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West Africa Reproductive Health Commdity Security

Study Phase 1

Task Report: 6

Regional Reproductive Health Policy

DELIVER
No Product? No Program. Logistics for Health

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Meba Kagone

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DELIVER
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Rationale for Reproductive Health Policy Analysis

This study includes a regional policy analysis to provide an updated picture of the reproductive health (RH) policy environment and to identify the main decision makers and their roles in this environment. The analysis describes what has taken place so far and what changes have occurred in RH programs and the lives of women and children as a result of these actions. The analysis will also identify what still needed to be done to enhance the results achieved so far, overcome the constraints, and fill the gaps, especially in the area of commodity security.

Background Information on the Reproductive Health Situation Analysis in West Africa

Maternal and infant mortality rates are still unacceptably high in the West Africa region. For example, the maternal mortality ratio is 400 per 100,000 live births worldwide, 280 in Asia, 190 in Latin America and the Caribbean, and 1,100 In West Africa. Infant mortality rate is still very high compared to other regions. Additionally, with these high mortality rates, there is a high level of population growth. For example, the population of sub-Saharan Africa will double by 2035. The rate of growth is fueled by unplanned and unwanted fertility. Fertility in the region remains high, between 5–7 children per woman, but the desired fertility is considerably lower. Family planning performance in the West African region is very weak. While modern contraceptive use is 40–50 percent around the world, only 13 percent of sub-Saharan women use modern family planning methods. For the Economic Community of West African States (ECOWAS) countries, modern contraceptive use is less than 10 percent for all member states, with the exception of Ghana (13 percent) and Cape Verde (46 percent). There is a startling contrast between the low use of contraceptives and a huge unmet demand for child spacing and limitation of birth among all women, ranging 18 percent in Niger to more than 40 percent in Togo. Moreover, Demographic and Health Surveys (DHS) show that a large percentage of men express a desire to space and limit births.

Unmet need for family planning has a significant impact on women and girls, as well as their infants and families. As a consequence of unmet need, the maternal mortality ratio, as well as the infant mortality rate, mentioned earlier, are very high. Many women in West Africa die or suffer serious disabilities from medically unsafe abortion procedures.

While the impact of HIV/AIDS in sub-Saharan Africa has received a great deal of media coverage and programs to mitigate the impact of that disease have increased, resources and political will for family planning programming appears to have stagnated. The steep drop in worldwide family planning funds from wealthy nations contributed to more than 300 million unintended pregnancies. Other constraints and gaps in the West African region include weak service delivery capacities of national governments; limited technical and management leadership; poverty that limits family expenditures on health; inadequate knowledge and poor health-seeking behavior by beneficiary populations; inadequate funding; and variable and unpredictable levels of donor support.

Reproductive Health Policies Environment

Policy environment is defined as the array of factors that affect program performance and that can be addressed through policy change and advocacy. Thus, the environment encompasses laws, including—

- constitutional and human right laws
- regulations and policies at national and operational levels
- decision-making processes surrounding policy formulation,
- planning and budgeting
- actual allocation of material and financial resources at all levels,
- use of data in policy analysis
- institutional arrangements for implementing programs
- will of leaders in legislative and executive branches to act
- regulatory climate for the commercial sector and for the medical profession
- support of civil society including religious leaders.

This section discusses the laws and policies in reproductive health (RH) and commitment from country leaders in the implementation of RH policies.

Reproductive Health Laws and Policies

A legal and policy framework is important for governments to orient and coordinate a coherent national response and mobilize needed internal and international resources.

- A major law in Francophone Africa was the 1920 French law, applied to the colonies in the 1930s, which imposed a total ban on contraception and abortion in Francophone Africa. But, this law has been repealed or modified in all countries to allow family planning programs to develop.
- All ECOWAS countries are formally committed to key international agreements and conventions that affect family planning/reproductive health (FP/RH), although the countries vary in the degree to which they have integrated them into national laws and policies
- The 1994 international conference on population and development had an important impact on RH policies in West Africa. It marks the turning point in the definition of RH and in the shaping of RH laws and policies.
- The concept of RH has evolved from only family planning to include HIV/AIDS and issues related to youth, men, and the elderly, including sex education, women rights, and maternal and child health.
- These changes necessitated a development of RH/FP policy, which usually includes safe motherhood, adolescent reproductive health, and prevention and management of unsafe abortions.

In March 1997 a symposium was held in Cotonou to discuss legal barriers to FP/RH, It was organized by International Planned Parenthood Federation (IPPF) with technical and financial support from the POLICY Project, USAID, UNFPA, and other international and regional organizations and participants including high-level officials from fifteen Francophone countries. The symposium concluded with the

Cotonou declaration pledging to reduce legal-policy barriers to FP/RH and to eliminate practices harmful to women's health. As a consequence, since 2000 several countries have enacted comprehensive RH laws and other countries have drafted similar legislative proposals.

Laws and policies affecting the reproductive lives of women have been analyzed in seven ECOWAS countries, including Ghana, Nigeria, Benin, Burkina Faso, Côte d'Ivoire, Mali, and Senegal. The laws and policies are as follows:

Population Policies

Each country has developed and adopted a population policy under the guidance and funding of international organizations, with the objective of slowing the population growth to keep pace with economic growth and improving the health of women and children through child spacing. Each population policy has a section on family planning, with stated objectives in terms of the contraceptive prevalence rate (CPR) to be reached and related activities to be carried out. However, there is no analysis of unmet needs for family planning or how to design programs and secure resources to target these unmet needs. As a consequence, FP programs do not meet the objective of slowing population growth or improving maternal and infant health. The Ministry of Planning is responsible for the implementation of the population policy for population issues and by the Ministry of Health for family planning. Other ministries, such as the Ministries of Women Affaires, Youth, and Sports, participate in implementing the FP/RH section.

In general, in all countries, there is no restriction for services for any segment of the population that need them. For example, in most of these countries, women can get contraceptives without the authorization of their husbands.

Policy for the Private and Nongovernmental Organization Sector

Most country governments know that private sector effort, including private health services and pharmacies, is necessary to achieve government objectives in health.

Most countries have provisions in their policies for the private sector. It has been an important source for family planning services. For example, in Ghana 52.2 percent of women using modern methods obtain them from private sources. In Nigeria, the private sector is also the primary source for contraceptives. In Burkina Faso, 19.3 percent of modern contraceptive users obtain the services from the private sector; whereas in Côte d'Ivoire [missing something].

Nongovernmental organizations (NGOs) are playing an ever-increasing role in providing family planning services. In all countries, private pharmacies play a role in providing contraceptive products to clients, although the importance of this source varies from country to country. For example, 26 percent of clients get their commodities from private pharmacies. In Mali, this proportion is 9.55 percent. In general, Anglophone countries are more involved with the private sector than their Francophone counterparts.

However, it is difficult to find a well-articulated policy that integrates the private sector and clearly describes its role in health programs and the incentives the government will provide to this sector to perform well. Government workplans do not elaborate on how actions will be taken to involve the private sector more effectively in commodity supplies.

NGOs are frequently sponsored by international organizations, and their performance is often hampered by limited resources.

The government and the private sector should have a formal partnership with an explicit description of roles and objectives, as well incentives for the private sector to perform its roles. Other laws and policies in ECOWAS countries include—

Reproductive Health/Commodity Policy

The Bamako initiative, a policy adopted in Bamako in 1989, had the goal of improving the health of women and children. One key point of the policy was to make drugs more available to these segments of the African population. The policy is the most important milestone in policy development and implementation around commodity security in West Africa and sub-Saharan Africa, in general.

It is a major health policy adopted by all sub-Saharan African countries under the guidance of the World Health Organization (WHO) and UNICEF.

Key components of this policy include—

- Restructuring of health services and decentralization.
- Autonomous management of health services with community participation and use of cost recovery mechanism for health services and drugs. The health facilities should be able to operate without outside financial assistance, including the purchase of drugs.
- Community participation in the planning process and the implementation of plans adopted.
- For drug and pharmaceutical policy, WHO has proposed a model list of essential drugs that can be adapted in each country. Each level of the health system should have an essential drug list tailored to its need.

External sources should plan the initial funding, which will be sustained later with costs recovered from the sales of drugs and services by the community.

Each country has implemented this policy according to its local context but, in general, in all countries where the Bamako initiative is implemented, the following characteristics are found:

- development and operation of health districts
- involvement of community members in managing health services and drug cost recovery system
- an essential list of generic drugs to be used in the country
- enacting laws to facilitate their import
- creating and operating a central procurement agency
- rationalizing drug prescription
- establishing a logistics system for the distribution, storage, and management of essential generic drugs at all levels of the health system, primarily at the regional, district, and service delivery levels.

In general, in these countries there is a drug and pharmaceutical policy that encompasses most elements cited above. Some of the policy documents made provision for providing incentives to the private sector so that it can be involved in the business of procurement and distribution of quality essential drugs, as well as local manufacturing of these drugs. However, there has never been an explicit statement in the policies regarding reproductive health drugs. More specifically, contraceptives have never been mentioned as an area to focus on, but these products are in all essential drug lists of all countries.

In most countries, contraceptives have always been managed separately from other commodities and handled by external donors from forecast to procurement and finance, which is why contraceptives have not received similar attention from the national supply chain managers through the cost recovery mechanism put in place to implement the Bamako initiative. As a result, management of these products is substandard and the consequences include frequent stockouts at service delivery sites.

The most important constraint in this area of commodity security is the withdrawal of donor support for contraceptives from several West African countries, leaving the country policymakers unprepared to fill

the gaps. A number of West African countries are now facing a crisis in contraceptive supply for the following reasons:

- The countries do not have a specific line item in their budget to purchase contraceptives. They should work quickly to create one with sufficient funding to purchase the contraceptives that are needed.
- Some countries use a poverty reduction fund to purchase contraceptives but this fund is unreliable.

USAID is currently providing support to a number of ECOWAS countries, including Ghana, Mali, Nigeria, Togo, and Cameroon, to develop a contraceptive security strategic plan to help meet the demand for these products. Other donors, the World Bank and UNFPA are also supporting the West African region to help improve contraceptive security.

Poverty Reduction Strategy

This strategy was developed in agreement with funding agencies to use funds made available by the relief of debt to fund key sensitive development areas, such as health, particularly women's health. In some countries, one objective of this fund is to (1) improve access to health services and essential drugs to the poor and (2) to promote women's health by improving reproductive health. As stated earlier, funds allocated to the poverty reduction strategy are used to purchase contraceptives and other reproductive health drugs. However, in some countries this fund is not readily available for use, which causes long delays before a request can be processed. Furthermore, the poverty reduction fund is tied to a program that has an end.

Operational Policies: Policies, Norms, and Procedures

Operational policies are those that govern services at the point of delivery. National laws and policies need to be translated into policy norms, standards, and rules that govern the delivery and quality of services, including those that affect, for example, personnel deployment, transportation, training, counseling, clinic organization, etc.

The Francophone Maximizing Access and Quality (MAQ) of 1995 in Ouagadougou identified policies, norms, and procedures (PNP) as a priority for all countries. The subsequent conference in 1999 and 2000 reported on the progress made by the countries in developing and implementing service PNP to provide the standards for accessible, quality services. The conference found that over the years countries have completed an important phase of consensus building in producing PNPs, which provides a solid base for quality of care. On the negative side, the finding was that PNPs were not sufficiently implemented to produce a measurable impact on quality and access improvements. The POLICY Project concluded that there was inadequate political commitment to support implementation of PNPs, based on the following:

- Discussions and presentations reflected a weakness in understanding how to analyze the policy environment and target advocacy to key decision makers. As a result, the development and dissemination of the PNPs in most countries were not fully supported at each stage and resources were often not provided for implementation.
- While country delegations tended to generalize about the obstacles they faced, formal and informal discussions helped characterize the policy nature of obstacles in citing such specific problems as—
    - lack of human and financial resources to implement key steps for PNP
    - opposition in the medical community to delegating tasks to other health personnel
    - pockets of resistance among policymakers in important areas, e.g. university hospital centers, medical schools, etc.
    - weak delivery structure policies, for example, referral systems, flow of supplies, and needed materials to implement PNPs

- uncooperative service providers
- sluggish administrative systems, and delays in reproduction and dissemination of PNP documents
- outright conflict among public agencies regarding responsibilities.

The following actions were recommended:

- Increase political commitment to implementing PNPs. Identify policy obstacles to successful implementation; and identify and analyze outlook of potential target audiences, and facilitate policy discussions with them.
- Support country MAQ working groups in conducting an analysis of the mechanisms available to them to implement PNPs, including laws, decrees, regulations, committees, boards, and taskforces, as well as individuals involved in the quality of care process and those who make key decisions.
- Maintain a regional focus on MAQ to strengthen individual country efforts. Facilitate a regional group (network) to exchange information on tools; document and disseminate experiences.

Linkages between Pharmaceutical Policies and Reproductive Health Policies

Although there are still important weaknesses in reproductive health programs design and implementation and there are drawbacks in implementing the policies, all ECOWAS countries have raised awareness and created the demand for family planning services. This demand is expected to growth steadily because the countries have a huge unmet need. The increasing demand requires an increased effort from country governments and their partners to ensure sustained commodity supplies. These needs are not expressed in the reproductive health policies, because commodity issues are included in countries pharmaceutical policies. These later policies do not single out reproductive health commodities for special attention but instead have a general objective of making essential drugs available in the countries. Family planning commodities are on the list of essential drugs to be procured in the counties. To make contraceptives available, a clear link needs to be made between reproductive health policy and pharmaceutical policy and awareness must be raised by the implementers of drug policy about the importance of family planning products to the lives of women of reproductive age.

Remarks on Political Commitment to Implementing Reproductive Health Policies and Programs

Political commitment is best illustrated by what the central government and its local branches do rather than what is stated in formal policy documents and action plans. Country high-level officials have made statements in support of reproductive health but there has not been a significant and sustained effort on their part to provide resources needed to implement family planning programs to meet the demand and satisfy unmet needs.

However, an exception is the implementation of the Bamako Initiative for which countries have demonstrated an effective level of commitment. The initiative also shows how well the donor community has demonstrated a high level of commitment to support the implementation of the policy by providing adequate resources and technical assistance.

Reproductive health policies in ECOWAS countries have always been jointly initiated and developed by external assistance and country relevant leaders. The countries expected that donors would provide the support for their implementation although it was not clear how long that support will last. One example is contraceptive supply, which was totally handled by donors until very recently. Consequently, countries have not committed themselves to supplying products. Now, it is important for them to demonstrate a larger commitment. Because several ECOWAS countries have experienced an abrupt severance of donor-supplied commodities, it is important that donors commit themselves to supporting the development of viable strategic plans for commodity security and financing their implementation for a reasonable period of time to allow countries to purchase their own products.

- Governments should commit to more effectively involve the private and NGO sectors in the implementation of reproductive health policies and laws.
- The current coordination mechanisms in place in a number of countries have shown major weaknesses, including the inability to identify problems and address them on time.
- To collect the necessary resources to implement the policies, an effective coordination mechanism involving all parties, including donors, private sector, NGOs, and religious organizations, should be developed and implemented.
- Governments should demonstrate a greater commitment to developing and implementing good governance best practices to overcome the constraints in implementing reproductive health laws, policy frameworks, and operational policies.

Conclusion

- Reproductive health commodities are not explicitly addressed in reproductive health policies or pharmaceutical policy. It is essential that contraceptives, necessary for saving women and infant lives, be clearly addressed in reproductive health policy. It is also important that all issues related to reproductive health policy be addressed in a comprehensive manner in one document instead of in several policy and program documents, which makes implementation ineffective.
- Given that contraceptive supplies pose similar problems in most West African countries, it is important that a regional approach be adopted rather than a single country approach.
- Reproductive health laws and policies are evolving and increasingly reflect the goals of ICPD.
- There must be a clear policy for public and private partnership to implement reproductive health services and ensure contraceptive security in the West African countries.

Appendix

Table 1. Policy and Programs in Reproductive Health (Part 1)

Existence of Policies Covering Reproductive Health							
Component of Reproductive Health	**Country**						
	Benin	**Burkina Faso**	**Cameroon**	**Côte d'Ivoire**	**Mali**	**Ghana**	**Senegal**
Family planning	1996: National Population Policy 1996: National maternal and Child Health, Family Planning, and Nutrition Program 1999: Policy and Norms in Family Health	1991: National Population Policy 1992: Policy and Standards for Maternal and Child Health/Family Planning 1996: Reproductive Health Strategic plan 1997: National Strategy of Safe Motherhood 2000: Revision of National Population Policy (draft)	1992: Standards for Maternal and Child Health/Family Planning 1992: National Population Policy 1996: Declaration of Health Policy	1999: Reproductive Health Services Policy Project 1999: Reproductive Health Services Standards 1999: National Program for Reproductive Health and Family Planning in Côte d'Ivoire	1991: National Population Policy 1990: Sectoral Health and Population Policy (revised post-ICPD) 1996: Policies Standards and Procedures in Reproductive Health/Family Planning In progress: National Reproductive Health Program	1999: National Population Policy, 1996 RH Service Policy and Standards, 1995: Vision 2020, 1996 Adolescent RH Policy (draft)	1997: National program for RH
Prenatal care	1996: National Population Policy 1997: Policy and Strategy for Development of the Sector, 1997-2001 1999: Policy and Standards in Family Health	1992: Policy and Standards for Maternal and Child Health/Family Planning 1994: National Program for Maternal and Child Health/Family Planning 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: Declaration of Health Policy	1987: National Committee for AIDS Control (CNLS) 1993: National AIDS and STD Control Program 1995: National AIDS, STD, and Tuberculosis Control Program	1990: Sectoral Health and Population Policy (revised post-ICPD) 1996: Policies Standards and Procedures in Reproductive Health/Family Planning	1996: RH Service Policy and Standards	1997: National program for RH

(Continued)

Existence of Policies Covering Reproductive Health							
STDs	1997: Policy and Strategy for Development of the Health Sector, 1997-2001 1996: National Population Policy Project 1999: Policy and Standards in Family Health	1990: National AIDS and STD Control Program	1989: National AIDS and Control Program 1992: Standards for Maternal and Child Health/Family Planning 1993: Primary Health Care Program 1996: Health Policy		1987: National AIDS and Control Program 1990: Sectoral Health and Population Policy (revised post-ICPD) 1994: Guidelines for Syndromic Management of STDs	1992: Guideline for AIDs Prevention and Control 1994: Population policy, 1996: RH Service Policy and Standards, 1997: National Policy on AIDS (draft), Adolescent RH Policy (draft)	1997: National program for RH

Sources : Politiques et programmes de santé reproductive après le Caire, une étude comparative de 8 pays, Septembre 1998. Politiques et programmes de santé reproductive après le Caire, une étude comparative de 5 pays de l'Afrique Francophone, Août 2000.

Table 2. Policy and Programs in Reproductive Health (Part 2)

Component of Reproductive Health	Benin	Burkina Faso	Cameroon	Côte d'Ivoire	Mali
Safe motherhood	1999: Norms and Standards, National Family Planning, Maternal and Child	1992: Policy and Standards for Maternal and Child Health/Family Planning 1997: National Strategy of Safe Motherhood	1992: Standards for Maternal and Child Health/Family Planning 1996: Health Policy	1999: Reproductive Health Services Policy Project 1999: Reproductive Health Services Standards 1999: National Program for RH/FP in Côte d'Ivoire	1993: Program for perinatal period developed and subsequently implemented
Post-abortion 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 Services Standards 1999: National Program for RH/FP in Côte d'Ivoire	1996: Policies Standards and Procedures in Reproductive Health/Family Planning
Reproductive health services for adolescents	1999: Policy and Standards Family Health	1999: Reproductive Health Strategic Plan	No policy	No policy but existence of project IVC/98PO3.1998	Nothing specific beyond the documents cited above which include reproductive health for adolescents.
Maternal and child nutrition	1999: Policy and Standards Family Health	1996: 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
Degree of support for reproductive health by political leaders President Prime Minister Members of Parliament Ministers	 High High Mixed High	 High High High Varies	 High Medium Varies Varies	 High No assessment Medium No assessment	 High Medium High No assessment

(Continued)

Component of Reproductive Health	Benin	Burkina Faso	Cameroon	Côte d'Ivoire	Mali
Degree of support for reproductive health and influence of religious leaders Support Influence	 Low High	 Low Low	 Mixed Low	 Medium Medium	 Medium Medium
Structure of reproductive health programs Vertical or integrated?	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
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

Source : Politiques et programmes de santé reproductive après le Caire, une étude comparative de 5 pays de l'Afrique Francophone, Août 2000.

Documents Consulted:

1. RHCS to Strengthen Maternal and Child Health. Paper presented by JSI/DELIVER at the 4th Ordinary Meeting of the ECOWAS Health Ministers

2. Draft reports of country assessment: Ghana and Burkina (DELIVER)

3. WARP REGION: Policy Environment Assessment: Reproductive Health/Family Planning POLICY project

4. Women of the World: Laws and Policies affecting their lives Anglophone Africa. Progress Report. 2001.

5. Les femmes à travers le monde. Lois et politiques qui influence leur vie reproductive : Afrique Francophone.