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NIGER FAMILY HEALTH PROJECTS

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**OPERATIONS RESEARCH PROGRAM, CENTER FOR POPULATION AND FAMILY HEALTH
SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY, USA**

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NIGER FAMILY HEALTH SERVICES PROJECT

PHASE I: EVALUATION OF FAMILY HEALTH MOTIVATION AND REFERRAL

PHASE II: SUPERVISION STRATEGIES FOR FAMILY PLANNING SERVICES

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NIGER FAMILY HEALTH SERVICES PROJECT: PHASE I
EVALUATION OF FAMILY HEALTH MOTIVATION AND REFERRAL

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SUMMARY

Use of modern contraceptives in the African Sahel remains low. However, in a community-based knowledge, attitudes and practices (KAP) survey conducted in Niamey, Niger, two years after the initiation of the first public sector family planning program, contraceptive prevalence was found to be higher than expected. Prevalence of modern methods use was 8.5 percent among women aged 15 to 49, and 9.7 in the subgroup currently in union, possibly representing the highest level in the Sahel at the time. Over 75 percent of adult females knew of at least one modern method. Among males, 58.9 percent knew of the pill and reported use of a modern method by the respondent or female partner was 11.6 percent. Radio and television had reached a larger proportion of the population than had the more traditional method of communication, the community meeting. Focus group data reinforced impressions that the concept of child spacing and contraceptive use are accepted.

INTRODUCTION

The francophone Sahelian countries of Africa¹ have very low rates of modern contraceptive use.² This has been attributed to many factors, including the economic value of children; the desire for multiple offspring because of relatively high infant and childhood mortality; government policies inimical to contraceptive distribution (the French law of 1920, prohibiting contraceptive promotion and distribution, remained in force into the 1980s in all but one of the Sahelian countries); conservative attitudes towards the role of women; and the lack of family planning information and services. This report, which summarizes selected findings of an operations research project conducted in Niamey, Niger, suggests that as changes occur in the factors above, including family planning promotion and availability, increases in prevalence rates may be expected in the Sahelian region.

BACKGROUND

Niger, a landlocked country with a total estimated population of 7,200,000, is experiencing a rapid rate of natural population increase. Based on preliminary data from the 1987 national census, the annual rate of natural population growth is approximately 3.1 percent. Niger is one of the poorest countries in the world: the World Bank estimated that the annual per capita GNP in 1986 was \$260 US. Economic problems in the 1970s and 1980s, engendered by the oil crisis and severe drought, have led to the recognition by Nigerien policy makers that already inadequate social services cannot keep pace with the growing population. This realization, and a growing appreciation of the health benefits of adequate childspacing, are resulting in increased family planning services within the public sector. The Law of 1920 prohibiting contraception has been abrogated and Niger is developing a population policy. In November 1984, the Ministry of Public Health and Social Affairs (MOPHSA) instituted Niger's first official family planning program.

Program initiation was vigorously encouraged at the highest level of government, including the Presidency. The program was initially conducted solely in the capital city of Niamey. At that time, the program's focus was the Centre National de Sante Familiale (CNSF), the National Family Health Center. Located in a residential neighborhood, the CNSF serves as a family planning clinic and is the primary family health training and research center for the country.

Prior to the inauguration of the CNSF, a small number of private and public sector physicians and midwives in Niamey had offered limited family planning services, consisting primarily of oral contraceptives. At the time the CNSF opened its doors, the ministry requested that all other public sector family planning services be temporarily

¹Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal

²Modern methods as defined here include oral contraceptives, the IUD, injectables, female barrier methods, condoms, voluntary sterilization and modern natural family planning.

stopped, in order to permit the Center to consolidate program planning, service delivery, and training for family planning providers. Consequently, the CNSF became virtually the sole source of public sector contraceptive supplies in the capital city until 1987, at which time limited services were decentralized to maternal and child health clinics. (In the interim, an unknown but small number of private practitioners continued to provide contraceptive services in an unofficial capacity.)

During its first two and a half years of operation, the CNSF's staff of trained midwives, backstopped by physicians, offered oral contraceptives, injectables, IUD insertion, male and female barrier methods, and referral for tubal ligation. The latter was available for medical reasons through physicians working in private and public sector clinics. CNSF medical and social service staff also provided gynecological and limited pediatric services; conducted contraceptive service delivery research; and participated in family health information, education and communication (IE&C) activities. The IE&C consisted of two major approaches, a mass media component and community meetings.

In the mass media approach, CNSF personnel gave numerous radio, television and newspaper interviews regarding the benefits of child spacing and obtained coverage of all conferences held at the Center. The presence of national religious and political leaders at the conferences was highlighted. For example, three months after the inauguration of the CNSF, the MOPHSA co-sponsored a national conference on family health. The conference brought together representatives from relevant ministries, influential religious and secular leaders, and the press. Discussions were publicized widely via the media, as were the statements supportive of child spacing made by religious and political leaders. Other news stories regarding the CNSF and its services appeared monthly in the media.

In early 1986, as part of the community outreach component, a team of CNSF and MOPHSA staff conducted a series of family planning IE&C meetings in the 50 Niamey neighborhoods. Such talks, conducted outdoors, are a traditional means of providing information to the community in Niger. The number of new and return visits to the CNSF increased by 25 percent in the two months immediately following the activity. Within three months, however, the numbers had decreased approximately to their previous level.

In 1987, the CNSF conducted repeat meetings in half the neighborhoods, with a strengthened family planning message. The 25 community meetings were held in the evenings and lasted approximately two hours. Each meeting was conducted by trained CNSF staff in a central place in the neighborhood. Residents in the neighborhoods were notified of the sessions in advance and invited to attend. During the meetings, the advantages of family planning were discussed and methods were described. Female participants were invited to come to the CNSF for family planning advice and contraceptive services; males were urged to encourage their spouses to attend family planning sessions at the Center or to come themselves to receive condoms. Between 200 and 350 adults attended each meeting, for a total of 7,000 participants out of an estimated adult population of 100,000 in the intervention neighborhoods. Approximately twice as many women as men attended.

Before proceeding with additional activities, including decentralization of services, the MOPHSA wished to answer a number of questions: Are community meetings an effective way of reaching the population with family planning messages? What is the family planning coverage provided by the CNSF? What population characteristics are associated with attendance at the CNSF and family planning acceptance in the population of Niamey?

The operations research project was developed to explore these questions. Focus groups and two community-based knowledge, attitude and practice (KAP) surveys were conducted, one with adult men and one with women, as a means of assessing the effects of the CNSF service delivery and IEC program.

DATA COLLECTION

KAP surveys

The female KAP survey was conducted during a six-week period in April and May 1987, following the second round of neighborhood family health information sessions. The 50 neighborhoods of Niamey were stratified into three socioeconomic levels on the basis of housing stocks and population density. Twelve neighborhoods were randomly selected according to their socioeconomic stratum, to yield two high, six middle and four low-level neighborhoods to be included in the survey.

Subsequently, in each of the 12 neighborhoods, five clusters of 20 households were randomly chosen. Each cluster was visited prior to the survey for the purposes of conducting a census of eligible women in each household, and randomly identifying one eligible respondent to be interviewed per household. Eligibility criteria for respondents were age (15 to 49 years) and residence in Niamey for at least six months of the previous year. In total, 100 women were selected per neighborhood (20 women in each of the five clusters in each neighborhood) for a projected sample of 1,200 respondents.

A total of 1,149 interviews were successfully completed. Only seven subjects refused to be interviewed. Another 44 could not be reached despite three return visits to the household.

The KAP data were weighted to adjust for neighborhood size in relation to the overall population of the city. Weighting also adjusted for the number of eligible women present in each sample household, since the sampling scheme underrepresented women residing in multiple female households (including women in polygamous households). Overall KAP results are reported for the weighted sample. In reporting contraceptive prevalence, selected unweighted data are also presented. Each use of unweighted data is noted in the text.

A sample of 509 men, aged 18 to 59, was obtained through a quota sampling method, with quotas determined according to the 1977 Department of Niamey General Population Census. The respondents were interviewed at their place of work or in meeting areas such as the markets and outside offices or mosques. Aside from the questions regarding obstetrical history and breastfeeding, the male questionnaire was

essentially the same as that used for the female survey.

Focus groups

A total of 6 focus groups on family planning issues were conducted with women. Two of the groups were composed of young unmarried women, two with young mothers (aged 19-24) and two with older mothers (age 25 and over). Group facilitators were trained social workers from the CNSF and the development division of the City of Niamey. The group sessions, each lasting approximately 1.5 hours, were tape recorded: a trained observer was also present to record interactions and take notes.

FEMALE KAP SURVEY FINDINGS

Characteristics of the KAP Survey Respondents

Major sociodemographic characteristics of the respondents are shown in Table 1. The average age of the respondents was 27.3 years and the great majority, 97.6 percent, were Muslim (not shown). Over two thirds of the sample had migrated to Niamey after age twelve, and most of the migrants came from rural zones or smaller Nigerien cities. The migration data are compatible with the rapid growth of Niamey: in 1977, its population was approximately 240,000; by 1987, estimates placed the population at 400,000.

Fifty-three percent of the sample had received no formal education and another 10 percent had attended Coranic school, which is primarily religious in nature. Just over 60 percent of the entire sample said they were unable to read a letter or a newspaper. Thirty-nine percent of the respondents reported being involved in income generating activities. As one indication of socioeconomic level, respondents were questioned regarding possessions in the home, specifically radios, televisions, motorcycles or motor scooters, and cars. Twenty-nine percent reported having no such equipment in the home. Thirty-four percent had no radio or television. The distribution of radio and television - important for mass communication campaigns - is reported in Table 1.

Forty-six percent of the respondents were currently in a monogamous marriage. Twenty-eight percent were married to men having two or more wives (polygamous marriage). Eight percent were in consensual union, defined as partners residing together continuously or for portions of the year without formal marriage. Just over 10 percent of women below age 25 were in polygamous union, a proportion which increased to almost half for women above age 35. The data may indicate a trend towards fewer polygamous marriages in the population over time: however, this is inconclusive since the husbands of younger women are on average themselves younger and may enter into additional marriages in future years.

Average age at first marriage for the 918 ever married women in the sample was 15.6 years, and fifteen percent had married under age 13. Age at first marriage did not vary significantly by ethnic group, but marked differentials were noted by age group, level of education, and by whether the respondent was in a monogamous or polygamous marriage (Table 2). Given that just over half of the women below age 20 had not yet

entered into a formal marriage or consensual union, the average age at first marriage for this cohort will increase over time as more of these young women enter into union in future years.

Fertility

Fifteen percent of the currently married women in the sample were currently pregnant. (Seven percent of the 89 women who were in consensual union - not formally married - were also pregnant.) The average number of children born live to the 918 ever-married women in the sample was 4.2. Table 3 shows parity for ever married women by selected sociodemographic characteristics. Parity was lower among women with higher educational levels and for those in monogamous marriage, compared with those in polygamous union. Standardization by age reduced but did not eliminate the parity differentials associated with education and type of marriage: data on duration of marriage by type of union were not collected to permit standardization of parity by this variable.

Half of the ever-married respondents who had experienced a live birth had done so before age 18. Average age at first live birth increased from 17.6 for women with no or only Coranic education, to 18.4 years for women who attended primary school, to 20.3 years for respondents who had received secondary or post secondary education. Similarly, women in the lowest socioeconomic group (as measured by a lack of all the household possessions listed previously) experienced their first live birth at 17.7 years on average, compared to 19.3 years for women in the highest bracket (as measured by the presence in the household of a car and at least one other possession such as a radio, television, bicycle or motorcycle.)

On average, respondents who had already experienced a live birth had lost 0.8 children through death. The average number of deceased children increased from 0.2 for women with some secondary education or higher (a ratio of 1 death to 14 children born alive to this group of women), to 1.0 for women with no schooling (a ratio of 1 death per 3.9 children ever born live).

In the sample, 728 women had at least two children. The average interval between the last two births was 34.7 months, which closely approximates the three-year duration of spacing indicated as being ideal by the majority of respondents. However, 29.8 percent of women with two or more children reported 24 months or less between their last two births. (Wherever possible, interviewers verified childrens' birthdates by examining civil registration cards.)

Traditional postpartum abstinence in Niamey tends to be relatively short, in keeping with the Islamic practice of 40 days. A quarter of respondents had abstained for only one month, and another quarter for two months. Fewer than 10 percent of respondents reported abstaining for over six months. The average duration of breastfeeding was 19.8 months. Shorter breastfeeding durations were associated with higher socioeconomic status and increased educational level.

For the sample as a whole, the average desired number of children was 5.4.

Women who did not yet have children indicated on average that they desired 4.4 children (a mode of 3 children), whereas those already having children indicated on average that 5.8 children (a mode of 5) were desired. When women with living children were asked how many additional children they wanted, the total desired family size which resulted from adding current plus desired children was 5.9, close to the overall number of 5.8 children this subgroup stated they wished to have. Fewer than 15 percent of respondents stated they did not know how many children they desired or gave nonnumeric answers such as "It's God's decision." Eighteen percent of all respondents said they did not want to have any additional children, a percentage that increased to 25.1 for women aged 30 to 34, and 55.8 percent for women aged 35-49. Twenty-one percent of women with 3 to 5 children desired no more, as did almost 60 percent of women with 6 or more children.

Family Planning Knowledge

Knowledge of modern family planning methods in this population was high (Table 4). Seventy-six percent of all female respondents could name at least one modern contraceptive method without prompting (not shown); and 92.7 percent recognized at least one method with prompting. Knowledge of all methods was highest in the 30 to 34 year age group, and lowest among women under 20. However, even in the latter group, upon prompting, 79.4 percent recognized at least one modern method.

Knowledge of more traditional methods of family planning (withdrawal, abstinence, rhythm based on traditional systems, charms and herbs) was lower than that of oral contraceptives among the female respondents (Table 4). The highest levels of knowledge of rhythm and abstinence were found in respondents over 40 years of age. Interviewers were trained to probe knowledge of "calendar" and "rhythm" methods in order to distinguish between traditional rhythm methods and modern natural family planning (NFP). No evidence was found of usage of modern calendar methods, basal body temperature, or cervical mucus monitoring – findings that are compatible with the absence of an NFP program in the city.

Family Planning Use

The current prevalence rate of modern method use, weighted for neighborhood size and the number of eligible women per household, was 8.5 percent, a high level for a Sahelian city. Another 16.9 percent of the sample reported current use of other methods (withdrawal, rhythm, abstinence, and traditional charms and herbs). In the original unweighted data, use of modern methods was reported by 10.6 percent of respondents, and use of traditional methods by 18.3 percent. Over a quarter of all respondents thus report current attempts to control their fertility.

When use of modern methods was examined by subgroups, weighted prevalence was 9.7 percent for women currently in union, and 15.2 percent for the group of respondents who were currently married, not pregnant, and not in the period of postpartum abstinence.

Oral contraceptives represented the modern method used most frequently in this population, followed by the IUD. Just under one percent of the sample reported use of tubal ligation. The latter questionnaires were rechecked and the responses were found to be plausible with respect to age and parity. It is known that tubal ligation is performed in Niamey for health reasons. It is of course possible that some women had confused other gynecological procedures for tubal ligation.

No respondent under age 20 reported current use of a modern method; 6.9 percent of women in this age group reported use of traditional methods including withdrawal and rhythm. Current use of modern methods was highest in the 30 to 34 age group, with 15.8 percent of respondents reporting use. The relationship between age and use of modern methods was highly significant ($p < .001$, by Chi square).

Current use of modern methods also varied significantly with parity, number of living children, education, marital status, place of residence until age 12, and household and neighborhood socioeconomic level (Table 5). The proportions currently using a modern method increased with number of living children (from 1.3 percent for women with no children to 14.9 percent for those having 6 or more), and with educational level (from 5.3 percent for women with no formal education to 12.2 percent for women with secondary/post secondary schooling). Women in monogamous marriages had a prevalence rate of 11.4 percent, as did women who had resided in Niamey since childhood (before 12 years of age). Differences among ethnic groups were not large but were statistically significant at the .05 level.

By neighborhood socioeconomic level, the prevalence rate - unweighted for neighborhood population size - for the combined population in the four lowest-level neighborhoods was 2.9 percent (range from 0 to 5.2 percent by neighborhood); in the six intermediate neighborhoods, 9.1 percent (range from 6.5 to 12.2 percent) and in the two highest neighborhoods, 27.2 percent (prevalence rates by neighborhood of 22.5 and 31.0 percent) (Table 5). Prevalence rose from 4.5 percent among the 338 women with no household possessions (no radio, television, motorcycle, or car) to 23.1 percent for the 229 women having a car and at least one of the other possessions (not shown).

Just over fifteen percent of all respondents reported ever use of modern methods. Of the 79 women (6.9 percent of all respondents) who had previously used a modern method but were not currently doing so, approximately half were not using any family planning and half stated they had switched to a traditional method. Modern methods were not readily available prior to the inauguration of the CNSF in late 1984, which suggests that many of the cases of discontinuation had occurred among women who initiated use within the two and a half years of the current program. Two-thirds of previous pill users had discontinued use or switched method, as had half of IUD and injectable users, and three-quarters of previous users of barrier methods. Forty percent of the previous users indicated they were currently pregnant, had been so recently, or desired a child. A quarter reported health concerns, cost and distance to service sites as reasons for discontinuation.

The CNSF represented the single most important source of contraceptives in Niamey, cited by over half of current users. MCH clinics and maternities were cited by over a third of current users, a finding that is compatible with the 1987 decentralization of

family planning services to selected sites. Ten percent of respondents named other sources, such as clinics in the private sector. (A proportion of respondents naming maternities may also have received methods from private maternity centers: The questionnaire did not specifically differentiate private from public sector sites.) In addition, two-thirds of all respondents had gone to an MCH center for maternal or child health care at least once during the two years prior to the survey, which suggests that these sites afford an important opportunity to reach target women with family planning information and services.

An association was noted between distance to the CNSF (the major source of contraceptives) and neighborhood prevalence level, although the distance from the CNSF to the most outlying survey point was relatively short. The prevalence rate (unweighted for neighborhood size) among respondents in the seven neighborhoods within two kilometers from the CNSF was 12.1 percent, whereas 7.0 percent of the respondents residing in the five neighborhoods two to five kilometers from the center were current users. However, neighborhoods with higher educational and socioeconomic status tended to be closer to the CNSF. Multiple regression analysis indicated that the effect of distance on prevalence rates was not statistically significant, once one controlled for the educational and the socioeconomic levels of respondents.

The most common reasons given for not using family planning were recent, current or desired pregnancy (33.4 percent of nonusers) and lack of information, particularly of personalized communication, reported by 25.1% of nonusers. The latter group of respondents made statements such as: "No one talked to me about family planning," "I've never thought of it," or "I need more information." Husband's disapproval, religious constraints, fear of health effects, and difficulty in acquiring methods were each cited by fewer than 5 percent of respondents.

Only a third of respondents stated that they had ever discussed family planning issues with their spouses. Just two percent indicated that their spouse was an important source of information on the subject.

Eighty-seven percent of respondents indicated an interest in using family planning in the future. The proportion stating such an interest was highest among women aged 15 to 24 (95 percent) and lowest in the 40 to 49 age group (44 percent).

Family Planning IEC

As stated, one goal of the project was to assess the effects of family planning IEC, including the neighborhood meetings. A total of 132 respondents (11.5 percent) indicated they had themselves attended a family planning meeting. Within this group, 82 indicated they had been present at the most recent series of meetings in the 25 neighborhoods, conducted in 1987. Attendees demonstrated greater knowledge of family planning methods: 90.2 percent spontaneously cited at least one modern method, compared to 74.1 percent for the remaining respondents. However, no statistically significant differences in contraceptive prevalence rates were discerned between those saying they had attended a CNSF session (earlier or most recent meetings) and those who had not.

Almost twelve percent of all respondents said they knew someone who had attended a meeting. Fifteen percent stated they had received family planning information as a result of the meetings, either directly or from another person who attended. The importance of these meetings as sources of information for the population as a whole appears relatively limited compared to that of the mass media. When respondents were asked to name sources of family planning information, 63 percent stated they had received information directly from the media, particularly radio and television. (As noted earlier two-thirds of respondents had a radio, television, or both in the home, and almost 40 percent were literate.) Next in importance as sources of information were MCH clinics (29.9 percent) and friends (29.0 percent).

MALE KAP SURVEY FINDINGS

Among the 509 males surveyed, 29.7 percent were under age 25 and 8.6 percent age 40 or older. The majority (60 percent) belonged to the Djerma ethnic group, followed by the Haoussa group at 21.4 percent. Fifty-eight percent had never attended school and close to 40 percent were in the lowest socioeconomic stratum, as measured by possession of household items. More than half (59.1 percent) were married and 50.1 percent were in a monogamous union.

More than one-third of the male respondents (37.8 percent) said they wanted six or more children; 42.2 percent wanted three to five children. Less than ten percent said that it is God who decides. Among those with children, one quarter had more than four living and 22 percent had at least one deceased child.

The proportion of males with knowledge of modern methods of contraception was smaller than that of females, although 58.9 percent named the pill without prompting. Use of a modern method by self or partner was reported by 11.6 percent (condom, 7.1 percent; pill, 3.7 percent; injectable, spermicide or IUD; 0.8 percent).

The majority of the sample expressed favorable attitudes toward family planning, even among those aged 30 and older. Sixty percent of that group favored family planning.

Radio, television and the press were the major sources of information on family planning. One respondent in five had personally attended a community meeting. The source of information, however, does not appear to be associated with use.

FOCUS GROUP FINDINGS

Focus group participants generally expressed positive attitudes regarding family planning and the use of contraceptive methods. Reasons frequently cited for the positive orientation were the need for women to rest between pregnancies, the desire for healthy infants and, to a lesser degree, financial considerations. Participants indicated that child spacing had traditionally been practiced in Niger and they were aware of changing social norms which reduce the use of traditional modes of spacing births. Although a few women indicated the belief that frequent births were hereditary and thus could not be

avoided, or that only God can select the timing and number of children a couple has, more common comments included:

"A long space between children is good, since everyone wants strong children."

"I know how bad having many babies close together can be for one's health, because I saw my sister suffer in this way.~

"I don't want to have too many children, because life these days is very expensive."

"Before, there weren't many babies born close together because women didn't get their periods after the last birth for a year or more. Now, women see their periods very soon and get pregnant quickly."

Family size aspirations reported by respondents tended towards a reduced number of children compared to traditional norms. Typical comments included:

"I want only three children because life these days is so expensive."

"I don't want to have more children than I could care for myself, if necessary."

"Having more than five children these days is very hard. I wouldn't want to do it."

Although much of the discussion centered on the desired number of children, participants generally expressed more comfort with the idea of child spacing than with the concept of consciously using contraception for limitation of family size. Concern was voiced that the Islamic religion sanctioned the former but not the latter, except in cases of severe health risk.

"A long space between births is fine, but you shouldn't decide on the number of kids you have."

"The Koran accepts child spacing... and even limiting the number of babies a women has, but only if her life is in danger."

"If you only have a few children, what will happen if some die?"

Few concerns arose regarding health risks associated with the use of contraception. The perception that men may be less favorably disposed to family planning was raised and participants tended to agree that women did not discuss the issue with men very openly.

"Our (male) friends and spouses won't want us to use modern methods, because they think we'll be unfaithful to them."

"Men want lots of kids - it makes them feel strong."

However, responsibility for avoiding unwanted pregnancies was generally - but not exclusively - acknowledged to be the woman's.

"It's a girl's responsibility (to take precautions), because once you're with (your boyfriend/partner), you can't refuse."

"There are a few young men who buy ... methods ... to avoid having children."

DISCUSSION AND CONCLUSIONS

Survey data indicate that the female population of Niamey has many characteristics common to African societies: early age at first marriage and childbirth, high parity, and a relatively long breastfeeding period. In addition, the proportions of respondents aged 25 to 39, of those having received any formal education, of those in polygamous union, and of those reporting the presence of a radio or television in the household, were similar to the proportions determined in separate community surveys conducted in Niamey and other capital cities of the Sahel. Socioeconomic status, as measured by educational levels and household possessions, was low for the majority of respondents.

Nonetheless, the prevalence rate of use of modern contraceptives methods, 8.5 percent for respondents aged 15 to 49, and 9.7 percent for those currently in union, was higher than expected, particularly since the official government family planning program (the predominant source of contraceptives reported by respondents) was initiated only two and a half years prior to the survey. Dakar is the only other Sahelian city with a documented contraceptive prevalence rate in a similar range (7.5 percent for women in union) and the family health program in Senegal officially started almost a decade earlier.

Sociodemographic variables associated with greater use were similar to those found in other African surveys: higher educational and socioeconomic levels, higher parity, and age between 30 and 35 years. Urbanization, as measured by residence in Niamey before age 12, was also associated with greater use. Even among women with no education, however, over 70 percent could spontaneously name at least one modern method and over 50 percent indicated an interest in using contraceptives in the future. Average desired family size for women who do not yet have children is just over 4, a substantial decline from African levels in the past.

Results from this cross sectional survey cannot be used to determine the rapidity of family planning acceptance in Niamey. However, the limited data available suggest a trend in rising contraceptive use and that the new government family planning program is contributing to this trend. A 1985 Vanguard study interviewed 166 randomly selected first time clients to the CNSF a few months after the center opened: only 6.6% were already using a modern method. Given that women who attend clinics are frequently among the more motivated and are otherwise not completely representative of the general population - 80 percent of the Vanguard sample came seeking family planning services - their prevalence rate at entry probably represents an overestimate of general community prevalence in 1985. Two community based IEC surveys were conducted in Niamey in 1988 and 1989 by Population Communication Services (PCS). Women in both surveys

were selected through random household cluster sampling similar to - but independent of - the study reported in this paper. In the 1988 survey, 13 percent of the respondents of reproductive age reported current use of modern methods, as did 22 percent of those in the 1989 survey. Respondents in the 1988 PCS survey were questioned regarding their source of contraception: over 90 percent reported receiving their service from the public sector, as did over 80 percent of current users in our survey.

Since the samples were not all drawn in the same manner and the respondents may not be directly comparable, the data cannot be interpreted as definitive proof of an increase in prevalence between 1985 and 1989. However, the results suggest a trend and may indicate that, where service delivery exists and is well publicized, an increase in prevalence levels can occur fairly rapidly even in a conservative African Moslem city such as Niamey. Careful monitoring of public sector family planning program statistics supplemented by additional community surveys can be used to determine the extent and magnitude of any trend.

In this milieu, with high baseline levels of family planning knowledge, project results suggested that community meetings - a time honored Nigerien method of providing information to the general public - do not serve a particularly efficient role in promoting family planning. The proportion of persons reached directly by the meetings is low compared to those who receive their information from the mass media. Over 60 percent of respondents possess a functioning radio, television or both in the home and two-thirds of respondents reported that such media represent for them an important service of information. Survey data show that the level of spontaneous knowledge of at least one modern method was over 70 percent in the overall sample; over 90 percent of respondents knew of at least one method with prompting. In such a setting, additional gains in knowledge can be marginal at best. Contraceptive prevalence levels among community meeting attendees (the group most directly touched by the program) were not statistically different from the overall survey population.

The KAP survey and focus group data indicated potential directions for program improvement. A response which merits testing are interventions directed at decreasing contraceptive dropout rates. Although it is recognized that 40 percent or more of dropouts may have done so because they had been using a method for spacing and stopped to have another child (a percentage similar to that found in the 1988 IEC survey), another quarter appear to have discontinued because of health concerns, cost, or other reasons amenable to program improvement. Such improvements could include increased emphasis on selecting the most appropriate method for each client, improved client counseling, follow-up of discontinuers, and greater dissemination of the information that methods in the Niger program are provided free of charge to women with financial need.

Outreach and education directed at underserved groups, including residents in lower socioeconomic neighborhoods represents another potential opportunity to increase usage. Outreach directed at young women is particularly important given the low age at first marriage and first birth in this population: although no respondents under 20 admitted to use of modern family planning methods, five percent in this age group used withdrawal or rhythm and ninety percent stated they were interested in family planning.

A cohesive IEC program appears desirable to address the problem of high level of knowledge and stated interest in using family planning, with substantially lower rates of use. The KAP finding that non-users indicated they "had never thought of family planning" suggests that more personalized messages which will stress the relevance of family planning to individuals with different life situations and needs may be effective in settings such as Niamey.

Focus group data reinforce the impression that the concept of child spacing and contraceptive use are well accepted and that family size norms are declining. Clarification of Islam's position on planning the number of one's children (which includes the concept that each family should not have more children than it can care for) may require further emphasis through the mass media and other avenues of communication, such as religious gatherings. In the male KAP survey conducted in Niamey in the same time period as the women's study reported here, the majority of the men interviewed expressed positive attitudes towards family planning. Such data need to be publicized to potentially encourage more discussion of family planning issues by partners.

As a result of survey findings, particularly the overall acceptance of the concept of family planning, the recently created Direction de la Planification Familiale in the Minist}re des Affaires Sociales et de la Promotion de la Femme, the CNSF, and the MOPHSA are implementing greater decentralization of service delivery points, are exploring the possibility of training paramedical staff in family planning, and, with donor support, are developing IEC strategies which concentrate on the mass media approach and which include non-didactic forms of delivering messages, such as dramas.

The Nigerien family planning program appears to be addressing important needs in Niamey. Current use of modern contraceptives may be higher than in any other Sahelian capital city. Studies such as the one described have provided data which can be used as a basis to develop additional strategies and which indicate areas requiring further evaluation. The experience acquired to date will serve to guide national family planning program expansion.

TABLES

TABLE 1

Distribution in percent of respondents,
by selected sociodemographic variables (N=1149)

<u>Age</u>	<u>%</u>	<u>Ethnic Group</u>	<u>%</u>
15-19	18.7	Djerma	46.0
20-24	22.5	Haoussa/Peuhl	27.3
25-29	21.0	Other Niger	16.1
30-34	16.9	Other Country	10.6
35-39	11.5	Unknown/NR	0.0
40-44	7.1		
45-49	2.0	Total	100.0
Unknown/ NR	0.3 ----		
Total	100.0		

<u>Place of Residence up to Age 12</u>	<u>%</u>	<u>Educational Level</u>	<u>%</u>
Niamey	32.1	None	53.4
Other City		Coranic	7.6
Niger	10.9	Primary	17.3
Rural	45.2	Secondary/	
Other Country	11.7	Post secondary	21.3
Unknown/NR	0.1	Unknown/NR	0.4
Total	100.0	Total	100.0

<u>Profession</u>	<u>%</u>	<u>Marital Status</u>	<u>%</u>
Housewife	52.7	Monogamous	45.8
Small commerce/ agriculture	32.3	Polygamous	28.1
Skilled worker	6.7	Consensual union	7.8
Student	8.2	Single/Widowed, Divorced/Separated	18.3
Unknown/NR	0.1	Unknown/NR	0.0
Total	100.0	Total	100.0

<u>Radio and Television</u>	<u>%</u>
Television and radio	31.4
Television only	2.5
Radio only	31.6
No Television or radio	34.1
Unknown/NR	0.4
Total	100.0

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TABLE 2

Average age at first marriage* for ever married respondents**,
by selected sociodemographic variables (N=918)

	Average Age at First Marriage
<u>Total</u>	15.6
<u>Educational Level</u>	
No formal education	14.5
Coranic	15.1
Primary	16.7
Secondary/Post Secondary	19.4
<u>Marital Status</u>	
Polygamous	14.8
Monogamous	16.1
<u>Age</u>	
Under 20	14.7
20 - 24	15.5
25 - 29	16.5
30 - 34	15.9
35 - 39	15.1
40 - 49	14.6

* refers to formal marriage

** includes 69 women who are currently widowed, divorced or separated.

TABLE 3

Mean parity for ever married respondents* with at least one live birth, by selected sociodemographic variables (N=918)

	Mean Parity
<u>Total</u>	4.2
<u>Age</u>	
< 20	1.4
20 - 24	2.2
25 - 29	3.6
30 - 34	5.1
35 - 39	6.2
40 - 49	7.7
<u>Educational level</u>	
No Education	4.7
Some Coranic	4.0
Some Primary	3.8
Secondary/Post Secondary	2.8
<u>Marital Status</u>	
Monogamous	3.9
Polygamous	5.1

* Includes 69 women who are currently widowed, divorced or separated.

TABLE 4

Knowledge, ever use and current use of modern contraceptive methods,
in percent (N=1149)

	% Knowing Method (prompted)	% Ever Use	% Current Use
<u>Modern</u>			
Oral contraceptive	85.5	10.7	3.9
IUD	78.5	3.9	2.2
Tubal Ligation	80.5	0.9	0.9
Injectable	70.3	1.7	0.7
Condom	47.3	2.3	0.6
<u>Spermicides</u>	<u>28.3</u>	<u>1.5</u>	<u>0.1</u>
Total Modern	92.7	15.4	8.5
<u>Other</u>			
Abstinence*	57.5	17.0	4.4
Rhythm method	57.1	20.3	7.6
Withdrawal	31.9	8.8	2.9
Traditional	<u>66.4</u>	<u>9.4</u>	<u>2.0</u>
Total Other	78.1	30.5	16.9

*Most cases refer to post-partum abstinence.

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TABLE 5

Prevalence of current use of modern methods, by selected sociodemographic characteristics.

Current Use %

<u>Age**</u>		<u>N=1145</u>
15-19	0.0	215
20-24	6.9	258
25-29	10.1	241
30-34	15.8	194
35-39	10.9	132
40-44	9.8	105
<u>Living children **</u>		<u>N=1147</u>
None	1.3	295
1-2	8.7	321
3-5	10.5	345
6+	14.9	186
<u>Educational level**</u>		<u>N=1145</u>
No Formal Education	5.3	614
Coranic	7.9	87
Primary	13.6	199
Second/Post Second	12.2	245
<u>Marital status **</u>		<u>N=1149</u>
Monogamous	11.4	526
Polygamous	7.3	323
Consensual Union	9.6	90
Single/Divorced/Widowed	2.8	210
<u>Ethnic Group *</u>		<u>N=1149</u>
Djerma	8.8	532
Haoussa	8.7	314
Other Nigerien	6.5	181
Non Nigerien	9.7	122
<u>Place of residence until age 12 *</u>		<u>N=888</u>
Niamey	11.4	369
Other city, Niger	8.4	125
Rural Niger	6.3	519

TABLE 5 (con't)

<u>Neighborhood socio-economic level</u>		<u>N=1149</u>
(Unweighted for neighborhood population size)		
High	27.2	180
Medium	9.1	578
Low	2.9	391

** Statistically significant at $p < .001$, Chi square test.

* Statistically significant at $p < .05$, Chi square test.

NIGER FAMILY HEALTH SERVICES PROJECT: PHASE II

SUPERVISION STRATEGIES FOR FAMILY PLANNING SERVICES

The Ministry of Health and Social Affairs of Niger (Ministere de la Santé Publique et des Affaires Sociales) undertook operations research on strategies for supervision in the national family planning program. Guidelines for supervision were drafted, tested, revised and retested. The following is a report of the seminar held in December 1989 to evaluate the guidelines and forms, and to make final recommendations for their adoption.

**REPORT OF THE EVALUATION SEMINAR
ON THE OPERATIONS RESEARCH PROJECT
TO DETERMINE SUPERVISION STRATEGIES IN NIGER**

An evaluation seminar on supervision strategies was held in the National Center for Family Health (Centre National de Santé Familiale) from December 19 to 21, 1989. Participating at the seminar were the coordinators of Maternal and Child Health/Family Planning and Social Action from the Ministry of Social Action and Women's Development (MSA/WD) as well as coordinators from the regional health education posts of Tahoua, Maradi, Dosso, Zinder, Tillabery and the Urban Community of Niamey (see list, Appendix 1).

The objective of this meeting was to finalize guidelines for the supervision of family planning services. The original and revised drafts (Appendix 2) and the results of their field trials were the subjects of this seminar. The purpose of the guidelines was to enable users to evaluate family planning activities in the health centers and detect any shortcomings and to assess the needs in equipment, contraceptive supplies and family planning training.

Overall, it was unanimously recognized that the revised guidelines were too long; one full working day was required to thoroughly and accurately follow them. Moreover, they did not include the results from previous supervision visits, a feature in the first draft of the guidelines which the supervisors found very useful.

Despite these shortcomings, the guidelines did assist the supervisors in identifying problems within the Ministry system which impeded the flow of family planning services. These included:

- deficiencies in contraceptives supply, materials and trained personnel
- lack of region-specific action programs
- the absence of numerical objectives for family planning at the national and regional levels
- poor quality of care
- insufficient education of the population, explaining the poor utilization of health centers and the refusal to use certain contraceptive methods
- inadequate technical and audio-visual materials and skills.

During discussions on the revised supervision instrument, observations made by the staff of the National Family Health Center and the Direction of Family Planning of the MSA/WD on the original version were communicated to the seminar participants. These observations contained recommendations regarding the supervisory tasks and sub-tasks. With these changes, certain observers preferred the first draft to the revised

version, which included many other changes, because they found it suited both the supervisors' and the workers' needs more adequately. The majority of the seminar participants agreed with this opinion. It was therefore decided to retain the original version, with the addition of a checklist (Appendix 3), as the official supervision guideline.

In discussing potential supervision strategies, two major types were identified. The first consisted of a supervisor reviewing all the tasks at a health center and the second type, the review of a specific task during any single supervision visit. Variations on these strategies were also considered; for example, the tasks could be divided into three groups, with each of these groups as the object of a supervision visit. Another proposal advocated the development of an integrated, multi-disciplinary supervision team at the departmental level.

After discussing the advantages and disadvantages of each strategy, it was decided that the local circumstances would determine which would be applied. However, the principle of supervisory responsibility flowing from the national level to the departments and from the departments to the regions would be retained. Since the coordinators were overwhelmed with responsibilities from several programs, the creation of the post of Supervising Midwife was deemed necessary.

As noted above, supervisors compiled lists of equipment and materials needed at the health centers during their field visits. As a result, posters, forms, and data collection materials were distributed in all departments.

Recommendations

Following the three days of reflection, the following recommendations were made.

- Ensure the complete training of regional supervision teams (clinical, IEC, IUD insertion, management, evaluation, supervision, curriculum development).
- Ensure regular documentation in the area of family planning.
- Define a numerical national population objective.
- Publicize and activate the national family planning action program.

PHASE II APPENDIX 1

LISTE DES PARTICIPANTS

Séminaire Stratégie de Supervision

des activités P.F du 19 au 21 Décembre 1989.

- ENCADREURS :

- Mme. LAQUALI SALAMATOU D.P.F
- Mme. ABDOULAYE FATOUMA D.P.F
- M. MARIKO SOULEYMANE D.P.F

- PARTICIPANTS :

- M. SMAILA RABE Coordonnateur EPS Tahoua
- M. AMADOU LAQUAL Coordonnateur EPS Maradi
- M. ADA MAHAMAN Coordonnateur Action Sociale Tahoua
- M. IDI HASSANE Coordonnateur EPS Dosso
- M. ISSA BAARE IBRAHIM Coordonnateur SMI/PF Zinder
- M. CHAIBOU IBRAH Coordonnateur SMI/PF Tahoua
- Mme. DAN DIGE HAMSATOU Sage-Femme Maradi
- M. MAINASSARA MAGE Chef C.M. Mayahi
- M. ADAMOU OUSMANE Coordonnateur SMI/PF Tillabéri
- M. ISSOUFOU BALARABE Coordonnateur SMI/PF Dosso
- Mme. MAIDAGI BIBATA Sage-Femme Boboye
- Mlle. THIOMBIANO JEANNE Sage-Femme CHD Tahoua
- Mme. ABDQU MAIMOUNA Coordinatrice Action Sociale
- M. HALI ADAMOU
- 6 Mme. DIALLO JEANNETTE Coordinatrice SMI/PF Communauté Urbaine.

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PHASE II APPENDIX 2

MSP/AS/GF/
DFF

Département de _____

Commune de _____

No. de fiche _____

Année _____

Mois _____

Périodicité _____

1. Tâche: Accueil de la cliente

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
1. Saluer la femme en langue maternelle	- Salutations faites			
2. Installer la femme (inviter à s'asseoir)	- Femme assise (installée)			
3. Observer le faciès de de la femme	- (faciès) observée			
4. Demander le but de la visite	- But recensé			
5. Orienter la femme vers le service approprié	- Femme orientée			

MSP/AS/G/:

No. de fiche _____

DPF
Département de _____

Année _____

Commune de _____

Mois _____

Périodicité _____

II. Tâche: Interrogatoire

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1.0 Etablir l'Etat Civil				
:1.1 Demander le nom	: 1.1 Nom demandé			
:1.2 " prénom	: 1.2 Prénom demandé			
:1.3 " âge	: 1.3 Age demandé			
:1.4 " parité	: 1.4 Parité "			
:1.5 " gestation	: 1.5 Gestation "			
:1.6 " fonction	: 1.6 Fonction "			
:1.7 " Situation matrimoniale	: 1.7 Situation mari- moniale demandée			
:1.8 " adresse	: 1.8 Adresse demandée			
:1.9 " âge dernier né	: 1.9 Age dernier né demandé			
:Demander les antécédents				
:2.0 Médicaux				
:2.1 Maux de tête	: 2.1 Question posée			
:2.2 Ictère	: 2.2 "			
:2.3 Tuberculose	: 2.3 "			
:2.4 Hémorroïdes	: 2.4 "			
:2.5 Diabète	: 2.5 "			
:2.6 Hypertension	: 2.6 "			
:2.7 Problèmes rénaux	: 2.7 "			

II. Tâche: Interrogatoire

(SUITE)

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:2.3 Drépanocytose	: 2.8 "	:	:	:
: Demander les antécédents	:	:	:	:
:3.0 Chirurgicaux	:	:	:	:
:3.1 Césariennes	: 3.1 Questions posée	:	:	:
:3.2 . GEU	: 3.2 "	:	:	:
:3.3 Autres interventions	: 3.3 "	:	:	:
: Demander les antécédents	:	:	:	:
:4.0 Gynécologiques	:	:	:	:
:4.1 Age aux lères règles	: 3.1 Question posée	:	:	:
:4.2 Cycle (durée)	: 4.2 "	:	:	:
:4.3 Durée des règles	: 4.3 "	:	:	:
:4.4 Règles abondantes ou non	: 4.4 "	:	:	:
:4.5 Signes accompagnateurs (dysménorrhée, vertiges)	: 4.5 "	:	:	:
: Demander les antécédents	:	:	:	:
:5.0 Obstétricaux	:	:	:	:
:5.1 Age au 1er accouchement	: 5.1 Question posée	:	:	:
:5.2 Nbre de grossesses menées à terme	: 5.2 "	:	:	:
:5.3 Intervalle entre les grossesses	: 5.3 "	:	:	:
:5.4 Nbre d'avortements	: 5.4 "	:	:	:
:5.5 Nbre accht prématuré	: 5.5 Question posée	:	:	:
:5.6 Nbre de mort-né	: 5.6 "	:	:	:
:5.7 Nbre d'enfants DCD	: 5.7 "	:	:	:
:5.8 Nbre d'enfants vivants	: 5.8 "	:	:	:
:5.9 DBR (date des dernières règles)	: 5.9 "	:	:	:

II. Tâche: Interrogatoire

(SUITE)

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
: Poser la question	:	:	:	:
: 6.0 Test	: 6.0 Question posée	:	:	:
: "Avez-vous jamais entendu / parler des différentes mé- : thodes de contraception?"	:	:	:	:

Je ne suis pas sûr que l'on pourrait te voir dans ce cas
 (formulation) était dans un autre endroit.

Je ne suis pas sûr que l'on pourrait te voir dans ce cas
 (formulation) était dans un autre endroit.

MSP/AS/CF/
DPF

Département de _____

Commune de _____

No. de fiche _____

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III. Tâche: Mener une séance d'IEC

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
1. Saluer l'assistance	1. Assistance saluée			
2. Annoncer le thème	2. Thème annoncé			
3. Poser une question pour développer le thème du jour	3. Question posée			
4. Développer le thème du jour	4. Thème développé			
5. Poser une 2ème question pour apprécier le degré d'assimilation	5. Question posée			
6. Remercier les femmes	6. Femmes remerciées			
Problèmes possible: sur				
Nombre de participantes	Femmes - Hommes	hommes +	femmes	
Local adapté	oui non Si non pourquoi			
Temps imparti à la séance	Trop court	trop long:	-	

Il est important de noter que la séance d'IEC doit être menée dans un lieu approprié et que les participantes doivent être informées à ce niveau de manière à assurer la participation ou de la population cible de la séance d'IEC.

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MSP/AS/CZ'
 DPF
 Département de _____
 Commune de _____

No. de fiche _____
 Année _____
 Mois _____
 Périodicité _____

IV. Tâche: Mener un counseling

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1. Saluer la femme	: 1. Femme saluée	:	:	:
:	:	:	:	:
:2. Poser une question : ouverte	: 2. Question posée	:	:	:
:	:	:	:	:
:Ex: Pourriez-vous me dire : pourquoi?	:	:	:	:
:	:	:	:	:
:3. En fonction des répo- : ses, répondre aux préoc- : cupations et aux soucis : de la : femme	: 3. Réponses données	:	:	:
:	:	:	:	:
:4. Exposer les avantages et : les inconvénients de la : méthode choisie par la : femme	: 4. Avantages et inconvénients exposés	:	:	:
:	:	:	:	:
:5. Poser selon le cas une : question "en comparaison : avec les rumeurs que : vous avez entendus"	: 5. Question posée	:	:	:
:	:	:	:	:
:6. Remercier la femme	: 6. Femme remerciée	:	:	:
:	:	:	:	:

MSP/AS/CF/
 DPF
 Département de _____
 Commune de _____

No. de fiche _____
 Année _____
 Mois _____
 Périodicité _____

V. Tâche: Examen clinique (général)

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1. Apprêter le matériel : tensionnètre + stéthoscope : médical pèse-personne + : toise, matériel d'examen : d'urine - table de con- : sultation	: 1. Matériel prêt	:	:	:
:2. Peser la femme	: 2. Femme pesée	:	:	:
:3. Noter le poids	: 3. Poids noté sur la : fiche	:	:	:
:4. Prendre la TA	: 4. TA prise	:	:	:
:5. Noter la TA	: 5. TA notée sur la : fiche	:	:	:
:6. Noter rapport : Taille/TA/Poids	: 6. Rapport	:	:	:
:7. Rechercher varices, : oedèmes, anéide	: 7. Varices, oedèmes : recherchés	:	:	:
:8. Observer si goître : il y a	: 8. Goître observé	:	:	:
:9. Recueillir un échantil- : lon d'urines	: 9. Echantillon : recueilli	:	:	:
:10. Chercher la présence de : l'albumine et du sucre : dans les urines	: 10. ^{Résultat} Présence notée : sur la fiche	:	:	:
:11. Palper les seins	: 11. Seins palpés	:	:	:
:12. Remplir fiche carte, : registre	: 12. Documents remplis	:	:	:
:13. Remercier la femme	: 13. Femme remerciée	:	:	:

MSP/AS/CR/ : _____
 DPF
 Département de _____
 Commune de _____

No. de fiche _____
 Année _____
 Mois _____
 Périodicité _____

VI. Boîte: Examen gynécologique

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1. Se laver les mains	: 1. Mains lavées	:	:	:
:2. Demander à la femme de vider sa vessie	: 2. Vessie vidée	:	:	:
:3. Apprêter le matériel : Table + escabot : Plateau stérile avec : spéculum stérile, doigtier, coton, antiseptique, pince à servir : bœc + eau, poubelle, : lampe allumée	: 3. Matériel prêt et complet	:	:	:
:4. Installer la femme en position gynécologique	: 4. Femme installée	:	:	:
:5. Nettoyer la vulve	: 5. Vulve nettoyée	:	:	:
:6. Observer l'état de la vulve	: 6. Vulve observée	:	:	:
:7.0 Faire le toucher vaginal combiné au palpér	:	:	:	:
:7.1 Prendre un doigtier	: 7.1 Doigtier en main	:	:	:
:7.2 Enfiler le doigtier	: 7.2 Doigtier enfilé	:	:	:
:7.3 Introduire les deux doigts dans le vagin	: 7.3 Les deux doigts introduits	:	:	:
:7.4 Apprécier l'état du vagin	: 7.4 Etat du vagin apprécié	:	:	:
:7.5 Apprécier l'état du col	: 7.5 Etat du col apprécié	:	:	:

7. imposer la main gauche au dessus de la Symphyse pubienne.

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:7.6 Apprécier l'état de l'utérus et ses annexes	: 7.6 Etat de l'utérus apprécié	:	:	:
<i>Retirer les doigts -</i> :7.8 Examiner les sécrétions vaginales	: 7.7 Sécrétions exami- nées	:	:	:
:7.9 Jeter le doigtier sale	: 7.8 Doigtier jeté	:	:	:
:8.0 Placer le spéculum	:	:	:	:
:8.1 Choisir le spéculum adapté	: 8.1 Spéculum appro- prié choisi	:	:	:
:8.2 Lubrifier le spéculum avec un antiseptique	: 8.2 Spéculum lubrifié	:	:	:
:8.3 Visser les valves	: 8.3 Valves vissées	:	:	:
:8.4 Introduire verticale- ment le spéculum	: 8.4 Spéculum intro- duit verticalement	:	:	:
<i>orienter la lampe allumée</i> :8.5 Tourner le spéculum à la position horizontale	: 8.5 Spéculum en posi- tion horizontale	:	:	:
:8.6 Réajuster afin de visuocquer et centrer le Col	: 8.6 Col visuocqué et centré	:	:	:
:8.7 Bien visser pour main- tenir le spéculum en place	: 8.7 Vls serrée	:	:	:
:8.8 Examiner l'état du col	: 8.8 Col examiné	:	:	:
:8.9 Faire prélèvement si nécessaire	: 8.9 Prélèvement fait	:	:	:
:8.10 Dévisser le spéculum	: 8.10 Spéculum dévissé	:	:	:
:8.11 Orienter le spéculum en position verticale	: 8.11 Spéculum en po- sition verticale	:	:	:
:8.12 Retirer le spéculum	: 8.12 Spéculum retiré	:	:	:
<i>eteindre la lampe</i> :9. Laver et stériliser le matériel	: 9. Matériel lavé et stérilisé	:	:	:
:10. Ranger le matériel	: 10. Matériel rangé	:	:	:

MSR/AS/CFP
DPP
Département de _____
Commune de _____

No. de fiche _____
Année _____
Mois _____
Périodicité _____

VII. Tâche: Prescrire la pilule

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
1. Accueil (Voir rubrique) - saluer la femme - installer la femme	1. Accueil fait - femme saluée - femme installée			
2. Counseling tout en expliquant les avantages et inconvénients de la Méthode	2. Counseling fait			
3. Examen général (voir rubrique)	3. Examen général fait			
4. Examen gynécologique (voir gynécologique)	4. Examen gynécologique fait			
5. Se Laver les mains	5. Mains lavées			
6. Prescrire la pilule adaptée	6. Pilule adaptée prescrite			
7. Expliquer la prise + effets secondaires	7. Prise expliquée 8. Explication faite			
8. Donner la plaquette si disponible	8. Plaquette remise			
9. Fixer le RDV	9. Rendez-vous fixé			
10. Demander la femme ce qui a été dit sur la prise et le RDV	10. Question posée			
11. Noter sur les registres examens et la prescription	11. Examens et prescription notés			
12. Remettre la carte à la femme	12. Carte remise			
13. Expliquer les effets secondaires possibles	13. Explication faite			
14. Remercier la femme	14. Femme remerciée			

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DPF

Département de _____

Commune de _____

No. de fiche _____

Année _____

Mois _____

Périodicité _____

VIII. Tâche: Technique d'injection

Pratiquer l'injection des produits contraceptifs

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
: 1. Accueil	: 1. Accueil fait	:	:	:
: - saluer la femme	:	:	:	:
: - installer la femme	:	:	:	:
: 2. Counseling tout en ex-	: 2. Counseling fait	:	:	:
: pliquant les avantages	:	:	:	:
: et les inconvénients de	:	:	:	:
: la méthode (complément	:	:	:	:
: d'information)	:	:	:	:
: 3. Examen général (voir	: 3. Examen général	:	:	:
: rubrique)	: fait	:	:	:
: 4. Examen gynécologique	: 4. Examen gynécologi-	:	:	:
: (voir rubrique)	: que fait	:	:	:
: 5. Se laver les mains	: 5. Mains lavées	:	:	:
: - avoir un plateau sté-	:	:	:	:
: rile avec seringue,	:	:	:	:
: aiguilles stériles, sa-	:	:	:	:
: von, eau, serviette, co-	:	:	:	:
: ton, alcool, haricot, cu-	:	:	:	:
: vette, produit à injecter:	:	:	:	:
: 6. Préparer le matériel	: 6. Matériel à portée	:	:	:
: -	: de main	:	:	:
: 7. Vérifier la date de	: 7. Date vérifiée	:	:	:
: péremption	:	:	:	:
: 8. Prendre la seringue	: 8. Seringue en main	:	:	:
: 9. Casser l'ampoule à	: 9. Ampoule cassée	:	:	:
: l'aide d'une compresse	: avec compresse	:	:	:
: 10. Aspirer totalement le	: 10. Produit aspiré	:	:	:
: produit	:	:	:	:
: 11. Désinfecter la peau	: 11. Peau désinfectée	:	:	:

VIII. Tâche: Technique d'injection

(SUITE)

Pratiquer l'injection des produits contraceptifs

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:12. Piquer profondément en : DM	: 12. Piqûre Piqûre IV faite	:	:	:
:13. Aspirer pour voir s'il : n'y a pas de sang	: 13. Aspiration faite	:	:	:
:14. injecter le produit très : lentement et totalement	: 14. Produit injecté : lentement et to-	:	:	:
:15. Retirer l'aiguille d'un : coup sec	: 15. Aiguille retirée	:	:	:
:16. Exposer l'endroit de : l'injection	: 16. L'endroit exposé : né	:	:	:
:17. Observer la femme pen- : dant 5 mn pour voir s'il : n'y a pas de réaction	: 17. Observation faite : 5 minutes	:	:	:
:18. Remplir fiches, cartes : et registres	: 18. Documents remplis	:	:	:
:19. Donner le RDV de la : prochaine injection	: 19. RDV donné	:	:	:
:20. Poser la question : "quelle est la date du : prochain RDV"	: 20. Question posée	:	:	:
:21. En cas de non compré- : hension, redonner la : réponse	: 21. Réponse donnée	:	:	:
:22. Remettre la carte à la : femme	: 22. Carte remise	:	:	:
:23. Remercier la femme	: 23. Femme remerciée	:	:	:

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BPF
 Département de _____
 Commune de _____

No. de fiche _____
 Année _____
 Mois _____
 Périodicité _____

IX. Tâche: Prescrire Condoms, Spermicides, Mousses etc

Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1. Accueil (voir rubrique)	: 1. Accueil fait	:	:	:
: - saluer la femme	: - femme saluée	:	:	:
: - installer la femme	: - femme installée	:	:	:
:2. Counseling tout en expli- : quant les avantages et : les inconvénients de la : méthode	: 2. Counseling fait	:	:	:
:3. Prescrire ou donner le : nombre suffisant de con- : doms, spermicides, Mousse:	: 3. Méthode prescrite : ou donnée	:	:	:
:4. Expliquer l'utilisation : de la méthode choisie	: 4. Explication faite	:	:	:
:5. Expliquer au mari l'uti- : lisation du condom (s'il : est présent)	: 5. Explication faite	:	:	:
:6. Poser la question est-ce : que vous avez compris...?	: 6. Question posée	:	:	:
:7. Expliquer à la femme de : revenir aux prochaines : règles pour une autre : méthode plus efficace	: 7. Explication donnée	:	:	:
:8. Remplir le registre : fiche et carte	: 8. Documents remplis	:	:	:
:9. Remettre à la femme sa : carte de visite	: 9. Carte remise	:	:	:
:10. Remercier la femme	: 10. Femme remerciée	:	:	:

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DPF
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 Commune de _____

No. de fiche _____
 Année _____
 Mois _____
 Périodicité _____

X. Tâche: Technique de Pose DIU

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:1. Engager une conversation avec la femme pour l'en- courager à se détendre	: 1. Conversation faite	:	:	:
:2. Saluer la femme	: 2. Femme saluée	:	:	:
:3. Vérifier les papiers	: 3. Papiers vérifiés	:	:	:
:4. Faire uriner la femme	: 4. Vessie vidée	:	:	:
:5. Rassurer la femme	: 5. Femme rassurée	:	:	:
:6. Montrer le stérilet à la femme	: 6. Stérilet montré	:	:	:
:7. Rappeler les informa- tions reçues concernant le DIU à la femme	: 7. Informations rap- pelées	:	:	:
:8. Installer la femme en position gynécologique	: 8. Femme installée	:	:	:
:9. Allumer la lampe	: 9. Lampe allumée	:	:	:
:10. Se laver les mains	: 10. Mains lavées	:	:	:
:11. Apprêter le matériel technique dans un pla- teau stérile	: 11. Matériel à portée de main	:	:	:
:12. Procéder à l'examen gynécologique (voir rubrique) et la pose du spéculum	: 12. Examen gynécolo- gique et la pose du spéculum faite	:	:	:
:13. Procéder à la technique d'insertion du DIU	:	:	:	:
:13.1 Mettre les gants	: 13.1 Gants mis	:	:	:

X. Tâche: Technique de Pose DIU

(SUITE)

Gestes et sous Gestes	Critères d'Appréciation	Geste fait		Observations ou remarques
		oui	non	
:13.2 Voir 1ère page				
:13.3 Prendre la pince à servir + tampon de coron <i>inhibé de 20/20/15</i>	:13.3 Pince en main à servir			
:13.4 Nettoyer le col	:13.4 Col nettoyé			
:13.5 Examiner l'état du col	:13.5 Col examiné			
:13.6 Placer le terraculum	:13.6 Terraculum placé			
:13.7 Mesurer la profondeur de l'utérus	:13.7 Utérus mesuré			
:13.8 Retirer l'hystéromètre	:13.8 Hystéromètre retiré			
:13.9 Lire la mensuration	:13.9 Mensuration lue			
:13.10 Monter le stérilet en fonction de la mensuration	:13.10 Stérilet ajusté			
:13.11 Insérer le stérilet	:13.11 Insertion faite			
:13.12 Retirer et jeter l'inserteur	:13.12 Inserteur retiré et jeté			
:13.13 Prendre les ciseaux	:13.13 Ciseaux en main			
:13.14 Ajuster et couper les fils	:13.14 Fils ajustés et coupés			
:13.15 Retirer le terraculum	:13.15 Terraculum retiré			
:13.16 Tamponner le col	:13.16 Col tamponné			
:13.17 Retirer le spéculum	:13.17 Spéculum retiré			
:13.18 Vérifier si la femme saigne	:13.18 Vérification faite			
:13.19 Mettre le matériel utilisé dans la cuvette d'eau contenant un antiseptique	:13.19 Matériel mis dans la cuvette			

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X. Tâche: Technique de Pose DIU

(SUITE)

: Gestes : et sous Gestes :	: Critères : d'Appréciation :	: Geste fait		: Observations ou : remarques :
		: oui	: non	
:13.20 Laver, stériliser le : matériel	: 13.20 Matériel lavé : et stérilisé	:	:	:
:13.21 Ranger le matériel	: 13.21 Matériel rangé	:	:	:
:13.22 Remplir la fiche, : carte et registre	: 13.22 Documents rem- : plis	:	:	:
:13.23 Prodiguer des conseils : d'hygiène, <i>notamment</i> , de : <i>Vérification de la pré-</i> : <i>sence des fils</i>	: 13.23 Conseils donnés	:	:	:
:13.24 Fixer le RDV prochain	: 13.24 RDV fixé	:	:	:
:13.25 Remercier la femme	: 13.25 Femme remerciée	:	:	:

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 Département de —
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N°-Fiche _____
 Année _____
 Mois _____
 Liste de contrôle du matériel de pose IIII Périodicité _____

Désignation	Quantité Disponibles	Besoins	Observations sur l'état
:1. Table gynécologique	:	:	:
:2. Escabot	:	:	:
:3. Stérilisateur	:	:	:
:4. Lampe (torche ou électrique)	:	:	:
:5. Chariot	:	:	:
:6. Poubelle	:	:	:
:7. Tambour (Compresseur & coton stériles)	:	:	:
:8. Plateau stérile	:	:	:
:9. 1 flacon d'alcool avec pince à servir	:	:	:
:10. Antiseptique	:	:	:
:11. Gants doigtiers stériles	:	:	:
:12. Stérilet	:	:	:
:13. Spéculum	:	:	:
:14. Hystéromètre ou sonde utérin	:	:	:
:15. Tenaculum ou pince à col	:	:	:
:16. Pince à faux germe	:	:	:
:17. Paire de ciseaux	:	:	:
:18. Grette d'eau	:	:	:
:19. Savon	:	:	:
:20. Serviette	:	:	:

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 au numéro de —

No Fiche —
 Année —
 Mois —
 Périodicité —

Liste de contrôle du matériel nécessaire
 pour la prescription de la pilule et l'injectable

Désignation	Quantité Disponibles	Besoins	Observations sur l'état
:1. Table gynécologique	:	:	:
:2. Balance	:	:	:
:3. Tensionnètre + stéthoscope médical	:	:	:
:4. Matériel d'examen d'urines	:	:	:
:5. Doigtier	:	:	:
:6. Spéculum stérile	:	:	:
:7. Lampe	:	:	:
:8. Plateau stérile	:	:	:
:9. Stérilisateur	:	:	:
:10. Chariot	:	:	:
:11. Pince à servir	:	:	:
:12. Documents (fiches, carte, registre)	:	:	:
:13. Produit contraceptif	:	:	:
:14. Coton	:	:	:
:15. Compresse	:	:	:
:16. Tambour	:	:	:
:17. Boc à antiseptique	:	:	:
:18. Haricot	:	:	:
:19. Poubelle	:	:	:
:20. Seringue stérile	:	:	:
:21. Aiguille stérile	:	:	:
:22. Alcool	:	:	:

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FICHE RECAPITULATIVE DES BESOINS
POUR SATISFAIRE NORMES MINIMALES
D'INTEGRATION

-o-o-o-o-o-o-o-

2.1 - Formation en P.F :

NOM DU PERSONNEL	CATEGORIE	à Former en			
		IEC	DIU	Clinique	Ges
	Médecin ou IDE				
	Sage-Femme				
	A.S				
	I.C -				
	Agent Assainis- sement				

2.2 - Matériels techniques manquants :

LISTE STANDARD	NBRG	DELAI DE LI- VRAISON	DESTINATAIRE

2.3 - Matériels supports visuels manquants :

LISTE STANDARD	NB	DELAI DE LI- VRAISON	DESTINATAIRE
Pagivoltes			
Affiches			
Badges			
Textes législatifs			
Manuels-guide			
Chemise P.F			

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12.4 - Besoin en contraceptifs pour assurer stock de sécurité :

CONTRACEPTIFS	NB	DELAI DE LIVRAISON	DESTINATAIRE
pilules standard	cycles		
pilule progestative	cycles		
épo-provera	ampoules		
cristérat	ampoules		
I.U			
. Lippes	unités		
. T Cooper			
condom	unités		
permicides			

12.5 - Besoins en documents de collecte et de transmission de données

DOCUMENTS	NB	DELAI DE LIVRAISON	DESTINATAIRE
registres			
fiches clinique P.F			
fiches rapport trimestriel d'activités			
manuel-guide			

12.6 - Autres besoins :

BESOINS	DELAI DE LIVRAISON.	RESPONSABLE
- Etude du milieu		
- Chiffre population de la Zone d'action		
- Définition d'objectifs		
- Liste stratégies		
- Liste activités		
- Répartition tâches		
- Calendrier d'activités		
- Réaménagement des locaux		
- Classement correcte des fiches .		

12.7 - ACTIVITES P.F :

TACHES	PERSONNE SU- PERVISEE	APPRECIATION ACCEPTABLE		AGENT SUPERVISE	REMARQUES
		Oui	Non		
Accueil de la cliente	!	!	!	!	!
Interrogatoire	!	!	!	!	!
Examen clinique	!	!	!	!	!
Examen gynécologique	!	!	!	!	!
Causeries	!	!	!	!	!
Counseling	!	!	!	!	!
Prescription pilule	!	!	!	!	!
Prescription injec- table	!	!	!	!	!
Prescription barriè- re	!	!	!	!	!
Pose de DIU	!	!	!	!	!
Stérilisation fémini- ne	!	!	!	!	!
Plan d'action	!	!	!	!	!

13.8 - CONCLUSIONS :

BEST AVAILABLE COPY

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PHASE II APPENDIX 3

GRILLE DE SUPERVISION DES ACTIVITES P.F

- Formation Sanitaire de :
- Date :
- Nom du Superviseur :
- Nom du Supervisé :

1/ - Résultats de la dernière Supervision :

- | | | |
|-------------------------------|-----------------|-----------------|
| - Dernier rapport d'activités | oui | non |
| - correctement rempli | <u> </u> | <u> </u> |
| - envoyé à temps | <u> </u> | <u> </u> |
- Taux d'utilisation par rapport à l'objectif fixé par le centre :
- Problèmes :
- rencontrés par le personnel

 - identifiés par le superviseur

.../...

2/ - LES TACHES :

	acceptable		problèmes rencontrés	solutions précisées
	oui	non		
2.1. Accueil	<input type="checkbox"/>	<input type="checkbox"/>		
2.2. Interrogatoire	<input type="checkbox"/>	<input type="checkbox"/>		
2.3. Examen clinique	<input type="checkbox"/>	<input type="checkbox"/>		
2.4. Examen gynécologique	<input type="checkbox"/>	<input type="checkbox"/>		
2.5. I.E.C	<input type="checkbox"/>	<input type="checkbox"/>		
2.6. Counseling	<input type="checkbox"/>	<input type="checkbox"/>		
2.7. Prescription Pillule	<input type="checkbox"/>	<input type="checkbox"/>		
2.8. Prescription et injection produits contraceptifs	<input type="checkbox"/>	<input type="checkbox"/>		
2.9. Prescription condoms et spermicides	<input type="checkbox"/>	<input type="checkbox"/>		
2.10. Pose D.I.U	<input type="checkbox"/>	<input type="checkbox"/>		
2.11. Plan d'action	<input type="checkbox"/>	<input type="checkbox"/>		
2.12. Gestion	<input type="checkbox"/>	<input type="checkbox"/>		

SIGNATURE

AGENT SUPERVISE
OU CHEF SUPERVISE

SUPERVISEUR