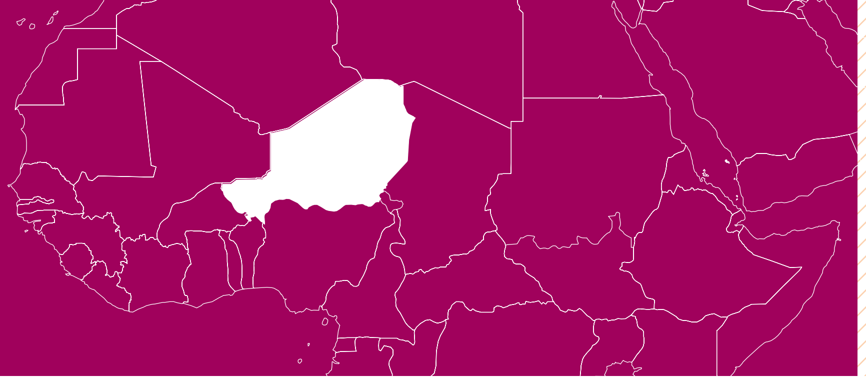
NIGER

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of the Niger's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of the Niger's national policy on family planning (FP) and reproductive health (RH) is included in a number of documents, including the 2006 Reproductive Health Law, the National Reproductive Health Program 2005–2009, the 2007 National Population Policy, and the Family Planning in Niger: 2012-2020 Action Plan (2012). The latter document's objectives are to achieve 50% contraceptive prevalence by 2020 through three strategic approaches: (1) improving the availability of FP services at all levels of the care continuum (community, public, and private health services); (2) increasing demand for FP services; and (3) promoting a conducive environment for voluntary FP uptake.

The government of Niger coordinates FP policies and implementation via two government agencies. The National Population Commission (based in the Ministry of Population, Women's Promotion, and Child Protection) coordinates all population activities, including advocacy and public awareness activities for FP (Health Policy Project, 2013). The Directorate of Maternal and Child Health in the Ministry of Public Health manages and coordinates all FP and maternal and child health services (Health Policy Project, 2013).

Legal status of abortion

Abortion in Niger is allowed to save the life and health of the woman and in cases of fetal impairment.

POSTABORTION CARE (PAC) TRAINING AND STANDARDS

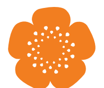
The government initially introduced PAC as a component of infection prevention, with trainings covering the use of manual vacuum aspiration. Training participants included providers and lower-level hospital staff, such as technicians and cleaners. The government has since expanded PAC programming to include training and supervision capacity building support, provision of manual vacuum aspiration instruments and other supplies required for sustainability, and integration of PAC in national norms, policies, and preservice training (Bolton et al., 2003).

At the central and regional levels, PAC trainings for health personnel cover emergency obstetric and neonatal care. In every region, PAC trainings cascade from the main health facilities to lower-level health centers to increase reach. These trainings focus on increasing the quality of care, the availability of qualified PAC personnel, and health service coverage.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT

Expanding contraceptive methods and informed choice to PAC clients

USAID FROM THE AMERICAN PEOPLE



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STRENGTHENING SERVICE DELIVERY

Niger is one of the first countries in West Africa to implement tracking software to manage health inventory. This software enables commodity monitoring and the identification of contraceptive bottlenecks and stock-outs in central and regional depositories (FP2020, 2016).

In 2013, the government integrated injectables into the minimum package of activities provided by community health workers. Since then, the government has also increased the number of community-based sites for contraceptive distribution by 1,228 (FP2020, 2016).

While PAC and FP services are available in hospital maternity wards, FP is not systematically offered to women who visit hospitals seeking services for abortion-related complications.

BARRIERS TO PAC

Women in Niger face multiple barriers to accessing PAC and FP services. The biggest challenges women face in accessing FP counseling and voluntary contraception are related to socioeconomic norms. Nigerien family and cultural dynamics largely center on the man's role as head of the household; women therefore are unable to freely access FP as a means to limit or space births (Potts et al., 2011). Moreover, women under the age of 18 require parental consent to access FP (EngenderHealth, 2016). There is also a need for additional training in hospitals and health centers to highlight the importance of PAC and to sensitize providers. Similarly, many facilities lack the equipment and supplies required to provide PAC and do not have dedicated space to conduct PAC counseling. The limited availability of skilled providers able to offer PAC is an additional barrier (EngenderHealth, 2016). High turnover in Niger's Ministry of Health has also impeded implementation of PAC norms and policies (Bolton et al., 2003). As a result, FP methods are available but not systematically offered to women who access PAC (Potts et al., 2011).

FINANCING MECHANISMS

Niger has a national health financing strategy geared toward universal health coverage, but the policy does not specifically address PAC. The government provides subsidies for PAC, including urgent care, syringes, and misoprostol.

Since 2002, the Nigerien government has provided FP methods for free (Potts et al., 2011), including spending nearly $2 million for contraceptives in 2009—triple the amount it spent in 2006 (HPP, 2013). In 2010, the government established budget line items for FP, including PAC commodities. Further, it added a specific budget line for the purchase of misoprostol in 2015.

NIGER		Year	Source
Demographic/background indicators			
Country population	**22,667,782**	2018	United Nations
Total fertility rate	7.6	2012	Demographic and Health Survey, 2012
Age at first birth	18.6		
Maternal mortality per 100,000 live births	535		
Newborn mortality per 1,000 live births	24		
Infant mortality per 1,000 live births	51		
Under-five child mortality per 1,000 live births	127		
Facility-based delivery	30%		
At least one antenatal visit during previous pregnancy	83%		
At least one postnatal visit during previous pregnancy	37%		
Abortion and FP-related indicators			
Number of unintended pregnancies	194,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unintended pregnancies averted due to use of modern contraceptive methods	206,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	73,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of maternal deaths averted due to use of modern contraceptive methods	840	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	15.9 %	2017	PMA2020, R2
Modern method contraceptive prevalence rate, all WRA	15.2%		
Knowledge of FP, all WRA	89%	2012	Demographic and Health Survey, 2012
Contraceptive use by type		2017	PMA2020, R2
Long-acting and permanent methods			
Sterilization (female)	0.6%		
Sterilization (male)	0.0%		
Intrauterine device	1.0%		
Implant	17.1%		
Short-acting methods		2017	
Injection (intramuscular and subcutaneous)	40.3%		
Pill	40.5%		
Other modern methods (e.g., female condom, cycle beads, and lactational amenorrhea method)	0.5%		
Unmet need for FP[3] (2018)	21%	2017	PMA2020, R2
Unmet need for birth spacing	18.6%		
Unmet need for limiting	2.4%		
Percentage of all women who received FP information during their last visit with a health service provider (2016)	23.3%	2017	PMA2020, R2

[1] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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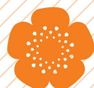

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