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Regional Health Profile West Africa

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Preface

This document is part of a series encompassing the countries and regions with which Sida collaborates in the field of health. The purpose with the series is to provide comparable information on the different settings in which Swedish health development co-operation takes place.

General country documents usually have a focus on macroeconomic issues. This is an effort to complement other information about collaborating countries with specific facts about their health situation and the health care sector.

Sida has decided on the format and outline for these profiles and has commissioned a number of consultants to write them. Each author is responsible for her/his text. The intention is, with time, to revise and update figures and facts in pace with accessible information.

For specific information about the Swedish health assistance please contact the Health Division within the Department of Democracy and Social Development at Sida.

It is hoped that these country and regional health profiles will be useful to both Sida's own staff and consultants and to others with a special interest in health and development co-operation in health.

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Contents

Executive Summary

The Regional Health Profile of West Africa shows that

1. The countries in the region are poor and little developed in an international comparison. Generally the region has had little or no development in the last decade when calculated per capita.
2. Civil conflicts have affected many of the countries, sometimes resulting in a complete collapse of the government system.
3. The countries rely heavily on aid. A great number of donors and non-governmental organisations are active in the region.
4. The health status of the population is in an international comparison poor.
5. Infectious diseases and perinatal disorders constitute the major burden of disease in the region.
6. AIDS is on the rise in the region and poses a serious threat for the future.
7. Public health services are often of inadequate quality and health care is underfinanced.
8. Attempts to improve health services both in terms of infrastructure and management have been made during most of the past decade, at times with limited success.
9. Health reform programmes are in place in many of the countries often receiving support from the World Bank and large donors from Europe, including the European Union.
10. The Swedish resource base with experience from West Africa is limted and largely confined to work with emergency operations and missionary organisations. Cape Verde and Guinea-Bissau which have been Sida programme countries represent an exception.

Even with a positive economic development it will be difficult for governments to maintain or increase the standard of living due to the high population growth rates in almost all the countries in the immediate years to come. There will therefore be a long lasting need for significant foreign assistance to relieve the situation of the people. If peace may come to the countries hit by war there will also be a tremendous need for rehabilitating them.

Any health assistance to the region must have a long term perspective. Experience has shown that sustainability is difficult in the region and with the present prospects it appears almost impossible for national governments to sustain programmes or projects initiated with foreign assistance if they are to rely only on their own resources.

1 Introduction

In 1998 the Swedish Parliament adopted a new policy for cooperation with Africa. The policy emphasised a cooperation in which all parties participate and benefit on equal terms. This new cooperation was summarised in the word "Partnership". The new policy also defined West Africa as a region with which Sweden should increase its collaboration.[1] Swedish assistance to the region has also increased since, mainly through export credits, support to debt payments and assistance to participation in international training courses for persons coming from the region. Humanitarian assistance through Swedish Non-governmental Organisations (NGOs) has also been important due to civil conflicts and refugee problems in the region.

Sida has prepared an action program for support to West Africa. An ambition from Sida is to enter into more specific collaboration with some of the countries in the region. In consequence most of the departments at Sida have been asked to present ideas for areas of possible collaboration with the region. The action programme suggests that support to the health sector in the region should increase.

The Health Unit has now called for a study on health needs and health care in the region. The aim of the study is to provide an update on the health situation and health services in West Africa (a Regional Health Profile) as well as an overview of current donor-supported activities in the health sector. The study should also provide an analysis of the strategic role that Sida could play in the region and generate some recommendations on how to proceed in the collaboration with one or several countries in the region.

The Health Unit at Sida has identified eight countries as being of particular interest in the Region given Sida's overall priorities.[3]

2 Description of the Region and its Socioeconomic Situation

2.1 Geography

The West African region is defined here as 23 countries in west and central Africa (the countries are listed in Annex 1).[4] Geographically the region is limited by the Atlantic Ocean in the west, by the Gulf of Guinea in the south and west (Cameroon and neighbouring countries) while it has no clear boundaries in the north and east.

The region extends from tropical areas in central Africa with large rain forests through tropical and sub-tropical climate zones with mixed forest and grassland in the west along the Gulf of Guinea to the dry and arid Sahara in the north.

The transition zone between the Sahara on the north and the more humid tropical areas to the south is called the Sahel. The Sahel runs from Mauritania in the west to Chad in the east. A relatively sparse savannah vegetation of grasses and shrubs predominates in the Sahel.

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[1] Riktlinjer för ökad satsning på Västafrika. Stockholm: Utrikesdepartementet, 1999.

[2] Reserapport: Burkina Faso, Côte d'Ivoire och Mali. Stockholm: AFRA/Sida, 1999.*

[3] The countries are Benin, Burkina Faso, Côte d'Ivoire, Ghana, Mali, Nigeria, Senegal and Togo

[4] Kartläggning av biståndet till Västafrika 1994/95–1998. Stockholm: AFRA/Sida, 1998.

The West African region is dominated by a plateau extending from slightly north of the Gulf of Guinea to the Sahara. It reaches elevations of some 1500 meters above sea level. There are significant mountain ranges in the west (extending through Guinea, Sierra Leone and Liberia) and in the east in Cameroon. The highest mountain of the region is the volcanic Cameroon mountain which peaks at 4070 m.

There are many rivers in the region, the most prominent being the Niger river. It is the third longest African river and is about 4,180 km long. It starts in Guinea, flows through Mali, Niger and Nigeria and has branches to several other countries. Its upper portions are navigable only during rainy seasons. The river has always played an important role in human civilisation in the region, signified by the fact that several of the main cities are located along the river. Another important river is the Volta river which flows from Burkina Faso down through Ghana.

The northern parts of the region are dominated by the Sahara which extends into north Africa while the southern parts are characterised by tropical climate. In between there is a sub-tropical zone.

2.2 Population

The total population in the 23 countries is around 225 million. The further to the south and closer to the Gulf of Guinea the higher the population density. Nigeria is the most populated country with almost half of the people living there.

The population in the region is rather young with the proportion of persons below 15 years of age varying from 45% to 54%. The population growth rate is generally high exceeding 3% in some of the countries.

There are many different ethnic groups in the region and hundreds of languages are spoken. In the northern and Western parts of the region Afro-Asian languages, such as Fulani and Hausa, are dominating while in the southern and eastern parts, languages belonging to the Niger-Congo language group are spoken. The Bantu languages belong to this group. In the eastern Sahara and sub-Saharan areas there are also people speaking Nilo-Saharan languages.

All the 23 countries in the region have a former colonial language as official language. French is the official language in 13 countries, English in 7, Portuguese in 3 and Spanish in one[6] (see Annex 1).

The rich ethnic diversity is one of the characteristics of the region. It is in particular the people in the Sahel region which have become well known for their traditions and strong ethnic heritage. Among groups to be mentioned in this context are the Mossi, the Fulani, the Tuareg, the Bobo, the Malinké and the Bambara.

The political and social life of Nigeria is influenced by the presence of some large ethnic groups. These are the pre-dominantly Muslim Hausa and Fulanis of the north, the Yorubas of the south west, where Lagos is situated, and the Ibos of the south-east. The Ibos are largely Christians. There are more than 250 ethnic groups in Nigeria in an estimated population of 113 million.

Islam was introduced in the region early and it is the dominating religion in the north. Islam has spread down from the north to the coastal areas and Muslims are found in all parts of the region. The Christians are more commonly found along the coastal areas.

[5] Based on information from Microsoft Encarta Encyclopedia 1996

[6] One country (Cameroon) has two official languages

Traditional beliefs are still important and a significant proportion of the people of the Sahel region are still considered to primarily be animists even though they may officially be counted as Muslims or Christians.

The large majority of the people in West Africa live in rural areas. Still the region has several big cities where urban life styles are well established. Some of the major cities are Dakar, Abidjan, Accra, Lagos, Douala and Yaoundé. People continuously migrate to the cities in search of employment and improved living conditions.

2.3 Socioeconomic Situation

The entire region can in an international comparison be classified as poor. According to Unicef's State of the World's Children the GNP per capita income is below US$ 1000 in all the countries except Gabon, Equatorial Guinea and Cape Verde.[7] The World Fact Book reports however a GNP per capita which is considerably higher. According to this source the GNP per capita in Ghana is US$ 1800 which would be more than twice as high as the one in Mali (US$ 790)[8]. This difference in per capita income would be more consistent with the general fact that the countries in the south of the region are better off than those in the north. In fact Mali, Burkina Faso and Chad are among the poorest countries in the world.

The growth per capita has been negative in nine of the countries in the period 1990–97 and very low in almost all the others (table 8).

Though data is scarce there is evidence that incomes are unequally distributed. In a study in 1994 it was found that 60% of the population in Nigeria lived beyond the poverty line[9]. Data in table 1 show that in the countries from where data are available the 20% of households which are in the highest income range dispose of 2–4 times more of the total household incomes than those 40% of all households in the lowest range.

People in the north have traditionally lived like nomads and pastoralists, while people in the south have lived from settled farming. As everywhere there is a drift from agriculture to other economic activities, but still an estimated 60% of the population in the region support themselves from subsistence farming.

South of the Sahara, in the Sahel, and in the most fertile areas north of the coastal forests, shifting agriculture – a method in which small areas were burned, cleared, and planted and then allowed to revert to bush – has given way to settled farming. Grains, especially maize, sorghum, millet, and rice, are the main crops outside the rainforests. Yams, manioc, cassava, plantain, and banana are important crops in the tropical zone covering the coastal hinterlands and forested areas.[10]

The main commercial output from the region is agricultural products. The larger share of the world's cocoa is produced in Ghana, the Ivory Coast, Benin and Togo. Mali and Burkina Faso are significant exporters of cotton. Vegetables and tropical fruits are produced and exported in large quantities to the European market from Côte d'Ivoire. Ground nuts are grown and exported from Senegal and other countries.

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[7] State of the World's Children 2000. New York: Unicef, 2000.

[8] The World Fact Book 1999. Washington: Central Intelligence Agency, 1999.

[9] ICRC Fact sheet Regional Office Nigeria

[10] Based on information from Microsoft Encarta Encyclopedia 1996

[11] ICRC Fact sheet Regional Office Nigeria

Fishing is an important source of income and employment along the coasts.

Trading has always been significant as a means of subsistence in the region, not least in the interior where trans-Saharan caravan routes in the past created the basis for rich kingdoms and cities, such as Timbuktu.

The region is rich in minerals but many of them remain in ground as the costs for their exploitation are high. Some of the minerals which are exported are uranium (Niger), gold (Mali, Burkina Faso, Ghana), bauxite (Guinea), manganese (Ghana), phosphate (Togo) and diamonds (Ghana, Sierra Leone). Nigeria has rich oil resources and oil constitutes around 90% of the country's export earnings.

2.4 Education

Education has high priority in the development strategies of the countries in the region. Development of human resources is seen as crucial to progress in the productive sectors, such as agriculture, but also for improvement of the health situation. Capacity and skills development are also essential in the current decentralisation process which requires significantly raised standards of personnel and people at all levels, in particular the periphery. The priority given to education should also be seen in the light of the fact that literacy rates and school attendance are low in a global context. Table 4 shows that median literacy rates in 1995 for the 23 countries were 54% for males and 28% for females. Primary school attendance rates vary from 17% (females in Guinea) to 100% (males and females in Cape Verde). After that there is continuous reduction in school attendance rates and only 4% (Chad) to 45% (Congo) of women enrole in secondary school according to these statistics.

The public schooling system is not only suffering from reduced attendance but also from inadequate quality of services. In a country like Burkina Faso needs for support to material, improvement of teaching skills and curriculum revision has been identified. One reason for the latter is that the present curriculum is based on the assumption that children will continue their education after grade six, while in reality few do so. Realizing this experts have also concluded that there will be need for a considerable amount of additional resources just to maintain the system at its present quality level given that an increasing number of children will require education.[12]

2.5 Political Situation

The present political situation in the region is characterised by lack of democracy and regional instability. Most of the countries are run by military governments. When elections have been held accusations of rigging have been widespread. Typically, one of the countries, Côte d'Ivoire, which may have been on its way to an open and democratic society was hit by a military coup in December 1999. This happened the same week that the country published a special section in Newsweek promoting the country as a prosperous nation of interest to foreign investors.

Countries like Nigeria and Togo have been under much pressure from foreign donors to improve their human rights record and move towards democracy. Due to their reluctance to do so, this has lead to a gradual reduction in foreign aid. Most recent data from the The World Fact Book[13] shows for instance that Nigeria only received an estimated US$ 39 million in aid as compared to Côte d'Ivoire which got US$ 1000 million.

[12] Landestrategi for Burkina. Copenhagen: Danida, 1995

[13] The World Fact Book 1999. Washington: Central Intelligence Agency, 1999.

For political reasons Nigeria gets by far the least aid per capita in the region even though its per capita income is among the lower. Things may change now as the military have stepped down from power and elections have been held.[14] Recent reports indicate that USAID is ready to assist Nigeria at large scale due to its growing importance as a democracy in the region.

In 1991 and 1992 civil conflicts broke out in Sierra Leone and Liberia. Civil war has been tormenting these countries since. This has lead to widespread instability in the region with large flows of refugees to neighbouring countries. A West African peace keeping force has intervened in the conflicts with limited success. The financial costs of this force have been a burden on the leading countries in the region, especially Ghana.

Civil unrest and conflicts have also hit other countries. In Guinea-Bissau a military coup in 1998 triggered extensive fighting between the coup makers and the government. The situation is still unstable. In Senegal an independence movement in Cassamance province has lead to widespread fighting in the area. A military coup in Niger at the beginning of 1999 lead to international condemnation and immediate withdrawal of development assistance.

On the positive side is that countries like Mali and Burkina Faso have made progress in the last few years in terms of democracy and development. Senegal has recently had a peaceful transition of power from one democratically elected government to another.

3 Health situation and Health Services in the Region

3.1 Health Status and Mortality

The health situation in the West African region is a reflection of the development stage which most of the countries in the region are at. The countries are mostly poor and their economies are not very well developed or diversified.

Unicef's report State of the World's Children publishes annually updated information on a number of indicators which reflect the social conditions and health in the countries of the World. The information is based on a number of sources, generally considered the best available when it comes to developing countries. This includes statistics compiled by the World Bank and the World Health Organisation and data collected through the Demographic and Health Surveys, an extensive USAID-funded project which has been operational for the last 14 years.

Data from this year's (2000) edition of the State of the Worlds' Children for the 23 countries in West Africa are presented in tables 1–8. The tables show that

- The infant mortality rate (IMR) varies from 54 (Cape Verde) to 182 (Sierra Leone) per 1000 live births. Thirteen of the countries have an IMR above 100.
- The under-five mortality rate varies from 73 (Cape Verde) to 316 deaths (Sierra Leone) per 1,000 live births. Sierra Leone has the highest under-five mortality in the world. Out of the 10 countries in the world with the highest under-five mortality four are in the region.
- Life expectancy at birth varies from 38 (Sierra Leone) to 69 (Cape Verde) years. Fourteen of the countries have a life expectancy of 50 years or less.

[14] Africa News Service, June 16, 1999. www.africanews. org.

- In the 17 countries from where data are available 4% (Senegal) to 21% (Burkina Faso) of infants are born with low birthweight.
- Available data suggests that exclusive breastfeeding in the first three months of life is less common than recommended by WHO.
- Of children under five 14% (Cape Verde) to 50% (Niger) suffer from moderate or severe malnutrition.
- Thirteen countries report that more than one quarter of under-fives suffer from moderate or severe stunting.
- Immunisation coverage rates vary from 27% to 99% for TB, from 21% to 96% for DPT, from 19% to 95% for polio and from 18% to 91% for measles. Only one country (The Gambia) has reported coverage rates above 90% for all six target diseases. Ten countries have reported coverage rates for DPT of less than 50%.
- Less than half of children with diarrhoea are managed with Oral Rehydration in thirteen of the countries.
- The total fertility rate (number of children born per woman during her reproductive age) varies from 3.5 (Cape Verde) to 6.8 (Niger). The fertility rates have generally gone down somewhat from 1990 to 1998. The median fertility rate in the countries is 5,5. Hence the high population growth rate.
- Maternal mortality is very high in the region with ratios ranging from 55 (Cape Verde) to 1100 (CAR) deaths per 100 000 live births.

From these data it can be concluded that premature and maternal mortality, malnutrition and high population growth rates characterise the region. An estimated 1.8 million deaths in children under five occur in the region every year. 44% of these take place in Nigeria.

Some indicators of particular relevance to health status and disease prevention are access to water and sanitation and women education.

From table 3 it can be seen that the percentage of the population with access to safe water varies from 34% (Sierra Leone) to 95% (Equatorial Guinea). In ten of the countries less than half of the population live with safe water within reach. With regards to adequate sanitation 6% (Mali) to 89% (Cameroon) have access to it. In fifteen of the countries less than half of the population have access to adequate sanitation.

In table 4 it can be seen that 7% (Niger) to 67% (Equatorial Guinea) of women are counted as literate. In thirteen of the countries less than one third of the women can read. Only Burkina Faso and Niger report similar low literacy rates for men.

Women are generally much less involved in education than men. When comparing primary school enrolment rates we find that with the exception of Cape Verde, which reports 100% school attendance, all the other 15 countries which have provided data reports lower enrolment rates for girls than for boys. The median for reported primary school attendance is 55% for boys and 46% for girls. For secondary school enrolment the medians have gone down to 23% for males and 12% for women. This means that in eleven of the 20 countries for which data are available 12% or less of the females enrol in secondary school.

The data presented clearly illustrates that there are significant health and nutrition problems in the region. This is due to many factors, among them poor living conditions with limited access to food, safe water and sanitation and low or no education of women.

In table 9 the 23 countries have been ranked for eight key indicators of social development. One of the indicators is economic, three are health outcome measures, one is related to delivery of health services, two are related to education and one to household standards linked to disease prevention. A score has been constructed for each of the countries by summing up the individual ranking numbers for each of the eight indicators and then calculating an average rank by dividing the sum by 8.

It can be seen from the results presented in table 10 that Cape Verde come out as the country best off in this assessment. The countries which score low on almost all the indicators are Mali, Chad, Central African Republic, Liberia, Burkina Faso, Guinea-Bissau, Niger and Sierra Leone. The oil-rich Nigeria is not doing too well either. This is particularly worrying given the large size of the population in the country.

3.2 Morbidity and Disease Patterns

The countries of West Africa share many characteristics with the rest of sub-Saharan Africa. The poverty and the socio-economic structure and development make infectious diseases the major cause of death and morbidity. In the World Health Report of 1999[15] attempts have been made to estimate the global burden of disease (BOD) for the world and by WHO region. The African region in the WHO covers all the countries in Africa except the ones north of Sahara and Sudan. Hence all the countries in West Africa are part of the WHO region.

The measure used to estimate the BOD is Disability-Adjusted Life Years – DALY – which takes into account both the burden from premature death and disability.

In the African region poverty-associated disorders such as communicable diseases, maternal and perinatal disorders and nutritional deficiencies account for 68% of the total burden of disease. For the world as a whole these disorders account for 41% of the burden of disease. Logically, non-communicable diseases only represent 17% of the BOD in Africa as compared to 43% for the world. Injuries constitute 15% of the disease burden in Africa as compared to 5% for the world.

Among the communicable diseases in Africa the most prominent in terms of disease burden were HIV/Aids (17%), malaria (11%), respiratory infections (7%), diarrhoea diseases (7%) and measles (5%). Maternal mortality represented 3% of the BOD and perinatal conditions 6%.

Two thirds of the world's deaths and disabilities due to communicable diseases, delivery disorders and nutritional deficiencies occur in Africa. Hence, there is both a regional and global interest in giving priority to prevention and cure for these diseases. Most of them are amenable to preventive interventions and infectious diseases in particular are curable once they occur.

A review of some of the countries in the region confirm the overall picture given by the analysis above for sub-Saharan Africa. In Mali the Demographic and Health Survey in 1995/96 showed that the leading causes of infant-juvenile mortality were malaria, Acute Respiratory Tract Infections (ARI), diarrhoeal diseases, epidemic meningitis, measles, malnutrition and neonatal tetanus.[16] Five of these disorders (excluding meningitis) account for about two thirds of the childhood deaths. Furthermore, malaria and diarrhoeal diseases alone represent 44% of the reasons for all consultation in medical services outside the capital Bamako.

[15] World Health Report 1999. WHO: Geneva, 1999.

[16] Mali-Unicef 1998-2000 Child Survival Programme in Mali. Bamako: Unicef, 1998.

In Burkina Faso about 18% of babies suffer from insufficient birthweight which limits their chances of survival. Malaria is the primary cause of death for children under age one, while measles and diarrhoea are the leading causes of death for children aged one to five. Among adults malaria is the leading cause of death followed by respiratory infections, including tuberculosis.[17]

In the Gambia about 60% of childhood deaths are caused by malaria, acute respiratory infections and diarrhoea. Malnutrition is a complicating factor for all childhood diseases, and many children have two or more diseases at the same time.[18]

Data from Nigeria provides further support to the overall conclusions on the morbidity pattern in the region. Diarrhoea, respiratory infections and malaria are major killers in Nigeria.[19]

Almost all countries report cholera and yellow fever as endemic to WHO. Epidemics of cholera has hit several of the countries in the last few years, sometimes resulting in serious emergencies.[20]

Parasitic diseaseas are important in the region not only because of malaria. Filariasis, leishmaniasis and haemorrhagic fever occur in several of the countries. Guinea worm is endemic in the region. A Guinea worm eradication programme is successfully run in the region with primary support from the Carter Foundation.

Schistosomiasis is common. For instance, urinary schistosomiasis in one of the 10 primary reasons for consultation among 5 to 14 year old in Mali.[21]

WHO, the World Bank and other donors have supported a large onchocerciasis (Riverblindness) control programme in 11 countries in Sahel since 1974. The headquarter is in Ouagadougou. The programme has been very successful virtually eliminating river blindness from the eleven countries. A continuation of the programme, called The African Programme for Onchocerciasis Control (APOC), has been established to eliminate Riverblindness throughout the rest of Africa.

Sexually transmitted diseases (STD) and the spread of HIV infections as well as other opportunistic diseases such as tuberculosis are becoming an increasingly serious public health threat in the region. Data from the UNAIDS show a clear rise in the number of HIV positive in the region. From Côte d'Ivoire it is reported that HIV-1 seroprevalence among women coming to antenatal clinics increased from 3% in 1986 to 12 percent in 1995.[22] Unfortunately the region may gradually catch up with the rest of Africa in terms of AIDS morbidity and mortality. The war and refugee situation in the region is contributing to this.

HIV seropositivity rates for pregnant women of 10–20% are reported from Abidjan, Bouaké (Côte d'Ivoire), Lomé, Ouagadougou and Bobo Dioulasso. Almost all major cities in the region had seroprevalence rates above 1% in 1997.[23]

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[17] Health and Nutrition Project. Burkina Faso. Staff Appraisal Report. Washington: World Bank, 1994:

[18] Health and Population Project. The Gambia. Staff Appraisal Report. Washington: World Bank, 1998.

[19] Federal Republic of Nigeria social sectors strategy review. Washington: World Bank, 1994.

[20] MSF 1998-1999 Activity Report. www.msf.org. October 1999.

[21] Mali-Unicef 1998-2000 Child Survival Programme in Mali. Bamako: Unicef, 1998.

[22] Côte d'Ivoire. UNAIDS/WHO Epidemological Fact Sheet. www.unaids.org. Jan 2000.

[23] UNAIDS/WHO Epidemological Fact Sheet. www.unaids.org. Jan 2000.

In Burkina Faso UNAIDS estimated that 370 000 persons were affected by an HIV infection at the end of 1997. This corresponds to an infection rate of 7% in the adult population. Since the beginning of the epidemic is was estimated that 250 000 Burkinabe had died from AIDS.[24]

The countries where AIDS is reported to be most common in West Africa are Côte d'Ivoire, Benin, Burkina Faso and Guinea-Bissau.[25] HIV-2 is more common in the region than in the rest of Africa.[26]

It may be appropriate to point out that James Wolfensohn, the World Bank President, on January 10 in the first speech ever of a WB President for the UN Security Council called for a grand coalition, with Africans in the lead, to step up the fight against AIDS in Africa. The epidemic has already claimed 13 million African lives, and orphaned 10 million children. Noting that today in Africa 23 million are living with HIV/AIDS, Wolfensohn said, "We face a major development crisis, and more than that, a security crisis. For without economic and social hope we will not have peace, and AIDS surely undermines both."[27]

Among women the most common causes of deaths are maternal conditions and infectious diseases. In Mali perinatal conditions in women was second cause of death among women older than 15 in 1996.[28] (The primary cause was cholera which ravaged the country that year.) The major reasons for death during and after delivery are haemorrhage, obstructed labour and eclampsia.

As elsewhere maternal mortality in the region is higher among young girls (15–19 years of age) and those with multiple deliveries behind them (35 years of age and above.)[29]

Women are also affected from the infectious diseases, not least HIV/AIDS. More often than men, they tend to suffer from anaemia and malnutrition.

The practice of Female Genital Mutilation (FGM) among women is widespread in the Sahel. FGM is a health risk in itself and it may also lead to complications later in life which put women at increased risk of maternal death. According to DHS surveys FGM procedures are nearly universal among women in Mali where about nine of 10 women have had at least some part of their external genitalia removed. Genital cutting is less common in Côte d'Ivoire and the Central African Republic (CAR), with prevalence levels of 43 percent among women ages 15 to 49.[30] Studies from Burkina Faso show a similar pattern as the one in Mali.[31] There are however also countries in the region where FGM is little practised.

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[24] Burkina Faso. UNAIDS/WHO Epidemological Fact Sheet. www.unaids.org. Jan 2000.

[25] Confronting AIDS: Public Priorities in a Global Epidemic. Washington: World Bank, 1999

[26] Andersson, Sören: HIV-1 and HIV-2 infections in Guinea-Bissau, West Africa: Studies of immune responses, prevailing viruses and epidemiological trends. Ph D Dissertation. Stockholm: Karolinska Institutet, 1999.

[27] Wolfensohn calls for "war on aids". World Bank Press Release. Washington: World Bank, Jan 2000.

[28] Mali-Unicef 1998-2000 Child Survival Programme in Mali. Bamako: Unicef, 1998.

[29] Mali-Unicef 1998-2000 Child Survival Programme in Mali. Bamako: Unicef, 1998.

[30] Female Genital Cutting: Findings from Demographic and Health Surveys. DHS+ Programme.

[31] Reserapport: Burkina Faso, Côte d'Ivoire och Mali. AFRA/Öst-Väst, Sida: Stockholm, 1999.

3.3 Health Services

Health services in the region are provided by the government system, NGOs and private providers. The majority of the NGOs are religious and usually receive significant funding from abroad. The public sector is usually the most important of the three in terms of quantity.

Public sector spending on health is in the range of US$ 5–10 per capita. Expenditures on health as percentage of GNP is in most cases below 5%.

The World Bank's 1994 publication Better Health in Africa recommended that countries needed to spend US$9–12 per capita to provide a minimum package of primary health care.[32] With the low national incomes and the little economic growth that the countries show, there is little suggesting that they will be able to reach this level just with their own resources. In fact the countries would have to make health care their primary priority and set aside all of their expected growth in the coming years to health if they were to reach the modest recommendation in the World Bank report.

The informal sector is a significant actor in curative services in all the countries. Traditional beliefs and practices remain strong in many communities, especially in the rural areas.

Private practitioners exist in all the countries in the region. They are usually relatively few in numbers and confined to the larger cities. The extent to which publicly employed staff is involved in private practices in their free time is not known but there are reasons to believe that the underpaid staff complement their incomes by providing advice and services at cost when they are off duty.

Significant sales of drugs over the counter without prescriptions take place in all countries of the region. Purchase of drugs is a major expenditure on health care in families. This is illustrated in table 11. Mali, from where the data are taken, have had a Unicef-supported programme based on the Bamako initiative and which seeks to promote rational use of drugs since 1987.

Table 11. Household expenditures on health in Mali 1997.[33]

Sources of spending	As percentage of total HH spending on health
Fees in public sector	3.1%
Care in private or informal sector	5.1%
Illicit private fees	3.1%
Traditional medicine	3.4%
Modern medicines	84.9%

Many of the countries rely heavily on financial support from abroad. For instance, 80% of health services in Chad are financed from abroad. Under such circumstances there is no sustainability in sight[34]. More typically, the proportion of public health services

[32] Better Health in Africa. Washington:World Bank, 1994.

[33] The World Bank and the Health Sector in Mali. An OED Country Sector Review. Washington: World Bank, 1998.

[34] Chad – Health and Safe Motherhood Project. Washington: World Bank, 1993.

financed with donor funds can be estimated at 20–30%.[35] Previously donor funds were used to support special programmes and activities, while lately there has been a move towards joint funding for general sector support (Sector Investment Programmes (SIP) or Sector-Wide Approach (SWAP)).

Access to health services is low in the Sahel countries while it is estimated to be somewhat higher for the countries in the south of the region. In Benin, access was however reported at 30% in 1994.[36] In Mali, the population living within 15 km of community health facility rose from 17 percent in 1995 to 39 percent as of December 1997.[37]

Utilisation of public health services is reportedly low in many of the countries. In Burkina Faso it is estimated that facilities work at least 30% below their full capacity.[38] In 1996, Malians visited a government or community health centre for curative services only 0.16 times per year on average. The continued low utilisation rates despite efforts to improve geographic access were said to be a consequence of several factors, including low quality of services at government facilities, inadequate outreach services, and client preferences for traditional medicine and self-medication. The fees charged at health centres were also felt to represent a deterrent for potential clients.[39] Another reason for low utlilisation is given from Togo. The low demand for PHC services there by the population is due to its perception that the cost for these services in the public sector is higher than their value. Patients therefore bypass lower levels and go directly to higher levels where secondary or tertiary care is provided. As a result, peripheral health units are grossly under-utilised.[40]

Concerning staff there is generally very few doctors per inhabitant in the region. This is due to low output from medical faculties but also due to a significant brain drain. Roughly half of all Ghana's doctors are practising in the United States.[41]

With regard to nurses the situation is generally better. In Mali, for instance, the population per physician is about 38,900, while there is 4528 persons per nurse and 22700 persons per midwife. These numbers indicate an adequate number of nurses, but a considerable shortage of doctors relative to the WHO recommended minimum rates for the Sahel countries of 1 per 10 000, and, for midwives, 1 per 5 000.[42] However, there tends to be an accumulation of qualified staff in the urban areas. For example, in Mali about 60 percent of all professional health staff, 64 percent of midwives and 39 percent of state registered nurses are located in the Bamako region, where only ten percent of the population lives.

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[35] The World Bank and the Health Sector in Mali. An OED Country Sector Review. Washington: World Bank, 1998.

[36] Benin – Health and Population Project. Staff Appraisal Report. Washington: World Bank, 1994.

[37] The World Bank and the Health Sector in Mali. An OED Country Sector Review. Washington: World Bank, 1998.

[38] Burkina Faso. Health Nutrition Project. Staff Appraisal Report. Washington: World Bank, 1994.

[39] The World Bank and the Health Sector in Mali. An OED Country Sector Review. Washington: World Bank, 1998.

[40] Togo Health Project. Project TGPE57824. Washington: World Bank, 1999.

[41] Ghanaian Chronicle, November 29, 1999

[42] The World Bank and the Health Sector in Mali. An OED Country Sector Review. Washington: World Bank, 1998.

In terms of formal organisation the health services almost invariably follow the same pattern. They are centralised with significant power given to the Ministry of Health. An illustrative example is given in the following from Benin.[43]

Benin's public health system has three levels: central, intermediate and peripheral. At the central level the Ministry of Health coordinates the formulation of sector policy and strategies. It synthesises requests for inputs from the regions into sector investment programmes and prepares corresponding annual investment and recurrent budget proposals for the sector. The MOH prepares medium-term investment plans in mobilising resources from external sources. It is responsible for setting and enforcing patient care norms and standards. It defines the functions and evaluates the performance of health facilities at all levels. The MOH is responsible for the deployment, supervision and evaluation of all categories of health personnel who work in the public health sector.

At the regional (province) level the Departmental Bureau of MOH (Direction Departemental de la Santé – DDS) is responsible for managing health programmes designed to implement the national health sector policy and strategy as adapted to the particular context of the region. The DDS is responsible for the allocation of resources within the region and for the provision of support to health facilities in the department and to central MOH in planning, management and evaluation of health sector activities. The DDS coordinates the preparation of draft budget requests submitted to the MOH for review and inclusion in the budget proposals.

At the sub-prefectoral (District) level the chief medical officer supervises the primary health care facilities operating in the sub-prefecture.

At the community health centre level, a state midwife or nurse manages community-level primary health care and supervises health centre staff.

The delivery of health services is usually organised in primary, secondary and tertiary level facilities. The following description from Senegal[44] provides a good illustration of how the health services usually are organised in the region.

The Senegalese health care system consists of a well defined network of public health facilities classified according to the level of care.

The first tier consist of 733 health posts (1 per 10 000 inhabitants) and 52 district health centres (1 per 150,000 inhabitants). Basic services provided by a health post include primary curative care, caring for the chronically ill (e.g. tuberculosis and leprosy patients), pre-natal consultations, family planning and the promotion of good nutrition, hygiene and water sanitation. District health centres are intended to provide first level referral to the health posts and limited hospitalisation services with a capacity of 10 to 20 beds.

At the second tier, there are 7 regional hospitals with a capacity of 100 to 150 beds located primarily in provincial cities and designed to provide the urban and rural population with some specialised care.

Finally, the third level of care encompasses 1 teaching hospital and 6 general hospitals all located in the capital, Dakar. The national role of these third-tier facilities is considerable. In 1993, they accounted for 35% of assisted deliveries and 50% of hospital admissions and 64% of the total hospital bed capacity in the country.

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[43] Adopted from Benin – Health and Population Project. Staff Appraisal Report. Washington: World Bank, 1994.

[44s] Senegal Integrated Health Sector Development Project. Staff Appraisal Report. Washington: World Bank, 1996.

It is true for many of the countries that there is an imbalance in allocations as teaching and central hospitals tend to get far too large share of the government budget in relation to their output. In the Gambia nearly 50% of all public resources are provided to the two largest hospitals in the country.

From reports on health services in the region it appears that a common characteristic is that the public services often are of poor quality due to inadequate supplies, insufficient and poorly trained manpower and low standards of management and limited capacity to absorb development programmes.

4 Health Reform and Sector-wide Approaches in the Region

As described above the organisation of health services usually follow a traditional pattern for Africa in which the central level is fully in charge of the budget, holds the funds and employs all staff. This is usually considered an inefficient way of organising health services leading to delays in release of funds and implementation of services. The system has also been seen as conducive to corruption.

During the past decade many of the countries in the region have embarked on sector reform programmes with the aim to decentralise and rationalise the management of health services.

In *Benin* the country in 1989 adopted a strategy to rehabilitate and re-equip health facilities after a long period of deterioration of the services. During the first half of the decade more than half of the health facilities were upgraded and improved. However, it became clear that the programme had too much of a focus on the infrastructure and that the quality of the health services had to be addressed.

In 1995 a new sector strategy was developed with the assistance from donors, most notably the European Commission. The strategy has many of the common elements of health reform programmes in the region. It aimed at

1) decentralisation and strengthening of sector management and administration;
2) reconfiguration of the referral system and strengthening of its capacity to provide technical support services to primary health care and nutrition; and
3) expansion of the participation of multiple stakeholders, including beneficiaries, in the planning, implementation and evaluation of national health policy and programs.

Activities proposed were the reorganisation of the MOH, the extension nation-wide of cost recovery, the creation of health management committees, the establishment of a central drug purchasing and procurement body which would assure affordable and available essential drugs and, finally, the establishment of fuller participation in the planning, coordination and evaluation of all parties in the health care system.

The plan which was developed for 1995–1999 put an emphasis on the development of the central MOH and department (DDS) capacity in planning and in the mobilisation and management of sector resources – both human and financial, and the gradual establishment of health districts. The donor consortium consisting of some 20 partners then decided to share the support for this health sector programme. Improvements in health services are now being supported by the France, Germany (GTZ), Switzerland,

the Netherlands, China, the African Development Bank and the Islamic Development Bank (IDB). Significant support is also given to strengthen priority health programmes, such as control of STDs and AIDS and MCH/FP services. These programmes are in particular supported by the multilateral donors. Canada is providing significant support for AIDS control to the Francophone countries in the region, including Benin.[45] Denmark is also giving support to the health sector in Benin.

Progress of the programme has generally been good even though limited capacity to manage the programme and improve the general conditions in the health sector have been obstacles for its implementation.

Both *Mali* and *Burkina Faso* have extensive programmes aimed at reforming health services which have been partly financed by loans from the World Bank. There are a number of other donors involved in the two countries, including the European Union. A Sida team found during a visit last year that the situation could be described as "donor crowding" and that neither of the ministries of health seemed to be seeking new partners or further aid.[46]

In *Mali* the country has had a programme based on the Bamako Initiative since 1990. The key elements of the policy have been decentralisation of health services management to local government at district (cercles) level, implementation of an essential drugs policy including an increasing role for the private sector, and cost recovery through a new financing strategy under which a large share of the recurrent costs are borne by the local population. An important part of the policy has been the creation of community managed health centres serving around 5000 persons.[47]

The health services in Mali are still in a poor condition and the general health situation is far from satisfactory. The various attempts to reform the services may have had a positive impact but may also have been by other factors beyond the control of the Ministry of Health. At present the various actors have been formally coordinated into a joint programme for health sector development which could qualify for a so called SWAP programme (Sector-wide Approach Programme).

The government in Burkina Faso has had as its policy since 1984 to expand and decentralise the health sector. It has however lacked the resources required to achieve these aims. Since 1990 a certain reorientation in the policy has taken place and a private sector in encouraged and growing. It has also taken over distribution and sales of drugs.[48] Districts have gradually been strengthened to manage health services but there is still a significant need for capacity building in this aspect.

The World Bank has assisted the MOH in the country since 1985. The on-going support from the Bank to health reform and AIDS control in Burkina Faso corresponds to a total lending of US$ 29 million. Other supporters are Germany, the Netherlands, France and the European Union. At the moment the leading donors are assisting the Ministry of Health in developing a SWAP-programme which may take off from the beginning of 2001.

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[45] Benin – Health and Population Project. Staff Appraisal Report. Washington: World Bank, 1995.

[46] Reserapport: Burkina Faso, Côte d'Ivoire och Mali. AFRA/Öst-Väst, Sida: Stockholm, 1999.

[47] Cooperation for Health Development. The World Health Organisation's support to programmes at country level. Country case study report: Mali. Geneva: Who, 1997.

[48] Landestrategi for Burkina Faso. Copenhagen: Danida, 1999. www. Danida.dk. Jan 1999.

Ghana has a health reform process going since the end of the 80'ies. Ghana is usually considered as one of the countries which have been most successful in integrating and decentralising health services.[49] The programme continues with significant support from, among others, the World Bank, Danida, United Kingdom and the European Union. (More details on the programme are given in Annex 3.)

In *Senegal* there is an Integrated Health Sector Development Programme. The primary objectives of the programme are to

1. Expand use of health services
2. Increase the overall efficiency of health care system in the mobilisation and use of services; and
3. Contribute to fertility reduction.

Within the public sector health planning is now based on the preparation of district and regional health plans, the reform of state hospitals and the promotion of cost sharing through mandatory health protection plans as well as optional community-based health insurance schemes. The provision of an integrated package of Primary Health Care services remains a major area of priority in the programme.[50]

It is interesting to note that the World Bank supported a project starting in 1991 which shared several elements of the health sector reform package in the current programme. An evaluation of the project highlighted

- the difficulties in dealing with human resources management reforms including redeployment of personnel in the absence of a significant decentralisation of health system management and broader civil service reform;
- the limited capacity of the central administrative structure to redefine their role away from direct control and management toward strategic and support functions;
- the need for a major legislative and regulatory reform of the pharmaceutical sector to achieve a meaningful shift to generic drug procurement and distribution.

These highlights are indeed relevant to most of the health sector reform programmes which are in progress in the region. Several of them may well become disappointments because of factors like the three identified in Senegal.

A country where efforts to introduce health sector reform have stopped is *Togo*. The World Bank has concluded that the government has no political commitment to health sector reform. The Bank has therefore decided to support a regional pilot project in the country rather than to try to impose a wide national reform programme on the MOH.[51]

In *Nigeria*, the country with the largest burden of disease in the region, there are so far no concerted efforts to reform health services. A reason is the very limited input from the international donor community in the country over the past decade.

[49] Cassels A, Janovsky K. A time for change: health policy, planning and organization in Ghana. Health Policy and Planning; 7(2): 144-154. Oxford University Press 1992.

[50] Senegal – Integrated Health Sector Development. Washington: World Bank, 1996.

[51] Togo – Health Project. Staff Appraisal Report. Washington:World Bank, 1999.

5 Multinational Health Sector Support in West Africa

There are a number of programmes and projects in the health sector in West Africa which receive support from multinational organisations. Some of the assistance has been reflected in chapter 4.

The most prominent actor in the region is the *World Bank* which together with the African Development Bank is a major lender to many of the countries. Among them are Ghana, Senegal, Burkina Faso, Mali and Benin. The Bank seeks to encourage the establishment of sector-wide programme approaches and works closely with other prominent multilateral and bilateral donors to encourage governments to adopt such programmes. The World Bank collaborates with WHO and Unicef in some of the leading global and/or regional initiatives which have important implications for the work at country level. Among them are the onchocerciasis (River blindness) control programme and Roll Back Malaria.

The European Union (EU) is supporting the health sector in several of the countries in the region through the European Commission (EC). The overall policy of the EU is to encourage integrated support packages which by preference are delivered in a sector-wide approach with all donors involved. The EU is also giving specific support to HIV/AIDS control in several of the countries.

The *World Health Organisation (WHO)* is supporting all the countries in the region through its regional and country programme. WHO is providing general system support to areas like health system development and health information systems. A number of technical programmes also receive support both at regional and country level. Among the more prominent are Roll Back Malaria, IMCI (Integrated Management of Childhood Illness) and control of emerging and reemerging epidemic diseases.

The primary areas of work for the *UNFPA* in the region is reproductive health including family planning and sexual health. Some prominent components in the UNFPA work are support to Family planning, Female Genitale Mutilation, gender issues and HIV/AIDS control.

UNFPA is seeking to support education in schools on population and family planning. However, this support has suffered from cut-downs in contributions.

Unicef has a strong experience in supporting health system development through the Bamako Initiative (BI) strategy in the region. More than 7000 health centres have been revitalised and are offering an essential care package (including vaccination and essential drugs) through the BI . This has made a sustainable difference where BI has been implemented. However quality of care remains weak. In 1999 a review of Bamako Initiative was organised with participation of 43 African countries. Lessons learned and recommendations are now taken into account by the UNICEF/WHO working group that should renew the implementation framework.

The Unicef Regional Office in Abidjan would like Unicef to benefit from Swedish support in the renewed Bamako Initiative framework as it will strengthen health system capacity at decentralised level, improve community participation, address major child killers (including HIV/AIDS) and pay attention to maternal mortality.

Unicef is supporting promising experiences aiming at maternal mortality reduction in the region. These activities do however suffer from insufficient financial support to become fully extended and make an impact. This refers to countries like Mali, Burkina, Benin, Guinea, Senegal and Niger.

Malaria and HIV/AIDS are getting further priority and importance in several countries in the region. Malaria is especially linked with the BI strategy. Unicef has adopted in the last regional management team a strategy framework that should orient and help country offices to select/ combine effective and relevant interventions to tackle HIV/AIDS. Focus is put on prevention among youth and mother-to-child transmission.

In most of the countries routine EPI (Expanded Programme on Immunization) is promoted and supported by Unicef. Unicef feels more attention is needed to ensure effectiveness and sustainability of the EPI.

UNAIDS has established The International Partnership against AIDS in Africa. It is working to fight the HIV/AIDS epidemic through stronger national programmes backed by four main lines of action:

- Encouraging visible and sustained political support,
- Helping to develop nationally-negotiated joint plans of action,
- Increasing financial resources, and
- Strengthening national and regional technical capacity.

The members of the Partnership are creating a framework that will help to rapidly deliver technical know-how to countries and national organizations where and when is needed, build on the capacity of national and regional technical specialist and technical agencies and develop regional mechanisms that rapidly disseminate lessons learned, especially successful actions from one setting to another.

Much more information on support to the health sector in West Africa from international organisations is given in Annex 3. It can be concluded from the review that there are a number of actors in the region. Their activities provide a number of opportunities for Sida to assist regional or country programmes.

6 Swedish Experience from Health Sector Support in West Africa

In comparison with other regions of Africa there are few Swedish organisations which have worked in West Africa for a long time. They are all mission services.

The former Portuguese colonies have received significant Swedish support over the years and there is considerable knowledge and experience on these countries in Sweden.

Over the last few years emergencies have introduced several Swedish organisations to the region. Swedish health care workers have also been engaged in relief programmes run by MSF and the Red Cross.

With regard to institutional and organisational links there are long standing relations between several Swedish churches and their sister organisations in the West African countries. These organisations are well established in their national context. The Swedish Red Cross and Smittskyddsinsitutet are organisations which have links with the region. Apart from that there are few institutional links between Sweden and the countries in the region.

It should be mentioned that the Director of the National Institute of Public Health in Burkina Faso recently visited Stockholm in order to seek institutional collaboration with the Karolinska Institute.

The countries for which there exist a reasonable Swedish manpower resource base in health care are Guinea-Bissau, Cape Verde, Central African Republic, Liberia and Sierra Leone.

A detailed description of recent Swedish collaboration in health with West Africa is given in Annex 2.

7 The Future

The Regional Health Profile has pointed to the great needs for support to the countries in West Africa. The health status of the populations is in an international comparison poor. Infectious diseases and perinatal disorders constitute the major burden of disease in the region. AIDS is on the rise. Public health services are often of poor quality and health care is grossly underfinanced. Attempts to improve health services both in terms of infrastructure and management have been made during most of the past decade with mixed results.

Some of the countries are among the poorest in the world. Generally the region has had little or no development in the last decade when calculated per capita. In addition, civil conflicts have affected many of the countries, sometimes resulting in a complete collapse of the government system.

There is little indicating that the development will improve in the immediate years ahead of us. Even with a positive economic development it will be difficult for governments to maintain or increase the standard of living due to the high population growth rates in almost all the countries. There will therefore be a long lasting need for significant foreign assistance to relieve the situation of the people. If peace may come to the countries hit by war there will also be a tremendous need for rehabilitating them.

Any health assistance to the region should have a long term perspective. There is evidence that sustainability is difficult to attain in the region. Given the prospects for the coming years it appears very difficult for national governments to take over the full financial responsibility for programmes or projects initiated with foreign assistance.

In consequence, there is a great need for Swedish assistance to the health sector either through bilateral agreements or international organisations.

List of abbreviations used in the report

ADRA	Adventist Development and Relief Agency
AFRO	WHO African Regional Office
AIDS	Aquired Immunodeficiency Syndrome
ARI	Acute Respiratory Tract Infections
ARO	Afrikagruppernas rekryteringsorganisation
ASDAP	Association for the Development and Strengthening of Activities on Population
CAR	Central African Republic
BI	Bamako Initiative
BOD	Burden of Disease
CAR	Central African Republic
CDC	Center for Disease Control (Atlanta)
CEDAW	Convention for the Elimination of all kind of Discrimination Against Women
CIA	Central Intelligence Agency
CRC	Convention for the Rights of Children
DALY	Disability-adjusted Life Years
Danida	Danish International Development Agency
DDS	Direction Departemental de la Santé
DFID	Department for International Development (UK)
DPT	Immunization against diphtheria, pertussis and tetanus
EC	European Commission
EU	European Union
EMC	Programme on Emerging, Reemerging and other Communicable Diseases
EPI	Expanded Programme on Immunization
FC	Female circumcision
FGM	Female Genital Mutilation
FP	Family Planning
GEEP	Group for the Study of Education of the Population
GNP	Gross National Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IDB	Islamic Development Bank
IDD	Iodine Deficiency Disorders
IDS	Integrated Disease Surveillance
IEC	Information, Education and Communication
IFRC	International Federation of Red Cross and Red Crescent Socities
IMCI	Integrated Management of Childhood Illness

IMR	Infant Mortality Rate
M or m	Meter
MCH	Maternal and Child Health
MOH	Ministry of Health
MPA	Minimum Package of Activities
MSF	Médicins sans Frontières
NGO	Non-governmental Organisations
PHC	Primary Health Care
PMU	Pingstmissionens u-landshjälp
Rainbo	Research, Action and Information Network for the Bodily Integrity of Women
RBM	Roll Back Malaria
SHIA	Svenska Handikapporganisationers Internationella Biståndsförening
Sida	Swedish International Development Cooperation Agency
SIP	Sector Investment Programme
SMI	Smittskyddsinstitutet
SMR	Svenska missionsrådet
SRC	The Swedish Red Cross
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SWAP	Sector-wide Approach
TBA	Traditional Birth Attendants
UCI	Universal Child Immunization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
Unicef	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Annex 1

Countries in the West African Region (as defined in this document)

In alphabetic order

	Country	Official Language
1	Benin	French
2	Burkina Faso	French
3	Cape Verde	Portuguese
4	Cameroon	French and English
5	Central African Republic	French
6	Chad	French
7	Congo (Brazzaville)	French
8	Equatorial Guinea	Spanish
9	Côte d' Ivoire	French
10	The Gambia	English
11	Gabon	French
12	Ghana	English
13	Guinea	French
14	Guinea-Bissau	Portuguese
15	Liberia	English
16	Mali	French
17	Mauritania	French
18	Niger	French
19	Nigeria	English
20	Sao Tomé and Principe	Portuguese
21	Senegal	French
22	Sierra Leone	English
23	Togo	French

Annex 2

Health Sector Support Provided to West Africa by Swedish organisations

The following is a description of current (1999) Swedish support to West Africa.

1 Bilateral assistance

Swedish has had little bilateral support to the West African region. The two countries which have been programme countries are Cape Verde and Guinea-Bissau. In Guinea-Bissau support has been given by Sida for many years to the national microbiological laboratory. The laboratory was destroyed in the war following the military coup in June 1998. Support has now been allocated for its renovation. Apart from that support to the health sector in Guinea-Bissau has been terminated.

A good number of health care specialists have over the years acquired experience from Guinea-Bissau as long or short term advisers.

2 Swedish NGOs

Swedish non-governmental organisations have been active in several of the other countries. Here follows a description of the most recent activities or projects by organisation.

- **Adventistsamfundet**

Adventistsamfundet received SEK 2.1 million in 1998/99 from Sida for renovation or rather reconstruction of a destroyed hospital in Masanga in *Sierra Leone* which Adventistsamfundet used to support. Due to the war it has not been possible to work with the project and funds have instead been diverted to a clinic for displaced persons in Waterloo outside Freetown.

Adventistsamfundet has provided funds for equipment and medicines to Cooper Memorial Hospital in *Liberia*.

It is of interest to note that Adventistsamfundet is supporting a local project aimed at improving the situation of women in *Togo*, a country where there is otherwise little Swedish contacts.

Support is given to Ileife hospital in *Nigeria* and the nurse training school attached to the hospital. No Swedish staff is employed at the hospital.

Adventistsamfundet is collaborating closely with Adventist Development and Relief Agency (ADRA) which has its headquarter in Washington D C. ADRA coordinates support to many countries from the Adventists around the world.

- **Diakonia**

Diakonia is supporting programmes and NGOs in Burkina Faso, Ghana, Mali, Mauritania, Senegal, Togo and Congo. The programmes are integrated welfare or development programmes. They main contain health care or health promotion components but apart from that Diakonia is not supporting any specific health care projects or activities in the region.

- **Hjälpmedelsinstitutet**

The Swedish Handicap Institute (Hjälpmedelsinstitutet) has supported training of rehabilitation and orthopedic technicians in the Francophone part of West Africa for local production of handicap equipment. Since 1994 this training programme has had around 155 participants from 15 countries in the region. Courses have been held in 1994 in Burkina Faso, in 1995 in Togo and in 1999 in Mali. The support from Sida for this was SEK 250 000 in 1999.

- **Läkare utan gränser (Médicins sans Frontières)**

MSF Sweden is a major recipient of Sida funds for work in West Africa. In 1999 the organisation received SEK 11 million for support to activities in the region which are run by the international MSF organisation. "Läkare utan gränser" does not run projects on their own.

Support is given to a hospital in Tubmanburg, Cape Mount, *Liberia*. Funds are also allocated for MSF' work in a camp for refugees from Sierra Leone in the northern parts of the country. Activities there focus on the provision of drinking water and food and improved sanitation. Swedish staff has been employed through MSF in Liberia.

In the Southern province of *Sierra Leone* the international MSF provides support to six clinics and the district hospital in Pujehun, eight clinics and the district hospital in Bo and two clinics in Bonthe. Many of the structures have been rehabilitated by MSF. Swedish funds are used for the work in Pujehun.

Support is given to a surgical programme run by MSF at Connaught Hospital in Freetown. An MSF team working in Brooke Fields Community Hospital is also receiving support. The team is in charge of hospital management and provides health care support to four clinics.

Several Swedish nurses and doctors have worked with MSF in Sierra Leone.

Läkare utan gränser supports MSF's work for medical assistance to refugees from Sierra Leone in camps situated in Forecariah region southeast of Conakry, *Guinea*. Swedish funds are used for the purchase of medical equipment, salaries to local staff and employment of international volunteers.

- **Nybygget (InterAct)**

Nybygget (InterAct) was created in 1996 through a fusion of Örebromissionen and HF/HB Missionen. Örebromissionen has worked in the *Central African Republic* for many years. Many Swedish doctors and nurses have been working with the health services in CAR through employment by Örebromissionen or nowadays Nybygget. There is still a significant input from Swedish staff even though much of the management has gradually been taken over by national staff of the Baptist Church of CAR (EBO).

The current health support from Nybygget goes to a hospital in Gamboula and a project in Bouar in the north. The latter is addressing village health problems.

In 1999 Nybygget received SEK 1 million from SMR for their health activities in CAR.

- **Pingstmissionens u-landshjälp (PMU) – Interlife**

PMU is providing support to several countries in the region.

In *Liberia* support is given to a mobile health team which has provided support and simple health services to people and displaced persons around Monrovia. In Foya PMU intends to rehabilitate a hospital which has been destroyed during the war. The support will be given both to infrastructure and technical capacity building. The work has been delayed due to security problems but it is expected to take off soon. The total support to Liberia via PMU amounts to SEK 4 million for 1998–99.

PMU sent used equipment worth SEK 70 000 to a clinic in *Côte d'Ivoire* last year.

In *Mali* PMU is supporting a programme which trains teachers in primary health care. In the current phase 20 teachers from different parts of the country will be trained.

PMU has collaborated with a sister organisation in Andoum, *Chad* since the 70'ies. Currently SEK 2.7 million is given for rehabilitation of a small hospital and clinics in the district. The hospital is housing a maternity ward which is also upgraded through the present funds. This project is run by the national organisation without long term Swedish technical assistance.

In Mondelam district in Chad, PMU supported an integrated village development project which has had an important health component. For some years a Swedish nurse worked in the project. Among other things she identified goitre as a major problem in the region. Thanks to interventions by her and the organisation, iodised salt has now been made available to the people.

- **Röda Korset (Swedish Red Cross)**

The Swedish Red Cross (SRC) is providing general support to the regional work of the Federation of Red Cross and Red Crescent Societies. The Federation has regional offices in Abidjan and Yaoundé which together cover most of West Africa. The office in Abidjan received around SEK 700 000 in 1999 and the one in Yaoundé SEK 500 000. A delegate from Central African Republic who works in Yaoundé is paid for from Swedish funds.

The Swedish Red Cross has direct collaboration with *Nigeria's* Red Cross. Support is given to a project which aims at training Community Based First Aid (CBFA) workers. These are paramedics or community members who are trained to teach the community on disease prevention. There are two international Red Cross delegates working in Nigeria., one of them is Swedish and works with health. The total amount set aside for this project is SEK 1.6 million.

SRC supports the Red Crescent Society in *Burkina Faso* in training CBFAs. The support amounted to SEK 300 000 last year. The support goes through the regional office and there is no Swedish involvement on the technical side.

SRC gave SEK 300 000 to operations in *Sierra Leone* in 1999.

During the 80'ies the Swedish Red Cross collaborated directly with the Red Cross in Sierra Leone. Several medical students were engaged in a programme based in the central hospital in Freetown which was supported through this programme.

The Swedish Red Cross has sister organisations in all the countries in the region. Many of these national Red Cross or Red Crescent societies run broad health programmes which receive international support.

- **Svenska Alliansmissionen**

Svenska Alliansmissionen supports a village health programme in Bebalem in *Chad*. The programme is run jointly with American and French sister organisations. A number of smaller health clinics are attached to the hospital. A Swedish nurse has worked in Bebalem since 1977. Around 50% of the Swedish funds for the Bebalem programme come from Sida and 50% from Alliansmissionen's members.

- **Svenska Missionsrådet (Swedish Mission Council)**

Svenska missionsrådet (SMR) is an organisation for coordination and support to mission services run by Swedish free churches. Assistance to some of the mission-run projects described above are channelled through SMR. (Pingstkyrkan/PMU is not a member of SMR.)

In addition to the projects described above, SMR in 1999 gave SEK 258 000 to a health clinic run by Lasariterna in *The Gambia*.

SMR is an important focal point for coordination of much of the development assistance provided by Swedish mission services.

- **Vänskapsföreningen Burkina Faso-Sverige (ASSAMBUS)**

Through the Swedish Friendship Association with Burkina Faso the hospital in Borås has provided support to the hospital in Bobo-Dioulasso in Burkina. Equipment for delivery services and training in use of the equipment has been given to the hospital. At the moment discussions are being held on how the support can be continued. There are also talks on a possible project through which the hospital in Bobo-Dioulasso could extend its nutrition services from the hospital to the community in villages in the region where the hospital is located.

- **Miscellaneous**

In Cape Verde Save the Children Sweden (Rädda Barnen) has assisted maternal and child health services for many years. The impact from this support on the development of the health system in the country has been quite satisfactory. Maybe some of the good health outcomes in Cape Verde can be ascribed to this Swedish project.

The programme in Cape Verde has been staffed for many years by Swedish midwives and in the early phases also by doctors.

Rädda barnen has also supported nutrition activities in *Guinea-Bissau*.

In the past the Swedish Africa Groups Volunteers Organisation (ARO) provided nurses as volunteers to the health sector in *Saõ Tomé and Principe*.

SHIA (Svenska Handikapporganisationers Internationella Biståndsförening) has supported rehabilitation services in *The Gambia* and *Ghana*.

During the years when the Swedish company Grängesberg was running the mining services in Liberia through LAMCO, a Liberian based company, Swedes were running a large hospital in Yekepa in the north of the country. During many years this hospital was staffed by Swedish nurses and doctors. It was an important place for Swedish research in malaria in the 70'ies and 80'ies.

Smittskyddsinstitutet (The Swedish Institute for Infectious Diseases Control) has worked in Guinea-Bissau for many years, over the last decade with HIV/Aids control. SMI is also in contact with several other institutions in the region, much through the HIV/Aids work.

3 Support given recently by Sida through other organisations

Sida's department for humanitarian assistance supports MCH-services in Freetown, *Sierra Leone* through Unicef. Part of the funds are used to employ a Swedish physician, Björn Forsén, with experience from emergency assistance in several countries in the region.

Sida provides general support to the International Committee of Red Cross which has *regional* offices in Lagos, Abidjan, Dakar and Sierra Leone. The latter was closed for much of 1999 because of the war.

For the coming year SEK 157 000 will be given to Caritas for their AIDS work in the region. Läkare i Världen (Médicins du Monde) have been allocated SEK 1.1 million for work in *Niger*.

Sida gave SEK 500 000 to WHO in 1998/99 for purchase of Yellow fever vaccine to be used during an outbreak in *Liberia*. SEK 2 million was also given to WHO last year for the purchase of vaccines to immunisation activities in *Guinea-Bissau*.

SAREC, Sidas research division, has provided support to on HIV/Aids research in *Ghana* and *Nigeria*.

Annex 3

Selected Information on Activities in West Africa Supported by Multinational Organisations and some Non-governmental Organisations

This annex contains a description of some of the activities of the leading multinational organisations in health in West Africa. The output is based on review of a number of programme documents, information on web-sites and information provided by the organisations themselves. Efforts have been made to focus on the countries which have been given priority by Sida in this review.

It has not always been possible to get in contact with the best informed person for a particular programme or country but a number of persons have been extremely helpful in providing information and material for the study. Acknowledgements of these contributions are given in the text. Still, the author is solely responsible for any statements or judgements made in the text.

World Health Organization (WHO)

1. In 1995 WHO started The Regional Accelerated Malaria Control Programme in the African region.The provision of funds of $18 million by WHO in 1997 and 1998 and additional funds from partners enabled the accelerated malaria programme to take off in 1997.

   Increased political support for malaria amongst African Heads of States and Government led to the development of the African Initiative on Malaria Control in the 21st Century (AIM), in April 1998. In July 1998, the Director General (DG) of the WHO in recognition of the importance of malaria control established Roll Back Malaria (RBM). The Roll Back Malaria is a world-wide partnership to halve the burden of malaria by 2010. It is supported by all the major multilateral and UN organisations. Since the goals and the concept of the two programs were similar, it was agreed that AIM should be called RBM in the African Region.

   The vision of Roll Back Malaria in the African Region is to control malaria in the African Region in order to contribute to its overall health and socio-economic development.

   The mission of the WHO African Regional Office (AFRO) is to provide technical orientation and support to the countries of the African Region based on the Resolutions and Recommendations of the Governing Bodies to ensure that malaria-related mortality is reduced by 50 per cent of the 2000 figures by the year 2010, and by the year 2030 malaria should cease to have significant public health importance.

   RBM in the African region is building on the foundations laid and the lessons learnt from the accelerated malaria control programme which was based on the Regional Malaria Control Strategy. The Strategies for the implementation of RBM in the African Region are:

- building and strengthening partnership at all levels of implementation;
- taking technical interventions to scale; contributing to Health Sector Reform;
- strengthening health information system and research; strengthening community participation; and integrating malaria control activities into primary health care.

2 WHO is running a programme at regional and country level called Integrated Diseseas Surveillance (IDS) which seeks to contribute to the improvement of epidemic preparedness and response and to the control of communicable diseases in the African Region. The programme supports countries in the development, adaptation and implementation of communicable diseases integrated surveillance strategy. It is also compiling data for the region and shares information with member states through the publication of periodic feedback and epidemiological bulletins. The programme collaborates with CDC Atlanta, DFID, European Union, Norad, UN Foundation and USAID.

3 Through its Division of Health Systems and Services Development at the Regional Office WHO is providing support to the development of National Health Systems, District Health Systems and Health Information Systems. Some of the functions of this work are to

- Develop a strategic framework for health sector reform and provide support to countries for the development and implementation of such reforms;
- Develop guidelines for and support countries in the analysis of the health sector and the elaboration or review of national health policies and strategic plans;
- Support countries in capacity building for the monitoring and evaluation of health systems development and the strengthening of its organization and management; and
- Support the development of comprehensive health care systems and adequate financing mechanisms.
- Elaborate tools for and support countries in the development of district health systems, the definition of cost effective essential health packages and the assessment of the performance of health districts;
- Support countries to improve home and community based care as an integrated part of district health care systems.
- Contribute to the strengthening of monitoring and evaluation functions and their integration into the national managerial process through the implementation of effective information systems;
- Co-ordinate the efforts of partners and countries in the field of health indicators measurement and use, health data management, and evaluation of health information systems.

4 Another regional WHO activity is the Programme on Emerging, Reemerging and other Communicable Diseases (EMC). The programme seeks to provide technical support to the countries of the African region in order to contribute to the reduction of morbidity, disability and mortality due to epidemic diseases through the improvement of epidemic preparedness, detection and response. Some of the functions are to

- support to countries in the development and dissemination of guidelines for epidemic prevention and control

- support to countries in training of health personnel in epidemiology and epidemic management
- support to countries in epidemic investigation
- support to countries in setting up contingency stocks of drugs, vaccines and other supplies for adequate management of epidemics
- collaborate with other partners in implementing interventions aimed at controlling epidemics at sub-regional and regional levels

5 The WHO Regional Committee for Africa has passed a resolution with recommends the adoption by member states of appropriate policies and strategies to eliminate female genital mutilation (FGM) and other harmful traditional practices. With the support of WHO, significant progress has been made in the formulation and development of policies and plans of action for accelerating the elimination of FGM. One example of this work is the intercountry workshop on FGM with participation from, among others, 10 member states in West Africa which was organised by WHO in collaboration with other partners, in Harare in December 1999.

6 Areas of potential Sida support would be regional malaria activities through the Roll Back Malaria initiative or support to some specific country work, like health reform work in either Mali or Burkina Faso.

WHO at country level

WHO is present in all the member states of the region. An exception is only made when civil unrest makes it impossible for the WHO staff to stay permanently in a country. Who is working with biannual plans which are agreed upon with the national governments. The financial support from WHO is usually considerably smaller than support coming from multilaterals like the World Bank and the EU or the bilateral donors. The importance of WHO is more on the political and technical side.WHO is often providing support to specific disease control activities. At the same time the organisation plays an important role in providing general expert advice on policy and health sector development matters in several of the countries.

Unicef

1. In West Africa Unicef has a strong experience in supporting health system development through the Bamako Initiative (BI) strategy. More than 7000 health centres have been revitalised and are offering an essential care package (including vaccination and essential drugs). This has made a sustainable difference where BI has been implemented. However quality of care remains weak. In 1999 a review of Bamako Initiative has been organised with participation of 43 African countries. Lessons learned and recommendations are taken into account by the Unicef/WHO working group that should renew the implementation framework.

2. Unicef is supporting promising experiences aiming at maternal mortality reduction in the region. These activities do however suffer from insufficient financial support to become fully extended and make an impact. This refers to countries like Mali, Burkina, Benin, Guinea, Senegal and Niger.

3. Malaria and HIV/AIDS are getting further priority and importance in several countries in the region. Malaria is especially linked with BI strategy. Unicef has adopted in the last regional management team a strategy framework that should orient and help country offices to select/ combine effective and relevant interventions to tackle HIV/AIDS. Focus is put on prevention among youth and mother to child transmission. Most country offices are integrating HIV/AIDS in their plan of action and new programmes of co-operation.

4. Routine EPI is a major concern in the region, and several years after Universal Child Immunization (UCI) EPI coverage remains low despite progress made through BI strategy. More attention is needed to ensure effectiveness and sustainability. In all target countries these approaches/programmes are promoted by Unicef. Programme budget planned vary from country to country from 800 000$/year to more than 12 000 000 $/year.

5. Mr Abdel Wahed El Abassi at the Unicef Regional Office in Abidjan would like Unicef to benefit from Swedish support in the renewed Bamako Initiative framework which will strengthen health system capacity at decentralised level, improve community participation, address major child killers (including HIV/AIDS) and pay attention to maternal mortality.

Examples of Unicef Country Support

The following section provides information on Unicef's programme in the countries which have been identified as being of primary interest to Sida. The information gives a general view of donor-assisted activities in the health sector in several of the countries and where this is the case efforts have been made not to repeat this information later.

Taking into consideration the high infant and maternal mortality rates which have been aggravated by the HIV/AIDS epidemic and in order to improve the public's general view of the quality of public health services Unicef's programme in health in *Burkina Faso* for the period 2001-2005 works in the spirit of the Bamako Initiative and will contribute to improving the access, utilisation and quality of primary health services including obstetric emergency services in 3 health regions. In collaboration with UNFPA, WHO, UNAIDS, WFP (World Food Programme) and the World Bank a decentralized health care system will be strengthened through

- strengthening of capacity to plan and manage health services in 3 health regions and 11 district health teams
- improvement of the quality of a Minimum Package of Activities (MPA) in 100 health centres
- the establishment of a general approach among adolescents and women to the control of HIV/AIDS through the integration of prevention of mother-child transmission in 3 urban health districts
- improvement of delivery services and involvement of the community in the management of health services in 6 health districts.

At the national level, the programme will collaborate closely with other donors, in particular the World Bank, the European Union and the Netherlands, in reinforcing the planning and management skills of the Ministry of Health and revitalising the EPI in the spirit of making the country self-sufficient in vaccines and vaccination activities. In collaboration with the Helen Keller Foundation the programme will assist the National Nutrition Cell (le Centre National de Nutrition) in the fight against micronutrient defi-

ciencies. The programme will also work with WHO and UNAIDS in reinforcing the operational capacities of the structures engaged in the fight against HIV/AIDS.

In *Mali* Unicef is supporting the ambitious health sector reform which has been in place since 1991. Important components in the reform are to offer a Minimum Package of Activities (MPA) which is a range of basic health care services, ensure the presence of a minimum technical standard, provide a sound organisation for the health services with clear definitions of responsibility, decentralisation and participation of the population.

Unicef's Survival Programme 1998–2002 is an integral part of the national ten year plan for social and health development. The programme aims at extending and improving the quality of health coverage, giving priority to rural and peri-urban areas, by supporting the delivery of a Minimum Package of Service Activities (MPA) to an increasing number of people. The portion of people with access to the MPA should increase from 33% to 75%. Referral services should also be strengthened in a similar manner. The programme aims at reducing mortality among women and children and promote the participation and empowerment of the population, particularly women, to manage their own health problems.

The support from Unicef has been successfully coordinated with support from the World Bank, the European Union, WHO and other donors into the Ministry's overall development plan.

In *Senegal* Unicef is supporting the Sector-wide Approach (SWAP), reflected in the PNDS (Plan National de Développement Sanitaire), 1998–2007. It contains a formal statement of health policy by the government and a five year programme, the PDIS (Programme de Développement Intégré de la Santé) from 1998 to 2002. This comprehensive health sector programme aims to achieve a number of objectives relating to maternal mortality, infant mortality, fertility rate, etc. All partners (government, external funding partners, health committees, local governments and NGOs) are implicated in this national effort. Unicef's current activities in the health sector, and related areas, include strengthening district and community systems, immunization and polio eradication, maternal mortality reduction, prevention in general, especially of HIV/AIDS, nutrition, female genital mutilation, guinea worm eradication and water and sanitation. In future more attention will be given to malaria, and to linkages between health and education. Unicef would welcome Sida's participation in the SWAP in Senegal.

In *Benin* Unicef is supporting the following activities for the period 1999–2003:

Reinforcement and decentralisation of the health system by contributing to the finalization of the normative framework of health district development, the elaboration and the implementation of Health district development plan; including the development of a sanitary map, staff training and the revitalization of all first level health facilities.

Improvement of quality of health care for adequate management of priority pathologies of Childhood (the Integrated Management of Childhood Illnesses – IMCI), of youth (STD, AIDS, etc) and women such as Emergency Obstetric Care.

National programs such as: The Expanded Programme of Immunization (EPI) to achieve 80% routine EPI national coverage and universal 0–5 years national coverage for polio immunization and Vitamin A supplementation through National Immunization Days; Elimination of Iodine Deficiency Disorders (IDD); Guinea Worm Eradication and Roll Back Malaria.

Improvement of access to safe drinking water, sanitation and hygiene mainly in Guinea worm endemic villages to reach the eradication of this disease as well as in programme convergence areas to support community initiatives and to reduce workload for women.

As part of the Advocacy and Communication programme the content of the Convention for the Rights of Children (CRC) and the Convention for the Elimination of all kind of Discrimination Against Women (CEDAW) are promoted and disseminated among the whole population through various channels involving politicians, the judiciary, the civil society, communities, women groups, young people and children. Female genital mutilation is an important theme, which is taken into account by this program.

Unicef is seeking further support for their programme activities. Out of the current budget corresponding to US$ 4 million, 1.4 million is covered from Unicef regular budget while the rest will have to be mobilized through extra-budgetary support.

In *Ghana* the health sector embarked on a sectorwide reform to set the direction towards the achievement of its national health goals. The health programme outlines Unicef's contribution to the Ministry of Health sectorwide strategic framework and programme of work, which was developed in collaboration with other partners such as Danida, DFID (UK), the Dutch government, the World Bank and WHO. Unicef's contribution reflects its comparative advantage and focuses on persisting common childhood diseases and disabilities through the child health promotion and disease control project and risk factors for maternal deaths through the maternal and infant health project. Nation-wide initiatives such as Roll Back Malaria, IMCI, elimination of maternal and neonatal tetanus, eradication of polio and dracunculiasis, community-based surveillance, and monitoring compliance to the code on breast-milk substitutes will be supported.

A geographic focus is placed at regional and district levels of northern Ghana for service delivery, social mobilisation and capacity building interventions aimed at reducing regional disparities in child survival indicators. The programme strengthens linkages and partnerships with NGOs, private sector providers, decentralised institutions and communities to improve service delivery and utilization.

The health component of Unicef's support has four components: Child health promotion, District PHC development, Safe motherhood and female reproductive health and elimination of Micronutrient deficiencies.

Increased attention has been given to issues of access by adolescents in the northern regions to information, counseling and management of STDs/HIV/AIDS and reproductive health. Support will be provided to curb mother to child transmission of HIV in districts with high prevalence of HIV/AIDS.

A number of achievements have been reported by Unicef, most notably in the areas of childhood immunization, training of TBAs, breastfeeding and problem identification and advocacy in the area of micronutrient deficiencies.

Parts of this information has been compiled with the kind assistance of Abdel Wahed El Abassi, Unicef Regional Office, Abidjan, Ian Hopwood, Unicef Country Office, Dakar, Nicola Pron, Unicef Country Office, Cotonou, Jacques Adande and Flavia Guidetti, Unicef Country Office, Ouagadougou, Omar Abdi, Unicef Country Offic, Accra and Jama Gulaid, Unicef Country Office, Lagos.

UNFPA

1. The primary areas of work for the UNFPA in the region is reproductive health including family planning and sexual health. Some prominent components in the UNFPA work are support to Female Genitale Mutilation, gender and HIV/AIDS.

2. UNFPA is seeking to support education in schools on population and family planning. However, this support has suffered from cut-downs in contributions. UNFPA would like to see Swedish support for this work.

3. Another area in which Swedish support would be welcome is adolescent reproductive health. It is an area of work which has not been given sufficient attention.

Examples of UNFPA Country Support

In *Burkina Faso* the major support from UNFPA is directed at extending reproductive health services in order to make such services available to a growing number of women. This component is implemented through the Population Council. Support is also given to HIV/AIDS control.

The organisation is also supporting advocacy for improved status of women and their rights in reproductive health.

FGM is prohibited by law in Burkina since 1996. UNFPA is supporting a the National Committee against FGM in training staff and implementing their plan of action.

The UNFPA is working closely with the AIDS control programme which is financed by The World Bank. The Bank is providing funds for procurement of contraceptives through the UNFPA. The UNFPA is also channelling funds from GTZ, UNAIDS and the Netherlands.

UNFPA has actively participated in the preparation of a national health plan which may form the basis for a Sector-wide Approach. The plan is expected to be approved at the end of this year.

UNFPA's is now in the phase of preparing for a new programme of assistance for the period 2001–2005. The areas in which Sida could provide support are adolescent health and Information, Education and Communication (IEC) in STI (Sexually Transmitted Infections)/AIDS control.

In *Benin* UNFPA is supporting an important Reproductive Health programme based on previous experiences with various implementing agencies. All of the projects within this programme have a strong focus on gender equality and seek to integrate on an equal basis men and women and to ensure that they are informed about their rights and responsibilities. Furthermore the projects also focus on the new generations, especially youth and adolescents, as to give them access to quality reproductive health services which will allow them to make informed choices and protect their reproductive health, especially with regard to sexually transmitted diseases and HIV/AIDS. The overall objective of the programme is to ensure access to high quality reproductive health care and confidential and reliable information to anyone regardless of income, gender age or marital status.

Beside the reproductive health sub programme UNFPA also supports a Population and Development Strategies Support programme including, *inter alia*, a women's empowerment project (including a Family Code and a National Policy for Women's Empowerment), the upcoming national census, Family Life Education and institutional strengthening of the Division of Population and Human Resources.

Finally, UNFPA is financing an innovative Advocacy sub-programme with a view of obtaining the active support of policy makers, legislators and traditional (kings and queens) and religious leaders (catholic and muslim) for women's empowerment, including girls education, and better access to and use of reproductive health services by women, men, youth and adolescents.

The amount of the ongoing Country Programme 1999–2003 is US$ 12 million. Shortfalls mean that there are projects that have to been scaled down and activities that cannot be undertaken.

Any additional assistance from Sida would be most welcome. UNFPA would like to intensify their activities to fight FGM in the Northern parts of Benin and to prevent the spread of HIV/AIDS, especially among young girls which is one of the most vulnerable groups in Benin today. UNFPA also hopes to be in a position to advocate strongly for the improvement of women's legal status via the adoption of a new civil code recognizing the basic rights of women as well as of men.

In *Senegal* UNFPA is supporting in particular reproductive health among young through for instance assistance to counceling centres for adolescents, prevention of HIV/AIDS/STIs and basic reproductive health services.

UNFPA is channelling funds from Luxembourg, Japan and some other UN Organisations.

UNFPA is participating in the joint sector support programme (PDIS) in Senegal.

Swedish assistance would be particularly useful in the area of health information system and family planning. Awareness and use of contraceptives is still low in Senegal. Programme support could be given to assist in the management, including monitoring and evaluation, of the national reproductive health programme.

FGM is prohibited by law since 1999. More than 1000 villages have been targetted for sensitization. Unicef is covering 300 of these villages while the remaining are still to be reached. UNFPA could have a role in this if funds would be available.

Parts of this information has been compiled with the kind assistance of Mr Lalan Mubiala, Director, Division for Western and Southern Africa and his staff at the UNFPA HQ, New York, and Mr Philippe Delanne, Country manager, Cotonou.

The World Bank

1. The World Bank (WB) is providing support, mostly through credits, to many of the countries in the region. The WB works closely with the African Development Bank and jointly the two are the leading international funders to health in the region.

2. The Bank seeks to encourage the establishment of sector-wide programme approaches and works closely with other prominent multilateral and bilateral donors to encourage governments to adopt such programmes. However, there are still few countries where such programmes are yet in place.

3. The World Bank collaborates closely with WHO and Unicef in some of the leading global and/or regional initiatives which have important implications for the work at country level. Among them are the onchocerciasis (River blindness) control programme and Roll Back Malaria (described earlier under WHO).

4. Through ACTa*frica* the World Bank has taken an active step to prioritize work against HIV/AIDS at country level in Africa. The initiative will lead to increased resource mobilisation and country assistance through technical and financial support. ACTa*frica* will be implemented in close collaboration with UNAIDS.

Examples of World Bank Country Support

In *Senegal* the Sector Investment Programme (SIP) is now well into implementation and fully funded from a variety of bilateral and multilateral agencies including the Nordic Development Fund. The programme is very comprehensive and covers all aspects of health system development and donors collaboration is often cited as best practice. The current credit covers 1998–2002 and amounts to US$ 50 million.

Potential areas where some additional resources might be needed include village-level (below the primary health care center) prevention programs, integrated management of pregnancy care and anti-tobacco campaigns.

Mali is just starting its Sector-wide Programme but at a very slow pace. The program's financing scheme is fully covered and there seems to be few requirements for additional financial resources at this stage.

Both Senegal and Mali programs are similar (i.e they cover tertiary, secondary and primary health care system development and address the cross sector issues of health finance and human resources management).

In *Burkina Faso* the World Bank is providing support to HIV/AIDS control and a health and nutrition project. Both programmes will terminate at the end of the year 2000. There is not yet a sector-wide programme approach in Burkina. However a joint programme of assistance to the Ministry of Health is currently planned and the World Bank is likely to participate. The project is expected to be launched next year.

In *Ghana* the World Bank is a leading funder of the sector support programme. Ghana is generally seen as one of the best examples in the region of a well integrated sector support programme with strong leadership from the Ministry of Health. The following text, which is an excerpt from the document which lays the foundation for the present World Bank support to the health sector in Ghana, provides insights into the fundaments of the programme.

The vision for the future development in the health sector and the policy framework has been articulated in the Medium Term Health Strategy Towards Vision 2020 (MTHS), and given an operational description in the Programme of Work (POW). The main strategies are to: (a) improve access, quality and the efficiency of primary health services; (b) strengthen and reorient secondary and tertiary service delivery to support primary health services; (c) develop and implement a programme to train adequate numbers of new health teams to provide defined services; (d) improve capacity for policy development and analysis, resource allocation, performance monitoring and evaluation, and regulation of service delivery and health professionals; (e) strengthen national support systems for human resources, logistics and supplies, financial management and health information; (f) promote private sector involvement in the delivery of health services; and (g) advocate for support in intersectoral action, specifically in population, food and agriculture, social welfare, local government, education, and water and sanitation agencies.

The policy and operational frameworks are the product of widespread consultations, and have received the endorsement of a wide number of stakeholders, including the donor community. The framework provided is comprehensive and visionary, clearly de-

fining sector priorities. Unlike most health policy documents, the Ghana framework provides specific resource allocation principles and outlines what changes are envisioned, and how these changes will be planned, implemented, and evaluated. The policy framework addresses issues in service provision, quality, efficiency, financing mechanisms and overall management. The framework is not a detailed blue-print, but it provides sufficient guidance and flexibility to provide a meaningful basis for implementation. Under this framework, the government maintains its leading role in health sector reform and has strong ownership of the program. The role of the Ministry of Health is clearly defined as one of policy making, financing, monitoring and regulation, while service provision is being moved out of the bureaucracy to a Ghana health service, the mission sector, and increasingly with private providers. The consolidation of multiple donor projects into a sector-wide approach further reduces duplication in managing various donor-driven projects and builds local capacity in planning and managing health services. The risk of the public sector not having the capacity to run a health system has been much reduced by eliminating the fragmentation of the status quo.

The World Bank has also recently assisted the Government of Ghana in designing a programme on Environmental Health which will work in a cross-sectoral manner with all the ministries that in various ways are responsible for activities which have immediate health consequences.

Parts of this information has been provided with the kind assistance of Mr Anwar Bach-Baouab, World Bank, Washington, Mr Jim Listorti, World Bank, Washington and Mr Ibrahim Magagi, World Bank Country Office, Ouagadougou

UNAIDS

UNAIDS has established The International Partnership against AIDS in Africa. It is working to fight the HIV/AIDS epidemic through stronger national programmes backed by four main lines of action:

- **Encouraging visible and sustained political support:** Members of the Partnership are engaging African political leaders and encouraging them to speak out and mobilize societies to implement AIDS prevention, care, and support services. These efforts will continue through Partnership-sponsored advocacy, media training and key consensus-building events at national and regional level.
- **Helping to develop nationally-negotiated joint plans of action:** In many countries across Africa, national officials are preparing inclusive strategic AIDS plans that bring together government and civil society and incorporate community-driven priorities. Country-based consultation missions, expanded financial and technical support for strategic planning, and resource mobilization strategies are among the tools being used.
- **Increasing financial resources:** The Partnership aims to significantly increase resources to respond to the epidemic. Recent studies suggest that at least a billion dollars a year are needed, in addition to currently allocated resources, to meet the prevention and care needs of Africa.

- **Strengthening national and regional technical capacity:** The members of the Partnership are creating a framework that will help to rapidly deliver technical know-how to countries and national organizations where and when is needed, build on the capacity of national and regional technical specialist and technical agencies and develop regional mechanisms that rapidly disseminate lessons learned, especially successful actions from one setting to another.

Examples of UNAIDS Country Support

UNAIDS is working at varying degrees in all the countries in the region. An example of work at country level has been provided from Nigeria by the organisation.

UNAIDS through the UN theme group is helping the *Nigerian* Government work on a national response to the epidemics. Nigeria is benefitting from a new context, characterized by a strong political engagement at the top (President) to bring HIV/AIDS as a priority. In the past 3 months, this has been translated in a number of actions: creation of the Presidential Committee on AIDS (a multisectoral committee at Ministerial level) and creation of a National Action Commission on AIDS (an advisory multisectoral body comprising the most important ministries, representatives of NGOs, associations of persons living with AIDS, and representatives of the private sector.)

A joint UNAIDS/World Bank mission, was organized in March 2000, to strengthen advocacy at all levels.

Although the approach will tend to be multisectoral (education, Women, Youth, Sports, etc.) needless to say that lots of actions will have to be backed up by the Ministry of Health (blood safety, screening and testing, care and support, etc.). So the idea is to bring even more than before the Ministry of Health as part of the sectors that will be involved in the national response.

By National response is meant that the Government has undertaken the first steps leading to a situation analysis, which will be followed by an analysis of the response. Later this year, work will continue to obtain a Strategic Plan log frame accompanied by budgeted actions plans which will prioritize the strategies and actions making a difference to alleviate STD/HIV/AIDS in the country.

Concurrently the World Bank is assisting Nigeria develop an interim Plan that will finance a series of actions that will be undertaken while the Strategic Plan and the mobilization of resources to finance it will take place. The idea is to maintain the momentum reached: high political will, donors interest, publicity, etc. and to show that something is being done while work goes on with the Strategic planning.

In *Burkina Faso* UNAIDS is supporting a number of activities such as technical assistance in developing a National AIDS Control plan for the period 2001–2005 including the involvement of seven ministries in the preparation of this plan, community response to individuals living with HIV/AIDS, analysis of the response to the AIDS epidemic at national, regional and district level in collaboration with le Centre National de la Recherche Scientifique et Technique (CNRST) among others. The programme has also arranged for a number of technical consultancies to support the programme as well as arranged intercountry seminars.

Parts of this information has been provided through the kind assistance of Kekoura Kourouma, UNAIDS Representative, Ouagadougou and Brigitte Impérial, UNAIDS Representative, Lagos.

The European Union

The European Union (EU) is supporting the health sector in several of the countries in the region through the European Commission (EC). The overall policy of the EU is to encourage integrated support packages which by preference are delivered in a sector-wide approach with all donors involved. The EU is also giving specific support to HIV/AIDS control in several of the countries.

Examples of EC country support

In *Senegal* the European Commission (EC) is providing general support to the Health Sector Programme in the range of _9 million/4 years and to the AIDS control programme (_3 million/5 years).

In *Burkina Faso* around 50% of the total support from the European Commission over the recent period of agreement has been given to the social sectors. Budgetary aid has been targeted, in particular towards helping with the operating expenses of the Ministries of Health and Education.

In the health sector, community support has concentrated on creating CAMEG (a central purchasing point for essential and generic medicines) and on the renewal of basic infrastructures and the equipment they need.

The EC is now actively involved in the earlier described activities to establish a joint sector support programme in Burkina.

EC is effectively involved in the *Mali* SWAP programme through an EDF 7 programme (_10,2 million) which ended this year, through a new 8 EDF program (_10.5 million/4 years) and through Structural Adjustement Programme FAS (_29,5 million/2years). The support is not targeted on specific activities. Instead it has defined conditionalities which are linked to the achievement of general health objectives.

In *Benin* the EC is collaborating with other donors, such as the World Bank, Unicef, Danida and Canada, in the joint programme for support to the health sector. However, Benin is not at the stage of a sector-wide approach but the donors are collaborating to avoid duplication of activities.

Parts of this information has been provided through the kind assistance of Dr Elisabeth Feret, EC, Brussels, Dr L Got, EC Representation, Dakar and Dr L Lob and Mr A Lopez-Peña, EC Representation, Bamako.

International Federation of Red Cross and Red Crescent Societies (IFRC)

The International Federation, founded in 1919, has a presence in almost every country in the world today through its national Red Cross and Red Crescent societies. The Federation provides humanitarian relief to people affected by disasters or other emergencies and development assistance to empower vulnerable people to become more self-sufficient. A strength of the organisation is the global network of National Societies and the Federation Secretariat in Geneva with its delegations strategically located to support Red Cross and Red Crescent activities in various regions.

A number of international donors are channelling funds to the work of the national Red Cross/Red Crescent Societies.

Examples of IFRC Work at Country Level

In *Burkina Faso* the Society runs dispensaries, laboratory and medical consultations, and a medico-social centre. It also has a programme to recruit blood donors. The primary health care programme's objective is to have a trained first aider in each family by the year 2000. The community-based first aid programme carries out training for first aiders nationwide. The Burkina Red Crescent (CRB) is pursuing disease prevention through an expanded programme of vaccination and a Mother and Child (MCH) programme (ante- and post-natal care).

The CRB has recently been active in assisting flood victims and in vaccinating against meningitis. A sanitation programme is being prepared for the Tuareg refugee programme. In cooperation with the Swedish Red Cross, the Society is developing a training programme for village first aiders.

Income generation activities are set up for women's groups, such as a village pharmacy and a grinding mill. There is also a training centre for young girls in Ouagadougou. The CRB is carrying out integrated projects benefiting women and mothers. These have several components: drilling for potable water, literacy, livestock breeding and first aid training (with Spanish Red Cross involvement).

There are four income-generating projects on a branch-to-branch cooperation basis with institutional development elements. Fund-raising activities include selling second-hand clothes in a bazaar at headquarters.

There is an environmental education project, including restoration, protection and management of the ecosystem, which is designed for young people in village groups. In addition, the Danish Red Cross is financing a training centre for out-of-school young girls, and some partnership microprojects.

External assistance is received from the Federation and ICRC, and several Red Cross Societies like the Danish (environmental education, income-generation and community projects, among others) and Swedish (community-based first aid, dispensary, institutional development).

In *Mali* around 400 paramedics are trained each year. These include nursing auxiliaries, safety supervisors and basic health workers. The Society also provides first aid courses for the general public and Red Crescent volunteers. Preventive health care activities are vaccination, sanitation, malaria, HIV/AIDS and health education. Seven treatment centres situated outside zones covered by the Ministry of Health are responsible for people suffering from leprosy and tuberculosis. Nine community health posts give medical assistance and are specialized in disease prevention through mothers' clubs and rural youth structures. Nutrition education and rehabilitation centres fight malnutrition among children under five. There is also an eye centre with two secondary outposts. The Society actively recruits voluntary blood donors in cooperation with the national blood transfusion centre.

The Mali red Crescent is currently assisted by the Swiss, Danish and French Red Cross Societies, the Federation and the ICRC. This assistance is in the fields of dissemination, disaster relief, health, logistics, and assistance to refugees returning to Mali.

Rainbo

One of Sida's priority areas is Reproductive and Sexual Health with a particular focus on adolescents health and women's rights. An organisation which works at regional level on these issues is presented here.

Rainbo stands for **R**esearch, **A**ction and **I**nformation **N**etwork for the **Bo**dily Integrity of Women and it is an international not-for-profit organization working on issues within the intersection between health and human rights of women. Starting with the issue of female circumcision/female genital mutilation (FC/FGM), Rainbo explores means of preventing this and other forms of gender-based violence and violations. The ultimate goal of the work is to promote and protect the reproductive and sexual health and rights of women and girls.

Rainbo provides technical assistance to international and donor agencies and work in partnership with local organizations to develop and advance effective programs and policies to deal with these crucial issues.

The work of the organisation is focused on programs in Africa and in African immigrant and refugee communities. Central to the mission of Rainbo is to act as a catalyst for initiatives at the community level by:

1. facilitating the flow of information and the networking between local organizations and others at the national, regional, and international levels;
2. promoting and enhancing the skills of local professionals, leaders, and activists;
3. providing and identifying sources for financial support to projects, particularly those that are visionary, creative, or ground breaking;
4. developing technical materials for use by health, human rights, and other professionals to facilitate their positive contribution to advancing women's rights.

The board of trustees and staff are multi-cultural with a rich diversity of professional experiences and personal backgrounds and a strong African leadership.

Example of Rainbo's work at country level

The Africa Adolescent Project - Promoting the Reproductive Health and Rights of Adolescents

The adolescent project is a two-year pilot initiative (1999–2001) targeting adolescents in two Francophone West African countries – *Mali* and *Senegal* – with the goal of empowering youth and promoting their reproductive health and rights, particularly for adolescent girls. The project also aims to strengthen the institutional capacity of NGOs working on adolescent reproductive health and rights, and to promote exchanges among youth and women's organizations.

Adolescents from participating countries will be involved in the project design, implementation and monitoring. Programs generated within the adolescent project will address issues such as female circumcision/female genital mutilation, rape, incest, and other gender based violence and violations against adolescent girls and women.

Rainbo will offer technical assistance in project design, implementation, monitoring and evaluation. The organisation will provide funds to participating organizations over the two years of the project duration and assist them in publishing and disseminating the project results.

The adolescent project will collaborate with in-country organizations that have expertise in training on women's reproductive health and rights and organizations that promote active participation of young adults in their programs. In collaboration with these organizations, the project aims to:

- **Promote adolescents' knowledge** about reproductive health and rights, and provide them with a space to address these issues.
- **Mobilize adolescents** to research and advocate for their reproductive health and rights.
- **Mobilize the community** for a broad-based support of reproductive health and rights projects for youth.
- **Respond to the needs of girls** who have been targets of gender based violence and violations
- **Build a network** of community key players to support adolescent reproductive health and rights projects. This network will target health care providers and educators, media professionals, law enforcement officials and policymakers, and women's non-governmental organizations (NGOs).

The project will work through:

- **Media advocacy:** the project will forge alliances with the media and utilize it to disseminate accurate, positive and gender-sensitive information on reproductive health and rights, especially that of adolescent girls. Collaborations are encouraged between media experts and participating adolescents and organizations to develop the necessary technical know-how to effectively utilize different types of media to impact the society at large.
- **Peer education and training**: participating organizations will train adolescents to be educators and advocates on reproductive health and rights within their schools, families and communities.
- **Mobilization of key «gatekeepers»:** participating organizations and adolescents will carefully examine and assess the attitudes and views of key gatekeepers (parents, religious and civic leaders, health care providers policy makers, etc.) towards adolescent reproductive health and rights in order to arrive at effective strategies to mobilize positive forces or counter oppressive behaviours among them.
- **Direct delivery of services and activities:** programs and activities designed within the project will respond to the needs of the targeted populations. For example, projects might create support groups, forums, counseling for adolescent victims of gender-based violence, or income-generating activities.

Before any of the above objectives can be accomplished, collaborating organizations and participating adolescents must:

- **Analyze environmental factors and social norms** that affect issues of reproductive health and rights of young people; for example, existing health services, current government policies, prevailing hierarchies defining the role and status of adolescents in their communities.
- **Review existing studies** establishing past and current trends in issues related to adolescent reproductive health; for example, the prevalence of sexually transmitted diseases (STDs), female circumcision / female genital mutilation and other gender-based violence and violations among youth.

- **Identify best practices** from previous adolescent programmatic and operational initiatives and investigate ways of adapting them to reality of the individual communities.

The adolescent project operates on the premise that working in close relationship with carefully selected implementing organizations is key to the success of the project. Organizations selected meet the following criteria:

- Organizations with programs that promote active participation and encourage **leadership of adolescents**.
- Organizations that are able to demonstrate **expertise in designing effective programs and training** methods on issues of adolescents' reproductive and sexual health and rights.
- Organizations which have a track record in **collaborating with other groups**.

The two organizations selected are:

Association for the Development and Strengthening of Activities on Population (ASDAP), Mali

Created in 1994 ASDAP aims at strengthening governmental and non-governmental initiatives designed to improve women and adolescent reproductive health. Since 1995, ASDAP has been able to design and implement a comprehensive program targeted at adolescents both in schools and in the informal sector. As part of this program on adolescents' reproductive health, a peer-educators network, now composed of approximately 180 adolescents, was put into place to conduct information, education and communication (IEC) and advocacy and sensitization activities. ASDAP also publishes a newsletter, ADORES, a valuable communication tool for in or out-of-network adolescents.

Rainbo's adolescent project will collaborate with ASDAP to train ASDAP's network of peer-educators and 10 supervisors on reproductive rights issues. The training will be based on an existing training module on reproductive health to be reevaluated by a multidisciplinary team composed of a jurist, a sociologist-historian, and an expert in communication and rights advocacy, so as to include gender and rights issues. Rainbo will also provide technical assistance to develop and strengthen ASDAP's communication and skill-learning media, such as the newsletter.

Group for the Study of Education of the Population (GEEP), Senegal

A dynamic non-governmental organization run by researchers, professors and students, GEEP focuses on adolescents at school. The organization has branched out into various urban and rural clubs called «Clubs for Family Life Education». These clubs carry out an extensive scope of activities that go beyond traditional family life education. Activities include sensitization campaigns on adolescent reproductive and sexual health, contests on population and development issues faced by young people, and, more recently, prevention of gender-based violence at school. The organization enjoys support from many national ministries.

GEEP will collaborate with Rainbo on a school-based adolescent project. The project will comprise the following elements:

- Participatory development of a module on adolescents reproductive health and rights.

- Advocacy and sensitization activities with school officials, health care providers and other key actors.
- Placement of the Reproductive Health and Rights module in the schools curricula
- Assessment of project impact on the target populations.

The projects in both countries will be launched in December 1999.

Statistical Tables from the State of the World's Children 2000.

Table 1: Basic indicators

		Under-5 mortality rate		Infant mortality rate (under 1)		Total Population (thousands)	Annual no. of births (thousands)	Annual no. of under-5 deaths (thousands)	GNP per capita (US$)	Life expectancy at birth (years)	Total adult literacy rate	Primary school enrolment ratio (gross)		
	Under-5 mortality rank	1960	1998	1960	1998	1998	1998	1998	1997	1998	1995		lowest 40%	highest 20%
Benin	**22**	300	165	176	101	5781	238	39	380	53	32	76	-	-
Burkina Faso	**22**	315	165	181	109	11305	519	86	250	45	19	40	-	-
Cameroon	**27**	255	153	151	94	14305	562	86	620	55	63	88	-	-
Cape Verde	**65**	164	73	110	54	408	13	1	1090	69	69	131	-	-
Central African Rep.	**18**	327	173	187	113	3485	130	22	320	45	40	58	-	-
Chad	**13**	325	198	195	118	7270	318	63	230	47	48	65	-	-
Congo	**47**	220	108	143	81	2785	121	13	670	49	74	114	-	-
Côte d'Ivoire	**28**	300	150	195	90	14292	533	80	710	47	40	71	18x	44x
Equatorial Guinea	**20**	316	171	188	108	431	17	3	1060	50	78	149x	-	-
Gabon	**30**	287	144	171	85	1167	43	6	4120	52	63	-	-	-
Gambia	**59**	364	82	207	64	1229	49	4	340	47	39	77	-	-
Ghana	**49**	215	105	127	67	19162	711	75	390	60	64	76	20	42
Guinea	**14**	380	197	215	124	7337	309	61	550	47	36	48	11	50
Guinea-Bissau	**11**	336	205	200	130	1161	48	10	230	45	31	64	9	59
Liberia	**6**	288	235	190	157	2666	117	28	490x	48	45	35x	-	-
Mali	**5**	517	237	293	144	10694	499	118	260	54	32	37	-	-
Mauritania	**16**	310	183	180	120	2529	102	19	440	54	37	83	14x	47x
Niger	**3**	354	280	211	166	10078	488	137	200	49	13	29	19	44
Nigeria	**15**	207	187	123	112	106409	4114	769	280	50	57	89	13	49
Sao Tome and Principe	**61**	-	77	-	60	141	6	0	290	64	57x	-	-	-
Senegal	**38**	300	121	173	70	9003	358	43	540	53	33	69	11	59
Sierra Leone	**1**	390	316	220	182	4568	211	67	160	38	31	50	3x	63x
Togo	**30**	267	144	158	81	4397	181	26	340	49	51	119	-	-

Table 2: Nutrition

			% of children (1990-99*) who are:			% of under-fives (1990-98*) suffering from:					
						underweight		wasting	stunting		
	Under-5 mortality rank	% of infants with low birthweight 1990-97*	exclusively breastfed (0-3 months)	breastfed with complementary food (6-9 months)	still breastfeeding (20-26 months)	moderate & severe	severe	moderate & severe	moderate & severe	Vitamin A supplementation coverage rate (6-59 months) 1998	% of households consuming iodized salt 1992-98*
Benin	**22**	-	15	97	65	29	7	14	25	100	79
Burkina Faso	**22**	21	5	56	-	30	8	13	29	97	23
Cameroon	**27**	13	16	-	29	22	5	6	29	-	82
Cape Verde	**65**	9	18	-	-	14	2	6	16	-	99
Central African Rep.	**18**	15	23	-	-	27	8	7	34	-	65
Chad	**13**	-	2	81	62	39	14	14	40	0	55
Congo	**47**	16	43x	95x	27x	17x	3x	4x	21x	93	-
Côte d'Ivoire	**28**	12	4	77	-	24	6	8	24	-	-
Equatorial Guinea	**20**	-	-	-	-	-	-	-	-	-	20
Gabon	**30**	-	32	-	-	-	-	-	-	-	-
Gambia	**59**	-	-	8	58	26	5	-	30	-	0
Ghana	**49**	8	37	-	66	27	8	11	26	90	10
Guinea	**14**	13	52	-	15	-	-	12	29	97	37
Guinea-Bissau	**11**	20	-	-	-	23x	-	-	-	-	-
Liberia	**6**	-	-	17	25	-	-	-	-	-	-
Mali	**5**	16	13	33	60	40	17	23	30	93	9
Mauritania	**16**	11	60	64	59	23	9	7	44	80	3
Niger	**3**	15	1	-	47	50	20	21	41	82	64
Nigeria	**15**	16	2	52	43	36	12	9	43	-	98
Sao Tome and Principe	**61**	7	-	-	-	16	5	5	26	-	-
Senegal	**38**	4	16	69	50	22	-	7	23	0	9
Sierra Leone	**1**	11	-	94	41	29	-	9	35	-	75
Togo	**30**	20	15	-	77	25	7	12	22	-	73

Table 3: Health

		% of population with access to safe water 1990-98*			% of population with access to adequate sanitation 1990-98*			% of routine EPI vaccines financed by government 1995-98*	% fully immunized 1995-98* 1-year old children					
	Under-5 mortality rank	total	urban	rural	total	urban	rural	total	TB	DPT	polio		pregnant women tetanus	ORT use rate (%) 1990-98*
Benin	**22**	56	71	46	27	57	8	15	92	81	81	82	66	33
Burkina Faso	**22**	42	66	37	37	41	33	100	72	37	42	46	54	18
Cameroon	**27**	54	81	41	89	99	84	27	72	46	42	44	49	34
Cape Verde	**65**	65	84	44	27	42	14	100	84	80	79	66	51	83
Central African Rep.	**18**	38	55	21	27	38	16	4	53	46	47	39	37	34
Chad	**13**	54	48	56	27	79	11	100	43	24	24	30	27	29
Congo	**47**	34	53	7	69	-	-	0x	29	23	21	18	30	41
Côte d'Ivoire	**28**	42	56	32	39	71	17	95	84	61	61	66	44	29
Equatorial Guinea	**20**	95	88	100	54	61	48	95	99	81	81	82	70	-
Gabon	**30**	67	80	30	-	72	-	-	72	54	54	32	4	39
Gambia	**59**	69	80	65	37	83	23	30	99	96	95	91	96	99x
Ghana	**49**	65	88	52	32	75	25	100	86	68	68	62	45	36
Guinea	**14**	46	69	36	31	54	19	25	69	56	56	58	48	80x
Guinea-Bissau	**11**	43	-	-	46	-	-	0	82	63	60	51	46	-
Liberia	**6**	46	79	13	30	56	4	0	28	19	19	31	14	94x
Mali	**5**	66	87	55	6	12	3	100	84	52	52	57	62	29
Mauritania	**16**	37	34	40	57	73	41	0	69	28	28	20	63	51
Niger	**3**	61	70	59	19	78	5	80	46	22	21	27	19	21
Nigeria	**15**	49	58	40	41	50	32	100	27	21	22	26	29	86x
Sao Tome and Principe	**61**	82	-	-	35	-	-	-	80	73	72	59	31	74x
Senegal	**38**	81	96	70	65	92	46	100	80	65	65	65	34	39
Sierra Leone	**1**	34	58	21	11	17	8	3	79	56	56	68	42	-
Togo	**30**	55	84	40	37	70	20	80	73	37	41	32	41	23

Table 4: Education

		Adult literacy rate						Primary school enrolment ratio								
		1980		1995		No. of sets per 1000 population 1996		1990-97* (gross)		1990-96* (net)						
	Under-5 mortality rank	male	female	male	female	radio	television	male	female	male	female	male	female	1990-95*	male	female
Benin	**22**	26	10	45	19	108	18	96	56	78	46	52	34	61	23	10
Burkina Faso	**22**	18	4	29	10	32	8	48	31	37	24	38	28	75	11	6
Cameroon	**27**	59	30	75	52	162	29	93	84	81x	71x	71x	70x	66	32	22
Cape Verde	**65**	65	40	81	61	179	4	132	129	100	100	-	-	60x	28	26
Central African Rep.	**18**	36	12	54	27	84	5	71	46	65	43	70	55	24	15	6
Chad	**13**	47	19	62	35	249	1	85	44	66	37	44	29	59	16	4
Congo	**47**	64	38	83	67	124	11	119	109	99x	93x	-	-	55	62	45
Côte d'Ivoire	**28**	32	13	49	31	157	62	81	60	63	47	59x	46x	75	33	16
Equatorial Guinea	**20**	76	44	89	67	427	10	-	-	-	-	-	-	-	-	-
Gabon	**30**	54	28	74	53	182	54	-	-	-	-	87	86	59	-	-
Gambia	**59**	37	13	53	25	164	4	87	67	72	57	51	43	80	30	19
Ghana	**49**	57	30	75	53	238	93	83	70	-	-	70	69	80	45	29
Guinea	**14**	34	11	50	22	47	10	63	34	34x	17x	39	26	80	18	6
Guinea-Bissau	**11**	32	7	48	16	42x	-	81	47	58x	32x	-	-	20x	9x	4x
Liberia	**6**	42	14	62	28	318	27	51x	28x	-	-	59x	53x	-	31x	12x
Mali	**5**	19	8	40	25	49	4	41	27	32	21	45	36	82	12	6
Mauritania	**16**	41	18	49	27	150	25	88	79	64	55	55	53	64	21	11
Niger	**3**	14	3	21	7	69	12	36	22	30	19	31x	21x	73	9	5
Nigeria	**15**	45	22	66	47	197	57	100	79	-	-	60	58	80	33	28
Sao Tome and Principe	**61**	-	-	-	-	272	166	-	-	-	-	-	-	-	-	-
Senegal	**38**	31	12	43	23	141	41	76	62	64	53	48	42	85	20	12
Sierra Leone	**1**	30	9	45	18	251	12	59	41	-	-	-	-	-	22	13
Togo	**30**	48	18	67	35	217	17	140	99	93	69	73x	64x	71	40	14

Table 5: Demographic Indicators

		Population (thousands) 1998		Population annual growth rate (%)		Crude death rate		Crude birth rate		Life expectancy		Total fertility rate			
	Under-5 mortality rank	under 18	under 5	1970-90	1990-98	1970	1998	1970	1998	1970	1998	1998	1998	1970-90	1990-98
Equatorial Guinea	**20**	213	74	1.0	2.5	24	16	40	41	40	50	5.5	44	2.4	4.9
Cape Verde	**65**	193	60	1.2	2.2	12	6	40	32	57	69	3.5	56	5.4	5.3
Guinea	**14**	3779	1234	1.9	3.0	27	17	51	42	37	47	5.5	30	5.0	5.0
Sierra Leone	**1**	2304	808	2.0	1.7	30	25	49	46	34	38	6.0	34	4.6	3.2
Central African Rep.	**18**	1723	557	2.3	2.1	22	19	43	37	42	45	4.9	39	3.4	2.8
Chad	**13**	3805	1314	2.3	2.9	26	18	49	44	38	47	6.0	22	5.1	3.7
Mali	**5**	5745	1965	2.4	2.4	26	16	51	47	42	54	6.5	28	5.1	4.2
Sao Tome and Principe	**61**	75	26	2.4	2.1	-	10	-	33	-	64	4.7	44	5.0	3.7
Mauritania	**16**	1277	431	2.5	2.8	22	13	45	40	43	54	5.5	53	8.1	5.3
Burkina Faso	**22**	6128	2137	2.6	2.8	25	19	53	46	39	45	6.5	16	6.8	4.8
Benin	**22**	3109	1015	2.7	2.7	25	13	53	41	43	53	5.8	39	6.2	4.3
Cameroon	**27**	7213	2416	2.8	2.8	21	12	45	39	44	55	5.3	46	6.2	4.4
Congo	**47**	1470	513	2.8	2.8	20	16	46	44	46	49	6.0	59	5.2	4.1
Ghana	**49**	9709	3144	2.8	3.0	17	9	47	37	49	60	5.1	36	3.6	3.6
Nigeria	**15**	53769	17607	2.8	2.5	22	15	50	39	43	50	5.1	41	5.6	4.4
Senegal	**38**	4648	1571	2.8	2.6	25	13	49	40	41	53	5.5	44	3.8	3.8
Togo	**30**	2313	788	2.8	2.8	20	15	45	41	44	49	6.0	31	6.6	4.1
Gabon	**30**	527	185	3.1	2.8	21	16	33	38	44	52	5.4	51	6.0	4.3
Guinea-Bissau	**11**	567	196	3.1	2.2	28	20	42	42	36	45	5.7	22	4.5	3.6
Liberia	**6**	1453	432	3.1	0.4	21	15	49	44	46	48	6.3	44	5.5	1.0
Niger	**3**	5526	1997	3.1	3.3	26	17	59	48	38	49	6.8	19	6.0	5.3
Gambia	**59**	570	200	3.4	3.6	28	17	50	40	36	47	5.2	29	6.1	5.1
Côte d'Ivoire	**28**	7340	2266	3.7	2.6	20	16	52	37	44	47	5.0	44	5.7	3.7

Table 6: Economic Indicators

		GNP per capita (US$)	GNP per capita average annual growth rate (%)		Annual rate of inflation (%)	% of population below $1 a day	% of central government expenditure allocated to (1992-98*)			ODA inflow in millions US$	ODA inflow as a % of recipient GNP		
	Under-5 mortality rank	1997	1965-80*	1990-97*	1990-97*	1990-96*	health	education	defence	1997	1997	1970	1997
Sierra Leone	**1**	160	-0.3	1.7	11	-	6x	31x	17x	225	10	2	8
Niger	**3**	200	1.7	0.8	7	-	7	17	14	370	13	4	11
Mali	**5**	260	2.4	-3.3	6	-	4	15	12	501	6	3	18
Liberia	**6**	490x	-	1.0	5	-	-	-	-	110	25	-	5
Guinea-Bissau	**11**	230	0.8	-1.0	6	-	-	-	-	92	8	5	2
Chad	**13**	230	-1.9	1.0	7	-	8x	8x	-	225	13	4	8
Guinea	**14**	550	2.7	-2.9	9	-	-	-	-	268	14	11	5
Nigeria	**15**	280	2.8	0.9	9	18x	4x	21x	4x	444	4	7	25
Mauritania	**16**	440	-	12.1	15	-	-	-	-	24	5	-	0
Central African Rep.	**18**	320	5.6	-0.1	9	-	-	-	-	40	1	6	12
Equatorial Guinea	**20**	1060	-	-0.6	5	-	7x	12x	4x	40	10	1	8
Benin	**22**	380	-0.8	1.4	29	-	7	22	5	493	7	5	18
Burkina Faso	**22**	250	1.3	2.7	6	26	3x	11x	29x	382	9	-	19
Cameroon	**27**	620	-2.7	1.0	45	88	1x	3x	4x	125	47	-	14
Côte d'Ivoire	**28**	710	0.5	-	-	-	5x	11x	9x	95	7	8	3x
Gabon	**30**	4120	2.1x	0.3	10	-	2x	9x	8x	455	16	1	9
Togo	**30**	340	-0.1	1.5	6	31x	4x	23x	-	250	22	3	22
Senegal	**38**	540	-2.5	-1.9	7	62	-	-	-	341	17	4	14
Congo	**47**	670	4.2	0.7	43	31	1x	3x	3x	202	1	4	8
Ghana	**49**	390	-	-1.7	57	-	-	-	-	33	81	-	44
Gambia	**59**	340	-0.5	0.0	7	54	-	-	-	427	9	4	11
Sao Tome and Principe	**61**	290	0.7	-5.7	35	-	10x	13x	10x	130	18	11	20
Cape Verde	**65**	1090	1.7	-1.2	9	-	5x	20x	11x	124	8	3	6

Table 7: Women

	Under-5 mortality rank	Life expectancy females as a % of males	Adult literacy rate females as a % of males	Enrolment ratios females as a % of males 1990-97*		Contraceptive prevalence (%)	% of pregnant women immunized against tetanus	% of births attended by trained health personnel	Maternal mortality ratio† reported
		1998	1995	primary school	secondary school	1990-99*	1995-98*	1990-99*	1990-98*
Benin	**22**	106	43	58	43	37	66	60	500
Burkina Faso	**22**	102	34	65	55	12	54	27	-
Cameroon	**27**	106	69	90	69	19	49	58	430
Cape Verde	**65**	108	75	98	93	53	51	54	55
Central African Rep.	**18**	109	51	65	40	15	37	46	1100
Chad	**13**	107	56	52	25	4	27	15	830
Congo	**47**	111	81	92	73	-	30	-	-
Côte d'Ivoire	**28**	102	63	74	48	15	44	47	600
Equatorial Guinea	**20**	106	75	-	-	-	70	5	-
Gabon	**30**	106	72	-	-	-	4	80x	600
Gambia	**59**	107	47	77	63	12	96	44	-
Ghana	**49**	105	72	84	64	22	45	39	210
Guinea	**14**	102	44	54	33	29	48	31	670
Guinea-Bissau	**11**	107	34	58	44x	1x	46	25	910
Liberia	**6**	104	46	55x	39x	6x	14	58x	-
Mali	**5**	106	63	66	50	7	62	24	580
Mauritania	**16**	106	55	90	52	4	63	40	550
Niger	**3**	106	32	61	56	8	19	18	590
Nigeria	**15**	106	72	79	85	6	29	31	-
Sao Tome and Principe	**61**	-	-	-	-	10x	31	86x	-
Senegal	**38**	106	54	82	60	13	34	47	560
Sierra Leone	**1**	108	40	69	59	4x	42	-	-
Togo	**30**	104	53	71	35	24	41	51	480

Table 8: The rate of progress

		Under-5 mortality rate			Average annual rate of reduction (%)			GNP per capita average annual growth rate (%)		Total fertility rate				
	Under-5 mortality rank	1960	1990	1998	1960-90	1990-98	required† 1998-2000	1965-80	1990-97	1960	1990			
Benin	**22**	300	185	165	1.6	1.4	42.9	-0.3	1.7	6.9	6.6	5.8	0.1	1.6
Burkina Faso	**22**	315	196	165	1.6	2.2	42.9	1.7	0.8	6.7	7.3	6.5	-0.3	1.5
Cameroon	**27**	255	139	153	2.0	-1.2	39.1	2.4	-3.3	5.8	5.9	5.3	-0.1	1.3
Cape Verde	**65**	164	73	73	2.7	0.0	20.2	-	1.0	7.0	4.3	3.5	1.6	2.6
Central African Rep.	**18**	327	177	173	2.0	0.3	45.2	0.8	-1.0	5.6	5.5	4.9	0.1	1.4
Chad	**13**	325	198	198	1.7	0.0	52.0	-1.9	1.0	6.0	6.6	6.0	-0.3	1.2
Congo	**47**	220	110	108	2.3	0.2	21.7	2.7	-2.9	5.9	6.3	6.0	-0.2	0.6
Côte d'Ivoire	**28**	300	150	150	2.3	0.0	38.1	2.8	0.9	7.2	6.3	5.0	0.4	2.9
Equatorial Guinea	**20**	316	206	171	1.4	2.3	44.7	-	12.1	5.5	5.9	5.5	-0.2	0.9
Gabon	**30**	287	164	144	1.9	1.6	36.1	5.6	-0.1	4.1	5.1	5.4	-0.7	-0.7
Gambia	**59**	364	127	82	3.5	5.5	7.9	-	-0.6	6.4	5.9	5.2	0.3	1.6
Ghana	**49**	215	127	105	1.8	2.4	20.3	-0.8	1.4	6.9	6.0	5.1	0.5	2.0
Guinea	**14**	380	237	197	1.6	2.3	51.7	1.3	2.7	7.0	6.3	5.5	0.4	1.7
Guinea-Bissau	**11**	336	246	205	1.0	2.3	53.7	-2.7	1.0	5.1	6.0	5.7	-0.5	0.6
Liberia	**6**	288	235	235	0.7	0.0	60.6	0.5	-	6.6	6.8	6.3	-0.1	1.0
Mali	**5**	517	254	237	2.4	0.9	61.0	2.1x	0.3	7.1	7.1	6.5	0.0	1.1
Mauritania	**16**	310	183	183	1.8	0.0	48.0	-0.1	1.5	6.5	6.0	5.5	0.3	1.1
Niger	**3**	354	320	280	0.3	1.7	69.3	-2.5	-1.9	7.3	7.6	6.8	-0.1	1.4
Nigeria	**15**	207	190	187	0.3	0.2	49.1	4.2	0.7	6.5	6.0	5.1	0.3	2.0
Sao Tome and Principe	**61**	-	90	77	-	2.0	12.5	-	-1.7	-	-	4.7	-	-
Senegal	**38**	300	147	121	2.4	2.4	27.4	-0.5	0.0	7.0	6.3	5.5	0.4	1.7
Sierra Leone	**1**	390	323	316	0.6	0.3	75.4	0.7	-5.7	6.2	6.5	6.0	-0.2	1.0
Togo	**30**	267	152	144	1.9	0.7	36.1	1.7	-1.2	6.6	6.6	6.0	0.0	1.2

Table 9. Ranking score for the 23 countries in Region when compared to each other.

(A low score indicates good performance.)

	GNP	Under five Mortality	Infant Mortality Rate	Life Expectancy	Literacy Rate	School attendance	DPT coverage at age 1	Access to water	Average Score	
Benin	12	11	11	7	19	12	1	10	10,4	
Burkina Faso	19	12	13	20	22	20	16	19	17,6	
Cameroon	6	10	10	4	5	8	14	12	8,6	
Cape Verde	2	1	1	1	3	4	4	7	2,9	
Central African Rep.	15	14	15	21	13	17	15	20	16,3	
Chad	20	18	16	16	10	15	19	13	15,9	
Congo	5	5	6	12	2	6	20	23	9,9	
Côte d'Ivoire	4	9	9	17	12	13	9	18	11,4	
Equatorial Guinea	3	13	12	10	1	3	3	1	5,8	
Gabon	1	7	8	9	6	1	12	5	6,1	
Gambia	13	3	3	18	14	10	1	4	8,3	
Ghana	11	4	4	3	4	11	6	8	6,4	
Guinea	7	17	18	19	16	19	10	15	15,1	
Guinea-Bissau	21	19	19	22	20	16	8	17	17,8	
Liberia	9	20	21	15	11	22	23	16	17,1	
Mali	18	21	20	5	18	21	13	6	15,3	
Mauritania	10	15	17	6	15	9	18	21	13,9	
Niger	22	22	22	13	23	23	21	9	19,4	
Nigeria	17	16	14	11	8	7	22	14	13,6	
Sao Tome and Principe	16	2	2	2	7	2	5	2	4,8	
Senegal	8	6	5	8	17	14	7	3	8,5	
Sierra Leone	23	23	23	23	21	18	11	22	20,5	
Togo	14	8	7	14	9	5	17	11	10,6	

Table 10. Ranking of the 23 countries when taking into account their relative rank for 8 indicators of social development within the Region. (A low score indicates good performance).

Ranking	Average score	
Cape Verde	2,9	
Sao Tome and Principe	4,8	
Equatorial Guinea	5,8	
Gabon	6,1	
Ghana	6,4	
Gambia	8,3	
Senegal	8,5	
Cameroon	8,6	
Congo	9,9	
Benin	10,4	
Togo	10,6	
Côte d'Ivoire	11,4	
Nigeria	13,6	
Mauritania	13,9	
Guinea	15,1	
Mali	15,3	
Chad	15,9	
Central African Rep.	16,3	
Liberia	17,1	
Burkina Faso	17,6	
Guinea-Bissau	17,8	
Niger	19,4	
Sierra Leone	20,5	

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