Sustainable domestic financing of family planning: The Challenge Initiative engages local elected officials in francophone West Africa

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Abstract

Francophone West Africa records some of the world's least favourable reproductive health indicators, in a context of abrupt contraction of international family planning (FP) financing, marked in 2025 by the withdrawal of the leading global donor. From a socio-anthropological perspective on local public action, this article analyses the approach of The Challenge Initiative (TCI), which combines managerial coaching, political advocacy and financial engagement of local governments. Drawing on a mixed retrospective study covering 28 cities in six Ouagadougou Partnership countries between 2016 and 2025, the analysis shows that more than 1,000 elected officials and technical agents were trained, that municipalities committed 1.66 billion FCFA and disbursed 946 million (57%), and that additional users of modern methods increased fivefold between 2021 and 2025. The structured engagement of local elected officials constitutes a

replicable lever for sustainability, conditional on budgetary institutionalization and sustained advocacy.
Keywords: *family planning; domestic financing; local governments; local public action; social appropriation; legitimacy; Ouagadougou Partnership*

Résumé

L'Afrique de l'Ouest francophone présente certains des indicateurs de santé reproductive les moins favorables au monde, dans un contexte de contraction brutale des financements internationaux de la planification familiale (PF), marquée en 2025 par le retrait du premier bailleur mondial. Dans une perspective socio-anthropologique de l'action publique locale, cet article analyse l'approche de The Challenge Initiative (TCI), qui combine coaching managérial, plaidoyer politique et engagement financier des collectivités locales. À partir d'une étude rétrospective mixte couvrant 28 villes de six pays du Partenariat de Ouagadougou entre 2016 et 2025, l'analyse montre que plus de 1 000 élus et agents techniques ont été formés, que les communes ont engagé 1,66 milliard de FCFA et décaissé 946 millions (soit 57 %), et que le nombre d'utilisateurs additionnels de méthodes modernes a quintuplé entre 2021 et 2025. L'engagement structuré des élus locaux constitue un levier réplicable de pérennisation, à condition d'une institutionnalisation budgétaire et d'un plaidoyer soutenu.
Mots-clés : *planification familiale ; financement domestique ; collectivités locales ; action publique locale ; appropriation sociale ; légitimité ; Partenariat de Ouagadougou*

1. Introduction

Worldwide, approximately 260,000 women died in 2023 from pregnancy, childbirth or post-partum complications, around 70% of them in sub-Saharan Africa, while the Sustainable Development Goals target fewer than 70 maternal deaths per 100,000 live births by 2030 (WHO et al., 2025; United Nations, 2024). Francophone West Africa remains one of the most challenged sub-regions: the maternal mortality ratio reaches 385 deaths per 100,000 live births in Côte d'Ivoire, 349 in Togo

and 237 in Senegal, and modern contraceptive prevalence is among the lowest in the world (INS and ICF, 2023; WHO et al., 2025). Yet a large share of this mortality is preventable: expanding the supply of family planning (FP) reduces unintended pregnancies, unsafe abortions and maternal deaths, while producing considerable health, demographic and economic benefits (Cleland et al., 2012; Ahmed et al., 2012).

FP financing is one of the best-documented areas of global health, and its architecture has undergone, since 2024-2025, an unprecedented upheaval. International FP aid, long concentrated among a handful of donors (five governments providing nearly 90% of funding, the largest accounting for about 41% of contributions), has contracted sharply (FP2030, 2025). The withdrawal in early 2025 of the world's leading donor, combined with reductions in official development assistance announced by several others, has placed nearly 70% of international FP financing under effective cuts or imminent risk (FP2030, 2025), with immediate consequences: stock-outs of injectable contraceptives and implants, halted product orders, loss of health-worker posts and the weakening of civil society organizations. Yet needs remain massive: the cost of ending unmet need for family planning in 120 priority countries by 2030 has been estimated at 68.5 billion dollars, far above announced funding (UNFPA, 2019). This underinvestment is all the more paradoxical given that every additional dollar invested in contraceptive services saves about 2.5 dollars in maternal, newborn and abortion care (Guttmacher Institute, 2025).

This contraction of international aid cascades directly from the global to the national and then the local level. In Ouagadougou Partnership (OP) countries, where FP programmes remained heavily dependent on external funding,

the donor retreat threatens the continuity of commodity supply, awareness campaigns, the remuneration of community agents and, ultimately, the very provision of services to populations. The transition from FP2020 to FP2030 broadened the regional agenda to sexual and reproductive health, equity, youth and domestic resource mobilization, elevated to a priority at the 14th Annual Meeting of the Ouagadougou Partnership (RAPO) held in Lomé in December 2025 (Ouagadougou Partnership, 2025). The sustainability of FP financing has thus become the central strategic question of the sub-region: without a domestic relay, the gains of fifteen years of investment (rising contraceptive prevalence, fewer unintended pregnancies, structured services) risk being lost.

At the national level, public budget allocations to FP remain structurally low in most OP countries, rarely commensurate with the commitments made in national plans. National budget lines, where they exist, are often only partially executed, and dependence on donor-funded inputs remains high, for both contraceptive commodities and field activities. It is precisely this vulnerability that the 2025 crisis exposes: FP financing still too dependent on external sources, insufficiently anchored in national and local public resources, and therefore exposed to shifts in the aid environment. Recent Partnership discussions, which highlighted in Lomé the domestic financing models of Nigeria, Chad, Cameroon and Madagascar, reflect a regional awareness of this necessity (Ouagadougou Partnership, 2025).

Decentralization, undertaken in most West African countries since the 1990s, transferred to local governments competencies in community health, public hygiene and social action (Abimbola et al., 2019). Municipalities thus hold a legal mandate and an own budget that can be mobilized for FP. Yet this lever has long remained underused: weak political

prioritization, limited awareness of transferred competencies, the absence of dedicated budget lines and limited management capacity have kept FP at the margins of municipal budgets. Redirecting part of FP financing towards the local level therefore requires simultaneously the political engagement of elected officials, budgetary institutionalization and sustained technical support.

In response to this configuration, The Challenge Initiative (TCI), a platform supported by the William H. Gates Sr. Institute for Population and Reproductive Health at Johns Hopkins University, promotes a demand-driven scale-up model in which local governments enrol voluntarily, co-finance interventions and progressively internalize high-impact practices (The Challenge Initiative, 2024). This article describes and analyses, from a socio-anthropological perspective, the approach deployed by TCI in six Ouagadougou Partnership countries, showing how the combination of managerial coaching, structured political advocacy and financial engagement of local governments helps to anchor the domestic financing of FP. It draws out the measurable results, the conditions for sustainability and advocacy messages for decision-makers.

2. Financing family planning: modes, mechanisms, actors and challenges

2.1. A plurality of sources and mechanisms

The financing of family planning does not stem from a single source, but from a heterogeneous assemblage of actors and mechanisms. These broadly include national public financing (Ministry of Health budget lines); local public financing (local government budgets); international aid (bilateral and multilateral donors, foundations); out-of-pocket payment by

households; insurance mechanisms and universal health coverage; the private sector and corporate social responsibility; contributions from faith-based and community organizations; and, more recently, digital financing platforms (mobile money). Each of these channels engages distinct actors, time-frames and accountability logics. It is their articulation (their financing "mix"), rather than the performance of any single source, that determines the overall resilience of the system (Witter et al., 2020; Knowledge SUCCESS, 2023).

2.2. Health insurance and universal health coverage

Among these mechanisms, health insurance and universal health coverage (UHC) are expanding but remain marginal for FP in francophone West Africa. Insurance coverage is still low and, above all, while contraception is almost always included in essential service packages, most emerging insurance schemes in sub-Saharan Africa exclude it from their reimbursable benefit packages (Hagos et al., 2023). National UHC arrangements (universal health coverage schemes in Senegal and Côte d'Ivoire, targeted free-care regimes elsewhere) still integrate FP unevenly, so that the cost of commodities and services rests largely on household out-of-pocket payment or on donors. Fully integrating FP into insured benefit packages, with clearly defined covered methods and purchasing arrangements, is one of the most promising levers for sustainable and equitable financing (Hagos et al., 2023).

2.3. Free provision of FP: scope and limits

The free provision of FP services (the removal of direct payment by the user at the point of care) holds a central yet ambivalent place in this landscape. On the demand side, lifting the financial barrier markedly increases contraceptive uptake: in Burkina

Faso, fee abolition raised the probability of using a method by about 86% (Tiendrebeogo et al., 2022); systematic reviews nonetheless recall that contraceptive demand is not always price-sensitive and that other barriers (social, informational and quality-related) weigh heavily (Korachais et al., 2016). Free provision also has a symbolic and political dimension: it asserts FP as a right and a public good rather than a commodity (UNFPA, 2012). But it displaces the financing question rather than removing it: a service that is "free" for the user must be paid for by someone, whether the State, the municipality, a donor or an insurer. This is precisely where the sustainability stake lies. The free FP Special Days funded by the municipal budgets of the 28 cities illustrate locally financed, and therefore potentially durable, free provision, as opposed to free provision underwritten by volatile external funding. To think about free provision, from a socio-anthropological perspective, is to ask who pays, in the name of which values, and with what effects on the access equity of the poorest households.

2.4. Challenges heightened by the current context

This landscape is now under strain. Persistent dependence on external aid, the weakness and under-execution of national budget lines, the frequent exclusion of FP from insurance packages, and the burden of out-of-pocket payment on households together describe a fragmented and vulnerable financing system. The 2025 shock (the withdrawal of the world's leading donor and cascading cuts) acts as a revealer: it exposes the fragility of an insufficiently domestic model and accelerates the search for more stable mechanisms (FP2030, 2025). It is within this space of constraints and recompositions that the experience analysed here is situated, exploring one

path among others: anchoring FP financing in local government resources and broadening the social base that supports it.

3. Theoretical and conceptual framework

3.1. Financing health: an object at the crossroads of disciplines

The financing of family planning cannot be reduced to a technical or accounting matter. It lies at the crossroads of several disciplines (health economics, political science, public health), but it is first of all a social fact, in that it engages power relations, value systems, gender and reproductive norms, hierarchies of legitimacy and logics of community belonging. To enter a budget line for contraception in the budget of a West African municipality is to perform a political and symbolic act as much as a financial one: it publicly acknowledges the legitimacy of regulating births in societies where fertility remains a major social, religious and identity issue. This article therefore adopts a socio-anthropological perspective, attentive to actors, their representations and strategies, and to the social processes through which an exogenous norm (the domestic financing of FP) is negotiated, appropriated or contested at the local level.

3.2. A socio-anthropological reading of local public action

The analysis draws first on the sociology of public action, which views policies not as the top-down application of central decisions but as the product of interactions among a plurality of actors (elected officials, health workers, religious and customary leaders, civil society, technical partners) endowed with distinct resources and interests (Lascoumes and Le Galès, 2007). From this perspective, decentralization appears less as an administrative transfer than as a recomposition of local

arenas of power, where the legitimacy to govern reproductive health is renegotiated (Abimbola et al., 2019). The anthropology of development, in turn, illuminates the encounter between imported devices (coaching models, catalytic funds, high-impact practices) and local social logics: every development project is a space of translation and negotiation, never a mere execution (Olivier de Sardan, 1995). Finally, the notion of governmentality allows the managerial coaching and accountability tools to be read as technologies for the conduct of conduct, shaping "responsible" elected officials and "autonomous" municipalities (Foucault, 2004).

3.3. Social capital, legitimacy and brokerage

Three concepts more specifically structure the interpretation. Social capital (the networks, norms of reciprocity and trust that facilitate collective action) accounts for the capacity of Advocacy and Monitoring Groups to mobilize resources beyond the municipal budget (Bourdieu, 1980; Putnam, 1993). Legitimacy, in its traditional, religious and rational-legal forms, sheds light on the decisive role of customary chiefs and religious authorities in the social acceptability of FP. Brokerage, finally, understood through the figure of the broker who links the worlds of development and local societies, helps to conceptualize the role of coaches, champion elected officials and religious leaders as go-betweens connecting the global norm of domestic financing to the expectations of populations (Bierschenk et al., 2000).

4. Materials and methods: a socio-anthropological approach

4.1. Study design

This was a multicentre retrospective cross-sectional study with a mixed (quantitative and qualitative) approach. It combines the description of a complex intervention with the analysis of its effects on process indicators (budgetary institutionalization, training of elected officials) and outcome indicators (financial commitments, disbursements, additional modern contraceptive users).

Epistemologically, the approach belongs to a socio-anthropology of social change: it prioritizes understanding actors' logics and processes of appropriation, and articulates framing quantitative data with qualitative material (semi-structured interviews and direct observation) gathered as close as possible to local decision-making arenas (Olivier de Sardan, 1995).

4.2. Setting and study population

The study covers 28 cities supported by TCI in six Ouagadougou Partnership countries between 2016 and 2025: eight cities in Senegal (Dakar, Guédiawaye, Pikine, Mbour, Thiès, Kaolack, Touba, Saint-Louis), nine cities in Côte d'Ivoire (Abidjan, Bouaké, Anyama, Cocody-Bingerville, Daloa, Vavoua, Séguéla, Mankono, Korhogo), one city in Togo (Lomé), and several cities in Benin, Burkina Faso and Niger that participated in the initial phase (2016-2021) or the NextGen phase (2022-2025) (The Challenge Initiative, 2024; Kandji et al., 2024). The units of analysis are cities; the units of observation are municipal coordination structures, Advocacy and Monitoring Groups (AMGs), health officials and local elected officials.

4.3. Description of the intervention

The TCI intervention is organized around five successive phases: (i) Start-up, corresponding to initial advocacy and enrolment of municipalities; (ii) Surge and Implementation, marked by large-scale deployment of High Impact Practices; (iii) Pre-graduation, characterized by the establishment of Advocacy and Monitoring Groups; (iv) Graduation, when the city reaches a sufficient level of autonomy; and (v) Post-graduation, a consolidation phase.

Managerial coaching, delivered by Program Managers and Master Coaches, follows the Lead, Assist, Observe, Monitor (LAOM) coaching model (Graham et al., 2025). It relies on three standardized tools: the Coaching Log, the Coaching Assessment, and the RAISE self-assessment (Reflection and Action to Improve Self-Reliance and Effectiveness), conducted quarterly and based on the six WHO health system building blocks: governance, service delivery, financing, human resources, health information and health products (WHO, 2007). Operationalization follows seven steps: (1) marketing the TCI model to mayors; (2) signing a letter of commitment and submitting an Expression of Interest dossier; (3) developing the municipal programme for FP and adolescent and youth sexual and reproductive health (FP/AYSRH); (4) signing partnership agreements; (5) establishing mobilization and monitoring bodies; (6) creating a dedicated budget line; and (7) coaching for effective disbursement.

This phased sequencing, from Start-up to Post-graduation, structures a trajectory of progressive empowerment: each city is not the passive beneficiary of a one-off input, but a partner guided, step by step, towards domestic ownership of its own FP/AYSRH programming.

4.4. Data sources

The systematic document review covered annual municipal budgets, council deliberations establishing FP/AYSRH budget lines, municipal orders creating AMGs, payment vouchers and bank statements of dedicated accounts co-signed by the municipality and the health system, TCI quarterly and annual reports, and Local Development Plans and Annual Work Plans.

Semi-structured qualitative interviews were conducted with mayors and deputies, municipal councillors, district health officials, AMG members, and TCI coaches and Program Managers. Direct observation focused on managerial coaching sessions, meetings of Coordination and Management Units (CMUs), training workshops for municipal councillors and advocacy actions before municipal councils. Health indicators (additional modern contraceptive users) were extracted from national health information systems (DHIS-2) consolidated by TCI according to the standard Track20 methodology.

4.5. Variables and indicators

The main variables analysed were: (i) the number of elected officials and technical agents trained; (ii) the number of cities with a dedicated FP/AYSRH budget line; (iii) annual municipal commitments; (iv) actual disbursements; (v) the disbursement rate, defined as the ratio of disbursements to commitments; and (vi) the cumulative number of additional modern contraceptive users. Amounts were aggregated in CFA francs (FCFA); conversion to US dollars uses an average exchange rate of 600 FCFA to USD 1.

4.6. Data analysis

Quantitative data were aggregated by city, country and TCI phase, then compared between the initial phase (2016-2021)

and the NextGen phase (2022-2025). Descriptive analyses covered frequencies, percentages and cumulative trends. Qualitative data underwent thematic content analysis along the six health system building blocks. Triangulation of sources strengthened the internal validity of the results.

4.7. Ethical considerations

The study falls within the monitoring, evaluation and learning activities conducted by TCI in partnership with municipalities, regional health directorates and the ministries of health of the countries concerned. No individual patient data were collected. Regional health authorities and municipalities were informed of the documentation objectives and consented. Participation in qualitative interviews was voluntary. The financial data used are drawn from public documents.

5. Results

5.1. Mobilization and training of local elected officials

Between 2016 and 2025, the TCI platform grew from 12 cities in the initial phase (2016-2021) to 28 cities during the NextGen phase (2022-2025), across six OP countries. More than 1,000 municipal councillors and technical agents received structured training on the role of FP in local development, in reducing maternal and child mortality and in poverty reduction. This training helped broaden the political consensus around FP and build, in each city, a core of champion officials carrying internal advocacy.

5.2. Budgetary institutionalization and coordination

All supported cities integrated a dedicated FP/AYSRH budget line into their municipal budgets and multi-year work plans.

Coordination structures were established in all cities, built around two complementary bodies: the Coordination and Management Unit (CMU), which meets monthly to steer technical and financial execution, and the Joint Steering Committee (JSC), which meets quarterly to validate results and report to the municipal council and regional authorities.

The High Impact Practices (HIPs) promoted by TCI, namely community information, education and communication, free FP Special Days (FPSDs), Postpartum Family Planning (PPFP) and service delivery by Community Health Workers (CHWs), are progressively integrated into national policies and supervision tools (Cleland et al., 2006; HIPs, 2022).

This budgetary institutionalization is not an end in itself: it conditions the effective deployment of field activities. The amounts committed by municipalities finance the organization of free FP Special Days, the stipends and equipment of community health workers, the procurement of awareness materials, the holding of educational talks and the functioning of coordination bodies. Domestic financing thus translates directly into local activities, and then into services delivered to populations, establishing a continuous results chain that links the municipal council's deliberation to the user of a contraceptive method.

5.3. Consolidated domestic financial mobilization

Over 2016-2025, the municipalities of the 28 cities supported by TCI in OP countries committed a cumulative 1,664,859,600 FCFA (about USD 2.77 million) for FP and reproductive health. Of this total, 946,301,340 FCFA (about USD 1.58 million) were actually spent, an overall disbursement rate of 57%. Table 1 summarizes the main aggregated results.

Table 1: Summary indicators of domestic resource mobilization for FP in 28 Ouagadougou Partnership cities, 2016-2025

Indicator	Cumulative value 2016-2025	Note
Cities supported	28	6 OP countries
Local officials and technical agents trained	> 1,000	Men and women combined
Total amount committed by municipalities	1,664,859,600 FCFA	≈ 2.77 M USD
Amount effectively disbursed	946,301,340 FCFA	≈ 1.58 M USD
Overall disbursement rate	57%	Weighted average
Additional users (2021)	66,225	Initial reference
Additional users (2025)	331,809	×5 in 4 years

Source: compilation of municipal budget data and TCI reports 2016-2025.

5.4. Post-graduation trajectories: the Ivorian experience

The Advocacy and Monitoring Groups institutionalized in Abidjan and Bouaké illustrate the acceleration that follows the pre-graduation phase. Seven AMGs were created there by municipal order, each comprising on average twelve members (local authorities, community and religious leaders, health officials and civil society representatives).

Between 2024 and 2025, municipal commitments in these graduated cities rose from 59.2 million to 70.8 million FCFA (+19.6%); disbursements increased from 19.5 to 33.7 million FCFA (+72.9%), bringing the average disbursement rate to 41%. Over the same period, the cumulative number of additional

modern contraceptive users rose from a negative balance of 3,140 (reflecting an initial decline in users) to 24,684 in Abidjan, and from 5,257 to 13,384 in Bouaké, demonstrating the direct translation of financial mobilization into effective service use.

5.5. Diversification of local financing sources

Beyond municipal budgets, the TCI experience documents the emergence of complementary local financing sources. In Lomé, the diocese of the Evangelical Baptist Mission Churches of the Kingdom of Christ (EMBERC) committed in 2025 to contribute annually to FP financing in the Greater Lomé Health Region, with a first instalment of 200,000 FCFA. The Reverend Dr ALIDJINOU, president of the diocese, also chairs the Agoè-Nyivé AMG, demonstrating the capacity of faith-based organizations to move from communication relay to local funder.

In the graduated cities of Côte d'Ivoire, AMGs are exploring several innovative mechanisms: crowdfunding via mobile money, solicitation of private companies under their corporate social responsibility, and mobilization of local foundations. These innovations remain to be consolidated, but their emergence attests to the capacity of local mechanisms to diversify their financing sources once the institutionalization of FP/AYSRH is achieved.

5.6. Trends in FP service use

The cumulative number of additional modern contraceptive users in the 28 cities supported by TCI rose from 66,225 in 2021 to 331,809 in 2025, a fivefold increase over four years. For comparison, over the 2011-2021 decade the Ouagadougou Partnership as a whole reached about 4 million additional users across nine countries, an average of some 444,000 additional users per country.

This progression, which exceeds the per-country average observed across the Partnership, suggests a concentration and intensity effect specific to the urban approach: by targeting densely populated localities and combining financing, coordination and high-impact practices, the model achieves rapid, measurable gains within a circumscribed territory.

6. Discussion

6.1. A structured conversion of political commitment into effective financing

The observed results confirm that the engagement of local elected officials can become a strategic lever for sustaining FP financing, provided it is structured by an explicit support mechanism. Three elements distinguish the TCI approach from classic health advocacy models. First, the mayor's signed letter of commitment and the Expression of Interest dossier establish a contractual logic between the city and the technical partner, breaking with the non-binding declarations of intent usually observed in decentralized health programmes (Abimbola et al., 2019). Second, the rule of at least a 25% annual increase in allocated amounts builds a predictable budgetary trajectory that shields FP from short-term political trade-offs. Third, the institutionalization of AMGs by municipal order creates a durable body, independent of the electoral cycle, that continues financial advocacy after TCI withdraws (Avocé et al., 2024).

6.2. The challenge of effective disbursement

The overall disbursement rate of 57% between 2016 and 2025 represents a substantial improvement over the rates observed in the early phases of the programme, but remains perfectible.

Several factors explain the gap between commitments and actual spending: the administrative burden of municipal procedures, political instability linked to leadership changes after elections, and the complexity of public expenditure validation circuits. These findings are consistent with the literature on decentralized health financing in sub-Saharan Africa (Witter et al., 2020; Hsiao and Heller, 2007). Continuous coaching for disbursement and regular facilitation of the AMGs appear to be the main levers for reducing these bottlenecks.

6.3. A response to the contraction of international financing

The global context is characterized by a retreat of international financing for family planning, heightened by the COVID-19 pandemic, Sahelian security crises and climate shocks (Riley et al., 2020; WRC, 2024). The TCI model offers a partial response to this contraction by demonstrating that trained and supported local governments can mobilize substantial domestic resources. The rise from 66,225 to 331,809 additional users between 2021 and 2025 shows that local financial mobilization translates into effective service use, consistent with dynamics documented at the regional level (WRC, 2024; Brown et al., 2014).

The relevance of this model has further increased with the 2025 shock. The withdrawal of the world's leading FP donor, which alone provided nearly 41% of international aid, and the reductions announced by several other donors have placed about 70% of international FP financing under cuts or imminent risk, causing commodity stock-outs and post losses (FP2030, 2025). In this context, the domestic resources mobilized by the 28 cities (1.66 billion FCFA committed) do not substitute for international aid, but they form a more predictable financing

base, anchored in local taxation and less exposed to decisions in foreign capitals. They thus offer a partial buffer against donor disengagement and a foothold for rebuilding a more resilient financing architecture (Guttmacher Institute, 2025).

6.4. From domestic financing to service delivery

One of the major contributions of this experience is to make visible the causal chain linking domestic financing to the effective provision of services. Too often, financial advocacy stops at the inscription of a budget line, without documenting what that line concretely produces. Yet the data from the 28 cities show a coherent sequence: the political engagement of elected officials generates a budget allocation; that allocation, when disbursed, finances high-impact activities (special days, community awareness, postpartum family planning, community health-worker services); these activities widen access and translate into a measurable rise in the number of users. The fivefold increase in additional users between 2021 and 2025, concurrent with the financial scale-up, illustrates this transmission. This finding has practical significance: it justifies assessing local financing not by the amount committed alone, but by the volume of services it enables, and therefore prioritizing the disbursement rate and utilization indicators as performance measures. It also highlights the vulnerability of this chain: any failing link (a commitment not disbursed, an activity not conducted) interrupts the translation of financing into services, making coaching for disbursement and accountability monitoring all the more crucial.

6.5. A sociological reading: power, legitimacy and appropriation

Beyond its programmatic effectiveness, the experience lends itself to a properly sociological reading. The financial engagement of municipalities can be analysed as a process of institutionalization in the sociological sense: a practice first carried by a few champion elected officials sediments into a rule (the budget line, the order creating the AMG), detaches itself from those who initiated it and eventually imposes itself as self-evident (Lascoumes and Le Galès, 2007). The mobilization of religious and customary leaders, extending to the financial commitment of a diocese in Lomé, illustrates a shift in legitimacy: FP, long perceived as an exogenous norm potentially competing with local fertility values, and on which public opinion in OP countries remains divided (Amewunou and Asunka, 2026), is reframed as a legitimate cause once endorsed by recognized moral authorities. Here we observe a work of appropriation, through which an imported device is re-signified within local categories of the common good, community responsibility and the protection of families (Olivier de Sardan, 1995). Coaches, champion officials and religious leaders act as intermediaries (development brokers) who translate the technical grammar of domestic financing into arguments audible in municipal and community arenas (Bierschenk et al., 2000). This perspective also illuminates resistances and delays: the low disbursement rate stems not only from administrative procedures, but from power relations, competing priorities and the still ambivalent place of reproductive health in the local social order.

6.6. Conditions for sustainability and replicability of local financing

The sustainability of local FP financing cannot be decreed: it is built through a convergent set of conditions that the experience of the 28 cities helps to specify. The first is budgetary institutionalization: entering a dedicated FP/AYSRH line in the municipal budget nomenclature, backed by a council deliberation, transforms a personal commitment into an institutional obligation that survives political turnover (Knowledge SUCCESS, 2023). The second is the predictability of the financial trajectory, secured by the rule of an annual increase of at least 25% in allocations and by quarterly monitoring of disbursements. The third is the existence of durable bodies independent of the electoral cycle, the Advocacy and Monitoring Groups, endowed with a formal mandate and, ideally, an own budget. The fourth is accountability, supported by standardized tools (Coaching Log, Coaching Assessment, RAISE) that make visible the gaps between commitments and expenditure. The fifth, finally, is the diversification of sources: mobilizing the private sector under corporate social responsibility, contributions from faith communities and mobile-money financing platforms, which reduce dependence on a single source (Knowledge SUCCESS, 2023). Together, these conditions move local financing from a one-off, personal act to a durable, self-sustaining system.

Several conditions appear necessary to reproduce this dynamic. The first is the self-selection of municipalities: enrolment rests on a voluntary act by the mayor and municipal council, generating a higher level of initial commitment than an externally imposed intervention. The second is the existence of a national policy framework favourable to decentralization and reproductive health. The third is the combination of structured

managerial coaching and a catalytic fund (Challenge Fund), which creates both the technical capacity and the financial incentive for local engagement (The Challenge Initiative, 2024). The Ivorian experience further shows that the post-graduation phase can catalyse innovative domestic mobilization mechanisms (mobile money, faith-based financing, corporate social responsibility) that extend beyond the strictly municipal framework (Knowledge SUCCESS, 2023).

To these micro and meso conditions is added a macro condition: the articulation between the local and national levels. Municipal financing remains, by construction, modest relative to needs; its purpose is not to cover the entirety of FP costs, but to secure an incompressible base, to signal the political commitment of the territory and to attract co-financing. Its sustainability therefore requires that the State recognize and encourage this effort (through conditioned transfers, matching mechanisms or the integration of FP into sectoral allocations) rather than offloading it onto local governments alone. It is on this condition that local domestic financing, complementary and not substitutive, can durably buffer the shocks of international aid.

6.7. The socio-utilitarian significance of the study

The significance of this study is not merely academic: it lies first in what it offers, concretely, to the societies concerned. For West African municipalities, the study validates a tested and sequenced pathway (seven operational steps, standardized coaching tools, coordination bodies) that any city council can adopt to convert a political intention into funded and monitored services; it thereby transforms a singular experience into a public good of knowledge, directly reusable by local

decision-makers. For national governments and their partners, it provides empirical evidence that local taxation can durably carry part of the reproductive health effort, and thus informs the design of matching transfers and budget nomenclatures at a moment when the 2025 donor retreat forces every ministry of finance to arbitrate. For communities, and first of all for women and adolescents, the practical stake is immediate: a municipal budget line that is actually disbursed means contraceptive methods that remain available when external aid falters, hence unintended pregnancies, unsafe abortions and maternal deaths averted (Ahmed et al., 2012; Cleland et al., 2012). By documenting, finally, how religious and customary authorities move from tolerance to financial co-responsibility, the study shows a socially negotiated way of anchoring FP in the local moral order, reducing the conflictuality that too often surrounds reproductive health programmes. The social utility of the research is thus twofold: it equips public action (tools, indicators, replicable conditions) and it protects, through the continuity of financing, tangible gains in health, schooling and household economic well-being.

6.8. Key advocacy messages

Beyond analysis, the experience of the 28 cities lends itself to advocacy messages addressed to the various actors in FP financing in francophone West Africa.

To national governments and ministries of finance: enter family planning as a protected line in local budget nomenclatures, and condition State transfers on the existence and effective execution of this line. Investing in FP is one of the most cost-effective public health investments: every additional dollar spent on contraceptive services saves about 2.5 dollars in maternal and newborn care (Guttmacher Institute, 2025).

To mayors and local elected officials: make FP a marker of good local governance and development, increase the municipal allocation every year, and ensure the effective disbursement of committed amounts (the leading bottleneck observed across all cities).

To technical and financial partners: favour catalytic models that strengthen local capacity and ownership rather than durably substituting for national budgets, and support the transition to domestic financing instead of withdrawing abruptly (FP2030, 2025).

To civil society organizations, community and religious leaders: sustain the Advocacy and Monitoring Groups, broaden the social base of FP financing and demonstrate, through the example of faith-based contributions, that reproductive health is a common good.

To communities, households and service users: regard family planning as a household investment in maternal and child health, education and family economic well-being; take ownership of local accountability spaces (community committees, Advocacy and Monitoring Groups) to track the use of public funds; and voice a demand for quality, accessible and respectful services, since the sustainability of financing also depends on the buy-in and voice of those most concerned.

6.9. Study limitations

Several methodological limitations must be acknowledged. The retrospective cross-sectional design without an external comparison group does not strictly isolate the intervention's own effect from concurrent national and regional dynamics. Financial data vary in granularity across cities and periods, which may affect the precision of aggregations. The conversion of amounts into USD uses an average exchange rate without

correction for local inflation. Finally, service-use indicators come from routine information systems (DHIS-2), whose quality varies from country to country.

7. Conclusion

This article set out to answer a question that the 2025 contraction of international aid has made pressing: can the financing of family planning in francophone West Africa be durably anchored in domestic resources, and under what conditions? The analysis of the TCI experience in 28 cities of six Ouagadougou Partnership countries between 2016 and 2025 provides an empirically grounded and theoretically situated answer. Read through the sociology of public action and the anthropology of development, the results show that domestic financing is neither a decree nor a transfer of burden: it is a social process, in which an exogenous norm becomes a local rule through the combined work of contractual commitment, managerial coaching, budgetary institutionalization and the brokerage of champion elected officials and religious authorities.

The factual record supports this reading. More than 1,000 elected officials and technical agents were trained; all 28 cities created and maintained a dedicated FP/AYSRH budget line; municipalities committed 1.66 billion FCFA and disbursed 946 million, a 57% disbursement rate; and the number of additional users of modern contraception rose from 66,225 to 331,809 between 2021 and 2025. The study thereby establishes a documented causal chain running from the municipal deliberation to the user of a contraceptive method, and identifies its weak link: effective disbursement, which remains the decisive frontier between announced and real financing.

The socio-utilitarian import of these findings is direct. For municipalities, the model offers a replicable seven-step pathway; for States and partners, it demonstrates that catalytic support and matching mechanisms are more sustainable than substitution; for communities, and above all for women and adolescents, locally financed services mean continuity of access, and therefore pregnancies, unsafe abortions and maternal deaths averted, at the very moment when external funding is faltering.

Four priorities follow for action: sustain and extend FP budget lines within local budget nomenclatures, in dialogue with ministries of finance; institutionalize the Advocacy and Monitoring Groups, with their own mandate and budget, so that advocacy survives electoral cycles; strengthen accountability through the quarterly use of standardized monitoring tools; and diversify local financing sources by building on faith-based, private-sector and mobile-money contributions. None of these priorities requires waiting for a return of international aid; all of them consolidate the social base on which sustainable FP financing ultimately rests.

At a time when the international architecture of reproductive health financing is being recomposed, the experience analysed here invites a change of perspective: to regard cities no longer as subsidiary executants but as central actors of health development, and to invest accordingly in their planning, financing and accountability capacities. It is at this local level, where legitimacy, resources and needs meet, that the sustainability of family planning in francophone West Africa will largely be decided.

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