The Gambia

Demographic and Health Survey 2019-20

Key Indicators

Republic of The Gambia

The Gambia Demographic and Health Survey 2019-20

Key Indicators Report

The Gambia Bureau of Statistics
Banjul, The Gambia

The DHS Program
ICF
Rockville, Maryland, USA

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The 2019-20 The Gambia Demographic and Health Survey (2019-20 GDHS) was implemented by The Gambia Bureau of Statistics (GBoS) in partnership with the Ministry of Health (MoH). Data collection took place from November 21, 2019 to March 30, 2020. Funding for the 2019-20 GDHS was provided by the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Health Organization (WHO), ActionAid International The Gambia/Network Against Gender Based Violence, the National Nutrition Agency (NaNA), and The Government of the Republic of The Gambia. ICF provided technical assistance through The DHS Program, a USAID-funded project providing support and technical assistance in the implementation of Demographic and Health Surveys in countries worldwide.

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FOREWORD

The Gambia Bureau of Statistics (GBoS) is pleased to present the preliminary results of the 2019-20 Gambia Demographic and Health Survey (GDHS). The 2019-20 GDHS is the second Demographic and Health Survey conducted in The Gambia and is a follow-on to the 2013 survey. The 2019-20 GDHS provides an opportunity to inform policy and provide data for planning, implementation, and monitoring and evaluation of national health programmes. GBoS wishes to express its appreciation to those who were involved in the implementation of the 2019-20 GDHS and the preparation of this Key Indicators Report.

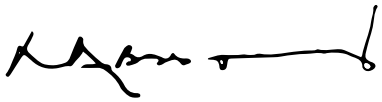
Our sincere appreciation is extended to the United Nations Population Fund (UNFPA) for taking the lead in the initiation, resource mobilization, and provision of professional advice, which led to the successful implementation of the survey.

Particular thanks go to the following:

- United States Agency for International Development (USAID), for providing the funding for organizing and conducting the 2019-20 GDHS.
- UNICEF, UNDP, WHO, ActionAid International The Gambia/Network Against Gender Based Violence, NaNA, and The Government of The Gambia for providing funds.
- ICF for providing technical support, training of fieldwork staff, consultations, recommendations, and analyses of the data collected.
- The Steering Committee and Technical Working Group for respectively ensuring that enough funds were mobilized for the successful conduct of the survey and instruments were thoroughly reviewed and adapted.

The survey would not have been possible without the good work and dedication of hundreds of people. In particular, we wish to express our appreciation to the fieldwork monitors (coordinators and quality control teams), data processing team, supervisors, interviewers, biomarker technicians, and drivers for their active participation in and contribution to this work.

Above all, we appreciate the cooperation of all of the survey respondents who have made the 2019-20 GDHS a success.



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1 INTRODUCTION

The 2019-20 Gambia Demographic and Health Survey (GDHS) is the second Demographic and Health Survey to be conducted in The Gambia and is a follow-on to the 2013 GDHS. It was implemented by The Gambia Bureau of Statistics (GBoS) in collaboration with the Ministry of Health. Data collection took place from November 21, 2019 to March 30, 2020. Funding was provided by the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Health Organization (WHO), ActionAid International The Gambia/Network Against Gender Based Violence, the National Nutrition Agency (NaNA), and The Government of The Republic of The Gambia. ICF provided technical assistance through The DHS Program, a USAID-funded project providing support and technical assistance in the implementation of Demographic and Health Surveys in countries worldwide.

This Key Indicators Report presents preliminary selected findings of the 2019-20 GDHS. A comprehensive analysis of the data will be presented in a final report later in 2020.

1.1 SURVEY OBJECTIVES

The primary objective of the 2019-20 GDHS is to obtain comprehensive data necessary to benchmark the strides made since 2013 in the broad areas of population, health, and nutrition and to provide estimates of key indicators which are vital for policy and strategic planning. The survey is designed to produce estimates of key indicators at the national level, for urban and rural areas, and for each of the Local Government Areas (LGAs).

Specifically, the 2019-20 GDHS:

- collected data on fertility levels and preferences; contraceptive use; maternal and child health; infant, child, and neonatal mortality levels; maternal mortality; gender; nutrition; awareness about HIV/AIDS; and other health issues relevant to the achievement of the Sustainable Development Goals (SDGs);
- provides information on availability, access, and use of mosquito nets as part of the national malaria eradication programme;
- measured contraceptive knowledge and use, fertility, fertility preferences, and the factors that determine fertility levels and trends;
- obtained data on key aspects of child health, including immunisation coverage among children, and prevalence and treatment of diarrhoea, fever, and symptoms of acute respiratory infection among children under 5 years;
- collected data on knowledge and attitudes of women and men about HIV and AIDS, potential exposure to the risk of HIV infection (e.g., high-risk behaviours and condom use), and on the coverage of prior HIV testing;
- collected data on self-reported sexually-transmitted infections;
- provides information on other health issues such as injections, tobacco use, hypertension, diabetes, and health insurance;
- obtained data on women's empowerment, domestic violence, fistula, and female genital cutting;
- tested household salt for the presence of iodine;

- obtained data on child feeding practices, including breastfeeding, and collected anthropometric measures to assess the nutritional status for children under age 5 and women age 15-49;
- conducted anaemia testing of women age 15-49 and children age 6-59 months;
- and conducted malaria testing of children age 6-59 months.

2 SURVEY IMPLEMENTATION

2.1 SAMPLE DESIGN

The sampling frame used for the 2019-20 GDHS was based on an updated version of the 2013 Gambia Population and Housing Census (2013 GPHC) conducted by The Gambia Bureau of Statistics (GBoS). The census counts were updated in 2015-16 based on district-level projected counts from the 2015-16 Integrated Household Survey (IHS). Administratively, The Gambia is divided into eight Local Government Areas (LGAs). Each LGA is subdivided into districts and each district is subdivided into settlements. A settlement, a group of small settlements, or a part of a large settlement can form an enumeration area (EA). These units allow the country to be easily separated into small geographical area units, each with an urban or rural designation. There are 48 districts, 120 wards, and 4,098 EAs in The Gambia; the EAs have an average size of 68 households.

The sample for the 2019-20 GDHS was a stratified sample selected in two stages. In the first stage, EAs were selected with a probability proportional to their size within each sampling stratum. A total of 281 EAs were selected.

In the second stage, the households were systemically sampled. A household listing operation was undertaken in all of the selected clusters. The resulting lists of households served as the sampling frame from which a fixed number of 25 households was systematically selected per cluster, resulting in a total sample size of 7,025 selected households. Results from this sample are representative at the national, urban, and rural levels, and at the LGAs levels.

All women age 15-49 who were either permanent residents of the selected households or visitors who stayed in the households the night before the survey were eligible to be interviewed. Additionally, in half of the selected households, men age 15-59 were eligible to be interviewed. In the households where the male interview took place, biomarker tests were also performed. Haemoglobin testing for anaemia was done in each of these households among eligible women age 18-49 and young emancipated women age 15-17 who consented to being tested. With the parent's or guardian's consent, children age 6-59 months and young non-emancipated women age 15-17 were also tested for anaemia in each household. Children age 6-59 months were also eligible for malaria testing using a rapid diagnostic test (RDT), with parental consent. In addition, height and weight measurements were conducted on children age 0-59 months and women age 15-49. Finally, a sample of one eligible woman in each household from which the male sample was drawn was randomly selected to be asked questions about domestic violence.

2.2 QUESTIONNAIRES

Five questionnaires were used for the 2019-20 GDHS: the Household Questionnaire, Woman's Questionnaire, Man's Questionnaire, Biomarker Questionnaire, and Fieldworker Questionnaire. These questionnaires, based on The DHS Program's standard questionnaires, were adapted to reflect the population and health issues relevant to The Gambia. Suggestions were solicited from various stakeholders representing government ministries and agencies, nongovernmental organisations, and international donors. All questionnaires were written in English, and interviewers translated the questions into the appropriate local language to carry out the interview.

The Household Questionnaire listed all members of and visitors to the selected households. Basic demographic information was collected on each person listed, including age, sex, marital status, education, and relationship to head of household. For children under age 18, survival status of parents was determined. The data on age

and sex of household members were used to identify women and men eligible for individual interviews. The Household Questionnaire also collected information on characteristics of the household's housing unit, such as source of water; type of toilet facilities; materials used for flooring, external walls, and roofing; ownership of various household goods; access to and use of mosquito nets; and testing of the iodine content in household salt.

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

- Background characteristics (including age, education, and media exposure)
- Reproduction and child mortality
- Contraception
- Antenatal, delivery, and postnatal care
- Vaccinations and childhood illnesses
- Maternal and child health and nutrition
- Marriage, sexual activity, and fistula
- Fertility preferences
- Women's work and husbands' background characteristics
- Knowledge, awareness, and behaviour regarding HIV/AIDS and other sexually transmitted infections (STIs)
- Other health issues (e.g., injections, smoking, and health insurance)
- Non-communicable diseases (e.g., hypertension and diabetes)
- Female genital cutting/mutilation
- Adult and maternal mortality
- Domestic violence

The Man's Questionnaire was used to collect information from all eligible men age 15-59 in half of all households. These men were asked questions on the following topics:

- Respondent's background
- Reproduction
- Contraception
- Marriage and sexual activity
- Fertility preferences
- Employment and gender roles
- HIV/AIDS
- Other health issues (e.g., injections, smoking, female genital cutting/mutilation, hypertension, diabetes, and health insurance)

In addition, the Biomarker Questionnaire was used to record the results of the anthropometric measurements and haemoglobin and malaria testing.

The Fieldworker Questionnaire served as a tool for conducting analyses of data quality. Fieldworkers filled out a 2-page self-administered questionnaire on their general background characteristics after the main training and before the fieldworkers entered the field. No personal identifiers are attached to The Gambia DHS fieldworkers' data file.

2.3 ANTHROPOMETRY, HAEMOGLOBIN, AND HIV TESTING

The 2019-20 GDHS incorporated three biomarkers: anthropometry, haemoglobin, and malaria testing, the results of which were recorded in the Biomarker Questionnaire. For haemoglobin and malaria testing, a consent statement was read to all eligible respondents or to the parent or adult responsible for children and young non-emancipated women age 15-17 and the women themselves. This statement explained the purpose of the tests, informed them that the results would be made available as soon as the test was completed, and requested permission for the test to be carried out.

Anthropometric measurements

In households selected for biomarker collection, height and weight measurements were recorded for children age 0-59 months and women age 15-49. Weight measurements were obtained using lightweight, electronic SECA 878 scales with a digital screen and a mother and child function. Height measurements were carried out with measuring boards made by Weigh and Measure, LLC. Children younger than age 24 months were measured while lying down on the board, while standing height was measured for older children and for women.

Malaria testing

Malaria testing was carried out among children age 6-59 months using RDTs which provided respondents with immediate feedback regarding their malaria status. Results of the RDT tests were given to the child's parent or another adult who was responsible for the child's care. Children with a positive malaria test were given treatment and those with severe malaria were referred to a nearby health facility for treatment. The results are being used to calculate the overall prevalence of malaria among children in this age group.

Anaemia testing

Blood specimens were collected from all children age 6-59 months and women age 15-49 who consented to testing for anaemia. Blood samples were drawn from a drop of blood taken from a finger prick (or a heel prick for young children age 6-11 months, who have small fingers) and collected in a microcuvette. Haemoglobin analysis was carried out on-site using a battery-operated portable HemoCue 201+ analyser, which produces a result in less than 1 minute. Results were given verbally and in writing. Parents of children with a haemoglobin level below 8 g/dl were advised to take the child to a health facility for follow-up care. Likewise, non-pregnant women and pregnant women were referred for follow-up care if their haemoglobin level was below 8 g/dl and 9 g/dl, respectively. All households in which anthropometry measurements, anaemia testing, malaria testing, or all three were conducted were given a brochure explaining the causes and ways to prevent anaemia.

2.4 PRETEST

Fifteen participants (10 females and 5 males) took part in training to pretest the GDHS survey questionnaires over a 4-week period from August 27 to September 21, 2019. The first 2 weeks featured classroom training focused on questionnaire content. On September 8, all participants took part in one day of field practice using paper questionnaires. Using the paper questionnaires filled out during the field practice, participants were trained on the computer-assisted personal interviewing (CAPI) system, an electronic data capture system programmed on tablet computers, from September 10-17.

On September 11, all participants received a half-day training on anthropometry and their role as assistants in taking measurements. They practiced measuring adults as if they were children and then practiced on children under 5 both standing and lying down. Seven participants also practiced as assistants during the standardization exercise on September 14.

The DHS Program staff and consultants cofacilitated the training with GBoS personnel in English. The training consisted of classroom lectures and discussion, mock interview demonstrations in front of the class, and interview practice in pairs in English and in local languages. Tests and quizzes were given throughout training to monitor progress and identify gaps in understanding. Furthermore, four guest lecturers presented on mosquito net programs and malaria treatment, family planning methods, immunisation, and domestic violence.

The biomarker technician training was held from September 10–21, 2019 at the same venue in a separate room. Five participants (2 women and 3 men), as well as 2 biomarker coordinators (1 woman and 1 man), were trained on the paper biomarker questionnaires and on biomarker collection. The training utilised a variety of different learning tools such as formal lectures on the technical aspects of biomarker collection, instructions on how to fill the questionnaires, informal discussion using case scenarios, videos to demonstrate the process of biomarker collection, demonstrations using adults, and hands-on practice with children and adults. In addition to the aforementioned training, the biomarker technicians participated in anthropometry standardisation exercises, one using adults on September 13 and another with children on September 14. On September 16, children and mothers came to the venue, and biomarker technicians practiced the entire biomarker collection from start to finish as they would do in the field. After all exercises, there was group discussion, and feedback was provided to technicians.

From September 18-20, interviewers and biomarker technicians conducted practice fieldwork to solidify skills learned during pretest training, and to provide a simulated fieldwork experience to test survey materials. Three teams comprised of 1 supervisor, 3 female interviewers, 1 male interviewer, and 1-2 biomarker technicians practiced data collection in the field in three communities in Brikama LGA, in both urban and rural areas. Each team was assigned a cluster and returned to that same cluster each day. Each team was expected to complete 16 households, half of which were selected for the man's questionnaire and biomarkers. Feedback was provided to individuals and teams during this exercise and during daily debriefs.

2.5 TRAINING OF FIELD STAFF

The 2019-20 GDHS main training was held from October 16 to November 14, 2019. Eighty-eight participants (60 women and 28 men) were trained on the paper questionnaires and the CAPI system, including one day of paper-based fieldwork and four days of CAPI-based fieldwork. The biomarker technician training was held from October 30 to November 14 at the same venue in a separate room. Eighteen participants (7 women and 11 men) were trained on the paper biomarker questionnaires and on biomarker collection.

A Training of Trainers (TOT) was conducted from October 14-15, for the four master trainers from GBoS. The purpose of the TOT was to prepare the master trainers for the main training. Topics included adult learning principles, effective facilitation, and expectations for trainers and participants.

The main fieldwork training was led by the master trainers and backstopped by The DHS Program staff and consultants. The interviewer training was conducted in English, and sessions discussed concepts, procedures, and methodology of conducting the survey. Participants were guided through the questionnaires. As there were no translations to local languages, one day was devoted to reviewing the questionnaires in the most common local languages to discuss and agree upon the verbal translations. In addition, three guest lecturers presented on mosquito net programs and malaria treatment, family planning methods, and immunisation.

The training included presentations, lectures, hands-on exercises, mock interviews, role-plays, group work, and quizzes. In-class exercises included probing for age, checking age consistencies, copying information from the vaccination cards, completing the reproductive calendar, and practicing interviews. All participants also received training on how to test household salt for iodine. Tests and quizzes were given throughout training to monitor progress and identify gaps in understanding.

On October 31, all participants took part in one day of field practice using the paper questionnaires. Each participant was expected to complete at least one household and one individual questionnaire. These questionnaires were later used during the CAPI training.

On November 1, all supervisors, all male enumerators, and 18 female enumerators received a half-day training on anthropometry and their role as assistants in taking measurements. They practiced measuring adults as if they were children and then practiced on children under 5 both standing and lying down. These participants also practiced as assistants in anthropometry on November 7 and 8, as well as during the CAPI field practice. This allowed each team to have three trained assistants for anthropometry with the male enumerator serving as the primary assistant and the supervisor and one female enumerator as a backup.

Once training on use of paper questionnaires concluded, The DHS Program data processing staff and information technology (IT) personnel from GBoS conducted a weeklong training on CAPI. From November 2-8, participants learned about features of the data collection system, different scenarios, and technical issues typically encountered during fieldwork, and ways to resolve issues.

The biomarker classroom portion of the training commenced from October 30 to November 14 and was attended by 18 participants (7 women and 11 men), all of whom were community health nurses. The training was led by The DHS Program staff and consultants with assistance from two biomarker coordinators from the NaNA and the Laboratory at the Edward Francis Teaching Hospital in Banjul, respectively, along with support from GBoS staff. Biomarker training included classroom instruction on anthropometric measurements, anaemia, and malaria testing, appropriate procedures for obtaining informed consent, recording of biomarker information in the Biomarker Questionnaire, and reporting results back to the respondents with referrals, as needed. Additionally, daily break-out sessions were held, whereby trainees had the opportunity for hands-on practice on both adults and children.

A child anthropometry standardisation exercise was carried out on November 5. Biomarker teams worked in pairs to measure children at 10 stations (five children less than 24 months and five children 24-59 months). Each team performed two independent measurements on each child. This was then repeated on 10 different children with the pair reversing roles, so the assistant was now the main measurer and vice versa. Following the standardisation exercise, the results of the exercise were presented, and feedback was provided. All trainees passed the standardization exercise, and there was no need for re-standardisation.

Team supervisors received additional training that covered the roles and responsibilities of supervisors, including how they should organise fieldwork, monitor interviews, and conduct quality control checks on paper and CAPI questionnaires. Additionally, team supervisors, as well as field coordinators and quality control monitors, were trained on the use of the Biomarker Procedural Checklist. Biomarker field coordinators were trained on the Biomarker Technical Checklist. All sections on each item in the checklist were reviewed to ensure that they were fully understood.

From November 9-13, interviewers and biomarker technicians conducted practice fieldwork to solidify skills learned during the training, and to provide a simulated fieldwork experience to test survey materials. Sixteen teams comprised of 1 supervisor, 3 female interviewers, 1 male interviewer, and 1-2 biomarker technicians practiced data collection in the field in two communities in Brikama LGA, in both urban and rural areas. Each team was expected to complete 16 households in their assigned cluster, half of which were selected for the man’s questionnaire and biomarkers. Feedback was provided during the exercise and debriefs. All teams successfully closed their clusters and sent the data to the central office.

On November 14, the teams came together for a final debriefing session to provide feedback about the questionnaires, the CAPI system, interviewer/biomarker technician interchange, language issues, field

procedures, and any other issues encountered during the field exercise. The DHS Program and GBoS addressed all the issues and remaining questions before fieldwork launched.

2.6 FIELDWORK

Fieldwork was carried out from November 21, 2019 to March 30, 2020 by 15 teams, with each team consisting of six members, typically with the following composition: one supervisor, three female interviewers, one male interviewer, and one biomarker technician.

All 15 teams initially began work in and around the Banjul and Kanifing LGAs, followed by a short break from December 15 to January 6 to observe the holidays. A 1-day refresher training was held on January 7 to ensure that all aspects of the survey were well understood by all, review team performance, discuss common mistakes and issues, highlight best practices, and clarify any questions. Teams were then deployed to the various LGAs to resume fieldwork.

Fieldwork monitoring was an integral part of the 2019-20 GDHS. Two quality control teams, each comprised of one female monitor, one male monitor, and one biomarker monitor, were continuously in the field visiting teams to closely monitor data collection and quality, review their work, identify any issues, and provide feedback. In addition to quality control teams, fieldwork coordinators also visited teams regularly to monitor their work, resolve any issues that arose, and provide support as needed. During field visits, monitors provided the teams they visited with critical feedback to improve their performance. All monitors used the GDHS field-check tables, based on data from the completed clusters, to illustrate problems specific to each team visited.

2.7 DATA PROCESSING

All electronic data files were transferred via the Internet File Streaming System (IFSS) to the GBoS central office. IFSS automatically encrypts the data and sends the data to a server which in turn downloads the data to the data processing supervisor's password protected computer in the central office. The data processing operation included secondary editing, which required resolution of computer-identified inconsistencies and coding of open-ended questions. The data were processed by two IT specialists and three secondary editors who took part in the main fieldwork training; they were supervised remotely by The DHS Program staff. Data editing was accomplished using CSPro software. During the fieldwork, field-check tables were generated to check various data quality parameters, and specific feedback was given to the teams to improve performance. Secondary editing and data processing were initiated in November 2019 and completed in May 2020.

3 KEY FINDINGS

3.1 RESPONSE RATES

Table 1 shows response rates for the 2019-20 GDHS. All 6,985 households in the selected housing units were eligible for the survey, of which 6,736 were occupied. Of the occupied households, 6,549 were successfully interviewed, yielding a response rate of 97%. Of the households successfully interviewed, 1,948 were completed in 2019, and 4,601 were completed in 2020.

In the interviewed households, 12,481 women age 15-49 were identified for individual interviews; interviews were completed for 11,865 women, yielding a response rate of 95%, which is a four percentage point increase from the 2013 GDHS. Among men, 5,337 were eligible for individual interviews, of which 4,636 completed an interview, thus producing a response rate of 87%, a five percentage point increase from the previous survey.

Table 1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), The Gambia DHS 2019-20

	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	4,322	2,663	6,985
Households occupied	4,146	2,590	6,736
Households interviewed	3,969	2,580	6,549
Household response rate[1]	95.7	99.6	97.2
Interviews with women age 15-49			
Number of eligible women	6,906	5,575	12,481
Number of eligible women interviewed	6,510	5,355	11,865
Eligible women response rate[2]	94.3	96.1	95.1
Household interviews in subsample			
Households selected	2,158	1,333	3,491
Households occupied	2,078	1,313	3,391
Households interviewed	2,003	1,308	3,311
Household response rate in subsample[1]	96.4	99.6	97.6
Interviews with men age 15-59			
Number of eligible men	3,252	2,085	5,337
Number of eligible men interviewed	2,732	1,904	4,636
Eligible men response rate[2]	84.0	91.3	86.9

Note: No interviews could take place in one of the PSU's due to lack of accessibility.
[1] Households interviewed/households occupied.
[2] Respondents interviewed/eligible respondents.

3.2 CHARACTERISTICS OF RESPONDENTS

Table 2 shows the distribution of women and men age 15-49 interviewed in the 2019-20 GDHS by background characteristics. For the most part, the female and male populations have similar distributions. In both populations, the proportion of women and men in each age group generally decreases with increasing age, reflecting the comparatively young age structure of the population in The Gambia.

Almost all women (96%) and men (97%) are Muslim. Four percent of women and 3% of men are Christian, while less than 1% of women and men are of another religion or have no religion.

Table 2 Background characteristics of respondents

Percent distribution of women and men age 15-49 by selected background characteristics, The Gambia DHS 2019-20

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	22.2	2,633	2,687	25.8	1,097	1,079
20-24	18.4	2,181	2,082	18.8	802	731
25-29	18.9	2,248	2,194	14.9	634	641
30-34	13.6	1,619	1,626	12.3	524	519
35-39	12.1	1,438	1,485	11.7	499	506
40-44	8.7	1,028	1,054	8.4	357	365
45-49	6.0	718	737	8.0	342	360
Religion						
Islam	96.4	11,443	11,584	96.5	4,104	4,087
Christianity	3.5	418	278	3.4	143	108
Other religion	0.0	3	2	0.0	2	3
No religion	0.0	1	1	0.1	6	3
Ethnic group						
Mandinka/Jahanka	33.4	3,961	3,701	33.1	1,408	1,231
Wollof	12.5	1,487	1,679	13.8	587	615
Jola/Karoninka	11.1	1,311	782	11.0	470	283
Fula/Tukulur/Lorobo	18.2	2,156	2,569	18.2	774	959
Serere	3.6	425	376	3.3	139	137
Sarahule	7.3	868	1,143	7.0	297	354
Creole/Aku Marabout	0.5	55	64	0.6	24	35
Manjago	1.2	143	105	1.5	63	47
Bambara	1.2	147	161	1.5	63	73
Other Ethnic Group	0.9	110	82	0.9	37	31
Non-Gambian	10.1	1,201	1,203	9.2	393	436
Marital status						
Never married	31.2	3,704	3,226	60.0	2,552	2,377
Married	63.2	7,501	8,067	38.5	1,637	1,768
Living together	0.2	25	16	0.2	7	3
Divorced/separated	3.8	453	390	1.1	45	43
Widowed	1.5	182	166	0.3	13	10
Residence						
Urban	73.7	8,747	6,510	77.6	3,299	2,496
Rural	26.3	3,118	5,355	22.4	955	1,705
Local Government Area						
Banjul	1.4	163	947	1.9	80	467
Kanifing	21.8	2,590	1,612	24.4	1,040	634
Brikama	44.7	5,299	2,355	46.2	1,967	884
Mansakonko	3.6	431	1,030	3.1	134	331
Kerewan	9.5	1,129	1,391	8.2	351	466
Kuntaur	4.4	522	1,319	3.3	142	374
Janjanbureh	5.0	595	1,262	4.8	202	453
Basse	9.6	1,137	1,949	8.0	340	592
Education						
No education	34.7	4,119	4,963	21.6	921	1,251
Primary	15.6	1,854	1,972	16.8	716	748
Secondary or higher	49.7	5,892	4,930	61.5	2,618	2,202
Wealth quintile						
Lowest	16.8	1,998	3,334	14.8	632	1,068
Second	18.0	2,135	2,253	18.0	768	863
Middle	19.3	2,292	2,270	19.9	848	834
Fourth	21.8	2,591	2,035	20.6	875	684
Highest	24.0	2,849	1,973	26.6	1,132	752
Total 15-49	100.0	11,865	11,865	100.0	4,255	4,201
50-59	na	na	na	na	381	435
Total 15-59	na	na	na	na	4,636	4,636

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.
na = Not applicable

Table 2 shows that about 3 in 10 women (31%) and 6 in 10 men (60%) have never been married, which is largely unchanged from the 2013 survey. The majority of women (63%) are currently married, compared with only 39% of men; less than 1% of women and men are living with someone as if married. The data further show that female respondents are more likely than male respondents to be divorced or separated (4% versus 1%) or widowed (2% versus less than 1%). A large majority of women and men (74% and 78%, respectively) live in urban areas. By LGA, the largest proportion of female and male respondents (45% and 46%, respectively) are in Brikama, while the smallest proportion of women and men are in Banjul (1% and 2%, respectively).

Fifty percent of women and 62% of men in The Gambia have a secondary or higher education (this is a 10 percentage point increase among women and a 6 percentage point increase among men since 2013). Sixteen percent of women and 17% of men have a primary education, and 35% of women and 22% of men have no education (a decrease from 47% and 31%, respectively, since 2013).

3.3 FERTILITY

Women who were interviewed in the 2019-20 GDHS were asked to report the total number of sons and daughters they had given birth to during their lifetime. To ensure complete reporting, women were asked separately about children living at home, those living elsewhere, and children who had died. A complete birth history was obtained from each respondent, including information on the sex, date of birth, and survival status of each child. Age-specific and total fertility rates (TFRs) were calculated directly from the birth history data.

Table 3 shows age-specific fertility rates among women by 5-year age groups for the 3-year period preceding the survey. The table also shows the total fertility rate (TFR), which is a summary measure of the level of fertility and serves as an estimate for the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the current observed age-specific rates. If fertility were to remain constant at current levels, a woman from The Gambia would bear an average of 4.4 children in her lifetime. The TFR for rural areas (5.9 births per woman) is two children higher than that for urban areas (3.9 births per woman). Across the various age groups, fertility is consistently higher among rural than urban women. The TFR peaks among rural and urban women in the 25-29 age group.

Table 3 Current fertility

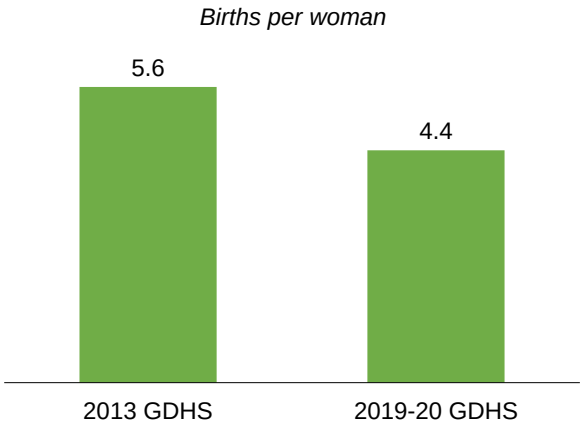
Age-specific and total fertility rates, general fertility rate, and crude birth rate for the 3 years preceding the survey, according to residence, The Gambia DHS 2019-20

	Residence		
Age group	Urban	Rural	Total
10-14	1	1	1
15-19	51	103	65
20-24	151	249	174
25-29	211	275	227
30-34	176	251	196
35-39	128	183	143
40-44	49	89	60
45-49	16	28	19
TFR (15-49)	3.9	5.9	4.4
GFR	131	196	148
CBR	32.5	38.9	34.4

Notes: Age-specific fertility rates are per 1,000 women. Rates are for the period 1-36 months preceding the interview. Rates for the 10-14 age group are based on retrospective data from women age 15-17.
TFR: Total fertility rate expressed per woman
GFR: General fertility rate expressed per 1,000 women age 15-44
CBR: Crude birth rate, expressed per 1,000 population

Figure 1 presents trends in the TFR since the 2013 GDHS. The overall fertility rate in The Gambia has declined from 5.6 births per woman in 2013 to 4.4 births in 2019-20.

Figure 1 **Trends in total fertility rate**



3.4 TEENAGE PREGNANCY AND MOTHERHOOD

The issue of adolescent fertility is important on both health and social grounds. Children born to very young mothers are at increased risk of sickness and death. Teenage mothers are more likely to experience adverse pregnancy outcomes and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

Table 4 Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage of women age 15-19 who: Have had a live birth	Are pregnant with first child	Percentage who have begun childbearing	Number of women
Age				
15	0.8	0.2	1.0	468
16	2.1	2.3	4.4	565
17	9.1	3.2	12.4	551
18	15.9	5.1	21.1	519
19	24.8	4.5	29.3	529
Residence				
Urban	8.5	2.8	11.3	1,901
Rural	16.2	4.1	20.2	732
Local Government Area				
Banjul	8.5	1.6	10.1	35
Kanifing	9.0	3.3	12.3	535
Brikama	6.9	2.5	9.4	1,174
Mansakonko	14.0	3.6	17.6	98
Kerewan	13.5	2.2	15.7	259
Kuntaur	21.3	7.2	28.5	129
Janjanbureh	17.5	5.0	22.4	142
Basse	17.9	3.5	21.4	261
Education				
No education	28.6	7.6	36.2	435
Primary	17.9	3.2	21.1	470
Secondary or higher	4.1	2.0	6.1	1,728
Wealth quintile				
Lowest	16.4	5.3	21.7	463
Second	15.0	4.2	19.2	486
Middle	13.6	3.7	17.3	521
Fourth	5.8	1.9	7.8	604
Highest	4.4	1.2	5.7	558
Total	10.6	3.1	13.8	2,633

Table 4 shows the percentage of women age 15-19 who have given birth or were pregnant with their first child at the time of the survey, according to background characteristics. Overall, 14% of women age 15-19 have begun childbearing: 11% have had a live birth, and 3% were pregnant with their first child at the time of the interview. Only 1% of women have already begun childbearing at age 15, but the proportion having children increases rapidly with age, reaching 29% among women age 19. Rural teenagers tend to start childbearing earlier than urban teenagers (20% versus 11%). Early childbearing among teenagers is most common in

Kuntaur (29%) and least common in Brikama (9%). Teenagers with no education or only primary education (36% and 21%, respectively) are more likely to have started childbearing than the national average (14%) or teenagers with a secondary education (6%). Early childbearing decreases with increasing wealth, falling from 22% among women in the lowest wealth quintile to 6% among those in the highest wealth quintile.

Trends at the national level show that there was a decline in adolescent childbearing from 18% in 2013 to 14% in the 2019-20 GDHS.

3.5 FERTILITY PREFERENCES

Information on fertility preferences is used to assess the potential demand for family planning services for the purposes of spacing or limiting future childbearing. To elicit information on fertility preferences, several questions were asked of currently married women (pregnant or not) regarding whether they wanted to have a/another child and, if so, how soon.

Table 5 shows that the majority of married women in The Gambia express a desire to control their future fertility. Only 18% of women do not want to have any more children or are sterilised. While the desire to limit fertility increases by number of living children, the overall desire for more children remains relatively robust. For example, 98% of respondents with no children want to have a child; 78% say that they want to have a child soon (within 2 years), while 20% want to have a child later or are undecided when. However, even among women with five children, over half (65%) say that they want to have another child. The proportion of women who say that they want to stop childbearing or are sterilised rose slightly, from 16% in 2013 to 18% in 2019-20.

The proportion of women who want to have another child soon increased from the previous survey (30% in 2013 to 35% in 2019-20). However, the proportion of women who want to wait 2 or more years before having a child decreased from 47% in 2013 to 37% in 2019-20.

Table 5 Fertility preferences by number of living children

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, The Gambia DHS 2019-20

	Number of living children[1]							
Desire for children	0	1	2	3	4	5	6+	Total
Have another soon[2]	78.4	43.6	38.7	34.0	29.3	24.3	12.3	34.7
Have another later[3]	7.6	46.3	48.9	45.9	45.6	36.2	20.3	36.6
Have another, undecided when	12.1	7.5	6.0	9.0	5.0	4.5	1.7	6.2
Undecided	0.8	1.3	1.8	2.4	4.3	4.7	7.8	3.5
Want no more	0.0	0.6	2.8	6.3	14.5	27.3	54.3	16.9
Sterilised[4]	0.2	0.0	0.0	0.7	0.6	0.8	1.5	0.6
Declared infecund	0.9	0.8	1.8	1.7	0.7	2.2	2.1	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	745	1,184	1,143	1,178	1,008	804	1,464	7,526

[1] The number of living children includes the current pregnancy
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilisation

3.6 FAMILY PLANNING

Family planning refers to a conscious effort by a couple to use contraceptives to limit or space the number of children they have. Contraceptive methods are classified as modern or traditional. Modern methods include female sterilisation, male sterilisation, intrauterine device (IUD), implants, injectables, the pill, condoms,

standard days method, and lactational amenorrhoea method (LAM). Other methods such as rhythm, withdrawal, and folk methods are grouped as traditional.

Table 6 shows the percent distribution of currently married women by the family planning method they use, according to background characteristics. Only 19% of currently married women of reproductive age are using a method of contraception. Among married women, use of modern methods (17%) is far more common than use of traditional methods (2%). The most widely used method is injectables (8%), followed by implants (6%).

The use of contraception rises with age, peaking at 24% among currently married women age 35-39 before declining to 18% among women age 45-49.

In general, currently married women in The Gambia do not begin to use contraception until they have had at least one child. Twenty percent of married women in urban areas use contraception, compared with 17% of women in rural areas. There is considerable variation in contraceptive use by LGA. Women from Basse are the least likely to use any method of contraception (9%), whereas women from Banjul are most likely (23%), followed closely by women from Brikama and Kerewan (22% each). However, no strong pattern in the use of contraception exists with increasing educational attainment or wealth.

Use of any contraceptive method has increased by 10 percentage points in the past 7 years; 9% of currently married women age 15-49 reported using a method in the 2013 GDHS, compared with 19% in the 2019-20 GDHS. The proportion of currently married women who use modern contraceptive methods increased to 17% from 8% in the same period. The percentage of women using injectables doubled from 4% in 2013 to 8% in 2019-20.

Among sexually active unmarried women, 41% are using a contraceptive method, all of whom are using a modern method. The most commonly used methods among sexually active unmarried women are implants (20%) and injectables (11%).

Table 6 Current use of contraception according to background characteristics

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to background characteristics; and percent distribution of sexually active unmarried women age 15-49 by contraceptive method currently used, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Any method	Any modern method	Modern method										Any tradi-tional method	Traditional method			Not currently using	Total	Number of women
			Female sterili-sation	Male sterili-sation	Pill	IUD	Inject-ables	Implants	Male condom	Female condom	SDM	LAM		Rhythm	With-drawal	Other			
								CURRENTLY MARRIED WOMEN											
Number of living children																			
0	1.6	1.3	0.0	0.2	0.3	0.0	0.6	0.1	0.0	0.0	0.0	0.0	0.3	0.0	0.3	0.0	98.4	100.0	939
1-2	15.2	13.0	0.0	0.0	1.1	0.5	7.2	3.5	0.5	0.0	0.1	0.0	2.2	0.2	1.1	0.9	84.8	100.0	2,268
3-4	21.5	19.3	0.6	0.0	2.3	1.0	9.1	5.9	0.3	0.0	0.1	0.1	2.2	0.1	0.9	1.1	78.5	100.0	2,134
5+	27.7	25.9	1.3	0.0	3.0	0.6	11.2	9.3	0.3	0.0	0.0	0.2	1.8	0.1	0.2	1.4	72.3	100.0	2,185
Age																			
15-19	5.4	4.5	0.0	0.0	0.4	0.0	3.5	0.5	0.1	0.0	0.0	0.0	0.9	0.0	0.0	0.9	94.6	100.0	497
20-24	13.4	10.3	0.0	0.0	0.9	0.1	5.9	3.0	0.2	0.0	0.2	0.1	3.1	0.4	1.5	1.2	86.6	100.0	1,115
25-29	18.9	16.5	0.0	0.0	1.4	0.2	8.4	6.1	0.3	0.0	0.2	0.1	2.4	0.0	1.5	0.9	81.1	100.0	1,749
30-34	21.7	20.8	0.5	0.1	2.1	0.5	10.2	6.7	0.3	0.0	0.0	0.2	1.0	0.0	0.4	0.6	78.3	100.0	1,381
35-39	23.6	21.5	0.7	0.0	3.1	1.3	10.5	5.4	0.4	0.0	0.0	0.1	2.1	0.2	0.3	1.6	76.4	100.0	1,273
40-44	22.6	21.8	1.4	0.0	2.8	1.4	6.8	8.5	0.7	0.0	0.0	0.1	0.8	0.0	0.0	0.8	77.4	100.0	889
45-49	18.3	16.8	2.3	0.0	2.0	0.5	7.0	5.1	0.0	0.0	0.0	0.0	1.5	0.4	0.0	1.1	81.7	100.0	623
Residence																			
Urban	20.0	17.9	0.6	0.0	2.0	0.8	8.4	5.6	0.4	0.0	0.1	0.1	2.0	0.1	1.0	0.9	80.0	100.0	5,133
Rural	16.7	15.3	0.6	0.0	1.7	0.2	7.4	5.2	0.1	0.0	0.0	0.1	1.4	0.1	0.1	1.2	83.3	100.0	2,393
Local Government Area																			
Banjul	23.0	21.7	1.3	0.0	5.1	0.7	7.8	6.2	0.3	0.0	0.0	0.3	1.4	0.8	0.4	0.2	77.0	100.0	85
Kanifing	17.2	15.9	0.3	0.0	1.8	0.9	7.4	5.0	0.3	0.0	0.0	0.1	1.3	0.4	0.1	0.8	82.8	100.0	1,376
Brikama	22.2	19.7	0.6	0.1	2.0	0.8	9.7	5.7	0.5	0.0	0.2	0.1	2.6	0.0	1.5	1.0	77.8	100.0	3,143
Mansakonko	15.2	14.4	0.4	0.0	1.5	0.0	7.6	4.5	0.1	0.0	0.0	0.2	0.8	0.0	0.1	0.6	84.8	100.0	308
Kerewan	22.2	20.8	1.2	0.0	2.2	0.2	9.2	7.7	0.3	0.0	0.0	0.0	1.4	0.3	0.1	1.0	77.8	100.0	813
Kuntaur	15.9	14.1	0.6	0.0	0.6	0.1	8.4	4.2	0.0	0.0	0.0	0.2	1.8	0.1	0.1	1.6	84.1	100.0	432
Janjanbureh	20.2	18.2	0.4	0.1	2.1	0.8	8.0	6.6	0.2	0.0	0.0	0.1	2.0	0.0	0.1	1.9	79.8	100.0	466
Basse	8.6	7.8	0.3	0.0	1.6	0.1	2.2	3.4	0.1	0.0	0.0	0.2	0.8	0.0	0.0	0.8	91.4	100.0	903
Education																			
No education	18.4	16.8	0.6	0.0	1.8	0.3	7.9	5.9	0.2	0.0	0.0	0.2	1.6	0.0	0.5	1.1	81.6	100.0	3,571
Primary	17.6	15.2	1.2	0.0	0.9	0.3	7.0	5.3	0.2	0.0	0.2	0.1	2.4	0.2	0.9	1.4	82.4	100.0	1,298
Secondary or higher	20.2	18.4	0.2	0.1	2.6	1.1	8.9	4.9	0.6	0.0	0.1	0.0	1.8	0.2	0.9	0.7	79.8	100.0	2,657
Wealth quintile																			
Lowest	17.5	15.7	0.4	0.0	1.4	0.3	7.7	5.7	0.1	0.0	0.0	0.1	1.8	0.1	0.3	1.4	82.5	100.0	1,536
Second	18.0	15.3	0.6	0.0	1.7	0.3	7.1	5.2	0.1	0.0	0.0	0.2	2.7	0.0	1.2	1.5	82.0	100.0	1,475
Middle	17.9	16.2	0.8	0.0	1.4	0.3	8.0	5.2	0.1	0.0	0.3	0.1	1.6	0.1	0.7	0.8	82.1	100.0	1,532
Fourth	22.5	20.5	0.7	0.0	2.5	0.8	10.5	5.2	0.6	0.0	0.0	0.1	2.0	0.0	0.9	1.0	77.5	100.0	1,495
Highest	18.8	17.7	0.3	0.1	2.5	1.2	7.0	5.9	0.7	0.0	0.0	0.0	1.0	0.4	0.3	0.3	81.2	100.0	1,488
Total	18.9	17.1	0.6	0.0	1.9	0.6	8.1	5.5	0.3	0.0	0.1	0.1	1.8	0.1	0.7	1.0	81.1	100.0	7,526

Continued…

Table 6—Continued

Background characteristic	Any method	Any modern method	Modern method										Any tradi-tional method	Traditional method			Not currently using	Total	Number of women
			Female sterili-sation	Male sterili-sation	Pill	IUD	Inject-ables	Implants	Male condom	Female condom	SDM	LAM		Rhythm	With-drawal	Other			
SEXUALLY ACTIVE UNMARRIED WOMEN[1]																			
Residence																			
Urban	42.0	42.0	0.0	0.0	5.1	0.2	11.2	19.7	5.3	0.4	0.0	0.0	0.0	0.0	0.0	0.0	58.0	100.0	97
Rural	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	100.0	3
Total	41.4	41.4	0.0	0.0	4.9	0.2	10.9	19.9	5.1	0.4	0.0	0.0	0.0	0.0	0.0	0.0	58.6	100.0	101

Note: If more than one method is used, only the most effective method is considered in this tabulation. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
SDM = Standard days method
LAM = Lactational amenorrhoea method
[1] Women who have had sexual intercourse within 30 days preceding the survey.

3.7 NEED AND DEMAND FOR FAMILY PLANNING

Unmet need for family planning refers to fecund women (currently married or in union), who are not using contraception, but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting). An estimate of the size and composition of the population of women who have an unmet need for family planning services is useful for planning purposes in reproductive health programmes.

The criteria used within The DHS Program to identify women with an unmet need for family planning have followed the Bradley et al. 2012 definition over the past several years. This definition was employed in determining the percentage of women who have an unmet need for family planning (Table 7).

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

Percentage of currently married women age 15-49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Unmet need for family planning	Met need for family planning (currently using)		Total demand for family planning[3]	Number of women	Percentage of demand satisfied[1]	
		All methods	Modern methods[2]			All methods	Modern methods[2]
CURRENTLY MARRIED WOMEN							
Age							
15-19	29.3	5.4	4.5	34.8	497	15.7	13.0
20-24	23.2	13.4	10.3	36.6	1,115	36.5	28.1
25-29	23.9	18.9	16.5	42.8	1,749	44.2	38.6
30-34	23.1	21.7	20.8	44.8	1,381	48.5	46.3
35-39	25.4	23.6	21.5	49.1	1,273	48.2	43.9
40-44	24.3	22.6	21.8	46.9	889	48.2	46.5
45-49	22.2	18.3	16.8	40.5	623	45.2	41.5
Residence							
Urban	23.9	20.0	17.9	43.9	5,133	45.5	40.8
Rural	24.7	16.7	15.3	41.4	2,393	40.3	37.0
Local Government Area							
Banjul	24.6	23.0	21.7	47.7	85	48.3	45.5
Kanifing	25.3	17.2	15.9	42.5	1,376	40.5	37.3
Brikama	22.9	22.2	19.7	45.2	3,143	49.3	43.6
Mansakonko	25.0	15.2	14.4	40.2	308	37.9	36.0
Kerewan	24.6	22.2	20.8	46.8	813	47.4	44.4
Kuntaur	23.9	15.9	14.1	39.8	432	39.9	35.4
Janjanbureh	17.9	20.2	18.2	38.1	466	53.0	47.8
Basse	29.5	8.6	7.8	38.1	903	22.5	20.5
Education							
No education	24.2	18.4	16.8	42.6	3,571	43.2	39.4
Primary	26.7	17.6	15.2	44.3	1,298	39.7	34.3
Secondary or higher	22.9	20.2	18.4	43.2	2,657	46.9	42.6
Wealth quintile							
Lowest	23.2	17.5	15.7	40.8	1,536	43.0	38.5
Second	25.2	18.0	15.3	43.2	1,475	41.6	35.4
Middle	25.4	17.9	16.2	43.3	1,532	41.3	37.5
Fourth	21.9	22.5	20.5	44.4	1,495	50.6	46.1
Highest	25.1	18.8	17.7	43.8	1,488	42.8	40.5
Total	24.2	18.9	17.1	43.1	7,526	43.9	39.6
SEXUALLY ACTIVE UNMARRIED WOMEN[4]							
Residence							
Urban	44.9	42.0	42.0	86.8	97	48.3	48.3
Rural	*	*	*	*	3	*	*
Total	45.1	41.4	41.4	86.5	101	47.9	47.9

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed. Numbers in this table correspond to the revised definition of unmet need described in Bradley et al., 2012.

[1] Percentage of demand satisfied is met need divided by total demand

[2] Modern methods include female sterilisation, male sterilisation, pill, IUD, injectables, implants, male condom, female condom, emergency contraception, standard days method (SDM), lactational amenorrhoea method (LAM) and other modern methods

[3] Total demand is the sum of unmet need and met need.

[4] Women who have had sexual intercourse within 30 days preceding the survey.

Specifically, women are considered to have an unmet need for spacing if they are:

- At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next 2 years or are unsure if or when they want to become pregnant
- Pregnant with a mistimed pregnancy
- Postpartum amenorrhoeic for up to 2 years following a mistimed birth and not using contraception

Women are considered to have an unmet need for limiting if they are:

- At risk of becoming pregnant, not using contraception, and want no (more) children
- Pregnant with an unwanted pregnancy
- Postpartum amenorrhoeic for up to 2 years following an unwanted birth and not using contraception

Women who are classified as infecund have no unmet need because they are not at risk of becoming pregnant.

Women using contraception are considered to have a met need. Women using contraception who say they want no (more) children are considered to have a met need for limiting, and women who are using contraception and say they want to delay having a child or are unsure if or when they want a (another) child are considered to have a met need for spacing.

Total demand, percentage of demand satisfied, and percentage of demand satisfied by modern methods are defined as follows:

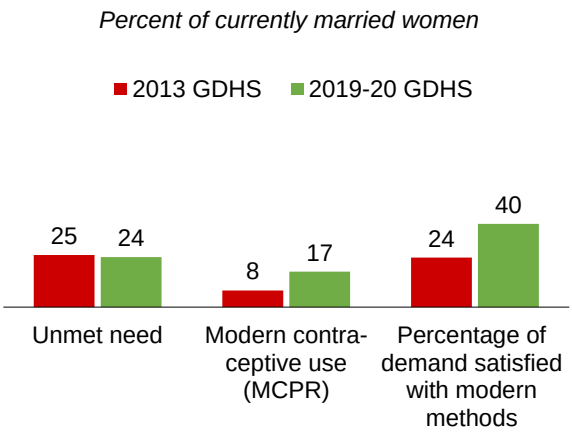
- **Total demand for family planning:** the sum of unmet need (for spacing and limiting) and total contraceptive use
- **Percentage of demand satisfied:** total contraceptive use divided by the sum of unmet need and total contraceptive use
- **Percentage of demand satisfied by modern methods:** use of modern contraceptive methods divided by the sum of unmet need and total contraceptive use

Table 7 presents data on unmet need, met need, and total demand for family planning services for currently married women. Overall, 24% of currently married women have an unmet need for family planning. Nineteen percent of currently married women have a met need for family planning—that is, they are currently using a contraceptive method—and this has doubled since 2013 when 9% of women had a met need for family planning. The total demand for family planning among currently married women is 43%, and the total demand satisfied is 44%, almost entirely by modern methods (40%). Thus, if all currently married women who said they want to space or limit their children were to use family planning methods, the contraceptive prevalence rate (CPR) would increase from 19% to 43%.

The level of unmet need varies by background characteristics. Unmet need is highest among currently married women age 15-19 (29%). Total unmet need among urban and rural currently married women is roughly the same (24% and 25%, respectively). Across LGAs, unmet need is highest in Basse (30%) and lowest in Janjanbureh (18%). There is no clear pattern by wealth or education with unmet need.

Figure 2 shows trends in unmet need, modern contraceptive use, and percentage of demand met with modern methods. Overall, unmet need has remained relatively stable since 2013, falling from 25% to 24%. Modern contraceptive use and percentage of demand satisfied with modern methods have both increased since the 2013 GDHS (from 8% and 24% to 17% and 40%, respectively).

Figure 2 **Trends in unmet need, modern contraceptive use, and percentage of demand satisfied with modern methods**



3.8 EARLY CHILDHOOD MORTALITY

Infant and child mortality rates are basic indicators of a country's socioeconomic situation and quality of life (UNDP 2007). Estimates of childhood mortality are based on information collected in the birth history section of the Woman's Questionnaire, which includes questions about women's childbearing experience including the number of sons and daughters who live with their mother, the number who live elsewhere, and the number who have died. For each live birth reported in the birth history, information was collected on the name, date of birth, sex, whether the birth was single or multiple, and survivorship. For living children, information was also collected on the age at last birthday and whether the child resided with the mother. For children who had died, the respondent was asked to provide the age at death. Mortality rates for specific periods preceding the survey were calculated using direct estimation procedures and are shown in Table 8.

Table 8 Early childhood mortality rates

Neonatal, post-neonatal, infant, child and under-5 mortality rates for 5-year periods preceding the survey, The Gambia DHS 2019-20

Years preceding the survey	Neonatal mortality (NN)	Post-neonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
0-4	29	13	42	15	56
5-9	31	18	50	16	65
10-14	33	17	50	31	79

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

This information is used to directly estimate the following five mortality rates:

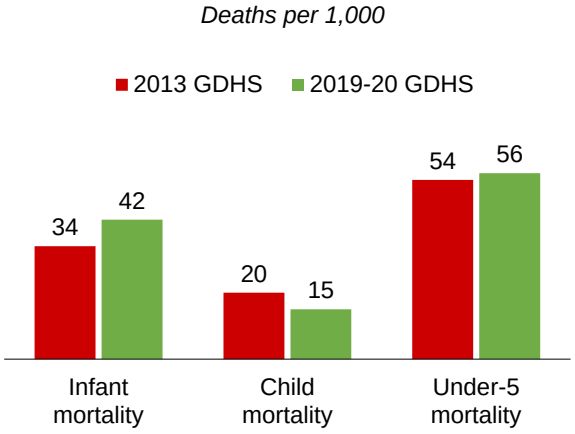
- **Neonatal mortality:** the probability of dying within the first month of life
- **Postneonatal mortality:** the probability of dying after the first month of life, but before the first birthday (the difference between infant and neonatal mortality)
- **Infant mortality:** the probability of dying before the first birthday
- **Child mortality:** the probability of dying between the first and the fifth birthday
- **Under-5 mortality:** the probability of dying between birth and the fifth birthday

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to age 12 months.

Table 8 presents early childhood mortality rates for the 15 years preceding the survey. Under-5 mortality for the period 0-4 years before the survey (which corresponds approximately to the calendar years 2015-16 to 2019-20) is 56 deaths per 1,000 births. Most of the mortality occurs during the first year of life, as the infant mortality rate is 42 deaths per 1,000 births, while mortality between the first and the fifth birthday is only 15 deaths per 1,000 children surviving to their first birthday. Mortality during the first month (neonatal mortality), is higher than post neonatal mortality (29 deaths per 1,000 births versus 13 deaths per 1,000 births) and accounts for 69% of the overall infant mortality.

Another way to look at trends in mortality levels involves the comparison of estimates from surveys conducted at different points in time. Results from the 2013 and 2019-20 GDHS are presented in Figure 3. Trends from the previous survey indicate an increase in infant and under-5 mortality in the 5 years preceding each survey. However, child mortality declined in the same period.

Figure 3 **Trends in childhood mortality**



3.9 MATERNAL CARE

Proper care during pregnancy and delivery is important for the health of both the mother and the baby. In the 2019-20 GDHS, women who had a live birth in the 5 years preceding the survey were asked a number of questions about maternal care. Mothers were asked whether they had obtained antenatal care during the pregnancy for their most recent live birth in the 5 years preceding the survey. For each live birth over the same period, mothers were also asked what type of assistance they received at the time of delivery. Questions were asked about postnatal care for the most recent birth. Table 9 summarises information on the coverage of these maternal health services.

Table 9 Maternal care indicators

Among women age 15-49 who had a live birth in the 5 years preceding the survey, percentage who received antenatal care from a skilled provider for the most recent live birth, percentage with four or more ANC visits for the most recent live birth, percentage with eight or more ANC visits for the most recent live birth, and percentage whose most recent live birth was protected against neonatal tetanus; among all live births in the 5 years preceding the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women age 15-49 who had a live birth in the 2 years preceding the survey, percentage who received a postnatal check during the first 2 days after giving birth, according to background characteristics, The Gambia DHS 2019-20.

	Women who had a live birth in the 5 years preceding the survey					Live births in the 5 years preceding the survey			Women who had a live birth in the 2 years preceding the survey	
Background characteristic	Percentage receiving antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage with 8+ ANC visits	Percentage whose most recent live birth was protected against neonatal tetanus[2]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage of women with a postnatal check during the first 2 days after birth[3]	Number of women
Mother's age at birth										
<20	96.8	75.8	3.9	56.1	565	86.2	86.7	824	86.3	333
20-34	98.0	78.5	4.3	73.2	3,784	83.8	83.4	5,614	87.6	2,269
35-49	97.6	79.9	3.9	68.9	1,022	82.6	82.8	1,215	90.0	527
Residence										
Urban	98.6	76.1	4.5	67.5	3,589	88.3	88.3	5,008	89.1	2,022
Rural	96.1	83.3	3.6	76.9	1,783	75.4	75.0	2,645	85.6	1,108
Local Government Area										
Banjul	99.1	82.2	7.7	74.7	57	94.9	93.8	74	88.1	26
Kanifing	97.0	79.2	8.6	67.0	990	90.1	90.7	1,313	88.3	535
Brikama	99.6	75.6	2.4	66.0	2,193	87.6	87.3	3,114	90.4	1,243
Mansakonko	99.2	81.5	5.5	74.8	228	70.7	70.0	335	82.9	138
Kerewan	99.2	84.9	5.2	81.5	610	92.1	90.1	925	90.5	387
Kuntaur	92.1	80.5	2.3	75.2	314	61.8	62.6	476	80.5	196
Janjanbureh	87.4	83.6	4.8	68.7	337	73.6	75.3	483	83.5	200
Basse	99.3	76.0	2.3	78.6	641	74.8	74.7	934	84.4	403
Mother's education										
No education	97.5	76.8	3.3	73.1	2,454	78.5	78.2	3,543	86.1	1,391
Primary	98.1	78.3	3.9	72.7	945	82.6	81.8	1,381	84.2	594
Secondary or higher	98.1	80.7	5.4	66.5	1,973	91.4	91.7	2,729	91.9	1,145
Wealth quintile										
Lowest	95.5	82.3	3.7	75.6	1,156	71.6	71.3	1,731	83.0	704
Second	97.7	75.3	2.5	72.0	1,126	80.3	80.4	1,622	87.5	666
Middle	98.9	74.1	3.7	71.8	1,126	85.0	84.7	1,602	88.7	663
Fourth	98.9	76.1	4.0	68.2	1,026	90.4	90.3	1,406	90.1	572
Highest	98.3	85.4	7.4	64.1	937	96.1	95.9	1,293	91.3	525
Total	97.8	78.5	4.2	70.6	5,372	83.8	83.7	7,653	87.9	3,129

Note: If more than one source of assistance was mentioned, only the provider with the highest qualifications is considered in this tabulation.
[1] Skilled provider includes doctor, nurse, and midwife.
[2] Includes mothers with two injections during the pregnancy of her most recent live birth, or two or more injections (the last within 3 years of the most recent live birth), or three or more injections (the last within 5 years of the most recent live birth), or four or more injections (the last within 10 years of the most recent live birth), or five or more injections at any time prior to the last live birth
[3] Includes women who received a check from a doctor, nurse, midwife, auxiliary nurse, community nurse attendant, community birth companion, or village health worker

Antenatal care

Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period (within 42 days after delivery). In The Gambia, skilled providers trained to assist during delivery included doctors, nurses, and midwives.

Table 9 shows that 98% of mothers reported seeing a health professional at least once for antenatal care for the most recent birth in the 5-year period before the survey, which has increased from the 86% reported in the 2013 GDHS. This indicator is almost uniformly high among mothers regardless of background characteristics. Nevertheless, women living in Janjanbureh (87%) are the least likely to report receiving antenatal care from a skilled provider.

Overall, 79% of women had four or more ANC visits, which is roughly the same as the 78% in the 2013 GDHS. Rural women were more likely than urban women to have four or more ANC visits (83% and 76%, respectively). Among the LGAs, 85% of women in Kerewan had four or more ANC visits, compared with 76% of women residing in Brikama and Basse. The likelihood of having four or more ANC visits increases with the mother's education level. Seventy-seven percent of mothers with no education had four or more ANC visits, compared with 81% of mothers with a secondary or higher education. There is no clear relationship between receiving four or more ANC visits and wealth. Very few women (only 4%) had eight or more ANC visits, which is the number of visits currently recommended by the World Health Organization.

Tetanus toxoid vaccination

Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus, a cause of infant death due primarily to unsanitary conditions at childbirth. Full protection is considered to be provided to an infant if the mother received two injections during the pregnancy of her last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth. Seventy-one percent of women received the number of tetanus toxoid injections required to provide full protection for their most recent birth in the 5 years preceding the survey. Women in urban areas were less likely to receive full protection against tetanus than women in rural areas (68% versus 77%). At the LGA level, women in Kerewan were most likely to have received full protection (82%), whereas those in Brikama were least likely (66%). There is a negative relationship between the probability of being protected against neonatal tetanus and rising levels of wealth and education.

Delivery care

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother and/or baby (Van Lerberghe and De Brouwere 2001; WHO 2006). Table 9 shows that 84% of births in The Gambia are assisted by a skilled medical professional. Assistance at delivery by a skilled provider is far higher in urban (88%) than rural (75%) areas. There is substantial variation among LGAs, with Banjul having the highest percentage (95%) and Kuntaur having the lowest (62%). As expected, there is a positive relationship between mother's education and skilled assistance at delivery, rising from 79% among mothers with no education to 91% among those with secondary or higher education. Wealth follows a similar pattern to mother's education, rising from 72% among women in the lowest wealth quintile to 96% among women in the highest wealth quintile.

Table 9 also shows that 84% of births occur in health facilities. This is an increase from the 2013 GDHS, when only 63% of births took place in a health facility. The percentage of facility deliveries varies across residence and LGAs. Overall, urban areas have a greater percentage of facility deliveries than rural areas (88% versus 75%). Among LGAs, facility deliveries are least common Kuntaur (63%) and most common in Banjul (94%). There is a positive relationship between the likelihood that a birth is delivered in a health facility and the mother's level of education, rising from 78% among those with no education to 92% among those with secondary or higher education. Place of delivery also correlates positively with wealth quintile; 71% of births to women in the lowest quintile take place in a health facility, compared with 96% of births to women in the highest quintile.

Postnatal care for the mother

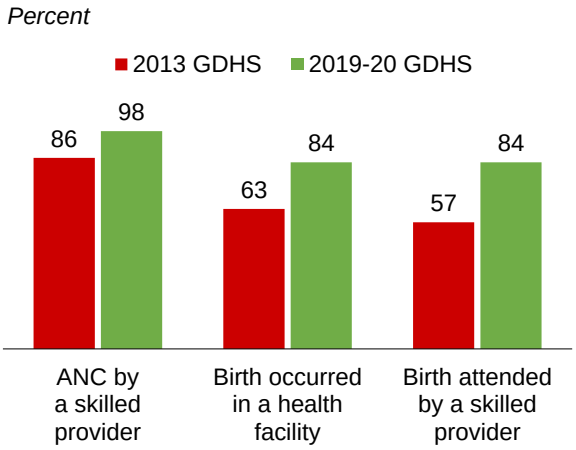
A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child.

Safe motherhood programmes recommend that all women receive a check on their health within 2 days after delivery.

Overall, 88% of women with a birth in the 2 years preceding the survey received postnatal care within 2 days after delivery. As shown in Table 9, there is a slight difference between women in urban (89%) and rural (86%) areas in receiving timely postnatal care. Kerewan and Brikama had the highest percentage of women receiving timely postnatal care (91% and 90%, respectively). Kuntaur had the lowest proportion of women receiving timely postnatal care (81%). The percentage is highest for women with a secondary or higher education (92%). The percentage rises with household wealth, from 83% in the lowest wealth quintile to 91% in the highest wealth quintile.

Figure 4 shows trends in maternal health care from the 2013 GDHS to the 2019-20 GDHS. The percentage of women receiving ANC from a skilled provider increased from 86% in 2013 to 98% in 2019-20. The proportion of women whose births occurred in a health facility increased from 63% in 2013 to 84% in 2019-20. Similarly, the proportion of women whose births were attended by a skilled provider has increased from 57% to 84% over the same period.

Figure 4 **Trends in maternal health care**



3.10 CHILD HEALTH AND NUTRITION OF CHILDREN

The 2019-20 GDHS collected data on a number of key child health indicators, including vaccinations of young children, treatment practices when a child is ill, infant feeding practices, and the nutritional status of children.

Vaccination of children

Universal immunisation of children against common vaccine-preventable diseases is crucial to reducing infant and child mortality. In The Gambia, routine childhood vaccines include BCG vaccine (tuberculosis), HepB vaccine (hepatitis B), DPT-HepB-Hib or pentavalent vaccine (diphtheria, tetanus, pertussis, hepatitis B, and *Haemophilus influenzae* type b), oral polio vaccine or OPV (poliomyelitis), inactivated polio vaccine or IPV (poliomyelitis), pneumococcal conjugate vaccine or PCV, rotavirus vaccine or RV, yellow fever vaccine, measles vaccine or measles/rubella (MR) vaccine, meningitis A vaccine[1], DPT booster[2], and polio booster.

In The Gambia, the BCG vaccine and a birth dose of the HepB vaccine are usually given shortly after birth; a birth dose of the oral polio vaccine (OPV 0) is given within 2 weeks of birth. The first two doses of pentavalent, PCV, RV, and OPV (excluding OPV 0) are given approximately at age 2 and 3 months. The third doses of pentavalent, PCV, and OPV are given at 4 months along with a dose of IPV. Another dose of OPV

[1] The Gambia introduced meningitis A vaccine in 2019 via a national campaign. However, although data were collected on its coverage, the meningitis A vaccine has been excluded from Table 10 because some of the children for whom vaccination data were collected were outside of the age range eligible to receive it. However, the meningitis A vaccine data will be available in the GDHS data set.

[2] The Gambian routine vaccinations include a DPT booster for children age 18 months. However, due to an error in the questionnaire, information on this vaccine was only collected for children who had a vaccination card that was observed, and not for children whose vaccination information was collected by mother's recall. As such, the results have been excluded from the table. For children age 24-35 months who had a vaccination card that was observed, 79% received a booster dose of DPT.

(OPV 4) and a first measles or MR vaccination and yellow fever vaccination should be given at age 9 months. A booster dose of DPT should be given one year after the third dose of pentavalent and an OPV booster (polio booster) and a second measles or MR vaccination are given at 18 months.

The 2019-20 GDHS collected information on vaccinations for all children born in the 3 years before the survey. For each of these children, mothers were asked whether they had a vaccination card for the child, and, if so, whether the interviewer could see it. When a mother was able to show the vaccination card to the interviewer, the dates of vaccinations received were copied from the card to the questionnaire. If a child never received a vaccination card or if the mother was unable to show the card to the interviewer, the mother was asked specific questions about whether the child had received each vaccine. In the 2019-20 GDHS, the vaccination card was observed for 96% of the children age 12-23 months and 90% of the children age 24-35 months for whom vaccination data were obtained (data not shown). The information presented below on vaccination coverage is based on both information taken from the vaccination cards and information obtained from the mothers' reports.

According to the guidelines developed by the World Health Organization, children are considered to have received all basic vaccinations when they have received BCG vaccine, three doses of DPT vaccine (given as pentavalent), three doses of polio vaccine (excluding the birth dose of OPV), and a vaccination against measles (given as either measles only or as MR).

A second critical measure of vaccination coverage is the proportion of children age 12-23 months and 24-35 months who have received "all age-appropriate" vaccinations. The Gambian immunisation programme considers a child age 12-23 months to have received all age-appropriate vaccinations if the child has all basic vaccinations along with a birth dose of HepB, two additional doses of OPV, one dose of IPV, three doses of PCV, two doses of RV, one dose of yellow fever vaccine, and one dose of measles or MR. In this report, a child age 24-35 months has received all age-appropriate vaccinations if the child has received all age-appropriate vaccines relevant for a child age 12-23 months, plus a sixth dose of OPV and a second dose of measles or MR.[3]

Table 10 presents data on vaccination coverage among children age 12-23 months and 24-35 months, according to background characteristics. Eighty-five percent of children age 12-23 months received all basic vaccinations, and 77% received all age-appropriate vaccinations. Less than 1% of children age 12-23 months did not receive any vaccinations.

For both basic and age-appropriate vaccinations, coverage is higher in rural areas than urban areas. Coverage at the LGA level for basic vaccinations was highest in Mansakonko (92%), followed by Kerewan (91%) and lowest in Banjul (77%). Similarly, age-appropriate vaccination coverage was highest in Mansakonko (88%) and lowest in Banjul (72%).

Among children age 24-35 months, 71% have received the second dose of measles or MR vaccine, and 64% received a polio booster. Overall, only 30% of children age 24-35 months received all age-appropriate vaccinations by the date of the interview. Coverage of all age-appropriate vaccinations is lowest in Banjul (15%) and highest in Mansakonko (45%).

Overall, basic vaccination coverage among children age 12-23 months has improved since the 2013 GDHS, rising nine percentage points from 76% to 85%. Age-appropriate vaccination information is not available for comparison with the previous survey.

[3] The Gambian immunisation programme considers a child age 24-35 months to have received all age-appropriate vaccinations if the child has received all age-appropriate vaccines relevant for a child age 12-23 months, plus a sixth dose of OPV, a second dose of measles or MR, and a booster dose of DPT.

Table 10 Vaccinations by background characteristics

Percentage of children age 12-23 months and children age 24-35 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), percentage with all basic vaccinations, and percentage with all age appropriate vaccinations, according to background characteristics, The Gambia DHS 2019-20

	Children age 12-23 months:																						Children age 24-35 months:			
			DPT-HepB-Hib[2]			Polio[3]						Pneumococcal			Rotavirus											
Background characteristic	BCG	HepB (birth dose)[1]	1	2	3	OPV 0 (birth dose)	OPV 1	OPV 2	OPV 3	OPV 4	IPV	1	2	3	1	2	Yellow fever	Measles/ Measles Rubella 1	All basic vacci-nations[4]	All age appro-priate vacci-nations[5]	No vacci-nations	Number of children	Measles/ Measles Rubella 2	Polio booster	All age appro-priate vacci-nations[6]	Number of children
Sex																										
Male	99.3	99.3	98.5	96.4	92.0	98.8	97.6	95.2	90.4	84.8	92.3	98.6	94.9	91.7	98.1	95.1	90.4	90.7	85.2	77.0	0.2	749	72.3	64.8	29.8	760
Female	98.6	98.4	98.1	96.5	93.5	97.9	97.5	95.5	90.5	85.7	91.9	98.4	96.4	92.9	97.4	94.2	89.2	89.5	83.9	77.3	0.7	706	68.6	62.3	29.5	672
Birth order																										
1	99.6	98.3	98.0	94.7	90.9	97.8	96.3	93.7	88.3	78.3	91.3	97.9	93.6	91.0	97.1	92.6	87.9	86.0	79.8	71.3	0.1	307	71.1	60.4	26.6	297
2-3	98.9	98.9	97.7	97.0	93.6	98.2	97.4	96.7	91.2	86.9	92.6	98.1	96.6	92.7	97.5	95.0	89.6	90.8	85.9	79.2	0.8	548	70.0	64.5	30.3	531
4-5	99.3	99.4	99.4	96.6	92.8	98.9	97.3	93.2	90.1	86.9	92.2	99.6	95.3	91.6	97.7	94.8	90.5	91.0	86.5	80.0	0.4	331	68.6	62.8	29.7	334
6+	98.1	98.8	98.9	97.0	93.1	98.6	99.6	97.1	91.6	87.8	91.8	98.9	96.1	93.9	99.1	96.1	91.7	92.4	84.9	76.3	0.1	269	73.5	66.3	32.0	270
Vaccination card																										
Seen	99.5	99.2	99.0	97.8	95.3	99.5	99.1	97.9	94.7	90.7	92.2	99.1	97.8	95.6	98.8	96.8	91.1	91.7	88.7	82.4	0.0	1,356	74.7	75.5	35.4	1,203
Not seen/no card	91.9	94.1	89.2	77.1	57.7	83.0	76.4	60.6	31.2	10.8	90.0	91.1	65.4	46.7	84.0	65.5	72.3	69.0	28.3	6.3	5.9	99	48.7	1.0	0.0	229
Residence																										
Urban	99.1	98.8	97.9	95.5	91.1	98.4	96.6	94.0	88.6	81.8	90.3	98.0	94.2	90.4	97.2	93.4	87.2	87.1	81.6	73.2	0.5	964	65.5	57.5	23.3	970
Rural	98.7	99.0	99.2	98.2	96.0	98.3	99.4	97.9	93.9	92.1	95.6	99.5	98.4	96.1	98.8	97.1	95.1	96.0	90.4	84.9	0.4	492	81.2	76.4	43.0	462
Local Government Area																										
Banjul	98.9	97.7	97.7	93.4	87.9	97.7	96.5	93.4	85.3	80.0	87.3	97.7	93.4	86.7	97.7	93.2	85.3	85.1	76.9	72.0	1.1	13	48.2	43.5	14.6	16
Kanifing	98.0	98.0	95.1	90.1	86.0	98.1	94.3	90.5	85.9	79.3	85.1	95.7	91.2	86.5	95.1	90.1	85.8	84.9	78.9	73.4	1.1	229	58.4	51.6	22.3	234
Brikama	100.0	99.6	99.1	98.0	94.1	99.1	97.5	95.8	90.9	84.1	92.7	99.1	95.5	92.9	98.3	95.2	89.3	89.2	84.5	75.0	0.0	616	71.1	63.4	27.6	649
Mansakonko	99.4	98.5	99.1	97.8	96.8	98.5	100.0	97.7	94.4	91.6	98.0	100.0	98.1	96.8	96.9	96.1	97.7	97.1	92.1	88.1	0.0	67	84.8	80.8	45.0	55
Kerewan	100.0	100.0	100.0	99.7	98.3	99.2	99.6	98.6	94.7	90.8	95.1	100.0	99.7	96.9	100.0	98.1	93.2	95.1	90.6	81.8	0.0	176	84.6	74.0	44.3	150
Kuntaur	97.3	99.5	100.0	96.2	93.5	99.1	99.6	97.1	91.3	88.8	95.0	99.6	97.1	94.6	98.6	96.2	94.1	94.1	85.4	81.2	0.0	87	73.6	73.1	30.4	80
Janjanbureh	97.8	97.8	98.6	96.7	91.7	95.6	98.2	94.3	85.8	87.3	94.9	98.6	96.7	92.4	98.6	95.8	91.8	93.5	81.8	78.5	1.4	85	72.2	64.6	29.9	86
Basse	96.9	96.9	97.1	95.5	90.5	96.0	97.7	95.6	91.0	86.8	91.5	97.7	95.5	90.7	96.4	93.3	87.9	89.4	84.9	78.6	1.5	182	67.7	62.9	30.9	162
Education																										
No education	97.9	98.5	97.9	96.0	92.4	97.8	97.7	95.3	89.4	85.1	91.0	98.0	95.0	91.6	97.2	94.3	88.4	89.5	83.6	76.5	0.9	625	70.2	63.5	29.9	655
Primary	99.7	99.7	97.7	95.5	92.6	98.1	98.5	95.0	88.3	83.4	90.0	98.5	95.1	91.0	97.2	93.9	90.4	90.2	83.3	73.5	0.0	304	72.4	64.8	29.4	248
Secondary or higher	99.8	98.9	99.3	97.4	93.3	99.1	96.8	95.6	92.8	86.5	94.5	99.2	96.6	93.9	98.7	95.5	91.2	90.8	86.4	80.1	0.2	527	70.1	63.2	29.6	529
Wealth quintile																										
Lowest	98.4	98.7	99.0	97.2	93.8	97.8	98.8	96.5	91.7	90.0	94.0	99.4	97.4	93.9	98.8	96.3	93.4	94.0	87.5	81.9	0.5	317	76.1	72.2	37.9	305
Second	99.5	99.5	98.3	97.6	94.7	98.3	96.3	95.5	91.7	86.0	93.1	98.3	96.0	93.8	97.7	95.2	89.8	92.2	86.6	77.8	0.0	300	73.2	63.1	32.1	304
Middle	99.2	98.6	99.3	96.3	91.2	98.2	97.6	95.7	87.7	84.1	93.0	99.3	95.0	91.1	97.3	92.7	88.9	89.4	81.3	75.2	0.5	315	66.0	58.2	24.8	279
Fourth	98.0	98.9	96.2	92.7	89.4	98.8	96.7	92.0	89.2	81.0	88.6	96.7	92.4	89.7	97.4	93.3	89.0	88.2	82.8	72.5	1.0	275	72.1	59.8	28.7	283
Highest	99.8	98.8	98.8	98.3	94.7	98.8	98.3	97.0	92.0	84.6	91.1	98.8	97.1	92.9	97.3	95.8	87.6	85.6	84.5	78.0	0.2	248	64.2	64.2	23.7	262
Total	99.0	98.9	98.3	96.4	92.8	98.3	97.5	95.3	90.4	85.3	92.1	98.5	95.6	92.3	97.8	94.7	89.8	90.1	84.6	77.2	0.4	1,456	70.5	63.6	29.7	1,432

BCG = Bacille Calmette-Guérin
DPT = Diphtheria-pertussis-tetanus
HepB = Hepatitis B
Hib = Haemophilus influenzae type b
OPV = Oral polio vaccine
IPV = Inactivated polio vaccine
Note: Children are considered to have received the vaccine if it was either written on the child's vaccination card or reported by the mother. For children, whose vaccination information is based on the mother's report, date of vaccination is not collected. The proportions of vaccinations given during the first and second years of life are assumed to be the same as for children with a written record of vaccination.
[1] For children whose vaccination information is based on the written record of vaccination, children are considered to have received hepatitis B (birth dose) if this vaccine is recorded on their card, regardless of when the dose was administered; similarly, for children whose vaccination information is based on the mother's report, children reported to have received HepB (birth dose) regardless of whether the mother reported it was administered within 24 hours of birth.
[2] DPT-HepB-Hib is sometimes referred to as pentavalent
[3] OPV 0 is the polio vaccination given at birth.
[4] BCG, three doses of DPT-HepB-Hib, three doses of polio vaccine (excluding polio vaccine given at birth), and one dose of measles containing vaccine
[5] BCG, hepatitis B (birth dose), three doses of DPT-HepB-Hib, five doses of oral polio vaccine, one dose of IPV, three doses of pneumococcal vaccine, two doses of rotavirus vaccine, one dose of yellow fever vaccine, and one dose of measles containing vaccine
[6] BCG, hepatitis B (birth dose), three doses of DPT-HepB-Hib, six doses of oral polio vaccine, one dose of IPV, three doses of pneumococcal vaccine, two doses of rotavirus vaccine, one dose of yellow fever vaccine, and two doses of measles containing vaccine

Treatment of childhood illnesses

Pneumonia and other acute respiratory infections (ARIs), fever, and dehydration from diarrhoea are important contributing causes of childhood morbidity and mortality in developing countries (WHO 2003). Prompt medical attention when a child has the symptoms of these illnesses is, therefore, crucial in reducing child deaths. To obtain information on health-seeking behaviours surrounding these common childhood illnesses, mothers were asked if any of their children under age 5 had experienced the following in the 2 weeks preceding the survey: a cough accompanied by short, rapid breathing or difficulty breathing as a result of a chest-related problem (symptoms of an acute respiratory infection); a fever; or an episode of diarrhoea. Mothers who indicated that their child had experienced such symptoms were then asked if treatment or advice was sought from a health facility or provider. For children with diarrhoea, the mother was asked additional questions about treatment given to the child. Note that the morbidity data collected are subjective, that is, they are based on the mother's perception of illness with no validation from medical personnel. In addition, the prevalence of these illnesses may fluctuate with changes of seasons. Overall, 5% of children under age 5 showed symptoms of an ARI, 15% exhibited fever, and 19% experienced diarrhoea in the 2 weeks preceding the survey (data not shown).

Table 11 shows that treatment from a health facility or provider was sought for 64% of the children with fever and 62% of the children with diarrhoea. Forty-four percent of children with diarrhoea were given fluid from an oral rehydration salt (ORS) packet, 33% were given zinc supplements, and 21% were given both ORS and zinc supplements. In addition, treatment from a health facility or provider was sought for 70% of children with symptoms of an ARI.[4]

Whether advice or treatment was sought varied by background characteristic and symptoms. For symptoms of ARI and fever, children in urban areas were just about as likely as those in rural areas to have treatment sought from a health facility or health provider (71% vs 69% and 65% vs 63%, respectively). However, for diarrhoea, children in urban areas were much less likely to be taken for treatment than their rural counterparts (58% vs 70%). There is some difference in advice or treatment for children by sex; for symptoms of ARI, 73% of boys and 67% of girls were brought for advice or treatment; for fever, 63% of boys and 66% of girls were brought for advice or treatment; for diarrhoea, it was 64% of boys and 60% of girls. However, differences by background characteristics for some categories should be interpreted with caution as the estimates are based on small numbers of children who were sick with fever or diarrhoea.

[4] Symptoms of an ARI include short, rapid breathing, which is chest-related, and/or difficult breathing, which is chest-related.

Table 11 Treatment for ARI symptoms, fever, and diarrhoea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had fever in the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, and among children under age 5 who had diarrhoea in the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, percentage given a fluid made from oral rehydration salt (ORS) packets, percentage given zinc, and percentage given ORS and zinc, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Children with symptoms of ARI[1]		Children with fever		Children with diarrhoea				
	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet	Percentage given zinc	Percentage given ORS and zinc	Number of children
Age in months									
<6	64.4	35	46.4	129	55.3	16.5	15.8	5.3	151
6-11	84.6	44	65.1	191	65.5	42.1	34.8	20.7	217
12-23	69.5	70	66.2	302	65.6	46.4	42.6	26.0	455
24-35	76.5	62	65.4	197	62.5	54.7	32.0	23.5	294
36-47	68.3	65	69.2	166	54.5	43.7	27.8	18.7	173
48-59	59.4	56	67.7	120	62.7	51.4	28.2	21.0	113
Sex									
Male	72.8	196	62.7	594	63.7	43.5	31.9	20.1	765
Female	66.7	137	65.9	510	60.4	45.4	34.9	22.4	638
Residence									
Urban	71.3	204	64.8	715	58.3	42.7	32.1	19.7	943
Rural	68.7	128	63.1	389	70.3	47.8	35.8	24.1	460
Local Government Area									
Banjul	(69.5)	4	59.5	18	52.5	37.2	21.2	15.7	17
Kanifing	64.3	98	68.2	235	54.2	39.1	23.7	13.8	244
Brikama	(79.6)	85	60.3	395	58.1	43.3	33.4	20.6	610
Mansakonko	(61.9)	15	59.1	72	57.2	40.7	19.5	11.3	68
Kerewan	(64.1)	29	72.7	74	82.6	61.2	42.7	31.7	124
Kuntaur	67.1	43	65.3	97	70.4	39.2	33.8	19.6	121
Janjanbureh	*	11	60.0	79	58.9	40.4	17.3	13.5	82
Basse	76.0	47	68.7	134	75.0	52.7	59.2	38.6	136
Mother's education									
No education	67.9	153	61.2	529	61.2	42.4	34.4	20.3	618
Primary	60.5	46	72.4	200	63.1	45.8	36.8	24.0	287
Secondary or higher	76.5	133	64.1	376	63.0	45.9	29.9	20.5	497
Wealth quintile									
Lowest	66.8	71	59.5	252	62.8	41.4	31.9	21.6	327
Second	75.7	65	58.1	232	61.3	44.6	33.3	22.2	293
Middle	73.7	72	69.8	221	71.6	52.3	38.3	26.8	266
Fourth	(57.1)	59	65.7	228	59.9	42.5	33.2	17.3	290
Highest	(77.2)	65	70.1	172	54.5	41.3	29.5	17.2	226
Total	70.3	332	64.2	1,104	62.2	44.3	33.3	21.1	1,403

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Symptoms of ARI include short, rapid breathing which was chest-related and/or difficult breathing which was chest-related.
[2] Includes advice or treatment from the following sources: public sector, private medical sector, shop, market, and itinerant drug seller. Excludes advice or treatment from a traditional practitioner.

Nutritional status of children

Anthropometric indicators for young children based on weight (kg) and height/length (cm) were collected in the 2019-20 GDHS to provide outcome measures of nutritional status. As recommended by WHO, evaluation of nutritional status in this report is based on a comparison between three indices for the children in this survey with indices reported for a reference population of well-nourished children. The three indices (height-for-age, weight-for-height, and weight-for-age) are expressed as standard deviation (SD) units from the median for the reference group (WHO Multicentre Growth Reference Study Group 2006).

A total of 4,385 children (unweighted) under age 5 were eligible for weight and height measurements. For some of the eligible children, however, complete and credible data on height, weight, and/or age were not obtained. In this report, height-for-age and weight-for-height data are based on 95% of eligible children, while weight-for-age is based on 96% of eligible children.

Table 12 shows the nutritional status for children under age 5, according to the three anthropometric indices. Height-for-age is a measure of linear growth. Children whose height-for-age is below minus 2 standard deviations (-2 SD) from the median of the reference population are considered short for their age, or stunted, which is a condition that reflects the cumulative effects of chronic malnutrition. Children whose height-for-age falls below minus 3 standard deviations (-3 SD) from the median of the reference population are considered severely stunted. The data show that 18% of children under age 5 are stunted (below -2 SD), and 4% are severely stunted (below -3 SD). Boys are more likely to be stunted (19%) than girls (16%). Children in urban areas are slightly less likely to be stunted than children in rural areas (16% and 20%, respectively). There are some variations among LGAs. Stunting ranges from a high of 25% in Kuntaur to a low of 10% in Banjul. The prevalence of stunting generally decreases with increasing levels of the wealth.

Children whose weight-for-height is below minus 2 standard deviations (-2 SD) from the median of the reference population are considered to be wasted (or thin). Children whose weight-for-height falls below minus 3 standard deviations (-3SD) from the median of the reference population are considered to be severely wasted, which is typically the result of inadequate food intake or from a recent episode of illness or infection causing weight loss. Five percent of Gambian children are wasted and 1% are severely wasted. Wasting is similar among children in urban areas and rural areas (5% each). There is also little difference in wasting between boys (6%) and girls (4%). The proportion of children who are wasted generally remains steady across increasing levels of the mother's education and wealth.

Table 12 also shows the proportion of children whose weight-for-height is more than 2 standard deviations (+2 SD) above the reference median. These children are considered to be overweight, which is a measure of overnutrition and results from an imbalance between energy consumed (too much) and energy expended (too little). Two percent of children under age 5 fall into this category. While there is generally little difference between the proportions of children who are heavy for their height across the various background characteristics, there is some variation between age groups.

Children whose weight-for-age is below minus 2 standard deviations (-2 SD) from the median of the reference population are considered to be underweight and those below minus 3 standard deviations (-3SD) from the median of the reference population are considered to be severely underweight. Underweight is a composite index of weight-for-height and height-for-age that reflects children who are stunted, wasted, or both. As shown in Table 12, 12% of Gambian children are underweight, with 2% classified as severely underweight. The proportion of underweight children varies by sex, with 13% of boys but only 10% of girls, being underweight. Additionally, children in rural areas (14%) are more likely to be underweight than children in urban areas (11%) By LGA, the proportion ranges from a high of 15% in both Janjanbureh and Kerewan to a low of 8% in Banjul. While there is no clear relationship between the mother's education and the percentage of underweight children, mothers in poorer wealth quintiles have a higher percentage of children underweight.

Table 12 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Height-for-age[1]				Weight-for-height					Weight-for-age				
	Percent-age below -3 SD	Percent-age below -2 SD[2]	Mean Z-score (SD)	Number of children	Percent-age below -3 SD	Percent-age below -2 SD[2]	Percent-age above +2 SD	Mean Z-score (SD)	Number of children	Percent-age below -3 SD	Percent-age below -2 SD[2]	Percent-age above +2 SD	Mean Z-Score (SD)	Number of children
Age in months														
<6	2.3	9.0	-0.7	499	0.2	3.1	8.1	0.2	494	2.8	5.7	1.1	-0.4	499
6-8	3.0	16.2	-0.8	173	3.3	4.0	9.3	0.1	173	4.9	11.4	4.3	-0.5	173
9-11	2.0	15.8	-0.9	208	4.3	11.4	2.6	-0.4	208	4.3	11.0	2.3	-0.7	208
12-17	5.8	21.2	-1.2	436	0.1	4.2	0.8	-0.5	436	1.6	13.2	0.1	-0.9	438
18-23	7.3	28.0	-1.5	351	0.5	4.6	0.2	-0.4	351	3.2	14.2	0.0	-1.0	351
24-35	3.5	20.1	-1.2	757	0.2	3.8	1.0	-0.3	758	1.0	11.2	0.3	-0.9	770
36-47	3.8	18.4	-1.1	812	0.0	3.2	0.8	-0.5	816	2.4	12.5	0.0	-1.0	820
48-59	1.4	12.8	-0.8	700	0.6	9.1	0.6	-0.7	708	1.6	13.4	0.0	-1.0	705
Sex														
Male	3.9	18.5	-1.1	2,062	0.4	5.9	2.0	-0.4	2,067	1.8	12.8	0.6	-0.9	2,075
Female	3.2	16.4	-1.0	1,876	0.8	4.1	2.3	-0.3	1,877	2.6	10.4	0.4	-0.8	1,889
Mother's interview status														
Interviewed	3.4	17.0	-1.0	3,590	0.7	5.3	2.3	-0.4	3,588	2.3	11.6	0.6	-0.8	3,615
Not interviewed, but in household	0.8	18.8	-1.1	103	0.0	0.5	0.2	-0.3	103	0.0	10.9	0.0	-0.9	103
Not interviewed, not in household[3]	5.9	23.8	-1.1	245	0.0	4.1	1.4	-0.5	253	1.5	12.6	0.0	-1.0	246
Residence														
Urban	3.2	16.3	-1.0	2,576	0.7	4.9	2.5	-0.3	2,582	2.2	10.5	0.6	-0.8	2,594
Rural	4.1	19.7	-1.2	1,362	0.4	5.3	1.5	-0.4	1,362	2.2	13.8	0.3	-1.0	1,370
Local Government Area														
Banjul	1.9	10.1	-0.7	37	0.0	2.4	3.1	-0.2	37	0.5	7.8	0.0	-0.5	37
Kanifing	3.0	13.2	-0.8	664	0.2	5.0	2.6	-0.3	669	1.6	9.2	0.9	-0.7	669
Brikama	3.5	17.2	-1.0	1,635	0.9	4.7	2.9	-0.3	1,635	2.6	10.3	0.7	-0.8	1,646
Mansakonko	3.5	16.2	-1.1	190	0.0	5.5	1.7	-0.5	190	0.8	12.1	0.2	-1.0	190
Kerewan	4.7	17.3	-1.1	435	0.5	6.4	1.2	-0.5	435	2.0	14.7	0.0	-1.0	442
Kuntaur	4.9	25.2	-1.4	218	0.2	3.9	1.5	-0.4	219	1.6	13.8	0.2	-1.0	220
Janjanbureh	3.1	19.4	-1.2	264	0.2	6.5	2.0	-0.4	264	3.0	15.2	0.6	-1.0	264
Basse	3.1	20.8	-1.1	495	0.7	5.0	0.6	-0.4	495	2.3	14.1	0.1	-0.9	495
Mother's education[4]														
No education	3.3	17.4	-1.1	1,679	0.4	4.0	1.6	-0.4	1,678	2.3	11.9	0.3	-0.9	1,697
Primary	3.1	17.7	-1.0	679	1.5	6.0	2.1	-0.4	679	2.9	10.6	0.3	-0.8	681
Secondary or higher	3.7	17.1	-1.0	1,184	0.5	5.7	3.1	-0.3	1,182	2.0	12.1	1.1	-0.8	1,189
Don't know	*	*	*	2	*	*	*	*	2	*	*	*	*	2
Wealth quintile														
Lowest	5.0	22.5	-1.3	868	0.2	3.9	1.5	-0.4	867	1.8	15.0	0.2	-1.0	871
Second	4.1	19.5	-1.1	814	0.5	5.8	2.8	-0.4	815	2.7	13.8	0.3	-0.9	822
Middle	2.5	15.7	-1.1	824	1.0	5.1	1.8	-0.4	831	2.4	11.1	0.5	-0.9	831
Fourth	1.5	13.4	-0.9	701	0.6	6.5	1.2	-0.5	703	1.4	8.6	0.5	-0.8	707
Highest	4.3	15.3	-0.8	731	0.7	4.2	3.6	-0.2	727	2.8	8.8	1.2	-0.6	733
Total	3.5	17.5	-1.0	3,938	0.6	5.1	2.1	-0.4	3,944	2.2	11.6	0.5	-0.8	3,964

Note: Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Recumbent length is measured for children under age 2; standing height is measured for all other children

[2] Includes children who are below -3 standard deviations (SD) from the WHO Growth Standards population median

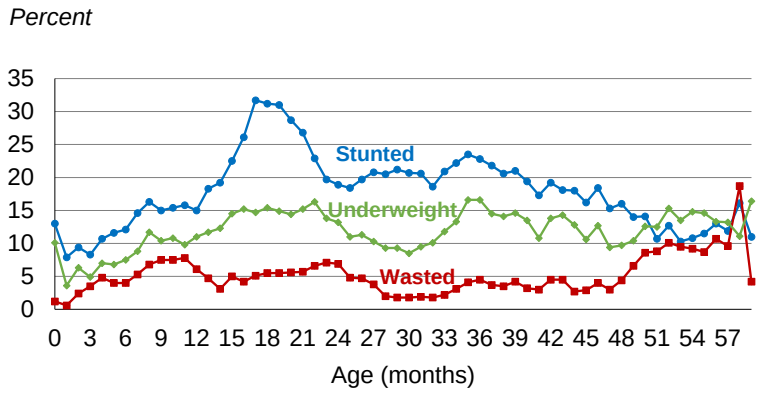
[3] Includes children whose mothers are deceased

[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

A comparison of data on anthropometric measures in the 2013 and 2019-20 GDHS surveys shows that all three nutritional status indices (stunting, wasting, and underweight) have improved in the last 5 years. In this period, stunting decreased from 25% to 18%, wasting decreased from 12% to 5%, and the proportion of underweight children decreased from 16% to 12%. The proportion of overweight (weight-for-height above +2 SD) children decreased slightly from 3% in 2013 to 2% in 2019-20.

The nutritional status of children varies with age, as shown in Figure 5. For the first 17 months of life the prevalence of stunting increases, after which, it remains relatively stable before precipitously declining between the ages of 19 and 25 months. Stunting then increases gradually until the age of 35 months, before beginning a fairly steady decline throughout the rest of the age groups. Overall, the prevalence of stunting oscillates between 8% and 32%.

Figure 5 **Nutritional status of children by age**



Note: *Stunting* reflects chronic malnutrition; *wasting* reflects acute malnutrition; *underweight* reflects chronic or acute malnutrition or a combination of both. Plotted values are smoothed by a five-month moving average.

Relative to stunting, the percentage of children wasted and underweight is lower throughout the younger age groups; however, the indicators converge around age 50 months. Wasting prevalence ranges from less than 1% to 19%, while the prevalence of underweight children ranges from 4% to 17%.

Infant and Young Child Feeding practices

Appropriate infant and young child feeding (IYCF) practices include early initiation of breastfeeding within the first hour of life, exclusive breastfeeding in the first 6 months of life, continued breastfeeding up to age 2 years or beyond, introduction of a range of safe solid and semisolid foods at age 6 months, and gradual increases in the amount of food given and frequency of feeding as the child gets older. It is also important for children to receive a diverse diet—eating foods from different food groups to ensure that macronutrient and micronutrient requirements are met (WHO 2008).

The 2019-20 GDHS collected data on infant and young child feeding (IYCF) practices for all children born in the 2 years preceding the survey. Table 13 shows breastfeeding practices by child's age. Contrary to the recommendation that children under age 6 months be exclusively breastfed, only 54% of the infants under age 6 months were found to be exclusively breastfed. In addition to breast milk, 25% of infants under age 6 months consume plain water, less than 1% consume non-milk liquids, 5% consume other milk, and 14% consume complementary foods. Seventeen percent of infants under age 6 months are fed using a bottle with a nipple, a practice that is discouraged because of the risk of illness to the child. Seventy-five percent of children age 6-8 months receive timely complementary foods, and 52% of children age 18-23 months have been weaned.

Exclusive breastfeeding among children younger than age 6 months increased over the last 6 years, from 47% in 2013 to 54% in 2019-20. The proportion of children under 6 months who are not breastfeeding stayed relatively stable from 2013 to 2019-20 (1% to 2%, respectively).

Table 13 Breastfeeding status according to age

Percent distribution of youngest children under age 2 who are living with their mother, by breastfeeding status and the percentage currently breastfeeding; and percentage of all children under age 2 using a bottle with a nipple, according to age in months, The Gambia DHS 2019-20

	Breastfeeding status										
Age in months	Not breast-feeding	Exclusively breast-feeding	Breast-feeding and consuming plain water only	Breast-feeding and consuming non-milk liquids[1]	Breast-feeding and consuming other milk	Breast-feeding and consuming comple-mentary foods	Total	Percentage currently breast-feeding	Number of youngest children under age 2 living with the mother	Percentage using a bottle with a nipple	Number of all children under age 2
0-1	3.9	74.8	15.9	0.0	4.3	1.1	100.0	96.1	315	10.9	320
2-3	0.8	56.7	25.6	1.1	6.2	9.6	100.0	99.2	284	21.3	291
4-5	1.8	28.2	34.0	0.1	4.4	31.4	100.0	98.2	297	20.3	300
6-8	1.4	2.2	18.6	1.3	2.1	74.5	100.0	98.6	319	21.6	323
9-11	1.7	0.1	6.2	0.7	1.0	90.4	100.0	98.3	413	12.5	427
12-17	6.5	0.0	2.6	0.2	0.5	90.2	100.0	93.5	787	13.2	810
18-23	51.7	0.0	0.7	0.0	0.5	47.1	100.0	48.3	596	11.8	646
0-3	2.4	66.2	20.5	0.5	5.2	5.2	100.0	97.6	599	15.8	611
0-5	2.2	53.6	25.0	0.4	4.9	13.9	100.0	97.8	897	17.3	910
6-9	1.0	1.5	15.4	1.1	1.5	79.5	100.0	99.0	449	17.7	460
12-15	4.0	0.0	3.4	0.2	0.8	91.6	100.0	96.0	541	13.9	548
12-23	26.0	0.0	1.8	0.1	0.5	71.7	100.0	74.0	1,383	12.6	1,456
20-23	64.4	0.0	0.2	0.0	0.0	35.4	100.0	35.6	403	11.4	439

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfeeding, breastfeeding and consuming plain water, non-milk liquids, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

[1] Non-milk liquids include juice, juice drinks or other liquids

The minimum acceptable diet indicator is used to assess the proportion of children age 6-23 months who meet minimum standards with respect to IYCF practices (WHO 2017). Specifically, children age 6-23 months who have a minimum acceptable diet meet all three IYCF criteria below:

1. Breastfeeding, or not breastfeeding and receiving two or more feedings of commercial infant formula; fresh, tinned, or powdered animal milk; or yogurt.

2. Fed with foods from five or more out of the following eight groups: (a) breastmilk; (b) grains, roots, and tubers, including porridge and fortified baby food from grains; (c) legumes and nuts; (d) dairy products (milk, yogurt, and cheese); (e) eggs; (f) meat, poultry, fish, and shellfish (and organ meats); (g) vitamin A-rich fruits and vegetables (and red palm oil); and (h) other fruits and vegetables.

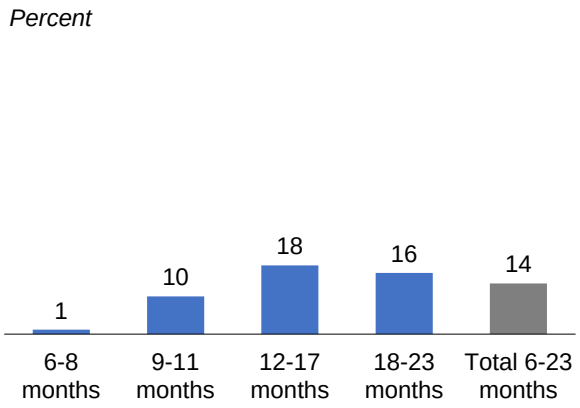
3. Fed the minimum recommended number of times per day, according to age and breastfeeding status

   (a) For breastfed children, minimum meal frequency is receiving solid, semisolid, or soft food at least twice a day for infants age 6-8 months and at least three times a day for children age 9-23 months.

   (b) For non-breastfed children age 6-23 months, minimum meal frequency is receiving solid, semisolid, or soft food, or milk feeds, at least four times a day. At least one of the feeds must be a solid, semisolid, or soft food.

Figure 6 shows the percentage of children being fed the minimum acceptable diet, by age. In total, only 14% of children age 6-23 months have met the criteria for a minimum acceptable diet. Children age 6-8 months (1%) are much less likely than children in other age groups to consume an acceptable diet (10%-18%).

Figure 6 **Minimum acceptable diet according to age, in months**



3.11 ANAEMIA PREVALENCE IN CHILDREN AND WOMEN

Anaemia is a condition that is marked by low levels of haemoglobin in the blood. Iron is a key component of haemoglobin, and iron deficiency is estimated to be responsible for half of all anaemia globally (Kassebaum, et al. 2014). Other causes of anaemia include malaria, hookworm, and other helminths, other nutritional deficiencies, chronic infections, and genetic conditions. Anaemia is a serious concern for children because it can impair cognitive development, stunt growth, and increase morbidity from infectious diseases. In addition to causing weakness, frequent tiredness, and lowered resistance to disease, anaemia can be a particularly serious problem for pregnant women, leading to premature delivery and low birth weight.

The 2019-20 GDHS includes direct measurement of haemoglobin levels among children age 6-59 months and women age 15-49 using the HemoCue 201+ system. This system consists of a battery-operated photometer and a disposable microcuvette coated with a dried reagent that serves as the blood collection device. For the test, a drop of capillary blood taken from the respondent's fingertip or, in the case of some young children, the heel is drawn into the microcuvette. The blood in the microcuvette is analysed using the photometer, which electronically displays the haemoglobin concentration.

For the haemoglobin testing carried out among children age 6-59 months, during the fieldwork, parents or guardians were immediately given the results of their child's test. In cases where the haemoglobin reading was below 8.0 g/dl, the parent or guardian was referred to MoH facilities for follow-up. Ninety-five percent of eligible children were tested for anaemia (data not shown).

Table 14 presents anaemia levels for children age 6-59 months, by selected background characteristics. Children with <7.0 g/dl of haemoglobin are classified as having severe anaemia, those with 7.0-9.9 g/dl as having moderate anaemia, and those with 10.0-10.9 g/dl as having mild anaemia. Children with <11.0 g/dl are classified as having anaemia. Overall, 45% of children had some degree of anaemia. Twenty-four percent of children were mildly anaemic, 20% were moderately anaemic, and 1% were severely anaemic. Anaemia prevalence increases with age peaking at 59% among children age 12-17 months, and then declines to its low of 29% among those age 48-59 months. Anaemia prevalence varies by LGA, from a low of 30% in Brikama to a high of 77% in Kuntaur. Boys were more likely to be anaemic than girls (47% and 42%, respectively). In addition, there is a negative association between prevalence of anaemia and increasing levels of education and wealth.

Table 14 Prevalence of anaemia in children

Percentage of children age 6-59 months classified as having anaemia, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Anaemia status by haemoglobin level				Number of children age 6-59 months
	Any anaemia (<11.0 g/dl)	Mild anaemia (10.0-10.9 g/dl)	Moderate anaemia (7.0-9.9 g/dl)	Severe anaemia (<7.0 g/dl)	
Age in months					
6-8	36.2	19.8	16.0	0.5	167
9-11	54.6	24.7	29.3	0.6	206
12-17	59.1	25.3	32.4	1.4	434
18-23	55.6	23.7	29.5	2.4	351
24-35	51.4	28.8	21.9	0.7	758
36-47	38.8	25.8	12.1	0.9	811
48-59	29.4	17.3	11.2	0.9	697
Sex					
Male	47.0	25.2	20.8	1.0	1,792
Female	42.3	22.9	18.4	1.1	1,631
Residence					
Urban	37.1	23.3	13.4	0.4	2,249
Rural	59.5	25.6	31.6	2.3	1,174
Local Government Area					
Banjul	33.4	19.8	13.6	0.0	31
Kanifing	45.3	27.9	16.5	0.8	568
Brikama	30.1	21.1	8.8	0.2	1,440
Mansakonko	47.9	21.6	25.3	0.9	168
Kerewan	58.7	27.0	30.3	1.4	383
Kuntaur	76.7	24.7	45.2	6.8	195
Janjanbureh	59.7	25.4	31.4	2.8	218
Basse	59.1	27.0	31.5	0.7	419
Mother's education[1]					
No education	51.0	26.7	22.7	1.6	1,463
Primary	46.5	23.4	22.0	1.0	583
Secondary or higher	38.1	21.5	16.0	0.5	1,003
Don't know	*	*	*	*	2
Wealth quintile					
Lowest	63.6	28.9	31.5	3.2	763
Second	45.3	21.8	23.0	0.5	706
Middle	40.2	23.0	17.0	0.3	722
Fourth	41.0	25.9	14.8	0.3	624
Highest	29.9	20.3	9.0	0.6	608
Total	44.8	24.1	19.6	1.1	3,423

Notes: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed. Table is based on children who stayed in the household on the night before the interview and who were tested for anaemia. Haemoglobin in grams per decilitre (g/dl).
[1] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Table 15 presents anaemia levels for women age 15-49 by selected background characteristics. Levels of anaemia were classified as severe, moderate, or mild based on the haemoglobin concentration in the blood, according to criteria developed by WHO (DeMaeyer et al. 1989), and whether the woman was pregnant or not. Non-pregnant women with <12.0 g/dl are considered anaemic. More specifically, non-pregnant women with <8.0 g/dl of haemoglobin are classified as having severe anaemia, those with 8.0-10.9 g/dl as having moderate anaemia, and those with 11.0-11.9 g/dl as having mild anaemia. For pregnant women, those with <11.0 g/dl are anaemic. Those with <7.0 g/dl are severely anaemic, those with 7.0-9.9 g/dl are moderately anaemic, and those with 10.0-10.9 g/dl are mildly anaemic.

Among all eligible women age 15-49, 96% were tested for anaemia (data not shown). Prevalence of anaemia, based on haemoglobin levels, is adjusted for smoking using CDC formulas (CDC 1998). Overall, 44% of women in The Gambia suffer from anaemia, with 26% being classified as mildly anaemic, 17% as moderately anaemic, and 1% as severely anaemic. By LGA, the prevalence of any anaemia ranges from 39% in Brikama to 62% in Kuntaur. There is a negative association between anaemia and mother's education, falling from 51%

among those with no education to 39% among those with a secondary or higher education. There is also a negative association between anaemia and wealth. Pregnant women (55%) are more likely to have anaemia than their breastfeeding (47%) and non-breast feeding/non-pregnant counterparts (42%).

Table 15 Prevalence of anaemia in women

Percentage of women age 15-49 with anaemia, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Anaemia status by haemoglobin level: Any (NP <12.0 g/dl / P <11.0 g/dl)	Mild (NP 11.0-11.9 g/dl / P 10.0-10.9 g/dl)	Moderate (NP 8.0-10.9 g/dl / P 7.0-9.9 g/dl)	Severe (NP < 8.0 g/dl / P < 7.0 g/dl)	Number of women
Age					
15-19	43.5	26.4	16.1	1.0	1,287
20-29	43.1	25.2	16.9	0.9	2,185
30-39	45.3	26.1	17.9	1.2	1,489
40-49	46.7	25.8	18.9	2.1	897
Number of living children					
0	41.6	25.6	15.0	1.0	2,088
1	43.0	26.0	16.3	0.7	728
2-3	43.2	23.2	18.9	1.1	1,167
4-5	46.0	28.6	15.7	1.6	968
6+	50.9	26.3	22.8	1.8	908
Maternity status					
Pregnant	54.8	26.8	27.3	0.7	441
Breastfeeding	46.6	27.7	18.1	0.8	1,352
Neither	42.4	25.1	15.9	1.4	4,065
Residence					
Urban	39.9	25.1	14.1	0.7	4,273
Rural	56.1	27.6	25.8	2.6	1,585
Local Government Area					
Banjul	41.9	24.8	16.1	1.0	81
Kanifing	40.2	26.5	13.0	0.8	1,305
Brikama	38.6	24.9	13.2	0.5	2,561
Mansakonko	52.8	26.7	24.0	2.2	228
Kerewan	54.0	27.5	23.8	2.7	553
Kuntaur	62.3	27.4	30.6	4.4	256
Janjanbureh	53.7	23.3	26.9	3.5	292
Basse	53.3	26.9	25.6	0.8	583
Education					
No education	51.1	25.7	23.3	2.1	2,023
Primary	46.2	28.3	16.5	1.4	944
Secondary or higher	38.9	25.1	13.3	0.5	2,892
Wealth quintile					
Lowest	56.1	25.5	27.5	3.1	976
Second	49.8	29.2	19.2	1.5	1,011
Middle	43.9	25.5	17.6	0.8	1,172
Fourth	43.2	28.1	14.5	0.6	1,229
Highest	33.8	22.0	11.3	0.5	1,470
Total	44.3	25.8	17.3	1.2	5,858

Note: Prevalence is adjusted for smoking status, if known, using formulas in CDC, 1998.

3.12 OWNERSHIP AND USE OF MOSQUITO NETS

The use of insecticide-treated mosquito nets is a primary health intervention designed to reduce malaria transmission in The Gambia. An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment.

All households in the 2019-20 GDHS were asked if they owned mosquito nets and, if so, what type and how many. Table 16 presents the percentage of households with at least one ITN, the average number of nets per household, and the percentage of households with at least one ITN for each two persons who stayed in the household the previous night, according to background characteristics. Among all households in The Gambia, 77% possess at least one ITN. On average, there are 2.8 ITNs per household.

Household ownership of at least one ITN is highest in Kuntaur (97%) and lowest in Kanifing (64%). The percentage of households that own at least one ITN generally decreases with increasing wealth, from 93% of households in the lowest wealth quintile to 62% of households in the highest quintile.

Over one-third (36%) of households in The Gambia have at least one ITN for every two persons who stayed in the household the night before the survey. The percentage of households with at least one ITN for every two persons who stayed in the household the night before the survey is lower among urban households (32%) than rural households (50%). By LGA, the percentage of households with at least one ITN for every two persons who stayed in the household the night before the survey is highest in Mansakonko (59%) and lowest in Kanifing (30%). The percentage of households with at least one ITN for every two persons decreases with increasing wealth, from a high of 50% in the lowest wealth quintile to a low of 23% in the highest quintile.

Table 16 Household possession of insecticide-treated nets

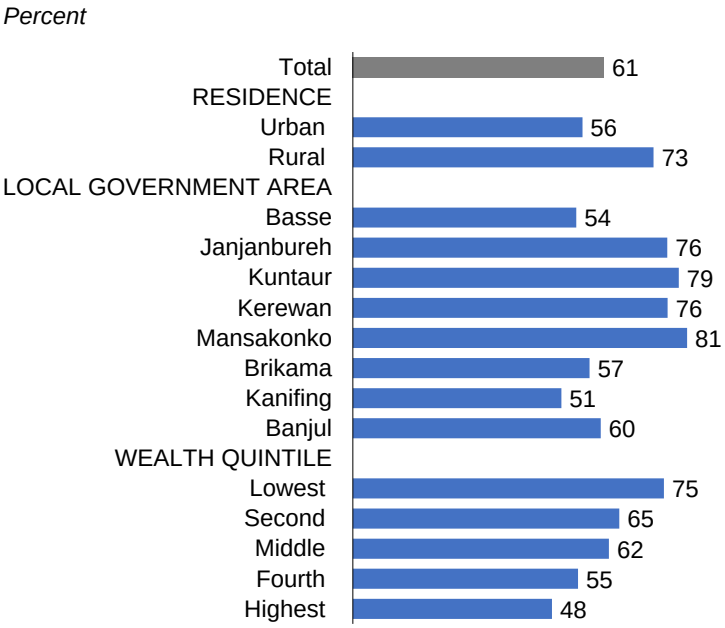
Percentage of households with at least one insecticide-treated net (ITN); average number of ITNs per household; and percentage of households with at least one ITN per two persons who stayed in the household last night, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage of households with at least one insecticide-treated net (ITN)[1]	Average number of insecticide- treated nets (ITN)[1] per household	Number of households	Percentage of households with at least one insecticide-treated net (ITN)[1] for every two persons who stayed in the household last night[2]	Number of households with at least one person who stayed in the household last night
Residence					
Urban	71.7	2.3	4,989	32.1	4,951
Rural	95.4	4.3	1,560	49.8	1,552
Local Government Area					
Banjul	70.1	1.6	155	41.7	154
Kanifing	63.8	1.8	1,655	30.1	1,640
Brikama	74.8	2.6	2,790	30.9	2,775
Mansakonko	93.3	3.7	282	59.3	278
Kerewan	94.2	4.0	636	51.1	629
Kuntaur	96.7	4.5	254	53.1	254
Janjanbureh	94.6	3.9	332	54.6	331
Basse	87.5	3.7	443	32.4	442
Wealth quintile					
Lowest	92.5	3.7	1,233	50.2	1,227
Second	82.3	2.8	1,367	40.0	1,351
Middle	74.2	2.5	1,489	36.7	1,474
Fourth	76.0	2.6	1,216	31.2	1,210
Highest	61.8	2.3	1,244	23.1	1,241
Total	77.3	2.8	6,549	36.3	6,503

[1] An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment. In the 2013 GDHS, this was known as a long-lasting insecticidal net (LLIN).
[2] Percentage of de facto household population who could sleep under an ITN if each ITN in the household were used by up to two people

Figure 7 shows the percentage of the de facto population with access to an ITN. Access to an ITN is measured by the proportion of the population that could sleep under an ITN if each ITN in the household were used by up to two people. Overall, 61% of the population has access to an ITN. This is an increase of 16 percentage points (45%) from the 2013 GDHS. ITN access is higher among those living in rural areas (73%) and those living in Mansakonko (81%). ITN access decreases with increasing wealth quintiles, from 75% in the lowest wealth quintile to 48% in the highest wealth quintile.

Figure 7 **Percentage of the de facto population with access to an ITN in the household**



Community-level protection against malaria helps reduce the spread of the disease and offers an additional layer of protection against malaria for those who are most vulnerable—children under age 5 and pregnant women. This section describes the use of mosquito nets among these groups.

As shown in Table 17, 44% of children under age 5 slept under an ITN the night before the survey. ITN use by children under age 5 is higher in urban areas (50%) than in rural areas (41%). The proportion of children who slept under an ITN the night before the survey is highest in Janjanbureh (60%) and lowest in Basse (34%). The proportion of children who slept under an ITN the night before the survey generally decreases with increasing wealth quintiles, from 55% among children in the lowest wealth quintile to 31% among children in the highest wealth quintile. Among households with at least one ITN, nearly half of children (49%) slept under an ITN the night before the survey.

Table 17 also shows that 44% of pregnant women slept under an ITN the night before the survey. Among households with at least one ITN, 49% of pregnant women slept under an ITN the night before the survey.

In areas of high malaria transmission, by the time an individual reaches adulthood, she or he has acquired immunity that protects against severe disease. However, pregnant women—especially those pregnant for the first time—frequently regain their susceptibility to malaria. Although malaria in pregnant women may not manifest itself as either febrile illness or severe disease, it is frequently the cause of mild to severe anaemia. In addition, malaria during pregnancy can interfere with the maternal-foetal exchange that occurs at the placenta, leading to the delivery of low birth weight infants.

In the 2019-20 GDHS, women who had a live birth in the 2 years preceding the survey were asked if they took any SP/Fansidar during the pregnancy leading to their most recent birth and, if so, how many times they took SP/Fansidar. Women were also asked if the SP/Fansidar was received during an antenatal visit.

Table 17 Use of insecticide-treated nets by children and pregnant women

Percentage of children under age 5 who slept under an insecticide-treated net (ITN) the night before the survey; and among children under age 5 in households with at least one ITN, percentage who slept under an ITN the night before the survey; percentage of pregnant women age 15-49 who slept under an ITN the night before the survey; and among pregnant women age 15-49 in households with at least one ITN, percentage who slept under an ITN the night before the survey, according to background characteristics, The Gambia DHS 2019-20

	Children under age 5 in all households		Children under age 5 in households with at least one ITN[1]		Pregnant women age 15-49 in all households		Pregnant women age 15-49 in households with at least one ITN[1]	
Background characteristic	Percentage who slept under an ITN[1] last night	Number of children	Percentage who slept under an ITN[1] last night	Number of children	Percentage who slept under an ITN[1] last night	Number of pregnant women	Percentage who slept under an ITN[1] last night	Number of pregnant women
Residence								
Urban	40.8	5,187	48.0	4,406	39.9	614	45.9	534
Rural	49.9	2,800	51.5	2,713	53.0	303	55.1	291
Local Government Area								
Banjul	53.1	76	62.1	65	(43.6)	9	(56.6)	7
Kanifing	38.9	1,344	49.9	1,048	38.0	150	44.5	128
Brikama	39.8	3,247	45.7	2,830	37.5	385	42.2	341
Mansakonko	55.6	350	56.5	345	56.2	44	57.9	43
Kerewan	54.8	979	56.5	950	55.4	98	59.1	91
Kuntaur	56.6	483	57.6	474	64.5	64	66.9	62
Janjanbureh	60.0	511	61.9	495	71.1	55	72.3	54
Basse	34.4	996	37.6	912	36.7	113	42.0	99
Wealth quintile								
Lowest	54.9	1,820	57.4	1,742	59.4	195	62.6	185
Second	47.4	1,723	50.7	1,611	50.0	202	53.7	188
Middle	45.3	1,631	51.4	1,437	47.9	198	54.1	175
Fourth	37.1	1,479	42.7	1,283	36.4	155	40.5	139
Highest	30.6	1,333	39.1	1,045	22.6	168	27.6	138
Total	44.0	7,987	49.3	7,119	44.2	917	49.2	825

Note: Table is based on children and pregnant women who stayed in the household the night before the interview. Figures in parentheses are based on 25-49 unweighted cases.

[1] An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment. In the 2013 GDHS, this was known as a long-lasting insecticidal net (LLIN)

Table 18 shows that 98% of women with a live birth in the 2 years preceding the survey reported taking at least one dose of SP/Fansidar during the pregnancy; 80% reported taking two or more doses of SP/Fansidar, and 52% reported taking three or more doses of SP/Fansidar. While there is little variation by background characteristics in the percentage of women receiving at least one dose of SP/Fansidar, greater variations are seen for subsequent doses. For instance, while there is no urban to rural gap (98% each) among those who received at least one dose, this gap increases to four percentage points among those who received at least three doses. A similar trend is seen by education and wealth. The percentage of women with a live birth in the last 2 years who received two or more doses of SP/Fansidar during pregnancy generally increases with rising education and wealth, and the differences are more pronounced for women who received three or more doses of SP/Fansidar during pregnancy.

Table 18 Use of intermittent preventive treatment (IPTp) by women during pregnancy

Percentage of women age 15-49 with a live birth in the 2 years preceding the survey who, during the pregnancy that resulted in the last live birth, received one or more doses of SP/Fansidar, received two or more doses of SP/Fansidar, and received three or more doses of SP/Fansidar, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage who received one or more doses of SP/Fansidar[1]	Percentage who received two or more doses of SP/Fansidar[1]	Percentage who received three or more doses of SP/Fansidar[1]	Number of women with a live birth in the 2 years preceding the survey
Residence				
Urban	97.7	80.4	53.7	2,022
Rural	97.6	78.5	49.4	1,108
Local Government Area				
Banjul	93.7	71.7	35.9	26
Kanifing	97.6	80.2	57.4	535
Brikama	98.2	81.3	53.3	1,243
Mansakonko	95.8	77.4	49.6	138
Kerewan	99.0	82.0	53.4	387
Kuntaur	98.5	74.6	46.6	196
Janjanbureh	95.3	70.6	36.2	200
Basse	96.4	80.4	53.3	403
Education				
No education	97.6	78.3	48.7	1,391
Primary	95.3	79.3	50.8	594
Secondary or higher	98.9	81.6	57.2	1,145
Wealth quintile				
Lowest	98.2	76.9	46.5	704
Second	96.1	77.9	49.2	666
Middle	97.9	82.8	53.7	663
Fourth	98.3	81.5	54.1	572
Highest	97.8	80.1	59.6	525
Total	97.7	79.7	52.2	3,129

3.13 PREVALENCE, DIAGNOSIS, AND PROMPT TREATMENT OF FEVER AMONG CHILDREN

In moderately to highly endemic areas of malaria, acute clinical disease is usually confined to young children who suffer high parasite densities. If untreated, this condition can progress very rapidly to severe malaria, which can lead to death. The diagnosis of malaria is based on clinical criteria and is supplemented by the detection of parasites in the blood (parasitological or confirmatory diagnosis). Fever is a major manifestation of malaria in young children, although it also accompanies other illnesses. In The Gambia, artemisinin-based combination therapy (ACT) is the recommended first-line treatment for uncomplicated malaria.

In the 2019-20 GDHS, for each child under age 5, mothers were asked if the child had experienced an episode of fever in the 2 weeks preceding the survey and, if so, whether treatment or advice was sought. Information was also collected about the type and timing of the treatment given.

Table 19 shows the percentage of children under age 5 who had a fever in the 2 weeks preceding the survey. Also shown, among those children with a fever, are the percentage for whom advice or treatment was sought; the percentage who had a drop of blood taken from a finger or heel prick (presumably for a malaria test); and among children who took any antimalarial drug, the percentage who took any ACT.

Fifteen percent of children under age 5 had a fever during the 2 weeks preceding the survey. The prevalence of fever is roughly the same among children in rural and urban areas (16% and 15%, respectively). Advice or treatment was sought for 64% of children with a fever, and 27% had blood taken from a finger or heel for testing. Advice or treatment for fever is about as likely to be sought for children in urban areas and rural areas (65% and 63%, respectively). Nearly half of all children with a fever who took any antimalarial drug (47%) took an ACT, however this number is based on few cases and thus should be interpreted with caution.

Table 19 Prevalence, diagnosis, and prompt treatment of children with fever

Percentage of children under age 5 with fever in the 2 weeks preceding the survey; among children under age 5 with fever, percentage for whom advice or treatment was sought, percentage who had blood taken from a finger or heel; and among children under age 5 with fever who took any antimalarial drug, percentage who took any artemisinin-based combination therapy (ACT), according to background characteristics, The Gambia DHS 2019-20

	Children under age 5		Children under age 5 with fever			Children under age 5 with fever who took any antimalarial drug	
Background characteristic	Percentage with fever in the 2 weeks preceding the survey	Number of children	Percentage for whom advice or treatment was sought[1]	Percentage who had blood taken from a finger or heel for testing	Number of children	Percentage who took any ACT	Number of children
Residence							
Urban	14.9	4,796	64.8	31.9	715	(40.1)	29
Rural	15.6	2,501	63.1	18.9	389	*	10
Local Government Area							
Banjul	25.3	71	59.5	27.7	18	*	1
Kanifing	18.8	1,248	68.2	29.2	235	*	10
Brikama	13.1	3,005	60.3	34.3	395	*	15
Mansakonko	23.1	314	59.1	17.9	72	*	8
Kerewan	8.5	866	72.7	31.6	74	*	2
Kuntaur	21.8	443	65.3	11.3	97	*	1
Janjanbureh	17.4	455	60.0	20.2	79	*	0
Basse	15.0	895	68.7	22.3	134	*	2
Wealth quintile							
Lowest	15.4	1,630	59.5	17.7	252	*	6
Second	15.0	1,548	58.1	25.7	232	*	8
Middle	14.6	1,518	69.8	29.5	221	*	6
Fourth	16.7	1,362	65.7	29.9	228	*	7
Highest	13.9	1,240	70.1	37.5	172	*	11
Total	15.1	7,297	64.2	27.3	1,104	(46.7)	39

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Includes advice or treatment from the following sources: public sector, private sector, shop, market, itinerant drug seller, and other. Excludes advice or treatment from a traditional practitioner.

3.14 MALARIA PREVALENCE

The prevalence results presented in Table 20 are based on the use of a rapid diagnostic test (RDT). The RDT used in the 2019-20 GDHS was SD Bioline Malaria Ag P.f/Pan, a test that detects malaria antigens from capillary blood samples. In general, malaria prevalence was found to be very low in The Gambia. Less than 1 percent of the children tested were found to be positive for malaria. One reason for the observed low prevalence is that the 2019-20 GDHS survey was conducted between November and March, during the dry season. Malaria in The Gambia is known to be highly seasonal, with transmission occurring as *Anopheles gambiae s.l.* populations expand during and immediately after the single annual rainy season that usually lasts from June to October (Jawara et al. 2008).

Table 20 Prevalence of malaria in children

Percentage of children age 6-59 months classified as having malaria by rapid diagnostic testing (RDT), according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Malaria prevalence according to RDT	
	RDT positive	Number of children
Residence		
Urban	0.5	2,238
Rural	0.3	1,169
Local Government Area		
Banjul	0.0	31
Kanifing	0.3	568
Brikama	0.7	1,432
Mansakonko	0.0	166
Kerewan	0.0	381
Kuntaur	0.2	194
Janjanbureh	0.5	218
Basse	0.5	418
Wealth quintile		
Lowest	0.3	758
Second	0.4	703
Middle	0.7	720
Fourth	0.0	623
Highest	0.8	604
Total	0.4	3,408

RDT = Rapid Diagnostic Test (SD Bioline Pf/Pan)

3.15 HIV/AIDS AWARENESS, KNOWLEDGE, AND BEHAVIOUR

Knowledge of ways to reduce HIV transmission is important in the fight against HIV/AIDS. HIV prevention programmes focus their messages and efforts on several important aspects of behaviour to avoid the spread of HIV. These include using condoms every time a person has sexual intercourse and limiting the number of sexual partners to one uninfected partner who has no other partners. To ascertain the depth of knowledge about modes of HIV prevention, the 2019-20 GDHS respondents were asked questions about these specific behaviours.

Knowledge of HIV prevention methods among women and men age 15-49 is presented in Table 21. Knowledge is generally high in The Gambia where 71% of women and 78% of men know that the risk of HIV can be reduced by using condoms during sexual intercourse. Eighty-six percent of women and 89% of men say that limiting sexual intercourse to one uninfected partner who has no other partners can reduce the chances of getting HIV. Overall, 66% of women and 74% of men believe that both practices are protective.

Women and men age 15-19 have much lower levels of knowledge of these HIV prevention methods than people age 20 and older. For women and men age 15-49, rural women and men were slightly more knowledgeable about each of these prevention methods than their urban counterparts, except for the knowledge of condom use among women. Women and men with a secondary or higher level of education are more knowledgeable about HIV prevention methods than those with no education or a primary education. While there is a generally positive relationship between wealth and knowledge of HIV prevention methods among women, no clear association is present among men.

Although knowledge of HIV prevention is relatively high, some misconceptions about HIV transmission are still common in The Gambia. For instance, 33% of women and 36% of men 15-49 say HIV can be transmitted by mosquito bites. In addition, 29% of women and 33% of men believe it can be transmitted by sharing food with a person who has HIV (data not shown). These are the two most common misconceptions about HIV in the country.

Table 21 Knowledge of HIV prevention methods

Percentage of women and men age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting HIV by using condoms every time they have sexual intercourse and by having one sex partner who is not infected and has no other partners, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage of women who say HIV can be prevented by:				Percentage of men who say HIV can be prevented by:			
	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of women	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of men
Age								
15-24	64.5	82.2	59.4	4,814	71.9	84.4	67.1	1,898
15-19	58.5	79.3	53.8	2,633	65.7	79.5	61.2	1,097
20-24	71.8	85.8	66.2	2,181	80.5	91.0	75.1	802
25-29	74.5	87.0	68.6	2,248	79.7	92.9	77.0	634
30-39	76.5	88.0	71.6	3,057	83.0	93.1	80.2	1,023
40-49	77.6	89.3	72.9	1,746	85.9	92.5	82.3	699
Residence								
Urban	71.9	85.1	65.8	8,747	77.3	88.6	72.8	3,299
Rural	70.1	87.2	67.5	3,118	80.7	91.0	79.2	955
Local Government Area								
Banjul	76.6	91.5	74.3	163	88.6	92.4	84.1	80
Kanifing	75.3	86.4	69.6	2,590	87.3	93.1	83.7	1,040
Brikama	71.0	84.4	64.1	5,299	71.9	85.8	66.6	1,967
Mansakonko	69.0	89.7	65.3	431	73.4	89.9	70.3	134
Kerewan	81.3	96.0	80.4	1,129	81.0	92.0	79.3	351
Kuntaur	58.1	73.4	55.2	522	78.8	89.4	77.1	142
Janjanbureh	75.1	87.2	72.3	595	87.8	94.5	86.2	202
Basse	59.0	82.1	55.8	1,137	75.5	88.6	74.9	340
Education								
No education	66.5	83.6	62.7	4,119	72.1	86.4	69.1	921
Primary	65.8	83.8	60.8	1,854	70.9	84.6	66.2	716
Secondary or higher	76.6	87.7	70.5	5,892	82.1	91.3	78.2	2,618
Wealth quintile								
Lowest	67.5	83.0	63.9	1,998	81.3	90.7	79.0	632
Second	67.1	87.2	63.7	2,135	73.0	88.9	71.1	768
Middle	67.7	85.4	62.8	2,292	77.2	88.6	73.5	848
Fourth	72.7	85.4	66.5	2,591	77.7	87.1	72.2	875
Highest	79.1	86.8	72.4	2,849	80.6	90.3	75.7	1,132
Total 15-49	71.4	85.7	66.3	11,865	78.1	89.1	74.2	4,255
50-59	na	na	na	na	81.7	91.1	80.1	381
Total 15-59	na	na	na	na	78.4	89.3	74.7	4,636

na = Not applicable
[1] Using condoms every time they have sexual intercourse
[2] Partner who has no other partners

3.16 COMPREHENSIVE KNOWLEDGE OF HIV PREVENTION AMONG YOUNG PEOPLE

Table 22 shows knowledge of HIV prevention among young people age 15-24. Knowledge of HIV prevention is defined as knowing that both condom use and limiting sexual intercourse to one uninfected faithful partner are HIV prevention methods, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission (that HIV can be transmitted by mosquito bites or by sharing food with a person who has HIV). Knowledge of how HIV is transmitted is crucial to enabling people to avoid HIV infection, and this is especially true for young people, who are often at greater risk because they may have shorter relationships with more partners or engage in other risky behaviours.

Table 22 shows that 22% of young women and 18% of young men have comprehensive knowledge of HIV prevention. The proportion with comprehensive knowledge generally increases with age and educational attainment. Across LGAs, the largest percentage of young women demonstrating comprehensive knowledge is in Kerewan (31%), while Basse has the lowest level (7%). For men, the LGA with the highest percentage with comprehensive knowledge is Kanifing (27%), while the lowest is Basse (7%).

Table 22 Comprehensive knowledge about HIV prevention among young people

Percentage of young women and young men age 15-24 with comprehensive knowledge about HIV prevention, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Women age 15-24		Men age 15-24	
	Percentage with comprehensive knowledge about HIV prevention[1]	Number of women	Percentage with comprehensive knowledge about HIV prevention[1]	Number of men
Age				
15-19	19.1	2,633	15.0	1,097
15-17	18.0	1,584	11.6	624
18-19	20.7	1,048	19.4	472
20-24	26.4	2,181	22.7	802
20-22	25.5	1,382	20.3	517
23-24	28.0	799	26.9	284
Marital status				
Never married	25.0	3,133	18.4	1,865
Ever had sex	30.0	272	22.8	716
Never had sex	24.5	2,861	15.7	1,149
Ever married	17.6	1,681	(6.7)	33
Residence				
Urban	24.6	3,557	19.8	1,478
Rural	16.2	1,256	12.7	420
Local Government Area				
Banjul	28.0	64	21.5	27
Kanifing	27.5	1,079	27.0	416
Brikama	23.2	2,150	18.0	938
Mansakonko	14.1	166	20.7	58
Kerewan	31.1	448	12.6	165
Kuntaur	12.8	209	10.5	51
Janjanbureh	17.6	245	12.1	93
Basse	7.3	452	6.5	152
Education				
No education	11.2	974	4.7	286
Primary	10.8	756	7.2	351
Secondary or higher	28.8	3,083	24.3	1,261
Total 15-24	22.4	4,814	18.2	1,898

Note: Figures in parentheses are based on 25-49 unweighted cases.
[1] Comprehensive knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and knowing that HIV is not transmitted by mosquito bites or by sharing food with a person who has HIV

Information on sexual behaviour is important in designing and monitoring intervention programmes to control the spread of HIV. The 2019-20 GDHS included questions on respondents' sexual partners during the 12 months preceding the survey and during their lifetime. Information was also collected on use of condoms at respondents' last sexual intercourse. These questions are sensitive, and it is recognised that some respondents may have been reluctant to provide information on recent sexual behaviour. Results are shown in Table 23.1 for women and Table 23.2 for men.

Overall, less than 1% of women age 15-49 reported that they had two or more partners in the past 12 months. The mean number of lifetime partners among all women who have ever had sexual intercourse is 1.4.

Ten percent of men age 15-49 reported that they had two or more partners in the past 12 months. Among men who had two or more partners in the past 12 months, 26% reported using a condom during their last sexual intercourse. The mean number of lifetime partners among all men age 15-49 who have ever had sexual intercourse is 3.9.

Table 23.1 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months: Women

Among all women age 15-49, percentage who had sexual intercourse with more than one sexual partner in the past 12 months and percentage who had intercourse in the past 12 months with a person who was neither their husband nor lived with them; among those having more than one partner in the past 12 months, percentage reporting that a condom was used during last intercourse; among women age 15-49 who had sexual intercourse in the past 12 months with a person who was neither their husband nor lived with them, percentage reporting that a condom was used during last sexual intercourse with such a partner; and among women who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, The Gambia DHS 2019-20

	All women			Women who had 2+ partners in the past 12 months		Women who had intercourse in the past 12 months with a person who was neither their husband nor lived with them		Women who ever had sexual intercourse	
Background characteristic	Percentage who had 2+ partners in the past 12 months	Percentage who had inter-course in the past 12 months with a person who was neither their husband nor lived with them	Number of women	Percentage who reported that a condom was used during last sexual inter-course	Number of women	Percentage reporting that a condom was used during last sexual intercourse with such a partner	Number of women	Mean number of sexual partners in lifetime[1]	Number of women
Age									
15-24	0.2	3.2	4,814	*	12	23.1	155	1.2	1,806
15-19	0.1	1.8	2,633	*	4	(14.2)	47	1.1	503
20-24	0.4	5.0	2,181	*	8	27.0	108	1.2	1,302
25-29	0.1	3.1	2,248	*	2	36.0	69	1.3	1,934
30-39	0.2	2.9	3,057	*	7	29.5	88	1.4	2,976
40-49	0.6	1.8	1,746	*	10	(26.7)	32	1.5	1,740
Marital status									
Never married	0.2	6.3	3,704	*	9	27.1	232	1.6	506
Married/living together	0.2	0.2	7,526	*	17	*	14	1.3	7,327
Divorced/separated/ widowed	0.8	15.4	635	*	5	27.0	98	1.7	623
Residence									
Urban	0.3	3.5	8,747	(22.6)	28	26.9	307	1.4	5,984
Rural	0.1	1.2	3,118	*	4	33.7	37	1.2	2,473
Local Government Area									
Banjul	0.8	6.1	163	*	1	39.5	10	1.7	105
Kanifing	0.6	5.4	2,590	*	16	25.9	140	1.5	1,733
Brikama	0.2	2.9	5,299	*	9	25.1	155	1.4	3,589
Mansakonko	0.6	1.9	431	*	3	*	8	1.4	331
Kerewan	0.1	1.1	1,129	*	1	*	13	1.2	865
Kuntaur	0.0	0.4	522	*	0	*	2	1.2	434
Janjanbureh	0.1	1.3	595	*	0	*	7	1.3	483
Basse	0.1	0.8	1,137	*	1	*	9	1.2	915
Education									
No education	0.2	1.1	4,119	*	8	(14.3)	45	1.3	3,784
Primary	0.3	2.4	1,854	*	6	(38.0)	45	1.4	1,438
Secondary or higher	0.3	4.3	5,892	*	17	28.2	255	1.4	3,235
Wealth quintile									
Lowest	0.1	1.4	1,998	*	2	(37.7)	28	1.3	1,609
Second	0.1	2.7	2,135	*	2	(20.0)	59	1.4	1,606
Middle	0.3	3.2	2,292	*	7	21.0	74	1.4	1,706
Fourth	0.3	2.6	2,591	*	7	26.6	67	1.4	1,715
Highest	0.5	4.1	2,849	*	14	34.0	116	1.4	1,820
Total	0.3	2.9	11,865	(21.8)	32	27.7	345	1.4	8,457

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

Table 23.2 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months: Men

Among all men age 15-49, percentage who had sexual intercourse with more than one sexual partner in the past 12 months and percentage who had intercourse in the past 12 months with a person who was neither their wife nor lived with them; among those having more than one partner in the past 12 months, percentage reporting that a condom was used during last intercourse; among men age 15-49 who had sexual intercourse in the past 12 months with a person who was neither their wife nor lived with them, percentage reporting that a condom was used during last sexual intercourse with such a partner; and among men who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, The Gambia DHS 2019-20

	All men			Men who had 2+ partners in the past 12 months		Men who had intercourse in the past 12 months with a person who was neither their wife nor lived with them		Men who ever had sexual intercourse	
Background characteristic	Percentage who had 2+ partners in the past 12 months	Percentage who had inter-course in the past 12 months with a person who was neither their wife nor lived with them	Number of men	Percentage who reported that a condom was used during last sexual inter-course	Number of men	Percentage reporting that a condom was used during last sexual intercourse with such a partner	Number of men	Mean number of sexual partners in lifetime[1]	Number of men
Age									
15-24	4.4	22.0	1,898	56.7	84	56.2	418	3.1	733
15-19	2.5	14.1	1,097	*	27	47.5	154	3.4	274
20-24	7.1	32.9	802	(60.6)	57	61.4	264	3.0	459
25-29	9.7	32.3	634	48.9	61	57.6	205	3.9	490
30-39	11.9	18.4	1,023	23.2	122	62.6	188	3.9	916
40-49	24.8	9.3	699	5.4	173	53.9	65	4.8	647
Marital status									
Never married	5.9	28.8	2,552	63.4	149	58.1	734	4.3	1,189
Married/living together	17.3	6.9	1,645	5.1	284	55.0	113	3.6	1,548
Divorced/separated/ widowed	11.8	49.8	58	*	7	*	29	(5.6)	48
Type of union									
In polygynous union	85.5	1.9	226	1.6	193	*	4	3.7	207
Not in polygynous union	6.4	7.7	1,418	12.5	91	54.5	109	3.6	1,341
Not currently in union	6.0	29.2	2,610	64.6	156	58.2	763	4.3	1,238
Residence									
Urban	10.1	22.8	3,299	32.3	333	59.8	754	4.2	2,157
Rural	11.3	12.8	955	7.3	108	45.0	122	2.9	629
Local Government Area									
Banjul	7.6	22.9	80	(32.3)	6	73.4	18	4.7	59
Kanifing	11.1	27.3	1,040	45.8	116	65.3	283	4.3	701
Brikama	9.5	21.1	1,967	24.8	188	56.4	414	4.2	1,254
Mansakonko	7.4	10.1	134	*	10	(58.5)	14	2.8	81
Kerewan	9.1	10.8	351	(4.1)	32	53.1	38	2.8	226
Kuntaur	14.4	12.0	142	12.3	20	(53.3)	17	2.3	95
Janjanbureh	10.2	14.7	202	(10.4)	21	38.2	30	3.3	138
Basse	14.2	18.2	340	15.6	48	40.8	62	3.3	230
Education									
No education	13.9	14.0	921	6.8	128	50.3	129	2.9	674
Primary	9.0	17.7	716	17.3	65	46.4	127	3.7	441
Secondary or higher	9.5	23.7	2,618	38.6	247	61.6	620	4.4	1,671
Wealth quintile									
Lowest	10.6	14.7	632	8.3	67	43.5	93	2.9	423
Second	8.9	16.0	768	9.6	69	48.7	123	3.2	469
Middle	12.1	19.3	848	17.7	103	52.7	163	3.7	585
Fourth	10.3	22.6	875	30.5	90	60.6	198	4.1	581
Highest	9.9	26.4	1,132	51.4	112	66.8	299	5.0	728
Total 15-49	10.4	20.6	4,255	26.2	440	57.8	876	3.9	2,785
50-59	27.9	3.0	381	2.4	106	*	12	5.9	356
Total 15-59	11.8	19.1	4,636	21.6	547	57.8	887	4.1	3,141

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Means are calculated excluding respondents who gave non-numeric responses.

3.17 COVERAGE OF HIV TESTING SERVICES

Knowledge of HIV status helps HIV-negative individuals make specific decisions to reduce risk and increase safer sex practices so that they can remain disease free. Among those who are HIV infected, knowledge of their status allows them to take action to protect their sexual partners, access treatment, and plan for the future.

To assess awareness and coverage of HIV testing services, GDHS respondents were asked if they had ever been tested for HIV. If they said that they had, they were asked if they received the results of their last test and where they had been tested. If they had never been tested, they were asked if they knew a place where they could go to be tested.

Tables 24.1 and 24.2 show that more than two-thirds of respondents age 15-49 (70% of women and 69% of men) knew of a place where they could get an HIV test. Respondents age 15-19 (48% of women and men each) were less likely than those age 20-49 to know a place where they could go to be tested. Never-married respondents who had never had sex were less likely than others to know a place to get an HIV test (52% of women and men each). For both women and men, knowledge of where to get an HIV test generally rises with increasing levels of education and wealth.

Tables 24.1 and 24.2 also show coverage of HIV testing. Among respondents age 15-49, a larger proportion of men (73%) than women (58%) have never been tested. Overall, 39% of women and 25% of men have ever been tested and have received the results of their last test. The likelihood of having ever had an HIV test and receiving the results of the last test was lowest in the 15-19 age group (7% of women and 4% of men) and for respondents who had never married and had never had sex (5% of women and 7% of men). While the probability of receiving results after being tested rises with wealth for women and men, there is no clear relationship with education. Thirteen percent of women and 9% of men age 15-49 were tested in the 12-month period preceding the survey and were told the results of the last test they took.

Table 24.1 Coverage of prior HIV testing: Women

Percentage of women age 15-49 who know where to get an HIV test, percent distribution of women age 15-49 by testing status and by whether they received the results of the last test, percentage of women ever tested, and percentage of women who were tested in the past 12 months and received the results of the last test, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of women by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of women
		Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age								
15-24	57.9	18.1	2.2	79.7	100.0	20.3	7.5	4,814
15-19	48.2	7.4	1.3	91.2	100.0	8.8	3.4	2,633
20-24	69.5	31.0	3.3	65.7	100.0	34.3	12.4	2,181
25-29	76.5	47.8	5.0	47.3	100.0	52.7	18.3	2,248
30-39	81.6	58.6	4.8	36.7	100.0	63.3	17.4	3,057
40-49	77.3	48.3	3.2	48.5	100.0	51.5	11.7	1,746
Marital status								
Never married	55.8	11.1	0.9	88.0	100.0	12.0	4.2	3,704
Ever had sex	78.4	47.3	4.4	48.3	100.0	51.7	17.5	509
Never had sex	52.2	5.4	0.4	94.3	100.0	5.7	2.1	3,195
Married or living together	76.8	50.8	4.9	44.3	100.0	55.7	17.0	7,526
Divorced/separated/ widowed	79.1	53.8	3.1	43.0	100.0	57.0	11.5	635
Residence								
Urban	69.9	38.3	2.5	59.2	100.0	40.8	13.2	8,747
Rural	71.7	39.5	6.5	54.0	100.0	46.0	11.4	3,118
Local Government Area								
Banjul	71.1	38.6	3.2	58.2	100.0	41.8	12.1	163
Kanifing	73.6	42.9	2.8	54.3	100.0	45.7	14.5	2,590
Brikama	69.1	36.8	1.9	61.3	100.0	38.7	13.3	5,299
Mansakonko	65.6	41.9	4.8	53.3	100.0	46.7	11.2	431
Kerewan	74.6	44.2	5.5	50.3	100.0	49.7	12.7	1,129
Kuntaur	67.2	46.2	2.0	51.8	100.0	48.2	16.0	522
Janjanbureh	69.8	21.0	10.5	68.5	100.0	31.5	4.0	595
Basse	68.2	36.2	7.6	56.2	100.0	43.8	9.6	1,137
Education								
No education	68.4	40.7	5.0	54.4	100.0	45.6	11.7	4,119
Primary	68.4	41.5	4.5	54.0	100.0	46.0	13.8	1,854
Secondary or higher	72.3	36.2	2.2	61.5	100.0	38.5	13.1	5,892
Wealth quintile								
Lowest	67.7	35.8	6.0	58.1	100.0	41.9	11.0	1,998
Second	66.4	36.4	4.3	59.3	100.0	40.7	12.2	2,135
Middle	68.7	38.1	3.9	58.0	100.0	42.0	12.9	2,292
Fourth	70.7	38.4	2.1	59.5	100.0	40.5	12.1	2,591
Highest	76.3	42.8	2.3	54.9	100.0	45.1	14.7	2,849
Total	70.4	38.6	3.5	57.9	100.0	42.1	12.7	11,865

[1] Includes 'don't know/missing'

Table 24.2 Coverage of prior HIV testing: Men

Percentage of men age 15-49 who know where to get an HIV test, percent distribution of men age 15-49 by testing status and by whether they received the results of the last test, percentage of men ever tested, and percentage of men who were tested in the past 12 months and received the results of the last test, according to background characteristics, The Gambia DHS 2019-20

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of men by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of men
		Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age								
15-24	54.2	8.0	0.8	91.2	100.0	8.8	2.6	1,898
15-19	47.6	4.3	0.9	94.8	100.0	5.2	1.7	1,097
20-24	63.3	13.2	0.7	86.2	100.0	13.8	3.8	802
25-29	71.8	28.4	1.8	69.8	100.0	30.2	11.5	634
30-39	79.6	39.3	2.4	58.3	100.0	41.7	12.9	1,023
40-49	87.7	48.9	1.8	49.4	100.0	50.6	16.0	699
Marital status								
Never married	59.5	14.3	1.1	84.6	100.0	15.4	5.0	2,552
Ever had sex	67.6	21.8	1.9	76.4	100.0	23.6	7.3	1,233
Never had sex	51.9	7.3	0.3	92.4	100.0	7.6	2.8	1,319
Married or living together	81.6	41.4	2.1	56.5	100.0	43.5	14.2	1,645
Divorced/separated/ widowed	90.4	51.9	3.3	44.7	100.0	55.3	11.2	58
Residence								
Urban	70.8	28.4	1.2	70.4	100.0	29.6	9.9	3,299
Rural	60.6	14.6	2.4	83.0	100.0	17.0	4.1	955
Local Government Area								
Banjul	66.1	29.2	1.2	69.6	100.0	30.4	10.1	80
Kanifing	73.7	28.7	1.9	69.4	100.0	30.6	10.1	1,040
Brikama	69.2	29.3	0.9	69.9	100.0	30.1	10.0	1,967
Mansakonko	54.3	19.9	4.1	76.0	100.0	24.0	4.9	134
Kerewan	65.4	18.1	1.8	80.1	100.0	19.9	6.2	351
Kuntaur	71.9	14.1	3.8	82.1	100.0	17.9	4.5	142
Janjanbureh	46.1	9.7	1.1	89.2	100.0	10.8	4.0	202
Basse	69.4	14.6	2.0	83.5	100.0	16.5	4.5	340
Education								
No education	60.2	19.1	2.0	78.9	100.0	21.1	6.7	921
Primary	58.7	18.3	1.5	80.2	100.0	19.8	6.4	716
Secondary or higher	74.1	29.4	1.3	69.3	100.0	30.7	9.9	2,618
Wealth quintile								
Lowest	61.4	15.1	2.5	82.4	100.0	17.6	4.0	632
Second	63.1	19.2	1.1	79.7	100.0	20.3	5.9	768
Middle	69.2	28.8	1.0	70.2	100.0	29.8	11.2	848
Fourth	72.3	29.3	1.4	69.3	100.0	30.7	11.2	875
Highest	72.6	29.4	1.7	68.9	100.0	31.1	9.1	1,132
Total 15-49	68.5	25.3	1.5	73.2	100.0	26.8	8.6	4,255
50-59	88.0	53.9	3.2	42.9	100.0	57.1	13.5	381
Total 15-59	70.1	27.7	1.6	70.7	100.0	29.3	9.0	4,636

[1] Includes 'don't know/missing'

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