

CHAPTER 1: INTRODUCTION

This chapter presents a brief background of The Gambia as a country, including aspects of the national health and population policies. It further presents the survey objectives, methodology, design and organisation. The chapter, therefore, lays the foundation of the report.

1.1 The Gambia: geography, population and socio-economic aspects

The Gambia is a small country located on the West African Atlantic coast and is bordered by Senegal to the north, east and south. It covers an area of 10,680 square kilometres and stretches an approximately 400-kilometre length on either side of The Gambia River, which divides the country in almost two equal halves. The Gambia experiences two climatic seasons, a long dry spell from October to May and a rainy season during June to September. The main backbones of The Gambian economy are agriculture and tourism.

The Gambia attained full independence in 1965. Maintenance of multi-party democracy, adherence to the rule of law and preservation of fundamental human rights constitute an integral part of the country's political framework. The latest democratic change of government took place in October 2001.

The last census was held in 1993 and based on this, current projections put The Gambian population at 1.4 million (51 percent female, 49 percent male), with an annual growth rate of 4.2 percent (*Central Statistics Department*). The next population and housing census is scheduled to take place during May 2003. As per 1993 census, the crude birth and death rates were estimated at 46.2 and 19 per thousand respectively, and the total fertility rate was estimated at 6.04. Infant and child mortality levels in The Gambia are estimated at 85 and 135 per

thousand respectively, and these high levels probably explain why life expectancy is as low as 55. At least 70 percent of The Gambian population resides in rural areas and the adult literacy rate is estimated at 37 percent. About 95 percent of the population are Muslim, the rest mainly Christians.

1.2 Health Policy and Other Health Initiatives

The National Health Policy 1994-2000, the basis of health initiatives and programmes in The Gambia over the past five years had focused on Family Health, embracing Maternal and Child Health including Family Planning, Adolescent Health, Nutrition and Immunisation among its major thrust. This policy, provided the direction for most of the interventions undertaken by the public and private health sectors geared towards the reduction of maternal and infant morbidity and mortality.

The period under review (1990-2000) prior to this survey (2001) also witnessed the trial of key interventions aimed at improving maternal and child health and includes: (i) the construction and provision of modified horse-driven carts with bed sitting facilities for use as transportation in the event of obstetric emergencies; (ii) the construction of a wooden and fibre made ambulance with diesel-driven engine also for obstetric emergency referral; (iii) the installation of radio-communication networks in the motor ambulances and at referral facility level to facilitate obstetric referrals; (iv) the construction of maternity-waiting homes at strategically located referral health facilities for the admission and management of pregnant women before delivery; (v) the establishment of a special cadre of nurse mid-wives trained in obstetric life saving skills to serve in the major health centres in the rural areas in the provision of obstetric emergencies.

However, most of these interventions, though demonstrated some positive results, could not be sustained as a result of financial, technical and socio-economic barriers. The Department of State for Health has recently reviewed, revised and replaced the National Health Policy with a new policy in September 2001 with the theme “changing for good”. The health policy aims at provision of quality health care services within an enabling environment, delivered by appropriately and adequately trained, skilled and motivated personnel at all levels of care with the involvement of all stakeholders to ensure a healthy population. A key component of the policy is the essential care package which aims at addressing the common causes of morbidity and mortality, especially for women, children, the under-served and the marginalised. The policy focuses on improving efficiency and effectiveness in the organisation and management of the health sector through management reform, creation of popular structures for re-enforcing community participation in decision making and devolution of responsibilities, authority and resources to the hospital and divisional health management teams and village development committees.

The public health service delivery system is three tier, based on the primary health care strategy. Presently, services are provided by three public hospitals, 36 health facilities at the secondary level and 492 health posts at the primary level. The public health system is complemented by 34 private and NGO clinics. The health policy focuses on 20 programme areas, including child health, reproductive health and nutrition among others. A set of health packages for men, women and adolescents are provided for in the policy and effective monitoring, evaluation and quality assurance are emphasized.

Community-based primary health care (PHC) activities have been running in selected villages in rural Gambia since 1980. The extra facilities in the PHC villages include: a government paid Community Health Nurse for about every 5-7 villages, a community volunteer Village Health Worker and a Trained Traditional Birth Attendant. These provide continuous health education, treatment of simple

illnesses and injuries, essential drugs and act as a link between village-level PHC services and referral health services available at dispensaries and health centres. Maternal and child health services with a vaccination programme are accessible to residents in both PHC and non-PHC villages.

Population Policy and Programme

Faced with largely unfavorable economic conditions, rapid deforestation aggravated by rapid population growth, the Government of the Gambia decided to adopt a National Population Policy in 1992. The policy designed to curb the rapid rate of population growth had the overall goal of improving the quality of life and raising the standards of living of all Gambians. For the attainment of the goals of the policy, strategic components have been identified and included: reproductive/sexual health and family planning, education, family and gender relations, youth, environment, nutrition, population distribution and urbanization, migration, information, education and communication/advocacy, research, capacity building and legislative reforms.

Activities have been identified as an integral part of the national population programme. In view of the cross cutting nature of some of the activities of the population programme, an attempt has been made to harmonize the population policy and programme with other government initiated policies and programmes. Key among these programmes is the national education policy, the Gambia environment action plan, and the housing, Health and Family Planning/RH Policies.

The major targets of the national population policy include the:

- Reduction of the Maternal mortality rate 1050 per 100,000 (1990) to 800 per 1000 by the year 2000 and to 500 per 100,000 by 2004.

- Reduction of the total fertility rate from 6.04 (1993) to 5.5 by 2000 and 5 by 2004.
- Extend primary health care services from 60% (1985) to 80% of rural population by 2000 and to 100% by 2004.
- Increase contraceptive prevalence from current estimates of 7% (modern methods) to 15% by 2000 and 22.5% by 2004.
- Reduce pregnancy among women aged 15 – 19 years and 35 years and above by 20% by 2000 and by another 50% by 2004.
- Increase the coverage of the expanded programme for immunization of children under age 2 years from 83% (1994) to 90% by 2000 and to 100% by 2004.
- Reduce infant mortality rate from 92 per 1000 1993 to 72 per 1000 by 2000, and to 56 per 1000 by 2004.

A key strategy identified by the policy in achieving these goals is improved access to health services throughout the country and the introduction of measures geared towards the improvement of the quality of Health Services in general. Improvements in the area of maternal and child health services has been particularly singled out for attention.

Mortality

In spite of considerable achievements in terms of mortality decline during the past three decades, mortality levels in the Gambia remain among the highest in the sub-region. Infant mortality estimated at 84 deaths per 1000 live births in 1993 recorded significant decline from levels estimated at 167 deaths in 1983.

Over the same period, under-five mortality was estimated to have declined from 260 deaths per 1000 in 1983 to 129 deaths in 1993. Lower levels of child and under-five mortality have been observed in the Banjul and Kanifing Municipal areas when compared to other regions of the Gambia, although, in general, mortality levels have declined significantly across all regions during the past three decades.

Fertility

Fertility levels in the Gambia are among the highest in the world. Although a modest decline in levels was recorded over the past two decades, levels remain high. During the period 1973- 83, fertility was estimated at 6.4 declining to 6.02 in 1993. This modest decline in fertility was in part attributed to contraceptive use among the population and changes in marital patterns observed during the period. Disparities have been observed in fertility levels among divisions with the levels lowest in Banjul and Kanifing municipal areas and highest in the predominantly rural local government areas.

Similar differentials have been observed among ethnic groups. Regional and ethnic differences in fertility may be explained by differences in levels of contraceptive use, attitude to family size and variations in marital patterns, in general. Estimates from the MICS 2 report indicate that the total fertility rate is 5.4 children per woman.

1.3 Background to the survey

The Government of The Gambia has always been committed to the “Health for All” year 2000 and beyond Alma Ata Declaration (1978) as well as other conventions such as the 1987 Global Conference on Safe Motherhood, the 1990 Convention on the Rights of the Child and the 1994 ICPD-Cairo Plan of Action,

amongst others. A unique recommendation from all these conventions was the reduction of maternal mortality by half by the year 2000 and the provision of a comprehensive reproductive health programme using the life cycle approach from birth to death.

The 1987 conference on safe motherhood brought about increased awareness in the health sector on the issue of maternal mortality following which the “sisterhood” method of estimating levels of maternal mortality was first tested in The Gambia in 1987. This field test was done by the MRC field station located in one of the rural divisions of The Gambia and a total of 90 maternal deaths were identified. The lifetime risk of maternal death was estimated to be higher than one woman in twenty (*Greenwood et al.*). Subsequently, this revelation by the MRC study sparked a new impetus into the “silent epidemic” of maternal mortality following which the Department of State for Health through its MCH/FP programme commissioned a national survey in 1990. The results, which were quite startling, revealed a maternal mortality level of 1,050 per 100,000 live births nationally. There were variations between urban (600 per 100,000) and rural communities with trained birth attendants (894 per 100,000), and communities without trained birth attendants (1,600 per 100,000).

Recent isolated studies on maternal mortality have suggested a general decline in those areas. However, in the absence of a viable vital registration system in The Gambia, there has been a felt need to conduct another national survey, since the 1990 survey. Furthermore, the Department of State for Health’s proposed shift from MCH/FP service provision into a broad-focussed reproductive health programme also requires the availability of current baseline information and the identification of relevant process indicators, all of which justify the need to establish current levels of mortality and use of contraceptives.

It should be noted that current national policies and programmes continue to refer to data obtained from the 1990 maternal mortality study, the 1990 Gambia

contraceptive prevalence and fertility determinants survey as well as the 1993 population and housing census as baseline benchmarks both for programme intervention and implementation. This long period to some extent renders the data quite obsolete and unsuitable for many national and development purposes. A simple compromise has been that of making comprehensive demographic, health and socio-economic projections. However, one important limitation of statistical projections is the period between the time the base data were collected and the time span of the projections. The probable margin of error in making projections with reference periods of eight or more years ago could be so large to warrant the acceptance of such projections within any reasonable statistical intervals.

Since there has been no comprehensive national survey on maternal, infant and child mortality during the past 10 years, and given that it would take a number of years before the final analyses of data obtained from the forthcoming census, it was found prudent to carry out a comprehensive study that would collect information on key reproductive health indicators. Furthermore, the complexity involved in studying maternal mortality compounded by its rarity of occurrence in the general population has necessitated conduction of a specialised study. Such a study would be useful in filling in the data deficiencies and providing baseline data for programme intervention and evaluation, especially in an era of a general shift of emphasis of population programmes from vertical family planning activities in favour of a more generally accepted concept - reproductive health.

1.4 Objectives of the survey

- a) To establish current levels of maternal, peri-natal, neonatal and infant mortality rates.
- b) To establish the current levels of contraceptive prevalence rates and barriers to use.

- c) To elicit how the situation has improved or otherwise during the last ten years.
- d) Make practical recommendations to Department of State for Health for subsequent and long-term actions required.

CHAPTER 2: SURVEY DESIGN AND METHODOLOGY

2.1 Sample design

A multi-stage stratified cluster sampling procedure was used for this study. The country is divided into 41 Districts and each of these districts was identified as a stratum. Stratification by districts increases the efficiency of the sample given the homogeneity of the districts

The sample size for the study was 4000 households and was based on the level of maternal mortality which was estimated at 1050 per 100,000 at the time of the study . According to WHO/UNICEF, 1997 publication on Sisterhood Method in Estimating Maternal Mortality, 4,000 households or less would be adequate for study of maternal mortality if the level of maternal mortality is at least 500 per 100,000.

Based on the Rule of Thumb, a 15 per cent sample of EAs (240) was selected for this study, which is also more than adequate for the study of other variables like contraceptive prevalence, infant mortality, fertility and its determinants. The selection of population elements were done at two stages:

Stage One

A representative sample of 240 Enumeration Areas (EAs) were randomly selected and allocated based on the Probability Proportional to the Size (PPS) of the district using random numbers. The EA is a cluster of settlements with an estimated population of 500 peoples.

Stage two

A total of 4,000 households were then allocated to the districts with probability proportional to the size of each district. For the 240 selected EAs, a specified number of households were randomly selected for interview using a systematic sampling procedure. A complete listing of selected households members was done and all eligible male and female respondents were interviewed.

2.2 Survey organisation

A survey coordinator at the Department of State for Health who was also one of the six survey team members, took charge of the overall coordination of the survey operation. The survey team members comprising of the Department of state for Health, Population Secretariat and the Central statistics department were responsible for the Survey design, training of enumerators, providing technical guidance during data collection and report writing.

Teams of interviewers were dispatched to cover the 240 enumeration areas and each team included approximately five interviewers and a supervisor.

The survey tools included a compound and household schedules, female and male questionnaires. The compound and household schedules were used to collect information on local government area, health division and household number, together with residence, sex, age, education and eligibility status of the household members. The female and male questionnaires were administered to women aged 15-49 years and men aged 18 years and above respectively. The survey instruments were similar to the core modules of the Demographic and Health Survey questionnaires (Macro International), with adaptation to suit The Gambian needs. In addition a review of medical records in the three main hospitals in The Gambia (Royal Victoria Hospital, Farafenni Hospital and

Bansang Hospital) was carried out in November 2001 to undertake firsthand assessment of the maternal mortality situation at the major referral facilities.

In addition, there was a data entry supervisor who was a computer specialist at the Central Statistics Department. He designed data entry screens, allocated batches to data entry assistants and later merged all entries in datasets. He was also responsible for the final data cleaning and editing exercises.

Data entry was done in 3 locations (Department of State for Health, Central Statistics Department and National Population Secretariat), using IMPS (Integrated Microcomputer Processing Systems) software. Coding, database merging and data cleaning were done using SPSS (Statistical Package for Social Sciences). Finally, data manipulations, statistical analysis and indirect demographic estimations were done using STATA 6.0 statistical software and MORTPAK.

2.3 Development of Survey Instruments

The Survey team with support and guidance of the Technical Team prepared the survey instruments by adapting the Demographic and Health survey modules. The main instruments for this study are: the male questionnaire which was used to obtain information from males 18 years and above, female questionnaire, which obtained information from females, 15-49 years and household questionnaire.

The household questionnaire contain information on Local Government Area (LGA), Districts and Household numbers. For each person listed on the household questionnaire, relationship to head of household, age, and sex are recorded.

The female questionnaire contain the following key information:

Respondent's background

Reproduction

Contraception

Marriage

Fertility preferences

Maternal mortality

The male questionnaire on the other hand, contained the following information:

Respondent's background

Contraception

Marriage

Maternal mortality

2.4 Recruitment, Training and Pre-Testing of Instruments

For the conduct of this survey, 50 enumerators and 10 supervisors were recruited and trained for 10 days. During the training period, the questionnaires were interpreted in local languages for better comprehension of the enumerators and supervisors. A two-day pre-test of all the instruments was conducted and comments received during the exercise helped in improving the instruments.

2.5 Field Data Collection

The fieldwork lasted for 45 days. The total number of households covered is 3989. The males and females interviewed in these households were 5038 and 5786 respectively.

The data collection exercise was conducted in teams of 5 and a supervisor headed each team. Three Technicians worked with these teams to provide technical advice during fieldwork.

2.6 Data Coding, Entry, Cleaning and Analysis

A Statistician who is a computer specialist at the Central Statistics Department designed data entry screens. This was followed by the coding of the instruments.

Data entry was done in 3 locations (Department of State for Health, Central Statistics Department and National Population Secretariat), using IMPS (Integrated Micro-computer Processing Services). Merging of databases and data cleaning were done using SPSS (Statistical Package for Social Sciences). Finally, data manipulations, statistical analysis and indirect demographic estimations were done using STATA 6.0 statistical software and MORTPAK.

CHAPTER 3: CHARACTERISTICS OF SURVEY POPULATION

This chapter presents information on some of the socio-economic and demographic characteristics of the survey population such as age, sex, marital status, residence, education, employment and distribution according to health districts and local government areas. The main focus is on the background characteristics of the respondents to the survey questionnaires.

3.1 Background characteristics of respondents

Demographic and selected socio-economic characteristics of the survey population are presented in Tables 1 and 2. A total of 5,786 women aged 15-49 years and 5,050 men aged 18 years and above were interviewed. The age distribution was similar between male and female respondents, with the majority aged between 20 and 29 years. On the other hand, the age distribution of the respondents shows a similar pattern for women and men, with the proportion of respondents in each group declining with increasing age.

About 58 percent of both men and women reside in rural areas, while 42 percent live in urban areas. The Gambia is divided into eight local government areas, however, the majority of the respondents live in four areas: Brikama (21 percent), Kanifing (20 percent), Kerewan (19 percent) and Basse (13 percent). These local government areas are roughly distributed across the country.

Distribution by type of settlement and health district was also analysed. Respondents in this survey were fairly balanced in PHC villages (36 percent), non-PHC villages (33 percent) and 31 percent in urban areas. On the other hand, The Gambia is divided into six health districts and the majority of the respondents (47 percent) came from the Western Division. It should be noted that the Western Division (along the Atlantic coast) is the most populated with nearly half of the country's population.

3.2 Marital status and type of marital union

At least two-thirds of the survey population were either married or in some form of informal marital union (Table 1) There were more married women (72 percent) than men (61 percent) and a third of the men were either single or had never married. Only about 2 percent of the survey population were either widowed, divorced or separated.

Although 56 percent of all married respondents were in monogamous unions, nearly half of the married female respondents were in polygamous relationships. The significant level of polygamy could be due to the fact that the majority of The Gambian population (93 percent) believe in the Muslim faith which allows men to marry up to 4 wives.

Table 1: Demographic characteristics of the survey population

Characteristic	Male Number(percent)		Female Number (percent)		Total	
Age group:						
15-19*	307	(6.1)	1068	(18.5)	1375	(12.69)
20-24	721	(14.3)	1131	(19.6)	1852	(17.09)
25-29	654	(13.0)	1198	(20.7)	1852	(17.09)
30-34	591	(11.7)	816	(14.1)	1407	(12.98)
35-39	538	(10.7)	711	(12.3)	1249	(11.53)
40-44	472	(9.4)	474	(8.2)	946	(8.73)
45-49	383	(7.6)	258	(4.5)	641	(5.92)
50-54	305	(6.0)	-----	-----	305	(2.81)
55+	838	(16.6)	-----	-----	838	(7.73)
Not stated	241	(4.8)	130	(2.3)	371	(3.42)
Marital status:						
Single	1648	(32.6)	1337	(23.1)	2985	(27.5)
Married	3091	(61.2)	4141	(71.6)	7232	(66.7)
Living together	6	(0.1)	10	(0.2)	16	(0.1)
Widowed	17	(0.3)	69	(1.2)	86	(0.8)
Divorced	45	(0.9)	93	(1.6)	138	(1.3)
Separated	9	(0.2)	8	(0.1)	17	(0.2)
Not stated	234	(4.6)	128	(2.2)	362	(3.3)
Type of marital union:						
Monogamous	1960	(63.3)	2106	(50.7)	4066	(56.1)
Polygamous	1061	(34.3)	1965	(47.3)	3026	(41.7)
Not stated	76	(2.5)	80	(1.9)	156	(2.2)
Ethnicity:						
Mandinka	1505	(29.8)	1855	(32.1)	3360	(31.0)
Fula	1053	(20.9)	1195	(20.7)	2248	(20.7)
Wolof	731	(14.5)	865	(15.0)	1596	(14.7)
Jola	374	(7.4)	513	(8.9)	887	(8.2)
Sarahule	284	(5.6)	349	(6.0)	633	(5.8)
Serere	240	(4.8)	274	(4.7)	514	(4.7)
Others	291	(5.8)	326	(5.6)	617	(5.7)
Not stated	572	(11.3)	409	(7.1)	981	(9.1)
Number of living children:						
0	1577	(31.2)	6	(0.1)	1583	(16.9)
1	444	(8.8)	724	(16.8)	1168	(12.5)
2	406	(8.0)	740	(17.2)	1146	(12.2)
3	382	(7.6)	674	(5.6)	1056	(11.3)
4	387	(7.7)	601	(13.9)	988	(10.6)
5	303	(6.0)	514	(12.0)	817	(8.7)
6 and above	1120	(22.2)	786	(18.2)	1906	(20.4)
Not stated	431	(8.5)	264	(6.1)	695	(7.4)

* includes only 18-19 years for males

3.3 Education level of survey population

There has been a notable improvement in education in The Gambia since the inauguration of the AFPRC government in 1994. However, the majority of the survey respondents (58 percent of males, 66 percent of females) had attained no formal education (Table 2). In general, men are more likely to attend school and to reach higher levels of education than women; 28 percent of men attended secondary or higher school, compared with 20 percent of women. This assessment is based on the formal western type of education system. There is a special type of formal education in Arabic called Madrassa practised by some communities in The Gambia, but could not easily be assessed by this survey.

Table 2: Selected socio-economic characteristics of the survey population

Characteristic	Male		Female		Total	
	Number	(percent)	Number	(percent)	Number	(percent)
Education level attained:	2912	(57.7)	3803	(65.7)	6715	(62.0)
No education	445	(8.8)	614	(10.6)	1059	(9.8)
Primary	1051	(20.8)	1007	(17.4)	2058	(19.0)
Secondary	359	(7.1)	153	(2.6)	512	(4.7)
Post-secondary	285	(5.7)	209	(3.6)	494	(4.6)
<i>Not stated</i>						
Religion:	4622	(91.5)	5426	(93.8)	10048	(92.7)
Islam	188	(3.7)	221	(3.8)	409	(3.8)
Christianity	6	(0.1)	6	(0.1)	12	(0.1)
Traditional/animist	1	(0.0)	-----		1	(0.0)
Others	233	(5.0)	133	(2.3)	366	(3.4)
Occupation:	1140	(22.6)	2558	(44.2)	3698	(34.1)
Unemployed	1695	(33.6)	2170	(37.5)	3865	(35.7)
Farmers	579	(11.5)	507	(8.8)	1086	(10.0)
Service & market sales	715	(14.2)	152	(2.6)	867	(8.0)
Professionals,	199	(3.9)	61	(1.1)	260	(2.4)
technicians	206	(4.1)	68	(1.2)	274	(2.5)
Craft & related trade	268	(5.3)	122	(2.1)	390	(3.6)
Unskilled workers	248	(4.9)	148	(2.6)	396	(3.7)
Others not classified						
<i>Not stated</i>						
Local government area:	387	(7.7)	354	(6.1)	741	(6.8)
Banjul	1069	(21.2)	1107	(19.1)	2176	(20.1)
Kanifing	987	(19.5)	1266	(21.9)	2253	(20.8)
Brikama	245	(4.9)	396	(6.8)	641	(5.9)
Mansakonko	970	(19.2)	1034	(17.9)	2004	(18.5)
Kerewan	339	(6.7)	343	(5.9)	682	(6.3)
Kuntaur	413	(8.2)	504	(8.7)	917	(8.5)
Janjanbureh	640	(12.7)	782	(13.5)	1422	(13.1)
Basse						
Residence:	2865	(56.7)	3400	(58.8)	6265	(57.8)
Rural	2185	(43.3)	2385	(41.2)	4570	(42.2)
Urban	-----		1	(0.0)	1	(0.0)
<i>Not stated</i>						
Type of settlement:	1740	(34.5)	2132	(36.9)	3872	(35.7)
PHC	1712	(33.9)	1836	(31.7)	3548	(32.7)
Non-PHC	1576	(31.2)	1809	(31.3)	3385	(31.2)
Urban	22	(0.4)	9	(0.2)	31	(0.3)
<i>Not stated</i>						
Health division:						

Western Division	2385	(47.2)	2689	(46.5)	5074	(46.8)
Lower River Division	253	(5.0)	396	(6.8)	649	(6.0)
North Bank West	473	(9.4)	504	(8.7)	977	(9.0)
North Bank East	515	(10.2)	558	(9.6)	1073	(9.9)
Central River Division	787	(15.6)	857	(14.8)	1644	(15.2)
Upper River Division	635	(12.6)	779	(13.5)	1414	(13.0)
Not stated	2	(0.0)	3	(0.1)	5	(0.0)

3.4 Employment status and occupation

Occupation was categorised in six groups consistent with The Gambian Central Statistics System for easy comparison with data from other surveys. According to Table 2, over a third of the survey population were unemployed, nearly 70 percent of them women. Among those employed, the main occupation was peasant agriculture. About 34 percent of the men and 38 percent of the women were farmers. The other occupations included service and market sales (10 percent), professional and technical work (8 percent), unskilled work (3 percent), craft and related trade (2 percent) and other work not classified elsewhere (4 percent).

CHAPTER 4: CONTRACEPTION

The information provided by The Maternal Mortality, Contraceptive Prevalence and Fertility Determinant Study (2001) on contraception is of great significance to the efforts in addressing sexual and reproductive health issues in The Gambia. Firstly, the information will assist us in measuring reproductive health programme performance from 1990 to date; secondly, indicators on contraception can be formulated using current data; and given the emergence of HIV/AIDS, knowledge, attitude and practice on contraception particularly condoms by young people would be invaluable in the various HIV/AIDS interventions.

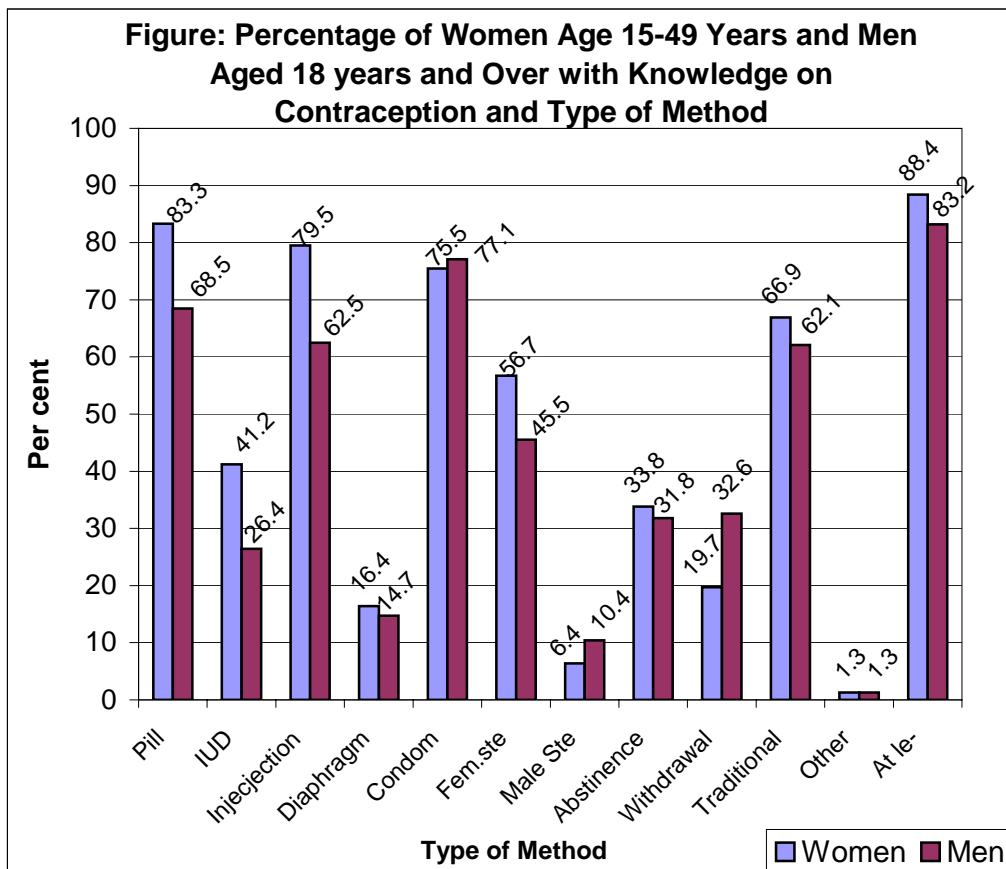
Knowledge on contraception and where to obtain them are crucial elements in the decision of whether to adopt a contraceptive method and the choice of which method to use. A positive attitude towards family planning is an additional prerequisite for use. Data collected in this survey on contraceptive knowledge, attitudes and sources are presented in this chapter. While the focus is placed on women, some results from the men's questionnaire will also be presented, since men play an important role in the realisation of reproductive health goals. The chapter also discusses knowledge, attitude and practice according to selected background characteristics

4.1 Knowledge of family planning methods

The question "Have You Ever Heard of (METHOD)" is used to elicit information on knowledge on contraception. Respondents affirm all the methods they knew spontaneously. For the methods not answered spontaneously, a probing method was used by which a brief description of the methods were made to ascertain if they knew the method or not. For every known method, whether spontaneous or probed, respondents were asked whether they ever used the method.

The percentage of All Women, 15-49 years, Married women, 15-49 knowing a contraceptive method by age, specific method and residence is presented in Table 3.

As shown by the table, knowledge on family planning method is extremely high with 92.3 per cent of currently married and 88.4 per cent of All women knowing at least one method of family planning. With the method type, 84.2% ever heard of a modern method whilst 75.7 ever heard of a Traditional method.

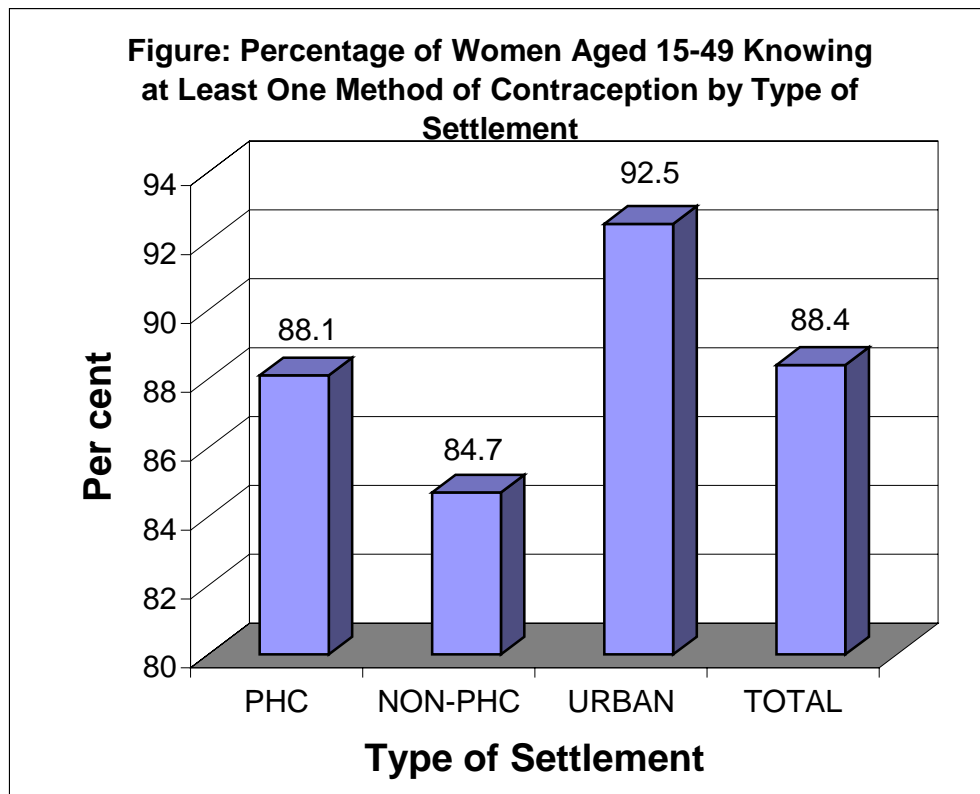


Percentage of All Men 18 years and over knowing a contraceptive method by age and specific method is presented in table 3. As the table shows, knowledge on contraception among men is relatively lower with 83.2 per cent knowing at least one method of contraception compared to 88.4 per cent for All Women. On the other hand, knowledge on contraception is higher for both married men and women when compared to those unmarried. As can be seen in tables 3 and 4,

knowledge level increases to 92.3% and 85.4% for married women and men respectively. Given that men tend to be better exposed than women, their lower knowledge level compared to women can partly be attributed to the fact that by and large, men tend to regard reproduction as the responsibility of women and have not recognize fully their conjugal responsibilities in promoting reproductive health at the family level.

With the method mix, Knowledge on pill is highest among all the categories of women. 87 per cent of All married women have heard of a pill, followed by Injectables (84.6), Condoms (76.0), Traditional method – juju (72.9) per cent whilst the least known method is Male sterilization.

Regarding knowledge by selected background characteristics, Table 3 further shows that knowledge on contraception increases with age. As can be seen from the table, knowledge peaks at 35-39 years and starts declining from age 40 years. This trend is observed for All Married Women and All Women.



Regarding knowledge on specific contraceptive method by men, table 4 shows that Condoms is better known by men followed by Pills. Interestingly, male sterilization is the least known method. As is the case with the females, knowledge level increases with age, peaking at age group 35-39 years and then declines. This is probably due to the generation gap which invariably, will lead to varying levels of exposure to family planning information and services.

Regarding urban and rural differentials, among women knowledge of family planning is higher among urban married women (93.0) as compared to urban married women (91.2)..On the other hand, knowledge on contraception is higher among rural married men (86.5%) than urban married men (83.6%) as shown in table 4. This can be due to the intensive reproductive health and family planning activities being implemented at the community level which could have led to more awareness creation among rural married men compared to their urban counterparts.

In contrast the knowledge gap between urban and rural married women has narrowed down between 1990 to date. In the 1990, GCPFDS, the difference in knowledge between urban and rural was about 16 per cent whilst this current study puts it at (1.8 per cent). The high knowledge of contraception among women both rural and urban areas can be largely attributed to the innovative approaches and the renewed vigour given to the provision of reproductive health information and services targeting women in the country.

Table 3: Percentage of all women (15-49) and of married women (15-49) knowing a contraceptive method, by age, specific method and residence, MCH 2001.

Age	Pill	IUD	Injection	Diaphragm	Condom	Fem. steril.	Male steril.	Abstinence	Withdrawal	Tradition	Other	At least one	Count
ALL WOMEN													
15-19	69.3	21.5	64.4	10.2	71.9	35.3	4.4	25.5	11.6	51.0	1.4	79.9	1,067
20-24	86.4	42.4	81.2	18.6	81.3	57.6	6.9	36.5	21.0	67.7	1.4	91.4	1,131
25-29	89.7	48.2	86.3	18.3	82.4	62.8	7.6	37.4	23.2	73.1	1.7	94.0	1,190
30-34	89.1	49.6	86.5	21.3	77.5	67.2	7.5	37.7	22.8	74.3	1.2	90.9	816
35-39	91.4	50.6	88.5	16.2	77.8	66.2	6.2	36.7	21.5	74.3	1.5	94.9	711
40-49	88.8	45.4	85.0	16.5	69.3	66.1	6.4	34.4	22.4	74.9	.8	93.3	732
NS.	7.2	1.4	5.8	.7	5.0	2.2	-	1.4	-	5.8	-	7.2	139
Total	83.3	41.2	79.5	16.4	75.5	56.7	6.4	33.8	19.7	66.9	1.3	88.4	5,786
ALL MARRIED WOMEN													
15-19	74.8	19.7	71.9	8.4	67.4	40.3	2.9	24.8	12.9	60.0	1.6	85.2	310
20-24	87.0	40.5	83.2	15.3	78.4	60.3	5.8	36.1	18.9	71.4	1.7	91.7	760
25-29	89.4	46.0	86.5	16.6	81.5	63.0	5.8	35.6	21.8	73.5	1.8	94.1	1,022
30-34	88.4	47.6	85.9	19.7	75.5	67.1	6.9	36.5	20.3	74.8	1.0	90.1	715
35-39	91.1	48.6	87.9	15.3	77.0	65.8	6.2	36.6	20.9	74.3	1.5	94.9	661
40-49	88.6	45.0	84.8	15.4	68.4	66.1	6.0	33.7	22.4	75.8	.9	93.5	664
NS.	87.5	25.0	87.5	12.5	75.0	37.5	-	12.5	-	87.5	-	87.5	8
Total	87.8	43.5	84.6	15.9	76.0	62.4	5.8	34.9	20.3	72.9	1.4	92.3	4,140
ALL MARRIED WOMEN OF URBAN AREAS													
15-19	3.6	.4	2.2	.4	3.1	-	-	9.8	.4	6.3	-	90.2	224
20-24	10.6	.8	6.2	.6	5.2	-	.2	17.2	2.4	8.6	-	91.8	500
25-29	17.2	.6	11.9	.6	4.0	.2	.2	17.8	1.8	10.2	-	93.9	628
30-34	18.7	1.1	16.3	-	3.0	1.1	-	16.8	.9	11.2	.2	91.2	465
35-39	16.7	1.2	20.0	1.4	2.6	1.9	.2	21.2	1.7	12.0	.2	94.6	424
40-49	14.4	1.9	15.8	-	.7	2.8	-	14.9	2.1	9.2	-	94.6	423
NS.	-	-	25.0	-	-	-	-	-	-	-	-	100.0	4
Total	14.5	1.0	12.7	.5	3.2	1.0	.1	16.9	1.6	9.9	.1	93.0	2,668
ALL MARRIED WOMEN OF RURAL AREAS													
15-19	12.8	-	1.2	-	9.3	-	-	1.2	-	2.3	-	72.1	86
20-24	20.0	2.3	5.8	1.9	11.2	-	-	6.2	1.9	10.0	.8	91.5	260
25-29	29.7	4.8	9.1	2.0	8.6	.3	.3	8.4	2.5	8.6	1.3	94.4	394
30-34	36.0	10.4	15.2	2.4	10.8	.8	-	9.2	4.4	10.0	.8	88.0	250
35-39	35.0	8.4	19.8	.4	6.3	1.3	.8	8.0	2.1	12.2	-	95.4	237
40-49	33.2	12.9	23.2	1.2	5.0	5.8	.4	8.3	2.1	13.3	.4	91.7	241
NS.	25.0	-	-	-	-	-	-	-	-	-	-	75.0	4
Total	29.5	6.9	13.1	1.6	8.5	1.4	.3	7.6	2.4	10.1	.7	91.2	1,472

Table 4: Percentage of all men 18 years + and of married men 18 years + knowing a contraceptive method, by age, specific method and residence, MCH 2001.

Age	Pill	IUD	Injec- tion	Diap- hram	Con- dom	Fem.ste -rilitn.	Male steril.	Abst- inence	With- drawal.	Tradi tion	Other	At le- ast one	Count
ALL MEN													
15-19	61.9	15.7	56.1	9.6	85.3	30.4	7.4	22.8	20.8	43.3	.6	84.6	312
20-24	70.4	25.4	61.3	16.0	87.9	41.2	9.1	31.6	33.5	53.6	2.0	92.6	692
25-29	75.5	32.0	67.2	22.3	86.0	45.4	14.4	34.1	41.8	60.9	2.0	94.0	665
30-34	78.0	39.7	75.5	24.5	91.2	54.1	15.5	37.3	45.4	70.3	1.0	93.1	592
35-39	79.3	33.9	71.9	19.6	87.2	50.9	13.7	35.0	38.9	67.8	1.7	96.1	540
40-49	77.9	32.3	72.9	14.7	84.2	57.2	13.0	36.5	35.4	71.2	1.2	91.5	855
NS.	51.8	14.6	47.0	5.6	51.3	38.3	4.6	26.5	20.9	59.9	1.0	58.8	1,399
Total	68.5	26.4	62.5	14.7	77.1	45.5	10.4	31.8	32.6	62.1	1.3	83.2	5,055
ALL MARRIED MEN													
15-19	81.8	36.4	81.8	18.2	90.9	27.3	18.2	36.4	27.3	54.5	-	100.0	11
20-24	82.3	27.8	74.7	3.8	87.3	50.6	3.8	39.2	26.6	60.8	-	100.0	79
25-29	79.8	28.8	73.2	18.7	84.0	45.1	12.5	33.9	36.6	66.9	2.3	97.3	257
30-34	77.9	38.9	76.9	23.1	91.4	55.9	14.0	35.4	43.1	74.4	1.2	90.0	429
35-39	80.6	33.6	72.8	19.1	87.8	53.5	14.1	35.0	37.8	70.5	1.6	95.4	434
40-49	78.1	32.5	73.3	14.4	84.1	58.1	12.5	36.4	34.8	72.0	1.1	91.4	799
NS.	62.5	17.4	56.5	6.5	61.7	46.1	5.2	31.3	24.7	72.5	1.3	70.4	1,086
Total	73.2	27.9	67.9	13.6	77.9	51.6	10.2	34.2	32.7	71.5	1.3	85.4	3,095
ALL MARRIED MEN OR URBAN AREAS													
15-19	100.0	50.0	100.0	25.0	100.0	25.0	25.0	75.0	50.0	50.0	-	100.0	4
20-24	77.8	38.9	77.8	11.1	94.4	66.7	5.6	72.2	61.1	55.6	-	100.0	18
25-29	68.4	36.7	62.2	25.5	83.7	41.8	14.3	36.7	50.0	62.2	2.0	86.7	98
30-34	72.6	42.2	70.4	27.4	94.3	50.4	17.8	38.3	54.8	69.1	1.3	86.5	230
35-39	71.4	37.7	62.3	23.6	88.4	48.7	16.1	36.7	44.2	61.8	1.0	89.9	199
40-49	74.1	40.3	69.3	22.4	90.9	52.8	17.6	38.9	48.6	68.5	2.0	86.9	352
NS.	60.2	24.6	53.1	11.0	68.6	41.4	10.0	32.7	38.2	69.6	1.6	70.2	309
Total	69.5	36.0	63.9	20.7	85.0	48.0	15.0	37.3	46.7	67.0	1.6	83.6	1,210
ALL MARRIED MEN OF RURAL AREAS													
15-19	71.4	28.6	71.4	14.3	85.7	28.6	14.3	14.3	14.3	57.1	-	85.7	7
20-24	83.6	24.6	73.8	1.6	85.2	45.9	3.3	29.5	16.4	62.3	-	100.0	61
25-29	86.8	23.9	79.9	14.5	84.3	47.2	11.3	32.1	28.3	69.8	2.5	100.0	159
30-34	83.9	35.2	84.4	18.1	87.9	62.3	9.5	32.2	29.6	80.4	1.0	94.0	199
35-39	88.5	30.2	81.7	15.3	87.2	57.4	12.3	33.6	32.3	77.9	2.1	100.0	235
40-49	81.2	26.4	76.5	8.1	78.7	62.2	8.5	34.5	23.9	74.7	.4	94.9	447
NS.	63.4	14.5	57.9	4.8	58.9	48.0	3.3	30.8	19.3	73.6	1.2	70.5	777
Total	75.6	22.7	70.5	9.0	73.3	53.8	7.1	32.1	23.8	74.4	1.2	86.5	1,885

Knowledge on contraception by PHC status is presented in Table 5. For All Married women and ALL Women, the table shows that knowledge on contraception is higher in PHC than non-PHC villages. The proportion of Married women who knew at least a method of contraception in the PHC and non-PHC villages are 93% and 91.2% respectively. The proportions for All Women and All Married Women are 88.1% and 84.7% respectively.

Table5: Percentage of all women (15-49) and of married women (15-49) knowing a contraceptive method, by specific method and PHC settlement, MCH, 2001.

PHC settlement	Pill	IUD	Injection	Diaphragm	Condom	Fem. steril.	Male steril.	Abstinence	Withdrawal	Traditional	Other	At least one	Count
ALL WOMEN													
PHC	82.6	33.5	79.9	9.8	69.8	58.5	4.3	36.7	15.5	70.6	1.0	88.1	2,133
Non-PHC	79.3	36.6	75.4	17.6	72.2	53.4	6.7	30.1	15.5	61.1	1.6	84.7	1,835
Urban	88.2	54.6	82.9	22.9	85.4	58.0	8.5	34.1	29.0	68.4	1.5	92.5	1,809
NS	88.9	77.8	88.9	22.2	88.9	55.6	11.1	22.2	11.1	55.6	-	88.9	9
Total	83.3	41.2	79.5	16.4	75.5	56.7	6.4	33.8	19.7	66.9	1.3	88.4	5,786
ALL MARRIED WOMEN													
PHC	88.2	37.4	85.6	9.9	72.1	64.2	3.9	39.8	16.8	76.2	1.0	93.0	1,635
Non-PHC	85.5	37.9	82.0	15.9	73.0	59.3	6.2	30.7	14.5	68.2	1.7	91.2	1,335
Urban	89.9	58.2	86.2	24.2	84.8	63.5	8.1	32.8	31.7	73.6	1.7	92.6	1,163
NS	100.0	85.7	100.0	14.3	100.0	57.1	14.3	28.6	14.3	57.1	-	100.0	7
Total	87.8	43.5	84.6	15.9	76.0	62.4	5.8	34.9	20.3	72.9	1.4	92.3	4,140
ALL MARRIED WOMEN OF URBAN AREAS													
PHC	25.2	4.9	11.0	1.2	5.5	-	.6	9.8	3.1	11.0	-	90.8	163
Non-PHC	35.7	9.1	12.8	1.1	9.9	1.1	.3	5.1	1.1	9.3	.8	88.5	375
Urban	27.6	6.4	13.4	1.8	8.5	1.7	.2	8.3	2.9	10.1	.8	92.3	931
NS	66.7	-	66.7	-	-	-	-	-	-	33.3	-	100.0	3
Total	29.5	6.9	13.1	1.6	8.5	1.4	.3	7.6	2.4	10.1	.7	91.2	1,472
ALL MARRIED WOMEN OF RURAL AREAS													
PHC	13.9	1.0	13.3	.1	2.2	.9	.1	19.4	1.1	9.4	.1	93.3	1,472
Non-PHC	13.0	.4	12.2	.3	1.8	1.0	.2	14.6	.5	9.5	.1	92.2	960
Urban	25.0	3.4	11.2	3.9	15.9	1.3	-	10.8	9.9	14.7	-	94.0	232
NS	-	-	25.0	-	-	-	-	-	-	-	-	100.0	4
Total	14.5	1.0	12.7	.5	3.2	1.0	.1	16.9	1.6	9.9	.1	93.0	2,668

4.2 Ever Use of family Planning methods

Women and men interviewed in the survey who said that they have heard of a method of family planning were asked if they had ever used it. Ever use of family planning methods thus refers to use of a method at any time whether presently or in the past. Table 6 and 7 show the percentage of All Women (15-49), All married Women (15-49) and Men 18 years and over who have ever use contraception by age, specific method and residence.

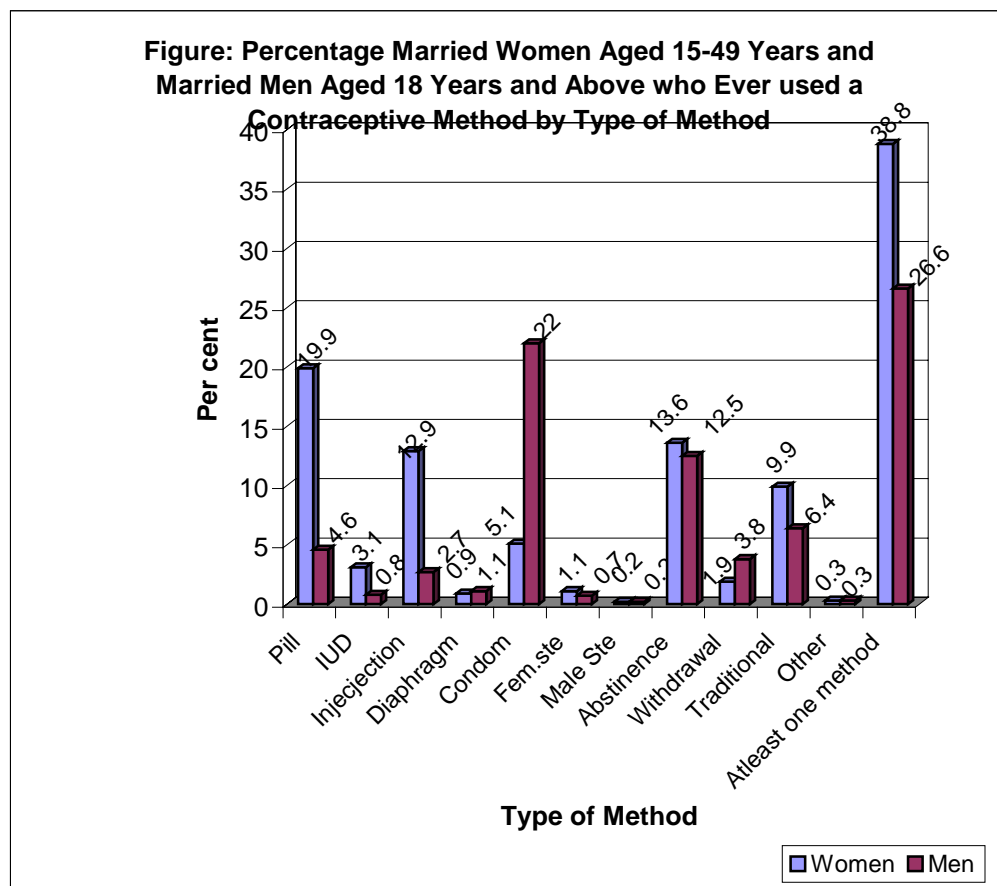


Table 6 Percentage of all women (15-49) and currently married women (5-49) who have ever used a contraceptive method, by age, specific method and residence, MCH, 2001

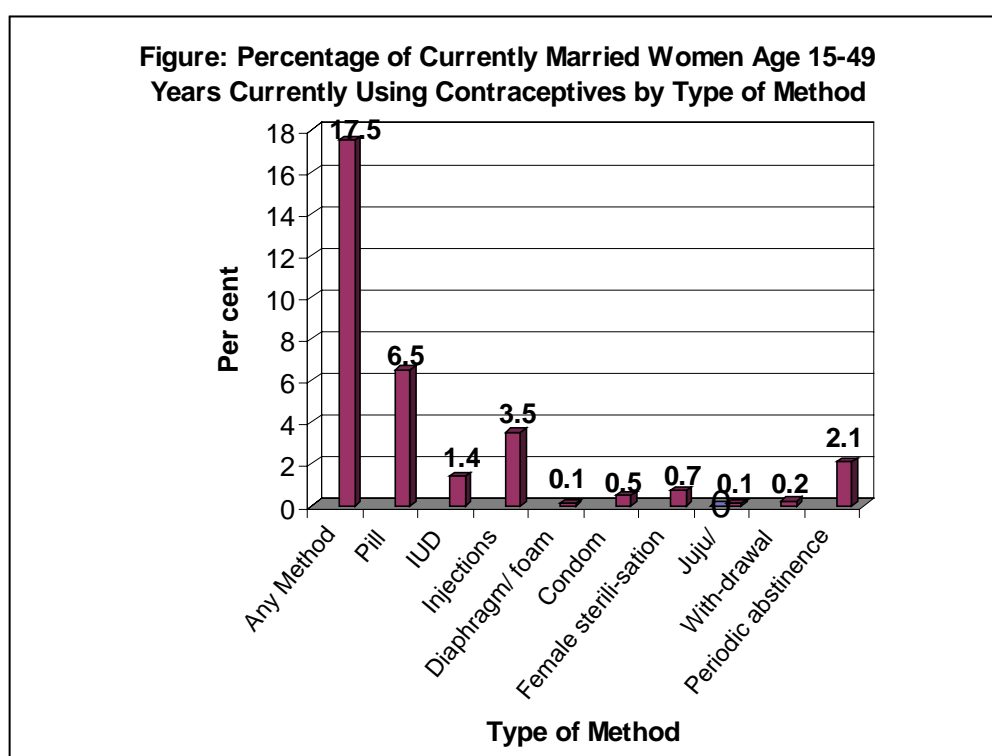
Age	Pill	IUD	Injec- tion	Diap- hragm	Con- dom	Fem.ste -rilitn.	Male steril.	Abst- inence	With- drawal.	Tradi tion	Other	At le- ast one	Count
ALL WOMEN													
15-19	3.2	.5	1.0	.5	5.1	.2	.1	3.6	.7	3.1	.1	5.5	1,067
20-24	12.2	1.2	5.4	1.1	8.1	.1	.2	10.0	2.2	7.6	.2	20.8	1,131
25-29	22.4	2.5	10.6	1.4	7.0	.2	.2	13.1	1.8	9.2	.4	40.7	1,190
30-34	26.2	4.5	16.7	1.2	7.8	.9	-	13.5	3.1	11.2	.6	54.5	816
35-39	24.9	4.4	20.3	1.0	4.1	1.7	.4	15.8	2.0	12.1	.1	49.9	711
40-49	21.7	5.9	18.9	.8	2.3	3.8	.1	12.3	2.0	10.8	.1	47.0	732
NS.	.7	-	.7	-	-	-	-	-	-	-	-	.7	139
Total	17.1	2.8	10.7	1.0	5.9	.9	.2	10.7	1.9	8.4	.3	33.2	5,786
ALL MARRIED WOMEN													
15-19	6.1	.3	1.9	.3	4.8	-	-	7.4	.3	5.2	-	8.4	310
20-24	13.8	1.3	6.1	1.1	7.2	-	.1	13.4	2.2	9.1	.3	24.1	760
25-29	22.0	2.3	10.9	1.2	5.8	.2	.2	14.2	2.1	9.6	.5	39.8	1,022
30-34	24.8	4.3	15.9	.8	5.7	1.0	-	14.1	2.1	10.8	.4	50.3	715
35-39	23.3	3.8	20.0	1.1	3.9	1.7	.5	16.5	1.8	12.1	.2	47.7	661
40-49	21.2	5.9	18.5	.5	2.3	3.9	.2	12.5	2.1	10.7	.2	47.1	664
NS.	12.5	-	12.5	-	-	-	-	-	-	-	-	12.5	8
Total	19.9	3.1	12.9	.9	5.1	1.1	.2	13.6	1.9	9.9	.3	38.8	4,140
ALL MARRIED WOMEN OF URBAN AREA													
15-19	12.8	-	1.2	-	9.3	-	-	1.2	-	2.3	-	17.4	86
20-24	20.0	2.3	5.8	1.9	11.2	-	-	6.2	1.9	10.0	.8	31.2	260
25-29	29.7	4.8	9.1	2.0	8.6	.3	.3	8.4	2.5	8.6	1.3	50.0	394
30-34	36.0	10.4	15.2	2.4	10.8	.8	-	9.2	4.4	10.0	.8	72.8	250
35-39	35.0	8.4	19.8	.4	6.3	1.3	.8	8.0	2.1	12.2	-	65.0	237
40-49	33.2	12.9	23.2	1.2	5.0	5.8	.4	8.3	2.1	13.3	.4	73.0	241
NS.	25.0	-	-	-	-	-	-	-	-	-	-	25.0	4
Total	29.5	6.9	13.1	1.6	8.5	1.4	.3	7.6	2.4	10.1	.7	54.8	1,472
ALL MARRIED WOMEN OF RURAL AREA													
15-19	3.6	.4	2.2	.4	3.1	-	-	9.8	.4	6.3	-	4.9	224
20-24	10.6	.8	6.2	.6	5.2	-	.2	17.2	2.4	8.6	-	20.4	500
25-29	17.2	.6	11.9	.6	4.0	.2	.2	17.8	1.8	10.2	-	33.4	628
30-34	18.7	1.1	16.3	-	3.0	1.1	-	16.8	.9	11.2	.2	38.3	465
35-39	16.7	1.2	20.0	1.4	2.6	1.9	.2	21.2	1.7	12.0	.2	38.0	424
40-49	14.4	1.9	15.8	-	.7	2.8	-	14.9	2.1	9.2	-	32.4	423
NS.	-	-	25.0	-	-	-	-	-	-	-	-	-	4
Total	14.5	1.0	12.7	.5	3.2	1.0	.1	16.9	1.6	9.9	.1	29.9	2,668

Table 7: Percentage of all men 18 years + and currently married men 18 years + who have ever used a contraceptive method, by age, specific method and residence, MCH, 2001

Age	Pill	IUD	Injec- tion	Diap- hragm	Con- dom	Fem.ste -rilitn.	Male steril.	Abst- inence	With- drawal.	Tradi tion	Other	At le- ast one	Count
ALL MEN													
17-19	.3	-	.3	.3	28.2	-	-	.3	1.9	1.0	-	28.5	312
20-24	1.0	.3	.4	.7	41.6	.3	-	1.7	4.8	.7	.1	42.6	692
25-29	1.7	.5	1.1	1.1	48.7	.3	-	4.4	6.2	1.4	-	50.4	665
30-34	5.1	.3	2.5	2.4	46.3	.2	.3	8.6	6.3	3.5	.2	51.4	592
35-39	5.9	.7	3.5	1.7	34.8	.6	.2	10.4	6.3	5.6	-	40.7	540
40-49	6.7	1.2	3.9	.8	24.6	.7	.2	12.5	4.3	6.0	.4	31.1	855
50+	2.4	.6	1.6	.3	6.0	1.0	.1	12.2	2.4	7.2	.3	8.4	1,399
Total	3.4	.6	2.0	.9	28.8	.6	.1	8.4	4.4	4.4	.2	32.2	5,055
ALL MARRIED MEN													
17-19	-	-	-	-	27.3	-	-	-	-	-	-	27.3	11
20-24	1.3	1.3	-	-	27.8	-	-	6.3	1.3	2.5	-	29.1	79
25-29	2.3	.4	1.2	1.6	34.6	.4	-	8.6	4.7	2.3	-	37.0	257
30-34	6.3	.2	3.0	2.8	41.3	-	.2	10.5	4.7	4.0	.2	47.6	429
35-39	6.0	.9	3.7	1.6	30.4	.5	.2	11.1	4.8	6.5	-	36.4	434
40-49	6.8	1.3	4.0	.9	23.5	.8	.3	13.1	4.1	6.4	.4	30.2	799
50+	2.7	.8	1.9	.3	6.5	1.1	.1	14.8	2.8	8.7	.4	9.2	1,086
Total	4.6	.8	2.7	1.1	22.0	.7	.2	12.5	3.8	6.4	.3	26.6	3,095
ALL MARRIED MEN URBAN													
17-19	-	-	-	-	25.0	-	-	-	-	-	-	25.0	4
20-24	5.6	5.6	-	-	44.4	-	-	11.1	5.6	5.6	-	50.0	18
25-29	1.0	-	1.0	1.0	43.9	1.0	-	6.1	7.1	2.0	-	44.9	98
30-34	7.0	.4	1.3	3.5	50.9	-	.4	9.1	5.7	3.9	.4	57.8	230
35-39	5.0	1.5	2.5	2.0	43.7	1.0	-	7.0	7.5	4.5	-	48.7	199
40-49	7.7	2.3	2.6	.9	34.9	.6	.6	9.1	7.4	4.5	.9	42.3	352
50+	4.2	1.9	1.3	.6	12.3	1.0	.3	10.7	4.5	10.7	.6	16.5	309
Total	5.6	1.6	1.8	1.5	34.5	.7	.3	8.9	6.3	5.8	.5	40.0	1,210
ALL MARRIED MEN RURAL													
17-19	-	-	-	-	28.6	-	-	-	-	-	-	28.6	7
20-24	-	-	-	-	23.0	-	-	4.9	-	1.6	-	23.0	61
25-29	3.1	.6	1.3	1.9	28.9	-	-	10.1	3.1	2.5	-	32.1	159
30-34	5.5	-	5.0	2.0	30.2	-	-	12.1	3.5	4.0	-	35.7	199
35-39	6.8	.4	4.7	1.3	19.1	-	.4	14.5	2.6	8.1	-	26.0	235
40-49	6.0	.4	5.1	.9	14.5	.9	-	16.3	1.6	7.8	-	20.6	447
50+	2.1	.4	2.2	.1	4.2	1.2	-	16.5	2.1	7.9	.3	6.3	777
Total	4.0	.4	3.3	.8	14.1	.7	.1	14.7	2.2	6.8	.1	18.0	1,885

.According to table 6, 38.6 per cent of currently married women have ever used a contraceptive method. With the method mix, 27.6% and 21.2 have ever used a modern and traditional method respectively. For the urban rural differentials, 54.8 per cent and 29.9 per cent of All married women have ever used a method in the urban and rural areas respectively.

Regarding method use by All Women, the pill is reported highest (19.9%) followed by injection (12.9%), condom (5.1%) and the least reported modern method is male sterilization.(0.2%). Among the traditional methods, periodic abstinence is reported highest (10.7%) followed by withdrawal (1.9%). The same trend can be observed in the table for urban and rural married women.



The table further indicates that Ever use of contraception increases with increases in age for both categories of women up to age 30-34 when it starts declining with further increases in age cohorts.

By contrast, Ever used of family planning among All men 18 years and over as shown in table 7 is 32.2 per cent which is one per cent lower than the Ever Used of method by All Women. Whilst Pills and Abstinence reported highest for Ever Used by women, Condoms and Abstinence were reported highest by men (29.8

and 8.4 respectively). The method least used by men as shown by the table is male sterilization. Ever Used of family planning by men also increases with age up to 30-34 years when it starts declining. By comparing tables 6 and 7, it can be noted that Ever Use of contraception is higher for All men (32.2%) compared to All married men (26.6), whilst Ever use of contraception is higher among married women than All women. This can be attributed to the high prevalence of condom use among single men as can be deduced from table 7. The table further shows that condom use among married men is quite low implying that most condom use is geared towards prevention of sexually transmitted infections. And as expected, condom use is higher in urban areas than rural areas for both men and women be they married or not.

4.4 Current use of family planning methods and contraceptive prevalence

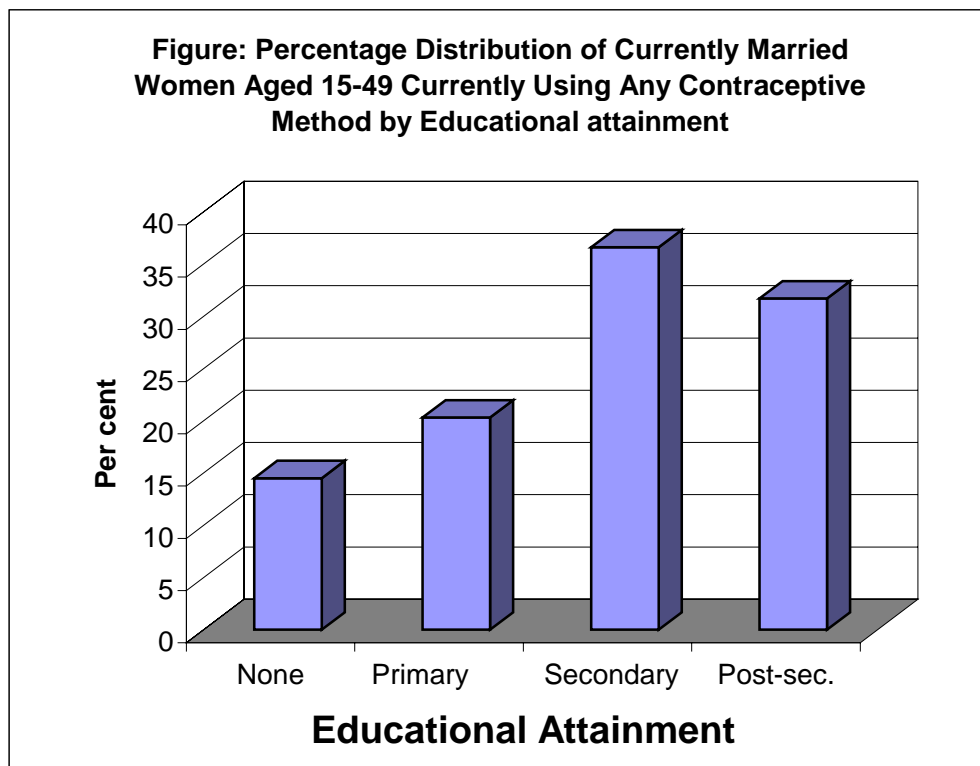
The level of current use of family planning is one of the indicators most frequently used to assess the success of family planning programme activities. It is also widely used in the analysis of the determinants of fertility. This section focuses on the levels and differentials in family planning use among population sub-groups with particular emphasis on the method mix among users.

The contraceptive prevalence rate (CPR) – the percentage of currently married women who are currently using a method of family planning --- is estimated at 17.5 percent. Three quarters of the current users are using a modern method. The CPR for modern methods is 13.4 percent, while 2.4 percent and 1.6 percent of currently married women are using traditional and other methods respectively (Table 8).

The most popular methods are the pill, injections and periodic abstinence, which are each currently used by at least 2 percent of married women. Less than 1 percent of married women have been sterilised. Family planning use rises with age from 7 percent among married women aged 15-19 to a peak of 21) percent among those aged 35-39, after which it falls to 12 percent among women 45-49 years. This trend is similar when considering use of modern contraceptive methods only.

Table 8 further demonstrates that some women are much more likely to be using contraception than others. Urban (**married**) women are more likely to be using contraceptive methods (20 percent) than rural women (17 percent). Surprisingly, contraceptive prevalence is lowest in PHC villages (15 percent). There are large differentials in current contraceptive use by level of education. Fifteen percent of currently married women with no formal education are currently using a method, compared with 20 percent with some primary education, and 34 percent of those

with secondary or post-secondary education. The differentials are higher for modern method use.

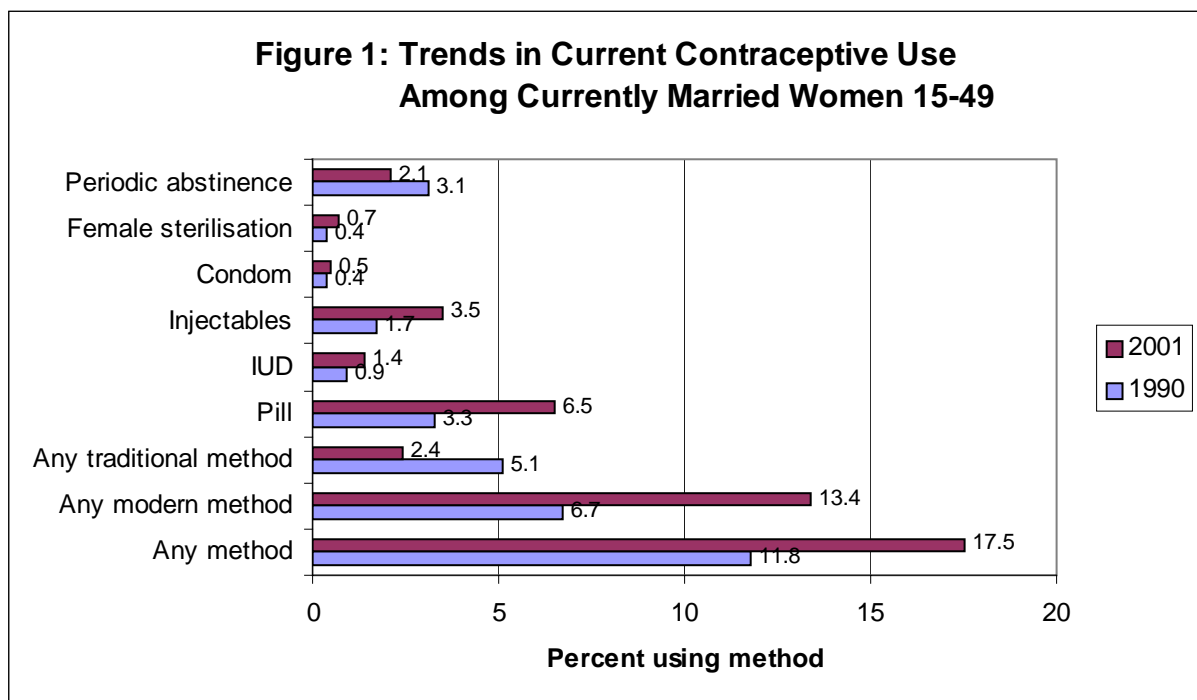


Contraceptive use rises with the number of living children. It is expected that once individuals or couples achieve their reproductive goals, they would be sufficiently motivated to use a family planning method. The percentage of currently married women using any method increases from 13 percent among women with one child to 20 percent among those with three or more children. From this data, it is probably true that few women in The Gambia begin to adopt contraception seriously until after they have had several children, perhaps so as to be sure of their survival. Due to the few responses to the question: “how many children did you have just before you started using family planning?”, it is rather difficult to confirm this result since the differences are not significant enough.

Based on the results from the 1990 Gambian Contraceptive Prevalence and Fertility Determinants Survey, the contraceptive prevalence rate in The Gambia has only increased slightly over the past decade, rising from 12 percent in 1990

to 17.5 percent in 2001 (Figure 1). The results not only show the overall increase, but also document the changes that have occurred with the method mix. Contraceptive prevalence for modern methods has increased faster than overall prevalence, from 6.7 percent in 1990 to 13.4 percent in 2001, a fifty percent increase. Methods with have increased fastest are the pill and injectables. On the other hand, use of traditional methods reduced by half during the same period, from 5.1 percent in 1990 to 2.4 percent in 2001. A clear interpretation of this result could be that Gambian women are continuously abandoning their traditional practises and adopting modern ways of fertility regulation, a success story for the national family planning programme.

In contrast, current use of family planning among All men is 20.9 per cent slightly higher (3 per cent) than that of All women. This is due largely by an upsurge in condom use. Thirty four per cent of males 25-29 years are currently using a condom. In GCPFDS, 1990, condom use constitute 8.4 per cent of the method mix compared to 16.6 per cent observed by this study. Abstinence on the other



hand, is the second highest (2.1) in terms of current use. The same scenario was observed in the 1990 GCPFDS.

It should however be noted that even though condoms can prevent pregnancy, most men use condom to prevent Sexually transmitted infections (STIs) (as shown above) and would not use them if there were better methods in the prevention of STIs

Regarding current use by age differentials, condom being the dominant method is predominantly used by the young people between 15 and 29 years old. This particular age group is vulnerable to societal ills including teenage pregnancy, unsafe abortion, STI infection etc and high levels of condom use among them would make a significant contribution to the efforts in addressing sexual and reproductive health problems of young people including HIV/AIDS.

Table 8: Percentage of all men 18 years and over, currently using a contraceptive method, by age and specific method, MCH 2001.

Age	Pill	IUD	Injec- tion	con- dom	Diaph- ragm	Fem.ste -rilitn.	Male steril.	Abst- inence	With- drawal.	Foam- tablet	Tradi -tion	other Atle ast one	Count
ALL MEN													
15-19	-	-	-	19.6	-	-	-	.3	.3	-	.3	-	312
20-24	.4	-	.4	32.9	-	-	-	.6	.3	.1	.1	-	692
25-29	1.5	.2	.3	34.4	-	-	-	1.4	.2	-	-	.2	655
30-34	3.9	.5	1.5	24.0	-	-	-	2.0	.3	-	.7	.5	592
35-39	3.5	-	2.8	15.4	-	-	-	3.5	.4	-	1.9	-	538
40-49	4.1	1.1	2.3	8.9	.1	.5	-	4.3	-	-	1.6	.5	855
NS.	1.2	.1	.9	1.7	-	.6	-	2.7	.1	-	.9	-	1,394
Total	2.1	.3	1.2	16.6	-	.3	-	2.4	.2	-	.9	.2	5,038
ALL MARRIED MEN													
15-19	-	-	-	-	-	-	-	-	-	-	-	-	11
20-24	-	-	1.3	12.7	-	-	-	1.3	-	-	-	-	79
25-29	2.3	.4	.4	13.7	-	-	-	2.7	.4	-	-	-	256
30-34	4.9	.7	1.9	16.6	-	-	-	2.6	.2	-	.9	.7	429
35-39	3.9	-	2.8	11.8	-	-	-	4.4	.5	-	2.1	-	433
40-49	4.0	1.1	2.4	7.8	.1	.5	-	4.6	-	-	1.8	.3	799
NS.	1.2	.1	1.2	1.6	-	.8	-	3.5	.2	-	1.2	-	1,088
Total	2.9	.5	1.7	7.9	-	.4	-	3.7	.2	-	1.3	.2	3,095
ALL MARRIED MEN OF URBAN AREAS													
15-19	-	-	-	-	-	-	-	-	-	-	-	-	4
20-24	-	-	-	16.7	-	-	-	-	-	-	-	-	18
25-29	4.1	1.0	1.0	17.5	-	-	-	1.0	-	-	-	-	97
30-34	5.7	1.3	1.7	20.9	-	-	-	2.2	.4	-	1.7	1.3	230
35-39	4.5	-	2.5	17.2	-	-	-	3.5	1.0	-	.5	-	198
40-49	6.0	2.3	1.7	14.5	.3	.3	-	1.7	-	-	.9	.3	352
NS.	2.9	.3	1.0	3.2	-	1.6	-	1.6	.6	-	1.0	-	311
Total	4.6	1.1	1.6	13.5	.1	.5	-	2.0	.4	-	.9	.3	1,210
ALL MARRIED MEN OF RURAL AREAS													
15-19	-	-	-	-	-	-	-	-	-	-	-	-	7
20-24	-	-	1.6	11.5	-	-	-	1.6	-	-	-	-	61
25-29	1.3	-	-	11.3	-	-	-	3.8	.6	-	-	-	159
30-34	4.0	-	2.0	11.6	-	-	-	3.0	-	-	-	-	199
35-39	3.4	-	3.0	7.2	-	-	-	5.1	-	-	3.4	-	235
40-49	2.5	.2	2.9	2.5	-	.7	-	6.9	-	-	2.5	.2	447
NS.	.5	-	1.3	.9	-	.5	-	4.2	-	-	1.3	-	777
Total	1.8	.1	1.9	4.4	-	.4	-	4.7	.1	-	1.5	.1	1,885

Table 9: Percent distribution of currently married women by contraceptive method currently used, according to selected background characteristics.

Characteristic	Any method	Contraceptive method									Not currently using	Number of women
		Pill	IUD	Injections	Diaphragm/foam	Condom	Female sterilisation	Juju/herbs	Withdrawal	Periodic abstinence		
Age												
15-19	6.9	2.9	0.3	0.0	0.3	0.0	0.0	0.0	0.0	2.3	93.1	306
20-24	17.4	7.1	0.7	1.5	0.0	0.9	0.0	0.3	0.1	3.4	82.7	747
25-29	17.8	7.5	1.6	2.7	0.1	0.5	0.1	0.2	0.3	2.2	82.5	998
30-34	19.6	7.4	2.0	4.4	0.1	1.0	0.4	0.0	0.3	1.7	80.5	703
35-39	21.0	7.6	1.4	6.0	0.0	0.3	0.9	0.0	0.2	2.0	79.2	649
40-44	18.9	4.9	2.4	5.9	0.0	0.2	2.8	0.2	0.0	0.7	80.9	425
45-49	11.5	1.3	1.3	3.1	0.0	0.0	3.6	0.0	0.4	0.9	88.5	226
Total	17.5	6.5	1.4	3.5	0.1	0.5	0.7	0.1	0.2	2.1	82.6	4,054
Type of settlement												
PHC	14.8	3.9	1.1	3.2	0.0	0.3	0.6	0.2	0.1	2.7	85.5	1,605
Non-PHC	18.9	8.0	1.5	3.8	0.1	0.8	0.5	0.0	0.1	1.8	81.2	1,302
Urban	19.5	8.3	1.8	3.3	0.2	0.7	1.3	0.2	0.4	1.5	80.4	1,140
Education level												
None												
Primary	14.5	4.5	0.7	3.0	0.0	0.4	0.8	0.1	0.2	2.1	85.7	3,157
Secondary	20.3	10.9	1.5	4.1	0.0	1.0	0.0	0.2	0.0	1.5	79.7	414
Post-sec.	36.6	16.4	6.6	5.0	0.5	1.9	0.8	0.5	0.5	2.7	63.2	378
	31.7	11.7	3.3	10.0	0.0	0.0	0.0	0.0	0.0	3.3	68.3	60
No. of living children												
1	13.1	5.8	1.1	0.7	0.2	0.7	0.2	0.5	0.0	1.8	87.0	571
2	21.7	9.6	1.9	2.2	0.2	1.1	0.3	0.2	0.0	3.3	78.3	635
3+	19.9	6.7	1.6	5.2	0.0	0.4	1.1	0.1	0.3	2.1	80.2	2,369
Parity at first use of FP												
0	33.3	17.1	4.6	4.0	0.0	0.0	0.7	0.0	0.0	0.7	67.1	152
1	37.9	10.8	1.6	4.8	0.0	1.2	0.7	0.5	0.5	9.6	62.6	564
2	34.8	17.0	2.2	7.1	0.6	1.1	1.1	0.0	0.6	2.2	64.8	182
3+	36.7	11.4	3.2	14.5	0.0	0.0	3.9	0.0	0.7	1.1	63.1	282

4.5 Source of family planning information

In order to assess the effectiveness of dissemination of family planning information, all male and female respondents in the survey were asked about how they first heard about family planning and from which source they got most of the information. This was complemented by questions to reflect the most recent source of family planning: "In the last 6 months, have you heard or witnessed a programme about family planning? If yes, what was your source of information?"

The data from this survey indicate that the most prominent source of family planning information is the radio, reported by over 60 percent of all men and women interviewed. This was followed by the television, mainly by urban dwellers and clinical or community health workers reported mainly by rural respondents. Age of the respondents was not a determining factor, but education level attained reflected how one would receive family planning information. Apart from the radio, the more educated respondents tended to receive most of the family planning information from the television compared to the less educated whose biggest source were health workers. This trend is clearer when Western Division health district (mostly urban) is compared to the other mostly rural divisions.

Tables 10 and 11 present the distribution of women and men by source of family planning messages in the six months preceding the interview. There is more exposure of men than women to family planning messages on both radio and television. Eighty-seven percent of the men and 75 percent of the women reported that they had heard or seen a family planning message on radio or television in the previous six months. Radio is by far the most prominent of the two media; only 14 percent of either women or men had seen a family planning message on television in the previous six months and almost all of them were from Western Division health district (urban).

Table 10: Percent distribution of women by source of family planning messages in the 6 months prior to the interview, according to selected background characteristics.

Background characteristic	Heard about family planning in last 6 months by/on:										Total
	Number of women	Radio	T.V	Newspaper	Posters	Health worker/ Clinic	Community health worker/CBD	Traditional communica-tors	Other	Can't remember/ don't know	
Age											
<20	341	61.6	14.7	0.0	0.3	6.7	6.5	0.6	7.9	1.8	100.0
20-34	1,369	59.8	14.2	0.2	0.2	12.9	7.7	0.8	1.5	2.9	100.0
35+	629	64.7	11.6	0.2	0.0	11.8	7.0	1.8	1.0	1.9	100.0
Type of settlement											
PHC	862	61.9	3.3	0.1	0.0	15.4	11.7	1.8	2.1	3.7	100.0
Non-PHC	676	55.6	18.9	0.0	0.2	12.7	7.5	1.2	0.9	0.1	100.0
Urban	797	65.6	20.1	0.3	0.3	6.9	2.3	0.1	3.6	0.0	100.0
Education level											
None	1,519	66.2	7.2	0.1	0.0	14.0	8.1	1.2	0.8	2.5	100.0
Primary	264	64.0	12.5	0.0	0.4	9.1	8.3	0.8	1.5	3.4	100.0
Secondary	442	46.6	31.9	0.2	0.2	7.5	3.9	0.2	7.2	2.3	100.0
Post-sec.	68	32.4	42.7	1.5	1.5	4.4	7.4	1.5	7.4	1.5	100.0
Ethnicity											
Mandinka	833	62.8	9.8	0.0	0.0	12.5	8.3	1.1	2.6	2.9	100.0
Fula	442	67.2	10.2	0.0	0.2	9.5	8.1	1.4	1.1	2.3	100.0
Wolof	355	56.3	18.0	0.6	0.3	11.0	9.9	1.7	1.1	1.1	100.0
Jola	207	68.6	14.0	0.5	0.5	9.7	2.4	0.5	1.5	2.2	100.0
Sarahule	125	54.4	9.6	0.0	0.0	21.6	4.8	0.8	1.6	7.2	100.0
Serere	132	47.7	25.0	0.0	0.0	7.6	9.1	0.8	8.3	1.5	100.0
Others	122	56.6	20.5	0.0	0.0	13.1	4.9	0.0	2.5	2.5	100.0
Residence:											
Rural	1,230	65.2	2.6	0.1	0.1	15.3	10.2	1.8	1.5	3.3	100.0
Urban	1,109	57.1	25.7	0.2	0.2	7.8	4.2	0.2	3.1	1.7	100.0
Health district:											
Western Division	1,167	58.8	24.6	0.1	0.1	8.1	2.8	0.3	3.3	2.1	100.0
Lower River Div.	181	70.2	0.6	0.0	0.0	16.0	7.2	0.6	2.2	3.3	100.0
North Bank West	169	58.0	7.7	0.0	0.6	8.9	17.2	2.4	3.0	2.4	100.0
North Bank East	276	65.6	1.1	0.4	0.4	9.1	18.8	1.8	1.1	1.8	100.0
Central River Div	273	61.5	3.7	0.4	0.0	17.6	9.9	2.2	1.1	3.7	100.0
Upper River Div.	273	64.1	1.1	0.0	0.0	23.1	6.2	1.8	0.0	3.7	100.0

Table 11: Percent distribution of men by source of family planning messages in the 6 months prior to the interview, according to selected background characteristics.

Background characteristic	Heard about family planning in last 6 months by/on:										Total
	Number of men	Radio	T.V	Newspaper	Posters	Health worker/ Clinic	Community health worker/CBD	Traditional communicators	Other	Can't remember/ don't know	
Age											
<20	101	58.4	15.8	0.0	0.0	5.0	7.9	2.0	5.0	5.9	100.0
20-34	829	67.1	17.3	0.2	0.6	3.5	5.1	0.1	2.5	3.4	100.0
35+	555	77.7	13.7	0.4	0.4	1.6	3.4	0.4	0.7	1.4	100.0
Type of settlement											
PHC	615	79.0	4.4	0.3	0.2	3.7	6.7	0.8	2.0	2.9	100.0
Non-PHC	535	69.9	16.6	0.0	0.2	3.4	5.6	0.6	0.9	2.8	100.0
Urban	634	68.5	21.5	0.3	1.0	1.7	1.3	0.2	2.8	2.8	100.0
Education level											
None	946	81.5	6.3	0.0	0.1	2.8	3.7	0.6	2.0	3.0	100.0
Primary	157	75.8	7.0	1.3	0.0	4.5	6.4	0.0	1.9	3.2	100.0
Secondary	500	63.4	22.2	0.4	0.6	3.4	5.0	0.6	1.6	2.8	100.0
Post-sec.	166	46.4	40.4	0.0	2.4	1.2	3.6	0.0	3.0	3.0	100.0
Ethnicity											
Mandinka	577	74.4	13.3	0.2	0.5	2.4	3.1	0.4	2.8	2.9	100.0
Fula	362	75.7	11.6	0.3	0.0	2.8	4.4	1.4	1.9	1.9	100.0
Wolof	291	67.0	17.2	0.3	0.3	2.4	5.8	0.7	2.4	3.8	100.0
Jola	141	74.5	12.1	0.0	0.0	5.0	1.4	0.0	2.8	4.3	100.0
Sarahule	113	85.0	3.5	0.0	0.9	4.4	3.5	0.0	0.0	2.7	100.0
Serere	97	60.8	14.4	0.0	0.0	6.2	13.4	0.0	0.0	4.1	100.0
Others	105	61.9	30.5	0.0	0.0	1.9	2.9	0.0	1.0	1.9	100.0
Residence:											
Rural	874	81.7	2.5	0.2	0.7	2.1	2.4	0.1	2.0	3.4	100.0
Urban	919	62.7	26.4	0.2	0.2	3.7	6.3	0.9	2.1	2.4	100.0
Health district:											
Western Division	901	65.2	24.8	0.3	0.7	2.2	1.2	0.2	2.2	3.2	100.0
Lower River Div.	84	91.7	0.0	0.0	0.0	2.4	1.2	0.0	4.8	0.0	100.0
North Bank West	152	70.4	5.3	0.7	0.0	4.0	18.4	0.0	0.0	1.3	100.0
North Bank East	183	76.5	6.6	0.0	0.0	1.6	10.9	0.6	1.6	2.2	100.0
Central River Div	232	78.9	3.5	0.0	0.7	4.7	3.5	2.2	3.9	2.5	100.0
Upper River Div.	241	85.1	1.2	0.0	0.0	4.2	4.6	0.4	0.0	4.6	100.0

4.6 Source of family planning methods

Data on the source of modern family planning methods is useful for programme managers and implementers. In this survey, women and men who reported knowing or having heard about a contraceptive method were asked where they would obtain the method. Tables 12 and 13 show that in urban centres, 82 percent of women and 71 percent would obtain their methods from public medical sources. Government hospitals and health centres are the most common sources of contraceptive methods. Private medical sources are reported by 18 percent of urban women and 26 percent of men. On the other hand, 83 percent of female and 80 percent of male rural dwellers report obtaining their modern methods from public medical sources. Data show inaccessibility of private medical sources in rural areas from where only between 7 and 9 percent of the respondents report obtaining their methods. Community-based distributors appear more common in rural areas as compared to urban centres. On average, 11 percent of rural residents obtain their methods from community-based distributors as compared to less than 3 percent of urban dwellers.

The distribution of public medical sources between rural and urban men and women is almost similar and highest for any consideration. Private medical sources vary considerably between rural and urban settings. Less than half of rural women obtain methods from private medical sources compared to their urban counterparts; similarly, rural men's private sources account for about a third when compared to their urban counterparts. As noted earlier, community-based sources are most common in rural areas. Rural women who obtain modern methods from community-based health workers are about ten times those resident in urban centres and similarly, more than thrice of rural men obtain modern methods from community-based health workers as compared to urban men.

Table 12: Percent distribution of female respondents who have ever heard about family planning by sources of methods, according to residence and specific contraceptive method.

Source	Pill	IUD	Injections	Diaphragm/ foam	Condom	Female sterili- sation	Male sterili- sation	All modern methods
URBAN								
Medical public	82.3	82.1	84.4	73.2	72.3	92.9	84.5	81.7
Govt. hospital	20.1	21.9	21.2	18.6	17.1	64.7	64.5	27.4
Govt. health centre	53.9	50.0	54.3	46.4	49.4	24.1	18.0	46.9
MCH clinic	8.3	10.2	8.9	8.2	5.8	4.1	2.0	7.4
	16.9	17.4	14.9	26.1	26.7	6.7	11.0	17.5
Medical private	1.3	1.5	1.0	0.9	1.4	0.8	0.0	1.2
Private hospital	4.4	2.4	2.8	8.4	14.8	0.7	2.0	5.5
Pharmacy	0.0	0.0	0.1	0.4	0.5	0.1	0.0	0.1
Religious body GFPA clinic	11.2	13.5	11.0	16.4	10.0	5.1	9.0	10.7
Community- based workers	1.0	0.5	0.8	1.0	1.1	0.4	4.5	0.8
GFPA CBD	0.3	0.3	0.4	0.6	0.4	0.1	0.0	0.3
Government CBD	0.1	0.0	0.1	0.0	0.2	0.0	0.0	0.1
GFPA field worker	0.3	0.1	0.1	0.2	0.2	0.1	0.5	0.2
TBA/VHW VHS/CHN	0.2	0.1	0.1	0.0	0.2	0.2	0.5	0.1
	0.1	0.0	0.1	0.2	0.1	0.0	3.5	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RURAL								
Medical public	80.7	86.3	84.9	67.9	71.4	97.2	91.3	82.9
Govt. hospital	9.0	17.3	9.8	9.3	7.2	75.3	82.6	21.7
Govt. health centre	61.5	56.7	64.1	40.1	55.0	20.1	6.1	52.1
MCH clinic	10.2	12.3	11.0	18.5	9.2	1.8	2.6	9.1
	5.9	5.4	5.6	11.6	13.1	0.8	0.9	6.5
Medical private	1.5	1.2	1.5	0.3	1.2	0.1	0.0	1.1
Private hospital	1.2	0.8	1.3	6.5	6.7	0.3	0.0	2.3
Pharmacy	0.0	0.0	0.0	0.0	0.4	0.1	0.0	0.1
Religious body GFPA clinic	3.2	3.4	2.8	4.8	4.8	0.3	0.9	3.0
Community- based workers	13.4	8.4	9.5	20.7	15.5	2.1	7.8	10.6
GFPA CBD	5.9	3.6	4.0	9.3	6.8	0.6	2.6	4.6
Government CBD	0.6	0.4	0.5	1.4	0.8	0.6	2.6	0.6
GFPA field worker	2.2	2.0	1.8	2.4	1.9	0.3	0.0	1.7
TBA/VHW VHS/CHN	1.7	0.1	0.2	0.7	2.7	0.3	0.9	1.1
	3.0	2.3	3.0	6.9	3.3	0.3	1.7	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 13: Percent distribution of male respondents who have ever heard about family planning by sources of methods, according to residence and specific contraceptive method.

Source	Pill	IUD	Injections	Diaphragm / foam	Condom	Female sterilisation	Male sterilisation	All modern methods
URBAN								
Medical public	77.5	73.7	79.2	66.5	49.0	90.9	85.8	71.2
Govt. hospital	23.7	22.1	26.7	17.9	15.0	70.8	65.9	29.6
Govt. health centre	50.3	47.0	49.4	44.7	31.3	19.3	18.4	38.7
MCH clinic	3.5	4.6	3.1	3.9	2.7	0.8	1.5	2.9
Medical private	20.2	24.3	18.7	31.4	46.2	7.6	11.3	26.0
Private hospital	0.9	0.9	0.7	1.0	1.4	0.2	0.8	0.9
Pharmacy	5.5	4.5	5.0	9.4	34.6	1.4	1.9	12.7
Religious body	0.1	0.0	0.1	0.2	0.2	0.1	0.0	0.1
GFPA clinic	13.7	18.9	12.9	20.8	10.0	5.9	8.6	12.3
Community-based workers	2.4	2.0	2.2	2.2	4.9	1.5	3.1	2.8
GFPA CBD	0.5	0.3	0.7	1.0	0.7	0.5	0.8	0.6
Government CBD	0.5	0.3	0.3	0.5	1.2	0.1	0.0	0.5
GFPA field worker	0.1	0.0	0.0	0.0	0.1	0.0	0.4	0.1
TBA/VHW	0.7	1.1	0.5	0.7	2.3	0.5	0.8	1.1
VHS/CHN	0.6	0.3	0.7	0.0	0.6	0.4	1.1	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RURAL								
Medical public	79.8	85.0	85.8	64.0	63.4	97.0	96.8	80.2
Govt. hospital	9.0	16.2	12.5	13.0	6.0	78.3	77.8	22.5
Govt. health centre	63.2	55.8	64.9	36.5	50.2	17.1	17.7	50.5
MCH clinic	7.6	13.0	8.4	14.5	7.2	1.6	1.3	7.2
Medical private	7.0	6.7	5.7	18.0	19.7	0.5	0.0	9.0
Private hospital	1.5	0.8	1.2	1.0	0.9	0.2	0.0	1.0
Pharmacy	2.1	0.6	1.4	8.0	11.9	0.0	0.0	4.1
Religious body	0.1	0.0	0.0	0.0	0.4	0.1	0.0	0.1
GFPA clinic	3.3	5.3	3.1	9.0	6.5	0.2	0.0	3.8
Community-based workers	13.2	8.3	8.6	18.0	16.9	2.6	3.4	10.9
GFPA CBD	7.8	4.3	5.1	10.5	8.2	0.9	2.0	5.8
Government CBD	2.2	1.6	1.9	3.5	3.8	0.4	0.7	2.2
GFPA field worker	1.4	0.0	0.1	0.5	1.4	0.2	0.0	0.7
TBA/VHW	0.9	0.6	0.6	1.0	2.8	0.3	0.0	1.2
VHS/CHN	0.9	1.8	0.9	2.5	0.7	0.8	0.7	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

4.7 Reasons for non-use

Table 14 presents the main reasons for not using family planning given by currently married non-users. The desire for more children was the most common reason for non-use among both women (27 percent) and men (29 percent). Breast feeding among the women (12 percent) and religion among the men (19 percent) were also key factors for non-use. For both sexes, lack of knowledge on family planning was a contributing factor for not using contraception.

Table 14: Percent distribution of currently married women and men who are not currently using a contraceptive method, by main reason for non-use, according to age.

Reason for not using contraception	Women			Men		
	Age			Age		
	<30	30-49	Total	<30	30+	Total
Wants children	29.7	23.8	26.8	33.8	28.7	29.3
Side effects	0.6	1.7	1.1	0.4	0.5	0.5
Health concerns	1.7	2.7	2.2	0.0	0.9	0.8
Fatalistic	0.1	0.6	0.3	0.0	0.1	0.0
Fear of sterility	0.6	0.6	0.6	0.0	0.5	0.4
Too young	5.0	0.3	2.7	9.8	0.5	1.6
Sexually inactive	0.4	1.9	1.1	1.1	2.3	2.1
Currently pregnant	11.4	5.8	8.7	4.7	2.8	3.0
Lack of knowledge	8.5	9.7	9.0	12.0	12.0	12.0
Hard to get methods	0.1	0.7	0.4	0.7	0.8	0.8
Cost too much	0.1	0.4	0.2	0.4	0.3	0.3
Partner opposed	6.3	6.5	6.4	0.7	1.1	1.0
Respondent opposed	3.0	3.9	3.4	8.4	9.5	9.4
Religion	3.2	4.3	3.8	7.3	20.8	19.2
Other people opposed	0.1	0.3	0.2	0.0	0.1	0.1
Infrequent sex	0.5	1.1	0.8	0.7	0.8	0.8
Menopausal/hysterectomy	0.2	4.1	2.1	0.4	0.9	0.8
Breast feeding/period not returned	15.2	9.2	12.3	7.6	4.9	5.2
Difficult to get pregnant	1.4	5.5	3.4	0.4	1.2	1.1
Inconvenient	1.9	1.8	1.8	1.5	2.7	2.6
Other	6.2	9.0	7.6	10.2	8.7	8.9
Don't know	4.0	6.2	5.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women/men	1,726	1,624	3,350	275	2,043	2,318

During the survey, respondents who were currently not using family planning were asked whether they intended to use it in future. Table 15 presents the main reasons for not using family planning given by currently married non-users who never intended to use contraception in future. Male responses were classified in broad categories to get a general picture while more detailed answers were obtained from female respondents. Again among women, the desire for more children was the most common reason (26 percent) why they never intended to use contraception, followed by opposition to family planning by partner (11 percent), lack of knowledge (11 percent) and religion (9 percent). Seven percent of female non-users who do not intend to use in future completely oppose family planning use.

Table 15: Percent distribution of currently married women and men who are not using a contraceptive method and do not intend to use in the future, by main reason for non-use, according to age.

Reason for not using contraception	Women			Men		
	Age			Age		
	<30	30-49	Total	<30	30-49	Total
Wants children	36.8	19.6	26.4	29.5	18.6	19.4
Side effects	0.7	2.7	1.9			
Other health concerns	4.4	4.5	4.5	1.9	3.0	2.9
Fatalistic	0.2	1.0	0.7			
Fear of sterility	1.3	0.7	0.9			
Lack of knowledge	9.8	11.0	10.6	--N/A--	--N/A--	--N/A--
Hard to get methods	0.4	0.4	0.4			
Cost too much	0.2	0.4	0.3			
Partner opposed	13.1	8.9	10.6	1.0	1.4	1.3
Respondent opposed	8.0	6.5	7.1	25.7	23.0	23.1
Religion	9.7	8.9	9.2	27.6	38.3	37.5
Other people opposed	0.7	0.6	0.7			
Infrequent sex	0.2	1.2	0.8			
Menopausal/hysterectomy	0.2	6.9	4.2	--N/A--	--N/A--	--N/A--
Difficult to get pregnant	1.3	8.1	5.4			
Inconvenient	3.3	2.8	3.0			
Other	6.4	11.3	9.3			
Don't know	3.5	4.7	4.2	14.3	15.8	15.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women/men	549	844	1,393	105	1,245	1,350

Younger women are more likely than older women to cite desire for more children and opposition by partner as the main reasons for not intending to use family planning. Other important reasons cited by female non-users 30 years and over are related to infecundity and menopause. The majority of the men cited opposition from other people (38 percent), religion (23 percent) and desire for more children (19 percent) as the main reasons for their lack on intention to use contraception in future.

4.8 Intention to use family planning and method preference

Respondents were asked whether or not they intended to use a method to delay or avoid pregnancy at any time in the future, irrespective of whether they were current users or non-users. Half of the women and 44 percent of the men said they were intending to use.

Among the female respondents who indicated intention to use contraception in future, 54 percent were intending to use a method within the next 12 months. Within this period, 36 percent of the women say they prefer to use the pill while 37 percent say they prefer injectables (Table16). These preferences were similar in all types of settlements, with PHC village residents indicating more preference for injectables while urban dwellers mostly prefer the pill. The less educated female respondents gave more preference to the injectables while the more educated preferred the pill. The higher the number of living children the higher the preference for injections to the pill. Little preference was given to other modern methods: IUD (5 percent), condom (4 percent) and female sterilisation (1 percent).

Among the traditional methods, periodic abstinence was preferred by 8 percent of the women who intended to use contraception within the next 12 months. Highest preference for periodic abstinence was given respondents from PHC villages (13 percent), especially those from the Lower River Division (43 percent).

Table 16: Percent distribution of women intending to use contraceptive methods within the next 12 months by preferred method, according to selected background characteristics.

Characteristic	Preferred contraceptive method										Number of women
	Pill	IUD	Injections	Diaphragm/foam	Condom	Female sterilisation	Norplant	Rhythm counting days	Periodic abstinence	Other	
Age											
15-19	37.3	1.5	30.6	0.0	9.7	0.0	0.8	0.8	9.7	8.2	134
20-24	44.8	2.2	31.2	0.0	4.4	0.6	0.3	0.0	9.5	5.4	317
25-29	39.2	4.7	36.6	0.8	3.4	0.3	0.5	0.3	7.4	5.5	380
30-34	31.3	5.8	40.7	0.4	2.9	0.0	0.4	0.0	8.2	9.1	243
35-39	25.9	6.9	44.8	0.9	1.7	3.5	0.0	0.0	5.6	7.8	232
40-44	33.7	7.0	43.0	0.0	1.2	4.7	0.0	0.0	3.5	5.8	86
45-49	28.6	3.6	42.9	0.0	0.0	7.1	0.0	0.0	0.0	14.3	28
Total	36.2	4.5	37.4	0.4	3.7	1.2	0.4	0.1	7.5	6.9	1,420
Type of settlement											
PHC	27.8	2.5	44.4	0.0	2.5	1.2	0.4	0.0	13.2	6.4	486
Non-PHC	37.5	5.8	39.0	0.4	2.8	1.3	0.0	0.0	5.8	6.2	467
Urban	43.5	5.4	28.5	0.9	5.8	1.1	0.7	0.4	3.5	8.2	464
Education level											
None											
Primary	29.9	2.6	43.5	0.1	2.1	1.5	0.3	0.0	10.0	8.3	917
Secondary	40.8	4.1	42.0	0.0		1.2	0.6	0.0	2.4	3.6	169
Post-sec.	55.3	10.9	17.3	1.1	4.1	0.0	0.4	0.8	1.9	4.1	266
	33.3	8.3	14.6	4.2	6.8	2.1	0.0	0.0	10.4	10.4	48
					12.5						
No. of living children											
1	45.7	3.4	25.7	1.1	5.1	0.0	1.1	0.0	7.4	7.4	175
2	46.5	4.7	30.9	0.8	2.7	0.0	0.0	0.4	8.2	5.5	256
3+	29.0	4.6	44.8	0.3	1.3	2.2	0.4	0.0	7.7	8.1	783
Health district											
Western Div.	46.5	7.6	27.4	0.6	5.1	1.1	0.4	0.3	2.5	7.3	727
Lower River Div	11.5	2.2	36.0	0.0	2.9	0.7	0.0	0.0	43.2	2.9	139
North Bank W.	29.4	1.5	55.2	0.7	0.0	0.7	1.5	0.0	0.0	9.6	136
North Bank E.	25.6	1.2	46.5	0.0	2.3	1.2	0.0	0.0	11.6	5.8	86
Central River	26.7	1.4	53.8	0.0	1.9	2.4	0.0	0.0	5.7	6.7	210
Upper River	33.9	0.0	44.6	0.8	4.1	0.8	0.0	0.0	5.8	7.4	121

4.9 Attitudes towards family planning

Effective and efficient use of contraceptive methods can easily be achievable when the users have a positive attitude towards family planning. In this survey, information on attitudes was collected by asking all men and women on what they thought about availing family planning information and services to young people, married or unmarried persons. On top of this, female respondents were further asked whether or not they approved of couples using a method to avoid pregnancy. Such information can be useful in the formulation of family planning policies as it indicates the extent to which further awareness is needed to increase acceptance of family planning. Disapproval of family planning by any community usually acts as a barrier to adoption of the methods.

Tables 17 and 18 present the general attitudes towards family planning by all women and men respectively. About two-thirds of both men and women agree that family planning services should be available to young people. Respondents in rural areas were more likely to approve availability of services to young people than urban dwellers, and more currently married women (74 percent) than married men (56 percent) were highly likely to give this approval. On the other hand, 91 percent and 82 percent of women and men respectively approve provision of family planning information to married persons. Approval of provision of family planning information to unmarried persons is low at about 60 percent by both men and women. Most of the positive attitude towards provision of family planning information and services was given by mid-aged respondents (30-35 years), however, disapproval increases with age among male respondents. In all comparisons, rural dwellers and those less educated seemed more likely to give more positive responses to all attitudinal issues addressed.

Among the female respondents, approval of contraceptive use in married couple was high at 81 percent. The majority of those who felt it good for couples to use

a method to avoid pregnancy were married (73 percent). At least 22 percent of single women also approve use of contraception by married couples.

Although both men and women in the same households were interviewed, it not possible to assess approval of family planning between married couples since the survey did not collect detailed information of marital relationships within the households. Similarly, married respondents were not asked whether they thought their spouses approved of family planning and therefore the survey missed the opportunity of examining the extent to which husbands and wives report accurately on their spouses' attitudes.

Table 17: Percent distribution of all women by general attitudes towards family planning, according to selected background characteristics

Characteristic	FP services should be available to young people		FP information should be available to married persons		FP information should be available to unmarried persons		Couples to use a method to avoid pregnancy	
	Yes	No	Yes	No	Yes	No	Approve	Disapprove
Age								
<20	15.4	20.8	17.3	17.9	15.9	19.7	16.8	26.2
20-35	57.8	54.0	56.7	52.2	57.6	54.4	57.0	48.6
36+	26.8	25.2	26.1	29.9	26.5	25.9	26.2	25.2
Total	64.8	35.2	91.1	8.9	59.2	40.8	80.8	19.2
Residence								
Urban	40.7	49.4	43.6	41.8	43.2	43.8	43.6	38.8
Rural	59.3	50.6	56.3	58.2	56.8	56.2	56.4	61.2
Marital status								
Single	21.1	25.6	23.0	19.9	22.9	23.1	22.5	26.2
Married	74.4	70.5	72.7	77.4	71.8	74.3	73.2	71.2
Living together	0.2	0.2	0.2	0.0	0.2	0.1	0.2	0.2
Widowed	2.2	2.0	2.2	1.6	2.6	1.5	2.1	1.4
Divorced	1.9	1.6	1.8	0.9	2.3	0.9	1.8	0.9
Separated	0.2	0.1	0.1	0.2	0.1	0.2	0.1	0.1
Education level								
None	66.0	67.2	66.1	75.8	64.8	69.7	66.4	76.0
Primary	12.2	9.8	11.3	11.2	12.2	9.9	11.4	9.2
Secondary	18.7	20.3	19.7	11.9	19.8	18.0	19.3	12.8
Post-sec.	3.0	2.8	3.0	1.1	3.1	2.5	2.9	2.0
Health district								
Western Division	48.7	51.1	49.0	44.0	50.2	44.8	49.3	42.1
Lower River Division	9.4	3.0	7.5	2.4	9.2	4.2	7.8	3.1
North Bank West	6.7	8.7	7.5	5.3	6.3	9.2	7.0	10.8
North Bank East	9.0	11.5	11.2	3.5	8.4	14.2	11.3	2.7
Central River Division	15.2	12.5	14.1	18.6	15.9	13.5	14.1	17.5
Upper River Division	11.2	13.2	10.6	26.1	10.0	14.0	10.5	23.8

Table 18: Percent distribution of all men by general attitudes towards family planning, according to selected background characteristics

Characteristic	FP services should be available to young people		FP information should be available to married persons		FP information should be available to unmarried persons	
	Yes	No	Yes	No	Yes	No
Age						
<20	7.4	4.3	6.3	6.3	7.5	4.8
20-35	50.2	32.2	46.5	30.5	51.7	31.8
36+	42.4	63.6	47.2	63.1	40.8	63.4
Total	63.6	36.4	81.7	18.3	59.6	40.4
Residence						
Urban	46.5	47.5	47.1	43.2	47.8	44.6
Rural	53.5	52.5	52.9	56.8	52.3	55.4
Marital status						
Single	42.6	24.3	38.3	24.9	43.9	24.5
Married	55.6	74.6	60.0	74.5	54.1	74.7
Living together	0.2	0.1	0.2	0.0	0.2	0.1
Widowed	0.2	0.5	0.3	0.3	0.3	0.3
Divorced	1.2	0.4	1.1	0.3	1.3	0.3
Separated	0.3	0.0	0.2	0.0	0.2	0.1
Education level						
None	50.0	71.5	54.2	75.5	49.0	70.7
Primary	10.2	7.2	9.5	8.2	10.5	7.6
Secondary	30.4	15.5	27.3	12.6	30.9	15.8
Post-sec.	9.3	5.9	9.0	3.8	9.7	5.8
Health district						
Western Division	50.5	49.1	49.6	46.9	51.8	44.6
Lower River Division	6.3	3.0	5.5	4.3	5.3	5.2
North Bank West	7.8	8.6	8.6	5.7	7.8	8.9
North Bank East	8.8	12.1	11.8	4.9	9.2	12.7
Central River Division	15.2	14.9	14.3	20.7	15.0	16.2
Upper River Division	11.3	12.4	10.3	17.6	10.9	12.4

CHAPTER 5: FERTILITY

The fertility preference of any society is a key determinant of fertility levels of that society. Previous studies including the 1990 GCPFDS indicate the prevalence of pronatalist tendencies in Gambian society. From these studies it was observed that education and socio-economic factors influence fertility preference. In this survey women were asked a question on their fertility preference. All women including those who had living children and those without were asked about their fertility preference.

In the absence of complete registration of vital events in The Gambia, estimates of fertility and mortality have traditionally relied on indirect estimation techniques using data from censuses and surveys. This survey collected data on births in the year preceding the survey and data on children ever born. Assessment of the quality of data showed that for the purpose estimating fertility, the data on births in the year preceding the survey have not been quite reliable. This is attributable to the possibility of births occurring out of the reference period being reported by respondents.

Estimates of fertility using children ever born have however been found to be of better quality and present reasonable estimates. Notwithstanding the relative reliability of such estimates, it is worth noting that research has shown that, in general, data from surveys and censuses have indicated the under-reporting of children ever born. This is often attributed to the omission of children who died shortly after birth. The fertility estimates presented in this report have been arrived at using data on children ever born.

In the recent past fertility levels in The Gambia have been, generally, high even when compared to other developing countries. This has been of concern to government as exemplified in the strategies mapped out in the National Population Programme to reduce fertility levels. Research on fertility differentials, in the past, has shown differences in levels across regions. For the purpose of planning, therefore, it would have been interesting to look at fertility differentials across health divisions.

The possibility of estimating fertility for each of the health regions was explored but due to the small number of cases in some of the regions an attempt at indirect estimation of fertility did not yield plausible results. In this chapter an attempt has been made to present findings on current fertility levels looking at urban-rural differentials across regions and educational attainment of women.

5.1 Fertility Preference

The fertility preference of any society can be regarded as a key determinant of fertility behaviour of that society. One of the objectives of this study, therefore, was to look at the fertility preference of the population of this country, focusing on women of reproductive age (15-49 years). During the data collection for this survey, women were asked questions on their desired number of children and the timing of having an additional child. Both women who had no living children and those with at least a living child were asked this question. In this section of the report an attempt would be made to examine the findings of the survey with respect to women in marital union at the time of the survey.

5.1.1 Fertility Preference and Urban/Rural Residence

All indications from the responses on desired number of children as shown by the data from this survey point to pro-natalist tendencies in Gambian society. From the tables on desired number of children (Tables 19 and 20) for urban and rural areas, it can be seen that more than half the women in marital union did not give a numerical response to the question. Most women have indicated 'as many as God wills', undecided/do not know or did not respond to the question. Even more striking is the fact that about a third of women reported that they would like to have as many children as God wills (ie 31.2 per cent in urban and 37.7 per cent in rural areas). This observation could be interpreted to imply that most women may not employ fertility regulation measures but would instead let their fertility take the natural course. This

assertion is even more apparent looking at the desire for children among high parity women.

For urban women with 7 or more children, for example, 29 per cent indicated that they would like to have as many children as God wills with comparative proportion among rural women being 38 per cent. Similarly, over 20 per cent of women with 7 or more children in both urban and rural areas would like to have 6 or more children.

Table 19: Percentage Distribution of Women (Currently in Marital Union) Resident in Urban Areas by Number of living Children and Number of Desired Children, 2001

Desired Number of Children	Number of Living Children								Total
	0	1	2	3	4	5	6	7 or more	
0	0.0	0.8	0.4	0.0	0.0	0.0	0.0	0.0	0.2
1	0.0	0.4	0.4	0.4	1.1	0.0	0.0	0.0	0.3
2	1.3	3.2	3.5	2.9	5.3	3.0	5.6	3.2	3.4
3	6.5	7.1	9.1	6.7	5.3	6.6	6.7	9.6	7.2
4	12.3	13.0	13.0	15.4	15.3	17.5	7.8	11.7	13.7
5	7.7	12.6	10.5	10.4	8.9	9.6	7.8	11.7	10.2
6 or more	20.0	13.4	15.8	15.0	17.4	16.9	17.8	21.3	16.5
As many as God wills	31.0	29.2	29.5	31.7	30.5	37.3	33.3	28.7	31.2
Undecided/DK	11.6	10.7	6.7	6.7	7.4	1.8	10.0	7.4	7.7
No Response	9.7	9.5	11.2	10.8	8.9	7.2	11.1	6.4	9.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

What has been observed in the findings on fertility preference in urban and rural areas should be of concern to those working in the population field. In view of the potential effects of urbanization on desired family size, a wider gap would have been expected in the desired number of children between urban and rural women. The findings of this survey, however, indicate only marginal differences in desired

number of children between urban and rural women with rural women desiring more children than their urban counterparts. This may explain the high levels of fertility being experienced in the country and calls for concerted efforts to change fertility behaviour in the country as a whole.

Table 20: Percentage Distribution of Women (Currently in Marital Union) Resident in Rural Areas by Number of living Children and Number of Desired Children, 2001

Desired Number of Children	Number of Living Children								Total
	0	1	2	3	4	5	6	7 or more	
0	0.0	0.0	0.0	0.0	0.5	0.3	0.0	0.3	0.1
1	0.3	0.0	0.3	0.5	0.5	0.3	0.0	0.6	0.3
2	1.6	1.5	1.9	1.6	2.4	0.9	2.8	0.6	1.6
3	1.9	0.9	4.3	3.4	1.9	3.4	0.8	3.2	2.5
4	2.5	7.4	7.9	6.0	7.0	6.2	8.7	5.1	6.3
5	5.4	7.4	4.3	7.3	9.4	7.1	4.3	5.7	6.5
6 or more	24.4	25.7	26.0	25.9	24.1	26.6	26.0	23.2	25.3
As many as God wills	44.4	38.2	37.4	35.1	33.0	35.9	39.0	40.8	37.7
Undecided/DK	10.8	11.5	10.0	11.3	10.2	12.1	8.3	11.1	10.7
No Response	8.6	7.4	7.9	8.9	11.0	7.1	10.2	9.2	8.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

5.1.2 Fertility Preference and Ethnicity

Previous research on fertility has shown differentials across ethnic groups. Such differences have been explained by variations in socio-cultural beliefs and practices and urban/rural residence. The table on ethnic differentials in desired number of children among women with no living child does not show much difference across the ethnicity groups (see Table 21). Although notable differences have been observed in the proportion of women reporting to desire 6 or more children and those desiring as many children as God wills, there are similarities in the combined proportion of women desiring 6 or more children and those who have no numerical response to the question on desired number of children. For all ethnic groups, under 10 per cent of women have been reported to desire less than 4 children. This may be indicative of pronatalist tendencies among all ethnic groups in The Gambia which goes further to explain the high fertility levels being experienced currently.

Table 21: Percentage Distribution of Women (Currently in Marital Union) who Have no Living Child by Ethnicity, Residence and Number of Desired Children, 2001.

Desired Number of Children	Ethnicity					Residence	
	Mandinka	Fula	Wolof	Jola	Sarahule	Urban	Rural
0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1	0.6	0.0	0.0	0.0	0.0	0.0	0.3
2	0.6	1.8	0.0	0.0	8.8	1.3	1.6
3	3.6	1.8	1.5	7.1	0.0	6.5	1.9
4	4.1	7.3	5.9	7.1	8.8	12.3	2.5
5	6.5	1.8	5.9	10.7	2.9	7.7	5.4
6 or more	23.1	24.5	16.2	32.1	17.6	20.0	24.4
As many as God wills	45.0	40.0	48.5	17.9	26.5	31.0	44.4
Undecided/DK	6.5	17.3	16.2	14.3	2.9	11.6	10.8
No Response	10.1	5.5	5.9	10.7	32.4	9.7	8.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

5.1.3 Fertility Preference and Educational Attainment

Findings on desired number of children discussed in the previous tables indicate general similarities in the desired number of children across population groups. Data on desired number of children among women with varying educational levels show that women with secondary level education and above desire, slightly, smaller number of children than those with no education or primary education (**see Table 22**). For example, whereas under 6 per cent of women with no education and those with primary education desire less than 4 children, the comparative proportion among women with secondary education and above is about 12 per cent. For those desiring as many children as God wills, about a third of women all women, irrespective of educational attainment, fell in this category. One can infer from this finding that although education has negative effect on desired number of children, this effect is limited.

Table 22: Percentage Distribution of Women (Currently in Marital Union) who Have no Living Child by Educational Attainment and Number of Desired Children, 2001			
Desired Number of Children	Educational Attainment		
	No Education	Primary	Secondary and Above
0	0.0	0.0	0.0
1	0.1	0.0	0.5
2	2.2	2.1	3.7
3	3.6	2.7	8.2
4	6.8	9.1	15.9
5	8.2	10.2	6.7
6 or more	20.0	19.3	17.7
As many as God wills	37.7	34.8	31.0
Undecided/DK	10.2	11.8	9.1
No Response	11.2	10.2	7.2
Total	100.0	100.0	100.0

In theory the desired number of children in any society is expected to translate into actual fertility behaviour of that population. This assertion may not necessarily hold in real life. In The Gambia socio-cultural beliefs surrounding fertility are such that a question on desired number of children may be answered with caution, especially where a numerical response is expected. In view of the fact that the majority of respondents in this survey indicated a non-numerical response to the question on desired number of children, one may conclude that women in this country may be doing very little to limit their number of children. Of concern in this finding is the fact that not much variation has been observed in the desired number of children across varying population groups.

Although no multivariate analysis has been undertaken with this data set to establish the relationship between fertility behaviour and preference, in view of the observed gap in fertility levels across women of varying socio-economic status, one can conclude that women of this country are, in general, pro-natalist. This can be seen in the high fertility levels observed even among women with secondary education and above. For fertility control programmes in The Gambia to be effective, there is need

for the populace to change their attitudes in the area of desired family size. In the absence of such a change in attitude the fertility levels being experienced in the country are likely to remain high for a long time.

5.2 FERTILITY LEVELS

Fertility levels in Sub-Saharan Africa have for many years been among the highest in the world. The high fertility in the region has been largely attributed to socio-cultural and economic reasons. In the past, the economic value attached to children and the cultural prestige of having a large number of children have, in part, explained the high demand for children in Sub-Saharan Africa. To this day this explain, to an extent, persistent high fertility levels of the region. Notwithstanding the high fertility levels in the region, levels have been declining in the recent past. This has been attributed to improvements in socio-economic status, which has impacted on fertility behaviour.

5.2.1 Fertility Trends

Trends in fertility behaviour and levels in the Gambia are not quite different from the Sub-Saharan Africa experienced. Fertility levels in The Gambia remained the same over the period 1973 to 1983 with the TFR estimate put at 6.4. Subsequent estimates of TFR, however, indicated a declining trend in levels. Results of the 1993 census indicated a TFR of 6.04, a decline of 6 per cent over the inter-censal period. This decline has been attributed to a number of factors ranging from an increase in age at first marriage, higher educational attainment (i.e. secondary education and above) among women, lower proportion of women of reproductive age being in marriage, the effects of rapid urbanization, to the influence of contraceptive use, especially among women aged 15-29, (CSD, 1996).

Research has shown that education has a dual effect on fertility. Firstly, education tends to delay women's entry into marriage, hence their exposure to childbearing. Education, on the other hand, leads to improved socio-economic status of women and invariably has a negative impact on their desire for large families.

Estimates of fertility obtained from this survey indicate a decline in fertility in The Gambia, although, at a slow pace. In Table 23 below fertility has been estimated at 6.01, which shows a decline in fertility of 0.5 per cent since the 1993 Census. The rate of decline may be marginal but considering what it takes to change fertility behaviour, especially in Sub-Saharan Africa, such a decline can be viewed as a positive indication of looming changes in fertility behaviour in The Gambia.

Table 23: Age-Specific Fertility Rates (per 1000 Women), Mean Age at Childbearing and Total Fertility Rates, 1983, 1993 and 2001			
Age Group of Women	Age-Specific Fertility Rates		
	1983	1993	2001
15-19	200.1	167.3	151.8
20-24	293.0	271.5	280.3
25-29	284.7	275.9	322.4
30-34	222.4	220.8	254.7
35-39	160.6	159.3	115.7
40-44	77.2	75.4	55.9
45-49	40.4	38.2	20.6
Mean Age At Childbearing	-	28.3	26.56
TFR	6.4	6.04	6.01

Source: *1983 and 1993 Censuses and 2001 National Survey on Mortality and Contraceptive Prevalence.*

A closer look at age specific fertility rates presented in the table against those observed in previous censuses reveals more encouraging signs. For example, whereas fertility for the teenage population (15-49) was estimated at 200.1 births per 1000 in 1983 and 167.3 in 1993, the estimate for this survey is 151.8. Similarly, estimates for women aged 20-24 were put at 293.0, 271.5 and 280.3 for 1983, 1993 and 2001, respectively.

These figures indicate a general decline in fertility among the younger generation of women, especially among teenagers. This is indeed quite encouraging and if the

trend continues this would be in line with the policy objectives of the National Population Policy.

5.2.2 Differentials in Fertility

As indicated earlier in this chapter, fertility behaviour is influenced by varying factors. A study of differentials across some of these factors should, therefore be undertaken to ascertain, to an extent, the varying degrees these factors tend to influence fertility. This should be of interest to policy makers and those responsible for programme implementation to better focus policies and programmes so that their objectives are met. In The Gambia various programme interventions both from the public and private sectors have in the past designed and implemented programmes aimed at bridging the gap between various strata of our society. The findings presented below would, therefore, contribute to our better understanding of the effect of socio-economic factors on fertility behaviour in The Gambia.

Urban-Rural

Table 24 below indicates that, in general, fertility levels are higher in rural areas than in urban areas. Disparities in levels are even more pronounced in the younger ages. The age specific fertility rates show that among teenagers, rural fertility levels are higher than urban areas by about 48 percent. For women aged 20-24, fertility among rural women exceeds that of urban women by 25 per cent with the fertility gap narrowing with age. The table also shows that mean age at child bearing for urban women is higher than that of rural women by about 2 years. A comparison of TFR between urban and rural areas indicates lower levels in urban than in rural areas with the urban TFR estimated at 5.31 and that of rural estimated at 6.49.

The disparities observed in fertility levels among urban and rural women is as expected. Previous research on fertility differentials in The Gambia and elsewhere have shown a similar situation. Urban-rural differentials in fertility levels can be explained by a myriad of factors. In the Gambian situation this can, partly, be explained by higher socio-economic status of urban women, in general, and higher educational attainment in particular. Other factors could be higher contraceptive

prevalence rates in urban than in rural areas and the tendency for urban women to be more inclined to smaller family sizes than their rural counterparts.

Table 24: Age-Specific Fertility Rates (per 1000 Women), Total Fertility Rate and Mean Age At Childbearing by Urban-Rural Residence				
Age Group of Women	Children Ever Born		Age-Specific Fertility Rates	
	Urban	Rural	Urban	Rural
15-19	0.190	0.350	99.2	192.3
20-24	1.020	1.740	239.3	318.5
25-29	2.350	3.450	240.7	368.1
30-34	3.370	5.230	193.0	278.9
35-39	4.360	6.050	172.9	080.8
40-44	4.840	6.460	85.0	43.4
45-49	5.370	7.060	31.0	16.1
Mean Age At Childbearing			27.80	25.85
TFR			5.31	6.49

Educational Attainment

Various studies have shown the negative impact education has on fertility levels in many societies. Notwithstanding these research findings some studies have found that for education to impact on fertility it has to be beyond primary education level. According to the UN (1987) for education to negatively affect fertility, women would have to attain at least seven years of education or more. In the Gambia fertility analysis of both the 1983 and 1993 censuses showed that fertility levels are highest among women with no education and those with only primary school level of education than those with secondary education and above. This trend was found to be similar to those observed in other Sub-Saharan African countries.

Presented in Table 25 below are fertility estimates for women with varying educational attainment. Fertility estimates presented in the table show that levels are highest among women with no education and those with primary education than those with secondary education and above. Most of the differences in fertility levels across varying educational levels can, however, be found among teenage women. This is probably because differences in fertility behaviour are more pronounced in this age bracket.

Regarding estimates of TFR, the estimates show that women with no education tend to have more than two children in excess of women with secondary education and above. Similarly, women with only primary level education have close to two children in excess of their counterparts with secondary education and above. Comparison of the TFR of women with no education and those with primary education, however, reveals that fertility levels among those with no education is only slightly higher. Differentials in mean age at childbearing also show a similar pattern. The narrow gap in fertility levels between women with no education and those with primary school education tends to confirm the UN assertion that for education to impact on fertility it has to exceed the 7-years threshold.

Disparities in fertility levels among women with different levels of education can both be explained by the potential for education to delay women's entry into marriage and the fact that women with higher levels of education are both more likely to be resident in urban areas and may enjoy higher socio-economic status than other women. Residence in urban areas can either influence their fertility behaviour or afford them better access to family planning information and services.

Table 25: Age-Specific Fertility Rates (per 1000 Women), Total Fertility Rate and Mean Age At Childbearing by Urban-Rural Residence.

Age Group of Women	Children Ever Born			Age-Specific Fertility Rates		
	No Education	Primary	Secondary and Over	No Education	Primary	Secondary and Over
15-19	0.429	0.286	0.079	211.1	163.6	49.5
20-24	1.752	1.548	0.584	291.9	285.4	161.9
25-29	3.350	2.880	1.642	330.7	250.6	247.8
30-34	4.847	4.127	2.943	229.6	244.7	235.9
35-39	5.609	5.184	3.779	103.9	145.2	65.1
40-44	6.101	5.586	3.625	65.4	59.2	17.2
45-49	6.591	6.444	3.714	24.0	21.8	6.4
Mean Age At Childbearing				25.87	26.54	27.58
TFR				6.28	5.85	3.92

Fertility in PHC and Non-PHC Villages

One may question the rationale for fertility analysis in PHC and Non-PHC villages in view of the limited socio-economic differences between the two types of villages. In view of the potential effect of the PHC programme on fertility behaviour and preference, it may be of interest to examine fertility differentials between the two types of villages. The only available comparison of fertility levels in PHC and non-PHC villages in The Gambia was undertaken in the 1990 GCPFDS. This survey showed that fertility levels were slightly lower in non-PHC villages than in PHC villages, a finding the study found surprising in view of the better access to family planning services in PHC villages (GCPFDS, 1990).

The fertility analysis presented below (Table 26) reveal that fertility levels are higher in non-PHC than PHC villages. Differences observed in fertility levels between the two types of villages are, however, marginal, probably, reflecting similarities in socio-economic status. PHC and Non-PHC villages are predominantly rural settlements with identical socio-economic characteristics with the only difference being the

possibility of better access to family planning information and services for PHC villages. It is not surprising, therefore, for the gap in fertility between the two types of settlements to be this narrow.

Table 26: Age-Specific Fertility Rates (per 1000 Women), Total Fertility Rate and Mean Age At Childbearing (PHC Villages)				
Age Group of Women	Children Ever Born		Age-Specific Fertility Rates	
	PHC Villages	Non-PHC Villages	PHC Villages	Non-PHC Villages
15-19	0.297	0.355	176.6	183.9
20-24	1.656	1.585	309.9	268.4
25-29	3.320	2.960	380.7	278.9
30-34	5.282	4.288	310.0	230.9
35-39	6.054	5.241	23.7	169.9
40-44	6.101	6.131	15.8	121.9
45-49	6.550	6.851	5.9	43.9
Mean Age At Childbearing			25.53	27.15
TFR			6.11	6.49

5.3 CONCLUSION

Findings of this study confirm a desire for large families in Gambian society. This findings show that socio-economic differences exist in the number of children desired but in general, there is a great desire for a large number of children in The Gambia. For this country to experience rapid decline in fertility, therefore, there is need for significant changes in attitude to family size. Modernisation and increasing demand on parents to educate and care for their children could certainly influence the desire for children over time. With the general, improvement in educational attainment across the country, it is hoped that attitudes would change over time.

Although the findings of this survey indicate a general decline in levels of fertility in The Gambia, the observed levels remain high even by sub-Saharan Africa

standards. The fertility estimates, however, seem to confirm differentials in fertility levels across socio-economic groups. This finding provides an opportunity to intervention programmes to develop and focus their programmes on specific population groups. The influence of education on fertility also shows the need for the intensification of the campaign on the improvement of girls' education, which would improve the socio-economic status of women in general, and have the desired negative effect on fertility, in particular. Overall, however, the observed high levels of fertility call for the intensification of programme efforts towards the promotion of family planning and fertility regulation.

CHAPTER 6: PERI-NATAL, NEONATAL, INFANT AND CHILD MORTALITY

Reduction of both infant and childhood mortality, and the incidence of high risk pregnancies are major objectives of National Population Policies in the developing world. This chapter presents levels of infant and childhood mortality in The Gambia, and national estimates of neonatal and peri-natal mortality. In addition, information on selected risk factors for infant and childhood mortality are presented. The data presented here are important not only in the understanding of the demographic profile, but also in the design of policies and programmes aimed at the reduction of infant and child mortality.

6.1 Key risk factors for infant and neonatal mortality

This section examines the relative importance of infant and neonatal mortality risk factors. Generally, infants have a greater probability of dying if they are born to mothers who never received antenatal care, tetanus toxoid vaccination or who never sought care from qualified personnel with midwifery skills during delivery. In this survey, women who had ever been pregnant were asked whether they received pregnancy-related check-ups and whether they received an immunisation during their last pregnancy. Information was also sought on the place of delivery and the carer during child birth.

6.1.1 Assistance during delivery

The type of assistance a woman receives during birth of her child has important health consequences for both mother and child. The data from this survey indicate that 52 percent of the births in The Gambia are delivered in medical facilities, the majority of which in rural health centres or dispensaries (34 percent) and only 18 percent in hospitals. The rest of the births are delivered in the community, assisted by friends or relatives (27 percent), traditional birth attendants (14 percent) or with no assistance at all (7 percent). Results further indicate that 54 percent of the deliveries are attended to by qualified medical personnel (doctor, nurse or midwife). On the

other hand, 25 percent and 20 percent of the deliveries are administered by traditional birth attendants and relatives or friends respectively.

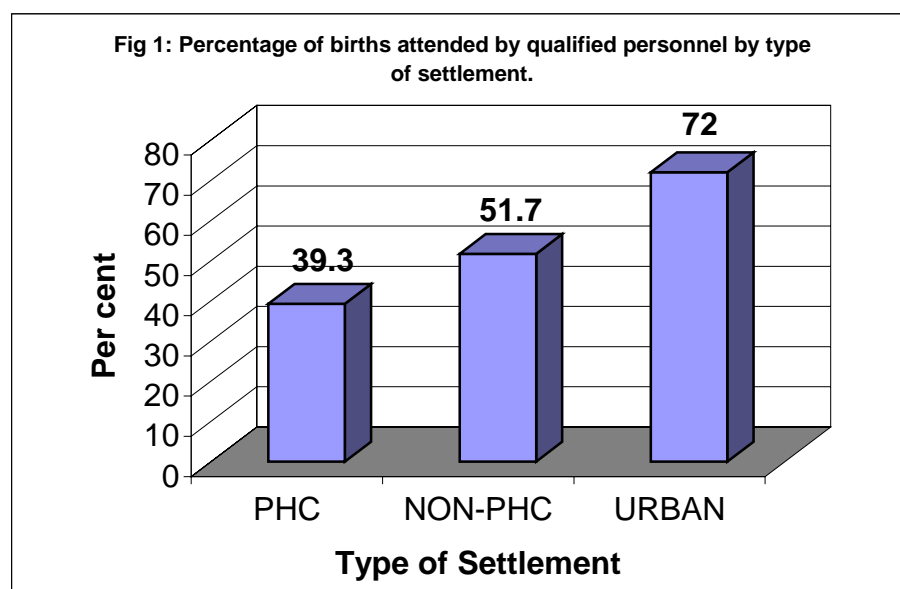
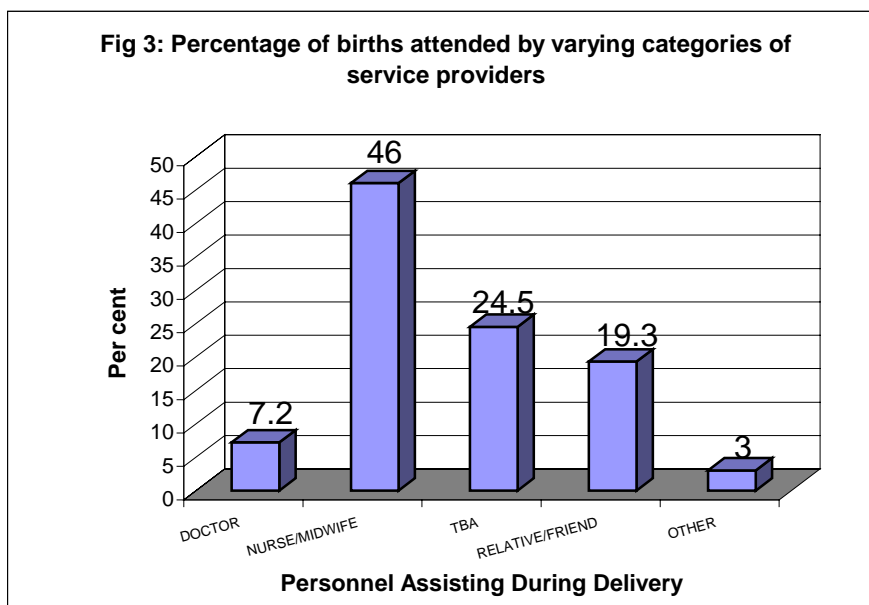
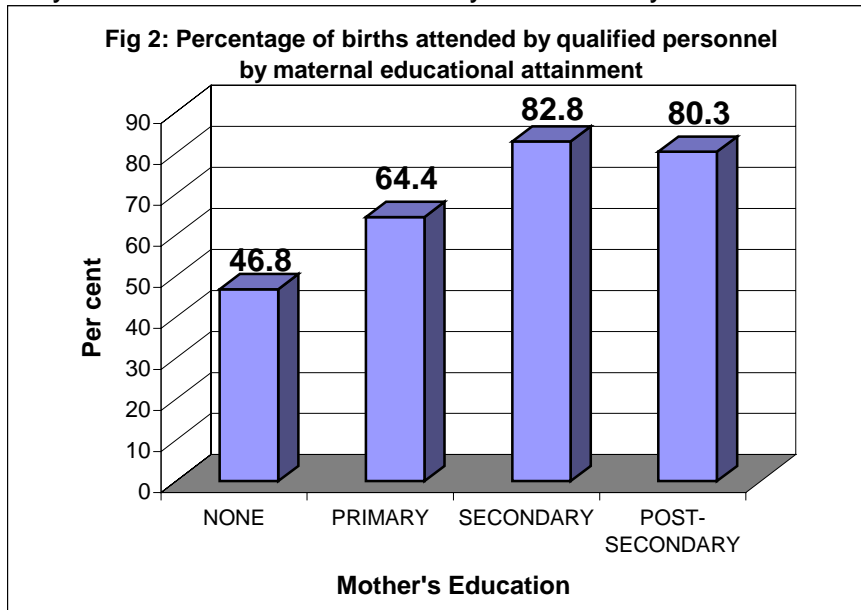


Table 27 shows the percent distribution of women who have ever been pregnant by type of assistance during delivery, according to selected background characteristics. Data indicate that

assistance at delivery varies by characteristics of the mother. Births to older women are more likely to occur in the community whereas births to younger women tend to receive better medical care during delivery. As would be expected, births in urban areas are more likely to be assisted by medical personnel (doctor, nurse or midwife) than rural births. Appropriate medical assistance during delivery is more available to women in non-PHC villages, while their counterparts in PHC villages are more likely to utilise the services of the traditional birth attendants. Regional differences in types of assistance at delivery are also prominent. Trained medical personnel assist the highest proportion of births (more than 85 percent) in Banjul and Kanifing, the rather urbanised centres and lowest (less than 35 percent) in Kuntaur and Janjanbureh, the typically rural areas. The proportion of deliveries assisted by doctors, nurses and midwives increases from 47 percent of deliveries by women with no education to 82 percent of deliveries by women with secondary or higher education. As would be expected, women who receive antenatal care during pregnancy are more likely to deliver with medical assistance than women who

receive no antenatal care. Women who do not visit antenatal care clinics are more likely to deliver in the community assisted by traditional birth attendants, relatives

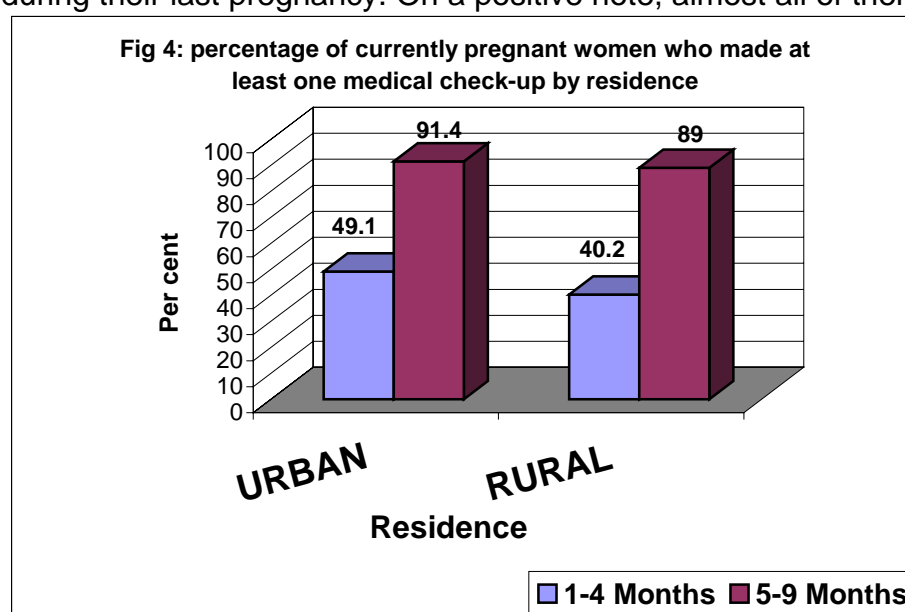
and friends.



6.1.2 Antenatal care and TT immunisation

Information was obtained on medical check-ups and how many times this occurred during the last pregnancy. The results indicate that over 97 percent of the women who have ever been pregnant visited someone for a pregnancy-related check-up

during their last pregnancy. On a positive note, almost all of them were checked by a



doctor (8 percent) and nurse or midwife (92 percent). For over 70 percent of the last pregnancies, mother made four or more antenatal care visits, while 23 percent made between one and three visits.

Tetanus toxoid injections are given during

pregnancy for the prevention of neonatal tetanus, a common cause of death among infants in the developing world. The majority of the Gambian women attend antenatal care clinics and receive tetanus toxoid vaccination after five or more months of pregnancy. Over 90 percent of the women reported receiving at least one tetanus toxoid immunisation during the last pregnancy. However, among those who received only one immunisation during the last pregnancy, 55 percent had never any such immunisation before.

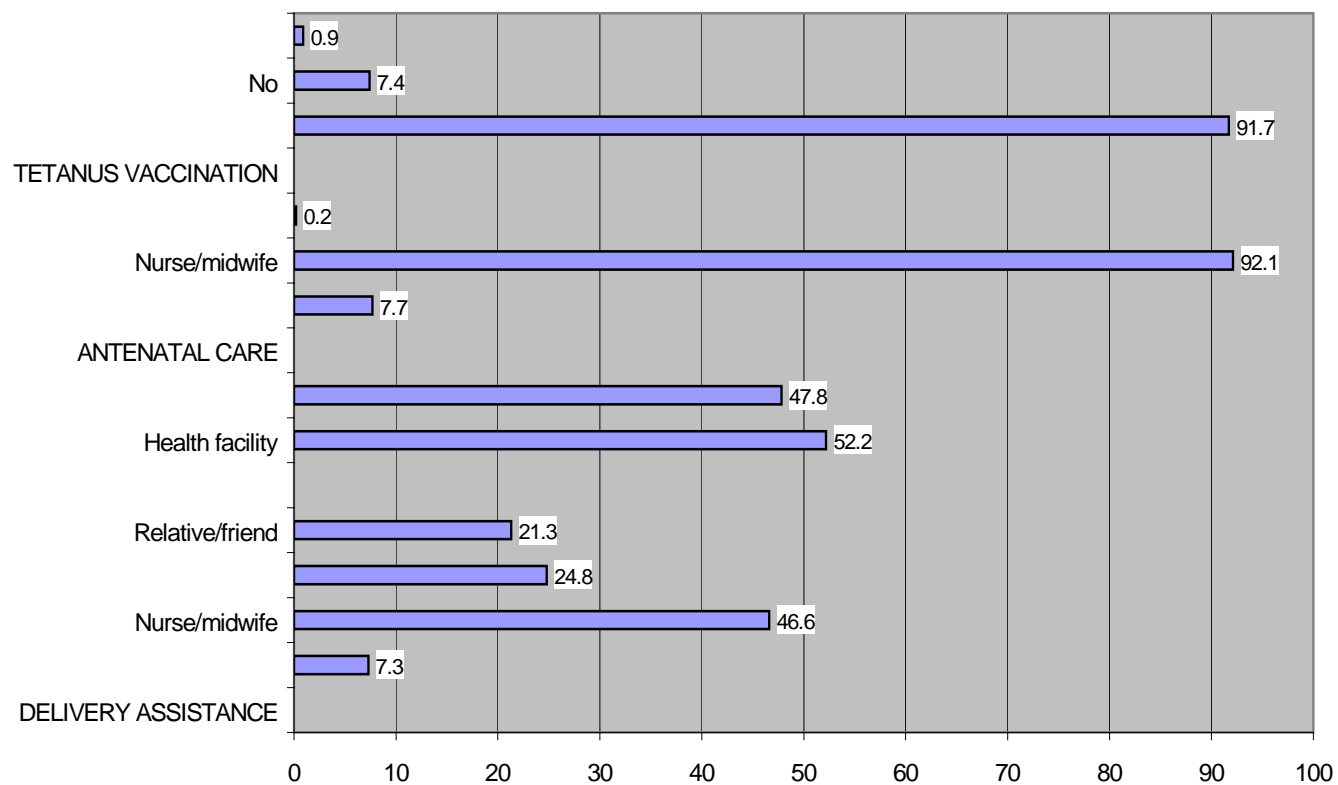
Nine percent of the women interviewed were currently pregnant and these were interviewed on issues related to antenatal care and tetanus toxoid immunisation. Of these, 68 percent were currently five to nine months pregnant while 32 percent were one to four months of pregnancy. Among those with young pregnancies, less than

half had had a pregnancy-related medical check-up as compared to over 85 percent with older pregnancies (Table 28). Over 30 percent of the currently pregnant women had not received and tetanus toxoid vaccination. Pregnant women resident in rural areas were less likely to utilise antenatal care and immunisation services as compared to their urban counterparts.

6.1.2 Transport during delivery

Availability of efficient and affordable transport means to the nearest health facility plays a big role in ensuring good outcomes from a pregnancy. In this survey, female respondents who had ever had a live birth were asked whether they went out of their community to deliver their last baby and what transport mode they used. The data indicate that 70 percent of the deliveries took place within the villages or towns of residence. However, of the 30 percent who opted to go out of their communities, the most common mode of transport was the vehicle (79 percent), followed by the horse or donkey (13 percent). The main reasons for choosing the mode of transport were because it was the most easily available means (65 percent) or because it was an emergency with no other alternative (17 percent).

Figure 2: Percent Distribution of Births by Antenatal Care and Delivery Characteristics



N.B: Based on last pregnancy

Percent

Table 27: Percent distribution of women who have ever been pregnant by type of assistance during delivery, according to selected background characteristics

Background characteristic	<u>Assistance during delivery</u>					Total	Number of women
	Doctor	Nurse/midwife	TBA	Relative/friend	Other		
Mother's age							
<20	8.0	50.9	16.5	21.2	3.3	100.0	212
20-34	6.3	47.9	25.0	17.9	2.9	100.0	2564
35+	8.6	41.6	24.9	21.6	3.3	100.0	1379
Type of settlement							
PHC	5.9	33.4	42.2	15.9	2.7	100.0	1584
Non-PHC	7.4	44.3	16.5	28.1	3.6	100.0	1336
Urban	8.4	63.6	10.6	14.2	3.2	100.0	1232
Local Government Area:							
Banjul	5.1	87.4	1.9	0.9	4.7	100.0	215
Kanifing	10.9	76.9	4.1	6.7	1.4	100.0	715
Brikama	7.8	48.8	23.4	16.0	4.0	100.0	936
Mansakonko	8.8	29.0	47.3	12.9	1.9	100.0	317
Kerewan	8.4	38.7	25.9	25.2	1.8	100.0	742
Kuntaur	4.4	27.2	31.6	32.4	4.4	100.0	272
Janjanbureh	4.2	23.0	33.2	34.7	5.0	100.0	404
Basse	2.9	30.1	36.9	26.5	3.6	100.0	558
Mother's education							
None	6.2	40.6	27.5	22.3	3.3	100.0	3167
Primary	10.5	53.9	19.6	14.8	3.6	100.0	438
Secondary	8.7	74.1	10.7	4.3	2.2	100.0	447
Post-secondary	16.4	63.9	6.6	6.6	6.5	100.0	61
Antenatal care visits							
None	12.0	29.0	19.0	36.0	4.0	100.0	100
1-3	4.7	39.4	29.4	24.6	1.8	100.0	911
4 or more visits	7.8	49.1	23.6	17.3	2.2	100.0	3065
The Gambia	7.2	46.0	24.5	19.3	3.0	100.0	4155

Table 28: Percent distribution of women who are currently pregnant by utilisation of antenatal and immunisation services and residence

Utilisation of service	Months of pregnancy		Number of women	
	1-4	5-9	Currently married	All women
URBAN				
At least one medical check-up				
Yes	49.1	91.4	125	143
No	50.9	8.6	37	38
Health facility visited for check-up				
Hospital	30.8	11.6	19	21
Health centre/dispensary	57.7	69.6	80	93
MCH clinic	3.9	15.2	17	18
Private hospital/clinic	3.9	2.7	3	4
Pharmacy	3.9	0.0	1	1
PHC/community health worker	-----	-----	-----	-----
Others	0.0	0.9	1	1
At least 1 TT vaccination				
Yes	65.4	70.6	81	94
No	34.6	29.4	37	41
RURAL				
At least one medical check-up				
Yes	40.2	89.0	215	225
No	59.8	11.0	77	81
Health facility visited for check-up				
Hospital	13.9	5.6	14	15
Health centre/dispensary	58.3	59.0	119	126
MCH clinic	19.4	23.0	47	48
Private hospital/clinic	0.0	1.1	2	2
Pharmacy	-----	-----	-----	-----
PHC/community health worker	5.6	11.2	21	22
Others	2.8	0.0	1	1
At least 1 TT vaccination				
Yes	58.3	80.1	153	162
No	41.7	19.9	50	50

6.2 Levels of peri-natal and neonatal mortality

Peri-natal mortality includes late foetal deaths and deaths during the first week of life while neonatal mortality is defined as the probability of dying within the first four weeks of life. Women were asked questions about each live birth they had ever had. Questions covered date of birth, sex of child, current age, survival status and if dead,

age at death. Respondents were further asked whether they had ever given birth to a foetus or baby (at least 7 months) that never breathed, cried or showed any sign of life and number times this occurred.

Direct estimation methods were employed. Birth histories of the female respondents were assessed and based on the reported date of deaths, a direct estimate of perinatal mortality gives a rate of 54.9 per 1,000 total births. Similarly, a direct estimate of neonatal mortality gives a rate of 31.2 per 1,000 live births. However, due to the small numbers involved, variations in peri-natal and neonatal mortality according to background characteristics yielded no meaningful results and are not presented here.

Previous studies conducted by MRC in the late 90s in URD, an impoverished part of the country, revealed a neonatal mortality rate of 39 per 1000 live births and over half of these deaths that occurred in the first week of life were due mainly to prematurity with infections predominating later after this initial period.

However, since this survey in 2001 is the first ever to establish peri-natal and neonatal mortality levels at national level, no attempt is made here for comparison with the MRC results. Results from the DHS 1994 – 1999 in the sub region revealed similar and or higher rates of neonatal mortality as follow: Ghana 32, Senegal 39, and Guinea 52 per 1000 live births respectively. It has been further stated that two-thirds of neonatal deaths occur in the first week of life and two-thirds of those deaths take place in the first 24 hours.

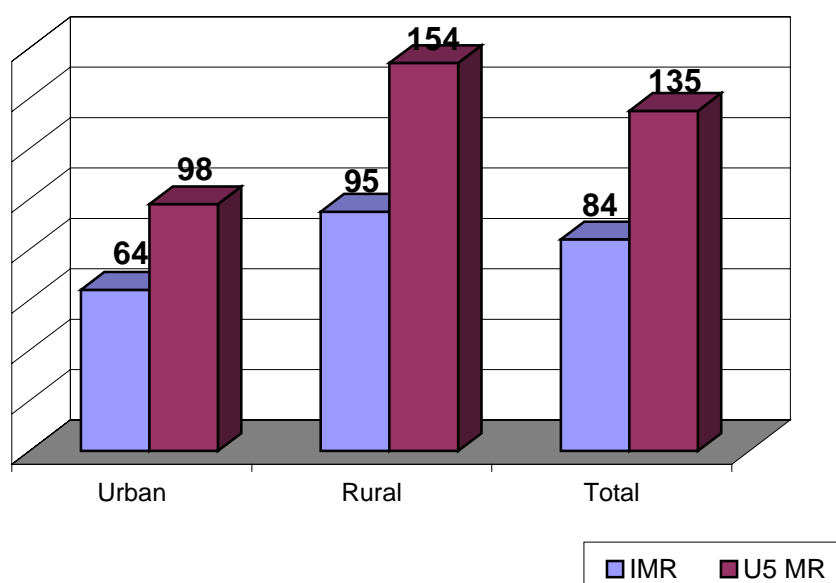
Again, this 2001 survey is the first-ever to have established peri-natal mortality rates at national level however, studies from else where have documented major causes of deaths during the peri-natal period (ie during late pregnancy & around the time of birth) as well as the neonatal period (ie at birth and the first 4 weeks of life). These include: poor maternal health; inadequate antenatal care; mismanagement of complications during pregnancy and delivery; unhygienic practices during and immediately after childbirth and, inappropriate care of the newborn. Notably, within the first week of life or soon after, tetanus claims the lives of thousands of newborns

in the sub-region. Notwithstanding this alarming situation, the Gambia has registered success attributable to the maternal tetanus immunization policy with resultant high coverage rates of 71% (MICS, 2000). This can be justified by the sharp decline in the number of reported cases of neonatal tetanus from 32 in 1990 to only one over the past five years.

6.3 Levels of infant and child mortality

By definition, the infant mortality rate is taken as the probability of dying between birth and the first birthday. On the other hand, child mortality looks at the probability of dying between exact age one and the fifth birthday, and under-five mortality the probability of dying between birth and the fifth birthday. Using indirect estimation methods (and adopting Coale-Demeny North life table) with five-year period before the survey, current national levels of infant, child and under-five mortality rates are estimated at 84, 56 and 135 per 1,000 live births respectively. These estimates seem to imply that there has, hardly, been any improvement in infant and child survival in The Gambia since 1993.

Fig 5: Infant and under-five mortality by residence



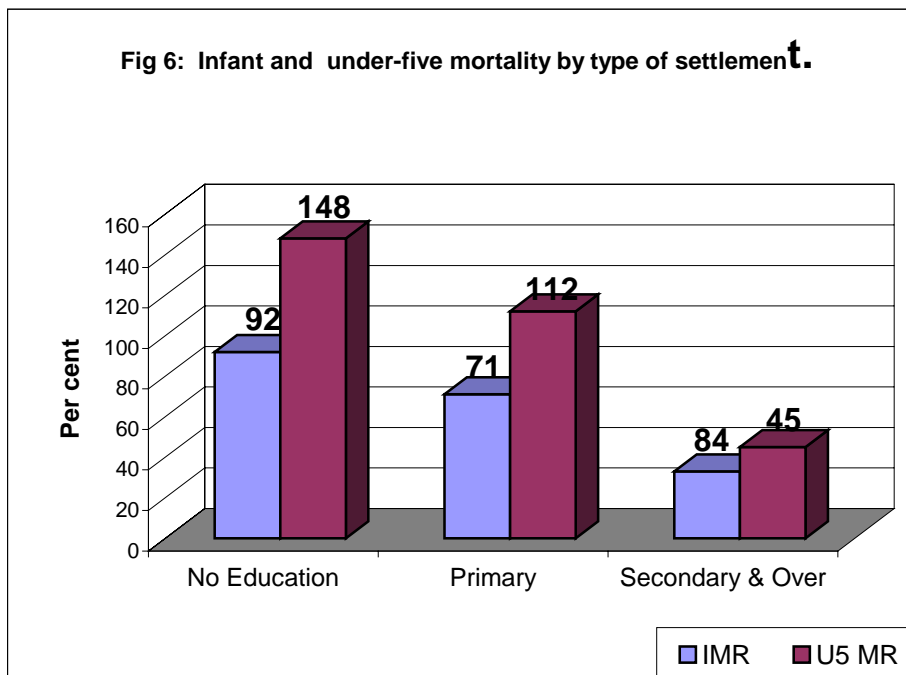
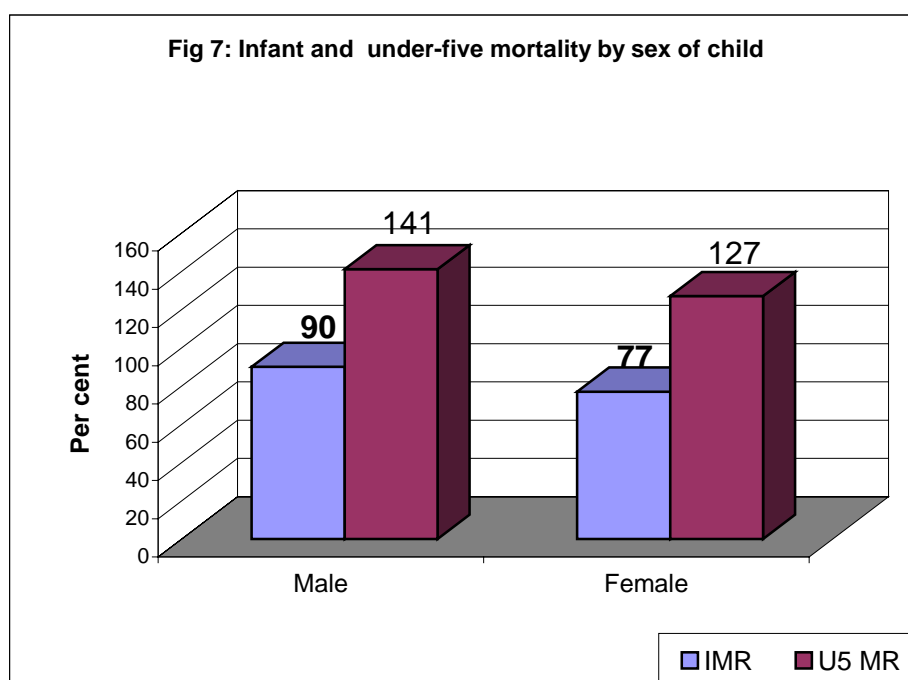


Table 29 shows estimates of infant and child mortality rates for the five-year period preceding the survey according to selected background characteristics. All child mortality

indicators are poorest in rural areas with infant mortality levels above 90 per 1,000 live births compared to urban areas where infant and child mortality are below 70 per 1,000 live births. Similar differences have been observed in levels of child and under-five mortality between urban and rural areas. The variations observed in the infant and under-five mortality levels can be attributed to a host of factors. These relate to better access to health services among urban dwellers and higher socio-economic status etc.

A review of the estimates on infant, child and under-five mortality reveals that



children in PHC villages have slightly better chances of survival than those of non-PHC villages. The gap in the observed mortality levels between children of the two types of settlements is however higher for under-five mortality.

Various studies on infant and child survival within this country and without indicate that maternal educational attainment influences the survival of children. Results of both the 1990 GCPFDS and the 1993 Census showed that children of women with secondary level education and above have better chances of survival than children of women with lower levels of education. A similar pattern has been observed in the results of this study with levels of infant, child and under-five mortality levels being higher for children of women with no education than those with either primary or secondary education and above. Disparities in levels of mortality among children of women with different levels of education are highest between those with no education and those with secondary education and above.

Although mortality levels are higher among children of women with no education than those with primary education, the gap is not very wide. This may be because differences in socio-economic status of women with no education and those with primary education may not be as pronounced as the difference between those with

no education and those with secondary education and above, on one hand, and on the other hand the difference between those with primary education and those with secondary education and above. These differences may be reflecting differences in lifestyle, access to health services and living standards in general.

Research has shown that for biological reasons females have better chances of survival during early childhood than their male counterparts. Findings of this study arrived at similar conclusion with girls having better survival chances than boys during early childhood. The mortality gap between the sexes is however, wider for infant mortality than for child and under-five mortality, although male mortality is higher for all categories of children.

It may be surprising that infant and child survival has not significantly improved in the recent past in view of interventions in the health sector over the years. Although investment in the health sector has increased considerably in the past, investment in the sector has, largely, not been able to cope with demand for services. This has, partly, been due to rapid population growth. For example, although there was an increase in Government recurrently expenditure in the health sector over the period 1990/91 to 1996/97, the per capita expenditure on health in 1996/97 almost remained at levels of 1990/91 (Public Expenditure Review, 1998). Other factors may also explain the slow pace of decline in mortality levels in this country.

Table 29: Estimates of Infant, Child and Under-Five Mortality by Socio-Economic and Demographic Characteristics, 2001

Background Characteristics	Infant Mortality	Child Mortality	Under-Five Mortality
Residence			
Urban	64	37	98
Rural	95	66	154
Type of Settlement			
PHC	79	50	125
Non-PHC	88	66	148

Educational Attainment of Mother

No Education	92	63	148
Primary	71	44	112
Secondary and Above	33	12	45

Sex of Child

Male	90	56	141
Female	77	54	127

The Gambia	84	56	135
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Although compelling evidence may not exist in The Gambia on the effect of the cold-chain on vaccine efficacy, evidence from some developing countries has shown the negative effect of a poor cold-chain on vaccine efficacy. In view of the poor state of electricity supply in The Gambia, it would not be surprising if this is impacting on vaccine efficacy in the country. This is evident in the deaths due to vaccine preventable diseases. In addition, deaths among children due to malaria remain high in spite of frantic efforts in the area of malaria prevention.

The reasons for such disparities in infant child survival across population groups can only be inferred since a study of the underlying factors may be beyond the scope of this study. Mortality differentials observed across socio-economic groups point to the need for attention to be focused on certain population groups to reduce disparities in levels of mortality.

CHAPTER 7: MATERNAL MORTALITY

The Gambia is one of the countries that has been reported to have very high levels of maternal deaths, with maternal mortality ratios above 1,000 maternal deaths per 100,000 live births. This is confirmed by a number of small-scale studies (*Walraven et al 2000*) that have been conducted by the British Medical Research Council (MRC) in rural Gambia. A review of medical records in the 3 main government hospitals in The Gambia (Farafenni, Bansang and Royal Victoria Hospital) to get a first hand assessment of the maternal mortality situation in the country was carried out in November 2001. Discussions were held with staff of the maternity wings and available maternity statistics were analysed. The general conclusion from this review was that annual health facility-based maternal mortality was very high and highest during the months of August to November every year. The main contributing factors included lack of trained medical personnel in the referral facilities, a poor national blood transfusion service and limited sensitisation of the general population on ways of minimising maternal deaths (e.g. early booking for delivery and breaking some traditional practices).

The estimates presented in this chapter are therefore of unique importance as they try to fill a vacuum for reliable, national estimates of maternal mortality. The maternal mortality estimates are based on information about survivorship of respondents' sisters using indirect estimation techniques. These techniques of estimation, termed the "sisterhood method" (*Graham et al. 1989*), utilise data from respondents about their sisters in estimating the lifetime risk of maternal mortality. Such an estimate would naturally run into the problem of reference period to about 12 years before the survey. On the other hand, there is uncertainty on how much this method estimates current maternal mortality, unless it is assumed that mortality has been relatively constant over the years.

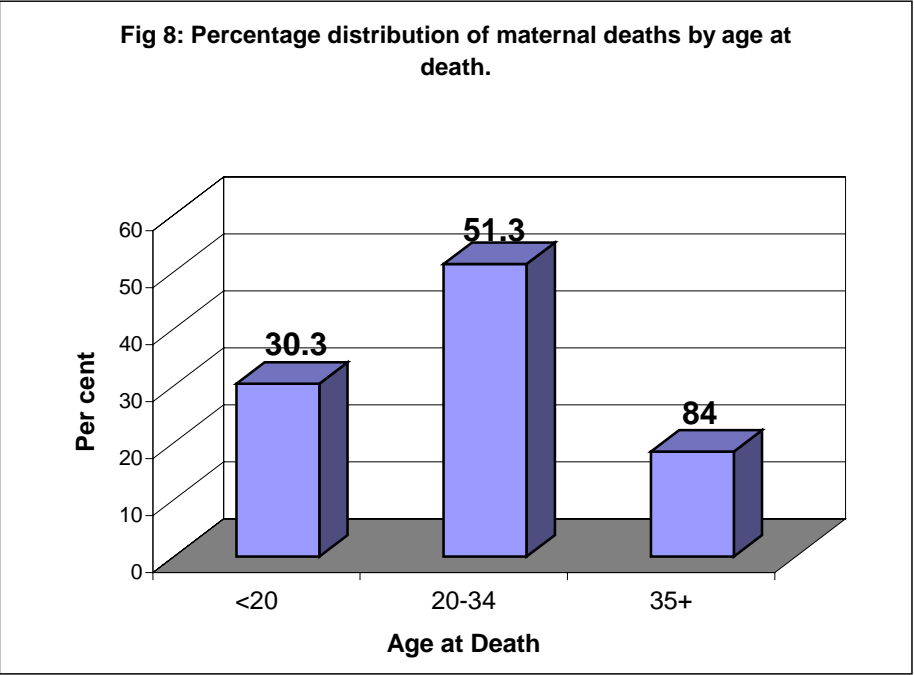
7.1 Description and assessment of methodology

During the survey exercise, both female and male respondents were asked to list all their siblings, that is, all the children born to their mother, starting with the first-born, and whether or not each of these siblings was still alive at the survey date. For those who were alive, current age was collected, while for the deceased siblings, information was sought on the year of death and age at death. In order to establish deaths that were maternity-related, respondents were further asked four questions for all sisters who died at age 12 years or older: “Was [NAME OF SISTER] pregnant when she died?”; and if not, “Did she die during childbirth?”; and if not, “Did she die within two months after the end of a pregnancy or childbirth?” and if so, “Was her death due to complications of pregnancy or childbirth?”. It can be seen that this information will not only give an estimate of maternal risk but a complete profile of person-years of exposure to the risk of mortality.

Completed age was the basis of estimation of the maternal mortality ratio. All respondents with missing age were excluded from the model. There were about 15 percent of the responses with missing information on the deaths. Imputations were made to establish whether or not they qualified to be classified as maternal deaths. For instance, those missing sex of the sibling but had correctly answered maternal death-related questions, the sex was taken to be female and therefore included in the maternal mortality model. Responses with no information on the type of maternal death, but had indicated the death as having been as a result of complications of pregnancy or child birth, were imputed to be pregnancy-related. On the other hand, responses on symptoms before death were used to impute the type of death in case it was missing.

7.2 Characteristics of maternal deaths

Table 30 gives a summary of the maternal deaths according to selected characteristics. Based on answers from 5,656 female respondents aged 15-49 and



3,666 male respondents aged 18-49, 261 maternal deaths were recorded. Half of the maternal deaths occurred between the ages of 20 and 34 years, although a significant 30 percent were below 20 years of age. There was no difference in age distribution in PHC villages, non-PHC villages and urban areas.

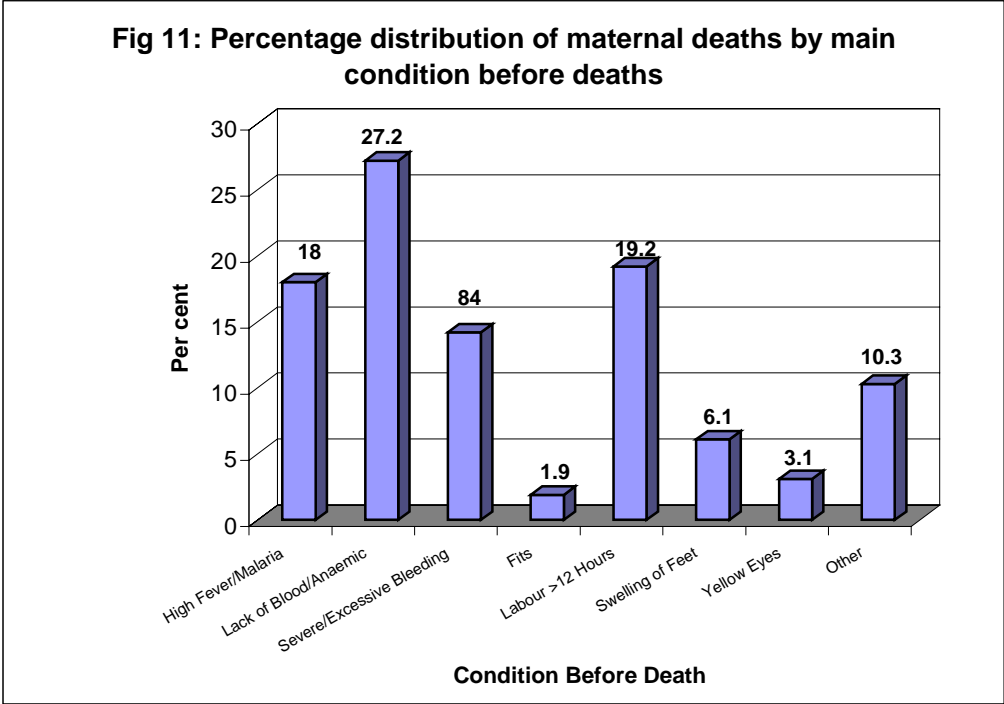
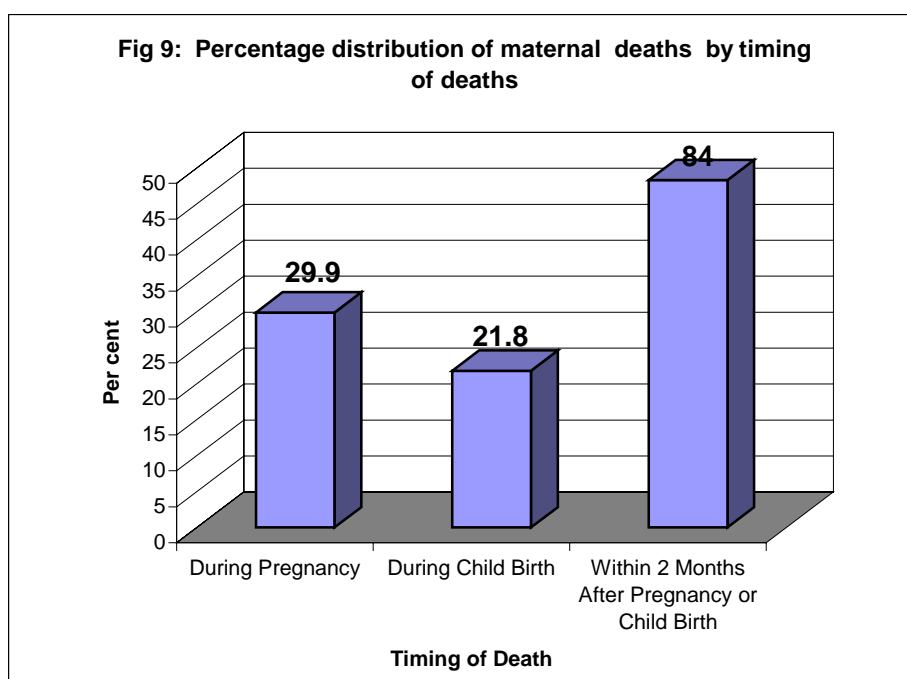


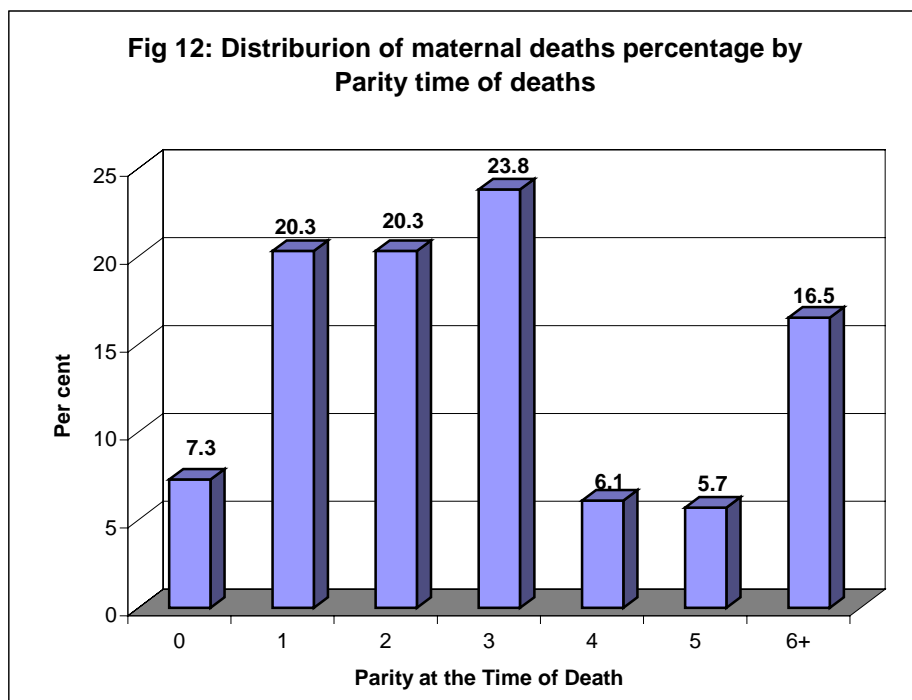
Table 30: Distribution of maternal deaths by selected characteristics

Characteristic	Maternal deaths	Percentage
Age at death		
<20	79	30.3
20-34	134	51.3
35+	48	18.4
Type:		
Deaths during pregnancy	78	29.9
Deaths during child birth	57	21.8
Deaths within 2 months after pregnancy or child birth	126	48.3
Main condition before death:		
High fever/malaria	47	18.0
Lacked blood/anaemic	71	27.2
Severe/excessive bleeding	37	14.2
Fits	5	1.9
Labour > 12 hours	50	19.2
Swelling of feet	16	6.1
Yellow eyes	8	3.1
Others	27	10.3
Place of death:		
Hospital	82	31.4
Health centre/dispensary	37	14.2
At home	125	47.9
TBA's home	0	0.0
Neighbour's/friend's home	14	5.4
Other	3	1.1
Carer at time of death		
Doctor	81	31.0
Midwife/nurse	41	15.7
TBA	3	1.1
Relative	131	50.2
Other	5	1.9
Parity at time of death		
0	19	7.3
1	53	20.3
2	53	20.3
3	62	23.8
4	16	6.1
5	15	5.7
6+	43	16.5

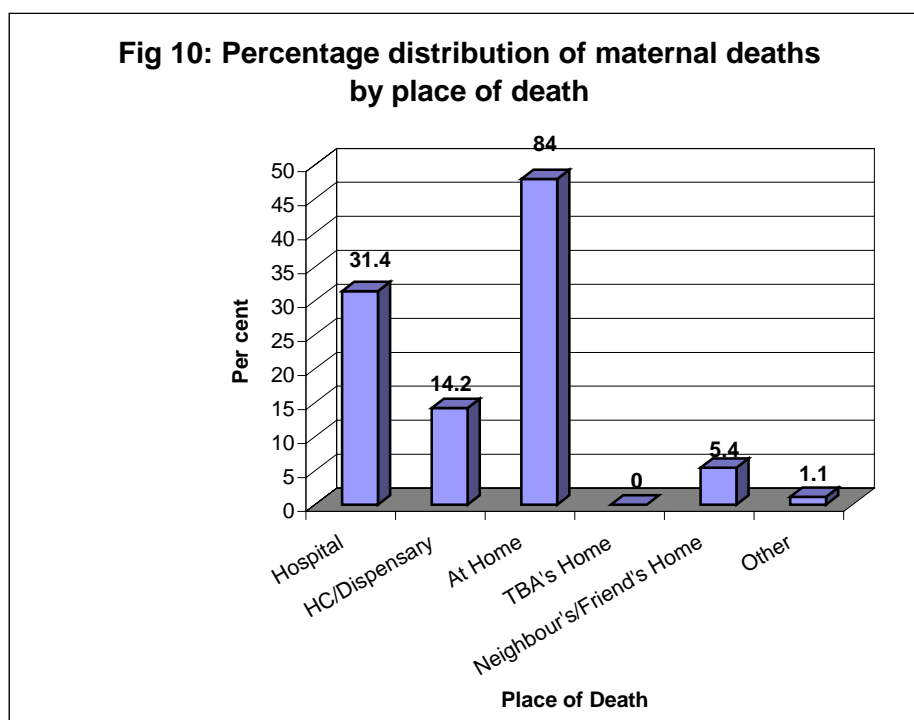
It was outside the scope of the survey to obtain information on the clinical causes of maternal deaths since medical records were not part of the survey tools. However, in order to get an idea on the causes of maternal deaths, respondents who had reported death of a sister due to maternal-related causes were asked a further question: “What did she exactly suffer from or what happened to her just before she passed away”.

This would give the main symptoms, a proxy indicator for the clinical causes. The data indicate that the main causes of maternal death were related to anaemia, prolonged labour, malaria in pregnancy and excessive bleeding.





Nearly half of the maternal deaths occurred at home and had been attended to by relatives or neighbours. Forty-six percent of the deaths occurred in hospitals or health centres and had been attended to by qualified medical personnel (doctors, nurses or midwives). Over 60 percent of the maternal deaths had given birth to between 1 and 3 children during their lifetime, however there was a significant 17 percent maternal deaths with parity 6 and above.



7.3 Indirect estimates of maternal mortality (sisterhood method)

Data were aggregated by five-year age-groups of respondents. For each age group, information on the number of maternal deaths among all sisters of respondents and on the number of “sister units” of risk was used to estimate the lifetime risk of dying from maternal causes. The method also provided an overall estimate of maternal mortality for sisters of all respondents combined which refers to an average period in time of 10-12 years before the survey.

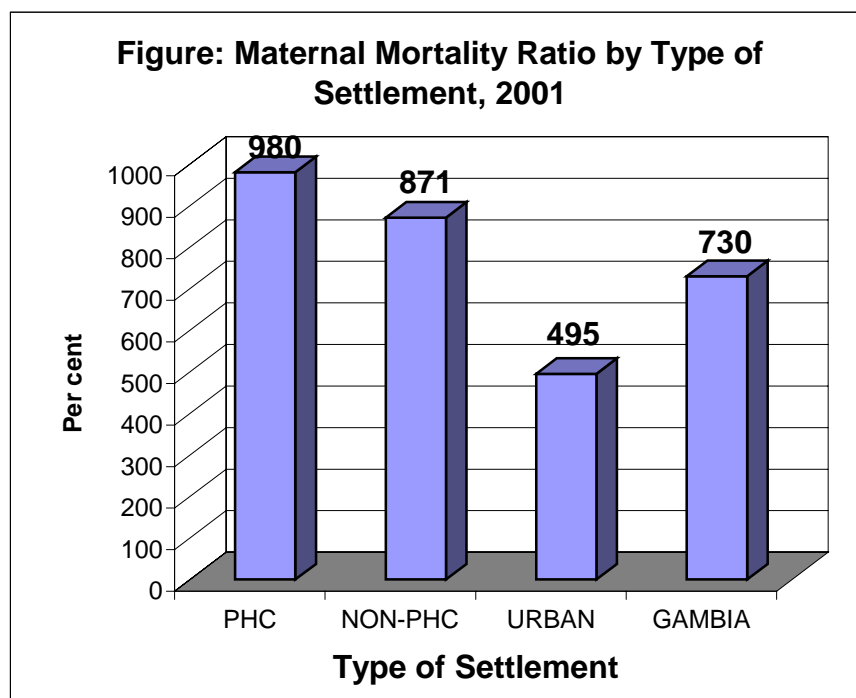
The indirect maternal mortality estimates using the sisterhood method are presented in Table 31. The overall lifetime risk is 0.043, implying a risk of dying from maternity-related causes of about 1 in 23 women. From the computations, the maternal mortality ratio (MMR) is estimated at 730 maternal deaths per 100,000 live births. This varies from 980 per 100,000 in PHC villages to 871 per 100,000 in non-PHC villages and 495 in urban areas. On the whole, this is an indication that maternal mortality in rural areas is nearly twice as high when compared to urban areas.

Table 31: Estimates of maternal mortality using the indirect (sisterhood) method

Age of respondents	No. of respondents (a)	No. of sisters reaching age 15 (b)	No. of maternal deaths (c)	Adjustment factor (d)	Sister units of exposure to risk (e)=(b)x(d)	Lifetime risk of maternal death (f)=(c)/(e)
15-19	1,375	1515	22	0.107	162.1	0.1357
20-24	1,852	2722	28	0.206	560.7	0.0499
25-29	1,852	3001	46	0.343	1029.3	0.0447
30-34	1,407	2322	34	0.503	1168.0	0.0291
35-39	1,249	1980	53	0.664	1314.7	0.0403
40-44	946	1294	41	0.802	1037.8	0.0395
45-49	641	939	37	0.900	845.1	0.0438
15-49	9,322	13,773	261	-	6117.8	0.0427
TFR 1987-91 = 5.95 (Source: Gambia contraceptive prevalence & fertility determinants survey, 1990)						
$MMR = (1 - [(1 - \text{Lifetime risk})^{1/TFR}]) \times 100,000 = 730$						

7.4 Conclusion

The currently quoted figure for the MMR in The Gambia is 1,050 per 100,000 live births, based on the 1990 Maternal Mortality Survey. The estimated MMR from this survey is 730 per 100,000 live births. It might be rather misleading to conclude that there has been an improvement in maternal health services in the country.



This is because the two surveys employed different methods. While the 1990 survey interviewed only heads of households and women within the households who had been pregnant in the past 2 years, the 2001 survey was an indirect interview of all male and female respondents in the sampled households about the survivorship of their sisters. There were small studies done by the MRC in rural Gambia using the sisterhood method, but their representativeness of the entire Gambian population remains questionable. This therefore calls for regular national surveys with similar methodology in order to arrive at not only more reliable and comparable estimates of maternal mortality, but also the important components and differentials thereof in order to guide policy formulation in this area.

CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

This chapter highlights a summary of the results from the survey and attempts to put forward a set of recommendations to the Department of State for Health for improvements in the delivery of health services. Adoption of some or all the recommendations will further strengthen the current health system and contribute positively to the implementation of the National Health Policy.

8.1 Main conclusions from the survey

A number of results were analysed in the preceding chapters and this was in line with the stated survey objectives. The main conclusions from the survey can be summed up as below:

- There is generally low family planning knowledge among the Gambian population. This is reflected in the fact that more than half of the Gambian adult population do not know any method of family planning and this directly explains why the general rate of contraceptive prevalence is low among both urban and rural residents. Based on results from past surveys, contraceptive prevalence in The Gambia has only increased slightly over the past decade, rising from 12 percent in 1990 to 17.5 percent in 2001.
- High mortality levels are observed in infants, children and mothers. For instance, an infant mortality rate of 99 per 1,000 and a maternal mortality ratio of 730 per 100,000 live births are by all considerations to the higher side.
- Many maternal deaths occur at a tender age. More than half of the maternal deaths occurred below 35 years of age and the risk of dying from maternity-related causes is about 1 in 23. This risk in rural areas is nearly twice as high that in urban areas. The MMR in rural areas, whether in PHC villages or non-PHC villages, is still rather high. This is a cause for concern.
- The main causes of maternal death in The Gambia are related to anaemia, prolonged labour, malaria in pregnancy and excessive bleeding. A significant

number of maternal deaths occurred at home and are attended to by relatives or neighbours. Fewer pregnant or expectant mothers receive the services of qualified medical personnel. This could be as a result of poor referral services.

- Extra PHC services have not had much impact in the selected villages. All reproductive health indicators are lowest in PHC villages as compared to non-PHC villages, implying that the additional health services in the PHC villages have not created a significant impact on the overall life style and well-being of The Gambian population.

8.2 Recommendations

It is clear from the survey results that The Gambia has poor levels of reproductive health indicators. A lot needs to be done in order to improve the state of reproductive health in line with the objectives of the National Health Policy and ICPD. With the current stable political environment in the country, this is possible. The following recommendations are suggested.

1. There is need to consider adopting a national policy favouring professional midwifery care for all births, coupled with the establishment of standards for quality of care. Most importantly, the policy should consider a good environment for attracting and retaining skilled medical personnel. Specific issues to consider include an attractive salary package, accommodation and consideration for further studies.
2. The DOSH needs to put in place a viable referral system with particular attention to the development of major health centres to facilitate the provision of essential and comprehensive obstetric emergency care. In addition there is need to ensure the provision of at least minimum drugs and equipment to manage obstetric emergencies.
3. The national blood transfusion service of the Gambia needs to be strengthened so that adequate and safe blood is available in referral facilities at all times. This

could be done through national blood donation campaigns in order to create a reliable blood bank. Availability of safe blood will help save the many maternal deaths that are in most cases due to anaemia and haemorrhage.

4. The national health policy emphasises community participation in decision making for health service delivery. Communities should be sensitised to take expectant mothers to health facilities on time and should be accompanied by energetic relatives instead of the current practice of accompaniment by elderly women who cannot provide adequate support.
5. The policy of addressing the issue of malaria-in-pregnancy should be fully supported in order to reduce the number of maternal deaths due to malaria. Prophylaxis should be given against malaria in pregnancy along with the interventions of the Insecticide Treated Nets for mothers and children.
6. More effort is needed in social mobilisation about family planning. This is a challenging area given that polygamy is allowed in the Muslim faith and practised by nearly half of all married women, but more than half of the female respondents intended to use family planning in the near future. This is a positive result, which should be explored in order to bring men on board.
7. No programme can succeed without partnership with political leaders. Political commitment to the National Health Policy and global strategies (e.g. safe motherhood, making pregnancy safer, ICPD 1994 Programme of Action) will go a long way in ensuring improvements in reproductive health indicators and better health for the population. All interventions should ensure maximum involvement of political leaders at all levels, through providing feedback to them and lobbying them to include reproductive health issues in all legislation and policies.
8. Similar or future surveys on maternal health, gender and or reproductive health should explore the extent to which husbands and wives report accurately on their spouse's attitude towards family planning.

9. The poor maternal and neonatal indicators revealed by the survey is a breach of the fact that 'healthy mothers are children's first line of defence against death, mal-nutrition and a cycle of poverty and disease'. Therefore, The Gambia Government must adopt and fully implement the National Reproductive Health Policy (2001-2006) and the Strategic Plan of Action (2001-2006) to avail women and adolescent girls access to a full range of quality reproductive health services.
10. While it is important to establish Maternal Mortality Ratios, it is of equal importance that an analysis of every maternal death case is undertaken to establish the underlying causes, hence the need to put in place viable maternal death audit committees at every health facility. This audit system should also be used for peri-natal and neonatal deaths.
11. Given the poor reproductive health indicators as revealed by the results of this study, there is need to disseminate the results at all levels to increase awareness on the state of reproductive health in the country.
12. Future studies should attempt to investigate the effects of type of marital union on infant, child and maternal mortality and to further investigate and document the socio-cultural factors contributing to maternal mortality, especially relating to deliveries and maternal deaths occurring at home.
13. There is an urgent need to promote the involvement of men in all matters of reproductive health to help curb the prevailing high maternal and child deaths.
14. There is need to intensify the campaign among mothers in the area of awareness creation on the importance of growth and development monitoring of the child up to age five years through regular MCH clinic attendance.

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