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Memorandum

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From
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Subject
Foreign Trip Report (AID/RSSA): Mali, July 31-August 11, 1981

To
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Director, Centers for Disease Control (CDC)
Through: Horace G. Ogden
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SUMMARY

Following a visit made by Jay Friedman to Mali in November 1980 (see Foreign Trip Report, February 24, 1981), the Family Planning Evaluation Division (FPED) was requested by USAID/Bamako and the Ministry of Health and Social Affairs of Mali, to evaluate family planning services in Mali and to conduct a study to measure the complications resulting from hospitalized incomplete abortions. Both activities were implemented in collabortion with Ms. Nadine Burton of the International Fertility Research Program (IFRP), Research Triangle Park, North Carolina.

From December 1980 through mid-February 1981, Dr. Dalmat, Mr. Friedman, and Ms. Burton planned the evaluation and developed preliminary data collection instruments based on guidelines provided by Malian counterparts. Dr. Binkin, Mr. Friedman, and Ms. Burton prepared for the abortion monitoring study. Both study protocols were reviewed and modified with Malian counterparts during the first part of the February 26-March 25, 1981 trip (see Foreign Trip Report, May 14, 1981). Data were collected, and preliminary findings and recommendations of the evaluation of family planning services were presented to officials of the Ministry of Health and Social Affairs during the remainder of the trip. Monitoring of abortion complications and administrative support procedures were also initiated during this trip.

As part of the evaluation, Michael Dalmat completed the computer analysis of record review forms and the development of statistical tables at CDC from April through June 1981, with the assistance of the Statistical Services Branch of FPED--most notably Wick Warren and Martha Cowart. The analysis of

these forms provided the basis for establishing profiles of users of family planning services and determining the mix of contraceptive methods used and the number of active users at four points in time during the study period, January 1, 1979-February 28, 1981.

After an PPED review of the findings, Michael Dalmat and Nadine Burton returned to Mali (July 27-August 11, 1981) for further consultation in interpreting the data and preparing program recommendations. Officials of the Ministry of Health and Social Affairs committed to establishing priorities among the three types of recommendations presented during the final presentation (August 8, 1981): (1) activities and program changes that are intended to improve the services provided to current users of family planning services, (2) new program developments that would result in providing services to new users in communities already served as well as in communities not presently served, (3) research activities that are intended to provide input into the formulation of national policies related to family planning, as well as program-specific policies and plans. The Malian officials also agreed to develop a preliminary timetable for the implementation of program recommendation prior to December 1981 when the CDC/IFRP team has been invited to return to Mali.

The most important recommendations made by the evaluation team include the following:

1. Prior to extending the availability of family planning services to maternity-MCH centers that do (do not) currently offer them either through outreach activities or by other means, it is essential that the Family Health Division regionalize the management of its program and complete the staffing of key positions.

2. As part of regionalized management, a logistics system, a methodology for technical supervision and continuing staff development, a program for improved user information, education, and communication, and an approach to continuous monitoring/evaluation/program development need to be developed and implemented.

3. The Malian Association for the Promotion and Protection of the Family (AMPPF), an International Planned Parenthood Federation (IPPF) affiliate, should continue to provide family planning services through its three urban centers.

4. Malians at the policy and program level should be exposed to what has been accomplished by other francophone, Islamic African countries in providing child-spacing services within the context of MCH services. A study visit of Malians to Tunisia, for example, would be the most effective means of accomplishing this objective.

5. Once the Malians have developed their set of priorities and a preliminary timetable for their implementation, a coordinated strategy should be developed by USAID/Mali and the centrally-funded AID intermediaries to support Malian initiatives.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Bamako, Mali, July 31-August 11, 1981, at the request of USAID/Mali, DS/POP/FPSD, and the Ministry of Public Health and Social Affairs of Mali (MOPHSA) provided followup consultation to MOHSA in interpreting the results of the Malian family planning evaluation and in developing program recommendations. This consultation was provided after a 2-day consultation with William Bair, Population Officer, Regional Economic Development Services Office (REDSO)/West Africa in Abidjan, Ivory Coast, to discuss current and potential CDC and IFRP activities in West Africa as well as the preparation and distribution of the book, Contraceptive Technology (African edition). (see separate Foreign Trip Report, July 30-August 29, 1981.) Following the Malian consultation, Dr. Dalmat met in Tunisia, Kenya, Nigeria, and England, with 4 of the 5 African co-authors of Contraceptive Technology (African edition), to review their final critiques of the manuscript. During these visits, Dr. Dalmat also discussed the distribution of the book with the authors, officials from the Governments of Tunisia and Kenya, and AID representatives (see separate Foreign Trip Report, July 30-August 29, 1981; Contraceptive Technology). Travel was performed in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population/AID/Washington and CDC/CHPE/FPED.

II. PRINCIPAL CONTACTS

A. USAID/Mali
Mr. Thomas Park, Health, Nutrition, and Population Adviser

B. Ministry of Public Health and Social Affairs (MOPHSA)
Mr. Mamadou N. Traore, Director of Planning
Dr. S. Konate, Deputy Director of Planning
Dr. Liliane Barry, Chief, Division of Family Health
Mme. Sira Dembele, Planning Division
Dr. Mamadou Lamine Traore, Surgeon, Point G. Hospital
Mme. Fatimata Keita, Chief Midwife, Institute National de Prevoyance Sociale

C. Association Malienne Pour la Promotion et la Protection de la Famille (IPPF Affiliate)
Mr. Abdoul Tounkara, Research and Evaluation Officer

III. EVALUATION OF FAMILY PLANNING SERVICES IN MALI

A. Introduction
As a followup to a visit made to Bamako by Mr. Jay Friedman of CDC in November 1980, the MOPSHA expressed the desire to evaluate family planning services and to conduct a study of hospitalized cases of complications resulting from incomplete abortions in Mali (see Trip Report dated February 24, 1980). The IFRP and the CDC were asked to collaborate with the MOPSHA in implementing these activities.

Previously, the IFRP had collaborated with the MOPHSA in implementing a Maternity Care Monitoring Study at the Hamdallaye Maternity Clinic, which is

located in the suburbs of Bamako. Similarly, the CDC had previously assisted the MOPHSA in its smallpox-measles vaccination campaigns. In the framework of a collaborative agreement established between the three organizations, two research activities were initially planned: a study to evaluate family planning services in Mali, which have been provided since 1972, and a study of complications of hospitalized abortions in Mali with the aim of assessing their sociomedical cost to Malian society.

The second activity is being implemented and will be the subject of a special report after the study has been completed. The first activity has been completed, and this report includes the findings of the evaluation of family planning services. Data were collected during the period, February 26-March 25, 1981 (see Trip Report dated May 14, 1981). Findings were presented to the MOPSHA during this TDY in Mali.

B. Study Objectives

The Division of Family Health (DFH), MOPHSA, receives support from the UNFPA to strengthen MCH services which are provided in 56 maternity-MCH centers. This program is in its fourth year, and the MOPHSA plans to use the results of this evaluation to: (1) assess what can be done to improve family planning services, which are currently offered in the maternity-MCH centers; (2) determine how and at what pace family planning services can be introduced in the 22 maternity-MCH centers which are not yet participating in the child-spacing program; (3) assess the needs for technical assistance, training, and other resources for the implementation of the two points mentioned above; (4) prepare a proposal for continued UNFPA funding and explore other sources of complementary assistance.

USAID/Mali intends to use this evaluation as one of several inputs into the development of an MCH/family planning support strategy. Further, this evaluation has provided an open forum for rethinking the role of the Malian Family Planning Association (AMPPF) as it relates to the DSF and its role in family planning in general.

C. Methodology

1. Development of the Study Plan

On the basis of preliminary agreements established between the MOH and Mr. Friedman during his November 1980 visit to Mali, the evaluation was to address the following points:

The quality and completeness of quantitative reports and statistical data generated by family planning service activities;

The number of continuing active users by method, continuation rates, and reasons for discontinuation;

The age groups and social classes served (and whether there are unmet needs among them);

Extension of the geographic coverage of the program;

Expansion of the services provided by the program, including research on the causes of infertility and its treatment and the unmet needs for sterilization services;

The impact of social, cultural, administrative, and logistical constraints on program operations;

Clinic and central planning and management needs;

Training needs of staff providing family planning services;

Ongoing evaluation and research activities by DSF and AMPPF staff;

The provision of family planning services for the next 5 years.

In preparation for the evaluation, we developed a detailed outline of study questions, the practical uses of the information to be collected in answering the questions, and the instruments for collecting the data. The proposed study questions focused on four areas of investigation:

Services offered and users of services;
Factors effecting efficient delivery of services;
Quality of care;
Availability and utilization of other MCH services complementary to family planning.

The data required to answer the study questions were collected through the use of five data collection instruments and procedures: (1) Review of family planning user records; (2) review of monthly reports; (3) logistics review; (4) staff interviews; and (5) interviews with users of maternity-MCH facilities.

2. Data Collection

a) Composition of the Evaluation Team

Dr. Liliane Barry, DFH, MOPHSA
Ms. Jasmine Abel, DFH, MOPHSA
Mr. Abdoul Tounkare, AMPPF
Ms. Sira Dembele, Planning Division, MOPHSA
Mr. Lassana Siby, Planning Division, MOPHSA
Mr. Jay Friedman, CDC
Dr. Michael Dalmat, CDC
Ms. Nadine Burton, IFRP

Before starting the field work, the evaluation team met in Bamako to review and revise the proposed study plan and the data collection instruments. Necessary modifications were made at this time. The team then proceeded to select the study centers to be evaluated, and a pretest was conducted at the maternity-MCH center in Badalabougou to assess the validity of the data collection instruments and to train the members of the evaluation team in their use. The pretest was followed by the revision and finalization of the questionnaires which were then reproduced, after which the field work began.

b) Selection of Study Centers

Our Malian collaborators indicated to us that 21 of the 56 maternity-MCH centers operating in Mali currently offer family planning services. Eight additional centers will soon offer family planning services, and five centers offer services based on their own initiative but under the supervision of the DSF. The remaining 22 centers do not yet participate in the Malian child-spacing program.

The AMPPF offers family planning services in its Centre Pilote located in Bamako as well as in its Segou and Baguinda centers. Originally, we proposed to evaluate eight centers: four reputed to provide good services and four known to operate poorly. We wanted to identify the factors that might explain the differences between these two groups of centers. Our Malian counterparts, however, preferred not to prejudge the performance of the centers. The selection of evaluation centers suggested by our counterparts was made so as to include centers which were offering family planning services at four levels of the health system of Mali:

Bamako:	PMI Centrale Centre Pilote
Regional Capital:	Koulikoro Segou Hospital
Cercle (District) Headquarters:	Niono Kolokani PMI Famory
Arrondissement (subdistrict) Headquarters:	Baguinda Fana Mana Katibougou

Each center was visited by a team of three or four persons who collected the data during a single visit which lasted several hours, using the five data collection instruments.

c) Issues studied through the Use of Each Data Collection Instrument (See Figure 1 on next page).

FIGURE 1

Study Issues Investigated Through the
Use of Each Data Collection Instrument

Review of Family Planning User Records

1. Social and economic characteristics and pregnancy outcome of users by method.
2. Method changes.
3. Current status of method use.
4. Apparent presence of contraindications to methods used.
5. Apparent thoroughness of client screening.

Review of Monthly Reports

1. Consistency of reporting.
2. Seasonal variation in user levels: prenatal, postnatal, and family planning consultations.

Logistics Review

1. Average consumption of supplies by method over a 6-month period.
2. Number of months supply on hand by method.
3. Physical inventory.
4. Consistency of physical inventory with last month's report.
5. Lead time required to receive new shipment of supplies from time of requisition.
6. Mechanism that triggers a request for resupply.
7. Occurrence of stockouts within last 6 months.
8. Status of storage facility.

Staff Interview

1. Training and experience in family health services and family planning.
2. Competing responsibilities of staff providing family planning.
3. Extent and nature of outreach.
4. Frequency and type of technical supervision.
5. Access to continuing education opportunities.
6. Ability to communicate in local languages.
7. Periods of greatest and least activity in the center.
8. Work schedule in the center.
9. Services or activities that are needed but not offered at present and the availability of time to carry them out.
10. Availability of external resources.
11. Procedures and norms with respect to family planning services:
    - number of cycles of pills provided during first and subsequent visits;
    - availability of family planning services throughout the work-week.
12. Availability of nutrition (breastfeeding, weaning, supplementation) and STD prevention education to clients.
13. Availability of iron and folic acid tablets for women of reproductive age.
14. Demand for sterilization.
15. Technical knowledge:
    - contraindications and secondary effects of the pill and IUD;
    - symptoms, treatment, and referral of PID.
16. Availability and status of equipment.

Client Interviews

1. Present or former use of family planning services.
2. Perception of waiting period to receive services.
3. Distance from residence to center and travel time and cost.

d) Study Period

The study period chosen for all centers was January 1, 1979 through February 28, 1981. The January start date was chosen in order to leave a period of 6 months between mid-year 1978 when the maternity-MCH centers began providing family planning services and the study period to allow for the accumulation of a user case load. As the AMPPF Centers have been providing family planning services since as early as 1972, the January 1979 start date is somewhat arbitrary but does provide for consistency in the study period for all study centers.

e) Study Procedures

Review of Family Planning User Records

Samples, ranging from 10 percent of user records in the case of large centers, to 100 percent in the case of small centers, were systematically drawn from the files of study centers after taking a random start.

In all Ministry maternity-MCH centers, family planning user records are organized alphabetically by the last name of the user. In the largest of these centers that was studied, serving 51 percent of all users from the maternity-MCH centers studied, the records of inactive users have been weeded out at least once and kept separately from the records of women presumed to be active. In this center, we selected every "kth" record from among the "active" records.

In AMPPF centers studied, records are not separated according to the status of the client. In these centers, we drew every "kth" record from among all available records. All AMPPF centers file user records chronologically by the month and year of the user's first visit. In the largest center, serving 90 percent of all AMPPF users, records were drawn using the every "kth" approach from among the January 1979-February 1981 records. However, in the two other AMPPF centers, the number of records available was so small that every "kth" record was drawn from all records, independent of the date of first visit.

Review of Monthly Service Statistics Reports

Monthly reports were reviewed for 3 months for both 1979 and 1980 to explore possible seasonal variations in new acceptor admissions and/or revisits by continuing users. A rainy season month, a dry, cool winter month, and the Muslim holy month of Ramadan were selected as follows:

	1979	1980
Rainy season	August	July
Ramadan	July	August
Dry, cool winter	December	December

Because transportation is most difficult during the rainy season, and women are busy preparing meals and making special arrangements during Ramadan, we anticipated lower user levels during these months than in December, which offers the best conditions for travel and activities away from the home.

Logistics Review

The logistics data were studied in most centers using the most recent 6 month period in which all 6 monthly reports were available. Therefore, the period

under investigation varied from center to center within the last 14 months. Results from inventories were compared with stock levels reported in the January or February 1981 monthly report. Questioning pertaining to stockouts was limited to the 6 months that immediately preceded the evaluation.

Staff Interviews

In each center, a head midwife is responsible for family planning services. She was interviewed using a "Staff Interview" questionnaire. In addition, a second, and in a few cases a third person, were also interviewed. These persons were nurses and midwives who assist the head midwives in providing services, or the physicians responsible for supervising their work.

User Interviews

In the few centers where many users were present at the time of the evaluation, women were selected systematically after taking a random start. In several centers, very few (if any) family planning users were present, so the evaluation team members interviewed any woman who came to the center during the field visit.

D. Results

1. Analysis of Individual User Records

This section summarizes the results obtained through the analysis of the family planning user records and interviews, as well as from information contained in monthly service statistics reports. It should be noted that the user records are an invaluable source of information, are well designed, and require only minor formatting modifications.

The profile of persons who use family planning services was obtained through the analysis of family planning users records.

Who uses family planning services?

We estimate that approximately 0.2 percent of women between the ages of 15 and 44 use a modern method of contraception in Mali at the present time. This figure does not take into account the private sector (Pharmacie Populaire, private consultations, and the dispensaries or large organizations).

The Centre Pilote serves 63 percent of the users included in this study. Due to this high proportion of users in this one clinic, we have grouped the users accordingly for the analysis of the family planning user records:

PMI Centrale (a DSF maternity-MCH center)
Other PMI Centers (other DSF maternity-MCH centers)
Centre Pilote (an AMPPF center)
Other AMPPF Centers

During the study period, we found that there were records available for 468 women from the PMI Centrale, 445 women from "Other PMI Centers," 4,652 women from Centre Pilote, and 538 women from "Other AMPPF Centers," for a total of 6,103 women.

From 1972 to January 1979, an additional 4,852 women had utilized the family planning services of the Centre Pilote. However, since these dates precede the study period, these women's records were not examined as part of the study.

In addition, we estimate that 400 to 600 women used the family planning services offered at PMI centers that are not included in this study. In summary, approximately 11,600 women have used the family planning services offered by the PMI and AMPPF centers at some time or another since 1972. Below, we compare the major characteristics of users of family planning services according to the four groups previously described. Women from the Centre Pilote are, generally speaking, younger than users of other groups. The women from "Other PMI Centers" are the oldest from among the four groups. Seventy-eight percent of users of the Centre Pilote are less than 30 years old; 54 percent are between 20 and 24 years of age. Fifty-three percent of users from "Other PMI Centers" are less than 30 years old, while 49 percent are between 20 and 24 years of age.

It is important to note that 60 percent of users of the Centre Pilote have never been married, while 54 percent of users of "Other AMPPF Centers" and 44 percent of PMI Centrale users have the same profile. Within the group of centers with the highest proportion of users from rural communities, "Other PMI Centers," 22 percent of women had never been married. Seventy-four percent of users of "Other PMI Centers" were married at the moment of the study as compared to 33 percent from the Centre Pilote. It is notable that 42 percent of women who have never been married indicate having 1 or 2 children; 16 percent have three or more, while 42 percent have none.

With the exception of the Centre Pilote where the proportion of monogamous to polygamous marriages is higher (65 percent to 35 percent, respectively), in all centers, the proportion between monogamous and polygamous marriages is roughly equal. Sixty-one percent to 75 percent of women studied were married before the age of 20 (61 percent at the Centre Pilote, 64 percent at PMI Centrale, 76 percent at "Other PMI Centers").

The great majority of users in all centers have attended school: 71 percent, Centre Pilote; 85 percent, "Other AMPPF Centers;" 85 percent, PMI Centrale, and 56 percent, "Other PMI Centers." Forty-four percent of users of "Other PMI Centers" have not attended school while 15 percent of these women have received secondary or superior level education compared to 18 percent at the PMI Centrale, 13 percent at the Centre Pilote, and 18 percent at the "Other AMPPF Centers."

We have determined the socioeconomic status of users through the occupation of the woman herself and/or that of her husband when entered on the form. We grouped the women as follows:

High status: including women and/or their husbands who are government employees and merchants.

Medium status: including women and/or their husbands who are farmers and craftsmen.
Low status: including women and/or their husbands who are factory workers and laborers.

Students and housewives whose husbands' professions were not available were classified separately. Where we were able to group users by socioeconomic status, we observed that 77 percent from the Centre Pilote, 73 percent from the "Other AMPPF Centers," and 83 percent from the PMI Centrale were classified as being of high status. Forty-one percent of users of "Other PMI Centers" were of high status, 39 percent were of medium status, and 20 percent were classified as low status, which represents roughly twice the proportion of low status users found in the three other groups.

Generally speaking, users of all the PMI centers have a higher parity than those of the AMPFF centers. This is not surprising, given the age distribution and the marital status observed in these centers. Twenty-six percent of users at the Centre Pilote and 21 percent of those of "Other AMPPF Centers" have no living children as compared to 7 percent at the PMI Centrale and 15 percent at the "Other PMI Centers." We found that 52 percent and 58 percent of women using the services of the two groups of PMI centers have three or more living children as compared to 34 percent and 15 percent of users of the two groups of AMPPF centers, respectively.

Given that the users of Centre AMPPF have a tendency to be relatively young and of lower parity, it is not surprising to note that 91 percent of users at the Centre Pilote and 84 percent in "Other AMPPF Centers" desire to have more children in comparison to 76 percent of users at PMI Centrale and 67 percent at "Other PMI Centers."

In order to be able to determine which users were still active at the moment of the study, we adopted the following definition. A user was considered active if, at the moment of the study, her individual record form indicated that she still had in hand a supply of the contraceptive method of choice (pill, condom, foam, or jelly). IUD users were considered active for 2-1/2 years after the IUD insertion. Table 1 indicates the distribution of active users by method and by group of centers at the time of the study.

TABLE 1

Contraceptive Method Used by Users of Study Centers at the Time of the Evaluation

	Centre Pilote (%)	Other AMPPF Centers (%)	PMI Centrale (%)	PMI Centers (%)
None	56	79	44	42
Total Active	44	21	56	58
IUD	18	7	17	12
Pills	25	14	39	46
Other	1	0	0	0
TOTAL	100	100	100	100
Number	(500)	(57)	(100)	(131)

This table indicates that PMI Centrale and "Other PMI Centers" have a higher percentage of users still contracepting, but it must be remembered that in these centers inactive files have been sorted out and put in storage at least once. Thus, a valid comparison cannot be made. There are about 1-1/2 times more users of the pill than the IUD from the Centre Pilote and twice as many from the "Other AMPPF Centres" as compared to 3 times as many in the PMI Centres.

In summary, the users of the AMPPF Centers are younger, the majority have never been married, they have fewer living children, and a greater percentage do not want more children as compared to the users of the PMI Centres. Generally speaking, most users of all centers have attended school and are of a high or medium socioeconomic status. The pill is by far the preferred method of contraception in all centers, and the proportion of clients who are actively using a method varies from 21 percent to 58 percent.

What methods of contraception have women been using?

Before their first visit to the Centre Pilote, 53 percent of women had not used any method of contraception. After their first visit, 8 percent have continued without any method of contraception; 65 percent began using the pill; 23 percent had an IUD inserted, and 3 percent began using another method.

At the time of the study, we found that of the 8 percent of women who, after their first visit used no method of contraception, 85 percent continued without a method, while 14 percent adopted one method or another.

For women who began using an IUD after their first visit, 63 percent were still using the IUD at the time of the study while 11 percent switched to the pill. Twenty-six percent of these women were judged to have discontinued utilization of family planning services offered at the center.

Of the 65 percent who were using the pill after their first visit, 33 percent were still using the pill, 2 percent had switched to the IUD, and 65 percent had dropped out by the time of the study. It is not known if these women who gave up contraception chose to become pregnant or whether they decided to obtain family planning services from a pharmacy or a private physician outside of the public program. It may well be that stockouts of contraceptives (i.e., the pill), an event reported by several centers during the 6 months preceding the study, contributed substantially to this discontinuation.

We found that 92 percent of women who were not using any method of contraception before coming to the center elected to adopt a method. However, 58 percent of these women had dropped out of the program by the time of the study.

Five percent of the women included in this study were already using the pill before they came to the center for the first time. Among these, 16 percent dropped out after their first visit and did not resume the use of a method at the time of the study. Sixty-three percent of women who used the pill before they came to the center for the first time were still using it after their first visit. However, of this group, 62 percent had

dropped out by the time of the study. The remaining 21 percent of this group (those who utilized the pill before coming to the center for the first time) switched to the IUD and were still considered to be active users at the time of the study.

In summary, a large number of pill users discontinued its use: 62 percent of those who were using the pill before coming to the center and 65 percent of those who chose the pill after their first visit to the center. In comparison, the percentage discontinuing use of the IUD was extremely low, 26 percent and 0 percent, respectively.

It is noteworthy that the proportion of women who were using the pill and switched to the IUD (2 percent) is considerably lower than the proportion of users of the IUD who switched to the pill (11 percent).

Is there a difference between active users and those who dropped out or who never used contraception?

The profile of these three types of women will allow one to identify the actions that need to be taken in order to encourage nonusers to select a method of contraception and to encourage active users to continue using a method. We observed at the Centrale Pilote, the PMI Centrale, and in "Other PMI Centers," that the IUD was consistently more often used among active users than among those who discontinued contraception.

TABLE 2

Use of IUD and Pill as Percentage of All Active Users and as Percentage of All Discontinued

	Active		Discontinued	
	IUD(%)	Pill(%)	IUD(%)	Pill(%)
Centre Pilote	42	55	5	87
PMI Centrale	38	62	9	88
Other PMI Centers	22	78	2	74

At the Centre Pilote, a slightly higher percentage of active users (30 percent) has three or more living children in comparison with those who dropped out (24 percent) and those who have never used contraception (20 percent). In addition, a slightly higher percentage of active users (13 percent) do not wish to have any more children relative to those who dropped out (7 percent) and those who have never used contraception (4 percent).

At the Centre Pilote, the active users have more living children, have a tendency not to want more children, and are older in comparison with dropouts and women who have never used contraception. In this center, a greater proportion of active users are 30 years of age or older (26 percent) as compared to 19 percent of dropouts and 18 percent of those who have never used contraception.

It appears that a greater proportion of women who have never used contraception have not attended school as compared to the other women: 39

percent of never-users, 28 percent of active users, and 27 percent of those who dropped out.

At the PMI Centrale, a larger percentage of the patient records of active users indicated that they had received a pelvic examination and that their sociomedical history had been completed (61 percent) in comparison to those who dropped out (52 percent).

We also found that active users tend to be older, to have more living children, and to present fewer method contraindications to the method of choice than others. In the "Other PMI Centers," vis-a-vis those users who dropped out, active users have more children (56 percent as compared to 32 percent); they are more likely to want more children (36 percent as compared to 22 percent have three or more children); they are more likely to be older than 30 years of age (56 percent as compared to 40 percent); and are more likely to be of a lower socioeconomic status (23 percent as compared to 7 percent).

Is there a difference between pill users, IUD users, and women who used no method of contraception at the moment of the study?
The last group, women who were not using contraception at the time of the study, includes users who had dropped out and women who have never accepted contraception.

The reason for developing the three profiles of women mentioned above is to establish whether or not the characteristics of users conform to the guidelines provided by the Haitian Government for the use of specific methods. In addition, these user profiles may contribute to identifying those actions needed to increase the percentage of new acceptors who stay with the program.

Only at the Centre Pilote were we able to identify a sufficient number of IUD users to allow us to make a comparison among the three groups. At the PMI Centrale and in "Other PMI Centers," we are only able to compare pill users and women who had never accepted a method of contraception.

At the Centre Pilote, pill users are younger than IUD users and are approximately the same age as women who had not accepted a method of contraception: 87 percent of pill users are less than 30 years of age as compared to 6 percent of IUD users and 80 percent of women who had not accepted a method of contraception.

A higher percentage of pill users (69 percent) has never been married as compared to 4 percent of IUD users and 64 percent of those who had not accepted a method of contraception. Roughly equal proportions of IUD users are monogamous (28 percent) and polygamous (22 percent).

Pill users are more often nulliparous (33 percent) than IUD users (12 percent), but their parity is approximately the same as that of women using no method of contraception (28 percent). A higher percentage of IUD users indicated they do not want any more children (22 percent) in comparison with pill users (4 percent) and women who use no method of contraception (7 percent).

We note that pill users have the same basic profile as women who did not accept a method of contraception. They tend to be younger, less often married, have less children, and are more likely to want more children than IUD users. A possible explanation of this observation is that a large portion of these women were former pill users who subsequently dropped out. At the PMI Centrale and "Other PMI Centers," we also found that the profiles for pill users and women who use no method of contraception are similar.

What percentage of women indicated that they want no more children at the time of their first visit?

A total of 15 percent of women from all study centers have indicated that they do not want to have more children at the time of their first visit: 9 percent at the Centre Pilote, 14 percent at the "Other AMPPF Centers," 24 percent at PMI Centrale, and 33 percent at "Other PMI Centers." Of women who do not want to have more children, 5 percent used no method of contraception, 38 percent used an IUD, 41 percent used the pill, 11 percent used another method, 3 percent had had a tubal ligation performed, and 2 percent gave no response.

If the proportion of 15 percent is representative of the 3,640 women whom we have estimated are active users of modern methods of contraception in Mali, potentially 550 easily identifiable women may be interested in tubal ligation.

It is important to identify the proportion of women who use each method that does not want to have more children in order to find out if the program is effectively serving their wishes, at least theoretically. Eleven percent of women using no method of contraception, 22 percent of those using an IUD, 9 percent of those using the pill, and 90 percent of those using injectables, reported that they did not want to have more children.

Is there a difference between users who travel from 5 to 14 kilometers to receive family planning services at the Centre Pilote and those who live closer to the center?

Based on analysis in other developing countries, we were surprised to observe that 36 percent of women travel 5 to 14 kilometers to receive the services of this center. In order to better understand why this is true and to get an impression of the characteristics of women who are so motivated, we have compared the profile of this group of women to that of women who live closer to the center:

A higher percentage of women who live 5 to 14 kilometers from the center are 30 years of age or older (28 percent) as compared to 15 percent of those who live closer to the center (1-4 km).

A higher percentage of women who live 5 to 14 kilometers from the center are married: 44 percent as compared to 30 percent of those living within a kilometer and 26 percent of those living from 1-4 kilometers from the center.

A higher percentage of these women (5-14 kilometers) have two or more living children: 52 percent as compared with 33 percent of those who

live less than 1 kilometer from the center and 40 percent of those who live 1-4 kilometers from the center.

In addition, a higher percentage of these women have a lower economic status: 15 percent as compared to 8 percent of those who live less than 1 kilometer from the center and 4 percent of those who live 1-4 kilometers from the center.

This profile reminds us of the active users profile, i.e., those who are older, have more living children, and are more likely to be married. These factors seem to be important characteristics of women who are motivated to use contraception as has been the case in other developing countries at the beginning stages of a family planning program.

Since roughly half-a-million women in Mali are 30-44 years old and tend to be multiparous, one can surmise that there is a large number of unserved women who are potentially receptive to family planning services or would make conscientious users. However, what we do not know is how well informed they are about family planning. Taking into account the number of centers that offer family planning services and their locations vis-a-vis the geographic distribution of the population, we can speculate that at present, the vast majority of these women do not have easy access to family planning services.

2. Quality and Management of Family Planning Services

a) Integration with Other Family Health Services

We observed that in general, family planning services are offered in the same building as other family health services. Family planning activities are generally assigned to a midwife who sometimes has an assistant. Through interviewers, we learned that staff members who were not directly responsible for family planning activities were not concerned about it and often expressed their ignorance of the subject.

At the time of the study, we observed that none of the centers studied offered systematic orientation to users or other clients for the prevention of sexually transmitted diseases or sex education. However, in the Katibougou Center, the head midwife had at one time organized educational sessions on these subjects, which she later had to discontinue due to lack of time.

Although we did not systematically inquire about activites related to lactation and nutrition as related to family planning, our conversations with center staff led us to believe that such activities are offered on an ad hoc basis.

Our examination of monthly service statistics reports and our discussions with center staff indicated to us that relative to the number of deliveries handled by maternities, a significant proportion of women come for prenatal care and almost no women come for postnatal care. On the other hand, based on our analysis of the same reports, it is our impression that a significant proportion of infants are seen in PMI centers. We were told by staff members that cross-referencing of users of family planning services and the users of other services is done on an ad hoc basis, and that it is not a customary practice.

In summary, it is our impression that family planning activities are not yet very well integrated with other family health activities. This is confirmed by the fact that many health professionals continue to insist on receiving a salary supplement to offer family planning services despite the stated policy of the Family Health Division opposing this practice.

b) Supervision and Continuing Education of Staff Members

Of the 11 midwives in charge of family planning activities that we interviewed during the course of the evaluation, only three had received any sort of technical supervision. With the exception of their initial training in family planning, none of the midwives had benefited from in-service training programs nor had they been able to maintain ongoing professional contact with colleagues for the purpose of sharing experiences and information.

c) Logistics

The basic tendency observed in all centers, with the exception of the Centre Pilote and the PMI Centrale, is that staff wait until contraceptive stocks fall to a dangerously low level before attempting to obtain new supplies. New supplies are requested through a written request or in person on the part of staff members going to Bamako. The Centrale Pilote and the PMI Centrale receive additional stocks as needed directly from the national stores of AMPPF and DSF, respectively, which are located on the premises of both of these centers. More than half of the centers evaluated reported experiencing a stockout of pills in the 6 months prior to the evaluation.

The storage room at the AMPPF uses the first-in, first-out (FIFO) method of stock management. It is clean, well ventilated, and uses adequate stacking and storage procedures. While being well protected from the rain and adequately ventilated, the Family Health Division's warehouse does not employ standard stacking and storage procedures nor the FIFO method. Use of FIFO is somewhat complicated by the fact that the current supplier of pills does not furnish either the manufacturing or expiration dates. Thus, the clinic would have to add the date of receipt to the cartons as a surrogate for manufacturing or expiration date.

d) Information, Education, and Communication

Information, education, and communication (IEC) services are offered informally to women who come to the centers to receive family planning services. In three centers, the staff have at sometime promoted family planning through community meetings organized by social affairs officials. At centers where we made inquiries, we did not detect an effort by center staff to promote family planning among women seeking prenatal or well-baby services or among those who had just delivered at the maternity center.

IEC activities may be limited because staff are still somewhat technically unsure of themselves. Half were not familiar with 40 percent or more of the contraindications and secondary effects associated with the pill and, particularly, the IUD. The other half were familiar with 80 percent of these conditions. All midwives were aware of 80 percent or more of the basic symptoms of PID.

In order to determine whether time was available to make home visits and to complete outreach activities, we asked midwives if they had the time to implement any new activities that they had previously identified as being

important but we lacking. Over half of the midwives responded affirmatively. According to most midwives, the availability of time was not as important a factor in explaining the absence of home visits and outreach activities as the unavailability of a means of transportation.

Mana is a Protestant Mission center supervised by the Family Health Division. We learned that the nurse-midwife systematically counsels young adults to wait until they have at least one or more children before beginning child-spacing. The de facto policy was to provide family planning services only to multiparous women unless the husband and wife, in the presence of the nurse-midwife, insisted on using contraceptives at an earlier stage. Two of 30 acceptors at Mana had 12 or more pregnancies and were advised by the supervising physician not to have more children. The two women began using contraceptives but, due to stockouts, they ceased use of the pill, became pregnant, and died in childbirth. Sterilization facilities were not accessible, and the nurse-midwife had had bad experiences with the IUD and, therefore, the pill was the only recommended method, although sterilization or the IUD may have been indicated. While the practices at Mana are not representative of the Family Health Division's norms, they do confirm that norms need to be clarified and interpreted through supervision to all midwives providing family planning services.

e) Structure and Staff Responsibilities

At the time of the study, all program direction, administrative and developmental responsibilities, including training, were borne by the director and an assistant. Pressures of daily problem-solving, largely administrative, did not leave sufficient time for the staff to develop a logistics system, to monitor program performance through a review of reports sent in by the PMIs, nor to provide technical supervision or continuing education following initial training. These factors may help to explain the fact that less than half of the PMIs that studied family planning services are providing services to 50 or more active users.

f) Quality of Services

The present policy of the AMPPF and of the Family Health Division is that all family planning users are to receive a pelvic examination before being supplied with a method of contraception. They are supposed to have their blood pressure taken and have their medical histories recorded. The study of individual patient records revealed that in three centers, 80 percent or more of new acceptors did not receive either a gynecologic exam nor a blood pressure reading. In five centers, approximately 40 percent of the medical histories had not been completed.

E. Recommendations

1. Family Health Division

a) The overall recommendation is that family planning activities should be consolidated and strengthened in the near future prior to any significant expansion in the number of distribution points from which family planning services are made available.

b) The Family Health Division needs to be restructured and reinforced.

c) Delegation of authority by the director to other staff members is required in the following functional areas:

Logistics of supplies, materials, and equipment.
Coordination of training.
Execution of IEC activities.
Technical supervision and continuing education.

d) The management of service delivery should be regionalized with respect to:

Supervision.
Restocking and accountability for supplies.
Continuing education.
The channeling of service statistics reports.

e) Central responsibilities should include:

Planning for program development with the benefit of service statistics and internal assessments or evaluations.
Liaison with national and international institutions.
Development of training programs and IEC activities.
Establishment of work standards and technical policies of the DSF.
Coordination of continuing education.
Administration of the staff and resource management.
Coordination of logistics.

f) The following new staff members are required

<u>at the central level:</u>
Assistant Director
Supply Officer

<u>Regionally</u>
Regional and technical supervisors responsible for:
1. technical supervision;
2. continuing education of regional staff in collaboration with the coordinator for training and IEC;
3. local logistics (inventory control, resupply);
4. coordination and promotion of local IEC activities;
5. supervision of the collection of service statistics and the preparation of regional reports; and

A driver for each supervisor.

g) <u>Logistics System</u>
1. A regionalized system for the distribution of family planning materials needs to be established.
2. Once that system is operational, other family health supplies needed by Family Health Division personnel should be integrated into this system.
3. A modified "push" system for resupply is needed.

h) Training activities need to be strengthened

1. Training programs need to be modified or developed to reach all PMI staff members in addition to the initial training of midwives to provide family planning services.
2. Continuing education is needed for midwives who have been trained initially and are currently providing family planning services.
3. A brief intensive training program for community social workers (assistants sociales) is needed in support of promotional activities within the community. Topics might include:

   The relationship between family planning and maternal-child health, and the importance of family planning to all services offered by the Family Health Division;

   The preferred profiles of users by method;
   Contraindications to the use of specific methods;
   Danger signs of specific methods;
   Importance of female barrier contraceptive methods;
   Importance of voluntary sterilization and a referral system;
   Techniques for effective IEC.

4. Regional technical supervisors and the supply officer need to be trained to operate the new logistics system once developed.
5. Regional technical supervisors will need to be trained in concepts and techniques of technical supervision and continuing education that are well adapted to Mali.

i) IEC

1. Staff need to be trained in techniques to motivate active users and to recognize and respond to complaints or side effects to prevent discontinuation.
2. An outreach program should focus on three high risk groups initially:

   Older high parity women;
   Students and other adolescents (sex education);
   Unmarried mothers.

j) The emphasis given to special methods should be reconsidered.

1. Barrier methods should be emphasized in at least three instances:

   For the prevention of PID;
   During the transition period between the use of one method and another;
   In response to personal preferences.

2. Voluntary Sterilization

3. Reevaluation of Injectable Contraceptives in terms of:

   the relative risk associated with its use as compared to maternal mortality;
   the return of fertility after discontinuation;
   complications and side effects;
   method acceptability;
   continuation rates.

   Demonstration projects outside of PMIs should be considered and tested as a complimentary means of providing safe, cost-effective services to people who cannot reach the PMIs or AMPPF centers.

2. AMPPF

   a) Services

      1) The AMPPF should continue providing family services in urban communities and should consider expanding to other cities. This recommendation is supported by the profile of its users: generally younger, more unmarried, and lower parity women than found in maternity-MCH centers.

      2) The AMPPF may want to consider implementing a demonstration project for sex education in schools.

      3) The AMPPF should consider assisting in the development of a regionalized referral system for voluntary sterilization.

   b) Research topics that AMPPF might want to undertake that can contribute to public health policy and the safe and cost-effective delivery of services might include the following topics:

      1) Attitude of religious leaders toward contraception;
      2) Attitude of influential male role models toward contraception;
      3) Epidemiologic surveillance of MCH activities in collaboration with the Family Health Division, the School of Medicine, and the Division of Health Statistics.

   c) Evaluation
      An evaluation of the past activities and achievements of the AMPPF as inputs into the definition of the future role of the association is needed.

3. Special Activities

   a) We recommend that a group of Malians participate in a study tour to observe mature programs in French-speaking Muslim countries which integrate family health and family planning. Insights gained during such a trip could have a constructive impact on the development of family planning services in Mali.

   b) Specific epidemiologic studies pertaining to the influence of family planning on the health of children in Mali might include, but not be limited to, the study of:

1) Birth weights, infant development, infant and child mortality;
2) Complications of pregnancy.

c) A core of Malians should receive training in the planning and analysis of research related to reproductive health.

V. FOLLOWUP ACTIVITIES

Mr. William Bair (Population Officer, REDSO/West Africa) informed Dr. Dalmat during his July 30, 1981 consultation in Abidjan, that a request for contraceptive commodities had been forwarded by the Ministry of Public Health and Social Affairs (MOPHSA) of Mali to Family Planning International Assistance (FPIA) through USAID/Mali on behalf of the Family Health Division (MOPHSA) and the Malian Family Planning Association. While in Mali, Dr. Dalmat inquired about the status of the request with Mr. Thomas Park (Health Officer, USAID/Mali). Mr. Park requested that Dr. Dalmat make further inquiry directly with FPIA's African Office in Nairobi upon arrival in Kenya after completion of the Mali and Tunisia portions of his trip.

Dr. Dalmat met with Andrew J. Franklin (Assistant Regional Director, FPIA), on August 19, 1981 in Nairobi, and learned that the Malian request for commodities had been received and forwarded to FPIA's headquarters in New York. Dr. Dalmat communicated that a prompt response to the request was viewed as a top priority by Mr. Park, as this was the first request of its kind made through USAID/Mali by the MOPHSA. Mr. Franklin offered to cable his office in New York that day to relay the sense of urgency. He also informed Dr. Dalmat that FPIA does not maintain a stock of NeoSampoon and that it is unlikely that FPIA would be able to fill that portion of the request.

While in London, following his consultancies in Kenya and Nigeria, Dr. Dalmat met with Mr. James Chapman, Director of Supply Acquisition and Distribution (IPPF) on August 24, 1980. Among other topics, Dr. Dalmat discussed FPIA's response to the Malian request for NeoSampoon. Mr. Chapman offered to send an emergency shipment of NeoSampoon to complement the rest of the FPIA shipment at the request of the Malian Family Planning Association. Cables explaining how to request this emergency shipment were sent to the Malian Family Planning Association and to the IPPF Regional Office in Nairobi.

Dr. Dalmat and Ms. Burton met with Ms. Susan Nalder (West African Coordinator, Columbia University) at IFRP in Research Triangle Park, North Carolina, on September 9, 1981. At the request of Mr. Park, Ms. Burton and Dr. Dalmat briefed Ms. Nalder on the status of family planning in Mali, the findings and recommendations included in the evaluation report, and their perceptions of what needs to be done to support family planning in Mali in the near future.

Following this briefing, Mr. Park recommended that Ms. Nalder postpone her reconnaisance trip to Mali so that she could join the CDC/IFRP team of consultants during its next trip to Mali.

Michael Dalmat

APPENDIX 1

TABLES 1-20

Sampling probabilities were not equal in the four groups of study centers:

Malian Family Planning Association (AMPPF)

1. Centre Pilote
2. Other AMPPF Centers (2)

Family Health Division

3. PMI Centrale
4. Other PMI Centers (6)

For example, in the Centre Pilote, a 10% sample was drawn as compared to the 100% sample taken from some of the smaller centers managed by the AMPPF and the Family Health Division. Thus, before making estimates of proportions and means for all centers in the aggregate, weighting factors need to be applied to account for these unequal probabilities. In Tables 1-20 that follow, the percentages are based on unweighted data and thus are valid for each group taken on its own. Attempts to calculate simple averages for all centers taken together with the data presented in these tables will produce inaccurate results.

TABLE 1: SYSTEMATIC SAMPLING WITH RANDOM START

	AMPPF			DSF			
	CENTRE PILOTE	OTHER (2)	SUB TOTAL	PMI CENTRALE	OTHER (6)	SUB TOTAL	TOTAL
SAMPLE FRAME	4652	538	--	468	445	--	--
SAMPLE OF CLIENTS	500	57	557	100	142	242	799
WEIGHTING FACTOR TO BE APPLIED	10	1-4*	--	4	1-4*	--	--

* WILL VARY BY CENTER.

LIMITATIONS

1. DSF CENTERS PERIODICALLY SORT OUT "INACTIVES."
2. CENTRE PILOTE SAMPLE FRAME EXCLUDES 4,852 RECORDS OF CLIENTS WHO BEGAN THE PROGRAM SOMETIME BETWEEN THE START OF AMPPF SERVICES (1974) AND THE STUDY PERIOD BEGINNING ON JANUARY 1, 1979.
3. IN ONE OF THE "OTHER" CENTERS, THE SAMPLING PROCEDURE WAS NOT COMPLETED DUE TO TIME CONSTRAINTS.

TABLE 2: ARE THERE DIFFERENCES BETWEEN THE AMPPF AND DSF CLIENTS WITHIN BAMAKO AND ELSEWHERE?

	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRALE	OTHER
1. AGE				
15-19	12.4	18.2	11.2	14.2
20-24	41.9	27.3	30.6	25.8
25-29	23.5	29.1	26.5	13.3
30-34	10.1	10.9	12.3	18.4
35-39	8.3	7.3	11.2	13.3
40-44	2.4	3.6	6.1	5.8
45-49	1.4	3.6	2.1	9.2
TOTAL % (#)	100.0	100.0	100.0	100.0
	(494)	(55)	(98)	(120)
2. AGE AT FIRST MARRIAGE				
< 14	16.6	*	20.0	7.6
15-19	44.2	*	44.5	68.2
20-24	33.7	*	33.3	19.7
25-29	5.5	*	2.2	4.5
TOTAL % (#)	100.0	*	100.0	100.0
	(181)	(19)	(45)	(66)
3. EDUCATION				
NONE	29.4	15.0	14.5	44.0
PRIMARY	57.7	67.5	67.5	41.0
SECONDARY	10.0	17.5	15.7	9.0
SUPERIOR	2.9	0.0	2.4	6.0
TOTAL % (#)	100.0	100.0	100.0	100.0
	(489)	(40)	(83)	(134)

ARE THERE DIFFERENCES BETWEEN THE AMPPF AND DSF CLIENTS WITHIN BAMAKO AND ELSEWHERE?

PAGE 2

	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRALE	OTHER
4. OCCUPATION				
C/S (CS,SB) HIGH STATUS	31.3	35.6	47.2	28.4
C/S (F,O) MIDDLE STATUS	4.3	8.9	4.2	26.8
C/S (L,D) LOWER STATUS	5.3	4.4	5.6	14.2
OTHER HOUSEWIVES	25.8	33.3	11.1	15.7
STUDENTS	33.3	17.8	31.9	14.9
TOTAL % (#)	100.0	100.0	100.0	100.0
	(438)	(45)	(72)	(134)
5. MARITAL STATUS				
NEVER MARRIED	60.3	54.4	44.3	22.2
PREVIOUSLY MARRIED	6.7	8.8	5.2	3.8
MONOGAMOUS	21.5	17.5	25.8	36.6
POLYGAMOUS	11.5	19.3	24.7	37.4
TOTAL % (#)	100.0	100.0	100.0	100.0
	(494)	(57)	(97)	(131)
6. DISTANCE TO CENTER				
< 1 (KILOMETER)	16.3	28.1	36.4	55.5
1-4	43.7	61.4	41.4	27.7
5-14	36.4	1.8	20.2	7.3
15 +	3.6	8.7	2.0	9.5
TOTAL % (#)	100.0	100.0	100.0	100.0
	(497)	(57)	(99)	(137)
7. NUMBER OF LIVING CHILDREN				
0	26.2	21.4	6.9	14.9
1	29.6	32.1	23.0	14.2
2	9.5	12.5	18.4	12.7
3 +	34.7	34.0	51.7	52.2
TOTAL % (#)	100.0	100.0	100.0	100.0
	(493)	(56)	(87)	(134)

ARE THERE DIFFERENCES BETWEEN THE AMPPF AND DSF CLIENTS WITHIN BAMAKO AND ELSEWHERE?

	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRALE	OTHER
8. NUMBER OF DECEASED CHILDREN				
0	72.6	50.0	46.0	57.0
1	17.1	25.0	35.0	13.3
2	7.4	19.6	9.5	11.9
3 +	2.9	5.4	9.5	17.8
TOTAL % (#)	100.0	100.0	100.0	100.0
	(485)	(56)	(63)	(155)
9. DESIRE ADDITIONAL CHILDREN				
NO	9.4	14.0	23.8	32.8
YES	90.6	84.0	76.2	63.9
UNSURE	0.0	2.0	0.0	3.3
TOTAL % (#)	100.0	100.0	100.0	100.0
	(487)	(50)	(84)	(119)
10. NUMBER REPORTED ABORTIONS				
0	74.2	75.6	61.7	73.7
1	19.7	19.5	31.9	22.6
2 +	6.1	4.9	6.4	3.7
TOTAL % (#)	100.0	100.0	100.0	100.0
	(461)	(41)	(47)	(133)
11. CURRENTLY USED METHODS				
NONE	55.6	79.0	44.0	42.2
IUD	18.4	7.0	17.0	12.2
PILL	24.8	14.0	39.0	46.6
OTHER	1.2	0.0	0.0	0.0
TOTAL % (#)	100.0	100.0	100.0	100.0
	(470)	(57)	(100)	(131)

TABLE 3: METHOD USED PRIOR TO FIRST VISIT TO CENTER BY AMPPF AND DSF CLIENTS

	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRAL	OTHER
NONE	84.8	89.5	71.0	64.8
IUD	3.6	1.8	6.0	5.6
ORAL	7.6	3.5	4.0	7.0
INJECTABLE	0.6	0.0	0.0	0.7
TRADITIONAL	0.6	1.8	3.0	4.2
NR	2.8	3.5	16.0	17.6
TOTAL	100.0	100.0	100.0	100.0
N	(500)	(57)	(100)	(142)

TABLE 4: METHOD USED AFTER THE FIRST VISIT BY AMPPF AND DSF CLIENTS

	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRAL	OTHER
NONE	9.4	3.5	2.0	3.5
IUD	26.0	17.5	29.0	17.6
ORAL	61.6	75.9	61.0	65.9
FOAM, JELLY	0.2	0.0	0.0	0.0
INJECTABLE	0.4	0.0	0.0	7.8
STERILIZATION	1.0	0.0	0.0	0.0
OTHER	0.4	0.0	0.0	0.0
NR	1.0	3.5	8.0	5.6
TOTAL	100.0	100.0	100.0	100.0
N	(500)	(57)	(100)	(142)

TABLE 5: METHODS USED BY ACTIVE CLIENTS OF AMPPF AND DSF (MARCH 1981)

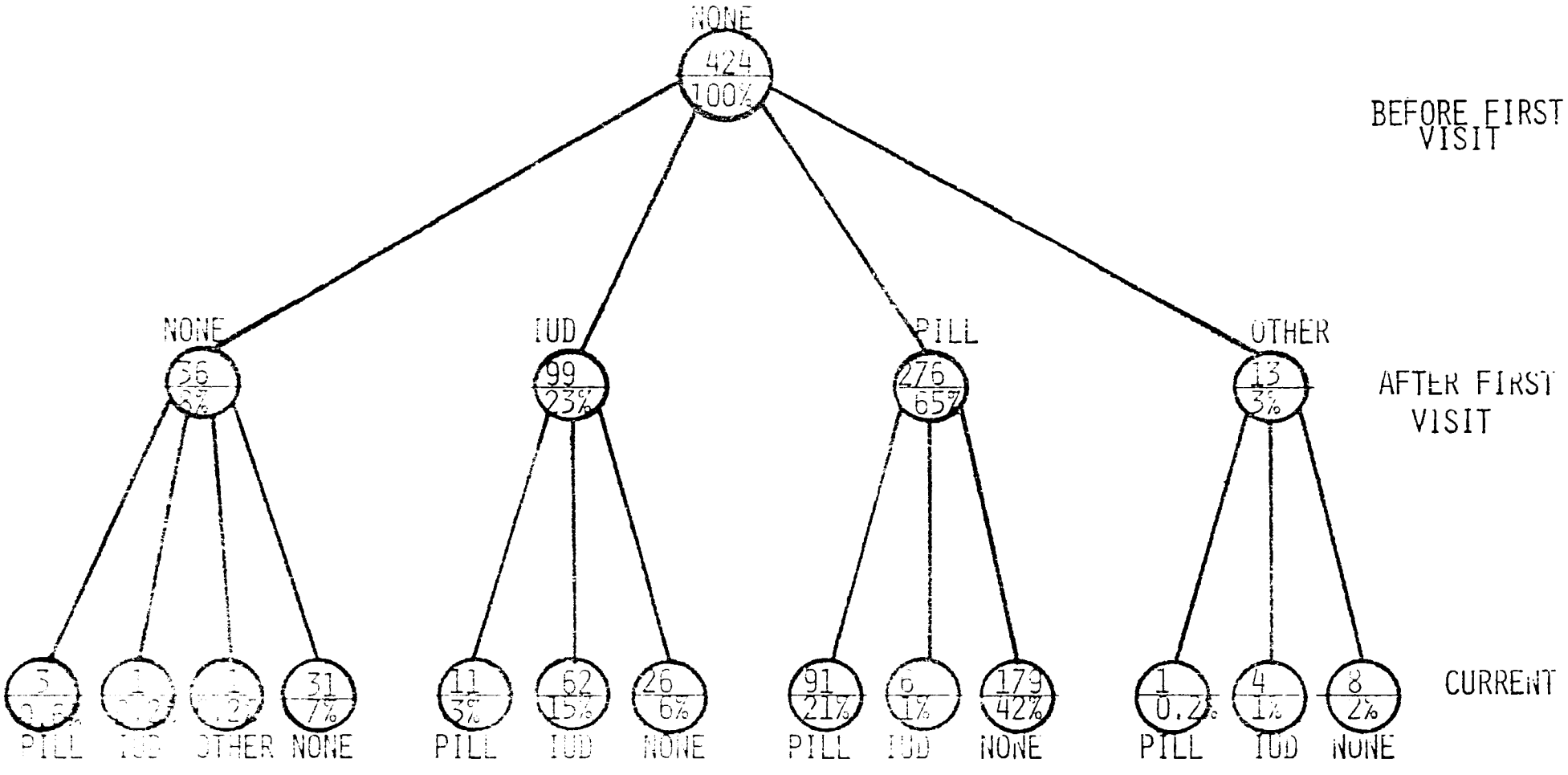
	AMPPF		DSF	
	CENTRE PILOTE	OTHER	PMI CENTRAL	OTHER
PILL	55.9	*	68.4	69.3
IUD	41.4	*	29.9	18.2
OTHER	2.7	*	0.0	0.0
NR	0.0	*	1.7	12.5
TOTAL	100.0		100.0	100.0
N	(222)	(12)	(57)	(88)

TABLE [illegible]:

METHOD CHANGES AMONG

CENTRE PILOTE CLIENTS WHO DID NOT

USE A METHOD BEFORE COMING TO THE CENTER



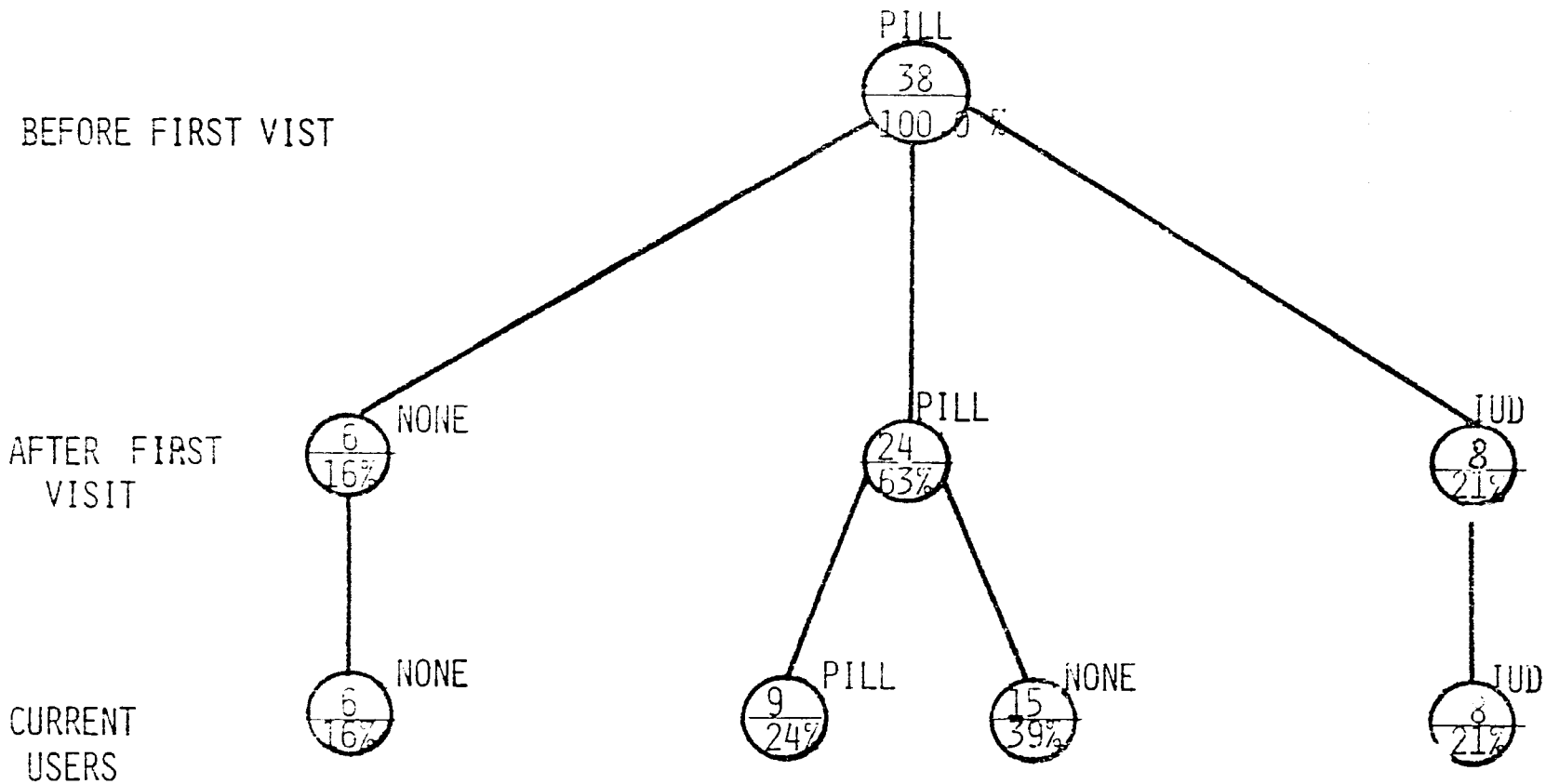
DROP OUT FROM PILL = 65%

SHIFT TO PILL FROM IUD = 11%

DROP OUT FROM IUD = 26%

TABLE 2:

METHOD CHANGES AMONG CENTRE PILOTE CLIENTS WHO BEGAN USE OF THE PILL BEFORE COMING TO THE CENTER



INITIAL DROP-OUT = 16%

" CONTINUATION WITH PILL = 63%

" SHIFT TO IUD = 21%

SUBSEQUENT PILL DROP-OUT = 63%

NET CONTINUATION WITH PILL = 24%

NET DROP-OUT (ALL METHODS) = 55%

TABLE 8: CRUDE ESTIMATE OF WOMEN 15-44 WHO USE MODERN CONTRACEPTIVE METHODS

1.	Study center estimate	2,538
2.	10% of PMI Centrale acceptors prior to 1979, whose records we did not review (i.e., 4,852) are still active	485
3.	40 active users served by each of the eleven PMIs currently providing family planning services but not evaluated. (40 is the average for non-Bamako centers)	440
4.	10 active users served by the eight PMIs that are just starting to provide family planning services	80
5.	20 active users served by each of the five PMIs offering family planning services at their own initiative	100
Gross estimate of total active users in Mali through health system		3,643

Women 15-44 in Mali = 1,567,800

% of women 15-44 provided with modern methods through AMPPF and DSF = 0.2%

TABLE 9: HOW DO CURRENT USERS FROM THE CENTRE PILOTE DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

		CENTRE PILOTE		
		CURRENT USER	PREVIOUS USER	NEVER USER
AGE	15-19	11.8	11.5	15.6
	20-29	62.3	69.2	66.7
	30-39	20.0	17.6	14.4
	40-49	5.9	1.7	3.3
	TOTAL	100.0	100.0	100.0
	N	220	182	90
EDUCATION	NONE	27.8	27.0	38.5
	PRIMARY	60.3	56.2	53.8
	SECONDARY	8.7	13.5	6.6
	SUPERIOR	3.2	3.3	1.1
	TOTAL	100.0	100.0	100.0
	N	219	178	91
OCCUPATION	HIGH STATUS	57.6	65.6	44.8
	MIDDLE STATUS	15.1	9.8	13.8
	LOW STATUS	6.8	11.5	10.3
	OTHER HOUSEWIVES	13.7	9.8	27.6
	STUDENTS	6.8	3.3	3.4
	TOTAL	100.0	100.0	100.0
	N	73	61	29
MARITAL STATUS	NEVER MARRIED	56.4	62.3	67.4
	PREVIOUSLY M.	6.8	6.0	7.9
	MONOGAMOUS	23.2	19.7	20.2
	POLYGAMOUS	13.6	12.0	4.5
	TOTAL	100.0	100.0	100.0
	N	220	183	89
DISTANCE TO CENTER	< 1	10.4	19.0	11.0
	1-4	45.0	42.4	44.0
	5-14	34.5	35.9	41.7
	15 +	4.1	2.7	3.3
	TOTAL	100.0	100.0	100.0
	N	220	184	91
DESIRE ADDITIONAL CHILDREN	NO	13.2	7.1	4.4
	YES	86.8	92.9	95.6
	TOTAL	100.0	100.0	100.0
	N	213	182	90

HOW DO CURRENT USERS FROM THE CENTRE PILOTE DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

PAGE 2

		CENTRE PILOTE		
		CURRENT USER	PREVIOUS USER	NEVER USER
NUMBER OF LIVING CHILDREN	0	23.6	27.7	29.7
	1	26.9	32.6	30.8
	2	19.4	15.3	19.8
	3 +	30.1	23.9	19.7
	TOTAL	100.0	100.0	100.0
	N	216	184	91
NUMBER OF REPORTED ABORTIONS	0	72.4	76.9	74.7
	1	20.6	16.6	22.0
	2 +	7.0	6.5	3.3
	TOTAL	100.0	100.0	100.0
	N	199	169	91
METHODS USED AFTER LAST VISIT	NONE	1.8	6.5	100.0
	IUD	42.0	5.4	0.0
	PILL	54.8	86.5	0.0
	OTHER	1.4	1.6	0.0
	TOTAL	100.0	100.0	100.0
	N	215	185	88
CONTRAINDICATIONS NOTED TO METHOD AFTER FIRST VISIT	NONE	87.4	82.7	40.7
	1 +	8.1	11.4	5.5
	NO RESPONSE	4.5	5.9	53.8
	TOTAL	100.0	100.0	100.0
	N	222	185	91
COMPLETENESS OF CLIENT RECORD (page 2)	BLANK	1.8	2.7	2.2
	INCOMPLETE	52.2	56.2	75.8
	COMPLETE	45.1	41.1	22.0
	NO RESPONSE	0.9	0.0	0.0
	TOTAL	100.0	100.0	100.0
	N	222	185	91

TABLE 10: HOW DO CURRENT USERS FROM THE PMI CENTRALE DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

		PMI CENTRALE		
		CURRENT USER	PREVIOUS USER	NEVER USER
AGE	15-19	13.0	12.1	*
	20-29	55.5	60.6	*
	30-39	24.1	18.2	*
	40-49	7.4	9.1	*
	TOTAL	100.0	100.0	*
	N	54	33	10
EDUCATION	NONE	14.9	14.5	*
	PRIMARY	72.4	57.1	*
	SECONDARY	10.6	25.0	*
	SUPERIOR	2.1	3.6	*
	TOTAL	100.0	100.0	*
	N	47	31	8
OCCUPATION	HIGH STATUS	50.0	*	*
	MIDDLE STATUS	10.0	*	*
	LOWER STATUS	6.7	*	*
	OTHER HOUSEWIVES	3.3	*	*
	STUDENTS	0.0	*	*
	NO RESPONSE	30.0	*	*
	TOTAL	100.0	*	*
	N	30	18	6
MARITAL STATUS	NEVER MARRIED	46.3	43.8	*
	PREVIOUSLY MARRIED	5.6	3.1	*
	MONOGAMOUS	25.9	25.0	*
	POLYGAMOUS	22.2	28.1	*
	TOTAL	100.0	100.0	*
	N	54	32	10
DISTANCE TO CENTER	<1	30.9	51.5	*
	1-4	47.3	27.3	*
	5-14	20.0	18.2	*
	15 +	1.8	3.0	*
	TOTAL	100.0	100.0	*
	N	55	33	10
DESIRE ADDITIONAL CHILDREN	NO	25.0	22.6	*
	YES	75.0	77.4	*
	TOTAL	100.0	100.0	*
	N	44	31	9

HOW DO CURRENT USERS FROM THE PMI CENTRALE DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

PAGE 2

		PMI CENTRALE		
		CURRENT USER	PREVIOUS USER	NEVER USER
NUMBER OF LIVING CHILDREN	0	6.5	10.0	*
	1	21.8	23.3	*
	2	30.4	26.7	*
	3 +	41.3	40.0	*
	TOTAL	100.0	100.0	*
	N	46	30	10
NUMBER OF REPORTED ABORTIONS	0	59.3	*	*
	1	40.7	*	*
	2 +	0.0	*	*
	TOTAL	100.0	*	*
	N	30	15	5
METHODS USED AFTER LAST VISIT	NONE	0.0	0.0	*
	IUD	37.7	9.1	*
	PILL	62.3	87.9	*
	OTHER	0.0	3.0	*
	TOTAL	100.0	100.0	*
	N	53	33	4
CONTRAINDICATIONS NOTED TO METHOD AFTER FIRST VISIT	NONE	89.3	84.9	*
	1 +	7.1	12.1	*
	NO RESPONSE	3.6	3.0	*
	TOTAL	100.0	100.0	*
	N	56	33	10
COMPLETENESS OF CLIENT RECORD (page 2)	BLANK	7.1	0.0	*
	INCOMPLETE	32.2	48.5	*
	TOTAL	60.7	51.5	*
	N	56	33	10

TABLE 11: HOW DO CURRENT USERS FROM THE "DSF OTHER" CENTERS DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

		"DSF OTHER" CENTERS		
		CURRENT USER	PREVIOUS USER	NEVER USER
AGE	15-19	14.1	15.6	*
	20-29	35.9	44.4	*
	30-39	40.6	22.2	*
	40-49	9.4	17.8	*
	TOTAL	100.0	100.0	*
	N	64	45	8
EDUCATION	NONE	47.3	34.8	*
	PRIMARY	37.8	47.8	*
	SECONDARY	8.1	10.9	*
	SUPERIOR	6.8	6.5	*
	TOTAL	100.0	100.0	*
	N	74	46	9
OCCUPATION	HIGH STATUS	33.3	48.4	*
	MIDDLE STATUS	37.5	22.6	*
	LOWER STATUS	23.2	6.5	*
	OTHER HOUSEWIVES	5.3	16.1	*
	STUDENTS	1.8	6.4	*
	TOTAL	100.0	100.0	*
	N	56	31	8
MARITAL STATUS	NEVER MARRIED	20.8	25.6	*
	PREVIOUSLY MARRIED	1.4	4.7	*
	MONOGAMOUS	43.1	30.2	*
	POLYGAMOUS	34.7	39.5	*
	TOTAL	100.0	100.0	*
	N	72	43	10
DISTANCE TO CENTER	< 1	62.1	50.0	*
	1-4	25.7	32.6	*
	5-14	6.8	8.7	*
	15 +	5.4	8.7	*
	TOTAL	100.0	100.0	*
	N	74	46	10
DESIRE ADDITIONAL CHILDREN	NO	35.6	22.2	*
	YES	64.4	68.9	*
	TOTAL	100.0	100.0	*
	N	59	45	10

HOW DO CURRENT USERS FROM THE "DSF OTHER" CENTERS DIFFER FROM PREVIOUS AND NEVER USERS FROM THAT CENTER?

PAGE 2

		"DSF OTHER" CENTERS		
		CURRENT USER	PREVIOUS USER	NEVER USER
NUMBER OF LIVING CHILDREN	0	13.3	20.5	*
	1	12.0	18.2	*
	2	20.0	29.6	*
	3 +	54.7	31.8	*
	TOTAL	100.0	100.0	*
	N	75	44	9
NUMBER OF ABORTIONS REPORTED	0	74.7	76.8	*
	1	22.7	20.9	*
	2 +	2.6	2.3	*
	TOTAL	100.0	100.0	*
	N	75	43	9
METHODS USED AFTER LAST VISIT	NONE	0.0	15.2	*
	IUD	22.1	2.2	*
	PILL	77.9	73.9	*
	OTHER	0.0	8.7	*
	TOTAL	100.0	100.0	*
	N	77	46	5
CONTRAINDICATIONS NOTED TO METHOD AFTER FIRST VISIT	NONE	88.3	71.7	*
	1 +	2.6	6.5	*
	NO RESPONSE	9.1	21.8	*
	TOTAL	100.0	100.0	*
	N	77	46	10
COMPLETENESS OF CLIENT RECORD (page 2)	BLANK	19.5	6.5	*
	INCOMPLETE	26.0	39.1	*
	COMPLETE	54.5	54.4	*
	TOTAL	100.0	100.0	*
	N	77	46	10

TABLE 12: What methods were used at the time of the last visit and at the time of the evaluation by clients of study centers?

	At the Time of the Last Visit								Current Use						
	None	IUD	Pill	Injectable	Other	NR	TOTAL	N	None	IUD	Pill	Other	NR	TOTAL	N
AMPPF															
Segou	--	13.9	86.1	--	--	--	100.0	43	83.7	4.7	11.6	--	--	100.0	43
Centre Pilote	21.2	20.4	56.0	0.6	0.6	1.2	100.0	500	55.6	18.4	24.8	1.2	--	100.0	500
DSF															
PMI Centrale	4.0	23.0	62.0	1.0	--	10.0	100.0	100	43.0	17.0	39.0	--	--	100.0	100
Centre Famory	2.3	23.3	72.1	--	--	2.3	100.0	43	37.2	23.3	37.2	--	2.3	100.0	43
Katibougou	--	--	100.0	--	--	--	100.0	30	--	--	100.0	--	--	100.0	30
Mana	6.7	--	56.7	13.3	--	23.3	100.0	30	43.3	--	30.0	--	26.7	100.0	30

TABLE 13: ARE THERE DIFFERENCES BETWEEN THE CENTRE PILOTE CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		CENTRE PILOTE		
		PILL	IUD	NOT CURRENT
AGE	15-19	15.6	7.6	12.8
	20-29	71.3	53.3	67.9
	30-39	12.3	29.3	17.1
	40-49	0.8	9.8	2.2
	TOTAL	100.0	100.0	100.0
	N	122	92	274
EDUCATION	NONE	22.6	31.5	30.7
	PRIMARY	66.1	55.0	55.6
	SECONDARY	9.7	7.9	11.1
	SUPERIOR	1.6	5.6	2.6
	TOTAL	100.0	100.0	100.0
	N	124	89	270
MARITAL STATUS	NEVER MARRIED	69.4	41.1	63.5
	PREVIOUSLY MARRIED	5.6	8.9	6.6
	MONOGAMOUS	19.4	27.8	20.1
	POLYGAMOUS	5.6	22.2	9.8
	TOTAL	100.0	100.0	100.0
	N	124	90	274
OCCUPATION	HIGH STATUS	50.0	37.7	54.0
	MIDDLE STATUS	13.1	9.4	10.0
	LOWER STATUS	7.9	1.9	11.0
	OTHER HOUSEWIFE	13.2	9.4	14.0
	STUDENT	7.9	3.9	3.0
	NR	7.9	37.7	8.0
	TOTAL	100.0	100.0	100.0
	N	38	53	100
DISTANCE TO CENTER	<1	19.4	13.3	16.3
	1-4	42.7	48.9	42.6
	5-14	33.9	33.4	37.9
	15 +	4.0	4.4	3.2
	TOTAL	100.0	100.0	100.0
	N	124	90	277

ARE THERE DIFFERENCES BETWEEN THE CENTRE PILOTE CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		CENTRE PILOTE		
		PILL	IUD	NOT CURRENT
DESIRE ADDITIONAL CHILDREN	NO	4.1	22.1	6.6
	YES	95.9	77.9	93.4
	TOTAL	100.0	100.0	100.0
	N	122	86	274
NUMBER OF LIVING CHILDREN	0	32.8	12.4	28.1
	1	27.9	25.8	31.8
	2	18.8	21.4	17.0
	3 +	20.5	40.4	23.1
	TOTAL	100.0	100.0	100.0
	N	122	89	277
NUMBER OF ABORTIONS REPORTED	0	74.8	67.2	75.6
	1	20.3	21.4	19.1
	2 +	4.9	11.4	5.3
	TOTAL	100.0	100.0	100.0
	N	123	70	262

TABLE 14: ARE THERE DIFFERENCES BETWEEN THE PMI CENTRALE CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		PMI CENTRALE		
		PILL	IUD	NOT CURRENT
AGE	15-19	13.1	*	9.3
	20-29	57.9	*	60.5
	30-39	23.7	*	20.9
	40-49	5.3	*	9.3
	TOTAL	100.0	*	100.0
	N	38	16	43
EDUCATION	NONE	8.8	*	11.4
	PRIMARY	73.5	*	62.9
	SECONDARY	14.7	*	22.9
	SUPERIOR	3.0	*	2.8
	TOTAL	100.0	*	100.0
	N	34	13	35
MARITAL STATUS	NEVER MARRIED	51.4	*	42.9
	PREVIOUSLY MARRIED	8.1	*	4.7
	MONOGAMOUS	21.6	*	23.8
	POLYGAMOUS	18.9	*	28.6
	TOTAL	100.0	*	100.0
	N	37	17	42
OCCUPATION	HIGH STATUS	*	*	*
	MIDDLE STATUS	*	*	*
	LOWER STATUS	*	*	*
	OTHER HOUSEWIVES	*	*	*
	STUDENTS	*	*	*
	NR	*	*	*
	TOTAL	*	*	*
	N	18	11	24
DISTANCE TO CENTER	<1	34.2	*	44.2
	1-4	43.1	*	32.6
	5-14	21.1	*	20.9
	15 +	2.6	*	2.3
	TOTAL	100.0	*	100.0
	N	38	17	43
DESIRE ADDITIONAL CHILDREN	NO	16.1	*	22.5
	YES	83.9	*	77.5
	TOTAL	100.0	*	100.0
	N	31	13	40

ARE THERE DIFFERENCES BETWEEN THE PMI CENTRALE CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		PMI CENTRALE		
		PILL	IUD	NOT CURRENT
NUMBER OF LIVING CHILDREN	0	6.2	*	7.5
	1	21.9	*	25.0
	2	34.4	*	25.0
	3 +	37.5	*	42.5
	TOTAL	100.0	*	100.0
	N	32	14	40
NUMBER OF ABORTIONS REPORTED	0	*	*	*
	1	*	*	*
	2 +	*	*	*
	TOTAL	*	*	*
	N	20	7	20

TABLE 15: ARE THERE DIFFERENCES BETWEEN THE "OTHER DSF" CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		OTHER DSF		
		PILL	IUD	NOT CURRENT
AGE	15-19	13.2	*	17.4
	20-29	34.0	*	47.8
	30-39	41.5	*	21.7
	40-49	11.3	*	13.1
	TOTAL	100.0	*	100.0
	N	53	11	46
EDUCATION	NONE	46.6	*	34.0
	PRIMARY	37.9	*	48.0
	SECONDARY	10.3	*	12.0
	SUPERIOR	5.2	*	6.0
	TOTAL	100.0	*	100.0
	N	58	16	50
MARITAL STATUS	NEVER MARRIED	17.5	*	26.5
	PREVIOUSLY MARRIED	1.8	*	6.1
	MONOGAMOUS	42.1	*	32.7
	POLYGAMOUS	38.6	*	34.7
	TOTAL	100.0	*	100.0
	N	57	15	49
OCCUPATION	HIGH STATUS	27.7	*	41.7
	MIDDLE STATUS	36.1	*	27.8
	LOWER STATUS	27.7	*	5.5
	OTHER HOUSEWIVES	6.4	*	16.7
	STUDENTS	2.1	*	5.5
	NR	0.0	*	2.8
	TOTAL	100.0	*	100.0
	N	47	10	36
DISTANCE TO CENTER	<1	61.7	*	52.8
	1-4	28.3	*	28.3
	5-14	8.3	*	7.6
	15 +	1.7	*	1.3
	TOTAL	100.0	*	100.0
	N	60	14	53
DESIRE ADDITIONAL CHILDREN	NO	35.6	*	23.9
	YES	64.4	*	76.1
	TOTAL	100.0	*	100.0
	N	45	14	46

ARE THERE DIFFERENCES BETWEEN THE "OTHER DSF" CLIENTS WHO USE THE PILL, THE IUD, AND THOSE WHO ARE NOT CURRENTLY USING A METHOD?

		OTHER DSF		
		PILL	IUD	NOT CURRENT
NUMBER OF LIVING CHILDREN	0	11.7	*	20.0
	1	15.0	*	16.0
	2	18.3	*	32.0
	3 +	55.0	*	32.0
	TOTAL	100.0	*	100.0
	N	60	15	50
NUMBER OF ABORTIONS REPORTED	0	75.0	*	70.8
	1	21.7	*	22.9
	2 +	3.3	*	6.3
	TOTAL	100.0	*	100.0
	N	60	15	48

TABLE 16: What proportion of women using contraceptive methods at the time of their first visit said they wanted to have more/no more children?

	NONE		IUD		PILL		INJECTABLE		STERILIZATION		NO RESPONSE		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
NO	6	10.7	43	22.1	46	9.1	12	(92.3)	3	75.0	2	8.7	112	14.1
YES	49	87.5	133	68.2	422	83.6	1	(7.7)	0	--	15	65.2	620	77.9
UNSURE	0	0.0	2	1.0	3	0.6	0	--	0	--	0	--	5	0.6
NO RESPONSE	1	1.8	17	8.7	34	6.7	0	--	1	25.0	6	26.1	59	7.4
TOTAL	56	100.0	195	100.0	505	100.0	13	100.0	4	100.0	23	100.0	796	100.0

TABLE 17: What methods were being used by those women who said they wanted to have more children or that they did not want more children?

	No More Children		More Children		TOTAL	
	#	%	#	%	#	%
No method	6	5.5	49	8.1	55	7.7
IUD	43	39.1	133	22.0	176	24.6
Pill	46	41.8	422	69.8	468	65.5
Injectable	12	10.9	1	0.1	13	1.8
Sterilization	3	2.7	0	--	3	0.4
TOTAL	110	100.0	605	100.0	715	100.0

TABLE 18: WHAT IS THE MARITAL STATUS OF STUDENTS?

Never Married	91.9
Previously Married	0.5
Monogamous	4.6
Polygamous	1.0
No Response	2.0
Total	100.0
N	197

TABLE 19

IF STUDENTS DO NOT ENTER THE CALCULATIONS HOW FAR DO AMPPF AND DSF CLIENTS COME FOR SERVICES?

		CURRENT USERS	PREVIOUS USERS	NEVER USERS
CENTRE PILOTE	<1	16.9	18.4	14.7
	1-4	42.9	40.8	36.8
	5-14	34.4	37.7	45.6
	15 +	4.5	2.3	2.9
	NR	1.3	0.8	0.0
	TOTAL	100.0	100.0	100.0
	N	154	130	68
PMI CENTRALE	<1	27.5	50.0	*
	1-4	52.5	28.6	*
	5-14	17.5	17.8	*
	15 +	0.0	3.6	*
	NR	2.5	0.0	*
	TOTAL	100.0	100.0	*
	N	40	28	8
OTHER DSF	<1	55.4	56.4	*
	1-4	27.7	23.0	*
	5-14	7.7	10.3	*
	15 +	6.1	10.3	*
	NR	3.1	0.0	*
	TOTAL	100.0	100.0	*
	N	65	39	9

TABLE 20: ARE THE CENTRE PILOTE CLIENTS COMING FROM 5-15 KM DIFFERENT FROM THOSE LIVING CLOSER TO THE CENTER?

	CENTRE PILOTE		
	1	1-4	5-14
METHOD			
NONE	12.3	21.9	25.4
IUD	16.1	23.7	17.0
PILL	70.4	53.5	55.9
OTHER	1.2	0.9	1.7
TOTAL	100.0	100.0	100.0
	(81)	(215)	(177)
MARITAL STATUS			
NEVER MARRIED	69.1	67.9	50.0
PREVIOUSLY	11.1	6.5	5.6
MONOGAMOUS	14.8	17.7	28.1
POLYGAMOUS	4.9	7.9	16.3
TOTAL	100.0	100.0	100.0
	(81)	(215)	(178)
AGE			
15-19	18.5	12.5	10.2
20-29	66.7	69.0	61.6
30-39	14.8	14.8	23.1
40-49	0.0	3.7	5.1
TOTAL	100.0	100.0	100.0
	(81)	(216)	(177)
NUMBER OF LIVING CHILDREN			
0	24.7	33.3	19.3
1	42.0	27.1	28.7
2	13.6	17.6	20.4
3 +	19.7	21.9	31.5
TOTAL	100.0	100.0	100.0
	(81)	(210)	(181)

ARE THE CENTRE PILOTE CLIENTS COMING FROM 5-15 KM DIFFERENT FROM THOSE LIVING CLOSER TO THE CENTER?

PAGE 2

	CENTRE PILOTE		
	1	1-4	5-14
HIGH STATUS	56.0	56.6	59.0
MIDDLE STATUS	8.0	15.1	10.8
LOWER STATUS	8.0	3.8	14.5
OTHER HOUSEWIVES	28.0	18.9	9.6
STUDENTS	0.0	5.6	6.0
TOTAL	100.0	100.0	100.0
	(25)	(53)	(83)

ARE THE CENTRE PILOTE CLIENTS COMING FROM 5-15 KM DIFFERENT FROM THOSE LIVING CLOSER TO THE CENTER?

PAGE 2

	CENTRE PILOTE		
	1	1-4	5-14
HIGH STATUS	56.0	56.6	59.0
MIDDLE STATUS	8.0	15.1	10.8
LOWER STATUS	8.0	3.8	14.5
OTHER HOUSEWIVES	28.0	18.9	9.6
STUDENTS	0.0	5.6	6.0
TOTAL	100.0	100.0	100.0
	(25)	(53)	(83)