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.
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.
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.

### Demographic/background indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country population</td>
<td>22,667,782</td>
<td>2018</td>
<td>United Nations</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>7.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at first birth</td>
<td>18.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality per 100,000 live births</td>
<td>535</td>
<td>2012</td>
<td>Demographic and Health Survey, 2012</td>
</tr>
<tr>
<td>Newborn mortality per 1,000 live births</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality per 1,000 live births</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under-five child mortality per 1,000 live births</td>
<td>127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility-based delivery</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one antenatal visit during previous pregnancy</td>
<td>83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one postnatal visit during previous pregnancy</td>
<td>37%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Abortion and FP-related indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unintended pregnancies</td>
<td>194,000</td>
<td>2017–2018</td>
<td>FP2020 Core Indicator 2017–18 Summary Sheet</td>
</tr>
<tr>
<td>Number of unintended pregnancies averted due to use of modern contraceptive methods</td>
<td>206,000</td>
<td>2017–2018</td>
<td>FP2020 Core Indicator 2017–18 Summary Sheet</td>
</tr>
<tr>
<td>Number of unsafe abortions averted due to use of modern contraceptive methods</td>
<td>73,000</td>
<td>2017–2018</td>
<td>FP2020 Core Indicator 2017–18 Summary Sheet</td>
</tr>
<tr>
<td>Number of maternal deaths averted due to use of modern contraceptive methods</td>
<td>840</td>
<td>2017–2018</td>
<td>FP2020 Core Indicator 2017–18 Summary Sheet</td>
</tr>
<tr>
<td>Modern method contraceptive prevalence rate, all women of reproductive age (WRA)</td>
<td>15.9%</td>
<td>2017</td>
<td>PMA2020, R2</td>
</tr>
<tr>
<td>Modern method contraceptive prevalence rate, all WRA</td>
<td>15.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of FP, all WRA</td>
<td>89%</td>
<td>2012</td>
<td>Demographic and Health Survey, 2012</td>
</tr>
</tbody>
</table>

### Contraceptive use by type

#### Long-acting and permanent methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Prevalence</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization (female)</td>
<td>0.6%</td>
<td>2017</td>
<td>PMA2020, R2</td>
</tr>
<tr>
<td>Sterilization (male)</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrauterine device</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant</td>
<td>17.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Short-acting methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Prevalence</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection (intramuscular and subcutaneous)</td>
<td>40.3%</td>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>40.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other modern methods (e.g., female condom, cycle beads, and lactational amenorrhea method)</td>
<td>0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet need for FP(^1) (2018)</td>
<td>21%</td>
<td>2017</td>
<td>PMA2020, R2</td>
</tr>
<tr>
<td>Unmet need for birth spacing</td>
<td>18.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet need for limiting</td>
<td>2.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of all women who received FP information during their last visit with a health service provider (2016)</td>
<td>23.3%</td>
<td>2017</td>
<td>PMA2020, R2</td>
</tr>
</tbody>
</table>

\(^1\) 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.
REFERENCES


