



# REPOSITIONING FAMILY PLANNING IN NIGER

Status of Family Planning Programs in Niger

*Brief*

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## Overview

Since 2001, the United States Agency for International Development (USAID), the World Health Organization (WHO), the William and Flora Hewlett Foundation, and other partners have collaborated with African governments on an initiative to raise the priority of family planning (FP) in their national programs by strengthening political commitment and increasing resources. This concept is known as “repositioning family planning” (RFP). In 2011, the RFP initiative gained momentum when national leaders from eight francophone West African countries approved the Ouagadougou Call to Action, a commitment to take concrete actions to increase FP use.

This brief summarizes the key findings and recommendations from a 2012 assessment of Niger’s RFP initiative.

Niger has one of the fastest growing populations in the world. Women have an average of seven children each, and half of the population is under age 15 and thus will

be entering childbearing years soon. Rapid population growth is a concern for Niger’s leaders because the country already suffers from food insecurity, poor health, and extreme poverty. By enabling couples to plan their families, FP programs could help to slow population growth. Survey data indicate that there is considerable unmet need for FP information and services: nearly one in six (16%) married women ages 15–49 would like to space or limit future births but are not using contraception.

## Enabling Policies

In general, Niger has a favorable policy environment for family planning. Several key policies needed to implement a strong FP program are in place, including the 2006 Reproductive Health Law, the National Reproductive Health Program (2005–2009), and the 2007 National Population Policy. Since 2006, the government has provided all FP methods free-of-

**Considerable progress has been made in the past five years, evident by**

- A favorable policy environment
- Growing public support for FP
- Increased funding for contraceptive commodities
- Provision of FP free-of-charge and its inclusion in the Minimum Package of Services that all public health facilities must provide

**Yet, challenges remain to**

- Meet unmet need for FP
- Extend services to rural areas
- Ensure that people have adequate information about contraceptive methods

charge in public health facilities. Family planning is included in the Minimum Package of Services that the government requires each health facility to provide. In 2010, the government established a line item for contraceptive commodities and has provided funds for this purpose annually. Niger has a national plan of action for repositioning family planning, which was finalized at the 2011 Ouagadougou conference. The Health Policy Project team noted that some policies could use updating and that a policy change is needed to expand community-based provision of injectable contraceptives.

High-level government officials have made public statements supporting family planning. In his inaugural speech in 2011, Prime Minister Brigi Raffini emphasized the importance of reproductive health (RH) and the need to reduce maternal mortality.

## Program Implementation

Capturing the rapid progress made in recent years, Niger’s Family Planning Program Effort score, which rates 30 indicators reflecting policies, services,

evaluation, and access to contraceptives in national FP programs, has risen from 26 in 2004 to 55 in 2009. The highest score is 100, so there is still room for improvement.<sup>1</sup> The 2009 Contraceptive Security Index for Niger was 46.5 on a scale of 100, indicating a relatively low level of contraceptive security.<sup>2</sup>

Two government agencies are responsible for overseeing population and FP programs:

- The National Population Commission (CONAPO), based in the Ministry of Population, Women’s Promotion, and Child Protection, is responsible for coordinating and harmonizing all population activities. CONAPO implements advocacy and public awareness activities. Some key informants recommended that the commission be strengthened so it could fulfill its mandate as a coordinating body.
- The Directorate of Maternal and Child Health (DSME) in the Ministry of Public Health (MOPH) is responsible for managing and coordinating FP services, as well as maternal and child health services. The HPP team noted that the directorate’s daily management responsibilities and heavy workload seem to take precedence over strategic leadership and coordination. Key informants considered the DSME to have an adequate number of staff at the national level but emphasized that districts and communities need more medical professionals and trained community health workers (CHWs).

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; 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 intrauterine device (IUD), and the male condom is low.

Two national nongovernmental organizations (NGOs) provide FP/RH services:



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- The *Association Nigérienne pour le Bien-Etre Familial* (ANBEF) provides comprehensive sexual and reproductive health services in clinics and mobile units, with a focus on serving youth and disadvantaged groups.
- Animas Sutura has a social marketing program for an oral contraceptive called Sutura.

The government includes NGOs, civil society groups, and private providers in advisory groups and consultative meetings.

Overall, the policy change to provide free FP services in public facilities has been beneficial, with some women emboldened to seek FP services. However, the decision was taken without assessing the financial implications of free FP services or the effect on the already overburdened health system. District health facility managers worry that the central government will not reimburse them for the extra costs, and FP clients often endure long waits or have to make repeat visits to obtain family planning because the providers are overloaded and commodities are often out of stock.

In all regions of Niger, there is a need for awareness-raising and information about family planning and related health issues. Women understand the consequences of closely spaced births, but they have inadequate information on contraceptive choices. Providers give cursory information on all contraceptive methods and focus on methods they can provide. Women are interested in long-term methods such as the Jadelle implant, but it is hard to find. Also, some CHWs and other providers may limit method choice based on the woman's age and previous childbearing, even though norms and standards do not condone this practice. Key informants said that women seeking family planning are sometimes treated badly by health providers and told to come back another day.

Niger has finalized a Contraceptive Security Plan for 2012–2015. In 2010, the government established a line item for RH products, including contraceptives, and has provided about US\$122,000 per year since then. The United Nations Population Fund provides nearly all of Niger's contraceptive supplies. It spent nearly US\$2 million for contraceptives in 2009—triple the amount it spent in 2006.

Several key informants stated that the current favorable environment offers an unprecedented opportunity to expand FP programs. They said that men and religious leaders are less resistant to family planning than before, although they recognize the need for continued education of men and religious leaders. The *école des maris* (husbands' school) has helped to foster local male FP champions. Women's inequality remains a barrier to use of FP services. Most women have a heavy work burden and are unable to ask for their husband's support.

The HPP team did not find evidence of an FP research agenda or funding allocated to research. It also reported that there is little technical capacity for the collection, analysis, and communication of FP information.

## Community-Based Distribution

Many Nigeriens have to travel long distances to obtain healthcare, as only 42 percent of the population live within 5 km of a health facility. Some areas have mobile outreach vans to provide FP services, but their schedule is erratic because staff and/or a vehicle are not always available. Community health workers are active, but they are only allowed to provide condoms and refills for oral contraceptives. Clients must travel to the health center for the first prescription of pills and for injectables and long-term methods.

CHWs are typically volunteers who work either at health huts or in their villages. Some communities support them and provide some payment for their services, but other communities provide no support. CHWs provide a broad range of health services, with a focus on child health. They have been providing contraceptives since the early 1990s. Some CHWs are permitted to provide injectables, such those based in a health center who have sufficient education and training. The MOPH recently established a standardized training program for CHWs that specifies minimum qualifications and provides job descriptions.

Increasingly, African countries are setting up programs to allow trained community-based workers to provide injectable contraceptives. New WHO guidelines affirm that this can be done safely in the context of targeted monitoring and evaluation. 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. To make this change, the government would need to develop a comprehensive policy on community health that would allow CHWs to provide injectables. CHWs would need training to ensure adequate quality of care, and a supervisory system and improved commodity availability would need to be in place.

Key informants recommended that the curriculum for CHWs be revised to provide more information about the positive effects and benefits of each contraceptive method and explain how to refer clients to clinics for methods other than pills and condoms. They also suggested that CHWs receive job aids such as brochures, posters, scales, and story boards.

## Recommendations

Based on its assessment, the HPP team compiled the following recommendations for Niger's government to:

- **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.
- **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.
- **Support the implementation of the Contraceptive Security Plan for 2012–2015.** The DSME and partners need to continually monitor the plan. The steering committee for the plan will likely need support and strengthening in implementation and monitoring.
- **Strengthen the capacity of the DSME in management and coordination of FP/RH services.** Technical assistance could help the



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directorate to improve coordination and provide greater support to FP programs in the districts and communities.

The HPP team's recommendations for civil society organizations are to:

- **Form a strong network to advocate for improved RH/FP policies and for CSO participation in the design, implementation, and monitoring of RH/FP policies.**
- **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.
- **Urge decisionmakers to allocate more national resources to support FP services and information throughout the country.**
- **Intensify their efforts to monitor the government's national and international commitments to FP programs and provide**

**regular updates on progress toward greater support for FP programs.**

- **Intensify support to the network of Muslim and Christian leaders involved in family planning.**

## Assessment Report

During 2011–2012, the USAID-funded Health Policy Project (HPP) conducted assessments in two francophone West African countries to document the status of repositioning FP initiatives. Futures Group, with funding from the William and Flora Hewlett Foundation, conducted six additional assessments. These assessments can serve as a benchmark to highlight gaps in expanding access to FP and identify areas where challenges remain and more attention and resources are needed. The assessments used the Framework for Monitoring and Evaluating Efforts to Reposition Family Planning, developed by the MEASURE Evaluation project.<sup>3</sup>

In Niger, HPP conducted the assessment during October 12–29, 2011. The HPP team interviewed 33 key informants, including government officials, civil society organizations, donors, local leaders, and

community health workers, and visited the districts of Say and Kollo. The HPP team also identified the policy and operational barriers to community-based distribution of contraceptives.

For the full report including the sources for cited data, see

McDavid, E., and S. Attama. 2012. *Repositioning Family Planning in Niger: A Baseline*. Washington, DC: Futures Group, Health Policy Project. Available at: [www.healthpolicyproject.com](http://www.healthpolicyproject.com).

## Resources

<sup>1</sup>Ross, John, and Ellen Smith. 2010. *The Family Planning Effort Index: 1999, 2004, and 2009*. Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

<sup>2</sup> 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. United States Agency for International Development (USAID) DELIVER Project, Task Order 1. 2009. *Contraceptive Security Index 2009: A Tool for Priority Setting and Planning*. Arlington, VA: USAID | DELIVER Project, Task Order 1.

<sup>3</sup> Judice, N., and E. Snyder. 2012. *Framework for Monitoring and Evaluating Efforts to Reposition Family Planning*. Chapel Hill, NC: MEASURE Evaluation PRH. Accessed on July 15, 2013, from <http://www.cpc.unc.edu/measure/publications/SR-12-63>.

## Contact Us

Health Policy Project  
One Thomas Circle NW, Suite 200  
Washington, DC 20005  
[www.healthpolicyproject.com](http://www.healthpolicyproject.com)  
[policyinfo@futuresgroup.com](mailto:policyinfo@futuresgroup.com)

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