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REPOSITIONING FAMILY PLANNING IN NIGER

A Baseline

This publication was prepared by Elizabeth McDavid and Anipah Kodjo of the Health Policy Project.

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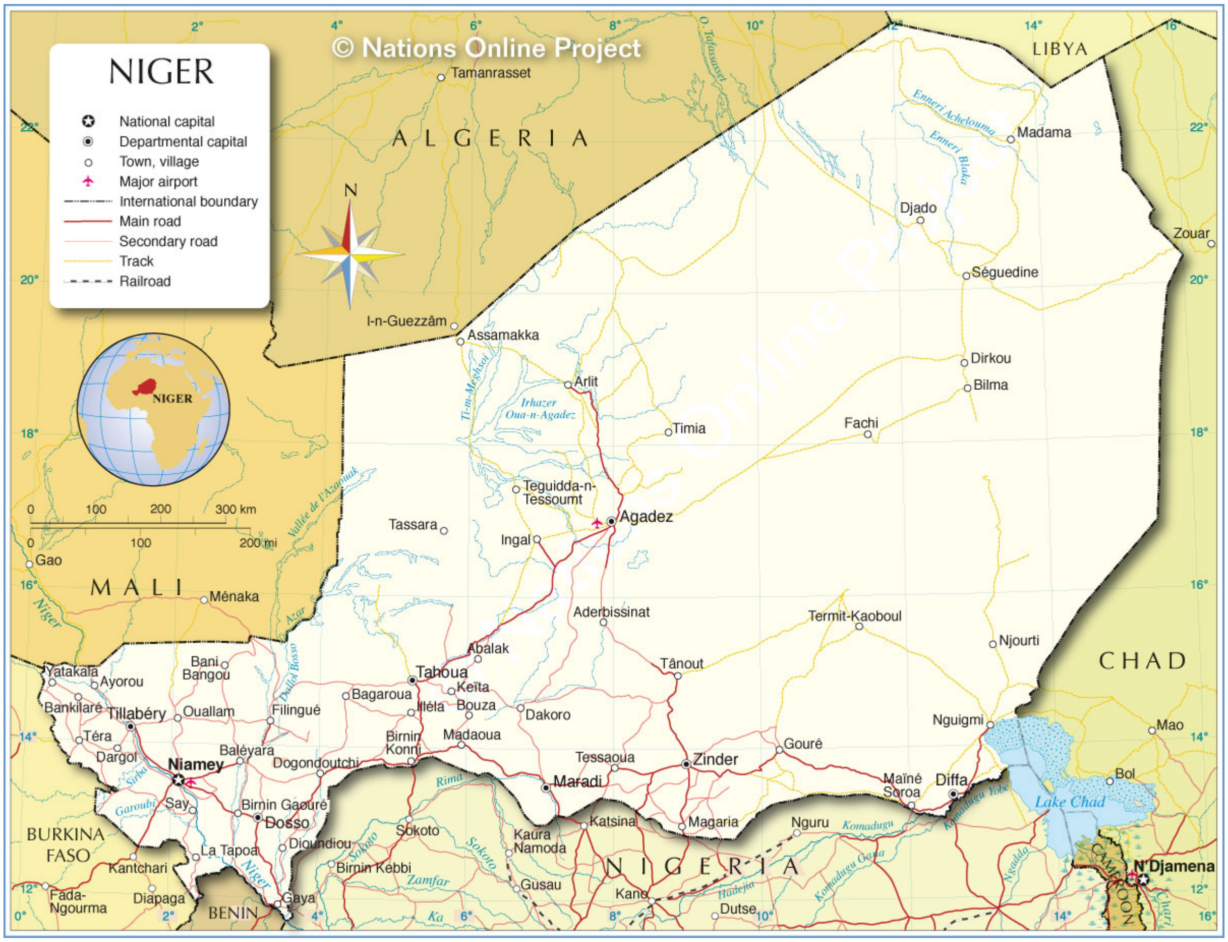
Repositioning Family Planning in Niger: A Baseline



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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANBEF	*Association Nigérienne pour le Bien Etre Familial*
AWARE II	Action for West Africa Region II
CBD	community-based distribution
CHW	community health worker
CONAPO	National Population Commission
CPR	contraceptive prevalence rate
CSP	Contraceptive Security Plan
DHS	Demographic and Health Survey
DSME	Directorate of Maternal and Child Health
FHI	Family Health International
FP	family planning
HIV	human immunodeficiency virus
HPP	Health Policy Project
INS	National Institute of Statistics
IR	intermediate result
M&E	monitoring and evaluation
MOPH	Ministry of Public Health and Fight against Epidemics
MPPFPE	Ministry of Population, Women's Promotion, and Child Protection
NGO	nongovernmental organization
PDS	National Health Development Plan
PNSR	National Plan for Reproductive Health
PRB	Population Reference Bureau
PRODEM	Multisectoral Demographic Project
SDRP	Accelerated Development and Poverty Reduction Strategy
SO	strategic objective
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

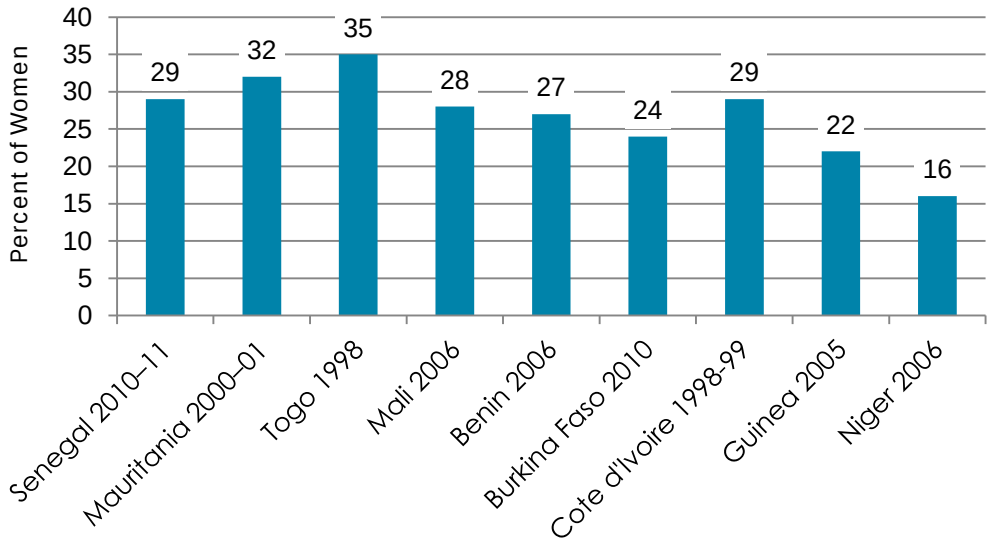
INTRODUCTION

Demographic pressures and lack of progress toward the Millennium Development Goals have encouraged countries and donors to "take a new look" at family planning (FP). Since 2001, the United States Agency for International Development (USAID), the World Health Organization (WHO), and other important partners have joined with national governments in sub-Saharan Africa in an initiative to raise the priority for family planning programs, known as repositioning family planning. The initiative was established to ensure that family planning remains a priority for donors, policymakers, and service providers in sub-Saharan Africa in an era when HIV, malaria, and tuberculosis programs dominate the global health agenda and receive a majority of the resources.

Although family planning is one of the most cost-effective, high-yield interventions to improve health and accelerate development, West Africa is lagging behind all other regions in FP use. With an average of 5.5 children per woman, the region has one of the highest fertility rates and fastest growing populations in the world. High fertility leads to many unplanned pregnancies that pose serious health risks for mothers and children. In Francophone West Africa, approximately three women die from maternal causes every hour (WHO, 2010), and one child under age five dies every minute (UNICEF, 2011).

There is substantial demand for family planning in Francophone West Africa. In six of the nine countries recently surveyed, an estimated one-third or more of currently married women have an unmet need for family planning (see Figure 1).

Figure 1: Unmet Need for Family Planning



Source: Demographic and Health Survey data (accessed at: http://www.statcompiler.com/)

Community-based programming is showing promise for expanding access to family planning. Many African countries have community-based programs to provide contraceptive methods and information to underserved groups, such as rural residents and the urban poor.

There are vast regional inequalities in access to and use of contraceptives between urban and rural populations, with rural populations almost always having fewer options. Bringing FP services into communities is an important strategy to improve access to family planning and satisfy unmet need. Several models for the provision of community-based services have been successfully tested in the region. In Francophone Africa, community-based distribution (CBD) for family planning is identified as an underutilized strategy to reach women in rural areas. Family planning is just one of the many health services that use CBD, and community health worker (CHW) training and supervision is usually integrated with these other services (child health services, malaria and diarrhea prevention and treatment, acute respiratory infections treatment, vaccinations, neonatal care, prenatal care, safe motherhood, as well as information on these and other health issues). Currently, in most Francophone West African countries, CHWs offer only condoms and refills on oral contraceptives and referrals.

The goal of USAID's Repositioning Family Planning initiative is to increase political and financial commitment to family planning in sub-Saharan Africa, which will lead to expanded access and help meet women's stated desires for safe, effective modern contraception (USAID, unpublished). The initiative has identified three key approaches or intervention areas for achieving this goal: (1) advocating for policy change; (2) strengthening leadership; and (3) improving capacity to deliver services. At the February 2011 Ouagadougou conference, "Population, Development, and Family Planning: The Urgency to Act" (www.conferenceouagapf.org/), the participating eight Francophone countries drafted action plans for repositioning family planning and appointed focal persons to spearhead implementation of these plans.[1] At a conference on civil society involvement in family planning in September 2011 in Mbour, Senegal, additional focal persons were named from civil society organizations and the action plans were further refined. CBD features prominently in the action plans.

While many activities are underway to reposition family planning, most countries lack a mechanism to assess the success of their efforts (Judice and Snyder, 2011). In response to this gap, in 2011, the MEASURE Evaluation Population and Reproductive Health project developed a results framework to assess efforts to reposition family planning. The Framework for Monitoring and Evaluating Efforts to Reposition Family Planning can be used by international donors, governments, and health programs to evaluate their efforts; identify gaps in strategies to reposition family planning in countries; and inform funding decisions, program design, policy and advocacy, and program planning and improvement (Judice and Snyder, 2011).

After an initial pilot test in Tanzania by MEASURE Evaluation, the Health Policy Project (HPP) adapted and pilot tested the framework in Togo and Niger. At the same time, the project conducted an in-depth assessment of the countries' policy and operational barriers to CBD, given its potential as a service delivery modality to increase access to and use of family planning in the region. This report presents the results of the pilot test and assessment in Niger.[2] The findings provide a strong baseline to assess progress in efforts to reposition family planning.

[1] The eight countries included Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, and Togo.
[2] The results of the pilot test and assessment in Togo are also available (visit www.healthpolicyproject.com).

NIGER: BACKGROUND

Niger's population is increasing at an average annual rate of 3.6 percent, making it the fastest growing country in the world. In comparison, the growth rate for West Africa, as well as sub-Saharan Africa as a whole, is 2.6 percent (PRB, 2011). It is projected that Niger will double its 2010 population of 15.2 million by 2025 (INS and Macro International, 2007). Niger's population could reach 55 million by 2050 (PRB, 2011), which would make it the second most populous country in West Africa after Nigeria (Government of Niger, 2006). With nearly half (49%) of Niger's population under age 15, it has the highest proportion of young people among all the world's countries (PRB, 2011). This large proportion of youth has major implications for future socio-economic development.

The 2006 Niger Demographic and Health Survey (DHS) indicated that the contraceptive prevalence rate (CPR) was 11 percent for all methods and 5 percent for modern methods. Nearly one in six married women (16%) want to space or limit future births but are not using family planning. Women in Niger have one of the highest fertility rates in the world, with an average of seven children during their lifetime (INS and Macro International, 2007). A more recent study funded by the United Nations Population Fund (UNFPA) shows considerable improvement, with CPR at 16 percent for modern methods (18% for all methods) (MOPH, 2010). FP champions in Niger appear to be hopeful that the 2011 DHS will validate the results of the study. Notably, the 2006 DHS attributed the gap between unmet need and the CPR to the following main factors:

Box 1. Ratio of Health Professionals to Population, 2007

Doctors	**1:29,231**
Nurses	**1:10,358**
Midwives	**1:5,931**

Source: Ministry of Finance/INS, 2008

- Lack of information or incorrect information about family planning
- Lack of access to family planning, with only 42 percent of the population living within five kilometers of an integrated health center (Ministry of Finance/INS, 2008)

Besides limited geographic accessibility, Niger has a critical shortage of health workers, especially at the district and community levels. The new government pledges to recruit another 1,158 health professionals (Niger dans le Web, 2011), but many more health workers are needed. The World Health Organization recommends a ratio of 2.28 healthcare professionals per 1,000 people (WHO, 2006). However, as shown in Box 1, in Niger health professionals cover many thousand people.

The rapid population growth outpaces advances in the areas of education, health, agricultural production, and employment; and contributes to extremely weak social indicators (see Box 2) and chronic food insecurity, with annual shortages between crops in June and September. The rapid growth also affects the environment, including potable water, as well as housing and employment (Guengnant, 2010).

Among West African countries, Niger has the largest geographical area, but the population is unevenly distributed. Nearly all of the people (94%) live in the southernmost strip of arable land, and the remaining 6 percent inhabit the vast desert in the north (Ministry of Finance/INS, 2009). Most of the population is

rural; only 20 percent live in urban areas, mainly in the three largest cities (Niamey, Maradi, and Zinder) (Government of Niger, 2006). About 99 percent of the population is Muslim (MOPH, 2010).

Box 2. Key Health Indicators

Maternal mortality ratio:	**590 deaths per 100,000 births**
Vaccination coverage:	**29% of children 12–23 months old**
Infant mortality rate:	**81 deaths per 1,000 births**
Women ages 15–49 with no formal education:	**84%**
Child malnutrition:	**50% of children under age 5 are stunted**
Girls ages 15–19 who are married:	**59%**

Source: Macro International and INS, 2007; WHO, 2012a

To respond to these demographic and socio-economic challenges, the government of Niger adopted a new National Population Policy in 2007. Its objective is to reduce the annual population growth rate from 3.3 percent to 2.4 percent by 2015 through increased use of modern contraceptive methods and an emphasis on girls' education to reduce early marriage and encourage smaller families. Strategies also include the provision of correct and complete information about family planning to dispel rumors and raise awareness of the benefits of family planning.

Niger's National Family Planning Program (1984–1994) permitted the country to take small steps in introducing family planning to the nation. It identified FP indicators and began small-scale programming. The National Health Development Plan (PDS) for 1991–2004, which lays out the national health strategy, made a strategic choice to fold family planning into reproductive health (RH), where nine units covering RH issues, including family planning, were divided among four major areas. Family planning was put under "women's health." The PDS was well oriented toward obstetric care, but it marginalized FP and prenatal care. The National Plan for Reproductive Health's (PNSR) verdict on the PDS was that it was a failure, since no reductions in maternal mortality or signs of slowing the demographic increase took place using this strategy (PNSR 2005–2009). Since that time, the Ministry of Public Health and Fight against Epidemics (MOPH)[3] has revised its norms and standards to include family planning, and training has occurred. The PDS (2011–2015) gives priority to strengthening health services, expanding access to primary healthcare, addressing reproductive health, and improving management systems.

Two in three women (67%) using modern contraceptive methods receive their method from the public sector—mainly from integrated health centers (45%) and maternities (14%) and also from health posts (4%) and public hospitals (4%). The private sector is gradually expanding. It serves one in four (24%) modern contraceptive users—mainly in pharmacies (11%) and private hospitals and clinics. The remaining sources are itinerant sellers and shops. The pill is the most popular contraceptive method;

[3] The Ministry of Public Health and Fight against Epidemics is abbreviated as MOPH in this document for ease of reading. Note that the French abbreviation is MSP/LE.

sources of the pill are about evenly split between public and private outlets. The public sector provides nearly all injectables. Use of female sterilization, the IUD, and the male condom is low (Macro International and Ministry of Finance/National Institute of Statistics, 2007).

Community-based distribution of contraceptives in Niger began in the early 1990s. CARE and later UNFPA provided it in about 100 villages. Since that time, a few other organizations have begun supporting CBD, mostly through integrated programming. Today, it is more widespread but still does not cover the whole country. It is highly dependent on donor-funded projects, although the government is trying to introduce a uniform training program. CHWs are usually charged with an integrated package of interventions focused on malaria prevention/mosquito nets, the Integrated Management of Childhood Illnesses package at the community level, immunization, prenatal and birth planning, and nutrition. Again, this work is dependent on donor projects.

As noted, the CHWs can provide only condoms and oral contraceptive refills. For initial pill prescriptions and other contraceptive methods, clients need to go to health centers. Injectable contraceptives are provided at the health center level, where staff are trained.

There is also a mobile outreach component, in which health providers from the districts visit health centers to provide FP methods not usually available there. This activity is controversial because of its high cost. It is limited to areas that receive donor funding.

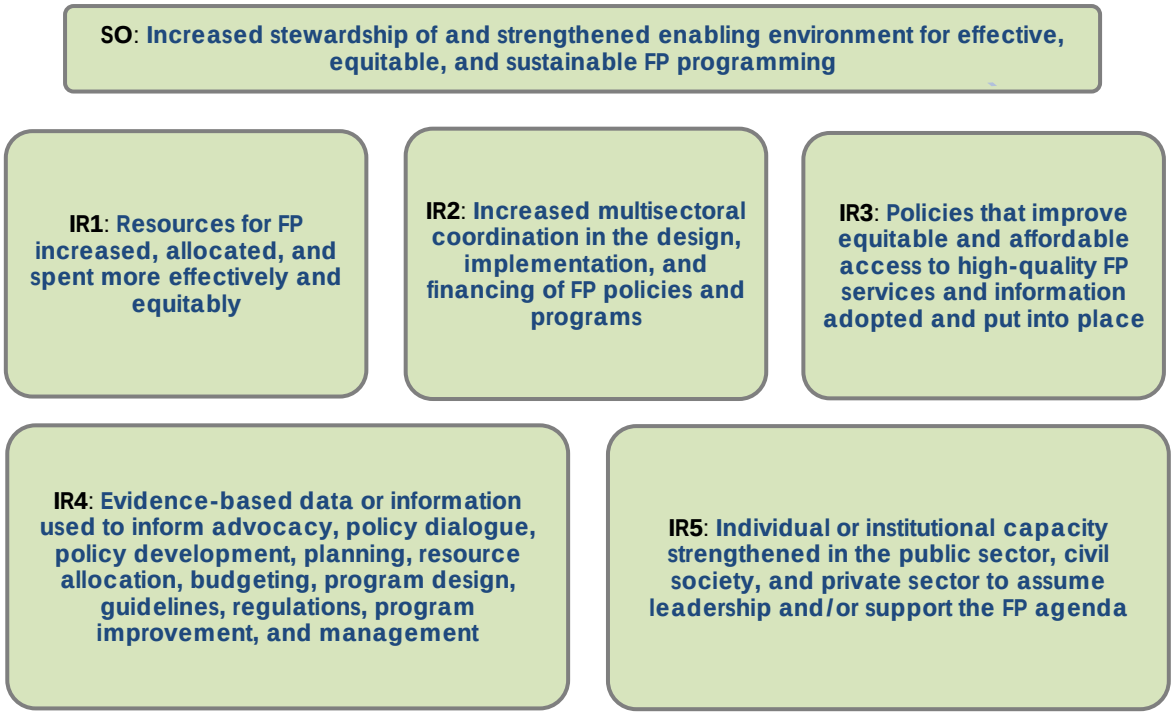
FRAMEWORK FOR ASSESSING THE REPOSITIONING FP INITIATIVE

The overall strategic objective (SO) of the Framework for Monitoring and Evaluating Efforts to Reposition Family Planning (hereafter referred to as the M&E Framework) is "Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming." Under the SO, there are three illustrative indicators:

1. Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program
2. Instances of documented improvement in the enabling environment, using a validated instrument
3. Evidence of FP policies implemented and resources allocated and subsequently used in relation to the same FP policy

Each IR has specific indicators that contribute to overall achievement of the IR (see Figure 2).

Figure 2. Results Framework for Strengthening Commitment to and Increased Resources for Family Planning



Source: Judice and Snyder, 2011

Methodology

This study included two components:

1. Pilot testing of the M&E Framework
2. In-depth assessment of policy and operational barriers to community-based distribution

Document review and key stakeholder interviews

An HPP staff member and a local consultant conducted the study. Field work took place in Niger from October 12–29, 2011. The M&E Framework was pilot tested through conducting a document review and key stakeholder interviews. HPP used the framework first tested in Tanzania in 2011—adapting its components, indicator sheets, and interview guides for use in West Africa and translating them into French. HPP initially tested the framework in Togo and then further adapted it for Niger by eliminating redundancies and using the interview guides developed for the Tanzania pilot test to facilitate the flow of conversation.

First, the HPP team reviewed policies, strategies, program materials, and other information related to the framework and policy barriers to CBD. Next, the team conducted key informant interviews based on the guides tailored to Niger (see Annexes 3 and 4). In collaboration with the Directorate of Maternal and Child Health (DSME), the team selected two districts—Say and Kollo. The criteria were that one district be where an Action for West Africa Region II (AWARE II) pilot project was planned;[4] the other district be where CHWs perform CBD activities, including family planning, but an AWARE II pilot project was not planned; and both districts be located within a short distance from the capital to conserve travel time and cost.

The key informants were identified through (1) contacts of the AWARE II project, (2) documents, and (3) subsequently, other informants (see Table 1). Those interviewed included two of the four focal persons for the Repositioning Family Planning Initiative; government and donor focal persons identified and nominated at the Ouagadougou FP conference in February 2011; and civil society organization (CSO) focal persons identified at the Dakar conference for CSOs in September 2011. In Niger (and Togo), HPP interviewed a small number of CHWs and local leaders to assess the various policy barriers to CBD.

Table 1: Affiliation and Sex of Key Informants Interviewed in Niger

	Government Officials	Donors	Cooperating Agencies/Civil Society Orgs.	CHWs	Local Leaders	Total
Men	6	2	6	1	4	19
Women	4	1	6	2	1	14
Total	10	3	12	3	5	33

[4] At the time the team was in Niger, AWARE II was planning a pilot activity for CBD in two districts, but the activity was subsequently cancelled.

The team conducted individual interviews, but in many cases, the informant called in a colleague for additional information, which enriched the responses. The interview findings were cross checked for consistency and entered into the records after each day's interviews. Overall, the interviews helped confirm the findings of the document review and provided some additional information on the implementation status of various plans. In addition, the interviews helped identify barriers not previously identified during the document review.

Ethical considerations

The protocol and data collection instruments for both study components were submitted to the Futures Group Research Ethics Committee and deemed exempt from review by an Institutional Review Board.

Study Limitations

The study group may not be representative of Niger as a whole. The two districts visited—Say and Kollo—are relatively close to the capital Niamey. As in many African countries, ethnicity, language, and geography in Niger create significant differences among regions within its borders. Anecdotal information collected suggests that circumstances in other districts may be different from those found in these two districts. For example, the ethnic groups in Say and Kollo (mostly Peul and Djerma) are different from most of the rest of the country (Hausa, Toubou, and Peul). Time, distance, and cost prevented the team from visiting districts in the country's interior.

Despite these limitations, this study provides an important baseline for repositioning family planning in the country and identifies key challenges to raising family planning on the agenda and expanding FP services through CBD.

ASSESSMENT FINDINGS

This section presents the findings from the pilot test of the M&E Framework. The findings are presented according to the SO indicators and intermediate results, as delineated in the framework. Annex 2 summarizes the findings in table format.

SO: Increased Stewardship of and Strengthened Enabling Environment for Effective, Equitable, and Sustainable FP Programming

Indicator 1: Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program

In 1993, the Government of Niger created the National Population Commission (CONAPO) to implement the first National Population Policy (1990). The commission is part of the Ministry of Population, Women's Promotion, and Child Protection (MPPFPE) and is responsible for coordinating and harmonizing all population activities. CONAPO comprises a national office, regional offices in each of Niger's eight regions, and 36 district offices. Many informants reported that the commission is still dysfunctional and thus needs to be made operational. One informant from a partner organization described it as "multisectoral, but ceremonial."

"Policies and policy implementation are two different things… good policies exist but implementing them is another matter and involves resources, which are lacking in Niger."
—A MOPH official

The MPPFPE oversees and implements advocacy and public awareness activities on population and FP issues. As such, the ministry implements the World Bank-funded Multi-Sector Demographic Project (PRODEM), which takes a multisectoral approach to addressing these issues. PRODEM includes government agencies, such as the DSME, and two local nongovernmental organizations (NGOs)—the *Association Nigerienne pour le Bien-Etre Familiale* (ANBEF)[5] and *Animas Sutura*. ANBEF provides comprehensive sexual and reproductive health services in clinics and mobile units, with a focus on serving youth and disadvantaged groups. According to informants, PRODEM has never been evaluated. The project ends in 2012, and informants did not know if there would be a follow-on issued.

The DSME oversees all maternal and child health activities, including family planning. According to the key informants, the directorate has a huge portfolio and is under tremendous pressure to oversee, coordinate, and implement all the service delivery aspects of maternal and child health. Several respondents said that the DSME's planning, organization, and coordination are inadequate. They mentioned the lack of efficient management despite adequate staffing at the national level. It appears that daily management responsibilities and heavy workload take precedence over strategic leadership and coordination. One key informant stated that "One part does not know what the other part is doing." This

[5] ANBEF is the local affiliate of the International Planned Parenthood Federation.

situation could change, since on the day the HPP team completed its work in Niger, the government announced a reshuffling of many posts, including a new head of DSME.

Some donor representatives stated that the directorate is so slow in implementing activities that allocated resources are not used in a timely manner and sometimes have to be returned.

In summary, the respondents indicated that while government entities are in place to oversee and actively manage the FP program, the coordination and implementation of their activities need to be improved.

Indicator 2: Evidence of documented improvement in the enabling environment for family planning using a validated instrument

Data from two validated instruments are available to assess the enabling environment for family planning in Niger: the Family Planning Program Effort (FPE) Score and Contraceptive Security Index.

The FPE Score was developed as an international measure to gauge key areas of each country's FP program. It is based on ratings of 17 indicators related to the supply chain, finance, the health and social environment, access to FP, and use of FP. Niger's score has risen markedly in recent years—from 26.3 in 2004 to 55 in 2009—indicating major progress, especially in the areas of policies and plans to strengthen the FP program (Ross and Smith, 2010). However, as the highest score is 100, Niger's score still indicates considerable room for improvement.

The Contraceptive Security Index is based on ratings of 17 indicators related to the supply chain, finance, the health and social environment, access to FP, and use of FP. The 2009 Contraceptive Security Index for Niger was 46.5, demonstrating a relatively low level of contraceptive security (USAID | DELIVER, 2009). In addition, the DSME, WHO, and other partners created a 14-point questionnaire (MOPH and WHO, unpublished) to assess Niger's repositioning FP efforts in advocacy. It has only been applied once, and it is unclear how it will be used beyond evaluating advocacy efforts.

Indicator 3: Evidence of FP policies implemented, resources allocated, and subsequently used in relation to the same FP policies

A review of policies shows that Niger has many key policies in place to implement a strong FP program. In 2006, the Government of Niger passed the Reproductive Health Law, which establishes the right of all citizens to access services, information, and education about reproductive health. Also in 2006, the government issued a declaration that certain RH services (including all FP methods) will be free-of-charge (MOPH, 2006). Since then, the government has allocated resources and made efforts to implement this policy. However, according to the informants, actual implementation is slow.

Inadequate staffing is a key factor limiting access to FP services. Respondents, including CHWs and providers at other levels, said that the DSME has sufficient staff at the *national level* to implement the FP program, but districts and communities need more qualified and better trained CHWs and medical professionals, such as nurses, midwives, and doctors (see Box 1 on page 3).

Increasingly, African countries are setting up programs to allow trained community-based workers to provide injectable contraceptives. New WHO guidelines affirm that this practice can be done safely in the context of targeted monitoring and evaluation (WHO, 2012b). This innovation would greatly expand access to family planning in Niger, given the role of CHWs as frontline health providers and the growing demand for injectables.

Some respondents expressed the need for a comprehensive policy on community health that would allow CHWs to provide additional FP methods such as injectables (besides condoms and pill refills) and would create a plan and strategy for sustaining CHWs and the services they provide. To make this change, CHWs would need training to ensure adequate quality of care, and a supervisory system and improved commodity availability would need to be in place. The DSME plans to revise and update most policies and/or strategies in conjunction with the development of the new National Development Plan scheduled for 2015.

In 2007, the MOPH adopted the Contraceptive Security Plan (CSP) (2007–2011). It includes an assessment of the RH situation in Niger, a full projection for the time period, a strategic framework, objectives with indicators, a budget, a capacity-building plan, and a monitoring and evaluation plan. The DSME and UNFPA have done an evaluation of the CSP, and the DSME is finalizing a new plan for 2012–2015. After donor support for the previous contraceptive supply system ended in the 1990s, the government had to rebuild the entire system, with much difficulty. Today, it retains control over the CSP.

Although key informants in the MOPH stated that annual reports and evaluations exist and show that resources are used to implement policies, the HPP team was not able to locate any document or report related to implementation other than the PNSR.

Intermediate Result 1: Resources for Family Planning Increased, Allocated, and Spent More Effectively and Equitably

The M&E Framework has four indicators related to resources for family planning:

- IR1.1: Total resources *spent* on family planning (by source and by activity/program area)
- IR1.2: Number of new financing mechanisms identified and tested
- IR1.3: Total resources *allocated* to family planning (by source and by activity)
- IR1.4: New and/or increased resources are committed to family planning in the last two years

The HPP team was unable to identify the total resources spent or allocated for family planning in Niger. Such data do not seem to be available. Data are, however, available for expenditures and budget allocations for contraceptive supplies. The team recommends that these data serve as proxy indicators for FP resources until more comprehensive data become available. As indicated below, existing data show important progress in the provision of contraceptives, suggesting increased contraceptive use.

All the respondents recognized that UNFPA provides most of the contraceptive supplies in Niger. UNFPA provided data for contraceptive procurement, covering all recipients (both public and private agencies) from 2006–2009. These data show that expenditures for contraceptive commodities have more than tripled in just four years (see Table 2).

Table 2: UNFPA Expenditures for Contraceptive Commodities, 2006–2009

Year	US$ Spent[6]
2006	523,474
2007	398,417
2008	1,539,294
2009	1,954,105

Source: UNFPA, 2010

According to partner organizations, the Government of Niger established a budget line item for reproductive health products, including contraceptives, in 2010, and the country has regularly provided 55 million West African CFA francs[7] in funding each year. Donors contribute to health programs through a "common fund." However, the HPP team was unable to find information on the size of the fund; how and when the money is programmed and spent; and whether family planning is included.

Consistent with UNFPA's data, ANBEF expenditures for contraceptive commodities have also increased dramatically in recent years. The organization's 2010 expenditures were nearly eight times greater than those in 2008 (see Table 3). Its staff also reported that the International Planned Parenthood Federation's headquarters contributed some free pills but were not able to provide an amount.

Table 3: ANBEF Expenditures for Contraceptive Commodities, 2008-2010

Year	Amount (US$)
2008	2,553
2009	10,073
2010	20,300
Total	32,926

Source: ANBEF, 2011

Animas Sutura, a local NGO that expanded its HIV work to include family planning, has introduced a socially marketed pill, Sutura. The HPP team did not obtain any information on Sutura sales. Nevertheless, contraceptive sales indicate that the private sector can successfully find its place in the Niger FP market.

[6] Based on 450 CFA = US$1.
[7] Approximately US$122,000 (exchange rate 450 CFA = US$1).

According to UNFPA, donors also provided funding for advocacy. In 2009, UNFPA and WHO contributed 7 million CFA and 8 million CFA, respectively. This included validation of an advocacy tool and training of trainers.

In terms of human resources, the government recognizes the need for more health professionals. In 2011, it recruited 450 doctors and is currently recruiting another 1,518 health professionals, including midwives, nurses, and technicians.

Intermediate Result 2: Increased Multisectoral Coordination in the Design, Implementation, and Financing of FP Policies and Programs

This IR assesses the extent to which various disciplines, such as health, education, agriculture, and the environment, as well as the public and private sectors, are involved in FP policymaking and implementation. In general, the HPP team found numerous examples of multisectoral coordination, which will be reported under the various sub-IRs.

IR2.1: Evidence of FP programs incorporated into national strategic and development plans

Population and FP issues are integrated into national policy statements and plans. Support for these issues reaches to the highest levels of government. When the new Niger government announced its General Policy Statement in 2011 after the inauguration of the newly elected President Issoufou, five out of nine of the principal points focused on population.

The most important health and development policies mention family planning and often include FP indicators and budgets. In the health sector, these documents include the PDS and PNSR and regional plans. The Ten Year Education Development Plan includes family planning. Similarly, the national policies on youth, gender, water and sanitation, women's promotion, and child protection include family planning (see Box 3).

Box 3: Key National Policies and Plans that Include Family Planning

- **General Policy Statement (2011)**
- **Rural Development Strategy (2003)**
- **National Population Policy (2007)**
- **National Health Development Plan (2011–2015)**
- **National Reproductive Health Program (2005–2009)**
- **Ten Year Education Development Plan (2007)**
- **National Gender Policy (2008)**
- **National Policy on Food and Nutrition (2006)**
- **National Rural Development Strategy (2003)**
- **National Policy on Social Protection (2011)**

As previously discussed under Indicator 1, the Government of Niger tasks PRODEM with the coordination of all advocacy, information, and sensitization related to family planning. The DSME is responsible for implementing all activities related to the provision of maternal and child health services, including family planning.

IR2.2: Evidence of governments engaging multiple sectors in FP activities

The government has engaged multiple sectors—including health, education, rural development, gender, food and nutrition, and social protection—in FP activities. Examples of multisectoral engagement in family planning can be found in the policy statements, strategies, and plans listed in Box 3.

IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy

As previously mentioned (see Indicator 1), the DSME is the main body that coordinates multisectoral planning of FP activities. According to representatives of its partners, the directorate does not always take the lead in coordinating partners; often the partners initiate activities. One representative of a partner organization stated that "The government is obliged to take the leadership role and the partners accompany the process, but there are a lot of difficulties in coordination."

Under the CSP, two multisectoral committees—one technical and one for coordination—were established. Both committees include the private sector, religious leaders, and local NGOs. Most informants stated that these committees need assistance to become operational and that more effective implementation could be achieved with better coordination and closer follow-up on the plan.

According to the respondents, although multisectoral structures have been established, they need strengthening.

IR2.4: Evidence of government support for private sector participation in family planning

The government includes NGOs, civil society groups, and private providers in advisory groups and consultative meetings. One specific example of private sector participation in family planning is the government's approval for social marketing of the pill. In 2006, the MOPH authorized *Animas Sutura* to sell the Sutura pill and allowed it to be included in the national pharmaceutical company's list of products. While public facilities provide all contraceptive methods free-of-charge, the Sutura pill offers clients a choice of brands and convenient access.

Intermediate Result 3: Policies that Improve Equitable and Affordable Access to High-Quality FP Services and Information Adopted and Put into Place

IR3.1: Existence of national or subnational policies or strategic plans that promote access to family planning services and information

Niger has several policies that promote access to FP services and information. The Reproductive Health Law of 2006 provides the framework for FP programs. Family planning is included in the Minimum Package of Services that the government requires each health facility to provide. The HPP team observed that the RH Law was posted on the wall in many government, NGO, and partners' offices.

The PDS 2005–2009, which was just evaluated, focused on maternal and child health. According to government informants, PRODEM and the DSME implement the plan. In the preface of the document, the authors make it clear that "the central preoccupations of the PDS are the sick person, demographic increase, and mother and child health. This is why the strategic objective of the PDS is to contribute to the reduction of maternal, infant, and child mortality by improving the effectiveness and quality of the

health system using its current potential." The government adopted the new PDS for 2011–2015 in January 2012.

The PNSR (2005–2009) is another mechanism that facilitates access to information and services and follows from the PDS.

Each of Niger's eight regions (which include the capital as one region) developed their own regional health development plans, and at least some districts, such as Boboye (MOPH, 2011) developed district health development plans. This shows that the national health plan is rolled out to the regions and districts for implementation.

IR3.2: Existence of national or subnational policies or strategic plans that promote access to FP services and information for underserved populations

All of Niger's important policy documents aim to create an enabling environment for achieving the Millennium Development Goals, combating poverty, and promoting sustainable and sustained economic growth for the people of Niger (Prime Minister's Office, 2007). In 2002, Niger established the Poverty Reduction Strategy for 2005–2009 and, in 2007, issued a revised policy, the Accelerated Development and Poverty Reduction Strategy (SDRP) for 2008–2012. The SDRP provides the framework for all of Niger's policies and other strategies. It targets family planning by setting the objective of achieving a total fertility rate of 6 children per woman by 2012. Niger has developed a series of strategies, declarations, and plans for different sectors to ensure alignment and harmonization with the SDRP.

Most Nigeriens can be considered underserved or vulnerable, as only 42 percent of the population lives within 5 kilometers of a health facility. The RH Law passed in 2006 and the General Declaration on Population (2007) state that FP services are to be provided free-of-charge to the client.

Reaching rural people is a key aspect of FP programs, as more than 80 percent of the population live in rural areas. Community-based provision of contraceptives is a central factor in improving access to FP services and information. The government informants stated that the current package of CBD services does not yet include all contraceptive methods. Also, the current policy on CBD needs to be revised to allow CHWs to provide a greater variety of contraceptive methods to meet the needs of more women.

Each time the government plans to develop an updated or follow-on policy or strategy (e.g., PDS, PNSR, or CSP), it first evaluates the previous one. Out of this analysis come lessons learned, best practices, ideas for new initiatives, research, new commitments, and new ways of working. The government then incorporates these into the new versions. For example, the PDS 2005–2009 does not emphasize CBD for family planning, but the new draft (2011–2015) emphasizes CBD as a way to increase access in rural areas.

IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy

Most respondents could cite at least two or three different guidelines or plans that accompany national FP policies. They noted that implementing instructions or operational guidelines exist for the PNSR. Documents that provide information on implementing parts of FP policies include the Road Map for Fighting Maternal Mortality (2006–2015), the norms and standards for reproductive health, the CBD guide and training plan, and the "Note on implementing the free services policy." Local leaders

interviewed confirmed that health staff implement policies through FP information and services. The CBD guide and training plan need to be updated, according to informants.

IR3.4: Evidence that policy barriers to access to FP services and information have been identified and/or removed

The decision to make FP services free to all clients was taken without looking at the financial implications and ensuring that the necessary adjustments in the health system were in place. Respondents considered the provision of free FP services to be highly beneficial in removing financial barriers to accessing FP services. The local leaders have first-hand experience of the positive effects of free services on their community. For instance, one leader stated that women are more likely to present for FP services if they are free, and husbands are more inclined to allow them to use family planning.

At the same time, health facility management committees worry that they will not be reimbursed for the cost of the free FP services. These committees disburse the funds required to provide free services to the clients. One facility management committee member expressed concern that the government would not reimburse the committee for the 200 million CFA spent on the provision of free services.

IR 3.5: Evidence of the implementation of policies that promote FP services and information

This topic has been covered in previous sections under IR2 and IR3.

Intermediate Result 4: Evidence-based Data or Information Used to Inform Policy Dialogue, Policy Development, Planning, Resource Allocation, Budgeting, Advocacy, Program Design, Guidelines, Regulations, and Program Improvement and Management

This IR assesses the extent to which policies and programs are grounded in data and information to ensure that there is a sound rationale for selecting the program strategies, activities, and other elements.

IR4.1: Evidence of data or information used to support repositioning FP efforts

The government's most common piece of information used to convince leaders of the importance of family planning is that Niger may become the second most populous country in West Africa by 2050 if its population continues to grow at the current rate. Government leaders appear to understand the implications this will have on health, education, water resources, education, and agriculture and now use this information to encourage contraceptive uptake.

Current policies and program strategies are based on the earlier projections and data from the 2006 DHS and 1995 Multiple Indicator Cluster Survey (MICS). The 2010 contraceptive prevalence study found that the contraceptive prevalence rates for modern methods and all methods was 16 percent and 18 percent, respectively. The studies used to inform the new health and population policies were the 2006 DHS and the 1995 MICS. The recently completed MOPH study on contraceptive prevalence will serve as a basis for future strategies and plans.

Both the UNFPA and WHO have a focal person to follow progress and support FP repositioning in Niger. The agencies have also contributed to the development of a 14-point questionnaire to measure progress.

IR4.2: Evidence of international best practices incorporated into national health standards

According to respondents, the best practices adopted in Niger include CBD, communication, sensitization of men and religious leaders, and advocacy. However, implementation of these best practices is somewhat limited; for example, CBD for family planning includes only pill refills and condoms. According to government respondents, the *école des maris* (school for husbands) is a local best practice that targets men and will feature prominently in future plans. These respondents also indicated that mother and child health is put much more in the forefront than family planning in the *écoles des maris*.

IR4.3: Evidence of a defined and funded research agenda in family planning

The HPP team was unable to find evidence of an FP research agenda, nor of funding allocated to FP research. A representative of one partner stated that research "is the most neglected component."

IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis, and communication of FP information

Similar to the finding from IR4.3, the HPP team found little technical capacity to collect, analyze, and disseminate FP information. In theory, the DSME has the capabilities required to undertake a research program, but the team did not find any evidence of an FP research agenda. In addition to the directorate, the team also met with NGOs that have capacity in research for family planning, but they mainly conduct research based on their program needs (e.g., related to project baseline/endline studies and knowledge attitudes, and practice studies) and involve the DSME as a partner.

Intermediate Result 5: Individual or Institutional Capacity Strengthened in the Public Sector, Civil Society, and Private Sector to Assume Leadership and/or Support the FP Agenda

IR5.1: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning FP activities

Interviews with partners, government, and donors, as well as visits to ANBEF and *Animas Sutura's* headquarters in Niamey, confirm that these two national NGOs can independently implement repositioning FP activities. Both NGOs have been actively involved in refining Niger's Repositioning Family Planning Action Plan developed at the Ouagadougou West Africa FP conference in February 2011. They provide information and services in areas where they work and have mobilized funds to support repositioning FP activities.

IR5.2: Evidence of government departments or other entities established or strengthened to support the FP agenda

According to government and NGO informants, the MPPFPE has expanded its role and strengthened its mandate to coordinate all population-related advocacy and sensitization with the initiation of PRODEM supported by the World Bank. The ministry involves diverse partners in repositioning FP activities. Under PRODEM, the UNFPA has strengthened the Ministry of Education by providing support and training to introduce age-appropriate sexual and RH modules at different levels in the education system.

IR5.3: Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment to family planning

In Niger, FP champions exist at all levels, and the government and its partners focus on strengthening them. The respondents provided many examples of strong advocacy skills among government and religious leaders, civil society organizations, and other Nigerien actors as FP champions.

"An opening in FP exists and there is a lot of interest now (that the government aims to develop a long-lasting FP strategy and make contraception available to everyone)."

—A government official

High-level leaders have made public statements supporting family planning. In his speech in 2011 to introduce the new government and its general policy, Prime Minister Brigi Raffini emphasized reproductive health and the need to reduce maternal mortality.

Respondents said that the government has instructed local authorities and leaders to use every possible occasion for FP advocacy. Hence, all regional and local-level authorities (administrative and traditional leaders) are to include FP messages in their speeches on all occasions. For example, on October 10, 2011, local leaders took advantage of International Family Planning Day to advocate for family planning. At a health center, an area chief made a speech on the benefits of family planning. In Niamey, the First Lady and the Minister of Public Health presided over the day's events and activities. They used the opportunity to sensitize and inform attendees—including youth, religious leaders, parliamentarians, men, and women—on family planning.

Animas Sutura has built the capacity of a highly popular traditional wrestler to be a champion for condoms. Each time he wins a fight, he holds up the condom package. This has translated into advertising on television, radio, and posters in the country. In addition, the NGO has built the capacity of three popular women singers, all named Fati (collectively called "the Three Fatis") to be FP champions. According to partners, before the Three Fatis began championing family planning, one could not talk openly about it and had to use terms such as "birth spacing" or "responsible parenthood." The Three Fatis contributed to this change by singing openly about family planning.

The *école des maris* (husbands' school) is one activity that develops local male FP champions. Several informants in the health districts and from local and international NGOs reported that men and religious leaders are now much less resistant to family planning but that some people still remain unconvinced of its benefits.

Support for family planning is growing. A donor representative stated, "Religious leaders are starting to become cognizant of the fact that FP is helpful for the family's health and that the arable land is limited. But more people still need to be convinced." An NGO representative agreed: "We can now talk openly about 'family planning' and not only 'responsible parenthood' or 'birth spacing.' We can say 'family planning' and not get a negative reaction. However, the battle is not won yet. We still need to watch the soup on the fire (*Il faut surveiller la soupe sur le feu*)."

IR5.4: Number of regional/national centers or collaboratives for shared education and research in family planning

The HPP team identified the National Center for Reproductive Health (CNSR), a structure of the DSME, as a referral center and center of excellence. Created in 1995, the CNSR was intended to incorporate the new vision of reproductive health articulated by the Cairo International Conference on Population and Development and be a center of excellence, research, and training in reproductive health. However, the CNSR has not fulfilled these expectations. It has only four staff and does not have a gynecologist on staff. Thus, it does not have the level of specialized services intended at its creation. Apart from the sonogram unit that continues to be busy, the center can no longer deal with infertility, genital cancers, or any curative functions. It functions today more like a simple health center that is not visited often.

The HPP team did not find any research collaboratives or centers that share FP research. Government and partner respondents confirmed that any time a partner conducts research, it does so in collaboration with the DSME and shares the results.

Overall, the assessment found that many policies exist but are in need of revision, which is an ongoing process. Strategies and plans to implement the policies exist, and they often include indicators, benchmarks, budgets, and M&E plans, but translating this to action is difficult. Niger also needs to improve its coordination and management of the FP/RH program and develop and strengthen FP champions, especially in rural areas, where more than 80 percent of the population live.

BARRIERS TO COMMUNITY-BASED DISTRIBUTION OF FAMILY PLANNING IN NIGER

Community-Based Programs in West Africa

Community-based programs typically offer oral contraceptives and condoms and increasingly injectables. The programs either offer contraceptives free-of-charge or sell them at a subsidized price. Some countries have an existing cadre of CHWs, while others have set up a network of community distributors working under public or private programs to promote FP and other health issues.

Several West African countries have implemented successful community-based FP programs. However, many programs were implemented as pilot studies and were not sustained or scaled up. For example, a pilot project in Mali to provide community-based programming increased contraceptive prevalence from 23 percent at baseline to 68 percent at the end of the project (Leonard, nd). Factors that contributed to the project's success include (1) recent adoption of national policies that facilitated women's access to family planning; (2) the integrated nature of the project; (3) the relative sophistication of the NGO sector in Mali; and (4) prior long and sustained efforts to raise awareness of family planning and increase access to CBD in some areas. Similarly, a pilot project in Senegal found that CBD was effective in quickly expanding access to FP/RH services in remote areas (Sanogo et al., 2004). While the pilot in Mali was not scaled up, another project is underway in the country. In Senegal, the NGO, Childcare, has recently designed another pilot project to test whether CHWs can provide injectables at the community level.

One aspect of CBD programs capturing the attention of health officials is the potential for providing injectable contraceptives in the community. Ten international organizations have endorsed the conclusions of a technical consultation held at the World Health Organization in 2009. Based on a review of scientific and programmatic experience, the experts concluded that trained CHWs can screen clients effectively and provide progestin-only injectables safely (WHO et al., 2010).

Injectables are the most popular contraceptive method in East and Southern Africa, accounting for 36 percent of all contraceptive use. In West and Central Africa, they are not as popular, making up about 13 percent of all contraceptive use. Nevertheless, injectable use has increased sharply in West and Central Africa in the past decade (Ross, unpublished).

Several countries in Francophone West Africa are conducting pilot studies on CHW provision of injectables. For example, in Burkina Faso, the Ministry of Health and Gesellschaft für Internationale Zusammenarbeit (GIZ) are currently conducting such a study (Douti, 2002). In Togo, the USAID-supported AWARE II project is also piloting provision of injectables by CHWs. The lessons learned from these pilot studies can be used to scale up CBD programs and develop appropriate national policies and operational guidelines.

CHWs and village health workers of different types have existed in Niger for decades. They provide a broad range of health services, especially related to child health. Adding family planning to their work is relatively recent, beginning in the early 1990s. Currently, the CBD program allows for condoms and pill refills. However, this program is not yet implemented nationwide. Injectables are not available at the community level—only at the health centers.

Barriers

Informants identified barriers to FP provision in the community, especially in rural areas; and the document review done for the M&E Framework assessment confirmed these barriers. Since family planning in the community is not widely available, many respondents could only inform the HPP team about access to family planning in more general terms. This section summarizes both supply- and demand-side barriers that hamper improvement in community-based family planning.

Supply-side Issues

Restrictions on provision of pills and injectables. Most CHWs in Niger are only allowed to provide oral contraceptive refills and condoms. Clients need to travel to the health center for the first prescription of pills and for injectables and long-term methods. Although the integrated CBD program in Niger has historically only allowed condoms and pill refills, this depends on the level of education and training of the CHW. Sometimes CHWs provide injectables when their education and training permit it. For example, the HPP team met a CHW based in a health center (as opposed to a health hut where most CHWs work) who was able to provide injectables because he was trained and close to the supplies.

Lack of contraceptive supplies. Stockouts are a major barrier and take place at all levels in the system for various reasons. For example, supplies are not ordered in a timely manner, or the CHW does not inform the health center that her/his levels of supplies are low, or vehicles are in need of repair and cannot make a trip. Stockouts discourage clients from using family planning. Respondents at the district level noted that women often travel 7–8 km to obtain a method. One respondent said, "If you tell her that there is a stockout, she will be discouraged and not come back, and you will start at zero with her. Stockouts are a big reason for women abandoning FP." The community is the last link in a fragile chain of RH products supply. Stockouts at the community level have a long impact because typically the CHWs receive their supplies from the health centers when staff visit them to supervise.

Varied qualifications among CHWs. CHWs typically are volunteers and serve at either health huts or work independently in their villages, although there are exceptions. In addition, less educated community liaisons sometimes work with the CHWs. The MOPH recently established a standardized training program for CHWs that specifies minimum requirements and provides job descriptions. The program is implemented as the ministry recruits new CHWs.

Lack of guidelines on CHW responsibilities and financial support. The existing guidelines for CHWs are inadequate, according to NGO informants and CHWs. CHWs perform many tasks already, and yet they are being asked to do more and more. Some communities support them and provide some payment for their services, while others provide no support. In addition, CHWs do not see a clear career path for themselves. They want to be able to receive the training needed so they can become paid employees and have a future where they can advance.

Incomplete guidance for CHWs. The CBD curriculum focuses heavily on side effects and does not say enough on the positive effects and benefits of each method. Also, the curriculum does not explain how to refer clients to clinics for methods other than pills and condoms. Respondents suggested that CHWs receive job aids for communication and service provision. The specific aids mentioned were brochures, posters, scales, and story boards.

Disrespectful treatment of FP clients. Health providers can also be barriers: women seeking family planning are sometimes treated poorly at the health center, dismissed, or told to wait or come back on another day. Such treatment discourages women who are likely to have taken hours off to seek care. When they receive poor treatment on their first visit, they often do not return.

Health provider bias. Sometimes CHWs and other providers have preferences for specific methods based on whether the client has not yet had a child or is young or old, even though the norms and standards do not condone this practice. Often women are not aware of the various contraceptive methods and do not receive complete information. Their only choice is what they find on site.

Long distances to travel. According to the 2006 DHS, only 42 percent of the population lives within 5 km of a healthcare facility. This means that geographic access is a huge issue for women who work all day in the fields, have children to care for, and cannot wait a long time to receive services that are considered preventive in nature. Even in the case of communities, not every village has a CHW, so a woman might have to walk several kilometers to reach a CHW.

Erratic schedule of mobile outreach teams. Often clients have to wait until the mobile outreach team arrives to get a method. However, outreach activities are sometimes postponed because of vehicle problems or unavailability of staff.

Demand-side Issues

When assessing operational policy barriers to CBD demand, respondents mentioned some barriers to family planning generally, as well as CBD barriers. They are reflected together in this report.

Need for awareness raising, information, and advocacy for family planning. All respondents stressed the need to reach all regions of the country with awareness raising, information, and advocacy for FP and related health issues. They acknowledged that it is much easier to discuss family planning in Niger today than before and that it no longer has to be couched as birth spacing or responsible parenthood. They also reported that women understand the consequences of closely timed births and that men are starting to understand that pregnancy wears women out. In addition, the link between family planning and abortion, although not studied in Niger, was identified as an indicator of unmet need for family planning. Respondents in all sectors said that people now understand the link between development and population growth. Despite all this progress, respondents emphasized that the battle is not yet won in Niger and that it is important to closely follow the situation and use policy champions. One CHW emphasized that Niger has a long way to go in terms of FP adoption and use. At the same time, respondents frequently said that Niger is currently experiencing an unprecedented opportunity for family planning.

"Women understand the value of FP. As soon as they give birth, they come (to the clinic) for FP. Sometimes her husband comes and requests FP for his wife."
—A community health worker

Need for continued education of religious leaders and men. While several informants said that religious leaders and men are less resistant to family planning, they noted that many places still exist where it is difficult to convince traditional and religious leaders of the benefits of family planning. For example, they mentioned Maradi as one of the most conservative regions in the country. Respondents also noted an emergence of new "preachers," who are not necessarily trained Islamic Imams, but nevertheless preach against family planning. These are usually very conservative young men. In contrast, some respondents reflected changing attitudes. Speaking of Say, home of Niger's Islamic university, a health provider stated, "In Say, Islam is a motor of sensitization and not a hindrance to FP as one might think. People's thinking has evolved." Other respondents believe that religious opposition may be a convenient excuse. One respondent said, "People hide behind religion as an excuse not to advance."

"FP needs to be integrated and linked to local issues, such as land tenure and inheritance, local social and religious issues…

The country requires an intensive, massive, and permanent FP campaign."
— Government official

Inadequate information on contraceptive choices. When counseling clients, providers generally give only cursory information on all methods and focus on the methods they are able to provide. This lack of information on the full range of methods prevents a woman from choosing the one most suitable for her. When women find out that long-term methods such as Jadelle and the intrauterine device exist, they are interested in learning more. CHWs in the Say area informed the HPP team that women tend to abandon pills and injectables in favor of Jadelle but that Jadelle is more difficult to find.

Women's inequality. The Family Code of 2010 recognizes that women have the same rights as men and addresses inheritance, land, and other important issues. However, it did not pass in Parliament; it is likely to be reintroduced, however. Opposition to the Family Code reflects the difficulties that women face in their daily lives: they are required to do most of the household work, work in the fields, and take care of children; they cannot ask their husbands to help. "A woman does not feel she can negotiate with her husband," said one CHW.

Street sellers. The many street sellers who sell pills that may have expired and provide incorrect information about when and how to take the pills hamper the access of women to a secure and reliable source of family planning. In addition, these informal sector street sellers compete with CHWs for market share.

Poverty. Many people struggle to make a living, and thus, men and women have little leisure time to attend information sessions in the community, and they may not be able to afford to pay for travel to health centers for FP and other health services.

RECOMMENDATIONS FOR REPOSITIONING FP IN NIGER

Niger has made considerable progress in creating a more enabling environment for family planning. Nevertheless, much remains to be done to strengthen ongoing activities to reposition family planning. According to respondents, the present environment offers opportunities for actions that would not have been possible just a short time ago. Several recommendations for the government and its technical and financial partners emerged from this assessment:

1. **Support the translation and dissemination of the 2006 RH Law to all levels.** The Niger RH Law has been printed in French and disseminated to most agencies and structures that work in reproductive health throughout the country. Since a great majority of the country does not read French, it is important to translate this law into national languages (at least Hausa and Djerma) and use the translations to reach the most remote areas through community radio.

2. **Support the development of a long-term FP strategy and plan, including a communication plan.** Although family planning is reflected in several plans in different sectors, no single FP strategy and plan exists in Niger to enhance planning and coordination in this area. Development of such a plan should also include a tool, such as the FamPlan software, to assist stakeholders to make decisions based on projections of alternative scenarios and estimated program costs. The Repositioning Family Planning Action Plan could serve as a transition to a long-term strategy and plan.

3. **Support continued advocacy for religious and traditional leaders.** Evidence-based advocacy is important for decisionmakers, thought leaders, and key gatekeepers. Religious and traditional leaders, both at the national level and in communities, are important leaders and should be included in such advocacy. Use of the RAPID Model has been beneficial in other countries and could be adapted for use in Niger both at the national and local levels—for example to champion increased funding for commodities and mobilization to ensure that local CHWs receive payments.

4. **Support the implementation of the Contraceptive Security Plan for 2012–2015.** The DSME and partners will need to make a concerted effort to continually monitor the plan. The steering committee for the plan will likely need support and strengthening, since many respondents identified weaknesses in implementation and monitoring.

5. **Support the DSME to revise and implement a CBD policy.** Many respondents emphasized the lack of access/availability of long-term methods and also highlighted the overly restrictive norms for CHWs. Although there is a CHW training manual, a policy will heighten the profile of CHWs and could feed into an updated manual. The CBD policy should be clear about how CHWs will refer clients for long-term methods and manage rumors and misinformation. It should incorporate strategies for sustainability of the CBD strategy.

6. **Strengthen the capacity of the DSME in management and coordination,** including monitoring of FP policies. Many respondents spoke of the workload of the directorate and the difficulty it experiences in managing all the partners and making sure that interventions are coordinated, effective, and, where possible, supportive of one another and especially the goals of

the DSME. Technical assistance to help the directorate strengthen its coordination function could provide better coherence of programming at the national level and quicker and more sustainable results in the districts and communities where people receive services.

7. **Strengthen the ability of CONAPO to fulfill its mandate.** CONAPO has a complete structure, with national, regional, and district offices around the country, and has a mandate to coordinate all population initiatives. However, the commission is facing many challenges in implementing its work and needs assistance to plan, strategize, and carry out its mandate.

8. **Revise service delivery protocols to allow trained CHWs to provide an initial supply of oral contraceptives as well as injectables and implants.** About 2,500 CHWs have been trained to provide FP services, including injectables and implants. The current MOPH protocols do not permit them to apply their training. The pilot study in Blitta and Haho in Togo demonstrated that CHWs could safely provide an initial supply of pills and give injectables.

9. **Increase the government's funding for contraceptive commodities.** To prevent frequent stockouts of contraceptives at the district and community levels, the government should allocate more funds to the line item for RH products, including contraceptives.

This assessment shows that Niger has made many efforts, even since the Ouagadougou Call to Action in February 2011, to reposition family planning. The assessment can serve as a benchmark to highlight gaps in expanding access to family planning, including through community-based programming, and to identify areas where challenges remain strong and more attention and resources are needed.

ANNEX 1: PERSONS INTERVIEWED

Modibo Maiga, Sr. Technical Advisor, Policy AWARE II
Dr. Salamatou Diallo, AWARE II representative in Niger and MOH, DSME
Bako Bagassa, Executive Director Animas Sutura
Gado Sabo Issa, President ONG Lafia Matassa
Dr. Mariama Pascal, Repositioning FP Focal Person UNFPA
Salaou Nouhou, Technical Assistant, M&E, PRODEM MPPFPE
Hamidou Bonhamni, Leader Koollou Kouara
Souaibou Mamadou, Community Leader Say
Mounkaila Sita, Focal Point, Repositioning FP Say District Hospital
Amou Mamane Hamidou, Intern Sante de la Reproduction pour une Maternité sans Risque (Dimol)
Fati Amadou, CHW Kollou Kouara
Mme Saratou Sanda, Deputy Director MOPH, DSME
Rob Eiger, Technical Advisor Animas Sutura
Mme. Zara Hachimou, Program Director ANBEF
Moctar Maiga, President Alliance des Leaders Religieux
Martine Camacho, Technical Assistant Communications, PRODEM MPPFPE
El Hadi Abdoulwahab Souna, Religious Leader Kollou Kouara

Dr. Sadou, Chief district medical Officer Kollo District Hospital
Amadou Maizongo, Director of Communications, Say District Hospital
Souleymane Issoufou, Secretary General MPPFPE
Mme Nafissa Imourou, Program Officer Sante de la Reproduction pour une Maternite sans Risque (Dimol)
Aichatou Daouda Mamane, CHW
Dr. Fanta Diabate Diallo, Sr. Technical Advisor, FP/RH AWARE II
William Noble, USAID Liaison US Embassy
Robert Luneburg, Food for Peace Officer US Embassy
Dr. Balkissa Adamou, Focal Point, Repositioning FP , WHO
Dr. Yaroh Asma Gali, Director General MOPH, DSME
Mme Moussa Nounpoua, Focal Point, Repositioning FP Kollo District Hospital
Abdoulaye Lamine, Community Leader Say
Dr. Bakary Saidou, Deputy Chief Medical Officer Say District Hospital
Mme. Traore Salamatou, President Reproductive Health for Safe Motherhood.(Dimol)
Abdou Salam Souley, CHW Torodi

Note: Three persons interviewed wished to remain anonymous. In addition, the team met with a women's self-help group (of about 15 women) in Kollou Kouara.

ANNEX 2: REPOSITIONING FAMILY PLANNING RESULTS AND INDICATORS FOR NIGER

Repositioning Family Planning Results and Indicators for Niger			
Results	**Indicators**	**Information**	**Indicator Source**
Strategic Objective: Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming	**1**: Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program	CONAPO is responsible for coordinating all population activities, but it needs to do more to fulfill its mandate. PRODEM could improve its planning and coordination work. The DSME oversees FP/maternal and child health services; it could do more to provide leadership and coordinate the work of various partners.	Key informant interviews
	2: Evidence of documented improvement in the enabling environment for family planning using a validated instrument	The enabling environment is improving. The Family Planning Effort Score rose from 26.3 in 2004 to 55 in 2009, on a scale of 100. The Contraceptive Security Index was 46.5 in 2009. Partners filled in 14-point questionnaire on repositioning family planning in 2010.	Family Planning Effort Score 2004 and 2009 (Ross and Smith, 2010); Contraceptive Security Index (USAID | DELIVER Project, 2009); Questionnaire developed with partners (Government, WHO, UNFPA)
	3: Evidence of FP policies implemented, resources allocated, and subsequently used in relation to the same FP policies	Policies are implemented, such as free FP services. Norms and standards reflect policies. Partners would welcome a policy change to permit CHWs to provide injectable contraceptives.	Key informant reporting on evaluations of projects; quarterly reports coming in from the different districts and regions; RH norms and standards
IR1: Resources for family planning increased, allocated, and spent more effectively and equitably	**IR1.1**: Total resources *spent* on FP (by source and by activity/program area)	Data on total expenditures are not available. However, expenditures for contraceptive commodities have tripled from US$523,474 in 2006 to US$1,954,105 in 2009.	Spreadsheet provided by UNFPA
	IR1.2: Number of new financing mechanisms for family planning identified and tested	*Animas Sutura* began social marketing of oral contraceptives in 2006.	Key informant interviews and public advertising

Repositioning Family Planning Results and Indicators for Niger			
Results	**Indicators**	**Information**	**Indicator Source**
	IR1.3: Total resources *allocated* to FP (by source and by activity)	In 2011, the government recruited 450 new doctors and is now currently recruiting 1,518 other health professionals. The CSP includes costs for RH products.	Niger dans le Web: Sur la piste de la renaissance: Les 100 jours à la loupe http://africatime.com/niger/index.asp; Excel spreadsheet provided by UNFPA; Niger Contraceptive Security Plan, 2007–2010
	IR1.4: New and/or increased resources are committed to FP in the last two years	Niger is committing 55 million CFA for FP through a budgetary line item established in 2010. New health staff will also help FP.	Data from UNFPA and ANBEF
IR 2: Increased multisectoral coordination in the design, implementation, and financing of FP policies and programs	**IR2.1**: Evidence of FP programs incorporated into national strategic and development plans	Population and FP is a major concern of key policy documents, and they include family planning indicators.	Document review; SDRP 2008–2012; PDS 2005–2009; DGPP issued in 2007
	IR2.2: Evidence of governments engaging multiple sectors in FP activities	The government has engaged the following sectors in family planning: health, education, rural development, gender, food and nutrition, and social protection. PRODEM is a multisectoral project.	Key informant interviews; Contraceptive Security Plan
	IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy	The DSME was strengthened by the acquisition of parts of PRODEM management. The MPPFPE was strengthened by acquisition of the PRODEM.	Key informant interviews
	IR2.4: Evidence of government support for private sector participation in FP	Government approved *Animas Sutura* to market the Sutura pill in 2006.	Letter from Ministry of Public Health authorizing Sutura sales

Repositioning Family Planning Results and Indicators for Niger			
Results	**Indicators**	**Information**	**Indicator Source**
IR 3: Policies that improve equitable and affordable access to high-quality FP services and information adopted and put into place	**IR3.1**: Existence of national or subnational policies or strategic plans that promote access to FP services and information	Niger has moved to highlight demographic issues and family planning in its policy documents. It is clearly aware of the link between population and development. Many policy documents are in place to support strong FP. However, the *Statut Personnel du Niger* (equivalent of the Niger Family Code) did not pass in 2010.	SDRP 2008–2012, PDS 2005-2009, PNSR 2005–2009, National Population Policy 2007; Key informant interviews
	IR3.2: Existence of national or subnational policies or strategic plans that promote access to FP services and information for underserved populations	Niger's regional and districts develop sub- national plans based on the PDS and they do include targets for FP and budgets. Since 82% of population is rural and only 42% has health coverage, policies directly take into account these conditions. FP is part of the package of essential services.	Key informant interviews; review of Boboye District Health Plan
	IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy	Norms and standards for RH; Niger's CSP; and the harmonized CBD training module, as well as evidence of application of these norms.	Key informant Interviews, review of 2 generations of DSRP, PDS. Documents: Norms and standards for RH, Niger's CSP, and the harmonized CBD training module
	IR3.4: Evidence that policy barriers to access to FP services and information have been identified and/or removed	Each time the country renews one of its plans (DSRP, PDS, PNSR, CSP, etc.), it does an evaluation and identifies gaps and new practices that need to be addressed/included in the new ones, constantly updating its policies.	Norms and standards document, CSP; note on implementing free services; key informant interviews with community leaders and service providers
	IR3.5: Evidence of the implementation of policies that promote FP services and information	NGO and government reports and plans. Government note on implementing the free services mandate. In addition the PDS has monitoring and evaluation documents.	Document review

Repositioning Family Planning Results and Indicators for Niger			
Results	**Indicators**	**Information**	**Indicator Source**
IR 4: Evidence-based data or information used to inform advocacy, policy dialogue, policy development, planning, resource allocation, budgeting, program design, guidelines, regulations, program improvement, and management	**IR4.1**: Evidence of data or information used to support repositioning family planning efforts	Alarming population growth rates combined with meager growth prospects have pushed the government to develop policies that seek to contain population growth and encourage FP use.	MICS and DHS are sources of data the government uses. National Census is taking place in Niger now (end 2011). DHS for Niger has been postponed.
	IR4.2: Evidence of international FP best practices incorporated into national health standards	CBD, work with religious leaders, male engagement, developing FP champions, and other behavior change communication efforts are part of standards now.	Norms and standards for RH
	IR4.3: Evidence of a defined and funded research agenda in family planning	Unable to find this evidence. Research is "the most neglected component" (FP partner)	Key informant interviews
	IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis, and communication of FP information	The government has the capability to do this (in the DSME), but not the leadership. NGOs fund research they are interested in. Government accompanies them.	Key informant interviews
IR 5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the family planning agenda	**IR5.1**: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning FP activities	ANBEF and *Animas Sutura* are main NGO FP actors, although many others are involved in FP. ANBEF and *Animas Sutura* can independently implement activities, mobilize funds, and account for them with results.	Key informant interviews with donors
	IR5.2: Evidence of government departments or other entities established or strengthened to support the FP agenda	MPPFPE's role expanded with the advent of the PRODEM, and they were forced to become more active in advocacy and sensitization.	PRODEM document; key informant interviews

Repositioning Family Planning Results and Indicators for Niger			
Results	**Indicators**	**Information**	**Indicator Source**
	IR5.3: Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment to FP	Niger takes every opportunity to sensitize groups and advocate for FP. Top leaders (First Lady presided the recent International Contraceptive Day), ministers, and local leaders are tasked with including FP in all of their speeches and outings in public. There is still reticence on the part of government actors. Other popular entertainment figures (the "three Fatis" and a champion wrestler) are FP champions.	Videos reviewed by the HPP team; key informant interviews
	IR5.4: Number of regional/national centers or collaboratives for shared education and research in family planning	The National Center for Reproductive Health is the key center of excellence and reference in Niger.	Key informant interviews

ANNEX 3: SEMI-STRUCTURED INTERVIEW GUIDE FOR NATIONAL LEADERS

Introductory Questions for Key Informants

Verbal Informed Consent Language

Hello, my name is [_____]_ and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Niger/Togo? This list may be used in a report or other publicly available documents.

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer:_____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ **Time ended**:_____

Background Information

Check to indicate whether respondent is male or female.

- ☐ Male
- ☐ Female

Age of respondent: _____

1. **Name of key informant**: _____`_____

2. **Name of organization**: _____

   Position in organization_____

   How long in position_____

3. **Name of donor funding FP-related portfolio in your organization** (if relevant):

   _____

4. **Please tell me about your organization's work related to family planning**.

5. **Did you ever provide FP services**?
   - ☐ Yes
   - ☐ No

6. **Do you ever, or do you currently, supervise FP providers**?
   - ☐ Yes
   - ☐ No

(*Note: Interviewer should consider the organization's work and check off those areas of the framework that the respondent may be able to inform.*)

- ☐ IR1—Resources
- ☐ IR2—Multisectoral
- ☐ IR3—Policy
- ☐ IR4—Information
- ☐ IR5—Capacity
- ☐ Community FP

Questions related to IR4.1 (for all organizations)

1. **Does your program do any work to promote evidence-informed decision making in family planning?**

☐ Yes
☐ No
If yes, please describe your work.

Questions Related to SO

The discussion guides for each result area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

For all respondents

SO.1

1. Is there a government established body that oversees family planning?
    a. Please tell me about the body's roles and responsibilities.
2. Does the organization have power, influence, funding? Does it actively coordinate and manage the FP program?
3. What are the organization's limitations?
4. In your opinion, does the government play a leadership role in family planning?

Questions Related to IR1

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

USAID Mission

IR1.1/1.3

1. Are any USG agencies other than USAID funding FP information, services, or projects? If so, do you know how much these agencies allocate to FP-related work?

2. How much funding does USAID allocate to family planning annually? Can you, please, provide documentation of the amount allocated and/or disbursed?

3. Do you track the amount of funds allocated and spent by USAID on different types of FP interventions (i.e., commodities, BCC, enabling environment, etc.)? If so, can you share that information with me?

4. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)

5. When was the most recent budget/allocation doc/disbursement record released?

6. Can we get a copy of the budget/allocation doc/disbursement record?

7. If not, is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning from USAID and from other sources?

IR1.2

1. Have you funded organizations to test alternative financing mechanisms for family planning? Please describe.

2. If not, are there any other donors or organizations working on those issues? Which one?

3. What types of financing mechanisms are being explored by the government?

4. How are these mechanisms reviewed?

5. Who suggests new ideas for health financing?

6. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. How does your program work to strengthen funding for family planning?

2. Can you think of any achievements resulting from your strengthening efforts? New commitments for FP funding?

IR1.4.1

1. How is money budgeted, allocated, and disbursed for family planning at the district level? Please describe.

2. Are you familiar with instances of increased FP funding at that level? Please tell me about this.

Donor-Funded Projects

IR1.1/1.3

1. Do you track budget information as part of your project work?
2. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)
3. When was the most recent budget/allocation doc/disbursement record released?
4. Can we get a copy of the budget/allocation doc/disbursement record?
5. If not, is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning that is coming from USAID? From other donors? From the government? From private sources?

IR1.2

1. Does your organization work on alternative financing mechanisms for family planning?
2. If not, is there an organization working on those issues? Who?
3. What other financing mechanisms are being explored by the government?
4. How are these mechanisms reviewed?
5. Who suggests new ideas for health financing?
6. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. How does your program work to strengthen funding for family planning?
2. Can you think of any achievements resulting from your strengthening efforts? New commitments for FP funding?
3. How do you document successes in this area?

IR1.4.1

1. How is money budgeted, allocated, and disbursed for family planning at the district level? (What is the process?)
2. How would we learn about increases for FP funding at that level?

Government or Local NGOs

IR1.1/1.3

1. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)

2. When was the most recent budget/allocation doc/disbursement record released?

3. What is the total annual amount from the national budget destined for the purchase of contraceptives during the last three years? (2009_____ 2010_____ 2011_____)

4. Is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning that is coming from USAID? From other donors? From the government? From private sources?

5. Are contraceptive methods easily available at all levels of the health system, including the community level?
   - ☐ Yes
   - ☐ No

   (If no, explore what makes them unavailable at different levels; frequency of stockouts)

6. Does the Contraceptive Security Plan take into account the supply needs of NGOs and private providers?
   - ☐ Yes
   - ☐ No

   (Explore how supply needs are/are not taken into account)

IR1.2

1. What other financing mechanisms are being explored by the government?

2. How are these mechanisms reviewed?

3. Who suggests new ideas for health financing?

4. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. Have there been any new commitments for FP funding by the government or other non-USAID sources recently?

IR1.41

1. How is money budgeted, allocated, and disbursed for FP at the district level? (What is the process?)

2. How would we learn about increases for FP funding at that level?

Questions Related to IR2

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

For USAID and Implementing Partners

IR2.1

1. Is family planning included in the poverty reduction strategy? What was the process for including family planning into this strategy document?

2. Has family planning been included in other key strategy documents?

3. What is positive about the way family planning has been included in these documents?

4. What is missing in terms of how family planning has been incorporated?

IR2.2

1. Is there a national population steering committee or commission?

2. If not, what is the primary government organization responsible for family planning?

3. Does this body involve groups from outside the health sector? From outside government sector?

4. How does this governmental organization involve groups from other sectors? (Examples could include in the design, implementation, financing, and/or monitoring and evaluation of FP policies and programs.)

IR2.3

1. Is there a multisectoral group that focuses on family planning? Who helped to form this group? What is the purpose of this group?

2. What has the group done in terms of advising on or setting FP policies; ensuring compliance to FP polices or norms; and developing plans to implement FP policies?

3. Does the group have power, influence, or support from the government?

4. Does your project work to strengthen this multisectoral group?

5. Can you think of any achievements resulting from your strengthening efforts?

IR2.4

1. Are there barriers to private sector participation in FP policy development or service delivery?
2. Historically, what has been the greatest barrier to private sector involvement in FP policy development and/or service delivery?
3. Has your organization worked to remove these types of barriers?
    a. If not, which organizations do?
    b. If yes, when and how were these barriers overcome? What was your organization's role in the process? Do you have any documentation of that success?

Government or Local NGOs

IR2.1

1. Is family planning included in the poverty reduction strategy?
    a. What was the process for including FP into this strategy document?
2. Has family planning been included in other key strategy documents?
3. What is positive about the way family planning has been included in these documents?
4. What is missing in terms of how family planning has been incorporated?

IR2.2

1. Is there a national population steering committee or commission?
2. What is the primary government organization responsible for family planning?
3. Does this body involve groups from outside the health sector? From outside government sector?
4. How does this governmental organization involve groups from other sectors? (Examples could include in the design, implementation, financing, and/or monitoring and evaluation of FP policies and programs.)

IR2.3

1. Is there a multisectoral group that focuses on family planning? Who helped to form this group?
2. What is the purpose of this group?
3. What has the group done in terms of advising on or setting FP policies; ensuring compliance to FP polices or norms; and developing plans to implement FP policies?
4. Does the group have power, influence, or support from the government?

5. Is there a multisectoral committee for contraceptive security? Is the private sector a member? Is the committee functional? What is the frequency of meetings and when was the last one held?

IR2.4

1. Are there currently any barriers to private sector participation in FP policy development and/or service delivery?

    a. If so, what are they?

2. Historically, what has been the greatest barrier(s) to private sector participation in FP policy development and/or service delivery?

3. When and how were these barriers overcome? What was your organization's role in the process?

4. How could we document that success?

Questions Related to IR3

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

(Note to interviewer: For each of these questions, if the informant responds that there is such a policy or plan, ask how you could get access to the policy document.)

USAID or Donor-Funded Organizations

IR 3.1

1. Are you familiar with a national FP policy or a national policy that includes family planning (e.g., RH policy, health policy, population policy)?

2. Is there a national policy to ensure contraceptive security?

3. Are there any national guidelines that have been developed to guide the provision of FP services?

4. Were stakeholders working at the subnational level involved in policy development?

5. Are there any specific subnational policies related to family planning?

IR 3.2

1. Are you familiar with national policies or guidelines that promote access to FP services for underserved populations? *(Note: "Underserved populations" may be defined by the country context. This could include youth, men, people living with HIV, the poor, the rural, postpartum women, and others.)*

IR 3.3

1. Is there a national plan related to family planning? An FP implementation or operational plan?

2. Are there subnational plans for providing FP services? Are these plans developed at the subnational level?

IR 3.4

1. Are there any policy barriers to providing FP services and information in this country? (*Example probes: Policy barriers may include taxation on contraceptive commodities, lack of guidelines on providing FP methods and information, limitations on medical personnel providing FP services*)

2. Are you familiar with initiatives to identify or remove policy barriers to family planning?

    a. Please describe these barriers and how they were identified and removed.

IR 3.5

1. Is family planning a priority in this country for the government, donors, and/or the population?
2. Is there broad support for family planning in this country? Please describe any support or opposition for family planning.
3. Is the MOPH or another organization monitoring the implementation of FP policies and plans?
    a. Who is responsible? Do they produce reports about the implementation of FP policy?
4. Are there barriers in the release of funding for family planning *(refer to IR1 indicators)*?
5. Are you or your organization working at the subnational level?
    a. Do you have any documentation of the planning and implementation of family planning subnationally?

Questions Related to IR4

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

All Respondents

IR4.1

1. In terms of moving the FP agenda forward in this country, what was the last important decision made by the government or your organization related to family planning?
2. Who made the decision?
3. Was there a data review process to inform the decision? If so, what data were reviewed?
4. In your opinion, was it an evidence-informed decision?
5. Is there any documentation of using evidence to inform the decision?

IR4.2

1. Does Niger have standards of care or protocols related to providing RH services? Do these standards include family planning?
2. In your opinion, do these standards of care/protocols include current best practices in family planning?
3. What aspects have been overlooked or need to be updated?

IR4.3

1. Is there a defined research agenda related to family planning in this country?
2. How was it developed?
3. Has the research agenda been funded? By whom?
4. Who implements and monitors the research agenda?
5. How do you get data about family planning in this country?

IR4.4

1. If an international NGO is conducting most of the research and data generation, is there a local organization that is receiving capacity-building support in data collection, analysis, and dissemination?

2. Did anyone conduct an assessment of this organization's capacity before providing capacity-building assistance?

3. What are the strengths of this organization?

4. What are the limitations?

5. Has anyone conducted training events focused on data collection, analysis, and communication of information related to family planning? Can you please provide more information about this?

6. Do you have indicators and tools to measure the implementation of policies, especially RH policies ?

Questions Related to IR5

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

Donor-Funded Organizations or Donor Missions

IR5.1

1. Has your organization trained or assisted champions/networks/organizations/institutions to independently implement activities in one or more of the following areas: policy dialogue, planning, priority setting, resource allocation, program improvement, and/or advocacy for family planning?

2. Did you collect baseline information about the individuals'/organizations' capacity?

3. Can you think of an example of a capacity-building success story based on your work?

4. *Possibly question the M&E person at the organization*: Do you have a program indicator that measures increases in knowledge and/or capacity following a training event or technical assistance? If so, can you share results that you have reported to the indicator?

IR5.2

1. What is the primary government body responsible for overseeing family planning? Are there other departments or governmental entities that work on FP issues? When were they established?

2. Are there any newly formed local civil society groups/associations/networks/coalitions that support the FP agenda?

    a. If so, when was it (or were they) formed?

3. What role does the organization play in promoting the FP agenda? Is this a greater or lesser role than the organization has held in the past?

IR5.3

1. If your program works with public or private sector leaders, do you track increases in demonstrated commitment for family planning?

2. Can you share successes in strengthening leadership commitment to family planning?

3. How do you document your successes?

Government or Local NGOs

IR5.2

1. What is the primary government body responsible for overseeing family planning? Are there other departments or governmental entities that work on FP issues? When were they established?

2. Are there any newly formed local civil society groups/associations/networks/coalitions that support the FP agenda?

3. If so, when was it (or were they) formed?

4. What role does the organization play in promoting the FP agenda? Is this a greater or lesser role than the organization has held in the past?

IR5.3

1. Does your organization track statements of support and demonstrated commitment for family planning by public and private sector leaders?

    a. Please provide some examples.

Barriers to Family Planning at the Community Level

If respondents have said or demonstrated that they or their organization work or are knowledgeable of family planning at the community level, please use these questions to explore about operational or policy barriers to community-based distribution of family planning at the community level.

1. **Are you aware of any ongoing or past pilot projects in Niger that give communities better access to contraceptives?**

☐ Yes
☐ No

If yes, which products/methods were/are available?
(Collect information on who the contact person is so we can interview this person.)

2. **What do you think are the barriers women encounter when they seek an FP method at the community level?**

If not brought up, ask about the following (check):

Are methods easily available at the community level?
☐ Yes
☐ No

Is it easy for CHWs to get resupplied at the health posts or health centers ?
☐ Yes
☐ No

Do women need the permission of their husband/partner to receive FP methods?
☐ Yes
☐ No

Can unmarried women receive a method?
☐ Yes
☐ No

Can unmarried men get condoms?
☐ Yes
☐ No

Are there some methods women cannot get unless they already have children?
☐ Yes
☐ No

Do people have to pay for FP methods?

☐ Yes
☐ No

Is there an age requirement for people to receive FP methods?

☐ Yes
☐ No

(Explore "no" responses and ask interviewee how laws/ policies/ standards/guidelines or operational policies could be underlying causes of the barriers identified.)

3. What do you think are the major barriers CHWs face in the delivery of family planning?

If not brought up, ask about the following (check):

Do CHWs have adequate skills and knowledge to provide FP?

☐ Yes
☐ No

Do CHWs have contraceptive supplies?

☐ Yes
☐ No

Are CHWs allowed to provide pills and injectables ?

☐ Yes
☐ No

Do laws/policies/guidelines/norms allow CHWs to provide family planning?

☐ Yes
☐ No

Do CHWs prioritize family planning?

☐ Yes
☐ No

Do CHWs receive supervision and support to provide family planning?

☐ Yes
☐ No

(Explore "no" responses and ask interviewee how laws/ policies/ standards/guidelines or operational policies could be underlying causes of the barriers identified.)

4. Has your organization trained enough CHWs in family planning (first provision of pills, injectables). How long was the training? What is the frequency of refresher training? What is the profile of the CHW and what is the gender breakdown?

5. **What are the attitudes of the community toward family planning? (Explore the attitudes of men, women.)**

6. **How do you think contraceptives could be made more easily available at the community level?**

ANNEX 4: INTERVIEW GUIDE FOR CHWS, LOCAL LEADERS

Evaluating Repositioning Family Planning Efforts and Assessing Barriers to Community-Based Distribution

Country:_____

Date:_____

Interview Guide for Community Health Workers

Verbal Informed Consent Language

Hello, my name is [_____] and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Niger/Togo? This list may be used in a report or other publicly available documents.

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer:_____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ **Time ended**:_____

Background Information

Check to indicate whether respondent is male or female.

- ☐ Male
- ☐ Female

Age of respondent: _____

1. Name of respondant: _____

2. District/subdistrict/village: _____

   Type of CHW (if applicable):_____

   How long in position_____

3. Do you provide FP services?
   - ☐ Yes
   - ☐ No

Educational background—circle what applies (revise as appropriate for Niger):

Years of primary:_____

Years of secondary:_____

CBD training:_____ months

Other: _____

Interest in/Opposition to Family Planning in the Community

1. **As far as you know, are women who live in this community generally interested in using family planning?**

   ☐ Yes
   ☐ No
   (Explore reasons why and why not.)

2. **As far as you know, is there any opposition to women using family planning in this community?**

   ☐ Yes
   ☐ No
   (Explore opposition from husband, family, religious leaders, community leaders, etc., and the reasons for the opposition.)

Availability of Family Planning

3. **What contraceptive methods are available in your community? *(Probe for each and check.)***

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
If yes, who provides:____	If yes, who provides:____	If yes, who provides:____
_____	_____	_____
Other:_____	**Other**:_____	**Other**:_____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
If yes, who provides:____	If yes, who provides:____	If yes, who provides:____
_____	_____	_____

4. **If no, ask: What are the reasons the method(s) is (are) not available at the community level?**

Condoms:

Pills:

Injectables:

Other (specify):

Other (specify):

Other (specify):

5. **Do you think that the methods should be available at the community level?**

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
Please explain:_____	Please explain:_____	Please explain:_____
_____	_____	_____

Other:_____ **Other**:_____ **Other**:_____

☐ Yes ☐ Yes ☐ Yes

☐ No ☐ No ☐ No

Please explain:_____ Please explain:_____ Please explain:_____

_____ _____ _____

6. Have you been trained to provide:

Condoms: **Pills**: **Injectables**:

☐ Yes ☐ Yes ☐ Yes

☐ No ☐ No ☐ No

Other:_____ **Other**:_____ **Other**:_____

☐ Yes ☐ Yes ☐ Yes

☐ No ☐ No ☐ No

If "no": What were the reasons that you were not trained in FP? *(Explore: Is family planning not part of basic training, or other?)*

If "yes": Do you think that you can safely provide these methods?

☐ Yes

☐ No

(If response is no, probe the reasons: insufficient training; lack of experience; lack of demand for method, etc.)

7. According to policies/standards, are you (CHWs) allowed to provide:

Condoms: **Pills**: **Injectables**:

☐ Yes ☐ Yes ☐ Yes

☐ No ☐ No ☐ No

Other:_____ **Other**:_____ **Other**:_____

☐ Yes ☐ Yes ☐ Yes

☐ No ☐ No ☐ No

(Probe which methods CHW is not allowed to provide and how he/she knows.)

8. Do you have the supplies you need to provide:

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
Other:_____	**Other**:_____	**Other**:_____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

(If no, probe what is missing: contraceptive method or other supplies, and whether he/she knows the reasons there are stockouts or lack of supplies.)

9. In your work to provide family planning, do you receive regular supervision?

☐ Yes
☐ No

If yes, by whom: _____ How often:_____

Other encouragement: Explain:

Knowledge of Laws/Policies and Policy Barriers

10. What do you know about (explore):

Niger's RH Policy
☐ Never heard about it
☐ Received orientation

Niger's SRH Law
☐ Never heard about it
☐ Received orientation

Policy guiding the work of CHWs?

Anything else?

Describe what CHW knows about polices/laws:

11. **How well do you think the policies/laws are actually implemented at the community level?**

12. **Can you think of any other policy that would help you better provide family planning?**

13. **Can you think of any other policies that would make it easier for people to use family planning?**

Barriers to Family Planning Provision and Use

1. **What do you think are the barriers women encounter when they seek an FP method at the community level:**

   Explain:

(If not brought up, ask about and explore the following.)

- Do women need the permission of their husband/partner to receive an FP method? (Explain.)
- Can unmarried women receive a method?
- Can unmarried men get condoms?
- Are there some methods women cannot get unless they already have children?
- Cost? Do people have to pay for FP methods? (Niger) Do you know that the Niger Government has declared Family Planning to be free-of-charge?
- Lack of female providers
- Stockouts of methods

2. **How do you think contraceptives could be made more easily available at the community level?**

3. **What particular barriers, if any, do you face as a man (or woman) in providing family planning?**

Improvements in Government Support and Services

1. **Have you noticed any improvements in terms of government support of family planning recently? If yes, please explain and tell me when this improvement began. If no, do you have any suggestions for how the government could improve its support for family planning?**

2. **Have you noticed any improvements in terms of availability of contraception at the community level recently? If yes, please explain and tell me when this improvement began. If no, do you have any suggestions for how availability of family planning could be improved at the community level?**

(Thank you very much for your time. This information will assist us in providing information on family planning at the community level to the government.)

Evaluating Repositioning Family Planning Efforts and Assessing Barriers to Community-Based Distribution

Country:_____

Date:_____

Interview Guide for Community Leaders

Verbal Informed Consent Language

Hello, my name is [_____] and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Niger/Togo? This list may be used in a report or other publicly available documents.

- ☐ YES, verbal consent was received
- ☐ NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer:_____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ **Time ended**:_____

Background Information

Check to indicate whether respondent is male or female.

- ☐ Male
- ☐ Female

Age of respondent: _____

District/subdistrict/village:_____

Type of leader:_____

How long in leadership position:_____

Age of respondent:_____

Educational background—circle what applies (revise as appropriate for Niger):

Literate:

- ☐ Yes
- ☐ No

Years of primary:_____ Years of secondary:_____ Other:_____

Interest in/Opposition to Family Planning in the Community

1. **As far as you know, are women who live in this community generally interested in using family planning?**

☐ Yes
☐ No
(Explore reasons why and why not.)

2. **As far as you know, is there any opposition to women using family planning in this community?**

☐ Yes
☐ No
(Explore opposition from husband, family, religious leaders, community leaders, etc., and the reasons for the opposition.)

Availability of Family Planning in the Community

3. What contraceptive methods are available in your community? *(Probe for each and check).*

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
If yes, who provides:____	If yes, who provides:____	If yes, who provides:____
_____	_____	_____
Other:_____	**Other**:_____	**Other**:_____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
If yes, who provides:____	If yes, who provides:____	If yes, who provides:____
_____	_____	_____

4. Do you think that the methods should be available at the community level?

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
Please explain:_____	Please explain:_____	Please explain:_____
_____	_____	_____
Other:_____	**Other**:_____	**Other**:_____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
Please explain:_____	Please explain:_____	Please explain:_____
_____	_____	_____

5. As far as you know, are community health workers allowed to provide:

Condoms:	**Pills**:	**Injectables**:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

Other:_____	**Other**:_____	**Other**:_____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

(Probe which methods CHW is not allowed to provide and why.)

Knowledge of Laws/Policies and Policy Barriers

6. **Are you aware if Togo/Niger has policies and laws related to family planning?**

☐ Yes
☐ No

(Probe the names of the policies and laws and what the respondent knows about them.)

7. ***If aware of policies*: How well do you think Niger's policies related to family planning are actually implemented at the community level?**

8. **Do you think that Niger's policies related to family planning are sufficient to ensure access to family planning at the community level?**

☐ Yes
☐ No

(If no, probe for policy barriers.)

Barriers to Family Planning Provision and Use

1. **What do you think are the barriers women encounter when they seek an FP method at the community level?**

Explain:

If not brought up, ask about and explore following and have informant explain/describe:

- Do women need the permission of their husband/partner to receive FP methods?

- Do women fear that husbands/partners do not approve of family planning? If yes, is this actually the case?
- Can unmarried women receive a method?
- Can unmarried men get condoms?
- Are there some methods women cannot get unless they already have children?
- Cost? Do people have to pay for FP methods?
- Is there a lack of female providers? Are there mostly male providers?
- Do people fear side effects?
- Are there stockouts of contraceptive methods? If so, which methods?

2. **How do you think contraceptives could be made more easily available at the community level?**

3. **Are there any barriers to community-based workers providing contraceptives?**

☐ Yes
☐ No

4. **If yes, please explain.**

Improvements in Government Support and Services

5. **Have you noticed any improvements in terms of government support of family planning in Niger recently? If yes, please explain and tell me when this improvement began and how the renewed support has been shown.** ***(Probe: speeches, increased funding, new policies.)***

6. **Have you noticed any improvements in terms of availability of contraception at the community level recently? If yes, please explain and tell me when this improvement began and what the reasons are for the improvement**

7. **Is there anything else you would like to say about what could be done to increase access to family planning at the community level?**

(Thank you very much for your time. This information will assist us in providing information on family planning at the community level to the government.)

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