BASELINE REPORT

USAID Kulawa Project

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Cover page photo: A health worker in a community health center takes the temperature of a child. Photo credit: Save the Children.

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CONTENTS

LIST OF TABLES

ACRONYMS AND ABBREVIATIONS

AFD	Agence Française de Développement (French Agency for Development)
ANC	Antenatal Consultations
CS	Health Post (*Case de Santé*)
CSI	Integrated Health Center (*Centre de Santé Intégré*)
DH	District Hospital
DHS	Demographic and Health Survey
ENAFEME	Enquête Nationale sur la Fecondité et la Mortalité des Enfants de moins de cinq ans (National survey on fertility and mortality of children under five)
FP	Family Planning
GBV	Gender Based Violence
GEM	Gender Equitable Men
INS	Institut National des Statistiques (National Statistics Institute)
MCHC	Mother and Child Health Centers
mCPR	Modern Method Contraceptive Prevalence Rate
NGO	Non-Governmental Organization
ODK	Open Data Kit
PIRS	Performance Indicator Reference Sheet
RH	Reproductive Health
SBC	Social Behavior Change
SGBV	Sexual and Gender-Based Violence
SMART	Standardized Monitoring and Assessment of Relief and Transitions
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WRA	Women of Reproductive Age

SUMMARY OF PERFORMANCE INDICATORS

Performance indicators	Maradi	Tillabéri	Zinder	Overall
A- Knowledge, use and attitudes about family planning				
Contraceptive prevalence rate: **all methods**				
All women (15-49 years)	23.6%	14.8%	6.7%	15.2%
Women (15-24 years)	18.3%	12.1%	8.0%	13.2%
Women (25-49 years)	27.6%	16.5%	5.9%	16.6%
Contraceptive prevalence rate: **modern methods**				
All women (15-49 years)	17.4%	14.7%	4.8%	12.0%
Women (15-24 years)	12.7%	12.1%	6.3%	10.2%
Women (25-49 years)	20.9%	16.3%	3.8%	13.2%
Percentage of target population with increased knowledge of family planning/other health services.	39.2%	40.3%	18.2%	31.1%
Women (15-49 years)	66.3%	59.2%	33.1%	52.1%
Men (15-54 years)	4.6%	9.5%	0.4%	3.7%
Percentage of target population with positive attitudes toward family planning	91.1%	92,.3%	81,.2%	87,.4%
Women (15-49 years)	95.6%	96.8%	80.5%	90.1%
Men (15-54 years)	85.3%	85.0%	82.0%	83.9%
Percentage of audience who recall hearing or seeing a specific family planning/reproductive health (family planning/reproductive health) message supported by the USG	39.0%	26.3%	28.1%	32.1%
Women (15-49 years)	32.9%	25.2%	41.8%	34.5%
Men (15-54 years)	46.7%	28.2%	11.8%	28.9%
B- Recent fertility and antenatal care				
Adolescent birth rate (per 1000)	282	249	290	278
Percentage of women who had four or more antenatal visits during last pregnancy	56.0%	50.4%	48.8%	52.2%
C- Contraceptive demand and unmet needs				
Women 15-24 years				
Unmet need (spacing) (%)	1.6%	0.8%	0.4%	1.0%
Unmet need (limiting) (%)	0.2%	0.0%	0.0%	0.1%
Total unmet need (%)	**1.8%**	**0.8%**	**0.4%**	**1.1%**
Met need (spacing) (%)	19.2%	13.2%	4.6%	13.4%
Met need (limiting) (%)	0.7%	0.0%	0.4%	0.4%
Total met need (%)	**19.9%**	**13.2%**	**4.9%**	**13.8%**

Performance indicators	Maradi	Tillabéri	Zinder	Overall
Total demand (spacing) (%)	20.8%	14.0%	4.9%	14.4%
Total demand (limiting) (%)	0.9%	0.0%	0.4%	0.5%
Total contraceptive demand (%)	**21.7%**	**14.0%**	**5.2%**	**14.8%**
Demand satisfied by modern methods (%)	67.0%	94.2%	66.7%	75.6%
Demand satisfied by all FP methods (%)	91.8%	94.2%	93.3%	92.7%
Women 15-49 years				
Unmet need (spacing) (%)	1,3%	1,0%	0,1%	0,9%
Unmet need (limiting) (%)	2,8%	0,8%	1,6%	1,7%
Total unmet need (%)	4,1%	1,7%	1,7%	2,6%
Met need (spacing) (%)	23,7%	16,0%	6,2%	16,3%
Met need (limiting) (%)	1,6%	0,4%	0,9%	1,0%
Total met need (%)	25,3%	16,4%	7,1%	17,3%
Total demand (spacing) (%)	25,0%	17,0%	6,4%	17,2%
Total demand (limiting) (%)	4,4%	1,2%	2,4%	2,7%
Total contraceptive demand (%)	29,4%	18,2%	8,7%	19,9%
Demand satisfied by modern methods (%)	69,0%	89,8%	56,5%	74,1%
Demand satisfied by all FP methods (%)	86,2%	90,4%	80,7%	86,9%
D- Gender-based violence				
Percentage of target population with at least a moderate equity score on the Gender Equitable Men (GEM) scale	50.2%	44.6%	59.7%	52.8%
Women (15-49 years)	31.2%	34.9%	43.9%	36.9%
Men (15-54 years)	74.2%	60.4%	78.5%	73.5%
Percentage of target population stating that it is justified to hit or beat his wife	54.6%	69.2%	60.6%	60.0 %
Women (15-49 years)	76.3%	85.1%	86.4%	82.1%
Men (15-54 years)	27.0%	43.3%	29.9%	31.1%
E- Vaccination of children				
Percentage of children completely vaccinated by 12 months	57.2%	28.7%	46.2%	48.8%
F- Service provision				
Proportion of providers with a positive attitude towards the use of family planning and its services by adolescents	39.2%	39.2%	46.5%	42.3%
Percentage of health care units with at least one service provider trained to manage and report sexual and gender-based violence (SGBV)	61.2%	58.5%	43.5%	53.3%
Number of newborns receiving postnatal care within two days of delivery in USG-supported programs (from the sample of the survey)	15,473	6,654	31,090	53,217

Performance indicators	Maradi	Tillabéri	Zinder	Overall
Number of newborns receiving postnatal care within two days of delivery in USG-supported programs (extrapolated to the USAID Kulawa area)	37,844	58,146	158,437	254, 427
Percentage of women who give birth in a facility and start or leave with a modern contraceptive method before discharge	23.0%	37.0%	28.0%	28.0%
Percentage of women who give birth in a facility and receive counseling on family planning before discharge.	59.0%	87.0%	73.0%	70.0%
Service Availability Index	16.4%	19.7%	20.0%	18.7%

INTRODUCTION

Background

Despite significant progress recorded in recent decades in the areas of maternal and child health in Niger, significant challenges still persist. Maternal, neonatal, and infant mortality remain a concern, with prevalence levels still high, thus confirming the need to continue to undertake major efforts to satisfactorily improve the health of mothers, newborns, babies, and children in Niger. Indeed, malnutrition and micronutrient deficiencies remain a major public health concern, affecting particularly young children and pregnant and lactating women. The prevalence of chronic malnutrition in children under five is 47.0%, above the "30% threshold" set by the World Health Organization (WHO, SMART Survey, 2022). The rate of wasting among women aged 15 to 49 is 3.0%. The maternal mortality rate is 553 per 100,000 live births and the mortality rate for children under five is 104 per 1,000 (AFD, 2020). Rapid population growth, coupled with a lack of access to health services and strong social and behavioral norms at community level, and consequently limited access to information on health, family planning (FP), and nutrition, have an increasingly negative impact on family health, especially on children, the most vulnerable segment of the population. Despite strong political will to reverse these trends, the challenges remain enormous.

Project Description

The United States Agency for International Development (USAID) Kulawa project is a five-year (2020-2025) initiative to support the Government of Niger in improving health, family planning (FP), and nutrition outcomes in Maradi, Zinder, and Tillabéri regions. Meaning "to care for" in Hausa, USAID Kulawa collaborates with the Ministry of Public Health, Population and Social Affairs (MOPH/P/SA), local government, health providers, and communities to implement activities that will reach 1.4 million women of reproductive age, 1.1 million children under age five, and 2.6 million youth and adolescents ages 15-35, with a focus on youth ages 10-24, in 17 health districts in Maradi, Zinder, and Tillabéri.

In collaboration with the MOPH/P/SA, Save the Children (SC) leads USAID Kulawa with partners Pathfinder International, PRONTO International, and Viamo, and works in partnership with local government, national non-governmental organizations (NNGOs), and beneficiary communities.

USAID Kulawa's Theory of Change is grounded in our development hypothesis: If local populations, including youth, have greater access to integrated high quality maternal, newborn, and child health (MNCH)/FP and nutrition services, and if linkages between these services at the community and facility levels and with other sectors are strengthened, and if community demand for, engagement, and trust in services grows, then utilization will increase, social and behavior change (SBC) will occur at the institutional and individual levels, and health outcomes will improve. Resilience in the Sahel Enhance (RISE) II operating principles of community-led development, systems strengthening, inclusive targeting, and collaboration for

collective impact guide USAID Kulawa's approaches and are complemented by an emphasis on women and youth empowerment, gender equality, collaborating, learning, and adapting (CLA), and resilience.

USAID Kulawa envisions resilient communities, including their most marginalized and disadvantaged members, benefiting from better access and use of high quality maternal, newborn and child health, family planning and reproductive health (RH), and nutrition services, collaborative alliances across communities and facilities and across health sectors and other sectors, stronger governance and accountability of local systems and institutions.

The objective of the USAID Kulawa project is to increase the use of quality maternal, neonatal, and infant-child health, family planning and nutrition services in the areas of intervention. The activities will achieve the objective through the following results:

Result 1: Increased availability and accessibility to quality services, including for young people.
Result 2: Improved quality of care systems in the delivery of health services.
Result 3: Strengthened integration in the delivery of health services.
Result 4: Increased functional capacity of local organizations in the health sector.

USAID Kulawa also features several important crosscutting objectives, including improved management of shocks, risks, and stresses; enhanced social, economic, and political agency of women and adolescents/youth; and enhanced governance of institutions and organizations.

In order to establish the baseline situation of the project in the communities of intervention, this assessment was conducted by GRADE Africa in the three regions of project intervention (Maradi, Tillabéri and Zinder) complements the first study conducted in 2021 to establish the baseline. This report presents the main results and findings of this evaluation.

1. EVALUATION OBJECTIVES

1.1 Global objective

The main objective of this study is to establish the reference levels of specific project indicators not covered by the first study. This will allow the project team to be able to ensure or adjust the targeting, to measure the changes linked to the interventions and to highlight the potential for project integration, sustainability and scaling up.

1.2 Specific objectives

The study pursues specifically two sub-objectives:

Have relevant data for indicators related to project themes, which are maternal, neonatal and infant-child health (including prenatal and postnatal care), nutrition, sexual and reproductive health, sexual and gender-based violence, and family planning;
Formulate recommendations based on the evidence from the study to help decision-making in the context of project interventions.

2. GENERAL METHODOLOGY

2.1 Sites and target populations

The study sites are made up of all the localities of intervention of the USAID Kulawa project in the three target regions, namely Maradi, Tillabéri and Zinder. Depending on the health area to which it belongs, each locality is attached to a case de santé/health post (CS) or a health center.

This baseline survey was conducted at household and health facility level. The household survey targeted women aged 15 to 49, men aged 15 to 54, and children aged 0 to 35 months. The health facility assessment looked at health providers and health facilities. Calculations of the size of the target population are based on population projections from 2012 to 2035 by department, as provided by the National Institute of Statistics (Annex 3).

2.2 Study design and methods

The methodological approach is quantitative through a survey of households and health facilities. Depending on the target, specific tools were used to collect information relating to the main USAID Kulawa project indicators.

A form was designed to list all the households in a locality. In addition, using a questionnaire, information on the composition of the household was collected from the head of the household or his legal representative, who was assumed to be able to provide information on the household.

2.2.1 Household survey

The project interventions target several segments of the population (men, women, and children). The project has numerous indicators relating to these segments on which the data collection focused, particularly among households. To this end, a variety of tools were necessary for the data collection. Many project performance indicators have a reference metadata sheet (see USAID Performance Indicator Reference Sheet (PIRS), which guided collection tools design and calculations of the indicators.

2.2.2 Survey of health facilities

The purpose of the health structures' evaluation was to determine the levels of access and use of maternal and child health services (ANC and RH/FP in particular) and nutrition. It also aimed to establish the status of

the equipment needed to provide quality health services. The ultimate goal is to ensure that people, especially women and children, receive the best possible health services. A specific tool has been designed for healthcare providers (see Appendix 4 on the main project indicators and collection methods).

2.3 Sampling

2.3.1 Household survey

Sampling frame

The USAID Kulawa project has a database of 3,692 interventions sites in the Maradi, Tillabéri and Zinder regions. A "site" is a village that is attached to a CS or a health center. In this database, each village appears with all its geographical identifiers (region, district, and municipality of attachment). This database served as a sampling frame for drawing the survey sample.

Sampling size

It is expected that the results will be representative of the scale of each region of intervention. The process of determining the sample size was therefore conducted to satisfy this condition and fit the budget. The size of the sample was then modeled on the proportions of the different targets by region.

Table 1: USAID Kulawa zone demographics

Regions	Districts	Total Population	12-23 months	Women of reproductive age	10-24 years old
Maradi	Aguié	352 248	27 980	76 329	117 190
	Dakoro	902 716	71 704	195 610	300 327
	Gazaoua	229 876	18 259	49 812	76 478
	Guidan Roumdji	749 924	59 568	162 501	249 494
	Tessaoua	738 662	58 673	160 061	245 748
Tillabéri	Balleyara	153 613	12 202	33 124	51 106
	Filingué	439 795	34 934	94 834	146 317
	Kollo	667 306	53 005	143 892	222 008
	Say	251 818	20 002	54 300	83 778
	Tillabéri	325 986	25 894	70 293	108 453
Zinder	Damagaram Takaya	345 788	27 467	73 946	115 041
	Dungass	507 374	40 302	108 501	168 800
	Gouré	470 025	37 335	100 514	156 374
	Kantché (Matamèye)	572 345	45 462	122 395	190 415
	Magaria	828 367	65 799	177 145	275 592
	Mirriah	727 651	57 799	155 607	242 084
	Takeita	353 887	28 110	75 678	117 736
Total USAID Kulawa		**8 617 381**	**684 495**	**1 854 542**	**2 866 941**

Source: Save the Children Niger, 2022

From Table 1 above, the proportions of different target populations were calculated. The result obtained is recorded in Table 2 below.

Table 2: Weight of study sub-populations by age group

Regions	Districts	12-23 months	WRA 15-49 years	10-24 years
Maradi	Aguié	7.9	21.7	33.3
	Dakoro	7.9	21.7	33.3
	Gazaoua	7.9	21.7	33.3
	Guidan Roumdji	7.9	21.7	33.3
	Tessaoua	7.9	21.7	33.3
Tillabéri	Balleyara	7.9	21.6	33.3
	Filingué	7.9	21.6	33.3
	Kollo	7.9	21.6	33.3
	Say	7.9	21.6	33.3
	Tillabéry	7.9	21.6	33.3
Zinder	Damagaram Takaya	7.9	21.4	33.3
	Dungass	7.9	21.4	33.3
	Gouré	7.9	21.4	33.3
	Kantché (Matameye)	7.9	21.4	33.3
	Magaria	7.9	21.4	33.3
	Mirriah	7.9	21.4	33.3
	Takeita	7.9	21.4	33.3

The result shows constant and equal proportions between health districts, i.e., 7.9% for children aged 12-23 months, 21.7% for women of childbearing age (15-49 years) and 33.3% for 10–24-year-old. The calculation of the sample size is based on the following formula:

$$n = \frac{t_{\alpha}{}^{2} * p(1-p) * d * (1+k)}{m^{2}{}_{\alpha} * \bar{X}}$$

Where n is the number of households to survey; $\bar{X}$ is the average number of the target population per household; t_∝^2 is the quantile of order (1-∝/2) of the centered reduced normal distribution, squared; m_∝^2 is the absolute margin of error associated with the level of confidence (1-∝) associated with the estimate of p; p is the prevalence of the indicator of interest; d is the sampling effect; and k is the nonresponse rate. The sizes of the samples obtained according to the target populations are recorded in Table 3 below.

Table 3: Sample size calculation

Region	Target Groups	Proportion value	Design Effect	Non-response rate	Minimum number of individuals/ stratum	Average number per household targeted	Number of households to include in a stratum
Maradi	12-23 months	7.9%	2	0.07	168	0.3	561
	Women 15-49 years	21.7%	2	0.07	391	1.3	301
	10-24 years	33.3%	2	0.07	511	0.4	1,278
Tillabéry	12-23 months	7.9%	2	0.07	168	0.3	561
	Women 15-49 years	21.7%	2	0.07	391	1.3	301
	10-24 years	33.3%	2	0.07	511	0.4	1,278
Zinder	12-23 months	7.9%	2	0.07	168	0.3	561
	Women 15-49 years	21.7%	2	0.07	391	1.3	301
	10-24 years	33.3%	2	0.07	511	0.4	1,278

Thus, the sample size for all three regions is 3,840 households distributed as follows:

Table 4: Sampling distribution by region

Region	Number of households to survey
Maradi	1,280
Tillabéri	1,280
Zinder	1,280
Total	**3,840**

The size of the sample is identical between the different target groups and between the three regions of intervention of the project.

Sampling plan

The sampling plan for this survey is of the two-stage stratified type. The primary survey unit, the cluster, is the intervention site or village. Each region corresponds to a sampling stratum. For the selection, no distinction was made between urban and rural areas in each region. In each stratum, the first stage sample was drawn independently by a systematic draw. The second stage was also taken independently in each primary unit drawn in the first stage and in a systematic manner.

As indicated above, a sampling base made up of all the USAID Kulawa project intervention sites is available. It contains 3,692 sites or localities. The sampling frame was set for each target region according to the

municipality and the department, in alphabetical order. At the first stage of sampling, 120 clusters (sites or locality of intervention) were systematically selected with equal probability from all three sampling strata, 40 clusters per stratum, by conducting a systematic random selection with equal probability to survey the 3,840 households (Appendix 5). Such a selection procedure offers an implicit stratification by department level and within each region.

After drawing the first stage statistical units, a counting operation was conducted in each site selected the same day of the survey, in order to have the exact number of ordinary households residing in the site. This made it possible to compile a complete list of all the households from which was drawn, at the second stage, a sample of 32 households following a systematic selection. At the time of the household visits, all household members were identified using the household questionnaire. This operation made it possible to identify the members eligible for individual interviews. Individual questionnaires intended for women aged 15 to 49, mothers and guardians of children aged 0 to 35 months and men aged 15 to 54 were administered in each selected household, depending on the presence of eligible persons.

During the survey, in case of absence or refusal to participate in the survey, the household was replaced by the next or the previous household on the list. Once a site was selected and if the security or geographical accessibility conditions were not met, it was automatically replaced among the villages on the replacement list.

It is important to note that prior to the data collection phase, the scope of work and the methodology for this study were submitted to IRB for review and approval, which confirmed that this study adheres to the accepted ethical standards of a genuine research study.

2.3.2 Survey of health facilities and service providers

The household survey was coupled with an assessment of health structures and a survey of service providers. This assessment is representative of the type of structure and geographical area (region/department) in the three regions. For this assessment, the regions were also considered as strata. The sample size defined was 146 health structures, or 17% of the 871 structures in the area covered by the USAID Kulawa project, with a confidence level of 95% and a margin of error of 5%. The health structures visited were made up of district hospitals (12/12, i.e., 100%); Mother and Child Health Centers (3/3, or 100%), centre de santé intégré/integrated health centers (83/257, or 30%) and case de sante/health posts (48/598, or 30%).

All district hospitals (DH) and mother and child health centers (MCHC) in the three regions were targeted by the study. With regard to centre de santé intégré/integrated health centers (CSIs) and case de sante/health posts (CS), all of the 120 intervention sites or villages sampled for the household survey or frequented by their populations were counted and automatically visited for the health facilities assessment. The complement of CSIs and CSs was drawn randomly from the respective databases of CSIs and CSs in all three regions/strata to reach a total of 146 health structures. Depending on the type of health structure, the team interviewed one (1) manager per structure, one (1) service provider per CS, two (2) per CSI, two (2)

per MCHC, three (3) per district hospital. For health facilities where the number of providers is greater than the number of providers to be surveyed, RH/FP service providers were selected for the study.

Inclusion criteria

For this study, the participant inclusion criteria were based primarily on age and sex for the household survey and acceptance to participate in the survey. The study population consisted of women aged 15 to 49, men aged 15 to 54, children aged 0 to 35 months and health care providers residing in the project intervention area. These criteria were intended to cover the people targeted by project interventions. For the service providers, the criterion was the fact of practicing in the health structure selected. The providers were randomly selected across types and domains of service in RMNCH among all providers present at time of survey, made up of doctors, nurses and midwives.

Participants recruitment and registration

Once the households were selected, the data collection team began their visits. The team first contacted the head of the household or their representative, in order to obtain their consent to participate in the study. A questionnaire was administered for the composition of the household, and in order to have some household characteristics. The head of the household or their representative gave their authorization for the participation of the other members of the household in the study. To this end, a person was randomly drawn among men aged 15 to 54 and another among women aged 15 to 49. The data collection agents first requested informed consent from the selected individuals before administering the questionnaires.

Informed consent

Informed consent was collected from participants and in a private setting. For the women, the interviews were conducted in isolated places and in the absence of a third party. Study participants were given the option to sign the consent form, decline, or postpone the decision. Individuals were given time to decide whether they wanted to participate or not. It was made clear to all participants that the purpose of the study was to establish baseline values for the USAID Kulawa project intervention, and that at the end of the intervention a similar exercise would be conducted to determine the extent to which the project had brought changes in health sector.

Additionally, participants were assured that they could decline to answer any questions posed by the interviewers, and that they could withdraw their consent at any time. The questionnaires were given by interviewers of the same gender as the participants in order to minimize discomfort and bias. A document to obtain specific consent for unmarried minors between the ages of 15 and 17 had been drawn up. This consent was obtained from their biological or adoptive parents, in order to obtain their consent for questioning these minors. The children were then informed that their parents agreed for them to be interviewed but they also had the choice of accepting or refusing the interview without any constraint or discomfort. As marriage automatically confers emancipatory majority status, there was no specific consent for married minors. At health facility level, letters of authorization from the Niger Ethics Committee and the

General Secretariat of the Ministry of Public Health, Population and Social Affairs facilitated the collaboration of service providers for the survey. On the day of the interviews, the collection agent obtains the consent of the head of the health facility to conduct all the interviews necessary for the study. Subsequently, an isolated office was chosen to conduct the various interviews in order to guarantee confidentiality without disrupting service delivery.

2.4 Assessment tools

The tools used for this evaluation survey consisted of an individual questionnaire for "Women aged 15 to 49", an individual questionnaire for "Men aged 15-59", an "Inventory of health centers" and an individual “Healthcare provider” questionnaire. The tools included aspects from previously validated tools from DHS (version 8) and custom, newly designed components that were validated by the USAID Kulawa gender and FP teams. Data collection was conducted using the ODK application installed on tablets. The individual female questionnaire was administered to female members who fulfilled the criteria and who had given their consent to participate in the evaluation. The household and male questionnaires were also administered to obtain information on the households of the eligible women. The household questionnaire was addressed to the head of household or to any competent member of the household, able to provide information on the household. The individual male questionnaire only concerned the spouses of the women interviewed.

Data security

The management of the data collected followed security protocols. Necessary measures were taken to ensure data confidentiality and avoid any breach with security level and restriction parameters set according to the tasks (server access, data management, safeguarding, etc.). Data files are stored on an ONA server with limited access. A sufficiently strong password protects any unauthorized access to its content.

2.5 Results evaluation indicators

The USAID Kulawa monitoring and evaluation framework includes monitoring indicators. Annex 6 on collection tools by indicator presents a summary of the evaluation indicators included in this report.

2.6 Recruitment and training of data collection agents

The recruitment of survey agents was conducted from November 1 to 6, 2022 in Niamey, respecting the usual procedure for recruiting data collection agents at GRADE Africa. This is successively the recruitment announcement, the receipt of application forms, the review of application forms, the pre-selection of potential candidates and the interview for the selection of candidates to be trained. After the training and based on the performance of the participants, 54 interviewers, including twelve team leaders, were retained and nine interviewers were put on the waiting list as reservists.

From November 9 to 14, 2022, at the General Seyni Kountché Stadium in Niamey, the selected candidates were trained on the USAID Kulawa project, the study (Methodology, Assent/consent forms, Questionnaires), the ODK application and its use and ethical principles.

2.7 Monitoring and follow-up

Data collection took place from November 17 to December 3, 2022. An itinerary had been drawn up for each team in order to facilitate their movement and vehicle management. The methodology adapted in the field consisted first of presenting the objective of the mission to the village chief, convening a village general assembly to explain to the whole community the objective of the mission and to ask for their cooperation. After this presentation to the community, the data collection agents proceeded first to count the households, then to select the eligible households. Each team leader established the distribution of households to be surveyed by each interviewer. In accordance with the protocol of this study, consent/assent was required before each interview through the forms previously prepared for this purpose for households and also for health facilities.

For the CSs whose village names did not appear in the file, the heads of the respective CSIs, sometimes with the assistance of village chiefs, helped to identify and find them. In order to have quality data, the team leaders, in addition to conducting the survey, checked the completed forms before sending them to the server. After each village, the teams were invited to synchronize the data collected. At central level, data extraction was conducted every two days to check the quality of the data. The central coordinator was responsible for conducting this task and sharing the observations and comments resulting from the analysis with the various regional supervisors, who in turn passed on the information to the team leaders. About 35% of the questionnaires were checked for quality.

2.8 Data collection report

The population data collected are recorded in Table 5. The highest non-response rate, which nevertheless remains low, was 6% in the Zinder region. It remains close to that recorded in Maradi (5%). The non-response rate was almost negligible in Tillabéri (1%). This non-response rate remains overall lower than the error rate introduced when calculating the sample, which is 7%.

Table 5: Number of households surveyed and non-response rate

Region	Expected	Surveyed	Non-response rate
Maradi	1280	1213	5%
Tillabéri	1280	1263	1%
Zinder	1280	1202	6%
Total	**3840**	**3678**	**4%**

For health facilities, 146 were surveyed. The CSIs are the most numerous (83), followed by the CS, which number 48 for all three regions.

Table 6: Number of health facilities and service providers surveyed

Structure type	Maradi	Tillabéri	Zinder	Total
District Hospital (DH)	4	3	5	12
Mother and Child Health Center (MCHC)	1	1	1	3
Centre de santé intégré/integrated health centers (CSI)	27	29	27	83
Case de sante/health post (CS)	18	6	24	48
Total health facilities	**50**	**39**	**57**	**146**
Providers surveyed	**84**	**71**	**99**	**254**

A Mother and Child Health Center (MCHC) was surveyed in each region. For district hospitals (DH), 4 were surveyed in Maradi, 3 in Tillabéri and 5 in Zinder, making a total of 12 district hospitals.

The selection of CSI and CS depended on the random choice of sites or villages. Once the sites or villages had been randomly selected, the sites or villages come with their linked CSI and CS. In the case of Tillabéri region, the selected sites or villages are attached to 6 CS and 29 CSI.

2.9 Limitations

This study has some contextual or methodological limitations. The results of the study are only representative of the USAID KULAWA project intervention. It should be noted that the volatile security situation made it impossible to visit some initially sampled villages which were subsequently substituted. Some health facilities considered CSIs do not have the required staff and adequate services of a CSI. According to information received from mothers in the Tillabéri region, the health record book of some children was kept by providers due to non-payment of the 1,000 CFA franc ($1.65) fee required by the health structures.

3. MAIN RESULTS

3.1 Sociodemographic characteristics of the population surveyed

The study's target population consists of women aged 15 to 49 and men aged 15 to 54. The survey results show that adolescents and young people represent 40.9% among women and 21.6% among men. Overall, the 25 to 29 age group is the most represented in the sample for both sexes. Regional disparities across age groups are observed. The proportion of women aged 15-24 are almost equivalent in Tillabéri (38.6%) and Zinder (39.7%) but higher in Maradi (43.3%). Among men, regional disparities are observed among 30-34 years old with 17.0% in Tillabéri and 18.4% in Zinder against 11.8% in Maradi.

The distribution of the population by marital status indicates a high proportion of monogamous married people among women (67.7%) as well as among men (62.8%). Single people are relatively poorly represented with 6.0% among women and 17.3% among men. Regional analyses highlight differences according to the marital status of respondents. Polygamous married women are more represented in Maradi (29.6%) than in Tillabéri (15.4%) and Zinder (20.9%). The same trends emerge among men. With regard to the level of education, the majority of women (56.9%) have no education while among men, Koranic instruction (51.6%) represents the large part of the sample. Analyses by region highlight disparities of attendance at secondary level of education, regardless of gender. Indeed, women from Zinder (2.5%) are less represented than those from Maradi (9.0%) and Tillabéri (11.2%) for secondary education. Household heads represent 82.2% among men against 13.3% among women. At regional level, there are more female heads of households in Zinder (20.3%) compared to Maradi (9.5%) and Tillabéri (8.4%).

Table 7: Sociodemographic characteristics of the population surveyed

Age groups	Maradi n=1011	Tillabéri n=920	Zinder n=709	Overall n=2640	Maradi n=819	Tillabéri n=549	Zinder n=669	Overall n=2037
	Women				Men			
15-19 years	23.0%	19.8%	19.1%	20.8%	14.4%	12.8%	6.5%	10.8%
20-24 years	20.3%	18.8%	20.6%	20.1%	11.8%	12.2%	9.3%	10.8%
25-29 years	23.3%	20.1%	20.7%	21.6%	19.3%	15.6%	17.2%	17.8%
30-34 years	12.6%	15.9%	14.9%	14.2%	11.8%	17.0%	18.4%	15.5%
35-39 years	10.1%	12.3%	10.0%	10.6%	14.3%	14.8%	18.1%	16.0%
40-44 years	5.2%	7.7%	8.7%	7.1%	13.3%	13.1%	12.9%	13.1%
45-49 years	5.5%	5.3%	6.1%	5.7%	9.0%	14.4%	9.4%	10.2%
50-54 years	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	8.1%	5.8%
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Marital Status	**Maradi**	**Tillabéri**	**Zinder**	**Overall**	**Maradi**	**Tillabéri**	**Zinder**	**Overall**
	Women				Men			
Married monogamous	61.6%	73.2%	70.8%	67.7%	57.1%	64.5%	68.5%	62.8%
Married polygamist	29.6%	15.4%	20.9%	23.1%	22.1%	8.7%	22.1%	18.5%
Divorced / Separated	0.7%	1.5%	5.0%	2.5%	0.6%	1.3%	1.1%	0.9%
Widower / widow	0.6%	0.7%	0.6%	0.6%	0.0%	1.1%	0.5%	0.4%

Single / Never Married	7.5%	9.1%	2.7%	6.0%	20.2%	24.4%	7.9%	17.3 %
Free Union	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100. 0**
Education								
None	53.5 %	56.1%	61.0%	56.9%	8.6%	27.1%	11.5%	14.5 %
Literate	7.9%	0.4%	5.0%	5.1%	6.0%	0.9%	1.1%	3.0%
Koranic	17.2 %	12.7%	25.4%	19.3%	43.4%	35.0%	75.5%	51.6 %
Primary	12.4 %	19.3%	6.1%	11.6%	21.9%	22.2%	7.0%	17.1 %
Secondary	9.0%	11.2%	2.5%	7.0%	19.4%	14.2%	4.6%	13.2 %
Superior	0.0%	0.4%	0.0%	0.1%	0.9%	0.6%	0.3%	0.6%
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100. 0**
Relationship								
Head of household	9.5%	8.4%	20.3%	13.3%	80.3%	74.3%	91.9%	82.5 %
Wife or husband	81.7 %	75.3%	73.3%	77.1%	0.1%	0.0%	0.2%	0.1%
Son or daughter	8.1%	11.0%	5.1%	7.6%	18.8%	22.0%	7.2%	15.9 %
Son / daughter-in-law	0.2%	3.2%	0.2%	0.9%				
Grandson/daughter or child of wife/ husband	0.2%	0.4%	0.2%	0.3%	0.6%	1.5%	0.5%	0.8%
Father / mother	0.0%	0.1%	0.0%	0.0%				
Brother or sister	0.0%	0.2%	0.0%	0.1%	0.0%	1.1%	0.3%	0.4%
Co-wife	0.1%	0.0%	0.6%	0.3%				
Other relative	0.1%	0.5%	0.2%	0.2%	0.0%	0.6%	0.0%	0.2%
Adopted/ guardianship	0.0%	0.9%	0.0%	0.2%	0.1%	0.4%	0.0%	0.2%

Not related	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.1%
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

3.2 Family planning knowledge, use and attitudes

This section assesses the study population's levels of knowledge and use of contraceptive methods, as well as their attitudes about family planning.

3.2.1 Knowledge of FP and other health services

This indicator is the proportion of men (aged 15-54 years) and women (aged 15-49 years) with knowledge of FP/other health services within the target population. A person is assumed to know about FP methods/other health services only when they meet at least three (3) of the following: a) can identify at least three (3) family planning methods (modern or traditional); b) states where a modern FP method can be obtained; c) can identify the period of a woman's menstrual cycle when she is most likely to become pregnant; and, d) can identify as a myth the belief that if a woman has already used a contraceptive method, it is more difficult for her to become pregnant later.

Table 8: Proportion of all men and women with knowledge of FP

FP knowledge (%)		Maradi	Tillabéri	Zinder	Overall
Women (15-49 years)	Yes	**66.3%**	**59.2%**	**33.1%**	**52.1%**
	No	33.7%	40.8%	66.9%	47.9%
	Total	100.0	100.0	100.0	100.0
Men (15-54 years)	Yes	**4.6%**	**9.5%**	**0.4%**	**3.7%**
	No	95.4%	90.5%	99.6%	96.3%
	Total	100.0	100.0	100.0	100.0
Total	**Yes**	**39.2%**	**40.3%**	**18.2%**	**31.1%**
	No	60.8%	59.7%	81.8%	68.9%
	Total	100.0	100.0	100.0	100.0

The results of the study (Table 8) show that 52.1% of women and 3.7% of men demonstrated having a broad knowledge of modern contraceptive methods (at least three of the aforementioned criteria).

3.2.2 Promotion of RH/FP messages by the United States Government

The indicator is the percentage of the audience who recall hearing or seeing a specific FP/RH message promoted by the United States Government (USG) within the previous 24 months. The “audience” is defined as the target population for the particular FP/RH message (e.g., women of childbearing age). “Recall” refers to the percentage that can spontaneously name (or recognize when mentioned) a particular FP/RH message. “Specific FP/RH message promoted by USG” refers to a communication promoted by USG with an identifiable aspect (e.g., logo, character, etc.) that the respondent could not name unless s/he had

been exposed to the communication. This indicator is calculated as a percentage and is specific to the reporting year.

Numerator: sample-weighted number of audience who recall a specific FP/RH message promoted by the USG.
Denominator: total sample-weighted number of audience surveyed x 100.

The United States Government, through its Agency for International Development (USAID), supports family planning and reproductive health programs in Niger. This support aims, among other things, to raise awareness and inform populations about the dimensions of FP, to make FP services available and to organize advocacy actions to help populations benefit from these services without major constraints.

Table 9: Proportion of audience who recalled hearing or seeing a specific message (RH/FP) promoted in the past 24 months by USG-funded programs

RH/FP Message Promoted by USG Funded Programs	Region			Overall
	Maradi	Tillabéri	Zinder	
Women (15-49 years)				
Yes	**32.9%**	**25.2%**	**41.8%**	**34.5%**
No	67.1%	74.8%	58.2%	65.5%
Total	100.0	100.0	100.0	100.0
Men (15-54 years)				
Yes	**46.7%**	**28.2%**	**11.8%**	**28.9%**
No	53.3%	71.8%	88.2%	71.1%
Total	100.0	100.0	100.0	100.0
Overall				
Yes	**39.0%**	**26.3%**	**28.1%**	**32.1%**
No	61.0%	73.7%	71.9%	67.9%
Total	100.0	100.0	100.0	100.0

The results show that more than one in three women (34.5% of women aged 15 to 49) from the three regions declared having heard a specific reproductive health/family planning message promoted by programs funded by the USG. Women in the Zinder region seem to have more access to the messages, with 41.8%. The Tillabéri region records the lowest level of exposure to the messages, with 25.2%.

3.2.3 Current use of modern contraception

The results show that 12.0% of the women surveyed are currently using a modern contraceptive method in the project area.

Table 10: Rate of use of modern contraceptive methods

Usage rate	Maradi	Tillabéri	Zinder	Overall
All methods				
All women	23.6%	14.8%	6.7%	15.2%
Women 15-24 years	18.3%	12.1%	8.0%	13.2%
Women 25-49 years	27.6%	16.5%	5.9%	16.6%
Modern Methods				
All women	17.4%	14.7%	4.8%	12.0%
Women 15-24 years	12.7%	12.1%	6.3%	10.2%
Women 25-49 years	20.9%	16.3%	3.8%	13.2%

The highest rate of use among women is in Maradi region with 17.4% of users. The Zinder region has the lowest rate of use of modern contraceptive methods (4.8%).

3.2.4 Attitudes about family planning

The indicator is the proportion of the target population with a positive attitude towards FP and FP methods. It measures the attitudes towards FP of individuals among the target populations in the project area in order to allow USAID Kulawa to measure attitudinal factors contributing to behavioral outcomes, and to help the project prioritize intermediate factors for implementation. Key elements of the definition:

Target audience: Men (15-54 years); Women of childbearing age (15-49 years)
"Positive" attitude towards FP: a positive attitude is a favorable or positive evaluation of FP brought about by beliefs, experience, or emotions.

Inquiry statements:

The survey statements use a 5-point Likert scale (i.e., strongly agree, agree, neither agree nor disagree, disagree, strongly disagree); a "positive" score per question should either strongly agree/agree or disagree/strongly disagree, depending on the focus of the question, and indicate a favorable assessment of FP.

To what extent do you agree or disagree with the following statements:

1. A husband and wife should talk about birth spacing and contraceptive methods.
2. Men whose wives use contraceptives lack authority over their wives and families.*
3. It is shameful to be associated with a woman who uses contraceptives.*
4. A wife is justified in asking her husband to use a condom if she knows he has .a disease that can be sexually transmitted.
5. A husband and wife should use contraceptives to limit the number of children they have.

** Signifies reverse scoring*

Numerator: sample-weighted number of target audience with a positive attitude towards FP and FP methods
Denominator: Sample-weighted number of target audience surveyed

The analyses show that, in all the regions studied, 9 women out of 10 aged 15 to 49 (90.1%) have a positive attitude towards family planning. The regions of Maradi (95.6%) and Tillabéri (96.8%) record higher rates of women with a positive attitude towards family planning. Women in Zinder region seem less favorable to family planning with a rate of 80.5%.

Table 11: Proportion of target population with a positive attitude towards FP

Attitudes toward FP		Maradi	Tillabéri	Zinder	Overall
Women	Positive	95.6%	96.8%	80.5%	90.1%
	Negative	4.4%	3.2%	19.5%	9.9%
	Total	100.0	100.0	100.0	100.0
Men	Positive	85.3%	85.0%	82.0%	83.9%
	Negative	14.7%	15.0%	18.0%	16.1%
Total	Total	100.0	100.0	100.0	100.0
	Positive	**91.1%**	**92.3%**	**81.2%**	**87.4%**
	Negative	8.9%	7.7%	18.8%	12.6%
	Total	100.0	100.0	100.0	100.0

For all the regions of the study, nearly 4 out of 5 men (83.9%) have a positive attitude towards family planning. The regions of Maradi and Tillabéri, as with women, have the highest proportions of men with a positive attitude. Analyses by sex reveal that women (90.1%) have a more positive perception of FP than men (83.9%).

3.2.5 Demand satisfied for family planning

The main indicator is the percentage of adolescent girls and young women (15-24 years), or their partners, who are in union or sexually active, unmarried, and who do not want a child or no more children (limitation), or delay the next pregnancy (spacing) and are currently using a modern method of contraception. Women using a traditional method are assumed to have an unmet need for modern contraception.

Numerator: number of adolescent girls and young women (aged 15-24 years) using any modern contraceptive method, including female sterilization, male sterilization (partner), pill, IUD, injectables, implants, male condom (partner), female condom, emergency contraception, a vaginal method, the lactational amenorrhea method, or other modern methods.
Denominator: Total number of adolescent girls and young women (ages 15-24) who have a met or unmet need for family planning (total demand for family planning).

The **procedures for calculating** the indicators on the need and demand for FP are detailed in Annex 7.

Table 12: Indicators of contraceptive demand and unmet need (15-24 years)

Indicators	Maradi	Tillabéri	Zinder	Overall
Unmet need for spacing (%)	1,6%	0,8%	0,4%	1,0%
Unmet need for limiting (%)	0,2%	0,0%	0,0%	0,1%
Total unmet need (%)	1,8%	0,8%	0,4%	1,1%
Met need for spacing (%)	19,2%	13,2%	4,6%	13,4%
Met need for limiting (%)	0,7%	0,0%	0,4%	0,4%
Total met need (%)	19,9%	13,2%	4,9%	13,8%
Total demand for FP (spacing) (%)	20,8%	14,0%	4,9%	14,4%
Total demand for FP (limiting) (%)	0,9%	0,0%	0,4%	0,5%
Total demand for FP (%)	21,7%	14,0%	5,2%	14,8%
Demand satisfied by modern methods (%)	67,0%	94,2%	66,7%	75,6%
Demand satisfied by all FP methods (%)	91,8%	94,2%	93,3%	92,7%

A significant portion of total contraceptive demand among young people (14.8% in the three regions) is met by modern or traditional contraceptive methods (92.7%). Considering only modern methods, this coverage is 75.6% for all three regions. Tillabéri is distinguished by a high proportion of demand satisfied by modern methods (94.2%). This does not seem to be the case for Zinder and Maradi (91.8% and 67.0%).

The proportion of unmet need for family planning among people remains low overall, with 1.3% of total unmet need. While these unmet needs are lower in Tillabéri (0.0%) and Zinder (0.0%), they are relatively higher in Maradi (3.0%). Also, in Maradi, the unmet need for birth spacing is greater than for limitation.

The overall results for women aged 15-24 years showed significant regional differences. In Maradi, the demand for FP demand is 21.7%, most of which is for spacing. Among the 21.7% with a demand for FP, 67% have their demand satisfied with a modern method. Compared to other regions, Maradi has a somewhat stronger demand for FP, but only two thirds of it is met by a modern method. The goal of the project in Maradi could be to close the gap of demand satisfied by modern methods by helping to shift users of traditional FP methods to modern methods, while working to increase knowledge, understanding and access to modern methods for those with an unmet need. Conversely, in Zinder, the situation is slightly different. There, total demand is very low (5.2%), and demand satisfied by a modern method is similar to Maradi (66.7%). Here, it may be more useful to focus on increasing demand for FP, particularly on improving knowledge about the healthy timing and spacing of pregnancies, as well as improving attitudes towards FP (e.g., dispelling myths, promoting joint decision-making on FP use with partners, etc.). The modern method contraceptive prevalence rate (mCPR) cannot increase in Zinder if the demand for FP does not increase first.

3.3 Fertility and prenatal care

3.3.1 Adolescent fertility

The indicator is the adolescent birth rate or the number of births to women aged 20-24 years per 1,000 women during the previous five years (WHO 2010). It is a subset of the age-specific fertility rates (TFPA/ASFR).

Numerator: number of live births to girls aged 20-24 years in the previous five years (total weighted number of live births over the last 5 years divided by 5).
Denominator: Total population of adolescent girls aged 20-24 surveyed.

In terms of reproductive health, adolescent fertility plays a major role. Maternity-related death risks are high for adolescent girls and their babies. In Niger, women aged 20-24 years record 34% of maternal deaths (EDSN, 2012) and their babies are five times less likely to survive than those of women aged over 24 years. Neonatal and infant mortality rates are 43‰ and 72‰ respectively (ENAFEME-2021).

Table 13: Adolescent fertility rate

Region	Surveyed population of women aged 20-24 years	Total number of live births of 20-24 year olds over the last five years	Crude birth rate (per 1000) of adolescent girls
Maradi	205	325	282
Tillabéri	194	244	249
Zinder	145	222	290
Total	**544**	**791**	**278**

Table 13 shows that the rate of 278 live births per 1,000 adolescent girls aged 20-24 years in the previous five years is still high in the USAID Kulawa project regions (Maradi, Tillabéri and Zinder). The Tillabéri region is characterized by a lower rate of 249‰ compared to the other regions which have rates above 280‰.

3.3.2 Antenatal consultations

The indicator is the percentage of women who had four or more antenatal visits during the last pregnancy. This indicator measures the percentage of women of reproductive age (15-49 years) with a live birth who received antenatal care (ANC) four or more times during their most recent pregnancy. ANC should be provided by trained health personnel. “Skilled health personnel” refers to doctors, nurses, midwives, skilled birth attendants or clinical officers. Visits to trained or untrained traditional birth attendants (TBAs) are excluded.

Numerator: sample-weighted number of women (15-49 years) who received at least four antenatal visits with a skilled health professional during the most recent pregnancy that resulted in a live birth in the past five last years.
Denominator: sample-weighted number of women (15-49 years) who had a live birth in the past five years.

Prenatal visits are a great opportunity to raise awareness and strengthen women's reproductive freedoms. In addition to medical monitoring of pregnancy and promotion of infant feeding, these visits are opportunities to offer contraceptive methods to women.

Table 14: Proportion of women aged 15 to 49 who made at least one antenatal visit during their last pregnancy

Antenatal consultations during the last pregnancy	Maradi n=781	Tillabéri n=563	Zinder n=475	Total n=1819
Yes	93.5%	93.5%	91.2%	92.7%
No	6.5%	6.5%	8.8%	7.3%
Total	**100.0**	**100.0**	**100.0**	**100.0**

The results in Table 14 show that 9 out of 10 women made at least one prenatal visit during their last pregnancies, in the three regions. No significant regional disparities were observed.

As for the analysis of the number of prenatal visits conducted, the results of the survey (Table 15) show that 5 out of 10 women made four or more prenatal visits during their last pregnancies in the regions of Maradi, Tillabéri and Zinder.

Table 15: Proportion (%) of women aged 15 to 49 having attended 4 ANC or more during the last pregnancy

Number of ANC	Maradi n=781	Tillabéri n=563	Zinder n=475	Total n=1819
4 ANC and more	55.4%	52.1%	49.6%	52.6%
Less than 4 ANC	44.6%	46.0%	48.8%	46.4%
No response	0.0%	1.9%	1.6%	1.0%
Total	**100.0**	**100.0**	**100.0**	**100.0**

Full monitoring of the pregnancy is a guarantee for a safe motherhood, but this follow-up must be provided by qualified personnel (doctor, nurse, midwife) for better care of the pregnant woman.

3.3.3 Prenatal consultations by a health professional

Data on prenatal consultations were collected during the facility assessment, at facility level. This might be the reason why most women were counseled by a qualified health professional. Data analysis shows that most prenatal consultations for women of reproductive age are provided by qualified personnel, i.e.,

personnel with the knowledge and skills necessary to assist the woman during pregnancy and capable of provide effective care for both mother and child after birth.

Table 16: Proportion of women whose antenatal consultations were provided by a qualified health professional

Antenatal consultations by a qualified health professional	Maradi n=781	Tillabéri n=563	Zinder n=475	Total n=1819
Yes	93.5%	93.0%	89.4%	92.1%
No	6.5%	6.3%	10.6%	7.9%
Total	**100.00**	**100.00**	**100.0**	**100.0**

The results in Table 16 show that 9 out of 10 consultations are carried out by a Doctor, a Nurse or a Midwife.

3.4 Gender-based violence (GEM scale)

3.4.1 Population opinion on violence against women

The indicator is the proportion of people who consider wife beating an acceptable way for a husband to discipline her for any reason. The "target population" reflects a group intended to benefit from domestic violence messages. Based on the WHO checklist found in the study on women's health and intimate partner violence against women, evaluators can ask:

Sometimes a husband is annoyed or irritated by the things his wife is doing. In your opinion, would a husband be justified in hitting or beating his wife:

- If she is unfaithful?
- If she disobeys her husband?
- If she argues with her husband?
- If she refuses to have sex with him?
- If she doesn't clean the house properly?

Numerator: Sample-weighted number of respondents who answered “yes” to any of the questions related to what justifies the wife being beaten by her husband, as indicated above.
Denominator: Sample-weighted total number of respondents.

Table 17: Proportion of the target population stating that hitting or beating a wife would be justified

Justification for hitting or beating wife		Maradi Women (n=1011) Men (n=819)	Tillabéri Women (n=920) Men (n=549)	Zinder Women (n=709) Men (n=669)	Total Women (n=2640) Men (n=2037)
Men (15-54 years)	Yes	**27.0%**	**43.3%**	**29.9%**	**31.1%**
	No	73.0%	56.7%	70.1%	68.9%
	Total	100.0	100.0	100.0	100.0
Women (15-49 years)	Yes	**76.3%**	**85.1%**	**86.4%**	**82.1%**
	No	23.7%	14.9%	13.6%	17.9%
	Total	100.0	100.0	100.0	100.0
Total	Yes	**54.6%**	**69.2%**	**60.6%**	**60.0 %**
	No	45.4%	30.8%	39.4%	40.0 %
	Total	100.0	100.0	100.0	100.0

The results show that women approve of hitting or beating a wife more than men. It appears that 82.1% of women maintain that it would be justified to hit or beat a wife against 31.1% of men.

Analyses by region show that men in Tillabéri (43.3%) are far more likely to approve of hitting or beating their wives than men in Maradi and Zinder, 27.0% and 29.9%, respectively. On the other hand, women in Zinder (86.4%) approve of this more than those in Maradi and Tillabéri (76.3%, 85.1%).

Table 18: Proportions of target population stating that hitting or beating a wife would be justified, by type of question

	Maradi	Tillabéri	Zinder	Total	Maradi	Tillabéri	Zinder	Total
	Women				Men			
	● If she's unfaithful?							
Yes	50,1%	78,7%	78,4%	67,7%	20.3%	34.2%	19.6%	23.8%
No	44,1%	17,8%	17,6%	27,8%	73.0%	48.5%	69.2%	65.1%
Undecided	5,8%	3,5%	4,0%	4,5%	6.7%	17.3%	11.2%	11.1%
Total	100,0	100,0	100,0	100,0	100.0	100.0	100.0	100.0
	● If she disobeys her husband?							
Yes	48,3%	58,4%	55,4%	53,7%	17.1%	29.3%	12.3%	18.8%
No	46,3%	33,8%	39,6%	40,2%	76.6%	54.3%	73.4%	69.5%
Undecided	5,4%	7,8%	4,9%	6,1%	6.4%	16.4%	14.4%	11.7%
Total	100,0	100,0	100,0	100,0	100.0	100.0	100.0	100.0
	● If she quarrels with her husband?							
Yes	36,6%	45,0%	25,7%	36,6%	12.8%	23.3%	11.1%	15.1%
No	57,8%	40,3%	70,8%	55,2%	79.1%	61.6%	77.1%	73.7%

	Maradi	Tillabéri	Zinder	Total	Maradi	Tillabéri	Zinder	Total
	Women				Men			
Undecided	5,6%	14,7%	3,5%	8,2%	8.1%	15.1%	11.8%	11.2%
Total	100,0	100,0	100,0	100,0	100.0	100.0	100.0	100.0
	• If she refuses to have sex with him?							
Yes	38,7%	60,1%	34,4%	45,0%	12.9%	21.9%	22.7%	18.6%
No	55,0%	30,7%	57,4%	47,2%	75.7%	57.9%	70.0%	69.0%
Undecided	6,3%	9,2%	8,2%	7,8%	11.4%	20.2%	7.3%	12.4%
Total	100,0	100,0	100,0	100,0	100.0	100.0	100.0	100.0
	• If she doesn't do the housework properly?							
Yes	30,0%	40,0%	41,8%	36,6%	7.0%	17.9%	9.1%	10.6%
No	65,5%	50,4%	53,6%	57,1%	83.8%	67.9%	77.1%	77.3%
Undecided	4,6%	9,6%	4,7%	6,3%	9.3%	14.2%	13.8%	12.1%
Total	100,0	100,0	100,0	100,0	100.0	100.0	100.0	100.0

3.4.2 Gender Equitable Men (GEM) Scale

The indicator is the percentage of the target population with at least a moderate equity score on the GEM scale. This index measures attitudes towards gender norms for intimate relationships or different social expectations for men and women, using the Gender Equitable Men (GEM) scale.

Numerator: The number of sample-weighted target people who score moderate or high on the GEM scale.
Denominator: the number of target people interviewed.

The GEM scale calculation procedures are detailed in Annex 8.

Scoring procedures:

Each of the above items is rated on a 3-point scale, where 1 = agree, 2 = partially agree, and 3 = disagree. The answers to each item should be added together according to the point value assigned to the answer. The total point value for the GEM scale ranges from 24 to 72. Each score results in a low equity score (24-39 points); moderate (40-56 points); and high (57-72 points).

Table 19 presents the results of the index according to the percentage of men and women ranked low, medium, and high in terms of overall acceptance of more equitable norms. The GEM scale was constructed from responses from the following four sub-themes: violence domain, sexual relations domain, reproductive health and disease prevention domain, and domestic chores, and everyday life domain.

The GEM scale analysis results show that 5.8% of men and 2.9% of women strongly support equitable gender norms. By region, men from Zinder (8.7%) and Tillabéri (6.5%) approve of fair gender norms more

than those from Maradi (2.4%). Among women, Tillabéri records the highest rate of high equity (12.0%) against very low rates of high equity in Maradi (0.1%) and Zinder (0.3%).

Table 19: Target population proportion who support equitable gender norms

GEM scale		Maradi	Tillabéri	Zinder	Total
Men	Low equity	25.8%	39.6%	21.5%	26.5%
	Moderate equity	71.8%	53.9%	69.8%	67.7%
	High equity	2.4%	6.5%	8.7%	5.8%
	Total	**100.0**	**100.0**	**100.0**	**100.0**
Women	Low equity	68.8%	65.1%	56.1%	63.1%
	Moderate equity	31.1%	22.9%	43.7%	34.0%
	High equity	0.1%	12.0%	0.2%	2.9%
	Total	**100.0**	**100.0**	**100.0**	**100.0**
Total	Low equity	49.8%	55.4%	40.3%	47.2%
	Moderate equity	49.1%	34.7%	55.6%	48.7 %
	High equity	1.1%	9.9%	4.1%	4.1%
	Total	**100.0**	**100.0**	**100.0**	**100.0**

It should be noted that, in all regions, men scored higher on the GEM scale than women.

3.5 Vaccination of children by 12 months

The indicator is the percentage of children who are completely vaccinated by 12 months (one dose of BCG vaccine, three doses of poliomyelitis vaccine, three doses of DPT3 vaccine and one dose of measles vaccine).

Numerator: number of surveyed children (aged 12-23 months) who received 1*BCG, 3*DTP3 and 1* measles vaccines by 12 months and have appropriate documentation.
Denominator: Total number of surveyed children (aged 12-23 months) with vaccination card.

Only children whose vaccination card was seen by the data collection agent were included in the denominator and among these children only those who are fully vaccinated were identified. It should also be noted that children whose vaccination dates are not reported on the cards were not considered in the numerator.

Vaccination is recognized as one of the most effective measures to prevent mortality, morbidity, and complications from infectious diseases in children. According to USAID's performance indicator, a child is considered fully immunized when it has received one BCG vaccine, three doses of DTP3 vaccine and one dose of measles vaccine. During the survey, the information collected on the vaccination of children aged 12-23 months comes from two complementary sources: vaccination records and/or cards (which makes it

possible to accurately establish vaccination completeness, as well as the compliance with the vaccination schedule), and the mother's declaration, based on the answers given when no vaccination document for the child was available.

Table 20: Proportion of children aged 12-23 months according to vaccination card availability

Vaccination card availability		Maradi n=576	Tillabéri n=641	Zinder n=579	Total n=1796
Vaccination card	Yes, verified	52.2%	33.1%	39.1%	43.1%
	Yes, not verified	37.5%	51.5%	43.7%	42.9%
	No record	10.3%	15.4%	17.2%	14.0%
	Total	**100.0**	**100.0**	**100.0**	**100.0**

The analyses of vaccination cards availability show that the cards of 43.1% of the children were seen by the data collection agents in all the regions of the study. The availability of the cards is highest in Maradi (52.2%), followed by Zinder (39.1%). In Tillabéri, vaccination records were scarcely available (31.1%).

The results also show that 14.0% of children do not have a vaccination card. Zinder records the highest rate of children without vaccination cards (17.2%) and Maradi has the lowest rate (10.3%).

Table 21: Proportion of children aged 12-23 months completely vaccinated by 12 months of age (children with cards verified)

Vaccination card availability		Maradi n=79	Tillabéri n=67	Zinder n=78	Total n=224
Completely vaccinated	No	42.8%	71.3%	53.8%	51.2%
	Yes	57.2%	28.7%	46.2%	48.8%
	Total	**100.0**	**100.0**	**100.0**	**100.0**

The results of the study show that 48.8% of children aged 12 to 23 months are fully vaccinated in the three regions of the study. The vaccination rate is higher in Maradi (57.2%), followed by Zinder (46.2%). The Tillabéri region has the lowest vaccination rate (28.7%).

3.6 Service provision

3.6.1 Attitude of providers towards adolescents

The indicator is the percentage of providers with positive attitudes towards youth/adolescents using FP and other health services. This index measures health providers' attitudes toward adolescents (15-19 years) and youth (20-24 years) using family planning and other adolescent sexual and reproductive health services (ASRH).

Numerator: Number of providers who express positive attitudes towards youth/adolescents using FP and other health services
Denominator: number of providers studied during the USAID Kulawa assessment

The procedures for calculating provider attitude towards adolescent indicators are detailed in Annex 9.

Literature demonstrates that the unwelcoming behaviors and judgmental attitudes of health workers are real obstacles to the use (and/or continuity) of health services, particularly among adolescents. Adolescent embarrassment or embarrassment discussing sensitive topics with health providers, less supportive provider attitudes toward FP use, and disappointment with how health providers ask questions, uncertainty about what providers do with the information, and being treated disrespectfully, and even being refused service by their health providers are often cited as discouraging. Health providers are sometimes uncomfortable with topics or mistakenly believe that providing age-appropriate reproductive health information will encourage sexual activity.

Table 22: Proportion of providers with a positive attitude towards the use of FP and its services by adolescents

Service provider attitude	Maradi n=401	Tillabéri n=269	Zinder n=505	Total n=1175
Positive	35.7%	33.8%	46.5%	39.4%
Negative	64.3%	66.2%	53.5%	60.6%
Total	**100.0**	**100.0**	**100.0**	**100.0**

Our analyses (see Table 22) reveal that 39.4% of service providers in the study area say they have a positive attitude towards family planning. Service providers in Zinder seem more favorable than those of Maradi (35.7%) and Tillabéri (33.8%).

3.6.2 Health facilities with at least one service provider trained to care for and refer victims of sexual and gender-based violence (SGBV)

The indicator is the percentage of health facilities in the geographic area of study (e.g., country, region, community) with at least one provider who has been trained in the last three years in the identification, care and support of sexual gender-based violence (SGBV). This indicator is measured at DH, MCHC and CSI level, where USAID Kulawa-supported SGBV training takes place. CS level establishments are not included.

This indicator is calculated as follows:

> (Number of health facilities reporting having at least one provider who has been trained in the last three years for the clinical management of victims of SGBV/Total number of health facilities surveyed) x 100.

The results show that 53.3% of units have at least one service provider trained to deal with SGBV. Maradi (61.2%) and Tillabéri (58.5%) seem to have more health units with at least one service provider trained to manage SGBV than Zinder (43.5%).

Table 23: Percentage of health facilities with at least one service provider trained to manage and refer SGBV

SGBV health facilities	Maradi	Tillabéri	Zinder	Total
Yes	61.2%	58.5%	43.5%	53.3%
No	38.8%	41.5%	56.5%	46.7%
Total	**100.0**	**100.0**	**100.0**	**100.0**

3.6.3 Delivery in a health facility and discharge with a modern contraceptive method

According to the results, 28.0% of women who gave birth in a facility started or left with a modern contraceptive method before discharge. Women from Tillabéri (37.0%) and Zinder (28.0%) seem to benefit from this advantage more than those from Maradi (23.0%).

Table 24: Percentage of women who give birth in a facility and who initiated or left with a modern contraceptive method before discharge

FP before discharge	Maradi n=32 197	Tillabéri n=14 132	Zinder n=38 599	Total n=84 928
Yes	23.0%	37.0%	28.0%	28.0%
No	77.0%	63.0%	72.0%	72.0%
Total	**100.0**	**100.0**	**100.0**	**100.0**

3.6.4 Delivery in a facility and counseling on post-partum family planning (PPFP) use before discharge

The analyses show that in the study area more than 3 women out of 5 (70.0%) who give birth in a facility receive advice on family planning before leaving.

The regions of Zinder (73.0%) and Tillabéri (87.0%) have more women receiving advice on family planning before discharge than in the Maradi region (59.0%).

Table 15: Percentage of women who give birth in a facility and received counseling on post-partum family planning before discharge

Advice before discharge	Maradi n=32 197	Tillabéri n=14 132	Zinder n=38 599	Total =84 928
Yes	59.0%	87.0%	73.0%	70.0%
No	41.0%	13.0%	27.0%	30.0%
Total	**100.0**	**100.0**	**100.0**	**100.0**

3.6.5 Newborns and postnatal care

Table 26: Number of newborns who receive postnatal care within two days of delivery in USG-supported programs

	Maradi	Tillabéri	Zinder	Total
Number of newborns receiving postnatal care within 48 days of delivery (September 2021 to August 2022)	15,473	6,654	31,090	53,217
Number of newborns receiving postnatal care within 48 days of delivery extrapolated to the USAID Kulawa zone*	**37,844**	**58,146**	**158,437**	**254,427**

* The results obtained from the sample were extrapolated to the entire population of the Kulawa zone by taking into account the proportion of the newborns that received postnatal care within 48 days compared to the total number of newborns recorded in the sampled population; and that proportion was then applied to the entire population of newborns of the 3 regions.

3.6.6 Service availability indicators

The indicator is the Service Availability Index which measures three tracer indicator areas: health infrastructure, health workforce and service utilization, using an unweighted average (see **Annex 10 for calculation procedures**). Studies show that barriers to health care utilization on the demand side exist but have less impact when health care services are available and accessible. This is why Niger and its partners are increasing their investments in health systems and ensuring that women and girls have access to health services. This study sought to assess the level of service availability in project areas. The general service availability index is a composite score of indicators calculated from three domains: health infrastructure, health personnel and use of services. The health infrastructure score is a composite score that includes three domains: facility density per 10,000 population, inpatient bed density per 10,000 population, and maternity bed density per 10,000 population. The service utilization score is a composite of two domains: outpatient visits and hospital utilization.

Table 27: Service availability indices

Indices (%)	Maradi	Tillabéri	Zinder	Total
Health Services Infrastructure Index	28.5	25.8	25.9	26.8
Health workforce index	6.8	4.1	4.6	5.3
Service utilization index	13.8	29.2	29.5	24.0
Service Availability Index	**16.4**	**19.7**	**20.0**	**18.7**

The results of the study (see Table 27) show that the overall service availability score in the USAID Kulawa project areas is 18.7%, indicating very low potential availability of health services. Indeed, the indices of infrastructure, health personnel and use of services amount to 26.8, 5.3 and 24.0 respectively against an

expected normal value of 100. These low scores can be attributed to poor scores in the following subdomains:

The density of one (1) health structure per 10,000 inhabitants is well below the target value of two (2) health structures per 10,000 inhabitants.
The inpatient bed density of 7.4 beds is much lower than the target value of 25 beds per 10,000 inhabitants.
The density of 2.2 maternity beds per 10,000 pregnant women is also well below the target value of 10 beds per 10,000 pregnant women.
The health professional workforce index of 5.3 agents per 10,000 inhabitants is almost four times lower than the WHO target of 23 agents per 10,000 inhabitants.
The hospital utilization score is 4.6 admissions against a norm of 10 admissions per 100 inhabitants.

Analyses by region show that health services are more available in Zinder (20.0) and Tillabéri (19.7) than in Maradi (16.4). Indeed, the differences are due to low use of services in the Maradi region with a score of 13.8 against 29 in Tillabéri and Zinder. It should be noted that Maradi records the highest index of health services infrastructure.

Since the USAID Kulawa project does not build structures, provide beds, or hire staff, project activities are unlikely to affect performance on this indicator.

CONCLUSION

This baseline survey measured the baseline indicators of the USAID Kulawa project, specifically highlighting levels of knowledge, use, and attitudes about FP; recent fertility and prenatal care; gender-based violence (GEM scale); vaccination of children aged 12-23 months; and health service availability indicators. The basic picture of contraceptive demand and unmet need for family planning indicates that in addition to improving the supply of RH/FP, the USAID Kulawa project must also work to create demand. In a context of low contraceptive prevalence such as in Niger, the low levels of unmet need for FP would express more a weakness of the demand than a performance of the supply or the accessibility of RH/FP products and services. In summary, the project main indicators are as follows:

Low knowledge of FP and other health services: 52.1% of women and 3.7% of men demonstrated having a broad knowledge of modern contraceptive methods and other health services. Two things contribute to low knowledge of contraceptive methods: low knowledge of when a woman is most likely to become pregnant and the myth that if a woman has already used birth control, it is more difficult for her to get pregnant later. Efforts are still needed to respond to these findings in order to increase the knowledge of the project areas' population on contraceptive methods.

Low modern contraceptive prevalence: 12.0% of women surveyed currently use a modern contraceptive method in the project area. Project activities should focus efforts on improving contraceptive use.

Positive attitudes towards family planning: in all the study regions, 8 out of 10 women aged 15 to 49 (83.9%), and more than 3 out of 4 men (90.1%), have a positive attitude towards family planning. A positive attitude reflects positive beliefs, experiences, or emotions with regards to family planning.

High adolescent fertility: the rate of 278 live births per 1,000 adolescent girls now aged 20-24 is still high in the project area. Considering the direct links between maternal mortality and early fertility, efforts are needed to raise the age at first pregnancy among adolescent girls in the project intervention areas.

Low prevalence of prenatal consultations: 5 out of 10 women (52.6%) made at least 4 prenatal visits during their last pregnancies. Complete monitoring of pregnancy being the guarantee of safe motherhood, efforts are still necessary so that all pregnant women can benefit from a minimum number of prenatal consultations by qualified personnel (doctor, nurse, midwife, qualified midwife).

Low level of gender equity approval (GEM scale): 5.8% of men and 2.9% of women strongly support equitable gender norms. Men approve of gender equity more than women. More effort and

commitment are expected from the USAID Kulawa project to improve indicators in the areas of violence, sexual relations, reproductive health, disease prevention, domestic chores and daily life.

Low achievement of child vaccination: 48.8% of children aged 12 to 23 months are fully vaccinated in the study regions. Conversely, 51.2% of children did not receive all the required vaccines. Efforts must be made by USAID Kulawa so that all children can benefit from this series of vaccinations in accordance with WHO recommendations, against the main vaccine-preventable diseases.

Very low health service availability score: the overall service availability score in the project areas of 18.7% indicates very low potential access to health services. Indeed, the indices of infrastructure, health personnel, and use of services amount to 26.8, 5.3 and 24.0 respectively against an expected normal value of 100. Efforts are still needed to improve the ratios of health facility per inhabitant; hospital beds per inhabitant; maternity beds per pregnant women and the ratios of health professionals per inhabitant.

Low contraceptive demand: nearly 20% of the women questioned would like to delay or stop future pregnancies. Women generally do not seem interested in limiting pregnancies and are generally not interested in spacing them. As knowledge of FP is low particularly among men, work could be directed to promote healthy timing and spacing of pregnancies, delaying the first pregnancy, and appropriately spacing of the subsequent ones. A key element in this regard is to improve knowledge about the health benefits of well-timed and spaced pregnancies, as well as knowledge about different FP method options to support this, including the promotion of more effective methods (such as the IUD and implants, which have higher protection rates and are less prone to misuse, such as method failure or gaps in coverage), and knowledge of how to stop use these methods when a woman wants to get pregnant again. Men will be very important actors in targeting the SBC interventions to support the delay of first pregnancies and the spacing of subsequent births.

ANNEXES

Annex 1: Health infrastructure sampled

Table 28: Health infrastructure

	Maradi	Tillabéri	Zinder	Total
a) Structures				
Number of district hospitals	4	3	5	12
Number of Mother and Child Health Centers	1	1	1	3
Number of CSIs	27	29	27	83
Number of CSs	18	6	24	48
Total number of health structures	50	39	57	146
Total number of health structures	314	169	391	874
Population in 2022 in the USAID Kulawa zone	**2,973,426**	**1,838,518**	**3,805,437**	**8,617,381**
Number of structures per 10,000 inhabitants	1,1	0,9	1,0	1,0
Target value	2,0	2,0	2,0	2,0
Score	52.8	46.0	51.4	50.7
b) Hospital beds				
Number of hospital beds	635	290	667	1592
Number of hospital beds per 10,000 inhabitants	2.1	1.6	1.8	1.8
Target value	25.0	25.0	25.0	25.0
Score	8.5	6.3	7.0	7.4
c) Maternity beds				
Number of maternity beds	156	100	157	413
Population of women aged 15-49 in 2022 in the USAID Kulawa zone	**644,311**	**396,441**	**813,783**	**1,854,535**
Number of maternity beds per 10,000 women	2.4	2.5	1.9	2.2
Target value	10.0	10.0	10.0	10.0
Score	24.2	25.2	19.3	22.3

Annex 2: Health personnel and use of services in the facility surveyed

Table 29: Health personnel

Health staff	Maradi	Tillabéri	Zinder	Total
a) Main health professionals				
Main health professionals	467	175	404	1046
Main health professionals per 10.000 inhabitants	1.6	1.0	1.1	1.2
Target value	23.0	23.0	23.0	23.0
Score	**6.8**	**4.1**	**4.6**	**5.3**
Use of services				
b) Use				
Outpatient consultations per year	222 454	181 256	402 956	806 666
Outpatient consultations per person/year	0.1	0.1	0.1	0.1
Target value	5.0	5.0	5.0	5.0
Score	**1.5**	**2.0**	**2.1**	**1.9**
c) Utilization				
Number of hospital discharges/year	77 903	103 855	216 310	398 068
Hospital discharges per 100/year	2.6	5.6	5.7	4.6
Target value	10.0	10.0	10.0	10.0
Score	**26.2**	**56.5**	**56.8**	**46.2**

Annex 3: USAID Kulawa zone demographics

Table 30: USAID Kulawa zone demographics

Region	Districts	Total population	12-23 months	PLW 15-49 years	10-24 years
Maradi	Aguié	352 248	27 980	76 329	117 190
	Dakoro	902 716	71 704	195 610	300 327
	Gazaoua	229 876	18 259	49 812	76 478
	Guidan Roumdji	749 924	59 568	162 501	249 494
	Tessaoua	738 662	58 673	160 061	245 748
Tillabéri	Balleyara	153 613	12 202	33 124	51 106
	Filingué	439 795	34 934	94 834	146 317
	Kollo	667 306	53 005	143 892	222 008
	Say	251 818	20 002	54 300	83 778
	Tillabéry	325 986	25 894	70 293	108 453
Zinder	Damagaram Takaya	345 788	27 467	73 946	115 041
	Dungass	507 374	40 302	108 501	168 800
	Gouré	470 025	37 335	100 514	156 374
	Kantché (Matameye)	572 345	45 462	122 395	190 415
	Magaria	828 367	65 799	177 145	275 592
	Mirriah	727 651	57 799	155 607	242 084
	Takeita	353 887	28 110	75 678	117 736
Total USAID Kulawa		**8 617 381**	**684 495**	**1 854 542**	**2 866 941**

***Source**: INS Niger, 2017 (https://www.stat-niger.org/projections)*

Annex 4: Key primary indicators

Table 31: Key primary indicators

Performance indicator	Data collection method
1. Modern contraceptive method prevalence rate	Household survey
2. Teenage birth rate	Household survey
3. Service Availability Index	Structural assessment
4. Percentage of children 12-23 months fully immunized	Household survey
5. Percentage of health units with at least one service provider trained to manage and refer SGBV	Structural assessment
6. Percentage of adolescent girls and young women whose family planning needs are met with modern methods	Household survey
7. Number of newborns receiving postnatal care within two days of delivery in USG-supported programs	Structural assessment
8. Percentage of women who had four or more antenatal visits during last pregnancy	Household survey
9. Percentage of target population with at least moderate equity score on the Gender Equity Men (GEM) scale	Household survey
10. Percentage of providers with positive attitudes toward FP use, youth/adolescents using FP and other services	Structural assessment
11. Percentage of target population with better knowledge of FP/other health services	Household survey
12. Percentage of target population with positive attitudes towards FP	Household survey
13. Percentage of audience who recall hearing or seeing a specific USG-supported family planning/reproductive health (FP/RH) message	Household survey
14. Percentage of women who give birth in a facility and start or leave with a modern contraceptive method before discharge	Structural assessment
15. Percentage of women who deliver in a facility and receive pre-discharge family planning counseling	Structural assessment

Annex 5: List of sites

Table 32: List of sites

No	Region	Communes	District	CSI	CS	Villages
1	Maradi	Aguié	Aguié	Guidan Dawaye		Dan Dawa
2	Maradi	Aguié	Aguié	Aguié		Gamji sabou
3	Maradi	Aguié	Aguié	Débi		Hardo habou
4	Maradi	Aguié	Aguié	Maiguizawa Kagnou		Karoubni
5	Maradi	Aguié	Aguié	Nakikarfi	Nakikarfi	Roubabia Peulh
6	Maradi	Tchadoua	Aguié	Gawaro	Gawaro	Chantali Peulh
7	Maradi	Tchadoua	Aguié	Danbouzou	Danbouzou	Guicki
8	Maradi	Tchadoua	Aguié	Magami		Magami
9	Maradi	Dakoro	Dakoro	Kornaka		Dalla
10	Maradi	Dakoro	Dakoro	Sabon Machi		Maza Tsaye
11	Maradi	G. Roumdji	G. Roumdji	Guidan Roumdji		Bagouari garin
12	Maradi	G. Roumdji	G. Roumdji	Kouroungousao		Cpt mai karfi
13	Maradi	G. Roumdji	G. Roumdji	Guidan Roumdji		Dan madatchi
14	Maradi	G. Roumdji	G. Roumdji	Dargue		Doumana ara
15	Maradi	G. Roumdji	G. Roumdji	Guidan Roumdji		Garin bagouari
16	Maradi	G. Roumdji	G. Roumdji	Dan Tourke		Garin magagi
17	Maradi	G. Roumdji	G. Roumdji	Tiadi	Dan zeina	Goulougoutchi
18	Maradi	G. Roumdji	G. Roumdji	Kouroungousao	Maikarhi	Guidant amani
19	Maradi	G. Roumdji	G. Roumdji	Dan Tourke		Kalangawa
20	Maradi	G. Roumdji	G. Roumdji	Chadakori		Kemro sofoua
21	Maradi	G. Roumdji	G. Roumdji	Halbaoua		Koumkoussoum
22	Maradi	G. Roumdji	G. Roumdji	Nwala		Mairigua sofoua
23	Maradi	G. Roumdji	G. Roumdji	Chadakori	Guidan tawaye	N'wala serkin toudou +cpt
24	Maradi	G. Roumdji	G. Roumdji	Sae Saboua	Mallumai saboua	Sae saboua
25	Maradi	G. Roumdji	G. Roumdji	Tibiri		Sourra sarkin galma
26	Maradi	G. Roumdji	G. Roumdji	Guidan Roumdji		Toda peulh
27	Maradi	G. Roumdji	G. Roumdji	Dargue		Yakaou
28	Maradi	G. Roumdji	G. Roumdji	Karazome		Zongon-samaila
29	Maradi	Gangara	Gazaoua	Dan Kolio	Birnin kouka	Guidan Kajé
30	Maradi	Gangara	Gazaoua	Malam Dawey	Malan dawey	Malan dawey
31	Maradi	Gazaoua	Gazaoua	Birnin Guéza	Assaya	Assaya
32	Maradi	Gazaoua	Gazaoua	Bougouzaoua	Bougouzaoua	El Gahia
33	Maradi	Gazaoua	Gazaoua	Birnin Guéza	Birnin guéza	Hardo Issa
34	Maradi	Gazaoua	Gazaoua	Birnin Guéza	Birnin guéza	Mayaki

No	Region	Communes	District	CSI	CS	Villages
35	Maradi	Gazaoua	Gazaoua	Bougouzaoua	Yadagamou	Yadagamou
36	Maradi	Baoudeta	Tessaoua	Baoudeta	Sarba	Totsa
37	Maradi	Hawan Dawki	Tessaoua	Hawan Dawki	Tchola	Toumboudouhou
38	Maradi	Korgom	Tessaoua	Korgom	Dadin sarki	Dadin Sarki
39	Maradi	Korgom	Tessaoua	Romaza	Koufai	Koufai
40	Maradi	Tessaoua	Tessaoua	Gounaka	Kalgo	El Dawa Haoussa
41	Tillaberi	Taghazar	Ballayara	Kossey		Syrsani
42	Tillaberi	Taghazar	Ballayara	Csi urbain		Mbama2
43	Tillaberi	Taghazar	Ballayara	Tabla		Syrsani 1
44	Tillaberi	Taghazar	Ballayara	Kabe		Zamtourey
45	Tillaberi	Taghazar	Ballayara	Tabla		Gohinjo 2
46	Tillaberi	Filingué	Filingué	Filingue		Badebayé
47	Tillaberi	Filingué	Filingué	Bakin toullou		Bakin Toulou 2
48	Tillaberi	Filingué	Filingué	Sabon gari	Tidiba	Tidiba
49	Tillaberi	Fourfeye centre	Filingué	Itchiguine		Kouka 2
50	Tillaberi	Imanane	Filingué	Bonkoukou		Touwila
51	Tillaberi	Imanane	Filingué	Diguina		Gao Aljanna
52	Tillaberi	Tondi Kandia	Filingué	Tibewa		Deytagui Koura Koira
53	Tillaberi	Tondi Kandia	Filingué	Attologa		Naguizé
54	Tillaberi	Tondi Kandia	Filingué	Damana		Sourgo koara
55	Tillaberi	Dantchandou	Kollo	Banizoumbou		Carre
56	Tillaberi	Dantchandou	Kollo	Dantchandou		Falanga
57	Tillaberi	Hamdoullaye	Kollo	Fataboki		Fataboki peulh
58	Tillaberi	Hamdoullaye	Kollo	Kollo djogono		Kirou foudou beri
59	Tillaberi	Karma	Kollo	Karma		Moulkou2
60	Tillaberi	Karma	Kollo	Goube		Tondikokou
61	Tillaberi	Kirtachi	Kollo	Babangata	Tondifou	Tondifou
62	Tillaberi	Kirtachi	Kollo	Sounga		Sounga peulh(ga kaina)
63	Tillaberi	Kollo	Kollo	Sakey koirazeno		Daitegui zarma
64	Tillaberi	Kouré	Kollo	Boula gandatche		Boula koira tegui
65	Tillaberi	Liboré	Kollo	Sorey bene		Sorey ganda
66	Tillaberi	Namaro	Kollo	Larba touloumbo		Koutoume bigaré
67	Tillaberi	Namaro	Kollo	Larba touloumbo		Koya
68	Tillaberi	N'Dounga	Kollo	N'dounga		Fondobon
69	Tillaberi	Youri	Kollo	Youri		Bouériré
70	Tillaberi	Gueladjo	Say	T foulbe		Gassangari
71	Tillaberi	Say	Say	Tientiargou		Seino Koba
72	Tillaberi	Say	Say	Ganki bassarou	Finaré	Finaré

No	Region	Communes	District	CSI	CS	Villages
73	Tillaberi	Tamou	Say	Django		Ouro baba
74	Tillaberi	Tamou	Say	Django		Bogga
75	Tillaberi	Anzourou	Tillabery	Kofouno		Doukou koira tegui
76	Tillaberi	DESSA	Tillabery	Kandadji		Kandadji
77	Tillaberi	DESSA	Tillabery	Famale		Haoussa guabo
78	Tillaberi	Kouthèye	Tillabery	Assani		Kassani goungo
79	Tillaberi	Kouthèye	Tillabery	Syrsane haoussa		Kobague
80	Tillaberi	Sakoira	Tillabery	Diambala		Kalangou
81	Zinder	Droum	DS de Mirriah	Gogo		GARIN KALLKO
82	Zinder	Dakoussa	DS de Takieta	Zangon Dachi		Dan Jigawa 2
83	Zinder	Garagoumsa	DS de Takieta	Gaouna	Aroungouza	Aloulouba2
84	Zinder	Garagoumsa	DS de Takieta	Gaouna		Tarami
85	Zinder	Tirmini	DS de Takieta	Magrami		Gafai
86	Zinder	Tirmini	DS de Takieta	Magrami	Rouan Kouka	Magna oukou 1
87	Zinder	Dogo Dogo	DS Dungass	Dina		Fokouni
88	Zinder	Dungass	DS Dungass	Dungass		Dan Gora
89	Zinder	Goushi	DS Dungass	Baboujé	Majéwa Tataré	BOUZALI
90	Zinder	Goushi	DS Dungass	Goushi	Yakaouda	SAROU
91	Zinder	Mallaou	DS Dungass	Doungouzourou		Dagangam
92	Zinder	Mallaou	DS Dungass	Baraguini		Walwa
93	Zinder	Gouré	DS Gouré	Kargueri	Dalari	Dagradi
94	Zinder	Gouré	DS Gouré	Kargueri	Bassori	Garin Gabass
95	Zinder	Gouré	DS Gouré	Gamdou Doumdoum	Challagel	Kangouri 2
96	Zinder	Gouré	DS Gouré	Kargueri		Mainari- Bouzou
97	Zinder	Gouré	DS Gouré	Zagari	Bouzounkaza	Zangouna
98	Zinder	Guidiguir	DS Gouré	Abari		Guizibouk 1
99	Zinder	Guidiguir	DS Gouré	FALAMA		Tegogina
100	Zinder	Bandé	DS Magaria	Kakitama		Garin liman
101	Zinder	Dan Tchiao	DS Magaria	Dan Tchiao	Bangaya	Garin Jimis
102	Zinder	Magaria	DS Magaria	Tinkim	Farayé	Dadin Sarki
103	Zinder	Magaria	DS Magaria	Mai damoussa	Satoumaoua	Zoudi
104	Zinder	Sasoumbroum	DS Magaria	Sasoumbroum	Goungara	Madja
105	Zinder	Washa	DS Magaria	Gayi	Illala Barma	Illala Habou
106	Zinder	Yekoua	DS Magaria	Jalgawassa	Dounawa	Guidan Dawa
107	Zinder	Yekoua	DS Magaria	Jalgawassa		Mai Killia
108	Zinder	Chirnawa Est	DS Matameye	Chirnawa Tagabass	Marekou	Intarnatsa
109	Zinder	Dan Barto	DS Matameye	Dan Barto	Zakarawa	Tsaba Toulou
110	Zinder	Doungou	DS Matameye	Maiwando	Baban Djibji	Guidan Zagagoua

No	Region	Communes	District	CSI	CS	Villages
111	Zinder	Kantché	DS Matameye	Dan Goudao	Kourni Bandwa	DOGWON DAWA
112	Zinder	Kourni	DS Matameye	Kourni	Ragana Haoussa	Inkitchissou sani
113	Zinder	Mataméye	DS Matameye	Katofou		Gomba Bougage
114	Zinder	Tsaouni	DS Matameye	Ban Nama	Marké Bougagé	Bagudawa
115	Zinder	Tsaouni	DS Matameye	Ban Nama		Zané Galadimawa
116	Zinder	Yaouri	DS Matameye	Yaouri	Garaké	Wadigawa
117	Zinder	Damagaram Ta Kaya	DS Ta Kaya	Gueza		Gueza bougaje
118	Zinder	Damagaram Ta Kaya	DS Ta Kaya	Gueza	Chantier Garin Kori	Wawiram
119	Zinder	Guidimouni	DS Ta Kaya	Guidimouni	Guéguéri	Garin Gouzou
120	Zinder	Guidimouni	DS Ta Kaya	Chanya	N'goul kokao	Rimka

Annex 6: Data collection tools by indicator

Table 33: Data collection tools by indicator

Indicators	Target population
1. Prevalence rate of modern methods of contraception	Women 15-49 years
2. Adolescent birth rate	Young women aged 20-24 years
3. % of children fully vaccinated by 12 months	Children from 12 to 23 months
4. Percentage of adolescent girls and young women whose need for family planning is met by modern methods	Women 15-24 years
5. Percentage of target audience who say wife beating is an acceptable way for husbands to discipline their wives	Men (15-54 years); women of childbearing age (15-49 years).
6. Percentage of target population with at least a moderate equity score on the GEM scale.	Men (15-54 years); women of childbearing age (15-49 years).
7. Percentage of target population with improved knowledge of FP/other health services	Men (15-54 years); women of childbearing age (15-49 years).
8. Percentage of target populations with a positive attitude towards FP	Men (15-54 years); women of childbearing age (15-49 years).
9. Percentage of audience who recall hearing or seeing a specific family planning/reproductive health (FP/RH) message supported by the USAID Kulawa program	Men (15-54 years); women of childbearing age (15-49 years).
10. Percentage of women who made 4 or more visits for ANC during her last pregnancy.	Women 15-49 years
11. Percentage of women who gave birth in a facility and who received advice on FP before discharge	Women 15-49 years
12. Percentage of women and men who experienced sexual violence in the past 12 months	Men (15-54 years); women of childbearing age (15-49 years).
13. Percentage of the population with a positive attitude to report cases of sexual violence	Men (15-54 years); women of childbearing age (15-49 years).
14. Proportion of population aware of local GBV committees.	Men (15-54 years); women of childbearing age (15-49 years).

Annex 7: Calculations of indicators of need and demand for family planning

Percentage of women with a) unmet need for family planning, b) met need for family planning, c) total demand for family planning by spacing, limiting and total, and percentage of the demand for family planning that is satisfied.

Definition

Percentage of currently married women, all women and sexually active unmarried women with:

1. unmet need for family planning, (by limiting and spacing)
2. women whose need for family planning is satisfied (for limiting and spacing)
3. total demand for family planning whether for spacing, limiting and total (1+2)
4. Percentage of total demand for family planning that is satisfied with any method
5. Percentage of total demand for family planning satisfied by modern methods

Coverage:

Baseline population:

a) All women
b) Currently married
c) Sexually active unmarried women

Period: current situation at the time of the survey

Numerators:

1) **Unmet need for contraception: Number of women who are not using a method of contraception and are:**

a) For spacing (v626a = 1):

fertile and say they want to wait two or more years for their next birth;

fertile and do not know if they want another child;

fertile, wants another child, but does not know when to give birth;

pregnant and wanted an ongoing pregnancy later; Or

postpartum amenorrhea and last desired delivery later

b) To limiting (v626a = 2):

fertile and does not want any more children;

pregnant and did not want a current pregnancy; Or

postpartum amenorrhea and did not want the last delivery

c) Total unmet need: Number of women with an unmet need for family planning for spacing or limiting (v626a = 1 or v626a = 2)

2) **Met need for contraception: number of women using a method of contraception and**
a) For spacing (v626a = 3):

not considered limiting (see below)

b) To limit (v626a = 4):

don't want any more children;

are sterilized; Or

say they cannot get pregnant when asked about their desire to have future children

c) Total met need (v626a = 3 or v626a = 4): number of women with a met need for spacing or limiting

3) **Total demand for contraception: Number of women with a met or unmet need:**
a) For spacing (v626a = 1 or v626a = 3)
b) To limit (v626a = 2 or v626a = 4)
c) Total (v626a in 1, 2, 3, 4)

4) **Demand satisfied: number of women using a contraceptive method (v626a dans 3.4)**

5) **Demand met by modern methods:** Number of women using modern contraceptive methods including female sterilization, male sterilization, pill, IUD, injectables, implants, male condom, female condom, emergency birth control, vaginal methods, breastfeeding amenorrhea method, or other modern methods (v313 = 3).

Denominators:

Indicators of unmet needs, met needs and total demand:

Number of

a) All women aged 15-49 years
b) Women currently married (v502 = 1)
c) Sexually active unmarried women – including women who are not currently married or in a consensual union (single, divorced, widowed and separated) and who had sex in the last 30 days (v502 ≠ 1 & v528 in 0: 30)

Demand satisfaction indicators:

Number of

a) All women aged 15-49 years
b) Women currently married (v502 = 1)
c) Sexually active unmarried women – including women who are not currently married or in a consensual union (single, divorced, widowed and separated) and who had sex in the last 30 days (v502 ≠ 1 & v528 in 0: 30) who have either an unmet need for family planning or a met need for family planning (v626a in 1, 2, 3, 4)

v626a Unmet need for contraception (Definition 3)

v313 Current usage by method type

v502 Currently/formerly/never in union

v528 Time elapsed since last sexual intercourse (in days)

v005 Female individual sample weight

Indicators of unmet, met needs and total demand:
Numerator divided by the denominator, multiplied by 100.

The calculation of the numerators for the indicators of met and unmet need first considers the contraceptive status. Women who use contraception are considered to have a met need for FP.

For women not using contraception, determining the need for family planning involves several additional steps. Non-users are separated into those who are currently married and those who are not married but are sexually active. An unmarried woman is considered to be sexually active if the woman has had sexual intercourse in the 30 days preceding the survey. Unmarried women who are not sexually active are considered not at risk of pregnancy and therefore do not need family planning.

To assign need status to married, sexually active single non-users, these women are separated into two groups: (1) those who are pregnant or postpartum amenorrhea and (2) those who are not pregnant or postpartum. Women are considered postpartum amenorrheic if their period has not returned since their last live birth during the two-year period preceding the survey.

Unmarried, sexually active married non-users who are not pregnant or in postpartum amenorrhea are further separated into those who are considered fertile and those who are infertile. Women are classified as infertile if they fall into one of the following categories:

married for more than 5 years, had no children in the last 5 years and never used contraception;
answered “I can't get pregnant” to the question about wanting to have future children;
answered is “menopause/hysterectomy” for the reason of not using contraception;
answered to time since last period is > 6 months and non-amenorrheic postpartum (0-59 months);
answered to time since last period is “menopause/hysterectomy” or “never menstruated”; or
answered to time since last period is "last period was before last birth" and last birth was 5+ years ago.

Infertile women do not need family planning. Other women who do not need it include married women or sexually active unmarried women who are not using contraception and who are:

pregnant and wanted the current pregnancy;
postpartum amenorrhea and wanted their last delivery; or
fertile and wants another child in next 2 years

Single, married, sexually active non-users have an unmet need for spacing if they are:

pregnant and want a pregnancy later;
postpartum amenorrhea and wanted their last delivery later; or
fertile and want next child in 2 years or more, want another child but undecided when or undecided if they want another child.

Single, married, sexually active non-users have an unmet need for limitation if they are:

pregnant and did not want the current pregnancy at all;
postpartum amenorrhea and did not want their last delivery at all; or
fertile and does not want any more children.

Demand satisfaction indicators:

Numerator divided by the denominator, multiplied by 100.

The numerator of the satisfied demand proportion includes the number of women currently using a contraceptive method while the numerator of satisfied demand by modern methods includes the number of women using a modern contraceptive method.

The denominators include women with a met need (those using contraception whether the method is a modern method or a traditional method) and those with an unmet need for family planning.

Annex 8: GEM scale calculation

This index measures attitudes towards gender norms for intimate relationships or different social expectations for men and women, using the Gender Equitable Men (GEM) scale.

Calculated as:

N: the number of sample-weighted target people who score moderate or high on the GEM scale

D: the number of target people interviewed

Target audience: Men (15-59 years); women of childbearing age (15-49 years)

GEM scale for Niger: 4 subtopics and 24 statements in total. They are:

Domain of violence:

There are times when a woman deserves to be beaten
A woman must tolerate violence to keep her family together
It's okay for a man to beat his wife if she's unfaithful
A man can hit his wife if she refuses to have sex with him
If someone (man or woman) insults a man, he must defend his reputation with force
A man using violence against his wife is a private matter that should not be discussed outside the couple

Domain of sexual relations:

It is the man who decides what type of sexual relationship to have
Men are always ready to have sex
Men need sex more than women
A man needs other women even if everything is fine with his wife
You don't talk about sex, you just do it
It disgusts me when I see a man acting like a woman
A woman should not initiate sex
A woman who has sex before getting married does not deserve respect

Domain of reproductive health and disease prevention:

Women who have condoms in their possession are wanton or immoral
Men should be outraged if their wives ask them to use a condom
It is the woman's responsibility to avoid becoming pregnant
It is only when a woman has a child that she is a real woman
A real man produces a male child

Domain of domestic tasks and daily life:

Cleaning a baby's bottom, bathing and feeding children is the responsibility of the mother
A woman's role is to take care of her home and family
The husband decides on the purchase of the main household items
The man should have the final say on decisions in his home
A wife should obey her husband in all things

Scoring Procedure:
Each of the above items is rated on a 3-point scale, where 1 = agree, 2 = partially agree, and 3 = disagree. The answers to each item should be added together according to the point value assigned to the answer. The total point value for the GEM scale ranges from 24 to 72. Each score results in a low equity score (24-39 points); moderate (40-56 points); and high (57-72 points). Then, associations between the GEM scale and variables such as condom use, contraceptive use and intimate partner violence can be analyzed. GEM scale scores were also compared before and after an intervention.

Annex 9: Calculation of the attitude of providers towards adolescents indicator

This index measures health providers' attitudes toward adolescent (15-19 years) and youth (20-24 years) using family planning and other adolescents sexual and reproductive health services (ASRH).

“Positive” attitudes are those that should logically lead to positive ASRH outcomes.
The themes and attitude reports listed below.

Result of the indicator calculated as follows:

Numerator: Number of providers who express positive attitudes towards youth/adolescents using FP and other health services
Denominator: number of providers studied in the USAID Kulawa assessment

This indicator will include providers from various settings, including doctors, nurses and midwives, from various service areas (e.g., MNCH, nutrition, RH/FP, etc.) depending on who is selected to participate in assessment of the healthcare facility on their site.

Index themes and attitude reports:

Attitudes towards FP and SRH information and services offered to young people:

6. Single adolescents seeking sexual and reproductive health services should be advised to abstain when requesting contraceptives.
7. Discussing sex with unmarried women and men is shameful.
8. Unmarried adolescents should not receive contraceptives because culture and religion prohibit sex before marriage.
9. Parents should be informed if their unmarried daughters come to a health facility to seek reproductive health services.
10. I would scold an unmarried teenager for asking for birth control.
11. I would refuse to provide contraceptives to teenagers before marriage.
12. It is acceptable to teach unmarried young people about contraception.
13. Reproductive health services are only available to married women.
14. Women and men of all ages should be seen at the clinic for sexual and reproductive health services if they request it.

Norms and beliefs about adolescents and young people:

15. My personal beliefs guide how I provide adolescent health services.
16. Only girls should receive information on sexual and reproductive health because they are the ones who have the most problems related to sexual behavior.

17. If a client does not voluntarily tell me that he has been the victim of violence perpetrated by members of his family, I should not ask him directly because that is none of my business.
18. By definition, boys cannot be sexually assaulted.
19. Boys and girls should not be given information about puberty as it will encourage them to engage in sexual behavior.
20. Educating young people on topics related to reproductive health leads to sexual immorality.
21. If a boy or a girl has a genital ulcer, it's because he or she is easy.
22. If a young woman walks into a health facility and says she was sexually assaulted, she probably did something to deserve it.

Attitudes towards the clinical and political environment:

23. Educational materials on sexual and reproductive health should be freely accessible to unmarried boys and girls.
24. Young people should enjoy the same level of confidentiality as adults when receiving sexual and reproductive health services.
25. Schools and institutions should work together to provide reproductive health information and services to young people.
26. Sexual and gender-based violence among young people should receive government attention as an important social problem.
27. It is important to ensure that all services provided to young people are provided in private so that no one else in the clinic can overhear.

Response options:
Totally disagree - 1 // Disagree - 2 // Agree - 3 // Totally agree - 4

Scoring procedures:
Subject scores are averaged to calculate total scores for main headings and subscales ranging from 1 to 4. Higher scores (55 -88) represent more positive attitudes towards young people and use of SRH services.

The surveys include both dependent variables (i.e., provider attitudes) and independent variables (i.e., provider demographics).

Annex 10: Calculation of the service availability index

The indicator is the Service Availability Index which measures three tracer indicator areas: health infrastructure, health workforce and service utilization, using an unweighted average.

Health infrastructure:

a) # of establishments supported by USAID Kulawa per 10,000 inhabitants / 2 * 100 (max / 100)
b) # of inpatient beds in USAID Kulawa-supported facilities per 10,000 population/25 * 100 (max. 100)
c) # of maternity beds in USAID Kulawa supported facilities per 10,000 population/10 * 100 (max/100)

Health staff:

d) Number of basic health staff in USAID Kulawa supported facilities per 10,000 population/23 * 100 (max/100)

Facility use:

e) # of outpatient visits per person/year in USAID Kulawa-supported facilities/5 * 100 (max/100).
f) # of hospital discharges per 100 inhabitants/year/10 * 100 (max/100).

The service availability index is calculated as follows:

[((a+b+c)/3) +d+ ((e+f)/2)]/3

“Basic health workforce” includes:

CSI: CSI manager and the midwife
Hospitals: Director of the hospital, pediatric department manager including CRENI, maternity department manager including FP, Hygiene Sanitation department manager, Medicine department manager, reception service manager
CSME: CSME director, pediatric service manager including CRENI, maternity manager including FP, maternal and neonatal health service manager, Hygiene Sanitation service manager.

Annex 11: Demand Satisfied for Family Planning

Table 34: Demand Satisfied for Family Planning

		Maradi	Tillabéri	Zinder	Total
WOMEN 15 - 49 YEARS					
Unmet need for family planning	Unmet need for spacing (%)	1.3%	1.0%	0.1%	0.9%
	Unmet need for limiting (%)	2.8%	0.8%	1.6%	1.7%
	Total unmet need (%)	4.1%	1.7%	1.7%	2.6%
Met need for family planning	Met need for spacing (%)	23.7%	16.0%	6.2%	16.3%
	Met need for limiting (%)	1.6%	0.4%	0.9%	1.0%
	Total met need (%)	25.3%	16.4%	7.1%	17.3%
Total demand for family planning	Total Demand for FP (spacing) (%)	25.0%	17.0%	6.4%	17.2%
	Total Demand for FP (limiting) (%)	4.4%	1.2%	2.4%	2.7%
	Total contraceptive demand (%)	29.4%	18.2%	8.7%	19.9%
Demand satisfied for family planning	Demand satisfied by modern methods (%)	69.0%	89.8%	56.5%	74.1%
	Demand satisfied by all FP methods (%)	86.2%	90.4%	80.7%	86.9%
WOMEN 15 - 24 YEARS					
Unmet need for family planning	Unmet need for spacing (%)	1.6%	0.8%	0.4%	1.0%
	Unmet need for limiting (%)	0.2%	0.0%	0.0%	0.1%
	Total unmet need (%)	1.8%	0.8%	0.4%	1.1%
Met need for family planning	Met need for spacing (%)	19.2%	13.2%	4.6%	13.4%
	Met need for limiting (%)	0.7%	0.0%	0.4%	0.4%
	Total met need (%)	19.9%	13.2%	4.9%	13.8%
Total demand for family planning	Total Demand for FP (spacing) (%)	20.8%	14.0%	4.9%	14.4%
	Total Demand for FP (limiting) (%)	0.9%	0.0%	0.4%	0.5%
	Total contraceptive demand (%)	21.7%	14.0%	5.2%	14.8%
Demand satisfied for family planning	Demand satisfied by modern methods (%)	67.0%	94.2%	66.7%	75.6%
	Demand satisfied by all FP methods (%)	91.8%	94.2%	93.3%	92.7%
WOMEN 25 - 49 YEARS					
Unmet need for family planning	Unmet need for spacing (%)	1.1%	1.1%	0.0%	0.8%
	Unmet need for limiting (%)	4.8%	1.3%	2.6%	2.9%

		Maradi	Tillabéri	Zinder	Total
	Total unmet need (%)	5.9%	2.4%	2.6%	3.7%
Met need for family planning	Met need for spacing (%)	27.3%	17.9%	7.3%	18.4%
	Met need for limiting (%)	2.3%	0.7%	1.2%	1.4%
	Total met need (%)	29.6%	18.6%	8.5%	19.9%
Total demand for family planning	Total Demand for FP (spacing) (%)	28.4%	19.0%	7.3%	19.2%
	Total Demand for FP (limiting) (%)	7.1%	2.0%	3.8%	4.4%
	Total contraceptive demand (%)	35.5%	21.0%	11.1%	23.6%
Demand satisfied for family planning	Demand satisfied by modern methods (%)	70.0%	87.8%	53.2%	73.5%
	Demand satisfied by all FP methods (%)	83.5%	88.7%	76.6%	84.3%

Annex 12: Synoptic sheet of indicators

Performance indicators	Maradi	Tillabéri	Zinder	Total
A- Knowledge use and attitudes about family planning				
Contraceptive prevalence rate				
All methods				
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=1011	n=920	n=709	n=2640
All women (15-49 years)	23.60%	14.80%	6.70%	15.20%
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=447	n=372	n=286	n=1105
All women (15-24 years)	18.30%	12.10%	8.00%	13.20%
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=564	n=548	n=423	n=1535
All women (25-49 years)	27.60%	16.50%	5.90%	16.60%
Modern Methods				
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=1011	n=920	n=709	n=2640
All women	17.40%	14.70%	4.80%	12.00%
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=447	n=372	n=286	n=1105
Women 15-24 years	12.70%	12.10%	6.30%	10.20%
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=564	n=548	n=423	n=1535
Women 25-49 years	20.90%	16.30%	3.80%	13.20%
Percentage of women with increased knowledge of family planning/other health services.	**Maradi**	**Tillabéri**	**Zinder**	**Total**
	n=1011	n=920	n=709	n=2640
	66.30%	59.20%	33.10%	52.10%
Percentage of men with increased knowledge of family planning/other health services.	**Maradi**	**Tillabéri**	**Zinder**	**Total**
	n=819	n=549	n=669	n=2037
	4.60%	9.50%	0.40%	3.70%
Percent of target audience with a positive attitude towards family planning	**Maradi**	**Tillabéri**	**Zinder**	**Total**
	91.1%	92.3%	81.2%	87.4%
Percentage of women with positive attitudes toward family planning.	**Maradi**	**Tillabéri**	**Zinder**	**Total**
	n=1011	n=920	n=709	n=2640
	95.6%	96.8%	80.5%	90.1%
Percentage of men with positive attitudes toward family planning.	**Maradi**	**Tillabéri**	**Zinder**	**Total**
	n=819	n=549	n=669	n=2037
	85.3%	85.0%	82.0%	83.9%
	Maradi	**Tillabéri**	**Zinder**	**Total**

Performance indicators	Maradi	Tillabéri	Zinder	Total
Percentage of women who recall hearing or seeing a specific family planning/reproductive health (family planning/reproductive health) message supported by USG.	n=1011	n=920	n=709	n=2640
	32.90%	25.20%	41.80%	34.50%
Percentage of men who recall hearing or seeing a specific family planning/reproductive health (family planning/reproductive health) message supported by USG.	n=819	n=549	n=669	n=2.037
	46.7%	28.2%	11.8%	28.9%
Percentage of audience who recall hearing or seeing a specific family planning/reproductive health message (family planning/reproductive health) supported by USG.	n=1830	n=1469	n=1378	n=4677
	39.0%	26.3%	28.1%	32.1%
B- Recent fertility and antenatal care				
	Maradi	**Tillabéri**	**Zinder**	**Total**
Adolescent birth rate (per 1000)	n=242	n=178	n=141	n=561
	47‰	32‰	44‰	42‰
	Maradi	**Tillabéri**	**Zinder**	**Total**
Percentage of women who had four or more antenatal visits during last pregnancy.	n=781	n=563	n=475	n=1819
	56.00%	50.40%	48.80%	52.20%
C- Contraceptive demand and unmet needs				
WOMEN 15- 49 YEARS				
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=1011	n=920	n=709	n=2640
Unmet need for spacing (%)	1.30%	1.00%	0.10%	0.90%
Unmet need for limiting (%)	2.80%	0.80%	1.60%	1.70%
Total unmet need (%)	4.10%	1.70%	1.70%	2.60%
Met need for spacing (%)	23.70%	16.00%	6.20%	16.30%
Met need for limiting (%)	1.60%	0.40%	0.90%	1.00%
Total met need (%)	25.30%	16.40%	7.10%	17.30%
Total Demand for FP (spacing) (%)	25.00%	17.00%	6.40%	17.20%
Total Demand for FP (limiting) (%)	4.40%	1.20%	2.40%	2.70%
Total contraceptive demand (%)	29.40%	18.20%	8.70%	19.90%
Demand satisfied by modern methods (%)	69.00%	89.80%	56.50%	74.10%
Demand satisfied by all FP methods (%)	86.20%	90.40%	80.70%	86.90%
WOMEN 15- 24 YEARS				
	Maradi	**Tillabéri**	**Zinder**	**Total**
	n=447	n=372	n=286	n=1105
Unmet need for spacing (%)	1.60%	0.80%	0.40%	1.00%
Unmet need for limiting (%)	0.20%	0.00%	0.00%	0.10%
Total unmet need (%)	1.80%	0.80%	0.40%	1.10%
Met need for spacing (%)	19.20%	13.20%	4.60%	13.40%
Met need for limiting (%)	0.70%	0.00%	0.40%	0.40%
Total met need (%)	19.90%	13.20%	4.90%	13.80%

Performance indicators	Maradi	Tillabéri	Zinder	Total
Total Demand for FP (spacing) (%)	20.80%	14.00%	4.90%	14.40%
Total Demand for FP (limiting) (%)	0.90%	0.00%	0.40%	0.50%
Total contraceptive demand (%)	21.70%	14.00%	5.20%	14.80%
Demand satisfied by modern methods (%)	67.00%	94.20%	66.70%	75.60%
Demand satisfied by all FP methods (%)	91.80%	94.20%	93.30%	92.70%
D- Gender based violence				
	Maradi	**Tillabéri**	**Zinder**	**Total**
Percentage of women with at least a moderate gender equity score on the Gender Equitable Men (GEM) scale.	n=1006	n=917	n=705	n=2628
	31.20%	34.90%	43.90%	36.90%
Percentage of men with at least a moderate fairness score on the GEM scale	n=819	n=549	n=669	n=2037
	74.20%	60.40%	78.50%	73.50%
Percentage of target women stating that hitting or beating their wife would be justified	n=1011	n=920	n=709	n=2640
	76.30%	85.10%	86.40%	82.10%
Percentage of target men who say hitting or beating their wives is justified	n=819	n=549	n=669	n=2037
	27.00%	43.30%	29.90%	31.10%
E- Vaccination of children (12-23 months)	n=79	n=67	n=78	n=224
Percentage of children 12-23 months fully immunized	57.20%	28.70%	46.20%	48.80%
F- Service provision				
Proportion of providers with a positive attitude towards the use of family planning and its services by adolescents	n=84	n=71	n=99	n=254
	39.20%	39.20%	46.50%	42.30%
Percentage of health units with at least one service provider trained to manage and identify SGBV.	n=50	n=39	n=57	n=146
	61.20%	58.50%	43.50%	53.30%
Number of newborns receiving postnatal care within two days of delivery in USG-supported programs.	15 473	6 654	31 090	53 217
Percentage of women who give birth in a facility and start or leave with a modern contraceptive method before discharge	n=32 197	n=14 132	n=38 599	n=84 928
	23%	37%	28%	28%
Percentage of women who give birth in a facility and receive counseling on family planning before discharge	n=32 197	n=14 132	n=38 599	n=84 928
	59%	87%	73%	70%
Service Availability Index	n=50	n=39	n=57	n=146
	16.4%	**19.7%**	**20.0%**	**18.7%**
Health Services Infrastructure Index	28.5	25.8	25.9	26.8
Health workforce index	6.8	4.1	4.6	5.3
Service utilization index	13.8	29.2	29.5	24.0