

## **Communication for the Promotion of Sexual Reproductive Health and family planning in Côte d'Ivoire**

**Bassémory KONE**

University Félix Houphouët-Boigny, Abidjan-Côte d'Ivoire UFR Information,  
Communication and Arts, Department of Communication  
[konebassemory@gmail.com](mailto:konebassemory@gmail.com)

### **Abstract**

The present study aims to examine the attitudes and behaviors of populations towards Sexual Health and Reproduction / Family Planning (SRH / FP) with a view to identifying the main barriers that hinder decision-making favorable to SRH / FP and the factors associated with the low use of SRH / FP services. In Côte d'Ivoire, initiatives are helping to inform and create demand for SRH services among the population. But the fact is that the field of SRH / FP is marked by a very slow improvement of the indicators despite the efforts of the government and all of its technical and financial partners. Maternal mortality estimated at 614 deaths per 100,000 live births remains a concern, contraceptive prevalence of 14% is relatively low with a high rate of unmet need estimated at 27%. Although communication initiatives are being undertaken, the study found that traditional stereotypes, cultural beliefs and practices regarding women's social roles persist. These include, early marriages and excision, the belief that it is God who gives children and the persistence of the woman's perception of her reproductive function. In addition, the absence of law on SRH / FP, the asymmetry of information at the level of providers on SRH / FP, the frequent breaks in stocks and the geographical distribution of products the main structural problems identified. For a better SRH / FP, it is essential to build capacities of services SRH / FP, promote the promotion of the access to the care and the fight against the socio-cultural barriers. Therefore it is fundamental for a better appropriation of SRH / FP and its prioritization at all levels that the communication plan initiated by the National Mother Child Health Program at the end of its different activities is subject to validation, involving all stakeholders in the field.

**Keywords:** Communication, Promotion, Sexual reproductive health, Family planning

## 1. INTRODUCTION

One of the central issues of development is the achievement of the demographic dividend, ie the acceleration of economic growth that results from changes in the age structure of the population due to the consequent decline in the population. This necessarily requires sustained communication on sexual reproductive health / family planning (SRH / FP), which is often perceived as taboo. However, SRH / FP is not just the right of individuals and couples to family planning (UNFPA,). But it is the right to reach the highest standard of sexual reproductive health. It includes their right to make decisions regarding reproduction without discrimination, coercion and violence. For example, the 2012 London Family Planning Summit aims to ensure better access to modern contraception for an additional 120 million women and girls worldwide by 2020. In Côte d'Ivoire, initiatives contribute to informing and creating the demand for SRH services among populations. However, despite the existence of the National Strategic Plan for Reproductive Health (PSNSR), the field of SRH / FP is marked by a very slow improvement in indicators despite the efforts of the Government and all its technical and financial partners. Maternal mortality estimated at 614 deaths per 100,000 live births remains a concern, contraceptive prevalence of 14% is relatively low with a high rate of unmet need estimated at 27%. Why do not people adopt the desired SRH / FP behaviors in Côte d'Ivoire? What are the main barriers to achieving a client-centered SRH / FP? Answering these questions necessarily involves defining a theoretical and methodological framework, the content of which is explained below.

## 2. MATERIALS AND METHODS

### Reference theories

The study aims to examine the attitudes and behaviors of populations towards SRH / FP with a view to identifying the main barriers that hinder decision-making in favor of SRH / FP and factors associated with low utilization of SRH / FP services. The conduct of the various analyzes was made with reference to the theory of planned behavior and the theory of decision. In addition to being decided, three types of factors are necessary: Judgments on the desirability of the behavior and its consequences, considerations on the influence and the opinion of the relatives on the behavior related to the social norms; Beliefs about the subject's ability to perform the behavior ie self-efficacy. Attitudes towards SRH / FP and SRH / FP products, the influence of the applicant's relatives, self-efficacy. To do this, it is necessary to present to the population the benefits of FP, to present the various forms of implementation of SSR / FP and especially to propose a realistic framework of a set of behaviors and practices useful for achieve a good PF. The theory of planned behavior follows the Theory of reasoned action (Fishbein and Ajzen: 1975) in its quest for an explanation of the relationship between attitude and behavior in human action. It turns out that the individual's decision to engage in a particular behavior is based on the results that the individual hopes to achieve as a result of the behavior. Therefore, the intention to perform a certain behavior precedes the actual behavior. Thus, the belief that the performance of the behavior will lead to a specific result. Behavioral intention is therefore a function of the behavioral attitude and the subjective norms regarding this behavior. Subjective attitudes and norms are unlikely to be equally weighted in predicting behavior. Three criteria that may affect the relationship between behavioral intention and behavior: the correspondence between the measure of intention and the level of specificity; the stability of intention between the moment it is given and the moment when the behavior is performed; and the degree to which the execution of the

intention is under the voluntary control of the individual. However, ART ignores the links between individuals, both the interpersonal and social relationships in which they operate, and the social structures that govern social practice. To overcome the limits of ART, the theory of planned behavior has been developed (1985). It postulates that human behavior, in order to be effective, must first be decided / planned, hence the name of the theory of planned behavior (Ajzen, 1991).

#### *What about the theory of decision?*

Concerning the decision theory, it should be noted that it is very close to the previous theory in that it encourages the individual to make a decision that goes in the direction of the protection and the promotion of his interests. This is a theory that requires a prerequisite. For the concerned person to take his decision, he must have an overview of the problematic that concerns him. He must understand all the implications of the upcoming decision so that he is informed about the benefits of its decision-making. *"The theory of the decision is constructed so as to be able to integrate different types of uncertainties, and we will have a theory that will be able to apply to the problems of decision which are posed to agents located in environments of various natures"* (Kast , 2002, 8). Applied to the field of health, this theory describes the best possible ways to use medical care to produce health or even utility (Phelps, 95, 86). In reality, this theory is placed both from the point of view of the provider and from that of the health service applicants. The claimant's decision to claim SRH / FP benefits is undoubtedly influenced by variations in medical practice, the underlying causes of which lie in misinformation about the marginal effectiveness of benefits in the form of SRH / FP to estimate social losses associated with them (Phelps, 95, 87). Like the previous theory, it is an inspiring theory of Management Science and Psychological Sciences. And in terms of SRH / FP, for its effective implementation, it requires real decision-making on the part of the people. *This reflection is based on a methodology that should now be highlighted.*

### **3. Methodology**

The documentary review in its preparatory phase consisted of a first documentary approach, based on an electronic magazine with search engine "Google" and keyword «SRH» and "FP". This step led to the identification of needs and documentary resources whose exploitation led to the clarification of the research problem. In accordance with the documentary resources previously identified, the collection of documents has enabled the collection of qualitative and quantitative data from national and international institutions. Ministry of Health and Public Hygiene (MHPH), National Program for Mother and Child Health (NPMCH) National Program of AIDS Control (NPAC), National Institute of Statistics (NIS), technical and financial partners such as ENGERDER HEALTH, UNFPA, JHUCCP, WHO, UNESCO, etc. The main sources are the 2011-2012 DHS, the 2016 MICS survey, the global AIDS report, the annual report of the health sector indicators in Côte d'Ivoire. These documents were analyzed according to the defined research objectives. The selection of documents followed two inclusion criteria: the year of publication; the nature of the source. Documents in the gray literature and those from official sources, educational or research documents were also favored. Documents with deficiencies in abstract, title, introduction or conclusion were excluded from the document base.

### **4. RESULTS**

#### **Major initiatives in reproductive sexual health**

In 1994 the International Conference on Population and Development agreed that family planning should apply to anyone who wants it. Governments should therefore create the condition to support people's rights to family planning. Family planning rights involve the enjoyment of other rights such as the right to health, the right to education and the right to lead a life with dignity. The conference defines sexual and reproductive health as a complete state of physical, mental and social well-being ... in all areas related to the reproductive system. Reproductive health therefore means that people are able to have a healthy and fulfilling sex life and have the opportunity to reproduce and be able to freely decide when and how often to do so. Since 1948, several treaties, conventions and agreements have led to significant advances in reproductive sexual health, especially that of deciding the number of children and the spacing of births. Thus, reducing concerns about unwanted pregnancies can lead to building the relationship between partners and ensuring a healthy and fulfilling sex life at the 2nd Ordinary Session of the Conference of African Ministers of Health held in October 2005 in Gaborone, Botswana the Hemispheric Strategic Framework for Sexual and Reproductive Rights was adopted. This strategic framework is endorsed by the AU Heads of State in January 2006 in Khartoum, Sudan. However, it was in 2007 with the development of the Maputo Action Plan (MPoA 2007-2010) that the issue of Sexual Reproductive Health is shared at the continental level. The plan is based on Sexual and Reproductive Health and Rights (SRHR) in its full context as defined in ICPD / MPoA 1994 and ICPD + 20, taking into account the life cycle approach. These elements of SRHR include Sexual and Reproductive Health of Adolescents and Youth, maternal and newborn care, medical abortion services, family planning, prevention and management of sexually transmitted infections, including HIV and AIDS, prevention and management of infertility, prevention and management of reproductive cancers, finding solutions to the concerns of men and women in their mid-life, health and development, reduction of gender-based violence, communication and interpersonal counseling, and health education. Article 14 (2) (c) of the Maputo Protocol states that: *"States shall take all appropriate measures to protect the reproductive rights of women, particularly by permitting medical abortion, sexual assault, rape incest and when the pregnancy endangers the mental and physical health of the mother or the life of the mother or fetus "*. According to the World Health Organization (WHO) *"health is a complete state of physical, mental and social well-being, and not just the absence of disease or infirmity. Possession of the highest attainable standard of health is one of the fundamental rights of every human being, regardless of race, religion, political opinion or economic or social status. The health of all peoples is a fundamental condition of world peace and security; it depends on the closest cooperation of individuals and States "*. On the basis of this definition, States therefore make strong commitments in the area of SRH. They ensure respect and promotion of women's rights to health, including sexual and reproductive health. States have therefore taken all appropriate measures to ensure women's access to adequate health services, affordable costs and reasonable distances, including information, education and communication programs for women, especially those living in rural areas. They also opted to provide women with prenatal, postnatal and nutritional services during pregnancy and breastfeeding. Thus, they hope to improve existing services; to protect the reproductive rights of women, particularly by allowing safe abortion, sexual assault, rape, incest and when the pregnancy endangers the mother's mental and physical health or the mother's life or fetus. The Maputo Protocol states that *"States shall adopt and implement appropriate measures to ensure the protection of the right of women to respect for their dignity and protection against all forms of violence, including sexual and verbal violence"*. The revised Maputo Plan of Action 2016-2030 for the implementation of the Hemispheric Strategic Framework for Sexual and Reproductive Rights is in line with the 2007-2015 Maputo Plan of Action and

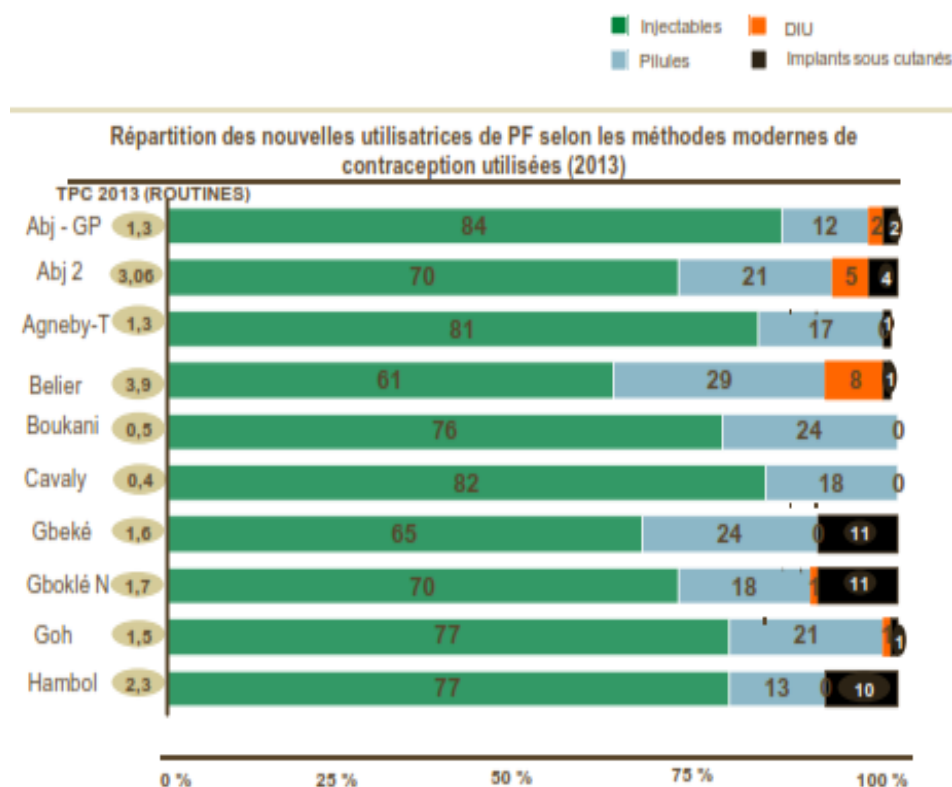
seeks to lead the continent towards achieving the goal of universal access to sexual and reproductive health services in Africa beyond 2015. This is a long-term plan for the period up to 2030, focusing on nine areas of action: political commitment, leadership and governance; health legislation; financing & investments in health; strengthening of health services & human resource development; partnerships and collaborations; information and education; responsibility & monitoring and evaluation; investing in vulnerable and marginalized populations; and improving SRHR for adolescents and youth.

### **The situation of SSR in In Côte d'Ivoire**

Several initiatives have been taken for SRH / FP. Thus, the National Population Policy document in its April 2007 version set the objective of reducing the level of fertility by increasing the average number of children per woman from 4.6 in 2005 to 3.5 in 2025 through the promotion of family planning. The Poverty Reduction Strategy Paper (Maiga, M & M Kouamé 2015, 15) in the context of the enhancement of human capital the government aims to control population growth from 2.9 in 2013 to 2, 85 in 2015. In addition, in 2012 The National Health Development Plan (MSLS, 2012: 45) has made it a priority to promote family planning in order to "improve maternal health and that of children under 5 years of age years (Specific Objective 3). Family planning (FP) then emerged as the appropriate strategy to improve socio-economic development indicators in Côte d'Ivoire (reduction of maternal mortality and child mortality, better investment in school enrollment of children, improvement per capita, etc.). It is with this in mind that this country has set itself the goal of improving the demand and supply of family planning services. In addition, the road map to accelerate the reduction of maternal, neonatal and child morbidity and mortality in Côte d'Ivoire 2008-2015 (MSHP, 2008: 38) aims to provide regular supplies of SRH / FP products. In the same vein is developed the strategic plan for family planning 2013-2016 with a target of 30% in 2016 the contraceptive prevalence rate of modern methods (MSLS, 2014: 2). At the MAPUTO conference (UA, 2016 8), African states found that around 58% of women who want to avoid pregnancy do not use effective contraceptive methods and account for a disproportionately high proportion of women. % of unwanted pregnancies 70% of the poorest people in Africa do not have access to health services for prenatal care and delivery, while 78% of women and newborns in need of care medical complications of pregnancy and childbirth and complications during and after delivery do not receive them, and 73% of pregnant women living with HIV do not receive antiretroviral drugs that would protect their lives and to avoid mother-to-child transmission By the end of 2014 (AU, 2016: 9), the total cost of reproductive health care in Africa is estimated at \$ 17.2 billion per year. \$ 2 billion if all women's contraceptive needs are met, \$ 11.2 billion for pregnancy-related care, \$ 3.1 billion for maternal and newborn HIV care and \$ 0.7 billion for care related to four major curable STIs (chlamydia, gonorrhea, syphilis, trichomoniasis). *What is the situation of SSR / FP in Côte d'Ivoire?*

From now on, FP services are integrated into all health facilities with a maternity ward, but only around 65% of health facilities in Côte d'Ivoire offer basic family planning services (pills / injectable / condoms). Long-term methods are offered in 07% of MSDS for the intrauterine contraceptive device, 11.9% for implants and 0.5% for Voluntary Surgical Contraception according to the statistics of the regional directorates of health in Abidjan in 2014. Côte d'Ivoire has high maternal (614 ‰ live), neonatal (38 ‰), infant (68 ‰), juvenile (43 ‰) and infant-juvenile (108 ‰) mortality rates. Contraceptive prevalence by modern methods increased from 9.8% in 1998 to 13.9% in 2012. Unmet need for FP is estimated at 27% according to the 2012 DHS-CI for women of childbearing age and the Synthetic Fertility

Index (FSI) is estimated at 5 children per woman in 2012, illustrating one of the highest fertility levels in the world. The contraceptive prevalence rate (all women) in fourteen (14) years has changed only very slowly, from 9.8% in 1998 to 13.9% in 2012 with large regional disparities, while the potential demand for contraception is 46.6% including unmet need (27%). 41% of all women in union do not want more children for the next 2 years or more. Comparing the results of the EDS-CI II with those of the EDS-CI III, it appears that the intention to use a contraceptive method in the future has increased from 31% to 40%. On the other hand, the intention not to use a contraceptive method decreased from 62% to 48% between the two surveys. 21% of all women in union do not want to have children anymore. The prevalence of modern methods (EDS-CI, 2012) results in low contraceptive use among all adolescent girls (28.7%) and unmarried and sexually active adolescents (30.2%)



Source: Routine data, DIPE 2013 (MSLS, 2014: 16).

Contraceptive prevalence is 14%, while the unmet need rate is 27% in the general population and 33% among youth (Somian, 2015). Short-term methods such as injectable and pills were the most commonly used (MSLS, 2014: 16). With 75% and 19% of women who used contraception in 2013. Long-acting methods such as the intrauterine contraceptive device(2%) and subcutaneous implants (4%) are used very often. few women in Ivory Coast. Several factors may explain the low use of modern contraceptives in Côte d'Ivoire, among others: Low level of education of women; Absence of professional activity; Spouse not supportive of the use of FP; No discussion between spouses on contraception; Poor quality of information received in relation to methods; rural residence. In addition, there is an involuntary exclusion of men from PMTCT by the reproductive health system. The main reasons men do not accompany their partners in health facilities were time, work and culture constraints. Men often explain that they have commitments or that their time is limited because of their work or studies and that it prevents them from accompanying their partner. The issue of SRH / FP is very acute in adolescents and young people. Despite sexuality, an

early reproductive life estimated at 13% of general fertility and unmet need of about 33% (EDS 2012), they do not always have easy access to contraceptive services and methods. Teenagers and young people (aged 10-24) represent 31% of the Ivorian population. 55% of 15-19 year olds are very vulnerable to HIV. - 47% of teachers reported having sex with their students, according to a 2010 study. The prevalence of HIV in the general population is 3.7%. However, there is a feminization of the epidemic. The prevalence in men (15 to 49) is 2.7% against 4.6% in women of childbearing age. In the adolescent and youth population, this difference in prevalence is sharper. In fact, among girls aged 15 to 19 and 20 to 24, the prevalence of HIV is 0.9% and 3.6%, respectively. While among boys of the same age groups, the prevalence is 0.1% and 0.5%, respectively. The epidemic does not affect the different regions of the country uniformly. Urban residents are more affected (4.3%) than those in rural areas (3.1%). According to the activity reports of the health establishments, the number of patients who had an STI syndrome was 8,117 of whom 772 were under 15 years of age. For all age groups, females represent 2/3 of the cases

The age groups most affected by unwanted pregnancies are those aged 10 to 14 and 15 to 19 years. In fact, 32% of girls aged 15 to 19 years had an unwanted pregnancy, 31% of whom wanted to have this pregnancy later and 01% did not want it (EDS 2012, 95). The categories most affected by unwanted pregnancies are adolescent girls or young unmarried women, school children, out-of-schoolers, rural and urban residents, apprentices, domestic helpers and those who live in the street. Early fertility is 3 times higher among out-of-school girls (39%) than girls in school (14%). In school, 70% of pregnant girls are under 18 years old. In 2013, GBV control platforms identified 1,131 cases of all ages. The diagnosis of the working groups shows that the age groups most exposed to violence are those aged 10 to 14 and 15 to 19 years. Gender-based violence affects young women as young men, school-going, out-of-school, rural, urban, men who have sex with men, domestic girls, young people who have transactional sex. 12% of women were married before the age of 15 (EDS 2011-2012) and 36% before the age of 18. About 6% of men were married before the age of 18. The proportion of female victims of FGM is 38%, of which 53% have been mutilated before the age of 5 years. Domestic violence affects nearly 36% of women. More than 32% of girls aged 15-19 were victims of physical violence coupled with sexual violence. Among girls aged 20-24, this proportion is 44%. For girls aged 15-17 and 20-24, the prevalence of exclusively sexual assault is 5.9% and 6.0%, respectively, compared with 4.9% among women aged 15-49. The basic study of the AgirPF project (PNSSU 2016: 12) reveals that 82 sites are supported in the Abidjan region for the provision of family planning services. The baseline analysis showed that: 9% of the sites where providers were oriented to the needs of adolescents and young people; 11% of sites where providers are trained to provide services to adolescents and youth. The majority of health facilities offered only 3 methods of contraception namely the pill, the injectable and the condom. The services are not quality because the customers do not have the free choice and the premises do not guarantee the confidentiality. The SRH of Adolescents and Youth (SRH AY) Good Practice Guidance developed in 2011 highlights four good practices that need to be implemented together to maximize the impact of SAHIA interventions. These include comprehensive sexuality education, adolescent and youth-friendly SRH services, support for families and communities; and the empowerment of the girl. The different activities of promoting SRH / FP targeting young people to increase the use of modern contraception have focused mainly on peer education to encourage safer sexual behavior, and high-level public events for children encourage communities to abandon harmful practices. The study qualitative study conducted by *Médecins du Monde* in 2016 among students in the sanitary district of Soubré (2016 PNSSU: 12) shows abstinence and fidelity are difficult and not achievable because,

this message is contrary to standards currently disseminated in teenage girls and girls. The analysis of SRHAY demand for FP in Côte d'Ivoire reveals that the FP centers are not frequented by adolescents. The most used methods are counting days, condoms purchased at the shop, pills the next day bought at the private pharmacy. The difference in invoked and latent reasons for non-use of FP presents three categories of women; "Pre-family", "Aspire to family" and "Plan family". Women in the "pre-family" category are generally fertile and sexually active adolescents who live with their parents, and do not consider motherhood or having their own family. Their main need is the avoidance of pregnancies. Because they feel too young with a health risk and a lack of resources to become a mother. The terminology "family planning" is not suitable for teenage girls who have not yet founded a home. It is therefore appropriate to speak of contraception.

## 5. DISCUSSIONS

*The main communication interventions revolve around capacity building actions, local communication partnership, social marketing, social and community mobilization and mass communication campaigns.*

Training and capacity building activities involve both students, teachers and health providers. As a result, SRH / FP has been introduced into the human rights and citizenship education's programs in grammar schools. Teachers have benefited from lifeskills training since 2009. Health providers have benefited from capacity building (contraceptive technology, SAAJ I). There is a project to introduce SRH / FP in National Institute of Health Training (INFAS) training curricula. In terms of partnership NGOs, technical and financial support partners are involved in the implementation of SRH / FP (ASFI / AGIR / PF & UNFPA) for the supply of contraceptive products, personnel transport, ASFI / DMOSS promote access to schools for SRH / FP interventions). As part of social marketing, radio spots and TV broadcast on contraceptives he targets. The ministry in charge of youth and the implementing partners (AIBEF, AIMAS, AgirPF) organize awareness campaigns coupled with the SR service offer (caravan healthy youth, carnivals, special days). Interpersonal communication channels are the channels through which people interact and communicate directly with each other. These are meetings, ceremonies, parties, or meeting settings. The first circle of interaction and interpersonal communication is usually the family. At the community level, there are meetings of notables around the traditional chief, meetings / talks and activities of associations as well as home visits, counseling sessions with service providers. Listening centers and health clubs promote SRH to adolescents and youth. The interpersonal approach was developed around local activities such as door-to-door activities (workshops, garages, hairdressing salons, schools ...), discussion groups, peer educators' awareness, home visits, health clubs in schools, carnivals are organized during World Women's Day. In terms of information and demand generation for RH services (the framework of the "Zero Pregnancy in Schools" campaign), a green line (number 107) and a website ([www.dmoos.org](http://www.dmoos.org)) were in the service of SSR / FP. However, it should be noted, on the basis of the EDSCI II and III, that in the last months preceding the survey of the EDSCI III, 73%. Women and 67% of the men did not hear on the radio, or on television, or read in the newspapers, a message about family planning. According to the 1998-99 DHSIT II, the levels of exposure to family planning messages were better, as the proportions of non-exposure to family planning messages at the time were 60% for women and 58% among men. 90% of non-contraceptive users did not talk about family planning with either a field worker or a health facility in the last 12 months before the survey. The SSR / FP policy analysis of the communication intervention focused on SSR / FP makes it possible to say that Côte d'Ivoire has a National



Strategic Plan for Reproductive Health (PSNSR), a Strategic Plan for the Safety of Reproductive Health Products (PSSPSR), a Roadmap for the Reduction of Neonatal and Infant Maternal Mortality, and since June 2014, the National Budget Action Plan (PANB) for PF 2015-2020. All of these documents include activities to reach populations with low FP coverage. It has been argued, therefore, that the National Mother Child Health Program (NESP) and the National School and University Health Program (PNSSU) aim to reduce the morbidity and mortality associated with sexuality among women. And men; improve sexual health among young people and adolescents; Promoting the health of students by providing them with a set of preventive, curative and promotional services

However, these strategies and policies are highly handicapped in their implementation due to the absence of a national communication strategy to promote the different approaches adopted at national level. Indeed, FP is in a process of national repositioning at the level of Côte d'Ivoire. For nearly two decades, Côte d'Ivoire has received very little external funding to support its SSR / FP promotion activities. To do this, the EngenderHealth Project, implemented by EngenderHealth, developed a CCSC strategy, in collaboration with the National Mother Child Health (NESP) Direction-Coordination and the different stakeholders in SSR / FP in Cote d'Ivoire. Ivory. The purpose of this SBCC strategy was to provide the AgirPF project and other stakeholders in the FP community with information and tools that can help develop high-impact behavior change communication for FP. The activities of this strategy were implemented by AgirPF, as part of a communication campaign for the promotion of SRH / FP among girls aged 15 to 24, women seeking a marriage and marriage union women living in couples. Similarly, insufficiently structured advocacy efforts at all levels, low community participation and insufficient number of Community Health Workers (CHWs) have only allowed for partial implementation of social norms activities involving the media, opinion leaders, religious leaders, traditional leaders in this case the network ARSIP (Alliance of Religious for the fight against HIV / AIDS and other Pandemics). It appears, therefore, that this uncoordinated communication is not part of an integrated communication plan with little impact on the evolution of SSR / FP practices. Indeed, in a country where the sexual majority is set at 18 (Law 72-852 of 21 December 1972), of a cohort of young people aged 15 to 24 (Unicef 2014, 19), 58.5% claim to see had early sexual intercourse (before 18 years). 68.3% of them are girls 54% of young people aged 15 to 19 say they have had sex. Only 38.8% of them used a condom during last sexual intercourse. This figure is down from the figures of the AIDS Indicator Survey (EIS 2005). 3.5% of women under 15 and 21.1% of women aged 15 to 19 report having a live birth (MISC 16: 87). 5% of women aged 15 to 19 are pregnant with a first child. The low impact of communication is also reflected in the persistence of pregnancy in schools. During the school year 2016-2017 (DPSS, 2016) 4471 cases of pregnancies are recorded in the secondary school against 4054 cases for the year 2015-2016, a rate of progression of 1.10% in one year. Of the 4471 cases registered in 2016-2017 920 girls are 19 years old (20.57%), 2398 (53.63%) are between 15 years old and 18 years old and 1153 cases (25.78%) are located between 9 and 14 years old. Primary education is not spared by this phenomenon. In fact, for the 2015-2016 school year, there are 404 cases of pregnancy in this level of education, compared to 512 in 2014-2015, with 51 cases in girls under 12 years of age and 353 cases in 12 years and older. *What are the explanatory factors for the low impact of communication in promoting SRH / FP?*

Communication about SRH / FP is immune to the persistence of these beliefs and social norms. They are rooted in the weakness of communication between parents and their children. "On issues of sexuality, adolescents do not talk about sexuality with their overtones ... teenagers are ashamed to talk about sexuality issues with their parents because they are

closed on such topics, so that they are afraid "(UNICEF 2014, 11). Parents often do not share their responsibility for the education of their children. They tend to blame media such as television and the internet. *"Parents are also deprived ... interventions to their attention could facilitate the creation of more comfortable and more structured exchanges for the family"* (UNICEF 2014, 11). One can also observe the persistence of some traditional practices harmful to SSRAJ such as early marriages and excision. These practices are not always perceived as Gender Based Violence (GBV). GBV is a taboo subject, a private matter that families and the community often settle amicably. Also adolescents and young people find it difficult to report cases of GBV. In addition, the belief that it is God who gives the children subsists and the woman continues to be perceived in her reproductive function. As such, SRH / FP is not seen as a necessity. In addition to socio-cultural barriers, structural difficulties do not promote the promotion of SRH / FP. First, it is about the problems inherent in the health system itself. They take their sources in Absence of law on SRH / PF (Only a drafted version). It shows that the four good practices in the WHO SSRAJ are not implemented on a scale and the SRH / FP rights priorities are not specific to SRH of young people and adolescents. There is also information asymmetry at the level of providers, and some providers have complete information on rights in SRH / FP, while others have limited knowledge of SRH / FP. Added to this, the small number of staff dedicated to SRH / FP, the limited time available to talk about FP and rights in SRH / FP and the fact that spaces dedicated to SRH / FP seem stigmatizing for men do not favor not the proper delivery of SRH / FP services by providers who are distinguished by poor reception in maternity and health centers. In a second step, SRH / FP products help to reinforce customer resistance. The lack of availability, which is characterized by frequent stock-outs, the poor geographical distribution of products on the national territory is one of the weak links in the chain. There are also the side effects of certain products, the reliability of certain contraceptive methods that lead to, and unwanted pregnancies.

## **6. CONCLUSION AND PERSPECTIVES**

Despite Côte d'Ivoire's commitments at the international level to improve SRH / FP with the support of Technical and Financial Partners, it faces challenges. Certainly communication actions have been conducted to bring people to a change in sustainable behavior in the field of SRH / FP. It is regrettable, however, that these are not part of an integrated communication. As a result, traditional stereotypes, cultural beliefs and practices regarding women's social roles persist. These include, early marriages and excision, the belief that it is God who gives children and the persistence of the woman's perception of her reproductive function. In addition, absence of law on SRH / FP, asymmetry of information at the level of providers on SRH / FP, frequent breaks in stocks, the geographical distribution of products the main structural problems identified. In the perspective of an emerging economy through the achievement of the demographic dividend the issue of SRH / FP is crucial. The acceleration of economic growth can undoubtedly be achieved by reducing the number of dependents relative to the labor force. This involves building the capacity of SRH / PR services, promoting access to care and combating socio-cultural barriers. It is therefore

fundamental for a better appropriation of SRH / FP and its prioritization at all levels that the communication plan initiated by the PNSME at the end of these different activities is subject to validation, involving all stakeholders in the field.

## References

- Ajzen, I. (1992). "A Comparison of the Theory of Planned Behavior and the Theory of Reasoned Action". *Personality and Social Psychology Bulletin*. 18: 3-9. DOI: 10.1177 / 0146167292181001 10.1177 / 0146167292181001.
- Azen, I. (1991): "Theory of planned behavior," *Organizational Behavior and Human Decision Processes*, 50: 179-211.
- Berned, M. (2015). Stigma, an impediment to the development of PMTCT in Africa, in: transversal N ° 76, January-February
- Caron-Bronchard, L, R. (2010). "an interactive eco-social dynamic model to better understand the contribution of the media in shaping social norms in health" in the media and health: the emergence of appropriation social norms, coll. Health and Society, Quebec, Quebec University Press, p.9-30
- DPSS (2016). Pocket School Statistics 2016-2017, MENET-FP
- PRSP (2009). Development and Poverty Reduction Strategy, A1bidjan
- ENGERDER HEALTH (2011). Survey of Knowledge, Attitudes and Practices of men and women on the use of PMTCT / HIV services in Abidjan in 2011
- Fishbein, M. &Ajzen, I (1975). *Belief, Attitude and Behavior: An Introduction to Theory and Research*, Reading MA Addison Wesley
- KAST, R (2002), the theory of the decision, editions the DISCOVERY, Paris
- Maiga, M.&Kouamé,M (2015). *Repositioning Family Planning in Côte d'Ivoire: Situational Analysis*, Washington, DC: Future Group. Health policy Project.
- MSHP (2008). Roadmap to accelerate the reduction of maternal, neonatal and child morbidity and mortality Ivory Coast 2008-2015
- MSHP (2016). National Health Development Plan 2016-2020
- MSLS (2014). National Budgeted Action Plan for Family Planning Côte d'Ivoire 2015-2020, July 2014
- MSLS (2012). National Plan for Sanitary Development 2012-2015
- Phelps E, C. (1995). *The Foundations of Health Economics*, Col. New Horizons, New York - 2016 PNSSU, Consultation Meeting on Sexual and Reproductive Health of Adolescents and Youth (SSRAI) in Cote de ivoire: Meeting Report on 16 and 17 November 2016, Abidjan
- Somian, N, N (2015),the AIBEF wants to learn from successful strategies (online) available:<https://www.fratmat.info/index.php/nos-unes/yao-n-dry-l-aibef-wants-to-inspire-strategies-to-success> (March 18, 2018)
- UNICEF (2014). *Comparative Analysis of AIDS Vulnerability and Response in Adolescents and Youth in Côte d'Ivoire 2005-2012, Final Report*.
- African Union (2016), Maputo 2021-2030 Action Plan for the Operationalization of the Continental Strategic Framework for Sexual Health and Reproductive Rights, Addis Ababa
- Lebel J. (2003). *health an ecosystem approach*, IDRC, Ottawa