

## Chapter 4. Gender Implications of Changes in the Social Sectors

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At Independence Tajikistan inherited a well-established system of social services, including education, health and social protection. Since 1992, however, the social sectors have suffered from severe financial constraints. Although spending on the social sectors has increased in absolute terms it has failed to keep pace with either inflation or population growth (Table 4.1, section A). As a result real social expenditures per capita have fallen dramatically. Total spending on the social sectors in 1998 amounted to just over 7 percent of GDP compared with a fifth in 1992 (Table 4.1, section B).

One of the main reasons for the decline in social spending has been a fall in the Government's ability to mobilize resources. Between 1992 and 1998, government expenditures as a share of GDP in Tajikistan fell by two thirds from 58 percent to 17 percent. The collapse in GDP *combined* with lower government spending has meant that real allocations to the social sectors have declined precipitously. Although social spending as a share of all government spending has remained between 35 and 40 percent (with the exception of 1995), a stable share of a declining cake means less real spending. Spending on the health and education subsectors has declined sharply to between only a *quarter* and a *third* of pre-independence levels.

The challenge now is to maintain the country's human development inheritance. This inheritance is under threat both from reduced supply and increasing barriers to access among the poor. Since women and children are the main beneficiaries of social spending, it is likely that this will have a gendered impact.

### 4.1 Education

Universal access to free basic education is a key element of children's rights. The guarantee of such universal access was a notable achievement of the Soviet system and at independence, Tajikistan had almost universal literacy. School was compulsory from ages 7 to 15, and there was also an extensive system of kindergartens for preschool age children and technical and vocational schools for post-compulsory education. In addition, Tajikistan had a number of higher education institutions including what is now the Tajik State University.

**Table 4.1 Social Expenditures in Tajikistan, 1992-1998**

(Amounts in millions of Russian rubles before 10 May, and in millions of Tajik rubles thereafter)

<b>A. In absolute values</b>							
	1992	1993	1994	1995 <sup>a</sup>	1996	1997	1998 <sup>b</sup>
Total Gov. Spending	42,560	383,408	1,054,294	-	60,108	107,632	162,168
Total State Expenditure	37,453	329,056	945,245	12,132	51,854	94,711	113,991
Total Social Spending <sup>c</sup>	12,857	134,898	345,343	3,032	15,951	34,574	47,571
Education	7,207	55,653	149,007	1,521	6,516	13,166	15,425
Health	3,679	34,297	110,059	943	4,011	8,259	7,602
Social Security	1,971	9,086	9,310	71	299	1,354	1,344
Cash compensation	0	35,862	76,967	497	5,125	1,748	3,589
Social Protection Fund						10,047	19,611
<b>B. In percentage of GDP<sup>d</sup></b>							
Total State Expenditures	57.8	52.1	55.0	26.5	16.8	15.0	17.1
Total Social Spending <sup>c</sup>	19.9	21.3	20.1	6.6	5.2	5.5	7.2
Education	11.1	8.8	8.7	3.3	2.1	2.1	2.3
Health	5.7	5.4	6.4	2.1	1.3	1.3	1.1
Social Security	3.0	1.4	0.5	0.2	0.1	0.2	0.2
Cash compensation	0.0	5.7	4.5	1.1	1.7	0.3	0.5
Social Protection Fund						1.6	2.9
<b>C. In percentage of total state expenditures</b>							
Total Social Spending <sup>c</sup>	34.3	41.0	36.5	25.0	30.8	36.5	41.7
Education	19.2	16.9	15.8	12.5	12.6	13.9	13.5
Health	9.8	10.4	11.6	7.8	7.7	8.7	6.7
Social Security	5.3	2.8	1.0	0.6	0.6	1.4	1.2
Cash compensation	0.0	10.9	8.1	4.1	9.9	1.8	3.1
Social Protection Fund						10.6	17.2
<b>D. Real social expenditure per capita (1993 prices)</b>							
Total State expenditure	153,204.6	57,688.6	36,271.7	83.0	67.4	62.4	51.7
Total social spending (p.c.)	52,592.6	23,649.7	13,251.8	20.7	20.7	22.8	21.6
Education	29,480.8	9,756.8	5,717.8	10.4	8.5	8.7	7.0
Health	15,049.3	6,012.8	4,223.3	6.4	5.2	5.4	3.5
Social Security	8,062.5	1,592.9	357.3	0.5	0.4	0.9	0.6
Compensation payments	0.0	6,287.2	2,953.4	3.4	6.7	1.2	1.6
Social Protection Fund						6.6	8.9

Notes: <sup>a</sup> Data for 1995 are from May 1-December 31.<sup>b</sup> Data for 1998 are for January through September. Execution rates are at Republican level and refer to the planned budget.<sup>c</sup> Total social spending is the sum of the indicated items and may differ from official figures.<sup>d</sup> Due to the differential value of cash and non-cash rubles prior to the currency reform of May 1995, fiscal data as a percentage of GDP before and after the currency reform are not comparable.

Source: World Bank, 1999.

Since independence there is growing evidence of a reversal in educational attainment. The impact of transition on educational outcomes may be thought of as threefold.

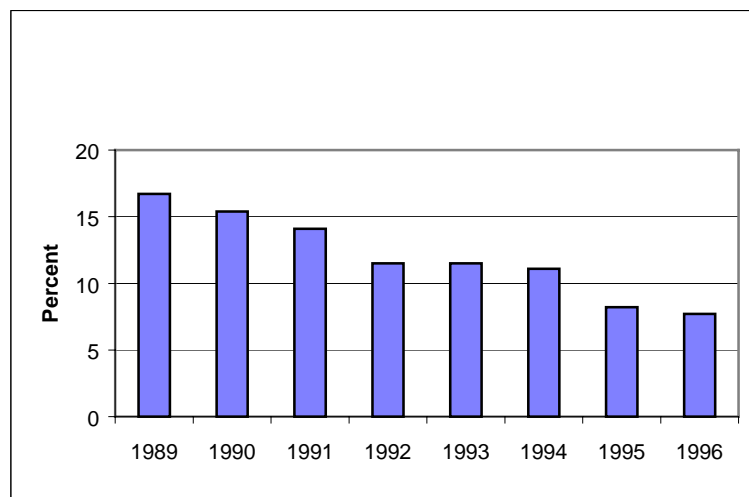
1. Firstly, there may be reduced **enrolment**. With transition the meaning of "free" education has changed. High inflation and reduced real government expenditure has given rise to an increasing number of self-financed educational establishments and the growth of informal charges in public institutions. Most schools have introduced charges for textbooks and meals and some have introduced fees to supplement (or replace) the wages (which are not paid) of the teachers. Parents who are unable to afford the cost of textbook, uniforms, or even shoes, may simply withdraw their children altogether.
2. Secondly, there may be reduced **attendance**. Children who are enrolled may not actually attend school regularly: either for the reasons given above or because the children are needed as family labor (working in the home looking after younger children, or working on family land or in the hired labor market to supplement household income).
3. Thirdly, there may be reduced **learning attainment**. Children may be enrolled and be attending school, but may not actually be learning anything. The teacher may be absent on a second job (that actually pays wages), or there may be no textbooks, it may be too cold to concentrate due to lack of heat, or the child may be anaemic and/or malnourished and too lethargic to learn.

There are, therefore, issues related both to the supply of education (in terms of buildings textbooks and teachers) and also the demand for education. Both sides of the equation need to be addressed. Below we look at the evidence for changes in educational outcomes, particularly by gender, and possible policy responses.

#### 4.1.1 Pre-School Education

The network of pre-schools was not as extensive in Tajikistan as elsewhere in the Soviet Union; even in 1989 it is estimated that only 17 percent of 3-6 year olds were enrolled in kindergarten, compared with 31 percent in the Kyrgyz Republic, 39 percent in Uzbekistan and 52 percent in Kazakhstan (UNICEF 1998). However, as Figure 4.1 shows, since then enrolment rates have halved to just under 8 percent in 1996.

**Figure 4.1 Kindergarten Net Enrolment Rate (3-6 year olds)**  
(%)



Source: UNICEF 1999.

The trends in enrolment rates reflect changes both in the supply of places and in demand (Table 4.2). Over the period 1990-1998 the number of kindergartens shrank by 40 percent, from 958 to 562. This was largely the result of the closure of enterprise-based (employer-provided) kindergartens, with most of the decline taking place in rural areas. However, over the same period the number of children enrolled in pre-schools fell by three-quarters, from 150,000 to 53,000 with the result that the number of children per 100 places fell from 129 (i.e., over demand) to 82 (i.e., over supply). Increasingly it appears that Tajik families prefer to take care of their children at home. Fewer girls than boys are enrolled, but as this has not changed significantly over time, there does not appear to be a gender dimension to falling pre-school enrolment. If anything the *share* of girls in the total number of children has risen rather than fallen.

The SSA/WID survey in 1998 included a question to mothers with children of pre-school age on whether their children attended kindergarten and if not why not. The results are shown in Table 4.3. Only 28 percent of women with pre-school children use nursery facilities (38 percent in urban areas and 19 percent in villages). Just over a tenth stated that children were not attending to rising costs and a further tenth due to worries over the standard of care. The majority however simply preferred to care for their children at home, although a number of these women also mentioned lack of heating and personnel and concerns over food safety. Fees were a greater issue for women living in urban areas, while physical access was cited by one in five rural women.

**Table 4.2 Selected Statistics on Pre-School Education, 1990-1998**

	1990	1992	1994	1995	1996	1997	1998
Number of establishments	958	822	790	555	601	562	562
Urban	556	551	545	406	461	406	442
Rural	402	271	245	149	140	156	120
Number of children (000s)	150	115	109	78	71	62	53
(% of which are girls)				(26)	(45)	(44)	(36)
Of which urban	115	92	87	65	57	49	42
(% of which are girls)				(23)	(45)	(43)	(35)
Rural	36	24	22	13	14	13	11
(% of which are girls)				(42)	(48)	(46)	(41)
Number of children per 100 places	129	105	100	90	93	90	82
Enrolment rate per 100 children	15.2	10.5	9.4	6.9	6.3	6.3	6.0

Source: SSA, *Gender Statistics in the Republic of Tajikistan*.

**Table 4.3 Utilization of Nursery Facilities by Mothers of Pre-School Children (%)**

	Total	Urban	Rural
Using pre-school establishment	28	38	19
Not using:			
Very high fees	11	13	9
Poor standard of care	11	15	8
Too far to travel	16	8	21
Prefer to keep at home	43	41	44
<b>Total</b>	100	100	100

Source: SSA, *Gender Statistics in the Republic of Tajikistan*.

The decline in enrolment in kindergartens is of particular concern given the part that they can play in raising child welfare, both in terms of freeing the parent to participate in other activities, specifically paid employment, and the developmental value of pre-school education, as well as their role in health interventions (Klugman et al. 1997).

#### 4.1.2 Compulsory Education

##### *Enrolment*

Schooling is compulsory in Tajikistan for children from age 7 to 15. It is divided into primary education (until age 10) followed by lower level of secondary education. Enrolment rates have historically been high, upwards of 94 percent (Table 4.4). Following Independence and the subsequent upheaval of economic transition and civil unrest, rates fell to a low of 85

percent in 1996 since when they have recovered somewhat. In the school year 1998-1999 it is estimated that 89 percent of 7 to 15 year olds were enrolled in school.

Fewer girls than boys attend school, particularly after primary school (Table 4.4). In 1998 there were 89 girls per 100 boys enrolled in lower secondary schools. Analysis of the TLSS found the gender gap in net enrolment rates for 12-16 year olds to be higher in urban areas than in rural areas; with 89 percent of boys enrolled compared with 75 percent of girls in urban areas and 90 percent of boys and 80 percent of girls in rural areas. This in part reflects parental fears for their daughters' safety as they mature, and this fear is greater in urban than rural areas. As we have already discussed in Section 2, in Garm town a large proportion of girls now finish school at grade 6 and one of the main reasons is parents' fear that their daughters will be harassed or assaulted by soldiers at checkpoints in the town.

**Table 4.4 Selected Statistics for Enrolment in Compulsory Education, 1990-1998**  
(%)

	1990	1992	1995	1996	1997	1998
Gross enrolment rate for basic education (7-15)	94.0	89.6	86.5	85.4	87.5	89.1
Ratio of enrolled girls per 100 boys						
Primary (ISCE level 1)	96	na	92	95	94	92
Lower secondary (ISCE Level 2)	97	na	96	92	90	89

Sources 1990 and 1992 from UNICEF 1998; 1995-1998, SSA, *Gender Statistics in the Republic of Tajikistan*.  
na - not available.

Enrolment has also fallen due to the rising cost of education. With transition the meaning of "free" education has changed. High inflation and reduced real government expenditure has given rise to an increasing number of self-financed educational establishments and the growth of informal charges in public institutions. Most schools have introduced charges for textbooks and meals and some have introduced fees to supplement (or replace) the wages (which are not paid) of the teachers. Given the choice of educating a boy or a girl child, it seems that parents may be more willing to invest in a son's secondary education than a daughter's. Whatever the reason, a worrying gender gap in compulsory education is opening up.

### *Attendance*

Enrolment rates tell only part of the story. In reality some children who are enrolled cannot *attend* schools regularly as they do household work or trade in the streets. According to World Bank data, the number of dropouts from primary and secondary schools in 1997 was estimated to be as high as 37,900. As the costs associated with education increase, this number may be expected to rise. Many poor families are unable to purchase textbooks, school uniforms, and to cover transport expenditures, while conversely children are able to

supplement the family income by working in the home or in informal activities. Thus growing poverty and social stratification have effectively begun to result in the exclusion from education of children from poor families. This is confirmed by analysis of the TLSS.

Over a third (37 percent) of children aged between 7 and 15 reported that they had been absent from school for two or more weeks during the last academic year (Table 4.5). Furthermore there was a clear relationship with the household's financial well-being. A significantly greater proportion of children in the bottom quintile of the distribution of per capita equivalent household consumption have missed school for two weeks or more in the last academic year (44 percent) as compared with those in the top quintile (31 percent).

**Table 4.5 Absence from School and Household Poverty**  
(%)

	Poorest 20%	2	3	4	Richest 20%	All Taj	All Boys	All Girls
Missed school for 2 weeks or more in last academic year (N=3,471 children aged between 7 and 15)								
Yes	44	36	39	34	31	37	37	37
No	56	64	61	66	69	63	63	63
Reason for absence								
No clothes/shoes	44	30	35	21	24	32	34	31
Illness	8	13	14	20	25	15	135	18

Note: all chi-square significant at (p<0.001).

Source: Falkingham 2000a.

When the reason for absence are examined, the two most common reasons (excluding bad weather) are no clothes/shoes and ill health. There is a striking difference between children in rich and poor households, with 44 percent of those in the bottom quintile reporting that they missed school due to lack of clothing compared to "just" 24 percent of those in the top. In contrast, a quarter of those children living in rich households missed school through ill health compared to just 8 percent of poor children.

This raises a number of issues for policymakers. The deterioration in access to education has so far been mainly tackled from the supply-side factors. Both the World Bank and ADB are supporting school improvements and capacity building. However, it is also important to look at the demand side and the barriers and constraints facing the poor in accessing education, and the factors causing high absence rates. Guaranteeing continued access to basic education for all must remain a priority of the Government of Tajikistan.

### ***Quality of Education***

Finally, attending school is also not sufficient in itself to ensure that they are learning anything. Both the environment in which education takes place and the content of the teaching are of vital importance.

During the civil war an estimated \$100 million of damage was done to schools. The fall in real government expenditure on education since then has meant that many schools have not been adequately repaired and there has been a considerable decline in the infrastructure. Many schools remain unheated during the winter, which makes concentration difficult. This may be exacerbated by the poor nutritional status of some children. Fatigue and cold make learning doubly difficult. Class size is often large and there is a shortage of teaching material. This means that the instruction is teacher-centered rather than child-centered and children with special needs, such as dyslexia, go unrecognized.

Learning is further hindered by a shortage of personnel. It is estimated that 4,000 qualified personnel from the education sector migrated to other countries during the civil conflict, and many others have left the profession in search of better paid jobs elsewhere in Tajikistan. Thus between 1991 and 1997 the number of teachers in general education schools fell from 99,122 to 91,285. Parents have had to pool reserves to support the ongoing educational process for their children. Over the last two years the Government has made a concerted effort to recruit and retain teachers. Students have been invited to teach at schools and the number of unfilled teaching positions has fallen from 11,500 to 8,500 in 1998. However, the expansion may have been at the expense of quality. Of the total number of teachers only 62 percent have higher education, 20 percent have special secondary education, and 18 percent have secondary or incomplete higher.

In the SSA/WID survey in 1998 women with school-age children were asked their opinion on the current quality of schooling (Table 4.6). Less than half of women living in rural areas, and a third of women in urban areas, were satisfied. Of those that were not satisfied, the two most common complaints were absence of teachers and lack of textbooks. The introduction of fees has also cause for concern, particularly among urban women. Many of these quality issues will be addressed in the forthcoming ADB social sector rehabilitation project, which will focus on basic education through the provision of basic textbooks for basic education across the country, school rehabilitation and refurbishment in pilot schools, and teacher and management retraining for new skills and methods..

#### **4.1.3 Post-Compulsory Schooling**

Post-compulsory schooling (often called upper secondary schooling) is from age 14 or 15 and is divided into three types of school:

- (i) *General secondary schools* offering a two-four year program of study, possibly leading onto higher education, with entry on a selective basis;

- (ii) *Technical schools* offering 3-5 year programs of technical study leading to a diploma and the opportunity to continue studies. These institutions provide medical and technical (e.g., engineering) education as well as in the field of the arts;
- (iii) *Vocational schools* providing vocational courses of 1-3 years or more. Students train for employment in a specialized occupation.

**Table 4.6 Opinion on the Current Quality of Schooling  
Among Women with School Age Children  
(%)**

	Total	Urban	Rural
Satisfied with schooling	44	35	48
Not satisfied	41	53	34
Don't know	15	12	17
Reason for dissatisfaction:			
Absence of teachers	62	63	59
Introduction of fees	35	45	20
Extended school day	9	11	5
Insufficient materials inc. textbooks	64	57	74

Source SSA, *Gender Statistics in the Republic of Tajikistan*.

**Table 4.7 Selected Statistics on Enrolment in Post-Compulsory Education, 1990-1998**

	1990	1992	1995	1996	1997	1998
Enrolment rate General secondary education (15-18%)*	41.5	29.7	38.6	41.7	34.1	30.9
Enrolment rate Techn/vocational education (15-18%)*	9.8	8.6	8.8	6.6	6.2	5.4
Ratio of enrolled girls per 100 boys:						
General Secondary	104		71	68	63	63
Professional technical colleges	69		89	99	95	94
Vocational secondary	58		37	35	35	34

Sources \*1990 and 1992 from UNICEF 1998; 1995-98, SSA *Gender Statistics in the Republic of Tajikistan*.

The number of students in post-compulsory education has fallen. The proportion of teenagers aged 15-18 in education has fallen from over 50 percent in 1990 to 36 percent in 1998. There have been significant gender disparities within this decline. In the past, there were almost as many girls as boys participating in continuing education. In 1990 there were 111,000 boys compared with 107,000 girls. Most girls attended general secondary schools, while a larger minority of boys went

Enrolment rates have declined sharply for post-compulsory education. Rates for girls have fallen by almost twice that for boys—indicating the risk of a significant gender gap opening up.

onto the professional and vocational institutions. However, over the period 1990-1998, the number of boys enrolled in post-compulsory education fell by 28 percent from 111,000 to 80,000, while the number of girls fell by 53 percent, from 107,000 to 50,000. Thus a significant gender gap has opened up. There are now just 63 girls per 100 boys in general secondary schools, whereas in 1990 there were 104 girls per 100 boys (Table 4.7).

**Table 4.8a** Number of Students Studying at Technical Secondary Schools and Distribution of Subjects by Gender

	1990		1998	
	Male	Female	Male	Female
No. of students	24,152	16,741	10,005	9,377
Studying (%):				
Industry	26	12	36	13
Building	12	2	9	<1
Agriculture	16	1	11	1
Economics	15	10	10	4
Health Care <sup>1</sup>	16	41	13	44
PE & Sport			3	-
Education	10	31	11	36
Art & Cinematography	4	3	7	2
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

<sup>1</sup> in 1990 health care included PE and sport.

Source: derived from SSA, *Gender Statistics in the Republic of Tajikistan*.

**Table 4.8b** Number of Students Studying at Vocational Institutions and Distribution of Subjects by Gender

	1990		1998	
	Male	Female	Male	Female
No. of students	43,585	25,175	56,412	19,134
Studying (%):				
Industry	15	4	11	6
Agriculture	13	2	9	2
Economics	1	<1	7	4
Health Care <sup>1</sup>	13	11	5	9
PE & Sport			4	<1
Education	56	80	50	68
Art & Cinematography	3	3	1	1
Protection of Public Security & Defence			3	<1
Law			10	10
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

<sup>1</sup> in 1990 health care included PE and sport.

Source: derived from SSA, *Gender Statistics in the Republic of Tajikistan*.

Tables 4.8a and 4.8b present information on the range of subjects studied by boys and girls and how these too have changed over time. There is a clear pattern of segregation between the sexes, with girls much more likely to study subjects related to health care and education, while boys are more likely to study industry, agriculture and business related subjects. This division of learning is then reflected in the division of labor examined in Table 3.6 in Chapter 3 above.

#### 4.1.4 Higher Education

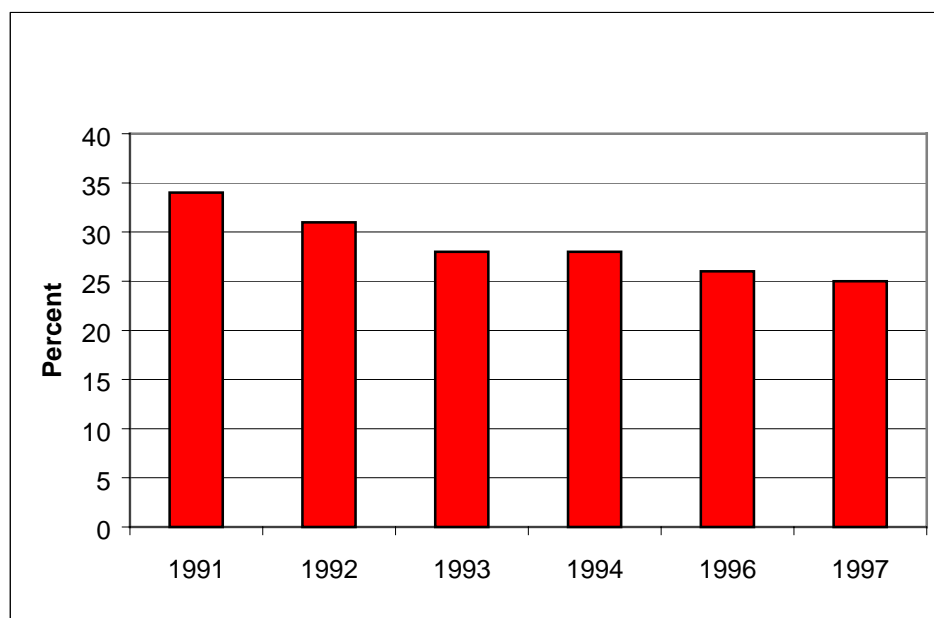
At present there are 24 higher education establishments in Tajikistan, offering training in 130 specialties. In contrast to other educational institutions, the numbers enrolled in higher education establishments has remained remarkably constant (Table 4.9). Competition for places to study subjects such as economics, management, business, foreign languages, trade, is fierce with up to 5 applicants for each place.

**Table 4.9 Selected Statistics for Enrolment in Tertiary Education, 1990-1998**

	1990	1992	1995	1996	1997	1998
Enrolment rate tertiary education (18-22)*	9.4	9.3	na	9.4	8.9	na
Ratio of enrolled girls per 100 boys:						
Higher education	58		37	35	35	34

Sources \*1990 and 1992 from UNICEF 1998; 1995-1998, SSA *Gender Statistics in the Republic of Tajikistan*.  
na - not available

However, although general enrolment is buoyant, this masks a growing differential between young men and women. In fact the number of young men in higher education has actually increased between 1991 and 1998, from 43,600 to 57,100, whilst the number of young women has fallen from 25,200 to 19,400 (Figure 4.2). Women now constitute under a quarter of all those in tertiary education.

**Figure 4.2 Share of Women in Tertiary Education**

Source: UNICEF 1999.

In an attempt to reverse this trend, quotas have been introduced for some subjects. However there remain clear gender disparities between disciplines (Table 4.10).

**Table 4.10 Number of Students Studying at Higher Institutions by Subject and Gender**

Field of study	No. of students	% Female
Teaching	2,215	68
Humanities, religion & theology	14,342	43
Fine & applied arts	771	16
Law	6,910	23
Social sciences	18,893	26
Trade and enterprise management	4,045	39
Mass media	316	24
Natural sciences	6,670	14
Mathematics	2,124	24
Medical science & health care	4,832	36
Engineering	6,222	12
Agriculture, forestry & fishing	4,400	6
Others	3,706	3
<b>Total</b>	<b>75,546</b>	<b>25</b>

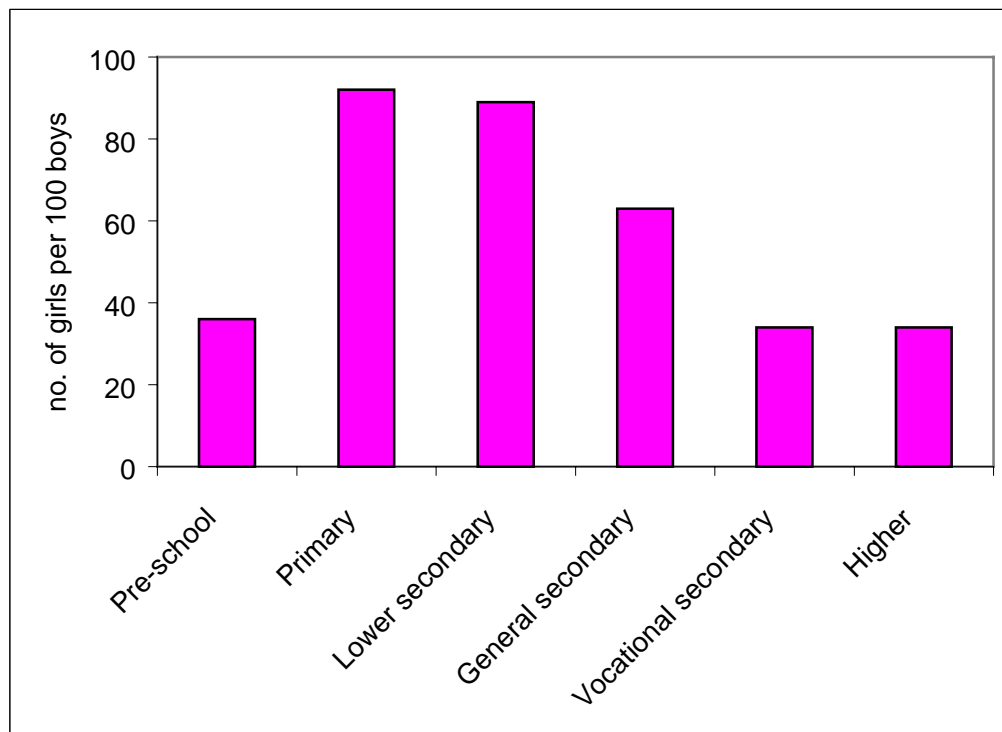
Source: Derived from SSA, *Gender Statistics in the Republic of Tajikistan*.

To summarize:

- (i) Although enrolment in pre-school institutions was not high historically, since 1990 enrolment rates have fallen from 15 percent of 3-6 year olds to just 6 percent. The fall has affected both boys and girls.
- (ii) Enrolment in compulsory education has fallen from 94 percent of 7-15 year olds in 1990, to 89 percent in 1998. The ratio of girls to boys has also fallen.
- (iii) Enrolment in compulsory education have fallen from 94 percent of 7-15 year olds in 1990, to 89 percent in 1998. The ratio of girls to boys has also fallen.
- (iv) Enrolment in post compulsory education have fallen from around 51 percent of 15-18 year olds in 1990, to 36 percent in 1998. The ratio of girls to boys has fallen dramatically. In 1990 there were 104 girls per 100 boys in general secondary school. In 1998 there were only 63 girls per 100 boys.
- (v) The gender gap in higher education has also widened, from 58 girls per 100 boys in 1990 to just 34 in 1998.

Urgent action is needed to halt the widening chasm between the educational achievement of boys and girls (Figure 4.3). Highest priority is rightly being given to basic education, but as highlighted in Chapter 3.2 it is also essential to focus on technical and vocational training of both boys and girls.

**Figure 4.3 The Gender Gap in Education**



## 4.2 Health and Health Care

Upon gaining independence Tajikistan inherited a complex but inefficient health care system characterized by substantial excess human and physical infrastructure. There has been a steady decrease in public spending on health during the transition period. Health expenditure as a percentage of GDP has dropped from 6.4 percent in 1994, to 1.5 percent in 1999. These considerable reductions have eroded the capacity of the health system to provide effective and accessible medical care to the public. At the same time there has been a re-emergence and upsurge in the incidence of infectious diseases, notably malaria, typhoid fever, tuberculosis, and measles as well as respiratory and intestinal infection, reflecting declining health status (and poor water/sanitation), particularly in young children who are most vulnerable to these conditions (Table 4.11).

**Table 4.11 Population Health Indicators, 1990-1997**

	1990	1991	1992	1993	1994	1995	1996	1997
Female life expectancy at birth <sup>a</sup>	72.3	72.8	70.9	68.2	68.5	71.2		
Male life expectancy at birth <sup>a</sup>	67.1	67.4	65.2	56.5	63.2	65.5		
Tuberculosis incidence <sup>b</sup> (per 100,000 population)	47.0	39.6	30.1	11.7	15.7	35.2	28.1	35.5
Typhoid fever incidence <sup>b</sup> (per 100,000 population)	33.5	23.7	-	27.7	23.4	26.7	269	613
Malaria incidence <sup>b</sup> (per 100,000 population)	3.3	5.5	7.3	11.1	42.4	106	282	497
SDR ischaemic heart disease <sup>a</sup> (All ages per 10,000)	280	252	244	272	290	285		
SDR circulatory system diseases <sup>a</sup> (All ages per 10,000)	490	482	518	604	640	593		
SDR cerebrovascular disease <sup>a</sup> (All ages per 10,000)	134	151	155	152	139	115		
SDR malignant neoplasms <sup>a</sup> (All ages per 10,000)	114	111	146	97	82	66		
SDR external causes, injury <sup>a</sup> (All ages per 10,000)	57	54	78	271	76	58		

Source: <sup>a</sup> WHO Health for All Database; <sup>b</sup> WHO 1999.

### 4.2.1 Deteriorating Health Status

Although official government statistics report a decrease in birth and death rates, and a slight improvement in life expectancy (see Table 2.1), health status in Tajikistan remains insecure. Tajikistan struggles with a double burden of disease, with both chronic non-communicable diseases (in a profile similar to Western countries) and infectious diseases (where the profile is closer to developing countries). Cardiovascular and pulmonary diseases (strongly associated with unhealthy lifestyles, including excess alcohol and tobacco use and high fat diets) account for over 50 percent of mortality while infectious diseases disproportionately affect young children, contributing to the high under-5 mortality rates (120/1,000 in 1997).

Worryingly communicable diseases has returned as a major threat to the Tajik population. Table 4.11 shows large rises in the incidence of tuberculosis, typhoid fever and malaria. This is associated with the breakdown in the clean water supply and sewage infrastructure, as well as the collapse in public health measures such as mosquito control and immunisation. Waterborne diseases have increased as the water supply in many areas is not safe (WHO 2000). The TLSS found that less than half of all households have access to piped water, with nearly a quarter reliant on water from river/lake/ponds and a further eighth on spring water (probably actually the best source!). Of those who have piped water, a quarter reported that water was only available for five hours a day or less; and only 36 percent reported 24-hour availability (Falkingham 2000a).

#### *Child Health*

Children have been among those hit hardest by deteriorating living conditions. Seven major nutrition/anthropometry surveys have been carried since 1994, by the Aga Khan Foundation (AKF), CARE, German Agro Action (GAA), and Action Against Hunger (Table 4.12). Although the findings are not directly comparable because of important design and methodological differences, they do all clearly document a worsening trend. The surveys were conducted in different parts of Tajikistan on children between the ages of 6 and 59 months (children are the most physiologically vulnerable to food shortages and therefore this age group is the most sensitive indicator of the nutritional status of a given population group). The most useful surveys may be the series conducted by AKF in Gorno-Badakhshan (GBO), because they have been carried out biannually since 1994 in the same region of Tajikistan. They indicate a steady deterioration in nutritional status.

There does not appear to be any *systematic* bias in favor of male children, as has been found to be the case in studies in neighboring parts of South Asia. However, there is some evidence from some of the studies that girl children are more malnourished than boys. There is also evidence that mothers are cutting back on their own nutritional intake to ensure there is food for their children. A study by United Nations High Commission on Refugees (UNHCR) and Relief International (1996) found that women are more likely to suffer from malnutrition because they eat last and less.

**Table 4.12 Prevalence of Acute and Chronic Malnutrition in Children Under 5 Years (%)**

NGO	Moderate Wasting	Moderate Stunting
CARE (1994)	3.6	30.0
GAA (1996)	10.0	40.7
GAA (1998)	11.0	46.0
AKF (1994)	2.9	40.4
AKF (1996)	5.8	44.6
AKF (1998)	6.1	53.8
Action Against Hunger (1999)	6.7	41.0

Note: Moderate wasting, or acute malnutrition, denotes current nutrition and health problems, and is defined as weight-for-height scores of below minus 2 standard deviations (-2SD) from the reference mean. Moderate stunting, or chronic malnutrition, denotes chronic exposure to insufficient food and ill health, and is defined as height-for-age scores of below minus 2 standard deviations from the reference population.

### *Women's Health Status*

High birth rates, high rates of maternal and infant mortality, relatively large numbers of abortions, and rising prevalence of sexually transmitted diseases (STDs) all contribute to low women's health status. Maternal mortality appears to have peaked at 96.3 per 100,000 live births in 1995, although the figures presented in Table 4.13 below should be treated with caution.

**Table 4.13 Indicators of Women's Health Status**

	1990	1991	1992	1993	1994	1995	1996	1997
Infant mortality rate <sup>a</sup>	40.4	40.4	48.1	46.5	42.4	30.6	na	na
Maternal mortality rate <sup>a, b</sup>	41.8	53.2	69.9	74.0	87.6	96.3	84.5	64.6
Abortions per 100 live births <sup>a</sup>	25.6	24.3	26.2	21.5	13.6	19.6	21.3	18.2
Prevalence of syphilis <sup>c</sup>	na	1.6	na	na	na	19.6	19.0	22.6
Prevalence of gonorrhoea <sup>c</sup>	na	na	na	na	na	19.1	11.4	12.1
Prevalence of trichomoniasis <sup>c</sup>	na	na	na	na	na	28.4	12.0	12.0

Source: <sup>a</sup> WHO Health for All Database; <sup>b</sup> WHO 1999; <sup>c</sup> UNFPA 1999.  
na - not available

Most maternal deaths are directly related to pregnancy: 38 percent haemorrhages, 27 percent toxemia, 11 percent sepsis and 8 percent unsafe abortion (UNFPA 1999). The high proportion due to haemorrhages could be related to especially high rates of anaemia. It is estimated that more than 40 percent of the adult population suffer from anaemia and that this rises to 60 percent in the case of women of child-bearing age (UNDP 2000). During the Soviet period comprehensive pre-natal care included at least 15 health facility visits, and 90 percent of all births were delivered in maternity wards. With the deterioration of health services since independence women, especially poor women, are increasingly giving birth at home without medical assistance (see Figure 4.5 and 4.6). Many maternal deaths could be prevented if women had ready access to trained birth attendants in a sterile environment.

Data concerning the incidence and prevalence of STDs within the population of Tajikistan are inconsistent. According to the dermatological-venereal disease center in Dushanbe, the prevalence of syphilis had increased 14-fold, from 1.6 per 100,000 population in 1991 to 22.6 in 1997 (UNFPA 1999). However, rates of gonorrhoea have declined, despite the fact that the prevalence of gonorrhoea is usually higher than syphilis. It is likely that all estimates are under-estimates as the collection of epidemiological data has suffered along with the deterioration of other services. In a 1995 study of female garment workers in a Dushanbe factory, 66 percent had at least one STD case and 62 percent had trichomoniasis, while a recent survey of 1,034 women in Khatlon oblast found one STD case in 75 percent of cases selected for a pelvic examination (UNFPA, 1999). Thus STD rates in Tajikistan are significant and a high priority needs to be given to both prevention and treatment.

Prior to the 1990s contraceptive use was very limited and estimates suggest that only three of sexually active individuals used any form of modern contraception (UNFPA 1999). As was the case elsewhere in the Soviet Union, the main form of "contraception" was abortion. Over the last nine years, the donor community has been active in providing both information concerning, and supplies of, modern contraceptives and in 1999 contraceptive prevalence was estimated at around 30 percent. The TLSS found that of married women of reproductive age who were not currently pregnant 43 percent reported that they were currently using contraceptives. Of these, just under 20 percent were using traditional methods (abstinence, withdrawal, rhythm method, water douche), 70 percent were using IUD, 5 percent other modern methods (including pill, condoms and injections) and 5 percent specified other methods including lactational amenorrhea. Despite the improvement in the availability of modern contraception, abortion rates remain high. In 1990 the number of abortions was 256 per 1,000 live births. Use of contraceptives among men appears to be extremely low (UNFPA 1999).

In summary, the general health status of women and children within Tajikistan is poor and deteriorating. Much of the recent decline in health is associated with the rise of infectious diseases which in turn is related to the degradation of the health care infrastructure since independence.

#### 4.2.2 Health Services

During the Soviet era, the health care system in Tajikistan was characterized by widespread access and high levels of service use. Health care provision was extensive and free at the point of delivery. However, since independence health services have deteriorated rapidly in the face of severe financial constraints, exacerbated by extensive damage to infrastructure during the civil war. Health care expenditure as a percentage of the declining state budget has dropped from 11.6 percent in 1994 to 8.1 percent in 1997, and real spending on health care is now less than a *tenth* of its pre-independence level (Table 4.14). The decline in government expenditure has been accompanied by a reduction in beds and personnel, and the number of hospital beds per 1,000 population is now around the average for the European Union (EU). However, although beds have been cut, few facilities have been closed and there has actually been an increase in the number of hospitals.

The precipitous decline in real government expenditures has eroded the capacity of the health system to provide effective and accessible medical care to the public. After salaries have been met, there are few resources left over for drugs and food, let alone maintenance. A facility survey in two raions (districts) in Spring 1999 found that half of all FAPs (physician assistant/midwife posts) and SVAs (rural physician clinics) did not have adequate functioning cold-chain equipment, two-thirds were unable to conduct growth monitoring, and over half had no oral rehydration salt in stock at the time of the survey (World Bank, 1999).

The widening gap between the health care budget and the actual costs of care has resulted in an increased burden on the household; both in terms of official charges and, more commonly, under-the-counter or informal payments. Although in principle drugs required as part of inpatient treatment remain free, the scarcity of drugs and supplies in medical facilities has led to an increasing number of patients having to purchase them. Furthermore, local budgetary constraints and petrol shortages have eroded the capacity of the ambulance service, and often patients have to provide their own transportation to medical facilities. Most importantly, informal user charges for consultations are frequently being imposed to help subsidize salaries. Health workers are among the lowest paid in Tajikistan. In 1998 the average monthly salary among employees in the health sector was \$4.80, compared to the workforce average of \$11 and \$33 for workers in key enterprises, such as state mining, electricity and manufacturing companies (WHO 2000). As well as being low, salaries in the public sector are often paid late, with arrears of several months being common. Given this, many physicians and nurses are increasingly reliant on informal payments and in-kind gifts from patients.

**Table 4.14 Selected Indicators of Health Care Resources in Tajikistan, 1990-1997.**

	1990	1991	1992	1993	1994	1995	1996	1997
Health spending as % of GDP			5.7	5.4	6.4	2.1	1.3	1.3
Health as % of State Budget			9.8	10.4	11.6	7.8	7.7	8.1
Doctors per 10,000	25.8	24.6	22.6	21.8	22.2	21.0	20.4	19.4
Total doctors	13,526	13,144	12,544	12,132	12,638	12,104	11,964	11,771
Nurses per 10,000	82.0	79.4	72.9	72.3	67.7	62.4	54.6	52.4
Total nurses	42,888	42,425	40,473	40,181	38,484	35,911	31,988	31,680
Pharmacists per 10,000	1.2	1.3	1.2	0.4	0.4	0.7	1.4	1.3
Total pharmacists	626	690	639	230	200	440	802	758
Beds per 10,000	108.1	111.5	112.1	107.2	88.1	80.7	73.1	69.6
Total hospital beds	56,534	59,565	62,242	59,531	50,132	46,483	42,856	42,058
Hospitals per 100,000	7.0	7.0	7.0	7.0	7.2	7.2	7.1	6.8
Total hospitals	365	374	386	389	408	412	416	411

Source: WHO Regional Office for Europe, Health for All Database.

### 4.2.3 Growing Inequalities in Access to Health Care

With the contraction in government expenditure, informal, unofficial user charges are increasingly being used to both to pay wages and to help subsidize the high cost of operating and inefficient health care system. According to the TLSS, 48 percent of people had to pay something for their last medical consultation and 17 percent provided a gift. Hospitalization represents a major expenditure for most households, with the average amount spent on medicines (TJR\$37,000), representing more than the total income for most households in a month (Figure 4.4). There is evidence that rising out-of-pocket costs have restricted access to care for growing numbers of the population (Falkingham 2000b).

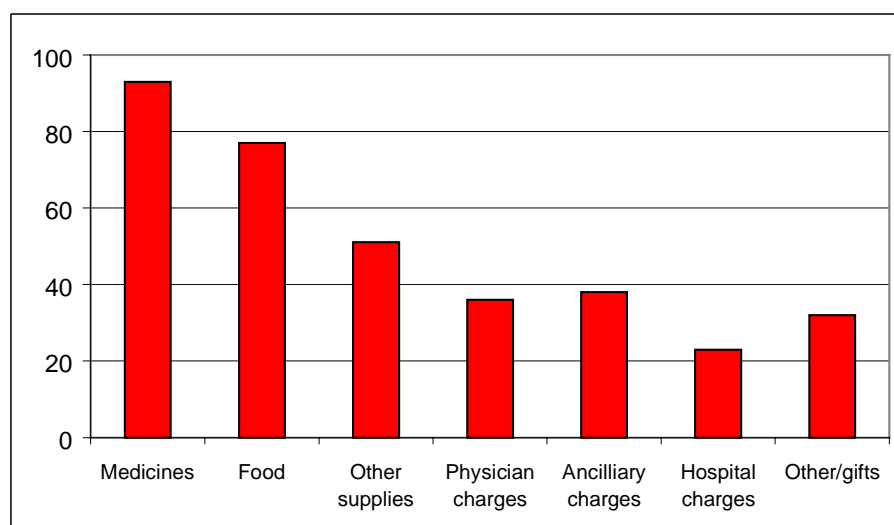
**Figure 4.4 Proportion Paying for Hospital Services (%)**

Table 4.15 presents data from the TLSS on both health status and health-seeking behavior. Health status varied by age and gender. The majority of people in Tajikistan reported that their health status over the last year was "good" or "very good". Not surprisingly prevalence of both chronic and acute morbidity increased with age, and women generally reported higher levels of morbidity than men in the same age group.

**Table 4.15 Self-reported Morbidity by Age and Gender (%)**

	Men			Women		
	0-15	16-64	65+	0-15	16-64	65+
Chronic illness lasting more than six months						
Yes	3.3	12.0	38.0	2.7	14.1	41.0
Acute illness in the last two weeks						
Yes	6.1	7.6	19.8	4.7	10.9	26.6
Sought medical assistance in last two weeks						
Yes	4.3	4.8	11.4	3.0	8.8	13.1
Needed, but did not seek	3.2	5.0	16.7	2.4	7.7	21.8
Hospitalized in the last year						
Yes	3.1	5.7	10.1	2.5	8.3	5.8

Source: Author's own analysis of the TLSS, May 1999.

Overall, a relatively low proportion of the overall population (6 percent) sought medical assistance in the two weeks prior to the survey or reported being hospitalized in the last year (5 percent). This compares with utilization rates in Britain of 16 percent, and 9 percent respectively (ONS, 1998). Again rates varied by age and gender, with women being more

likely to see a medical practitioner than men. However, after controlling for differential morbidity, there was no significant gender differential in health-seeking behavior. A higher proportion of those aged 65 and over sought medical assistance than younger groups, but after controlling for morbidity, utilization rates among elderly people were actually lower than for the population as a whole. In fact, a higher proportion of older people, especially women, reported that they needed medical assistance but did *not* seek such care than reported having a consultation.

Of those who reported that they needed medical assistance but that they did *not* seek such assistance, the majority of respondents (52 percent) self-medicated using traditional or over-the-counter medicines (Table 4.16). However, a third of all respondents in the TLSS who needed health care but did not seek medical assistance cited expense as the main reason for not doing so. Thus lack of financial resources is now a barrier to access to health care for a significant proportion of the population irrespective of age group.

**Table 4.16 Reasons Why Respondents Did Not Seek Medical Assistance (%)**

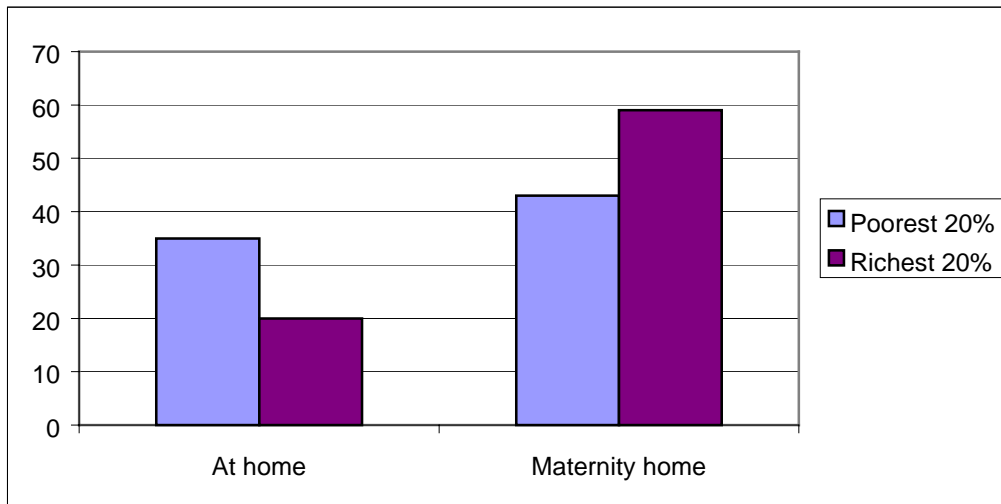
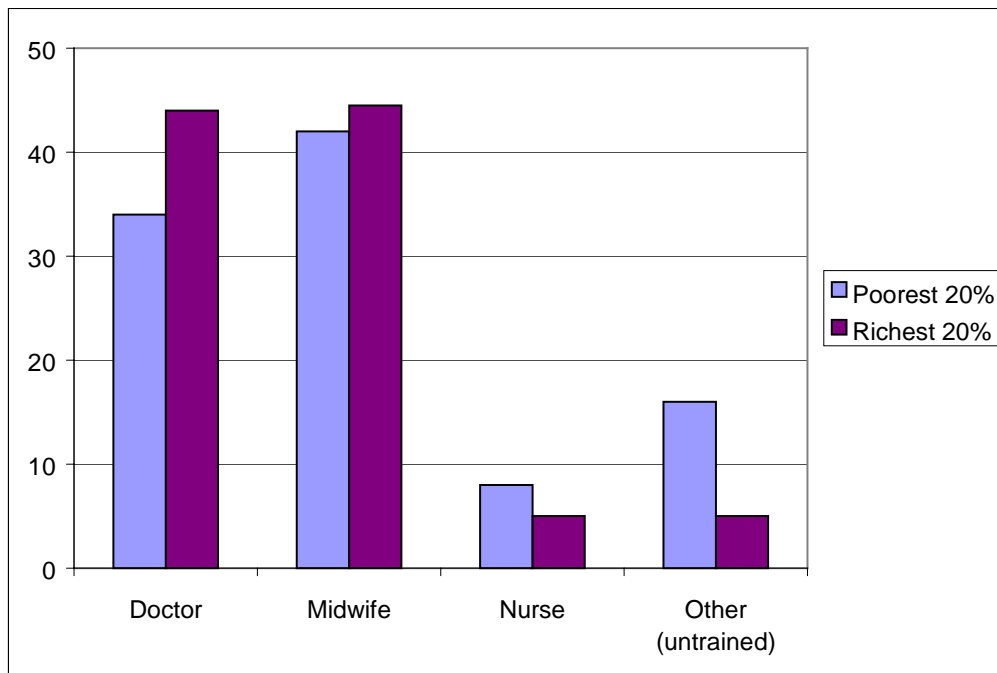
	Men			Women		
	0-15	16-64	65+	0-15	16-64	65+
Self-medicated	48	55	47	61	52	47
Believed problem would go away	9	8	6	15	8	5
Too far/facility closed/poor service	4	2	6	4	3	5
Could not afford	35	33	33	18	34	39
Other	4	2	8	3	4	5

Source: Author's own analysis of the TLSS, May 1999.

### ***Access to Reproductive Health Care***

As noted above women's health has been particularly impacted by changes in the health system and the erosion of access to adequate basic services. During the Soviet period there was comprehensive prenatal care. However, of respondents pregnant during the TLSS survey, 37 percent had had no consultations or prenatal care, with nearly half of these women (44 percent) citing inability to afford it as the main barrier to reproductive care. Moreover, cost was reported as the main reason for *not* using contraceptives by four out of five of the 57 percent of women of reproductive age who were not pregnant and not contracepting.

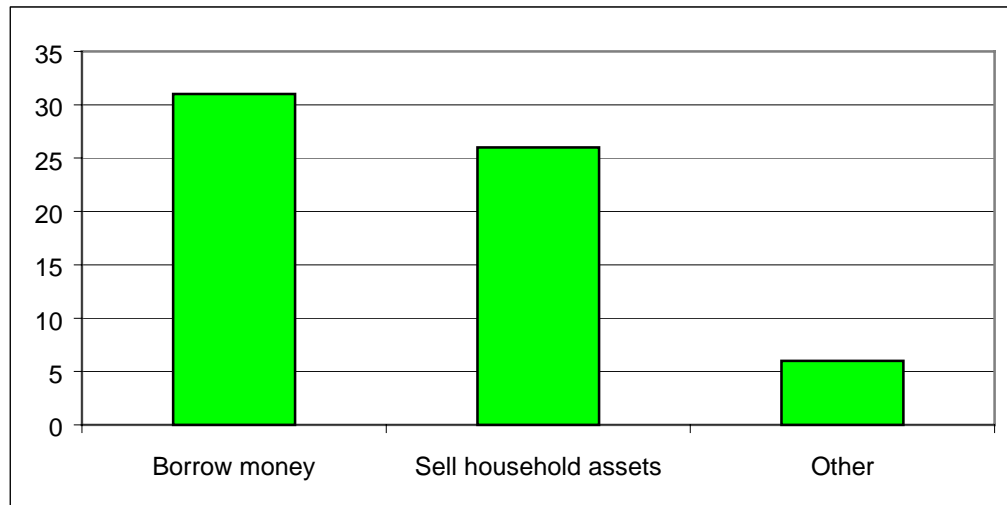
Almost one third of women surveyed delivered their last child at home (Figure 4.5). The poorest women are most affected, with 16 percent delivering without trained help, compared with only 5 percent of the top quintile suffering the same circumstance (Figure 4.6).

**Figure 4.5 Place of Delivery****Figure 4.6 Assistance at Delivery**

The majority of those that do seek health care, report difficulty in paying for it—41 percent said that they found it "very difficult" and a further 52 percent "difficult". Almost one third of households are going into debt in order to afford health care, and increasing numbers are reported having to resort to the sale of household assets. Ability to pay for health care is now a major problem among the poor and there is growing evidence that, despite informal

systems of targeting, access to health care is being affected (Figure 4.7). The challenge facing policymakers is how to take the issue of informal payments into account *and* to ensure that equity in access to health care is achieved. What is clear is that poor women in Tajikistan can no longer afford "free" health care.

**Figure 4.7 Coping Strategies to Pay for Health Care**



In summary:

- (i) Significant health risks are re-emerging within Tajikistan. There was been a rise in communicable and infectious diseases.
- (ii) There is evidence of a steady deterioration in child nutritional status.
- (iii) Women's reproductive health is poor. The prevalence of STDs is high and growing. Utilization of pre-natal care is falling and it is likely that maternal mortality is high and rising.
- (iv) Much of the decline in health status is related to the degradation of the health service infrastructure combined with the rising costs to the household of health care.
- (v) Access to health care has fallen and informal payments now constitute a significant barrier to access. Given that women and children are the primary consumers of health care services, this has worrying gender equity implications

### 4.3 Social Protection

Prior to independence there was a comprehensive system of social welfare benefits. With a guarantee of full employment, unemployment was unknown. For those unable to work there was an extensive system of invalidity and old age benefits, and for families with young children there were generous child benefits. Coverage of benefits was universal and almost every household was eligible for at least one. In addition to cash benefits there were numerous "benefits-in-kind" including free pre-school and child care, free or heavily subsidized holiday camps, subsidized housing and utilities, free cultural and sport facilities, and generous maternity leaves. Many of these social welfare benefits were delivered via the state-owned enterprise.<sup>12</sup> It is estimated that social transfers made up 14 percent of total gross income within the FSU (Atkinson and Micklewright 1992).

Over the last five years, civil conflict and the economic and social dislocation associated with transition has both exacerbated the disadvantage of the "old poor"—pensioners, families with large numbers of children and single parent families—and given rise to new groups of poor in need of social cash transfers. Most prominent among these are the "working". Today the earnings of many breadwinners are simply no longer sufficient to cover the costs of daily living and average per capita income is lower than minimal consumption budget.

At the same time, the ability of the Government to fund social protection has been severely curtailed. As Table 4.1 showed, the state budget has fallen in real terms. Existing systems of assistance to the most vulnerable have come under increasing pressure due to rising numbers of people in need coinciding with tightening fiscal constraints. The value of benefits has fallen in real terms and the number of recipients has been reduced rather than expanded. Thus in 1999, the formal safety net in terms of cash transfers contributed just 5 percent to total household income.

Women and children have been particularly hard hit by the collapse of the inherited system of social security benefits. In the past there was an extensive system of benefits for families with children, including one-off birth payment, payments for mothers on maternity or child-care leave, monthly allowances for children aged 0-18 months and 1.5-16 years additional benefits for single mothers and mothers of more than four children, payment for expenses related to the education of disabled children, and several others. The economic dislocation during transition weakened the ability to continue to provide a universal system of benefits to all families with children. With insufficient resources and a growing number of people in "need", targeting of family allowances was introduced. Today there are just two main types of social protection benefit in Tajikistan: the cash compensation program offering social assistance type benefits to the poor, and pensions providing social insurance type benefits to the elderly, disabled, and bereaved.

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<sup>12</sup> For a discussion of the operation of the social safety net in the Soviet Union prior to transition (see Barr, 1994 and Falkingham et al., 1997).

Vulnerable groups in Tajikistan are currently supported by a complex mix of both formal and informal safety nets, with benefits in cash and in-kind from government, nongovernment organizations (NGOs) and the extended family and wider community. However, by far the most significant source of support to the poor is that provided by the *informal safety net*—by community groups, NGOs, and the family. Most important within this is the home production of vital foodstuffs, transfers of food and other goods between members of the extended family and wider community, and cash remittances from household members currently living outside the household either in another part of Tajikistan, elsewhere in the FSU, or further afield. According to analysis of the TLSS, remittances accounted for over 11 percent of total cash household income in 1999 and the imputed value of home production accounted for nearly a fifth of total expenditures. Below we examine the extent and effectiveness (or lack thereof) of the formal safety net, before turning to look at the informal safety net.

#### 4.3.1 The Cash Compensation Program

The cash compensation program (CCP) was introduced in March 1996 to replace the existing system of child allowances and a universal bread subsidy. The level of payment in 1999 was TJR500 per eligible person per month—sufficient to buy just two loaves of bread! Eligibility is determined by a commission, which includes both work place representatives and local staff of the Ministry of Social Protection (MSP) and is limited to membership of one of four target groups:

- Families with per capita income of less than two times the level of the minimum wage (TJR4,000 in 1999). The benefit is then payable for each child under the age of 8.
- Families with children under age 16 who have lost one or both parents and who are receiving a survivor's pension.
- Disabled (regardless of employment status) and non-working pensioners with pensions below the minimum pension level of TJR2,000.
- Students in vocational, specialized secondary and higher education regardless of any scholarships received.

In 1998 the Ministry of Finance estimated that 1,092,000 people were eligible to receive cash compensation payments (17 percent of the total population), of whom 64 percent were children, 8 percent students, and 28 percent pensioners and invalids. However, according to administrative data, in October 1998 only 160,000 people were in receipt of a CCP benefit, i.e., just 15 percent of those who were estimated to be eligible and just 3 percent of the population.

In 1998 it is estimated that the CCP was in arrears to the tune of TJR2.1 billion, and this was in addition to the TJR3 billion estimated to be outstanding from the previous year. In 1999, the picture was even worse, as only TJR0.5 billion was paid out during the first half of the year. In order to improve payment rates, in March 1999 two reforms were made to the program: the paperwork required for claiming the benefit was simplified and the duration for

the period of the claim was increased to three months to reduce transaction costs (for many families it cost more to travel to collect the benefit than the value of the benefit itself). However, there is little sign that these have been successful.

**Table 4.17 Eligible and Actual Beneficiaries of the Cash Compensation Program, April 1998**

Beneficiary	Number
<b>Total eligible beneficiaries (% of population)</b>	<b>1,092,000 (19%)</b>
Of whom:	
Children	708,000
Students	83,000
Pensioners and invalids	301,000
Actual beneficiaries	160,000
(% of eligible beneficiaries / population)	(15% / 3%)

Source: World Bank (2000).

Less than 1 percent of households in Tajikistan in May 1999 were actually receiving any cash compensation payments—the main poverty alleviation benefit.

Cash compensation payments are currently being given at a level insufficient to lift families and older people out of poverty. Its nominal value has remained unchanged since March 1996 and in autumn 1999 the monthly payment of TJRs500 barely covered the cost of two loaves of bread, or less than 2 percent of the minimum consumption basket of TJRs32,083. As a result low-income households with children are offered little protection by the state against falling into poverty.

Households in the TLSS were asked in May 1999 whether there was anyone in the household eligible for 15 different benefits. Despite the fact that, according to the TLSS, nearly half (47 percent) of households had incomes that would qualify them for a cash compensation payment for a child under eight, only 5 percent of households reported that they were eligible for such a payment; and of these only a fifth reported actually receiving a benefit (Falkingham 2000a). This points to both considerable confusion in the beneficiary population concerning eligibility for cash compensation payments (CCP) and worrying levels of nonpayment of benefit among claimants.

### 4.3.2 Pensions

In 1998, 557,000 people, or 9 percent of the population, were registered as receiving a pension or other social insurance type benefit (Table 4.18). Of these, the majority (65 percent) were registered as in receipt of an old age pension, but one in 10 pensioners were in receipt of a disability pension and just over a further one in 10 were receiving a survivor's pension. Around 59,000 elderly persons who had accumulated insufficient entitlement during

their working life for a minimum old age pension received a social pension.<sup>13</sup> Approximately two-fifths of pensioners are women.

Again data from the TLSS found that the majority of households (56 percent) who reported being eligible for a benefit did *not* actually receive any payment in the last month. Two thirds of households also reported being at least one month in arrears. The average period of arrears for old age pension payments was four months (Falkingham 2000a).

**Table 4.18 Pensioners in 1992-1998**  
(’000)

	1992	1993	1994	1995	1996	1997	1998
Total number of people	545	604	585	566	555	548	557
of whom % female	55	47	48	45	42	37	42
Old age pension	397	408	401	382	370	359	360
Disability	54	65	65	65	65	60	59
Survivors	91	84	66	69	73	71	63
Employment service	1.2	2.1	2.1	2.6	3.4	4.7	
Social	40	52	58	56	53	56	59
Working pensioners		52	47	42	35	37	36

Source: SSA.

Pensions are no longer paid at a level sufficient to ensure that old people do not fall into poverty. The value of pensions relative to salaries has declined from 50 percent in 1995 to 35 percent in 1998 (UNDP 1999). Given that the real value of salaries has also been falling over this period, pensions have become almost worthless. In 1998, the average pension was TJRs3,019 (US\$3.88) a month and the minimum pension was TJRs2,000 (Table 4.19). About 73,000, or 13 percent of all pensioners, receive the minimum pension. In addition, 300,000 pensioners received a pension below that of the minimum pension and are officially entitled to cash compensation.

The pensions system is functioning somewhat better than the cash compensation system, but there remain significant problems with arrears and the average value of pensions is too low to maintain individuals without alternative forms of support.

<sup>13</sup> In the budget for CY2000, it is planned to eliminate the overlap between the Social Protection Fund and the CCP, with all pensions below the minimum being brought up to TJRs2,000 monthly. This will effectively abolish social pensions.

### 4.3.3 The Informal Safety Net

In the absence of any meaningful system of state transfers, the informal, or non-governmental, safety net has assumed critical significance in providing support to the most vulnerable groups during transition. Here we include both humanitarian assistance from international donors and NGOs, as well as support from local NGOs, community groups, friends, and family.

**Table 4.19 Adequacy of Pension Payments, 1994-1998**

	1994	1995	1996	1997	1998
Average salary	40,449	785	3,116	4,975	8,590
Average pension	18,032	392	876	1,062	3,019
Minimal pension	11,776	256	483	483	2,000
Ratio of average pension to salary %	45	50	28	21	351

Source: SSA, quoted in UNDP 1999. Note 1994 figures are in Russian roubles.

#### *Humanitarian Assistance*

Tajikistan remains critically dependent upon the humanitarian support of the world community. It is estimated that in 1999 Tajikistan's food deficit amounted to 360,000 million tons out of an overall need of between 800,000 and 850,000 million tons, and an economic study by the European Community in 1997 estimated that 16.4 percent of all households were food insecure (Freckleton 1997). At the beginning of 1999 there were almost 1.4 million beneficiaries receiving food aid (i.e., nearly a quarter of the population) through a variety of programs, including food-for-work (FFW), agricultural support, and institutional and vulnerable group feeding (UN 1998). Key organizations in delivering food assistance include The World Food Programme, CARE International, German Agro-Action, Save the Children UK, Save the Children US, Mercy Corp International, Aga Khan Foundation, the Agency for Technical Cooperation and Development (ACTED), and Mission Ost.

Criteria for receipt of food aid vary between the various organizations. However, virtually all use categorical targeting and common selection criteria include single old age pensioners, disabled pensioners, war widows, orphans, and families without breadwinners. These correspond to many of the beneficiary categories under the old Soviet system of welfare.

Humanitarian assistance forms an important part of total household resources for those that receive it. According to the TLSS, 23 percent of all households reported the receipt of food aid in the last seven days and the imputed value food aid made up 8 percent of the income of the poorest households, compared with 6 percent from social transfers (Table 4.20).

**Table 4.20 Structure of Total Household Income (%) by Quintile Group of Households Ranked by Per Capita Household Expenditure**

	Poorest 20%	2	3	4	Richest 20%
Labor income (incl. employer subsidies)	32	34	34	38	42
Sale of food & crops	16	18	17	14	10
Sale of private belongings & livestock	14	13	18	16	15
Sale of commercial goods	1	3	2	2	3
Rent	<1	-	-	<1	<1
Withdrawal of savings/repayment of debts	2	2	2	3	3
Inter-household transfer (gifts or loans)	14	12	9	10	12
Aid	8	7	7	6	4
Social Transfers (inc. pensions and child benefits)	6	6	5	5	5
Others	7	5	5	6	6
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: Authors own analysis of the TLSS.

Table 4.16 also highlights the importance of remittances (both in cash and in kind) from relatives or friends outside the household.

### *Community and Inter-Household Support*

Family ties, traditional institutions, and local cultural identity are crucial factors in providing social support. Tajikistan is rich in this form of social capital. A well known example is “hashar,” when the whole neighborhood gathers on weekends to assist any person in the community to construct a house or help with other household activities for free. ECHO Survey found that 17.5 percent of all households had received cash or food gift from a relative or friend in Tajikistan and 5 percent remittance from relative outside Tajikistan. This is probably an underestimate of inter-household transfers as it likely that many people will not perceive foodstuffs “temporarily” borrowed from neighbors as a gift or transfer (Kandiyoti 1999).

However, there is evidence that traditional social support networks are coming under pressure. As discussed in Section 3.2.4, lack of resources has meant that people are no longer able to maintain traditional levels of Tajik hospitality. In the WID/SSA survey of 1,008 households in 1998, a third of urban women and a fifth of rural women reported that they were no longer able to entertain guests with the result that their social networks are considerably weakened. A recent study in GBAO also found that traditions of mutual help and sharing are becoming strained. Although neighbors still help each other out with small quantities of food and basic goods on a regular basis, many women pointed out that it was increasingly difficult to ask neighbors for help as so many people were experiencing difficulties with producing or acquiring sufficient food for their own households (Kanji and Gladwin 2000).

**In summary**

- (i) Formal systems of social protection have all but collapsed.
- (ii) Only an estimated 15 percent of people eligible for social assistance were receiving it, and the value of benefits is in any case insufficient to lift families out of poverty.
- (iii) The pensions system is somewhat better but there remain significant problems with arrears and benefit adequacy.
- (iv) Informal safety nets are coming under strain as more and more pressure is put upon them.
- (v) Tajikistan remains critically dependent upon humanitarian support. Food aid makes up a greater share of the income of poor households than social transfers.