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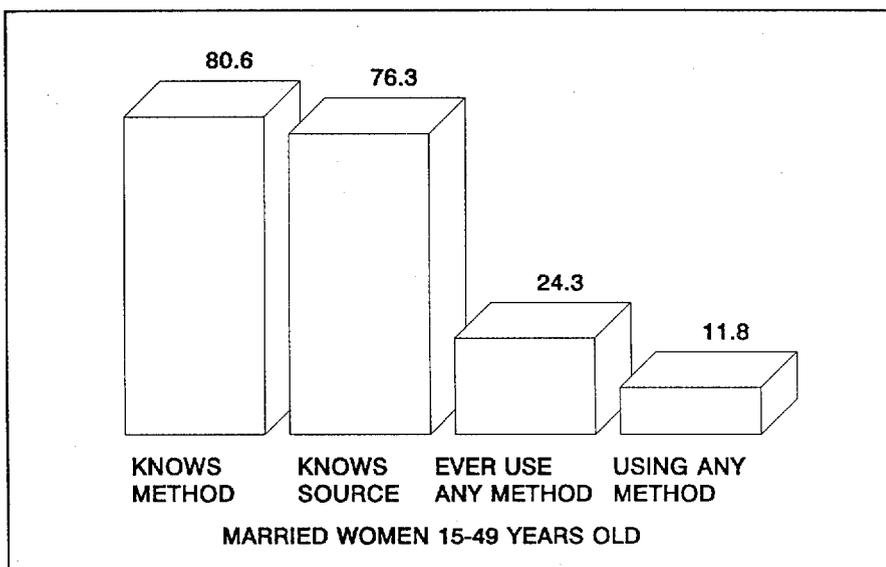
REPUBLIC OF THE GAMBIA



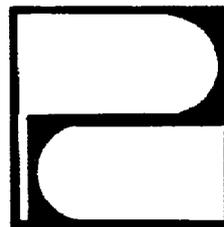
*Medical and Health Services Directorate, Ministry of Health and Social Welfare.  
Human Resources Unit. Ministry of Trade, Industry and Employment.*

### Gambian Contraceptive Prevalence and Fertility Determinants Survey

#### GCPFDS- 1990



*Center For Applied Research  
in Population and Development  
(CERPOD)  
The Population Council*



JANUARY 1993

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**Gambian Contraceptive Prevalence and Fertility Determinants Survey**  
**1990**

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This report presents findings from the Gambian Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS). The survey was a collaborative effort between the Medical and Health Services Department of the Ministry of Labour, Health, and Social Welfare, Banjul, The Gambia, the Human Resources Unit of the Ministry of Trade, Industry and Employment, Banjul, The Gambia, the Center for Applied Research in Population and Development (CERPOD) of the Sahel Institute, Bamako, Mali and The Population Council. The survey questionnaire was based on the questionnaire developed for the Demographic and Health Surveys (DHS) Program by the Institute for Resource Development/Macro Systems, Inc. (IRD), financed by the U.S. Agency for International Development. Financing for the 1990 Gambia survey was provided by the United Nations Fund for Population Activities (UNFPA) and the World Bank (Women in Development Project). Additional funding for data analysis and dissemination was provided by the Government of The Netherlands and the Canadian International Development Agency, through a Grant Agreement with The Population Council and CERPOD.

Additional information on the GCPFDS may be obtained by writing to CERPOD, Institut du Sahel, B.P. 1530, Bamako, Mali or by writing to the Director of Health Services, Medical and Health Services Directorate, Ministry of Health, Banjul, the Gambia.

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## FOREWORD

This Contraceptive Prevalence and Fertility Determinants Survey happens to be the first National Survey of its kind in the Gambia. The survey in itself is timely in that it provides us with a sound data base on issues of contraception and determinants of fertility which no doubt will be helpful in setting targets and evaluating future interventions in these areas.

Secondly as programmes and plans are being developed to implement the population policy, the study can give directions to possible areas for consideration in addressing the issues of contraception and fertility which are central to the population policy.

There is no doubt that this report itself is not exhaustive and that the accumulated data base will remain as reservoir for future analysis on any related subject of interest.

The conduction of such a study and the compilation of such a report are no mean tasks. A lot of effort, hardwork and dedication have been contributed to ensure the success of this task.

My special thanks go to the sponsors of the study - UNFPA (through its strengthening Maternal Child Health and Family Planning Programme GAM 89 P01), the World Bank (through the Women In Development Project), the Dutch and Canadian Governments (through a grant agreement with CERPOD and the Population Council, for the project "Strengthening Maternal Child Health and Family Planning Programs in the Sahel" - PRPPF).

I also want to express my thanks to CERPOD for analysing and compiling the Report.

Finally I hope that all users of this report will find useful in all aspects of this work.

HON. LANDING JALLOW SONKO  
MINISTER OF HEALTH AND  
SOCIAL WELFARE

# **CHAPTER I**

## **BACKGROUND**

### **1.1 History, Geography, and Economy**

The Gambia is a small, West African country which covers 10,669 square kilometers. Inland, the country spans 350 kilometers from west to east on either side of the Gambia River, varying in width from about 50 kilometers near the mouth of the river to about 24 kilometers upstream. The country is bound to the north, south and east by Senegal, and to the west by the Atlantic Ocean. The Gambia River, which runs the entire length of the country from the east to the Atlantic Ocean, divides the country almost equally into two halves.

The Gambian climate is almost typically Sahelian, with a long dry season from October to May and heavy rainfall during the months of July and August. The rainfall distribution tends to be irregular, and The Gambia has experienced recurrent droughts. In fact, the average annual rainfall has declined over the past two decades from 1,200 mm. to approximately 850 mm. in the southwest, and from 1,000 mm. to approximately 600 mm. in the northeast.

The estuary basin of the Gambia River is virtually a tidal inlet with salt water intrusion ranging from 180 kilometers in the rainy season to 250 kilometers in the dry season. Irrigable land areas are therefore limited and agriculture, the backbone of the Gambian economy, is mostly rain-fed. As a result, agricultural activity is subject to wide seasonal fluctuations, and production levels are vulnerable to variations in rainfall.

After over two centuries of colonial rule under the British, The Gambia gained internal self-government in 1963 and full independence with Dominion Status on February 18, 1965. The country became a sovereign republic within the Commonwealth in 1970. 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. Equality under the law is the most significant characteristic of the judicial system, and The Gambia has maintained one of the best human rights records in the developing world.

The Gambian economy witnessed impressive growth during the first decade of independence (1965-1975), with real GDP growth averaging 4.5 per cent per annum. However, the following ten years (1975-1985) saw a drastic slow down in economic growth. The rate of growth of real GDP averaged just below 3 per cent per annum during this period. Performance was much worse during the latter half of this period and, by early 1985, the underlying internal and external imbalances had assumed major proportions owing to combination of external factors, expansionary financial policies. The growing imbalances were reflected in very slow and at time, negative economic growth, accelerating inflation, and external payments deficits. To arrest this deterioration, the Government adopted a comprehensive medium-term Economic Recovery Program (ERP) in mid-1985.

Major policy changes were introduced with emphasis on allowing market forces a greater role activities; and public sector activities are subjected to much more rigorous criteria of economic efficiency.

In 1990 the Government launched the Program for Sustained Development (PSD). The aims of the PSD are to consolidate the economic benefits derived from reforms initiated under the ERP and introduce policy measures required for sustained growth and development. Its specific objectives are to achieve an annual growth rate of 5.5 per cent by 1992/93; and to reduce current account deficit as a ratio of GDP from 21 per cent in 1989 to about 17 per cent in 1992/93.

## **1.2 Population**

The Gambia is one of the rare West African countries to have conducted three population and housing censuses since 1960, and it is now preparing a fourth census for 1993. These censuses provide a good basis for the study of the Gambia's demographic profile and population dynamics during the past 30 years. Nonetheless, these data have been only minimally exploited.

On the basis of these census statistics, Gambia's population has increased from 493,499 in 1973 to 687,817 in 1983 (Central Statistics Department, 1987). This population is expected to reach 1,434,000 by the year 2010 (Cepod, 1992). The population growth rate

increased during this 10 year period and is expected to increase further during the coming years due mainly to a downward mortality trend. The population growth rate was estimated at 3.4% per year in 1983.

The high rate of population growth results from the combination of a high crude birth rate of 50 per thousand, a crude death rate of 21 per thousand and a positive net migration rate of 0.6 percent.

Fertility levels in the Gambia are quite high. Based on the 1983 census data, it was estimated that the total fertility rate (TFR) for the Gambia is 6.4. Banjul's TFR (5.5) was lower than the national average, and women with a primary or higher level of education also experienced lower fertility, with a TFR of 5.8.

It is estimated that the Gambian population exhibits one of the highest mortality levels in the world. The 1983 census data provide an estimate of the infant mortality rate equal to 167 per thousand. The probability of dying between the first and fifth birthdays is also remarkably high. Nearly 1 out of 10 children who survive to their first birthday will die before they are 5 years old. These high levels of infant and child mortality partially explain why life expectancy at birth is as low as 41.3 for males and 44.2 for females.

One consequence of the high level of fertility is the high proportion of young people in the population. Approximately 44 percent of the population is under 15 years of age. A corresponding indicator of the youthful population structure is the country's high dependency ratio equal to 88 per cent.

The Gambian population is predominantly rural. The percentage of Gambians living in cities is only 21.2 percent. However, the population growth rate in the cities, especially in Banjul and Kanifing Urban District Zone, is much higher than in the rural areas. The rapid urbanization experienced has resulted in a high population density in the urban areas, especially in the capital, Banjul, with 3,600 persons per square kilometer. In Banjul south this density is as high as 9,400 per square kilometer.

Levels of education in the Gambia are still quite low. In 1983, the adult literacy rate was estimated to be 23 per cent. However, primary school enrolment has increased since 1960. In 1987, the primary school enrolment was estimated to be 56 per cent.

TABLE 1.1. THE GAMBIA: BASIC SOCIO-DEMOGRAPHIC INDICATORS

1	Population (mid-1990)	860,000
2	Population Growth Rate (% per year)	3.4
3	Crude Birth Rate - 1983 (per thousand)	50.0
4	Crude death rate - 1983 (per thousand)	21.0
5	Net migration rate - 1983 (% per year)	0.6
6	Total Fertility Rate - 1983	6.4
7	Infant Mortality Rate - 1983 (per thousand)	167
8	Life expectancy at Birth - 1983	
	- Male	41.3
	- Female	44.2
9	Percentage of population under 15 years - 1983	44.0
10	Percentage of urban population - 1983	21.2
11	Population per doctor (1987)	16217
12	Population per hospital bed - 1987	860
13	Adult literacy rate - 1983 (percent)	23
14	Primary school enrolment - 1987 (percent)	56
15	GNP per capita - 1990 US \$	302

Source: Central Statistics Department, Ministry of Finance and Economic Affairs (1991) "Statistical Abstract of the Gambia 1990"

### 1.3 Health Policy and Programs

In accordance with the Alma-Ata Declaration of 1978, the Gambian government aims at providing adequate health care for the entire population by the year 2000. Since 1979, The Gambia has made substantial progress in the health sector. The development of a good health infrastructure through the primary health care (PHC) strategy, has increased pre- and post-natal care and has expanded the immunization program to the point that The Gambia could boast a higher immunization coverage in the early 1980s than many countries could claim by the end of the decade.

Despite these efforts which have been made in the health sector, The Gambia still experiences among the highest rates of infant, child and maternal mortality in the developing world. According to the national maternal mortality survey conducted by the Medical and Health Department, the maternal mortality rate is estimated at 1050 deaths per 100,000 live births per year, as compared to 600 in neighboring Senegal. The figures are even worse when one considers only the rural population. Furthermore, within the rural sector, there are important differences between the maternal mortality statistics in the PHC and non-PHC villages. The maternal mortality rate in the former is estimated as 890 per 100,000 live births as compared to 1600 per 100,000 live births in the non-PHC villages.

Due to major efforts on the part of the Gambian Family Planning Association (GFPA), family planning services were available earlier in The Gambia than in most of the countries in the Sahel. Modern Family Planning Services were introduced in The Gambia in 1968 with the formation of GFPA. Integration of maternal and child health services (MCH) with family planning services has been ongoing for nearly three decades. However, even though contraceptive prevalence is higher in The Gambia than in many sub-Saharan countries, the level of this prevalence is still low. This may explain why the National Population Policy which has been recently adopted by the Gambian government has set the target of increasing contraceptive prevalence from the currently estimated rate of 7-10 percent to 20 percent by 1996 and to 30 percent by the year 2000.

#### **1.4 Population Policy and Programs**

The overall objective of the Gambia's population policy is to increase the country's capability in striking a balance between population growth and the pace of economic progress so as to ensure sustained development. The National Population Policy for Socio-Economic Development was approved by the Cabinet and passed by Parliament in 1992.

Several population projects implemented with the assistance of various donors encompass a wide range of population issues. These projects focus on the following domains:

- maternal and child health and family planning;
- information, education and communication related to population issues;
- data collection and data analysis;
- formulation of a national population policy;
- enhancement of women's status.

## **1.5 Objectives of the Survey**

As part of the UNFPA's "Improvement of MCH/FP Services Project", the Medical and Health Services Department of the Ministry of Labor, Health and Social Welfare planned to conduct a nationwide Contraceptive Prevalence Survey to gather baseline information on current levels of contraceptive use. At the same time, the Ministry of Trade, Industry and Employment (MOTIE) was preparing to conduct a nationwide Fertility Determinants Survey as part of their activities toward the formulation of a comprehensive population policy for the country under UNFPA funded Project GAM/87/P01. After a series of discussions between the Department of Medical and Health Services, the Ministry of Trade, Industry and Employment and the UNFPA, the two surveys were merged into one. Hence, the Gambian Contraceptive and Fertility Determinants Survey came into existence.

The principal objectives of the survey are to obtain accurate information on contraceptive prevalence rates and on the factors that influence fertility. The following specific objectives should be highlighted:

- to measure the knowledge, attitude and practice of contraceptive use among Gambian women and men;
- to obtain information on trends and levels of fertility in the Gambia;
- to identify the effects of the proximate fertility determinants;
- to obtain information on infant and child mortality.

All the above objectives are meant to provide baseline indicators for the:

- Estimation of current contraceptive prevalence rates in the Gambia;
- Development of Family Planning and Maternal and Child Health interventions;
- Formulation and implementation of a population policy for the Gambia.

## **1.6 Organization of the Survey**

### **SAMPLE DESIGN**

The sample frame used for the GCPFDS is the same as that used for the 1983 population and housing census. There was a total of 1,307 enumeration areas (EAs) in the sample frame, and for each enumeration area, the population size in 1983 was available. Due to the tremendous variation in the number of people residing in the EAs, each EA was divided into segments in the following way:

- less than 750 persons 1 segment,
- from 750 to 1249 persons 2 segments,
- from 1250 to 1749 persons 3 segments.

The selection of the segments proceeded in two steps. First, 10 percent of the EAs in each local government area (LGA) were selected with a probability proportional to the number of segments in the EA. Second, one segment was selected in each one of the EAs with a probability equal to the reciprocal of the number of segments in the EA. This methodology necessitated the estimation of weighing factors for each local government area (i.e. the sample was not self-weighing). Finally, 25 per cent of the households in each selected segment were sampled, and all women aged 13 to 49 in the selected households were interviewed. The male questionnaire was administered to half of the men aged 18 and over in the 25 percent of households selected from each segment.

### **QUESTIONNAIRES**

The Gambian Contraceptive Prevalence and Fertility Determinants Survey included three survey instruments:

- The Household Schedule
- The Female Questionnaire
- The Male Questionnaire

The household schedule contained information on local government area (LGA), enumeration area, district and household number, as well as relationship of respondent to head of household and the results of up to three interviewer visits. For each person declared to usually live or currently staying in the household, the following information was obtained: relationship to head of household, residence, sex, age, education, fostering and eligibility status.

The female questionnaire was administered to those aged 13-49 years old in the sample. The survey instrument was similar in design to the core module of the Demographic and Health Survey (DHS) questionnaires (IRD / Macro Systems), although there are a few questions in the GCPFDS not found in the DHS questionnaire and some questions in the DHS instrument not found in the GCPFDS questionnaire. The female questionnaire contained the following seven sections:

- 1 Respondent's background;
- 2 Reproduction;
- 3 Contraception;
- 4 Health and breast-feeding;
- 5 Marriage;
- 6 Fertility preferences;
- 7 Husband's background and woman's work.

The male questionnaire was administered to selected men aged 18 years and older and contained the following modules:

- 1 Respondent's background;
- 2 Contraception;
- 3 Marriage;
- 4 Reproductive and social attitudes.

## **FIELD WORK**

The survey field work was organized as follows. In charge of the entire operation were one coordinator and three technicians. Each technician headed a survey team, and

each team was placed in charge of one geographic area: the South Bank, the North Bank and the Banjul area.

Each team included approximately four interviewing groups, with each group consisting of a supervisor and approximately five interviewers. The distribution of the survey staff by function was as follows:

Coordinator	1
Technicians	3
Supervisors	10
Enumerators	45

In addition there was one office editor, who was also the computer specialist.

The field work commenced on September 29, 1990. The North and South Bank field work was completed at the end of November. The Banjul team finished its work the first week of December. After a thorough office editing, it was determined that two segments needed to be revisited in order to resolve numerous inconsistencies discovered among the answers to the questionnaire. Recall visits were organized for the affected households in the two EAs. These recall visits required an additional 10 days.

#### **DATA ENTRY AND CROSS TABULATION**

Data entry and preliminary frequency tables were done using the International System for Survey Analysis (ISSA) program. Coding and data entry began in March of 1991 and ended in May of 1991. Cross tabulation of survey results was done using the Statistical Package for Social Sciences (SPSS), version 4.0.

## 1.7 Background Characteristics of the Survey Respondents

### AGE AND SEX COMPOSITION OF THE HOUSEHOLD SURVEY

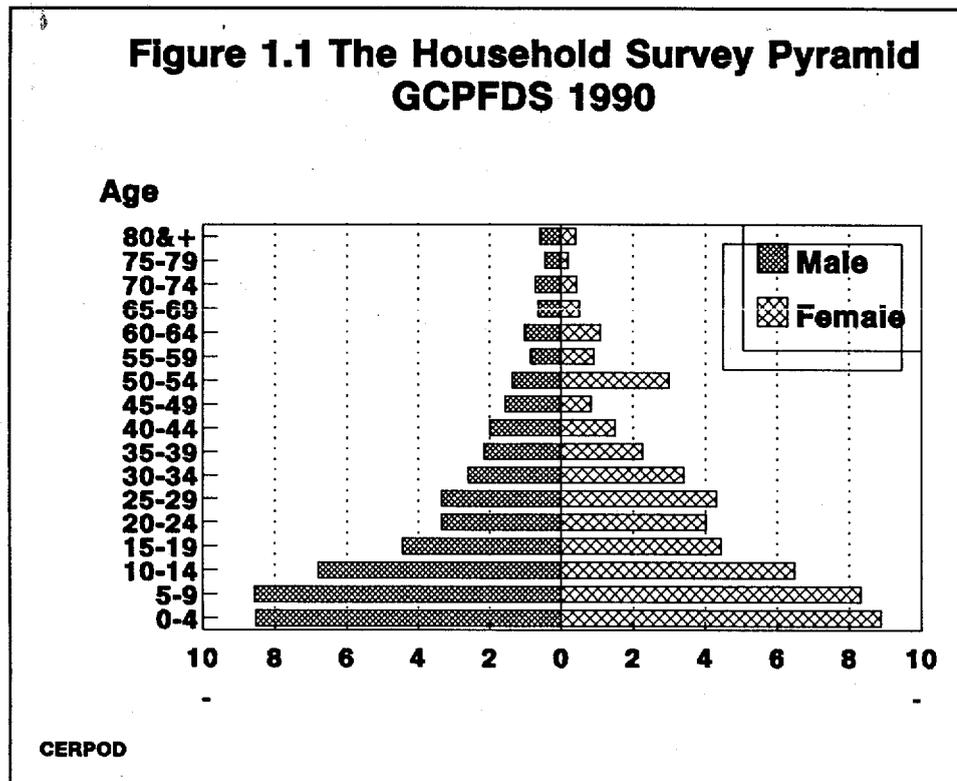
The household survey of the GCPFDS enumerated 13874 residents of whom 6792 were males and 7082 were females. The estimated sex ratio of this population was 95.9, slightly lower than the 1983 population and housing census' sex ratio (99.0). Table 1.2 and Figure 1.1 present data on the age and sex distribution of the enumerated population. As expected, the Gambian population is quite young: 47.6% and 56.5% of the sample are under 15 and 20 years of age, respectively. On the other hand, only 4% of the population is aged 65 years and older.

TABLE 1.2 AGE AND SEX COMPOSITION PER 10,000 PERSONS, GCPFDS, 1990

Age	Male	Female	Total	Sex Ratio
0	122	126	248	96.8
1-4	732	763	1495	95.9
5-9	857	832	1689	103.0
10-14	679	648	1327	104.8
15-19	444	445	889	99.8
20-24	333	403	736	82.6
25-29	334	431	765	77.5
30-34	261	340	601	76.8
35-39	216	227	443	95.2
40-44	199	150	349	132.7
45-49	157	83	240	189.2
50-54	137	300	437	45.7
55-59	84	91	175	92.3
60-64	101	109	210	92.7
65-69	62	52	114	119.2
70-74	73	45	118	162.2
75-79	45	19	64	236.8
80&+	60	41	101	146.3
Total	4 895	5105	10000	95.9

One surprising finding of the household age and sex composition analysis are the relative numbers of women aged 40 to 44, 45 to 49 and 50 to 54 in the sample. There is an important under-count in the age group 45-49 and a corresponding over-count in the age group 50-54. This phenomenon often occurs in surveys of this type where upper and lower age limits are given for the respondent. In the GCPFDS, women aged fifty and over were ineligible for interview. Thus some interviewers tended to overstate the age of women 40 to 49 in order to avoid filling out a questionnaire.

The sex ratio for the age group 10-14 is over 100 and is just under 100 for the age group 15-19, namely 99.8. The reason for this finding is that the age span of female respondents in the GCPFDS is 13-49, not 15-49 which is the usual age range retained for fertility surveys and for the DHS program, in particular.

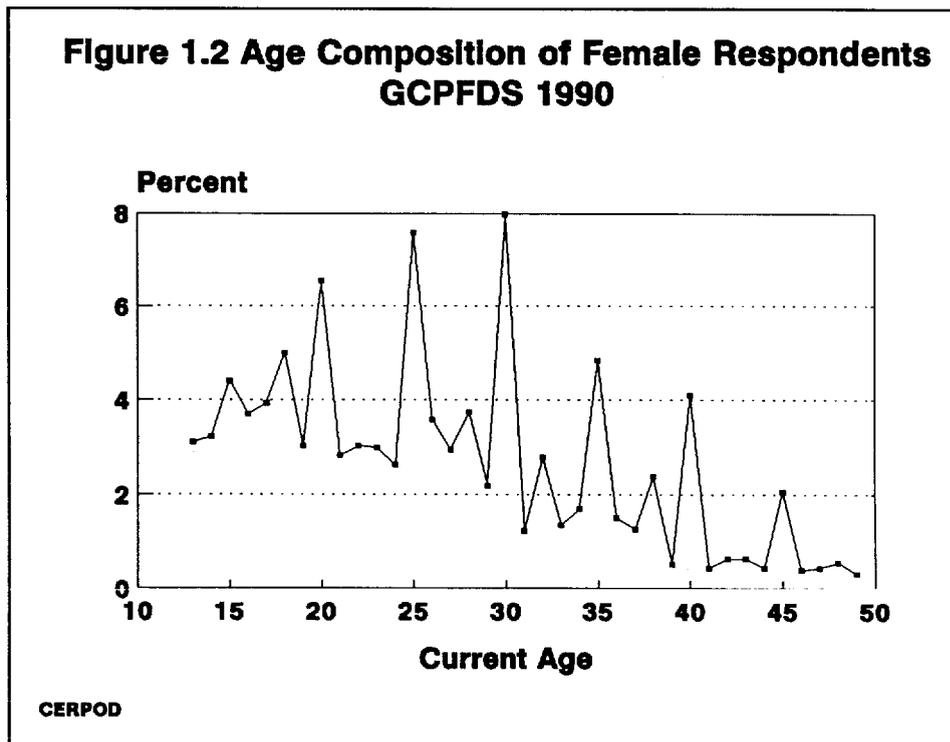


## AGE COMPOSITION

The distribution of female respondents by single years of age which appears in Figure 1.2 is quite irregular. The percentages of women with reported ages ending in digits 0 or 5 are severely over-estimated. Correspondingly, the percentages of women reporting ages ending in digits 4 and 9 are grossly under-reported. Age heaping such as this is quite common in African countries where civil registration systems are weak or lacking altogether. In order to limit the effects of age heaping but also to avoid having too small number of

cases by analyzing single year age groups, the results are presented in five year age groupings.

A close look at Table 1.3 reveals that there are more women in the age group 25-29 (19.8%) than in the age group 20-24 (18.1%), and that there are significantly more women aged 25-29 than 30-34 (14.9%). This would suggest that women have been displaced from the age group 30-34 to the age group 25-29. Therefore, on the average, women in the age group 25-29 are actually somewhat older than they are reported to be.



On the other hand, contrary to expectation, the percentage of women in the ten year age group 40-49 is lower than the percentage of women in the five year age group 35-39. This under representation in the age group 40-49 is partly the result of the overstatement of the age of older women in order not to have to fill out the female questionnaire for these individuals, as outlined above.

## RESIDENCE AND ETHNICITY

Over a fourth of the female respondents, namely 27.2 percent, live in urban areas. This figure is higher than the one set forth in the 1983 Census report (21.2%). The comparison suggests that even though three fourths of the population is living in rural areas, the rate of growth of the urban population is significantly higher than that of the rural population.

For the needs of the analysis, the rural population was divided into two groups: the population living in primary health care villages (PHC) and those living in non-primary health care villages (non-PHC). From Table 1.3 it is clear that the primary health care program of the Gambia has made significant progress. Sixty percent of the rural population was living in villages covered by the primary health care program at the time of the survey.

There are several ethnic groups in the Gambia. The three largest groups are the Mandinka (38.1 %), the Fula (19.4 %), and the Wollof (16.6 %). Because of the small numbers of respondents in the other ethnic group categories, the remaining individuals were regrouped as "other". In order of decreasing population size, the other ethnic groups sampled were the Sarahule, Jola, Serer, Manjago and Aku.

The Ministry of Health has divided the Gambia into three health regions for health service management purposes. More than half of the female respondents reside in the Western Health Region, 14% reside in the Central Health Region, and 32% reside in the Eastern Health Region.

**Table 1.3. Characteristics of the Sample: Female Individual Questionnaire  
GCPFDS, 1990**

	%	Weighted	Unweighted
<b>AGE GROUPS</b>			
13-14	6.5%	163	159
15-19	20.3%	511	505
20-24	18.2%	457	453
25-29	19.8%	498	504
30-34	14.9%	375	379
35-39	10.4%	261	265
40-49	10.0%	252	252
N.S.	0.2%	4	4
<b>PLACE OF RESIDENCE</b>			
Urban	27.2%	683	571
Rural	72.8%	1831	1943
PHC Villages	44.0%	1109	1175
Non-PHC Villages	28.6%	722	768
<b>LOCAL GOVERNMENT AREA</b>			
Banjul	5.4%	135	135
Kombo St Mary	20.2%	510	396
Brikama	16.8%	423	446
Mansakonko	6.7%	168	193
Kerewan	18.8%	473	486
Kuntaur	6.1%	153	172
Georgetown	11.9%	301	321
Basse	14.2%	358	372
<b>HEALTH REGION</b>			
Western	54.2%	1361	1279
Central	13.8%	347	377
Eastern	32.0%	803	855
TOTAL	100.0%	2521	2521

Note: Percentages may not add to 100 due to rounding.

	%	Weighted	Unweighted
<b>LEVEL OF INSTRUCTION</b>			
None	73.8%	1857	1904
Primary	11.1%	279	272
Secondary	15.1%	381	341
<b>ETHNIC GROUP</b>			
Mandinka	38.1%	960	972
Fula	19.4%	489	502
Wolof	16.6%	419	413
Jola	7.0%	177	169
Sarahule	7.3%	183	190
Serere	4.7%	119	111
Others	6.9%	173	163
<b>RELIGION</b>			
Islam	96.1%	2421	2428
Christianity	3.3%	84	77
Others	.6%	15	15
<b>LIVING CHILDREN</b>			
0	30.7%	774	749
1	13.4%	339	343
2	13.7%	346	350
3	12.1%	304	312
4	11.7%	294	299
5+	18.4%	463	468
TOTAL	100.0%	2521	2521

Note: Percentages may not add to 100 due to rounding.

## EDUCATION

As in most African countries, the level of education is quite low, especially for women. Almost three fourths of the female respondents never attended school. The percentage of respondents who did not continue beyond primary school is 11 percent and the percentage who attended secondary or higher levels is 15 %.

As evidenced in Table 1.4, it appears that the proportion of women who have ever been to school declines sharply with age. The percentage of women who have ever been to school is estimated as 52.8% for the age group 13-14, 34.6% for the age group 20-24, and only 10.3% for the age group 40-49. Based on this data, one may justifiably conclude that levels of school enrollment have been improving during the last 30 years.

As expected, school enrollment rates are much higher in the urban sector than in the rural sector. Over half of the urban women (56.3%) have ever attended school, compared to only 15% of their rural counterparts. In the rural area, women residing in primary health care villages are more highly educated than women residing in non-primary health care villages. 19.5% of the women in PHC villages have obtained some formal education, whereas only 8% of the women in non-PHC villages have ever attended school. A partial explanation for this fact may be that PHC villages are more highly populated than non-PHC villages and so are more likely to have schools present.

Among the ethnic groups, a higher percentage of Wolof women have ever attended school than women in any other ethnic group. Over one third of the Wolof respondents have been to school, as compared to one fourth of the Mandinka and one sixth of the Fula.

The health region differentials exhibit an expected pattern. The Western Region which includes the urban areas, sets itself apart from the other two health regions with 42.1% of women having ever attended school. The Central Region with 8.3% and the Eastern Region with 7.2% are essentially rural areas and lag far behind the Western Region in their levels of female school attendance.

TABLE 1.4 PERCENT DISTRIBUTION OF RESPONDENTS BY LEVEL OF EDUCATION ACCORDING TO AGE, RESIDENCE AND ETHNIC GROUP, GCPFDS, 1990

	EDUCATION			Total	Unweighted Number
	None	Primary	Secondary		
<b>Age</b>					
13-14	47.2	39.6	13.2	100	159
15-19	56.5	16.7	26.9	100	505
20-24	65.4	10.7	23.9	100	453
25-29	83.3	7.6	9.0	100	504
30-34	86.9	4.8	8.3	100	379
35-39	85.9	6.5	7.6	100	265
40-49	89.7	3.6	6.7	100	252
<b>Type of Residence</b>					
Urban	43.7	15.1	41.2	100	571
Rural	85.0	9.6	5.4	100	1943
PHC Villages	80.5	12.1	7.4	100	1175
Non PHC Villages	92.0	5.7	2.4	100	768
<b>Ethnic Groups</b>					
Mandinka	74.7	11.8	13.5	100	972
Fula	82.8	9.4	7.8	100	502
Wollof	64.0	10.5	25.5	100	413
Others	72.0	11.6	16.4	100	633
<b>Health Region</b>					
Western Region	57.9	16.6	25.5	100	1279
Central Region	91.7	4.6	3.7	100	377
Eastern Region	92.8	4.6	2.6	100	855
<b>Total</b>	<b>73.8</b>	<b>11.1</b>	<b>15.1</b>	<b>100</b>	<b>2520</b>

Education is one of the most important determinants of the phenomena being studied in this survey, namely fertility levels, contraceptive knowledge, attitudes and practices, infant and childhood mortality and health service utilization. The other correlates of the dependent variables taken into consideration in this report may also be associated with education and thus any apparent relation with the dependent variable of interest may be spurious. Therefore, it is important to keep in mind the association between these independent variables and education when interpreting the various cross-tabulation tables. The inter-relations among independent variables in the survey are depicted in Table 1.5.



## **CHAPTER II**

### **MARRIAGE AND EXPOSURE TO THE RISK OF PREGNANCY**

Determination of levels and differentials in the proximate determinants of fertility is among the principal objectives of the Gambian Contraceptive Prevalence and Fertility Survey. In particular, it is widely known that exposure to the risk of pregnancy is highly correlated with the age at first marriage or union, which in turn is determined by socioeconomic and cultural variables. Among the latter, ethnicity plays an important role in defining the conditions (and the costs) of marriage, while education and place of residence are strong predictors of the marriage form and its stability. Due to the rise of "new" or non-traditional forms of sexuality and marriage, especially in the urban areas of less developed countries, marriage was defined in the analysis of the GCPFDS data to include both formal unions and consensual (living together) arrangements.

Within marriage, other proximate determinants of fertility and contraceptive use, such as the durations of breast-feeding, post-partum amenorrhea and the frequency of intercourse, provide important information on the mechanisms regulating levels and norms of fertility behavior in the given population.

This chapter will first present results from the analysis of data concerning marriage patterns and trends in age at marriage. This information will be followed by results from the analyses of the proximate determinants of fertility other than contraception and abortion, as outlined above.

#### **2.1 Current Marital Status**

Table 2.1 and Figure 2.1 present data on the current marital status of the Gambian women, according to age. Based on the definition of marriage which includes both legal unions and consensual arrangements, nearly three-quarters of the women aged 13-49 are defined to be "married". Four percent of the women are widowed, divorced or separated, and approximately 1 out of every 5 women has never been married. Proportions married in the 15-49 age group compare well with results from the 1986 Senegalese DHS (76.2%)

and are considerably lower than the proportions found for Mali in 1987 (97.1%).

**Table 2.1. Percent Distribution of All Women by Current Marital Status, According to Age, GCPFDS, 1990**

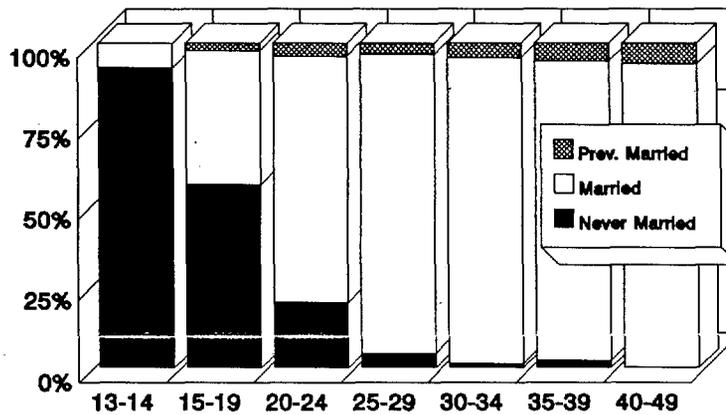
	MARITAL STATUS			TOTAL	Unweighted Count
	SINGLE	MARRIED	PREVIOUSLY MARRIED		
<b>AGE GROUPS</b>					
13-14	92.8	7.2	0.0	100.0	159
15-19	56.4	41.4	2.3	100.0	505
20-24	20.0	76.1	4.0	100.0	451
25-29	4.4	92.1	3.4	100.0	504
30-34	1.5	94.2	4.3	100.0	379
35-39	2.2	92.6	5.4	100.0	265
40-49		93.6	6.4	100.0	252
Missing					7
<b>TOTAL ALL AGE GROUPS</b>	<b>22.4</b>	<b>73.9</b>	<b>3.7</b>	<b>100.0</b>	<b>2521</b>
<b>TOTAL 15-49</b>	<b>17.5</b>	<b>78.5</b>	<b>4.0</b>	<b>100.0</b>	<b>2356</b>
<b>TOTAL 20-49</b>	<b>6.8</b>	<b>88.8</b>	<b>4.4</b>	<b>100.0</b>	<b>1851</b>

\* Previously married includes divorced, separated and widowed. Numbers may not add up to 100 due to rounding.

Considering the oldest age group with 0% having never married, it is evident that in the Gambia essentially all women will enter into some form of marital union during their reproductive years. Furthermore, the norm is to marry young, as evidenced by the fact that even 7% of 13-14 year old girls are currently married, and by the observation that by age 25-29 only 4% of women have never married.

Finally, the data suggest that a woman will spend a very large proportion of her reproductive years in some form of union. This hypothesis is supported by the fact that the probability or prevalence of marriage increases rapidly at the younger ages and remains consistently high for the older ages (over 90% of the women aged 25-29 and up are currently married.)

**Figure 2.1. Marital Status by Age  
GCPFDS 1990**



Previously Married includes Widowed, Divorced, Separated

CERPOD

## 2.2 Age at First Union

In the GCPFDS, all women currently in union were asked to report the month and year when they started to live with their first partner. For a number of reasons, the answers to this question are known to be unreliable. First of all, as is the case in most developing countries, dating events in time is a difficult task for many people. Secondly, marriage in the Gambia, as in many other countries in sub-Saharan Africa, occurs in a number of steps. At which stage of this process a woman considers herself married may well vary from one individual to another. Third, it is the custom among certain sub-groups of the population to send a young girl to live in the household of her future husband at an age prior to the consummation of the marriage, itself. In this case, the age at which the girl begins living with her first partner is not necessarily the same age at which she is truly at risk of becoming pregnant. Thus caution should be taken in interpreting the responses to questions on the date and/or age at first marriage.

Table 2.2 presents the results of the analysis of the data gathered in response to the question on the age at which the respondent started living with her first husband or partner. There are 32 cases (12.9%) for which information on age at first union is unavailable. Considering the distribution of women by age at first union, Table 2.2 reveals that over 50% of the Gambian women marry before reaching 18 years of age. An additional 12% marry between ages 18 and 19, while fewer than 10% marry at ages 20 years and over.

If one were to exclude the oldest age group from the analysis, it appears that the age at first union in the Gambia has been increasing over time. This statement is based on the observation that the median age at first union rises from 16.9 years for the 35-39 year old group to 17.6 years for the 20-24 year old group.

TABLE 2.2. PERCENT DISTRIBUTION OF WOMEN BY AGE AT FIRST UNION AND MEDIAN AGE AT FIRST UNION, ACCORDING TO CURRENT AGE, GCPFDS, 1990

CURRENT AGE	AGE AT FIRST UNION					TOTAL	WEIGHTED NUMBER	MEDIAN AGE *
	NEVER MARRIED	<15	15-17	18-19	20&+			
13-14	94.4	5.6	0.0	0.0	0.0	100.0	160	**
15-19	56.5	12.7	27.1	3.7	0.0	100.0	510	**
20-24	20.1	13.2	43.0	15.0	8.6	100.0	453	17.6
25-29	4.5	17.6	49.2	13.5	15.3	100.0	490	17.0
30-34	1.4	18.7	49.6	16.8	13.3	100.0	369	16.9
35-39	2.3	16.3	53.9	14.3	13.2	100.0	258	16.9
40-49	0.0	10.8	51.0	22.1	16.1	100.0	249	17.3
Missing							32	
TOTAL	22.6	14.3	41.1	12.3	9.5	100.0	2521	**

\* Age by which 1/2 are ever-married.  
 \*\* Omitted due to censoring.

Table 2.3 and Figure 2.2. present data on the median age at first union among women aged 20-49 years, according to selected background characteristics. For the total population, the median age at first union is given as 17.1 years. The largest differential around this population median is found when considering sub-groups by level of education. A positive relationship exists between the age at first union and the level of education, with unschooled women having a median age at first union equal to 16.8 years - nearly 6.5 years younger than the median for women who have studied at the secondary level or higher.

Differentials by urban-rural residence are also quite notable with urban women marrying at an age approximately two years older than rural women (19.1 and 16.8 respectively). The health region differentials in median age at first marriage are the smallest, differing by only one year from a high of 17.7 for the Western Region to a low of 16.6 for the Central Region.

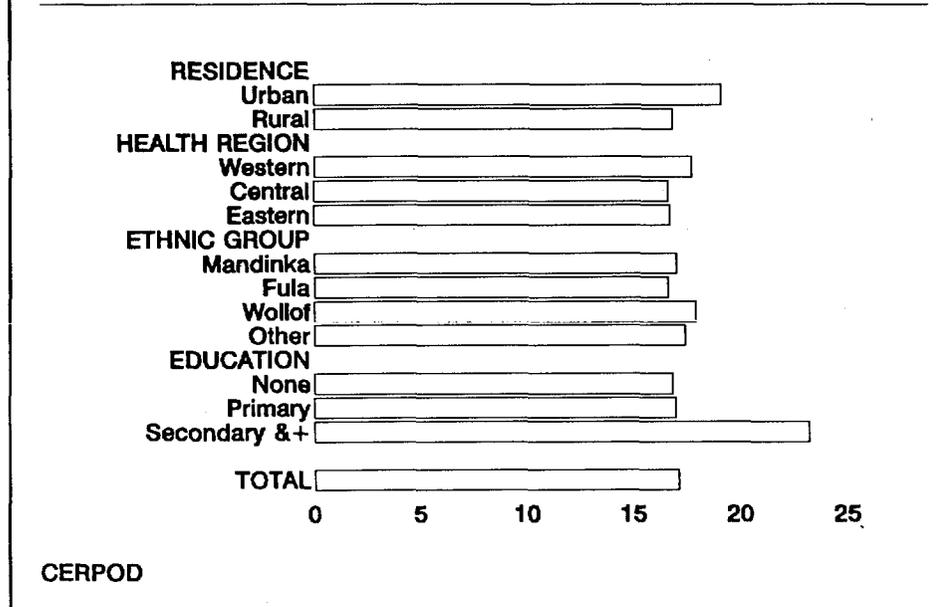
Finally, considering the differentials by ethnic group, Fula women marry the earliest (16.6 years), and Wollof women marry the latest (17.9 years). Further analysis of the median age at first marriage by current age and according to ethnic group reveals that the age at first union is rising among the younger women. However, the patterns are irregular, most notably being the higher ages reported by the oldest women. This phenomenon is interpreted to be an artifact of reporting errors due to the inability to date events in time - a problem known to increase with age (or with time since the event's occurrence).

TABLE 2.3 MEDIAN AGE AT FIRST UNION AMONG WOMEN AGED 20-49 YEARS, BY CURRENT AGE AND SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

BACKGROUND CHARACTERISTIC	CURRENT AGE					WOMEN AGED 20-49
	20-24	25-29	30-34	35-39	40-49	
<b>RESIDENCE</b>						
Urban	21.7	18.3	18.4	18.3	18.9	19.1
Rural	16.9	16.8	16.6	16.7	16.9	16.8
- PHC	16.8	17.0	16.7	16.9	16.9	16.9
- NON-PHC	17.1	16.5	16.5	16.3	17.0	16.7
<b>HEALTH REGION</b>						
Western	18.4	17.5	17.5	17.2	17.6	17.7
Central	16.6	16.6	16.4	17.0	17.0	16.6
Eastern	16.8	16.6	16.5	16.4	16.9	16.7
<b>ETHNIC GROUP</b>						
Mandinka	17.4	17.0	16.8	16.6	17.1	17.0
Fula	16.8	16.4	16.3	16.7	17.1	16.6
Wollof	18.6	17.7	17.7	17.5	18.0	17.9
Other	17.8	17.2	17.1	17.5	17.5	17.4
<b>EDUCATION</b>						
None	16.9	16.7	16.6	16.7	17.0	16.8
Primary	16.6	17.2	-	-	-	17.0
Secondary+	*	22.9	20.5	-	-	23.2
<b>TOTAL</b>	<b>17.6</b>	<b>17.0</b>	<b>16.9</b>	<b>16.9</b>	<b>17.3</b>	<b>17.1</b>

- Less than 20 weighted cases  
\* Censored

**Figure 2.2. Median Age at First Union Among Women Aged 20-49 Years  
GCPFDS 1990**



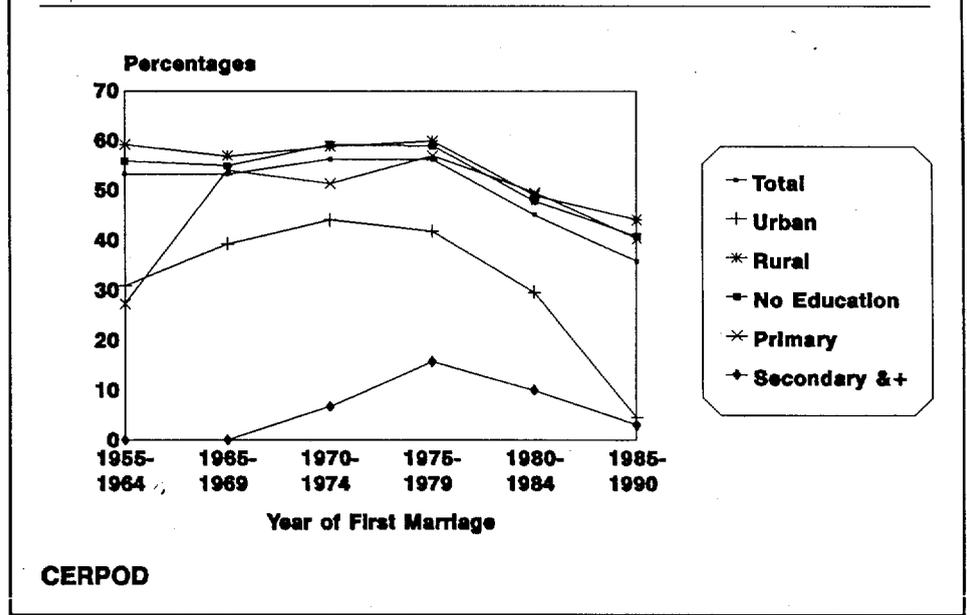
About half of the women ever-married at the time of the survey (48%) married before age 16. This proportion is largely composed of rural women living in the Central and Eastern regions, with a primary or lower level of education. The distribution by marriage cohort (years of marriage) is skewed to the right, with higher proportions married before age 16 in the older marriage cohorts. Figure 2.3. shows the sharp decline in proportions married before age 16 for the successive marriage cohorts. In addition to the observed irregularities by cohort, proportions married before age 16 are lower and the shape of the decline for the successive cohorts more accentuated for the urban and well-educated.

Trends and differentials in age at first union are depicted in table 2.4.

Table 2.4. Percent of Ever-Married Women Married for the First Time Before Age 16 by Calendar Years in Which Marriage Took Place, According to Selected Characteristics, GCPFDS, 1990

BACKGROUND CHARACTERISTIC	PERCENT OF EVER-MARRIED WOMEN MARRIED FOR THE FIRST TIME BEFORE AGE SIXTEEN						TOTAL
	YEAR OF FIRST MARRIAGE						
	1955-1964	1965-1969	1970-1974	1975-1979	1980-1984	1985-1991	
<b>PLACE OF RESIDENCE</b>							
URBAN	30.9	39.3	44.0	41.8	29.6	4.5	29.2
RURAL	59.2	56.9	58.8	59.9	48.9	44.0	53.1
<b>HEALTH REGION</b>							
WESTERN	46.5	43.7	52.4	46.9	37.6	23.3	39.4
CENTRAL	59.4	51.2	55.9	61.7	51.2	41.3	53.3
EASTERN	60.5	68.6	61.7	64.4	53.5	49.3	58.1
<b>LEVEL OF INSTRUCTION</b>							
NONE	55.8	54.9	59.2	59.0	47.8	40.8	52.1
PRIMARY	27.3	53.9	51.3	57.0	49.5	40.3	46.2
SECONDARY +	0	0	6.7	15.7	10.0	3.0	7.1
<b>ETHNIC GROUP</b>							
MANDINKA	60.9	57.3	50.0	54.2	51.9	36.4	50.0
FULA	52.3	56.9	61.2	78.4	53.2	47.6	59.0
WOLLOF	51.0	32.8	60.5	47.5	35.4	32.1	41.6
JOLA	53.4	39.1	65.4	57.1	28.9	25.2	45.8
SARAHULE	71.1	65.4	64.4	56.9	43.0	34.4	50.8
SERERE	31.9	66.4	37.4	30.8	30.6	4.4	28.8
OTHERS	11.0	35.7	56.8	21.9	34.1	27.5	30.6
TOTAL	53.3	53.2	56.2	56.2	45.1	35.7	48.3
UNWEIGHTED COUNT	129	204	304	426	411	474	1948

Figure 2.3. Ever-Married Women Married Before Age 16  
GCPFDS 1990



## 2.3 Polygamy

In the GCPFDS, each woman who was legally married or living together with a partner, was asked how many other wives her husband or partner had besides herself. The results of the analysis of the responses to this question are presented in Tables 2.5 and 2.6.

**Table 2.5. Percent Distribution of Number of Co-spouses Among Currently Married Women Aged 13-49, GCPFDS, 1990**

NUMBER OF CO-SPOUSES	%
Monogamous	49.4
1	29.1
2	16.3
3 or more	4.7
Not Stated	.6
Total	100.0

Approximately 50% of women currently in union, aged 13-49, live in monogamous marriages. The other half live in polygamous unions, most of whom have one co-spouse (29.1%) or two co-spouses (16.3%).

**TABLE 2.6 PERCENT OF CURRENTLY MARRIED WOMEN IN A POLYGAMOUS UNION, BY AGE AND SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990**

BACKGROUND CHARACTERISTIC	CURRENT AGE					TOTAL	
	15-19	20-24	25-29	30-34	35-39		40-49
<b>RESIDENCE</b>							
Urban	-	-	32.1	41.3	43.2	59.0	37.6
Rural	34.7	41.2	55.5	66.4	58.5	62.9	53.5
- PHC	38.5	44.0	56.7	71.1	60.5	63.7	56.3
- NON-PHC	30.8	37.6	53.7	60.7	54.7	61.3	49.6
<b>HEALTH REGION</b>							
Western	28.4	32.0	47.1	52.1	50.0	59.8	45.5
Central	-	-	48.6	58.9	71.0	65.1	53.2
Eastern	35.2	46.6	58.4	73.2	55.7	63.4	55.7
<b>ETHNIC GROUP</b>							
Mandinka	33.8	43.2	47.4	63.6	61.9	66.7	53.0
Fula	32.8	-	46.9	52.2	43.5	50.0	41.3
Wollof	-	37.9	52.8	57.1	-	-	48.4
Other	-	38.8	59.8	65.7	55.4	67.2	55.8
<b>EDUCATION</b>							
None	36.8	39.9	53.2	64.4	56.3	61.4	52.9
Primary	-	-	-	-	-	-	45.2
Secondary+	-	-	-	-	-	-	23.7
<b>TOTAL</b>	<b>34.6</b>	<b>37.0</b>	<b>51.3</b>	<b>60.8</b>	<b>55.8</b>	<b>61.9</b>	<b>50.4</b>

- Less than 20 weighted cases

Table 2.6 reveals that the overall probability of being in a polygamous union increases with age, although the relationship is not directly (and in all cases) linear. This phenomenon is difficult to interpret as it may reflect a true declining trend in the prevalence of polygamy, but it may well be an artifact reflecting the probability that a women is more likely to be in a polygamous union the longer she has been married (the more time her husband has to take additional wives).

Polygamy in the Gambia is more prevalent in the rural areas (53.5%) than in the urban areas (37.6%). Within the rural sector, women living in primary health care villages (PHC) are more likely to be in polygamous unions than women living in non-primary health care villages (56.3% and 49.6% respectively). The relationship between modernization (urban residence serving as a proxy) and polygamy is not straightforward. Many hypotheses have been set forward to explain this relationship based on variables, including among others, household structure, cost of living, modes of production and norms/preferences associated with modern education. Although the urban-rural differential in the Gambia may be in the expected direction, it is nonetheless surprising the extent to which polygamy prevails in the urban area. Further analysis is needed in order to detail causal pathways and differentials in the prevalence of polygamy.

Regional differentials in the prevalence of polygamy are small with the Western (highly urban) region having the lowest percent of women in polygamous unions (45.5) and the Eastern region having the highest percent (55.7).

The ethnic group differentials are noteworthy, especially in terms of their relationship to age at first union. If the duration of marriage is a strong predictor of the probability of being in a polygamous union, then one would expect the prevalence of polygamy to be higher among the Fula who demonstrate the lowest median age at first marriage. The opposite is in fact the case. The Fula are the least likely to enter into a polygamous union (41.3%) of all the ethnic groups observed. This finding encourages the researcher to look more closely at differences in mode of production and family organization by ethnic group in determining the predominant influences on marriage structure in the Gambia.

## **2.4 Exposure to the Risk of Pregnancy**

Determination of levels and trends in fertility and contraceptive use require analysis of the determinants of women's "exposure" to the risk of pregnancy. As already discussed, marriage patterns are an important determinant of overall fertility differentials. However, within marriage itself (as loosely defined), a number of other factors come into play in determining an individual's exposure to the "risk" of becoming pregnant. A woman is defined to be at risk if she is sexually active, ovulating and fecund.

In the Gambian Contraceptive Prevalence and Fertility Determinants Survey, numerous questions were asked in order to gain information on the proximate determinants of fertility as specified above. A currently married woman was defined to be sexually active if she had intercourse in the 4 weeks preceding the survey. Ovulation was measured indirectly. Women who were pregnant or who had not resumed menstruating since the birth of their last child were considered anovulatory. The most problematic variable to assess, even indirectly, was fecundity, defined as the ability to conceive. Women were determined to be infecund if they had no birth in the five years preceding the survey and had never used contraception. A major objection to this definition is that some proportion of the women (a decreasing proportion with age) were not married (or sexually active) during some part of the five year period preceding the survey. This problem is greatest for the youngest women, and so they were excluded from the analysis of "infecundity".

Table 2.7 presents the distribution of women by exposure status, according to current age. It should be noted that the categories in the table are defined hierarchically, but in reality are not necessarily mutually exclusive (for example, a woman can be both amenorrheic and sexually inactive). If the order of the categories were changed, a somewhat different distribution of cases would be obtained.

Approximately 12% of currently married women in the Gambia are pregnant. Overall, this percentage declines with age from a high of 20.4% for the 15-19 year old group to a low of 3.4% for the 40-49 year old group. Twenty percent of the currently married Gambian women are classified as amenorrheic. One expects to find the observed higher

prevalence of amenorrhea among the younger women who experience higher fertility rates.

Excluding the youngest women from the analysis, it is estimated that approximately 16% of the married women in the Gambia are infecund. As expected, the percent infecund rises with age from a low of 10.7% for the 20-24 year old to 36.9% of the oldest women.

Nineteen percent of the women have not had intercourse in the four weeks preceding the survey and are thus classified as "sexually inactive". It should be noted that these percentages would be higher for every age group were sexual activity placed higher in the hierarchy of categories. In particular, the trend in percent sexually inactive by age is not readily interpreted since some proportion of the women classified infecund are also sexually inactive. Since infecundity increases with age, it is expected that the percent sexually inactive is increasingly underestimated as age increases in Table 2.7.

TABLE 2.7. PERCENT DISTRIBUTION OF CURRENTLY MARRIED WOMEN BY EXPOSURE STATUS, ACCORDING TO AGE, GCPFDS, 1990

EXPOSURE STATUS	CURRENT AGE						TOTAL
	15-19	20-24	25-29	30-34	35-39	40-49	
PREGNANT	20.4	13.3	14.2	9.9	7.8	3.4	11.7
AMENORRHEIC	18.0	23.1	24.2	19.3	19.0	10.6	19.9
INFECOND	-	10.7*	11.1	19.3	24.0	36.9	16.3
SEXUALLY INACTIVE	21.8	22.0	14.8	15.3	21.5	22.0	19.0
EXPOSED	39.8	30.9	35.7	36.3	27.7	27.1	33.1
TOTAL	100	100	100	100	100	100	100
WEIGHTED NUMBER	211	346	459	353	242	236	1847

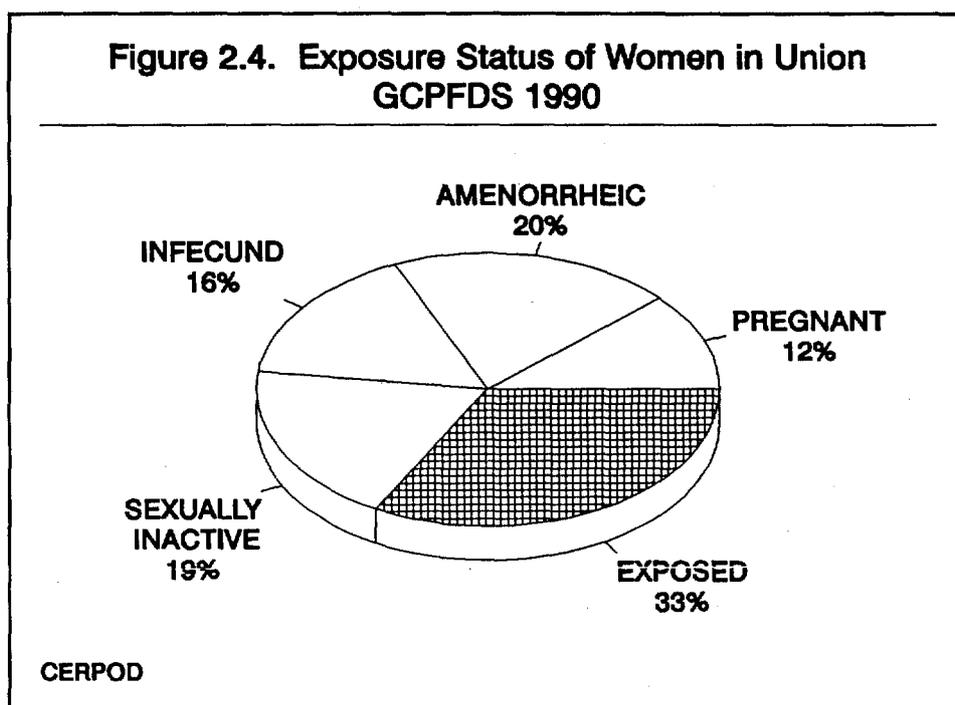
Note: Table does not take into account current contraceptive status in determining percent exposed to the risk of pregnancy.

- The definition of "infecund" is having had no births in the 5 years preceding the survey and never having contracepted. 15-19 year old were excluded from the analysis because many of them were not exposed to the risk of pregnancy (i.e. not married) during a large part of the 5 year period preceding the survey.

\* This group also has some (significant) proportion of women who were not married and not at risk of pregnancy during some proportion of the 5 year period preceding the survey.

After subtracting the percents pregnant, amenorrheic, infecund and sexually inactive, the residual is defined to be the percent of women in each age group who are exposed to the risk of becoming pregnant. It should be noted that some percentage of these women are currently contracepting and may not truly be exposed.

**Figure 2.4. Exposure Status of Women in Union  
GCPFDS 1990**



By this definition, 33% of Gambian women currently in union are exposed to the risk of pregnancy. Although the percent exposed is highest among the youngest women, the percent exposed does not fall off substantially with age. More will be said on the subject of demand and need status in relation to exposure status in Chapters 4 and 5.

## **2.5 Breast-feeding, Postpartum Amenorrhea and Abstinence**

The interval between two births may be divided into three periods: 1) the period of post-partum insusceptibility, 2) the period of exposure to the risk of pregnancy, and 3) the period of gestation or pregnancy, itself. Although gestation may be disrupted due to spontaneous/induced abortion or miscarriage, excluding these events, the duration of pregnancy is generally given as 40 weeks. The middle period of the birth interval, defined as the period of exposure to the risk of pregnancy, is highly variable in length and depends on factors such as fecundity, use of contraception and frequency of intercourse. Several of these factors were discussed in the previous section.

The period of insusceptibility is the segment of the birth interval during which a woman is anovulatory. The duration of post-partum anovulation is largely determined by breast-feeding practices, including duration, frequency and intensity. There exists a positive relationship between these breast-feeding variables and the duration of anovulation. Since a woman is unable to directly observe the return of ovulation, the return of menses is used as a proxy since the two events are highly correlated. However, it should be noted that ovulation may occur prior to the return of menses, thus placing a woman at risk of becoming pregnant during the period of amenorrhea.

There is another factor which may contribute to the duration of postpartum insusceptibility in some populations, and this is the duration of postpartum abstinence. The latter is only significant in lengthening the first segment of the birth interval if its duration exceeds the duration of postpartum amenorrhea. Hence for comparative purposes, data on the duration of postpartum abstinence will also be analyzed in this chapter.

In the GCPFDS, all women who had given birth during the five year period preceding the survey were asked questions concerning whether or not they breastfed each infant and for how long. Furthermore, for each live birth in the 5 years preceding the survey, the women were also asked how many months had passed between the birth and the return of their menses. In the case of the most recent birth (open interval), the respondents were asked if they abstained from sexual relations following the birth (and for what duration if they had resumed relations by the time of the survey).

Analysis of data on reported durations of breast-feeding, amenorrhea and postpartum abstinence has revealed that the information is highly unreliable due to such factors as recall bias and problems in dating events in time. Thus the "current status" method commonly used in epidemiological studies to determine disease prevalence, duration and incidence is applied to the data at hand and has been found to provide robust indicators.

The current status methodology is based on the formula:

$$\text{PREVALENCE} = \text{INCIDENCE} \times \text{DURATION}$$

In the GCPFDS, data on the prevalence of breast-feeding and postpartum amenorrhea are available for all live births occurring during the five year period preceding the interview. Data on the prevalence of postpartum abstinence is available only in

reference to the most recent live birth (if this open interval birth occurred in the preceding five years). In other words, women were asked whether or not they were still breast-feeding and whether or not their menses had returned since the birth of each child during the past five years. Women were asked if they had resumed sexual relations since the birth of their last child.

Table 2.8 presents the proportions of infants still breastfed, (or mothers) still amenorrheic and still abstaining by number of months since birth. Only live births which occurred during the interval 0-35 months prior to the survey are included in this analysis. The mean durations of breast-feeding, amenorrhea and abstinence are calculated using the "current status" formula:

$$\text{DURATION} = \text{PREVALENCE}/\text{INCIDENCE}$$

Prevalence is defined as the total number of infants (births) whose mothers are currently breast-feeding (amenorrheic, abstaining). Incidence is defined as the average number of live births per month during the 36 month period preceding the survey.

The results presented in Table 2.8 and Figure 2.5 indicate that breast-feeding remains a common practice in the Gambia. More than half of all infants born within the three year period preceding the survey were currently being breastfed at the time of the survey. At 21 months, the mean duration of breast-feeding in the Gambia is in the middle range of those recorded in sub-Saharan Africa. Comparative figures for a number of other DHS countries are given in Table 2.10. It is noteworthy that the proportions of infants being breastfed remain consistently high through the first year of life. The proportions remain moderately high, falling quite gradually and steadily through the second year of life. After 23 months, the proportion being breastfed declines by nearly 50%.

TABLE 2.8 PROPORTIONS OF WOMEN (13-49) STILL BREAST-FEEDING, POSTPARTUM AMENORRHEIC, AND ABSTAINING BY MONTHS SINCE BIRTH, AND MEAN DURATIONS OF BREAST-FEEDING, AMENORRHEA AND ABSTINENCE, GCPFDS, 1990

MONTHS SINCE BIRTH	STILL BREAST-FEEDING	STILL AMENORRHEIC	STILL ABSTAINING	WEIGHTED NUMBER OF BIRTHS
0- 1	96.2	86.8	83.0	53
2- 3	84.3	86.3	80.4	51
4- 5	87.9	65.5	58.6	58
6- 7	93.3	63.3	53.3	60
8- 9	92.3	69.2	48.1	52
10-11	80.4	51.0	35.3	51
12-13	82.1	43.6	37.2	78
14-15	82.5	46.2	33.8	80
16-17	73.3	38.3	35.0	60
18-19	62.8	34.9	34.9	43
20-21	68.4	42.1	28.1	57
22-23	54.2	32.2	18.6	59
24-25	28.2	20.5	9.0	78
26-27	17.0	14.8	18.2	88
28-29	22.4	16.4	20.9	67
30-31	23.9	17.9	13.4	67
32-33	12.5	12.5	6.2	64
34-35	24.0	12.0	8.0	50
TOTAL	58.2	40.0	32.9	1116*
MEAN	21.0	14.4	11.8	

\* Includes births occurring in the period 0 - 35 months prior to the survey.

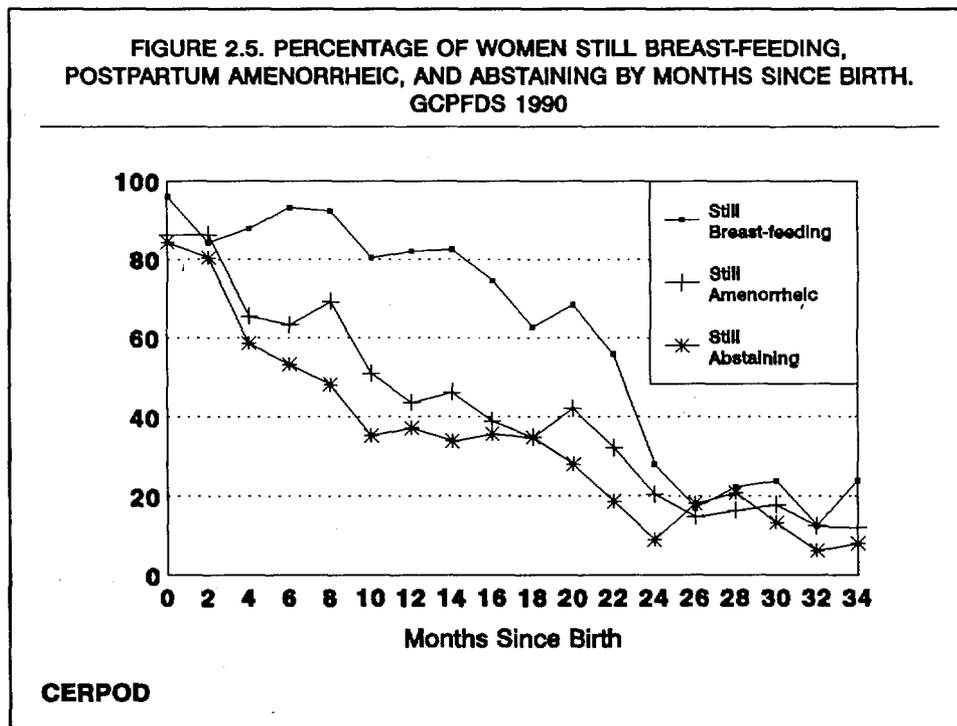
Postpartum amenorrhea refers to the period following a birth before the return of the menstrual cycle. During this period a woman is usually infecund. The duration of postpartum amenorrhea is highly variable and depends to a large extent on the woman's physiological condition (nutritional and weight change factors), as well as on the intensity, frequency and duration of lactation. Thus one notes the strong correlation between the duration of breast-feeding and the duration of postpartum amenorrhea.

The mean duration of postpartum amenorrhea in the Gambia is 14.4 months. Given the association between the durations of breast-feeding and amenorrhea, it is not surprising that the duration of postpartum amenorrhea in the Gambia is among the middle range of values observed in sub-Saharan Africa (see Table 2.10). Whereas in many societies in the absence of breast-feeding, women resume menstruating on the average two to three months postpartum (Page et al, 1982), in the Gambia, less than 20% of the mothers had resumed menstruating by the same point in time. Furthermore, at one year postpartum, approximately 50% of the mothers were still amenorrheic. Especially noteworthy is the

observation that at two years postpartum, as many as 20% of the mothers stated they were still amenorrheic.

The practice of postpartum abstinence though believed to be on the decline, is still highly prevalent among certain populations and sub-groups in sub-Saharan Africa. In most societies where postpartum abstinence is practiced, its duration is linked to the duration of breast-feeding. Together these behaviors are culturally reinforced with the health and survival of the mother and newborn at stake. The relationship between the durations of breast-feeding and abstinence varies between populations, in some cases the two appear to be complements, in other cases complements and substitutes. As mentioned previously, the duration of postpartum abstinence only exerts an influence on the period of postpartum insusceptibility if its duration exceeds that of postpartum amenorrhea.

In the case of the Gambia, the mean duration of postpartum abstinence is approximately 12 months, inferior to the mean duration of amenorrhea. Nonetheless, an average 12 month duration of postpartum abstinence is remarkably long for a Muslim country which is assumed to hold to the Islamic dictate of a 40 day waiting period.



Considering the proportions abstaining by months since birth, it is interesting to note that there is a substantial decline in the percentage abstaining after two to three months postpartum - the interval which encompasses the 40 day waiting period.

Table 2.9 and Figure 2.6 present data on differentials in the proximate determinants of post-partum insusceptibility, according to selected background characteristics of the mother. The data reveal that women under the age of 30 breastfeed their infants on the average two months longer than women thirty and over. Differentials in breast-feeding practices by place of residence are small, with rural women breast-feeding on the average one month longer than urban women. Within the rural sector, the mean duration of breast-feeding in the primary health care villages is approximately one month less than in the non-primary health care villages.

Regional differentials in breast-feeding practices range from a low mean of 19.9 months in the Western region to a high of 22.1 months in the Eastern region. Correspondingly, excluding the ethnic group classified "other", differentials in the mean duration of breast-feeding range from a low of 20.7 months for the Fula to a high of 22.1 months for the Mandinka.

Numerous studies have shown that one of the strongest predictors of duration of breast-feeding is the level of education. The most highly educated women are hypothesized to breastfeed for the shortest duration due to the incompatibility between breast-feeding and labor force participation. The Gambian data partially support this hypothesis as it is observed that children born to women with a secondary or higher level of education have the shortest mean duration of breast-feeding at 17.1 months. However, the inverse relationship between level of education and duration of breast-feeding is not directly linear. According to Table 2.9, children born to women with a primary level of education are nursed slightly longer than children born to women who have never attended school.

As expected, the differentials in the mean duration of postpartum amenorrhea closely parallel those of the mean duration of breast-feeding. Mothers who are under thirty, rural and living in the Eastern health region are, on the average, amenorrheic the longest. The Wolof demonstrate the longest duration of post-partum amenorrhea, even though the Mandinka exhibit the longest duration of breast-feeding. The differentials in postpartum

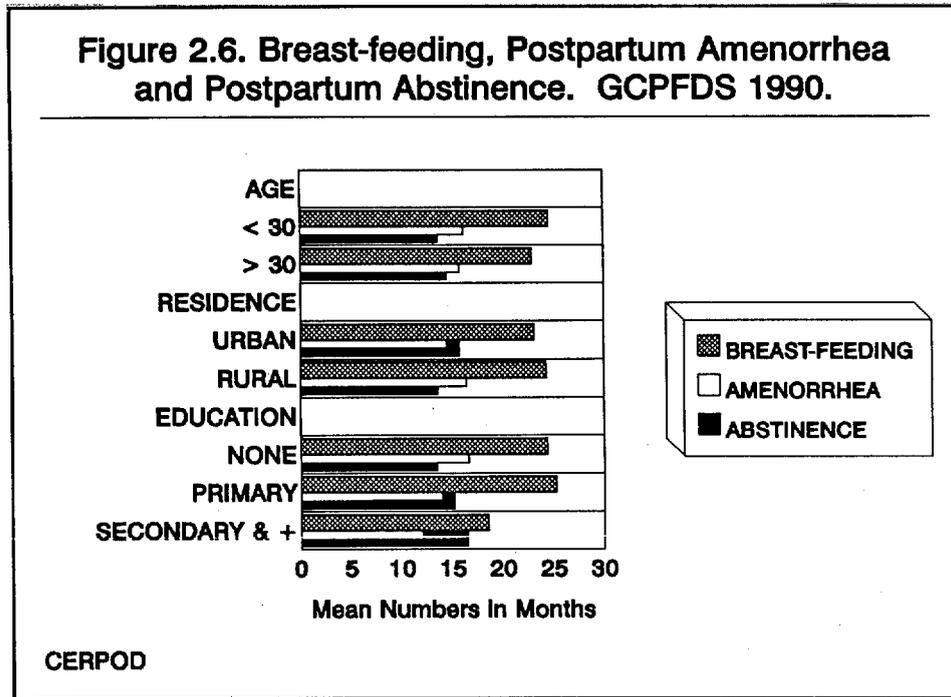
amenorrhea by level of education exhibit an interesting reversal. As was true in the case of breast-feeding, the mean duration of postpartum amenorrhea is shortest among women with the highest level of education (12.6 months). However, women with a primary school level of education share the 12.6 month duration of amenorrhea, this despite the fact that they present the longest duration of breast-feeding.

TABLE 2.9 MEAN DURATION OF BREAST-FEEDING, POSTPARTUM AMENORRHEA AND POSTPARTUM ABSTINENCE (CURRENT STATUS ESTIMATES BASED ON BIRTHS WITHIN 36 MONTHS OF THE INTERVIEW DATE), BY SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

BACKGROUND CHARACTERISTIC	BREAST-FEEDING	AMENORRHEA	ABSTINENCE	WEIGHTED* NUMBER OF BIRTHS
<u>AGE</u>				
<30	21.7	14.5	11.8	743
30&+	19.8	14.1	12.2	370
<u>RESIDENCE</u>				
Urban	20.1	13.5	13.5	197
Rural	21.3	14.6	11.6	911
-PHC	20.7	14.0	11.3	550
-NON PHC	21.9	15.5	12.2	361
<u>REGION</u>				
Western	19.9	12.9	11.9	512
Central	21.9	15.2	12.8	171
Eastern	22.1	16.0	11.7	424
<u>ETHNIC GROUP</u>				
Mandinka	22.1	14.7	12.8	437
Fula	20.7	13.7	11.7	236
Wolof	21.0	16.4	9.1	158
Other	19.5	13.2	12.3	281
<u>EDUCATION</u>				
None	21.2	14.7	11.6	935
Primary	22.3	12.6	13.0	97
Secondary &+	17.1	12.6	14.8	80
<u>TOTAL</u>	21.0	14.4	11.8	1116
* Includes live births occurring 0-35 months prior to the survey.				

Perhaps most noteworthy and enigmatic in the analysis of the proximate determinants are the differentials in the levels of postpartum abstinence. On two accounts the findings are contrary to those expected: 1) The differentials do not work in the same direction as those of breast-feeding and amenorrhea. 2) The differentials are, in the case of certain variables, quite large.

**Figure 2.6. Breast-feeding, Postpartum Amenorrhea and Postpartum Abstinence. GCPFDS 1990.**



Contrary to the differentials in breast-feeding and amenorrhea, mothers under the age of thirty exhibit a somewhat shorter duration of postpartum abstinence than mothers 30 years and older (11.8 months and 12.2 months, respectively). Similarly the mean duration of postpartum abstinence among rural women is nearly two months less than the duration of urban women, even though the latter have shorter durations of breast-feeding and postpartum amenorrhea. In the case of the ethnic group differentials, it is the order of magnitude of the difference in the mean which is most striking. The mean duration of postpartum abstinence among the Mandinka is nearly 4 months longer than the same among the Wollof (12.8 months and 9.1 months, respectively).

Finally, the differentials by level of education are also intriguing. Contrary to expectation, the most highly educated women (who demonstrate the shortest mean durations of breast-feeding and amenorrhea), exhibit the longest mean duration of postpartum abstinence. At 14.8 months, this duration is more than three months longer than the same for women who had never attended school. The levels and differentials in the proximate

determinants (including the surprisingly high levels of postpartum abstinence in a predominantly Muslim country), as well as their relationship to one another and their overall impact on contraceptive prevalence and fertility deserve further analysis. Results would be particularly useful in deepening our understanding of family demographics and in developing strategies for family planning service delivery in The Gambia.

TABLE 2.10. COMPARATIVE DHS ESTIMATES OF THE MEAN DURATION OF BREAST-FEEDING, POSTPARTUM AMENORRHEA AND POSTPARTUM ABSTINENCE FOR SELECTED SUB-SAHARAN AFRICAN COUNTRIES

COUNTRY	BREAST-FEEDING	AMENORRHEA	ABSTINENCE	DHS YEAR
GAMBIA*	21.0	14.4	11.8	1990
SENEGAL	18.8	16.2	7.9	1986
MALI	21.6	15.3	7.0	1987
LIBERIA	17.0	11.2	13.2	1986
GHANA	20.4	14.0	13.5	1988
TOGO	22.6	14.4	17.5	1988
BURUNDI	23.8	19.1	3.5	1987
KENYA	19.4	10.9	5.9	1989

\* The Gambia data is from the 1990 Contraceptive Prevalence and Fertility Determinants Survey.

## CHAPTER III

### FERTILITY

The Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS) of the Gambia is the only nationwide investigation which addresses fertility levels, trends and differentials in the country. Other demographic operations which have collected some fertility data are the 1963, 1973 and 1983 censuses. However, these are less detailed and are less reliable than those of the GCPFD Survey.

The reproduction section of the survey instrument was one of the most important ones and required considerable training of and attention on the part of the interviewers. As is customary, fertility questions concerning the number of children living with the respondent, the number of children living away, the number of children who have died and the age at first birth were asked. More detailed fertility information was collected in the live birth history section of the women's questionnaire. For each of the respondent's live births, pertinent information including sex, birth date, survival status and age at death, if appropriate, was collected. Contrary to most fertility surveys, the GCPFDS also asked for each child whether or not the child has been fostered out. This information was collected in order to enable analysis of the relationship between fertility and child fostering.

The fertility information, along with background socio-economic information collected in other sections of the survey, provide data for the analysis of fertility levels, differentials and trends. The fertility levels and differential analyses in this chapter are followed successively by analyses of pregnancy at the time of the survey, of children ever born, and of age at first birth. Therefore, this chapter investigates not only fertility levels and trends, but also gives insights on age at first birth which is an important determinant of fertility in a population such as the Gambian, among whom fertility control is quite limited.

### **3.1 Fertility Levels and Differentials**

Table 3.1 and Figure 3.1 present the total fertility rates (TFR) for the periods 1988-1990, 1985-1987 and 0-4 years before the survey and the mean number of children ever born to women aged 40-49, according to selected background characteristics (residence, health region, level of education and ethnic group). The two five year age groups, 40-44 and 45-49, have been regrouped into one in order to avoid the small number of observations in some subgroups of the sample of women. Age-specific fertility rates for the three periods are given in table 3.2.

The TFR is a cross-sectional measure which pertains to the specified period. It provides, in this analysis, a measure of recent fertility levels. On the other hand, the mean number of children ever born to women aged 40 to 49 is a cohort measure which approximates the achieved parity of women who have attained menopause or are about to attain menopause. This cohort's fertility experience began on the average approximately 35 years ago.

For the period 0 to 4 years before the survey, the total fertility rate is estimated as 5.9. This is the number of children a woman would have by the end of her reproductive lifetime if she experiences the age-specific fertility rates of the period and no mortality. This estimate may be compared to the 1988-1990 and 1985-1987 period estimates. For the more recent period the TFR is 5.54 and for the other, the TFR is 6.65.

There is quite a large difference between the two estimates of approximately one child. It is unlikely that fertility has declined in the Gambia by this amount in a so short a period of time. A more likely explanation is that the difference is partly an artifact of errors in the reporting of children's month and year of birth. Misreporting of birthdate is not uncommon in countries where civil registration is weak or lacking, and the extent (and consequences) of misreporting appear to be more severe in African countries than in Latin American and Asian countries. One of the consequences of this displacement is an underestimation of fertility in the most recent three-year period as compared to the previous one (IRD, 1990). Due to these reporting errors and their effect on TFR estimates, it is

advised that estimates for the five year period preceding the survey be used instead of the estimates for the two three-year periods.

TABLE 3.1 TOTAL FERTILITY RATE FOR THE CALENDAR PERIODS 1988-90 AND 1985-1987 AND FOR THE PERIOD 0-4 YEARS BEFORE THE SURVEY, AND THE MEAN NUMBER OF CHILDREN EVER BORN TO WOMEN AGED 40-49, BY SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

	Total Fertility Rates		0-4 years before the survey	Mean number of children ever born to women 40-49
	1985- 1987	1988- 1990		
Type of Residence				
Urban	5.05	4.37	4.68	5.60
Rural	7.23	5.97	6.40	6.69
Phc villages	7.42	6.06	6.60	6.82
Non Phc village	6.85	5.78	6.10	6.47
Health Region				
Western	6.30	5.36	5.83	5.71
Central	7.80	5.55	6.38	7.87
Eastern	6.69	5.88	6.06	6.76
Level of schooling				
None	7.16	5.82	6.30	6.58
Primary	5.24	6.61	6.64	6.33
Secondary and higher	3.03	3.60	5.09	3.96
Ethnic Group				
Mandinka	7.34	5.53	6.19	6.81
Fula	6.26	5.99	6.11	5.71
Wollof	6.03	4.93	5.46	5.90
Others	6.09	5.65	5.83	6.45
All women	6.65	5.54	5.95	6.40

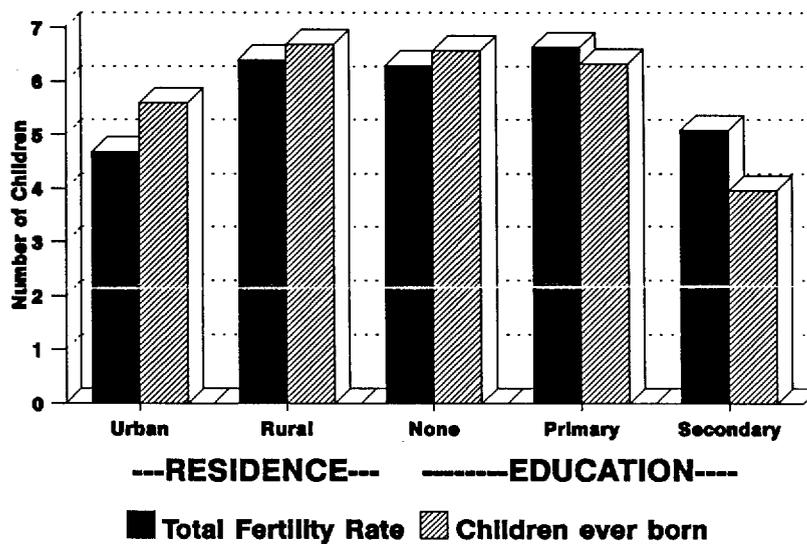
Based on the TFR estimates, it may be concluded that fertility in the Gambia is quite high even though it appears to be slightly lower than in neighbouring countries. For example, the estimated TFR for Mali and Senegal from the DHS are respectively 6.9 and 6.6 (Traoré and others, 1989 and Ndiaye and others, 1988). As will become evident in this section's summary of findings, the apparent lower level of fertility in the Gambia is not due to data quality differentials but is the logical result of differences in levels of the proximate determinants of fertility in the three countries.

For each one of the selected background variables analyzed, one observes important differentials in fertility levels, which in some cases are quite large. The level of fertility in the urban setting is significantly lower than the level of fertility in the rural areas. Urban women experience a TFR of 4.68, while their rural counterparts experience a TFR of 6.40, resulting in a difference of approximately 2 children.

The rural women may be subdivided into two groups: those living in villages with primary health care services and the others. Fertility seems to be slightly higher in the first group than in the second, a somewhat surprising finding. Family planning services are supposed to be more available in primary health care villages than in non-primary health care villages. Education appears to be a fertility level determinant at least as important as urbanization (and of course the two variables are known to be highly correlated). While fertility levels appear to be approximately the same for women who have never been to school and for women who have attained no higher than a primary level of education, the difference between these groups and women with a secondary level of education or higher is quite important. The mechanisms by which education operates to affect fertility outcome are through intervening proximate determinants such as age at first marriage, contraceptive use, duration of breastfeeding and post-partum abstinence.

Considering the remaining two selected characteristics, health region and ethnic group, differences in fertility levels are also apparent, although to a lesser degree than those evidenced when considering the other two variables. In fact, a great deal of the variation found in the health region and ethnic group variables may be explained by education and urbanization differentials within health regions and ethnic groups. The Western Health Region which exhibits the lowest fertility level is more urbanized and has achieved higher levels of female education than the Central and Eastern Health Regions. Likewise, Wolof women, who exhibit the lowest fertility are more highly educated and more urbanized than the women in the other ethnic groups.

**Figure 3.1 TFR 0-4 Years Before Survey and CEB to Women 40-49 by Residence and Level of Education. GCPFDS 1990.**



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**TABLE 3.2 AGE-SPECIFIC FERTILITY RATES (per 1,000 women) FOR THE CALENDAR YEAR PERIODS, 1985-87 AND 1988-90, AND FOR THE PERIOD 0-4 YEARS BEFORE THE SURVEY, GCPFDS, 1990**

Age	Period 1985-87	Period 1988-90	0-4 years before the survey
15-19	221.0	154.0	167.0
20-24	293.8	247.7	270.3
25-29	257.6	243.9	237.8
30-34	234.2	178.8	228.2
35-39	152.9	125.2	130.4
40-49	85.1	79.5	77.7
TFR	6.65	5.54	5.95

## 3.2 Fertility Trends

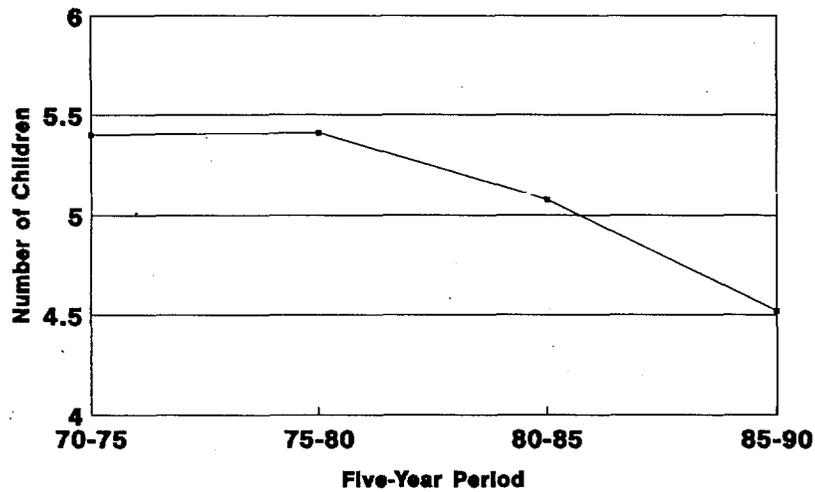
As was discussed in the previous section, the large differential in the TFRs for the three-year periods, 1985-1987 and 1988-1990, is mainly due to birth date misplacement. However, by comparing the TFR estimate for the period 0-4 years preceding the survey to the average number of children ever born to women aged 40 - 49, it is possible to obtain information regarding fertility trends. Table 3.3 presents comparative information on fertility trends in the form of age-specific fertility rates for seven five-year periods preceding the survey. However, it should be emphasized again that this data is subject to error due to birth date misplacement.

Despite the erratic fluctuations evident in Table 3.3, when one considers the figures of the last 20 years one may conclusively state that fertility has declined in the Gambia. Taking into account only the last twenty years and the age span 15-34, Figure 3.2 which presents cumulated age-specific fertility rates for women aged 15-34, evidences a fertility decline during the last 15 years. This result is consistent with the one derived in Table 3.1 which compared the TFR of 5.95 for the last five year period with the average number of children ever born to women aged 40-49, estimated as 6.40.

TABLE 3.3 AGE-SPECIFIC FERTILITY RATES (per 1,000 women) FOR FIVE YEAR PERIODS BEFORE THE SURVEY BY AGE OF THE MOTHER AT THE TIME OF BIRTH, GCPFDS, 1990

	Five-Year Periods Before the Survey						
	0-4	5-9	10-14	15-19	20-24	25-29	30-34
15-19	167.0	222.9	227.5	266.9	237.1	191.9	243.5
20-24	270.3	275.8	312.5	260.5	280.8	295.7	
25-29	237.8	302.7	267.3	282.8	31.3		
30-34	228.2	213.7	274.7	269.6			
35-39	130.4	198.0	147.8				
40-49	77.7	130.4					

**Figure 3.2 Cumulated Age Specific Fertility Rates for Women 15-34 for the Last Four Five-Year Periods Before Survey. GCPFDS 1990.**



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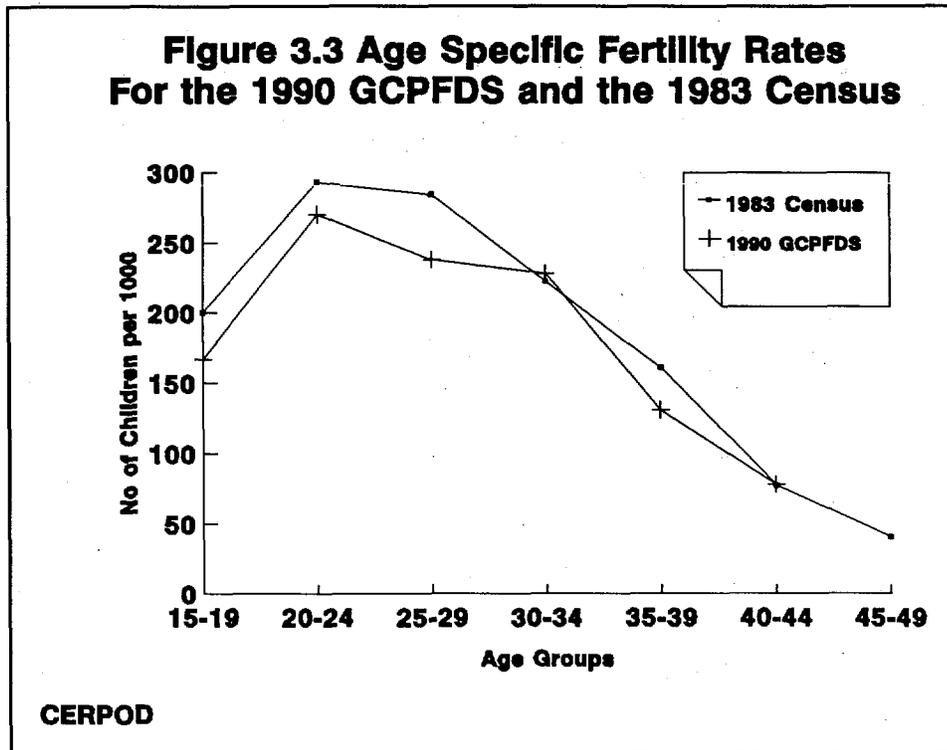
Table 3.4 which presents age-specific fertility rates from the 1983 census and from the GCPFDS, confirms our conclusion. The TFRs are estimated as 6.4 and 6.0 respectively.

**TABLE 3.4 AGE-SPECIFIC FERTILITY RATES (per 1000 women) AND THE TOTAL FERTILITY RATE, 1983 CENSUS AND 1990 GCPFDS**

Age group	1983 Census	0-4 years before GCPFDS
15-19	200.1	167.0
20-24	293.0	270.3
25-29	284.7	237.8
30-34	222.4	228.2
35-39	160.6	130.4
40-44	77.2	77.7 *
45-49	40.4	
TFR	6.39	5.95

\* 40-49 age group

**Figure 3.3 Age Specific Fertility Rates  
For the 1990 GCPFDS and the 1983 Census**



The TFR of 5.95 for the five year period preceding the survey is lower than the mean number of children ever born to women aged 40 to 49, estimated as 6.40. If these estimates are accurate, it would mean that women who are 40-49 years old would have had fewer children than they actually had if they had experienced the fertility rates of the most recent five year period. In other words, fertility would have declined slowly during the last years.

For most of the socio-economic sub-groups which appear in Table 3.1 and Figure 3.1, we also note a fertility decline when comparing the TFRs for the 0-4 years preceding the survey with the mean number of children ever born to women aged 40-49 years. The education variable is being excluded from the analysis due to the small number of women aged 40-49 who have ever attended school. Except for the Western Health Region and for Fula women, the mean number of children ever born is consistently higher than the TFR for the five year period, confirming the proposed decline in fertility. This fertility decline is greatest among urban women, Wollof women and women in the Central Health Region. While the large decline in fertility among urban women and Wollof women (mostly urban)

is anticipated since contraception is expected to penetrate urban areas before rural areas, the fertility decline differentials by health region are surprising. Fertility decline does not appear to have occurred in the Western Health Region which includes Banjul and Kombo Saint Mary where most of the urban women live. However, the figures show that fertility level is lower in the Western Health Region than in the other two, which is expected. Since fertility has declined for the urban women this would mean that fertility has increased among the rural women of the Western Health Region. In any case, further analysis is needed in order to give a satisfactory explanation.

### 3.3 Current Pregnancy

Another commonly employed measure of current fertility is the percentage of women who were pregnant at the time of the survey. However, pregnancy is often under-reported, especially by those women in the early stages of pregnancy. Nevertheless, the measure, when estimated for different age groups, provides reliable information on the timing of fertility since under-reporting of the event affects all age groups in the same manner. Thus the level of fertility, but not its timing, is biased due to under-reporting of current pregnancy.

TABLE 3.5 PERCENT DISTRIBUTION OF CURRENTLY MARRIED AND ALL WOMEN PREGNANT AT THE TIME OF THE SURVEY, GCPFDS, 1990

Age	Currently Married Women		All Women	
	Percent	Unweighted Numbers	Percent	Weighted Numbers
15-19	20.6	218	8.8	505
20-24	13.5	345	10.1	453
25-29	14.1	461	13.1	504
30-34	10.0	355	9.3	379
35-39	7.6	242	7.3	265
40-49	3.4	235	3.2	252
Total	11.7	1856	9.3	2358

At the time of the survey 11.7 percent of all married women and 9.3 percent of all women were pregnant. Among all women the highest percentages are found successively for the age groups 25-29 and 20-24, and the lowest percentages are found at the youngest and oldest ages of the childbearing span. For married women the highest percentage is found for the age group 15-19, successively followed by the age groups 25-29 and 20-24. The notably higher percentage pregnant in the age group 15-19 among married women is consistent with short first birth intervals and a pattern of early marriage and first births (the median age at first marriage in the GCPFDS is 17.1, from Table 2.3, and the median age at first birth is 17.4, from Table 3.8).

### 3.4 Children Ever Born

Table 3.6 presents the distributions of currently married women and all women by the number of the children ever born and, for each age group, the mean number of children ever born.

TABLE 3.6 PERCENT DISTRIBUTION OF ALL WOMEN AND CURRENTLY MARRIED WOMEN BY NUMBER OF CHILDREN EVER BORN AND MEAN NUMBER OF CHILDREN EVER BORN, ACCORDING TO AGE, GCPFDS, 1990

Age	Number of Children Ever Born											Total	Mean	Number of women		
	0	1	2	3	4	5	6	7	8	9	10&+					
Currently Married Women																
15-19	37.3	42.6	17.2	2.9									100.0	0.86	218	
20-24	11.2	23.3	31.9	20.1	9.4	2.7	1.2	0.3					100.0	2.08	345	
25-29	4.9	7.5	18.2	18.4	21.3	16.9	7.5	4.0	0.9	0.4			100.0	3.53	461	
30-34	5.7	4.8	8.8	13.7	14.5	17.7	14.2	9.1	8.3	1.7	1.4		100.0	4.55	355	
35-39	1.3	1.7	5.9	5.9	14.0	14.0	15.7	10.6	8.5	12.3	10.2		100.0	6.10	242	
40-49	2.1	4.3	4.7	6.4	11.2	10.3	9.4	10.7	10.3	15.0	15.5		100.0	6.48	235	
Married Women	9.1	12.8	15.5	12.9	13.1	11.2	8.1	5.6	4.2	4.0	3.6		100.0	3.84	1856	
All Women																
15-19	71.4	20.2	7.2	1.2									100.0	0.38	505	
20-24	26.3	22.6	25.4	15.6	7.0	2.0	0.9	0.2					100.0	1.65	453	
25-29	8.6	8.2	17.7	17.1	20.9	15.9	6.8	3.6	0.8	0.4			100.0	3.35	504	
30-34	6.9	4.8	9.0	13.8	14.4	17.8	13.6	9.0	7.7	1.6	1.3		100.0	4.44	379	
35-39	3.1	1.5	6.1	7.6	13.7	13.4	14.9	9.5	8.0	13.0	9.2		100.0	5.92	265	
40-49	2.0	4.0	6.4	6.4	10.8	10.0	9.6	11.6	10.0	14.4	14.8		100.0	6.40	252	
All Women	24.1	11.9	13.0	10.6	10.8	9.1	6.5	4.5	3.4	3.3	2.8		100.0	2.96	2358	

The mean number of children ever born is 2.96 for all women and 3.84 for currently married women. For both groups of women the mean rises sharply from 0.86 and 0.38 respectively for the age group 15-19 to 6.48 and 6.40 for the age group 40-49. This picture indicates that completed family size in the Gambia, although not among the highest recorded in Africa, is still quite high.

Another way to analyse fertility levels is to consider the percentage of women with high parity by age. For example, in the age group 40-49, the percentage of women with at least 6 live births is over 60 percent, and those with 8 or more live births is close to 40 percent. Even the percentage of women aged 40 to 49 with 10 or more live births is quite notable. More than one in seven women has had 10 or more children by the end of her childbearing years.

The differences between the two panels of Table 3.6 are mainly due to the fact that most childbearing occurs within marriage. The differences are greater for the youngest women among whom the proportions married are much lower than among the older women, who are virtually all married.

Especially noteworthy in Table 3.6 is the low level of primary sterility among the target population. Since it may be assumed that childlessness in the Gambia, as in all Sub-Saharan African countries, is involuntary and is due either to sterility of the woman or sterility of her partner, primary sterility levels may be estimated by the percentage of women who are childless at age 40. This percentage is equal to 2 for the Gambia, whereas for Mali and Senegal it is higher than 3 percent (Traoré and others 1989, Ndiaye and others, 1988).

### **3.5 Children Ever Born and Age at First Marriage**

Since most of childbearing occurs within marriage, one would expect, all else being equal, that the earlier the age at first marriage, the higher the achieved fertility. However, as it is demonstrated in Table 3.7, when one controls for the number of years elapsed since first marriage, the effect of age at first marriage on fertility levels appears to be insignificant. The only figures which should be highlighted are those for women who were married 0-4 years prior to the survey. Among these women, the mean number of children ever born to women aged 20 years and over at marriage is about 40 to 50 percent higher than the averages for the other three age categories.

TABLE 3.7 MEAN NUMBER OF CHILDREN EVER BORN TO EVER MARRIED WOMEN BY AGE AT FIRST MARRIAGE, ACCORDING TO NUMBER OF YEARS SINCE FIRST MARRIAGE, GCPFDS, 1990

Years since 1st marriage	Age at First Marriage				Total	Number of Women
	<15	15-17	18-19	20&+		
0-4	0.92	0.85	0.89	1.31	0.95	389
5-9	2.42	2.75	2.78	2.18	2.60	391
10-14	3.62	4.13	3.72	3.76	3.94	434
15-19	5.02	5.09	4.91	4.78	5.02	330
20-24	5.82	6.66	5.95	4.61	6.26	231
25-29	7.81	6.27	7.04	5.96	6.70	132
30&+	7.37	7.32	7.11			49
Total	4.00	4.03	3.51	2.82	3.79	1956

### 3.6 Age at First Birth

The age at which women begin childbearing is an important determinant of overall fertility levels, especially in populations where use of contraception is quite low. In such populations, one would expect that the earlier women begin childbearing, the higher would be their fertility. Secondly, the demographic and medical literature has shown that childbearing before the age of 18 poses greater health risks to both the mother and the child than childbearing after 18. As can be seen from Table 3.8, the median age at first birth is quite low, ranging from 16.3 to 17.4 years for the five year age groups. Considering women over the age of twenty, one may conclude that between 43.8% and 58.8% of their first births occurred too early, meaning before their eighteenth birthday.

From Table 3.8 one may NOT conclude with confidence that the age at first birth has been increasing during the past 30 years. The oldest women (40-49) have virtually the same median age at first birth (17.2) as the youngest women for whom a median age at first birth is available (17.4). Nonetheless, there is an approximate one unit year difference between ages at first birth for the age group 20-24 and the middle three age groups of women.

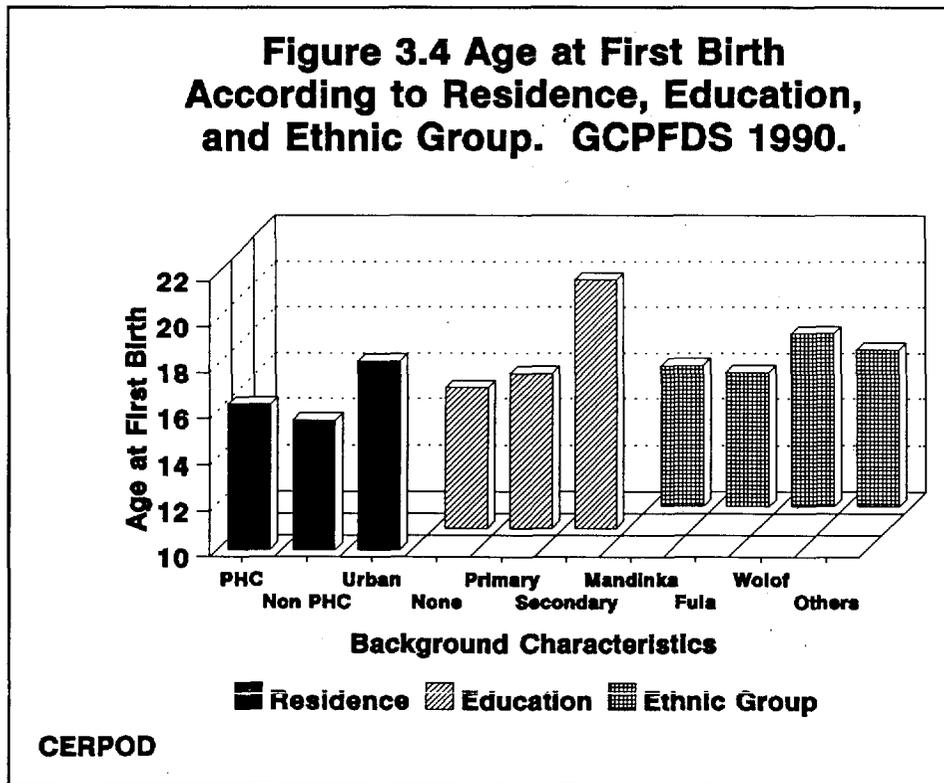
TABLE 3.8 PERCENT DISTRIBUTION OF ALL WOMEN BY AGE AT FIRST BIRTH (INCLUDING CATEGORY "NO BIRTHS") AND MEDIAN AGE AT FIRST BIRTH, ACCORDING TO CURRENT AGE, GCPFDS, 1990

	No birth	Age at first birth						Total	Median	Number of women
		<15	15-17	18-19	20-21	22-24	25&+			
15-19	69.8	7.7	19.4	3.0				100	*	500
20-24	25.7	8.5	35.3	20.4	8.5	1.6		100	17.4	442
25-29	7.9	11.7	46.1	16.6	8.3	7.2	2.3	100	16.4	474
30-34	7.1	12.5	40.9	17.3	10.8	7.1	4.3	100	16.5	356
35-39	3.1	9.2	49.6	18.0	9.2	5.7	5.3	100	16.3	232
40-49	2.1	8.5	39.6	21.7	13.2	6.8	8.1	100	17.2	236
ALL	24.2	9.7	36.8	15.1	7.5	4.2	2.5	100	17.4	2240

\* Omitted due to censoring.

### 3.7 Differentials in Age at First Birth

From Figure 3.4 and Table 3.9 it appears that age at first birth varies considerably according to current socio-economic characteristics.



The largest differential is observed when considering the education variable, where the median age at first birth for women with secondary or higher level of schooling is over 4 units higher than the age for women with no or primary levels of education. The next highest differential is found in the residence category, where rural women's first birth occurs on the average at an age two years younger than urban women. Differentials by ethnic group are smallest, although one still finds a difference of .7 years when comparing the Wollof with the Fula women.

TABLE 3.9 MEDIAN AGE AT FIRST BIRTH AMONG WOMEN AGED 25-49 BY CURRENT AGE, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristics	Current Age				
	25-29	30-34	35-39	40-49	All Ages
<b>Primary Health Care</b>					
PHC Villages	16.5	15.8	16.2	16.3	16.3
Non PHC Villages	15.4	15.6	15.7	16.1	15.6
Urban	17.4	18.3	17.8	19.0	18.2
<b>Place of Residence</b>					
Urban	17.4	18.3	17.8	19.0	18.2
Rural	16.1	15.7	16.0	16.2	16.0
<b>Level of Education</b>					
None	16.0	15.8	16.0	16.9	16.1
Primary	15.9	17.7	16.2	19.0	16.7
Secondary	21.4	20.3	19.5	21.5	20.8
<b>Ethnic Groups</b>					
Mandinka	16.3	15.9	15.5	16.6	16.1
Fula	15.8	15.5	15.8	16.5	15.8
Wollof	17.2	17.4	17.5	18.3	17.5
Others	16.2	16.8	16.9	17.9	16.8
<b>Total</b>	16.1	16.7	16.2	17.0	16.5

## **CHAPTER IV**

### **CONTRACEPTION**

The Gambian Contraceptive and Fertility Determinants Survey (GCPFDS) is the first of its kind to provide nationally representative information on knowledge of, attitudes toward and practice of contraception in the Gambia. Collection of data relating to family planning issues was, in fact, the primary objective of the GCPFDS. Analysis and evaluation of this information was determined to be a necessary phase in the development of a national population policy and in the reformulation of maternal and child health activities. Of special concern in targeting populations at high risk, are differentials in knowledge, attitudes and practices according to selected background characteristics, including urban-rural residence and level of education.

This chapter focuses on results from the analysis of data relating to family planning issues in the Gambia. Information will be presented concerning the respondents' knowledge of methods, their sources of information and supply, and problems they perceive relative to the use of the various methods. Contraceptive use data will be evaluated relative to past and current use, with special attention given to the rhythm method. Data on the characteristics of non-users will be presented, along with information on the intention to use contraception in the future. Attitudes towards becoming pregnant and towards contraceptive use will also be analyzed.

In the GCPFDS, knowledge of the various contraceptive methods was first elicited spontaneously with the question, "Have you ever heard of (METHOD)?" If the answer was no, knowledge of the method was probed with a brief description. If knowledge of the method was affirmed spontaneously or with probe, the respondent was then asked if she had ever used the method. Regardless of her response to the "ever-use" question, the respondent was then asked where she would go to obtain the method if she desired to use it. Additionally, the respondent was queried as to what she perceived to be the main

problem, if any, with the method.

#### **4.1 Knowledge of Methods and Sources**

Knowledge of contraceptive methods and their appropriate source of supply is a necessary precondition for contraceptive use. In the GCPFDS, respondents were asked to acknowledge having heard of both modern and traditional methods of contraception. The former category includes the pill, the IUD, injection, vaginal methods (diaphragm/foam/jelly), the condom, female and male sterilisation. The second category includes periodic abstinence, withdrawal, juju and "other". Women who claimed knowledge of a particular method were then asked where they would go to obtain the method. It should be noted that this source of supply question was asked for ALL methods including periodic abstinence and withdrawal. Since the question was structured in such a manner, the category "Nowhere" was included as a possible response. This helped to minimize, but did not eliminate, inconsistencies between reported methods and their corresponding sources.

Table 4.1 presents data on knowledge of methods among all and currently married women, according to the specific method, by age and place of residence. In general, knowledge of at least one method of family planning and its source is remarkably high in the Gambia. 80% of all women claimed to have heard of at least one method, three quarters of the women claimed knowledge of at least one modern method, and slightly more than 60% of the women had ever heard of at least one traditional method.

The corresponding percentages for currently married women were quite similar to those for all women. 81% of currently married women had ever heard of at least one method. Slightly fewer than three quarters of the married women had heard of at least one modern method, and 64% had ever heard of at least one traditional method. Thus married women evidenced a slightly greater familiarity with traditional methods than all women, while the opposite holds true for modern methods.

TABLE 4.1 PERCENTAGE OF ALL WOMEN (15-49) AND OF MARRIED WOMEN (15-49) KNOWING A CONTRACEPTIVE METHOD, BY AGE, SPECIFIC METHOD AND RESIDENCE, GCPFDS, 1990.

AGE	ANY METH.	PILLS	IUDS	INJECTIONS	DIA/FOAM /GEL	CONDOMS	FEMALE STER.	MALE STER.	ANY MODERN	PER. ABST.	WITHDRAW	JUJU	OTHER	ANY TRADIT.	COUNT
<b>ALL WOMEN</b>															
15-19	77.2%	69.5%	26.1%	57.3%	10.9%	48.7%	30.3%	5.3%	72.7%	10.7%	7.8%	47.2%	.6%	50.7%	511
20-24	80.5%	72.3%	34.8%	63.2%	20.7%	55.1%	37.8%	0.7%	74.7%	24.6%	11.6%	56.1%	3.1%	63.9%	457
25-29	85.9%	77.6%	29.2%	66.9%	13.3%	50.3%	37.6%	8.5%	79.2%	16.5%	10.9%	64.0%	3.1%	69.4%	498
30-34	79.1%	66.5%	28.3%	61.1%	13.3%	40.6%	34.7%	7.8%	71.7%	19.4%	10.9%	60.7%	3.5%	65.8%	375
35-39	80.5%	69.0%	27.5%	64.0%	12.7%	39.4%	34.0%	5.9%	75.6%	18.1%	8.2%	58.1%	3.3%	63.5%	261
40-49	78.4%	63.8%	25.4%	56.7%	11.1%	36.2%	36.8%	5.0%	69.4%	16.1%	8.7%	56.0%	4.3%	62.8%	252
TOTAL	80.5%	70.6%	28.9%	61.8%	13.9%	46.6%	35.1%	7.5%	74.3%	17.4%	9.8%	56.8%	2.8%	62.3%	2354
<b>ALL MARRIED WOMEN</b>															
15-19	80.3%	70.1%	20.9%	58.5%	9.4%	39.4%	30.2%	3.5%	73.9%	9.6%	4.4%	50.2%	1.5%	54.1%	211
20-24	78.1%	69.2%	30.4%	60.0%	16.9%	51.6%	35.0%	0.1%	70.9%	22.4%	8.3%	56.1%	2.9%	63.3%	346
25-29	85.5%	76.5%	26.9%	65.5%	11.7%	47.0%	36.3%	7.3%	78.2%	15.3%	8.9%	62.9%	3.4%	68.3%	459
30-34	78.8%	65.8%	27.0%	60.0%	12.2%	38.8%	33.6%	7.0%	71.0%	18.7%	10.0%	60.6%	3.5%	65.6%	353
35-39	79.7%	67.7%	25.0%	62.3%	10.8%	36.5%	32.8%	5.3%	74.4%	16.6%	5.2%	59.0%	3.1%	62.9%	242
40-49	78.2%	63.0%	24.7%	56.3%	10.4%	35.2%	35.9%	3.4%	69.0%	16.3%	8.9%	57.5%	4.6%	64.4%	236
TOTAL	80.6%	69.5%	26.3%	61.0%	12.2%	42.6%	34.3%	6.6%	73.3%	16.9%	8.0%	58.5%	3.2%	64.1%	1847
<b>MARRIED WOMEN OF URBAN AREAS</b>															
15-19	93.6%	75.7%	32.2%	75.7%	32.2%	71.0%	46.7%	0.0%	87.1%	25.7%	12.9%	59.6%	6.4%	72.5%	20
20-24	93.2%	86.0%	53.0%	81.9%	39.8%	76.1%	57.9%	33.4%	87.8%	49.4%	24.4%	63.3%	3.6%	82.7%	72
25-29	92.1%	83.9%	46.3%	78.7%	19.1%	66.5%	53.8%	21.3%	85.0%	24.3%	18.6%	62.0%	1.5%	72.1%	87
30-34	93.9%	82.3%	52.0%	82.7%	22.5%	67.1%	57.1%	24.6%	90.5%	32.5%	24.2%	67.9%	.0%	79.1%	75
35-39	100.0%	94.1%	60.8%	89.6%	27.5%	74.9%	62.1%	16.3%	97.1%	35.6%	11.8%	69.7%	.0%	78.5%	44
40-49	91.4%	79.0%	50.0%	75.3%	26.3%	69.8%	55.4%	10.2%	87.1%	30.6%	16.1%	68.7%	.0%	78.4%	60
TOTAL	93.7%	84.0%	50.4%	80.7%	26.9%	70.4%	56.2%	20.7%	88.7%	33.6%	19.4%	65.4%	1.4%	77.6%	357
<b>MARRIED WOMEN OF RURAL AREAS</b>															
15-19	78.9%	69.4%	19.8%	56.9%	7.0%	36.2%	28.7%	3.9%	72.4%	7.9%	3.5%	49.5%	1.0%	52.5%	190
20-24	74.1%	64.8%	24.5%	54.3%	10.9%	45.3%	29.0%	4.0%	66.5%	15.4%	4.1%	54.2%	2.8%	58.3%	275
25-29	83.9%	74.6%	22.0%	62.1%	10.0%	42.0%	32.0%	4.1%	76.4%	13.1%	6.7%	63.1%	3.9%	67.5%	369
30-34	74.7%	61.6%	20.3%	54.1%	9.5%	31.3%	27.4%	2.3%	66.0%	15.0%	6.1%	58.5%	4.4%	61.9%	277
35-39	75.0%	61.5%	17.3%	56.4%	7.2%	28.3%	26.6%	2.9%	69.1%	12.5%	3.8%	57.2%	3.9%	60.1%	196
40-49	73.6%	57.5%	16.0%	49.8%	4.9%	23.3%	29.2%	1.1%	62.8%	11.4%	6.4%	53.6%	6.2%	59.6%	175
TOTAL	77.3%	65.9%	20.5%	56.3%	8.7%	35.9%	29.1%	3.2%	69.6%	12.9%	5.3%	56.9%	3.7%	60.9%	1483

The differentials in knowledge of methods by type are fairly consistent across the two groupings of women. The pill is the most widely known contraceptive method (70%), followed by injection (61%), the traditional method - juju (57%), and the condom (45%). Knowledge of male sterilisation (fewer than 1 out of every 10 respondents) is considerably less prevalent than knowledge of female sterilisation (approximately 1 out of every 3 respondents). Male sterilisation and withdrawal were the least well known methods within the modern and traditional groupings, respectively.

The widespread knowledge of contraceptive methods is further confirmed by Table 4.2, which depicts unprompted and prompted knowledge by method and age.

TABLE 4.2. PERCENTAGE OF ALL MARRIED WOMEN (15-49) KNOWING A CONTRACEPTIVE METHOD, UNPROMPTED AND PROMPTED, BY SPECIFIC METHOD, GCPFDS, 1990

CONTRACEPTIVE METHODS												
AGE	PILLS		IUDS		INJECTION		DIA/FOAM/GEL		CONDOM		FEMALE STER.	
	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED
15-19	52.5%	17.6%	12.4%	8.5%	42.2%	16.2%	6.7%	2.7%	32.0%	7.4%	23.5%	6.7%
20-24	59.5%	9.7%	21.7%	8.8%	49.3%	10.8%	1.1%	5.8%	37.7%	14.0%	22.1%	12.9%
25-29	63.2%	13.4%	21.2%	5.7%	52.2%	13.3%	7.3%	4.4%	32.6%	14.4%	25.5%	10.8%
30-34	55.0%	10.8%	20.5%	6.5%	49.2%	10.8%	7.4%	4.9%	28.2%	10.6%	26.4%	7.2%
35-39	56.2%	11.5%	18.3%	6.7%	52.2%	10.2%	7.0%	3.8%	26.3%	10.2%	24.6%	8.2%
40-49	52.1%	10.9%	15.1%	9.5%	46.0%	10.3%	6.0%	4.4%	23.0%	12.2%	26.4%	9.5%
TOTAL	57.4%	12.1%	19.0%	7.4%	49.1%	11.9%	7.7%	4.5%	30.6%	12.0%	24.8%	9.5%

AGE	MALE STER		PER. ABST.		WITHDRAWAL		JUJU		OTHER		COUNT
	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	SPONT	PROBED	
15-19	2.6%	.9%	6.3%	3.3%	2.0%	2.4%	34.6%	15.7%	1.5%	.0%	211
20-24	6.3%	3.8%	15.5%	6.9%	3.8%	4.5%	41.7%	14.4%	2.3%	.6%	346
25-29	4.3%	3.0%	11.4%	3.9%	3.2%	5.7%	46.8%	16.1%	3.0%	.4%	459
30-34	4.5%	2.6%	11.5%	7.2%	3.4%	6.6%	47.9%	12.7%	2.7%	.8%	353
35-39	3.0%	2.3%	11.1%	5.5%	2.6%	2.6%	45.4%	13.6%	2.7%	.4%	242
40-49	2.9%	.5%	12.2%	4.1%	3.4%	5.5%	42.1%	15.4%	4.6%	.0%	236
TOTAL	4.2%	2.4%	11.7%	5.3%	3.1%	4.8%	43.8%	14.7%	2.8%	.4%	1847

As evidenced in Table 4.2, most married women aged 15-49 who claimed knowledge of a contraceptive method, did so without probing. On the average, women aged 30 and older were less likely to possess knowledge (both spontaneous and probed) than were the younger women.

TABLE 4.3 PERCENT OF ALL WOMEN (15-49) AND CURRENTLY MARRIED WOMEN (15-49) KNOWING ANY CONTRACEPTIVE METHOD AND KNOWING A SOURCE, BY SPECIFIC METHOD, GCPFDS, 1990

METHOD	KNOW METHOD		KNOW SOURCE	
	ALL WOMEN	CURRENTLY MARRIED WOMEN	ALL WOMEN	CURRENTLY MARRIED WOMEN
ANY METHOD	80.5	80.6	75.5	76.3
ANY MODERN METHOD	74.3	73.3	65.9	65.5
PILL	70.6	69.5	60.9	60.4
IUD	28.9	26.3	24.5	22.6
INJECTION	61.8	61.0	52.8	52.8
VAGINAL METH.	13.9	12.2	12.6	11.4
CONDOM	46.6	42.6	40.7	36.9
FEM. STER.	35.1	34.3	28.9	28.5
MALE STER.	7.5	6.6	5.4	4.6
ANY TRAD. METHOD	62.3	64.1	58.4	60.3
PER. ABST.	17.4	16.9	15.7	15.6
WITHDRAWAL	9.8	8.0	8.6	6.8
TRAD. (JUJU)	56.8	58.5	51.9	54.1
OTHER	2.8	3.3	2.6	3.3
NUMBER	2354	1847	2354	1847

If a woman claimed knowledge of a given method, she was then asked where she would go to obtain the method. Frequencies of responses to this question were also consistent in ranking across the two groupings of women, as shown in Table 4.3. Furthermore, the percent of women knowing a source for any given method was, in all cases, nearly as high as the percent knowing the method, itself.

76% of the women knew of a source for at least one method. 66% knew a source for at least one modern method, and approximately 60% knew a source for at least one traditional method. Differentials in the percentages knowing a source by method directly parallel the pattern of differentials in knowledge of methods.

## **4.2 Knowledge of Contraceptive Methods and Sources by Background Characteristics**

Differentials in the knowledge of contraception by age and residence are presented in Table 4.1 and Figure 4.1. For the country as a whole and for both urban and rural areas, the level of knowledge of modern methods of contraception clearly exceeds the level of knowledge of traditional methods, at all ages.

Considering the entire population of married women, the shape of the age distribution of knowledge is similar for modern and traditional methods. For both, the age group 25-29, demonstrates the highest level of knowledge (78.2% for any modern method and 68.3% for any traditional method). After age 30, the percentage of married women knowing any modern or any traditional method is fairly stable.

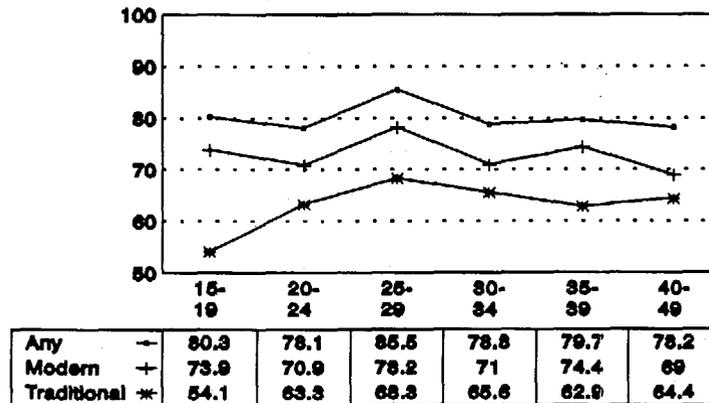
It is especially interesting to note that whereas, on the whole, women under 30 are more likely to know of contraceptive methods than women over 30, in the urban areas the older women are somewhat more likely than the younger women to know of modern methods.

Considering the entire sample population, pills and injectables are the most widely known methods in urban and rural areas alike. Juju ranks third in the rural and fourth in the urban areas among the most widely known methods. 70.4% of urban women claimed knowledge of condoms and 65.4% of juju. Among residents of rural areas these same percentages were 35.9 and 56.9, respectively.

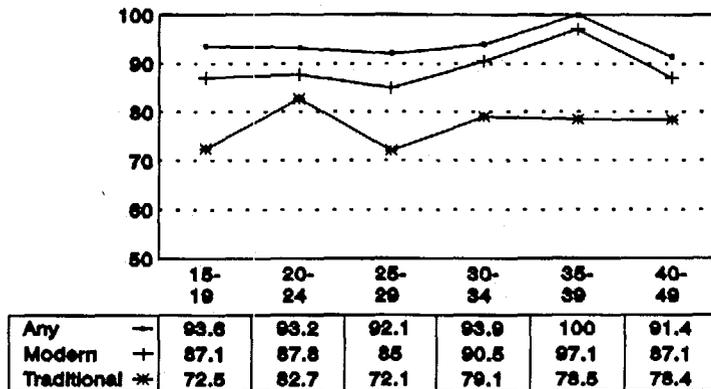
Differentials in knowledge by place of residence, according to the particular method, are displayed in Figure 4.2. Differentials in the percent of currently married women knowing any MODERN method and a source for any MODERN method are presented in Table 4.4, according to selected background variables.

As discussed previously, the differentials by age of women are small, with women aged 25-29 demonstrating the highest level of knowledge of a modern method and its source (78% and 72%, respectively).

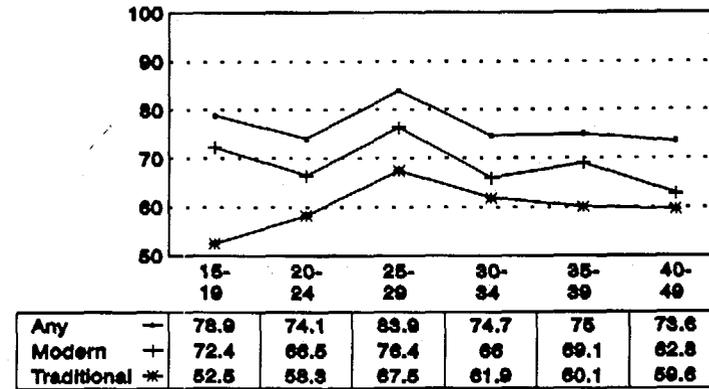
Percentage of Currently Married Women Knowing a Contraceptive Method by Age  
GCPFDS 1990



Percentage of Currently Married Women Knowing a Contraceptive Method by Age  
Urban Areas  
GCPFDS 1990



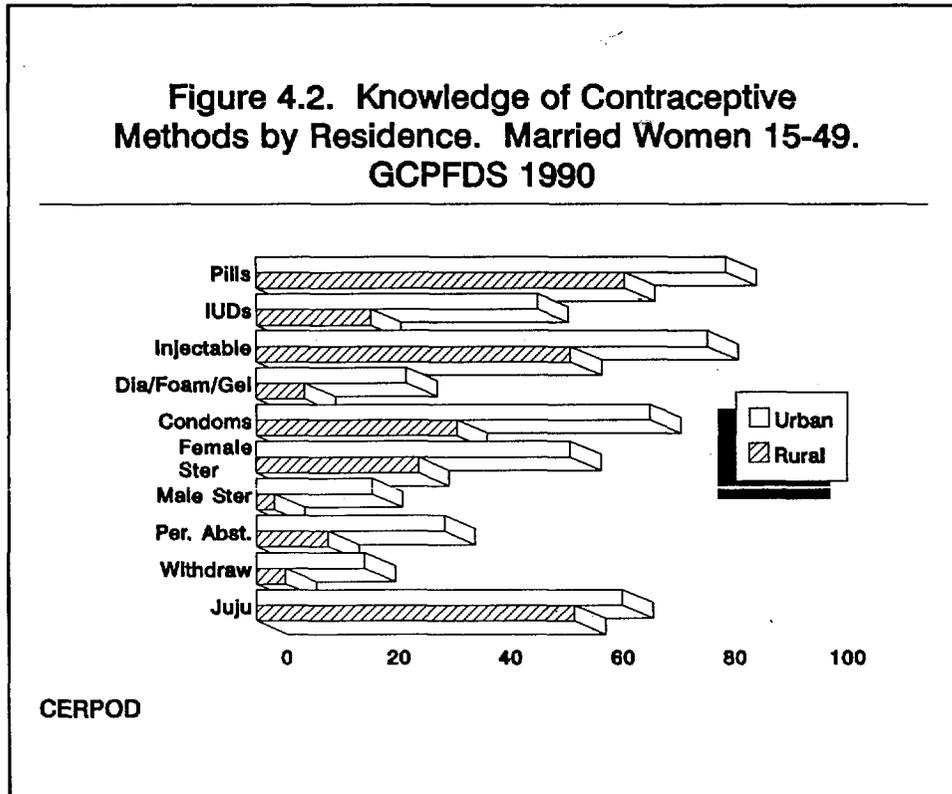
Percentage of Currently Married Women Knowing a Contraceptive Method by Age  
Rural Areas  
GCPFDS 1990



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Figure 4.1. Knowledge by Age and Residence, Married Women 15-49.  
GCPFDS, 1990

**Figure 4.2. Knowledge of Contraceptive Methods by Residence. Married Women 15-49. GCPFDS 1990**



Nearly 90% of urban women claimed knowledge of at least one modern method of contraception, and 79% knew of a source. The equivalent percentages among rural women were considerably lower at 70% and 62%, respectively. The differentials within the rural sector by primary health care village status are noteworthy. Although women residing in primary health care (PHC) villages are more likely to have heard of a modern method and to know a source for the method than women not living in PHC villages, the differentials are not as great as one might expect, given the difference in health service availability between the two groups.

Most striking when considering the ethnic group differentials is the extent to which knowledge of a modern method and its source among the Fula falls below the population average. This finding suggests that special efforts should be made to extend services and information to the Fula population.

TABLE 4.4 PERCENT OF CURRENTLY MARRIED WOMEN (15-49) KNOWING AT LEAST ONE MODERN METHOD, AND KNOWING A SOURCE FOR A MODERN METHOD, BY SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990.

BACKGROUND CHARACTERISTIC	KNOW ANY MODERN METHOD	KNOW A SOURCE FOR MODERN METHOD	NUMBER OF WOMEN
<u>AGE</u>			
15-19	73.9	62.6	211
20-24	70.9	65.3	346
25-29	78.2	71.8	459
30-34	71.0	63.8	353
35-39	74.4	66.1	242
40-49	69.0	58.3	236
<u>RESIDENCE</u>			
URBAN	88.7	79.4	357
RURAL	69.6	62.1	1483
-PHC	72.2	65.0	879
-NONPHC	65.7	58.0	604
<u>HEALTH REGION</u>			
WESTERN	77.4	69.1	875
CENTRAL	67.3	56.3	282
EASTERN	70.2	64.7	682
<u>ETHNIC</u>			
MANDINKA	76.5	71.2	701
FULA	64.4	54.6	403
WOLLOF	76.2	72.7	281
OTHER	74.4	62.2	462
<u>EDUCATION</u>			
NONE	70.3	62.1	1580
PRIMARY	87.9	82.3	147
SECONDARY+	95.7	90.3	119
<u>TOTAL</u>	73.3	65.5	1847

Finally, and not surprisingly, the largest differentials are discovered when considering the education variable. The relationship between knowledge of a modern method (source) and level of education is positive. Nearly 96% of married women with a secondary level of education or higher know of at least one modern method. The equivalent percent for women who never attended school is 70%. Furthermore, over 90% of the most highly educated women know of a source for a modern method, whereas only 62% of women with no schooling know the same.

### **4.3 Knowledge of Supply Sources**

Table 4.5 and Figure 4.3. present the distribution of all women knowing a contraceptive method regardless of actual use, according to the supply source they would use if they wanted to use the method. For all methods of modern contraception, excluding sterilisation, the Gambian Family Planning Association (GFPA) clinic was cited most frequently as the preferred source. In the case of female and male sterilisation, government hospital was most frequently cited as the supply source. Other principal sources given for modern contraceptives (pill, IUD, injection, vaginal methods and condom) were government hospitals, government health clinics and, to a lesser extent, MCH clinics.

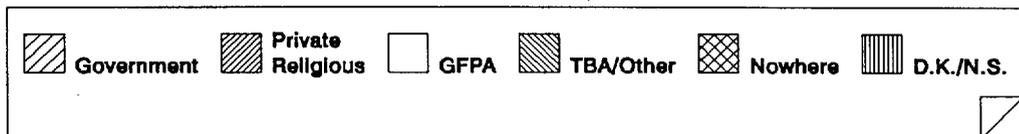
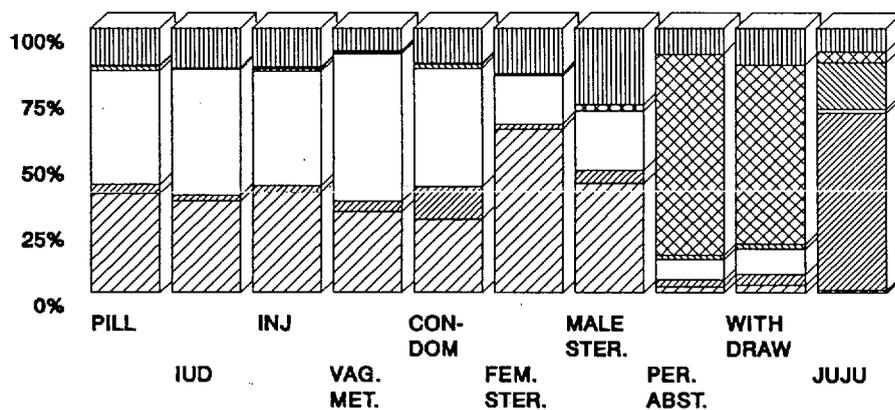
Considering traditional methods of contraception, "nowhere" was cited most frequently as the source of supply for periodic abstinence (76%) and withdrawal (68%), whereas "religious body" (marabout) was the preferred source for the traditional method, juju (67%). In the case of the latter, 15% of the women also named a source "other" than those listed among the possible responses.

Finally, it is revealing to note that the percent of women stating they did not know a source was over 25% for male sterilisation, was between 12 and 17 percent for the pill, IUD, injection, condom and female sterilisation, and was less than 11% for the remaining categories.

TABLE 4.5 PERCENT DISTRIBUTION OF MARRIED WOMEN (15-49) KNOWING A CONTRACEPTIVE METHOD BY SUPPLY SOURCE NAMED, ACCORDING TO SPECIFIC METHOD, GCPFDS, 1990

SOURCE	CONTRACEPTIVE METHOD									
	PILL	IUD	INJ.	VAG. METH	CON-DOM	FEM. STER	MALE STER	PER. ABST	WITH	JUJU DRAW
Govt. Hosp.	13.3	15.4	14.6	9.0	9.6	48.1	36.1	1.6	1.8	0.2
Govt. Health Clinic	14.6	11.7	16.9	14.7	11.9	8.9	3.4	0.5	0.4	0.5
MCH Clinic	9.6	7.5	6.5	6.9	6.3	5.0	1.8	0.2	0.8	0.3
Priv. Hosp. or Clinic	1.4	1.8	1.6	2.4	1.6	1.5	4.3	0.6	0.0	0.1
Pharmacy	2.0	0.4	0.9	1.7	10.5	0.2	0.7	0.0	0.0	0.0
Religious Body	0.0	0.0	0.0	0.0	0.2	0.1	0.0	1.9	3.9	66.9
GFPA Clinic	32.6	42.5	36.1	49.7	37.7	16.3	21.8	5.6	6.4	0.9
GFPA CBD	3.9	1.8	2.0	3.0	2.9	0.7	0.0	0.7	1.6	0.4
GFPA Fieldworker	6.6	3.3	5.2	3.1	4.2	1.2	0.5	1.4	1.7	0.3
TBA	1.4	0.3	0.9	0.0	1.3	0.0	0.0	0.5	1.8	2.5
Other	0.2	0.1	0.1	0.3	0.2	0.1	0.0	1.2	0.0	15.2
Nowhere	0.5	0.1	0.6	0.7	0.7	0.8	2.4	76.2	67.9	4.0
Don't Know	13.7	14.4	14.0	7.9	12.5	16.8	27.9	7.3	10.8	8.2
Not Stated	0.2	0.6	0.6	0.7	0.5	0.3	1.0	2.4	3.0	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wtd. Number	1663	680	1454	328	1097	826	176	410	231	1337

Figure 4.3. Percent Distribution of Married Women (15-49) Knowing a Method by Supply Source Named GCPFDS 1990



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## 4.4 Acceptability of Method

Table 4.6 presents the distribution of women who know a method according to the main problem they perceive to be associated with the method. On the one hand, this information is important in identifying obstacles which differentially affect the use of the various methods. Such information is invaluable in the design of family planning IEC strategies. On the other hand, the information should be interpreted cautiously, as experience from this and other Demographic and Health Surveys has revealed that the question on acceptability is often not readily understood.

TABLE 4.6 PERCENT DISTRIBUTION OF WOMEN (15-49) WHO HAVE EVER HEARD OF A CONTRACEPTIVE METHOD BY MAIN PROBLEM PERCEIVED IN USING THE METHOD, ACCORDING TO SPECIFIC METHOD, GCPFDS, 1990

MAIN PROBLEM PERCEIVED	PILL	IUD	INJ.	VAG. METH	CON-DOM	FEM. STERILIS.	MALE	PER. ABST	WITH DRAW	JUJU
NOT EFFECTIVE	4.9	2.5	2.7	3.6	2.5	1.4	1.1	4.8	14.6	4.8
PARTNER DISAP.	2.5	1.9	2.8	1.4	3.0	1.6	1.1	1.5	0.8	2.2
INCONVENIENT TO USE	2.2	2.1	2.3	1.6	3.5	0.3	0.5	2.6	4.9	1.6
DIFFICULT TO GET	1.5	0.3	0.6	0.7	0.6	0.2	0.7	0.2	1.5	1.5
HEALTH CONCERN	4.7	5.4	7.1	3.9	2.8	7.3	9.3	1.6	0.0	0.4
COSTS TOO MUCH	0.3	0.0	0.4	0.3	0.1	0.3	1.4	0.0	0.0	3.1
RELIGION	0.0	0.0	0.0	0.0	0.1	0.0	0.5	0.0	0.0	0.1
OTHER	1.1	0.5	0.5	0.3	0.3	0.3	0.0	1.2	0.8	1.1
NONE	21.3	16.7	16.8	21.2	16.4	18.5	6.6	48.5	28.7	27.4
DON'T KNOW	61.0	67.7	65.7	64.9	69.8	69.5	76.0	36.0	42.2	55.2
NOT STATED	0.6	2.9	1.0	2.1	1.0	0.8	2.7	3.8	6.5	2.5
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
NUMBER	1665	695	1457	332	1100	829	181	413	236	1350

Indicative of the confusing nature of the question is the observation that for every method except periodic abstinence, the respondents most frequently answered "I don't know" to the question concerning the main perceived problem with the method. Furthermore, the second most common response was "none", (except in the case of periodic abstinence for which "none" was the most frequent response). Thus one may conclude that of all the

contraceptive methods studied, the Gambian population perceives the fewest problems relative to the use of periodic abstinence.

Of all the methods considered, withdrawal has the highest percentage of respondents who declared the method ineffective (14.6%). Partner disapproval appears to be a greater problem with the use of modern contraception than with the use of traditional methods. The highest percentage stating their husbands disapproved of a method is found in the "condom" category (3%). Of course, it should be kept in mind that a woman would only know her husband's feelings on a method (or her own) to the extent that the method is publicized and discussed. Since the condom is a method used by men, women are far more likely to know their partner's feelings about this method than about others.

Condoms and withdrawal are perceived to be the most inconvenient methods to use. Cost and accessibility were infrequently cited as perceived problems, except in the case of juju where 3% of respondents declared the method too costly.

Health concerns only arise to any significant degree when considering modern methods. In particular, over 9% of respondents perceive health issues to be the major problem with male sterilisation, 7% with female sterilisation, 7% with the injection, and 5% with the IUD and the pill.

In summary, one may conclude that among those who know of particular methods, most do not perceive of (or do not know of) any problem with their use. In the case where problems were cited, health concerns are the major problem associated with modern methods and effectiveness with traditional methods.

## 4.5 Ever Use of Contraception

Summary information on ever use of contraception for all and currently married women by age residence is presented in Table 4.7. In the Gambia, approximately one fourth of all women have ever used a method of contraception. 13% of all women have ever used a modern method, and an even lower percent (11%) claimed to have ever used a traditional method. The percentages for currently married women are only 1 to 2 percentage points higher for ever use of all methods, modern and traditional.

Among modern methods, the pill is the most commonly used by all women (9.3%), followed by injections (3.7%), the IUD (1.9%) and the condom (1.6%). Sterilisation, female or male, is quite rare in the Gambia. The pattern and levels of ever use of modern contraception by currently married women are quite similar to those of all women.

Interestingly, ever use of traditional methods of contraception in the Gambia is less prevalent than ever use of modern methods. This finding is consistent with the fact that modern methods are better known by Gambian women than traditional methods at all ages and for both urban and rural areas. The most frequently used traditional methods among all and married women is periodic abstinence (6.4% and 7.1%, respectively), followed by juju and the category classified "other". Withdrawal was infrequently cited as a method of contraception ever used by both categories of women.

Ever use of contraception by all women rises with age from a low of 6% for 15-19 year olds to a high of 32% for 35-39 year olds and drops again to 28% for the oldest women. The age pattern of use holds for the pill and the injection, but the oldest women are most likely to be sterilised and the younger women are most likely to have ever used the condom.

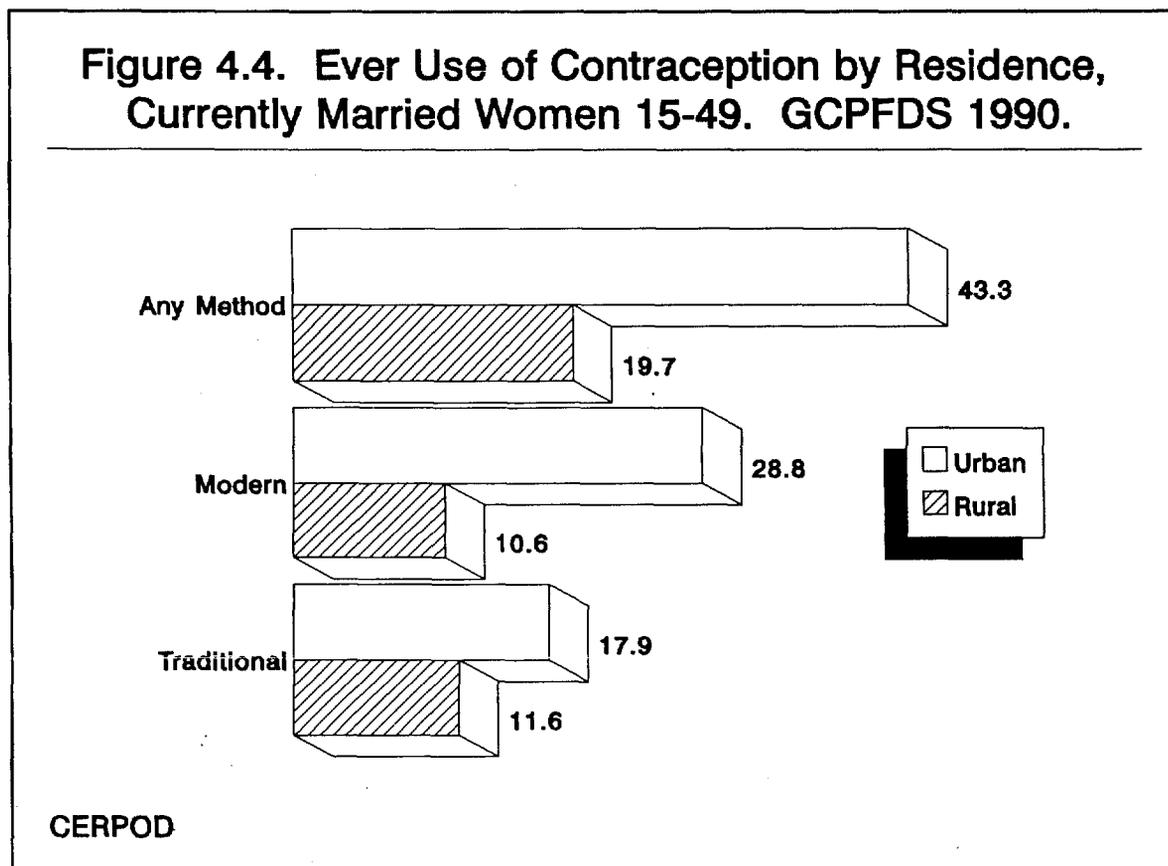
The age pattern of use of traditional methods is less variable. Although only 3% of the youngest women have ever used a traditional method of contraception, the percent rises substantially to 13% for the 20-24 year olds, and remains in the 13 to 15 % range for the remaining age groups.

Table 4.7. PERCENTAGE OF ALL WOMEN (15-49) AND CURRENTLY MARRIED WOMEN (15-49) WHO HAVE EVER USED A CONTRACEPTIVE METHOD, BY AGE, SPECIFIC METHOD AND RESIDENCE. GCPFDS, 1990

AGE	ANY METH	PILLS	IUDS	INJECTIONS	DIA/FOM/CONGEL	DOMS	FEMALE STER.	MALE STER.	ANY MODERN	PER. ABST.	WITHDRAW	JUJU	OTHER	ANY TRADIT.	COUNT
<b>ALL WOMEN</b>															
15-19	5.9%	1.4%	.3%	.2%	.0%	.7%	.0%	.0%	2.6%	1.9%	.2%	1.1%	.3%	3.5%	511
20-24	23.3%	8.7%	1.6%	.9%	1.0%	3.1%	.0%	.0%	12.4%	8.4%	.6%	3.9%	2.4%	13.5%	457
25-29	26.6%	13.7%	2.3%	3.3%	.2%	2.1%	.2%	.3%	16.7%	6.8%	1.0%	4.8%	2.5%	13.0%	498
30-34	25.9%	10.7%	1.8%	3.9%	.6%	1.3%	.0%	.3%	14.5%	7.3%	.8%	4.9%	2.0%	14.5%	375
35-39	31.7%	14.8%	3.1%	12.2%	.5%	1.0%	.9%	.0%	23.6%	7.6%	.0%	4.3%	2.5%	12.9%	261
40-49	27.6%	10.0%	4.0%	7.6%	.9%	1.0%	2.7%	.0%	16.4%	8.5%	.8%	4.1%	3.1%	14.9%	252
TOTAL	22.0%	9.3%	1.9%	3.7%	.5%	1.6%	.4%	.1%	13.2%	6.4%	.6%	3.7%	2.0%	11.5%	2354
<b>ALL MARRIED WOMEN</b>															
15-19	8.8%	2.3%	.0%	.5%	.0%	.9%	.0%	.0%	3.6%	3.6%	.0%	.9%	.6%	5.1%	211
20-24	25.2%	9.4%	1.5%	.8%	.4%	2.5%	.0%	.0%	13.1%	9.4%	.6%	4.0%	2.3%	14.7%	346
25-29	24.7%	11.9%	2.1%	3.0%	.2%	1.5%	.2%	.3%	14.5%	6.0%	1.1%	4.5%	2.8%	12.1%	459
30-34	26.0%	10.5%	1.7%	4.1%	.6%	1.1%	.0%	.4%	14.6%	7.1%	.5%	4.9%	2.2%	14.4%	353
35-39	30.1%	12.9%	1.5%	11.9%	.5%	.8%	.9%	.0%	21.4%	7.7%	.0%	4.2%	2.4%	13.1%	242
40-49	27.4%	9.0%	3.7%	8.1%	1.0%	1.1%	2.3%	.0%	15.8%	8.7%	.8%	4.4%	3.4%	15.5%	236
TOTAL	24.3%	9.8%	1.8%	4.3%	.4%	1.4%	.5%	.1%	14.1%	7.1%	.6%	4.0%	2.3%	12.8%	1847
<b>MARRIED WOMEN OF URBAN AREAS</b>															
15-19	25.7%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	19.3%	.0%	.0%	6.4%	25.7%	20
20-24	41.7%	18.1%	6.0%	.0%	1.8%	1.4%	.0%	.0%	24.1%	15.0%	1.4%	7.2%	1.8%	22.2%	72
25-29	35.5%	22.5%	5.6%	4.1%	1.2%	3.8%	.0%	1.5%	25.5%	8.9%	1.2%	4.1%	1.5%	12.7%	87
30-34	49.8%	26.9%	7.8%	4.4%	3.1%	2.7%	.0%	1.7%	34.7%	9.6%	.0%	8.2%	.0%	17.8%	75
35-39	60.8%	26.1%	5.9%	18.6%	2.9%	.0%	2.9%	.0%	43.2%	17.0%	.0%	5.9%	.0%	22.9%	44
40-49	41.5%	19.9%	13.0%	11.9%	3.8%	4.3%	5.9%	.0%	31.3%	12.8%	.0%	1.7%	.0%	14.5%	60
TOTAL	43.3%	21.3%	7.1%	6.2%	2.3%	2.5%	1.4%	.7%	28.8%	12.5%	.6%	5.2%	1.1%	17.9%	357
<b>MARRIED WOMEN OF RURAL AREAS</b>															
15-19	7.0%	2.5%	.0%	.5%	.0%	1.0%	.0%	.0%	4.0%	2.0%	.0%	1.0%	.0%	3.0%	190
20-24	20.9%	7.1%	.3%	1.0%	.0%	2.8%	.0%	.0%	10.3%	7.9%	.3%	3.1%	2.4%	12.8%	275
25-29	22.1%	9.5%	1.3%	2.8%	.0%	1.0%	.3%	.0%	12.1%	5.1%	1.0%	4.3%	3.1%	11.8%	369
30-34	19.7%	6.1%	.0%	4.1%	.0%	.7%	.0%	.0%	9.2%	6.4%	.7%	4.1%	2.7%	13.6%	277
35-39	23.5%	10.0%	.5%	10.5%	.0%	.9%	.5%	.0%	16.7%	5.8%	.0%	3.9%	2.9%	11.1%	196
40-49	22.6%	5.3%	.5%	6.9%	.0%	.0%	1.1%	.0%	10.5%	7.2%	1.1%	5.4%	4.5%	15.8%	175
TOTAL	19.7%	.5%	.3%	3.9%	.0%	1.1%	.3%	.0%	10.6%	5.8%	.6%	3.7%	2.6%	11.6%	1483

As was the case with modern methods of contraception, the age pattern of ever use of traditional methods among currently married women is quite similar to the pattern of all women, but the level of use is slightly higher among the former.

Differentials in ever use by residence are also depicted in Figure 4.4. below.



The urban-rural differentials work in the expected direction, with 43% of married women in urban areas having ever used any contraceptive method, as compared to the lower 19.7% ever use among those living in rural areas. The higher level of ever use among urban women also holds for both modern and traditional methods, (28.8% versus 10.6% for modern methods and 17.9% versus 11.6% for traditional methods in urban and rural areas, respectively). It is interesting to note, however, that ever use of traditional methods is slightly higher than ever use of modern methods in the rural areas. The fact that the level

of knowledge of modern contraception exceeds the level of knowledge of traditional methods among the rural population, as discussed above, may suggest that the non-availability of modern contraception is at least partly responsible for a lower ever use of modern methods in the rural areas.

In summary, it is important to note that the level of ever use of MODERN contraception in the Gambia is approximately twice the level found in neighboring countries. The 1986 Demographic and Health Survey in Senegal reveals that only 6.3% of all women and 5.7% of married women had ever used a modern method of contraception. The corresponding percentages for Mali are even lower at 3.2% and 3.4% (1987). Credit for the "comparatively" high levels of ever use of modern contraception in the Gambia must in large part be given to the Gambian Family Planning Association which has been in existence since the late 1960s.

#### **4.6 Current Use of Contraception**

Table 4.8 presents data on current use of contraception for all women and for currently married women by age and residence. This table provides the most reliable indicators by which family planning program impact may be evaluated. Furthermore, this information may be used to project potential fertility reduction attributable to specific family planning program features. The method-mix for current users is presented in Figure 4.5.

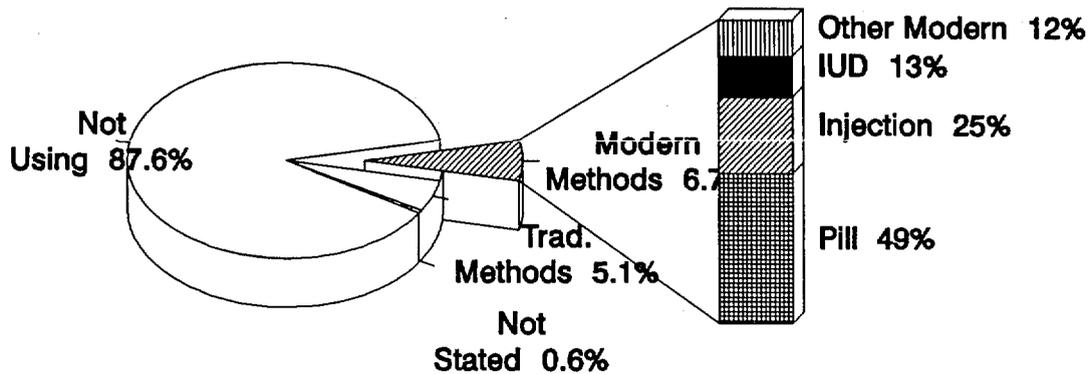
The age patterns and levels of current contraceptive use among all women and currently married women are quite similar, and thus the discussion here will be limited to currently married women who are the principal target group of family planning programs. Overall, 12% of currently married women are currently using any method of contraception. Use of any modern method (6.7%) is slightly greater than use of any traditional method (5.1%).

TABLE 4.8. PERCENTAGE OF ALL WOMEN (15-49) AND OF MARRIED WOMEN (15-49) WHO USED A CONTRACEPTIVE METHOD AT THE TIME OF THE SURVEY, BY AGE, SPECIFIC METHOD AND RESIDENCE, GCPFDS, 1990.

AGE	ANY METH.	ANY MODERN METHOD	PILLS	IUDS	INJECTIONS	DIA/FOAM/GEL	CONDOMS	FEMALE STER.	ANY TRAD. METHOD	PER. ABST.	TRADITIONAL (JUJU)	OTHER	NONE	NOT STATED	TOTAL	COUNT
<b>ALL WOMEN</b>																
15-19	3.2%	1.3%	.6%	.3%	.2%	.0%	.2%	.0%	2.1%	1.4%	.4%	.3%	96.2%	.6%	100.0%	511
20-24	13.0%	6.3%	3.5%	.7%	.7%	.3%	1.1%	.0%	6.9%	4.8%	.7%	1.3%	85.7%	1.3%	100.0%	457
25-29	13.7%	8.1%	5.6%	.6%	1.4%	.0%	.3%	.2%	5.6%	3.0%	1.6%	1.0%	85.4%	.8%	100.0%	498
30-34	14.5%	7.6%	4.2%	1.5%	1.4%	.0%	.5%	.0%	6.9%	3.5%	1.5%	1.9%	85.5%	.0%	100.0%	375
35-39	13.5%	10.4%	3.4%	1.7%	4.8%	.0%	.0%	.5%	3.2%	2.1%	.4%	.7%	86.5%	.0%	100.0%	261
40-49	9.5%	8.0%	.8%	1.7%	1.8%	.0%	1.0%	2.7%	1.6%	.8%	.4%	.4%	90.5%	.0%	100.0%	252
TOTAL	10.9%	6.4%	3.1%	.9%	1.4%	.1%	.5%	.4%	4.5%	2.7%	.9%	.9%	88.5%	.5%	100.0%	2354
<b>ALL MARRIED WOMEN</b>																
15-19	4.3%	1.4%	.9%	.0%	.5%	---	.0%	.0%	2.9%	2.3%	.0%	.6%	94.4%	1.4%	100.0%	211
20-24	12.8%	5.3%	3.2%	.9%	.6%	---	.6%	.0%	7.6%	5.7%	.7%	1.2%	85.9%	1.3%	100.0%	346
25-29	13.2%	7.3%	4.9%	.7%	1.2%	---	.3%	.2%	5.8%	3.0%	1.7%	1.1%	85.9%	.9%	100.0%	459
30-34	14.1%	7.4%	4.2%	1.3%	1.4%	---	.5%	.0%	6.7%	3.4%	1.3%	2.0%	85.9%	.0%	100.0%	353
35-39	13.2%	9.7%	3.2%	.9%	5.1%	---	.0%	.5%	3.4%	2.2%	.4%	.8%	86.8%	.0%	100.0%	242
40-49	9.6%	7.9%	.8%	1.8%	1.9%	---	1.1%	2.3%	1.6%	.8%	.4%	.4%	90.4%	.0%	100.0%	236
TOTAL	11.8%	6.7%	3.3%	.9%	1.7%	---	.4%	.4%	5.1%	3.1%	.9%	1.1%	87.6%	.6%	100.0%	1847
<b>MARRIED WOMEN OF URBAN AREAS</b>																
15-19	25.7%	.0%	.0%	.0%	.0%	---	.0%	.0%	25.7%	19.3%	.0%	6.4%	74.3%	.0%	100.0%	20
20-24	26.2%	12.2%	9.0%	3.2%	.0%	---	.0%	.0%	14.0%	10.4%	1.8%	1.8%	70.2%	3.6%	100.0%	72
25-29	17.5%	10.4%	7.4%	1.5%	.0%	---	1.5%	.0%	7.1%	3.0%	2.6%	1.5%	81.0%	1.5%	100.0%	87
30-34	36.4%	26.4%	17.3%	6.1%	3.0%	---	.0%	.0%	9.8%	3.4%	3.4%	3.0%	63.6%	.0%	100.0%	75
35-39	30.4%	24.4%	5.2%	2.9%	13.4%	---	.0%	2.9%	5.9%	5.9%	.0%	.0%	69.6%	.0%	100.0%	44
40-49	23.2%	23.2%	.0%	7.1%	5.9%	---	4.3%	5.9%	.0%	.0%	.0%	.0%	76.8%	.0%	100.0%	60
TOTAL	26.2%	16.5%	7.9%	3.8%	3.3%	---	1.1%	1.4%	8.7%	5.3%	1.7%	1.7%	72.7%	1.1%	100.0%	357
<b>MARRIED WOMEN OF RURAL AREAS</b>																
15-19	2.0%	1.5%	1.0%	.0%	.5%	---	.0%	.0%	.5%	.5%	.0%	.0%	96.5%	1.5%	100.0%	190
20-24	9.3%	3.4%	1.7%	.3%	.7%	---	.7%	.0%	5.8%	4.4%	.4%	1.0%	90.0%	.7%	100.0%	275
25-29	12.3%	5.7%	4.4%	.5%	1.5%	---	.0%	.3%	5.6%	3.1%	1.5%	1.0%	86.9%	.8%	100.0%	369
30-34	8.2%	2.4%	.7%	.0%	1.0%	---	.7%	.0%	5.8%	3.4%	.7%	1.7%	91.8%	.0%	100.0%	277
35-39	9.5%	6.6%	2.8%	.5%	3.3%	---	.0%	.0%	2.9%	1.4%	.5%	1.0%	90.5%	.0%	100.0%	196
40-49	4.9%	2.7%	1.1%	.0%	.5%	---	.0%	1.1%	2.2%	1.1%	.6%	.5%	95.1%	.0%	100.0%	175
TOTAL	8.4%	4.3%	2.2%	.3%	1.3%	---	.3%	.2%	4.3%	2.6%	.7%	1.0%	91.1%	.5%	100.0%	1483

TOTALS MAY NOT ADD DUE TO ROUNDING.

**Figure 4.5. Current Use of Family Planning by Method, Currently Married Women 15-49. GCPFDS 1990.**

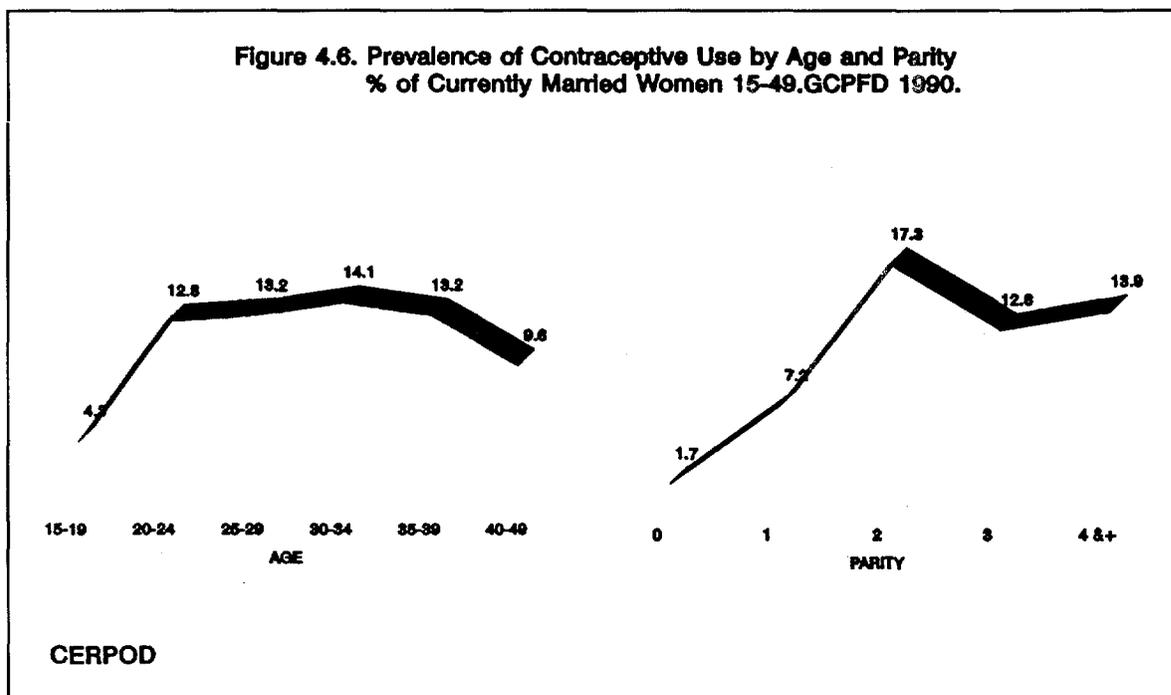


CERPOD

Prevalence rates by age and parity are depicted in Figure 4.6. Similar to the age pattern of ever use of all methods, women in the middle groups of the age range are most likely to be current users (13 to 14%), followed by the eldest women (10%). The youngest women are the least likely to be current users (4%).

The age pattern of current use probably reflects conscious family planning strategies rather than differentials in acceptability or awareness of family planning methods. The youngest, newly married women are most eager to begin childbearing and thus demonstrate the lowest level of current use. Women in the middle age range have the highest proportions contracepting, reflecting the desire to space and perhaps also to limit childbearing. The falling off in contraceptive use among the oldest women may reflect their perception of decreased fecundity (decreased need) despite their desire to limit childbearing, since the pattern holds for both modern and traditional methods. This explanation is

supported by the pattern of current use according to parity as presented in Figure 4.6.

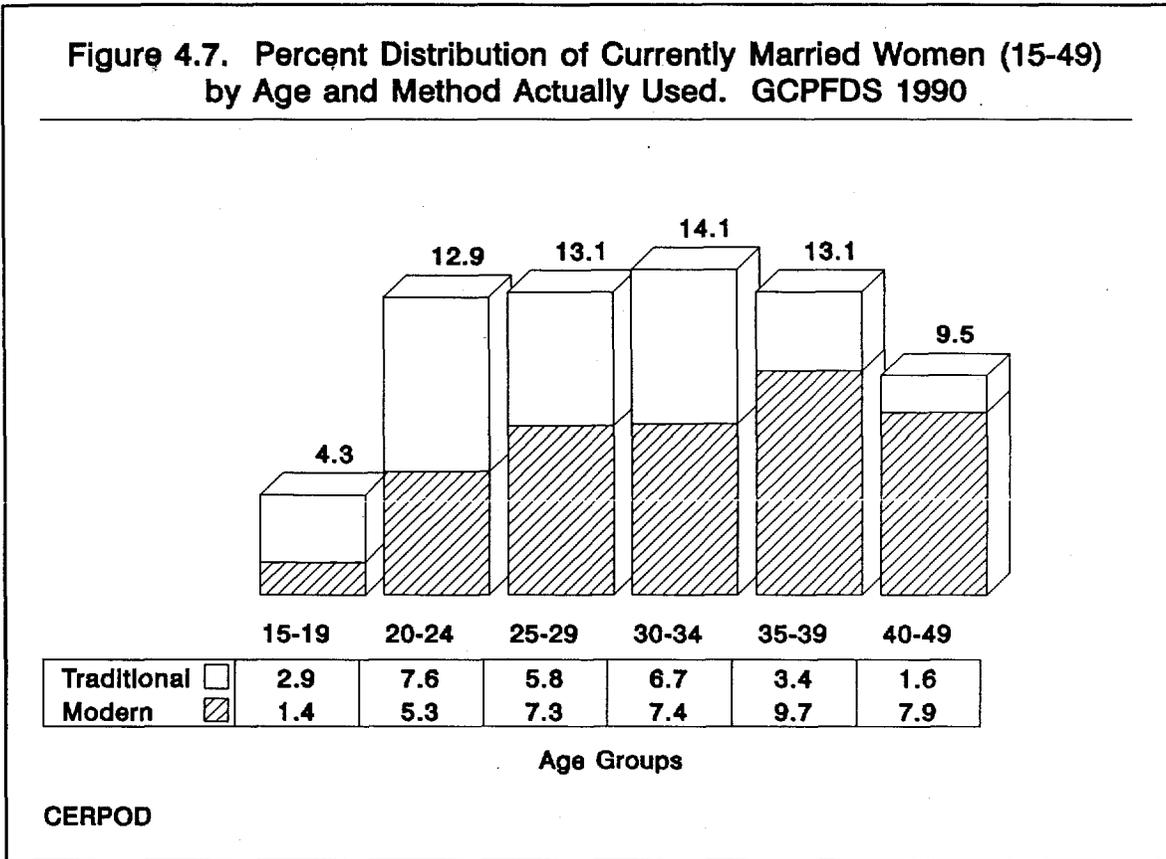


Among modern methods of contraception, the pill is the most commonly used (3.3%), followed by injections (1.7%). Less than 1% of married women are current users of the remaining modern methods. The condom and female sterilisation are most commonly used by the oldest women. Among the youngest, currently married women, the pill and the injection are the only two modern methods currently used.

Figure 4.7 which presents the current method mix for married, current users reveals that although, overall, married women are more likely to be using modern than traditional methods, among the younger women, traditional methods are preferred. 2.9% of 15-19 year olds are currently using at least one traditional method, whereas only 1.4% are using any modern method. Similarly 7.6% of 20-24 year olds are currently using any traditional method, whereas only 5.3% of the same group are current users of any modern method.

Among traditional methods of contraception, periodic abstinence is the most popular, followed by the category "other". It is the subject of future research to ascertain what "other" traditional methods women declare they are using and to investigate in depth the age

patterns of contraceptive use. The complementarity of traditional and modern methods in family planning strategies appears to be a promising research topic.



## 4.7 Current Use by Background Characteristics

The relationship between current contraceptive use and selected background characteristics is examined by method for currently married women in Table 4.9 and Figure 4.8. Urban women are three times more likely to be contracepting than rural women (26% and 8% respectively). The strong association between place of residence and contraceptive use is further evidenced in the differentials by health region. Women in the mostly urban, Western health region are four times more likely to be contracepting than women in the Central health region, and 10 times more likely to be contracepting than women in the Eastern health region.

That these differentials largely reflect variation in contraceptive availability is supported by the following observations:

- (1) Among women residing in the rural areas, those residing in primary health care villages are four times more likely to be contracepting (12%) than those residing in non-primary health care villages (3%);
- (2) Current use of any MODERN method of contraception is more strongly associated with place of residence, than use of any TRADITIONAL method.

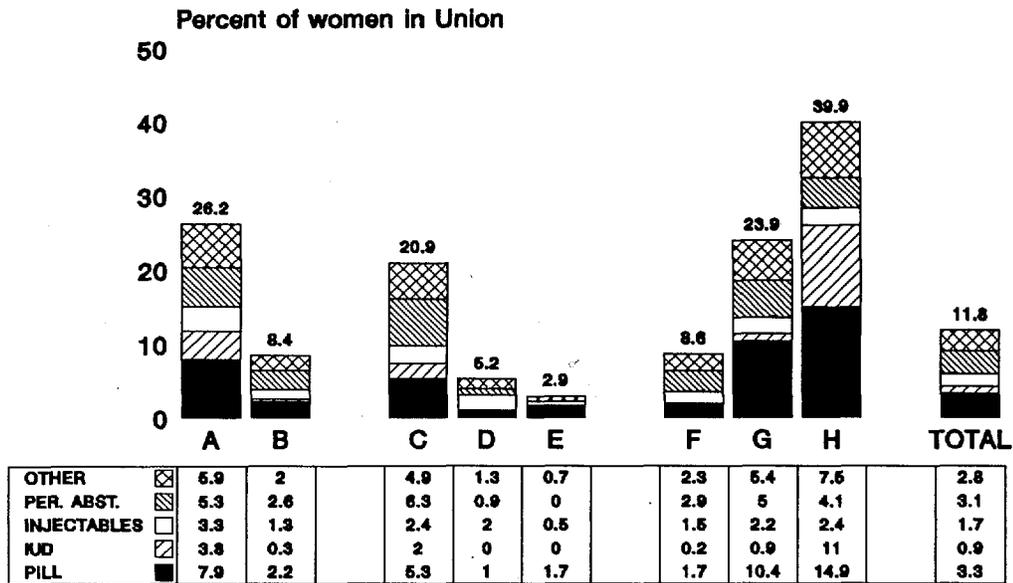
With respect to specific modern methods, the pill is the most commonly used contraceptive in both urban and rural areas, in both primary health care and non-primary health care villages, and in the Western and Eastern health regions. Interestingly, only in the Central health region do married women use the injection more often than the pill.

Considering differentials by ethnic group, the Wolof exhibit the highest percent currently using any method (14.3%), and the Fula the lowest (8.6%). However, it is interesting to note that while the Wolof are nearly four times more likely to be using modern than traditional methods, the Mandinka achieve a 13% current use by a nearly 50/50 mix of modern (5.2%) and traditional (7.7%) methods.

TABLE 4.9 PERCENT DISTRIBUTION OF CURRENTLY MARRIED WOMEN (15-49) BY CONTRACEPTIVE METHOD CURRENTLY USED, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS  
GCPFDS, 1990

BACKGROUND CHARACTERISTIC	ANY METHOD	ANY MODERN METHOD	PILL	IUD	INJECTION	VAGINAL METHOD	CONDOM	FEMALE STER.	ANY TRAD. METHOD	PER. ABST.	WITH-DRAWAL	JUJU	OTHER	NOT STATED	NOT USING	TOTAL	NUMBER
<b>RESIDENCE</b>																	
Urban	26.2	17.5	7.9	3.8	3.3	0.0	1.1	1.4	8.7	5.3	0.0	1.7	1.7	1.1	72.7	100.0	357
Rural	8.4	4.3	2.2	0.3	1.3	0.0	0.3	0.2	4.3	2.6	0.0	0.7	1.0	0.5	91.1	100.0	1483
- PHC	11.9	5.3	2.7	0.4	1.6	0.0	0.4	0.2	6.5	4.2	0.0	0.7	1.6	0.1	88.0	100.0	879
- NON-PHC	3.4	2.4	1.4	0.0	0.8	0.0	0.0	0.2	1.1	0.3	0.0	0.8	0.0	1.1	95.5	100.0	604
<b>REGION</b>																	
Western	20.9	11.3	5.3	2.0	2.4	0.0	0.9	0.7	9.6	6.3	0.0	1.1	2.2	1.1	78.0	100.0	875
Central	5.2	3.3	1.0	0.0	2.0	0.0	0.0	0.3	1.9	0.9	0.0	0.7	0.3	0.3	94.4	100.0	282
Eastern	2.9	2.3	1.7	0.0	0.5	0.0	0.0	0.1	0.5	0.0	0.0	0.5	0.0	0.1	97.0	100.0	682
<b>ETHNIC GROUP</b>																	
Mandinka	12.9	5.2	2.4	0.4	1.8	0.0	0.3	0.3	7.7	4.7	0.0	1.3	1.7	0.0	87.1	100.0	701
Fula	8.6	5.8	3.6	0.8	1.2	0.0	0.2	0.0	2.7	1.7	0.0	0.5	0.5	1.0	90.4	100.0	403
Wolof	14.3	11.4	4.7	2.6	2.3	0.0	1.3	0.5	2.9	1.8	0.0	0.8	0.3	1.4	84.4	100.0	281
Other	11.6	7.0	3.4	1.0	1.4	0.0	0.2	1.0	4.6	2.6	0.0	0.8	1.2	0.8	87.6	100.0	462
<b>EDUCATION</b>																	
None	8.6	3.8	1.7	0.2	1.5	0.0	0.1	0.3	4.7	2.9	0.0	0.9	0.7	0.7	90.7	100.0	1580
Primary	23.9	15.3	10.4	0.9	2.2	0.0	0.9	0.9	8.7	5.0	0.0	2.2	1.5	0.6	75.4	100.0	147
Secondary+	39.9	33.2	14.9	11.0	2.4	0.0	3.8	1.1	6.8	4.1	0.0	0.0	2.7	0.0	60.1	100.0	119
<b>NUMBER LIVING CHILDREN</b>																	
0	1.7	1.7	1.2	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.5	96.8	100.0	210
1	7.2	3.0	1.5	0.4	0.3	0.0	0.8	0.0	4.2	3.2	0.0	0.7	0.3	0.3	92.4	100.0	296
2	17.3	9.5	5.9	2.3	1.3	0.0	0.0	0.0	7.8	4.9	0.0	1.5	1.4	0.6	82.1	100.0	322
3	12.6	7.6	5.6	1.4	0.3	0.0	0.0	0.3	4.9	3.9	0.0	0.7	0.3	0.8	86.6	100.0	289
4+	13.9	7.9	2.5	0.6	3.3	0.0	0.6	0.9	5.9	2.9	0.0	1.1	1.9	0.4	85.7	100.0	730
<b>TOTAL</b>	<b>11.8</b>	<b>6.7</b>	<b>3.3</b>	<b>0.9</b>	<b>1.7</b>	<b>0.0</b>	<b>0.4</b>	<b>0.4</b>	<b>5.1</b>	<b>3.1</b>	<b>0.0</b>	<b>0.9</b>	<b>1.1</b>	<b>0.6</b>	<b>87.6</b>	<b>100.0</b>	<b>1847</b>

**Figure 4.8. Contraceptive Prevalence Differentials  
GCPFDS 1990**



A: URBAN; B:RURAL; C:WESTERN; D:CENTRAL; E:EASTERN; F:NO EDUCATION; G:PRIMARY; H:SECONDARY & + CERPOD

Among all ethnic groups, the pill is the most widely used form of modern contraception, and periodic abstinence the most widely used traditional method of contraception. Only in the case of the Mandinka are married women more likely to be using periodic abstinence (4.7%) than to be using the pill (2.4%).

The largest differentials in current use of contraception are discovered when considering the educational categories. Whereas forty percent of women with a secondary level of education or higher are currently using at least one method of contraception, only 9% of women who had never attended school are themselves current users.

The strong positive association between current contraceptive use and level of education holds for modern methods, but not for traditional methods. In the case of the latter, the differentials are small and non-linear. 5% of women with no education, 7% of women with secondary or higher education and 9% of women with a primary level of

education reported current use of at least one traditional method of contraception.

Among married women with no education, periodic abstinence is the most prevalent method currently used (2.9%), followed by the pill (1.7%) and injection (1.5%). Among married women with a secondary or higher level of education, the pill is most commonly used (14.9%), followed by the IUD (11.0%) and periodic abstinence (4.1%).

In regard to parity, the information in Table 4.9 suggests that the number of surviving children positively influences current contraceptive use among currently married women in the Gambia. However the relationship is not linear. Women with 4 or more living children are 8 times more likely to be using contraception (13.9%) than women with no living children (1.7%). Women with two living children have the highest percent current use (17.3%). This pattern holds for modern and traditional contraceptive practices, and probably reflects the strong desire among women to space their children during what they perceive to be their most fertile reproductive period (mid 20s to mid 30s).

Finally, in regard to the differentials by number of living children, it is noteworthy that the patterns of use of periodic abstinence and the pill are similar to the pattern of use for any method. However, injections and female sterilisation appear to become more popular as the number of living children increases. This data may reflect women's differentially choosing a contraceptive method based on the desire to space or to limit births.

## 4.8 Number of Children at First Use

In the GCPFDS, women who claimed to have ever used a method of contraception (modern or traditional) were asked how many living children, if any, they already had when they first did something or used a method to avoid getting pregnant. This information is useful as an indicator of the willingness to postpone a first birth and to space future births.

Table 4.10 presents the distribution of the number of children at first use among ever married women by current age. Considering only the 26% of these women who have ever used a method, almost half (11.5%) first used a method when they had one living child. Women with no living children and with two living children appear to be equally likely to first initiate contraceptive use (approximately 6% of all ever-married women who ever used a contraceptive method.)

Finally the data suggest that there may be a trend toward earlier first use of contraception among the Gambian population of married women. This hypothesis is supported by the observation that while only 8.9% of ever married women aged 40-49 first used a contraceptive method when they had 1 surviving child, 15.3% of the 20-24 year olds first used a method when they had only 1 surviving child.

TABLE 4.10 PERCENT DISTRIBUTION OF EVER-MARRIED WOMEN BY NUMBER OF LIVING CHILDREN AT TIME OF FIRST USE OF CONTRACEPTION, ACCORDING TO CURRENT AGE, GCPFDS, 1990

AGE	NEVER USED	NUMBER OF LIVING CHILDREN AT TIME OF FIRST USE						MISSING	TOTAL NUMBER
		0	1	2	3	4+			
15-19	88.1	2.1	6.3	1.3	0.0	0.9	1.3	100.0	223
20-24	73.4	4.9	15.3	3.5	0.8	0.3	1.8	100.0	365
25-29	73.2	4.7	12.1	4.9	2.2	2.2	0.7	100.0	476
30-34	73.5	4.1	13.2	3.9	2.3	3.0	0.0	100.0	369
35-39	68.2	3.8	9.5	7.0	3.1	8.4	0.0	100.0	256
40-49	71.1	3.4	8.9	5.5	2.4	8.3	0.4	100.0	252
TOTAL	74.1	4.0	11.5	4.4	1.9	3.4	0.7	100.0	1940

## 4.9 Knowledge of the Fertile Period

In an effort to ascertain women's knowledge of female reproductive physiology, the GCPFDS asked all respondents the following question: "When during her monthly cycle do you think a woman has the greatest chance of becoming pregnant?" This information is especially important in the evaluation of the effectiveness of use of periodic abstinence as a method of contraception in the target population. The distribution of responses to the question is presented in Table 4.11.

56% of all women in the sample and 71% of women who have ever used periodic abstinence believe that a woman is most fertile "right after her period has ended." Only 6% of all women and 7% of users of periodic abstinence correctly identified the middle of the cycle as the most fertile period.

These results should be interpreted with caution, since it was difficult to accurately categorize many of the women's responses to this open-ended question. Thus women who stated that they are most fertile AFTER their period has ended may well have been referring to the middle of the ovulatory cycle, but simply did not add the necessary precision. Further evidence that women may have greater knowledge than the data indicate is found in the relatively low percentages within both groups whose response to the question was "I don't know."

TABLE 4.11 PERCENT DISTRIBUTION OF ALL WOMEN (15-49) AND WOMEN WHO HAVE EVER USED PERIODIC ABSTINENCE BY KNOWLEDGE OF THE FERTILE PERIOD DURING THE OVULATORY CYCLE, GCPFDS, 1990

FERTILE PERIOD	ALL WOMEN	EVER USED PERIODIC ABSTINENCE
During her period	6.1	1.9
Right after her period has ended	55.9	70.7
Middle of the cycle	5.7	7.3
Just before her period begins	8.9	8.1
At any time	4.9	6.4
Other	0.1	0.0
Don't Know	18.4	5.5
Missing or not stated	0.1	0.0
TOTAL	100.0	100.0
Weighted Number	2354	151

## 4.10 Source of Supply (Information) of Contraception

Table 4.12 and Figure 4.9 present data on the source of supply (or information) of contraceptives among current users. The distribution of responses is given for supply methods (pill, injection, vaginal methods, condoms), clinic methods (IUD and female sterilisation), modern methods (supply and clinic), and for the individual methods - pill, injection, female sterilisation, IUD and periodic abstinence.

Overall the public sector is the principal supplier of modern methods of contraception to current users. Government hospitals or clinics supply nearly 70% of all current users of modern methods. The Gambian Family Planning Association clinics (GFPA) supply another 20%.

Correspondingly, government institutions are the sources of supply for nearly 70% of current users of supply methods, with government health clinics supplying 27%, MCH clinics supplying 24% and government hospitals supplying 17%. The Gambian Family Planning Association clinics are also major sources for supply methods (21%).

TABLE 4.12 PERCENT DISTRIBUTION OF CURRENT USERS (15-49) BY MOST RECENT SOURCE OF SUPPLY OR INFORMATION, ACCORDING TO SPECIFIC METHOD, GCPFDS, 1990

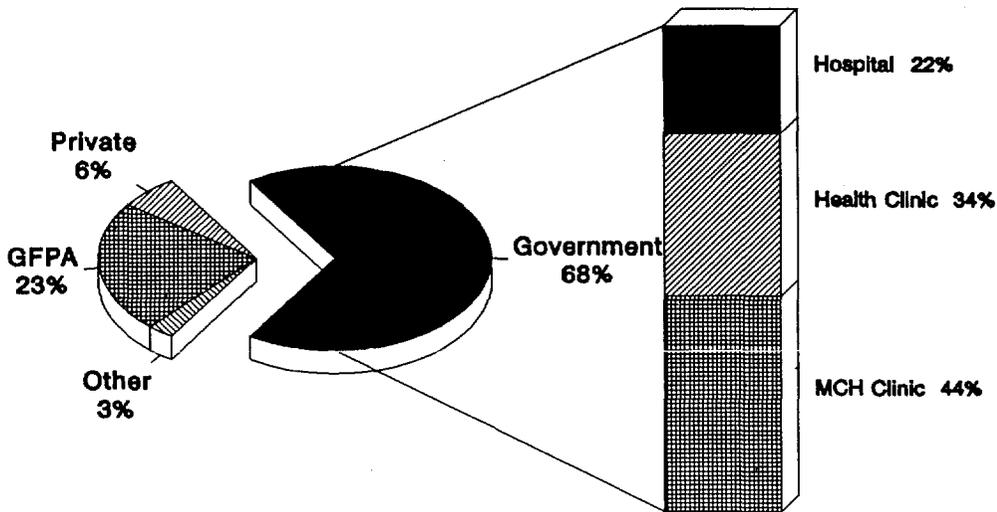
SOURCE	TOTAL SUPPLY METHODS*	PILL	INJECTION	TOTAL CLINIC METHODS+	FEM. STER.	IUD	TOTAL MODERN METHODS#	PERIODIC ABST.
Govt. Hosp.	16.8	15.2	18.7	54.8	74.8	44.4	24.7	1.4
Govt. Health Clinic	26.9	29.3	25.3	9.7	0.0	14.6	23.3	1.4
MCH Clinic	24.4	23.0	29.6	3.2	0.0	5.8	20.0	2.9
Priv. Hosp. or Clinic	0.8	1.8	0.0	9.7	10.8	10.4	2.7	0.0
Pharmacy	4.2	4.3	3.9	0.0	0.0	0.0	3.3	0.0
Religious Body	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GFPA Clinic	21.0	22.0	17.2	16.1	0.0	20.5	20.0	2.0
GFPA CBD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GFPA Fieldworker	4.2	3.1	5.3	0.0	0.0	0.0	3.3	0.0
TBA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	1.7	1.3	0.0	6.5	14.3	4.3	2.7	90.7
Don't Know	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Wtd. Number	119	74	33	31	9	22	150	64

\* Supply methods include pill, injection, vaginal methods and condom

+ Clinic methods include IUD and female sterilization

# Modern methods include supply and clinic methods

**Figure 4.9 Percent Distribution of Current Users by Source of Supply or Information  
GCPFDS, 1990**



CERPOD

Government hospitals are the principal source of supply for clinic methods (55%), largely due to their provision of female sterilization (75%). GFPA clinics provide 16% of clinic methods - specifically IUDs (20%). It is of particular interest to note that 14% of women who have been sterilized stated "other" as their source of supply. An explanation for this response category is not readily available.

Finally, among current users of periodic abstinence, 91% of their sources of information fell in the category "other", which included friends and family members.

#### **4.11 Attitude Toward Becoming Pregnant**

Table 4.13 presents information concerning the attitude toward becoming pregnant in the next few weeks among currently married, non-pregnant, sexually active, non-

contracepting women by the number of living children they have. This data provide a basis by which unmet need for family planning services may be evaluated.

Responses to the question toward becoming pregnant in the next few weeks were grouped into three categories: "Happy", "Unhappy" and "Would not matter". Overall, 58% of the respondents would be happy to become pregnant in the next few weeks. The percent who would be happy falls from a high of 93% of those with no living children to a low of 43% of those with 4 or more living children.

31% of the respondents declared they would be unhappy if they became pregnant in the next few weeks. The percent who would be unhappy is positively associated with the number of living children. Whereas only 3% of those with no living children would be unhappy if they became pregnant, 43% of those with 4 or more children would be unhappy.

Finally, 10% of the target population answered the question with the response "It would not matter". There exists no direct relationship between the number of living children and the percent of respondents who answered "It would not matter".

TABLE 4.13 PERCENT DISTRIBUTION OF CURRENTLY MARRIED, NON-PREGNANT WOMEN (15-49) WHO ARE SEXUALLY ACTIVE AND WHO ARE NOT USING ANY CONTRACEPTIVE METHOD, BY ATTITUDE TOWARDS BECOMING PREGNANT IN THE NEXT FEW WEEKS, ACCORDING TO NUMBER OF LIVING CHILDREN, GCPFDS, 1990

NUMBER OF LIVING CHILDREN	ATTITUDE TOWARDS BECOMING PREGNANT				TOTAL	WEIGHTED NUMBER
	HAPPY	UNHAPPY	WOULD NOT MATTER	MISSING		
NONE	92.8	3.2	3.1	0.8	100.0	120
1	63.2	26.2	10.6	0.0	100.0	135
2	60.0	30.2	9.9	0.0	100.0	144
3	52.9	33.9	13.2	0.0	100.0	131
4+	42.7	43.0	12.2	2.0	100.0	298
TOTAL	57.9	30.8	10.4	0.8	100.0	828

#### 4.12 Reasons for Non-Use

Currently married, non-pregnant, sexually active, non-contracepting women who state they would be unhappy if they became pregnant in the next few weeks, are prime candidates for family planning services. Understanding why these individuals are not using contraception is a first step toward increasing contraceptive use in the population.

According to Table 4.14, the principal reason why those "in need" of contraception are not contracepting is lack of knowledge (33.5%). This primary ranking holds across the two age groups considered. Overall, "wanting more children" and "husband disapproval" rank second (12.6%) and third (11.8%) as reasons for nonuse. These relative rankings also hold across the age group categories.

Whereas among women under the age of 30, "postpartum or breast-feeding" (10.8%) is also an important reason for nonuse, "health concerns" (8.6%), "religion" (8.5%) and "other" (8.4%) were frequently cited as reasons for nonuse among women 30 years and over.

Given the relatively high levels of knowledge of contraceptive methods and their sources in the Gambia, it is somewhat surprising that "lack of knowledge" is the principal reason why those "in need" of contraception (as loosely defined above) are not contracepting. Further research on this issue is warranted.

TABLE 4.14 PERCENT DISTRIBUTION OF CURRENTLY MARRIED, NON-PREGNANT WOMEN (15-49) WHO ARE SEXUALLY ACTIVE AND WHO ARE NOT USING ANY CONTRACEPTIVE METHOD AND WHO WOULD BE UNHAPPY IF THEY BECAME PREGNANT IN THE NEXT FEW WEEKS, BY MAIN REASON FOR NONUSE, ACCORDING TO AGE, GCPFDS, 1990

REASON FOR NONUSE	AGE		TOTAL
	<30	30+	
WANT CHILDREN	14.8	9.9	12.6
LACK OF KNOWLEDGE	36.3	30.1	33.5
OPPOSED TO FP	0.9	1.7	1.3
HUSBAND DISAPPROVES	13.6	9.6	11.8
OTHERS DISAPPROVE	0.0	0.8	0.4
HEALTH CONCERNS	4.4	8.6	6.3
DIFFICULT TO GET	5.3	2.4	4.0
COSTS TOO MUCH	0.7	0.8	0.7
INCONVENIENT TO USE	0.9	0.0	0.5
INFREQUENT SEX	0.0	2.9	1.3
FATALISTIC	0.7	0.8	0.7
RELIGION	3.8	8.5	5.9
POSTPARTUM/BREAST-FEEDING	10.8	3.5	7.2
MENOPAUSAL/SUBFECUND	0.0	5.0	2.2
OTHER	3.6	8.4	5.8
DON'T KNOW	4.7	6.9	5.7
TOTAL	100.0	100.0	100.0
WEIGHTED NUMBER	141	115	255

### 4.13 Future Use

Responses to questions on intention to use contraception in the future provide useful information to planners who would like to estimate future demand for family planning services. Table 4.15 provides this information for the population of currently married women who are not contracepting by the number of living children.

One out of every two women has no intention to contracept in the future. On the average this percentage holds regardless of parity. Forty percent of the women say they do intend to contracept in the future. This figure is also fairly constant across all parity groupings, although women with no children evidence the lowest percent intending to contracept in the future.

TABLE 4.15 PERCENT DISTRIBUTION OF CURRENTLY MARRIED NON-USERS (15-49) BY INTENTION TO USE IN THE FUTURE, ACCORDING TO NUMBER OF LIVING CHILDREN, GCPFDS, 1990

INTENTION TO USE IN THE FUTURE	NUMBER OF LIVING CHILDREN					TOTAL
	NONE	1	2	3	4+	
YES	34.0	40.7	36.3	38.5	41.1	38.9
NO	54.0	46.4	51.5	48.8	46.5	48.6
DON'T KNOW	10.4	12.6	11.1	11.1	11.2	11.3
MISSING	1.6	0.3	1.1	1.7	1.2	1.2
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
WEIGHTED NUMBER	206	274	266	252	629	1628

Data on intention to use contraception in the future should be interpreted with caution as it is widely known that intentions often are not translated into action. Furthermore, as evidenced above, a fairly high proportion of the respondents replied they did not know if they intend to use contraception in the future (11.3%), a relatively strong indication that family planning and contraception are not yet planned, culturally reinforced and normalized behaviors in the Gambia.

#### 4.14 Preferred Method

Considering currently married women who are not contracepting but who intend to use a method in the future, Table 4.16 presents the distribution of their method preferences, according to dichotomized age categories.

Among those who intend to use in the future, the pill is the preferred method (44%), closely followed in preference by injections (33%). Less than five percent of the respondents gave any other method as their preferred choice for future use.

Variations by age exist, with women under 30 preferring the pill (50%) over injections (28%). The opposite holds true for women 30 years and older who prefer injections (41%) over the pill (35%).

Overall, only 6% of the women stated they did not know what method they preferred to use in the future. Women 30 and over were somewhat less likely to specify a method than women under 30 (7% and 6%, respectively).

TABLE 4.16 PERCENT DISTRIBUTION OF CURRENTLY MARRIED NON-USERS (15-49) INTENDING TO USE IN THE FUTURE BY PREFERRED METHOD, ACCORDING TO CURRENT AGE, GCPFDS, 1990

PREFERRED METHOD	UNDER 30 YEARS	30 YEARS AND OLDER	ALL AGES
PILL	49.5	35.0	44.0
IUD	3.9	3.0	3.6
INJECTION	27.9	41.1	32.9
VAGINAL METHODS	0.2	0.0	0.1
CONDOM	1.5	0.0	1.0
FEMALE STERILIZATION	0.2	2.9	1.3
MALE STERILIZATION	0.0	0.0	0.0
PERIODIC ABSTINENCE	3.4	4.1	3.7
WITHDRAWAL	0.0	0.0	0.0
FOAMING TABLETS	1.2	1.2	1.2
TRADITIONAL (JUJU)	5.4	4.2	4.9
OTHER	1.0	1.2	1.0
DON'T KNOW	5.8	7.0	6.3
MISSING	0.6	0.4	0.1
TOTAL	100.0	100.0	100.0
WEIGHTED NUMBER	394	240	634

## **4.15 Attitude Toward Family Planning**

Previous sections of this chapter have revealed a large discrepancy between the level of knowledge of family planning methods and sources on the one hand and their use on the other in the Gambia. Chapter V will present additional data on unmet need for family planning services, the level of which is high enough to call into question the reasons behind the low levels of contraceptive use. Figure 4.10 summarizes the discrepancy between knowledge and use of contraception among currently married women in the Gambia.

One obstacle to use frequently cited in low-use countries is husband disapproval. This section will investigate wives' perceptions of their husbands' feelings about contraceptive use. Once again the results of this analysis should be interpreted with caution as women's perceptions of their husbands' feelings may or may not be correct. Additional research is necessary to actually compare women's perceptions with their husbands' statements as revealed in the male questionnaire.

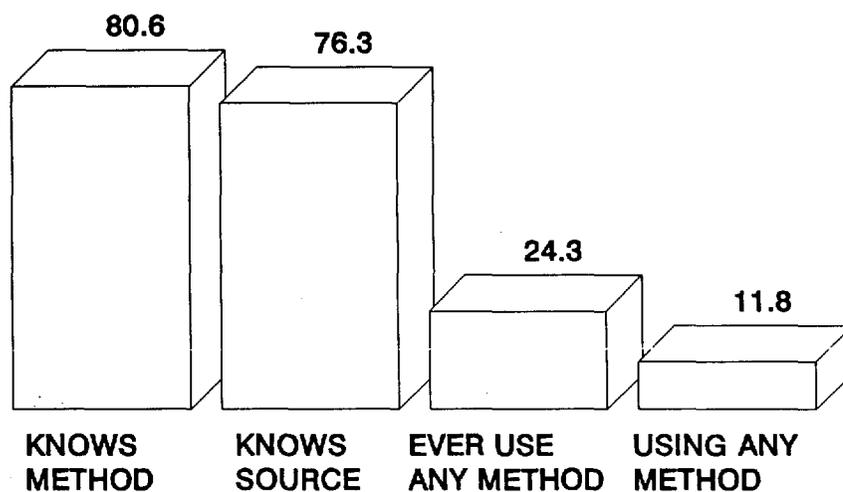
Table 4.17 examines women's attitudes toward the use of family planning in relation to their perceptions of their husbands' attitudes toward the same. This information is presented only for currently married women who know of at least one method of contraception.

Overall, 37% of the women believe their husbands approve of family planning, 26% believe their husbands disapprove and 35% stated they did not know how their husbands felt about family planning.

78% of the women approve themselves of family planning, 19% disapprove and less than 1% had no opinion.

Considering cross-classifications, 34% of the women approve and believe their husbands also approve, 15% approve but believe their husbands disapprove, and 28% approve but do not know whether their husbands approve or disapprove. Two percent of the women disapprove but believe their husbands approve of family planning, 11% disapprove and believe the same of their husbands, and 6% disapprove but do not know their husbands' opinion.

**Figure 4.10. Percentage of Family Planning Knowledge and Use  
Currently Married Women 15-49  
GCPFDS 1990**



CERPOD

**TABLE 4.17 PERCENT DISTRIBUTION OF CURRENTLY MARRIED WOMEN KNOWING A CONTRACEPTIVE METHOD BY HUSBAND'S AND WIFE'S ATTITUDE TOWARD THE USE OF FAMILY PLANNING, GCPFDS, 1990**

WIFE'S ATTITUDE	HUSBAND'S ATTITUDE				TOTAL
	APPROVES	DISAPPROVES	DON'T KNOW	NOT STATED	
APPROVES	34.2	14.9	28.0	1.5	78.5
DISAPPROVES	1.9	10.6	6.2	0.2	18.8
DON'T KNOW	0.0	0.0	0.3	0.0	0.3
NOT STATED	0.8	0.7	0.7	0.1	2.3
TOTAL	36.8	26.2	35.2	1.8	100.0

#### **4.16 Attitude Toward Family Planning by Background Characteristics**

The distributions of currently married women who approve of family planning and who believe their husbands approve of family planning are presented according to selected background characteristics in Table 4.18. This information is of particular importance in defining target populations for family planning services and in interpreting differentials in contraceptive utilization practices.

Excluding the youngest age group, one observes in Table 4.18 an inverse relation between age and percent of women who approve of family planning. This association suggests a generational effect whereby younger women are assumed to be more receptive toward new ideas and practices.

There is no direct relation between women's age and percent who believe their husbands approve of family planning. This may reflect the interaction between the indirect generational effect just specified and the opposing direct influence of age, whereby older women (and men) who have larger families may be more responsive to family planning practices.

Further evidence of family size influences on opinions concerning family planning is given in the approval distribution according to number of living children. Excluding the category 4+ living children, there exists a positive relation between number of living children and the percent of women (husbands) approving of family planning.

As is expected, percents approving are higher in urban than in rural areas. This differential extends to the health region categories, wherein one notes the highest percents approving in the mostly urban, Western health region.

Considering differentials within the rural sector by PHC/non-PHC residence, the percents approving of family planning are only slightly higher in the primary health care villages. This is a somewhat discouraging finding given the greater availability of family planning services (methods and information) in the primary health care villages.

Except for the Wollof who present the highest percent of women and husbands approving of family planning (87% and 41% respectively), differentials by ethnic group are

small.

Finally, percent approving is most strongly and positively associated with level of education. Whereas only 76% of women with no education approve of family planning, 94% of those with secondary or higher level of education approve. Furthermore, women with the highest level of education are two times more likely to claim they have husbands who approve of family planning (68%) than women who have never been to school (32%).

TABLE 4.18 PERCENT OF CURRENTLY MARRIED WOMEN (15-49) KNOWING A METHOD WHO APPROVE OF FAMILY PLANNING AND WHO SAY HUSBAND APPROVES OF FAMILY PLANNING, ACCORDING TO BACKGROUND CHARACTERISTICS, GCPFDS, 1990

CHARACTERISTIC	WOMAN APPROVES	HUSBAND APPROVES
AGE		
15-19	76.8	29.3
20-24	82.8	39.2
25-29	79.8	38.5
30-34	77.3	37.4
35-39	77.4	34.9
40-49	74.7	37.6
LIVING CHILDREN		
0	73.1	24.5
1	79.0	36.6
2	79.8	38.6
3	80.5	40.6
4+	78.7	38.1
RESIDENCE		
Urban	85.2	51.9
Rural	76.7	32.4
- PHC	78.1	35.9
- NONPHC	74.6	27.0
REGION		
Western	83.5	48.4
Central	72.7	28.7
Eastern	73.8	23.0
ETHNIC		
Mandinka	77.8	39.6
Fula	77.0	31.7
Wollof	87.1	40.9
Other	75.9	34.0
EDUCATION		
None	75.9	31.6
Primary	90.1	57.6
Secondary+	93.8	68.0
TOTAL	78.5	36.8

## 4.17 Discussion of Family Planning

It is important in the design of educational strategies to have an idea of the extent to which partners discuss family planning issues with one another. Table 4.19 summarizes this information for currently married women who know of at least one method by the number of times they discussed family planning with their husband in the past year.

Nearly three quarters of the women claimed to have never discussed family planning with their husbands in the past year. 17% discussed the same once or twice, and only 7% discussed family planning three times or more during the past year.

The youngest women are the least likely to discuss this topic with their husbands, while women in the middle of their reproductive years are the most likely. A probable interpretation of these findings is that women in the middle of their reproductive years who have already born some children but who consider themselves still highly fertile, have the greatest need to space and or limit childbearing. Among these women the demand for family planning services is likely to be greatest, and thus they have the most to gain by obtaining their husbands' approval and support in the use of contraceptive methods.

TABLE 4.19 PERCENT DISTRIBUTION OF CURRENTLY MARRIED WOMEN (15-49) KNOWING A METHOD BY NUMBER OF TIMES DISCUSSED FAMILY PLANNING WITH HUSBAND IN THE PAST YEAR, ACCORDING TO CURRENT AGE, GCPFDS, 1990

AGE	NEVER	ONCE OR TWICE	THREE TIMES OR MORE	DON'T KNOW	TOTAL	NUMBER OF CASES
15-19	80.6	14.5	1.9	2.9	100.0	169
20-24	74.2	15.7	8.8	1.4	100.0	270
25-29	72.7	19.4	6.9	0.9	100.0	392
30-34	75.1	13.1	10.3	1.5	100.0	277
35-39	72.8	19.6	7.1	0.5	100.0	192
40-49	72.0	16.5	8.5	3.0	100.0	183
ALL AGES	74.3	16.7	7.5	1.5	100.0	1484

## **CHAPTER V**

### **FERTILITY PREFERENCES**

Among the principal objectives of the Gambian Contraceptive and Fertility Determinants Survey (GCPFDS) was the measurement of knowledge of, attitudes toward and practice of contraception among Gambian men and women. To achieve this end, it was necessary to obtain information concerning the number of children and length of birth spacing intervals desired by women and men (or by couples). In this chapter, fertility preference data on the desire for additional children, preferred birth intervals, the need for family planning services, and ideal family size will be presented.

The fertility preferences section of the GCPFDS asked each woman currently in union (married or living together with a partner): "Would you like to have a (another) child or would you prefer not to have any (more) children?" If the woman declared herself to be pregnant, she was asked: "After the child you are expecting, would you like to have another or would you prefer not to have any more children?" If a woman stated she would like to have another child, she was then asked how long she wanted to wait before having her next child.

Women who wanted additional children were also asked how long they preferred the birth interval to be between their last and next birth. All women currently in union who had two or more births were asked what they thought about the interval between their last two births. All women irrespective of marital status were asked a question concerning desired total family size (IDEAL). Those who had no living children were asked: "If you could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?" Women who had living children were asked: "If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?"

Responses to each of the questions outlined above were analyzed according to various sociodemographic characteristics, and the results of these analyses are presented in

this chapter.

## 5.1 Desire for Children

Figure 5.1 and Table 5.1 present the distribution of all women currently in union according to their desire for children in the future. 11.5% of all women currently in union want no more children, while another 36.7% want to wait at least two years before having another child. Based on these two percentages alone, one may have a first estimation that approximately one out of every two women currently in union is in need of family planning services to limit or space births.

TABLE 5.1 PERCENT DISTRIBUTION OF WOMEN CURRENTLY IN UNION BY DESIRE FOR CHILDREN, ACCORDING TO NUMBER OF LIVING CHILDREN, GCPFDS, 1990

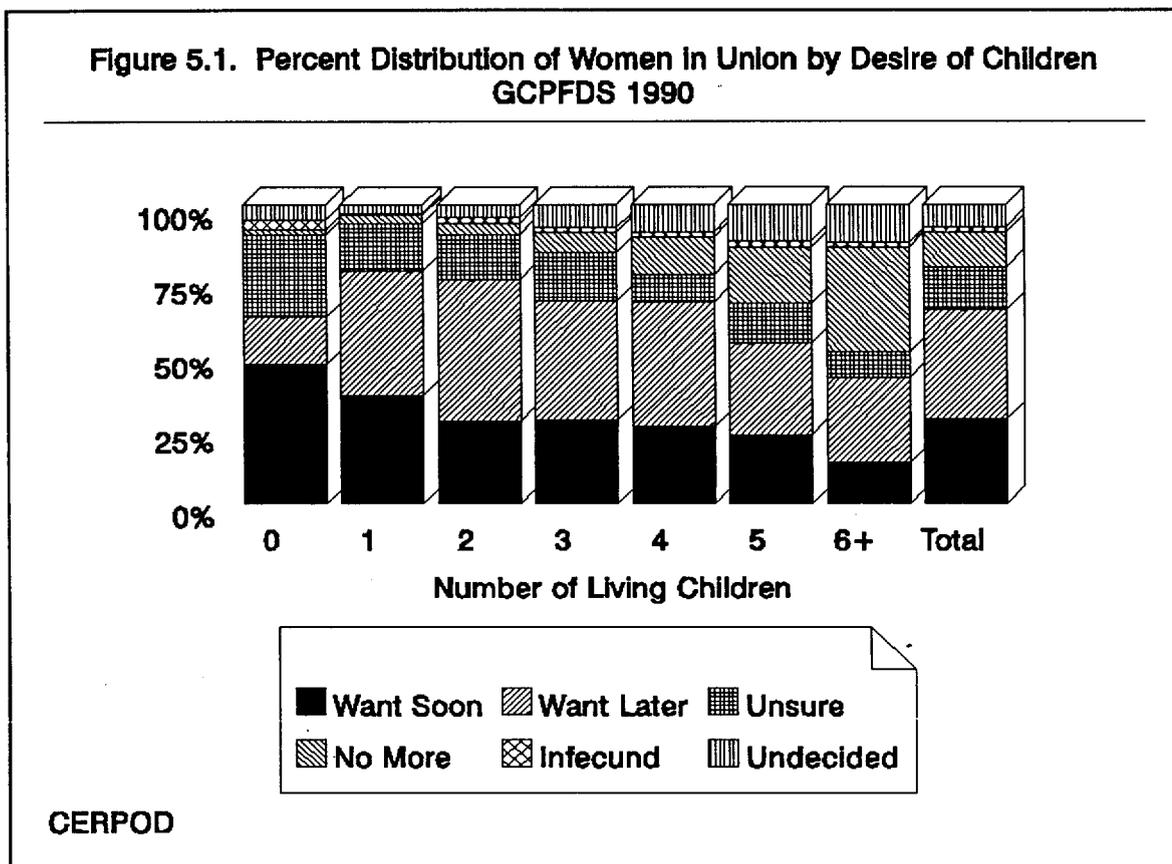
Desire for Children	Number of Living Children*							Total (%)
	0	1	2	3	4	5	6+	
Want Another Soon**	46.8	36.0	27.6	28.0	25.6	23.0	13.6	28.2
Later***	15.6	42.0	47.5	40.1	42.1	30.7	28.7	36.7
Unsure When	27.6	15.9	15.0	16.1	9.2	13.4	8.6	14.6
Want No More	1.7	2.9	3.7	6.9	12.4	19.0	35.3	11.5
Declared Infecund	3.3	0.6	2.2	1.4	1.8	1.9	1.5	1.8
Undecided or Don't Know	5.0	2.6	4.0	7.5	8.9	12.0	12.3	7.2
Total (%)	100	100	100	100	100	100	100	100

\* Including current pregnancy  
 \*\* Wants next birth within 24 months  
 \*\*\* Wants to delay next birth 24 months or more

Twenty-eight percent of the women want another child soon (in less than two years). Another twenty-two percent want another, but do not know when, or are undecided about whether or not they want another child in the future. Approximately two percent of the women declared themselves to be infertile

Data on the desire for children in the future by number of living children a woman already has are presented in Table 5.1 and Figure 5.1. The percent of women currently in

union who desire no more children increases from 2% of those who have no living children to 35% of those with 6 or more living children. Correspondingly, the percent who want another child soon (in less than two years) falls from a high of 47% of those with no living children to a low of 14% of those with 6 or more living children.



Especially noteworthy is the comparison of responses from women with no living children and women with one living child. Only 16% of the former group desire to have a child after an interval of two years or more, whereas 42% of the latter group desire their next birth to occur after a minimum elapse of two years. This data suggest that while the desire to limit births in the population may be only moderate, the desire to space births is strong, especially among women with 1 to 4 living children.

Table 5.2 presents the pattern of fertility preferences by age of woman. Given the strong correlation between parity and age, one observes, as expected, an age-specific fertility preference pattern which closely follows the parity-specific pattern evidenced in Table 5.1, with some exceptions (youngest age and zero parity groups).

TABLE 5.2 PERCENT DISTRIBUTION OF WOMEN CURRENTLY IN UNION BY DESIRE FOR CHILDREN, ACCORDING TO AGE, GCPFDS, 1900

Desire for Children	Age							Total (%)
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Want Another								
Soon*	32.1	30.3	31.6	27.6	24.1	24.7	12.7	28.2
Later**	44.5	47.6	44.0	36.3	26.6	13.7	6.8	36.8
Unsure When	19.6	15.6	13.2	13.7	15.8	12.6	7.9	14.6
Want No More	0.0	2.0	4.7	11.1	18.2	37.1	54.8	11.5
Declared Infecund	0.0	1.1	0.7	1.4	2.5	3.3	9.5	1.7
Undecided or Don't Know	3.8	3.4	5.8	9.9	12.8	8.6	8.3	7.2
Total (%)	100	100	100	100	100	100	100	100

\* Wants next birth within 24 months  
 \*\* Wants to delay next birth 24 months or more

The proportion of women who want no more children rises with age from an absolute low level of 0% for the youngest age group to a high of 55% for the oldest age group. Table 5.2 confirms the finding of the parity-specific analysis that there is a strong desire to delay the next birth to a minimum interval of two years. Nearly one out of every two women under the age of thirty prefers to wait at least two years before having their next child. Corresponding to their increasing desire to have no more children, the proportion of women who want to delay their next birth two years or more falls with age as does the proportion of women who want their next birth soon (less than two years).

The distribution of women currently in union who want no more children is presented in Table 5.3 according to parity and to selected background characteristics. This variable is chosen for in-depth analysis because the proportion of women who want no more children is often considered to be the single most important indicator of fertility preference. For this analysis, the parity groups were collapsed into two categories due to the small numbers of

cases within each sub-group.

TABLE 5.3 PERCENT DISTRIBUTION OF WOMEN CURRENTLY IN UNION WHO WANT NO MORE CHILDREN BY NUMBER OF LIVING CHILDREN AND SELECTED BACKGROUND CHARACTERISTICS, 1990.

Background Characteristics	Number of Living Children*		
	0 - 3	4 +	Total(%)
<b>RESIDENCE</b>			
Urban	(5.1)	40.5	19.8
Rural	3.6	18.0	9.4
<b>REGION</b>			
West	5.0	28.7	14.8
Central	(4.8)	16.1	9.6
East	(2.4)	16.8	8.1
<b>LEVEL OF EDUCATION</b>			
None	3.8	20.9	11.3
Primary	(3.6)	(38.5)	(12.7)
Secondary	(6.1)	(34.6)	(12.1)
<b>ETHNIC GROUP</b>			
Mandinka	(3.2)	18.3	9.9
Fula	(3.2)	17.4	8.6
Wollof	(5.6)	30.6	15.0
Other	(4.6)	28.0	14.0
<b>TOTAL (%)</b>	4.0	22.4	11.5

\* Includes current pregnancy  
Percentages in parentheses are based on less than 20 weighted cases.

Considering place of residence, it is noted that urban women are two times more likely to desire no more children than their rural counterparts. The greater desire of urban women to limit births holds across the two parity groups. Furthermore, regardless of parity, the highest proportion of women wanting no more children is found in the Western health region.

In terms of the dichotomous education variable (some or none), one observes that women with any education are only slightly more likely to desire no more children (12%) than woman who have received no education (11%). It should be noted that one would expect greater differentials between educational categories if it was possible to increase the number of education groupings and so increase the specificity of the descriptive variable. However, as stated previously, the number of cases in each sub-group were too small to render such an analysis meaningful.

Numbers of cases in the ethnic group categories were also too small to compare proportions by parity. However, considering the total sample of women currently in union, the Wolof exhibit the highest proportion wanting no more children (15%) and the Fula exhibit the lowest proportion (9%).

In general, it is of interest to note that when considering the entire population of women currently in union, the relative differences in proportions of women wanting no more children by background characteristics analyzed in Table 5.3 are actually quite small. The largest differential is observed when comparing urban-rural status.

## **5.2 Need for Family Planning**

Unfortunately, the GCPFDS questionnaire did not include questions regarding the planned status of last pregnancy, making it impossible to derive standard DHS measures of family planning need (Westoff, 1988; Westoff and Ochoa, 1991;)<sup>1</sup>. Given this limitation, "need" for family planning may nonetheless be crudely estimated based on proportions of women in union who desire to limit or delay future births. However, some of these women are actually not at risk of conceiving, either because they are infertile or because they are currently contracepting. Thus a more refined analysis of the need for family planning services excludes infertile and contracepting women from the population currently at risk.

Table 5.4 and Figure 5.2 present this basic measure of unmet need for family planning among women currently in union that are not contracepting and are considered to be fecund, by selected background characteristics. In this analysis, "need" is defined as incorporating those women currently in union who are fertile and non-contracepting, who either desire to have no more children, desire to delay their next birth to a minimum interval of two years or who are undecided about whether to have another birth or when

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<sup>1</sup> The "instantaneous unmet need" as defined by Westoff would include women who are currently pregnant or amenorrheic if they declare that their last or actual pregnancy was mistimed or unwanted. Bongaarts (1990, 1991) suggests an adjustment upwards of the "unwanted status" of last pregnancies (usually under-reported on surveys) by recoding all births occurring after a woman attain her desired family size as "unwanted".

to have the next birth. Including this last group in the analysis of unmet need results in an upper limit estimate of the need for family planning services.

TABLE 5.4 PERCENT DISTRIBUTION OF CURRENTLY MARRIED WOMEN WHO ARE IN NEED OF FAMILY PLANNING, BY SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristic	In Need of Family Planning*		Total
	Want No More	Want to Postpone/ Undecided**	
<b>RESIDENCE</b>			
Urban	11.8	38.0	49.8
Rural	8.2	55.8	64.0
<b>REGION</b>			
West	10.5	46.3	56.8
Central	7.7	60.3	68.0
East	7.4	57.1	64.5
<b>ETHNIC GROUP</b>			
Mandinka	8.2	50.7	58.9
Fula	7.2	53.7	60.9
Wolof	9.5	57.0	66.5
Other	11.2	50.0	61.2
<b>LEVEL OF EDUC.</b>			
None	9.4	54.5	63.9
Primary	( 8.7 )	40.7	49.4
Secondary+	( 3.3 )	38.0	41.3
<b>TOTAL</b>	<b>8.9</b>	<b>52.3</b>	<b>61.2</b>

\* Includes women who are not contracepting and who want no more births or want to postpone the next birth for 2 or more years.

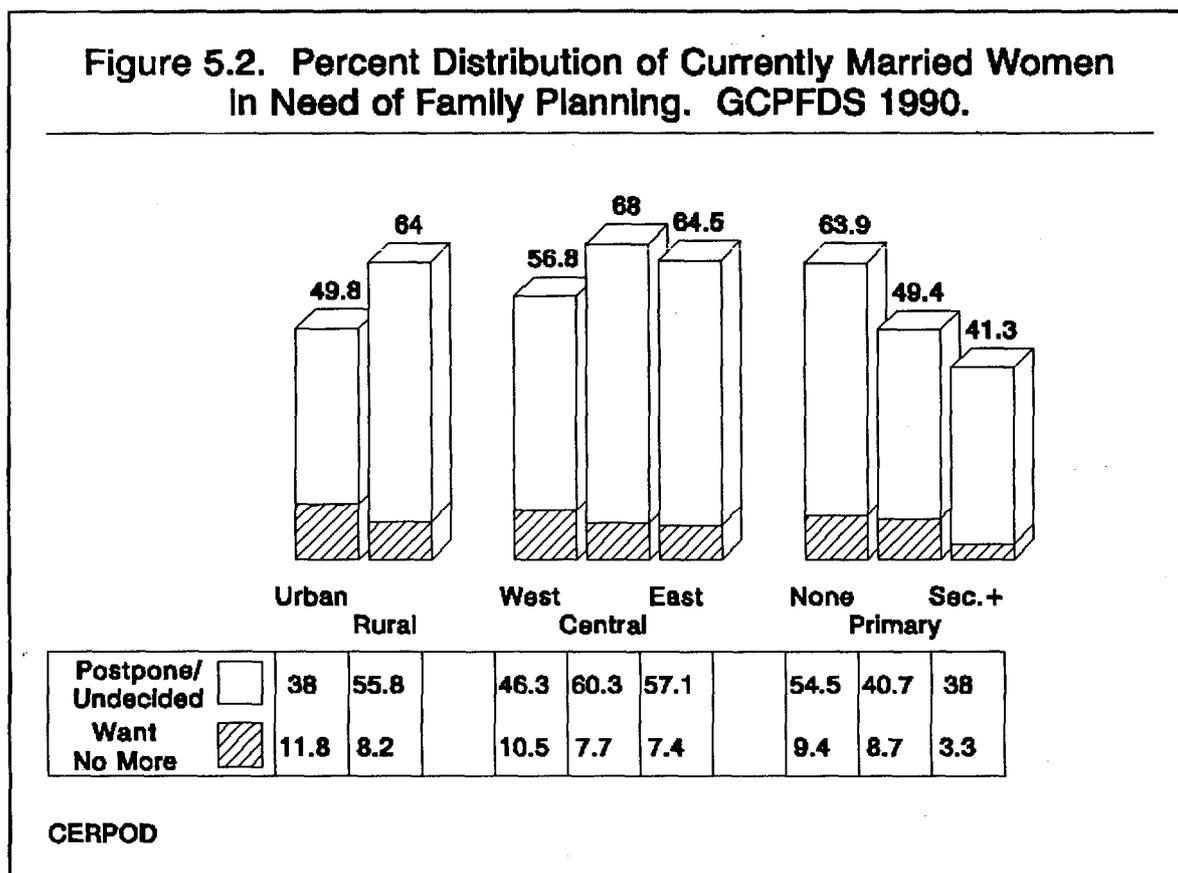
\*\* Includes women who are undecided about whether or not to have another birth or about the timing for the next birth.

( ) Percentages in parentheses are based on fewer than 20 cases.

Overall, 61% of Gambian women currently in union are determined to be in need of family planning services as "need" is defined in the preceding paragraph. Among this 61% in need, six out of seven women want to postpone or are undecided about whether or when to have a next child, and the remaining one out of seven women wants no more children.

The need for family planning services is higher among rural (64%) than urban (50%) women. Furthermore, the unmet need for family planning services is greatest in the Central Health region (68%) and lowest in the Western health region (57%). Ethnic differentials in unmet need range from a high of 66% among the Wolof to a low of 59% among the Mandinka. Finally, women who have received no education are more likely to be in need

of family planning services (64%) than women who have received any education (between 41% and 49%).



Unfortunately, the numbers of women currently in union and at risk of conceiving (fertile and non-contracepting) who expressed the intention to use contraception in the future were too small within the various sub-groupings to perform a meaningful analysis by an "intention to use contraception" variable.

### 5.3 Ideal Family Size

The information in Table 5.5 was obtained in response to the question concerning the number of children a respondent would choose to have in the hypothetical situation

were she beginning her reproductive years anew.

Given that 1 out of every 2 respondents gave a non-numeric answer to the question (in particular "It's up to God"), it may be concluded that the question was not readily understood, and thus the results should be interpreted with caution. Furthermore, in noting that the percent of non-numeric responses increases with parity (and so with age), the responses of the higher parity women are interpreted to be less reliable than those of the lower parity (younger) women.

TABLE 5.5 PERCENT DISTRIBUTION OF ALL WOMEN BY IDEAL NUMBER OF CHILDREN AND MEAN IDEAL NUMBER OF CHILDREN FOR ALL WOMEN AND FOR WOMEN CURRENTLY IN UNION, ACCORDING TO NUMBER OF LIVING CHILDREN, GCPFDS, 1990.

Ideal Number of Children	Number of Living Children*							Total
	0	1	2	3	4	5	6+	
0	0.6	0.3	0.0	0.3	0.6	0.0	0.3	0.4
1	0.4	0.8	0.6	0.0	0.0	0.0	0.0	0.3
2	5.1	1.8	3.0	1.2	0.3	0.6	0.4	2.4
3	9.1	5.6	3.2	4.0	1.1	2.0	1.2	4.8
4	16.3	9.9	11.4	8.7	4.3	3.5	2.5	9.8
5	9.1	9.4	8.9	5.7	6.5	6.9	2.6	7.5
6+	18.5	22.6	22.0	26.7	28.6	29.4	26.3	23.6
Non-numeric	39.0	47.6	50.7	51.9	57.1	54.6	66.0	49.8
Missing	1.8	2.0	0.3	1.6	1.4	3.0	0.7	1.6
TOTAL	100	100	100	100	100	100	100	100
Number	729	350	341	304	297	224	273	2518
MEAN IDEAL NUMBER**								
All women	5.0	5.7	5.8	6.2	6.8	6.9	7.1	5.8
Number	432	177	167	142	123	95	91	1227
Women in union	6.0	6.0	5.8	6.3	6.9	6.9	7.2	6.4
Number	96	146	152	135	117	90	89	825

\* Includes current pregnancy.

Non-numeric responses include: "as many as God wills" and "Don't Know"

\*\* Excludes women who gave non-numeric responses.

Based on an average ideal number of children equal to eight for the open interval (6+).

The mean ideal number of children desired, calculated on the basis of numeric responses, is 5.8. This number is slightly lower than the actual current fertility of all women in the Gambia (6.0). Based on this comparison, the evidence in Table 5.5 suggests that women in the Gambia are having more children than they actually desire.

Considering all women in the survey who gave numeric responses to the question (biased toward younger, lower parity women), the mean ideal number of children ranges from 5.0 for those with no living children to 7.1 for those with 6 or more living children. Between these two extremes, the relationship between the number of living children and the mean ideal number of children is positive but not directly linear.

Considering only currently married women, the mean ideal number of children is slightly higher at 6.4. The range of values for the mean ideal number spans between a low of 5.8 for women with 2 living children to a high of 7.2 for women with 6 or more living children.

Adjustments to the estimates of unmet need for family planning (section 5.2) with GCPFDS data, are possible taking into consideration the number of women who declared an ideal number of children superior to their actual number of children (see Bongaarts, 1990, 1991, for a discussion of this topic). Due to the large number of non-numeric answers to the question on ideal family size in the Gambian sample, this analysis was not attempted here. However, investigation of alternative methods for estimating the unmet need for family planning in populations where non-numeric answers to the ideal family size question are prevalent, is an interesting topic for further analysis using the GCPFDS data.

## CHAPTER VI

### MORTALITY

In the Gambian Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS), data on infant, childhood and adult mortality were collected to provide the necessary information for a comprehensive demographic description of the Gambian population. Specifically, mortality indicators are essential for the evaluation of health programs and the targeting of populations at high risk. Furthermore, mortality data are a necessary component of the study of the proximate determinants of fertility, and in particular the interactions between birth spacing, contraceptive use and infant/child survival.

The first section of this chapter will discuss the survey methodology pertaining to the collection and analysis of mortality data. This section will also include the results of a preliminary assessment of the quality of the mortality data.

The second section of this chapter will present the results of the direct estimation of levels and trends in mortality rates defined for five age intervals:

- *Neonatal mortality*      the probability of dying in the first month of life;
- *Post-neonatal mortality*      the probability of dying between the exact ages of one month and twelve months;
- *Infant mortality*      the probability of dying between birth and exact age one;
- *Childhood mortality*      the probability of dying between the first and fifth birthdays;
- *Under five mortality*      the probability of dying between birth and exact age five.

The direct estimation of mortality was calculated on a period basis rather than on a birth cohort basis for the following reasons:

- (i) program evaluation requires period-specific rates, and
- (ii) information for the calculation of cohort-based rates for births in the five years preceding the survey is only partially available.

The third section of this chapter will present direct estimates of differentials in infant,

childhood and under five mortality by selected socioeconomic characteristics of the mother and other demographic characteristics.

The fourth and final section will compare and contrast estimates of infant and child mortality levels and trends derived from various sources and based on both direct and indirect estimation techniques.

## **6.1 Methodology and Data Quality**

Data for the estimation of mortality rates were collected in the reproduction section of the women's individual questionnaire. The section began with questions concerning the aggregate childbearing experience of the respondents (i.e. the number of sons and daughters currently living in the household, those who live elsewhere and those who have died.) These questions were followed by a retrospective birth history in which data were obtained on the type of birth (singleton or multiple), sex, date of birth, survivorship status and current age or age at death of each of the respondent's live births. The data obtained from these questions were used to calculate infant and childhood mortality rates.

The reproductive birth history, in which data were collected from respondents aged 13-49 as of the survey date, is subject to well-known structural biases and data collection errors. Concerning the former, the data based uniquely on the experience of women aged 15-49 in 1990 should in no case be considered representative of the period covered by the birth history (that is the 35 years preceding the survey date.) In particular, the data are subject to a truncation bias whereby there is no information on births to women aged 40 to 49 years for the period 10 to 15 years preceding the survey.

The data collection errors common to reproductive birth histories include under-reporting of events (especially births and deaths of infants who died soon after birth), misreporting of date of birth, and misreporting of age at death (for example, rounding to the age of 12 months for age of infant death). In general, these data problems tend to be less serious for time periods close to the survey date.

Although this analysis does not attempt to undertake a complete evaluation of the

mortality data quality, the results of some standard quality checks are presented below.

The ratio of deaths in the first week of life to deaths in the first month of life (see Table 6.1) provides information concerning the under-reporting of early infant deaths.

TABLE 6.1. DISTRIBUTION OF DEATHS BY CALENDAR PERIOD, SEX AND AGE AT DEATH, GCPFDS, 1990

AGE AT DEATH	1986-1990*			1981-1985			1976-1980		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
PANEL A									
0-6 DAYS (A)	42	45	87	54	31	85	49	20	69
0-29 DAYS (B)	53	56	109	70	43	113	56	51	107
<365 DAYS (C)	91	85	176	107	75	182	87	82	169
A/B	0.79	0.80	0.80	0.77	0.72	0.75	0.87	0.39	0.64
B/C	0.58	0.66	0.62	0.65	0.57	0.62	0.64	0.62	0.63
PANEL B									
8 MONTHS	1	2	3	0	0	0	1	3	4
9 MONTHS	1	1	2	4	0	4	1	3	4
10 MONTHS	0	1	1	1	1	2	1	0	1
11 MONTHS	0	0	0	2	1	3	2	0	2
12 MONTHS	19	17	36	29	20	49	19	24	43
13 MONTHS	1	0	1	1	0	1	0	0	0
14 MONTHS	1	2	3	0	1	1	0	1	1
15 MONTHS	2	0	2	0	0	0	1	1	2
16 MONTHS	0	1	1	2	2	4	0	1	1

\* Includes exposure in 1990 during the months of the interview

While there is no singular expected value of this ratio, it is known that mortality declines throughout infancy and that the value of this ratio would be expected to increase as the overall level of mortality decreases (endogenous causes of mortality come to predominate over exogenous causes). A ratio of less than 0.25 indicates severe under-reporting of early infant deaths.

As shown in Table 6.1, the ratio of deaths in the first week to deaths in the first month hovers between 0.70 and 0.90 for both sexes combined in all three time periods, suggesting, with the possible exception of the female ratio for the earliest time period, that early infant deaths are not severely under-reported.

Further evidence of the omission of early infant deaths is given by a low ratio of neonatal deaths to all infant deaths. As presented in Table 6.1, these ratios range from 0.57 to 0.66 for the three time periods being evaluated. Comparing this range to those of other DHS countries at similar mortality levels, no greater under-reporting of early infant deaths in this survey is apparent.

Panel B of Table 6.1 provides further evidence by which the reported age distribution of deaths may be evaluated. In particular, considerable digit preference (heaping) at 12 months of age is evident. To the extent that such heaping results from the misreporting of the age of deaths occurring in the late post-neonatal period, infant mortality will be biased downward and child mortality will be biased upward. One possible solution to this problem is to adjust the data by reassigning half the deaths at 12 months to infant deaths. Such an adjustment results in a considerable increase in the infant mortality rate for both sexes combined of approximately 11% for the ten year period preceding the survey. Correspondingly, the child mortality rate (probability of dying between the first and fifth birthdays) is reduced by approximately 13% for the same time period.

Finally, it should be mentioned that certain measures were taken to impute a date of birth and/or age at death for "unknown" or "not stated" cases. Briefly, of the approximately 7600 births reported in the reproductive history, 27% were reported without a month of birth and 2% (135 cases) provided no year of birth. Concerning this latter group, 102 were cases of infants or children who had died. Since the majority of cases with an unstated year of birth were cases who had died, it was decided to assign these cases a year of birth following the distribution of births of all cases in the sample who had died. This decision was made following an exploratory analysis of the demographic characteristics of the cases who had died (whether there were gross differences in the distribution of birth orders, mother's age at birth, etc. between the cases who had died and those who survived.) Further adjustments in the program assigning a year of birth were based on the reported birth order of the target child (and restricting the previous birth interval to a minimum of nine months).

## 6.2 Mortality Levels and Trends

Table 6.2 and Figure 6.1 display infant, childhood and under five mortality rates for the three five-year periods preceding the survey. Total numbers of births in sub-categories for the three time periods were too small to perform a differential analysis by population characteristics. Thus the analysis is limited to the total sample population.

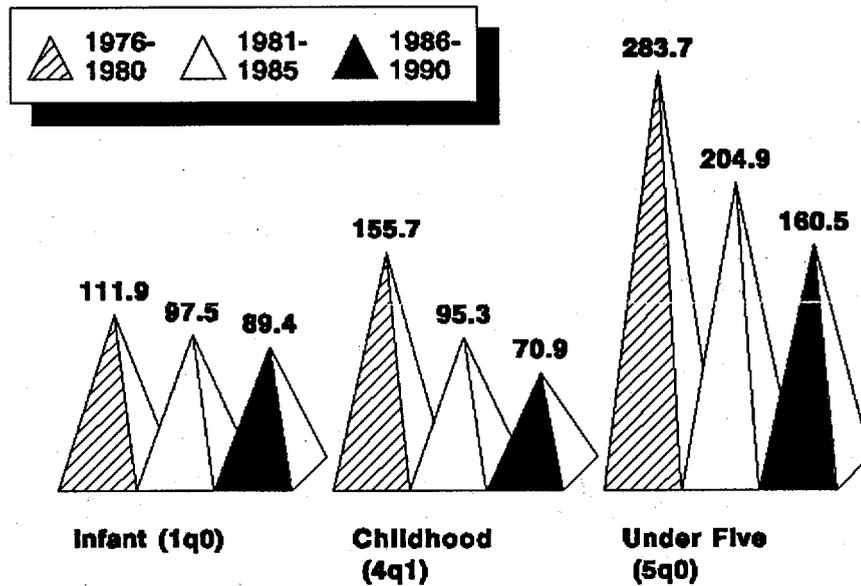
TABLE 6.2 INFANT, CHILDHOOD AND UNDER FIVE MORTALITY BY FIVE YEAR CALENDAR PERIODS, GCPFDS, 1990

Period	Neo-Natal	Post Neonatal	Infant (1q0)	Childhood (4q1)	Under Five (5q0)
1976-1980	65.0	39.7	111.9	155.7	283.7
1981-1985	62.8	35.2	97.5	95.3	204.9
1986-1990*	57.7	33.6	89.4	70.9	160.5
Percent Decline 1976-1980 to 1986-1990	11.2	15.4	20.1	54.5	43.4

\* Includes exposure in 1990 during the months of the interview.

Unequivocally, there has been a remarkable decline in all five mortality indicators in the Gambia since the mid-1970s. Neonatal mortality (probability of dying in the first month of life) has fallen by an estimated 11% during the 15 year period. Post-neonatal mortality (probability of dying between 1 month and 12 months of age) is estimated to have fallen by 15% during the same time period. It is of interest to note that the relative levels of the two infant mortality indicators have remained fairly constant during the period under study. Specifically, the post-neonatal mortality rate for the earliest period (40) is 39% lower than the neonatal mortality rate for the same period (65). The post-neonatal mortality rate for the most recent time period (34) is 41% lower than the corresponding neonatal mortality rate (58).

**Figure 6.1. Infant, Childhood and Under Five Mortality by Five Year Calendar Periods. GCPFDS 1990.**



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The infant mortality rate has fallen by just over 20% during the fifteen year period, from an estimated 112 deaths per 1000 births in the 1976-1980 period to just under 90 deaths per 1000 births in the most recent period. Most notable, however, is the precipitous decline in childhood mortality. During the fifteen year period under study, the probability of dying between the first and fifth birthdays is estimated to have fallen by over 54%. This steady and large decline in childhood mortality contributes heavily to the observed trend in under five mortality. Specifically, it is estimated that the probability of a child's dying before his or her fifth birthday has fallen from a probability of 28% to a probability of 16%.

### 6.3 Mortality Differentials

Restricting the analysis to the ten year period from 1981-1990, sufficient numbers of cases are available to calculate rates for sub-groups. Table 6.3 presents infant and childhood mortality indicators by socioeconomic characteristics of the mother, including place of residence, ethnic group and level of education.

TABLE 6.3 SOCIOECONOMIC DIFFERENTIALS IN INFANT AND CHILD MORTALITY, 1981-1990, GCPFDS, 1990

	Infant Mortality (1q0)	Child Mortality (4q1)	Under Five Mortality (5q0)
<b>RESIDENCE</b>			
Urban	84	28	114
Rural	102	94	198
<b>RURAL*</b>			
PHC	104	82	187
Non-PHC	99	109	212
<b>HEALTH REGION</b>			
West	83	52	138
Central	125	89	215
East	102	117	224
<b>ETHNIC GROUP</b>			
Mandinka	102	94	198
Fula	92	93	190
Wollof	81	64	149
Other	106	64	172
<b>LEVEL OF EDUCATION</b>			
None	100	84	186
Primary	96	82	184
Secondary	(59)	(23)	(92)
<b>TOTAL</b>	<b>97</b>	<b>81</b>	<b>181</b>

Note: The rates presented include exposure during 1990 through the months of the survey.

\*All rural respondents were classified according to whether or not they lived in a primary health care village.

Figures in parentheses are based on fewer than 20 deaths.

Although rural mortality is higher for all three indicators, there is considerable variation in the level of this difference according to the indicator estimated. While infant mortality is only 20% higher in rural than urban areas, childhood mortality is nearly 300% higher in the rural areas. The relatively low estimate of childhood mortality in the urban areas is a subject for further study.

The GCPFDS included a variable classifying all rural respondents according to whether or not they lived in a primary health care village. Table 6.3 reveals that infant mortality is slightly higher in the primary health care (PHC) villages than in the non-PHC villages. The relationship is reversed when considering indicators of childhood and under five mortality. Further information concerning the criteria for becoming a primary health care village (and the services therein provided) is necessary in order to formulate hypotheses concerning the mortality differentials by PHC village type.

Regional differentials in mortality are also quite notable. The Western health region exhibits the lowest mortality for all three indicators, with a probability of dying before the fifth birthday of approximately 14%. Infant mortality is highest in the Central region (125 deaths per 1000 births), whereas childhood mortality is highest in the Eastern health region (approximately 12 % of all children who survive to their first birthday die before their fifth birthday).

The relative levels of the mortality indicators are not consistent when comparing the differentials by ethnic group. Although the Wolof exhibit the lowest levels of both infant and childhood mortality (81 and 64, respectively), the group classified "other" simultaneously exhibits the highest estimate of infant mortality (106) while sharing the Wolof's relatively low level of childhood mortality (64).

Finally, Table 6.3 presents estimates of mortality according to the mother's level of education. Unfortunately, the number of births to women in the "secondary +" educational category was too small to provide a reliable estimate. Otherwise, the differentials suggest a slightly higher mortality experienced by those born to mothers with no education as compared to those born to mothers with some primary education.

Mortality differentials by sex, mother's age, birth order and length of the preceding birth interval for the time period, 1981-1990, are presented in Table 6.4 and Figure 6.2. Mortality by sex differs by approximately 21% in the case of infant mortality and by approximately 5% in the case of childhood mortality, with the lower rates being consistently female.

Given the greater value and care given to male children in the Gambia, the higher male infant and child mortality rates may, at first glance, appear somewhat surprising.

However, a possible explanation may be that due to the greater value placed on male children, women are more likely to omit reporting female deaths than male deaths in the reproductive history (recall bias). Further analysis of the mortality differentials by sex is warranted.

TABLE 6.4 DEMOGRAPHIC DIFFERENTIALS IN INFANT AND CHILD MORTALITY, 1981-1990, GCPFDS, 1990

	Infant Mortality (1q0)	Child Mortality (4q1)	Under Five Mortality (5q0)
<b>SEX</b>			
Male	107	83	192
Female	88	79	171
<b>MOTHER'S AGE</b>			
Less than 20	105	78	178
20-24	80	83	167
25-34	102	80	189
35+	120	101	241
<b>BIRTH ORDER</b>			
1	108	73	177
2-3	86	77	165
4-6	71	84	160
7+	174	99	284
<b>PRECEDING BIRTH INTERVAL*</b>			
Less than 2 year	143	96	233
2-3 years	72	75	153
4+ years	94	90	188
<b>TOTAL</b>	<b>97</b>	<b>81</b>	<b>181</b>

Note: The rates presented include exposure during 1990 through the months of the survey (November and December).

\* Based on births of order two and higher.

As depicted in Figure 6.2, differentials in infant mortality by mother's age at birth of the child exhibit the expected J-shaped pattern. Infant mortality is high for those born to women less than 20 years old (105), declines for births to women aged 20-24 and 25-34 years (80 and 102, respectively) and rises to a maximum level of 120 for births to women in the oldest age group (35+ years). As expected, infant mortality differentials by birth order display a similar pattern:

What is exceptional about the Gambian data is the surprising rise in the estimate of infant mortality for the longest (4+ years) preceding birth interval group. This pattern of infant mortality stands in stark contrast to the pattern of steady decline with increasing length of preceding birth interval found in other African Demographic and Health Surveys. One possible explanation, which requires further investigation, is that the births with a long preceding birth interval (4+ years) are disproportionately concentrated in high mortality families such that in many cases, another child was born and died in the preceding 4+ year interval, but the birth was not reported by the mother. This phenomenon would result in the misclassification of the target child to a preceding birth interval (4+ years) which, in fact, is longer than the actual preceding birth interval.

One would expect demographic characteristics to have their greatest impact on infant mortality differentials, with a weakening strength of effect on levels and differentials in childhood mortality. This expectation is supported by the data (see Table 6.4). Whereas child mortality ranges from 78 to 101 when considering mother's age at birth, infant mortality ranges from 80 to 120. Correspondingly, child mortality does not evidence a strong association with birth order, ranging from 73 for the first birth order, to 99 for birth order 7+. Infant mortality, on the other hand, increases more than two-fold from a low of 71 for birth order 4-6 to a high of 178 for birth order 7+.

The largest differentials in infant mortality are associated with the length of the preceding birth interval. As documented in innumerable studies (and in particular in the current Demographic and Health Surveys worldwide), infant mortality is highest for those births having a preceding birth interval of less than two years. The GCPFDS is no exception. Infant mortality in this sub-group is estimated as 143 deaths per 1000 births in the first year of life.

In contrast to infant mortality differentials which vary by as much as 100% when comparing preceding birth interval groups, the levels of childhood mortality vary by only 28% (with a low value of 75 for a preceding birth interval of 2-3 years and a high value of 96 for a preceding birth interval of less than two years). In fact, what is probably far more important than preceding birth interval in explaining differentials in childhood mortality is the length of the succeeding birth interval. It is the latter which is likely to affect the

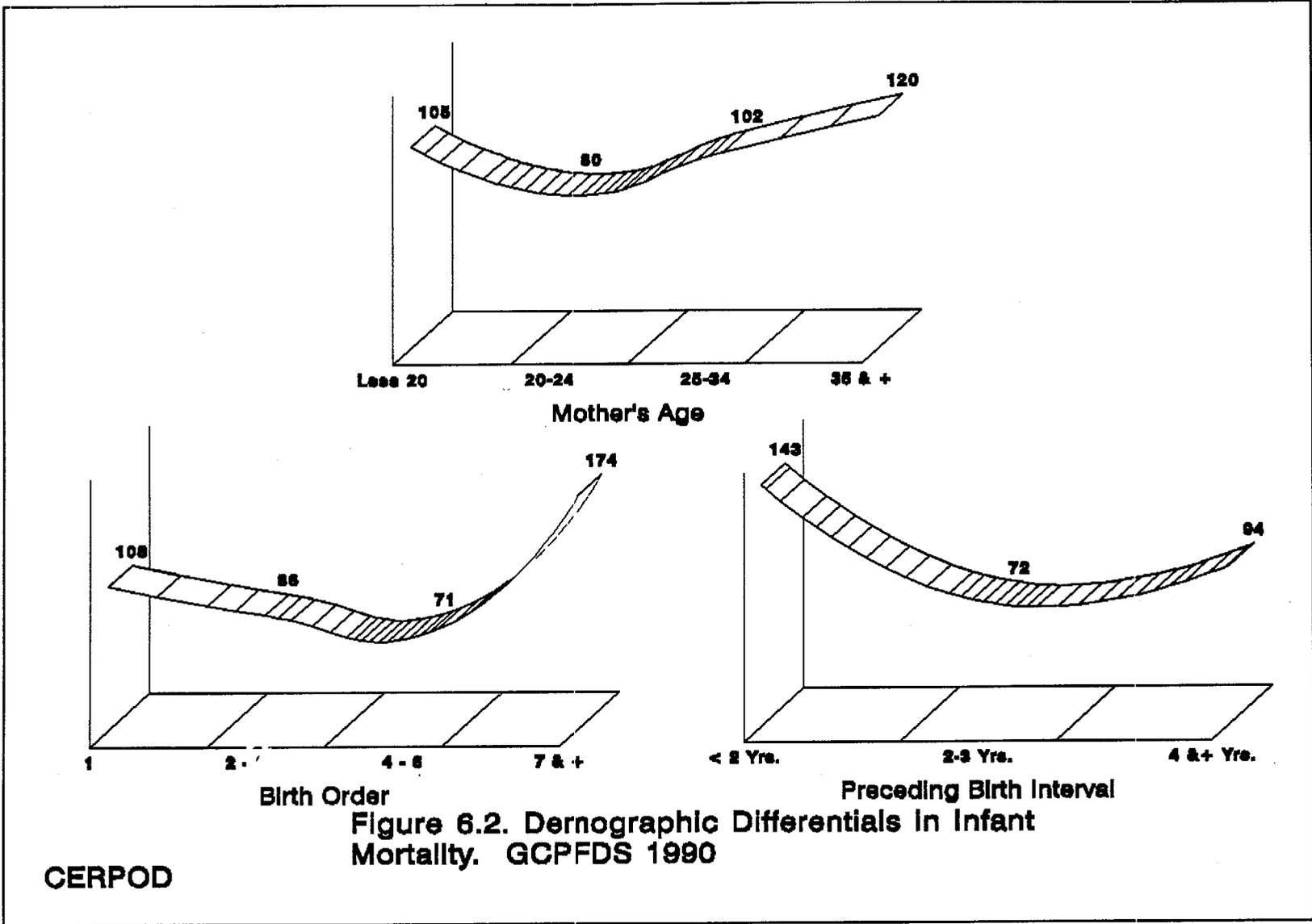


Figure 6.2. Demographic Differentials in Infant Mortality. GCPFDS 1990

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duration of breast-feeding and age at weaning, factors known to be strongly predictive of the level of childhood mortality.

## 6.4 Comparative Estimates

Estimation of the mean number of children ever born, surviving, dead and proportion dead by age of mother provides an alternative perspective on the childhood mortality experience of the study population. As evidenced in Table 6.5, one-fifth of all children born to women aged 15-49 have died. For the group of women who have completed childbearing, 25% of the children they have ever born have died. With the exception of the 40-44 year old group, the proportion dead increases with age of mother, as expected. This deviation from the expected pattern suggests probable greater omission in reporting births of children who have died.

TABLE 6.5 MEAN NUMBER OF CHILDREN EVER BORN, SURVIVING, DEAD AND PROPORTION DEAD BY AGE OF MOTHER, GCPFDS, 1990

Age of Woman	Ever Born	Mean Number of Children:		
		Surviving	Dead	Proportion Dead
15-19	0.4	0.3	0.1	0.139
20-24	1.6	1.4	0.2	0.147
25-29	3.3	2.8	0.5	0.148
30-34	4.4	3.4	1.0	0.219
35-39	5.9	4.5	1.4	0.234
40-44	6.0	4.6	1.4	0.232
45-49	6.4	4.8	1.6	0.248
All Ages	3.1	2.5	0.6	0.202

Based on the methodology originally developed by Brass (1964), data on the average number of children ever born, surviving and dead may be used to indirectly estimate early age mortality and the time reference to which these values refer. Choice of the most appropriate model life table to use in this analysis is certainly debatable. However, for the purposes of comparison to the direct estimates, the indirect estimates based on the Coale-Demeny North model will be considered. This family was chosen based on the argument

in the UN Manual X that in populations "where breast-feeding is common and where weaning occurs at a relatively late age, one may reasonably expect child mortality (4q1) to be relatively higher than infant mortality (1q0) since breast-feeding may successfully prevent deaths due to malnutrition and infectious disease among young infants." (p.15) In this situation, it is proposed that infant and childhood mortality in the Gambia are likely to be best represented by the North family.

A basic assumption of the methodology is that a child's risk of dying is a function only of the age of the child and not of other factors, such as mother's age or the child's birth order. Thus the indirect estimates based on the reports of women aged 15-19 at the time of the survey are excluded from the analysis since the mortality risk of children born to young women is known to be greater than the risk of children born to older women.

The indirectly estimated childhood and under five mortality rates referring to selected time periods are compared to the associated direct estimates in Table 6.6. The childhood mortality rates differ by 11% and the under five mortality rates differ by 6%. In both cases, the indirectly estimated rate is higher.

TABLE 6.6 COMPARISON OF DIRECT AND INDIRECT MORTALITY ESTIMATES FOR SELECTED TIME PERIODS, GCPFDS, 1990.

	(4q1)	Date	(5q0)	Date
INDIRECT	80	1988	218	1984
DIRECT	71	86-90	205	81-85

Another source of indirect estimates of infant and childhood mortality is provided by the 1983 Gambian Population and Housing Census General Report. Based on the Trussell regression equations as applied to the North Model Life Table Family, the infant mortality rate (1q0) in 1983 was estimated to be 146. The under five mortality rate (5q0) in 1977 was estimated to be 258.

The corresponding direct estimates derived from the GCPFDS are: a) infant mortality rate of 97 for the 1981-1985 period (44% lower) and b) under five mortality rate of 284 for the 1976-1980 period (10% higher).

## **CHAPTER VII**

### **MATERNAL AND CHILD HEALTH CARE**

In the Health Section of the women's individual questionnaire information was collected on three topics: tetanus immunization, prenatal care and delivery assistance. For each live birth which occurred during the five years preceding the survey, the following questions were asked:

- Was the mother given a neonatal tetanus injection during the pregnancy?
- Did anyone check on the pregnancy? If yes, the professional category of the most qualified person who checked on the pregnancy was recorded.
- Who assisted with the delivery? The profession of the most qualified person who assisted with the delivery was also recorded.

In this chapter, the information collected as defined above, is analyzed in relation to selected background socio-demographic characteristics (residence, health region, ethnic group and level of education) in order to gain an insight on the associated use of health services in the Gambia. The first section of this chapter deals with prenatal care and neonatal tetanus immunization, and the second section considers medical assistance during delivery.

#### **7.1 Prenatal Care and Neonatal Tetanus Immunization**

As revealed in Table 7.1, the percentage of children born during the five years preceding the survey whose mother did not receive any medical care during her pregnancy is quite low in the Gambia. This percentage (2.5) is much lower than the levels found in most of the Demographic and Health Surveys conducted in Sub-Saharan Africa. For example, this percentage is as high as 35.7 in Senegal (N'diaye et al., 1987) and as high as 62.4 in Mali (Traoré et al., 1988).

Over three-fourths (75.9%) of the mothers of children born during the five years preceding the survey received pre-natal care by a trained nurse or a midwife at least once

during their pregnancy. The mothers who were seen by a medical doctor represent only 15 percent of the population concerned. Therefore, over 90 percent of the pregnant women during the five years preceding the survey had some form of contact with the modern health system. Most of the other women who received prenatal care were seen by traditional birth attendants.

When considering the different background characteristics of the mother, no significant differences in the percentage of children whose mothers received prenatal care are evident (see Table 7.1 and Figure 7.1). Essentially, all the sub-groups defined by these variables have a percentage of women who received ANY prenatal care which exceeds 95 percent.

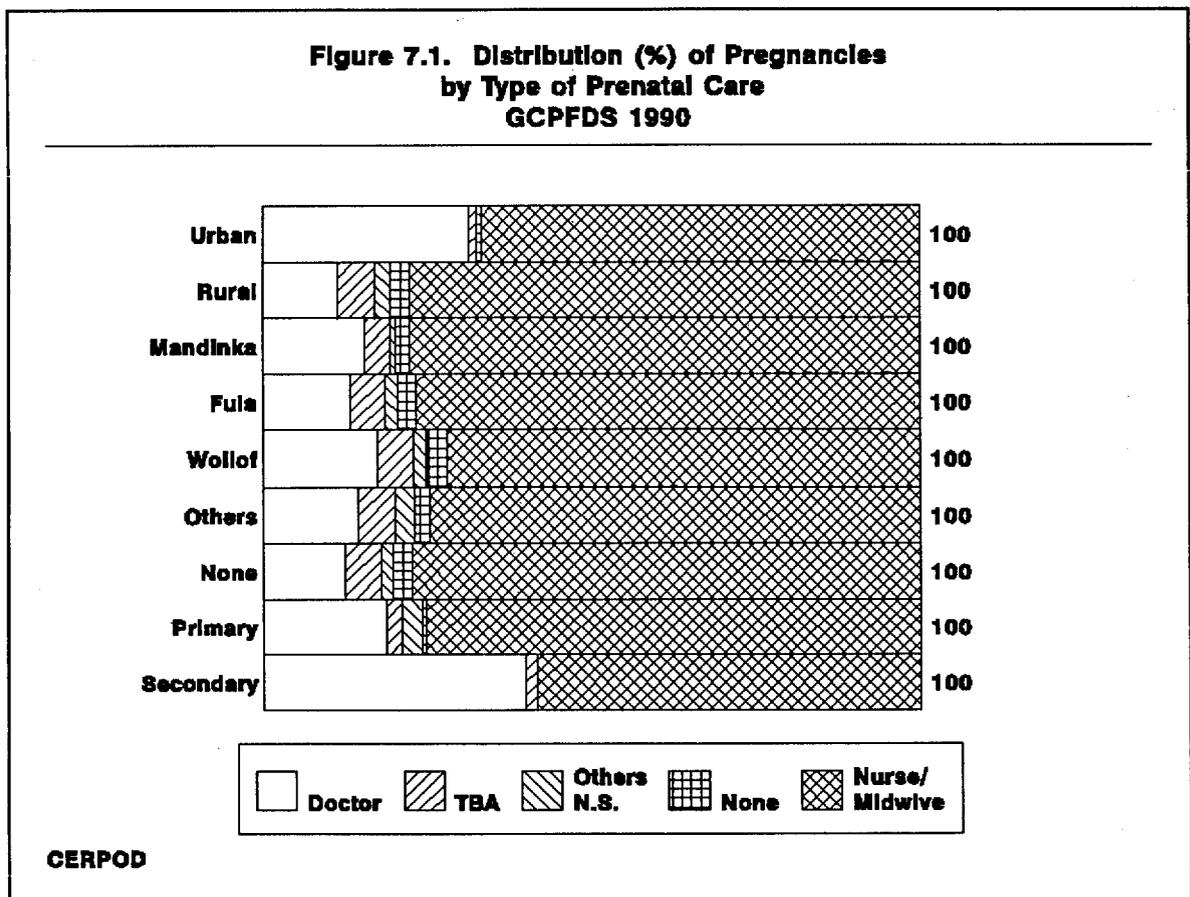
Table 7.1 AMONG BIRTHS IN THE FIVE YEARS PRECEDING THE SURVEY, PERCENT WHOSE MOTHER RECEIVED PRENATAL CARE BY TYPE OF HEALTH PERSONNEL PROVIDING CARE ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

	Doctor	Nurse/ Midwife	TBA	Other	Not Stated	No Care	All	Tetanus
<b>Health Region</b>								
Western	18.4	72.5	4.4	0.3	2.2	2.3	100	89.3
Central	10.9	81.8	4.2	0.3	0.0	2.8	100	91.3
Eastern	11.8	78.0	6.3	1.1	0.4	2.5	100	95.4
<b>Type of Settlement</b>								
Urban	31.2	67.0	1.1	0.0	0.0	0.7	100	94.3
Rural	11.2	77.9	5.9	0.7	1.5	2.9	100	91.3
PHC	12.4	77.9	6.1	0.3	0.6	2.6	100	92.4
Non-PHC	9.4	77.9	5.4	1.2	2.9	3.3	100	89.5
Unknown	9.1	90.9	0.0	0.0	0.0	0.0	100	
<b>Ethnic Group</b>								
Mandinka	15.3	77.8	4.0	0.2	0.6	2.1	100	93.2
Fula	13.2	76.8	5.3	1.1	0.9	2.8	100	93.4
Wollof	17.4	72.1	5.4	0.3	1.7	3.1	100	90.3
Others	14.3	74.8	5.8	0.7	2.2	2.2	100	89.3
<b>Education</b>								
None	12.5	77.5	5.4	0.7	1.1	2.8	100	91.6
Primary	18.6	75.3	2.6	0.0	3.1	0.5	100	92.3
Secondary	39.8	58.4	1.9	0.0	0.0	0.0	100	95.0
Unknown	100.0	0.0	0.0	0.0	0.0	0.0	100	
<b>Total</b>	<b>15.0</b>	<b>75.9</b>	<b>4.9</b>	<b>0.6</b>	<b>1.2</b>	<b>2.5</b>	<b>100</b>	<b>91.9</b>

Rather, the interesting variable to note is the percentage of women who were able to see a medical doctor during their pregnancy. As was already mentioned, only 15 percent of all the pregnancies were followed by a medical doctor. Among ethnic groups, there is

little difference in the percent whose pregnancies were assisted by medical doctors. The Wollof women, however, were somewhat more likely to see a medical doctor than the others. The percentage seen by a medical doctor is much higher among urban women than among rural women: 31.2 % of the former as opposed to 13.2 % of the latter, and among this latter group, the percentage is higher in the PHC villages than in the non-PHC villages.

Again, as is the case for the other differential analyses of demographic phenomena in this report, the most striking differences are associated with female education. The percentage of women who have seen a medical doctor during their pregnancy is 12.5 for women who have never attended school, 18.6 for women with a primary level of education and 39.6 for women with secondary or higher level of education. Therefore, the probability of being seen by a medical doctor during pregnancy is more than three times higher for the most educated women than for those who have never been to school.



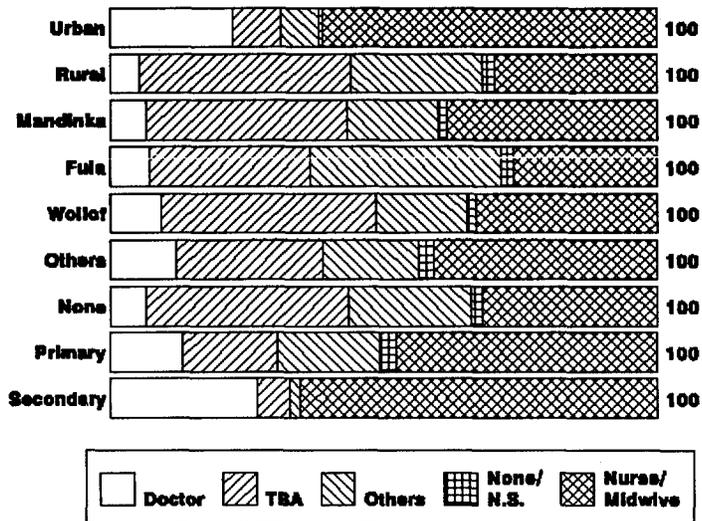
Despite the above differences, the great majority of pregnant women who gave birth during the five years preceding the survey, whatever their background characteristics, were immunized against tetanus. For each socio-demographic subgroup analyzed, the percentage approximates 90, and is sometimes higher. This is an encouraging result of the immunization program which was launched by the Gambian government in the early 1980s.

## **7.2 Delivery Assistance**

The results of the analysis of "assistance with delivery" are noticeably different from the results issuing from the analysis of "prenatal care". While over 90 percent of the prenatal care was provided by personnel from the modern health system, this percentage is only equal to 44.1 for delivery assistance (Table 7.2). Furthermore, the differentials according to background characteristics are much greater. Overall, deliveries assisted by individuals from the modern health system are followed closely in frequency by deliveries assisted by traditional birth attendants (33.1%). If on the one hand, the percentage of births occurring without any assistance is negligible (0.8%), on the other hand, the percentage of births assisted by individuals classified "other" is quite important (20%).

Deliveries occurring in the Western Health Region are much more likely to be assisted by a person from the modern health system than deliveries in the other two health regions. These differences are due mainly to the fact that medical personnel are predominantly in the capital, Banjul (Western Health Region). Women from the Central Health Region, which is closer to Banjul than the Eastern Health Region, are slightly more likely to be assisted by modern health personnel during delivery than women from the Eastern Health Region: 31.9% and 26.3% respectively.

**Figure 7.2. Distribution (%) of Pregnancies by Delivery Assistance  
GCPFDS 1990**



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**Table 7.2** AMONG BIRTHS IN THE FIVE YEARS PRECEDING THE SURVEY, PERCENT DISTRIBUTION BY PERSON ASSISTING WITH DELIVERY, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

	Doctor	Nurse/ Midwife	TBA	Other	Not Stated	No Care	All
<b>Health Region</b>							
Western	12.9	47.4	24.5	12.5	2.1	0.6	100
Central	5.9	26.0	42.7	23.7	0.0	1.7	100
Eastern	3.1	23.2	41.1	31.4	0.5	0.7	100
Unknown	11.1	55.6	33.3	0.0	0.0	0.0	100
<b>Type of Settlement</b>							
Urban	22.2	61.2	8.9	6.9	0.2	0.5	100
Rural	5.2	29.5	38.8	24.1	1.5	0.9	100
PHC	5.4	35.5	41.5	16.2	0.6	0.8	100
Non-PHC	4.9	20.2	34.6	36.3	2.9	1.1	100
<b>Ethnic Group</b>							
Mandinka	6.4	38.4	36.8	16.8	0.6	1.0	100
Fula	7.2	26.0	29.4	35.1	0.9	1.5	100
Wollof	9.1	33.1	39.4	16.7	1.7	0.0	100
Others	11.9	40.7	26.9	17.8	2.2	0.5	100
<b>Education</b>							
None	6.5	32.0	37.0	22.5	1.2	0.9	100
Primary	13.1	47.6	17.3	18.8	2.1	1.0	100
Secondary	26.7	65.2	6.2	1.9	0.0	0.0	100
Unknown	0.0	100.0	0.0	0.0	0.0	0.0	100
<b>Total</b>	<b>8.4</b>	<b>35.7</b>	<b>33.1</b>	<b>20.7</b>	<b>1.2</b>	<b>0.8</b>	<b>100</b>

Among the different ethnic groups, the Mandinka lead in the use of modern medical health personnel for delivery (44.8%), followed by the Wollof (32.2%) and the Fula (33.2%). Urban mothers have a probability of being assisted during delivery by modern health personnel which is more than twice as high as those from rural areas. As in the case of prenatal care, education is the most important correlate of modern health service delivery assistance. Only 38.5% of uneducated mothers were assisted by modern health system personnel as compared to 91.9% of the most highly educated mothers. The relative difference is even more dramatic if we consider only medical doctors. Noting only 6.5% of the uneducated mothers were assisted by a medical doctor, the corresponding percentage for the most educated women was more than four times as high.

Traditional births attendants provide delivery assistance to women who do not have the opportunity of being assisted by modern health system personnel. The traditional birth attendants provide outpatient health services in rural areas (both in PHC and non-PHC villages). The high proportion of deliveries being assisted by persons other than modern health system personnel or traditional birth attendants should be a concern for health authorities. Given the existence of a functioning primary health care system in many areas of the rural sector, the proportion of deliveries assisted by an individual classified "other" in the rural areas (24.1) should be investigated. It may well be that a large part of those classified "other" are, in fact, assistants to trained TBAs.

## **CHAPTER VIII**

### **MALE SURVEY**

In addition to household and female questionnaires, the GCPFDS included a male questionnaire which was administered to a sample of men aged 18 and older. As outlined in Chapter 1, the male questionnaire was designed to obtain information relating to key family planning topics, including contraceptive use and fertility determinants. The questionnaire contained four modules. The first module provides background information on the respondents. The other three modules provide information on contraception, marriage and fertility preferences and reproductive attitudes.

In this chapter, results obtained from the analysis of the male questionnaire are presented. Topics to be covered include marriage, fertility, contraception and fertility preferences.

#### **8.1 Characteristics of the Sample**

Among the 1387 males selected in the sample, 1328 were successfully interviewed. Thus, 4.3 percent of the selected men were not interviewed and approximately one fifth of those were cases who refused to be interviewed. Other explanations for "unsuccessful" interviews include: absence of the selected individual and individual not found at home after several visits.

Table 8.1 presents the distribution of males according to age group, place of residence, health region, ethnic group and level of education. The weighted and unweighted number of cases are also given. Approximately one third of the men are under 30 years of age, and one fourth are over 50 years. Males between the ages of 30 and 49 represent approximately 40% of the sample.

The distribution of the male sample by place of residence is quite similar to the female distribution. 28.5 percent of the men live in urban areas as compared to 27.1 percent of the women. The small difference between the two figures may be the result of

a higher rate of rural-urban migration among the male population. The residential distribution of men according to health region is also quite similar to the analogous female distribution. More than half of the male respondents live in the Western Health Region, which includes the urban areas, Banjul and Kombo Saint Mary. There are more than twice as many men in the Eastern Health Region as in the Central Health Region.

TABLE 8.1 PERCENT DISTRIBUTION OF MALE RESPONDENTS ACCORDING TO BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristic	%	Weighted Number	Unweighted Number
<b>Age</b>			
18-30	34.6	459	454
30-39	21.7	288	284
40-49	18.1	240	241
50&+	25.5	338	344
<b>Residence</b>			
Urban	28.5	378	319
Rural	71.5	947	1004
PHC villages	59.2	561	593
Non PHC villages	40.4	383	408
Not Stated	0.3	3	3
<b>Health Region</b>			
Western	57.7	765	723
Central	13.7	182	198
Eastern	28.5	378	402
<b>Ethnic Group</b>			
Mandinka	34.6	459	461
Fula	24.7	327	335
Wollof	14.5	192	192
Jola	7.7	102	99
Sarahule	7.2	96	98
Others	11.2	149	138
<b>Level of Education</b>			
None	72.1	955	975
Primary	7.2	96	91
Secondary &+	20.7	274	257
<b>Total</b>	<b>100.0</b>	<b>1325</b>	<b>1323</b>

According to Table 8.1, five major ethnic groups contribute nearly 90% of the total sample population. The Mandinka represent about one third of the sample, followed by the Fula who represent approximately one fifth of the sample. The three other groups are, in order of descending population weight, the Wollof, the Jola, and the Sarahule. There are several other minor ethnic groups which together represent less than 12% of the population.

Rates of school enrolment and completion do not appear to differ greatly by sex. As in the case of the women, nearly three fourths (72.1 percent) of the men have never been to school. The fact that there is such a small difference between the sexes in the percent never having attended school may be a statistical artifact, explained by the observation that the sample of men is older than the sample of women.

Comparison of the percentages of those who have ever attended school by sex suggests that, as expected, it is easier for males than for females to continue with their education once they are enrolled. Whereas 7.2% and 20.7% of males have, respectively, a primary and secondary level of education, the corresponding percentages for females are 11.1% and 15.1%. This differential pattern of school enrolment and completion by sex is found in most countries in sub-Saharan Africa.

Table 8.2 demonstrates that as in the case of the female sample, the level of education among males also varies by age, health region, place of residence and ethnic group. Enrolment rates, as well as level of education decrease with increasing age. For example, the percent of males aged 18 to 29 with a secondary or higher level of education is 36 percent, which is more than 6 times greater than the corresponding percentage for males aged 50 and over.

The level of education is much higher in the Western Health Region than in the Central and Eastern Health Regions. Whereas 59% of the male respondents in the Western health region never attended school, 90% of the men residing in the other health regions never attended school. Urban-rural differentials in the level of education are perhaps the most striking. Over half the urban male respondents have been to school as compared to less than 20% of the rural male respondents. Within the rural area, primary health care villages are better off than non-primary health care villages. In PHC-villages, 21 percent have attended school as compared to 10 percent in the non-PHC villages. Important differences in the level of education by ethnic group is also evidenced in Table 8.2. The Jola and the Wollof are the most highly educated with 35 percent who have attended school. The lowest levels of educational achievement are found among the Fula (17.1 percent) and the Sarahule (5.2 percent).

TABLE 8.2 PERCENT DISTRIBUTION OF MALES BY LEVEL OF EDUCATION, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristic	None	Primary	Sec.&+	Total	Wtd. Number	Unwtd. Number
<b>Age</b>						
<30	53.3	10.7	36.0	100	458	454
30-39	73.5	6.6	19.9	100	287	284
40-49	79.1	7.5	13.4	100	239	241
50&+	91.4	2.7	5.9	100	338	344
<b>Health Region</b>						
Western	58.6	9.9	31.5	100	765	723
Central	89.6	1.6	8.7	100	183	198
Eastern	90.7	4.5	4.8	100	378	402
<b>Residence</b>						
Urban	43.1	12.2	44.7	100	378	319
Rural	83.6	5.2	11.2	100	947	1004
PHC villages	79.1	5.9	15.0	100	561	593
Non PHC vill.	90.1	4.2	5.7	100	383	408
Not Stated	100.0	0.0	0.0	100	3	3
<b>Ethnic Groups</b>						
Mandinka	70.7	5.9	23.4	100	458	461
Fula	82.9	7.0	10.1	100	327	335
Wollof	65.3	6.7	28.0	100	193	192
Jola	64.7	13.7	21.6	100	102	92
Sarahule	94.8	3.1	2.1	100	96	98
Others	51.4	10.1	38.5	100	148	138
<b>Total</b>	<b>72.1</b>	<b>7.2</b>	<b>20.8</b>	<b>100</b>	<b>1325</b>	<b>1323</b>

## 8.2 Marriage and Polygamy

According to Table 8.3 it appears that 65 percent of the male respondents were married at the time of the survey and 5 percent were divorced, widowed or separated. The percentage of the male population estimated to be single at the time of the survey is 30 percent. The percent single decreases sharply by age within the first five age groups. From a high of 92.4 percent for the first age group, the percent single declines to 28.8 percent for the age group 30-34, and 3.1% for the age group, 35-39, before reaching its lowest level of 0% for the age group 45-49. The data suggest that virtually all males will marry at least once in their lifetime.

TABLE 8.3 PERCENT DISTRIBUTION OF MALES BY MARITAL STATUS, ACCORDING TO AGE AT THE TIME OF THE SURVEY, GCPFDS, 1990

Age	Single	Married /Union	Div, Sep. Widow	N.S.	Total	Unweighted
<20	92.4	5.4	1.1	1.1	100	91
20-24	82.8	13.3	3.9	0.0	100	177
25-29	58.1	38.2	3.8	0.0	100	185
30-34	28.8	63.8	7.5	0.0	100	158
35-39	3.1	86.7	10.2	0.0	100	126
40-44	3.0	92.5	4.5	0.0	100	136
45-49	0.0	98.1	1.9	0.0	100	105
50&+	1.5	92.9	5.6	0.0	100	344
Total	30.3	64.6	5.1	0.1	100	1322

As in most Sahelian countries, polygamy is a common practice in the Gambia. According to Table 8.4, over one third, (35.7%), of the respondents who were married at the time of the survey were in polygamous unions. The prevalence of polygamy increases sharply with age. Whereas only 13.8 percent of the men aged 18-29 were in polygamous unions, the corresponding percents for the other age groups are 21.8, 40.0 and 50.2 respectively for the age groups 30-39, 40-49 and 50 and over.

Within every socio-demographic sub-group, polygamy is practiced. Furthermore, regardless of the sub-group considered, the percentage of men in polygamous unions is never negligible. The smallest percent one finds in Table 8.4 is for males with a secondary or higher level of education (20%).

However, some notable differentials in the prevalence of polygamy are observable in Table 8.4. The prevalence of polygamy among men who never attended school is almost twice as great as the prevalence among the most highly educated men. Fula men are the least likely to be in polygamous unions (25.7 percent). Conversely, Sarahule men exhibit the highest observed prevalence of polygamy among all the sub-groups considered (58.2%).

TABLE 8.4 PERCENT DISTRIBUTION OF MEN IN POLYGAMOUS UNIONS BY AGE AND SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Characteristic	<30	30-39	40-49	50&+	Total
<b>Education</b>					
None	14.5	23.7	41.1	52.1	38.3
Primary	-	-	-	-	29.4
Secondary	-	8.6	37.5	-	20.0
<b>Ethnic Group</b>					
Mandinka	9.1	22.4	44.0	58.1	42.5
Fula	10.6	12.1	25.0	46.3	25.7
Wolof	-	23.8	40.0	36.4	30.1
Jola	-	-	-	36.4	35.1
Sarahule	-	-	-	70.8	58.2
Others	-	25.0	39.4	37.0	32.0
<b>Health Region</b>					
Western	10.0	18.3	40.4	41.0	31.0
Central	-	22.2	44.7	62.5	44.9
Eastern	13.2	28.4	37.9	56.9	39.6
<b>Residence</b>					
Urban	13.0	18.8	45.6	38.7	31.3
Rural	14.0	23.1	38.2	52.8	37.0
PHC Village	20.5	24.2	37.5	48.7	36.8
Non-PHC Vill	8.2	21.4	39.4	58.4	37.2
<b>Total</b>	<b>13.8</b>	<b>21.8</b>	<b>40.0</b>	<b>50.2</b>	<b>35.7</b>

From the percent distribution of men by the number of wives shown in Table 8.5, one notes that most of the polygamous men have two wives. However, the probability of being in a polygamous union increases substantially with age as does the number of wives. If for the age group 30-39 only about 8 percent of those in polygamous unions have three wives or more, the same percentage is nearly four times as high (31%) among those aged 50 and over.

TABLES 8.5 PERCENT DISTRIBUTION OF MEN BY THE NUMBER OF WIVES, ACCORDING TO AGE, GCPFDS, 1990

Age	1 Wife	2 Wives	3&+Wives	N.S.	Total
<30	87.0	7.0	1.7	4.3	100
30-39	77.8	19.2	1.7	1.3	100
40-49	59.7	31.8	8.5	0.0	100
50&+	49.7	34.1	15.3	0.9	100
<b>Total</b>	<b>64.2</b>	<b>26.3</b>	<b>8.3</b>	<b>1.2</b>	<b>100</b>

### **8.3 Fertility**

All ever married male respondents were asked how many "own sons" and "own daughters" they had at the time of the survey. It should be noted that this measure (live children) is influenced not only by the level of fertility (live births) but by the level of mortality. As shown in Table 8.6, the percentage of men with no living children drops dramatically from 30.7 percent for those under 30 years to 4.8 percent for those aged 50 years and over.

In most cases, the fertility level differentials by background variables vary in the expected direction. The mean number of living children is lower in the urban area (3.8) than in the rural area (5.0). However, within the rural sector, the average number of living children is slightly lower in non-PHC villages than in PHC villages. This may be due to the fact that the level of child mortality is expected to be lower in the PHC villages. Thus the lower mean number of living children in the non-PHC villages may actually be due to higher child mortality rather than due to lower fertility.

Considering the ethnic group differentials, the mean number of living children is highest among the Sarahule (6.4), followed by the Mandinka (5.5). The lowest mean number of living children is found among the Fula (3.6).

In regard to differentials by levels of education, as expected men who have ever attended school demonstrate lower fertility (as measured indirectly by the mean number of living children) than those who have never attended school.

Finally, it is interesting to note that the number of living children and the proportion of men in polygamous unions appear to be strongly associated. The mean number of living children for monogamous and polygamous men are 3.2 and 7.5, respectively. Among polygamous men, those with two wives have 6.7 living children while those with three or four wives have, on the average, 10.8 living children.

TABLE 8.6 PERCENT DISTRIBUTION OF EVER-MARRIED MEN BY THE NUMBER OF LIVING CHILDREN, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

	Number of Living Children									Mean	
	0	1	2	3	4	5	6	7	8&+	No.	%
<b>Age</b>											
<30	30.7	36.0	21.9	5.3	4.4	0.9	0.9	0.0	0.0	1.2	100
30-39	14.3	14.3	19.3	18.5	12.6	10.1	2.9	2.9	5.0	3.0	100
40-40	5.2	6.0	9.4	15.5	15.9	12.4	9.9	6.9	18.9	5.3	100
50&+	4.8	6.6	4.2	7.8	8.1	12.0	8.1	9.6	38.9	6.9	100
<b>Residence</b>											
Urban	13.4	14.4	16.3	13.9	10.0	10.5	3.8	4.8	12.9	3.8	100
Rural	9.7	11.4	10.2	11.7	10.9	10.3	7.1	6.3	22.4	5.0	100
PHC Vill.	9.0	10.8	9.3	12.5	10.8	11.2	7.6	6.8	22.0	5.2	100
Non PHC	10.7	12.1	11.7	10.4	11.4	8.7	6.4	5.7	22.8	4.8	100
<b>Health Region</b>											
Western	10.8	13.3	12.3	14.1	11.2	11.0	7.0	4.9	15.3	4.2	100
Central	12.2	8.6	9.4	13.7	6.5	9.4	6.5	7.9	25.9	5.6	100
Eastern	9.3	11.7	11.7	8.2	12.0	9.3	5.2	6.9	25.8	5.4	100
<b>Ethnic Group</b>											
Mandinka	7.3	9.1	9.5	12.0	11.7	12.3	5.4	6.3	26.5	5.5	100
Fula	14.9	18.2	13.2	12.4	7.4	9.1	6.2	4.1	14.5	3.6	100
Wollof	8.9	12.2	12.2	13.8	12.2	8.9	8.9	5.7	17.1	4.5	100
Jola	8.2	8.2	9.6	15.1	13.7	9.6	11.0	8.2	16.4	4.6	100
Sarahule	14.9	9.0	14.9	3.0	7.5	6.0	3.0	9.0	32.8	6.4	100
Others	12.2	11.2	13.3	14.3	14.3	11.2	5.1	7.1	11.2	4.3	100
<b>Education</b>											
None	10.4	11.4	10.7	11.4	11.4	10.0	6.0	6.7	22.0	5.0	100
Primary	11.5	21.2	7.7	15.4	9.6	21.2	0.0	1.9	11.5	3.5	100
Sec.&+	12.4	12.4	20.0	17.1	6.7	7.6	11.4	1.9	10.5	3.8	100
<b>Marital Status</b>											
Monog.	14.6	16.3	15.8	14.7	11.0	11.9	4.7	3.7	7.3	3.2	100
Polyg.	3.4	4.6	4.3	7.6	10.4	7.3	9.1	10.1	43.3	7.5	100
<b># of wives</b>											
1 Wife	14.6	16.3	15.8	14.7	11.0	11.9	4.7	3.7	7.3	3.2	100
2 Wives	2.5	4.1	4.5	9.5	10.7	9.5	9.9	11.2	38.0	6.7	100
3 or 4	0.0	2.6	3.9	2.6	10.4	1.3	7.8	7.8	63.6	10.8	100
TOTAL	10.6	12.1	11.6	12.2	10.8	10.2	6.3	6.0	20.2	4.8	100

## 8.4 Contraceptive Knowledge

Respondents to the GCPFDS male questionnaire were asked if they had ever heard of the various contraceptive methods. If they answered in the negative for a given method, knowledge of the method was then probed with a brief description. Whenever a method was known, whether spontaneously or probed, the respondent was then asked whether he had ever used the method, where he would go to obtain the method if he wanted to use it, and in his opinion, what was the

main problem, if any, with using the method.

Table 8.7 summarizes the male respondents' answers to the questions on knowledge of contraceptive methods. Among the modern methods, the pill, the condom and injections are the best known with a combined (spontaneous and probed) level of knowledge equaling 60%, 57%, and 50%, respectively. It is interesting to note that whereas 30 percent of the male respondents had heard of female sterilization, only 10 percent had heard of male sterilization.

TABLE 8.7 PERCENTAGE OF MEN KNOWING A SPECIFIC METHOD ACCORDING TO THE NATURE OF KNOWLEDGE AND CURRENT AGE, GCPFDS, 1990

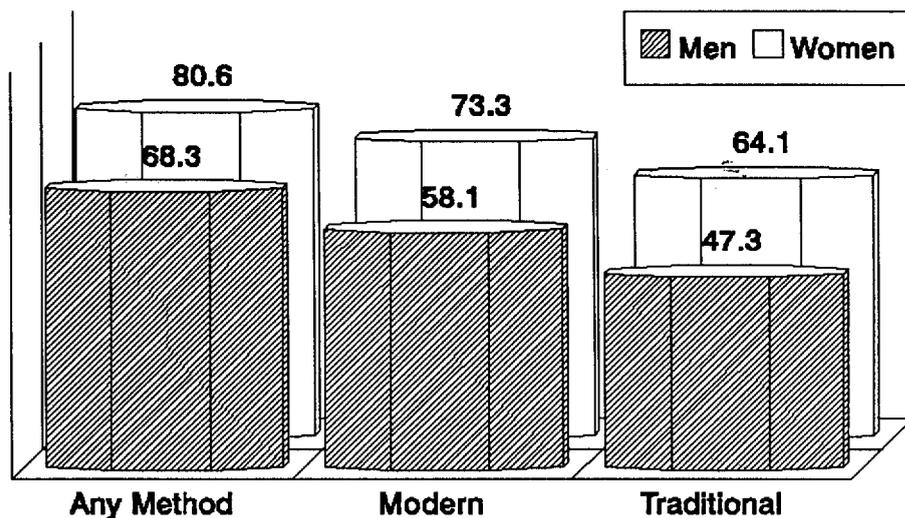
Age	PILL		IUD		INJECTION		DIAPHRAGM		CONDOM		FEM. STER.		MALE STER.	
	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.
<20	48.4	6.6	12.0	8.7	33.7	12.0	9.8	3.3	62.0	7.6	22.8	3.3	9.8	2.2
20-24	58.0	11.0	20.0	12.2	43.6	18.2	13.2	11.0	64.1	8.3	24.2	14.3	8.8	5.0
25-29	47.8	12.9	14.6	4.9	36.0	14.5	9.1	4.8	56.8	14.6	14.5	10.8	4.3	3.8
30-34	57.5	13.8	23.1	7.5	48.1	13.1	11.9	6.3	63.5	8.8	26.9	11.3	6.3	6.9
35-39	54.7	14.8	12.4	7.8	37.5	19.5	5.5	3.1	46.5	15.5	18.8	5.5	3.9	0.8
40-44	50.4	14.3	25.4	4.5	39.6	14.9	15.7	5.2	45.9	10.5	24.1	11.3	11.2	4.5
45-49	44.3	17.9	15.1	11.3	40.6	16.0	6.6	3.8	44.3	9.4	24.8	9.5	9.4	6.6
50&+	33.7	9.2	7.1	4.7	22.2	10.4	4.7	0.9	19.2	10.6	15.1	10.1	1.8	1.5
Total	47.5	12.1	15.2	7.2	35.7	14.3	9.0	4.5	46.2	10.8	20.2	10.0	6.0	3.6

	PER. ABST.		WITHDRAWAL		TRADITIONAL		OTHER	
	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.	Spon.	Prob.
<20	14.1	1.1	13.0	5.4	23.9	10.9	0.0	1.1
20-24	9.9	4.4	12.7	9.9	33.7	15.5	1.1	1.1
25-29	7.5	7.0	7.5	16.7	38.7	15.1	1.1	0.0
30-34	12.5	10.6	10.7	13.8	48.4	14.5	0.6	0.0
35-39	9.3	4.7	3.9	10.2	45.7	10.1	0.8	0.0
40-44	10.4	9.7	5.2	14.9	47.4	14.3	2.2	0.0
45-49	13.2	1.9	5.6	11.2	47.6	7.6	2.8	0.9
50&+	5.9	4.1	3.6	4.4	46.6	9.1	0.9	0.3
Total	9.4	5.6	7.2	10.3	42.4	12.1	1.1	0.4

Among the traditional methods, with levels of knowledge equaling 15 and 17.5 percent respectively, abstinence and withdrawal are not very well known. On the other hand, the traditional method, juju, was known by over 50% of the men surveyed.

As depicted in Figure 8.1, and considering the fact that male respondents are older than female respondents, both modern and traditional contraception are better known to the female than to the male respondents.

**Figure 8.1. Percentage of Males and Females Knowing at Least One Contraceptive Method GCPFDS 1990**



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Table 8.8 presents differentials in knowledge of contraceptive methods according to selected background characteristics. Considering modern methods first, the percentage of men knowing a method is significantly lower for the oldest age group (40%) when compared to those aged less than 40 (66%). Differentials in knowledge of traditional methods by age group are less striking.

In the urban areas, knowledge of modern contraception is much higher than in the rural areas. Within the rural sector, it appears that primary health care village activities do have some effect on knowledge of family planning methods. In PHC villages knowledge of modern methods is 56 percent whereas in non-PHC villages it is only 45 percent. The corresponding figures for traditional methods are 49% (PHC) and 41% (non-PHC).

The Fula and the Sarahule are the ethnic groups with the lowest levels of contraceptive knowledge. While for all other ethnic groups the percent of men knowing at

least one modern method is over 60, the same figure for these two ethnic groups is under 50 percent.

The greatest variability in contraceptive knowledge is found when considering the educational categories. Knowledge of at least one modern method among those with a secondary level of education or higher (89%) is nearly twice as great as the level of knowledge among those who have never been to school (48%).

TABLE 8.8 PERCENTAGE OF MALES KNOWING AT LEAST ONE MODERN METHOD AND AT LEAST ONE TRADITIONAL METHOD ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristics	At Least 1 Modern Method	At Least 1 Trad. Method	At Least 1 Modern or 1 Trad.
<b>Age</b>			
<30	66.7	39.7	71.5
30-39	66.0	52.1	73.6
40-49	58.2	53.3	69.2
50&+	39.9	49.6	58.7
<b>Health Region</b>			
Western	67.2	50.1	75.9
Central	46.7	44.0	61.2
Eastern	45.2	43.2	56.2
<b>Residence</b>			
Urban	75.4	50.5	82.8
Rural	51.2	46.0	62.5
PHC Vill.	55.6	49.0	67.4
Non-PHC Vill.	44.6	41.5	55.1
<b>Ethnic Group</b>			
Mandinka	62.5	52.5	72.7
Fula	49.5	41.6	59.8
Wollof	60.1	50.3	74.1
Jola	66.7	52.9	75.5
Sarahule	43.8	36.5	55.2
Other	64.4	43.0	69.1
<b>Education</b>			
None	47.5	45.5	60.8
Primary	74.0	46.3	77.1
Secondary&+	89.4	53.8	90.9
<b>Marital Status</b>			
Married	52.6	50.3	66.0
Monogamous	53.6	47.6	65.4
Polygamous	50.8	55.2	67.0
Not married	70.9	40.4	73.6
Total	58.1	47.3	68.3

## 8.5 Problems with Methods

In the GCPFDS, each male respondent who claimed knowledge of a given method was then asked what he perceived to be the main problem, if any, with the method. Answers given to this question are summarized in Table 8.9. Of particular interest is the extent to which "don't know" is given as a response for every method - both modern and traditional. In the case of almost every modern method, two thirds of the respondents who knew of the method said that they did not know what was the main problem with the method. This suggests that knowledge of modern methods may be somewhat superficial among the target population. On the other hand, the two traditional methods, periodic abstinence and withdrawal, exhibit the lowest percentages in the response category "I don't know" (36.7 and 29.8 percent, respectively).

The next most common answer to the question was "no problem". The percentage of males giving this answer ranges from 14% for sterilization to 31% for the condom, and among traditional methods, 32% for withdrawal and 39% for periodic abstinence. Ineffectiveness of the method appears to be somewhat important only for withdrawal (11.5%), juju (5.6%) and periodic abstinence (5%). Cost does not appear to be a perceived problem, since for all methods, except for juju, less than 1 percent declare the cost to be too high.

"Health concerns" was a somewhat more frequent response for modern methods than for traditional methods: male sterilization (8.7%), female sterilization (8.2%), foam/jelly (6.6%), injection (6.2%), IUD (6.0%) as compared to juju (0.7%), withdrawal (1.7%), and periodic abstinence (3.0 %). Among the modern methods, the condom had the lowest percent stating health concerns as a perceived problem (3.4%). It is somewhat surprising that the percentage of men perceiving health concerns to be the principal problem with use is virtually the same for three methods as dissimilar as the pill, the condom, and periodic abstinence.

A noteworthy finding is the virtual absence of "religion" as a perceived problem in the use of contraception. Even though Islam, which is the most important religion in the

Gambia, is not against modern contraception, one might have expected to find a higher percent of Muslims with a negative attitude toward the use of family planning methods than was found. In fact, only two males stated "religion" to be a problem in the use of contraception.

TABLE 8.9 PERCENT DISTRIBUTION OF MALES WHO HAVE EVER HEARD OF A METHOD BY MAIN PROBLEM PERCEIVED IN USING THE METHODS, ACCORDING TO THE SPECIFIC METHOD, GCPFDS, 1990

	Pill	IUD	Injec- tion	Diaph/ Foam/ Jelly	Condom	Female Steril.	Male Steril.	Per. Abst.	With- drawal	Trad. (juju)
Not effective	3.7	3.0	1.8	2.2	1.8	0.7	0.8	5.0	11.5	5.6
Partner Disapproves	1.1	2.0	1.4	1.7	1.1	1.7	0.8	1.5	2.1	0.8
Inconvenient to use	1.1	1.7	1.4	3.3	5.3	1.2	2.4	6.5	15.3	2.8
Difficult to get	1.1	1.7	0.8	2.2	2.1	1.5	3.2	0.5	0.4	3.6
Health Concern	3.5	6.0	6.2	6.6	3.4	8.2	8.7	3.0	1.7	0.7
Cost too much	0.5	0.3	0.2	0.0	0.4	0.5	0.8	0.0	0.4	2.5
Others	1.1	1.0	1.1	1.7	1.3	2.7	0.0	4.5	1.7	1.8
None	20.6	17.1	16.1	22.7	30.7	14.2	14.3	38.7	31.5	23.4
Religious reasons	0.3	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.1
Don't know	65.6	61.5	68.7	55.8	51.7	66.3	65.9	36.7	29.8	55.3
Not Stated	1.3	5.7	2.6	3.9	1.8	2.7	3.2	3.5	5.5	3.4
Total	100	100	100	100	100	100	100	100	100	100
Weighted Numbers	791	299	665	181	758	401	126	199	235	727

## 8.6 Method Sources

Since it is widely accepted that contraceptive use depends not only on knowledge of methods, but on knowledge of method sources (and availability at those sources), respondents who claimed knowledge of a particular method were then asked where they would go to obtain the method. As displayed in Table 8.10, the GFPA sources (clinic, CBD and field worker) are the most frequently cited sources for modern contraceptive methods, excluding sterilization. The next most commonly cited sources are governmental consisting of government hospitals, government and MCH clinics. In the case of male and female sterilization, government hospitals were the most frequently cited sources.

It is important to note certain inconsistencies and other surprising answers among the results presented in Table 8.10. There are sources mentioned or the answer "don't know" given by a few respondents for methods such as periodic abstinence and withdrawal.

Furthermore, GFPA has been mentioned for male and female sterilization by an important proportion of respondents (27.6 and 18.3 %). Given that GFPA sources do not perform sterilization procedures and that NO source is logically appropriate for abstinence and withdrawal, one should conclude that the respondents who gave these answers do not really "know" the method as they claim.

TABLE 8.10 PERCENT DISTRIBUTION OF MALES KNOWING A CONTRACEPTIVE METHOD BY SOURCE OF SUPPLY  
GCPFDS, 1990

	Pill	IUD	Injec.	Diaph.	Condom	Female Ster.	Male Ster.	Per. Abst.	With.	Trad.	Other
Govt. Hospital	9.9	9.7	10.2	5.0	8.5	45.5	37.8	3.5	3.0	0.3	6.7
Govt. Health Clinic	10.7	8.7	13.2	8.9	9.8	9.2	7.1	3.5	1.7	0.3	0.0
MCH Clinic	5.1	5.7	3.9	4.4	3.3	2.0	0.0	0.0	0.4	0.0	0.0
Private Hosp./Clinic	1.0	0.7	2.6	1.1	1.3	2.7	3.9	0.0	0.0	0.0	0.0
Pharmacy	5.6	3.3	3.2	3.9	16.6	0.7	0.0	0.0	0.0	0.1	0.0
Religious Body	0.6	0.0	0.2	0.0	0.0	0.0	0.0	3.0	1.3	35.4	6.7
GFPA Clinic	41.1	52.7	42.4	60.6	36.7	18.3	27.6	9.5	7.7	1.5	0.0
GFPA CBD	3.0	1.0	1.7	1.7	3.6	0.2	0.0	0.0	0.9	0.3	0.0
GFPA Field Worker	5.7	2.7	4.5	4.4	5.8	0.5	0.0	1.0	1.7	0.0	0.0
TBA	0.9	0.0	1.1	0.0	0.8	0.0	0.0	0.5	0.4	3.7	0.0
Others	0.3	0.3	0.2	1.1	2.2	0.2	0.8	3.0	2.6	12.2	13.3
Nowhere	0.5	0.0	0.6	0.0	0.8	0.7	0.0	61.8	68.8	3.7	20.0
Marabou	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	2.1	35.6	10.0
Don't know	15.2	11.7	14.9	6.1	9.8	18.3	20.5	10.1	4.7	4.8	0.0
Not Stated	0.5	3.7	1.5	2.8	0.8	1.5	2.4	3.0	4.7	2.1	43.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	791	300	665	180	757	402	126	197	234	727	30

## 8.7 Contraceptive Use

In Section 2 of the male questionnaire, a respondent who claimed knowledge of a specific contraceptive method was then asked whether he had ever used the method. Table 8.11 presents the consequent information on differentials in contraceptive use according to selected background characteristics. This table includes the percent ever use of modern contraceptive methods, the percent ever use of traditional methods and the percent ever use of contraception, either modern or traditional.

Before comparing ever-use data by sex, it should be noted that the two groups are not strictly comparable. In other words, the female respondents were all in their reproductive years - and so potentially at risk of becoming pregnant and, therefore,

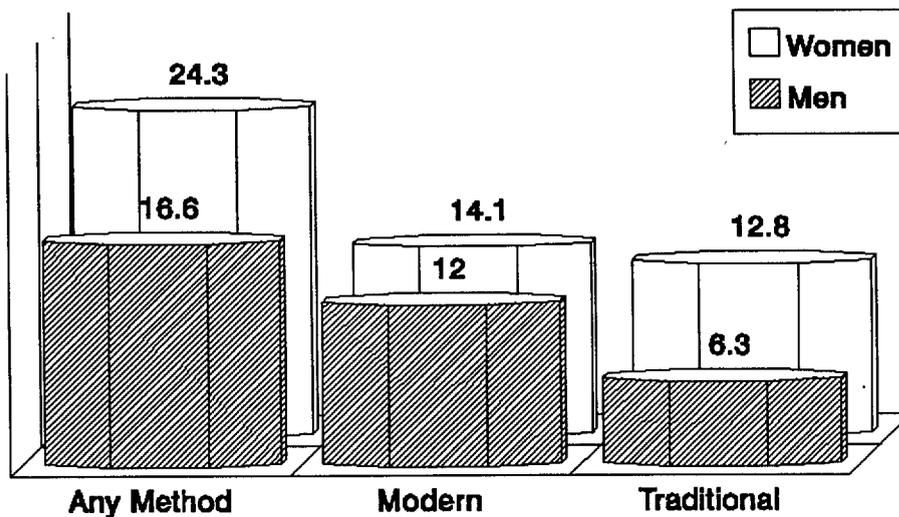
potentially in need of contraception. On the other hand, among the actual spouses of the male respondents are some women who are over 50 years of age and are not at risk of conceiving (and therefore not in need of contraception). In this consideration, one might expect reported utilization rates to be higher among the women.

However, other factors also come into play. For example differential distribution by age is also an important factor influencing contraceptive use. On one hand, an older population has had a longer period in which 'ever-use' may take place. Conversely, a younger population may be more likely to first use contraception (especially modern methods). Thus it is difficult to predict how these factors will interact in determining the ultimate differentials in ever-use by sex.

When one considers only married respondents, the prevalence of ever use of any method is somewhat higher among females than among males. In the case of the women, one out of every four (24.3%) had ever used a contraceptive method, as compared to one out of every six men (16.6%). Although the difference in ever use of modern methods is quite small when one compares the figures for married men and women (12% and 14%, respectively), the difference in ever use of traditional methods is much greater: married men (6.3%) versus married women (12.8%).

It is probable that part of the difference between the sexes in regard to ever use of contraception is attributable to the difference in the age distribution between the wives of the male respondents (older) and the female respondents, themselves (younger). Another explanation for the observed difference is that in some cases, men may not be aware that their wives have ever used a particular contraceptive method. This may be particularly true in the case of the traditional method, juju, which would explain the larger observed difference in ever use of traditional methods by sex as compared to ever use of modern methods.

**Figure 8.2. Percentage of Married Males and Females Who Ever Used at Least One Contraceptive Method  
GCPFDS 1990**



CERPOD

Quite different results are observed when one compares the ever-use data by sex for the unmarried population. Whereas ever use of contraception was significantly higher for married women than for married men, ever use of contraception among single men (27.6%) is twice as high as the analogous figure for single women (13.6%). Most of the difference in the rates of every use among single individuals is due to differences in the rates of every use of modern methods of contraception. Among males, 26.9% have ever used a modern method, whereas the corresponding figure for females is 10.1%. Considering traditional methods, ever use is higher among the women than among the men.

Considering the other differentials presented in Table 8.11, most of them work in the expected direction. Furthermore, the strength of the association between ever use and background characteristic is stronger for modern methods. As predicted, ever use of contraception is strongly and negatively associated with age. Ever use of modern

contraception decreases from a high of 23.6% among males aged under 30 years to a low of 5.3% among males aged 50 and over.

In regard to place of residence, ever use of contraception is higher in the urban areas than in the rural, and higher in the Western health region (mostly urban) than in the other two health regions. Within the rural sector, ever use of modern methods is three times greater in the PHC villages (15.9%) than in the non-PHC villages (5.2%). Interestingly enough, ever use of traditional methods is also significantly higher in the PHC (8.0%) than in the non-PHC villages (1.3%).

TABLE 8.11 PERCENT OF MEN WHO HAVE EVER USED AT LEAST ONE MODERN METHOD OR AT LEAST ONE TRADITIONAL METHOD, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Characteristics	At Least 1 Modern	At Least 1 Trad.	At Least 1 Mod. or Trad.
<b>MALES</b>			
<b>Age</b>			
<30	23.6	3.1	24.8
30-39	21.9	8.0	26.4
40-49	12.1	8.3	18.0
50&+	5.3	3.8	8.9
<b>Health Region</b>			
Western	24.6	8.5	30.1
Central	9.9	2.2	11.0
Eastern	3.2	0.3	3.4
<b>Residence</b>			
Urban	29.1	5.3	32.0
Rural	11.5	5.2	15.1
PHC Village	15.9	8.0	21.4
Non PHC	5.2	1.3	6.0
<b>Ethnic Group</b>			
Mandinka	17.9	6.5	22.1
Fula	8.0	2.4	9.8
Wollof	16.7	2.1	17.2
Jola	28.4	15.5	38.2
Sarahule	5.2	0.0	5.2
Others	30.2	8.1	36.2
<b>Education</b>			
None	7.6	3.1	10.2
Primary	24.0	9.4	31.6
Secondary&	44.7	10.9	49.8
<b>Married</b>			
Monogamous	12.0	6.3	16.6
Polygamous	14.0	6.2	18.4
Polygamous	8.5	6.3	13.3
Not Married	26.9	2.7	27.6
<b>Total</b>	<b>16.5</b>	<b>5.3</b>	<b>19.9</b>
<b>FEMALES</b>			
All women	13.2	11.5	22.0
Married women	14.1	12.8	24.3
Not married women	10.1	6.9	13.6

Important differences in ever use of contraception exist among the ethnic groups. Excluding the category "others", the Jula exhibit the highest rate of ever use of modern methods (28.4%), followed by the Mandinka (17.9%) and Wollof (16.7%). Ever use of modern methods is quite low among the Fula (8%) and the Sarahule (5.2%).

Not surprisingly, the most striking variations in ever use rates are discovered when considering differentials by level of education. The association between level of education and ever use of modern methods of contraception is strongly positive, rising from a low rate of ever use equal to 7.6% among those with no education to a high of 44.7% among those who have studied at the secondary level or higher.

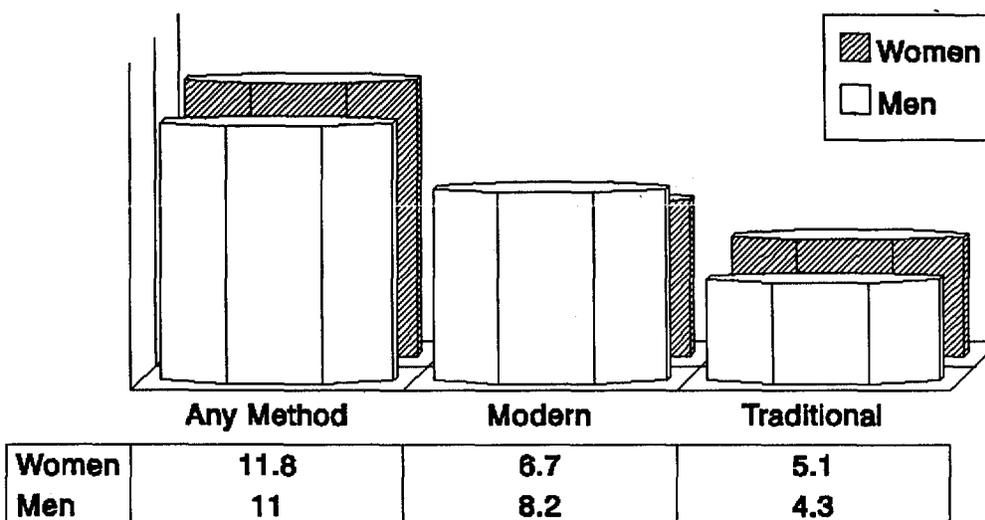
Figures on current use of contraceptive methods are given in Table 8.12. Among the married sub-group, the percentage of women using any contraceptive method at the time of the survey is comparable to the figure for men: 11.8 and 11.0 percent, respectively. However, there are some important differences in use by sex, when one considers the type of method used. Men are more likely to report use of a modern method than women, whereas the latter group exhibit a somewhat higher prevalence of use of traditional methods.

Among those not currently in union, the reported use of contraception is significantly higher among men than women. Whereas 19.4% of the single men are current users, the corresponding figure for single women is 7.7%. The differentials in current use, according to the selected socio-demographic characteristics, are quite comparable to the 'ever use' differentials.

TABLE 8.12 PERCENT OF MEN WHO ARE CURRENTLY USING AT LEAST ONE MODERN METHOD OR AT LEAST ONE TRADITIONAL METHOD, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS GCPFDS, 1990

Background Characteristic	At Least 1 Modern	At Least 1 Trad.	At Least 1 Mod. or Trad.
<b>Age</b>			
<30	16.1	3.5	17.4
30-39	13.8	5.9	17.4
40-49	10.5	5.9	14.6
50&+	4.4	2.4	5.9
<b>Health Region</b>			
Western	17.8	6.5	21.0
Central	7.1	1.6	8.7
Eastern	1.3	0.8	1.9
<b>Residence</b>			
Urban	23.5	6.1	26.5
Rural	6.9	3.4	9.0
PHC Vill.	9.3	4.8	12.3
Non PHC	3.4	1.6	3.9
<b>Ethnic Group</b>			
Mandinka	12.2	5.2	15.5
Fula	5.5	3.1	8.0
Wollof	13.0	0.5	13.0
Jola	17.6	10.8	22.5
Sarahule	2.1	0.0	2.1
Others	22.8	6.0	24.8
<b>Education</b>			
None	4.9	2.6	6.5
Primary	16.7	9.4	21.1
Secondary&+	33.1	8.0	36.9
<b>Married</b>			
Monogamous	8.2	4.3	11.0
Polygamous	9.3	4.4	12.1
Not Married	6.4	4.2	9.1
Not Married	19.4	4.0	20.3
<b>Total</b>	<b>11.6</b>	<b>4.2</b>	<b>14.0</b>
<b>FEMALES</b>			
All women	6.4	4.5	10.9
Married women	6.7	5.1	11.8
Not married women	5.3	2.4	7.7

**Figure 8.3. Percentage of Married Males and Females Actually Using a Contraceptive Method  
GCPFDS 1990**



**CERPOD**

As Table 8.13 indicates, the greatest difference between married and single men in terms of current use is in the frequency of current use of condoms. Whereas for all men, condoms are the most frequently used method of contraception (8.4%), most of this use is contributed by single men (18.1%). In fact, married men (their wives) are more likely to be using the pill (3.6%) than to be using the condom (2.8%). The relatively high level of condom use among the single men is encouraging and should be reinforced by adequate IEC campaigns and condom availability.

TABLE 8.13 PERCENT OF MALES CURRENTLY USING SPECIFIED METHOD, ACCORDING TO MARITAL STATUS, GCPFDS, 1990

Method	Married	Not Married	All Men
Pill	3.6	2.9	3.4
IUD	1.3	0.0	0.8
Injection	2.2	1.3	1.8
Diaphragm	0.8	0.4	0.7
Condom	2.8	18.1	8.4
Female ster.	1.0	0.2	0.7
Male ster.	1.3	0.6	1.0
Abstinence	2.0	1.7	1.9
Withdrawal	1.3	2.6	1.8
Tablet/foam	0.6	0.4	0.5
Traditional	2.2	0.8	1.7
Other	1.0	0.4	0.8

## 8.8 Attitude Toward Family Planning

Male respondents were asked a number of questions in order to assess their attitude toward family planning. Table 8.14 presents the percentage of males who believe that it is acceptable to provide family planning information on the radio. The overall level of approval is quite high at 82.5 percent. Approval declines with age, from a high of 86.4% among those under age 30 to a low of 72.5% for those aged 50 and over.

Differences in approval according to the selected background characteristics exist, but are not large. The most notable differentials are found when comparing residents of PHC villages (85.7%) with residents of non-PHC villages (77.8%), and when comparing men with different levels of education. Whereas only 79% of men who never attended school approve of family planning messages on the radio, over 91% of those who ever attended school approve it.

**TABLE 8.14 PERCENTAGE OF MALES WHO BELIEVE IT IS ACCEPTABLE TO HAVE MESSAGES ABOUT FAMILY PLANNING ON THE RADIO, BY AGE AND SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990**

Characteristics	Age				Total
	<30	30-39	40-49	50&+	
<b>Residence</b>					
Urban	88.2	80.9	87.7	65.2	82.3
Rural	85.2	90.2	81.4	74.6	82.5
PHC vill.	89.5	91.5	84.2	78.3	85.7
Non PHC	78.6	88.2	77.6	70.2	77.8
<b>Health Region</b>					
Western	85.8	86.9	85.3	72.1	83.0
Central	89.3	87.9	76.3	76.8	82.5
Eastern	86.0	88.5	81.4	71.8	81.4
<b>Ethnic Group</b>					
Mandinka	86.3	89.0	84.7	71.3	82.1
Fula	81.9	81.8	80.8	66.7	77.9
Wollof	87.3	86.8	91.2	88.2	88.0
Jola	90.0	90.5	70.6	70.6	80.4
Sarahule	97.2	88.9	82.4	56.0	82.3
Others	86.2	92.9	79.4	93.1	87.2
<b>Education</b>					
None	82.3	85.8	80.4	71.2	79.1
Primary	91.8	-	-	-	91.6
Sec.&+	90.9	89.5	93.8	95.0	91.2
<b>Total</b>	86.4	87.5	83.3	72.5	82.5

Males were also asked whether they approved of couples using a contraceptive method in order to avoid pregnancy. As shown in Table 8.15, the level of approval is high even though it is a bit lower than the level of approval of family planning messages on the radio. Differentials in approval of contraceptive use according to socio-demographic characteristics are greater than those observed when considering approval of family planning information. The percent approving of contraceptive use decreases from a high of 79.2% among men less than 30 years of age to 52.4% among men over 50 years.

Approval of contraceptive use is somewhat greater among the Jola (80.4%) and the Wollof (75.0%) than among the Sarahule (61.5%) and the Fula (66.0%). Considering the other background variables, we find, as expected, that approval is higher in urban (74.9%) than in rural areas (67.5%), in PHC (69.6%) than in non-PHC villages (64.8%), among educated (88%) than among non-educated (63%) males.

TABLE 8.15 PERCENTAGE OF MALES WHO APPROVE OF COUPLES USING A METHOD TO AVOID PREGNANCY, BY AGE AND SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Characteristics	Age				Total
	<30	30-39	40-49	50&+	
<b>Residence</b>					
Urban	85.1	76.6	78.9	43.9	74.9
Rural	75.8	78.9	61.7	54.4	67.5
PHC Vill.	75.6	82.9	64.0	57.3	69.6
Non PHC	76.2	72.4	58.2	50.9	64.8
<b>Health Region</b>					
Western	81.6	79.2	74.1	55.2	74.0
Central	73.2	78.8	52.6	51.8	63.4
Eastern	75.4	75.9	55.9	48.7	64.2
<b>Ethnic Group</b>					
Mandinka	82.2	79.1	64.7	54.4	70.1
Fula	76.7	75.3	63.5	43.2	66.0
Wolof	76.1	75.5	82.4	64.7	75.0
Jola	90.0	90.5	70.6	70.6	80.4
Sarahule	69.4	88.9	58.8	32.0	61.5
Others	86.2	71.4	70.6	65.5	75.8
<b>Education</b>					
None	71.2	72.5	61.9	50.5	62.9
Primary	87.8	-	-	-	87.4
Secondary&+	88.5	94.7	84.4	75.0	88.3
<b>Total</b>	<b>79.2</b>	<b>78.7</b>	<b>66.5</b>	<b>52.4</b>	<b>69.9</b>

Additional questions were asked in order to gain a greater knowledge of Gambian men's attitudes on fertility issues. Respondents were asked the ideal age at which a woman should get married and why this age was appropriate. Table 8.16 presents the distribution of responses given by each age group as justification of their choice of the ideal age at first marriage.

Except for the answer category 'religion/tradition' which is cited more frequently as age increases, age does not appear to be associated with any other answer in Table 8.16. Approximately one half of the respondents cited physical maturity as justification for the ideal age at first marriage which they cited. Education was a main concern among 23.3 percent of the respondents. Interestingly, 5.8 percent of the respondents cited an early age at first marriage' in order to 'avoid pre-marital pregnancy and 2.1% in order to avoid premarital sex. The emphasis on early marriage as a means on preventing premarital sex and childbearing is a common feature of the Sahelian countries.

TABLE 8.16 PERCENT DISTRIBUTION OF MALE RESPONDENTS BY THE REASON GIVEN TO JUSTIFY THE IDEAL AGE AT FIRST MARRIAGE, GCPFDS, 1990

Age	Relig./ tradit.	Avoid preg- nancy	Avoid pre-mar. sex	Ensure early birth	Obtain educa- tion	Attain matu- rity	Other	Total
<30	15.2	5.7	2.0	2.0	31.7	43.4	0.2	100
30-39	14.8	5.3	3.5	0.7	25.0	50.7	1.1	100
40-49	23.5	5.6	0.9	1.7	18.8	49.6	0.4	100
50&+	25.7	6.6	1.8	0.9	13.7	51.3	0.3	100
Total	19.3	5.8	2.1	1.4	23.2	48.2	0.5	100

Finally respondents were asked why people might prefer to have many children. The results are presented in Table 8.17, controlling for age. Half of the respondents said that a large number of children was simply given as a gift of nature. The second most common answer was that many children are desired as economic assets. A relatively small percent of the respondents (3.6%) claimed that people prefer to have a lot of children in order to offset the loss of children due to high levels of infant and child mortality.

TABLE 8.17 PERCENT DISTRIBUTION OF MALE RESPONDENTS BY THE REASON GIVEN FOR HAVING MANY CHILDREN, ACCORDING TO AGE, GCPFDS, 1990

Age	Gift of Nature	Infant Mort.	Econ. Assets	Social prestige	Other	Don't Know	Not Stated	Total
<30	42.1	3.3	36.9	7.9	0.9	6.6	2.4	100
30-39	50.5	4.2	30.3	9.4	1.4	3.5	0.7	100
40-49	55.6	4.2	29.7	4.2	1.7	4.2	0.4	100
50&+	53.6	3.0	33.1	5.0	0.6	4.4	0.3	100
Total	49.3	3.6	33.2	6.8	1.1	4.9	1.1	100

## 8.9 Intention to Use Contraception

Males who were not currently using contraception were asked whether or not they intended to use contraception in the future, and if yes, when. Table 8.18 summarizes the answers given to these questions, according to the number of living children. Nearly, sixty percent of the male respondents not using contraception at the time of the survey do not intend to use contraception at any time. The remaining 40 percent are divided between those who intend to use contraception in the next 12 months (16.4%), those who intend to

use contraception later than in the next 12 months (8.1%), and those who are unsure about future use (15.1%). There is no obvious association between the intention to use contraception in the future and the number of living children a man currently has.

TABLE 8.18 PERCENT DISTRIBUTION OF MEN WHO ARE NOT CURRENTLY USING ANY CONTRACEPTIVE METHOD BY INTENTION TO USE IN THE FUTURE, ACCORDING TO THE NUMBER OF LIVING CHILDREN GCPFDS, 1990

Intention to Use	0	1	2	3	4	5	6	7	8&+	Total
Intend to use										
In the next 12 months	15.4	26.6	20.2	14.8	10.5	18.0	18.0	9.6	13.6	16.4
Later	11.0	11.7	9.6	1.1	12.8	10.1	4.0	9.6	4.7	8.1
Unsure about using	15.4	18.1	10.6	13.6	18.6	14.6	14.0	26.9	11.8	15.1
Do not intend to use	57.1	43.6	56.4	69.3	54.7	57.3	64.0	53.8	68.6	59.2
Not stated	1.1	0.0	3.2	1.1	3.5	0.0	0.0	0.0	1.2	1.2
Total	100	100	100	100	100	100	100	100	100	100
Number	91	94	94	88	86	89	50	52	169	813

## 8.10 Fertility Preferences

In order to investigate the fertility preferences of Gambian men, the male respondents were asked whether they would like to have a (another) child or whether they would prefer not to have any (more) children. Table 8.19 displays the percent distribution of men by desire for a (another) child, according to the number of living children. It is striking to note the extent to which men, who already have a large number of children, still desire at least one additional child. For example, 65 percent of the men who have 8 children or more would still like to have another child.

Another salient observation is the weakness of the association between the number of living children and the percentage of men who desire to have an additional child. The percentage of males who would not like to have another child does increase slightly with the number of living children, but with some irregularities in the trend. Among those who have 0 to 5 living, the highest percent of men desiring no more children is found among those who have 3 living children (12.4%). The percent desiring no more children falls to 6.1% among those with 4 living children before rising slightly to 8.4% among those with 5 living

children. The percent desiring no more children jumps to 24.1% among those with 6 living children and fluctuates around this level for those with 7 or more living children.

It should also be noted the extent to which the male respondents stated they were not sure whether or not they wanted an additional child (7.4%). Of particular interest is the relatively high percent of men with NO living children who claimed they were unsure whether or not they wanted a (another) child (5.2%).

TABLE 8.19 PERCENT DISTRIBUTION OF MEN BY DESIRE FOR ADDITIONAL CHILDREN, ACCORDING TO THE NUMBER OF LIVING CHILDREN, GCPFDS, 1990

	Number of living children									Total
	0	1	2	3	4	5	6	7	8&+	
Another	91.8	91.9	86.0	85.0	85.7	77.9	67.2	67.9	64.5	79.7
No more	0.0	4.5	10.3	12.4	6.1	8.4	24.1	26.8	21.0	12.2
Not sure	5.2	2.7	2.8	2.7	8.2	12.6	8.6	5.4	14.0	7.4
Not Stated	3.1	0.9	0.9	0.0	0.0	1.1	0.0	0.0	0.5	0.8
Total	100	100	100	100	100	100	100	100	100	100
Number	97	111	107	113	98	95	58	56	186	921

In order to estimate what the male respondents perceive to be the ideal number of children, those with no living children were asked: "If you could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?" Those respondents with living children were similarly asked: "If you could go back to the time you did not have any children and could choose exactly the number to have in your whole life, how many sons and daughters would you like to have?"

The answers given in response to these questions are summarized in Table 8.20. The most notable feature of this table is the extent to which non-numeric responses were given, the most common being 'as many as God wills'. The extent to which individuals give a non-numeric response to this question is often used as an indirect indicator of the population's readiness for family planning services.

In the case of the male sample, nearly 60 percent of the respondents gave a non-numeric answer, including 'it's up to God' or 'as many as God wills'. The differences in the frequency of non-numeric responses according to the selected background characteristics are important. The percent giving a non-numeric response increases with age from 52.2% of

those under 30 years of age to 64.4% of those aged 50 and over. Rural respondents were nearly twice as likely as their urban counterparts to give a non-numeric response.

TABLE 8.20 PERCENT DISTRIBUTION OF MEN BY IDEAL NUMBER OF CHILDREN, ACCORDING TO SELECTED BACKGROUND CHARACTERISTICS, GCPFDS, 1990

Background Charac.	Numeric Answers						Total	Num.	Non-No.
	<4	4	5	6	7	8&+			
<b>Age</b>									
<30	13.7	7.8	23.5	19.6	11.8	23.5	100	52.2	113
30-39	8.3	16.7	14.6	20.8	9.4	30.2	100	56.6	235
40-49	10.0	13.3	11.1	22.2	7.8	35.6	100	59.1	235
50&+	6.1	9.1	12.1	11.1	4.0	57.6	100	64.4	334
<b>Residence</b>									
Urban	12.1	25.0	24.2	18.5	4.8	15.3	100	37.1	210
Rural	6.6	4.7	8.5	18.0	9.5	52.6	100	66.2	707
PHC	9.3	7.0	7.8	17.8	7.0	51.2	100	64.5	408
Non PHC	2.5	1.3	8.8	18.8	12.5	56.3	100	68.9	296
<b>Ethnic Group</b>									
Mandinka	6.6	5.7	14.8	20.5	9.0	43.4	100	57.1	315
Fula	6.8	6.8	16.9	18.6	10.2	40.7	100	71.1	242
Wollof	14.9	14.9	14.9	19.1	6.4	29.8	100	58.9	124
Jola	7.0	14.0	18.6	9.3	4.7	46.5	100	36.1	72
Sarahule	0.0	20.0	6.7	26.7	6.7	40.0	100	74.2	66
Others	14.0	28.0	8.0	18.0	6.0	26.0	100	46.0	100
<b>Education</b>									
None	4.3	8.1	11.5	17.1	8.1	50.9	100	65.6	764
Primary	15.6	15.6	21.9	21.9	12.5	12.5	100	30.8	52
Secondary	20.0	22.9	21.4	20.0	5.7	10.0	100	28.8	104
<b>Polygamy</b>									
Mono	10.6	13.1	17.8	21.2	9.3	28.0	100	56.6	594
Poly	3.9	9.8	6.9	10.8	4.9	63.7	100	64.4	326
<b>Total</b>	<b>8.6</b>	<b>12.1</b>	<b>14.5</b>	<b>18.0</b>	<b>8.0</b>	<b>38.8</b>	<b>100</b>	<b>59.3</b>	<b>920</b>

The analysis by ethnic group reveals significant differences between the sub-groups in the frequency with which they gave non-numeric responses. The percent stating 'the number of children one has is determined by God' ranges from a low of 36.1% among the Jola to a high of 74.2% among the Sarahule.

The most striking differentials in the percent giving non-numeric responses are observed when considering the education variable. Whereas only 29% of the male respondents with a secondary or higher level of education gave a non-numeric response, over 65% of those who had never attended school are classified in the non-numeric category.

Considering now the numeric responses, it can be seen in Table 8.20 that on the

whole, the ideal number of children for the male respondents is quite high. 39% of those who gave a numeric response stated 8 or higher as the ideal number of children. Approximately two thirds of the same sub-group gave 6 or higher as the ideal number of children.

Differentials in the ideal number of children according to the selected background characteristics work in the expected directions. Among those who gave numeric answers, the ideal number of children increases with the age of the respondent, is higher among rural than among urban respondents, decreases with increasing level of education, and is higher for those in polygamous (as contrasted with monogamous) unions.

As was discussed in the fertility preferences chapter for the women's questionnaire, data on fertility preferences need to be interpreted with caution. It has been demonstrated that the hypothetical nature of the question on ideal number of children is not well understood by many respondents - and, in fact, numeric responses to these questions may better reflect the actual childbearing experience of the respondent than the desired (if the differentiation between actual and desired can even be made). Additional research into the determinants (and measures) of unmet need for family planning and the demand for family planning are certainly warranted.

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## **APPENDIX A SURVEY PERSONNEL**

### 1. TASK FORCE MEMBERS

DR. MELVILLE O. GEORGE - CHAIRMAN  
MR. ALIEU NDOW  
DR. KABIR CHAM  
DR. PAP WILLIAMS  
MRS. BERTHA MBOGE  
MR. EBOU JOBATEH  
DR. MUJAHID  
MR. TUNDE THOMAS TAYLOR  
MS. AISHA CAMARA

### MEMBER OF THE MCH/FP UNIT

DR. REUBEN MBOGE  
MR. ISMAILA NJIE  
MRS. FLORENCE BAHOU

### 2. SURVEY DESIGN

MR. LAMIN NYABALLY  
MR. FALLU NJIE

### 3. SUPERVISORS OF THE TECHNICIANS THE STUDY

MR. OUSMAN SABALLY  
MR. BABUCARR CEESAY  
MR. SHERRIFO SONKO  
MR. PA SAHOR

4. In addition, acknowledgement is also made to all interviewers who spent endless time to collect all the data and to all those who provided secretarial backup.

### 5. DATA PROCESSING

MR. MOUSSA DOLO  
MR. ISSA GUINDO

6. Acknowledgement should be made to DR. Thomas T. Kane who prepared the coding manual, the list of tables and the plan for analysis.

## **APPENDIX B QUESTIONNAIRES**

- B1. COMPOUND SCHEDULE**
- B2. HOUSEHOLD QUESTIONNAIRE**
- B3. FEMALE QUESTIONNAIRE**
- B4. MALE QUESTIONNAIRE**

SURVEY ON CONTRACEPTIVE PREVALENCE AND FERTILITY  
DETERMINANTS IN THE GAMBIA  
COMPOUND SCHEDULE

LOCAL GOVERNMENT AREA..... [ ][ ]

ENUMERATION AREA NO..... [ ][ ][ ][ ]

NAME OF VILLAGE/TOWN.....

DISTRICT .....

HEALTH REGION.....

TYPE OF SETTLEMENT	PHC	1
	NON-PHC	2
	PHC & NON-PHC	3
	URBAN	4

IF (3), SPECIFY WHETHER HOUSEHOLD.....	PHC	1
	OR NON-PHC	2

COMPOUND NO	NAME OF H/HEAD	H/HOLD NO	SERIAL NO	REMARKS



SURVEY OF CONTRACEPTIVE PREVALENCE AND  
 FERTILITY DETERMINANTS IN THE GAMBIA  
 HOUSEHOLD QUESTIONNAIRE

LOCAL GOVERNMENT AREA..... [ ][ ]

ENUMERATION AREA NO..... [ ][ ][ ][ ][ ]

NAME OF VILLAGE/TOWN.....

DISTRICT .....

HEALTH REGION.....

TYPE OF SETTLEMENT	PHC	1
	NON-PHC	2
	PHC & NON-PHC	3
	URBAN	4

IF (3), SPECIFY WHETHER HOUSEHOLD.....	PHC	1
	OR NON-PHC	2

HOUSEHOLD NUMBER..... [ ][ ]

NAME OF RESPONDENT.....

RELATIONSHIP TO HEAD OF HOUSEHOLD.....

-----  
 ROUND OF DATA COLLECTION    1            2            3            FINAL VISIT  
 -----

DATE

INTERVIEWER'S NAME

-----  
 RESULT\*\*  
 -----

NEXT VISIT : DATE	.....	TOTAL NUMBER
		OF VISITS
TIME	.....	.....

-----  
 \* RESULT CODES :    1 COMPLETED    2 NOT AT HOME    3 POSTPONED  
                           4 REFUSED            5 PARTLY COMPLETED  
                           6 OTHER (SPECIFY.....  
 -----

	FIELD EDITED BY	OFFICE EDITED BY	KEYED BY
NAME	.....	.....	.....
DATE	.....	.....	.....



CONTINUATION SHEET

NO:	USUAL RESIDENTS:	RELATIONSHIP:	RESIDENCE :	SEX :	AGE:	EDUCATION:	FOSTERING:	ELIGIBILITY:	FEMALE:	MAL
:	AND VISITORS :	TO HEAD OF :	:	:	:	:	:	SUCCESS:	SUCCI	:
:	HOUSEHOLD :	:	:	:	:	:	:	FULLY :	FULI	:
:	:	:	:	:	:	:	:	INTER-:	INTH	:
:	Please give me :	:	Does Did :	Is :	How :	What is the:	ONLY FOR :	Line number:	VIEWED?	:
:	the names of :	:	(NAME NAME)(NAME:	hold:	highest :	CHILDREN :	of eligible:	:	VII	:
:	persons who :	:	usu- sleep:	male :	is :	level of :	UNDER 15 :	or indivi-	TICK :	WEI
:	usually live in:	:	ally here :	or :	she/:	education :	YEARS OLD:	dual inter-	IF YES:	:
:	your household :	:	live last :	fema-:	he? :	he/she :	Do any of:	view (18&)	:	:
:	or staying with:	:	here?night?	le :	attained? :	his/her :	(13-49)	:	:	:
:	you now, star- :	:	:	:	SEE CODES :	parents :	:	:	:	:
:	ting with the :	:	:	:	BELOW :	usually :	:	:	:	:
:	head of house- :	:	:	:	:	live in :	:	:	:	:
:	hold. :	:	:	:	:	his house:	:	:	:	:
:	:	:	:	:	:	hold?	:	:	:	:
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
08:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	08 08	
09:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	09 09	
10:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	10 10	
11:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	11 11	
12:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	12 12	
13:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	13 13	
14:						IN :		YES NO :	M F :	
			YESNOYESNO:	M F :	YEARS					
			1 2 1 2:	1 2 :	...			1 2 :	14 14	

TICK IF CONTINUATION SHEET USED [ ] [ ] NUMBER OF ELIGIBLE MALES [ ] [ ] NUMBER OF ELIGIBLE FEMALES [ ] [ ]

JUST TO MAKE SURE THAT I HAVE A COMPLETE LISTING:

- 1) Are there any other persons such as small children or infants that we have not listed? YES.... (Enter each in table) No.....
- 2) In addition, are there any other people who may not be members of your family, such as domestics servants, lodgers or friends who usually live here? YES.... (Enter each in table) No....
- 3) Do you have any guests or temporary visitors staying here, or anyone else who slept here last night ? YES.... (Enter each in table) No.....

CODES FOR EDUCATION LEVEL:	NONE	1	PRIMARY	2
	SECONDARY TECHNICAL	3	HIGH SCHOOL	4
	VOCATIONAL	5	COLLEGE/UNIVERSITY	6
	DK	98		

CONTINUATION SHEET

1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
5:											
6:											
7:											
18:											
19:											
20:											
21:											

TICK IF CONTINUATION SHEET USED [ ] [ ] NUMBER OF ELIGIBLE MALES [ ] [ ] NUMBER OF ELIGIBLE FEMALES [ ] [ ]

JUST TO MAKE SURE THAT I HAVE A COMPLETE LISTING:

- 1) Are there any other persons such as small children or infants that we have not listed? YES.... (Enter each in table) No.....
- 2) In addition, are there any other people who may not be members of your family, such as domestics servants, lodgers or friends who usually live here? YES.... (Enter each in table) No....
- 3) Do you have any guests or temporary visitors staying here, or anyone else who slept here last night? YES.... (Enter each in table) No.....

CODES FOR EDUCATION LEVEL:	NONE	1	PRIMARY	2
	SECONDARY TECHNICAL	3	HIGH SCHOOL	4
	VOCATIONAL	5	COLLEGE/UNIVERSITY	6
	DK	98		



SURVEY OF CONTRACEPTIVE PREVALENCE AND  
FERTILITY DETERMINANTS IN THE GAMBIA

INDIVIDUAL QUESTIONNAIRE (FEMALES 13-49)



LOCAL GOVERNMENT AREA..... [ ][ ]  
 ENUMERATION AREA NO..... [ ][ ][ ][ ]  
 NAME OF VILLAGE/TOWN.....  
 DISTRICT .....  
 HEALTH REGION.....  
 TYPE OF SETTLEMENT

PHC	1
NON-PHC	2
PHC & NON-PHC	3
URBAN	4

IF (3), SPECIFY WHETHER HOUSEHOLD..PHC	1
OR NON-PHC	2

HOUSEHOLD NUMBER..... [ ][ ][ ]  
 LINE NUMBER OF WOMAN..... [ ][ ]  
 LINE NUMBER OF HUSBAND..... [ ][ ]

ROUND OF DATA COLLECTION	1	2	3	FINAL VISIT
-----				
DATE				[ ][ ][ ][ ][ ][ ][ ]
-----				

INTERVIEWER'S NAME

-----

RESULT \*\*

----- [ ]

NEXT VISIT : DATE	.....	.....	.....	TOTAL NUMBER
TIME	.....	.....	.....	OF VISITS

-----

RESULT CODES : 1 COMPLETED      2 NOT AT HOME      3 POSTPONED  
 4 REFUSED                      5 PARTLY COMPLETED  
 6 OTHER (SPECIFY).....

-----

FIELD EDITED BY      OFFICE EDITED BY      KEYED BY

NAME	.....	.....	.....
DATE	.....	.....	.....

-----

SECTION 1 : RESPONDENT'S BACKGROUND

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
101	RECORD NUMBER OF PEOPLE LISTED IN THE HOUSEHOLD SCHEDULE	NUMBER OF PEOPLE.....[ ][ ]	
102	RECORD NUMBER OF CHILDREN AGED 5 AND UNDER LISTED IN THE HOUSEHOLD SCHEDULE WHO NORMALLY LIVE IN THE HOUSEHOLD	NUMBER OF CHILDREN AGED FIVE OR UNDER.....[ ][ ]	
103	What is your nationality ?	GAMBIAN..... 1 NON-GAMBIAN..... 2 SPECIFY..... 3 (COUNTRY)	
104	First I would like to ask some questions about you and your household. For most of the time until you were 12 years old, did you live in a village, or a town or a city?	VILLAGE..... 1 TOWN..... 2 CITY..... 3	
105	How long have you been living continuously in this..... (Name of village, town, city)	ALWAYS..... 1--->107 VISITOR..... 2--->107 YEARS.....[ ][ ]	
106	Just before you moved here, did you live in a village, in a town or in a city ?	VILLAGE..... 1 TOWN..... 2 CITY..... 3	
107	In what month and year were you born ?	MONTH.....[ ][ ] DK MONTH.....98 YEAR.....[ ][ ] DK YEAR.....98	
108	How old were you at your last birthday ?	AGE IN COMPLETED YEARS.....[ ][ ]	
	COMPARE AND CORRECT 107 AND/OR 108 IF INCONSISTENT		
109	Are you attending school now ?	YES..... 1 NO..... 2-->113	
110	Which level of school are you attending ?	PRIMARY..... 1 SECONDARY TECHNICAL.. 2 HIGH SCHOOL..... 3 VOCATIONAL..... 4 COLLEGE/UNIVERSITY... 5	
111	In which Grade are you ?	GRADE.....[ ]	
112	What is the highest level of school you intend to attain?	PRIMARY..... 1 SECONDARY TECHNICAL.. 2 HIGH SCHOOL..... 3 VOCATIONAL..... 4 COLLEGE/UNIVERSITY... 5	>112

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
113	Have you ever attended school ?	Yes..... 1 NO..... 2	2--->118
114	What was the highest level of school you attended: primary, secondary technical, high school, vocational, or college/university	Primary..... 1 Sec.Technical..... 2 High school..... 3 Vocational..... 4 College/University. 5	
115	What was the highest Grade you completed at that level?	GRADE.....[ ]	
116	CHECK 115 :		
	NOT FINAL GRADE [ ]	FINAL GRADE [ ]	-----> 119
117	Why did you not complete the level for which you had registered ?	GOT MARRIED..... 1 GOT PREGNANT..... 2 FINANCIAL DIFFICULTY. 3 HOUSEWORK/FARM WORK.. 4 POOR PERFORMANCE..... 5 OTHERS..... 6 (specify) DK.....98	>119
118	Why did you not attend school ?	SCHOOL TOO FAR..... 1 FINANCIAL DIFFICULTY. 2 RELIGIOUS OPPOSITION. 3 TRADITIONAL..... 4 HOUSEWORK/FARMWORK... 5 HAD TO TAKE A JOB.... 6 OTHERS..... 7 (specify) DK....,.....98	>120
119	CHECK 110 AND 114 :		
	PRIMARY [ ]	SECONDARY TECHNICAL OR HIGHER [ ]	----->121
120	Can you read a letter or newspaper easily, with difficulty or not at all	EASILY..... 1 WITH DIFFICULTY..... 2 NOT AT ALL..... 3	
121	How many years of Koranic education do you have?	YEARS.....[ ][ ]	
122	Do you listen to a radio at least once a week?	YES.....1 NO.....2	

<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
23 What is the major source of drinking water for members of your household?	STANDPIPE OR RUNNING WATER IN HOUSE STANDPIPE NOT IN HOUSE RAINWATER WELL WITH HANDPUMP WELL W/O HANDPUMP BOREHOLE STREAM, LAKE, RIVER OTHER.....	1 2 3 4 5 6 7 8
(SPECIFY)		
24 What is the major source of water for household use other than drinking (e.g handwashing, cooking) for members of your household?	STANDPIPE OR RUNNING WATER IN HOUSE STANDPIPE NOT IN HOUSE RAINWATER WELL WITH HANDPUMP WELL W/O HANDPUMP BOREHOLE STREAM, LAKE, RIVER OTHER.....	1 2 3 4 5 6 7 8
(SPECIFY)		
25 How long does it take to go there, get water and come back straight to your house?	MINUTES.....[ ][ ] HOURS.....[ ][ ] ON PREMISES.....[ ][ ]	
26 What kind of toilet facility does your household have?	WATER CLOSET..... PAN..... PIT LATRINE..... V.I.P ..... OTHER..... (SPECIFY) NO FACILITY/BUSH.....	1 2 3 4 5 6
27 Does your household have:		YES NO
Electricity?	Electricity.....	1 2
A radio that is working?	Radio.....	1 2
A television?	Television.....	1 2
A refrigerator?	Refrigerator.....	1 2
28 Does any member of your household own:		YES NO
A bicycle?	BICYCLE.....	1 2
A motorcycle?	MOTORCYCLE.....	1 2
A car or truck?	CAR OR TRUCK.....	1 2
A tractor?	TRACTOR.....	1 2
129 MAIN MATERIAL USED FOR ROOF (INTERVIEWER : RECORD OBSERVATION)	ALUMINIUM, ASBESTOS OR GALVANISED IRON SHEETS..... CONCRETE..... THATCH/GRASS..... OTHER..... (SPECIFY)	1 2 3 4

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
130	MAIN MATERIAL USED FOR OUTER WALLS (INTERVIEWER : RECORD OBSERVATION)	CEMENT BLOCKS..... 1 LANDCRETE..... 2 BURNT BRICKS..... 3 MUD, EARTH..... 4 KRINTING ..... 5 KRINTING WITH CEMENT PLASTERING.. 6 OTHER..... 7 (SPECIFY)	
131	MAIN MATERIAL USED FOR FLOOR (INTERVIEWER : RECORD OBSERVATION)	EARTH/MUD..... 1 CEMENT..... 2 FILES..... 3 OTHER..... 4 (SPECIFY)	
132	What is your religion?	ISLAM..... 1 CHRISTIANITY..... 2 TRADITIONAL/ANIMISM 3 OTHERS..... 4 (SPECIFY) DK..... 98	
133	What is your ethnic group?	MANDINKA..... 1 FULA..... 2 WOLLOF..... 3 JOLA..... 4 SARAHULE..... 5 SERERE..... 6 MANJAGO..... 7 AKU..... 8 OTHERS..... 9 (SPECIFY).....	

SECTION 2. REPRODUCTION

<u>Q</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
01	Have you ever been pregnant?	Yes ..... 1 NO..... 2---->227 NOT SURE..... 3---->227	
02	At what age did you first get pregnant?	YEARS.....[ ][ ] DK.....98	
03	How long ago did your last pregnancy end?	MONTHS.....[ ][ ][ ] DK.....98	
04	What was the outcome of your last pregnancy?	LIVE BIRTH.....1 STILL BIRTH.....2 MISCARRIAGE.....3 ABORTION.....4	
05	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES.....1 NO.....2--->210	
06	Do you have any sons or daughters you have given birth to who are now living with you?	YES.....1 NO.....2--->208	
07	How many sons live with you? And how many daughters live with you?	SONS AT HOME...[ ][ ] DAUGHTERS AT HOME.....[ ][ ]	
08	Do you have any sons or daughters you have given birth to who are alive but do not live with you?	YES..... 1 NO..... 2 --->210	
09	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you?	SONS AWAY.....[ ][ ] DAUGHTERS AWAY [ ][ ]	
10	Have you ever given birth to a boy or a girl who was born alive but later died? IF NO, PROBE : Any (other) boy or girl who cried or showed any sign of life but only survived a few hours or or days?	YES..... 1 NO..... 2--->212	
11	How many boys have died? And how many girls have died?	BOYS DEAD.....[ ][ ] GIRLS DEAD.....[ ][ ]	
12	SUM ANSWERS TO 207, 209, 211, AND ENTER TOTAL	TOTAL.....[ ][ ]	
13	CHECK 212 : Just to make sure that I have this right: you have had in Total [ ][ ] live births during your life. Is that correct? YES NO PROBE AND CORRECT [ ] [ ] 205-21 AS NECESSARY		
14	CHECK 212: ONE OR MORE BIRTHS [ ] ----> (GO TO 215) NO BIRTHS-----> 227		

15. Now I would like to talk to you about all of your births, wheter still alive or not starting with the first one you had.

(RECORD NAMES OF ALL THE BIRTHS IN 216, RECORD TWINS AND TRIPLETS ON SEPARATE LINES

```

-----
16      : 217 : 218 : 219 : 220 : 221 : 222 : 223 : 224
nat name :      : Is(NAME):In what: Is(NAME:IF ALIVE:IF ALIVE :IF LESS THAN:IF HEAD
as given :      : a boy or:month : Still :how old :      :15 YEARS OLD:How old was
o your   :      : girl?   :andyear:alive? :was(NAME) :AGE       :he/she when
first,   :      : was     :      :at his/ :Is(NAME) :      :he/she died
ext)birth? :      : (NAME) :      :her last:living :With whom :      :
:        :      : born?   :      :birth-  :with you?:does he/she :IF "1 YEAR" PRO
:        :      :         :      :day?    :      :lives?    :How many months
:RECORD  :      : PROBES: :      :         :      :         :old was (NAME)?
:SINGLE  :      : What is: :      : RECORD :      :         :
:OR MUL-:      : his    :      : AGE IN :      : IF 15+ GO TO:RECORD DAYS IF
:TIPLE  :      : birth- :      : COMPLE- :      : NEXT BIRTH :LESS THAN 1
:BIRTH  :      : day?   :      : TED    :      :           :MONTH, MONTHS IF
:STATUS :      : OR:In  :      : YEARS  :      :           :LESS THAN TWO
:        :      : what   :      :         :      :           :YEARS, OR YEARS.
:        :      : season :      :         :      :           :
:        :      : was he/: :      :         :      :           :
:        :      : she born? :      :         :      :           :
-----
1       :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH)
-----
2       :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH.....
-----
3       :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH)
-----
4       :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH.....
-----
15      :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH)
-----
16      :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH.....
-----
17      :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH)
-----
18      :SING...:BOY...1:MONTH...:YES...1:AGE IN :YES...1 :FATHER... 1 :DAYS....[ ][ ]
:MULT...:GIRL...2:YEAR...:NO...2: YEARS : (GO TO  :OTHER REL.2 :MONTHS..[ ][ ]
:        :      :      :SKIP TO: :NEXT     :SOMEONE...3 :YEARS...[ ][ ]
:        :      :      : 224   : :BIRTH)  :GO TO NEX  : (GO TO NEXT
:        :      :      :      : :{ }[ ] :No.....2 :BIRTH)    :BIRTH.....
-----

```



<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
227	Are you pregnant now?	YES.....1 NO.....2--->232 NOT SURE.....3--->232	
228	For how many months have you been pregnant?	MONTHS.....[ ][ ] DK..... 98	
229	Since you have been pregnant, have you been given any injection to prevent the baby from getting tetanus, that is, convulsions after birth?	YES.....1 NO.....2 DK.....9	
230	Have you seen anyone for a check on this pregnant?	YES.....1 NO.....2--->232	
231	Whom did you see?  PROBE FOR TYPE OF PERSON AND RECORD MOST QUALIFIED	DOCTOR.....1 NURSE/MIDWIFE.....2 T.B.A.....3 OTHER.....4 (SPECIFY)	
232	How long ago did your last menstrual period start?	DAYS AGO.....[ ][ ] WEEKS AGO.....[ ][ ] MONTHS AGO.....[ ][ ] YEARS AGO.....[ ][ ] BEFORE LAST BIRTH 96 NEVER MENSTRUATED 97	
233	When during her monthly cycle do you think a woman has the greatest chance of becoming pregnant?  PROBE What are the days during the month when a woman has the greatest chance of becoming pregnant?	DURING HER PERIOD...1 RIGHT AFTER HER PERIOD HAS ENDED....2 IN MIDDLE OF CYCLE..3 JUST BEFORE HER PERIOD BEGINS.....4 AT ANY TIME.....5 OTHER.....6 (SPECIFY) DK.....98	
234	PRESENCE OF OTHERS AT THIS POINT	NO OTHERS.....1 CHILDREN UNDER 10...2 HUSBAND.....3 OTHER MALES.....4 OTHER FEMALES.....5	

**SECTION 3. CONTRACEPTION**

01 Now I would like to talk about a different topic. There are various ways methods that a couple can use to delay or avoid a pregnancy. Which of the ways or methods have you heard about ? CIRCLE CODE 1 IN 302 FOR EACH METHOD MENTIONNED SPONTANEOUSLY. THEN PROCEED DOWN THE COLUMN, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE 2 IF METHOD IS RECOGNISED AND CODE 3 IF NOT RECOGNISED. THEN FOR EACH METHOD WITH CODE 1 OR 2 CIRCLED IN 302, ASK 303 - 305 BEFORE PROCEEDING TO THE NEXT METHOD.

	302 Have you ever heard of (METHOD)?	303 Have you ever used (METHOD)?	304 Where would you go to obtain (METHOD) if you wanted to use it?	305 In your opinion What is the main problem if any using METHOD?
	READ DESCRIPTION	(METHOD)?	(CODES BELOW)	
1 PILL 'Women can take a pill everyday.'	YES/SPONT... 1-> YES/PROBED.. 2-> NO..... 3*	YES....1 NO.....2	[ ][ ] [ ][ ] OTHER....	[ ][ ] [ ][ ] OTHER....
2 IUD ' Women can have a loop or coil place inside them by a doctor or nurse.'	YES/SPONT... 1-> YES/PROBED.. 2-> No..... 3*	YES....1 NO.....1	[ ][ ] [ ][ ] OTHER....	[ ][ ] [ ][ ] OTHER....
3 INJECTION 'Women can have an injection by a doctor or nurse which stops them from becoming pregnant for several months.'	YES/SPONT... 1-> YES/PROBED.. 2-> NO..... 3*	YES....1 NO.....2	[ ][ ] [ ][ ] OTHER.....	[ ][ ] OTHER....
4 DIAPHRAM/FOAM/JELLY 'Women can place a sponge, suppository diaphragm, jelly or cream inside them before intercourse.'	YES/SPONT... 1-> YES/PROBED.. 2-> NO..... 3*	YES....1 NO.....2	[ ][ ] [ ][ ] OTHER....	[ ][ ] [ ][ ] OTHER....
5 CONDOM 'Men can use a rubber sheath during intercourse.'	YES/SPONT... 1-> YES/PROBED.. 2-> NO..... 3*	YES....1 NO.....2	[ ][ ] [ ][ ] OTHER... OTHER.....	[ ][ ] [ ][ ] OTHER.....

CONTINUE ON NEXT PAGE MORE METHODS)	* = next method	CODES FOR 304	CODES FOR 305
	GOVT. HOSPITAL	01	NOT EFFECTIVE 01
	GOVT. HEALTH CLINIC	02	PARTNER DISAPPROVES 02
	HCH CLINIC	03	INCONVENIENT TO USE 03
	PRIVATE HOSPITAL OR CLINIC	04	DIFFICULT TO GET 04
	PHARMACY	05	HEALTH CONCERN 05
	RELIGIOUS BODY	06	COSTS TOO MUCH 06
	GFPA CLINIC	07	OTHERS 07
	GFPA CBD	08	NONE 08
	GFPA FIELDWORKER	09	DK 98
	TBA	10	
	OTHERS	11	
	NOWHERE	12	
	DK	98	

	302 Have you ever heard of (METHOD)?	303 Have you ever used (METHOD)?	304 Where would you go to obtain (METHOD if you wanted to use it?) (CODES BELOW)	305 In your opinion What is the main problem if any using METHOD?
	READ DESCRIPTION			
06 FEMALE STERILISATION	YES/SPONT..1-> 'Women can have an operation to avoid having any more children	YES...1 YES/PROBED.2-> NO.....3*	[ ][ ] OTHER ....	[ ][ ] OTHER....
07 MALE STERILISATION	Yes/SPONT..1-> 'Men can have an operation to avoid having any more children	YES...1 YES/PROBED.2-> NO.....3*	[ ][ ] OTHER.....	[ ][ ] OTHER....
08 PERIODIC ABSTINENCE	YES/SPONT..1-> Couples can avoid intercourse on certain days when the women is more likely to become pregnant	YES...1 YES/PROBED.2-> NO.....3*	[ ][ ] OTHER .....	[ ][ ] OTHER....
09 WITHDRAWAL	'Men can be careful and pull out before climax.'	Yes/SPONT..1-> YES/PROBED.2-> NO.....3*	[ ][ ] OTHER....	[ ][ ] OTHER....
10 TRADITIONAL	'Women put on JUJU and use herbs to avoid or delay pregnancy.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	[ ][ ] OTHER ....	[ ][ ] OTHER....
11 ANY OTHER METHOD	Yes/SPONT..1-> 'Apart from the ones we have mentioned, have you heard of any other methods/ways to avoid or delay pregnancy ? SPECIFY.....'	YES...1 YES/PROBED.2-> NO.....3*	[ ][ ] OTHER ....	[ ][ ] OTHER....

* = next method	CODES FOR 304	CODES FOR 305
GOVT. HOSPITAL	01	NOT EFFECTIVE 01
GOVT. HEALTH CLINIC	02	PARTNER DISAPPROVES 02
HCH CLINIC	03	INCONVENIENT TO USE 03
PRIVATE HOSPITAL		DIFFICULT TO GET 04
OR CLINIC	04	HEALTH CONCERN 05
PHARMACY	05	COSTS TOO MUCH 06
RELIGIOUS BODY	06	OTHERS 07
GFPA CLINIC	07	NONE 08
GFPA CBD	08	DK 98
GFPA FIELDWORKER	09	
TBA	10	
OTHERS	11	
NOWHERE	12	
DK	98	

306 CHECK 303 : NOT A SINGLE "YES" (NEVER USED) (GO TO 307) AT LEAST ONE "YES" (EVER USED) 309

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
307	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES .....1 NO.....2-->328	
308	What have you used or done? Correct 302-303 AND OBTAIN INFORMATION FOR 304-306 AS NECESSARY		
309	CHECK 303 : EVER USED PERIODIC [1] ABSTINENCE	NEVER USED PERIODIC [2]----->311 ABSTINENCE	
10	The last time you used periodic abstinence, you how did you determine which days you had to abstain?	BASED ON CALENDER 1 BASED ON BODY TEMPERATURE 2 BASED ON CERVICAL MUCUS 3 BASED ON BODY TEMP. AND MUCUS 4 OTHER..... 5 (SPECIFY) NO SPECIFY SYSTEM 6	
11	How many living children, if any, did you already have when you first did something or used a method to avoid getting pregnant?	Number of Children.....[ ][ ]	
12	CHECK 227 : NOT PREGNANT OR NOT SURE [1]	PREGNANT [2]----->327	
13	Are you currently doing something or using any method to avoid getting pregnant?	YES.....1 NO.....2----->327	
14	Which method are you using?	PILL.....01----->315 IUD.....02-----  INJECTIONS.....03  >318 DIAPHRAGM/JELLY....04   CONDOM.....05-----  FEM. STERILISATION...06----->319 MALE STERILISATION..07----->319 PERIODIC ABSTINENCE.08-----  WITHDRAWAL.....09  >318 FOAMING TABLETS....10   TRADITIONAL.....11   OTHER.....12-----  (SPECIFY)	
15	At the time you first started using the PILL, did you consult a doctor or a nurse?	YES.....1 NO.....2 DK.....98	
16	At the time you last got pills, did you consult a doctor or a nurse ?	YES..... 1 NO..... 2 DK.....98	
17	How much does one packet (cycle) of pills cost you?	COST. (DALASIS) [ ][ ] FREE.....98 DK.....99	



<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>																												
328	Do you intend to use a method to avoid pregnancy at any time in future?	YES..... 1 No..... 2 DK.....98	1----->330																												
329	Why not?	DISAPPROVE OF F/P.... 1 PARTNER DISAPPROVES.. 2 HEALTH CONCERNS..... 3 RELIGIOUS REASONS.... 4 WANTS CHILDREN..... 5 OTHER..... 6 (SPECIFY) DK.....98	>332																												
330	Which method would you prefer to use?	PILL.....01 IUD.....02 INJECTIONS.....03 DIAPHRAGM/JELLY.....04 CONDOM.....05 FEM.STERILISATION.....07 PERIODIC ABSTINENCE...08 WITHDRAWAL.....09 FOAMING TABLETS.....10 TRADITIONAL.....11 OTHER.....12 (SPECIFY) DK.....98																													
331	Do you intend to use (PREFERRED METHOD) in the next 12 months?	YES.....1 NO.....2 DK.....98																													
332	In the last month, have you heard a message about family planning on the radio or attended a public meeting on family planning?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>RADIO</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>MEETING</td> <td>1</td> <td>2</td> <td>98</td> </tr> </tbody> </table>		YES	NO	DK	RADIO	1	2	98	MEETING	1	2	98																	
	YES	NO	DK																												
RADIO	1	2	98																												
MEETING	1	2	98																												
333	Is it acceptable to you that family planning information is provided on radio?	ACCEPTABLE.....1 NOT ACCEPTABLE.....2 DK.....98																													
334	Under what conditions would you approve of abortion carried out by a doctor ?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>LIFE OF WOMAN IS IN DANGER</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>DANGER TO HEALTH OF WOMAN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>WOMAN IS UNMARRIED</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>DANGER TO HEALTH OF CHILD TO BE BORN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>CANNOT AFFORD MORE CHILDREN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>WOMAN WANTS ABORTION</td> <td>1</td> <td>2</td> <td>98</td> </tr> </tbody> </table>		YES	NO	DK	LIFE OF WOMAN IS IN DANGER	1	2	98	DANGER TO HEALTH OF WOMAN	1	2	98	WOMAN IS UNMARRIED	1	2	98	DANGER TO HEALTH OF CHILD TO BE BORN	1	2	98	CANNOT AFFORD MORE CHILDREN	1	2	98	WOMAN WANTS ABORTION	1	2	98	
	YES	NO	DK																												
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CANNOT AFFORD MORE CHILDREN	1	2	98																												
WOMAN WANTS ABORTION	1	2	98																												

SECTION 4 : HEALTH AND BREASTFEEDING

401 CHECK 226:

ONE OR MORE LIVE BIRTHS SINCE OCTOBER 1985      NO LIVE BIRTH SINCE OCTOBER 1985      [2]----->SKIP TO 501

402 ENTER NAME AND SURVIVAL STATUS OF EACH BIRTH SINCE OCTOBER 1985 IN TABLE, BEGIN WITH LAST BIRTH. ASK QUESTIONS ABOUT EACH BIRTH.

LINE NUMBER FROM Q.216	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]
	:LAST BIRTH :NAME..... :ALIVE...DEAD...	:NEXT TO LAST BIRTH: :NAME..... :ALIVE.....DEAD..	:SECOND FROM LAST :NAME..... :ALIVE...DEAD...	:THIRD FROM LAST :NAME..... :ALIVE...DEAD...
403 When you were pregnant with (NAME):	: YES.....1	: YES.....1	: YES.....1	: YES.....1
were you given injection to prevent the baby from getting tetanus ?	: NO.....2 : DK.....98	: NO.....2 : DK.....98	: NO.....2 : DK.....98	: NO.....2 : DK.....98
404. When you were pregnant with (NAME) did you see anyone for a check on this pregnancy ? IF YES whom did you see? PROBE FOR TYPE OF PERSON AND RECORD THE MOST QUALIFIED	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5
405. Who assisted with the delivery (NAME) ? PROBE FOR TYPE OF PERSON AND RECORD THE MOST QUALIFIED	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5	:DOCTOR.....1 :TRAINED NURSE/ :MIDWIFE.....2 :TRADITIONAL :BIRTH :ATTENDANT.....3 :OTHER.....4 :(SPECIFY)....5 :NO ONE.....5
406. Did you feed (NAME) at the breast ?	: YES.....1 : NO.....2 :(IF NO SKIP TO : 409)	: YES.....1 : NO.....2 :(IF YES SKIP TO : 409)	: YES.....1 : NO.....2 :(IF YES SKIP TO : 409)	: YES.....1 : NO.....2 :(IF NO SKIP TO : 409)
407. Are you still breastfeeding (NAME)? (IF DEAD CIRCLE '2')	: YES.....1 :(IF YES SKIP TO : 409) : NO (OR DEAD)..2	: YES.....1 :(IF YES SKIP TO : 409) : NO (OR DEAD)..2	: YES.....1 :(IF YES SKIP TO : 409) : NO (OR DEAD)..2	: YES.....1 :(IF NO SKIP TO : 409) : NO (OR DEAD)..2

CONTINUATION SHEET FOR BRESTFEEDING

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407A. Why did you stop breastfeeding (NAME) ?
:CHILD DIED...01 :CHILD DIED...01 :CHILD DIED...01 :CHILD DIED... 01
:CHILD REACHED :CHILD REACHED :CHILD REACHED :CHILD REACHED
:WEANING AGE...02 :WEANING AGE...02 :WEANING AGE...02 :WEANING AGE.. 02
:CHILD BECAME :CHILD BECAME :CHILD BECAME :CHILD BECAME
:SICK.....03 :SICK.....03 :SICK.....03 :SICK..... 03
:CHILD HAVE :CHILD HAVE :CHILD HAVE :CHILD HAVE
:DIARRHOEA....04 :DIARRHOEA....04 :DIARRHOEA....04 :DIARRHOEA.... 04
:I BECAME :I BECAME :I BECAME :I BECAME
:PREGNANT.....05 :PREGNANT.....05 :PREGNANT.....05 :PREGNANT..... 05
:INSUFFICIENT :INSUFFICIENT :INSUFFICIENT :INSUFFICIENT
:MILK.....06 :MILK.....06 :MILK.....06 :MILK..... 06
:I HAD TO WORK.07 :I HAD TO WORK.07 :I HAD TO WORK.07 :I HAD TO WORK.07
:CHILD REFUSED :CHILD REFUSED :CHILD REFUSED :CHILD REFUSED
:BREAST.....08 :BREAST.....08 :BREAST.....08 :BREAST.....08
:INCONVENIENT..09 :INCONVENIENT..09 :INCONVENIENT..09 :INCONVENIENT..09
:OTHER REASON..10 :OTHER REASON..10 :OTHER REASON..10 :OTHER REASON..10
-----
408. How many months did you breatfeed (NAME)?
:MONTHS [ ][ ] :MONTHS [ ][ ] :MONTHS [ ][ ] :MONTHS [ ][ ]
:UNTIL DEATH.... :UNTIL DEATH.... :UNTIL DEATH.... :UNTIL DEATH....
: : : :
-----
409. How many months after the birth of (NAME) did your period return?
:MONTHS [ ][ ] :NOT RETURNED..96:NEVER RETURNED..96:NEVER RETURNED..96
: : : :
:(ALL SKIP TO 411) :(ALL SKIP TO 411):(ALL SKIP TO 411)
: : : :
-----
410. Have you resumed sexual relations since the birth of (NAME)?
:Yes (PREG.)....1 : : :
:NO.....2 : : :
:(IF NO GO TO NEXT : : :
: COLUMN) : : :
-----
411. How many months after birth of (NAME) did you resume sexual relation?
:MONTHS [ ][ ] :MONTHS [ ][ ] :MONTHS [ ][ ] :MONTHS [ ][ ]
: : : :
:(GO TO NEXT : (GO TO NEXT : (GO TO NEXT : (GO TO NEXT
: COLUMN) : COLUMN) : COLUMN) : COLUMN)
: : : :
-----
412. CHECK 407 FOR LAST CHILD STILL BREASTFEED
: : : :
: YES.....1 : NO.....2 : SKIP TO 501 :
: : : :
-----
413. How many times did you breastfeed last night between sundown and sunrise?
:NUMBER OF : : :
:TIMES.....[ ][ ] : : :
:AS OFTEN AS CHILD: : : :
:WANTED.....98 : : :
-----
414. How many times did you breastfeed yesterday during daylight hours ?
:NUMBER OF : : :
:TIMES.....[ ][ ] : : :
:AS OFTEN AS CHILD: : : :
:WANTED.....98 : : :
-----

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SECTION 5 : MARRIAGE

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
501	Have you ever been married or lived with a man?	YES.....1 NO.....2	----->523
502	Are you now married or living with a man, or are you widowed, divorced or not now living together?	MARRIED.....1 LIVING TOGETER.....2 WIDOWED.....3 DIVORCED.....4 SEPARATED.....5	----->507
503	Does your husband/partner live with you or is he now staying elsewhere?	LIVING WITH HERE....1 STAYING ELSEWHERE...2	
504	Does your husband/partner have any other wives besides yourself?	YES.....1 NO.....2 DK.....98	----->507 ----->507
505	How many other wives does he have?	NUMBER OF WIFES...[ ] DK.....98	
506	Are you his first, second wife?	RANK.....[ ]	
507	How old were you when you started living with your (first) husband or partner ?	Age.....[ ][ ]	
508	Do you think this was at an earlier age than desirable ?	YES.....1 NO.....2 DK.....98	----->510 ----->510
509	Why did you think you started living with your (first) husband or partner at an earlier age than desirable?	RELIGIOUS FACTORS...1 FAMILY TRADITION...2 ECONOMIC CONDITION..3 NO OPPORTUNITIES OF FURTHER EDUCATION...4 GOT PREGNANT.....5 OTHER .....6 (SPECIFY).....7 DK.....98	
510	Have you been married to or lived with a man once or more than once?	ONCE.....1 MORE THAN ONCE.....2	----->514
511	In what month and year did you start living with your: 1st husband mth [ ][ ] DK.....98 Year [ ][ ] DK.....98  2nd husband mth [ ][ ] DK.....98 Year [ ][ ] DK.....98  3rd husband mth [ ][ ] DK.....98 Year [ ][ ] DK.....98	512 How did the marriage end? DEATH.....1 DIVORCE.....2 ABANDONMENT.3  DEATH.....1 DIVORCE.....2 ABANDONMENT.3 NOT ENDED...4  DEATH.....1 DIVORCE.....2 ABANDONMENT.3 NOT ENDED...4	513 In what month and year did the marriage end? mth [ ][ ] DK.....98 year [ ][ ] DK.....98  mth [ ][ ] DK.....98 YEAR [ ][ ] DK.....98  mth [ ][ ] DK [ ][ ] YEAR.....98 DK.....98

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO		
			YES	NO	DK
514	Are your mother and father still alive?	MOTHER ALIVE FATHER ALIVE	1 1	2 2	98 98
515	Are your (first) husband's/partner's mother and father still alive?	MOTHER ALIVE FATHER ALIVE	1 1	2 2	98 98
516	CHECK 514 AND 515: AT LEAST ON PARENT NOT LIVING OR DK [ ]--> (GO TO 517)	ALL ALIVE [2]			-----> 519
517	Was (MENTION PARENTS NOT ALIVE NOW OR DK) alive at the time you began living together with your (first) husband or partner?	WOMAN'MUM WOMAN'DAD FIRST HUSBAND'S MOTHER FIRST HUSBAND'S FATHER	1 1 1 1	2 2 2 2	98 98 98 98
518	CHECK 517 : SOME PARENT ALIVE AT MARRIAGE [1] NO PARENT ALIVE AT MARRIAGE [2]				-----> 522
519	At the time you began living together, did you and your (first) husband/partner live with any of these parents for at least six months?	YES..... NO.....			1 2->521
520	For about how many years did you live together with a parent at that time?	YEARS..... UP TO THE PRESENT.....			{ } [ ] 97
521	Are you now living either with your parents or your husband's parents?	YES..... NO.....			1 2
522	In how many localities have you lived for six months or more since you were first married (started living together) including this place?	NUMBER OF LOCALITIES.....			[ ] [ ] -->524
523	Have you ever had sexual intercourse?	YES..... NO.....			1 2--->533
524	Now we need some details about your sexual activity in order to get a better understanding of contraception and fertility. How old were you when you first had sexual intercourse?	AGE.....			{ } [ ]
525	Have you had sexual intercourse in the last four weeks?	YES..... NO.....			1 2--->527
526	How many times ?	TIMES.....			{ } [ ]

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
527	When was the last time you had sexual intercourse?	DAYS AGO.....[ ][ ] WEEKS AGO.....[ ][ ] MONTHS AGO.....[ ][ ] BEFORE LAST BIRTH.....[ ][ ]	
528	CHECK 227: NOT PREGNANT OR NOT SURE [1]                      PREGNANT [2]		----->532
529	CHECK 313: NOT USING                      [1]                      USING [2]		----->533
530	What is the main reason that you are not using a method to avoid pregnancy?	WANT CHILDREN..... 01 LACK OF KNOWLEDGE..... 02 OPPOSED TO F.P..... 03 HUSBAND DISAPPROVES..... 04 OTHERS DISAPPROVES..... 05 HEALTH CONCERNS..... 06 DIFFICULT TO GET..... 07 COST TOO MUCH..... 08 INCONVENIENT TO USE..... 09 INFREQUENT SEX..... 10 FATALISTIC..... 11 RELIGION..... 12 POSTPARTUM/BREASTFEEDING.13 MENOPAUSAL/SUBFECUND.....14 OTHER.....15 (SPECIFY) DK.....98 NS.....99	
531	If you become pregnant in the next few weeks, would you feel happy, unhappy, or would it not matter very much?	HAPPY.....1 UNNHAPPY.....2 WOULD NOT MATTER.....3	
532	What sex would you prefer for your excepted (next) child or doesn't it matter?	MALE.....1 FEMALE.....2 DOESN'T MATTER.....3	
533	PRESENCE OF OTHERS AT THIS POINT	No others.....1 Child under 10.....2 Husband.....3 Other males.....4 Other Females.....5	

SECTION 6 : FERTILITY PREFERENCES

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
601	CHECK 502: CURRENTLY MARRIED OR LIVING TOGETHER [1]	ALL OTHERS [2]	-----> 613
602	CHECK 227 AND MARK BOX. Now I have some questions about the future NOT PREGNANT OR NOT SURE [1] Would you like to have a (another) child or would you prefer not to have any (more) children? PREGNANT [2] After the child you are expecting would you like to have another or would you prefer not to have any more children?	HAVE ANOTHER.....1 NO MORE.....2 CAN'T GET PREGNANT.....3 UNDECIDED OR DK.....8 NS.....9	
603	Would you prefer your expected (next) child to be a boy or a girl or doesn't it matter?	BOY..... 1 GIRL..... 2 DOESN'T MATTER..... 3	
604	How long would you want to wait now before the birth of a (another) child?	TIME TO WAIT MONTHS..... [ ] YEARS..... [ ] DK.....98	
605	CHECK 218: How old would you like your youngest child to be when you have your next child?	AGE OF YOUNGEST YEARS..... [ ] NO LIVING CHILD.....97 DK.....98	
606	CHECK 216: TWO OR MORE BIRTHS	LESS THAN TWO BIRTHS	-----> 609
607	What do you think of the time difference between your last two births?	TOO SHORT.....1 TOO LONG.....2 AS DESIRED.....3 DK.....8 NS.....9	
608	What was the main reason?	RELIGIOUS.....1 FAMILY TRADITION.....2 HUSBAND DECISION.....3 LACK OF FP KNOWLEDGE...4 NO ACCESS TO FP.....5 FAILURE OF FP METHOD....6 CO-WIVES HAD MORE CHILDREN.....7 INCIDENCE OF INFANT MORTALITY.....8 OTHER.....9 (SPECIFY) DK.....98	

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
609	For how long should a couple wait before starting sexual intercourse after the birth of a baby	MONTHS.....[ ][ ] YEARS.....[ ][ ] OTHERS.....98 (SPECIFY)	
610	Should a mother wait until she has completely stopped breastfeeding before starting to have sexual relations again or doesn't it matter?	WAIT.....1 DOESN'T MATTER.....2	
611	Do you think that your husband/partner approves or disapproves of couples using a method to avoid pregnancy?	APPROVES.....1 DOESN'T MATTER.....2	
612	How often have you talked to your husband/partner about his subject in the past year?	NEVER.....1 ONCE OR TWICE.....2 THRICE OR MORE.....3 DK.....98	
613	In general, do you approve or disapprove of couples using a method to avoid pregnancy?	APPROVE.....1 DISAPPROVE.....2	
614	CHECK 207 AND 209:		
	HAS NO LIVING CHILDREN [1] If you could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?	NUMBER OF SONS...[ ][ ] NUMBER OF DAUGHTERS.....[ ][ ] AS MANY AS GOD WILLS.....97 DK.....98 NS.....99	
	HAS LIVING CHILDREN [2] If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life how many sons and daughters would you like to have?	NUMBER OF SONS [ ][ ] NUMBER OF DAUGHTERS.....[ ][ ] AS MANY AS GOD WILLS.....97 DK.....98 NS.....99	

SECTION 7 : HUSBAND'S BACKGROUND AND WOMAN'S WORK

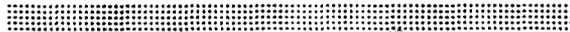
NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
701	CHECK 501 : EVER MARRIED OR LIVED WITH A MAN [1]	ALL OTHERS [2]	----->715
ASK QUESTIONS ABOUT CURRENT OR MOST RECENT HUSBAND/PARTNER			
702	Now I have some questions about your (most recent) husband/partner Did your husband/partner ever attend school?	YES..... 1 NO..... 2 DK..... 8	----->706 ----->706
703	What was the highest level of school he attended: primary, secondary technical, high school, vocationnal, or college/university	PRIMARY..... 1 SECONDARY TECHNICAL. 2 HIGH SCHOOL..... 3 VOCATIONAL..... 4 COLLEGE/UNIVERSITY.. 5 DK..... 8	
704	What was the highest Grade he completed at that level?	GRADE..... [ ] DK..... 98	
705	CHECK 703 : PRIMARY      SECONDARY      TECHNICAL [1]      OR HIGHER      [2]		----->707
706	Can (could) he read a letter or newspaper easily, with difficulty or not at all?	EASILY..... 1 WITH DIFFICULTY.... 2 NOT AT ALL..... 3 DK..... 98	
707	What is (was) the nationality of your husband /partner ?	GAMBIAN..... 1 NON-GAMBIAN..... 2 SPECIFY..... 3 (COUNTRY)	
708	What is (was) the religion of your husband/partner?	ISLAM..... 1 CHRISTIANITY..... 2 TRADITIONNAL/ANIMISM.3 OTHERS..... 4 (SPECIFY) DK..... 98	
709	What is (was) the ethnic group of your husband/partner?	MANDINKA..... 1 FULA..... 2 WOLLOF..... 3 JOLA..... 4 SARAHULE..... 5 SERERE..... 6 MANJAGO..... 7 AKU..... 8 OTHERS..... 9 (SPECIFY)	
710	What kind of work does (did) your husband/partner mainly do?		
711	CHECK 710 : DOES (DID) NOT WORK IN AGRICULTURE [ ] (GO TO 712)	WORKS (WORKED) IN AGRICULTURE [ ]	----->713

<u>NO</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
712	Does (did) he work most of the time, part of the time, seasonally or irregularly?	Most.....1 Part.....2 Seasonally.....3 Irregularly.....4 OTHER.....5	
713	Does (did) your husband/partner work mainly on his or family land or on someone else's land?	HIS/FAMILY LAND.....1 SOMEONE ELSE'S LAND.....2	----->715
714	Does (did) he work mainly for money or does (did) he work for a share of the crops?	MONEY.....1 A SHARE OF CROPS.....2	
715	Aside from their usual housework, mainly women work in order to earn money. Are you currently doing any work for money, other than on a farm or business run by your family?	YES.....1 NO.....2	----->722
716	What is your occupation, that is, what kind of work do you do?	..... .....	
717	In a typical day, week or month, how much do you earn for this work?	AMOUNT D..... PER HOUR.....1 PER DAY.....2 PER WEEK.....3 PER MONTH.....4 BY YEAR.....5	
718	Do you usually work at this job most of the time, part of the time, or do you work seasonally or irregularly?	MOST.....1 PART.....2 SEASONALLY.....3 IRREGULARLY.....4 OTHER.....5	
719	On a typical day when you are doing this work, how many hours do you spend working?	HOURS.....[ ][ ]	
720	On a typical working day, how long does it take you to travel to the place where you work? PROBE: About how many minutes or hours?	HOURS.....[ ][ ] MINUTES.....[ ][ ] WORKS WHERE RESIDES..97	
721	Most of the time when you work for money, do you decide how <u>all</u> the money you earn will be used, how <u>some</u> of it will be used, or does <u>someone else</u> decide how your earnings are used?	DECIDES ABOUT ALL.... 1 DECIDES ABOUT SOME... 2 SOMEONE ELSE DECIDES. 3	
722	Whether you have worked in the past or not, do you think it is alrith for a mother to work away from home, if her children can be adequately cared for?	YES..... 1 NO..... 2 DK.....98	

QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
723 And how would the members of your family feel about you working away from home? Would they be against it or wouldn't they mind?	AGAINST.....1 WOULDN'T MIND.....2 SOME EACH WAY.....3 UNCERTAIN.....4	
----- 724 CHECK 219, 222, 715 : HAS LIVE CHILDREN (AGE 8 LIVING AT HOME AND IS ALL OTHERS CURRENTLY WORKING [ ] [ ]-----> 727		
725 While you are working do you usually have your children under age 6 with you, sometimes have them with you, rarely have them with your or never have them with you?	USUALLY.....1----->727 SOMETIMES.....2 RARELY.....3 NEVER.....4	
726 Who usually takes care of your children under age 6 while you are working?	HUSBAND.....01 OTHER CHILDREN.....02 OTHER RELATIVES IN OR NEAR HOUSEHOLD.....03 OTHER RELATIVES FATHER AWAY.....04 NEIGHBOURS.....05 FRIENDS/ACQUAINTANCES.06 SERVANTS/HIRED HELP...07 THEY ARE AT SCHOOL ...08 INSTITUTIONAL CHILD CARE SERVICE.....09 OTHER.....10 (SPECIFY)	
----- 727 CHECK 501 : EVER MARRIED/ LIVED WITH A MAN [ ] NEVER MARRIED/ LIVED WITH A MAN [ ]-----> 732		
728 What was the age of your first husband at the time of your marriage?	AGE.....[ ][ ] DK.....98	
729 Before you were first married or lived with a man, did you ever work for money other than on a farm or business run by your family?	YES.....1 NO.....2----->732	
730 What was your occupation, that is what kind of work did you do?	..... .....	
731 Most of the time when you worked for money before marrying/living with a man, did you decide how all the money you earned would be used, how some of it would be used, or did someone else decide how your earnings would be used?	DECIDED ABOUT ALL.....1 DECIDED ABOUT SOME.....2 SOMEONE ELSE DECIDE....3	
----- 732 THANK THE RESPONDENT FOR ALL THE TIME SHE HAS SPENT WITH YOU.		

SURVEY OF CONTRACEPTIVE PREVALENCE AND  
FERTILITY DETERMINANTS IN THE GAMBIA

INDIVIDUAL QUESTIONNAIRE (MALES 18 AND ABOVE)



LOCAL GOVERNMENT AREA.....[ ][ ]

ENUMERATION AREA NO..... [ ][ ][ ][ ][ ][ ][ ]

NAME OF VILLAGE/TOWN.....

DISTRICT.....

HEALTH REGION.....

TYPE OF SETTLEMENT	PHC	1
	NON-PHC	2
	PHC & NON-PHC	3
	URBAN	4

IF (3), SPECIFY WHETHER HOUSEHOLD.....	PHC	1
	OR NON-PHC	2

HOUSEHOLD NUMBER.....[ ][ ]

LINE NUMBER.....[ ][ ]

NAME OF MAN.....

LINE NUMBER OF WIFE (1).....[ ][ ]

LINE NUMBER OF WIFE (2).....[ ][ ]

LINE NUMBER OF WIFE (3).....[ ][ ]

LINE NUMBER OF WIFE (4).....[ ][ ]

ROUND OF DATA COLLECTION	1	2	3	FINAL VISIT
--------------------------	---	---	---	-------------

DATE

INTERVIEWER'S NAME

RESULT\*\*

NEXT VISIT : DATE	.....	.....	.....	TOTAL NUMBER OF VISITS
TIME	.....	.....	.....	.....

\*\* RESULT CODES :    1 COMPLETED    2 NOT AT HOME    3 POSTPONED  
                           4 REFUSED            5 PARTLY COMPLETED  
                           6 OTHER (SPECIFY).....

	FIELD EDITED BY	OFFICE EDITED BY	KEYED BY
NAME	.....	.....	.....
	.....	.....	.....

**SECTION 1. RESPONDENT'S BACKGROUND**

<u>NO.</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
101	What is your nationality?	GAMBIAN..... 1 NON GAMBIAN..... 2 Specify ..... (COUNTRY)	
102	First I would like to ask some questions about you and your household. For most of the time until you were 12 years old, did you live in a village, or a town or a city?	VILLAGE..... 1 TOWN..... 2 CITY..... 3	
103	How long have you been living continuously in this..... (NAME OF VILLAGE, TOWN, CITY)?	ALWAYS..... 1--->105 VISITOR..... 2--->105  YEARS.....[ ][ ]	
104	Just before you moved here, did you live in a village, in a town or in a city?	VILLAGE..... 1 TOWN..... 2 CITY..... 3	
105	In what month and year were you born?	MONTH.....[ ][ ] DK MONTH.....98 YEAR.....[ ][ ] DK YEAR.....98	
106	How old were you at your last birthday?  COMPARE AND CORRECT 105 AND/OR 106 IF INCONSISTENT	AGE IN COMPLETED YEARS [ ][ ]	
107	What is your religion?	ISLAM..... 1 CHRISTIANITY.... 2 TRADITIONNAL/ANIMIS 3 OTHERS..... 4 (SPECIFY) DK..... 98	
108	What is your ethnic group?	MANDINKA..... 1 FULA..... 2 WOLLOF..... 3 JOLA..... 4 SARAHULE..... 5 SERERE..... 6 MANJAGO..... 7 AKU..... 8 OTHERS..... 9 (SPECIFY)	
109	Have you ever attended school?	YES..... 1 NO..... 2----->113	

<u>NO.</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
110	What was the highest level of school you attended: primary, secondary technical, high school, vocational, or college/university	PRIMARY..... 1 SECONDARY TECHNICAL 2 HIGH SCHOOL..... 3 VOCATIONAL..... 4 COLLEGE/UNIVERSITY 5	
111	What was the highest Grade you completed at that level?	GRADE [ ]	
112	CHECK 110: PRIMARY [ ]                      SECONDARY TECHNICAL OR HIGHER [ ]		-----> 114
113	Can you read a letter or newspaper easily, with difficulty or not at all?	EASILY..... 1 WITH DIFFICULTY.... 2 NOT AT ALL..... 3	
114	How many years of Koranic education do you have?	YEARS [ ][ ]	
115	Do you listen to a radio at least once a week?	YES..... 1 NO..... 2	
116	What kind of work do you mainly do?	..... .....	
117	CHECK 116 : DOES NOT WORK IN AGRICULTURE [ ]	WORKS IN AGRICULTURE [ ]	----->119
118	Do you work most of the time, part of the time, seasonally or irregularly?	MOST..... 1 PART..... 2 SEASONALLY..... 3 IRREGULARLY..... 4 OTHER..... 5	----->201
119	Do you work mainly on your own or family land or non someone else's land?	HIS/FAMILY LAND. 1 SOMEONE ELSE'S LAND 2	
120	Do you work mainly for money or do you work for a share of the crops?	MONEY..... 1 A SHARE OF CROPS. 2	

**SECTION 2 : CONTRACEPTION**

01. Now I would like to talk about a different topic. There are various ways or methods that a couple can use to delay or avoid a pregnancy. Which of these ways or methods have you heard about? CIRCLE CODE 1 IN 202 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE COLUMN READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE 2 IF METHOD IS RECOGNISED AND CODE 3 IF NOT RECOGNISED. THEN FOR EACH METHOD WITH CODE 1 OR 2 CIRCLED IN 202, ASK 203 - 205 BEFORE PROCEEDING TO THE NEXT METHOD

	202 Have you heard (Method)?	203 Have you ever used?	204 Where would you go to obtain (METHOD) if you wanted to use it?	205 In your what is the main problem with using (METHOD)?
READ DESCRIPTION	(METHOD) ?	(CODES BELOW)		
PILL 'Women can take a pill everyday.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] OTHER.....	[ ][ ] OTHER.....
IUD 'Women can have loop or coil placed inside them by a doctor or a nurse.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] OTHER.....	[ ][ ] OTHER.....
INJECTIONS 'Women can have an injection by doctor or nurse which stops them from becoming pregnant for several months.'	YES/SPONT..1-> YES>PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] OTHER.....	[ ][ ] OTHER...
DIAPHRAGM/FOAM/JELLY 'Women can place a sponge, suppository, diaphragm, jelly or cream inside them before intercourse.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] OTHER.....	[ ][ ] OTHER.....
CONDOM 'Men can use a rubber sheath during intercourse'.	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] OTHER.....	[ ][ ] OTHER.....

CONTINUE ON NEXT PAGE OR MORE METHODS)

\* =next method.

CODES FOR 204		CODES FOR 205	
GOVT.HOPITAL	01	NOT EFFECTIVE	01
GOVT. HEALTH CLINIC	02	PARTNER DISAPPROVES	02
MCH CLINIC	03	INCONVENIENT TO USE	03
PRIVATE HOSPITAL OR CLINIC	04	DIFFICULT TO GET	04
PHARMACY	05	HEALTH CONCERN	05
RELIGIOUS BODY	06	COST TOO MUCH	06
GFPA CLINIC	07	OTHERS	07
GFPA CBD	08	NONE	08
GFPA FIELDWORKER	09	DK	98
TBA	10		
OTHERS	11		
NOWHERE	12		
DK	98		

	READ DESCRIPTION	(METHOD)	WANTED TO USE (CODES BELOW)	MAIN PROBLEM USING METHOD
6	FEMALE STERILISATION 'Women can have an operation to avoid having any more children.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] [ ][ ]
7	MALE STERILISATION 'Men can have an operation to avoid having any more children.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 No....2	[ ][ ] [ ][ ]
8	PERIODIC ABSTINENCE 'Couples can avoid intercourse on certain days when the woman is more likely to become pregnant.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO... 2	[ ][ ] [ ][ ]
9	Withdrawal, 'Men can be careful and pull out before climax.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] [ ][ ]
10	TRADITIONAL 'Women put on JUJU and use herbs to avoid or delay pregnancy.'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] [ ][ ]
11	ANY OTHER METHOD 'A part from the ones we have mentioned, have you heard of any other methods/ ways to avoid or delay pregnancy? SPECIFY.....'	YES/SPONT..1-> YES/PROBED.2-> NO.....3*	YES...1 NO....2	[ ][ ] [ ][ ]

\* =next method.

CODES FOR 204		CODES FOR 205	
GOVT.HOSPITAL	01	NOT EFFECTIVE	01
GOVT. HEALTH CLINIC	02	PARTNER DISAPPROVES	02
MCH CLINIC	03	INCONVENIENT TO USE	03
PRIVATE HOSPITAL OR CLINIC	04	DIFFICULT TO GET	04
PHARMACY	05	HEALTH CONCERN	05
RELIGIOUS BODY	06	COSTS TOO MUCH	06
GFP A CLINIC	07	OTHERS	07
GFP A CBD	08	NONE	08
GFP A FIELDWORKER	09	DK	98
TBA	10		
OTHERS	11		
NOWHERE	12		
DK	98		

206 CHECK 203 : NOT A SINGLE "YES"? AT LEAST ONE "YES"  
(NEVER USED) [ ]-----> (GO TO 207) (EVER USED) [ ]----> 209

10.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
07	Have you and your wife(s)/partner ever used any thing or tried to delay or avoid having a child?	YES.....1 NO.....2--> 212	
-----			
08	What have you used or done? CORRECT 202-203 AND OBTAIN INFORMATION FOR 204 TO 206 AS NECESSARY.		
-----			
09	How many living children, if any did you already have when you first did something or used a method to avoid having a child?	NUMBER OF CHILDREN [ ][ ]	
-----			
10	Are you and your wife(s)/partener(s) currently doing something or using any method to avoid having a child ?	Yes..... 1 No..... 2--->212	
-----			
11	Which method(s) are you using?	PILL.....01 IUD.....02 INJECTIONS.....03 CONDOM.....04 DIAPHRAGM/JELLY.....05 FEM.STERILISATION...06 MALE STERILISATION..07 PERIODIC ABSTINENCE.08 WITHDRAWAL.....09 FOAMING TABLETS....10 TRADITIONNAL.....11 OTHER.....12 (SPECIFY)	} >216
-----			
2	Do you intend to use a method to avoid pregnancy at any time in the future?	YES..... 1-->214 NO..... 2 DK.....98-->216	
-----			
3	Why not?	DISAPPROVE OF F/P... 1 PARTNER DISAPPROVES. 2 HEALTH CONCERNS..... 3 RELIGIOUS REASONS... 4 WANTS CHILDREN..... 5 OTHER..... 6 (SPECIFY) DK.....98	} >216
-----			
4	Which method would you prefer to use?	PILL.....01 IUD.....02 INJECTIONS.....03 CONDOM.....04 DIAPHRAGM/JELLY.....05 FEM.STERILISATION...06 MALE STERILISATION..07 PERIODIC ABSTINENCE.08 WITHDRAWAL.....09 FOAMING TABLETS....10 TRADITIONNAL.....11 OTHER.....12 (SPECIFY) DK.....98	

<u>Q.</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>																												
15	Do you intend to use (PREFERRED METHOD) in the next 12 months?	YES.....1 NO.....2 DK.....98																													
16	Where would you go to get information about family planning ?	GOVT.HOPITAL.....01 GOVT. HEALTH CLINIC.02 MCH CLINIC.....03 PRIVATE HOSPITAL OR CLINIC.....04 PHARMACY.....05 RELIGIOUS BODY.....06 GFPA CLINIC.....07 GFPA CBD.....08 GFPA FIELDWORKER...09 TBA.....10 OTHERS.....11 (SPECIFY) DK.....98																													
217	Is it acceptable to you that family planning information is provided on radio?	ACCEPTABLE.....1 NOT ACCEPTABLE.....2 DK.....98																													
218	In general, do you approve or disapprove of couples using a method to avoid pregnancy?	APPROVE.....1 DISAPPROVE.....2																													
219	Under what conditions would you approve of abortion carried out by a doctor?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>LIFE OF WOMAN IS IN DANGER</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>DANGER TO HEALTH OF WOMAN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>WOMAN IS UNMARRIED</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>DANGER TO HEALTH OF CHILD TO BE BORN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>CANNOT AFFORD MORE CHILDREN</td> <td>1</td> <td>2</td> <td>98</td> </tr> <tr> <td>WOMAN WANTS ABORTION</td> <td>1</td> <td>2</td> <td>98</td> </tr> </tbody> </table>		YES	NO	DK	LIFE OF WOMAN IS IN DANGER	1	2	98	DANGER TO HEALTH OF WOMAN	1	2	98	WOMAN IS UNMARRIED	1	2	98	DANGER TO HEALTH OF CHILD TO BE BORN	1	2	98	CANNOT AFFORD MORE CHILDREN	1	2	98	WOMAN WANTS ABORTION	1	2	98	
	YES	NO	DK																												
LIFE OF WOMAN IS IN DANGER	1	2	98																												
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DANGER TO HEALTH OF CHILD TO BE BORN	1	2	98																												
CANNOT AFFORD MORE CHILDREN	1	2	98																												
WOMAN WANTS ABORTION	1	2	98																												

SECTION 3 MARRIAGE

<u>NO.</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
301	Have you ever been married or lived with a woman ?	YES.....1 NO.....2	----->405
302	Are you now married or living with a woman or are you widowed divorced or not now living together?	MARRIED.....1 LIVING TOGETHER.....2 WIDOWED.....3 DIVORCED.....4 NOT NOW LIVING TOGETHER.....5	
03	At what age did you first get married?	YEARS.....[ ][ ] DK.....98	
04	How many wives do you have?	ONE WIFE.....1 TWO WIVES.....2 THREE WIVES.....3 FOUR WIVES.....4 MORE THAN FOUR WIVES.....5	
05	What was the reason for marrying again?	SOCIAL PRESTIGE.... 1 FAMILY TRADITION....2 WE HAD NO CHILDREN.....3 DESIRE FOR MORE CHILDREN.....4 MIGRATION.....5 OTHER.....6 (SPECIFY) DK.....98	
06	At the time of marriage to her how old was your first wife, second wife.....?	AGE DK FIRST WIFE [ ][ ] 98 SECOND WIFE [ ][ ] 98 THIRD WIFE [ ][ ] 98 FOURTH WIFE [ ][ ] 98	

**SECTION 4. REPRODUCTIVE AND SOCIAL ATTITUDES**

<u>NO.</u>	<u>QUESTIONS AND FILTERS</u>	<u>CODING CATEGORIES</u>	<u>SKIP TO</u>
401	How many own sons do you have? And how many own daughters do you have?	SONS  DAUGHTERS	[ ] [ ]  [ ] [ ]
402	NOW I HAVE SOME QUESTIONS ABOUT THE FUTURE: Would you like to have a (another) child or would you prefer not to have any (more) children?	HAVE ANOTHER.....1 NO MORE.....2 NOT SURE OR DK.....98	
403	CHECK 401: HAS NO LIVING CHILDREN [ ] If you could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?	NUMBER OF SONS [ ] [ ] NUMBER OF DAUGHTERS [ ] [ ] AS MANY AS GOD WILLS.....97 DK.....98	
404	HAS LIVING CHILDREN [ ] If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many sons and daughters would you like to have?	NUMBER OF SONS [ ] [ ] NUMBER OF DAUGHTERS [ ] [ ] AS MANY AS GOD WILLS.....97 DK.....98	
405	Do you approve of a girl going to school?	YES.....1----->40 NO.....2 DK.....98----->40	
406	Why not? Give reason.	..... ..... .....	
407	In your opinion, at what age should a girl get married?	AGE [ ] [ ] ON ATTAINING PUBERTY.....97 DK.....98----->40	
408	Why do you consider this age to be appropriate?	RELIGION/TRADITION..... 1 AVOID PRE-MARRIAGE PREGNANCY..... 2 AVOID FORNICATION..... 3 ENSURE EARLY BIRTH..... 4 OBTAIN EDUCATION..... 5 ATTAIN MATURITY..... 6 OTHER..... 7 (SPECIFY) DK..... 98	
409	Why do you think people want to have as many children as possible?	GIFTS OF NATURE.....1 INFANT MORTALITY.....2 ECONOMIC ASSETS.....3 SOCIAL PRESTIGE.....4 OTHER.....5 (SPECIFY) DK.....98	

THANK THE RESPONDANT FOR ALL THE TIME HE HAS SPENT WITH YOU.