

Knowledge Brief

Health, Nutrition and Population Global Practice

IMPROVING RESULTS OF DISTRICT HEALTH PLANS IN NIGER

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KEY MESSAGES:

The Ministry of Public Health (MOH) in Niger has used Rapid Results Initiatives (RRIs) to achieve targets for reproductive health and nutrition. Key outcomes of this approach include:

- Mobilization of regions and districts to overcome constraints to assisted deliveries, family planning (FP), nutritional counseling and measles vaccination, and thus achieve Disbursement Linked Indicators (DLIs).
- Collaboratively planned provision of mobile health services, door-to-door visits and outreach to remote and underserved areas, by health teams and communities.
- Engagement of local leaders to help health centers increase coverage of services to women and children, including mapping of households with low uptake of health services; implementing social sanctions to reduce home births.
- Inclusion of FP and assisted deliveries and other messages on reproductive health and nutrition in sermons of religious leaders.

The Government of Niger has rated RRI as one of the top innovations in its national health plan. The MOH and the regions are bound by annual performance contracts to improve results using RRIs.

Background

While Niger has made some progress on reproductive health and nutrition outcomes, there has been limited movement on key indicators. The fertility rate in Niger (about 7 births per woman) is among the highest in Sub-Saharan Africa. The proportion of births attended by skilled health personnel increased modestly from 2012 to 2015 (from 29%ⁱ to 39%ⁱⁱ).

Modern contraceptive use for all women has increased from 12% in 2012ⁱⁱⁱ to 15% in 2017^{iv}. And about 42%^v of children under five are affected by stunting due to poor feeding practices. The weak empowerment of women, and the low quality and utilization of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH + N) services are among the biggest challenges. The coverage of

ⁱ Niger's Demographic and Health Survey (DHS), National Statistics Office, 2012.

<https://dhsprogram.com/pubs/pdf/SR205/SR205.pdf>

ⁱⁱ Sustainable Development Goals: Niger's Data Portal, United Nations Statistics Office.

<http://niger.opendataforafrica.org/vhapnnc/sustainable-development-goals-of-niger>

ⁱⁱⁱ Niger's (DHS), National Statistics Office, 2012.

^{iv} Performance Monitoring and Accountability (PMA) 2020, National Institute of Statistics and The Bill & Melinda Gates Institute for Population and Reproductive Health at The Johns Hopkins Bloomberg School of Public Health.

<https://www.pma2020.org/pma2017-niger-soi-table-en>

^v World Development Indicators, World Bank, 2017.

services is an obstacle, considering that 83%^{vi} of the population lives in rural areas.

In late 2015, the MOH launched the Population and Health Support Project (PHSP), anchored in Niger’s National Health Development Plan (2011-2015 and 2017-2021). It improved services in health centers and community interventions in five regions (Dosso, Maradi, Tahoua, Tillaberi and Zinder). The MOH receives payment for results achieved against DLIs, which are validated annually.

This brief focuses on five DLIs addressed by the project: 1) number of women between 15-49 utilizing modern contraceptive methods; 2) adolescents under the age of 20 utilizing modern contraceptive methods; 3) number of births delivered by a trained health professional; 4) infants having received nutrition counselling and an updated growth chart; and 5) number of children under five vaccinated against measles.

Observed DLIs	Baseline (2014) ^{vii}	Annual achievement (as of 2018)	Achievement
DLI1: Number of women (15-49 years) utilizing modern contraceptives	549,304	1,491,453	Target surpassed
DLI2: Birth delivered by a trained health professional	317,748	251,103	No change, except in select communities ^{viii}
DLI3: New acceptors (girls <20 years) using modern contraceptives	5,239	88,609	Target surpassed
DLI4: Children <1 year of age having received nutritional counseling and an updated growth chart	1,389	360,679	Target surpassed
DLI5: Children 0-11 months immunized with measles	730,410	811,193	Target surpassed

The main mechanism of support in districts has been RRIs, which are an action-learning initiative that support teams to test new innovations. RRIs are 100- day initiatives, often done in series. They are results-focused and, hence,

^{vi} World Development Indicators, World Bank, 2017.

^{vii} Annual data for Niger from the health information management system, HMIS.

reinforce the results orientation of the district health plan. The operational RRIs are implemented two to three times annually at the level of health centers with technical support from respective districts. Lessons-learned from each are then used to improve activities planned by the district. The teams implementing RRIs include personnel from health centers, posts and community health workers (CHWs) as well as community members. This reinforces links between demand and supply-side actors and strengthens health service-community collaboration. RRIs are based on the premise that collaboration helps communities identify solutions and tackle difficult – generally non-technical – constraints to achieving DLIs. The project included work in 53 districts and 836 health centers by 944 RRI teams.

Methodology. This knowledge brief presents the three main areas of learning from districts in which the RRIs were used. Outcome harvesting was used to capture and document these findings. Stakeholder interviews were conducted during a two-week field visit in May 2019 using a sample of district visits in Dosso and Tahoua. RRI teams validated the results during a knowledge-sharing workshop in Niamey in April 2019.

WHAT IS OUTCOME HARVESTING?

Outcome harvesting is a **qualitative assessment tool** to learn from complex development processes that involve multiple actors. In this approach, an **outcome is defined as a change of behavior, relationship, or action** of the beneficiaries or groups with whom a program works directly. The tool can provide results stories to learn from implementation experiences.

Result Areas

I. Improved Results-Based Learning in Districts

53 districts implemented 100-day (3-4 month) RRIs to advance the DLIs. Through a cyclical process of results-based planning, monitoring and learning, health centers, local government authorities and communities developed and tested ways to improve the effectiveness of district health activities.

Results stories

Key achievements included:

- Systematic involvement of community members and local government in health planning, often for the first time. RRI teams consisted of health personnel and community members (doctors, midwives, women

^{viii} RRI interventions to increase DLI2 (assisted birth), were successful in some communities, where traditional birth assistants were active in RRI teams. More focus is required to improve this indicator.

leaders, religious leaders, etc.) for results-based learning to advance the DLIs and were facilitated by a local coach trained on RRI methodology.

- RRI teams met on a weekly basis to manage the implementation of plans for the DLIs. This created a culture of participatory monitoring, problem identification, learning and course correction. The teams used a local dashboard and work plan to monitor their actions.
- The districts financed RRI activities through their annual health plan and budgeted and integrated the RRI lessons to adjust planned activities. Some stakeholders also provided financial and in-kind contributions to support the implementation of the DLI plans. This increased participation of the community and ownership around the results of the RRIs.
- The autonomy of managing the cyclical RRI learning, increased the leadership of districts and health centers, as well as the voice and participation of communities in health planning.

RESULT STORY FROM RESULT AREA I: Contribution of community to achieving DLIs

Long distances and lack of financial means are key hurdles to pre-natal consultation and assisted delivery. In health centers that increased assisted delivery, villagers organized transportation (cars, carts, motorcycles) for pregnant women. The practice continued months after the end of an RRI cycle.

Local communities also pooled funds to improve the conditions of the health center, including ensuring soap, beds, and a maternity area.

Project Contribution

Key PHSP activities supported these outcomes:

- The MOH signed annual performance plan with the regions, which included targets for RMNCH+N indicators.
- Regions conducted stakeholder analysis that identify stakeholders that had influence on the achievement of DLIs, and that helped communities create strategies to address the DLIs.
- The MOH trained 1,022 results coaches at the national, regional, district and community levels. The coaches provided mentorship and leadership coaching to RRI teams.
- The MOH facilitated knowledge-exchange across districts to share lessons, facilitate scale-up of innovations and provide technical support.

- The MOH developed operational guidelines and a decree that created a national committee to oversee the results-based learning.

II. Social mobilization that resulted in increased demand for RMNCAH + N

RRI teams mobilized local leaders and conducted Social and Behavioral Change Communication (SBCC) to generate demand for RMNCH + N services and develop innovative measures for addressing issues arising along the RRI process.

Results stories

Key achievements included:

- Districts organized door-to-door caravans to underserved areas. These caravans mobilized community leaders to communicate messages to families not utilizing health service. Additionally, with the help of RRI Coaches, participants in the caravans mapped their communities, identifying remote areas and pockets of households that did not seek out health services.
- RRI teams organized awareness-raising talks on local radios, involving women, religious and traditional leaders.
- Health centers offered free mediation services and counseling to families and couples reluctant to services. This increased understanding and willingness to utilize FP, skilled deliveries, vaccination and nutritional counseling.
- In some communities, traditional birth attendants (TBAs) accompanied pregnant women to health centers and conducted SBCC. The acceptance of TBAs to engage in such work was a game changer. They accepted because of their role in the RRI team and newfound awareness of the risks associated with home births.
- CHWs tracked pregnant women and infants “lost to follow-up” and went door-to-door to visit these families. This increased the number of infants with an updated growth chart, and vaccinations.
- Some religious leaders included FP and skilled birth attendance in their weekly sermons. played a key role in defeating rumors and changing social norms around FP.
- Some villages chiefs implemented sanctions on home deliveries, penalizing families that did not use assisted delivery services.

Project Contribution

Key PHSP activities supported these outcomes:

- RRI teams developed 100-day plans to advance the DLIs and held weekly meetings to monitor progress on these plans and make corrective actions when planned

activities did not see the intended results.

- RRI teams held community-wide evaluations of progress at the 50 and 100 day-mark, to review results toward the DLIs, identify effective practices and scale-up successful strategies in the district health plan.

RESULT STORY FROM RESULT AREA II: Systematic and collaborative mobile services

Before RRI, some health centers conducted door-to-door and mobile outreach services to deliver services, but these activities only involved health personnel.

These activities now happen weekly and involve community members in the activities. Community members now have a voice in the planning and implementation of the door-to-door activities.

III. Improved Delivery of Services by Health Centers

Results stories

Key achievements included:

- Health centers offered mobile services to women and children in remote villages on a monthly basis. The involvement of community members and the increased frequency improved access.
- Some health centers started offering FP services at night to women and adolescents. This provided much-needed privacy to beneficiaries. Night visits to households helped increase adolescents' use of FP.
- The health centers in Dosso and Tillaberi organized discussion groups in "safe spaces" with adolescents on the use of modern contraceptives.
- Health centers undertook surveys and consultations in the community to understand the perception of services, and how to make improvements.
- Health centers in Dosso and Tillaberi created a separate maternity wing a few steps away from the health center to address the privacy concerns of women.
- Health centers in the district of Maradi publicized the prices of services. This standardized prices and was fundamental in overcoming corruption.
- Regions trained health professions on ethical standards for delivering services. This helped strengthen the professionalism of health agents when communicating with clients.

Project Contribution

Key PHSP activities, including the provision of technical support and targeted training and coaching to implement

activities in the RRI work plan, supported these outcomes.

RESULT STORY FROM RESULT AREA III: Shifting role of traditional birth attendants

The lack of TBAs is a challenge to increasing skilled birth attendance. To counter this, some health centers trained TBAs and used RRIs to jumpstart their work.

TBAs agreed to accompany pregnant women to health centers and played a major role as mediators to promote the utilization of health services, information campaigns and advocacy efforts.

Conclusions

RRIs mobilized districts to work with communities to improve their health plans and make significant progress on key indicators. In doing this, it has supported new innovations, and empowered decentralized leadership and learning. The approach has, in effect, created a platform and entry point to support improved service delivery in communities. The RRIs produced many significant innovations that have been scaled-up partially across districts. The MOH is now working to figure out how to scale-up to the national level. Finally, there is a need for further MOH support to reinforce M&E at district/community level and the quality of services in facilities.

References

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The Health, Nutrition and Population Knowledge Briefs of the World Bank are a quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions. For more information on this topic, go to: www.worldbank.org/health.