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NIGER FAMILY PLANNING AND DEMOGRAPHY PROJECT

FIRST EVALUATION

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Niger Family Health and Demography Project

First Evaluation

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ABBREVIATIONS

AAAS	Assistant social worker*
AHA	Sanitation worker*
BCR	Bureau of Census (Niger)*
BuCen	Bureau of Census (U.S.)
KAP	Knowledge, Attitudes and Practices
CDD	Center for Documentation and Dissemination
CIDES	Center for economic and social information and dissemination*
CHD	Departmental hospital*
CLA	Seat of an arrondissement*
CM	Medical Center*
CNSF	National Family Health Center*
CONAPO	National Population Commission*
CTP	Principal Technical Consultant*
CYP	Contraceptive Years of Protection
DAAP	Directorate for Financial Affairs and Administration
DDS	Departemental Health Directorate*
DEP	Directorate for studies and programming*
DES	Directorate for health facilities*
DFEPS	Directorate for training and health education*
DIS	Directorate for Health Infrastructure
DPF	Directorate for family planning*
DSMI	Directorate for Maternal Child Health Care
DQ	Municipal dispensary*
DR	Rural dispensary*
DSD	Directorate for Statistics and Demography
DSI	Directorate for statistics and computer services*
EMIJ	Infant and childhood mortality survey*
ENICAS	National school for certified nurses and social workers*
ENMM	National survey on mortality and morbidity*
ENSP	National public health school*
FAC	Faculty of Medecin
FAN	Niger Armed Forces
FEAP	Women of reproductive age*
FHI	Family Health International (American research organization)
FMAP	Married women of reproductive age*
FH	Family Health
FP	Family Planning
GON	Government of Niger
IC	Certified nurse*
IDE	Registered nurse*
IEC	Information, Education, Communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
IUSSP	International Union of the Scientific Study of Population
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MIS	Management Information System
MP/MR	Ministry of Plan and Regional Development*
MSP/AS/CF	Ministry of Public Health, Social Affairs and Women's Affairs*
NDHS	Niger Demographic and Health Survey

NFHDP	Niger Family Health and Demography Project
ONPPC	National Office of Pharmaceuticals*
PES	Post Enumeration Survey
PM	Health Post*
PMI	Maternal and child health center*
PNADD	National plan of action in the area of demography*
ProAG	Project Agreement
REDSO	Regional economic development service office
SIM	Sudan Interior Mission
SMI	Another abbreviation for maternal child care*
SNIS	National Health Information System
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TOT	Training of Trainers
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development (Mission to Niger)
WHO	World Health Organization
UEDD	Unit for demographic studies for development*
ZD	Enumeration area*

*Acronym represents French language terms

Niger Family Planning and Demography Project

First Evaluation

Executive Summary

The Niger Family Health and Demography project is a five year effort started in August 1988 as a cooperative undertaking between the Government of Niger (GON) and USAID. A five member team carried out a first evaluation of the Project in April 1989. The Team consulted with officials of the Ministry of Plan (MOP) and with the Ministry of Public Health, Social Affairs and Women's status (MSP/AS/CP), surveyed current family planning service delivery in five Departments and in the Commune of Niamey, reviewed workplans and project implementation, and conducted an extensive document review. The scope of work for this evaluation called for a review of the current status of family planning and demographic analysis and research, the establishment of key indicators for measuring inputs, outputs and project achievement, and recommendations for data collection and record keeping.

The scope of work was modified in discussions with USAID and the GON to include consideration whether planning and organization for project implementation and input are adequate to insure effective start-up and effective project execution. The Team found that a well conceived implementation plan had been developed in the project paper and was set forth in detail in the Project Agreement, in the Request for Proposals for a Management and Technical Assistance Team for family planning and in arrangements for U.S. technical assistance for census processing. It was found that:

- o The implementation plan is being followed:
- o The schedule proposed for implementation is being followed with only minor delays of a few months.
- o Procedures and systems to manage and support the establishment of the family planning system and for demographic development are being put in place.
- o Adequate resources for the program are being made available.

The Team concluded therefore that in its current phase (its eighth month), the Project planning and organization for project implementation and input are adequate and that a promising start has been made.

Family Planning Component

The team reviewed the current situation with respect to service delivery, management, contraceptive supply and logistics, training, and activities for information education and communications (IEC). It found that:

1. The MPH/AS/CF had made considerable progress in organizing and staffing a Directorate of Family Planning responsible for organizing and planning the national family planning effort.

2. The GON and USAID should give priority to early implementation of actions currently programmed to strengthen the DPF (office space, vehicle support, , technical assistance, staff training). Priority attention is also recommended to strengthen the system of contraceptive supply and management.

3. Although a great deal of information exists on the current situation, this information was scattered and not easily collected; service statistics are poor and not well understood by service providers. This points to the need to strengthen data collection and record keeping.

4. There has been a rapid growth in the past 12 - 18 months in FP service delivery in Niger - both in number of service points and in the number of contraceptors; service delivery of FP is now available in all urban areas. The team was able to establish base line estimates on the number of contraceptors in December 1987 and 1988.

5. Partly as a result of this rapid growth, performance levels in service delivery are low. The low level of performance in most health facilities requires a sustained and directed effort in the areas of supervision, training, logistics and contraceptive supply, management information and IEC in order to affect improvements in quality (the lack of supervision and of trained service providers raises concerns about the quality of service) and volume of service in existing centers. **Consequently, the need to improve performance in health facilities now providing FP service should be the priority concern of DPF.**

6. Since family planning service is already established in 114 health facilities - compared to 146 projected in the Project Agreement - it is evident that over the life of the project further expansion of the system is likely to result in more than 146 centers providing FP service and is likely to take place in the system of rural dispensaries. This expansion will require training for nurses. However, a constraining factor is the prevailing lack of sufficient health agents in rural areas. This problem needs further study and top management attention of MSP/AS/CF.

This review enabled the Team to recommend key indicators to be used by the project in each area in order to track inputs, outputs and project achievement. Detailed recommendations for data collection and recording keeping were made (Chapter IIF).

Demography Component

The Team reviewed the current situation with respect to: the processing of 1988 census data; availability of other demographic and health data; training needs for demographic personnel; the availability and dissemination of demographic documentation; and the use of demographic data in development planning. The Team found that the Department of Statistics and Demography (DSD) had already made

considerable progress in the process of integrating demographic data into development planning. This process will be further strengthened by:

- o technical assistance being provided under the project to help the Census Bureau in the timely processing and analysis of 1988 census results (Chapter III A);

- o provision of more detailed health and demographic data by the national demographic and health survey (NDHS) scheduled in 1991 or 1992 (Chapter III B).

- o by increasing the technical capability of the Unité des Etudes Démographiques pour le Développement (UEDD) by a variety of training programs. (Chapter III C).

- o by increasing available demographic information by the establishment of documentation and diffusion centers (Chapter III D),

- o by assisting in the integration of demographic data including results of the 1988 census and the NDHS into development planning through a series of workshops and seminars (see Chapter III E.)

NIGER FAMILY PLANNING AND DEMOGRAPHY PROJECT

FIRST EVALUATION

I. Introduction¹

A. The goal² of the Niger Family Health and Demography project (NFHDP) is to assist the Government of Niger in its efforts to achieve a rate of population growth that is consistent with the growth of economic resources and productivity and to improve mother and child health.

The Family Health Component is to strengthen the capacity of the Directorate of Family Planning (DFP) in the Ministry of Public Health, Social Affairs and Women's Status (MSP/AS/CP) to implement an effective national family planning program nation wide.

The Demographic Research and Analysis Component is to strengthen the capacity of the Directorate of Statistics and Demography (DSD) in the Ministry of Plan and Regional Planning (MP/RP) to conduct and analyze demographic research.

B. The NFPDP began operations in August 1988 following the signature of the Project Agreement (ProAg) between the Government of the Republic of Niger (GON) and USAID. The project has a planned life of five years. U.S. financial assistance of \$11 million is planned. The ProAg provided for a baseline evaluation to take place early during the start of the Project³.

C. The scope of work of the evaluation as developed with USAID and the Government was to :

- o Examine the current status of both the Family Planning and Demographic components of the Project ;
- o Determine whether planning and organization for project implementation and input are adequate and appropriate to assure effective start-up and satisfactory project execution.
- o Formulate and propose key indicators for measuring inputs, outputs and project achievements.
- o Recommend procedures for data collection and record keeping to monitor effectively key indicators Family Planning Component over the life of the Proect.

D. The evaluation took place April 6 - May 5, 1989. The team was composed of five members including three specialists in management, demography, and training and IEC provided by the AID-funded Population Technical Assistance Project and two Nigerien specialists in family planning and demography assigned to the team by the Directorate of Family Planning (DPF) of the MSP/AS/CF and the Directorate of Statistics and Demography (DSD) of the Ministry of Plan and Regional Planning (MP/RP).

1 See Annex I for Scope of Work

2 See Annex II

3 See Annex III

E. The methodology adopted for the evaluation covered:

1. A complete documentation review
2. Interviews with the personnel of MSP/AS/CP and MP/MR-DSD, USAID and other donors
3. Field visits to the Departments of Tahoua, Maradi, Zinder, Dosso, and the city of Niamey
4. Analysis of the following components of the Family Planning Program:
 - FP service delivery
 - Management, Supervision and Coordination
 - Contraceptive supply and logistics
 - Training
 - IEC
5. Analysis of the following aspects of the Demography component :
 - Processing of the 1988 Census
 - Availability of other demographic and health data
 - Training needs in demography
 - Availability of demographic documentation
 - Utilization of demographic information in development planning
6. Review of findings, conclusions and recommendations with representatives of the Government and USAID; their observations to be taken into account in the preparation of the final report.

G. The draft report of the Evaluation Team was reviewed by a joint committee of GON and USAID on May fifth and endorsed with several suggestions.

H. The final report which follows was submitted to the GON and USAID by the Population Technical Assistance Project in May.

II NATIONAL FAMILY PLANNING PROGRAM

A. FP Service Delivery

1. Current Situation

a. Introduction

This chapter examines the status of FP service delivery as clarified by various reports and by field visits carried out by the Evaluation Team in April 1989. The service delivery objectives of the Project as defined in the ProAG are reviewed together with the "objectively verifiable indicators defined in the Project Design Summary, Logical Framework (Annex II). Key indicators for monitoring service delivery are then defined. A final section summarizes the Team's conclusions.

b. Overview - Current status of FP service delivery

The evaluation team conducted a review of FP service delivery in Niger by document review, interviews with key personnel and visits to five departments and several arrondissements. Even though there may be some repetition in findings, it was felt that the information gathered should be presented department by department. Overall, as of April 1989, the situation may be summed up as follows:

- o A total of over 114 service points operating, most for less than a year. FP services now integrated in health services of all 39 Medical Centers.
- o Low level of performance in many health facilities:
 - Newness of FP service in many health facilities
 - Lack of trained personnel
 - Lack of supervision
 - lack of simple IEC materials at the departmental level and a need for sustained, programmed IEC promotion to develop clientele.
 - Lack of clinical supplies and equipment.
 - A prevailing practice of providing most clients with only one month's supply of contraceptives requiring frequent return visits by contraceptors and discouraging family planning.
- o Rapid growth in FP service points and service delivery in Niamey in the past two years.
- o Rapid growth in FP service points in the past 18 months, particularly in Tahoua and the communes of Maradi and Zinder.

- o Gradual movement toward the introduction of FP services into postes medicaux and dispensaires ruraux;
- o A growing requirement for other trained personnel to manage additional service points which Departments hope to integrate into additional health facilities;
- o A reliable system of service statistics not yet in place.

b. Baseline Estimate of Numbers of Contraceptors

The team developed data on the number of contraceptors country wide based on:

- o data on contraceptives distributed to health facilities in 1989 and sales from pharmacies.
- o data on the number of contraceptors in Niamey commune based on sample surveys carried out in Niamey in April 1987 and August 1988.
- o data on the number of contraceptors in Maradi and Zinder communes based on the sample survey carried out in August 1988.
- o A review of service statistics reported by Niamey, and the Departments of Dosso, Maradi, Tahoua, Tillaberi, and Zinder.

The result is an estimate of 19,000 - 20,000 contraceptors using oral contraceptives, injectables or the IUD as of December 1988. The city of Niamey accounts for nearly 12,000 or about 60% of this total and the communes of Maradi and Zinder account for about 3,000 or about 15% . The estimates for the three communes are considered reasonably close to reality because the data are based on reliable sample surveys taken in August 1988 and projected forward. The overall total for the nation is also believed approximately correct because:

- i) the number of IUD users is essentially that from Niamey (about 4100 Dec. 1988 and 2600 Dec. 1987);
- ii) data for contraceptors protected by the the pill or injectables (about 15,000 to 16,000 in December 1988 and about 10,000 to 11,000 in December 1987) lead to an estimate of couple years of contraceptive protection for calendar year 1988 of about 12,500 to 13,500 CY- P -- which agrees quite closely with CY- P derived separately from oral contraceptives and injectables actually distributed (Chapter II C).

However, the breakdown of contraceptive distribution by Department poses a problem. The Team recommends that a special effort be made this year i to collect reliable data on numbers of contraceptors from all Departments for December 1989. Comparisons with December 1987 and December 1988 can be made for Niamey city and the country as a whole. Starting in December 1989 it should be possible to compare contraceptive prevalence department by department with subsequent years.

c. Niamey Urban Area (1988 pop: 398,000)

Data collected by the National Family Health Center (CNSF) show a steady increase in contraceptors among women of reproductive age (FEAP) in Niamey each year since FP services were initiated in 1984/85.

By April 1987, modern contraceptive prevalence registered 8.3% of the estimated 82,500 FEAP in the city. Women using the pill, injectables or the IUD as a method of protection numbered 5,700 (est). In addition, tubal ligatures according to the same sample amounted to 0.9% of contraceptive prevalence (740 women) and 0.7% of the women (580) reported they were using a barrier method (condom/spermicide) for contraceptive protection.

Sixteen months later, in August 1988, a second sample survey showed that the rate of contraceptive prevalence had risen to 13.1% of the 88,300 FEAP in the city. Women using the pill, injectables or the IUD now numbered 10,737 est. The rapid growth of 88.3% - 3.9% per month - in contraceptors using these methods is explained by the continued program of IEC and by a ten-fold increase in the number of service points as FP services were introduced during 1987/88 into the city's ten MCH clinics.

The availability of bench mark data for April 1987 and August 1988 enables estimates by interpolation and projection of the numbers of women using modern methods of contraception as of December 1987 and December 1988. These estimates in turn lead to estimates of the number of person years of contraceptive years protection (CYP). As noted in section (b), the estimates of CYP accord reasonably well with data on the distribution of contraceptive products in 1988. See Chapter IIC.

Table 1. Estimates of Numbers of Contraceptors and CY-P in CY 1988 in Niamey

	<u>Est. Number of Contraceptors</u>				<u>Indicated CYP</u>
	<u>April</u> <u>1987</u>	<u>Dec.</u> <u>1987</u>	<u>Aug.</u> <u>1988</u>	<u>Dec</u> <u>1988</u>	<u>CY 1988</u>
Pill	3222	4400	5898	6500	5450
Inject.	661	900	1183	1300	1100
IUDs	1817	2600	3656	4100	3350
	5700	7900	10737	11900	9900

Source: Estimates by Base Evaluation Team, April 89.

The August 1988 survey reveals that 61% of current contraceptors frequent the CNSF, 36% other health centers, and 4% pharmacies. The CNSF is the national reference center for research, promotion, training and for FP services, including child spacing, sterility explorations, and for high risk pregnancy cases. It is the largest FP delivery center in the country. During 1984-88, it helped 28,000 women adopt a modern method of family planning. New contraceptors registered by the

Center in 1988 numbered 6,858. Along with considerable recruitment of new clients there has been a considerable drop-out. Based on contraceptive prevalence in the city, and country-wide data on distribution of contraceptive products, the Evaluation Team judged that active clients of the Center numbered in the range of 7000 - 8000 at the end of 1988.

The 1988 survey of contraceptive use also provides information on reasons given by women for discontinuation of current use. The main reason was the desire for a pregnancy (44%) followed by reasons of health (16%). However, it is apparent that most of the large number of women who ever tried a modern method at the CNSP have not resumed family planning after dropping out. In order to understand the situation better, DPF with assistance from Family Health International (FHI) initiated in April 1989 a prospective study of drop outs among new clients over an eight months period. Results should be available early in 1990 to help guide program management.

As of April 1989, a total of 20 FP service points existed in the City compared to 11 as of April 1988. In addition to the CNSF, DPF counts 10 Social and MCH care centers, 6 maternities and 3 dispensaries (**Table 2**). As noted above, the number of women contraceptors equals about 11,400, with 7,000 - 8,000 served by the CNSF and 3,400 - 4,400 served by 19 other centers, half of which are newly established. CNSF staff includes 13 midwives, 2 registered and 4 certified nurses, a gynecologist and a pharmacist. Other centers in the city counted 36 personnel trained in family planning: 4 physicians, 28 midwives and 4 social workers (assistants sociaux).

A review carried out by DPF in December 1988 (**Annex 4**) revealed numerous weaknesses in service delivery and pointed to the need for training at all levels, additional supplies and materials, and better space allocations. One problem pointed out to the evaluation team is the long delay experienced by some clients in obtaining service and a relatively unwelcoming attitude by some service providers.

The outlook is for continued growth in contraceptive prevalence with a need to strengthen the IEC program and a need to focus on management of the centers and the attitude of family service providers vis a vis the public.

c. Dosso Department (1988 Pop: 1,019,000)

Family planning was started in most locations in Dosso Department during the fall of 1986. The 1988 Annual Report of Health Activities reports FP services available in ten health centers in operation. As of April 1989, FP services were available at 14 service points including two in the capital of the Department, one in each of the administrative centers of the four outlying arrondissements (Gaya, Douchi, Boboye and Loga) and in six canton towns (Falmey, Kioto, Tanda, Tibiri, Mataukari and Guecheme). Service statistics provided by the Departmental MCH/FP coordinator are shown in **table 3**.

A survey on the integration of MCH/FP activities in the Department carried out by a DPF/CNSF team from March 28 - April 1, 1989 (**Annex 5**) revealed the following problems:

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- o irregular supply of contraceptives
- o lack of IEC materials
- o lack of personnel trained in FP (only 7 trained)
- o lack of clinical equipment and materials (eg, blood pressure guages)
- o early drop outs among new clients.

The survey recommends formulation of a Departmental plan of action to include programs for training service providers and for IEC (in collaboration with the DFEPS - Directorate for Training and Health Education). It also recommends the formulation of action plans to promote FP by each medical center, including targets for client development in each health facility.

Data on FP clientele are presented by centers in terms of old (or former) and new clients. There may be double counting in the annual numbers cited for old and new clients. In any case, the data include women who have ceased FP activities at the service center where they are registered. Based on these weak statistics, the best that can be done to estimate numbers of current contraceptors in Dosso is to suggest that the number probably is equal to or greater 1500 as of December 1988. However data for the country as a whole would suggest that the number of contraceptors at that date would be less.

Dosso Department is considering a substantial expansion of family planning services by the establishment of service points in rural dispensaries where there are two or more health agents. As of April, the Department Health Office was considering introducing service in the following dispensaries:

Arrond. of Dosso:	Sanbera, Tandoban
Arrond. of Douthi:	Gogonkilia, Kore Meroua
Arrond. of Boboye:	Kaygolo, Harikanassou, Pabiji
Arrond. of Gaya:	Bengou, Kawara, nDebe
Arrond of Loga:	Moussadey, Falwel

This expansion will require training both health agents at each dispensary.

d. Maradi Department (1988 pop: 1,388,000)

As of early 1989, the Evaluation Team counted 17 FP service points in the Department, of which 8 in Maradi Commune, 7 in the administrative centers of the arrondissements of Dakara, Aguié, Gazaoua, Mayayi and Gidan Roumja, and two in the canton towns of Tibiri and Dan Issa (see **Table 4**). Personnel trained for the arrondissements of Madarounfa and Tessaoua had been transferred elsewhere so that these locations were temporarily without service providers.

Data provided by the Departmental Health Office (DDS)) show a low level of activity at nearly all the centers, reflecting (1) the fact that most have been established only since the clinical training program held in Maradi in March 1988., and (2) the lack of an organized IEC effort in the Department (as in other Departments).

The available data on contraceptors (new and old or former) would suggest the number of active clients would lie in the range of 1500 -2500. According to the sample survey carried out in 1988, contraceptive prevalence in Maradi commune

amounted to 8.03%, of which 6% were using oral contraceptives or injectables and 2% a barrier method. Based on a population of 112,965 persons in the city, and 24,850 women of reproductive age, it appears that slightly under 1,500 women were using pills or injectables at the time of the survey (summer 1988). Estimates of the number of contraceptors countrywide would suggest that the number of contraceptors for the Department as a whole can reasonably be estimated at 1,500 - 2000 women at the end of 1988.

e. Tahoua Department (1988 Pop: 1,3 million)

FP activities by the public sector date back to the fall of 1986 when a service point for family planning was established in PMI/Tahoua commune. Limited family planning services have also been provided for several years by the SIM private hospital located at Galmi. However, the extension of family planning throughout the Departement dates from the conduct of clinical training in FP in Tahoua in July/August 1988. Since, then, family planning service points have been established in all the administrative centers of Birni Nkonni, Illela, Tchintabaraden, Keita, Bouza and Madaoua arrondissements, and new service points have been provided in the Department's capital of Tahoua commune. In all 13 service points are functioning at 9 geographic locations.

FP services include counseling, pill prescription and the distribution of condoms and spermicides. The health authorities prefer oral contraceptives to the use of injectables because when problems arise it is possible to cease activity if pills are used. The Department has had a limited capability in Tahoua commune to insert IUDs; currently this capacity has been extended to Madoua and Birni Nkonni and is shortly to be provided to the Medical Center at Keita.

With the exception of PMI/Tahoua and the Maternity at Birni nKonni, other centers offering FP services are operating at a very low level, a fact reflecting their newness and the lack of promotion. Based on visits to PMI/Tahoua, Maternity/Birni NKonni and Maternity/CHD and the data presented in **Table 5**, contraceptors are estimated by the Evaluation Team as of April 1989 to number about 800 women.

In meetings with the Department Health Director and the MCH/FP coordinator, the following problems were identified:

- o Inadequate numbers of personnel trained in FP; each service point should have at least two trained service providers;
- o lack of equipment (e.g., Keita, Birni Nkonni);
- o lack of simple IEC materials (signs, posters, leaflets, flip charts)
- o lack of reagents to permit laboratories in the Medical Centers to conduct analyses to identify STDs;

Because of long distances separating towns, the Department faces a problem in organizing regular supervision of its health facilities. The MCH/FP coordinator notes that he has been able to organize supervisory visits to outlying arrondissements at most twice a year, with visits to centers in Illela and Birni N'Konni being more frequent and visits to centers in Tahoua commune occurring frequently.

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The large distances to a FP service point also pose a problem to women in outlying areas desiring family planning. Accordingly, the Department is considering establishing several new service points at health posts (postes medicaux) and in rural dispensaries where personnel permit: Tamaska, Tilia, Abalak, Tassara, Bararaoua and Malbaza.

f. Tillaberi Department (1988 Pop: 1,322,000)

As of early 1989, there were 14 FP service points in Tillaberi Department, 5 of which had been established within a 12 month period. These service points are located in the medical centers of the six arrondissement towns and in the canton towns of Abala, Balleyara, Boukougou, Banibangou, Torodi, Bankilare, Gotheye and Ayorou. Activity levels in several of these points are as yet at very low levels (Table 6).

Data provided by the DDS show a total of 1079 "new cases" and 3,406 "cas suivis". The new cases are new contraceptors registered by health facilities during 1988. The "cas suivis" are old or former clients including women who are still practicing FP and women who have stopped.

FP services included IEC activities, counselling and referrals, and the prescription and supply of pills, injectables and barrier methods. No facilities yet exist for IUD insertions or removals.

The Chief Health Officer of the Department interviewed in April suggested the possibility of opening other service points where midwives or female nurses were posted: Mangaize (DR/ Maternity), Fandou (PMI), Karma (DR), Sansane Haous (DR) and Mehane (DR).

g. Zinder Department (1988 pop:1,411,000)

FP services for the most part were established following the clinical training course carried out in Zinder for service providers in October 1987. As of April 1989, service points were found operating in eight health facilities in Zinder commune, and in eleven facilities in the arrondissements of Myrria, Magaria, Matamayé, Goure and Tanout (Table 7). In all, services are now available in 9 urban/town centers.

Visits to the maternity of CM/Myrria, the PMIs of Birni and Fan in Zinder Commune and to the maternity of the CHD, also in Zinder Commune, show these centers serving only a few women:

Est. No. of Contraceptors - April 1989

Maternity/Myrria	50 - 55
PMI/Myrria	40 - 50
PMI/Birni (Zinder)	50
PMI/FAN (Zinder)	55 - 60
Maternity/CHD (Zinder)	110

The pill is the predominant method, followed as a distant second by injectables. Only a few IUDs have been inserted (33), all at the CHD by the

resident expatriate gynecologist (Mme Nazarene). Currently, eight of the 11 maternities in the Department are providing FP services: 1 (of 3) in Zinder Commune, the maternities in the five administrative centers of the outlying arrondissements and in Kantche and Belbedji. The maternity at Dungas is expected to institute FP services later in 1989. The 5 PMIs in Zinder commune have all initiated FP services. The PMIs in the medical centers of Myrria, Matrameye, Magaria and Tanout are reported to be located in separate physical facilities from the maternities of these centers and to be providing FP services.

The Department is considering further extension of FP services to the canton level where staffing permits:

- o Takaya (Arrondissement of Myrria)
- o Dungas (DR/Mat.) and Bande, both in the Arrondissement of Magaria.

Service statistics in Zinder, as in the case of the other Departments visited, are reported in terms of new and old (or former) clients, which include women who have ceased FP activities and which may include all women who ever received a method for any period whatsoever at the center.

The 1988 sample survey of contraceptive prevalence carried out by the DPF with the help of John Hopkins Population Communication Services Project in the summer of 1988 showed 8.03% of FEAP sampled (in Maradi and Zinder communes) practicing a modern method of contraception. Three quarters said they were using the pill and one-fourth said they were using condoms/spermicides for contraception. This data indicated that with a total population of 120,000 persons and some 26,400 FEAP, the number of women using oral contraception in Zinder commune was about 1600. Given this relatively reliable estimate and adding several hundred more contraceptors served by the relatively new centers in outlying areas, the evaluation team concluded that about 2,000 women in the Department were probably practicing FP using oral contraception or injections, as of the end of 1988.

h. Diffa and Agadez

Information gathered by DPF indicate there were 14 health facilities offering family planning service in Agadez as of April 1989, and that the three *Centres Medicaux* in Diffa were also offering FP service. Other information was not available.

3. Purposes and Key Indicators

a. Purposes and Objectively Verifiable Indicators Defined by the Project

i. Project Purpose

The purpose of the project is to strengthen the capacity of Nigerien Institutions to plan, support and monitor family planning services on a national basis. A sub purpose is to improve the capacity of the MSP/AS/CF to delivery family health services as an integral part of health services.

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ii. Objectively verifiable indicators defined by the Project

Objectively verifiable indicators of achievement of these purposes are defined in the Pro Ag (p. 19) and in the log frame (Annex II, page 1):

- o MSP/AS operates FP programs in all 7 Departments with established procedures for management, annual planning and contraceptive supply,
- o 146 health facilities offer family planning including IEC, counseling and contraceptive distribution as integral part of their family health services.
- o Government of Niger (GON) conducts periodic analyses of problems and progress of FP program.
- o Contraceptive prevalence among married women of reproductive age reaches 7% (vs 1% now).

iii Comments on above indicators

a. FP services in 7 departments:

The former Department of Niamey was divided in 1987 into two administrative parts, the Commune of Niamey and the Department of Tillaberi.

b. 146 Health Facilities:

This number was derived in the Project Paper by adding the number of medical centers (39), to the total number of existing PMIs (28) and maternities (78). Since FP services within a CM will normally only be integrated into the maternity and the PMI, the number in question could be interpreted as only 78 plus 28 or 106.

However, two important points need to be made.

First, the number of maternities and PMI is increasing and it is likely that nearly all if not all CMs will be provided with a PMI physically separate from the maternity during the coming five years. Furthermore, it is likely that additional maternities will be gradually established in new geographic localities as personnel permits.

Secondly, the Departments are already in the process of integrating FP services into activities of medical posts (PMs), municipal dispensaries (DQs) and where possible rural dispensaries (DRs).

The conclusion is that by the end of the project it is likely that the MSP/AS/CF will have succeeded in integrating FP to some degree in virtually all PMIs, all maternities, all PMs, all DQs and at least in those rural dispensaries where a midwife is assigned or where two nurses are working.

If FP is introduced into 20% of the 226 DRs, the total number of service points could reach 180 - 220. As noted in project paper's economic and social analysis of the project feasibility, benefit-cost returns will improve substantially if more contraceptors are developed early in the project so that the strategy should be to develop as many FP services points as possible, bearing in mind the priority need first is to gear up to support existing service points adequately.

c. 7% Contraceptive Prevalence Rate Goal

It appears that this rate is derived from of a goal of 116,000 current contraceptors [specified in the project paper (PP)] and an estimate of FMAP as of summer 1993. The goal of 116,000 current contraceptors by the end of the project was apparently based on an estimate of the number of contraceptors required to enable Niger to follow a low case scenario of demographic growth. Two observations are pertinent. First, the bulk of contraceptors under the national program are likely to be derived from the urban population - by definition the population of the 7 communes and 32 chefs lieux d'arrondissement. This population amounted to 1.1 million persons in 1988 and is expected to rise to about 1.45 million by August 1993.

Assuming a 25% urban contraceptive prevalence rate by then, the number of women contracepting would amount to about 80,000. Whether a higher rate of contraceptive prevalence in urban areas will be achieved, and whether a significant number of women in semi urban and rural areas (canton towns and surrounding areas) can be reached is a question which only time will tell.

The conclusions to be drawn from this discussion are:

- o DPF and USAID should recognize that the urban areas will generate most of the gains in family planning service delivery during the life of the Project; but
- o In order to reach the Project Objective of a 7% contraceptive prevalence rate, significant delivery will need to be achieved in semi urban and rural areas;
- o That In the planning process, it will be desirable for Departments and the Commune of Niamey to formulate with the DPF targets for providing contraceptive coverage in these areas by the end of the project.

B. Key Indicators of Achievement

[Indicators for monitoring project inputs and outputs necessary to develop and support FP service delivery, that is training, IEC, management, equipment and supplies and contraceptives, are treated in the following chapters.]

Achievement in establishing an effective SMI /FP system as an integral part of the health system can be monitored by a series of indicators which are summarized in **figure 1**. Of these the most important - to be derived from the programs management information system - are:

- o Growth of FP clients as measured by growth in consultations at different service points.
- o Number of working service providers.
- o Growth in the volume of contraceptors, by health facility, arrondissement and department, calculated by counting active client files.
- o Quantity of contraceptive products (particularly oral contraceptives, IUDs and injectables) required/distributed for FP service points each year, by health facility, arrondissement and by department.
- o Contraceptive prevalence in urban areas, measured at particular points in time by sample surveys.
- o geographic coverage, in urban areas and in populations of semi and rural areas within, say, five miles of a rural FP service point.

4. Conclusions

Rapid growth in service nationwide in 1988 has resulted in service delivery now being available in all urban centers (39). Partly as a result of this rapid growth, the Evaluation Team observed that performance levels measure in active clients per service center is very low in most health facilities and departments. It was observed that more trained personnel and strengthened supervision is need to insure quality of service. Moreover, the logistic system for contraceptive supply and distribution needs to be redesigned and reinforced to take into account the increase in the number of health facilities offering FP services and their great geographic distribution.

In order to effect improvements in quality and volume of service in existing health facilities, a sustained and directed effort in areas of planning, supervision, training, logistics and contraceptive supply and management information is required. The Team observed that the Project Implementation Plan appears well designed for such an effort. DPF should give priority to this effort..

The team concluded that the indicative objective of establishing FP services in 146 health centers probably will be surpassed and probably should be revised to take into account the establishment of FP services in medical posts (postes medicales) and in rural dispensaries. This conclusion is relevant to the achievement of the 7% contraceptive prevalence goal by 1992. Analysis suggests that this goal will not likely be achieved by family planning service in urban areas alone. A considerable extension of service delivery in semi urban and rural areas will be required. The Team recommends accordingly that annual work plans of the Departments include targets for providing contraceptive coverage in both urban and rural areas. Recommendations for data collection and record keeping for key indicators of service delivery development are set forth in Chapter IIF.

Figure 1 Key Indicators of Family Planning Service Delivery

- o No. of service points
- o No. of trained FP service providers at service points
- o Geographic distribution of service points and coverage in urban areas
- o Variety of free choice
 - multiple service points and alternatives for service
 - availability of different methods
- o No. of active contraceptors
- o No. of inactive contraceptors (for reason of child bearing)
- o Drop-out rates
- o Quantity of contraceptives delivered and used
- o Quality of counseling and service
- o Contraceptive prevalence.

Source: Evaluation Team, April 1989

Table 8: No. of Health Facilities Providing FP Services By Department, as of April 1989

Department	No. of Health Facilities
Niamey Commune	20
Dosso	14
Maradi	17
Tahoua	13
Tillaberi	14
Zinder	19
Agadez	14
Diffa	3
Total	114

Source: Evaluation Team, April 1989

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Health Facilities Providing Family Planning Services, April 1989
 Table 2
 Departement : City of Niamey

	Name or type of Health Facility	Location	Estimated no. of service providers	New, existing or former clients*			Observations
				New Clients	Existing or Former Clients	Total	
1	CNSF	C. de Niamey	16				IUD insertions possible
2	Mat. La Morde	"	2	253	1212	1465	
3	Mat. Centrale	"	4	16	12	28	IUD insertions possible
4	PMI République	"	3	88	164	252	IUD insertions possible
5	PMI Fan	"		214	436	850	
6	PMI La Morde	"	1	175	596	771	
7	PMI Yantalla	"	2	389	1311	1700	IUD insertions possible
8	PMI Abidjan	"	2	136	337	473	IUD insertions possible
9	PMI Boukoki	"	2	12	27	39	
10	PMI Gankalle	"	4	196	381	577	IUD insertions possible
11	Mat. Médina	"	1	88	164	252	IUD insertions possible
12	PMI G. Républicain	"	1	227	1231	1458	
13	CNSS Kalley	"	4	78	367	445	IUD insertions possible
14	CNSS Marouey	"	7	217	1249	1465	IUD insertions possible
15	Disp. Goudel	"		217	21	48	
16	Disp. Lazaut	"					
17	PMI Poudrière	"	3	176	657	833	IUD insertions possible
18	Mat. Poudrière	"					
19	Mat. Yantalla Talladje	" Dr					

According to: "Rapport d'Activités en Planification Familiale des Centres de PMI, des Maternités, du CNSF de la Commune de Niamey, Année 1988".

* The data include inactives and drop-outs.

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- o No. of active contraceptors
- o No. of inactive contraceptors (for reason of child bearing)
- o Drop-out rates
- o Quantity of contraceptives delivered and used
- o Quality of counseling and service
- o Contraceptive prevalence.

Source: Evaluation Team, April 1989

Health Facilities Providing Family Planning Services, April 1989
 Table 3
 Departement : Dosso

	Name or type of Health Facility	Location	Est. Number of Service Providers	New, Existing or Former Clients			Observations
				New clients	Existing or Former Clients	Total	
1	Mat./CHD	C. de Dosso	1	51	19	70	IUD insertions possible IUD insertions possible IUD insertions possible
2	PMI/CM	"	1	576	1 768	2 344	
3	PMI/CM	Doutchi	2	163	539	702	
4	Mat./CM	Doutchi					
5	PM	Mataukari					
6	PM	Tibiri	1	49	7	56	
7	DR	Guechemi					
8	PMI/CM	Loga	1				
9	PMI/CM	Birni	1	138	637	775	
10	PM	Falmey		64	56	120	
11	DR	Kiota		106	160	266	
12	PMI/CM	Gaya		181	414	595	
13	PM	Dioundiou		33	49	82	
14	DR	Tanda		160	106	266	
		Total	7	1 521	3 755	5 276	

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Health Facilities Providing Family Planning Services, April 1989

Table 4

Departement : Maradi

	Name or type of Health Facility	Location	Est. Number of Service Providers	New, Existing or Former Clients			Observations
				New clients	Existing or Former Clients	Total	
1	PMI 17 Portes	C. de Maradi	7 1	34"	177"	211"	73 contraceptors - Avril 89 (incl IUD)
2	Mat. 17 Portes	"	2 1	159	344	517	400 à 500 contraceptors - Avril 89
3	PMI Andoumé	"	1	14	45	59	
4	PMI CNSS	"	1 +1	70	104	174	
5	Mat. CHD	"	1 + 1 + 1	50	120	170	IUD insertions possible
6	Mat. CM	"	2 1	34	270	304	170 contraceptors - Avril 89
7	PMI Sabongari	"	1 + 1				
8	PMI Place du Chef	"	1	73	290	363	
9	PMI/CM	CLA Aguié	1 + 1	15	43	58	IUD insertions possible
10	CM	CLA Dakoro	1	49	144	193	
11	PMI/CM	CLA Tessaoua	2				40 - 45 contraceptors
12	PMI/CM	CLA Gazaoua	1	24	84	106	
13	Mat./CM	CLA G. Roumji	1	53	69	122	
14	Mat./CM	CLA Madarounfa					Service temporarily suspended
15	Mat./CM	CLA Mayahi	1	10	31	41	Service temporarily suspended
16	PMI/OR	Tibiri	1				
17	DR	Dan Issa	1				IUD insertions possible

*Includes inactives and drop-outs based on 4th qtr 88 reports

C.L.A. = Seat of arrondissement

"Base on first qtr 89 report

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Health Facilities Providing Family Planning Services, April 1989
 Table 5
 Departement : Tahoua

	Name or type of Health Facility	Location	Est. Number of Service Providers	New, Existing or Former Clients*			Observations
				New clients	Existing or Former Clients	Total	
1	PMI/Tahoua	C. de Tahoua	2			960	230 contraceptors IUD insertions done
2	PMI/CNSS	"	1			Na	IUD insertions done
3	PMI/FAN	"	1			28	
4	PMI/CM	"	1			21	
5	Mat./CHD	"	3			Na	24 contraceptors, April 89
6	Mat./CM	CLA Bouza	1			18	
7	Mat./CM	CLA/Liéla	1			20	
8	Mat./CM	CLA Birni N'Konni	2			120	256 contraceptors, April 89
9	Mat./CM	CLA Madaoua	3			36	IUD insertions done
10	Mat./CM	CLA Tchir Tabaraden	2			31	
11	Mat./CM	CLA Keita	2			81	IUD insertions done
12	PMI	Galmi"	3			Na	24 contraceptors, April 89
13	Mat./CM	Mabaza	1				

* According to : "Rapport annuel d'activité 1988 : Direction Départementale de la Santé". Data include inactives and drop-outs.

" : A de Birni N'Konni

C.L.A. = Seat of arrondissement

Health Facilities Providing Family Planning Services, April 1989
 Table 6
 Département : Tillabéri

	Name or type of Health Facility	Location	Est. Number of Service Providers	New, existing and former clients*			Observations
				New clients "	Existing or Former Clients	Total	
1	Mat./CM	CLA Tillabéri		133	458	591	
2	PM	Ayorou		12	65	77	
3	Mat./CM	CLA Tera		135	467	602	
4	PM	Gotheye		76	410	486	
5	PM	Bankilaré		15	16	31	
6	Mat./CM	CLA Say		153	442	595	
7	PM	Torodi		33	36	69	
8	Mat./CM	CLA Ouallam		179	398	577	
9	PM	Banibangou		3	28	31	
10	Mat./CM	CLA Kollo		183	446	629	
11	Mat./CM	CLA Filingue		99	326	425	
12	CR	Bonkougou		24	28	52	
13	CR	Balléyara		103	251	354	
14	CR	Abala		31	35	66	
				1179	3406	4585	

* According to "Rapport annuel 1988, Situation Sanitaire du Département de Tillabéri". Data include inactives and drop-outs..
 New clients are those using oral contraceptives and injectables

Health Facilities Providing Family Planning Services, April 89
Table 7
Departement : Zinder

	Name or type of Health Facility	Location	Est. Number of Service Providers	New, existing or former clients*			Observations
				New clients	Existing or Former Clients	Total	
1	PMI Stade	C. de Zinder	2	372	186	558	50 contraceptors
2	PMI Birni	"	2				
3	PMI Zengou	"	2	217	352	569	
4	PMI CNSS	"	2	241	289	530	56 contraceptors - IUD insertions done
5	PMI FAN	"	1				
6	D. Q. Sabongari	"	1				109 contraceptors-33 IUD insertions done
7	D. Q. Chari Zamna	"	1				
8	Mat. CHD	"	2	65	61	126**	
9	Mat./CM	CLA Myrria	1	53	91	144	52 contraceptors
10	PMI/CM	CLA Myrria	2				52 contraceptors
11	Mat./CM	CLA Magaria	1	43	69	122	IUD insertions done
12	Mat./CM	CLA Matamaye	1	125	32	1458	
13	PMI/CM	CLA Matamaye	2				
14	Mat./CM	CLA Gouré	1	42	69	121	
15	Mat./CM	CLA Tanout	1	10	168	178	
16	PMI/CM	CLA Tanout	2				
17	Mat./DR	Kantché"	1				
18	Mat./PM	Tesker""	1				
19	Mat./DR	Belbedji "" ""	1				

According to : "Rapports du 4ème trimestre 1988".

* The data include inactives and drop-outs

** New clients are those using oral contraceptives and injectables

" Magaria ; "" Gouré ; "" "" Tanout.

B. Management, Supervision and Coordination

1. Summary

Management of the national family planning program is the responsibility of the Directorate of Family Planning within the Ministry of Public Health and Social Affairs. This is a relatively new Directorate established in 1988 and still in the process of developing its organization, staff, work space, work plans, procedures and management systems. Technical assistance for management and project implementation is expected to be in place by September 1989.

The evaluation team found:

1. The new Directorate staffed and functioning with a Directrice of great experience in administering FP programs; appropriate delegations of responsibility.
2. Difficult working conditions in DPF: shortages of space, vehicles, office equipment ; being worked upon.
3. A need to strengthen supervision and coordination.
4. A need for clarification of the role of the National Family Health Center (CNSF) ; nevertheless, it is clear that the CNSF is a strong supporting institution for FP development in Niger.
5. A detailed project implementation plan agreed upon in the ProAG (and amplified in the Request for Proposals for a Management and Technical Assistance (TA) Team) ; being followed.
6. Arrangements for a management and technical assistance team to help DPF develop and put into place needed management systems and procedures.
7. USAID adequately staffed and organized to make its contribution to project management and implementation - USAID actions underway for procurement of inputs and provision of financing.

The team concluded that arrangements for management, supervision and coordination which are being made appear sufficient for effective project execution.

2. Current Situation

Responsibility for the management of the national family planning program rested largely with the CNSF until 1988 when the Directorate of Family Planning (DPF) was established within the Ministry of Health under the Secetaire d'Etat Charge de La Condition Feminine et Des Affaires Sociales. It is the DPF which has the operational responsibility for the family health component of NFHDP.¹ The former head of CNSF became the first and current head of DPF (Mme Maidouka). A report of 1988 activities of the DPF indicates progress achieved and difficulties encountered in the first year (Annex VI).

¹ The DSD manages the demographic component of the Project. See Part III.

a. Strategy, Decentralization and Institutional Setting

The strategy adopted by Niger is the integration of FP and MCH services in existing health facilities and services. The public health care system is organized so as to decentralize management.

The national level includes the Directorates of the Ministry of Health and the Health Schools. Under the national level, there are eight Departmental Health Directorates (DDS), including one staffed only in March 1989 for Niamey Commune. In this decentralized system, the DDS are responsible for management of health activities of their Departments including administrative sub-divisions (the arrondissements). There are 39 arrondissements, whose administrative center is located either in one of the seven Departmental capitals or in one of 32 Chefs Lieux d'Arrondissements.

Each arrondissement is provided with a Medical Center (CM) run by a physician (increasingly) or an experienced graduate nurse. Maternities and Mother Child Health Care centers (PMI), medical posts (PM) and rural and municipal dispensaries (DQ or DR) report to the CMs.

At a third level, the PMs and dispensaries are responsible for support and monitoring village health teams each usually made up of two village health workers (securistes) and two traditional birth attendants (matrones). Under the Project implementation plan, the feasibility of using village health workers for some family planning services is to be tested.

The fourth level concerns the management of individual health facilities by the head midwife and/or nurse. This includes their management of FP services.

b. National Level

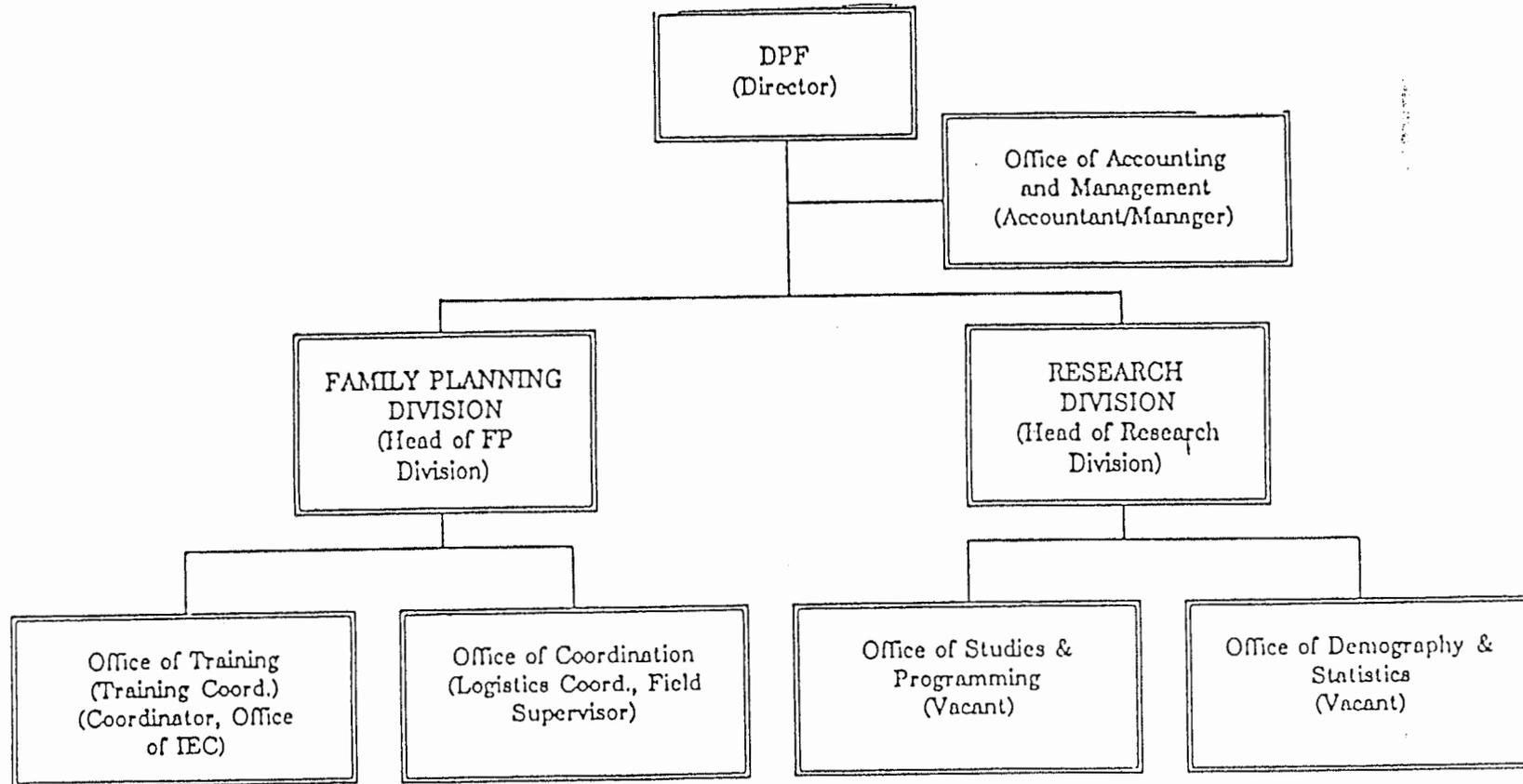
The DPF manages the program at the national level in collaboration with other Directorates of the Ministry including the Directorate for Financial Affairs and Administration (DAAP), the Directorate for Training and Health Education (DFEPS), the Directorate for Studies and Programming (DEP) and the Directorate for Maternal Child Health Care (DSMI), Directorate for Health Infrastructure (DIS)], with the pre-service schools of health (Faculty of Medicine, ENSP and ENICAS) and the National Office of Pharmaceuticals (ONPPC).

DPF is organized as shown in **figure 2**, which also shows principal delegations of responsibility. Under the Directrice and Deputy Directrice three principal units: the FP Division, An Office of Accounting and Management (one person) and a Research Division.

The FP Division is headed by Mme Salamatou Laouali, a graduate midwife with considerable experience in FP and a talent for trouble shooting, supervision and monitoring. The FP Division has offices of training, IEC and coordination. The Office of Training (Mme Aissata Bagnan) manages FP training (in coordination with the Directorate of Training and Health Education). The IEC Office is headed by Mme Kadi Traore. The office of coordination is responsible for field supervision (Mme Fatoumata Abdoulaye) and logistics (Mme F. Kane) including equipment and contraceptive procurement (with USAID).

ORGANIZATION CHART OF MSP/AS/CF

Directorate of Family Planning



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The Office of Accounting and Management (one person, Mr. Alioune Beri) is responsible for personnel and financial management. The Research Division, intended eventually to have two offices for studies and programming and for demography and statistics, is currently a one person office (M. Katiella).

Many of the staff are recent arrivals still learning their jobs. It is recognized that training of staff members will be required and such training is planned, both on the job and in formal training programs (see Section IID).

The staff of DPF will moreover be buttressed by a technical assistance team consisting of three long-term consultants (ten person years) and the availability of some 43 person months of short term consultants. A detailed job description for each long term advisors is set forth in the Request for Proposal, Niger Family Health Component of Project, issued by USAID and AID/REDSO in March 1989. The contract for this management and TA team is expected to be let shortly. Proposals received from prospective contractors include detailed work plans for the first two years. The contract for this team is expected to be awarded by summer 1989. The long term advisors are expected to arrive in September 1989:

i) Chief of Party and Management Analysis: will work with the Directrice of DPF and staff to put into operation the organization and procedures appropriate to the management of the national program.

ii) Long term advisor to work with the Training Coordinator to furnish technical assistance and know-how needed and to help plan and implement the training program.

iii) Long term advisor to work with the IEC Coordinator to furnish technical assistance and know how and help plan and implement the IEC program.

iv) Short term consultants for work in management development, logistics, training, IEC, and operations research (20 person months).

c. Current Operating Problems of DPF

These include lack of sufficient office space, vehicles (one vehicle was supplied during the evaluation team's visit), lack of office supplies and equipment including computers and lack of an operating budget. These are short term problems whose solution appear in sight. The office space problem is being addressed by the Ministry by moving personnel to other office space and providing more rooms on the second and third floor of the Ministry. USAID has ordered vehicles - one was delivered during the team's visit - and computer equipment and office equipment and supplies. Logistical support by the Management Team will alleviate the operational problems currently being experience.

d. Establishment of Management Procedures and Systems

A concern identified in the implementation plan spelled out in the ProAG (page 33) and detailed in the scope of work of the Management and TA Team is the need to develop management systems and procedures early in the Project. The management analyst is to work with the Directrice of DPF and her staff to help develop and put into operation:

- o short and long term plans including the annual work plan for 1989/90
- o instruments and procedures for program monitoring and to evaluate progress toward attainment of project objectives
- o a personnel management system including supervision (protocols for mid-level managers), performance standards(standards of care for service providers), human resource development and personnel evaluation.
- o a financial management system including program budgeting, overall fiscal management
- o a comprehensive management information system.
- o a logistics management system insuring proper ordering, importing, warehousing, and distribution of contraceptive products and other equipment and supplies.
- o Standard Operations Manuals

The Directorate has initiated a number of steps to develop its managements systems and procedures and to develop management generally. A first effort was national seminar on Management of FP Programs held in Niamey from 7 to 18 November. Recommendations of this seminar (Annex 7) echo the need for these systems and procedures. One outcome of this seminar was the preparation of a supervisory protocol, now under review.

The Directorate has also been collaborating with the DEP which is developing a Ministry-wide Management Information System (MIS) which will provide data for all levels to track performance of individual centers, arrondissements, departments and the nation in various sectors, including MCH and FP. A seminar was organized during the team's visit to present the proposed MIS to the DDS and representatives of all the Directorates for comment and review.

e. Mangement role of USAID

USAID has an important management role in procurement of inputs financed by AID under the ProAg. Among other things, USAID is expected to:

- o Arrange long term training in the U.S.
- o Contract for the Management and TA Team

- o Procure BUCEN and other TA for the Demography Component of the Project
- o Procure contraceptive health and medical equipment and supplies and vehicles for the Project and household furnishings and appliances for the Management and TA Team.

In addition, DPF and USAID collaborate closely in planning inputs, monitoring project execution and in carrying out audits and evaluations. The USAID Population Officer (Mme Susan Wright) is also responsible, under the direction of the USAID Health Officer, for providing technical direction to the Management and TA Team. Financial management of the Project is under review of the USAID controller. The Evaluation Team observed that USAID appears adequately organized and staffed to carry out its role in project management and coordination.

f. Management at The Departmental and Arrondissement Levels

The team met with the Health Directors of Tillaberi, Tahoua, Maradi and Dosso and observed that each was well informed about the activities of the program and its implementation in his Department and had definite ideas on how it should be extended further.

Each Department has a full-time person responsible for maternal child health and family planning coordination. The team met the coordinators for Dosso, Maradi, Zinder and Tahoua and observed:

- i) They are apparently not in a position to make as many supervisory field trips (every three months) as would be desirable.
- ii) For the most part they do not understand service statistics and they need to organize themselves to maintain data on contraceptive consumption, stocks and needs in their Departments.
- iii) They need training in supervision - guidance, support and motivation of service providers and in management of MCH/FP programs in the field (in small groups and on-the-job accompanying an experienced person).

The Team observed that no Department has a satisfactory perception of the volume of FP services being delivered or the rate of draw-down of contraceptive stocks. All Departments will benefit from the management information system (SNIS) being introduced by the Ministry of Health. They all need to develop short and medium term plans tied into overall national objectives and planning. This was also a recommendation of the Niamey Management Training Seminar cited above and will be an important concern for the DPF.

By contrast Department management knew in detail their personnel involved in family planning. Health Directors and FP coordinators are concerned about the availability of personnel [particularly midwives who are concentrated in Niamey (where their husbands are)] and about the need for training in FP of service providers, particularly in centers where the trained provider has been transferred out without a trained replacement. The same concern was evident at the

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arrondissement level by the heads of the Medical Centers. The Project implementation Plan calls for a national training team to handle local training. [However, a recent review in Dosso (Annex V) recommends a departmental training team. This should be considered where sufficient trained personnel are available.]

The team was able to discuss the FP program with the heads of the Medical Centers of Myrria (Zinder), Tessaoua (Maradi) and Birni nKonni (Dosso). Under the Project all CM heads are to be trained in Family Planning Management as well in some cases in service provision. The CMs will be the center points for assuring proper integration of FP services into the activities of health centers, for Departmental/Arrondissement level IEC efforts, for identifying training needs and possibilities for extending the program to new geographic areas.

A point that was not clear to the team is how the Departmental FP coordinator will relate to and work with the CM heads and the Assistant Social usually assigned to each CM.

g. Management at Health Facility Level

This is the front line for FP promotion and service delivery. The team was informed of instances and observed some where centers lacked FP equipment and supplies. It is also clear that FP service points are now being established in locations distant from the CMs so that regular visits for supervision, guidance and support is a problem. It will be important to make working conditions for family health services as good as possible - i.e., clear guidelines on what is expected of the center, adequate supplies of materials and contraceptives and to extend a good deal of encouragement to the service providers by way of frequent visits to learn of their problems and progress and, importantly, to help them do their reports right. A situation to be avoided is a center which rarely receives a helpful visit and considers itself forgotten at the end of the road. The team suggests preparation of center profiles as management tool useful to the CM Chief, the CM - AS and the DDS FP coordinator.

h. Data collection, record keeping and project monitoring

The review of service delivery (Chapter II A) and of management shows that the interrelated management functions of data collection, record keeping and project monitoring provide managers and technicians with necessary information to manage the programs, to determine if inputs are being provided as needed, to assure that planned outputs are being realized and to judge if the Project is achieving its purpose. The PROAG sets forth a reasonable monitoring plan (figure 3) which in the opinion of the Evaluation Team should enable the DPF and USAID to track performance effectively. Recommendations for actions and procedures to develop and strengthen data collection and record keeping are set forth in Chapter IIF.

3. Coordination and Communications

The process of establishing formal and informal lines of coordination, communication and collaboration with other Directorates in the Ministry and with the DDS and departmental FP/MCH coordinators is well advanced. For example, the DPF and the Directorate of Maternal Child Health Care (DSMI) collaborated in

December of a review of MCH/FP activity in Niamey Commune (Annex IV). It is of course the responsibility of the Secretary General of the Ministry under the Minister to assure necessary coordination and collaboration among the several Directorates.

There is also a need to assure coordination outside the Ministry. For example, apparently improved coordination should be sought with the Ministry of Plan, and in particular with the Directorate of Statistics and Demography (formerly Directorate of Statistics and Computing). It was observed for example that a DSD representative was not involved in the seminar on the SNIS being developed, and that previously similar studies of infant mortality had been carried out by DSD now and by MSP/AS/CF at about the same time without either organization being aware of the other study. Coordination on the IEC program is also required with the Ministries of Information, Youth and Sport and with the Ministry of Education in the area of Family Life Education.

Close coordination and collaboration is also desired with the CNSF which continues as a national center for referrals, research, promotion and service training with substantial resources provided by UNFPA (The head of the center is also the Director of the UNFPA Family Planning project .) But the role of the Center is currently ambiguous and needs clarification. Undoubtedly, the Center offers important management resources for the development of the FP service delivery system in the country, and for IEC activities. The team observed several examples of collaboration among the staff of the Center and DPF, for example the surveys of FP development in Niamey and Dosso mentioned in Section IIA. Currently, the CNSF continues to warehouse contraceptives provided by donors and makes distributions within Niamey commune and to the seven Departments in a somewhat haphazard fashion. As noted in the next chapter, the contraceptive supply system needs to be developed under DPF management and it is intended eventually to integrate it into the Ministry's system for delivering drugs to health facilities.

Finally, there is a need to coordinate donors inputs. An example is the support being provided by USAID and by UNFPA. UNFPA reports that it is focussing its assistance through the CNSF for the Departments of Maradi, Tillaberi and Dosso. AID's support through the DPF is for the FP program nationwide. This coordination is best handled by MPS/AS/CF-DPF and should be reflected in annual work plans for the national program and for Departments. The Team noted that the 1989 work plans for training and IEC prepared by DPF do coordinate support available from both donors.

Figure 3: Sources and Methods for Project Monitoring

Monitoring Plan: The Ministry of Plan, the Ministry of Public Health and Social Affairs and USAID/Niger will collaborate in monitoring the progress of the NFHDP. Project monitoring will ensure that the parties have accurate, timely information on the technical, managerial and financial aspects of the project. The mechanisms for project monitoring described below will allow the MP, the MPH/SA and USAID/Niger to determine the status of inputs and outputs with respect to established bench marks and schedules, as well as to ensure that project funds are being disbursed legally and for the intended purposes.

Sources and Methods for Project Monitoring

1. Project Agreement and Project Implementation Letters: This Project Agreement and Project Implementation Letters to be issued by USAID/Niger provide the objectives and guidelines for measuring project progress.

2. Annual workplans: The MOPH/SA and the MP will prepare annual workplans for implementation of their respective project components. The USAID/Niger Health Development Office and the contractors will assist the Ministries in the preparation of the work plans which will require the approval of USAID/Niger.

3. Financial Management and Reporting: The long term contractor will be responsible for establishing workplans for the team and issuing financial reports for the Family Health Component which show planned and actual expenditures and explain any variance that may exist. The responsible U.S. Cooperating Agency will generate financial reports with respect to implementation of the Demographic Research and Analysis component. Financial reports are to be produced quarterly and will list disbursements and accruals by budget line item for the current quarter, shown comparatively with cumulative disbursements. The DPF and the DSI[DSD] will provide regular financial reports satisfactory to A.I.D. for any funds they may disburse.

4. Technical Reports: Short technical reports will be submitted each quarter by the DPF and the DSI to summarize activities undertaken during the quarter and identify any problems or bottlenecks in project implementation. Both agencies will submit annual technical reports in conjunction with their annual work plans. The annual reports will provide a detailed review of project progress with specific reference to the targets and schedules established at the beginning of the year. The long-term contractor will assist the DPF in the preparation of all technical reports. Short term consultants will also be expected to submit concise trip reports.

5. Consultation with Implementing Agencies: There will be frequent consultations between the USAID/Niger Health Development Office and its counterparts in the MOPH/SA and the MP. At a minimum, quarterly meetings will be held with the Directors of the DPF and the DSI to review the quarterly technical reports. An annual project review meeting will be held with senior officials of the MP and the MOPH/SA to review the annual technical reports and the work plans. As needed additional consultation with the Directors and other involved GRN staff will occur.

6. Site Visits: Site visits will be particularly important for the Family Health Component. A plan for service delivery expansion that identified the health facilities in which services are to be introduced is to be provided by the MOPH/SA at the beginning of each year. Site visits will be made to these facilities during the course of each year by DPF staff and the USAID Population Program Coordinator. The site visits will be structured to investigate such issues as service provider perceptions of the training after they return to their duty posts, levels of service delivery, adequacy of contraceptive supply, availability of IEC materials and level of IEC activity in the surrounding communities, maintenance of record keeping systems, supervision of service providers and problems and bottlenecks perceived by the service providers.

Source: Project Agreement, pages 55 and 56.

4. Key Indicators to Measure Inputs, Outputs and Achievement for Project management.

a. Inputs

The main inputs are those for the on-going operations of the DPF (training, IEC, supervision, logistics, MIS and general management) and financing of the TA team, including short term consultants. The Project also funds equipment for DPF operations and will fund three evaluations planned over the life of the project and an audit (See log frame, Annex 3).

b. Outputs

The main outputs relating to management, supervision and coordination as defined in the log frame are:

- o annual work plans
- o supervisory protocols and quarterly visits
- o Standards of service care established and applied
- o Management information system in place

In addition, one would need to add:

- o A financial management system in place, including program budgeting, accounting providing accurate reports of disbursement on a expenditures in terms of approved budget items.
- o Effective procurement and logistics system in place (see next Chapter).
- o An effective system for planning, implementing, supervising and monitoring in place covering FP development in the seven Departments and the Commune of Niamey.
- o Trained. motivated staff in place
- o Rational and timely coordination of resources provided by the Government and donors.
- o Timely activity and progress reporting

c. key indicators for Management

- o Soundly developed plans and budgets are available and being carried out.

- o Technical assistance for management in place and DPF staffed; training program for staff elaborated.
- o Operating Manuals prepared and in use; standards for service delivery care and supervision established.
- o Supervision is being carried out according to standards and procedures established and as monitored by regular reports by supervisors on the situation and problems in their areas.
- o Effective coordination developed with other actors and with donors
- o Financial management system in place providing effective controls and financial resources as required and data.
- o Procurement and logistic system in place providing supplies and equipment on timely basis, and a data base in place providing accurate information on stocks and inventories.
- o The management information system is operative and producing reliable data on volume and trends in FP consultations, number of contraceptors by center and administrative sub-division.
- o Project monitoring system in place; timely and accurate activity and progress reporting.

d Situation Sought At End of Project

The end of project situation sought is the achievement of institutional capacity of Nigerien institutions to plan, support and monitor FP services on a national basis, and secondarily to build the capacity of the MSP/AS/CF to deliver FP services as an integral part of health services. In terms of management, this means (ideally):

- o a well organized and staffed Directorate of Family Planning. It would be characterized by
- o sound planning (annual and medium term) in which in practice are implemented without undue delays and within budgets;
- o problem solving capability; ability to analyze problems and conceptualize and test solutions;
- o efficient system for procurement and supply of contraceptives country wide (see next section).

- o effective communications and collaboration with other Directorates in the Ministry, with decentralized administrative health structures and with outside agencies.
- o a management information system able to track performance of individual centers, and administrative sub-division accurately in timely fashion.
- o tested and proven methods of program implementation to maintain and extend FP services to increasing numbers of families and proven ability to monitor program implementation.

C. Contraceptive Supply Including Logistics

1. Summary

The increase in the FP service throughout the country in the past 18 months has aggravated the problem of contraceptive supply which for many years has been geared mainly to support a small number of centers in and around Niamey. As a result, the DPF faces a number of problems with the existing system of contraceptive procurement and distribution.

- The current system of is haphazard and needs to be systematized as soon as possible.
- DPF should assume control and management of the system.
- Coordination with donors needs to be strengthened to insure effective planning and programming for timely and adequate procurement and supply.

These problems are being addressed. DPF has recruited an experienced logistics manager. The Project Implementation Plan includes a sound program for developing a responsive, national contraceptive supply system. The Ministry has developed a Management Information System which will if properly implemented provide reliable data on contraceptive consumption and stocks at the field level. The requirement now is to put the proposed contraceptive supply system into place.

2. Current Situation

a. Contraceptive Supply

The availability of contraceptives is based on supplies provided by donors - mainly USAID, UNFPA, the World Bank and IPPF - and imports by ONNPC (with GON budget funds and proceeds from contraceptive sales in the pharmacies). The requirements for the program include oral contraceptives, IUDs, injectables, condoms, and spermicides.

Contraceptive distribution by CNSF in 1988 amounted to 59,205 cycles of pills, 5,836 doses of injectables, 2,877 IUDs, 227,274 condoms and 146,617 units of spermicides. Contraceptive distribution by ONPPC in 1988 amounted to 62.875 cycles of oral contraceptives, 6,526 doses of injectables and 75,918 condoms. All together , 122,080 cycles of pills (9400 CY-P) and 12,362 doses of injectables (about 3100 CY-P) were distributed representing about 12,500 couple years of protection.

The Evaluation Team estimated that in 1988 the city of Niamey accounted for over 60% of family planning services being provided in the country.. It estimated that the growth in the number of contraceptors in Niamey was 47% during 1988 (based on objective data for the period April 1987 - August 1988). It is apparent that substantial growth in numbers of contraceptors also took place in the communes of Zinder and Maradi. and that nationwide the number of health facilities providing FP services had increased rapidly in 1988. As a result, the Team concluded that overall national growth in contraceptors in 1988 could be

estimated at 47%. This growth is attributed both to increased FP clientele at the various health facilities offering FP and the increasing number of health facilities providing family planning services. The result is an overall increase in requirements and a wider geographic distribution to be handled by the logistics system.

With respect to requirements, the team observed several problems which DPF will need to address:

i) The large number of different brands which complicate the problem of procurement, distribution and supply. In particular, the number of brands of oral contraceptives should be reduced. In principal, Niger could manage well with two brands , Lo Feminal and Ovrette.

ii) The current problem of insufficient supply of injectables to meet demand, at least outside the areas of Niamey, Dosso, Filingue.

iii) A need for closer coordination and planning with donors on the procurement of contraceptives [which could be accomplished by the establishment of a joint contraceptive supply committee chaired by DPF and including representatives of ONPPC, CNSF, UNFPA, USAID , the World Bank and other interested donors].

AID procurement for country program is centrally managed by AID/Washington and is based on a system of projecting needs for five years, with estimates up-dated each fall. Contraceptives provided by USAID in Africa tend to be limited to a low dose pill (Lo-Feminal), a progestin only pill (ovrette), copperT (T 380), condoms and vaginal foaming tablets (conceptrol). The U.S. does not provide injectables. In Niger, there is an agreement that USAID would provide pills, IUDs, condoms and spermicides and that UNFPA would provide injectables.

Estimates of requirements for the Niger program in 1989 and subsequent years were made in November 1988 by a CDC consultant. Requirements were based on an estimate of 13,072 contraceptors in 1988. The consultant apparently did not have access to data on ONPPC distributions in 1988 or the results of the CAP studies showing contraceptive prevalence in Niamey, Zinder and Maradi as of August 1988. As a result his estimate of the number of contraceptors in 1988 is considerably lower than the estimate of 18,000 women which the USAID has been using.¹ This raises a concern whether the quantities being procured by USAID for 1989 will be sufficient.

Data provided by CNSF showed stocks as of March at low levels and the Mission was requesting urgent shipment by air of pills.

¹ DPF has estimated 20,000 contraceptors. The Evaluation Team's examination of available data suggested that the number of contraceptors protected by oral contraceptives, injectables or the IUD was at least 19,000 persons as of December 1988.

b. Logistics Management

Until 1988, the National Center for Family Health was responsible for and managed FP logistics for the country, in cooperation with the National Pharmaceutical Office (ONPPC), through its chief pharmacist. This responsibility was country wide but it should be recognized that the bulk of distribution was in the Niamey urban area and to a lesser extent in Tillaberi and Dosso Departments.

With the establishment of the Directorate for Family Planning in the MSP/AS/CF, the responsibility for FP logistics is to be transferred from the Center to the DPF and DPF has recruited an experienced logistician, Mme Kane (who previously managed the CNSF warehouse) to assume charge of contraceptive supply and logistics for the Directorate.

The situation in April 1989 is that DPF has administrative responsibility for contraceptive distribution. However, the supplies are physically stored in the CNSF pharmacy and distributions are currently made by the CNSF pharmacist in response to field requests. A record of monthly distributions showing stocks on hand for different contraceptives was initiated by CNSF in January.

In this situation, lines of responsibility are not clear cut, a problem that DPF recognizes. It is expected that the situation will be clarified during 1989. The basis of the solution appears to lie in plans to build a new national warehouse that will be needed to store the increasing quantities of contraceptives as the program expands. Some funds are available for such construction. The warehouse would be built on the site of CNSF in Niamey, where land is available. The DPF logisitian would assume control of the warehouse and contraceptive supply.

With respect to field supply, the team observed a haphazard approach to distribution of contraceptives to Departments and Arrondissements and a lack of reliable data of stocks on hand or consumption. Because supply is becoming a more complex problem as more service points are being established in health facilities and as many service points are being located outside the chefs lieux d'arrondissement and the Departmental capitals, it is evident that supply needs to be systematized at a very early date. The new management information system being established by the Ministry should facilitate this process (see section d following).

c. Training in Logistics

A three day logistics module was organized as part of a management training course held in Niamey in November 1988. The course provided training in:

- o determining the logistic structure needed at the field level
- o determining how to avoid overstocking and stock-outs
- o forecasting contraceptive needs, and
- o reporting data on service delivery and logistics for program monitoring.

Additional training will be needed for a substantial number of persons at local, regional and national levels.

d. Management information System (MIS)

The MIS worked out by the Directorate of Studies and Programming (DEP) (with assistance from Tulane University and inputs from the various Directorates of the Ministry) includes a quarterly report of contraceptive stocks as well as a client file form and a form to mark quantities of contraceptives distributed and number of new contraceptors. As noted earlier, the proposed system is currently being reviewed with the users.

e. Other Procurement and Supply

USAID has initiated procurement of 4 vehicles, computers, office furniture, equipment and supplies. The project is also to bear costs of fuel and maintenance. In addition, a fund is to be allocated to each arrondissement for the purchase of equipment and supplies. The plan calls for each CM director to identify equipment and supply needs of facilities with the arrondissement up to the amount allocated.

3. Objectives, Strategy and Plans for Contraceptive Supply and Logistics Management

Objectives and plans are set forth in the ProAG (pgs. 31, 32) and in recommendations provided for the project feasibility study by a CDC team in April 1987²: The objective is ensure that an adequate supply of contraceptives is available and that appropriate stock levels are always maintained at each point in the delivery system. The strategy is to integrate the contraceptive supply system with the existing system using ONNPC for delivering pharmaceutical to health facilities.

a. Inputs

With respect to inputs the plan provides:

i. In coordination with other donors, the Project will finance the procurement of contraceptives in sufficient quantity to meet demand (expected to rise in line with an increase in contraceptors from 18,000 end 1988 to 116,000 by the end of the project.

ii. The project will finance the purchase of vehicles including two long bed four wheel drive crew cabtrucks purchased for use of supervisory staff can also be used for emergency supply of contraceptives, but normally supplies will be distributed by the existing MPH/AS supply system.

iii. In addition to the vehicles a fund will be allocated to each arrondissement for the purchase of equipment and supplies. Each CM director will identify the equipment and supply needs of health facilities within the arrondissement up to the amount allocated.

² CDC, Trip Report (AID/RSSA), Preparation of Contraceptive Logistics Portion of Project Implementation Design, Atlanta, June 1987.

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iv, Contraceptives, vehicles and medical equipment will constitute the bulk of commodity procurement under the NFHDP. The Project will also finance procurement of a variety of equipment and supplies ranging from calculators to typewriters to micro computers and maintenance and fuel for the vehicles.

v. Operational research into non governmental mechanisms of service delivery. The Project will finance technical and financial assistance for the study to be carried out by DPF in collaboration with ONPPC to test the feasibility of using privately pharmaceutical *depots* as distributors on non-prescription contraceptives. [The feasibility of a community based distribution system using village health teams will also be studied, as noted in Chapter B above.]

b. Outputs

With respect to outputs, the plan provides for:

i. The design and installation by DPF (with the help of a contraceptive supply specialist and the Management Team) of a Product Flow System to establish procedures and manuals for ordering, receiving, stocking and distributing contraceptives at all levels of the supply system. The MSP/AS/CF will designate contraceptive supply managers at each point in the distribution chain. The requirement for an intermediate warehouse and a warehouse manager will be examined by the contraceptive supply specialist (following arrival of the management and TA team to work with DPF).

ii. A management information system will provide data necessary to assure stock control and maintenance of adequate stock levels at various points in the system.

4. Key Indicators to measure inputs, outputs and project achievements with respect to contraceptive procurement and logistics

a. Key Indicators measuring progress in the supply of project inputs

Major inputs are equipment and supplies including vehicles, contraceptives, fuel. Account also needs to be taken of personnel provided by the GON for logistics management and training (considered in Chapter D) and TA provided by USAID. Indicators of commodity supply are the annual procurement plan, records of shipments, receiving reports, records of distribution and draw-downs in the field. Indicators of personnel provided are based on designations of personnel responsible for supply management by the Ministry and Departments, as reported in quarterly activity and annual reports and work plans. TA is tracked by project implementation orders for technical assistance issued by USAID and the DPF, reports of TA missions, quarterly and annual reports.

b. Key Indicators of project outputs

Outputs are contraceptives delivered, supplies and equipment in place and in use, a logistics system in place with trained people assigned to make it work. [The logical framework (Annex II) lists as outputs the availability of contraceptives and a logistics system in place; it lists objectively verifiable indicators data on the volume of contraceptives delivered and the MIS and delivery systems installed and working.] The evaluation team proposes the follow key indicators for measuring output:

- o Annual data of contraceptives delivered
- o Inventories showing equipment and supplies in place in health facilities and headquarters.
- o Data showing personnel assigned to logistics management and personnel trained in it.
- o The establishment and regular operation [designation of chairman and reporter, drafting of terms of reference, agreement of donors to participate, schedule of meetings - propose every six month starting in June/July] of a Contraceptive Procurement and Coordination Committee, as evidenced by minutes, reports and decisions reflecting effective coordination with donors and ONPPC..
- o The design and implementation of a Product Flow System:
 - Design Team established and completes report, September - October 1989.
 - Construction of Depot
 - Procedures and Manuals for the PFS completed, October - December 1989
 - Designation of field managers at each point of distribution chain, October - March 1989/90.
 - Implementation of System through training workshops and by FP coordinators/supervisors, January-June 1990.
- o Installation of Management Information System (Part of National Health Information System)
 - Review of Proposed MIS by users, April 1989
 - Test of Proposed System, May - December 1989
 - Installation MIS, 1990

- o Reports (Integrated in the DPF reporting system)
 - Quarterly, Sep 1989 - June 1993
 - Annual (in conjunction with publication of annual work plan), 1989 - 1990 - 1991 - 1992 - 1993
 - Ad hoc reports (By coordinators, supervisors and field managers of the Product Flow System
 - Annual Health Activity Reports of the Departmental Health Directors.
- o Operational Research Study, 1990
 - Designate Project Manager of Study
 - Identify Pharmacies and Depots for Study, Completion of Project Design.
 - Implement Study
 - Final Report and Decision to Implement Recommendations
 - Initiate program of commercial distribution of contraceptives products through depots.

D. TRAINING

1. Introduction

Training in family planning can be divided into clinical, management and IEC. With regard to the clinical training there are three aspects : use of all methods including IUD insertion, use of all other methods and use of barrier methods only.

Training in FP started in 1983 with the UNFPA funding of the CNSF. Services at all the PMIs in Niamey were provided next. At the same time, due to transfers of personnel trained in FP services and demand from the clients, services were begun in the departmental capitals and in the main towns in the departments of Dosso and Tillaberi.

With the assistance of INTRAH a 4-week clinical course (no IUD insertion) was given in Zinder (1987), Maradi (1988) and Tahoua (1988). Altogether 74 service providers were trained. Follow-up evaluation has been conducted by INTRAH of the trainees in the three courses. INTRAH has also assisted with the development of an in-service training course built on these courses.

In addition to the clinical training some personnel has been trained in FP management and IEC. Apart from training abroad, a course in FP management (27 participants) was given in Niamey in 1988 and an IEC course in Dosso in 1989.

2. Current Situation

a. Training of Service Providers

At the end of 1988 there had been 345 participants in courses, both in-country and abroad. To these should be added 3 midwives who just returned from a clinical course in Mauritius and the social workers in the IEC course in Dosso. The distribution among the different categories of service providers are as follows:

55	physicians,
121	midwives,
67	registered nurses (IDE)
18	licensed practical nurses (IC), and
33+	social agents

Even though the total count is 345 course participants many have participated in more than one course which explains why only 294 service providers have been trained. Also some people who have been trained are no longer providing the services. Thus an attempt was made to find out how many trained service providers there were in each department. The information presented below is not complete and further work is needed to complete it..

Niamey

In the capital city, services are provided at CNSF, 10 PMIs, 6 maternities and 3 dispensaries by 4 physicians, 38 midwives and 1 nurse for a total of 43 services

providers. In addition, 8 social workers have been trained in IEC and 1 IDE and 2 ICs in IEC and management of contraceptives. One of the trainers at ENSP (Ecole Nationale de Sante Publique) -- a midwife -- has also received FP training including IUD insertion. CNSF, 7 PMIs and 2 maternities have personnel trained in IUD insertion. The DPF staff has also received FP training.

Dosso

In Dosso services are provided in 12 different towns with 14 different service points. However, only two physicians, four midwives and one nurse for a total of 7 have been trained in FP service delivery. The physicians and two midwives are also trained in IUD insertion. In addition, the MCH coordinator at the DDS has been trained in IEC and FP management. The department is planning to start FP service delivery in 12 other locations.

Tahoua

The course in July 1988 had 21 participants. Five of these have already left the department. Two people trained in FP have been transferred to Tahoua. Trained personnel is currently working at 13 service points in 8 different localities. Services are provided by 4 physicians, 8 midwives (6 -- IUD insertion) and 6 nurses for a total of 18. Two physicians, one midwife, one nurse and the MCH coordinator has also been trained in FP management. One physician and one social worker has received IEC training.

Tillaberi

There are 14 service points in the department. Information about the number of trained personnel at these service points was not obtained.

Maradi

In Maradi 17 service points are functioning, 6 without trained personnel. More could be started if trained personnel were available. The service points are in 10 different towns. At this time there are 21 trained service providers, 2 physicians, 16 midwives and 3 nurses. One social worker (at DDS) has received IEC training. The MCH coordinator, one midwife and one nurse have participated in FP management courses. There were 25 participants in the Maradi course of which two were from Zinder.

Zinder

The training course in Zinder had 28 participants. Currently, 2 physicians, 13 midwives, and 6 nurses for a total of 21 are providing services at 19 service points in 9 localities. One physician and one midwife has been trained in FP management and one social worker in IEC.

Diffa

FP services are currently provided by the three Medical Centers. The MCH coordinator, and a social worker has been trained in

management and the DDS has clinical training. None of the people currently providing services have clinical training.

Agadez

The Department Health Office has advised the DPF that as of April 1989 14 health facilities provide FP, including two hospitals not run by MSP/AS. IUD insertions are done at these hospitals. Two physicians, two midwives and one social worker have received training, but the total may be greater since the information received from Agadez was incomplete.

Summary

Table IX summarizes the current situation in all departments. Even with no information from 2 departments, it is obvious that of the 294 people trained since 1983 only about half are providing FP services. Others are working in the DPF but many have been lost within the system due to transfers. This points to the fact that a system has to be established by which DPF can track the personnel and make sure that they are in a situation in which they can provide family planning services.

The number of transfers can be quite high. Zinder since the 1987 course less than 2 years ago has already lost 9 of the 30 people trained. Since usually only one person is trained for each service point, a transfer will generally mean that the FP services will end until the DDS can find another trained person for the position. This has already occurred in some departments.

On-the-job training with close supervision could be a way to resolve this problem. However, it should be noted that there are at this time no regional training teams who can deal with this issue, nor are most supervisors sufficiently trained in this area, even when close supervision is possible.

There is a definite need for more training in all departments, especially in those which have not been covered by regional training; i.e., Dosso, Agadez and Diffa.

According to the information provided by DEP there are currently 107 physicians (Niamey 64), 259 midwives (Niamey 118), 839 nurses (Niamey 350) and 221 social workers (Niamey 94) working for MSP/AS/CF. For the different departments (excluding Niamey) an additional 30 physicians, 98 midwives, 676 nurses and 121 social workers constitute the primary pool from which further trainees could be taken. Thus, if 60 service providers are trained each year, as planned, over 90% of all physicians and midwives in the departments could be able to deliver family planning services at the beginning of 1991, especially if midwife students at ENSP are also trained for FP services delivery.

b/ Training in Sterilization Techniques

In all departments visited (Dosso, Tahoua, Maradi and Zinder) female sterilization is provided in emergencies and when the couple demands it.

Vasectomy was not discussed during any of the visits. However, apart from the gynecologists who work in Niamey no specific training has been provided. It should be noted that apart from expatriates there is no specialist in gynecology outside Niamey (one has been assigned to Zinder).

c. Training in Laboratory Techniques

According to the DDS directors in the different departments, practically all CMs and CHDs have the capabilities but not the resources to diagnose the different STDs. Currently diagnostics is only done in the different departmental capitals and in Niamey. Tests for AIDS is only done in Niamey hospital and technicians elsewhere have not been trained to perform these tests. When materials are provided for differential diagnosis of STDs the technicians should probably receive a refresher course in the area.

d Family Planning Management Training

A first requirement for training is that of the staff of DPF. This staff training will be accomplished both on-the-job with the help of long term and short term advisors and by sending staff to specialized training programs. It is recommended that the annual work plan for training specifically take into account staff training needs.

Record-keeping and contraceptive supply management were included as topics in the courses given in the departments (Tahoua, Maradi and Zinder). According to the performance at the service delivery points this training was not sufficient. Thus personnel need additional training in these two areas. With the introduction of the new system for record-keeping and quarterly reports such training is obviously even more necessary.

Supervision of the FP activities suffers from the lack of logistic support and motivation, but also from the lack of training. It should be pointed out, however, that the two first mentioned factors have to be resolved first **before** training can be effective. It should be noted that unless the supervisor firmly believes in the need for family planning and encourages the FP activities the personnel will not work efficiently.

e. IEC Training

Specific training in IEC for MSP/AS/CF personnel has so far consisted of one course in IEC given in Niamey, the on-going course in Dosso, and training of a few selected individuals outside the country.

In addition, the departmental FP courses also included some training in IEC, focused on giving counseling and small group talks. The participants in those courses need further training either in short seminars or on-the-job to become proficient in convincing the population about the benefits of using modern contraceptives.

It should be noted that in order to provide effective IEC to the male population it is necessary to train male personnel specifically in that area. The

different DDS directors have found that in order to encourage the use of condoms male personnel has to be trained to promote and distribute the condoms.

f. Training of Trainers

One of the objectives of the USAID project is to ensure that a national training team is set up. At this time, the CNSF, ENSP and DFEPs have personnel who can be called on to do training in various subjects. However, additional training of the trainers will be necessary, especially in FP. A TOT course is planned for this year. Most of the members of the team will not be full-time which will restrict their availability for FP training courses.

The TOT training should carefully consider the previous experiences and training of the participants, and provide a training which is focused on skills development rather than theory.

g. In-Service Training Curricula

A curriculum for basic clinical in-service training has been developed based on the experience obtained during the three departmental courses. The curriculum includes physiology, FP methods (except IUD insertion), counseling and small group talks, record-keeping and contraceptives management. The inclusion of the last two in the training is not sufficient to ensure reliable records and good management of the stock. Otherwise the 4-week curriculum seems adequate.

Apart from the basic clinical training clinicians also need further training in the follow-up of clients and in motivational techniques in order to try to reduce the number of women who abandon family planning for reasons other than that they want another child or no longer can get pregnant.

Midwives and physicians are currently trained in IUD insertion at CNSF which has a sufficient number of clients for such training. Courses abroad are also used for clinical training including IUD insertion.

In each departmental main town a hospital physician needs to be trained in IUD insertion and what to do when complications occur (such as disappearance of the thread with IUD still in uterus). Midwives will refer such cases to the hospital.

In addition, an IEC curriculum has been developed which was used in Dosso. The curriculum is designed for a 2-week course. Due to the fact that the course in Dosso was given simultaneously with this evaluation it was not possible to review the curriculum. It is also too early to evaluate what additional training in IEC is needed, since so few have been trained in IEC.

In the other areas (management, and sterilization and laboratory techniques) discussed above no curricula have been developed. Apart from certain areas in management, such as record-keeping, contraceptives management, refresher courses in MST diagnostics, supervision, etc., training needs will probably be covered by courses outside the country.

h. Pre-service training

The different categories of health workers are trained in three different schools: Medical faculty, which trains physicians, ENSP which trains IDEs, midwives, social workers and laboratory technicians, and ENICAS which trains ICs, sanitation workers (AHA) and aides to social workers (AAAS). There were no AAAS students admitted last year.

Medical School

Medical students are trained in a 6-year program. Family planning is brought up briefly in the courses given in gynecology and obstetrics. It can be assumed that the medical students also are introduced to family planning at their practical rotations at the maternities and PMIs. In addition, the course in Community Health includes a discussion of family planning. Starting this year medical students will be required to spend one week at the CNSF.

Even though exposed to family planning during the training it can not be said that the physician graduates with sufficient knowledge and understanding to practice family planning. Thus, it is necessary to explore the possibilities of creating a course in family planning at the school including longer practice at CNSF in order to ascertain that the medical students have sufficient exposure to the subject.

ENSP (National Public Health School)

Four different groups are trained in three-year courses. The midwifery students are exposed to family planning subjects in their courses in Gynecology, Obstetrics, Community Health, and Population and Demography. In addition, they participate in FP activities at the CNSF, the maternities and PMIs during their practical rotation. They do not learn to insert the IUD.

The nursing students are exposed to family planning topics in their courses in Community Health and Population and Demography. In addition, they may participate in FP activities at the PMI. However, their exposure is obviously much less than the midwifery students.

The students in social work has a 10-hour course in FP methods and participate in FP activities during their practical rotations.

Laboratory technicians are trained in MST diagnostics in their rotation at the EDHMM (Grandes Endemies) and at the hospital in Niamey.

One staff member, a midwife, at the school has received training in all aspects of FP. The social worker responsible for the supervision of the practical rotation at the CNSF has not been specifically trained in family planning. TOT courses have been given at the school (latest in 1987) and many of the teachers have received training in pedagogy. Only 3-4 new teachers have not had additional training in pedagogy.

ENICAS (National School for Certified Nurses and Social Workers)

One of the teachers at the school participated in the FP course given in Zinder. Last year she gave a course in FP to the ICs, but she has been transferred. No other teacher has been trained in family planning methods so no course can be given at this time.

Family planning is discussed in the health education course and all IC students spend two months each at a maternity and a PMI where family planning services may be provided. However, no special program exists for the practical rotation. Thus, ICs have a notion of FP and can participate in IEC activities at their assigned post as necessary with some further training.

The teachers at ENICAS have not received much training in pedagogy or IEC. The ICs and AAASs who work at the DRs will serve an important role with regard to the sensitization of the population in the rural areas. Thus it would seem that the planned project could benefit from training the teaching staff at ENICAS in IEC and pedagogy.

Summary

Apart from the introduction of the in-service curricula at all the schools, objectives and guidelines should be established for the practical work the students perform at the maternities, PMIs, CNSF and in the rural rotation to ensure that they receive sufficient practice to deliver family planning services after graduation.

In addition, the teaching staff at all the schools including the university, should receive additional training in pedagogy, clinical service delivery and IEC. Inclusion of FP in the preservice training will also to some extent serve to motivate the graduates since it will be an expected part of their service performance, not another task added to what for them is already a heavy work schedule.

Future Training Plans

The DPF has a 1989 plan for its training activities. The chart of objectives and indicators on the following pages indicates how the current training plan is related to the objectives of the USAID project. It should also be noted here that the USAID project plans to provide technical assistance to DPF in the form of a training advisor for three years in addition to the short-term technical assistance and other support noted in the chart.

The second phase of the UNFPA project will also include some training activities. Its plan projects the training of 100 midwives, 30 physicians, 35 nurses and 24 social workers. Given the trainee pool as discussed above it would seem that some of the training should focus on additional training of already trained personnel in areas where deficiencies exist.

The figure of objectives and indicators on the following pages describes the activities which will be financed by the USAID project during the next 5 years.

CONCLUSIONS

In all departments, FP activities have already been started at the CMs and most maternities and PMIs. However, since at most facilities only one person has been trained there is a definite need to train at least twice as many people as are already providing FP in the departments. However, it should be noted that in order to reach the goal of training 240 new service providers by the end of the project, it seems that the training will also have to include training of nurses at the DRs and introduction of family planning at these facilities.

The support for training by other donors and the limited number of physicians and midwives may mean that the USAID project may have to reconsider the training goals. This year UNFPA is sponsoring the training of 24 people in clinical training and the World Bank 15 (including IUD insertion) in Tunisia. Thirty will be trained at CNSF in IUD insertion. Thus it at this time appears unlikely that USAID will train 60 service providers per year over the next four years.

Very little has been done in the area of IEC training. The current situation (See IEC chapter and above) shows that although the population may know about modern FP methods, there is a need for health care personnel to further motivate the women and men to use the FP services on a consistent basis. IEC campaigns and constituency development activities can only provide the beginning of such motivation. The health care personnel has to be ready and able to reinforce the campaigns and to further motivate the women to use FP consistently to prevent unwanted pregnancies. For this practically all personnel need further training.

To ensure that graduating students are proficient in FP methods and health education, the training at the different schools need to be reinforced, especially in terms of skills development, since the theory is already taught to some extent. For that protocols should be developed for the practical rotations of the students.

The survey of the current situation shows that there are certain aspects of the clinical service delivery which needs to be improved. Such improvements could be accomplished through a close supervision and on-the-job training. Supervisors should be taught to be attentive to such problems and to provide the on-the-job training which is necessary.

RECOMMENDATIONS

The activities of other donors points to the need for a close coordination and good planning by the DPF to avoid duplication in the training area. Such coordination and planning is already underway. To provide sufficient information for the DPF training it is recommended that:

1. A computerized database be established with the following information for each person trained:
 - * Personnel number (necessary for tracking of personnel movements)
 - * Name

- * Basic training (Med, SF, IDE, AS, etc.)
- * Training in FP per type of training
 - ** Basic FP knowledge (new graduates at this time)
 - ** Contraceptive technology - basic clinical training
 - ** IEC course
 - ** IUD insertion
 - ** Management
 - ** Training Methodology
 - ** Other (specified)
- * Work place
- * Function (Chef CM, Responsable, Medecin Chef, etc.)

2. To track the movement of personnel, DPF should regularly coordinate its database with the personnel file maintained by MSP/AS/CF.
3. A yearly survey of active service providers by department to complete and revise the database.
4. Although the final selection of trainees should be made on the DDS level, yearly lists should be obtained of personnel at all the CMs, PMIs, Maternities, PMs and possibly DRs to determine the possible training pool for the coming year by comparing the list to the database of trained personnel.
5. Optimally, each DDS should have a dossier for each employee with an enumeration of the employee's training. This folder should be transferred with the employee. To include all training such a system should be established by DFEPS, DEP. However, it would be possible for DPF to start since it would assist the DDS in his assignment of personnel within the departments.
6. The selection of the national training team should be closely coordinated with DFEPS.
7. The TOT course for the national training team should be designed so that previous knowledge and training of the team members are taken into account. It should be focused on practice of skills rather than theory.

(Section prepared by Dr. Ericsson).

Table IX: Personnel trained and currently providing services

	Physicians	Midwives	Nurses	Social Workers	Comments
Niamey	4	38	1	8	
Tillaberi					No info
Dosso	2	4	1	1	
Tahoua	4	8	6	1	*
Maradi	2	16	3	1	*
Zinder	2	13	6	1	
Diffa	1			1	*
Agadez	2	2		1	
TOTAL	17	81	17	14	

Source: Evaluation Team, April 1989.

*Physicians in charge of DDS included in total.

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TRAINING
USAID PROJECT: OBJECTIVES AND SUGGESTED INDICATORS AND MEASUREMENTS

OBJECTIVES	INDICATORS	MEASUREMENTS	CRITERIA	INPUT MEASURES	REMARKS
Train 240 service providers; 60/year	# physicians # midwives # nurses trained + providing services	lists of course participants yearly lists of serv. prov.	increase in active serv. prov. = 50/year	cost/course total trng cost cost/serv.prov.	1989 plan: 40 serv. prov. +17 abroad with IUD insertion
Train 60 serv. prov. in IUD insert; 15/year	# physicians # midwives trained in IUD insertion	yearly lists of trainees yearly lists of serv. prov.	increase in active serv. prov. = 15/year	cost/trainee total trng cost cost/serv.prov.	1989 plan: 30 condition: equipment available
Train 14 MDs in sterilization techn.: 2/dept.	# physicians trained + providing services	End of project: # MDs trained +prov. serv.	End of project: 2 trained MDs at each CHD	cost/trainee total trng cost cost/serv.prov.	condition: equipm. avail. assistance: maybe AVSC(ONG)
Train 46 supervisors in FP management	# MCH coordinators trained # Chfs CMS trained	Lists of -trainees -MCH coord. -Chfs CMS	End of project: Each acting - MCH coord. - Chef CM trained	cost/course total trng cost cost/serv.prov.	May need to train a group last year of project
Train 80 social workers in IEC and FP methods	#social workers trained + providing services	yearly lists of trainees yearly lists of serv. prov.	increase in active serv. prov. = 20/year	cost/trainee total trng cost cost/serv.prov.	1989 plan: 40 serv. prov. + 3 at CAFS
Train staff of MS/AS schools; 15 trained	# teachers trained	Lists of -trainees -ENSP staff -ENICAS staff -FAC staff	End of project: trained staff: -ENSP - 10 -ENICAS - 3 -FAC - 2	cost/trainee total trng cost tech.asst. cost	May need to train a group last year of project
National trng team:10-12 trainers	Year when team is in place # of trainers # courses given by team	Yearly reports # of trainers # courses given by team	Team in place: Beginning 1990 Team in place: End of project	total trng cost tech.asst. cost	Replacements may have to be trained during years 2 - 5 1989 plan: 12

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TRAINING
USAID PROJECT: OBJECTIVES AND SUGGESTED INDICATORS AND MEASUREMENTS

OBJECTIVES	INDICATORS	MEASUREMENTS	CRITERIA	INPUT MEASURES	REMARKS
Train 30 pharmacists (ONPPC) 15/year 2;5	# pharmacists trained + providing services	lists of course participants list of ONPPC pharmacists	End of project: 30 pharmacists trained + providing services!	cost/course total trng cost cqst/serv.prov.	
Train 5 DPF administrators	type of trng for each administrator	Yearly reports End of project: -list DPF staff -trng of each staff member	End of project: all staff appropriately trained	Cost/trng Cost/trainee Total cost	Current plan: IEC coord:MA Research: MA Trng:US sh.term course 1989
All graduating serv. prov. trained in FP -physicians -midwives -nurses	All schools: -FP curriculum -FP practice protocols -15 IUD insertions for physicians + midwives	Yearly reports: asst provided End of project: review at each school of: -curriculum -practical training (protocols)	End of project: each school: -FP curriculum =inserv curr. -protocols for FP practice -physician+ midwife grads competent-IUD	tech.asst. cost total + per school	
All graduating serv. prov. trained in IEC -social workers -nurses -midwives	ENSP + ENICAS: -IEC curriculum -IEC practice protocols	Yearly reports: asst provided End of project: review at each school of: -curriculum -practical training (protocols)	End of project: ENSP + ENICAS: -IEC curriculum =inserv curr. -protocols for IEC practice	tech.asst. cost total + per school	
All graduating lab techs + pharmacist trained for FP related tasks	University: -FP curriculum -STD curr. ENSP(lab tech): -STD curriculum -STD practice protocols	Yearly reports: asst provided End of project: review at each school of: -curriculum -practical training (protocols)	End of project: each school: -STD curr. =inserv curr. -STD practice protocols	tech.asst. cost total + per school	Suggested but not included in current project

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TRAINING
USAID PROJECT: OBJECTIVES AND SUGGESTED INDICATORS AND MEASUREMENTS

OBJECTIVES	INDICATORS	MEASUREMENTS	CRITERIA	INPUT MEASURES	REMARKS
Schools have FP teaching materials	Each school: Def. necessary materials available end of project	Each school: Lists of: -necess. mat. -available mat. end of project	End of project: Each school: all necess. mat. for FP instruction	Cost of mat.: total + per school	
Coordination of training activities	Computer data base with all FP trainees Use of DEP/DES data base to determine trainee pool Annual review of training's impact on serv. delivery Yearly training plans	Yearly reports Computer data base DEP/DES print-outs Yearly training plans	Computer data base: 6 months after project start Annual reviews of data base Evidence of coordination with DEP/DES Reports include: -active serv. prov. -MSP/AS staff yet to be trained Training plans: # trainees # courses types of trng places, dates support needed!	Cost computer training	Note: not a separate objective in project but should be included

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E. INFORMATION, EDUCATION AND COMMUNICATIONS (IEC)

1. Introduction

The two topics, constituency development and IEC, are treated together here, since the two are difficult to separate. In practice, any activity which is undertaken to promote a product creates a constituency for that product. IEC activities promoting FP is aimed at creating a constituency which will use modern FP methods and promote their use in the community. In the USAID project, the IEC activities directed towards other community groups are listed under the label constituency development.

The strategy for IEC activities adopted by DPF assumes that FP services will be available with trained staff before they are promoted to the public. Thus, even though CNSF was opened in 1984, it was first during 1985 that FP messages were broadcast over the radio. The current strategy for FP is outlined in the Figure pps 59 - 61.

2. Current Situation

a. IEC Activities

Since 1985 the following activities have taken place (some with USAID funding through centrally funded projects):

- o Counseling of women with problem pregnancies (including short birth interval) to adopt family planning -- everywhere FP services are available; in 1988 about 7000 consultations, 82% in Niamey.
- o Health Education talks at PMIs -- everywhere FP services are available; in 1988 about 1250 discussion groups, 74% in Niamey.
- o Community meetings with FP topics -- started in Niamey in 1986; not a general activity, especially in the departments.
- o Short FP messages broadcast over radio and television -- started in 1985. New messages are being field-tested.
- o Focus group meetings to determine what messages are going to be used -- Niamey, Maradi and Zinder. The messages are now being field-tested.
- o Production of a contraceptives sample case to be used in counseling women in the selection of a FP method. This sample case is not available at each service point. 300 cases have been produced for distribution at the national seminar in May.
- o Design of a FP logo to be used in IEC campaigns. Used in the production of the visual materials listed below.
- o Printing of cloths with FP logo -- ready for distribution at the national seminar in May.

- o Fabrication of badges and bumper stickers for distribution at the national seminar in May.
- o Radio plays with family planning messages -- broadcasting started 2 months ago.
- o National seminar on family health and development for MSP/AS directors and others implicated in FP promotion, 1987/88?
- o National seminar on Family Education for school teachers, 1987? 1988? # participants?
- o KAP study in Niamey organized by Columbia University. The field work was carried out in March/April 1987.
- o KAP study in Niamey, Maradi, and Zinder organized by John Hopkins University. The field work was carried out June/August 1988.
- o Seminar for dissemination of the results of the Columbia University KAP study for 25 participants in September 1988.
- o Seminar for 15 "femme relais" in Niamey, March 1989
- o Departmental conference for opinion leaders, Zinder, 30 participants, Nov. 1988.

In addition, the following activities are in the planning or production stages:

- o Television plays with family planning messages. Broadcasting will start in May 1989.
- o A national conference for opinion leaders, 75 participants, May 1989.
- o 200 placards for display in the FP centers -- in production.
- o Film on family planning and illegal abortions.

b. IEC Materials

The availability of materials for IEC activities is very limited. A field survey in the departments of Tahoua, Zinder, Maradi, Dosso and the city of Niamey has shown that the following material is available:

- o At the CNSF audiovisual equipment which is seldom used even at the center. Few people can use the equipment. Staff at the PMIs may borrow the equipment but has not availed itself of that opportunity.
- o A small library at the CNSF with FP literature and posters.
- o Sample cases (mentioned above) have been distributed at the regional training seminars and to some other service providers. It should be noted that they are not available at all service points (e.g.,

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in Dosso 5 of 14 centers have one), and that when more than one service provider works at a center they have to share one.

- o The IPPF flipchart was distributed at the INTRAH course in Zinder. Thus it is available in Zinder but not elsewhere.
- o The DDS in Tahoua has a videocassette for FP promotion, but no way to use it, except through the director's personal videoplayer.

Apart from the materials enumerated above, no other materials are available for promotion of family planning, This is mostly due to the lack of emphasis on IEC during the start-up phase. However, note that materials have been produced for distribution at the National seminar in May, and that placards are being produced.

c. Knowledge and Attitudes towards Family Planning

The discussion below highlights the results of the two KAP studies. It should be noted that a comparison between the two studies are hampered by the fact that the two studies had a slightly different focus, used different questions and did not report the results in the same way. Tables A and B describe the characteristics of the samples.

Table 10 : KAP studies: selected characteristics of females participating in surveys

	Niamey 87	Niamey 88	M/Z 88
Median age	26	27.5	27.9
Married %	73.9	84.8	83.8
No schooling %	53.4	56.7	61.2
Higher education %	2.1	3.4	6.6
Living children (mean)	3.6	3.0	3.3
No schooling	3.9	3.3	3.5
Higher education	2.6	3.6	3.2
deal no. children			
No schooling	6.1	5.6	5.5
Higher education	4.4	6.0	5
Birth interval < 2 years %	29.8		
Desired spacing < 2 years%	---	2.3	5.4

Table 11 : KAP studies: selected characteristics of males participating in surveys

	Niamey 87	Niamey 88	M/Z 88
% under 30	50.3	54.9	46.2
Married %	61.5	50.0	61.0
No schooling %	57.9	17.1*	17.7*
Higher education %	15.9	14.8	1.7
Living children (mean)	3.8	3.7	4.5
No schooling	3.4	—	—
Higher education	2.8	—	—
Ideal no. children	5.2	5.4	6.1
Desired spacing < 2 years%	—	1.7	13.6

* Due to differences in sampling methods between the two studies

The differences among the samples are thus minor. It should be noted, however, that the male sample in Maradi/Zinder had less education than the one in Niamey and that only in the 1987 Niamey sample did the education of the women influence the actual and ideal number of children desired. It should also be noted that although very few women desire a child spacing interval of less than 2 years, about 30% of the women had their last child within 2 years of the previous one.

Tables C and D show the knowledge about the different FP methods.

Table 12 : Knowledge about FP methods among women; spontaneous and assisted recall

	N 87		N 88	M/Z 88
	spont.	asst.	asst.	asst.
Pill	72.9	85.5	89.7	78.3
Injection	41.6	70.3	80.2	4.6
IUD	54.3	78.5	81.0	53.3
Condoms	9.8	47.3	66.3	37.0
Spermicides	4.7	28.3	31.0	26.0

Table 13 : Knowledge about FP methods among men;
spontaneous and assisted recall

	Spontaneous			Assisted		
	N 87	N 88	M/Z 88	N 87	N 88	M/Z 88
Pill	58.9	88.3	60.3	73.3	93.5	70.0
Injection	21.6	60.7	43.6	52.3	70.3	51.4
IUD	27.5	53.4	31.1	61.5	69.8	39.3
Condoms	28.9	69.2	52.1	59.7	93.3	71.9
Spermicides	12.0	33.3	22.6	19.4	50.0	31.9

As can be expected the number of men and women who knows the different FP methods is much higher in Niamey than in Maradi and Zinder. Obviously also the method used by most FP acceptors -- the pill -- is also the one best known -- 90% of the samples in Niamey and 70% of the samples in Maradi and Zinder.

The majority of the Niamey 87 sample had received information about FP methods via either the radio or television. The audience for these two media is very high as shown by the KAP study in 1988. The planned radio and television messages would thus serve to provide information about the FP methods and also about where they are available.

It should also be noted that in the 1987 sample more women in the 30 to 39 age range know about FP than in the other age ranges. Thus young women constitute a group which needs to be targeted for information.

d. Summary of IEC Activities

The following points can be made about the IEC activities to date and the knowledge and attitudes towards family planning:

- o The messages on radio and television are effective in spreading information about the FP methods.
- o Most women and men (90% +) desire a child spacing interval of at least 2 years.
- o Although most women desire such an interval, 30% of the women (Niamey 87) had an interval of less than 2 years between their two last children.
- o Any messages about FP has to take into account religious beliefs.
- o Most men are positive to the concept of child spacing and to the use of FP methods. Only 4.6% of the women in the 1987 Niamey sample gave the refusal of their partner as a reason for not using contraceptives.
- o Although knowledge is high, there is a lack of information about how to obtain the methods and in motivation among both men and women.

3. Health Education

At MSP/AS/CF health education is organized within the DFEPS (Directorate of Training and Health Education) which has a division for health education. This division which is divided into 3 bureaux for respectively research, production and training is responsible for all production of IEC materials and for all training in health education within MSP/AS/CF. In 1988 over 60% of its activities involved family planning.

Main outside funding for its general activities is provided by the World Bank (Project IDA) and WHO (logistics and materials). France will also contribute by funding a health education specialist.

Currently the DFEPS is setting up regional divisions which will mainly be responsible for training and coordination of health education activities in the different departments. When these regional bureaux are established activities will be further decentralized by assigning a health educator to each CM.

The cooperation between DPF and DFEPS at this point is excellent. It should be noted, that the selection of the IEC trainers for the national training team should be coordinated with DFEPS as should all the training including that of the staff at the national schools.

Future Activities

Apart from the planned activities discussed above there are various other activities planned by the DPF and others. The World Bank will provide IEC materials to DPF and CNSF. The continuation of the UNFPA project will also include IEC activities, among others a module in IEC for the training of village health worker teams. It should be noted that the UNFPA funding will mainly be channeled to the CNSF and the departments of Tillaberi and Dosso.

In addition the USAID project will provide long-term technical assistance in IEC (3 years) and will fund various activities as discussed in the figure on the following pages. In the chart is noted the activities DPF has planned for 1989 which correspond to objectives of the USAID project.

The fact that other donors are involved in IEC activities points to the need for DPF to coordinate the activities. The general plan which has been put forth for 1989 indicates that such coordination will occur.

Conclusions

Although IEC activities have been carried out since 1985, the last 6 months have seen a real increase in such activities. In addition many other donors are involved in supporting IEC activities in Niger.

The campaign planned to be carried out during the USAID project is thus well underway. This, in conjunction with the support from other donors, may mean that the project staff in coordination with the DPF may be able to reprogram some of the resources planned for the IEC campaign. If such reprogramming occurs it is recommended that the money be allocated to the training of FP service providers in

IEC, especially with regard to motivating the women to continue the use of modern FP methods as long as they desire to postpone child bearing. This type of training fits well under the IEC objectives as stated in the project paper and there is a documented need for such training.

The strengthening of DFEPS with the assistance of the World Bank creates the opportunity to strengthen the IEC campaign and means that resources are available in the country for the production of IEC materials. The planned IEC expert at DFEPS should also be able to provide assistance to DPF. Such cooperation should also facilitate the integration of DPF messages into the health education campaigns carried out by other areas of the health services.

Currently, one of the problems mentioned by almost all service providers is that women tend to abandon the use of contraceptives even when they do not wish to resume child bearing. The results of the current study of contraceptive users and the reasons for stopping the use of contraceptives should be used to design the IEC messages in such a way that women are encouraged to use family planning whenever they need it.

Research activities should be carried out to make sure that the IEC campaign has the intended effects. The stress should be focused on motivating the women to use FP, since the majority of the population residing in areas where FP services are available, seems to be aware of the possibility that FP methods can be used, but do not avail themselves of the services for various reasons.

(Section prepared by Dr. Ericsson).

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CONSTITUENCY DEVELOPMENT AND IEC
USAID PROJECT: OBJECTIVES AND SUGGESTED INDICATORS AND MEASUREMENTS

OBJECTIVES	INDICATORS	MEASUREMENTS	CRITERIA	INPUT MEASURES	REMARKS
2 national FP conferences held	Information re conferences Participation in community outreach by com. org.	Yearly reports Reports of conferences	2 conf. held Increase in participation in community outreach by com. org. after conf.	cost/conf. tech.asst. cost	1989 plan: conference in May Possible funding by OPTIONS
National Family Health Week: Year 5	National FH week declared Activities with distribution of FP mat. Coverage in mass media	Report of activities during week Survey of mass media coverage	National FH week held 1993 During week in all depts: IEC activities distribution of IEC mat. mass media coverage before/during participation of national leaders	Cost of distributed IEC mat. Project costs for planning + participation tech.asst. cost	
2 study tours to other African countries	Study tours: dates # participants countries	Reports	Study tours conducted	cost/tour	
Coordination of IEC activities	Coordination with DFEPS Use of regional DFEPS reps Coordination of donor support Yearly IEC plan Annual review of IEC impact + needs	Yearly reports Yearly IEC plans	Evidence of coordination -with DFEPS -of donor sup. Reports include: -IEC activities -participation of DFEPS IEC plans: Training plans: -IEC activ. -participation of DFEPS support needed	Project costs for IEC coordination (if possible)	Note: not a separate objective in project but should be included

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CONSTITUENCY DEVELOPMENT AND IEC
USAID PROJECT: OBJECTIVES AND SUGGESTED INDICATORS AND MEASUREMENTS

OBJECTIVES	INDICATORS	MEASUREMENTS	CRITERIA	INPUT MEASURES	REMARKS
Provide IEC mat. to all service points	Availability of IEC mat. at each service point	Yearly survey of IEC mat. at the service points	End of project: Each FP prov.: -sample case -flipchart -brochures -badges: buttons	Total + yearly cost/type mat. Total cost all materials	1989 plan: 300 sample cases badges
Community level activities at each service point	# community meetings/year/center	Quarterly reports Yearly reports	Each FP center: 3 community meetings/quarter		
Audience research in three depts	Focus groups -Dosso -Tahoua -Agadez -Diffa	Reports	Research completed 1990 Messages in use by 1991	cost/dept tech.asst. cost total cost	
IEC campaign	IEC mat. distribution Radio/TV messages broadcast Radio/TV plays broadcast Newspaper ads Cooperation with community organizations	Yearly reports Amount + type of IEC mat. distributed -cloth -teeshirts -brochures -buttons -bumper stickers	During project: -distribution of IEC mat. -radio/TV messages + plays -monthly ads -participation of com. org. 50% of activ.	cost/IEC mat. cost for ads cost for radio/TV production cost of distribution Total cost	1989 plan: -cloth -bumper stickers for distribution in May -radio/TV messages+plays broadcast before May
Placement of billboards + signs	Presence of billboards + signs	Yearly reports Observation of billboards + signs in communities	End of project: In each com. with FP serv.: -billboards -signs	cost of mat. cost of distribution	1989 plan: -200 placards Replacements may be needed
2 seminars on FH programming for radio/TV	Information re seminars Increased FH coverage in radio/TV	Yearly reports Reports of seminars	2 seminars held Increased FH coverage in radio/TV after seminars	cost/seminar tech.asst. cost	

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F. Recommended procedures for data collection and record keeping to track key FP indicators

1. Data Collection

a. Service Statistics

The MIS being installed by the MSP/AS makes provision for the collection on a quarterly basis of FP service data, including:

- o Population and FEAP around service points (w/i 5 kms)
- o Number of new contraceptors ("nouvelles acceptrices")
- o Number of contraceptors ("utilisatrices").

The data will be compiled quarterly by service providers at each health facility where FP service has been established and forwarded to the next administrative level (normally, the medical center). Thus the medical center should receive a quarterly report from each health facility which should give the number of FP consultations during the period, and the number of contraceptors at the end of the period. The number of contraceptors should show new contraceptors recruited during the period and the cumulative total of all contraceptors at the end of the reporting period.

The proposed MIS introduces a form which health centers will use to tally consultations and new contraceptors ("Fiche de Pointage"), according to method of contraception prescribed. This form will in principle be used to replace the traditional register of FP consultations. It should be borne in mind that for most managers of health centers the register is a well established basic management tool. Moreover, it is not apparent how a supervisor can check to see if the tally sheet (s) have been correctly prepared. For these reasons, it is recommended that the introduction of the tally sheet (Fiche de Pointage) should be tested carefully before requiring the abandonment of the register system.

The MIS also proposes the use of a standard client form (currently being tested in Tahoua). This form will be used to obtain an accurate count of total contraceptors at given points in time. This is a workable system. In fact an accurate count of total contraceptors can only be obtained at any point in time by a system which files client folders by method and by category (active or inactive) as is planned by the MIS.

However, definitions of active contraceptors need to be developed.

For IUD contraceptors, a practical definition of an active contraceptive is the client who has had a revisit within two years. After two years, if she has not been seen by the service provider of her center, her file should be placed among the inactives.

For women using oral contraceptives, a practical definition of "active" is a client who keeps her appointment for a resupply visit. If she misses her

appointment, after a reasonable period of time her file should be placed among the inactives. A similar procedure is used for women using injectables.

In order to report on the number of contraceptors [By definition a contraceptive (fr. consultante) is active], the center needs only to count the number of active client files.

The reliability of service statistics is often poor because filing and reporting procedures are not understood and not followed. A great deal of support and guidance should be programmed by departments coordinators to help health facilities record and report reliable data.

b. Annual Audit of Service Statistics and Management of FP

In order to insure accurate service data for all centers at least once a year, it is recommended that DPF organize an annual audit of service statistics and management of FP in all health facilities offering FP service. Baseline data giving estimates of the number of contraceptors for December 1987 and December 1988 have been derived. It is recommended that a special effort be made to control end of calendar year reports by centers starting in December 1989. This can be accomplished by organizing teams from DPF/DDS to visit all service points in the different departments. The teams will examine current operations, identify current problems and make end-of-year counts of contraceptors.

c. Profiles (Data Base) for FP Service Points

It is recommended that a standard data sheet or profile be developed for each health facility where FP service is introduced. The sheet is used to summarize information of the center's target area, personnel, the inventory of equipment and materials, date FP service began, and the volume of FP service provided. Data sheets should be prepared by centers with the assistance of the Departmental FP coordinator and kept up to date. A set of these data sheets should be maintained in loose leaf binders at the arrondissement level, the Departmental level and at the DPF. These profiles will be useful in the establishment of targets by center and in the development of annual work plans by Departments. They will constitute part of the data base for the project

d. Survey Data on Contraceptive Prevalence

Estimates of contraceptive prevalence can be derived from service statistics by calculating the ratios of contraceptors to FEAP. More reliable data on contraceptive prevalence can be obtained by surveys of contraceptive prevalence using a sampling scheme to collect data by interviews, as has already been done for Niamey, Zinder and Maradi. Other urban centers where such surveys would be useful are Agadez, Tahoua and Birni nKonni. Depending on the timing of the national family health and demography survey to be undertaken either in 1991 or 1992, the DPF in collaboration with DSD might wish to consider an urban center oriented survey in January - February 1990 (some 18/19 months after the surveys done in August 1988).

e Quality of counseling and FP clinical service

Data can be collected by examining supervisory reports, by site visits, from CAP studies, focus groups and by ad hoc surveys such as the FHI survey underway to study reasons for drop out rates in Niamey.

f. Data on Pregnancy Intervals

Consideration should be given to the use of MCH records to provide an indication of the effect of the FP programming on the spacing of pregnancies. Prenatal histories obtained at PMIs could provide data on the interval since last pregnancy together with a pre-pregnancy history of contraceptive use. Comparison of mean inter-pregnancy intervals could then be made between acceptors and non acceptors of FP.

g. Data on Contraception Supply, Consumption and Stocks

Data on the supply of contraceptive products can be collected easily from receiving reports maintained by Project Management (Logistics Coordinator). The logistic manager at the national level will keep records of distributions to Departments (and Niamey Commune) and of stocks. Contraceptive supply managers at the departmental and arrondissement levels will maintain records of their distributions. These records should provide data on a quarterly and annual basis. Stock control should be assured by periodic physical inventories (every six months).

Data on consumption and stocks on hand of different health facilities are to be furnished through the national health information system by a quarterly report on use of contraceptives (Rapport Trimestriel de Consommation) furnished in the first instance by health facilities with cumulative reports prepared at the arrondissement and departmental levels. However, a caveat is in order as experience in many countries show that much supervision and guidance is needed to produce regular reports and reliable data from health centers. The Departmental MCH/FP coordinators will also need to work with the health facilities on this reporting job.

h. Data on training

The Training Coordinator in DPF should collect and document data on training at the time of and in the report of the training session or workshop. Additional data will be collected during the process of evaluation by competency testing and follow up of trainees at their work sites. **DPF will need to create a computerized Training Data Base (See Chapter IID). The data base should include a roster of trainees and data such as person months of training, cost, dates of training, place, and subject and should be keyed to the trainees employment number.** The annual training work plan and budget prepared by DPF will also be an important source of training data.

i. Data on IEC Activities

Data on IEC Activities should be maintained by the IEC coordinator in collaboration with FP coordinators. The data collected should include information on posters and other visual aids distributed, the volume of IEC informational activities (small group talks, radio and TV time for spots and slogans, talk shows, dramas), budgets and workplans, inventories of equipment and audio visual materials, audience research and research carried out to determine message themes.

j. Data on inputs

Inputs can be accurately tracked by financial data recording obligations, sub obligations and expenditures. Many of the inputs will be tracked by the system of project implementation orders used by USAID. Others will be tracked by the system of purchase orders established and by the maintenance of inventory records.

2. Record Keeping

Record keeping is a management function relating closely to data collection and project monitoring. As noted in the management chapter, the three functions should be designed to ensure that managers and technicians have ready access to timely and accurate information. With respect to record keeping, the important mechanisms are:

- o The annual work plan and budget
- o Quarterly reports
- o Annual reports
- o Data base development and management
- o Financial accounting
- o Inventorying
- o Technical reporting on Training Programs, Consultancies and Study Missions
- o Departmental Analyses, studies and site visits
- o Evaluations and audits
- o Research and surveys

a. Annual Work Plan and Budgets

Annual work plans should include the annual budget and should establish objectives and schedules of planned activities for each of the major elements of the family planning component of the Project. These elements should include service delivery development, management development, training, IEC, contraceptive procurement and supply, other procurement and logistic support, research and studies, and data collection and project monitoring.

b. Quarterly Reports

DPF should prepare quarterly reports summarizing activities carried out in accordance with the annual workplan and identifying problems. It will be found convenient to append various technical reports.

c. Annual Reports

The annual report should be seen as a major record keeping tool for the Project. It should analyze progress achieved during the year toward Project purposes and in the light of the annual work plan. It will cover all elements of the project. Consideration should be given to producing one annual report covering both the family planning and demographic components of the Project. This can be done by having the annual report prepared by DSD incorporated in that of the one done by DPF.

d. Data Base Development and Management

The project will need at least three data bases to cover service delivery (see above), training (see Chap IID) and contraceptive supply and distribution (see Chap IIC).

e. Financial Accounting

It is recommended that a computerized system of financial accounting be installed to enable DPF to issue quarterly financial reports showing planned and actual disbursements and accrued disbursements by budget item. Tracking total Project expenditures will require financial data from the USAID controller covering disbursements for local or US procurement handled by USAID/Niger or AID/W (contraceptives, FP supplies, training, technical assistance, equipment). Consideration should be given to including financial data on the demography component with that of the family planning component.

f. Inventorying

Physical inventories should be taken of consumable supplies, equipment and materials in storage at least every six months and recorded in Project inventory reports.

g. Technical Reports

An important source of information is to be found in the technical reports which should be prepared on all technical assistance consultancies (preferably in French), training programs, study missions, and seminars.

h. Departmental Analyses, Studies and Site Visits

Site visits, analyses and studies of the family planning situation at the Department and Arrondissement level will provide important information for managing the program and should be well documented by reports made available to the Department, Arrondissement and headquarters.

i. Evaluations and Audits

The three evaluations planned and the audits carried out will constitute important project records.

j. Research and surveys

Results of operations research such as the study currently underway on women in Niamey giving up family planning and surveys - such as the CAP studies carried out in 1988 in Niamey, Maradi and Zinder should be provided in reports as part of the record keeping process.

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III. DEMOGRAPHIC RESEARCH AND ANALYSIS¹

A. PROCESSING AND ANALYSIS OF 1988 CENSUS DATA

1. Current Status.

The 1988 General Census of the Population of Niger was carried out between 20 May and 3rd June 1988. The Post -Enumeration Survey (PES) took place between 30 June and 14th July 1988. Provisional results based on a manual count were published in September 1988.

At the commencement of the NFHD project (April 1989) the status of census data processing was as follows:

The coding of the 10% sample took place between November 1988 and February 1989. It was not possible, however, to start keying these data because the list of village codes for the country was not available. This list is currently being developed and is scheduled to be available for the whole country by June 1989. In the meantime, the keying of the 90% of the data for the Department of Zinder started in mid-March because the village codes were available for this department. Enough of the village codes list is scheduled to be available in May so that keying of the 10% sample can start at that time.

Matching of the PES questionnaires with Census questionnaires has begun for the Department of Tillaberry. It is estimated that the matching will take 3-4 months. A sample of ZDs (Zone d'Enumeration) selected for the PES will be revisited in July or August 1989 to resolve questionable matches and to determine the status of individuals found in the PES but not in the Census, and persons enumerated in the Census but not in the PES. It is estimated that the data entry of PES questionnaires will be completed by December 1989, and that the analysis will be complete when the results are available for the complete census.

The main problem encountered by the BCR is the low productivity rates for all major tasks, in particular coding and data entry operations. At the current rate, the coding operation would take 12 months and the data entry operation 12 months (June 1990). A system of incentives (salary supplements) and sanctions has therefore been developed in order to improve the productivity rate. If the new minimum productivity rate is attained, then the coding operation for the whole country should be finished in 8 months, and data entry in 9-10 months (April 1990). The tabulations for the whole country could then be available by June 1990.

Another problem that could affect the productivity of processing Census data is the fact that out of 3 data processing staff trained, 2 have left BCR. Supplemental training by BUCEN to 4 new data processors is now being provided in order to alleviate this problem. Even with this supplemental training, additional technical assistance by BUCEN will be needed.

A methodological report is completed and awaiting publication, due end of May, 1989.

¹ Section prepared by Dr. Scats.

2. Objectives.

To assist in the processing and analysis of the 1988 Census data so that it will be available for integration into the 1992-96 National Development Plan, and also into the planning processes of key sectors. This will be done by:

- o Providing technical and other assistance for data processing
- o Providing technical assistance in the analysis of data quality(PES)
- o Providing technical assistance in the production of special analytical reports on key issues

3. Inputs

- a) 2 Micro computers
- b) 2 UPS (onduleurs)
- c) 9 pm Technical assistance from BUCEN (details to be decided)
- d) 4 pm Technical assistance in the preparation of analytical reports (details to be decided)

4. Key Indicators

- a) The micro-computers and UPS are delivered and in use by the end of June
- b) Processing of the 10% sample completed by October 1989
- c) Processing of the 90% completed by June 1990
- d) Processing of the PES completed by June 1990
- e) Analysis of the 10% completed by December 1989
- f) Analysis of the 90% completed by October 1990
- g) Analysis of the PES completed by August 1990
- h) Plan of analysis for Workshops available prior to preparation of Analytical Reports
- i) Preparation of the following analytical reports:
 - 1. Population of each department
 - 2. Population structure (Age/sex) for each arrond.

- 3. Fertility, mortality,
- 4. Migration
- 5. Socio-economic and cultural characteristics (by arrond.)
- 6. Characteristics of households and dwellings
- 7&8 Other topics to be decided.

It should be noted that dates for completion are provisional and are subject to review.

5. Measures of Progress

- a) Receipts for computer equipment and site visits
- b)-d) Data processing: Consultants' reports and BCR status reports
- e)-f) Analysis: Consultants' and other reports, including publication of Final Results of Census
- g) Analysis of PES: Consultants' reports and published results of the PES.
- h) Plan of analysis for special analytical reports disseminated to Workshop participants (See Section c)
- i. Analytical reports published and disseminated

6. End of Project Status

- o Census data analysis completed
- o Integration of census data into 1992-96 National Development Plan and other sectorial planning documents.

B. AVAILABILITY OF DEMOGRAPHIC AND HEALTH DATA

1. Current Status

In addition to the analysis of the 1977 Census, and the Provisional Results of the 1988 Census, the following demographic data are available:

- a) Surveys by UEDD/DSI (Unite des etudes demographiques pour le developpement/Direction de la Statistique et Informatique):

Survey of Infant and Cildhood Mortality (Enquete de Mortalite Infantile et Juvenile, EMIJ). The data were collected in 1986 but have not yet been analysed due to lack of personnel.

- b) Surveys by the Ministere de Sante Publique/Affaires Sociales et de la Condition Feminine (MSP/AS/CF):

Two KAP (Knowledge, Attitude and Practice) Surveys have been carried out in collaboration with other institutions:

- o "*Rapport de l'enquete en sante familiale*", with Columbia University. Survey of women of reproductive age in Niamey (1987)
- o "*Male and Female Knowledge, Attitudes and Practice*", with Johns Hopkins University. Two surveys: 1 of women of reproductive age and another of men, carried out in Niamey, Maradi and Zinder in 1988.

These two surveys provide information on fertility and family planning behavior including contraceptive prevalence.

The *National Survey on Mortality and Morbidity (Enquete nationale sur Mortalite et Morbidite, ENMM)* was carried out in 1985, in collaboration with Tulane University, and provides information on the use of maternal and child health services, and cause specific mortality (children <5 yrs)

The *National Survey on the Utilisation of Health Services (Enquete nationale sur l'utilisation des services de sante)* was carried out in 1987 in collaboration with Tulane University and provides information on use of maternal and child health services; numbers of live born children & numbers of children who have died in previous 5 years.

c) Estimates of infant mortality are included in a 1985 World Health Organisation (WHO) report: *Situation sanitaire du Niger: Rapport du coordinateur national des programmes Organisation Mondiale de Sante (OMS)*

d) Other government departments such as the Ministry of the Interior (Vital Registration/Etat Civile), and the Ministry of Education (Education et Population) collect demographic data, but no analyses have yet been carried out. It should be noted, however, that a demographic study on Vital Registration is planned by the Ministry of the Interior.

e) The University of Niamey is not involved in any demographic research at this time.

At present there does not appear to be much collaboration between the MSP/AS/CF and the Direction de la Statistique et Demographie (DSD) with respect to the collection and analysis of health data. The integration of the Health Statistics system into the general statistical service would have the advantage of avoiding duplication of effort and would permit the health statistics to benefit from the experience of the DSD. An example of duplication is the two separate Infant Mortality surveys carried out by the two organisations.

2. Objectives

To carry out a national demographic and health survey (*Enquete nationale demographique et de Santé*) (NDHS/ENDS) which will:

- o provide detailed data for development planning and service evaluation, supplementing that obtained in the 1988 Census

- o provide experience to DSD personnel in participating in an international program of data collection

The NDHS will be part of the world-wide program of demographic and health surveys conducted with the assistance of the Westinghouse Research Institute. It will require 24-27 mths from the initial design phase through to the production and presentation of final results. An important consideration is the availability of DSD, and especially UEDD personnel to undertake this survey. This is estimated, at a minimum, to be 1 demographer, 2 statisticians, and 2 computer programmers. In addition, specialised services such as cartography, data processing, etc. are to be provided by the DSD. Timing of the survey will be dependent upon the progress of the analysis of the census, and planning for the survey is unlikely to be able to start before late 1990. Staff should be available at that time and other activities scheduled accordingly.

In addition to the core components of the survey, the topics of particular interest to the Govt. of Niger- eg. migration, require further specification.

3. Inputs.

- o 12.5 p.m. of t.assistance starting in late 1990, and involving 18 visits of approximately 3 weeks by DHS program staff
- o In country costs of field work- eg. transportation, payment of field workers, questionnaire production, etc.
- o 1 4WD vehicle for field work
- o Assistance with secondary analysis (details to be decided in consultation with DSD/MSP/DHS)
- o Payment for part time local researchers (duties to be decided)

4. Key Indicators.

- i. Planning of Survey
 - a) Staff allocated to work on survey
 - b) Consulation between DSD/MSP/DHS to identify specific components equired.
 - c) Outline of research design
 - d) Survey budget
 - e) Time-table for survey and analysis
- a)-e) to be completed by late 1990

ii Implementation of Survey

- a) Pre-field work phase (eg sampling, questionnaire development, training, etc. to be completed by mid 1991 MTH8
- b) Data collection and verification to be completed within 4 mth time period MTH 12
- c) Coding to be completed with 3 mths of end of field work MTH 15
- d) Data entry and processing to take approx. 4 mths and to start as soon as data available from field
- e) Prelim. tabs and analysis of results available 4-5 mths after end of fieldwork MTH 16
- f) Final and sec. data analysis to be completed approx. 12mths after end of fieldwork MTH24.

iii. Publication of Result

- a) Preliminary report of survey findings to be produced in French approx. 5 mths after end of fieldwork MTH 17
- b) Principal survey report presenting detailed findings to be produced in French approx. 12 mths after end of field work Mth 24-27
- c) Summary report (Eng. and Fr.) presenting major findings for non-technical audience to be produced approx. 12 mths after end of fieldwork..... MTH 24-27.

5. Progress Measures

i. Planning of Survey

- a) Report from DSD/UEDD
- b) Report giving details of specific survey components required by GON.
- c)-e) Report of first visit of DHS staff and presentation of timetable, budget, and outline of research design

ii. Implementation

- a) Copies of sample frame, final version of questionnaire, training programs for supervisors and interviewers etc. to be available.

- b) Site visits, receipts for fieldwork costs; Reports on field procedures (DHS consultants)
- c) Coding manual available
- d) Reports from data processing consultants
- e) Preliminary tabs available for distribution to planners and policy makers
- f) DHS consultants reports on each visit made during this phase

iii Publication of Results

- a) 250 copies of preliminary report distributed to planners, program officials, institutions, and interested donor agencies
- b) 800-1000 copies of Principal report to be available
- c) 800-1000 copies of Summary report distributed to policymakers and planners in all relevant sectors.

6. End of Project Status

Three basic reports should have been produced and disseminated widely. Detailed analyses might not be available in time to be integrated into the 1992-96 Development Plan. By 1993, however, relevant survey results should be incorporated into annual reports and other planning documents for particular sectors. For example: 1. Comparison of 1991 NDHS data and 1985 ENMM data could be used by MSP/AS/CF to evaluate Maternal and Child Health (MCH) programs; 2. Comparison of 1987 and 1988 KAP data with 1991 NDHS data could be used to evaluate Family Planning programs.

C. TRAINING OF DEMOGRAPHIC PERSONNEL

1. Current Status.

- a) Personnel of UEDD

The long term objective of the UEDD is to put in place a multi-disciplinary team capable of assisting the government formulate and implement population policies and integrate demographic factors into development planning.

Since the creation of this Unit in 1984, with financial support from the United Nations Fund for Population Activities (UNFPA) and the Government of Niger, a major step has been taken towards the realisation of this objective. The Unit now has among its personnel most of the disciplines required:

- o A national director of the Unit-Demographer
- o A counterpart to the CTP (Conseil Technique Principal/Principal Technical Consultant) - Economist
- o A sociologist
- o 2 Demographers
- o 1 Statistician/Demographer
- o 1 "Adjoint technique de la statistique"
- o 1 "Agent technique de la statistique"

Among these are 5 senior researchers (of whom 3 are demographers), 2 intermediate level and 1 junior.

In order to complete the Unit, the following are required:

- o 1 Geographer
- o 1 Senior Statistician
- o 1 person to carry out documentation activities

The national personnel includes 2 secretaries, one funded by the Government of Niger, and the other by UNFPA.

In addition to the national personnel, it should be noted that the UNFPA provides the services of the CTP. A PhD in Demography filled this position until 2 May 1988. Since then the UEDD has been awaiting his replacement.

b) Training of current personnel:

- o Long term

There are two demographers with Masters level training working in the UEDD, and one elsewhere in the DSD.

- o Short term

There are three "technicians" who have attended short term (2mth) courses in Population and Development in Paris as part of their duties at UEDD.

- o Currently being trained

There are three senior staff (1 UEDD; 1BCR; 1 DSD- other Dir.) who are away receiving masters level training.

c) Future training needs

The need for demographic training has been identified in the National Plan of Action in the area of Demography (PNADD), (see Annex) where both the long term and medium and short term training needs were specified as follows:

o Long term

The PNADD calls for 5 demographers each year for 5 years starting in 1988 to enter training, resulting in 25 trained demographers at the end of this period.

o Medium term

The PNADD also identified the need for training regional personnel and others in the area of population and development. A minimum of 95 persons, it was suggested, should receive such training over the 5 year period. This type of training would permit a rapid exposure to both the tools of demography and also to the integration of population variables into development planning.

o Short term training

A series of seminars/workshops to raise awareness of and to popularise demographic issues, as well as to teach some demography are also envisaged in the PNADD. Over the next 5 years, it is estimated that approximately 600 people should attend such seminars/workshops.

In implementing this program, consideration must be given to the possible conflicting needs of sustaining ongoing programs and that of training personnel. Long term training will need to be scheduled to fit in with the availability of replacement staff so that the demographic establishment remains constant.

d) Training needs of non-demographic personnel

It would be useful for all members of the multi-disciplinary group at UEDD, including the non-demographers, to be able to benefit from medium and short term training in population and development and the techniques of integration. Additional short and medium term training for data processing personnel would address some of the needs in this area which is currently under resourced (see Section A)

2. Objective of Project:

To contribute to the strengthening of the capacity of the Ministère du Plan to undertake demographic research and analysis by providing financial support for the following training activities:

i. Long term in the U.S.

- 1 PhD in Demography
- 1 MS in Demography

Coursework and research by candidates should be appropriate for their future work in Niger, emphasise the application of demography to development planning, and provide technical expertise. This assumes 1 candidate with a Masters Degree and one with the equivalent to Bachelors level training. If suitable candidates at these levels are not available, the period and level of training may need to be revised.

ii a) Medium term training abroad

Participation in training programs in demography and related areas of 2-4 mths duration

ii b) Short term training abroad

Participation in training programs of up to 2 mths duration, or attendance at relevant international conferences eg. IUSSP.

Eligibility to attend short and medium term training programs abroad might include those involved in data processing as well as analysis.

iii. Short term training in Niger.

Five 2 week workshops on Demography, Policy and Planning for people from Ministries with primary responsibility in these areas. The workshops will provide exposure to the techniques and methods of integration of population variables into development planning. The workshops will be held in association with the preparation of the analytical reports of the Census (see A.) The workshops will provide a means of planning and monitoring these analyses as well as increasing the skills of the participants.

3. Inputs

a) Long term in the United States

- Financial support for 3yrs for 1 PhD candidate
- Training in English
- Tuition and fees
- Travel costs

- Financial support for 2 yrs for 1 Masters candidate
- Training in English
- Tuition and fees
- Travel costs

b,i) Medium term abroad (2-4 mths) 16p.m. over 4 years

- Tuition
- Travel

- b,ii) Short term abroad (<2mths) 20 p.m. over 5 years
- c) Short term training in Niger: Financial support for five 2 week workshops
Local costs, per diems, etc)(see also A & E)

4. Key Indicators

- a) Long term training
 - i. Identification of 2 candidates
 - ii. Commencement and completion of English language training to an acceptable level
 - iii. Commencement of training in the US.
 - iv. End of training and return to Niger
 - v. Commencement of work in appropriate position in DSD
- b) Medium and Short term training abroad
 - i. Identification of relevant courses , meetings, and timetable for these (annual)
 - ii. Identification of candidates
 - iii. Participation at relevant courses, meetings
 - iv. Return to Niger
- c) Short term training in Niger
 - i. Program of workshops to be developed including timetable, scope, etc
 - ii. Budget for workshop program
 - iii. Identification of workshop leaders and participants for each topic s specific workshop
 - iv. Tabulations of Census data to be available for prior distribution
 - v. Workshops held. "Rapport de Synthese" produced.

5. Progress Measures

- a) Long term training in the U.S.
 - i. Reports from the Min. du Plan/DSD identifying candidates and authorising study leave.
 - ii-iii Reports to US AID Training Section on student progress; Receipts for tuition, travel, etc.
 - iv Record of completion of study program; Travel receipts
 - v. Reports from M. du PI/DSD of placement and date work commenced
- b) Medium and Short term training abroad
 - i. Annual receipt of timetables and lists of relevant courses and meetings
 - ii Ministry reports identifying candidates and authorising leave
 - iii-iv Receipts for registration, travel, etc; Conference and Study Leave reports from participants
- c) Short term training in Niger
 - i. Provision of workshop program
 - ii Provision of workshop budgets
 - iii Provision of lists of leaders and participants for each workshop
 - iv Relevant Census tabulations distributed before each special topic workshop
 - v Workshop reports; receipts from participants
 - vi Receipt of "Rapport de Synthese"

6. End of Project Status.

The training component will have produced two senior level demographers, with appropriate training in the area of population and development. This will enhance the analytical skills of the Min du Plan/DSD.

Depending on the length of the courses, there will have been 4-6 attendances at demographic or related training programs abroad (of 2-4 mths duration), and 10 or more attendances at conferences or training programmes of less the 2 mths duration financed by this component. These medium and short term training experiences abroad will extend the knowledge base of data processors, planners and demographic researchers preparing the 1992-96 Development Plan.

Five workshops will have been held in conjunction with the production of the special topic analytical reports. The result of these workshops should be participation by planners in key sectors in determining the content of these reports, and their subsequent use in the preparation of the National Development Plan.

D. AVAILABILITY OF DEMOGRAPHIC DOCUMENTATION

1. Current Situation

ia) Documentation

At present in Niger there is no specialised demographic documentation centre. There are, however, several libraries and centers which contain demographic material along with other types of documentation:

- o In the DSD there is a Center for Documentation and Dissemination (CDD) which look after the documentation for the entire DSD. The Centre d'Information et Difusions Economiques et Sociales (CIDES) deals with documentation at a general and national level.

- o There is a general library at the University of Niamey, as well as libraries for each faculty.

b) Dissemination

To date, the major means of disseminating demographic information have been through:

- o The Seminar at Kollo, including the Demographic Profile of Niger, and the subsequent distribution of its Proceedings to participants and throughout Government.
- o The publication of the Final Results of the 1977 Census, and the Provisional Results of the 1988 Census
- o The Seminar presenting the results of the 1988 Kap survey carried out in Association with Columbia University (*Seminaire sur la Diffusion et l'Exploitation des Resultats de l'Enquete CAP du 15 au 16 septembre 1988 au Niamey*)

ii. Future Needs

In general the PNADD has previewed the creation or strengthening of services to provide demographic information to all relevant Ministeries by:

- o The creation by the end of 1989 of a library at the UEDD which would deal exclusively with demographic material is envisaged.
- o There will be an increasing need at the BCR for an Archive Section which would contain all the documentation relating to Censuses.

- o The production of a half-yearly Information Bulletin and "*Notes de Synthèses*" on the demographic situation in Niger, together with a number of non-technical seminars as ways of disseminating information on matters relating to population.

2. Objectives:

To assist in increasing the availability of demographic information by the establishment of documentation and dissemination centers. These centers would receive and disseminate reports, books, journals, data tapes, etc. The project would do this by:

- i. Establishing such centers in the DSD, The University of Niamey, and possibly at another site yet to be identified.
- ii Providing each centre with an annual budget to purchase materials, journal subscriptions, etc.
- iii Assisting each center in acquiring the relevant demographic materials which are provided free of charge by US AID and the U.N.
- iv Providing technical and financial assistance to implement a plan for dissemination of demographic information to government agencies, scholars, and others.

3. Inputs

- a) 4 p.m. of technical assistance to develop and implement a dissemination program
- b) Financial assistance for the purchase of books, journals and other materials
- c) Financial assistance for local costs in disseminating demographic information. Details of this assistance are to be clarified, but might include postage, photo-copying etc.
- d) Assistance in receiving US AID and UN documents. This component also requires clarification.

4. Key Indicators

- i. Documentation activities
 - a) Sites for documentation centers identified and made available by June, 1989
 - b) Staff assigned to centres by August 1989
 - c) Annual purchase lists and budgets prepared by each center

- d) Subscriptions purchased before end of 1989
- e) Books and other materials purchased
- ii. Dissemination activities
 - a) Visit by Consultant to advise on dissemination program before end of 1989
 - b) Distribution lists drawn up
 - c) Other dissemination activities planned with consultant
 - d) Implementation of dissemination program.

5. Progress Indicators

- i. Documentation activities
 - a)& b) Sites visits and reports from host institutions
 - c) Purchase lists and budgets provided annually
 - d) Receipts for subscriptions provided
 - e) Receipts for books and other materials purchased
 - d) Annual site visits
- ii Dissemination activities
 - a) Report from Consultant
 - b) Receipt of dissemination program
 - c) Distribution lists available
 - d) Report on implementation of dissemination program
 - e) Lists of users, subscribers etc. of documentation centers.

6. End of Project Status

Two or three specialised demographic documentation centers will have been established. Their dissemination activities should be providing accessible and timely demographic information to government agencies and other end-users.

E. USE OF DEMOGRAPHIC INFORMATION FOR DEVELOPMENT PLANNING

1. Current Situation

a) Introduction

Before the 1988 general Census of the Population, the main sources of demographic data have been:

- o The results of the 1977 Census
- o Several sample surveys

The Analytical Report of the 1977 Census provided information on mortality, fertility, and population distribution, as well as socio-economic indicators. It should be noted, however, that these results did not include the important variable: international migration.

In February 1986, the UEDD produced a demographic profile of Niger, based on the 1977 Census results, and including population projections from 1988-2000. This document was the basis for subsequent integration of demographic factors into development planning.

- #### b) The National Seminar on Population and Development, Kollo, 1-5 July, 1986.

This seminar gathered together decision makers and representatives of national organisations interested in population issues. An analysis of the demographic situation in Niger was presented, and a Plan of Action formulated to integrate this information into the 1987-1991 National Development Plan. The Plan of Action took account of the impact of population growth on various key sectors (Health, Education, Employment, Urbanisation). The Proceedings of this seminar were published and distributed by the UEDD.

- #### c) The 1987-1991 National Development Plan.

This quinquennial plan was the first to integrate demographic data into sectorial development planning. It included a chapter on Demography presenting indicators such as fertility and mortality rates, and life-expectancy as well as population projections. The main sectors where population variables were integrated into planning were: Health, Education, and Agriculture.

- #### d) The National Plan of Action in the area of Demography

The *Programme Nationale d'Actions dans le Domaine de Demographie (PNADD)* was produced by the Direction de la Statistique et Informatique (DSI) in April 1988. It outlined the activities in the area of demography which would lead to better understanding of population issues and to the integration of this into development planning. These were:

- o Analyses of the 1988 Census
 - o Specific studies- eg . particular population groups; aspects of demographic behavior such as migration (through a health and demographic survey)
 - o Development of studies and the production of technical reports of integration of demographic variables into sectorial planning - Population and Education; Population and Household budget and consumption patterns; Population and accomodation; Population and rural development.
- e) Activities of the UEDD

This unit has produced a number of documents on trends and characteristics of the population of Niger. These have included the presentation of various possible growth scenarios and their consequences for development in sectors such as education, employment, self-sufficiency in food production, the environment.

2. Objective

All elements of the Demography component of the NFHD project contribute to the overall long term objective of increasing the availability of demographic analyses so that population variables will be integrated into development planning. When analyses of the 1988 Census and the results of the DHS are available towards the end of the project, this element will provide technical assistance for the dissemination of this information to policy makers, planners and others. This could be through the workshops (see A&C), or may involve other dissemination activities. Details of this are to be clarified.

3. Inputs

2 p.m. of technical assistance for dissemination activities, possibly in association with the workshops planned to prepare the special analytical reports.

4. Key Indicators

- i. Consultant visits
- ii Program for dissemination activities
- iii Reports on dissemination activities
- iv [Possible] Production and dissemination of special topic analytical reports

5. Measures of Progress

- i Consultant Report(s) on visit (s)
- ii Provision of Program for dissemination activities
- iii Reports on dissemination activities

- iv (Possible) Proceedings of Workshops provided, and Special Topic reports produced

6. End of Project Status.

The integration of population variables into development planning relates to the process of ensuring that demographic data are available, are understood, and are taken into account in plans and policies as these are formulated. This process has already started in Niger. Evidence that that the NFHD project has contributed to the strengthening of integration activities would be:

- i. The establishment and functioning of the National Commission on Population (*Commission nationale de population : CONAPO*) to implement such activities and to provide the relevant information through the increased technical capability of UEDD.

- ii The Development of a specific National Population Policy by 1991

- iii The 1992-97 National Development Plan will included demographic data not only in the Chapter on Population, but also in chapters on development in relevant key sectors.

- iv Annual reports of Ministeries, and other planning and program management documents should include demographic information to assist in allocation of investment budget resources, program evaluation, etc.

- v The demographic variables used in these documents should not only be those relating to population size and growth, but should recognise the importance of changes in population composition and distribution.

- vi In both national and sectorial analyses- eg planning for development projects, projections of the factor concerned should be related to population projections- (labor force participation rates and cohort changes).

IV. REFERENCES

The following documents were consulted by the Evaluation Team:

-- Curriculum de formation des prestataires de services en planification familiale au Niger, Volume 1 et 2, MSP/AS, USAID et INTRAH, 1989

AID/REDSO, Request for Proposal No. REDSO/WCA/Niger 89-005, Abidjan, March 1989.

Alichina, I.K. & Diallo, Y.M., Programme national d'actions dans la domaine de la demographie, MP/PR, DSI, Niamey 1988

Boube, F., La planification familiale au Niger, Expose fait le 7 Novembre 1988, Niamey, 1988

CDC, Trip report - Niger: Logistics Technical Assistance and Training (Preparation of contraceptive logistics portion of project implementation design), Atlanta, U.S., 1987

Diallo, Y. & Alichina, I. K., Rapport de mission en vue de l'elaboration d'un programme national d'actions dans le domaine demographique, Niamey, 1988

Ericsson, S., Elaboration d'un plan d'utilisation du personnel de la Sante: Methodes et recommandations, MSP/AS, DEP, Niamey, 1988

GON/USAID, Project Agreement, Family Health and Demography - Convention de Financement, Projet Sante Familiale et Demographie, Niamey, August 1988.

Institut du Sahel, Centre d'etudes et de recherches sur la population pour le developpement, Programme d'action de N'Djamena concernant la population et le developpement au Sahel, N'Djamena, 1988

Lapham, R.J., Demography component for a PID: Family health and demography project, Niamey, 1987

MP/PR, Plan quinquennal de developpement 1987 - 1991, Niamey 1987

MP/PR, Seminaire national sur population et developpement, Kollo, 1 - 5 Juillet, 1986, Niamey, 1986

MP/PR, BCR, Compte rendu de la revue tripartite du projet Recensement General de la Population (unpublished), Niamey 1989

MP/PR, BCR, Rapport d'activites du projet Recensement General de la Population (unpublished), Niamey 1989

MP/PR, BCR, Recensement general de la population 1977: Resultats definitifs. Rapport d'analyse 1985, Niamey 1985

MP/PR, BCR, Recensement general de la population 1988: Resultats provisoires. Niamey 1989

MSP/AS, CNSF, Rapport de la mission sur l'integration des activites SMI/PF dans le departement de Dosso, Niamey 1989

MSP/AS, DDS Dosso, Rapport d'activites et bilan de la situation sanitaire 1988, Dosso 1989

MSP/AS, DDS Tahoua, Situation sanitaire du departement de Tahoua: rapport annuel d'activites 1988, Tahoua, 1989

MSP/AS, DDS Tillaberi, Situation sanitaire du departement de Tillaberi: rapport annuel d'activites 1988, Niamey, 1989

MSP/AS, DEP, Enquete nationale sur la mortalite et la morbidite, Tulane University, Niamey 1987

MSP/AS, DEP, Enquete nationale sur l'utilisation des services de sante, Tulane University, Niamey 1987

MSP/AS, DPF, Male and female knowledge, attitudes, practice, Johns Hopkins University/PCS, Niamey, 1988

MSP/AS, DPF, Plan d'action 1989, Niamey 1989

MSP/AS, DPF, Rapport d'activites annee 1988, Niamey 1989

MSP/AS, DPF, Rapport d'interviews de groupes, Maradi - Zinder, Johns Hopkins University/PCS, Niamey, 1988

MSP/AS, DPF, Rapport de l'enquete en sante familiale, connaissances, attitudes, pratiques (C.A.P.), Projet de recherche operationnelle, Columbia University, Niamey, 1987

MSP/AS, DPF, Rapport sur les visites d'entretien et recensement des besoins en matiere de planification familiale de la communaute urbaine de Niamey, Niamey, 1989

OMS, Situation sanitaire du Niger: Rapport du coordonnateur national de programme Organisation Mondiale de la Sante, Niamey 1985

Onanga, B. & Yatshita, M., Follow-up of INTRAH-trained FP service providers trained in Zinder, INTRAH trip report #435, Chapel Hill, 1988

Schubert, J.W., Family Health: IEC needs assessment, JHU/PCS, Niger, Niamey 1987

Thiam, D. & Yatshita, M. Clinical FP skills workshop, Tahoua July -August 1988, INTRAH trip report #202, Chapel Hill, 1988

USAID/Niger, Niger Family Health and Demography Project, 683-0258, Project paper (Document du Projet, Projet de Santé Familiale et Démographie, volume 1, Niamey 1988

Vintsintejin, Gilberte, projet de sante familiale et de demographie au Niger: Analyse de besoins en formation, Niamey [1987]

A N N E X I

STATEMENT OF WORK

STATEMENT OF WORK

I. Background

The bilateral Niger Family Health and Demography Project (NFHDP), to be implemented over five years with a planned life of project budget of \$11 million, was signed in August 1988. A baseline evaluation is planned at the beginning of project implementation to document the initial status of programs to be aided by the project; to define the key indicators of project success for use in subsequent evaluations of the project; and to define how progress in achieving purpose level indicators (and outputs) will be tracked.

The goal of the NFHDP is to assist the Government of Niger in its efforts to achieve a rate of population growth that is consistent with the growth of economic resources and productivity. The Family Health Component will improve the capacity of the Directorate of Family Planning (DFP), in the Ministry of Public Health, Social Affairs and Women's Status (MSP/AS/CF) to implement an effective national family planning program nationwide. The Demographic Research and Analysis Component will improve the capacity of the Directorate of Statistics and Computer Services (DSI) in the Ministry of Plan and Regional Planning (MP/RP) to conduct and analyse demographic research.

II. Objectives of the Evaluation

This PIC-T requests the services of three persons (one management specialist and one training/IEC specialist in family planning, and one demographer/planner) to perform a baseline evaluation for the NFHDP. The baseline evaluation to be undertaken through this contract will be used to determine the status of the national family planning and demographic research programs at the start of the project, and to establish guidelines for assessing NFHDP achievements.

The contract team performing the baseline evaluation shall accomplish the following objectives:

- a) Determine the current status of the following aspects of the national family planning program
 - family planning service delivery
 - constituency development
 - training of health personnel
 - information-education-communication
 - management, supervision and coordination
 - contraceptive supply, including logistics
 - capability of performing operations research;
- b) Establish key indicators for measuring inputs, outputs, and project achievements in each of the above areas;

- c) Determine the current status of the following aspects of demographic research and analysis:
 - processing of the 1988 Niger census
 - utilization of demographic information for planning
 - availability of other demographic and health data
 - training needs of demographic personnel
 - availability of demographic documentation
 - dissemination of demographic data
- d) Establish key indicators for measuring inputs, outputs and project achievements in each of the demographic elements listed in c).
- e) Recommend procedures for data collection and record-keeping to track the key indicators for both main project elements over the life of the project.

III. Composition of the Evaluation Team and Qualifications

The contract team will work under the direction of the USAID/Niger Health Development Office (HDO). They will work in close collaboration with the project managers and staff of the Directorate of Family Planning in the MSP/AS/CF and the Directorate of Statistics and Computer Services in the MP/RP. A counterpart from each of these directorates will be assigned to assist the team.

Personnel to be recruited are:

1. One management specialist in family planning, with PhD or Master's level education in Public Health, Administration or Management, or MD with extensive management experience in public health. The management specialist will serve as team leader with primary responsibility for the organization of data collection and preparation and production of the report.
2. One person with public health background and experience in design and implementation of family planning programs, including information-education-communication and training activities in family planning.
3. One demographer with experience in design and implementation of demographic research programs at a national level and use of demographic data in program planning.

Each person must have a minimum of three years professional experience working with international family planning or demographic programs, and each must demonstrate familiarity with such programs in a developing country, preferably in the Sahel. (French minimum 3 /3 for all team members).

The contract team will be assisted by at least one staff member of the DPF and one from the DSI, to be assigned to the evaluation team for the duration of the activity.

IV. Activities to be Performed

To accomplish the objectives stated above, the team will:

- (1) review all relevant documents including the NFHDP Project Paper (the Logical Framework which defines the NFHDP's goals, purposes, inputs and outputs, is included as Attachment III), reports from the Directorate of Family Planning and the Directorate of Statistics and Computer Services, reports and project agreements from other donor agencies working with the same directorates, government policy statements and regulations concerning family planning and demography;
- (2) review all available, relevant service statistics;
- (3) interview directors and staff of the DPF and the DSI and government personnel from other directorates implicated in family planning service delivery or demographic planning, as appropriate;
- (4) visit field sites in order to observe actual levels of family planning service delivery, personnel capability, and IEC activities;
- (5) involve the counterparts assigned by the DPF and DSI in all aspects of the evaluation, including preparation of the final report, and insure that report recommendations are fully understood and agreed upon by the staff of the two directorates.

The NFHDF Logical Framework (Attachment III) and the evaluation section of the NFHDP Project Paper (Attachment IV) will serve as a guide for the development of a more detailed research design by the contract team.

V. Contribution of the Government of Niger

The DPF and the DSI will both assign at least one staff member to the evaluation team for the duration of the activity. For site visits to health facilities outside of Niamey, the MSP/AS/CF will provide a vehicle and chauffeur.

VI. Timing

The team should arrive in Niger in early March for a period of one month. Initial meetings will be held with the USAID Health Development Office and the Directorates of Family Planning and Statistics and Computer Services. Progress reviews shall be held periodically during the course of the consultants' stay.

VII. Reports

The team shall produce a comprehensive baseline evaluation report responsive to the requirements set forth in this scope of work. USAID/Niger reserves the right to provide additional detailed instructions and technical direction during the course of the team's work. An outline of the report shall be provided to USAID within ten days of arrival of the team in Niamey. A draft report in French and English will be completed in time for review by USAID/Niger and relevant Ministry officials five work days prior to departure. Four copies in English and four in French of the final report shall be submitted by the team prior to departure.

A N N E X II

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORKProject Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>A. Program or Sector Goal</u>	<u>A. Measures of Goal Achievement</u>		
To help achieve a rate of population growth consistent with the growth of economic resources and productivity.	1. Reduction in crude birth rate and rate of natural increase. 2. Reduced level of infant and maternal mortality 3. Economic growth exceeds population growth.	Analysis of national health & population data	- Couples use FP to limit family size as well as to space births - Lower infant and maternal mortality are valid indicators of more widely spaced births, and hence lower birth rates
<u>B. Project Purpose</u>	<u>B. Conditions that will indicate that purpose has been achieved: End of Project Status</u>		
To strengthen the capacity of Nigerien institutions to plan, support & monitor FP services on a national basis, and to produce & use demographic analyses for national planning.	1.1 MOPH/SA operates FP program in all 7 departments with established procedures for management, annual planning, contraceptive supply. 1.2 146 health facilities offer FP services including IEC, contraceptive distribution, counseling 1.3 GON conducts periodic analyses of problems and progress FP program 1.4 7% MWRA contracepting (vs. 1% now)	- Govt of Niger documents - Consultant reports - Evaluations - Annual Reports - Evaluations - Site visits - Service statistics - Consultant reports - Surveys - Service statistics	GON will continue to provide policy support, personnel & financing for delivery of FP services & demographic research
<u>Subpurposes</u>			
1. To build the institutional capacity of the MOPH/SA to deliver FP services as an integral part of health services			

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	1.5 Graduating medical & nursing students have competency in FP	- School records - (Tests, reports)	
	1.6 Plan for further extension FP services established	- Government of Niger reports	
2. To build the capacity of the Ministry of Plan to conduct demographic research & analyses	2.1 Ministry of Plan demographic data base used in preparing 1992-96 Five Year Plan and other planning documents	- Five Year Plan	
	2.2 Demographic data base used for Allocation of investment budget resources, programming for development projects and guidance to technical ministries	- GON reports and studies	
<hr/>			
<u>C. Outputs</u>	<u>C. Magnitude of Outputs</u>		
<u>A. FP Component</u>	<u>A. FP Component</u>		
1. FP constituency development	1. 2 national C.D. conferences held	1. Reports	1. GON agrees to held conferences
2. FP program personnel trained - in-service - pre-service	2.1 In-service: 5 program managers, 10 trainers, 46 mid-level managers, 344 service providers trained 2.2 Pre-service: 2 curricula revised and implemented	2.1 Reports, site visits 2.2 Medical school, ENSP, ENICAS records, curricula	2.1 MOPH/SA makes appropriate personnel available for training 2.2 MOPH/SA accepts curriculum reform
3. IEC campaign implemented	3.1 4 audience research activities carried out 3.2 Departmental and arrondissement IEC activities carried out	3 Reports, review of materials, site visits	3. Cooperation of concerned MOPH/SA offices

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NAARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
2. Demographic and health survey	2. Report of demographic survey prepared	2. Review plan and report	2. GON provides personnel and other contributions
3. Trained demography personnel	3. Min. Plan staff trained in demog. (1 PhD, 1 MA), 20 trained staff participate in planning.	3. Review records	3. GON provides appropriate candidates and assignments once personnel are trained
4. Documentation and dissemination of demographic data	4. 3 libraries established.	4. Review report, site visits	4. GON provides library sites
D. Inputs			
<u>Type and Quantity (\$000)</u>			
1. Technical Assistance	1.1 10 Person Years LT	USAID records	Dollar/CFA Exchange rate does not decrease substantially from \$1/300 CFA
- L/T advisors	1.2 6.6 Person Years ST		
2. Training	2.1 370 PM In-country	\$ 634	Inputs delivered as planned
	2.2 30 PM 3rd country	\$ 71	
	2.3 44 PM U.S. ST	\$ 220	
	2.4 144 PM U.S. LT	\$ 375	
3. IEC	3. IEC Campaigns/ Materials	\$ 577	
4. Operations Research	4. 2 OR Studies	\$ 344	
5. Demographic Research	5. Surveys/materials	448	
6. Contraceptives/ Health equipment	6.1 Contraceptives	\$ 1,490	
	6.2 Health Equip/Supplies	350	
7. Equipment	7.1 6 microcomputers	\$ 42	
	7.2 5 vehicles/parts	\$ 144	
	7.3 Office equip./furn/sup	\$ 54	
8. Evaluation	8. 3 studies	\$ 356	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	3.3 1 mass media FP campaign completed		
	3.4 IEC Materials distributed to all FP service providers		
4. Contraceptives available and logistics system in place	4.1 Contraceptives delivered (offering up to 414,000 CYP)	4. Review plans and reports, site visits	4. GON permits import/distribution of contraceptives
	4.2 MIS and delivery systems installed		
5. FP management and supervision systems instituted	5.1 Annual workplans prepared for each year, 2-5	5. Review plans and reports, site visits	5. Personnel and logistical support available
	5.2 Supervisory protocols and quarterly visits implemented		
	5.3 Standards of care designed		
	5.4 MIS and evaluation procedures in place		
6. Findings from O.R. Projects disseminated	6. 2 O.R. projects aimed at private and mixed contraceptive distribution completed	6. Review plans and reports, site visits	6. GON supports OR; personnel available.
B. <u>Demographic Research Component</u>	B. <u>Demographic Research Component</u>		
1. Census data processed and analyzed	1.1 Analysis of census data quality completed	1. Review report	1. GON/donor financing of census is adequate and
	1.2 8 special analyses of census completed		

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Niger Family Health and Demography (683-0258)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
9. Audit	9.	Survey/audit	\$ 100
10. Local costs	10.1	Office rent/util	\$ 133
	10.2	45 P/Y admin. personnel	\$ 248
	10.3	Op. Expenses	\$ 113
	10.4	Misc. (travel, overhead, (inflation)	\$ 207
Subtotal			\$10,159
Contingency			\$ 841
Total			\$11,000

(inflation factored into line items)

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A N N E X I I I

EVALUATION PLAN FOR THE NIGER FAMILY HEALTH
AND DEMOGRAPHY PROJECT

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**EVALUATION PLAN FOR THE NIGER FAMILY HEALTH
AND DEMOGRAPHY PROJECT**

Evaluation of the project will be particularly important given the nascent stage of the Niger population/family health program. The evaluation will serve to objectively measure progress towards the attainment of project objectives and to identify obstacles to project implementation. All evaluations will be conducted by external evaluators.

Evaluation of the NFHDP will occur in three stages. First, a baseline assessment will be conducted in order to provide an estimate of the key output indicators at the beginning of the project. This will provide a standard of comparison against which the results of later evaluations can be measured. The baseline assessment will be conducted in 1989. The project will finance three person-months of technical assistance for the purpose of developing baseline indicators.

The second stage will be a mid-point evaluation to be conducted in 1991. This study will serve to measure progress with respect to the output and purpose indicators and to identify the important factors facilitating or impeding project implementation. Three person-months of technical assistance will be provided to conduct the mid-point evaluation.

In 1993 a final evaluation of the project will be conducted. The final evaluation will assess whether the project achieved its purposes and outputs as set forth in the project design. The Log Frame contains explicit and quantified measures of project purposes and outputs. The precision of the output measures will simplify the task of the evaluators in determining if the project met its objectives. The project will support 5 person-months of technical assistance to conduct the final evaluation.

Detailed research designs will be developed prior to each evaluation in collaboration with the evaluation team. As guidance to the evaluation teams and USAID, key questions to be addressed by the evaluation teams are set forth below.

(1) Were the inputs delivered in the quantity and manner prescribed by the project design? If not, what changes were made and for what reason?

The project description and the financial plan describe in detail the nature and level of project inputs. Please see logical framework for summary description.

During the course of project implementation it may prove advisable or necessary to alter the allocation of resources, thereby lowering or raising input levels in any one area. The assessment of inputs should be primarily concerned with determining what inputs were delivered, how these contrast with the original project design and the reasons for re-allocation of resources. The mid-term evaluation may also suggest modifications of inputs (and appropriate design changes required).

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(2) What are the principal obstacles to implementation?

Key to the evolution of the Niger population program will be identification of the principal obstacles to program implementation. The history of family planning and population programs in the Sahel and in sub-Saharan Africa generally is fairly short; hence, there is relatively little experience to draw upon in predicting the major barriers to implementation. An implementation analysis will identify the important obstacles as guide to the evolution of population programs in Niger and elsewhere in the region. A priori, it is possible to hypothesize a parsimonious set of factors that may impede or facilitate implementation - adequacy of the original project design, technical skills of the staff, adequacy of resources, administrative procedures and regulations and attitudes of service providers. Accordingly, the implementation analysis might focus on the following questions.

o Was the original design technically sound? The Log Frame contains a number of explicit assumptions upon which the design rests (e.g., continuation of GON support of family planning), as well as assumed linkages between project elements (e.g., that training will be followed by service delivery). The realism of these of these assumptions and presumed linkages needs to be tested as the project evolves.

o Do the personnel have the skills needed to carry out their roles in the family health and demographic research programs? This is really a two part question. First, did the training yield the predicted changes in knowledge, skills and attitudes? All training sessions will be evaluated for their impact on the trainees. This will be complemented by a compilation of individual evaluations to determine the efficacy of the training program as a whole. Second, did the training neglect important skills or attitudinal barriers that can be shown to be of importance to program implementation? Trainee follow-up and the reports of the Technical Services Group can be used to identify domains inadequately treated during the training.

o Are the resources provided adequate to achieve the project objectives? While the best possible estimates have been made of the resources needed to carry out the project, the implementation analysis should benefit from project experience to re-assess the level of resources needed from USAID and the GON to achieve the project objectives. Inaccurate estimates of resource requirements during project design or the inability to deliver resources may prove a major barrier to project implementation.

o Are there significant logistical or administrative barriers to project implementation? For example, the contraceptive logistics system may prove difficult to maintain. Alternatively, specific legal or administrative requirements - such as the requirement that women obtain the permission of the husband before obtaining contraceptives - may inhibit project implementation. These and other pertinent administrative issues will have to be identified and their impact assessed during the implementation analysis.

o Do service provider perceptions and attitudes serve as a barrier to program implementation? It is as yet unknown whether service providers will be supportive of the integration of family health into other health services. The importance they attach to family health and their role in its promotion may be a critical element in the project's success. Hence, the implementation analysis will need to assess service provider attitudes and perceptions.

The factors suggested here as potentially important for project implementation are neither exhaustive nor will they necessarily prove to be the factors deemed of principal interest at the time of the evaluations. Rather, they are illustrative of the concerns to be addressed by the implementation analysis and as a guide to the factors that are, a priori, of concern to the project designers.

(3) Were the project purpose and outputs achieved?

The Project Description and the Log Frame have described in detail the project purposes and the magnitude of the anticipated outputs. The mid-point and final evaluations will determine the extent to which purpose and outputs have been achieved. In particular, the assessments of project purpose will address the following questions:

- o Does a national FH program exist with established procedures for management, annual planning and contraceptive supply?
- o Are the anticipated number of health facilities (146) offering family health services?
- o Is there a system of periodic internal review of the FH program?
- o Is there a plan for further extension of FH services?
- o Did the project provide the projected level of contraceptive protection?
- o Do newly educated doctors, nurses and midwives have technical competence in FH?
- o Is the Ministry of Plan making use of demographic data in macro-economic planning and allocation of investment budget resources?

The following questions are to be included in assessment of project outputs:

- o Were the anticipated number of people trained in the prescribed areas?
- o Were the projected IEC activities realized in kind and number?
- o Were the management procedures and system described in the project design implemented?

o Were the two operations research projects implemented and did they yield usable results?

o Was the census data processed and analyzed in accordance with the project design?

o Was the Niger Demographic and Health Survey conducted? If so, how have the data been used to improve program management?

o Have the demographic libraries been established and was the demographic data dissemination program implemented?

It should be recognized at the outset that attribution of the observed outputs solely to the project may prove difficult. The contributions of the GON and other donors independent of the NFHDP, as well as secular changes in the socioeconomic environment may confound efforts to draw direct causal links between project inputs and the status of the population program in 1992. Despite potential difficulties in demonstrating causality, the evaluation of output indicators will provide valuable information as to the progress of the population program.

A N N E X E IV

RAPPORT SUR LES VISITES D'ENTRETIEN ET
RECENSEMENT DES BESOINS EN MATIERE
DE PLANIFICATION FAMILIALE
DE LA COMMUNAUTE URBAINE DE NIAMEY

INTRODUCTION :

Dans le souci d'améliorer les prestations de service en matière de planification familiale, des visites d'entretien et de recensement des besoins nous ont amené du 30 Novembre 1988 au 9 Décembre 1988 et du 3 Janvier 1989 au 5 Janvier 1989 dans vingt deux (22) formations sanitaires publiques dont onze (11) P.M.I , trois (3) maternités, six (6) dispensaires périphériques, au CHU et au CNSI et onze (11) structures sanitaires privées dont quatre (4) cabinets, cinq (5) salles de soins et deux (2) cliniques.

Vingt et une (21) de ces formations mènent des activités de planification familiale.

Ces visites s'effectuaient de 9 h à 12 h et concernaient 2 à 3 formations par jour. Elles regroupaient le responsable du service (généralement le médecin), les sages-femmes, l'infirmier major et l'assistante sociale. Les sages-femmes étaient les principales concernées parce qu'étant les responsables des prestations de services en Planification Familiale.

LA METHODOLOGIE : adoptée était sous forme de questions relatives au :

- personnel en place
- personnel formé en P.F
- différentes activités menées en matière de P.F
- matériel disponible
- matériel manquant
- local disponible pour la P.F
- stock en contraceptifs.

LES DIFFERENTES ACTIVITES :

I - LA CONTRACEPTION ORALE

Au cours de ces visites, il ressort que la contraception orale est la plus acceptée. Elle est pratiquée presque partout dans dix sept (17) formations sanitaires. Quelques cas d'hypertension artérielle ont été signalés avec le lo-femenal et des métrorragies avec le microlot et l'ovrette.

II - LA POSE DE DIU :

Elle est pratiquée dans sept (7) formations sanitaires dont le C.N.S.F, la Maternité Poudrière, la PMI Garde Républicaine, la C.N.S.S Maourey, la Maternité Centrale, la P.M.I Lamordé et la Maternité Lamordé.

Trois problèmes majeurs se posent à cette pratique. Il s'agit notamment de la formation du personnel, la disponibilité du local, le matériel.

- la formation du personnel

Sept (7) centres de PMI (FAN, Boukoki, Poudrière, Goudel, Aéroport, Ialladjé, lazaret).

Deux (2) dispensaires (koira tégui et ligue Islamique).

Une (1) maternité (poudrière) et le CHU ont un problème de formation du personnel.

Sur l'ensemble du personnel formé en planification familiale, il y a cinq (5) médecins sur dix neuf (19) au total.

Quarante trois (43) sages-femmes sur 130

Deux (2) infirmiers d'Etat sur cinquante (50)

Sept (7) Assistants Sociaux sur vingt huit (28)

Sept (7) infirmiers certifiés sur quatre vingt dix (90)

Une (1) aide sociale sur trente une (31).

Les infirmiers, assistants et aides sociaux n'ont reçu aucune formation en matière de Planification Familiale hors mis ceux du Centre National de Santé Familiale ne serait-ce en IEC (Information - Education et Communication).

- le local :

Sur les vingt deux (22) structures sanitaires publiques visitées, neuf (9) ont un problème de local, car la même salle sert de consultation prénatale et de contraception.

Il est à signaler que ces deux activités se mènent tous les jours. Il s'agit des centres de PMI Abidjan, Yantalla, Boukoki, des maternités lamordé et poudrière, des dispensaires koira tégui et ligue Islamique et le C.N.S.S Kalley.

.../...

- Le Matériel :

En dehors des sept (7) formations sanitaires qui font la pose de DIU, tous les autres centres ont un problème de matériel adéquat pour cette technique.

Ci-jointes en annexes les fiches représentant la situation spécifique de chaque centre.

III - LA METHODE INJECTABLE :

est pratiquée dans huit (8) centres C.N.S.F, P.M.I FAN, PMI Boukoki, PMI yantala, PMI Lamordé, Maternité Centrale, Maternité Lamordé et CNSS Kalley. L'injection est faite par la sage-femme.

Il est à noter qu'à l'ouverture du CNSF il a été recommandé que la méthode injectable comme la pose de DIU soient pratiquées uniquement par ce dernier et la PMI Lamordé. Ce n'est que maintenant que la plupart des formations sanitaires envisagent de commencer ces deux activités.

IV - L'I.E.C :

Elle est menée dans dix neuf centres au moins une fois par semaine suivie du counseling. A entendre parler certains responsables de service, il semble que certaines catégories du personnel ne s'intéressent pas à cette activité en dehors des sages-femmes.

V - LA METHODE DE BARRIERE :

est utilisée par les clientes en cas d'erreur de prise de pilule ou en attendant la méthode choisie.

S'agissant du stock de contraceptifs toutes les formations sanitaires qui mènent des activités de planification familiale ont un stock suffisant et des cas de péremption n'ont pas été remarqués. L'approvisionnement se fait au C.N.S.F avec le rapport d'activités de la formation.

PROBLEMES :

Signalons les plaintes de certains centres de santé relatives au renvoi des femmes référées au CNSF, la rupture des fiches de consultation de P.F ainsi que

la diversité des pilules. La question de savoir où adresser aussi les rapports d'activités a fait l'objet d'inquiétude (au C.N.S.F, à la DSMI ou la DPF ?). Pour notre part les problèmes majeurs que nous avons rencontrés, étaient le manque d'encadrement pour des débutantes que nous sommes et le manque d'un protocole type de supervision.

SUGGESTIONS :

Pour une meilleure couverture de prestations de services en matière de P.F nous suggérons :

- une sensibilisation du personnel sur le travail en équipe surtout en matière d'I.E.C.
- une formation du personnel à tous les niveaux
- une mise en place du matériel nécessaire pour la pose du DIU
- une standardisation des pilules au niveau national
- une élaboration d'un protocole type de supervision
- un souhait de mise en place d'un système d'informations sanitaires des rapports d'activités.
- une intégration des activités de planification familiale dans le programme de certaines formations sanitaires périphériques qui sont stratégiques et déservent des populations cibles tels que :
 - les dispensaires Lazaret, Koiratégui et Ligue Islamique .

La seconde étape de notre visite a concerné les formations sanitaires privées à savoir :

- quatre (4) cabinets médicaux (Dr. ALOU - TALFI - SOUNA - ALHERI de Hme. BFN).
- Cinq (5) salles de soins (ABDOULAYE ALFARI - BOUBACAR CHARLEMAGNE, HAMANE NASSIROU, DARI SOULEY, DAMOURE ZIKA).
- Deux (2) cliniques (Goukarre et Koba).

De cette visite, il ressort que ces centres de santé ne reçoivent qu'un nombre

négligeable de clientes en prestations P.F. Ce qui fait qu'il n'y a pas de données exactes du nombre de femmes qui ont été vues.

Parmi ces clientes certaines sont référées au C.N.S.F ou à la maternité centrale.

Dans le domaine d'IEC en matière de P.F seul DAMOURE ZIKA organise des séances de films en collaboration avec l'Ambassade de France et des causeries dans les quartiers de Lamordé.

Tous les responsables de ces formations sanitaires privées ont apprécié notre visite et ont formulé le voeu d'avoir plus de collaboration avec le Ministère de la Santé sur certains programmes de santé (par exemple le P.E.V). Ils ont demandé un guide en clinique P.F et si possible une formation au C.N.S.F.

CONCLUSION

En conclusion pour une amélioration des activités en matière de planification familiale, il serait souhaitable :

- de former le personnel de santé surtout celui des dispensaires périphériques
- d'équiper les centres de santé de matériel en pose DIU
- de superviser périodiquement les activités.

Ont effectué ces visites :

- Mme. ABDOULAYE FATOUHA D.P.F
- Mme. LAOUALI SALAMATOU D.P.F
- Mme. ZATAKA AISSATA D.S.M.I
- Mme. ZADA AICHATOU C.N.S.F.

A N N E X E V

RAPPORT DE MISSION SUR L'INTEGRATION
DES ACTIVITES DE SMI / PP DANS LE
DEPARTEMENT DE DOSSO
DU 28 MARS AU 1ER AVRIL 89

RÉPUBLIQUE DU NIGER
CONSEIL MILITAIRE SUPRÊME
MINISTÈRE DE LA SANTÉ PUBLIQUE
ET DES AFFAIRES SOCIALES
CENTRE NATIONAL DE SANTÉ FAMILIALE

RAPPORT DE MISSION SUR L'INTEGRATION
DES ACTIVITES DE SMI/PF DANS LE
DEPARTEMENT DE ZOSSO.
DU 28 MARS AU 1ER AVRIL 89/

PAR : . Mme DJATAOU OUASSA, DIRECTRICE DU CENTRE
NATIONAL DE SANTE FAMILIALE CHEF DE MISSION
. Dr. RAMAKAVELO MAURICE PROJET NER/88/P06/CNSF
. Mme AGBESSI LAURE RESPONSABLE IEC AU CNSF
. Mme LAOUALI SALAMATOU CHEF DE LA DIVISION P.F
. Mme HADIZA DJIBO ADJOINTE COORDINATEUR PMI
DE LA COMMUNE DE NIAEMY.

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1 - INTRODUCTION :

2.

Suite à la promulgation des textes législatifs du 7 Avril 1988 autorisant la pratique de la contraception sur toute l'étendue de la République du Niger et aux recommandations de la Conférence Internationale sur "la Maternité Sans Risques" qui s'est tenue à Niamey du 30 Janvier au 3 Février 1989, la Direction de la PF, la DSMI et le Centre National de Santé Familiale organisent des missions conjointes afin de promouvoir les activités de santé familiale et de planification familiale (SF/PF) dans tous les départements.

La présente mission s'est déroulée du 28 Mars au 1er Avril 89 au niveau du département de Dosso comme préalable au démarrage du renforcement des activités de SMI/PF, dans le cadre de la 2e phase du projet NER/88/P06.

2 - OBJECTIFS :

2.1. Objectif général : réduire la mortalité maternelle et infanto-juvénile

2.2. Objectif intermédiaire : promouvoir les activités de planification familiale dans la zone de rayonnement de toute formation sanitaire.

2.3. Objectifs spécifiques :

a) évaluer le niveau d'intégration effective des activités de PF au niveau de la formation sanitaire et de sa zone.

b) Recenser les besoins en formation en PF du personnel, en équipement, en matériels pour PF et en contraceptifs et dresser avec les responsables une ébauche de plan d'action pour 1989.

c) Tenir des séances de travail avec le personnel sur :
- la gestion d'un programme de PF
- l'IEC et la PF
- les méthodes modernes de contraception.

d) Diffuser les textes législatifs sur la contraception.

3 - METHODOLOGIE ET CALENDRIER

3.1. La méthodologie retenue a été la suivante :

a) passage au niveau du CM de chaque arrondissement pour :
- observer le personnel dans son milieu de travail
- recenser les besoins
- discuter leurs problèmes.

./...

b) Séance de travail avec participation du personnel des CM visitées et de synthèse au niveau de la direction départementale de la santé pour disposer d'une ébauche du schéma d'intégration des activités de PF et de plan d'action 89.

c) La collecte des renseignements a été faite selon la fiche figurant à l'annexe.

Un canevas très simple de plan d'action réaliste a été proposé et se trouve aussi à l'annexe.

3.2. Le calendrier adopté avec les responsables sanitaires départementaux est le suivant :

Date	!	Lieux visités
Mardi 28 Mars	!	- CM de Birni
	!	- DDS Dosso
	!	
Mercredi	!	
29 Mars	!	- CM de Loga
	!	- CM de Doutchi
	!	
Jeudi 30 Mars	!	- CM de Gaya
	!	- CM Dosso
	!	
Vendredi	!	
31 Mars	!	Séance de travail au niveau de la DDS de Dosso avec du personnel venu des CM visitées, animée par l'équipe centrale en tournée.
	!	
Samedi	!	
1er Avril	!	Synthèse avec le DDS et le coordonnateur de PMI du département de Dosso
	!	

4 - LES RESULTATS DE L'EVALUATION :4.1. Taux de couverture en PF dans le département de Dosso :

Population du département en 1988	=	1.019.997
Femmes en âge de procréer ou F.A.P (25 %	=	254.999
Nombre d'acceptrices en PF (1988)	=	5.397

Taux de couverture : 2,11%

4.2. CM de Dogondoutchi :

- Population arrondissement	:	317.035
- F A P :.....	:	79.258
- Nombre total acceptrices	:	702 *(non compris chiffre de tibiri Guéchémé et Matankari)

Couverture en PF : 1%

Personnel formé en PF : 1 Médecin, 1 S.F (pose DIU) (Gestion et pose DIU)

Besoins en formation PF : Gestion 1

I E C 3

Technique 3

Problèmes recensés = . approvisionnement irrégulier en contraceptifs
 . absence de supports audio-visuels en PF
 . fiches PMI non adaptées
 . lère consultation prénatale tardive
 . supervision irrégulière des ESV
 . pas de suivi des grossesses à haut
 risques (G.A.H.R.)

Recommandations : . approvisionnement régulier en contraceptifs
 . formation du personnel en PF
 . supervision régulière du niveau central
 . fourniture documents en PF et matériel
 audio-visuels.

4.3. CM Birni N'Gaouré

Population arrondissement	:	205.636
F.A.P.	:	51.409
Nombre total d'acceptrices:	:	775 * (Falmey et Kiota non compris)
Couverture en PF	:	1,5 %
Personnel formé en PF	:	1 S.F, 1 I.D.E(nouvellement affecté)
Besoins en formation	:	Gestion 1
		Technique 3
		I E C 1

Problèmes recensés :

- . 1 seul tensiomètre pour toute la CM
- . pas de doigtier
- . pas de boîte gynécologique
- . absence de matériel audio-visuel en PF
- . aucun personnel formé en PF
- . accouchements à domicile
- . pas de suivi G.A.H.R

Recommandations :

- . approvisionnement en matériel technique
- . formation du personnel
- . meilleur travail d'équipe
- . documentation à fournir en PF
- . sensibilisation à intensifier
- . approvisionnement régulier en contraceptifs.

4.6. Commune de Dosso :	!	<u>Arrondissements Dosso</u>
Population : 27.092	!	218 726 Hts
F. A. P. : 6.773	!	54 681

Nbre total acceptrices : 2.414

Couverture en PF : 35,6 %

Personnel formé en PF : 3 : 1 M, 2 SF et
1 TSSO

Besoins en formation : Gestion 2
I E C 2
Technique 5

Problèmes recensés : absence matériel IEC

- . personnel de maternité non formé en PF
- . abandon de méthode après 4 à 6 mois

d'utilisation

- . insuffisance sensibilisation population
- . besoins en formation
- . accouchements à domicile.

Recommandations :

- . formation en PF
- . sensibilisation population en PF
- . fournir maquette utérus
- . matériel IEC à fournir.

4.7. En résumé les problèmes recensés sont :

- a) - tensiomètre
- b) - le manque de programme arrêté en IEC/PF
- c) - accent non mis sur les grossesses à haut risque (G.A.H.R.) dans les consultations prénatales

d) besoins aigus en formation sur les 3 volets de PF (IEC, Méthodes, Gestion)

e) insuffisance du travail en équipe pour la PF dans la formation sanitaire

f) approvisionnement en contraceptifs non rationnel

g) équipement incomplet

h) inexistance matériels audio-visuels

i) mauvaise collecte des données, et manque de retro-information.

5 - NOS RECOMMANDATIONS :

5.1. Sur l'intégration de la PF : compte tenu des ressources en personnel formé en PF dans le département de Dosso à savoir :

- . Un noyau de formateurs à la DDS avec le Coordonnateur Départemental de PMI plus le Médecin de PMI de Dosso plus la sage-femme (en même temps membre de l'AFN au niveau de la commune),
- . une CM, Birni n'ayant pas une population très importante mais disposant de personnel formé en PF
- . une autre CM, Doutchi disposant d'un médecin formé en gestion et une sage-femme formée en PF,

Le Département de Dosso pourrait dès maintenant adopter le "schéma d'intégration de la PF" suivant

lère étape : à Dosso, à Birni et à Doutchi, commencer par :

- choisir un objectif soit 10 % de la population-cible
- assurer approvisionnement ou stock en contraceptifs pour le groupe-cible à atteindre et selon les méthodes à lancer
- dresser un calendrier de campagnes d'I.E.C pour les autorités, et pour les différentes communautés socio-culturo-professionnelles ou religieuses
- intégrer automatiquement la PF dans l'éducation pour la santé faite dans toutes les activités du centre (consultations des nourrissons, CPN, après accouchements, consultations post-natales),
- assurer consultations PF tous les jours
- faire une collecte correcte des données et bon suivi des clients
- faire une réunion mensuelle des 3 formations sanitaires où l'on essaie de bien lancer la PF pour voir les problèmes et rectifier le tir

- supervision par l'équipe départementale et l'équipe centrale tous les 2 mois au moins
- faire une recherche sur :
 - . les facteurs de continuation ou d'abandon
 - . l'intégration des pharmacies populaires pour distribuer certaines méthodes.

2e étape : - Former le personnel des autres CM compte tenu des difficultés rencontrées :

- _ formation des médecins à la gestion
- formation des sage-femmes à la pose de DIU au CNSF
- équiper ces CM
- assurer stock contraceptifs
- planifier campagnes d'IEC (mettre l'accent sur l'intégration des E.S.V.)
- assurer les prestations de PF
- faire une bonne collecte des données et un bon suivi
- prévoir les visites de supervision formation avec rétro-information.

3e étape : . former personnel des dispensaires ruraux selon méthodes à lancer.

- . Equiper les centres et assurer le stock de contraceptifs
- . planifier les campagnes d'IEC et intégrer les ESV dans la distribution des méthodes de barrière.
- . Veiller à une bonne diffusion des textes législatifs sur la contraception au Niger
- . assurer les prestations
- . s'assurer d'une bonne collecte de données avec rétro-information pour le suivi du programme
- . planifier et réaliser les visites de supervision pour soutenir le programme.

4e étape : Evaluation sera faite par l'échelon central avec lequel l'équipe des formateurs/ superviseurs du département élaboreront le plan d'action départemental pour l'année suivante et avec des objectifs réalistes.

5.2. Sur les consultations prénatales :

- assurer une meilleure organisation des consultations prénatales afin de permettre le dépistage et le suivi des grossesses à haut risque qui devraient être référées en milieu plus équipé afin d'éviter la mortalité maternelle

- Uniformiser la fiche de CPN
- fournir un aide-mémoire des examens et conduite à tenir à chaque centre
- assurer une bonne collecte des données sur le nombre de GHR dépistées et le nombre de celles qui ont accouché en milieu surveillé, les décès.
- Sensibiliser automatiquement pour la PF et savoir le nombre qui ont opté pour la méthode irréversible.

5.3. Sur les consultations de nourrissons :

- devraient aussi être utilisées pour sensibiliser les mères à la PF surtout lors des séances du P.E.V. et lors des consultations foraines
- les mères des enfants à risque devraient adopter une méthode de PF.

5.4. Pour l'Elaboration du Plan d'Action 89 en PF par chaque CM, on pourrait suivre le canevas suivant :

PLAN D'ACTION EN P.F.

Pour l'année :.....

- FORMATION SANITAIRE (préciser) de :

- a) Population de la zone d'action =
- b) population-cible ou femme en âge de procréer =
- c) Nombre actuel d'utilisatrices de PF selon méthode =
 - taux de couverture de l'ensemble =
- d) objectifs fixés pour l'année = ou taux de couverture visé =
soit nombre de nouvelles acceptrices/mois =.....
- e) les activités préconisées pour atteindre cet objectif :

Activités / Tâches détaillées	! Responsables !	! Date ou période d'exécution !	! Besoins !
. <u>Campagne d'I.E.C.</u> :	!	!	!
-	!	!	!
-	!	!	!
-	!	!	!
-	!	!	!
. <u>Formation du personnel</u>	!	!	!
(préciser nom, catégorie et domaine nécessitant formation)	!	!	!
. <u>Equipement / Matériels</u>	!	!	!
(préciser le nombre chaque fois)!	!	!	!

. <u>Contraceptifs</u> :	!	!	!
-	!	!	!
-	!	!	!
-	!	!	!
-	!	!	!
. <u>Collecte des données</u>	!	!	!
-	!	!	!
-	!	!	!
. <u>Supervision</u>	!	!	!
-	!	!	!
-	!	!	!

f). Les problèmes majeurs pouvant freiner les activités de PF et préconisés :

f.1. Au centre :

-
-
-

f.2. Dans la communauté :

-
-
-

Date et signature du (ou de la) responsable de
la formation sanitaire :

6 - CONCLUSIONS : cette tournée marathon a permis à l'équipe en mission de :

avec
- constater dans les CM visitées/les responsables sanitaires du département de Dosso, les principales lacunes et les problèmes dans l'intégration et la mise en exécution du programme de PF dont les nouveaux textes législatifs viennent de sortir et qui seront désormais largement diffusés dans ce département.

- Rappeler de façon pratique les notions de base essentielles pour assurer cette intégration lors des séances de travail tenues avec les responsables dans leur CM d'abord puis à une grande réunion à la DDS.

- Demander à la DDS d'élaborer avec ses collaborateurs le plan d'action 89 pour l'intégration de la PF dans les formations sanitaires et de nous les faire parvenir dans les meilleurs délais.

- Réaliser l'insuffisance de la collecte de données entraînant une mauvaise estimation des besoins en contraceptifs occasionnant dès fois une rupture de stock néfaste au programme Nous participerons à l'amélioration de cette situation.

- Se rendre compte que le dépistage et le suivi des grossesses à haut risque nécessite une meilleure organisation dans chaque formation sanitaire

- suggérer la nécessité de supervision périodique pour soutenir l'intégration des activités de PF et la sensibilisation des autorités locales.

7 - REMERCIEMENTS :

Nous ne pourrions terminer ce rapport sans adresser à toute l'équipe de ce département tous nos vifs remerciements pour la très haute qualité de l'accueil, créant un climat de travail propice et sans lequel cette mission n'aurait pas pu réussir./.

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A N N E X E VI

RAPPORT D'ACTIVITES

ANNEE 1988

DIRECTION DE LA PLANIFICATION FAMILIALE

(731) 13150 pour attribution

V'

RAPPORT D'ACTIVITES

ANNEE 1988

DIRECTION DE LA PLANIFICATION FAMILIALE

INTRODUCTION :

La Direction de la Planification Familiale a été créée le 22 janvier 1988. Elle fait partie des neuf (9) Directions du Ministère de la Santé Publique, des Affaires Sociales et de la Condition Féminine (MSP/AS/CF).

A ce titre elle est chargée de :

- Appliquer et de veiller à l'application de la politique en matière de planification familiale.
- Promouvoir l'intégration des Activités de P.F dans toutes les formations sanitaires et les équipes de santé villageoise.
- Contribuer à la définition et à l'application d'une politique nationale en matière de population.
- Promouvoir la recherche en P.F
- coordonner toutes les activités de P.F à l'échelon national.
- collaborer avec les services, les ministères concernés et les différents bailleurs de fonds intervenant dans le cadre du programme National de P.F
- gérer toutes les ressources mises à sa disposition .

Pour atteindre ces objectifs, la Direction de la Planification Familiale a eu à mener les activités suivantes :

- Contribution à la promulgation des textes législatifs autorisant la contraception (3/88) (Voir annexe II).

.../...

- Réformulation du document du projet FNUAP pour la deuxième phase 3/88.
- Mise en place d'un système d'analyse et de collecte des données en P.F (fiche clinique, fiche de stock des contraceptifs, fiche de rapport trimestriel (1/88 - 6/88)).
- Formulation du document du projet bilatéral entre l'USAID et le NIGER, projet intitulé Santé Familiale et Démographie d'un montant de onze millions de dollars (huit millions pour le domaine Santé Familiale) et trois millions pour le domaine de la Démographie.

Le volet Santé Familiale comporte plusieurs points :

- Formation de deux cent cinquante six (256) Agents de la santé de toutes catégories confondues.
- Renforcement des Activités I.E.C
- Approvisionnement des contraceptifs pour toute la durée du projet qui est de cinq (5) ans (1988-1992°
- Logistique .

Le projet fut approuvé le 17 Août 1988 .

Dans le cadre de la formation les activités suivantes ont été menées :

- Séminaire départemental pour les prestataires cliniques à Tahoua d'une durée de quatre(4) semaines (Juillet 1988) vingt et un (21) agents (5 médecins, 10 Sage-Femmes, 6 infirmiers diplômés d'Etat).
- Séminaire départemental pour la prestation clinique à Maradi pour vingt deux agents.
- Séminaire de diffusion de l'enquête Cap réalisée à Niamey en 1986-1987 auprès de 509 Hommes et 1149 femmes, du 15 au 16 Septembre 1988,(participants 31).
- Atelier National sur la gestion des programmes de P.F (logistique, planification, supervision) Niamey du 7 au 18 Novembre 1988,(vingt cinq (25) participants).

.../...

- Séminaire départemental de sensibilisation des dirigeants d'Opinion en matière de Planification familiale à Matamèye du 7 au 11 Novembre 1988, (30 participants)
- Formation en pose de DIU pour sages-femmes et médecins, début des activités mi-Mai 1988 à ce jour.
- La Formation a eu lieu au Centre National de Santé Familiale après élaboration des objectifs de stage pratiqué en pose de DIU; le document élaboré a été amendé par la Direction de la Formation et de l'Education pour la Santé (DFEPS) et la Direction de la Santé Maternelle et Infantile (DSMI). Il y a eu également élaboration du pré-test à l'intention des stagiaires. Ce programme de formation de pose de DIU est conçu à l'intention des sages-femmes et médecins ayant déjà reçu une formation au préalable en planification familiale.
- Elle a touché les départements de Zinder, Maradi, Dosso, Tillabéry, *Tahoua*

Activités de formation à l'extérieur :

- Stage de formation en management, des programmes de P.F à Lomé, durée quatre (4) semaines, (trois (3) participants) deux (2) médecins, une (1) technicienne de l'action sociale).
- Information, Education, Communication
Lomé, quatre (4) semaines (un (1) médecin).
- Outils et stratégies d'Evaluation
Lomé (1 sage-femme).
- Bien-être familial intégré
Planification Familiale et bien-être de la famille, élaboration des projets, gestion et supervision DAKAR six (6) semaines de formation (une (1) sage-femme)
- Ile Maurice huit (8) semaines (quatre (4) sages-femmes).
Contrôle de la fécondité dans le programme de planification familiale.
- Formation à Abidjan : 10 Octobre au 21 Octobre 1988
(une (1) sage-femme) Directrice du C.N.S.F.

*gestion de Programmes de Soins de Santé Primaires
y compris la Santé Maternelle et Infantile et la*

- *Planification Familiale pour les Pays de l'Afrique Francophone et des Antilles du 31-10-88 au 28-11-88 à Abidjan OPF Adjointe*
- Séminaire sur les persuadeurs du village

(un assistant social deux (2) semaines (C.N.S.F.)).

- Formation clinique en planification familiale avec pose du DIU ; 15 sages-femmes en Tunisie financé par le projet I.D.A.

Activités d'Information, d'Education et de Communication (I.E.C)

- Signature d'un projet d'IEC en santé familiale entre le MSP/AS/CF et le PCS (Durée du projet dix neuf (21) mois du 1er Décembre 1987 au 31 Août 1989.
- Formation des chercheurs pour les interviews de groupe.
- Le 22 Décembre 1987 fabrication des boîtes d'échantillons confectionnées au Musée National comme moyen audio-visuels.
- Du 11 au 22 Janvier 1988 s'est tenu un séminaire atelier sur l'I.E.C, il regroupait vingt trois (23) participants du MSP/AS/CF , du Ministère de l'Information, de l'Association des Femmes du Niger.
- Au cours de ce séminaire, il a été créé l'emblème de la planification familiale, des messages ont été élaborés par les participants et pré-testés au niveau de la commune de Niamey.

Du 22 au 27 Février 1988 ont été réalisées les interviews de groupe à Zinder et à Maradi du 29 au 5 Mars 1988.

- Les membres de l'Equipe de Recherche étaient composés de quatre (4) chercheurs de Niamey (deux (2) assistants sociaux, une (1) infirmière, une (1) aide sociale et quatre (4) chercheurs de Zinder (deux (2) sages-femmes, un assistant social).

À Maradi, l'Equipe est composée des mêmes chercheurs de Niamey, d'un infirmier d'Etat et une aide sociale. Le travail a été effectué en présence de Monsieur RUTH KOMFIELD Assistant Technique de PCS (USAID).

- En Mars 1988, mise sur pied de l'enquête de référence d'IEC ; pour cela les activités suivantes ont eu lieu : du 9 au 13 Mars 1988.

.../...

Réunion pour rédiger le rapport d'interview de groupe ainsi que l'organisation matérielle de l'Etude sur l'IEC.

Le 9 Mars 1988 : réunion pour approbation de l'Emblème de la planification familiale.

- En Juillet 1985 finalisation de l'Emblème sur la planification familiale.
- 110 boîtes de présentation des contraceptifs ont été distribuées entre le CNSF, les centres sociaux et de PMI, les participants aux séminaires de Zinder, Maradi, Dosso, Tahoua sur la planification familiale et les cadres de santé qui ont participé au séminaire d'IEC.

Le Travail d'enquête

a été réalisé dans les trois villes prévues : Niamey, Maradi, Zinder. Il y a eu au total 1935 interviews de groupe.

- A Niamey 760 interviews de femmes et 425 d'hommes pour une durée de vingt trois jours pour les femmes et vingt six jours pour les hommes.
- A Maradi et Zinder, 500 interviews femmes et 250 interviews hommes pour une durée de treize (13) jours. Cette activité a été assurée à Niamey par dix (10) enquêteurs de Niamey, plus personnel du Centre National de Santé Familiale.
- Saisie des données a été effectuée par personnel du C.N.S.F, de la D.P.F et d'autres personnes recommandées par la Direction des Etudes et de la Programmation en collaboration avec Monsieur DAL' HUNTIGON Coordonnateur général de la Recherche à J. HOPKINS.
- Séminaire de sensibilisation des dirigeants d'Opinion s'est tenue à Matamèye du 7 au 11 Novembre 1988, il réunissait trente (30) participants.
- Fabrication des pagnes avec l'emblème de la planification familiale déjà fait, seront distribués au séminaire National de sensibilisation des dirigeants d'Opinion prévu pour Février et reporté en Avril 1989.
- Les rapports sur l'enquête CAP menée dans les ville de Niamey, Maradi, Zinder viennent d'être finalisés.

.../...

- Les résultats de l'enquête CAP menée par COLUMBIA UNIVERSITE et le C.N.S.F ainsi que les résultats de l'enquête CAP en IEC menée par la D.P.F, nous permettra d'élaborer un programme national d'IEC en tenant compte des recommandations proposées.
- A la suite des Interviews des groupes réalisées à Niamey, Maradi, Zinder, des messages ont été confectionnés et ont été testés au niveau de la Communauté.
- Il est prévu la conception et les fabrications des badges, auto-colants et la réalisation des pancartes à placer au niveau des différents services de SMI/PF. L'activité est en cours de réalisation par la division de l'Education pour la santé et le bureau de l'IEC de la Direction de la planification familiale et le service social du Centre National de Santé Familial .
- Réalisation d'émissions radiophoniques et télévisées est en cours. Pour cela les services concernées ont identifié les publics (groupes) cibles et les principaux messages sont en cours d'élaboration.
- Un séminaire national de sensibilisation des dirigeants d'opinion regroupant soixante dix (70) participants devait se tenir en Octobre 1988 ; il a été reprogrammé pour la première semaine d'Avril 1989 pour une durée de cinq jours .
- Actuellement la Division de l'Education pour la santé en collaboration avec la D.P.F, le C.N.S.F sont entrain de préparer deux (2) pièces théâtrales en Djerma, Français et Haoussa, ils sont en contact direct avec la troupe de l'O.R.T.N. de Niamey, la pièce en Haoussa sera joué à Zinder par la troupe de Zinder.
Dans le cadre du programme d'IEC, un programme d'Education à la vie familiale est en cours de préparation avec la Fédération Internationale de planification familiale.

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ACTIVITES DE PRESTATIONS

(voir annexe I pour rapport détaillé des activités)

Communauté Urbaine de Niamey

Année 1988

C.N.S.F. Nouvelles Consultantes

1488 + 822 + 1002 = 3312 Nouvelles consultantes
C.O + C.I + DIU

P.M.I + Maternités et Dispensaires

2194 + 66 + 32 = 2292 Nouvelles consultantes
C.O + C.I+ DIU

Communauté Urbaine de Niamey

TOTAL NOUVELLES = 5604

Pour les Départements de Tillabéry, Dosso, Tahoua, Maradi, Diffa

TOTAL NOUVELLES = 1653

- Activités de Recherches

Deux études ont été Identifiées au niveau de la Recherche à savoir une étude sur l'hypofécondité dans la région de Diffa et une étude sur les raisons d'abandon de différentes méthodes de contraception modernes utilisées au Centre National de Santé Familiale.

Les protocoles de Recherche ont été élaborés voir en Annexe n° III et IV

Organismes financiers de ces deux (2) recherches.

- Banque Mondiale, F.N.U.A.P et F.H.I

- La première étude a été évaluée à cinq (5) millions financée par la Banque Mondiale, la deuxième étude est entièrement financée par F.H.I pour un montant de 55 000 dollars.

- L'Etude sur les raisons d'abandon des différentes méthodes a débuté le 15 Février 1989, elle devait démarrer en Décembre 1988.

- Accords

. Signature du document du Projet FNUAP pour une durée de cinq (5) ans (1988-1992) . Montant un (1) million de dollars (Gouvernement Nigérien + FNUAP).

.../...

HO

- . Signature du document de Projet bilatéral intitulé Projet Santé Familiale et Démographie d'un montant de onze (11) millions de dollars sur cinq ans (1988-1992).

Huit millions (8.000.000) pour la santé familiale et trois millions (3.000.000) pour le recensement 1988.

Le domaine d'intervention desdits projets :

- Formation
- I.E.C (Information, Education, Communication)
- Logistique
- Approvisionnement en contraceptifs
- Organisation des services de prestation
- Recherche Opérationnelle

- Accords signés entre FHI (Family - Health - International) et la Direction de la Planification Familiale pour l'étude sur les raisons d'abandon des moyens contraceptifs utilisés au Centre National de Santé Familiale et l'achat d'un microordinateur pour l'Etude ; ce dernier sera mis à la disposition du C.N.S.F.
- Signature d'un protocole d'accord entre l'IPPF et le MSP/AS/CF est en cours. Les domaines d'interventions ont été déjà discutés.
- Signature d'un protocole d'accord entre le Cerpod et le MSP/AS/CF en cours de discussion (les domaines d'intervention du CERPOD sont :
 - l'Assistance technique
 - La formation en informatique
 - La mise en place du système de collecte des données SMI/P.F
 - Le matériel Informatique
- Les Organismes Intervenant dans le programme de Planification Familiale.
 - FNUAP
 - U.S.A.I.D
 - Banque Mondiale
 - U.N.I.C.E.F

.../...

- Logistique

- Cinq (5) véhicules doivent être achetés par l'U.S.A.I.D, dont une 505 break pour les différentes études prévues et après les études, le véhicule sera à la disposition de la Direction de la Planification Familiale.

- Supervision

- Trois (3) activités de supervision ont eu lieu (Département de Tillabéry, Communauté Urbaine de Niamey, département de Zinder). Ceci nous a permis de recenser les besoins en formation et en matériel technique, de voir les problèmes que rencontrent les Agents sur le terrain. Une analyse de la situation a été faite. A la suite des résultats de l'analyse, une commande de matériel technique a été lancée à l'O.N.P.P.C, financée par la Banque Mondiale.

Il est prévu une supervision tous les trois (3) mois pour l'année 1989.

- Evaluation

Trois (3) activités d'évaluation ont eu lieu dans les départements de Zinder, Maradi, Tahoua.

A la suite de cette évaluation plusieurs recommandations ont été émises, notamment la révision du Curriculum de formation en P.F utilisé pour les trois (3) formations ultérieures ; cette activité a déjà commencé le 15 Février 1989. Une équipe composée de trois (3) formateurs de l'ENSP, des Agents des différentes directions concernées dont la D.P.F , la D.F.E.P.S , le C.N.S.F.

- Apports :

- U.S.A.I.D
- Banque Mondiale
- U.N.I.C.E.F
- I.P.P.F
- PCS
- F.H.I

.../...

Problèmes Rencontrés

- Organisation du service même
- Logistique
- Exonération des taxes douanières sur l'acquisition des contraceptifs
- Logistique
(manque de véhicule, manque de carburant, acheminement difficile des correspondances, manque de planton.
- Local
local très exigu pour les activités.

Conclusion et Suggestion

- Définition claire des différentes attributions D.P.F et C.N.S.F
- La Direction de la planification familiale doit être une Direction de Terrain comme la DHMM et du P.E.V .
- Chercher les moyens qui puissent alléger le système d'exonération sur les contraceptifs et le matériel technique.
- La logistique trouvera peut être une solution, il est très difficile de mener des Activités sans moyen de déplacement .

RAPPORT D'ACTIVITES EN PLANIFICATION FAMILIALE
DES DEPARTEMENTS - 1er - 2ème - 3ème Trimestre 1988

Activités		Contraception	Contraception	Pose D.I.U	Nombre de condoms	I.E.C	
Départements		Orale	injectable		et spermicides	counseling	
					servis.		
Tillabéry 2ème trimestre	- Téra	N = 134	N = 10	26 cas référés	Condoms 621 Spermicides 621	IEC : 60 séances Counseling : 262	
	- Gothèye	A = 357	A = 71				
	- Say						
	- Bankilaré						
Dosso	- PMI Dosso Commune 1er-2e-3e trimestre			10 cas référés	Condoms 8811 Spermicides 347	IEC : 85 séances Counseling : 341	
	- Loga 1er-2e-3e trimestre						
	- Kiota 1er-2ème trimestre	N = 586 A = 1223	N = 118 A = 187				
	- Doutchi 1er-2ème trimestre						
	- Dioundou 3ème trimestre						
	- Birni N'Gaouré 3ème trimestre						
	- Falmey 3è. trimestre						
	- Gaya 3e. "						
	- Tibiri 3e. "						
	Maradi	- Maternité 2e. 3e. trimestre					
- PMI place du Chef 3ème trimestre + 4e. T.		N = 1082	N = 49	N = 7			
- PMI 17 portes 3ème trimestre		A = 1960	A = 314	A = 7			
- Dispensaire Andoumé 3ème trimestre							
- CM Mayahi 4ème trimestre.							

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Activités	Contraception Orale	Contraception injectable	Pose D.I.U	Nombre de condoms et spermicides servis	I.E.C counseling
Départements					
Maradi (suite). - C.M. Dakoro 4ème trimestre - PMI Sabongari 2ème-3ème trimestre - Guidan-Roundji 3ème trimestre - C.N.S.S Maradi 3ème trimestre	Suite	Suite	Suite	Suite	Suite
- P.M.I Commune Tahoua Département 2ème - 3ème trimestre Tahoua	N = 135 A = 394	N = 1 A = 2	N = 5 A = 8	Condoms : 2175 Spermicides : 532	IEC : 37 Séances Counseling : 135
Diffa - P.M.I - 2ème et 3ème trimestre.	N = 61 A = 359	N = 1 A = 3	-	Condoms : 1500 Spermicides : 240	Counseling :
TOTAL	N = 1743 A = 3718	N = 158 A = 281	N = 12 A = 15	Condoms : 13187 Spermicides : 1836	IEC : 315 Counseling : 1202

N : Nouvelles consultantes

A : Anciennes Consultantes .

ACTIVITES	Contraception Orale	Contraception Injectable	Pose D.I.U	Nombre de condoms et spermicides	I.E.C et Counseling.
FORMATIONS SANITAIRES					
P.M.I. GAMKALLE	N = 185 A = 379	Décembre 88 N = 3 A = 1	N = 8 A = 1	Condoms 1150 Spermicides 740	66 séances d'IEC Counseling 185
P.M.I. REPUBLIQUE	N = 88 A = 164				96 séances d'IEC Counseling 88
P.M.I. GARDE REPUBLICAINE	N = 226 A = 1231		N = 1		66 séances d'IEC Counseling 226
C.N.S.S. KALLEY	N = 71 A = 343	N = 7 A = 24	48 cas référés	condoms 27 cas spermicides 48 cas	156 counselings
C.N.S.S. MAOUREY	N = 207 A = 1236	N = 2 vient de démarrer	N = 8 A = 13	condoms 2012 spermicides 2012	IEC = 72 pour ^{participants} 1582 Counselings 207
Dispensaire GOUDEL	N = 26 A = 21	N = 1	3 cas référés		Counselings 26
<u>TOTAL</u>	N = 3682 A = 17648	N = 888 A = 3590	N = 1034 A = 3694	Nbre condoms 6057 Nbre spermicides 4514	I.E.C = 909 Counseling = 5611

N : Nouvelles consultantes .

A : Anciennes consultantes.

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RAPPORT D'ACTIVITES EN PLANIFICATION FAMILIALE
DES CENTRES DE PMI , DES MATERNITES, DU
CENTRE NATIONAL DE SANTE FAMILIALE DE LA COMMUNE
DE NIAMEY. - ANNEE 1988.

ACTIVITES FORMATIONS SANITAIRES	Contraception Orale	Contraception Injectable	Pose D.I.U	Nombre de condoms et spermicides servis	I.E.C et Counseling
C.N.S.F	N = 1488 A = 9440	N = 822 A = 3459	N = 1002 A = 3668	N = 2895 A = 1762	Counseling : 3211
MATERNITE LAMORDE	N = 218 A = 1135	N = 30 A = 74	N = 5 A = 3		Counseling 200
MATERNITE CENTRALE 4ème trimestre 1988	N = 9 A = 7	N = 6 A = 5	N = 1 A = 0	N = 10 cas A = 5 cas	
P.M.I. REPUBLIQUE	N = 88 A = 164	-	-	-	I.E.C 96 séances.
P.M.I FAN	N = 212 A = 631	N = 2 A = 5	4 cas référés au 1er trimestre	32 cas	IEC 70 séances 510 counseling
P.M.I LAMORDE	N = 151 A = 565	N = 15 A = 22	N = 9 A = 9		IEC 188 séances
P.M.I YANTALLA	N = 389 A = 1311	21 cas référés au Centre Nationale de Santé Familiale.			48 séances IEC
P.M.I. ABIDJAN	N = 136 A = 337	10 cas référés au C.N.S.F	18 cas référés		IEC 48 séances
P.M.I. BOUKOKI (activités démarrées au 4ème trimestre).	N = 12 A = 27				IEC 16 séances
P.M.I. POUDRIERE	N = 176 A = 657	16 cas référés au Centre National de Santé Familiale			IEC 143 séance Counseling 802

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A N N E X V I I

RECOMMANDATIONS
PROGRAMME SEMINAIRE NATIONAL SUR LA GESTION
DES PROGRAMMES DE PLANIFICATION FAMILIALE
NIAMEY DU 7 AU 18 NOVEMBRE 1988

07

PROGRAMME SEMINAIRE NATIONAL SUR LA GESTION
DES PROGRAMMES DE PLANIFICATION FAMILIALE
NIAMEY DU 7 AU 18 NOVEMBRE 1988

R E C O M M A N D A T I O N S

- 1°) Considérant les grandes orientations politiques de notre pays en matière de Planification Familiale telles que définies dans le plan quinquénel 1987-1991,
- 2°) Considérant les objectifs du Programme National de Planification Familiale,
- 3°) Considérant l'objectif général assigné au présent séminaire à savoir Développer les connaissances des participants sur le principe de la gestion des programmes de planification familiale, en particulier dans les domaines de la logistique, de la planification et de la supervision.

Le séminaire recommande :

- 1- La tenue des séminaires régionaux sur la gestion des programmes en planification familiale
 - 2- L'Elaboration d'un plan d'action National en matière de planification familiale
 - 3- L'Elaboration des messages bien adaptés de sensibilisation au niveau des zones périphériques par les masses médias au moins une fois par semaine
 - 4- La mise en place d'un système adéquat d'approvisionnement des formations sanitaires en contraceptifs par la création des magasins régionaux
 - 5- L'Adoption d'une gamme bien précise et limitée des contraceptifs oraux utilisables sur le plan National
 - 6- Standardisation des supports de collecte de données en matière de planification familiale
 - 7- La mise en place des moyens nécessaires pour assurer un suivi correct des programmes de planification familiale
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8- L'Elaboration dans les meilleurs délais des plans d'action régionaux en matière de planification familiale

9- Développement de manière intégrale les cours de planification familiale dans le programme de formation des écoles de santé.

Fait à Niamey,
le 18 Novembre 1988

A N N E X E VIII

CURRICULUM DE FORMATION DES PRESTATAIRES
DE SERVICE EN PLANIFICATION FAMILIALE

CURRICULUM DE FORMATION DES PRESTATAIRES
DE SERVICE EN PLANIFICATION FAMILIALE

Ce Curriculum comprend :

A) - Les Principaux Thèmes Développés :

- 1) La Politique Nationale en Matière d'Espacement des Naissances
- 2) L'Anatomie des Organes de Reproduction
- 3) Le Cycle Menstruel
- 4) Les Méthodes d'Espacement des Naissances
 - (A) Les Méthodes Naturelles et Traditionnelles
 - (B) Les Méthodes Modernes :
 - la contraception hormonale (pilule, injectable)
 - le dispositif intra-utérin
 - les méthodes de barrières et chimiques
 - la contraception chirurgicale ou stérilisation volontaire masculine et féminine.
- 5) Examen physique et gynécologique - Anamnèse
- 6) Allaitement et contraception
- 7) Les Maladies Sexuellement Transmissibles (MST et SIDA)
- 8) La Stérilité
- 9) L'IEC (Information - Education - Communication)
- 10) La gestion des services de Planification Familiale
- 11) Le Stage Pratique et ses Objectifs

B) - Les Recommandations d'Utilisation (y compris les modalités d'évaluation)

C - Un Calendrier de Formation

D - Un Pré Post-test.

A N N E X I X

Acknowledgements

Annex IX

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Mr. John Eaton, Director
Mr. Cary Coulter, Deputy Director
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Dr. Jim Aldriss, Medical Director, Galmi Hospital
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Dr. Agnes, CM/Myrria (EEC Advisor)
Dr. Korna, CM/Tessaoua
Dr. Yahaya Amadou, DDS/Tillaberi
Dr. Issoufou Ide, DDS/Tahoua
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M. Issa Barre Ibrahim, SMI/PF Coordinator, Zinder
M. Issoufou Balarabe, SMI/PF Coordinator, Dosso
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