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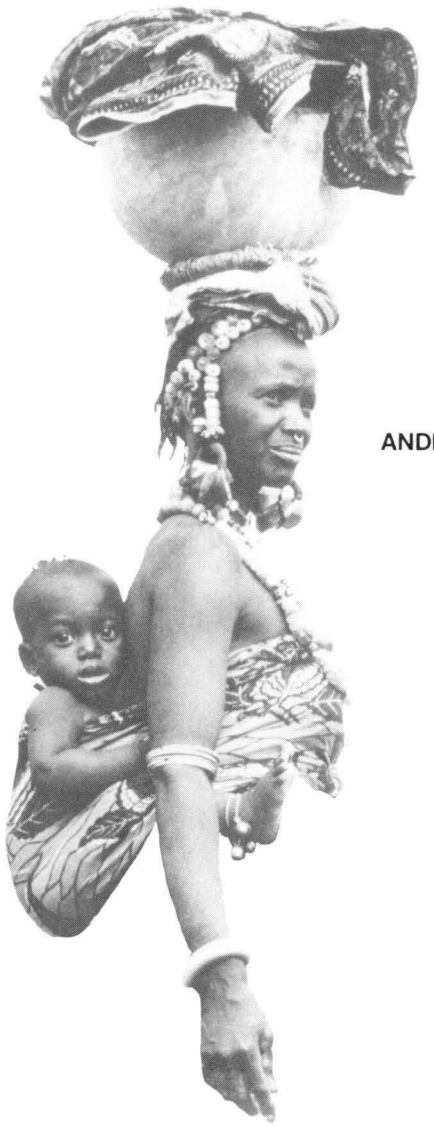

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ANDRE LAPLANTE, FARAN SAMAKE, GEORGE F. BROWN

Contents

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Background to family planning in Mali

The French-speaking countries of West Africa constitute one of the last remaining regions of the world in which family planning is not recognized as an important element in health and population policies. While there are a few countries in which private family planning services are tolerated, and one or two in which pilot projects are being set up, Mali is the only one that has committed itself to a national family planning program integrated into its maternal and child health services. Before examining the progress made in Mali over the last three years, or assessing the significance of the Malian experience, it is important to look at the reasons why the francophone countries of West Africa seem so reluctant to adopt family planning.

It was only 20 years ago that the wealthier countries of the world became really concerned about the population problems of the non-industrialized countries, and of the peoples then still living under colonial systems. In the French-speaking countries of West Africa, the first Western pressure for the introduction of family planning came about 10 years ago — some time after its appearance in Asia and in the English-speaking parts of Africa. This time lag may be explained in a number of ways. First, unlike the Anglo-Saxon countries, France advocated — and continues to advocate — a pronatalist policy. A law passed in 1920 and repealed only four years ago forbade the manufacture or importation of contraceptives and all publicity on the subject. This law is still in force in all francophone countries of West Africa except Mali. Secondly, most promoters of family planning were recruited in the Anglo-Saxon countries; the administrative and linguistic barriers they had to contend with were major obstacles. It is also important to note that the presentation of the subject by foreign agencies is resented as an unwelcome intrusion. A third set of factors has probably had an effect: the population situation in a number of countries in the region — specifically, those of the Sahel — is very different from that prevailing in the English-speaking countries of West Africa. Density is very low, and urbanization is not nearly so far advanced; the scattered population causes serious problems, particularly with regard to the per capita cost of infrastructures (roads, health and educational facilities, and so on). In short, circumstances were, and still are, unfavourable to the spread of family planning in the French-speaking countries of West Africa.

Despite these obstacles, some signs of interest and of activity emerged between 1965 and 1970. In Dakar, the private Blue Cross clinic was established and played a major role in succeeding years in the training of health personnel from neighbouring countries. From 1969 to 1971, training courses were organized by the Family Planning Centre of Quebec, with financial support from the Ford Foundation and the Canadian government. Official delegations from all the French-speaking countries of the area, except Guinea, attended these courses. However, only one country — Mali — was then considering an official family planning program.

Five years ago, Mali was experiencing more or less the same problems of health and production as its neighbours. Urbanization, though less advanced than in the coastal

states, was nevertheless proceeding at an equally rapid pace. Popular groups in Mali, such as the Women's Union and the trade unions, began to discuss family planning, and the authorities became aware of the need for contraception that was making itself felt among the population. The independent spirit of the Malian leaders probably hastened their decision to distribute information about contraceptive techniques. By their refusal to situate family planning in the context of a demographic policy, as advocated by most of the international co-operation agencies, the country's leaders spared themselves a long debate on a subject that is still far from clear. Malian acceptance of family planning fell within the framework of traditional values, and was based on reasons of health and family welfare about which there can be no controversy.

In 1971, the government of Mali decided, in co-operation with the International Development Research Centre, to establish a two-year pilot project whose overall objective would be to assemble the data necessary for the formulation of a national family planning program. To this end, a pilot clinic was to be established in the capital, Bamako, with four branch clinics located in various health facilities in the city. A research team was to study the characteristics of the actual and potential clientele, traditional practices related to fertility, possible means for establishing a national program, and the implications of such a program on health. Research was also planned into the possible demographic consequences of the spread of family planning. For its part, the IDRC provided technical and financial assistance.

In committing itself to the project, the Malian government was aware of the risks as well as the promise inherent in it. It would be the first government-sponsored experiment conducted in a French-speaking country in the region; its success or failure would have a considerable influence on the attitudes of neighbouring countries. After three years, Mali is deeply committed to a national program, and its pilot project has made possible some clarification of the whole question of family planning in the region.

Some results of the Malian pilot project

Mali is one of the world's least urbanized countries: more than 90 per cent of its five million people live in rural communities. Bamako, the country's only large city, has a population of about 250,000, and was the obvious location for the first official family planning activities. Services were actually officially dispensed only at the Bamako pilot clinic for the first two years of the project. In discussing the Malian results, we shall distinguish two phases, the first from January 1972 to January 1974 which saw the development of the pilot activities, and the second, beginning in January 1974, which constitutes a period of transition towards a truly national program.

During the first phase, the pilot clinic received more than 2,000 clients in about 10,000 consultations (initial visits and follow-up visits). Although the clinic offered IUDs and anovulants without favouring either method, the great majority of clients chose the former (71 per cent for the IUDs against 17 per cent for the pills, with six per cent choosing various other methods) (Table I). In the same period, six per cent of clients sought advice on problems of sterility and under-fertility. The continuance rate for all methods was assessed at 71 per cent one year after acceptance of the first method.

While not representative of the female population of childbearing age in Bamako, the centre's clientele does have some characteristics in common with it. The ethnic breakdown of the clientele is not significantly different from that of the female population of Bamako. The relative proportion of monogamous and polygamous clients (62 per cent and 38 per cent, respectively) is markedly different from that observed in the female population of Bamako: the 1960-61 population survey assessed the proportion of monogamous women at 54 per cent while wives of polygamous union constituted 46 per cent.[1] This difference between the clientele of the clinic and the population of the city could be explained simply by the fact that the probability of a woman's being a member of a polygamous household increases with age, and that the 46 per cent proportion naturally includes the group of women over 45 years of age. On the other hand, the proportion of widows, divorcees and single women in the clientele (34 per cent) is substantially higher than in the larger population; similarly, the literacy rate of the clientele (65 per cent) is very much higher than the rate for the total female population of Bamako (Table II).

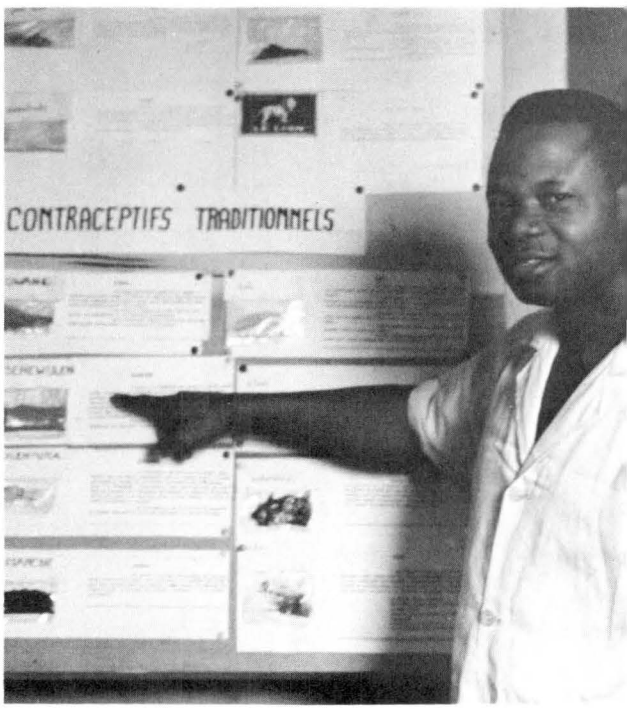
There is nothing spectacular about the volume of clients treated at the pilot clinic: in a two-year period, about five per cent of the childbearing population of Bamako have made use of these official services. Nor can it be said that the whole population shows the same interest in contraception. In order to assess the figures properly, however, they must be related to the sum of the activities undertaken by the Malian team during this initial two-year period.

At the start, the organizers of the project decided to proceed slowly and cautiously, allowing for any resistance that might make itself felt along the way. Extreme care was exercised in the matter of information. Throughout these two years — and up to the present — no mass information campaign was undertaken. However, many opportunities for discussion were created in intellectual, medical, and legal circles. Before clinical activities began, conside-

ration had already been given to the possibility of amending Mali's laws regulating contraceptive information and use. It was not until after the repeal of the French law of 1920 and the adoption by the government of a decree authorizing contraceptive practices[2] that information meetings were held at the neighbourhood level in Bamako. Probably the only contribution of the mass media (radio and press) to the project was to legitimize contraception by reporting on the debates that took place at various meetings and conferences.

Two such gatherings attracted special attention from the media: the first Inter-African Seminar on Sex Education[3] in April 1973 was attended by a score of delegations from French-speaking African countries, and was the subject of a number of radio programs and some front-page articles in the country's only daily newspaper. The Inter-Union Seminar on Family Planning, at which the Malian labour movement studied and approved the family planning program, also received extensive coverage from the Bamako newspaper and the state radio system. In both cases, observers from other countries had an opportunity to examine the initial stages of the Malian pilot project and to discuss it in depth. Despite this media coverage, public information was not a very significant factor. Word-of-mouth messages and the individual actions of medical personnel were the main channels of communication with the public, and the main means of recruiting clients.

In keeping with its overall objective, the pilot project included a major research component. Even before the clinic opened, a team attached to the centre in Bamako had studied various problems of research and evaluation.



A system of clinical statistics went into operation with the opening of the clinic, and five reports on the characteristics of the clients have been prepared to date.

Detailed research was also conducted on traditional fertility control practices and the changes they are undergoing in an urban environment. The pilot centre now has a large collection of traditional products related to fertility and sexual activity (contraceptives, abortifacients, remedies for sterility, aphrodisiacs, etc.). Special attention was given to the study of birth spacing through such practices as sexual abstinence and prolonged nursing in

various urban and rural regions of Mali. The results of these studies have been utilized throughout the program, particularly in training and information activities.[4] For example, the results of the studies of traditional contraceptive practices have been used extensively in seminars, courses, and even in neighbourhood meetings. Among other things, they have served to show the part that modern contraception could play in communities in which traditional fertility control practices are in decline. The fact that Malian society is heir to a long tradition of birth spacing was an important element in the acceptance of family planning ideas, both in medical and government circles and among the clients of the pilot centre.

It was also in this first phase that the Malian team devoted some effort to the training of medical and paramedical personnel. The pilot clinic had been so structured as to allow the largest possible number of doctors and midwives who had already received training in Montreal, Dakar, and New York to initiate their fellow members of the team. Since the clinic opened, eight doctors and 10 paramedics attached to maternities and maternal-child facilities in Bamako have been taking part in consultations every week. Gradually, groups of trainees, nurses, and midwives acquired the practical experience for the activities of future branch clinics. About 30 paramedics were trained in this way. In conjunction with this, lectures were given at the three schools of health and at the Department of Social Affairs, so that health workers would be equipped to provide correct information on family planning.

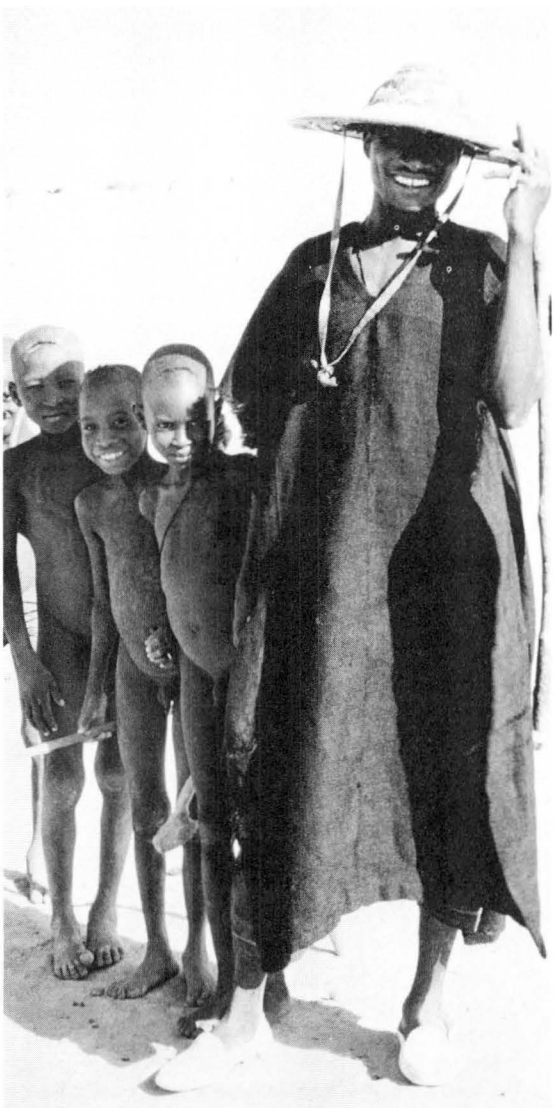
At the end of the initial period, the program took some major steps forward. In July 1973, the Ministry of Health and Social Affairs judged that the experience of the pilot centre was sufficiently conclusive to warrant an initial expansion. By a ministerial decision, a network of 12 branch clinics was to be established; they would be incorporated into health facilities in the six regional capitals, including Bamako (a total of seven in Bamako and one in each of the other five regional capitals). When set up, this network would cover six of the seven cities in Mali with more than 10,000 population, which means almost the entire urban population of the country.

The year following this decision saw Mali advancing steadily towards a national program. While preparations were being made for the opening of the new branches, and medical teams from the provinces were attending training courses in Bamako, the Ministry of Health and Social Affairs was preparing for a broad-based reorganization. For a few months, the problems of administration and co-ordination associated with the creation of a network of branch clinics delayed expansion. At the end of 1974, six clinics were operating in Bamako (the pilot centre and five new branches). Between January and December of 1974, the network received 1,240 new clients and dispensed 6,143 consultations (initial and follow-up visits).

Finally, also during the same period, the Minister of Health announced the planned merging of the maternal and child-health services through the establishment of a National Family Health Service. Under the authority of a director general, the service will consist principally of a national training and research centre (formed from the present pilot centre in

Bamako), an urban demonstration centre, and a rural demonstration centre. In addition to being responsible for the reorganization of maternal and child health clinics (which will be known as family health clinics), the new service will plan the creation of clinics in regional capitals, chief towns, and various centres of agricultural and industrial development. The present program calls for 23 clinics to be operating by December 1977.

Thus, less than three years after the opening of the pilot clinic in Bamako, Mali is committing itself to a national family planning program. Family planning will henceforth be one of the health services provided by the government, and its expansion will be linked to the expansion of national public health facilities in Mali.



The significance of the Malian experiment

In order to assess the scope of the Malian experiment, it seems to us essential to examine the reasons behind it. Let us first of all take note of the factors that were not involved. At no time did the Malian experiment have demographic objectives. There was never any question of using family planning to reduce the rate of population increase. Population problems and their economic ramifications are naturally of concern to Malian leaders, but they are not considered a priority. Even if they were, the health facilities currently available to the Malian government would not be sufficient for the achievement of significant results, even 15 or 20 years from now. The circumstances that led the government to establish family planning services, mentioned at the beginning of this report, need to be examined more closely.

The same elements that triggered the gradual process of acceptance and proliferation of family planning in the West exist in the Malian case. As in the West, concern for family planning developed from immediate needs expressed by urban dwellers, rather than from long-range demographic planning. As in the industrialized countries, the most basic reasons for action are related to the new problems that women and families face as a result of the phenomenon of urbanization. As early as 1969, the Union des Femmes maliennes — the Malian Women's Union — was expressing concern; there was growing awareness of the health and social problems created by unwanted or inadequately spaced births. Doctors became alarmed: a growing abortion rate was becoming apparent in the cities of Mali as elsewhere in the world. Other factors such as increasing educational and employment opportunities for women and an increase in the divorce rate were creating new problems that called for new solutions.

Of the various situations that led to the Malian initiative, some are closely related to sociocultural characteristics peculiar to the continent and to the region. Thus, the spacing of births has long been a practice of traditional African societies: a very prolonged period of nursing, and usually sexual abstinence until a child was weaned, were imposed on women. These customs should not be disregarded. When the onset of a new pregnancy obliges a nursing mother to wean her child, this often means the death of the child. A study by Pierre Cantrelle in the Siné-Saloum region of Senegal made this very clear. According to Cantrelle's findings, the mortality rate for children weaned following pregnancy of the mother between 12 and 18 months after their birth reaches 500 per 1,000, compared with the general infant mortality rate of 200 per 1,000.[5]

Urbanization has considerably weakened traditional birth spacing customs, and the consequent changes in the birth rate have created a number of critical situations. The motivation of women attending the pilot clinic in Bamako confirms the importance of this factor: 68 per cent of them over the first two years of the clinic's operation expressed the desire to space their children; only 22 per cent wanted to stop having children; and six per cent wanted to postpone the arrival of their first. This motivation pattern is very different from what was observed in Asian or Western countries when they adopted family planning. According to Berelson, "Rural and illiterate

peoples are more interested in preventing births than in spacing them (in the West, too, the latter, more complex form of family planning was late in appearing)".[6] In traditional African societies, on the other hand, it seems that the desire to space births has definitely been the rule, and it is primarily for the purpose of maintaining a reasonable interval between children that people in these societies resort to contraception.

In this connection, another set of circumstances peculiar to French-speaking countries of West Africa helped create the need for contraception. The age of women at marriage is very low in the countries of the Sahel (about 15 to 17 years in Mali). By delaying marriage, education for girls has led to disastrous consequences: clandestine — and sometimes fatal — abortions, marital problems, and students dropping out of school at senior levels. Regulations inherited from the French regime require that a secondary school student who becomes pregnant leave school, with no hope of re-entering later at the same level. Every year, an appreciable proportion of students at the *baccalauréat* level have to drop out of school and give up the advantages acquired through years of effort. The moral and political dilemmas posed by this situation have yet to be resolved, but there is no doubt that the catastrophes it produces have helped to intensify the demand for family planning.

All these phenomena — and here is the key point — relate to immediate needs felt by urban populations. There is a popular consensus on the necessity of finding short-term answers to these needs. This is what the Malian government sought to do in adopting its family planning program. Here too, the approach chosen by the Malians is the same as that followed by movements and institutions in the wealthier countries. The fact that the latter now wish to promote family planning largely for considerations of long-term demographic planning makes no difference. Seen in this perspective, the true significance of the Malian program is clear: it is essentially one element in a policy for improved health and social welfare.

Malian health resources are scarce, and enormous problems have yet to be solved. Mali's efforts to control the major endemic diseases, improve sanitation, combat malnutrition, and improve maternal and child health are just beginning. In this context, it would be unrealistic to seek to cut off population growth by rapidly extending family planning services to the entire country. It would also be dangerous: there is no apparent way in which it could be done without diverting a con-

siderable proportion of available health personnel from priority activities. In this sense, the current Malian program is a realistic one.

The program does not seek to forge ahead with the creation of new needs for contraception, or to modify the aspirations of the population — too many other vital health needs remain unfulfilled. Concentration of medical resources in the cities makes it possible to respond to the current needs of urban dwellers without compromising the satisfaction of other health requirements. In time, health facilities will expand and contraception will become available to a broader cross-section of the Malian population (on the same basis as vaccination services, nutritional education, and so on). In the Malian view, family planning can achieve its objectives only if it develops in harmony with other family health activities.

Sooner or later, family planning will become generalized and will be, as it is in the West, an essential factor in the control of population growth. When that time comes, the Malians will have had long experience in the field. They will have acquired the expertise necessary for broader operations. In so doing, they will have been able to relieve some of the individual and family problems that are the inevitable consequence of modernization and urbanization.

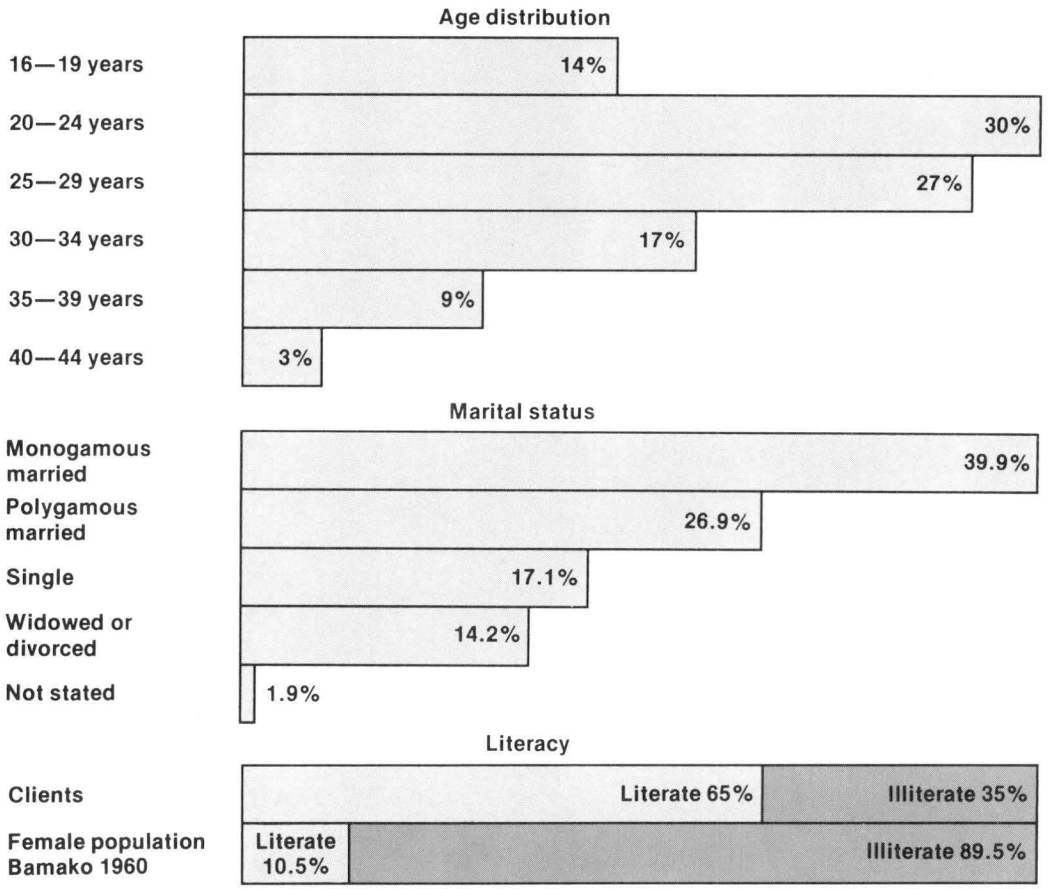
TABLE I

Distribution of clients of the Pilot Family Planning Centre by method or treatment chosen 1972-1974

Method or treatment chosen / Period	IUD	Pill	Other	Consultation for sterility	Not stated	Totals	Follow-up visits
1972	414	46	41	25	—	526	1167
1973	777	72	60	57	45	1011	4345
1974	741	337	65	74	90	1307	5179
Totals	1932	455	166	156	135	2844	
% Total stated treatments	71%	17%	6%	6%	—	—	

TABLE II

Various characteristics of clients of the Pilot Family Planning Centre 1972-1974



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(3) Education sexuelle en Afrique tropicale. International Development Research Centre, Ottawa, 1973.

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