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THE 2014 CONTRACEPTIVE PREVALENCE SURVEY

Republic of Mauritius

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EXECUTIVE DETAILS

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FOREWORD

I am pleased to present the Republic of Mauritius 2014 Contraceptive Prevalence Survey (2014 CPS) Report. The 2014 CPS is the fourth survey in this series. Previous surveys were carried out in 1985, 1991 and 2002.

The CPS is an important tool for monitoring and evaluating our Reproductive Health Services, in particular the National Family Planning Programme. It provides us with statistics about use of contraception, reasons behind choices and practices; characteristics, knowledge and preferences of contraceptive users; fertility rates, determinants, trends and differentials; child feeding practices, nutritional status of children; awareness and attitudes regarding HIV/AIDS awareness and teenage pregnancy amongst other useful information. In addition, the 2014 CPS includes data on infertility; Reproductive Health perception and behaviour; breast self-examination; awareness of Pap smear examination; consumption of tobacco and alcohol; diabetes and hypertension during pregnancy.

The results also show that key maternal and child health indicators, including antenatal care coverage and medical assistance at delivery, have improved. However, the survey also documents a number of challenges, particularly relating to fertility and family planning.

It is expected that the 2014 CPS will guide policymakers, programme managers, health care practitioners and social scientists about the recent demographic trends whilst providing the required evidence base to help them in their medium and longer term strategies and challenges that lie ahead.

The 2014 CPS survey was a collaborative effort between the Ministry of Health and Quality of Life and the Mauritius Institute of Health with the financial support of the United Nations Fund for Population Activities (UNFPA). It was conducted in Mauritius and Rodrigues from July to September 2014.

This entire survey was made possible by the hard work and dedication of many stakeholders and individuals, who are too many to name here. To all of them I wish to express my deep gratitude and appreciation.

Dr. (Mrs) Geeta Daby
Executive Director
Mauritius Institute of Health

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The 2014 Contraceptive Prevalence Survey has been conducted by the Mauritius Institute of Health (MIH) at the request of the Ministry of Health and Quality of Life (MOH & QL) and we are indebted to the UNFPA for the support in funding the project.

We are grateful for the invaluable support from Mr J. Sunkur, Chief investigator and Mr R. Beebeejaun as Co-investigator of the survey. The survey would not have been possible without the contribution of the field staff, coders and data entry clerks to whom we are very thankful.

We wish to express our appreciation of the technical committee who contributed to the successful completion of this project

Finally, we would like to thank Mrs. T. Rozbully, Senior Statistical Officer, MOH & QL; Mrs I. Jugroop and Mrs. H.D.A. Venkatachellum, Executive Assistants, MIH; Mr S. Mogaul, Printing and Publishing Officer, MIH and to all other staff of the MIH who have directly or indirectly contributed to this undertaking.

EXECUTIVE SUMMARY

The 2014 Contraceptive Prevalence Survey (2014 CPS) is the fourth survey of its kind to be carried out in the Republic of Mauritius following the 1985, 1991 and 2002 CPSs. This survey is an important evaluation tool for identifying the strengths and weaknesses of the family planning programme.

The 2014 CPS was based on 1,680 respondents for the Island of Mauritius and 400 respondents for the Island of Rodrigues. The primary purpose of the 2014 survey was to provide detailed information on fertility, family planning, contraceptive source, breastfeeding, HIV/AIDS related knowledge and attitude and infertility. The 2014 CPS also included modules on reproductive health perception and behaviour.

Island of Mauritius

FERTILIY

Determinants of Fertility. Age of menarche marks the onset of the reproductive capability of a woman. Results of 2014 CPS show that median age of menarche of women age 15-49 years is 11.7 years. The median age of menarche has slightly declined over time: from 11.9 years among women age 45-49 years to 11.4 years among women age 15-19 years.

Trend and Differentials. Mauritius has witnessed a rapid fertility decline within a short period of time: from 6 births per woman in the 60s to less than 2 births per woman at present. TFR measured from the vital statistics was 1.45 for the period 2012-2014.

Results from 2014 CPS show that the TFR for Mauritius for the three-year period preceding the 2014 CPS is 1.38 children per woman, which is lower than the TFR measured for the three-year period preceding the 2002 CPS (1.97 children per woman). Urban women have slightly more children than rural women (1.44 versus 1.33). Moreover, the data reveals that Christians have more children (1.94) than Muslims (1.40) and Hindus (1.15).

Fertility levels are closely related to household socio-economic status (SES). Women living in high-SES households have fewer children (1.28) than women living in low-SES households (2.03).

Mauritian women tend to begin sexual intercourse before marriage. Results show that the median age at first sexual intercourse is 19.8 years and the median age at first marriage is 21.4 years among women age 25-49 years.

Premarital Conception. Premarital conception has slightly increased from 10.1% in 2002 to 13.4% in 2014 among currently and formerly married women age 15-49 years.

Teenage Pregnancy and Motherhood. 12.1% of teenagers (women age 15-19 years) currently in union have already begun childbearing: 10.6% are already mothers and 1.5% are pregnant with their first child.

Fertility Planning. Results of the 2014 CPS show that 70.2% of currently married women age 15-49 years who have had a live birth in the five years preceding the survey stated that their most recent pregnancy was planned (wanted) and 25.7% stated that it was unplanned (mistimed and unwanted).

Further, the proportion of unplanned pregnancies has increased from 22.0% in 2002 to 25.7% in 2014 among currently married women age 15-49 years who have had a live birth in the five years preceding the survey.

Infertility. 10% of currently married women age 15-49 years reported having fertility problems. 80.3% of them knew where to seek medical help but only 54.3% of them intend to seek medical help to get pregnant.

ABORTION

Abortion is on the rise. The proportion of women age 15-49 years who reported having had at least one abortion (either spontaneous or induced abortion) has increased slightly from 15.5% in 2002 to 15.8% in 2014. Moreover, it is noted that the proportion of women age 15-49 years who reported having had at least one induced abortion has increased from 3.4% in 2002 to 5.0% in 2014.

The main reasons given by women for their last induced abortion were "financial problems" (21.4%), "did not want (anymore) children" (21.4%), and "spacing next pregnancy" (21.3%)

MATERNAL CARE

Antenatal Care. Almost all women (98.1%) received antennal care for their last live born child from a health professional. The majority (76.4%) received care from the public sector, 12.3% from the private sector and 11.3% received care from both the public and private sector simultaneously. 77.7% of women received regular antenatal care (i.e they made four or more visits to a provider).

Moreover, almost all deliveries in Mauritius are conducted by a doctor.

Place and type of Delivery. Results from the 2014 CPS show that 99.4% of births occurred in health facilities. 83.8% married women age 15-49 years delivered their last liveborn child in a government hospital) in 2014. It is worth mentioning that the proportion of deliveries in private hospitals has slightly increased from 13.6% in 2002 to 15.6% in 2014 among currently married women age 15-49 years.

Tobacco and alcohol consumption during pregnancy. Tobacco and alcohol consumption during pregnancy are major risk factors for poor pregnancy outcomes. 1.9% of women age 15-49 years who have had a live birth were smoking and 3.4% were drinking alcohol during their pregnancy for their last liveborn child.

Diabetes and Hypertension during Pregnancy. Among women who have had a liveborn child 8.8% of them reported that they have been diagnosed for diabetes and 14.5% for hypertension during pregnancy. Moreover, 3.6% of them have been diagnosed for both diabetes and hypertension.

FAMILY PLANNING

Knowledge of Contraception. Knowledge of contraception is almost universal in Mauritius since 99.6% of currently married women age 15-49 years knew at least one method of contraception in 2014. The mean number of methods known is indicative of the extent of knowledge of family planning methods. Overall, currently married women age 15-49 years know an average of 8.9 contraceptive methods. Further, knowledge of any contraceptive method is 94.0% among teenagers (15-19 years)

Current Use of contraception. 63.8% of currently married women age 15-49 years are using a method of contraception including 32% who are using a modern method. Withdrawal is the leading method, used by 28.5% of currently married women age 15-49 years. Among modern methods, the most commonly used are male condom (10.6%), pill (8.9%) and tubal ligation (7.3%).

Trends in Contraceptive Use. Use of contraception has declined over the years as the contraceptive prevalence rate for currently married women age 15-49 years has decreased from 75.9% in 2002 to 63.8% in 2014. This is more significant for modern methods which have declined from 40.7% in 2002 to 32.0% in 2014 among currently married women age 15-49 years.Traditional method has decreased from 35.2% to 31.8% during the same period.

Contraceptive Source. Government is the leading source for contraceptives (54.8%) followed by the private sector (34.7%), Action Familiale (6.6%) and MFPWA (3.8%) among current users of any contraceptive method who are currently married and of age 15-49 years.

It should be pointed out that the private sector has become an increasingly important provider of contraceptives over the years as the corresponding proportion was 23.7% in 2002.

Unmet Need for Family Planning. The 2014 CPS results reveal that unmet need for family planning in Mauritius is 12.5% among currently married women age 15-49 years (4.1% unmet need for spacing; 8.4% unmet need for limiting). Moreover, 62.4% of women with unmet need for family planning do not intend to use a contraceptive method sometime in the future.

BREASTFEEDING

Breastfeeding is nearly universal in Mauritius, and 96.6% of mothers stated that their last liveborn child born two years preceding the survey was breastfed. However, the mean duration of any breastfeeding is 12.6 months and the mean duration of exclusive breastfeeding is 4.4 months among last liveborn children born in the five years preceding the survey.

REPRODUCTIVE HEALTH PERCEPTION AND BEHAVIOUR

Sexuality education. Sexuality education is still not in the formal school curriculum. Students are sensitized on healthy lifestyles and sexual and reproductive health issues through the Family Life Education programme, which is conducted on an adhoc basis in schools by governmental and non-governmental organizations.

However, when asked to cite the most important source of information on sexual matters 22.7% of respondents cited teachers followed by parents (19.7%) and media (mass, printed and electronic) (15.5%).

Respondents stated that the best age for students to have sexuality education in school is at 12-15 years. Teacher with special training in sexuality education (72.5%) would be the most suitable person to teach sexuality education.

Parental involvement in Sexuality Education. 68.1% of respondents said that their parents talked about menstrual cycle to them before reaching age 18, followed by puberty (58.1%) and no sex before marriage. (53.4%) Less than half of the respondents (44.9%) reported that they have had talks on responsible sexual behaviour with their parents before reaching age 18.

22.5% of respondents stated that they never had talks with their parents before reaching age 18.

Breast self examination (BSE). Result of the 2014 CPS show that 72.4% of respondents have heard/read about this examination and their main source of information on BSE for the first time was from the newspaper/radio/TV (32.7%).

60.6% of respondents have not carried out BSE despite having heard/read about this examination. The most important reason cited by respondents for not carrying out BSE is "don't know how to do BSE" (46.6%) followed by "don't think that BSE is important" (26.0%).

Pap Smear. 39.3% of respondents age 15-49 years have heard/read about Pap smear. 35.5% of respondents who have heard heard/read about Pap smear and who have had sexual intercourse have had a Pap smear. 65.5% of respondents have had their last Pap smear at a government-run facility (government mobile clinic, 46.2%; government hospital, 19.3%), 30.8% at a privately-run health facility (private hospital/doctor's office) and 3.7% at MFPWA clinic

HIV/AIDS

HIV Awareness. The Majority, 98.3% of all respondents have heard about AIDS in 2014 and 74.7% of them knew where they can get an HIV test.
Government hospital is the most cited place (83.9%) that provides HIV testing.

Knowledge of HIV/AIDS Prevention. The proportion of respondents who knew that something can be done to avoid getting HIV/AIDS has increased from 73.3% in 2002 to 88.8% in 2014.

The two most common ways to avoid getting HIV/AIDS according to respondents were condom use (78.6%) and having only one sexual partner (57.2%).

Knowledge of Mother to Child Transmission of HIV. 77.0% of respondents who have heard about HIV/AIDS know that HIV can be transmitted from mother to child during pregnancy. 28.8% of respondents had knowledge of all the three ways HIV can be transmitted from mother to child.

Stigma and discrimination. 66.2% of respondents said they would take care of a family member living with HIV. However, 43.2% said they would want to keep secret the HIV-positive status of a family member and only 43.1% stated that they would buy vegetables from a vendor who has HIV.

Island of Rodrigues

FERTILIY

Determinants of Fertility. Age of menarche marks the onset of the reproductive capability of a woman. Survey results show that the median age of menarche of Rodriguan women age 15-49 years is 12.3 years. The median age of menarche has slightly declined over time: from 13.0 years among women age 45-49 years to 11.7 years among women age 15-19 years.

Trend and Differentials.

Rodriguan women tend to have sexual intercourse before marriage. Results show that the median age at first sexual intercourse is 17.7 years and the median age at first marriage is 19.9 years among women age 25-49 years.

Premarital Conception. Overall**,** 30.6% of first born babies were born before first union or within the first 7 months of first union among ever-married women age 15-49 years.

Fertility Planning. Results of the 2014 CPS show that 53.2% of currently married women age 15-49 years who have had a live birth in the five years preceding the survey stated that their most recent pregnancy was unplanned (mistimed and unwanted) and 45.6% stated that it was planned (wanted).

Further, the proportion of unplanned pregnancies has increased from 42.5% in 2002 to 53.2% in 2014 among currently married women age 15-49 years who have had a live birth in the five years preceding the survey.

Teenage Pregnancy and Motherhood. 29.5% of teenagers (women age 15-19 years) currently in union have already begun childbearing: 22.7% are already mothers and 6.8% are pregnant with their first child.

ABORTION

11.3% of women age 15-49 years had at least one spontaneous abortion and 1.2% had at least one induced abortion.

Asked what a woman should do if she has an unwanted pregnancy, 92.2% of respondents age 15-49 years thought that the woman should not have an induced abortion

MATERNAL CARE

Antenatal Care. Almost all women (97.4%) received antenatal care for their last live born child from a health professional. Those who received antenatal care were asked where they received antenatal care and who provided most of the antenatal care. 99.8% mentioned that they received care from the public sector. There is no private sector (private doctor/clinic) in Rodrigues. 65.0% of women received regular antenatal care (i.e they made four or more visits to a provider). Moreover, almost all deliveries in Rodrigues are conducted by a doctor.

Place and type of Delivery. There is no private hospital/doctor in Rodrigues. Consequently, 99.3% of currently married women age 15-49 years delivered their last liveborn child in the government hospital. 29.2% had a caesarean section.

Tobacco and alcohol consumption during pregnancy. Tobacco and alcohol consumption during pregnancy are major risk factors for poor pregnancy outcomes. 3.2% of women age 15-49 years who have had a live birth were smoking and 1.4% were drinking alcohol during their pregnancy for their last liveborn child.

Diabetes and Hypertension during Pregnancy. Among women who have had a liveborn child 4.3% of them reported that they have been diagnosed for diabetes and 20.2% for hypertension. Moreover, 1.9% of them have been diagnosed for both diabetes and hypertension.

FAMILY PLANNING

Knowledge of Contraception. Knowledge of contraception is universal in Rodrigues. The mean number of methods known is indicative of the extent of knowledge of family planning methods. Overall, currently married women age 15-49 years know an average of 10.7 contraceptive methods.

Current Use of contraception. 73.6% of currently married women age 15-49 years are using a method of contraception including 7.1% who are using a traditional method. Pill is the leading method ,used by 31.9% of currently married women age 15-49 years. Calendar (5.5%) is the most commonly used NFP method.

Trends in Contraceptive Use. Use of contraception has slightly declined over the years as the contraceptive prevalence rate for currently married women age 15-49 years has decreased from 74.1% in 2002 to 73.6% in 2014. Use of modern methods has decreased from 70.4% in 2002 to 66.5% in 2014 among currently married women age 15-49 years. However, use of traditional methods has increased from 3.8% in 2002 to 7.1% in 2014.

Contraceptive Source. Government is the leading source for contraceptives (88.8%) followed by Action Familiale (6.6%) among current users of any contraceptive method who are currently married and of age 15-49 years.

Unmet Need for Family Planning. The 2014 CPS results reveal that unmet need for family planning in Rodrigues is 14.8% among currently married women age 15-49 years (5.9% unmet need for spacing; 8.9% unmet need for limiting). Moreover, 39.3% of women with unmet need for family planning are not sure to use a contraceptive method sometime in the future.

BREASTFEEDING

Breastfeeding is nearly universal in Rodrigues and 98.8% of mothers stated that their last liveborn child born two years preceding the survey were breastfed. The mean duration of any breastfeeding is 14.9 months and the mean duration of exclusive breastfeeding is 5.9 months among last liveborn children born in the five years preceding the survey.

REPRODUCTIVE HEALTH PERCEPTION AND BEHAVIOUR

Sexuality education is still not in the formal school curriculum. Students are sensitized on healthy lifestyles and sexual and reproductive health issues through the Family Life Education programme, which is conducted on an adhoc basis in schools by governmental and non-governmental organizations.

However, when asked to cite the most important source of information on sexual matters 20.0% of respondents cited teachers followed by friends/colleagues (17.0%).

Respondents stated that the best age for students to have sexuality education in school is at 12-15 years. Teacher with special training in sexuality education (77.7%) would be the most suitable person to teach sexuality education.

Parental involvement in Sexuality Education. 53.4% of respondents said that their parents talked about no sex before marriage before

reaching age 18 followed by menstrual cycle (49.3%). Less than half of the respondents (42.4%) reported that they have had talks on responsible sexual behaviour with their parents before reaching age 18.

31.4% of respondents stated that they never had talks with their parents before reaching age 18.

Breast self examination. Results of the 2014 CPS show that 81.3% of respondents have heard/read about this examination and their main their first source of information on BSE for the first time was from the newspaper/radio/TV (56.5%).

46.4% of respondents have not carried out BSE despite having heard/read about this examination. The most important reason cited by respondents for not carrying out BSE is "don't know how to do BSE" (61.2%) followed by "don't have any symptoms" (25.5%).

Pap Smear. 52.8% of respondents age 15-49 years have heard/read about Pap smear. Respondents have heard/read about Pap smear for the first time from the newspaper/radio/television (58.8%) and Government health centre personnel (22.7%).

18.1% of respondents who have heard heard/read about Pap smear and who have had sexual intercourse have had a Pap smear. 82.7% of respondents have had their last Pap smear at the government hospital, 11.3% at MFPWA clinic

HIV/AIDS

HIV Awareness. The majority, 99.3% of all respondents have heard about AIDS in 2014 and 87.8% of them knew where they can get an HIV test.

Government hospital is the most cited place (100.0%) that provide HIV testing followed by PILS (95.1%).

Knowledge of HIV/AIDS Prevention. The proportion of respondents who knew that something can be done to avoid getting HIV/AIDS has increased from 86.2% in 2002 to 95.8% in 2014.

Condom use (92.0%) and having only one sexual partner (64.5%) are the two most common ways to avoid getting HIV/AIDS according to respondents.

Knowledge of Mother to Child Transmission of HIV. 72.1% of respondents who have heard about HIV/AIDS know that HIV can be transmitted from mother to child during pregnancy. 35.8% of respondents had knowledge of all three of the basic ways HIV can be transmitted from mother to child.

Stigma and discrimination. 71.9% of respondents said they would take care of a family member living with HIV. However, more than half (54.2%) said they would want to keep secret the HIV-positive status of a family member.

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1.0 Introduction

Reproductive and sexual health care, including family planning services and information, is recognized not only as a key intervention for improving the health of men, women and children but also as a human right. Family planning programs have been the centerpiece of government efforts to reduce fertility. These programs, which provide access to contraceptive information and services, make it easier for couples to plan the number of children that they would like to have.

Family planning (FP) is one of the most "health-promoting "and cost-effective activities in public health promotion and has the potential to avert approximately 30% of maternal and 10% of child deaths (Cleland et al, 2012). Thus, FP contributes to achieving the Millennium Development Goals (MDGs) through healthier birth spacing and by reducing mortality and morbidity associated with pregnancy (Yearkey et al, 2009). Moreover, according United Nations (2012), for countries that have achieved Millennium Development Goal 5 on improving maternal health, meeting women's contraceptive needs has played an important role. MDG 5a aimed to reduce the maternal mortality ratio by three quarters between 1990 and 2015, and MDG 5b aimed to achieve universal access to reproductive health, including family planning. Therefore, along with providing skilled maternal care, offering family planning is essential to averting maternal death.

The utilization of modern contraceptives is an important component of maternal, new-born, and child health services (WHO, 2005). It plays a significant role in fertility reduction by facilitating both the spacing and limiting of pregnancies in women of reproductive age (Bogale, 2011). According to the World Health Organization (2012), satisfying the unmet need for family planning alone could cut the number of maternal deaths by almost a third. However, an estimated 215 million women who would prefer to delay or avoid pregnancy continue to lack access to safe and effective contraception.

According to the most recent data available, significant regional differences regarding fertility and contraceptive prevalence have been reported. As a region, sub-Saharan Africa has the highest fertility level in the world, with an average total fertility rate (TFR) of 5.1 in 2009 (World Bank 2011). In most countries in the region, the TFR has declined over time, but the TFR has remained constant in some countries since 2000, or even risen. As a result of high fertility and low levels of contraceptive use, sub-Saharan Africa had the highest population growth rate among developing countries during 2005-2010, an annual rate of 2.4 percent compared with 1.4 percent in South Asia and 1.1 percent in Latin America (World Bank, 2011). Pakistan has one of the highest fertility rates in Asia, and the lowest rates of contraceptive use, resulting in poor reproductive health indicators for women and high neonatal mortality (Aga Khan University, 2012).

Worldwide, contraceptive prevalence has increased from 55% in 1990 to 63% in 2010. In turn, unmet need for family planning has decreased from 15% in 1990 to 12% in 2010 (Alkema et al. 2013). The World Health Organization (2013) has reported that the highest contraceptive prevalence is in Asia and Latin America, whereas sub-Saharan African countries have the lowest contraceptive prevalence. Countries in East Africa have observed a greater increase in modern contraceptive use than countries in West and Central Africa (Emina et al, 2014). The average contraceptive prevalence rate (CPR) in sub-Saharan Africa in 2009 was 21 percent, far lower than in South Asia (51 percent), Latin America and Caribbean (75 percent), and East Asia (77 percent) (World Bank 2011).

The distribution of contraceptive users by methods used is quite distinct across regions and countries. Short-term and reversible methods, such as the pill, injectable and condom, were more commonly used than other methods in Africa and Europe whereas longer-term and permanent methods, such as sterilization, implants and the IUD, were more common in Asia and Northern America (Biddlecom and Kantorova, 2013). Modern contraceptive methods are among main methods used, since nine out of every 10 contraceptive users in the world rely on modern methods. Short-acting and reversible methods are more commonly used than other methods in developed countries whereas longer-acting and highly effective clinical methods are used more frequently in the developing countries. Thus, in developed countries as a whole, contraceptive prevalence was highest for the pill (16 per cent) and the male condom (14 per cent). Those two methods accounted for almost half of overall contraceptive use in the developed countries, while only two out of every 10 users relied on female sterilization or the IUD. By contrast, in developing countries the methods with the highest prevalence were female sterilization (22 per cent) and the IUD (17 per cent), accounting for 60 per cent of overall contraceptive use.

Although many United Nations member countries, particularly those in the developed world, have strong family planning programs, this is not the case in sub-Saharan Africa, where despite a rise in contraceptive prevalence, many women continue to have unmet need for contraception (UNFPA, 2012). The resultant high fertility is associated with high levels of maternal mortality, especially among the poorest communities. In Uganda, the maternal mortality ratio was estimated to be much higher than the worldwide average in 2011, at 438 per 100,000 births (UBOS & ICF International Inc, 2012). An estimated one-third of women who give birth in developing countries are below age 20, which exposes them to greater risk of illness and death related to maternal causes (WHO, 2012).

Extensive research and rigorous clinical trials have led to improvement in existing methods of contraception and also to the development of new, more effective and acceptable contraceptive methods with fewer side effects (Abasiattai, 2006). According to Blanc et al. (2009), in developing countries, contraceptive use among young women, whether married or unmarried, involves a lot of experimentation and is inconsistent. Additionally, young women face many barriers to the use of family planning services, which include fear, embarrassment, cost, and lack of knowledge (Blanc et al. 2009). Bongaarts et al, (2013) also stated that failure to effectively manage the fertility rate and rapid population growth had adverse effects on development indicators such as education, poverty, and life expectancy, particularly for maternal and child health.

Family planning is a key investment in reducing the broader costs of health care (Singh and Darroch, 2012) and reducing risks associated with pregnancy and childbirth. Likewise, increasing contraceptive use is one way to encourage reduction of maternal mortality and improve both maternal and child health. It also gives women more sexual decision-making power, empowers women, and this could have other effects in STI and HIV/AIDS prevention (Garcia-Moreno and Turmen, 1995). Nowadays, many countries have invested in family planning programs. Many of these programs aim to increase contraceptive use through improving the family planning supply and service environment, based on the assumption that greater supply and better service quality will lead to more use (World Bank, 2011).

Therefore, in order to provide the rapid feedback necessary to evaluate and improve family planning information and service delivery programs, Contraceptive Prevalence Surveys are now being conducted throughout the world. Contraceptive Prevalence Surveys do more than reveal the extent of contraceptive use. A Contraceptive Prevalence Survey (CPS) is a regional or national probability sample survey designed primarily for family planning program management and evaluation. This survey coiled information on the knowledge and use of contraception in relation to desire for more children, availability of family planning services, choice of contraceptive method, and many other factors. They provide rapid feedback to program administrators on the use of family planning services and on program success in serving women at risk of unwanted pregnancy.

Mauritius has a track record in carrying out Contraceptive Prevalence surveys (CPS) since 1985. This CPS was conducted with a representative sample of women in the reproductive age group throughout the islands of Mauritius and Rodrigues. The Ministry of Health and Quality of Life initiated the CPS surveys to provide high quality data on the family planning programme and reproductive health indicators. The four CPS surveys carried out to date are a major landmark in the development of family planning data base for Mauritius. The information provided in the CPS surveys assists policy makers and programme administrators in planning and implementing population programmes.

1.1 Significance of Study

Despite a high contraceptive prevalence rate, in Mauritius, a shift in method mix has been noted since a considerable increase in the use of reliable methods has been discerned. There is also evidence that women are not making optimum use of family planning services.

According to the 2002 CPS, the contraceptive prevalence rate among currently married women aged 15-49 years was 75.9 % for all methods. Despite a relatively high contraceptive prevalence rate in Mauritius, it was noted that an increasing proportion of contraceptive users opted for the withdrawal method (27.1%), while the use of modern methods declined with the use of the pill being the second most popular method (15.8%) and condoms were used by 9.1%. The modern methods therefore contributed only 40.7 % of the CPR.

In Mauritius, abortion is illegal except in cases where the mother's life is in danger. The 2002 CPS reported that the proportion of women aged 15-44 years who reported having had at least one

abortion (spontaneous or induced) increased from 9.3 percent in 1991 to 14.4 percent in 2002. Among the same group of women those who reported having had at least one induced abortion increased from 1.8 percent in 1991 to 3.2 percent in 2002.

Further reports from government hospitals recorded 1,276 cases with post abortion complications in 2014. This figure does not differentiate between spontaneous and induced abortions, while about 6% of the maternal deaths were due to complications of unsafe abortion.

Inadequate counseling on contraceptive methods results in improper use of these methods which inevitably leads to teenage pregnancy. The inaccessibility and unavailability of these methods further contribute in the occurrence of unprotected sexual activity. Sometimes even when family planning services are freely accessible many young and unmarried people do not take full advantages of these services mainly because of social and cultural barriers.

Mauritius is a signatory to the Plan of Action of the 1994 ICPD in which countries committed to the provision of the highest possible level of reproductive health services to all its citizens. Our family planning programme has shifted its focus from achieving demographic targets to improving the reproductive health of the population. The results of the last CPS carried out in 2002 have shown that a significant proportion of married women were using less reliable contraceptive methods resulting in unintended pregnancies.

Moreover, it has been cited in the ICPD Programme of Action 1994 that **"**All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. (Paragraph 7.16)"

Hence, the scope of this survey was designed to gather information on a broad range of areas including knowledge, use, and preference for methods; to identify women who may need services; to reveal hindrances to the use of services; and to uncover opportunities to make quality services available on sexuality, child bearing, child 'rearing and health care

1.2 Objectives of the Survey

The primary aim of the 2014 CPS was to provide up-to-date information on the use of contraceptive methods for Islands of Mauritius and Rodrigues. This main aim was pursued through the following objectives:

1) To measure the change in contraceptive prevalence rate;
2) To identify the reasons for use and non-use of contraceptives;
3) To identify future intentions of contraceptive use; and
4) To formulate recommendations.

RESEARCH METHODOLOGY 2

2.0 Introduction

This chapter describes and explains the methodology deployed in this study to address the aims and objectives enumerated in chapter 1. It explores several aspects of contraceptive prevalence surveys (CPS) laying down the useful guidelines regarding the research process including data collection, analysis and interpretation of data in a systematic way.

2.1 Research Design

The research design refers to the conceptual structure within which the research would be conducted. For this study, a cross-sectional household-based survey of both quantitative and qualitative nature was undertaken in Mauritius and Rodrigues employing a structured questionnaire that overlapped into both inductive and deductive processes, thus, providing an in-depth analysis to address the aim and objectives of the study.

2.2 Sampling Design

The sampling frame of this study constituted of both single and married women aged 15 to 49 years in Mauritius and Rodrigues. Respondents from both the rural and urban areas in all the nine districts of Mauritius were selected and as regards to Rodrigues, all the health zones were studied.

The sampling technique applied was a nationally representative probability sample drawn from a multistage method. At the first stage in Mauritius, a total of 48 enumeration areas (EAs) were randomly selected as primary sampling units (PSUs) so that the number of EA per district is proportional to the population size of each district. In each EA, a listing of all households was carried out followed by a stratified sampling to select 35 women (30 ever-married and 5 never married) aged between 15 and 49 years for interview. Therefore, 48 EAs from 9 districts yielded a sample size of 1680 women. On the other hand, same technique was applied for Rodrigues to select 20 EAs from which 20 women (16 ever-married and 4 never married women) were randomly selected from each EA. The sample amounted to 400 respondents. Thus, a total sample size of 2,080 women aged 15 to 49 years were studied in Mauritius and Rodrigues.

The sample size was calculated from a study population of 342,038 women aged 15-49 years (SM, 2010) using the statistical formula, as shown below:

$$n \geq \frac{Z^2Pq}{d^2}, \text{ where}$$

n = minimum sample size.

Z = level of confidence of 95% or 2.

P = estimate of contraceptive use (75%).

q = proportion of non-use (25%).

d = degree of precision or error of 2.5%.

So, the minimum sample size amounted to: $n \geq \frac{2^2 \times 75 \times 25}{2.5^2} \geq 1{,}200$

Therefore, the overall sample size amounting to 2,080 women was adequate for generalization of the survey findings allowing in-depth analysis and cross tabulation of variables.

Moreover, sample weights were taken into account for correcting any bias that would result from ignoring the variation in sampling fractions that are used in the survey.

2.3 Data Collection Methods and Techniques

A pre-designed and pre-coded questionnaire was conducted face to face interviews for collecting responses from the subject selected for the study. The questionnaire was transliterated in the Creole dialect so as to maintain standardization in the administration of the questions. Hence, response bias was minimized.

2.3.1 Research Instrument

The questionnaire included narrative responses relevant to the main aim and objectives that were analyzed to obtain insights from the respondents laying emphasis on the six components to quality family planning care

a) Choice of contraceptive methods
b) Information given to the users
c) Provider competence
d) client/provider relations
e) Re-contact and follow-up mechanisms, and
f) An appropriate constellation of services

Figure 1 depicts the conceptual framework including both the dependent and independent variables which were used to develop the questionnaire.

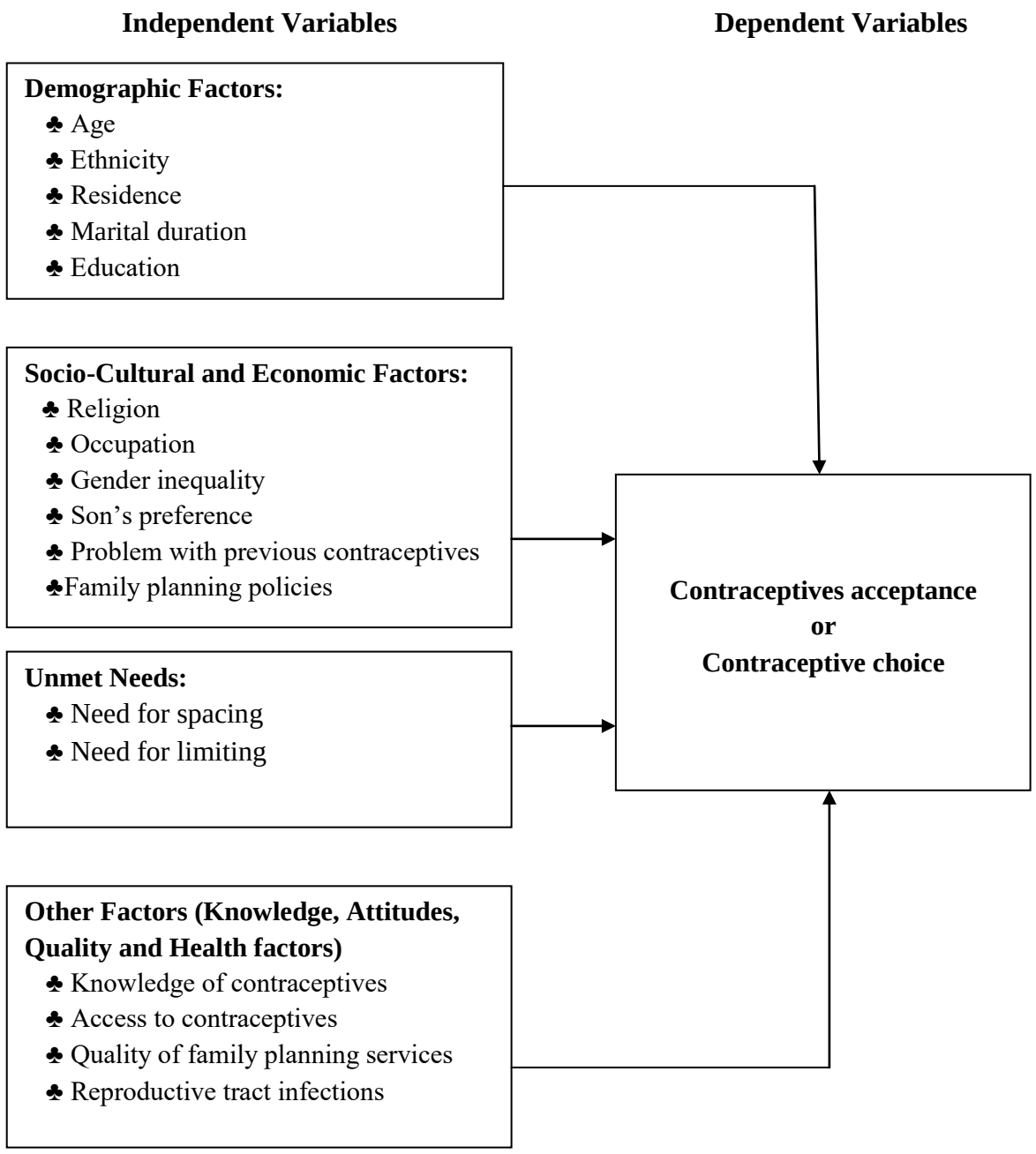


Figure 1: The Conceptual Framework for Determining Contraceptives Acceptance, Choice and Condom Usage

2.3.2 Data Collection

The study was conducted from July to September 2014 covering a total of 2080 respondents. Trained interviewers contacted the selected respondents for interviews at their place of residence.

Prior to the interviews, several materials were developed for use in training the personnel involved in the fieldwork. An interviewer's manual, including general guidelines for conducting an interview as well as specific instructions for asking each of the questions in the questionnaires, was prepared and given to all field staff

2.3.3 Response Rate

A high response rate is the key to legitimizing a survey's results. Thus, one of the main aims of the investigators was to promote a high participation rate. Almost all the respondents who were selected to participate and who could be reached agreed to be interviewed and those who were not willing to contribute were randomly replaced from the population. Therefore, a response rate of 100% was achieved.

2.3.4 Validity and Reliability

Validity entails the extent to which a questionnaire or test measures what it purports to measure and reliability relates to consistency of results over a period of time. Hence, consideration regarding validity and reliability were taken into account for this study.

2.3.4.1 Pre testing

A pre-testing of the questionnaire was carried out in order to check for glitches in wording of the questions, lack of clarity of instructions and any other loopholes or flaws in the questionnaire that could impede the instrument's ability to collect data. Also, the time taken to administer the questionnaire was estimated. The recommendations and suggestions following the pre-testing were considered in order to bring minor changes and corrections to the questionnaire.

2.3.4.2 Reliability of Data

To ensure the reliability of data, the investigators and supervisors closely monitored the data collection exercise. Completed questionnaires were checked for completeness and consistency and any missing or ambiguous information entailed a revisit to the respondent.

2.4 Data Analysis

After the completion of data collection exercise, all duly filled questionnaires were edited before they were captured on computers. The data was cleaned for typing errors and inconsistencies and for analysis SPSS software version 18.0 was used. The findings were assessed for reliability and comparability and presented as text, graphs and tables.

2.5 Results Development

After analysis of the data, the investigators wrote this report based on the findings of the survey and related secondary data and have formulated some recommendations. The report was subsequently submitted to the Ministry of Health and Quality of Life (Government of Mauritius) after final approval of the relevant Steering Committee.

2.6 Ethical Considerations

Before its implementation, permission to conduct the study was sought from the ethical committee of the Ministry of Health and Quality of Life through the Director General Health Services and the Island Commissioner of Rodrigues was informed accordingly.

Participation of the interviewees in the study was on a voluntary basis and the objective of the study was clearly explained to the participants. The respondents' right was protected while collecting data by informed consent and confidentiality throughout the survey and the collected data was used only for the purpose of this study only.

SECTION A
ISLAND OF MAURITIUS
2014 CPS

CHARATERISTICS OF HOUSEHOLDS 3

3.0. Introduction

This chapter provides an overview of the profile of the 2014 CPS household sample. For the 2014 CPS, a household was defined as a person or a group of persons, related or unrelated, who live together in the same dwelling unit and share a common source of food. Information is presented on the housing facilities and household possessions.

3.1 Dwelling Characteristics

Table 1 shows that 11.7 percent of the households lived in dwellings with one or two rooms, 45.9 percent had three or four rooms and 42.4 percent had five rooms or more. Likewise, 7.5 percent of the households comprised of one or two people, 58.2 percent comprised of three to four people, and 34.3 percent comprised of five people or more. Moreover, 53.6 percent of the households had three or more sleeping rooms while the rest had less than three sleeping rooms.

3.2 Access to Drinking Water

Use of improved drinking water has increased in all regions of the world since 1990, however significant proportions of the population in sub-Saharan Africa and Oceania continue to use rivers, lakes, ponds and irrigation canals as their main source of drinking water (UNICEF and WHO, 2015). Increasing access to improved drinking water is one of the Millennium Development Goals (MDGs) and in order to improve the overall efficiency of water supply in Mauritius, the government has set up a plan to facilitate the optimum use of the existing infrastructure and ensure sustainable and cost effective development of future infrastructure by 2025 (MDG Status Report, 2013). The source of drinking water is a vital indicator of whether it is suitable for drinking. Improved sources include a piped source within the dwelling, yard, or plot; a public tap/stand pipe or a borehole; a protected well or spring; and rainwater (WHO and UNICEF, 2010). As illustrated in table 1, all the households in Mauritius have access to an improved source of drinking water and the most common source of improved drinking water is piped inside the dwelling unit (93.7%).

3.3 Sanitation Facilities and Waste Disposal

Ensuring adequate sanitation facilities is another Millennium Development Goal and a household is classified as having an improved toilet if the toilet is used only by members of one household (i.e., it is not shared) and if the facility used by the household separates the waste from human contact (WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, 2004). Table 1 indicates that all the households had access to an improved toilet facility. 54.5 percent of the households reported that the toilet was connected to an absorption pit, 35.3 percent were connected

to sewage, 8.2 percent were connected to a septic system and 2 percent of the household had pit latrine.

Table 1: Dwelling characteristics of households

Characteristics	Household		
	Weighted percentage	Weighted number	Unweighted number
Number of people			
1-2	7.5	125	123
3-4	58.2	977	987
> 5	34.3	578	570
Number of rooms			
1-2	11.7	196	218
3-4	45.9	772	773
> 5	42.4	712	689
Number of sleeping rooms			
One	9.5	159	180
Two	36.9	620	646
Three or more	53.6	901	854
Sources of drinking water			
Piped inside housing unit	93.7	1574	1579
Piped outside on premises	6.0	100	98
Public fountain	0.2	4	2
Tank wagon	0.1	2	1
Type of toilet facilities			
Flush connected to sewerage	35.3	592	574
Flush connected to absorption pit	54.5	916	931
Flush connected to septic tank	8.2	138	139
Pit latrine	2.0	33	36
Total	**100.0**	**1,680**	**1,680**

2014 CPS, Mauritius

3.4 Household Possessions

The possession and use of household durable goods have multiple effects and implications. Having access to a radio or television exposes household members to updated daily events, information, and educational materials. Likewise, a refrigerator prolongs food storage and keeps food fresh and hygienic. A means of transportation allows greater access to services away from the local area and enhances social and economic activities.

Table 2 provides information on household possessions. 98.3 percent of the households owned a television, 68.8 percent of households had fixed telephone and 96.4 percent owned a mobile phone. Notably, 55.8 percent of the households were connected to the Internet and 63.5 percent owned a personal computer or laptop. 79.8 percent owned a washing machine and 59.6 percent of the households had a water tank. In addition, 42.0 percent of the households had a means of transportation.

Table 2: Household possessions

Possession	Household		
	Weighted percentage	Weighted number	Unweighted number
Television	98.3	1651	1650
Fixed Telephone	68.8	1155	1131
Car//Van//Double Cab	42.0	706	726
Personal Computer//Laptop	63.5	1067	1019
Internet	55.8	937	879
Cable TV Channels	52.4	881	859
Dishwashing Machine	2.0	33	32
Washing Machine	79.8	1341	1350
Air Conditioner	17.4	292	294
Clothes Dryer	1.0	17	19
Water Tank	59.6	1001	1003
Secondary Vacation Home	2.1	35	38
Mobile Phone	96.4	1620	1619

2014 CPS, Mauritius

BACKGROUND CHARACTERISTICS OF RESPONDENTS 4

4.0 Introduction

This chapter provides an overview of the profile of the sample who was interviewed in the survey and their characteristics are summarized in table 3. The participants were asked to provide information about socio-demographic data such as religion, age, marital status, educational level, occupation and socio economic status.

4.1 Socio-demographic Profile of Respondents

Background characteristics of all women and currently married women age 15-49 years interviewed in the 2014 CPS are presented in Table 3. Overall, 29.1 percent of the respondents were young adults (aged 15–24) at the time of interview.

Education is an important factor in influencing an individual's attitude and outlook on various aspects of life. Generally, educational attainment in Mauritius is high. Data on level of educational attainment was categorized into three groups: less than completed primary schooling; completed primary schooling; and more than completed primary schooling. The first group includes those who did not have formal education as well as those who had some primary schooling and the second group includes those who have completed primary schooling. The third group includes those who have some secondary schooling, pre-vocational education, completed secondary schooling and tertiary or vocational education. The 2014 CPS reveals that the majority of respondents have received education beyond primary level (79.9 percent).

Table 3 also shows that 53.6 percent of respondents are Hindus and 57.6 percent are rural dwellers. The household socio-economic status (SES) is a composite measure and is calculated by assigning weights to reported ownership of household durable goods and household characteristics of respondents. These weights are then scored for each respondent and categorized by low, middle and high status according to the respondent's total score. The 2014 CPS results reveal that 63.0 percent of respondents are living in middle-SES households.

Overall, 61.9 percent of respondents are currently married[1](57.9 percent are married legally/religiously and 4.0 percent are in consensual union), 2.3 percent are widowed, 4.5 percent are divorced or separated, and 31.3 percent have never been married. Data on occupation was categorized into four groups: professional/technical[2]; service worker[3]; manual worker[4]; and

[1] Currently married women are women who have been legally/religiously married and are not either divorced, widowed or separated. Women living in consensual unions are also included in this category. The terms 'currently married' and 'currently in union' have been used interchangeably in this report.

[2] Includes managers, professionals and technicians (teachers, accountants, nurses, clerks and police officers etc.). It should be pointed out that the term "professionals" has been used in this report and it refers to the "professional/technical" group.

[3] Includes sales and craft and related trade workers (hairdressers and counter cashiers etc.).

[4] Includes skilled agricultural workers and export oriented enterprise manual workers (machine operators and assemblers etc.).

homemaker/student. Data from the 2014 CPS reveal that the majority of respondents are homemakers/students (50.7 percent).

Table 3: Percent distribution of women age 15-49 years by selected background characteristics

Background characteristics	All women age 15-49			Currently married women age 15-49		
	Weighted percentage	Weighted number	Unweighted number	Weighted percentage	Weighted number	Unweighted number
Age group						
15-19	15.2	255	132	1.5	16	22
20-24	13.9	233	193	7.7	80	94
25-29	13.7	230	213	14.6	152	172
30-34	15.5	260	297	20.5	214	278
35-39	13.2	221	301	18.1	188	280
40-44	13.4	226	262	18.1	188	235
45-49	15.2	255	282	19.4	202	242
Occupation						
Professional/Technical	19.2	322	311	18.8	196	250
Service worker	17.8	299	319	20.0	208	266
Manual worker	12.3	207	235	14.4	150	191
Homemaker/Student	50.7	852	815	46.8	486	616
Religion						
Hindu	53.6	900	895	53.4	556	708
Muslim	21.2	356	362	21.7	226	289
Christian	25.2	424	423	24.9	258	326
Education						
Less than completed primary	7.9	132	141	9.1	95	120
Completed primary	12.3	206	249	16.6	172	223
More than completed primary	79.9	1,342	1,290	74.3	773	980
Residence						
Urban	42.4	712	700	41.2	429	546
Rural	57.6	968	980	58.8	611	777
Household socio-economic status						
Low	18.8	316	332	19.6	203	258
Middle	63.0	1,059	1,043	61.6	640	814
High	18.2	305	305	18.9	197	251
Marital status						
Currently married (legal/religious)	57.9	972	1,240	93.5	972	1,240
Consensual union	4.0	68	83	6.5	68	83
Widowed	2.3	38	38	N.A	N.A	N.A
Divorced/Separated	4.5	76	76	N.A	N.A	N.A
Never married	31.3	526	243	N.A	N.A	N.A
Total	**100.0**	**1,680**	**1,680**	**100.0**	**1,040**	**1,323**

2014 CPS, Mauritius

4.2 Educational Attainment by Background Characteristics

The importance of mother's education for child health and nutrition has been well documented. Evidence shows that educational attainment of the mother plays an important role in determining child survival. Emina et al. (2009) observed that children whose mothers are educated tend to live in more hygienic environments and are more likely to be vaccinated and have better nutritional outcomes. Other studies have shown that more educated women have longer birth intervals and give birth at low risk ages (Mukuria et al. 2005), and their children tend to have better nutritional outcomes.

Table 4 shows the distribution of currently married women age 15-49, by their educational attainment, according to background characteristics. The proportion of women with less than completed primary schooling increases steadily with age; from 5.9 percent among those aged 15-19 to 13.9 percent among those aged 45-49. By contrast, women in lower age group are more likely to have secondary education or higher.

Data from table 4 also reveals that women who reside in urban areas are much more likely to have higher levels of educational attainment than their rural counterparts (82.1 percent versus 68.9 percent).

Likewise, the level of education increases with increasing socio-economic status. Women with high socio-economic status are much more likely to have higher levels of educational attainment, from 53.7 percent in the low socio-economic status to 91.9 percent in the high socio-economic status.

Table 4: Percent distribution of currently married women age 15-49 by highest level of education attended or completed, according to background characteristics

Background Characteristics	Highest level of education			Total	Weighted number of women
	<completed primary	completed primary	>completed primary		
Residence					
Urban	4.4	13.5	82.1	100.0	429
Rural	12.3	18.8	68.9	100.0	611
Age group					
15-19	5.9	5.9	88.2	100.0	16
20-24	3.7	2.5	93.8	100.0	80
25-29	3.3	8.6	88.1	100.0	152
30-34	9.3	17.8	72.9	100.0	214
35-39	6.9	21.2	72.0	100.0	188
40-44	13.3	18.6	68.1	100.0	188
45-49	13.9	21.9	64.2	100.0	202
Socio-economic status					
Low	22.2	24.1	53.7	100.0	203
Middle	7.7	16.9	75.5	100.0	640
High	.5	7.6	91.9	100.0	197
Total	**9.1**	**16.6**	**73.3**	**100.0**	**1040**

2014 CPS, Mauritius

4.3 Exposure to Mass Media

Exposure to information on television and radio can increase people's knowledge and awareness of new ideas, social changes, and opportunities as well as affect their perceptions and behaviours, including those related to health. The 2014 CPS collected information on the exposure of respondents to the common electronic media. Respondents were asked whether they have heard or saw a family planning message on radio or television. This information is important to determine the media channels to use in disseminating health information to targeted audiences.

Table 5 shows the percentage of currently married women age 15-49, who were exposed to different types of media by background characteristics. Overall, 57.3 percent of women have heard or saw a family planning message on both radio and television. 56.3 percent of the women were more likely to use radio as compared to television (52.6 percent).

The use of radio and television was relatively same among both urban and rural areas (57 percent and 47 percent, respectively). Considering the differentials in table 5, there is small variation in the percentage of women who watch television or listen to radio by age group. The proportion of women using radio and television to hear or see a family planning message increases steadily with level of education and socio economic status.

Table 5: Percentage of currently married women age 15-49 who are exposed to radio or television, by background characteristics (n=1033*)

Background Characteristics	Radio	Television	Both radio and TV
Residence			
Urban	56.6	47.7	41.5
Rural	56.7	46.6	42.8
Age group			
15-19	60.0	43.8	43.8
20-24	51.3	41.0	33.3
25-29	57.6	50.0	43.4
30-34	57.9	48.6	45.3
35-39	56.4	47.3	44.1
40-44	58.3	50.8	45.5
45-49	55.6	41.9	37.4
Socio-economic status			
Low	51.5	43.3	38.5
Middle	58.5	48.9	44.3
High	56.3	44.7	39.8
Education			
Less than completed primary	50.0	40.2	35.9
Completed primary	51.2	38.4	35.5
More than completed primary	58.8	49.9	44.7
Total	**56.3**	**52.6**	**57.3**

**7 missing cases*

2014 CPS, Mauritius

4.4 Employment Status

Employment status may have implications for an individual's health status. Worldwide priorities in women's health have themselves been changing from a narrow focus on maternal and child health to the broader framework of sexual and reproductive health and to the encompassing concept of women's health, which is founded on a life-course approach. Employment increases household income and decreases economic hardship, both of which improve physical and psychological well-being. Numerous studies have demonstrated that poverty leads to poor health status (Thompson, Wells, & Coats, 2012).

Table 6 shows the percent distribution of 2014 CPS respondents according to current employment. Overall, 51.5 percent of women were currently engaged in some economic activity. Table 6 also indicates that the proportion of women who were currently employed increased with age, peaking in the 40-44 age group. With regard to the other employment differentials presented in table 6, women living in urban areas, women who completed secondary school or higher, and women in the highest socio economic status were much more likely to be currently employed than other women.

Table 6: Percent distribution of currently married women age 15-49 by employment status, according to background characteristics

Background Characteristics	Currently employed	Not Currently employed	Missing	Total	Weighted number of women
Residence					
Urban	57.1	1.4	41.5	100.0	429
Rural	47.5	2.1	50.4	100.0	611
Age group					
15-19	12.5	12.5	75.0	100.0	16
20-24	40.0	0.0	60.0	100.0	80
25-29	50.3	2.6	47.1	100.0	152
30-34	54.0	3.3	42.7	100.0	214
35-39	56.4	0.5	43.1	100.0	188
40-44	58.2	1.1	40.7	100.0	188
w45-49	46.0	2.0	52.0	100.0	202
Socio-economic status					
Low	41.4	3.4	55.2	100.0	203
Middle	51.3	1.2	47.5	100.0	640
High	63.0	2.0	35.0	100.0	197
Education					
Less than completed primary	36.8	3.2	60.0	100.0	95
Completed primary	43	1.7	55.3	100.0	172
More than completed primary	55.1	1.7	43.2	100.0	773
Total	**51.5**	**1.8**	46.7	**100.0**	**1040**

2014 CPS, Mauritius

4.5 Occupation

Apart from occupation exerting a causal effect on health, the strong correlation between occupation and health may stem from reverse causality, with health constraining occupational choice. Moreover, occupation has an important position within the social structure, which defines access to resources and constraints that can have implications for health and mortality. Case and Deaton (2005) shows that the self-reported health of manual workers is lower and declines more rapidly with age than that of non-manual workers. In the 2014 CPS, respondents who were employed were asked to specify their occupation.

Table 7 shows the percent distribution of currently married women age 15-49 employed by occupation, according to background characteristics. Data from table 7 also reveals that only 18.8 percent of women are employed in professional or technical positions. Respondents age 15-19 (68.8 percent) are more likely to be homemaker as compared to the older respondents.

As expected, rural women are substantially more likely to work as manual worker and homemaker (16.0 percent and 50.2 percent, respectively) than their urban counterparts (11.9 percent and 41.3 percent, respectively). Similarly a much higher percentage of respondents living in urban areas are more likely to work in the professional/technical and service sectors (25.4 percent and 21.2 percent, respectively), as compared to the rural respondents (14.2 percent and 19.1 percent, respectively).

Women with higher levels of educational attainment are most likely to work in the professional or technical sector (24.9 percent). By contrast, respondents with less than primary education are most likely to work as homemaker (56.4 percent). The reason is probably that women with less education have few employment opportunities, while it is easier for educated women to obtain employment in better sectors.

54.9 percent of women in the lowest socio economic group work as homemaker as compared to women in the highest socio economic group (35.2 percent). Women with the highest socio economic status are most likely to be employed in sales and services (42.9 percent) as compared to only 1.5 percent with the lowest socio economic status.

Table 7: Percent distribution of currently married women age 15-49 employed by occupation, according to background characteristics

Background Characteristics	Professional / Technical	Service worker	Manual worker	Homemaker	student	Total	Weighted number of women
Residence							
Urban	25.4	21.2	11.9	41.3	0.2	100.0	429
Rural	14.2	19.1	16.0	50.2	0.3	100.0	611
Age group							
15-19	6.3	12.5	6.3	68.8	6.3	100.0	16
20-24	10.0	18.8	11.3	58.8	1.3	100.0	86
25-29	24.2	19.6	9.2	46.4	0.7	100.0	163
30-34	20.6	23.8	12.6	43.0	0.0	100.0	231
35-39	21.4	21.9	13.4	43.3	0.0	100.0	206
40-44	20.6	18.5	20.1	40.7	0.0	100.0	213
45-49	13.3	17.2	17.7	51.7	0.0	100.0	239
Socio-economic status							
Low	1.5	18.6	24.5	54.9	0.5	100.0	203
Middle	16.9	21.7	13.9	47.3	0.2	100.0	640
High	42.9	15.8	5.6	35.2	0.5	100.0	197
Education							
Less than completed primary	0.9	13.7	29.1	56.4	0.0	100.0	95
Completed primary	0.0	16.6	28.7	54.5	0.0	100.0	172
More than completed primary	24.9	22	11.1	41.7	0.2	100.0	773
Total	**18.8**	**20**	**14.4**	**46.5**	**0.3**	**100.0**	**1040**

2014 CPS, Mauritius

FERTILITY 5

5.0 Introduction

Population growth and decline, mainly affected by fertility, is also a concern for planners and programmers, as well as policy makers. It is one of the principal components of population dynamics that determine the size, structure, and composition of the population in any country. Fertility varies between countries, mainly due to differences in cultural, economic and health factors which interfere with the process of human reproduction. In recent decades, the growth of the developing world population has considerably outpaced that of high income countries. The highest growth rates of population are almost entirely concentrated in poor countries, whereas the smallest rates of population growth are observed in most of the developed countries. Africa has the highest rate of fertility and the largest percentage of population growth. Most of the population in Africa is very young (Population Reference Bureau, 2009).

5.1 Current Fertility Levels

The level of current fertility is one of the most important topics in this report because of its direct relevance to population policies and programmes. Mauritius has witnessed a rapid fertility decline within a short period of time: from 6 births per woman in the 60s to less than 2 births per woman at present. The total fertility rate (TFR) represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.

Table 8 shows that the TFR for Mauritius for the three-year period preceding the 2014 CPS is 1.38 children per woman, which is lower than the TFR measured for the three-year period preceding the 2002 CPS (1.97 children per woman).

Moreover, according to the digest of demographic statistics (2014), it is noted that the TFR has been declining over the last decade from 1.88 in 2005 to 1.40 in 2014. Hence, the TFRs measured from the two different sources, i.e. from the CPS and demographic statistics, are showing not only a downward trend in fertility but also that the fertility level is well below the replacement level[5] of 2.1 children per woman.

The Total Fertility Rate for Mauritius for the three-year period preceding the 2014 CPS is 1.38 children per woman

***Fertility level is below the replacement level of 2.1 children per woman**

2014 CPS, Mauritius

[5] Replacement level fertility is the total fertility rate at which a population exactly replaces itself from one generation to the next, without migration.

5.2 Fertility by Background Characteristics

Fertility is known to vary by background characteristics; therefore, it is crucial to study the relationship between these characteristics and fertility. Table 8 shows the total fertility rate by background characteristics and it is observed that fertility is slightly higher in urban areas (1.44 births per woman) than in rural areas (1.33 births per woman). The data also reveals that Christians have more children (1.94) than Muslims (1.40) and Hindus (1.15).
It is also noted that women living in high-SES households have fewer children (1.28) than women living in low-SES households (2.03).

Table 8: Total fertility rate for the three years preceding the survey by selected background characteristics, 2014 CPS

Background characteristics	Total Fertility Rate*
Residence	
Urban	1.44
Rural	1.33
Religion	
Hindu	1.15
Muslim	1.40
Christian	1.94
Household socio- economic status	
Low	2.03
Middle	1.23
High	1.28
Total	**1.38**

*Rate is for women 15-49 years

2014 CPS, Mauritius

5.3 Children Ever Born and Living

Data on the number of children ever born reflect the accumulation of births to women over their entire reproductive years and therefore have limited reference to current fertility levels, particularly when the country has experienced a decline in fertility. Table 9 shows the distribution of women by the number of children ever born, as well as the average number of children ever born and those still surviving by women's age.

Overall, it is observed that women in the sample have given birth to an average of 2.04 children. Out of that number, 2.0 children are still alive, indicating that around 2 percent of the children ever born to 2014 CPS respondents have died.

Reflecting the natural family-building process, the number of children that women have borne increases with woman's age from an average of 1.51 births among women age 25-29 to an average of 2.44 births among women 45-49. Likewise, the likelihood of a woman's children death also

increases with woman's age from an average of 0.02 children or around 1 percent death among women age 25-29 to an average of 0.08 children or 3 percent death among women age 45-49.

Table 9: Median age at first sexual intercourse and median age at first marriage among women age 25-49 years up

Age	Number of children ever born									number of women	mean number of children born	mean number of living children
	0	1	2	3	4	5	6	8	Total			
15-19	36.4	50.0	13.6	0.0	0.0	0.0	0.0	0.0	100.0	16	1.06	1.06
20-24	38.2	37.8	21.1	1.0	2.0	0.0	0.0	0.0	100.0	86	1.23	1.23
25-29	25.2	38.8	28.3	6.9	0.8	0.0	0.0	0.0	100.0	163	1.51	1.49
30-34	11.5	27.6	46.9	11.7	2.0	0.3	0.0	0.0	100.0	231	1.85	1.82
35-39	6.1	20.6	45.5	23.1	4.0	0.7	0.0	0.0	100.0	206	2.12	2.09
40-44	5.6	12.0	49.7	25.2	4.1	2.6	0.7	0.0	100.0	213	2.33	2.29
45-49	4.4	9.9	49.5	27.7	5.7	2.0	0.3	0.3	100.0	239	2.44	2.36
Total	**12.2**	**22.5**	**42.7**	**17.9**	**3.3**	**1.1**	**0.2**	**0.1**	**100.0**	**1154**	2.04	2.00

2014 CPS, Mauritius

5.4 Age at First Birth

Age at first birth plays a significant role in the future life of each individual woman and possesses a direct relationship with fertility. The age at which child bearing begins influences the number of children a woman bears throughout her reproductive period, in other words, the whole reproductive life span. Thus, the mother's age at first birth influences the total number of births that she might have in her life, which impacts the size, composition, and future growth of the population (Mathews and Hamilton, 2009). Moreover, social organizations as well as cultural settings have an influence on the pace of family formation and childbirth (Falls, 2007).

Table 10 presents the distribution of women by age at first birth, according to their current age. For women under age 25, the median age at first birth is not shown because less than 50 percent of women in those ages had given birth at the time of the survey. Overall, the median age at first birth is 22.9 years for women 25-49. The median age at first birth has declined over time from 23.7 years among women age 45-49 years to 22.5 years among women age 25-29 years.

Table 10: Median age at first birth among women age 25 – 49 years

Age group	Median age at first birth (years)
25-29	22.5
30-34	22.7
35-39	22.8
40-44	22.3
45-49	23.7
25-49	**22.9**

2014 CPS, Mauritius

5.4.1 Age at First Birth by Background Characteristics

Table 11 shows that the median age at first birth by background characteristics. The median age at first birth is relatively same for both urban and rural areas. The median age at first birth increases with socio economic status, with the impact of socio economic status more pronounced among women with high socio economic status. Women with low socio economic status (21.8 percent) give birth to their first child about two years earlier than women with high socio economic status (23.9 percent). The median age at first birth is lower among women who have less than completed primary education as compared to the other counterparts.

Table 11: Median age at first birth among women age 15-49 years and 25-49, according to background characteristics

Background Characteristics	Women age 25-49
Residence	
Urban	23.5
Rural	22.4
Socio-economic status	
Low	21.8
Middle	23.0
High	23.9
Education	
Less than completed primary	20.4
Completed primary	22.1
More than completed primary	23.3
Total	**22.9**

2014 CPS, Mauritius

5.5 Teenage Pregnancy and Motherhood

The issue of adolescent fertility is crucial on both health and social grounds. Globally, it is estimated that 16 million girls aged 15-19 give birth each year (World Health Organization, 2011). It is well documented that teenage mothers are at risk for long-term problems in many areas of life, including school failure, poverty and physical illness. Likewise, there is growing evidence that associations between teenage motherhood and poor health outcomes can be explained by young mothers' long-term socioeconomic disadvantage (Smith, 2009).

Figure 2 highlights the percent distribution of women age 15-19 who are mothers or who are pregnant with their first child at the time of the 2014 CPS. Overall, 12.1 percent of teenagers have already begun childbearing[6]: 10.6 percent are already mothers and 1.5 percent are pregnant with their first child. This proportion has increased from 10.9 percent in 2002 to 12.1 percent in 2014.

Figure 2 also indicates that 13.8 percent of teenagers in rural areas have already begun childbearing (i.e. already mothers or pregnant with their first child) compared with 8.9 percent of teenagers in urban areas[7] in 2014.

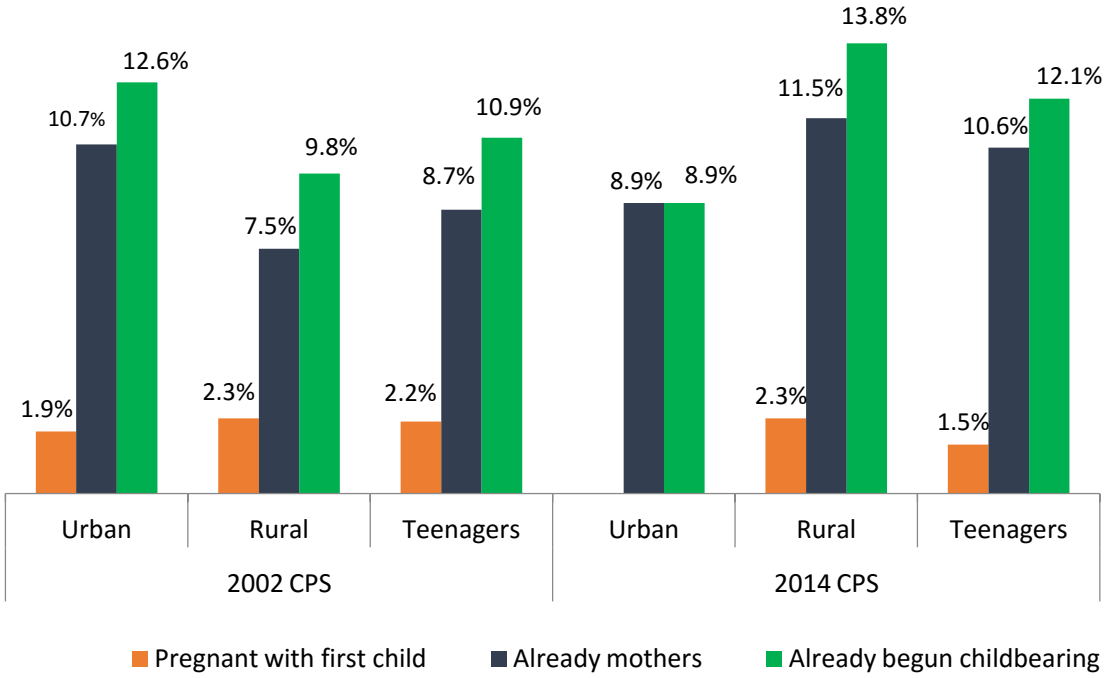


Figure 2: Percent distribution of teenagers age 15-19 years who are mothers or pregnant with their first child by residence

2014 CPS, Mauritius

[6] All these teenagers (who have already begun childbearing) are currently in union.

[7] There were no reported cases of teenagers living in urban areas who were pregnant with their first child at the time of the 2014 CPS.

5.6 Premarital Conception

The rise in premarital conceptions, brought about by the changing mores, could have compounding effects on subsequent fertility that could offset the modest declines in overall fertility presently achieved. Kaljee et al (2007) highlighted that the consequences of premarital sexual involvement are damaging on many levels. On an emotional level they often include a profound sense of guilt, shame and regret. On a physical level they often include HIV, STIs, unwanted pregnancy and, on a social level, stigmatization.

Figure 3 shows that premarital conception[8] has slightly increased from 10.1 percent in 2002 to 13.4 percent in 2014 among currently and formerly married women age 15-49 years.

The results of the 2014 CPS also indicate that the proportion of first born babies born before first union has increased from 3.4 percent in 2002 to 5.0 percent in 2014 and the proportion of first born babies born within the first 7 months of first union has increased from 6.7 percent in 2002 to 8.4 percent in 2014**.**

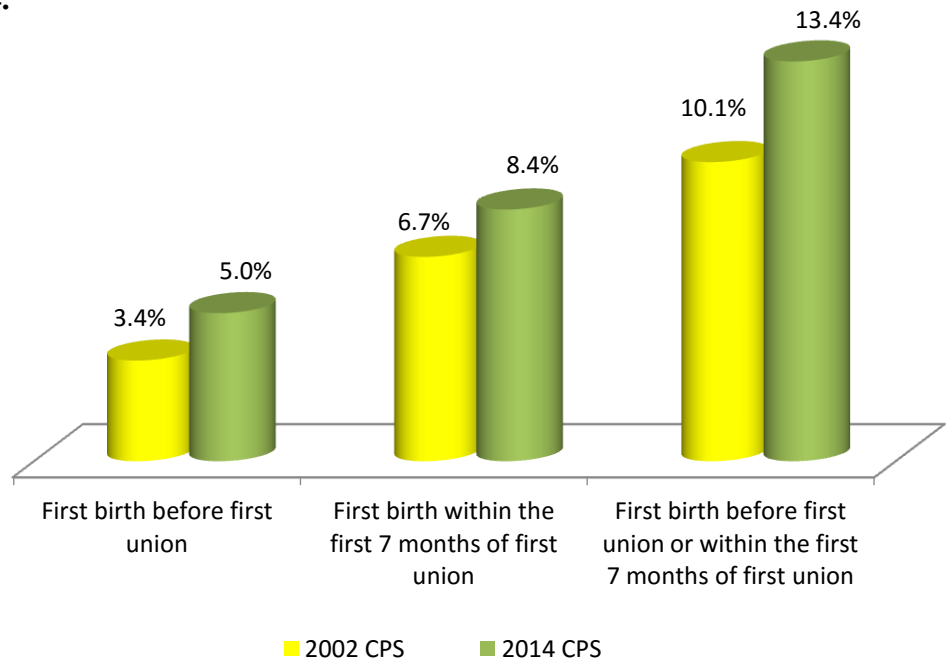


Figure 3: Percent distribution of respondents whose first birth occurred before first union or within the first 7 months of first union among ever-married women age 15-49 years

2014 CPS, Mauritius

Table 12 shows the percent distribution of ever-married women age 15-49 years whose first birth occurred before first union or within the first 7 months of first union, by selected demographic characteristics. It is observed that the proportions of first birth before first union for rural and urban women are almost the same (5.0 percent). Overall, 27.2 percent of Christians have given a first birth before first union or within the first 7 months of first union compared with 10.2 percent for Hindus and 5.8 percent for Muslims. The proportion of first birth within the first 7 months of first union is

[8] Women who have had a first birth before first union or within the first 7 months of first union.

higher among women who have not completed primary education (9.8 percent) compared with women who have received education beyond primary level (8.2 percent).

Table 12: Percent distribution of ever-married women age 15-49 years whose first birth occurred before first union or within the first 7 months of first union by selected background characteristics

Background characteristics	First birth before first union	First birth within the first 7 months of first union	First birth before first union or within the first 7 months of first union	No. of women
Residence				
Urban	5.1	8.2	13.3	406
Rural	5.0	8.6	13.6	563
Religion				
Hindu	2.9	7.3	10.2	518
Muslim	2.3	3.5	5.8	212
Christian	12.0	15.2	27.2	239
Level of education				
Less than completed primary	5.3	9.8	15.1	88
Completed primary	7.5	8.8	16.3	174
More than completed primary	4.4	8.2	12.6	707
Total	**5.0**	**8.4**	**13.4**	**969**

2014 CPS, Mauritius

5.7 Abortion

Abortion is associated primarily with pregnancies resulting from contraceptive failure and pregnancies among women who did not use contraception even though they did not intend to become pregnant.

Induced abortion plays an important albeit temporary function in the decline in global fertility, though the precise impact is difficult to estimate. Unintended pregnancy and induced abortion can be prevented by expanding and improving family planning services and choices, reaching out to communities and underserved population groups. An increase in contraceptive prevalence and in the use of effective contraceptive methods reduces the incidence of abortion (Singh et al, 2005)

Moreover, the mortality and morbidity risks associated with unsafe induced abortion depend on the facilities and the skill of the abortion provider, the intervention method used, the general health of the woman and the stage of her pregnancy.

Figure 4 shows that the proportion of women age 15-49 years who reported having had at least one abortion (either spontaneous or induced abortion) has increased slightly from 15.5 percent in 2002 to 15.8 percent in 2014. Moreover, it is noted that the proportion of women age 15-49 years who reported having had at least one induced abortion has increased from 3.4 percent in 2002 to 5.0 percent in 2014.

However, like many surveys from other countries where abortion is illegal or restricted, the data on abortion may not be reliable. The CPS results are liable to under-reporting for induced abortion and over-reporting for spontaneous abortion since abortion in Mauritius was not permitted under any circumstances until recently[9].

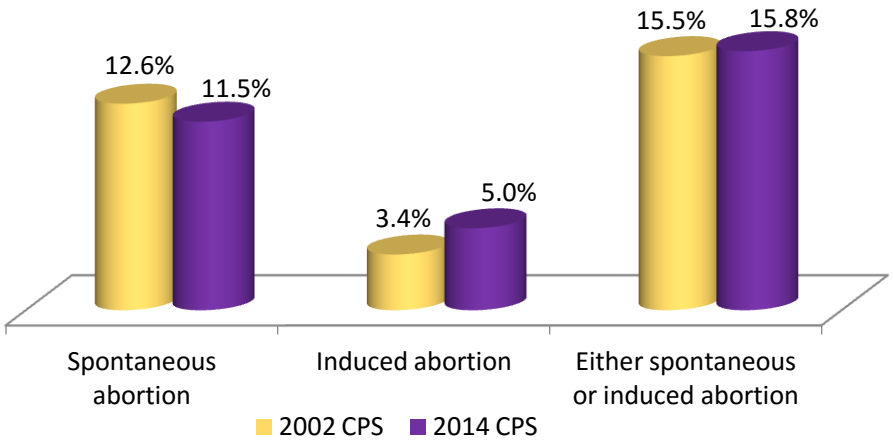


Figure 4: Percent distribution of respondents age 15-49 years who reported having had at least one abortion

2014 CPS, Mauritius

Figure 5 shows that the proportion of women who have had at least one abortion (either spontaneous or induced abortion) is higher among rural women than among urban women (16.7 percent versus 14.5 percent).

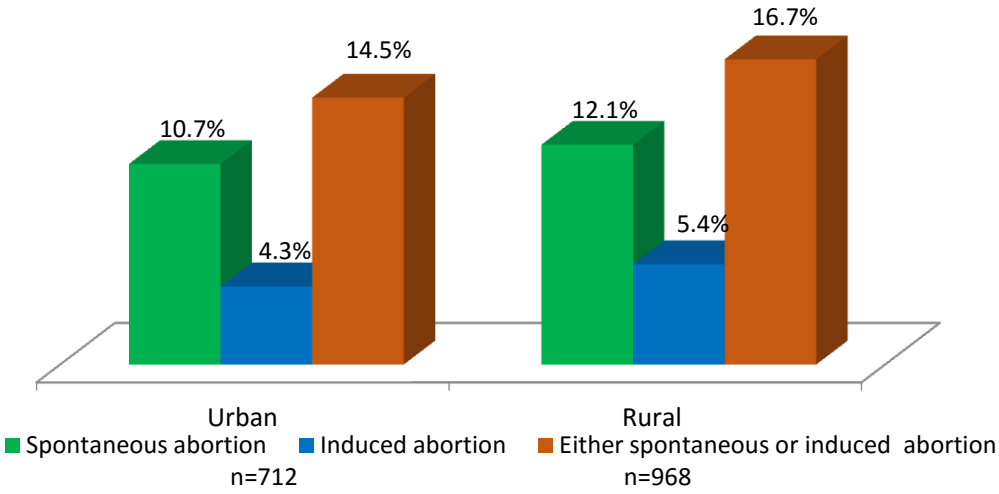


Figure 5: Percent distribution of respondents age 15-49 years who reported having had at least one abortion by residence

2014 CPS, Mauritius

[9] In 2012, the law was amended and abortion is allowed under four specific circumstances: (1) the continued pregnancy will endanger the pregnant person's life (2) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (3) there is a substantial risk that the continued pregnancy will result in a severe malformation of the foetus (4) the pregnancy has not exceeded its fourteenth weeks and results from a case of rape, sexual intercourse with a female under the age of 16 or sexual intercourse with a specified person, which has been reported to the police or medical practitioner.

5.7.1 Respondents age 15-49 years who have had at least one induced abortion

Among those who have had at least one induced abortion, 60.0 percent of them had one abortion, 31.9 percent had 2 abortions and the remainder had 3 or more abortions at the time of the interview. The majority of respondents said that their last induced abortion[10] (65.7 percent) was carried out by a doctor as shown in figure 6.

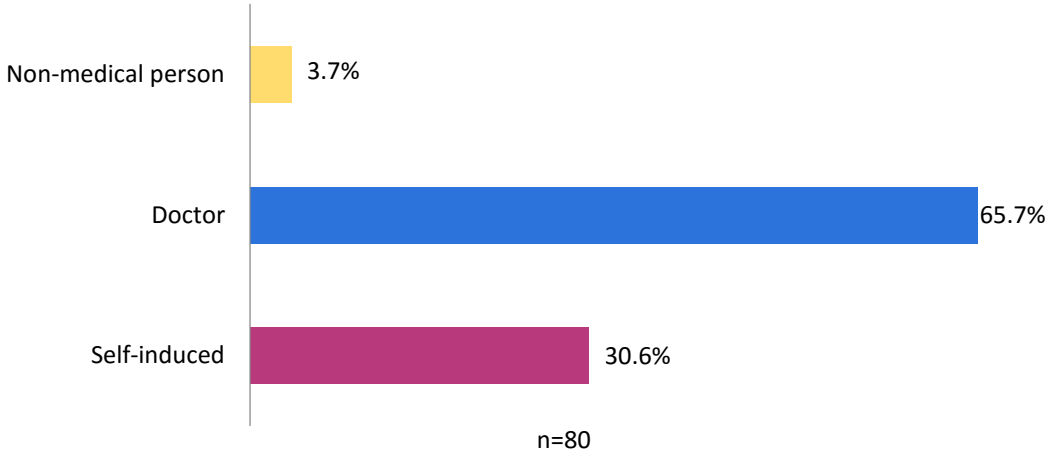


Figure 6: Percent distribution of respondents who have had at least one induced abortion by the person who carried out the last abortion

2014 CPS, Mauritius

Table 13 shows that an equal proportion of respondents cited either "financial problems" (21.4 percent), "did not want (anymore) children" (21.4 percent), or "spacing next pregnancy" (21.3 percent) as the most important reason for having had this last induced abortion.

Table 13: Percent distribution of respondents who have had at least one induced abortion by most important reason cited for having had the last abortion

Most important reason	Percentage
Pregnancy was life/health threatening	7.9
Risk of birth defects	10.3
Financial problems	21.4
Respondent did not want (anymore) children	21.4
Spacing next pregnancy	21.3
Partner did not want (any) children	13.8
Did not have a partner	2.1
Other	1.9
Total	**100.0**

2014 CPS, Mauritius

[10] Only 96.4% of respondents age 15-49 years who reported having had at least one induced abortion answered questions about their last induced abortion.

Respondents were then asked: "What was the attitude of the father towards you having this last abortion?". Overall, 78.4 percent of respondents stated that "the father did not oppose that I was having this last abortion" (Figure 7).

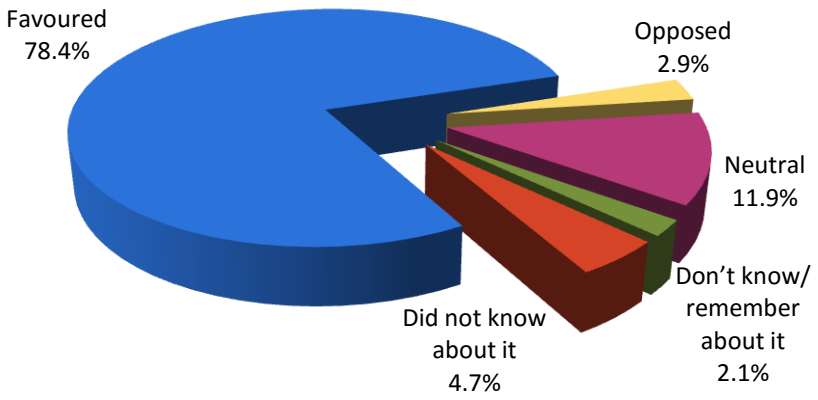


Figure 7: Percent distribution of respondents who have had an induced abortion by the attitude of the father towards respondent having this last abortion

2014 CPS, Mauritius

5.7.2 Opinions on induced abortion among all respondents age 15-49 years

Respondents were asked: "If a woman has an unwanted pregnancy, what should she do?". Overall, 64.2 percent of respondents age 15-49 years thought that she should not have an induced abortion (since 38.0 percent said that she should give the baby up for adoption and 26.2 percent said that she should keep the baby) and 18.6 percent said that she should have an induced abortion. The remainder (17.2 percent) did not know what the woman should do.

However, when asked if a woman should have an induced abortion under certain circumstances, a significant proportion of respondents age 15-49 years (as shown in Figure 8) were in favour of the woman having an induced abortion when:

- Her life is endangered by the pregnancy (82.9 percent);
- Her health is endangered by the pregnancy (76.4 percent);
- The foetus has a deformity (73.9 percent);
- The pregnancy has resulted from rape (65.7 percent); and
- The pregnancy has resulted from incest (64.6 percent).

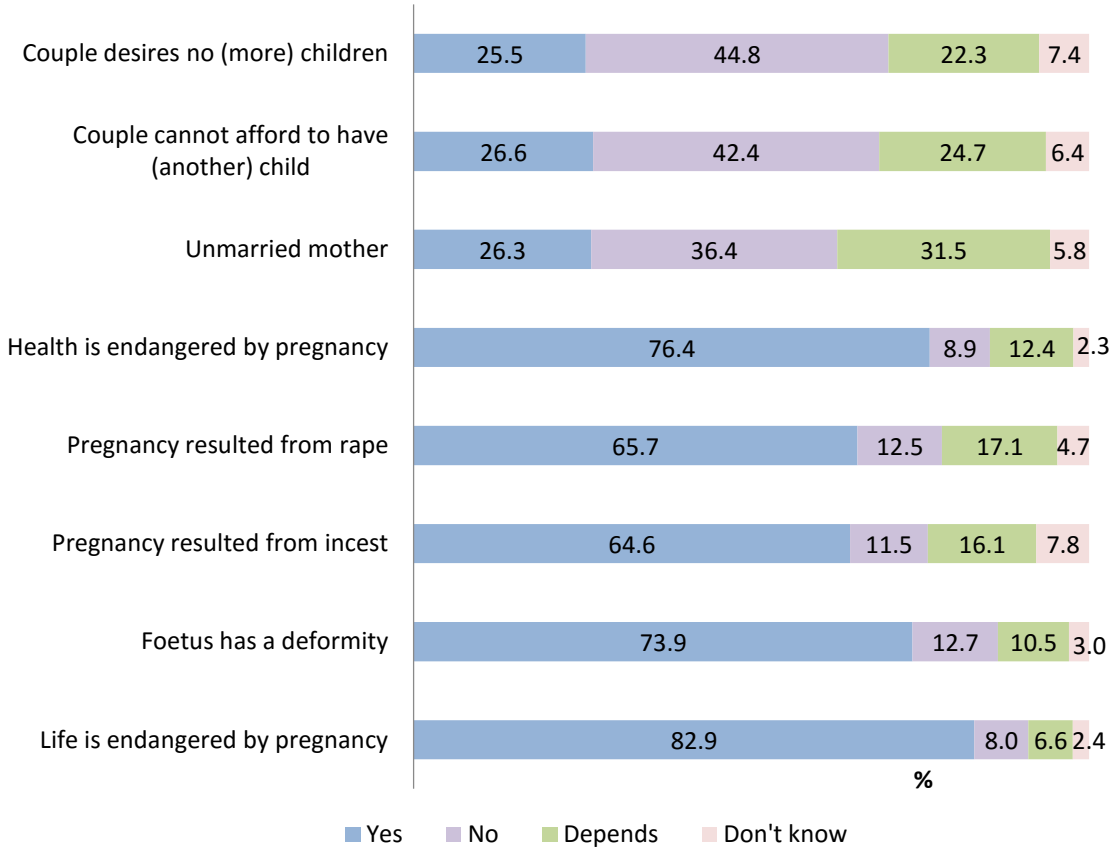


Figure 8: Percent distribution of respondents age 15-49 years about their opinion on induced abortion

2014 CPS, Mauritius

5.8 Infertility Problems

Infertility has been described as a stressor and a life crisis for individuals or couples, which results in a lower quality of life and marital conflicts (Klemetti et al, 2010). Depending on its underlying causes, infertility can be treated by a range of medical options. The World Health Organization (WHO) estimates, that approximately 8%-10% of couples experience some form of infertility problem. However, the incidence of infertility may vary from region to region.

The 2014 CPS results reveal that 10.0 percent of currently married women age 15-49 years (104) reported having fertility problems[11]; however, when asked about their fertility problems, only 80.7 percent of them answered.

Table 14 shows the percent distribution of currently married women age 15-49 years who reported their fertility problems by selected background characteristics. The results reveal that most of them do not have a child (refer to the last row of the table). It is noted that among currently married women age 15-49 years who have fertility problems, 50.0 percent are in the age group 25-34 and

[11] Including those who reported the fertility problems of their partner.

73.4 percent have been married for five years or more. The data also reveals that 2.0 percent of them have been treated for pelvic inflammatory disease (PID). PID is an infection of a woman's reproductive organs that may lead to infertility.

Table 14: Percent distribution of currently married women age 15-49 years who have fertility problems by age group and marriage duration, according to the number of living children

Background characteristics	No child	One living child or more	Total
Age group			
15-19	2.5	-	1.7
20-24	14.6	6.7	12.2
25-29	28.8	17.3	25.3
30-34	19.8	36.2	24.7
35-39	16.1	23.7	18.4
40-44	9.6	6.3	8.6
45-49	8.6	9.8	9.0
Marriage duration			
Less than 1 year	6.9	-	4.8
1 year up to 2 years	11.2	-	7.8
2 years up to 5 years	17.5	6.0	14.0
5 years or more	64.4	94.0	73.4
Total	**100.0**	**100.0**	**100.0**
Total number of respondents	58	26	84

2014 CPS, Mauritius

Figure 9 shows that 54.3 percent of currently married women age 15-49 years who have fertility problems said that they do intend to seek medical help to get pregnant in the future.

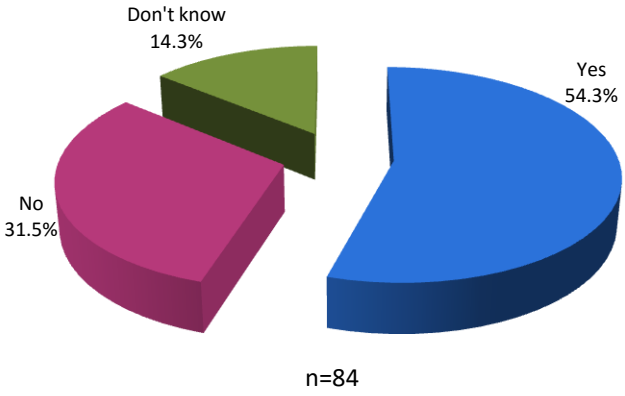


Figure 9: Percent distribution of currently married women age 15-49 years with fertility problems who intend to seek medical help to get pregnant in the future

2014 CPS, Mauritius

These respondents were then asked if they knew a place where they can seek medical help to get pregnant. Figure 10 shows that 80.3 percent of them knew where to seek medical help to get pregnant.

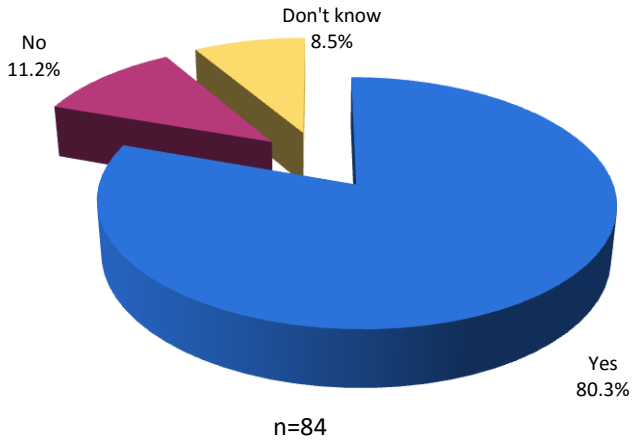


Figure 10: Percent distribution of currently married women age 15-49 years with fertility problems who knew where to seek medical help to get pregnant

2014 CPS, Mauritius

Among those who knew where medical services to get pregnant are offered, 53.7 percent have sought medical help to get pregnant as shown in figure 11.

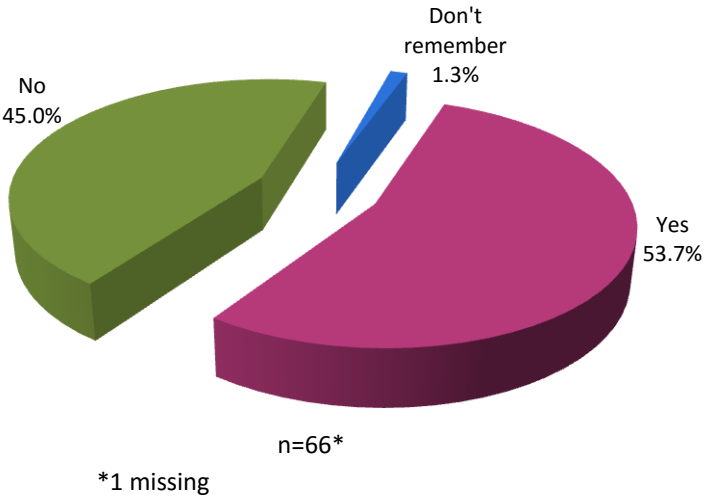


Figure 11: Percent distribution of currently married women age 15-49 years with fertility problems who have sought medical help to get pregnant among those who knew where such medical services are offered

2014 CPS, Mauritius

Further analysis shows that 80.6 percent of currently married women age 15-49 years who have sought medical help to get pregnant have been mostly to a private clinic or to a private doctor for their treatment as shown in figure 12.

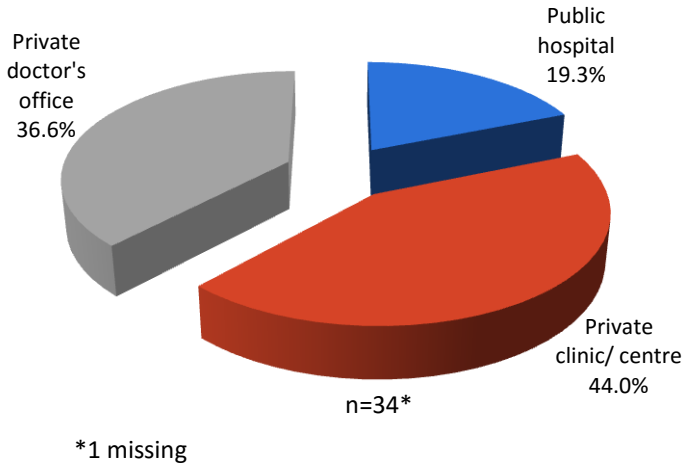


Figure 12: Percent distribution of currently married women age 15-49 years with fertility problems who have sought medical help to get pregnant by the facility they went mostly to for treatment

2014 CPS, Mauritius

Moreover, 44.1 percent of currently married women age 15-49 years who have sought medical help to get pregnant said that their fertility problems (or that of their partner's) have been diagnosed. However, due to the small sample size, the causes of infertility have not been given out.

FERTILITY PREFERENCES 6

6.0 Introduction

Fertility preferences as a concept and measured construct has no single definition within the literature and debates between the measurement of and the merits between preferences, intentions, and desires are prevalent (Yeatman et al, 2013). Information on fertility preferences is of paramount importance to family planning programs because it is used to assess the potential demand for family planning services for the purposes of spacing or limiting future childbearing.

Nevertheless, interpretation of the results of fertility preferences are, in most cases, hypothetical and thus subject to change and retionalization.

6.1 Desire for More Children

Fertility preferences are closely related to the number of living children a woman has. In general, as the number of living children increases, the desire to have another child decreases and vice versa. Therefore, information about the desire for more children is important for understanding future reproductive behaviour. The provision of adequate and accessible family planning services is dependent on the availability of such information. In the 2014 CPS, currently married women were asked whether they want to have another child, and if so how soon. The wording of the question varied slightly if the respondent was pregnant to ensure that pregnant women were not asked about the wantedness of the current pregnancy but the desire for subsequent children

Table 15 shows future reproductive intentions of currently married women 15-49 years by the number of living children. 9.2 percent of women want to have another child soon (within two years) while 8.2 percent want another child two or more years later. 67.7 percent want no more children or have been sterilized. Overall, 68.6 percent of currently married women aged 15-49 year want to either stop or postpone childbearing.

The desire to stop childbearing increases with the number of living children from 6.6 percent among women with no children to 61.9 percent among women with 4 or more children. On the otherhand as expected the desire to have a child is higher (60.7 percent) among women with no children than among women with 3 children (1.7 percent).

Fertility Preferences by Number of Living children

Table 15: Percent distribution of currently married women by desire for children, according to the number of living children.

	Number of lining children					
Desire for children	0	1	2	3	>=4	Total
Wants soon	40.4	17.6	0.9	0.9	0.0	9.2
Wants later	20.3	23.3	1.3	0.8	0.0	8.2
Undecided	5.4	10.9	1.1	0.0	1.2	3.6
Wants no more	6.6	40.5	83.3	65.0	61.9	60.4
Sterilized	0.0	0.3	3.5	22.8	32.3	7.3
Declared infecund	26.6	6.2	8.6	10.2	4.5	10.3
Missing	0.6	1.0	1.4	0.4	0.0	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total number of women	123	229	447	186	54	1039

2014 CPS, Mauritius

6.2 Unplanned and Unwanted Fertility

Unintended pregnancy is an important public health problem around the world, occurring in all cultures and affecting women of all ages and all socio-economic and educational backgrounds. Therefore, accurate documentation of reproductive intentions is important for understanding a population's fertility rates, fertility-related behaviors, and contraception needs.

Respondents who have had a live birth in the five years preceding the survey and who were not pregnant at the time of the interview were asked whether their most recent pregnancy was wanted *then* (planned), wanted *later* (mistimed), or *not* wanted (not wanted at all). The same question was asked to respondents who have had a live birth in the five years preceding the survey about their current pregnancy if they were pregnant at the time of the interview.

Table 16 shows the percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by the planning status of their most recent pregnancy. The results of the 2014 CPS show that 70.2 percent of them stated that their most recent pregnancy was planned (wanted) and 25.7 percent stated that it was unplanned (mistimed and unwanted).

Table 16: Percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by the planning status of their most recent pregnancy

Planning status	Currently married women age 15-49 years	
	2002 CPS	2014 CPS
Wanted	72.0	70.2
Mistimed	13.5	16.2
Unwanted	8.5	9.5
Not sure	6.0	4.1

2014 CPS, Mauritius

Figure 13 shows that the proportion of unplanned pregnancies has increased from 22.0 percent in 2002 to 25.7 percent in 2014 among currently married women age 15-49 years who have had a live birth in the five years preceding the survey. Hence, this finding underscores the need to target women in need of more effective contraceptive methods.

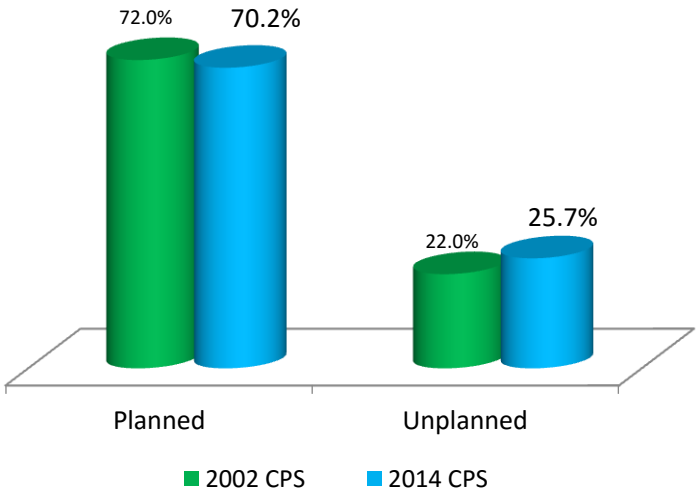


Figure 13: Percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by planning status of their most recent pregnancy

2014 CPS, Mauritius

PROXIMATE DETERMINANTS OF FERTILITY 7

7.0 Introduction

Since the transition from high to low fertility is now virtually universal, it is clear that its onset does not depend on the level of development and that the path it will follow is not necessarily determined by socio-economic factors such as levels of education, female employment, or urbanization (Bongaarts, 2002). Therefore, it is imperative to study the proximate determinants of fertility to improve the understanding of fertility behavior, its variations among different sub-groups and underlying causes of the variations. The proximate determinants of fertility analysed in the 2014 CPS were; the start of menstruation (age of menarche), age at first sexual intercourse and age at first marriage.

7.1 Age of Menarche

Age at menarche is an important component in the reproductive life of women since it marks the onset of the reproductive capacity and is associated with the development of secondary sexual characteristics. Evidence from high-income countries suggests that early onset of menarche (i.e., the first menstrual cycle) may be linked to early sexual initiation (Windle et al, 2004). Moreover, Gomez et al (2011) stated that menstruation starting at an earlier age in most countries increases the period of exposure to the risk of adolescent fertility. Age at menarche is therefore a potentially important contextual variable when investigating age at marriage, age at sexual debut, age at first birth and lifetime fertility.

Table 17 shows that the median age of menarche of women age 15-49 years is 11.7 years. It is also noted that the median age of menarche has slightly declined over time: from 11.9 years among women age 45-49 years to 11.4 years among women age 15-19 years.

Table 17: Median age of menarche among women age 15 – 49 years

Age group	Median age at menarche (years)	n
15-19	11.4	255
20-24	11.7	232
25-29	11.6	227
30-34	11.7	259
35-39	11.7	219
40-44	11.9	223
45-49	11.9	257
15-49	*11.7*	*1,672*[*]

[*] *8 respondents did not report their age of menarche*

2014 CPS, Mauritius

7.2 Age at First Sexual Intercourse and Age at First Marriage

Age at first sex and first marriage has important implications for gender relations and the organization of family life in societies (Mensh et al., 2005). Worldwide, there has been a general trend of declining age at first sex and an increasing age at first marriage (Marston et al., 2009). On the other hand, in many African countries, Mensch et al. (2006) have reported that age at first sex has remained the same or increased. In addition, the variation in the timing of first sex has been attributed to diverse environmental and social factors such as access to family planning programs, culture, and the prevalence of HIV/AIDs (Wellings et al., 2006).

Marriage and first sexual intercourse are observed to be the prominent determinants since they are primary indicators of women's exposure to the risk of pregnancy and, therefore, are important for an understanding of fertility. Therefore, trends in age at first marriage or at first sexual intercourse may help explain changes in fertility level.

Information on age at first sexual intercourse and age at first marriage among women age 25-49 years is presented in table 18. The median age at first sexual intercourse is 19.8 years and the median age at first marriage is 21.4 years among women age 25-49 years.

It should be noted that younger cohorts (women age 15-24 years) are omitted from the analysis in order to avoid a bias since less than 50 percent of respondents in the age groups 15-19 and 20-24 did not have sexual intercourse or did not get married by age 15 or 20 respectively.

Table 18: Median age at first sexual intercourse and median age at first marriage among women age 25 – 49 years

Age group	Median age at first sexual intercourse (years)	Median age at first marriage (years)
25-29	19.8	21.4
30-34	19.8	21.3
35-39	19.4	21.1
40-44	19.5	21.0
45-49	20.9	21.9
25-49	**19.8**	**21.4**

2014 CPS, Mauritius

7.3 Recent Sexual Activity by Background Characteristics

In the absence of effective contraception, the probability of pregnancy is highly dependent upon the frequency of intercourse. Therefore, information on sexual activity can be used to refine measures of exposure to pregnancy. Table 19 shows the distribution of women age 15-49 by timing of last sexual intercourse, according to background characteristics. 50.7 percent of women age 15-49 were sexually active during the four weeks preceding the interview and 14 percent reported that they had never had sex.

The proportion of women who were sexually active in the four weeks preceding the survey increases with age, peaking in the 35-39 age group (74.1 percent) and decreasing thereafter. As expected, the frequency of sexual activity among women who are married or currently in a union is higher than that among women who are not married, divorced or separated. However, it is observed that 10.7 percent of never-married women had sexual activity including 1.1 percent in the four weeks preceding the survey.

Women with higher education are less likely to have been sexually active in the past four weeks (48.2 percent) than their counterparts in other categories. Moreover, women working as service worker are more likely to have been sexually active in the past four weeks (60.4 percent) preceding the survey as compared to the other counterparts. Data from table 19 also shows that women with high socio-economic status are more likely to have been sexually active in the four weeks preceding the survey.

Table 19: Percent distribution of women age 15-49 by timing of last sexual intercourse, according to background characteristics

Background characteristic	Timing of last sexual intercourse: Within the past 4 weeks	Timing of last sexual intercourse: More than 4 weeks	missing	Never had sexual intercourse	Total	Number of women
Age group						
15-19	7.1	5.7	0.0	87.2	100.0	255
20-24	29.2	14.8	0.0	56.0	100.0	233
25-29	59.5	16.7	0.0	23.8	100.0	230
30-34	71.0	19.5	0.0	9.5	100.0	260
35-39	74.1	21.4	0.0	4.5	100.0	221
40-44	62.8	31.5	0.0	5.7	100.0	226
45-49	54.4	39.4	0.0	6.2	100.0	255
Marital Status						
Married (legal/Religious)	80.6	19.4	0.0	0.0	100.0	972
Consensual union	77.3	21.6	1.1	0.0	100.0	68
Widowed	0.0	100.0	0.0	0.0	100.0	38
Divorced/separated	13.9	86.1	0.0	0.0	100.0	76
single (never Married)	1.1	9.6	0.0	89.3	100.0	526
Residence						
Urban	51.6	21.0	0.0	27.3	100.0	712
Rural	50.0	21.4	0.0	28.5	100.0	968
Education						
<completed primary	52.9	37.7	0.0	9.4	100.0	132
completed primary	65.6	30.5	0.0	3.9	100.0	206
>completed primary	48.2	18.2	0.0	33.6	100.0	1342
Occupation						
Professional	52.9	17.9	0.0	29.2	100.0	322
Service Worker	60.4	23.6	0.0	16.0	100.0	299
Manual Worker	55.6	34.6	0.0	9.8	100.0	207
Homemaker/Student	45.3	18.5	0.0	36.2	100.0	852
Household socio-economic status						
low	53.8	27.2	0.0	19.0	100.0	316
middle	48.5	21.9	0.0	29.6	100.0	1059
high	55.3	12.9	0.0	31.8	100.0	305
Total	**50.7**	**21.3**	**0.0**	**28.0**	**100.0**	**1680**

2014 CPS, Mauritius

7.4 Median Age at First Marriage by Background Characteristics

Table 20 presents differentials in the median age at first marriage among women age 25-49 by selected background characteristics. As expected, rural women tend to marry at a younger age than urban women. The median age at first marriage among urban women (22.0 years), is higher than the median age at first marriage among rural women (20.9 years).

Table 20 also shows a difference in the age at first marriage by educational level. The median age at first marriage among women who have education beyond primary level is 21.8 years, more than two years higher than the median age among women who have not completed primary education (19.1 years).

The median age at first marriage also rises with socio-economic status. Among women in the lowest socio-economic status, the median age at first marriage is 20.1 years compared to 22.4 years among women in the highest socio-economic status.

Table 20: Median age at first marriage among women age 25-49 years, according to background characteristics

Background Characteristics	Women age 25-49
Residence	
Urban	22.0
Rural	20.9
Socio-economic status	
Low	20.1
Middle	21.4
High	22.4
Education	
Less than completed primary	19.1
Completed primary	20.2
More than completed primary	21.8
Total	**21.4**

2014 CPS, Mauritius

FAMILY PLANNING 8

8.0 Introduction

Family planning (FP) is one of the most "health-promoting "and cost-effective activities in public health promotion and has the potential to avert approximately 30 percent of maternal and 10 percent of child deaths (Cleland et al, 2012). Thus, FP contributes to achieving the Millennium Development Goals (MDGs) through healthier birth spacing and by reducing mortality and morbidity associated with pregnancy (Yearkey et al, 2009). Therefore, information on family planning is important for understanding one of the principal determinants of fertility and also serves as a key measure for assessing the success of the national family planning program.

The key focus in this chapter is on the knowledge and use of family planning methods and the channels through which the women receive information about family planning methods. Information on the service providers from which users obtain their methods is also presented. Moreover, the chapter looks at the level of unmet need for family planning and factors relating to nonuse of contraception.

8.1 Knowledge of Contraceptive Methods

Knowledge of contraceptive methods is linked to the utilization of family planning services among women of reproductive age. However, misperceptions about contraceptive methods and their side effects, and general mistrust of modern contraception are important barriers to utilization of the family planning services.

Knowledge of any contraceptive method among currently married women age 15-49 years is 99.6%.

2014 CPS, Mauritius

To address this gap, the 2014 CPS included questions on knowledge of family planning methods by asking the respondents if they had heard of the various ways or methods by which a couple could delay or avoid pregnancy. Overall, 99.6 percent of currently married women age 15-49 years knew at least one method of contraception in 2014.

Figure 14 shows that male condom (94.6 percent), tubal ligation (92.5 percent) and pill (90.2 percent) are the most commonly known supplied methods[12], and that calendar (50.7 percent), temperature (50.2 percent) and sympto-thermal (39.5 percent) are the most commonly known natural family planning (NFP)[13] methods among currently married women age 15-49 years.

[12] Supplied methods: Tubal ligation; vasectomy; pill; 1-month injectable; 3-month injectable; IUD; male condom; female condom; diaphragm; foaming tablet; implant; contraceptive patch; and emergency contraceptive pill.

[13] NFP methods: Sympto-thermal; mucus; temperature; calendar; and cycle beads.

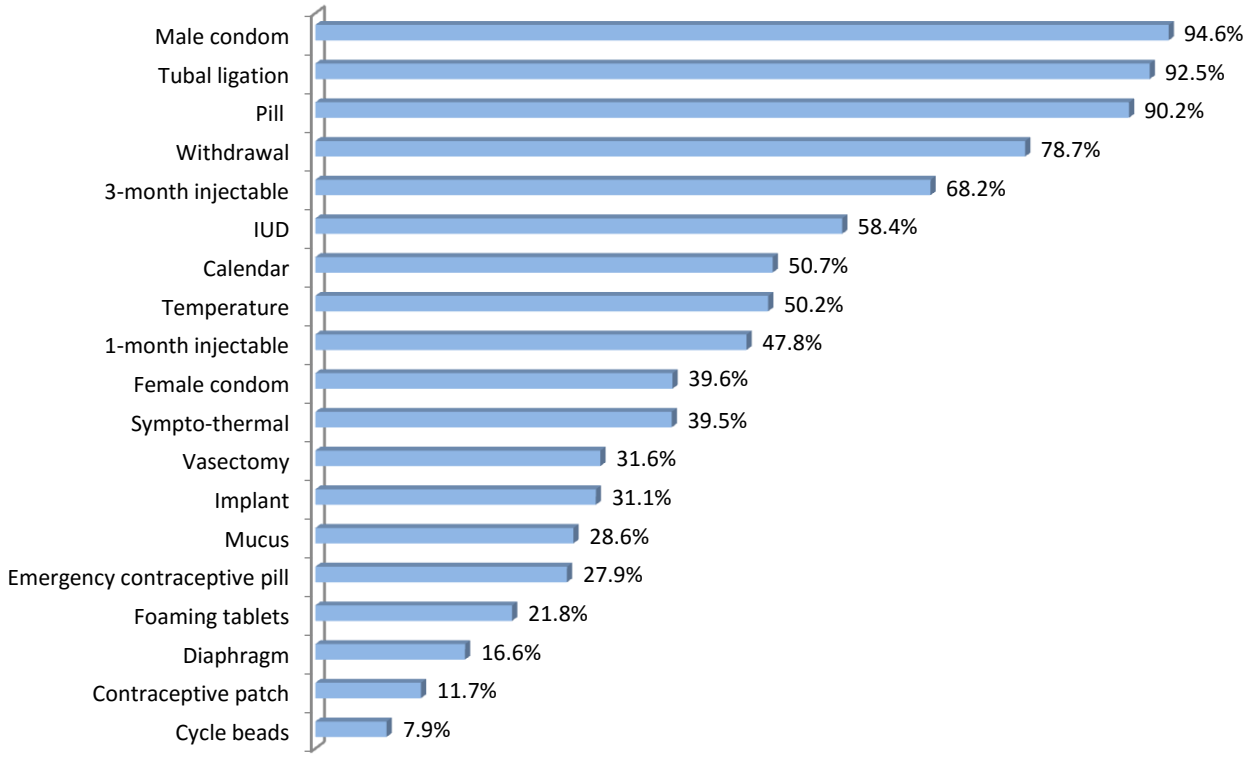


Figure 14: Percent distribution of currently married women age 15-49 years who know a family planning method by specific method

2014 CPS, Mauritius

Table 21 shows that knowledge of contraceptive methods has declined over years for almost all methods. For instance, knowledge of pill has declined from 99.0 percent in 2002 to 90.2 percent in 2014 among currently married women age 15-49 years. However, knowledge of methods, such as female condom has increased from 17.1 percent in 2002 to 39.6 percent in 2014 among currently married women age 15-49 years.

Like previous CPSs, the contraceptive methods have been classified into three categories (i.e. by supplied methods, natural family planning (NFP) methods and withdrawal method) but in order to compare the data with other countries, the contraceptive methods have also been classified into two categories (i.e. by modern methods[14] and traditional methods[15]) in the 2014 CPS.

The mean number of methods known is indicative of the extent of knowledge of family planning methods. Overall, currently married women age 15-49 years know an average of 8.9 contraceptive methods[16].

The 2014 CPS findings also reveal that knowledge of any contraceptive method is 94.0 percent among teenagers (15-19 years) and likewise for any modern contraceptive method.

[14] Modern methods: Tubal ligation; vasectomy; pill; 1-month injectable; 3-month injectable; IUD; male condom; female condom; diaphragm; foaming tablet; implant; contraceptive patch; emergency contraceptive pill; sympto-thermal; mucus and temperature.

[15] Traditional methods: Withdrawal; calendar; and cycle beads.

[16] Out of the 19 methods reported by respondents.

Table 21: Percent distribution of women who know a family planning method by specific method

Contraceptive method	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15-49	**15-49**	**15-44**	**15-49**	**15-49**	**15-44**	**15-44**
	2014 CPS			**2002 CPS**			**1991 CPS**
Any method	98.4	99.6	99.7	99.0	99.9	99.9	99.7
Any supplied	98.1	99.2	99.2	-	-	-	-
Tubal ligation	85.6	92.5	92.0	88.1	93.3	93.2	92.3
Vasectomy	33.3	31.6	32.1	27.2	28.1	27.8	23.9
Pill	88.6	90.2	90.3	97.5	99.0	99.1	99.3
3-month injectable	58.7	68.2	68.2	79.8	86.6	86.1	94.1
1-month injectable	40.2	47.8	48.9	-	-	-	-
IUD (Intrauterine device)	48.6	58.4	58.3	70.5	79.3	78.2	88.2
Male condom	92.0	94.6	95.2	92.1	94.4	94.4	95.0
Female condom	41.4	39.6	42.1	18.2	17.1	17.7	-
Diaphragm	17.0	16.6	17.9	16.2	16.5	16.9	9.5
Foaming tablets	20.8	21.8	22.4	27.9	31.1	30.4	23.3
Implant	26.6	31.1	32.5	28.7	33.1	34.8	5.3
Emergency contraceptive pill	27.7	27.9	29.4	-	-	-	-
Contraceptive patch	12.4	11.7	12.7	-	-	-	-
Any NFP method	58.2	64.5	65.6				
Sympto-thermal	33.7	39.5	39.7	47.0	52.4	52.7	36.4
Mucus	22.9	28.6	29.2	29.4	33.5	33.0	23.6
Calendar	46.8	50.7	51.8	58.3	64.0	65.1	54.5
Temperature	42.7	50.2	50.9	65.2	72.0	71.6	78.9
Cycle Beads	8.0	7.9	8.4	-	-	-	-
Withdrawal	65.6	78.7	79.0	75.6	85.7	86.3	74.8
Number of women	1,680	1,040	838	2,698	2,002	1,692	3,508
Any modern method	98.2	99.3	99.3	-	-	-	-
Any traditional method	72.1	81.9	82.1	-	-	-	-
Mean number of methods known	8.3	8.9	9.0	-	-	-	-
Mean number of modern methods known	7.1	7.6	7.7	-	-	-	-

– : Not available

2014 CPS, Mauritius

8.2 Current use of Contraceptive Methods

The level of current use of contraceptive methods is the aspect of contraceptive practice that is of greatest interest to family planning policymakers as it measures the coverage of family planning programmes. The contraceptive prevalence rate (CPR) is usually defined as the percentage of currently married women using a method of contraception.

Table 22 shows that the contraceptive prevalence rate for currently married women age 15-49 years has decreased from 75.9 percent in 2002 to 63.8 percent in 2014.

The contraceptive prevalence rate among currently married women age 15-49 years is ***63.8%.***

2014 CPS, Mauritius

The 2014 CPS findings show that withdrawal (28.5 percent) is the most commonly used method among currently married women age 15-49 years followed by male condom (10.6 percent), pill (8.9 percent) and tubal ligation (7.3 percent). Calendar (3.2 percent) is the most commonly used NFP method.

Table 22 also shows that an almost equal proportion of currently married women age 15-49 years are using modern methods (32.0 percent) and traditional methods (31.8 percent).

Fertility decline is often associated with an increase in contraception and abortion. However, paradoxically, although the contraceptive prevalence rate among currently married women age 15-49 years has declined significantly in Mauritius from 75.9 percent in 2002 to 63.8 percent in 2014, the total fertility rate measured from the vital statistics has declined to well below replacement level during the same period. At this point, it is very difficult to interpret the relationship between contraceptive use, fertility level and abortion since, as already mentioned, there is no reliable data on abortion. It can only be said that one of the main reasons for non-contraceptive use among women who have an unmet need for family planning is “health concerns”

Current use of short term contraceptive methods (except condoms) has declined over the years among currently married women age 15-49 years; for instance, the proportion of pill users has declined from 15.8 percent in 2002 to 8.9 percent in 2014. However, current use of long term methods (except sterilization) has slightly increased; for instance, the proportion of implant users has increased from 0.1 percent in 2002 to 0.9 percent in 2014.

In 2014, current use of female condom and one-month injectable was 0.1 percent and 0.3 percent respectively among currently married women age 15-49 years whilst in 2002, no respondents reported use of these methods since female condom and one-month injectable were not available in Mauritius until around 2006. It should also be noted that no respondents reported current use of these available methods, namely, cycle beads, vasectomy and emergency contraceptive pill (which is a back-up method) at the time of the 2014 CPS. Incidentally, contraceptive patch is not available in Mauritius.

Table 22: Percent distribution of women who are currently using a method of contraception

Contraceptive method	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15-49	**15-49**	**15-44**	**15-49**	**15-49**	**15-44**	**15-44**
	2014 CPS			**2002 CPS**			**1991 CPS**
Tubal ligation	4.7	7.3	6.0	6.8	8.9	7.2	7.2
Vasectomy	0.0	0.0	0.0	0.1	0.1	0.1	0.2
Pill	5.8	8.9	10.2	12.0	15.8	17.7	20.9
3- month injectable	0.8	1.3	1.5	2.3	3.1	3.1	4.1
1- month injectable	0.2	0.3	0.4	-	-	-	-
IUD	1.1	1.6	1.6	1.0	1.3	1.4	2.8
Male condom	6.8	10.6	11.5	7.0	9.1	9.9	13.3
Female condom	0.06	0.1	0.1	-	-	-	-
Foaming tablets	0.06	0.1	0.1	0.2	0.2	0.2	0.4
Implant	0.6	0.9	1.1	0.1	0.1	0.1	0.0
Contraceptive patch	-	-	-	-	-	-	-
Total supplied methods	**20.2**	**31.1**	**32.5**	29.5	38.6	39.7	48.9
Sympto-thermal	0.2	0.4	0.5	0.9	1.2	1.2	1.5
Mucus	0.1	0.1	0.2	0.3	0.3	0.4	0.5
Calendar	2.1	3.2	3.8	6.0	8.1	8.2	5.5
Temperature	0.3	0.5	0.4	0.4	0.6	0.7	1.7
Cycle beads	0.0	0.0	0.0	-	-	-	-
Total NFP methods	**2.7**	**4.2**	**4.8**	7.6	10.2	10.5	9.2
Withdrawal	**18.0**	**28.5**	**29.4**	20.3	27.1	28.3	16.1
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Currently using any method	40.9	***63.8***	66.7	57.2	***75.9***	78.5	74.7
Not using any method	59.1	36.2	33.3	42.8	24.1	21.5	25.3
Number of women	1,680	1,040	838	2,698	2,002	1,692	3,508
Modern Method	20.8	32.0	33.5	31.1	40.7	42.0	52.6
Traditional Method	20.2	31.8	33.2	26.3	35.2	36.5	21.6

–:Not available

2014 CPS, Mauritius

8.2.1 Current use of contraception by background characteristics

Analyzing current use of contraception by background characteristics is important because it helps identify subgroups of the population to target for family planning services. Figure 15 shows the percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by type of method they are using according to some selected background characteristics.

Occupation

Overall, the proportion of contraceptive use by occupation slightly differs - ranging from 62.8 percent among homemakers/students to 66.1 percent among manual workers. Use of withdrawal is higher among homemakers/students (30.3 percent) than among the other three groups whilst use of NFP methods is higher among professionals (9.2 percent) than among service workers (5.3 percent) and homemakers/students (3.0 percent).

Religion

The proportions of contraceptive use among Hindus and Muslims are almost similar (62.6 percent and 62.4 percent respectively) whilst that of Christians is 67.8 percent. However, contraceptive use by type of method differs between Hindus and Muslims: 29.8 percent of Muslims are using supplied methods compared with 24.6 percent of Hindus.

Number of living children

The data shows that there is a direct relationship between contraceptive use and the number of living children: contraceptive use is lowest among current users who have no children (22.9 percent) and highest among current users who have 4 children or more (79.9 percent). Moreover, current use of supplied methods is higher among women who have 4 children or more (52.1 percent) than among women who have less than 4 children.

Level of educational attainment

Overall, contraceptive use by level of educational attainment does not vary much - ranging from 62.4 percent among women who have completed their primary schooling only to 66.9 percent among women who have not completed their primary schooling. Use of NFP methods is more popular among women who have received education beyond primary level (5.3 percent) than among the other groups.

Age group

The contraceptive prevalence rate by age group shows that contraceptive use rises with increasing age among current users age 20-39 years (from 45.7 percent for the age group 20-24 to 72.9 percent for the age group 35-39) followed by a decrease among current users age 40-49 years (from 69.0

percent for the age group 40-44 to 52.1 percent for the age group 45-49). However, although contraceptive use is higher in the age group 35-39 than among the other age groups, a significant proportion of current users in this age group are using withdrawal method (31.8 percent), which is a less effective method.

Residence

There is a marked difference in contraceptive use between urban and rural dwellers: 67.9 percent of rural dwellers are using contraceptives compared with 57.9 percent of urban dwellers. It is noted that withdrawal method is more commonly used among rural dwellers than among urban dwellers (34.0 percent versus 20.7 percent), and that an almost equal proportion of rural and urban dwellers are using supplied methods (about 31 percent). At this point, it should be noted that, unlike in many other African countries, there is universal access to family planning services in Mauritius. There is an extensive network of government family planning service points in the rural areas as well as in the urban areas and these services are offered free of user cost.

Household socio-economic status

Contraceptive use varies slightly by household socio-economic status - ranging from 63.1 percent among women living in middle-SES households to 65.4 percent among women living in low-SES households. It is noted that supplied methods are more commonly used among current users living in low-SES households (36.0 percent) than among the other groups, and that NFP methods are more commonly used among current users living in high-SES households (7.0 percent) than among the other groups.

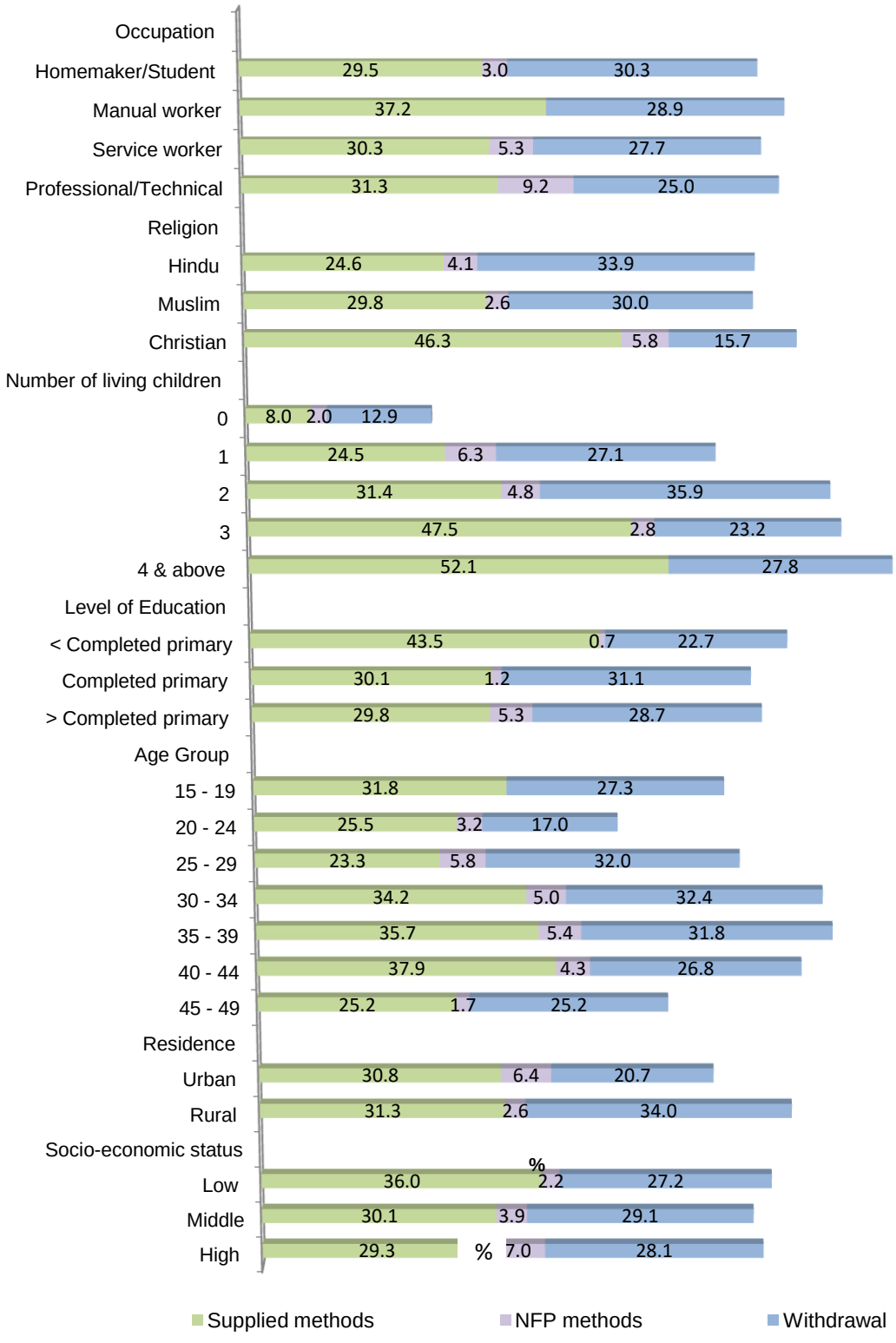


Figure 15: Percent distribution of currently married women age 15 - 49 years who are currently using a contraceptive method by type of method, according to selected background characteristics

2014 CPS, Mauritius

8.3 Withdrawal Method (a traditional method)

Being the most commonly used method among currently married women age 15-49 years, table 23 shows the percent distribution of those using withdrawal method by most important reason cited for using this method. Almost one in three stated that "withdrawal method is very safe to use" (31.2 percent) and almost one in four (23.3 percent) stated that "their partner prefers it".

Table 23: Percent distribution of currently married women age 15-49 years who are currently using withdrawal method by most important reason cited for using this method

Most important reason	Percentage
Very effective	13.8
Very safe (few or no side effects)	31.2
Easy to use	22.8
Partner prefers it	23.3
Allows spontaneity during intercourse	0.5
Religious belief	0.6
No cost involved	3.5
No preparation or supplies	0.5
Allows man to remain in complete control	1.3
Other	1.9
Don't know/Don't remember	0.7
Total	**100.0**
Total number of respondents	297

2014 CPS, Mauritius

Figure 16 shows that the majority of currently married women age 15-49 years who are currently using withdrawal method (99.2 percent) find that this method is "effective" to some varying extent (somewhat effective, 11.9 percent; effective, 69.9 percent; very effective, 17.4 percent).

Moreover, the majority of current users of withdrawal method (92.6 percent), which has not been charted here, are not willing to shift method.

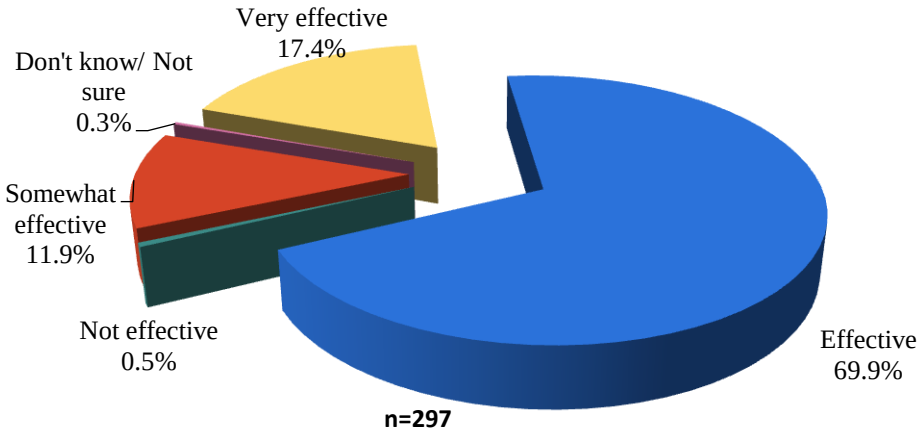


Figure 16: Percent distribution of currently married women age 15-49 years who are currently using withdrawal method by their perceived level of effectiveness of this method

2014 CPS, Mauritius

8.4 Purpose of Contraceptive Use: Birth Spacers versus Birth Limiters

The distinction between birth spacers and limiters[17] has important programmatic implications for family planning services. Contraceptive use differs between spacers and limiters: spacers tend to use short term methods and tend to be childless or with one child, whereas limiters tend to use long term or permanent methods and tend to have 2 children or more. The results of the 2014 CPS show that contraceptive use[18] for limiting births predominates: 80.3 percent are limiters and 19.7 percent are spacers. Figure 17 shows that 18.6 percent of spacers and 0.7 percent of limiters do not have a child.

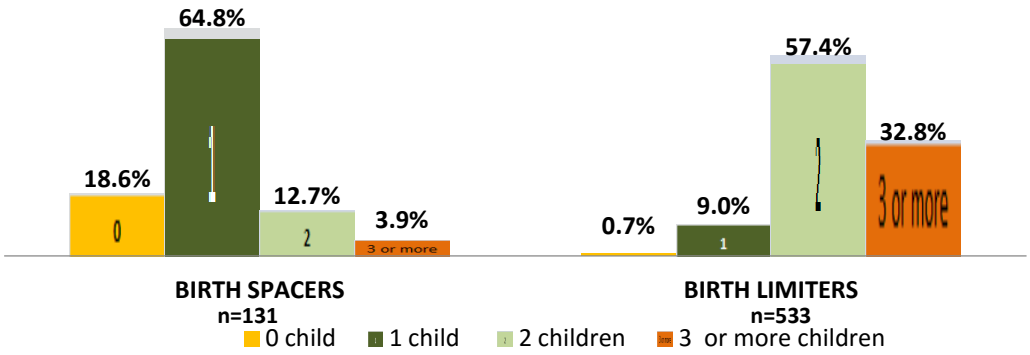


Figure 17: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by purpose of use, according to the number of living children

2014 CPS, Mauritius

Figure 18 shows that the majority of current users of long term methods (tubal ligation, IUD and implant), short term methods and natural family planning methods (sympto-thermal, mucus, temperature and calendar) are birth limiters. Moreover, surprisingly, the majority of current users of withdrawal method, which is a less effective method, are using this method in order to limit childbearing.

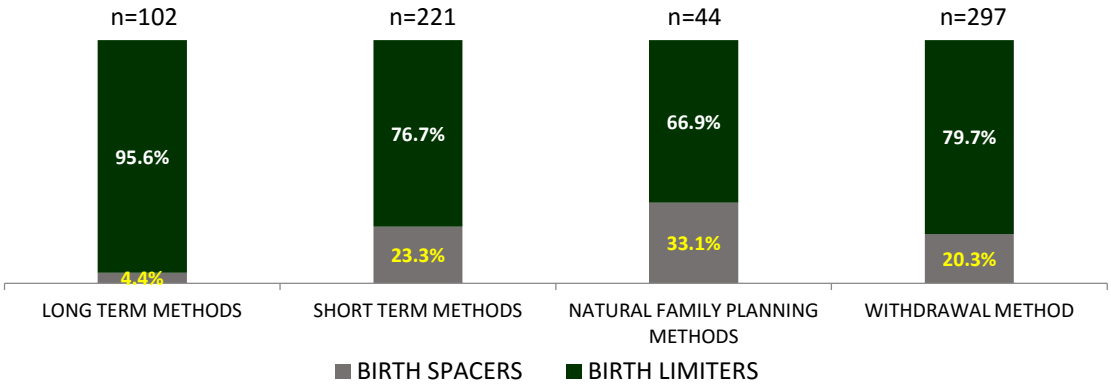


Figure 18: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by purpose of use, according to type of method

2014 CPS, Mauritius

[17] Birth spacers and limiters are current users of a contraceptive method. The purpose of contraceptive use differs for a birth spacer and for a birth limiter: For the former, the client wants a/another child later whereas for the latter, the client does not want a/another child.

[18] The data refer to current users age 15-49 years and who are currently married.

Table 24 shows that the most common reason given by limiters for using a contraceptive method is "having enough children" (61.0 percent) followed by "financial implications in raising more children" (18.7 percent). As for spacers, the most common reason cited is "for the family's benefit" (32.8 percent) followed by "financial implications in raising more children" (24.4 percent).

Table 24: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by most important reason cited for limiting or spacing birth

Most important reason	Limiter	Spacer	Total
Have enough children	61.0	-	49.0
To recover health	-	12.4	2.4
Financial implications in raising more children	18.7	24.4	19.8
To devote more time to family	5.2	-	4.2
Want to work outside the house	0.6	-	0.5
For the family's benefit	-	32.8	6.4
House is too small	0.2	-	0.1
Want to study	0.2	0.5	0.2
Family pressure	0.1	-	0.1
Respondent is working	0.8	20.9	4.8
Too difficult to raise another child	4.4	-	3.5
Husband does not want any more children	2.2	-	1.8
Health concerns	5.3	-	4.3
Age factor (too young/too old)	0.7	1.3	0.9
Other	0.6	7.7	2.0
Total	**100.0**	**100.0**	**100.0**

- : Nil

2014 CPS, Mauritius

8.5 Trends in Contraceptive Use

Trends in current use of family planning can be used to monitor and evaluate the success of family planning programmes over time. Figure 19 shows the percent distribution of currently married women age 15 - 49 years who are currently using a contraceptive method by type of method. The contraceptive methods have been classified by supplied methods, natural family planning (NFP) methods and withdrawal method[19] as well as by modern methods and traditional methods.

Results of 2014 CPS indicate that the use of supplied methods has decreased from 38.6 percent in 2002 to 31.1 percent in 2014 among currently married women age 15-49 years. Likewise, use of NFP methods has decreased from 10.2 percent in 2002 to 4.2 percent in 2014 whilst use of withdrawal method has increased slightly from 27.1 percent in 2002 to 28.5 percent in 2014.

[19] Refer to second paragraph on p.45 for further explanation.

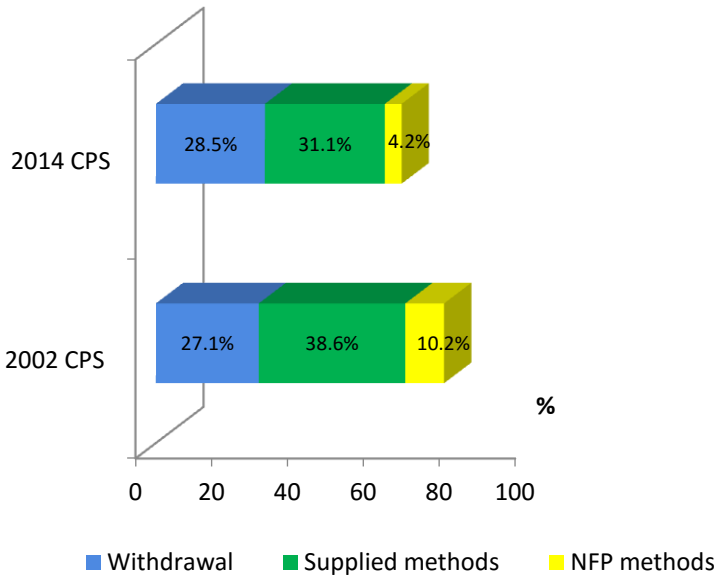


Figure 19: Percent distribution of currently married women age 15 - 49 years who are currently using a contraceptive method by type of method

2014 CPS, Mauritius

Figure 20 shows that use of modern methods has decreased from 40.7 percent in 2002 to 32.0 percent in 2014 among currently married women age 15-49 years. Concomitantly, use of traditional methods has decreased from 35.2 percent in 2002 to 31.8 percent in 2014.

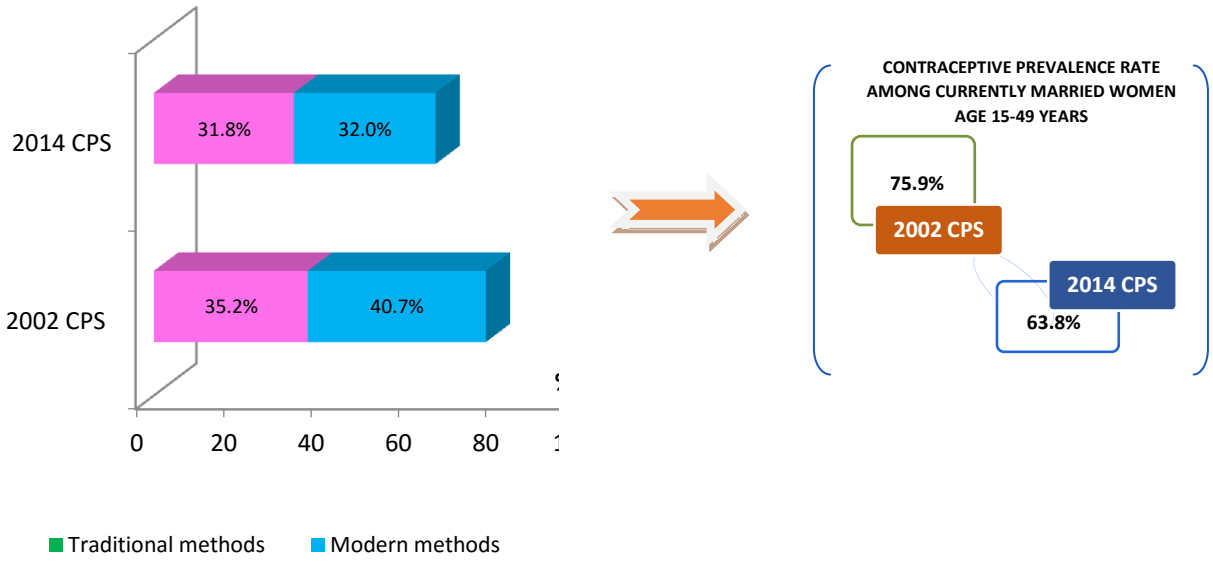


Figure 20: Trends in contraceptive use among currently married women age 15-49 years

2014 CPS, Mauritius

8.6 Contraceptive Source

Information on where women obtain their contraceptive method is useful for family planning managers to evaluate their programme and to forecast procurement needs. All current users of modern contraceptive methods at the time of the survey were asked the most recent source of their methods. Data from table 25 shows that government is the leading source for contraceptives (54.8 percent) followed by the private sector (34.7 percent), Action Familiale (6.6 percent) and MFPWA (3.8 percent) among current users of any contraceptive method (except withdrawal method) who are currently married and of age 15-49 years. It should be pointed out that the private sector has become an increasingly important provider of contraceptives over the years as the corresponding proportion was 23.7 percent in 2002.

Table 25: Percent distribution of current users of any contraceptive method (except withdrawal method) by most recent contraceptive source

Recent contraceptive source	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15 - 49	**15 - 49**	**15 - 44**	**15 - 49**	**15 - 49**	**15 - 44**	**15 - 44**
		2014 CPS			**2002 CPS**		**1991 CPS**
Government[20]	54.6	54.8	53.7	58.1	58.4	58.3	68.0
MFPWA[21]	3.7	3.8	4.0	7.4	7.4	6.7	15.3
Action Familiale[22]	6.6	6.6	7.5	10.3	10.5	10.7	7.5
Private Sector*	35.2	34.7	34.8	24.2	23.7	24.2	9.3

* Includes pharmacy, private hospital, private doctor and supermarket

2014 CPS, Mauritius

[20] Government has an extensive network of family planning service points (165 family planning service points) and the services are offered free of user cost.

[21] Mauritius Family Planning and Welfare Association (MFPWA) is a non-governmental organization that delivers reproductive health services, such as family planning; the prevention and management of HIV and AIDS through voluntary counselling and testing (VCT); screening for cancers of the reproductive systems; counselling; and family life education at both primary and secondary school level. MFPWA provides family planning services, which are not free of user cost, at 2 static service points.

[22] Action Familiale (AF) is a non-governmental organization that promotes sympto-thermal method, which is a natural family planning method (NFP). In addition to its NFP programme, Action Familiale conducts a human and family life education program in secondary schools and youth clubs; and a marriage counseling and psychotherapy service for those with conjugal and marital problems. AF provides family planning services at 39 static service points.

8.7 Contraceptive Counselling

Contraceptive counselling is an essential component in family planning service delivery since interactions between family planning providers and their clients, and the messages conveyed during those interactions, can affect continued and correct use of the method as well as client satisfaction with the service. Therefore, good communication between clients and family planning providers during counseling is a key to informed choice.

Overall, 48.7 percent of current users of a contraceptive method, who are currently married and of age 15-49 years, are using a supplied method[23] of contraception and figure 21 shows that 68.7 percent of those who are currently using a supplied method were advised on how to use this method by a family planning provider.

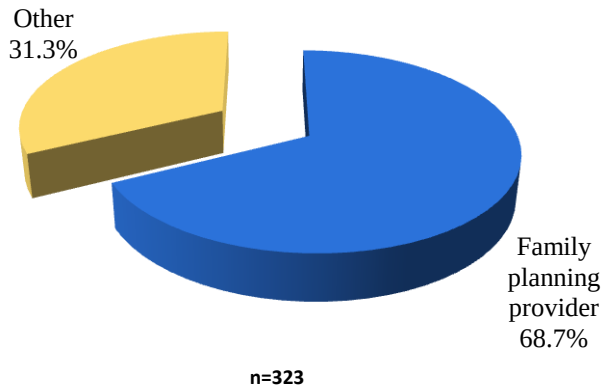


Figure 21: Percent distribution of currently married women age 15-49 years who are currently using a supplied method of contraception by who advised them on how to use this method

2014 CPS, Mauritius

Respondents, who were advised by a family planning provider[24] on how to use the supplied method that they are currently using, were asked if the following issues were discussed with them by the provider:

- Instructions to follow while using their contraceptive method;
- The possible side effects that they might experience while using their contraceptive method;
- Measures to be taken in case of side effects;
- To make a return visit in case of problems/concerns with their contraceptive method; and
- Other methods of contraception.

[23] Refer to the footnote on p.44 for the list of supplied methods. Overall, 60.0% of current users of supplied methods, who are currently married and of age 15-49 years, obtained their recent source of supply from the government, 37.2% from the private sector and 2.8% from MFPWA.
[24] Doctor, nurse, midwife and Community Health Care Officer/Family Planning Officer.

Figure 22 shows that a significant proportion of these respondents received advice on the above-mentioned topics. For instance, 62.7 percent were advised about the possible side effects that they might experience while using their method.

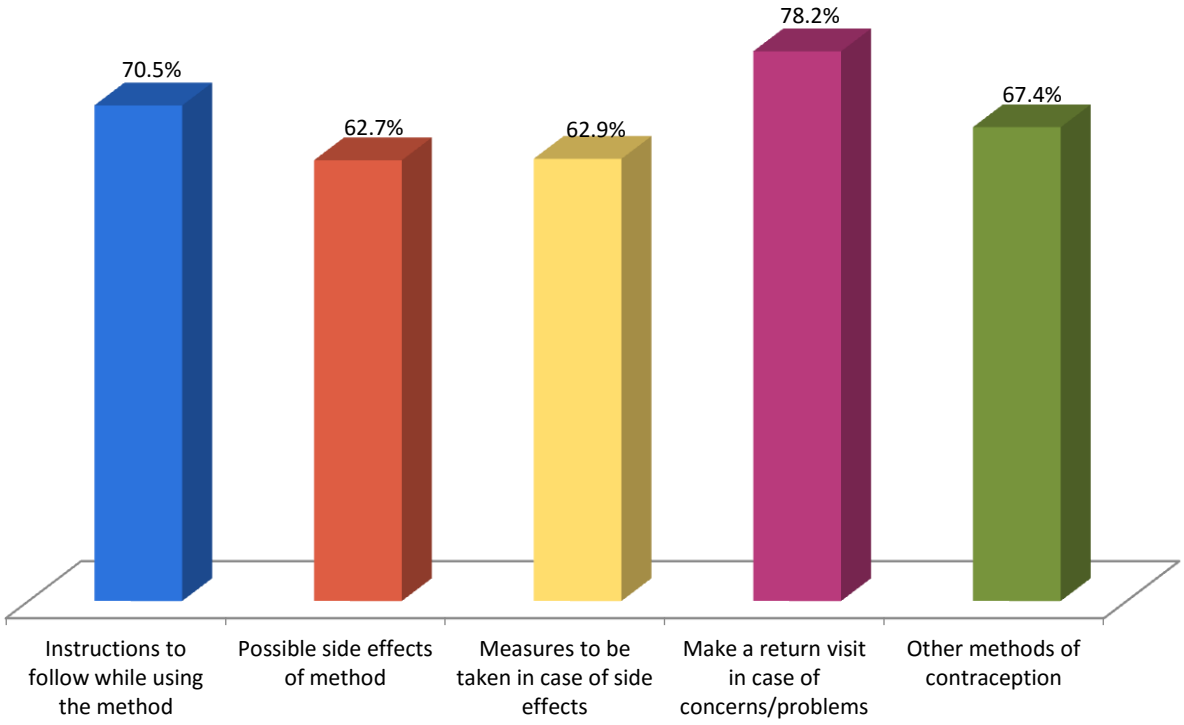


Figure 22: Percent distribution of currently married women age 15-49 years who are currently using a supplied method of contraception by specific issues discussed with the family planning provider who had advised them on how to use this method

2014 CPS, Mauritius

8.7.1 IUD Users[25]

Client and health provider interactions also offer important opportunities to promote counseling on risk behaviors. Since IUD users might not make a return visit to the same family planning provider who inserted their IUD, it was important to ascertain if the IUD users knew the maximum length of time that they can keep an IUD after insertion. Overall, 80.8 percent of IUD users reported that the family planning provider who had inserted their IUD had informed them about the maximum length of time that they can keep an IUD after its insertion, but when these users were asked to state the maximum number of years, only 44.6 percent of all IUD users could give the correct answer (i.e. 10 years after insertion). Hence, this finding is subject to a recall bias.

[25] Current users of IUD among currently married women age 15-49 years.

8.8 Unmet Need for Family Planning

Monitoring the "need" for contraception has been increasingly recognized as central to family planning efforts. By providing evidence about women whose contraceptive demand is not fully satisfied, data on unmet need can demonstrate the work left to be done in assisting women and couples to prevent unintended pregnancies. Therefore, one of the aims of the family planning programmes is to meet the demand for contraception and thereby reduce or eliminate the unmet need. Unmet need for family planning refers to the condition of wanting to avoid or postpone childbearing but not using any method of contraception. Unmet need joins together contraceptive behaviour and fertility preferences: it measures the gap between the desired fertility and contraceptive practices.

The 2014 CPS results reveal that unmet need for family planning in Mauritius is 12.5 percent among currently married women age 15-49 years (4.1 percent unmet need for spacing; 8.4 percent unmet need for limiting) as shown in Figure 23.

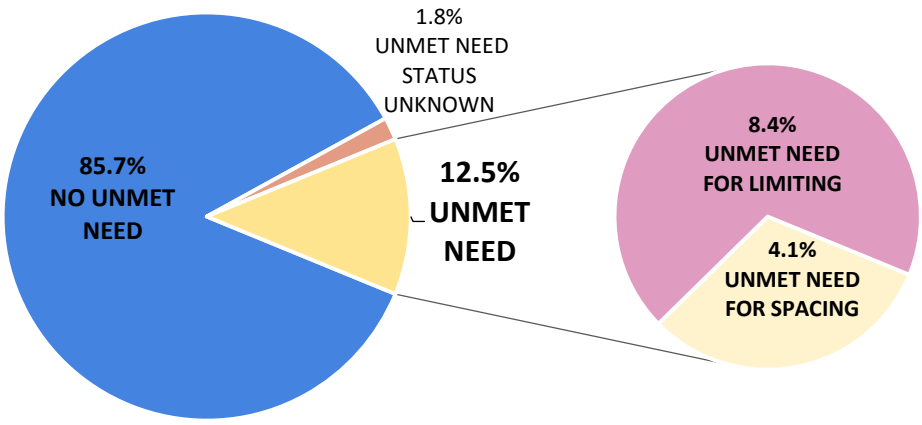


Figure 23: Unmet need status for family planning among currently married women age 15-49 years

2014 CPS, Mauritius

For the 2014 CPS, the revised estimates from Bradley et al. (2012)[26] were used in the computation of the unmet need for family planning. According to this definition, women of reproductive age (15-49 years) who are in union have an unmet need if they are fecund, do not want a child in the next two years or at all, and are not using any method of contraception, either modern or traditional. Pregnant women and women experiencing post-partum amenorrhea (and who gave birth within two years prior to the survey) are classified as having an unmet need if they indicated that their current pregnancy or recent pregnancy was unintended.

Table 26 shows the results of the unmet need status for family planning among currently married women age 15-49 years by selected characteristics. For instance, unmet need for family planning

[26] http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf

among currently married women living in low-SES households is 13.5 percent compared with 10.1 percent for those living in high-SES households.

Table 26: Unmet need status for family planning among currently married women age 15-49 years by selected background characteristics

Background characteristics	No unmet need	Percent distribution of currently married women with an unmet need for family planning: For spacing	For limiting	Unmet need (total)	Unknown unmet need status	Number of currently married women age 15-49
Religion						
Hindu	85.3	3.1	9.5	12.6	2.0	556
Muslim	87.9	2.4	7.8	10.2	1.9	226
Christian	84.5	7.8	6.4	14.2	1.3	258
Socio-economic status						
Low	82.5	6.1	7.4	13.5	4.0	203
Middle	85.8	3.8	9.1	12.9	1.3	640
High	88.7	3.0	7.1	10.1	1.3	197
Level of education						
<Completed primary*	85.8	3.4	7.3	10.7	3.5	95
Completed primary	85.5	0.8	11.9	12.7	1.7	172
>Completed primary	85.7	4.9	7.7	12.6	1.6	773
Residence						
Urban	83.8	4.9	9.4	14.3	1.9	429
Rural	87.0	3.5	7.7	11.2	1.7	611
TOTAL	**85.7**	**4.1**	**8.4**	**12.5**	**1.8**	**1,040**

* Includes 8 cases of no schooling

2014 CPS, Mauritius

Table 27 shows the percent distribution of currently married women age 15-49 years with unmet need for family planning by the most important reason for not currently using contraceptive methods. Policy declarations typically assume that lack of access to services is the root cause of unmet need for family planning; however, this is not the case in Mauritius since only 0.6 percent of currently married women age 15-49 with unmet need for family planning stated that the facility is too far away to obtain a method of contraception. Moreover, as already mentioned[27], Mauritius has an extensive network of family planning service points.

The most important reasons for non-use of contraceptives identified by currently married women with unmet need for family planning are health concerns (21.7 percent) and opposition to contraception by husband/partner (14.4 percent).

[27] Refer to the footnotes on p.56.

Table 27: Percent distribution of currently married women age 15-49 years with unmet need for family planning by most important reason for not currently using a contraceptive method

Most important reason for not using a contraceptive method	Unmet need		
	For spacing	For limiting	Total
Fertility-related reasons	**49.7**	**21.5**	**30.7**
Infrequent sex	7.9	17.3	14.2
Trying to get pregnant	10.6	-	3.5
Currently breastfeeding/postpartum	19.6	1.7	7.5
I got pregnant while using that method	-	2.5	1.7
Currently pregnant	11.6	-	3.8
Method-related reasons	**19.6**	**56.3**	**44.1**
Contraception is not (very) effective	-	2.7	1.8
Experienced side effects	9.5	5.6	6.9
Fear of side effects	0.0	5.3	3.5
Inconvenient to use	4.0	13.3	10.2
Health concerns	6.1	29.4	21.7
Opposition to use	**17.0**	**18.6**	**18.1**
Husband/partner objects to using method	13.2	15.0	14.4
Moral/religious objection	0.0	2.6	1.8
Don't want to use a method	3.8	1.0	1.9
Access-related reasons	**1.8**	-	**0.6**
Facility/source of method too far away	1.8	-	0.6
Other	**11.9**	**3.7**	**6.4**
Total	**100.0**	**100.0**	**100.0**
Total number	43	87	130

2014 CPS, Mauritius

8.9 Intention to Use Contraception in the Future

Currently married women (age 15-49 years) with unmet need for family planning were asked whether they intended to use any method in the future. Table 28 shows that, overall, 62.4 percent of women with unmet need for family planning do not intend to use a contraceptive method sometime in the future.

Table 28: Percent distribution of currently married women age 15-49 years who have an unmet need for family planning by future intention to use a contraceptive method

Intention for nonuse	Unmet need		Total
	For spacing	For limiting	
Future Intention			
Intend to use	43.0	8.4	18.7
Do not intend to use	23.0	79.0	62.4
Unsure about use	34.1	12.6	19.0
Total	**100.0**	**100.0**	**100.0**
Total number	35	83	118*
*Excludes 12 missing cases			

2014 CPS, Mauritius

Combining the estimate of unmet need for family planning with data on current contraceptive use provides a picture of the total potential demand for family planning in a country - that is what the demand would be if all currently married women acted on their stated preferences. For family planning programme, the estimate is useful because it helps in revealing the size and characteristics of the potential market for contraceptives.

Another related indicator is the proportion of demand satisfied for family planning: it is useful in assessing overall levels of coverage for family planning programmes. As levels of contraceptive use increase, the proportion of demand satisfied increases. This indicator has been modified to focus on modern contraceptive methods and is known as the proportion of demand satisfied by modern methods; it considers women who are using a traditional method as having an unmet need for better (modern) contraceptive method.

As already mentioned, the contraceptive prevalence rate is 63.8 percent (12.5 percent, for spacing; 51.3 percent for limiting) and the unmet need for family planning is 12.5 percent (4.1 percent, for spacing; 8.4 percent, for limiting) among currently married women age 15-49 years.

The estimates of the total demand for family planning, the proportion of demand satisfied by any method and the proportion of demand satisfied by modern methods are shown in Box 1.

BOX 1

TOTAL DEMAND FOR FAMILY PLANNING =

UNMET NEED FOR FAMILY PLANNING + CURRENT CONTRACEPTIVE USE (ANY METHOD) = 12.5% + 63.8% = 76.3%
(16.6%, TOTAL DEMAND FOR SPACING; 59.7%, TOTAL DEMAND FOR LIMITING)

PROPORTION OF DEMAND SATISFIED BY ANY METHOD = CURRENT CONTRACEPTIVE USE (ANY METHOD) / TOTAL DEMAND FOR FAMILY PLANNING = 63.8% /76.3% = 83.6%

PROPORTION OF DEMAND SATISFIED BY MODERN METHODS = CURRENT CONTRACEPTIVE USE (MODERN METHODS) / DEMAND FOR FAMILY PLANNING = 32.0% / 76.3% = 41.9%

2014 CPS, Mauritius

MATERNAL AND CHILD HEALTH 9

9.0 Introduction

Pregnancy and childbirth complications are the leading cause of disability and death for women of reproductive age in developing countries. A number of factors can impact the health of a woman, the health of her baby, and the outcome of her pregnancy, including utilization of health care services related to pregnancy, location and type of assistance at delivery. Therefore, proper care during pregnancy, at the time of delivery, and in the postpartum period is important to the health of both the mother and her baby. This chapter presents the type of care that Mauritian women received during pregnancy and at the time of delivery. It also collected a range of information on potential risk factors that contribute to poor outcomes as well as infant and child mortality.

9.1 Antenatal Care

Early and regular checkups by trained medical providers are very important in assessing the physical status of women during pregnancy. To ensure the optimal health of mother and child, experts recommend that prenatal care is initiated during the first trimester of pregnancy, continues throughout gestation at specified intervals.

9.1.1 Antenatal Care Coverage

Access to proper medical attention and hygienic conditions and proper medical assistance at the time of delivery can reduce the risk of complications and infections for both mother and child (WHO, 2006). Under normal circumstances, WHO recommends that a pregnant woman without complications have at least four antenatal care (ANC) visits to provide sufficient care. It is possible during these visits to detect reproductive health risk factors. In the event of any complication, more frequent visits are advisable and admission to a hospital may become necessary.

Table 29 presents data on the coverage of antenatal care services for the last live born child. 98.1 percent of women received antenatal care during pregnancy. Those who received antenatal care were asked where they received antenatal care and who provided most of the antenatal care. The majority (76.4 percent) received care from the public sector (Government hospital/health centre), 12.3 percent from the private sector (private doctor/clinic) and 11.3 percent received care from both the public and private sector simultaneously. Among those who received antenatal care from both the public and private sectors, 75.2 percent stated that they sought most of the antenatal care from the public. This implies that on the whole, 84.5 percent received antenatal care from the public sector and 15.5 percent from the private sector.

9.1.2 Assistance at Delivery of Antenatal Care

One of the most critical factors determining whether a woman survives an emergency, life-threatening situation during, and in the period directly following delivery, is the care she receives from a skilled birth attendant. Internationally a birth is considered to have received regular care if the mother said that she had made at least four antenatal care visits where she was seen by a trained

medical provider. Table 29 also shows that 77.5 percent of women received regular antenatal care (i.e they made four or more visits to a provider) for their last live born child. 55.9 percent made more than eight antenatal care visits. Moreover, results of the 2014 CPS show that almost all women (99.7 percent) received antenatal care from a health care provider; 66.2 percent received care from nurse/midwife and 33.5 percent from doctor. However, almost all deliveries in Mauritius are conducted by a doctor.

Table 29: Percent distribution of births by type of provider for ANC, type of facility where ANC was sought, and number of ANC visits, and percent distribution of last births by the stage of pregnancy at the time of first and last visits

Antenatal care indicator:	Total (%)
Number of weeks pregnant when first learned that you were pregnant	
<6	54.1
6-12	37.6
13+	3.7
Don't Remember	4.6
Source for ANC (%)	
Public Sector	76.4
Private Sector	12.3
Both Public and Private sector	11.3
ANC Provider (%)	
Doctor	33.5
Nurse	47.9
Midwife	18.3
Other	0.3
Number of ANC Visits	
<4	1.3
4	1.4
5-7	11.7
8	8.5
9-10	30.1
11+	25.8
Don't Remember	21.2
Number of weeks pregnant at first ANC visits	
<8	18.8
8-12	49.1
13-16	19.9
17+	7.7
Don' Remember	4.6
Place of Delivery (%)	
Government Hospital	84.3
Private clinic	14.8
Home	0.6
Abroad	0.2
Type of Delivery (%)	
Normal	68.7
Caesarian	30.5
Forceps/ventouse	0.8
Weight of baby at birth (%)	
Normal	89.0
Underweight	7.5
Overweight	3.5
Not sure	0.2

2014 CPS, Mauritius

9.1.3 Place of Delivery

An important effort to reduce the health risks of mothers and children is to increase the proportion of babies delivered in a safe and clean environment, and under the supervision of health professionals. Data from table 29 shows that 99.1 percent of births occurred in a health institutions; 84.3 percent of women stated that they delivered their last live born child at government hospital, 14.8 percent in private clinics and 0.6 percent (8 out of 1274) at home. This correlates with routine statistics which shows that around 80 percent of all delivery in Mauritius occur in Government hospitals.

9.1.4 Type of Delivery

Overall, 68.7 percent of currently married women age 15-49 years had a normal delivery, 30.5 percent had a caesarean section delivery and 0.8 percent had a forceps/ventouse delivery for their last birth. It is also noted that the proportion of caesarean section delivery is higher in private hospitals than in government hospitals (42.2 percent versus 30.2 percent).

9.1.4.1 Delivery by Caesarian Section

The 2014 CPS obtained information on the frequency of caesarian section. Table 30 presents data on normal and caesarian section deliveries for the last live born child by selected characteristics. 30.5 percent of last live born child was delivered by caesarian section.

Rural women were slightly more likely to deliver by caesarian section (32.7 percent) than urban women (27.5 percent). The likelihood of a caesarian section delivery increased with age of the mother varying from 21.4 percent among mothers age 15-19 years to a peak of 36.1 percent among women age 35-39 years.

Relating delivery by caesarian section to the number of living children, it was found that 36.4 percent of mothers with one living child had delivered by caesarian section compared to 26.2 percent among mothers with 2 living children. Education seems to influence mode of delivery since the more women are educated the more they are likely to deliver by caesarian section, For example, 33.8 percent of women who have attended university have delivered by caesarian section compared to 26.9 percent of women with primary education.

Similarly, professional women are more likely to deliver by caesarian section (36.6 percent) compared to manual worker (27.1 percent).

Table 30: Mode of delivery of last live born child by background characteristics

Mode of Delivery	Normal(%)	Caesarian(%)	Forceps/Ventouse(%)	Total
Residence				
Urban	71.6	27.5	0.9	427
Rural	66.7	32.7	0.7	737
Age group				
15-19	78.6	21.4	0.0	10
20-24	71.1	28.9	0.0	56
25-29	68.5	31.5	0.0	123
30-34	66.2	32.3	1.5	204
35-39	63.2	36.1	0.7	194
40-44	70.7	28.9	0.4	202
45-49	73.0	25.9	1.1	230
Religion				
Hindu	67.4	31.8	0.8	537
Muslim	72.1	26.8	1.1	219
Christian	68.6	31.1	0.3	263
Education				
No School	43.0		0.0	6
Primary	72.3	26.9	0.8	281
Secondary	67.7	31.5	0.8	665
University/Technical	66.2	33.8	0.0	68
Number of living children				
1	61.5	36.4	2.1	259
2	73.0	26.2	0.5	490
3	68.8	31.2	0.0	207
>=4	65.0	35.0	0.0	63
Occupation				
Professional	62.4	36.6	0.9	173
Service worker	69.8	29.5	0.7	210
Manual Worker	72.9	27.1	0.0	169
Homemaker/Student	69.1	29.9	1.0	467

2014 CPS, Mauritius

9.1.4.2 Reasons for Caesarian Section

Respondents were asked about the most important reasons they had to deliver by caesarian section. Figure 24 shows that the five most common reasons were previous caesarian section (19.4 percent),followed by malpresentation (15.5 percent), baby too big (12.1 percent), baby started to suffer (11.4 percent) and prolonged labour (10.2 percent). 5.3 percent of mothers had high blood pressure and 7.4 percent had requested for caesarian section. 12.7 percent of women had delivered by caesarian section for other reasons which included amongst others; passage too small, loss of water, health problem and multiple births and 5.1% did not know the reason why a caesarean section was carried out.

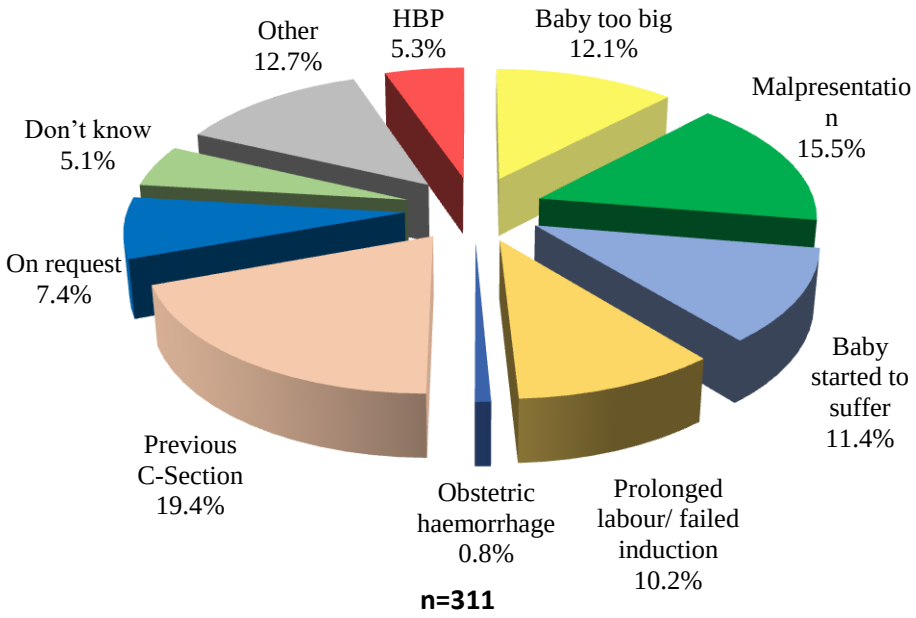


Figure 24: Reasons for women to deliver by caesarian section

2014 CPS, Mauritius

9.1.5 Exposure to Safe Pregnancy Messages during Pregnancy

The 2014 CPS collected information on whether women received information on Nutrition, Breastfeeding, Contraception and Postnatal Care among others during antenatal care visits for their last pregnancy. Figure 25 shows that more than 50.0 percent of these mothers said that they were informed. The most common subjects on which they received information were; breastfeeding (85.7 percent), Nutrition (84.6 percent), smoking (75.8 percent) and alcohol (75.0 percent). The subject on which they were least informed was contraception (55.7 percent). Surprisingly, only about one in two (56.2 percent) received information on warning signs of pregnancy complications at the time they were pregnant.

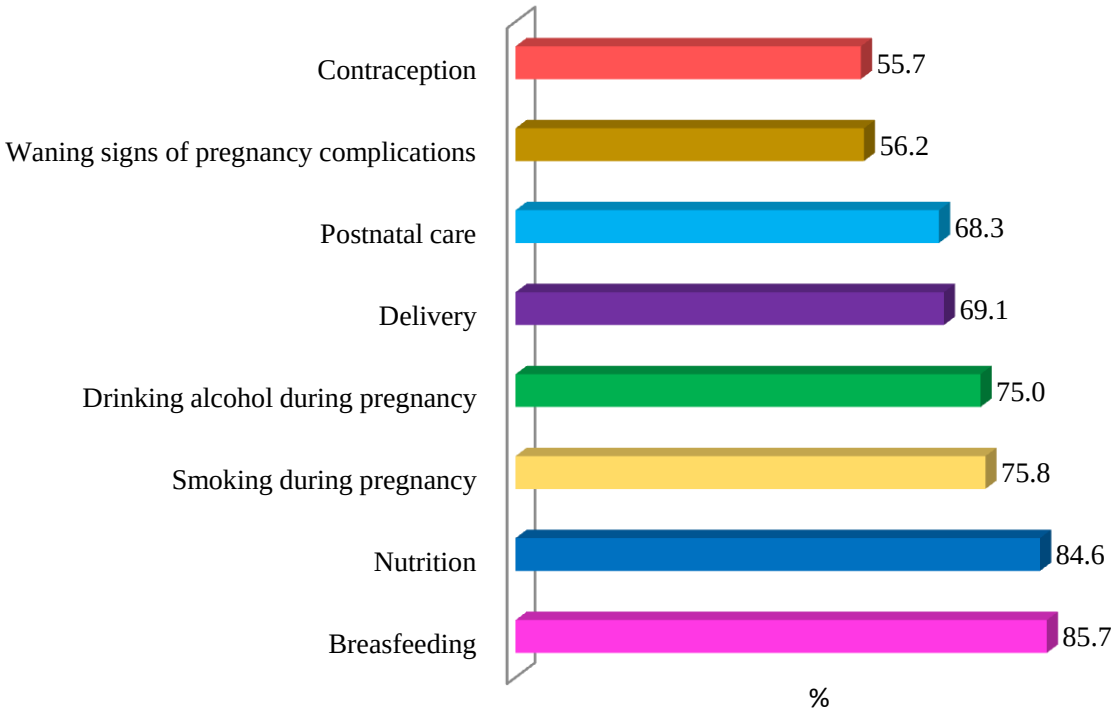
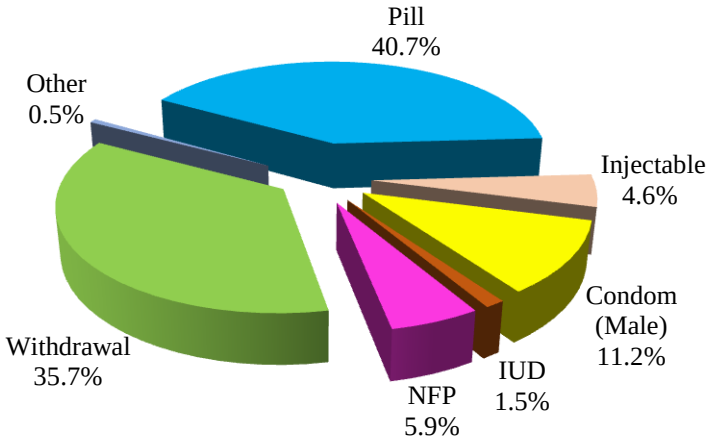


Figure 25: Percentage of women exposed to safe pregnancy messages during pregnancy

2014 CPS, Mauritius

9.1.6 Method Failure Resulting in Pregnancy for Last Born Child

Women who became pregnant for their last born child were asked if they were using a contraceptive method when they got pregnant. Surprisingly, 16.0 percent of respondents said they got pregnant while using a contraceptive method and the method used were withdarawal (35.7 percent) and NFP method (5.9 percent) as shown in figure 26. On the whole, 58.0 percent were using a supplied method.



n=162

Figure 26: Method failure resulting in pregnancy for last live born child

2014 CPS, Mauritius

9.2 Risk Factors and Pregnancy

Monitoring the risk profile of the population is an extremely important step to ensure the health of the nation as future trends in disease burden relate to current trends in risk factors. There is a need to consider a range of factors contributing to problems in pregnancy, nutrition and women's tobacco and alcohol use during pregnancy. The respondents were asked questions in relation to tobacco and alcohol consumption as well as whether they had any disorders such as diabetes or hypertension during their pregnancies

9.2.1 Smoking and Drinking During Pregnancy

Smoking and alcohol consumption affect adult health, and may adversely affect children's health. Tobacco and alcohol consumption during pregnancy are major risk factors for poor pregnancy outcomes. Smoking during pregnancy is linked to low birth-weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome, and infant respiratory problems whilst alcohol consumption during pregnancy is linked to miscarriages, stillbirth and premature delivery.

The 2014 CPS data reveals that 1.9 percent of women age 15-49 years who have had a live birth[28] were smoking during their pregnancy for their last liveborn child. Further analysis reveals that 73.6 percent of them[29] were smoking daily.

It is also noted that 3.4 percent of women age 15-49 years who have had a live birth were drinking alcohol during their pregnancy for their last liveborn child. Moreover, the data reveals that 7.0 percent of them[30] were drinking daily.

9.2.2 Diabetes and Hypertension during Pregnancy

When women have had a problem in one pregnancy, they are more likely to have a problem, often the same one, in subsequent pregnancies. Before becoming pregnant, women may have a disorder that can increase the risk of problems during pregnancy. These disorders include high blood pressure, diabetes, kidney disorders, kidney infections, heart failure, sickle cell anemia, and sexually transmitted diseases. Therefore, women who have one of these disorders need special care and must be closely monitored.

Women who have had a liveborn child were asked if they have been medically diagnosed for diabetes and hypertension. The results show that 8.8 percent of them have been diagnosed for diabetes and 14.5 percent for hypertension. Moreover, 3.6 percent of them have been diagnosed for both diabetes and hypertension.

The median age at which the respondents have been diagnosed for diabetes was 34.3 years.

Figure 27 shows that 31.6 percent have been diagnosed for diabetes during their pregnancy for their last liveborn child.

[28] Overall, 1,019 women age 15-49 years have had a live birth.
[29] Among women who were smoking during their pregnancy for their last liveborn child.
[30] Among women who were drinking during their pregnancy for their last liveborn child.

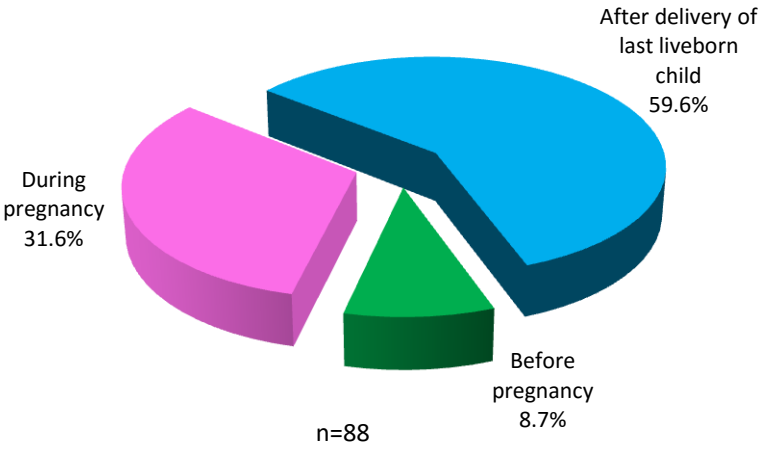


Figure 27: Percent distribution of women age 15-49 years who have been diagnosed for diabetes before, during or after their pregnancy for their last liveborn child

2014 CPS, Mauritius

The median age at which the respondents have been diagnosed for hypertension was 28.2 years.

Figure 28 shows that 47.2 percent have been diagnosed for hypertension during their pregnancy for their last liveborn child.

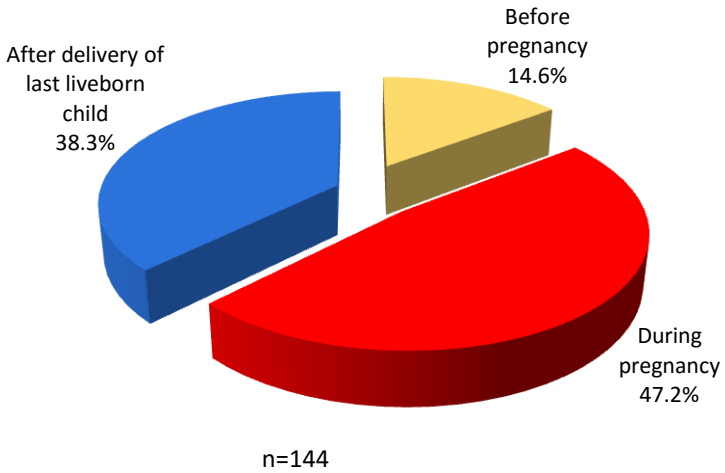


Figure 28: Percent distribution of women age 15-49 years who have been diagnosed for hypertension before, during or after their pregnancy for their last liveborn child

2014 CPS, Mauritius

9.3 Child Health

Early childhood growth, development and health monitoring is widely accepted and considered as an important indicator of future health outcomes (Panpanich et al. 2000). In developed countries, child growth and development monitoring programs are typically delivered through routine measurement of height (or length) and weight, screening tests and discussions with parents to ascertain the achievement and timing of key developmental milestones, and parental education regarding child development, health, illness and safety.

9.3.1 Birth Weight

A child's birth weight is an important indicator of the child's vulnerability to the risk of childhood illness and the chances of survival. Children whose birth weight is less than 2.5 kilograms are considered to have a higher than average risk of early childhood death. Table 28 shows that only 7.5 percent of the last live born child weighted less than 2.5 kilograms according to respondents. 3.5 percent were overweight that is more than 4 kilograms, but the majority (89.0 percent) had normal weight.

9.3.2 Nutrition of Children

Adequate nutrition is essential for good health and is critical to children's growth and development. The period from conception to age 2 is especially important for optimal physical, mental, and cognitive growth, health, and development. Unfortunately, this period is often marked by macro- and micronutrient deficiencies that interfere with optimal growth. Thus, the nutritional status of children under age 5 is an important proxy measure of children's health. This chapter focuses upon infant feeding and nutritional status of children of the 2014 CPS.

9.3.2.1 Breatfeeding

Proper feeding practices during infancy and childhood are essential for attaining and maintaining proper nutrition and health, and for development of infants and children (Kumar et al, 2006). Breastfeeding is the best way to provide infants with the nutrients they need. It also provides numerous short- and long-term health benefits. Exclusive breastfeeding[31] is recommended up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

The 2014 CPS asked mothers who reported having had a live birth in the two years preceding the survey whether they ever breastfed their last liveborn child. The results show that 96.6 percent of their last liveborn child born two years preceding the survey were breastfed. This proportion has increased by 3.2 percentage points between 2002 and 2014 (as shown in Figure 29).

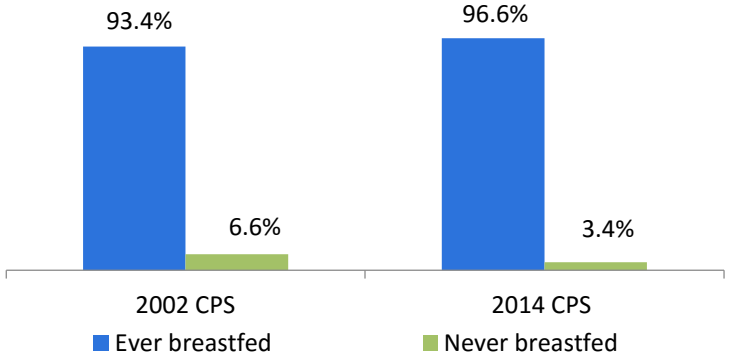


Figure 29: Percent distribution of respondents who have ever breastfed their last liveborn child born in the two years preceding the survey

2014 CPS, Mauritius

[31] Exclusive breastfeeding is defined as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for the first 6 months of life, but allows the infant to receive oral rehydrating salt (ORS), drops and syrups (vitamins, minerals and medicines).

The 2014 CPS data indicates that among the last liveborn children born in the five years preceding the survey who were ever breastfed, 32.8 percent of them were breastfed within one hour of birth compared with 21.4 percent in 2002. The results of the 2014 CPS also show that the mean duration of any breastfeeding is 12.6 months and the mean duration of exclusive breastfeeding is 4.4 months among last liveborn children born in the five years preceding the survey (Table 31). Care should be taken in interpreting these figures since there might be a recall bias.[32]

Table 31: Breastfeeding Indicators

Percent distribution of last liveborn children born in the *two years preceding the survey* who were ever breastfed and the mean duration of any breastfeeding and exclusive breastfeeding of last liveborn children born in the *five years preceding the survey*

		Mean duration (in months) of:	
CPS	Ever breastfed	Any Breastfeeding	Exclusive Breastfeeding
1991	71.9	13.6	1.1
2002	93.4	13.6	2.0
2014	96.6	12.6	4.4

2014 CPS, Mauritius

[32] It should be noted that the indicator for exclusive breastfeeding among last liveborn children born in the six months preceding the survey could not be calculated because of the small number of cases.

REPRODUCTIVE HEALTH PERCEPTION AND BEHAVIOR 10

10.0 Introduction

Reproductive and sexual health contributes significantly to both wellbeing and ill health of the population. Unsafe sexual behaviours represent a public health challenge and present a persistent challenge in the fight against the spread of STIs and HIV infection. Therefore, it is important to understand factors acting at different levels to influence sexual behaviour. This chapter examines the reproductive health perception and behavior among the women in the 2014 CPS focussing on education and counselling. There is a pressing need for advocacy, and policy support for the development of friendly sexual and reproductive health services in Mauritius.

10.1 Source of Information on Sexual Matters

Respondents[33] were asked to cite the most important source of information on sexual matters. Table 32 shows that 22.7 percent of respondents cited teachers and 19.7 percent cited parents as the most important source of information on sexual matters. Moreover, media (mass, printed and electronic) was cited by 15.5 percent of respondents.

Table 32: Percent distribution of respondents by most important source of information on sexual matters

Most important source of information	Percentage
Mother/Father	19.7
Partner/Husband/Boyfriend	10.3
Other family member/Relative	10.5
Friend/Colleague	15.7
Doctor/Nurse/Midwife	5.7
Teacher	22.7
Books/Newspaper/Magazines/Brochures/Flyers	8.3
Internet/Social media/ Radio/ TV	7.2
Total	**100.0**
Total number of respondents	1,680

2014 CPS, Mauritius

10.2 Family Life Education in Schools

In the past few years, there has been an ongoing debate about school-based sexuality education in Mauritius. Although the process of introducing sexuality education in the school curriculum has been set in motion since long ago, it is still not included in the formal curriculum at schools in Mauritius.

[33] Throughout this section, respondents refer to all women age 15-49 years unless stated otherwise.

Students are sensitized on healthy lifestyles and sexual and reproductive health issues through the Family Life Education programme, which is conducted on an adhoc basis in schools by governmental and non-governmental organizations.

The 2014 CPS asked respondents[34] if topics, such as responsible sexual behavior, contraceptive methods and HIV/AIDS were ever discussed with them at school. Figure 30 shows that menstrual cycle (71.0 percent) and puberty (67.9 percent) were the two most common topics that were cited by respondents. It is noted that slightly less than two in five respondents were given talks on contraceptive methods (39.1 percent). Further analysis of the data shows that 24.3 percent of respondents were not given talks on any of these topics at school.

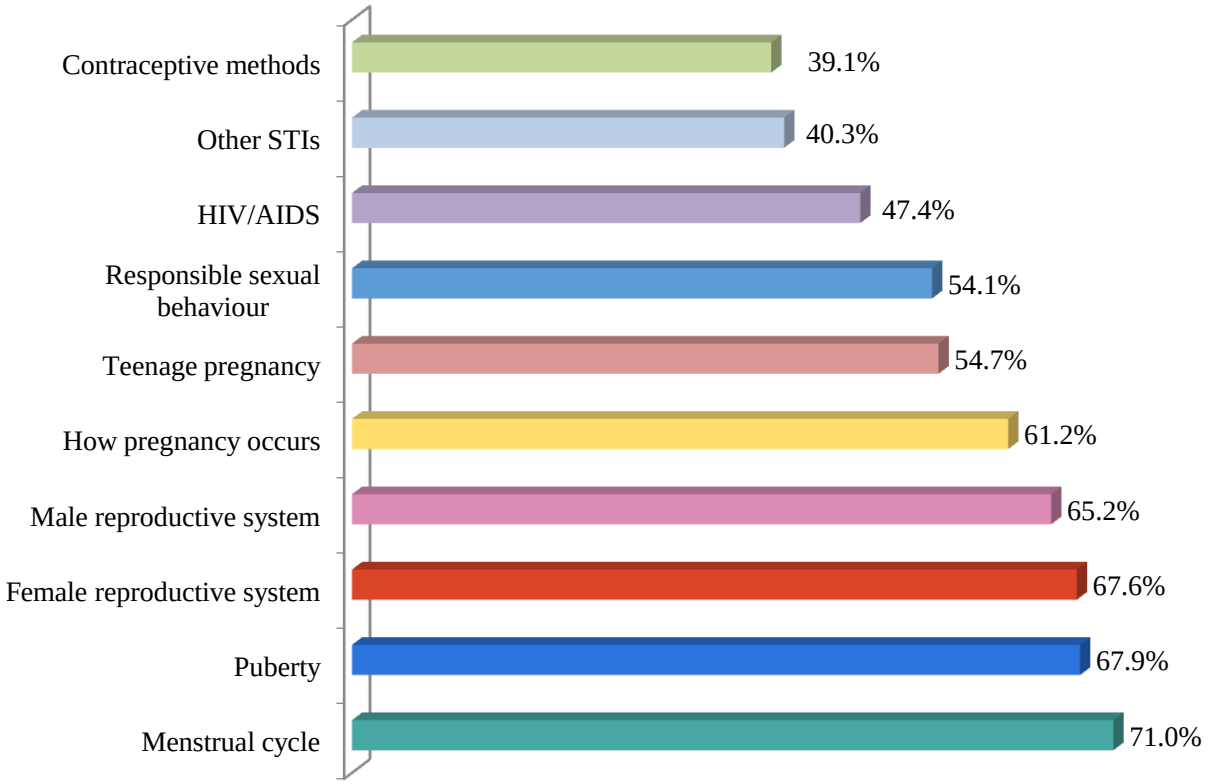


Figure 30: Percent distribution of respondents who have been given talks on sexual and reproductive health issues at schools by specific topic

2014 CPS, Mauritius

10.3 School-based Sexuality Education

School-based sexuality education can be an important and effective way of reducing risky sexual behaviour among young people. Since there is a lack of information on the opinions of people on this matter, respondents were asked if the following components of sexuality education should be taught at school: human reproduction, contraceptive methods, STIs including HIV/AIDS, and responsible sexual behaviour.

[34] Excluding 8 respondents who had no schooling.

Figure 31 shows that the majority of respondents agree that the above-mentioned components should be taught at schools. For instance, 92.2 percent of respondents stated that "responsible sexual behaviour" should be taught at school. However, a minority of respondents (1.4 percent) said that none of these components, i.e. human reproduction; contraceptive methods; STIs including HIV/AIDS; and responsible sexual behaviour, should be taught at school.

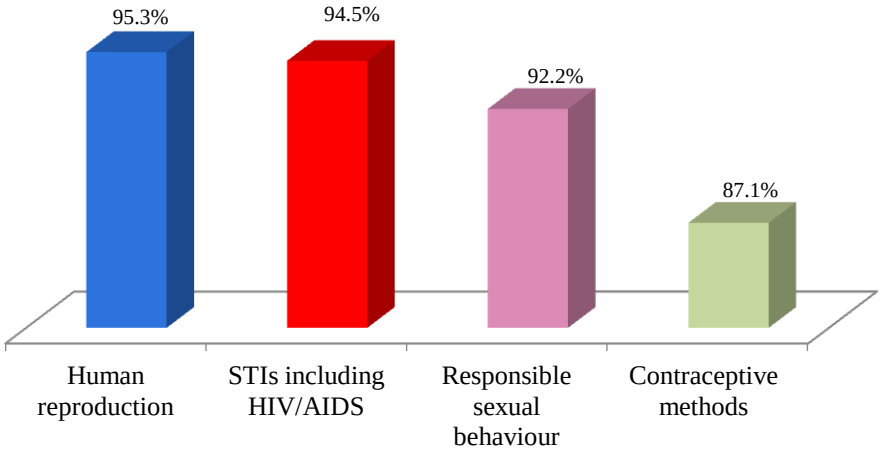


Figure 31: Percent distribution of respondents who agree that sexuality education should be taught at school by specific component

2014 CPS, Mauritius

Respondents, who agreed that specific components of sexuality education should be taught at school, were then asked the best age at which students should be taught these components at school.

Figure 32 reveals that a significant proportion of respondents said that these components should be taught at ages 12 to 15. For instance, 66.8 percent of respondents said that contraceptive methods should be taught at ages 12 to 15 years.

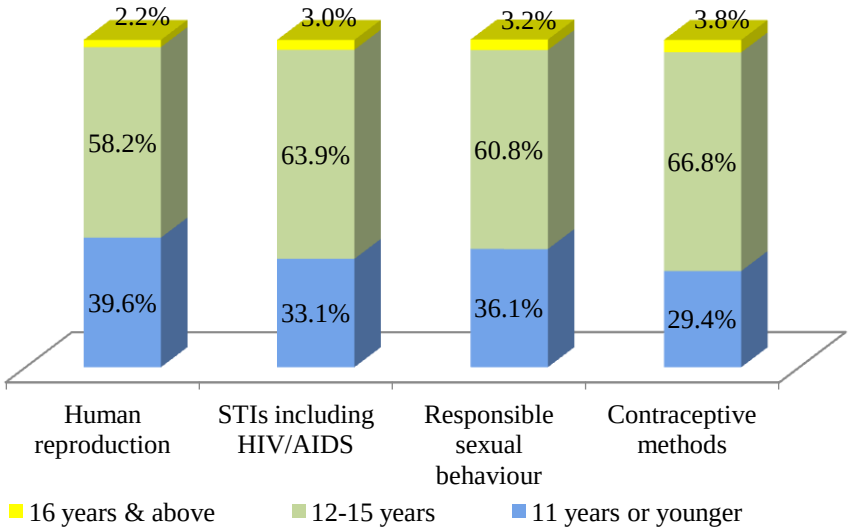


Figure 32: Percent distribution of respondents who stated the best age at which students should be taught sexuality education at school by specific component

2014 CPS, Mauritius

Some of the arguments that opponents of school-based sexuality education put forward in their discussions are listed in table 33. Respondents were asked if they agree with these arguments.

Table 33: Percent distribution of respondents about their opinions on the arguments that opponents of school-based sexuality education put forward in their discussions

Argument against sexuality education	Agree (percent)	Disagree (percent)	Don't know/ No response (percent)
School-based sexuality education may lead to early onset of sexual activities among young people.	33.0	59.7	7.4
Sexuality education should be taught only at home.	4.4	92.7	3.0
Sexuality education is against my religious belief.	5.1	88.0	6.9
Teachers do not have enough training to teach sexuality education.	50.9	33.9	15.2

2014 CPS, Mauritius

Overall 59.7 percent of respondents disagree that school-based sexuality education may lead to early sexual initiation among young people; 92.7 percent of them disagree that sexuality education should be taught only at home; and 88.0 percent of them disagree that sexuality education is against their religious belief. However, 50.9 percent of respondents agree that teachers do not have enough training to teach sexuality education.

Respondents were then asked: "Who would be the most suitable person to teach sexuality education at school if sexuality education is included in the formal curriculum at schools in Mauritius?".

Table 34 shows that almost 3 in 4 respondents stated that a teacher with special training in sexuality education (72.5 percent) would be the most suitable person to teach sexuality education.

Table 34: Percent distribution of respondents about their opinion on who is the best person to teach sexuality education at school

Best person to teach sexuality education	Percentage
Teacher with special training in sexuality education	72.5
Biology teacher	16.4
Form teacher	4.8
Other teacher	1.8
Doctor/Psychologist	0.7
Family Planning Health Provider	1.3
Don't Know	2.4
Total	**100.0**

2014 CPS, Mauritius

10.4 Parental Involvement in Sexuality Education

Since sexuality education is an ongoing process, parental involvement is also important in promoting healthy lifestyles among adolescents. Respondents who were 19 years old and above at the time of the interview were asked if their parents had ever talked to them on some components of sexuality education before they reached age 18 and the same question was asked to respondents who were below 18 years old.

Figure 33 shows that 68.1 percent of respondents said that their parents talked about menstrual cycle to them before reaching age 18. Less than half of the respondents (44.9 percent) reported that they have had talks on responsible sexual behaviour with their parents before reaching age 18.

Overall, the mean number of topics that respondents reported discussing with their parents before reaching age 18 was 4.6 topics.

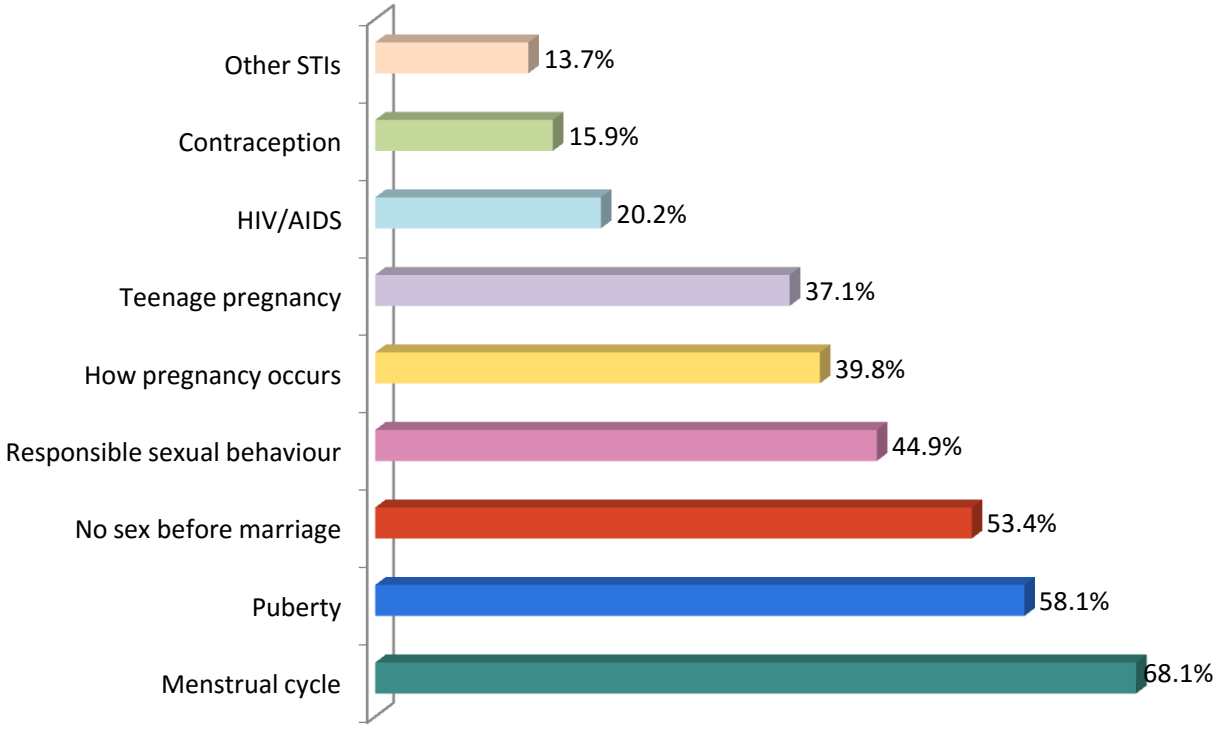


Figure 33: Percent distribution of respondents who discussed reproductive health topics with their parents before reaching age 18 by specific topic

2014 CPS, Mauritius

At this point, it should be mentioned that 22.5 percent of respondents stated that they never had talks with their parents before reaching age 18 on any of these nine components of sexuality education. Hence, the results reveal that parents should be sensitized about their key role in the sexuality education of their children.

10.5 Breast Self-Examination

Breast self-examination (BSE) is a screening method used for early detection of any anomalies that could be linked to breast cancer[35]. Respondents were asked if they have heard/read about breast self-examination (BSE). Figure 34 shows that 72.4 percent of respondents have heard/read about this examination.

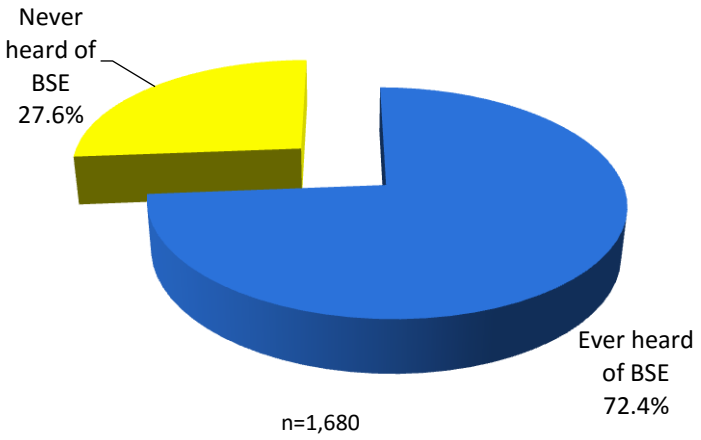


Figure 34: Percent distribution of respondents who have heard/read about breast self-examination

2014 CPS, Mauritius

Respondents who have heard/read about BSE were then asked about their first source of information on BSE. Table 35 shows that 32.7 percent of respondents obtained their information on BSE for the first time from the newspaper/radio/TV.

Table 35: Percent distribution of respondents who have heard/read about breast self-examination by first source of information

First source of information	Percentage
Private doctor	6.2
Government health centre personnel	26.2
Family member	10.9
Friend/Colleague	12.9
Newspaper/Radio/TV	32.7
Books/Magazines/Brochures	6.6
MFPWA	1.7
Internet/Social media	2.7
Total	**100.0**
Total number of respondents	1,216

2014 CPS, Mauritius

[35] Breast cancer is the most common cancer among women in the Republic of Mauritius - 471 new cases of breast cancer was diagnosed among women in 2013. Overall, 37.9% of all new cases of cancer among women were due to breast cancer in the Republic of Mauritius in 2013 whilst worldwide, it was 56.0%. Moreover, 166 women died of breast cancer in 2013 in the Republic of Mauritius.

Figure 35 shows that 60.6 percent of respondents have not carried out BSE despite having heard/read about this examination.

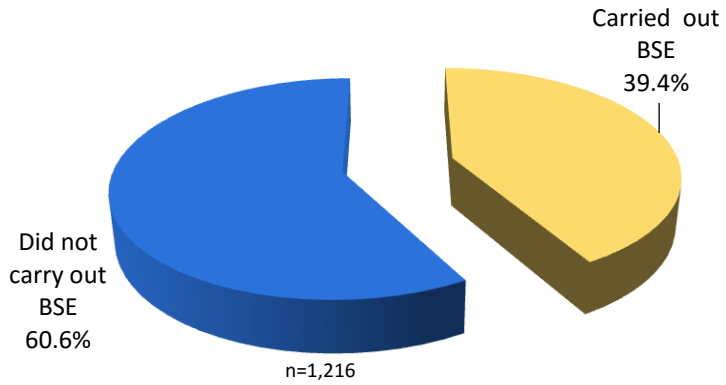


Figure 35: Percent distribution of respondents who have carried out breast self-examination

2014 CPS, Mauritius

Table 36 shows that the most important reason cited by respondents for not carrying out BSE is "don't know how to do BSE" (46.6 percent) followed by "don't think that BSE is important" (26.0 percent).

Table 36: Percent distribution of respondents by the most important reason cited for not carrying out breast self-examination

Most important reason	Percentage
Don't know how to do BSE	46.6
Don't think that BSE is important	26.0
Don't believe in the efficacy of the test	1.0
Don't have any symptoms	24.5
Scared of being diagnosed with breast cancer	2.0
Total	**100.0**
Total number of respondents	737

2014 CPS, Mauritius

10.6 Pap Smear

Pap smear is a screening test to detect abnormal cervical cells and cervical cancers[36]. Respondents were asked if they have heard/read about Pap smear. Figure 36 shows that 39.3 percent of respondents age 15-49 years have heard/read about Pap smear.

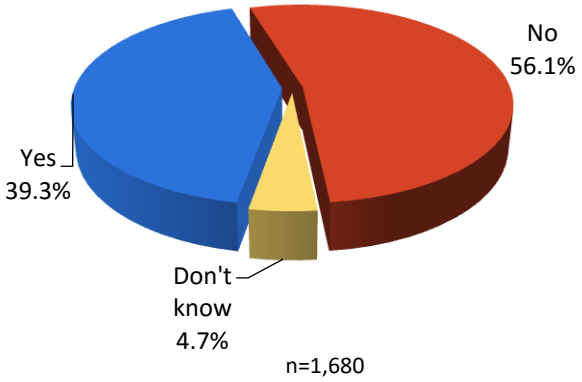


Figure 36: Percent distribution of respondents age 15-49 years who have heard/read about Pap smear

2014 CPS, Mauritius

Respondents who have heard/read about Pap smear were asked: "Where did you hear/read about Pap smear for the first time?". Table 37 shows that an almost equal proportion of respondents have heard/read about Pap smear for the first time from the government health centre personnel (31.3 percent) and the newspaper/radio/television (29.0 percent).

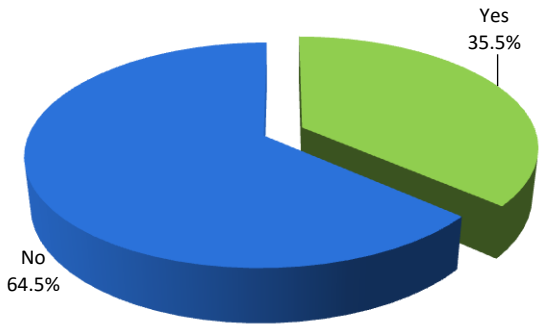
Table 37: Percent distribution of respondents who have heard/read about Pap smear examination by first source of information

First source of information	Percentage
Private doctor	7.5
Government health centre personnel	31.3
Action Familiale	2.0
Family member	9.5
Friend /Colleague	13.4
Newspaper/Radio/ TV	29.0
Books/Magazines/ Brochures	3.0
MFPWA	1.0
Private clinic	0.6
Pharmacy/Pharmacist	0.1
Internet /Social media	2.4
Total	**100.0**
Total number of respondents	660

2014 CPS, Mauritius

[36] Cervical cancer is the second most common cancer among women in the Republic of Mauritius - 95 new cases of cervical cancer were diagnosed in 2013. Overall, 7.6% of all new cases of cancer among women were due to cervical cancer in the Republic of Mauritius in 2013 whilst worldwide, it was 12.0%. Moreover, 36 women died of cervical cancer in 2013 in the Republic of Mauritius.

Respondents who have heard/read about Pap smear and who have had sexual intercourse were asked if they have had a Pap smear. Figure 37 shows that 35.5 percent of them have had a Pap smear.



n=547

Figure 37: Percent distribution of respondents who have had a Pap smear among those who have heard/read about Pap smear and who have had sexual intercourse

2014 CPS, Mauritius

Since the 2014 CPS did not capture the exact age at which the respondents[37] have had their last Pap smear, it can only be said that 35.4 percent of them have had a Pap smear more than 3 years preceding the survey and 25.5 percent of them have had it within a year preceding the survey (see Figure 38).

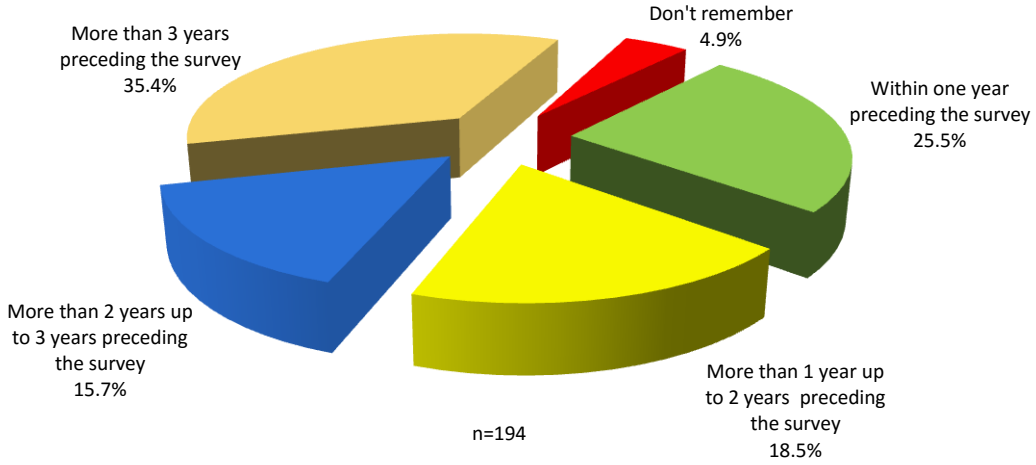


Figure 38: Percent distribution of respondents who have had a Pap smear by the number of years preceding the survey when their last Pap smear was carried out

2014 CPS, Mauritius

[37] It should be noted that figure 37 & 38 refer to respondents who have heard/read about Pap smear and who have had sexual intercourse.

Figure 39 shows that 65.5 percent of respondents have had their last Pap smear at a government-run facility (government mobile clinic, 46.2 percent; government hospital, 19.3 percent), 30.8 percent at a privately-run health facility (private hospital/doctor's office) and 3.7 percent at MFPWA clinic.

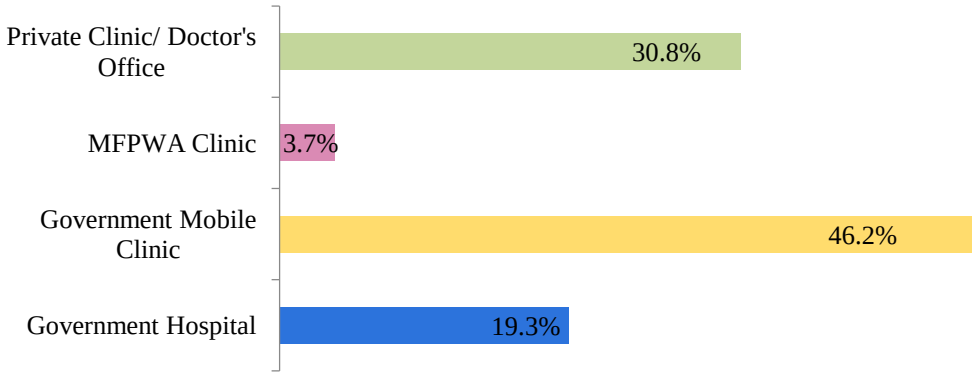


Figure 39: Percent distribution of respondents who reported having had a Pap smear by the facility where their last Pap smear was carried out

2014 CPS, Mauritius

Respondents who never have had a Pap smear despite having heard/read about Pap smear and having had sexual intercourse were asked for the most important reason for not having had a Pap smear.

Table 38 shows that 36.0 percent of them never thought of having one and 14.0 percent did not feel that the test was necessary.

Table 38: Percent distribution of respondents by the most important reason cited for not having had a Pap smear

Most important reason	Percentage
Doctor has not recommended it	5.0
Healthy and has no gynaecological problems	11.9
Does not feel test is necessary	14.0
Does not have time to go for a test	6.0
Never thought of having a Pap smear	36.0
Is afraid of the results	3.7
Is afraid that Pap smear could be painful	5.8
Too embarrassed to get the test or a pelvic exam	1.5
Has no partner/Not sexually active	2.6
Too young	1.1
Don't know where to do the test	0.9
Heard test is done at a particular age	1.1
Other	1.8
Don't know/Refused to answer	8.6
Total	**100.0**
Total number of respondents	353

2014 CPS, Mauritius

HIV/AIDS AWARENESS KNOWLEDGE AND ATTITUDES 11

11.0 Introduction

HIV/AIDS is a public health concern, with both immediate and long-term health, social and economic consequences. The first HIV case was reported in 1987 in Mauritius[38] and a National AIDS Control Programme was then established for primary prevention[39]. The 2014 CPS included a series of questions that addressed respondents' knowledge of HIV prevention, their awareness of modes of HIV transmission, and behaviours that can prevent the spread of HIV.

11.1 HIV Awareness

Overall, 98.3 percent of all respondents[40] have heard about AIDS in 2014 (1,652) and 74.7 percent of them knew where they can get an HIV test.

Respondents who knew where they can get an HIV test were asked to name the various places that provide HIV testing. The most common cited place is government hospital (83.9 percent) followed by government health centre (35.5 percent), private clinic (24.9 percent), PILS[41] (19.1 percent), private laboratory (17.5 percent), mobile clinic (16.5 percent), and private doctor's office (8.2 percent) as shown in Figure 40.

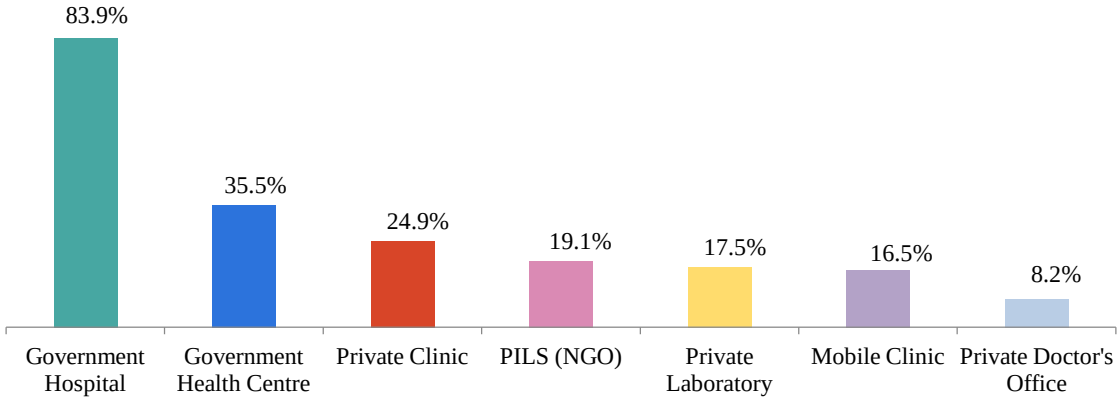


Figure 40: Percent distribution of respondents who cited different places where they can get an HIV test by specific place

2014 CPS, Mauritius

[38] The HIV prevalence rate (for both men and women age 15-49 years) was 0.92% in 2014 and 1.08% in 2002. The cumulative total of HIV cases since October 1987 to December 2014 stood at 6,090 (4,716 males and 1,374 females) in the Republic of Mauritius. During the same period, the number of AIDS-related deaths was 953.

[39] Primary prevention: Information; education; blood transfusion safety; and voluntary counselling and testing.

[40] Throughout this section, respondents refer to all women age 15-49 years who have heard about HIV/AIDS unless stated otherwise.

[41] PILS (Prévention Information Lutte contre le Sida) is an NGO that is engaged in the national response against AIDS.

11.2 Knowledge of HIV/AIDS Prevention

Respondents who have heard about HIV/AIDS were asked whether there are any measures that can be taken to avoid getting HIV/AIDS. Figure 41 shows that the proportion of respondents who knew that something can be done to avoid getting HIV/AIDS has increased from 73.3 percent in 2002 to 88.8 percent in 2014.

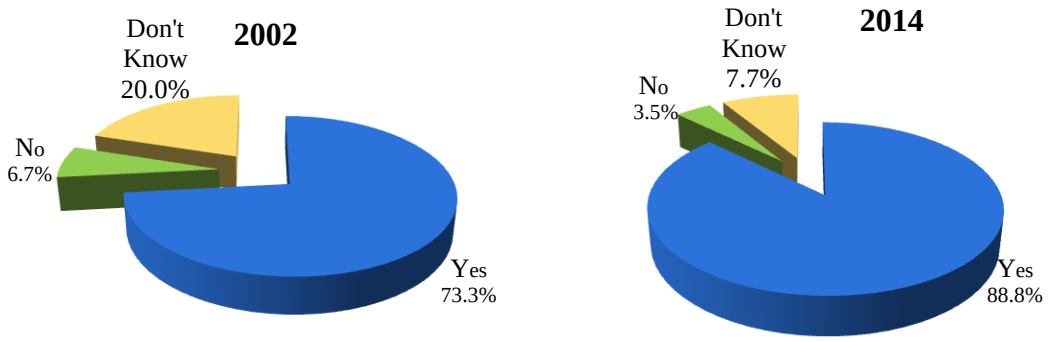


Figure 41: Percent distribution of respondents who knew about ways to avoid getting HIV/AIDS

2014 CPS, Mauritius

11.3 Unprompted Knowledge of Ways to avoid getting HIV/AIDS

Respondents who knew about the different ways to avoid getting HIV/AIDS were asked, without being prompted, to mention all the ways that they knew of to avoid getting HIV/AIDS. Figure 42 shows that use of condoms (78.6 percent) and having only one sexual partner (57.2 percent) are the two most common ways cited by respondents.

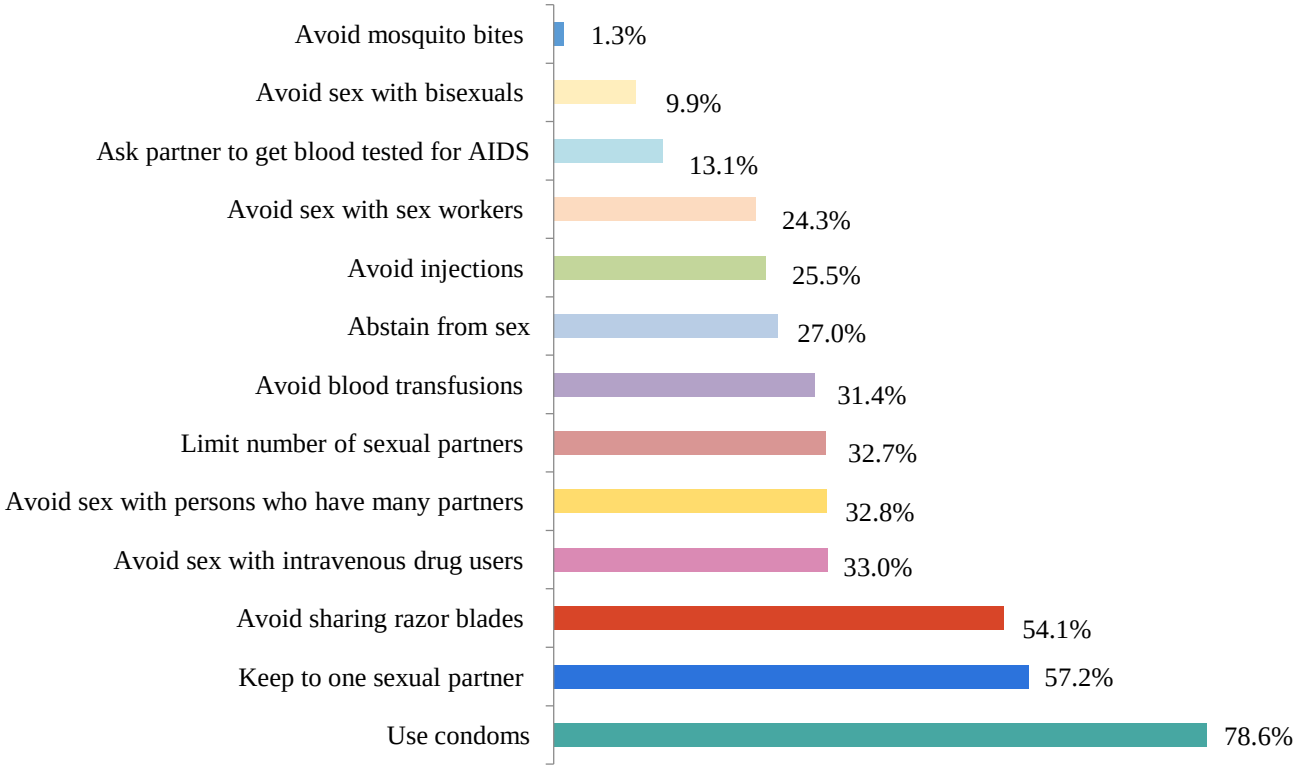


Figure 42: Percent distribution of respondents who stated without being prompted about ways to avoid getting HIV/AIDS by specific way

2014 CPS, Mauritius

11.4 Knowledge of Mother to Child Transmission of HIV

Knowledge of mother to child transmission of HIV during pregnancy, during delivery and during breastfeeding is an essential component of Information, Education and Communication (IEC) preventive efforts.

Respondents who have heard about HIV/AIDS were asked whether HIV can be transmitted from mother to child during pregnancy, during delivery and during breastfeeding. Figure 43 shows that 77.0 percent of respondents know that HIV can be transmitted from mother to child during pregnancy.

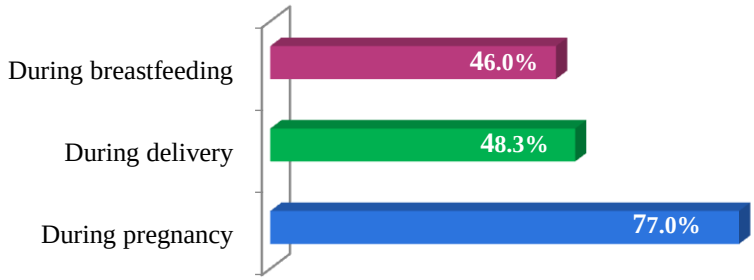


Figure 43: Percent distribution of respondents who knew about the modes of HIV transmission from mother to child by specific mode

2014 CPS, Mauritius

Figure 44 shows that 83.5 percent of respondents[42] know at *least one* mode of HIV transmission from mother to child (1 mode, 24.6 percent; 2 modes, 30.1 percent; 3 modes, 28.8 percent). The remainder stated either "no" or "don't know" to all three modes including a minority of respondents who said "no" to all three modes (2.1 percent).

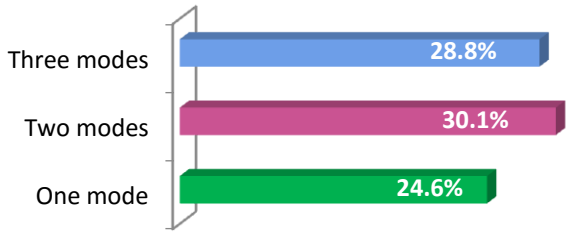


Figure 44: Percent distribution of respondents who stated accurately the number of modes that HIV can be transmitted from mother to child

Three modes of HIV transmission from mother to child: during pregnancy, during delivery and during breastfeeding

2014 CPS, Mauritius

11.5 Knowledge of Mother to Child Transmission of HIV by Background Characteristics

Table 39 shows the percentage distribution of women age 15-49 who know that HIV can be transmitted from mother to child by specific mode and by background characteristics. It is observed that the strongest relationship with knowledge of mother to child transmission of HIV is education. Women who have not completed primary education report the lowest level of knowledge of mother to child transmission of HIV compared to women with higher education.

[42] Among those who have heard about HIV/AIDS.

Data from table 39 indicate that the proportion of women who know that HIV can be transmitted from mother to child during breastfeeding decreases with age reaching its peak at 53.2 percent in the 25-29 age group. Differences in knowledge of mother to child transmission of HIV did not show such wide variation for marital status on all the three ways mentioned.

In addition, professional women are more likely to have knowledge of mother to child transmission of HIV (88.9 percent for pregnancy, 53.2 percent for delivery and 46.5 percent for breastfeeding) than the other counterparts. Women in the high socio-economic group are more likely to report knowledge of HIV transmission from mother to child during pregnancy and delivery. Professional women are more likely to have knowledge of mother to child transmission of HIV than the other counterparts. Moreover, knowledge of mother to child transmission of HIV on all three modes are higher among urban than rural residents, and increases with educational attainment.

Table 39: Percentage distribution of women age 15-49 who know that HIV can be transmitted from mother to child by specific mode; by background characteristics

Background characteristic	During pregnancy	During delivery	During breastfeeding	Number of women
Age group				
15-19	78.2	43.1	49.1	255
20-24	77.6	52.7	48.9	233
25-29	78.4	50.2	53.2	230
30-34	75.4	47.6	43.9	260
35-39	80.0	53.7	44.6	221
40-44	76.2	50.7	44.2	226
45-49	73.5	41.4	38.2	255
Marital Status				
Married (legal/Religious)	75.9	50.0	46.6	972
Consensual union	64.3	49.0	41.9	68
Widowed	72.8	46.9	38.4	38
Divorced/separated	77.0	47.6	46.4	76
Single (never Married)	80.8	45.1	45.8	526
Residence				
Urban	83.1	48.6	43.4	712
Rural	72.5	48.1	47.5	968
Education				
<completed primary	66	47.2	41.3	132
completed primary	64.6	36.5	38.2	206
>completed primary	79.8	50.2	47.6	1342
Occupation				
Professional	88.9	53.2	46.5	322
Service Worker	75.8	50.5	46.1	299
Manual Worker	69.8	49.7	43.9	207
Homemaker/Student	74.5	45.2	46.2	852
Household socio-economic status				
low	68.9	41.1	44.7	316
medium	78.3	50.8	47.0	1059
high	80.5	46.7	43.7	305
Total	**77.0**	**48.3**	**46.0**	**1680**

CPS 2014, Mauritius

11.6 Stigma and Discrimination

The HIV/AIDS epidemic has generated fear, anxiety, and prejudice against people living with HIV and AIDS, and people who are HIV positive face widespread stigma and discrimination. These societal attitudes can adversely affect both people's willingness to be tested for HIV and their adherence to antiretroviral therapy. Reducing stigma and discrimination is therefore an important factor in the prevention, management, and control of the HIV epidemic.

Respondents were asked if they would be willing to take care of a family member living with HIV in their household; to buy vegetables from a vendor who has HIV; if HIV-positive teachers should continue to teach; and if they would want to keep secret the HIV-positive status of a family member. Figure 45 shows that for instance, 66.2 percent of respondents are willing to take care of a family member living with HIV.

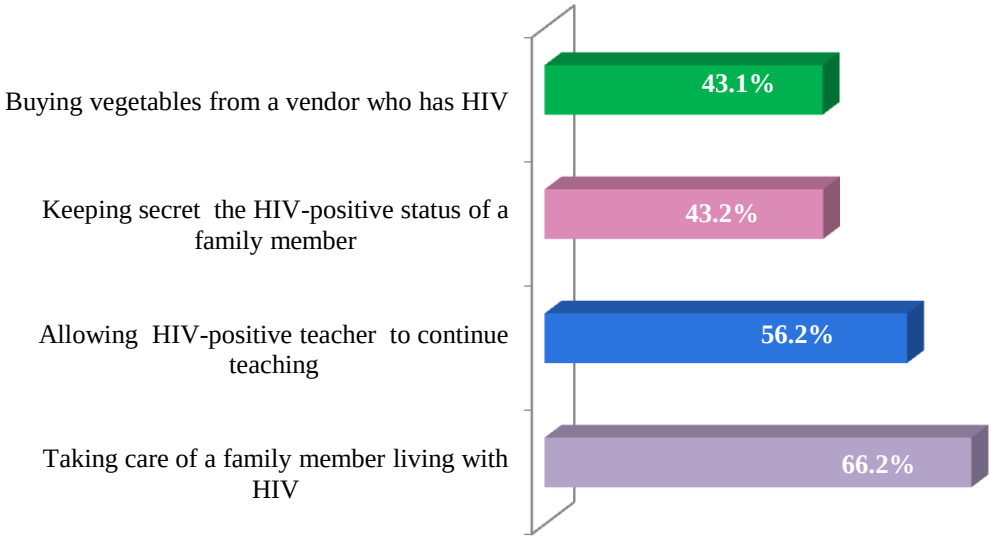


Figure 45: Percent distribution of respondents on their attitudes towards HIV-infected persons

2014 CPS, Mauritius

As an indicator of acceptance towards people living with HIV/AIDS, the response for each above-mentioned item was summed up for each respondent. Each tolerant (or positive) response had a score of 1. An intolerant (or negative) response had a score of 0. The total scores were categorized by more tolerant (with a score of 4); tolerant (with a score of 3); less tolerant (with a score of 1 or 2); and no tolerance (with a score of 0).

Figure 46 reveals that 15.7 percent of respondents are more tolerant towards any of the four items listed above, 24.6 percent are tolerant, 45.2 percent are less tolerant and 5.3 percent are not tolerant. The remainder (which has not been charted here) stated either "no" or "don't know" to all four items.

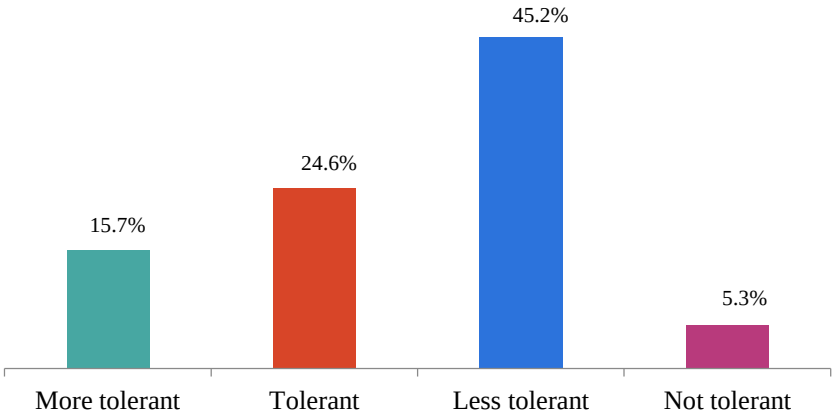


Figure 46: Percent distribution of respondents by their level of tolerance towards HIV-infected persons

2014 CPS, Mauritius

However, it should be pointed out that one limitation of this indicator is that it is restricted to only four items, and this could limit a fair examination of the true level of tolerance towards HIV-infected people. Moreover, there may be a bias since respondents may be reticent to express negative attitudes towards HIV-infected people.

11.7 Accepting Attitudes towards those Living with HIV

Table 40 shows the percentage distribution of women age 15-49 expressing specific accepting attitudes toward people with HIV/AIDS, by background characteristics. 66.2 percent of women reported that they would be willing to care for a family member with HIV at home, however, differences were observed across selected characteristics of women. Women from urban region (73.1 percent) were more willing to care for a family member with HIV at home. Women in lower socio-economic group also reported a lower level of agreement to this response (60.2 percent). In addition, women with higher education were more willing to care for a family member with HIV at home.

Regarding preparedness to buy vegetables from a vendor infected with HIV, women with higher education (44.5 percent) were more comfortable with buying fresh vegetables from an infected person as compared to the other counterparts. Women from rural region (40.7 percent) were also less likely to report preparedness to buy vegetables from an HIV positive vendor reported compared to urban women (46.5 percent).

56.2 percent of women believe an HIV positive teacher should be able to continue teaching. Again this measure of acceptance is affected by education with increasing acceptance as women's education increase (36.8 percent – 59.9 percent). Women from urban region (62.8 percent) are more likely to accept an HIV positive teacher to continue teaching. Likewise, Women from high socio-economic group reported a higher level of agreement to this response (60.9 percent).

Surprisingly, professional (49.4 percent) and single women (46.2 percent) are more likely to keep the HIV positive status of a family member in secret.

Table 40: Percentage distribution of women age 15-49 expressing specific accepting attitudes toward people with HIV by background characteristics

Background characteristic	Taking care of a family member living with HIV	Buying vegetables with a vendor who has HIV	Allowing HIV-positive teacher to continue teaching	Keeping secret the HIV positive status of a family member	Number of Women
Age group					
15-19	61.2	34.8	55.7	44.5	255
20-24	71.3	45.0	60.2	50.2	233
25-29	69.8	48.5	68.4	46.0	230
30-34	63.5	41.3	50.8	37.0	260
35-39	72.1	52.6	56.8	44.7	221
40-44	64.5	40.1	51.1	38.7	226
45-49	62.1	41.2	51.3	41.7	255
Marital Status					
Married (legal/Religious)	63.5	43.1	54.5	42.1	972
Consensual union	71.8	46.4	54.0	28.5	68
Widowed	67.5	38.8	51.9	55.9	38
Divorced/separated	72.6	54.1	56.4	41.3	76
single (never Married)	69.4	41.6	59.8	46.2	526
Residence					
Urban	73.1	46.5	62.8	45.5	712
Rural	61.1	40.7	51.3	41.4	968
Education					
<completed primary	63.9	42.8	36.8	25.7	132
completed primary	59.6	34.3	42.9	39.1	206
>completed primary	67.4	44.5	59.9	45.3	1342
Occupation					
Professional	74.6	52.3	72.2	49.4	322
Service Worker	68.3	46.8	57.1	42.1	299
Manual Worker	69.6	41.4	46.3	36.2	207
Homemaker/Student	61.3	38.7	52.1	42.8	852
Household socio-economic status					
low	60.2	40.3	47.0	41.2	316
medium	66.6	45.0	57.5	44.3	1059
high	70.6	39.5	60.9	41.3	305
Total	**66.2**	**43.1**	**56.2**	**43.2**	**1680**

CPS 2014, Mauritius

RECOMMENDATIONS 12

In line with the findings of the 2014 CPS, the following recommendations were anticipated;

A. Fertility

1. Encourage newly married couples to have more than two children so as to increase the percentage of active population and reduce the trend of an ageing population.
2. Setting up of pre-marital counselling units.

Key Recommendation:

3. Intensive campaign among women in the vulnerable groups to adopt contraceptive methods to limit the number of births.

B. Family Planning

4. Promote premarital and marital counselling and the use of contraceptive methods available in the public and private sectors to reduce/eliminate induced abortion.
5. Target a zero per cent home delivery.
6. Intensify awareness campaigns at all levels on family planning services.
7. Reinstate home visits for family planning services, particularly in deprived areas.
8. Replenishment and renewal of contraceptives to be done by the general nurse in the absence of Community Health Worker.
9. Policy decision to be taken on prescription of contraceptive methods to minors.
10. Further encourage male involvement in family planning.

Key Recommendation:

11. Encourage the use of modern and long lasting methods of contraception.
12. Setting up of dedicated family planning clinics in busy government health centres.

C. Breastfeeding

13. Advocate to allow 1 hour time off for breast feeding/expression of breast milk for officers of the public sector.
14. Encourage the availability of Crèche at workplaces in order to facilitate and promote breastfeeding.
15. Capacity building of nurses working in maternity section to encourage all mothers to start breastfeeding their new-born babies within the first hour of birth.

Key Recommendation:

16. Encourage mothers to breastfeed exclusively during maternity leave and onwards for at least 6 months.

D. Sexuality Education

17. Intergenerational activities to ease conversation and communication between parents and children on topics such as reproductive health and sex education.
18. Train parents through PTA meetings to enhance their skills to be able to talk about sexuality to their children, especially during the pre-adolescent period where children are still receptive

Key Recommendation:

19. Introduce sexuality education in the school curriculum at primary and secondary levels.
20. In the ante-natal clinics and family planning clinics, nurses/officers can initiate an introduction on the importance of sex education and the role of parents in this process.

E. Reproductive Health Perceptions and Behaviour

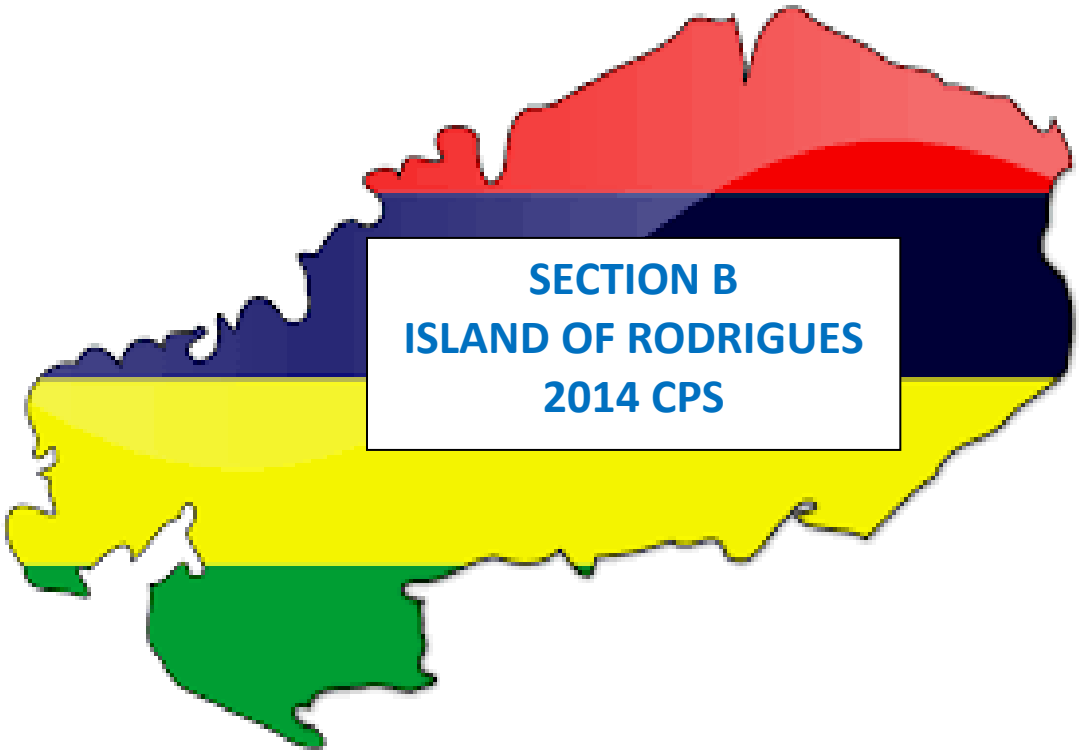
21. Promote optimum control of gestational diabetes and hypertension during pregnancy.
22. Promote birth spacing and limiting in women with diabetes and hypertension.

Key Recommendation:

23. Enhance health education on the risk factors, namely tobacco and alcohol.
24. Close follow-up of women with gestational diabetes to prevent and retard development of Type 2 diabetes.

F. HIV/AIDS

25. Intensify campaigns to increase public awareness on HIV/AIDS to further reduce stigma and discrimination



SECTION B
ISLAND OF RODRIGUES
2014 CPS

CHARATERISTICS OF HOUSEHOLDS 13

13.0. Introduction

This chapter provides an overview of the profile of the 2014 CPS household sample for the island of Rodrigues. It provides information on the dwelling characteristics, access to drinking water and sanitation and various goods and amenities available in respondents' households.

13.1 Dwelling Characteristics

Table 41 shows that 30.8 percent of the households lived in dwellings with one or two rooms, 49.0 percent had three or four rooms and 20.2 percent had five rooms or more. Similarly, 7.2 percent of the households comprised of one or two people, 55.9 percent comprised of three to four people, and 36.9 percent comprised of five people or more. In addition, only 32.4 percent of the households had three or more sleeping rooms while the rest had less than three sleeping rooms.

13.2 Access to Drinking Water

As illustrated in table 41, the source of drinking water for 98 percent of households is piped water either inside the dwelling unit or on premises. About 1.1 percent of households obtain their drinking water from public fountain, 0.3 percent from tank wagon and 0.6 percent from well or river. Overall, 99.4 percent of households in Rodrigues use an improved source of drinking water (water from unprotected wells or rivers being considered as unsafe)

13.3 Sanitation Facilities and Waste Disposal

Overall, all the households use some type of improved sanitation facility as shown in table 41 and the pit latrine being the main toilet facility in nearly half of the households (49.5 percent) in Rodrigues. 30.5 percent of the households reported that the toilet was connected to an absorption pit, 1.2 percent was connected to sewage and 18.9 percent were connected to a septic system

Table 41: Dwelling characteristics of households

Characteristics	Household		
	Weighted percentage	Weighted number	Unweighted number
Number of people			
1-2	7.2	29	26
3-4	55.9	223	224
≥ 5	36.9	148	150
Number of rooms			
1-2	30.8	123	127
3-4	49.0	196	196
≥ 5	20.2	81	77
Number of sleeping rooms			
One	19.6	78	80
Two	48.0	192	197
Three or more	32.4	130	123
Sources of drinking water			
Piped inside housing unit	54.1	216	225
Piped outside on premises	43.9	176	168
Public fountain	1.1	5	4
Tank wagon	0.3	1	1
Well/river	0.6	2	2
Type of toilet facilities			
Flush connected to sewerage	1.2	5	3
Flush connected to absorption pit	30.5	122	131
Flush connected to septic tank	18.9	75	73
Pit latrine	49.5	198	193
Total	**100.0**	**400**	**400**

2014 CPS, Rodrigues

13.4 Household Possessions

The 2014 CPS also collected information on possession of durable commodities and means of transportation. Table 42 illustrates that 93.7 percent of the households owned a television, 34.4 percent of households had fixed telephone and 94.6 percent owned a mobile phone. 14.2 percent of the households were connected to the Internet and 28.5 percent owned a personal computer or laptop. 24.0 percent owned a washing machine and notably 92.7 percent of the households had a water tank. In addition, 13.5 percent of the households had a means of transport.

Table 42: Household possessions

Possession	Household		
	Weighted percentage	Weighted number	Unweighted number
Television	93.7	375	371
Fixed Telephone	34.4	138	131
Car//Van//Double Cab	13.5	54	53
Personal Computer//Laptop	28.5	114	119
Internet	14.2	57	60
Cable TV Channels	44.3	177	179
Dishwashing Machine	0.2	1	1
Washing Machine	24.0	96	98
Air Conditioner	1.0	4	5
Clothes Dryer	-	-	-
Water Tank	92.7	371	374
Secondary Vacation Home	1.7	7	9
Mobile Phone	94.6	378	378

2014 CPS, Rodrigues

BACKGROUND CHARACTERISTICS OF RESPONDENTS 14

14.0 Introduction

This chapter provides an overview of the profile of the respondents from Rodrigues who were interviewed in the survey and are summarized in table 3.

14.1 Socio-demographic Profile of Respondents

Table 43 shows the percent distribution of all women and currently married women age 15-49 years who have been interviewed in the 2014 Contraceptive Prevalence Survey by various background characteristics. Overall, young women age 15-24 years comprise 30.7 percent of the survey population.

Data on level of educational attainment has been categorized into three groups: less than completed primary schooling; completed primary schooling; and more than completed primary schooling. The first group includes those who did not have formal education as well as those who had some primary schooling and the second group, as its name suggests, includes those who have completed primary schooling. The third group includes those who have some secondary schooling, pre-vocational education, completed secondary schooling and tertiary or vocational education. The 2014 CPS reveals that a large majority of respondents have received education beyond primary level (55.9 percent).

The household socio-economic status (SES) is a composite measure and is calculated by assigning weights to reported ownership of household durable goods and household characteristics of respondents. These weights are then scored for each respondent and categorized by low, middle and high index according to the respondent's total score. The results reveal that 52.4 percent of respondents are living in low-SES households.

Overall, 55.2 percent of respondents are currently married[43] (35.9 percent are married legally/religiously and 19.3 percent are in consensual union), 1.5 percent are widowed, 7.8 percent are divorced or separated, and 35.5 percent have never been married.

Data on occupation was categorized into four groups: professional/technical[44]; service worker[45] ; manual worker[46]; and homemaker/student. The CPS findings reveal that the majority of respondents are homemakers/students (66.5 percent).

[43] Currently married women are women who have been legally/religiously married and are not either divorced, widowed or separated. Women living in consensual unions are also included in this category. The terms 'currently married' and 'currently in union' have been used interchangeably in this report.

[44] Includes managers, professionals and technicians (teachers, accountants, nurses, clerks and police officers etc.). It should be pointed out that the term "professionals" has been used in this report and it refers to the "professional/technical" group.

[45] Includes sales and craft and related trade workers (hairdressers and counter cashiers etc.).

[46] Includes skilled agricultural workers and export oriented enterprise manual workers (machine operators and assemblers etc.).

It should be noted that the majority of people living in Rodrigues are Christians and that the sample population comprises of 99.7 percent of Christians.

Table 43: Percent distribution of women age 15-49 years by selected background characteristic

Background characteristics	All women age 15-49			Currently married women age 15-49		
	Weighted percentage	Weighted number	Unweighted number	Weighted percentage	Weighted number	Unweighted number
Age group						
15-19	17.2	69	44	3.4	8	9
20-24	13.5	54	39	10.4	23	29
25-29	16.2	65	58	17.7	39	43
30-34	16.5	66	96	21.2	47	75
35-39	13.2	53	59	16.9	37	47
40-44	12.1	48	57	15.8	35	49
45-49	11.2	45	47	14.5	32	36
Occupation						
Professional/Technical	9.0	36	40	11.3	25	32
Service worker	13.7	55	47	10.9	24	31
Manual worker	10.8	43	48	11.7	26	34
Homemaker/Student	66.5	266	265	66.0	146	191
Education						
Less than completed primary	30.5	122	138	36.7	81	108
Completed primary	13.6	54	61	16.7	37	48
More than completed primary	55.9	224	201	46.5	103	132
Household socio-economic status						
Low	52.4	210	204	50.2	111	145
Middle	38.3	153	156	38.4	85	111
High	9.2	37	40	11.4	25	32
Marital status						
Currently married (legal/religious)	35.9	144	187	65.0	144	187
Consensual union	19.3	77	101	35.0	77	101
Widowed	1.5	6	9	NA	0	NA
Divorced/Separated	7.8	31	29	NA	0	NA
Never married	35.5	142	74	NA	0	NA
Total	100.0	400	400	100.0	221	288

2014 CPS, Rodrigues

14.2 Educational Attainment by Background Characteristics

Table 44 shows the distribution of currently married women age 15-49, by their educational attainment, according to background characteristics. Data from table 44 illustrates that women in lower age group are more likely to have secondary education or higher.

Table 44 also reveals that the level of education increases with increasing socio-economic status. Women with high socio-economic status are much more likely to have higher levels of educational attainment, from 34.2 percent in the low socio-economic status to 83.3 percent in the high socio-economic status.

Table 44: Percent distribution of currently married women age 15-49 by highest level of education attended or completed, according to background characteristics

Background Characteristics	Highest level of education			Total	Weighted number of women
	<completed primary	completed primary	>completed primary		
Age group					
15-19	0.0	12.5	87.5	100.0	8
20-24	4.3	0.0	95.7	100.0	23
25-29	28.2	7.7	64.1	100.0	39
30-34	44.7	14.9	40.4	100.0	47
35-39	43.2	18.9	37.8	100.0	37
40-44	51.4	22.9	25.7	100.0	35
45-49	46.9	37.5	15.6	100.0	32
Socio-economic status					
Low	47.7	18.0	34.2	100.0	111
Middle	31.4	16.3	52.3	100.0	86
High	4.2	12.5	83.3	100.0	24
Total	**36.7**	**16.7**	**46.5**	**100.0**	**221**

2014 CPS, Rodrigues

14.3 Exposure to Mass Media

The 2014 CPS assessed exposure to the media by asking respondents whether they have heard or saw a family planning message on radio or television. Table 45 shows the percentage of currently married women age 15-49, who were exposed to radio or television for family planning messages by background characteristics. Overall, 38.1 percent of women heard or saw a family planning message on both radio and television compared to 58.9 percent of the women who stated radio only and 46.4 percent television only.

Data from table 45 also indicates that the proportion of women using radio and television to hear or see a family planning message increases steadily with age group, level of education and socio economic status.

Table 45: Percentage of currently married women age 15-49 who are exposed to radio or television for family planning messages, by background characteristics (n=220*)

Background Characteristics	Radio	Television	Both radio and TV
Age group			
15-19	37.5	12.5	18.6
20-24	60.9	47.8	30.4
25-29	56.4	51.3	41.0
30-34	58.7	48.9	40.4
35-39	56.8	37.8	30.6
40-44	60.0	42.9	40.0
45-49	65.6	59.4	53.1
Socio-economic status			
Low	54.5	46.4	35.5
Middle	67.1	43.5	38.8
High	52.0	56.0	44.0
Education			
Less than completed primary	62.5	44.4	35.7
Completed primary	48.6	43.2	32.4
More than completed primary	60.2	49.5	37.9
Total	**58.9**	**46.4**	**38.1**

**1 missing case*

2014 CPS, Rodrigues

14.4 Employment Status

The 2014 CPS asked respondents whether they were employed at the time of the survey and table 46 shows the percent distribution of 2014 CPS respondents according to current employment. Overall, 33.2 percent of women are currently engaged in some economic activity.

Table 46 indicates that the proportion of women who are currently employed relatively varies with age peaking in the 40-44 age group (42.9 percent).

The likelihood that a woman is employed increases with her education. The proportion of women who are employed increases from 17.5 percent among those with less than completed primary education to 45.8 percent among those with higher education.

Likelihood of employment also increases with increasing socio economic status; 67.9 percent of women in the highest socio economic status are currently employed, as compared with 23.6 percent of women in the lowest socio economic status.

Table 46: Percent distribution of currently married women age 15-49 by employment status, according to background characteristics

Background Characteristics	Currently employed	Not Currently employed	Missing	Total	Weighted number of women
Age group					
15-19	0.0	0.0	100.0	100.0	8
20-24	20.7	0.0	79.3	100.0	23
25-29	41.9	0.0	58.1	100.0	39
30-34	29.3	0.0	70.7	100.0	47
35-39	31.9	2.1	66.0	100.0	37
40-44	42.9	0.0	57.1	100.0	35
45-49	36.1	2.8	61.1	100.0	32
Socio-economic status					
Low	23.6	0.8	75.6	100.0	111
Middle	35.5	0.9	63.6	100.0	85
High	67.9	0.0	32.1	100.0	25
Education					
Less than completed primary	17.5	1.0	81.5	100.0	81
Completed primary	32.5	2.4	65.1	100.0	37
More than completed primary	45.8	0.0	54.2	100.0	103
Total	**33.2**	**0.8**	**66.0**	**100.0**	**221**

2014 CPS, Rodrigues

14.5 Occupation

Table 47 shows the percent distribution of currently married women age 15-49 employed by occupation, according to background characteristics. Overall, data from table 47 reveals that only 11.3 percent of women are employed in professional or technical positions. Respondents age 15-19 (88.9 percent) are more likely to be homemaker as compared to the older respondents.

Women with higher levels of educational attainment are most likely to work in the professional or technical sector (23.7 percent). By contrast, respondents with less than primary education are most likely to work as homemaker (81.5 percent).

75.6 percent of women in the lowest socio economic group were homemaker as compared to women in the highest socio economic group (32.1 percent). In contrast, women with the highest socio economic status are most likely to be employed as professionals (52.3 percent) as compared to only 0.8 percent with the lowest socio economic status.

Table 47: Percent distribution of currently married women age 15-49 employed by occupation, according to background characteristics

Background Characteristics	Professional / Technical	Service worker	Manual worker	Homemaker	student	Total	Weighted number of women
Age group							
15-19	0.0	0.0	0.0	88.9	11.1	100.0	8
20-24	3.4	10.3	6.9	79.3	0.0	100.0	23
25-29	23.3	16.3	2.3	58.1	0.0	100.0	39
30-34	9.3	9.3	10.7	70.7	0.0	100.0	47
35-39	10.5	4.3	19.1	66.0	0.0	100.0	37
40-44	14.3	14.3	14.3	57.1	0.0	100.0	35
45-49	5.6	13.9	19.4	61.1	0.0	100.0	32
Socio-economic status							
Low	0.8	8.0	15.5	75.6	0.0	100.0	111
Middle	12.9	17.1	6.4	62.6	1.0	100.0	85
High	52.3	2.8	12.7	32.1	0.0	100.0	25
Education							
Less than completed primary	0.9	6.4	11.3	81.5	0.0	100.0	81
Completed primary	0.0	11.3	23.6	65.1	0.0	100.0	37
More than completed primary	23.7	14.4	7.8	53.3	0.8	100.0	103
Total	**11.3**	**10.9**	**11.7**	**65.6**	**0.4**	**100.0**	**221**

2014 CPS, Rodrigues

FERTILITY 15

15.0 Introduction

This chapter focuses on the level of current fertility and table 48 shows that the TFR for Rodrigues for the three-year period preceding the 2014 CPS is 2.70 children per woman.

Table 48 also illustrates the total fertility rate by background characteristics and it is observed that women living in high-SES households have fewer children (2.21) than women living in low-SES households (2.89).

In addition, data from table 48 show that woman with higher education have fewer children (2.65) than women with less than completed primary education (5.90).

The Total Fertility Rate for Rodriguess for the three-year period preceding the 2014 CPS is 2.70 children per woman

2014 CPS, Rodriguess

Table 48: Total fertility rate for the three years preceding the survey by selected background characteristics, 2014 CPS

Background characteristics	Total Fertility Rate*
Education	
< than completed primary	5.90
Completed primary	3.39
> than completed primary	2.65
Household socio- economic status	
Low	2.89
Middle	2.80
High	2.21
Total	**2.70**

*Rate is for women 15-49 years

2014 CPS, Rodrigues

15.1 Children Ever Born and Living

Table 49 shows the distribution of women by the number of children ever born, as well as the average numbers of children ever born and those still surviving by women's age. Overall, it is observed that women in the sample have given birth to an average of 2.51 children, out of which 2.43 children are still alive, indicating that around 3 percent of the children ever born to 2014 CPS respondents have died.

Reflecting the natural family-building process, the number of children that women have borne increases with woman's age from an average of 2.01 births among women age 25-29 to an average of 3.48 births among women 45-49. Likewise, the likelihood of a woman's children death also

increases with woman's age from an average of 0.02 children or around 1 percent death among women age 25-28 to an average of 0.08 children or 3 percent death among women age 45-49.

Table 49: Percent distribution of all women by number of children ever born, and mean number of children ever born and mean number of living children, according to age group

Age	Number of children ever born									number of women	mean number of children born	mean number of living children
	0	1	2	3	4	5	6	8	Total			
15-19	37.5	62.5	0.0	0.0	0.0	0.0	0.0	0.0	100.0	8	0.67	0.67
20-24	0.0	70.8	25.0	4.2	0.0	0.0	0.0	0.0	100.0	23	1.31	1.31
25-29	2.3	31.8	34.1	25.0	6.8	0.0	0.0	0.0	100.0	43	2.01	1.99
30-34	1.9	20.4	50.0	16.7	11.1	0.0	0.0	0.0	100.0	54	2.20	2.13
35-39	0.0	11.1	42.2	28.9	13.3	2.2	2.2	0.0	100.0	44	2.65	2.58
40-44	0.0	2.4	26.2	42.9	16.7	7.1	2.4	2.4	100.0	42	3.38	3.14
45-49	0.0	9.8	17.1	31.7	17.1	14.6	9.8	0.0	100.0	40	3.48	3.39
Total	**1.8**	**22.2**	**32.9**	**25.6**	**11.0**	**4.0**	**2.1**	**0.3**	**100.0**	**254**	2.51	2.43

2014 CPS, Rodrigues

15.2 Age at First Birth

Table 50 presents the distribution of women by age at first birth, according to their current age. For women under age 25, the median age at first birth is not shown because less than 50 percent of women in those ages had given birth at the time of the survey. Overall, the median age at first birth is 21.5 years for women 25-49.

Table 50: Median age at first birth among women age 25 – 49 years

Age group	Median age at first birth (years)
25-29	20.6
30-34	22.0
35-39	21.9
40-44	21.7
45-49	21.2
25-49	**21.5**

2014 CPS, Rodrigues

15.2.1 Age at First Birth by Background Characteristics

Table 51 shows that the median age at first birth by background characteristics. The median age at first birth increases with socio economic status, from 21.1 for women in low socio economic status to 22.9 for women in the high socio economic status. In addition, the median age at first birth is higher among women who have completed primary education as compared to the other counterparts.

Table 51: Median age at first birth among women age 15-49 years and 25-49, according to background characteristics

Background Characteristics	Women age 25-49
Socio-economic status	
Low	21.1
Middle	21.7
High	22.9
Education	
Less than completed primary	20.9
Completed primary	21.9
More than completed primary	22.0
Total	**21.5**

2014 CPS, Rodrigues

15.3 Teenage Pregnancy and Motherhood

The factors associated with teenage pregnancy and childbearing are intriguing and important for health, economic and social concerns. Figure 47 highlights the percent distribution of women age 15-19 who are mothers or who are pregnant with their first child at the time of the 2014 CPS. It is observed that 29.5 percent of teenagers (15-19 years) have already begun childbearing[47]: 22.7 percent are already mothers and 6.8 percent are pregnant with their first child. This proportion has increased significantly from 20.6 percent in 2002 to 29.5 percent in 2014.

[47] Overall, 61.9% of teenagers who had already begun childbearing were married and 38.1% had never been married at the time of the 2014 CPS.

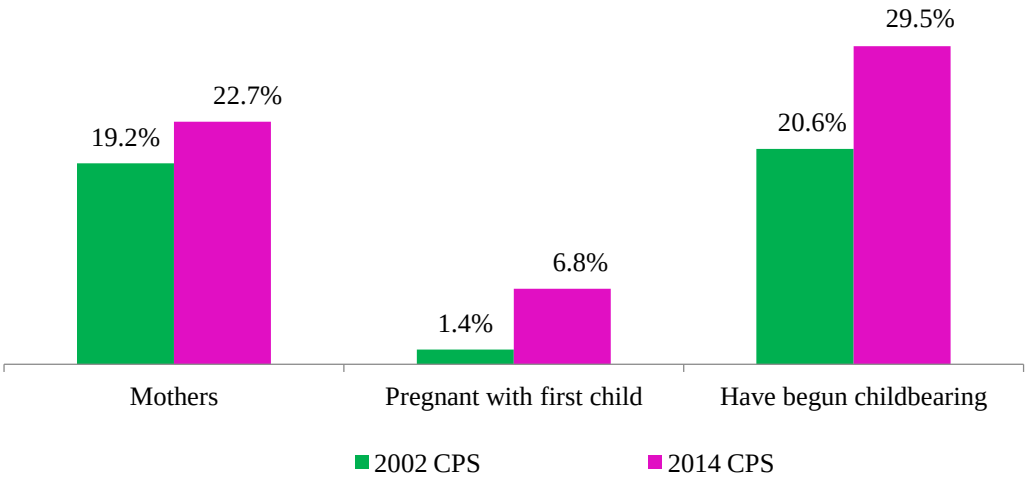


Figure 47: Percent distribution of teenagers age 15-19 years who are mothers or pregnant with their first child

2014 CPS, Rodrigues

15.4 Premarital Conception

Premarital childbearing has always been of concern to policy makers because of the emotional and economic vulnerability of young women and the resulting consequences for their children. Figure 48 shows the percent distribution of ever-married women age 15-49 years whose first birth occurred before first union or within the first 7 months of first union. Overall, 30.6 percent of first born babies were born before first union or within the first 7 months of first union among ever-married women age 15-49 years.

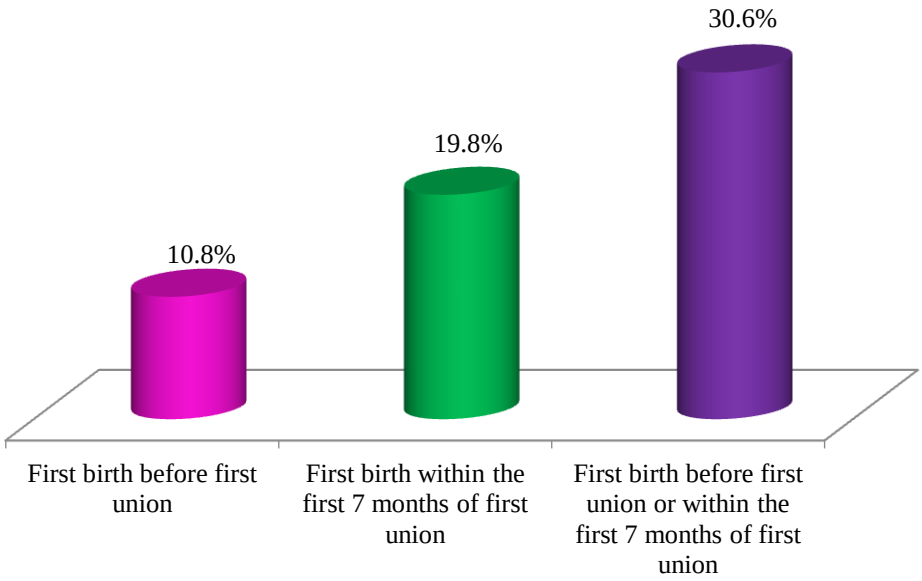


Figure 48: Percent distribution of respondents whose first birth occurred before first union or within the first 7 months of first union among ever-married women age 15-49 years

2014 CPS, Rodrigues

The results of the 2014 CPS indicate that premarital conception[48] has slightly increased from 21.4 percent in 2002 to 30.4 percent in 2014 among currently and formerly married women age 15-49 years as shown in figure 49.

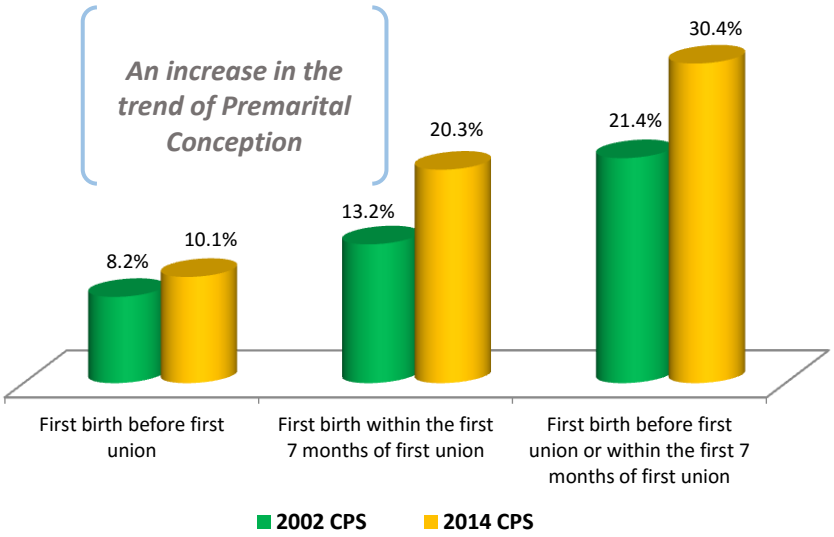


Figure 49: Premarital conception among respondents *age 15-44 years*

2014 CPS, Rodrigues

15.5 Abortion

Figure 50 shows that 12.2 percent of women age 15-49 years had at least one abortion. It is also noted that 11.3 percent of respondents age 15-49 years had at least one spontaneous abortion and 1.2 percent had at least one induced abortion.

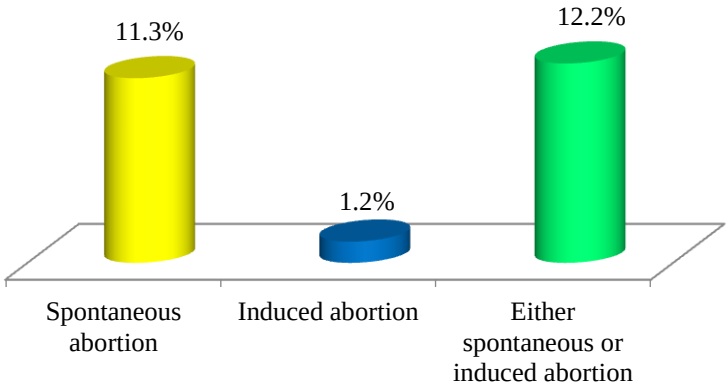


Figure 50: Percent distribution of respondents age 15-49 years who reported having had at least one abortion

2014 CPS, Rodrigues

[48] Women who have had a first birth before first union or within the first 7 months of first union.

However, like many surveys from other countries where abortion is illegal or restricted, the data on abortion may not be reliable. The CPS results are liable to under-reporting for induced abortion and over-reporting for spontaneous abortion since abortion in Rodrigues was not permitted under any circumstances until recently[49].

Figure 51 shows that the proportion of women age 15-44 years who reported having had at least one abortion (either spontaneous or induced abortion) has decreased slightly from 12.0 percent in 2002 to 11.8 percent in 2014.

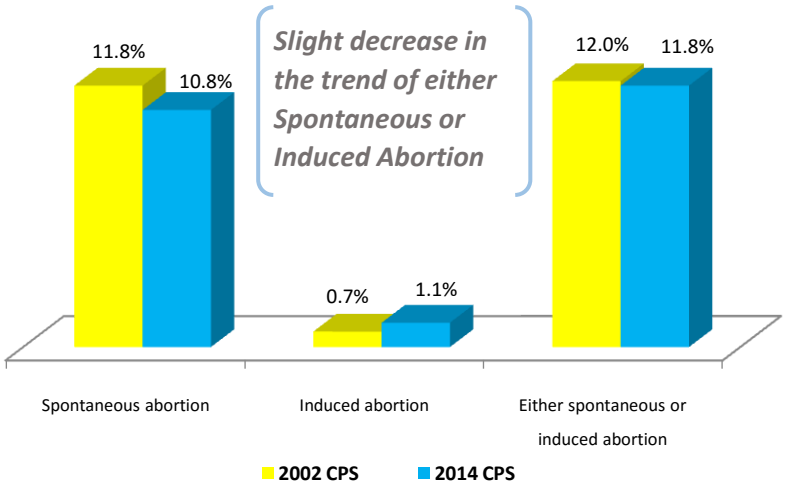


Figure 51: Respondents *age 15-44 years* who reported having had a least one abortion

2014 CPS, Rodrigues

15.5.1 Opinions on Induced Abortion among All Respondents Age 15-49 years

Respondents were asked: "If a woman has an unwanted pregnancy, what should she do?". Overall, 92.2 percent of respondents age 15-49 years thought that the woman should not have an induced abortion (since 49.8 percent said that she should give the baby up for adoption and 42.4 percent said that she should keep the baby) and 4.5 percent stated that she should have an induced abortion. The remainder (3.3 percent) did not know what the woman should do.

However, when asked if a woman should have an induced abortion under certain circumstances, a significant proportion of respondents age 15-49 years (as shown in figure 52) were in favour of the woman having an induced abortion when:

- Her life is endangered by the pregnancy (73.8 percent);
- Her health is endangered by pregnancy (66.6 percent) and;
- The foetus has a deformity (52.3 percent).

[49] In 2012, the law was amended and abortion is allowed under four specific circumstances: (1) the continued pregnancy will endanger the pregnant person's life (2) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (3) there is a substantial risk that the continued pregnancy will result in a severe malformation of the foetus (4) the pregnancy has not exceeded its fourteenth weeks and results from a case of rape, sexual intercourse with a female under the age of 16 or sexual intercourse with a specified person, which has been reported to the police or medical practitioner.

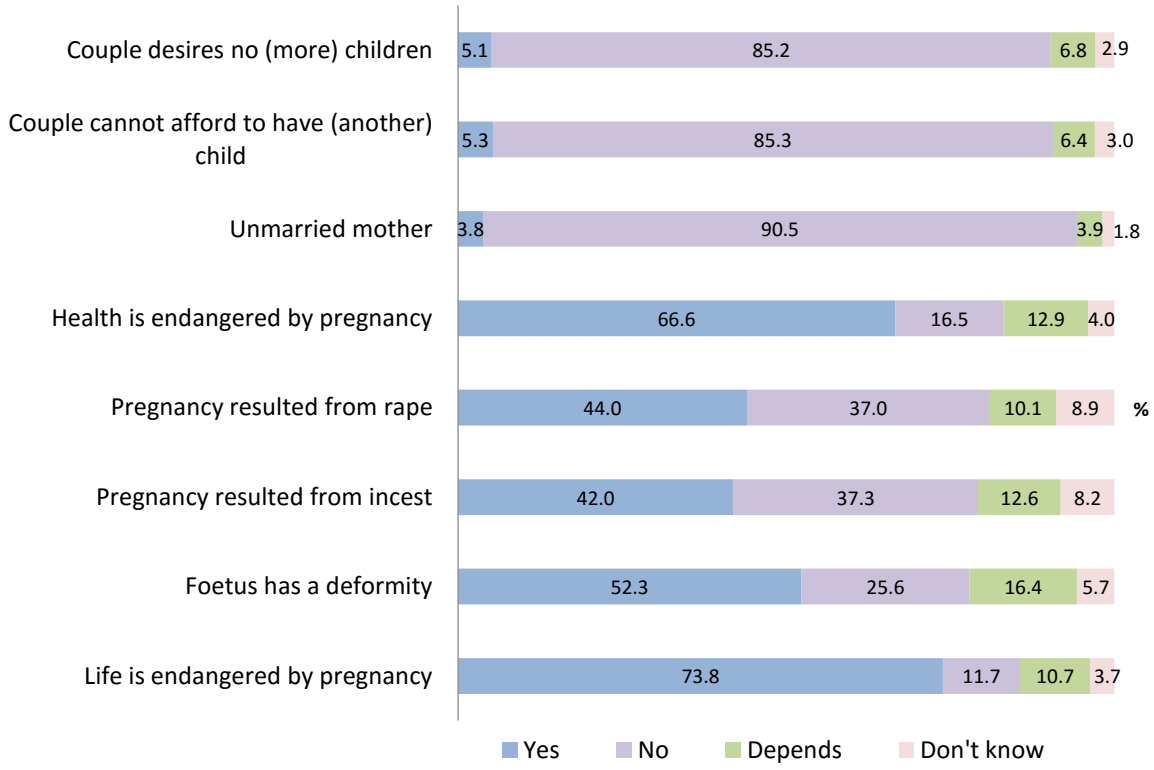


Figure 52: Percent distribution of respondents age 15-49 years about their opinion on induced abortion

2014 CPS, Rodrigues

It is also noted that a significant proportion of respondents age 15-49 years stated that unmarried mothers (90.5 percent) as well as couples who cannot afford a/another child (85.3 percent) or who do not desire the child (85.2 percent) should not have an induced abortion.

FERTILITY PREFERENCES 16

16.0 Introduction

Information on fertility preferences is of paramount importance to family planning programs because it is used to assess the potential demand for family planning services for the purposes of spacing or limiting future childbearing.

Nevertheless, interpretation of the results of fertility preferences are, in most cases, hypothetical and thus subject to change and retionalisation.

16.1 Desire for more Children

Fertility preferences are closely related to the number of living children a woman has. In general, as the number of living children increases, the desire to have another child decreases and vice versa. Therefore, information about the desire for more children is important for understanding future reproductive behaviour. The provision of adequate and accessible family planning services is dependent on the availability of such information. In the 2014 CPS, currently married women were asked whether they want to have another child, and if so how soon. The wording of the question varied slightly if the respondent was pregnant to ensure that pregnant women were not asked about the wantedness of the current pregnancy but the desire for subsequent children

Table 52 shows future reproductive intentions of currently married women age 15-49 years by the number of living children. 7.9 percent of women want to have another child soon (within two years) while 12.4 percent want another child two or more years later. 63.3 percent want no more children or have been sterilized. Overall, 65.1 percent of currently married women age 15-49 years want to either stop or postpone childbearing.

The desire to stop childbearing increases with the number of living children from 19.6 percent with no children to 67.7 percent among women with 4 children or more. On the otherhand as expected the desire to have a child is higher (41.5 percent) among women with no children than among women with 3 children (7.6 percent)

Fertility Preferences by Number of Living children

Table 52: Percent distribution of currently married women by Desire for children, according to the number of living children.

	Number of living children					
Desire for children	0	1	2	3	>=4	Total
Wants soon	30.9	15.1	5.9	6.3	0.0	7.9
Wants later	10.6	30.2	12.2	5.6	0.0	12.4
Undecided	28.4	21.6	13.3	1.2	0.0	10.6
Wants no more	19.6	33.2	61.0	53.3	67.7	52.7
Sterilized	0.0	0.0	2.0	23.9	25.3	10.6
Declared infecund	10.6	0.0	5.7	9.7	7.0	5.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total Number of women	9	48	75	51	38	221

2014 CPS, Rodrigues

16.2 Unplanned and Unwanted Fertility

Respondents who have had a live birth in the five years preceding the survey and who were not pregnant at the time of the interview were asked whether their most recent pregnancy was wanted *then* (planned), wanted *later* (mistimed), or *not* wanted (not wanted at all). The same question was asked to respondents who have had a live birth in the five years preceding the survey about their current pregnancy if they were pregnant at the time of the interview.

Table 53 illustrates the percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by the planning status of their most recent pregnancy. The results of the 2014 CPS show that 45.6 percent of them stated that their most recent pregnancy was planned (wanted) and 53.2 percent stated that it was unplanned (mistimed and unwanted).

Table 53: Percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by the planning status of their most recent pregnancy

Planning status	**Currently married women age 15-49 years**	
	2002 CPS	**2014 CPS**
Wanted	52.0	45.6
Mistimed	25.8	32.5
Unwanted	16.7	20.7
Not sure	5.6	1.2

2014 CPS, Rodrigues

Figure 53 indicates that the proportion of unplanned pregnancies has increased from 42.5 percent in 2002 to 53.2 percent in 2014 among currently married women age 15-49 years who have had a live birth in the five years preceding the survey. Hence, this finding underscores the need to target women in need of more effective contraceptive methods.

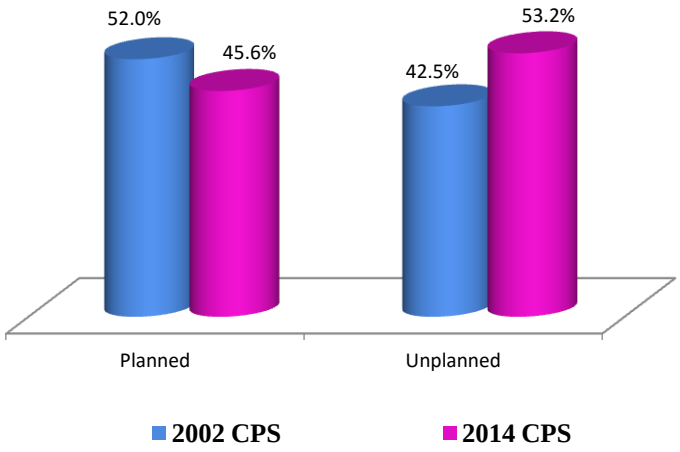


Figure 53: Percent distribution of currently married women age 15-49 years who have had a live birth in the five years preceding the survey by planning status of their most recent pregnancy

2014 CPS, Rodrigues

PROXIMATE DETERMINANTS OF FERTILITY 17

17.0 Introduction

The proximate determinants of fertility helps to improve the understanding of fertility behavior, its variations among different sub-groups and underlying causes of the variations. The proximate determinants of fertility analysed in the 2014 CPS were; the start of menstruation (age of menarche), age at first sexual intercourse and age at first marriage.

17.1 Age of Menarche

Table 54 shows that the median age of menarche of women age 15-49 years is 12.3 years. It is noted that the median age of menarche has declined over time: from 13.0 years among women age 45-49 years to 11.7 years among women age 15-19 years.

Table 54: Median age of menarche among women age 15-49 years

Age group	Median age at menarche (years)	n
15-19	11.7	67
20-24	12.1	54
25-29	12.5	65
30-34	12.2	66
35-39	12.5	53
40-44	12.6	48
45-49	13.0	45
15-49	*12.3*	*398*[*]

[*]2 respondents aged 16 reported "not yet "

2014 CPS, Rodrigues

17.2 Age at First Sexual Intercourse and Age at First Marriage

Table 55 shows that the median age at first sexual intercourse is 17.7 years and the median age at first marriage is 19.9 years among women age 25-49 years.

It should be noted that younger cohorts (women age 15-24 years) are excluded from the analysis for median age at first marriage in order to avoid a bias since less than 50 percent of respondents in the age groups 15-19 and 20-24 did not get married by age 15 or 20 respectively whilst women age 15-

19 has been excluded in the calculation for age at first sexual intercourse since 50 percent of the respondents age 15-19 did not have sexual intercourse[50].

Table 55: Median age at first sexual intercourse and median age at first marriage among women age 25 – 49 years

Age group	Median age at first sexual intercourse (years)	Median age at first marriage (years)
20-24	17.4	-
25-29	17.1	19.4
30-34	18.1	20.9
35-39	18.0	19.8
40-44	17.6	19.0
45-49	17.7	19.5
25-49	**17.7**	**19.9**

2014 CPS, Rodrigues

17.3 Recent Sexual Activity by Background Characteristics

Table 56 shows the distribution of women age 15-49 years by timing of last sexual intercourse, according to background characteristics. 61.2 percent of women age 15-49 years were sexually active during the four weeks preceding the interview and 16.7 percent reported that they had never had sex.

The proportion of women who were sexually active in the four weeks preceding the survey increases with age, peaking in the 35-39 age group (82.4 percent) and decreasing thereafter. As expected, the frequency of sexual activity among women who are married or currently in a union is higher than that among women who are not married, divorced or separated. However, it is observed that 52.9 percent of never-married women had sexual activity including 21 percent in the four weeks preceding the survey.

Women working as manual worker are more likely to have been sexually active in the past four weeks (73.2 percent) preceding the survey as compared to the other counterparts. Data from table 56 also shows that women with low socio-economic status (65.5 percent) are more likely to have been sexually active in the four weeks preceding the survey.

[50] The median age at first sexual intercourse for respondents *age 20-49 years* is 17.6 years (which has not been charted).

Table 56: Percent distribution of women age 15-49 by timing of last sexual intercourse, according to background characteristics

Background characteristic	Timing of last sexual intercourse		missing	Never had sexual intercourse	Total	Number of women
	Within the past 4 weeks	More than 4 weeks				
Age group						
15-19	20.0	13.9	0.0	66.1	100.0	69
20-24	58.2	30.3	0.0	11.5	100.0	54
25-29	71.8	17.5	0.0	10.7	100.0	65
30-34	72.3	24.2	0.0	3.6	100.0	66
35-39	82.4	10.8	0.0	6.9	100.0	53
40-44	70.1	25.5	0.0	4.4	100.0	48
45-49	61.7	38.3	0.0	0.0	100.0	45
Marital Status						
Married (legal/Religious)	87.6	12.4	0.0	0.0	100.0	143
Consensual union	89.2	10.8	0.0	0.0	100.0	77
Widowed	42.1	57.9	0.0	0.0	100.0	6
Divorced/separated	56.8	43.2	0.0	0.0	100.0	31
single (never Married)	21.0	31.9	0.0	47.1	100.0	142
Education						
<completed primary	72.7	22.6	0.0	4.7	100.0	122
completed primary	77.1	18.6	0.0	4.3	100.0	54
>completed primary	51.0	22.7	0.0	26.3	100.0	224
Occupation						
Professional	61.1	19.3	0.0	19.6	100.0	36
Service Worker	47.9	46.4	0.0	5.7	100.0	55
Manual Worker	73.2	24.1	0.0	2.7	100.0	43
Homemaker/Student	62.0	17.2	0.0	20.9	100.0	266
Household socio-economic status						
low	65.5	22.5	0.0	12.1	100.0	210
middle	54.6	22.9	0.0	22.5	100.0	153
high	64.1	16.9	0.0	19.0	100.0	37
Total	**61.2**	**22.1**	**0.0**	**16.7**	**100.0**	**400**

2014 CPS, Rodrigues

FAMILY PLANNING 18

18.0 Introduction

This chapter focuses on the knowledge and use of family planning methods and the channels through which the women receive information about family planning methods. Information on the service providers from which users obtain their methods is also presented. Moreover, the chapter looks at the level of unmet need for family planning and factors relating to nonuse of contraception.

18.1 Knowledge of Contraceptive Methods

Knowledge of any contraceptive method is universal among women in the reproductive age group (15-49 years) in Rodrigues.

Knowledge of any contraceptive method among currently married women age 15-49 years is 100%.

Figure 54 shows that pill (98.8 percent), male condom (98.6 percent), 3-month injectable (95.3 percent) and tubal ligation (89.0 percent) are the most commonly known supplied methods[51], and that calendar (63.0 percent), sympto-thermal (62.6 percent) and temperature (57.1 percent) are the most commonly known natural family planning (NFP)[52] methods among currently married women age 15-49 years.

[51] Supplied methods: Tubal ligation; vasectomy; pill; 1-month injectable; 3-month injectable; IUD; male condom; female condom; diaphragm; foaming tablet; implant; contraceptive patch; and emergency contraceptive pill.

[52] NFP methods: Sympto-thermal; mucus; temperature; calendar; and cycle beads.

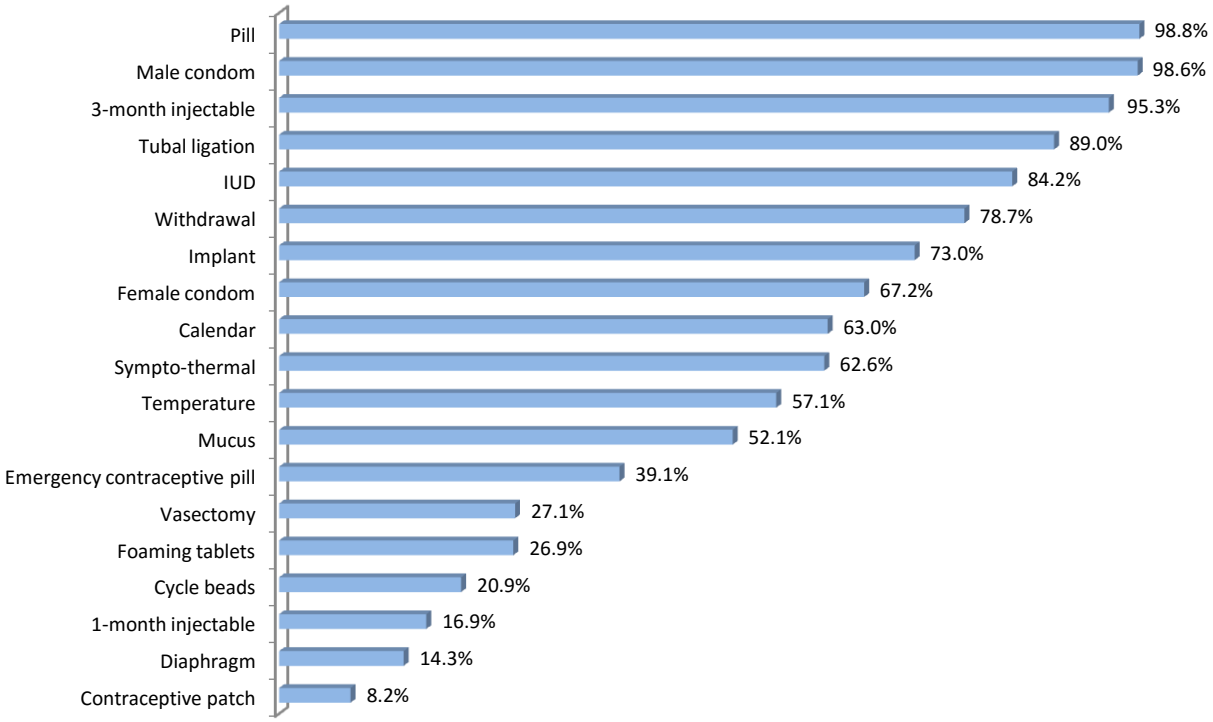


Figure 54: Percent distribution of currently married women age 15-49 years who know a family planning method by specific method

2014 CPS, Rodrigues

Table 57 shows that knowledge of methods, such as implant has increased significantly from 31.8 percent in 2002 to 73.0 percent in 2014 among currently married women age 15-49 years.

Like previous CPSs, the contraceptive methods have been classified into three categories (i.e. by supplied methods, natural family planning (NFP) methods and withdrawal method) but in order to compare the data with other countries, the contraceptive methods have also been classified into two categories (i.e. by modern methods[53] and traditional methods[54]) in the 2014 CPS.

The mean number of methods known is indicative of the extent of knowledge of family planning methods. The 2014 CPS results reveal that currently married women age 15-49 years know an average of 10.7 contraceptive methods[55].

[53] Modern methods: Tubal ligation; vasectomy; pill; 1-month injectable; 3-month injectable; IUD; male condom; female condom; diaphragm; foaming tablet; implant; contraceptive patch; emergency contraceptive pill; sympto-thermal; mucus and temperature.

[54] Traditional methods: Withdrawal; calendar; and cycle beads.

[55] Out of the 19 methods reported by respondents.

Table 57: Percent distribution of women who know a family planning method by specific method

Contraceptive method	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15-49	**15-49**	**15-44**	**15-49**	**15-49**	**15-44**	**15-44**
	2014 CPS			**2002 CPS**			**1991 CPS**
Any method	100.0	100.0	100.0	100.0	100.0	100.0	99.1
Any supplied	100.0	100.0	100.0	-	-	-	-
Tubal ligation	82.6	89.0	89.0	75.4	81.4	81.2	89.3
Vasectomy	30.1	27.1	27.5	33.2	32.9	31.6	32.8
Pill	98.6	98.8	99.6	98.4	99.5	99.7	98.6
3-month injectable	89.7	95.3	95.5	91.4	94.1	94.0	98.6
1-month injectable	12.3	16.9	16.9	-	-	-	-
IUD (Intrauterine device)	73.2	84.2	84.3	84.6	90.8	91.3	93.0
Male condom	98.6	98.6	98.8	94.4	96.8	97.0	93.6
Female condom	68.7	67.2	70.1	26.8	27.5	27.5	-
Diaphragm	14.7	14.3	15.7	17.8	15.6	15.5	14.2
Foaming tablets	20.1	26.9	26.7	41.8	45.0	45.1	20.3
Implant	68.9	73.0	75.5	28.8	31.8	32.2	4.1
Emergency contraceptive pill	39.9	39.1	42.9	-	-	-	-
Contraceptive patch	7.6	8.2	8.7	-	-	-	-
Any NFP method	75.1	79.7	79.0				
Sympto-thermal	51.6	62.6	62.4	78.2	82.2	82.7	87.3
Mucus	44.7	52.1	49.2	57.8	62.8	61.8	64.6
Calendar	58.3	63.0	63.3	61.2	63.6	64.5	61.2
Temperature	50.5	57.1	55.0	77.8	80.1	80.0	86.4
Cycle Beads	17.1	20.9	24.4	-	-	-	-
Withdrawal	71.7	78.7	79.8	63.6	69.3	69.9	64.1
Number of women	400	221	189	500	371	335	345
Any modern method	100.0	100.0	100.0	-	-	-	-
Any traditional method	81.4	87.3	89.0	-	-	-	-
Mean number of methods known	10.0	10.7	10.9	-	-	-	-
Mean number of modern methods known	8.5	9.1	9.2	-	-	-	-

- : Not available

2014 CPS, Rodrigues

18.2 Current Use of Contraceptive Methods

The level of current use of contraceptive methods is an indicator that is used to evaluate family planning programmes and is a major determinant of fertility.

Table 58 shows that the contraceptive prevalence rate for currently married women age 15-49 years has slightly decreased from 74.1 percent in 2002 to 73.6 percent in 2014.

The 2014 CPS findings show that pill (31.9 percent) is the most commonly used supplied method[56] among currently married women age 15-49 years followed by 3-month injectable (11.3 percent) and tubal ligation (10.6 percent), and that calendar (5.5 percent) is the most commonly used NFP method.

The contraceptive prevalence rate among currently married women age 15-49 years is
73.6%.
2014 CPS, Rodrigues

As already mentioned, the contraceptive methods have also been classified by modern and traditional methods. Table 58 also shows that use of modern methods is more common than use of traditional methods among currently married women age 15-49 years (66.5 percent versus 7.1 percent).
Current use of 3-month injectable, which is a short term contraceptive method, has declined over the years among currently married women age 15-49 years: from 25.1 percent in 2002 to 11.3 percent in 2014. However, current use of tubal ligation method, which is a long term method, has slightly increased among currently married women age 15-49 years: from 7.3 percent in 2002 to 10.6 percent in 2014.

In 2014, current use of female condom and implant was 0.3 percent and 5.4 percent respectively among currently married women age 15-49 years whilst in 2002, no respondents reported use of these methods since female condom and implant were not available at that time. It should also be noted that no respondents reported current use of these available methods, namely, cycle beads, vasectomy, and emergency contraceptive pill (which is a back-up method) at the time of the 2014 CPS in Rodrigues. Incidentally, contraceptive patch and 1-month injectable are not available in Rodrigues.

[56] Refer to the footnotes on p.115 for the lists of supplied and NFP methods.

Table 58: Percent distribution of women who are currently using a method of contraception

Contraceptive method	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15-49	**15-49**	**15-44**	**15-49**	**15-49**	**15-44**	**15-44**
		2014 CPS			**2002 CPS**		**1991 CPS**
Tubal ligation	8.4	10.6	8.6	5.8	7.3	6.6	4.6
Vasectomy	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pill	25.3	31.9	35.4	18.0	23.4	24.8	22.9
3-month injectable	9.9	11.3	12.8	19.4	25.1	26.9	22.0
1-month injectable	-	-	-	-	-	-	-
IUD	0.9	1.7	1.9	4.6	5.7	5.1	3.2
Male condom	3.4	3.1	2.3	2.0	2.7	2.4	5.5
Female condom	0.2	0.3	0.4	-	-	-	-
Foaming tablets	0.0	0.0	0.0	1.0	1.1	1.2	0.3
Implant	3.4	5.4	6.3	-	-	-	-
Contraceptive patch	-	-	-	-	-	-	-
Total supplied methods	51.5	64.4	67.8	50.8	65.3	67.0	58.5
Sympto-thermal	0.2	0.4	0.4	2.6	3.5	3.9	4.4
Mucus	0.8	1.5	1.7	0.8	1.1	0.6	3.8
Calendar	3.1	5.5	5.5	1.6	2.2	2.4	0.9
Temperature	0.2	0.3	0.3	0.4	0.5	0.6	0.3
Cycle beads	0.0	0.0	0.0	-	-	-	-
Total NFP methods	4.2	7.7	8.0	5.4	7.3	7.5	9.4
Withdrawal	0.9	1.6	1.4	1.6	1.6	1.8	2.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Currently using any method	56.6	***73.6***	77.2	57.8	***74.1***	76.1	70.1
Not using any method	43.4	26.4	22.8	42.2	25.9	23.9	29.9
Number of women	400	221	189	500	371	335	345
Modern Method	52.7	66.5	70.3	54.6	70.4	72.1	67.0
Traditional Method	3.9	7.1	6.9	3.2	3.8	4.2	2.9

– : Not available

2014 CPS, Rodrigues

18.2.1 Current use of contraception by background characteristics

Figure 55 shows the percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by type of method they are using according to some selected background characteristics. The figures in italics in the chart show the contraceptive prevalence rate for the different categories.

Occupation

Overall, the proportion of contraceptive use by occupation differs - ranging from 58.1 percent among service workers to 84.9 percent among professionals. Use of supplied methods is higher among manual workers (68.3 percent) than among the other three groups whilst use of NFP methods is higher among professionals (29.8 percent) than among the other groups.

Number of living children

Contraceptive use is lowest among current users who have no children (21.2 percent) and highest among current users who have 1 child (79.7 percent). Moreover, current use of NFP methods is higher among women who have no children (10.6 percent) than among women who have children.

Level of educational attainment

Overall, contraceptive use by level of educational attainment varies - ranging from 67.3 percent among women who have completed their primary schooling only to 75.7 percent among women who have received education beyond primary level.

Age group

The contraceptive prevalence rate by age group shows that contraceptive use rises with increasing age among current users age 25-39 years (from 74.5 percent for the age group 25-29 to 83.0 percent for the age group 35-39) followed by a decrease among current users age 40-49 years (from 69.4 percent for the age group 40-44 to 52.8 percent for the age group 45-49). Hence, contraceptive use is higher among currently married women in the age group 35-39, and it is noted that a higher proportion of current users in this age group are using NFP methods (14.9 percent) than the other age groups.

Household socio-economic status

Contraceptive use is higher among women living in high-SES households (82.9 percent). Moreover, use of NFP methods is more common among them (26.6 percent) than among the other groups.

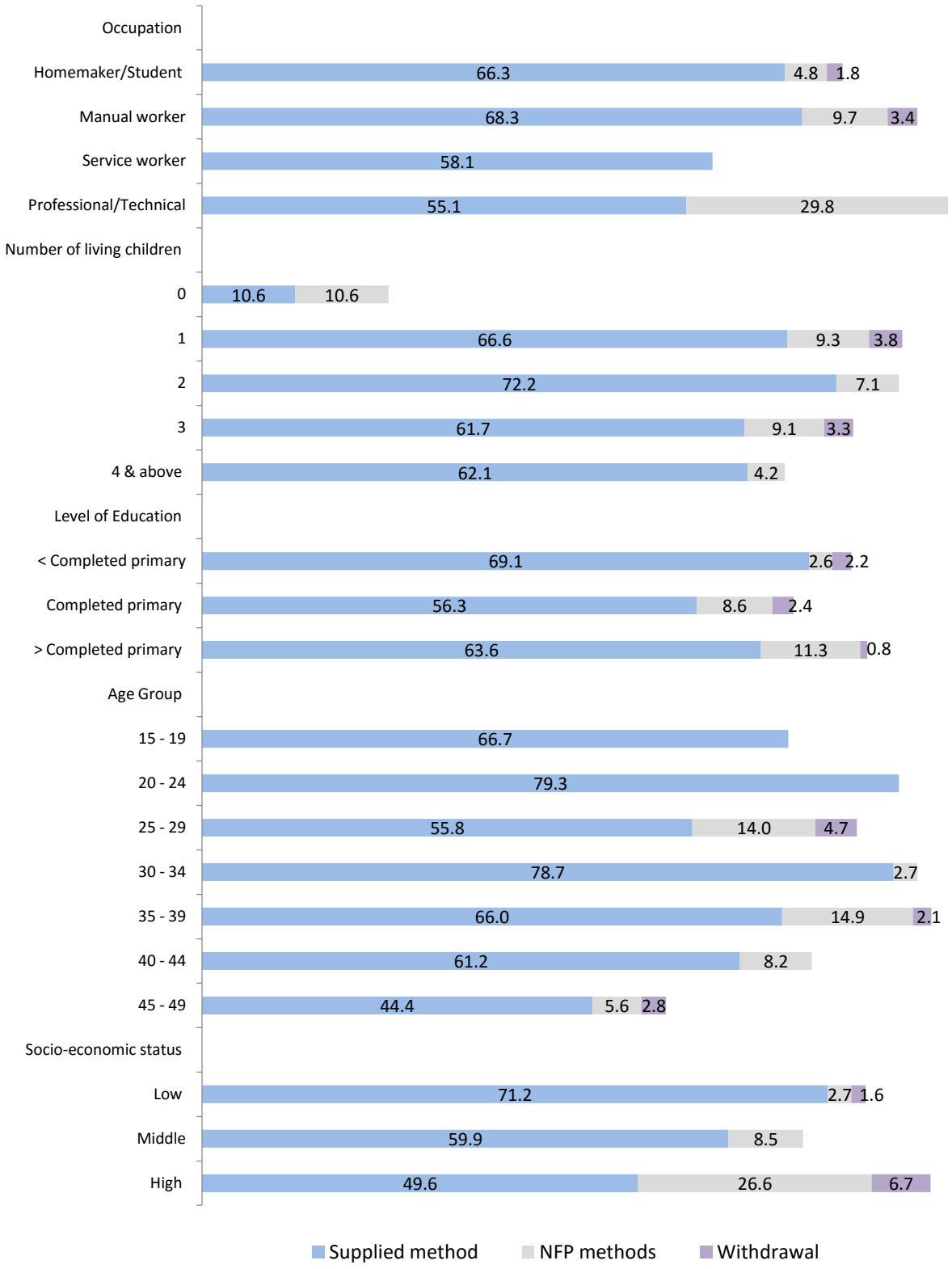


Figure 55: Percent distribution of currently married women age 15 - 49 years who are currently using a contraceptive method by type of method, according to selected background characteristics

2014 CPS, Rodrigues

18.3 Purpose of Contraceptive Use: Birth Spacers versus Birth Limiters

The distinction between birth spacers and limiters[57] has important programmatic implications for family planning services. Contraceptive use differs between spacers and limiters: spacers tend to use short term methods and tend to be childless or with one child, whereas limiters tend to use long term or permanent methods and tend to have 2 children or more. The results of the 2014 CPS show that contraceptive use[58] for limiting births predominates: 62.6 percent are limiters and 37.4 percent are spacers. Figure 56 shows that 3.0 percent of spacers do not have a child.

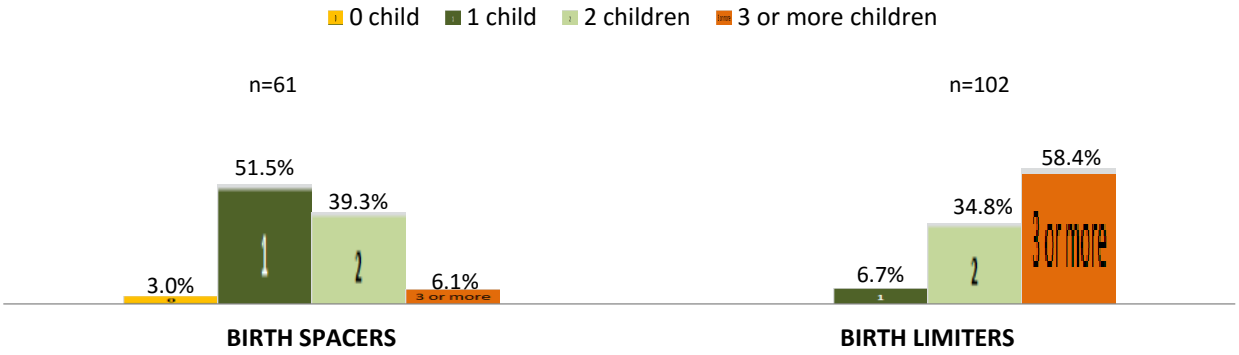


Figure 56: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by purpose of use, according to the number of living children

2014 CPS, Rodrigues

Figure 57 shows that the majority of current users of long term methods (tubal ligation, IUD and implant) and short term methods are using these methods to limit their births[59].

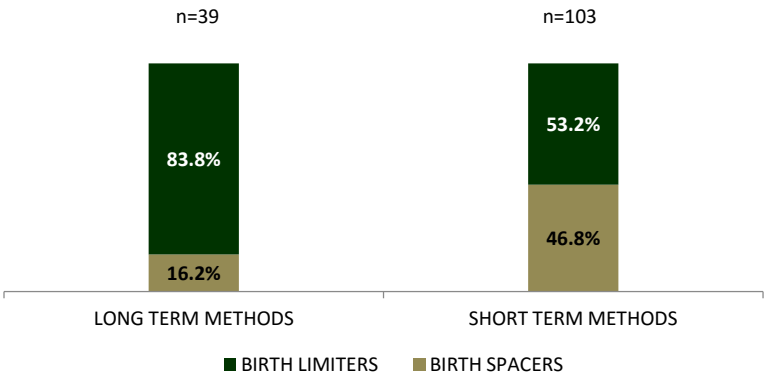


Figure 57: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by purpose of use, according to type of method

2014 CPS, Rodrigues

[57] In this section birth spacers and limiters are current users of a contraceptive method. The purpose of contraceptive use differs for a birth spacer and for a birth limiter: For the former, the client wants a/another child later whereas for the latter, the client does not want a/another child.

[58] In this section, the data refer to current users age 15-49 years and who are currently married.

[59] Due to small number of cases, current users of natural family planning methods and withdrawal method have not been charted.

Table 59 shows that the most common reason given by limiters for using a contraceptive method is "financial implications in raising more children" (42.3 percent) followed by "having enough children" (40.6 percent). As for spacers, the most common reason cited is "for the family's benefit" (46.5 percent) followed by "financial implications in raising more children" (37.9 percent).

Table 59: Percent distribution of currently married women age 15-49 years who are currently using a contraceptive method by most important reason cited for limiting or spacing birth

Most important reason	Limiter	Spacer	Total
Have enough children	40.6	-	25.4
To recover health	-	9.9	3.7
Financial implications in raising more children	42.3	37.9	40.6
To devote more time to family	2.2	-	1.4
Want to work outside the house	0.8	-	0.5
For the family's benefit	-	46.5	17.4
Respondent is working	1.5	5.7	3.1
Too difficult to raise another child	1.7	-	1.1
Husband does not want any more children	0.6	-	0.4
Health concerns	10.4	-	6.5
Total	**100.0**	**100.0**	**100.0**

- : Nil

2014 CPS, Rodrigues

18.4 Trends in Contraceptive Use

The contraceptive methods have been classified by supplied methods, natural family planning (NFP) methods and withdrawal method[60] as well as by modern methods and traditional methods.

Figure 58 shows that use of supplied methods has slightly decreased from 65.3 percent in 2002 to 64.4 percent in 2014 among currently married women age 15-49 years. However, use of NFP methods has slightly increased from 7.3 percent in 2002 to 7.7 percent in 2014 whilst use of withdrawal method has remained constant at 1.6 percent. The results clearly show that couples favour use of supplied methods.

[60] Refer to second paragraph on p. 116 for further explanation.

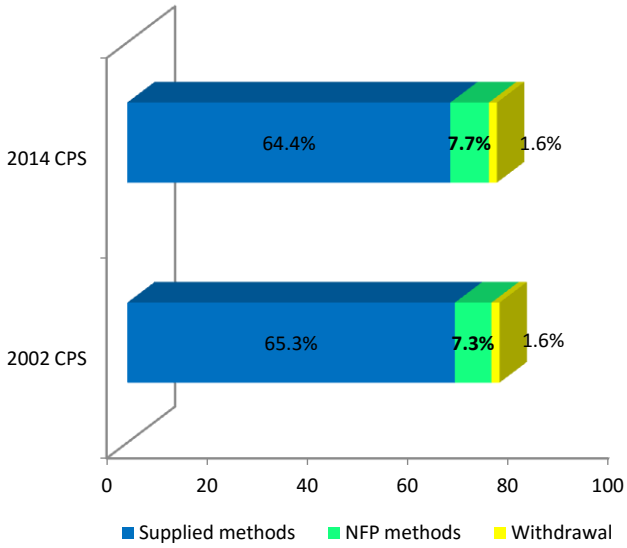


Figure 58: Percent distribution of currently married women age 15 - 49 years who are currently using a contraceptive method by type of method

2014 CPS, Rodrigues

Figure 59 shows that use of modern methods has decreased from 40.7 percent in 2002 to 32.0 percent in 2014 among currently married women age 15-49 years. Concomitantly, use of traditional methods has decreased from 35.2 percent in 2002 to 31.8 percent in 2014.

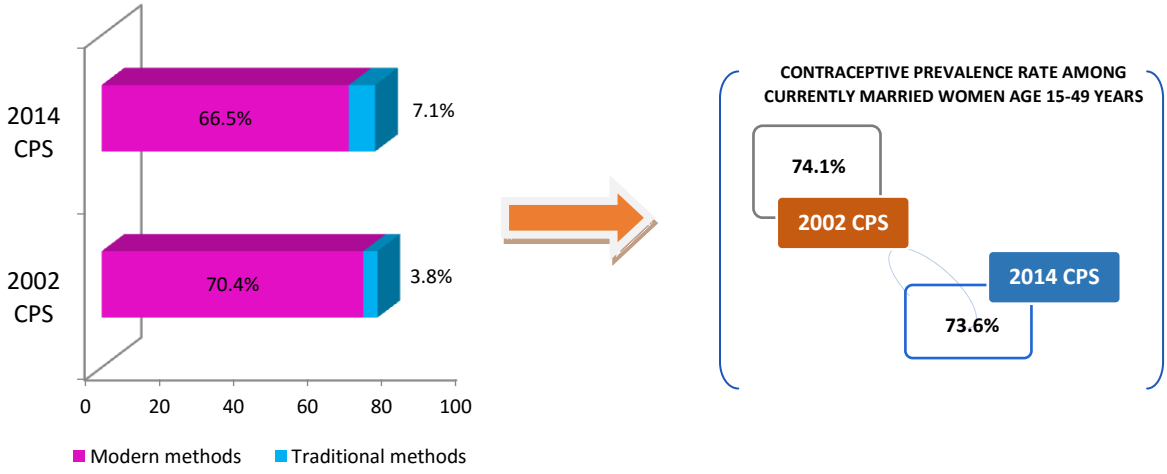


Figure 59: Trends in contraceptive use among currently married women age 15-49 years

2014 CPS, Rodrigues

18.5 Contraceptive Source

Information on sources of contraceptives is useful for family planning managers and implementers. Data from table 60 show that government is the leading source for contraceptives (88.8 percent) followed by Action Familiale (6.8 percent), MFPWA (2.5 percent), and the private sector (2.0 percent) among current users of any contraceptive method (except withdrawal method) who are currently married and of age 15-49 years. It should also be pointed out that government has become

an increasingly important provider of contraceptives over the years since the corresponding proportion was 57.8 percent in 2002.

Table 60: Percent distribution of current users of any contraceptive method (except withdrawal method) by most recent contraceptive source

Recent contraceptive source	All women age	Currently married women age	Currently married women age	All women age	Currently married women age	Currently married women age	Currently married women age
	15 - 49	**15 - 49**	**15 - 44**	**15 - 49**	**15 - 49**	**15 - 44**	**15 - 44**
		2014 CPS			**2002 CPS**		**1991 CPS**
Government[61]	89.9	88.8	87.6	58.6	57.8	58.5	62.2
MFPWA[62]	1.7	2.5	2.7	31.1	31.3	30.2	20.2
Action Familiale[63]	4.8	6.8	7.4	7.9	8.2	8.5	16.7
Private Sector*	3.6	2.0	2.2	2.5	2.6	2.8	0.9

* Includes pharmacy, private hospital, private doctor and supermarket

2014 CPS, Rodrigues

18.6 Contraceptive Counselling

Contraceptive counselling is an important component in family planning service delivery. Research shows that counselling has a positive impact on contraceptive knowledge and use as well as on its continuation. Overall, 87.4 percent of current users of a contraceptive method, who are currently married and of age 15-49 years, are using a supplied method[64] of contraception.

[61] Government has an extensive network of family planning service points (17 family planning service points) and the services are offered free of user cost.

[62] Mauritius Family Planning and Welfare Association (MFPWA) is a non-governmental organization that delivers reproductive health services, such as family planning; the prevention and management of HIV and AIDS through voluntary counselling and testing (VCT); screening for cancers of the reproductive systems; counselling; and family life education at both primary and secondary school level. MFPWA provides family planning services, which are not free of user cost, at 2 static service points.

[63] Action Familiale is a non-governmental organization that promotes sympto-thermal method, which is a natural family planning method (NFP). In addition to its NFP programme, Action Familiale conducts a human and family life education program in secondary schools and youth clubs, and a marriage counseling and psychotherapy service for those with conjugal and marital problems. Action Familiale provides family planning services at 2 static service points.

[64] Refer to the footnote on p. 115 for the list of supplied methods. Overall, 95.2% of current users of supplied methods, who are currently married and of age 15-49 years, obtained their recent source of supply from the government, 2.6% from MFPWA and 2.1% from the private sector.

Figure 60 shows that 94.2 percent of those who are currently using a supplied method were advised on how to use this method by a family planning provider.

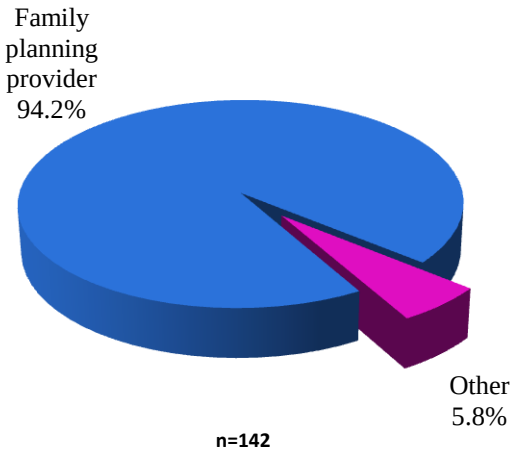


Figure 60: Percent distribution of currently married women age 15-49 years who are currently using a supplied method of contraception by who advised them on how to use this method

2014 CPS, Rodrigues

Respondents, who were advised by a family planning provider[65] on how to use the supplied method that they are currently using, were asked if the following issues were discussed with them by the provider:

- Instructions to follow while using their contraceptive method;
- The possible side effects that they might experience while using their contraceptive method;
- Measures to be taken in case of side effects;
- To make a return visit in case of problems/concerns with their contraceptive method; and
- Other methods of contraception.

Figure 61 shows that a significant proportion of these respondents received advice on the above-mentioned topics. For instance, 58.7 percent were advised about the possible side effects that they might experience while during their contraceptive method.

[65] Doctor, nurse, midwife and Community Health Care Officer/Family Planning Officer.

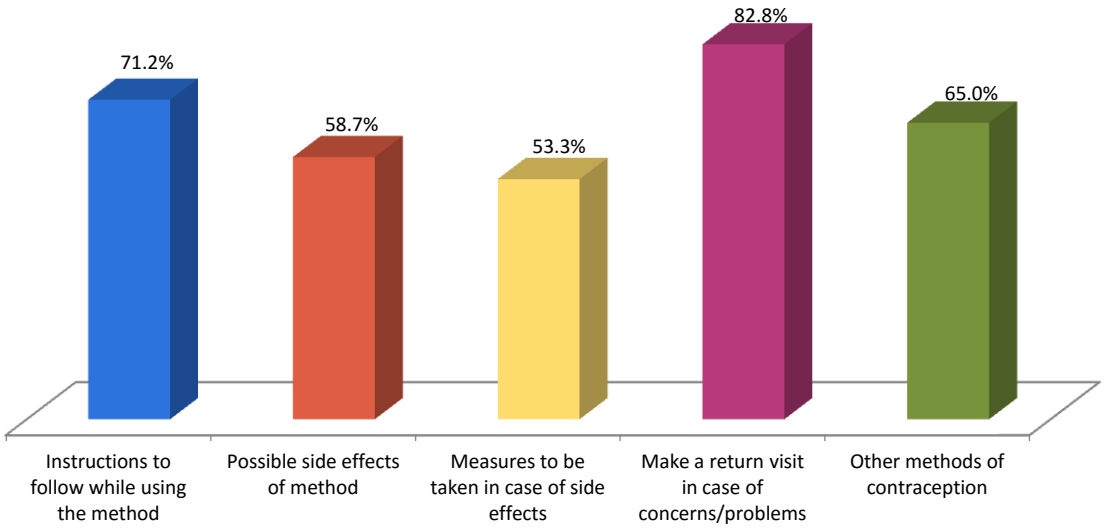


Figure 61: Percent distribution of currently married women age 15-49 years who are currently using a supplied method of contraception by specific issues discussed with the family planning provider who had advised them on how to use this method

2014 CPS, Rodrigues

18.7 Unmet Need for Family Planning

Unmet need measures the gap between the desired fertility and contraceptive practices. Data from figure 62 reveal that unmet need for family planning in Rodrigues is 14.8 percent among currently married women age 15-49 years (5.9 percent unmet need for spacing; 8.9 percent unmet need for limiting).

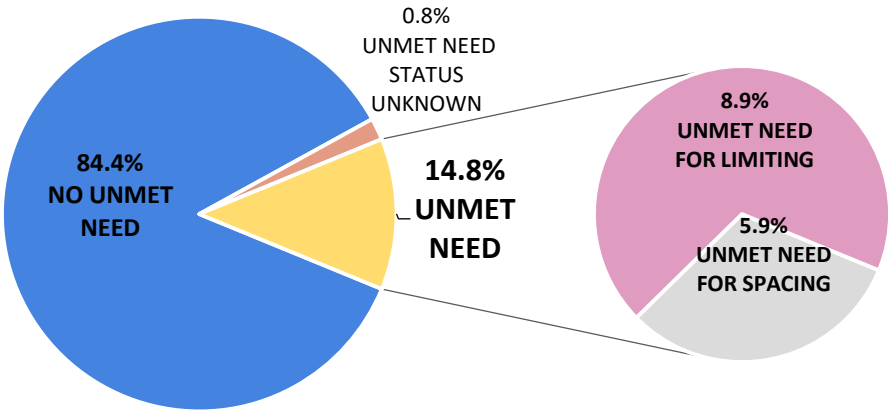


Figure 62: Unmet need status for family planning among currently married women age 15-49 years

2014 CPS, Rodrigues

For the 2014 CPS, the revised estimates from Bradley et al. (2012)[66] were used in the computation of the unmet need for family planning. According to this definition, women of reproductive age (15-49 years) who are in union have an unmet need if they are fecund, do not want a child in the next two years or at all, and are not using any method of contraception, either modern or traditional. Pregnant women and women experiencing post-partum amenorrhea (and who gave birth within two years prior to the survey) are classified as having an unmet need if they indicated that their current pregnancy or recent pregnancy was unintended.

Table 61 shows the results of the unmet need status for family planning among currently married women age 15-49 years by selected characteristics. For instance, unmet need for family planning among currently married women living in middle-SES households is 21.6 percent compared with 10.2 percent for those living in low-SES households.

Table 61: Unmet need status for family planning among currently married women age 15-49 years by selected background characteristics

Background characteristics	No unmet need	Percent distribution of currently married women with an unmet need for family planning			Unknown unmet need status	Number of currently married women age 15-49
		For spacing	For limiting	Unmet need (total)		
Socio-economic status						
Low	88.2	4.4	5.8	10.2	1.6	111
Middle	78.4	9.6	12.0	21.6	0.0	85
High	88.2	0.0	11.8	11.8	0.0	25
Level of education						
<Completed primary*	83.3	4.5	11.1	15.6	1.1	81
Completed primary	85.1	1.9	10.6	12.5	2.4	37
>Completed primary	85.1	8.4	6.5	14.9	0.0	103
TOTAL	**84.4**	**5.9**	**8.9**	**14.8**	**0.8**	**221**

* Includes 7 cases of no schooling

2014 CPS, Rodrigues

Table 62 shows the percent distribution of currently married women age 15-49 years with unmet need for family planning by the most important reason for not currently using contraceptive methods. The most important reason for non-use of contraceptives identified by currently married women with unmet need for family planning is health concerns (50.3 percent).

[66] http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf

Table 62: Percent distribution of currently married women age 15-49 years with unmet need for family planning by most important reason for not currently using a contraceptive method

Most important reason for not using a contraceptive method	Unmet need		Total
	For spacing	For limiting	
Fertility-related reasons	**60.7**	**22.6**	**37.8**
Infrequent sex	11.8	-	4.7
Trying to get pregnant	10.9	-	4.4
Currently breastfeeding/postpartum	0.0	7.7	4.6
I got pregnant while using that method	7.0	0.0	2.8
Currently pregnant	31.0	14.9	21.3
Method-related reasons	**39.2**	**73.7**	**60.0**
Experienced side effects	-	16.1	9.7
Health concerns	39.2	57.6	50.3
Opposition to use	**0.0**	**3.6**	**2.2**
Husband/partner objects to using method	-	3.6	2.2

2014 CPS, Rodrigues

Currently married women age 15-49 years with unmet need for family planning were asked whether they intended to use any method in the future. Overall, 39.3 percent of women with unmet need for family planning are not sure to use a contraceptive method sometime in the future (as shown in Table 63).

Table 63: Percent distribution of currently married women age 15-49 years who have an unmet need for family planning by future intention to use a contraceptive method

Intention for nonuse	Unmet need		Total
	For spacing	For limiting	
Future Intention			
Intend to use	35.4	26.4	30.0
Do not intend to use	17.5	39.5	30.7
Unsure about use	47.1	34.2	39.3
Total	**100.0**	**100.0**	**100.0**

2014 CPS, Rodrigues

Combining the estimate of unmet need for family planning with data on current contraceptive use provides a picture of the total potential demand for family planning in a country - that is what the demand would be if all currently married women acted on their stated preferences. For family planning programme, the estimate is useful because it helps in revealing the size and characteristics of the potential market for contraceptives.

Another related indicator is the proportion of demand satisfied for family planning: it is useful in assessing overall levels of coverage for family planning programmes. As levels of contraceptive use increase, the proportion of demand satisfied increases. This indicator has been modified to focus on modern contraceptive methods and is known as the proportion of demand satisfied by modern methods; it considers women who are using a traditional method as having an unmet need for better (modern) contraceptive method.

As already mentioned, the contraceptive prevalence rate is 73.6 percent (27.5 percent, for spacing; 46.1 percent for limiting) and the unmet need for family planning is 14.8 percent (5.9 percent, for spacing; 8.9 percent, for limiting) for currently married women age 15-49 years.

The estimates of the total demand for family planning, the proportion of demand satisfied by any method and the proportion of demand satisfied by modern methods are shown in Box 2.

BOX 2

TOTAL DEMAND FOR FAMILY PLANNING =

UNMET NEED FOR FAMILY PLANNING + CURRENT CONTRACEPTIVE USE (ANY METHOD) =
14.8% + 73.6% = 88.4%
(33.4%, TOTAL DEMAND FOR SPACING; 55.0%, TOTAL DEMAND FOR LIMITING)

PROPORTION OF DEMAND SATISFIED BY ANY METHOD = CURRENT CONTRACEPTIVE USE (ANY METHOD) / TOTAL DEMAND FOR FAMILY PLANNING = 73.6% /88.4% = 83.3%

PROPORTION OF DEMAND SATISFIED BY MODERN METHODS = CURRENT CONTRACEPTIVE USE (MODERN METHODS) / TOTAL DEMAND FOR FAMILY PLANNING = 66.5% / 88.4% = 75.2%

2014 CPS, Rodrigues

MATERNAL AND CHILD HEALTH 19

19.0 Introduction

This chapter presents the health care that a mother receives during pregnancy and at the time of delivery. The 2014 CPS collected a range of information on the type of care that Rodriguan women received during pregnancy including information on antenatal care.

19.1 Antenatal Care

Early and regular checkups by trained medical providers are very important in assessing the physical status of women during pregnancy. To ensure the optimal health of mother and child, experts recommend that prenatal care is initiated during the first trimester of pregnancy, continues throughout gestation at specified intervals.

19.1.1 Antenatal Care Coverage

Under normal circumstances, WHO recommends that a pregnant woman without complications have at least four ANC visits to provide sufficient care. It is possible during these visits to detect reproductive health risk factors. In the event of any complication, more frequent visits are advisable and admission to a hospital may become necessary.

Table 64 presents data on the coverage of antenatal care services for the last live born child. 97.4 percent of women received antenatal care during pregnancy. Among those who received antenatal care, 99.8 percent stated that they received most of the antenatal care from the public sector (Government hospital/health centre). There is no private sector (private doctor/clinic) in Rodrigues. However 0.2 percent of respondent mentioned that they received care from both the public and private sector simultaneously which clearly shows that they meant private sector in the island of Mauritius.

19.1.2 Assistance at Delivery of Antenatal Care

One of the most critical factors determining whether a woman survives an emergency, life-threatening situation during, and in the period directly following, delivery is the care she receives from a skilled birth attendant. Internationally a birth is considered to have received regular care if the mother said that she had made at least four antenatal care visits where she was seen by a trained medical provider. Table 64 shows that 64.6 percent of women received regular antenatal care (i.e they made four or more visits to a provider) for their last live born child. 40.7 percent made more than eight antenatal care visits. Moreover, results of the 2014 CPS show that all women (100.0 percent) received antenatal care from a health care provider; 74.4 percent received care from nurse/midwife and 25.6 percent from doctor. However, almost all deliveries in Rodrigues are conducted by a doctor.

Table 64: Percent distribution of births by type of provider for antenatal care, type of facility where antenatal care (ANC) was sought, and the number of antenatal care visits, and percent distribution of last births by the stage of pregnancy at the time of first and last visits.

Antenatal care indicator	Total
Number of weeks pregnant when first learned that you were pregnant	
<6	40.5
6-12	42.6
13+	10.3
Don't Remember	6.6
Source for ANC (percent)	
Public Sector	99.8
Private Sector	NA
Both Public and Private sector	0.2
ANC Provider (percent)	
Doctor	25.6
Nurse	27.9
Midwife	46.5
Number of ANC Visits	
<4	1.5
4	1.1
5-7	10.3
8	12.5
9-10	20.5
11+	20.2
Don't Remember	33.9
Number of weeks pregnant at first ANC visits	
<8	8.5
8-12	44.0
13-16	17.8
17+	20.8
Don' Remember	8.9
Place of Delivery (percent)	
Government Hospital	99.2
Private clinic	NA
Home	0.3
Ambulance	0.5
Type of Delivery (percent)	
Normal	65.9
Caesarian	33.6
Forceps/ventouse	0.5
Weight of baby at birth (percent)	
Normal	82.9
Underweight	8.5
Overweight	8.6

2014 CPS, Rodrigues

19.1.3 Place of Delivery

An important component of the effort to reduce the health risks of mothers and children is to increase the proportion of babies delivered in a safe and clean environment, and under the

supervision of health professionals. Data from table 64 shows that 99.2 percent of births occurred at government hospital, 0.5 percent stated that they delivered in the ambulance and 0.3 percent at home.

19.1.4 Type of Delivery

Overall, 65.9 percent of currently married women age 15-49 years had a normal delivery, 33.6 percent had a caesarean section delivery and 0.5 percent had a forceps/ventouse delivery for their last birth.

19.1.4.1 Delivery by Caesarian Section

The 2014 CPS obtained information on the frequency of caesarian section. Table 65 presents data on normal and caesarian section deliveries for the last live born child by selected characteristics. 33.6 percent of last live born child was delivered by caesarian section.

Delivery by a caesarian section was highest among adolescent (15-19 years). Relating delivery by caesarian section to the number of living children, it was found that 32.2 percent of mothers with one living child had delivered by caesarian section compared to 43.1 percent among mothers with 3 living children. Moreover, professional women are more likely to deliver by caesarian section (36.6 percent) compared to manual worker (19.6 percent).

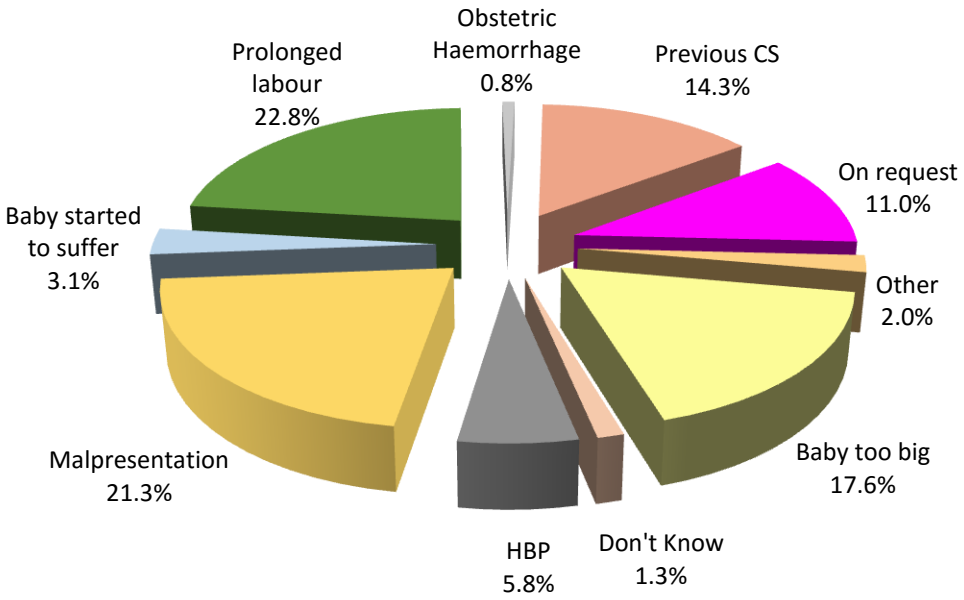
Table 65: Mode of delivery of last live born child by background characteristics.

Mode of Delivery	Normal	Caesarian	Forceps/Ventouse	Total
Age group				
15-19	35.0	65.0	0.0	12
20-24	83.0	17.0	0.0	32
25-29	66.4	33.6	0.0	51
30-34	63.7	35.3	1.0	63
35-39	64.2	34.2	1.6	49
40-44	60.7	39.3	0.0	46
45-49	71.9	28.1	0.0	45
Education				
No School	63.6	36.4	0.0	7
Primary	62.1	37.9	0.0	162
Secondary	70.9	28.0	1.1	124
University/Technical	69.2	30.8	0.0	5
Number of living children				
1	67.8	32.2	0.0	90
2	68.3	30.1	1.6	90
3	56.9	43.1	0.0	64
>=4	69.7	30.3	0.0	54
Occupation				
Professional	63.4	36.6	0.0	25
Service worker	73.9	26.1	0.0	40
Manual Worker	80.4	19.6	0.0	42
Homemaker/Student	61.4	31.9	0.7	191

2014 CPS, Rodrigues

19.1.4.2 Reasons for Caesarian Section

The most important reasons cited by respondents for having had a caesarian section delivery were prolonged labour (22.8 percent) followed by malpresentation (21.3 percent), baby too big (17.6 percent), previous caesarian (14.3 percent) and on request (11.0 percent) (Figure 63).



n=100

Figure 63: Reasons for women to deliver by caesarian section

2014 CPS, Rodrigues

19.1.5 Exposure to Safe Pregnancy Messages during Pregnancy

The 2014 CPS collected information on whether women received information on Nutrition, Breastfeeding, Contraception and Postnatal Care among others during antenatal care visits for their last pregnancy. Figure 64 shows that more than 50 percent of these mothers said that they were informed. The most common subjects on which they received information were; breastfeeding (84.4 percent), smoking during pregnancy (78.3 percent), drinking alcohol during pregnancy (78.2 percent) and nutrition (77.0 percent),. The subject on which they were least informed was contraception (52.5 percent). Surprisingly, only about one in two (55.7 percent) received information on warning signs of pregnancy complications at the time they were pregnant.

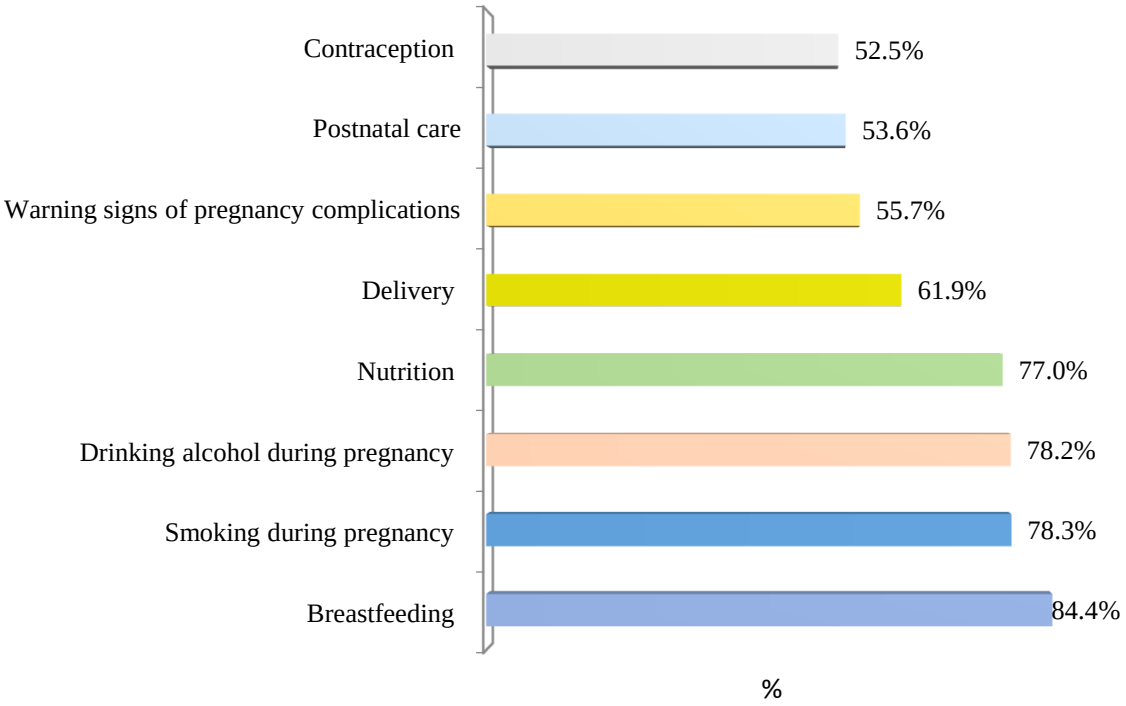
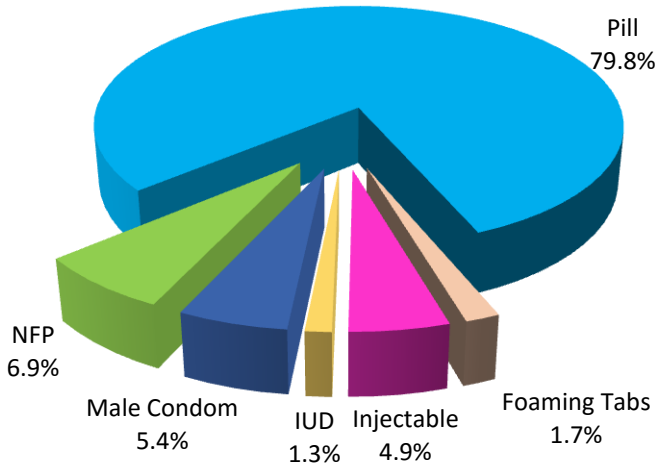


Figure 64: Percentage of women exposed to safe pregnancy messages during pregnancy

2014 CPS, Rodrigues

19.1.6 Method Failure Resulting in Pregnancy for Last Born Child

Women who became pregnant for their last born child were asked if they were using a contraceptive method when they got pregnant. Surprisingly, 18.3 percent of respondents said they got pregnant while using a contraceptive method and the method used, were pill (79.8 percent) , male condom (5.4 percent), 3-month injectable (4.9 percent) and NFP method(6.9 percent) as shown in figure 65. In fact 93.1 percent were using a supplied method.



n= 55

Figure 65: Method failure resulting in pregnancy for last live born child

2014 CPS, Rodrigues

19.2 Risk Factors and Pregnancy

Monitoring the risk profile of the population is an extremely important step to ensure the health of the nation as future trends in disease burden relate to current trends in risk factors. The respondents were asked questions in relation to tobacco and alcohol consumption as well as whether they had any disorders such as diabetes or hypertension during their pregnancies

19.2.1 Smoking and Drinking during Pregnancy

Smoking and alcohol consumption affect adult health, and may adversely affect children's health. Tobacco and alcohol consumption during pregnancy are major risk factors for poor pregnancy outcomes. Smoking during pregnancy is linked to low birth-weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome, and infant respiratory problems whilst alcohol consumption during pregnancy is linked to miscarriages, stillbirth and premature delivery.

The 2014 CPS data reveals that 3.2 percent of women age 15-49 years were smoking during their pregnancy for their last liveborn child[67]. Further analysis reveals that 34.4 percent of them[68] were smoking daily.

It is also noted that 1.4 percent of women age 15-49 years who have had a live birth were drinking alcohol during their pregnancy for their last liveborn child.

19.2.2 Diabetes and Hypertension during Pregnancy

Women who have had a liveborn child were asked if they have been medically diagnosed for diabetes and hypertension. The results show that 4.3 percent of them have been diagnosed for diabetes[69] and 20.2 percent for hypertension. Moreover, 1.9 percent of them have been diagnosed for both diabetes and hypertension.

The median age at which the respondents have been diagnosed for hypertension was 27.8 years.

Figure 66 shows that 48.0 percent have been diagnosed for hypertension during their pregnancy for their last liveborn child.

[67] Overall, 298 women age 15-49 years have had a live birth.
[68] Among women who were smoking during their pregnancy for their last liveborn child.
[69] Due to small number of cases, the median age at which respondents have been diagnosed for diabetes has not been calculated.

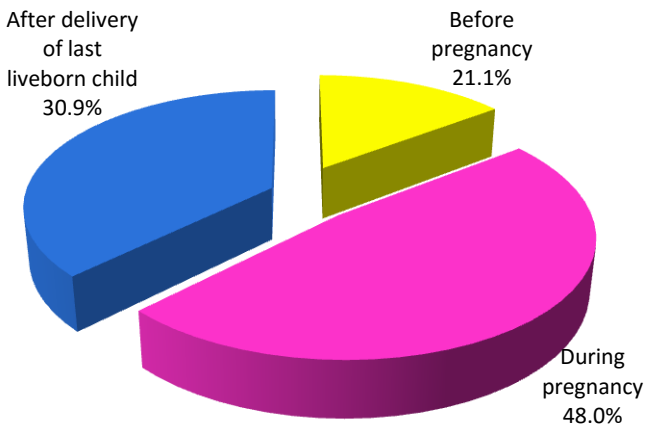


Figure 66: Percent distribution of women age 15-49 years who have been diagnosed for hypertension before, during or after their pregnancy for their last liveborn child

2014 CPS, Rodrigues

19.3 Child Health

Early childhood growth, development and health monitoring is widely accepted and considered as an important indicator of future health outcomes (Panpanich et al. 2000).

19.3.1 Birth Weight

A child's birth weight is an important indicator of the child's vulnerability to the risk of childhood illness and the chances of survival. Children whose birth weight is less than 2.5 kilograms are considered to have a higher than average risk of early childhood death. Table 64 shows that 8.5 percent of the last live born child weighted less than 2.5 kilograms according to respondents. 8.6 percent were overweight that is more than 4.0 kilograms, but the majority (82.9 percent) had normal weight.

19.3.2 Nutrition of Children

Adequate nutrition is essential for good health and is critical to children's growth and development. Thus, the nutritional status of children under age 5 is an important proxy measure of children's health. This chapter focuses upon infant feeding and nutritional status of children of the 2014 CPS.

19.3.2.1 Breastfeeding

Breastfeeding is the best way to provide infants with the nutrients they need. Exclusive breastfeeding[70] is recommended up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

[70] Exclusive breastfeeding is defined as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for the first 6 months of life, but allows the infant to receive oral rehydrating salt (ORS), drops and syrups (vitamins, minerals and medicines).

The 2014 CPS asked mothers who reported having had a live birth in *the two years preceding the survey* whether they ever breastfed their last liveborn child. Figure 67 shows that 98.8 percent of their last liveborn child born two years preceding the survey were breastfed.

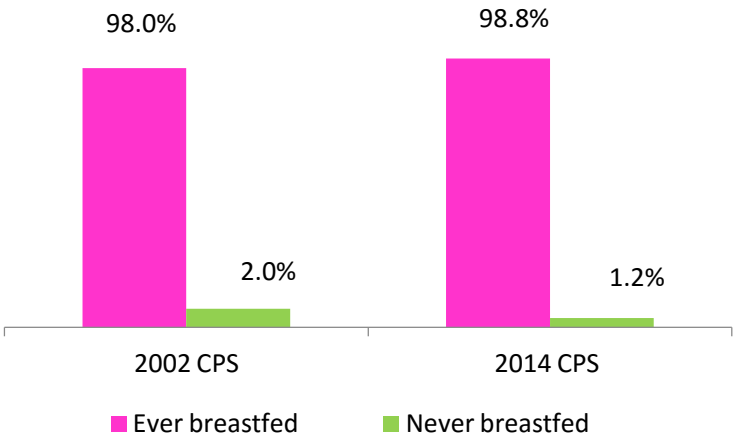


Figure 67: Percent distribution of respondents who have ever breastfed their last liveborn child born in the two years preceding the survey

2014 CPS, Rodrigues

The 2014 CPS data indicates that among the last liveborn children born in the five years preceding the survey who were ever breastfed, 24.0 percent of them were breastfed within one hour of birth compared with 40.1 percent in 2002. The results of the 2014 CPS also show that the mean duration of any breastfeeding is 14.9 months and the mean duration of exclusive breastfeeding is 5.9 months among last liveborn children born in the five years preceding the survey (Table 66). Care should be taken in interpreting these figures since there might be a recall bias.[71]

Table 66: Breastfeeding Indicators

Percent distribution of last liveborn children born in the *two years preceding the survey* who were ever breastfed and the mean duration of any breastfeeding and exclusive breastfeeding of last liveborn children born in the *five years preceding the survey*

		Mean duration (in months) of:	
CPS	percent ever breastfed	Any Breastfeeding	Exclusive Breastfeeding
1991	92.0	16.0	-
2002	98.0	11.6	1.8
2014	98.8	14.9	5.9

2014 CPS, Rodrigues

[71] It should be noted that the indicator for exclusive breastfeeding among last liveborn children born in the six months preceding the survey could not be calculated because of the small number of cases.

REPRODUCTIVE HEALTH PERCEPTION AND BEHAVIOR 20

20.0 Introduction

This chapter examines the reproductive health perception and behavior among the women in the 2014 CPS focussing on education and counselling.

20.1 Source of information on Sexual Matters

Respondents[72] were asked to cite the most important source of information on sexual matters. Table 67 shows that 20.0 percent of respondents cited teachers and 17.0 percent cited friends/colleagues as the most important source of information on sexual matters.

Table 67: Percent distribution of respondents by most important source of information on sexual matters

Most important source of information	Percentage
Mother/Father	13.6
Partner/Husband/Boyfriend	2.1
Other family member/Relative	8.6
Friend/Colleague	17.0
Doctor/Nurse/Midwife	11.7
Teacher	20.0
Books/Newspaper/Magazines/Brochures/Flyers	5.4
Internet/Social media/ Radio/ TV	10.0
Action Familiale	6.6
Other	5.1
Total	**100.0**
Total number of respondents	400

2014 CPS, Rodrigues

20.2 Family Life Education in Schools

In the past few years, there has been an ongoing debate about school-based sexuality education in Rodrigues. Although the process of introducing sexuality education in the school curriculum has been set in motion since long ago, it is still not included in the formal curriculum at schools.

Students are sensitized on healthy lifestyles and sexual and reproductive health issues through the Family Life Education programme, which is conducted on an adhoc basis in schools by governmental and non-governmental organizations.

The 2014 CPS asked respondents[73] if topics, such as responsible sexual behavior, contraceptive methods, and HIV/AIDS were ever discussed with them at school. Figure 68 shows that menstrual

[72] Throughout this section, respondents refer to all women age 15-49 years unless stated otherwise.

cycle (61.7 percent) and puberty (60.5 percent) were the two most common topics that were cited by respondents. It is noted that slightly more than one in three respondents were given talks on contraceptive methods (36.2 percent). Further analysis of the data reveals that 34.1 percent of respondents were not given talks on any of these topics at school.

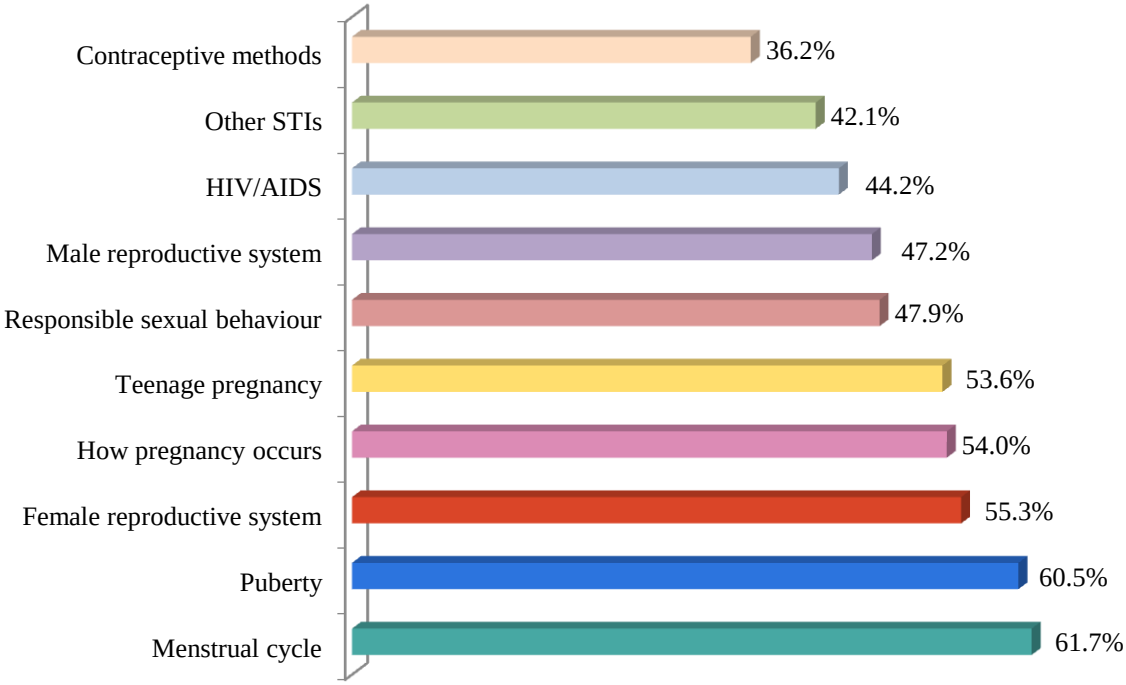


Figure 68: Percent distribution of respondents who have been given talks on sexual and reproductive health issues at schools by specific topic

2014 CPS, Rodrgues

20.3 School-based Sexuality Education

School-based sexuality education can be an important and effective way of reducing risky sexual behaviour among young people. Since there is a lack of information on the opinions of people on this matter, respondents were asked if the following components of sexuality education should be taught at school: human reproduction, contraceptive methods, STIs including HIV/AIDS, and responsible sexual behaviour.

Figure 69 shows that the majority of respondents agree that the above-mentioned components should be taught at schools. For instance, 92.6 percent of respondents stated that "responsible sexual behaviour" should be taught at school. However, a minority of respondents (2.1 percent) said that none of these components, i.e. human reproduction; contraceptive methods; STIs including HIV/AIDS; and responsible sexual behaviour, should be taught at school.

[73] Excluding 7 respondents who had no schooling.

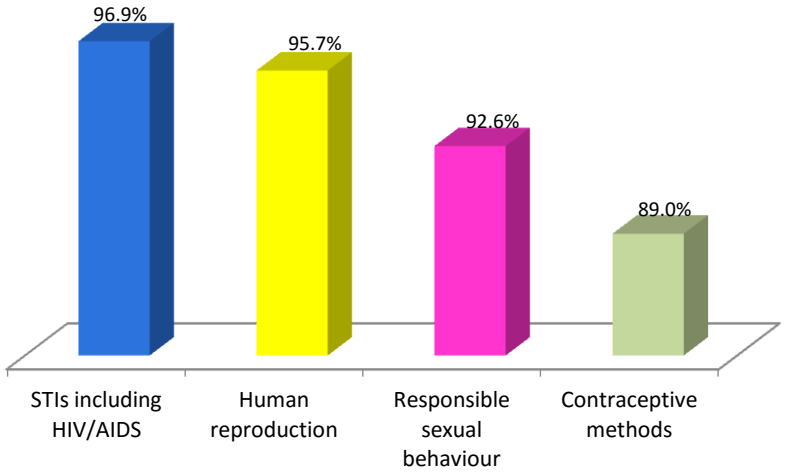


Figure 69: Percent distribution of respondents who agree that sexuality education should be taught at school by specific component

2014 CPS, Rodrigues

Respondents, who agreed that specific components of sexuality education should be taught at school, were then asked to state the best age at which students should be taught these components at school.

Figure 70 reveals that a significant proportion of respondents said that these components should be taught at ages 12 to 15. For instance, 66.8 percent of respondents said that contraceptive methods should be taught at ages 12 to 15 years.

An equal proportion of respondents (33.4 percent) thought that "STIs including HIV/AIDS" and "responsible sexual behaviour" should be taught at age 11 years or younger, and slightly more than half of the respondents (53.9 percent) stated that "human reproduction" should be taught at age 11 years or younger.

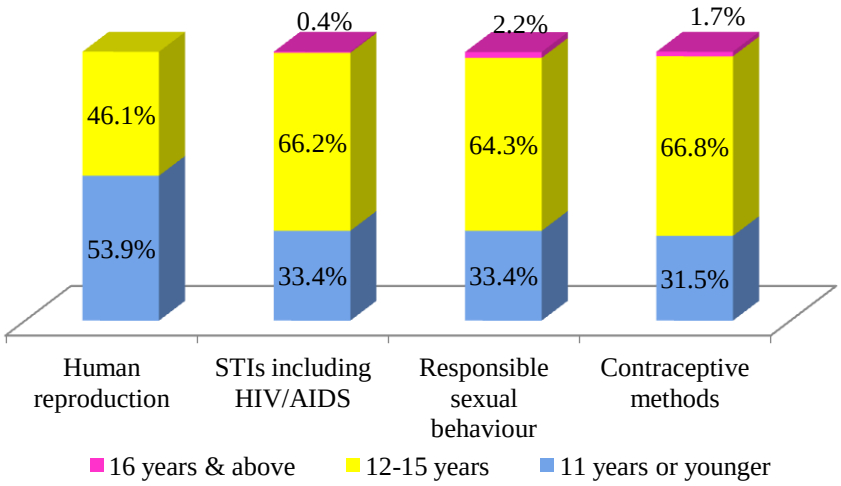


Figure 70: Percent distribution of respondents who stated the best age at which students should be taught sexuality education at school by specific component

2014 CPS, Rodrigues

Some of the arguments that opponents of school-based sexuality education put forward in their discussions are listed in Table 68. Respondents were asked if they agree with these arguments.

Table 68: Percent distribution of respondents about their opinions on the arguments that opponents of school-based sexuality education put forward in their discussions

Argument against sexuality education	Agree (percent)	Disagree (percent)	Don't know/ No response (percent)
School-based sexuality education may lead to early onset of sexual activities among young people.	16.3	79.2	4.6
Sexuality education should be taught only at home.	2.8	95.8	1.4
Sexuality education is against my religious belief.	3.0	89.6	7.4
Teachers do not have enough training to teach sexuality education.	39.8	47.3	12.9

2014 CPS, Rodrigues

Overall 79.2 percent of respondents disagree that school-based sexuality education may lead to early sexual initiation among young people; 95.8 percent of them disagree that sexuality education should be taught only at home; 89.6 percent of them disagree that sexuality education is against their religious belief; and 47.3 percent of respondents disagree that teachers do not have enough training to teach sexuality education.

Respondents were then asked: "Who would be the most suitable person to teach sexuality education at school if sexuality education is included in the formal curriculum at schools in Rodrigues?".

Table 69 shows that slightly more than 3 in 4 respondents stated that a teacher with special training in sexuality education (77.7 percent) would be the most suitable person to teach sexuality education.

Table 69: Percent distribution of respondents about their opinion on who is the best person to teach sexuality education at school

Best person to teach sexuality education	Percentage
Teacher with special training in sexuality education	77.7
Biology teacher	7.0
Form teacher	1.4
Other teacher	1.0
Doctor	0.6
Family Planning Health Provider	8.1
Other	1.0
Don't Know	3.1
Total	**100.0**

2014 CPS, Rodrigues

20.4 Parental involvement in Sexuality Education

Since sexuality education is an ongoing process, parental involvement is also important in promoting healthy lifestyles among adolescents. Respondents who were 19 years old and above at the time of the interview were asked if their parents had ever talked to them on some components of sexuality education before they reached age 18 and the same question was asked to respondents who were below 18 years old.

Figure 71 shows that 53.4 percent of respondents said that they have had talks with their parents before reaching age 18 on not having sex before marriage. Less than half of the respondents (42.4 percent) reported that they have had talks on responsible sexual behaviour with their parents before reaching age 18. Overall, the mean number of topics that respondents reported discussing with their parents before reaching age 18 was 4.2 topics.

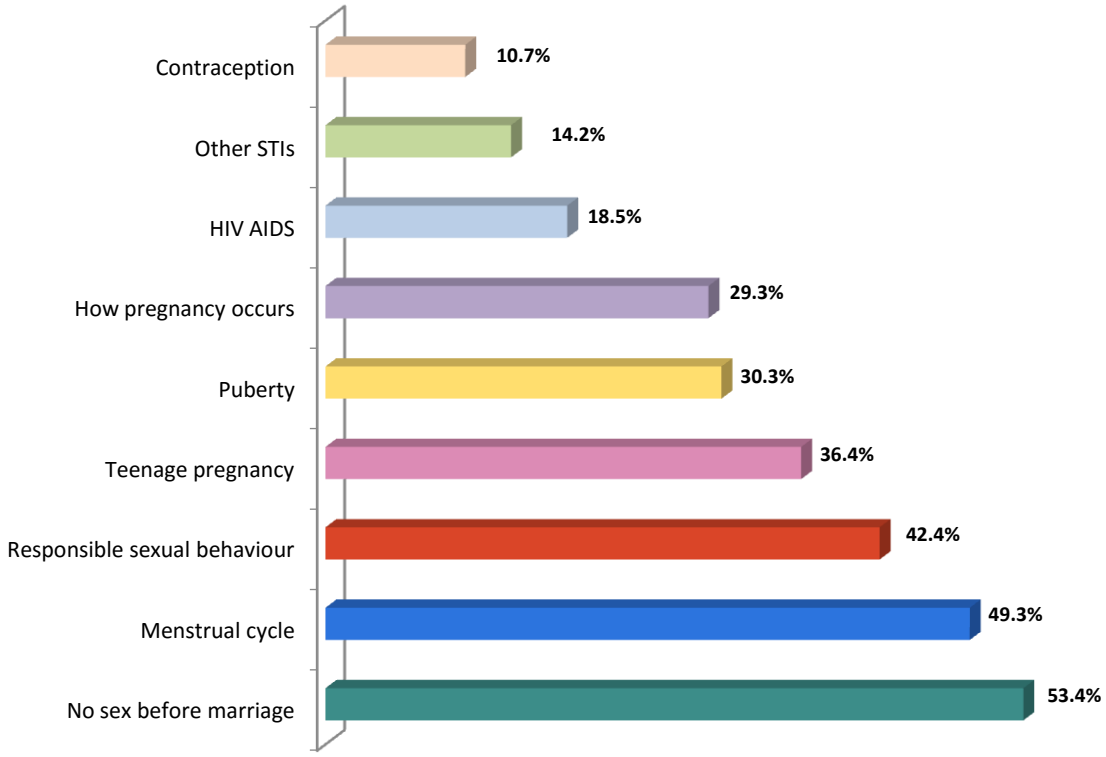


Figure 71: Percent distribution of respondents who discussed reproductive health topics with their parents before reaching age 18 by specific topic

2014 CPS, Rodrigues

At this point, it should be mentioned that 31.4 percent of respondents stated that they never had talks with their parents before reaching age 18 on any of these nine components of sexuality education. Hence, the results reveal that parents should be sensitized about their key role in the sexuality education of their children.

20.5 Breast Self-Examination

Breast self-examination (BSE) is a screening method used for early detection of any anomalies that could be linked to breast cancer.

Respondents were asked if they have heard/read about breast self-examination (BSE). Figure 72 shows that 81.3 percent of respondents have heard/read about this examination.

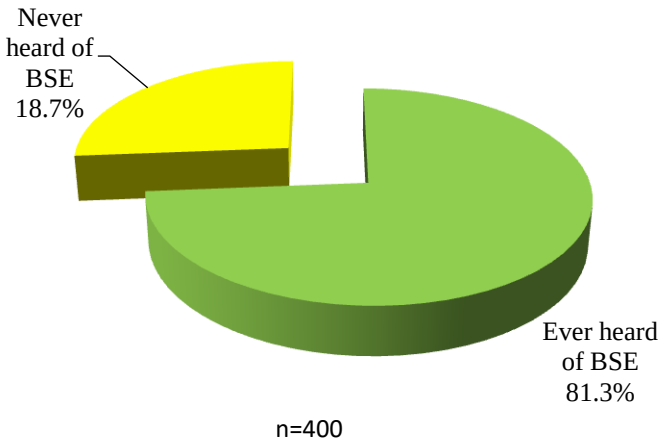


Figure 72: Percent distribution of respondents who have heard/read about breast self-examination

2014 CPS, Rodrigues

Respondents who have heard/read about BSE were then asked about their first source of information on BSE. Table 70 shows that 56.5 percent of respondents obtained their information on BSE for the first time from the newspaper/radio/TV.

Table 70: Percent distribution of respondents who have heard/read about breast self-examination by first source of information

First source of information	Percentage
Private doctor	0.2
Government health centre personnel	20.8
Family member	10.0
Friend/Colleague	6.2
Newspaper/Radio/TV	56.5
Books/Magazines/Brochures	4.4
MFPWA	1.9
Total	**100.0**
Total number of respondents	325

2014 CPS, Rodrigues

Figure 73 shows that 46.4 percent of respondents have not carried out BSE despite having heard/read about this examination.

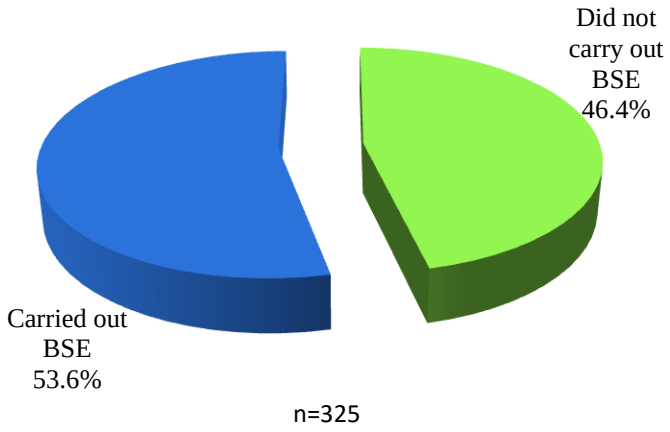


Figure 73: Percent distribution of respondents who have carried out breast self-examination

2014 CPS, Rodrigues

Table 71 shows that the most important reason cited by respondents for not carrying out BSE is "don't know how to do BSE" (61.2 percent) followed by "don't have any symptoms" (25.5 percent).

Table 71: Percent distribution of respondents by the most important reason cited for not carrying out breast self-examination

Most important reason	Percentage
Don't know how to do BSE	61.2
Don't think that BSE is important	3.8
Don't believe in the efficacy of the test	2.4
Don't have any symptoms	25.5
Scared of being diagnosed with breast cancer	2.4
Never thought of it	3.7
Don't have time	1.0
Total	**100.0**
Total number of respondents	151

2014 CPS, Rodrigues

20.6 Pap Smear

Pap smear is a screening test to detect abnormal cervical cells and cervical cancers. Respondents were asked if they have heard/read about Pap smear. Figure 74 shows that 52.8 percent of respondents age 15-49 years have heard about Pap smear.

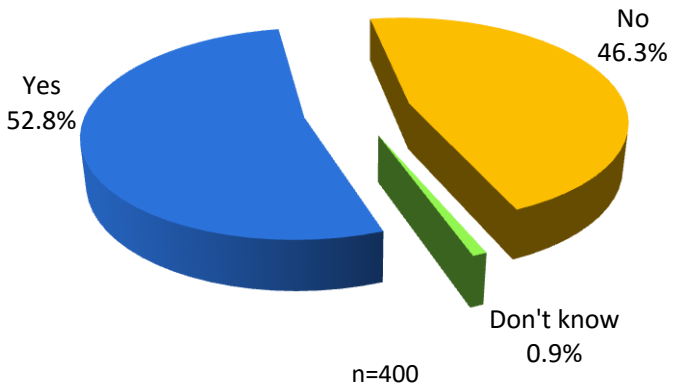


Figure 74: Percent distribution of respondents age 15-49 years who have heard/read about Pap smear

2014 CPS, Rodrigues

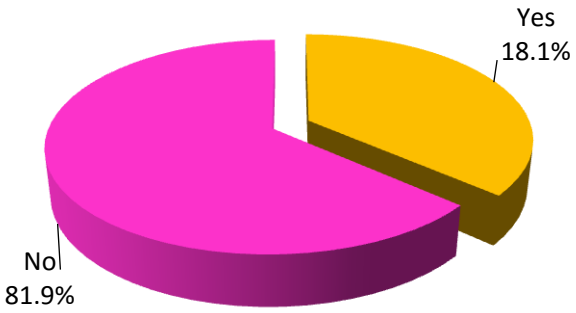
Respondents who have heard/read about Pap smear were asked: "Where did you hear/read about Pap smear for the first time?". Table 72 shows that 58.8 percent of them heard/read about Pap smear for the first time from the newspaper/radio/television.

Table 72: Percent distribution of respondents who have heard/read about Pap smear examination by first source of information

First source of information	Percentage
Government health centre personnel	22.7
Family member	5.5
Friend /Colleague	6.9
Newspaper/Radio/TV	58.8
Books/Magazines/Brochures	1.5
MFPWA	4.0
Internet /Social media	0.8
Total	**100.0**
Total number of respondents	211

2014 CPS, Rodrigues

Respondents who have heard/read about Pap smear and who have had sexual intercourse were asked if they have had a Pap smear. Figure 75 shows that 18.1 percent of them have had a Pap smear.

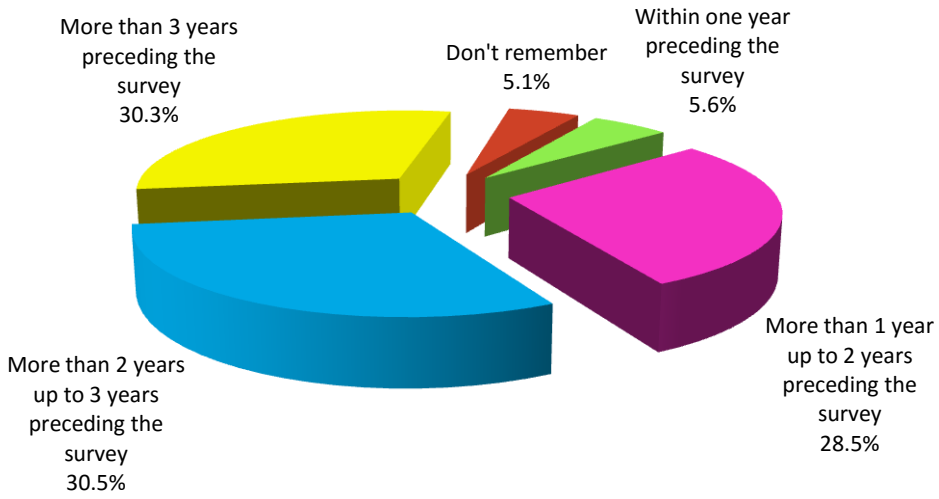


n=195

Figure 75: Percent distribution of respondents who have had a Pap smear among those who have heard/read about Pap smear and who have had sexual intercourse

2014 CPS, Rodriguess

Since the 2014 CPS did not capture the exact age at which the respondents[74] have had their last Pap smear, it can only be said that 30.3 percent of them have had a Pap smear more than 3 years preceding the survey and 5.6 percent of them have had it within a year preceding the survey (see figure 76).



n=35

Figure 76: Percent distribution of respondents who have had a Pap smear by the number of years preceding the survey when their last Pap smear was carried out

2014 CPS, Rodrigues

[74] It should be noted that figures 75 & 76 refer to respondents who have heard/read about Pap smear and who have had sexual intercourse.

Figure 77 shows that 82.7 percent of respondents have had their last Pap smear at the government hospital, 11.3 percent at MFPWA clinic and 6.0 percent at a private clinic/doctor's office[75].

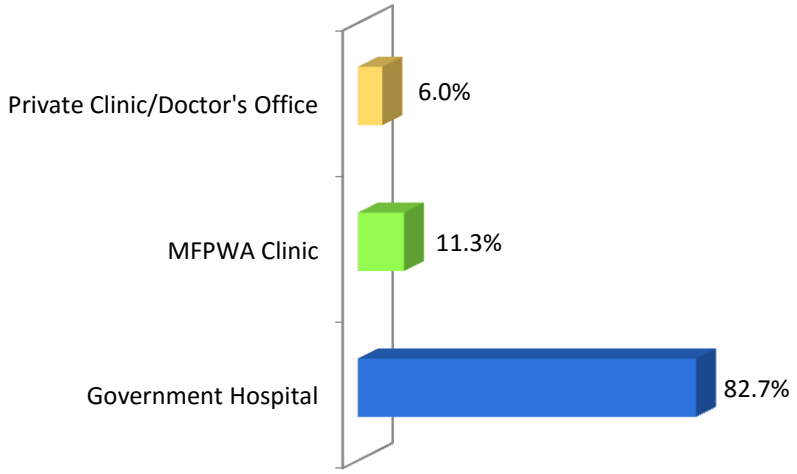


Figure 77: Percent distribution of respondents who reported having had a Pap smear by the facility where their last Pap smear was carried out

2014 CPS, Rodrigues

Respondents who never have had a Pap smear despite having heard/read about Pap smear and having had sexual intercourse were asked for the most important reason for not having had a Pap smear.

Table 73 shows that 44.6 percent of them never thought of having one and 16.1 percent did not feel that the test was necessary.

Table 73: Percent distribution of respondents by the most important reason cited for not having had a Pap smear

Most important reason	Percentage
Doctor has not recommended it	4.1
Healthy and has no gynaecological problems	7.1
Does not feel test is necessary	16.1
Does not have time to go for a test	6.2
Never thought of having a Pap smear	44.6
Is afraid of the results	7.2
Is afraid Pap smear could be painful	3.9
Too embarrassed to get the test or a pelvic exam	2.0
Has no partner/Not sexually active	0.8
Don't know/Refused to answer	8.0
Total	**100.0**
Total number of respondents	160

2014 CPS, Rodrigues

[75] These respondents must have had their test outside Rodrigues as there are no privately-run health facilities in Rodrigues.

HIV/AIDS AWARENESS KNOWLEDGE AND ATTITUDES 21

21.0 Introduction

The 2014 CPS included a series of questions that addressed respondents' knowledge of HIV prevention, their awareness of modes of HIV transmission, and behaviours that can prevent the spread of HIV. In this way, those groups of individuals most in need of information and most at risk of HIV infection can be monitored.

21.1 HIV Awareness

Overall, 99.3 percent of all respondents[76] have heard about AIDS in 2014 (397) and 87.8 percent of them knew where they can get an HIV test.

Respondents who knew where they can get an HIV test were asked to name the various places that provide HIV testing. Figure 78 indicates that the most common cited place is government hospital (100 percent) followed by PILS[77] (95.1 percent) and private laboratory (93.3 percent). Although there are no private clinics in Rodrigues, it is noted that 84.8 percent said that they can get an HIV test at a private clinic.

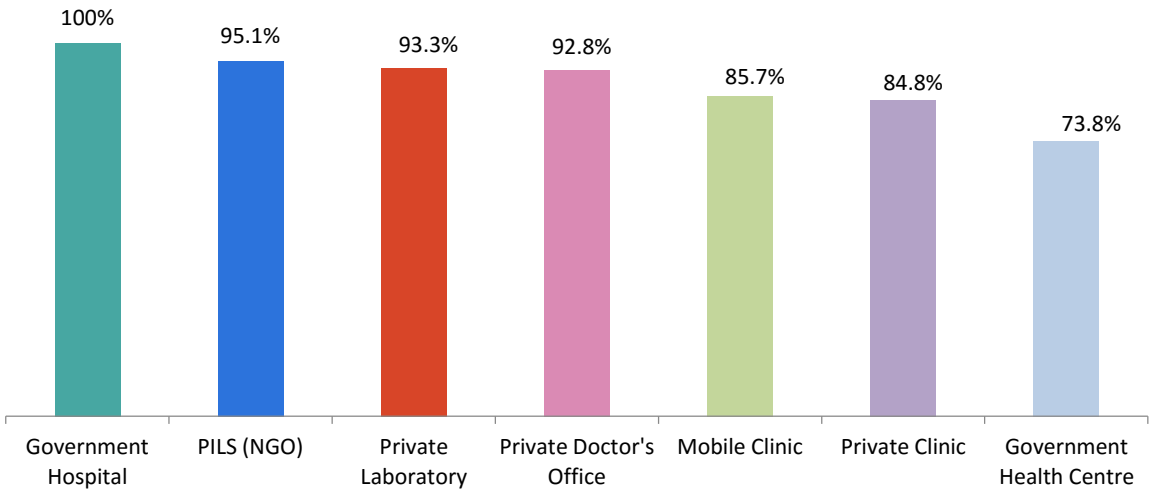


Figure 78: Percent distribution of respondents who cited different places where they can get an HIV test by specific place

2014 CPS, Rodrigues

[76] Throughout this section, respondents refer to all women age 15-49 years who have heard about HIV/AIDS unless stated otherwise.

[77] PILS (Prévention Information Lutte contre le Sida) is an NGO that is engaged in the national response against AIDS.

21.2 Knowledge of HIV/AIDS Prevention

Respondents who have heard about HIV/AIDS were asked whether there are any measures that can be taken to avoid getting HIV/AIDS. Figure 79 shows that the proportion of respondents who knew that something can be done to avoid getting HIV/AIDS has increased from 86.2 percent in 2002 to 95.8 percent in 2014.

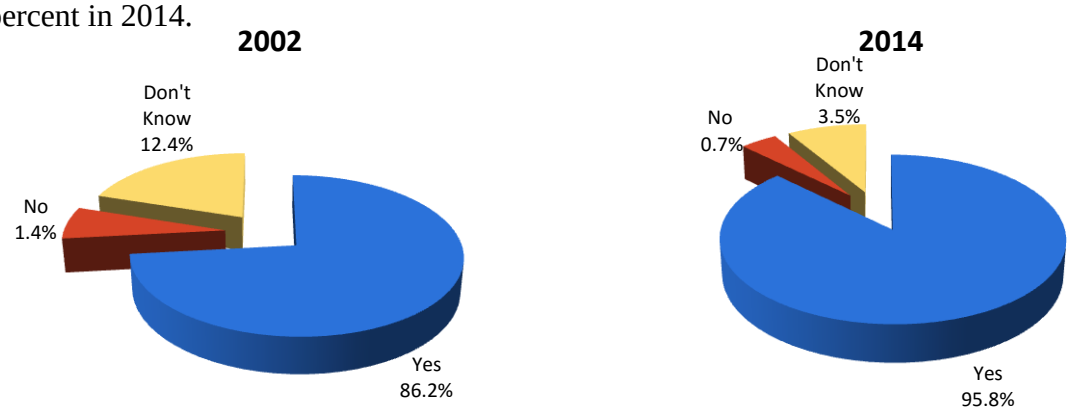


Figure 79: Percent distribution of respondents who knew about ways to avoid getting HIV/AIDS

2014 CPS, Rodrigues

21.3 Unprompted Knowledge of ways to avoid getting HIV/AIDS

Respondents who knew about ways to avoid getting HIV/AIDS were asked, without being prompted, to mention all the ways that they knew of to avoid getting HIV/AIDS. Figure 80 shows that use of condoms (92.0 percent) and having only one sexual partner (64.5 percent) are the two most common ways cited by respondents.

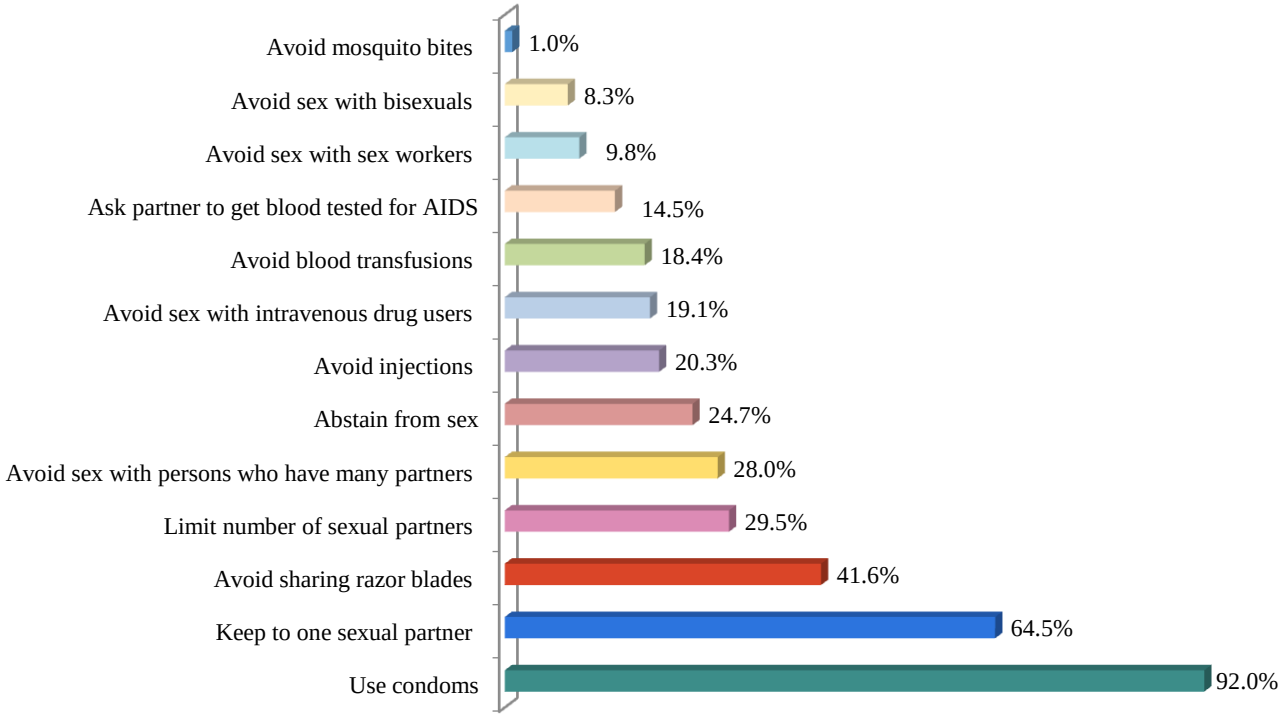


Figure 80: Percent distribution of respondents who stated without being prompted about ways to avoid getting HIV/AIDS by specific way

2014 CPS, Rodrigues

21.4 Knowledge of Mother to Child Transmission of HIV

Knowledge of mother to child transmission of HIV during pregnancy, during delivery and during breastfeeding is an essential component of Information, Education and Communication (IEC) preventive efforts.

Respondents who have heard about HIV/AIDS were asked whether HIV can be transmitted from mother to child during pregnancy, during delivery and during breastfeeding. Figure 81 shows that 72.1 percent of respondents know that HIV can be transmitted from mother to child during pregnancy.

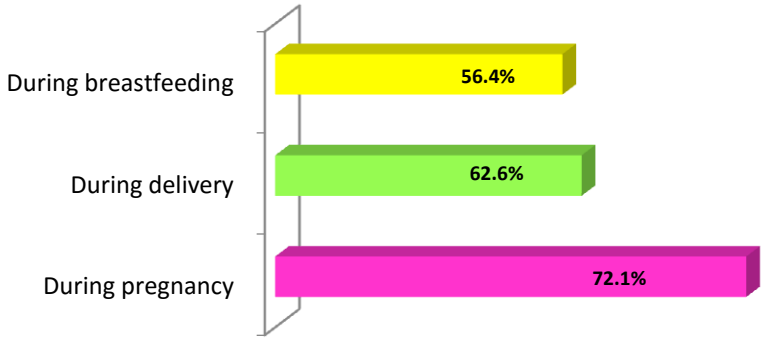


Figure 81: Percent distribution of respondents who knew about the modes of HIV transmission from mother to child by specific mode

2014 CPS, Rodrigues

Figure 82 shows that 87.7 percent of respondents[78] know at *least one* mode of HIV transmission from mother to child (1 mode, 20.3 percent; 2 modes, 31.6 percent; 3 modes, 35.8 percent). The remainder stated either "no" or "don't know" to all three modes including a minority of respondents who said "no" to all three modes (1.9 percent).

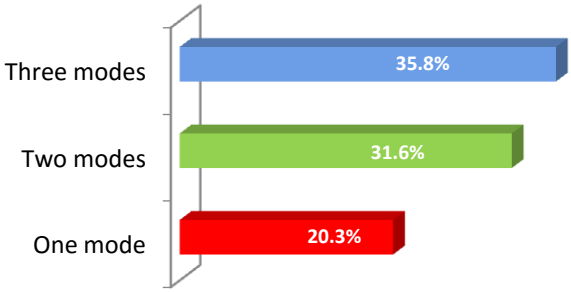


Figure 82: Percent distribution of respondents who stated accurately the number of modes that HIV can be transmitted from mother to child

Three modes of HIV transmission from mother to child:
during pregnancy, during delivery and during breastfeeding

2014 CPS, Rodrigues

[78] Among those who have heard about HIV/AIDS.

21.5 Knowledge of Mother to Child Transmission of HIV by Background Characteristics

Table 74 shows the percentage distribution of women age 15-49 years who know that HIV can be transmitted from mother to child by specific mode and by background characteristics. It is observed that the proportion of women who know that HIV can be transmitted from mother to child during pregnancy, delivery and breastfeeding increases with age.

Data from table 74 indicate that professional women are more likely to have knowledge of mother to child transmission of HIV (75.7 percent for pregnancy, 78.2 percent for delivery and 64.1 percent for breastfeeding) than the other counterparts. Differences in knowledge of mother to child transmission of HIV did not show such wide variation for marital status on all the three ways mentioned. Moreover, Women in the high socio-economic group are more likely to report knowledge of HIV transmission from mother to child during pregnancy and delivery.

Table 74: Percentage distribution of women age 15-49 who know that HIV can be transmitted from mother to child by specific mode and by background characteristics

Background characteristic	During pregnancy	During delivery	During breastfeeding	Number of women
Age group				
15-19	71.1	63.7	56.5	69
20-24	71.4	71.7	54.5	54
25-29	72.1	58.7	66.2	65
30-34	71.4	63.6	51.2	66
35-39	69.7	50.9	62.4	53
40-44	73.5	72.3	61.1	48
45-49	-	-	-	45
Marital Status				
Married (legal/Religious)	71.6	57.8	59.4	143
Consensual union	78.7	67.5	58.3	77
Widowed	90.0	57.1	81.0	6
Divorced/separated	74.5	66.9	57.1	31
single (never Married)	67.7	64.0	51.1	142
Education				
<completed primary	76.7	63.0	56.5	122
completed primary	51.9	50.5	52.5	54
>completed primary	74.5	65.3	57.3	224
Occupation				
Professional	75.7	78.2	64.1	36
Service Worker	63.3	76.0	54.2	55
Manual Worker	80.6	64.4	57.9	43
Homemaker/Student	72.0	57.3	55.6	266
Household socio-economic status				
low	71.3	57.2	53.7	210
medium	72.0	67.1	60.4	153
high	76.6	73.6	55.2	37

CPS 2014, Rodrigues

21.6 Stigma and Discrimination

Respondents were asked if they would be willing to take care of a family member living with HIV in their household; to buy vegetables from a vendor who has HIV; if HIV-positive teachers should continue to teach; and if they would want to keep secret the HIV-positive status of a family member. Figure 83 shows that for instance, 71.9 percent of respondents are willing to take care of a family member living with HIV.

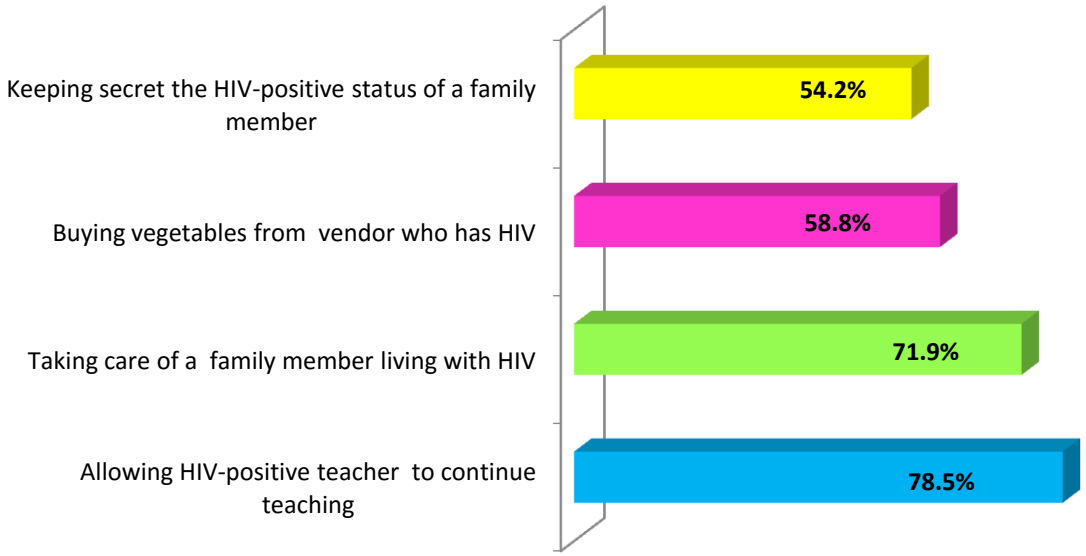


Figure 83: Percent distribution of respondents on their attitudes towards HIV-infected persons

2014 CPS, Rodrigues

As an indicator of acceptance towards people living with HIV/AIDS, the response for each above-mentioned item was summed up for each respondent. Each tolerant (or positive) response had a score of 1. An intolerant (or negative) response had a score of 0. The total scores were categorized by more tolerant (with a score of 4); tolerant (with a score of 3); less tolerant (with a score of 1 or 2); and no tolerance (with a score of 0).

Figure 84 reveals that 28.2 percent of respondents are more tolerant towards any of the four items listed above, 34.3 percent are tolerant, 31.1 percent are less tolerant and 3.8 percent are not tolerant. The remainder (which has not been charted here) stated either "no" or "don't know" to all four items.

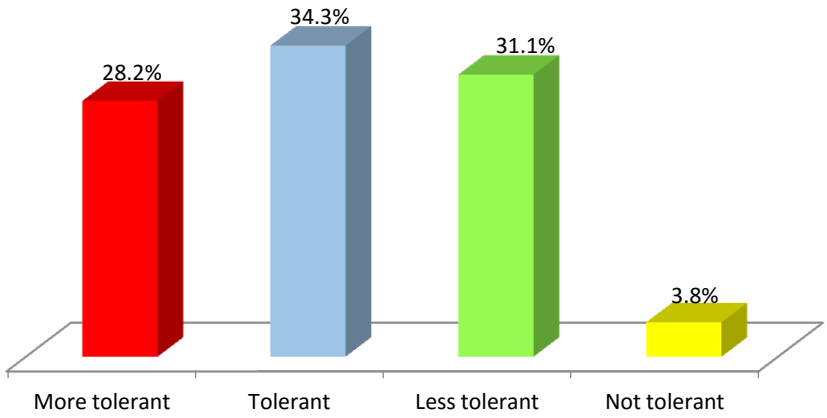


Figure 84: Percent distribution of respondents by their level of tolerance towards HIV-infected persons

2014 CPS, Rodrigues

However, it should be pointed out that one limitation of this indicator is that it is restricted to only four items, and this could limit a fair examination of the true level of tolerance towards HIV-infected people. Moreover, there may be a bias since respondents may be reticent to express negative attitudes towards HIV-infected people.

21.7 Accepting Attitudes towards those Living with HIV

Table 75 shows the percentage distribution of women age 15-49 years expressing specific accepting attitudes toward people with HIV/AIDS and by background characteristics. Differences were observed across selected characteristics of women. Women in lower socio-economic group also reported a lower level of agreement to this response (62.9 percent) compared to 91.2% in the high socio economic group. In addition, women with higher education were more willing to care for a family member with HIV at home. Moreover, married women (75.9 percent) are more willing to take care of a family member living with HIV

Regarding preparedness to buy vegetables from a vendor infected with HIV, women in higher socio economic group (63.3 percent) were more comfortable with buying fresh vegetables from an infected person as compared to the other counterparts.

78.5 percent of women believe an HIV positive teacher should continue to teach. Again this measure of acceptance is affected by socio economic status with increasing acceptance as women's socio economic status increase (73.3 percent – 84.5 percent). Likewise, Women age 15-19 reported a higher level of agreement to this response (89.9 percent).

Surprisingly, professional (54.3 percent) and single women (61.5 percent) are more likely to keep the HIV positive status of a family member in secret.

Table 75: Percentage of women age 15-49 expressing specific accepting attitudes toward people with HIV/AIDS, by background characteristics

Background characteristic	Taking care of a family member living with HIV	Buying vegetables with a vendor who has HIV	Allowing HIV-positive teacher to continue teaching	Keeping secret the HIV positive status of a family member	Number of Women
Age group					
15-19	72.1	50.6	89.9	69.6	69
20-24	65.3	70.9	88.4	71.0	54
25-29	75.7	57.8	78.8	57.4	65
30-34	70.2	59.8	65.5	53.4	66
35-39	70.1	47.5	67.3	31.4	53
40-44	65.3	63.1	75.3	45.7	48
45-49	85.8	65.8	84.4	43.0	45
Marital Status					
Married (legal/Religious)	75.9	61.9	75.5	44.8	143
Consensual union	66.0	56.3	74.0	59.8	77
Widowed	66.9	71.9	71.9	30.0	6
Divorced/separated	68.3	48.8	64.5	55.3	31
single (never Married)	72.0	58.8	87.4	61.5	142
Education					
<completed primary	71.8	61.3	72.5	45.6	122
completed primary	60.2	46.5	56.9	36.8	54
>completed primary	74.7	60.5	86.9	63.1	224
Occupation					
Professional	87.8	57.1	94.9	54.3	36
Service Worker	87.7	63.3	81.7	62.3	55
Manual Worker	76.0	58.1	74.9	48.7	43
Homemaker/Student	65.7	58.3	76.2	53.4	266
Household socio-economic status					
low	62.9	57.2	73.3	52.3	210
medium	79.3	60.0	84.1	56.0	153
high	91.2	63.3	84.5	57.8	37
Total	**71.9**	**58.8**	**78.5**	**54.3**	**400**

CPS 2014, Rodrigues

RECOMMENDATIONS 22

In line with the findings of the 2014 CPS reflected in this report, the following recommendations were anticipated;

G. Fertility

1. Encourage communication among members of the family.
2. Review approach of sexual education in school
3. Sensitisation of both parents and children conducted by health personnel.
4. Setting up of pre-marital counselling units.

Key Recommendation:

5. Promote discussion about family planning between partners before conception.

H. Family Planning

6. Improve the supply of contraceptive methods in government outlets as not all methods are currently available.
7. More awareness campaign on emergency contraceptive pills.
8. Distribution of pamphlets on contraceptive methods to reach larger target groups.
9. To provide better and continuous training of health services providers.
10. Setting up of " Ecoles des Parents" to provide information about contraception, domestic violence etc
11. Bring education and services closer to the public like in sports events,(comite villageoise)
12. Policy decision to be taken on prescription of contraceptive methods to minors.
13. Encourage male involvement in family planning.
14. Target low socio economic group, since they are using the services least.
15. Better plan social aid benefits to avoid misuse by unmarried mother who have many children.
16. To provide mandatory training on family planning for beneficiaries of social aid.

Key Recommendation:

17. More accessibility to contraception and explanation about usage in youth centres and youth counselling centre.
18. Use of social media (facebook) to reach teenagers.

I. Breastfeeding

19. Train 'Agent de Sante' to accompany mothers who breastfeed their children.
20. Advocate to allow 1 hour time off for breast feeding/expression of breast milk for officers of the public sector.

21. Intensify campaign on the benefits and importance of breastfeeding (Mass media, talks, brochure).
22. Provide breastfeeding corner in working place.
23. Intensify campaign during World Breastfeeding Week. (Essay competition,debates, Slam Competition)

Key Recommendation:

1. Continue Health Education Programme before, during and post-deliveryof infants.

J. Sexuality Education

24. Sexual education as from pre-primary school
25. More aggressive sensitisation campaign with emphasis on negative consequences of teenage pregnancy;socio-economic, physical and psychological To include sexuality education in the school curriculum
26. Promote moral values education

Key Recommendation:

27. Train parents through PTA meetings to enhance their skills to be able to talk about sexuality to their children, especially during during the pre-adolescent period where children are still receptive.

K. Reproductive Health Perceptions and Behaviour

28. Family Life Education at worksite targeting male and to increase communication among partners/husband/boyfriend.
29. Seminars for young people/couple on SRH
30. Training of teachers so that they are better equipped to address SRH issues.
31. More awareness campaign using mass media, TV, radio, pamphlets, leaflets, posters.
32. Demonstration on how to do self-breast examination for women and young girls,
33. Optimum control of gestational diabetes and hypertension during pregnancy.

Key Recommendation:

34. Sensitisation about negative consequences of alcohol and smoking during pregnancy through drama, school talks,slam ect…
35. Encourage women to conceive before 35years(4.3 percent diabetes, 20.2 percent HTN)
36. Reinforce Campaign on Family Life Education and SRH

L. HIV/AIDS

37. To have a continued and improved Mass Education on Attitude, respect, Right and Responsibility

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APPENDIX 1: Questionnaire

REPUBLIC OF MAURITIUS

Ministry of Health and Quality of Life/Mauritius Institute of Health

2014 CONTRACEPTIVE PREVALENCE SURVEY

INDIVIDUAL INTERVIEW QUESTIONNAIRE

AUGUST 2014

MAURITIUS CONTRACEPTIVE PREVALENCE SURVEY 2014

INSTRUCTIONS TO INTERVIEWERS:

(i) IDENTIFY THE RESPONDENT (**WOMAN AGED 15-49 YEARS**) AS PER THE LIST HANDED TO YOU FOR THE FACE-TO-FACE INTERVIEW.

(ii) **CIRCLE OR INSERT** RESPONSES IN THE SPACES PROVIDED OR WRITE AS INSTRUCTED.

(iii) CAREFULLY FOLLOW THE **STEPWISE INSTRUCTIONS** IN THE QUESTIONNAIRE.

INFORMED CONSENT

Hello. My name is _____. I am conducting a survey about reproductive health issues for the Ministry of Health and Quality of Life. The information collected will help the government to plan for its reproductive health services.

You have been selected for the survey. Your views are important and therefore, your participation in the survey will be greatly appreciated. The interview will take about 30 to 60 minutes. All the answers that you give will be strictly confidential. Shall we begin?

Signature of interviewer: _____ Date:……/……/……

DD MM YY

RESPONDENT AGREES TO BE INTERVIEWED ……...1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED …….. 2 END

INDIVIDUAL INTERVIEW QUESTIONNAIRE

QUESTIONNAIRE NUMBER: | | | |

RECORD OF VISITS:

VISIT	First	Second	Third
Date:	……/……/……	……/……/……	……/……/……
Time:	**AM** **PM**	**AM** **PM**	**AM** **PM**
Status of Interview*:			
Appointment for Revisit: WRITE DATE AND TIME	……/……/…… _____ **AM** _____**PM**	……/……/…… _____ **AM** _____**PM**	
Name of Interviewer:			

*: **CODES FOR STATUS OF INTERVIEW: 1**=Completed interview; **2** =Not at home; **3** =Refused; **4**=Other _____ **(SPECIFY)**

Enumeration Area Code: | | | | | | | Locality: _____

Address of Interviewee: _____
(House number and Street)

_____
(Village/Town)

	QUALITY CHECK		
Staff	**Name**	**Initials**	**Date**
Field Supervisor			……/……/……
Data Entry Clerk			……/……/……

SECTION 1: RESPONDENT'S BACKGROUND & HOUSEHOLD CHARACTERISTICS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100.	How old were you at your last birthday? **(Ki laze òu finne gagné pou òu dernier anniversaire?)**	☐☐ **COMPLETED YEARS**	
101.	What is your date of birth? **(Ki òu date de naissance?)**	☐☐ **DAY** ☐☐ **MONTH** ☐☐☐☐ **YEAR**	
102.	What is your religion? **(Ki òu rélizion?)**	Hindu .....1 Muslim .....2 Christian .....3 Other: _____ 4 **(SPECIFY)** No religion 5	
103.	What is the **highest level** of school you attended? **(Ki pli grand niveau l'école òu finne allé?)** **►NOTE:** **^IF RESPONDENT SAYS SECONDARY EDUCATION THEN PROBE IF PRE-VOCATIONAL OR MAINSTREAM SECONDARY SCHOOLING: RECORD EITHER <u>OPTION 4 OR 5.</u>** ***IF RESPONDENT SAYS VOCATIONAL EDUCATION THEN PROBE THE HIGHEST LEVEL OF SECONDARY SCHOOLING: RECORD EITHER <u>OPTION 6 OR 7</u>.**	No School .....1 Pre-Primary .....2 Primary .....3 Pre-Vocational^ (*Secondary*).....4 Secondary^ .....5 Some Secondary (Form I, II, III IV or Prevoc. I , 2, 3, 4) **PLUS** Vocational* .6 Secondary (≥Form V) **PLUS** Vocational* .....7 University/Technical.....8	→105 104

104. What is the highest grade you **completed** at [NAME HIGHEST LEVEL OF SCHOOL ATTENDED (CHECK Q103)] level?
(Ki pli grand classe òu finne terminer dans [NOMME NIVEAU L'EDUCATION (verifier Q103)]?)

►**FOR EXAMPLE:**
RESPONDENT SAYS PRIMARY IN Q103.
ASK: "What is the highest grade you completed at primary level?

ANSWER: PASSED CPE
RECORD 3 IN **BOX A** AND 6 IN **BOX B**
OR
ANSWER: FAILED CPE
RECORD 3 IN **BOX A** AND 5 IN **BOX B**

RESPONDENT SAYS SECONDARY IN Q103.
ASK: "What is the highest grade you completed at secondary level?

ANSWER: FORM 1 BUT DID NOT COMPLETE
RECORD 5 IN **BOX A** AND 0 IN **BOX B**

►**RECORD** _____
(EDUCATION/COURSE NAME)

►**CHECK Q103:** INSERT OPTION No. ↓ **BOX A**

RECORD **No.** FOR HIGHEST GRADE ↓ **BOX B**

LEVEL	**YEAR**	**CODE**
SOME SECONDARY (FORM I, II, III, IV OR PREVOC.1 ,2, 3, 4) **PLUS** VOCATIONAL	**1ST** . . . **4TH**	61 . . . 64
SECONDARY (≥FORM V) **PLUS** VOCATIONAL	**1ST** . . . **4TH**	71 . . . 74
UNIVERSITY/ TECHNICAL	**1ST** . . . **9TH & +**	81 . . . 89

105. What is your **main** current occupation?
(Ki travail principalement òu faire actuellement?)

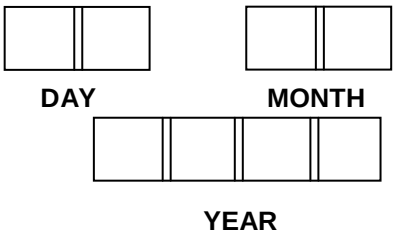
►**RECORD** _____
(JOB TITLE)

(ONE ANSWER ONLY)

Manager/ Professional 1
Technician/Officer 2
Service Worker / Sales Worker 3
Craft and Related Trade Worker/PME 4
Skilled Agricultural/Building/Municipal Worker/Drivers/Manual Worker 5
Export Oriented Enterprise Manual Worker 6
Homemaker.....7
Student.....8
Retired.....9
Other: _____ 10
(SPECIFY)

108

106.	Are you currently employed? **(Eski òu pé travail actuellement?)**	Yes ..... 1 No 2	→ 108
107.	Who is your employer? **(Ki sane là òu employeur?)**	Public ..... 1 Private ..... 2 Para-statal ..... 3 Self Employed 4	
108.	What is your current marital status? **(Eski òu marié….?)** **(PROBE)**	Married (legal or religious) ..... 1 Consensual Union ..... 2 Widowed ..... 3 Divorced/Separated ..... 4 Single (Never married) 5	110 →109
109.	Thus, you have never been married or lived with a man? **(Alors, jamais oune marié ou bien oune vivre avec ène missié?)**	Have been in union ..... 1 Never been in union …… 2	→ Go back to Q108 and correct →118
110.	How many times have you been married/lived with a man? **(Combien fois òu finne marié/vivre avek ène missié?)**	☐☐ **TIMES**	
111.	►If Q108=1 or 2 (currently married or in consensual union), then **BEGIN**: "What day, month and year did you begin living with your current (husband/partner)?" **(Ki jour, mois ek l'année ki òu ti commence vivre avec òu (mari/partnère) d'actuel?)** ►If Q108=3 or 4 (widowed/divorced/ separated), then **BEGIN**: "What day, month and year did you begin living with your (late/last) (husband/ partner)?" **(Ki jour, mois ek l'année ki òu ti commence vivre avec òu (défunt/dernier) (mari/partnère)?)**	☐☐ **DAY** ☐☐ **MONTH** ☐☐☐☐ **YEAR**	
111a.	**CHECK Q108 AND CHECK Q110:** What (is/was) the date of birth of your (current/late/last) (husband/partner)? **(Ki date de naissance de òu (actuel/défunt/dernier)(mari/partnère)?)**	☐☐ **DAY** ☐☐ **MONTH** ☐☐☐☐ **YEAR**	

☞	**CHECK Q110 (NUMBER OF TIMES MARRIED OR LIVED WITH A MAN):** **► IF Q110=1 → Q113** **► IF Q110>1 → Q112**		
112.	What day, month and year did you begin living with your first (husband/partner)? **(Ki jour, mois ek l'année ki òu ti commence vivre avek ou prémier (mari/partnère)?)**	 **DAY** **MONTH** **YEAR**	
113.	►If Q108=1 or 2 (currently married or in consensual union), then **BEGIN**: "What was the highest level of school your current (husband/partner) attended?" **(Ki pli grand niveau l'école òu (mari/partnère) d'actuel finne allé?)** ►If Q108=3 or 4 (widowed/divorced/ separated), then **BEGIN**: "What was the highest level of school your (late/last) (husband/ partner) attended?" **(Ki pli grand niveau l'école òu (défunt/dernier) (mari/partnère?) ti finne allé?)** ►**NOTE:** **^IF RESPONDENT SAYS SECONDARY EDUCATION THEN PROBE IF PRE-VOCATIONAL OR MAINSTREAM SECONDARY SCHOOLING: RECORD EITHER <u>OPTION 4 OR 5</u>.** ***IF RESPONDENT SAYS VOCATIONAL EDUCATION THEN PROBE THE HIGHEST LEVEL OF SECONDARY SCHOOLING: RECORD EITHER <u>OPTION 6 OR 7.</u>**	No school ……1 Pre-primary ……..2 Primary ……3 Pre-Vocational^(Secondary)……..4 Secondary^……..5 Some Secondary (Form I, II, III IV or Prevoc. I , 2, 3, 4) **PLUS** Vocational* ..6 Secondary (**≥**Form V) **PLUS** Vocational*.....7 University/Technical……8 Don't know/Don't Remember 9	→ 115 114 → 115

<table>
<tr>
<td>114.</td>
<td>►If Q108=1 or 2 (currently married or in consensual union), then BEGIN:

“What is the highest grade your (husband/ partner) completed at [NAME HIGHEST LEVEL OF SCHOOL ATTENDED (CHECK Q113)] level?”
(Ki pli grand classe òu (mari/partnère) finne terminer dans [NOMME NIVEAU L’EDUCATION (verifier Q113)]?)

►If Q108=3 or 4 (widowed/divorced/ separated), then BEGIN:

“What was the highest grade your (late/last) (husband/ partner) completed at [NAME HIGHEST LEVEL OF SCHOOL ATTENDED (CHECK Q113)] level?”
(Ki pli grand classe òu (défunt/dernier) (mari/partnère?) ti finne terminer dans [NOMME NIVEAU L’EDUCATION (verifier Q113)]?)

►FOR EXAMPLE:
RESPONDENT SAYS AFTER PROBING “MY HUSBAND WENT TO SECONDARY SCHOOL ONLY” IN Q113.
ASK: “What is the highest grade your husband completed at <u>secondary</u> level?”
ANSWER: “PASSED FORM IV”
RECORD 5 IN BOX A AND 4 IN BOX B

►RECORD _____
(EDUCATION/COURSE NAME)</td>
<td>►CHECK Q113: INSERT OPTION No. ↓ BOX A
RECORD No. FOR HIGHEST GRADE ↓ BOX B

<table>
<tr><th>LEVEL</th><th>YEAR</th><th>CODE</th></tr>
<tr><td>SOME SECONDARY (FORM I, II, III, IV OR PREVOC. I ,2, 3, 4) PLUS VOCATIONAL</td><td>1ST
.
.
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4TH</td><td>61
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64</td></tr>
<tr><td>SECONDARY (≥FORM V) PLUS VOCATIONAL</td><td>1ST
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4TH</td><td>71
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74</td></tr>
<tr><td>UNIVERSITY/ TECHNICAL</td><td>1ST
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9TH & +</td><td>81
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89</td></tr>
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<td></td>
</tr>
<tr>
<td>115.</td>
<td>► If Q108=1 or 2 (currently married or in consensual union), then BEGIN:

“What is the main current occupation of your (husband/partner)?”
(Ki travail òu (mari/partnère) principalement faire actuellement?)

►If Q108=3 or 4 (widowed/divorced/separated), then BEGIN:

“What was the main current occupation of your (late/last) (husband/ partner) at the time you were together?”
(Ki travail òu (défunt/dernier) (mari/partnère) principalement ti pé faire quand li ti là?)

►RECORD_____
(JOB TITLE)

(ONE ANSWER ONLY)</td>
<td>Manager/ Professional.....1
Technician/Officer 2
Service Worker and Sales Worker.....3
Craft and related trade worker/PME 4

Skilled agricultural/building/municipal workers/drivers/manual worker 5
Export Oriented Enterprise manual worker 6

Homemaker.....7
Student.....8
Retired.....9
Other: _____ 10
(SPECIFY)</td>
<td>118</td>
</tr>
</table>

116.	► If Q108=1 or 2 (currently married or in consensual union), then **BEGIN**: "Is your (husband/ partner) currently employed?" **(Eski òu (mari/partnère) travail actuellement?)** ►If Q108=3 or 4 (widowed/divorced/ separated), then **BEGIN**: "Was your (late/last) (husband/partner) employed at the time you were together?" **(Eski òu (défunt/dernier) (mari/partnère) ti apé travaille quand li ti là?)**	Yes ..... 1 No 2	→ 118
117.	► If Q108=1 or 2 (currently married or in consensual union), then **BEGIN**: "Who is the employer of your (husband/ partner)?" **(Ki sane là employeur òu (mari/partnère)?)** ►If Q108=3 or 4 (widowed/divorced/ separated), then **BEGIN**: "Who was the employer of your (late/last) (husband/ partner) at the time you were together?" **(Ki sane là ti employeur òu (défunt/dernier) (mari/partnère) quand li ti là?)**	Public ..... 1 Private ..... 2 Parastatal ..... 3 Self Employed 4	
118.	How many people, including you, live in the household? **(Combien personnes en tout reste dans sa lacaze là y compris òu?)**	☐☐ **PERSONS**	
119.	How many rooms are occupied by you and members of the household? (excluding toilet, bathroom & kitchen?) **(Combien la chambre òu ek les reste dans sa la case là occuper sans compte toilette, salle de bain ek la cuisine?)**	☐☐ **ROOMS**	
120.	How many rooms in your household are used for sleeping purposes? **(Combien la chambre òu ek les reste dans sa la case là servi pou dormi?)**	☐☐ **ROOMS**	
121.	What is the **main** source of water for the household? **(Comment òu gagne de l'eau principalement pou òu la caze?)** **(► READ OPTIONS)** △**1. Robinet de l'eau dan la caze;** **2. Robinet de l'eau dan la cour; 3. Robinet publique; 4. Camion citerne; 5. Puit/rivière**	Piped inside housing unit ..... 1 Piped outside on premises ..... 2 Public fountain ..... 3 Tank wagon ..... 4 Well/river ..... 5 Other: _____ 6 **(SPECIFY)**	
122.	What kind of toilet facility does your household have? **(Ki qualité connection toilette òu éna pou òu lacaze?)** **(► READ OPTIONS)** △**1. Toilette connecté avek sewerage;** **2. Toilette connecté avek absorption pit ;** **3. Toilette connecté avek septic tank; 4. Pit latrine**	Flush connected to sewerage ..... 1 Flush connected to absorption pit ..... 2 Flush connected to septic tank ..... 3 Pit latrine ..... 4 Other: _____ 5 **(SPECIFY)**	

123.	Please tell me whether your household has the following items? **(Eski dans òu lacaze òu éna sa banne zaffaires là?)** **(► READ ITEMS A – M)** **► NOTE : RECORD 1 OR 2 IN BOXES** **△ A.Télevision; B. Téléphone fix; C. Voiture/Van/ 4 par 4; D. Computer personelle ou ordinateur individuel/ laptop ou ordinateur portable; E. Internet pou computer personelle ou laptop; F. Chaines TV Satellite; G. Machine à vaiselle ; H. Machine à laver; I. Climatiseur; J. Machine à sèche linge; K. Réservoir de l'eau ; L. Maison sécondaire/ de vacance M. Téléphone portable**		
		1. YES / **2. NO** A. Television A. ☐ / A. ☐ B. Fixed Telephone B. ☐ / B. ☐ C. Car/Van/Double Cab C. ☐ / C. ☐ **D. Personal Computer (PC) / Laptop** *D.* ☐ / *D.* ☐ E. Internet (PC or Laptop) E. ☐ / E. ☐ F. Cable TV Channels F. ☐ / F. ☐ G. Dishwashing Machine G. ☐ / G. ☐ **H. Washing Machine** *H.* ☐ / *H.* ☐ I. Air Conditioner I. ☐ / I. ☐ J. Clothes Dryer J. ☐ / J. ☐ K. Water Tank K. ☐ / K. ☐ **L. Secondary/Vacation Home** *L.* ☐ / *L.* ☐ M. Mobile Phone M. ☐ / M. ☐	
124.	What is your average **monthly household expenditure** (in Rs.)? **(En moyenne, combien dépense faire en tou par mois pou òu la caze?)**	**Rs.** ☐☐☐☐☐☐	
125.	What is your average **monthly household income** (in Rs.)? **(En moyenne, combien l'argent par mois rentrer en tou pou òu la caze?)**	**Rs.** ☐☐☐☐☐☐	
126.	What is your average **personal monthly income** (in Rs.)? **(En moyenne, combien personnellement òu gagner par mois?)**	**Rs.** ☐☐☐☐☐☐	

SECTION 2: FERTILITY

☞CHECK FOR THE PRESENCE OF OTHERS BEFORE CONTINUING; MAKE EVERY EFFORT TO ENSURE PRIVACY.

200.	How old were you when you had your first menstruation? **(Ki l'age òu ti ti éna kan oune gagne òu premier régle?)**	☐☐ **COMPLETED YEARS** **NOT YET, RECORD '98'**	→201 →202
201.	When did you have you last menstruation? **(Quand oune gagne òu dernier régle?)**	☐☐ ☐☐☐☐ **MONTH** **YEAR** **IF NOT SURE/DON'T KNOW RECORD '98' FOR MONTH AND RECORD '9898' FOR YEAR**	
202.	Have you ever had a sexual intercourse? **(Eski oune déjà gagne éne rélation sexuel?)**	Yes ..... 1 No 2	→204 →203
203.	If you could choose exactly the number of children to have in your whole life, how many children would that be? **(Si òu ti capave choisir exactement combien zenfans òu ti pou gagner dan òu la vie, combien zenfans òu ti pou gagner?)**	☐☐ **IF NONE, RECORD '00'** **IF NOT SURE/DON'T KNOW, RECORD '98'**	→400
204.	How old were you when you had sexual intercourse for the first time? **(Ki l'age òu ti éna kan òu ti gagne òu premier rélation sexuel?)**	☐☐ **COMPLETED YEARS**	
205.	Have you had sexual relations in the last 4 weeks? **(Eski òu finne gagne relations sexuels dan sa 4 derniers semaines là?)**	Yes ..... 1 No 2	
206.	Have you ever been pregnant ? **(Eski òu finne déjà tombe enceinte?)**	Yes ..... 1 No 2	
207.	Are you currently pregnant? **(Eski ou enceinte là?)** **► CHECK :** **IF Q207=1 THEN Q206 SHOULD BE 1. PROBE AND CORRECT, IF NECESSARY**	Yes ..... 1 No ..... 2 Not sure/Don't know 3	→208 **IB** 210

208.	How many weeks pregnant are you ? **(A combien semaines de grossese òu été?)**	☐☐ **WEEKS**	
209.	Just before you got pregnant for this current pregnancy, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future? **(Juste avant òu tombe enceinte pour sa grossesse là, eski òu ti envie tombe enceinte lérla, ou tombe enceinte après, ou pas tombe enceinte sa lérla ou à aucun moment dan le future?)**	Wanted to get pregnant then ..... 1 Wanted to get pregnant later ..... 2 Did not want pregnancy then or any time in the future ..... 3 Not sure 4	**IB** 210
☞ **IB** 210	**CHECK Q206 (EVER BEEN PREGNANT) AND Q207 (CURRENT STATUS OF PREGNANCY):** **►IF Q206=1 ⟶ Q211** **►IF Q206=2 AND Q207=2 OR 3 ⟶ Q210**		
210.	If you could choose exactly the number of children to have in your whole life, how many children would that be? **(Si òu ti capave choisir exactement combien zenfans òu ti pou gagner dan òu la vie, combien zenfans óu ti pou gagner?)**	☐☐ **IF NONE, RECORD '00'** **IF NOT SURE/DON'T KNOW, RECORD '98'**	→ 400
211.	How many living children that you gave birth to do you have, even if they do not currently live with you? **(Combien zenfans ki oune donne naissance ki encore vivant òu énan, même si zotte pas reste avec òu actuellement?)**	**IF NONE, RECORD '00'** → ☐☐ **RECORD NUMBER OF LIVING CHILDREN** → ☐☐	→ 214 → 212
212.	Of these, how many are boys and how many are girls? **(Parmi zotte, combien garçons ek combien tifi òu éna?)**	☐☐ **BOYS** ☐☐ **GIRLS** ►SUM Q212 AND CHECK IF RECORDED NUMBER IN Q211=Q212 **IF NO BOYS OR NO GIRLS, RECORD '00' EITHER IN THE BOX FOR BOYS OR GIRLS**	
213.	If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many children would you have? **(Si òu ti alle lépoque cotte òu pas ti éna oken zenfans ek cotte òu ti capave choisir exactement combien zenfans òu ti pou gagner dan òu la vie, combien zenfans òu ti pou gagner?)**	☐☐ **IF NONE, RECORD '00'** **IF NOT SURE/DON'T KNOW, RECORD '98'**	→ 215
214.	If you could choose exactly the number of	☐☐	

	children to have in your whole life, how many children would that be? **(Si òu ti capave choisir exactement combien zenfans òu ti pou gagner dan òu la vie, combien zenfans óu ti pou gagner?)**	**IF NONE, RECORD '00'** **IF NOT SURE/DON'T KNOW, RECORD '98'**	
215.	Have you ever had a child that you gave birth to, who was born alive but later died, including those who may have died in the first hour(s) or day(s) after birth? **(Eski òu fine déjà donne naissance éne zenfan ki ti né vivant mais ki finne mort après, même si li finne mort dans les prémier heures ou jours après so naissance?)**	Yes ..... 1 No 2	→ 218
216.	How many children died? **(Combien zenfans finne morts?)**	☐☐	
217.	Of those who died, how many were boys and how many girls? **(Parmi banne zenfans ki finne morts, combien garçons et combien tifi ti éna?)**	☐☐ **BOYS** ☐☐ **GIRLS** ►SUM Q217 AND CHECK IF RECORDED NUMBER IN Q216=Q217 **IF NO BOYS OR NO GIRLS, RECORD '00' EITHER IN THE BOX FOR BOYS OR GIRLS**	
218.	►SUM ANSWERS TO Q211 AND Q216: RECORD TOTAL LIVE BIRTHS ☐☐ **IF NONE, RECORD '00'** **NOTE: LIVE BIRTHS INCLUDE A CHILD BORN ALIVE AS WELL A CHILD BORN ALIVE BUT DIED IN THE FIRST HOURS OR DAYS AFTER BIRTH**		
219.	Have you ever had a still birth? **(Eski òu finne déja gagne éne zenfan morts-nés?)**	Yes ..... 1 No 2	→221
220.	How many still births have you had? **(Combien zenfans morts-nés òu finne gagné?)**	☐☐ **STILL BIRTHS**	
221.	SO ALTOGETHER YOU HAD A TOTAL OF ☐☐ **(Q218+Q220)** BIRTHS? 1. YES **2.** NO → ►**CHECK Q211, Q212, Q216, Q217, Q218 AND Q220 AND MAKE CHANGES IF NECESSARY**		

222.	Have you ever had an ectopic pregnancy? **(Eski òu finne déja gagne éne grossesse kotte baba dan ventre là ti pé developer en dehors la case baba?)** ►**NOTE:** An ectopic pregnancy is a complication of pregnancy in which the embryo implants outside the uterine cavity. Most ectopic pregnancies occur in the fallopian tube, but implantation can also occur in the cervix, ovaries, and abdomen.	Yes ..... 1 No 2	→ 224
223.	How many ectopic pregnancies have you had? **(Combien grossesses ki oune gagner kotte baba dan ventre là inne developer en dehors la case baba?)**	☐☐ **ECTOPIC PREGNANCIES**	
224.	Have you ever had a miscarriage or an induced abortion? **(Eski òu finne déjà faire éne fausse couche ou bien oune finne faire baba aller?)**	Yes ..... 1 No 2	→ **IB** 227
225.	How many miscarriages have you had? **(Combien fausse couche òu fine faire?)**	☐☐ **MISCARRIAGES** **IF NONE, RECORD '00'**	
226.	How many induced abortions have you had? **(Combien fois òu fine faire baba aller?)**	☐☐ **INDUCED ABORTIONS** **IF NONE, RECORD '00'**	→ **IB** 227
☞ **IB** 227	**CHECK 221 (*TOTAL NUMBER OF BIRTHS*):** ►**IF Q221≤1 GO TO 229** ►**IF Q221> 1 GO TO 227**		
227.	Have you had any pregnancy that resulted in either multiple live births **or** multiple births? **(Eski òu fine déja énan éne accouchement cotte oune fine gagne plisieur baba ki ti né vivants ou morts?)** ►**Note:** Multiple births imply live birth(s) and still birth(s) or only still births.	Yes ..... 1 No 2	→ 228 → 229

228.

A. ►**INSTRUCTIONS TO INTERVIEWER CHECK Q221:**

PROBE THE NUMBER OF PREGNANCIES THAT RESPONDENT HAD FOR THE RECORDED NUMBER OF TOTAL BIRTHS. RECORD ANSWER IN BOX.

NOTE: ANSWER SHOULD BE LESS THAN RECORDED NUMBER IN Q221 SINCE ONE MULTIPLE BIRTH IS THE RESULT OF ONE PREGNANCY ONLY*.

☐☐ +

INSERT RECORDED NUMBER IN Q223 ☐☐ +

INSERT RECORDED NUMBER IN Q225 ☐☐ +

INSERT RECORDED NUMBER IN Q226 ☐☐ +

CHECK Q207: IF Q207=1 (CURRENTLY PREGNANT), RECORD '1' IN BOX ELSE IF Q207=2 OR 3 (NOT CURRENTLY PREGNANT OR NOT SURE), RECORD '0' IN BOX. ☐☐

TOTAL NUMBER OF PREGNANCIES _____

_____

***FOR INSTANCE, A RESPONDENT HAD A TOTAL OF 5 BIRTHS: 1 SINGLE BIRTH, 1 STILL BIRTH FOLLOWED BY 1 MULTIPLE BIRTH (TRIPLETS). THE NUMBER OF TOTAL BIRTHS=5 BUT THE NUMBER OF PREGNANCIES =3.**

B. ► **THEN ASK**

SO ALTOGETHER YOU HAD A TOTAL OF ☐☐ **PREGNANCIES** (IF CURRENTLY PREGNANT ADD "....**INCLUDING YOUR CURRENT PREGNANCY**")**?**

1.YES

2. NO →**PROBE AND MAKE CHANGES IF NECESSARY**

GO TO INSTRUCTION BEFORE Q230

IB
230

229.

A. ►**INSTRUCTIONS TO INTERVIEWER**

INSERT RECORDED NUMBER IN Q221 ☐☐

\+

INSERT RECORDED NUMBER IN Q223 ☐☐

\+

INSERT RECORDED NUMBER IN Q225 ☐☐

\+

INSERT RECORDED NUMBER IN Q226 ☐☐

\+

CHECK Q207: IF Q207=1 (CURRENTLY PREGNANT), RECORD '1' IN BOX ELSE IF Q207=2 OR 3 (NOT CURRENTLY PREGNANT OR NOT SURE), RECORD '0' IN BOX. ☐☐

_____

TOTAL NUMBER OF PREGNANCIES _____

B. ► **THEN ASK**

SO ALTOGETHER YOU HAD A TOTAL OF ☐☐ **PREGNANCIES** (IF CURRENTLY PREGNANT ADD "....**INCLUDING YOUR CURRENT PREGNANCY**")**?**

1.YES

2. NO → ►**CHECK Q211, Q212, Q216, Q217, Q218, Q220, Q221, Q223, Q225, Q226 AND MAKE CHANGES IF NECESSARY**

IB 230

CHECK Q218 (*TOTAL NUMBER OF LIVE BIRTHS*):

►**IF Q218 ≥ 1 THEN CONTINUE**

►**ELSE IF Q218 = 0 THEN GO TO INSTRUCTIONS BEFORE Q240**

IB 230

230.	When did you deliver your first live born child? **(Ki jour, mois ek ki l'année òu ti accouche òu premier zenfan ki ti né vivant ?)**	☐☐ DATE ☐☐ MONTH ☐☐☐☐ YEAR ☐☐ **IF <u>DON'T REMEMBER</u>, RECORD '98'** **IF <u>UNKNOWN</u>, RECORD '99'**	232 →231
231.	How many years has it been since then? **(Combien l'années finne gagné dépi sa?)**	☐☐ **YEARS** **IF DON'T REMEMBER, RECORD '98'**	
232.	When did you deliver your last live-born child? **(Ki jour, mois ek ki l'année òu ti accouche ou dernier zenfan ki ti né vivant?)** ►**NOTE:** IF DELIVERY RESULTED IN MULTIPLE LIVE BIRTHS OR MULTIPLE BIRTHS, THE QUESTION IS ABOUT THE **<u>LIVE BORN CHILD</u>** WHO WAS BORN **<u>LAST</u>**.	☐☐ DATE ☐☐ MONTH ☐☐☐☐ YEAR ☐☐ **IF <u>DON'T REMEMBER</u>, RECORD '98'** **IF <u>UNKNOWN</u>, RECORD '99'**	234 →233
233.	How many years has it been since then? **(Combien l'années finne gagné dépi sa?)**	☐☐ **Years** **IF DON'T REMEMBER, RECORD '98'**	
234.	How did that pregnancy for your **last live born child** end? **(Quand óu ti accouche sa dernier zenfan ki ti né vivant, eski òu ti accouche li seulement ou avek plisieur?)** ►**NOTE: <u>PROBE</u>**	Single live birth ..... 1 Multiple live births ..... 2 Multiple births (live birth(s) and still birth (s)) 3	
235.	How many weeks pregnant were you when this pregnancy ended? **(A combien semaines de grossesse òu ti été quand oune accouche li?)**	☐☐ **WEEKS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
236.	For this last live born child, just before you got pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future? **(Pou sa dernier zenfan ki ti né vivant, juste avant ki òu tombe enceinte pou li, eski òu ti envi tombe enceinte lerla, ou tombe enceinte après ou pas tombe enceinte sa lérla ou à aucun moment dan le future?)**	Wanted to get pregnant then ..... 1 Wanted to get pregnant later ..... 2 Did not want pregnancy then or any time in the future ..... 3 Not sure 4	

237.	Is this last live-born child still alive? **(Eski sa dernier zenfan ki ti né vivant encore la?)**	Yes ..... 1 No 2	→ 239 → 238
238.	How old was this last live born child when he/she died? **(Ki l'age ki sa dernier zenfan ki ti né vivant ti énan quand li finne mort?)**	**EITHER** ☐☐ **DAYS** **OR** ☐☐ **COMPLETED MONTHS** **OR** ☐☐ **COMPLETED YEARS**	
239.	After this last live birth did you get pregnant again? **(Aprés sa dernier zenfan ki ti né vivant, eski òu finne tombe enceinte encore?)**	Yes ..... 1 No 2	→ **IB** 240 → **IB** 300
☞ **IB** 240	**CHECK Q207(*PREGNANCY STATUS*) :** **►IF Q207=1 (CURRENTLY PREGNANT) THEN GO TO <u>INSTRUCTIONS BEFORE Q300</u> OTHERS CONTINUE**		
240.	How did your <u>most recent</u> pregnancy end? **(Pou òu pli récent grossesse comment sa finne terminer?)**	Still birth (single)..... 1 Multiple still births..... 2 Miscarriage ..... 3 Induced abortion ..... 4 Ectopic pregnancy 5	
241.	For your most recent pregnancy, just before you got pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future? **(Pour sa pli récent grossesse, juste avant òu ti tombe enceinte eski òu ti envi tombe enceinte lérla, ou tombe enceinte après, ou pas tombe enceinte sa lérla ou à aucun moment dan le future?)**	Wanted to get pregnant then ..... 1 Wanted to get pregnant later ..... 2 Did not want pregnancy then or any time in the future ..... 3 Not sure 4	
242.	How many weeks pregnant were you when this pregnancy ended? **(A combien semaines de grossesse òu ti été quand sa grossesse là finne terminer?**	☐☐ **WEEKS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
243.	When did that pregnancy end? **(Ki mois ek l'année ki sa grossesse là finne terminer?)**	☐☐ **MONTH** ☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	**IB** 300

SECTION 3: ANTE NATAL CARE & BREASTFEEDING

☞ IB 300	**CHECK Q218 (*TOTAL NUMBER OF LIVE BIRTHS*):** **►IF Q218 ≥ 1 THEN CONTINUE** **►IF Q218=0 THEN GO TO INSTRUCTIONS BEFORE Q332** ►NOTE: FOR THE RESPONDENT WHOSE LAST DELIVERY RESULTED IN MULTIPLE LIVE BIRTHS OR MULTIPLE BIRTHS, THE QUESTIONS ARE ABOUT THE **LIVE BORN CHILD** WHO WAS BORN **LAST**.		
☞	**NOW I AM GOING TO TALK ABOUT YOUR LAST LIVE BORN CHILD** **(MAINTENANT MO POU COZE LORS OU DERNIER ZENFAN KI TI NÉ VIVANT)**		
300.	For your last live born child how was the delivery carried out? **(Comment òu ti accouche òu dernier zenfan ki ti né vivant?)**	Normal ..... 1 Caesarean ..... 2 Forceps/Ventouse 3	→ 302 → 302
301.	What was the most important reason that you had to deliver by Caesarean Section? **(Pou ki pli grand raison òu ti accoucher par caesarian?)** **(ONE ANSWER ONLY)**	Baby too big ..... 1 Malpresentation ..... 2 Baby started to suffer ..... 3 Prolonged labour/ failed induction ..... 4 Obstetric haemorrhage ..... 5 Previous C-Section ..... 6 On request ..... 7 Don't know ..... 8 Other: _____ 9 **(SPECIFY)**	
302.	Where did you give birth to that child? **(Cotte òu ti accouche sa zenfan là?)**	Government Hospital ..... 1 Private clinic ..... 2 At home ..... 3 Other: _____ 4 **(SPECIFY)**	
303.	Was the weight of the baby at birth normal, underweight (less than 2500 grams) or overweight (greater than 4000 grams)? **(Kan sa zenfan là ti né, eski so poids ti normale, faible (moins ki 2.5 kgs) ou fort (plis ki 4 kgs)?)**	Normal weight ..... 1 Underweight ..... 2 Overweight ..... 3 Not sure 4	
304.	Were you using a contraceptive method when you got pregnant? **(Eski òu ti pé servi kitte méthode de contraception quand òu ti tombe enceinte?)**	Yes ..... 1 No ..... 2 Not sure/ Don't remember 3	306

305.	Which method? **(Ki méthode òu ti pé servi?)**	Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	
306.	How many weeks pregnant were you when you **first** learned that you were pregnant at that time? **(Lor combien semaines de grossese òu ti été quand premier fois oune conné ki òu enceinte?)**	☐☐ **WEEKS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
307.	During your pregnancy for this child, did you have any antenatal care visits? **(Pendant òu grossesse pou sa zenfan là, eski òu ti suivre service anté natal)**	Yes ..... 1 No 2	→ 314
308.	How many weeks pregnant were you at the time of your first antenatal care visit? **(Lor combien semaines de grossese òu ti été quand oune alle pou òu prémier visite anté natal?)**	☐☐ **WEEKS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
309.	Where did you receive your antenatal care? **(Ki cotté òu ti suivre service anté natal?)**	Government hospital/health centre .... 1 Private doctor/clinic ..... 2 Both Government and Private ..... 3 Other _____ 4 **(SPECIFY)**	→ 311 → 311 → 310 → 311
310.	Overall, where did you go mostly for the antenatal care visits? **(Ki coté òu ti plis suivre service anté natal?)**	Government hospital/health centre ..... 1 Private doctor/clinic 2	

311.	Who provided **most** of the antenatal care? **(Ki sanne là ti donne òu service anté natal pli beaucoup fois?)**	Doctor ..... 1 Nurse ..... 2 Midwife ..... 3 Other _____ 4 **(SPECIFY)**	
312.	Overall, how many times did you receive antenatal care during that pregnancy? **(En tou, combien fois oune gagne soins anté natal pendant òu grossesse?)**	☐☐ **TIMES** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
313.	During those visits, did you receive any information about: **(Pendant sa banne visits anté natal là, eski òu ti gagne banne renseignements lor:)** (► **READ A-H**) △ **A. Nutrition/Alimentation B. Fumer pendant grossesse C. Boire l'alcol pendant grossesse D. Allaitement E. Accouchement F. Contraceptives G. Banne signes ki montrer complications de grossesse H. Soins postnatales**	YES NO A Nutrition..... 1 2 B Smoking during pregnancy..... 1 2 C Drinking alcohol during pregnancy..... 1 2 **D Breastfeeding..... 1 2** E Delivery..... 1 2 F Contraception..... 1 2 G Warning signs of pregnancy complications.....1 2 **H Postnatal care..... 1 2**	
314.	In the **three months before your pregnancy**, or just before you realized you were pregnant, how often did you smoke? **(Trois mois avan òu tombe enceinte ou juste avan ki oune conner ki òu enceinte, combien fois òu ti pé fumer?)**	Daily/ Almost daily ..... 1 → 315 3-5 times per week ..... 2 → 316 Once or twice per week ..... 3 → 316 Once or twice per month ..... 4 → 316 Never/almost never ..... 5 → 317	
315.	On average, how many cigarettes did you smoke each day? **(En moyenne, combien cigarettes òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** → 317 ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'** → 317	
316.	On the days that you did smoke, how many cigarettes did you usually smoke on average **per day?** **(Banne jours ki òu ti pé fumer, combien cigarettes en moyenne òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	

317.	**During your pregnancy**, how often did you smoke? **(Pendant òu grossesse, combien fois òu ti pé fumer?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 318 → 319 → 319 → 319 → 320
318.	On average, how many cigarettes did you smoke each day? **(En moyenne, combien cigarettes òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	→320
319.	On the days that you did smoke, how many cigarettes did you smoke on average **per day**? **(Banne jours ki òu ti pé fumer, combien cigarettes en moyenne òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	
320.	During your pregnancy, how often were you exposed to tobacco smoke? **(Pendant òu grossesse, combien fois òu ti exposer avek la fumée cigarette?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 321 → 322 → 322 → 322 → 323
321.	On average, how many minutes or hours per day were you exposed to tobacco smoke **per day**? **(En moyenne, combien minutes ou l'heure temps òu ti exposer avek la fumée cigarette par jour?)**	**EITHER** ☐☐ **MINUTES** **OR** ☐☐ **HOURS** **AND** ☐☐ **MINUTES** **OR** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	→ 323 → 323 → 323

322.	On the days, that you were exposed to tobacco smoke, how many minutes or hours were you exposed to tobacco smoke on average **per day?** **(Banne jours ki òu ti exposer avek la fumée cigarette, combien minutes ou l'heure temps òu ti pé exposer avek la fumée cigarette par jour?)**	**EITHER** ☐☐ **MINUTES** **OR** ☐☐ **AND** ☐☐ **HOURS** **MINUTES** **OR** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
323.	<u>During your pregnancy</u>, how often did you take alcohol? **(Pendant òu grossesse, combien fois òu ti pé prend l'alcol?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 324 → 325 → 325 → 325 → 326
324.	On average, how many drinks did you have **each day**? **(En moyenne, combien verres òu ti pé prend par jour?)** **►NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	→ 326 → 326
325.	On the days that you took alcohol, how many drinks did you have on average **per day**? **(Banne jours ki òu ti prend l'alcol, en moyenne combien verres òu ti pé prend par jour?)** **►NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	

326.	Have you ever been medically diagnosed for diabetes? **(Eski ine déjà dire òu ki òu diabétique kan oune faire un test médicale?)**	Yes ..... 1 No 2	→ 329
327.	When? **(Quand?)**	Before this pregnancy ..... 1 During this pregnancy ..... 2 After delivery of this last live born child 3	
328.	How old were you when you were first medically diagnosed for diabetes? **(Ki l'age òu ti éna kan premier fois ine découvert medicallement ki òu diabétique?)**	☐☐ **COMPLETED YEARS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
329.	Have you ever been medically diagnosed for high blood pressure? **(Eski finne déjà dépister médicalement ki òu énan tension fort?)**	Yes ..... 1 No 2	→ **IB** 332
330.	When? **(Quand?)**	Before this pregnancy ..... 1 During this pregnancy ..... 2 After delivery of this last live born child 3	
331.	How old were you when you were first medically diagnosed for high blood pressure? **(Ki l'age òu ti éna quand premier fois ti dépister médicalement ki òu enan tension fort?)**	☐☐ **COMPLETED YEARS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	**IB** 332

☞ IB 332	**CHECK Q207(*PREGNANCY STATUS*):** **►IF Q207 = 1 (CURRENTLY PREGNANT) CONTINUE** **►ELSE IF Q207 = 2 THEN GO TO INSTRUCTIONS BEFORE Q360**		
332.	For this current pregnancy, were you using a contraceptive method when you got pregnant? **(Pou sa grossese là, eski òu ti pé servi kitte méthode contraception quand òu ti tombe enceinte?)**	Yes ..... 1 No ..... 2 Not sure/ Don't remember 3	→ 333 334
333.	Which method? **(Ki méthode òu ti pé servi?)**	Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution) ..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	
334.	How many weeks pregnant were you when you first learned that you were pregnant? **(Lor combien semaines de grossese òu ti été quand prémier fois oune appranne ki òu enceinte?)**	☐☐ **WEEKS**	
335.	So far, have you had any antenatal care visits? **(Ziska présent, eski òu finne faire visites anté natale?)**	Yes ..... 1 No 2	→ 336 → 342
336.	How many weeks pregnant were you when you went for your first antenatal care? **(Lor combien semaines de grossese òu ti été quand prémier fois oune finne faire òu prémier visite anté natale?)**	☐☐ **WEEKS**	
337.	Where are you receiving your antenatal care? **(Ki cotté òu pé suivre service anté natal?)**	Government hospital/health centre ..... 1 Private doctor/clinic ..... 2 Both Government and Private ..... 3 Other _____ 4 **(SPECIFY)**	→ 339 → 339 → 338 → 339

338.	So far, where are you going mostly for the antenatal care visits? **(Ziska présent, cotte oune finne plis aller pou òu banne visites anté natale ?)**	Government hospital/health centre ..... 1 Private doctor/clinic 2	
339.	So far, who is providing most of the antenatal care? **(Ziska present, ki sanne là pé plis suivre òu pou òu soins anté natal?)**	Doctor ..... 1 Nurse ..... 2 Midwife ..... 3 Other _____ 4 **(SPECIFY)**	
340.	So far, how many times have you received antenatal care for this current pregnancy? **(Ziska présent, combien fois oune gagne soins anté natal pendant sa grossesse là?)**	☐☐ **TIMES**	
341.	During those visits, have you received any information about: **(Pendant sa banne visites anté natal, eski oune gagne renseignement lor :)** (► **READ A-H**) **△A. Nutrition/Alimentation B. Fumer pendant grossesse C. Boire l'alcol pendant grossesse D. Allaitement E. Accouchement F. Contraceptives G. Banne signes ki montrer complications de grossesse H. Soins postnatales**	YES NO A Nutrition……1 2 B Smoking during pregnancy……1 2 C Drinking alcohol during pregnancy……1 2 **D Breastfeeding……..1 2** E Delivery…… .1 2 F Contraception……1 2 G Warning signs of pregnancy complications……..1 2 **H Postnatal care……..1 2**	
342.	In the **three months before your pregnancy** or just before you realized you were pregnant, how often did you smoke? **(Trois mois avan òu tombe enceinte ou bien juste avan ki oune conner ki òu enceinte, combien fois òu ti pé fumer?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 343 → 344 → 344 → 344 → 345
343.	On average, how many cigarettes did you smoke **each day**? **(En moyenne, combien cigarettes òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	→345 → 345
344.	On the days that you did smoke, how many cigarettes did you smoke on average **per day**? **(Banne jours ki òu ti pé fumer, combien cigarettes en moyenne òu ti pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	

345.	**<u>During this pregnancy</u>**, how often are you smoking? **(Pendant òu grossesse, combien fois òu pé fumer?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 346 → 347 → 347 → 347 → 348
346.	On average, how many cigarettes are you smoking **each day**? **(En moyenne, combien cigarettes òu pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY**	→ 348
347.	On the days that you are smoking, how many cigarettes do you smoke on average **per day**? **(Banne jours ki òu pé fumer, combien cigarettes en moyenne òu pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY**	
348.	How often are you being exposed to tobacco smoke? **(Combien fois òu pé exposer avek la fumée cigarette?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 349 → 350 → 350 → 350 → 351
349.	On average how many minutes or hours **per day** are you being exposed to tobacco smoke? **(En moyenne, combien minutes ou l'heure temps òu pé exposer avek la fumée cigarette par jour?)**	**EITHER** ☐☐ **MINUTES** **OR** ☐☐ **AND** ☐☐ **HOURS** **MINUTES** **OR** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	→ 351 → 351 → 351
350.	On the days, that you are exposed to tobacco smoke, how many minutes or hours are you being exposed to tobacco smoke on average **per day?** **(Banne jours ki òu exposer avek la fumée cigarette, combien minutes ou l'heure temps òu pé exposer avek la fumée cigarette?)**	**EITHER** ☐☐ **MINUTES** **OR** ☐☐ **AND** ☐☐ **HOURS** **MINUTES** **OR** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	

351.	During this pregnancy, how often are you taking alcohol? **(Pendant òu grossesse, combien fois òu pé prend l'alcol?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 352 → 353 → 353 → 353 → **IB** 354
352.	On average, how many drinks are you having **each day**? **(En moyenne, combien verres òu pé prend par jour?)** ►**NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	→ **IB** 354 → **IB** 354
353.	On the days that you are taking alcohol, on average, how many drinks are you having **per day**? **(Banne jours ki òu pé prend l'alcol, en moyenne combien verres òu pé prend par jour?)** ►**NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	**IB** 354
☞ **IB** 354	**CHECK Q218 (*NUMBER OF LIVE BIRTHS*):** ►**IF Q218 = 0 CONTINUE, OTHERS GO TO INSTRUCTIONS BEFORE Q360**		
354.	Have you ever been medically diagnosed for diabetes? **(Eski ine déjà dire òu ki òu diabétique kan oune faire un test médicale?)**	Yes ..... 1 No 2	→ 357
355.	When? **(Quand?)**	Before this pregnancy ..... 1 During this pregnancy 2	
356	How old were you when you were first medically diagnosed for diabetes? **(Ki l'age òu ti éna kan premier fois ine découvert medicallement ki òu diabetique?)**	☐☐ **COMPLETED YEARS** **IF DON'T REMEMBER, RECORD '98'**	

357.	Have you ever been medically diagnosed for high blood pressure? **(Eski finne déjà dépister médicalement ki òu énan tension fort?)**	Yes ..... 1 No 2	→ 358 → **IB** 360
358.	When? **(Quand?)**	Before this pregnancy ..... 1 During this pregnancy 2	
359.	How old were you when you were first medically diagnosed for high blood pressure? **(Ki l'age òu ti éna quand premier fois ti dépister médicalement ki òu énan tension fort?)**	☐☐ **COMPLETED YEARS** **IF DON'T REMEMBER, RECORD '98'**	**IB** 360
☞ **IB** 360	**CHECK Q226 *(NUMBER OF INDUCED ABORTIONS):*** **►IF Q226 ≥1 CONTINUE, ELSE IF Q226=0 THEN GO TO INSTRUCTIONS BEFORE Q366**		
360.	In what month and year did you have your last induced abortion? **(Ki mois ek ki l'année dernier fois òu fine faire baba aller)**	☐☐ ☐☐☐☐ **MONTH** **YEAR** **IF NOT SURE/DON'T KNOW RECORD '98' FOR MONTH AND RECORD '9898' FOR YEAR**	
361.	Who performed this last abortion? **(Ki sanne là ti faire avortement là?)**	Self-induced ..... 1 Doctor ..... 2 Nurse ..... 3 Non-medical person ..... 4 Other: _____ 5 **(SPECIFY)**	
362.	What was the **main** reason that you decided to have this abortion? **(Pou ki pli grand raison òu ti decider pou faire sa avortement là?)** **(ONE ANSWER ONLY)**	Pregnancy was life or health threatening..... 1 Risk of birth defects..... 2 Financial problems..... 3 Respondent did not want (anymore) children..... 4 Spacing next pregnancy..... 5 Partner did not want (any) children..... 6 Did not have a partner.....7 Other _____ 8 **(SPECIFY)**	

363.	What was the attitude of the child's father towards you having that abortion? **(Ki ti l'atttitude papa sa zenfan là envers òu lor faire sa avortement là?)**	Favoured…….. 1 Opposed…….. 2 Neutral…….. 3 Did not know about it……..4 Don't know/ Don't Remember…..……5	
364.	Were you using any method of contraception at the time you got pregnancy? **(Eski òu ti pé servi éne méthode de contraception quand òu ti finne tombe enceinte?)**	Yes ..... 1 No ..... 2 Not sure/Don't know/Don't remember... 3	→ 365 **IB** 366
365.	Which method of contraception was that? **(Ki method de contraception ti été sa?)**	Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	**IB** 366

BREASTFEEDING

IB
366

CHECK Q218 (RESPONDENT EVER HAD A LIVE BIRTH)

►IF Q218=0 THEN GO TO SECTION 4

ELSE

►IF Q218≥1 THEN CHECK Q232 (DATE OF DELIVERY OF LAST LIVE BORN CHILD)

IF:

BORN IN DECEMBER 2008 OR BEFORE	BORN IN JANUARY 2009 OR AFTER
↓	↓
GO TO SECTION 4	**CONTINUE**

366.	Has your menstrual period returned since you last gave birth? **(Eski oune gagne ou règle après òu dernier accouchement?)**	Yes ..... 1 No, because pregnant since ..... 2 No 3	→ 367 → 368 → 368
367.	How many months after your last gave birth did it return? **(Combien mois après òu accouchement òu finne gagne òu règle**?	☐☐ **MONTHS** **IF LESS THAN ONE MONTH, RECORD '00'** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	
368.	**During your pregnancy** for this most recent live born child, did anyone discuss with you about breastfeeding your baby? **(Pendant òu grossesse de sa dernier zenfan ki ti né vivant là, eski kikaine ti coze ar òu lor allaitement de òu baba?**	Yes ..... 1 No ..... 2 Don't know/Don't remember 3	→ 369 → 370 → 370
369.	Who was the first to discuss with you about breastfeeding your baby? **(Ki sane là ti coze ar òu en prémier lor allaitement de òu baba?)** **(ONE ANSWER ONLY)**	Doctor ..... 1 Midwife/Nurse ..... 2 Breastfeeding counselor ..... 3 Friend ..... 4 Family member/Relative ..... 5 Other _____ 6 **(SPECIFY)**	
370.	While you were pregnant, did you receive any advice about the health benefits of breastfeeding? **(Pendant òu grossesse, eski òu ti gagne conseil lor banne l'avantages ki gagner pou la santé quand allaiter?)**	Yes ..... 1 No ..... 2 Don't know/Don't remember 3	

371.	Please, name two health benefits for a baby who has been breastfed: **(Ou capave dire moi s'il vous plait deux l'avantages pou la santé ki éne baba gagner quand allaite li:)** ***DO NOT READ OPTIONS***	A.Protects baby from respiratory infection ..... 1 B.Protects baby from gastro intestinal infection ..... 2 C.Protects baby from allergies ..... 3 **D.Boost growth and intelligence ..... 4** E.Protects baby from obesity ..... 5 F.Promote bonding and development. 6 G.Lowers risk of childhood diabetes… 7 **H.Other: _____ 8** **(SPECIFY)** I. No/Don't know…….. 9	
372.	Please, name two health benefits for a mother who has breastfed her baby: **(Ou capave dire moi s'il vous plait deux l'avantages pou la santé ki éne maman gagner quand li allaiter:)** ***DO NOT READ OPTIONS***	A. Reduces postpartum depression.... 1 B. Life can be easier- no formula to buy/ no bottles to warm at night ..... 2 C. Loses weight..... 3 **D. Reduces risk of cancer ..... 4** E. Reduces risk of breast cancer ..... 5 F. Reduces risk of ovarian cancer .... 6 G. Other: _____ 7 **(SPECIFY)** **H. No/Don't know 8**	**IB** 373
IB 373	**CHECK Q237 (LAST LIVE BORN CHILD STILL ALIVE):** **►IF Q237=1 THEN CONTINUE ELSE** **►IF Q237=2 GO TO SECTION 4**		
373.	Did you have skin-to-skin contact with your baby **within the first 24 hours** after he or she was born? *(By skin-to-skin contact we mean holding the baby so that his/her bare skin was next to your bare skin)* **(Eski oune met òu baba peau à peau contre òu dan les premier 24 heures après ki li ti né?)**	Yes ..... 1 No ..... 2 Don't remember 3	→ 374 → 375 → 375

374.	About how long after your baby was born did you first have skin to skin contact? **(Après combien les temps ki òu baba finne née ki oune mette li peau à peau contre òu?)**	Immediately/within a few minutes ..... 1 Within an hour ..... 2 More than 1 hour, up to 12 hours later 3 More than 12 hours later 4	
375.	Did you ever breastfeed your last live born child? **(Eski òu ti déjá allaite òu dernier zenfan ki ti né vivant?)**	Yes ..... 1 No 2	→ 376 → Go to Section 4
376.	During the first few days after delivery, did anyone show you how to put your baby to the breast? **(Eski kikaine ti montrer òu comment mette òu baba au sein dan banne premier jours après òu l'accouchement?)**	Yes ..... 1 No ..... 2 Don't know/Don't remember 3	→ 377 → 378 → 378
377.	Who **first** showed you? **(Ki sanne là ti montrer òu <u>en premier</u>?)** **(ONE ANSWER ONLY)**	Doctor ..... 1 Midwife/nurse ..... 2 Breastfeeding counselor ..... 3 Friend ..... 4 Family member/Relative ..... 5 Other: _____ 6 **(SPECIFY)**	
378.	How soon after your baby was born did you first put him/ her to the breast? **(Après combien temps dépi ki òu baba ti née oune mette li au sein pou là prémiere fois?)**	Immediately/within a few minutes ..... 1 Within an hour after birth ..... 2 More than 1hour,up to 5 hours later.... 3 More than 5 hours, up to 24 hours later 4 More than 24 hours later 5	

379.	What were the main reasons you decided to breastfeed this last live born child? **(Ki banne pli grand raisons ki oune décide allaite òu dernier zenfan ki ti né vivant?)** **(MULTIPLE ANSWERS)** **A. Di lait mama meilleur pou baba B. Allaitement pli pratique C. Allaitement li gratuit D. Allaitement empêche allergies E. Allaitement aide à perdi poids F. Allaitement éne bon kitchose pou faire G. Papa zenfan là ti oulé ki òu allaiter H. Banne dimoune ine conseil òu pou allaiter I. Di lait mama empêche infections J. Autre**	A. Breast milk is better for baby ..... 1 B. Breastfeeding is more convenient 2 C. Breastfeeding is free of cost ..... 3 **D. Breast milk prevents allergies ... 4** E. Breastfeeding helps weight loss .... 5 F. Breastfeeding is the right thing to do 6 G. Child's father wanted you to breastfeed ..... 7 **H. Other people advised you to breastfeed ..... 8** I. Breast milk prevents infections ..... 9 J. Other: _____ 10 **(SPECIFY)** K. Don't know 11	
380.	Are you currently breastfeeding? **(Eski òu pé allaite òu zenfan actuellement?)**	Yes ..... 1 No 2	→**IB** 385 → 381
381.	For how many **days or months** did you breastfeed this last live born baby? **(Pou combien jours ou mois òu ti allaite sa dernier baba ki ti né vivant là?)**	**EITHER** ☐☐ **DAYS** **OR** ☐☐ **MONTHS** **AND** ☐☐ **DAYS** **OR** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	

382.	What is the main reason you stopped breastfeeding? **(Pou ki pli grand raison ki oune arrête allaiter?)** **(ONE ANSWER ONLY)**	Teething ..... 1 Child/Baby refused to take breast ..... 2 Felt it was time to stop ..... 3 Resumed work ..... 4 Pregnant ..... 5 Not producing any/adequate milk ..... 6 Other: _____ 7 **(SPECIFY)**	
383.	How old was the child when he or she was fed something other than breast milk*? **(Ki l'age òu zenfan ti éna quand oune donne li éne lotte kitchose apar di lait maternel*?)** ***INCLUDES: JUICE, INFANT FORMULA,WATER,SOLID FOODS OR ANYTHING ELSE***	**EITHER** ☐☐ **DAYS** **OR** ☐☐ **AND** ☐☐ **MONTHS** **DAYS** **OR** ☐☐ **IF <u>DON'T KNOW</u>, RECORD '<u>98</u>'**	
384.	Did you give this child anything from a bottle with a nipple in the last 24 hours? **(Dan dernier 24 heures temps, eski ounne donne zenfan là kitchose pou boire avek éne biberon?)**	Yes ..... 1 No ..... 2 Don't know/Don't remember 3	Go to section 4
IB 385	**CHECK Q380(CURRENTLY BREASTFEEDING):** **►IF Q380=1 THEN CONTINUE** **►ELSE IF Q380=2 THEN GO TO SECTION 4**		

385.	During the last 24 hours how many times did you breastfeed this child? **(Dan dernier 24 heures temps, combien fois oune allaite òu zenfan?)**	☐☐ **NUMBER OF BREASTFEEDINGS**	
386.	How old was the child when he or she was fed something* other than breast milk? **(Ki l'age òu zenfan ti éna quand oune donne li éne lotte kitchose* apar di lait maternel?)** ***INCLUDES: JUICE, INFANT FORMULA,WATER, SEMI SOLID FOODS, SOLID FOODS OR ANYTHING ELSE**	**EITHER** ☐☐ **DAYS** **OR** ☐☐ **MONTHS** **AND** ☐☐ **DAYS** **OR** ☐☐ **IF NOT STARTED ANYTHING, RECORD '88'** **IF DON'T KNOW, RECORD '98'**	
387.	Did you give this child anything from a bottle in the last 24 hours? **(Dan dernier 24 heures temps, eski ounne donne zenfan là kitchose pou boire avek éne biberon?)**	Yes ..... 1 No ..... 2 Don't know/Don't remember 3	
388.	During the last 24 hours did you give this child any of the following? **(Dan dernier 24 heures temps, eski oune donne zenfan là sa banne kitchose là:)** **(► READ ALL OPTIONS)**		

	YES	NO
A. Breast milk **(Di lait mama)**	1	2
B. Water **(De l'eau)**	1	2
C. Milk other than breast milk **(Di lait autre ki di lait mama)**	1	2
D. Infant formula **(Di lait dan boite pou zenfan)**	1	2
E. Juice, tea or other liquids **(Jus, di thé ou autre liquide)**	1	2
F. Semisolid foods **(Aliments semi solides)**	1	2
G. Solid foods **(Aliments solides)**	1	2

GO TO SECTION 4

SECTION 4: FAMILY PLANNING

➢ **Now, I would like to talk to you about contraceptive methods that people use to space or limit the number of their children.**
(Astère là, mo pou cause ar òu lor banne méthodes de contraception ki dimoune servi pou espace ou limite zotte nombre de zenfans.)

		400	401	402	403
	(►READ ALL METHODS)	Have you ever heard of it?	Do you know how to use it?	Have you ever used it?	Do you know where to get it?
A	Tubal Ligation (Female Sterilisation) **(Attache tube/ Stérilisation féminin)**	1. Yes →Q401 2. No → B	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →B 2. No → B
B	Vasectomy (Male Sterilisation) **(Stérilisation masculin)**	1. Yes →Q401 2. No → C	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →C 2. No → C
C	Pill **(Pillule)**	1. Yes →Q401 2. No → D	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →D 2. No → D
D	3-Month Injectable (Depo-Provera) **(Piqûre 3-mois)**	1. Yes →Q401 2. No → E	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →E 2. No → E
E	1-Month Injectable **(Piqûre 1-mois)**	1. Yes →Q401 2. No → F	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →F 2. No → F
F	IUD **(L'appareil/ sterilét)**	1. Yes →Q401 2. No → G	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →G 2. No → G
G	Male Condom **(Capote masculin)**	1. Yes →Q401 2. No → H	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →H 2. No → H
H	Female Condom **(Capote féminin)**	1. Yes →Q401 2. No → I	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →I 2. No → I
I	Diaphragm **(Diaphragme)**	1. Yes →Q401 2. No → J	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →J 2. No → J
J	Foaming Tablets/Jelly **(Comprimés mette dan lécors/gêle)**	1. Yes →Q401 2. No → K	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →K 2. No → K
K	Implant **(Implante)**	1. Yes →Q401 2. No → L	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →L 2. No → L
L	Emergency Contraception **(Contraception d'urgence)**	1. Yes →Q401 2. No → M	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →M 2. No → M
M	Sympto-Thermal **(Thermomette ek la glaire)**	1. Yes →Q401 2. No → N	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →N 2. No → N
N	Mucus Method **(La glaire)**	1. Yes →Q401 2. No → O	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →O 2. No → O
O	Count Days (Calendar) **(Compte jours/calendrier)**	1. Yes →Q401 2. No → P	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →P 2. No → P
P	Temperature **(Température)**	1. Yes →Q401 2. No → Q	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →Q 2. No → Q
Q	Withdrawal (Take Precaution) **(Rétrait /Prend precautions)**	1. Yes →Q401 2. No → R	1. Yes →Q402 2. No → Q402	1. Yes →R 2. No → R	
R	Cycle Beads **(Collier de cycle)**	1. Yes →Q401 2. No → S	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →S 2. No → S
S	Contraceptive Patch **(Patch contraceptive)**	1. Yes →Q401 2. No → T	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →T 2. No → T
T	Any Other: _____ **(SPECIFY)**	1. Yes →Q401 2. No → Q404	1. Yes →Q402 2. No → Q402	1. Yes →Q403 2. No → Q403	1. Yes →Q404 2. No → Q404

404.	How did you hear or read about a method of contraception for the **first** time? **(Comment òu finne tander ou lire lor éne méthode de contraception pou la prémière fois?)** **(ONE ANSWER ONLY)** ► ***CHECK IF Q400A TO Q400T=2. IF NOT, PROBE.**	Private Doctor ..... 1 Government Health Centre Personnel 2 Action Familiale ..... 3 Husband/Partner ..... 4 Other Family Member/ Relative ..... 5 Friend ..... 6 Colleague ..... 7 Newspapers, radio or TV ..... 8 Books, magazines or brochures ..... 9 MFPWA ..... 10 Private Clinic ..... 11 Pharmacy/pharmacists ..... 12 Internet/Social media ..... 13 Teacher..... 14 Never heard/read about birth control*..... 15 Other _____ 16 **(SPECIFY)**	→406
405.	In the past four years, have you heard or saw a family planning message on the radio or television? **(Dans sa quatre dernier l'années là, eski òu fine ecouter ou guette éne message de family planning lor radio ou bien télévision?)** △ **READ BOTH A AND B**	Yes No A. Radio ..... 1 2 B. Television 1 2	406
406.	**RECORD HERE IF RESPONDENT HAS EVER USED AT LEAST ONE METHOD OF CONTRACEPTION (SEE ANSWERS TO Q402)** 1. **YES → (IF ANY Q402 A-T=1) CONTINUE** 2. **NO → (IF ALL Q402 A-T =2) GO TO INSTRUCTIONS BEFORE Q453 – MODULE C**		

MODULE A: CURRENT USERS AND PAST USERS

407.	When you decided <u>for the first time</u> to use a method of contraception, did you discuss it with someone? **(Kan òu ti décide pou servi éne méthode de contraception pou la prémiere fois, eski òu ti discute sa avec kikaine?)**	Yes ..... 1 No ..... 2 Don't remember 3	→ 408 410

△ READ AND CODE	**408.** When you decided <u>for the first time</u> to use a method of contraception, with whom did you discuss it <u>first</u>? **(Quand òu ti décide pou servi ène méthode de contraception pou la prémière fois, avek ki òu ti discute sa en premier?)**	**409.** Did this person encourage you to use a method of contraception? **(Eski ça dimoune là ti encourage òu pour servi éne méthode de contraception?)**
A. Husband or Partner **(Mari/partnère)**	1. Yes→ **Q409** 2. No.→ **B**	1. Yes→ **Q410** 2. No.→ **Q410**
B. Other Family Member/Relative **(Autre mêmbre de la Famille/famille)**	1. Yes→ **Q409** 2. No.→ **C**	1. Yes→ **Q410** 2. No.→ **Q410**
C. Friend **(Camarade)**	1. Yes→ **Q409** 2. No.→ **D**	1. Yes→ **Q410** 2. No.→ **Q410**
D. Religious Official **(Prêtre)**	1. Yes→ **Q409** 2. No.→ **E**	1. Yes→ **Q410** 2. No.→ **Q410**
E. Medical/ Paramedical staff **(Personnel medical/paramédical)**	1. Yes→ **Q409** 2. No.→ **F**	1. Yes→ **Q410** 2. No.→ **Q410**
F. Other _____ **(Autre) (SPECIFY)**	1. Yes→ **Q409** 2. No.→ **Q410**	1. Yes→ **Q410** 2. No.→ **Q410**

410.	What month and year you used a method of contraception for <u>at least one month</u> for the first time? **(Ki mois ek ki l'année òu ti pé servi éne méthode de contraception pou la prémière fois pou au moins éne mois ou plis?)**	**MONTH** **YEAR**	
411.	How many children did you have when you began using a method of contraception for the first time? **(Combien zenfans òu ti éna kan oune commence servi ène méthode de contraception pou la prémière fois?)**	**CHILDREN** **IF NONE, RECORD '00'**	
412.	Are you currently using a method of contraception? **(Eski òu pé servi ène méthode de contraception actuellement?)**	Yes ..... 1 No 2	→ **IB** 413 → **IB** 428

►CURRENT USER STARTS HERE

IB 413	**CHECK Q406 (EVER USED A METHOD) AND Q412 (CURRENTLY USING A METHOD):** **►IF Q406 = 1 AND Q412 = 1 THEN CONTINUE**		
413.	Which method are you using? **(Ki méthode òu pé servi?)**	Tubal Ligation (Female Sterilisation) 11 Vasectomy (Male Sterilisation) ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male)..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution) ..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)** **NATURAL FAMILY PLANNING (NFP) METHODS**	414 417 → 415 417
414.	What was the month and year when the sterilization was performed? **(Ki mois ek ki l'année l'opération là ti faire?)**	☐☐ **MONTH** ☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER / DON'T KNOW, RECORD '98'**	→ 417 → 417
415.	What is the maximum number of years can you keep using the IUD once it has been inserted? **(Kan ine mette éne sterilét/appareil, d'après òu pou combien l'année en tou capave laisse li?)**	☐☐ **YEARS (IF ALL THE TIME, RECORD '99')** ☐☐ **IF DON'T REMEMBER / DON'T KNOW, RECORD '98'**	

416.	Has the health provider who inserted your IUD informed you that the IUD should be removed after 10 years as it is no longer effective in preventing a pregnancy? **(Eski sa personnel médical ki ti met òu (sterilét/appareil) ti dire òu ki bisin rétire li après 10 ans parski li né pli éfficace pour empêche éne grossesse?)**	Yes ..... 1 No ..... 2 Don't remember 3	
417.	What was the most important reason for choosing this method? **(Pou ki pli grand raison oune choisir sa méthode là?)** **(ONE ANSWER ONLY)**	A doctor recommended ..... 1 Very effective ..... 2 Very safe (few or no side effects) ..... 3 Saw advertisements (TV, radio, press, brochures) ..... 4 Easy to use ..... 5 Partner prefers it ..... 6 Knows somebody who uses it ..... 7 Curiosity/wanted to try it ..... 8 Allows spontaneity during intercourse ..... 9 Religious beliefs ..... 10 No cost involved ..... 11 No preparation or supplies ..... 12 Allows man to remain in complete control ..... 13 Other: _____ 14 **(SPECIFY)** Don't know/Don't remember 98	
418.	Do you have any problems or concerns with using your current method? **(Eski òu éna kitte problêmes ou bien soucis avek méthode ki òu pé servi?)**	Yes ..... 1 No 2	→ **IB** 421

419.	What is the most important problem or concern? **(Ki pli grand problême ou soucis òu énan?)** **(ONE ANSWER ONLY)**	**METHOD RELATED REASONS** Experienced/Experiencing side effects 1 Health concerns/fear of side effects . … 2 Sometimes not available ..... … 3 Cost of contraceptive ..... … 4 Deeply unsatisfied with the method .. ….5 Sometimes difficult/inconvenient to use...6 Less effective method/got pregnant while using it ……7 Sometimes forget to use ..... ….8 **OPPOSITION TO USE** Husband/partner disapproves ……..9 **ACCESS RELATED REASONS** Travelling time to obtain method too long ..... …10 Travelling cost to obtain method too high……..11 Other: _____ 12 **(SPECIFY)**	→ 420 **IB** 421
420.	What is the most common side-effect you (are/have) (experiencing/ experienced)? **(Ki pli grand l'éffet sécondaire/indésirable (ki òu apé/oune) gagner?)** **(ONE ANSWER ONLY)**	Nervousness ..... 1 Dizziness/Vertigo ..... 2 Loss weight ..... 3 High blood pressure ..... 4 Gastritis ..... 5 Amenorrhea ..... 6 Headache ..... 7 Bleeding ..... 8 Increase libido ..... 9 Decrease libido ..... 10 Weight gain ..... 11 Breast problem ..... 12 Other: _____ 13 **(SPECIFY)**	**IB** 421

☞ **IB** 421	**CHECK Q413 (METHOD BEING CURRENTLY USED):** **►IF Q413 = 11 OR 12 (STERILIZATION) THEN GO TO Q425** **►IF Q413 = 20 – 34 OR 51, 52, 61 THEN GO TO Q422** **►IF Q413 = 41 (WITHDRAWAL) THEN GO TO Q421**		
421.	How would you rate use of withdrawal method with regards to effectiveness at preventing pregnancy? **(Comment òu trouve éfficacité méthode rétrait /prend précaution pou êmpêche éne grossesse?)**	Very effective ..... 1 Effective ..... 2 Somewhat effective ..... 3 Not effective ..... 4 Don't know/ Not sure 5	
422.	Would you prefer to use a different method of family planning from the one you are currently using? **(Eski òu ti pou préfère servi éne lotte méthode de contraception apar séki òu pé servi actuellement?)**	Yes ..... 1 No 2	→ 425
423.	Which method would you prefer to use? **(Ki méthode òu ti pou préfère servi?)** **(ONE ANSWER ONLY)**	Tubal Ligation (Female Sterilisation) . 11 Vasectomy (Male Sterilisation) ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution) ..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	

424.	What is the most important reason that you have not yet shifted to that method? **(Pou ki pli grand raison ki òu panne encore commence servi sa méthode là?)** **(ONE ANSWER ONLY)**	**METHOD RELATED REASONS** Doctor will not prescribe it ..... 1 Cost of contraceptive ..... 2 Not available/unreliable supplies……. 3 Difficult to obtain ..... 4 Fear of side effects ..... 5 Difficult to use ..... 6 Fear of surgical procedure ..... 7 **OPPOSITION TO USE** Husband/Partner objects to it ..... 8 Moral/Religious objection ..... 9 **ACCESS RELATED REASONS** Facility/Source of method too far away. 10 Do not know how/where to obtain it .. 11 Haven't thought/Made up my mind .... 12 Other: _____ 13 **(SPECIFY)**	
425.	Why are you using a contraceptive method? **(Ki faire òu pé servi ène méthode de contraception?)** ►**READ OPTIONS**	To space **your** births **(Espace òu bannes naissances)** ..... 1 To have no more births **(Pas oulé encore enfants)** 2	→ 426 → 427
426.	What is the most important reason why you want to space your birth? **(Pou ki pli grand raison, eski òu envie espace òu banne naissances?)** **(ONE ANSWER ONLY)**	To recover my health ..... 1 For my children's health/benefit ..... 2 Financial constraint/situation ..... 3 For the well being of my family ..... 4 I am working ..... 5 Other: _____ 6 **(SPECIFY)**	**IB** 437
427.	What is the most important reason why you do not want to have any more children? **(Pou ki pli grand raison, òu pas envie gagne encore zenfans?)** **(ONE ANSWER ONLY)**	Have enough children ..... 1 Financial implications in raising more children ..... 2 To devote more time to my family ..... 3 I want to work outside the house ..... 4 Our house is too small ..... 5 Want to study ..... 6 Family pressure ..... 7 I am working ..... 8 Too difficult to raise another child ..... 9 My husband does not want any more 10 Health concerns ..... 11 Other: _____ 12 **(SPECIFY)**	**IB** 437

►PAST USER STARTS HERE			
☞ IB 428	**CHECK Q406 (EVER USED A METHOD) AND Q412 (NOT CURRENTLY USING A METHOD)** **►IF Q406 = 1 AND Q412 = 2 THEN CONTINUE**		
428.	What was the **first** family planning method you ever used for **at least 1 month**? **(Ki prémier méthode de contraception ki oune déjà servi pendant au moins 1 mois ou plis?)** **NATURAL FAMILY PLANNING (NFP) METHODS**	Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom(Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	
429.	How many children did you have when you started using a method of contraception the first time? **(Combien zenfans òu ti éna quand oune commence servi éne méthode de contraception pou la prémiere fois?)**	☐☐ **CHILDREN** **IF NONE, RECORD '00'**	
430.	What was the method you **last** used? **(Ki dernier méthode òu ti pé servi?)** **►NOTE*:** **IF RESPONDENT SAYS TUBAL LIGATION THEN PROBE.** **CIRCLE OPTION 11 ONLY:** • **IF SHE SAYS SHE GOT PREGNANT WHILE USING THE METHOD AND SHE OR HER HUSBAND/PARTNER DID NOT USE ANY OTHER METHOD AFTERWARDS.** **OTHERWISE CIRCLE OPTION 60 SINCE SHE IS A CURRENT USER.** **IF RESPONDENT SAYS VASECTOMY THEN PROBE.** **CIRCLE OPTION 12 ONLY:** • **IF SHE SAYS THAT SHE GOT PREGNANT EVEN THOUGH HUSBAND/PARTNER HAD A**	Tubal Ligation (Female Sterilisation)*. 11 Vasectomy (Male Sterilisation)* ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom(Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature 34	

	VASECTOMY AND THAT SHE OR HER HUSBAND/PARTNER DID NOT USE ANY OTHER METHOD AFTERWARDS **OR** • **SHE DOES NOT CURRENTLY HAVE A HUSBAND OR PARTNER AND SHE IS NOT USING ANY CONTRACEPTIVE METHOD AND SAYS THAT THE LATE HUSBAND OR FORMER PARTNER HAD A VASECTOMY.** **OTHERWISE CIRCLE OPTION 60 SINCE SHE IS A CURRENT USER.**	Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Currently uses a method..... 60 Other: _____ 61 **(SPECIFY)**	→ Go back to Q402 and correct
431.	What month and year you stopped using the last method? **(Ki mois ek ki l'année òu finne arrête servi sa dernier méthode là?)**	☐☐ **MONTH** ☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	
432.	What is the main reason that you or your (husband/partner) are not currently using a contraceptive method? **(Pou ki pli grand raison ki òu ou bien òu (mari/partenaire) pa pé servi éne méthode de contraception actuellement?)** ►**NOTE*: IF RESPONDENT SAYS: "TRYING TO GET PREGNANT" THEN PROBE FOR HOW LONG SHE IS TRYING TO GET PREGNANT.** **IF LESS THAN FIVE YEARS (‹5) THEN RECORD OPTION 2** **ELSE** **IF FIVE YEARS OR MORE (≥5) THEN RECORD OPTION 11**	**FERTILITY RELATED REASONS** Does not currently have a husband/ partner or not sexually active ..... 1 **Trying to get pregnant*** ..... 2 Currently breastfeeding/ postpartum . 3 Health concerns ..... 4 I got pregnant while using that method 5 Currently pregnant ..... 6 Hysterectomy (surgical removal of uterus) ..... 7 Pre-menopause/ menopause ..... 8 Medically not possible to get pregnant.. 9 Partner infertile..... .10 **Trying to get pregnant for at least 5 years(≥5) and did not succeed** .... 11 **METHOD RELATED REASONS** Contraception is not (very) effective . 12 Experienced side effects ..... 13 Fear of side effects ..... 14 Inconvenient to use ..... 15 **OPPOSITION TO USE** Husband/partner objects to using method ..... 16 Moral/religious objection 17	1, 2, 3, 4, 5, 6 → 435 7, 8, 9, 10, 11 → **IB** 437 12 → 435 13, 14 → 433 15 → 435 16 → 434 17 → 435

		ACCESS RELATED REASONS Travel cost to obtain method too high ..... 18 Facility/source of method too far away ..... 19 Other: _____ 20 **(SPECIFY)**	435
433.	What is the most common side-effect you (experienced/ feared to experience)? **(Ki pli grand l'éffet sécondaire/indésirable ki oune (gagner/peur gagner)?)** **(ONE ANSWER ONLY)**	Nervousness ..... 1 Dizziness/Vertigo ..... 2 Weight loss..... 3 High blood pressure ..... 4 Gastritis ..... 5 Amenorrhea ..... 6 Headache ..... 7 Bleeding ..... 8 Increase libido ..... 9 Decrease libido ..... 10 Weight gain ..... 11 Breast problems ..... 12 Other: _____ 13 **(SPECIFY)**	435
434.	What is the main reason your (husband/partner) is against the use of the method? **(Pou ki pli grand raison ki òu (mari/partnère) contre servi sa méthode là?)** **(ONE ANSWER ONLY)**	Experienced side-effects ..... 1 I was always sick ..... 2 He wanted to remain in complete control ..... 3 I gained weight ..... 4 Moral/Religious objection ..... 5 Is unwilling/too difficult to follow instructions to use method ..... 6 I lost weight ..... 7 Other: _____ 8 **(SPECIFY)** Don't know/ Don't remember 98	

435.	Do you think that you will use a contraceptive method any time in the future? **(Eski òu pensé ki dan le future òu pou servi ène méthode de contraception?)**	Yes ..... 1 No ..... 2 Not sure / Don't know 3	→436 **IB** 437
436.	What method would you want to use? **(Ki méthode òu pou envie servi?)** **(ONE ANSWER ONLY)**	Tubal Ligation (Female Sterilisation) 11 Vasectomy (Male Sterilisation) ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male)..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)** Do not know yet 71	**IB** 437

MODULE B: SOURCE OF CONTRACEPTIVE METHOD

IB
437

ALL CURRENT USERS (CHECK IF Q406=1 AND Q412=1) AND PAST USERS (CHECK IF Q406=1 AND Q412=2) SHOULD ANSWER MODULE B.

► RECORD HERE:

1. **PAST USER**
2. **CURRENT USER**

QUESTIONS Q437- Q452:
FOR PAST USERS, QUESTIONS ARE ABOUT THE LAST CONTRACEPTIVE METHOD USED

FOR CURRENT USERS, QUESTIONS ARE ABOUT THE CURRENT CONTRACEPTIVE METHOD BEING USED

437.	**► CHECK Q430 (PAST USERS) OR Q413 (CURRENT USERS) FOR METHOD HAVING LAST USED / IS CURRENTLY USING** ►If Q430 OR Q413= 11-28 OR 51-52 OR 61 **(OTHER THAN NFP METHOD)**, then **BEGIN**: The last time you used [NAME METHOD], where did you or your (husband/partner) get it? **(Kan dernier fois òu ti servi [NOMME METHODE DE CONTRACEPTION], dépi ki coté òu ou bien òu (mari/partenaire) ti gagne méthode là?)** ►If Q430 OR Q413=31-34 **(NFP METHOD)**, then **BEGIN**: The last time you used [NAME METHOD], where did you or your (husband/partner) obtain your recent instructions for this method? **(Kan dernier fois òu ti servi [NOMME METHODE DE CONTRACEPTION], dépi ki coté òu ou bien òu (mari/partenaire) ti gagne pli récent conseils lor sa méthode là?)** **► NOTE IF Q430 (PAST USERS) OR Q413 (CURRENT USERS) = 41 (WITHDRAWAL METHOD) THEN CIRCLE OPTION 13**	**PUBLIC SECTOR** Government Hospital/Health Centre…….1 Factory or workplace provided by government staff ..... .2 **PRIVATE SECTOR / NGO** MFPWA clinic ..... 3 Action Familiale ..... 4 Pharmacy ..... 5 Private clinic or physician ..... 6 Vending Machine ..... 7 Shop (not pharmacy) ..... 8 Factory or workplace provided by Action Familiale staff ..... 9 Factory or workplace provided by MFPWA staff .....10 Outside country: _____ 11 **(SPECIFY)** Other: _____ 12 **(SPECIFY)** **NO SOURCE** 13	
438.	☞**CHECK Q437:** **► RECORD HERE IF THE RECENT SOURCE OF LAST/CURRENT METHOD IS :** **1. PUBLIC** **2. PRIVATE / NGO/ OPTION "OTHER"**] **GO TO Q439** **3. NO SOURCE→ GO TO INSTRUCTIONS BEFORE Q450**		
439.	Who first advised you to go to that place? **(Ki sane là ti conseille òu pou alle là bas prémier fois?)** **(ONE ANSWER ONLY)**	Doctor ..... 1 Nurse/Midwife ..... 2 Community Health Care Officer ..... 3 Myself (Saw messages on TV) ..... 4 Pharmacist ..... 5 Husband/Partner ..... 6 Other Family member/Relative ..... 7 Myself (Heard radio messages) ..... 8 Friend ..... 9 Colleague…… 10 Nobody / By myself ..... 11 Other: _____ 12 **(SPECIFY)**	

440.	►If Q430 OR Q413= 11-28 OR 51-52 OR 61 **(OTHER THAN NFP METHOD)**, then **BEGIN**: What was the **main** reason you selected that place for you to obtain your (last/current) method of contraception? **(Pou ki pli grand raison òu ti choisir sa place là pou gagne òu (dernier/actuelle) méthode de contraception?)** ►If Q430 OR Q413=31-34 **(NFP METHOD)**, then **BEGIN**: What was the **main** reason you selected that place for you to obtain recent instructions on the method of contraception? **(Pou ki pli grand raison òu ti choisir sa place là pou gagne òu pli récent conseils lor sa méthode là?)** **(ONE ANSWER ONLY)**	**ACCESS-RELATED REASONS** Closer to home ..... 1 Closer to or provided at work ..... 2 Availability of transport ..... 3 Convenient..... 4 **SERVICE-RELATED REASONS** Staff competent/friendly ..... 4 Clean facility ..... 5 Offers privacy ..... 6 Short waiting time ..... 7 Opening hours convenient ..... 8 Use other services at the facility ..... 9 Wanted anonymity ..... 10 **METHOD-RELATED REASONS** Lower cost/cheaper ..... 11 Free of user cost ..... 12 Other: _____ 13 **(SPECIFY)** Don't know/ Don't Remember 98	
441.	Who advised you mostly at that place about how to use that contraceptive method that you (were/are) using? **(Ki sanla ti donne òu plis conseils là bas comment pou servi sa méthode là ki òu (ti pé/ pé) servi?)** **(ONE ANSWER ONLY)**	Obstetrics and Gynaecologist ..... 1 Doctor ..... 2 Nurse/Midwife ..... 3 Community Health Care Officer/ Family Planning Officer ..... 4 Action Familiale Educator ..... 5 Pharmacist ..... 6 Nobody/ By myself ..... 7 Other: _____ 8 **(SPECIFY)**	442 449a
442.	When you received the information concerning use of the method, did this provider tell you about other contraceptive methods? **(Kan òu ti gagne conseils lor comment servi sa méthode là, eski sa personnel là ti dire òu lor lézotte méthodes de contraception?)**	Yes ..... 1 No 2	→ 444
443.	Did the provider explain how effective your method is compared to other contraceptive methods? **(Eski personnel là ti explique òu lor éfficacité de òu méthode comparer ar lézotte méthodes de contraception?)**	Yes ..... 1 No 2	

444.	Did the provider explain the possible side effects of your method? **(Eski personnel là ti explique òu lor l'éffet sécondaire/indésirable ki òu capave gagner kan servi méthode là?)**	Yes ..... 1 No 2	
445.	Were you told what to do if you experienced side effects while using the method? **(Eski ti dire òu ki bisin faire kan òu gagne l'éffet sécondaire/indésirable kan servi méthode là?)**	Yes ..... 1 No 2	
446.	Did the provider inform you about the instructions to follow while using the method? **(Eski personnel là ti donne òu instructions ki òu bizin suivre kan òu servi sa méthode là?)**	Yes ..... 1 No 2	
447.	Did the provider inform you that you should make a return visit in case of concerns/problems while using the method? **(Eski personnel là ti dire òu ki òu bisin révini en cas ki òu gagne banne soucis ou bien problèmes kan òu servi sa méthode là?)**	Yes ..... 1 No 2	
448.	Overall, how would you rate the level of satisfaction of the family planning services that you have received at that place? **(En génerale, ki niveau de satisfaction òu pou donner lor sa bannes service family planning ki oune gagner là bas?)**	Very satisfied ..... 1 Satisfied ..... 2 Somewhat satisfied ..... 3 Not satisfied ..... 4 Don't know/Don't remember 98	**IB** 450 → 449 → **IB** 450

449. Why (were/are) you not satisfied of the family planning services that you (received/are receiving) at that facility?
(Ki faire òu (pas ti/pas) satisfait de sa service family planning ki òu (ti pé/pé) gagner dan sa centre là?)

DO NOT READ OPTIONS : TICK THE ANSWER(S)
(MULTIPLE ANSWERS)

A. Family planning officer was not polite	
B. Waiting time to receive services too long	
C. Lack of contraceptive commodity	
D. Family planning officer was not available	
E. No privacy- other persons could hear conversation	
F. Family Planning doctor not available	
G. Family Planning doctor was not polite	
H. Other: _____ **(SPECIFY)**	

449a	Have you or your (husband/partner) always used the same source since you started using this contraceptive method? **(Eski òu ou bien òu (mari/partenaire) ti tout le temps alle sa place dépi ki oune commence servi sa methode là?)**	Yes ..... 1 No..... 2	→ **IB** 450
449b	► **CHECK Q437 (RECENT SOURCE)** Which source were you or your (husband/partner) using **previously** before going to [NAME RECENT SOURCE]? (**Ki coté òu ou bien òu (mari/partenaire) ti pé aller avan [NOMME PLACE LA]?**	►**NOTE:** INSERT OPTION NUMBER **(USE SAME OPTION NUMBER AS IN Q437 BUT *OPTION N0.* FOR Q449b ≠ Q437)**	
449c	What was the main reason that you or your (husband/partner) stopped using this source? **(Ki pli grand raison òu ou bien òu (mari/partenaire) ine arrête servi sa place là?)** **(ONE ANSWER ONLY)**	**ACCESS-RELATED REASONS** Far from home ..... 1 Transport not easily available ..... 2 **SERVICE-RELATED REASONS** Staff incompetent/ not friendly ..... 3 Facility not clean ..... 4 Did not offer privacy..... 5 Long waiting time ..... 6 Inconvenient opening hours ..... 7 Wanted anonymity ..... 8 Service no longer available ..... 9 **METHOD-RELATED REASONS** Too expensive ..... 10 Not free ..... 11 Other: _____ 12 **(SPECIFY)** Don't know/ Don't Remember.....98	
☞ **IB** 450	**CHECK Q438 (RECENT SOURCE OF METHOD)** **► IF Q438=2 OR 3 GO TO Q450** **► ELSE IF Q438 = 1 THEN GO TO INSTRUCTIONS BEFORE Q462**		
450.	Are you aware that the Ministry of Health gives contraceptives free of user cost? **(Eski òu conné ki Ministère de la Santé donne contraceptives gratuitement?)**	Yes ..... 1 No 2	

451.	Which type of facilities would you plan to use next time to seek FP services/information? **(Ki cotté òu compte aller lotte fois pou gagne service ou bien reseignement lor family planning?)** **(ONE ANSWER ONLY)**	Public ..... 1 Private/NGO ..... 2 None ..... 3 Will stop using FP ..... 4 Don't know 5	→ **IB** 462 → 452 **IB** 462
452.	What would be the **main** reason that you still would not go for a contraceptive method at a public health facility? **(Pou ki pli grand raison, òu toujours pa pou alle gagne éne méthode de contraception dan éne centre de santé gouvernement?)** **(ONE ANSWER ONLY)**	Method not available ..... 1 Opening time not convenient ..... 2 Waiting time too long ..... 3 Staff not polite ..... 4 Method not reliable ..... 5 Don't like using facilities at government 6 Concern about cleanliness of facility .. 7 Not interested in shifting method ..... 8 Other: _____ 9 (SPECIFY)	**IB** 462

MODULE C: NEVER USER STARTS HERE

☞ **IB** 453	**CHECK:** **Q406 (EVER USED A CONTRACEPTIVE METHOD)** **► IF Q406=2 THEN CONTINUE**		
453.	Do you think that you can get pregnant at the present time? **(Eski òu pensé ki òu capave tombe enceinte à présent?)**	Yes ..... 1 No ..... 2 Not sure ..... 3 Currently pregnant **(Check Q207=1)** . 4	→ 455 454 → 458
454.	What is the main reason why you think that you (cannot/are not sure to) get pregnant at the present time? **(Pou ki pli grand raison òu penser ki (òu pas/ òu pas sûre) pou capave tombe enceinte à présent?)** **(ONE ANSWER ONLY)** **►NOTE*: IF RESPONDENT SAYS: 'HAS TRIED TO GET PREGNANT' THEN PROBE FOR HOW LONG SHE HAS TRIED TO GET PREGNANT.** **IF LESS THAN FIVE YEARS (‹5) THEN RECORD OPTION 4** **ELSE** **IF FIVE YEARS OR MORE (≥5) THEN RECORD OPTION 8** **^ PROBE IF RESPONDENT SAYS THAT SHE HAD TUBAL LIGATION THEN RECORD OPTION 10** **+ PROBE IF RESPONDENT SAYS THAT PARTNER HAD VASECTOMY THEN RECORD OPTION 10**	Does not currently have a partner/is not sexually active ..... 1 Currently breast-feeding/postpartum . 2 Health concerns ..... 3 **Has tried to get pregnant* for less than 5 years (‹5) and did not succeed** ..... 4 Hysterectomy (surgical removal of uterus) ..... 5 Pre-menopause/ menopause ..... 6 Medically not possible to get pregnant^ 7 **Has tried to get pregnant* for at least 5 years (≥5) and did not succeed** . 8 Partner infertile+ ..... 9 Currently uses a method….. ..... 10 Other: _____ 11 **(SPECIFY)** Don't know/Don't remember ..... 98 Refuse to answer 99	458 **IB** 462 **IB** 462 Go back to **Q402** and correct it **IB** 462

455.	What is the main reason you are not using a method to prevent pregnancy at present? **(Pou ki pli grand raison, òu pas pé servi éne méthode de contraception ki pou empêche òu tombe enceinte à présent?)** (**ONE ANSWER ONLY)** **►NOTE*: IF RESPONDENT SAYS: 'WANT TO GET PREGNANT' THEN PROBE FOR HOW LONG SHE HAS BEEN TRYING TO GET PREGNANT.** **IF LESS THAN FIVE YEARS (‹5) THEN RECORD OPTION 2** **ELSE** **IF FIVE YEARS OR MORE (≥5) THEN RECORD OPTION 5**	**FERTILITY RELATED REASONS** Does not currently have a husband/ partner or is not sexually active ..... 1 **Want to get pregnant * and has been trying for the past 5 years (‹5)** .....2 Currently breastfeeding/postpartum..... 3 I am too old ..... 4 **Want to get pregnant * and has been trying at least 5 years (≥5)**……5 **METHOD RELATED REASONS** Fear of side effects ..... 6 Health reasons ..... 7 Method not available ..... 8 The methods are ineffective ..... 9 The methods are difficult to use ..... 10 Cost of method too high ..... 11 Don't want to use a method ..... 12 No knowledge about the methods ..... 13 **OPPOSITION TO USE** Husband/Partner objects ..... 14 Moral /Religious objection ..... 15 **ACCESS RELATED REASONS** Family planning facility too far away .. 16 Travel cost to obtain method too high 17 Knows no source/facility to obtain a method ..... 18 Not worth the trouble/negligence ..... 19 Haven't thought/made up my mind ... 20 Other: _____ 21 **(SPECIFY)**	458 →456 458 →457 →458 458

456.	What is the most common side-effect you fear to experience? **(Ki pli grand l'éffet sécondaire/indésirable òu peur pou gagner?)** **(ONE ANSWER ONLY)**	Nervousness ..... 1 Dizziness/Vertigo ..... 2 Weight loss..... 3 High blood pressure ..... 4 Gastritis ..... 5 Amenorrhea ..... 6 Headache ..... 7 Bleeding ..... 8 Increase libido ..... 9 Decrease libido ..... 10 Weight gain ..... 11 Breast problem ..... 12 Other: _____ 13 **(SPECIFY)**	458
457.	What is the main reason your (husband/partner) is against the use of a contraceptive method? **(Pou ki pli grand raison ki òu (mari/partnère) contre ki òu servi éne méthode de contraception?)** **(ONE ANSWER ONLY)**	I am often sick ..... 1 He wants to remain in complete control ..... 2 Moral/religious objections ..... 3 Is unwilling to use method..... 4 Feels that instructions of using the method are too difficult ..... 5 Other: _____ 6 **(SPECIFY)** Don't know/ Don't Remember 98	
458.	Do you think that you will use a contraceptive method any time in the future? **(Eski òu penser ki òu pou servi ène méthode de contraception pli tard?)**	Yes ..... 1 No ..... 2 Not sure 3	**IB** 462

459.	Which method would you want to use? **(Ki méthode òu pou envie servi?)** **(ONE ANSWER ONLY)**	Tubal Ligation (Female Sterilisation) . 11 Vasectomy (Male Sterilisation) ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Sympto-Thermal ..... 31 Mucus Method ..... 32 Count Days (Calendar) ..... 33 Temperature ..... 34 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)** Do not know yet …… 71	→ **IB** 462
460.	Do you know where to obtain the method or information about the method? **(Eski òu conné cotte òu pou gagne ène méthode de contraception ou bien gagne renseignement lor méthode là?)**	Yes ..... 1 No 2	→ **IB** 462
461.	Which place you would most likely want to go to obtain a contraceptive method or information about the method? **(Cotte òu ti pou plis envie allé pou gagne ène méthode de contraception ou bien gagne renseignement lors sa méthode là?)** **(ONE ANSWER ONLY)**	Government Hospital/Health Centre…. 1 MFPWA clinic ..... 2 Action Familiale ..... 3 Pharmacy ..... 4 Private clinic/Private doctor office ..... 5 Vending Machine/shop (not pharmacy) 6 Factory or Place of work ..... 7 Other: _____ 8 **(SPECIFY)**	**IB** 462

MODULE D: CURRENT FERTILITY PREFERENCE AND POTENTIAL FP USE

FOR ALL RESPONDENTS <u>EXCEPT</u> THOSE WHO ARE SUB-FECUND OR WHO ARE STERILISED OR THOSE WHO ARE NOT YET SEXUALLY ACTIVE

☞ **IB** 462

CHECK: Q202 (EVER HAD SEXUAL INTERCOURSE)
Q413 (METHOD CURRENTLY BEING USED)
Q432 (REASON FOR NOT CURRENTLY USING A METHOD)
Q454 (DO NOT THINK CAN GET PREGNANT PRESENTLY)
Q455 (NOT USING A METHOD TO PREVENT PREGNANCY)

▼

462A. <u>RECORD HERE</u> IF RESPONDENT SHOULD ANSWER MODULE D:

1. YES **(FIRST CHECK THE BRACKETED INSTRUCTIONS GIVEN BELOW: <u>IF NONE</u> THEN CONTINUE: <u>GO TO 462</u>)**

2. NO (
IF Q202=2 THEN GO TO SECTION 5 OR
IF Q413=11 OR 12 THEN GO TO IB 469 OR
IF Q432= 7 OR 8 OR 9 OR 10 OR 11 THEN GO TO IB 469 OR
IF Q454= 5 OR 6 OR 7 OR 8 OR 9 THEN GO TO IB 469 OR
IF Q455=5 THEN GO TO IB 469
)

462.	**CHECK: Q221 (TOTAL BIRTHS)** Looking into the future, do you intend to have (a/another) baby at some time (IF CURRENTLY PREGNANT (Q207=1) ADD "....after this pregnancy")? **(Eski ou énan l'intention dan le future gagne (éne/ encore) zenfan (SI ENCEINTE ACTUELLEMENT (Q207=1) DIRE " ….après òu grossese"?)**	Yes ..... 1 No ..... 2 Up to God / fate ..... 3 Not sure 4	→ 463 465
463.	When do you actually want to have a baby? **(Kan òu envie gagne éne zenfan?)**	In less than 2 years ..... 1 2 years or after ..... 2 Not sure/Don't know 3	

464.	**CHECK: Q207 (PREGNANCY STATUS)** **Q211 (NO. OF LIVING CHILDREN)** **IF Q211=0, ASK:** **‘‘**How many children would you like to have in the future (IF CURRENTLY PREGNANT ADD “....**after this pregnancy**”)?” **(Combien zenfan òu envie gagner dan le future (SI ENCEINTE ACTUELLEMENT DIRE “ ….après òu grossese”)?)** **IF Q211≥1, ASK:** **‘‘**How many **more** children would you like to have in the future (IF CURRENTLY PREGNANT ADD “....**after this pregnancy**”)? ’’ **(Combien zenfan òu encore envie gagner dan le future (SI ENCEINTE ACTUELLEMENT DIRE “ ….après òu grossese”) ?)**	☐☐ Children As many as possible ..... 66 Up to God /fate ..... 77 Don’t know 98	
465.	**IF Q462=1,3 OR 4 BEGIN WITH:** After you have all the children you want, do you think that you would be interested in an operation that would prevent you from having any more children? **(Aprés ki oune gagne tou òu zenfans ki òu oulé, eski òu penser òu pou interessé ek ène l’operation ki pou empêche òu gagne encore zenfan?)** **IF Q462=2 BEGIN WITH:** Do you think that you would be interested in an operation that would prevent you from having any more children? **(Eski òu penser òu pou interessé ek ène l’operation ki pou empêche òu gagne encore zenfan?)**	Yes ..... 1 No ..... 2 Not sure 3	→ 466 468
466.	Do you know where to go for this operation or to obtain information about it? **(Eski òu conné ki coté pou aller pou faire sa l’operation là ou bien gagne reseignements lor sa l’operation là?)**	Yes ..... 1 No 2	→ **IB** 469

467.	Where? **(Ki côté?)** **►NOTE: IF MORE THAN ONE PLACE MENTIONED, RECORD THE ONE SHE WOULD MOST LIKELY USE.** **(ONE ANSWER ONLY)**	Government Hospital/Health Centre ... 1 Private Clinic/Private Hospital ..... 2 MFPWA clinic ..... 3 Private Doctor Office ..... 4 Outside country _____ 5 **(SPECIFY)** Other: _____ 6 **(SPECIFY)**	**IB** 469
468.	What is the main reason you would not be interested in the operation? **(Pou ki pli grand raison, òu pas intéresser avek sa l'opération là?)** **(ONE ANSWER ONLY)**	**FERTILITY RELATED REASONS** I am too young/too old (approaching menopause) ..... 1 Still want to be able to conceive ..... 2 Does not have a partner/not sexually active ..... 3 **METHOD RELATED REASONS** Fear of operation ..... 4 Do not like operation ..... 5 Satisfied with present method ..... 6 Prefers other contraceptive method ... 7 Doesn't know enough about method . 8 Cost of method ..... 9 **OPPOSITION TO USE** Husband/partner objects ..... 10 Moral/religious objection ..... 11 Haven't thought about it ..... 12 Children too young ..... 13 Not worth the trouble ..... 14 Other: _____ 15 **(SPECIFY)** Don't know/ Not sure 98	**IB** 469 **IB** 469

MODULE E: NATURAL FAMILY PLANNING (NFP) METHODS

☞CHECK TO DETERMINE RESPONDENT'S USE OF NATURAL FAMILY PLANNING (NFP) METHODS: SYMPTO THERMAL, MUCUS, COUNTING DAYS & TEMPERATURE

☞ IB 469	**CHECK Q413 (CURRENT USER OF NFP) AS WELL AS Q402M, Q402N, Q402O, Q402P (EITHER EVER USER OR NEVER USER OF NFP)** **► CURRENT USER OF NFP** **IF Q413 =31 OR 32 OR 33 OR 34 → Q470** **ELSE** **► EVER USED <u>AT LEAST ONE</u> (≥1) METHOD OF NFP** **IF OPTION 1 HAS BEEN RECORDED FOR <u>ANY</u> METHOD FOR Q402M TO Q402P → Q469** **ELSE** **► NEVER USER OF AN NFP METHOD** **IF Q402M=2 <u>AND</u> Q402N=2 <u>AND</u> Q402O=2 <u>AND</u> Q402P=2 → GO TO IB MODULE F**	
469.	What was the month and year that you stopped using a natural family planning method? **(Ki mois ek ki l'année òu finne arrête servi éne méthode naturel de planning familiale?)** ☐☐ MONTH ☐☐☐☐ YEAR ☐☐ **IF DON'T REMEMBER, RECORD '98'** **CHECK:** **<u>BEFORE AUGUST</u> 2009 OR DON'T REMEMBER** → **GO TO IB MODULE F** **<u>IN AUGUST 2009 OR AFTER</u>** → **CONTINUE WITH Q47O**	
470.	**☞RECORD HERE IF RESPONDENT OF NATURAL FAMILY PLANNING METHOD IS:** **1. CURRENT USER** **2. RECENT PAST USER (STOPPED IN <u>AUGUST</u> 2009 OR AFTER)**	

	471	472	473	474	475	476
△READ AND CODE	Have you ever kept a chart/ calendar/ diary for (NAME NFP METHOD)? **(Eski oune déjà écrire dan éne charte/calendrier/diary pou (NOMME NFP METHODE)?**	"Are you currently keeping a chart/ calendar/ diary for (NAME NFP METHOD)?" **(Eski ou pé écrire actuellement dan éne charte/calendrier/diary pou (NOMME NFP METHODE)?**	**If Q472=1, BEGIN:** "For how many *months* have you been keeping the chart/ calendar/ diary?" **(Dépi combien mois òu pé ecrire dan éne charte/calendrier/diary?) If Q472=2, BEGIN:** "At the time you kept a chart/ calendar/ diary, for how many *months* did you do so?" **(A l'époque ki òu ti pé ecrire, pou combien mois òu fine écrire dan éne charte/calendrier/diary?) ► NOTE:RECORD EXACT NUMBER OF MONTHS ELSE IF EXACT NUMBER OF MONTHS IS NOT KNOWN RECORD NUMBER CODE AS GIVEN ON THE NEXT PAGE***	Have you ever recalled without writing down your fertility sign for (NAME NFP METHOD)? **(Eski oune déja rapelle òu signe de fertilité sans écrire pou (NOMME NFP METHODE)?**	"Are you currently trying to recall without writing down your fertility sign for (NAME NFP METHOD)?" **(Eski òu pé éssaye rapelle ou signe de fertilitité actuellement sans écrire pou (NOMME NFP METHODE)?**	**If Q475=1, BEGIN:** "For how many *months* have you been trying to recall?" **(Dépi combien mois òu pé éssaye rapelle?)** **If Q475=2, BEGIN:** "At the time you were trying to recall, for how many *months* did you do so? **(A l'époque ki òu ti pé éssaye rapelle, pou combien mois ou ti pé éssaye rapelle?) ► NOTE: RECORD EXACT NUMBER OF MONTHS ELSE IF EXACT NUMBER OF MONTHS IS NOT KNOWN RECORD NUMBER CODE AS GIVEN ON THE NEXT PAGE***
A. Counting days	1. Yes→Q472 2. No→Q474	1. Yes→Q473 2. No→Q473	☐☐☐ **Q474**	1. Yes→Q475 2. No→ B	1. Yes→Q476 2. No→ Q476	☐☐☐ **B**
B. Temperature Method Only	1. Yes→Q472 2. No→Q474	1. Yes→Q473 2. No→Q473	☐☐☐ **Q474**	1. Yes→Q475 2. No→C	1. Yes→Q476 2. No→ Q476	☐☐☐ **C**
C. Mucus Method Only	1. Yes→Q472 2. No→Q474	1. Yes→Q473 2. No→Q473	☐☐☐ **Q474**	1. Yes→Q475 2. No→D	1. Yes→Q476 2. No→ Q476	☐☐☐ **D**
D. Sympto Thermal (Both Temp-erature and Mucus)	1. Yes→Q472 2. No→Q474	1. Yes→Q473 2. No→Q473	☐☐☐ **Q474**	1. Yes→Q475 2. No→Q477	1. Yes→Q476 2. No→Q476	☐☐☐ **Q477**

***CODES FOR Q473 AND Q476**

RESPONDENT KNOWS ***EXACT NUMBER*** OF MONTHS: RECORD EXACT NUMBER	
RESPONDENT GIVES AN ***APPROXIMATE*** ANSWER:	**CODE**
• LESS THAN 12 MONTHS	800
• 12 MONTHS TO LESS THAN 24 MONTHS	801
• 24 MONTHS TO LESS THAN 36 MONTHS	802
• 36 MONTHS TO LESS THAN 84 MONTHS	803
• MORE THAN 84 MONTHS	804
RESPONDENT DOESN'T REMEMBER	898

477. ☞**RECORD HERE THE NFP METHOD BEING USED OR HAVING LAST USED:**

FOR CURRENT USERS (Q470=1)	**FOR RECENT PAST USERS (Q470=2)**
↓	↓
CHECK Q413 AND RECORD	**CHECK Q471 TO Q476 AND ASK**
	"WHAT WAS THE LAST NATURAL FAMILY PLANNING METHOD THAT YOU USED?" **(Ki dernier méthode naturel de planning familiale ki oune servi?) AND RECORD**

1. **COUNTING DAYS**
2. **TEMPERATURE**
3. **MUCUS**
4. **SYMPTO THERMAL**

►NOTE: FOR Q478-Q490, WHERE THERE IS A SUBSTITUTE TO BE MADE, REFER TO Q477.

478. Where did you hear or read about (NAME METHOD) for the first time?
(Côte òu finne tander ou bien lire lor [NOMME METHODE] pou la prémiere fois?)

(ONE ANSWER ONLY)

Religious person/Priest	1
Private doctor	2
Action Familiale	3
Radio	4
TV	5
Government Health Staff	6
Family member/Relative..	7
Friend	8
Colleague	9
Learned from book(s)/magazines	10
Learned from Internet/Social media	11
Other: _____ **(SPECIFY)**	12

479.	In what year were you first taught or learned about (NAME METHOD)? **(Ki l'année ki inne montrer òu ou ki oune appranne pou la prémiere fois lor (NOMME METHODE)?**	☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
480.	Who **first** taught you to use or how did you learn (NAME METHOD) for the first time? **(Ki sanne là ti montrer òu comment servi (NOMME METHODE) ou bien ki façon oune apprane comment servi (NOMME METHODE) pou la prémiere fois?)** **(ONE ANSWER ONLY)**	Religious person/Priest ..... 1 Private Doctor ..... 2 Action Familiale ..... 3 Government Health Staff ..... 4 Family Member /Relative. .....5 Friend.....6 Colleague..... 7 Learned from Internet/Social media ... 8 Radio or TV ..... 9 Learned from book(s)/magazines ..... 10 Other: _____ 11 **(SPECIFY)**	**IB** 483
481.	After that person taught you, did he/she help you or talk to you again about (NAME METHOD)? **(Kan sa dimoune là ti montrer òu lor (NOMME METHODE), eski li ti aide òu aprés ou bien coze ar òu encore lor sa méthode là?)**	Yes ..... 1 No 2	→ **IB** 483
482.	How **many more** times did you get help or teaching from that person? **(Combien fois encore, òu finne gagne so l'aide ou so l'enseignement?)**	☐☐ **TIMES** **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	**IB** 483
IB 483	**CHECK Q470 (CURRENT USER OF NFP OR PAST USER OF NFP)** **► IF Q470=1 GO TO Q483** **►IF Q470=2 GO TO Q487**		
483.	In addition to (NAME METHOD) that you are using, have you ever used at the same time another birth control method during your fertile days? **(En plus de (NOMME METHODE) ki òu pé servi, eski òu finne déjà servi ène lotte méthode de contraception en même temps pendant òu banne jours ki òu fertile?)**	Yes ..... 1 No 2	→ **IB** Module F

484.	Which method have you used more often? **(Ki méthode ki oune servi pli souvent?)** **(ONE ANSWER ONLY)**	Condom (Male) ..... 1 Foaming Tablets/Jelly ..... 2 Diaphragm ..... 3 Withdrawal (Take Precaution)..... 4 Other: _____ 5 **(SPECIFY)**	
485.	How often have you used the method? **(Combien fois oune servi sa méthode là?)**	Always, in all cycles ..... 1 Sometimes, occasionally ..... 2 Rarely ..... 3 Don't know/ Don't remember 4	
486.	What is the reason have you been practising the other method during your fertile days? **(Pou ki raison oune servi éne lotte méthode pendant òu banne jours ki òu fertile?)** △ **READ OPTIONS** **(ONE ANSWER ONLY)**	To prevent pregnancy **(Pou empêche grossesse)** ..... 1 To prevent STIs including HIV/AIDS **(Pou empêche maladies sexuellement transmissibles inclus VIH/Sida)** ..... 2 For both reasons **(Pou tou les deux raisons)** ..... 3 Other: _____ 4 **(Autre)** **(SPECIFY)** Don't know/Don't remember 5	**IB** Module F
►RECENT PAST USER OF NFP STARTS HERE			
487.	Why have you stopped using (NAME METHOD)? **(Ki faire òu finne arrête servi (NOMME METHODE)?)**	To become pregnant ..... 1 Feared of getting pregnant while using method ..... 2 Too complicated ..... 3 Did not like abstinence ..... 4 Husband/Partner did not like abstinence ..... 5 Menopausal/ Pre-menopausal ..... 6 Medically not possible to get pregnant 7 Partner infertile ..... 8 Loss contact with instructor ..... 9 Not sexually active/did not have a partner at that time..... 10 Got pregnant while using method ..... 11 Not convenient to use ..... 12 Not effective ..... 13 Other: _____ 14 **(SPECIFY)**	**IB** Module F

488.	Did you change to another method after you stopped using (NAME METHOD)? **(Eski òu finne change méthode après ki òu finne arrête servi (NOMME METHODE)?**	Yes ..... 1 No 2	→ **IB** Module F
489.	When did you start using another method after having stopped (NAME METHOD)? **(Kan oune arrête servi [NOMME METHODE], après combien les temps oune commence servi sa lotte méthode là?)**	Immediately ..... 1 Within one year (≤ 1 year)..... 2 More than 1 year, up to 2 years ..... 3 More than two years (>2 years) 4	
490.	Which method was that? **(Ki méthode sa ti été?)** **(ONE ANSWER ONLY)**	Tubal Ligation (Female Sterilisation)… 11 Vasectomy (Male Sterilisation) ..... 12 Pill ..... 20 3-Month Injectable ..... 21 1-Month Injectable ..... 22 IUD ..... 23 Condom (Male) ..... 24 Condom (Female) ..... 25 Diaphragm ..... 26 Foaming Tablets/Jelly ..... 27 Implant ..... 28 Withdrawal (Take Precaution)..... 41 Cycle Beads ..... 51 Contraceptive Patch ..... 52 Other: _____ 61 **(SPECIFY)**	**IB** Module F
IB MODULE F	**CHECK: Q432 (REASON FOR PAST USER NOT CURRENTLY USING A METHOD)** **Q454 (REASON FOR NEVER USER FOR NOT BEING ABLE TO GET PREGNANT)** **Q455 (REASON FOR NEVER USER FOR NOT USING A METHOD TO PREVENT PREGNACY)** **Q487 (RECENT PAST USER OF NFP HAVING STOPPED USING METHOD)** **►IF Q432 =2, 9,10 OR 11 → GO TO Q491 OR** **►IF Q432 =7,8 → GO TO Q492 OR** **►IF Q454 = 4,7, 8 OR 9 → GO TO Q491 OR** **►IF Q454 = 5,6 → GO TO Q492 OR** **►IF Q455 = 2 OR 5 → GO TO Q491 OR** **►IF Q487= 7 OR 8 → GO TO Q491 OR** **►IF Q487= 6 → GO TO Q492** **►<u>OTHERS</u> GO TO SECTION 5 (REPRODUCTIVE HEALTH PERCEPTIONS AND BEHAVIOURS)**	

MODULE F: INFERTILITY

491.	Looking to the future, do you yourself intend to seek any medical help to have (a/another) baby? **(Dan le future, eski òu même éna l'intention gagne l'aide médicale pou òu capave gagne (éne/ éne lotte) zenfan?)**	Yes ..... 1 No ..... 2 Don't know..... 3	
492.	Do you know a place where you can seek medical diagnostic or treatment for help to become pregnant? **(Eski óu conne éne l'endroit cotte òu capave alle gagne éne diagnostique/constat ou traitement médicale pou aide òu tombe enceinte?)**	Yes ..... 1 No ..... 2 Don't know..... 3	☐ 499c
493.	**CHECK: Q108 (MARITAL STATUS)** Have you or your (husband/partner) ever been to a doctor or medical facility to seek medical diagnostic or treatment to help you to become pregnant? **(Eski òu ou bien òu (mari/partnére) finne dèja alle cotte éne doktére ou dan éne centre medical pou alle gagne éne diagnostique ou éne traitement médicale pou aide òu tombe enceinte?)**	Yes ..... 1 No ..... 2 Don't know/ Don't remember 3	☐ 499c
494.	Going back to you or your (husband's/partner's) **first visit** when you sought medical help for becoming pregnant, in what month and year was that visit? **(Ki mois ek ki l'année ti été kan prémier fois òu ou bien òu (mari/partnére) ti alle gagne l'aide médicale pou aide òu tombe enceinte?)** **(IF HUSBAND/PARTNER'S 1ST VISIT PRECEDED HERS, RECORD THAT DATE)**	☐☐ **MONTH** ☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	
495.	**►CHECK: Q494 (FIRST MEDICAL VISIT)** When you or your (husband/partner) **first** went for medical help in (NAME MONTH AND YEAR), for how many months or years have you or your (husband/partner) been trying for you to become pregnant? **(Kan òu ou bien òu (mari/partnére) ti finne faire sa visite médicale là pou la prémiere fois là en (NOMME MOIS EK L'ANNEE), sa ti faire dépi combien mois ou l'années ki òu ou bien òu (mari/partnére) ti pé essaye pou ki òu tombe enceinte?**	**EITHER** ☐☐ **MONTHS** **OR** ☐☐ **YEARS** **OR** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW, RECORD '98'**	

496.	When you and your (husband/partner) went for medical help to become pregnant, was the problem(s) identified? **(Kan òu ou bien òu (mari/partnére) ti finne alle gagne l'aide médicale pou òu tombe enceinte, eski probléme là ti identifié?**	Yes ..... 1 No 2	→498

497. Did you or your (husband/partner) have the following problems:(► **READ A-E** AND CODE ALL THAT APPLY).

(Eski òu ou bien òu (mari/partnére) ti éna sa banne problemes là?) ► **LIRE A-E**

(MULTIPLE ANSWERS)

	YES	NO
A. Problems with ovulation (includes hormonal dysfunction)? **(Problème ovulation (inclus problème hormonale)**	1	2
B. Blocked tubes? **(Tubes bouchés)**	1	2
C. Endometriosis (a disease in which tissue from the inside of uterus fixes to other places)? **(Endométriose - éne maladie cotte banne tissu dépi dan la caze baba alle dépose dan lézot place dan les corps)**	1	2
D. Semen or sperm problems (low count, poor motility, varicocele)? **(Problème sperme (péna assez, movement faible, grossisement banne la veines dan testicules)**	1	2
E. Any other problems? _____ **(Autres problèmes?)** **(SPECIFY)**	1	2

498.	During the past 12 months, were you (or your (husband/partner)) pursuing medical help for you to become pregnant? **(Dan sa dernier 12 mois là, eski òu (ou bien òu (mari/partnére)) fine alle gagne l'aide médicale pou òu capave tombe enceinte?)**	Yes ..... 1 No 2	→ 499a
499.	During the past 12 months, how many visits have you (or your (husband/partner)) made to a doctor to help you to get pregnant? **(Dan dernier 12 mois là, combien visite òu (ou bien òu (mari/partnére)) fine alle cotte éne doktér pou gagne l'aide médicale pou òu capave tombe enceinte?)**	☐☐ **VISITS** ☐☐ **IF DON'T REMEMBER, RECORD '98'**	
499a.	Where did you seek the treatment mostly? **(Cotte oune alle gagne traitement plis?)** **(ONE ANSWER ONLY)**	Public hospital ..... 1 Private Clinic/ Private Centre ..... 2 Private Doctor Office..... 3 MFPWA clinic..... 4 Outside Country _____ 5 **(SPECIFY)** Other: _____ 6 **(SPECIFY)**	

499b.	In what month and year was your (most recent/last) visit for help to become pregnant? **(Ki mois ek ki l'année ti été kan oune faire òu (pli récent/ dernier) visite pou alle gagne traitement médicale pou òu capave tombe enceinte)?**	☐☐ **MONTH** ☐☐☐☐ **YEAR** ☐☐ **IF DON'T REMEMBER/ DON'T KNOW RECORD '98'**	
499c.	Have you ever been treated for an infection in your fallopian tubes, womb, or ovaries, also called a pelvic infection, pelvic inflammatory disease, or PID? **(Eski òu finne déja traiter pou éne infection dans òu tubes fallopiene, l'uterus/la caze baba ou ovaires – ki aussi connu comme infection ou inflammation pelvis ou bien PID?)** **►NOTE: PROBE IF DON'T KNOW: IT IS A FEMALE INFECTION THAT SOMETIMES CAUSES ABDOMINAL PAIN OR LOWER STOMACH CRAMPS. INFECTIONS OF THE VAGINA ALONE, ENDOMETRIOSIS** (a disease in which tissue from the inside of uterus fixes to other places)**, PELVIC TUMORS AND CYSTS DO NOT COUNT AS PELVIC INFECTIONS.**	Yes ..... 1 No ..... 2 Don't know/ Don't Remember 3	Go to **Section 5**

SECTION 5: REPRODUCTIVE HEALTH PERCEPTIONS AND BEHAVIOURS

☞**NOTE: THIS SECTION APPLIES TO ALL RESPONDENTS**

☞*Now, I have some questions on sexuality education:*

►**READ EACH TOPIC FROM THE TABLE FOR QUESTIONS 500-501:**

TOPIC **DK : DON'T KNOW** **NR : NO RESPONSE**	**500.** Should **(NAME TOPIC)** be taught at school? **(Eski (NOMME TOPIC) bizin enseigner dan l'école?)**	**501.** At what age should **(NAME TOPIC)** be taught to students? **(Ki l'age bizin enseigne ça banne étudiants là lor (NOMME TOPIC)?)**
A. Human Reproduction **(Reproduction humaine)**	1. YES → GO TO Q**501A** 2. NO → GO TO Q500B 8. DK → GO TO Q500B 9. NR → GO TO Q500B	→ GO TO Q500B
B. Contraceptive Methods **(Méthodes de contraception)**	1. YES → GO TO Q**501B** 2. NO → GO TO Q500C 8. DK → GO TO Q500C 9. NR → GO TO Q500C	→ GO TO Q500C
C. Sexual Transmitted Infections including HIV/AIDS **(Infections sexuellements transmissibles inclus VIH/Sida)**	1. YES → GO TO Q**501C** 2. NO → GO TO Q500D 8. DK → GO TO Q500D 9. NR → GO TO Q500D	→ GO TO Q500D
D. Responsible Sexual Behaviour **(Comportement sexuel responsable)**	1. YES → GO TO Q**501D** 2. NO → GO TO Q502 8. DK → GO TO Q502 9. NR → GO TO Q502	→ GO TO Q502

502. Now I want to read some reasons for which one may oppose teaching sexuality education in school. Please tell me if you agree or don't agree.
(Ena banne raisons pou ki dimoune pas d'accord ki l'éducation sexuelle enseigner dan l'école. Dire moi si òu d'accord ou pas avek sa banne raisons ki mo pou dire òu.)

(► READ A – D AND CIRCLE OPTIONS

DK : DON'T KNOW
NR : NO RESPONSE

	AGREE	DISAGREE	DK	NR
A. Sexuality education may lead to early onset of sexual activities in adolescence. **(L'éducation sexuelle capave influence banne jeunes commence activité sexuelle trop tôt)**	1	2	8	9
B. Sexuality education should be taught only at home. **(L'éducation sexuelle bizin montrer seulement dan la caze)**	1	2	8	9
C. Sexuality education is against my religious beliefs **(L'éducation sexuelle contre mo croyance réligieuse)**	1	2	8	9
D. Teachers do not have enough training to teach such courses **(Professeur péna assez formation pou enseigne sa banne cours là)**	1	2	8	9

503. **►CHECK Q100 (AGE OF RESPONDENT)**
IF Q100≥18 ASK:
"Before you were 18 years old, did your mum or dad **ever** talked to you about **(NAME TOPIC)**?" **(► READ A-I)**
(Avant ki òu ti gagne 18 ans, eski òu mama ou papa ine dèja cozé avek òu lor (NOMME TOPIC))?
IF Q100<18 ASK:
"Did your mum or dad **ever** talked to you about **(NAME TOPIC)**?" **(► READ A – I)**
(Eski òu parent ine dèja cozé avek òu lor (NOMME TOPIC)?)
DK/DR : DON'T KNOW/ DON'T REMEMBER
NR : NO RESPONSE

	YES	NO	DK/DR	NR
A. Puberty	1	2	8	9
B. Menstrual cycle	1	2	8	9
C. How pregnancy occurs	1	2	8	9
D. Not having sexual intercourse before marriage	1	2	8	9
E. Responsible sexual behaviour	1	2	8	9
F. Teenage pregnancy	1	2	8	9
G. Methods of contraception	1	2	8	9
H. HIV/AIDS	1	2	8	9
I. Other sexually transmitted infections	1	2	8	9

☞**CHECK: Q103 (HIGHEST LEVEL OF SCHOOL)**
►IF Q103=1 → GO TO 506
►IF Q103>1 → CONTINUE

► READ EACH TOPIC FROM THE TABLE FOR QUESTIONS 504-505:

TOPIC **DK: DON'T KNOW** **NR: NO RESPONSE**	**504.** **"**Have you ever been given talks at school about **(NAME TOPIC)**?" **(Eski òu finne déjà gagne causerie lor (NOMME TOPIC) dan l'école?)** **(► READ A - J)**	**505.** How old were you when you were first given talks at school on **(NAME TOPIC)**? **(Ki l'age òu ti éna kan ti cause lor (NOMME TOPIC) ar òu pour la prémiere fois dan l'école?)**
A. Puberty **(Puberté)**	1. YES → GO TO Q**505A** 2. NO → GO TO Q504B 8. DK → GO TO Q504B 9. NR → GO TO Q504B	☐☐ → GO TO Q504B
B. Menstrual Cycle **(Cycle menstruel)**	1. YES → GO TO **Q505B** 2. NO → GO TO Q504C 8. DK → GO TO Q504C 9. NR → GO TO Q504C	☐☐ → GO TO Q504C
C. Female Reproductive System **(Système reproductive de banne madames)**	1. YES → GO TO **Q505C** 2. NO → GO TO Q504D 8. DK → GO TO Q504D 9. NR → GO TO Q504D	☐☐ → GO TO Q504D
D. Male Reproductive System **(Système reproductive de banne missiès)**	1. YES → GO TO **Q505D** 2. NO → GO TO Q504E 8. DK → GO TO Q504E 9. NR → GO TO Q504E	☐☐ → GO TO Q504E
E. Teenage Pregnancy **(Grossese adolescent)**	1. YES → GO TO **Q505E** 2. NO → GO TO Q504F 8. DK → GO TO Q504F 9. NR → GO TO Q504F	☐☐ → GO TO Q504F
F. How Pregnancy Occurs **(Comment tombe enceinte)**	1. YES → GO TO **Q505F** 2. NO → GO TO Q504G 8. DK → GO TO Q504G 9. NR → GO TO Q504G	☐☐ → GO TO Q504G

G. Responsible Sexual behaviour **(Comportement sexuel responsable)**	1. YES → GO TO **Q505G** 2. NO → GO TO Q504H 8. DK → GO TO Q504H 9. NR → GO TO Q504H	→ GO TO Q504H
H. Contraceptive Methods **(Méthodes de contraception)**	1. YES → GO TO **Q505H** 2. NO → GO TO Q504I 8. DK → GO TO Q504I 9. NR → GO TO Q504I	→ GO TO Q504I
I. HIV/AIDS **(VIH/SIDA)**	1. YES → GO TO **Q505I** 2. NO → GO TO Q504J 8. DK → GO TO Q504J 9. NR → GO TO Q504J	→ GO TO Q504J
J. Other Sexually Transmitted Infections **(Lézot infections sexuellements transmissibles)**	1. YES → GO TO **Q505J** 2. NO → GO TO Q506 8. DK → GO TO Q506 9. NR → GO TO Q506	→ GO TO Q506

506.	In your opinion, who or what was the most important source of information that you had about topics related to sexual matters? **(D'après òu, ki sane là ou ki source d'information ki ti pli important oune gagner lor topic de sexualité?)** **(ONE ANSWER ONLY)**	Mother ..... 1 Father ..... 2 Partner/ Husband ..... 3 Other Family Member/Relative ..... 4 Boyfriend ..... 5 Friend ..... 6 Colleague ..... 7 Doctor ..... 8 Nurse/ Midwife ..... 9 Teacher ..... 10 Books ..... 11 Newspapers, magazines, brochures, flyers ..... 12 Internet/Social media ..... 13 Radio ..... 14 TV ..... 15 Other: _____ 16 **(SPECIFY)**	

507.	If sexuality education is formally introduced in secondary school curriculum, who do you think would be the most appropriate person to teach the subject? **(Si l'éducation sexuelle pou enseigner dan l'école sécondaire, d'après òu, ki sanne là ki pli bien placé pou enseigne sa sujet là?)** (**ONE ANSWER ONLY)**	Biology teacher ..... 1 Teacher with special training in sexuality education ..... 2 Form teacher ..... 3 Physical Education teacher..... 4 Other teacher : _____ 5 **(SPECIFY)** Other : _____ 6 **(SPECIFY)** Don't know 7	**RB** 508
☞ **RB** **508**	☞*Now, I have some questions about a medical test:*		
508.	Have you heard about a test called PAP Smear (a test that takes a sample of cells from the cervix, or opening of the uterus to detect cancer)? **(Eski oune déjà tander lor sa test ki appêle PAP Smear (li éne test kot prend éne échantillon de banne cellules de cervix ou l'ouverture de l'utérus pou détecter cancer)?)**	Yes ..... 1 No ..... 2 Don't know 3	**RB** 514
509.	How did you hear/read about the test for the **first** time? **(Couma òu finne tander ou lire lor sa test là pou la prémière fois?)** **(ONE ANSWER ONLY)**	Private doctor ..... 1 Government Health Centre Personnel 2 Action Familiale ..... 3 Husband/Partner ..... 4 Other Family Member/Relative..... 5 Friend ..... 6 Colleague..... 7 Newspapers, radio or TV ..... 8 Books, magazines or brochures ..... 9 MFPWA ..... 10 Private Clinic ..... 11 Pharmacy/Pharmacist ..... 12 Internet/Social media ..... 13 Other: _____ 14 **(SPECIFY)**	**IB** 510

☞ **IB** 510	☞ **CHECK Q202 (EVER HAD SEXUAL INTERCOURSE):** **► IF Q202=1 GO TO Q510** **►IF Q202=2 THEN GO TO RB 514**		
510.	Have you ever had a PAP Smear test? **(Eski òu fine déjà faire test PAP Smear?)**	Yes ..... 1 No 2	→ 513
511.	When did you have the test done? **(Kan oune faire sa test là?)**	Within the last year (≤1 year) ..... 1 More than1 year, up to 2 years ..... 2 More than 2 years, up to 3 years ..... 3 More than 3 years ago (>3 years)..... 4 Don't remember 98	
512.	Where? **(Ki coté?)**	Government hospital ..... 1 Government mobile clinic ..... 2 MFPWA clinic ..... 3 Private clinic/Doctor ..... 4 Other: _____ 5 **(SPECIFY)**	**RB** 514
513.	What is the main reason you have never had a PAP smear? **(Pou ki pli grand raison ki jamais òu panne faire sa test là?)** **(ONE ANSWER ONLY)**	Doctor has not recommended it ..... 1 I am healthy and has no gynaecologic problems ..... 2 Does not feel test is necessary ..... 3 Does not have time to go for a test ..... 4 Never thought of it ..... 5 Is afraid of the results ..... 6 Is afraid it could be painful ..... 7 Too embarrassed to get the test or a pelvic exam. ..... 8 Cost ..... 9 Has no partner/ Not sexually active ..... 10 Other: _____ 11 **(SPECIFY)** Don't know ..... 98 Refuse to answer 99	**RB** 514

RB 514	☞ *Now, I have some questions about pregnancy and abortion:*		
514.	Do you think that a woman **always** has the right to decide about her pregnancy, including whether or not to have an abortion? **(Eski òu penser ki éne madame éna toujours droit pou decide lor so grossesse y compris lor faire éne avortement ou pas?**	Yes ..... 1 No 2	

515. Under which of the following conditions is it alright for a woman to have an abortion? **(Dan ki conditions li correk pou éne madame faire éne avortement?)**

(► READ A - H)

	YES	NO	DEPENDS	DON'T KNOW
A. Her life is endangered by the pregnancy **(So la vie en danger par sa grossese là)**	1	2	3	8
B. The foetus has a deformity **(Malformation de so baba dan ventre)**	1	2	3	8
C. The pregnancy has resulted from incest **(So grossese li suite à éne incest)**	1	2	3	8
D. The pregnancy has resulted from rape **(So grossese li suite à éne viole)**	1	2	3	8
E. Her health is endangered by the pregnancy **(So la santé en danger par sa grossese là)**	1	2	3	8
F. She is unmarried **(Li pas marié)**	1	2	3	8
G. The couple cannot afford to have (another) child **(Couple là péna les moyen pou éne (lot) zenfan)**	1	2	3	8
H. Couple desire no (more) children **(Couple là pas lé éne (encore) zenfan)**	1	2	3	8

516.	If a woman had an unwanted pregnancy, what should she do? **(Si éne madame énan éne grossesse ki li pa oulé, ki li bisin faire?)** **(► READ OPTIONS 1-3)** ⚠ **1. Gagne zenfan là ek garde li 2. Gagne zenfan là ek donne li pou adoption 3. Faire éne avortement**	Have the baby and keep it ..... 1 Have the baby and give it up for adoption ..... 2 Have an abortion ..... 3 Don't know 4	**RB** 517
☞ **RB 517**	*Now, I have some questions about smoking:*		

517.	Have you ever tried cigarette smoking, even one or two puffs? **(Eski òu fine déjà fume cigarette, même éne ou deux bouffée?)**	Yes ..... 1 No 2	→ **RB** 525
518.	How old were you when you smoked a cigarette for the first time? **(Ki l'age òu ti éna kan òu ti fumer pou la prémiére fois?)**	☐☐ **COMPLETED YEARS** **IF DON'T REMEMBER, RECORD '88'** **IF REFUSES TO ANSWER, RECORD '99'**	
519.	Are you still smoking? **(Eski òu encore pé fumer actuellement?)**	Yes ..... 1 No 2	→ **RB** 525
520.	How often do you smoke? **(Combien fois òu fumer?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Very rarely 5	→ 521 → 522 → 522 → 522 → **RB** 525
521.	On average, how many cigarettes do you smoke **each day**? **(En moyenne, combien cigarettes òu pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	→ 523 → 523
522.	On the days that you do smoke, how many cigarettes do you usually smoke on average **per day?** **(Banne jours ki òu pé fumer, combien cigarettes en moyenne òu pé fumer par jour?)**	☐☐ **CIGARETTES PER DAY** ☐☐ **IF DON'T REMEMBER/ REFUSES TO ANSWER, RECORD '98'**	
523.	Would you like to stop smoking? **(Eski òu envie arrête fumer?)**	Yes ..... 1 No ..... 2 Refuse to answer 3	
524.	Do you know a place where you can seek advice or treatment for helping you to stop smoking? **(Eski òu conne éne l'endroit cotte òu capave gagne conseil ou traitement pou aide òu arrête fumer?)**	Yes ..... 1 No 2	**RB** 525

☞ **RB** 525	☞ *Now, I have some questions about drinking alcohol:*		
525.	How often do you take alcohol? **(Combien fois òu prend l'alcol?)**	Daily/ Almost daily ..... 1 3-5 times per week ..... 2 Once or twice per week ..... 3 Once or twice per month ..... 4 Never/almost never 5	→ 526 → 527 → 527 → 527 → **RB** 529
526.	On average, how many drinks are you having each day? **(En moyenne, combien verres òu pé prend par jour?)** **►NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	→ 528 → 528
527.	On the days that you are taking alcohol, on average, how many drinks are you having **per day**? **(Banne jours ki òu pé prend l'alcol, en moyenne combien verres òu pé prend par jour?)** **►NOTE: WE COUNT A DRINK AS 1 CAN OF BEER OR 1 GLASS OF WINE OR 1 SHOT OF LIQUOR OR 1 SHOT OF WHISKY OR ONE SHOT OF RHUM.**	☐☐ **DRINKS PER DAY** ☐☐ **IF REFUSES TO ANSWER, RECORD '98'**	
528.	With whom do you **usually** drink alcohol? **(Avek ki sanne là òu habituer boire l'alcol?)** **(ONE ANSWER ONLY)**	With my husband/partner .....1 With other family member(s)/relative(s)...2 With person(s) I just meet .....3 With my friend(s) .....4 With colleague(s).....5 I usually drink alone.....6 Other: _____ 7 **(SPECIFY)**	**RB** 529

☞ RB 529	☞ *Now, I have questions about some medical conditions that you may have*		
529.	Have you ever been medically diagnosed for diabetes? **(Eski ine déjà dire òu ki òu diabétique kan oune faire un test médicale?)**	Yes ..... 1 No 2	→ 532
530.	How old were you when you were first medically diagnosed for diabetes? **(Ki l'age òu ti éna kan premier fois ine découvert medicallement ki òu diabétique?)**	☐☐ **COMPLETED YEARS** **IF DON'T REMEMBER, RECORD '98'**	
531.	Where are you following treatment? **(Ki côté òu pé suivre traitement?)** **(MULTIPLE ANSWERS)** **►NOTE: IF RESPONDENT GIVES ONLY ONE ANSWER THEN PROBE TO FIND OUT IF SHE IS FOLLOWING TREATMENT AT OTHER PLACES AS WELL.**	A.Government Hospital/Health Centre .....1 B.Private clinic ..... 2 C.Private doctor office ..... 3 D.Ayurvedic doctor office..... 4 E.Treatment recommended by pharmacist..... 5 F.Natural remedies .....6 G.Other: _____ 7 **(SPECIFY)** H.Not following any treatment 8	
532.	Have you ever been medically diagnosed for high blood pressure? **(Eski finne déjà dépister médicalement ki òu énan tension fort?)**	Yes .....1 No 2	→ **RB** 535
533.	How old were you when you were first medically diagnosed for high blood pressure? **(Ki l'age òu ti éna quand premier fois ti dépister médicalement ki òu énan tension fort?)**	☐☐ **COMPLETED YEARS** **IF DON'T REMEMBER, RECORD '98'**	
534.	Where are you following treatment? **(Ki côté òu pé suivre traitement?)** **(MULTIPLE ANSWERS)** **►NOTE: IF RESPONDENT GIVES ONLY ONE ANSWER THEN PROBE TO FIND OUT IF SHE IS FOLLOWING TREATMENT AT OTHER PLACES AS WELL.**	A.Government Hospital/Health Centre .....1 B.Private clinic ..... 2 C.Private doctor office ..... 3 D.Ayurvedic doctor office..... 4 E.Treatment recommended by pharmacist..... 5 F.Natural remedies ..... 6 G.Other: _____ 7 **(SPECIFY)** H.Not following any treatment 8	**RB** 535

☞ **RB 535**	☞ *Now I have some questions about breast self-examination:*		
535.	Have you ever heard of breast self-examination where a woman examines her breasts herself to detect if there are any problems or changes in her breasts? **(Eski oune déjà tander lor éne examen cotte éne madame li même li examine so seins pou detecter si éna probleme ou changement dans so seins ?)**	Yes ..... 1 No 2	→ 600
536.	How did you hear or read about this examination **for the first time?** **(Couma oune tander ou lire lor sa examen là pou la prémière fois?)** **(ONE ANSWER ONLY)**	Private Doctor ..... 1 Government Health Centre Personnel 2 Husband/Partner ..... 3 Other Family Member/Relative ..... 4 Friend ..... 5 Colleague..... 6 Newspapers, radio or TV ..... 7 Books, magazines or brochures ..... 8 MFPWA ..... 9 Private Doctor ..... 10 Internet/Social media ..... 11 Other: _____ 12 **(SPECIFY)**	
537.	How is it done? **(Comment faire sa examen là?)**	One finger ..... 1 Three fingers and the palm ..... 2 Anyhow ..... 3 Don't know..... 4 Other: _____ 5 **(SPECIFY)**	
538.	Do you carry out this examination? **(Eski ki òu faire sa examen là?)**	Yes ..... 1 No 2	→ 541

539.	How often do you do it, on average? **(En moyenne, combien fois òu faire li?)**	Daily ..... 1 Weekly..... 2 Monthly ..... 3 Once per year ..... 4 Other: _____ 5 **(SPECIFY)**	
540.	When? **(Quand?)**	Before menses ..... 1 During menses ..... 2 After menses ..... 3 Anytime 4	Go to 600
541.	**What is the most important reason** that you have you not carried out this examination? **(Pou ki pli grand raison ki òu panne faire sa examen là?)** **(ONE ANSWER ONLY)**	I don't know how to do it..... 1 I don't think it is important ..... 2 I don't believe in the efficacy of the test ..... 3 I don't have any symptom ..... 4 I am scared of being diagnosed with breast cancer ..... 5 Other: _____ 6 **(SPECIFY)**	Go to 600

SECTION 6: HIV/AIDS

☞NOTE: THIS SECTION APPLIES TO ALL RESPONDENTS

600.	Have you ever heard of an illness called HIV/AIDS? **(Eski òu finne déjà tanne parler éne maladie ki appelle VIH/SIDA?)**	Yes ..... 1 No **(Thank the respondent and end the interview and write the time it ended at the end of the questionnaire)**..... 2	
601.	Do you know where you can get an HIV test done? **(Eski òu conner ki côté òu capave faire éne test SIDA?)**	Yes ..... 1 No 2	→603
602.	Where? **(Ki côté?)** **(MULTIPLE ANSWERS)**	A. Government Hospital ..... 1 B. Government Health Centre ..... 2 C. Private Clinic ..... 3 D. Private Doctor ..... 4 E. PILS (NGO) ..... 5 F. Mobile Clinic ..... 6 F. Private Lab ..... 7 G. Other: _____ **(SPECIFY)**	
603.	Is there anything a person can do to avoid getting HIV/AIDS? **(Eski ène dimoune capave faire kitchose pou évite gagne HIV/SIDA?)**	Yes ..... 1 No ..... 2 Don't know 3	→605 →605

604. What can a person do?
(Ki dimoune là capave faire?)
RECORD ALL POSSIBLE RESPONSES

	MENTIONED	NOT MENTIONED
A. Use condoms	1	2
B. Abstain from sex	1	2
C. Have only one partner/stay faithful to one partner	1	2
D. Limit number of sexual partners	1	2
E. Avoid sex with sex workers	1	2
F. Avoid sex with persons who have many partners	1	2
G. Avoid sex with bisexuals	1	2
H. Avoid blood transfusions	1	2
I. Ask partner to get blood tested for AIDS	1	2
J. Avoid injections	1	2
K. Do not share razors/blades, needles or syringes	1	2
L. Avoid sex with persons who inject drugs intravenously	1	2
M. Avoid mosquito bites	1	2
N. Other: _____ **(SPECIFY)**	1	2

605.

☞ *Now I am going to talk about the ways HIV/AIDS can be transmitted:*
(Astere nou alle lor banne façon ki VIH/SIDA transmette:)

First tell me any of the ways you know HIV/AIDS can be transmitted.

(Tout d'abord, dire moi banne façon ki òu conné comment VIH/SIDA capave transmette.)

►INSTRUCTIONS TO INTERVIEWER →

FIRST CIRCLE 1 FOR THE ALL WAYS MENTIONED SPONTANEOUSLY IN THE COLUMN A.

THEN READ OUT EACH ROUTE NOT MENTIONED: ASK WHETHER RESPONDENT HEARD OF IT AND CIRCLE EITHER 2 OR 3 IN COLUMN B.

	(A).	(B).	
	SPONTANEOUS	YES	NO
A. Penetrative sexual intercourse	1	2	3
B. Blood transfusion	1	2	3
C. From mother to child	1	2	3
D. Sharing of needles or syringes by drug addicts	1	2	3
E.Sharing food, cups or glasses with a person	1	2	3
F. Mosquito/insect bites	1	2	3
G. Touching or hugging	1	2	3
H. Swimming pools	1	2	3
I. Using toilets	1	2	3
J. Kissing	1	2	3
K. Sharing razors/blades	1	2	3
L. Other: _____ **(SPECIFY)**	1	2	3

606.	According to you, is it possible that a person who looks healthy may have the HIV/AIDS virus? **(D'après òu, eski li possible ki éne dimoune ki paret en bonne santé capave éna VIH/SIDA?)**	Yes ..... 1 No ..... 2 Don't know 3	
607.	Is there any cure for HIV/AIDS? **(Eski éna éne guerison pour VIH/SIDA?)**	Yes ..... 1 No ..... 2 Don't know 3	
608.	Are there any special drugs that a medical health provider can give to a woman infected with the HIV/AIDS virus to reduce the risk of transmission to the baby? **(Eski éna éne medicament spéciale ki éne personnel médical capave donne éne madame ki infectée avek VIH/SIDA pou diminuer risque transmission virus là à so baba?)**	Yes ..... 1 No ..... 2 Don't know 3	
609.	Can the virus that causes AIDS be transmitted from a mother to her baby: **(Eski virus ki cause SIDA capave transmette par un mama à so ti baba:)** **(► READ OPTIONS)** A.During pregnancy? **(Pendant grossesse?)** B.During delivery? **(Pendant accouchement?)** C.During breastfeeding? **(Pendant allaitement?)**	YES NO DK A. Pregnancy…… 1 2 8 B. Delivery …… 1 2 8 C. Breastfeeding ……. 1 2 8	
610.	If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household? **(Si éne membre de òu famille tombe malade avek SIDA, eski òu disposer soigne li dans òu lacaze?)**	Yes ..... 1 No ..... 2 Don't know 3	

611.	If you knew that a shopkeeper or a food vendor has AIDS, would you buy groceries or food from him or her? **(Si òu conner ki éne boutiquier ou éne marchand ki vende manger éna SIDA, eski òu pou faire òu commission ou achête manger ar li?)**	Yes ..... 1 No ..... 2 Don't know 3	
612.	If a teacher has the AIDS virus but is not sick, should the teacher be allowed to continue teaching in school? **(Si éne professeur éna virus SIDA mais li pas malade, eski bisin laisse li continuer enseigner dan l'école?)**	Yes ..... 1 No ..... 2 Don't know 3	
613.	If a member of your family has AIDS, would you want it to remain a secret? **(Si éne membre òu famille éna SIDA, eski òu pou envie garde so maladie éne secret?)**	Yes ..... 1 No ..... 2 Don't know 3	

THANK THE RESPONDENT FOR GIVING HER TIME AND RECORD THE TIME THE INTERVIEW ENDED:

TIME INTERVIEW ENDED _____:_____

APPENDIX 2: Field Staff, Data Manager and Data Entry Clerks

ISLAND OF MAURITIUS

Supervisor

Mrs. SOOKUN B. Fawziah
Mrs. VARSALLY Shafinaz
Mrs. JOYSURY Mala
Mrs. SAMY Kaleyvani

Interviewer

Mrs. JUGROOP Indu
Mrs. JUNKEESAW- SEETUL Viswanee
Mrs. SEETUL Bhumika
Mrs. DOOKHIT Sarita
Mrs. SOMUN Wendy
Mrs. GUREEBOO Farzanah
Mrs. SEEGOOLAM Priya
Ms. RAMHOTA Oumah Devi
Mrs. CHUNDUNSING Marie Nadine
Mrs. CALISTE Marie Christina
Mrs. DOOKHY Jayshree
Mrs. BEELONTALLY Housnah Bibi
Mrs. LACHINIGADOO Cindy
Ms SOOGUND Saamiyah Bibi
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Mrs BIKHOO Goonabai
Mrs VARSALLY Mehroon Beebee
Mrs MARDAMOOTOO Pourvedi
Mrs MUNISAMY Emavadee
Mrs. KISHNAH Surekha
Mrs. VENKATACHELLUM Hema Devi Arnasalon
Mrs POKHUN Sarda
Mrs. JOYPAUL Malika Devi
Mrs. LUCHMUN Deenita
Ms. JHOOMUCK Jayantee.

Mrs. RAMJUS Bhavna
Ms. TAUCOOR Suraya
Mrs. JUGESSUR Simladevi
Mrs. JEETUN Lakranee
Mrs. LALLMOHAMED Noorjahan
Mrs. GOOMANNY Bhaukauraly Abida
Mrs. TEELUCK Geraldine Charnier
Mrs. CODABUX Hanna Bibi
Mrs. JATOOA Geeta Anjalee
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Mrs. AUGNOO Krishnawtee
Ms LUCKUNSING Sanjwantee
Mrs. BHUNJUN Chandrowtee
Ms. CHINIEN-CHETTY Vijayambal
Mrs. COSSAR Autar Pratima
Mrs. DWARKA Saloni Devi
Mrs. UNUTH Veedulah
Mrs BISSOONDEEAL Soomawtee
Mrs. PURUSRAM Vashnibye
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Mrs. CHOTHI Govindan Chanda
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ISLAND OF RODRIGUES

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Ms. PERRINE Jane Diana
Mrs. BOUTON Aishah Azad
Mrs. RAVINA Marie Joanita
Ms. FELICITE Marie Primerose
Mrs. NEMOURS Patricia

Mrs. HENRIETTE Anette Steddy

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Mrs. WATERSTONE Marie Marlene

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Mrs. MEUNIER Marie Noelle

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Mrs. BEGUE Marie Rose Daniella

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