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POLICY  
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**Post-Cairo  
Reproductive Health  
Policies and Programs:  
A Study of Five Francophone  
African Countries**

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Ellen Wilson**

**August 2000**



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The POLICY Project

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## Preface

The mission of the Network for Reproductive Health Research in Africa (RESAR) is to improve reproductive health through research and training. The organization receives grants for operations under project performance contracts with governmental and nongovernmental organizations as well as with bilateral and multilateral donors involved in reproductive health. RESAR is currently made up of 10 national units in Francophone Africa called CRESARs.

The goal of the POLICY Project is to create supportive policy environments for family planning and reproductive health programs, including HIV/AIDS, through the promotion of a participatory policy process and population policies that respond to client needs. The project has four components—policy dialogue and formulation, participation, planning and finance, and research—and is concerned with crosscutting issues such as reproductive health, HIV/AIDS, gender, and intersectoral linkages.

*POLICY Occasional Papers* are intended to promote policy dialogue on family planning and reproductive health issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of policy audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations.

An up-to-date listing of POLICY publications is available on the project's website. Copies of POLICY publications are available at no charge. For more information about the project and its publications, please contact:

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## Acknowledgments

This paper reflects findings from five case studies conducted by RESAR with financial and technical support from the POLICY Project. RESAR's Justine Tantchou coordinated the research, which was carried out by country teams. Country case studies were conducted and written by RESAR members and reviewed by Tantchou and POLICY's Ellen Wilson. Titles and authors of the case studies are given below:

- *Formulation de politiques post-Caire: Le cas de la République du Bénin* by Béatrice Aguessy and Elisabeth Fourn.
- *Formulation de politiques et mise en œuvre des programmes post-Caire: Etudes de cas sur la santé de la reproduction au Burkina Faso* by Stanislas Paul Nebié and Idrissa Ouedraogo.
- *Formulation de politiques et mise en œuvre des programmes post-Caire: Etudes de cas sur la santé de la reproduction au Cameroun* by Paschal Awah and Justine Tantchou.
- *Formulation de politiques et des programmes post-Caire: Le cas de la Côte d'Ivoire* by Zoumana Kamagate and Aminata Noëlle Sangaré.
- *Formulation de politiques et mise en œuvre des programmes post-Caire: Etudes de cas sur la santé de la reproduction au Mali* by Hafsatou Diallo, Tamo Tamboura, and Mahamadou Traore.

The full text of the individual country reports, in French, can be obtained by contacting RESAR at the following address:

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We heartily thank everyone who contributed to this evaluation of reproductive health policy development and program implementation in Francophone Africa. We give special thanks to the respondents in the five countries who found the time for multiple interviews in spite of their busy schedules and who so graciously provided the interviewers with numerous documents.

We also give thanks to the POLICY Project for its moral, financial, and technical support. In particular, we wish to thank Jen Marenberg for her tireless assistance with the editing of this paper and Karen Hardee and Kokila Agarwal for reviewing earlier versions. Finally, we would like to thank Elizabeth Schoenecker and Barbara Crane for their helpful comments. The opinions expressed in this report, however, do not necessarily reflect those of USAID.





## Executive Summary

The 1994 Cairo International Conference on Population and Development (ICPD) increased worldwide focus on reproductive health. Many countries have been working to revise their reproductive health policies in accordance with the ICPD *Programme of Action*. In 1998, the Network for Reproductive Health Research in Africa (RESAR), with support from the POLICY Project, conducted case studies in five Francophone African countries—Benin, Burkina Faso, Cameroon, Côte d'Ivoire, and Mali—to examine field experiences in formulating and implementing reproductive health policies. Findings were based on in-depth interviews with key informants active in the reproductive health field in their respective countries.

Because the five countries are located in the same region, they exhibit many similarities, yet each differs slightly in the challenges it faces and the approaches it takes to confront them. In general, the five countries have made considerable progress in integrating the concept of reproductive health into policies and programs, although more needs to be done to disseminate new policies and implement effective programs. While some aspects of reproductive health generate opposition, particularly programs for youth and programs against female genital cutting, overall support for reproductive health has increased in recent years. Governments are allowing nongovernmental organizations (NGOs) to participate in policy formulation, and most countries are devoting more internal resources to reproductive health. Though these changes are encouraging, continued resistance on the part of the public sector to full partnership with NGOs, as well as the varying capabilities of many NGOs, has hindered NGO participation. Moreover, countries are still highly dependent on support from international donors for their funding. Less progress has been made in program implementation than in policy formulation. Some concrete changes are apparent, but the task of converting the concept of reproductive health into a reality in the field is sure to be a long, slow process.

Poverty and underdevelopment in the region are major constraints to reproductive health programs; consequently, countries must focus their efforts on priority interventions and use their existing resources more efficiently. The case studies also highlight the need to continue efforts to create broad-based support for reproductive health programs, improve coordination among stakeholders, strengthen NGOs so that they can effectively participate in the policy process, and enhance the financial sustainability of programs.



## Abbreviations

ABBEF	Association for Family Well-Being of Burkina Faso
ABPF	Beninese Family Planning Association
AIBEF	Association for Family Wellness of Côte d'Ivoire
AIDS	Acquired immune deficiency syndrome
AMPPF	Malian Association for the Promotion and Protection of the Family
BUNAP	National Population Bureau (Côte d'Ivoire)
CNLS	National Committee for AIDS Control
CONACOPP	National Committee for the Coordination of Population Programs (Mali)
CONAPO	National Population Council (Burkina Faso, Côte d'Ivoire)
DHS	Demographic and Health Survey
DSF	Directorate of Family Health (Benin)
GNP	Gross national product
GTZ	German Technical Cooperation Agency
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IMSC	Integrated Management of Childhood Disease
IPPF	International Planned Parenthood Federation
KFW	Kreditanstalt für Wiederaufbau
MCH	Maternal and child health
NACP	National AIDS Control Program
NGO	Nongovernmental organization
PSSP	Health and Population Policy (Mali)
RESAR	Network for Reproductive Health Research in Africa
ROBS	Network of Beninese Health NGOs
SFPS	Family Health and AIDS Prevention Project
STD	Sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization





# Post-Cairo Reproductive Health Policies and Programs: A Study of Five Francophone African Countries

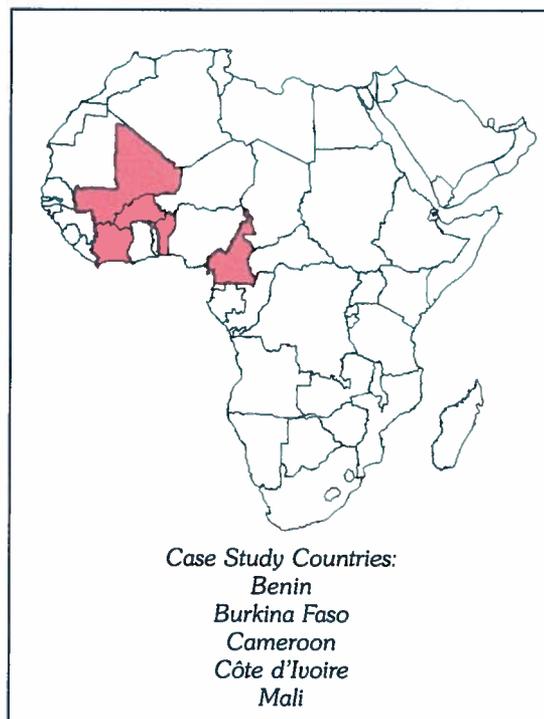
## Introduction

Since the ICPD in 1994, reproductive health has been a focus of health programs worldwide. Many countries have worked to revise reproductive health policy in accordance with the ICPD *Programme of Action*. In 1997, POLICY conducted case studies in eight countries—Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal—to examine field experiences in developing and implementing reproductive health policies. In 1998, RESAR conducted similar case studies in five Francophone African countries—Benin, Burkina Faso, Cameroon, Côte d’Ivoire, and Mali.

RESAR’s purpose in conducting the studies was not to provide quantitative measurements of reproductive health indicators or an exhaustive inventory of reproductive health laws and policies but to improve understanding of reproductive health policy formulation and implementation. The study was qualitative, drawing on the perspectives of key informants—individuals who play an important role in formulating and implementing reproductive health policies and plans. The divergent perspectives show that the issues are often more complex than they appear in a written policy. Together, the different points of view provide a clearer picture of the

situation regarding reproductive health. In addition, given that all respondents are prominent in the reproductive health field, their perspectives actually influence the development of policies and programs in their respective countries.

In each country, two to three members of the Reproductive Health Research Committee—the country’s local branch of RESAR—conducted the study. Research teams included at least one medical specialist and one social science specialist. The team carried out the fieldwork for the case studies between October and



December 1998, by interviewing 25 to 29 key informants in each country in the fields of population and reproductive health. Informants were selected from ministries, universities, NGOs, women's groups, the private sector, donors, U.S. technical assistance organizations, service providers, and parliaments. The interview guide covered the following topics: the definition of reproductive health; reproductive health priorities and policy formulation; structures responsible for policy development (including the level of participation of various groups); support for and opposition to reproductive health; the role of NGOs and the private sector;

implementation of services; national and international funding of reproductive health activities; and remaining challenges to reproductive health policy and program implementation. Interviews focused on the sections of the guide for which the respondent had knowledge and expertise. Interviews were recorded and transcribed for analysis.

The content of the case studies, which is based primarily on expert opinions and various documents, reflects the situation at the time of the interviews. Since then, all the countries have continued to make progress in implementation.





## Reproductive Health Context in the Five Countries

The geographic, demographic, economic, and social contexts vary among the five countries. Total population size ranges from 6 million in Benin to more than 15 million in Côte d'Ivoire (see Table 1). In all five countries, the population is predominately young (nearly 50 percent under 15 years of age) and rural. Women of childbearing age represent about 25 percent of the population. Gross national product (GNP) per capita is low, and poverty affects the majority of the population.

According to the Demographic and Health Surveys (DHS) conducted between 1991 and 1998, the various reproductive health indicators shown in Table 1 remain poor despite efforts of the last 20 years. The table shows that the total fertility rate is high—about six children per woman (between 5.2 in Cameroon and 6.9 in Burkina); the rate is even higher in rural areas. High fertility leads to a rate of natural increase of 2.7 in Cameroon and Côte d'Ivoire, 2.9 in Burkina Faso, 3.0 in Benin, and 3.1 in Mali. Mortality remains a concern in that the average infant mortality rate is about 100 per 1,000 live births

(ranging from 77 in Cameroon to 123 in Mali), and the average maternal mortality rate is 550 per 100,000 live births. Illegal, induced abortions and resulting complications contribute to an average of 25 percent of maternal deaths. The proportion of women who take advantage of prenatal health care is low, particularly in Mali and Burkina Faso, and the proportion of women who give birth without the assistance of a health care professional is high in all five countries, contributing to the high maternal mortality rate. The contraceptive prevalence rate for modern methods remains at or below 7 percent, with significant disparities between urban areas (12–20%) and rural areas (4–7%) even amid efforts undertaken by governments and NGOs. The rate of HIV infection among the adult population is highest in Côte d'Ivoire (10.1%) and lowest in Mali and Benin (1.7% and 2.0%, respectively). The rate of female circumcision varies widely among the countries (from 5% in Cameroon to 94% in Mali). The practice of full breastfeeding for six months is high (over 90%) in all the countries.



**TABLE 1. DEMOGRAPHIC AND REPRODUCTIVE HEALTH CHARACTERISTICS  
IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1990s**

ITEM	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Population (mid-1998)	6,000,000	11,300,000	14,300,000	15,600,000	10,100,000
Land area (sq. miles)	2,710	105,637	179,691	122,780	471,116
Annual rate of growth	3.0	2.9	2.7	2.7	3.1
Percent of population under age 15	49	48	44	43	47
GNP per capita in US\$	350	230	610	660	240
Literacy rate					
Female	26	9	52	30	23
Male	49	29	75	50	39
Total fertility rate	6.3	6.9	5.2	5.7	6.7
Prevalence of contraceptive use (women in union)					
All methods	16	8	19	17	7
Modern methods	3	4	7	6	5
Maternal mortality (per 100,000 live births)	498	566	430	597	577
Infant mortality (per 1,000 live births)	94	94	77	89	123
Percent of women having at least one prenatal visit	80	59	79	85	47
Births attended by health professional (%)	64	42	58	45	40
Prevalence of HIV (adults 15–49)	2.0	7.2	4.9	10.1	1.7
Proportion of circumcised women	50	70	5	43	94
Contribution of abortion to maternal mortality (%)	15	n/a	23	n/a	n/a

*Sources:*

DHS. 1993–98.

World Bank. 1998. *World Development Indicators*.

Population Reference Bureau. 1998 and 1999. *World Population Data Sheet*.

UNAIDS/WHO. 1998. *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Diseases*.



## The Policy Process: Definitions of Reproductive Health, Policies, and Priorities

The focus on reproductive health in Francophone Africa developed much later than in other regions. For many years after independence, most of the five countries in this study operated under pronatalist policies. Family planning services were not introduced into national health programs until the mid- to late 1980s. Their late introduction was due in part to a 1920 French law forbidding abortion and promotion of contraceptives. The law has now been repealed in all of the countries except Benin and Mali, where it is no longer enforced, though it remains in effect. Policies related to population issues have evolved in all of the countries, albeit at varying speeds. Initially, policies focused on maternal and child health (MCH) programs, then MCH with family planning, and, finally, reproductive health. Among the five countries, Mali was the first to adopt an official population policy (1990), followed by Burkina Faso (1991), Cameroon (1992), Benin (1996), and Côte d'Ivoire (1997).

All the countries that participated in this study have adopted the ICPD definition of reproductive health (see box at right). The concept of reproductive health was further refined at the First Regional Forum on Reproductive Health for Central and West Africa (the Ouagadougou Forum) in September 1996. The forum was organized by the Family Health and AIDS Prevention (SFPS) Project

and supported by several donors, including the World Health Organization (WHO) and the United Nations Population Fund (UNFPA). The conference divided reproductive health into four major categories—children's health, women's health, adolescent health, and men's health—each containing various components. This general framework

### **ICPD Definition of Reproductive Health**

*“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services which contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”*

*Paragraph 7.2  
ICPD Programme of Action*

guided the development of national policies and programs in each of the five countries.

In addition, the implementation strategy for the Africa region developed by the WHO Office for Africa (validated by two workshops in May and August 1998 in Bamako and Libreville) follows a slightly different approach that includes the following six components (WHO, 1998):

- safe motherhood;
- adolescent sexual and reproductive health;
- prevention of untimely and unwanted pregnancies;
- sexually transmitted disease (STD) and HIV/AIDS control;
- prevention, early screening, and management of cervical cancer; and
- reduction of female genital cutting, domestic violence, and sexual violence.

All of the countries are working to revise policies, standards, and procedures to incorporate the new reproductive health perspective. Côte d'Ivoire approved a comprehensive reproductive health policy in October 1998; Mali and Benin have drafted their policies but are still awaiting final approval. Burkina Faso and Cameroon have not yet finished drafting their policies. Although no explicit priorities have been set, country programs tend to emphasize MCH programs, birth spacing, and STD/AIDS prevention while placing less emphasis on infertility, cancers of the reproductive tract, reproductive rights, and family planning for purposes of birth limitation (which is still culturally unacceptable to most of the population). The focus on reproductive health has also emphasized gender issues, the social context for health, and quality of care and has led to more programs addressing services for youth and men and the prevention of female genital cutting.

In each country, the Ministry of Planning is responsible for population policy while the Ministry of Health is responsible for health policy, including reproductive health. The ministries for youth (national education and youth) and for women are also involved in certain aspects of reproductive health. Table A1 in the appendix summarizes the evolution of the various reproductive health policies.

**Benin.** The focus of health programs in Benin has gradually expanded. In the 1960s, the emphasis was on MCH; now, it encompasses general reproductive health. Family planning services first became available when the Beninese Family Planning Association (ABPF) was founded in 1972. The government began to include family planning in its programs after the 1978 Alma Ata Conference, but the concept of family planning was poorly accepted by the population. In 1987, the government folded family planning into a broader focus of family well-being and added a nutrition component. Consequently, the Ministry of Health had to restructure, and the Directorate of Family Health (DSF) was created in May 1994. Following the ICPD a few months later, Benin committed itself to a reproductive health focus. In 1996, participants in the Ouagadougou Forum further refined the concept of reproductive health and concluded that each country should define an essential services package for each of four areas: children's health, women's health, adolescent health, and men's health. Benin defined its essential services packages in January 1997.

Benin drafted a population policy in 1995 and adopted it in 1996 after a change in government. The National Commission on Human Resources and Population, which is composed of ministries directly concerned with population issues, is the national agency responsible for coordinating population activities. The





Population and Planning Unit, a body under the Ministry of Planning, oversees the commission.

In the health sector, a roundtable adopted the *1995–1999 Health Strategy* in January 1995, identifying five areas of intervention: decentralization of the health pyramid, reinforcement of managerial skills, improved financing, improved treatment of principal diseases, and improved reproductive health. To help institute the strategy, Benin adopted a strategic framework in March 1997, *Policy and Strategy for Development of the Health Sector, 1997–2001*. Under the framework, DSF is responsible for creating, monitoring, and evaluating reproductive health programs in accordance with the health strategy. A policy specific to reproductive health, *Policy and Standards in Family Health*, was finally adopted in March 1999 (after fieldwork for this case study was completed).

Benin uses the same definition of reproductive health as the ICPD. Some key informants felt that the concept is too broad to be translated into a concrete reality. A representative of the Ministry of Health asked, “What are the activities we should include in reproductive health today? Reproductive health to me is a vast area where we cannot have an impact unless we target some specific areas.” A donor representative, however, said, “There is no problem regarding the definition of reproductive health. It’s more a problem regarding implementation of the content of the document.”

Through a series of workshops, technical experts and representatives of

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*“Reproductive health to me is a vast area where we cannot have an impact unless we target some specific areas.”*

Representative of the  
Ministry of Health, Benin

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NGOs and government agencies involved in reproductive health reached a consensus on the definition of reproductive health and on the most pressing reproductive health priorities. According to one university respondent, reproductive health is defined as a “triple well-being: physical, mental, and social in all matters relating to the reproductive system and to its functions and processes, and not the absence of disease.” Respondents emphasized four priority areas of reproductive health: MCH, family planning, STDs, and nutrition. In reality, existing programs and the availability of resources dictate which areas receive the greatest attention.

**Burkina Faso.** Drafted in 1978, the first program protecting MCH in Burkina Faso emphasized nutrition. The second program, drafted in 1988 and covering 1988–1992, focused on primary health care and included family planning activities for the first time. A national population policy, which intended among other things to regulate fertility and reduce demographic growth, was adopted on June 10, 1991. The third MCH program, covering 1994–1998, had the same objectives as the population policy and included family planning in the essential services package for health centers. On the legislative front, a law against female genital cutting was passed in 1997, but it has not been implemented.

Following the ICPD, Burkina Faso’s National Population Council (CONAPO) updated the population policy to include reproductive health as a national priority. To consider the concerns of all stakeholders, CONAPO used a participatory process to revise the policy. In July 2000, initial revisions had been completed but the policy was not yet in its final form.

Numerous ministries share responsibility for implementing the national population policy, which includes reproductive health. CONAPO (within the



Ministry of the Economy and Finance) plays the most significant role. The Directorate of Family Health (within the Ministry of Health) is in charge of developing, planning, implementing, and following up on programs to protect mothers, children, youth, men, and the elderly. Other social ministries that are active at different levels in policy formulation include the Ministry of Social Action and the Family; the Ministry for the Promotion of Women (created in June 1997); the Ministry for Youth and Sports; the Ministry of Basic Education and Literacy; the Ministry of Secondary and Higher Education and Scientific Research (through the Faculty of Health Sciences, which is responsible for reproductive health teaching reform); and the Ministry of Communication and Culture, which contributes to publicizing reproductive health and providing information. CONAPO and the Directorate of Family Health in the Ministry of Health are responsible for coordinating policy and reproductive health actions. No specific committee has been created to monitor implementation of the ICPD *Programme of Action*, a factor contributing to a lack of coordination among agencies involved in reproductive health.

Respondents agree that the concept of reproductive health in Burkina Faso has significantly changed since the ICPD. According to one person, “Reproductive health policies before the ICPD were primarily focused on population and family planning programs with less emphasis on STD/AIDS control, women’s rights, sexual education, and maternal and child health.” The emphasis is no longer on controlling population growth but rather on improving the quality of life. New target groups are being taken into account: youth, men, and the elderly. The training of health professionals now includes instruction in counseling, contraceptive technology, quality of care,

gender, and STD/AIDS control. Another respondent said, “After Cairo, it is undeniable that new policies have been created and old ones have been revised, in order to include the overall concept of reproductive health in medical interventions. Only the policy on abortion has not changed in that it is forbidden except with exceptional medical conditions and certain cases of proven abuse.”

In defining reproductive health, the Directorate of Family Health initiated a series of activities to develop a draft reproductive health strategy (Ministère de la Santé de Burkina Faso, 1998). The strategy adopts the four categories defined by the Ouagadougou Forum—children’s health, adolescent health, women’s health, and men’s health—and creates a fifth category: the health of the elderly. The strategy further describes elements common to all five categories, including family planning; STD/AIDS prevention; the fight against all practices harmful to reproductive health; reproductive health information, education, and communication (IEC); community participation; family life education; and responsible parenthood. Unfortunately, the strategy has not yet been completed because of coordination and funding problems. As a result, this definition and its categories have not been sufficiently disseminated.

Respondents expressed concern about the absence of established priorities at the national level as well as about the need for rapid completion of the draft strategic plan. In the absence of a final, approved document on reproductive health, each partner or institution establishes its own priorities based on the national situation, its own concerns, and the approaches others have tried. For example, UNFPA seems to focus its priorities on family planning, youth, gender, promotion of women’s status, and STD/AIDS control. UNICEF

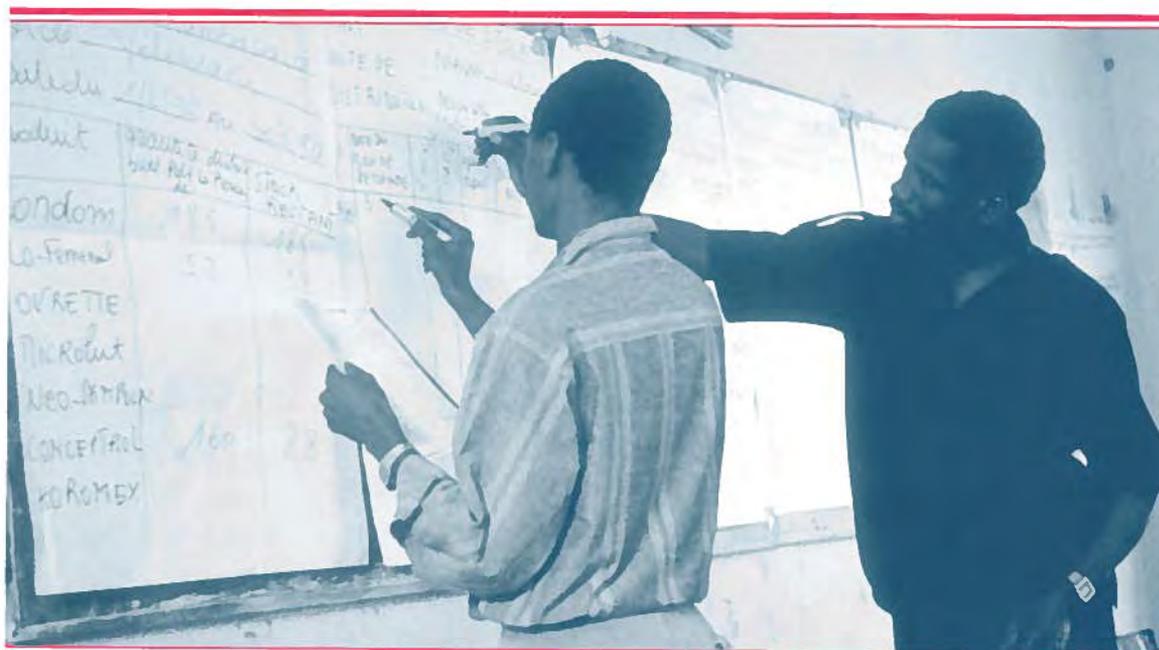


targets children's health and improved status of adolescent girls and women. CONAPO and the Association for Family Well-Being of Burkina Faso (ABBEF) emphasize contraception, STD/AIDS control, women's rights, promotion of income-generating activities, and service delivery through mobile clinics and community-based distribution.

**Cameroon.** In 1992, the government of Cameroon manifested its concern about population growth and adopted the *National Population Policy*, a significant departure from its pronatalist orientation of the 1960s and 1970s. The policy's primary objective is to "...improve the level and quality of life of populations within the limits of the resources available and in accordance with human dignity and the fundamental rights of man to health, nutrition, education, employment, and housing." Even though the policy formulation process did not sufficiently involve representatives of civil society, implementation has been relatively effective. Since the ICPD and the Fourth World Conference on Women, policymakers have been revising the population policy to meet the two conferences' objectives. According to

respondents, the institutional framework for population issues has been very unstable. The government agency responsible for population has changed from a directorate in the Ministry of Planning (1982–1992) to a subdirectorate under the Directorate of Planning and Development in the Ministry of Economy and Finance (1992–1997) to a directorate in the Ministry of Public Investments and Land Management (1997 to present). This structural instability has prevented the National Population Committee from meeting.

The health policies that guide current practices include the *Standards of Maternal and Child Health Care and Family Planning*, adopted in 1992; the *Implementation of Primary Health Care, 1993*; and the *Declaration of Health Policy, 1996*. The 1996 health policy is the cornerstone supporting reorientation and reinforcement of the district health system. It distinguishes three operational levels, each offering an essential services package that includes reproductive health care. No specific policy for reproductive health has been developed. Coordination of reproductive health services was the responsibility of the Directorate of Family and Mental Health until 1995, at which



time the directorate was demoted to the level of a subdirectorate. This demotion in administrative standing, together with the director's departure, seriously affected the office's ability to fulfill its coordinating role. Consequently, the different reproductive health components (STDs, AIDS, maternal health, child survival, and family planning) have developed independently of one another.

Policies in other sectors also address various aspects of reproductive health. In 1997, the Ministry of the Female Condition adopted an action plan, "Women and Development," to implement the recommendations of the Fourth World Conference on Women. The Ministry of Youth and Sports is currently writing a youth sector policy in cooperation with the scout movement to emphasize educational talks for youth and adolescents and to address the need for separate reproductive health services for youth.

Cameroon adopted a pronatalist policy in 1968; since then, however, the policy environment has gradually become more favorable to family planning. A service provider stated that "the topic of family planning was taboo when we began around 1972. With the findings of studies conducted on maternal mortality and perinatal mortality, the government authorized a family planning clinic in Yaoundé in 1975." However, family planning activities remained limited to major urban centers with private doctors until 1984, when the president made a general statement on responsible parenthood. From that time, services gradually expanded, particularly through projects supported by USAID, UNFPA, and the German Cooperation Agency (GTZ), and, in 1990, a new law that allows pharmacists to dispense contraceptives. In early 1996 after the ICPD, family planning was integrated with MCH, and contraceptives were included on the national list of essential drugs.

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*"The concept of reproductive health has remained in Yaoundé."*

Peripheral-level service provider, Cameroon

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Workshops to define reproductive health have been postponed; consequently, Cameroon has not yet reached a consensus on a definition. While awaiting the official consensus, various organizations have tried with mixed results to define reproductive health in the spirit of Cairo. One Ministry of Health respondent defined reproductive health as "a reorientation of family planning services that integrates the management of STD programs, HIV infection, and complications resulting from illegal abortions, with prenatal care, postnatal care, child health care, etc." Understanding of reproductive health is especially vague outside the capital. As one service provider at the peripheral level said, "The concept of reproductive health has remained in Yaoundé."

Respondents identified the following priority reproductive health problems in Cameroon: rising maternal and child mortality rates; low prevalence of contraceptive use; high prevalence of sexually transmitted infections; high rate of unwanted pregnancy among young girls and adolescents and related complications; and illegal, induced abortion. In view of these factors, one respondent stated, "The priority of priorities remains safe motherhood." Numerous respondents' answers, however, made it clear that priorities have not yet been set at the national level. Some respondents indicated that priorities are based primarily on the

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*"Everything happens as if there were no plan. If there's money in a given area, that's all it takes for a leader to consider that area to be a priority."*

Respondent, Cameroon

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availability of donor funding. According to one respondent, “Everything happens as if there were no plan. If there’s money in a given area, that’s all it takes for a leader to consider that area to be a priority.”

**Côte d’Ivoire.** From its independence in 1960 until the early 1990s, Côte d’Ivoire was a pronatalist country. The late President Houphouët Boigny believed that Côte d’Ivoire had enough land and resources for 50 million inhabitants, or a tenfold increase over the population at that time. According to a respondent from the National Population Bureau (BUNAP), the conclusions from the 1974 conference entitled “Côte d’Ivoire: Outlook 2000” provided the basis for the country’s early population policy. The policy was based on the idea that strong demographic growth can be beneficial due to economies of scale despite resulting social costs.

During this pronatalist period, the only family planning program in the country was run by the Association for Family Well-Being of Côte d’Ivoire (AIBEF), which was established in 1979 as a member agency of the International Planned Parenthood Federation (IPPF). From the time of its creation to 1990, AIBEF worked behind the scenes and faced much opposition. Support for the organization grew during the early 1990s, leading up to the ICPD. During that time, the government signed a bilateral project with USAID to entrust AIBEF with the delivery of family planning services in Abidjan and four regional capitals.

Many respondents stated that, for many years, it was difficult to gain policymakers’ support for family planning policies because of resistance to the concept of limiting births. In the 1990s, however, family planning became more acceptable as proponents focused on the contribution of family planning to MCH. In 1993, the government instituted a national family planning program, and, in 1994, a 19-

person delegation from Côte d’Ivoire attended the ICPD. These actions demonstrated an increased willingness of government officials to focus on reproductive health issues.

In this propitious climate, a series of meetings was organized, beginning in November 1995, to develop a population policy with support from UNFPA. A 1996 workshop to consider the ICPD recommendations, analyze existing programs, and formulate the *National Population Policy* led to the policy’s adoption in March 1997.

In April 1996, Côte d’Ivoire adopted its first *National Plan for Health Development, 1996–2005*, following a series of meetings with experts from the World Bank, officials from the Ministry of Health, service providers, representatives from NGOs and the private sector, and community leaders. The plan defines the institutional framework, structures, human and financial resources, programs, and strategies for accomplishing objectives, including those in the area of reproductive health. The overall objective is “the improvement of the state of health and wellness of the population through improved qualitative and quantitative balance between the supply of health services and the basic needs of the population.”

Several reproductive health programs fall under the National Plan for Health Development. The Program for Primary Health Care ensures the provision of the essential services package at the community level. The Expanded Immunization Program—a vertical program—aims to eradicate poliomyelitis, eliminate neonatal tetanus, and control other childhood diseases. The National Program of Child Health runs several programs, including diarrheal disease control, acute respiratory infection control, and breastfeeding; and its primary goal is to control childhood diseases through

training and integrated management of childhood diseases. The National Program for AIDS, STDs, and Tuberculosis Control was created in 1987 in response to the HIV epidemic; its goal is to reinforce multisectoral action, encourage social mobilization, and promote and support community responses. The goals of the National Program for Reproductive Health and Family Planning are in accordance with the *National Plan for Health Development* and the *National Population Policy*.

Further advances were made in the policy environment in December 1998, when Parliament—in response to the efforts of the Ministry of Family and the Promotion of Women and the Ivorian Women’s Rights Association—passed laws against female genital cutting and early, forced marriages. Three documents addressing reproductive health were drafted in October 1998 and approved in 1999: *Reproductive Health Services Policy*, *Reproductive Health Service Standards*, and *National Program for Reproductive Health and Family Planning in Côte d’Ivoire*.

The institution responsible for developing and implementing population policy is the Ministry of Planning, with assistance from the following organizations: the National Population Council (CONAPO), an advisory body charged with assisting the government in defining population policy and monitoring the performance of activities; the regional population councils; and BUNAP, which is responsible for coordinating the development of population policies, strategies, and programs.

The Executive Directorate of the National Program for Reproductive Health and Family Planning is the structure responsible for developing reproductive health policy within the Ministry of Health. The Ministry of Planning and other social

ministerial departments cooperate with bilateral and multilateral cooperation agencies, implementing agencies, and NGOs in the formulation of reproductive health activities.

In efforts to define reproductive health, the Ministry of Health and UNFPA organized a National Reproductive Health Symposium in June 1996 with participation from a broad range of governmental and nongovernmental institutions. The objective of the symposium was to improve understanding of the concept of reproductive health and its components by adopting a consensual operational definition specific to the Ivorian context. In the end, the symposium adopted the ICPD definition. The name of the national program, National Program for Reproductive Health and Family Planning, explicitly reminds all stakeholders that reproductive health cannot be reduced to family planning. Despite efforts to involve all levels in the development of the definition, service providers so poorly understand the concept of reproductive health that they confuse it with family planning. One respondent representing the government said, “There were some difficulties understanding on our part, but also on the part of the people we were speaking to and our target audience because the ‘medical’ aspect is seen but not the other [aspects].”

The definitional issue notwithstanding, the major problem facing the national reproductive health program is not dissemination of the ICPD concept of reproductive health but rather coordination among all the other programs responsible for one or more aspects of reproductive health. Respondents could not even agree on which institution was responsible for coordination. Some cited the Ministry of Health, others the Executive Directorate of the National Program for Reproductive Health and Family Planning, and still others, BUNAP. The reproductive health





program for youth is one critical area for which the ministries of Health and Youth need to improve collaboration if they are to implement the program effectively.

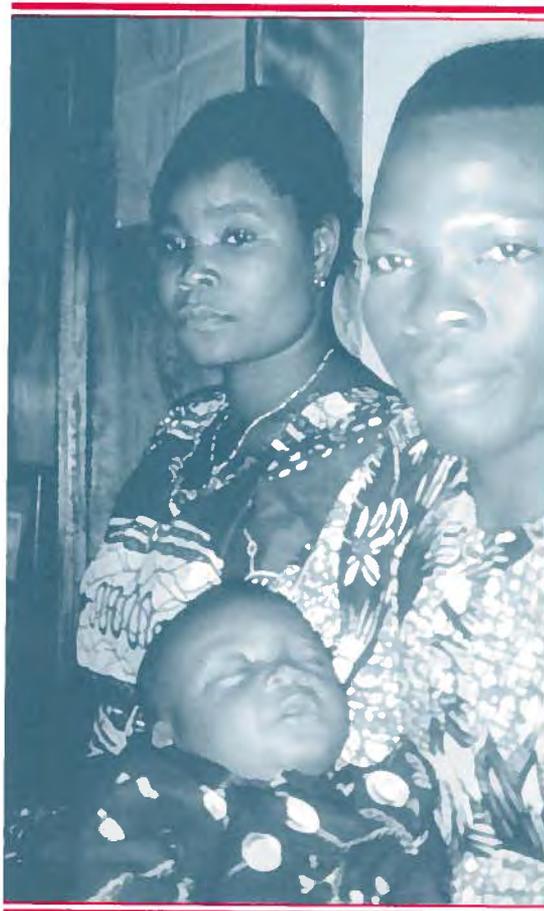
Neither the National Reproductive Health Symposium nor the approved National Program for Reproductive Health and Family Planning assigned priority to program areas in their various documents. Based on donor support, however, the main priorities seem to be family planning (as an essential element of safe motherhood), the control of STD/HIV/AIDS, and the reproductive health of young people.

**Mali.** The first family planning program in Mali began in 1972 with the creation of the Malian Association for the Promotion and Protection of the Family (AMPPF). In its early years, AMPPF devoted itself primarily to IEC and advocacy activities rather than to service delivery. Family planning services first became available after the Alma Ata Conference in 1978, when the government adopted a Primary Health Care Strategy and integrated family planning services with MCH activities. Family planning activities were constrained, however, by the 1920 French law forbidding both abortion and the promotion of contraceptives. Over time, the situation changed; while this law is still in effect, it no longer poses an obstacle to family planning activities and services. For example, in January 1991, a ministerial letter authorized women of childbearing age to use family planning without the consent of parents or a spouse (MSPAS, 1991).

The *Sectoral Health and Population Policy (PSSP)*, adopted in December 1990, provides the political orientation and institutional framework for health and population issues. This policy is based on the conceptual framework of the Bamako Initiative: increased health coverage, accessibility of essential drugs, and community participation (see box, page 18). Adopted in 1991, the *Population Policy* outlines all the measures to be taken by the

government to affect levels and trends in demographic variables. Although these policies preceded the ICPD, they contain many of the principles of the ICPD. One respondent asserted that the elements of reproductive health were already being implemented before the conference: "The ICPD is not the beginning point, it is the concept that is new." Another agreed by saying, "What changed after the ICPD was seeing all the elements linked."

Since the ICPD, new policies have been developed and old policies revised to reflect the new focus on reproductive health. The PSSP has been strengthened, and some new elements have been added. The new *Program of Priority Investments in Population, 1996–2000*, which is the action plan for implementation of the 1991 *Population Policy*, makes reproductive health its first component. The *Maternal and Child Health Policies and Standards* were replaced with *Policies, Standards, and*



*Procedures for Reproductive Health and Family Planning*, which focuses on the health of the whole individual.

Governmental and nongovernmental partners from all levels were involved in developing new guidelines, which were widely disseminated (although a donor respondent stated that the dissemination has been inadequate at the subnational level).

The National Planning Directorate of the Ministry of the Economy, Planning, and Integration is the structure responsible for developing and following up on the 1991 *Population Policy*. A population unit was created within the directorate in 1983 to consider population issues. In 1993, an advisory body, the National Council for the Coordination of Population Programs (CONACOPP), was formed to replace the population unit. CONACOPP's primary purpose is to provide advice and suggestions for all population projects and programs, implementation of population policy, and demographic and economic change in the country. Population councils were also planned at decentralized levels (region, circle, arrondissement, and commune); according to respondents, however, these decentralized units have not been able to fulfill their roles because of lack of funds and lack of understanding of their value.

Leadership for health policy was entrusted to the Ministry of Health. On the operational level, most aspects of reproductive health are the responsibility of the National Directorate of Public Health, through the Division of Family and Community Health. The Program for Health and Social Development, 1998–2002, proposes the creation of a reproductive health directorate. Coordination among actors in the area of reproductive health is

problematic. Coordinating structures function to some degree, but the respective roles of NGOs and state agencies are not clearly defined. Administrative decentralization could exacerbate the problem further, but the issue is recognized as a priority by all respondents and thus is likely to be addressed.

Mali's policy documents and standards use a slightly amended version of the ICPD definition of reproductive health as appropriate to the Malian context. The concept of reproductive health in Mali includes a set of preventive, curative, and promotional measures intended to improve the care of vulnerable groups, including "the mother/child pair, youth, and adolescents in order to reduce infant, child and maternal mortality and morbidity and thus to promote the well-being of all individuals." The respondents almost unanimously declared that all reproductive health aspects are addressed at one level or another except the issue of abortion, which is forbidden by law in all cases when it is not therapeutic, and "women's rights issues," which "are not taken into account anywhere," according to one respondent.

Reproductive health priorities have not yet been formally identified at the national level; however, they seem to focus on family planning and eradication of harmful practices, such as excision. Some respondents mentioned that trends, such as the worldwide movement against female circumcision, often help determine priorities, as do donor preferences. The need for setting clear priorities is real. As one respondent commented, "Mali is a country where everything seems to be a priority, but can one do everything at once and in the same way?"





## Participation, Support, and Opposition

The ICPD recognized that participation of all reproductive health partners is essential for successful implementation of the *Programme of Action*. In the five countries, most respondents confirmed that NGOs and other civil society representatives have been invited to attend meetings at the national or subnational levels to formulate reproductive health policies and programs. Some NGOs, however, think that the government is not sufficiently open and that opportunities for effective participation are limited. Moreover, government does not consider NGOs to be true partners in the process of planning and implementing reproductive health programs. A frequently cited constraint to fuller NGO participation is the relatively limited skills of most such organizations.

Support for reproductive health is increasing, although some components still encounter resistance. For example, many groups do not yet support the fight against female circumcision or the provision of family planning services to adolescents. In general, government officials and politicians were reported to be fairly receptive to reproductive health programs, but they are constrained by social conservatism at the grassroots level and by religious group opposition.

**Benin.** According to Beninese government representatives, civil society has participated fully in developing reproductive health policies and programs. One respondent from a government agency said, “The representatives of NGOs have always been involved in training workshops organized both inside and outside the country to be able to gather useful information for their sphere of activity.” According to a respondent from the Ministry of Health, other stakeholders such as local leaders and donors were involved in consensus meetings; however, some NGOs participated only as guests and did not feel they were involved since they could not contribute to creating the national programs. For example, *Policy and Standards in Family Health* was developed entirely by government representatives, with NGOs invited to the final presentation of the policy document. One limitation on full NGO participation is that most of the organizations are relatively new and have limited capabilities. The establishment of the Network of Beninese Health NGOs (ROBS) reflects the desire of the NGOs to unite in an effort to increase their influence and effectiveness.

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*“The political will exists, but there is a certain amount of social resistance that the policy is not prepared to attack.”*

NGO respondent, Benin

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Opinions are divided between support of and opposition to reproductive health policy. Opponents use the 1920 French law still in effect in Benin to attack the program. A government executive indicated that the clergy in particular believe that "...the use of condoms is an open door to debauchery and encourages infidelity." According to respondents, the public is not well informed about reproductive health principles because the new policy has not yet been widely disseminated. An NGO respondent indicated, "The political will exists, but there is a certain amount of social resistance that the policy is not prepared to attack." Public support will probably grow with time, and the socioeconomic context is working in favor of reproductive health. "Life is becoming more and more difficult and the deteriorating economic situation encourages the population to be a bit more responsible in procreating," stated a respondent from the Ministry of Health.

**Burkina Faso.** Many respondents from NGOs and civil associations in Burkina Faso believe that their level of participation in formulating policies is insufficient. They believe that government agencies consult them only to a limited extent on matters of implementation and the search for financing. Donors and respondents from cooperating agencies agree that the level of NGO and civil participation is insufficient and that government agencies sometimes reject NGO participation in policy formulation, even though the government could benefit from the NGOs' skills. In contrast, many respondents from government structures assert that NGOs are regularly invited to participate in the process from the outset.

Government support for reproductive health is high at the national level. In the *Declaration of General Policy of the Prime Minister* (July 1996), the government committed itself to promoting IEC actions for AIDS prevention, assisting AIDS

orphans, educating girls, and improving the status of women, youth, and the elderly. The National Assembly of Burkina Faso participated in the ICPD and committed to promoting the status of women and girls. In the 1998 action plan of the Ministry for the Promotion of Women, general objectives are structured around promoting women's access to resources, improving education for girls, improving women's health, and protecting women's rights. The president of the republic made six commitments, one of which deals with the economic and social promotion of women. The establishment of training and production centers for young girls in Sourou Province is one concrete step taken by the government to fulfill its commitments.

Popular support for reproductive health remains low, however. Interviews with community leaders suggest that a lack of awareness and understanding of reproductive health is the primary constraint. Leaders did not oppose reproductive health activities when they understood them.

**Cameroon.** Since the ICPD, a proliferation of NGOs has been working in reproductive health, a phenomenon explained by the relaxation of laws in 1990 regarding the creation of associations; by the increased availability of funding for reproductive health activities; and by the encouragement of donors who appreciate the greater flexibility, administrative ease, and closeness to the community of NGOs as compared with the public sector. NGOs help the government in the field, although some respondents expressed concern about coordination problems. According to one Ministry of Health respondent, "The action of the NGOs is a waste of time if there is no coordination." In response, the Ministry of Health, with the support of UNFPA, set up a unit to oversee coordination with the NGOs, although some NGO respondents expressed concern about conflicts of interest with the ministry.

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*“Yes, the government is involved. But is the maximum being done? One has the impression that there is more talk than concrete action.”*

Donor, Cameroon

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Support for reproductive health is mixed. The public frequently equates reproductive health with family planning, which many community leaders still consider an attempt “to prevent Africans from reproducing,” as one respondent explained. Some people still do not have a positive attitude toward condom use to prevent STDs and AIDS because they believe they are being tricked into not procreating. Reproductive health for adolescents is another sensitive area. As one respondent from an NGO indicated, “According to many parents, talking about sexual relations with adolescents exposes youth to bad behavior; [the parents] do not understand why you have to talk about sexuality with your children.” In addition, health workers are often unwilling to provide reproductive health services to adolescents. Moreover, the Choas Arabs, the only ethnic group in Cameroon to practice female genital cutting, resist all efforts to end the practice.

The religious diversity of Cameroon makes it difficult to generalize about the position of religious leaders regarding reproductive health. The Protestant churches support all government health policies and provide reproductive health services through their health centers. The Catholic Church opposes those elements of the policy related to artificial contraception. Many Islamic leaders oppose IEC programs that talk to youth about sexuality, and some oppose women’s use of contraception.

In the absence of a clear reproductive health policy, nearly all respondents said that it is difficult to assess the level of support among national leaders for

reproductive health. Some respondents suggested that the delay in formulating a policy reflects the lack of commitment on the part of decision makers. One donor respondent commented, “Yes, the government is involved. But is the maximum being done? One has the impression that there is more talk than concrete action.” At the local level, administrators have supported reproductive health programs, although local and regional elected officials have been much less involved, preferring not to deal with sensitive issues and thus run the risk of offending voters.

**Côte d’Ivoire.** Since the ICPD, the number of NGOs in Côte d’Ivoire has multiplied, and they have been actively involved in formulating and implementing reproductive health policies, according to both government and NGO respondents. The government has been particularly supportive of NGO participation; it created a unit within the Ministry of Health to coordinate NGO activities and has channeled over 750 million CFA francs (US\$1.25 million) to NGOs active in the health sector, according to respondents.

Most respondents felt that the participation of civil society in all levels of the process (formulation, adoption, and implementation of policies and programs) is positive. They believe that NGOs have a role to play in social mobilization, IEC, and community actions. However, some respondents acknowledged that some NGOs are primarily interested in enriching themselves or lack needed skills. An NGO respondent said, “Theoretically, the participation of NGOs is positive, but the problem is that the lack of professionalism

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*“Theoretically, the participation of NGOs is positive, but the problem is that the lack of professionalism makes it difficult to gain trust.”*

NGO respondent, Côte d’Ivoire

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## **The Bamako Initiative**

The Bamako Initiative is a strategy to improve primary health care, including reproductive health. Given that the five case study countries are implementing the initiative, it helps to define the framework in which reproductive health services are delivered. The Bamako Initiative has important implications for community participation in decision making, financing, and quality of services.

African Ministers of Health launched the Bamako Initiative in 1987 in Bamako, Mali, at a conference sponsored by WHO and UNICEF. The initiative's objective is to ensure that high-quality primary health care is available to the entire population at an affordable price. Conference participants recognized that the quality of public health services was poor. Health centers frequently lacked basic drugs, infrastructure was deteriorating, qualified personnel were in short supply, and staff were not motivated. Consequently, use of services was low, and the population sought other (and frequently unreliable) alternatives. Furthermore, mismanagement and inefficiency squandered scarce resources.

The Bamako Initiative focuses on a few key strategies to improve the quality of health services while improving the effective use of resources.

- ❑ Communities contribute financially to their own health services, primarily through user fees, on the premise that even the poor will pay for high-quality services. Community funding is sufficient to cover all nonsalary recurrent costs.
- ❑ Communities participate in decision making related to their health services through locally elected health committees.
- ❑ Village health workers are trained to conduct outreach activities.
- ❑ Emphasis is placed on provision of an essential services package, which includes cost-effective interventions and generic, essential drugs.
- ❑ Health services are delivered through a decentralized, district-based health system.

By the end of 1994, 33 countries—primarily in Africa—had adopted the Bamako Initiative along with countries in Asia and Latin America. All five case study countries are implementing the Bamako Initiative to varying degrees. Côte d'Ivoire began implementing the initiative in 1992 in nine districts and plans to extend it to all 29. Cameroon has also started to implement it in five out of 10 provinces. In Benin, the program was integrated into some health centers starting in 1988; by 1991, nearly all peripheral health centers were involved. In Burkina Faso, the Ministry of Health piloted the Bamako Initiative in six provinces in 1989 and extended it to nearly all health posts and centers in 1993. Mali has the most extensive program; the formal conceptual framework was developed in 1989 and continues through implementation of the Sectoral Health and Policy and covers the entire country.

In general, the initiative has had a positive impact. Assessments show that use of services has increased significantly as a result of improved quality. Low-cost, quality drugs are more readily available, and resources generated by the initiative are sufficient to cover not only recurrent costs but also additional health activities. At the same time, a number of challenges have arisen, but programs are working to address them. Community health committees do not always adequately reflect the community; women in particular are generally underrepresented. Health committees lack transparency and accountability in their management of community funds. And while quality has significantly improved, particularly as related to the availability of drugs, more improvements need to be made.



makes it difficult to gain trust." In response, the NGO network, Collective of NGOs Active in Côte d'Ivoire, held a workshop in February 1999 to develop a code of conduct for NGOs and to improve their practices.

The commercial sector has been less involved than NGOs. A commercial sector representative expressed frustration over appeals for participation during policy formulation but not during implementation.

The National Program for Primary Health Care/Bamako Initiative, which started in 1992, has been encouraging community participation. According to the National Plan for Health Development, the program is the main means of implementing the new health strategy, *Health for All in the Year 2000*. Management committees were created by decree to involve communities in managing their own health according to the principles of primary health care. So far, the program has been fully implemented in just nine districts covered by UNICEF, but the objective is to cover the entire country.

At the national level, Côte d'Ivoire has seen little organized opposition to reproductive health. Awareness-raising activities led by AIBEF were tolerated from the beginning in Abidjan. However, when it came to expanding family planning activities outside Abidjan, opponents to family planning invoked the 1920 French law. Family planning is still at times equated with birth limiting, which provokes considerable resistance, while the concept of birth spacing is more acceptable. According to some respondents, the principal resistance came from the medical establishment, which supported the pronatalist policy of the time. One service provider indicated that, initially, the public distrusted family planning but did not oppose it; over time, the situation improved as a result of experience and positive

reports from those who partook of family planning services.

According to an AIBEF respondent, policymakers in Côte d'Ivoire have committed their support to reproductive health in general. The President of the National Assembly, the President of the Republic, and the Minister of Health demonstrated their support and took concrete action by signing a bilateral agreement with USAID and accepting technical and financial support from UNFPA. These commitments reflect the government's new openness to reproductive health programs.

However, some issues that affect traditional practices, such as female genital cutting, pose problems. Despite the 1998 law forbidding female genital cutting, support for efforts to eradicate the practice is lukewarm because certain politicians fear that they will alienate their electorate. One respondent, a parliamentarian, stated, "I would vote for the law against female circumcision if I didn't have to defend such ideas in my territory. I'm sure I wouldn't be reelected!" In addition to female genital cutting, abortion is still highly controversial, although postabortion care is included as an integral part of the national reproductive health program.

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*"I would vote for the law against female circumcision if I didn't have to defend such ideas in my territory. I'm sure I wouldn't be reelected!"*

Parliamentarian, Côte d'Ivoire

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**Mali.** Though NGO involvement in health in Mali began before the ICPD, the conference helped reinforce NGO participation in policy development and, especially, in implementation. Mali was one of the countries that included NGO representatives in its official delegation to the ICPD. NGOs have become privileged



partners and participate at all stages of reproductive health policy and program development. They are grouped under the Bamako-based NGO network Groupe Pivot/Health and Population, which facilitates coordination and involvement at all levels (policy development, document approval, program implementation, operations research, and evaluation). In addition to NGOs, the private business sector (offices and clinics, associations of doctors and private pharmacists, and so forth) is a partner in reproductive health but is less involved in policy development.

Community participation has been expanding since the implementation of the *Sectoral Health and Population Policy*, which authorized communities to manage their own health issues, including reproductive health. Federations of community health associations participate in the development and approval of policies and programs.

The case study interviews revealed persistent opposition to some aspects of reproductive health, such as youth programs and efforts to eradicate female genital cutting; in addition, discussion of sexuality is still taboo. Respondents said that though many Islamic leaders fiercely oppose some aspects of reproductive health, some support it. All respondents mentioned that the National Union of Muslim Women of Mali is opposed to the eradication of female genital cutting. Nevertheless, opposition has not prevented the government from adopting action plans to address reproductive health. One respondent spoke for many when he said, "There is a sort of resistance to certain aspects. For example, old people say that they can no longer change their attitude toward the issue of female circumcision and that we have to increase awareness among young people."

The attitudes of many religious groups have changed. Previously, several groups

fiercely opposed family planning, but now some wholeheartedly defend it for married couples. Reproductive health programs have encouraged the involvement of religious groups and have even sponsored the participation of both male and female members of the groups in family planning study trips to Islamic countries with strong family planning programs (Iran, Egypt, Indonesia, and Niger (Forum on Reproductive Health and Islam in Africa)) to learn from their experiences.

Policymakers are well informed about reproductive health issues and support the concept at least to the extent that they have organized many forums and workshops on reproductive health since the ICPD. The highest national authorities (namely the President of the Republic, the Minister of Health, the Minister of the Promotion of Women, Children, and the Family) all support the ICPD *Programme of Action*, in addition to various reproductive health projects and programs. Thus, while the general population hesitates, high-level authorities are committed to reproductive health.





## Policy Implementation

Although not all ICPD goals have been met, all five countries have taken action in the field to implement the ICPD and Ouagadougou Forum resolutions. At the operational level, several programs have been developed to reach specific groups, particularly youth and adolescents. Moreover, reproductive health is increasingly considered in the broader context of gender issues; some countries have even taken steps to improve the status of women through measures such as girls' education programs.

The government still provides most reproductive health services, but NGOs are predominant in areas such as youth programs, women's rights, and the fight against female genital cutting. While respondents acknowledged the important contributions of NGOs, they also noted the difficulties of coordinating interventions between government and the growing number of NGOs.

In the spirit of the Bamako Initiative (see box, page 18), all of the countries have made some attempt to increase community participation in the management of government health services. In some countries, participation is effective in only a few districts. Mali has gone the furthest in empowering communities throughout the country to manage their own health services.

One of the Cairo recommendations was to integrate services to increase the efficiency of reproductive health programs and to better meet the needs of clients by offering reproductive health services in the same place and at the same time. Unfortunately, many obstacles have prevented service integration from becoming a reality, particularly at the peripheral level. All of the countries, however, are making some progress, including training nursing personnel to be able to provide a broader range of services.

**Benin.** The Ministry of Health developed a reproductive health program, coordinated by the DSF, that is based on two 1996 *National Population Policy* objectives (increased life expectancy and responsible parenthood), the 1996 DHS results, and the ICPD and Ouagadougou Forum recommendations. The program has four elements as follows:

- women's health, including safe motherhood and gynecological care;
- children's health, including neonatology services and well-child care;
- youth health, including family life education, reproductive health care, and the promotion of an environment for youth favorable to a gender approach; and
- men's health, with an emphasis on awareness of men's reproductive health

responsibilities and management of sexual dysfunctions and genital cancers.

In addition, the program outlines activities that could contribute to the achievement of objectives under all four elements. Activities include family planning, STD/HIV/AIDS control, nutritional promotion, and the control of practices harmful to reproductive health (especially female genital cutting). Complementary components include sanitation; environmental protection; literacy training; education, particularly for girls; and increased popular awareness of population issues.

Public entities such as the National AIDS Control Program, public health centers, and social promotion centers provide services. In addition, the ABPF and many other NGOs provide reproductive health services or conduct IEC campaigns, frequently in areas where public sector coverage is inadequate. Public structures offer general integrated services. For instance, in a public maternity ward, basic MCH services (pre- and postnatal care, delivery, vaccinations), family planning services, and IEC are available. NGOs more often work in specific areas, such as family planning; the ABPF, however, is an exception, offering a broad range of services extending to family planning, prenatal care, and reproductive health for youth, including counseling. In general, however, implementation of programs with a new reproductive health orientation is not far advanced. A necessary first step is to increase service providers' awareness of reproductive health and then deliver additional reproductive health training to such providers.

Respondents disagreed over the benefits of integrating services and the level of integration achieved thus far. Some respondents accounted for the

disagreement by explaining that the concept of integration as conceived by the ICPD may not be universally understood.

At the government level, the Ministry of Health and several other ministries are involved in reproductive health activities coordinated by DSF. For example, the Ministry of Youth collaborates with DSF on two projects. An official from DSF cooperates with an official from the Ministry of Youth to undertake activities in the field for youth health, such as setting up youth centers.

**Burkina Faso.** "In general, in terms of reproductive health policies and strategies in Burkina, we tend to remain at the theoretical level. Because we do not start developing strategies and objectives with our existing means, stumbling blocks arise and there is no follow-through." Despite the difficulties pointed out by the respondent, efforts at implementation have been made and new or revised policies have been integrated into directives. Since the ICPD, the government has emphasized the education of girls, with the goal of reducing the rate of female illiteracy. It has also focused on gender, population education, family life education, and human rights. Moreover, it has revised school texts to eliminate sexist stereotypes and created satellite schools and centers of nonformal education with a system of mandatory quotas (50 percent reserved for girls). Other initiatives include training and production centers for young girls and revision of the Penal Code in 1996 to

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*"In general, in terms of reproductive health policies and strategies in Burkina Faso, we tend to remain at the theoretical level. Because we do not start developing strategies and objectives with our existing means, stumbling blocks arise and there is no follow-through."*

Respondent, Burkina Faso

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include prison sentences for the practice of female genital cutting.

In addition to various government actions, several donors have participated in the implementation of projects. For example, UNFPA has always supported population and reproductive health programs. WHO helped the government develop the *National Strategy for Safe Motherhood*, a youth program, an evaluation of reproductive health needs, and the Integrated Management of Childhood Disease (IMSC) program. CONAPO conducts research on reproductive health, including family planning, youth health, and community-based services. UNICEF develops activities to improve the status of women and adolescent girls and to promote emergency obstetrical care and the health of children. GTZ is active in research and family planning and participates in the development of training curricula for family planning and community-based services. The World Bank is active through the Population and AIDS Control Project, which is dedicated to decreasing fertility and the spread of AIDS. USAID works through the SFPS Project, which develops models for high-quality services; the agency also participates in the development of national documents such as the revision of norms and standards.

Many NGOs and associations in Burkina Faso play a decisive role in developing and implementing reproductive health programs. In an attempt to coordinate activities, they are grouped under the Permanent Secretariat of NGOs and the NGO Monitoring Office.

The public sector typically provides MCH and family planning services. Except for the pharmaceutical sector, which is primarily limited to large towns, the for-profit and not-for-profit private sector is only slightly developed. Social marketing is a recent strategy that is so far focused on

condom distribution and oral rehydration therapy. Oral contraceptives and sometimes injectables are regularly sold in the market without prescription, thus testifying to unmet demand.

The essential services package provided at various levels of the health pyramid includes MCH and family planning services. Integrating services, however, is challenging, particularly because of the wide range of skills required of health personnel. As an executive at the Ministry of Health said, "How are we going to integrate all these reproductive health ideas that call on skills in such widely different fields?" As a result, many structures still offer services on different days; however, some progress is being made toward integration. RESAR instituted an integrated approach to offer high-quality postabortion care and modern contraceptive methods; the effort is yielding positive results. The ABBEF and DSF, with financial assistance from UNFPA, developed youth counseling services that are still in the experimental stage. Youth services are rare, but discussions are far advanced to integrate them into other structures, such as youth and cultural centers under the Ministry of Youth and Sports, training centers for young farmers under the Ministry of Agriculture, or other establishments under the Ministry of Secondary and Higher Education.

Constraints to effective implementation of reproductive health programs are varied. At the clinic level, personnel are highly mobile and poorly motivated, efforts to monitor the implementation of reproductive health programs are limited, and service providers lack information about reproductive health. Financial resources, infrastructure, and supplies are inadequate. At the community level, cultural practices such as female genital cutting, religious beliefs prohibiting the use of condoms, and the general low social status of women

hinder improvements in reproductive health. In addition, the extreme poverty of many beneficiaries makes the cost of services prohibitive to them.

**Cameroon.** Cameroon's adoption of health policies has not been followed up by an action plan or adequate sectoral strategies. For example, norms for MCH and family planning services have not been expanded to cover other areas of reproductive health such as STD/AIDS, postabortion care, genital infections, or diseases, including cancer. Nonetheless, the lack of an action plan has not prevented the implementation of programs in the field. For example, contraceptives are now available throughout the country, and the number of private structures offering family planning services has increased. The fight against STD/AIDS has gained in intensity, as have immunization programs for poliomyelitis. Particularly at the central level, additional progress has been made in the battle against gynecological cancers. IEC materials are being used to increase men's awareness of reproductive health issues and men's role in reproductive health, and personnel are undergoing training to provide a broader range of reproductive health services.

Public clinics provide most reproductive health services. Community-based services are still not highly developed. Social marketing provides condoms and pills and, since early March 1999, oral rehydration therapy. In addition, several NGOs offer reproductive health services, such as the IPPF affiliate Cameroon National Association for Family Welfare, which delivers integrated services for contraception and provides activities in the youth centers of four towns, counseling, prenatal care, and STD management. The private sector, both for-profit and not-for-profit, is highly developed and operates many private

clinics as well as hospitals affiliated with religious groups.

Health structures are organized to supply a maximum number of services needed by the population. The *Standards of Maternal and Child Health Care and Family Planning* stipulates that services must be integrated. In fact, they are necessarily integrated in health centers where the nurse, who generally has a wide range of skills, often works alone. Moreover, given that provision of the essential services package requires generalists, the government is undertaking the ongoing training of personnel. Currently, almost 22 percent of service delivery points include integrated family planning, and almost 40 percent address diarrhea, acute respiratory infections, immunization, and newborn monitoring, according to a Ministry of Health representative.

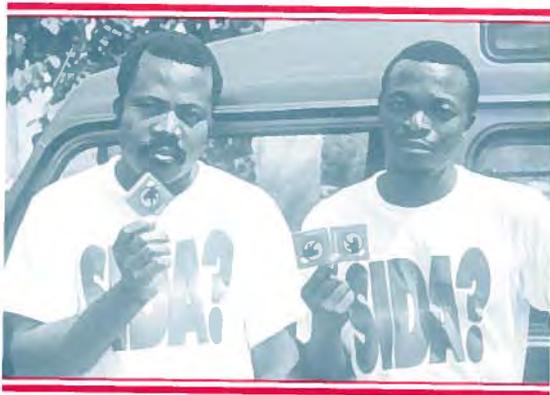
Inadequate infrastructure and resources and insufficient and unequal distribution of personnel make it difficult to deliver the full range of services. Other constraints include sociocultural barriers, such as community and religious attitudes toward reproductive health for adolescents, and legal barriers, such as the absence of a legal framework requiring service providers to offer services to adolescents.

**Côte d'Ivoire.** On an operational level, both the Triennial Population Plan and Triennial Action Plan for the Development of Women are under development in Côte d'Ivoire. Plans already completed and partially implemented include the Expanded Immunization Program Action Plan, the Strategy for Management of Childhood Diseases, and the National AIDS, STDs, and Tuberculosis Control Action Plan. The National Program for Reproductive Health and Family Planning is implementing activities. The Project for





the Development of Integrated Health Services is also being operationalized through the application of the essential services package at peripheral levels and the simultaneous reinforcement of priority national programs for family planning (entrusted to AIBEF) and STD/HIV/AIDS (managed by the National Program for AIDS, STDs, and Tuberculosis Control).



In 1996, Côte d'Ivoire operated 1,364 public health establishments. In addition, the private sector claimed 53 hospitals and private offices, 82 businesses with a medical service, and 212 private nursing stations. Only 3 to 4 percent of public sector facilities had already integrated family planning into their services, although the National Program for Reproductive Health and Family Planning envisions the progressive introduction of reproductive health services into all public health units. Currently, AIBEF provides most family planning and STD/AIDS services through its own clinics and at family planning service delivery points in some public clinics. The Ministry of Health and the World Bank selected AIBEF to implement family planning service delivery in rural zones under the Project for Development of Integrated Health Services. AIBEF manages nine clinics and supports family planning activities in 15 Ministry of Health hospitals and 87 Ministry of Health distribution points. It also provides community-based distribution in several locations. The social

marketing program, implemented by Population Services International, is another source of services, offering condoms, oral contraceptives, and oral rehydration solution.

Côte d'Ivoire and donors such as UNFPA have initiated projects, including a youth project under the Ministry of Youth, a project for family life education with the Ministry of Education, and a project for reproductive health in the military. Service providers have been trained in postabortion care and reproductive tract infection treatment while syndromic diagnosis of STDs is being integrated into the essential services package. In addition, the government is developing a program for the prevention of female genital cutting, although activities are not yet underway.

Several constraints inhibit the effective implementation of reproductive health. Health services are concentrated in the south of Côte d'Ivoire, particularly in the capital Abidjan, and coverage in the north is deficient. Health personnel have been inadequately trained, and those who have undergone training are frequently not given the supplies necessary to carry out their functions. Sociocultural factors also pose challenges to improving reproductive health. For example, 70 percent of women in Côte d'Ivoire are illiterate (World Bank, 1998) and therefore have little access to information about family planning and other reproductive health services; consequently, they are susceptible to misinformation and rumors and hold many false beliefs regarding the dangers of family planning. Some programs, such as those for youth, are controversial and meet with resistance. Finally, decisive action to implement policies is frequently lacking. According to one respondent, "There are too many hesitations in implementation."

**Mali.** As mentioned, Mali's 1990 *Sectoral Health and Population Policy*

provides the overarching policy orientation for the health sector, including reproductive health. A 10-year plan for health and social development (Plan Décennal de Développement Sanitaire et Social, 1998–2007) and a five-year program (Programme de Développement Sanitaire et Social, 1998–2002) were created to help operationalize the *Sectoral Health and Population Policy*, including its components regarding reproductive health. Plans and programs for some specific areas of reproductive health have also been developed or revised since the ICPD, including plans for AIDS control, STD control, and the elimination of excision, and programs related to perinatal care, NGOs, and integrated care for childhood diseases.

Under the *Sectoral Health and Population Policy*, Mali has emphasized the decentralization of health service delivery. Starting from the community level, each level in the health pyramid has a well-defined role as follows:

- village groups and urban neighborhoods provide an essential services package and community management of health centers;
- the circle level is responsible for making primary referrals, supervising the first level, and planning and management;
- the regional level provides secondary referral care and technical assistance to the circles; and
- the national level is responsible for orientation and strategic planning, defining norms and procedures, and evaluation.

Community participation is a key strategy to improving access to health services. The Health, Population, and Rural Hydraulics Project was developed to carry out the *Sectoral Health and Population Policy*, focusing specifically on

extension of health coverage, availability of medications, community participation, and water provision. A central component of the project has been the construction of community health centers, which are built and equipped with combined state and community resources, managed by community committees, and maintained through cost recovery. In five years, 374 community health centers were built or renovated under the project, with 300 more envisioned for the next five years.

Both the public and private sectors (NGOs, community associations, private and religious clinics) carry out activities. Liberalization of regulations governing the practice of private medicine before the ICPD has facilitated the growth of the private sector. NGOs have been particularly active in developing projects related to adolescent reproductive health and the elimination of excision.

The government of Mali had already begun integrating services before the ICPD. It established a spatial integration system with a precise description of the positions and duties of service providers. Policies, standards, and procedures have been revised and integration improved, but the optimal level of integration has not yet been achieved because, as one respondent says, “structures are inadequate to integrate all the new aspects.” Another respondent spoke of the “inadequacy of personnel and training.” One respondent said that family planning, postnatal visits, STD screening, newborn monitoring, and immunization are some integrated services that are offered by the

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*“[The NGOs] are truly independent; there are some that do not want to refer to the state structures, and that often creates conflicts in roles and responsibilities.”*

Regional-level respondent, Mali

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same staff at the same places. At the peripheral level, community health centers have the technical capabilities to provide the essential services package, including curative, preventive, and promotional activities. Staff have received some training in reproductive health, primarily family planning.

One constraint to implementing reproductive health programs is poor coordination of interventions. Several respondents mentioned that NGOs have helped the state provide services, but coordination between the state and the numerous NGOs has been difficult. As one respondent at the regional level said, “[The NGOs] are truly independent; there are some that do not want to refer to the state structures, and that often creates conflicts in roles and responsibilities.” Some regions have tried to address coordination problems by organizing regional forums. Another constraint is related to personnel. Though considerable efforts have been made to improve geographic access to health services, the number of personnel is insufficient, with just one doctor per 17,000 inhabitants and one midwife per 23,000 inhabitants. Additional constraints concern inadequacy of infrastructure and funding and sociocultural factors.



## Financial Resources for Reproductive Health

The five countries examined in this case study, especially Benin, Burkina Faso, and Mali, are poor countries with weak economies; consequently, they depend heavily on donor funding to implement their projects. With the exception of Côte d'Ivoire, the countries do not have a specific line item for reproductive health; therefore, it is difficult to determine the amount of money the governments allocate to reproductive health. For health programs in general, government budget allocations are low, but two of the five countries have made praiseworthy efforts to increase their contribution. Mali allocated 10.8 percent of its national budget to health in 1996, surpassing the 10 percent recommended by WHO. Côte d'Ivoire dedicated only 8 percent of its budget to health but dramatically increased its contribution to reproductive health between 1995 and 1997. With a contribution of less than 5 percent of its budget allocated to health programs, Cameroon seems to be the least committed.

The primary donors and technical agencies involved in reproductive health sectoral programs and projects are UNFPA, USAID, WHO, the World Bank, GTZ, UNICEF, United Nations Development Program (UNDP), and IPPF. IPPF is an international NGO that contributes to the financing of national family planning associations.

Although respondents acknowledge the critical importance of donor support, some expressed concern about overdependence on donors and the continuity of programs when donors withdraw. Respondents also emphasized that improving effective use of funds is as important as generating more money. Efforts to improve program sustainability are being made by implementing and reinforcing the cost-recovery system specified in the framework of the Bamako Initiative (see box, page 18).

**Benin.** Government financing for reproductive health in Benin remains low. Most respondents agreed that donors finance almost all reproductive health activities. According to a respondent from a training research center, however, "The most important innovation of the decade of the 1990s is community financing, and in 1994, it was estimated that 85 percent of health clinics were self-financed through community management, with the government participating only in the payment of salaries."

The primary donors and technical agencies involved in reproductive health in Benin are UNFPA, USAID, and UNICEF. These organizations are followed by the WHO, GTZ, UNDP, World Bank, and IPPF. UNFPA, for example, gave Benin US\$10 million in financing, of which \$5 million was for reproductive health in the



five-year program ending in 1998. Overall, donor contributions for reproductive health have increased since the ICPD. Some respondents, however, criticized the absence of a coordinating structure for donors, noting that the lack of such structure hinders the efficient allocation of resources.

Responses from the Benin case study show that underuse of available funds stemming from administrative sluggishness is a major concern. For example, Phase II of the Ministry of Health's IEC and Health Project was not carried out because officials were not able to develop a description of the program's goals and scope in a timely fashion. One respondent pointed out another difficulty: "Funds provided by donors for reproductive health are not always used for activities. There are examples of several Ministry of Health projects that were not carried out successfully because of poor management or allocation of funds and resources to activities different from what was defined in the terms of reference."

**Burkina Faso.** In Burkina Faso, the government allocated 19 percent of its funds to the social sectors in 1997 (Ministère de l'Économie et des Finances, 1998), close to the 20 percent recommended by the 1995 World Summit for Social Development in Copenhagen. The UNFPA progress report on the flow of resources allocated for population activities estimated that about 5 percent of financing for population activities comes from the government; 80 percent from funds allocated by donors for projects in partnership; 10 percent from NGOs; and 5 percent from various other associations (UNFPA, 1998). According to the report's conclusion, "In general, we note a weakness in internal resources (state and NGO) for financing population activities. If it hadn't been for the government credit from the World Bank and Kreditanstalt für

Wiederaufbau (KfW), the share of internal resources would have been fairly weak."

The primary donors that provide support to Burkina Faso for population policy are the World Bank and KfW, which, respectively, provided 61 and 20 percent of total spending for population activities in 1997 (Ministère de la Santé, 1998). Other donors included the United Nations (UNFPA, UNDP, UNICEF, UNAIDS), USAID (through the SFPS Project), the Netherlands, Denmark, the Rockefeller Foundation, and Family Planning Action International. NGOs active in Burkina Faso include Save the Children, Plan International, World Solidarity, IPPF, and the Population Council.

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*"Projects funded by the donors that have come to term have been either inadequately assumed by the government, or not at all."*

*National institution representative, Burkina Faso*

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Donor assistance has been invaluable in getting reproductive health programs established, but respondents expressed concern that the country has grown too dependent on outside sources and that the sustainability of programs cannot be ensured over the long term. As one representative of a national institution said, "Projects funded by the donors that have come to term have been either inadequately assumed by the government, or not at all." USAID's departure in 1995 is an edifying example. USAID had ensured the national provision of contraceptive supplies, but after the agency's departure, the national structures were ill prepared to take over that function such that stockouts have been frequent.

As part of an effort to increase the sustainability of health programs, including reproductive health, the Bamako Initiative

was launched in 1993. The goal was to acquire standardized kits of generic drugs, to train health personnel and members of management committees, and to supply each health center with a drug kit and management tools. Many lenders, including the World Bank, supported the creation of a purchasing cooperative for generic drugs. In the beginning, the results of the cost-recovery strategy were excellent. Community involvement increased and considerable income was generated. Difficulties arose, however, when program managers accelerated the process in 1994. Popular participation ebbed, other donors felt crowded out by the World Bank and lost interest, and a lack of control over the management of funds led to significant misappropriations. To deal with these problems, the Ministry of Health created 11 regional health offices in 1996 to replace the 30 former provincial offices that were recognized as incapable of managing the situation.

**Cameroon.** In Cameroon, the Ministry of Health's total budget for fiscal year 1995–1996 was less than 5 percent of the national budget (Ministère de la Santé, 1998), the lowest allocation of the five case study countries. The government therefore relies heavily on foreign financial assistance. International aid received in 1996 accounted for 66 percent of total public health spending, according to a Ministry of Health respondent. Government funds are used primarily for infrastructure redevelopment, payment of salaries, and health unit operating expenses. The development of reproductive health programs is funded principally by donors. The Ministry of Health's budget contains no line item

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*“We have no particular interest in reproductive health. It is one activity among many others in the ministry.”*

Ministry of Health representative, Cameroon

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specific to reproductive health. As one Ministry of Health representative said, “We have no particular interest in reproductive health. It is one activity among many others in the ministry.” In fact, donor funding for reproductive health would seem to replace ministerial funds, which get used for programs that are less attractive to donors.

In Cameroon, the primary reproductive health donors cited by key informants are UNFPA, USAID, and the World Bank. Other donors include UNICEF, UNDP, WHO, GTZ, the European Union, and the African Development Foundation. Several respondents criticized the donors for their lack of coordination.

To ensure the sustainability of services, the government is increasingly taking steps to mobilize internal resources, particularly the spread of cost recovery through drug purchases and the payment of services in health centers. Some hospitals have even obtained a special waiver permitting them to use 50 percent of receipts collected locally. Community participation began in the late 1970s and has been reinforced since 1989 by the Bamako Initiative. Nonetheless, the initiative has been successfully implemented in only five out of 10 of Cameroon's provinces, primarily in the English-speaking region, where policy has called for community participation in health management since the colonial era. Because of the long tradition of community involvement, the government had no trouble convincing the population in the English-speaking provinces to accept the principle of participation. In contrast, the initiative has not yet taken hold in the French-speaking provinces because people have become accustomed to receiving free care.

The Northwest Province is one area where community participation has succeeded. In 1995, the Provincial Health Delegation developed the Northwest



Health Fund, to which village communities in each health district make monthly or annual contributions to finance health services in the province. One service provider said that funds from the central level are unreliable, but, "...thanks to this [community] fund, our activities don't stop often." Locally elected health committees are responsible for managing materials, equipment, and funds from cost recovery.

**Côte d'Ivoire.** Currently, the Ministry of Health receives over 8 percent of Côte d'Ivoire's general operating budget. It is difficult, however, to determine the proportion of government contributions specifically allocated for reproductive health programs because contributions primarily cover infrastructure and salaries. Nonetheless, the budget for the National Program for Reproductive Health and Family Planning has increased dramatically in the past few years, from 3 million CFA francs in 1995 to 300 million in 1996 to 650 million in 1997 (according to a respondent from the National Program for Reproductive Health and Family Planning). AIBEF activities receive state support through an annual subsidy of 200 million CFA francs. In 1998, other NGOs active in the health sector received 554 million CFA francs from the Ministry of Health to cover fixed operating expenses.

Both the government and NGOs are making efforts to promote the sustainability of programs through cost recovery. At AIBEF, clients pay for the first visit (200 CFA francs). Follow-up services are free, but products require payment. In other structures, such as the National Institute of Public Health, payment is made according to the type of service except in the case of prevention activities (nutrition, immunization, child follow-up, etc.), which are free. Implementation of the Bamako Initiative in nine districts represents another effort to increase cost

recovery. The unavailability of essential drugs and limited success in collecting fees have, however, undermined the cost-recovery system.

Through certain donors or specific programs, it is possible to assess the scope of interventions according to level of financing. In the project for developing integrated health services, the World Bank provided \$13.5 million for the reproductive health and STD/AIDS component. UNFPA contributed \$12.5 million under its government assistance program (1997–2001), including \$6.5 million for reproductive health activities. The regional SFPS Project, funded by USAID, has provided \$40 million between 1995 and 2000 for activities supporting development and skill acquisition. Other donors in reproductive health include the African Development Bank, the European Union, UNESCO, WHO, UNICEF, and donor organizations from France, Japan, Germany, Belgium, and Canada.



Given the substantial levels of government and donor contributions to reproductive health, several respondents concurred that the primary problem is not a lack of financial resources but rather the ineffective use of those resources. As one recent report affirms, "The weak performance of the public health system is not related to an inadequate budget... It results from the choice of the allocation of resources that has given precedence up to

now to the tertiary level and curative care to the detriment of the primary and secondary levels of the health pyramid..." (Tapinos et al., 1998). Similarly, one respondent reported that resource allocation does not always correspond to priorities, as was the case with one project on adolescent sexual and reproductive health, which, according to one respondent, began "...without an evaluation of the needs of the youth because people were in a hurry to have the financial resources."

**Mali.** Mali has no separate line item for reproductive health, but respondents agree that reproductive health accounts for a significant part of the overall health budget. Government contributions to health increased in recent years from 9.6 percent of the total budget in 1997 to 10.0 percent in 1998 and 10.8 percent in 1999 (MSPAS, 1997–1999). Moreover, the government finances some NGOs, such as the AMPPF and the Health, Population, and Rural Hydraulics Project; however, most funds for NGOs come from donors.

Primary donors include UNFPA, USAID, UNICEF, WHO, and international NGOs and associations (Plan International, Population Council). Most respondents felt that lender resources have increased since the ICPD; in fact, they have decreased. The proportion of health sector funds received from donors dropped from 57.9 percent in 1997 to 46.7 percent in 1998 and 35.3 percent in 1999 (MSPAS, 1997–1999); however, given that donor contributions are still extremely important in absolute terms, reproductive health financing remains heavily dependent on foreign aid. Funding for family planning and AIDS programs is generally sufficient,

but other areas of reproductive health do not receive as much attention.

To continue projects after foreign financing ends, Mali has, like all the other countries in the subregion, implemented the Bamako Initiative. It conducted the first experiments with cost recovery in the late 1980s but did not develop the conceptual framework for the initiative until August 1989. At that time, goals, objectives, and strategies were recorded in the "Plan for the Stimulation of Primary Health Care/ Bamako Initiative: Conceptual Framework."

The first implementation stage of the Bamako Initiative was the development and implementation of a master plan for supplying essential drugs, thereby making it possible to ensure the availability of essential drugs even in peripheral structures. The next stage was the development and negotiation of health maps by the health services at the circle level. Finally, as mentioned, community health centers were established with community participation and cost recovery, and referral and cost-sharing systems were established within each circle.

One respondent stressed the importance of not only increasing funds but also using existing funds efficiently: "The health niche is lucrative and everyone knows it. Financial resources have been wasted with respect to the results obtained." To avoid duplication and waste, the new Health and Social Development Program is designed to provide services through a coherent "program approach" rather than a piecemeal, vertical "project approach."



## Summary and Conclusion

Not surprisingly, the five case studies reveal many similarities. After all, the five countries share a similar colonial heritage, exhibit many of the same general social and cultural patterns, and confront some of the same general economic and developmental challenges. The countries also interact regularly. They participate in the same regional conferences that help to shape their policies; they use their neighbors' policies and programs as models; and they consult the same technical experts and donor representatives who travel throughout the region and apply similar ideas in each

country. Despite the similarities, however, each country has its own unique history, culture, and political context, all of which lead to differences in the specific challenges faced by the five countries and the approaches to addressing them.

Table 2 shows the progress made by each country in formulating and implementing reproductive health policies and programs. While the context in all five countries has limited the delivery of high-quality reproductive health services to much of the population, all five countries have made significant progress in developing reproductive health policies.

**TABLE 2. PROGRESS TOWARD IMPLEMENTING POST-CAIRO REPRODUCTIVE HEALTH (RH) POLICIES AND PROGRAMS, 1998**

COUNTRY	ADOPTION OF ICPD DEFINITION	PARTICIPATION AMONG STAKE-HOLDERS	SUPPORT AMONG STAKE-HOLDERS	SETTING PRIORITIES AMONG RH ELEMENTS	RH PROGRAM IMPLEMENTATION	MOBILIZATION OF RESOURCES FOR RH
Rating scale	++ adopted ICPD + toward ICPD = the same	++ high + partial = low	++ broad + partial = low	++ fully set + partially set = not set	++ full + partial/in progress = little/no change	++ strong + partial = little/no change
Benin	++	+	+	+	+	=
Burkina Faso	++	++	+	=	=	+
Cameroon	+	++	+	=	+	+
Côte d'Ivoire	++	++	+	=	+	++
Mali	++	++	+	=	+	++

*Note: The assessment reflects the judgment of the local study teams.*

Except for Cameroon, all the countries held workshops following the ICPD to spread the concept of reproductive health and to arrive at a consensus on the meaning of the term in each country's context. While Côte d'Ivoire is the only country to have developed and disseminated a program specific to reproductive health, all of the countries have incorporated the concept into new plans for health and population. And some countries revised the national population policy to include reproductive health. Many respondents commented, however, that the new policies require further dissemination and that the concept of reproductive health is still not widely understood, particularly outside the capital city.

The case studies revealed that governments have warmed to civil society participation in developing and implementing reproductive health programs and that the number of reproductive health NGOs in the countries has multiplied in recent years. However, the effectiveness of such participation is uncertain. Several respondents cited the institutional weakness of many NGOs. For their part, several NGO representatives said that although they are often invited to attend workshops, the invitation is usually a formality, and they are not included as active partners, which limits their ability to effectively participate.

Only in the past 10 years has political support for family planning programs begun to take root in the five case study countries. Support increased as leaders, first, began to perceive family planning as a critical element of MCH rather than as a means to control population growth and, second, came to understand the potential negative consequences of rapid population growth. Leaders have also had an easier time accepting the new focus on the broader, more integrated concept of reproductive health and its emphasis on

overall health. However, some components of reproductive health, including reproductive health services for youth and programs for the elimination of female genital cutting, have been controversial and have elicited opposition. In addition, many respondents commented that, although the political leadership may be supportive, the population is generally socially conservative and lags behind. Religious leaders, particularly Islamic and Catholic leaders, have also opposed some aspects of reproductive health.

Little progress has been made in setting reproductive health priorities. As countries have developed reproductive health programs, they have tried to address the full range of issues outlined in the ICPD *Programme of Action* without systematically assessing which areas should receive high priority. When national programs embrace all reproductive health components without identifying priorities, each organization is left to set its own priorities according to its own perceptions. Setting national priorities is critical to the effective channeling of the region's limited resources to support programs in areas of greatest need.

Though the five countries were already implementing some reproductive health programs before the ICPD, the new reproductive health concept focused on issues that had not previously received much attention. These issues have been largely incorporated into policies and programs but are just beginning to be implemented in the field. Some of the newer projects address areas such as female genital cutting and reproductive health services for youth and men. In addition, personnel are being trained to increase their understanding of the new reproductive health orientation and to improve their skills in order to provide a broader range of integrated reproductive health services.



Despite these efforts, actual implementation of programs lags far behind policy formulation. Numerous challenges confront those trying to make high-quality reproductive health care available and accessible to the population. Some frequently cited obstacles include a lack of personnel and the unequal distribution of existing personnel and infrastructure (generally concentrated near the capital city). At the same time, social issues, such as the generally low status of women and women's low income and education levels, are serious barriers to reaching women with reproductive health information and services. Poor coordination is another problem that has hindered program implementation. The integrated reproductive health approach requires the involvement of a large number of actors to implement the various parts of the program. A few of these actors include representatives from the ministries of Education, Health, and Planning, donor agencies, and NGOs. All of the countries reported that coordination among these actors has been problematic. However, many respondents pointed out that only a few years had passed since the ICPD, and it was therefore not surprising that implementation was still incomplete. Initially, countries focused on the development of plans and policies to guide interventions—a process that is now nearly complete. Currently, they are turning their attention to interventions in order that the comprehensive reproductive health services described in the plans and policies are actually available in the field.

All five countries have limited financial resources and rely heavily on donor assistance. Despite these constraints, they are trying to mobilize internal resources for reproductive health. Mali and Côte d'Ivoire in particular devote a substantial portion of their budgets to health in general and reproductive health in particular. All of the countries, but especially Mali, are making efforts to mobilize community resources through cost recovery. In addition to the quantity of resources, however, more effort needs to be devoted to ensuring the effective and efficient use of resources.

In conclusion, all of the countries have made tremendous progress toward developing reproductive health policies and programs, and, at the same time, they have become more receptive to the participation of civil society in the policy formulation process. While the five countries have initiated activities to improve the delivery of reproductive health services, they still need to do much in the area of implementation. Poverty and underdevelopment in the region are major constraints, making it more important that countries focus on priority interventions and improving the efficient use of existing resources. The case studies also highlighted the need to continue efforts to create broad-based support for reproductive health programs, improve coordination among stakeholders, and strengthen the growing number of NGOs that can effectively participate in policy processes.



# Appendix



## **Summary Tables of Reproductive Health Policies and Programs**



## Summary Tables of Reproductive Health Policies and Programs

**TABLE A1. EXISTENCE OF POLICIES COVERING REPRODUCTIVE HEALTH IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1999**

COMPONENTS OF REPRODUCTIVE HEALTH	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Family planning	<p>1996: National Population Policy</p> <p>1996: National Maternal and Child Health, Family Planning, and Nutrition Program</p> <p>1999: Policy and Norms in Family Health</p>	<p>1991: National Population Policy</p> <p>1992: Policy and Standards for Maternal and Child Health/Family Planning</p> <p>1996: Reproductive Health Strategic Plan</p> <p>1997: National Strategy of Safe Motherhood</p> <p>2000: Revision of National Population Policy (draft)</p>	<p>1992: Standards for Maternal and Child Health/Family Planning</p> <p>1992: National Population Policy</p> <p>1996: Declaration of Health Policy</p>	<p>1999: Reproductive Health Services Policy</p> <p>1999: Reproductive Health Service Standards</p> <p>1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire</p>	<p>1991: Population Policy</p> <p>1990: Sectoral Health and Population Policy (revised post-ICPD)</p> <p>1996: Policies, Standards and Procedures in Reproductive Health/ Family Planning</p> <p>In progress: National Reproductive Health Program</p>
Prenatal care	<p>1996: National Population Policy</p> <p>1997: Policy and Strategy for Development of the Health Sector, 1997-2001</p> <p>1999: Policy and Standards in Family Health</p>	<p>1992: Policy and Standards for Maternal and Child Health/Family Planning</p> <p>1994: National Program for Maternal and Child Health/Family Planning</p> <p>1997: National Strategy of Safe Motherhood</p>	<p>1992: Standards for Maternal and Child Health/Family Planning</p> <p>1992: National Population Policy</p> <p>1993: Primary Health Care Program</p> <p>1996: Declaration of Health Policy</p>	<p>1999: Reproductive Health Services Policy</p> <p>1999: Reproductive Health Service Standards</p> <p>1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire</p>	<p>1990: Sectoral Health and Population Policy (revised post-ICPD)</p> <p>1996: Policies, Standards and Procedures in Reproductive Health/ Family Planning</p>

**TABLE A1. EXISTENCE OF POLICIES COVERING REPRODUCTIVE HEALTH IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1999 (CONT.)**

COMPONENTS OF REPRODUCTIVE HEALTH	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
STDs	<p>1997: Policy and Strategy for Development of the Health Sector, 1997-2001</p> <p>1996: National Population Policy</p> <p>1999: Policy and Standards in Family Health</p>	<p>1990: National AIDS and STD Control Program</p>	<p>1989: National AIDS Control Program</p> <p>1992: Standards for Maternal and Child Health/Family Planning</p> <p>1993: Primary Health Care Program</p> <p>1996: Health Policy</p>	<p>1987: National Committee for AIDS Control (CNLS)</p> <p>1993: National AIDS and STD Control Program</p> <p>1995: National AIDS, STD, and Tuberculosis Control Program</p>	<p>1987: National AIDS Control Program</p> <p>1990: Sectoral Health and Population Policy (revised post-ICPD)</p> <p>1994: Guidelines for Syndromic Management of STDs</p>
HIV/AIDS	<p>1997: Policy and Strategy for Development of the Health Sector, 1997-2001</p> <p>1996: National Population Policy</p> <p>1999: Policy and Standards in Family Health</p>	<p>1990 National AIDS and STD Control Program</p> <p>1990-93 Medium Term Plan I</p> <p>1993-95 Medium Term Plan II</p>	<p>1989: National AIDS Control Program</p> <p>1992: Standards for Maternal and Child Health/Family Planning</p> <p>1993: Primary Health Care Program</p> <p>1996: Health Policy</p> <p>1999: AIDS re-search program</p>	<p>1987: CNLS</p> <p>1993: National AIDS and STD Control Program</p> <p>1995: National AIDS, STD, and Tuberculosis Control Program</p>	<p>1987: National AIDS Control Program</p> <p>1990: Sectoral Health and Population Policy (revised post-ICPD)</p>
Infertility	<p>1996: National Maternal and Child Health, Family Planning, and Nutrition Program</p> <p>1999: Norms and Standards in Reproductive Health Policy</p>	<p>1992: Policy and Standards for Maternal and Child Health/Family Planning</p> <p>1994: National Program for Maternal and Child Health/Family Planning</p>	<p>1992: Standards for Maternal and Child Health/Family Planning</p>	<p>1999: Reproductive Health Services Policy</p> <p>1999: Reproductive Health Service Standards</p> <p>1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire</p>	<p>1996: Policies, Standards and Procedures in Reproductive Health/Family Planning</p>
Safe motherhood	<p>1999: Norms and Standards, National Family Planning, Maternal and Child Health Program</p>	<p>1992: Policy and Standards for Maternal and Child Health/Family Planning</p> <p>1997: National Strategy of Safe Motherhood</p>	<p>1992: Standards for Maternal and Child Health/Family Planning</p> <p>1996: Health Policy</p>	<p>1999: Reproductive Health Services Policy</p> <p>1999: Reproductive Health Service Standards</p> <p>1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire</p>	<p>1993: Program for perinatal period developed and subsequently implemented</p>



**TABLE A1. EXISTENCE OF POLICIES COVERING REPRODUCTIVE HEALTH IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1999 (CONT.)**

COMPONENTS OF REPRODUCTIVE HEALTH	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Postabortion care	1999: Norms and Standards, National Family Planning, Maternal and Child Health Program	1998: Development of two experimental projects	No policy	1999: Reproductive Health Services Policy  1999: Reproductive Health Service Standards  1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire	1996: Policies, Standards and Procedures in Reproductive Health/ Family Planning
Genital tract infections	1999: Norms and Standards, National Family Planning, Maternal and Child Health Program	1994: Policy and Standards for Maternal and Child Health/Family Planning  1996: Reproductive Health Strategic Plan  1997: National Strategy of Safe Motherhood	1992: Standards for Maternal and Child Health/Family Planning  1992: National Population Policy  1993: Primary Health Care Program  1996: Health Policy	1999: Reproductive Health Services Policy  1999: Reproductive Health Service Standards  1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire	Included in 1990 Sectoral Health and Population Policy. No specific document.
Reproductive health services for adolescents	1999: Policy and Standards in Family Health	1996: Reproductive Health Strategic Plan  1996: National Youth Health Program (being developed)	No policy	No policy but existence of project IVC/98/PO3.1998	Nothing specific beyond the documents cited above which include reproductive health for adolescents; other considerations in progress.
Maternal and child nutrition	1999: Policy and Standards in Family Health	1994: National Maternal and Child Health/Family Planning Program  1997: National Nutrition Action Plan	1992: Standards for Maternal and Child Health/Family Planning	Policy and program in the approval process	Being drafted.
Genital cancers	1999: Policy and Standards in Family Health	1992 Policy and Standards for Maternal and Child Health/Family Planning  1994: National Maternal and Child Health/Family Planning Program	1992: Standards for Maternal and Child Health/Family Planning  1994: Primary Health Care Program	1999 Reproductive Health Services Policy  1999: Reproductive Health Service Standards  1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire	1996: Policies, Standards and Procedures for Reproductive Health/ Family Planning



**TABLE A1. EXISTENCE OF POLICIES COVERING REPRODUCTIVE HEALTH  
IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1999 (CONT.)**

COMPONENTS OF REPRODUCTIVE HEALTH	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Female circumci- sion	1999: Policy and Standards in Family Health	1990: Creation of National Commit- tee against Exci- sion  1997: Law penaliz- ing practice of fe- male genital cut- ting  1998: Action Plan of the Ministry for the Promotion of Women	No policy	No assessment (n/a)	National Committee against Practices Harmful to the Health of Women and Children cre- ated by Decree No. 382/PM-RM of the 12/31/1996 Na- tional Action Plan for the Abandon- ment of Excision, drafted in 1997, fi- nalized and pre- sented to the Coun- cil of Ministers in 1998
Violence against women	None	1998: Action Plan of the Ministry for the Promotion of Women	1997: National Ac- tion Plan for the In- tegration of Women in Devel- opment	National Policy for the Development of Women  National Action Plan for Women currently in the adoption process	National Action Plan for the Promo- tion of Women 1996-2000 (not limited to violence against women, ad- dresses many other topics as well)





**TABLE A2. POLICY ENVIRONMENT FOR IMPLEMENTING REPRODUCTIVE HEALTH PROGRAMS IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1998**

COMPONENTS OF POLICY ENVIRONMENT	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Level of participation in the development of reproductive health policies and programs by: <ul style="list-style-type: none"> <li><input type="checkbox"/> Ministries (other than Health)</li> <li><input type="checkbox"/> NGOs involved in reproductive health</li> <li><input type="checkbox"/> Women's lobbies</li> <li><input type="checkbox"/> Religious leaders</li> <li><input type="checkbox"/> Community leaders</li> <li><input type="checkbox"/> University</li> </ul>	High Medium Low Very low Medium Medium	High Medium Medium Low Medium High	High High Medium Medium Medium High	High Medium Medium Low High Almost nonexistent	High High Low Medium High Medium
Degree of support for reproductive health by political leaders: <ul style="list-style-type: none"> <li><input type="checkbox"/> President</li> <li><input type="checkbox"/> Prime Minister</li> <li><input type="checkbox"/> Members of Parliament</li> <li><input type="checkbox"/> Ministers</li> </ul>	High High Mixed High	High High High Varies	High Medium Varies Varies	High No assessment Medium No assessment	High Medium High No assessment
Degree of support for reproductive health and influence of religious leaders: <ul style="list-style-type: none"> <li><input type="checkbox"/> Support</li> <li><input type="checkbox"/> Influence</li> </ul>	Low High	Low Low	Mixed Low	Medium Medium	Medium Medium
Existence of a plan for implementation of reproductive health policies and programs <ul style="list-style-type: none"> <li><input type="checkbox"/> National level</li> <li><input type="checkbox"/> Subnational level</li> </ul>	Yes Yes	Yes Yes	Not yet Yes	Being developed Being implemented	Yes Yes
Structure of reproductive health programs <ul style="list-style-type: none"> <li><input type="checkbox"/> Vertical or integrated?</li> </ul>	Integrated: maternal and child health/family planning/STDs	Partially integrated	Gradually integrating services in health centers, including the National AIDS Control Program /EPI/nutrition/MCH/family planning	Implementation in progress (prenatal/reproductive health/family planning)	Integrated particularly for family planning/postnatal care, immunization



**TABLE A2. POLICY ENVIRONMENT FOR IMPLEMENTING REPRODUCTIVE HEALTH PROGRAMS IN FIVE FRANCOPHONE AFRICAN COUNTRIES, 1998 (CONT.)**

COMPONENTS OF POLICY ENVIRONMENT	COUNTRY				
	BENIN	BURKINA FASO	CAMEROON	CÔTE D'IVOIRE	MALI
Knowledge of reproductive health components of reproductive health policy and programs by service providers: <input type="checkbox"/> in the public sector <input type="checkbox"/> in the private sector <input type="checkbox"/> in NGOs	Low Low Medium	Medium Medium Low	Medium Medium Low	Medium Low Medium (high for AIBEF, low for the rest)	Low Very low Very low
Training on various reproductive health components for service providers belonging to: <input type="checkbox"/> the public sector <input type="checkbox"/> the private sector <input type="checkbox"/> NGOs	Mixed Low Low	Medium Low High	Medium Medium Low	Medium Low High for most AIBEF providers	Medium Medium Medium
Increase in resources allocated to reproductive health following the resolutions of the ICPD in 1994: <input type="checkbox"/> of the public sector <input type="checkbox"/> of the private sector <input type="checkbox"/> of NGOs <input type="checkbox"/> of donors	Yes Yes Yes Yes	Yes No assessment Yes Yes	Yes Yes Yes Yes	Yes No Yes Yes	Yes Yes Yes Yes
Adequacy of resources for implementation of reproductive health programs	Inadequate	Substantial for family planning and AIDS control	No assessment	No assessment	Adequate for family planning/AIDS; insufficient for other elements
Percent of national resources for implementation of reproductive health programs (% of national budget)	Very low	20% of national budget allocated to social sectors including health	5% for health	8% for health, significant increase for reproductive health in 1997	11% for health, no separate budget for reproductive health



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1. *Reproductive Health and Human Capital: A Framework for Expanding Policy Dialogue* by Barbara Seligman, Daniel Kress, William Winfrey, Imelda Feranil, and Kokila Agarwal. April 1997.
2. *Post-Cairo Reproductive Health Policies and Programs: A Comparative Study of Eight Countries* by Karen Hardee, Kokila Agarwal, Nancy Luke, Ellen Wilson, Margaret Pendzich, Marguerite Farrell, and Harry Cross. September 1998.
3. *The Art of Policy Formulation: Experiences from Africa in Developing National HIV/AIDS Policies* by John Stover and Alan Johnston. August 1999.
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