

# Knowledge Brief

## Health, Nutrition and Population Global Practice

### STAKEHOLDER ANALYSIS TO MANAGE FOR RESULTS: EXPERIENCE OF NIGER IN HEALTH

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#### KEY MESSAGES:

The Ministry of Public Health (MOH) in Niger used the Net-Map stakeholder mapping method to identify strategies to mobilize district and community actors to improve key reproductive health and nutrition (RHN) indicators, most importantly (1) women's use of modern contraceptive means; (2) assisted delivery by a trained health professional; and (3) mothers of infants having received nutritional counseling. Stakeholder mapping helped achieve the following outcomes:

- By involving community change agents, including husbands, religious and traditional leaders, health districts are able to engage influential actors in awareness-raising and mediation activities surrounding RHN services, thus facilitating improved results.
- By building on partnerships between different stakeholders, health districts are gradually expanding their networks for assisted delivery, which is increasingly being practiced by pregnant women.
- To address the key challenge of weak coordination between actors delivering preventative nutritional counseling, health districts collaborate with community health workers to reach more mothers, thus increasing the scope, scale, and quality of their intervention results.

Implementation of the strategies is reviewed twice per year by the district teams to ensure the number of women and children utilizing RHN services is increasing, and successful activities are integrated into the district's annual health plan.

#### BACKGROUND

Despite years of development programming, Niger has seen limited change in its reproductive health and nutritional (RHN) outcomes. The proportion of births attended by skilled health personnel has increased modestly between 2012 and 2015 (from 29%<sup>i</sup> to 39%<sup>ii</sup>). Modern contraceptive use for all women has increased from 12% in 2012<sup>iii</sup> to 15% in 2017.<sup>iv</sup>

The objective of the Population and Health Support Project (PHSP) is to increase the utilization of RHN services. Achieving this requires new approaches to reinforce the health system, as well as to mobilize actors at the regional, district, and

community levels to respond to constraints. The mobilization of actors can be complex, and needs may differ across communities. Stakeholder mapping is a tool that can be used to plan social mobilization strategies to influence stakeholders toward results.

This brief presents results from stakeholder analyses conducted by the Ministry of Public Health (MOH) to support health districts in Niger to plan social mobilization strategies that enhance three Disbursement Linked Indicators (DLIs), namely: (1) number of women between 15 and 49 utilizing modern contraceptive methods; (2) number of births delivered by a trained health

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>.

professional; and (3) mothers of infants having received nutrition counseling and an updated growth chart. The stakeholder analyses examined the questions: *Who can influence changes in the results indicators at the district level, and how?* These questions guided the mapping of the social networks of stakeholders around each indicator.

**Methodology.** Focus groups were held in a sample of districts in five regions of Niger (Dosso, Tillabery, Maradi, Tahoua, and Zinder). The Net-Map method was used in the focus groups to facilitate the mapping of knowledge and perceptions of social networks and constraints.<sup>v</sup> The focus groups for each district consisted of 12 people, including personnel from health centers, local authorities, and community leaders (such as traditional practitioners and religious leaders). The focus group discussions for each indicator had the following structure:

- **Identification of actors:** The groups identified government, nongovernment, and community actors who could influence the indicator.
- **Relationships to advance results:** The groups visually mapped the links between actors who could influence the DLIs, focusing on four types of relationships:
  - i) **Access to services**—this link visualized relationships to access health services to influence each DLI.
  - ii) **Knowledge flows**—this link visualized relationships to share knowledge (training, counseling, etc.).
  - iii) **Social pressure**—this link visualized relationships of social pressure, such as family pressures.
  - iv) **Collaboration**—this link visualized the coordination among health system actors to deliver services.
- **Type of influence:** The groups agreed on whether the influence of each actor on the DLIs was positive or negative.
- **Barriers:** The groups identified potential leverage and barriers in the network to advance the DLIs.
- **Power:** The groups built “influence towers” to reflect the relative power of each actor (the higher the influence tower, the greater the influence). The level of influence was then proportionally translated into circle sizes in the mapping.

The maps from the focus groups were digitalized using Excel and Datamuse softwares, and districts were supported to develop strategies to address the indicators. The transcripts from the focus groups provided complementary qualitative information.

## KEY FINDINGS

### DLI 1: Womens' Utilization of Contraceptives

**Access to contraceptives.** The mapping showed the main distribution channels for contraceptive products in the districts are health centers, health posts, pharmacies, and clinics. Women are the main recipients of contraceptive services, and

husbands are often excluded. Perceived barriers included the lack of information on where to find in-stock contraceptive products; the attitudes of health professionals providing counseling; and feelings of stigma around accessing contraceptives at health centers.

**Knowledge flows.** Formal channels for information on family planning for women included nongovernment organizations (NGOs), health centers, and community radio. The role of community health workers (CHWs) was notably weak. The main source of information for men included husbands' schools (also known as *Ecole des Maris*) and religious leaders. Misconceptions around modern contraceptives were perceived as a barrier to improving service utilization.

**Social pressures.** The impact of barriers in the provision of contraceptive services to women in Tillabery district is amplified by social pressures in the community. The most influential actors on women's decisions to utilize contraceptives were husbands, religious leaders, and opinion leaders, all of whom were seen to have a community influence of similar strength to health providers. The main barrier identified was that women may require permission to use contraceptive services.

**Collaboration.** The MOH and health districts play an important role in vertical collaboration, but horizontal collaboration to coordinate the delivery of services was weak. In districts, most horizontal collaboration was among religious groups, health centers, and NGOs. The relationship between the health center and community actors was weak in most districts.

### DLI 2: Women Delivered by a Trained Health Professional

**Access to assisted delivery.** The main provision of services was by health centers, health posts, and district hospitals. Perceived barriers related to concern of the husband or head of household about the costs of hospital services and transport, and about male medical professionals assisting women. In some districts, local taxis are organized to bring the woman in labor to the health center, addressing a barrier to accessing services.

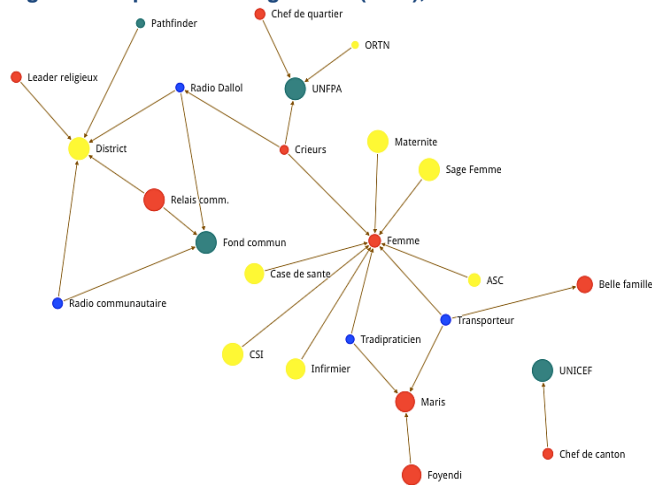
**Knowledge flows.** The promotion of assisted delivery is mainly by NGOs and development programs that mobilize traditional leaders, women leaders, griots, and community radio. The engagement of these actors is not consistent across districts. In districts such as Boboye and Doutchi, religious and traditional leaders (such as marabouts, imams, and traditional practitioners) promote assisted delivery services and refer women to the health center. All focus groups identified a gap in information-sharing with family members, specifically husbands, with most information about pregnancy services directed at

v. Net-Map is a participatory method for stakeholder mapping to render social network graphs and foster discussions among actors. “Net-Map: Collecting Social Network Data and Facilitating Network Learning through

Participatory Influence Network Mapping.” Eva Schiffer and Jennifer Hauck, 2010. <https://journals.sagepub.com/doi/10.1177/1525822X10374798>.

women (Figure 1). Also, CHWs and health professionals did not provide outreach communication to families to promote utilization of assisted delivery services.

**Figure 1: Map of Knowledge Links (DLI2), Doutchi District**

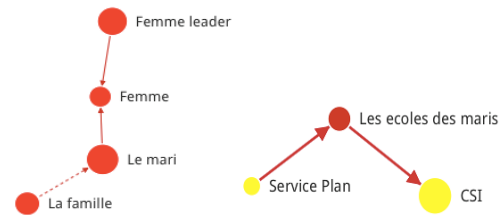
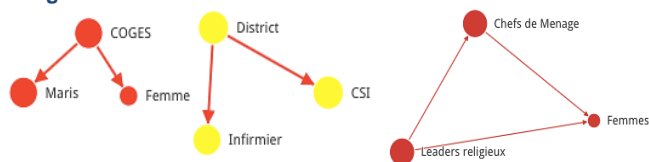


**Legend:**  
**Actors.** Yellow- Public health service providers; Red- Community actors; Green- NGOs or government. (CSI stands for *Centre de Santé Intégrés*).  
**Links.** Brown- Product and service flows.  
**Influence.** Circle size.

**Social pressures.** In the districts, social pressures were from community leaders, heads of households, religious leaders, community associations (such as husbands’ schools and the health management committee or (also known as *Comité de Gestion* or COGES), and husbands (Figure 2 provides an example). The influence of these actors may be either positive or negative on the women’s decision-making. When favorably mobilized, community leaders may promote assisted delivery in families, as well as influence attitudes of health professionals.

**Collaboration.** Collaboration is often around training. The health districts play a central role in training NGOs, religious leaders and health professionals to promote and deliver services. This is in coordination with the national level and various development partners. However, horizontal collaboration in the delivery of services is weak, and in some districts collaboration between government and NGOs was notably absent. However, there are examples of positive collaboration in some districts based on a specific program experience.

**Figure 2: Map of Social Pressure Links (DLI2), Boboye and Fillingue Districts**



**Legend:**  
**Actors.** Yellow- Public health service providers; Red- Community actors.  
**Links.** Red- Social pressures.  
**Influence.** Circle size.

**DLI 3: Nutritional Counseling of Children**

**Access to nutritional products and services.** Nutritional services are managed by the health district and delivered by the health centers and health posts. In some districts, NGOs work with the health centers and community health committee (also known as *Comité de Santé* or COSAN) to conduct outreach services (Figure 3). The NGOs often work directly with CHWs and midwives. However, the focus is often on the treatment of severe malnutrition, rather than on growth promotion and monitoring to prevent malnutrition. In some districts, NGOs may bring children to the health center for treatment. The main source of nutritional products is often through private vendors, pharmacies, and traditional practitioners. In some districts, nutritional kits are available through NGOs and the World Food Program.

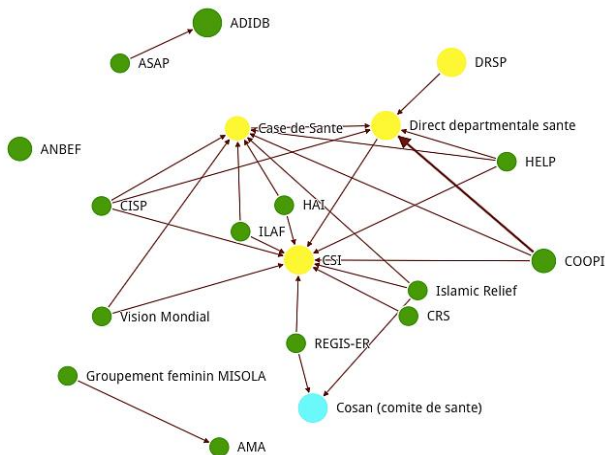
**Knowledge flows.** The health center, health posts, CHWs, COSAN, community radio, NGOs, traditional practitioners, and community associations (particularly women’s groups and husbands’ schools) provide nutritional information to women and their families (Figure 4). The health district plays a central role in training these actors. CHWs and midwives provide direct counseling to mothers and may refer malnourished children to the health center for treatment. In some districts, NGOs mobilize community actors and CHWs to conduct behavioral change communication.

**Social pressures.** Figure 4 also shows that caregivers face social pressures from grandmothers, other mothers, heads of households, husbands, and midwives that can positively or negatively influence their nutritional knowledge and practices, such as breastfeeding and child feeding. These influences could be harnessed to reinforce nutritional practices of caregivers. Grandmothers were reported as having a strong influential role to pressure the family to follow nutritional advice.

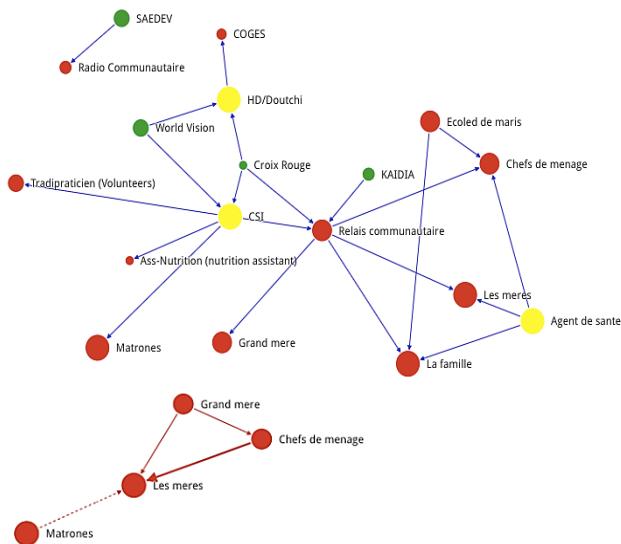
**Collaboration.** The focus groups reported overall weak collaboration among actors delivering nutritional services. In most districts, the focus groups described the nutrition efforts as fragmented, with gaps in the provision of services. However, in some districts such as Fillingue, there are positive examples of collaboration between health centers, local associations, and

the district administration to provide nutrition services. The focus groups recommended that the district administration play a larger role in facilitating coordination among NGOs, government sectors (health, agriculture, water), and the community.

**Figure 3: Map of Nutritional Service Links (DLI4), Tillabery District**



**Figure 4: Maps of Knowledge Flows and Social Pressure Links (DLI4), Tillabery and Tera Districts**



**Legend:**

**Actors.** Yellow- Public health service providers; Red- Community actors; Green- NGOs.

**Links.** Blue- Counseling and knowledge flows; Brown- Product and service flows; Red- Social pressures.

**Influence.** Circle size.

**OPERATIONAL CONSIDERATIONS**

Stakeholder mapping is now being used routinely by districts in Niger to plan interventions. Below are examples of how findings

from the mapping have been used by districts to plan actions to reinforce results of health plans, as well as identify key challenges and priorities.

**Contraceptive utilization.**

- To promote acceptance of these services, districts have involved community and religious leaders and husbands’ schools in awareness-raising, door-to-door caravans, and counseling.
- To address concerns around stigma to accessing contraceptives, some districts have organized night services as well as ensuring information on where contraceptive stock is available
- To address barriers to women’s access to services, districts have trained CHWs and health professionals to involve family members to mediate access to services for women.

**Assisted delivery.**

- To facilitate social support for utilizing assisted delivery services, districts have involved community leaders and CHWs to promote services by going door-to-door to mediate access to the services by talking to families to identify pregnant women.
- Districts have worked with community groups to arrange transport services for women to come to the health center.

**Nutrition counseling.** A key challenge for improving nutrition is the coordination between the health centers, local associations, NGOs, and CHWs to deliver preventative nutritional counseling and growth promotion and monitoring.

**Challenges.** A key challenge is scaling up the successful lessons implemented in specific districts in the national health program. While one district develops a solution, many lessons are not scaled-up across districts. This is being managed through an annual participatory evaluation to share lessons learned across districts as well as regular knowledge exchange workshops, where the districts present their new strategies to advance the indicators.

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