American Journal of Health Research
2025, Vol. 13, No. 4, pp. 210-225
https://doi.org/10.11648/j.ajhr.20251304.12

Research Article

Progress and Prospects for the Institutionalization and Scale-Up of Postpartum Family Planning in Togo

Wankpaouyare Gmakouba[1, 3, *], Komi Ameko Azianu[2], Mazabalo Bini[3], Salaraga Bantakpa[3], Pitabinaw è Deabalo[5], Labaguibe Gangak[4]

[1]Department of Public Health, Bircham International University, Madrid, Spain

[2]Interdisciplinary Research Laboratory in Social and Health Sciences, University Joseph Ki-Zerbo, Ouagadougou, Burkina Faso

[3]Research and Planning Department, Ministry of Health and Public Hygiene, Lomé, Togo

[4]National Program for the Control of HIV/AIDS, Sexually Transmitted Infections, and Viral Hepatitis, Ministry of Health and Public Hygiene, Lomé, Togo

[5]Faculty of Medicine and Allied Health Professions, University of Clermont Auvergne, Clermont-Ferrand, France

Abstract

Introduction: Maternal mortality remains a major public health challenge globally, particularly in low-income countries. Among the key prevention strategies, family planning plays a critical role by promoting adequate birth spacing, which helps reduce maternal complications and deaths. In particular, postpartum family planning (PPFP) is essential in preventing closely spaced pregnanciesa known risk factor for maternal morbidity and mortality. In Togo, while efforts have been made to integrate PPFP into national health policies, significant barriers persist, including limited access to services and sociocultural obstacles. The study aimed to analyze accountability mechanisms, existing synergies, and the scale-up level of postpartum family planning (PPFP), based on the core components developed by the High Impact Practices (HIP) Family Planning Secretariat. *Methodology:* This qualitative study of 40 key stakeholders in the healthcare system assesses the status of the institutionalisation of PFPP. Data were collected via semi-structured interviews and analysed using Excel and SPSS v2021 software. *Results:* The results reveal a high availability of contraceptive products and equipment (82%), an efficient monitoring system (86%), but also highlight weaknesses in training (79%) and community involvement (67%). The sustainability of the initiative will depend on better institutional anchoring, multi-sectoral integration, and sustainable funding. *Conclusion:* The scale-up of postpartum family planning (PPFP) in Togo shows significant promise; however, critical improvements are still needed in provider training, effective service integration, and meaningful community engagement. The long-term sustainability of this initiative will rely on strong political commitment, sufficient and sustained funding, and the implementation of a genuinely integrated approach. Furthermore, addressing sociocultural barriers remains essential to maximizing the reach and effectiveness of PPFP interventions.

Keywords

Family Planning, Postpartum, Maternal Health, Scalability, Community Engagement

[*]Corresponding author: makoubafredi@gmail.com (Wankpaouyare Gmakouba)

Received: 4 June 2025; **Accepted:** 17 June 2025; **Published:** 7 July 2025

1. Introduction

Maternal mortality remains a major global challenge, predominantly affecting low-income countries where many deaths are preventable [1]. Among the most effective strategies for reducing maternal and child mortality, family planning (FP) plays a crucial role. By facilitating birth spacing and enabling women to delay early or unintended pregnancies, FP contributes to reducing medical complications and mortality risks [2]. Indeed, family planning could prevent over 30% of maternal deaths and 10% of child mortality if couples maintained at least a two-year interval between births [3]. Postpartum family planning (PPFP), in particular, is essential in preventing closely spaced and unintended pregnancies during the first 12 months following childbirth. By improving access to contraceptive methods after delivery, PPFP enables birth spacing, enhances maternal and child health, and promotes family well-being. Like many sub-Saharan African countries, Togo is striving to integrate PPFP into its national health policies. However, limited access to services, low awareness, and sociocultural barriers remain significant challenges [4]. In this context, scaling up PPFP in Togo emerges as a necessity to maximize the benefits of these interventions.

2. Background and Justification

Despite progress in reproductive health, the use of modern contraceptive methods remains low, with a contraceptive prevalence rate of 23% among married women [5]. Togo exhibits a relatively high fertility rate, with an average of 4.3 children per woman in 2020 [6]. Insufficient birth spacing significantly contributes to obstetric complications and infant mortality. Furthermore, family planning services are often underutilized during the postpartum period due to a lack of information, persistent myths about contraception, and a shortage of qualified health personnel [7]. To improve access to and acceptability of PPFP, the Togolese Ministry of Health, in collaboration with technical and financial partners, is working toward the systematic integration of these services into postnatal care.

The expansion and scaling up of PPFP is justified by several factors. First, studies have shown that early adoption of postpartum contraceptive methods significantly reduces unintended pregnancies and improves maternal and child health outcomes [8]. Postpartum family planning (PPFP) plays a critical role in reducing unplanned and closely spaced pregnancies key risk factors for maternal and child health [9]. By promoting a birth interval of at least 24 months, PPFP helps decrease maternal and neonatal mortality and morbidity [4]. Integrating family planning into postnatal care is an effective strategy to improve access to contraceptive methods tailored to the specific needs of postpartum women, thereby enhancing reproductive autonomy and reducing the risk of unintended pregnancies [10, 11].

Second, integrating PPFP services within health facilities enhances accessibility, particularly for women in rural areas with limited healthcare offerings [9]. Third, implementing a multisectoral approach that involves healthcare workers, community leaders, and media is crucial for overcoming sociocultural barriers and promoting the uptake of PPFP services [13]. Finally, from an economic perspective, family planning helps reduce costs associated with maternal and neonatal healthcare, thereby freeing up resources for other health priorities [14].

Scaling up PPFP in Togo thus represents a key strategy for achieving national health and development goals. Its success depends on strong political commitment, adequate funding, enhanced training for healthcare providers, and effective community mobilization. This study aims to provide an overview of the components of PPFP in Togo.

3. Literature Review on Postpartum Family Planning

The essential components of PPFP are built on several strategic pillars. Counseling and awareness-raising activities inform women and couples about available contraceptive options and the benefits of birth spacing [3]. The provision of contraceptives aims to ensure the availability of a wide range of methods (long-acting reversible contraceptives, hormonal methods, barrier methods, and emergency contraception) to meet postpartum needs [15]. Integration into maternal health services ensures continuity of care during antenatal visits, childbirth, and postnatal follow-up [4]. Capacity building through continuous training of healthcare personnel is a critical lever for respectful and appropriate service delivery [16]. Finally, the establishment of monitoring and evaluation systems enables assessment of intervention outcomes and informs policy decisions [9].

PPFP is embedded within a systemic approach to health system strengthening. It relies first on a policy and regulatory framework that facilitates universal access to contraception by reducing financial, geographic, and sociocultural barriers [4]. The development of infrastructure and logistics ensures continuous availability of contraceptive methods, particularly in underserved areas [17].

Human resource strengthening, through ongoing professional development, enhances the quality of counseling, method management, and respect for women's rights [18]. Community outreach efforts involving opinion leaders and community intermediaries foster service uptake and address cultural resistance [9]. Health information systems that generate reliable data support evidence-based decision-making and optimize intervention efficiency [3].

PPFP improves the integration of postnatal health services, promoting continuous and effective care; it strengthens in-

tersectoral collaboration between maternal, child, and reproductive health programs, and contributes to better resource management ensuring optimal use even in resource-limited settings [15, 16, 18].

PPFP is recognized by the WHO as an essential strategy for reducing maternal and child mortality [4]. It has been incorporated into national policies in many countries worldwide; however, access remains uneven, especially in low-income countries where geographic, financial, and sociocultural barriers persist [17, 18]. In sub-Saharan Africa, unmet needs remain high due to limited healthcare coverage and social norms that discourage contraceptive use [9]. Initiatives are underway to overcome these access barriers, but progress remains slow, often hampered by poor method acceptance related to beliefs and lack of information [17, 18].

In Togo, although favorable policies for family planning exist, the implementation of PPFP remains limited, particularly in rural areas [18]. Service provision remains inadequate, and unmet demand is high [9]. Efforts supported by partners such as the WHO aim to further integrate PPFP into postnatal care through provider training and awareness campaigns [4]. The success of these initiatives will depend on strong community engagement, a strengthened health system, and effective resource management.

4. Study Objective

The general objective of this study is to assess the scalability of postpartum family planning (PPFP) in Togo. Specifically, the study aims to analyze the accountability mechanisms, existing synergies, and the current scale-up level of PPFP based on the core components developed by the HIPs Secretariat.

5. Methodology

5.1. Study Design

This is a cross-sectional study designed to evaluate the scale-up of PPFP components. The study was conducted from September 20 to 26, 2024.

5.2. Sampling

A non-probability sampling method was used to select the study participants. The sample consisted of stakeholders from the health system, particularly from the Ministry of Health, working at the level of family planning service delivery points.

5.3. Sample

A total of 40 key stakeholders, including 10 women, were interviewed in this study on the scale-up of immediate postpartum family planning.

5.4. Data Collection

Data were collected through individual interviews using a semi-structured questionnaire. The questionnaire included six dimensions (see Table 1) based on the PPFP components: satisfaction index according to PHI Secretariat dimensions, and suggestions for improving services. The questionnaire was pre-tested prior to deployment. After completion, the data were exported in Excel format and subsequently converted into SPSS format for analysis. Content analysis was used for the literature review.

5.5. Operationalization of PPFP Components

Table 1 below outlines the six essential components of PPFP, namely: availability of supplies, equipment, and contraceptive methods at health facilities; availability of personnel for providing PPFP services; continuous staff training; monitoring and evaluation; governance; and community engagement [19]. These components are clearly structured, allowing for the quick identification of critical areas.

The study variables are distributed across dimensions corresponding to the PPFP components (Table 1). For each variable, a closed-ended question was formulated:

1) availability of supplies, equipment, and contraceptive methods at the health facility (5 variables),
2) availability of personnel to provide PPFP services,
3) continuous training (3 variables),
4) monitoring and evaluation (4 variables),
5) governance (3 variables), and
6) community engagement (5 variables).

The proportion of positive responses was calculated for each dimension and for all dimensions combined.

Table 1. *Operationalization of the Core Components of Postpartum Family Planning (PPFP).*

Components	Description	Variables	Application Modalities
Availability of supplies, equipment, and methods within	Refers to the availability of services, equipment, and methods within the facility for all clients seeking a method	1. Availability of FP services 2. Availability of contraceptive products 3. Availability of equipment for administering FP	- Yes - No

Components	Description	Variables	Application Modalities
the health facility	during the immediate postpartum period.	methods 4. Availability of tools for administering FP methods 5. Availability of guidelines	
Availability of personnel for PPFP service delivery	Takes into account the training and availability of staff to ensure the functioning of the PPFP service at all times.	1. Availability of trained FP personnel 2. Availability of a schedule for PPFP services	- Yes - No
Continuous training	Concerns the training of various healthcare provider cadres in delivering and counseling on PPFP services.	3. Availability of a capacity-building plan for PPFP 4. Ongoing training of providers in PPFP 5. Quarterly & semi-annual supervision of PPFP providers	- Yes - No
Monitoring & evaluation	Establishment of a monitoring and evaluation system and reporting on counseling and method uptake among immediate postpartum clients.	1. Availability of monthly activity report templates and health information documentation tools 2. Production of monthly activity reports 3. Training on DHIS2 4. Organization of review and monitoring meetings	- Yes - No
Governance	Commitment of health facility leadership and staff to promote PPFP.	1. PPFP included in the facility's work plan 2. Allocation of resources for PPFP 3. Integration of PPFP into the health service package	- Yes - No
Community engagement	Strengthening links with community programs to promote awareness of ANC and postpartum options (including immediate contraceptives).	1. Community dialogue 2. Guided visits 3. Awareness campaigns 4. Local radio broadcasts 5. Suggestion box for client feedback	- Yes - No

Adapted from High-Impact Practices in Family Planning (HIPs). Key Implementation Components for Four Service Delivery HIPs. Washington, DC: USAID; June 2024 [19].

5.6. Data Collection Techniques and Tools

Individual interviews were conducted using a semi-structured questionnaire comprising twenty-five (25) questions divided into three (3) sections: (i) sociodemographic data (3 questions), (ii) implementation of PPFP components (21 questions), and (iii) improvement suggestions (1 question). Sections one and three included open-ended questions, while the second section consisted exclusively of closed-ended questions related to the PPFP components. A literature review was also conducted to complement the interviews.

5.7. Data Analysis

The Likert scale is used in our analysis to structure and quantify subjective perceptions, such as satisfaction. Although embedded within a qualitative approach, this method allows for the identification of general trends while providing respondents with the opportunity to freely express their views through open-ended comments.

The scale-up index for each variable, as well as the overall index, was calculated based on the proportion of positive responses. The interpretation thresholds were as follows: the index is considered very satisfactory if the percentage of positive « yes » responses is ≥ 80%; satisfactory if ≥ 60% and < 80%; and less satisfactory if < 60%.

Responses were coded and analyzed using Excel and SPSS version 21 software.

6. Results

6.1. Accountability Mechanisms

In Togo's Postpartum Family Planning (PPFP) program, several accountability mechanisms, strategic partnerships, and operational collaborations have been set up to strengthen the effectiveness of High-Impact Practices (HIPs). These accountability mechanisms include regular focused meetings aimed at tracking progress, identifying challenges, and making necessary adjustments to interventions [20, 21]. Rather than working in isolation, HIPs are integrated into a cohesive,

system-wide approach. The strong commitment from health authorities at all levels demonstrates clear national ownership, which helps hold all stakeholders accountable.

The National Health Information System (NHIS), through the integration of data into the District Health Information Software 2 (DHIS2), plays a vital role in monitoring, although HIP data are often combined with other indicators [20, 21].

There are also key platforms such as the Scale-Up Technical Working Group (GTT PAGE), which supports this effort by organizing regular meetings, advocating strategically, and mobilizing resources. The Community of Practice (CoP) encourages knowledge sharing, capacity building, and collective learning among stakeholders [20, 22].

On a broader scale, initiatives like the Ouagadougou Partnership and FP2030 provide frameworks for shared accountability, strategic alignment, and tracking progress on commitments at regional and international levels [5].

Regarding alliances, PPFP engages a multisectoral group of actors, including the Ministries of Health, Education, Planning, and Social Action; decentralized services such as prefectural health directorates; Technical and Financial Partners (TFPs) like the United Nations Population Fund (UNFPA), World Health Organization (WHO), West African Health Organization (WAHO), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the Coordination Unit for Ouagadougou Partnership (UCPO), Jhpiego, Integrated Health, Liverpool School of Tropical Medicine (LSTM); as well as Civil Society Organizations (CSOs) including the Togolese Association for Family Welfare (ATBEF) and its Youth Action Movement, and the Network of Civil Society Organizations for Reproductive Health/Family Planning (ROSCI SR/PF). This diversity of actors facilitates improved multisectoral coordination.

Regarding synergies, partners often pool resources and coordinate complementary activities. Functional coordination structures 5xista c both national and local levels, although improving collaboration between Technical and Financial Partners and government leadership remains a work in progress [20, 21]. Ongoing programs such as Nutrition Integration, Essential Newborn Care, Postpartum Family Planning/Reproductive Health (INSPIRE), FP2030, and LSTM are well aligned with national priorities and utilize shared tools like the African Francophone Network for Sexual and Reproductive Health and Rights Advocacy (AFROSAF) to assess the scalability of HIPs [5]. Altogether, these elements reflect a strong, collaborative, and integrated approach, which is essential for reaching reproductive health and family planning goals in Togo.

6.2. Analysis by PPFP Components

In total, 40 key actors, including 10 women working directly at service delivery points, were interviewed for this study on scaling up immediate postpartum family planning. Tables 3 to 8 present quantitative data on contraceptive method availability, staff training, monitoring systems, and governance. The overall satisfaction index is generally positive, though scores vary across different areas:

1) The availability of contraceptive services and related equipment is considered satisfactory, showing good commitment. However, there are still gaps, particularly in ongoing training and supervision.
2) Supplies availability scored 82%, indicating good access, though stock shortages remain a concern.
3) Continuous training of staff scored 79%, reflecting some progress, but irregular training sessions weaken service quality.
4) Monitoring and evaluation mechanisms scored 86%, highlighting the importance of rigorous oversight, although training on DHIS2 was seen as inadequate.

6.2.1. Availability of Supplies, Equipment, and Methods at Health Facilities

Table 2 below shows results related to the availability of contraceptive products and the equipment necessary to implement PPFP. An 80% score for product and equipment availability suggests good access, which is crucial to ensure women can use contraceptive methods. However, guideline availability was a bit lower at 70%, indicating possible gaps in provider information and support, which could impact the quality of care.

Table 2. *Availability of Supplies, Equipment, and Methods in Health Facilities.*

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Availability of contraceptive products	80% (32/40)	Very satisfactory
Availability of supplies for administering FP methods	80% (32/40)	Very satisfactory
Availability of equipment for administering FP methods	80% (32/40)	Very satisfactory
Availability of FP guidelines	70% (28/40)	Satisfactory
Counseling and provision of PPFP services	100% (40/40)	Very satisfactory
Total	82% (164/200)	Very satisfactory

6.2.2. Availability of Personnel for Providing Postpartum Family Planning Services

Table 3 below assesses the presence and training of personnel involved in postpartum family planning (PPFP). A score of 70% for the availability of trained staff is satisfactory but also highlights the need to increase the number of qualified professionals to ensure continuous and high-quality care. The availability of a service delivery schedule for PPFP (75%) is a positive aspect, 6xista underscores the importance of rigorous planning and effective human resource management.

Table 3. *Availability of Personnel for the Provision of Postpartum Family Planning Services.*

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Availability of trained personnel	70% (28/40)	Satisfactory
Availability of a PPFP service schedule	75% (30/40)	Satisfactory
Total	72% (58/80)	Satisfactory

6.2.3. Continuous Training of Personnel

Continuous training (Table 4) is crucial to maintaining the quality of services. With a score of 79%, it is evident that efforts are being made to keep skills updated. Quarterly and semi-annual supervision (87%) is a positive indicator of commitment to maintaining high standards, but there remains a need to ensure more regular and systematic training.

Table 4. *Continuous Training of Personnel.*

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Training of providers in PPFP & contraceptive technology	70% (28/40)	Satisfactory
Providers receive quarterly & semiannual supervision	87% (35/40)	Very satisfactory
Total	79% (63/80)	Satisfactory

6.2.4. Monitoring and Evaluation Mechanism

Table 5 shows that 100% of respondents confirm the existence of documentation tools, which is a strong point for data collection and performance monitoring. However, only 50% reported having received training on DHIS2. This highlights the need to improve user skills on this platform to optimize data use for decision-making. The production of monthly activity reports (100%) demonstrates good organization in monitoring interventions.

Table 5. *Monitoring and Evaluation Mechanism.*

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Availability of physical & digital tools for health information documentation	100% (40/40)	Satisfactory
Training on DHIS2	50% (20/40)	Less satisfactory
Production of monthly activity reports	100% (40/40)	Very satisfactory
Review and monitoring organization	95% (38/40)	Very satisfactory

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Total	86% (138/160)	Very satisfactory

6.2.5. Governance

Table 6 below presents the governance surrounding the immediate postpartum family planning, with an overall score of 81%. The inclusion of PFPP in work plans (75%) and the allocation of resources (95%) are positive aspects. However, the integration of PFPP into health services (75%) indicates that efforts are still needed to ensure synergy among the different components of healthcare delivery.

Table 6. Governance.

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
The facility includes PPFP in its work plan	75% (30/40)	Satisfactory
Resource allocation for PPFP	95% (38/40)	Very satisfactory
Integration of PPFP into health services	75% (30/40)	Satisfactory
Total	81% (98/120)	Very satisfactory

6.2.6. Community Engagement

With an overall score of 67% (Table 7), this section highlights the need to improve community engagement. While awareness campaigns and radio broadcasts scored high (95%), other elements such as community dialogue (70%) and guided visits (37%) require particular attention. This underscores the importance of strengthening interactions between healthcare providers and communities to overcome sociocultural barriers.

Table 7. Community Engagement.

Criteria	Proportion of «Yes» Responses (%); n/N	Scale-up Index
Client opinion suggestion box	50% (20/40)	Not satisfactory
Community dialogue	70% (30/40)	Satisfactory
Guided visit	37% (15/40)	Not satisfactory
Awareness-raising	95% (38/40)	Very satisfactory
IEC & CCC	95% (38/40)	Very satisfactory
Local radio broadcasts	50% (20/40)	Not satisfactory
Total	67% (161/240)	Satisfactory

6.2.7. Overall Scale-Up Index

Table 8 presents a satisfactory overall scale-up score of 77.5%. This result reflects meaningful progress in the scale-up of postpartum family planning (PPFP). However, it also reveals disparities across components, particularly those with lower scores, which require focused attention to guide future planning and improvements.

Table 8. Overall Scale-Up Index.

Components	Overall Scale-Up Score (%) n/N	Scale-up Index
Availability of supplies, equipment, and methods in health facilities	82% (164/200)	Very satisfactory
Availability of personnel for PPFP service delivery	72% (58/80)	Satisfactory
Ongoing staff training	79% (63/80)	Satisfactory
Monitoring & evaluation mechanism	86% (138/160)	Very satisfactory
Governance	81% (98/120)	Very satisfactory
Community engagement	67% (161/240)	Satisfactory
Total	77.5% (682/880)	Satisfactory

6.2.8. Identified Gaps by Dimension

Table 9 highlights the key challenges encountered in the implementation of immediate postpartum family planning (PPFP), such as stockouts, insufficient qualified personnel, and fragmented service delivery. The analysis across dimensions reveals systemic dysfunctions that call for a prompt and structured response. These findings underscore the need for an integrated approach to improve service quality, strengthen community engagement, and guide future interventions to ensure full functionality and sustainability of the model.

Table 9. Identified Gaps by Relevant Dimensions.

Components	Reported Shortcomings
Availability of supplies, equipment, and methods in health facilities	Stock-outs, lack of certain equipment, and absence of some methods limiting full access to a range of choices for postpartum women. The high cost of certain family planning methods remains a major barrier to accessibility.
Availability of personnel for PPFP service delivery	An insufficient number of trained staff present in services, especially outside regular working hours, compromises the continuous and quality provision of PPFP. The absence or unavailability of personnel during non-standard hours is a major obstacle to uninterrupted postpartum family planning services, limiting continuous access.
Ongoing staff training	Irregular capacity-building sessions and updates on technical skills reduce service quality and adherence to the latest clinical guidelines.
Monitoring & evaluation mechanism	The absence of systematic mechanisms to monitor PPFP indicators limits the ability to improve performance and report on progress.
Governance	The lack of an integrated approach between PPFP, RMNCH, and nutrition hinders coordinated service delivery, reducing intervention effectiveness and beneficiary coverage. Policy silos and lack of coordination between programs (e.g., PPFP, MNCH, nutrition, HIV, immunization) lead to fragmented interventions and undermine overall health system effectiveness. Low involvement of local decision-makers and poor coordination among local institutions (health, decentralization and traditional leadership, social action, education) impede coherent implementation of PPFP interventions.
Community engagement	Low community involvement, persistent myths, taboos, and rumors about contraception, and the absence of targeted awareness strategies limit demand and acceptability of PPFP services. High levels of dissatisfaction among users of maternal and child health services.

7. Discussion

7.1. Study Limitations

7.1.1. Methodological Limitations

This study relies exclusively on a qualitative approach, employing semi-structured interviews conducted with various stakeholders involved in the implementation of postpartum family planning (PPFP) across thre health zones in Togo. While this method enabled the collection of rich, context-specific perspectives, it presents several methodological limitations. First, the absence of quantitative data precludes the ability to measure the direct impact of the PPFP model on key indicators such as the postpartum contraceptive uptake rate or effective coverage. This constraint limits our capacity to establish a causal link between the implemented interventions and observed reproductive health outcomes [23].

Moreover, the data are based on self-reported accounts, making them vulnerable to several biases that may affect their validity. Social desirability bias, for instance, could lead participants to tailor their responses to align with perceived norms or expectations especially on sensitive topics such as contraception and sexuality [24]. Some responses may also contain unintentional inaccuracies, such as confusion about the name or type of contraceptive method used [25]. In addition, the lack of objective verification due to the absence of triangulation with clinical data, direct observations, or health records limits the ability to assess the accuracy of reported information [26].

Furthermore, the absence of a longitudinal design restricts our understanding of how the program's effects evolve over time, particularly regarding the sustainability of gains or possible declines in implementation quality. As such, the study offers a static snapshot, rather than a dynamic analysis of progress. Lastly, the sample's geographic and sociocultural representation is limited. The thre health zones do not reflect the full contextual diversity of the country, warranting caution in any attempt to generalize findings at the national level [27].

7.1.2. Model Limitations

The PPFP scale-up model piloted in Togo offers notable strengths, particularly through its systemic approach built around six core components: service availability, provider competencies, local coordination, advocacy, monitoring and evaluation, and community engagement. This structured framework facilitated progressive ownership among field actors and enabled more coherent implementation. However, stakeholders identified several structural limitations. The model remains predominantly vertical in nature, hampering its integration into basic health services and its alignment with other key programs such as maternal, newborn, and child health (MNCH) and nutrition [28]. This siloed approach complicates the delivery of a truly integrated and holistic model of maternal and child health.

Additionally, while the "minimum intervention package" approach is operational, it lacks the flexibility to adapt to the specific realities of individual districts, reducing its effectiveness in the most vulnerable areas [29]. Another underdeveloped aspect of the model is the limited inclusion of user voices and experiences. Although participatory tools such as suggestion boxes or community dialogues are theoretically part of the model, they are rarely implemented, and feedback from women is seldom integrated into service adaptation or improvement efforts.

This shortcoming reflects broader structural challenges, including resistance to change among some providers or local leaders, who may be hesitant to adopt innovative practices around postpartum contraception. Furthermore, the differentiated roles of women, men, and youth in the acceptability of PPFP are insufficiently explored. Gender norms, taboos surrounding adolescent sexuality, and weak male involvement continue to undermine community buy-in and exacerbate access inequities.

Compounding these issues is the heavy workload borne by providers, exacerbated by chronic shortages of qualified personnel. This undermines both the quality and continuity of services, particularly in rural areas or outside of standard working hours. If left unaddressed, these limitations risk jeopardizing the sustainability of scale-up achievements.

Research from sub-Saharan Africa confirms that successful family planning programs require user-centered approaches that explicitly consider social and gender determinants [5, 7, 12]. Moreover, literature on health systems strengthening advocates for institutionalizing social accountability mechanisms and placing greater value on lived experiences as key levers for ensuring equitable, responsive, and rights-based care [4, 30].

7.2. Overall Assessment of the PPFP Scale-Up

The overall score of 77.5% reflects a relatively advanced institutionalization of PPFP at the national level, 10xista conceals substantial regional and systemic disparities. Some regions particularly rural or peripheral ones exhibit weaker implementation due to inadequate health infrastructure, a shortage of qualified staff, and limited supervision. Additionally, local ownership of the PPFP approach varies: some teams have fully embraced the practice, while others continue to view it as a time-limited project. A lack of ongoing provider training and the absence of accountability mechanisms hinder service standardization.

Although PPFP is now included in health information systems via DHIS2, poor data disaggregation hampers targeted monitoring, especially in underserved areas. Continued dependence on donor funding jeopardizes the approach's sustainability, particularly in zones not covered by partner interventions. Similar challenges have been documented in other countries such as Senegal, where consistent contraceptive availability and enhanced supervision significantly im-

proved service delivery [31].

Our study highlights promising local ownership of the PPFP approach; however, it remains heavily dependent on external technical support, which undermines its long-term viability. Service improvements were driven by provider training and better organizational practices, but gaps persist, particularly regarding input availability and integration with other health programs like MNCH and nutrition.

While coordination mechanisms have helped mobilize stakeholders, institutional anchoring at the regional level remains weak, resulting in uneven scale-up. The success of reproductive health interventions in some areas appears linked to simplified protocols and provider support. Moreover, our findings underscore district-level variability, with stronger results in areas where local health leaders demonstrated proactivity.

Finally, while technical and financial partner support has been critical, this reliance raises concerns about continuity once external support diminishes.

7.3. Success Factors in the Scale-Up Process

The qualitative analysis of PPFP scale-up across thre health zonesin Togo identifies several key enablers that facilitated the model's operationalization in health facilities. Although local ownership varied, certain cross-cutting elements played a pivotal role.

Strong commitment from facility leaders (e.g., head nurses, midwives) and district health management teams was a major driver. This commitment translated into improved service organization, regular coordination meetings, and the use of planning tools. In some districts, local committees were established to prioritize PPFP, enhancing ownership dynamics. This finding aligns with other scale-up experiences that emphasize the importance of local leadership and decentralized governance as catalysts for institutionalization [31, 32].

The availability of a harmonized toolkit (supervision checklists, action plans, PPFP-specific data collection tools) was decisive in structuring interventions and enabling more consistent monitoring. Ongoing provider training strengthened clinical and organizational competencies, improving the quality and reliability of services.

Technical partner support including module development, on-site coaching, and formative supervision was essential, especially in the early stages of scale-up. These supports allowed interventions to be adapted to local realities, a factor consistently highlighted in the literature as critical to successful program expansion [33, 34].

The integration of the PPFP intervention package into routine health services improved postpartum service organization. Clear role delineation, systematic counseling, and increased availability of contraceptive methods in maternity and postpartum units enhanced care continuity. By embedding within existing routines, PPFP became a more visible and sustained component of maternal health services.

This strategy is in line with evidence-based recommendations that emphasize embedding postpartum contraception within the continuum of obstetric and neonatal care to maximize effectiveness [12, 35].

Our findings echo successful experiences in other low- and middle-income countries. For instance, PPFP programs in Indonesia and Bangladesh demonstrated that integration into existing health systems coupled with ongoing technical support and strong local engagement fosters effective scale-up [36].

7.4. Constraints and Challenges

The scale-up of postpartum family planning in Togo faces multiple structural, organizational, and community-level challenges. User satisfaction with maternal and child health services remains modest, limiting the intervention's overall impact [7, 37].

7.4.1. Logistical and Human Resource Challenges

A major constraint is the frequent stock-outs of contraceptive supplies, especially in peripheral health facilities. These disruptions undermine service continuity and 11xista cr user trust, particularly among youth. This issue is exacerbated by shortages of personnel trained in logistics and by excessive workloads due to overall staffing deficits [7, 9, 30].

While the overall availability of contraceptives is rated at 82% a generally satisfactory figure significant disparities 11xista cross specific methods, including pills, injectables, implants (e.g., Jadelle), IUDs, and condoms. Given medical contraindications and personal preferences, access to a broad range of methods is essential to ensure informed choice. Thus, even temporary shortages of certain methods may impede access to suitable contraception.

Health worker availability, estimated at 72%, also masks disparities in geographic distribution and service hours. Limited staff presence outside regular working hours compromises both continuity and quality of PPFP services. The absence of staff during evenings, weekends, or holidays is a major barrier to uninterrupted service access, negatively affecting user satisfaction and overall effectiveness. This highlights the need for stronger human resources, more flexible work schedules, and institutional commitment to 24/7 service coverage especially in maternity units. Continuous availability of qualified personnel is a cornerstone of high-quality reproductive healthcare; its absence is often linked to lower service uptake and user satisfaction [7, 37].

High costs of certain family planning methods remain a significant barrier to access, especially for vulnerable populations, and constitute a major obstacle to successful scale-up. These financial barriers not only reduce uptake of modern methods but also exacerbate reproductive health inequalities.

7.4.2. Service Fragmentation and Duplication of Efforts

The segmentation of health programs often referred to as "working in silos" poses a serious threat to health system efficiency and performance in Togo. This fragmented organization leads to parallel interventions, weak coordination among stakeholders, and redundant efforts, all of which compromise the delivery of integrated, continuous, and user-centered care.

A particularly concerning structural issue is the functional segmentation of programs, which results in duplicated activities and inefficient use of resources. For instance, separate training sessions are often conducted for logistics management across the Expanded Program on Immunization (EPI), family planning, nutrition, and prevention of mother-to-child transmission of HIV. These parallel initiatives consume overlapping human, financial, and material resources, ultimately compromising system efficiency..

Adopting an integrated approach would allow for the pooling of resources, harmonization of training, and development of cross-cutting competencies, thereby facilitating unified management of essential inputs. Such integration would also foster more coherent governance and enhance alignment with universal health coverage objectives. Given the current decline in donor funding, it is crucial to establish continuous training programs focused on service integration across postpartum family planning (PPFP), maternal, newborn, and child health (MNCH), nutrition, and immunization [4, 38]. This would also promote more coherent governance and better alignment with universal health coverage goals. Evidence from sub-Saharan Africa indicates that integrated services not only improve coverage and quality of care but also reduce operational costs, highlighting the importance of this approach for sustainable health system strengthening [39].

7.4.3. Multi-Stakeholder Coordination Challenges

Coordination among the various actors involved in PPFP implementation ministries, regional health authorities, NGOs, and community leaders varies significantly across districts. The absence of clear mechanisms for joint planning and inter-institutional accountability limits intervention impact and hinders action synergy. This multi-stakeholder governance challenge is well-documented in the literature as a common barrier to the implementation of integrated health policies [28].

Although some accountability mechanisms have been established to support stakeholder engagement by reinforcing commitments, fostering alignment, and facilitating coordination their scope remains limited. These mechanisms largely rely on goodwill and mutual trust, without formal legal enforcement, which weakens their effectiveness in tracking and implementing concrete actions.

The lack of formal scoring systems or clear incentives further diminishes their ability to ensure large-scale results. Establishing robust and transparent accountability mechanisms is essential to sustain commitments in family planning [40]. However, when such mechanisms are non-binding, their impact remains limited, especially in contexts where financial and human resources are insufficient to support coherent implementation.

7.4.4. Challenges Related to Community Engagement and Social Norms

Sociocultural resistance continues to pose challenges in some areas, particularly regarding adolescent reproductive health. Deeply rooted taboos surrounding adolescent sexuality and the stigmatization of contraceptive use among young women hinder community ownership of services. The limited engagement of certain religious and community leaders further constrains the effectiveness of awareness-raising efforts. To overcome these barriers, it is essential to strengthen community dialogue and implement context-sensitive social mobilization strategies [6, 40].

In summary, while substantial progress has been made in scaling up postpartum family planning (PPFP), significant structural challenges remain. A profound reform of both logistical and programmatic governance is necessary to promote integrated service delivery. Such an integrated approach is not only more efficient but also more resilient in resource-constrained settings. The long-term success of PPFP will depend on the health system's capacity to break out of siloed approaches, enhance multi-stakeholder coordination, and foster social acceptance through sustained community engagement.

7.5. Contextual Factors Analysis

Findings from this study reveal considerable variability in the implementation and performance of the PPFP model across the thre health zones. While some districts demonstrated effective ownership, improved coordination, and continuous enhancement of service delivery, others faced fragmented implementation, hindered by structural constraints and adverse contextual factors.

7.5.1. Variability in Implementation

This heterogeneity is partly explained by the degree of involvement of health zones directorates, the dynamism of the health zones management teams, and the quality of local leadership. In districts where health officials demonstrated strong mobilization and supervisory capabilities, PPFP activities were better integrated into routine health services. Conversely, districts with weak supervision or frequent staff turnover showed limited ownership. These observations highlight that consistent leadership and high-quality supervision are critical determinants of success in reproductive health initiatives [41].

7.5.2. Influential Contextual Factors

Geographic and socio-economic conditions also shaped outcomes. Remote rural areas, characterized by limited road access and weak network coverage, faced greater difficulties in ensuring regular follow-up, maintaining supply chains, and mobilizing community-based health workers. Low literacy levels and conservative social norms in certain communities further restricted access to information and acceptance of PPFP, especially among youth. A similar study in Guinea found that social acceptability of PPFP varies greatly across local contexts, necessitating interventions tailored to specific community dynamics [42].

7.5.3. Lessons Learned

A comparative analysis of the districts reveals several key learning points. The most successful districts benefited from active multi-stakeholder coordination mechanisms, consistent support from technical partners, and strong commitment from community health workers. They also succeeded in creating synergies between services such as family planning, maternal and child health, and nutrition, thereby enhancing the effectiveness of the integrated approach. In contrast, districts without a clear institutional anchoring strategy were less successful in systematizing the PPFP model.

These findings reinforce the importance of a contextually informed and adaptive approach to scale-up efforts, as evidenced by PPFP scale-up experiences in Senegal and Ethiopia. In both countries, success was closely tied to flexible interventions that were responsive to local constraints [12, 36]. Our study illustrates that standardizing interventions without accounting for local realities diminishes prospects for sustainability and large-scale impact.

7.5.4. Sustainability of Achievements

A major issue highlighted by this study is the capacity of Togo's health system to sustain the achievements of PPFP scale-up beyond external support. Although notable improvements were recorded in supported facilities such as service organization, provider training, and availability of contraceptive supplies the durability of these results remains uncertain in a context of heavy reliance on technical and financial partners.

7.5.5. Capacity to Sustain Gains Without Program Support

Most health facilities involved in the study demonstrated fragile mechanisms for maintaining gains in the absence of external support. The renewal of data collection tools, continuation of training, formative supervision, and supply of contraceptives still largely depend on project-based funding. This reflects a common challenge in health projects, particularly in resource-limited settings, where innovations introduced through pilot initiatives often struggle to become institutionalized [42]. To achieve real sustainability, it is imperative to integrate the PPFP model into national and regional strategic planning documents. Although some intervention components have been incorporated into Ministry of Health guidelines, full systematization remains to be achieved.

7.5.6. Role of the Decentralized Health System

The role of health zones directorates is pivotal in sustaining efforts after the end of external support. The study shows that districts where the health zone team led took an active role in coordination, planning, and supervision tended to maintain results more effectively. This confirms the importance of strong local leadership and effective decentralization of responsibilities in reproductive health strategies [43, 44].

However, to strengthen this dynamic, it is necessary to align human, technical, and financial resources at the local level. Consolidating achievements should involve greater synergy among health programs (family planning, immunization, nutrition, MNCH), notably through integrated approaches and cross-training for providers, allowing more efficient use of existing resources [28].

7.6. Future Perspectives

Findings from this study indicate that the scale-up of the PPFP model in thre health zonesof Togo holds promising potential for expansion to other areas of the country. However, this expansion requires a strategic reflection on conditions for sustainability, integration, and institutional ownership.

7.6.1. Geographic Expansion

The experience in the thre health zones provides a solid foundation for a phased expansion to other regions. This should be guided by clear selection criteria, such as the existence of active coordination structures, maternity service coverage, and the level of commitment of regional health authorities. Unplanned expansion risks diluting gains, especially in a context of gradually decreasing support from technical and financial partners.

7.6.2. Strengthening Local Ownership

One of the main conditions for the sustainability of the PPFP model is its integration into local health governance frameworks. The scale-up process should promote the gradual transfer of responsibilities to health zone management led and he's staff. Active community involvement through trained and supported community health workers also remains a key driver of social anchoring for the intervention.

7.6.3. Multisectoral Integration and Systems Approach

Persistent fragmentation between vertical health programs (family planning, immunization, PMTCT, nutrition) contin-

ues to undermine efficiency. Implementing integrated approaches for training, supervision, and logistical management is essential to optimize available resources. The development of a continuing education module on the integration of PPFP, MNCH, nutrition, and immunization services would be particularly relevant, especially in settings with limited human and financial resources.

7.6.4. Institutional Consolidation

In the medium term, the sustainability of the PPFP model will depend on its explicit integration into national and regional policy and planning documents. Stronger political support, appropriate budgeting, and the institutionalization of tools and processes developed are necessary to sustain achievements. Furthermore, the decentralized health system must be strengthened to ensure local governance and continuous supervision of interventions.

7.7. Strategic Recommendations

Based on the study's findings, the following recommendations are proposed to strengthen the impact and sustainability of the PPFP model:

For expansion to other areas: i) implement a phased scale-up strategy to other districts, based on objective selection criteria and enhanced support, ii) document and disseminate lessons learned from the thre health zones to guide new implementations.

For strengthening local ownership: i) integrate PPFP into regional development plans and local management tools (annual work plans, supervision, monitoring and evaluation), ii) build the capacities of the health zone led and he's staff in integrated management, multisectoral coordination, and community mobilization, iii) Encourage the involvement of local governments and community leaders in promoting PPFP.

To address identified challenges: i) promote an integrated service delivery approach through joint training of providers in PPFP, MNCH, nutrition, and immunization, ii) establish shared logistics management mechanisms to pool resources and reduce duplication across programs, iii) strengthen community awareness strategies to improve social acceptance and address barriers related to sociocultural norms.

8. Conclusion

The study on the scale-up of the postpartum family planning (PPFP) model highlights notable advances in service delivery, provider capacity building, and intervention coordination. Structured around six pillars, the model improved contraceptive availability, enhanced provider skills through targeted training, and streamlined postnatal service organization. Key innovations include the adoption of standardized tools, active participation of community health workers, and establishment of multisectoral coordination mechanisms.

Nevertheless, the scale-up faced major constraints. Logistically, stockouts, insufficient staffing outside business hours, and a lack of equipment in certain health facilities were observed. Institutionally, weak integration of the model into regional governance mechanisms hindered its systematization. Additionally, unfavorable social norms toward postpartum contraception and the fragmentation between health programs (immunization, MNCH, nutrition, PMTCT) limited potential synergies.

An integrated approach is therefore essential to improve effectiveness and optimize resource use.

This study's originality lies in its multi-site and participatory methodology, offering a contextualized understanding of local practices and implementation dynamics. It provides valuable insights for policymakers and technical partners, identifying success factors, bottlenecks, and strategic levers for improved planning.

The sustainability of the PPFP model will depend on strong commitment from local authorities, its integration into national health policies and plans, and sustained financing. Continuous provider training using an integrated approach, strengthened local governance, and community ownership will be critical to ensuring long-term impact.

Future directions should include the long-term evaluation of the model's impact on contraceptive coverage and unmet needs. Expanding to other districts, with adaptations to local specificities, is also recommended. Strengthened synergy among public, community, and partner actors is vital to building a health system that is equitable, effective, and resilient serving postpartum women with dignity and care.

Abbreviations

AFROSAF	African Francophone Network for Sexual and Reproductive Health and Rights Advocacy
ATBEF	Association Togolaise Pour le Bien- être Familial
CoP	Community of Practice
CSOs	Civil Society Organizations
DC	District of Columbia
DHIS2	District Health Information Software 2
EPI	Expanded Programme on Immunization
FP2030	Family Planning 2030
GTT PAGE	Groupe Technique de Travaille et de Passage à Grande échelle
HIPs	High-Impact Practices in Family Planning
HIV	Human Immunodeficiency Virus
INSPiRE	Nutrition Integration, Essential Newborn Care, Postpartum Family Planning/ Reproductive Health
IUD	Intrauterine Device
LSTM	Liverpool School of Tropical Medicine
MNCH	Maternal, Newborn, and Child Health
NGO	Non-Governmental Organization

NHIS	National Health Information System
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PPFP	Postpartum Family Planning
ROSCI SR/PF	Réseau Des Organisations de la Société Civile Intervenant En Santé Reproductive / Planification Familiale
SPSS	Statistical Package for the Social Sciences
TFP	Technical and Financial Partners
UCPO	Coordination Unit for Ouagadougou Partnership
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization

Authors Contributions

Wankpaouyare Gmakouba: Conceptualization, Data curation, Formal Analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing

Komi Ameko Azianu: Conceptualization, Data curation, Formal Analysis, Methodology, Validation, Writing – review & editing

Mazabalo Bini: Conceptualization, Data curation, Formal Analysis, Methodology, Validation, Writing – review & editing

Salaraga Bantakpa: Conceptualization, Data curation, Formal Analysis, Methodology, Validation, Writing – review & editing

Pitabinaw è Deabalo: Formal Analysis, Writing – review & editing

Labaguibe Gangak: Formal Analysis, Writing – review & editing

Conflicts of Interest

The authors declare no conflicts of interest.

Appendix

Table 10. *Documents consulted for the documentary analysis.*

No	Document Title	Method of Access
01	Outil d'évaluation de la scalabilité des Pratiques à Haut Impact (PHI) de l'OMS - Bureau AFRO.	Online
02	Key implementation components for four service delivery HIPs	Online
03	Rapport annuel de suivi des données sanitaires 2021	Online
04	Bilan des engagements nationaux pour la PF dans les pays du Partenariat de Ouagadougou.	Online
05	Planification familiale 2030: Feuille de route pour l'Afrique de l'Ouest francophone.	Online
06	Compte rendu des réunions du Groupe Technique de Travail pour le Passage à Grande Échelle (GTT PAGE) Document de synthèse interne détaillant les activités de plaidoyer, de mobilisation des ressources et de coordination technique.	Online
07	Politique nationale de santé horizon 2030	physical
08	Plan national de développement sanitaire 2023-2027	physical
09	Plan d'action national budgétisé de planification familiale au Togo 2023-2026	physical
10	Document de programme WEZOU	physical
11	DSMI PF Rapport 2022	physical
12	Document du projet Sahel Women's Empowerment and Demographic Dividend (SWEDD)	physical
13	Rapport d'évaluation de la politique nationale de santé 2012-2022	physical
14	Rapport d'évaluation du plan national de développement sanitaire 2017-2022	physical

References

[1] Organisation mondiale de la Santé. Mortalité maternelle. 2025. https://www.who.int/fr/news-room/fact-sheets/detail/maternal-mortality

[2] Saizonou J, Makoutodé P, Mongbo V, Affo A, Zannou FR, Atadé W. Déterminants de l'utilisation des services de planification familiale en post-partum au Bénin. Rev Afr Sci Soc Santé Publique. 2021; 3(1): 124-36.

[3] Organisation mondiale de la Santé. Stratégies de programmation pour la planification familiale du post-partum. Genève: OMS; 2014.

[4] Organisation mondiale de la Santé. Delivering quality health services: A global imperative for universal health coverage. Genève: OMS; 2018.

[5] FP2030. Planification familiale 2030: Feuille de route pour l'Afrique de l'Ouest francophone. 2023 https://fp2030.org

[6] UNFPA. State of World Population 2022: Seeing the Unseen. New York: United Nations Population Fund; 2022.

[7] Gmakouba, W., Azianu, K. A., Gangak, L., Kombate, G., Bini, M., et al. (2025). Availability of Health Services and Preparedness for Basic Emergency Obstetric and Newborn Care in Togo. World Journal of Public Health, 10(2), 106-119. https://doi.org/10.11648/j.wjph.20251002.14

[8] Ross JA, Winfrey WL. Contraceptive use, intention to use and unmet need during the extended postpartum period. Int Fam Plan Perspect. 2001; 27(1): 20-7.

[9] Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. Lancet. 2012; 380(9837): 149-56. https://doi.org/10.1016/S0140-6736(12)60609-6^#[

[10] Moore, Z., Pfitzer, A., Gubin, R., Charurat, E., Elliott, L., & Croft, T. (2015). Missed opportunities for family planning: An analysis of pregnancy risk and contraceptive method use among postpartum women in 21 low- and middle-income countries. Contraception, 92(1), 31-39.

[11] Borda M, Winfrey W. Postpartum fertility and contraception: An analysis of findings from 17 countries. Baltimore: Jhpiego; 2010.

[12] Organisation mondiale de la Santé. Maintaining essential health services: Operational guidance for the COVID-19 context interim guidance. 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1

[13] Prata N, Fraser A, Huchko MJ, Gipson JD, Withers M, Lewis S, et al. Women's empowerment and family planning: A review of the literature. J Biosoc Sci. 2017; 49(6): 713-43.

[14] Sadinsky S, Ahmed Z. A time for change: Advancing sexual and reproductive health and rights in a new global era. Guttmacher Policy Rev. 2021; 24: 14-21.

[15] Gaffield ME, Egan S, Temmerman M. It's about time: WHO and partners release programming strategies for postpartum family planning. Glob Health Sci Pract. 2014; 2(1): 4-9.

[16] High Impact Practices in Family Planning. Planification familiale du post-partum immédiat: Un composant essentiel des soins à l'accouchement. 2017. https://www.fphighimpactpractices.org/wp-content/uploads/2020/04/PHI_Planification-familiale-du-post-partum-immédiat-FR.pdf

[17] Sear R, Sheppard P, Coall DA. Cross-cultural evidence does not support universal acceleration of puberty in father-absent households. Philos Trans R Soc Lond B Biol Sci. 2019; 374(1770): 20180124.

[18] USAID. Family planning training resource package for pre-service education. 2020. https://www.fptraining.org/

[19] High-Impact Practices in Family Planning. Key implementation components for four service delivery HIPs. Washington, DC: USAID; 2024 juin.

[20] Groupe Technique de Travail et de Passage à Grande Échelle. Compte rendu des réunions du Groupe Technique de Passage à Grande Échelle. Togo: Ministère de la Santé; 2023.

[21] Ministère de la Santé et de l'Hygiène Publique. Rapport annuel de performance 2022. Togo: Ministère de la Santé; 2023.

[22] Ouagadougou Partnership. Bilan des engagements nationaux pour la PF dans les pays du Partenariat de Ouagadougou. 2023: https://partenariatouagadougou.org

[23] Creswell JW, Poth CN. Qualitative inquiry and research design: Choosing among five approaches. 4th ed. Thousand Oaks: Sage Publications; 2016.

[24] Tourangeau R, Yan T. Sensitive questions in surveys. Psychol Bull. 2007; 133(5): 859.

[25] Fabic MS, Choi Y, Bird S. A systematic review of Demographic and Health Surveys: Data availability and utilization for research. Bull World Health Organ. 2012; 90: 604-12.

[26] Bradburn NM, Sudman S, Wansink B. Asking questions: The definitive guide to questionnaire design. Hoboken: John Wiley & Sons; 2004.

[27] Patton MQ. Qualitative research & evaluation methods: Integrating theory and practice. 4th ed. Thousand Oaks: Sage Publications; 2014.

[28] Atun R, de Jongh T, Secci F, Ohiri K, Adeyi O. Integration of priority population, health and nutrition interventions into health systems: Systematic review. BMC Public Health. 2010; 10: 347. https://doi.org/10.1186/1471-2458-10-347

[29] Paina L, Peters DH. Understanding pathways for scaling up health services through the lens of complex adaptive systems. Health Policy Plan. 2012; 27(5): 365-73.

[30] Gmakouba W, Bantakpa S, Bini M. Towards humanised and respectful childbirth in Togo: Promoting women's dignity and rights in obstetric settings. Int J Res Innov Soc Sci. 2024; 8(12): 4318-24.

[31] Sanogo D, RamaRao S, Jones H, N'diaye P, M'bow B, Diop CB. Improving quality of care and use of contraceptives in Senegal. Afr J Reprod Health. 2003; 7(2): 57-73.

[32] Mangham LJ, Hanson K. Scaling up in international health: What are the key issues? Health Policy Plan. 2010; 25(2): 85-96. https://doi.org/10.1093/heapol/czp066

[33] Yamey G. Scaling up global health interventions: A proposed framework for success. PLoS Med. 2011; 8(6): e1001049. https://doi.org/10.1371/journal.pmed.1001049

[34] Fixsen DL, Naoom SF, Blase KA, Friedman RM, Wallace F. Implementation research: A synthesis of the literature. Tampa: University of South Florida; 2005.

[35] Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: An analysis of 172 countries. Lancet. 2012; 380(9837): 111-25.

[36] Simmons R, Shiffman J. Scaling up health service innovations: A framework for action. In: Scaling up health service delivery. Geneva: WHO; 2007. p. 1-30.

[37] Gmakouba W, Azianu KA, Kpakpassoko N, Bini M, Bantakpa S. Evaluation of pregnant women's satisfaction with antenatal care at Haho Health Zone Hospital using the Erin Multi-attribute Model. Cent Afr J Public Health. 2025; 11(2): 62-9. https://doi.org/10.11648/j.cajph.20251102.13

[38] Bossert TJ, Beauvais J, Bowser D. Decentralization of health systems: Preliminary review of four country case studies. Bethesda: Partnerships for Health Reform, Abt Associates; 2000.

[39] Dudley L, Garner P. Strategies for integrating primary health services in low- and middle-income countries at the point of delivery. Cochrane Database Syst Rev. 2011; (7). https://doi.org/10.1002/14651858.CD003318.pub3

[40] Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: A review of evidence on interventions commonly accepted as best practices. Glob Health Sci Pract. 2015; 3(3): 333-40. https://doi.org/10.9745/GHSP-D-15-00126

[41] Hodgins S, D'Agostino A, D'Agostino E. The quality-coverage gap in antenatal care: Toward better measurement of effective coverage. Glob Health Sci Pract. 2014; 2(2): 173-81. https://doi.org/10.9745/GHSP-D-14-00017

[42] Raj A, Dey A, Boyce S, Seth A, Bora S, Chandurkar D, et al. Associations between mistreatment by a provider during childbirth and maternal health complications in Uttar Pradesh, India. Matern Child Health J. 2017; 21(9): 1821-33. https://doi.org/10.1007/s10995-017-2298-0

[43] Mills A, Rasheed F, Tollman S. Strengthening health systems. In: Jamison DT, Breman JG, Measham AR, et al., editors. Disease Control Priorities in Developing Countries. 2nd ed. New York: Oxford University Press; 2006.

[44] Organisation mondiale de la Santé. Practical guidance for scaling up health service innovations. Genève: OMS; 2009.