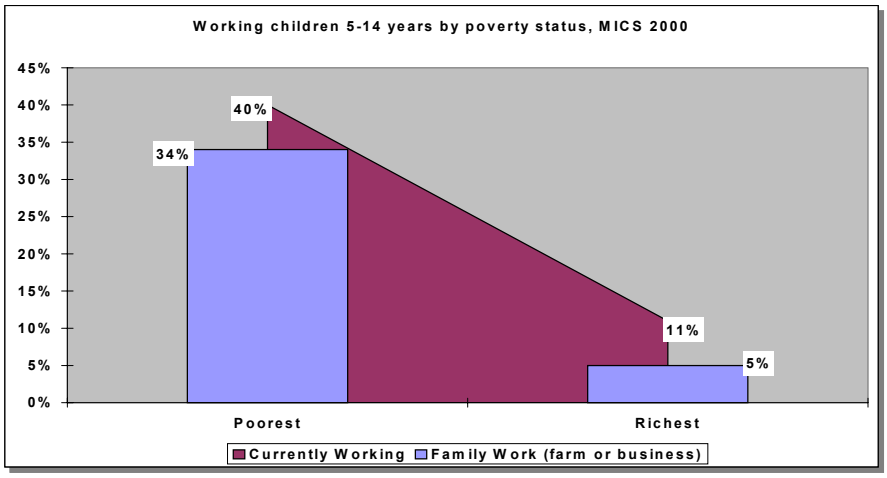
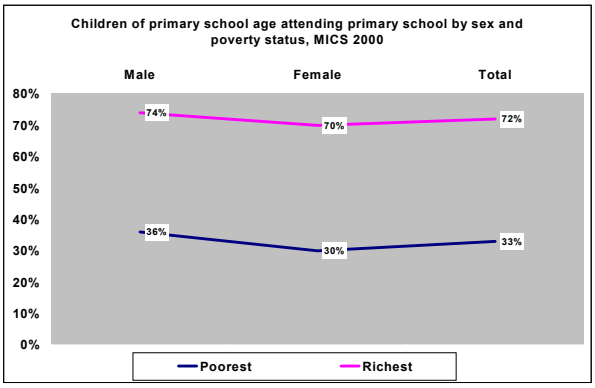
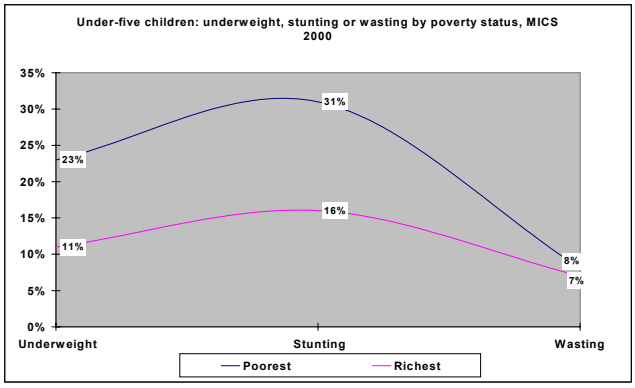
REPUBLIC OF THE GAMBIA

The Gambia Multiple Indicator Cluster Survey Report, 2000







Government of The Gambia in collaboration with UNICEF

Contents

List of Figures

Foreword and Acknowledgements

The Declaration and Plan of Action adopted at the World Summit for Children, held in New York in September 1990, established a set of goals for the decade 1990 to 2000. With regards to this, a study was first conducted in 1996 and a similar or even more comprehensive one conducted in May/June 2000. Both studies were aimed at monitoring progress made by The Gambia towards the attainment of the Mid-decade and End-decade goals set during the above-mentioned Summit.

By the ratification of the CRC and CEDAW, The Gambia like many UN member States committed itself to the improvement of the plight of children and women by the year 2000. The two conventions are not only comprehensive and holistic in nature but also have high impact on the plight of children and women when implemented simultaneously. The social and welfare status of both women and children will be markedly improved, thereby enhancing sustainable development in each member state.

To evaluate the efforts towards implementation of these conventions, UNICEF in collaboration with other UN agencies such as WHO, UNFPA and the US Public Health Services develop the Multiple Indicate Cluster Survey (MICS). The MICS is a household survey that examines the behaviours of a comprehensive set of indicators related to the welfare of children and women. The modules development for the survey captured data on Household (economy), Education, Child Labour, Maternal Mortality, Water and Sanitation, Salt Iodization and health i.e. Oral Rehydration Solution (ORS), Child Mortality, Tetanus Toxoid, Maternal & Newborn Health, Contraceptive use, HIV/AIDS, Vitamin A supplementation, Breastfeeding care of illness, Malaria, Immunization and Anthropometry.

In 2000, The government of The Gambia in collaboration with UNICEF and other partners carried out the second MICS to monitor progress made at End-decade as articulated in the National Plan of Action. The survey was conducted through inter-agency collaboration with the Central Statistics Department acting as the leading/co-ordinating agency. Collaborating agencies included the Department of State for Health (DoSH), Department of State for Education (DoSE), Department of Community Development, Women's Bureau, Department of Water Resources, Department of Social Welfare and other NGOs such as the Gambia Family Planning Association (GFPA) and the Gambia-German Family Planning Project (GGFPP). The prototype questionnaires developed by UNICEF were used with some modification to suit the local conditions. However, in The Gambia a module on Knowledge on Rehydration solutions was added to determine the rate at which women know how to prepare the salt-sugar solution (SSS) as it is necessary, as ORS packet may not be available at certain times when needed.

A word of thanks and gratitude are in order here for all persons and agencies that participated in the different phases of this study especially UNICEF-Banjul Office that funded the survey. Similar sentiments are also extended to the Co-ordinator, Mr. Nyakassi M.B Sangyang and his supporting colleagues, Mr Alieu Saho and Mr Alieu Sarr for their administrative assistance as well as their invaluable contributions in the preparation of the report. I also register my gratitude to Ms Isatou Sissoho, WATSAN Project Officer and Mr Sheriffo Sonko, Project Officer, Monitoring and Evaluation both of UNICEF-Banjul Office for their support in providing logistics needed for the implementation of the study and technical support respectively. Last but not least, I would like to extend our sincere thank and appreciation to Mr. Edrissa Ceesay and Ms Lolly Jallow our programmers both of CSD for their invaluable efforts in providing the required tables. Finally, we hope that all scholars, researchers, planner and decision-makers would find these research results useful.

Alieu S.M. Ndow

Director of Statistics

February 20, 2002

Executive Summary

The 2000 Gambia Multiple Indicator Cluster Survey (MICS) is a nationally representative survey of households, women, and children. The main objectives of the survey are to provide up-to-date information for assessing the situation of children and women in The Gambia at the end of the decade. Another objective is to furnish data needed for monitoring progress towards the goals established at the World Summit for Children as a basis for future action.

Infant and Under Five Mortality

- Distortions in the MICS data on deaths among children preclude obtaining estimates of very recent mortality rates. The data from the 1993 Census show that the infant and under-five mortality rate were 84 and 129 per 1, 000 respectively. Estimates from the MICS2 appear to suggest that both infant and under-five mortality have increased to 98 and 141 per 1, 000 respectively. In fact, the IMR and U5MR data from UNICEF (2000) also do suggest that both have increased. Estimates from UNICEF indicate both the IMR and U5MR at 92 and 128 per 1, 000 respectively.

Education

- Fifty-two per cent of children of primary school age in The Gambia are attending primary school. School attendance in the Basse and Janjanbureh are significantly lower than in the rest of the country at 29 and 30 per cent respectively. At the national level, there is slight difference between male and female primary school attendance at 54 and 49 per cent respectively.
- Almost all (97 per cent) the children who enter the first grade of primary school eventually reach grade five.
- Less than half (36 per cent) of the population over age 15 years is literate. The percentage literate declines from 52 per cent among those aged 15-24 to 16 per cent among the population aged 65 and older. In a similar trend literacy rates decline from among those who live in Banjul from 64 to 20 per cent from among those who live in Basse.

Water and Sanitation

- Eighty-four per cent of the population has access to safe drinking water – 95 per cent in urban areas and 77 per cent in rural areas. The situation in the Janjanbureh region is lower than in other regions. About 71 per cent of the population in this region get its drinking water from a safe source.
- Eighty-eight per cent of the population of The Gambia is living in households with sanitary means of excreta disposal. The traditional pit latrine is inclusive and this in most places is not regarded as an ideal sanitary means of excreta disposal due to its nature.

Child Malnutrition

- Seventeen per cent of children under age five in The Gambia are underweight or too thin for their age. Nineteen per cent of children are stunted or too short for their age and eight per cent are wasted or too thin for their height.
- Children whose mothers have secondary or higher education are the least likely to be underweight and stunted compared to children of mothers with less education.
- Children of women in the richest quintile are least likely to underweight and stunted than those of women in the poorest quintile.

Breastfeeding

Approximately 36 per cent of children aged less than four months are exclusively breastfed. At age 6-9 months, 36 per cent of children are receiving breast milk and solid or semi-solid

foods. By age 20-23 months, about half (54 per cent) of the children are continuing to breastfeed.

Salt Iodization

- About eight per cent of households in The Gambia have adequately iodised salt a level considerably lower than recommended. The percentage of households with adequately iodised salt ranges from 2 per cent in Kerewan to 33 per cent in the Janjanbureh LGA.

Vitamin A Supplementation

- Within the six months prior to the MICS, about 4 per cent of children aged 6-59 months received a high dose Vitamin A supplement. Approximately 2 per cent did not receive a supplement in the last 6 months but did receive one prior to that time.
- The data suggest that mother's level of education is not inversely related to the likelihood of Vitamin A supplementation. The percentage receiving a supplement in the last six months decreases from 4 per cent among children whose mothers have no education to less than one per cent among children of mothers with secondary or higher education.
- Only about 14 per cent of mothers with a birth in the year before the MICS received a Vitamin A supplement within eight weeks of the birth.
- For women in the richest quintile, about 13 per cent of women with a birth in the last 12 months received Vitamin A supplements compared to 17.3 per cent of women in the poorest quintile.

Low Birth weight

- Approximately 12 per cent of infants are estimated to weigh less than 2,500 grams at birth. This percentage is somewhat higher than the average for the Latin America and Caribbean region at 9 per cent.

Immunisation Coverage

- Almost all (99 per cent) of children aged 12-23 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 97 per cent. The percentage declines for subsequent doses of DPT to 95 per cent for the second dose, and 90 per cent for the third dose.
- Similarly, 97 per cent of children received Polio 1 by age 12 months and this declines to 88 per cent by the third dose.
- The coverage for measles vaccine is almost the same as DPT3 at 88 per cent.
- Over half, six in every ten of children had all eight recommended vaccinations in the first 12 months of life.
- Vaccination coverage is highest among male than female children at 65 and 58 per cent respectively.
- Vaccination coverage is highest among children whose mothers have secondary or higher education. The education differences are not significant across different doses of different vaccines. However, vaccination coverage is lower among children with primary educated mothers, suggesting that drop out rates are higher among children with primary educated mothers.
- Across wealth quintiles, vaccination coverage is highest among the fourth richest (66 per cent) and lowest among the poorest (60 per cent).

Diarrhoea

- Approximately 74 per cent of children with diarrhoea received one or more of the recommended home treatments (i.e., were treated with ORS or RHF).

- Only 27 per cent of children with diarrhoea received increased fluids and continued eating as recommended.

Acute Respiratory Infection

- Eight per cent of under-five children had an acute respiratory infection in the two weeks prior to the survey. More than 70 per cent of these children were taken to an appropriate health provider.

IMCI Initiative

- Among under-five children, who were reported to have had diarrhoea or some other illness in the two weeks preceding the MICS, 27 per cent received increased fluids and continued eating as recommended under the IMCI programmed.
- Among children across poverty quintiles, there is not much difference among children of women in varying poverty levels with 24 per cent of children in poorest quintile and 28 per cent of those in the richest quintile receiving increased fluids and continued eating.
- Thirty-nine per cent of mothers know at least two of the signs that a child should be taken immediately to a health facility.
- Maternal education positively influences health seeking behaviour of mothers as 46 per cent of mothers with secondary education and above knowing at least two signs for seeking immediate health care compared to 38 per cent of women with no education.
- Forty-seven per cent of caretakers in the richest quintile compared to 37 per cent in the poorest have knowledge of at least two sign for seeking immediate health care.

Malaria

- In The Gambia, 42 per cent of under five children slept under a bed-net the night prior to the survey interview. However, about 35 per cent of the bed-nets used are impregnated with insecticide.
- Approximately 62 per cent of children with a fever in the two weeks prior to the MICS interview were given Paracetamol to treat the fever and 55 per cent were given Chloroquine while only 3 per cent were given Fansidar. A relatively considerable percentage of children (12 per cent) were given some other medicine.

HIV/AIDS

- Thirty-four per cent of women aged 15-49 know all three of the main ways to prevent HIV transmission – having only one uninfected sex partner, using a condom every time, and abstaining from sex.
- Twenty per cent of women correctly identified three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected.
- Twenty-five per cent of women of reproductive age in The Gambia know a place to get tested for AIDS and about 7 per cent have been tested.
- The percentage of women who have sufficient knowledge of HIV transmission and the percentage who know where to get tested for HIV increases dramatically with the level of education. Similarly the proportion of women with sufficient knowledge on HIV transmission decrease with an increase in poverty level.

Contraception

- Current use of contraception was reported by 9 per cent of married or in union women. The most popular methods are the pill and injections, which are used by four per cent of married women followed by IUD, which accounts for 1 per cent of married women. Contraceptive use is highest among the better educated and richest.

Prenatal Care

- Seven out of ten women with recent births in The Gambia are protected against neonatal tetanus. The vast majority of these women received two or more doses of tetanus toxoid within the last three years. Coverage of vaccination against neonatal tetanus toxoid is not significantly affected either by education or wealth index.
- Virtually all women in The Gambia receive some type of prenatal care and 91 per cent receives antenatal care from skilled personnel (doctor, nurse, and midwife). There is no significant difference between women across education and wealth index categories.

Assistance at Delivery

- A doctor, nurse, or midwife delivered about 55 per cent of births occurring in the year prior to the MICS survey. This percentage is highest in Banjul at 91 per cent and lowest in Kuntaur at 29 per cent. The level of education and wealth index are associated with assistance at delivery by skilled personnel.

Birth Registration

- The births of 32 per cent of children under five years in The Gambia have been registered. Birth registration coverage is highest for children aged 6-11 months and lowest for those aged 48-59 months. Coverage is influenced by maternal education and wealth index quintile.

Orphanhood and Living Arrangements of Children

- Overall, 73 per cent of children aged 0-14 are living with both parents. Children who are not living with a biological parent comprise 10 per cent and children who have one or both parents' dead amount to 8 per cent of all children aged 0-14.
- The situation of children in Banjul slightly differs from that of other children. In Banjul, the rate at which children live with both parents is lowest, and with mother only when father is alive is higher than in other regions. This can be attributed to the high rate of emigration of both parents and also non-residential polygamy, among others.

Child Labour

- About two per cent of children aged 5-14 years engage in paid work. About twice as many – 4 per cent – participate in unpaid work for someone other than a household member.
- Less than half of children (43 per cent) engage in domestic tasks, such as cooking, fetching water, and caring for other children, for less than four hours a day while 4 per cent spend more than four hours a day on such tasks.

Summary Indicators

World Summit for Children Indicators		
Under-five mortality rate	Probability of dying before reaching age five	**To be provided later**
Infant mortality rate	Probability of dying before reaching age one	**To be provided later**
Underweight prevalence	Proportion of under-fives who are too thin for their age	17.1 percent
Stunting prevalence	Proportion of under-fives who are too short for their age	19.1 percent
Wasting prevalence	Proportion of under fives who are too thin for their height	8.2 percent
Use of safe drinking water	Proportion of population who use a safe drinking water source	84.0 percent
Use of sanitary means of excreta disposal	Proportion of population who use a sanitary means of excreta disposal	87.9 percent
Children reaching grade five	Proportion of children entering first grade of primary school who eventually reach grade five	96.6 percent
Net primary school attendance rate	Proportion of children of primary school age attending primary school	51.6 percent
Literacy rate	Proportion of population aged 15+ years who are able to read a letter or newspaper	36.4 percent
Antenatal care	Proportion of women aged 15-49 attended at least once during pregnancy by skilled personnel	90.7 percent
Contraceptive prevalence	Proportion of married women aged 15-49 who are using a contraceptive method	9.0 percent
Childbirth care	Proportion of births attended by skilled health personnel	54.6 percent
Birth weight below 2.5 kg.	Proportion of live births that weigh below 2500 grams	11.8 percent
Iodised salt consumption	Proportion of households consuming adequately iodised salt	7.5 percent
Children receiving Vitamin A supplementation	Proportion of children aged 6-59 months who have received a Vitamin A supplement in the last 6 months	3.7 percent
Mothers receiving Vitamin A supplementation	Proportion of mothers who received a Vitamin A supplement before infant was 8 weeks old	14.0 percent
Exclusive breastfeeding rate	Proportion of infants aged less than 4 months who are exclusively breastfed	36.1 percent
Timely complementary feeding rate	Proportion of infants aged 6-9 months who are receiving breast milk and complementary food	35.7 percent
Continued breastfeeding rate	Proportion of children aged 12-15 months and 20-23 months who are breastfeeding	96.8 percent (12-15) 53.9 percent (20-23)
DPT immunisation coverage	Proportion of children immunised against diphtheria, pertussis and tetanus by age one	91.7 percent
Measles immunisation coverage	Proportion of children immunised against measles by age one	88.0 percent
Polio immunisation coverage	Proportion of children immunised against polio by age one	94.0 percent
Tuberculosis immunisation coverage	Proportion of children immunised against tuberculosis by age one	92.9 percent
Children protected against neonatal tetanus	Proportion of one year old children protected against neonatal tetanus through immunisation of their mother	77.1
ORT use	Proportion of under-five children who had diarrhoea in the last 2 weeks who were treated with oral rehydration salts or an appropriate household solution	74.2 percent
Home management of diarrhoea	Proportion of under-five children who had diarrhoea in the last 2 weeks and received increased fluids and continued feeding during the episode	27.1 percent
Care seeking for acute respiratory infections	Proportion of under-five children who had ARI in the last 2 weeks and were taken to an appropriate health provider	74.9 percent
Pre-school development	Proportion of children aged 36-59 months who are attending some form of organised early childhood education program	16.3 percent

Indicators for Monitoring Children's Rights		
Birth registration	Proportion of under-five children whose births are reported registered	32.2 percent
Children's living arrangements	Proportion of children aged 0-14 years in households not living with a biological parent	10.2 percent
Orphans in household	Proportion of children aged 0-14 years who are orphans living in households	0.6 percent (both parents) 7.9 percent (one parent)
Child labour	Proportion of children aged 5-14 years who are currently working	26.9 percent
Indicators for Monitoring IMCI and Malaria		
Home management of illness	Proportion of under-five children reported ill during the last 2 weeks who received increased fluids and continued feeding	23.5 percent
Care seeking knowledge	Proportion of caretakers of under-five children who know at least 2 signs for seeking care immediately	39.4 percent
Bednets	Proportion of under-five children who sleep under an insecticide impregnated bednet	35.1 percent
Malaria treatment	Proportion of under five children who were ill with fever in the last 2 weeks who received anti-malarial drugs	56.0 percent
Indicators for Monitoring HIV/AIDS		
Knowledge of preventing HIV/AIDS	Proportion of women who correctly state the 3 main ways of avoiding HIV infection	33.9 percent
Knowledge of misconceptions of HIV/AIDS	Proportion of women who correctly identify 3 misconceptions about HIV/AIDS	19.6 percent
Knowledge of mother to child transmission	Proportion of women who correctly identify means of transmission of HIV from mother to child	37.7 percent
Attitude to people with HIV//AIDS	Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS	24.2 percent
Women who know where to be tested for HIV	Proportion of women who know where to get a HIV test	25.2 percent
Women who have been tested for HIV	Proportion of women who have been tested for HIV	7.2 percent

I. Introduction

Background of the Survey

At the World Summit for Children held in New York in 1990, the government of The Gambia pledged itself to a Declaration and Plan of Action for Children. Subsequently, a National Programme of Action (NPA) for Children was developed and implemented. An Inter-ministerial Committee and a multi-sectoral Technical Working Group was established by government with mandate to produce the *1992-2003 National Programme of Action for the Survival, Protection and Development of Gambian Children.* The Programme of Action analysed the overall situation of children in The Gambia and identified their existing unmet needs as well as the challenges they present nationally. Due to financial resource constraints, government incorporated the goals and objectives of the NPA into the National Health Policy in order to strengthen and sustain service delivery in the programme areas of Malaria Control, Acute Respiratory Infections, Safe Motherhood, and the Expanded Programme of Immunisation, Diarrhoea Control and Nutrition.

The Plan of Action also called for the establishment of mechanisms for monitoring progress toward the goals and objectives set for the year 2000. Toward this end, UNICEF, in co-ordination with other international organisations, has developed a core set of 75 indicators of specific aspects to the situation of children. A MICS survey was conducted in 1996 to measure progress at mid-decade. The 2000 Gambia MICS survey has been implemented to provide end-decade information on many of the indicators. Information on other indicators will be derived from the vital registration system and various diseases monitoring systems.

The Gambia's MICS2 was conducted by the Central Statistics Department in collaboration with other government Departments such as the Department of Social Welfare, Department of Community Development, Department of Water Resources, Women's Bureau, Department of State for Health and Department of State for Education. Other NGOs such as Gambia Family Planning Association (GFPA) and Gambia German Family Planning Programme also participated. Funding was provided by The Gambia UNICEF office. This report presents results on the principal topics covered in the survey and on the World Summit indicators.

Background

DEMOGRAPHIC SITUATION

Population Size and Growth

The Gambia's population estimated at 1,038,145 in 1993 recorded one of the fastest growth rates in the world in the recent past. With an estimated annual growth rate of 4.2 per cent, the population doubling time is estimated at about 17 years. Such a rate of population growth is alarming in view of the accelerated growth experienced since 1983. It is worth noting that over the period 1973-83 the population recorded a growth rate of 3.4 per cent per annum. This rapid increase in the rate of population growth has been partly attributed to high fertility, declining mortality and the effect of migration. Across regions, disparities have been observed in levels of population growth with Kanifing and Brikama Local Government Areas recording the highest growth rates (8.4 and 7.8 per cent respectively, between 1983 and 1993)

over the past two decades. Over the period 1983-93, the urban population was estimated to have grown at the rate of 6.2 per cent per annum compared to a rural growth rate of 3.2 per cent per annum.

Population Distribution and Urbanisation

As is the experience in many developing countries, there is increasing urbanisation in The Gambia with large population movements from rural to urban areas. According to data from the 1993 census, over a quarter of the population (26.1 per cent) of the country live in Banjul and Kanifing Municipal areas and about half (49 per cent) of the population live in Banjul, Kanifing and Brikama Local Government Areas. Rapid population growth and increased population density is becoming a major concern in view of the involvement of a sizeable proportion of the Gambian population in agriculture. Since 1963, population density has increased from 30 persons per square kilometre to 46 person in 1973, 64 persons in 1983 and 97 persons per square kilometre in 1993. With an estimated population of 1.3 million, the density now stands at 121 persons to a square kilometre. The implications of such an increase in population density on available arable land for cultivation and therefore on the welfare of largely agricultural population is indeed worrying to policy makers.

Another worrying demographic development is the rapid increase in the urban population. Until the 1970s population movements from rural to urban areas were not of much concern to policy makers. This was because such movements were mainly seasonal with rural migrants moving to urban areas in search of menial jobs during the dry season (stretching from December to May) and returning to rural areas at the beginning of the rains. Since the Sahelian droughts of the mid-1970s, however, the propensity for such migrants to settle in urban areas has increased considerably. This has been because, due to consecutive years of droughts, rural income levels have considerably declined forcing many rural dwellers to seek economic refuge in urban areas. The resultant effect has been the swelling of urban populations in The Gambia. Political instability in the sub-region and the relative political and economic stability in The Gambia also attracted large numbers of migrants from the sub-region, mainly into urban areas. Consequently, the proportion of the population resident in urban areas increased from 22.9 per cent in 1973 to 30.8 per cent in 1983 and 37.1 per cent in 1993. This development in addition to having economic consequences in terms of increased urban unemployment, increase pressure on the limited social amenities in urban areas. The health and education sectors are probably the worse hit as these sectors struggle to keep pace with the increasing demand for these facilities.

Age Structure

The Gambia, as is characteristic of most high fertility countries, has a largely youthful population. The proportion of the population aged below 15 years increased from 41.3 per cent in 1973 to 43.8 per cent in 1993. This young age structure is depicted in the results of this study with 46.0 per cent of the enumerated population aged less than 15 years. For the population aged 15-64 years, the proportion of the population in that age category declined from 52.5 per cent in 1973 to 51.5 per cent in 1983 and 51.3 per cent in 1993. The comparative proportion of the population in this age category from the results of this study is 51.0 per cent. For the population aged less than 18 years, results of the 1973 census showed that 46.5 per cent of the population fall in that age group compared to 49.5 per cent in 1983, 50.4 per cent in 1993 and 50.9 per cent according to the 2000 MICS results. The population aged 65 years and over which constituted 3.9 per cent of the population in 1973 only

constituted 3.7 per cent of the population in 1983 and 3.2 per cent in 1993. For the MICS data 3.0 per cent of the population was aged 65 years and over.

This age structure may be mainly attributable to high fertility and mortality levels experienced in The Gambia over the last three decades. The review above indicates similarities in the age structure as observed from three consecutive censuses and from the MICS results. The apparent increase in the youthful population as observed in the MICS may be surprising in view of the fact that over the years there have been declines in fertility and mortality and therefore an increase in longevity. The persistently high levels of migration into the country, particularly from Sierra Leone, Southern Senegal, Liberia, Nigeria and Guinea-Bissau, which has been experienced over the years, may explain this. Observed similarities in age structure between the results of the MICS2 and the previous censuses is an indication of the accuracy of age reporting for the MICS2.

Fertility

Fertility levels in The Gambia are among the highest in the world. Although a modest decline in levels was recorded over the past two decades, levels remain high. During the period 1973-83, fertility was estimated at 6.4 declining to 6.0 in 1993. This modest decline in fertility was in part attributed to contraceptive use among the population and changes in marital patterns observed during the period. Disparities have been observed in fertility levels among regions with the levels lowest in Banjul and Kanifing municipal areas and highest in the predominantly rural Local Government Areas. Similar differentials have been observed among ethnic groups. Regional and ethnic differences in fertility may be explained by differences in levels of contraceptive use, attitude to family size and variations in marital patterns, in general. Estimates from the MICS2 indicate that the total fertility rate is 5.4 children per woman.

Mortality

In spite of considerable achievements in terms of mortality decline during the past three decades, mortality levels in The Gambia remain among the highest in the sub-region. Infant mortality estimated at 84 deaths per 1000 live births in 1993 recorded significant decline from levels estimated at 167 deaths in 1983. Over the same period, under-five mortality was estimated to have declined from 260 deaths per 1000 in 1983 to 129 deaths in 1993. Lower levels of child and under-five mortality have been observed in the Banjul and Kanifing municipal areas when compared to other regions of The Gambia, although, in general, mortality levels have declined significantly across all regions during the past three decades. Similarly mortality levels in urban areas have been found to be higher than in rural areas. Such differences in levels of mortality may be attributed to a host of factors. These range from differential access to health services, differentials in socio-economic status of the population across regions to differences in nutritional status across regions. Variations observed in mortality levels across ethnic groups have also been partly attributed to differences in access to health services across regions. Probably due to the effect of improved access to health services throughout the country over the past two decades, a considerable decline was observed in differentials in mortality levels across regions.

Estimates of both under-five and infant mortality from the MICS2 appear to suggest that child mortality has increased in The Gambia. The U5MR and IMR are estimated at 141 and 98 per 1, 000 respectively. The upsurge in child mortality rates, which has been experienced in other sub-Saharan African countries, should be viewed with caution since it is difficult to

establish from a single data source. Furthermore, the quality of the MICS data on mortality was not very good.

Maternal educational attainment is negatively correlated with child mortality. For example, under-five mortality for children born to mothers with no education in 1993 was estimated at 138 deaths per 1000 live births compared to 120 among children of women with primary level education and 88 deaths per 1000 for children of women with secondary education and above.

The decline in mortality levels has translated into improvements in life expectancy with the life expectancy for both sexes increasing from 42.8 years in 1983 to 55 years in 1993. Improvements in mortality observed in The Gambia may not be explained by a single factor but improvements in access to health services have been singled out as a major factor. Achievements of the Primary Health Care Programme in bringing health services close to rural communities, in particular, has been singled out as having greatly influenced levels of mortality. Improvements in access to health services with the establishment of additional health facilities over the past decade and beyond are believed to have accounted for part of the mortality decline. In view of the influence of education on infant and child survival, gains in survival among children has also been partly attributed to improvements in female educational attainment over the period.

Population Policy and Programme

Faced with largely unfavourable economic conditions, rapid deforestation aggravated by rapid population growth, the Government of the Gambia decided to adopt a National Population Policy in 1992. The policy designed to curb the rapid rate of population growth had the overall goal of improving the quality of life and raising the standard of living of all Gambians. For the attainment of the goals of the policy, strategic components have been identified. These include reproductive/sexual health and family planning, education, family and gender relations, youth, environment, nutrition, population distribution and urbanisation, migration, information education and communication/advocacy, research, capacity building and legislative reform. Activities have been identified as integral parts of the national population programme.

In view of the cross cutting nature of some of the activities of the population programme, an attempt has been made to harmonise the National Population Policy and Programme with other government initiated programmes. Key among these programmes are the National Education Policy, The Gambia Environment Action Plan, the Housing, Health and Family Planning Policies.

The major targets of the National Population Policy have been identified as:

- Reduce the maternal mortality rate from 1050 per 100,000 (1990) to 800 per 1,000 by the year 2000 and to 500 per 100,000 by 2004;
- Reduction of the total fertility rate from 6.0 (1993) to 5.5 by 2000 and 5 by 2004.
- Extend primary health care services from 60 per cent (1985) to 80 per cent of the rural population by 2000 and to 100 per cent by 2004
- Increase contraceptive prevalence from current estimates of 7 per cent (modern methods) to 15 per cent by 2000 and 22.5 per cent by 2004

- Reduce pregnancy among women aged 15-19 years and 35 years and above by 20 per cent by 2000 and by another 50 per cent by 2004
- Increase the coverage of the Expanded Programme for Immunisation of children under age 2 years from 83 per cent (1994) to 90 per cent by 2000 and to 100 per cent by 2004
- Reduce infant mortality rate from 92 per 1000 (1993) to 72 per 1000 by 2000, and to 56 per 1000 by 2004

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

HEALTH SITUATION

Human deprivation has for long been measured in terms of material possession. In view of the pivotal importance of health in the general well being of mankind, however, recent development paradigm have adopted indices of human development which consider the state of health of the population as an important input. A considerable number of indices in this report may be affected by the state of health of the population, in general, and the state of health services in the country in particular. It would be useful, therefore, to provide some information on the state of health of The Gambia in this chapter to facilitate a better understanding of some of the findings of this study.

Health Care Delivery System

Until the adoption of the Primary Health Care (PHC) strategy in 1979, the healthcare delivery system in The Gambia was largely centralised with the only government run referral hospitals in Banjul and Bansang. The PHC strategy was adopted with the main aim of making health care more accessible and affordable to the majority of Gambians. A key target of the PHC was mainly rural settlements with a population of over 400 persons. For each PHC village a Village Health Worker (VHW) and a Traditional Birth Attendant (TBA) was trained to provide primary health care in their communities. The Village Health Workers (VHWs) are assigned the role of maintaining the supply of essential drugs, the provision of outpatient care, making home visits and carrying out health education programmes. The Traditional Birth Attendants (TBAs) assist in deliveries and identify and refer at-risk mothers. Health care delivery at the primary level in The Gambia is provided through the PHC programme.

At the secondary level health care is delivered through a number of major and minor health centres. These have been identified as 7 major health centres 12 minor health centres and 19 dispensaries. The Major Health Centres are staffed by resident doctors, registered and enrolled nurses and other auxiliary staff. Minor Health Centres until recently, when doctors were posted to a number of them, only had registered and enrolled nurses and other support staff. Dispensaries, on the other hand, are staffed by enrolled and community health nurses. Health care provision at the secondary level entails our-patient services and in-patient services at a small scale. Although reports indicate that there have not been major changes in the number of secondary services in the past 15 years, there have been major improvements in the quality of services with the upgrading of 7 major health centres. Cases that cannot be handled by this level of health services are referred to the hospitals.

At the tertiary level, health services are provided by three hospitals. These hospitals are located in Banjul, Farafenni and Bansang. Farafenni Hospital, opened not long ago, will go a long way in providing much needed referral services in the rural areas. The Royal Victoria Hospital (RVH), located in Banjul, is the main referral hospital offering specialist consultant services. The hospital operates a pharmacy, laboratory services and a polyclinic, which provides secondary level health services to Banjul and the surrounding urban area. Farafenni hospital provides referral services to people of the North Bank Division and adjacent areas. Although the hospital provides most specialist services, the hospital is yet to be fully operational. Bansang Hospital, the oldest rural hospital, serves the eastern part of the country with a catchment area covering about a third of the country's population. In addition to operating as a referral hospital, the hospital also operates a very busy outpatient department.

The health services that are provided by government-funded health institutions are supplemented by services provided by the private sector and non-governmental organisations (NGOs). Individuals and NGOs have established a number of health facilities, mainly in urban areas. Probably due to the higher costs involved in the provision of health services by the private sector, only a small proportion of the population is able to afford services provided by such facilities, hence the increasing demand on public-funded health services.

Human Resources

In the light of marked improvements both in terms of number of service delivery points and the quality of services, there has been a corresponding increase in the number of technical and professional health personnel. The number of doctors/dentists working in government run health services increased from 48 in 1987 to 128 in 1997, an increase of 166 per cent. Although more recent figures are not available, this number might have doubled by now in view of the dramatic increase in the number of Cuban doctors serving in the health sector now. The public health services depend to a large extent on expatriate doctors. A number of problems have been identified with services provided by these doctors. Language difficulties, different medical regimens and shortages between postings have been identified as problems faced with foreign expatriate doctors.

Records show that over the past decade or beyond, the number of nurses increased by 11 per cent. This might have led to improvements in quality of care in hospitals and health centres. Except for public health officers who recorded a decline in numbers over the period 1987-97, all other cadre of health personnel registered significant increases. Although the geographic distribution of health personnel is uneven, recent efforts at decentralising health services might have drastically reduced disparities in the ratio of population per health personnel across regions. The increase in the number of doctors serving in rural areas might have had the most impact, particularly with the posting of Cuban doctors in areas that have never been served by a resident doctor.

Achievements of the Health Care System

With the main objective of improved access to health services, between 1992 and 1994, government embarked on measures to decentralise primary and secondary services. Six divisional teams were created to manage and supervise service delivery at secondary and primary level health facilities. These measures together with improvements, in general, in health infrastructure, led to marked improvements in health in The Gambia. In addition to gains in the curative health sector, marked improvements were recorded in preventive health

services. Improvements in infant and child survival, as reviewed earlier, in this chapter have been largely attributed to improvements in both access and quality of health services.

The Expanded Programme for Immunisation (EPI) which was launched in 1979 is probably one of the most successful health initiatives in The Gambia. The programme, initially aimed at vaccinating children against measles, polio, pertusis, diphtheria and tetanus, has added yellow fever, Hepatitis B and Haemophillus Influenza Type B on to the list of target immunisable diseases. Immunisation coverage improved considerable over the past decade. For children aged less than one year, the proportion of fully immunised children increased from 65.5 per cent in 1990 to 87 per cent in 1995. Similarly, for children aged less than two years immunisation coverage improved from 80.9 per cent in 1990 to 87 per cent in 1995. Immunisation coverage among diseases differs, with immunisation for some diseases closed to complete coverage. Regional disparities have also been observed in coverage levels. The improvements in levels of immunisation coverage, particularly in the mid-1990s have accounted for the dramatic reduction in the incidence of immunisable diseases. However, between MICS 1 (1995) and MICS 2 (2000), overall immunisation coverage declined from 87 per cent to 62 per cent. This significant decline in coverage can be attributed to the ageing cold chain and the issue of sustainability of the EPI as less and less donor funding is forthcoming.

Constraints of the Health Care Delivery System

Notwithstanding the apparent gains of the health services of the Gambia over the past decade and beyond, the system is still faced with numerous constraints, which impede progress in the sector. Although infant and child survival has improved remarkably in the recent past, levels remain among the highest in the sub-region, a clear indication of a lot of room for improvement. Similarly, maternal mortality estimated at 1050 per 100,000 live births in 1990 is among the highest in the sub-region. These high levels of mortality are influenced by a host of factors with inadequacy of the health services as a key factor. Over the years it has been observed that resource allocation to the health sector has not been able to match the increasing demand for services. Although there has been an increase in Government recurrent expenditure in the Health Sector over the period 1990/91 to 1996/97, Government per capita expenditure on health in 1996/97 almost remained at the levels of 1990/91 (Public Expenditure Review, 1998). Considering a population growth rate of 4.2 per cent per annum and increased cost of health services over the period under review, the marginal increase in health expenditure is not likely to have much impact on the quality of health services.

The introduction of a cost recovery component in the health services is yet another problem faced by the health delivery system. Both the Drug Revolving Fund (DRF) and the Bamako Initiative have put in place mechanisms for cost recovery to facilitate the procurement of drugs. There are growing fears that user charges introduced in 1988 may already be posing a problem of affordability among rural communities and could serve as a disincentive.

Another important problem faced by the health sector is the shortage of ambulances. In remote areas of the country, the use of donkey or horse carts for the evacuation of patients is common. This probably prompted Government to initiate a programme of horse cart ambulances in the past. Although this initiative took off, it has largely been unsuccessful. The traditional carts, however, remain the main mode of transportation of the sick in many rural communities. In view of the poor state of roads in these areas, this mode of transport often poses a threat to the lives of patients.

Specialist services are still in high demand in The Gambia. Since most specialists are non-Gambians and usually on technical assistance, withdrawal of such assistance could adversely affect the quality of services in The Gambia. This state of affairs renders the health service delivery system of the country quite vulnerable. In addition to vulnerability due to reliance on non-Gambian health specialist, health funding in The Gambia is heavily dependent on donor assistance. This raises issues of sustainability in light of evidence of donor fatigue in the recent past.

Health Policy and Other Health Initiatives

The National Health Policy 1994-2000, the basis of health initiatives and programmes in The Gambia over the past 5 years, is currently under review. The main aim of this policy is to improve the health status of the Gambian people through the reduction of the high infant and maternal mortality rates currently being experienced in the country. To achieve this aim, disease prevention and health protection programmes have been prioritised. In view of the success of the PHC programme, it was decided that essential elements of the programme formed the basis of the policy. The thrust of the policy during the 1990s was to concentrate on:

- Family health, embracing maternal and child health, including family planning, adolescent health, nutrition and immunisation;
- Control of endemic diseases, principally malaria, acute respiratory infections (ARI) diarrhoeal diseases, leprosy and tuberculosis, sexually transmitted diseases (STD) and AIDS
- Health promotion using Information, Education and Communication (IEC) protocols and preventive health interventions to address non-communicable diseases
- Broad-spectrum training for different cadres of health personnel, at the village, secondary, tertiary and central levels of health care delivery.

The policy aims to consolidate gains made in the health sector and expand existing health services. In recognition of the influence of other factors on the health status of a population, which may be unrelated to advances in medical technology, the policy promotes inter-sectoral collaboration.

Survey Objectives

The 2000 Gambia Multiple Indicator Cluster Survey has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women in The Gambia at the end of the decade and for looking forward to the next decade;
- To furnish data needed for monitoring progress toward goals established at the World Summit for Children and a basis for future action;
- To contribute to the improvement of data and monitoring systems in The Gambia and to strengthen technical expertise in the design, implementation, and analysis of such systems.

II. Survey Methodology

Sample Design

The sample for The Gambia Multiple Indicator Cluster Survey (MICS) was designed to provide estimates of health indicators at the national level, for urban and rural areas, and for eight Local government Areas (LGA): Banjul, Kanifing, Brikama, Mansakonko, Kerewan, Kuntaur, Janjanbureh and Basse. The sample was selected in two stages. At the first stage, 128 census enumeration areas were selected with probability proportional to size. After a household listing was carried out within the selected enumeration areas, a systematic sample of 4,528 households was drawn. Because the sample was stratified by LGA, it is not self-weighting. For reporting national level results, sample weights are used. Full technical details of the sample are included in Appendix A.

Questionnaires

The questionnaires for The Gambia MICS were based on the MICS Model Questionnaire with some modifications and additions. A household questionnaire was administered in each household, which collected various informations on household members including sex, age, literacy, marital status, and orphanhood status. The household questionnaire also includes education, child labour, maternal mortality, water and sanitation, and salt iodisation modules. In addition to a household questionnaire, questionnaires were administered in each household for women age 15-49 and children under age five. For children, the questionnaire was administered to the mother or caretaker of the child. The questionnaire for women contains the following modules:

- ✓ Oral Rehydration Solution
- ✓ Child mortality
- ✓ Tetanus Toxoid
- ✓ Maternal and new-born health
- ✓ Contraceptive use
- ✓ HIV/AIDS.

The questionnaire for children under age five includes modules on:

- ✓ Birth registration and early learning
- ✓ Vitamin A
- ✓ Breastfeeding
- ✓ Care of Illness
- ✓ Malaria
- ✓ Immunisation
- ✓ Anthropometry

From the MICS model English version, key terms in the questionnaires were translated into four languages: Mandinka, Wollof, Fulla and Jola. The questionnaires were pre-tested during March 2000. Based on the results of the pre-test, modifications were made to the wording and translation of the questionnaires. For the full questionnaires, see Appendix B.

Fieldwork and Data Processing

The field staffs were trained in two groups, the first training was conducted for field supervisors and technicians and the second was conducted for interviewers and data entry operators. The first training was done for five days in late April 2000 and the second training in early May 2000. Seven teams collected the data; each was comprised of five interviewers, one driver, and a supervisor. The MICS Co-ordinator provided overall supervision with the

assistant of two other field co-ordinators. The fieldwork began in May 2000 and concluded in June 2000.

The data were entered on twelve microcomputers using the Integrated Microcomputer Processing System (IMPS) software and the analysis were done using the SPSS. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed. Procedures and standard programs developed under MICS and adapted to The Gambia questionnaire were used throughout. Data processing began in September 2000 and finished in January 2001.

III. Sample Characteristics and Data Quality

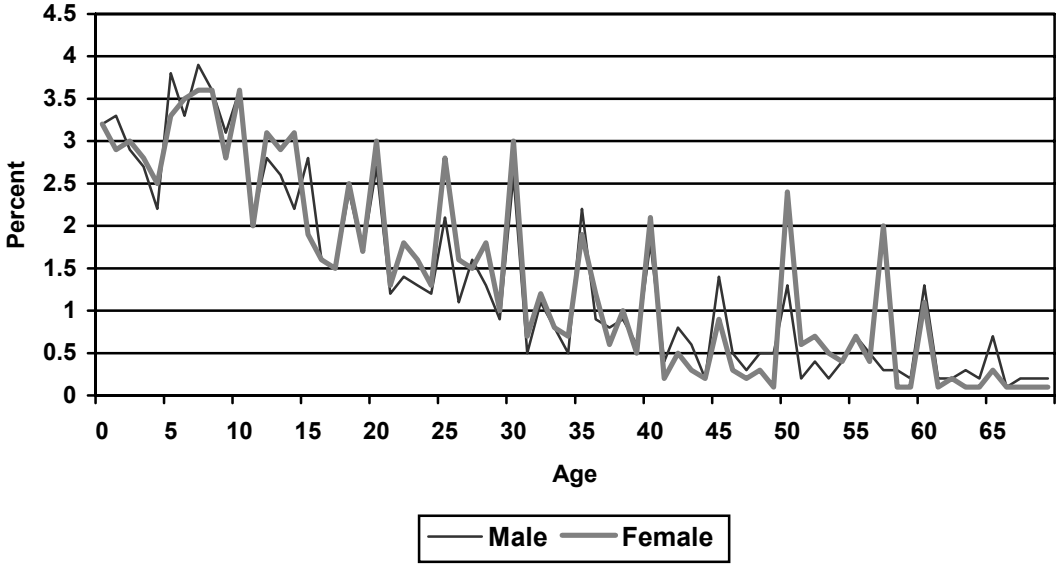
Response Rates

Of the 4, 536 households selected for The Gambia MICS sample, 4, 492 were found to be occupied (Table 1). Of these, 4, 478 were successfully interviewed for a household response rate of 99.7 per cent. The response rate was slightly higher in urban areas (99.9 per cent) than in rural areas (99.5 per cent). In the interviewed households, 6, 469 eligible women aged 15-49 were identified. Of these, 5,976 were successfully interviewed, yielding a response rate of 92 per cent. In addition, 3, 849 children under age five were listed in the household questionnaire. Of these, questionnaires were completed for 3, 632 children giving a response rate of 94 per cent.

Age Distribution and Missing Data

As shown in Table 2 and Figure 1, the single year age distribution of household members by sex exhibits some distortions centred around age 7 for females and on ages 7, 5, and 8 for males. There appears to be significant heaping of female children on ages 6-8 and perhaps a slight dearth of women ages 15-17. For both sexes, some digit preference is evident for ages ending in 0 and 5, a pattern typical of populations in which ages are not always known.

Figure 1: Single year age distribution of the household population by sex, The Gambia, 2000



As a basic check on the quality of the survey data, the percentage of cases missing information on selected questions is shown in Table 3. Less than one per cent of household members have missing information on their level of education and zero per cent is missing data on the year of education. Among female respondents, 0.5 per cent did not report a

complete birth date (i.e., month and year). Two per cent of women who had a birth in the 12 months prior to the survey did not report the date of their last tetanus toxoid injection. These low levels of missing data suggest that there were not significant problems with the questions or the fieldwork.

The data on number of hours for working children age 5-14 and complete birth date for children less than 5 years are the most likely among the selected information to be missing. Approximately three per cent of children are missing this information, which may be the result of women having difficulties in estimating the number of hours work, poor handling of infant welfare cards and absence of mother's of children during the time of the interview.

Characteristics of the Household Population

Information on the characteristics of the household population and the survey respondents is provided to assist in the interpretation of the survey findings and to serve as a basic check on the sample implementation.

Table 4 presents the per cent distribution of households in the sample by background characteristics. About 49 per cent of the households (2,219 households) are urban and 51 per cent (2,313 households) are rural. The Kanifing LGA comprises the largest of the five regions with 31 per cent of households while Brikama is next largest with 29 per cent. The remaining regions each contain between 3 and 16 per cent of households. Most of the households have between four and seven members. Fifty six per cent of the households contain at least one child under age five and 78 per cent contain at least one woman aged 15-49 years.

Table 5 shows the characteristics of female respondents aged 15-49. Women aged, 15-19 and 20-24 years comprise the highest percentage of the sample at 20 per cent each. This percentage declines steadily across age groups until age 45-49 where it is four per cent. This pattern is typical of countries in the region. Approximately, 73 per cent of women in the sample are currently married and 73 per cent have ever had a birth. The majority of women, about 71 per cent, have had no education while about 20 per cent have had at least some secondary education.

Table 6 shows the characteristics of children under age five. About half of the children are male and half are female. Approximately 81 per cent of mothers of children under age five have no education, about 10 percentage points significantly greater than the overall percentage of women with no education in the sample. Note that, for children whose mothers did not live in the household, the education of the child's caretaker is used. There are slightly less children aged less than six months than aged 6-11 months, a pattern, which is expected.

IV. Results

A. Infant and Under-Five Mortality

The *infant mortality rate* is the probability of dying before the first birthday. The *under-five mortality rate* is the probability of dying before the fifth birthday. In the MICS, infant and under five mortality rates are calculated based on an indirect estimation technique (the Brass method). The data used in the estimation are: the mean number of children ever born for five year age groups of women from age 15 to 49, and the proportion of these children who are dead, also for five year age groups of women. The technique converts these data into

probabilities of dying by taking account of both the mortality risks to which children are exposed and their length of exposure to the risk of dying.

The data used for mortality estimation are shown in Table 7. The mean number of children ever born rises from 0.32 among 15-19 year olds to 5.91 among 40-44 year olds and continues to increase to 6.69 among 45-49 year olds as expected since the number of children ever born should continue to rise with age. However, the proportion of children dead has an irregular pattern. In particular, the proportion of children dead among women aged 20-24 is low and the proportions among younger women appear to be high. This pattern may be affected by the age heaping noted in Figure 1 above. If some women in their twenties underreported their ages but reported the births and deaths of their children correctly then the deaths would effectively be moved downward toward age 15.

B. Education

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the World Summit for Children. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Early Childhood Education

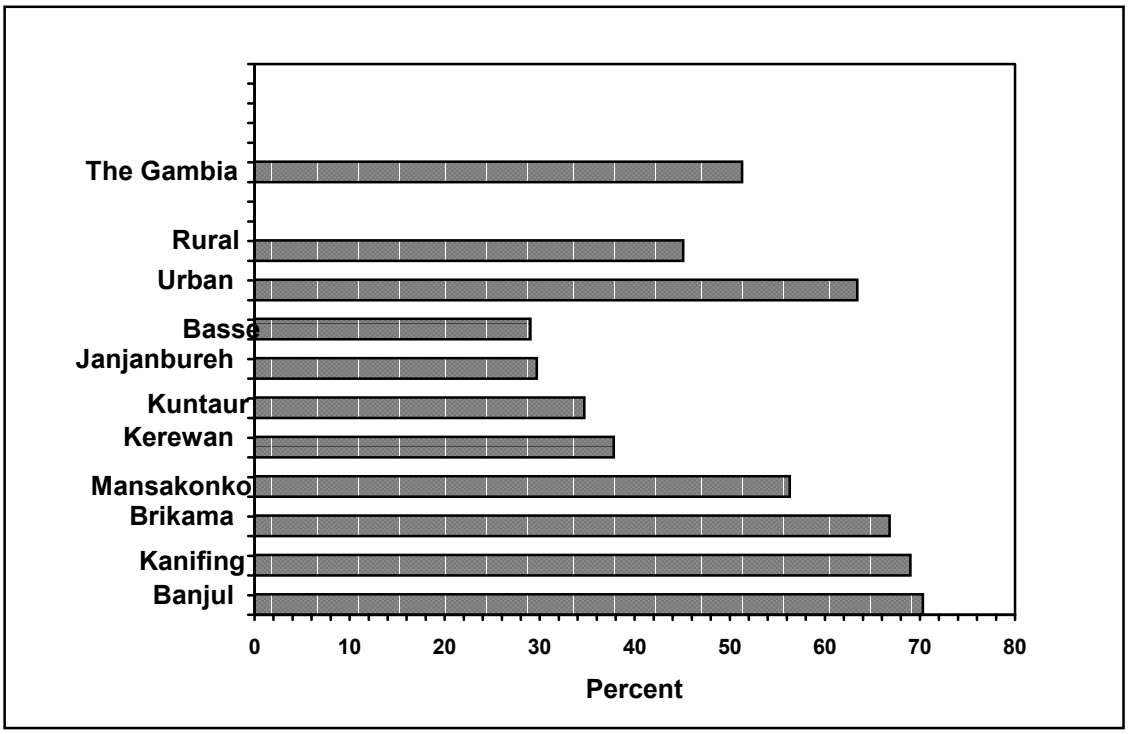
Overall, about 16 per cent of children aged 36-59 months are attending an organised early childhood education programme, such as kindergarten or community childcare with organised learning activities (Table 9). According to the EFA 2000, the GER for early childhood education is 17.7 per cent in 1998. This shows a slightly higher percentage although it was conducted two years prior to the MICS2. However, the difference in attendance rate can be attributed to the fact that EFA 2000 was a school-based survey whilst MICS2 was a household survey; hence the denominators for calculating the rates would be different. Approximately equal percentages of girls and boys are attending these programmes. There are large variations according to region ranging from three per cent of children in Janjanbureh to about 29 per cent in Banjul. In addition, 20 per cent of children in urban the areas attend early learning activities compared to about 14 per cent of children in rural areas. Relatively few children attend at age three (36-47 months) while the majority of children attend at age four (48-59 months). Finally, the education of the mother is strongly related to the likelihood that a child will attend an early childhood education programme. The percentage of children attending increases from 13 per cent to 42 per cent as the mother's education increases from none to secondary or higher education. Similarly, a larger proportion of children, (29 per cent), in the richest wealth index category attend some form of early childhood education compared with 11 per cent of children in the poorest category.

Basic Education

Nationally, about 52 per cent of children of primary school age in The Gambia are attending primary school (Table 10 and Figure 2). In urban areas, 64 per cent of children attend primary school while in rural areas 45 per cent attend. School attendance in Basse is significantly lower than in the rest of the country at 29 per cent. At the national level, the attendance rate is higher for males than females with primary school attendance rates of 54 and 49 per cent for males and females respectively. Differentials exist in the proportion of children attending primary school across wealth index categories with more than twice the proportion of children from the richest category, 72 per cent, compared to 33 per cent of children from the poorest quintiles. Almost all (97 per cent) of the children who enter the first grade of primary

school eventually reach grade five (Table 11). Virtually, there is no difference across rural-urban, gender and LGA.

Figure 2: Percentage of children of primary school age attending primary school, The Gambia, 2000



However, Basse and Kuntaur compared to other regions have lower percentages of children entering first grade of primary school who eventually reach grade five. Only slight differences have been observed across wealth index categories with the richest having slightly higher proportion, about 99 per cent, of children who entered grade one and eventually reaching grade five compared to about 95 per cent for children from the poorest quintiles.

Literacy

Less than half (36 per cent) of the population over age 15 years in The Gambia is literate (Table 12). The *literate* population includes those who are reported to read 'easily or with difficulty'. Overall, male literacy rates have been found to be almost double the female literacy rates (48 vs. 25 per cent). The percentage literate is lower in the Mansakonko, Kerewan, Kuntaur, Janjanbureh and Basse regions than in the Banjul, Kanifing and Brikama regions. However, the percentage literate among females is lowest in the Basse LGA compared to any other region. Literacy declines with increasing age. The percentage literate declines from 52 per cent among those aged 15-24 to 16 per cent among the population aged 65 and older. Across wealth index categories, the proportion of the population aged 15 years and older who are literate is highest for the richest category (63.2 per cent) and lowest for the poorest (16.7 per cent). According to the EFA 2000, literacy rates remained constant at 37.2 per cent from 1991 to 1994 and then dropped slightly and remained constant at 37.1 per cent from 1995 to 1998. By comparison, this survey result shows a slight further decline since 1998 instead of a rise.

C. Water and Sanitation

Use of drinking water

Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid, and schistosomiasis. Drinking water can also be tainted with chemical, physical and radiological contaminants with harmful effects on human health. In addition to its association with disease, access to drinking water may be particularly important for women and children, particularly in rural areas, who bear the primary responsibility for carrying water, often for long distances.

About 40 per cent of the population use drinking water from public tap and 19 per cent use tubewell/borehole with pump. The percentage of the population using water from unprotected dug well, piped into yard, protected dug well and piped into dwelling are 15, 10, 9 and 7 per cent respectively.

The source of drinking water for the population varies strongly by region (Table 13). In Banjul and Kanifing, 45 and 54 per cent of the population respectively get their water either from piped water in their dwellings or their yard or plot, whereas in other LGAs even lower than 7 per cent of the population use these sources for their drinking water. With regards to the public taps, which is the most important source of supply of drinking water, it is substantially lower in Kuntaur and Janjanbureh LGAs than in other regions. The use of tubewell/borehole as source of drinking water is more in regions that are predominantly rural than those entirely urban. The use of protected dug well is also significantly higher in Janjanbureh than other LGAs. Unprotected dug well, which is an important source (an unsafe source), is commonly used in Brikama, Janjanbureh and Basse LGAs. For the population across wealth index categories, access to safe drinking water sources is highest among the richer population than poor.

The population using *safe drinking water* sources is those who use any of the following sources for their drinking water supply: piped water, public tap, borehole/tubewell, protected well, protected spring or rainwater. Overall, 84 per cent of the population has access to safe drinking water – 95 per cent in urban areas and 77 per cent in rural areas. Access to safe drinking water is high in The Gambia although improvement is needed in other LGAs such as Kuntaur, Janjanbureh and Basse. In contrast to MICS 1996, there is a mark improvement in access to safe drinking water as it has increased from 69 to 84 per cent nationally. Similarly, access to safe drinking water has risen from 80 to 95 per cent in the urban areas and from 65 to 75 per cent in the rural areas. Also, according to MICS 1996, access to safe and convenient source of drinking water was lowest in Brikama with an accessibility rate of 49 per cent. Due to the intervention of the Brikama Area Council, European Development Fund (EDF) and other donors, there has been tremendous achievement in providing better access to safe drinking water and hence raising the accessibility rate to 77 per cent.

Use of sanitation

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoeal diseases and polio. *Sanitary means of excreta disposal* include: flush toilets connected to sewage systems or septic tanks, other flush toilets, improved pit latrines, and traditional pit latrines. About eighty-eight per cent of the population of The Gambia is living in households with sanitary means of excreta disposal (Table 14). This percentage is 96 in urban areas and 83 per cent in rural areas. Residents of Kuntaur LGA are much less likely than others to use sanitary means of excreta disposal. For the population

across wealth index categories a larger proportion of the richest category (98.5 per cent) have sanitary means of excreta disposal compared to the poorest category (71.5 per cent). About 12 per cent of the population use either open pits, bush/field or has no facilities. According to the MICS 2000 definition, proper sanitary facility includes pit latrine, which in The Gambian context is not regarded as an ideal sanitary means of excreta disposal due to the unsafe and unclean nature of this facility. There were few reported instances when women and/or children fell in pit latrines. Hence, with the exclusion of pit latrines as a sanitary means of excreta disposal, the total population with sanitary means of excreta disposal declines to about 23 per cent. In most regions this is even less than 10 per cent of the population with total sanitary means of excreta disposal. Also, without pit latrines, sanitary means of excreta disposal is available to 48 per cent of the population in the urban areas and to only 9 per cent in the rural areas.

D. Child Malnutrition

Nutritional status

Children's nutritional status is a reflection of their overall health. When children have access to an adequate food supply and are not exposed to repeated illness, they reach their growth potential and are considered well nourished.

In a well-nourished population, there is a standard distribution of height and weight for children under age five. Under-nourishment in a population can be gauged by comparing children to this standard distribution. The standard or reference population used here is the NCHS standard, which is recommended for use by UNICEF and the World Health Organisation. Each of the three nutritional status indicators is expressed in standard deviation units (z-scores) from the median of this reference population.

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

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

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

In Table 15, children who were not weighed and measured (approximately 1 per cent of children) and those measurements that are outside a plausible range are excluded. In addition, unknown birth dates for a small number of children known have been excluded.

Almost two in ten children under age five in The Gambia are underweight and four per cent are classified as severely underweight (Table 15). Nineteen per cent of children are stunted or too short for their age and eight per cent are wasted or too thin for their height. With reference to MICS 1996, the proportion of children malnourished has decreased from 21 to 17 per cent (weight for age) and 23 to 19 per cent (height for age) over a period of four years.

According to Table 15, children in Janjanbureh are more likely to be underweight, stunted and wasted than other children. Children whose mothers have secondary or higher education are the least likely to be underweight and stunted compared to children of mothers with less education. Boys appear to be slightly more likely to be underweight, stunted, and wasted than girls. The age pattern shows that a higher percentage of children aged 12-23 months are undernourished according to weight for age index, those age 36-47 months according to height for age index and those age 6-11 months according to weight for height index. This pattern differs from the international pattern which in relation to age and in respect of all the three indices, those aged 12-23 months are usually more undernourished, because at these ages many children cease to be breastfed and are exposed to contamination in water, food and environment. In The Gambia, most children continued to be breastfed even beyond the age of 23 months and as a result are not at the ages 12-23 months exposed to contamination. Children of mothers with no education are likely to be underweight, stunted and wasted than of children of women with higher educational attainment. Similarly children of women in the richest wealth index category are better nourished compared to those in poorest categories.

Breastfeeding

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. However, many mothers stop breastfeeding too soon, and there are often pressures to switch to infant formula, which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. The World Summit for Children goal states that children should be exclusively breastfed for four to six months, that breastfeeding should be complemented with appropriate foods from the age of around six months, and that children continue to be breastfed for two or more years.

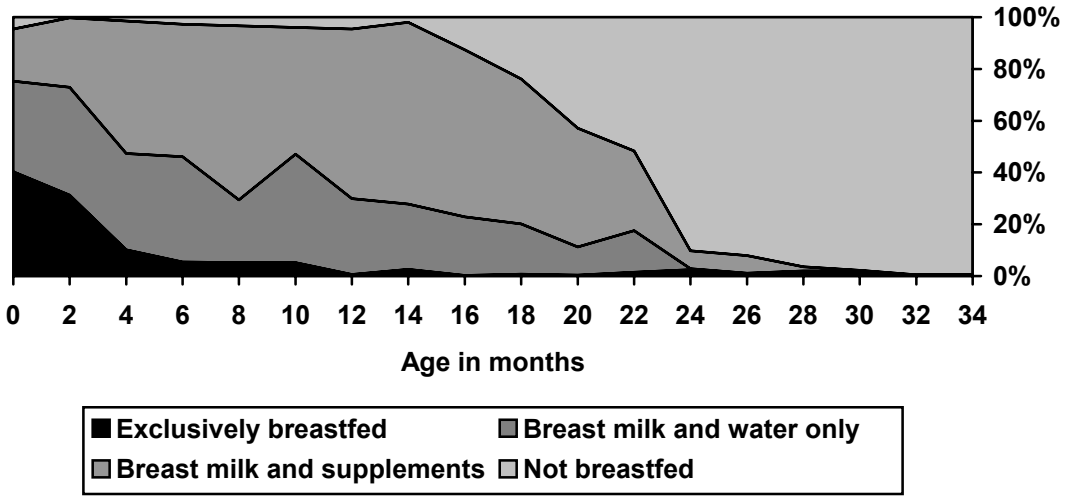
In Table 16, breastfeeding status is based on women's reports of children's consumption in the 24 hours prior to the interview. *Exclusive breastfeeding* refers to children who receive only breast milk and vitamins, mineral supplements, or medicine. *Complementary feeding* refers to children who receive breast milk and solid or semi-solid food. The last two columns of the table include children who are continuing to be breastfed at one and at two years of age. Exclusive breastfeeding and continued to be breastfed to 20-23 is higher among female children than male children. Complementary breastfeeding is higher among male children than female children. Also, exclusive breastfeeding is higher among children of mothers of secondary or more education than others and it rises with education and likewise for the urban than rural and to some extent wealth index categories. Complementary breastfeeding is also higher among urban children than those in the rural areas. However, this is due to the differences in the employment rates. As expected, children from the rural areas are breastfed longer compared to those in the urban areas for the same reason above. Similarly, children of mothers in poorest wealth categories are breastfed longer duration compared to those in the richest categories.

Approximately 36 per cent of children aged less than four months are exclusively breastfed. This has shown a rise by 8 per cent according to the Anthropometry Baseline Survey, 1998. At age 6-9 months, 36 per cent of children are receiving breast milk and solid or semi-solid

foods. By age 12-15 months, about 97 per cent of children are still being breastfed and by age 20-23 months, 54 per cent are still breastfed.

Figure 3 shows the detailed pattern of breastfeeding status by the child's age in months. Even at the earliest ages, the majority of children are receiving liquids or foods other than breast milk. The percentage of children exclusively breastfed diminishes rapidly to close to zero after three months. By the end of one year, almost all of the children are still breastfed.

Figure 3: Percentage distribution of living children by breastfeeding status, The Gambia, 2000



Salt Iodisation

A deficiency of iodine in the diet causes goitre, an enlargement of the thyroid gland, and can cause brain damage due to such a deficiency before birth or during infancy or childhood. The iodisation of salt is a low-cost way of preventing iodine deficiency disorders (IDD). In MICS, interviewers tested household salt for iodine levels by means of a testing kit. *Adequately iodised salt* contains 15 PPM (parts per million) of iodine or more.

Approximately 84 per cent of households had salt that was tested during the MICS (Table 17). It could be observed that 16, 23 and 15 per cent of the households in Banjul, Kanifing and Brikama LGAs respectively had no salt. This is because of the high concentration of single person households in these areas. As most of these households do not cook at home, they do not keep salt in their homes. Among households in which salt was tested, about 8 per cent had adequately iodised salt. This is very close to the results of the Iodine Deficiency Disorders survey conducted by the Nutrition Unit of the Department of State for Health in 1999, which, nationally, found 9 per cent of the households using iodised salt. Regional differences follow the same pattern with Central River Division with the highest percentage of iodised salt (23 per cent, IDD Survey, 1999) compared to an average of 24.5 per cent for Central River Division (North and South) according to MICS2. The Upper River Division (Basse) also has a high proportion, 21 per cent, of households using iodised salt. It is important to note that the regions with the highest consumption of iodised salt get their supplies from Senegal. The percentage of households with adequately iodised salt ranges from 2 per cent in the Kerewan to 33 per cent in the Janjanbureh region. Five per cent of urban households had adequately iodised salt compared to 10 per cent of rural households. Among households across wealth index quintiles, a larger proportion of the poorest households have adequately iodised salt compared to the richest households (Table 17).

Vitamin A supplementation

Vitamin A deficiency (VAD) can cause eye damage and blindness in children. It also impairs children's immune systems, increasing their chances of dying of common childhood diseases and undermines the health of pregnant and lactating women. Yet, vitamin A supplementation, food fortification or dietary change can easily prevent it. Based on UNICEF/WHO guidelines, in The Gambia, the Department of State for Health recommends that children aged 6-11 months be given one high dose of Vitamin A capsules a year and children aged older than one year be given two capsules. In this country, supplies of Vitamin A capsules is linked to immunisation services and are given when the child has contact with these services after six months of age. Vitamin A supplementation is also given annually both during the Nutrition Surveillance and National Immunisation Days. As a result of increased Vitamin A requirements during pregnancy and lactation, it is recommended that mothers take Vitamin A supplement within eight weeks of giving birth.

Within the six months prior to the MICS, about 4 per cent of children aged 6-59 months received the high dose Vitamin A supplement (Table 18). Approximately 2 per cent did not receive the supplement in the last 6 months but did receive one prior to that time. Also about two per cent of children received a Vitamin A supplement at some time in the past but their mother/caretaker was unable to specify when. Vitamin A supplementation coverage is lower in the Brikama Local Government Area (LGA) compared to the other regions.

The age pattern of Vitamin A supplementation shows that supplementation in the last six months declines from about 5 per cent among children aged 6-11 months to about 2 per cent among children aged 48-59 months. This is because the national Vitamin A supplementation started just a few days before the MICS2 fieldwork and as usual the younger children are more frequently visiting the Health Centres, where the supplementation is given, than the older children. There are no significant gender differentials in the per4centage of children who received Vitamin A supplementation (Table 18).

However, the mother's level of education is inversely related to the likelihood of receiving Vitamin A supplementation. The percentage receiving a supplement in the last six months decreases from four per cent among children whose mothers have no education to 3 per cent of those whose mothers have primary education and less than one per cent among children of mothers with secondary or higher education. Similarly, of the children of women in the poorest wealth index category 7 per cent received vitamin A supplementation compared to 3, 5 and 2 per cent among the second poorest, middle and richest categories respectively (Table 18).

Only about 14 per cent of mothers with a birth in the year before the MICS received a high dose of Vitamin A supplement within eight weeks of the birth (Table 19). This percentage is highest in the Kerewan LGA, about 41 per cent and lowest in the Basse LGA at 3 per cent. Vitamin A supplementation coverage is lowest amongst mothers of children with primary education; this may be because the coverage is higher in Kerewan where literacy rate is very low. However, there is no significant difference between mothers of children with primary education and those with secondary education and above (Table 19).

Low Birth Weight

Infants who weigh less than 2, 500 grams (2.5 kg.) at birth are categorised as low birth weight babies. Since many infants are not weighed at birth and those who are weighed may be a biased sample of all births, reported birth weight cannot be used to estimate the prevalence of

low birth-weight among all children. Normally, the percentage of births weighing below 2,500 grams is estimated from two items in the prototype questionnaire:

i) The mother's assessment of the child's **size** at birth (i.e., very small, smaller than average, average, larger than average, very large); and,
ii) The mother's recall of the child's **weight** or the weight as recorded on a health card if the child was weighed at birth. About 42 per cent of births in The Gambia were weighed at birth (Table 20).

As the size of the baby is considered unreliable, in the MICS 2 only the latter (weight recorded on health card) is taken into account. This proportion is then multiplied by the total number of children falling in the size category to obtain the estimated number of children in each size category who were of low birth weight. The numbers for each size category are summed to obtain the total number of low birth weight children. This number is then divided by the total number of live births to obtain the percentage of children whose birth weight are low.

Approximately 12 per cent of infants are estimated to weigh less than 2,500 grams at birth (Table 20). This percentage is somewhat higher than the average for the Latin America and Caribbean region at 9 per cent (UNICEF, 2000). The prevalence of low birth weight births varies slightly across regions but does not vary much between urban and rural areas or by mother's education (for mothers with primary and secondary and above). As expected the proportion of under-weight babies is lowest in Banjul and highest in Kuntaur and highest among children of mothers with no education than those with some education. A similar pattern has been observed across wealth index categories (Table 20).

E. Child Health

Immunisation Coverage

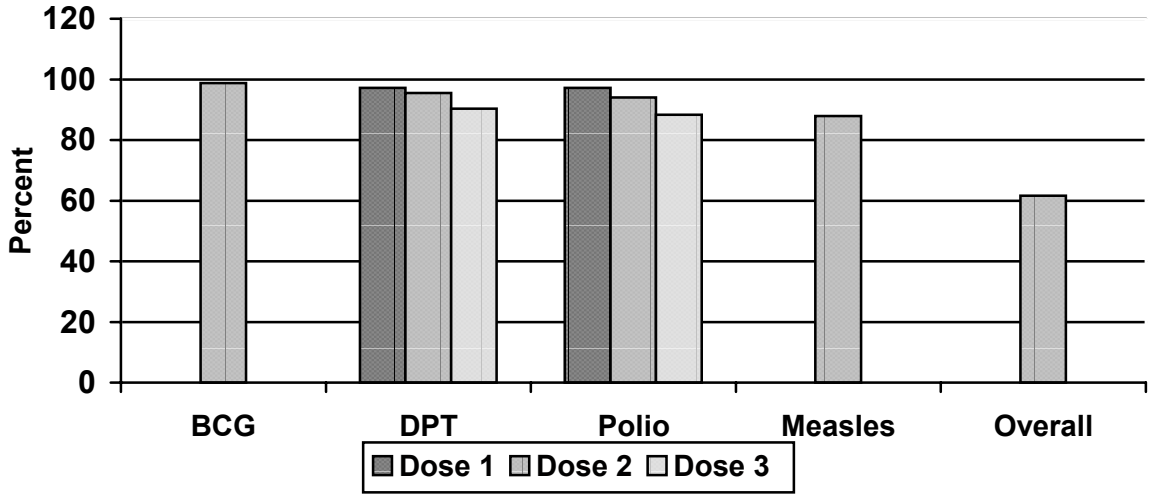
According to UNICEF and WHO guidelines, a child should receive a BCG vaccination to be protected against tuberculosis, three doses of DPT to be protected against diphtheria, pertussis, and tetanus, three doses of polio vaccine, and a measles vaccination by the age of 12 months. In the MICS 2, mothers were asked to provide vaccination cards for children under the age of five. Interviewers copied vaccination information from the cards onto the MICS questionnaire. Mothers were also probed to report any vaccinations the child received that did not appear on the card. Overall, 91 per cent of children had health cards. This has shown an increase of card retention from 78 per cent (MICS 1996) to 91 per cent. If the child did not have a card, a short description of each vaccine was read to the mother and asked to recall whether or not the child had received it and, for DPT and Polio, how many times.

Table 21 shows the percentage of children aged 12 to 23 months who received each of the vaccinations. The denominator for the table includes children aged 12-23 months and only children who are old enough to be fully vaccinated are counted. In the top panel, the numerator includes all children who were vaccinated at any time before the survey according to the vaccination card or the mother's report. In the bottom panel, only those who were vaccinated before their first birthday are included. For children without vaccination cards, the proportion of vaccines given before the first birthday is assumed to be the same as for children with vaccination cards.

Almost all (99 per cent) of children aged 12-23 months received a BCG vaccination by the age of 12 months and the first dose of DPT was given to 97 per cent of the children. The

percentage declines for subsequent doses of DPT to about 96 per cent for the second dose, and 90 per cent for the third dose (Figure 4 and Table 21). Similarly, 97 per cent of children received Polio 1 by age 12 months and this declines to 94 and 88 per cent respectively by the second and third doses. The coverage for measles vaccine by 12 months is almost the same as the coverage for third dose of Polio 3 at 88 per cent. As a result, the percentage of children who had all eight recommended vaccinations by their first birthday is 62 per cent. Overall, the immunisation coverage has dropped significantly from 87 to 62 per cent between MICS 1996 and 2000 respectively. This could be attributed to periodic shortages of some of these antigens in the health centres, the ageing cold chain and problems of sustainability in general.

Figure 4: Percentage of children aged 12-23 months who received immunisations by age 12 months, The Gambia 2000



In Table 22, the percentage of children aged 12-23 months currently vaccinated against childhood diseases is shown according to background characteristics. Unlike Table 21, the estimates in this Table refer to children who received the vaccinations by the time of the survey, even if they did not occur prior to the age of 12 months.

Overall vaccination coverage for male children, 65 per cent, is slightly higher than that of female children at 58 per cent. Urban children, on average, are less likely, 57 per cent, to be vaccinated compared to rural children at 65 per cent. Regional breakdowns are based on small numbers of cases and should be viewed with caution, but it appears that the Basse region has the highest coverage rates for most vaccinations and Janjanbureh LGA has the highest percentage of children who have received all of the recommended vaccinations. Basse LGA also has the highest percentage of children with health cards at 99 per cent. Vaccination coverage is highest among children whose mothers have secondary or higher education. However, educational differences are not significant across doses. On the other hand immunization coverage is lower among children of mothers in the richest wealth index category than those of children of mothers in the poorest category (Table 22).

Diarrhoea

Dehydration caused by diarrhoea is a major cause of mortality among children in The Gambia. Home management of diarrhoea – either through oral rehydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. Preventing

dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhoea.

In the MICS questionnaire, mothers (or caretakers) were asked to report whether their child had had diarrhoea in the two weeks prior to the survey. If so, the mother was asked a series of questions about what the child had to drink and eat during the episode and whether this was more or less than the child usually ate and drank. Overall, 22 per cent of under-five children had diarrhoea in the two weeks preceding the survey (Table 23). Diarrhoea prevalence was significantly higher in the Kuntaur LGA at 32 per cent than in other regions. The peak of diarrhoea prevalence occurs in the weaning period, among children age 6-23 months. As expected, the prevalence rate is lowest in Banjul and Kanifing and also among children of mothers with secondary or more education. The prevalence also is lowest among children of women in the richest wealth index category compared to those in the poorest categories (Table 23).

Table 23 also shows the percentage of children receiving various types of recommended liquids during the episode of diarrhoea. Since mothers were able to name more than one type of liquid, the percentages do not necessarily add to 100. Slightly more than one in three children received breast milk while they had diarrhoea. Children under age 12 months are especially likely to have received breast milk. About 27 per cent of children received gruel and 33 per cent received ORS. Children of mothers with no education appear to be less likely than other children to receive ORS while children of mothers with secondary or more education appear to be less likely to receive breast milk and gruel. Approximately seven in ten children with diarrhoea received one or more of the recommended home treatments (i.e., were treated with ORS or recommended home fluid (RHF).

About half of the under-five children with diarrhoea drank more than usual while 36 per cent drank the same or less (Tables 24). About 54 per cent at somewhat less, the same, or more than usual while 36 per cent ate much less than usual or none. Overall, only 27 per cent of children with diarrhoea received increased fluids and continued eating as recommended. Overall, there are no significant gender differences in the prevalence of diarrhoea (Tables 23 and 24).

Acute respiratory infection

Acute lower respiratory infections, particularly pneumonia, are one of the leading causes of child deaths in The Gambia. Children with acute respiratory infection are defined as those who had an illness with a cough accompanied by rapid or difficult breathing and whose symptoms were due to a problem in the chest, or both a problem in the chest and a blocked nose, or whose mothers did not know the source of the problem. Only 8 per cent of under-five children had an acute respiratory infection in the two weeks prior to the survey according to the above criteria (Table 25). Of these, 52 per cent were taken to Health Centre for treatment, and only 8 per cent each were taken to either a Hospital, Dispensary or to a MCH Clinic. Three per cent were taken to a VHW and 2 per cent to traditional healers. Overall, almost 75 per cent of children with ARI were taken to an appropriate health provider (i.e., Hospital, Health Centre, MCH Clinic and Dispensary). Interestingly, slightly more female children, 8 per cent, compared to male, 7 per cent, had acute respiratory infection in the two weeks before the survey (Table 25).

IMCI initiative

The Integrated Management of Childhood Illnesses (IMCI) is a programme developed by UNICEF and WHO that combines strategies for control and treatment of five major killers of

children – acute lower respiratory tract infections, diarrhoea dehydration, measles, malaria, and malnutrition. The programme focuses on the improvement of case management skills by health workers, improvement of the health system, and improvement of family and community practices in the prevention and early management of childhood illnesses. Appropriate home management of illness is one component of IMCI. The approach teaches mothers that appropriate home management of diarrhoea or any other illness requires giving more fluids and continuing to feed sick children in a normal manner.

Table 26 presents information on the drinking and eating behaviour of sick children. Less than half (47 per cent) of children were reported to have had diarrhoea or some other illness in the two weeks preceding the survey. Of these, 42 per cent drank more liquids during the illness and 59 per cent continued eating (i.e., ate somewhat less, the same, or more). Overall, only 24 per cent of ill children received increased fluids and continued eating as recommended under the IMCI programme. There are no gender differences in the proportion of children who reported illness in the last two weeks prior to the survey (Table 26).

Promoting knowledge among caretakers about when it is appropriate to seek care for ill children is another important component of the IMCI programme. In the MICS2, mothers or caretakers of children were asked to name all of the symptoms that would cause them to take a child to a health facility right away. The most common response, given by 74 per cent of mothers, was that they would take their child to a health facility right away if he/she developed a fever (Table 27). Twenty four per cent said that the child becoming sicker would cause them to take the child to a health facility and 16 per cent mentioned difficulty in breathing. Between 11 and 21 per cent of mothers cited an inability to breastfeed, fast breathing, blood in stools, and drinking poorly as reasons for taking a child to a health facility right away. Similarly, mothers or caregivers from the richest quintiles, 47 per cent, are more likely to know at least two signs compared to mothers or caregivers from the poorest quintiles, 37 per cent (Table 27).

Interestingly, mothers in Janjanbureh, 80 per cent, and to a lesser extent, in Mansakonko, 56 per cent, are more likely to know at least two signs for seeking care immediately than mothers in other regions. Overall, 50 per cent in the Kanifing, 38 per cent in Brikama, about 25 per cent in Kuntaur and 14 per cent in Basse. These regional differences are also reflected in the urban-rural and educational differentials. Urban mothers and those with education were more likely to mention at least two signs for seeking care than other mothers (Table 27).

Malaria

Malaria is a leading cause of death of children under-five in The Gambia. It also contributes to anaemia in children and is a common cause of school absenteeism. Preventive measures, especially the use of mosquito nets treated with insecticide, can dramatically reduce malaria mortality rates among children. In areas where malaria is common, international recommendations suggest treating any fever in children as if it were malaria and immediately giving the child a full course of recommended anti-malarial tablets. Children with severe malaria symptoms, such as fever or convulsions, should be taken to a health facility. Also, children recovering from malaria should be given extra liquids and food and should continue breastfeeding.

The MICS2 questionnaire incorporates questions on the use of bed-nets among children. In The Gambia, these questions were asked in all the regions since the regions are considered high-risk areas of malaria. Nationally, about 42 per cent of under-five children slept under a bed-net the night prior to the survey (Table 28). This percentage declines steadily with age.

Less than half of the infants under 6 months of age (44 per cent), a similar proportion of children aged 12-23 months and 38 per cent of children aged 48-59 months. Most of the bed nets are not treated with insecticide, however. In general the use of bed nets is more common in rural areas, and among the poor than the rich according to the MICS2 findings. Overall, only 35 per cent of the bed-nets are impregnated with insecticide. This has shown a slight improvement over four years in the use of impregnated bed-nets according to the MICS 1996 which shows a result of 28 per cent of children slept under dipped bed-nets. There is therefore a great need for more IEC programmes for the usage of permethrine as malaria is the highest killer disease among under-five children. There are no significant gender differences in the use of treated bed-nets among under-five children (Table 28).

Questions on the prevalence and treatment of fever were asked for all children under-five. Slightly more than one in ten under-five children were ill with fever in the two weeks prior to the MICS (Table 29). The prevalence of fever reaches 16 per cent of all children aged 6-11 months then declines to around 15 per cent for children aged 12-35 months and 15 per cent among children aged 48-59 months. Fever is less common among children whose mothers have secondary or higher education than among children of less educated mothers. Similarly, fever is more common among the children from the poorest quintiles than those from the richest quintiles. Regional differences in fever prevalence are not large, ranging from 7 in Banjul and Basse to 21 per cent in the Brikama LGA (Table 29).

Mothers were asked to report all of the medicines given to a child during their illness, that is, any medicine given at home and medicines given or prescribed at a health facility. Approximately 62 per cent of children were given Paracetamol and 55 per cent were given Chloroquine while 3 per cent were given Fansidar. A relatively considerable percentage of children (12 per cent) were given some other medicine. Overall, children with fever in Brikama, where malaria is probably most prevalent, are most likely to have received an appropriate anti-malarial drug. However, the results show a different pattern while those in Banjul, the least likely to be affected with malaria, receive an appropriate anti-malaria drug. Although the differentials are not wide, urban children are more likely than rural children to be treated appropriately with any anti-malarial drug. This may be explained by the relatively higher socio-economic status enjoyed by the urban population (Table 29).

F. HIV/AIDS

AIDS Knowledge

One of the most important strategies for reducing the rate of HIV/AIDS infection is the promotion of accurate knowledge of how AIDS is transmitted and how to prevent transmission. Among women aged 15-49, about 83 per cent have ever heard of AIDS (Table 30). This percentage is very high in urban areas (87 per cent) and somewhat lower in rural areas (79 per cent). For women with secondary level education and above 89 per cent reported to have heard of AIDS compared to 82 per cent of those with primary level education and 79 per cent of those with no education.

In the MICS, several statements about means of HIV/AIDS transmission were read to women and asked to state whether they believed the statements were true. Fifty-one per cent believe that having only one uninfected sex partner can prevent HIV transmission. About 50 per cent believe that using a condom every time one has sex can prevent HIV transmission. Overall, 32 per cent know all three ways and about 59 per cent were knows at least one of the means of preventing transmission (Table 30).

Accurate knowledge of the means of HIV/AIDS transmission is substantially lower among women in Basse than among women in other regions. Education is a very important factor in AIDS knowledge. The percentage who know all three ways of preventing transmission is nearly two times greater among women with secondary or more education compared to women with no education. Differences across age groups are not particularly large. The percentage of women who know all three ways ranges from about 24 per cent among 45-49 year olds to 38 per cent among 25-29 year olds and 37 per cent for those aged 30-34 years (Table 30).

Overall, 48 per cent of women correctly stated that AIDS couldn't be transmitted by supernatural means whereas about 31 per cent stated that AIDS couldn't be transmitted by mosquito bites (Table 31). Slightly more than five in ten women correctly believe that a healthy looking person can be infected. Women in the Kuntaur, Janjanbureh and Basse LGAs are less likely to know all three misconceptions about AIDS transmission compared to women elsewhere in the country. Women in Banjul are more likely to recognise all three misconceptions. Still, only about 39 per cent of women in Banjul correctly identified all three misconceptions. As expected, the level of educational attainment is positively related to knowledge on HIV/AIDS transmission. Regarding wealth index categories, no marked differentials have been observed on knowledge of HIV/AIDS transmission (Table 31).

Nationally, 56 per cent of women know that AIDS can be transmitted from mother to child (Table 32). When asked specifically about the mechanisms through which mother to child transmission can occur, 54 per cent said that transmission during pregnancy was possible, about 48 per cent said that transmission at delivery was possible, and about 43 per cent agreed that AIDS can be transmitted through breast milk. Slightly less than four in ten women know all three modes of transmission. This percentage does not vary much across background categories such as age, LGA and residence. Across levels of education, knowledge on HIV/AIDS transmission increases with an increase in educational attainment. However, there are no marked differentials between women with primary and secondary education and above. Women in the poorest wealth index categories tend to be least informed on the mode of HIV/AIDS transmission than women in the richest categories (Table 32).

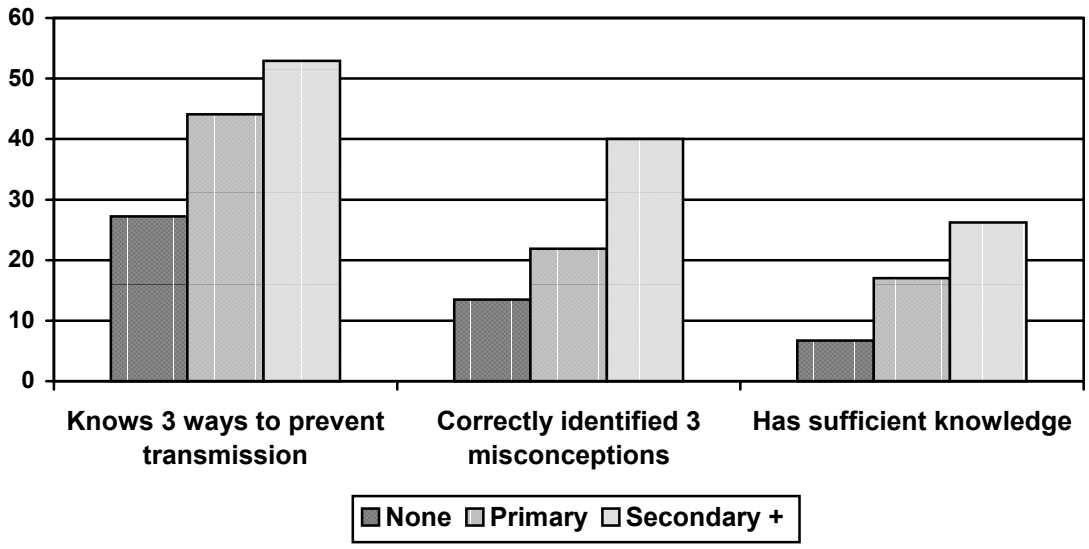
The MICS survey also attempted to measure discriminatory attitudes towards people living with HIV/AIDS. Respondents were asked whether they agreed with two questions. The first asked whether a teacher who has the AIDS virus should be allowed to continue teaching in school. The second question asked whether the respondent would buy food from a shopkeeper or food seller who the respondent knew to be infected with AIDS. Slightly more than one in five respondents believe that the teacher should not be allowed to work. Thirteen per cent would not buy food from a person with HIV/AIDS. However, about 76 per cent agree with neither discriminatory statement whilst 24 per cent agree with at least one discriminatory statement. Interestingly, the data suggest that urban women and those with secondary or higher education are more likely to express discriminatory attitude than rural women and those with no or primary education. Similar results can be observed among regions and across wealth index categories, for example, persons from the richest categories are more likely to express discriminatory attitude towards people with HIV/AIDS (Table 33).

Table 34 summarises information from two previous tables on AIDS knowledge (Tables 30 and 31). The second column shows the percentage of women who know all three ways of preventing HIV transmission – having one faithful uninfected partner, using a condom every time, and abstaining from sex. About 34 per cent of women know all three ways. The third

column of the table shows the percentage of women who correctly identified all three misconceptions about HIV transmission – that HIV can be transmitted through supernatural means, that it can be transmitted through mosquito bites, and that a healthy looking person cannot be infected. Nationally, about one in five women correctly identified these misconceptions. Finally, the fourth column of the table shows the percentage of women who have 'sufficient knowledge' of HIV/AIDS transmission. These are women who know all three ways of preventing HIV transmission and correctly identified all three misconceptions. In The Gambia, only 12 per cent of women aged 15-49 have sufficient knowledge of HIV/AIDS transmission.

Knowledge of HIV/AIDS transmission varies dramatically by level of education (Figure 5). Women with secondary or higher education are almost two times more likely to know all three ways to prevent transmission compared to women with no education. They are also three times more likely to correctly identify all three misconceptions about AIDS and four times more likely to have sufficient knowledge of HIV/AIDS transmission than women with no education.. Women in the richest categories of wealth index also have more sufficient knowledge of HIV/AIDS transmission compared to those in the poorest category (Table 34).

Figure 5: Percentage of women aged 15-49 who have sufficient knowledge of HIV/AIDS transmission by level of education, The Gambia, 2000



AIDS Testing

Voluntary testing for AIDS, accompanied by counselling, allows those infected to seek health care and to prevent the infection of others. Testing is particularly important for pregnant women who can then take steps to prevent infecting their babies. In some places, a relatively large proportion of people who are tested do not return to get their results due to fear of having the disease, fear that their privacy will be violated, or other reasons. The indicators shown in Table 35 are designed to monitor whether women know a place to get tested for HIV/AIDS, and whether they have been tested and told the result of the test.

Nationally, one in four women aged 15-49 years know a place to get tested for AIDS. Women living in Banjul are more likely to know a place, followed by those in Kerewan, Kanifing, Brikama, Kuntaur, Janjanbureh and Basse, respectively. Only 20 per cent of women with no education know a place to get tested compared to 28 per cent of women with primary school education and 44 per cent of women with secondary or higher education.

Overall about 7 per cent of women have been tested for AIDS. This percentage is highest in Kerewan at 15 per cent, lowest in Basse at 2 per cent and between 4-10 per cent in the other regions. Generally, the vast majority of women who have been tested were told the result; however, there is some variation across regions, age groups, and education levels. Among the regions, women in Basse are least likely to have been told their result. Adolescent women (15-19) are the least likely of any age group to have been tested and least likely to know the result. Finally, women with no education and with primary education are less likely to be tested than women with secondary or higher education. However, women with primary education are more likely to have been told the result of the test compared to women with secondary education and above. Women aged 15-49 years old who know where to get an AIDS test and who have been tested are higher among the richest wealth index categories and less among the poorest categories. The same pattern holds for women that have been tested and told their result (Table 35).

G. Reproductive Health

Contraception

Current use of contraception was reported by 9 per cent of married or in union women (Table 36). The most popular methods are the pill and injections, which are used by about 4 per cent of women respectively. The next most popular method is the IUD, the usage of which accounts for 0.8 per cent of married or women in union. Other methods such as female sterilisation, condoms, periodic abstinence, diaphram/foam/jelly and withdrawal are less used. Interestingly, the use of lactational amenorrhea method (LAM) is very insignificant at zero per cent. Compared with the 1990 Gambia Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS, 1990), there has been a slight decline in the use of any method of contraception from 12 to 9 per cent. Correspondingly, there has been a slight increase in the use of any modern method from 7 to approximately 9 per cent. Similarly, there have been slight increases in the use of pills and injections from 3 to 4 and 2 to 4 per cent respectively.

Contraceptive prevalence is highest in Banjul at 24 per cent, followed by Kuntaur LGA and Kanifing at 10 per cent each. Nine per cent of married or women in union in Brikama and Kerewan use a method of contraception. About 8 and 7 per cent use contraception in Basse and Mansakonko LGAs respectively. In Janjanbureh area, contraceptive use is rare, only 6 per cent of married women reported using any method. Adolescents are far less likely to use contraception than older women. Only about 2 per cent of married or women in union aged 15-19 currently use a method of contraception compared to 6 per cent of 20-24 year olds and about 11 per cent of 25-49 year old women. Comparatively, the use of traditional methods is generally very low, which suggests that more and more women now use modern methods of contraception. It is believed that the information on contraceptive use may be under-reported due to the following reasons:

- The questionnaire was mostly administered in the presence of men (mostly household heads) and/or other male family members who may not approve of the use of contraception. Thus, most women are reluctant to say that they use contraceptives, least they would be accused of promiscuity, prostitution, and/or infidelity to their husbands;
- Both the Islamic scholars and the Catholic Church do not approve of the use of contraceptives. For instance, over the past several years and to date, virulent campaigns were made against the use of contraceptives on both the radio and television by venerable Islamic scholars during the weekly Friday prayer sermons;

- The lack of political commitment and leadership from the highest level; and
- The scaling down of the activities of the Gambia Family Planning Association due to administrative and management problems coupled with the lack of resource flow from donors.

Women's education level is associated with higher contraceptive prevalence. The percentage of women using any method of contraception rises from 8 per cent among those with no education to about 13 per cent among women with primary education, and to 18 per cent among women with secondary or higher education. In addition to differences in prevalence rate, the method mix also varies by education. Regarding wealth index categories, the use of contraception is less among the poorest and highest among the richest at about 6 and 13 per cent respectively (Table 36).

Prenatal care

The quality of prenatal care can contribute to the prevention of maternal mortality by detecting and managing potential complications and risk factors, including pre-eclampsia, anaemia, and sexually transmitted diseases. Prenatal care also provides opportunities for women to learn the danger signs of pregnancy and delivery, to be immunised against tetanus, to learn about infant care, and be treated for existing conditions, such as malaria and anaemia.

Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus, a major cause of infant death that is due primarily to unhygienic conditions during childbirth. Two doses of tetanus toxoid during pregnancy offer full protection. However, if a woman was vaccinated during a previous pregnancy, she may only need a booster to give full protection. Five doses are thought to provide lifetime protection.

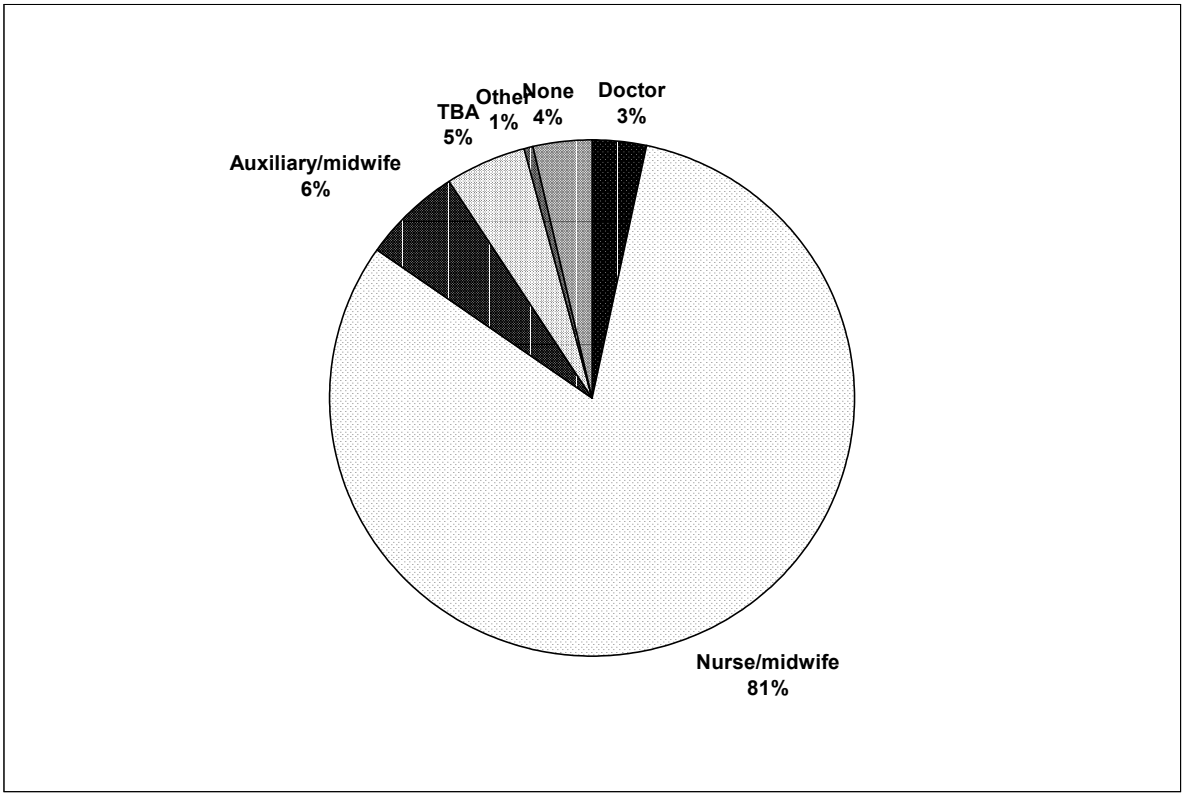
About three out of four women with recent births are protected against neonatal tetanus (Table 37). The vast majority of these women received two or more doses of tetanus toxoid within the last three years. Among the regions, women living in Kerewan are more likely to be protected (84 per cent) while those living in Janjanbureh are the least likely to be protected (63 per cent). Note, however, that the regional estimates are based on small numbers of cases and should be interpreted with caution. Women with no education are more likely to be protected against tetanus compared to those with either primary education or secondary or higher education.

The respondents who had had a birth in the year prior to MICS2 were asked whether they had received antenatal care and if so, what type of person provided the care. If the woman saw more than one type of provider, all were recorded in the questionnaire. Table 38 presents the percentage distribution of women with a birth in the year prior to the MICS by the type of personnel who delivered antenatal care. If the respondent mentioned more than one provider, she is categorised as having seen the most skilled person she mentioned. Women from among the poorest wealth index category are least likely to be protected against tetanus than those from among the richest category.

Virtually all women in The Gambia receive some type of antenatal care. Overall, about 91 per cent receive antenatal care from skilled personnel (doctor, nurse/midwife, and auxiliary midwife). About 3 per cent of women with a birth in the year prior to the survey received antenatal care from a doctor, 82 per cent from a nurse/midwife, and 6 per cent from an auxiliary midwife (Figure 6). Five per cent of women receive some type of care from traditional birth attendants. Note that auxiliary mid wives are more used for antenatal care in Basse, whilst in the other regions, excluding Kuntaur and Janjanbureh, under 5 per cent of

women received care from auxiliary mid wives. Generally, in all regions, nurse or mid wife are most likely to provide prenatal care. However, the use of traditional birth attendants for antenatal care is significant in Kerewan and Janjanbureh regions. Also delivery of antenatal care by doctors reduced from 15 per cent in 1990 to 3 per cent. This declined can be attributed to major increases and use of trained nurses/midwives over the years.

Figure 6: Percentage distribution of women with a birth in the last year by type of personnel delivering antenatal care, The Gambia, 2000



Assistance at Delivery

The provision of delivery assistance by trained attendants can greatly improve outcomes for mothers and children by the use of technically appropriate procedures, and accurate and speedy diagnosis and treatment of complications. *Skilled assistance at delivery* is defined as assistance provided by a doctor, nurse, or midwife. Skilled personnel (Table 39) delivered about 55 per cent of births occurring in the year prior to the MICS survey. This has shown an upward movement compared to the result (44 per cent) on assistance at delivery provided by any skilled personnel from the 1990 Gambia Contraceptive Prevalence and Fertility Determinant Survey (GCPFDS). However, assistance at delivery by a doctor has reduced from 8 per cent in 1990 to 4 per cent according to the MICS 2000. Assistance at delivery by any skilled personnel is highest in Banjul at 91 per cent and lowest in Kuntaur at 29 per cent. The more educated a woman is, the more likely she is to have delivered with the assistance of a skilled person.

Almost one in two, (47 per cent), of the births in the year prior to the MICS were delivered with the assistance of nurse/midwife. Doctors assisted with the delivery of 4 per cent of births and auxiliary midwife delivered about 3 per cent of births. Births delivered by auxiliary midwife were more in Banjul compared to any other region of the country. Delivery assistance by a doctor is also highest in Banjul compared to any other part of the country. In Kanifing, about 78 per cent of births are delivered by nurse or mid wife. In the other regions,

between 29 and 59 per cent of births are delivered with the assistance of any skilled personnel. As expected, delivery assistance by a doctor as well as delivery by any other skilled personnel is highest from among women in the richest category of the wealth index compared to the poorest category. Overall, traditional birth attendants assist in delivering a quarter of the births in the country (Table 39).

H. Child Rights

Birth Registration

The International Convention on the Rights of the Child states that every child has the right to a name and a nationality and the right to protection from being deprived of his or her identity. Birth registration is a fundamental means of securing these rights for children. The births of 32 per cent of children under-five years in The Gambia have been registered (Table 40). There are no significant variations in birth registration by gender. Registration is highest in children aged 6-11 months. Children in Basse and Kuntaur LGAs are more unlikely to have their births registered compared to children from other LGAs. However, this appears to be due primarily to a relatively large proportion of mothers in Basse and Kuntaur who do not know if their child's birth should be registered. Among those whose births are not registered, cost, travel distance, and lack of knowledge do not appear to be the main reasons. The main reason for not registering is the `Others' category, about 24 per cent, in which the majority of the respondents said it is the fathers' responsibility to register their children. With regards to education, birth registration increases the higher the mother's level of education. Birth registration is also highest with children from the richest wealth index category and lowest from children in the poorest wealth index category at 40 and 25 per cent respectively (Table 40).

Orphanhood and living arrangements of children

Children who are orphaned or living away from their parents may be at increased risk of impoverishment, discrimination, denial of property rights and rights to inheritance, various forms of abuse, neglect, and exploitation of their labour or sexuality. Monitoring the level of orphanhood and the living arrangements of children assists in identifying those who may be at risk and in tracking changes over time.

In The Gambia, about 73 per cent of children aged 0-14 are living with both parents (Table 41). A small percentage - 9 per cent – is living with their mother only although their father is alive. About 6 per cent are living with neither parent although both parents are alive. Nationally, children who are not living with a biological parent comprise 10 per cent and children who have one or both parents' dead constitute about 8 per cent of all children aged 0-14. Older children are more likely to live away from their biological parents than younger children. While about 4 per cent of children under-five are not living with a biological parent, 16 per cent of children aged 10-14 do so.

The situation of children in Banjul differs from that of other children in The Gambia. In the Banjul LGA, 63 per cent of children live with both parents. About 16 per cent live with their mothers only but their fathers are also alive and a relatively large proportion, 10 per cent, are living with neither parents even though both parents are alive. A similar situation also obtains in the Janjanbureh LGA. This pattern is most likely due to labour migration of men and, to some extent women migrating to Europe and America, single parenthood, non-residential polygamy and higher rates of divorce. The wealth index categories show that the proportion of children living with both biological parents is highest among those in the

poorest category, 80 per cent, than among the richest category, 64 per cent. This may be explained by the fact that most of the parents of children from the richest category are educated and were out of the country, at the time of the survey, either pursuing higher education or looking for greener pastures.

Child Labour

It is important to monitor the extent to which children work and the type of work in which they participate for several reasons. Children who are working are less likely to attend school and more likely to drop out. This pattern can trap children in a cycle of poverty and disadvantage. Working conditions for children are often unregulated with few safeguards against potential abuse. In addition, many types of work are intrinsically hazardous and others present less obvious hazards to children, such as exposure to pesticides in agricultural work, carrying heavy weights and scavenging in garbage dumps.

In The Gambia, the MICS survey estimates that only 2 per cent of children aged 5-14 years engage in paid work (Table 42). Twice as many – 4 per cent – participate in unpaid work for someone other than a household member.

'Domestic work' is defined as cooking, shopping, cleaning, washing clothes, fetching water, and caring for children. A significant percentage of children (43 per cent) do these tasks for less than four hours a day, while about 4 per cent spends four or more hours a day on such tasks. Overall, boys and girls do the same amount of domestic work as well as older children (aged 10-14) and (aged 5-9 years). Variations across regions are highest in the percentage of children who engage in more than four hours of domestic work a day. This ranges from under one per cent in Banjul and Mansakonko regions to 9 per cent in Basse (Table 42).

Children who have done any paid or unpaid work for someone who is not a member of the household or who did more than four hours of housekeeping chores in the household or who did other family work are considered to be 'currently working'. Overall, about 27 per cent of children are classified as currently working. There is no difference, among children currently working, between boys and girls. Regionally, the percentage of children currently working is lowest in Kanifing at 8 per cent and highest in Janjanbureh at 47 per cent. Rural children are more than twice likely to work than urban children. The wealth index shows that a staggering 40 per cent of working children are from the poorest households compared to only 11 per cent from the richest households. Similarly, 34 per cent of children from the poorest households work on family farm or business compared to only 5 per cent of children from the richest households (Table 42).

Appendix A: Sampling Error

Indicator	Description of indicator	Proportion	Standard error	Weighted cases	Relative error	-2SD (Lower Limit)	+2SD (Upper Limit)	Design effect
Under-five mortality rate	Probability of dying before reaching age five							
Infant mortality rate	Probability of dying before reaching age one							
Underweight prevalence	Proportion of under-fives who are too thin for their age	.035	.005	2554	.148	.025	.046	4.818
Stunting prevalence	Proportion of under-fives who are too short for their age	.063	.007	2554	.116	.048	.077	5.598
Wasting prevalence	Proportion of under fives who are too thin for their height	.011	.003	2554	.235	.006	.016	45.988
Use of safe drinking water	Proportion of population who use a safe drinking water source	.840	.023	30258	.028	.793	.887	.057
Use of sanitary means of excreta disposal	Proportion of population who use a sanitary means of excreta disposal	.879	.016	30258	.019	.846	.912	.037
Children reaching grade five	Proportion of children entering first grade of primary school who eventually reach grade five							
Net primary school attendance rate	Proportion of children of primary school age attending primary school	.516	.016	5695	.030	.484	.547	.050
Literacy rate	Proportion of population aged 15+ years who are able to read a letter or newspaper	.364	.016	16135	.045	.331	.397	.106
Antenatal care	Proportion of women aged 15-49 attended at least once during	.866	.033	1140	.038	.801	.931	.169

	pregnancy by skilled personnel							
Contraceptive prevalence	Proportion of married women aged 15-49 who are using a contraceptive method	.090	.006	4353	.068	.078	.103	1.408
Childbirth care	Proportion of births attended by skilled health personnel	.546	.017	1115	.031	.512	.580	.188
Birth weight below 2.5 kg.	Proportion of live births that weigh below 2500 grams	.141	.022	480	.153	.098	.184	1.647
Iodised salt consumption	Proportion of households consuming adequately iodised salt	.836	.005	4532	.006	.826	.846	.011
Children receiving Vitamin A supplementation	Proportion of children aged 6-59 months who have received a Vitamin A supplement in the last 6 months	.037	.005	3235	.148	.026	.047	16.048
Mothers receiving Vitamin A supplementation	Proportion of mothers who received a Vitamin A supplement before infant was 8 weeks old	.140	.015	1115	.105	.111	.169	3.514
Exclusive breastfeeding rate	Proportion of infants aged less than 4 months who are exclusively breastfed	.361	.050	235	.140	.260	.462	1.260
Timely complementary feeding rate	Proportion of infants aged 6-9 months who are receiving breast milk and complementary food	.357	.040	355	.113	.277	.438	.753
Continued breastfeeding rate	Proportion of children aged 12-15 months and 20-23 months who are breastfeeding	.435	.050	264	.114	.336	.535	.828
DPT immunisation coverage	Proportion of children immunised against diphtheria, pertussis and							

	tetanus by age one							
Measles immunisation coverage	Proportion of children immunised against measles by age one	.792	.127	42	.160	.538	1.046	.711
Polio immunisation coverage	Proportion of children immunised against polio by age one	.980	.051	42	.052	.878	1.081	.121
Tuberculosis immunisation coverage	Proportion of children immunised against tuberculosis by age one							
Children protected against neonatal tetanus	Proportion of one year old children protected against neonatal tetanus through immunisation of their mother	.771	.021	1115	.027	.729	.813	.143
ORT use	Proportion of under-five children who had diarrhoea in the last 2 weeks who were treated with oral rehydration salts or an appropriate household solution	.330	.019	785	.058	.292	.368	.623
Home management of diarrhoea	Proportion of under-five children who had diarrhoea in the last 2 weeks and received increased fluids and continued feeding during the episode	.271	.029	785	.106	.213	.328	1.042

Indicator	Description of indicator	Proportion	Standard error	Weighted cases	Relative error	-2SD Lower Limit	+2SD Upper Limit	Design effect
Care seeking for acute respiratory infections	Proportion of under-five children who had ARI in the last 2 weeks and were taken to an appropriate health provider	.077	.007	3632	.089	.064	.091	6.477
Pre-school development	Proportion of children aged 36-59 months who are attending some form of organised early childhood education program	.322	.018	3632	.056	.285	.358	.396
	Indicators for Monitoring Children's Rights							
Birth registration	Proportion of under-five children whose births are reported registered	.462	.014	3632	.030	.433	.491	.128
Children's living arrangements	Proportion of children aged 0-14 years in households not living with a biological parent	.102	.003	13749	.028	.096	.108	.378
Orphans in household	Proportion of children aged 0-14 years who are orphans living in households	.079	.005	13749	.061	.069	.088	1.952
Child labour	Proportion of children aged 5-14 years who are currently working	.269	.026	9406	.097	.216	.321	.970
	Indicators for Monitoring IMCI and Malaria							
Home management of illness	Proportion of under-five children reported ill during the last 2 weeks who received increased fluids and continued feeding	.271	.029	785	.106	.213	.328	1.042
Care seeking knowledge	Proportion of caretakers of under-five children who know at least 2 signs for seeking care immediately	.394	.011	3632	.028	.372	.416	.148
Bednets	Proportion of under-five children who sleep under an insecticide impregnated bednet	.416	.014	3632	.034	.388	.445	.246
Malaria treatment	Proportion of under five children who were ill with fever in the last 2 weeks who received anti-malarial drugs	.560	.033	538	.059	.493	.636	.445

		Indicators for Monitoring HIV/AIDS						
Knowledge of preventing HIV/AIDS	Proportion of women who correctly state the 3 main ways of avoiding HIV infection	.331	.023	1214	.071	.276	.367	.519
Knowledge of misconceptions of HIV/AIDS	Proportion of women who correctly identify 3 misconceptions about HIV/AIDS	.196	.010	5976	.049	.177	.215	.243
Knowledge of mother to child transmission	Proportion of women who correctly identify means of transmission of HIV from mother to child	.561	.008	5976	.015	.545	.578	.033
Attitude to people with HIV/AIDS	Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS	.242	.007	5976	.031	.227	.257	.175
Women who know where to be tested for HIV	Proportion of women who know where to get a HIV test	.252	.013	5976	.052	.226	.278	.296
Women who have been tested for HIV	Proportion of women who have been tested for HIV	.072	.005	5976	.063	.063	.081	4.596

Appendix B: List of Personnel Involved in The Gambia MICS 2000

Taskforce

Alieu S.M. N'Dow	Director, CSD
Nyakassi M.B. Sanyang	Statistician, CSD
Alieu Bahoum	Cadet Statistician, CSD
Amie Gaye	Senior Statistician, CSD
Mahen Sumner	Principal Statistician, CSD
Alieu Saho	Statistician, CSD
Lamin Fatty	Statistician, CSD
Lolley Jallow	Senior Programmer, CSD
Karamo Keita	Head, National Rehabilitation Centre, DSW
Modou Phall	Head, Nutrition Unit, DoSH
Amadou Wurrie Jallow	Health Officer, Malaria Control Unit, DoSH
Rohey Wadda	Programme Officer, SPACO
Mutarr Jammeh	Research Officer, GFPA
Nyakassi Jarju	Principal Planner, DoSE
Alhagie Nyangado	Planner, DoSE
Dr. Manfred Zahorta	Head, Gambia-German Family Planning Project
MomodouLamin Cham	Health Officer, ESU, DoSE
Faal Sanneh	Development officer, DCD
Sanjally Trawalley	Health officer, DoSH
Ernest Mendy	Health officer, DoSH
Isatou Sissoho	WATSAN Project Officer, UNICEF Banjul
Sheriffo Sonko	Monitoring & Evaluation Officer, UNICEF Banjul
Baba Danbappa	Health Project Officer, UNICEF Banjul
Jeneiri Sagnia	Education Project Officer, UNICEF Banjul

Interviewers

Mustapha Daffeh
Mustapha Fofana
Ousman Cham
Salimata Janneh
Alhagie Conteh
Bukary Gaye
Fatou Jamba
Abdoulie Jarra
Alieu Kujabi
Lamin Gibba
Bai Cham
Omar Touray
Muhammed A. Kah
Bakary Sanneh
Famara Nyabally
Pa Fofana
Kumba Badgie
Cherno Bahoum
Alhagie Ebou Ceesay
Lamin Samateh
Saiga Joof
Jainaba Konteh
Saihou S. Sanyang
Ndey Binta Bojang
Lamin Camara
Amadou Chorr

Data Entry Clerks

Aminata Deen
Yata Sey Chorr
Sainabou Jobe
Kumba Bah
Fatou Fatty Bittaye
Haddijatou Manjang
Fatmata Deen
Ndey Rohey Khan
Haddy Ceesay
Samba Njie
Haddy Conteh
Sarjo I.B. Gibba
Kaddy Kujabi
Isatou Ann
Abie Faye
Sainabou Mbenga
Nyara Jammeh N'Dow
Ramatoulaye Bojang
Nenneh Cole
Alhagie Nasiru Deen
Ebou Jawo
Baboucarr Jallow
Fatou Secka
Kabba N'Dow

Coders

Karamo Nyabally

Abu Camara
Aminata Deen
Ida Lowe Njie
Haddy Secka
Madi Gibba
Modou Njie

Alhagie Choi
Musa Jammeh
Lamin Jallow
Fabakary Jawneh
Fatou Darboe
Mamadou Krubally

Isatou Sarr

Field Supervisors

Alieu Saho
Lamin Fatty
Faal Sanneh
Amie Jarra
Ali D. Ceesay
Ernest Mendy
Momodou Lamin Cham

Data Entry Supervisors

Lolley Jallow
Edrisa Ceesay
Sainabou Jasseh

Coding Supervisors

Nyakassi M.B. Sanyang
Alieu Saho
Lamin Fatty

Field Co-ordinators

Nyakassi M.B. Sanyang
Alieu Bahoum
Alieu Sarr

Project Co-ordinator

Nyakassi M.B. Sanyang

Adviser

Alieu S.M. N'Dow, Director, CSD

APPENDIX C: TABLES

Table 1: Number of households and women, and response rates, The Gambia, 2000

	Urban	Rural	Total
Sampled households	2339	2197	4536
Occupied households	2316	2176	4492
Interviewed households	2313	2165	4478
Household response rate	99.9	99.5	99.7
Eligible women	3017	3452	6469
Interviewed women	2801	3175	5976
Women response rate	92.8	92.0	92.4
Children under 5	1419	2430	3849
Interviewed children under 5	1332	2300	3632
Child response rate	93.9	94.7	94.4

Table 2: Single year age distribution of household population by sex, The Gambia, 2000

	Male		Female			Male		Female	
Age	Number	Percent	Number	Percent	Age	Number	Percent	Number	Percent
0	482	3.2	489	3.2	37	115	.8	97	.6
1	496	3.3	441	2.9	38	129	.9	154	1.0
2	436	2.9	453	3.0	39	90	.6	82	.5
3	400	2.7	428	2.8	40	272	1.8	319	2.1
4	334	2.2	383	2.5	41	54	.4	31	.2
5	570	3.8	505	3.3	42	113	.8	73	.5
6	486	3.3	539	3.5	43	89	.6	48	.3
7	579	3.9	545	3.6	44	37	.2	36	.2
8	534	3.6	550	3.6	45	212	1.4	144	.9
9	458	3.1	434	2.8	46	79	.5	53	.3
10	536	3.6	549	3.6	47	52	.3	29	.2
11	312	2.1	301	2.0	48	82	.5	39	.3
12	417	2.8	482	3.1	49	69	.5	20	.1
13	382	2.6	438	2.9	50	197	1.3	374	2.4
14	321	2.2	470	3.1	51	23	.2	96	.6
15	417	2.8	293	1.9	52	63	.4	101	.7
16	235	1.6	245	1.6	53	34	.2	80	.5
17	229	1.5	233	1.5	54	53	.4	54	.4
18	363	2.4	379	2.5	55	104	.7	107	.7
19	256	1.7	258	1.7	56	69	.5	65	.4
20	409	2.7	460	3.0	57	44	.3	31	.2
21	177	1.2	198	1.3	58	45	.3	22	.1
22	216	1.4	278	1.8	59	27	.2	20	.1
23	190	1.3	242	1.6	60	197	1.3	170	1.1
24	174	1.2	195	1.3	61	23	.2	14	.1
25	313	2.1	429	2.8	62	27	.2	24	.2
26	165	1.1	238	1.6	63	40	.3	21	.1
27	234	1.6	227	1.5	64	32	.2	13	.1
28	187	1.3	273	1.8	65	100	.7	42	.3
29	140	.9	158	1.0	66	21	.1	8	.1
30	387	2.6	465	3.0	67	26	.2	9	.1
31	75	.5	110	.7	68	32	.2	12	.1
32	158	1.1	180	1.2	69	28	.2	8	.1
33	119	.8	120	.8	70+	386	2.6	227	1.5
34	80	.5	107	.7	Missing/DK	225	1.5	139	.9
35	324	2.2	299	2.9					
36	136	.9	177	1.2	Total	14914	100.0	15333	100.0

Table 3: Percentage of cases with missing information, The Gambia, 2000

	Reference population	Percent missing	Number
Level of education	Household members	.9	14874
Year of education	Household members	.0	14837
Number of hours worked	Working children age 5-14	.9	1736
Complete birth date	Women 15-49	.3	5976
Date of last tetanus toxoid injection	Women with a live birth in the last year	.4	1113
Ever been tested for HIV	Women 15-49	.1	5966
Complete birth date	Children under 5	3.3	3632
Diarrhoea in last 2 weeks	Children under 5	.0	3632
Weight	Children under 5	.7	3632
Height	Children under 5	.1	3632

Table 4: Percent distribution of households by background characteristics, The Gambia, 2000

	Area		
	Urban	Rural	Total
Banjul	5.2	.0	2.6
Kanifing	62.9	.0	30.8
Brikama	11.7	44.9	28.7
Mansakonko	1.5	6.4	4.0
Kerewan	10.5	20.3	15.5
Kuntaur	.7	4.7	2.8
Janjanbureh	1.1	7.0	4.1
Basse	6.3	16.7	11.7
Number of HH members			
1	11.1	7.3	11.1
2-3	16.5	11.4	16.5
4-5	21.1	17.6	21.1
6-7	19.2	22.0	19.2
8-9	12.1	14.6	12.1
10+	20.1	27.1	20.1
Total	100.0	100.0	100.0
At least one child age < 15	70.6	85.2	78.0
At least one child age < 5	48.2	63.1	55.8
At least one woman age 15-49	74.0	82.3	78.2
Number	2219	2313	4532
Unweighted	2339	2197	4536

Table 5: Percent distribution of women 15-49 by background characteristics, The Gambia, 2000

	Percent	Number	Unweighted
Banjul	2.2	132	1271
Kanifing	27.4	1637	846
Brikama	27.2	1627	635
Mansakonko	3.6	213	634
Kerewan	15.2	908	657
Kuntaur	3.1	187	673
Janjanbureh	3.8	230	635
Basse	17.5	1043	625
Urban	44.3	2648	2801
Rural	55.7	3328	3175
Age			
15-19	20.3	1214	1175
20-24	20.3	1210	1180
25-29	19.3	1153	1141
30-34	14.9	890	867
35-39	11.9	713	705
40-44	7.3	439	489
45-49	4.2	250	282
Not stated	1.8	107	137
Currently married	72.8	4353	4256
Formerly married	6.3	379	432
Never married	20.6	1232	1282
Not stated	.2	12	6
Ever given birth			
Yes	72.5	4330	4263
No	27.5	1646	1713
Education level			
None	70.7	4223	4177
Primary	9.4	564	540
Secondary +	19.9	1189	1259
Total	100.0	5976	5976

Table 6: Percent distribution of children under 5 by background characteristics, The Gambia, 2000

	Percent	Number	Unweighted
Male	49.9	1811	1859
Female	50.1	1821	1773
Banjul	1.3	47	479
Kanifing	23.7	862	484
Brikama	28.5	1032	451
Mansa Konko	3.0	108	362
Kerewan	16.2	590	455
Kuntaur	3.7	135	574
Janjabureh	3.4	123	365
Basse	20.1	731	462
Urban	37.6	1365	1322
Rural	62.4	2267	2300
Age			
< 6 months	10.6	386	407
6-11 months	12.0	437	429
12-23 months	23.0	835	827
24-35 months	20.1	731	767
36-47 months	18.4	667	651
48-59 months	15.3	556	525
Not stated	.6	21	26
Mother's education			
None	80.8	2936	2956
Primary	7.9	286	254
Secondary +	11.3	410	422
Total	100.0	3632	100.0

Table 7: Mean number of children ever born (CEB) and proportion dead by mother's age, The Gambia, 2000

		Mean number of CEB	Proportion dead	Number of women
Age	15-19	.323	.136	1214
	20-24	1.427	.121	1210
	25-29	3.007	.154	1153
	30-34	4.393	.155	890
	35-39	5.232	.170	713
	40-44	5.911	.198	439
	45-49	6.692	.243	250
	Not stated	3.436	.183	107
	Total	2.989	.169	5976

Table 8b: Mean number of children ever born (CEB) and proportion dead by mother's age and poverty ndex, The Gambia, 2000

		Mean number of CEB	Proportion dead	Number of women
Wealth Index Quintile				
Poorest	15-19	.637	.110	196
Age	20-24	1.930	.128	167
	25-29	3.703	.167	184
	30-34	4.992	.221	171
	35-39	5.737	.216	131
	40-44	5.893	.242	95
	45-49	7.404	.318	48
	Not stated	3.854	.376	16
Second	15-19	.403	.072	216
Age	20-24	1.669	.142	183
	25-29	3.220	.155	213
	30-34	4.851	.170	176
	35-39	5.784	.184	144
	40-44	6.672	.169	95
	45-49	6.854	.222	59
	Not stated	3.669	.226	21
Middle	15-19	.415	.264	232
Age	20-24	1.607	.104	244
	25-29	3.164	.146	217
	30-34	4.434	.166	164
	35-39	5.463	.179	142
	40-44	5.733	.213	117
	45-49	7.092	.291	42
	Not stated	3.931	.134	35
Fourth	15-19	.120	.103	276
Age	20-24	1.293	.130	273
	25-29	3.052	.163	247
	30-34	4.799	.134	174
	35-39	5.215	.131	145
	40-44	5.775	.227	75
	45-49	6.297	.182	54
	Not stated	2.995	.133	18
Richest	15-19	.145	.096	285
Age	20-24	.983	.107	328
	25-29	2.218	.129	284
	30-34	3.064	.064	202
	35-39	4.026	.129	145
	40-44	5.083	.097	54
	45-49	5.422	.161	44
	Not stated	2.069	.031	16
Wealth	15-19	1.063	.037	9
Index	20-24	2.099	.076	15
Quintile	25-29	3.641	.247	9
Not	30-34	7.588	.000	3
stated	35-39	5.080	.158	7
	40-44	7.287	.170	4
	45-49	9.848	.386	5
	Not stated	5.348	.000	0
Total		2.989	.169	5976

Table 9: Percentage of children aged 36-59 months who are attending some form of organized early childhood education programme, The Gambia, 2000

	Attending programme	Number of children
Male	16.1	583
Female	16.5	640
Banjul	28.6	14
Kanifing	25.7	297
Brikama	18.6	358
Mansakonko	17.6	36
Kerewan	7.7	185
Kuntaur	5.0	42
Janjabureh	2.9	35
Basse	11.2	255
Urban	20.3	460
Rural	13.9	763
36-47 months	11.1	667
48-59 months	22.5	556
Mother's education		
None	12.7	1004
Primary	19.4	88
Secondary +	42.1	131
Wealth Index Quintiles		
Poorest	11.2	240
Second	11.5	208
Middle	9.4	247
Fourth	19.0	297
Richest	29.2	220
Not Stated	42.3	11
Total	16.3	1223

Table 10: Percentage of children of primary school age attending primary school, The Gambia, 2000

	Male		Female		Total	
	Attending	Number	Attending	Number	Attending	Number
Banjul	73.0	37	67.5	37	70.3	74
Kanifing	70.3	544	67.8	636	69.0	1180
Brikama	69.2	878	64.0	779	66.8	1657
Mansakonko	59.9	103	53.0	113	56.3	216
Kerewan	39.0	500	36.4	459	37.8	959
Kuntaur	36.3	97	33.2	107	34.7	204
Janjabureh	29.6	123	29.8	142	29.7	264
Basse	32.2	553	26.0	588	29.0	1141
Urban	65.4	918	62.4	1037	63.8	1955
Rural	48.1	1916	42.0	1824	45.1	3740
Age						
7	33.1	579	28.9	545	31.0	1124
8	55.7	534	46.3	550	50.9	1083
9	58.2	458	49.7	434	54.1	892
10	60.2	536	56.3	549	58.2	1085
11	66.7	312	60.4	301	63.6	612
12	57.0	417	61.2	482	59.3	899
Wealth Index Quintiles						
Poorest	36.4	628	30.2	624	33.3	1253
Second	55.6	690	51.2	558	53.6	1248
Middle	52.2	555	42.1	594	47.0	1149
Fourth	56.9	502	58.6	541	57.8	1043
Richest	74.4	414	70.3	499	72.2	913
Not stated	60.0	45	47.0	45	53.5	90
Total	53.7	2834	49.4	2861	51.6	5695

Table 11: Percentage of children entering first grade of primary school who eventually reach grade 5, The Gambia, 2000

	Percent in grade 1 eventually reaching grade 2	Percent in grade 2 eventually reaching grade 3	Percent in grade 3 eventually reaching grade 4	Percent in grade 4 eventually reaching grade 5	Percent who reach grade 5 of those who enter grade 1
Male	98.9	99.9	98.1	99.5	96.4
Female	99.1	98.1	99.9	99.9	97.0
Banjul	99.2	99.0	100.0	100.0	98.2
Kanifing	100.0	98.5	98.0	100.0	96.5
Brikama	99.3	98.8	100.0	100.0	98.1
MansaKonko	99.2	98.5	100.0	98.6	96.3
Kerewan	100.0	100.0	100.0	100.0	100.0
Kuntaur	97.0	98.5	98.5	100.0	94.0
Janjanbureh	100.0	98.0	100.0	100.0	98.0
Basse	94.7	100.0	97.0	95.8	88.0
Urban	99.4	99.0	98.5	100.0	96.9
Rural	98.7	99.0	99.3	99.4	96.5
Wealth index Quintiles					
Poorest	98.4	99.3	96.7	100.0	94.5
Second	99.8	98.5	100.0	98.6	96.9
Middle	97.9	97.2	99.7	99.7	94.6
Fourth	98.4	99.9	98.5	100.0	96.8
Richest	99.9	100.0	98.7	100.0	98.6
Not stated	100.0	100.0	100.0	100.0	100.0
Total	99.0	99.0	98.9	99.7	96.6

Table 12: Percentage of the population aged 15 years and older that is literate, The Gambia, 2000

	Male			Female			Total		
	Literate	Not known	Number	Literate	Not known	Number	Literate	Not known	Number
Banjul	72.4	.1	177	55.7	.1	188	63.8	.1	365
Kanifing	67.3	.4	2198	45.7	.3	2097	56.7	.3	4295
Brikama	47.3	.3	2327	24.4	.1	2184	36.2	.2	4511
Mansakonko	31.9	.0	279	12.2	.2	324	21.3	.1	602
Kerewan	34.6	.5	1152	16.8	.2	1304	25.1	.4	2456
Kuntaur	43.6	.7	240	12.1	1.1	266	27.0	.9	505
Janjabureh	29.1	.3	375	12.0	.4	346	20.9	.3	720
Basse	36.2	.7	1201	7.4	.2	1479	20.3	.5	2680
Urban	64.1	.3	3410	40.4	.2	3449	52.2	.3	6859
Rural	36.5	.5	4538	13.5	.3	4738	24.8	.4	9276
Age									
15-24	63.0	.7	2664	41.0	.1	2781	51.8	.4	5445
25-34	54.8	.3	1859	24.9	.2	2308	38.2	.3	4167
35-44	43.6	.1	1360	14.1	.1	1314	29.1	.1	2674
45-54	30.5	.5	863	8.4	.5	990	18.7	.5	1853
55-64	28.1	.2	609	6.6	1.3	487	18.5	.7	1096
65+	20.5	.3	593	5.9	.0	307	15.5	.2	900
Wealth Index Quintiles									
Poorest	24.7	.3	1541	8.5	.6	1514	16.7	.4	3055
Second	39.5	.7	1428	13.1	.2	1607	25.5	.4	3035
Middle	44.4	.3	1523	16.7	.0	1580	30.3	.1	3103
Fourth	56.6	.5	1567	29.0	.2	1629	42.5	.4	3196
Richest	73.1	.4	1780	53.2	.2	1749	63.2	.3	3529
Not stated	34.0	.0	110	26.8	.0	108	30.4	.0	218
Total	48.4	.4	7948	24.9	.2	8187	36.4	.3	16135

Table 13: Percentage of the population using improved drinking water sources, The Gambia, 2000

	Main source of water													
	Piped into dwelling	Piped into yard or plot	Public tap	Tube-well/ Bore-hole with pump	Pro-tected dug well	Bottle water	Unpro-tected dug well	Pond River or stream	Tanker truck vendor	Other	Don't know	Total	Total with safe drinking water	No. of per-sons
Banjul	31.6	13.8	54.6	.0	.0	.0	.0	.0	.0	.0	.0	100.0	100.0	559
Kanifing	25.0	28.6	40.0	.5	1.2	.0	2.8	.0	.0	1.7	.0	100.0	95.5	7452
Brikama	.9	5.3	37.2	25.4	8.3	.0	22.6	.0	.0	.4	.0	100.0	77.0	8624
MansaKonko	.9	3.5	47.6	23.0	17.0	.0	8.0	.0	.0	.0	.0	100.0	92.4	1100
Kerewan	.2	4.4	41.2	32.4	12.0	.2	9.3	.0	.0	.3	.0	100.0	90.4	4742
Kuntaur	.3	.3	12.9	55.5	16.7	.0	14.0	.0	.0	.0	.3	100.0	86.1	1003
Janjabureh	2.2	.7	12.6	23.7	31.4	.4	29.1	.0	.0	.0	.0	100.0	70.9	1329
Basse	.4	.4	50.3	14.3	8.0	.0	25.4	.0	.0	.6	.0	100.0	73.3	5448
Urban	17.8	21.5	51.3	.6	3.3	.0	4.0	.0	.0	1.5	.0	100.0	94.6	11904
Rural	.4	2.1	32.2	30.5	11.9	.0	22.5	.0	.0	.2	.0	100.0	77.1	18354
Wealth Index Quintiles														
Poorest	.0	.0	22.3	34.9	14.9	.2	27.6		.0	.0	.0	100.0	72.3	5948
Second	.0	.0	37.0	30.1	9.5	.0	22.2		.0	.5	.0	100.0	76.8	5971
Middle	.0	1.2	51.2	20.9	9.7	.0	16.0		.0	1.1	.0	100.0	82.9	5951
Fourth	3.0	9.9	65.5	5.1	6.0	.0	9.4		.0	1.0	.0	100.0	89.6	5977
Richest	33.7	37.8	24.2	.2	1.8	.0	1.6		.0	.8	.0	100.0	97.6	5974
Not stated	1.0	4.7	16.2	53.1	19.1	.0	5.8		.0	.0	.0	100.0	94.2	439
Total	7.3	9.7	39.7	18.7	8.5	.0	15.2	.0	.0	.7	.0	100.0	84.0	30258

Table 14: Percentage of the population using sanitary means of excreta disposal, The Gambia, 2000

	Type of toilet facility											
	Flush to sewage system/ septic tank	Pour flush latrine	Improved pit latrine	Traditional pit latrine	River	Open pit	Other	No facilities/ bush/field	Missing	Total	Total with sanitary means of excreta disposal	No. of persons
Banjul	61.1	28.7	4.9	2.5	.0	.0	1.5	1.4	.0	100.0	97.2	559
Kanifing	24.6	13.4	23.6	35.8	.0	1.3	.9	.5	.0	100.0	97.3	7452
Brikama	1.1	2.2	4.5	83.9	.0	1.1	1.0	6.2	.0	100.0	91.7	8624
MansaKonko	1.0	.5	4.2	85.7	.0	.3	.2	8.1	.0	100.0	91.1	1100
Kerewan	.6	1.1	14.5	65.9	.0	.9	.0	16.8	.0	100.0	82.3	4742
Kuntaur	.2	3.3	.9	47.3	.0	4.7	.1	43.5	.0	100.0	51.8	1003
Janjanbureh	2.0	1.3	8.5	72.1	.0	1.5	.0	14.6	.0	100.0	83.9	1329
Basse	.7	3.0	4.0	72.2	.0	14.7	.0	5.3	.0	100.0	79.9	5448
Urban	19.1	10.6	17.9	47.9	.0	1.9	.9	1.7	.0	100.0	95.5	11904
Rural	.6	2.0	6.1	74.3	.0	4.8	.3	11.9	.0	100.0	83.0	18354
Wealth Index Quintiles												
Poorest	.0	.3	.6	70.5	.0	5.3	.1	23.1	.0	100.0	71.5	5948
Second	.1	.1	.5	86.2	.0	3.3	1.8	8.0	.0	100.0	86.9	5971
Middle	.0	2.2	9.0	75.4	.0	7.5	.4	5.4	.0	100.0	86.6	5951
Fourth	2.3	6.8	21.2	65.7	.0	1.9	.3	1.7	.0	100.0	96.1	5977
Richest	37.4	17.7	22.1	21.4	.0	.6	.0	.8	.0	100.0	98.5	5974
Not stated	2.3	.7	13.4	70.1	.0	.0	.0	13.4	.0	100.0	86.6	439
Total	7.9	5.4	10.7	63.9	.0	3.7	.5	7.9	.0	100.0	87.9	30258

Table 15: Percentage of under-five children who are severely or moderately undernourished, The Gambia, 2000

	Weight for age		Height for age		Weight for height		
	Percent below – 2 SD	Percent below –3 SD	Percent below – 2 SD	Percent below –3 SD	Percent below –2 SD	Percent below –3 SD	Number of children
Male	16.6	4.2	20.6	7.1	9.5	1.4	1300
Female	17.6	2.8	17.6	5.3	6.8	.8	1254
Banjul	6.2	1.0	13.7	3.3	3.3	.0	30
Kanifing	9.0	1.7	13.0	4.7	6.0	1.7	534
Brikama	11.3	1.9	14.9	3.9	5.2	.3	717
Mansa Konko	19.1	3.2	20.9	7.9	6.9	.4	83
Kerewan	21.0	5.4	25.6	8.7	9.0	2.5	482
Kuntaur	26.8	6.3	23.3	7.8	12.7	1.7	83
Janjanbureh	29.2	9.1	29.9	14.8	16.3	3.8	90
Basse	26.4	4.5	22.7	6.7	12.1	.0	535
Urban	9.4	1.7	13.2	4.1	5.9	1.4	880
Rural	21.2	4.5	22.3	7.3	9.4	1.0	1674
< 6 months	2.5	.7	4.0	1.5	5.5	1.1	231
6-11 months	15.4	3.6	8.1	1.5	13.2	2.4	321
12-23 months	23.2	3.6	23.5	6.8	11.7	1.6	659
24-35 months	18.6	5.3	21.8	7.4	6.7	.9	506
36-47 months	18.7	4.5	24.8	10.7	6.4	.6	461
48-59 months	13.0	1.4	19.9	4.9	3.6	.0	370
Not stated	4.4	.0	4.4	.0	.0	.0	5
Mother's education							
None	18.4	3.6	20.1	6.5	8.7	1.3	2071
Primary	15.2	3.6	18.6	7.1	3.1	.0	203
Secondary +	9.0	2.8	12.5	3.0	7.9	.8	280
Wealth Index Quintiles							
Poorest	19.7	3.7	23.8	7.6	7.0	1.1	523
Second	22.0	5.1	20.4	7.5	11.3	2.1	507
Middle	19.6	4.5	23.5	8.0	9.0	.6	557
Fourth	14.1	2.1	14.7	3.7	7.4	.5	546
Richest	9.1	2.2	12.6	3.8	6.2	1.5	384
Not stated	2.6	.0	4.5	.9	.8	.8	36
Total	17.1	3.5	19.1	6.2	8.2	1.1	2554

Table 16: Percent of living children by breastfeeding status, The Gambia, 2000

	Percent of children 0-3 months exclusively breastfed	Number of children	Percent of children 6-9 months receiving breastmilk and solid/semi-solid food	Number of children	Percent of children 12 –15 months breastfed	Number of children	Percent of children 20-23 months breastfed	Number of children
Male	34.7	111	39.4	182	97.1	140	49.8	135
Female	35.9	127	33.4	174	96.7	124	57.7	123
Banjul	32.4	3	63.6	4	90.9	3	37.8	4
Kanifing	42.5	71	67.5	71	97.2	64	32.0	45
Brikama	31.8	51	19.6	106	100.0	76	52.2	53
Mansakonko	24.2	10	37.0	8	100.0	9	60.0	4
Kerewan	25.0	47	23.8	54	95.0	52	56.8	57
Kuntaur	37.5	9	32.6	10	100.0	8	67.3	12
Janjanbureh	52.2	8	36.1	12	79.3	10	57.1	7
Basse	43.5	36	35.7	89	95.8	38	65.1	68
Urban	36.8	109	50.7	119	96.2	97	45.0	89
Rural	35.5	126	28.2	236	97.2	163	58.9	160
None	31.3	190	32.9	285	97.3	211	58.3	206
Primary	33.3	5	45.9	30	97.3	16	21.9	18
Secondary +	59.1	40	48.2	40	93.6	33	41.3	26
Wealth Index Quintiles								
Poorest	28.8	34	17.3	70	95.2	53	65.1	53
Second	26.6	46	23.0	73	94.7	70	49.6	55
Middle	35.2	48	34.3	78	96.6	38	60.5	59
Fourth	37.0	52	54.4	76	100.0	59	41.3	39
Richest	45.1	50	53.2	55	98.3	38	45.3	40
Not stated	86.9	5	24.9	3	100.0	2	92.5	3
Total	36.1	235	35.7	355	96.8	260	53.9	249

Table 17: Percentage of households consuming adequately iodized salt, The Gambia, 2000

	Percent of households with no salt	Percent of households in which salt was tested	Percent of households with salt testing		Number of households interviewed
			< 15 PPM	15+ PPM	
Banjul	16.3	82.8	96.7	3.3	116
Kanifing	22.6	75.4	95.4	4.6	1397
Brikama	14.8	84.6	96.2	3.8	1298
Mansakonko	7.0	92.5	95.6	4.4	180
Kerewan	6.1	91.9	97.7	2.3	702
Kuntaur	6.8	90.0	83.8	16.2	125
Janjanbureh	6.1	93.2	67.3	32.7	185
Basse	11.3	84.3	78.7	21.3	528
Urban	20.3	78.0	95.3	4.7	2219
Rural	9.2	89.0	90.1	9.9	2313
Wealth Index Quintiles					
Poorest	5.9	89.0	86.3	13.7	754
Second	5.9	92.6	93.1	6.9	748
Middle	15.8	92.7	94.3	5.7	823
Fourth	17.8	82.3	93.4	6.6	973
Richest	22.5	80.1	94.6	5.4	1180
Not stated	7.5	75.6	93.4	6.6	54
Total	14.6	83.6	92.5	7.5	4532

Note: Adequately iodized salt is salt testing 15 PPM (parts per million) or more.

Table 18: Percent distribution of children aged 6-59 months by whether they have received a high dose Vitamin A supplement in the last 6 months, The Gambia, 2000

	Percent of children who received Vitamin A:						
	Within last 6 months	Prior to last 6 months	Not sure when	Not sure if received	Never received	Total	Number of children
Male	3.9	2.1	1.6	3.1	89.4	100.0	1622
Female	3.5	2.0	2.7	3.3	88.5	100.0	1613
Banjul	4.0	1.2	1.2	4.0	89.5	100.0	41
Kanifing	1.4	1.2	.2	4.8	92.4	100.0	746
Brikama	1.2	.7	.5	2.5	95.1	100.0	935
Mansa konko	3.9	2.0	2.0	3.6	88.5	100.0	91
Kerewan	11.1	5.9	8.4	4.2	70.4	100.0	525
Kuntaur	2.6	.6	4.7	2.8	89.4	100.0	120
Janjanbureh	14.6	5.9	5.6	1.2	72.8	100.0	109
Basse	2.4	1.4	.7	1.9	93.6	100.0	667
Urban	2.2	1.1	1.2	4.1	91.5	100.0	1196
Rural	4.6	2.6	2.7	2.6	87.4	100.0	2039
6-11 months	4.8	1.4	1.1	1.1	91.6	100.0	437
12-23 months	4.6	1.3	2.4	2.7	89.1	100.0	835
24-35 months	3.9	3.0	1.4	3.3	88.5	100.0	731
36-47 months	3.7	2.5	2.9	4.4	86.5	100.0	667
48-59 months	1.6	1.9	2.7	3.7	90.2	100.0	556
Not stated	1.1	.0	.0	17.2	81.7	100.0	9
Mother's education							
None	4.2	1.8	2.2	3.5	88.3	100.0	2623
Primary	3.3	3.7	2.7	1.6	88.6	100.0	259
Secondary +	.4	2.7	1.1	1.9	93.9	100.0	353
Wealth Index Quintiles							
Poorest	6.8	4.1	3.8	3.8	81.5	100.0	623
Second	3.4	1.3	1.4	3.3	90.6	100.0	645
Middle	4.5	1.6	3.3	2.8	87.8	100.0	664
Fourth	2.1	2.1	1.4	2.7	91.6	100.0	682
Richest	1.7	1.2	.6	3.6	92.9	100.0	585
Not stated	3.6	.0	3.6	.0	92.7	100.0	36
Total	3.7	2.0	2.1	3.2	88.9	100.0	3235

Table 19: Percentage of women with a birth in the last 12 months by whether they received a high dose Vitamin A supplement before the infant was 8 weeks old, The Gambia, 2000

	Received Vitamin A supplement	Not sure if received	Number of women
Banjul	18.3	.8	13
Kanifing	12.7	.0	244
Brikama	**10.0**	.8	333
Mansakonko	15.0	1.9	36
Kerewan	40.5	.9	160
Kuntaur	11.2	1.2	44
Janjanbureh	16.2	2.0	36
Basse	3.4	1.3	249
Urban	13.4	.0	390
Rural	14.3	1.3	725
Mother's education			
None	14.6	1.0	892
Primary	11.4	.0	96
Secondary +	11.8	.5	127
Wealth Index Quintiles			
Poorest	17.3	.8	213
Second	14.2	1.4	224
Middle	14.7	1.9	236
Fourth	10.9	.0	234
Richest	12.6	.1	190
Not stated	17.5	.0	18
Total	14.0	.8	1115

Table 20: Percentage of live births in the last 12 months that weighed below 2500 grams at birth, The Gambia, 2000

	Percent of live births		
	Below 2500 grams	Weighed at birth	Number of live births
Banjul	5.0	63.5	13
Kanifing	8.3	66.7	244
Brikama	14.5	42.3	333
Mansakonko	7.5	37.4	36
Kerewan	8.9	48.3	160
Kuntaur	23.1	24.4	44
Janjanbureh	15.2	33.3	36
Basse	20.0	16.8	249
Urban	11.5	60.3	390
Rural	12.0	32.0	725
Mother's education			
None	12.6	39.0	892
Primary	8.0	37.9	96
Secondary +	10.2	65.4	127
Wealth Index Quintiles			
Poorest	15.7	21.1	213
Second	10.4	41.7	224
Middle	11.2	35.5	236
Fourth	11.0	47.9	234
Richest	11.3	65.3	190
Not stated	28.3	49.4	18
Total	7.8	43.0	1115

Table 21: Percentage of children age 12-23 months immunized against childhood diseases at any time before the survey and before the first birthday, The Gambia, 2000

	Percentage of children who received:										
	BCG	DPT1	DPT2	DPT3	Polio 1	Polio2	Polio3	Measles	All	None	No. of children
Vaccinated at any time before the survey According to:											
Vaccination card	87.4	87.4	81.8	70.8	88.5	86.9	77.9	83.0	60.8	.4	804
Mother's report	5.5	4.4	3.6	1.4	5.5	4.3	2.8	5.0	1.1	3.3	31
Either	92.9	91.8	85.4	72.2	94.0	91.2	80.7	88.0	61.9	3.7	835
Vaccinated by 12 months of age	98.8	97.2	95.5	90.3	97.2	94.0	88.3	87.9	61.6	0	835

Table 22: Percentage of children age 12-23 months currently vaccinated against childhood diseases, The Gambia, 2000

	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All	None	% with health card	Number of children
Male	94.7	92.1	85.7	73.7	93.2	91.4	81.2	88.6	65.1	2.8	92.6	439
Female	90.9	91.3	85.0	70.4	94.8	90.9	80.2	87.4	58.4	4.8	88.8	396
Banjul	90.5	89.5	85.7	77.1	92.4	88.6	75.2	82.9	65.7	5.7	76.2	10
Kanifing	93.3	94.3	78.1	63.8	94.3	92.4	80.0	88.6	57.1	2.9	93.3	187
Brikama	91.1	88.1	83.2	63.4	92.1	87.1	77.2	89.1	52.5	5.9	86.1	232
Mansakonko	83.8	83.8	83.8	76.5	85.3	82.4	76.5	80.9	64.7	10.3	89.7	20
Kerewan	92.5	90.3	88.8	76.1	94.0	89.6	82.8	87.3	64.9	3.0	88.8	174
Kuntaur	86.6	91.0	84.3	72.4	91.0	87.3	79.1	89.6	66.4	8.2	88.1	32
Janjanbureh	94.0	92.9	86.9	82.1	90.5	90.5	88.1	92.9	79.8	6.0	89.3	28
Basse	97.9	96.9	93.8	88.5	99.0	100.0	84.4	86.5	74.0	.0	99.0	152
Urban	91.7	93.1	82.5	70.0	93.8	91.1	78.1	86.0	57.4	3.7	90.6	314
Rural	93.6	90.9	87.1	73.4	94.1	91.2	82.3	89.2	64.7	3.8	90.9	521
Mother's education												
None	92.4	92.1	86.5	73.0	94.3	90.8	80.8	87.9	61.7	3.5	91.6	665
Primary	92.8	89.4	78.8	66.6	93.2	93.1	76.3	90.0	59.8	6.6	86.2	68
Secondary +	96.3	90.1	82.0	70.4	92.6	92.5	83.1	87.3	65.0	3.7	88.6	102
Wealth Index Quintiles												
Poorest	94.1	90.1	82.2	71.0	94.5	89.2	74.9	89.9	60.2	2.5	91.3	157
Second	91.8	91.2	88.1	72.4	89.8	87.3	83.1	86.1	64.1	5.9	90.4	191
Middle	90.4	90.0	88.6	75.9	96.2	92.6	79.2	87.2	60.4	3.6	88.2	163
Fourth	96.8	94.1	85.1	74.9	96.6	94.2	80.6	89.2	65.7	2.1	94.5	161
Richest	91.1	92.8	81.2	64.7	93.0	92.8	84.3	87.2	56.2	4.5	89.0	154
Not Stated	99.0	100.0	99.0	99.0	100.0	100.0	99.0	100.0	99.0	.0	100.0	10
Total	92.9	91.7	85.3	72.2	94.0	91.2	80.7	88.0	61.9	3.7	90.8	835

Table 23: Percentage of under-five children with diarrhea in the last two weeks and treatment with ORS or ORT, The Gambia, 2000

			Children with diarrhea who received:								
	Had diarrhea in last two weeks	Number of children under 5	Breast milk	Gruel	Local acceptable	ORS packet	Other milk or infant formula	Water with feeding	Any recom-mended treatment	No treatment	Number of children with diarrhea
Male	21.8	1811	38.2	27.2	17.0	35.5	13.9	33.4	77.2	22.8	395
Female	21.4	1821	34.2	26.1	19.2	30.5	12.5	28.9	71.1	28.9	389
Banjul	13.6	47	36.9	26.2	9.2	33.8	4.6	30.8	69.2	30.8	6
Kanifing	16.5	862	35.0	25.0	18.8	37.5	13.8	42.5	75.0	25.0	142
Brikama	21.1	1036	31.6	25.3	18.9	30.5	12.6	20.0	71.6	28.4	218
Mansakonko	24.0	108	37.9	21.8	13.8	35.6	11.5	16.1	70.1	29.9	26
Kerewan	24.0	590	40.4	22.0	20.2	41.3	10.1	21.1	69.7	30.3	141
Kuntaur	31.5	135	35.4	17.1	14.9	21.0	13.8	31.5	68.5	31.5	43
Janjanbureh	18.4	123	43.3	13.4	7.5	43.3	13.4	10.4	74.6	25.4	23
Basse	25.3	731	38.5	37.6	17.9	27.4	16.2	47.9	82.1	17.9	185
Urban	18.8	1365	33.7	23.5	16.1	36.3	13.3	32.0	72.6	27.4	256
Rural	23.3	2267	37.4	28.2	19.1	31.4	13.2	30.8	75.0	25.0	528
< 6 months	12.3	386	79.1	27.5	7.2	15.4	11.0	21.9	86.7	13.3	47
6-11 months	29.2	437	66.7	23.6	7.2	35.7	5.1	15.2	77.2	22.8	128
12-23 months	31.6	835	56.3	29.9	20.6	36.9	13.5	30.8	77.6	22.4	264
24-35 months	22.8	731	5.7	22.7	20.5	35.4	19.2	42.3	75.8	24.2	166
36-47 months	18.3	667	2.7	29.8	26.9	34.3	14.8	39.6	66.7	33.3	122
48-59 months	10.3	556	.0	22.8	14.5	13.8	11.0	25.9	52.6	47.4	57
Not stated	2.7	21	.0	.0	.0	58.6	.0	41.4	58.6	41.4	1
Mother's education											
None	22.7	2936	36.0	26.3	16.8	31.3	12.1	31.5	74.0	26.0	666
Primary	16.3	286	41.6	33.4	22.5	47.1	14.3	22.5	77.9	22.1	47
Secondary +	17.5	410	34.5	25.1	27.0	39.9	23.3	33.9	73.6	26.4	72
Wealth Index Quintiles											
Poorest	23.4	687	35.0	29.3	17.4	29.6	14.2	33.3	74.9	25.1	161
Second	22.2	724	36.1	23.2	20.6	37.2	11.8	24.9	74.8	25.2	161
Middle	25.0	740	38.6	26.8	14.4	32.3	15.0	24.6	70.3	29.7	185
Fourth	20.9	769	36.8	27.6	22.5	33.7	16.5	33.4	80.8	19.2	161
Richest	15.9	669	33.4	26.4	16.7	34.2	6.7	45.6	72.1	27.9	107
Not stated	24.0	43	32.2	25.3	2.3	10.4	4.6	30.9	43.6	56.4	10
Total	21.6	3632	36.2	26.7	18.1	33.0	13.2	31.2	74.2	25.8	785

Table 24: Percentage of under-five children with diarrhea in the last two weeks who took increased fluids and continued to feed during the episode, The Gambia, 2000

	Had diarrhea in last two weeks	Number of children under 5	Children with diarrhea who drank:				Children with diarrhea who ate:				Received increased fluids and continued eating	Number of children with diarrhea
			More	Same/Less	Missing/DK	Total	Somewhat less/same/ more	Much less/none	Missing/DK	Total		
Male	21.8	1811	43.8	37.9	18.3	100.0	57.3	32.7	10.0	100.0	27.8	395
Female	21.4	1821	45.9	34.0	20.0	100.0	50.2	39.2	10.6	100.0	26.4	389
Banjul	13.6	47	20.0	58.5	21.5	100.0	58.5	29.2	12.3	100.0	12.3	6
Kanifing	16.5	862	35.0	46.3	18.8	100.0	56.3	32.5	11.3	100.0	20.0	142
Brikama	21.1	1036	44.2	33.7	22.1	100.0	65.3	20.0	14.7	100.0	34.7	218
Mansakonko	24.0	108	32.2	35.6	32.2	100.0	42.5	42.5	14.9	100.0	17.2	26
Kerewan	24.0	590	33.0	42.2	24.8	100.0	47.7	44.0	8.3	100.0	15.6	141
Kuntaur	31.5	135	38.7	44.2	17.1	100.0	37.0	53.6	9.4	100.0	13.3	43
Janjanbureh	18.4	123	35.8	38.8	25.4	100.0	35.8	52.2	11.9	100.0	17.9	23
Basse	25.3	731	67.5	23.1	9.4	100.0	50.4	44.4	5.1	100.0	38.5	185
Urban	18.8	1365	38.6	39.4	22.0	100.0	54.3	32.9	12.8	100.0	22.6	256
Rural	23.3	2267	47.9	34.3	17.8	100.0	53.5	37.4	9.1	100.0	29.2	528
< 6 months	12.3	386	10.9	73.3	15.8	100.0	64.7	26.1	9.2	100.0	5.3	47
6-11 months	29.2	437	38.9	42.5	18.5	100.0	45.7	38.2	16.1	100.0	19.2	128
12-23 months	31.6	835	44.7	32.9	22.4	100.0	52.2	37.0	10.8	100.0	27.9	264
24-35 months	22.8	731	48.8	35.7	15.5	100.0	56.4	37.8	5.8	100.0	29.6	166
36-47 months	18.3	667	57.1	22.5	20.4	100.0	55.5	35.5	9.0	100.0	36.2	122
48-59 months	10.3	556	49.9	34.1	16.0	100.0	59.0	29.5	11.6	100.0	31.8	57
Not stated	2.7	21	41.4	58.6	.0	100.0	58.6	41.4	.0	100.0	41.4	1
Mother's education												
None	22.7	2936	45.3	35.8	18.8	100.0	53.4	36.8	9.8	100.0	27.9	666
Primary	16.3	286	50.0	34.1	15.9	100.0	56.7	31.8	11.5	100.0	24.7	47
Secondary +	17.5	410	37.3	38.6	24.1	100.0	55.1	30.9	14.0	100.0	20.8	72
Wealth Index Quintiles												
Poorest	23.4	687	42.7	40.2	17.1	100.0	52.0	40.2	7.7	100.0	24.4	161
Second	22.2	724	43.8	33.2	23.0	100.0	54.8	31.2	14.0	100.0	30.7	161
Middle	25.0	740	48.3	29.6	22.1	100.0	45.7	42.7	11.6	100.0	26.0	185
Fourth	20.9	769	47.8	39.9	12.4	100.0	57.9	34.9	7.2	100.0	26.6	161
Richest	15.9	669	40.4	39.6	20.0	100.0	64.3	26.1	9.3	100.0	27.6	107
Not stated	24.0	43	34.7	30.8	34.5	100.0	35.7	36.1	28.2	100.0	32.4	10
Total	21.6	3632	44.9	36.0	19.1	100.0	53.8	35.9	10.3	100.0	27.1	785

* Fewer than 25 cases

Table 25: Percentage of under-five children with acute respiratory infection in the last two weeks and treatment by health providers, The Gambia, 2000

	Had acute respiratory infection	Number of children under 5	Children with ARI who were taken to										Number of children with ARI
			Hospital	Health Centre	Dispensary	Village health worker	MCH clinic	Mobile/ outreach clinic	Private physician	Tradition-al healer	Other	Any appropriate provider	
Male	7.3	1811	10.9	43.3	7.8	2.7	9.6	2.2	.1	2.4	7.1	70.6	132
Female	8.2	1821	6.3	60.1	8.7	3.4	6.8	.4	.4	2.1	7.1	78.7	149
Banjul	4.0	47	68.4	10.5	.0	.0	21.1	.0	5.3	5.3	.0	100.0	2
Kanifing	4.1	826	30.0	75.0	5.0	.0	.0	.0	.0	5.0	10.0	90.0	36
Brikama	9.3	1036	4.8	47.6	16.7	2.4	7.1	2.4	.0	.0	4.8	76.2	97
Mansakonko	5.5	108	5.0	45.0	5.0	.0	.0	10.0	.0	.0	5.0	65.0	6
Kerewan	11.4	590	5.8	63.5	.0	1.9	1.9	.0	.0	5.8	1.9	73.1	67
Kuntaur	8.4	135	.0	29.2	8.3	.0	25.0	.0	2.1	4.2	4.2	60.4	11
Janjanbureh	4.4	123	25.0	56.2	18.7	6.2	6.2	12.5	6.2	.0	6.2	93.4	5
Basse	7.8	731	2.8	38.9	5.6	8.3	19.4	.0	.0	.0	16.7	66.7	57
Urban	4.5	1365	24.1	74.70	5.4	.0	.6	.0	.2	5.1	5.8	93.4	62
Rural	9.7	2267	4.0	45.9	9.1	4.0	10.2	1.6	.3	1.4	7.5	69.7	219
< 6 months	6.7	386	16.5	40.5	8.9	.0	1.3	1.2	.0	.0	8.9	68.4	26
6-11 months	7.8	437	5.5	45.9	27.7	1.0	12.7	1.9	.3	9.7	1.7	80.9	34
12-23 months	9.2	835	9.0	64.3	3.6	.0	13.4	.0	.0	3.7	3.4	82.5	76
24-35 months	8.2	731	5.4	36.3	8.8	13.9	3.3	3.8	1.0	.2	7.8	67.4	60
36-47 months	7.2	667	11.6	61.5	3.3	.0	9.0	.7	.0	.0	16.9	75.5	48
48-59 months	6.2	556	5.5	58.1	5.5	.0	3.8	.0	.0	.0	5.2	72.8	34
Not stated	9.9	21	.0	11.5	.0	.0	11.5	.0	.0	.0	.0	11.5	2
None	8.0	2936	8.0	48.1	7.5	3.7	9.4	1.5	.3	1.2	5.9	71.9	235
Primary	8.3	286	10.1	61.8	6.7	.0	2.0	.0	.0	1.0	16.4	80.6	24
Secondary +	5.6	410	11.0	85.4	17.9	.0	1.3	.0	.0	14.0	10.1	100.0	23
Wealth Index Quintiles													
Poorest	8.8	687	1.1	45.5	5.4	2.6	14.2	.6	.9	.4	7.3	63.1	61
Second	8.4	724	13.1	45.7	15.6	.0	6.8	1.1	.0	2.1	.5	82.2	61
Middle	10.7	740	.0	54.4	6.2	6.9	6.6	2.9	.0	3.3	11.1	72.0	79
Fourth	6.4	769	8.7	53.9	7.8	.7	8.9	.6	.0	.0	9.0	73.4	50
Richest	4.2	669	36.9	74.7	6.3	.0	.7	.0	.3	6.7	6.3	93.7	28
Not stated	6.2	43	11.2	22.5	.0	48.6	8.8	.0	.0	8.8	8.8	91.2	3
Total	7.7	3632	8.4	52.2	8.3	3.1	8.1	1.3	.2	2.2	7.1	74.9	281

Table 26: Percentage of children 0-59 months of age reported ill during the last two weeks who received increased fluids and continued feeding, The Gambia, 2000

	Reported illness in last two weeks	Number of children under 5	Children with illness who drank: More	Same/Less	Missing/ DK	Total	Children with illness who ate: Somewhat less/same/ more	Much less/none	Missing/ DK	Total	Received increased fluids and continued eating	Number of sick children
Male	46.7	1811	41.2	50.0	8.8	100.0	60.9	34.3	4.9	100.0	24.1	845
Female	46.9	1821	42.4	47.7	9.9	100.0	56.2	38.4	5.4	100.0	23.0	854
Banjul	37.4	47	24.0	68.2	7.8	100.0	69.8	25.7	4.5	100.0	17.3	17
Kanifing	40.9	862	28.8	63.6	7.6	100.0	70.2	25.3	4.5	100.0	17.2	353
Brikama	48.1	1036	41.9	47.9	10.1	100.0	66.8	26.3	6.9	100.0	28.1	499
Mansakonko	45.6	108	40.6	41.2	18.2	100.0	47.9	43.0	9.1	100.0	27.3	49
Kerewan	49.0	590	29.1	58.7	12.1	100.0	48.9	47.1	4.0	100.0	12.1	289
Kuntaur	57.3	135	35.6	53.5	10.9	100.0	44.1	50.2	5.8	100.0	15.2	77
Janjanbureh	29.9	123	37.6	46.8	15.6	100.0	33.9	58.7	7.3	100.0	17.4	37
Basse	51.7	731	66.1	28.0	5.9	100.0	50.2	46.4	3.3	100.0	34.3	378
Urban	42.1	1365	35.3	54.9	9.8	100.0	63.3	30.6	6.1	100.0	19.5	575
Rural	49.6	2267	45.1	45.7	9.1	100.0	56.1	39.3	4.6	100.0	25.6	1124
< 6 months	38.0	386	14.6	77.1	8.3	100.0	73.1	22.0	4.9	100.0	8.4	147
6-11 months	54.9	437	38.4	51.7	9.9	100.0	46.2	45.0	8.8	100.0	15.6	240
12-23 months	55.4	835	40.7	46.1	13.2	100.0	55.1	38.4	6.5	100.0	23.4	463
24-35 months	46.8	731	46.1	46.2	7.7	100.0	63.8	33.3	2.8	100.0	28.6	342
36-47 months	42.4	667	52.2	39.0	8.8	100.0	62.0	34.1	3.9	100.0	31.3	283
48-59 months	40.0	556	46.1	48.9	4.9	100.0	56.9	39.4	3.7	100.0	24.7	222
Not stated	14.6	21	17.6	82.4	.0	100.0	40.3	59.7	.0	100.0	17.6	3
Mother's education												
None	47.1	2936	42.6	47.7	9.7	100.0	56.2	38.8	5.0	100.0	24.0	1383
Primary	47.8	286	44.3	50.3	5.4	100.0	70.9	25.1	4.1	100.0	26.5	137
Secondary +	43.9	410	33.7	56.7	9.6	100.0	67.1	26.1	6.9	100.0	17.6	180
Wealth Index Quintiles												
Poorest	50.2	687	44.6	47.1	8.3	100.0	49.1	47.3	3.6	100.0	21.7	345
Second	45.1	724	43.2	44.6	12.1	100.0	55.9	36.9	7.1	100.0	27.0	326
Middle	52.6	740	46.7	42.3	11.0	100.0	53.0	41.5	5.5	100.0	25.1	389
Fourth	44.2	769	40.3	53.0	6.8	100.0	63.5	32.0	4.4	100.0	21.0	340
Richest	41.2	669	31.5	60.8	7.7	100.0	74.1	21.5	4.4	100.0	21.4	276
Not stated	53.7	43	42.1	42.5	15.4	100.0	67.3	20.2	12.6	100.0	38.3	23
Total	46.8	3632	41.8	48.8	9.4	100.0	58.5	36.4	5.1	100.0	23.5	1699

Table 27: Percentage of caretakers of children 0-59 months who know at least 2 signs for seeking care immediately, The Gambia, 2000

	Knows child should be taken to health facility if child:								
	Not able to drink /breastfeed	Becomes sicker	Develops a fever	Has fast breathing	Has difficult breathing	Has blood in stool	Is drinking poorly	Knows at least two signs	Number of caretakers
Banjul	9.2	31.9	86.4	23.8	25.7	21.7	8.6	45.9	47
Kanifing	23.3	40.1	77.5	33.3	30.8	30.6	22.9	50.2	862
Brikama	11.5	24.8	71.6	12.9	12.6	22.0	10.9	38.1	1036
Mansakonko	17.7	31.8	75.4	8.0	15.5	19.9	6.9	56.1	108
Kerewan	18.5	19.3	78.7	15.6	10.5	19.3	3.7	48.6	590
Kuntaur	8.2	9.4	75.4	7.7	5.4	3.5	.3	24.9	135
Janjanbureh	36.2	36.7	58.4	19.5	34.8	62.2	22.7	80.3	123
Basse	6.9	5.2	69.0	4.5	3.5	6.1	2.6	13.9	731
Urban	19.4	31.4	77.6	24.0	21.9	25.5	16.3	46.7	1365
Rural	13.0	19.1	71.2	12.0	11.6	18.3	7.4	35.0	2267
Mother's education									
None	14.8	22.8	73.1	15.9	14.1	19.4	9.3	37.9	2936
Primary	15.3	28.2	75.3	18.5	23.0	32.8	18.2	46.1	286
Secondary +	19.9	27.1	76.1	19.6	20.3	23.9	16.4	45.5	410
Wealth Index Quintiles									
Poorest	15.8	20.1	69.7	9.5	12.3	19.7	7.8	37.2	687
Second	12.0	18.1	75.1	11.6	9.2	20.8	6.1	36.5	724
Middle	15.3	20.0	73.0	13.5	12.0	17.6	9.6	38.3	740
Fourth	13.6	26.3	73.3	22.5	18.7	20.9	12.0	38.7	769
Richest	20.9	35.1	76.4	26.3	26.2	26.4	19.3	46.5	669
Not stated	14.3	16.4	85.5	4.9	8.7	19.9	3.8	44.4	43
Total	15.4	23.7	73.6	16.5	15.5	21.0	10.8	39.4	3632

Table 28: Percentage of children 0-59 months of age who slept under an insecticide-impregnated bednet during the previous night, The Gambia, 2000

	Slept under a bednet			Number of children	Bednet treated			Children who slept under a bednet
	Yes	No	DK/ missing		Yes	No	DK/ missing	
Male	42.5	57.1	.4	1804	33.8	65.2	1.0	755
Female	41.0	58.8	.2	1816	36.4	62.2	1.4	742
Banjul	37.4	62.4	.2	46	14.9	84.0	1.1	17
Kanifing	37.7	61.9	.4	860	17.1	81.7	1.1	312
Brikama	43.3	56.4	.2	1034	30.8	67.7	1.5	448
Mansakonko	73.2	26.8	.0	108	49.1	50.6	.4	79
Kerewan	45.6	54.2	.2	589	49.0	50.5	.5	267
Kuntaur	57.6	41.5	.9	134	40.1	59.3	.6	77
Janjanbureh	56.3	43.4	.3	123	36.1	63.4	.5	69
Basse	31.6	63.8	.2	726	46.5	51.4	2.1	228
Urban	35.8	63.8	.4	1361	20.9	78.3	.9	473
Rural	45.4	54.4	.2	2259	41.7	57.0	1.3	1024
< 6 months	44.4	54.7	.9	384	33.4	64.2	2.4	168
6-11 months	41.3	58.7	.0	437	32.1	67.0	.9	180
12-23 months	43.8	56.1	.1	833	37.7	60.7	1.7	360
24-35 months	43.0	56.7	.3	725	36.4	62.5	1.2	310
36-47 months	40.2	59.7	.0	664	31.9	68.1	.0	262
48-59 months	37.6	61.7	.7	556	35.9	63.0	1.2	208
Not stated	43.6	56.4	.0	21	57.3	42.7	.0	9
Wealth Index Quintiles								
Poorest	41.1	58.4	.5	684	41.2	55.6	3.2	283
Second	54.8	44.9	.3	722	36.4	63.6	.0	394
Middle	41.6	58.4	.0	740	42.5	55.9	1.6	299
Fourth	36.5	62.9	.6	765	29.1	70.8	.0	281
Richest	33.0	67.0	.0	665	20.6	77.6	1.7	210
Not stated	68.0	32.0	.0	43	44.4	55.6	.0	29
Total	41.8	57.9	.3	3620	35.1	63.7	1.2	1497

Table 29: Percentage of children 0-59 months of age who were ill with fever in the last two weeks who received anti-malarial drugs, The Gambia, 2000

	Had a fever in last two weeks	Number of children under 5	Children with a fever who were treated with: Para-etamol	Chloro-quine	Fansidar	Other	Don't know	Any appropriate anti-malarial drug*	Number of children
Male	14.4	1826	62.5	58.9	4.0	15.3	2.9	59.6	262
Female	15.3	1832	59.7	50.4	2.4	9.8	4.9	52.5	277
Banjul	7.3	47	65.7	68.6	14.3	11.4	.0	68.6	3
Kanifing	15.1	862	68.5	67.1	2.7	9.6	.0	68.5	130
Brikama	21.1	1036	65.3	57.9	1.1	13.7	3.2	57.9	218
Mansakonko	19.1	108	50.7	40.6	5.8	8.7	14.5	40.6	21
Kerewan	14.1	590	45.3	40.6	3.1	3.1	6.3	40.6	83
Kuntaur	12.5	135	50.0	45.8	.0	13.9	5.6	45.8	17
Janjanbureh	13.7	123	64.0	56.0	14.0	12.0	2.0	58.0	17
Basse	6.7	731	61.3	45.2	6.5	25.8	9.7	48.4	49
Urban	14.2	1365	63.5	57.7	4.1	11.0	2.7	58.8	194
Rural	15.2	2267	60.4	53.9	2.3	12.4	4.6	54.4	344
<6 months	10.7	386	34.2	46.0	1.1	15.3	.0	46.0	41
6-11 months	16.2	437	52.1	66.5	.0	15.0	6.7	66.5	71
12-23 months	15.0	835	59.6	46.6	1.9	14.1	5.3	46.8	125
24-35 months	15.2	731	60.0	58.0	5.3	12.0	2.2	59.6	111
36-47 months	15.9	667	74.3	58.2	5.6	12.2	2.7	59.7	106
48-59 months	14.7	556	70.9	56.9	.9	4.0	5.4	56.9	82
Not stated	9.5	21	100.0	20.1	15.1	.0	.0	20.1	2
Mother's education									
None	14.4	2936	58.7	54.8	3.1	10.6	4.6	55.6	423
Primary	19.9	286	73.0	66.1	2.8	22.3	.5	66.1	57
Secondary +	14.2	410	70.6	47.8	1.7	11.3	2.2	48.4	58
Wealth Index									
Poorest	16.4	687	54.2	49.8	2.6	9.2	4.4	49.8	112
Second	15.5	724	52.2	54.8	5.6	12.2	7.2	56.4	112
Middle	13.2	740	63.3	55.1	2.0	14.2	4.4	56.7	98
Fourth	15.7	769	65.4	56.6	1.7	11.9	1.5	56.9	121
Richest	13.4	669	76.5	62.4	2.3	13.2	1.8	62.4	90
Not stated	10.9	43	40.1	28.6	6.4	.0	6.4	28.6	5
Total	14.8	3632	61.5	55.3	2.9	11.9	3.9	56.0	538

Table 30: Percentage of women aged 15-49 who know the main ways of preventing HIV transmission, The Gambia, 2000

		Percent who know transmission can be prevented by:						
	Heard of AIDS	Have only one faithful uninfected sex partner	Using a condom every time	Abstaining from sex	Knows all three ways	Knows at least one way	Doesn't know any way	Number of women
Banjul	88.7	64.8	59.6	53.9	36.9	73.5	26.5	24
Kanifing	84.5	61.0	58.8	57.8	47.6	67.9	32.1	362
Brikama	82.1	51.5	52.2	36.6	31.3	58.2	41.8	343
Mansakonko	82.1	50.0	42.3	29.5	25.0	54.5	45.5	52
Kerewan	90.9	58.3	51.5	30.3	24.2	62.1	37.9	182
Kuntaur	79.5	39.3	36.9	33.6	23.0	47.5	52.5	34
Janjanbureh	80.6	38.0	42.6	22.2	18.5	48.1	51.9	39
Basse	73.6	27.4	28.3	26.4	16.0	39.6	60.4	177
Urban	86.9	57.4	56.9	48.3	38.8	66.2	33.8	604
Rural	79.0	45.1	42.3	31.7	25.5	50.9	49.1	610
15-19	**82.2**	**53.4**	**51.2**	**41.3**	**33.4**	**60.1**	**39.9**	**1184**
20-24	**86.4**	**59.4**	**52.3**	**47.1**	**35.5**	**67.4**	**32.6**	**1161**
25-29	**87.1**	**62.6**	**56.4**	**48.3**	**38.4**	**68.6**	**31.4**	**1110**
30-34	**88.1**	**65.0**	**56.9**	**46.5**	**36.8**	**70.5**	**29.5**	**839**
35-39	**82.7**	**55.6**	**44.0**	**40.3**	**29.7**	**58.7**	**41.3**	**692**
40-44	**80.3**	**52.3**	**43.2**	**38.3**	**27.6**	**57.7**	**42.3**	**432**
45-49	**81.5**	**50.8**	**35.0**	**39.1**	**23.7**	**56.8**	**43.2**	**239**
Education								
None	79.3	42.7	39.3	30.8	22.9	49.3	50.7	635
Primary	82.2	56.3	52.2	46.0	40.4	58.7	41.3	191
Secondary +	89.0	62.7	65.0	52.0	43.1	73.5	26.5	388
Wealth Index Quintiles								
Poorest	77.9	36.0	32.1	22.8	18.9	42.6	57.4	196
Second	88.9	59.1	59.5	43.3	35.2	66.0	34.0	216
Middle	80.9	49.3	44.3	34.6	28.0	54.6	45.4	232
Fourth	78.6	48.2	48.5	38.4	31.3	55.7	44.3	276
Richest	87.2	59.6	59.5	55.4	44.0	69.1	30.9	285
Not stated	95.9	73.0	49.4	32.2	4.7	76.9	23.1	9
Total	82.9	51.2	49.6	40.0	32.1	58.5	41.5	1214

Table 31: Percentage of women aged 15-49 who correctly identify misconceptions about HIV/AIDS, The Gambia, 2000

	Percent who know that:						
		AIDS cannot be transmitted by:					
	Heard of AIDS	Supernatural means	Mosquito bites	A healthy looking person can be infected	Knows all three miscon-ceptions	Knows at least one miscon-ception	Doesn't correctly identify any miscon-ception	Number of women
Banjul	93.2	65.8	48.3	75.2	38.9	84.1	15.9	132
Kanifing	83.2	54.7	36.4	60.9	25.4	72.1	27.9	1637
Brikama	85.0	52.3	32.1	52.8	20.9	67.2	32.8	1627
Mansakonko	85.3	39.9	23.2	40.4	11.2	56.9	43.1	213
Kerewan	93.6	53.1	36.2	72.9	25.1	80.5	19.5	908
Kuntaur	82.5	32.4	18.0	44.0	8.3	58.1	41.9	187
Janjanbureh	84.4	31.2	21.3	41.3	10.6	53.1	46.9	230
Basse	79.0	34.2	17.1	29.6	6.7	50.2	49.8	1043
Urban	87.5	55.4	36.3	61.2	25.0	73.5	26.5	2648
Rural	82.8	42.7	25.8	47.1	15.2	61.5	38.5	3328
15-19	82.9	42.5	28.2	51.1	18.6	62.5	37.5	1214
20-24	85.9	52.3	34.8	54.0	23.0	68.6	31.4	1210
25-29	87.4	52.4	31.4	59.1	20.8	72.8	27.2	1153
30-34	87.0	51.8	34.1	56.5	21.6	70.1	29.9	890
35-39	82.9	47.1	28.7	50.6	17.0	64.0	36.0	713
40-44	80.3	43.1	22.4	46.4	14.7	58.6	41.4	439
45-49	81.6	40.3	24.2	45.3	14.0	60.8	39.2	250
Not stated	89.5	48.3	26.7	48.0	12.8	70.7	29.3	107
Education								
None	82.0	41.7	23.6	46.1	13.5	59.9	40.1	4223
Primary	88.5	52.7	34.0	60.3	21.9	75.1	24.9	564
Secondary +	93.5	70.0	53.1	75.9	40.0	87.5	12.5	1189
Wealth Index								
Poorest	81.7	31.4	19.5	38.5	8.6	52.5	47.5	1006
Second	87.4	50.1	29.6	55.1	18.8	69.7	30.3	1105
Middle	85.3	47.1	27.9	48.1	17.2	63.4	36.6	1193
Fourth	81.4	50.1	31.4	55.8	22.4	67.6	32.4	1261
Richest	87.6	59.2	41.1	65.7	28.3	77.3	22.7	1358
Not stated	95.2	42.7	21.0	39.1	6.7	66.5	33.5	53
Total	84.9	48.4	30.5	53.3	19.6	66.8	33.2	5976

Table 32: Percentage of women aged 15-49 who correctly identify means of HIV transmission from mother to child, The Gambia, 2000

	Know AIDS can be transmitted from mother to child	Percent who know AIDS can be transmitted:				Did not know any specific way	Number of women
		During pregnancy	At delivery	Through breastmilk	Knows all three		
Banjul	74.3	71.5	58.3	43.0	38.0	26.7	132
Kanifing	64.7	62.2	55.6	44.7	39.6	35.7	1637
Brikama	51.8	50.6	46.0	43.3	38.4	48.3	1627
Mansakonko	48.4	46.8	45.7	45.7	43.4	51.9	213
Kerewan	63.0	62.1	50.2	43.4	39.3	37.1	908
Kuntaur	48.6	44.4	37.9	41.2	31.6	51.6	187
Janjanbureh	51.5	48.8	44.7	36.7	35.3	50.2	230
Basse	45.1	42.7	36.6	38.9	32.8	56.2	1043
Urban	63.6	61.1	53.9	45.8	40.6	36.8	2648
Rural	50.2	48.7	42.5	40.2	35.4	50.3	3328
15-19	52.0	49.4	43.2	40.2	35.4	48.9	1214
20-24	59.0	56.4	49.2	45.1	38.6	41.1	1210
25-29	61.7	60.5	53.8	46.6	42.4	38.5	1153
30-34	57.1	56.0	49.7	43.5	39.9	43.4	890
35-39	56.6	54.8	49.7	42.9	38.0	44.4	713
40-44	50.1	48.3	40.1	33.2	28.9	50.7	439
45-49	46.2	45.4	38.1	39.1	33.0	53.8	250
Not stated	47.4	40.3	32.8	40.0	30.2	54.2	107
Education							
None	49.3	47.5	41.5	39.5	34.9	51.2	4223
Primary	60.7	58.8	54.3	49.9	44.2	39.3	564
Secondary +	78.1	75.8	65.9	50.5	44.8	22.4	1189
Wealth Index Quintiles							
Poorest	44.2	43.0	39.3	35.8	32.6	56.3	1006
Second	53.7	52.3	46.4	43.5	38.0	46.9	1105
Middle	51.6	49.7	43.0	42.3	37.2	49.0	1193
Fourth	56.5	53.8	46.5	41.5	35.8	43.9	1261
Richest	70.4	68.2	59.4	48.0	42.9	30.1	1358
Not stated	60.7	60.1	54.5	56.3	53.7	39.9	53
Total	56.1	54.2	47.6	42.7	37.7	44.4	5976

Table 33: Percentage of women aged 15-49 who express a discriminatory attitude towards people with HIV/AIDS, The Gambia, 2000

	Percent of women who:				
	Believe that a teacher with HIV should not be allowed to work	Would not buy food from a person with HIV/AIDS	Agree with at least one discriminatory statement	Agree with neither discriminatory statement	Number of women
Banjul	36.2	20.5	40.1	59.9	132
Kanifing	30.4	17.3	33.8	66.2	1637
Brikama	18.7	10.4	21.7	78.3	1627
Mansakonko	15.3	6.3	16.9	83.1	213
Kerewan	31.2	24.0	34.1	65.9	908
Kuntaur	16.3	9.4	19.3	80.7	187
Janjanbureh	12.1	6.6	14.3	85.7	230
Basse	5.6	3.0	7.0	93.0	1043
Urban	28.6	16.5	31.8	68.2	2648
Rural	15.8	10.2	18.2	81.8	3328
15-19	18.6	9.7	20.3	79.7	1214
20-24	21.1	13.6	25.2	74.8	1210
25-29	24.4	15.3	27.7	72.3	1153
30-34	24.9	16.4	27.6	72.4	890
35-39	22.9	11.7	24.2	75.8	713
40-44	16.6	11.0	19.1	80.9	439
45-49	15.0	10.0	19.1	80.9	250
Not stated	22.6	12.9	24.8	75.2	107
Education					
None	16.2	9.8	18.3	81.7	4223
Primary	19.5	11.0	23.5	76.5	564
Secondary +	41.2	25.1	45.7	54.3	1189
Wealth Index Quintiles		.			
Poorest	14.0	8.8	16.0	84.0	1006
Second	17.1	10.6	20.0	80.0	1105
Middle	17.8	9.9	20.1	79.9	1193
Fourth	21.2	13.4	24.5	75.5	1261
Richest	34.6	20.7	37.8	62.2	1358
Not stated	7.1	1.8	7.5	92.5	53
Total	21.5	13.0	24.2	75.8	5976

Table 34: Percentage of women aged 15-49 who have sufficient knowledge of HIV/AIDS transmission, The Gambia, 2000

	Heard of AIDS	Know 3 ways to prevent HIV transmission	Correctly identify 3 misconceptions about HIV transmission	Have sufficient knowledge	Number of women
Banjul	93.2	49.1	38.9	24.1	132
Kanifing	83.2	46.8	25.4	18.9	1637
Brikama	85.0	31.5	20.9	12.3	1627
Mansakonko	85.3	26.3	11.2	5.4	213
Kerewan	93.6	33.5	25.1	9.4	908
Kuntaur	82.5	25.0	8.3	3.7	187
Janjanbureh	84.4	24.1	10.6	4.6	230
Basse	79.0	21.1	6.7	3.4	1043
Urban	87.5	41.4	25.0	16.0	2648
Rural	82.8	28.0	15.2	8.0	3328
15-19	82.9	32.1	18.6	10.9	1214
20-24	85.9	35.8	23.0	12.9	1210
25-29	87.4	38.4	20.8	12.6	1153
30-34	87.0	36.0	21.6	12.9	890
35-39	82.9	29.0	17.0	10.5	713
40-44	80.3	30.4	14.7	9.5	439
45-49	81.6	25.2	14.0	7.5	250
Not stated	89.5	34.3	12.8	6.3	107
Education					
None	82.0	27.2	13.5	6.7	4223
Primary	88.5	44.1	21.9	17.0	564
Secondary +	93.5	52.9	40.0	26.2	1189
Wealth Index Quintiles					
Poorest	81.7	20.6	8.6	3.4	1006
Second	87.4	35.8	18.8	12.2	1105
Middle	85.3	29.7	17.2	8.1	1193
Fourth	81.4	33.5	22.4	13.2	1261
Richest	87.6	47.0	28.3	19.0	1358
Not stated	95.2	14.6	6.7	1.4	53
Total	84.9	33.9	19.6	11.6	5976

Table 35: Percentage of women aged 15-49 who know where to get an AIDS test and who have been tested, The Gambia, 2000

	Know a place to get tested	Have been tested	If tested, have been told result	Number of women
Banjul	41.5	9.9	79.4	132
Kanifing	30.4	8.4	83.1	1637
Brikama	27.6	5.7	75.0	1627
Mansakonko	12.5	3.9	76.0	213
Kerewan	36.4	15.1	92.9	908
Kuntaur	18.1	6.5	88.6	187
Janjanbureh	15.0	6.5	70.7	230
Basse	7.8	1.6	70.0	1043
Urban	30.5	8.6	81.0	2648
Rural	21.0	6.1	86.3	3328
15-19	20.3	3.1	70.8	1214
20-24	28.6	6.7	84.3	1210
25-29	29.0	9.7	78.2	1153
30-34	27.7	9.7	84.3	890
35-39	24.6	9.7	96.1	713
40-44	19.1	5.5	96.9	439
45-49	22.0	7.2	75.8	250
Not stated	18.4	3.5	48.2	107
Education				
None	19.7	6.1	83.0	4223
Primary	27.7	6.8	91.2	564
Secondary +	43.8	11.4	82.2	1189
Wealth Index Quintiles				
Poorest	13.0	5.4	92.0	1006
Second	25.6	8.0	85.6	1105
Middle	20.9	5.7	71.0	1193
Fourth	28.2	6.3	83.0	1261
Richest	34.7	10.1	86.7	1358
Not stated	32.1	5.3	7.5	53
Total	25.2	7.2	83.5	5976

Table 36: Percentage of married or in union women aged 15-49 who are using (or whose partner is using) a contraceptive method, The Gambia, 2000

	Percent of married or in–union women who are using:															Number of currently married women
	No method	Female sterilization	Pill	IUD	Injections	Implants	Condom	Diaphragm/ foam/ jelly	LAM	Periodic abstinence	Withdrawal	Total	Any modern method	Any traditional method	Any method	
Banjul	76.5	.8	11.4	6.5	3.5	.0	.5	.0	.3	.3	.3	100.0	22.5	.9	23.5	67
Kanifing	89.9	.0	5.0	1.4	3.4	.0	.4	.0	.0	.0	.0	100.0	10.1	.0	10.1	1014
Brikama	91.0	.2	4.0	.5	3.9	.0	.0	.0	.0	.0	.7	100.0	8.4	.7	9.0	1166
Mansakonko	93.1	.0	3.1	.9	2.6	.0	.0	.0	.0	.4	.2	100.0	6.2	.6	6.9	161
Kerewan	90.9	.2	3.1	.2	4.6	.0	.0	.0	.0	.0	.0	100.0	9.1	.0	9.1	672
Kuntaur	89.7	.2	3.8	.9	5.4	.2	.0	.0	.0	.0	.0	100.0	10.3	.0	10.3	160
Janjanbureh	94.0	.0	2.1	.0	2.8	.0	.2	.9	.0	.0	.0	100.0	6.0	.0	6.0	194
Basse	92.4	.2	2.9	.9	4.0	.0	.0	.2	.2	.2	.2	100.0	7.1	.5	7.6	920
Urban	87.8	.0	6.7	1.5	3.3	.0	.3	.0	.1	.0	.0	100.0	12.1	.1	12.2	1687
Rural	93.0	.2	2.0	.5	4.2	.0	.0	.1	.0	.1	.4	100.0	6.6	.5	7.0	2666
< 20 years	98.4	.0	.8	.0	.8	.0	.0	.0	.0	.0	.0	100.0	1.6	.0	1.6	382
20-24years	93.6	.0	4.2	.0	1.8	.0	.0	.0	.0	.2	.3	100.0	5.9	.5	6.4	823
25-49 years	89.4	.2	4.1	1.1	4.7	.0	.1	.1	.1	.0	.2	100.0	10.3	.3	10.6	3148
Education																
None	92.4	.2	2.8	.4	3.8	.0	.1	.1	.0	.1	.2	100.0	7.3	.3	7.6	3548
Primary	87.4	.0	7.5	1.5	2.7	.0	.0	.0	.0	.0	.8	100.0	11.8	.8	12.6	331
Secondary +	82.4	.0	8.8	3.4	4.3	.0	1.0	.0	.0	.0	.1	100.0	17.4	.1	17.6	474
Wealth Index Quintiles																
Poorest	94.1	.0	1.7	.5	3.0	.0	.0	.4	.0	.0	.3	100.0	5.6	.3	5.9	839
Second	91.5	.5	3.3	.2	4.1	.0	.0	.0	.0	.0	.3	100.0	8.2	.3	8.5	847
Middle	93.5	.1	2.1	.3	3.6	.0	.0	.0	.0	.2	.2	100.0	6.1	.4	6.5	942
Fourth	87.6	.0	6.3	1.0	5.1	.0	.0	.0	.0	.0	.0	100.0	12.4	.0	12.4	838
Richest	87.4	.0	6.2	2.0	3.2	.0	.5	.0	.2	.0	.3	100.0	12.0	.6	12.6	842
Not stated	99.8	.0	.2	.0	.0	.0	.0	.0	.0	.0	.0	100.0	.2	.0	12.6	46
Total	91.0	.1	3.8	.8	3.8	.0	.1	.1	.0	.1	.2	100.0	8.7	.3	9.0	4353

Table 37: Percentage of mothers with a birth in the last 12 months protected against neonatal tetanus, The Gambia, 2000

	Percent of mothers with a birth in the last 12 months who:				
	Received at least 2 doses, last within 3 years	Received at least 3 doses, last within 10 years	Received at least 5 doses during lifetime	Protected against tetanus	Number of mothers
Banjul	76.2	.0	.8	77.0	13
Kanifing	74.6	.8	.0	75.4	244
Brikama	73.1	1.5	.0	74.6	333
Mansakonko	75.7	.9	.0	76.6	36
Kerewan	83.6	.0	.0	83.6	160
Kuntaur	71.2	.6	.0	71.9	44
Janjanbureh	62.6	2.0	2.0	66.7	36
Basse	79.2	1.3	.0	80.5	249
Urban	74.3	.5	.0	74.8	390
Rural	76.9	1.4	.1	78.4	725
Education					
None	76.8	1.3	.1	78.2	892
Primary	67.4	.0	.0	67.4	96
Secondary +	77.1	.0	.0	77.1	127
Wealth Index Quintile					
Poorest	76.4	1.3	.3	78.0	213
Second	72.2	2.9	.0	75.1	224
Middle	81.7	.0	.0	81.7	236
Fourth	78.4	1.1	.0	79.5	234
Richest	72.0	.0	.0	72.0	190
Not stated	54.9	.0	.6	55.4	18
Total	76.0	1.1	.1	77.1	1115

Table 38: Percent distribution of women aged 15-49 with a birth in the last year by type of personnel delivering antenatal care, The Gambia, 2000

	Person delivering antenatal care								
	Doctor	Nurse/ midwife	Auxiliary mid wife	Traditional birth attendant	Other/ Missing	No antenatal care received	Total	Any skilled personnel	Number of women
Banjul	15.1	73.0	3.2	.0	1.6	7.1	100.0	91.3	13
Kanifing	6.3	80.2	1.6	0.8	.8	10.3	100.0	88.1	244
Brikama	.8	96.2	.8	1.5	.0	.8	100.0	97.7	333
Mansakonko	3.7	79.4	3.7	7.5	1.9	3.7	100.0	86.9	36
Kerewan	1.7	73.3	2.6	19.0	.9	2.6	100.0	77.6	160
Kuntaur	1.9	78.7	7.5	7.5	1.9	2.5	100.0	88.1	44
Janjanbureh	5.1	54.5	9.1	17.2	4.0	10.1	100.0	68.7	36
Basse	4.0	73.8	18.8	2.7	.0	.7	100.0	96.6	249
Urban	5.9	83.0	1.6	2.1	.6	6.7	100.0	90.5	390
Rural	1.9	80.8	8.2	6.6	.6	1.9	100.0	90.9	725
Education									
None	2.9	80.2	6.7	6.1	.7	3.3	100.0	89.8	892
Primary	4.8	86.6	4.8	1.4	.0	2.4	100.0	96.2	96
Secondary +	5.0	86.9	1.2	.2	.1	6.7	100.0	93.0	127
Wealth Index Quintiles									
Poorest	3.8	74.0	8.8	11.0	.9	1.6	100.0	86.5	213
Second	.7	88.5	2.4	4.9	1.0	2.4	100.0	91.6	224
Middle	2.0	80.7	10.3	3.7	.0	3.4	100.0	93.0	236
Fourth	1.9	81.4	6.1	4.9	.9	4.8	100.0	89.4	234
Richest	9.2	81.8	1.4	1.0	.1	6.5	100.0	92.4	190
Not stated	2.4	95.5	1.5	.0	.0	.6	100.0	99.4	18
Total	3.3	81.5	5.9	5.1	.6	3.6	100.0	90.7	1115

Table 39: Percent distribution of women aged 15-49 with a birth in the last year by type of personnel assisting at delivery, The Gambia, 2000

	Person assisting at delivery									
	Doctor	Nurse/ midwife	Auxiliary midwife	Tradi-tional birth attendant	Relative/ friend	No one	Other/ missing	Total	Any skilled personnel	Number of women
Banjul	16.7	66.7	7.9	.8	.8	7.1	.0	100.0	91.3	3
Kanifing	4.0	77.8	1.6	3.2	4.0	7.1	2.4	100.0	83.3	244
Brikama	3.8	51.5	3.8	21.5	13.8	2.3	3.1	100.0	59.2	333
Mansakonko	.9	43.0	7.5	42.1	4.7	1.9	.0	100.0	51.4	36
Kerewan	7.8	37.9	4.3	38.8	9.5	1.7	.0	100.0	50.0	160
Kuntaur	5.0	23.7	.0	36.2	26.9	6.2	1.9	100.0	28.7	44
Janjanbureh	1.0	31.3	5.1	32.3	17.2	11.1	2.0	100.0	37.4	36
Basse	2.7	24.2	2.0	38.9	21.5	5.4	5.4	100.0	28.9	249
Urban	3.7	72.4	2.0	9.3	5.4	5.3	1.9	100.0	78.1	390
Rural	4.5	33.9	3.6	33.8	17.0	4.0	3.2	100.0	41.9	725
Education										
None	4.0	43.5	2.4	28.5	13.9	4.5	3.3	100.0	49.9	892
Primary	6.0	54.7	2.5	22.7	11.3	2.8	.0	100.0	63.2	96
Secondary +	4.4	69.1	8.1	4.1	7.7	5.2	1.5	100.0	81.5	127
Wealth Index Quintile										
Poorest	2.5	24.6	3.5	37.2	24.2	3.1	5.0	100.0	30.6	213
Second	5.3	38.9	7.3	31.8	13.5	1.0	2.1	100.0	51.5	224
Middle	5.1	45.0	1.3	30.6	8.9	6.1	2.9	100.0	51.4	236
Fourth	.8	58.7	2.6	18.0	12.3	4.6	2.9	100.0	62.2	234
Richest	8.1	71.9	.5	4.3	6.1	8.1	1.0	100.0	80.6	190
Not stated	.6	46.8	.0	45.2	6.9	.6	.0	100.0	47.4	18
Total	4.2	47.4	3.1	25.2	12.9	4.4	2.8	100.0	54.6	1115

Table 40: Percent distribution of children aged 0-59 months by whether birth is registered and reasons for non-registration, The Gambia, 2000

		Birth is not registered because:										
	Birth is registered	DK if birth registered	Costs too much	Must travel too far	Didn't know it should be registered	Late & didn't want to pay fine	Doesn't know where to register	Other	Reason DK or Missing	Missing	Total	No. of children
Male	33.9	4.8	.9	.8	11.9	.4	5.8	22.2	5.6	13.7	100.0	1811
Female	30.4	5.3	.8	.7	13.5	.3	6.8	25.3	5.0	12.0	100.0	1821
Banjul	41.5	2.7	.2	.4	.0	1.3	1.0	22.5	1.3	29.0	100.0	47
Kanifing	34.3	2.5	.2	.4	1.9	.2	.8	37.8	1.7	20.2	100.0	862
Brikama	49.4	3.1	1.1	.7	7.3	.0	2.4	22.4	1.1	12.4	100.0	1036
Mansakonko	42.5	7.7	.3	.6	16.3	2.5	6.6	10.2	2.8	10.5	100.0	108
Kerewan	30.5	9.7	.7	.7	3.3	.0	11.9	29.5	4.0	9.9	100.0	590
Kuntaur	11.3	6.4	.9	1.4	31.7	.5	12.9	13.4	11.3	10.1	100.0	135
Janjanbureh	34.2	12.9	1.9	4.4	7.1	1.9	5.5	8.8	6.6	16.7	100.0	123
Basse	7.8	5.4	1.3	.4	38.5	.4	13.0	11.0	15.8	6.3	100.0	731
Urban	36.9	2.6	.1	.3	4.7	.2	2.3	31.4	3.0	18.6	100.0	1365
Rural	29.3	6.6	1.3	1.0	17.6	.4	8.7	19.2	6.7	9.4	100.0	2267
< 6 months	28.5	7.1	.5	1.3	10.3	.2	5.9	35.7	5.2	5.3	100.0	386
6-11 months	37.0	5.7	1.0	.5	11.3	.1	9.1	23.3	4.7	7.3	100.0	437
12-23 months	32.3	4.3	.8	.4	14.3	.4	5.2	25.6	5.8	11.0	100.0	835
24-35 months	33.6	5.2	.7	1.0	11.6	.3	6.7	19.0	6.0	16.0	100.0	731
36-47 months	34.0	4.8	.9	.8	12.5	.2	4.9	22.0	4.8	15.2	100.0	667
48-59 months	26.6	4.8	1.3	.3	15.1	.6	7.2	21.3	4.7	18.0	100.0	556
Not stated	34.1	1.1	.0	1.6	10.2	.0	6.2	28.4	1.1	17.1	100.0	21
Mother's education												
None	29.8	5.6	.9	.8	15.0	.3	6.2	23.2	5.9	11.5	100.0	2936
Primary	41.4	2.6	1.5	.8	4.1	.3	5.4	26.9	3.2	13.7	100.0	286
Secondary +	42.6	2.9	.1	.0	2.4	.2	1.7	25.7	2.3	22.1	100.0	410
Wealth Index Quintile												
Poorest	25.0	8.9	2.8	1.6	20.1	.2	7.8	15.7	7.2	10.7	100.0	687
Second	37.0	8.0	.8	.4	12.5	.8	7.6	20.2	3.7	9.0	100.0	724
Middle	26.8	4.2	.2	.9	17.8	.0	8.3	23.7	8.3	9.8	100.0	740
Fourth	33.2	1.3	.4	.0	9.2	.4	6.0	31.9	5.3	12.4	100.0	769
Richest	39.8	2.9	.0	.7	2.7	.2	1.0	27.1	1.9	23.8	100.0	669
Not stated	22.1	11.9	.0	.2	31.0	.0	14.3	16.4	1.6	2.5	100.0	43
Total	32.2	5.1	.8	.7	12.7	.3	6.3	23.8	5.3	12.8	100.0	3632

Table 41: Percentage of children 0-14 years of age in households not living with a biological parent, The Gambia, 2000

		Living with neither parent				Living with mother only		Living with father only						
	Living with both parents	Father only live	Mother only alive	Both are alive	Both are dead	Father alive	Father dead	Mother alive	Mother dead	Impo-ssible to determine	Total	Not living with a biological parent	One or both parents dead	Number of Children
Male	73.9	.7	2.0	5.0	.8	9.3	3.1	2.9	.7	.3	100.0	8.5	7.3	6741
Female	71.3	.8	3.2	7.4	.5	9.3	3.5	1.7	.5	.3	100.0	11.9	8.5	7007
Banjul	63.2	1.0	2.7	10.0	.4	15.9	2.1	1.8	.1	.8	100.0	14.1	6.4	184
Kanifing	65.0	1.1	3.3	7.1	.3	13.8	4.1	2.7	.7	.3	100.0	11.8	9.5	2981
Brikama	71.6	.5	3.2	6.8	.4	9.0	3.6	3.4	.3	.3	100.0	10.9	7.9	3989
Mansakonko	71.6	1.2	3.5	9.6	.7	7.0	2.1	1.6	.3	.9	100.0	14.9	7.6	486
Kerewan	74.6	.5	2.9	5.2	.7	7.7	3.1	1.5	1.0	.3	100.0	9.2	8.2	2277
Kuntaur	79.3	.3	2.2	5.4	.7	4.1	2.9	1.5	.6	.7	100.0	8.6	6.7	485
Janjanbureh	77.7	1.3	2.4	10.5	1.3	2.3	.9	1.7	.5	.8	100.0	15.6	6.5	605
Basse	79.0	.6	.8	3.7	1.2	8.5	3.0	1.3	.8	.2	100.0	6.3	6.4	2742
Urban	65.3	.9	2.9	7.7	.5	13.5	4.2	2.4	.6	.4	100.0	11.9	9.0	4834
Rural	76.5	.6	2.5	5.4	.8	7.0	2.8	2.2	.6	.3	100.0	9.3	7.2	8914
0-4 years	80.6	.2	.6	2.7	.3	11.5	1.6	.7	.3	.3	100.0	3.8	2.9	4342
5-9 years	72.3	.8	2.6	7.1	.6	9.2	2.9	2.9	.4	.3	100.0	11.0	7.3	5199
10-14 years	64.6	1.2	4.8	8.8	1.1	7.1	5.4	3.2	1.2	.3	100.0	15.9	13.7	4207
Wealth Index Quintiles														
Poorest	79.7	.9	2.7	5.3	.9	4.4	2.6	1.7	.5	.4	100.0	9.7	7.6	2863
Second	73.3	.5	3.2	5.7	.6	8.7	3.3	2.2	.7	.2	100.0	10.0	8.3	2888
Middle	73.0	.7	2.1	5.4	.9	9.3	3.0	2.8	.7	.4	100.0	9.1	7.3	2782
Fourth	69.8	.6	2.2	6.7	.4	11.9	4.7	1.8	.5	.5	100.0	9.9	8.4	2690
Richest	64.2	1.0	3.0	8.7	.3	13.8	2.9	2.9	.6	.2	100.0	13.1	7.8	2309
Not stated	86.4	.0	2.4	2.8	.8	.6	2.1	2.4	1.4	.0	100.0	6.0	6.7	217
Total	72.6	.7	2.6	6.2	.6	9.3	3.3	2.3	.6	.3	100.0	10.2	7.9	13749

Table 42: Percentage of children 5-14 years of age who are currently working, The Gambia, 2000

			Domestic work				
	Paid work	Unpaid work	< 4 hours/day	4 or more hours/day	Family work (farm or business)	Currently Work	No. of children
Male	1.9	3.9	43.3	3.4	21	26.8	4593
Female	2.0	4.1	42.5	4.4	20	26.9	4813
5-9 years	2.1	4.5	42.1	3.8	20	26.8	5199
10-14 years	1.8	3.5	43.8	4.1	21	27.0	4207
Banjul	6.7	2.1	32.6	.1	5	13.4	129
Kanifing	.5	2.5	42.4	2.3	3	8.0	1957
Brikama	1.4	1.7	46.6	2.1	17	20.7	2748
Mansakonko	.1	13.3	48.3	.9	35	40.3	352
Kerewan	.6	4.7	41.2	2.4	26	30.0	1575
Kuntaur	1.9	2.0	39.6	5.6	23	30.1	321
Janjanbureh	.4	5.8	48.7	7.8	36	46.9	456
Basse	5.8	6.9	38.2	9.1	32	46.0	1868
Urban	.8	3.1	42.1	2.6	7	12.6	3216
Rural	2.6	4.5	43.8	4.6	27	34.3	6190
Wealth Index Quintiles							
Poorest	1.3	3.8	43.7	6.4	34.0	40.2	2034
Second	1.5	3.2	43.4	3.7	21.0	26.0	2029
Middle	2.6	5.5	42.6	3.5	21.6	30.1	1904
Fourth	3.5	4.2	40.1	3.6	14.4	23.2	1775
Richest	.7	3.3	44.7	1.9	5.3	10.5	1510
Not Stated	1.1	5.4	41.0	2.1	15.8	23.6	153
Total	2.0	4.0	42.9	3.9	20.1	26.9	9406

THE GAMBIA MICS2

HOUSEHOLD QUESTIONNAIRE

WE ARE FROM VARIOUS GOVERNMENT DEPARTMENTS (CENTRAL STATISTICS DEPT., DOSH, WOMEN'S BUREAU, DEPT. OF COMMUNITY DEVELOPMENT ETC.). WE ARE WORKING ON A PROJECT CONCERNED WITH FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT 1HR.30 MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. DURING THIS TIME I WOULD LIKE TO SPEAK WITH ALL MOTHERS OR OTHERS WHO TAKE CARE OF CHILDREN IN THE HOUSEHOLD.

MAY I START NOW? *If permission is given, begin the interview.*

HOUSEHOLD INFORMATION PANEL

*1. Enumeration Area number: __ __ __ __ __	2. Household number: __ __ __ __
3. Day/Month/Year of interview: __ __ / __ __ / __ __ __ __	4. *Interviewer name: __ __
5. Name of head of household:	
6. Area: Urban ..... 1 Rural 2	7.***(LGA):*** …….. *7AA. District…… *7BB. Settlement……..
8. Material of dwelling floor: Wood/tile ..... 1 Cement/concrete..... 2 Mud/earth..... 3 Other(*specify*) 4	8AA. What is the main roofing material? Thatch……1 Corrugated Iron…….2 Asbestos……3 Cement/concrete……..4 Other(specify)……5
8BB. Main construction materials of outside walls? Mud……1 Wood……..2 Brick……..3 Cement/concrete……..4 Thatched grass……5 Other……..6	9. Number of rooms in dwelling: __ __
9AA. On what basis does the household occupy the dwelling? Owning……1 Renting……2 Provided Rent Free……3	9BB. Does household have electricity, radio, television, refrigerator? Yes……..1 No……..2
9CC.Does member of the household own bicycle, motorcycle, car? Yes……..1 No……2	9DD. Does any member of the household own an animal drawn cart? Yes……1 No……2 DK……9
10. Result of HH interview: Completed……1 Refused..... 2 Not at home ..... 3 HH not found/destroyed ..... 4 Other (*specify*) 5	
11. No. of women eligible for interview: __ __	12. No. of women interviews completed: __ __
13. No. of children under age 5: __ __	14. No. of child interviews completed: __ __
15. Data entry clerk: __ _____	*15AA. Household size __ __
Interviewer/supervisor notes*: Use this space to record notes about the interview with this household, such as call-back times, incomplete individual interview forms, number of attempts to re-visit, etc.*	

EA no. _ _ _ _ Household no. _ _ _

OUSEHOLD LISTING FORM

RST, PLEASE TELL ME THE NAME OF EACH PERSON WHO USUALLY LIVES HERE, STARTING WITH THE HEAD OF THE HH.

/se survey definition of HH member). List the first name in line 01. List adult HH members first, then list children. Then ask: ARE THERE ANY OTHERS WHO LIVE HERE, EVEN IF THEY ARE NOT AT HOME NOW? *'HESE MAY INCLUDE CHILDREN IN SCHOOL OR AT WORK). If yes, complete listing. Then, ask and record answers to questions as described in Instructions for Interviewers.*

ld a continuation sheet if there is not enough room on this page. Tick here if continuation sheet used ☐

				Eligible for:			*For persons age* ***15 or over*** *ask Qs. 8 and 9*		*For children* ***Under age 15 years*** *ask Qs. 10-13*				
				WOMEN'S MODULES	CHILD LABOUR MODULE	CHILD HEALTH MODULES							
1. *ne o.*	2. *Name*	3. IS (*name*) MALE OR FEMALE? 1 MALE 2 FEM.	4. HOW OLD IS (*name*)? HOW OLD WAS (*name*) ON HIS/HER LAST BIRTHDAY? *Record in Completed Years* 99=DK*	5. *Circle Line no. if woman is age 15-49*	6. *For each child* ***age 5-14****:* WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? *Record Line no. of mother/ caretaker*	7. *For each child* ***under 5****:* WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? *Record Line no. of mother/ caretaker*	8. CAN HE/SHE READ A LETTER OR NEWSPAPER EASILY, WITH DIFFICULTY OR NOT AT ALL? 1 EASILY 2 DIFFICULT 3 NOT AT ALL 9 DK	9. WHAT IS THE MARITAL STATUS OF (*name*)?** 1 CURRENTLY MARRIED/ IN UNION 2 WIDOWED 3 DIVORCED 4 SEPARATED 5 NEVER MARRIED	10. IS (*name's*) NATURAL MOTHER ALIVE? 1 YES 2 NO⇨ 11AA 9 DK⇨ 11AA	11. *If alive:* DOES (*name's*) NATURAL MOTHER LIVE IN THIS HOUSE-HOLD? 1 YES 2 NO	*11AA. *IF NO* WHO IS THE ALTERNATIVE CARETAKER? 1 PATERNAL RELATIVE 2 MATERNAL RELATIVE 3 OTHER (SPECIFY)	12. IS (*name's*) NATURAL FATHER ALIVE? 1 YES 2 NO 9 DK	13. *If alive:* DOES (*name's*) NATURAL FATHER LIVE IN THIS HOUSE-HOLD? 1 YES 2 NO
NE	NAME	M F	AGE	15-49	MOTHER	MOTHER	E D N DK	M W D S N	Y N DK		Y N	Y N DK	Y N
1			___ ___	01	___ ___	___ ___							
2			___ ___	02	___ ___	___ ___							
3			___ ___	03	___ ___	___ ___							
4			___ ___	04	___ ___	___ ___							
5			___ ___	05	___ ___	___ ___							
6			___ ___	06	___ ___	___ ___							
7			___ ___	07	___ ___	___ ___							
8			___ ___	08	___ ___	___ ___							
9			___ ___	09	___ ___	___ ___							
0			___ ___	10	___ ___	___ ___							

RE THERE ANY OTHER CHILDREN LIVING HERE – EVEN IF THEY ARE NOT MEMBERS OF YOUR FAMILY OR DO NOT HAVE PARENTS LIVING IN THIS HOUSEHOLD? CLUDING CHILDREN AT WORK OR AT SCHOOL? *If yes, insert child's name and complete form.*

See instructions: to be used only for elderly household members (code meaning "do not know/over age 50").

EA no. __ __ __ Household no. __ __ __

OUSEHOLD LISTING FORM

RST, PLEASE TELL ME THE NAME OF EACH PERSON WHO USUALLY LIVES HERE, STARTING WITH THE HEAD OF THE HH.

lse survey definition of HH member). List the first name in line 01. List adult HH members first, then list children. Then ask: ARE THERE ANY OTHERS WHO LIVE HERE, EVEN IF THEY ARE NOT AT HOME NOW? *THESE MAY INCLUDE CHILDREN IN SCHOOL OR AT WORK). If yes, complete listing. Then, ask and record answers to questions as described in Instructions for Interviewers.*

dd a continuation sheet if there is not enough room on this page. Tick here if continuation sheet used ☐

				Eligible for:										
				WOMEN'S MODULES	CHILD LABOUR MODULE	CHILD HEALTH MODULES	*For persons age **15 or over** ask Qs. 8 and 9*		*For children **under age 15 years** ask Qs. 10-13*					
1. *ne o.*	2. *Name*	3. IS (*name*) MALE OR FEMALE? 1 MALE 2 FEM.	4. HOW OLD IS (*name*)? HOW OLD WAS (*name*) ON HIS/HER LAST BIRTHDAY? *Record in completed years* 99=DK*	5. *Circle Line no. if woman is age 15-49*	6. *For each child **age 5-14**:* WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? *Record Line no. of mother/ caretaker*	7. *For each child **under 5**:* WHO IS THE MOTHER OR PRIMARY CARETAKER OF THIS CHILD? *Record Line no. of mother/ caretaker*	8. CAN HE/SHE READ A LETTER OR NEWSPAPER EASILY, WITH DIFFICULTY OR NOT AT ALL? 1 EASILY 2 DIFFICULT 3 NOT AT ALL 9 DK	9. WHAT IS THE MARITAL STATUS OF (*name*)?** 1 CURRENTLY MARRIED/ IN UNION 2 WIDOWED 3 DIVORCED 4 SEPARATED 5 NEVER MARRIED	10. IS (*name's*) NATURAL MOTHER ALIVE? 1 YES 2 NO⇨ 11AA 9 DK⇨ 11AA	11. *If alive:* DOES (*name's*) NATURAL MOTHER LIVE IN THIS HOUSE-HOLD? 1 YES 2 NO	*11AA. *IF NO* WHO IS THE ALTERNATIVE CARETAKER? 1PATERNAL RELATIVE 2 MATERNAL RELATIVE 3 OTHER (SPECIFY)	12. IS (*name's*) NATURAL FATHER ALIVE? 1 YES 2 NO 9 DK	13. *If alive:* DOES (*name's*) NATURAL FATHER LIVE IN THIS HOUSE-HOLD? 1 YES 2 NO
NE	NAME	M F	AGE	15-49	MOTHER	MOTHER	E D N DK	M W D S N	Y N DK		Y N	Y N DK	Y N
1			___ ___	11	___ ___	___ ___							
2			___ ___	12	___ ___	___ ___							
3			___ ___	13	___ ___	___ ___							
4			___ ___	14	___ ___	___ ___							
5			___ ___	15	___ ___	___ ___							
6			___ ___	16	___ ___	___ ___							
7			___ ___	17	___ ___	___ ___							
8			___ ___	18	___ ___	___ ___							
9			___ ___	19	___ ___	___ ___							
0			___ ___	20	___ ___	___ ___							

RE THERE ANY OTHER CHILDREN LIVING HERE – EVEN IF THEY ARE NOT MEMBERS OF YOUR FAMILY OR DO NOT HAVE PARENTS LIVING IN THIS HOUSEHOLD? CLUDING CHILDREN AT WORK OR AT SCHOOL? *If yes, insert child's name and complete form.*

See instructions: to be used only for elderly household members (code meaning "do not know/over age 50").

EDUCATION MODULE

If interview takes place between two school years, use alternative wording found in Appendix 1.

*For persons **age 3 or over** ask Qs. 15 and 16*

*For children **age 3 through 17 years**, continue on, asking Qs. 17-22*

14. *Line no.*	15. HAS (*name*) EVER ATTENDED SCHOOL? 1 YES ⇨ Q.16 2 NO ⇩ NEXT LINE	16. WHAT IS THE HIGHEST LEVEL OF SCHOOL (*name*) ATTENDED? WHAT IS THE HIGHEST GRADE (*name*) COMPLETED AT THIS LEVEL? LEVEL: 00. PRESCHOOL 01 PRIMARY 02 JUNIOR SECONDARY 03 SENIOR SEC/HIGH 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA PRIMARY 07 MADRASSA SECONDARY 08 NON-STANDARD CURRICULUM 09 DK GRADE: 99 DK		17. IS (*name*) CURRENTLY ATTENDING SCHOOL? 1 YES ⇨ Q.19 2 NO	18. DURING THE CURRENT SCHOOL YEAR, DID (*name*) ATTEND SCHOOL AT ANY TIME? 1 YES 2 NO ⇨ Q.21	19. SINCE LAST *(day of the week),* HOW MANY DAYS DID (*name*) ATTEND SCHOOL? *Insert number of days in space below.*	20. WHICH LEVEL AND GRADE IS/WAS (*name*) ATTENDING? LEVEL: 00. PRESCHOOL 01 PRIMARY 02 JUNIOR SEC. 03 SENIOR SEC/HIGH 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA RIMARY 07 MADRASSA SEC. 08 NON-STANDARD CURRICULUM 09 DK GRADE: 99 DK		21. DID (*name*) ATTEND SCHOOL LAST YEAR? 1 YES⇨ **Q.22** 2 NO 9 DK ⇩ NEXT LINE	21AA. WHAT WAS THE REASON FOR (NAME) NOT ATTENDING SCHOOL LAST YEAR? 1. FINANCIAL 2. PREGNANCY 3. MARRIAGE 4. WORK FOR PAY 5. DOMESTIC WORK (UNPAID) 6. OTHERS- (SPECIFY)	22. WHICH LEVEL AND GRADE DID (*name*) ATTEND LAST YEAR? LEVEL: 00. PRESCHOOL 01 PRIMARY 02 JUNIOR SECONDARY 03 SENIOR SEC/HIGH 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA PRIMARY 07 MADRASSA SEC. 08 NON-STANDARD CURRICULUM 09 DK GRADE: 99 DK	
LINE	YES NO	LEVEL	GRADE	YES NO	YES NO	DAYS	LEVEL	GRADE	Y N DK		LEVEL	GRADE	
01			__ __	1 2	1 2	____		__ __				__ __	
02			__ __	1 2	1 2	____		__ __				__ __	
03			__ __	1 2	1 2	____		__ __				__ __	
04			__ __	1 2	1 2	____		__ __				__ __	
05			__ __	1 2	1 2	____		__ __				__ __	
06			__ __	1 2	1 2	____		__ __				__ __	
07			__ __	1 2	1 2	____		__ __				__ __	
08			__ __	1 2	1 2	____		__ __				__ __	
09			__ __	1 2	1 2	____		__ __				__ __	
10			__ __	1 2	1 2	____		__ __				__ __	

Now for each woman age 15-49 years, write her name and line number at the top of each page in the Women's Questionnaire.
For each child under age 5, write his/her name and line number AND the line number of his/her mother or caretaker at the top of each page in the Children's Questionnaire.
You should now have a separate questionnaire for each eligible woman and child in the household.

EDUCATION MODULE

If interview takes place between two school years, use alternative wording found in Appendix 1.

*For persons **age 3 or over** ask Qs. 15 and 16*

*For children **age 3 through 17 years**, continue on, asking Qs. 17-22*

14. *Line No.*	15. HAS (*name*) EVER ATTENDED SCHOOL? 1 YES ⇨ Q.16 2 NO ⇘ NEXT LINE	16. WHAT IS THE HIGHEST LEVEL OF SCHOOL (*name*) ATTENDED? WHAT IS THE HIGHEST GRADE (*name*) COMPLETED AT THIS LEVEL? LEVEL: 00 PRESCHOOL 01 PRIMARY 02 JUNIOR SECONDARY 03 SENIOR SECONDARY 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA PRIMARY 07 MADRASSA SECONDARY 08 NON-STANDARD CURRICULUM 9 DK GRADE: 99 DK	17. IS (*name*) CURRENTLY ATTENDING SCHOOL? 1 YES ⇨ Q.19 2 NO	18. DURING THE CURRENT SCHOOL YEAR, DID (*name*) ATTEND SCHOOL AT ANY TIME? 1 YES 2 NO ⇨ Q.21	19. SINCE LAST *(day of the week),* HOW MANY DAYS DID (*name*) ATTEND SCHOOL? *Insert number of days in space below.*	20. WHICH LEVEL AND GRADE IS/WAS (*name*) ATTENDING? LEVEL: 00. PRESCHOOL 01 PRIMARY 02 JUNIOR SECONDARY 03 SENIOR SEC/HIGH 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA RIMARY 07 MADRASSA SEC 08 NON-STANDARD CURRICULUM 09 DK GRADE: 99 DK	21. DID (*name*) ATTEND SCHOOL LAST YEAR? 1 YES⇨ **Q.22** 2 NO 9 DK ⇘ NEXT LINE	21AA. WHAT WAS THE REASON FOR (NAME) NOT ATTENDING SCHOOL LAST YEAR? 7. FINANCIAL 8. PREGNANCY 9. MARRIAGE 10. WORK FOR PAY 11. DOMESTIC WORK (UNPAID) 12. OTHERS- (SPECIFY)	22. WHICH LEVEL AND GRADE DID (*name*) ATTEND LAST YEAR? LEVEL: 00. PRESCHOOL 01 PRIMARY 02 JUNIOR SECONDARY 03 SENIOR SEC/HIGH 04 VOCATIONAL/SKILLS 05 TERTIARY 06 MADRASSA PRIMARY 07 MADRASSA SECONDARY 08 NON-STANDARD CURRICULUM 09 DK GRADE: 99 DK
LINE	YES NO	LEVEL	GRADE	YES NO	YES NO	DAYS	LEVEL	GRADE	Y N DK		LEVEL	GRADE
11			__ __	1 2	1 2	___		__ __				__ __
12			__ __	1 2	1 2	___		__ __				__ __
13			__ __	1 2	1 2	___		__ __				__ __
14			__ __	1 2	1 2	___		__ __				__ __
15			__ __	1 2	1 2	___		__ __				__ __
16			__ __	1 2	1 2	___		__ __				__ __
17			__ __	1 2	1 2	___		__ __				__ __
18			__ __	1 2	1 2	___		__ __				__ __
19			__ __	1 2	1 2	___		__ __				__ __
20			__ __	1 2	1 2	___		__ __				__ __

Now for each woman age 15-49 years, write her name and line number at the top of each page in the Women's Questionnaire.
For each child under age 5, write his/her name and line number AND the line number of his/her mother or caretaker at the top of each page in the Children's Questionnaire.
You should now have a separate questionnaire for each eligible woman and child in the household.

EA no. __ __ __ __ __ Household no. __ ____ __

CHILD LABOUR MODULE

To be administered to caretaker of each child resident in the household age 5 through 17 years. **** Country-specific adaptation may change age range through to age 17.**

Copy line number of each eligible child from household listing.

NOW I WOULD LIKE TO ASK ABOUT ANY WORK CHILDREN IN THIS HOUSEHOLD MAY DO.

1. *Line no.*	2. *Name*	3. DURING THE PAST WEEK, DID (*name*) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? *If yes*: FOR PAY? 1 YES, FOR PAY (CASH OR KIND) 2 YES, UNPAID 3 NO ⇨TO Q.5			3AA. *IF YES* WHAT TYPE OF WORK? *record answer as reported.*	3BB. WHY IS THE CHILD WORKING? 1.SUPPORT FAMILY 2.EDUCATION 3.OTHER (SPECIFY) 9. DK	4. *If yes:* SINCE LAST (*day of the week*), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK FOR SOMEONE WHO IS NOT A MEMBER OF THIS HOUSEHOLD? *If more than one job, include all hours at all jobs.* *Record response then ⇨ Q.6*		5. AT ANY TIME DURING THE PAST YEAR, DID (*name*) DO ANY KIND OF WORK FOR SOMEONE WHO IS NOT A MEMBER OF HIS HOUSEHOLD? *If yes*: FOR PAY? 1 YES, FOR PAY (CASH OR KIND) 2 YES, UNPAID 3 NO			6. DURING THE PAST WEEK, DID (*name*) HELP WITH HOUSEKEEPING CHORES SUCH AS COOKING, SHOPPING, CLEANING, WASHING CLOTHES, FETCHING WATER, OR CARING FOR CHILDREN? 1 YES 2 NO ⇨ TO Q.8		7. *If yes*: SINCE LAST (*day of the week*), ABOUT HOW MANY HOURS DID HE/SHE SPEND DOING THESE CHORES?	8. DURING THE PAST WEEK, DID (*name*) DO ANY OTHER FAMILY WORK (ON THE FARM OR IN A BUSINESS)? 1 YES 2 NO ⇘ NEXT LINE		9. *If yes*: SINCE LAST (*day of the week*), ABOUT HOW MANY HOURS DID HE/SHE DO THIS WORK?
LINE NO.	NAME	YES PAID	UNPAID	NO			NO.HRS		YES PAID	NPAID	NO	YES	NO	NO. HOURS	YE	NO	NO. HOURS
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____
		1	2	3					1	2	3	1	2	____ ____	1	2	____ ____

When all children in the age range have been covered, **GO TO MATERNAL MORTALITY MODULE ⇨**

EA no. __ __ __ __ __ Household no. __ __ __ __

OPTIONAL MATERNAL MORTALITY MODULE

Administer to each adult household member. Copy name and line number of each adult (age 15 or over) in the household. If one of these adults is not at home, another adult may respond for him/her. Indicate this by placing a '1' in column 3, and insert line number of proxy respondent in column 4

1. LINE NO. (FROM HH LIST)	2.NAME	3. IS THIS A PROXY REPORT? 1 YES ⇨Q. 4 2 NO ⇨ Q. 5	4. LINE NO. OF PROXY RESPONDENT	5. HOW MANY SISTERS (BORN TO SAME MOTHER) HAVE YOU EVER HAD? 99= DON'T KNOW	6. HOW MANY OF THESE SISTERS EVER REACHED AGE 15**? 99= DON'T KNOW	7. HOW MANY OF THESE SISTERS (WHO ARE AT LEAST 15 YEARS OLD) ARE ALIVE NOW? 99= DON'T KNOW	8. HOW MANY OF THESE SISTERS WHO REACHED AGE 15 OR MORE HAVE DIED? 99= DON'T KNOW	9. HOW MANY OF THESE DEAD SISTERS DIED WHILE PREGNANT, OR DURING CHILDBIRTH, OR DURING THE SIX WEEKS AFTER THE END OF PREGNANCY?* 99= DON'T KNOW

EA no. __ __ __ __ __ Household no. __ __ __ __

WATER AND SANITATION MODULE

This module is to be administered once for each household visited.
Record only one response for each question.
If more than one response is given, record the most usual source or facility.

1. WHAT IS THE MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD?	Piped into dwelling ..... 01 Piped into yard or plot ..... 02 Public tap ..... 03 Tubewell/borehole with pump ..... 04 Protected dug well ..... 05 Protected spring ..... 06 Rainwater collection ..... 07 Bottled water ..... 08 Unprotected dug well ..... 09 Unprotected spring ..... 10 Pond, river or stream ..... 11 Tanker-truck, vendor ..... 12 Other (*specify*) _____ 13 No answer or DK 99	
2. HOW LONG DOES IT TAKE TO GO THERE, GET WATER, AND COME BACK?	No. of minutes ..... __ __ __ Water on premises ..... 888 DK 999	
*2AA. WHY DO YOU PREFER THIS SOURCE OF DRINKING WATER AT THIS TIME OF THE YEAR?	Distance……1 Time……..2 Water quality……3 No better alternative……4 Financial……5 Other (specify)……..6	
*2BB. WHO PAYS FOR THE MAINTENANCE OF THE WATER SYSTEM?	Self……1 Community…….. 2 Central Government……3 Local Authority……4 Private……5 Don't know/No one……..6	
*2CC. HOW FAR IS YOUR WATER SOURCE FROM THE NEAREST TOILET FACILITY?	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
*2DD. HOW FAR IS YOUR WATER SOURCE FROM THE NEAREST WASTE DISPOSAL SITE?	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
*2EE. HAS ANY MEMBER OF THIS HOUSEHOLD EVER EXPERIENCED ANY SICKNESS AFTER DRINKING WATER FROM THIS SOURCE AT ANY TIME IN THE LAST TWELVE MONTHS?	Yes……..1 No……2	
3. WHAT KIND OF TOILET FACILITY DOES YOUR HOUSEHOLD USE?	Flush to sewage system or septic tank ..... 1 Pour flush latrine (water seal type) ..... 2 Improved pit latrine (e.g., VIP) ..... 3 Traditional pit latrine ..... 4 Open pit ..... 5 Bucket ..... 6 Other (*specify*) _____ 7 No facilities or bush or field 8	8⇨Q4AA

4. IS THIS FACILITY LOCATED WITHIN YOUR DWELLING, OR YARD OR COMPOUND?**	Yes, in dwelling/yard/compound ..... 1 No, outside dwelling/yard/compound ..... 2 DK 9	
*4AA. HOW FAR IS YOUR HOUSE/RESIDENCE FROM THE NEAREST TOILET FACILTY?	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
*4BB. HOW FAR IS YOUR HOUSE/RESIDENCE FROM THE NEAREST REFUSE DISPOSAL SITE?	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
*4CC. HOW FAR IS YOUR KITCHEN/COOKING PLACE FROM THE NEAREST TOILET FACILTY	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
*4DD. HOW FAR IS YOUR KITCHEN/COOKING PLACE FROM THE NEAREST DISPOSAL SITE	Less than 30metres……1 30 – 50 metres……2 51 – 100 metres……..3 Greater than 100metres……4	
5. WHAT HAPPENS WITH THE STOOLS OF YOUNG CHILDREN (0-3 YEARS) WHEN THEY DO NOT USE THE LATRINE OR TOILET FACILITY?	Children always use toilet or latrine ..... 1 Thrown into toilet or latrine ..... 2 Thrown outside the yard ..... 3 Buried in the yard ..... 4 Not disposed of or left on the ground ..... 5 Other (*specify*) _____ 6 No young children in household 8	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ __

SALT IODIZATION MODULE		
1. WE WOULD LIKE TO CHECK WHETHER THE SALT USED IN YOUR HOUSEHOLD IS IODIZED. MAY I SEE A SAMPLE OF THE SALT USED TO COOK THE MAIN MEAL EATEN BY MEMBERS OF YOUR HOUSEHOLD LAST NIGHT? *Once you have examined the salt, circle number that corresponds to test outcome.* ***Categories correspond to test kit recommended by UNICEF to be used in all MICS surveys.***	Not iodized 0 PPM (no colour) ..... 1 Less than 15 PPM (weak colour) ..... 2 15 PPM or more (strong colour) ..... 3 No salt in home ..... 8 Salt not tested 9	

GO TO WOMEN'S QUESTIONNAIRE ⇨

THE GAMBIA MICS2

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

QUESTIONNAIRE FOR INDIVIDUAL WOMEN

WOMEN'S INFORMATION PANEL		
This module is to be administered to all women age 15 through 49 (see column 5 of HH listing). Fill in one form for each eligible woman.		
1. Woman's line number (from HH listing).	Line number ..... __ __	
2. Woman's name.	Name _____	
3A. IN WHAT MONTH AND YEAR WERE YOU BORN? *Or:* 3B. HOW OLD WERE YOU AT YOUR LAST BIRTHDAY?	Date of birth Month/Year..... __ __ / __ __ __ __ DK date of birth ..... 999999 *Or:* Age (in completed years)..... __ __	 DK⇨3B

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ ___ Household no. __ __ __

REHYDRATION SOLUTIONS MODULE		
This module is to be administered to mother's of children under- five		
1. HAVE YOU EVER SEEN THIS **ORS** PACKET BEFORE?	Yes……1 No……..2	 2⇨Q.5
2. IF YES, CAN YOU TELL ME ITS PREPARATION?	Correct……..1 Incorrect……2	
3. WAS **ORS** AVAILABLE WHEN YOU NEEDED IT?	Always……1 Sometimes……2 Rarely……3 Never……..4	
4. WHERE DID YOU USUALLY GET IT?	VHW……1 MCH……2 HC/Hospital……3 Pharmacy……4 Other(specify)……5	
5. TELL ME HOW TO PREPARE **SSS**	Correct……1 Incorrect……2	
6. WHAT DO YOU THINK IS THE USE/BENEFIT OF **ORS/SSS?**	Replaces loss fluid……..1 Stop/cure diarrhoea……2 Other(specify)……..3 DK……9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

CHILD MORTALITY MODULE

This module is to be administered to all women age 15-49.
All questions refer only to LIVE births.
Follow instructions as provided in training. See Instructions for Interviewers.

1. NOW I WOULD LIKE TO ASK ABOUT ALL THE BIRTHS YOU HAVE HAD DURING YOUR LIFE. HAVE YOU EVER GIVEN BIRTH? *If "NO" probe by asking:* I MEAN, TO A CHILD WHO EVER BREATHED OR CRIED OR SHOWED OTHER SIGNS OF LIFE – EVEN IF HE OR SHE LIVED ONLY A FEW MINUTES OR HOURS?	Yes ..... 1 No 2	2⇨ CONTRA-CEPTIVE USE MODULE
2A. WHAT WAS THE DATE OF YOUR FIRST BIRTH? I MEAN THE VERY FIRST TIME YOU GAVE BIRTH, EVEN IF THE CHILD IS NO LONGER LIVING, OR IS THE CHILD OF A MAN OTHER THAN YOUR CURRENT PARTNER. *Or:* 2B. HOW MANY YEARS AGO DID YOU HAVE YOUR FIRST BIRTH?	Date of first birth Day/Month/Year ..... __ __/__ __/__ __ __ __ DK date of first birth ..... 99999999 *Or:* Completed years since first birth ..... __ __	DK⇨2B
3. DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE NOW LIVING WITH YOU?	Yes ..... 1 No 2	2⇨Q.5
4. HOW MANY SONS LIVE WITH YOU? HOW MANY DAUGHTERS LIVE WITH YOU?	Sons at home ..... __ __ Daughters at home ..... __ __	
5. DO YOU HAVE ANY SONS OR DAUGHTERS TO WHOM YOU HAVE GIVEN BIRTH WHO ARE ALIVE BUT DO NOT LIVE WITH YOU?	Yes ..... 1 No 2	2⇨Q.7
6. HOW MANY SONS ARE ALIVE BUT DO NOT LIVE WITH YOU? HOW MANY DAUGHTERS ARE ALIVE BUT DO NOT LIVE WITH YOU?	Sons elsewhere ..... __ __ Daughters elsewhere ..... __ __	
7. HAVE YOU EVER GIVEN BIRTH TO A BOY OR GIRL WHO WAS BORN ALIVE BUT LATER DIED?	Yes ..... 1 No 2	2⇨Q.9
8. HOW MANY BOYS HAVE DIED? HOW MANY GIRLS HAVE DIED?	Boys dead ..... __ __ Girls dead ..... __ __	
9. Sum answers to Q. 4, 6, and 8.	Sum ..... __ __	
10. JUST TO MAKE SURE THAT I HAVE THIS RIGHT, YOU HAVE HAD IN TOTAL (*total number*) BIRTHS DURING YOUR LIFE. IS THIS CORRECT? ☐ Yes ⇨ *Go to Q.11* ☐ NO ⇨ *CHECK RESPONSES AND MAKE CORRECTIONS BEFORE PROCEEDING TO Q.11*		
11. OF THESE (*total number*) BIRTHS YOU HAVE HAD, WHEN DID YOU DELIVER THE LAST ONE (EVEN IF HE OR SHE HAS DIED)?	Date of last birth Day/Month/Year ..... __ __/__ __/__ __ __ __	

*Did the woman's last birth occur within the last year, that is, since (**insert date**)?*

☐ *Yes, live birth in last year. ⇨ GO TO TETANUS TOXOID MODULE*

☐ *No live birth in last year. ⇨ GO TO CONTRACEPTIVE USE MODULE*

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

TETANUS TOXOID (TT) MODULE

This module is to be administered to all women with a live birth in the year preceding date of interview.

1. DO YOU HAVE A CARD OR OTHER DOCUMENT WITH YOUR OWN IMMUNIZATIONS LISTED? *If a card is presented, use it to assist with answers to the following questions.*	Yes (card seen)..... 1 Yes (card not seen)..... 2 No..... 3 DK 9	
2. WHEN YOU WERE PREGNANT WITH YOUR LAST CHILD, DID YOU RECEIVE ANY INJECTION TO PREVENT HIM OR HER FROM GETTING CONVULSIONS AFTER BIRTH (AN ANTI-TETANUS SHOT, AN INJECTION AT THE TOP OF THE ARM OR SHOULDER)?	Yes ..... 1 No..... 2 DK 9	 2⇨Q.4 9⇨Q.4
3. *If yes:* HOW MANY DOSES OF TETANUS TOXOID (ANTI-TETANUS INJECTIONS) DID YOU RECEIVE DURING YOUR LAST PREGNANCY?	No. of doses ..... __ __ DK 99	
How many TT doses were reported during last pregnancy in Q.3? ☐ *At least two TT injections during last pregnancy. ⇨ GO TO MATERNAL AND NEWBORN HEALTH MODULE* ☐ *Fewer than two TT injections during last pregnancy. ⇨ CONTINUE WITH Q.4*		
4. DID YOU RECEIVE ANY TETANUS TOXOID INJECTION (*additional probes*) AT ANY TIME BEFORE YOUR LAST PREGNANCY, INCLUDING DURING A PREVIOUS PREGNANCY OR BETWEEN PREGNANCIES?	Yes ..... 1 No..... 2 DK 9	 2⇨Q.7 9⇨Q.7
5. *If yes:* HOW MANY DOSES DID YOU RECEIVE?	No. of doses ..... __ __	
6A. WHEN WAS THE LAST DOSE RECEIVED? *Or:* 6B. HOW MANY YEARS AGO DID YOU RECEIVE THE LAST DOSE?	Date of last dose Month/Year..... __ __ / __ __ __ __ DK date ..... 999999 *Or:* Years ago..... __ __	 DK⇨6B
7. Add responses to Q.3 and Q.5 to obtain total number of doses in lifetime.	Total no. of doses ..... __ __	

GO TO MATERNAL AND NEWBORN HEALTH MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

MATERNAL AND NEWBORN HEALTH MODULE		
This module is to be administered to all women with a live birth in the year preceding date of interview.		
Use Q.7 and Q.8 only in countries where a local term for night blindness exists.		
1. IN THE FIRST TWO MONTHS AFTER YOUR LAST BIRTH, DID YOU RECEIVE A VITAMIN A DOSE LIKE THIS? *Show 200,000 IU capsule or dispenser.*	Yes ..... 1 No ..... 2 DK 9	
2. DID YOU SEE ANYONE FOR ANTENATAL CARE FOR THIS PREGNANCY? *If yes*: WHOM DID YOU SEE? ANYONE ELSE? *Probe for the type of person seen and circle all answers given.*	Health professional: Doctor ..... 1 Nurse/midwife ..... 2 Auxiliary midwife ..... 3 Traditional birth attendant ..... 4 Other (*specify*) _____ 6 No one 0	
3. WHO ASSISTED WITH THE DELIVERY OF YOUR LAST CHILD (*or name*)? ANYONE ELSE? *Probe for the type of person assisting and circle all answers given.*	Health professional: Doctor ..... 1 Nurse/midwife ..... 2 Auxiliary midwife ..... 3 Traditional birth attendant ..... 4 Relative/friend ..... 5 Other (*specify*) _____ 6 No one 0	
*3AA. DURING YOUR LAST PREGNANCY DO YOU RECEIVE ANY FEFA TABLETS(IRON TABLETS)	Yes ..... 1 No ..... 2 DK 9	
5. WAS (*name*) WEIGHED AT BIRTH?	Yes ..... 1 No ..... 2 DK 9	2⇨Q.7 9⇨Q.7
6. HOW MUCH DID (*name*) WEIGH? *Record weight from health card, if available.*	From card .....1 (grams) __ , __ __ __ From recall .....2 (grams) __ , __ __ __ DK 99999	
7. WHEN YOU WERE PREGNANT WITH YOUR LAST CHILD, DID YOU HAVE DIFFICULTY WITH YOUR VISION DURING THE DAYLIGHT?	Yes ..... 1 No ..... 2 DK 9	
8. DURING THAT PREGNANCY, DID YOU SUFFER FROM NIGHT BLINDNESS (***insert local term***)?	Yes ..... 1 No ..... 2 DK 9	
8AA. DURING PREGNANCY DID WOMAN(NAME) SLEEP UNDER A BEDNET TREATED WITH PERMETHRIN?	Yes ..... 1 No ..... 2 DK 9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

CONTRACEPTIVE USE MODULE

Ask Q.1 for all women age 15-49 and then follow the skip instruction carefully.
Questions on pregnancy and contraception are to be asked only of women who are currently married or in union.

1. ARE YOU CURRENTLY MARRIED OR LIVING WITH A MAN?	Yes ..... 1 No, widowed, divorced, separated ..... 2 No, never married 3	 2⇨NEXT MODULE 3⇨NEXT MODULE
1AA. TYPE OF MARITAL UNION	Monogamous 1 Polygamous 2	
2. NOW I AM GOING TO CHANGE TOPICS. I WOULD LIKE TO TALK WITH YOU ABOUT ANOTHER SUBJECT – FAMILY PLANNING – AND YOUR REPRODUCTIVE HEALTH. I KNOW THIS IS A DIFFICULT SUBJECT TO TALK ABOUT, BUT IT IS IMPORTANT THAT WE OBTAIN THIS INFORMATION. OF COURSE, ALL THE INFORMATION YOU SUPPLY WILL REMAIN STRICTLY CONFIDENTIAL. YOU WILL NEVER BE IDENTIFIED WITH THE ANSWERS TO THESE QUESTIONS. ARE YOU PREGNANT NOW?	Yes, currently pregnant ..... 1 No ..... 2 Unsure or DK 3	1⇨NEXT MODULE
3. SOME COUPLES USE VARIOUS WAYS OR METHODS TO DELAY OR AVOID A PREGNANCY. ARE YOU CURRENTLY DOING SOMETHING OR USING ANY METHOD TO DELAY OR AVOID GETTING PREGNANT?	Yes ..... 1 No 2	2⇨**Q4AA**
4. WHICH METHOD ARE YOU USING? *Do not prompt.* *If more than one method is mentioned, circle each one.*	Female sterilization ..... 01 Pill ..... 02 Loop(IUD) ..... 03 Injections ..... 04 Implants ..... 05 Condom ..... 06 Female condom ..... 07 Diaphragm ..... 08 Foam/jelly ..... 09 Lactational amenorrhoea method (LAM) ..... 10 Periodic abstinence ..... 11 Withdrawal ..... 12 Other (*specify*) _____ 13	⇨ NEXT MODULE
*4AA. HAVE YOU EVER USED ANY CONTRACEPTIVE METHOD?	Yes ..... 1 No 2	2⇨**Q4EE**
*4BB. HOW LONG DID YOU USE IT?	Less than one year 1 One to three years 2 More than three years 3 DK……..9	
4CC. WHY DID YOU STOP USING CONTRACEPTIVES?	Became pregnant while using……1 Wanted to become pregnant……..2 Husband disapproved……..3 Side effects……4	

	Access/availability……5 Religion against FP……6 Others(specify)……7 DK……9	
4DD. WHEN YOU WERE LAST PREGNANT, DID YOU WANT TO BECOME PREGNANT AT THAT TIME?	Yes……1 No pregnancy yet……2 Later……3 Not at all……4	
4EE. DO YOU INTEND TO USE A METHOD ANY TIME IN THE FUTURE?	Yes ..... 1 No..... 2 DK……9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Woman line no. __ __

HIV/AIDS MODULE

This module is to be administered to all women age 15-49.
See Instructions for Interviewers for further discussion of these questions.

1. NOW I WOULD LIKE TO TALK WITH YOU ABOUT WHAT YOU KNOW ABOUT SERIOUS ILLNESS, IN PARTICULAR, ABOUT HIV AND AIDS. HAVE YOU EVER HEARD OF THE VIRUS HIV OR AN ILLNESS CALLED AIDS?	Yes ..... 1 No..... 2	 2⇨Q.18
2. IS THERE ANYTHING A PERSON CAN DO TO AVOID GETTING HIV, THE VIRUS THAT CAUSES AIDS?	Yes ..... 1 No..... 2 DK 9	 2⇨Q.8 9⇨Q.8
3. NOW I WILL READ SOME QUESTIONS ABOUT HOW PEOPLE CAN PROTECT THEMSELVES FROM THE AIDS VIRUS. THESE QUESTIONS INCLUDE ISSUES RELATED TO SEXUALITY WHICH SOME PEOPLE MIGHT FIND DIFFICULT TO ANSWER. HOWEVER, YOUR ANSWERS ARE VERY IMPORTANT TO HELP UNDERSTAND THE NEEDS OF PEOPLE IN (***country name***). AGAIN, THIS INFORMATION IS ALL COMPLETELY PRIVATE AND ANONYMOUS. PLEASE ANSWER YES OR NO TO EACH QUESTION. CAN PEOPLE PROTECT THEMSELVES FROM GETTING INFECTED WITH THE AIDS VIRUS BY HAVING ONE UNINFECTED SEX PARTNER WHO ALSO HAS NO OTHER PARTNERS?	Yes ..... 1 No..... 2 DK 9	
4. DO YOU THINK A PERSON CAN GET INFECTED WITH THE AIDS VIRUS THROUGH SUPERNATURAL MEANS?**	Yes ..... 1 No..... 2 DK 9	
5. CAN PEOPLE PROTECT THEMSELVES FROM THE AIDS VIRUS BY USING A CONDOM CORRECTLY EVERY TIME THEY HAVE SEX?	Yes ..... 1 No..... 2 DK 9	
6. CAN A PERSON GET THE AIDS VIRUS FROM MOSQUITO BITES?	Yes ..... 1 No..... 2 DK 9	
7. CAN PEOPLE PROTECT THEMSELVES FROM GETTING INFECTED WITH THE AIDS VIRUS BY NOT HAVING SEX AT ALL?	Yes ..... 1 No..... 2 DK 9	
8. IS IT POSSIBLE FOR A HEALTHY-LOOKING PERSON TO HAVE THE AIDS VIRUS?	Yes ..... 1 No..... 2 DK 9	

9. CAN THE AIDS VIRUS BE TRANSMITTED FROM A MOTHER TO A CHILD?	Yes ..... 1 No..... 2 DK 9	2⇨Q.13 9⇨Q.13
10. CAN THE AIDS VIRUS BE TRANSMITTED FROM A MOTHER TO A CHILD DURING PREGNANCY?	Yes ..... 1 No..... 2 DK 9	
11. CAN THE AIDS VIRUS BE TRANSMITTED FROM A MOTHER TO A CHILD AT DELIVERY?	Yes ..... 1 No..... 2 DK 9	
12. CAN THE AIDS VIRUS BE TRANSMITTED FROM A MOTHER TO A CHILD THROUGH BREAST MILK?	Yes ..... 1 No..... 2 DK 9	
13. IF A TEACHER HAS THE AIDS VIRUS BUT IS NOT SICK, SHOULD HE OR SHE BE ALLOWED TO CONTINUE TEACHING IN SCHOOL?	Yes ..... 1 No..... 2 DK 9	
14. IF YOU KNEW THAT A SHOPKEEPER OR FOOD SELLER HAD AIDS OR THE VIRUS THAT CAUSES IT, WOULD YOU BUY FOOD FROM HIM OR HER?	Yes ..... 1 No..... 2 DK 9	
15. I AM NOT GOING TO ASK YOU ABOUT YOUR HIV STATUS (*use term understood locally*), BUT WE ARE INTERESTED TO KNOW HOW MUCH DEMAND THERE IS IN YOUR COMMUNITY FOR HIV TESTING AND COUNSELLING. SO, I WOULD LIKE TO ASK YOU: I DO NOT WANT TO KNOW THE RESULTS, BUT HAVE YOU EVER BEEN TESTED TO SEE IF YOU HAVE HIV, THE VIRUS THAT CAUSES AIDS?	Yes ..... 1 No..... 2	2⇨Q.17
16. I DO NOT WANT YOU TO TELL ME THE RESULTS OF THE TEST, BUT HAVE YOU BEEN TOLD THE RESULTS?	Yes ..... 1 No..... 2	
17. AT THIS TIME, DO YOU KNOW OF A PLACE WHERE YOU CAN GO TO GET SUCH A TEST TO SEE IF YOU HAVE THE AIDS VIRUS?	Yes ..... 1 No..... 2	
17AA. DID YOUR PARTNER USE A CONDOM WHEN YOU LAST HAD SEX?	Yes ..... 1 No..... 2 DK 9	
17BB. NAME THREE WAYS OF HIV PREVENTION	…… …… …… DK……..9	
17CC. NAME THREE WAYS OF HIV TRANSMISSION	…… …… …… DK……..9	

18. Is the woman a caretaker of any children under five years of age?

☐ *Yes. ⇨ GO TO QUESTIONNAIRE FOR CHILDREN UNDER FIVE*
and administer one questionnaire for each child under five for whom she is the caretaker.

☐ *No. ⇨ CONTINUE WITH Q.19*

19. Does another eligible woman reside in the household?

☐ *Yes. ⇨ End the current interview by thanking the woman for her cooperation and*
GO TO QUESTIONNAIRE FOR INDIVIDUAL WOMEN
to administer the questionnaire to the next eligible woman.

☐ *No. ⇨ End the interview with this woman by thanking her for her cooperation.*
Gather together all questionnaires for this household and tally the number of interviews completed on the cover page.

THE GAMBIA MICS2

EA no. __ __ ____ ____ __ Household no. __ ____ __ Caretaker line no. __ __ Child line no. __ __

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

This questionnaire is to be administered to all women who care for a child that lives with them and is under the age of 5 years (see Q.4 of the HH listing).
A separate form should be used for each eligible child.
Questions should be administered to the mother or caretaker of the eligible child (see Q.7 of the HH listing).
Fill in the line number of each child, the line number of the child's mother or caretaker, and the household and EA numbers in the space at the top of each page.

BIRTH REGISTRATION AND EARLY LEARNING MODULE		
1. Child's name.	Name _____	
2. Child's age (copy from Q.4 of HH listing).	Age (in completed years)..... __ __	
3. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF EACH CHILD UNDER THE AGE OF 5 IN YOUR CARE, WHO LIVES WITH YOU NOW. NOW I WANT TO ASK YOU ABOUT (*name*). IN WHAT MONTH AND YEAR WAS (*name*) BORN? *Probe*: WHAT IS HIS/HER BIRTHDAY? *If the mother knows the exact birth date, also enter the day; otherwise, enter 99 for day.*	Date of birth Day/Month/Year..... __ __/__ __/__ __ __ __	
4. DOES (*name*) HAVE A BIRTH CERTIFICATE? MAY I SEE IT? *If certificate is presented, verify reported birth date. If no birth certificate is presented, try to verify date using another document (health card, etc.). Correct stated age, if necessary.*	Yes, seen ..... 1 Yes, not seen ..... 2 No..... 3 DK 9	1⇨Q.5AA
5. *If no birth certificate is shown, ask*: HAS (*name's*) BIRTH BEEN REGISTERED?	Yes ..... 1 No..... 2 DK 9	2⇨Q6 9⇨Q.7
5AA. WHERE HAS THE BIRTH BEEN REGISTERED?	Health Centre……1 Medical & Health Headquarters……..2 DK……9	⇨Skip Q.8
6. WHY IS (*name's*) BIRTH NOT REGISTERED?	Transport costs too much** ..... 1 Must travel too far ..... 2 Did not know it should be registered..... 3 Late, and did not want to pay fine..... 4 Does not know where to register ..... 5 Other (*specify*) _____ 6 DK 9	
7. DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?	Yes ..... 1 No..... 2 No answer 8	

8. *Check age. If child is 3 years old or more, ask:* DOES (*name*) ATTEND ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION PROGRAMME, SUCH AS A PRIVATE OR GOVERNMENT FACILITY, INCLUDING KINDERGARTEN OR COMMUNITY CHILD CARE?	Yes ..... 1 No ..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
9. WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (*name*) ATTEND?	Number of hours ..... __ __	

GO TO NEXT MODULE ⇨

EA no. ___ ___ __ __ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

VITAMIN A MODULE		
Further optional questions are found in Appendix Two.		
1. HAS (*name*) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? *Show capsule or dispenser.*	Yes ..... 1 No ..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
2. HOW MANY MONTHS AGO DID (*name*) TAKE THE LAST DOSE?	Months ago ..... __ __ DK 99	
3. WHERE DID (*name*) GET THIS LAST DOSE?	On routine visit to health centre ..... 1 Sick child visit to health centre ..... 2 National Immunization Day campaign ..... 3 Other (*specify*) _____ 4 DK 9	
4. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE DAY TIME?	Yes ..... 1 No ..... 2 DK 9	
5. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE NIGHT TIME?	Yes ..... 1 No ..... 2 DK 9	 2⇨skip to Q7 9⇨skip to Q7
6. IS THIS PROBLEM DIFFERENT FROM OTHER CHILDREN IN YOUR COMMUNITY?	Yes ..... 1 No ..... 2 DK 9	
7. DOES YOUR CHILD HAVE NIGHT BLINDNESS? *(USE LOCAL TERM FOR NIGHT BLINDNESS)*	Yes ..... 1 No ..... 2 DK 9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

BREASTFEEDING MODULE		
1. HAS (*name*) EVER BEEN BREASTFED?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.2BB 9⇨Q.4
*1AA. DID YOU GIVE (*name*) THE FIRST MILK THAT COMES OUT OF THE BREAST (COLOSTRUM)?	Yes ..... 1 No ..... 2 DK 9	
2. IS HE/SHE STILL BEING BREASTFED?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.3 2⇨Q.2AA 9⇨Q.4
*2AA. FOR HOW LONG HAS *(NAME)* BREASTFED?	Number of Months ……	⇨skip to Q.4
*2BB. WHAT WERE THE REASONS FOR NOT BREASTFEEDING?	Less or no milk in mother's breast……1 Orphan……2 Preferred formula……..3 Mother ill or sick……4 Child refuse……5 Other (specify)……..6	 ⇨Q.4
3. SINCE THIS TIME YESTERDAY, DID HE/SHE RECEIVE ANY OF THE FOLLOWING: *Read each item aloud and record response before proceeding to the next item.*	Y N DK	
3A. VITAMIN, MINERAL SUPPLEMENTS OR MEDICINE?	A. Vitamin supplements 1 2 9	
3B. PLAIN WATER?	B. Plain water 1 2 9	
3C. SWEETENED, FLAVOURED WATER OR FRUIT JUICE OR TEA OR INFUSION?	C. Sweetened water or juice 1 2 9	
3D. ORAL REHYDRATION SOLUTION (ORS)?	D. ORS 1 2 9	
3E. TINNED, POWDERED OR FRESH MILK OR INFANT FORMULA?	E. Milk 1 2 9	
3F. ANY OTHER LIQUIDS?	F. Other liquids (*specify*) _____ 1 2 9	
3G. SOLID OR SEMI-SOLID (MUSHY) FOOD?	G. Mushy food 1 2 9	
4. SINCE THIS TIME YESTERDAY, HAS (*name*) BEEN GIVEN ANYTHING TO DRINK FROM A BOTTLE WITH A NIPPLE OR TEAT?	Yes ..... 1 No ..... 2 DK 9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

CARE OF ILLNESS MODULE		
1. HAS (*name*) HAD DIARRHOEA IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE LAST? *Diarrhoea is determined as perceived by mother or caretaker, or as three or more loose or watery stools per day, or blood in stool.*	Yes ..... 1 No ..... 2 DK 9	1⇨Q.2AA
2. IN THE LAST TWO WEEKS, HAS (*name*) HAD ANY OTHER ILLNESS, SUCH AS COUGH OR FEVER, OR ANY OTHER HEALTH PROBLEM?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.4 2⇨Q.11 9⇨Q.11
*2AA. DID YOU SEEK ADVICE OR TREATMENT FOR THE DIARRHOEA OUTSIDE THE HOME?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.3 9⇨Q.3
*2BB. HOW LONG AFTER THE ONSET OF DIARRHOEA DID YOU SEEK HELP?	Same day……1 1 – 2 days……2 3 days and after……..3	
3. DURING THIS LAST EPISODE OF DIARRHOEA, DID (*name*) DRINK ANY OF THE FOLLOWING: *Read each item aloud and record response before proceeding to the next item.*	Y N DK	
3A. BREAST MILK?	A. Breast milk 1 2 9	
3B. CEREAL-BASED GRUEL OR GRUEL MADE FROM ROOTS OR SOUP?	B. Gruel 1 2 9	
3C. ***other locally-defined acceptable home fluids (e.g., SSS, yogurt drink)***?	C. Other acceptable 1 2 9	
3D. ORS PACKET SOLUTION?	D. ORS packet 1 2 9	
3E. OTHER MILK OR INFANT FORMULA?	E. Other milk 1 2 9	
3F. WATER WITH FEEDING DURING SOME PART OF THE DAY?	F. Water with feeding 1 2 9	
3G. WATER ALONE?	G. Water alone 1 2 9	
3H. ***defined "unacceptable" fluids (e.g., cola, etc. (insert local names))***	H. Unacceptable fluids 1 2 9	
3I. NOTHING	I. Nothing 1 2 9	1⇨Q.5
4. DURING (*name's*) ILLNESS, DID HE/SHE DRINK MUCH LESS, ABOUT THE SAME, OR MORE THAN USUAL?	Much less or none ..... 1 About the same (or somewhat less) ..... 2 More ..... 3 DK 9	
5. DURING (*name's*) ILLNESS, DID HE/SHE EAT LESS, ABOUT THE SAME, OR MORE FOOD THAN USUAL? *If "less", probe:* MUCH LESS OR A LITTLE LESS?	None ..... 1 Much less ..... 2 Somewhat less ..... 3 About the same ..... 4 More ..... 5 DK 9	
6. HAS (*name*) HAD AN ILLNESS WITH A COUGH AT ANY TIME IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE	Yes ..... 1 No 2	 2⇨Q.11

LAST?	DK 9	9⇨Q.11
7. WHEN (*name*) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, QUICK BREATHS OR HAVE DIFFICULTY BREATHING?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.11 9⇨Q.11
8. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?	Blocked nose ..... 1 Problem in chest ..... 2 Both ..... 3 Other (*specify*) _____ 4 DK 9	1⇨Q.11 4⇨Q.11
9. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.11 9⇨Q.11
*9AA. HOW LONG AFTER THE ONSET OF ILLNESS DID YOU SEEK HELP?	Same day……1 1 – 2 days……2 3 days and after……..3	
10. FROM WHERE DID YOU SEEK CARE? ANYWHERE ELSE? *Circle all providers mentioned, but do NOT prompt with any suggestions.*	Hospital ..... 01 Health centre ..... 02 Dispensary ..... 03 Village health worker ..... 04 MCH clinic ..... 05 Mobile/outreach clinic ..... 06 Private physician ..... 07 Traditional healer ..... 08 Pharmacy or drug seller ..... 09 Relative or friend ..... 10 Other (*specify*) _____ 11	
Ask this question (Q.11) only once for each caretaker. 11. SOMETIMES CHILDREN HAVE SEVERE ILLNESSES AND SHOULD BE TAKEN IMMEDIATELY TO A HEALTH FACILITY. WHAT TYPES OF SYMPTOMS WOULD CAUSE YOU TO TAKE YOUR CHILD TO A HEALTH FACILITY RIGHT AWAY? *Keep asking for more signs or symptoms until the caretaker cannot recall any additional symptoms. Circle all symptoms mentioned, but do NOT prompt with any suggestions.*	Child not able to drink or breastfeed ..... 01 Child becomes sicker ..... 02 Child develops a fever ..... 03 Child has fast breathing ..... 04 Child has difficult breathing ..... 05 Child has blood in stool ..... 06 Child is drinking poorly ..... 07 Other (*specify*) _____ 08 Other (*specify*) _____ 09 Other (*specify*) _____ 10	

GO TO NEXT MODULE ⇨

EA no. __ __ ___ ____ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

MALARIA MODULE		
This module is for use in countries or regions at high risk of malaria. See manual for definition.		
1. IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE LAST, HAS (*name*) BEEN ILL WITH A FEVER?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.8 9⇨Q.8
2. WAS (*name*) SEEN AT A HEALTH FACILITY DURING THIS ILLNESS?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.6 9⇨Q.6
*2AA. WHEN (*name*) HAD MALARIA, HOW SOON DID YOU SEEK MEDICAL CARE?	Same day……..1 2 to 5 days……2 After 5 days ……3 After 2 weeks……4 Don't Know……9	
*2BB. FROM WHERE DID YOU SEEK CARE? *CIRCLE 1 FOR ALL SOURCES MENTIONED. DO NOT PROMPT, EXCEPT FOR TRADITIONAL HEALERS.*	Y N a. Hospital ……1 2 b. Health centre……1 2 c. Dispensary……1 2 d. Village health worker……1 2 e. MCH clinic……..1 2 f. Private physician……...1 2 g. Traditional healer……..1 2 h. Pharmacy or drug seller……..1 2 i. Relative or friend……..1 2 j. Other……...1 2	
3. DID (*name*) TAKE A MEDICINE FOR FEVER OR MALARIA THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.5 9⇨Q.5
4. WHAT MEDICINE DID (*name*) TAKE THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY? *Circle all medicines mentioned.*	Paracetamol ..... 1 Chloroquine ..... 2 Fansidar ..... 3 Other (*specify*) _____ 4 DK 9	
5. WAS (*name*) GIVEN MEDICINE FOR THE FEVER OR MALARIA BEFORE BEING TAKEN TO THE HEALTH FACILITY?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.7 2⇨Q.8 9⇨Q.8
6. WAS (*name*) GIVEN MEDICINE FOR FEVER OR MALARIA DURING THIS ILLNESS?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.8 9⇨Q.8
7. WHAT MEDICINE WAS (*name*) GIVEN? *Circle all medicines given before visiting a health facility or if no visit was made to a health facility.*	Paracetamol ..... 1 Chloroquine ..... 2 Fansidar ..... 3 Other (*specify*) _____ 4 DK 9	
*7 DID (*name*) RECOVER FROM THAT ILLNESS?	Yes ..... 1 No ..... 2 DK 9	
8. DID (*name*) SLEEP UNDER A BEDNET LAST NIGHT?	Yes ..... 1 No 2	 2⇨NEXT

	DK 9	MODULE 9⇨NEXT MODULE
9. WAS THIS BEDNET EVER TREATED WITH A PRODUCT TO KILL MOSQUITOS?	Yes ..... 1 No..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
10. WHEN WAS THE BEDNET LAST TREATED?	Months ago ..... __ __ DK 99	

GO TO NEXT MODULE ⇨

EA no. __ __ __ ____ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

IMMUNIZATION MODULE

If an immunization card is available, copy the dates in Qs.2-5 for each type of immunization recorded on the card. Qs.7-15 are for recording vaccinations that are not recorded on the card. Qs.7-15 will only be asked when a card is not available.

1. IS THERE A VACCINATION RECORD FOR (*name*)?	Yes, seen ..... 1 Yes, not seen ..... 2 No..... 3	 2⇨Q.7 3⇨Q.7

(a) Copy dates of all vaccinations from the card. *(b) Write '44' in day column if card shows that vaccination was given but no date recorded.*		Date of Immunization								
		DAY		MONTH		YEAR				
2. BCG	BCG									
2AA. HEP.B1	HEP.B									
2BB. HEP.B2	HEP.B									
2CC. HEP.B3	HEP.B									
3A. OPV0	OPV0									
3B. OPV1	OPV1									
3C. OPV2	OPV2									
3D. OPV3	OPV3									
*3AA. OPV4	OPV4									
*3BB. OPV5	OPV5									
4A. DPT1	DPT1									
4B. DPT2	DPT2									
4C. DPT3	DPT3									
4AA. DPT4 (BOOSTER)	DPT4									
5. MEASLES	MEASLES									
5AA. YELLOW FEVER	YELLOW FEVER									

6. IN ADDITION TO THE VACCINATIONS SHOWN ON THIS CARD, DID (*name*) RECEIVE ANY OTHER VACCINATIONS - INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY? *Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, and/or Measles vaccine(s). Go to Q.15 after you finish.*	Yes ..... 1 *(Probe for vaccinations and write '66' in the corresponding day column on Q. 2 to Q. 5.)* No..... 2 DK 9	1⇨Q.15 2⇨Q.15 9⇨Q.15
7. HAS (*name*) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES, INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY CAMPAIGN?	Yes ..... 1 No..... 2	 2⇨Q.15

	DK 9	9⇨Q.15
8. HAS (*name*) EVER BEEN GIVEN A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE LEFT SHOULDER THAT CAUSED A SCAR?	Yes ..... 1 No ..... 2 DK 9	
9. HAS (*name*) EVER BEEN GIVEN ANY "VACCINATION DROPS IN THE MOUTH" TO PROTECT HIM/HER FROM GETTING DISEASES – THAT IS, POLIO?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.12 9⇨Q.12
10. HOW OLD WAS HE/SHE WHEN THE FIRST DOSE WAS GIVEN – JUST AFTER BIRTH OR LATER?	Just after birth ..... 1 Later 2	
11. HOW MANY TIMES HAS HE/SHE BEEN GIVEN THESE DROPS?	No. of times ..... __ __	
12. HAS (*name*) EVER BEEN GIVEN "VACCINATION INJECTIONS" – THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS – TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, DIPHTHERIA? (SOMETIMES GIVEN AT THE SAME TIME AS POLIO)	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.14 9⇨Q.14
13. HOW MANY TIMES?	No. of times ..... __ __	
14. HAS (*name*) EVER BEEN GIVEN "VACCINATION INJECTIONS" – THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES?	Yes ..... 1 No ..... 2 DK 9	
15. PLEASE TELL ME IF (*name*) HAS PARTICIPATED IN ANY OF THE FOLLOWING NATIONAL IMMUNIZATION DAYS: POLIO DATE……../……./……. MENINGITIS DATE……../……./…… ***Insert date and type of vaccination given in the most recent NID campaigns.***	Y N DK *Polio* ..... 1 2 9 *Meningitis* 1 2 9	

GO TO NEXT MODULE ⇨

EA no. __ __ __ __ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

ANTHROPOMETRY MODULE		
After questionnaires for all children are complete, the measurer weighs and measures each child. Record weight and length/height below, taking care to record the measurements on the correct questionnaire for each child. Check the child's name and line number on the HH listing before recording measurements.		
1. Child's weight.	Kilograms (kg)..... ___ ___ . ___	
2. Child's length or height. *Check age of child:* ☐ *Child under 2 years old. ⇨ Measure length (lying down).* ☐ *Child age 2 or more years. ⇨ Measure height (standing up).*	Length (cm) Lying down..... 1 ___ ___ ___ . ___ Height (cm) Standing up..... 2 ___ ___ ___ . ___	
4. Result.	Measured ..... 1 Not present ..... 2 Refused..... 3 Other (*specify*) _____ 4	
5. Is there another child in the household who is eligible for measurement? ☐ *Yes. ⇨ Record measurements for next child.* ☐ *No. ⇨ End the interview with this household by thanking all participants for their cooperation. Gather together all questionnaires for this household and check that identification numbers are at the top of each page. Tally on the Household Information Panel the number of interviews completed.*		