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Family planning high impact practices in Francophone West Africa: ownership, strategies and use for programming

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Abstract

Background In the last 15 years, the High Impact Practices (HIPs) initiative has been designing and disseminating family planning (FP) HIPs, a collection of evidence-based practices. Evidence on implementation at the country level, when it exists, does not specifically reflect the West and Central Africa region. The objectives of this study are to 1) examine the extent to which FP HIPs are an integral part of FP programming in the region, 2) identify strategies being used for implementation and monitoring of HIPs and the associated challenges, and 3) examine paths to sustainability and scaling-up of HIPs.

Methods We used a mixed-methods approach consisting of a document review and key informant interviews (KIIs) to assess HIP implementation in the nine countries of the Ouagadougou Partnership (OP). We sought to interview three key informants representing government, non-governmental organizations, and donors, in each country. The interviews were conducted remotely via Zoom in French.

Results Use of HIP briefs is not very common, partly because their content is not tailored to specific contexts. Immediate Postpartum Family Planning (IPPFP), Community Health Workers (CHWs), and Mass Media (MM) stand out as the most widely implemented HIPs, with some level of adoption in almost every country, while Postabortion Family Planning (PAFP) and Pharmacies and Drug Shops (PDS) HIPs are less common. A lack of adequate training for providers and CHWs at both health facilities and pharmacies emerged as a significant barrier to the effective implementation of HIPs. Regarding sustainability, some countries are making efforts to integrate CHWs into the government payroll system.

Conclusions Efforts to raise awareness on HIPs should continue, engaging and supporting regional institutions to own and tailor HIPs products to regional contexts. As integration into the health systems and sustainability efforts continue, attention should be directed towards scale-up, so that the benefits of these practices can be expanded to more people and more equitably.

Keywords Family Planning, High Impact Practices, Francophone West Africa, Ouagadougou Partnership, Programming, Scale-up, Sustainability

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Background

Building on principles established at the 1974 World Population Conference in Bucharest, the 1994 International Conference on Population and Development (ICPD) affirmed that women should have the right to decide whether and when to have children, structuring the field of sexual and reproductive health and rights (SRHR). As a result, there has been a wealth of scientific evidence that use of contraception contributes to the survival of women and children and yields broader social and economic benefits for families and communities [1–3]. Recognizing the persistent barriers and challenges to bridge the gap between research and practice, the partnership for High Impact Practices (HIPs) in FP was born in 2010 [4, 5]. Grounded in implementation science, the purpose of the HIPs initiative is to promote the widespread adoption of practices that have been demonstrated to improve reproductive health outcomes, thereby bridging the gap between research evidence and programmatic practice. FP has continued to be a national development priority, notably since the 2012 London Summit on FP, which was convened to reignite commitment and to set ambitious goals by 2020 [6, 7]. The summit also launched the FP2020 (now FP2030) partnership, whose aim is to promote country leadership and engagement with civil society [8].

The most visible and influential outputs of the HIPs initiative have been the design and dissemination of FP HIPs, a collection of evidence-based practices identified by international researchers and program experts as highly impactful [7]. The criteria for a practice to be a HIP include scalability, replicability, sustainability, cost effectiveness, potential for application in a wide range of settings, and effectiveness in achieving FP outcomes [9–11]. The list of HIPs is updated periodically based on rigorous reviews by the HIP Technical Advisory Group, comprising international experts who assess peer-reviewed evidence of impact. These practices are organized into four categories: Service Delivery, Social and Behavior Change (SBC), Enabling Environment, and HIP Enhancements. The service delivery and SBC HIPs are further categorized as "proven" or "promising." The former refers to a practice "for which sufficient evidence exists to recommend widespread implementation provided there is careful monitoring of coverage, quality, and cost", while the latter characterizes practices "for which good evidence exists, yet more research is needed to fully document implementation experience and impact" [12–14]. Additional file 1 shows the current list of HIPs. Further, HIP briefs provide a synthesis of the evidence and experience on implementing the practices, with the aim of using the content in the HIPs to promote investment in evidence-based FP programs. Unlike a vertical programmatic intervention, the HIPs initiative relies on the global dissemination of these briefs to influence country-level programming through donors, implementing partners, and national governments.

While the promotion and implementation of HIPs have grown in low- and middle-income countries (LMICs) over the past decade, there is a dearth of information on whether or not these practices are being adopted and scaled up, and how best to optimize implementation and scale-up [10, 15]. Further, the extent to which these practices have gained ownership within Ministries of Health has not been thoroughly investigated. Examining indicators currently in use to monitor service delivery FP HIPs in Mozambique, Nepal, and Uganda, the Research for Scalable Solutions (R4S) project, which focuses on strengthening the evidence base and measurement of HIPs, noted that "indicators do not clearly capture if the practice is being implemented as defined in global guidance", and recommended that "implementers streamline data collection by updating registers to ensure that indicators can be clearly tagged to specific HIPs" [16]. While a few studies [10, 17, 18] have provided insights on the use and usefulness of HIPs in selected contexts, we often lack a holistic and detailed understanding of how the FP HIPs have been owned and operationalized at the country level to support FP programming. The evidence, when it exists, does not specifically reflect the West and Central Africa region. The region is characterized by some of the most challenging reproductive health indicators globally, marked by exceptionally high fertility rates and modern contraceptive prevalence rates (mCPR) that remain significantly below international averages. For example, while Niger consistently records the highest fertility levels worldwide, countries such as Chad, Mali, and the Democratic Republic of the Congo also exhibit critically low mCPR, while the stagnation of contraceptive uptake in Central African nations like Cameroon underscores the urgent need for context-specific ownership and scale-up strategies.

The objectives of this study are to 1) examine the extent to which FP HIPs are an integral part of countries' FP plans, 2) identify strategies being used to implement and monitor HIPs, and the associated challenges, and 3) examine paths to sustainability and scaling-up of HIPs.

Methods

We assessed HIPs implementation in the nine countries of the OP, namely, Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo. OP was launched in 2011 to accelerate progress in the use of FP services, with an ambitious goal of doubling the number of modern contraceptive users by 2030 [19]. We selected five HIPs for the assessment: Community Health Workers (CHWs), Immediate Postpartum Family Planning (IPPFP), Postabortion Family Planning (PAFP),

Table 1 Participants' institutions by country

Pays	Ministry of Health's Division of Family Health	Donors (USAID or UNFPA)	National or International HIPs Implementing partners/NGOs	Total
1. Benin	X	X	X	**3**
2. Burkina Faso		X		**1**
3. Cote d'Ivoire	X	X		**2**
4. Guinea	X	X		**2**
5. Mali	X	X		**2**
6. Mauritania	X	X		**2**
7. Niger		X		**1**
8. Senegal	X	X	X	**3**
9. Togo	X	X	X	**3**
Total	**7**	**9**	**3**	**19**

Pharmacies and Drug Shops (PDS), and Mass Media (MM). These practices were selected to ensure representation across different HIP categories (Service Delivery and SBC) and levels of evidence ('Proven' and 'Promising'), while focusing on interventions of high strategic priority for the Ouagadougou Partnership region. We used a mixed-methods approach consisting of a document review and key informant interviews (KIIs).

Document review

The review sought to investigate how HIPs fit within the relevant national guidelines and strategies in the target countries. Documents were obtained from OP's website and secretariat, and from Ministries of Health. Additional documents were obtained from key informants during the interviews. In total, we found or received 117 policy and programmatic documents related to FP or reproductive health in the nine countries. After screening the content for relevance to the study, 28 documents were selected, ranging from two to four documents per country.

Key informant interviews

Key informants sampling

The aim of the KIIs was to collect and document the strategies and practices used by stakeholders to advance the implementation of the five HIPs. We followed a purposive sampling strategy to recruit participants, stratified in three categories: FP program managers at Ministry of Health (MOH), local/international HIPs implementing organizations, and donors. We aimed to interview one person per category and per country. To do so, we utilized a list of 58 potential key informants provided by the OP Secretariat, which represented an exhaustive list of their main contacts across the nine countries. We employed a purposive sampling approach, initially contacting the primary focal point for each category. The OP Secretariat did not influence the selection beyond providing this initial contact list. If a key informant did not confirm participation after three reminders, the invitation was extended to the next available participant in the same category to minimize selection bias. The process continued until the period for data collection was over (April-September 2023). A total of 19 interviews were successfully conducted (see Table 1).

Data collection

The KII guide covered four main themes: Awareness of HIPs initiative and familiarity and use of guidance from HIP briefs; Strategic relevance of HIPs implementation and national coordination; Scope and patterns of HIP implementation; Collaboration between OP Secretariat and HIPs implementing actors (see Additional file 2 for more details). The interview guide was structured to differentiate between stakeholders' knowledge of the specific 'HIPs' brand and briefs, and their experience with the actual implementation of the service delivery or SBC practices, regardless of whether they identified them as formal HIPs. The interviews were conducted remotely via Zoom in French by a researcher and a notetaker. Subject to interviewees' permission, the interviews were recorded in Zoom.

Analysis

Interviews were transcribed verbatim. We employed a deductive coding approach for the analysis. A codebook was developed a priori based on the structured themes of the interview guide: 1) Awareness and Relevance, 2) Strategies for Implementation, 3) Challenges, and 4) Sustainability. Transcripts were coded against these themes using an Excel matrix. Data was analyzed within countries to identify local patterns and then synthesized across countries to identify regional trends. The results presented here reflect the cross-country thematic synthesis. The methodological quality and reporting of this study align with the Mixed Methods Appraisal Tool (MMAT) criteria; the completed checklist is available as Additional file 3.

Results

It is important to note that while participants discussed these interventions specifically as "High Impact Practices," the challenges identified—such as supply chain and training—often reflected broader systemic issues in general family planning practice within the region.

HIPs awareness and relevance to national FP objectives

While almost all participants are aware of HIPs, few reported having previously used HIPs briefs. Barriers cited include limited dissemination, low

contextualization of their content, and preponderance of examples from English-speaking and Asian countries. A participant in Mauritania insisted: *"I always emphasize the religious and socio-cultural factors. Sometimes, images or themes used may not be adapted to the context of a country."* Some participants argued that the content of briefs should be tailored to specific audiences. One participant explained: "*Funders and central level actors, for example, would prefer a certain format and content of the brief to support advocacy, while providers would welcome short summaries targeting clients and service provision.*" Other participants suggested that the content of the briefs be updated with new implementation insights, so that program managers have a full understanding of conditions under which a HIP may succeed.

HIP implementation and scale

Our results show that the IPPFP, CHWs and MM HIPs are implemented to some degree in almost all countries, while the implementation of PAFP is hampered by taboos surrounding abortion. PDS HIP is in a pilot phase in some countries, and nonexistent in others. The specific strategies used for these five HIPs, and the challenges encountered vary by country.

Strategies developed

Participants cited several strategies adopted to promote and strengthen the implementation of IPPFP, PAFP and CHWs. These include the development/updating of training modules and data collection tools, training and capacity building, provision of necessary equipment and service delivery kits, and establishment of monitoring and supervision systems. For CHWs, promotional activities and community-based distribution of contraceptive products allow CHWs to offer a diverse range of contraceptive methods.

To enhance the impact of MM HIP, several strategies have been implemented, including partnerships with television and radio stations broadcasting in local languages, the involvement of traditional and religious leaders in communication campaigns, and the engagement of youth associations in awareness-raising activities. The existence of community media is a key factor that enhances the effectiveness of MM. A participant in Burkina Faso stated: *"…The favorable factor is the development of mass media, especially community-based media, which incorporate health issues into their awareness-raising activities.."* Similarly, a participant in Niger stated: *In each municipality, there are two or three community radio stations that can effectively be used for awareness campaigns and advocacy in support of family planning."*

In the few countries where the PDS HIP is being piloted, interviewees reported that pharmacy staff receive training on creating a welcoming environment for contraceptive purchases, optimizing product display, and contraceptive resupply. A participant in Niger mentioned that implementation of PDS is currently under consideration. He said: *"But it's really only now that we are starting to push the thinking around this. We need to create conditions for these depots and pharmacies to be able to offer family planning services like others do."*

Challenges

Our results show that IPPFP services are sometimes not provided due to a lack of knowledge among providers and insufficient training. As noted by a participant in Côte d'Ivoire, *"Most healthcare providers think it is unsuitable to offer contraceptive methods, especially hormonal ones, to a woman who has just given birth and is expected to breastfeed. Healthcare workers are often not trained. This, therefore, constitutes a barrier to the implementation of the strategy."* This opinion is also shared by a participant in Niger, who stated: *"When we look at the percentages, they are still rather low… And this is largely due to the behavior of the staff themselves—up to now, it has not really been deeply instilled in their minds."* Sociocultural barriers also emerged as hindering the adoption of IPPFP. A participant in Senegal declared that *"The challenge I see with this high-impact practice is, let's say, the cultural challenge. All these women we are welcoming today, face various cultural challenges in embracing these approaches being used."* For both IPPFP and PAFP, other notable challenges include the frequent turnover of trained personnel, uneven distribution of staff, and the reluctance of some providers to offer IPPFP services.

According to participants, several challenges undermine the full operationalization of PDS. Staff are generally not trained to provide FP services, which limits the quality of services. Moreover, integrating data from the private sector into the national health information system remains difficult. Frequent stockouts of FP commodities, due to supply chain weaknesses, were also mentioned by key informants.

Lack of retention of CHWs due to irregular financial incentives emerged as a major challenge in most countries. Additionally, the quality of data produced by CHWs remains suboptimal, due to the heavy workload, lack of ongoing training, insufficient supervision, and unavailability of essential working tools. Frequent difficulties in the supply of contraceptive products were also reported. A participant from Mauritania stated: "*We truly have a supply problem for contraceptive products. CAMEC (*central procurement*) ensures distribution at the regional level, but at the departmental level and in remote rural areas, we really need help with that to ensure supply reaches the very last kilometer."*

Our results indicate that major factors limiting the effectiveness of MM include the absence of annual

communication plans, weak media coverage in rural areas, and insufficient human resources to carry out contextualized campaigns. The lack of contextualization of messages, particularly their translation into local languages, and an insufficient segmentation of target audiences, were also cited by many participants as barriers to the reach of *campaigns.* A participant from Benin stated that *"Currently, one of the challenges we face with mass media is, first and foremost, the use of local languages to effectively communicate our messages. While we produce a lot of content, it is mostly in French. However, we believe that productions need to increasingly be in local languages."*

Institutionalization and sustainability

Document review shows that implementation of HIPs is part of the efforts made by the nine countries to achieve national family planning objectives. The results of the interviews largely show that all countries have included HIPs in FP national reference documents. They also point to the idea that implementation of IPPFP is an integral part of efforts to improve maternal and child health. One participant reasoned that *"… a good strategy for IPPFP, and also for the distribution of contraceptive products at the community level, will contribute to the reduction of maternal mortality."* Participants also argued that FP, including IPPFP, is integrated into the package of activities for CHWs. Also, MM is generally integrated into SBC strategies and communication plans for FP.

Our results suggest that efforts are underway to ensure the sustainability of the CHWs through a fixed government salary for CHWs. This is the case in Benin, Burkina Faso, Cote d'Ivoire, Mali, and Niger. A participant from Côte d'Ivoire declared: *"The CHWs are recruited by the State, and they are also paid by the State. What remains now is to work on maintaining these achievements and, to sustain a high level of motivation among these actors so they can fully play their role in the provision of care".*

Discussion

The findings of this study, while focused on specific HIPs, reflect the broader systemic challenges characterizing family planning implementation in West Africa. Issues such as workforce shortages, supply chain disruptions, and data quality gaps are not unique to HIPs but are indicative of the general health system constraints in the region.

Our study fills important knowledge gaps on HIPs implementation in Francophone West Africa. To our knowledge, such an assessment had not been conducted to date. Our results show that use of HIPs briefs is not common, because their content is not tailored to specific contexts. A previous evaluation of HIPs similarly found that "A small segment of users is not using HIP products because the information presented in HIP products can be too basic to address a specific context of the country" and concluded that to fully capitalize on the potential of HIPs, it is essential to segment and target audience groups" [11]. Our findings suggest that while HIP briefs provide the 'what' and 'why', implementers often require more detailed, context-specific operational guides to address the 'how' of implementation in complex West African health systems. This concern raises the issue of the right balance between standardization and contextualization. The HIPs Partnership adopted standardization to create comparable practices across contexts and with examples from many contexts. While standardized briefs are useful, regional organizations should be supported and guided to develop by-products adapted to the context of that region. This disconnect suggests that the limited adoption of these practices may not be due to their irrelevance, but rather to a lack of systematic dissemination and operational guidance, contributing to the persistent weaknesses in the region's family planning programs. For instance, the difficulties reported in retaining Community Health Workers and sustaining mass media campaigns suggest that the barrier is often not the relevance of the practices themselves, but a program environment that lacks the resources and stability to sustain them.

Lack of training in specific HIPs, and perceptions by providers and CHWs (at health facilities and pharmacies) linked to social norms and taboos, emerged as barriers for effective implementation of HIPs, a finding reported in many studies [20–22]. With proper training and focused SBC interventions targeted at providers, these negative perceptions can be countered and provider competency improved, resulting in increased ownership of HIP implementation.

Poor quality of data from CHWs and pharmacies was commonly reported. Examining indicators currently in use to monitor service delivery FP HIPs in Mozambique, Nepal, and Uganda, the Research for Scalable Solutions (R4S) project recommended that "implementers streamline data collection by updating registers to ensure that indicators can be clearly tagged to specific HIPs" [16]. Targeted efforts, including digital solutions, should be explored to improve the quality of data from CHWs and pharmacies, for inclusion in the health management information system [23].

IPPFP was reported as the most widely implemented HIP. Many studies have analyzed the implementation and outcomes of IPPFP in different African contexts, and suggested that countries must promote and strengthen the integration of FP information and services into maternal and child health (MCH) services, a strategy known to curb unintended and closely spaced pregnancies [24–26]. As our results suggest, the number and quality of health providers remain a critical challenge in this respect.

Our results indicate that PDS is not widely implemented, yet the demographic and health surveys (DHS) show that the percentage of current users of modern contraceptive methods whose most recent supply or information was sought from a pharmacy was in the range between 13 and 34% in Cote d'Ivoire (2021), Guinea (2018), Benin (2018), Togo (2014) and Mauritania (2021), with proportions substantially higher in urban areas. A study in urban Kenya and urban Nigeria reported drug shops and pharmacies as the major source for oral contraceptive pills and emergency contraceptives and concluded that these outlets offer a unique opportunity to expand access to FP services by urban women, and especially younger or unmarried women [27].

Our assessment explored the institutionalization of five FP HIPs. To achieve lasting impact, FP HIPs should be institutionalized within existing health systems [28]. We also explored sustainability, defined as the ability of a program to continue producing positive outcomes and impacts over time, particularly when donor funding ends [29, 30]. Our participants largely discussed the sustainability of CHWs programs, the cornerstone of community health service delivery and demand generation. Participants and documents reviews suggest that efforts are underway in some countries to integrate CHWs in government payroll.

Limitations

The fact that only three representatives of HIPs implementing partners were interviewed (see Table 1) is a limitation. This low yield was due to a significantly higher non-response rate among implementing partners compared to donors and ministry officials, despite our protocol of sending three reminders and contacting alternates. Implementing partners often possess granular, technical knowledge of operational challenges that may differ from the perspectives of donors or Ministry officials. Additionally, for Burkina Faso and Niger, only donor representatives were interviewed. The lack of government perspectives in these two specific countries may limit the full characterization of public sector ownership and the internal challenges faced by the Ministry of Health in those contexts.

Conclusions

This study has shed light on the implementation of five FP HIPs in the countries of the Ouagadougou Partnership, a coalition of nine West African countries united to accelerate progress in FP service use. It has identified major challenges encountered and explored the extent to which these practices are being institutionalized and implemented with sustainability in mind. Efforts to raise awareness on HIPs should continue, engaging and supporting regional institutions to own, coordinate and tailor HIPs products to regional contexts. Importantly, as integration in the health systems and sustainability continue to take shape, attention should be directed towards scale-up, so that the benefits of these practices can be expanded to serve more people, more equitably and more lastingly.

Abbreviations

CAMEC	Centrale d'Achat des Médicaments Essentiels et Consommables médicaux (Central Procurement)
CHWs	Community Health Workers
DHS	Demographic and Health Surveys
EVIHDAF	Evidence for Sustainable Human Development Systems in Africa
FHI 360	Family Health International
FP	Family Planning
HIPs	High Impact Practices
ICPD	International Conference on Population and Development
IPPFP	Immediate Postpartum Family Planning
KIIs	Key Informant Interviews
LMICs	Low-income or middle-income countries
MCH	Maternal and child health
mCPR	Modern contraceptive prevalence rates
MM	Mass Media
MOH	Ministry of Health
NGO	Non-governmental organization
OP	Ouagadougou Partnership
PAFP	Postabortion Family Planning
PDS	Pharmacies and Drug Shops
PHSC	Protection of Human Subjects Committee
R4S	Research for Scalable Solutions
SBC	Social and behavior change
SMART-HIPs	Supporting Measurement and Replication Techniques for Family Planning High Impact Practices
SRHR	Sexual and reproductive health and rights
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12889-026-27319-y.

Additional file 1: List of High Impact Practices. Description of the current service delivery and SBC HIPs.

Additional file 2: Key Informant Interview Guide. The English translation of the questionnaire used for data collection.

Additional file 3: MMAT Checklist. Completed Mixed Methods Appraisal Tool checklist for the study.

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Authors' contributions

JCF was the study's Principal Investigator; he oversaw data collection and led the writing of the manuscript. JNM contributed to data collection, analysis and synthesis, and produced synthesis for the results section. NT led data collection, analysis and synthesis, and produced a first draft of the methods section.

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Data availability
Data and materials and available upon request, conditional to confidentiality.

Declarations

Ethics approval and consent to participate
The study protocol and tools underwent ethical review by FHI 360's Protection of Human Subjects Committee (PHSC) in the USA (Reference: FWA 00000025—IRB Registration # 00000793). It was determined that country level ethical approval was not needed. All study participants provided written informed consent via email before the interviews. Our study also adhered to the Declaration of Helsinki.

Consent for publication
Not applicable. The manuscript does not contain data from any individual person.

Competing interests
The authors declare no competing interests.

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