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**ASSESSING ADOLESCENT
REPRODUCTIVE HEALTH
POLICIES AND PROGRAMS**

*Case Studies from Burkina Faso,
Cameroon, and Togo*

by

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Executive Summary

At the 1994 International Conference on Population and Development (ICPD) in Cairo, more than 180 countries, including 38 sub-Saharan African countries, drafted and ratified the *Programme of Action* that includes support for the provision of sexual and reproductive health education, information, and services to adolescents. Addressing adolescent reproductive health (ARH) issues is particularly crucial in sub-Saharan Africa, where rates of maternal mortality, unsafe abortion, and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), among youth are the highest in the world. Despite the obvious importance of the topic, ARH remains a controversial subject in the sub-Saharan region. Consequently, the exercise of caution in approaching the subject has led to a gap between the declarations of governmental officials and the actual design of reproductive health policies and programs geared toward youth.

This paper provides a practical means of assessing reproductive health policies and programs geared toward adolescents. First, it presents major elements of ARH policy and program development and sets benchmarks against which future policy and program development can be measured. Second, the paper compares ARH policy and program development in three Francophone African countries: Burkina Faso, Cameroon, and Togo.

The major components of ARH policy and program development considered are as follows:

Political recognition and will—ARH in national policies and guidelines. Political recognition of a problem—and, by extension, will to address the problem—is a necessary first step in the process of national policy and program development. The extent to which ARH has become a government priority can be assessed according to the presence of ARH in national population, health, and education policies and programs.

Formulation of ARH policies/programs. Once a problem has been recognized and general guidelines have been established to address it, specific policies and programs can be formulated. Assessment of the formulation stage requires an examination of both governmental and nongovernmental ARH policies and programs according to the definition of target groups, the reproductive health issues addressed, and the objectives.

Implementation plan. Policy and program objectives are more attainable if policies and programs include plans for implementation. The assessment includes the availability of adequate resources for implementation as well as the scope of ARH program activities.

Monitoring and evaluation plan. Effective program design must include monitoring and evaluation tools whose application coincides with the onset of program activities. Assessment at this stage identifies the existence of monitoring and evaluation tools and then examines the methodology proposed for their use in ARH program planning.

Level of coordination and cooperation. Although difficult to institute, collaboration and coordination of public and private efforts (including nongovernmental organizations [NGOs]) are essential for successful ARH policy and program design and implementation. Thus, the assessment evaluates the roles of the partners involved in public and private ARH efforts in addition to their numbers. The assessment also considers the level of coordination among programs as an indicator of success.

Youth involvement. Involving youth in the various stages of policy and program formulation is crucial. The level and nature of youth involvement at each stage of policy and program design is assessed.

The comparative assessment of ARH policy/program design in Burkina Faso, Cameroon, and Togo indicates the following results:

- Since the 1994 ICPD, national policies and programs in the three countries have targeted adolescents and young adults. ARH receives attention in revised population policies, newly reoriented national health policies, national programs that combat acquired immune deficiency syndrome (AIDS), strengthened family life education (FLE) programs, and initiatives to eliminate female genital mutilation (FGM). Governments have further exemplified their interest in ARH by developing youth health units within their health ministries.
- Both governmental and nongovernmental programs address important reproductive health issues affecting youth. Cameroon and Burkina Faso are in the process of developing national youth health policies/programs, and Togo has already adopted such a program. In addition, several NGO ARH programs are operating in the three countries.
- The governmental and nongovernmental programs in the three countries offer promise. The scope of activities planned by the national youth policies/programs is broad and includes the revision and diffusion of legal texts related to ARH, research initiatives, provision of reproductive health services, and a wide range of information, education, and communication (IEC) activities. Most program managers believe that the human resources necessary for implementing the countries' ARH programs are available. In addition, the level of informal collaboration among local NGOs in all three countries is relatively high, and the NGOs have developed initiatives to increase and formalize their collaborative relationships.

Despite these encouraging results, the case studies indicate that Burkina Faso, Cameroon, and Togo have much yet to do. First, the countries' governments should clarify their positions and strengthen their commitment to ARH issues. At the time of this research, national policy and program documents expressed contradictory positions regarding ARH. In addition, several draft government documents had not yet received approval. Second, policy and program design needs improvement. NGO programs express their objectives and monitoring methods in vague terms, and both programmatic and geographic scopes of activity remain limited. These shortcomings could be overcome by increasing the direct involvement of youth in the policy and program design process and by instituting more actual, rather than informal, coordination between NGOs and the government and among NGOs. Finally, governmental and nongovernmental programs lack stable and adequate funding sources—a serious obstacle to program implementation.

Abbreviations

AAS	Association for African Solidarity (Burkina Faso)
ABBEF	Association Burkinabé pour le Bien-Être Familial (Burkina Faso)
AIDS	Acquired immune deficiency syndrome
APES	Amicale pour la Promotion de l'Equilibre Social (Burkina Faso)
APJAD	Association pour la Promotion de la Jeunesse Africaine pour le Développement (Burkina Faso)
ARH	Adolescent reproductive health
ATBEF	Association Togolaise pour le Bien-Être Familial (Togo)
CFJA	Centre de Formation des Jeunes Agriculteurs (Burkina Faso)
CAMNAFAW	Cameroonian Association for Family Well Being
CIDA	Canadian International Development Agency
CNLE	National Committee to Combat Female Circumcision (Burkina Faso)
CNLS	Comité National de Lutte contre le SIDA (Burkina Faso)
DHS	Demographic and health surveys
DPNP	Déclaration de Politiques Nationale de Population (Cameroon)
DSF	Division de la Santé Familiale
EPD	Education en matière de population et d'environnement pour le développement durable (Togo)
EmP/EVF	Education en matière de Population/Education à la Vie Familiale (Togo)
FGM	Female genital mutilation
FLE	Family life education
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IFORD	Institut de Formation et de Recherche Démographique (Cameroon)
IPPF	International Planned Parenthood Federation
KAP	Knowledge, attitudes, and practice
MCH	Maternal and child health
MST	Maladie sexuellement transmissible
NGO	Nongovernmental organization
NPP	National population policy

PANEM	Programme d'Action National pour Eliminer les Mutilations génitales féminines (Cameroon)
PAP II	Programme d'Action en matière de Population (Burkina Faso)
PHC	Primary health care
PNAHP	Project of National Adolescent Health Policy (Cameroon)
PNLS	Programme National de Lutte contre le SIDA (Togo)
PNSJA	National Adolescent Youth and Health Program (Togo)
PMSC	Programme de Marketing Social au Cameroun
PPLS	Projet Population et Lutte contre le SIDA (Burkina Faso)
RENAJEP/SR	Réseau National de la Jeunesse pour la Promotion de la Santé Sexuelle et Reproductive (Burkina Faso)
ROSACAM	Réseau des Organisations de Santé au Cameroun
SIDA	Syndrome immuno-défectaire acquis
STIs	Sexually transmitted infections
UNAIDS	United Nations Global Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
UERD	Unité d'Enseignement et de Recherche en Démographie (Burkina Faso)
URD	Unité de Recherche Démographique (Togo)
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
WHO	World Health Organization

Introduction

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, more than 180 countries, including 38 sub-Saharan African countries, signed a historic agreement committing themselves to the *Programme of Action* that includes provision of sexual and reproductive health information, education, and services to adolescents (United Nations, 1994). Adolescent reproductive health (ARH) is a human right, but international consensus needs to be translated into policies and programs within nations. The concept of ARH is still new and controversial in sub-Saharan Africa, particularly in Francophone Africa. Correspondingly, there is often an important gap between the declarations and resolutions made by policymakers and governmental officials and the actual design of reproductive health policies and programs geared toward youth (Pathfinder International, 1999).

Addressing ARH is crucial in sub-Saharan Africa, where it is a significant problem. First, the region has the world's highest rate of early childbearing and associated maternal mortality (United Nations, 1995). Second, trends favoring later marriage and premarital sexual activity, especially in urban areas and among educated youth, are associated with increased risks of unwanted pregnancy and induced abortion among adolescents (Coeytaux, 1988; WHO, 1993b). Abortions are especially dangerous to adolescent women; unlike older women, adolescent females are more likely to resort to unsafe and self-induced abortion and to even postpone abortion (Friedman, 1994). Unprotected sexual activity among unmarried youth is also closely associated with sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS). Africa has the highest HIV rate in the world, with infection rates particularly high among adolescents and young adults (Reid and Bailey, 1993). Finally, the deteriorating economic conditions that characterize most African countries have placed young people, especially young women, at increased risk of abusive, exploitative, and unsafe sexual encounters (Meekers and Calvès, 1997; McCauley and Salter, 1995).

Although adolescents' reproductive health obviously demands attention, adolescents have limited access to reproductive health information and services (Friedman, 1994). In most African countries, adolescents tend to possess inaccurate knowledge about reproduction and sexuality (Senderowitz, 1995), and the institutional response to current levels of knowledge among adolescents is extremely limited. In addition, family planning service programs target older, married women who have completed their childbearing or who wish to determine the spacing and timing of future births (Senderowitz, 1997a). Adolescents remain largely overlooked.

Often in reproductive health policymaking, married adolescents are included implicitly in more general policies dealing with family planning, safe motherhood, and HIV/AIDS. In making a commitment to the 1994 ICPD *Programme of Action*, countries must address adolescents' needs, either through existing policy and program mechanisms, if appropriate, or through specific policies and programs designed to meet the unique needs of adolescents and young adults.

This paper assesses the progress made by three countries in sub-Saharan Africa toward meeting the reproductive health needs of adolescents and young adults. The three countries in Francophone West Africa—Burkina Faso, Cameroon and Togo—represent countries that are rarely studied and that lag somewhat behind in developing reproductive health policies and programs, particularly for adolescents.

ARH Assessment Framework

Developing countries have responded to the 1994 ICPD with a marked increase in national health policymaking activity and, in particular, in ARH policy and programming activity. While policymakers and program planners may well need guidance as they expand their programming, the little information that exists on the elements of effective youth health policies and programs is poorly disseminated and thus largely unavailable to them (Hughes and McCauley, 1998; Adamchak et al., 2000). This paper provides an assessment tool that draws on both the emerging body of research pertaining to ARH policy and programs and the general policymaking and program evaluation literature. More specifically, this tool offers a comprehensive scheme against which the design and planning of ARH policy and programs can be assessed.

Several theoretical frameworks have elaborated the general process of policy development (for a complete review, see Stover and Johnston, 1999). Generally, these frameworks describe the various stages of the policy development process and identify the factors and actors that may play an influential role in shaping the policy agenda and issues at each stage (Grindle and Thomas, 1991). Most of these frameworks focus on *how* policies are made rather than on the policies' substance, content, or adequacy in addressing important policy issues (Dye, 1998: 317). Yet, the idea behind policy and program analysis is not only to describe the status quo but also to identify the constraints that laws and policies impose on strategic and program directions (Paxman and Zuckerman, 1987). Some of the first work in such analysis emerged in the context of family planning and contraception at the same time that policymakers were instituting ARH frameworks (Center for Reproductive Law and Policy, 1996; WHO, 1993a).

This policy tool is designed to facilitate the assessment of ARH policy and program development by describing the components of good ARH policies and programs. The results of this assessment can help those working on ARH issues to identify the weaknesses in policies as articulated by national governments and programs as outlined in government documents.

The policy tool used in this paper focuses on content analysis of national policies and program documents. In addition, information can be collected through interviews with key stakeholders. In broad terms, its purpose is to provide a format for identifying, analyzing, and presenting the content of ARH policy and programs. Gathering information on the current status of ARH policies and programming—with a primary focus on content and adequacy—can help identify gaps for creating awareness and formulating future policies and programs. It also can help set benchmarks against which future policy and program development and action can be measured (WHO, 1993a). Such assessment efforts can in fact be seen as the trigger for policy development itself, producing an improved policy environment that addresses the needs of adolescents.

Applying this framework to policies and program documents should be a key step in the ARH policy process. Faulty policy and program documents are less likely to lead to successfully implemented policies and programs and to positive ARH outcomes. Thus, policymakers, program managers, and others involved in ARH work can use this framework as a policy tool when designing and implementing ARH policies and programs. While government policies often guide nongovernmental organization (NGO) programs, the framework components related to programs can be used to assess the gaps in NGO documents as well.

Figure 1 presents the ARH assessment framework. Because the development of ARH policies and programs is relatively new, the framework focuses on the assessment of the first phases

of policymaking processes: political recognition, policy formulation, implementation planning, and monitoring and evaluation planning. The framework also considers implementation issues: the level of coordination and collaboration of private and public efforts and the level of youth involvement in ARH policy and program design. Each element of the framework is described below.

Political Recognition: ARH in National Policies and Guidelines

Political recognition—and, by implication, political will—is a necessary first step in the process of policy and program development (Dye, 1998; Stover and Johnston, 1999). In fact, a policy assessment might begin with a content analysis of post-ICPD policy documents to identify the emergence of ARH issues. Relevant policy texts include population, health, and education policies; program documents; and national guidelines that reveal whether adolescents have been recognized as a specific target group, whether ARH issues have been identified, and how the concept of ARH has been defined and operationalized. The existence of clear national guidelines is often pivotal to an ARH program's success (Birdthistle and Vince-Whitman, 1997). Statements by political leaders can also signal political recognition and the will to address ARH issues.

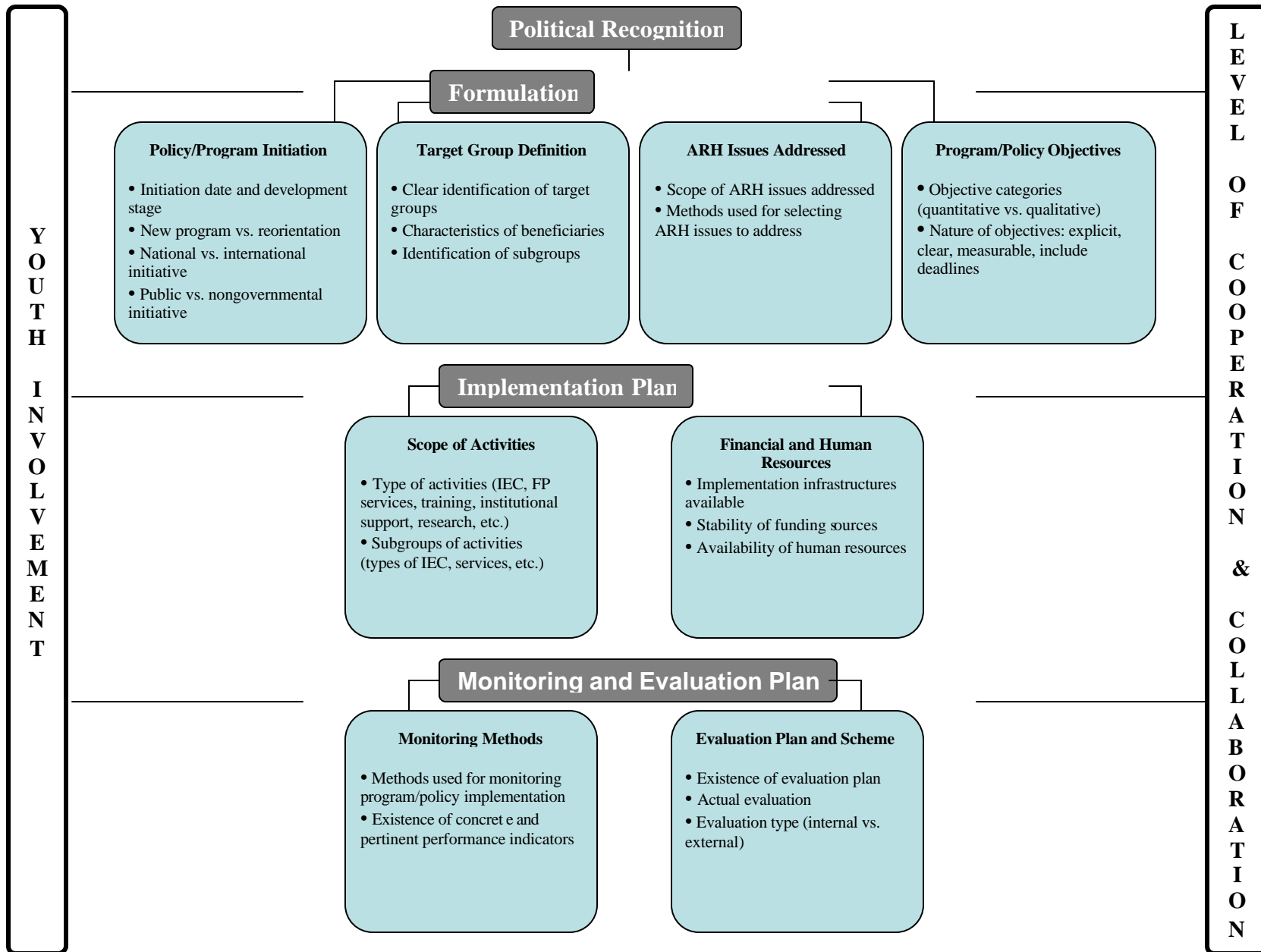
Formulation of ARH Policies and Programs

Once a problem has been recognized in *general* policies and guidelines, the next step usually calls for drafting and formulating *specific* policies and associated programs to address that problem. Given that NGOs have played a pioneering role in planning and implementing the ICPD agenda, policy formulation should consider both nongovernmental and governmental ARH programs. The framework includes four elements of policy and program formulation: policy/program initiation, target-group definition, ARH issues addressed, and policy/program objectives.

Policy/program initiation. The policy/program initiation component focuses on the degree of ARH policy and program development since the ICPD and examines the following characteristics of policies and programs:

- Date of creation and stage of development
- Whether a policy/program is new or a reorientation of an existing policy/program
- Whether a policy/program is a national/international or a governmental/nongovernmental initiative

Figure 1
Conceptual Framework for Evaluating Program and Policy Design on Adolescent Reproductive Health



Target-group definition. Explicit identification of the target audience facilitates the design of a program geared specifically to youth. Improper target-group identification is, however, a common problem caused in part by varying definitions of adolescence. In addition, program planners often focus on only the most accessible youth, such as those in school or in urban areas, thus underserving out-of-school and/or rural youth (UNFPA, 1997). Research further suggests that policymakers and program planners must avoid treating adolescents as a homogeneous group. Rather, they should recognize that the program needs of young people differ according to their sexual experience and other sociocultural factors (Hughes and McCauley, 1998; UNFPA, 1997). Consequently, target-group definition must consider the following three factors:

- Whether the target group has been clearly defined
- Characteristics of the target group
- Whether subgroups of adolescents have been identified according to specific criteria

ARH issues. The ICPD *Programme of Action* provides the initial context for describing the scope of ARH issues to be addressed by policies and programs. Yet, given similarities and differences in ARH needs across regions and countries (McCauley and Salter, 1995; Pathfinder International, 1999), the assessment should take into account the specific reproductive health needs of adolescents in each country. It should also evaluate whether the definition of reproductive health problems is based on an analysis of primary or secondary data, on informal feedback from the field, and/or on international standards.

Program/policy objectives. Setting clear objectives is crucial to policy and program success. Objectives have considerable influence on the way policies and programs are implemented and evaluated (CIDA, 1997). The framework distinguishes between quantitative and qualitative objectives and considers the following four dimensions for assessing program objectives:

- Explicitness (explicitly stating desired results rather than simply referring to activities to be performed)
- Clarity (well-defined terms and concepts)
- Measurement (whether objectives allow for verification of achievement)
- Timeframes (whether specific dates have been established for reaching each objective)

Implementation Plan

Policy and program objectives are more attainable if policies and programs include plans for implementation (Sabatier and Mazmanian, 1979). The implementation component of the framework examines the extent to which policies and programs clearly structure their implementation processes. It is important to examine both the scope of ARH program activities and the availability of adequate resources for implementation.

Scope of activities. Program activities are classified in broad categories (e.g., IEC, provision of ARH services, training, and research) and subcategories of activities (e.g., IEC through media campaigns, counseling activities, production of educational materials, and information to parents). The categorization of activities allows for easy identification of any gaps in each country's ARH activities.

Financial and human resources. Resource constraints are a crucial element that must be taken into account when assessing programs in developing countries (Hughes and McCauley, 1998). The framework considers both financial and human resources, and indicators include implementation structures (existing versus new), sources of funding, perceived stability of financial resources, and perceived availability of human resources.

Monitoring and Evaluation Plan

Effective program design includes monitoring and evaluation tools that are deployed with the onset of program activities (UNFPA, 1997). Monitoring and evaluation are important for several reasons. First, monitoring and evaluation activities provide documentation of different aspects of programs. Second, they demonstrate whether youth programs are exerting their intended influence and indicate the extent to which they are reaching their target audience. Evaluations of implementation experiences can then be used to strengthen and/or reformulate programs. Consequently, monitoring and evaluation activities aid in mobilizing community support and advocating for funding—and helping document policy and program success (Adamchak et al., 2000).

To optimize program and policy implementation, monitoring methods need to be clearly defined and planned. Two indicators used to assess the monitoring plan are the selected monitoring methods and the existence of concrete and pertinent performance indicators. The monitoring effort is subjected to assessment along three dimensions: existence of an evaluation plan, execution of an evaluation, and evaluation methods used (e.g., external or internal).

Level of Coordination and Cooperation

With respect to the implementation of ARH programs, collaboration and coordination of public and private efforts (including NGO efforts) have proven difficult, but they are essential elements of successful policy and program design (Senderowitz, 1997a; 1997b). Cooperation and coordination between public and private initiatives also contribute to flexible programming (Hughes and McCauley, 1998). Thus, the framework examines the roles as well as the number of partners involved in public and private efforts. It also considers the level of coordination among programs as an indicator of success.

Level of Youth Involvement

Several studies have stressed the crucial role of youth involvement in developing, implementing, and evaluating youth policies and programs (Senderowitz, 1995; Hughes and McCauley, 1998). Thus, the assessment examines the level and nature of youth involvement at each of these stages of the policy and program design process. The framework distinguishes between indirect and direct involvement. Examples of indirect youth involvement include surveys, adolescent focus groups, and informal feedback from the field. Direct involvement refers to activities in which adolescents are collaborative partners. Policies and programs may, for example, directly involve adolescents through formal consultations with youth group representatives and incorporation of youth as active participants in implementation (e.g., peer counselors).

Comparative Analysis

In 1999, the framework discussed in the previous section and shown in Figure 1 was used to compare the recent design of governmental and nongovernmental ARH policies and programs in Burkina Faso, Cameroon, and Togo. In addition to government programs, the assessment focused on the five to 10 major NGO initiatives on ARH in each country; an exhaustive assessment of all private initiatives targeted at adolescents was beyond the scope of the country case studies. In total, the assessment examined 24 NGO programs (see the appendix for the names of the programs reviewed).

The assessment in the three countries relied on two methods of data gathering: reviews of policy and program documents, and interviews with governmental officials (e.g., in ministries of health, education, and promotion of women) and managers of NGO programs with youth components. The documents reviewed included constitutional clauses, executive and ministerial decrees, legislation, orders, policy statements, administrative regulations and rules, judicial decisions, and government program statements.¹ For private sector program initiatives, the documentation included project descriptions, internal and/or external evaluation reports, strategic plans, and other documents related to the program. In the interviews, a structured questionnaire facilitated comparison across countries.

Political Recognition: ARH in National Policies and Guidelines

The emergence and place of ARH in national population policies, health policies, national AIDS prevention programs, and education policies provided a measure of each country's level of political recognition of ARH. Another measure of recognition was the existence of national policies and programs to eliminate female genital mutilation (FGM).

ARH in National Population Policies

Burkina Faso, Cameroon, and Togo elaborated their first national population policies two to three years before the 1994 ICPD. In each country, the population policy provides important government guidance on population and development issues, including health.

Burkina Faso. The concept of ARH per se is absent from the 1991 *National Population Policy* (NPP) (Burkina Faso, 1991) and is present only in the form of a discussion of issues facing adolescent mothers. The document's provision of ARH services amounts to a recommendation for promoting family life education (FLE), referred to as population education. As a result of the ICPD, however, the NPP has undergone revision.

The government's intent to implement the ICPD recommendations was first reflected in the *Letter of Intent on Sustainable Human Development*, adopted in 1995. The letter points to the emergence of the concepts of reproductive health and ARH through, first, the implementation of the

¹ While some of the government policy and program documents collected have not yet been officially adopted, they were included in the review because some were close to adoption and reflected the official position on the issue at the time. Such unofficial documents may have been modified and revised before final adoption.

primary health care (PHC) strategy and the integration of family planning and maternal and child health (MCH) services under the PHC system and, second, the inclusion of “youth health” in the minimum activity package (paquet minimum d’activités). Following the adoption of the *Letter of Intent on Sustainable Human Development*, the government updated the NPP in 1996 to reflect its new orientation toward adolescent and youth health.

The new NPP, which at the time of this research was still under revision, underscores the concept of reproductive health and recognizes “adolescents and youth” as a “vulnerable group” to be targeted by national policies. The new NPP outlines specific objectives as well as broad strategic orientations that directly pertain to ARH. One of the objectives is to “promote greater use of reproductive health services particularly among women, adolescents, and youth.” To achieve that objective, the NPP recommends the “promotion of reproductive health integrated services or youth-oriented reproductive health services, community involvement in the implementation of youth structures, and use of peer techniques to sensitize and inform youth.” The NPP also mentions as strategic orientations the “promotion of IEC programs in family planning among target groups” and the “promotion of FLE and sex education in the formal and informal education systems.”

To implement the new NPP, Burkina Faso’s Conseil National de Population created a second strategic action program, the Program for Action on Population 2001–2002 (PAP II) (Burkina Faso, 2000). The PAP II elaborates five subprograms and presents specific objectives and expected outcomes. One of the subprograms, entitled “Health and Reproductive Health,” sets forth a specific objective “to increase the number of structures offering reproductive health services to youth and adolescents by 2005 in both rural and urban areas with the participation of community and youth.” The expected outcomes follow:

- 10 percent of existing basic health structures and referring structures will offer reproductive health services to adolescents and youth.
- Eight existing youth centers will be reinforced with regard to the provision of ARH services.
- 10 new centers for the provision of ARH will open and operate in both rural and urban areas, with the participation of youth, communities, and departmental structures in charge of youth.

Cameroon. In July 1992, Cameroon adopted the *Declaration of National Population Policy* (DPNP) (République du Cameroun, 1993), which, at the time of this research, had not been modified since the ICPD.² While the term “reproductive health” is absent from the DPNP, the document mentions early childbearing, maternal mortality, and unwanted pregnancies as health issues. In addition, the DPNP recognizes “youth,” a generic term for the population under age 20, as a specific target group for employment, health, and education policies. In the area of health, the declaration’s main targets are mothers and children rather than adolescents per se. Thus, as in the 1991 Burkinabé NPP, the DPNP mentions ARH problems mainly in terms of adolescent mothers. The initiatives recommended by the DPNP to combat early childbearing and undesired pregnancies among adolescents consist mainly of “increasing the level of formal education among girls” and “promoting FLE and sex education among youth, taking into account their level of maturity” (République du Cameroun, 1993: 15, 35).

Togo. The government’s position on ARH as stated in the 1991 *National Population Policy* (NPP) (République Togolaise, 1991) is similar to that of the Cameroonian government. The NPP

² Some information gathered in the field did suggest, however, that the policy might be under review.

recommends family life education, referred to as “education in population and environment for sustainable development,” as the only ARH service targeted to adolescent mothers. As with the government of Burkina Faso, the Togolese government revised its population policy in response to the ICPD; it adopted its revamped NPP (République Togolaise, 1998) in October 1998. Compared with Burkina Faso’s revised NPP, however, the 1998 Togolese policy does not reflect the priorities of the ICPD *Programme of Action* in the area of ARH. The concepts of reproductive health and ARH are surprisingly absent from the document. Whereas the document recognizes “children and youth,” defined as the population under age 20, as a vulnerable group facing important problems, the NPP focuses primarily on issues such as “delinquency, drug abuse and other forms of exploitation, and lack of parental control” (République Togolaise, 1998: 29). As in the 1991 policy, the only ARH problem mentioned by the document is early childbearing. To combat the problem, the document recommends prevention strategies, namely, increasing the minimum age at first marriage to 20 years for girls and 21 years for boys and generalizing population education and FLE.

ARH in National Health Policies

While only Burkina Faso’s NPP underwent significant revision as a consequence of the ICPD, the ICPD in general marked a turning point in the three countries’ redirection of their health policies and programs toward ARH. Nonetheless, the level of attention devoted to youth and ARH in the countries’ national health policies varies.

Burkina Faso. The 1998 development of the *Strategic Plan for Reproductive Health (1998–2002)* (Burkina Faso, 1998) reflects the government’s new orientation as expressed in the *Letter of Intent on Sustainable Human Development* and the revised NPP. Like the revised NPP, however, the strategic plan had still not been officially adopted at the time of this research. The plan identifies “youth sexual and reproductive health” as one of its four programmatic domains. In fact, “[h]ealth of youth and adolescents is now a major concern for the government” (Burkina Faso 1998: 13), and the document emphasizes a range of ARH problems that extend to early childbearing, unwanted pregnancies, illegal abortions, exposure to STIs including AIDS, lack of information about sexuality, and inadequate reproductive health services. The general objectives of the strategic plan in the area of ARH are “to help youth to better understand their sexuality to promote responsible behavior and provide them with services they need” and “to reduce the number of unwanted pregnancies by 25 percent.”

To achieve these objectives, the strategic plan calls for a wide array of youth-oriented activities, as shown in Table 1. The description of the activities, however, lacks elaboration and precision. For instance, how will the “dialogue between parents and adolescents” be promoted? How many health and counseling structures will be created? Nonetheless, the range of strategic approaches for meeting ARH needs takes into account collaboration among private and public actors working in reproductive health as well as collaboration among various public service sectors, the promotion of research, and the promotion of women.

Table 1
Scope of Youth-Oriented Activities in Burkina Faso's
Strategic Plan for Reproductive Health (1998–2002)

Strategies	Activities
Capacity reinforcement and decentralization of services	<ul style="list-style-type: none"> ▪ Elaboration of protocols to promote access to contraceptive methods among youth ▪ Training of teachers and professors in communication and counseling techniques ▪ Creation of specific health and counseling structures for youth ▪ Expansion of the contraceptive distribution system ▪ Regular provision of basic contraceptives and equipment
IEC and advocacy	<ul style="list-style-type: none"> ▪ Promotion of dialogue between parents and adolescents on sexuality and responsible parenthood ▪ Organization of holiday clubs on family planning, sexuality, and unwanted pregnancies for pupils and teachers
Promotion of women and young women's status	<ul style="list-style-type: none"> ▪ Promotion of FLE
Reinforcement of intersectoral collaboration and partnership	<ul style="list-style-type: none"> ▪ Creation of a network of actors in reproductive health to coordinate youth-oriented actions
Promotion of research activities	<ul style="list-style-type: none"> ▪ Research on youth and male participation in family planning

Source: Burkina Faso, 1998

Cameroon. The impact of the ICPD on the elaboration of the new health policy is less obvious in Cameroon than in Burkina Faso and Togo. Nonetheless, the Ministry of Public Health's development and adoption of the 1995 *Maternal and Child Health Care and Family Planning (MCH/FP) Services Policy and Standards* (République du Cameroun, 1995) exemplifies the Cameroonian government's new orientation to the health sector. The MCH/FP policy marks the integration of family planning services with MCH services and the emergence of the concept of reproductive health (although the document never uses that term). As in Burkina Faso and Togo, the MCH/FP policy recognizes adolescents as one of its target groups. Youth, however, is narrowly defined as ages 11–19.

The objectives of the “adolescent care” component of the MCH/FP policy, as presented in the policy document, are stated in highly general terms. Adolescent care “aims at the physical, mental, and social health of this group with a multidisciplinary and multilevel approach.” Activities targeted at youth are defined as follows: “family life education for responsible parenthood, sex education, prevention of early pregnancies, prevention of early marriages, prevention of induced abortion, and prevention of STIs/AIDS” (République du Cameroun, 1995: 4). The document remains unclear, however, as to the actions to be implemented to prevent early pregnancies, abortions, and STIs.

As in the NPP, the MCH/FP activities reflect a focus on education (FLE and sex education) rather than an emphasis on access to reproductive health services. FLE for youth includes “individual essential needs, family relationships, sex education, prenuptial exams, and STIs/AIDS prevention,” but no information on family planning. Thus, although the policy declares that “every person of reproductive age is entitled to information on family planning” (République du Cameroun, 1995: 6) and “has the right to contraception” (p. 7), it clearly exhibits a reluctance to address explicitly the issue of adolescents' access to family planning information and use of family planning services. In addition, the policy does not recognize the need either to develop special health structures or centers for meeting the reproductive health needs of youth or to adapt the existing MCH/FP system to satisfy those needs.

Togo. The concept of reproductive health is first mentioned in the 1996 *National Health Policy* (République Togolaise, 1996b). The policy recommends the elaboration and implementation of “a reproductive health program that integrates MCH, contraception, STIs/AIDS, sterility, adolescent and youth health, and traditional practices harmful to women and children” (p. 13).

The impact of the 1994 ICPD on the orientation of Togo’s national health policies is most visible in a 1997 document, *Reproductive Health Policy and Standards* (République Togolaise, 1997a). The Family Health Division (DSF) of the Togolese Ministry of Health prepared the document. The preamble, which clearly acknowledges the influence of the ICPD *Programme of Action*, states, “Togo adopts the international definition of reproductive health” (République Togolaise, 1997a: 5). One of the reproductive health components identified by the document is adolescent and youth health, with youth broadly defined as ages 10–24. The general objective of the youth health component is “to promote a state of complete physical, mental, and social well-being among adolescents and youth aged 10 to 24 years old in school, universities, and out of school” (p. 5). To achieve this general goal, the document sets forth specific objectives, such as “to prevent early pregnancies, induced abortions, and STIs/AIDS by the provision of adequate contraceptive services,” “to promote sanitary activity in education in population and environment for sustainable development (EPD),” and “to promote prenatal visits.”

Activities directed toward youth enrolled in school and university include curative care, systematic medical visits, IEC (prevention of risky behavior, EPD, a gender approach), conferences/debates, provision of reproductive health services, “youth-for-youth” activities, dissemination of legal texts, vaccination, referral, and prenuptial visits. Activities planned for out-of-school youth include IEC in neighborhoods and villages, “youth-for-youth” activities, creation of youth centers, and prenuptial visits. The policy document also presents specific activities to be conducted at each level of the health structure and defines indicators of performance.

ARH in National HIV/AIDS Prevention Programs

While the three countries had instituted AIDS prevention and control programs before the 1994 ICPD, their recently reoriented programs confer greater status on youth with respect to HIV/AIDS.

Burkina Faso. The *National Multisectoral Plan to Combat STIs/AIDS* (Burkina Faso, 1994), elaborated in 1994 in the context of the Population and Fight Against AIDS Project (PPLS), includes the following IEC activities specifically targeted at youth: creation of an information, counseling, and STI screening center for youth in Ouagadougou; support of an “IEC–Youth” campaign in the regions; and creation of school magazines on STIs/AIDS.

Cameroon. The new *National Plan to Combat AIDS in Cameroon* (République du Cameroun, 1999), elaborated in 1999 by the Ministry of Health, also recognizes youth as a specific target. One of the objectives of the national plan is to “sensitize the population aged 15–24 with gender-specific methods” (République du Cameroun, 1999: 4). As in Burkina Faso, the accent is on IEC activities. The training of peer educators in STIs/HIV/AIDS prevention seems to be the method of choice for reaching youth. For example, activities include training of young adults responsible for schools’ health clubs, training-of-trainers in driving schools, and training of teachers and students in “teaching schools” (écoles normales). Plans also call for the screening of STIs and clinical care of HIV-infected patients, even though the target group is the “population at large” rather than youth.

Togo. The National AIDS Control Program (PNLS) recognizes both in-school and out-of-school youth as specific target groups. Overall, the target groups are broad and include youth ages 8–30, probably in an effort to capture all age groups represented in school. As in Burkina Faso and Cameroon, description of youth-oriented activities collected during interviews points to IEC activities, such as peer education and information campaigns for out-of-school adolescents and young adults and FLE and IEC programs for youth enrolled in school.

National Policies and Programs to Eliminate FGM

FGM, or female circumcision, is a harmful traditional practice that may threaten adolescent health. While several initiatives to combat FGM began before 1994 in the three countries, the initiatives have recently been strengthened.

Burkina Faso. The prevalence of female excision is extremely high—about 70 percent of girls are estimated to have undergone the procedure. The scale of the phenomenon has led to the establishment of a National Committee to Combat Female Circumcision (CNLE) and the 1992 adoption of a national plan to combat FGM. Through advocacy and IEC activities, and together with NGOs, the CNLE articulated the harmful consequences of FGM and succeeded in convincing policymakers and the assembly of the need to legislate against it. The political will to fight FGM is also visible in the new Strategic Action Program (2001–2005), which has set forth an objective of eliminating the practice of FGM before 2015 (Burkina Faso, 2000). The objective would be achieved by, among other things, enforcing relevant legal texts, conducting operations research, conducting advocacy campaigns among the general public and community leaders, and training FGM practitioners for new employment opportunities.

Cameroon. The prevalence of FGM is lower in Cameroon than in Burkina Faso; however, female circumcision is still practiced in three of 10 provinces. To address the issue, the Ministry of Women’s Condition elaborated the National Action Program for the Elimination of FGM (PANEM) (République du Cameroun, 1998c) in December 1998. As in Burkina Faso, the action plan targets the public at large, traditional midwives, opinion leaders, social workers, and women’s associations. IEC activities (e.g., plays, concerts) sensitize youth and adolescents. While the PANEM is a well-articulated document, it had not been adopted at the time of this research, and no legal action had been taken to make FGM illegal in Cameroon.

Togo. A law making FGM illegal in Togo (Law No. 98–016) was approved on November 17, 1998. Under the law, any person performing female circumcision may be sentenced to prison for two to five years and/or must pay from 100,000 to 1,000,000 CFAF. While the law against FGM is an important step in the battle against female circumcision, Togo has yet to institute a preventive program similar to those formulated in Burkina Faso or Cameroon.

ARH in National Education Policies and Programs

As seen, FLE, which is referred to as population education in Burkina Faso and EPD in Togo, was already a priority expressed in the pre-ICPD national population policies of the three countries. The countries’ more recent health policies, however, stress the necessity of further developing FLE programs. As a result, Burkina Faso, Cameroon, and Togo have strengthened or reoriented their FLE programs.

Burkina Faso. As early as 1985, Burkina Faso elaborated a “strategy for the introduction of population education in the formal system.” Two years later, it implemented a national program co-financed by the United Nations Population Fund (UNFPA). Moreover, Burkina Faso’s 1991 adoption of the NPP, the implementation of the third UNFPA cooperation program (1992–1996), and the 1994 ICPD all gave a boost to initiatives promoting FLE among youth. While population education has been integrated into secondary school curricula, the objective is to generalize it to the entire educational system. Thus, Burkina Faso has strengthened the existing program in FLE and expanded the target group for FLE to include adolescents enrolled at the primary level.

Besides the extension of the FLE program to the primary level of formal education, Burkina Faso implemented two programs targeted to youth enrolled in the nonformal education system. The first program, developed in 1995 and entitled Population Education for Rural Youth, targets youth enrolled in agricultural training centers (CFJA) and is implemented by the Ministry of Agriculture. Its objectives, as stated during interviews with ministry representatives, are “to introduce population education in the training curriculum in the CFJA” and “provide rural youth with reproductive health information and promote responsible parenthood.” The other program, entitled Population Education in the Literacy Campaigns, was launched in 1996 to target youth and adults enrolled in literacy centers. Objectives of the program are to generalize population education to the nonformal system, to reduce the rate of female dropouts, and to promote responsible sexual behavior among youth.

Cameroon. The 1988–1992 UNFPA cooperation program and the DPNP emphasized the promotion of IEC activities and the introduction of FLE in school curricula. In 1995, the *Law of Education Orientation* made the introduction of FLE a priority. Subsequently, the Cameroonian Ministry of Education drafted a document, entitled *Declaration of Health Policy in School Environment* (République du Cameroun, 1998a) that targets students at the kindergarten (ages 4–6), primary (ages 6–11), and secondary (ages 11–21) levels of education. According to the policy, FLE is one component of the primary health services to be implemented in schools. It is not possible to determine from the policy whether FLE is the only reproductive health activity planned for introduction into the education system. Even though the policy states that “health services” will be provided to children and adolescents in school through school infirmaries, health centers, or health clubs, the description of these services is not precise enough to determine whether reproductive health services are included.

Togo. As in Burkina Faso and Cameroon, Togo introduced the FLE program into the education system in 1985 as part of the UNFPA country program. In 1995, the program was revised and extended as described in the *Population Education and FLE Program* document (République Togolaise, 1996a). The content of the program was updated “in accordance with the recommendations of recent international conferences” to integrate new issues such as reproductive health, sustainable development, and gender equality. The objective of the new program is to continue the introduction of EPD at the secondary level of education and extend it to other educational institutions (e.g., Ecole Normale Supérieure, National Institute of Educational Sciences, and Direction de la Formation Permanente). Activities include training of teachers, professors, and inspectors; elaboration of new curricula; and school-based IEC activities for parents and community leaders (e.g., conferences, films, radio shows, and so forth). The component of EPD called “Reproductive Health” covers issues such as STIs/AIDS prevention, induced abortions, early pregnancies, responsible parenthood, and knowledge of the functioning of the human reproductive system. Gender issues are also mentioned as part of the new curriculum.

Formulation of ARH Policies and Programs

The three countries' political recognition of the reproductive health needs of adolescents in their respective national population, health, and education policies and guidelines has created a positive policy environment for the formulation of specific governmental and nongovernmental ARH policies and programs.

Policy/Program Initiation

Governmental policies/programs. The level of advancement in the formulation of national ARH policies and programs varies in the three countries. While the National Adolescent and Youth Health Program (PNSJA) in Togo was adopted in November 1997, neither Burkina Faso nor Cameroon had adopted a program or policy in adolescent health or reproductive health at the time of this research. The latter two countries were, however, preparing national youth health policies/programs. In 1996, Cameroon drafted a project document, entitled *Project of National Adolescent Health Policy in Cameroon* (PNAHP), which was revised in 1998 by the Ministry of Public Health. In Burkina Faso, the Ministry of Health asked Kangoyé and Kaboré (1998) to prepare a provisional policy document, entitled *National Youth Health Program (1998–2002)*, but that document had not been adopted at the time of this research. The recent change of staff within the Ministry of Health and at the top level of the DSF seems to have slowed the adoption process.

In Burkina Faso and Togo, the governments' commitment to addressing the reproductive health needs of adolescents is also visible in the creation of a National Youth Unit within the Ministry of Health. Burkina Faso established a Youth Services Department in 1996 within the DSF to "better address the needs of young people and involve youth associations in the implementation of population programs." Togo created the National Service for Youth Health in May 1996. Its mission, as stated in the official document, is to "document the health problems of youth and adolescents; implement structures to provide adequate health services to youth and adolescents; and establish an efficient framework of collaboration and coordination among actors in the area of youth health" (République Togolaise, 1997b: 1).

NGO programs. NGOs and youth associations in all three countries have also been active in designing and implementing ARH programs. Most of these NGO initiatives started after 1996, with international donor agencies and international organizations playing a critical role in the launch of the programs. In fact, 46 percent of NGO programs included in the analysis (see appendix for list of organizations) are components of larger international programs. International institutions (e.g., the UNICEF program on girls' education in Togo and the Population Council program on girls' training in Burkina Faso) directly implemented some of the programs while local organizations that are affiliates of larger international institutions managed others (e.g., CAMNAFAW in Cameroon, ABBEF in Burkina Faso, and ATBEF in Togo are the local affiliates of International Planned Parenthood Foundation [IPPF] in the three countries). Even when programs are not part of larger international initiatives, they generally receive international funding. In fact, a large majority of programs—92 percent—are partially or totally financed by international agencies.

Target Group Definition

Adolescents do not constitute a homogeneous group, and youth from various subgroups (e.g., age groups and gender groups) have different reproductive health needs that should be addressed differentially (Hughes and McCauley, 1998). The assessment examined whether programs in the

three countries identified subgroups of adolescents for their program activities and, if so, the criteria used to identify the subgroups.

Governmental policies/ programs. The three countries have defined target groups according to age. In Burkina Faso, the government's National Youth Health Program targets young people ages 10–24. In Cameroon, while the MCH/FP policy had defined youth as persons ages 11–19, the draft document of the youth program recognizes the need to extend the target group to those ages 10–24 for “strategic reasons.” Even though adolescents and youth ages 10–24 are the primary target groups of the three governmental programs, other groups such as parents, community leaders, teachers, and health providers are also the beneficiaries or “secondary targets” of specific training, IEC, or advocacy activities.

Consistent with Togo's 1996 *Reproductive Health Policy and Standards* (République Togolaise, 1997b), the PNSJA distinguishes two specific subgroups of adolescents: those in school and those out of school. Among out-of-school adolescents, the PNSJA identified four additional criteria for differentiating the subgroups: occupation, sociocultural environment (rural versus urban), level of education, and age. The document stresses the need to take into account the heterogeneity among adolescents when designing strategies to improve their health status. Similarly, Cameroon's draft *National Adolescent Health Policy* (République du Cameroun, 1998b) has identified specific subgroups of adolescents: youth and adolescents in school, youth and adolescents out of school, and youth in “difficult circumstances” (e.g., moral danger or handicapped). Burkina Faso defined no specific adolescent subgroups.

NGO programs. While specific target groups of NGO programs are not always clearly defined, especially in Togo, programs generally target the adolescent and young adult population at large. In general, girls and boys, in-school and out-of-school youth, adolescents, and young adults are supposed to benefit from the programs. In Togo, most NGO ARH programs conduct their activities at national or regional levels. In Cameroon and Burkina Faso, however, the geographic scope of programs is narrower, with priority assigned to urban youth. In the latter countries, programs conduct their activities in one or two cities (generally the capital city).

More than one-half of the NGO programs analyzed (67%) for this report do not differentiate their activities across the subgroups of youth they target. The lack of differentiation is especially apparent in Burkina Faso, where no program has identified subgroups of adolescents; and in Togo, where only two of five programs target subgroups. In Cameroon, however, about one-half of the programs differentiate their activities according to subgroups. Age is the differentiation criterion most often used; it is a proxy for sexual activity. Thus, the distinction across age groups is, in effect, a distinction between adolescents who are sexually active and those who are not sexually active.

Reproductive Health Issues Addressed

Governmental policies/programs. None of the existing or pending national youth health programs specifically addresses reproductive health. All three policies/programs are concerned with adolescent health in general and specific issues such as alcohol, cigarette, and drug consumption; road accidents; suicide; and nutritional deficiencies. However, reproductive health is at the heart of the three policies/programs in that they recognize early pregnancy, unwanted pregnancy, induced abortion, and STIs and HIV/AIDS as pressing issues faced by adolescents. In Burkina Faso, FGM is also included in the list of identified ARH issues.

According to policy documents, policymakers determined the above programmatic priorities by drawing on existing data from demographic and health surveys (DHS), local surveys, the census, and other sources. Especially in the case of Burkina Faso and Togo, the policy documents also clearly acknowledge the influence of the ICPD agenda on defining issues in need of attention.

NGO programs. The majority of NGO programs also address more than one reproductive health issue. In fact, all programs but one address STIs and HIV/AIDS, and one-half of the NGO programs in Burkina Faso focus exclusively on STIs and HIV/AIDS. In addition, 75 and 67 percent of NGO programs, respectively, have identified unwanted pregnancies/abortions and early pregnancies as priorities. Responsible parenthood and gender equity on the other hand do not appear to be popular issues among programs. Only four ARH programs have included gender equity or sexual abuse on their agenda. FGM is another neglected topic in all three countries' NGO programs.

The methods used by program managers to define the reproductive health issues in need of attention vary from one country to the next. In Togo, program managers simply adopted the priorities either expressed by international organizations, such as the World Health Organization (WHO), or voiced at international meetings, such as the ICPD. Only two NGO programs used primary or secondary data in addition to the above sources to determine priority issues. In Cameroon, several program managers relied on the results of existing ARH surveys, the results of surveys conducted by four NGO programs, or the results of focus-group discussions among youth. Program managers in Cameroon also turned to informal feedback from the field. Overall, few program documents in Cameroon refer to the ICPD or other international meetings.

In Burkina Faso, no program has relied on existing surveys to define the reproductive health issues it addresses, but three programs have collected or plan to collect their own data. In 1996, for instance, ABBEF collaborated with the German Cooperation Agency (GTZ) and the Population Council to conduct a survey entitled *Identification of Adolescent-Specific Needs in the Area of Sexual Health*. Both the ABBEF and Population Council used the results to define their program priorities. Other program managers have used priorities expressed by international organizations (UNAIDS and UNFPA). Finally, the three youth associations that implemented STI/HIV/AIDS prevention programs in Burkina Faso (APES, APJAD, and AAS) defined or redefined the orientation of their programs based on the results of the National Forum on Adolescent Sexual and Reproductive Health, held in Burkina Faso in September 1997. Organized by the Ministry of Sports and Youth and sponsored by UNFPA and the Population Council, the forum brought together 150 youth associations and defined ARH priorities to be addressed in the future.

Program Objectives

Governmental programs. Togo's and Burkina Faso's national youth health programs have set both general and specific objectives and clear timelines. In Togo, for instance, the general aim of the National Adolescent Youth and Health Program is to "create a physical and socio-cultural environment favorable to the promotion of in-school and out-of-school youth and adolescents' health" (République Togolaise 1997b: 16). The program's four intermediate objectives are to

- Make the National Service for Youth Health operational by 2002 by implementing decentralized structures provided with adequate staff and equipment;
- Reduce adolescent morbidity and mortality caused by early sexual activity, STIs/HIV/AIDS, accidents, drug usage, or other risky behaviors among youth;
- Motivate youth and adolescents, communities, opinion leaders, and political and religious authorities to adopt favorable attitudes vis-à-vis the promotion of youth health; and

- Reinforce relations among all actors (ministries, NGOs, and associations) involved in the program in particular and in adolescent and youth health in general by implementing a formal structure to coordinate activities and objectives and standardize management tools throughout the program (République Togolaise, 1997b: 17–18).

While the program has set deadlines to achieve specific objectives, some deadlines are no longer feasible. For example, with its program still not adopted at the time of this research, Burkina Faso missed the 1998 and 1999 deadlines set by the National Youth Program for conducting several activities. In Cameroon, the *National Adolescent Health Policy* is still in draft form, with no specific objectives formulated. Its 16 general objectives, however, pertain to broad-based goals, such as “train adolescents for responsible management of their health problems at all levels,” “help adolescents and young adults to avoid unwanted pregnancies and STIs,” and “encourage healthy and responsible attitudes among adolescents” (République du Cameroun, 1998b).

NGO programs. The majority of NGO programs have established objectives that are not easy to quantify. Yet a few programs—only eight of 24—have formulated objectives that are specified in clear and precise terms. Such objectives are measurable and include timeframes. Too often, programs formulate objectives in the form of long-term goals or global statements, such as “fight against STIs/HIV/AIDS among youth” or “promote IEC activities in ARH.” In addition, stated goals frequently rely on vague terminology, such as “develop responsible sexual attitudes among youth” or “develop self-promotion activities.”

Implementation Plan

An important programming principle for the design of successful sexual and reproductive health programs for young people is “[t]o make the most of what exists” (Hughes and McCauley, 1998). The three national youth policies/programs and most of the NGOs analyzed in this report follow that principle and use structures already in place to implement their ARH programs. Two other important elements of an implementation plan that are considered below are the scope of planned activities and the availability of monetary, material, and human resources.

Scope of Activities

Governmental policies/programs. The three national youth health programs have outlined a broad scope of activities for implementing their objectives; overall, the program plans are ambitious. Reproductive health activities include IEC and advocacy, provision of reproductive health services by reinforcing the existing health infrastructure, the training of health personnel, research activities, and political and legal actions that support adolescent health.

The three national youth health policies/programs stress the importance of changing the general public’s attitude toward adolescent health and promoting favorable behaviors through IEC activities. In Cameroon, for instance, policy objectives include “create messages for the public to promote a liberal but responsible attitude vis-à-vis youth sexuality,” “sensitize national community on taboos, beliefs and traditions that are harmful to youth health,” and “sensitize political and religious leaders and authority figures to health problems specific to youth” (République du Cameroun, 1998b). In Togo, the one program objective is to “encourage youth and adolescents, communities, opinion leaders, [and] political and religious authorities to adopt favorable attitudes vis-à-vis the promotion of youth health” (République Togolaise, 1997b). In Burkina Faso, the National Youth Health Program (Kangoyé and Kaboré, 1998) aims at “increasing the level of knowledge about youth health among

target groups in order to encourage favorable behaviors vis-à-vis youth health.” In support of its objective, Burkina Faso is planning a wide range of IEC and advocacy activities, including the production of materials (posters, brochures, t-shirts, and so forth), delivery of information sessions for social workers and parents, promotion of discussions and debates among parents and adolescents, development and delivery of radio shows and plays, and IEC for the general public.

In addition to IEC and advocacy, the three policies/programs have recognized the need to increase and improve access to health services for adolescents and young adults. In Burkina Faso, the first objective of the National Youth Health Program is to “increase the accessibility of health services,” and the second is to “offer quality services in health structures.” In Cameroon, the *National Adolescent Health Policy* is intended to “promote the access of adolescents to adequate care services.” In Togo, the objective is to “make available adequate structures and resources for the provision of quality health services targeted at youth.” To achieve these objectives, the strategy of the PNSJA in Togo is to provide adequate equipment and medicine (including contraceptives), to train health personnel in existing health structures to be more “youth-sensitive,” and to create new health units in schools and three health centers in prefectures. Similarly, the Burkina Faso program is working to ensure that 10 percent of existing basic health and referring structures offer reproductive health services to adolescents and young adults, infirmaries are open in schools, existing youth centers are outfitted with augmented equipment, and health practitioners receive additional training. In Cameroon, the descriptions of the activities aimed at improving the provision of health services to youth are less specific (e.g., screening, health care, and counseling activities).

The three policy/program documents also emphasize the need to conduct research activities on ARH. The Burkinabé Youth Health Program stresses the need to “promote research in various domains of adolescent health and nutrition.” Togo plans a national knowledge, attitudes, and practice (KAP) survey on youth health among adolescents and young adults, parents, teachers, opinion leaders, political and religious authorities, and health providers. While no details are available on the content of the research to be conducted in Cameroon, the *National Adolescent Health Policy* calls for operations research activities.

Finally, the three countries’ policy/program documents mention the revision and dissemination of legal texts relative to adolescent health. One of the objectives of the Burkinabé National Youth Health Program is to create a legal environment favorable to youth health, which involves the evaluation and revision of existing legal texts on youth health and the dissemination of legal provisions at various levels of the health service system. Cameroon recognizes the need to “revise the existing legal texts and to elaborate a legal framework adapted to adolescent and young adult’s health.” Togo plans to propose “new legal texts in favor of youth health.”

NGO programs. In the scope of activities among NGO ARH programs, IEC dominates. Peer education, educational discussions among youth, educational movies, plays and/or radio shows are the most common IEC strategies for reaching youth. In Cameroon, the majority of programs include IEC activities for parents and/or community leaders (educational discussions and debates among parents and adolescents) as well as counseling activities (often cited in documents but rarely defined clearly). About one-half of the programs produce IEC materials (t-shirts, caps, posters, or educational brochures or pamphlets) or run small information and counseling centers. In Burkina Faso, the range of IEC activities is narrower and, for the most part, consists of peer educator programs and educational movies, radio shows, or plays. In Togo, FLE is part of the IEC activities in the majority of programs, along with peer education and educational discussions.

While IEC activities are common in ARH programs in Burkina Faso, Cameroon, and Togo, few programs—only 10 of 25—provide reproductive health services to youth, and the majority of

programs that distribute or sell condoms to youth generally do so through their peer-educator programs. Only five programs have opened or plan to open clinics or health centers for adolescents where reproductive health services, such as gynecologic examinations, pregnancy tests, STI screening, and contraceptives, are or will be provided. Among those, the three programs initiated by the local representatives of IPPF (CAMNAFAW in Cameroon, ABBEF in Burkina Faso, and ATBEF in Togo) are the most significant. In Burkina Faso, the two youth centers opened by the ABBEF in Ouagadougou and Bobo-Dioulasso are viewed as model NGO programs.

Finally, operations or programmatic research is a marginal activity for the three countries' NGO ARH programs. While seven programs have used primary data to define the reproductive health problems they will address, their research activities are limited and only two NGOs (Centre Muraz in Burkina Faso and Horizon Jeunes in Cameroon) have developed a clear and well-developed operations research component and have used or plan to use research for program evaluation purposes. In both cases, local research institutions that are partners in the programs conduct the research activities.

Financial and Human Resources

Governmental policies/programs. Lack of adequate funding has been a critical issue in the implementation of the PNSJA in Togo. According to interviews conducted with representatives of the Ministry of Health, human resources were adequate for program implementation, but insufficient funds caused postponement of the program launch; as a result, only few of the planned activities have been conducted thus far. The sections of the documents devoted to financing the National Youth Health Program in Burkina Faso and the *National Adolescent Health Policy* in Cameroon are brief. In Cameroon, the documents mention international organizations and bilateral and multilateral cooperation as potential financing sources. In Burkina Faso, while the necessary human and financial resources have been identified and a budget presented, the documents provide no information on funding sources.

NGO programs. As mentioned, all but three programs are totally or partially funded by an international agency, thus confirming the crucial role of international organizations in the creation of NGO ARH programs. UNFPA, for instance, is a major source of international funding for NGO as well as governmental initiatives in ARH. One of the objectives of the UNFPA country programs in Cameroon (1998–2002), Burkina Faso (1997–2000), and Togo is to support programs promoting IEC and FLE, reproductive health services, and youth centers. In fact, three programs out of 11 in Cameroon, two out of eight programs in Burkina Faso, and one program in Togo receive partial or full funding from UNFPA. Other international organizations that have participated in the funding of the NGO programs in the three countries include the World Bank, USAID, GTZ, IPPF, United Nations Children's Fund (UNICEF), Red Cross, Alliance International, CARE International, United Nations Educational, Scientific, and Cultural Organization (UNESCO), and WHO.

While the vast majority of program managers believe that the necessary human resources are available for adequately implementing their ARH programs, fewer can point to the availability of financial resources. In fact, only one-half of program managers interviewed for this paper believe that the funding sources for their programs are stable. Programs initiated by youth associations are more likely to encounter funding problems than programs initiated by larger NGOs. In fact, all five of the youth association leaders interviewed for this report mentioned that the funding sources for the implementation of their programs were unstable.

Monitoring and Evaluation Plan

Ensuring that monitoring and evaluation elements are in place at program start-up is important to help document policy and program success and to identify aspects of policies and programs that require formulating or strengthening. Monitoring and evaluation results identify whether and how youth policies and programs are working, and if policies and programs are exerting their intended influence.

Monitoring

Government documents. The assessment examined whether program documents or program managers specified or described monitoring methods and performance indicators. It also examined whether indicators were concrete and pertinent in relation to program objectives. As mentioned, the national youth health programs elaborated in Burkina Faso and Togo have set forth both general and specific objectives as well as specific activities to achieve those objectives. For each specific objective and activity, the programs specify performance indicators referred to in Burkina Faso and Togo, respectively, as “results indicators” and “implementation indicators.” The draft version of Cameroon’s *National Adolescent Health Policy* does not specify performance indicators.

Table 2 presents examples of indicators and monitoring methods for Burkina Faso; Table 3 presents the same for Togo.

Table 2
Examples of Specific Objectives, Indicators, and Monitoring Methods
Included in Burkina Faso’s National Youth Health Program

Specific Objectives	Results Indicators	Monitoring Methods
<i>Specific Objective 1:</i> Increase youth’s physical and economic access to health services	<ul style="list-style-type: none"> ▪ Reduction of geographic range to be covered by health units ▪ Reduction in the price of health services and products 	<ul style="list-style-type: none"> ▪ Health statistics ▪ Surveys among adolescents ▪ Accounting documents
<i>Specific Objective 2:</i> Offer high-quality services in health structures	<ul style="list-style-type: none"> ▪ Availability of high-quality services in health structures ▪ Greater use of health services by youth 	<ul style="list-style-type: none"> ▪ Survey among youth ▪ Activity reports
<i>Specific Objective 3:</i> Increase the level of knowledge of various target groups about adolescent health in order to promote behaviors favorable to adolescent health	<ul style="list-style-type: none"> ▪ Knowledge among different target groups of the causes of and ways to prevent youth health problems ▪ Adoption by target groups of positive youth health behaviors 	<ul style="list-style-type: none"> ▪ KAP survey among target groups ▪ Final evaluation ▪ Analysis of youth health indicators
Activities	Implementation Indicators	Monitoring Methods
By 2000, open a new youth center in each of the nine health regions that do not have one (three centers per year)	<ul style="list-style-type: none"> ▪ Number of health regions with a youth center 	<ul style="list-style-type: none"> ▪ Report from DSF ▪ Visit to centers
By 2002, complete five operations research studies on ARH	<ul style="list-style-type: none"> ▪ Research conducted 	<ul style="list-style-type: none"> ▪ Activity report from DSF
Implement “youth-friendly” service hours in health centers in schools and youth centers	<ul style="list-style-type: none"> ▪ Youth-friendly service hours implemented 	<ul style="list-style-type: none"> ▪ Activity reports

Source: Burkina Faso, 1998: 62, 67, 71

Table 3
Selected Activities and Monitoring Indicators Included in Togo's
National Youth and Adolescent Health Program

Activities	Monitoring Indicators
Each year, train nine intermediary managerial staff in public health at WHO-Lomé for the regional units of the National Service	Number of managerial staff actually trained divided by number of managerial staff scheduled to be trained
Rent and equip three houses to serve as youth health centers in each préfecture	Number of houses rented and equipped divided by planned number of equipped houses
Formulate and adopt legal texts regarding the creation of a health insurance system for youth	Legal texts adopted
Supply 75 school infirmaries with essential medicine and contraceptives	Number of infirmaries supplied with essential medicine and contraceptive over planned number of supplied infirmaries

Source: République Togolaise, 1997b: 23–25, 27)

NGO documents. Most NGO program descriptions (80%) also include performance indicators, but they are not always pertinent to specific program objectives. “Opening a new center for youth” is a concrete indicator but does not measure the efficiency of a youth program. Similarly, “the impact of the program on national indicators” and “the evolution of number of program participants” may be pertinent measures of program performance; however, neither is sufficiently precise to serve as a concrete indicator. Less than one-half of the programs include concrete and pertinent performance indicators. Correspondingly, those programs that have set forth clear indicators have also set out clear and precise objectives, including timeframes.

For all three countries, the description of monitoring methods either provided by managers or noted in program documents is brief. Few programs provide a clear and detailed description of their monitoring plan (e.g., methods used, frequency, and person responsible for monitoring activities). The most frequently cited monitoring methods are periodic visits to the field, periodic reports (activity reports from supervisors, coordinators, or peer educators), and meetings.

Evaluation

Governmental programs. All of the documents describing the three national youth programs include an evaluation plan, although none of the programs had undergone an evaluation at the time of this research. At this point in program development, the documents include only general guidelines for evaluation, and the sections devoted to evaluation are brief. In Togo, for instance, the document provides guidelines for evaluation but offers little discussion of evaluation program needs. The program states,

The evaluation will focus on the availability of human, material, and financial resources, the management of those resources, whether or not the activity schedule is met, and the expected results. Evaluation indicators will be elaborated for each program activity. The evaluation should be conducted every two years by all persons involved in the program. The head of the program is responsible for the evaluation and can solicit the services of an external evaluator. Evaluation results will be used to modify the program activities (République Togolaise, 1997b: 20).

In Burkina Faso, one of the specific objectives of the National Youth Health Program is to “develop a monitoring and evaluation mechanism for program activities” (Kangoyé and Kaboré, 1998: 63). Of the two evaluations planned for Burkina Faso’s program, the first will be “a midterm evaluation during the second year of the program to be conducted with the support of external consultants and based on existing program information and field visits. The purpose of this first evaluation is to verify the strategies used, the adequacy of the activity and the program performance in order to take corrective measures if necessary.” The second and final evaluation “will use the same evaluation tools as the midterm evaluation adding a KAP survey among target groups to evaluate the efficiency, pertinence, and impact of the program” (Kangoyé and Kaboré, 1998: 61). Finally, Cameroon devotes only two lines of the program document to discussing an evaluation, which “should be made internally by the person in charge of activity monitoring in each governmental division involved in the program implementation” (République du Cameroun, 1998b: 19).

NGO programs. Nearly three-quarters of NGO programs in the three countries plan to undertake an evaluation. As with the monitoring methods, however, program managers or program documents provide few details regarding the content or mode of the evaluations. Less than one-half of the programs—11 out of 24—had undergone evaluation at the time of this research.³ For those programs, evaluations typically coincided with one of the following events: the end of a pilot program, the beginning of a new program phase, a midterm review, or, in most cases, a more informal periodic evaluation. Of the 11 programs evaluated, three were evaluated internally, four used external evaluators (either an individual from the funding agency or independent consultants), and four used both internal and external evaluators.

Periodic evaluation was the most common type of evaluation and generally consisted of reviewing the progress of program activities and evaluating whether the short-term process goals had been met. Indicators included the number of peer educators trained, the number of adolescents and young adults visited by peer educators, and the number of youth who visited the health center. Three midterm or final evaluations of pilot projects also tried to measure program success in changing adolescent ARH behaviors and attitudes. Such evaluations conducted surveys among target groups and often required a pre- and post-intervention research design. The pilot project, Horizon Jeunes, implemented by the social marketing program (PMSC) in Cameroon, for instance, used various attitude and behavior indicators to measure the effectiveness of the youth-targeted program. Indicators included knowledge of STI symptoms, knowledge of family planning methods, reported sexual activity with more than one partner, and reported condom use with a nonregular sexual partner.

Level of Coordination and Collaboration

Coordination and collaboration of governmental and nongovernmental efforts in ARH are critical, particularly because nongovernmental organizations tend to play a vital role in providing ARH information and services. Thus, the assessment considered the number of partners involved in each program, their roles, and the level of coordination among programs.

Coordination and collaboration among public and private actors. All three government documents stress the importance of coordination and collaboration among public and private actors dedicated to advancing youth health. In Burkina Faso, one specific objective is to “create an institutional framework to implement the youth health program at all levels of the Ministry of Health (central, intermediary, and peripheral) in collaboration with other youth programs” (Kangoyé and Kaboré, 1998: 63). In Cameroon, although the draft version of the *National Adolescent Health Policy*

³ Five programs were evaluated in 1999, five in 1998, and one 1996.

lists NGOs and national and international agencies as the main participants in policy implementation, it fails to acknowledge the importance of coordination and collaboration in policy implementation and does not specify coordination and collaboration in its policy objectives. The situation in Togo is similar to that in Burkina Faso in that one of the National Youth Health Program objectives is to “reinforce relations among actors working in youth health (ministries, NGOs, associations) by implementing a formal structure for the coordination of activities and objectives and the standardization of management tools” (République Togolaise, 1997b: 18). Activities recommended to achieve the coordination objective include a national and regional inventory of all actors working in the area of youth health; a yearly national workshop for government representatives, NGOs, associations, and funding agencies; and formation of a committee for the advancement of standard management tools (e.g., for data collection, monitoring, and evaluation).

While the policy/program documents of all three countries generally stress the need for coordination of public efforts across various ministries or across different sections of the same ministry, they make no specific references to such coordination. For instance, Burkina Faso’s National Youth Health Program makes no mention of the objectives of the new NPP and PAPII regarding youth health. Similarly, Cameroon’s and Togo’s policy and program documents do not identify previous or ongoing ARH initiatives.

NGO views on collaboration with government. NGO managers frequently cited the government and its ministries, or more generically the “civil services,” as partners in the formulation and implementation of their programs. The level of partnership varies by country, however. In Burkina Faso, all NGO programs officially involve the government as a partner. The government partners most often cited by NGO programs are governmental programs for AIDS prevention, such as the Comité National de Lutte contre le SIDA (CNLS) and Projet Population et Lutte contre le SIDA (PPLS). Other participating governmental bodies include the Ministry of Health, the DSF, and the Ministry of Youth. NGO programs funded by UNFPA and initiated in the context of the UNFPA country program from 1997–2000, for instance, are coordinated with other governmental initiatives through the DSF. While program managers or program documents cite ministries as partners, they rarely specify a partner’s role and the nature of the partnership, making it difficult to determine the level of collaboration.

In Cameroon, where less than one-half of NGO programs analyzed for this report have government partners, managers often describe the role of government partners in vague terms such as technical support, administrative support, support in personnel and structures, or even “moral caution.” Even when programs have signed a draft agreement with the Ministry of Health before initiating their activities, the involvement of the ministry is minimal and often amounts to the presence of a governmental official during public IEC events or ceremonies.

In Togo, all NGO programs but one involve a partnership with the government. Except for the program initiated by UNICEF on girls’ education, which was described in detail and is being implemented in close collaboration with the Ministry of National Education and Scientific Research and the Ministry for the Promotion of Women, collaboration with the government seems to consist mainly of noting the involvement of government offices or the occasional presence of government personnel at events.

Coordination among NGOs. The level of declared collaboration among local NGOs implementing ARH programs is relatively high in the three countries: 63 percent of programs involved several NGOs. Such collaborations are both pragmatic and convenient but rarely formalized. Instead, collaborations usually take the form of exchange of expertise or educational material, consultancy services, technical support, or support in the field for specific activities. Actual

coordination among programs is low in the three countries. Some program managers interviewed in Togo, for instance, mentioned the existence of informal coordination or of collaboration without real coordination.

Local research institutes are not typical partners in NGO programs in the three countries. While some programs have defined adolescent needs by relying on primary data collected by research institutes, few have established a formal partnership with a local research institute.

Steps to increase collaboration. NGOs have taken important steps to increase the level of collaboration among ARH initiatives. In Burkina Faso, a dissemination seminar on the results of an operations research effort on ARH catalyzed the development of a national network of youth associations working in ARH. Formed in 1997, the network is called RENAJEP/SR. It finalized its action plan following the National Forum on Adolescent Sexual and Reproductive Health, held in Burkina Faso in September 1997. The main objectives of RENAJEP/SR are to provide youth organizations with national, regional, and provincial coordination structures and with a national reference framework (the National Plan of Action in ARH) for all their ARH activities. For example, RENAJEP/SR coordinates the IEC programs implemented by APJAD, APES, and AAS for STIs/AIDS at the national, regional, provincial levels.

Cameroon is marked by a lack of formal collaboration among NGOs, as noted during an advocacy seminar that took place in Yaoundé in March 1999. The seminar, however, spurred the development of a network of NGOs and associations working in the area of health. Called ROSACAM, the network was created in May 1999. According to the official registration documents, the objectives of ROSACAM are “to create a framework of collaboration and dialogue for the integration of its members, elaborate some minimal common programs of action, and facilitate the connection of members with national and international organizations working in the area of health.” Although ROSACAM does not focus on NGOs working in ARH, it represents a promising attempt to increase collaboration among ARH programs in Cameroon. In the same vein, a ministerial decision dated April 14, 1999, detailed a legal framework for collaboration between the Ministry of Health, associations, and NGOs working in the domain of health. The decision allows for the official registration of each association that wants to collaborate with the Ministry of Health and benefit from the support of national health structures. Once registered, an association needs to identify projects each year that will work in collaboration with the ministry. The association then produces annual reports of activities.

Level of Youth Involvement

The 1994 ICPD stressed the need for stakeholder participation in designing and implementing reproductive health policies and programs. Involving youth in policies and programs to meet their needs is part of the trend in expanded stakeholder participation. The assessment examined the level and nature of youth involvement at each stage of the policy/program design process (formulation, implementation plan, and evaluation and monitoring plan) and distinguished between direct and indirect modes of involvement.

Mention of youth involvement in policy documents. Not all government documents identify youth involvement as a part of their program. However, where it is lacking, government representatives have orally identified youth involvement as important. In Burkina Faso, the policy document reads, “In this program, youth involvement, from elaboration until evaluation, is a

necessity” (p. 39). The document provides no further detail on how youth will be involved in the formulation, implementation, and evaluation of the program.

In Cameroon, the involvement of youth in the existing structures is part of the *National Adolescent Health Policy*'s global strategy. However, the description of the mode of youth involvement in the “structures” is vague. For example, descriptions such as “organization of adolescent movements,” “promotion of youth clubs by youth,” and “reinforcement of dialogue structures” (République du Cameroun, 1998b) are imprecise.

In Togo, the PNSJA document does not mention youth involvement. However, a representative of the Ministry of Health stated in interviews that youth organizations had been invited to national workshops to discuss program content.

Youth involvement in NGO programs. Results show that the majority of NGO program managers in the three countries (72 percent) said that youth were involved when the reproductive health issues and program objectives were defined. Nonetheless, the analysis of the interviews and program documents shows that, overall, such involvement was indirect. In Cameroon and Togo, programs that involved youth at the formulation stage—eight of 11 and three of five programs, respectively—relied on surveys conducted among youth, qualitative or quantitative surveys conducted among target groups, and informal feedback from the field.

In Burkina Faso, six program managers of eight declared that youth were directly involved during the formulation stage. One reason for the contrast between Burkina Faso and the other two countries is that youth associations in Burkina Faso run more programs than do youth organizations in Cameroon and Togo. In addition, as noted above, several national forums or events (e.g., the National Forum on Adolescent Sexual and Reproductive Health and the national week for the dissemination of results of research on sexual and reproductive health) have helped define national priorities in reproductive health and have called for the direct involvement of youth representatives in program development.

Youth involvement in evaluation. Only four of the 11 programs that have been evaluated for this report involved youth in their evaluation. For these four programs, youth involvement consisted of a “post-intervention survey” conducted among adolescent programs users (two programs), informal feedback from the field (one program), or youth representatives serving as participants on the evaluation team (one program).

In all three countries, members of youth organizations that have implemented ARH programs were asked if members of other organizations had requested them to provide any assistance to program managers in the development, implementation, or evaluation of those other organizations' programs. All five representatives of youth associations answered that the organizations had solicited their input at some point. Their involvement, however, consisted mainly of participation in meetings and forums (such as the National Forum in Adolescent Sexual and Reproductive Health in Burkina Faso or the World Forum of Youth in Vienna in 1995) or of informal involvement in the implementation of specific events.

Conclusion

Providing adolescents and young people with reproductive health information and services constitutes a vital component of the 1994 ICPD *Programme of Action*. Ensuring that policies and programs are designed appropriately to meet the reproductive needs of adolescents and young people is critical. This paper presents a policy tool to review ARH policy and program documents—a first step in assessing the implementation of policies and programs.

The framework (Figure 1) developed to assess ARH policy and program developments in Burkina Faso, Cameroon, and Togo identified six key elements as follows:

- Political recognition and will
- Policy and program formulation
- Implementation plan
- Monitoring and evaluation plan
- Coordination and cooperation
- Youth involvement

Based on the application of the assessment framework, the comparative analysis in Burkina Faso, Cameroon, and Togo revealed several achievements and challenges associated their ARH policies and programs.

Political Recognition and Will

Achievements: Since the 1994 ICPD, the three countries have clearly recognized adolescents and young adults as a target group within their national population, health, AIDS, FLE, and FGM policies and programs. Burkina Faso and Cameroon are developing specific national youth health policies, and Togo has already adopted such a policy. To ensure a focus on national health activities for youth, the Ministries of Health in Burkina Faso and Togo have established special youth health units. Government documents address several important reproductive health issues affecting youth, including early pregnancies, unwanted pregnancies, induced abortion, STI/HIV/AIDS, and FGM. They also note the lack of adequate and accessible services for adolescents.

Challenges: The fact that several government documents had not been approved at the time of this research raises some doubts about the political will to address ARH issues.

Formulation of ARH Policies and Programs

Achievements: Several NGO and youth associations have actively promoted ARH, and NGOs have developed ARH programs in each of the three countries. Government documents in Cameroon and Togo and some NGO documents in Cameroon acknowledge that adolescents do not constitute a single, homogeneous group and that youth from various groups have different reproductive health needs. This recognition has positively influenced the design of reproductive health activities aimed at youth. Program documents refer to boys and girls, to in-school and out-of-school youth, and to various age groups.

Challenges: The development of clear national guidelines for ARH that reflect the ICPD agenda has proceeded slowly, particularly in Cameroon. Even in Burkina Faso, where the government has been extremely proactive in formulating new policy and program documents reflecting the ICPD agenda on ARH, several important documents, including the National Youth Health Program, have yet to be ratified. Staff turnover within the Ministry of Health has also hampered official adoption of the program.

Some national policies in Cameroon and Togo take contradictory stances on adolescents. Togo's 1998 NPP, which is a reference document for policy development, identifies only early childbearing as an ARH issue and limits the provision of ARH services to promotion of family life education. Such an orientation is not congruent with the government's position on ARH as expressed in the *Reproductive Health Policy and Standards* and the National Youth Health Program. Similar contradictions exist in Cameroon among the DPNP, the MCH/PH policy, and the *National Plan to Combat AIDS*, which emphasize provision of information, and the *National Adolescent Health Policy*, which emphasizes the need for access to services.

Implementation Plan

Achievements: The scope of reproductive health activities planned by the three national youth policy/programs is broad and includes a wide array of IEC activities and the provision of reproductive health services. All NGO programs have wide-ranging IEC components, thereby increasing the chances of effectively reaching the adolescent and youth populations of the three countries. Program documents list the revision and dissemination of laws related to ARH as important policy endeavors. Program documents also list a range of recommended research topics.

All three governments and most NGO programs typically use their existing program structures to deliver ARH programs to adolescents and youth. Most government officials and NGO program managers believe that they command adequate human resources to implement their ARH programs.

Challenges: Despite the initiation of several NGO programs in ARH in the three countries, the geographic coverage of NGO programs remains limited, especially in Burkina Faso and Cameroon. Few NGOs have implemented activities at the national level, and most existing activities focus on urban areas, often the capital city. Furthermore, target groups are ill defined in NGO documents in Burkina Faso and Togo. NGO programs, particularly those in Burkina Faso and Togo, tend to undergo development without consideration of the needs of young people. Overall, the links between NGOs and local research institutes are weak in the three countries, and few programs specify a clear operations research component or call for establishing a formal partnership with local research institutes.

Gender equity issues, FGM, and responsible parenthood are acute social and cultural problems facing youth in the three countries. Yet, NGO programs rarely address these pressing social issues. While national programs pay some attention to these matters, the activities planned by national youth health programs fail to place sufficient stress on gender equality, an overriding principle of the ICPD *Programme of Action*; further, the definition of target groups does not account for gender.

Few NGO programs, with the exception of those that are part of larger international initiatives, have set forth clear objectives and implementation plans. National policies/programs, on

the other hand, tend to spell out specific objectives. The exception is Cameroon's *National Adolescent Health Policy*, which, at the time of this research, was still in draft form and had established its objectives in only general terms. Some of its national policy/program objectives are pegged to deadlines that are no longer feasible.

The NGO programs in the three countries focus on IEC such that the provision of reproductive health services remains relatively neglected. Where reproductive health services are in place, they generally amount to the distribution of free or subsidized condoms. Only five NGO programs in the three countries have opened or plan to open clinics or health centers for adolescents, and they are generally slated to be located in cities.

Both government and NGO program managers noted that they face financial resource constraints. In Togo, where the government has adopted the National Youth Health Program, lack of adequate funding seems to be a major obstacle to program implementation, and only a few planned activities were operating at the time of this research. The dependence of local programs on international funding jeopardizes their sustainability.

Monitoring and Evaluation Plan

Achievements: All of the documents describing the three national youth programs include an evaluation plan, although none of the programs had undergone evaluation at the time of this research. The national youth health programs elaborated in Burkina Faso and Togo have set performance indicators.

Challenges: Actual monitoring and evaluation of ARH programs—both governmental and NGO—tends to be nonexistent (e.g., Burkina Faso) or rudimentary. Monitoring and evaluation of programs is crucial to determining program success or the need for readjustment.

Level of Coordination and Cooperation

Achievements: One primary objective of ARH programs in the three countries is to increase and improve the level of coordination and collaboration among private and public actors in reproductive health and among various levels of the relevant ministries. Local NGOs collaborate well informally in the three countries, and some efforts are underway to establish more formal systems for collaboration, such as through the creation of NGO and association networks in Cameroon and Burkina Faso.

Challenges: Overall, while all three youth policy/program documents stress the need for coordination of public efforts across various ministries or across different sections of the same ministry, the same documents' lack of reference to other policies or programs is striking and suggests that both the definition and level of coordination need to be improved.

Despite a high level of informal collaboration among NGOs working in the ARH sector in Cameroon and Togo and the newly created NGO association network ROSACAM in Cameroon, the formal coordination among NGO programs in the two countries remains weak. In Burkina Faso, the NGO association/network RENAJEP/SR seems to be improving the level of coordination among NGO programs, although RENAJEP/SR has provided few details regarding its coordination mechanisms. The picture of collaboration between the public and private sectors in the domain of

ARH looks the same. The level of “declared” collaboration is relatively high, especially in Burkina Faso and Togo, but actual coordination between the public and private sector organizations working on ARH is low (Cameroon and Togo) or expressed in vague terms (Burkina Faso).

Level of Youth Involvement

Achievements: All three national programs recognize the importance of involving youth in the design, implementation, and evaluation of national youth programs.

Challenges: At the governmental level, while the three programs acknowledge the importance of involving youth in the design, implementation, and monitoring of national youth programs, the mode of achieving youth involvement is not clearly described. Although NGOs express youth involvement in program development and evaluation as an ideal, such involvement remains indirect, especially in Cameroon and Togo. Local youth organizations have been called upon mainly to attend meetings and forums or to participate in specific events.

Overall, the comparative analysis reveals that while the three countries have made progress since the ICPD in addressing the reproductive health needs of adolescents, much work remains to be done. This assessment framework was useful in giving structure to the analysis. The comparative analysis has set a benchmark against which future policy and program development and action in the three countries can be measured. The reasons underlying the very slow process of developing and adopting policy and program documents demand further investigation. Information on factors affecting the adoption of (or lack of) policies and programs would be useful to include in future assessments. Future assessments would also benefit from obtaining information on the political and social context in which ARH policies and programs are developed, including opposition to providing information and services for adolescents and advocacy for ARH. This policy tool can be applied in other geographic settings to gain greater understanding of ARH policy and program development.

Appendix: Main NGO Programs in ARH in Burkina Faso, Cameroon, and Togo

Executing Agencies (acronyms)	Organization Type	Program Name/Title
Burkina Faso		
ABBEF	NGO	Centres Jeunes pour Jeunes
Population Council	International	Projet 1000 Jeunes Filles
Initiative Privée Communautaire de Lutte contre le SIDA (IPC)	NGO	Appui technique et financier aux associations de lutte contre le SIDA
Centre Muraz/ Organisation de Coopération Contre les Grandes Endémies (OCCGE)	NGO	MST et VIH/SIDA chez les jeunes et dans la population générale de Bobo-Dioulasso
PROMACO	NGO	Projet de Marketing Social du Condoms
APJAD	Youth	IEC en MST/SIDA et PF avec animateurs relais
AAS	Youth	Activités d'IEC en MST/SIDA
APES	Youth	Activités d'IEC en MST/SIDA et PF
Cameroon		
PMSC	NGO	Horizon Jeunes
Youth Development Foundation (YDF)	Youth	Jeunes pour Jeunes
Femmes-Santé-Développement en Afrique Sub-Saharienne (FESADE)	NGO	Sexual education of adolescents
Organisation des Femmes pour la Sécurité Alimentaire et le Développement (OFSAD)	NGO	Sexual education of adolescents in a familial context
Service Catholique de Santé (SCS)	NGO	Éducation à la vie et à l'amour (EVA)
CAMNAFAW	NGO	Programme d'IEC jeunes
Scouts of Cameroon	NGO	Mobilisation des jeunes en SRA
Centre d'Animation Sociale et Sanitaire (CASS)	NGO	Éducation des jeunes
Cameroonian Red Cross	NGO	Éducation à la parenté responsable
Association Camerounaise pour la Santé des Adolescents (CSA)	NGO	Formation des pairs conseillers
Association de Lutte contre les Violences faites aux Femmes (ALVF)	NGO	Santé reproductive des femmes et des adolescentes
Togo		
UNICEF	International	Programme Éducation de Base des Filles
Croix Rouge Togolaise	NGO	Programme SIDA et MST « Agir avec les Jeunes »
Association Culturelle de Promotion et de Protection des Droits de l'Enfant et d'Éducation au Développement (ARC EN CIEL)	NGO	Programme d'Éducation à la Prévention des MST/SIDA
Clubs UNESCO	Youth	Programme Permanent d'Information, d'Éducation et de Communication en Santé Reproductive
ATBF	NGO	Prise en charge des besoins des jeunes en santé sexuelle et de la reproduction

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