

An Improbable Success: The Ouagadougou Partnership's Advances in Family Planning Across Francophone West Africa

By Janet Fleischman



About the author

Janet Fleischman, an independent consultant on women's global health, was commissioned in 2019 by the William and Flora Hewlett Foundation and the Bill & Melinda Gates Foundation to write this report documenting the history of the Ouagadougou Partnership. She completed her research in January 2020, before the first cases of COVID-19 were confirmed in Francophone West Africa (in Senegal and Burkina Faso) in March 2020. Accordingly, this report does not address the impact of COVID-19 in Francophone West Africa or the challenges it presents to the Ouagadougou Partnership's activities.

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Cover image: Contraceptive methods user couple in Dangbo, Benin. Photo by Yves-Constant Tamomo for EtriLabs.

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Sometimes innovation to spur social change arises in unexpected places. In 2011, in Ouagadougou, the capital of Burkina Faso, representatives from nine Francophone West African countries joined with international donors to launch a simple but radical plan. The idea was to expand access to contraception in a region that was dramatically lagging behind the rest of the continent in maternal and child health. What became known as the Ouagadougou Partnership achieved a level of success that was virtually unimaginable at the outset, when even discussing family planning in such conservative societies was perceived to be taboo. Now, almost a decade later, the partnership's impact and lessons for other regions warrant both celebration and reflection.

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By focusing on the impact of family planning – often messaged as birth spacing – as a driver of other health and development outcomes, this unique partnership has generated new momentum and exposed new challenges for regional collaboration and donor engagement. Pape Gaye, Senegalese President Emeritus of IntraHealth, sees this as a central theme for African development: “It’s time for us to start not only touting the value and health benefits of family planning, but also what it’s going to do in terms of development.”

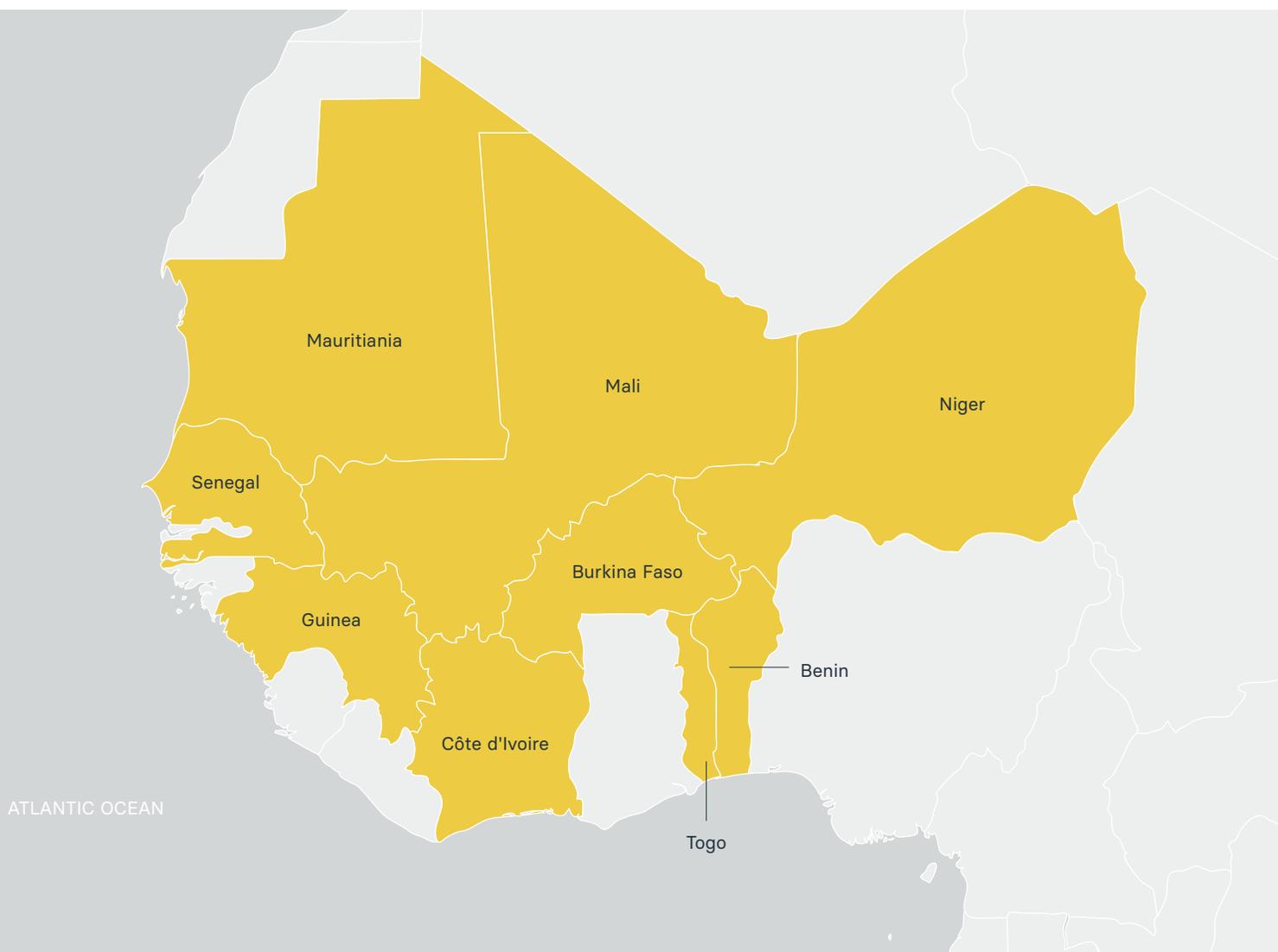
The nine Francophone countries of the subregion (Benin, Burkina Faso, Côte d’Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo) united around an ambitious regional goal – to reach

one million additional voluntary users of modern family planning methods by 2015, and 2.2 million more by 2020. The results have been impressive, especially given the low starting point of approximately 2.7 million users: by 2019, over 3.1 million additional voluntary users have been reached, Francophone West Africa has one of the fastest increases

in modern contraceptive rates among developing regions, and family planning funding from the core donors has more than doubled. Even more important for future prospects, the partnership has evolved into a dynamic and influential regional platform involving governments, donors, civil society, and implementing partners.

The story of this partnership reflects a unique historical convergence: a group of bilateral and philanthropic donors willing to commit to the subregion, country-level champions from government and civil society, supported by implementing partners, prepared to advance family planning for health and development reasons, and a shared interest in doing business differently to address egregious gaps in women's health and stalled indicators on family planning. By banding together, fueled by a shared commitment to achieving a regional goal, "friendly" competition among the countries, and grounded in data and evidence, the nine relatively small countries capitalized on their commonalities and made the region a more important geographic space and population size.

Map of the nine Francophone West African countries in the Ouagadougou Partnership.



This enabled the Francophone West African countries to outpace family planning progress in other developing countries, with a fraction of the resources. Examining how this improbable success came about is critical for understanding how the partnership can move forward and how its lessons can be applied to other regional efforts.

Regional Background and Inspiration for the Ouagadougou Partnership

The Ouagadougou Partnership (OP) was launched at a time when the health landscape in Francophone West Africa was alarming, accounting for some of the world's highest maternal, infant, and under-five mortality rates, and reflecting a considerable discrepancy with countries in Anglophone Africa. Underlying these data were some of the world's lowest family planning indicators and highest fertility rates, with modern contraceptive prevalence rates (mCPR) in Francophone

A mother with her baby during the 2017 OP donors caravan at the health and social promotion center of Sandogo in Burkina Faso. Photo by Senam Beheton for EtriLabs.



West Africa stuck and largely stagnant at an average 11 percent in 2011. According to Track20, which monitors progress toward achieving the goals of the FP2020 initiative, the mCPR among all women in 2011 ranged

from 14 percent in Burkina Faso to 10 percent in Senegal, to 7 percent in Mauritania; this compared with an average of 36 percent in Kenya. However, by 2019, those numbers had risen significantly, with the average mCPR in the OP countries reaching over 18 percent, and Burkina Faso at 27 percent, Senegal at 20 percent, and Mauritania at 10 percent.

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The impact of such low contraceptive use has resulted in some of the fastest growing populations, with the UN Population Division projecting that Niger alone will nearly triple by 2050, and presenting a critical challenge: would these countries capitalize on the dynamism of their youthful populations to advance economic growth and capture what is known as “the demographic dividend,” or would the pace of population growth in such low resource settings forestall improvements in economic development, health, and even contribute to insecurity?

In an interview in Ouagadougou, Prof. Nicolas Meda, the former Minister of Health of Burkina Faso, explained why these data sparked concern, “In West Africa, we were nine countries that found ourselves at a point in history where we were very behind in the process of the demographic transition.” He saw the partnership as means to address these issues: “Faced with that, we had to propose something that would permit our subregion to catch up. That’s the justification for the OP.”

In addition, the Francophone countries share other similarities that made a regional approach worth pursuing. They all have relatively small populations, a French colonial legacy evident in language, legal systems, and monetary policy (all but Guinea and Mauritania share the CFA franc), as well as many cultural and religious similarities. Underlying these issues is a complicated mix of unmet need (the percentage of women who do not want to become pregnant but are not using contraception) and high levels of desired fertility, cultural and religious sensitivities, and extensive

poverty and security concerns. For these reasons, according to Cheikh Mbacké, a Senegalese demographer who advises the William and Flora Hewlett Foundation: “Western and Central Africa was the last frontier for family planning and for the demographic transition in general.”

Despite the extreme health needs, the subregion had been effectively marginalized by global health donors, stemming from factors such as language barriers and the relatively small size of the countries. This was

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accentuated with family planning, which was considered too sensitive a topic in such conservative, pro-natalist countries. “These are hugely complicated personal, cultural, societal questions. It’s not just public health questions, like getting bed nets to people,” observed Margot Fahnestock, former program officer with the Hewlett Foundation. “It’s changing culture – that’s true for family planning writ large but really true in West Africa.”

Most donor support for family planning in sub Saharan Africa was Anglophone-centric, exacerbated when USAID closed a number of its missions in Francophone countries in the 1990s to cut costs. Scott Radloff, who was the director of USAID’s office of Population and Reproductive Health at the time, observed the challenges in the region: “Everyone saw that it was the region that lagged the most, that family planning was highly medicalized in that region, that there were many anti-contraception laws on the books from the French legacy, and that the French hadn’t promoted family planning in their former colonies in the way that DFID [the United Kingdom’s development agency] did with their former colonies.”

To change this dynamic meant confronting the causes of the abysmal indicators on maternal and child health and highlighting the positive role that could be played by increasing access to family planning. Prof. Coll Seck, former minister of health for Senegal, put it this way: “The added value of the partnership was that it put family planning and maternal health on the agenda nationally, internationally, and regionally in the least advanced countries.” She continued: “It was an instrument and a catalyst.” Although a few nongovernmental organizations were already working on family planning in the region, such as Marie Stopes International (MSI), the Population Council, and Population Services

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International (PSI), it was proving difficult to get much traction with the governments. Perri Sutton, a program officer with the Bill & Melinda Gates Foundation (BMGF), described how the partnership helped elevate the issue with the governments, noting: “It emerged out of a place of a lack of awareness, attention, priority for an issue that was absolutely core to women’s lives and to the development of this region. It was like nobody had turned the lights on for family planning in this region; there was indifference.”

Genesis of a Regional Partnership

When President Barack Obama took office in January 2009, those working on family planning in the US government realized that they faced an opportunity to elevate areas of global health that had not been prioritized under the George W. Bush administration. While attention to certain areas of global health had accelerated under Bush, through the creation of the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI), family planning was not among them, although the U.S. remained the largest donor to international family planning. In addition, U.S. presence in West Africa had been significantly diminished in the 1990s, when USAID closed a number of its missions in Francophone West Africa and reduced its operating budget.

In his first week in office, President Obama repealed the Mexico City Policy, which prevented foreign NGOs that received US support from performing, counseling, or advocating about abortion and thus denied U.S. funding to many women’s health and family planning programs. The repeal opened the door for USAID to resume support for organizations like the International Planned Parenthood Federation (IPPF) and its affiliates, and more broadly to re-engage on international family planning and reproductive health issues. The Obama administration also brought a new mantra on the importance of developing new global partnerships. All of this led some USAID officials to see an opportunity for the US to help accelerate family planning in the Francophone West African subregion.

At an IPPF meeting in London in 2009, representatives from the Hewlett Foundation and USAID decided to approach the French government about forming a partnership to advance family planning in Francophone West Africa. Scott Radloff from USAID, Sara Seims from Hewlett, and Monica Kerrigan from BMGF then met with representatives of the French government and proposed an initiative on family planning in West African countries that were of importance to the French, including four countries where USAID had missions (Mali, Guinea, Benin, and Senegal).

The purpose of reaching out to the French was to build on their unique role in the region and to encourage the French to engage more in sexual and reproductive health (SRH). Sara Seims explained why that mattered:

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“In the end of the day, nobody else had the influence with the medical and educated elite except the French.” The problem was that family planning and SRH were not on the agenda of the French government at the time.

They did, however, have financial and political interests in broadening collaboration with American entities, and had recently elevated attention to maternal and child health, linked to the G-8 meeting in Muskoka hosted by the Canadian government in 2010. Based on Canada’s call to reduce maternal, newborn, and under-five mortality in developing countries, France

launched the French Muskoka Fund for 2011–2015, 500 million euro per year focused on maternal, newborn, and child health in Francophone West Africa (the nine countries that became the OP plus Chad), to support the work of UNFPA, UN Women, UNICEF, and WHO. This was the first time that the French contributed to SRH as part of its international development strategy, which provided a hook for possible French investments in family planning in the OP countries.

Serge Rabier was the executive director of the French NGO Equilibres & Population, which conducted SRH advocacy with the French government, and he is now with the Agence Française du Développement (AFD). He explained that this increased French interest was due, in part, to the influence of French academic researchers, who saw the importance of supporting the demographic transition in Francophone West Africa for development in the region. As Rabier put it: “So it was not only an

argument on health, but it was also used with politicians to show that it was also an economic issue and a development issue.” In addition, French interest in engaging with USAID and the American foundations was related to their changing status in the region: “The fact was that French diplomats started to realize that France alone couldn’t cope with all the issues in the Sahel,” Rabier noted.

A key element that drove the creation of the partnership, but also contributed to an underlying fragility, was the importance of the personal relationships and committed individuals who propelled this early phase. On the American side, each donor had dedicated staff that were personally and professionally knowledgeable and passionate about the region: “In the beginning, when we were facing challenges building the donor partnership, there was a committed set of drivers, worker bees, that had strong connections to the subregion, a commitment to the Sahel, that goes back to all of them spending Peace Corps there,” one of them noted. “There were moments when we wanted to give up, but we were committed to the needs of the region, which

A young lady with her bike at the health and social promotion center of Sandogo in Burkina Faso.
Photo by Senam Beheton for EtriLabs.



helped us figure out how to get the donor partnership to work together.” Those who were involved in the early days of the partnership speak of a special chemistry and a commitment to change the status quo and transform access to family planning in these countries. “There was something very special about the people who worked on this. It was more than just a job – it was a passion and a desire to see these countries be successful,” noted Kerrigan.

Launch of the Ouagadougou Partnership

The donor group decided to hold a conference in Ouagadougou in February 2011, hosted by the government of Burkina Faso, under the name: “Population, Development, and Family Planning in Francophone West Africa: Urgent Action Needed.” Over the course of three days, some

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The conference was largely organized by Equilibres & Population, with a grant from the Hewlett Foundation. “The idea was to have a high-level splash, an advocacy moment; to put a big stamp in a place where it hadn’t happened before,” explained Margot Fahnestock.

Some of the key participants in the conference, such as Pape Gaye of IntraHealth, said that the launch of the partnership coincided with growing impatience with the region being

stuck in the same place on family planning. He saw this as rooted in myths that sub-Saharan Africa didn’t need family planning, that it was a Western import, all of which fueled a lack of country ownership. In his presentation at the conference, he tried to tackle this head on: “It was a lack of leadership with the same excuses,” he said. “We heard the same arguments 20 years ago! We can’t afford this anymore.”

To navigate the cultural sensitivities around contraception, the OP's messaging emphasized using contraception for birth spacing as a way to save the lives and protect the health of women and children, rather than limiting the number of children. This reflected the cultural and religious norms in the region that contributed to high desired fertility rates and where birth limitation was still socially stigmatized.

On the country leadership side, a network of national champions was essential to driving the partnership forward. The early leadership included Prof. Coll Seck in Senegal, Dr. Goudou Coffie in Côte d'Ivoire, Prof. Abdourahmane Diallo in Guinea, Prof. Meda in Burkina, as well as their key staff in the ministries of health, like Dr. Bocar Mamadou Daff in Senegal and Dr. Adama Kémou of Niger. Cheikh Mbacké referred to the leadership of Prof. Coll Seck and Dr. Daff as "the dream team." He continued: "They believed in family planning... they were able to move things. All the countries that made serious progress were due to that kind of leadership."

Group of OP stakeholders in Dakar, Senegal. Photo by Senam Beheton for EtriLabs.



New Tools – Development of Costed Implementation Plans (CIPs)

At the launch conference, the countries broke off into working groups with donors and implementing partners to set out their family planning priorities and strategies, as well as the funding gaps. However, the action plans that emerged were not “actionable;” they lacked the context of an overall strategy that would facilitate donor alignment.

The first concrete expression of the collaboration among the OP donors was to help countries prepare Costed Implementation Plans (CIPs), which was based on an effort that had been supported by USAID in Tanzania. The partners realized the potential value of developing these roadmaps with credible budgets, primarily as a way for countries to achieve better alignment of resources against their strategies and goals.

Accordingly, USAID funded FHI to support Senegal in developing its CIP and BMGF funded the consulting firm McKinsey & Company to assist Senegal as well as Burkina Faso and Niger, with the added goal of documenting the process to support replication by the other countries. USAID also funded Futures Group (now Palladium) and Hewlett funded the Futures Institute (now Avenir Health) to assist additional OP countries in developing CIPs. The CIPs became the foundational, organizing documents, which were designed to promote collaboration among donors, governments, civil society, and implementers. The idea was that the partners could come together and look at the same strategy, map donor and domestic financing, and identify the gaps in financing, which in turn would hopefully influence and align the donors.

Equally importantly, the CIPs promoted greater country ownership in defining the priorities and approaches appropriate to their specific context. In this way, the CIPs became tools for planning, advocacy, and negotiating alignment around national priorities.

Modibo Maiga, who helped several countries develop their CIPs through his work with Futures Group, noted that the countries soon saw the value of having a costed plan, and that civil society became engaged in the technical committees to develop the plans. Importantly, he said, “countries are very proud, they have strong ownership of it – they say it’s our CIP, not the partners.” According to Senegal’s Dr. Daff: “We always

said we wanted to get to 40 or something percent [mCPR], but we never costed it. This was a more scientific approach, that permitted us to understand what we were proposing, the impact on funding, effort, activities. How much would contraceptives cost? Training costs what? Which partners would be involved?"

The first CIPs were being developed in the lead up to the FP2020 London Summit in July 2012. Some of the donors hoped that, if the OP countries could present the CIPs at the summit, they might attract new funding for their country priorities. The OP ministers of health were invited to the summit to make commitments on family planning, which served to elevate family planning to the highest levels of the ministries. The London Summit marked the first time the OP participated on the global stage as a group, represented by Prof. Meda. Prof. Coll Seck noted that importance: "We went to London as the Ouagadougou Partnership."

"Things started clicking then," one USAID representative recalled. "The London Summit was announced for July 2012, and Burkina and Senegal were going to position themselves to make pledges, based on CIPs. It started to gel." FP2020 was inspired by the OP's CIP process, and soon thereafter adopted the CIP process for their other participating countries. The formula made sense: based on a CIP, a country would set goals for family planning and would make pledges toward achieving those goals, which donors could support.

Creating a Structure – The OPCU

It became clear that if the partnership was going to get traction, there needed to be an on-the-ground presence in the region and coordinating structure for the active donor group. Based on recommendations from McKinsey, the partnership decided in 2012 to establish a coordinating body in Dakar, Senegal, known as the Ouagadougou Partnership Coordinating Unit (OPCU). The partners decided to house the OPCU at IntraHealth.

Funding for the OPCU raised other issues. Neither of the bilateral donors, the US and France, were able to fund the OPCU. According to USAID's Scott Radloff: "There was good will between the donors, a recognition that each donor had unique strengths. We ruled out the idea for a central



Ouagadougou Partnership Coordination Unit team at the 2017 OP donors caravan in Niamey, Niger. From left to right: Rodrigue Nguana, Marie Ba, and Fatimata Sy. Photo by Yves-Constant Tamomo for EtriLabs.

fund for this [the OPCU], but would find some way to keep the partners coordinated.” The Hewlett Foundation had more flexibility in how it operated and agreed to fill the gap. Accordingly, Hewlett, then joined by BMGF, provided the initial budget of \$350,000 for two years. That budget has now grown to approximately \$3 million per year.

The OP needed a leader to run the OPCU who could work with the countries and the donors. Nothing proved to be as critical to get the partnership off and running as the hiring of Fatimata Sy. She brought deep experience in international organizations and regional realities, having worked with USAID, the World Bank, the Global Fund to fight AIDS, Tuberculosis and Malaria, and FHI360, combined with remarkable acuity in diplomacy and a graceful presence. “We brought our best selves and our organizations to the partnership, but until Fatimata, we couldn’t bring the country governments with civil society. She had the cultural gravitas to open doors at the highest levels of the ministries and the foundations,” Monica Kerrigan noted. “She was the perfect mixture of smart and strategic and incredibly committed.” Many observers credit Sy with forging relations with all stakeholders, not only governments but also women’s groups, other civil society actors, donors, and implementing partners.

Fatimata Sy worked to conceptualize the OPCU’s roles and functions, and focused especially on coordination. As she explained: “We don’t

implement, but we're going to be a platform to coordinate the donors, the countries, and to coordinate the donors with the countries." She also recognized the need to facilitate exchanges between the participating countries, and to give them the space to discuss among themselves, just like the donors were communicating among themselves. Importantly, Sy also saw the imperative to pull in other regional actors into the OP's strategic leadership, notably UNFPA and the West African Health Organization (WAHO), which were not part of the initial donors group.

Implementing the Vision

Phase I – Urgency to Act (2011–2015)

Phase II – Acceleration (2016–2020)

All the partners understood that the OP needed to focus on supporting country priorities. To accomplish this, the OPCU conducted two main events every year – the annual meeting and the donor caravan. These events were a way to both reward progress toward reaching the OP goals and to nudge those lagging behind.

Government representatives credit the OP with providing a platform for collaboration and sharing of best practices, and introducing constructive, "friendly" competition. Prof. Meda summarized how this moved the partnership: "If you want to go fast, go alone; if you want to go far, go together, as the saying goes. So to go together, we had to benefit from the experiences of other countries, and transfer it to others. We had to avoid the errors that some countries committed that could delay our progress and mutually encourage each other to go in the same direction. So there was added value to do better together."

Prof. Coll Seck emphasized the importance of the partnership and its meetings in presenting the countries with "the reality of our strategic choices," but also the mutual sense of comfort and familiarity that the countries had with each other, culturally and linguistically. "Personally, it helped me reflect and put in place strategies for Senegal. The meetings were between the [OP] countries, and we could speak French. It was the only meeting where we were so comfortable, where everyone understood each other."

Annual meeting

The annual meeting of the OP is the most important expression of the partnership's value and impact. This meeting provides an opportunity for all the partners to come together and to track national and regional progress. But equally important, it allows for frank dialogue between and among the different countries and actors. The annual meetings build synergies and coordination, assist countries to identify gaps to share high impact practices, while also helping to mobilize resources. As George Guiella, a Burkinabé demographer, noted, "It brought a new way of working, with clear objectives that pushed countries to provide more resources for their commitments. Every year you will be asked [about the country progress], and that wasn't there before. It's extremely important. It's a platform that reminds you of your commitments and asks where you are, and that accountability wasn't there before."

At a donor meeting in 2012, which was jointly hosted by AFD and the French Ministry of Foreign Affairs in Paris, the OP identified the need to articulate a regional goal. Although at the time there was little data to inform the goal, they decided they would aim for one million

additional contraceptive users for 2012–2015.

This was based on the limited available population data and historical growth trends. "We did the best we could in estimating it, and it represented tremendous growth," Perri Sutton from BMGF recalled. It is worth underscoring that this goal was extremely ambitious for the OP countries, since it meant that each of them would have to double their contraceptive prevalence rates in four years.

"It's a platform that reminds you of your commitments and asks where you are, and that accountability wasn't there before."

Success created more momentum for the partnership as well. The number of participants in the annual meetings is an illustration of the growing interest, starting with around 80 and growing to 400 in Cotonou in 2019. Those who took part in the early meetings described the excitement and inspiration that came from seeing and celebrating the regional progress toward achieving their ambitious goal. "Something is bringing them together – increased interest in the OP is the glue," Marie Ba, the new director of the OPCU, said. She described the value of the annual meeting: "People see the bigger picture. It helps countries identify bottlenecks and the OP helps come up with some solutions."

Many observers noted the new accountability that was introduced by the annual meetings, where governments were asked about their progress; if the objectives were not met, they had to explain why. Dr. Daff elaborated: “The annual meetings are the most important. People pushed for change. If people aren’t convinced, it won’t progress. If you don’t understand, you stop. To have regular meetings on the basis of defined plans – here are our activities, here’s what we’re lacking, here’s where we want to go. You listen to recommendations and criticism, which can be the most meaningful.”

According to El Bashir Sow, a Senegalese journalist who attended several of the annual meetings: “What I saw was people getting together, setting goals, saying what they will do in a year. I saw the delegations the next year show the results, and explain what didn’t work, and you could see they were bothered by it. The OP initiated a different way of working.” He continued: “Honestly, I saw enthusiasm at the annual meetings.”

Benin's Health Minister, Pr. Benjamin Hounkpatin, during the OP 8th annual meeting opening ceremony in Cotonou, Benin. Photo by Yves-Constant Tamomo for EtriLabs.



Setting Goals

Through the process of developing the CIPs, countries were for the first time setting goals for family planning, so experience and additional data were needed to bring the goals more in line with ambitious yet realistic acceleration of progress. In the early days, since this was a new process, it often involved an incomplete use of the data, which led to setting often unattainable goals. “They were so ambitious, they wanted to show their commitment, but they didn’t discuss achievability as part of accountability,” recalled Emily Sonneveld from Track20, which supports the OP with the data.

As the data improved, each country was able to set more realistic goals. The discussion focused more on what each country could achieve in the next five years and how groups like Track20 could help them measure that in a reasonable way. Sonneveld considers that the OP elevated the role of data, which she sees as “a step in the right direction around accountability. We’re not there yet, but having goals and annual progress toward those goals publicly available provides the transparency that is a crucial step in accountability.”

Shared Commitments and Friendly Competition

A feature of the OP that many observers highlight involves the “friendly competition” engendered by the partnership, a form of intensified south-to-south learning. Many of those involved commented on that dynamic, and how it played out in the annual meetings. Dr. Yolande Ky, director for family health at the Ministry of Health of Burkina Faso, put it this way:

“The advantage of the OP is that each [country] is accountable, and other countries watch us.” He continued: “It’s a powerful motor that stimulates countries to work harder.”

“The advantage of the OP is that each [country] is accountable, and other countries watch us.”

Ruth Levine, former Program Director for Global Population and Development at the Hewlett Foundation, provided further reflections on the importance of this competition for the

countries and the donors: “The successes of the OP were derived from the phenomenon of peer pressure across the governments of the region and across the donors. This peer pressure was reinforced by information

sharing in public settings.” She continued: “It made you fight harder to look good around the table.” She concluded that this presents lessons about exploring who are the right peers to influence the key decision-makers, and finding ways to take advantage of those incentives.

Others pointed to the importance of sharing experiences and innovations from different OP countries, many of which were led by NGOs like DKT, PSI, and MSI, which drove innovation and the introduction of new methods and practices. These included a range of areas, such as: task shifting to “de-medicalize” the provision of contraception, the introduction of self-injection (DMPA-SC/Sayana Press), mobile clinics, social marketing through pharmacies, “husbands schools” to engage men, sub-national budgets for family planning, and creating a national week of family planning. Discussions also concerned the allocation of national budget lines for family planning, often for purchasing contraceptives.

Many referred to the sense of pride that was evident around the regional results that they achieved. As one USAID representative noted, “These are intangibles that should not be underestimated. I think the countries had a sense of pride in being part of this and wanted to be the best.” Above all else, representatives from different governments, civil society, and donors described the OP’s catalytic effect as a facilitator and as a platform for advocacy. As Prof. Coll Seck noted: “We were so far behind, there were so many bottlenecks and challenges, but we felt that we were reflecting together, not that we were being manipulated or pushed to do something.”

Donor Caravans

Fatimata Sy established a donor “caravan” to enhance efficiencies and coordination by visiting two or three OP countries to see family planning activities linked to the partnership’s goals at the country level. The caravan was a response to a problem cited by countries that it was challenging to coordinate priorities and funding with multiple donors, especially when the donors visited at different times and participated in different sets of meetings. The caravans involved meetings with policymakers, funders, young people, and religious leaders, as well as site visits. The caravan became a yearly event to show the partners, especially the donors, the realities of different OP countries, as well as helping the countries understand the benefits for them of engaging with the OP

and family planning. As one USAID representative put it: “We tromped around to each other’s countries. We got out of our chairs and went, and that never happened before.” Another USAID representative saw the caravans as a way of keeping the human contact among the partners: “The caravans bring that – you see the impact on the community level, you see the impact at the broad level, how donors support the most vulnerable mothers and children.”

One of the clearest benefits of the caravans involved the advocacy opportunities provided through the meetings with high-level government officials. George Guiella, the demographer, explained that the caravans provided “a hat to protect them [the partners] to do advocacy under the cover of the OP. Otherwise, if you just go to Niger to discuss family planning, not many people will talk to you. But the OP has weight, is listened to and received at the highest levels.” He also described the positive impact of these group visits: “When the OP meets with authorities, it’s to congratulate them on their efforts and to encourage them to continue with their commitments. It’s difficult to go backwards after that – it brings the countries to engage and leads to more impact.”

The caravans sometimes yielded unexpected returns. The caravan that visited Burkina Faso in 2017 was received at high levels, including by President Roch Marc Christian Kaboré, which served to mobilize the other ministers and increase the government’s commitment to family

Visit to a community-based distribution center in Téméré, Niger, by a delegation of OP donors lead by Marie Ba. Photo by Yves-Constant Tamomo for EtriLabs.



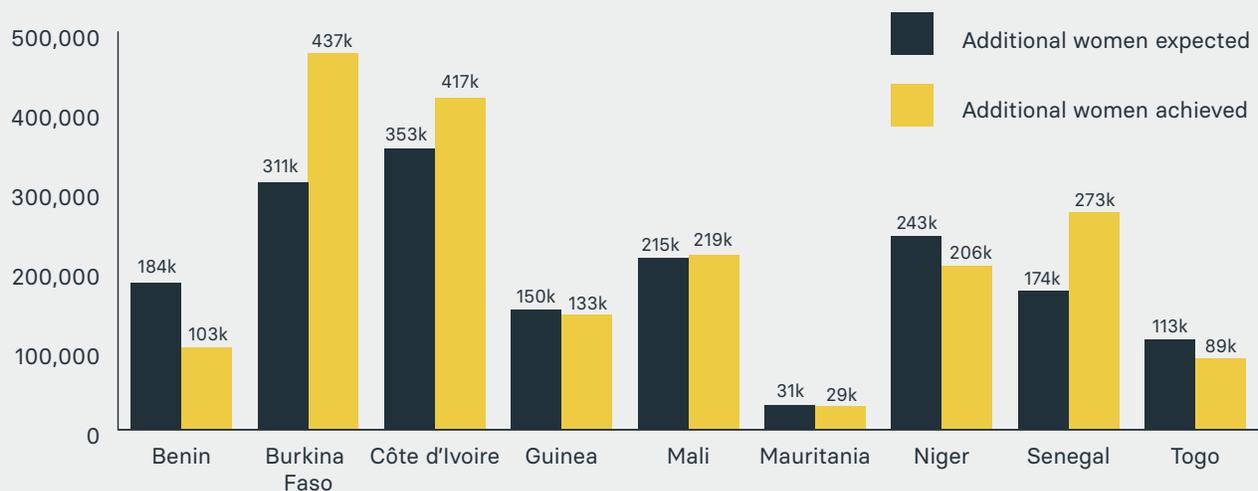
planning. This strong showing for family planning helped stimulate more donor interest in Burkina Faso, which in turn reinforced the country's engagement, and contributed to Melinda Gates's decision to visit Burkina Faso in 2018. This then led to the Bill & Melinda Gates Foundation signing an MOU with the government in September 2019 for increased coordination and support for agriculture, health and nutrition outcomes, including family planning as a key intervention area. "If not for the OP, we wouldn't have been able to do this," a USAID representative explained.

Focus on Data and Accountability

When the partnership was created, there was little in the way of data or mechanisms in place to track progress. The best available data usually came from the Demographic and Health Surveys (DHS), which were conducted every five years at best (although in 2012, Senegal initiated a continuous DHS, conducted every year). As each country needed better data for the CIPs, the dearth of reliable data presented a potential roadblock to understanding where the countries actually were and how they might advance. Once all nine countries had developed CIPs, the next step was to find ways to effectively track that progress.

To bolster capacity in national family planning programs, additional support was introduced through Track 20, with funding from BMGF. Track20 works with the FP2020 participating governments to access and use data to monitor progress toward FP2020's goals. While the OP is part of FP2020, Track20 undertook specific support to the OP countries with methodology, tools, and resources to calculate and validate their family planning data. These are the data that are presented at the annual meetings. The data monitoring was also improved through the work of PMA 2020, which included three OP countries – Burkina Faso, Côte d'Ivoire, and Niger – in its work on data collection and rapid surveys.

The OP's regional goal itself created a new sense of shared accountability. Many early participants referred to that sense of driving toward a bigger goal, beyond one's own country's goal as central to the regional momentum. Since the data from each country were shared, everyone could see clearly which country was contributing what to that regional goal. Fahnestock from Hewlett explained how the data helped motivate the partnership: "We started to see results in family planning, and we can't ignore that it drove everyone forward. If we hadn't seen



Comparison of additional women expected vs. additional women added in the nine Ouagadougou Partnership countries during the acceleration phase (2016–2019).

improvements in family planning through data, the partnership wouldn't have held together – we wouldn't have had credibility.”

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As the OP evolved, so too did the data. Instead of just looking at the annual progress, countries could be more strategic in how they prioritized their family planning investments to achieve the largest increases in mCPR within their strategies. The data showed the inequities in donor funding, which was then used to advocate for more domestic and international resource mobilization. In addition, the data showed that most of the country investments were in the supply side (services, commodities), but

not in building additional demand for family planning. This raised red flags that, inevitably, the momentum would slow without more intentionally addressing demand-side barriers to contraception.

Civil Society Engagement

The independence of civil society was limited in the OP countries, with little engagement on family planning issues and few examples of civil society holding their governments accountable. The OP provided an opportunity for civil society to grow in that space. While civil

society organizations were only marginally involved in the conference that launched the OP, a separate civil society meeting was convened in Senegal later in 2011, supported by USAID. The OPCU's work with civil society was strengthened with the addition of Rodrigue Ngouana, who accelerated the engagement of civil society and youth.

The involvement of civil society in family planning and health issues was new to most of the countries. "Family planning was seen as the business of medicine, of health," noted El Bashir Sow, the Senegalese journalist. He credited Fatimata Sy and the OPCU with giving "more vigor" to role of civil society. Sy herself saw the need for those "interconnections" and "mini-partnerships" to build a big movement for family planning. In general, civil society has been underappreciated, but as the OP developed, the role of civil society and implementing partners has grown.

In 2011, through a grant from the Hewlett Foundation, a new initiative was launched called Strengthening Civil Society for Family Planning in West Africa (CS4FP), which was later supported by the Netherlands as well. This has grown into a coalition of NGOs in all the OP countries. The goal is to strengthen the capacity of civil society organizations in advocacy and resource mobilization, and in the political dialogue with their governments. In addition, beginning in 2013, BMGF and AFD have co-funded a complementary civil society alliance through Equilibres & Population, a collaboration that emerged from the 2012 OP Annual

"The OP changed by involving civil society in policy development in all nine countries."

Meeting. "The OP changed by involving civil society in policy development in all nine countries," said Ousmane Ouedraogo, secretary general of the regional civil society coalition, "It was not a theoretical engagement; it stemmed from the CIPs. We positioned ourselves within that."

In 2015, the OP and CS4FP organized a workshop to help each country establish a civil society coalition with a formal structure and a charter. The group helps determine how civil society will contribute to the OP and to monitor their country's commitments. This also allowed better networking between countries, with the goal of finding ways to work together on a regional basis. This included facilitating exchanges between the countries, helping religious groups to visit each other, as well as youth groups and other technical exchanges. The OP received

some additional funding from BMGF and Hewlett to expand these regional exchanges.

Safietou Diop, president of Senegal's civil society coalition, spoke about how the OP brought the civil society partners from the region to the table: "We got together and saw the same traditions, situations in the region with cultural practices that were barriers to development. The common denominator in Guinea, Senegal, Mali [and elsewhere] was population growth. Having children too early, too late, too many – it kills women, and eliminates efforts and investments in education, health, the economic environment. We need a common effort or it will be devastating – we have a common destiny."

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Imam Moussa Fall, a religious leader in Senegal, described how the different civil society groups and alliances under the OP were sources of inspiration for each other. "We were inspired by the youth alliance, the parliamentarians and journalists who knew each other. Why not us?" This led to the creation of the religious alliance at the Abidjan meeting in (2014 or 2015), and the creation of groups in each country, and increased the collaboration between and among religious leaders in the OP countries.

The engagement of religious and customary leaders in the OP has been a critical element to build support for family planning, and the OP played a key role in linking the religious leaders with ministries of health. Given the strong ties among the religious leaders in the subregion, many have underscored the potential for even greater involvement in the OP and family planning, which one

referred to as "untapped potential." "Nothing can be done [in the region] without the religious leaders, and [the OP] understood that we had to be involved," according to Imam Fall. Dr. Daff credited the OP with engaging the religious leaders: "There was always a fear – people won't dare talk about family planning because they were afraid of the religious leaders."

That said, complexities have been evident, especially for those religious leaders who have a different perspective on family planning. Saliou Mbacké, the vice president of programs in the Alliance, expressed concerns about the language being used by the OP that does not always align with “religious messaging.” This includes using the term “sexuality” or even the word “sex.” “Language matters, the approach matters,” he said. “We talk about birth spacing, in line with religious values.” He called for the OP to “allow religious leaders to be protagonists in framing the message.”

A noticeable tension exists in the OP’s civil society efforts between the weight of the religious leaders, on the one side, and the rising voice of youth, on the other. As Safietou Diop put it: “The religious leaders see the world in a certain way, as opposed to the youth who want to address their problems – they see it as existential.”

The OP has elevated the voices and engagement of young people, based in part on the realization that youth now constitute over half of the

Youth ambassadors for Sexual and Reproductive Health and Family Planning during the OP 7th annual meeting in Dakar, Senegal. Photo by Yves-Constant Tamomo for EtriLabs.



population in these countries – 65 percent of the population are under 24 in Burkina Faso – and that they have distinct needs and

Young people are also raising significant issues that often challenge traditional social norms, notably involving access to contraception for unmarried youth.

perspectives that have to be addressed and reflected in plans, strategies, and programs. Young people are also raising significant issues that often challenge traditional social norms, notably involving access to contraception for unmarried youth.

At the start, youth leaders were simply invited to the annual meetings, but the OP soon moved to develop youth champions who would be part of the team that developed the country's action plans. The youth are now represented in the OP by youth ambassadors, and their participation

has led almost all the OP countries to include family planning for youth as a priority under the CIP. In addition, the OPCU is developing a new strategy for youth, and is working to ensure that they play a more institutionalized role in OP activities, including through a youth “think tank” to influence training and research. Importantly, youth were highlighted at the 2019 annual meeting.

However, identifying the best models to reach young people with family planning information and services remains a key challenge in all the countries, and diversifying the youth representation – to include those in and out of school, married and unmarried – has yet to be fully realized.

Moukailou Ouedraogo, the president of the youth ambassadors, said the OP had amplified and reinforced the role of young people: “When youth feel engaged and validated, it reinforces their commitment to the cause.” He raised the examples of how the youth have organized to press governments about specific commitments, such as increasing the budget for family planning for youth services in the CIPs, providing free contraceptives, creating for youth centers, and providing quality family planning services for youth.

The OP also reached out to journalists to report on family planning in their countries. This included establishing a prize for reporting on family planning sponsored by the OPCU and the Population Council, with the winner announced at the annual meeting. Journalists have also been invited to participate in the caravans. Some journalists

interviewed felt that these efforts by the OP validated their work and gave them institutional cover. Boureima Sanga, a Burkinabé journalist with *Sidwaya* who won an OP prize for his reporting in 2014 and 2017, expressed “great satisfaction to be appreciated,” and said that “we worked on SRH, but through the prize, others learned about it. So we gained visibility with our colleagues and the feeling of participating in attaining the OP’s objectives.”

Next Phase: Acceleration

At the 2015 annual meeting, Emily Sonneveldt from Track20 presented the results of the first five years. The OP had actually surpassed the goal of 1 million additional voluntary users, reaching almost 1.2 million. At that meeting, the partners discussed whether the OP should embark on a second phase, and if so, what the new goal should be for each country and for the region. The countries were ambitious and wanted to double the number, but the OPCU was more cautious and proposed a 15 percent increase per country, based on an analysis of where high impact interventions might be implemented. They therefore set a new goal of 2.2 million additional users, which represented an ambitious

yet achievable acceleration of recent trends.

As Fatimata Sy said, “Commit to what’s possible, and if you surpass it, all the better.”

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Before launching the new phase of the OP, the partners had to decide what their vision was for the partnerships and if they wanted to continue it or to merge into FP2020. They ultimately

decided not to merge but to continue with both initiatives and to find new ways to collaborate with FP2020. The OP’s mandate was extended to 2020, which meant that the CIPs had to be revisited for the new goals.

For those involved at that juncture, there was a sense that all the ingredients were present to truly accelerate progress, based on the lessons of the first phase. “We were confident,” Fatimata Sy remember. “They started calling me Madame Accelerator.”

Progress Toward Regional and Global Impact

Beyond its work to propel progress toward country-level and regional goals on family planning, the OP's global impact can be seen through its contributions to FP2020. It is clear that the OP influenced FP2020, and that the OP is considered to be a success story for the new way of working on family planning.

FP2020 was launched in July 2012 and includes 69 countries, nine of which are the OP countries. Although West and Central Africa are usually the last in CPR, the OP region is cited by FP2020 as an example of where the family planning objectives have been reached. In 2015, when FP2020 assessed the progress of all the regions, the OP was the only region to achieve the goal it set for itself. This was an important moment that showed not only that the OP had a seat at the global table, but that it had demonstrated progress that other countries and regions had not matched.

The collaboration between the OP and FP2020 continues to broaden, with the OP bringing regional credibility to FP2020's objectives. FP2020 and the OP share many of the same donors and country focal points. "The OP

A community health worker in Kaolack, Senegal providing women in her community counseling and post natal care at her home. The women are also given counseling about reproductive health issues and family planning. Photo by Jonathan Torgovnik/Getty Images/Images of Empowerment.



and FP2020 are sister efforts and have adopted each other's innovations through the years, like the focal point structure and the CIPs," noted Janet Holt, a program officer with the Hewlett Foundation.

The OP is keen to make sure that FP2020 shares lessons learned and avoids duplicating efforts. From the OPCU perspective, "if you work here, you work in collaboration with us," Marie Ba said. "We are proud of what we contributed to FP2020." Pape Gaye reflected on how FP2020 and the OP show that coalitions can work, especially with smaller countries, where donors often are reluctant to put money. "There is a lack of real south-to-south collaboration and missed opportunities when countries don't share, so the [Ouagadougou] partnership is teaching FP2020 and the world that there are opportunities that aren't leveraged when we're not working in a more connected way."

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In addition to the contributions to FP2020, the OP's impact can be seen in its work to expand impactful practices across the OP countries. A particular example involves its work on task-shifting reform and expanding the contraceptive method mix at the community level, including for self-injection, known as DMPA-SC/Sayana Press. The OP helped facilitate cross-country learning and study tours, as well as multi-donor engagement and investment, to enable the introduction and piloting of DMPA-SC at the community level in Senegal, Burkina Faso, and Niger. The OPCU facilitated information exchanges across all nine countries, assisting with the development of supportive policies for task shifting, product registration, and implementation planning, as well as assistance in seeking donor and implementing partner support to execute the plans. All nine countries

now have task shifting policies to allow community health workers to administer DMPA-SC without a prescription, and have introduced DMPA-SC in procurement plans and national strategies.

The OP's regional impact is also seen through its influence on certain implementing partners, which are adopting regional strategies on family planning to achieve efficiencies of scale. MSI, for example, has noted that

donors and governments are making more coordinated requests, which has allowed MSI to develop a greater regional presence in Francophone West Africa. They attribute this shift in part to the impact of the OP.

Challenges

To be sure, the OP faces many uphill battles in advancing family planning in the subregion, such as expanding the contraceptive method mix, engaging the private sector, and addressing cultural norms that promote high desired fertility. Some of the key challenges include the following:

Demand Creation

Addressing the issue of demand creation is critical but has not yet been effectively addressed by the OP countries or donors. Moving the needle on demand is complicated, and it is far harder to track progress than on service delivery. Ultimately, better indicators and measures are needed to understand and accelerate progress on individual agency, critical consciousness, intent to use, gender and social norms, and other factors that impact demand for family planning.

Countries that have seen dramatic increases in additional users of family planning, like Senegal and Burkina Faso, have not prioritized increasing demand, which raises the probability that mCPR progress will stall. “We’re cutting the low hanging fruit – unmet need. But if demand is not high, you will satisfy unmet need and go no further,” explained Cheikh Mbacké. It is also clear that the OP countries have to expand family planning access beyond urban areas to create demand in rural areas, where the majority of the population still live. As Sonneveldt from Track20 put it: “You won’t grow two points per year if you don’t have two points worth of women who want to postpone or prevent pregnancy.”

This is also a problem from the donor side. As Levine explained: “The donors’ skill set is the supply side and access issues, and that is clearly a need in the region with a lot of value and what the governments are focused on. But what seems to be the case is that that is not the largest part of the story – issues around women’s rights, cultural expectations around alternatives for women other than having 8 kids, demand side issues – that’s really where the action is.”

Insecurity in the Region

Rising extremism and terrorism in the Sahel, including by Al Qaeda and Islamic State affiliates, present grave threats to the OP countries, highlighted by recent attacks in Burkina Faso, Niger, and Mali, among others. In addition, abuses by security forces have fueled recruitment for jihadist groups. The insecurity in the region has broad impacts – killing, terrorizing and displacing civilians, forcing the closing of health facilities and schools, and leading countries like Burkina Faso to divert resources from the health sector to the military. Estimates indicate that Mali, for example, is spending less than 5 percent of its budget on health and 24 percent for security. Insecurity is also linked to land disputes between pastoralists and farmers, exacerbated by climate change and population pressures. All these security concerns risk undermining donor engagement in the region. Prof. Coll Seck summarized the concerns about the potential effect on the OP's goals, saying the security problems "could mean less resources for health, and in particular, for reproductive health and family planning." She then added: "When there's insecurity, women are the most vulnerable."

Funding Issues

The challenges of alignment of donor funding and inequities in funding for different countries continue to be issues for the OP. Despite the goal of supporting country priorities through the CIPs, actual alignment is often elusive, and all the donors do not operate in all the OP countries. Mauritania, Togo, Guinea and Benin, for example, are often not seen as strategic priorities for many donors, and therefore receive less support, raising issues of "donor orphans" within the OP.

One donor representative articulated skepticism about the progress on donor alignment: "I'm not convinced that the magical promise of aligning investments with CIPs is playing out." However, the OP countries are seeing more regional scale investment (specific funds and technical assistance made available to all nine countries), more multi-country investments, and more co-funding among OP donors than prior to the OP.

The funding questions also obscure an uncomfortable fact – most of the donor investments do not involve direct support to the West African

governments, with the notable exception of France and a couple of other specific program examples. Almost all the funding is channeled through international NGOs, whose programs have contributed the OP countries' achievements. While funding for family planning has nearly doubled for the OP countries since 2011, allowing more NGOs to work there and including some support to civil society groups, few of those resources went directly to the governments. This is not unique to the OP countries, but reflects how most donors operate, especially USAID, which remains the largest funder for international family planning. However, governments have benefitted from these greater resources through training of health care workers and strengthening of health systems, family planning campaigns, and provision of contraceptive commodities, which are donated by USAID and UNFPA for use in the public sector.

The funding gaps are especially evident for civil society organizations, with neither national governments nor donors providing significant funding. This is complicated by the fact that many civil society groups lack the level of governance systems that donors require. Yet support for civil society will be needed to help improve access to family planning and to hold their governments accountable for their commitments.

Women's and Girls' Agency and Empowerment

Ultimately, the success and sustainability of the OP may rest on how much it is able to link issue of family planning with broader women's and girls' empowerment. This view was expressed by Prof. Coll Seck, who saw family planning as part of a broader set of critical issues: "It's not just a problem of family planning, but a problem of respect for girls, their empowerment, giving them schools and safe environments, toilets. There

are many co-factors that we insisted on. It wasn't just a family planning message." The question then arises whether the OP will remain focused on family planning, or if it might expand its frame to promote women's and girls' agency and empowerment more broadly.

These are fundamental, transformational issues that involve changing gender norms and traditional practices, which is why they often engender such resistance. But Francophone

"It's not just a problem of family planning, but a problem of respect for girls, their empowerment, giving them schools and safe environments, toilets."

West Africa is changing and the issue of women's and girls' empowerment could drive broader development gains, as El Bashir Sow, the Senegalese journalist, pointed out. "It touches on social transformation – education for girls, the fight against FGM. Now we're seeing the fruits [of these efforts], with women as mayors, in the army, in positions of responsibility, fighting child marriage. Family planning is the same."

Sustainability

Many OP observers are questioning the best way to sustain and reinvent the partnership for the next phase, and how to keep the partners engaged – notably the governments and donors. Sanga, the journalist in Burkina Faso, framed the challenge, calling on the OP "not to let the fuse go out": "I'm afraid that the partners see progress and then go. But where we are, if we don't maintain the gains, we'll fall back. We have to continue

to progress." This also relates to a broader risk of having the progress plateau or stagnate, like it was before the OP was launched. Once that happens, it is even harder to get momentum going again.

"I'm afraid that the partners see progress and then go. But where we are, if we don't maintain the gains, we'll fall back. We have to continue to progress."

A key element for sustainability will involve whether the OP countries demonstrate the ownership and dynamism around family planning necessary to maintain and increase outside investments and to mobilize domestic resources for family planning. Ousmane Ouedraogo of the civil society coalition articulated these concerns,

saying "We need partners to finance these programs, but this has to be linked to dynamism from the countries. Do they have the capacity to do that? It's a big opportunity and a big concern – it's a question mark."

The OP has made slow steady progress, but that pace can lead to impatience by countries and donors alike. "It's hard to go fast, when you start at 10 percent (mCPR). But if you don't go fast, it creates donor fatigue," noted Prof. Coll Seck. "The best counsel I can give is that this can't be routine – it's a daily fight to try to find solutions for women and to listen to them. You have to be convinced of what you do, have all the necessary information, and fight daily to make it happen."

The Way Forward

The Ouagadougou Partnership is now at an inflection point. On the one hand, the movement is strong and growing, with committed countries and new donors joining the original group, including Canada, the Netherlands, an anonymous donor, and most recently the UK's DFID. New opportunities to expand access to family planning may also stem from rising global attention to universal health coverage. In the end of the day, the continued interest in advancing these goals on a regional basis is what the OP is all about, as Fatimata Sy often reminded the partners: "The OP isn't a project or a program, it's a movement. The OP is you. The donors, civil society, implementing partners, youth, women, parliamentarians, journalists – all the stakeholders."

The OP was built for the context of the Francophone West African subregion, and with adaptation and tailoring, the lessons and success factors for this partnership hold promise for other regions of the

Sexual education class at Mariama High school in Niamey, Niger. Photo by Murielle Anatohon for EtriLabs.





OP 8th annual meeting Photobooth session. Photo by Murielle Anatohon for EtriLabs.

world. Yet the OP has proven a powerful concept – that by joining together, a group of relatively small and marginalized countries with many barriers to expanding family planning can elevate attention and drive social change. Success also requires concerted engagement from national champions in government and civil society, working with international donors that are intentional about aligning resources.

“The OP isn’t a project or a program, it’s a movement. The OP is you. The donors, civil society, implementing partners, youth, women, parliamentarians, journalists – all the stakeholders.”

At a health post in Guediawaye, outside Dakar, Bator Diop works as a midwife with MSI providing family planning services to low income women. She may not deal directly with the OP, but she is keenly aware of the social changes she sees around family planning. “The new generation knows about the risks of closely spaced births. It was different with our mothers and grandmothers.” She continued: “Change is happening. I feel it.”

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