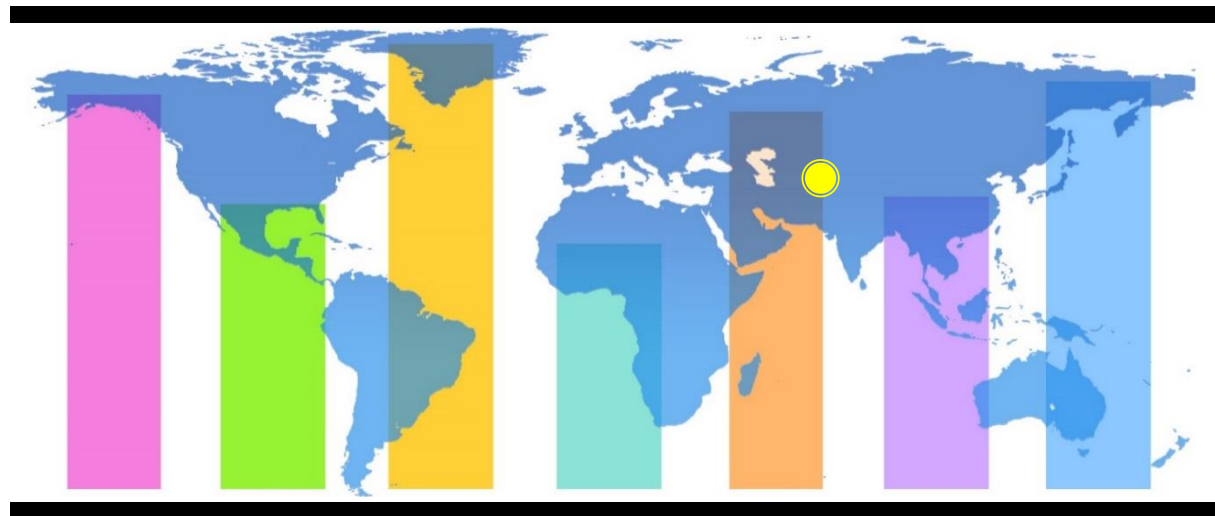# Tajikistan

Demographic and Health Survey

2023

Key Indicators

Tajikistan

Demographic and Health Survey 2023

Key Indicators Report

Statistical Agency under the President of the Republic of Tajikistan
Dushanbe, Republic of Tajikistan

Ministry of Health and Social Protection of Population of the Republic of Tajikistan
Dushanbe, Republic of Tajikistan

The DHS Program
ICF
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ACRONYMS AND ABBREVIATIONS

ANC   antenatal care
ARI   acute respiratory infection

CAPI   computer-assisted personal interviewing
CBR   crude birth rate
CSPro   Census and Survey Processing

DHS   Demographic and Health Survey
DRS   Districts of Republican Subordination

EA   enumeration area

FTF   Feed the Future

GBAO   Gorno-Badakhshan Autonomous Oblast
GFR   general fertility rate

HIV   human immunodeficiency virus

IT   information technology
IUD   intrauterine contraceptive device
IYCF   infant and young child feeding

LAM   lactational amenorrhea method

MoHSP   Ministry of Health and Social Protection of Population

ORS   oral rehydration salts

PSU   primary sampling unit

SD   standard deviation
SDG   Sustainable Development Goal
STI   sexually transmitted infection

TAR   total abortion rate
TFR   total fertility rate
TjDHS   Tajikistan Demographic and Health Survey
TPHC   Tajikistan Population and Housing Census

UNFPA   United Nations Population Fund
UNICEF   United Nations Children's Fund
USAID   United States Agency for International Development

WHO   World Health Organization

FOREWORD

The Statistical Agency under the President of the Republic of Tajikistan is pleased to present the results of the 2023 Tajikistan Demographic and Health Survey (TjDHS). The Statistical Agency wishes to express its appreciation to those involved in the implementation of the 2023 TjDHS and the preparation of this Key Indicators Report.

Particular thanks go to the following:

- The U.S. Agency for International Development (USAID) in Tajikistan, for providing the funding for organizing and conducting the 2023 Tajikistan DHS

- ICF, for providing technical support, training of fieldwork staff, consultations, recommendations, and analyses of the data collected

- The United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in Tajikistan, for providing additional funds

The survey would not have been possible without the good work and dedication of hundreds of people. In particular, we wish to express our appreciation to the field coordinators, supervisors, interviewers, health investigators, and drivers for their active participation in and contribution to this work.

Above all, we appreciate the cooperation of all of the survey respondents who have made the 2023 TjDHS a success.

Mr. Jamshed Nurmahmadzoda
Director, Statistical Agency under the President of the
Republic of Tajikistan

1   INTRODUCTION

The 2023 Tajikistan Demographic and Health Survey (TjDHS) is the third Demographic and Health Survey conducted in Tajikistan. The 2023 TjDHS was implemented by the Statistical Agency under the President of the Republic of Tajikistan (Tajstat) in coordination with the Ministry of Health and Social Protection of Population. Data collection took place from August 10 to November 28, 2023. ICF provided technical assistance through The Demographic and Health Surveys Program (DHS), which is funded by the United States Agency for International Development (USAID) and offers financial support and technical assistance for population and health surveys in countries worldwide. Other agencies and organizations that facilitated the successful implementation of the survey through technical or financial support were the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).

This Key Indicators Report presents a first look at selected findings from the 2023 TjDHS. A comprehensive analysis of the data will be presented in a final report later in 2024.

Survey Objectives

The primary objective of the 2023 TjDHS is to provide up-to-date estimates of basic demographic and health indicators. Specifically, the survey collected information on fertility and contraceptive use, maternal and child health and nutrition, childhood mortality, domestic violence against women, child discipline, awareness and behavior regarding HIV/AIDS and other sexually transmitted infections (STIs), and other health-related issues such as smoking.

The information collected through the 2023 TjDHS is intended to assist policymakers and program managers in designing and evaluating programs and strategies for improving the health of the country's population. The 2023 TjDHS also provides indicators relevant to the Sustainable Development Goals (SDGs) for Tajikistan.

2 SURVEY IMPLEMENTATION

2.1 SAMPLE DESIGN

The sampling frame used for the 2023 TjDHS is the 2020 Tajikistan Population and Housing Census (TPHC), conducted by the Statistical Agency under the President of the Republic of Tajikistan (Tajstat). Administratively, Tajikistan is divided into five administrative regions: Dushanbe, Districts of Republican Subordination (DRS), Sughd, Khatlon, and Gorno-Badakhshan Autonomous Oblast (GBAO). Each region is subdivided into urban and rural areas. The country is divided into 68 districts distributed over the country's regions. Each district is further divided into census divisions, which are subdivided into instruction areas. Each instruction area is divided into urban enumeration areas (EAs) and rural villages.

The sampling frame for the 2023 TjDHS is a list of EAs and natural villages covering all urban and rural areas of the country, with the primary sampling units (PSUs) being EAs in urban areas and natural villages in rural areas. An EA is a geographical area, usually a city block, consisting of an adequate number of households for efficient counting; each EA serves as a counting unit for the population census. The 2020 TPHC did not use EA maps. Urban EAs can be identified through a list of structures/households in the EA together with a description file. In rural areas, an EA is a natural village or part of a large village. Rural EAs can be identified with help from the village chief.

The sample was designed to yield representative results for the country as a whole, urban and rural areas separately, and each of the five administrative regions. In addition, as in the previous TjDHS survey, the sample was designed to allow certain indicators to be presented for the 12 districts in the Khatlon region covered under the Feed the Future program (FTF); these 12 districts were combined as a single FTF domain. The sampling frame excluded institutional populations such as persons in hotels, barracks, and prisons.

The 2023 TjDHS followed a stratified two-stage sample design. The first stage involved selecting sample points (clusters) consisting of EAs. EAs were drawn with a probability proportional to their size within each sampling stratum. A total of 370 clusters were selected, 166 in urban areas and 204 in rural areas.

The second stage involved systematic sampling of households. A household listing operation was undertaken in all of the selected clusters, and a fixed number of 22 households per cluster were selected through an equal probability systematic selection process, for a total sample size of approximately 8,140 households.

All women age 15–49 who were either permanent residents of the selected households or visitors who stayed in the households the night before the survey were eligible to be interviewed. Hemoglobin testing was performed in each household among eligible women age 15–49 who consented to being tested. With the parent's or guardian's consent, children age 6–59 months were also tested for anemia in each household. Height and weight information was collected from eligible women age 15–49 and children age 0–59 months in all households. In addition, one eligible woman in each household was randomly selected to be asked additional questions about domestic violence.

2.2 QUESTIONNAIRES

Three questionnaires were used in the 2023 TjDHS: the Household Questionnaire, the Woman's Questionnaire, and the Biomarker Questionnaire. The questionnaires, based on The DHS Program's model questionnaires, were adapted to reflect the population and health issues relevant to Tajikistan. Suggestions were solicited from various stakeholders representing government ministries and agencies, nongovernmental organizations, and international donors. After all questionnaires were finalized in English, they were translated into Russian and Tajik.

The Household Questionnaire was used to list all members of and visitors to selected households. Basic demographic information was collected on each person listed, including age, sex, marital status, education, and relationship to the head of the household. For children under age 18, parents' survival status was determined. The data on age and sex were used to identify women who were eligible for individual interviews. The Household Questionnaire also collected information on child discipline for one randomly selected child age 1–14 per household as well as information on the characteristics of the household's dwelling unit, such as source of water; type of toilet facilities; materials used for flooring, external walls, and roofing; and ownership of various durable goods.

The Woman's Questionnaire was used to collect information from all eligible women age 15–49. These women were asked questions on the following topics:

- Background characteristics: age, date of birth, duration of residency, previous residency, literacy, education, access to media, mobile phone ownership and use of mobile phones for financial transactions, and internet use

- Reproduction: number of children ever born, pregnancy history, reasons for abortion, child mortality, current pregnancy, and age at first menstrual period

- Contraception: knowledge and use of contraception, sources of contraceptive methods, family planning

- Pregnancy and postnatal care, child immunization, and health and nutrition: prenatal, delivery, and postnatal care; breastfeeding and complementary feeding practices; vaccination coverage; prevalence of and care seeking for diarrhea, acute respiratory infection (ARI), and fever; use of oral rehydration therapy; infant and young child feeding (IYCF) practices; and dietary diversity

- Marriage and sexual activity: marital status, age at first marriage, age at first sexual intercourse, recent sexual activity, number and types of sexual partners, co-wives, and use of condoms

- Fertility preferences: desire for more children, ideal number of children, gender preferences, intention to use family planning and who is making this decision, pressure to become pregnant, and exposure to media messages about family planning

- Husbands' background characteristics and women's work: husband's age, level of education, and occupation and respondent's occupation, sources of earnings, participation in decision making, house ownership, and attitude towards wife beating

- HIV/AIDS: knowledge of AIDS, knowledge of routes of HIV transmission, sources of information, behavior to avoid STIs and AIDS, stigma, and history of HIV testing

- Other health issues: alcohol consumption and smoking, breast exams, cervical cancer tests, problems in accessing health care, and noncommunicable diseases

- Domestic violence: information on the prevalence and incidence of physical, sexual, and emotional violence

- Calendar: a 5-year calendar of reproductive events (births, pregnancies, pregnancy terminations, pregnancy duration, and contraceptive use)

Because home-based vaccination records are rare in Tajikistan, the TjDHS also collected child vaccination data from health facilities following a protocol identical to that used in the 2012 and 2017 TjDHS surveys. Specifically, vaccination data were collected from mothers, either by viewing the home-based record or through mothers' recall, and from facility-based health vaccination cards. For the latter, consenting

mothers provided the address of the facility and the name of the provider; the team supervisor then visited the health facility and copied the records of each eligible child.

The Biomarker Questionnaire was used to record the results of anthropometry measurements and hemoglobin testing.

In addition, the self-administered Fieldworker Questionnaire collected information about the survey's fieldworkers: team supervisors, interviewers, and health investigators.

The 2023 TjDHS survey methodology and instruments were approved by the ICF Institutional Review Board. By law, Tajstat is mandated to conduct population-based surveys in Tajikistan, and local institutional review board approval is not required for the TjDHS. The Government of Tajikistan assigned Tajstat to implement the 2023 TjDHS in collaboration with the Ministry of Health and Social Protection of Population (MoHSP); the government also issued the edict for the creation of the 2023 TjDHS Interagency Steering Committee, which oversaw the approved survey implementation plan and protocols.

2.3   ANTHROPOMETRY AND ANEMIA TESTING

In addition to the data collected through interviews, the 2023 TjDHS incorporated two biomarkers: anthropometry and anemia testing. Data related to coverage of the anthropometric measures and the results of the anemia testing were recorded in the Biomarker Questionnaire. The protocol for anemia testing was reviewed and approved by the MoHSP and the ICF Institutional Review Board.

Anthropometry. Weight measurements were taken using SECA scales with a digital display (model number SECA 874). Height and length were measured with a ShorrBoard® measuring board. Children younger than age 24 months were measured lying down (recumbent length), while older children and adults were measured standing (height).

To assess the precision of measurements, 10% of children per cluster were randomly selected to be measured a second time. The DHS Program defines a difference of less than 1 centimeter between the two height measurements as an acceptable level of precision. Children with a z score of less than -3 or more than 3 for height-for-age, weight-for-height, or weight-for-age were flagged and measured a second time. The remeasurement of flagged cases was performed to ensure accurate reporting of height. Parents or guardians of children with a z score of -3 or less for weight-for-height were provided with a referral for severe acute malnutrition and instructed to take the child to a health facility for follow-up care.

Anemia. Blood specimens for anemia testing were collected from women age 15–49 who consented to be tested. Blood specimens were also collected from children age 6–59 months whose parents or guardians had given consent to the testing. Blood samples were drawn from a drop of blood taken from a finger prick (or a heel prick in the case of children age 6–11 months) and collected in a microcuvette. Hemoglobin analysis was carried out on-site using a battery-operated portable HemoCue® 201+ device. Results were provided verbally and in writing to those being tested. Parents or guardians of children with a hemoglobin level below 8 g/dl were provided with a referral and instructed to take the child to a health facility for follow-up care. Likewise, adults were referred for follow-up care if their hemoglobin levels were below 8 g/dl.

2.4   PRETEST AND CAPI TRAINING OF TRAINERS

Eleven women participated in training to pretest the TjDHS survey questionnaires over a 4-week period from May 10 through June 3, 2023. Classroom training, which took place from May 10 through May 21, focused on questionnaire content. Also, trainees visited a local health facility to practice recording vaccination dates from children's health cards and other vaccination forms kept at the facility. From May 22 through May 29, participants were instructed on using the computer-assisted personal interviewing (CAPI) system, an electronic data capture system programmed on tablet computers that the participants

used to implement the survey. Staff from The DHS Program and an ICF consultant based in Dushanbe led the training in Russian and Tajik with support from Tajstat personnel. In addition, senior subject specialists from the MoHSP attended the sessions to provide technical background on topics such as family planning and reproductive health, childhood immunization, and child health and nutrition. Abduvali Nabizoda from Tajstat delivered a lecture in Tajik on gender-based violence in Tajikistan.

The biomarker classroom portion of the training commenced on May 19 and continued through May 29, 2023. The biomarker training was attended by six participants, all of whom were medically trained specialists. The training, led by staff from The DHS Program in English with consecutive translation to Russian or Tajik, included classroom instruction focusing on anthropometry measurements, anemia testing, and recording of results in the paper Biomarker Questionnaire. The training was divided into three parts: classroom training on anthropometry and anemia, in-class standardization of tests and practice sessions, and fieldwork with interviewers. Classroom training of health investigators (a mixture of women and men) was conducted at the same venue as the training of interviewers, which allowed for close interactions between health investigators and interviewers.

The pretest fieldwork was conducted from May 30 through June 2, 2023. Interviewers and health investigators were divided into three teams and worked in the Districts of Republican Subordination, Rudaki district, and Chorgulteppa (in both urban and rural areas). A total of 72 women's interviews and 48 household interviews were conducted, and 36 Biomarker Questionnaires were completed. Most interviews were conducted in Tajik. Forty-four women were measured and tested for anemia; among children, 30 were measured and 25 were tested for anemia. At the end of each day, both during and after the pretest fieldwork, debriefing sessions were held and questionnaires were modified based on lessons drawn from the exercise.

The CAPI training of trainers started on June 5 and lasted for 5 days. Six information technology (IT) experts from Tajstat were assigned to attend the training of trainers, most of whom had previously taken part in the pretest training. The goals of the training were to provide CAPI system technical content and training materials and strengthen participants' training facilitation skills so that they could play a leadership role in the main training.

2.5   TRAINING OF FIELD STAFF

Eighty-three people (all women) participated in the 4-week main training course on interviewing, which consisted of lectures, demonstrations, and practice interviews. The training for TjDHS health investigators was attended by 35 trainees (24 women and 11 men), all of whom had some form of clinical training or medical research background.

The training of trainers for interviewers was conducted on July 3–5, 2023, prior to the main training. The purpose of the training of trainers was to prepare master trainers for the main training course. Seven trainers (all women) were selected, based on performance, from the 11 participants in the pretest. The trainers were recruited through the Tajstat regional offices; they later served as team supervisors, quality control field monitors, or regional coordinators during the 2023 TjDHS data collection.

The main fieldwork training, conducted from July 6 through August 4, 2023, was led by the seven master trainers and backstopped by staff from The DHS Program. The interviewer training was conducted in Tajik, and sessions included discussions of concepts, procedures, and survey methodology. Participants were guided through the questionnaires. In addition, senior subject specialists from the MoHSP attended the sessions to provide background on topics including family planning, reproductive health, childhood immunization, and child health and nutrition. As with the pretest training, Abduvali Nabizoda from Tajstat delivered a lecture on gender-based violence in Tajikistan. The training included presentations, lectures, hands-on exercises, mock interviews, role plays, group work, tutorial videos, and quizzes. In-class exercises included probing for age, checking age consistency, copying information from the vaccination

cards, completing the reproductive calendar, and practicing interviews. Also, participants received training on how to test household salt for iodine.

Once training on use of paper questionnaires concluded, Tajstat staff and an ICF consultant based in Dushanbe conducted a weeklong training course on computer-assisted personal interviewing in Tajik with backstopping by data processing staff from The DHS Program. The training, which took place from July 19 through July 28, 2023, was facilitated by five IT specialists who had attended the CAPI training of trainers. Participants learned about features of the data collection system, different scenarios and technical issues typically encountered during fieldwork, and ways to resolve issues.

The biomarker classroom portion of the training commenced on July 19 and continued through July 28, 2023. This training was led by staff from The DHS Program with assistance from the two biomarker master trainers. The biomarker training was also supported by three additional trainers who attended the pretest and demonstrated proficiency in all of the biomarker procedures. Training materials were presented in Russian with additional explanation in Tajik when necessary to aid the trainees in comprehension.

The biomarker training was divided into four parts: (1) classroom training on the 2023 TjDHS process, eligibility criteria, informed consent, and proper recording of results in the paper Biomarker Questionnaire; (2) classroom and practical training in the DHS techniques for anthropometry, including standardization exercises; (3) classroom and practical training in capillary blood collection and anemia testing; and (4) fieldwork practice with interviewers. Classroom training of the health investigators was conducted at the same venue as the interviewer training, allowing for close interactions between the health investigators and interviewers.

With regard to anthropometry, health investigators were trained to measure the height and weight of children and adults. The training on child height measurement included standardization exercises and restandardization exercises for health investigators who did not pass the standardization exercises. Inter-observer and intra-observer variations of the same measurements as well as the concepts of accuracy and precision were explained to the participants.

To give the biomarker training participants hands-on experience prior to field practice, the health investigators practiced skills with each other and with Tajstat staff, staff from The DHS Program, and interviewers. Six mothers with children visited at the start of anthropometry training to allow live demonstrations of the measurement protocols with adults and children. Following these demonstrations and further classroom training in anthropometry techniques, anthropometry standardization exercises were conducted at the training venue. Tajstat arranged for a total of approximately 110 children to be present at the training over the 5 days of practice and standardization.

In addition, a special session on anthropometry was held with all team supervisors. On the final day of the classroom training sessions, staff from The DHS Program met with team supervisors to explain the use of checklists provided to aid them in overseeing the health investigators' work. Supervisors were also provided a summary of the remeasurement procedures in which the supervisor and the health investigators revisited approximately two to three children per cluster together for quality control checks of anthropometry measurements.

To improve team coordination, a joint classroom session involving the health investigators was also organized with the interviewers at Tajstat before the beginning of field practice. All training participants and Tajstat staff were given an overview of biomarker collection in the 2023 TjDHS. This overview described eligibility for biomarker collection, use of the Household and Biomarker Questionnaires to record data, appropriate procedures for obtaining informed consent, and supply packing and transportation logistics. Collecting data of high quality was emphasized. Also, participants received a brief tutorial on how to assist in taking anthropometric measurements.

Throughout the training, participants were evaluated via in-class exercises, quizzes, and observations made during field practice. At the end of the training, teams were formed by selecting supervisors, interviewers, and health investigators. The supervisors received additional training in data quality control procedures, fieldwork coordination, and management. They also received training on copying immunization records from MoHSP form 63 and children's health cards directly to tablet computers.

Supervisors, interviewers, and health investigators were divided into 18 teams for field practice, with each team consisting of one supervisor, four interviewers, and two health investigators. Field practice took place in the Tesgar village of the DRS region in 18 clusters with prelisted residential households in nonsampled areas, giving the teams an opportunity to implement the survey in a real-world situation. Field practice took place over 3 days (July 29–31, 2023), and each interviewer visited a minimum of two households per day. During the field practice, a total of 269 women's interviews and 169 household interviews were completed. To allow for practice of biomarker collection, approximately 238 women were measured and 201 were tested for anemia. Among children, 174 were measured and 113 were tested for anemia.

2.6   FIELDWORK

Data collection was carried out by 15 field teams, each consisting of one female team supervisor, four female interviewers, and two health investigators (at least one of whom was female). Fieldwork started in most regions on August 10, 2023, and ended on November 28, 2023.

Fieldwork monitoring was an integral part of the 2023 TjDHS. Senior TjDHS technical staff from Tajstat, along with three DHS quality control field monitors, three biomarker quality control field monitors, five field coordinators, and four CAPI coordinators, visited teams regularly to review work and monitor data quality. Also, representatives from The DHS Program visited teams to monitor data collection and to observe anemia testing and height and weight measurements of women and children under age 5. During field visits, staff provided teams (supervisor, interviewers, and health investigators) with critical feedback to improve their performance. In addition, they used TjDHS field-check tables based on data from completed clusters to illustrate problems specific to each team visited. Field-check tables based on the completed questionnaires entered during fieldwork were generated in real time as fieldwork progressed and were available online via the SyncCloud platform. The tables were reviewed and discussed with the Tajstat staff on an ongoing basis to alert field teams to data quality issues found during the survey fieldwork and to ensure that quality data collection was maintained throughout the fieldwork.

2.7   DATA PROCESSING

The 2023 TjDHS used a Windows-based system. All electronic data files were transferred via a secure SyncCloud server to the Tajstat central office in Dushanbe, where they were stored on a password-protected computer. The data processing operation included secondary editing, which required resolution of computer-identified inconsistencies and coding of open-ended questions. The data were processed by five IT specialists/secondary editors who took part in the main fieldwork training, the training of trainers, and a refresher secondary editing training session; they were supervised remotely by staff from The DHS Program. Data editing was accomplished using CSPro software. Secondary editing and data processing were initiated in December 2023 and completed in February 2024.

3   KEY FINDINGS

3.1   RESPONSE RATES

Table 1 presents the response rates for the 2023 TjDHS. A total of 8,140 households were selected for the TjDHS sample, of which 8,070 were found to be occupied. Of the occupied households, 8,035 were successfully interviewed, yielding a response rate of over 99%. In the interviewed households, 9,930 women age 15–49 were identified as eligible for individual interviews. Interviews were completed with 9,879 women, yielding a response rate of over 99%.

Table 1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Tajikistan DHS 2023

	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	3,652	4,488	8,140
Households occupied	3,620	4,450	8,070
Households interviewed	3,597	4,438	8,035
Household response rate[1]	99.4	99.7	99.6
Interviews with women age 15–49			
Number of eligible women	4,245	5,685	9,930
Number of eligible women interviewed	4,218	5,661	9,879
Eligible women response rate[2]	99.4	99.6	99.5

[1] Households interviewed/households occupied
[2] Respondents interviewed/eligible respondents

3.2   CHARACTERISTICS OF RESPONDENTS

Table 2 presents the weighted and unweighted numbers and percent distributions of women interviewed in the 2023 TjDHS by selected background characteristics. The results presented in this report are based on weighted data that are representative of the country as a whole, urban and rural areas separately, and each of the country's regions.

One-third (34%) of the survey respondents are under age 25.

Eight in 10 respondents (84%) said that they were in good or very good health; only 2% reported their health status as bad or very bad.

A majority (75%) of respondents are currently married or living together with a partner as if married; 5% are divorced, separated, or widowed.

The majority of the 2023 TjDHS respondents live in rural areas (73%).

There is considerable variation in the distribution of respondents by region. Over one-third (36%) of respondents live in the Khatlon region, as compared with only 2% in GBAO.

Women in Tajikistan are generally well educated. Twelve percent of respondents have some higher education, 8% have a professional primary or middle education, 43% have a general secondary education, and 33% have a general basic education; only 1% of respondents have never attended school and 3% have attended only primary school.

Table 2 Background characteristics of respondents

Percent distribution of women age 15–49 by selected background characteristics, Tajikistan DHS 2023

Background characteristic	Weighted percent	Weighted number	Unweighted number
Age			
15–19	17.3	1,710	1,714
20–24	16.4	1,616	1,566
25–29	15.8	1,559	1,508
30–34	15.6	1,545	1,518
35–39	14.5	1,435	1,464
40–44	11.1	1,096	1,154
45–49	9.3	917	955
Self-reported health status			
Very good	20.8	2,059	1,946
Good	62.7	6,193	6,009
Moderate	14.6	1,442	1,732
Bad	1.8	173	181
Very bad	0.1	12	11
Marital status			
Never married	19.9	1,964	2,107
Married	74.4	7,349	7,151
Living together	0.4	43	52
Divorced/separated	3.9	385	412
Widowed	1.4	137	157
Residence			
Urban	27.4	2,705	4,218
Rural	72.6	7,174	5,661
Region			
Dushanbe	10.9	1,077	2,006
GBAO	1.6	157	815
Sughd	28.1	2,780	2,117
DRS	23.9	2,356	2,277
Khatlon	35.5	3,509	2,664
FTF districts[1]	19.6	1,937	1,354
Education			
No education	1.3	129	113
Primary	3.2	314	284
General basic	33.1	3,271	3,153
General secondary	42.8	4,230	3,882
Professional primary	1.2	121	145
Professional middle	6.6	656	757
Higher	11.7	1,157	1,545
Wealth quintile			
Lowest	18.6	1,842	1,636
Second	19.9	1,967	1,594
Middle	19.9	1,966	1,603
Fourth	19.9	1,964	1,756
Highest	21.7	2,140	3,290
Total	100.0	9,879	9,879

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.
[1] Data are based on information collected in the households selected in 44 clusters in the 12 districts included in the Feed the Future program (FTF) pilot areas in the Khatlon region.

3.3 FERTILITY

Table 3 shows the total fertility rate (TFR) and age-specific fertility rates among women by 5-year age groups for the 3-year period preceding the survey.

> **Total fertility rate**
> The average number of children a woman would have by the end of her childbearing years if she bore children at the current age-specific fertility rates. Age-specific fertility rates are calculated for the 3 years before the survey, based on detailed pregnancy histories provided by women.
> *Sample:* Women age 15–49

- If fertility were to remain constant at current levels, a woman in Tajikistan would bear an average of 3.5 children in her lifetime.

- Fertility is only slightly higher in rural areas than in urban areas. On average, rural women give birth to 3.5 children in their lifetime, while urban women give birth to 3.2 children.

- Fertility is low among adolescents (47 births per 1,000 women age 15–19), peaks at 280 births per 1,000 among women age 20–24, and decreases thereafter.

Trends: As shown in **Figure 1**, the overall TFR held steady at 3.8 children in 2012 and 2017 and then declined to 3.5 children in 2023. This downward trend is more evident among women in rural areas than urban areas. The TFR in rural areas declined from 3.9 in 2017 to 3.5 in 2023, whereas the TFR in urban areas declined from 3.3 in 2012 to 3.0 in 2017 before increasing to 3.2 in 2023.

Table 3 Current fertility

Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the 3 years preceding the survey, according to residence, Tajikistan DHS 2023

	Residence		
Age group	Urban	Rural	Total
10–14	[0]	[0]	[0]
15–19	36	51	47
20–24	245	292	280
25–29	192	184	186
30–34	107	107	107
35–39	56	58	58
40–44	12	15	14
45–49	[2]	[2]	[2]
TFR (15–49)	3.2	3.5	3.5
GFR	112	128	124
CBR	25.4	27.8	27.1

Note: Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates are for the period 1–36 months preceding the interview. Rates for the 10–14 age group are based on retrospective data from women age 15–17.
TFR: total fertility rate, expressed per woman
GFR: general fertility rate, expressed per 1,000 women age 15–44
CBR: crude birth rate, expressed per 1,000 population

Figure 1 Trends in fertility by residence

TFR for the 3 years before each survey

| 2012 TjDHS | 2017 TjDHS | 2023 TjDHS |
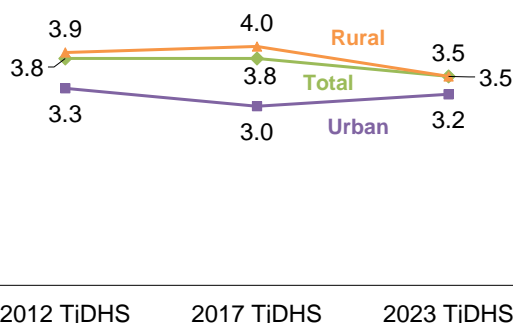
3.4 TEENAGE FERTILITY

Teenage pregnancy
Percentage of women age 15–19 who have ever been pregnant.
Sample: Women age 15–19

Table 4 shows the percentage of women age 15–19 who have given birth or were pregnant with their first child at the time of the survey, according to background characteristics.

- 7% of women age 15–19 have ever been pregnant.

- 3% of young women have had a live birth.

- Less than 1% of young women have had a pregnancy loss.

- 5% of young women are currently pregnant.

Table 4 Teenage pregnancy

Percentage of women age 15–19 who have ever had a live birth, percentage who have ever had a pregnancy loss, percentage who are currently pregnant, and percentage who have ever been pregnant, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Percentage of women age 15–19 who:				Number of women
	Have ever had a live birth	Have ever had a pregnancy loss[1]	Are currently pregnant	Have ever been pregnant	
Age					
15	0.0	0.0	0.0	0.0	405
16	0.0	0.0	0.0	0.0	340
17	0.0	0.0	0.4	0.4	326
18	2.6	0.2	7.5	10.0	310
19	11.0	0.3	18.3	28.3	329
Residence					
Urban	2.2	0.1	2.9	5.0	481
Rural	2.7	0.1	5.8	8.3	1,230
Region					
Dushanbe	1.4	0.0	1.3	2.6	203
GBAO	1.6	0.0	2.2	3.9	26
Sughd	3.1	0.0	6.4	9.5	473
DRS	3.2	0.3	5.5	8.3	416
Khatlon	2.2	0.1	4.8	6.7	592
FTF districts	1.9	0.2	5.4	7.3	336
Education					
None/primary	(5.0)	(0.0)	(12.4)	(17.4)	33
General basic	1.4	0.1	2.6	3.8	817
General secondary	4.3	0.1	7.6	11.5	634
Professional primary/middle	0.9	0.0	6.1	7.0	126
Higher	2.9	0.0	4.2	7.1	100
Wealth quintile					
Lowest	1.5	0.0	4.7	5.3	297
Second	2.0	0.2	2.8	4.8	358
Middle	2.5	0.3	6.3	8.8	339
Fourth	4.4	0.0	8.2	12.3	315
Highest	2.7	0.0	3.4	6.0	402
Total	2.6	0.1	5.0	7.3	1,710

Note: Figures in parentheses are based on 25–49 unweighted cases.
[1] Stillbirth, miscarriage, or abortion

3.5   FERTILITY PREFERENCES

> **Desire for another child**
>
> Women were asked whether they wanted more children and, if so, how long they would prefer to wait before the birth of the next child. Women who are sterilized are assumed not to want any more children.
>
> *Sample:* Currently married women age 15–49

Table 5 shows fertility preferences among currently married women age 15–49 by number of living children.

- 19% of women want another child soon (within the next 2 years), 5% want to have another child later (in 2 or more years), and 6% want another child but have not decided when.

- 35% of women want no more children and 2% are sterilized.

- The percentage of women who want no more children increases with number of living children, from 1% among women with no living children to 69% among those with six or more children.

Table 5 Fertility preferences according to number of living children

Percent distribution of currently married women age 15–49 by desire for children, according to number of living children, Tajikistan DHS 2023

Desire for children	Number of living children[1]							Total
	0	1	2	3	4	5	6+	
Have another soon[2]	50.5	36.2	24.7	12.4	6.8	4.3	4.3	18.9
Have another later[3]	0.1	11.4	7.8	4.3	1.3	0.9	0.8	4.9
Have another, undecided when	3.1	10.3	9.2	5.8	2.7	1.8	3.3	6.1
Undecided	15.0	25.1	28.3	26.8	23.6	22.5	18.5	25.1
Want no more	1.2	4.8	21.1	43.1	56.7	60.9	66.7	34.8
Sterilized[4]	0.0	0.6	1.3	2.5	3.4	5.1	1.9	2.2
Declared infecund	30.2	11.7	7.6	5.3	5.5	4.3	4.6	8.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	449	1,009	1,629	2,196	1,494	478	137	7,392

[1] The number of living children includes a woman's current pregnancy.
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilization

3.6   FAMILY PLANNING

3.6.1 Contraceptive Use

> **Contraceptive prevalence**
>
> Percentage of women who use any contraceptive method.
>
> *Sample:* Currently married women age 15–49

> **Modern methods**
>
> Include male and female sterilization, injectables, intrauterine devices (IUDs), contraceptive pills, implants, female and male condoms, emergency contraception, and the lactational amenorrhea method.

Table 6 presents data on contraceptive use among currently married women.

Table 6 Current use of contraception according to background characteristics

Percent distribution of currently married women age 15–49 by contraceptive method currently used, according to background characteristics, Tajikistan DHS 2023
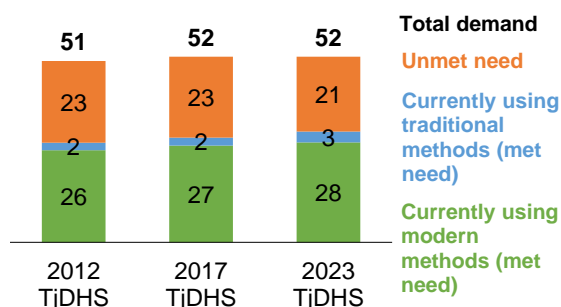
Background characteristic	Any method	Any modern method	Female steriliza-tion	Male steriliza-tion	IUD	Inject-ables	Implants	Pill	Male condom	Female condom	LAM	Other	Any tradi-tional method	Rhythm	With-drawal	Other	Not currently using	Total	Number of women
Number of living children																			
0	0.7	0.7	0.0	0.0	0.4	0.0	0.0	0.1	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	99.3	100.0	687
1–2	21.7	19.0	1.1	0.0	11.9	0.6	0.0	1.1	2.8	0.1	1.5	0.0	2.7	0.0	2.7	0.0	78.3	100.0	2,572
3–4	42.5	38.0	3.0	0.0	24.6	1.4	0.1	2.9	5.0	0.0	0.9	0.0	4.6	0.1	4.5	0.0	57.5	100.0	3,550
5+	43.4	40.2	4.5	0.2	26.7	1.9	0.0	2.8	3.5	0.0	0.5	0.2	3.2	0.0	3.2	0.0	56.6	100.0	584
Age																			
15–19	3.6	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.0	2.8	0.0	0.0	0.0	0.0	0.0	96.4	100.0	220
20–24	13.2	11.7	0.0	0.0	6.7	0.3	0.0	0.8	1.6	0.0	2.3	0.0	1.5	0.0	1.5	0.0	86.8	100.0	1,281
25–29	29.0	26.6	0.9	0.0	18.8	0.7	0.0	1.6	3.4	0.1	1.1	0.0	2.4	0.0	2.3	0.0	71.0	100.0	1,437
30–34	37.9	33.9	1.4	0.0	21.9	1.5	0.1	2.6	5.1	0.1	1.2	0.0	3.9	0.0	3.9	0.0	62.1	100.0	1,407
35–39	43.8	38.6	3.7	0.1	24.0	1.7	0.3	3.2	5.4	0.0	0.2	0.0	5.2	0.0	5.2	0.0	56.2	100.0	1,291
40–44	42.3	37.9	3.7	0.0	25.4	1.7	0.0	2.6	4.4	0.0	0.2	0.0	4.4	0.2	4.2	0.0	57.7	100.0	974
45–49	28.5	24.4	5.6	0.0	14.5	0.2	0.0	1.7	2.2	0.0	0.0	0.1	4.2	0.0	4.2	0.0	71.5	100.0	781
Residence																			
Urban	36.7	32.5	2.9	0.0	19.4	0.4	0.1	2.2	6.2	0.0	1.5	0.0	4.2	0.1	4.0	0.0	63.3	100.0	1,870
Rural	29.7	26.6	1.9	0.0	17.6	1.2	0.1	2.0	2.8	0.1	0.8	0.0	3.1	0.0	3.1	0.0	70.3	100.0	5,522
Region																			
Dushanbe	42.5	37.7	3.3	0.0	22.1	0.2	0.1	2.4	8.1	0.0	1.5	0.0	4.8	0.0	4.7	0.1	57.5	100.0	708
GBAO	36.4	35.4	0.6	0.0	26.1	1.5	0.0	2.6	4.5	0.0	0.0	0.0	1.1	0.0	1.1	0.0	63.6	100.0	109
Sughd	40.3	33.2	2.6	0.0	19.3	1.2	0.0	2.4	5.0	0.0	2.6	0.0	7.0	0.1	6.9	0.0	59.7	100.0	2,160
DRS	23.3	21.9	2.2	0.1	13.9	0.9	0.1	2.0	2.3	0.1	0.3	0.1	1.5	0.0	1.5	0.0	76.7	100.0	1,782
Khatlon	26.6	25.2	1.5	0.0	18.4	1.1	0.1	1.6	2.3	0.1	0.1	0.0	1.5	0.0	1.5	0.0	73.4	100.0	2,634
FTF districts	26.0	24.2	1.3	0.0	17.8	1.1	0.1	2.4	1.3	0.1	0.0	0.0	1.8	0.0	1.8	0.0	74.0	100.0	1,482
Education																			
None/primary	30.1	26.7	2.7	0.0	19.1	0.9	0.0	0.8	3.1	0.0	0.1	0.0	3.3	0.0	3.3	0.0	69.9	100.0	364
General basic	34.2	30.6	2.3	0.0	19.3	1.5	0.2	2.5	4.1	0.1	0.5	0.0	3.6	0.0	3.6	0.0	65.8	100.0	2,276
General secondary	29.7	26.6	2.1	0.0	17.7	0.9	0.0	2.0	2.8	0.0	1.0	0.0	3.1	0.0	3.1	0.0	70.3	100.0	3,391
Professional primary/ middle	27.9	23.8	1.7	0.0	14.2	0.2	0.0	1.2	3.8	0.3	2.3	0.0	4.2	0.0	4.2	0.0	72.1	100.0	551
Higher	34.3	30.6	1.8	0.0	18.3	0.6	0.1	1.6	6.5	0.0	1.7	0.0	3.7	0.3	3.4	0.1	65.7	100.0	811
Wealth quintile																			
Lowest	25.9	23.4	1.8	0.0	16.2	1.9	0.2	1.5	1.4	0.0	0.4	0.0	2.5	0.0	2.5	0.0	74.1	100.0	1,390
Second	28.6	26.4	1.6	0.0	18.2	0.9	0.0	1.7	3.2	0.0	0.9	0.0	2.2	0.0	2.2	0.0	71.4	100.0	1,451
Middle	28.8	25.6	1.6	0.0	17.1	1.1	0.1	2.1	3.2	0.0	0.4	0.0	3.2	0.0	3.2	0.0	71.2	100.0	1,512
Fourth	31.7	27.9	2.8	0.1	16.6	1.0	0.0	2.6	3.3	0.2	1.3	0.1	3.8	0.0	3.8	0.0	68.3	100.0	1,566
Highest	42.0	36.8	2.9	0.0	22.3	0.3	0.0	2.1	7.2	0.0	2.0	0.0	5.2	0.1	5.1	0.0	58.0	100.0	1,474
Total	31.5	28.1	2.1	0.0	18.1	1.0	0.1	2.0	3.7	0.0	1.0	0.0	3.4	0.0	3.4	0.0	68.5	100.0	7,392

Note: If more than one method is used, only the most effective method is considered in this tabulation.
LAM = lactational amenorrhea method

- 32% of currently married women are using a contraceptive method; 28% are using modern methods, and 3% are using traditional methods.

- IUDs remain the most commonly used contraceptive method among currently married women (18%), followed by male condoms (4%).

- Withdrawal is the predominant traditional method, used by 3% of currently married women.

Trends: The percentage of currently married women using a contraceptive method increased from 28% in 2012 to 32% in 2023 (**Figure 2**). Over this time period, use of modern methods rose from 26% to 28%.

Figure 2 **Trends in use of, need for, and demand for family planning**

Percentage of currently married women age 15–49

3.6.2 Need and Demand for Family Planning

Table 7 presents data on unmet need, met need, and total demand for family planning among currently married women. These indicators help evaluate the extent to which family planning programs in Tajikistan are meeting the demand for services. Data for sexually active unmarried women are not presented due to the low number of cases.

Unmet need for family planning
Percentage of women who (1) are not pregnant and not postpartum amenorrheic and are considered fecund and want to postpone their next birth for 2 or more years or stop childbearing altogether but are not using a contraceptive method, or (2) have a mistimed or unwanted current pregnancy, or (3) are postpartum amenorrheic and their most recent birth in the past 2 years was mistimed or unwanted.

Met need for family planning
Current contraceptive use (any method).

Sample: Currently married women age 15–49

Demand for family planning:	Unmet need for family planning + met need (current contraceptive use [any method])

Proportion of demand satisfied:	$\dfrac{\text{Current contraceptive use (any method)}}{\text{Unmet need + current contraceptive use (any method)}}$

Proportion of demand satisfied by modern methods:	$\dfrac{\text{Current contraceptive use (any modern method)}}{\text{Unmet need + current contraceptive use (any method)}}$

15

- 21% of currently married women have an unmet need for family planning.

- The total demand for family planning among currently married women is 52%; 61% of the demand for family planning is satisfied, 54% by modern methods.

Table 7 Need and demand for family planning among currently married women

Percentage of currently married women age 15–49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Unmet need for family planning	Met need for family planning (currently using)		Total demand for family planning[3]	Number of women	Percentage of demand satisfied[1]	
		All methods	Modern methods[2]			All methods	Modern methods[2]
Age							
15–19	18.0	3.6	3.6	21.6	220	16.6	16.6
20–24	25.2	13.2	11.7	38.4	1,281	34.4	30.4
25–29	26.2	29.0	26.6	55.2	1,437	52.5	48.2
30–34	24.6	37.9	33.9	62.4	1,407	60.6	54.4
35–39	20.5	43.8	38.6	64.3	1,291	68.1	60.0
40–44	11.6	42.3	37.9	53.9	974	78.6	70.4
45–49	7.4	28.5	24.4	36.0	781	79.3	67.7
Residence							
Urban	20.3	36.7	32.5	57.0	1,870	64.4	57.1
Rural	20.7	29.7	26.6	50.4	5,522	59.0	52.7
Region							
Dushanbe	21.5	42.5	37.7	64.0	708	66.4	59.0
GBAO	16.1	36.4	35.4	52.5	109	69.4	67.4
Sughd	16.4	40.3	33.2	56.7	2,160	71.1	58.7
DRS	25.8	23.3	21.9	49.1	1,782	47.5	44.5
Khatlon	20.4	26.6	25.2	47.0	2,634	56.6	53.5
FTF districts	21.3	26.0	24.2	47.3	1,482	55.0	51.2
Education							
None/primary	24.1	30.1	26.7	54.2	364	55.5	49.4
General basic	22.9	34.2	30.6	57.1	2,276	59.9	53.6
General secondary	18.9	29.7	26.6	48.6	3,391	61.1	54.8
Professional primary/ middle	20.4	27.9	23.8	48.3	551	57.8	49.2
Higher	19.6	34.3	30.6	53.9	811	63.6	56.8
Wealth quintile							
Lowest	21.7	25.9	23.4	47.6	1,390	54.4	49.1
Second	22.9	28.6	26.4	51.5	1,451	55.5	51.3
Middle	20.8	28.8	25.6	49.6	1,512	58.1	51.7
Fourth	19.4	31.7	27.9	51.1	1,566	62.0	54.6
Highest	18.2	42.0	36.8	60.2	1,474	69.8	61.1
Total	20.6	31.5	28.1	52.0	7,392	60.5	53.9

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al. 2012.
[1] Percentage of demand satisfied is met need divided by total demand.
[2] Modern methods include female sterilization, male sterilization, IUD, injectables, implants, pill, male condom, female condom, emergency contraception, lactational amenorrhea method (LAM), and other modern methods.
[3] Total demand is the sum of unmet need and met need.

Trends: The total demand for family planning among current married women has changed little over time (51% in 2012 and 52% in 2017 and 2023) (see **Figure 2**). Unmet need has also held steady (23% in 2012 and 2017 and 21% in 2023).

3.7   PREGNANCY OUTCOMES AND INDUCED ABORTION RATES

Abortion is legally available as a means of fertility regulation in Tajikistan. In addition to obtaining information on live births, the pregnancy history in the 2023 TjDHS gathered information on pregnancies that ended in a stillbirth, miscarriage, or induced abortion.

3.7.1 Pregnancy Outcomes

Pregnancy outcomes	
Live birth:	a child who was born alive, even if for a very short time
Stillbirth:	a child who was born dead (no signs of life) following a pregnancy that lasted 7 months (28 weeks) or longer
Miscarriage:	a pregnancy that ended involuntarily before completing 7 months (28 weeks)
Induced abortion:	a pregnancy that was voluntarily ended
Sample: Pregnancies among women age 15–49 ending in the 3 years preceding the survey	

Eighty-three percent of pregnancies occurring during the 3 years before the survey resulted in a live birth, 4% ended in an induced abortion, 12% ended in a miscarriage, and 1% ended in a stillbirth (**Table 8** and **Figure 3**).

Table 8 Pregnancy outcome by background characteristics

Percent distribution of pregnancies ending in the 3 years preceding the survey by type of outcome, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Pregnancy outcome				Total	Number of pregnancies
	Live birth	Stillbirth[1]	Miscarriage[2]	Induced abortion		
Age at pregnancy outcome						
<20	93.2	0.5	5.2	1.1	100.0	242
20–24	89.3	0.3	7.9	2.5	100.0	1,493
25–34	80.0	0.5	14.6	4.8	100.0	1,697
35–44	70.3	1.2	18.5	10.0	100.0	384
45–49	*	*	*	*	100.0	16
Pregnancy order						
First	94.1	0.3	5.0	0.7	100.0	900
Second	92.5	0.3	6.2	1.1	100.0	881
Third	82.5	0.9	12.6	4.0	100.0	832
Fourth	75.5	0.9	16.2	7.4	100.0	662
Fifth or higher	61.7	0.1	26.4	11.8	100.0	558
Residence						
Urban	79.1	0.7	16.3	3.9	100.0	1,014
Rural	84.8	0.4	10.4	4.4	100.0	2,818
Region						
Dushanbe	72.3	1.1	22.4	4.2	100.0	449
GBAO	86.7	0.4	9.1	3.8	100.0	47
Sughd	86.8	0.6	8.8	3.8	100.0	1,003
DRS	80.6	0.2	14.5	4.7	100.0	926
Khatlon	85.9	0.4	9.2	4.5	100.0	1,408
FTF districts	88.2	0.0	8.3	3.5	100.0	823
Education						
None/primary	87.4	0.6	10.0	2.0	100.0	176
General basic	78.6	0.3	15.1	6.0	100.0	1,128
General secondary	85.7	0.4	10.2	3.8	100.0	1,701
Professional primary/ middle	85.5	1.0	10.7	2.9	100.0	359
Higher	82.6	0.9	12.4	4.1	100.0	468
Wealth quintile						
Lowest	85.7	0.1	9.1	5.1	100.0	727
Second	84.5	0.4	11.4	3.7	100.0	739
Middle	83.5	0.4	11.0	5.1	100.0	793
Fourth	83.6	0.7	11.8	3.8	100.0	798
Highest	79.3	0.7	16.2	3.9	100.0	775
Total	83.3	0.5	11.9	4.3	100.0	3,832

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Stillbirths are fetal deaths in pregnancies lasting 28 or more weeks. When pregnancy duration is reported in months, stillbirths are fetal deaths in pregnancies lasting 7 or more months.
[2] Miscarriages are fetal deaths in pregnancies lasting less than 28 weeks. When pregnancy duration is reported in months, miscarriages are fetal deaths in pregnancies lasting less than 7 months.

Figure 3 Pregnancy outcomes

Percent distribution of pregnancies in the 3 years before the survey according to outcome
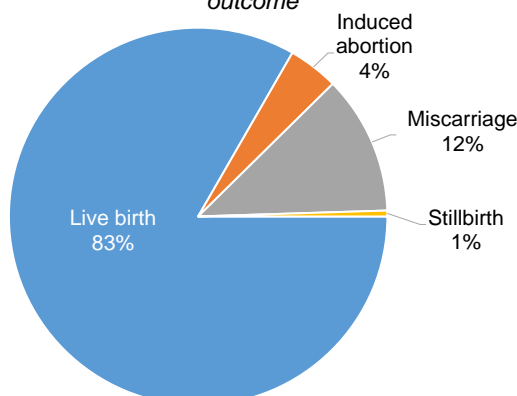
3.7.2 Total Abortion Rate

Table 9 shows the total abortion rate (TAR) and age-specific abortion rates among women by 5-year age groups for the 3-year period preceding the survey.

> **Total abortion rate**
>
> The average number of abortions a woman would have by the end of her childbearing years if she had abortions at the current age-specific abortion rates. Age-specific abortion rates are calculated for the 3 years before the survey, based on detailed pregnancy histories provided by women.
>
> ***Sample:*** Women age 15–49

- The total abortion rate (TAR) in Tajikistan is 0.2 abortions per woman. This means that the average number of abortions a Tajik woman will have at the current age-specific abortion rate is equivalent to 6% of the average TFR (3.5 children).

- The TAR is identical in urban and rural areas (0.2 abortions).

- The age-specific abortion rate increases from 1 abortion per 1,000 women in the 15–19 age group to a peak of 11 abortions per 1,000 women in the 25–29 age group.

Trends: Abortion rates continue to decline in Tajikistan; the TAR decreased from 0.5 abortions per woman in 2012 and 2017 to 0.2 in 2023. However, these data should be interpreted with caution due to the low number of cases and possible underreporting.

Table 9 Induced abortion rates

Age-specific and total induced abortion rates, and general abortion rates, for the 3 years preceding the survey, according to residence, Tajikistan DHS 2023

Age group	Residence		Total
	Urban	Rural	
10–14	[0]	[0]	[0]
15–19	0	1	1
20–24	6	8	8
25–29	11	11	11
30–34	8	5	6
35–39	6	9	8
40–44	1	2	2
45–49	[0]	[4]	[3]
TAR (15–49)	0.2	0.2	0.2
GAR	6	7	6

Note: Age-specific induced abortion rates are per 1,000 women. Estimates in brackets are truncated. Rates are for the period 1–36 months preceding the interview. Rates for the 10–14 age group are based on retrospective data from women age 15–17.
TAR: total induced abortion rate, expressed per woman
GAR: general induced abortion rate, expressed per 1,000 women age 15–44
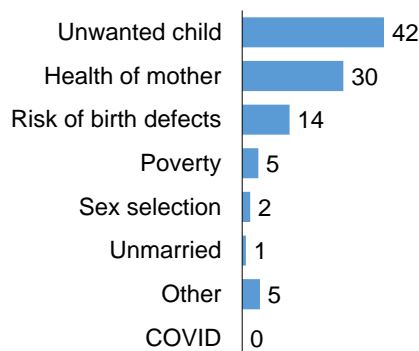
3.7.3 Reasons for Induced Abortion

An understanding of the reasons women have for deciding to undergo an induced abortion is helpful in planning programs to reduce induced abortions. **Figure 4** shows the percent distribution of induced abortions in the 3 years prior to the 2023 TjDHS according to the main reason the respondent decided to have the abortion.

- The main reasons reported by respondents were unwanted pregnancies (42%), concerns about their health (30%), risk of birth defects (14%), and poverty (5%).

- Notably, sex selection was the main reason for an induced abortion in only 2% of cases.

- None of the respondents cited having COVID as their main reason for an abortion.

Figure 4 **Reason for abortion**

Percent distribution of abortions in the 3 years prior to the survey according to main reason for abortion

Reason	Percent
Unwanted child	42
Health of mother	30
Risk of birth defects	14
Poverty	5
Sex selection	2
Unmarried	1
Other	5
COVID	0

Note: Total is less than 100% due to rounding.

3.8   EARLY CHILDHOOD MORTALITY

> **Neonatal mortality:** The probability of dying within the first month of life.
> **Postneonatal mortality:** The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality).
> **Infant mortality:** The probability of dying between birth and the first birthday.
> **Child mortality:** The probability of dying between the first and the fifth birthday.
> **Under-5 mortality:** The probability of dying between birth and the fifth birthday.

Table 10 presents estimates of childhood mortality for three successive 5-year periods prior to the 2023 TjDHS. The rates were estimated directly from information collected as part of a retrospective pregnancy history in which female respondents listed all of the children to whom they have given birth, along with each child's date of birth, survivorship status, and current age or age at death.

- The under-5 mortality rate for the 5-year period preceding the 2023 TjDHS was 24 deaths per 1,000 live births[1].

- The infant mortality rate—that is, deaths in the first year of life—was 20 deaths per 1,000 live births.

- The neonatal mortality rate was 10 deaths per 1,000 live births. This indicates that deaths during the first month of life account for half of all infant deaths.

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[1] According to the State Institution "Republican Center for Statistics and Medical Information" of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan, in 2023, based on annual registration data, the under-5 mortality rate was 14.4 deaths per 1,000 live births, and the mortality rate for children under 1 year of age was 12.0 deaths per 1,000 live births (source: Сборник "Здоровье населения и деятельность учреждений здравоохранения в 2023 году").

Table 10 Early childhood mortality rates

Neonatal, postneonatal, infant, child, and under-5 mortality rates for 5-year periods preceding the survey, Tajikistan DHS 2023

Years preceding the survey	Approximate calendar years	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
0–4	2019–2023	10	11	20	4	24
5–9	2013–2018	8	9	17	5	22
10–14	2008–2012	12	9	21	4	25

[1] Computed as the difference between the infant and neonatal mortality rates

Trends: The under-5 mortality rate decreased from 43 deaths per 1,000 live births in 2012 to 24 deaths per 1,000 live births in 2023 (**Figure 5**). Over this same period, neonatal mortality decreased from 19 deaths per 1,000 live births to 10 deaths per 1,000 live births. These rates should be interpreted with caution due to the small number of cases.

3.9   MATERNAL CARE

Proper care during pregnancy and delivery is important for the health of both the mother and the baby. **Table 11** presents key indicators related to maternal care.

3.9.1   Antenatal Care

Figure 5 **Trends in early childhood mortality rates**

Deaths per 1,000 live births in the 5-year period preceding the survey

Antenatal care from a skilled provider

Pregnancy care received from skilled providers, such as doctors and nurses/midwives.

Sample: Women age 15–49 who had a live birth or stillbirth in the 2 years before the survey
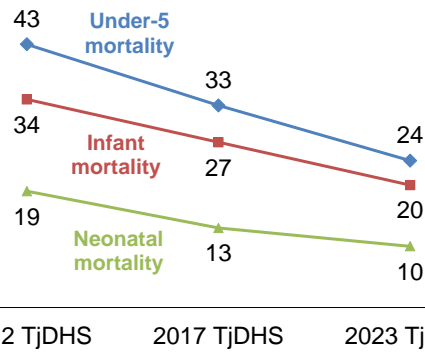
Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period.

- 8 in 10 women received ANC from a skilled provider for their most recent live birth in the 2 years before the survey (81%).

- 62% of women had four or more ANC visits during the pregnancy that resulted in their most recent live birth in the 2 years before the survey.

- 75% of women took iron-containing supplements during their most recent pregnancy that resulted in a live birth.

20

Table 11 Maternal care indicators

Among women age 15–49 who had a live birth and/or a stillbirth in the 2 years preceding the survey, percentage who received antenatal care (ANC) from a skilled provider for the most recent live birth or stillbirth, percentage with four or more ANC visits for the most recent live birth or stillbirth, and percentage who took any iron-containing supplements during pregnancy for the most recent live birth or stillbirth; among all live births and stillbirths in the 2 years preceding the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women age 15–49 with a live birth or stillbirth in the 2 years preceding the survey, percentage who received a postnatal check during the first 2 days after giving birth, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Women who had a live birth and/or a stillbirth in the 2 years preceding the survey				Live births and stillbirths in the 2 years preceding the survey			Women who had a live birth and/or a stillbirth in the 2 years preceding the survey	
	Percentage receiving antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage who took any iron-containing supplements during pregnancy[2]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage with a postnatal check during the first 2 days after birth[3]	Number of women
LIVE BIRTHS									
Mother's age at birth									
<20	86.1	64.7	74.3	127	99.3	96.5	151	95.9	127
20–34	81.1	62.6	75.4	1,759	97.4	94.9	1,875	88.8	1,759
35–49	79.3	55.7	65.8	181	98.3	91.8	186	88.5	181
Residence									
Urban	84.3	71.3	82.7	536	99.5	98.2	578	87.6	536
Rural	80.2	58.8	71.7	1,530	96.9	93.5	1,635	89.8	1,530
Region									
Dushanbe	91.0	78.6	92.0	208	99.4	98.6	222	82.3	208
GBAO	92.7	77.6	87.6	25	100.0	93.4	27	89.5	25
Sughd	90.3	84.2	71.7	576	99.1	98.4	620	94.1	576
DRS	81.9	59.4	73.8	472	93.4	87.4	501	88.6	472
Khatlon	71.3	42.6	72.0	785	98.5	95.4	844	87.9	785
FTF districts	79.7	46.9	74.0	471	98.8	98.1	507	86.4	471
Mother's education									
None/primary	77.1	42.6	62.2	103	95.3	86.2	109	88.9	103
General basic	82.2	59.4	69.1	545	95.5	90.7	572	86.3	545
General secondary	80.1	60.7	76.2	934	98.1	96.2	1,014	89.9	934
Professional primary/ middle	85.1	72.7	78.6	217	99.3	97.5	233	91.9	217
Higher	81.9	71.3	81.5	266	99.4	98.5	285	90.9	266
Wealth quintile									
Lowest	65.8	38.4	61.0	389	92.9	86.3	410	85.4	389
Second	80.7	54.1	72.0	410	97.7	94.6	425	90.2	410
Middle	83.1	65.9	78.4	419	98.4	96.5	460	92.6	419
Fourth	87.6	73.5	73.8	434	99.1	97.0	474	89.9	434
Highest	87.8	76.4	86.7	414	99.5	98.5	443	87.8	414
Total	81.3	62.1	74.5	2,066	97.6	94.7	2,213	89.2	2,066
STILLBIRTHS									
Total	*	*	*	11	*	*	11	*	11
LIVE BIRTHS AND STILLBIRTHS[4]									
Total	81.3	62.0	74.5	2,073	97.6	94.8	2,223	89.3	2,073

Note: If more than one source of assistance was mentioned, only the provider with the highest qualifications is considered in this tabulation. Stillbirths are fetal deaths in pregnancies lasting 28 or more weeks. When pregnancy duration is reported in months, stillbirths are fetal deaths in pregnancies lasting 7 or more months. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Skilled provider includes doctor, nurse, and midwife.
[2] Iron tablets and syrup
[3] Includes women who received a check from a doctor, midwife, nurse, or traditional birth attendant
[4] For women who had both a live birth and a stillbirth in the 2 years preceding the survey, data on antenatal care and postnatal checks are tabulated for the most recent birth only.

Trends: The proportion of women age 15–49 who received ANC from a skilled provider for their most recent live birth in the 2 years before the survey increased from 80% in 2012 to 94% in 2017 and then decreased to 81% in 2023. The cause of the decline between 2017 and 2023 is unknown but has been postulated to be caused by COVID.

3.9.2 Delivery Care

> **Institutional deliveries**
> Deliveries that occur in a health facility.
> *Sample:* All live births and/or stillbirths in the 2 years before the survey

> **Skilled assistance during delivery**
> Births delivered with the assistance of doctors and nurses/midwives.
> *Sample:* All live births and/or stillbirths in the 2 years before the survey

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that could lead to death or serious illness for the mother, baby, or both (Van Lerberghe and De Brouwere 2001; WHO 2006a).

- 95% of live births in the 2 years preceding the survey were delivered in a health facility.

- 98% of live births in the 2 years preceding the survey were delivered by a skilled provider.

Trends: The percentage of live births in the 2 years before the survey delivered by a skilled provider has increased markedly over time, from 88% in 2012 to 98% in 2023 (**Figure 6**).

Figure 6 **Trends in delivery assistance**

Percentage of live births in the 2 years preceding the survey delivered by a skilled provider

88   96   98

2012 TjDHS   2017 TjDHS   2023 TjDHS
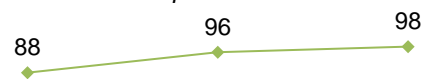
3.9.3 Postnatal Care for the Mother

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programs recommend that all women receive a check of their health during the first 2 days after delivery.

- A large majority of women who had a live birth in the 2 years before the survey received a postnatal check during the first 2 days after their most recent live birth (89%).

- 94% of women living in Sughd who had a live birth in the 2 years before the survey received a postnatal check during the first 2 days after their most recent live birth, as compared with 82% of women from Dushanbe.

3.10 CARE SEEKING FOR AND TREATMENT OF CHILD ILLNESS

Acute respiratory infection (ARI), fever, and dehydration from diarrhea are important contributing causes of childhood morbidity and mortality in developing countries (WHO 2003). Prompt medical attention when a child has the symptoms of these illnesses is, therefore, crucial in reducing child deaths. **Table 12** presents information on care seeking for ill children in Tajikistan. Overall, less than 2% of children under age 5 showed symptoms of an ARI, 11% had a fever, and 16% experienced diarrhea in the 2 weeks preceding the survey (data not shown).

- Advice or treatment was sought for 82% of children with ARI symptoms in the 2 weeks before the survey (**Table 12**).

- Advice or treatment was sought for 52% of children with a fever in the 2 weeks before the survey.

- Advice or treatment was sought for 64% of children with diarrhea in the 2 weeks before the survey.

- 63% of children with diarrhea received oral rehydration salts (ORS), 55% received zinc supplements, 38% received ORS and zinc supplements, and 30% received ORS, zinc supplements, and continued feeding.

Table 12 Treatment for ARI symptoms, fever, and diarrhea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had a fever during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, and among children under age 5 who had diarrhea during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, percentage given fluid from oral rehydration salt (ORS) packets, percentage given zinc, percentage given ORS and zinc, and percentage given ORS, zinc, and continued feeding, according to background characteristics, Tajikistan DHS 2023

| | Children with symptoms of ARI[1] | | Children with fever | | Children with diarrhea | | | | | |
Background characteristic	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet	Percentage given zinc	Percentage given ORS and zinc	Percentage given ORS, zinc, and continued feeding[3]	Number of children
Age in months										
<6	*	6	60.9	52	57.5	53.9	46.3	22.1	18.0	89
6–11	*	13	49.3	86	69.4	62.9	56.0	39.7	32.9	129
12–23	*	20	58.6	125	69.5	66.5	56.5	41.7	31.6	232
24–35	*	13	49.1	120	60.6	65.0	52.7	39.5	30.4	159
36–47	*	15	50.7	113	65.4	62.3	59.5	41.0	28.6	128
48–59	*	13	44.6	82	53.2	63.7	55.1	35.7	30.8	103
Sex										
Male	(89.4)	38	50.9	318	66.8	62.9	54.6	39.0	31.6	452
Female	(75.6)	42	53.1	259	60.5	63.8	55.2	36.9	27.2	388
Residence										
Urban	(83.4)	28	62.3	189	68.7	78.9	62.3	51.6	35.7	251
Rural	(81.6)	52	46.8	388	61.9	56.7	51.7	32.3	26.9	588
Region										
Dushanbe	*	12	67.7	88	77.8	89.1	68.6	62.6	42.8	126
GBAO	*	0	*	4	(31.2)	(57.4)	(47.9)	(32.9)	(25.5)	7
Sughd	(75.6)	33	50.7	238	60.7	71.0	47.7	35.2	26.0	269
DRS	*	10	41.9	95	57.8	48.9	48.7	32.0	25.6	166
Khatlon	*	25	51.3	152	65.2	52.7	59.7	33.3	29.5	272
FTF districts	*	18	58.6	69	74.0	58.3	66.4	41.9	36.7	139
Mother's education										
None/primary	*	1	*	21	(56.9)	(56.2)	(39.3)	(22.6)	(16.1)	34
General basic	*	19	44.8	189	61.9	57.7	50.4	35.0	27.2	257
General secondary	(83.5)	43	57.7	227	65.0	63.9	54.3	36.9	29.6	356
Professional primary/ middle	*	5	55.9	51	65.2	67.9	58.2	39.0	30.0	82
Higher	*	12	54.9	89	66.4	73.4	70.0	53.0	38.9	111
Wealth quintile										
Lowest	*	8	29.9	66	55.9	53.9	43.5	28.2	26.2	134
Second	*	23	50.2	122	59.1	60.9	48.3	33.5	27.8	166
Middle	*	15	53.4	105	65.4	52.4	51.6	27.8	22.1	170
Fourth	*	11	50.0	127	64.8	61.5	63.0	38.7	29.4	163
Highest	(77.9)	23	62.9	158	71.1	81.7	64.0	56.0	39.4	207
Total	82.2	80	51.9	578	63.9	63.3	54.9	38.0	29.6	839

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Symptoms of ARI include short, rapid breathing that is chest-related and/or difficult breathing that is chest-related.
[2] Includes advice or treatment from the following sources: public sector, private medical sector, shop, and market. Excludes advice or treatment from a traditional practitioner.
[3] Continued feeding includes children who were given more, the same as usual, or somewhat less food during the diarrhea episode.

3.11 CHILD NUTRITIONAL STATUS

Anthropometry is commonly used to measure child nutritional status. Anthropometric measurements are used to report on child growth indicators. The distribution of height and weight for children under age 5 was compared with the WHO Child Growth Standards reference population (WHO 2006b). The distribution of a well-nourished population will be similar to that of the reference population, while the distribution of a poorly nourished population will not. The indices height-for-age, weight-for-height, and weight-for-age can be expressed in standard deviation units (z scores) from the median of the reference

population. Values that are greater than two standard deviations below the median of the WHO Child Growth Standards are used to define malnutrition.

Stunting (assessed via height-for-age)

Height-for-age is a measure of growth faltering. Children whose height-for-age *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are considered short for their age (stunted). Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely stunted.

Sample: Children under age 5

Wasting (assessed via weight-for-height)

The weight-for-height index measures body mass in relation to body height or length and describes acute undernutrition. Children whose weight-for-height *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are considered thin (wasted). Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely wasted.

Sample: Children under age 5

Underweight (assessed via weight-for-age)

Weight-for-age is a composite index of height-for-age and weight-for-height that takes into account both wasting and stunting. Children whose weight-for-age *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are classified as underweight. Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely underweight.

Sample: Children under age 5

Overweight (assessed via weight-for-height)

Children whose weight-for-height *z* score is more than two standard deviations (+2 SD) above the median of the reference population are considered overweight.

Sample: Children under age 5

The 2023 TjDHS identified a total of 5,040 children under age 5 who were eligible for height and weight measurements. Valid height-for-age, weight-for-height, and weight-for-age measurements were obtained for 98% of eligible children (data not shown). Results for height-for-age, weight-for-height, and weight-for-age are shown in **Table 13**.

- 14% of children under age 5 are stunted (short for their age), and 4% are severely stunted.

- 6% of children under age 5 are wasted (thin for their height), while 5% are overweight.

- 5% of children under age 5 are underweight, and 1% are severely underweight.

Table 13 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of child growth: height-for-age, weight-for-height, and weight-for-age, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Height-for-age[1]				Weight-for-height					Weight-for-age			
	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean z score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Percent-age above +2 SD	Mean z score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean z score (SD)	Number of children
Age in months													
<6	1.7	5.8	0.3	626	5.4	14.6	5.0	−0.4	632	0.6	4.0	−0.1	641
6–11	3.3	9.3	−0.1	557	1.5	9.4	3.3	−0.1	554	0.7	5.2	−0.2	558
12–23	3.8	13.6	−0.6	1,033	1.4	9.3	4.5	−0.1	1,038	1.0	6.4	−0.4	1,044
24–35	4.3	16.9	−0.9	988	0.7	2.7	4.6	0.2	988	0.9	4.7	−0.3	996
36–47	5.8	17.0	−0.9	1,057	0.9	3.3	5.2	0.1	1,052	1.2	6.5	−0.4	1,060
48–59	3.7	14.3	−0.9	1,037	1.0	3.4	4.4	0.1	1,030	0.6	3.7	−0.4	1,045
0–23	3.1	10.3	−0.2	2,216	2.5	10.8	4.3	−0.2	2,224	0.8	5.4	−0.2	2,243
24–59	4.6	16.1	−0.9	3,082	0.9	3.2	4.7	0.2	3,069	0.9	5.0	−0.4	3,102
Sex													
Male	4.1	15.1	−0.6	2,782	2.1	6.9	3.9	−0.0	2,765	1.1	5.6	−0.4	2,793
Female	3.8	12.0	−0.6	2,516	1.1	5.8	5.2	0.0	2,528	0.6	4.7	−0.3	2,552
Mother's interview status													
Interviewed	3.9	13.6	−0.6	5,205	1.6	6.4	4.6	0.0	5,200	0.9	5.2	−0.3	5,252
Not interviewed but in household	(11.4)	(22.2)	(−0.9)	43	(3.1)	(7.1)	(3.2)	−0.1	43	(1.3)	(8.6)	(−0.5)	43
Not interviewed and not in the household[3]	0.4	9.6	−0.1	50	3.3	3.3	1.9	0.2	50	0.0	2.3	0.0	50
Residence													
Urban	2.6	10.9	−0.4	1,318	0.6	3.7	4.7	0.1	1,319	0.3	4.1	−0.2	1,325
Rural	4.4	14.6	−0.7	3,980	1.9	7.3	4.5	−0.0	3,974	1.0	5.5	−0.4	4,020
Region													
Dushanbe	1.9	8.7	−0.4	539	0.0	2.4	3.0	0.1	540	0.3	2.9	−0.1	540
GBAO	4.0	14.8	−0.9	76	0.6	2.3	2.9	0.1	77	1.6	4.6	−0.4	77
Sughd	2.8	13.8	−0.7	1,440	1.0	3.0	6.0	0.3	1,434	0.3	4.1	−0.2	1,441
DRS	3.8	13.9	−0.7	1,239	0.9	4.6	3.4	−0.0	1,243	1.1	5.8	−0.4	1,252
Khatlon	5.4	14.7	−0.5	2,004	2.9	11.1	4.7	−0.2	2,000	1.2	6.1	−0.4	2,035
FTF districts	6.1	14.4	−0.5	1,244	4.1	13.8	4.7	−0.2	1,241	1.4	6.7	−0.4	1,270
Mother's education[4]													
None/primary	3.9	17.5	−0.8	281	0.4	8.1	3.7	−0.0	285	0.9	9.1	−0.5	287
General basic	3.7	15.3	−0.7	1,566	1.0	4.4	4.9	0.0	1,560	1.0	5.4	−0.4	1,577
General secondary	4.3	12.9	−0.6	2,377	1.9	7.7	4.3	−0.0	2,374	1.0	4.7	−0.3	2,400
Professional primary/middle	5.3	14.3	−0.5	434	2.6	5.6	7.8	0.1	430	0.7	4.9	−0.3	435
Higher	2.7	10.5	−0.4	590	1.7	6.2	3.0	−0.0	594	0.1	4.7	−0.2	597
Wealth quintile													
Lowest	4.7	14.6	−0.8	1,064	1.9	7.5	3.4	−0.1	1,065	1.1	6.2	−0.5	1,071
Second	4.2	15.6	−0.6	1,088	2.0	7.8	3.8	−0.1	1,087	1.4	6.6	−0.4	1,096
Middle	4.4	13.5	−0.6	1,058	1.0	6.1	4.5	0.0	1,059	0.6	4.4	−0.3	1,073
Fourth	3.7	14.1	−0.6	1,074	2.5	7.3	6.1	0.1	1,067	0.8	5.2	−0.3	1,087
Highest	2.8	10.3	−0.4	1,013	0.5	3.0	5.1	0.2	1,015	0.4	3.4	−0.1	1,018
Total	4.0	13.7	−0.6	5,298	1.6	6.4	4.6	0.0	5,293	0.9	5.2	−0.3	5,345

Note: Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards. Figures in parentheses are based on 25–49 unweighted cases.
[1] Recumbent length is measured for children under age 2; standing height is measured for all other children.
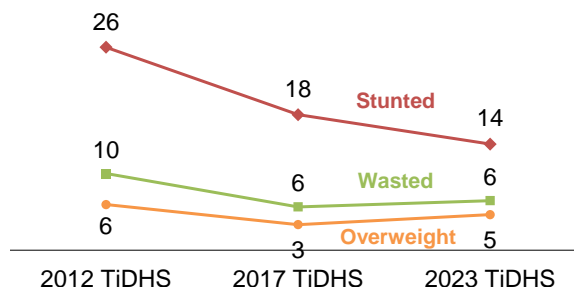[2] Includes children who are below −3 SD from the WHO Growth Standards population median
[3] Includes children whose mothers are deceased
[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Trends: The percentage of children under age 5 who are stunted decreased from 26% in 2012 to 14% in 2023 (**Figure 7**). The percentage of children who are wasted decreased from 10% in 2012 to 6% in 2017 and 2023. There has been little change over time in the percentage of children who are overweight (6% in 2012 versus 5% in 2023).

3.12   INFANT AND YOUNG CHILD FEEDING

Optimal infant and young child feeding (IYCF) practices are critical to the health and survival of young children. Recommended IYCF practices include early initiation of breastfeeding (within the first hour of life), exclusive breastfeeding for the first 6 months of life, and feeding children a diet that meets a minimum diversity standard (WHO and UNICEF 2021).

Figure 7 **Trends in nutritional status of children**

Percentage of children under age 5 who are malnourished

Early initiation of breastfeeding
Percentage of children born in the past 2 years who were put to the breast within 1 hour of birth.
Sample: Children born in the past 2 years

Exclusive breastfeeding under 6 months
Percentage of children age 0–5 months who were fed exclusively with breast milk during the previous day.
Sample: Youngest children age 0–5 months living with their mother

Minimum dietary diversity
Percentage of children age 6–23 months who were fed a minimum of five out of eight defined food groups during the previous day. The eight food groups are as follows: breast milk; grains, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, and cheese); flesh foods (meat, fish, poultry, and organ meat); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.
Sample: Youngest children age 6–23 months living with their mother

Key IYCF indicators are presented in **Table 14**.

- 41% of children age 0–23 months were breastfed within 1 hour of birth.

- 41% of children under age 6 months are exclusively breastfed.

- 28% of children age 6–23 months are fed with a minimum dietary diversity.

Unhealthy infant and young child feeding practices should be avoided because they can promote unhealthy weight gain and replace nutritious foods that provide important nutrients for children. For infants and young children, consumption of sweet foods and beverages increases the risk of dental caries and childhood obesity. The indicator definition below for unhealthy food consumption describes sentinel unhealthy foods, foods high in sugar, salt, or unhealthy fats that are commonly consumed by infants and young children (WHO and UNICEF 2021).

Table 14 Infant and young child feeding (IYCF) indicators

Percentage of children fed according to various IYCF practices, Tajikistan DHS 2023

Indicator	Indicator numerator and denominator	Value
Early initiation of breastfeeding[1]	Percentage of children born in the past 2 years who were put to the breast within 1 hour of birth	40.8
	Number of children born in the past 2 years	2,213
Exclusive breastfeeding under 6 months	Percentage of children age 0–5 months who were fed exclusively with breast milk during the previous day	40.8
	Number of youngest children age 0–5 months living with their mother	604
Minimum dietary diversity 6–23 months	Percentage of children age 6–23 months who were fed foods and beverages from at least 5 out of 8 defined food groups during the previous day	27.8
	Number of youngest children age 6–23 months living with their mother	1,440
Sweet beverage consumption 6–23 months	Percentage of children age 6–23 months who were given a sweet beverage during the previous day	64.9
	Number of youngest children age 6–23 months living with their mother	1,440
Unhealthy food consumption 6–23 months	Percentage of children age 6–23 months fed unhealthy foods during the previous day	35.2
	Number of youngest children age 6–23 months living with their mother	1,440

[1] Includes children born in the 2 years preceding the survey regardless of whether the children were living or dead at the time of the interview

Sweet beverage consumption

Percentage of children age 6–23 months who were given a sweet beverage during the previous day.
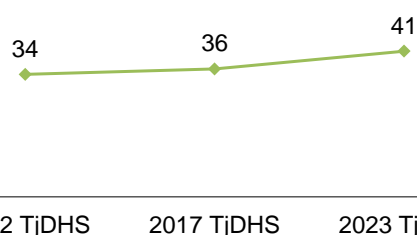
Unhealthy food consumption

Percentage of children age 6–23 months who were fed sentinel unhealthy foods during the previous day.

Sample: Youngest children age 6–23 months living with their mother

- 65% of children age 6–23 months were fed a sweet beverage.

- 35% of children age 6–23 months consumed unhealthy foods.

Trends: The percentage of children under age 6 months who are exclusively breastfed has increased steadily over time, from 34% in 2012 to 41% in 2023 (**Figure 8**).

3.13 DOMESTIC VIOLENCE AGAINST WOMEN

Gender-based violence against women has been acknowledged worldwide as a violation of basic human rights. Increasing research has highlighted the health burdens, intergenerational effects, and demographic consequences of such violence (United Nations 2006). This section focuses on domestic violence, one of the most common forms of gender-based violence against women and girls.

Figure 8 **Trends in exclusive breastfeeding**

Percentage of children age 0–5 months

34 36 41

2012 TjDHS   2017 TjDHS   2023 TjDHS

To monitor progress toward the elimination of domestic violence in Tajikistan, the DHS domestic violence module was administered in all households sampled in the 2023 TjDHS. In accordance with the World Health Organization's guidelines on the ethical collection of information on domestic violence, only one eligible woman per household was randomly selected for the module, and the module was not implemented if privacy could not be assured. Overall, of the 9,930 women eligible for the survey, 68% were eligible and selected for the domestic violence module. Among those selected for the module, 3% could not be interviewed due to privacy concerns or other reasons. Specially constructed weights were

used to ensure that the domestic violence subsample was nationally representative. The 2012 and 2017 TjDHS surveys involved a similar module and selection methodology. Notably, however, in the 2023 TjDHS data on intimate partner violence were collected not only from ever-married women and women who have ever lived with a man as if married but also from women who are not married but who have ever had an intimate partner.

> **Terminology for this section**
>
> **Husband:** a man with whom a woman is married or living with as if married.
>
> **Intimate partner:** a man with whom a never-married woman is in a relationship that involves physical and/or emotional intimacy and for which the relationship is or has the expectation of being longer lasting. As defined for the purposes of this section, an intimate partner is not a man or husband a woman is living with and is also not a boyfriend with whom her relationship is casual or a man with whom she has a one-time encounter.
>
> **Husband/intimate partner:** the current husband for currently married women; the most recent husband for divorced, separated, or widowed women; the current intimate partner for never-married women who currently have an intimate partner; and the most recent intimate partner for never-married women who do not currently have an intimate partner but had one in the past.
>
> **Boyfriend:** a man with whom a woman has a causal relationship and who she did not mention as an intimate partner.

In the 2023 TjDHS, information was obtained from women age 15–49 on their experience of violence committed by any perpetrator, including current and former husbands or other intimate partners. To capture intimate partner violence, ever-married women were asked about their experience of violence committed by their current and former husbands/live-in partners, and, if applicable, never-married women were asked about their experience of violence committed by their current and former intimate partners. More specifically, intimate partner violence was measured by asking women if their current or former husband/intimate partner ever did the following to them:

- *Physical violence:* push you, shake you, or throw something at you; slap you; twist your arm or pull your hair; punch you with his fist or with something that could hurt you; kick you, drag you, or beat you up; choke you or burn you on purpose; or attack you with a knife, gun, or other weapon

- *Sexual violence:* physically force you to have sexual intercourse with him when you did not want to, physically force you to perform any other sexual acts you did not want to, or force you with threats or in any other way to perform sexual acts you did not want to

- *Emotional violence:* say or do something to humiliate you in front of others, threaten to hurt or harm you or someone you care about, or insult you or make you feel bad about yourself

In addition to the questions on different forms of intimate partner violence, information was also obtained from all women about physical violence committed by anyone other than any husband/intimate partner since they were age 15 by asking if anyone had hit, slapped, kicked, or done something else to hurt them physically. Similarly, women were asked if they had experienced sexual violence committed by anyone other than any husband/intimate partner. Specifically, they were asked if at any time in their life, as a child or as an adult, they were forced in any way to have sexual intercourse or to perform any other sexual acts when they did not want to. Additionally, women who had ever been pregnant were asked about their experience of physical violence during any pregnancy (data not shown).

3.13.1 Experience of Different Forms of Violence

Physical violence and sexual violence may not occur in isolation; rather, women may experience a combination of different forms of violence.

Table 15 presents information on physical and sexual violence ever experienced by women age 15–49.

- About one in eight women age 15–49 (12%) have ever experienced physical or sexual violence: 10% have experienced physical violence only, less than 1% have experienced sexual violence only, and 2% have experienced both physical and sexual violence.

Table 15 Experience of different forms of violence

Percentage of women age 15–49 who have ever experienced different forms of violence by current age, Tajikistan DHS 2023

Age	Physical violence only	Sexual violence only	Physical and sexual violence	Physical or sexual violence	Number of women
15–19	3.6	0.0	0.0	3.6	1,091
15–17	2.1	0.0	0.0	2.1	676
18–19	6.1	0.0	0.0	6.1	415
20–24	8.5	0.4	0.8	9.7	1,039
25–29	10.5	0.7	1.2	12.4	1,031
30–39	15.0	0.5	2.3	17.7	1,963
40–49	10.8	0.2	2.3	13.3	1,324
Total	10.4	0.4	1.5	12.3	6,448

- The percentage of women who have experienced physical or sexual violence increases from 2% among those age 15–17 to 18% among those age 30–39 before declining among older women.

Trends: The proportion of women age 15–49 who have ever experienced physical or sexual violence decreased from 24% in 2017 to 12% in 2023.

3.13.2 Violence by the Current or Most Recent Husband/Intimate Partner

Intimate partner violence

Percentage of women who have experienced any of the specified acts of physical, sexual, or emotional violence committed by their current or most recent husband/intimate partner, ever and in the 12 months preceding the survey.

Sample: Women age 15–49 who ever had a husband or an intimate partner

Table 16 presents information on intimate partner violence experienced by women age 15–49.

Among women age 15–49 who have ever had a husband or intimate partner:

- 14% have experienced physical violence by their current or most recent husband/intimate partner.

- 2% have experienced sexual violence by their current or most recent husband/intimate partner.

- 7% have experienced emotional violence by their current or most recent husband/intimate partner.

- 16% have experienced physical, sexual, or emotional violence by their current or most recent husband/intimate partner.

Table 16 Intimate partner violence by background characteristics

Percentage of women age 15–49 who have ever had a husband or intimate partner and have ever experienced emotional, physical, or sexual violence committed by their current or most recent husband/intimate partner, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Emotional violence	Physical violence	Sexual violence	Physical and sexual	Physical and sexual and emotional	Physical or sexual	Physical or sexual or emotional	Number of women who ever had a husband/intimate partner
Age								
15–19	3.2	11.7	0.1	0.1	0.1	11.7	12.5	170
20–24	3.6	10.7	1.5	1.0	0.9	11.2	11.9	862
25–29	6.8	11.5	1.7	0.9	0.5	12.3	15.9	994
30–39	9.1	16.7	2.3	2.0	1.6	17.0	19.5	1,921
40–49	6.8	12.4	2.0	1.8	1.1	12.6	15.6	1,294
Residence								
Urban	8.3	13.1	2.1	1.8	1.4	13.4	16.4	1,354
Rural	6.6	13.6	1.8	1.4	1.0	14.0	16.4	3,887
Region								
Dushanbe	7.8	8.2	1.6	1.0	1.0	8.8	12.2	529
GBAO	8.2	17.6	1.5	1.0	0.7	18.1	19.2	78
Sughd	7.2	9.9	2.2	1.8	1.5	10.2	13.4	1,492
DRS	5.0	8.1	1.2	0.9	0.8	8.3	10.0	1,259
Khatlon	7.9	21.3	2.3	1.8	1.0	21.7	24.1	1,884
Marital status								
Never married	*	*	*	*	*	*	*	8
Currently has intimate partner	*	*	*	*	*	*	*	7
Had intimate partner	*	*	*	*	*	*	*	2
Ever married	7.0	13.5	1.9	1.5	1.1	13.9	16.4	5,233
Married/living together	6.0	12.6	1.4	1.1	0.6	12.9	15.4	4,890
Divorced/separated/ widowed	20.8	26.5	9.5	8.0	8.0	28.0	31.1	342
Employment								
Employed for cash	14.3	19.9	4.7	4.1	3.4	20.5	24.3	1,131
Employed not for cash	6.4	16.2	3.3	2.7	0.5	16.8	21.4	174
Not employed	5.0	11.5	1.1	0.7	0.5	11.9	13.9	3,936
FTF districts	2.5	14.7	0.3	0.1	0.1	14.9	16.0	1,072
Education								
None/primary	8.3	14.6	1.2	1.2	1.2	14.6	17.3	243
General basic	8.1	15.3	2.1	1.9	1.6	15.5	18.4	1,597
General secondary	5.1	11.9	1.9	1.3	0.7	12.5	14.5	2,416
Professional primary/middle	9.8	14.9	2.1	1.6	1.5	15.3	17.6	396
Higher	9.5	13.7	1.6	1.4	1.0	13.8	17.6	588
Wealth quintile								
Lowest	7.1	13.1	1.9	1.4	1.1	13.5	16.5	1,007
Second	7.7	15.3	1.7	1.3	1.3	15.7	18.4	1,041
Middle	6.5	15.2	2.3	1.9	1.1	15.7	18.1	1,020
Fourth	6.0	12.1	1.8	1.5	0.6	12.5	14.3	1,110
Highest	7.8	11.9	1.8	1.5	1.3	12.2	14.8	1,062
Total	7.0	13.5	1.9	1.5	1.1	13.9	16.4	5,241

Note: The term husband includes a partner with whom a woman is living as if married. Husband/intimate partner refers to the current husband for currently married women; the most recent husband for divorced, separated, or widowed women; the current intimate partner for never-married women who currently have an intimate partner; and the most recent intimate partner for never-married women who do not currently have an intimate partner but had one in the past. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Trends: Among ever-married women, the prevalence of all forms of violence by their current or most recent husband/partner is lower in 2023 than in 2012 and 2017. Overall, the prevalence of spousal physical, sexual, or emotional violence perpetrated by women's current or most recent husband/partner increased from 24% in 2012 to 31% in 2017 and then declined sharply to 16% in 2023.

3.14 HIV

3.14.1 Prevention Knowledge among Young People

Knowledge about HIV prevention
Knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting two major misconceptions about HIV transmission: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.
Sample: Women age 15–24

Knowledge of how HIV is transmitted is crucial in enabling people to avoid HIV infection, and this is especially true for young people, who are often at greater risk because they may have shorter relationships with more partners or engage in other risky behaviors. As shown in **Table 17**, only 10% of women age 15–24 have thorough knowledge of HIV prevention.

3.14.2 Sexual Behavior

Information on sexual behavior is important in designing and monitoring intervention programs to control the spread of HIV.

- Less than 1% of women age 15–49 have had sexual intercourse with two or more partners in the past 12 months.
- Among women age 15–49 who had sexual intercourse with a person who neither was their spouse nor lived with them in the 12 months before the survey, 26% used a condom the most recent time they had sex with such a partner. This estimate, however, should be interpreted with caution as the number of cases is very low.
- Among women age 15–49 who have ever had sexual intercourse, the mean number of lifetime sexual partners is 1.1 (**Table 18**).

Table 17 Knowledge about HIV prevention methods among young women

Percentage of young women age 15–24 with knowledge about HIV prevention, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Percentage with knowledge about HIV prevention[1]	Number of women
Age		
15–19	7.5	1,710
15–17	5.9	1,071
18–19	10.3	639
20–24	12.4	1,616
20–22	12.5	939
23–24	12.2	677
Marital status		
Never married	7.7	1,780
Ever had sex	*	6
Never had sex	7.8	1,774
Ever married	12.4	1,546
Residence		
Urban	10.7	908
Rural	9.6	2,419
Region		
Dushanbe	13.4	383
GBAO	16.8	42
Sughd	14.4	900
DRS	5.4	794
Khatlon	8.1	1,209
FTF districts	4.6	687
Education		
None/primary	9.7	87
General basic	6.8	1,118
General secondary	9.4	1,400
Professional primary/ middle	17.2	330
Higher	14.3	392
Wealth quintile		
Lowest	6.6	557
Second	7.2	679
Middle	10.8	682
Fourth	11.5	662
Highest	12.5	746
Total	9.9	3,327

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting two common misconceptions about transmission or prevention of HIV: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.

Table 18 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months

Among all women age 15–49, percentage who had sexual intercourse with more than one sexual partner in the past 12 months and percentage who had intercourse in the past 12 months with a person who neither was their husband nor lived with them; among women having more than one partner in the past 12 months, percentage reporting that a condom was used during most recent intercourse; among women who had sexual intercourse in the past 12 months with a person who neither was their husband nor lived with them, percentage who used a condom during most recent sexual intercourse with such a partner; and among women who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, Tajikistan DHS 2023

Background characteristic	All women			Women who had 2+ partners in the past 12 months		Women who had intercourse in the past 12 months with a person who neither was their husband nor lived with them		Women who ever had sexual intercourse[1]	
	Percentage who had 2+ partners in the past 12 months	Percentage who had intercourse in the past 12 months with a person who neither was their husband nor lived with them	Number of women	Percentage who reported using a condom during most recent sexual intercourse	Number of women	Percentage who reported using a condom during most recent sexual intercourse with such a partner	Number of women	Mean number of sexual partners in lifetime	Number of women
Age									
15–24	0.2	0.1	3,327	*	6	*	3	1.0	1,551
15–19	0.0	0.0	1,710	*	0	*	1	1.0	223
20–24	0.4	0.1	1,616	*	6	*	2	1.1	1,328
25–29	0.4	0.1	1,559	*	6	*	2	1.0	1,504
30–39	0.3	0.1	2,980	*	9	*	3	1.1	2,923
40–49	0.4	0.3	2,014	*	9	*	7	1.1	1,980
Marital status									
Never married	0.0	0.1	1,964	*	0	*	2	1.2	49
Married/living together	0.4	0.1	7,392	(9.9)	29	*	5	1.1	7,390
Divorced/separated/ widowed	0.1	1.3	522	*	1	*	7	1.1	520
Residence									
Urban	0.5	0.4	2,705	*	13	*	11	1.1	2,088
Rural	0.2	0.1	7,174	*	17	*	4	1.1	5,871
Region									
Dushanbe	0.5	0.4	1,077	*	5	*	5	1.1	795
GBAO	0.4	1.2	157	*	1	*	2	1.1	117
Sughd	0.2	0.1	2,780	*	6	*	2	1.1	2,284
DRS	0.3	0.1	2,356	*	7	*	2	1.1	1,918
Khatlon	0.3	0.1	3,509	*	11	*	4	1.0	2,846
FTF districts	0.2	0.0	1,937	*	4	*	1	1.0	1,580
Education									
None/primary	0.4	0.0	443	*	2	*	0	1.1	391
General basic	0.4	0.0	3,271	*	12	*	1	1.1	2,455
General secondary	0.2	0.1	4,230	*	9	*	6	1.0	3,596
Professional primary/ middle	0.2	0.3	778	*	2	*	2	1.0	602
Higher	0.4	0.4	1,157	*	5	*	5	1.1	915
Wealth quintile									
Lowest	0.2	0.1	1,842	*	3	*	2	1.1	1,516
Second	0.3	0.0	1,967	*	6	*	0	1.1	1,553
Middle	0.2	0.1	1,966	*	5	*	2	1.1	1,605
Fourth	0.2	0.0	1,964	*	4	*	0	1.0	1,647
Highest	0.5	0.5	2,140	*	12	*	10	1.1	1,638
Total	0.3	0.1	9,879	(10.1)	29	(25.7)	15	1.1	7,959

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Means are calculated excluding respondents who gave non-numeric responses.

3.14.3 Prior HIV Testing

HIV testing programs diagnose people living with HIV so that they can be linked to care and access antiretroviral therapy. Knowledge of HIV status helps HIV-negative individuals reduce risk and remain negative (**Table 19**).

- Nearly half of women age 15–49 (48%) have been tested for HIV and received the results of the test.

- The percentage of women who have been tested for HIV and received the results increases from 16% among those age 15–19 to 63% among those age 25–29 and declines thereafter.

- 19% of women were tested for HIV in the past 12 months and received the results of their last test.

Table 19 Coverage of prior HIV testing

Percent distribution of women age 15–49 by HIV testing status and by whether they received the results of the last test, percentage of women ever tested, and percentage of women who were tested in the past 12 months and received the results of the most recent test, according to background characteristics, Tajikistan DHS 2023

Background characteristic	Percent distribution of women by testing status and by whether they received the results of the most recent test				Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the most recent test	Number of women
	Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total			
Age							
15–24	35.9	0.6	63.5	100.0	36.5	21.0	3,327
15–19	16.3	0.1	83.7	100.0	16.3	11.8	1,710
20–24	56.6	1.1	42.2	100.0	57.8	30.8	1,616
25–29	63.4	1.3	35.4	100.0	64.6	24.2	1,559
30–39	56.9	0.8	42.4	100.0	57.6	16.9	2,980
40–49	44.9	0.5	54.6	100.0	45.4	13.4	2,014
Marital status							
Never married	13.9	0.1	86.0	100.0	14.0	7.7	1,964
Ever had sex	27.9	0.0	72.1	100.0	27.9	4.0	50
Never had sex	13.6	0.1	86.3	100.0	13.7	7.8	1,914
Married/living together	57.7	0.9	41.3	100.0	58.7	22.0	7,392
Divorced/separated/ widowed	45.7	0.4	53.9	100.0	46.1	14.4	522
Residence							
Urban	57.5	0.9	41.6	100.0	58.4	23.3	2,705
Rural	44.9	0.7	54.4	100.0	45.6	17.0	7,174
Region							
Dushanbe	68.1	1.0	30.9	100.0	69.1	25.8	1,077
GBAO	68.6	0.1	31.2	100.0	68.8	36.6	157
Sughd	51.8	0.2	48.0	100.0	52.0	21.3	2,780
DRS	36.6	0.7	62.7	100.0	37.3	14.7	2,356
Khatlon	46.7	1.1	52.2	100.0	47.8	16.4	3,509
FTF districts	43.5	1.4	55.1	100.0	44.9	12.4	1,937
Education							
None/primary	40.0	0.4	59.6	100.0	40.4	13.2	443
General basic	40.6	0.6	58.8	100.0	41.2	13.0	3,271
General secondary	48.1	0.8	51.1	100.0	48.9	18.3	4,230
Professional primary/ middle	64.4	0.8	34.8	100.0	65.2	34.7	778
Higher	63.7	1.0	35.3	100.0	64.7	28.0	1,157
Wealth quintile							
Lowest	36.2	0.4	63.4	100.0	36.6	12.3	1,842
Second	43.4	1.0	55.5	100.0	44.5	16.6	1,967
Middle	47.6	0.5	51.9	100.0	48.1	18.4	1,966
Fourth	50.6	0.8	48.6	100.0	51.4	20.4	1,964
Highest	62.2	0.9	36.9	100.0	63.1	25.1	2,140
Total	48.4	0.7	50.9	100.0	49.1	18.7	9,879

[1] Includes respondents who have not heard of HIV or who refused to answer questions on testing

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