Agir pour la Planification Familiale

PROJECT BRIEF NO. 9 · MARCH 2018

Using Baseline Data to Develop an In-Country Strategy for Improving Family Planning Use and Service and Service Delivery in Mauritania

BACKGROUND

Ensuring access to quality family planning (FP) services is a key part of national efforts in Mauritania to reduce maternal mortality rates, which are among the highest in the sub-region, at 582 maternal deaths per 100,000 live births (ONS, 2013). According to the World Health Organization (WHO), satisfying unmet need for FP alone could reduce the number of maternal deaths by almost one-third. In 2011, the modern method contraceptive prevalence rate (CPR) was about 18% in urban areas of Mauritania, while unmet need was 28% (ONS, 2014). At the time of the baseline study, the Government of Mauritania had not adopted its reproductive health (RH) law, which it drafted in 2007, but it had drafted a new National Strategic Plan for repositioning FP for the period 2014–2018.

In July 2013, the U.S. Agency for International Development (USAID)/West Africa Regional Health Office awarded a five-year, $29 million project, Agir pour la Planification Familiale (AgirPF), to EngenderHealth, with its core partner, Avenir Health (formerly Futures Institute). The project aims at increasing access to and use of quality FP services in selected urban and peri-urban areas of five West African Francophone countries (Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo).

Due to a delay in obtaining local authorities' approvals for the registration of EngenderHealth, activities in Mauritania were not fully launched until February 2014. As part of the start-up of AgirPF in Mauritania, the project conducted a baseline survey in the second half of 2015 to evaluate FP services and assess FP-related knowledge, attitudes, and practices among households in the capital city of Nouakchott. The late conduct of the baseline was due to: (i) delay in the opening of the office following the approvals for the registration, and (ii) cancellation of the recruitment of the first firm selected to conduct the study, due to a violation of some EngenderHealth rules during the process.

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METHODS

Aim and Objectives

Between October and November 2015, AgirPF conducted a baseline assessment study in Mauritania to help inform future project programming, provide a benchmark for comparisons over time, and identify priority areas and existing strengths and best practices on which to build.

Design, Methods, and Sample

The study design, which was consistent across all AgirPF countries, was a quasi-experimental design with a nonequivalent control group. The study consisted of a randomized household survey of 718 men aged 15–59 and 1,316 women aged 15–49; a facility survey of 37 intervention facilities and six nonintervention facilities; a survey of 45 providers present at one of these facilities on the day of the assessment. In addition, 20 key informant interviews with members of the district management team and with staff of civil society and nongovernmental organizations (NGOs) (15 men and five women) took place, as well as a survey of community health workers associated with a study facility.

The Western Institutional Review Board and the Review Board in Mauritania reviewed the study. Each participant provided written informed consent before any interview was conducted. Participants' names and other identifying information were not collected.

An independent research firm, DeGSta (which stands for Développement–Gouvernance–Statistique), conducted data collection, data management, and preliminary analysis. During data collection, AgirPF staff conducted regular monitoring with field visits.

SUPPLY

Availability of FP, Postpartum FP, and PAC Services

The average number of FP services provided daily was 7.1 at the intervention facilities and 11.2 at the nonintervention facilities.

Most short-acting methods were widely available, while the female condom and long-acting reversible methods were barely available and permanent methods were not offered at all (Table 1). Combined oral contaceptives, progestin-only pills, injectables (DMPA and Noristerat), and male condoms were available in the majority of the intervention and non-intervention facilities (between two-thirds and 100% of the sites).

Less commonly available FP methods were spermicides, emergency contraceptive pills,

Table 1: Percentage of facilities usually offering various FP methods, by zone

Type of service	Intervention (N=37*)	Nonintervention (N=6*)
Short-Acting Methods		
Combined oral contraceptives	81.1	83.3
Progestin-only pill	75.7	83.3
Injectable (DMPA)	69.4	83.3
Injectable (Noristerat)	69.4	100.0
Male condom	66.7	83.3
Female condom	27.8	50.0
Spermicide/vaginal foaming tablet	11.1	0.0
Emergency contraceptive pill	19.4	16.7
Standard days method	22.2	50.0
Long-Acting Methods		
Implant (Jadelle)	27.8	66.7
Implant (Implanon)	33.3	66.7
IUD	24.3	83.3
Female sterilization	0.0	0.0
Male sterilization	0.0	0.0
Counseling on:		
Natural family planning	52.8	83.3
Lactational amenorrhea	66.7	83.3
Dual protection	41.7	83.3
PAC and postpartum FP services		
Postabortion care (PAC)	27.8	50.0
Postpartum IUD	11.1	66.7

*A few sites lacked information on the availability of some methods. These were excluded in computing the percentage of sites offering the method.

standard days method (SDM), intrauterine devices (IUDs), female condoms, and implants (Implanon and Jadelle) were offered by 11% to 33% of the intervention sites and 0% to 83% of the nonintervention sites.

The majority of the intervention sites offered counseling on lactational amenorrhea (67%) and natural FP (53%), but fewer offered counseling on dual protection (42%), while each service is offered at 83% of the nonintervention sites. Postpartum FP services and postabortion care (PAC) were rarely available: Eleven percent of intervention sites offered postpartum IUD services, and 28% provided PAC. The situation was better in the nonintervention sites, 67% of which offered postpartum IUD insertion and 50% of which offered PAC. (Data on other postpartum FP services were not collected.)

In both the intervention and nonintervention zones, the two main reasons for facilities' not providing particular FP methods were a lack of trained staff and a lack of equipment, supplies, and commodities.

Mobile Outreach and Community-Based Health Education Services

Mobile outreach services were available at 12% of intervention facilities, provided by NGOs such as Santé Sans Frontières (SSF) and Association Mauritanienne pour la Promotion de la Famille (AMPF). None of the nonintervention facilities provided mobile outreach services.

Community-based health education was offered by 9% of the intervention facilities and 17% of the nonintervention facilities. Such education consisted of sensitization on health issues, including maternal and child health and RH/FP, and was conducted at some health facilities by community workers supported by NGOs.

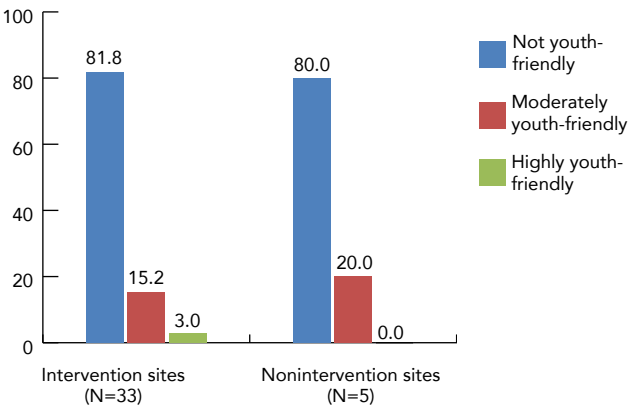
Youth-Friendly Services

The health facilities were assessed on eight aspects of "youth-friendly" service (YFS) delivery: (1) separate hours for adolescents; (2) a separate space for adolescent services; (3) a separate waiting room for adolescents; (4) at least one provider trained in YFS; (5) orientation of staff in YFS; (6) adolescent counseling on sexuality, pregnancy prevention, and prevention of sexually transmitted infections (STIs), including HIV; (7) provision of services to adolescents regardless of their marital status; and (8) requirement for parental/spousal consent for adolescents to receive services. Each facility received a point for responding positively to questions 1–7 and negatively to 8 and 0 otherwise. Facilities were then coded as "not youth-friendly" if their overall score was 0–2, "moderately youth-friendly" if it was 3–5, and "highly youth-friendly" if it was 6–8. The score was computed only for sites that responded to all eight questions (33 of 37 intervention sites and five of six nonintervention sites).

Most of the surveyed sites were not youth-friendly. Overall, 82% of the intervention sites and 80% of the nonintervention sites were not youth-friendly. Fifteen percent of the intervention sites and 20% of the nonintervention sites were moderately youth-friendly, and only 3% of the intervention sites were highly youth-friendly (Figure 1).

In fact, both intervention and nonintervention facilities had few characteristics conducive to youth-friendly services (Figure 2, page 4). Up to 70% of the intervention sites and 80% of the nonintervention sites required parental or spousal consent before offering FP services to an adolescent. In terms of service organization, fewer than 10% of the intervention sites had a separate waiting room for youth and a separate room for adolescent services, and only 18% offered services to youth

Figure 1. Percentage distribution of sites, by their youth-friendliness score, according to type of site



Source: Mauritania Baseline Study, AgirPF/EngenderHealth, 2015

during separate hours. None of the nonintervention sites had such arrangements. Moreover, few sites (less than 22%) had providers trained in YFS, had their staff oriented to YFS, or offered services to adolescents regardless of their marital status. However, more widespread, youth counseling on sexuality, safer sex, pregnancy prevention, and prevention of STIs, including HIV, was provided by fewer than half of the sites.

ENABLING ENVIRONMENT

Community Engagement in Service Provision

Most facilities did not have any system to engage communities in service provision, such as requesting the communities' help on waste management and in improvement of the quality of services. At only 11% of the intervention facilities and 33% of nonintervention facilities was there a system in place to determine clients' opinions about the health facility or service. Although 54% of intervention and 100% of nonintervention facilities reported holding formal meetings to discuss the quality of services, community members routinely took part in those meetings at only 16% of intervention facilities and at none of the nonintervention sites.

Availability of Guidelines and Protocols at Health Facilities

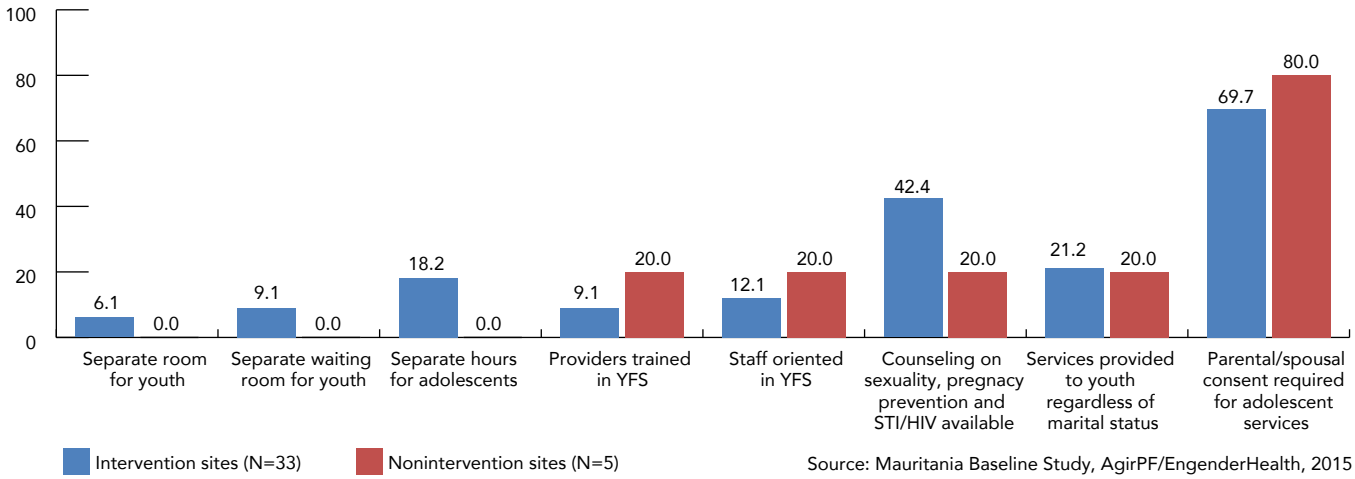
The facility audits assessed the availability at health facilities of four important RH service protocols and guidelines: the national RH service protocols; the WHO reference book *Family Planning: A Global Handbook for Providers*; a counseling guide (checklist) on information to cover during counseling sessions; and the protocol on response to female clients who are survivors of intimate partner violence.

No intervention facility had any of the protocols/guidelines available, and only one of the nonintervention facilities had the national RH service protocols available—despite the fact that the national RH program had distributed these protocols to all health facilities in Nouakchott a few years before. Unfortunately, the health facility managers tended to consider the documents they received as their personal belongings and took them with them when they are redeployed to other health facilities.

Provider-Imposed Barriers to FP

A large majority of providers reported that they would not prescribe various FP methods to a client of a certain age or without her husband's consent, setting a barrier for clients to obtain FP methods. More than 80% of providers said they would not prescribe oral contraceptives to a client below a minimum age, over a certain age, or without the husband's consent. Over 90% would not prescribe injectables to a client below a minimum age or over a maximum age, and 88% would not prescribe them to women who did not have a certain number of children. Overall, 46% and 94% of providers at the

Figure 2. Percentage of sites with selected youth-friendly characteristics, by type of site



Source: Mauritania Baseline Study, AgirPF/EngenderHealth, 2015

Table 2: Percentage of providers reporting various reasons for imposing an age-related barrier to FP methods, by type of site

Reasons for imposing an age-related barrier	Intervention (N=35)	Nonintervention (N=8)
National law does not allow it.	22.9	0.0
Health center/clinic policy does not allow it.	11.4	0.0
A woman and man should not be sexually active at that age.	57.1	12.5
A woman should have had one or more children before deciding to use this method.	25.7	25.0
A man should have had one or more children before deciding to use this method.	2.9	0.0
Other	5.7	37.5

intervention sites reported that they would not prescribe emergency contraceptive pills and the injectable contraceptive Noristerat, respectively, to a client younger than a certain age.

Table 2 shows the reasons for providers not offering FP methods to a client below a certain age, by zone. Notably, among the providers in the intervention sites who impose an age under which they do not offer an FP method, 57% of them did so just because they do not believe that a woman and man should be sexually active at that age, and 23% of them wrongly believe that the national law does not allow it.

Table 3: Number of living children and desired number of children among women of reproductive age, by type of site

	Intervention	Nonintervention
Total no. of living children	N=920	N=359
0	10.9	7.8
1-2	35.1	39.9
3-4	27.4	32.1
5+	26.6	20.1
Mean [95% CI]	3.1 [3.0, 3.3]	2.9 [2.7, 3.2]
Total no. of living children	N=404	N=92
0	2.1	0.0
1-2	5.3	9.1
3-4	32.8	48.9
5+	59.8	42.1
Mean [95% CI]	5.4 [5.1, 5.6]	4.6 [4.1, 5.1]

DEMAND

Reproductive Health Status

The average number of living children per woman was three in both the intervention and the nonintervention areas (Table 3). The desired number of children by women was five in Mauritania, which is greater than the desired number of children among women living in AgirPF project areas in Burkina Faso, Côte d'Ivoire, and Togo but less than in Niger. The desired number of children is nearly one child higher in the intervention zone (5.4) than in the nonintervention area (4.6). In the two areas, less than 10% of women desire fewer than three children.

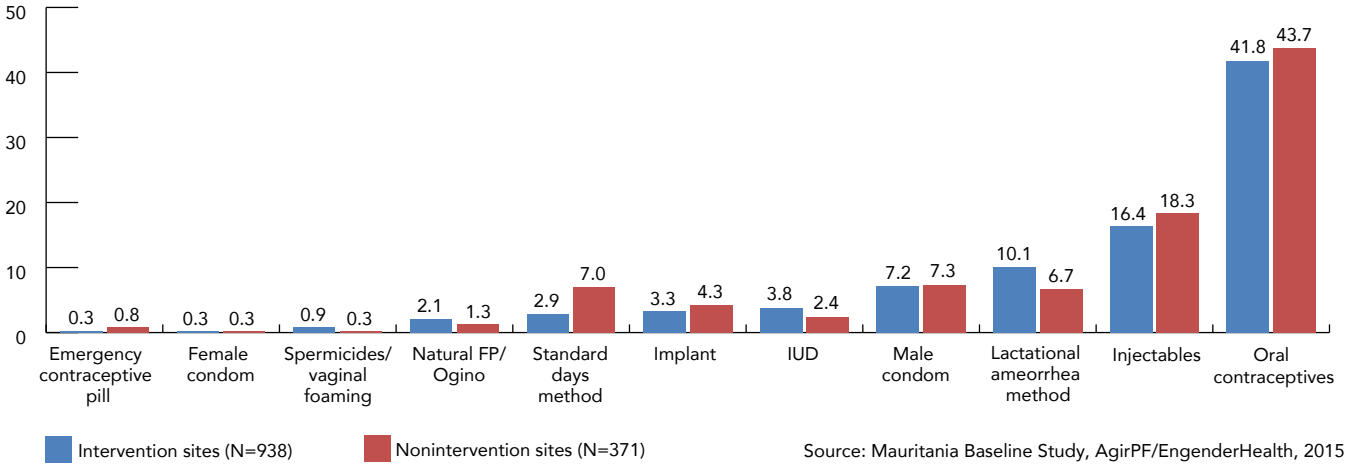
FP Method Use

Ever use of FP methods

Overall, 54.3% of women in the intervention site and 58.5% in the nonintervention site had ever used a modern FP method. Oral contraceptives were by far the most-used method, with 42% of women in the intervention sites and 44% of those in the nonintervention sites having ever used this method; injectables were the second most popular method, used by 16% and 18% of women, respectively (Figure 3, page 6). All other methods had been used by fewer than 10% of women in both areas.

Among men, the proportions who had ever used a modern FP method were 43% in the intervention site and 41% in the nonintervention site. In both areas, the pill, the male condom, and injectables were

Figure 3. Percentage of women who ever used a modern FP method, by method, according to type of site



Source: Mauritania Baseline Study, AgirPF/EngenderHealth, 2015

the most-used modern methods by males. In the intervention site, oral contraceptives had been used by 29%, male condoms by 18%, and injectables by 9%; all other methods had been used by fewer than 6%. In the nonintervention site, patterns of ever use differed: The male condom was the number one ever-used method (30%), followed by the pill (23%) and injectables (13%); all other methods had ever been used by fewer than 2% of the men.

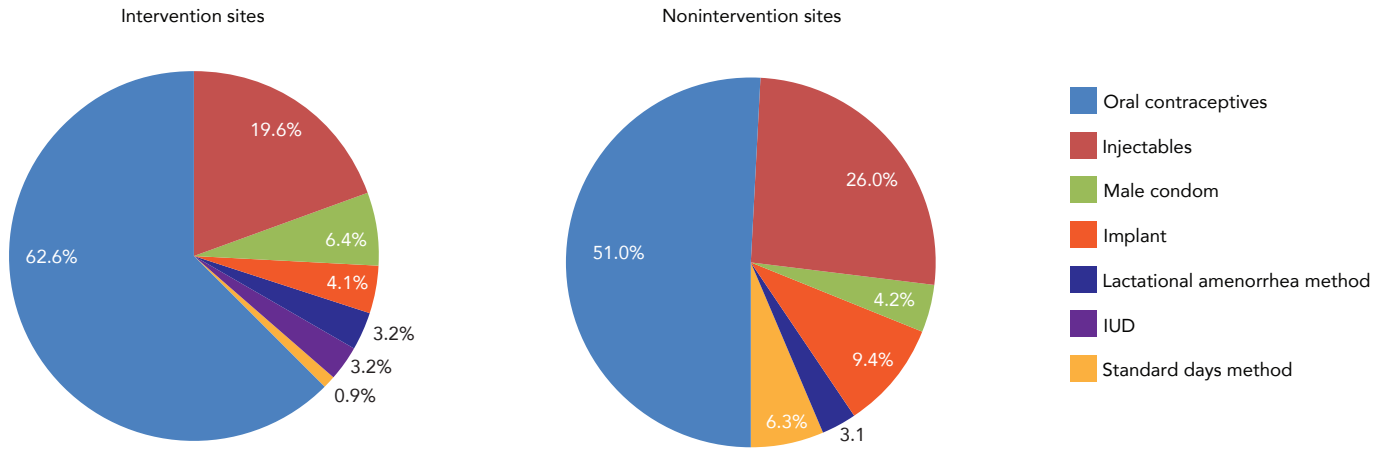
Current FP use

The modern contraceptive prevalence rate among women of reproductive age (15–49) was 29.8% in the intervention sites and 32.1% in the nonintervention sites.

The method mix in both areas was highly skewed (Figure 4): Oral contraceptives were the most commonly used FP method, by more than half of current contraceptive users (63% in the intervention site and 51% in the nonintervention site). Injectables were the current FP method of 20% of women in the intervention site and 26% of those in the nonintervention site. The proportions of women currently using other modern methods were each small, varying between 0% and 9%.

The modern-method CPR slightly increased, to 32.8% in the intervention sites and 35.7% in the nonintervention sites, when the analysis was limited to married women only. The method mix was similar

Figure 4. Percentage distribution of women of reproductive age who are currently using FP, by method, according to type of site



Source: Mauritania Baseline Study, AgirPF/EngenderHealth, 2015

to that of all women presented above. When data were stratified by group age, the method mix among women in younger was much skewed, due to very high utilization of oral contraceptives.

Future method use

Nearly half of the women interviewed believed that they would use an FP method in the future (47%), while 32% declared that they would not. Thirteen percent either said they had not yet decided or did not answer the question. The most desired contraceptive methods for future use in Mauritania, in both the intervention and nonintervention sites, were the pill (58.2% and 53.2%, respectively), injectables (18.9% and 25.0%), and implants (10.0% and 8.1%).

FP discussion among partners

Among married women in both the intervention and nonintervention zone, 49% had ever discussed FP methods with their partner. However, such discussion was not frequent, especially in the nonintervention zone. Among women who had ever discussed FP with their husband, 36% in the intervention and 57% in the nonintervention zone reported having not discussed FP with the partner during the last three months.

Exposure to information sources and FP messages

Women's exposure to FP messages was low in the surveyed area: Twenty-two percent of women in the intervention sites and 32% in the nonintervention sites had ever been exposed to FP messages. The majority who had received an FP message did so via television (16% of women in intervention sites and 27% in the nonintervention sites), followed by radio (9% and 13%, respectively) (Table 4).

Table 4: Percentage of women who received FP messages via various modes of communication, by zone

Mode of communication	Intervention (N=930)	Nonintervention (N=366)
TV	16.0	26.8
Radio	9.0	12.9
Community event	4.9	5.5
Poster/billboard/leaflet	2.5	1.1
Newspaper/magazine	2.1	2.5

CONCLUSION

The main objective of the baseline study was to depict the situation at the launch of the project, to inform project programming, provide a benchmark for comparisons over time, and identify priority areas existing strengths and best practices on which to build. The study combined different approaches (a facility audit, household surveys, and interviews with key informants).

The findings revealed that the availability of, access to, and quality of FP services in the survey areas were very challenging, while a potential demand for FP does exist. Past and current use of FP compared with the national level was relatively high, though still low for an urban setting.

THE WAY FORWARD

In light of the baseline study findings, the AgirPF team in Côte d'Ivoire is focusing programming efforts to improve the availability and quality of FP services, including postpartum and postabortion FP; YFS; community engagement; the availability of guidelines at facilities; and comprehensive information on FP.

Supply

- Provide health facilities with equipment for and supplies of intrauterine devices (IUDs) and hormonal implants.
- Train staff (providers and supervisors) on contraceptive technology, including long-acting methods, postpartum FP, the REDI[1] counseling approach, and infection prevention.

[1] REDI stands for Rapport building, Exploration of options, Decision-making support, and Implementing the decision to use a particular method. This framework for counseling is a client-centered approach to help clients choose the best contraceptive with which to achieve their reproductive intentions.

- Ensure that service protocols and guidelines are available at health facilities, to encourage adherence to national and international guidelines.
- Increase the promotion and supply of long-acting methods (implants and IUDs).
- Train staff responsible for health facilities on logistics management for contraceptive products.
- Bring FP services to underserved communities through culturally appropriate mobile outreach services and FP messages, as well as FP special days.
- Mainstream youth-friendly elements and the concept of sexual and reproductive rights into FP service delivery.

Enabling Environment

- Conduct advocacy with influential decision makers to increase funding for FP/birth spacing in general, and in particular the budget line for purchasing and securing contraceptive products.
- Adopt and implement legislation and regulations on RH/FP.
- Conduct trainings of health providers to remove barriers to the prescription of FP methods.

Demand

- Conduct social and behavior change communication campaigns to sensitize women on various FP methods.
- Work with civil society organizations to reach more people.
- Train existing community volunteers and community health workers to plan and implement outreach sensitization activities on FP.
- Use EngenderHealth's site walk-through approach to inform, inspire, and employ community leaders, civil society, and district advocates to improve community knowledge and awareness of FP services and to address social and gender norms that influence attitudes toward FP use.

REFERENCES

Office National des Statistiques (ONS). 2013. Recensement Général de la Population et de l'Habitat (RGPH) de 2013. Nouakchott, Mauritanie.

ONS. 2014. Suivi de la situation des femmes et des enfants: Enquête par grappes à indicateurs multiples. 2011. Rapport Final. Nouakchott, Mauritanie.

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