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# **FAMILY PLANNING ASSESSMENT FOR THE RESILIENCE IN THE SAHEL ENHANCED (RISE) INITIATIVE**



**Burkina Faso & Niger**

**February 28 – March 12, 2016**

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Cover photo: MSI worker provides one-on-one counseling to a woman in Tanziongo, Burkina Faso on different family planning options.  
*(Source: Thibaut Williams)*

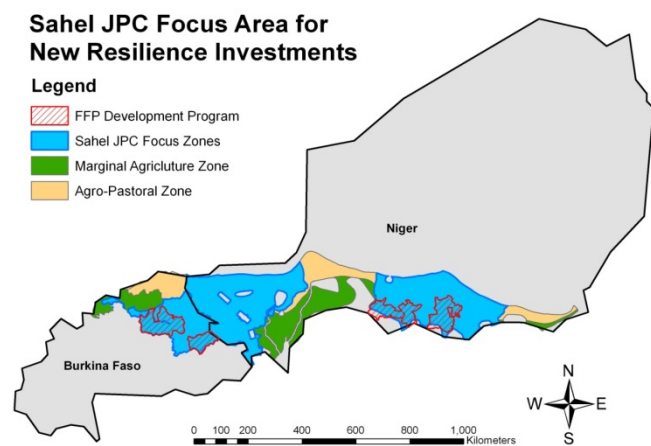
**LIST OF ACRONYMS**

AOR	Agreement Officer’s Representative
ASC	Community Health Workers (Agent de Santé Communautaire)
CBD	Community-Based Distribution
CIP	Cost Implementation Plan
CPR	Contraceptive Prevalence Rate
CSPS/CSI	Health Center
DHS	Demographic Health Survey
DSF	Family Health Directorate (Direction de la Santé de la Famille)
DSME	Maternal & Child Health Directorate (Direction de la Santé de la Mère et l’Enfant)
FP	Family planning
GoBF/GoN	Government of Burkina Faso/Government of Niger
HTSP	Healthy Timing and Spacing of Pregnancies
IUD	Intra-Uterine Device
ISSP	Population Sciences Institute (Institut Supérieur des Sciences de la Population)
LARC	Long-Acting Reversible Contraceptive
MNC&RH	Maternal, Neonatal, Child & Reproductive Health
MOH	Ministry of Health
MSI/SIFPO	Marie Stopes International/Support for International FP Organizations
OP	Ouagadougou Partnership
PMA 2020	Performance Monitoring & Accountability 2020
PRH	Office of Population & Reproductive Health
RISE	Resilience in the Sahel Enhanced
SBCC	Social & Behavior Change Communication
SOW	Statement of Work
SWEDD	Sahel Women’s Empowerment & Demographic Dividend Program
TFR	Total Fertility Rate

## 1. INTRODUCTION

USAID launched the RISE initiative in February 2014 to increase the resilience of chronically vulnerable households in targeted agro-pastoral and marginal agriculture zones in Niger and Burkina Faso (see Figure 1 for Map of the RISE Zone). RISE represents the totality of USAID’s humanitarian and development efforts to increase resilience by increasing economic well-being, strengthening governance and improving health and nutrition status.

**Figure 1. Map of the RISE Zone**



Rapid population growth – the Sahel accounts for some of the highest fertility rates in the world – threatens to erode RISE’s resilience gains. However, these population issues were not adequately addressed in RISE’s design due to the initial lack of family planning (FP) funds and restrictions on the use of other funds to increase FP use. Where possible, USAID has linked its modest ongoing FP investments within and outside the RISE zone to its resilience programs. As the majority of these investments primarily target urban and peri-

urban areas, supplying FP information and services in the rural RISE areas will present a unique set of challenges and opportunities.

Now, following advocacy from USAID/W and the Sahel Regional Office (SRO), USAID will program FP resources under RISE as of FY 2016. The USAID health experts supporting RISE are tasked with determining the most appropriate use of these resources to increase FP use within the RISE zone.

## 2. OBJECTIVE OF THE ASSESSMENT

The purpose of the assessment is to collect and analyze information in Burkina Faso and Niger to inform the programming of USAID’s projected FP resources under RISE. The Assessment Team structured the assessment by answering the following questions:

1. What is the context of FP use within the RISE zone in relation to demand, supply and the enabling environment?
2. What are USAID’s strategic advantages in increasing FP use within the zone?
3. What are USAID’s programming options for RISE’s future FP resources?

Please refer to the assessment’s statement of work (SOW) under Annex 1 for more detailed sub-questions.

### 3. METHODOLOGY

The FP Assessment Team consisted of the following members:

- Safia ABDOUWAHI, USAID/Niger Health Officer (Niger portion)
- Dr. Didier Mbayi KANGUDIE, USAID/West Africa Health Specialist
- Siobhan PERKINS, USAID/PRH Program Advisor
- Thibaut WILLIAMS, USAID/SRO Health Officer

Alex TODD-LIPPOCK (USAID/PRH) and Bakari TRAORE (USAID/Burkina Faso) also participated remotely to the extent that they were able.

The FP assessment team reviewed existing literature prior to visiting Burkina Faso from February 28 to March 6 and Niger from March 6 to 12 (see Annex 2 for a list of relevant background documents reviewed). Once in-country, the FP assessment team conducted qualitative interviews with key informants from the host government, international donors, implementing partners, and civil society. The FP assessment team visited ongoing FP activities (e.g., AGIR-PF, MSI/SIFPO) to observe FP service delivery and to meet with healthcare providers and current/potential FP users in the community. Please refer to Annexes 3 to 5 for visit agendas, the list of persons encountered and the data collection tools used during the assessment, respectively.

Following the collection of primary and secondary data in each country, the FP assessment team conducted a thorough analysis of strengths, weaknesses, opportunities and threats related to increasing the use of FP service in the RISE zone. The FP assessment team in consultation with local USAID health staff then identified potential programming options to better leverage existing FP and resilience



The FP Assessment Team discusses fertility with Islamic leaders in Niamey, Niger.  
(Source: Safia Abdoulwahid)

investments and to use RISE's new FP resources.

Limitations to this methodology included the limited time spent in each country. Given the distance from the capitals to much of the RISE zone and significant logistical and security constraints to travel, the FP assessment team was only able to visit a small part of the RISE zone of intervention. Time was particularly limited during the focus group discussions with community members.

## 4. FINDINGS

### 4.1 BURKINA FASO FINDINGS

Burkina Faso has one of the highest fertility rates in the world, with a Total Fertility Rate of 6.0 children per woman according to the latest Demographic Health Survey (DHS) in 2010. The latest round of data collected through the Performance, Monitoring & Accountability 2020 (PMA2020) reveal that the modern contraceptive prevalence rate (CPR) has increased from 15 percent in 2010 to 20.1 percent in 2015, which is still shy of the 25 percent target for 2015 established in Burkina Faso's costed

implementation plan (CIP), also known as the *Plan de Relance*. However, there are still promising signs of improvement. The use of long-acting reversible contraceptives (LARCs) has tripled in Burkina Faso over the past five years. Implants are the most common contraceptive currently used (39.5 percent of contraceptive users in union). PMA2020 also indicates that total demand for FP is increasing, although 60 percent of married women express no need for spacing or limiting of births.

Significant sociocultural and structural barriers to creating demand for FP use persist in Burkina Faso. Cultural norms value high fertility and gender equity issues prevent many women from making decisions regarding their own health and fertility. While most women are aware of FP, myths and misconceptions regarding side effects and return to fertility are common. Low levels of school completion and extremely limited economic prospects result in young women marrying and beginning childbirth when they are very young (median ages at marriage and first birth are 19 years and 20 years, respectively). Many of the persons encountered in this evaluation report that many previous demand creation efforts were not sufficiently grounded in the cultural context. Likewise, they report that much more work is needed to engage men and to find better ways of catering to the specific needs of youth. Respondents report that these barriers are particularly entrenched in the RISE zone. The Peul population within Sahel Region was often cited as being particularly hard to reach.

Burkina Faso has made significant strides in increasing access to FP services. Nearly all health facilities provide five or more modern contraceptive methods. FP services are integrated into general services at public health facilities, which are supported by a diverse and vibrant civil society. While the costs of

***“Burkina Faso adds the equivalent of Bobo Dioulasso [Burkina’s 2<sup>nd</sup> largest city] to its population every year.”***

*Dr. Edwige Adekambi  
DOMINGO,  
UNFPA Director*

these services are subsidized, the modest cost is still a barrier to access as shown by the very high turnout at Special Days, when FP services are free. Challenges within the overall health system (e.g., quality and quantity of clinical staff in rural areas) continue to pose barriers to FP use. The Government of Burkina Faso (GoBF) has a 500M CFA line item for family planning commodities, although actual expenditure is usually far less (projected at 160M in 2016).



In 2014 the Ministry of Health (MoH) began to experiment with taskshifting in a couple of Health Districts. In this pilot phase lower-level clinicians (e.g., birth attendants) were trained to provide LARCs within health facilities and community health workers (ASC) to provide injectables (Syanapress) and the initial supply of contraceptive pills. Many physicians within the MoH are wary of delegating these tasks to lower-level health workers given their perceived limited capacity. Due to these concerns

and the change in the profile of ASC, taskshifting has been stuck in an indefinite holding pattern despite promising results elsewhere in the region (e.g., Togo, Ethiopia). The MoH has also suspended its program of contracting to local NGOs for community-based distribution (CDB) of short-term methods (i.e., condom, pill refills). Following the election, there has been a number of high-level changes within MoH staffing, including a new DSF Director appointed just prior to our visit. Much of this new leadership has already publicly expressed their commitment to FP.

The GoBF's CIP expired in 2015. The political transition has delayed the evaluation of the former plan and the development of the next phase. The MoH plans on integrating the next FP CIP into a general maternal, neonatal, child and reproductive health (MNC & RH) plan. Civil society and some donors are concerned FP-specific commitments made under the Ouagadougou Partnership (OP) may be lost under this integrated plan.

Lastly, a recent development that has the potential to positively impact FP is the Sahel Women Empowerment and Demographic Dividend (SWEDD) program. With funding from the World Bank and the Gates Fund, this four-year program will provide \$35M to the GoBF to increase women's empowerment and expand access to reproductive health services.

Annex 6 provides a more detailed summary of the meetings and visits from Burkina Faso.

#### 4.2 NIGER FINDINGS

Niger has the single highest fertility rate in the world. Its TFR of 7.6 from the 2012 DHS has remained virtually unchanged since the surveys began measuring fertility in 1992. The Government of Niger (GoN) has set the extremely ambitious target of achieving a CPR of 50 percent by 2020. In 2012, the modern

contraceptive prevalence rate was only 12 percent, of which the lactational amenorrhea method accounted for four percent. The RISE zone – particularly Maradi Region – has some of the highest fertility rates and lowest FP use rates in the country. Rural, uneducated families are particularly underserved. Women marry and begin having children very young and Niger has one of the highest female illiteracy rates in the world.

Niger has very low unmet need for FP due to its pronatalist culture where desired family size – men

***“Au question de population, tel que vous le posiez, on est allergique à cause de l’approche.”***

*Nigerien Imam*

would like to have 11.5 children on average – is even higher than actual family size. Respondents report strong resistance to family planning throughout society. FP has traditionally been seen as a Western-imposed method to limit African fertility. While Islam is supportive of the spacing of births for the health of the mother and child, a very heated exchange among Imams during the assessment reveals that religious leaders are not necessarily on the same page on how to approach the issue. Respondents agree that it is better to address “responsible fertility” rather than FP.

Despite deeply entrenched pronatalist attitudes, promising approaches indicate that change in cultural norms is possible. Husband Schools, which were introduced in Niger in 2008, have been shown to be an effective, culturally-appropriate means to engaging men on issues of health and fertility. The Camber Collective recently completed a market segmentation study that provides a more nuanced picture of views on fertility. Meanwhile, recent initiatives to increase access to FP services – including the Gates Funded IMPACT program, the MoH’s introduction of Syanapress at Health Posts and Marie Stopes International (MSI) mobile clinics in the RISE zone – all prove that many women actively seek these services once they become available. A major barrier to increasing FP use appears to be the limited



A Husband School in Seno village in Tillaberi Region

(Source: Didier Mbayi Kangudie)



coverage of these types of promising interventions rather than purely resistance.

Increasing the supply of FP services in Niger presents both challenges and opportunities. Over half of the population lives over 15km from a health facility. Existing facilities are understaffed, particularly in rural areas as 70 percent of all healthcare workers reside in Niamey. FP services are free within the public sector and commodities are generally available. The MoH’s taskshifting pilot to allow ASC to provide Syanapress at Health Posts has yielded promising results. The MoH has developed an ambitious scale-up plan and is looking for external partners for support. Results from the ANIMAS pilot to provide Syanapress through community agents (relais communautaires) were less promising. The MoH has thus not approved the CBD of injectables given concerns regarding community agents’ capacity and inadequate supervision. While MSI’s mobile clinics have achieved impressive results over its past year of implementation in the RISE zone, its overlap with RISE’s community interventions and linkage with the formal health system can be improved.

The MoH will soon conduct a mid-term evaluation of its CIP to update regional targets and to recommend mid-course adjustments in strategy. There is currently no civil society platform for FP, although the MoH will soon establish a Technical Committee for the Monitoring of the CIP that will include Ministries, donors and civil society. The MoH’s Maternal and Child Health Directorate (DSME) has requested donor support to map FP interventions in Niger.

Annex 7 provides a more detailed summary of the meetings and visits from Niger.

## 5. CONCLUSIONS:

### 5.1 BURKINA FASO CONCLUSIONS

The FP Assessment Team identified the following strengths, weaknesses, opportunities and threats regarding FP within the RISE zone in Burkina Faso.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Well organized, dynamic civil society network</li> <li>• Advocacy at the national and sub-national levels (e.g., RCPFAS, URCB), including targeting traditional and religious leaders</li> <li>• FP commodities are generally available at points of service at a subsidized price for routine services</li> <li>• Integration of FP into general health service delivery, including post-partum family planning</li> <li>• PMA2020 and other data collection efforts reveal positive trend in FP indicators, esp. those related to LARCs</li> </ul>	<ul style="list-style-type: none"> <li>• Financial barriers to FP services exist even with subsidies</li> <li>• Insufficient commodities for additional Special Days</li> <li>• Insufficient equipment/consumables for administration of LARCs</li> <li>• Gender barriers, including:               <ul style="list-style-type: none"> <li>○ Lack of male engagement/support</li> <li>○ Limited dialogue between couples</li> <li>○ Male norms (FP associated with infidelity)</li> <li>○ Women lack decision-making power regarding their health &amp; fertility</li> </ul> </li> <li>• Cultural preference for high fertility, including:               <ul style="list-style-type: none"> <li>○ Values attached to early marriage/</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>• ISSP is a solid platform for research and education on population</li> <li>• Presence of cross-border FP programs</li> <li>• MSI mobile teams were rapidly mobilized to provide high-quality services, with an emphasis on LARC</li> </ul> <div data-bbox="224 579 703 999" style="border: 2px solid #800000; padding: 10px; margin: 10px 0;"> <p style="text-align: center;"><b><i>“When you have lots of children you can send some to school, some can take care of the livestock and some can work in the field.”</i></b></p> <p style="text-align: center;"><i>A woman in Tanziongo explaining how high fertility can be a risk management strategy</i></p> </div>	<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>○ childbearing</li> <li>○ Children associated with wealth</li> <li>○ Real or perceived high child mortality</li> <li>○ Competition among co-wives</li> <li>○ Children as a risk management strategy</li> </ul> </li> <li>• Religious prohibitions on the use of modern contraceptives</li> <li>• Myths &amp; misconceptions on FP (e.g., return to fertility, side effects)</li> <li>• GoBF’s suspension of contracts to NGOs for CBD</li> <li>• Medicalization of FP/delays in implementation of task shifting</li> <li>• Inconsistency/incoherence in FP policy implementation</li> <li>• Lack of consensus regarding integrated vs. vertical plan may result in delayed development of next CIP</li> <li>• Human mobility (e.g., transhumance, seasonal migration, artisanal gold mining, urbanization)</li> <li>• Communication strategies not sufficiently segmented and adapted to specific geographic &amp; cultural contexts</li> <li>• Low female literacy rates/ low levels of school enrollment &amp; completion among girls</li> <li>• Limited disbursement of GoBF’s line item for FP commodities</li> <li>• Poor data quality &amp; analysis through routine health information systems</li> <li>• MSI mobile clinics work in parallel to local health systems</li> <li>• High mobility and inadequate quantity/quality of health staff</li> </ul>
<p><b>OPPORTUNITY</b></p>	<p><b>THREATS</b></p>
<ul style="list-style-type: none"> <li>• Success of National FP Weeks &amp; Special Days</li> <li>• Presence and promising experiences with Husband Schools, Husbands &amp; Wives Schools, Safe Spaces, M2M/Care groups, Individu Famille et Communauté (IFC) and Djanjoba</li> <li>• Presence/trust of RISE partners within the target zone creates a platform for demand creation and service provision/referral</li> <li>• Presence of multisector platforms (e.g., RISE, Plateformes multifonctionnelles)</li> <li>• Introduction of new contraceptives (i.e., Sayanapress, Implanon)</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated MNC&amp;RH strategy may eclipse GoBF’s FP commitments under the OP</li> <li>• Chronic under-investment in education, including lack of USAID education programming</li> <li>• Limited USAID health staff, including PMI requirement for their staff not to spend &gt;10% on non-malaria programs</li> <li>• MSI mobile outreach approach may not lead to long-term local capacity building</li> <li>• Uncertainty regarding future FP funding (e.g., GoBF, USAID)</li> </ul>

- Transition in DSF leadership
- New commitments under OP to add 300,000 new users by 2020
- Upcoming Camber Collective market segmentation survey
- Build on traditional practices/religious texts for birth spacing
- RISE research on decision-makers for fertility
- Strengthen link between population research (e.g., ISSP) and action
- Use of RAPID to galvanize FP advocacy and to respect commitments under OP
- Collaboration with SWEDD
- Latent potential of Ministry of Finance’s Population Direction for high-level, multisector advocacy
- Presence of MSI in the RISE zone, including opportunity to learn from different service delivery/collaboration models
- Opportunity to more actively engage with youth
- New Minister of Health committed to FP as demonstrated by his support for the USAID-Bayer Contraceptive Security Initiative



MSI animators from the Kaya Mobile Team.  
(Source: Thibaut Williams)

## 5.2 NIGER CONCLUSIONS

The FP Assessment Team identified the following strengths, weaknesses, opportunities and threats regarding FP within the RISE zone in Niger.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• FP services are free in the public sector</li> <li>• GoN has a line item for consumables</li> <li>• Demonstrated effectiveness, scalability and sustainability of Husband Schools</li> <li>• Strong technical leadership from the MoH on FP issues</li> <li>• Presence of some dynamic local CBOs (e.g., SongES) and qualified international NGOs</li> <li>• RCPFAS has a nascent yet well thought-out strategy for FP advocacy</li> <li>• FP commodities are generally available at points of service for routine services</li> </ul>	<ul style="list-style-type: none"> <li>• Persistent gender barriers, including:                             <ul style="list-style-type: none"> <li>○ Lack of male engagement/support</li> <li>○ Limited dialogue between couples</li> <li>○ Male norms (FP associated with infidelity)</li> <li>○ Women lack decision-making power regarding their health &amp; fertility</li> </ul> </li> <li>• Deeply entrenched cultural preference for high fertility, including:                             <ul style="list-style-type: none"> <li>○ Values attached to early marriage/childbearing</li> <li>○ Children associated with wealth</li> <li>○ Real or perceived high child mortality</li> <li>○ Competition among co-wives</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>• Some positive trends in FP use rates reported in certain Health Districts</li> <li>• Presence of cross-border FP programs</li> <li>• MSI mobile teams were rapidly mobilized to provide high-quality services, with an emphasis on LARC</li> </ul> <div data-bbox="228 552 711 932" style="border: 2px solid #800000; padding: 10px; margin: 20px 0;"> <p style="text-align: center;"><b><i>“J’espère que c’est le retour de USAID!”</i></b></p> <p style="text-align: center;"><i>Dr. Kemou ADAMA, DSME Director, hoping that USAID will once again play a lead role in FP in Niger</i></p> </div>	<ul style="list-style-type: none"> <li>○ Children as a risk management strategy</li> <li>• Myths &amp; misconceptions on FP (e.g., return to fertility, side effects)</li> <li>• Divergent views among religious leaders on FP, which is often perceived as a Western imposition. FP associated with “limiting”, which is forbidden by Islam</li> <li>• Poor provider behavior, particularly for unmarried women seeking FP information &amp; services</li> <li>• Communication strategies not sufficiently segmented and adapted to specific geographic &amp; cultural contexts</li> <li>• Current profiles of relais communautaires doesn’t meet standards for providing injectables</li> <li>• Extremely low female literacy rates/ low levels of school enrollment &amp; completion among girls</li> <li>• Reliance on external partners for commodity procurement</li> <li>• Limited disbursement of GoN’s line item for consumables</li> <li>• Poor data quality &amp; analysis through routine health information systems</li> <li>• MSI mobile clinics work in parallel to local health systems</li> <li>• High mobility and inadequate quantity/quality of health staff</li> <li>• Very limited coverage of promising interventions/ practices (e.g., only 25% of CSI associated with a Husband School)</li> <li>• Inadequate health coverage/distance to health facilities</li> <li>• Current lack of a coordination mechanisms for civil society and PTFs</li> <li>• Limited overlap between MSI and RISE villages</li> </ul>
<p><b>OPPORTUNITY</b></p>	<p><b>THREATS</b></p>
<ul style="list-style-type: none"> <li>• Success of National FP Weeks &amp; Special Days</li> <li>• Presence and promising experiences with Husband Schools, Future Husband Schools, Safe Spaces and M2M/Care groups</li> <li>• Presence/trust of RISE partners within the target zone creates a platform for demand creation and service provision/referral</li> <li>• SAWKI experience with CBD</li> <li>• Presence of IMPACT in Zinder to increase collaboration with RISE</li> <li>• Presence of RISE multisector platforms</li> </ul>	<ul style="list-style-type: none"> <li>• Political Instability</li> <li>• Chronic under-investment in education, including lack of USAID education programming</li> <li>• Limited USAID/ Niger health staff</li> <li>• MSI mobile outreach approach may not lead to long-term local capacity building</li> <li>• Uncertainty regarding future FP funding (e.g., GoBF, USAID)</li> </ul>

- MoH vision to scale-up positive experiences with task shifting & CBD
- Build on current Camber Collective market segmentation survey to tailor SBCC messages targeting specific behaviors
- Engage religious leaders to build on traditional practices, religious texts for birth spacing and misconceptions of FP
- Review of 2012-2010 CIP as an opportunity for learning
- New data through PMA2020 and DHS 2017
- New Technical Committee for Monitoring of CIP to strengthen coordination
- RISE formative research on fertility (e.g., SAREL political economy analysis)
- Use of RAPID to galvanize FP advocacy and to respect commitments under OP
- Collaboration with SWEDD
- Presence of MSI in the RISE zone, including opportunity to learn from different service delivery/collaboration models
- Opportunity to more actively engage with youth



Women in Chileda waiting for FP services provided through a MSI mobile clinic.  
(Source: Didier Mbayi Kangudie)

## 6. RECOMMENDATIONS:

### 6.1 BURKINA FASO RECOMMENDATIONS

#### 6.1.1 Leveraging Existing RISE/FP Programming in Burkina Faso

The following adjustments within the scope of USAID’s existing resilience and FP programs in Burkina Faso could help strengthen FP services within the RISE zone:

- Introduce/increase messaging on health timing & spacing of pregnancies (HTSP) and early marriage through RISE community platforms (e.g., M2M/Care Groups, Husband Schools, Safe Spaces). RISE implementers can build on REGIS-ER’s ongoing study on decision-makers for fertility to better tailor its messaging.
- Have SAREL explore possibilities of strengthening link between research and action. SAREL has already worked with ISSP on the RISE baseline. SAREL could expand on this partnership to increase RISE implementer’s awareness and use of existing population research in Burkina Faso.
- Build on AgirPF’s advocacy platform using the RAPID tool. AgirPF and the HP+ projects could engage the Direction of Population to apply RAPID to East, Sahel and Center-North Regions.

- Strengthen link between RISE partners and AgirPF's West African Ambassador's Fund grant for FP service promotion in Bolsa Commune (Center-North Region).
- Apply the findings of the market segmentation study to be conducted by Camber Collective through AgirPF to future FP messaging.
- Strengthen linkages between AgirPF outreach sites in Maradi and IMPACT sites in Zinder with RISE partners to facilitate referrals and coordinated messaging
- Explore possibility of using SPRING's innovative, multimedia social & behavior change communication (SBCC) platform – including community radio and participatory community video – for messaging regarding fertility and/or early marriage.
- Learn from and potentially build on the experiences from Population Council's ongoing study on interventions to reduce early marriage.

### 6.1.2 Maximizing Future FP Investments in Burkina Faso

Based on the analysis above, the FP assessment team recommends using the new FP resources to be programmed through RISE for Burkina Faso for the following:

- **Expanding Access to LARCs through Mobile Teams:**

USAID will build on existing mobile teams in Center-North and Est Region to expand FP service delivery in the RISE zone with a continued emphasis on LARC. USAID will request MSI to place a greater priority on overlap with RISE villages (i.e., those supported by DFAPs and/or REGIS-ER). USAID will work more closely with district and regional health authorities to identify opportunities for host government



health system strengthening. Possible health system support may include transferring skills to local health center staff, providing logistical support for Special Days, or involving local authorities in planning and supervision. The opportunity exists to conduct operational research on the comparative effectiveness of different collaboration models. For example, USAID can compare the number of new FP users in those villages where there is partnership between mobile clinics and RISE community structures (e.g., M2M groups) for demand creation to those villages where there is no RISE presence. Similarly, RISE can determine if modern contraceptive use is higher in villages benefiting from a mobile team compared to those who do not.

- **Mixed-Media SBCC Campaign to increase demand for FP services:**

USAID will conduct a mixed-media SBCC campaign to increase demand for FP within the RISE zone. The SBCC campaign will address the gaps/weaknesses in current messaging mentioned above and will build on Camber Collective's market segmentation study. Mixed-media may include a mass media (e.g., community radio), social mobilization and interpersonal communication. The campaign

will provide an opportunity to conduct some basic operational research on innovative messages and approaches.

Pending the results of Pop Council's early marriage study and the abovementioned SBCC campaign, USAID will decide in FY 2017 whether to continue its SBCC efforts or to shift the focus towards a multi-sector delay of marriage intervention.

## **6.2 NIGER RECOMMENDATIONS**

### **6.2.1 Leveraging Existing RISE/FP Programming in Niger**

The following adjustments within the scope of USAID's existing resilience and FP programs in Niger could help strengthen FP services within the RISE zone:

- Strengthen the link between RISE's community-level activities and health structures through the expansion of Husband Schools and/or providing logistical support for outreach visits.
- Introduce/increase messaging on HTSP through RISE community platforms (e.g., M2M/Care Groups, Husband Schools, Safe Spaces). RISE implementers can build the Camber Collective market segmentation study in Niger.
- SAREL may have a role in increasing knowledge management and/or operational research related to FP. For example, SAREL could help RISE implementers monitor the trend in CSI's health indicators following introduction of a Husband School, or study/share SAWKI's experience with CBD.
- Build on AgirPF's advocacy platform using the RAPID tool already developed for Maradi and for religious leaders. Facilitate coordination between AgirPF sites in Guidan Roumji and Aguié and RISE community structures (i.e., REGIS-ER, LAHIA, SAWKI).
- Explore options to use E2A trained peer educators for future outreach to youth.
- Explore possibility of using SPRING's innovative, multimedia SBCC platform (i.e., community radio, participatory community video) for messaging regarding fertility and/or early marriage.
- USAID should attend the National FP Committee and the Technical Committee on RH Commodity Security.

### **6.2.2 Maximizing Future FP Investments in Niger**

Based on the analysis above, the FP Assessment Team recommends using the new FP resources to be programmed through RISE for Niger for the following:

- **Expanding Access to LARCs through Mobile Teams:**

USAID will expand the coverage of existing mobile teams in Tillaberi and Maradi Regions and to increase overlap with villages currently supported by core RISE partners. Mobile teams will continue to prioritize LARCs, while placing a greater emphasis on host government health system strengthening by transferring skills to local health center staff (e.g., management of side effects) and involving district and regional health authorities in planning and supervision.



Idrissa Nafissatou, an MSI Animator from the Tillaberi Mobile Team.

(Source: Thibaut Williams)

- **Support to GoN’s Task-Shifting Scale-Up in Zinder Region:**

years)

USAID will support the MoH’s approved plan to scale-up task-shifting of FP service

delivery through CBD, logistical support to host government outreach services and the expansion on injectables to Health Huts (Cases de Santé) in 1-2 currently un-supported Health Districts in Zinder. USAID will place an emphasis on capacity building of frontline health workers and supportive supervision by District/Regional-level staff.

- **Mixed-Media SBCC Campaign to increase demand for FP services:**

USAID will conduct a mixed-media SBCC campaign to increase demand for FP within the RISE zone. The SBCC campaign will address the gaps/weaknesses in current messaging mentioned above and will build on Camber Collective’s market segmentation study. In addition, USAID will promote couples’ dialogue and will engage religious leaders around culturally-appropriate messaging (e.g., responsible natality). Mixed-media may include mass media (e.g., community radio), social mobilization (e.g., religious leaders) and interpersonal communication. The campaign will provide an opportunity to conduct some basic operational research on innovative messages and approaches.

***“Il faut avoir de la patience.”***

*A Husband School member regarding the time it takes to change norms and attitudes.*

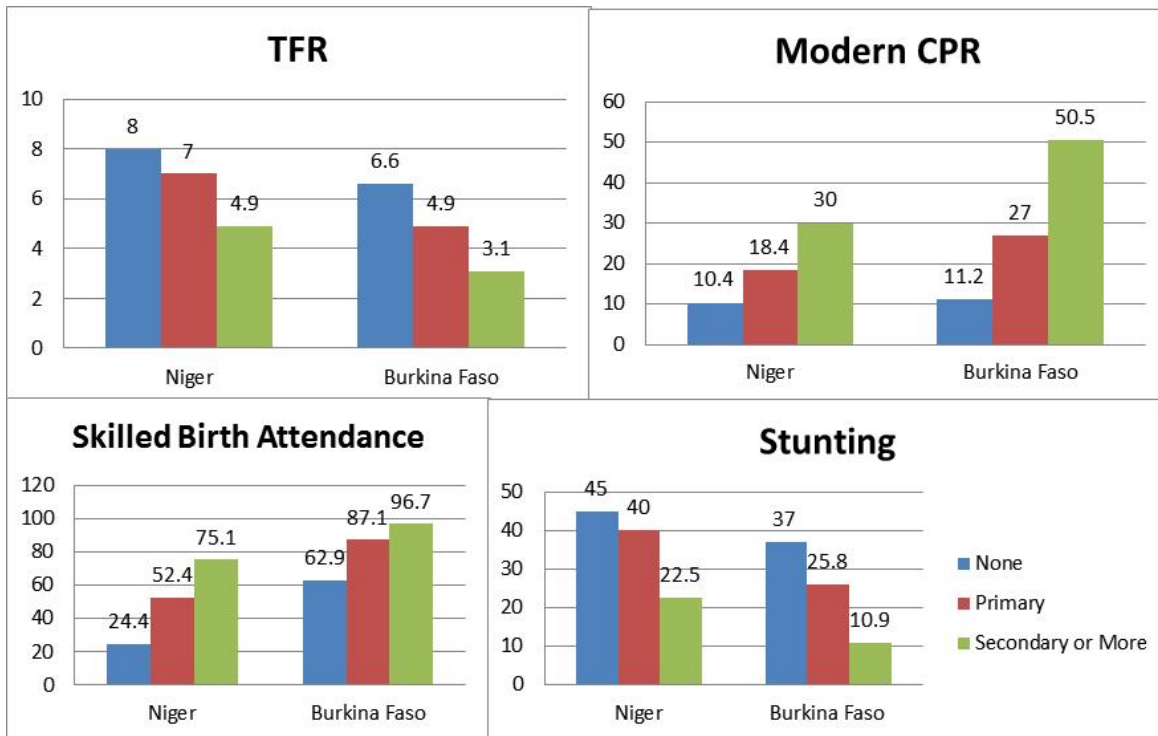


### 6.3 THE BIGGER PICTURE

In addition to the short/medium-term recommendations mentioned above, the following issues will be critical for the long-term impact of USAID's FP investments in the RISE zone.

- **Collaboration with SWEDD:** Given the size of the program and its relevance to USAID's resilience and FP agendas, USAID must maximize synergy between RISE and SWEDD. Initial dialogue with SWEDD staff at the global and regional levels has been encouraging. However, now that SWEDD is moving into the country-level design phase, opportunities for collaboration are less clear. Both units responsible for coordinating SWEDD at the national-level (i.e., PADS in Burkina Faso and the Ministry of Population in Niger) are open to working with USAID but actual input into the ongoing development of SWEDD's project components has been minimal. USAID will need to continue engaging with SWEDD at the regional and national levels to work out how effective collaboration can take place as they move towards implementation.
- **Greater Investments in Girls' Education:** This assessment makes it increasingly clear that investing in girls' education is critical to accelerating the fertility transition and facilitating overall development in the Sahel. Data consistently demonstrate that keeping girls in school – particularly in secondary school – has a multiplier effect on health, women empowerment and economic growth (see Figure 2). Girls with higher educational attainment are more likely to delay marriage, sexual initiation and childbearing, and are more likely to use modern contraception. Women's education is also associated with a wide range of positive child health outcomes, including nutritional status, immunization rates and use of health services. Data suggest that programs with complementary investments in education and family planning have a larger impact on slowing population growth and gender equity than programs investing in only one or the other.

**Figure 2. Health Outcomes by Educational Attainment**



This assessment recommends that RISE advocate for increased investment in girls' education within the zone of intervention. Ideally, USAID would program education funds through RISE with the recognition that keeping girls in school is equally if not more important than the USAID Education Strategy's focus on increasing new access to education. In the meantime, RISE should leverage its existing sources of funding to explore innovative options to keep girls in school. While this assessment recommends further research and analysis, initial opportunities could include:

- Engaging communities to emphasize the value and benefits of girl's education
- Promoting a gender-equitable distribution of household work
- Providing economic incentives to keep girls in school (e.g., WFP's experience with conditional cash transfers based upon school attendance)