PROGRAM BRIEF

Mobile Outreach for Family Planning in Rural Niger

Delivering and Adapting High Impact Practices in Fragile and Hard-to-Reach Settings

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Support for International Family Planning and Health Organizations (SIFPO) 2
INTRODUCTION

Modern contraceptive prevalence (mCPR) in Niger has increased gradually in recent years, reaching 15.6% in 2017.\(^1\) Despite incremental gains in use of voluntary family planning, the West African nation retains the highest total fertility rate globally, with women averaging over seven births each.\(^2\) This program brief demonstrates how a High Impact Practice\(^3\) can support access to voluntary family planning in fragile and hard-to-reach settings, like rural Niger. It also explores how proven service delivery models can be rolled out and adapted to these contexts.
Background

Currently, 83% of sexually active women in Niger reside in rural areas, presenting logistical challenges for accessing facility-based healthcare. A 2012 analysis demonstrated that during the dry season, less than 40% of Niger’s population lived within a one-hour walk of a health center. In the rainy season, when flooding made some routes impassable, less than 25% of the population lived within a one-hour walk of a health center.

To address challenges in accessing voluntary family planning and to accelerate progress towards increased mCPR, the Nigerien Ministry of Public Health (MoPH) developed a national-level action plan, which includes the use of mobile outreach services, a High Impact Practice proven to increase access to and use of voluntary family planning in geographically remote settings (Figure 1). In Niger, where large families remain the norm, operationalizing voluntary family planning programs remains challenging both in creating demand and delivering services.

Since late 2017, Population Services International (PSI), through the Support for International Family Planning and Health Organizations (SIFPO) 2 project, has supported the MoPH to conduct a proof of concept adaptation of mobile outreach service delivery in Dosso Region, Southeast Niger. In doing so, PSI seeks to develop and test a model that meets both the short-term objective of bringing services closer to rural populations, and the longer-term objective of sustainably strengthening the rural health system in Dosso. To this end, PSI has piloted an approach that builds local capacity, normalizes access in rural settings, and engages rural community health agents in the operationalization of mobile outreach, including provision of voluntary short-acting and long-acting reversible contraceptive (LARC) methods, and referral for voluntary permanent methods (PMs).

Figure 1: Mobile Outreach Models

Bringing mobile services to remote locations has been a strategy of family planning programs for decades. In designing its approach in Niger, PSI considered the many ways that mobile outreach is conducted, including across other PSI countries, by other international non-governmental organizations (NGOs), and by ministries of health. Generally, strategies fall into one of four categories:

- **NGO independent delivery**
  Autonomous service provision by an NGO may take place inside a stand-alone clinically-equipped van, or the NGO may bring portable tents or other materials to set up a temporary structure, or to modify a public space into a temporary clinic. This approach, especially when it uses a stand-alone van, is often the most resource intensive, however it is also generally able to provide all methods including voluntary permanent methods (PMs).

- **NGO delivery within public sector**
  Service delivery by an NGO takes place in a public clinic space, like a rural health post. It may provide all methods, but often cannot provide PMs, unless the NGO brings sterile equipment and supplies, and trained providers.

- **Public sector strengthening**
  The NGO supports public sector providers to jointly conduct mobile outreach services within the health zones. This approach focuses equally on building provider capacity/competence and delivering services.

- **Public sector independent delivery**
  The public sector operationalizes and staffs mobile outreach services independently. In some cases, they may receive reduced input from an NGO (e.g. limited only to supplies or logistical support). In other cases the public sector operates alone, without any NGO support.

For the purposes of this brief, service delivery models such as using dedicated providers and community-based distribution are considered distinct from mobile outreach services.
Identifying a gap and designing the intervention

Currently, the Nigerien public health system offers two points of contact for individuals seeking primary health care: the integrated health center (IHC), and the rural health post (RHP).

IHCs in Dosso Region are typically staffed with mid-level providers and serve a population of approximately 25,000. IHCs provide voluntary family planning, usually with short-acting methods, LARC, and at least one trained provider available. In Dosso Region, the family planning supply chain has remained stable for the past year; most methods are available at IHCs. PMs are not routinely available at IHCs.

RHPs in Dosso Region are staffed by rural community health agents, serve a population of approximately 5,000, and are generally 10-15 kilometers from the closest IHC. Many RHPs periodically offer short-acting family planning methods, notably combined oral contraceptive pills, progestin-only pills, and depot-medroxyprogesterone acetate (intra-muscular) injections. However, neither family planning services nor awareness raising are prioritized at this level of the health system; the community health agents administer curative care and are not routinely trained on voluntary family planning counseling and services.

The difference in availability and uptake of voluntary family planning between the IHC and RHP levels in Dosso Region demonstrated a clear gap for PSI and the public health authorities: if services were offered primarily at the IHC level, they weren’t necessarily reaching remote communities, who often have the highest unmet need and generally seek care at RHPs.

To fill this gap, the project team designed an intervention model that leveraged both the material and human resources of the public health sector and PSI (Figure 2).

In order to decide where the mobile outreach events would take place, PSI and the public health authorities in Dosso identified two districts where RHPs covered large populations or geographic areas but did not routinely offer voluntary family planning services. The selected districts were not actively receiving support from other NGOs focused on voluntary family planning.

The number of mobile outreach days per month (10) was negotiated between PSI and the district-level public health authorities, with funding for travel expenses and availability of public sector human resources.
resources largely determining the frequency at which the events could occur. Because the public sector’s collaboration with UNFPA has resulted in strong progress toward contraceptive security at the national and sub-national level in Niger, it was determined that the district-level public warehouses would dedicate contraceptive stock to mobile outreach events. Further, this aligned with the national-level action plan for family planning set out by the MoPH.

In the intervention design, forecasting of commodities is conducted by PSI communicating the average users reached during the mobile outreach events to the district warehouse, which then sets aside sufficient stock for 10 days of mobile outreach each month. PSI picks up the bundle of commodities at the beginning of the month, to avoid frequent return trips from the field to the warehouse. Sufficient consumables for outreach events, such as sharps boxes and gloves, are provided by PSI to supplement the MoPH supplies and bridge gaps in public sector procurement of these items, which remain a challenge in Niger.

The intervention uses a one-vehicle, five-person approach to deliver services at the RHPs. The vehicle and driver are provided by PSI. Four clinical staff travel in the vehicle, including: a PSI staff supervisor (either a doctor or midwife who has been trained to supervise other medical staff), a public sector district-level supervisor (a midwife or nurse who has been trained to supervise other medical staff), a PSI staff midwife, and a midwife from the closest public sector IHC. The PSI and public sector supervisors jointly oversee the mobile clinic operations (including quality assurance and coaching/supervision of the midwives), and they also pair up with the PSI and public sector midwives to provide services in two-person teams. The PSI and public sector midwives provide counseling and services to clients. In some instances, due the variable availability of supervisors, the five person-team is reduced to three people (a PSI midwife, an IHC-level midwife, and a PSI driver). In all cases, the provider team that delivers services also collects service delivery data using the nationally-approved family planning register. The IHC-based midwife is responsible for bringing the register back to the IHC and reporting the data to the district-level public health authorities using the public sector data management system.

To ensure sufficient human resources for the implementation of the mobile outreach events, PSI and the district health authorities identified and trained 18 mid-level IHC-based public providers to conduct mobile outreach services for voluntary family planning alongside PSI at the selected RHPs. All providers who underwent the training agreed to also receive supportive supervision by PSI staff while practicing at their respective IHCs, outside of the mobile outreach events. This was to ensure continuous skills building and assure clinical competency. Because permanent methods are outside of the clinical scope of the mid-level providers (as well as the community health agents who will ultimately be responsible for the sustained delivery of services following the pilot intervention), permanent methods were included in the intervention only as referrals, not as services offered at the outreach events. Following the trainings, service delivery through this mobile outreach model began in April 2018.
Bringing mobile outreach to the RHPs

Approximately one week prior to each outreach event, community liaisons affiliated with the RHP mobilize clients through mosque loudspeaker announcements and household visits. As a strategy to engage men and further generate demand for voluntary family planning, community liaisons also conduct financial-planning activities with male community members and couples before the outreach events. In these basic accounting activities, community liaisons support men to calculate the current costs of food, housekeeping, education and healthcare in their households, developing an approximate annual expense budget. Men are then guided through simple calculations to determine the costs associated with adding new family members to their household, and how multiple births in rapid succession will impact their expenditures. As polygyny is very common in the region, it is not uncommon for families to experience more than one pregnancy at a time; visual aids facilitate understanding of the calculations by showing, for example, multiple wives with multiple children. Following the budget discussion, community liaisons lead reflective discussion among men about family planning. These sessions provide a space to discuss the financial realities of providing for very large families using real budgets developed by the men themselves. In this very low mCPR setting, the purpose of these activities is to support men’s understanding of how voluntary family planning can help them better manage their household budgets and to facilitate joint decision making between couples about the use of voluntary family planning.
These demand generation efforts create interest around the mobile outreach events, meaning that women and girls are already waiting at the RHP when the mobile outreach teams arrive. Prior to offering services, the PSI and public sector providers facilitate group discussions, encouraging individuals to share what they already know about family planning, to ask questions about different methods, and to confront common rumors and misconceptions. Gender norms in Niger generally mean that only women and girls are present at these events, creating a comfortable environment for discussion among peers.

Following the group discussion, clients are seen for individual counseling visits within a private room inside the RHP. Although the RHPs are static health facilities, many clients only visit them when a mobile outreach event occurs. Therefore, it is important to ensure that clients receive clear, relevant information at the point of service; they may not interact with a provider again for several months.

During the individual counseling visits, each client is asked about her reproductive intentions, health history, and if she already has a preferred method of family planning. She is invited to touch and examine all methods available, and the provider discusses specifications of each method with her. As part of the visit, the client is specifically counseled on common side effects and health benefits of different methods, including regarding common bleeding changes. If she chooses to initiate, continue, or remove a method or switch methods, she is evaluated for medical eligibility and provided with that service, free of charge. Before leaving the RHP, each LARC client is counseled on her options for LARC removal. Removals can be conducted at the next mobile clinic at the given RHP, during a mobile clinic that takes place at a nearby RHP, or at the closest IHC, where PSI has trained at least one public sector provider. All removals associated with the mobile outreach events are conducted free of charge, regardless of where the client received her method.
During individual counseling and service provision visits, the PSI staff midwife or PSI clinical supervisor pair with the public sector supervisor or midwife and work as a team; one completes client record forms and commodity tracking as the other provides clinical care. Using this approach, each client visit averages 12 minutes in duration.

Client record forms are kept at the RHP and are the responsibility of the community health agent who staffs that RHP. Each client departs with a small notebook that summarizes the details of her visit (including, but not limited to, the method she received and its maximum use duration). The nationally-approved family planning register is brought to and from the mobile event by the IHC-based midwife; a summary sheet of the mobile event’s data is also aggregated on a separate form that PSI maintains independently for tracking the progress of the intervention.

While women wait outside the room for their visits, community health agents based at the RHPs provide other services to women and their children, such as child growth monitoring. Once all clients are seen, the PSI and public sector providers conclude services and travel to a new site the following day.
Intervention results

Using this model, between April 2018 and September 2019, the intervention conducted 177 outreach events, providing voluntary family planning services to 4,612 women and girls. Clients who were interested in voluntary family planning selected from a wide range of available methods. This resulted in a diverse method mix (Figure 3) and demonstrated significant proportional uptake of voluntary LARC compared to the national-level method mix (Figure 4). In addition to implants, injectables, IUDs, and pills, condoms were available for all clients who wished to take them. Clients interested in voluntary permanent methods were referred to the location of available services (the district hospital). Among users, 15% were adolescents age 19 or younger. Women and girls were not asked about their marital status; however, given Niger’s average age of marriage (15.7 years\(^1\)), many of these clients were likely married adolescents.

During the period of review, the mobile outreach teams also conducted 256 LARC removals (251 implants and 5 IUDs); these removals included methods originally provided by the mobile outreach teams and also by other public and private providers.

Each month, two PSI-supported mobile teams averaged a total of 10 outreach days, with approximately 25 clients served each day, reaching 4,612 users during the period of review.

**Figure 4: National-level Method Mix, Niger 2015 (Source: FP2020)**

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.
Using this mobile outreach approach, PSI and the Niger MoPH demonstrated a substantial increase in voluntary family planning users at the RHP level and fostered more robustly trained providers at the IHC level. However, PSI sought to integrate further sustainability measures into the model, to ensure continued impact following the intervention period. To work towards a more public sector-centric model—and one with the potential for continuity in Niger—the intervention team identified two entry points to evolve the service delivery model. The district-level MoPH was supportive of this effort, emphasizing that in efforts to create a more sustainable model it was important not to lose the momentum gained through the mobile outreach events.

First, the model was expanded to maximize task sharing. Per Nigerien MoPH norms, many low-level providers based at RHPs are, with enough training, authorized to administer all short-acting contraceptive methods, as well as insert and remove implants. As the mobile outreach model had not historically engaged these staff as family planning providers, PSI and the MoPH first began training these providers in high quality family planning counseling and service delivery in August 2019. Currently, instead of PSI and IHC staff working in pairs during outreach events, the IHC and RHP staff are beginning to work in a service delivery team, with PSI staff in a supervisory and support role. Rolling out this change requires both a shift in procedure and a shift in perspective: RHPs must internalize voluntary family planning as a service for which they are responsible to deliver. Accountability mechanisms such as supportive supervision during and after mobile outreach events, as well as rolling family planning data up from the RHP, support efforts to normalize voluntary family planning at the RHP.

Second, PSI is actively working with the district-level health authorities and the IHCs to include family planning services in field outings*, which are events...

*RHP providers like this woman are now being trained in FP services so they can offer a wider range of methods during and after the mobile outreach events.
that take place in a similar fashion to mobile outreach but focus on vaccine provision and routine maternal care, such as pre- and post-natal checkups. Like mobile outreach, field outings generally occur with IHC staff traveling to RHPs on a monthly basis to support service delivery. However, these outings are performed without external support from donors or NGOs, as they are within the typical remit of the IHC.

As the ongoing mobile outreach events work to normalize the extension of voluntary family planning counseling and services, additional support is now available from trained RHP providers. PSI supervisors and midwives periodically attend field outings to monitor the quality of services as well as to provide logistical support to the events in the form of consumables, when needed. Contraceptive commodities are brought by the IHC staff, who receive them directly from the MoPH at the district level. Because the IHC providers were trained through the intervention and have provided services through the mobile outreach events since April 2018, they are also able to coach and support the RHP providers. Data collection is similar to the mobile outreach events, where MoPH client forms and registers are used; client forms stay at the RHP and registers used in field outings return to the IHCs.

Integration of voluntary family planning services into field outings provides an opportunity to reach more clients and different client segments than traditional mobile outreach events, including new mothers who bring their children to receive vaccines. Routine inclusion of voluntary family planning into the field outing events, along with continued support to the RHP providers, may reduce the need for stand-alone family planning mobile services in the future and also better serve postpartum and mothers of young children with voluntary family planning services. Important to both the task-sharing and field outing events will be the continued leveraging of community liaisons to generate demand for voluntary family planning services through awareness raising.

*m English translation of Sorite Forains

mobile planning tools. As PSI and the MoPH engage these two entry points and transform the operating model of mobile outreach services in Dosso Region, the pilot is seeing initial, positive results, with increased provision of all methods available at the RHPs (which now include contraceptive implants). Further, initial field outings have demonstrated similar numbers of clients to the mobile outreach events, showing the promise of sustaining the short-term gains that the mobile outreach events achieved in reaching substantial numbers of voluntary family planning clients.

Conclusion

Mobile outreach services that enable rural clients to access high quality family planning counseling and a broad range of voluntary family planning methods are feasible and can result in increased family planning users even in fragile and hard-to-reach settings with very low mCPR, like rural Niger. As a proven High-Impact Practice, mobile outreach should be considered an effective way to reach populations with limited access to services. In addition to meeting latent demand, approaches to mobile outreach may also consider ways to strengthen rural health services. Training lower-cadre health providers in a wide range of methods has the potential to promote sustainability and continue meeting the additional demand for voluntary family planning created by the outreach events.

PSI is actively transforming its mobile outreach model in Niger to normalize delivery of voluntary family planning services outside of IHCs and ensure greater human resources for the delivery of family planning services in Dosso Region. Continued documentation and testing of this pilot model will contribute to the evolving discourse on mobile outreach and support the MoPH to achieve its mCPR goals. Through greater access to high-quality health services, women, girls, and families will continue to experience improved health outcomes, including decreases in unintended pregnancies and maternal mortality.
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