EDITORIAL

Overcoming Family Planning Challenges in Africa: Toward Meeting Unmet Need and Scaling Up Service Delivery

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Expanding access to family planning and addressing unmet needs for contraception are key goals for improving reproductive health. Poor access to family planning is associated with unintended pregnancies and poorer maternal and newborn outcomes, including abortion-related morbidity and mortality[1]. Addressing unmet need helps increase contraceptive use and reduces unintended pregnancies, leading to improved health outcomes and broad social and economic benefits for women, their families and societies. Unmet need reflects gaps in both demand and supply of contraceptive services. The challenges posed are greater in low- and middle-income countries (LMICs), especially in sub-Saharan Africa (SSA)[2]. Progress to reduce unmet need remains slow and more effective ways are required to expand family planning care on a larger scale.

Unmet need for family planning

Unmet need refers to the percentage of sexually active, fecund women who want no more children or to postpone having their next child, but who are not using contraception. It is an important indicator used for tracking progress, measured using an algorithm based on a set of standardized survey questions[3-4]. Traditional method users tend to have high failure rates and are considered to have an unmet need for a more effective method, lowering the percentage of demand for family planning satisfied with modern contraceptive methods.

Unmet need is also an important measure for advocacy and planning. Over 1990-2010, global contraceptive prevalence increased from 55% to 63% and unmet need for family planning decreased from 15% to 12%[5]. However, the number of women of reproductive age is still large and growing in many regions. In developing regions, about 214 million women of reproductive age (15-49) were estimated to have an unmet need for modern contraception in 2017, accounting for 84% of all unintended pregnancies[6]. Gaps in meeting women's needs persist especially among the poor, young, less educated and underserved with high fertility preferences. The level of unmet need is highest (21%) in sub-Saharan Africa and is 25% or higher in middle and western Africa, where the values estimated for 2010 were nearly identical to those in 1990[5].

Changes in the African family planning context

Although the future course of the SSA fertility transition is uncertain, it is becoming more heterogeneous as demand for family planning grows in more areas[7]. Family planning programs remain fragile and still require supportive political leadership, particularly in middle and western African countries[8]. In East Africa, Rwanda, Malawi and Ethiopia have recently achieved impressive progress, as did South Africa and Mozambique earlier. In Rwanda and Malawi, contraceptive prevalence rates now exceed 50% (over twice the SSA average) and more men than women want no more children, showing the impact of efforts to convince men of the benefits of family planning. In Francophone Africa, both Senegal and Burkina Faso have seen modest increases in contraceptive uptake, as have Mozambique, Kenya and Uganda in East Africa[9]. Other SSA countries can achieve similar success, despite facing comparable developmental challenges.

Much of this recent progress is due to political leaders showing increased commitment and advocacy of family planning as health and development priorities[10]. Local and international champions have included family planning associations and donors, spurred on by the 2012 London Summit that mustered more resources to fund family planning services. Strong community involvement has aided service expansion, improving the demand and supply of contraception. Community provision of injectable contraceptives has led to their rapid emergence as

SSA's most popular method[11]. Smaller family size ideals are taking hold in more countries, especially in cities, alongside growing acceptability of modern contraceptives. There are more initiatives to improve and expand services for underserved groups such as adolescents, post-partum and post-abortion women, although these often face resistance with little headway made to integrate family planning with other reproductive, maternal, newborn and child health services.

Limited progress in middle and West Africa

Nigeria illustrates the acute obstacles to addressing unmet need still to overcome. SSA's most populous country remains at the start of its contraceptive transition. Patriarchal and pronatalist views are dominant; political will to promote family planning is lacking; and health services are limited. In 2012, only 10% of married women aged 15-49 used modern contraception and over 90% of non-users did not discuss family planning with any health worker[12-13]. Demographic and Health survey responses across Africa document pervasive problems of poor spousal communication; family, community and religious opposition to use, reinforced by misinformation; a range of health concerns and feared side-effects; and access constraints, including limited method choice and poor counseling.

The Nigerian Urban Reproductive Health Initiative (NURHI), a multi-component program in six large cities, achieved a 10% increase in modern method use over 2010-14 and reduced fertility preferences[14]. It used demand generation activities (better messaging, training of providers needing behavior change, discussions with religious leaders) and improved access at health clinics and service delivery (with 'mini-makeovers' of clinic facilities and supply chain problems minimized). However, the sustainability of the changes in contraceptive use and fertility desires are uncertain, with scale-up activities not clearly built in and more attention to strengthening health systems desirable.

Strengthening family planning programs and health systems

Family planning programs reach targets more quickly and efficiently if they have embedded community-based components linked to the core health system building blocks and functions[15-16]. This calls for activities such as developing more effective leadership and partnerships at all levels, building more responsive financing strategies, task-shifting and strengthening community health worker teams, building follow-up and streamlining supply systems, implementation research, and an equity-based focus on reaching more disadvantaged groups. These activities and wish lists are difficult to realize. For example, regular healthcare providers, including some clinicians, often feel threatened by shifting tasks to trained paramedical workers[17] who themselves may be unable to meet their increased demands unless program managers tackle health workforce shortages, develop guidelines and supervisory practices, and assure fair wages, incentives and suitable work environments[18].

Well-managed attempts to strengthen community health systems can overcome such barriers. In Ethiopia, renewed political will helped generate an enabling policy and program environment to build a community-based health program integrated within the health system, with female health extension workers deployed throughout the country to spread family planning and achieve universal coverage of primary health care (PHC)[10,19]. Government and development partners committed increased financial and technical resources, while sustained advocacy further helped overcome contextual barriers and strengthened family planning agencies and providers. Earlier, Ghana became the second SSA country to develop a population policy, but this remained dormant until the turn of the century. Ghana then re-oriented PHC from sub-district health centers to community locations through its Community-based Health Planning and Services (CHPS) initiative, designed to improve PHC accessibility nationally. The CHPS was grounded in evidence from the Navrongo experiment for better family planning and child health services in the country's most impoverished and remote region[20]. This provided critical locally generated evidence showing that simple, low-cost services that engaged the community could significantly reduce fertility and child mortality, enabling onward scale up[21].

Scaling up family planning service delivery

The rise in international aid to fund large-scale global health programs catalysed interest in improving scale-up among global health donors and researchers[22]. Effective research and advocacy is also needed to build the case locally for scale up, as borne out by simulation-based projections for South Africa. Over 2015-30, an estimated 0.68% annual increase in contraceptive prevalence would result in 20% fewer unintended pregnancies, abortions and births, averting 7,000 newborn and child deaths and 600 maternal

deaths. These gains would cost $7 annually per user of modern contraception (or <0.5% of the 2014 national health budget), underlining intervention impact and cost-effectiveness[23].

Scale up has become a widely used term, but it is often loosely applied. Systematic guidance is now available on sustainable scale-up practices[24-27]. Perhaps the best known is the ExpandNet-WHO framework which defines scale up as "deliberate efforts to increase the impact of health service innovations, successfully tested in pilot or experimental projects, to benefit more people and to foster policy and programme development on a lasting basis"[24]. However, scale up does not follow a simple linear process and is not an exact science; it is also a craft[28]. It is context-specific with important variables including the role of the organizational structure and institutional, political, economic and socio-cultural constraints.

Scale up calls for developing a strategy formulated from best practices and applied to the most efficient scale, and then requires adapting innovations to different environments. Internationally-accepted best practices and case studies do not provide detailed operational plans on how to translate service access or quality of care into another context, but a review of the conceptual literature and interviews with implementation experts indicates some common success factors for scaling up. These include choosing a simple, technically sound intervention widely agreed to be valuable, strong leadership and governance, active engagement of a range of local implementers and other stakeholders including from the target community, adopting an integrated approach to scale up, tailoring it to the local situation, and decentralizing delivery[27].

Are we getting there?

The Ghanaian example shows the potential for scaling up promising initiatives in community-based family planning services, as well as risks to their derailment and opportunities for renewal. The initial rapid CHPS scale-up unexpectedly slowed nationally as the focus drifted from evidence-based, people-centered programing and away from community engagement, and as district-level management capacity became neglected in favor of clinic-based services. In 2007, the focus shifted back to community health systems strengthening, with expanded community health worker roles and enhanced skills, improved service quality, rigorous implementation research, district leadership development and support, and community engagement[29]. A phased systems development model led to more successful scale up[30]. This comprised formative research to develop strategy, micro-implementation research to show impact and the basis for scale-up at district level, and replication work on a progressively larger scale[31]. This helped strengthen the evidence base for family planning and other PHC services in Ghana, although their adoption by policymakers and politicians has not been straightforward.

Clearly, multiple factors can affect the course of efforts to expand quality family planning care on a larger scale in SSA. Despite available guidance, there are no blueprints and there is little consensus on how scale up should be done, how it should be measured, and ascertaining what are the drivers of success. Pressure to scale up before effectiveness is clearly established needs to be resisted, with additional socio-political concerns being the generation of political will, policy commitments at all levels, and country ownership, as well as paying careful consideration to the wider context. For example, the dominant narrative on the achievements noted in Ethiopia and Rwanda has narrowly engaged with the nature of their political systems that may not be suitable elsewhere[32], calling for different ways to promote social consensus.

Some challenges to scaling up are common to health policy and systems research more generally. These include the field's fragmentation, the dominance of a northern, biomedical research model and that of SSA (and other LMIC) domestic budgets favoring specialist, hospital-based tertiary care over PHC, and the lack of demand for health policy and systems research[33]. On the other hand, global advocacy for health policy and systems research and for the greater use of evidence in policy- and decision-making is growing as more countries seek to achieve universal health coverage now that it is more firmly on the global development agenda. This includes accessible, quality and equity-focused family planning.

The push for greater understanding and application of effective scale-up strategies would be easier to realize if projects and programs were designed with a scale up perspective from the outset. This requires greater focus on what the organizational sciences refer to as open-systems thinking (the interrelations between organizations and their larger socio-political and cultural context), as well as on incorporating research into implementation, or a process of 'learning and doing'[34]. Presently, SSA countries have a weak capacity for implementation science, organizational change and systems research. Work is often fragmented, piecemeal and descriptive. This situation calls for a changed mindset. Scale up is a long-term process, a reality often overlooked by administrators and funders with short-term horizons.

Conclusions

Family planning has long been neglected and poorly implemented in SSA, where the failure to develop a more comprehensive understanding of unmet need and a multi-component intervention package to address it continue to pose major developmental, health and rights challenges. More optimistically, awareness of the rationale for making family planning programs a higher priority to African health systems is increasing and several new regional success stories and implementation models have emerged. These indicate the potential for addressing unmet need and for scaling up family planning service delivery, despite the complexities involved and the added challenge of sustaining scaling up in the prevailing global economic environment. These would be easier to overcome if the research agenda gives more emphasis to scale up. Also, researchers will need to collaborate more with health planners to help outline and refine more successful implementation strategies in a given context.

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