What we know:
Rural clients in Niger often lack access to health services, and mobile outreach can bring voluntary family planning (FP) closer to them.

83% of sexually active women in Niger live in rural communities. Geographic distance between health facilities makes accessing FP services difficult for rural clients. Through the USAID-supported SIFPO2 project, PSI in Niger works with the Ministry of Public Health (MoPH) to deliver voluntary FP services through mobile outreach, a high impact practice. Between April 2018 and September 2019, the intervention paired PSI clinical staff with public sector midwives; together they traveled to rural health posts to offer voluntary FP services. The intervention conducted 177 day-long outreach events, providing voluntary FP services to 4,612 women and girls (fig.1), as well as removals of implants and IUDs, and referrals for voluntary permanent methods.

What we asked:
Is there a way to transform mobile outreach so that it better leverages local capacity, while still meeting the needs of women and girls?

In April 2019, PSI Niger and the SIFPO2 global team began to explore ways that the mobile outreach approach could better engage community health agents, who are lower-level clinical staff based at rural health posts. Historically, this cadre would not directly provide FP services, although they are permitted to do so according to the MoPH. To operationalize this task-shifting opportunity within a mobile outreach context, PSI Niger trained and equipped the community health agents to enable them not only to support the mobile outreach events but also to continue to provide voluntary FP services (including removals) after mobile teams departed.

Through this intervention, PSI Niger and the MoPH trained 36 community health agents based at rural health posts in high quality FP counseling and provision of a wide range of voluntary methods. This includes removals, as well as referrals for clients interested in taking up voluntary IUDs or permanent methods, which are outside of health agents’ permitted service delivery scope.

What we are finding:
Community health agents are rising to the task, taking more responsibility for FP services both during and after mobile outreach events.

Since training the 36 community health agents, the service delivery provider pairs now include a public sector midwife and a community health agent, with PSI Niger stepping back into a support and supervisory role. Furthermore, the mobile outreach events have become more fully integrated into existing, routine health extension events at the rural health posts, such as vaccine days.

In an initial assessments of this new model, mobile outreach teams of public sector providers continue to see strong client volumes at outreach events (an average of 27 clients per day) with a diverse method mix. Notably, contraceptive implants, which were not previously offered by the community health agents, are now being provided outside of mobile outreach events, suggesting sustainability of intervention outcomes.

What is to come:
Continued support, coaching, and data monitoring at the rural health facilities will help the intervention decide if this model is best suited for this context.

Given that much of Niger’s population resides in rural zones, it is important to continuously explore models that bring healthcare closer to communities. PSI and the Nigerien Ministry of Public Health look forward to monitoring the results of this intervention and assess its viability for scale in other rural zones.

2. While women were counseled in lactational amenorrhea method (LAM) as part of a wide range of family planning methods, uptake was not systematically captured in client data cards and registers. As a result, it is not included in the intervention method mix and LAM users are not included in the 4,612 women and girls reached.