22.2	902	70.6	553	59.3	668	26.8	542
Primary	24.3	1362	19.2	1961	70.6	1290	51.0	1297	23.1	1162
Secondary+	19.7	675	14.5	1028	63.4	732	47.2	777	22.1	626
Non-standard curriculum	(*)	3	(*)	6	(*)	0	(*)	2	(*)	0
Wealth Index Quintile										
Poorest	27.1	610	20.3	891	74.7	595	59.3	617	23.0	532
Second	27.6	614	21.9	874	72.3	505	53.7	630	21.7	482
Middle	21.5	539	17.6	789	63.1	497	52.5	532	22.8	505
Fourth	22.8	449	17.2	694	65.4	519	47.0	519	26.4	411
Richest	19.4	437	14.8	649	65.9	458	44.4	446	25.3	400
Total	24.1	2649	18.6	3896	68.5	2576	51.9	2744	23.7	2330

(*) Figures are based on less than 25 unweighted cases

[1]**MICS indicator 2.6**

[2]**MICS indicator 2.7**

[3]**MICS indicator 2.8**

Table 5: Iodized Salt Consumption

Percentage distribution of households by consumption of iodized salt, Iraq, 2011

	Percent of HHs in which salt was tested	Number of HHs	Percent of households with salt test result				Total	Number of HHs in which salt was tested or with no salt
			Percent of HHs with no salt	Not iodized 0 PPM	>0 and <15 PPM	15+ PPM[1]		
Area								
Urban	99.6	23665	0.2	40.9	27.2	31.7	100	23623
Rural	99.7	12029	0.1	55.4	25.0	19.5	100	12008
Wealth index quintiles								
Poorest	99.6	7083	0.2	59.2	25.0	15.6	100	7070
Second	99.6	7295	0.1	47.1	30.0	22.8	100	7275
Middle	99.6	7219	0.2	44.2	28.6	27.0	100	7209
Fourth	99.7	7011	0.2	44.2	25.6	30.0	100	7007
Richest	99.7	7086	0.1	34.2	23.1	42.6	100	7070
Total	99.7	35694	0.2	45.8	26.5	27.6	100	35631

[1] MICS indicator 2.16

Table 6a: Vaccinations in First Year of Life

Percentage of children aged 12-23 months immunized against childhood diseases at any time before the survey and before the first birthday, Iraq, 2011.

	Percentage of children who received:														
		DPT			Polio				Hepatitis						
	BCG[1]	1	2	3[2]	0	1	2	3[3]	1	2	3[4]	Measles[5]	All	None	Number of children aged 12-23 months
Vaccinated at any time before the survey															
According to:															
Vaccination card	68.3	65.6	60.3	55.1	68.9	65.5	60.5	55.1	69.7	65.7	55.1	51.9	51.5	0.0	7453
Mother's report	23.7	20.7	17.2	13.0	13.4	26.1	24.7	20.4	19.8	14.8	9.4	21.7	5.2	3.7	7453
Either	91.9	86.3	77.5	68.1	82.3	91.6	85.2	75.5	89.5	80.6	64.5	73.7	56.6	3.8	7453
Vaccinated by 12 months of age	91.3	85.0	75.4	63.5	81.7	90.3	82.8	70.4	88.9	79.4	60.2	64.2	45.4	3.8	7453

[1] **MICS indicator 3.1**
[2] **MICS indicator 3.3**
[3] **MICS indicator 3.2**
[4] **MICS indicator 3.5**
[5] **MICS indicator 3.4, MDG indicator 4.3**

Table 6b: Vaccinations in Second Year of Life

Percentage of children aged 18-29 months immunized against childhood diseases at any time before the survey, Iraq, 2011.

	Percentage of children who received:															
		DPT			Polio				Hepatitis							
	BCG[1]	1	2	3[2]	0	1	2	3[3]	1	2	3[4]	Measles[5]	MMR	Measles or MMR	None	Number of children aged 18-29 months
Vaccinated at any time before the survey *According to:*																
Vaccination card	63.6	61.2	57.0	53.2	63.6	61.0	57.0	53.2	64.4	61.2	53.0	51.2	41.7	53.5	0.0	7426
Mother's report	29.3	26.2	22.5	17.4	16.8	31.1	29.3	24.7	25.3	19.8	12.6	27.2	26.5	27.2	3.4	7426
Either	92.8	87.5	79.4	70.6	80.4	92.1	86.3	77.9	89.7	81.0	65.6	78.4	68.2	80.6	3.4	7426
Vaccinated by 12 months of age (18 for Measles and MMR)	92.1	85.3	75.9	62.8	79.8	89.8	82.5	69.4	89.1	79.0	58.4	74.5	58.7	76.3	3.5	7426

[1]**MICS indicator 3.1** (eligible children 18-29 months instead of 12-23)
[2]**MICS indicator 3.3** (eligible children 18-29 months instead of 12-23)
[3]**MICS indicator 3.2** (eligible children 18-29 months instead of 12-23)
[4]**MICS indicator 3.5** (eligible children 18-29 months instead of 12-23)
[5]**MICS indicator 3.4**, **MDG indicator 4.3** (eligible children 18-29 months instead of 12-23)

Table 7: Oral Rehydration Therapy

Percentage of children aged 0-59 months with diarrhoea in the last two weeks (before the survey) treated with Oral Rehydration Solution (ORS), Iraq, 2011.

	Had diarrhoea last 2 weeks	Number of Children aged 0-59 months	ORS Use Rate*	Number of children aged 0-59 months with diarrhoea
Sex				
Male	15.0	18590	23.8	2784
Female	13.9	17712	24.8	2464
Area				
Urban	13.8	21833	26.9	3020
Rural	15.4	14469	20.7	2227
Age				
0-11 months	20.6	7702	26.0	1589
12-23 months	20.2	7453	25.6	1504
24-35 months	13.0	7295	22.2	949
36-47 months	9.5	7235	22.9	689
48-59 months	7.8	6616	20.5	517
Mother's education				
None	14.8	8473	23.5	1254
Primary	15.3	17972	24.0	2756
Secondary +	12.5	9769	25.7	1225
Non-standard curriculum	15.0	87	(*)	13
Wealth Index Quintile				
Poorest	15.7	8432	18.8	1327
Second	15.4	8112	26.5	1249
Middle	14.9	7323	24.6	1094
Fourth	13.8	6644	26.6	920
Richest	11.4	5792	27.1	658
Total	14.5	36302	24.2	5248

(*) Figures that are based on less than 25 unweighted cases

Table 8: Home Management of Diarrhoea

Percentage of children aged 0-59 months with diarrhoea in the last two weeks (before the survey) who took increased fluids and continued feeding during the episode, Iraq, 2011

	Had Diarrhoea in last two weeks	Number of children aged 0-59 months	Children with diarrhoea who:									Received ORS or increased fluids	Received ORS or increased fluids AND continued feeding [1]	Number of children aged 0-59 months with diarrhoea
			Given much less to drink	Given somewhat less to drink	Given about the same to drink	Given more to drink	Given nothing to drink	Don't Know / Missing	Total	Ate somewhat less, or same or more	Ate much less or none			
Sex														
Male	15.0	18590	13.1	33.6	37.6	11.9	2.7	1.1	100	73.8	17.9	32.4	24.0	2784
Female	13.9	17712	12.3	33.6	38.6	12.3	2.8	0.4	100	75.6	18.1	34.0	24.4	2464
Area														
Urban	13.8	21833	14.8	31.3	37.3	13.5	2.4	0.6	100	73.3	20.5	36.5	26.5	3020
Rural	15.4	14469	9.9	36.6	39.1	10.2	3.2	1.0	100	76.5	14.5	28.6	21.1	2227
Age														
0-11 months	20.6	7702	11.1	32.9	40.2	10.8	4.2	0.7	100	65.2	13.4	33.6	22.8	1589
12-23 months	20.2	7453	13.0	34.4	36.3	14.1	1.8	0.4	100	77.7	20.4	35.6	27.2	1504
24-35 months	13.0	7295	14.3	32.8	37.8	11.7	2.4	0.9	100	80.8	18.7	31.6	24.2	949
36-47 months	9.5	7235	13.4	32.3	38.2	12.4	2.4	1.2	100	76.9	21.8	31.9	23.0	689
48-59 months	7.8	6616	13.2	36.2	37.0	10.2	2.2	1.2	100	80.4	19.0	29.5	21.6	517
Mother's education														
None	14.8	8473	14.5	35.6	36.3	8.8	3.6	0.7	100	74.1	18.5	30.4	21.5	1254
Primary	15.3	17972	12.3	33.8	39.2	11.2	2.9	0.6	100	75.1	17.6	31.8	23.3	2756
Secondary +	12.5	9769	12.0	31.0	37.2	17.6	1.6	0.0	100	73.1	19.1	39.3	29.2	1225
Non-standard curriculum	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	13
Wealth Index Quintile														
Poorest	15.7	8432	10.1	38.8	37.9	8.0	4.1	1.1	100	77.5	14.4	25.1	18.6	1327
Second	15.4	8112	13.2	33.1	37.8	13.0	2.2	0.8	100	74.7	18.2	36.3	26.4	1249
Middle	14.9	7323	14.8	32.4	37.7	12.2	2.5	0.4	100	71.7	20.5	32.8	23.0	1094
Fourth	13.8	6644	14.1	32.6	36.1	14.4	2.0	0.8	100	75.6	19.1	37.6	28.6	920
Richest	11.4	5792	12.0	27.2	42.5	15.2	2.3	0.8	100	72.5	19.1	37.9	27.2	658
Total	14.5	36302	12.8	33.6	38.1	12.1	2.7	0.8	100	74.7	18.0	33.2	24.2	5248

(*) Figures that are based on less than 25 unweighted cases

[1] **MICS indicator 3.8**

Table 9: Antibiotic Therapy of Suspected Pneumonia

Percentage of children aged 0-59 months with suspected pneumonia who received antibiotic treatment, Iraq, 2011.

	Had suspected pneumonia in the last two weeks	Number of children aged 0-59 months	Percentage of children aged 0-59 months with suspected pneumonia who received antibiotics in the last 2weeks[1]	Number of children aged 0-59 months with suspected pneumonia in the last 2 weeks
Sex				
Male	11.1	18590	69.5	2072
Female	9.2	17712	68.6	1632
Area				
Urban	10.4	21833	70.6	2265
Rural	10.0	14469	66.8	1440
Age				
0-11 months	11.2	7702	69.0	863
12-23 months	11.9	7453	69.8	888
24-35 months	9.5	7295	68.4	696
36-47 months	9.7	7235	69.3	704
48-59 months	8.4	6616	68.7	554
Mother's education				
None	12.0	8473	69.2	1015
Primary	10.3	17972	68.5	1852
Secondary +	8.5	9769	70.3	829
Non-standard curriculum	8.8	87	(*)	8
Wealth Index Quintile				
Poorest	10.2	8432	62.9	859
Second	11.4	8112	69.3	924
Middle	11.1	7323	72.9	810
Fourth	9.9	6644	70.0	659
Richest	7.8	5792	72.5	452
Total	10.2	36302	69.1	3704

(*) Figures that are based on less than 25 unweighted cases

[2]**MICS indicator 3.10**

Table 10: Use of Solid Fuel

Percentage distribution of household members according to type of cooking fuel, and percentage of households using solid fuel for cooking, Iraq, 2011.

	Percentage of households members in households using:												
	Electricity	Liquefied Petroleum Gas (LPG)	Kerosene	Coal	Wood	Straw, shrubs, grass	Animal dung	Agricultural crop residue	No cooking in hh	Other	Total	Solid fuel for cooking[1]	Number of hh members
Area													
Urban	0.2	99.3	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.1	23672
Rural	0.3	93.5	2.1	0.0	1.8	1.6	0.4	0.1	0.0	0.2	100.0	3.9	12029
Education of Household Head													
None	0.1	94.3	2.0	0.0	1.4	1.4	0.4	0.1	0.0	0.2	100.0	3.3	8103
Primary	0.2	97.2	1.0	0.0	0.7	0.6	0.1	0.0	0.0	0.1	100.0	1.2	18516
Secondary +	0.3	98.9	0.3	0.0	0.2	0.1	0.0	0.0	0.0	0.0	100.0	0.2	8753
Non-standard curriculum	0.3	96.4	2.6	0.0	0.7	0.0	0.0	0.0	0.0	0.0	100.0	0.7	312
Wealth Index Quintile													
Poorest	0.4	87.1	4.8	0.1	3.4	3.0	0.7	0.1	0.0	0.4	100.0	7.3	7082
Second	0.4	99.5	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	7295
Middle	0.2	99.7	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	100.0	0.0	7229
Fourth	0.1	99.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	7009
Richest	0.2	99.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	7086
Total	0.2	97.2	1.0	0.0	0.7	0.6	0.1	0.0	0.0	0.1	100.0	1.5	35701

[1]**MICS indicator 3.11**

Table 11: Use of Improved Water Sources

Percentage distribution of household population according to main source of drinking water and percentage of household population using improved drinking water sources, Iraq, 2011.

	Main Source of Drinking Water																			
	Improved sources										Unimproved sources									
	Piped into dwelling	Piped into compound, yard or plot	Piped to neighbour	Public Tap / stand-pipe	Tube well / bore-hole	Protected well	Protected Spring	Rain-water	Bottled Water	RO	Unprotected well	Unprotected Spring	Tanker Truck	Cart with tank / drum	Surface Water	Bottled Water[2]	Other	Total	Improved Source for drinking water[1]	Number of hh members
Area																				
Urban	63.1	4.1	0.2	0.0	0.4	1.9	0.3	0.0	8.9	17.8	0.0	0.1	2.1	0.3	0.1	0.4	0.2	100	96.7	148086
Rural	35.0	11.8	0.4	1.2	1.7	5.6	0.8	0.0	6.8	12.3	0.2	0.2	9.8	2.5	8.2	2.7	0.8	100	75.5	85190
Education of Household Head																				
None	50.3	8.3	0.3	0.6	1.3	4.4	0.9	0.0	4.3	13.7	0.1	0.1	8.9	1.1	4.0	1.3	0.3	100	84.1	53964
Primary	50.3	7.7	0.3	0.4	0.9	4.1	0.5	0.0	7.0	16.7	0.1	0.2	5.6	1.2	3.0	1.3	0.6	100	88.0	80190
Secondary +	56.7	5.5	0.2	0.4	0.6	1.9	0.3	0.0	11.2	15.9	0.1	0.1	2.2	1.0	2.5	1.1	0.4	100	92.7	96450
Non-standard curriculum	40.1	4.3	0.1	0.0	1.6	2.9	0.2	0.0	9.5	23.3	0.0	0.0	3.4	2.4	7.3	4.1	0.9	100	81.9	2561
Wealth Index Quintile																				
Poorest	19.1	13.3	0.7	1.2	2.0	6.6	1.5	0.0	3.4	16.4	0.2	0.4	17.9	2.9	11.5	2.3	0.7	100	64.1	46662
Second	46.3	11.1	0.5	0.8	1.3	4.3	0.4	0.0	7.0	16.7	0.1	0.1	4.7	1.5	2.8	1.7	0.6	100	88.5	46648
Middle	61.7	5.7	0.2	0.2	0.5	3.0	0.2	0.0	7.6	17.0	0.1	0.1	1.3	0.5	0.7	0.8	0.4	100	96.1	46652
Fourth	65.7	2.9	0.0	0.2	0.3	1.7	0.2	0.0	8.5	18.0	0.1	0.1	0.5	0.6	0.3	0.6	0.4	100	97.4	46660
Richest	71.3	1.5	0.0	0.0	0.2	0.6	0.2	0.0	14.2	10.7	0.0	0.0	0.1	0.2	0.0	0.7	0.0	100	98.8	46655
Total	52.8	6.9	0.3	0.5	0.9	3.3	0.5	0.0	8.1	15.8	0.1	0.1	4.9	1.1	3.1	1.2	0.4	100	89.0	233276

[1]**MICS indicator 4.1; MDG indicator 7.8**

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

Table 12: Type of Sanitation Facilities

Percentage distribution of household population according to type of toilet facility used by household, and the percentage of household population using improved sanitation facilities, Iraq, 2011.

	Type of Toilet Facility Used by Household												
	Improved Sanitation Facility						Unimproved Sanitation Facility						
	Flush to:												
	Piped sewer system	Septic Tank	Pit latrine	Ventilated improved pit latrine	Pit latrine with slab	Com-posting toilet	Flush to somewhere else	Flush to unknown place	Pit latrine without slab/ open pit	No facilities/ bush/ field	Total	Percentage of population using sanitation facilities	Number of household members
Area													
Urban	33.2	39.7	13.5	0.5	11.9	0.0	0.6	0.0	0.4	0.0	100	98.8	148086
Rural	4.2	37.9	34.7	1.0	12.6	0.1	1.7	0.0	4.8	2.8	100	90.4	85190
Education of household head													
None	18.7	34.8	30.1	0.7	9.0	0.0	1.1	0.0	2.8	2.5	100	93.3	53964
Primary	20.8	38.3	23.7	0.6	11.8	0.0	1.1	0.0	2.3	1.0	100	95.3	80190
Secondary +	26.7	41.7	14.3	0.7	14.1	0.0	0.8	0.0	1.3	0.3	100	97.5	96450
Non-standard curriculum	7.3	46.7	21.6	0.8	16.4	0.0	1.7	0.0	4.1	0.9	100	92.8	2561
Wealth Index Quintile													
Poorest	2.0	23.1	49.2	0.7	8.5	0.1	2.3	0.1	8.6	5.2	100	83.5	46662
Second	12.6	40.1	29.4	1.1	13.7	0.0	1.4	0.0	1.1	0.1	100	96.9	46648
Middle	23.6	45.2	14.5	0.7	14.9	0.0	0.7	0.0	0.3	0.0	100	98.9	46652
Fourth	33.5	43.5	9.3	0.5	12.6	0.0	0.4	0.0	0.1	0.0	100	99.4	46660
Richest	41.4	43.1	4.0	0.3	11.1	0.0	0.1	0.0	0.0	0.0	100	99.9	46655
Total	22.6	39.0	21.3	0.7	12.2	0.0	1.0	0.0	2.0	1.1	100	95.7	233276

Table 13: Water Chlorine Test

Percentage distribution of households by water chlorine, Iraq, 2011.

	Percent of households where chlorine was tested	Number of households	Percent of households with chlorine test result				Total	Number of households in which chlorine was tested or with no chlorine
			Percent of households with no chlorine	Less than 0.5	0.5 - 1	More than 1		
Area								
Urban	85.5	23665	30.0	18.1	16.6	35.2	100.0	20222
Rural	51.9	12029	52.6	20.5	8.9	18.0	100.0	6247
Wealth index quintiles								
Poorest	41.6	7083	53.3	19.9	9.5	17.3	100.0	2948
Second	70.7	7295	44.6	19.8	13.4	22.2	100.0	5159
Middle	81.7	7219	39.4	21.1	14.0	25.5	100.0	5899
Fourth	86.6	7011	29.6	18.2	15.9	36.3	100.0	6074
Richest	90.2	7086	21.4	15.5	18.2	44.9	100.0	6389
Total	74.2	35694	35.4	18.7	14.8	31.1	100.0	26469

Table 14: Handwashing

Percentage distribution of household population according to (visual) availability of water and detergent soap at handwashing place, Iraq, 2011.

	Percent households where place for handwashing was observed	Percent of households where place for handwashing was not observed			Total	Percent households where place for handwashing was observed where:				Total	Number of households where place of handwashing was observed
		Unavailable in dwelling	Permission not given to see	Other reason		Water and soap available[1]	Water available, soap not avail	Water not available, soap avail	Water and Soap not avail		
Area											
Urban	96.2	2.1	0.5	1.2	100	97.8	1.2	0.9	0.1	100	22776
Rural	87.7	10.5	0.4	1.4	100	94.4	3.2	1.6	0.8	100	10547
Education of Household Head											
None	90.6	7.5	0.5	1.4	100	95.9	2.6	1.1	0.4	100	7339
Primary	92.4	5.2	0.5	1.3	100	96.0	2.3	1.2	0.4	100	11118
Secondary +	95.6	2.2	0.4	1.0	100	97.7	1.1	1.0	0.2	100	14562
Non-standard curriculum	92.9	1.9	1.2	4.0	100	93.8	1.9	2.4	1.8	100	289
Wealth Index Quintile											
Poorest	82.4	14.8	0.5	2.3	100	92.6	4.7	1.7	1.0	100	5835
Second	92.2	5.5	0.6	1.8	100	94.8	2.8	1.8	0.5	100	6724
Middle	95.0	3.2	0.5	1.3	100	97.7	1.3	0.8	0.2	100	6858
Fourth	97.9	1.1	0.3	0.7	100	98.6	0.6	0.8	0.1	100	6866
Richest	99.3	0.2	0.2	0.2	100	99.2	0.3	0.6	0.0	100	7040
Total	93.4	4.9	0.4	1.3	100	96.7	1.8	1.1	0.3	100	33324

[1] **MICS indicator 4.5**

Table 15: Use of Contraception

Percentage of women aged 15-49 years currently married who are using (or whose husbands are using) a contraceptive method, Iraq, 2011.

	Percentage of women currently married using:																Number of women currently married
	Not using any method	Female sterilization	IUD	Injections	Implants	Pill	Male Condom	Female Condom	Diaphragm/ foam/ jelly	Extended breast-feeding	Periodic abstinence	Withdrawal	Other	Any modern method	Any traditional method	Any method[1]	
Area																	
Urban	46.0	3.0	9.8	2.7	0.1	16.2	2.3	0.1	0.6	1.8	1.1	16.4	0.1	34.6	19.3	54.0	22089
Rural	53.9	2.6	9.1	3.9	0.0	13.8	0.8	0.0	0.3	3.3	1.3	10.8	0.1	30.6	15.5	46.1	12149
Age																	
15-19	79.5	0.1	2.0	1.1	0.0	7.5	0.6	0.0	0.2	2.8	0.3	6.0	0.0	11.4	9.1	20.5	2296
20-24	61.3	0.1	5.5	2.1	0.0	12.3	1.8	0.1	0.4	3.3	0.9	12.2	0.0	22.3	16.4	38.7	5320
25-29	50.4	0.1	9.7	3.4	0.0	15.9	1.6	0.0	0.5	2.9	1.0	14.5	0.0	31.2	18.4	49.6	6681
30-34	42.8	1.0	11.6	3.8	0.1	17.8	2.2	0.0	0.6	3.2	1.0	15.8	0.0	37.2	20.0	57.2	6307
35-39	37.9	4.5	13.0	4.2	0.1	18.0	2.3	0.1	0.4	1.8	1.4	16.3	0.1	42.5	19.6	62.1	5841
40-44	36.7	7.9	11.7	3.5	0.0	18.0	1.8	0.1	0.5	1.0	1.8	16.8	0.2	43.6	19.8	63.3	4634
45-49	51.9	8.4	7.8	2.2	0.1	11.5	1.0	0.1	0.4	.0	1.9	14.4	0.3	31.4	16.6	48.1	3159
Number of living children																	
0	98.5	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.0	0.0	1.1	0.0	0.4	1.2	1.5	3807
1	66.9	0.2	2.2	.8	0.0	8.6	2.0	0.0	0.7	2.9	0.8	14.8	0.0	14.7	18.4	33.1	4378
2	48.5	0.2	10.0	2.4	0.0	15.4	2.3	0.1	0.5	2.4	1.3	16.9	0.0	30.9	20.6	51.5	5438
3	39.9	0.8	11.4	3.5	0.0	18.9	2.3	0.0	0.5	3.1	1.1	18.4	0.1	37.4	22.6	60.1	5293
4+	34.5	5.9	13.1	4.8	0.1	19.8	1.7	0.1	0.5	2.4	1.6	15.4	0.1	46.0	19.5	65.5	15320
Education																	
None	54.6	3.0	7.6	4.0	0.0	13.9	1.1	0.0	0.4	2.4	0.8	12.0	0.1	30.0	15.4	45.4	7987
Primary	49.5	2.7	10.3	3.4	0.0	14.9	1.7	0.0	0.4	2.5	1.0	13.7	0.0	33.2	17.3	50.5	15750
Secondary +	43.1	2.7	9.9	2.1	0.1	17.3	3.4	0.1	0.7	1.4	1.8	17.5	0.1	35.7	21.2	56.9	10219
Non-standard curriculum	54.2	10.1	6.9	5.1	0.0	11.0	0.1	0.0	0.5	.3	1.1	10.2	0.6	33.7	12.1	45.8	280
Wealth Index Quintile																	
Poorest	57.7	2.0	6.7	5.1	0.0	13.1	0.9	0.0	0.2	3.5	0.9	9.9	0.1	28.0	14.3	42.3	6429
Second	48.7	2.3	9.2	3.4	0.0	16.1	1.2	0.1	0.6	2.5	1.1	14.7	0.1	32.9	18.4	51.3	6911
Middle	48.2	2.7	9.9	3.0	0.0	15.5	1.6	0.1	0.6	2.1	0.9	15.3	0.1	33.4	18.3	51.8	7099
Fourth	45.9	3.4	10.5	2.7	0.1	15.8	2.2	0.0	0.3	2.1	1.3	15.7	0.1	35.0	19.1	54.1	6935
Richest	44.1	3.8	11.1	1.7	0.1	16.1	2.8	0.1	0.7	1.4	1.8	16.2	0.1	36.4	19.5	55.9	6863
Total	48.8	2.8	9.5	3.2	0.1	15.3	1.8	0.1	0.5	2.3	1.2	14.4	0.1	33.2	18.0	51.2	34237

[1]**MICS indicator 5.3; MDG indicator 5.3**

Table 16: Assistance at Delivery

Percentage distribution of women aged 15-49 with a birth in the last two years preceding the survey by type of personnel assisting at delivery, Iraq, 2011.

	Person Assisting at Delivery										
	Government doctor	Private doctor	Nurse/ certified midwife	Traditional birth attendant	Relative/ friend	Other/ missing	No attendant	Total	Any skilled personnel[1]	Delivery in health facility[2]	Number of Women who gave birth in preceding two years
Area											
Urban	54.4	10.2	28.1	6.1	0.9	0.3	0.1	100	92.7	78.9	8517
Rural	48.0	5.3	28.6	16.2	1.5	0.3	0.2	100	81.9	67.1	5312
Age											
Less than 20	55.9	7.6	27.5	7.6	1.2	0.3	0.0	100	91.0	78.9	1626
20-34	51.7	8.2	28.7	10.0	1.0	0.3	0.2	100	88.6	74.3	9973
35-49	50.0	9.5	27.1	11.7	1.2	0.3	0.0	100	86.7	71.2	2229
Education											
None	49.6	4.6	26.6	16.3	1.9	0.7	0.3	100	80.8	66.3	3097
Primary	51.7	7.1	29.4	10.4	1.0	0.2	0.1	100	88.3	73.9	6826
Secondary +	54.1	13.4	27.6	4.1	0.5	0.2	0.0	100	95.2	81.5	3895
Non-standard curriculum	(*)	(*)	(*)	(*)	(*)	(*)	(*)	100	(*)	(*)	11
Wealth Index Quintile											
Poorest	45.6	3.4	27.6	20.9	1.9	0.2	0.4	100	76.6	62.2	3067
Second	53.2	6.3	28.7	9.7	1.4	0.5	0.1	100	88.3	73.2	2969
Middle	54.2	7.5	28.8	8.0	0.8	0.5	0.0	100	90.6	76.4	2820
Fourth	55.5	9.6	29.7	4.4	0.6	0.2	0.0	100	94.8	80.3	2611
Richest	51.7	16.8	26.4	4.5	0.5	0.1	0.0	100	94.9	82.5	2361
Total	51.9	8.3	28.3	10.0	1.1	0.3	0.1	100	88.5	74.4	13829

(*) Figures are based on less than 25 unweighted cases

[1]**MICS indicator 5.7; MDG indicator 5.2**

[2]**MICS indicator 5.8**

Table 17: Primary School Net Attendance Ratio
Percentage of children of primary school aged 6-11 years attending primary or secondary school (NAR), Iraq, 2011.

	Males		Females		Total	
	Net Attendance Ratio (adjusted)	Number of children	Net Attendance Ratio (adjusted)	Number of children	Net Attendance Ratio (adjusted) [1]	Number of children
Area						
Urban	94.6	11619	90.8	10988	92.7	22607
Rural	89.9	7867	77.4	7532	83.8	15399
Age						
6	86.1	3385	82.7	3124	84.5	6509
7	93.7	3345	89.2	3164	91.5	6509
8	96.1	3219	89.6	3058	92.9	6276
9	95.0	3257	88.3	3176	91.7	6433
10	93.6	3262	84.0	3132	88.9	6394
11	91.8	3019	77.5	2866	84.8	5885
Mother's Education						
None	87.4	5645	74.3	5470	80.9	11116
Primary	93.7	8921	87.3	8406	90.6	17327
Secondary +	97.2	4654	95.9	4401	96.6	9055
Non-standard curriculum	92.7	265	75.9	241	84.7	506
Wealth Index Quintile						
Poorest	85.8	4489	67.6	4375	76.8	8863
Second	91.4	4211	85.8	4044	88.7	8256
Middle	94.8	3984	90.2	3649	92.6	7633
Fourth	96.3	3662	92.8	3482	94.6	7144
Richest	97.3	3140	96.0	2970	96.7	6110
Total	92.7	19486	85.3	18520	89.1	38006

[1] **MICS indicator 7.4; MDG indicator 2.1**

Table 18: Education Gender Parity

Ratio of girls to boys attending primary education, and ratio of girls to boys attending secondary education, Iraq, 2011.

	Net Primary Schools Attendance Ratio (NAR), Girls	Net Primary Schools Attendance Ratio (NAR), Boys	Gender Parity Index (GPI) for Primary School NAR[1]	Net Secondary Schools Attendance Ratio (NAR), Girls	Net Secondary Schools Attendance Ratio (NAR), Boys	Gender Parity Index (GPI) for Secondary School NAR[2]
Area						
Urban	90.8	94.6	0.96	53.9	57.0	0.95
Rural	77.4	89.9	0.86	25.1	44.5	0.57
Mother's Education						
None	74.3	87.4	0.85	35.8	45.5	0.79
Primary	87.3	93.7	0.93	40.3	48.5	0.83
Secondary +	95.9	97.2	0.99	72.8	73.7	0.99
Non-standard curriculum	75.9	92.7	0.82	27.5	35.0	0.78
Wealth Index Quintile						
Poorest	67.6	85.8	0.79	15.5	33.1	0.47
Second	85.8	91.4	0.94	31.8	44.6	0.71
Middle	90.2	94.8	0.95	43.4	51.3	0.84
Fourth	92.8	96.3	0.96	53.5	58.1	0.92
Richest	96.0	97.3	0.99	68.7	73.7	0.93
Total	85.3	92.7	0.92	42.9	52.2	0.82

[1]**MICS indicator7.9; MDG indicator 3.1**
[2]**MICS indicator7.10; MDG indicator 3.1**

Table 19: Primary School Completion and Transition to Secondary Education

Primary school completion rate and transition rate to secondary education, Iraq, 2011.

	Net Primary School Completion Rate	Gross Primary School Completion Rate[1]	Number of children of primary school completion age	Transition Rate to Secondary School[2]	Number of children who were in the last grade of primary school the previous year
Sex					
Male	43.7	92.0	3019	87.1	2713
Female	42.8	71.0	2866	91.2	1836
Area					
Urban	49.3	89.6	3492	90.1	3100
Rural	34.5	70.4	2393	86.0	1448
Mother's Education					
None	31.6	71.9	1946	88.2	1427
Primary	40.2	80.4	2495	88.3	1758
Secondary +	67.7	94.9	1334	92.2	1168
Non-standard curriculum	24.3	80.8	110	80.3	80
Wealth Index Quintile					
Poorest	22.5	57.1	1321	86.3	602
Second	36.8	81.1	1233	85.4	859
Middle	42.8	84.5	1168	88.4	971
Fourth	53.7	91.7	1163	90.1	1100
Richest	67.2	100.8	999	91.8	1017
Total	43.3	81.8	5885	88.7	4549

[1]**MICS indicator 7.7**
[2]**MICS indicator 7.8**

Table 20: Birth Registration

Percentage distribution of children aged 0-59 months where birth is registered, Iraq, 2011.

	Registered Birth[1]	Number of children aged 0-59 months
Sex		
Male	99.3	18590
Female	98.9	17712
Area		
Urban	99.4	21833
Rural	98.6	14469
Age		
0-11 months	97.6	7702
12-23 months	99.2	7453
24-35 months	99.7	7295
36-47 months	99.5	7235
48-59 months	99.6	6616
Mother's Education		
None	98.3	8473
Primary	99.2	17972
Secondary +	99.6	9769
Non-standard curriculum	99.6	87
Wealth Index Quintile		
Poorest	97.9	8432
Second	99.1	8112
Middle	99.5	7323
Fourth	99.6	6644
Richest	99.7	5792
Total	99.1	36302

[1]**MICS indicator 8.1**

Table 21: Child Labour

Percentage of children aged 5-14 years who are involved in child labour activities by type of work, Iraq, 2011.

	Working outside household		Percentage of hours in household chores (28+ per week)	Working for family business	Total Child Labour Percentage[1]	Number of children aged 5-14 years
	Paid work	Unpaid work				
Sex						
Male	0.9	1.4	0.3	5.8	7.9	32213
Female	0.2	0.7	1.4	3.9	5.9	30927
Area						
Urban	0.6	1.1	0.7	2.9	5.0	37755
Rural	0.5	1.2	0.9	7.9	9.9	25385
Age						
5-11 years	0.3	1.4	0.3	5.0	6.4	45704
12-14 yeas	1.8	2.2	2.1	12.6	8.2	17441
School Attendance						
Yes	0.4	1.1	0.4	4.6	6.0	46922
No	1.1	1.2	1.9	5.9	9.5	16218
Mother's Education						
None	0.6	1.4	1.2	6.1	8.7	18756
Primary	0.6	1.0	0.6	4.8	6.6	28442
Secondary +	0.4	1.0	0.6	3.3	4.9	15019
Non-standard curriculum	0.6	1.7	1.5	10.1	12.8	920
Wealth Index Quintile						
Poorest	0.6	1.6	1.1	9.1	11.6	14506
Second	0.7	1.0	0.6	5.0	6.8	13532
Middle	0.7	1.1	0.7	4.1	6.3	12687
Fourth	0.5	0.9	1.0	2.9	5.0	12013
Richest	0.3	0.8	0.5	2.3	3.7	10403
Total	0.6	1.1	0.8	4.9	6.9	63140

[1]**MICS indicator 8.2**

Table 22: Early Marriage

Percentage of women aged 15-49 years married before their 15th birthday, percentage of women aged 20-49 years married before their 18th birthday, percentage of women aged 15-19 years currently married, Iraq, 2011.

	Women 15-49 years		Women 20-49 years		Women 15-19 years	
	Percentage married before age 15[1]	Number of women aged 15-49 years	Percentage married before age 18[2]	Number of women aged 20-49 years	Percentage of women 15-19 currently married[3]	Number of women aged 15-19 years
Area						
Urban	5.3	35900	23.2	28180	18.4	7720
Rural	6.4	19280	26.3	14732	19.2	4548
Age						
15-19	4.8	12268	na	na	18.7	12268
20-24	4.6	10053	23.3	10053	Na	Na
25-29	4.2	8758	20.7	8758	Na	Na
30-34	6.1	7692	22.8	7692	Na	Na
35-39	6.6	6933	25.8	6933	Na	Na
40-44	8.4	5557	27.9	5557	Na	Na
45-49	8.8	3919	29.3	3919	Na	Na
Education						
None	10.0	11825	32.3	9918	25.8	1907
Primary	6.9	22705	28.6	18366	28.4	4339
Secondary +	1.8	20281	12.6	14264	9.5	6017
Non-standard curriculum	14.8	368	43.5	362	(*)	6
Wealth Index Quintile						
Poorest	7.5	10118	27.3	7830	18.9	2288
Second	6.5	10611	27.0	8327	18.1	2284
Middle	5.9	11119	25.7	8696	20.8	2424
Fourth	5.3	11419	23.9	8831	19.5	2589
Richest	3.9	11913	18.1	9229	16.5	2684
Total	5.7	55181	24.2	42912	18.7	12268

[1]**MICS indicator 8.6**
[2]**MICS indicator 8.7**
[3]**MICS indicator 8.8**
na : not applicable.

Table 23: Comprehensive Knowledge of HIV/AIDS Transmission for Women Aged 15-49 Years

Percentage of women aged 15-49 years who have comprehensive knowledge of HIV/AIDS transmission, Iraq, 2011.

	Percentage who know two ways to prevent HIV transmission[1]	Percentage who is aware of the three most common misconceptions[2]	Percentage with comprehensive knowledge (identify the two ways to prevent HIV and the three misconceptions)[3]	Number of women aged 15-49 years
Area				
Urban	22.1	7.7	3.8	35900
Rural	12.2	3.3	1.5	19280
Age				
15-24	16.4	7.1	3.1	22322
25-29	19.7	5.7	3.0	8758
30-39	21.3	5.7	3.1	14626
40-49	18.8	4.9	2.5	9476
Education				
None	7.1	1.1	0.5	11825
Primary	13.9	3.1	1.3	22705
Secondary +	30.8	12.6	6.4	20281
Non-standard curriculum	6.4	1.1	0.2	368
Wealth Index Quintile				
Poorest	7.3	1.9	0.9	10118
Second	14.3	4.1	1.9	10611
Middle	18.3	5.0	2.6	11119
Fourth	21.5	7.0	3.2	11419
Richest	29.6	12.0	6.1	11913
Total	18.6	6.2	3.0	55181

[1]The two prevention ways are: Having only one faithful uninfected sex partner, and using a condom every time

[2]These women are aware of the following: HIV cannot be transmitted through mosquito bites; HIV cannot be transmitted sharing food with someone with AIDS; and a healthy looking person can have AIDS virus

[3]**MICS indicator 9.1**

Table 24: Comprehensive Knowledge of HIV/AIDS Transmission for Women Aged 15-24 Years

Percentage of women aged 15-24 years who have comprehensive knowledge of HIV/AIDS transmission, Iraq, 2011

	Percentage who know two ways to prevent HIV transmission[1]	Percentage who is aware of the three most common misconceptions[2]	Percentage with comprehensive knowledge (identify the two ways to prevent HIV and the three misconceptions)[3]	Number of women aged 15-24 years
Area				
Urban	19.5	9.0	4.0	14354
Rural	10.6	3.9	1.5	7968
Age				
15-19	13.8	6.8	2.7	12268
20-24	19.5	7.6	3.6	10053
Education				
None	4.8	1.0	0.4	3996
Primary	10.4	3.1	1.2	8329
Secondary +	26.0	13.0	5.9	9989
Non-standard curriculum	(*)	(*)	(*)	8
Wealth Index Quintile				
Poorest	6.9	2.5	1.1	4024
Second	13.5	5.2	2.2	4131
Middle	16.1	6.1	2.7	4438
Fourth	18.0	7.9	2.9	4741
Richest	25.0	12.8	6.1	4987
Total	16.4	7.1	3.1	22322

[1]The two prevention ways are: Having only one faithful uninfected sex partner, and using a condom every time

[2]These women are aware of the following: HIV cannot be transmitted through mosquito bites; HIV cannot be transmitted sharing food with someone with AIDS; and a healthy looking person can have AIDS virus

[3]**MICS indicator 9.2; MDG indicator 6.3**

Table 25: Attitude Towards Domestic Violence

Percentage of women aged 15-29 years - attitude towards domestic violence, Iraq, 2011.

	If goes out without telling him	If she neglects the children	If she argues with him	If she refuses sex with him	If she burns the food	For any of the previous 5 reasons[1]	If she is a careless spender	If she discloses husband/household secrets	For any of the previous 7 reasons[2]	Number of women aged 15-49 years
Area										
Urban	36.0	31.8	32.1	29.6	14.1	48.7	24.4	43.7	53.7	35900
Rural	49.3	45.6	45.4	42.6	26.0	62.6	37.8	57.0	67.0	19280
Age										
15-19	39.0	35.1	35.0	28.4	17.6	52.3	28.2	48.5	58.0	12268
20-24	39.2	35.0	35.5	32.3	17.4	51.7	27.4	47.1	56.7	10053
25-29	41.1	36.7	37.5	36.1	18.2	54.1	29.2	48.7	58.6	8758
30-34	41.8	37.9	37.8	37.0	19.0	54.6	30.3	48.2	58.7	7692
35-39	41.2	38.4	37.9	37.1	18.9	55.0	30.4	49.0	59.2	6933
40-44	41.8	37.5	37.4	37.0	18.4	54.8	29.9	48.9	59.4	5557
45-49	43.0	38.5	38.6	38.2	19.3	55.2	30.4	48.5	59.1	3919
Social Status										
Currently married	44.1	39.7	40.2	39.3	19.7	57.1	31.3	50.7	61.2	34237
Was married	43.9	40.4	41.0	39.2	21.4	56.7	32.1	49.5	60.2	2129
Single	33.9	30.6	30.0	24.3	15.2	46.8	24.8	44.0	52.8	18814
Education										
None	51.7	46.9	46.9	45.1	28.7	63.1	39.6	57.2	66.6	11825
Primary	46.4	41.4	42.0	39.6	21.1	59.5	33.6	53.3	63.8	22705
Secondary +	27.4	24.9	24.7	21.5	8.7	41.1	17.8	37.4	47.1	20281
Non-standard curriculum	54.9	49.8	55.0	50.4	27.7	69.1	39.8	63.7	72.5	368
Wealth Index Quintile										
Poorest	55.3	51.1	52.2	47.0	33.1	66.4	45.1	61.4	69.8	10118
Second	44.4	40.3	39.6	38.0	20.1	57.3	32.1	51.4	62.2	10611
Middle	38.9	35.4	34.6	33.2	15.8	52.4	26.8	46.2	56.8	11119
Fourth	36.9	32.7	32.5	30.4	14.3	50.4	24.6	45.3	55.4	11419
Richest	29.9	25.8	27.2	24.5	9.9	43.6	19.3	39.5	49.4	11913
Total	40.6	36.6	36.8	34.2	18.2	53.6	29.1	48.4	58.3	55181

[1]**MICS indicator 8.14**

[2]*Being a careless spender and disclosing husband/household secrets are two options added in MICS4 questionnaires for Iraq only*

Table 26: Female Genital Mutilation/Cutting

Percentage of women aged 15-49 years who suffered female genital mutilation (FGM), and percentage of women who believe it should be continued or discontinued, Iraq, 2011.

	Women who were exposed to female genital mutilation[1]	Heard about female genital mutilation	Number of Women aged 15-49 years	Percentage distribution of women who believe the practice of FGM/C should be:				Total	Number of women who have heard about FGM/C
				Continued[2]	Discontinued	Depends	Do not know		
Area									
Urban	12.9	54.2	35900	6.2	86.6	1.2	6.0	100	19453
Rural	10.5	41.1	19280	11.8	77.1	1.7	9.4	100	7925
Age									
15-19	7.7	37.3	12268	6.9	86.1	1.2	5.8	100	4578
20-24	11.5	48.2	10053	7.0	85.3	1.2	6.5	100	4849
25-29	13.2	50.4	8758	7.2	84.9	1.1	6.8	100	4414
30-34	13.7	54.0	7692	7.4	84.6	1.2	6.9	100	4153
35-39	14.2	56.0	6933	8.4	82.8	1.3	7.5	100	3882
40-44	14.0	57.6	5557	9.2	80.7	2.0	8.0	100	3199
45-49	15.1	58.8	3919	10.7	79.2	1.5	8.7	100	2303
Education									
None	20.1	47.3	11825	19.1	70.3	1.5	9.0	100	5589
Primary	10.2	41.6	22705	7.5	82.1	1.4	9.1	100	9450
Secondary +	9.3	60.0	20281	3.0	91.5	1.1	4.3	100	12176
Non-standard curriculum	1.7	43.7	368	4.3	78.4	2.5	14.8	100	161
Female Genital Mutilation									
Exposed	0.0	42.7	48530	2.1	88.9	1.6	7.4	100	20714
Not exposed	100	100.0	6664	25.6	68.2	0.4	5.8	100	6664
Wealth Index Quintile									
Poorest	13.6	41.5	10118	15.9	72.5	2.0	9.7	100	4200
Second	16.7	48.5	10611	12.5	78.0	1.3	8.2	100	5151
Middle	15.5	50.9	11119	8.1	83.6	1.2	7.1	100	5658
Fourth	10.4	50.1	11419	4.7	87.3	1.1	6.9	100	5721
Richest	5.1	55.8	11913	1.7	92.8	1.2	4.4	100	6647
Total	12.1	49.6	55181	7.8	83.9	1.3	7.0	100	27378

[1] **MICS indicator 8.12**

Table 27: School Attendance of Orphaned Children

School attendance of children aged 10-14 years by orphanhood, Iraq, 2011.

	Percent of children whose mother and father have died	School attendance rate of children whose mother and father have died[1]	Percent of children of whom both parents are alive and child is living with at least one parent	School attendance rate of children of whom both parents are alive and child is living with at least one parent[2]	Double orphans to non-orphans school attendance ratio	Percent of children who are orphaned	School attendance of children who are orphaned	Percent of children who are not orphaned	School attendance of children who are not orphaned	Total number of children aged 10-14 years
Sex										
Male	0.3	79.6	92.6	89.5	0.89	6.9	84.2	89.5	0.94	15390
Female	0.4	59.0	91.7	73.7	0.80	7.1	67.5	73.7	0.91	14700
Residence										
Urban	0.4	68.5	92.2	87.4	0.78	6.9	82.2	87.4	0.93	18104
Rural	0.3	67.0	91.9	73.3	0.91	7.1	66.9	73.3	0.92	11987
Total	0.4	68.0	92.1	81.8	0.83	7.0	76.0	81.8	0.93	30090

[1]**MICS indicator 9.19; MDG indicator 6.4**
[2]**MICS indicator 9.20; MDG indicator 6.4**