Government Policies and Factors Influencing the Reproductive Health of Women in Some Selected Francophone African Countries

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Introduction

Every year nearly 510,000 women die of complications related to pregnancy and childbirth; and a majority of these deaths occur in developing countries. The world maternal mortality ratio (MMR) was estimated to be 400 per 100,000 live births (World Health Report, 2004, pg 120). Women of Africa face the highest risk of maternal mortality and morbidity of any region in the world. The maternal mortality ratio adjusted for 2000 is 940 for Sub Saharan Africa, 980 for Eastern and Southern Africa and 900 for West and Central Africa (UNICEF, 2007). One out of every 16 Sub Saharan women could die due to pregnancy or child births (UNICEF, 2007). Planning the family size and spacing the births is one's basic human right. However the increasing maternal deaths, which are preventable to a great extent, made the personal reproductive behaviour issue of individuals into a major concern of governments and international bodies. Women's health depends on their fertility related behaviour (Mukuria *et al*, 2005). Effective family planning could improve the health as well as the economical condition of a woman and her family (Gakidou E and Vayena E, 2007).

One of the WHO's Millennium Development Goal (MDG) is to reduce the maternal mortality ratio (MMR) by three quarters from the 1990 levels. All the member countries have vowed their commitment to meet this goal. Most of the governments assisted the couples to achieve their reproductive goals through governmental or non-governmental effort. But the recent WHO press brief shows, "despite faster growth and strengthened institutions, Africa, at its present rate, would still fail to achieve any of the Millennium Development Goals adopted by world leaders at the Millennium Summit in 2000. Mr. Schmidt-Traub said that this was largely because the whole of sub-Saharan Africa was currently off track to meet a single one of those Goals" (WHO, 2007).

Unlike many other developing countries where the small family are preferred at macro and micro level, in many of these African Francophone countries the preference is for larger family size. Average desired number of children among currently married women (15-49) is higher in the sub-Saharan Africa, ranges from 4 for Namibia to 9.2 for Chad, except for South Africa where it is 3.3 (DHS, 2006). Earlier colonial policies, culture and religious beliefs have restricted many women to plan their family so as to avoid repeated child births with lesser gaps and restrict the unwanted birth.. The Government's direct involvement in family planning has started much lately in many of the African countries. Recent support for Family planning efforts is based on the principles of human rights. United Nation's Millennium Development Goals cannot be achieved unless women's right and reproductive health are not addressed properly.

Family planning programs (FPP) were relatively successful in many of the Asian countries. Some can argue that majority of them were with anti-natalist policy with an aim of achieving replacement level of fertility. However, the programs were evolved as an outcome of concern with maternal and child health care. The programme outcome or success can be measured by various indicators. Status of women and the educational level of the population are two major components which reflect most directly on fertility and family planning success (Sathar Z. A. 1993). The densities of services, carefully planned programmes, supply of sensitively administered contraceptive choices are ingredients of success in FP programs (Sathar Z. A. 1993). Individual behaviours like child spacing through some FP measures and utilization of maternal healthcare services are some important behaviours for the health and wellbeing of the women (Mukuria, 2005). Unmet need or unwanted fertility is some measures to identify the need or ineffectiveness of the FP programs in a society.

Objectives of this paper

Looking at the above, this paper tries to focus on the reproductive health status of women in Francophone Africa. The specific objectives are to:

1) To study the reproductive health status of women in each of the selected countries.
2) To study the prevalence and pattern of family planning measures used.
3) To identify some important determinants which have high impact on the reproductive health behaviour of women for each country.

4) To review of the Government's programs and policies as well as the political commitment on contraception over a period of time to safe guard the health of the women.

The most recent Demographic Health Survey (DHS) datasets of these respective countries are used to study the objectives number 2 and 3. DHS report, UN Statistical Year book and World Population Policies 2005 are used to analyse the objectives number 1 and 4.

While family planning is linked to population control, this paper focuses on the positive impact of family planning on the reproductive health of women.

Methodology

Thirteen African Francophone countries are selected for this study - Benin, Burkina Fasco, Cameroon, Central African Republic (CAR), Chad, Cote d'Ivorie, Gabon, Ghana, Guinea, Mali, Niger, Senegal, and Togo. These countries have been classified into three groups, with respect to the Maternal Mortality Ratio in 2000 estimated by WHO, UNICEF and UNFPA (United Nations, 2006). Maternal Mortality Ratio (MMR) is the number of deaths of women occurring over a year while pregnant, or within 42 days of termination of pregnancy regardless of the cause of death per 100,0000 live births in that year (pg. 85).

Classification of countries for the analysis

Groups	Country	Maternal Mortality Ratio (2000)
Group I	Gabon, Ghana, Togo, Cote d'Ivorie and Senegal	401-700
Group II	Cameroon, Guinea, Benin and Burkina Fasco	701-1000
Group III	CAR. Chad, Mali and Niger	1001- 1700

Analysis and the results in the tables pertain to all women in the 15-49 age group irrespective of their marital union unless otherwise stated. Bivariate and multivariate analysis is done as per the need and presented in the text.

Findings

I. The reproductive health status of women in each of the selected countries.

The reproductive health status of women can be explored through many sources. Here the variables, age at first intercourse, teenage pregnancy, high risk births, obstetric care and skilled assistance at birth are taken as some indicators to study the reproductive health status of women in the selected countries.

Table 1: Indicators of the reproductive health status of women

Country	Median age at first sexual intercourse among women 20-49	Teenage pregnancy (Teens who had a child or currently pregnant) (%)	Latest births in three years preceding the survey		
			Birth was at high risk due to mothers age, parity and birth interval* (%)	Delivery at a health facility (%)	Skilled assistance during delivery (%)
Group I					
Gabon 2000	16.2	32.7	71	84.1	86.5
Ghana 2003	18.2	13.8	62	45.1	46.5
Togo 1998	17.3	19.4	68	49.1	50.5
Cote d'Ivorie 1999	16.1	31.0	70	48.1	47.7
Senegal 2005	18.7	18.9	75	63.6	53.2
Group II					
Cameroon 2004	16.5	28.4	71	60.0	62.8
Guinea 2005	16.0	31.8	75	31.3	38.9
Benin 2001	17.3	21.5	68	78.0	74.7
Burkina Fasco 2003	17.5	23.2	70	38.9	38.1
Group III					
CAR 1994/95	15.9	36.1	75	49.8	45.9
Chad 2004	15.8	36.3	80	12.2	16.9
Mali 2001	15.9	40.4	79	38.9	41.9
Niger 2006	15.7	39.3	84	18.6	19.0

Source: DHS datasets

* Births are defined as high risk if the mother was under age 18 or over age 34, already had three or more children, or gave birth less than 36 months after a previous live birth or giving birth more than 60 months after a previous live birth. Figures of Guinea, Niger, Senegal and Tanzania pertains to 1999, 1998, 1997 and 1999 respectively (DHS 2006)

a. Age at first intercourse

When woman engage in sexual intercourse, marry, and begin bearing children at an early age, during adolescence, it becomes difficult for her to pursue education and acquire skills needed for better work opportunities. In short it restricts her self-empowerment. Early age at sexual intercourse make a woman in a vulnerable situation of early child bearing and adds to the number of children a women eventually bears over the course of her lifetime. Social norms in many countries limit unmarried teenagers to access family planning services thus placing them at increased risk of unintended pregnancy, and sexually transmitted infections. The median age at first sexual intercourse among the 20-49 age groups is given in the table no. 1. The median age at first sexual intercourse ranges between 15.7 to 18.7 years in all the selected countries. Among the group III countries the median age at first sexual intercourse is less than 16 years.

b. Teenage pregnancy

When a woman becomes mother have greater consequences. Later child bearing benefits a woman and her children. Woman who postpone her motherhood until after her teens are likely to stay in school longer than her peers and likely to have fewer and healthier children. The table reveals that Group III countries (countries of highest MMR) have the lowest median age at first sexual intercourse and the teen age pregnancy is also high in these countries. The teenage child bearing, is relatively lesser in Group I countries, except Gabon and Cote d'Ivorie.

c. High risk births

Complications during pregnancy and pregnancy pose greatest risk for women's life, health and wellbeing during her childbearing years. According to DHS, births are defined as 'high risk births' if the mother was under age 18 or over age 34; already had three or more children; or gave birth less than 36 months after a previous live birth; or gave birth more than 60 months after a previous live birth. More than 60 percent of the latest births during three years preceding the survey are termed as high risk births in all the 13 countries. Among the

Group III countries three third of the births are high risk births, especially in Chad and Niger where it is 80 percent and 84 percent respectively.

d. Institutional delivery

Utilization of maternal health care facilities during Antenatal, Natal and Postnatal stages reduces considerable number of maternal and infant deaths. In Chad and Niger the institutional births are very low, 12.2 percent and 18.6 percent respectively. Among the Group I countries, Gabon has 80.1 percent of births in a health facility.

e. Skilled assistance at childbirth

Skilled assistance at childbirth is defined as births attended by a trained doctor, nurse or midwife. Skilled assistance at childbirth can reduce the risk of complications to mothers and infants due to problems such as haemorrhage, obstructed labour and puerperal infection. However, many women give birth without the assistance of a trained healthcare provider. The latest birth of women who had a live birth during the past three years are given in the table. The skilled assistance at birth ranges from 16.5 percent in Chad to 86.5 percent in Gabon.

On the whole, Group III countries fared badly on all the five indicators. It is, therefore, clear that higher MMR in these countries is due to early sexual intercourse and teenage pregnancy, high risk births and the deliveries taking place outside health facility or with the assistance of skilled personals.

II. Existing pattern of Family Planning usage

Woman's role as a mother is at times forced on them. There are times when a woman is in a vulnerable state to have a child. Even within marriage or union a woman wishes to space or limit the births. Otherwise the unwanted pregnancy could result into an unwanted birth or into termination of pregnancy. Access to effective and affordable contraception assists one to achieve their fertility goals as well as their well being.

Table 2. Percentage distribution of women who are not currently pregnant, by their current contraceptive use by their method choice and demand for contraception and percentage of women with unplanned birth who had a live birth during three years preceding the survey

Country	Women who are not pregnant at the time of the survey				Births preceding three years preceding the survey
	Current contraceptive use			Need for contraception	
	None (%)	Modern (%)	Traditional (%)	Unmet need (%)	Unplanned /Unwanted (%)
Group I					
Gabon 2000	61.3	15.5	23.2	17.6	49.4
Ghana 2003	77.0	16.3	6.0	21.4	44.7
Togo 1998	72.1	8.7	19.3	22.1	42.2
Cote d'Ivorie 1999	69.3	10.9	12.1	18.1	32.0
Senegal 2005	90.5	8.1	1.4	20.4	32.0
Group II					
Cameroon 2004	71.0	15.1	13.9	13.4	24.4
Guinea 2005	88.4	6.0	5.5	18.1	16.4
Benin 2001	79.9	7.5	12.6	21.8	26.5
Burkina Fasco 2003	84.4	10.9	4.7	22.8	25.8
Group III					
CAR 1994/95	84.2	3.9	11.9	10.7	23.3
Chad 2004	97.1	1.8	1.1	15.8	19.1
Mali 2001	90.3	6.7	3.0	24.8	22.2
Niger 2006	88.3	5.3	6.4	13.6	10.7

Source: DHS dataset

a. Contraceptive use

A woman is considered to be a current contraceptive user if she uses any method of contraception with the intent of delaying or avoiding pregnancy – even if her method is ineffective (DHS, 2006). The contraceptive prevalence rate (CPR) is used to study the existing usage of contraception among women.

In this paper, the women who were pregnant at the time of the survey were excluded from the analysis. On the whole contraceptive use is very low in all the countries. The contraceptive use is less than 10 percent in Chad (2.9%) and Mali (9.7%) from Group III countries and Senegal (9.6%) in Group I countries. Use of modern method of contraceptives is high among Gabon, Group I countries. Less than 7 percent of women from Group III countries use anyone method of modern contraceptives. Traditional methods are used more than modern method in Gabon, Togo, Cote d'Ivoire, Benin, CAR and Niger.

b. Need for Contraceptives

Need for contraceptives is an index computed from information on women's fertility preferences and current contraceptive use.

Met need is the percentage of women who want to control/regulate their births and so using some method of contraception. On the whole the demand met women are very low in all the selected countries. Relatively majority of the Group I countries women are fulfilling their demand by using any one method of contraception. Gabon 38.7 percent of women who want to regulate their birth are using some method of contraception. The demand met women are very low in the Group III countries. Three percent of women from Chad and 9.7 percent of women from Mali who wanted to regulate their births are using some method of contraception (not shown in the table).

Unmet need is defined as the percentage of all currently married women who are in need of contraception but are not currently using a method. Only women who were not pregnant at the time of the survey are taken in the analysis. Unmet need is observed higher in Group I and II countries, where more than 20 percent of women are with unmet need. Except Mali (24.8%), the other three countries in Group III have relatively lesser unmet need.

c. **Unplanned births (Unwanted fertility)**

Births that are mistimed or unwanted are termed as unintended births in this study. Women who gave birth during the three years preceding the survey are taken in the analysis. The percentages of women with unplanned birth are more than 40 percent in Ghana, Togo and Gabon (Group I countries). The percentages of women with unplanned births are less in Group III countries.

III. Socioeconomic determinants influencing the reproductive health of women

Recently the Commission on the Social Determinants of Health (CSDH), initiated by WHO, tries to explore the inequality in health and deepening the knowledge of socioeconomic determinants which predict the reproductive health of women. This paper explores some individual and socioeconomic determinants which influence the contraceptive use and unmet need. Two models of regression analysis are used. The first model uses the current users of any method who are not pregnant woman as the dependent variable and the second model uses the women with unmet need (Who are not pregnant) as the dependent variable. Women's characteristics like age, marital status, educational status, exposure to any one of the media (Radio, TV or Newspaper), work status, residence and household wealth (DHS wealth quintile index) are taken independent variables.

For all the countries, women in the age group 20-24 are more likely to use some method of contraception than the teenage women and women in the 25-49 age groups. In majority of the countries, currently married women/living in union women are more likely to use anyone method of contraception than the women who are not married/living in union. This is observed in all the Group III countries. In all the selected counties, educational level of women has high impact on the contraceptive use. As the educational level increases from primary to secondary and above, the women are more likely to use some kind of contraceptives. In all the countries, exposure to anyone of the media have positive relationship to contraceptive use; however their significance level differs differently in some countries. Working women are more likely to use some method of contraception in most of the selected countries except in countries Benin and CAR from Group II and Group III respectively. The urban women are more likely to use some contraception than the rural women except in Benin where this relationship is negative. The women from the richest households are more likely to use some method of contraception in all the countries except for Niger.

Logistic regression Model I. (Non pregnant women who are using any one method of contraception are taken as dependent variable)

Logistic Regression: Women currently using any one method of contraception and not pregnant are taken as dependent variable and age, marital status, educational status, place of residence, work status, media exposure and household wealth taken as independent variable.

	Age		Marital status	Educational Status		Media exposure	Work status	Residence	Wealth	
	Teens (RC)		Not married or not in union (RC)	No education (RC)		Not exposed to any media (RC)	Not working (RC)	Rural (RC)	Poorest (RC)	
	20-24	25-49	Married/in union	Primary	Secondary />	Media exposed	Working	Urban	Medium	Richest
Group I										
Gabon 2000	1.595***	0.759***	0.988	2.739***	5.702***	1.607***	1.100	1.631***	1.079	1.042
Ghana 2003	2.014***	1.772***	2.480***	1.753***	2.248***	1.481***	1.488***	1.065	1.205	1.399
Togo 1998	1.946***	1.546***	0.966	1.248***	2.654***	1.211***	1.064	1.021	1.138	1.017
Cote d'Ivorie 1999	2.032***	1.415**	0.677***	2.665***	3.540***	1.244*	1.268**	1.064	2.609***	4.336***
Senegal 2005	2.025***	2.994***	10.121***	3.148***	4.392***	1.130	1.497***	1.751***	1.836	1.804
Group II										
Cameroon 2004	1.701***	1.475***	1.523***	5.037***	9.604***	1.270***	1.192***	1.104	1.817***	2.364***
Guinea 2005	1.713***	1.056	0.916	1.354***	3.071***	1.062	1.423***	1.078	1.594***	2.391***
Benin 2001	2.646***	2.142***	1.556***	1.192*	2.778***	1.628***	0.974	0.797**	1.586***	2.261***
Burkina Fasco 2003	2.284***	1.853***	1.674***	1.887***	2.954***	1.145*	1.413***	2.030***	0.982	1.927***
Group III										
CAR 1994/95	1.967***	1.357**	1.628***	1.675***	4.517***	1.075	0.978	1.061	1.240	1.863***
Chad 2004	1.880***	1.308	3.500***	2.757***	8.491***	1.824***	1.566***	1.569	8.415**	18.095***
Mali 2001	2.357***	2.263	1.245**	1.808***	3.653***	2.351***	1.326***	1.788***	0.788	1.832***
Niger 2006	3.682***	2.887***	12.447***	1.631***	1.999***	1.989***	1.346***	1.855***	0.621***	0.759*
Tanzania 2004	3.984***	3.166***	2.256***	2.479***	1.830***	1.281***	1.845***	1.758***	1.117***	1.886***

Note: RC=Reference Category
***p <. 01; **p < .05; * < .10

Dependent Variable: Currently not pregnant women who are with unmet need

Logistic regression Model II. (Women with unmet need (not pregnant) taken as dependent variable)

Table : Logistic Regression – Currently not pregnant women with unmet need taken as dependent variable and age, marital status, educational status, place of residence, work status, media exposure and household wealth taken as independent variable.

	Age		Current Marital status	Educational Status		Media exposure	Work status	Residence	Wealth	
	Teens (RC)		Not married or not in union (RC)	No education (RC)		Not exposed to any media (RC)	Not working (RC)	Rural (RC)	Poorest (RC)	
	20-24	25-49	Married/in union	Primary	Secondary / >	Media exposed	Working	Urban	Medium	Richest
Group I										
Gabon 2000	1.329**	1.230*	4.548***	1.096	0.682	0.878	0.944	1.220**	0.843	0.708*
Ghana 2003	0.893	0.632***	> 10***	1.143	0.973	0.834*	1.004	0.861	0.933	0.599***
Togo 1998	0.937	0.846	6.908***	1.280***	0.752**	1.124	0.954	0.747***	0.994	1.032
Cote d'Ivorie 1999	1.380*	1.019	5.051***	0.811	0.572***	0.898	1.145	0.988	1.535**	1.019
Senegal 2005	0.954	0.771***	>50 ***	1.096	0.969	1.321***	0.962	0.972	1.020	0.892
Group II										
Cameroon 2004	1.260**	1.185	7.628***	1.213	0.869	1.041	0.860**	0.934	1.116	0.813
Guinea 2005	1.091	1.115	4.324***	1.252**	1.255*	1.162**	1.160	0.914	1.179*	1.072
Benin 2001	0.917	0.952	5.459***	1.024	0.720**	1.174**	0.821*	1.240**	1.163	1.228
Burkina Fasco 2003	1.492***	1.342***	9.150***	0.904	0.463***	1.334***	1.021	0.877	1.050	0.856
Group III										
CAR 1994/95	1.286*	1.108	4.719***	1.249**	1.297*	1.158	0.894	1.043	1.264	2.136
Chad 2004	1.080	0.677***	> 10***	1.367***	0.816	1.040	1.077	1.221	1.130	1.174
Mali 2001	0.882*	0.766***	6.753***	1.033	0.712***	1.144**	1.114**	1.277***	0.907	0.875
Niger 2006	1.189	1.079	> 50***	1.128	0.860	1.019	0.995	1.652***	0.948	0.929
Tanzania 2004	1.362***	1.296**	5.595***	0.992	0.783*	0.937	0.877	0.803**	0.959	0.804*

Note: RC=Reference Category
***p <. 01; **p < .05; * < .10

Unmet need is significantly very high among the married women than the unmarried/not living in union women, in all the selected countries. Educational level of women has negative

relationship with unmet need in most of the countries. Women from richest households are more likely to be with unmet need than the women from poorest households in some of the selected countries.

IV. An overview on the Policies, Programs and Political Commitments

Many of the sub-Saharan countries particularly the francophone countries of middle and Western Africa had pro-natalist policies inherited from their colonial past. FP and contraceptive activities were not permitted because of the French law forbidding both abortion and promotion of contraception.

a. Government's view on the health status

The expectation of life at birth for women in most of the countries is less than 50 years. (men's longevity is lesser than women in all the selected countries). All the selected countries governments consider the present life expectancy at birth and the present level of maternal mortality are unacceptable.

b. Government's view on the level of fertility

Government's view on the fertility level is changed over a period of time. The Total Fertility Rate TFR), is defined as the average number of children that would be born per women if all women lived to the end of their child bearing years and if current age specific fertility remained constant during their child bearing years. The TFR is very high in all the selected countries.

As per the level of TFR during 1975 the governments had different different opinions regarding the level of fertility. Some countries felt the level the TFR above 7 is satisfactory, and TFR 5 is too low in some other countries. By 2005 majority of the countries feels that their fertility level is high and changing the country's fertility policy to reduce the TFR. Gabon with TFR of 4 children per women feels that it is low and their fertility policy is to raise the fertility level of their country.

Table : Governments' view on fertility level, total fertility rate and fertility policy in the selected countries.

	Government view on fertility level					Total fertility rate per women	Fertility policy	
Country	1976	1986	1996	2001	2005	1975	2005	2005
Group I								
Gabon	Too low	Too low	Too low	Too low	Too Low	5.3	4.0	Raise
Ghana	Too high	Too high	Too high	Too low	Too high	6.9	4.4	Lower
Togo	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Too high	7.1	5.4	Lower
Cote d'Ivorie	Satisfactory	Satisfactory	Satisfactory	Too high	Too high	7.4	5.1	Lower
Senegal	Too high	Too high	Too high	Too high	Too high	7.0	5.0	Lower
Group III								
Cameroon	Too low	Too high	Too high	Too high	Too high	6.3	4.6	Lower
Guinea	Satisfactory	Too high	Too high	Too high	Too high	7.0	5.9	Lower
Benin	Satisfactory	Satisfactory	Satisfactory	Too high	Too high	7.1	5.9	Lower
Burkina Fasco	Satisfactory	Satisfactory	Too high	Too high	Too high	7.8	6.7	Lower
Group III								
CAR	Too low	Too high	Too high	Satisfactory	Satisfactory	5.7	5.0	No intervention
Chad	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Satisfactory	6.7	6.7	No intervention
Mali	Satisfactory	Satisfactory	Too high	Too high	Too high	7.1	6.9	Lower
Niger	Satisfactory	Too high	Too high	Too high	Too high	8.1	7.9	Lower

Source: National Population Policies 2001, UN Publication 2002; World Population Policies 2003: Economic and social Affairs, United Nations, 2004 and World Population Policies 2005: Economic and social Affairs, United Nations, 2006

c. **Government's view on contraception use**

Both abortion and promotion of contraception were prohibited during the French colonial rule changed over a period of time.The first step was taken by Tanzania by repealing the former law that prohibited advertisement of contraception in 1961. This was latter followed by Mali in 1972;

Cameroon and Senegal in 1980; Cote-d'Ivoire in 1982 and Burkina Faso in 1986.In many African countries contraceptives became available after the Alma Ata conference in 1978 (WHO, 1978) as a primary health care strategy with integrated family planning services. Another mile stone can be stated the second African Population conference held in Arusha in early 1984 (UN, 1984). This conference adopted the Kilimanjaro programme of action which provided the frame work for the formulation and implementation of population policies and programmes in Africa. Recommendations concerning FP included – Government should acknowledge FP and child spacing. Secondly incorporate FP into maternal and child health programs. Thirdly government should ensure availability and accessibility of FP to all couples and individuals seeking them free or at a subsidised price and finally that the governments should ensure availability a variety of methods to allow choice to all users. Integration of FP into Maternal and child health services during the late 1970s and early 1980s enabled government to assist couples to plan the size of their families and the timing of child birth.

Some government have lifted the prohibition in the distribution of contraception towards official support. The Cameroon and CAR governments provided support; Guinea and Niger governments modified the policies in this direction; and in Congo, Nigeria, Senegal and Tong the governments permitted Non-Governmental Organisations (NGO) to distribute contraceptive. Benin, Burkina Faso, Cote d'Ivoire and Chad which supported the work of NGOs in providing contraceptive services eventually moved towards directly providing FP services.

Recommendations of the 3rd African Population conference held in Dakar in 1992 – population policies and programs should be integrated in to development strategies focusing on human development; steps to make available to promote all contraceptive and fertility regulation methods including traditional and natural methods.

Government's views and policies with regards to the use of contraceptive methods have changed considerably during the recent years. By 2001 most countries have stated supporting family planning programs and contraceptives either directly (75%) through government facilities or indirectly (17%) through support of NGO activities. Even the pro- natalist government have changed their stance and accepted family planning and contraceptive use as an integral part of

maternal and child health programs. With the exception of Gabon in all other selected countries, Government either directly or indirectly support the distribution of contraception.

Table 3: Governmental support to access to contraceptives
Government level of support for modern methods of contraception (Pill, IUD, injectables, hormonal implants, condom, female barrier methods

Country	1976	1986	1996	2001	2003	2005
Group I						
Gabon	Limits	NS	NS	NS	NS	NS
Ghana	DS	DS	DS	DS	DS	DS
Togo	IDS	DS	DS	DS	DS	DS
Cote d'Ivorie	NS	NS	IDS	DS	DS	DS
Senegal	NS	DS	DS	DS	DS	DS
Group II						
Cameroon	IDS	DS	IDS	IDS	IDS	IDS
Guinea	NS	DS	DS	DS	DS	IDS
Benin	IDS	IDS	DS	DS	DS	DS
Burkina Fasco	NS	IDS	DS	DS	DS	DS
Group I						
CAR	NS	DS	DS	IDS	IDS	IDS
Chad	Limits	NS	IDS	IDS	IDS	DS
Mali	DS	DS	DS	DS	DS	DS
Niger	NS	DS	DS	DS	DS	DS

Source: National Population Policies 2001, UN Publication 2002; World Population Policies 2003: Economic and social Affairs, United Nations, 2004 and World Population Policies 2005: Economic and social Affairs, United Nations, 2006

Note: DS – Direct Support- Government directly supports the dissemination of information, guidance and materials through Government facilities; IDS – Indirect Support- The government indirectly supports provision of information, guidance and materials by non-governmental sources; NS – No Support- The government permits the provision of information, guidance and materials by non-governmental sources, but provides no support to such organisations; Limits- The government prevents access to information, guidance and materials in respect to modern methods of contraception.

Conclusions and Recommendations

Reproductive health status based on MMR ranges very widely in all the selected Francophone countries. The maternal mortality ratio estimated for 2000 is more than 420 in all the selected

countries. Among these countries the least MMR is found in Gabon (420) to the highest of 1600 in Niger. Countries where there is early and high risk pregnancy and lack of access to professional or skilled assistance for delivery contributed for high MMR. Comparing the reproductive health status of MMR with the current use of contraceptive, it clearly shows that countries using some method of contraceptives have lower MMR. For example Gabon has the lowest MMR of 420 among these countries and the CPR is highest, 36 percent; Niger and Chad have very high MMR of 1600 and 1100 respectively and their contraception use is a mere 7.6 percent for Niger and 2.5 percent for Chad. This shows clearly that the reproductive health status is closely linked with the use of contraception.

Therefore, there is need to improve FP programs by creating a demand in these countries and making contraceptives easily available and accessible for individuals. The governments need to work with NGOs having good experience in FP through public private partnership (PPP). While government can provide resources, NGOs have the know how to deliver the FP services to the masses. So the PPP in FP is going to yield better results in some of these countries where already NGOs are working in a big way.

Though these countries have adopted policies favourable to use FP services, they have a long way to go to achieve the MDG goal no. 5, reducing maternal mortality. It is not merely the financial commitment of the donors that is going to achieve the goal but it is the strong political commitment of these governments to promote FP in a big way is going to yield results. It is necessary not only to make the contraceptives available but also to break the barriers of access to reach the individuals.

Looking at the unwanted fertility in some of these countries, the demand for contraceptives is very low. So FP programmes must have a strong component of educating the masses along with a good supply of contraceptives. Innovative communication methods should be used to reach out the masses. Some of the locally appropriate mass media such as folklore and folk songs and dance may be used to deliver family planning messages.

It is expected that this study will enhance the planners and policy makers of these countries to find the gaps in reaching out to women who are in the pinnacle of need to enhance their health status.

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