



Agir pour la Planification Familiale

PROJECT BRIEF NO. 2 · OCTOBER 2016

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

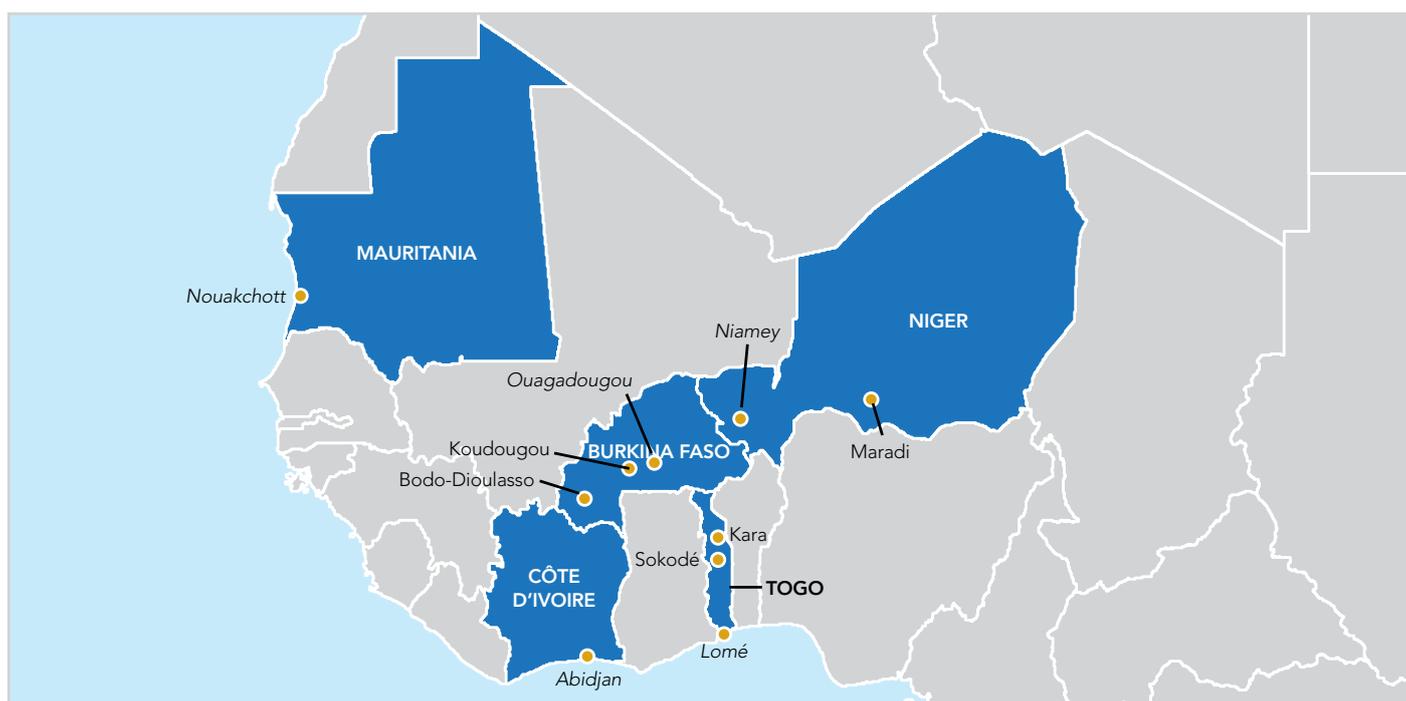
BACKGROUND

Ensuring access to quality family planning (FP) is critical to reducing the maternal mortality rate in Niger, which is the highest in the West African subregion (554 deaths per 100,000 live births) (INS & ICF International, 2013), as well as to improving reproductive health among individuals and couples. It has been estimated that if unmet need for FP is met, global maternal deaths would decline by almost one-third (Ahmed et al., 2012). Unmet need for FP is high (28%), and the modern contraceptive prevalence rate (CPR) is low (12%) (INS & ICF International, 2013).

In 2006, the Government of Niger adopted a reproductive health (RH) law to enable couples and women of reproductive age to have the freedom to determine the size of their family and to make decisions about their bodies and sexuality (République du Niger, 2014). This law allows couples and individuals to: (1) have the necessary information and education about the benefits, risks, and effectiveness of all contraceptive methods; (2) the right to decide freely and responsibly on matters related to RH, in compliance with the law, public order, and morality; and 3) the right to obtain health care of the highest quality and not to be exposed to practices that are harmful to their RH; further, any individual or couple has the right to access local, safe, effective, affordable, and acceptable services (Article 6). However, this law is not fully implemented, due to prevailing religious and sociocultural norms that limit FP access and use in Niger. Therefore, to ensure that individuals in Niamey and Maradi (the cities where AgirPF operates) share in the health and socioeconomic benefits of all efforts agreed to by the government of Niger, it will be instrumental to ensure that commitments made for FP2020 and the Ouagadougou Partnership¹ are achieved.

¹ FP 2020 is a global partnership that supports the rights of women and girls to decide, freely and for themselves, whether, when, and how many children they want to have. The Ouagadougou Partnership was launched in Ouagadougou, Burkina Faso, in February 2011, at the Regional Conference on Population, Development and Family Planning held by the nine governments of Francophone West African countries and their technical partners. The members of the Partnership pledged to use financial resources to accelerate progress in the use of FP services in Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo.

Figure 1: AgirPF project countries and cities



CONTEXT

In 2013, to support advancement toward maternal mortality rate reduction in Niger, the U.S. Agency for International Development (USAID)/West Africa Regional Health Office awarded a five-year project, Agir pour la Planification Familiale (AgirPF), to EngenderHealth with its core partner, Avenir Health (formerly the Futures Institute). The goal of AgirPF is to enable individuals and couples living in selected urban and peri-urban areas of Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo to make, and voluntarily act on, informed decisions about FP (see Figure 1).

Key to AgirPF's success in Niger will be to test, scale up, and replicate high-impact practices in a holistic manner (USAID & K4Health, 2015). Yet focusing on increasing the *supply* of services to meet high unmet demand rarely suffices to sustain long-term use and offer quality services that meet the needs and respect the rights of individuals. It is also critical to address the *resource and policy context* within which FP programs operate, as well as the *sociocultural environment* (RESPOND Project, 2014).

METHODS

Aim and Objectives

Between April 29 and May 21, 2014, AgirPF conducted a baseline assessment study in Niger 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 incorporated a quasi-experimental design, including a nonequivalent nonintervention group. The study consisted of five data collection elements: a randomized household survey of 720 men aged 15–59 and 1,429 women aged 15–49; a facility survey of 36 intervention facilities (15 in Niamey and 21 in Maradi) and 38 nonintervention facilities (16 in Niamey and 22 in Maradi); a survey of 127 providers present at one of these facilities on the day of the assessment (57 in Niamey and 70 in Maradi); 74 key informant interviews with members of the district management team and with staff of civil society and nongovernmental organizations (31 in Niamey and 43

in Maradi); and a survey of community health workers associated with a study facility (17 in Niamey and three in Maradi). The study methodology has been described in more detail in the scientific report (AgirPF, 2015a).

The study was reviewed by the Western Institutional Review Board and the Review Board in Niger. Each study participant provided written informed consent before any interview was conducted. Participants' names and other identifying information were not collected. Data collection, data management, and preliminary analysis were conducted by CKA Consulting. During data collection, AgirPF staff conducted regular monitoring with field visits.

Results

SUPPLY

Availability of Family Planning

Short-acting methods were more widely available than long-acting methods,² with the vast majority of intervention and nonintervention sites providing combined oral contraceptives (95% and 98%, respectively) and the injectable Depo-Provera, (92% and 95%) (Table 1). Male condoms were offered at more sites than female condoms at both intervention and nonintervention clinics (80% and

50%, respectively, for male condoms and 43% and 23% for female condoms). Emergency contraception was offered at 40% of intervention sites and 33% of nonintervention sites, while the standard days method (SDM) was offered at 13% of intervention sites and 22% of nonintervention sites. Of note, though, no Maradi intervention sites offered SDM. The most widely available long-acting method was the implant (Implanon or Jadelle). Male and female sterilization were not available at any site.

Postabortion Care Services

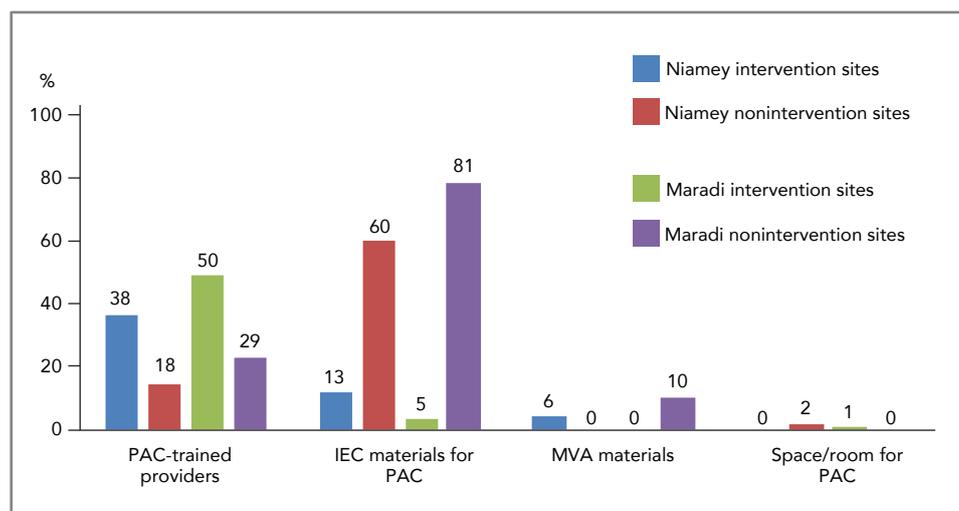
Postabortion care (PAC) services were drastically missing, due to the fact that health facilities lacked appropriate materials, space, and skilled providers for proper PAC service provision. Figure 2 (page 4) indicates that the vast majority of facilities were likely to lack both the necessary materials for manual vacuum aspiration (MVA) (not available at 90% or more of facilities) and trained providers (only 28% intervention sites in Niamey had a provider, compared with 39% of intervention sites in Maradi). The availability of information, education, and communication (IEC) materials for PAC was also strikingly low at intervention sites (9% of facilities). The environmental conditions of PAC provision were extremely unacceptable; fewer than 2% of facilities both in Niamey and Maradi had a room or space dedicated for PAC services. Providers used delivery rooms to perform these procedures.

Table 1: Percentage of facilities offering selected FP services

Contraceptive method	Total		Maradi		Niamey	
	Intervention (n=38)	Nonintervention (N=36)	Intervention (n=22)	Nonintervention (N=21)	Intervention (N=16)	Nonintervention (N=15)
Short-acting methods						
Combined pill	95	98	95	95	98	83
Injectables (DMPA)	92	95	91	90	100	100
Male condom	80	50	73	52	79	67
Female condom	43	23	36	19	35	17
Emergency contraception	40	33	36	38	58	42
Standard days method (SDM)	13	22	0	33	58	29
Long-acting/permanent methods						
Female sterilization	0	0	0	0	0	0
Male sterilization	0	0	0	0	0	0
Implant (Implanon®)	79	71	77	57	81	67
Implant (Jadelle®)	63	52	59	38	69	53
IUD	45	48	41	43	50	40

²“Available” is defined as a service offered on a daily basis by a skilled provider working at a health facility.

Figure 2: Percentage of health facilities providing various types of PAC services, by location and intervention status



Postpartum Family Planning

Postpartum FP (PPFP) remains a missed opportunity in Niamey as well as in Maradi, and AgirPF needs to continue to strongly advocate for its accessibility, promotion, and use at health facilities. The proportion of women who received counseling on PPFP was very low at both intervention and nonintervention sites. In Niamey, at nonintervention sites, 54% of pregnant women received FP counseling, but only 9% of postpartum women received PPFP counseling. The situation is even worse in Maradi, where only 37% of pregnant women and 2% of postpartum women were counseled about PPFP.

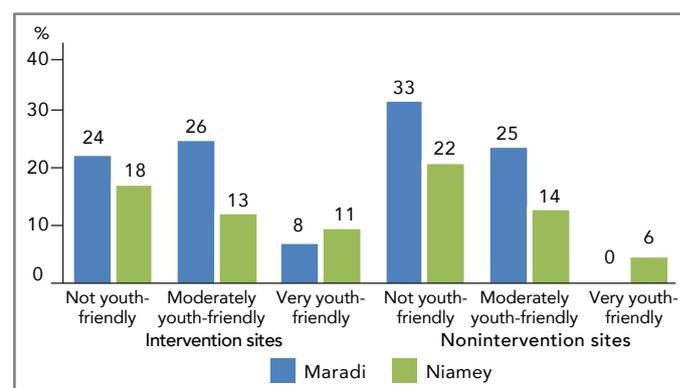
Regarding postpartum IUD provision at intervention and nonintervention sites, the data indicate that in Niamey, only five sites received training in postpartum IUD service provision—three intervention sites and two nonintervention sites—while in Maradi, only two sites received such training, but no postpartum IUD services were offered.

Youth-Friendly Services

Facilities were assessed on eight aspects of “youth-friendly” service (YFS) delivery: (1) separate hours for youth; (2) a separate space for youth services; (3) a

separate waiting room for youth; (4) training of providers in YFS; (5) orientation of staff in YFS; (6) youth counseling on sexuality, safer sex, pregnancy prevention, and prevention of sexually transmitted infections (STIs), including HIV; (7) requirement for parental/spouse consent for youth; and (8) provision of services to youth regardless of their marital status (AgirPF, 2015b). Overall, results show that there is a lot of work to be done in terms of improving the youth-friendly characteristics of health facilities (Figure 3). Only a small minority of intervention health facilities in Niamey and Maradi were ranked as “very youth-friendly” (8% and 11%, respectively).³

Figure 3. Percentage of facilities ranked as not, moderately, or very youth-friendly, by city and type of site



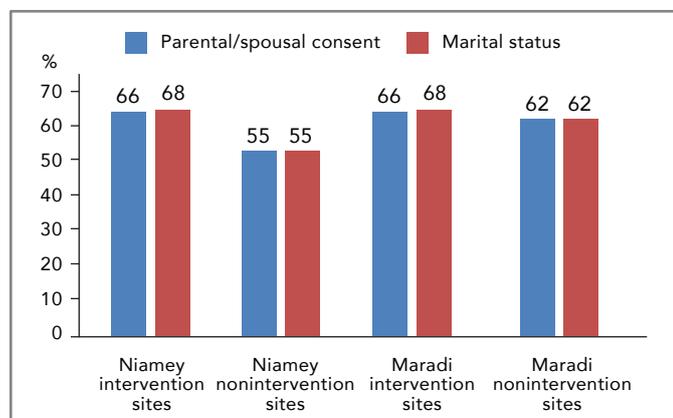
³ A composite score was calculated based on responses to questions in each of the eight assessed domains, which were coded as 1 or 0, for a maximum score of 8. Facilities were categorized as “not youth-friendly” if the score was 0–2, “moderately youth-friendly” if the score was 3–5, and “highly youth-friendly” if the score was 6–8.

ENABLING ENVIRONMENT

Provider-Imposed Barriers

In Niger, clients experience a range of barriers to FP use, such as (1) a minimum age, below which providers do not offer FP services, even if there is no medical contraindication; (2) a minimum number of children that a woman must have before having the right to use an FP method, even if there is no medical contraindication; (3) marital status; and (4) a requirement for parental consent for women younger than 18. In fact, while there is no policy or government-established barrier, provider barriers are common; Figure 4 illustrates that in Niamey and Maradi, 66% of providers from intervention sites and 53% of providers from nonintervention sites requested parental or spousal consent before providing FP services to clients. Similarly, 68% and 62% of providers at intervention and nonintervention sites, respectively, required clients to be married before they could receive FP services.

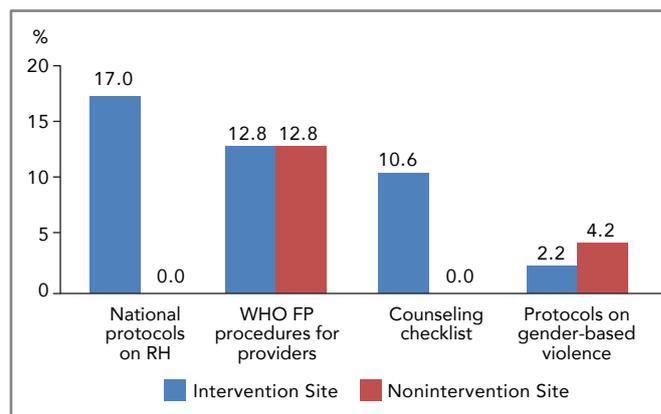
Figure 4. Percentage of sites imposing barriers to FP service provision, by barrier, city, and facility type



Supportive Documentation for FP Service Provision

A lot of progress remains to be made regarding the availability of national guidelines. In Niamey and Maradi, only 17% of intervention sites reported having national protocols on RH, 11% had a checklist for counseling, and 2% of intervention sites had a protocol on gender-based violence. But no nonintervention site had either the national protocol on RH or the FP counseling checklist. Similarly, 13% of both intervention and of nonintervention sites had World Health Organization (WHO) FP procedures for providers (Figure 5).

Figure 5. Percentage of sites having supportive documentation for FP service provision, by type of site



DEMAND

Reproductive Health Status and Desired Fertility

The overall modern method CPR in Niger was 41% in intervention communities and 38% in nonintervention communities. Compared with the four other AgirPF West African countries, women in Niger reported a significantly higher desired family size: five or more. In intervention communities, 87% of respondents desired 8–9 children, as did 94% in nonintervention communities.

Family Planning Method Use

History of FP use: In Niger, 65% of women in the intervention communities and 58% of women in the nonintervention communities reported they had ever used an FP method in the past.

Current modern CPR: Contraceptive prevalence was 41% in intervention areas and 38% in nonintervention communities. The pill was currently used by the majority of contraceptive users at intervention and nonintervention communities (58%), across all age-groups. However, a sizable proportion of women (27% in intervention communities and 29% in nonintervention communities) relied on the injectable. The percentage of women using male condoms was negligible (<1%).

Future method use: Almost all women (96%) had heard of an FP method. In particular, the majority reported having heard of short-acting methods, such as the pill and injectable. Fewer women knew about the implant,

the IUD, and permanent methods. As for intention to use a method in the future, the pill and injectable were most likely to be named, as shown in Table 2.

Table 2: Percentage of FP nonusers at the community level saying they intend to use an FP method in the future, by method

Contraceptive method	Intervention communities (N=177)	Nonintervention communities (N=194)
Pill	58	58
Injectable	27	29
Implant	7	8
IUD	2	1
Male condom	1	0
Female condom	0	1
Female sterilization	0	4
Male sterilization	0	0
Do not know	5	0

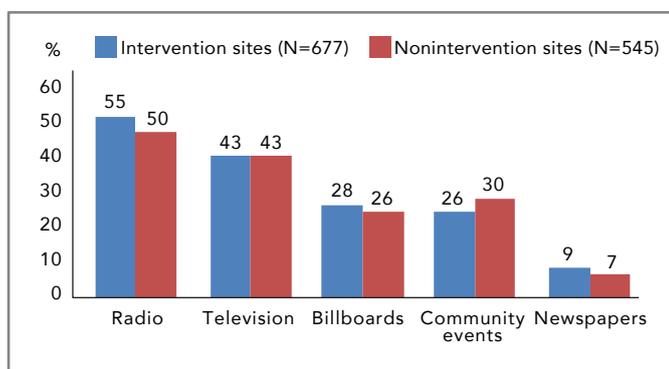
FP Discussion among Partners

The percentage of women who were married or cohabitating who had ever discussed FP methods with their husband or partner was 39% in the intervention areas and 50% in the nonintervention areas.

Exposure to FP Messages

In Niger, more than three-quarters of women reported that they had received FP messages; the majority of these did so via radio or TV (see Figure 6).

Figure 6: Percentage of women who received FP messages, by modes of communication



CONCLUSION

The AgirPF Niger baseline assessment pinpointed priority areas and provided a dependable benchmark upon which the project can build programmatic activities. These data are the foundation of AgirPF. They enable stakeholders to determine whether the objectives of the project are achieved throughout the project's lifecycle. These data assist decision makers to ensure that planning and implementation match need in the Niger context. Additionally, the baseline assessment is an important data source for researchers, as it demonstrates the condition of FP and PAC services in the Nigerien urban and peri-urban context at the time of data collection.

The following are key recommendations arising from the baseline analyses:

- Reasons why Nigerien women desire larger families than women in neighboring countries with similar contexts should be investigated and incorporated into social and behavior change communication (SBCC) strategies.
- Condom use is particularly low in Niger. Reasons for such a low level of use must be investigated and findings incorporated into SBCC strategies.
- Women should be sensitized to the range of FP methods, to achieve a method mix more reflective of the full range of contraceptive methods.
- To strengthen delivery of long-acting and permanent FP services, providers would benefit from retraining on implants and the IUD and should be equipped with IUD and implant supplies and insertion and removal materials, as well as receiving capacity building on permanent methods service provision.

THE WAY FORWARD

The results emphasize the need for program interventions that comprehensively and holistically address the multiple determinants of FP service quality and use and support the ability of individuals and couples to make decisions about childbearing:

1. The supply of services must be increased to meet growing need and to make high-quality services universally accessible and available.
2. The enabling environment must be strengthened by developing and implementing policies, guidelines, and practices that expand quality service delivery and that support increased demand, including overcoming gender-related and other societal barriers.
3. Demand for FP services must be increased, including through interventions to address poor service quality and access, policy barriers, and deeply rooted social and gender norms.

To address these gaps and weaknesses, AgirPF is implementing a “suite” of high-impact practices in the following strategic areas:

- Improving FP service quality, availability, and access, by supporting scale-up of the integration of FP into sexual and reproductive health services (such as postpartum and postabortion services), immunization services, and HIV-related care
- Mainstreaming youth-friendly elements into FP service delivery

- Training service providers in the REDI counseling framework (which stands for rapport building, exploration, decision making, and implementing)
- Bringing FP services to underserved communities to enhance voluntary and informed decisions about contraceptive use, by deploying mobile and outreach (Sorties foraines) services, conducting FP special days, and engaging community health workers in the distribution of contraceptives, including the injectable
- Educating and empowering clients and grassroots advocates, by using:
 - » Specific emerging high-impact practices to engage and foster FP discussion among partners and to increase quality FP information awareness, so that individuals and couples are more likely to be able to make childbearing decisions
 - » A population segmentation approach to facilitate behavior change toward FP use and to foster men’s involvement in reproductive health service utilization
 - » EngenderHealth’s site walk-through approach to inform, inspire, and employ community leaders, members of 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

This suite of high-impact practices will ensure that AgirPF-Niger will serve as a model for high-quality FP programming in Niger and that this model ultimately will be adopted and taken to scale by the Ministry of Health countrywide.

REFERENCES

- Agir pour la Planification Familiale (AgirPF). 2015a. *A scientific report on AgirPF baseline study conducted in urban/peri-urban areas in Burkina Faso, Niger, Togo and Côte d'Ivoire*. New York: EngenderHealth/AgirPF.
- AgirPF. 2015b. *Assessment of facility-, provider- and household-related aspects of family planning service delivery and utilization in four West African countries*. New York: EngenderHealth/AgirPF. Accessed at: www.engenderhealth.org/files/pubs/project/agirpf/AgirPF-2015-Baseline-Report.pdf.
- Ahmed, S., Li, Q., Liu, L., and Tsui, A. O. 2012. Maternal deaths averted by contraceptive use: An analysis of 172 countries. *Lancet* 380(9837):111–125.
- FP2020 & United Nations Foundation. 2014. *FP2020 Progress Report 2013-2014: Partnership in Progress*.
- Ouagadougou Partnership. 2012. *Family planning: Francophone West Africa on the move*. Dakar, Senegal.
- Republique du Niger. 2014. *Sur la Mise en Œuvre de la Charte Africaine des Droits de l'Homme et des Peuples*. Niamey. Accessed at: www.achpr.org/files/sessions/56th/state-reports/3-2003-2014/starep2_niger_2014_fra.pdf.
- The RESPOND Project. 2014. Holistic approach enhances FP programs: RESPOND's experience with the SEED Programming Model™. *RESPOND Project Brief No. 27*. August. New York: EngenderHealth/The RESPOND Project.
- U.S. Agency for International Development (USAID) West Africa. 2014. *Regional development cooperation strategy: 2015–2019*. Accra. Accessed at: www.usaid.gov/sites/default/files/documents/1860/USAID-WA-RDCS-Public-Version-June%202015.pdf.
- USAID and Knowledge for Health (K4Health). 2015. *Family planning high impact practice list*. Washington, DC. Accessed at: www.fphighimpactpractices.org/sites/fphips/files/hiplist_eng.pdf.



© EngenderHealth 2016. This work is licensed under the Creative Commons Attribution- Noncommercial-Share Alike 3.0 Unported License. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nc-sa/3.0/>. This publication was made possible by the generous support of the American people through the U.S Agency for International Development (USAID), under the terms of the cooperative agreement AID-624-A-13-00004. The contents are the responsibility of EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.

Writers: Andre Koalaga, Caitlin Shannon, Zakari Congo, Helen Baker, Ana Fried, Tonantzin Suarez and Mariama Moussa
Reviewers: Rouguiatou Diallo, Natasha Lerner, and Elizabeth Arlotti-Parish
Editor: Michael Klitsch. Graphic Designer: Robin Kintz

Agir pour la Planification Familiale
Route de Djangble No. 5880
Face Stade de Kegue
16BP110
Lome, Togo