



Scalability and Scale-Up Readiness of Family Planning High-Impact Practices in Cameroon, Côte d'Ivoire, Mauritania and Togo: A Comparative Cross-Sectional Study

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ABSTRACT

Background: Evidence-based family planning interventions may be effective on a small scale yet remain difficult to expand when health systems lack the resources, organisation or institutional support required for wider delivery.

Objectives: To compare the scale-up readiness of five family planning HIPs in Cameroon, Côte d'Ivoire, Mauritania and Togo and to identify the main factors that may support or hinder their expansion.

Methods: We conducted a comparative cross-sectional study using secondary data from an Excel-based scalability assessment tool developed from the AFROSAF. One sexual and reproductive health and family planning expert in each country completed the online assessment voluntarily. Five HIPs were assessed in four countries, yielding 20 country-practice observations. Fifteen criteria grouped into nine AFROSAF domains were scored on a 0–100 scale. The analysis was descriptive.

Results: PFPP had the highest mean readiness score (87.96), followed by community health workers (87.73), mobile outreach (81.25), postabortion family planning (79.86) and pharmacies/drug shops (63.89). CHW Cowere the only practice rated high in all four countries. The strongest domains were development process and health need, while resource availability, readiness to address access barriers and the scaling setting scored lower.

Conclusions: Four of the five HIPs showed substantial readiness for wider implementation, although important differences remained between countries. Pharmacy- and drug-shop-based family planning was the most context dependent. Decisions to scale up should consider not only evidence of effectiveness, but also financing, access barriers, delivery capacity and long-term sustainability.

Keywords: family planning, High Impact Practices, scalability, scale-up, postpartum family planning, community health workers, mobile outreach, pharmacies

INTRODUCTION

Family planning programmes often face a gap between evidence that an intervention works and the practical conditions needed to deliver it at scale. Expansion may be slowed by uncertain financing, unreliable commodity supply, workforce shortages, weak supervision or regulatory constraints. The High Impact



Practices in Family Planning (HIPs) initiative was developed to help programmes translate evidence into practical choices about service delivery and implementation [3–7].

Scalability and scale-up readiness describe related, but different, questions. Scalability concerns whether an intervention can be expanded without losing its core functions, quality or expected benefits. Scale-up readiness concerns the setting in which expansion would occur, including policy support, resources, service-delivery arrangements and institutional capacity. WHO/ExpandNet also emphasises that scale-up is not simply the replication of an intervention in more locations. Horizontal expansion generally needs to be accompanied by vertical institutionalisation through policy, financing, regulation and routine management systems [1,2].

The five HIPs examined in this study rely on different service-delivery platforms. Immediate postpartum family planning (PPFP) and postabortion family planning (PAFP) are closely linked to facility-based maternal and reproductive health services. Community health workers (CHWs) bring counselling, selected services and referrals closer to households. Mobile outreach can extend access beyond fixed facilities, particularly for underserved populations. Pharmacies and drug shops rely more heavily on private-sector regulation, product availability, quality assurance and effective referral. Although evidence supports all five approaches, the conditions required for expansion vary across settings [8–15].

Recent evidence from Francophone West Africa also suggests that uptake of HIPs remains uneven. PPFP and CHW approaches are relatively common, whereas PAFP and pharmacy-based models are less consistently integrated into national programmes [18]. We therefore compared the scale-up readiness of five HIPs in Cameroon, Côte d'Ivoire, Mauritania and Togo and examined the health-system domains most likely to support or constrain wider implementation.

METHODS

Study design and setting

We conducted a comparative cross-sectional study based on secondary analysis of data collected with an Excel-based scalability assessment tool developed from the African Scalability Assessment Framework (AFROSAF). The study included Cameroon, Côte d'Ivoire, Mauritania and Togo.

The assessment tool was made available online through Google Drive. In each country, one sexual and reproductive health and family planning (SRH/FP) expert completed the structured assessment voluntarily, drawing on knowledge of the national health system, family planning programme and the conditions affecting scale-up. The experts received virtual orientation on use of the tool before data collection. Data were collected between July and September 2026 and subsequently reviewed during a virtual validation meeting.

In addition, in each country, the completed assessment form was reviewed and validated during a one-day national workshop involving 10 experts drawn from the departments and programmes responsible for sexual and reproductive health. The multidisciplinary panel comprised two gynaecologists, three sexual and reproductive health specialists, one health planner, one statistician, and three midwives specialised in public health. The experts participated in a collective review of the completed assessment, examining the relevance and consistency of the ratings across the 15 AFROSAF criteria and nine domains. Their participation provided an opportunity to discuss country-specific health-system conditions, assess the appropriateness of the expert-assigned scores, identify potential discrepancies and reach a shared interpretation of the findings. This participatory validation process strengthened the institutional credibility and contextual relevance of the assessment while reducing reliance on the judgement of a single national respondent. Nevertheless, the initial scoring was conducted by one designated expert per country, and the validation workshops did not constitute independent assessments by multiple raters.

An SRH/FP expert was defined as a professional with at least five years of relevant experience in programming, policy, service delivery, monitoring and evaluation, or programme management. Experts were expected to have substantial knowledge of the national health system and family planning programme, including national policies, service-delivery arrangements, financing, commodities, human resources and



implementation constraints. Experience with one or more HIPs, programme scale-up, health-system strengthening or implementation research was considered an additional asset.

Experts were selected primarily on the basis of practical experience and substantive involvement in the national SRH/FP programme rather than professional title or academic position alone. This approach was intended to ensure that the assessment reflected operational knowledge of how family planning policies and services function in each health system. The four national assessors were medical doctors (MD) holding a Master of Public Health (MPH) and each had at least 10 years of professional experience in family planning within a Ministry of Health. The purposive selection prioritised familiarity with national family planning policy, implementation and health-system constraints rather than representativeness. One assessor was included per country; consequently, these assessments are individual expert appraisals and cannot be taken as a consensus of national stakeholders. [AUTHORS TO CONFIRM: precise recruitment pathway, current employment status and whether all four profiles meet these descriptors.]

Completed country forms were downloaded from Google Drive in Excel format, consolidated and checked for completeness and internal consistency. The unit of analysis was the country-practice combination rather than the individual expert, health facility, provider or service user.

Five family planning HIPs were selected a priori: immediate postpartum family planning (PPFP), postabortion family planning (PAFP), community health workers (CHWs), mobile outreach services, and provision of family planning services through pharmacies and drug shops. Assessing the five practices in four countries produced 20 country-practice observations.

Assessment framework and scoring

The Excel tool was developed from AFROSAF, a framework designed to assess the potential for scaling health interventions in African health systems [16]. It contains 15 criteria organised into nine domains: health need, development process, intervention content, political context, evidence for impact, resource availability, target unit and access barriers, scaling setting, and sustainability at scale. The operational definitions of all 15 criteria are set out in Table 1, and their grouping into nine domains, with domain-level aggregation rules, is summarised in Table 2.

WHO/ExpandNet was used alongside AFROSAF to interpret how interventions judged ready for expansion might move towards horizontal and vertical scale-up [1,2]. AFROSAF provided the measurement framework for criterion, domain and composite scores, whereas WHO/ExpandNet provided the broader implementation perspective. This allowed us to distinguish assessment of readiness from later decisions about where, how and through which institutional mechanisms scale-up should occur.

Each criterion was rated on a four-point agreement scale and converted to 25, 50, 75 or 100 points. In the original tool, responses recorded as 'Unknown' or 'Not applicable' were assigned a score of zero, and this rule was retained. Nine domain scores and one overall composite score were calculated for each country-practice combination. Composite scores of 78.7 or higher were classified as high scale-up potential, scores above 55.6 and below 78.7 as moderate, and scores of 55.6 or lower as low. The four ordered agreement response categories were converted to 25, 50, 75 and 100 points (from least to most favourable); "Unknown" and "Not applicable" were assigned zero according to the workbook. For domains with multiple criteria, the unweighted arithmetic mean of those criterion scores was used; single-criterion domain scores corresponded to the relevant criterion. The exact cross-domain weighting and composite-score formula were not documented in the manuscript and MUST be verified against the source workbook before claiming equal domain weights or full reproducibility. Thresholds are those of the source tool: low ≤ 55.6 ; moderate > 55.6 to < 78.7 ; high ≥ 78.7 . Scoring categories are ordinal expert judgements transformed numerically, not observed programme coverage or impact. Criterion scores were averaged within each domain as specified in Table 2. The exact weighting applied to the overall composite across the nine domains must be confirmed against the original Excel calculation formulas; no unverified weighting assumption is imposed here.



Table 1. Detailed operational definitions of the 15 AFROSAF criteria The definitions expand on the source manuscript labels and should be checked against the original instrument before submission.

Code	AFROSAF domain	Detailed operational criterion
A01	Health need	Contribution to universal health coverage and effective service coverage.
A02	Health need	Potential contribution to population health security and resilience.
A03	Health need	Potential to improve population health and equity.
A04	Development process	Whether the health-system problem addressed is explicitly defined.
A05	Development process	Whether the target population and intended reach are explicitly specified.
A06	Development process	Extent to which beneficiary needs, preferences and perspectives inform intervention design.
A07	Intervention content	Clarity of the intervention's core components and adaptability to local settings.
A08	Political context	Compatibility with current and foreseeable political priorities and conditions.
A09	Evidence for impact	Strength and relevance of evidence for anticipated benefits.
A10	Evidence for impact	Acceptability of additional effects or trade-offs arising from scale-up.
A11	Resource availability	Availability of finance, workforce, supplies and operational capacity for scale-up.
A12	Target unit / access barriers	Identification of barriers affecting intended users and feasible mitigation measures.
A13	Scaling setting	Suitability of the implementation environment for expansion.
A14	Scaling setting	Alignment with policies, organisational structures and institutional arrangements.
A15	Sustainability at scale	Likelihood that services, resources and institutional support can be maintained.

Table 2. AFROSAF domains, criteria and domain-level aggregation procedures

Domain	Criteria	Domain calculation
Health need	A01 UHC outcomes; A02 health security; A03 healthier populations	Mean A01–A03
Development process	A04 clearly defined problem; A05 clearly defined target population; A06 beneficiary orientation	Mean A04–A06
Intervention content	A07 intervention clearly defined with adaptable components	A07
Political context	A08 compatibility with current and foreseeable political environment	A08
Evidence for impact	A09 evidence of expected benefits; A10 acceptability of additional outcomes	Mean A09–A10
Resource availability	A11 availability of resources to support scale-up	A11
Target unit / access barriers	A12 access barriers identified and mitigation measures considered	A12
Scaling setting	A13 favourable context; A14 alignment with policy and institutional frameworks	Mean A13–A14
Sustainability at scale	A15 ability of the intervention to be sustained over time	A15

Outcomes and statistical analysis

The primary outcome was the composite scale-up potential score for each country-practice combination. Secondary outcomes were the nine AFROSAF domain scores and the classification of each observation as having high, moderate or low scale-up potential.

The completed Excel forms were combined into a single analytical dataset and checked for completeness and consistency of scoring. The analysis was descriptive. Means, standard deviations and ranges were calculated across countries and practices, and domain-level comparisons were used to identify areas of relative strength and weakness.

Inferential statistical tests were not performed because the dataset contained only 20 country-practice observations and the underlying ratings were based on structured expert judgement rather than probability sampling. The analysis was intended to describe patterns in readiness and identify relative strengths and weaknesses, not to make population-level statistical inferences.

Ethical considerations

The study used aggregated programme data generated through a scalability assessment exercise. No patient records, individual clinical data or personally identifiable information relating to service users or health providers were accessed or analysed.

Participation in the online assessment was voluntary. The national experts provided professional judgements about the selected practices and the conditions influencing their potential for scale-up. No personal or sensitive health information was collected or analysed.

RESULTS

Overall readiness and country patterns

Across the 20 country-practice observations, PPFP had the highest mean composite readiness score (87.96; SD 8.31), followed closely by CHWs (87.73; SD 4.85). Mobile outreach scored 81.25 (SD 12.57) and PAFP 79.86 (SD 11.70). Pharmacies and drug shops had the lowest mean score (63.89; SD 21.17) and the greatest variation between countries (Figure 1). The overall pattern by practice is illustrated in Figure 1, while country-specific scores and readiness categories are presented in Table 3.

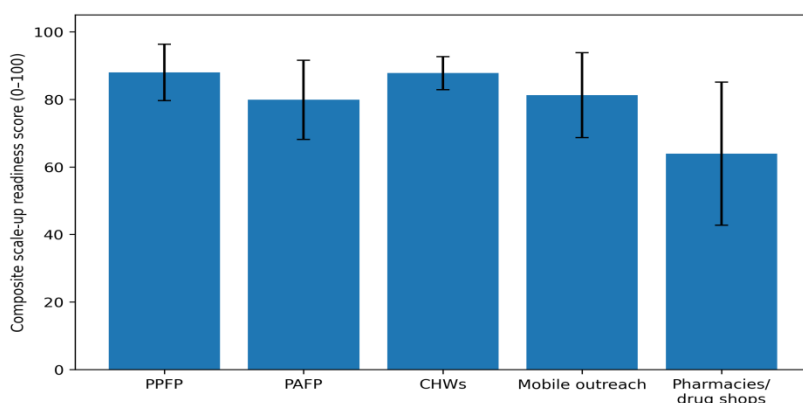


Figure 1. Mean composite scale-up readiness scores for five family planning High Impact Practices across Cameroon, Côte d'Ivoire, Mauritania and Togo. Error bars represent the sample standard deviation. PPFP, immediate postpartum family planning; PAFP, postabortion family planning; CHWs, community health workers.



When scores for the five practices were averaged within countries, Togo had the highest overall readiness (87.96; SD 7.19), followed by Cameroon (86.85; SD 1.87), Côte d'Ivoire (80.93; SD 14.59) and Mauritania (64.81; SD 17.76). Mauritania's lower average was mainly attributable to the pharmacy/drug-shop model and moderate ratings for PPFP, PAFP and mobile outreach rather than uniformly low readiness across all practices. Table 2 provides the 4×5 matrix of scores and readiness categories. Pharmacy/drug-shop provision ranged from 85.19 in Cameroon to 37.96 in Mauritania, compared with 56.02 in Côte d'Ivoire and 76.39 in Togo. Conversely, community health worker readiness was high in all four settings (82.87–93.52). These contrasting profiles suggest that country-level readiness varies across delivery platforms; they do not establish the causal contribution of individual health-system factors.

Table 3. Composite readiness scores and categories by practice and country

Practice	Cameroon	Côte d'Ivoire	Mauritania	Togo
Immediate postpartum FP	87.50 (High)	93.52 (High)	76.39 (Moderate)	94.44 (High)
Postabortion FP	86.11 (High)	83.33 (High)	62.50 (Moderate)	87.50 (High)
Community health workers	89.81 (High)	82.87 (High)	84.72 (High)	93.52 (High)
Mobile outreach	85.65 (High)	88.89 (High)	62.50 (Moderate)	87.96 (High)
Pharmacies/drug shops	85.19 (High)	56.02 (Moderate)	37.96 (Low)	76.39 (Moderate)

Practice-specific findings

PPFP was rated high in Cameroon, Côte d'Ivoire and Togo and moderate in Mauritania. PAFP showed the same pattern. CHWs were the only practice rated high in all four countries. Mobile outreach was rated high in Cameroon, Côte d'Ivoire and Togo and moderate in Mauritania. Pharmacies and drug shops showed the greatest variation, ranging from high readiness in Cameroon to low readiness in Mauritania (Tables 3 and 4). Table 4 summarises the dispersion of these scores across countries and shows the proportion of countries classified as having high readiness for each practice.

Table 4. Cross-country distribution of composite readiness scores by practice

Practice	Mean	SD	Minimum	Maximum	Range	High, n/4
Immediate postpartum FP	87.96	8.31	76.39	94.44	18.06	4-Mar
Postabortion FP	79.86	11.7	62.5	87.5	25	4-Mar
Community health workers	87.73	4.85	82.87	93.52	10.65	4-Apr
Mobile outreach	81.25	12.57	62.5	88.89	26.39	4-Mar
Pharmacies/drug shops	63.89	21.17	37.96	85.19	47.22	4-Jan

Cross-cutting readiness domains

At domain level, development process had the highest mean score (92.92), followed by health need (90.83). Intervention content (86.25), political context (85.00), evidence for impact (81.88) and sustainability at scale (81.25) also scored relatively highly. Lower scores were observed for scaling setting (76.88), resource availability (65.00) and target-unit/access-barrier readiness (61.25) (Figure 2; Table 4).

Figure 2 presents the distribution of the nine domain scores, and Table 5 reports their pooled means and standard deviations.

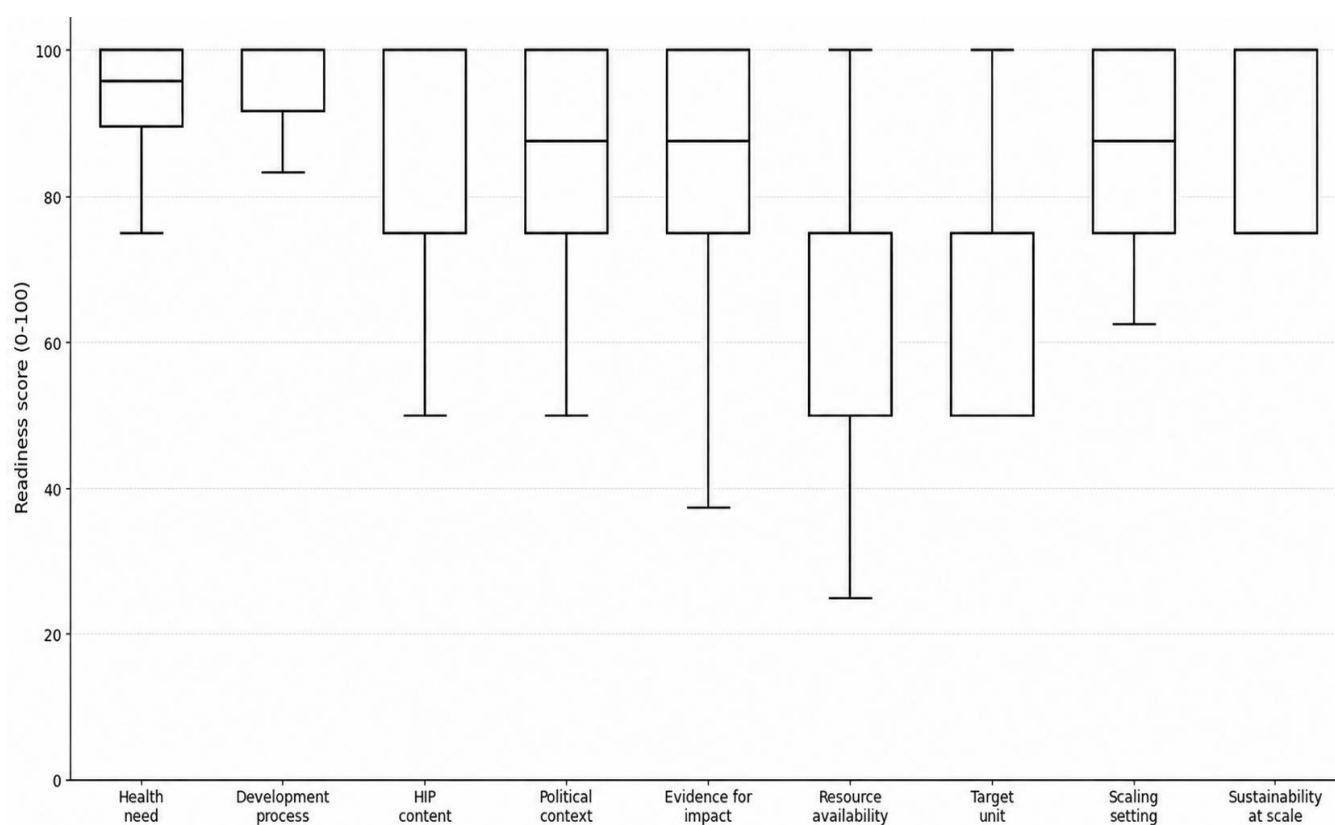


Figure 2. Distribution of AFROSAF domain scores across the 20 country-practice observations.

Boxes represent the interquartile range and median, and whiskers show the spread of the observations. 'Unknown' and 'Not applicable' responses were scored as zero in the source tool; therefore, some low scores may reflect incomplete information as well as limited readiness.

Table 5. Pooled readiness across AFROSAF domains

Scalability domain	Mean score	SD
Health need	90.83	12.65
Development process	92.92	13.32
Intervention content	86.25	26.25
Political context	85	17.01
Evidence for impact	81.88	21.64
Resource availability	65	29.69
Target unit / access barriers	61.25	33.91
Scaling setting	76.88	29.04
Sustainability at scale	81.25	36.16

Across several practices, high scores for health need and intervention development contrasted with lower scores for resources and access-barrier readiness.

DISCUSSION

This multicountry assessment found important differences in scale-up readiness across both practices and countries. PFPF, PAFP, CHWs and mobile outreach generally had favourable profiles, whereas the



pharmacy/drug-shop model was more dependent on national context. The findings show that evidence of effectiveness alone does not determine whether an intervention is ready for expansion. Financing, regulation, service-delivery capacity, supervision and institutional support remain important conditions for successful scale-up.

PPFP was one of the practices with the highest readiness scores. Childbirth provides a predictable contact with the health system and creates an opportunity to integrate contraceptive counselling and method provision into maternity and postnatal care [3,8,9]. The lower score observed in Mauritania, however, suggests that favourable evidence should not be translated automatically into uniform national expansion. Service organisation, provider capacity, commodity availability and national policy conditions still need to be considered.

PAFP also showed a favourable overall profile. Postabortion care offers an important opportunity to address contraceptive needs, but its institutionalisation can be influenced by the legal environment, stigma, provider attitudes and service organisation [4,10]. The moderate score in Mauritania supports the need for country-specific preparation rather than a single scale-up pathway for all settings.

CHWs had the most consistent profile and were the only practice rated high in every country. This finding is relevant to equity because community-based delivery can bring counselling, selected services and referrals closer to people who face geographic, financial or sociocultural barriers to facility use [5,11]. High readiness does not mean that CHW programmes require few resources. Sustainable implementation still depends on adequate financing, supervision, commodity supply, referral systems and integration within national workforce policies.

Mobile outreach also showed favourable readiness in most countries and may be especially useful where distance and sparse service networks limit access to a full contraceptive method mix [6,12,13]. Its implementation is nevertheless resource intensive. Transport, staffing, infection prevention, commodity continuity, quality assurance and follow-up must all function reliably. These operational requirements may explain why readiness was lower where resources and the wider implementation environment were less favourable.

The findings for pharmacies and drug shops were more variable. Private outlets can broaden access to short-acting methods and self-care products, but successful implementation depends on regulation, provider competence, quality assurance, product availability and functional referral pathways [7,14,15]. The wide range of country scores suggests that pharmacy-based family planning should be expanded selectively and only after the main regulatory and supervisory gaps have been addressed. The lower pooled score and greater between-country dispersion for pharmacy/drug-shop delivery may plausibly relate to variation in the authorisation and scope of practice of private outlets, training and competence of dispensers, contraceptive procurement and stock continuity, affordability and out-of-pocket payments, data reporting into public health information systems, supervision and quality assurance, and referral linkages to facilities for methods unavailable at retail outlets. These are mechanism-based interpretations rather than determinants empirically isolated by the current questionnaire; country-specific policy and service-delivery evidence is needed to determine which mechanisms explain each national rating.

The domain results help explain these differences. Health need and development process scored highly, while resource availability, readiness to address access barriers and the scaling setting were weaker. These domains are closely related to whether expansion can be implemented and sustained in routine services. WHO/ExpandNet recommends linking horizontal expansion with vertical institutionalisation so that geographic growth is supported by policy, financing and routine management systems [1,2]. More recent WHO guidance similarly emphasises stewardship, adaptation and learning rather than simple replication of an intervention [17].

Our findings are also consistent with recent evidence from Francophone West Africa, where PPFP and CHW approaches were relatively widespread while PAFP and pharmacy/drug-shop models were less consistently



integrated into national programming [18]. This pattern supports a sequenced approach to scale-up. Practices with high readiness may move towards wider coverage, while those with moderate readiness may first require targeted investment and those with low readiness may need additional diagnostic work or piloting.

Readiness assessment can also inform sustainability planning. Scale-up usually increases recurrent expenditure for commodities, transport, provider time, supervision, information systems and quality assurance. If these costs are not incorporated into national and subnational budgets, early gains may be difficult to maintain. WHO's recent guidance on postpregnancy family planning similarly identifies leadership, service delivery, workforce, information, commodities and financing as central to sustainable expansion [19].

STRENGTHS AND LIMITATIONS

A strength of this study is the use of a common framework across five service-delivery practices and four countries, which allowed structured comparison of different scale-up contexts. Linking AFROSAF with WHO/ExpandNet also helped connect measurement of readiness with broader implementation considerations. The study nevertheless has important limitations. Each country assessment was completed by a single SRH/FP expert, which may have introduced individual or institutional interpretation and did not allow assessment of inter-rater reliability or within-country disagreement. The scores reflect structured expert judgement and were not independently validated with facility, routine-service or population data. Assigning a score of zero to 'Unknown' and 'Not applicable' responses may have underestimated readiness when information was incomplete rather than genuinely unfavourable. The study was also limited to four countries, five HIPs and 20 country-practice observations, so the findings should not be interpreted as a general ranking of family planning interventions across Africa. Finally, the cross-sectional design reflects conditions at the time of assessment and cannot capture later changes in policy, financing, commodities, regulation or implementation capacity. "Readiness" in this analysis refers to expert-assessed enabling conditions at one point in time, not implemented geographic coverage, service quality, contraceptive uptake, method continuation, equity gains or cost-effectiveness. The single assessor per country precluded inter-rater reliability analysis and triangulation across government, professional bodies, private providers and service users. Future studies should include multiple respondents per country and independently measured implementation and health-system indicators. Rankings should be read as exploratory signals to guide country dialogue, not definitive performance league tables. Although the completed assessment in each country underwent review at a one-day workshop involving sexual and reproductive health departments and programmes, the initial scoring was performed by one expert per country. Workshop validation therefore strengthened institutional review but did not constitute independent multi-rater scoring or external validation against observed service-delivery outcomes.

CONCLUSION

Immediate postpartum family planning, postabortion family planning, community health workers and mobile outreach showed substantial scale-up readiness in the four study countries, although important differences remained between settings. Community health workers had the most consistently favourable profile, while pharmacy- and drug-shop-based family planning was more context dependent. Scale-up decisions should therefore be guided by both evidence of effectiveness and a realistic assessment of resources, access barriers, implementation capacity and sustainability.

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Authors' contributions

Wankpaouyare Gmakouba conceived the study, led the analysis and drafted the manuscript. Mazabalo Bini, Yao Dodzi Ganke and Labaguibe Gangak contributed to interpretation of the findings, critically revised the manuscript and approved the final version.



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Data availability

The consolidated analytical dataset is available from the corresponding author upon reasonable request.

Conflict of interest disclosure

The authors declare that no conflict of interest exists.

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