

Linking Family Planning to Resilience in the Sahel: A Pilot Intervention Based on Partnership and Integration

The African Sahel region is home to some of the most chronically vulnerable households in the world, living in some of the most fragile contexts.¹

Droughts are increasingly frequent and intensifying across the region, driving recurrent food and nutrition crises. National governments across the Sahel and their global counterparts have foreseen and worked hard to address these challenges. Women and children are among those most impacted. Poor access to health services, combined with recurrent epidemics and lack of access to reproductive and emergency care, are leading to high maternal mortality. Millions of children are at risk of malnutrition and underdevelopment.

In 2017, the Evidence to Action (E2A) Project (2011–present) launched the project “Building Resilience through Strengthening and Integrating Reproductive Health and Family Planning in Niger (RISE-FP)” in the Sahel, with support from the United States Agency for International Development (USAID). USAID solicited the project to integrate quality family planning programming into USAID’s RISE initiative, a groundbreaking initiative with multiple partners, launched in 2014, that focused on building the resilience of chronically vulnerable households in targeted agro-pastoral and marginal agriculture zones in Niger and Burkina Faso through supporting economic empowerment, strengthening governance, and improving health and nutrition. As part of the RISE-FP project, E2A proposed to pilot and document an innovative family planning (FP) and resilience intervention built on the concepts of integration and partnership between the health and non-health sectors. Although the intervention was relatively small in scale in comparison to that of E2A and RISE activities across the region, its significance is substantial.

Starting in the 2016 fiscal year, in recognition of a link between access to family planning and resilience outcomes, USAID began to allocate FP resources as a part of the resilience-focused RISE initiative. This intervention focused on identifying at least one strategy to optimize the blending of FP funding with resilience funding.

The field of Population, Health, and Environment (PHE) provided lessons to inform the intervention’s design. For example, PHE research has shown that rural community-based programs that link FP to health and natural resources management can produce synergistic outcomes such as increasing male engagement in family planning and improving women’s engagement in natural resources management.



PHOTOS Adama Ali Zourkaleini

APPROACH

GOAL

The intervention sought to build resilience in targeted communities through integrating FP/RH with resilience programming in partnership with a non-health RISE partner. E2A aimed to document and share lessons to inform donors and implementers for potential scale-up in Niger, as well as across the Sahel.

THEORY OF CHANGE

By increasing information about and the availability of health services—including FP and nutrition—as well as agriculture services (conservation farming), to a wider range of people in the communities, the resiliency of more households will increase, making households better able to withstand changes to their social, economic, and environmental systems.

NON-HEALTH RISE PARTNER

E2A collaborated with Resilience and Economic Growth in Sahel—Enhanced Resilience (REGIS-ER), a RISE partner and project implemented by the National Cooperative Business Association CLUSA International (NCBA CLUSA).

TARGET POPULATION/GEOGRAPHY

E2A targeted 13 villages in Zinder region of Niger, in two of three health districts where RISE-FP operated (Mirriah and Magaria)—five in Droum commune and eight in Bandé commune. Populations in these villages are among the hardest to reach in the RISE-FP zone, an area that covers 80 villages across three health districts of Zinder, where approximately 63 of those villages are served only by health posts rather than by relatively larger, more comprehensive health centers.

INTERVENTION DESIGN

REGIS-ER and Pathfinder signed a no-cost agreement for:

(1) development of a single, integrated job aid on conservation farming, family planning, and nutrition for joint use in seven target villages where both REGIS-ER and Pathfinder were present, and independent use by REGIS-ER in six of its target villages; (2) use of job aids by RISE-FP E2A-trained Community Based Distributors (CBDs) affiliated with Niger's district health facilities, and by conservation farmer (CF) leaders, who worked with the RISE project to improve farming practices, in home visits, and during community dialogues and/or farmer group meetings; (3) partner development of integrated indicators; and (4) joint supervision and monitoring. At the time of project implementation, by Nigerien law, CBDs could only distribute pills and condoms to repeat users, and farmer leaders were not permitted to distribute methods. All new users needed to initiate methods at a health facility. Thus, both CBDs and CF leaders focused on information provision, counseling, and making referrals. The intervention duration was nine months.

IMPLEMENTATION

Partners cross-trained each other's staff on FP and resilience, respectively, and developed shared messaging. With health facility staff and the Ministry of Health and Mother and Child Health Directorate (DSME), partners ensured job aids adhered to national protocols, and jointly implemented training of:

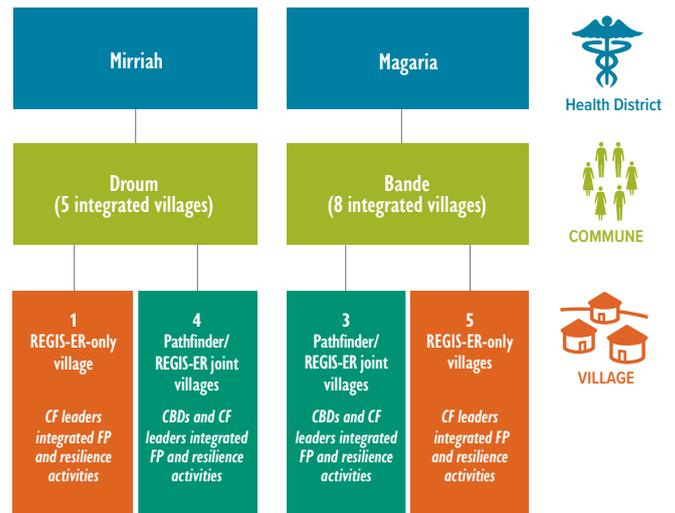
- Twenty-eight CBDs
- Four government representatives from the two districts and the regional health department
- Heads of the Bandé and Droum health centers
- Twenty-three CF leaders

Trainings covered family planning, nutrition, WASH, conservation farming, integrated job aid, joint data collection, and making referrals to health facilities.

DOCUMENTATION

Following implementation, an E2A consultant undertook qualitative data collection and analysis, focusing on the seven joint implementation villages. The consultant conducted interviews and focus group discussions (FGDs) on perceptions of integrated activities, with staff from both partners, CBDs and CF leaders, beneficiary groups, and local development committees. E2A staff conducted a desk review and analyzed monitoring data from health facilities and community agents in the 13 target sites.

RISE-FP Intervention Sites



As illustrated above, several villages were chosen in the Droum and Bande communes in which CBDs and/or CF leaders led "integrated activities," using the integrated job aid to educate their communities on agriculture, health, and nutrition. These sites are referred to as "integrated villages."

FINDINGS AND DISCUSSION

EXPANDING ACCESS TO INTEGRATED INFORMATION

Data from project monitoring indicated that, following trainings and delivery of the integrated flip charts, CF leaders and CBDs conducted household visits and awareness sessions to large groups of men and women, often separately by gender, across the 13 target villages. Thirteen of the original 23 trained CF leaders worked in the REGIS-only villages and 10 worked in the same villages with E2A. Notably, 20 of the 23 CF leader were male and engaged only with male farmers. A total of 83% of the individuals reached by farmer leaders were men. In the 7 villages where REGIS and E2A worked jointly, 28 CBDs, evenly distributed by gender, actively implemented integrated communications. They engaged an even balance of male and female beneficiaries (50% male, 50% female).

REACHING MEN WITH FAMILY PLANNING INFORMATION

Although the dataset is too small to make statistically significant comparisons or draw definitive conclusions, there is one notable observation: on average, CF leaders conducted slightly more household visits per agent than CBDs. CF leaders reached, proportionally and in absolute numbers, many more men than CBDs did. It is possible that this can be explained by the fact that most of the trained CF leaders were men, whereas CBDs were evenly split between men and women. In the Zinder region, it is also most culturally acceptable for men to speak to men, and women to women.

(Left) A REGIS-ER CF leader conducts a group discussion using the project-created integrated communications tool in Djan Kalgo village.



REACHING BENEFICIARIES WITH INTENT TO USE FP

Beneficiaries reached through household visits received referrals to facilities for the FP method of their choice, with one exception. If a beneficiary was already utilizing oral contraceptives or condoms, CBDs (not CF leaders) were empowered to resupply clients. Monitoring data from joint Pathfinder and REGIS-ER sites indicates that 429 individuals with intent to use FP for the first time were referred to clinics, 235 (55%) by CF leaders, and 194 (45%) by CBDs. Among those referred to initiate FP by both CBDs and CF leaders, 50% were referred for oral contraceptives, 30% for Sayana Press, 18% for Depo Provera, and 2% for Implanon. CBDs provided oral contraceptive pills to 1,481 repeat users and distributed an additional 16 female condoms and 84 male condoms. CBDs also counseled and referred 28 continuing FP users for oral contraceptive pills, injectables, and implants. Through the RISE-FP project, training was provided to clinicians on long-term and permanent methods in the referral facilities. However, no clients received referrals for IUDs, vasectomy, or sterilization, which project staff attributed to lack of demand among beneficiaries and lack of provider capacity. For example, following IUD training of six providers, only one could consistently insert IUDs. Intervention and monitoring systems did not allow the partners to trace the degree to which referrals were fulfilled—a significant limitation.

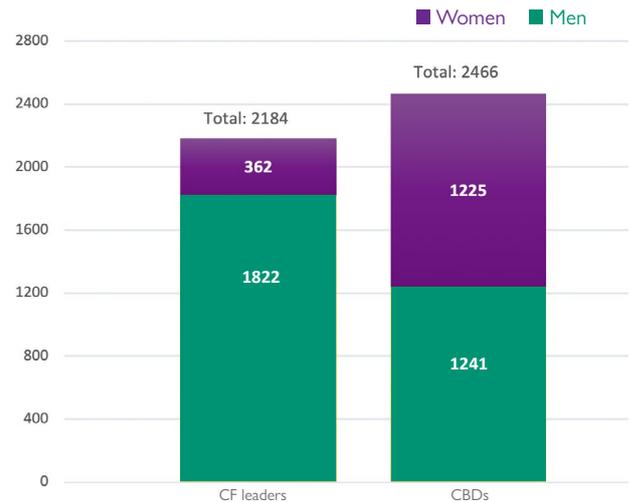
EXPANDING WOMEN'S ACCESS TO CONSERVATION FARMING TECHNIQUES

Although not formally monitored or documented, the implementation team learned that the joint training expanded conservation farming methods and techniques to women in the targeted villages. The CF leaders were all men and their CF groups were largely male, meaning that women rarely had the opportunity to learn about or implement conservation farming techniques. The 14 female CBDs who attended the joint training with REGIS-ER were very interested in the conservation farming techniques and, of their own initiative, each started her own demonstration plot in the villages, using techniques such as field rotation and composting with support from their farmer leader colleagues. These CBDs invited the women they worked with through their FP/RH counseling visits or group dialogue sessions to visit their fields. The CBDs reported observing a twofold increase in their harvests and through their example, many other women in the villages expressed interest and reportedly adopted these advanced techniques.

“It’s necessary that [FP and CF] work together. Because if you do CF, and you farm a hectare or a half-hectare [but] your family is more than a dozen people, you can’t feed them. But if you have a hectare and you do CF and you only have four children because you space births, you can feed them well and enroll them in school and do other things in your life.”

—Farmer leader during a focus group discussion, Bandé

THROUGH HOUSEHOLD VISITS, CBDS REACHED MORE TOTAL CLIENTS, BUT CF LEADERS REACHED MORE MEN. MEN REPRESENTED 83% OF INDIVIDUALS REACHED BY THE CF LEADERS COMPARED TO 50% OF CBDS.



INTEGRATION AND PARTNERSHIP BENEFITS

From staff and implementing agents, we concluded that the perceived benefits of the partnership and intervention included:

- **Production of a shared, integrated communication tool** that community agents from both partners indicated was effective, as it enabled them to articulate linkages among agriculture, nutrition, health and family planning, and support the holistic interests and needs of their target audiences
- **Ability to reach wider audiences** than with original communications materials and training, as reported by trained CBDs and CF leaders
- **Satisfaction of CF leaders and REGIS-ER staff** that, as a result of the collaboration, they could feel confident that the health referrals they made would lead to clients receiving a range of FP methods and quality services, whereas prior to the partnership, services were unpredictable
- **Perceived reductions in child diseases and deaths**, attributed by agents and beneficiaries to the idea that integrated messages and expanded access to conservation farming information and family planning helps families successfully achieve food self-sufficiency and good health.

The team also observed that agents and beneficiaries were consistently able to articulate linkages.

PARTNERSHIP CHALLENGES

Key informant interviews with staff from each partner conveyed a productive partnership that ultimately delivered the integrated intervention, essentially as originally envisioned, but with a few challenges. Principally, the partnership experienced several delays and had to contend with competing priorities. Staff from both organizations attributed these outcomes to a lack of synchronization in REGIS-ER and RISE-FP project cycles, since REGIS-ER was nearing close-out as the RISE-FP intervention began—and lost several staff as the project was beginning. Additionally, communication gaps between national and local level offices, and the need for national offices from both partners to be fully aligned with local decisions, presented significant delays along the way, particularly with regard to signing the memorandum of understanding (MoU).



RECOMMENDATIONS

Integrating family planning into resilience programming through health–non-health partnerships and scaling up the cross-training of staff and frontline workers (accompanied by development of an integrated communication tool), shows that staff, frontline workers, and end beneficiaries all understand the relations between health and agriculture and how using FP and practicing CF can enhance communities’ resilience. The findings also show promise for expanding access to family planning and may increase uptake of conservation farming practices, which would ultimately increase community resilience.

These findings reinforce the evidence from PHE literature indicating that such partnerships and integrated information are often successful at reaching men with FP information, and may encourage more supportive attitudes toward FP. Men often play an important decision-making role in women’s access to health services and family planning, particularly in this region. Results could produce synergy for household food security, health, and nutrition—and thereby resilience—across the Sahel, particularly for vulnerable women and children.

When considering scale-up, consider the following recommendations:

- 1 As a first step, assuming intent to design a partnership between health and non-health actors to collaborate towards resilience, and without any financial exchanges, implementers should prioritize development of a MoU articulating shared benefits.
- 2 When providing cross training, ensure that trainees not only understand why and what they are teaching, but that they also practice pre-tested, scripted integration messaging so that it becomes very comfortable for them to deliver.
- 3 Donors should better design for optimizing collaboration between health and non-health sectors, such as synchronizing project cycles. One way that donors may achieve this would be to provide results-based financial incentives to the other sector if they achieve certain results (that are not typically “part” of their own sector).
- 4 Focus on the potential of such partnerships and integrated initiatives to reach men with FP information and reach women with agriculture information and seek to refine our knowledge on how to optimize this value, so that benefits accrue towards the interdependent set of sectoral outcomes that are key to building resilience.

ENDNOTES: (i) Fragile contexts are formally defined by the Organisation for Economic Co-operation and Development (OECD) in the States of Fragility Report, available online at: www.oecd.org/dac/conflict-fragility-resilience/listofstateoffragilityreports.htm. (ii) Resilience is a complex concept, and used differently in distinct contexts. For the purposes of this brief, resilience is defined by USAID as, “the capacity of affected people, households, communities, countries and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth.” (USAID Resilience Strategy Review, Feb. 2017). (iii) An overview of PHE, and some of the most prominent tools and lessons, can be found online at www.k4health.org/toolkits/phe. (iv) All new FP users must initiate any method at a health center and all users who want a long-term method or injectable must go to a health center.



EXPANDNET

