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POPULATION/FAMILY PLANNING ASSESSMENT IN BENIN

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ABBREVIATIONS

ABEL	Beninese Association for Writers in National Languages (Association Béninoise des Ecrivains des Langues Nationales)
ABMS	Benin Association for Social Marketing (Association Béninoise du Marketing Social)
ABPF	Beninese Association for the Promotion of the Family (Association Béninoise pour la Promotion de la Famille)
ADR	Regional Development Association (Association de Développement Regional
AFJB	Benin Association of Women Jurists (Association des Femmes Juristes au Bénin)
AFVP	French Association of Volunteers for Progress (Association Française des Volontaires du Progrès)
AGDSD	Agency for Social Development (Agence pour la Dimension Sociale de Développement)
AGEPIB	Agency for the Management of Community-based Projects (Agence pour la Gestion des Projets aux Initiatives de Base
AIDS	Acquired Immunodeficiency Syndrom
APFEMR	Association for Promotion of Women in Rural Areas
ARI	Acute Respirator Illness
ASBL	Non-profit Association (Association Sans But Lucratif)
AVS	Volunteer Health Agent (Agent Volontaire de Santé)
Benin-Nature	Association for Nature Conservation
BINGOS	Benin Indigenous NGO Strengthening Project
BFH	Baby Friendly Hospital
CA	Central Purchasing Office (Centrale d'Achats)
CAMME	Medical Action Center for Mother and Child (Centre d'Action Médicale pour la Mère et l'Enfant du MTEAS)
CARDER	Regional Center for Action in Rural Development (Centre d'Action Régional pour le Développement Rural)
CBD	Community-based Distribution (Distribution à Base Communautaire)
CBRST	Beninese Scientific and Technical Research Center
CCS	Communal Health Complex (Complexe Communal de Santé)
CDD	Diarrheal Disease Control
CDEEP	Departmental Committee for Project Implementation and Evaluation
CEFORP	Population Training and Research Center
CEPEPE	Small Business Development Center (Centre de Promotion des Petites et Moyennes Entreprises)
CERPOD	Center for Applied Research on Population and Development
CFA	African Financial Community
CFI-France	France International Channel
CHD	Departmental Hospital Center (Centre Hospitalier du Département)
CI	Integrated clinics (Cliniques Intégrées)
CIDA	Canadian International Development Agency
CIE	International Children's Center (Centre International d l'Enfance)

CNBPF	National Committee of Benin for the Promotion of the Family
CNEEP	National Committee for the Evaluation and Support of Health Sector Programs (Comité National pour l'Evaluation et l'Encadrement des Programmes du Secteur Santé)
CNFVN	National Conference of the Active Forces of the Nation
CNHU	National University Hospital Center (Centre National Hospitalier Universitaire)
CNIFD	National Committee for the Integration of Women in Development
CNRHP	National Human Resources and Population Commission (Commission Nationale des Ressources Humaines et de la Population)
COGEC	Commune Level Health Management Committee (Comité de Gestion de la Commune)
COGES	Sub-prefecture Health Management Committee (Comité de Gestion de la Sous-préfecture)
CPR	Contraceptive Prevalence Rate (Taux de Prévalence Contraceptive)
CPS	Center for Social Promotion (Centre de Promotion Sociale)
CPSP	Country Program Stategic Plan
CREDESA	Regional Center for Health Development (Centre Régional pour le Développement de la Santé)
CREN	Center for Recovery and Nutrional Education (Centre de Recuperation et d'Education Nutritionnelle)
CRRHD/SF	Center for Research in Human and Demographic Reproduction/Family Health
CRS	Catholic Relief Services
CSCU	Metropolitan Area Health Center (Centre de Santé de Commune Urbaine)
CSD	District Health Center (Centre de Santé de District)
CSDO	Canadian Solidarity and Development Organization
CSSP	Sub-prefecture Health Center (Centre de Santé de Sous-préfecture)
CUGO	University Clinic of Gynecology and Obstetrics (Clinique Universitaire de Gynécologie-Obstétrique)
DAC	Cabinet Deputy Director (MSP)
DANA	Direction de l'Alimentation et de la Nutrition Applique
DAS	Social Affairs Directorate of MTEAS (Direction des Affaires Sociales du MTEAS)
DDS	Departmental Health Directorate (Direction Départementale de la Santé)
DESS	Diploma for Specialized Scientific Studies
DHAB	Directorate of Basic Hygiene and Health
DHS	Demographic and Health Survey
DIEM	Directorate of Infrastructure, Equipment, and Maintenance
DNPS	National Directorate of Health Protection (Direction Nationale de la Protection Sanitaire)
DPCE	Directorate of Planning, Coordination, and Evaluation
DPHL	Directorate of Pharmacies and Laboratories
DSAF	Directorate of Administration and Finance
DSF	Directorate of Family Health (Direction de la Santé Familiale)

ENIIAB	Benin National School of Nurses and Auxiliary Nurses (Ecole Nationale des Infirmiers et Infirmières Adjoints du Bénin)
EPI	Expanded Program of Immunization (Programme International pour la Formation en Santé)
EUMC	World Universities Welfare and Aid-Canada (Entre-aides Universitaires Mondiaux-Canada)
FAC	Fund for Aid and Cooperation
FAIB	Fund for Community-based Initiatives (UNDP) (Fonds d'Appui aux Initiatives de Base)
FAO	United Nations Food and Agriculture Organization
FCFA	African Financial Community Franc (Beninese currency)
FED	European Development Fund
FF	French Franc
FL	Family Life
FP	Family Planning (Planification Familiale)
FP/IEC	Family Planning IEC (IEC en Planificatioj Familiale)
FPLM	Family Planning Logistics Management (Project)
FSN	Foreign Service National
FSS	Faculty of Health Sciences
GAPOB	Groupement d'Achat des Pharmaciens d'Officine du Benin
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	German Association for Technical Cooperation (Gesellschaft für Technische Zusammemarbeit)
HAAC	High Authority for Audiovisual Services and Communication (Haute Authorité de l'Audio-visuel et de la Communication)
HIV	Human Immunodificiency Virus
IBFAN	International Baby Food Action Network
ICPD	International Conference on Population and Development
IDA	International Development Agency (Agence Internationale pour le Développement)
IDRC	Regional Center for International Development (Canada)
IEC	Information, Education, and Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INFRE	Institut National pour la Formation et la Recherche Education
INMES	National Medico-social Institute (Institut National Médico-Social)
INSAE	National Institute for Statistics and Economic Analysis (Institut National de la Statistique et de l'Analyse Economique)
INTRAH	Program for International Training in Health
IPC	Interpersonal Communication (Communication Interpersonnelle)
IPPF	International Planned Parenthood Federation (Fédération Internationale de la Parenté Planifiée)
IRSP	Regional Institute for Public Health (Institut Régional de Santé Publique)
IUD	Intrauterine Device
KAP	Knowledge, Attitudes, and Practice
LDC	Least Developed Country

MCC	Ministry of Culture and Communication (Ministère de la Culture et des Communications)
MCH	Maternal and Child Health (Santé Materno-Infantile)
MD	Doctor of Medicine
MDN	Minsitry of Defense
MDR	Ministry of Rural Development
MDRAC	Ministry of Rural Development and Cooperative Action (Ministère du Développement Rural et de l'Action Coopérative)
MEHU	Ministry of Environment, Housing, and Urban Development (Ministère de l'Environnement de l'Habitat et de l'Urbanisme)
MEPS	Educational Materials for Health Personnel, a WHO program for which INTRAH is a collaborating agency (Matériel Educatif pour les Personnels de Santé)
MERS	Ministry of Education and Scientific Research (Ministère de L'Education et de la Recherche Scientifique)
MIS	Management Information System (Système de Gestion de l'Information)
MISAT	Ministry of Domestic Affairs, Security Territory Administration (Ministère de l'Intérieure, de la Sécurité et Administration Territoriale)
MJL	Ministry of Justice and Legislation (Ministère de la Justice et de la Législation)
MJS	Ministry of Youth and Sport
MPRE	Ministry of Planning and Economic Restructuring (Ministère du Plan et de la Restructuration Economique)
MSP	Ministry of Health
MTEAS	Ministry of Labor, Employment, and Social Affairs (Ministère du Travail, de l'Emploi, et des Affaires Sociales)
NGO	Nongovernmental Organization
NPA	Non-proect Assistance
ONASA	Office National pour la Scurit Alimentaire
OR	Operations Research
ORS	Oral Rehydration Salts (Sels de Réhydratation Orale)
ORT	Oral Rehydration Therapy (Thérapie par Réhydratation Orale)
ORTB	Benin Office for Radio and Television (Office de Radiodiffusion et Télévision du Bénin)
PA	Project Assistance
PAE	Environmental Plan of Action
PANAN	National Action Plan for Food and Nutrition
PBASSP	Benin-Germany Primary Health Care Project (Projet Bénino Allemand de SSP)
PBEF	Project for Family Well-being (Projet Bien-être Familial)
PDSS	Project for Health Services Development (Programme de Développement des Services de Santé)
PHC	Primary Health Care (Soins de Santé Primaire)
PHN	Center for Population, Health, and Nutrition (USAID)
PMI	Center for Maternal and Infant Protection
PMSBS	Benin-Swiss Health Project
PNLS	National AIDS Program (Programme National de Lutte Contre le SIDA)
PopEd	Population Education (Education de la Population)

PSC	Personal Services Contract
PSI	Population Services International
PVO	Private Voluntary Organization
RAPID	Resources for the Awareness of Population Impact on Development Project
RDB	Radio Diffusion of Benin (Radio Diffusion du Bénin)
RDP	Radio Diffusion of Parakou (Radio Diffusion de Parakou)
REDSO/WCA	Regional Economic Development Services Office/West and Central Africa
RFI	Radio France Internationale
RGPH	General Census of Population and Housing (Recensement Général de la Population et de l'Habitat)
RH	Reproductive Health (Santé Reproductive)
RNES	National Essential Research in Health
SAD	German Development Service
SAP	Service of Preventive Activities; Structural Adjustment Program
SEATS	The Family Planning Services Expansion and Technical Support Project
SERO	Epidemiology and Operation Research Department (Service des Etudes Epidémiologiques et de la Recherche Opérationnelle)
SNIGS	National Health Management Information System (Système National d'Information et de Gestion Sanitaire)
SNS	National Systems of Statistics
SO	Strategic Objective
SRHP	Human Resources and Population Service
STD	Sexually Transmitted Disease (Maladies Sexuellement Transmissibles)
TAACS	Technical Advisors in AIDS and Child Survival
TFR	Total Fertility Rate
UNDP	United Nations Development Program (Programmes des Nations Unies pour le Développement)
UNFPA	United Nations Population Fund (Programme des Nations Unies pour les Activités de Population)
UNICEF	United Nations Children's Fund (Fonds des Nations Unies pour l'Enfance)
U.S.	United States
USAID	United States Agency for International Development (l'Agence Américaine pour le Développement International)
UVS	Health Village Unit (Unité Villageoise de Santé)
VCR	Video Cassette Recorder
WFP	World Food Program
WHO	The World Health Organization (Organisation Mondiale de la Santé)
WINS	Women and Infant Nutrition Support Project
WRA	Women of Reproductive Age (Femmes en Age de Reproduction)

EXECUTIVE SUMMARY

by Deirdre LaPin

Purpose and Background

Over the past ten years, the Republic of Benin (1994 population 5,185,000) has made considerable progress in improving the quality and distribution of primary and child health services throughout the country. Owing in part to a successful cost recovery scheme based on a revolving fund for essential drugs, community-level health centers have been able to maintain child immunization levels at around 70 percent each year since 1990. The incidence of severe dehydration due to diarrhea has likewise fallen 60-70 percent.

During the same period, however, progress in reproductive health—including family planning—has been slight. An estimated one percent of couples use a modern method of family planning. This low contraceptive prevalence rate (CPR) suggests a high unmet need for improved access and quality to reproductive health services in Benin. Consequences of the unmet need include a population growth rate of 2.9 percent, with an estimated doubling time of 25 years; a total fertility rate of about 6.8; lack of accurate and adequate information about family planning and population issues; poorly trained health staff who lack conviction about the importance of reproductive health; a growing rate of unsafe abortions and post-abortion complications; a high number of low birth weight babies; and others. Potential impacts of the high rate of population growth include the deflation of gains from economic reform, pressures on land and ecological systems, and the unequal social and health burden on women.

If Benin's experience in promoting family planning has been weak and fragmented, the causes are several. No national population strategy or policy has been developed, and the 1920 colonial anti-contraceptive law is still in force. Despite support for family planning at the highest level of the Ministry of Health, acceptance of the concept of spacing and limiting family size is uneven among policy-makers. Consequences of rapid population growth and a high fertility rate can no longer be ignored in Benin—especially in relation to their negative influence on maternal and child health.

It is evident that Benin needs a strong and forward-looking population/family planning (FP) program. Even before re-opening its office in Cotonou in 1991, the U.S. Agency for International Development (USAID) noted that high-quality, limited interventions in training, information, education, and communication (IEC), and commodities distribution were needed to complement the ongoing family planning efforts of the World Bank, United Nations Population Fund (UNFPA), and the International Planned Parenthood Federation (IPPF). In addition to its program focus on education, USAID has begun to add limited activities in condom social marketing for HIV/AIDS prevention and health education. By late 1993 USAID had commissioned a Situation Analysis of Family Planning Services in Benin from The Population Council, which was completed in May 1994. At the same time, USAID/Benin was encouraged to explore the expansion of its support to population, reproductive health, and family planning in the context of it Country Program Strategic Plan (CPSP) 1994-1999.

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From July 3 to August 6, 1994, an assessment team undertook a Population Sector Assessment to determine whether it would be programmatically advisable and administratively feasible to upgrade the level of Mission emphasis on population from that of a Target of Opportunity (as presented in the CPSP) to the level of a second Strategic Objective (SO) alongside the existing SO in the education sector. The purpose of the study was to assess the national population/FP sector in relation to others, identify the unmet needs in existing population/FP programs, and make recommendations of potential areas for future USAID assistance.

The Population Sector Assessment Team assembled expertise from a range of individuals and institutions in the population field: Aristide Aplogan (The Population Council), Mamadou Dicko and Baba Traore (CERPOD), Pape Gaye (INTRAH), Gerald Moore (logistics consultant), Julienne Ngo Som (WINS consultant), Deirdre LaPin (USAID/Washington, University of Michigan Fellow), and Mohammed Zarouf (team leader and family planning management consultant).

While in Benin, the team carried out a review of the literature; held discussions with officials from the Ministries of Health, Planning, Labor, and Education; met with bilateral and multilateral donors, nongovernmental organizations(NGOs), and representatives of the private sector. In addition, team members, separately or in groups, also visited 23 health facilities and three social promotion centers in five of Benin's six departments. Members also interviewed a range of individuals, from beneficiaries to ministry officials, about their work, experience, and expectations regarding family planning in Benin.

Scope of Work

The mandate of the Team was three-fold.

First, the Team sought to describe the current status of public sector family planning services in Benin commenting upon strengths and weaknesses of the different essential components of a FP program. The analysis of strengths and weaknesses would culminate in concrete recommendations for reinforcing strengths and/or addressing shortcomings in management, supervision, evaluation; facility-based service delivery sites and alternative contraceptive distribution systems; contraceptive procurement and logistics; staffing levels in relevant government and private entities; IEC; training; management information systems; record keeping for service statistics; quality of services; operations research; contraceptive pricing, cost effectiveness, and sustainability.

In addition, the Team assessed the viability of current and/or potential involvement of indigenous NGOs and other private sector entities and community groups in providing family planning information and services. It discussed the experience and potential for both clinic-based and nonclinic-based activities (e.g., social marketing, community-based distribution [CBD], community health education programs).

Second, the Team addressed key policy issues in the population sector. Specifically, it reviewed existing and planned official declarations, policies, and/or legislation that address the

question of population growth and its impact on general health services, national employment, food requirements, land distribution, the education sector, public works and utilities, etc. It assessed the extent to which demographic variables have been/are taken into account in the development planning process and commented on the existing institutional capacities for doing so. It studied the general political environment in relation to undertaking a strong population program and studied the current and/or potential involvement and needs of governmental and NGOs and private sector community groups in promoting population policy initiatives. Finally, it prescribed a plan of action for the next five years that would address shortcomings and otherwise strengthen the development planning process in Benin at a macro level.

Third, the Team examined the present and future-planned interventions and activities of other donors that support family planning activities and population initiatives in Benin. In light of this examination, it commented on the complementarity of other donors' efforts and made recommendations concerning future USAID interventions in the population/family planning sector.

Introduction

The Republic of Benin, slightly larger in size than the Commonwealth of Virginia, is situated west of Nigeria along the West African Guinea Coast. Over 50 ethnic groups reside in the country. The estimated 1994 population is 5,185,000 persons, based on the 1992 census at a growth rate of 2.9 percent. There are approximately 1,063,000 women of reproductive age (15-44) in Benin, and the total fertility rate of 6.8 bears witness to a pro-natalist tradition. Although family planning is not a popular notion, health and population indicators suggest that the unmet need for family planning is high. Excessively high rates of mortality—maternal (800 per 100,000 live births), infant (105.5 per 1,000), and child (80 per 1,000)—support this conclusion.

Since Independence in 1960 Benin has undergone numerous changes of government, most occurring in an early tumultuous period that ended with a Marxist military regime in 1972. Democratization began with the "National Conference of the Active Forces of the Nation" (CNFVN) held in February 1990. The conference lead to a free and fair presidential election the following year, and since then the country has continued to make progress toward a pluralistic, democratic government and a liberalized economy.

POPULATION ACTIVITIES AND THEIR INSTITUTIONAL CONTEXT

Overview: Structure and Evolution of Health Services

The organization of public health facilities in Benin is congruent with the country's administrative structure. This decentralized system resembles a pyramid. At the national level is the National University Hospital Center (CNHU), responsible for tertiary care and specialized medical and surgical cases. At the regional level is the Departmental Hospital Center (CHD, in four out of six departments). The CHD provides specialized care for complex cases referred from the peripheral clinics. Management of the CHD falls to the Departmental Health

Directorate (DDS), which is responsible for implementing national health policies, allocating resources, and coordinating health services throughout the department.

At the peripheral level are 84 referral centers known either as the Sub-prefecture Health Centers (CSSP) or Metropolitan Area Health Centers (CSCU). A number of CSSP/CSCU are adequately equipped and staffed to offer first referral care in primary health care (PHC), maternal and child health (MCH), and family planning for the rural Communal Health Complex (CCS, 90 in 517 communes) and the separate dispensaries and maternities (an additional 62 facilities). The sub-prefecture facilities are managed by the *Médecin Chef*, who is the district medical officer. In contrast, a nurse or midwife manages the CCS, which constitutes the primary care entry point into the system. In addition, some 313 Village Health Units (UVS), which pre-date the revised health structure of 1986, continue to serve small communities. Their services are rudimentary, and they are typically not staffed by medically trained personnel.

The concept of modern family planning has existed in Benin for about 20 years. In 1971, family planning activities began under an NGO, the National Committee of Benin for the Promotion of the Family (CNBPF). In 1982, the CNBPF became the Beninese Association for the Promotion of the Family (ABPF); ABPF is affiliated with IPPF, which provides a portion of its funding.

In subscribing in 1978 to the Alma Ata Declaration, the Government of Benin also opted for the provision of family planning services. Initially, ABPF supported family planning information and supplies in approximately 80 public health centers. By 1983, however, family planning services were integrated into government MCH. Public services for family planning were established with UNFPA funding through the Project for Family Well-being (PBEF). In principle the program ensures availability—in all government hospitals, health centers, and other health posts—of methods of family planning which will give couples and individuals freedom of choice in the spacing of births and/or limitation of family size.

Substantial progress has been made over the last 10 years in Benin's public health sector with regard to selected health strategies and interventions. Oral rehydration therapy is currently widely understood and practiced throughout the country. Benin's essential drug program, with a revolving fund financed by the community at commune and sub-prefecture level, has provided one model that inspired the 1987 "Bamako Initiative." An independent central purchasing office socks and supplies essential drugs to all health centers as well as to buyers from the private or NGO sectors. Community participation and financing of rural health centers through a system of management committees at commune (the COGEC) and sub-prefecture levels (the COGES) has helped to maintain full immunization coverage rates nationwide at nearly 70 percent each year since 1990.

Yet, high infant mortality rates persist, in part, because only half of the population has access to health services and because one-fifth actually use them. They also persist because progress in child health has not been matched by comparable advances in maternal and reproductive health, including family planning. Low modern contraceptive prevalence rates of about one percent, combined with poor prenatal and postnatal care, continue to bring about pregnancies that are too early, too frequent, too many, and too late. Other consequences include rising levels of unsafe abortion, postpartum and post-abortion complications, a high maternal mortality rate, and such social outcomes as abandoned children and infanticide,

couple infertility, and other deficiencies stemming from early and sudden weaning practices as a result of multiparity.

Other key government family planning efforts include establishment of the National MCH/FP Coordination Committee (CNEEP) and its counterparts at department level (CDEEP); the National MCH/FP/Nutrition Program with the "Alert" System for high-risk pregnancies (1991-1995); and UNFPA-supported programs in policy, analysis, population education and family life education. Additionally, in 1993 the Ministry of Planning created a Department of Human Resources and Population (SRHP) and the National Human Resources and Population Commission (CNRHP) to oversee development of a national population policy.

Today, despite notable progress in the health sector, Benin suffers from the absence of a global MCH and official family planning policy and low quality and use of services. Family planning is therefore evolving in Benin without a clear definition of target populations, objectives, or program strategies.

Institutional Analysis

The Government of Benin

The Ministry of Public Health (MSP) is mandated to develop and carry out national health and family planning policies and strategies; however, its activities are coordinated intersectorally with other ministries. They include the Ministry of Planning and Economic Restructuring (MPRE), the Ministry of Labor, Employment and Social Affairs (MTEAS), the Ministry of Education and Scientific Research (MERS), and the Ministry of Culture and Communications (MCC). Other ministries contribute indirectly to these activities. These are the Ministry of Rural Development (MDR), the Ministry of Youth and Sport (MJS), the Ministry of the Interior (MISPAT), the Ministry of Justice and Legislation (MJL), the Ministry of Defense (MDN), and the Ministry of the Environment, Housing, and Urban Development (MEHU).

The Ministry of Health coordinates sector policies and strategies and develops implementation plans from inputs provided by the departmental health directors, other ministries, NGOs, and donors. It collaborates with the Ministry of Planning in setting annual health sector budgets. It is also responsible for setting and enforcing patient care norms and standards and supervising and evaluating the performance of health facilities and personnel. Since May 1994, family planning activities have been given greater prominence as a separate service under the new Directorate of Family Health (DSF). This directorate also includes under an integrated umbrella other services for MCH activities, nutrition, and HIV/AIDS prevention. An analysis of family planning service delivery in the public sector appears in Section 1.3 below.

The Ministry of Planning and Economic Restructuring houses the Human Resources and Population Directorate responsible for coordinating the formulation of a national population policy. It also chairs the National Commission for Human Resources and Population, created in July 1993 to prepare a report for the 1994 International Conference on Population and Development (ICPD). The perspective of the CNRHP is more demographic than programmatic,

with passing attention given to reproductive health, family responsibility, and the better health of women and children. The MSP, despite its critical role in implementing any population and family planning policy, is not represented in the Commission's Cabinet. The absence of genuine partnership and dialogue between these two key ministries has been an obstacle to progress in population policy development.

Other Ministries support family planning in key ways. The Social Affairs Directorate (DAS) of the **Ministry of Labor and Social Affairs** has a permanent presence in metropolitan areas through its 71 social promotion centers and 200 social workers. The DAS child nutrition program offers nutritional and family health education to mothers who come to social promotion centers to receive food supplements for their children. DAS social workers frequently team up with health center staff to provide health education. Other initiatives which may serve as entry points to family planning include community-based readaptation, nutrition, MCH, prevention of sexually transmitted disease (STD)/HIV/AIDS, and skills training for women.

The Ministry of Education and Scientific Research supports development of curricula in health and family life education in schools. Institutions for research and training in health and population under the aegis of MERS include the National Medico-Social Institute (INMES), which trains nurses, midwives, and social workers; the Faculty of Medicine at the National University of Benin, which includes training in reproductive health; the Benin National School of Nurses and Auxiliary Nurses (ENIIAB) in Parakou; and the World Health Organization (WHO) Regional Institute for Public Health (IRSP), which offers Masters in Public Health degrees to students from Francophone West Africa.

Regional Centers for Action in Rural Development (CARDER), set up by the **Ministry of Rural Development**, have played a part in disseminating information to rural farming communities on such topics as sanitation, safe water supply, and disease prevention. These committees could also provide reliable information on family planning.

Radio and television are key sources of public information about health in the country. Historically managed by the **Ministry of Culture and Communications**, they now come under the newly created autonomous High Authority for Audiovisual Services and Communication (HAAC), which now permits expanded services through private broadcast ventures in the country.

The **Ministry of National Defense** has participated in immunization and HIV/AIDS prevention efforts and remains a potential partner in wider family planning information program. Similarly, the **Ministry of Justice** addresses the welfare of prisoners and will also become a collaborator in processing any future repeal of the Law of 1920 forbidding the sale of contraceptives. Finally, the **Ministry of Youth and Sport** caters to a key target group for family planning information.

NGOs and the Associative Movement

Local NGOs. Historically, local and national NGOs have played a unique role worldwide in advocating, initiating, and sustaining family planning programs. Their strengths include advocacy for reproductive rights, civic representation at the grass-roots level, innovative approaches to service delivery, and, often, their sustainability.

The NGO sector in Benin has grown from an estimated 32 organizations in the early 1980s, to 72 by 1989, to perhaps 500 modern associations in 1994. Several factors have encouraged the associative movement. First is the model provided by the successful expansion of community-based health and development committees, the COGEC and the COGES. A second is the reduction of the civil service staff, stipulated by nation's structural adjustment program, encouraging former government employees to undertake individual initiatives in the NGO sector. A third factor is the creation of associations tightly entwined with selected political parties. A fourth is the growing number of international NGOs or associations seeking local affiliates. A final and important reason for the growth of Benin's associative movement is the promise of donor financing and support. A United Nations Development Program (UNDP) community-based initiatives project, the social dimensions of adjustment initiative, and the BINGOS NGO Umbrella Project funded by USAID are examples.

The Benin Association for Family Planning, an IPPF affiliate, is the lead NGO in family planning. It has branches in the six departments and clinics in Cotonou, Porto Novo, and Parakou. ABPF has 53 staff members and 1,200 volunteers who address a range of family planning activities including IEC, reproductive health services, and family planning supplies and equipment for 80 public sector clinics of the MSP. Currently, ABPF is struggling to identify a clear role for itself in light of expanded—though still inadequate—government services in family planning. Coordination with the government-based Family Well-being Project, which supports an additional number of "integrated" clinics, has been limited.

International NGOs. Complementing the local NGO movement is a wide variety of international NGO partners. **AFRICARE** implements a the NGO umbrella project BINGOS, whose purpose is to strengthen management and implementation capacity through training in democratization and health. **Population Services International** (PSI) has been working with its counterpart, the Benin Association for Social Marketing (ABMS), in Benin since 1990 in the field of social marketing for contraceptives. **The French Association of Volunteers for Progress** (AFVP) supports PHC and AIDS control activities in Benin. Provision has been made for incorporating family planning in the AFVP program once a national policy has been established. **The German Volunteer Service** provides health technical assistance to government clinics (CSSP) in 10 sub-prefectures. **The U.S. Peace Corps** undertakes health activities in rural and urban areas and could become a valuable partner in community-based family planning education activities. **"Terre des Hommes"** participates in PHC and MCH activities, with an emphasis on nutritional rehabilitation. **Catholic Relief Services** has for many years managed a food distribution program for young children through the social promotion centers of the DAS. **The Canadian Solidarity and Development Organization** (CSDO) collaborates with the Ministry of Labor and Social Affairs in activities of promotion of women and women's status and with the MSP in the Extended Program of Immunization (EPI) and PHC. It discreetly promotes modern and traditional family planning activities. The

nongovernmental sector also includes the multiple religious orders and confessional institutions that have established health care facilities in Benin.

Private Commercial Services

Private commercial services are at times difficult to distinguish from voluntary nongovernmental structures. For the sake of discussion, however, the private health sector in Benin may be said to be comprised of private for-profit and not-for-profit hospitals, cooperative clinics, social marketing activities, private health centers and maternities, private medical practitioners, traditional medicine, and pharmacies.

Known elements in the private health sector infrastructure include 15 hospitals or polyclinics, 46 private surgeries, 56 maternity clinics, 59 private paramedical centers, four pharmaceutical companies, 86 registered pharmacies, and 231 local drug "depots" maintained by drug sellers. Among other initiatives, the Benin Association for Social Marketing (ABMS) sells condoms through a commercial network of distributors and petty traders to support the national HIV/AIDS prevention project. A central purchasing office for generic essential drugs, the *Centrale d'Achat*, is a non-profit, independent entity, having a Management Committee and Administrative Board separate from government. Impetus for the *Centrale* arose from the community-based revolving drug scheme, but sales may extend to any authorized drug outlet, public, NGO, or private commercial. The scheme, which covers about one-third of the population, may also be appropriate for future contraceptive distribution. Finally, 10 private cooperative clinics managed by qualified medical personnal have also been created in localities selected by the MSP.

Multilateral Agencies

Multilateral agencies include notably the World Bank's second Health Services Development Project (PDSS II, 1995-2000, US$31 million in International Development Agency (IDA) funds, plus other donor contributions), which will make a concerted contribution to family planning within an integrated PHC/MCH/FP approach. The family planning component (US$2 million) supports the expansion of FP services and their integration into the minimum package of service at all levels of the health system and equipment and a limited supply of contraceptives, possibly through the Central Purchasing Office for essential drugs. While the policy and management reforms of PDSS II will benefit a family planning program in combination with the limited population sectoral funding, this project is inadequate to address the broad range of population program needs that must be addressed.

UNFPA, in its current program (1995-1998, approximately US$10 million), will continue its efforts in enhancing donor coordination, population policy development, support to PBEF and APBF, and a concerted program of IEC and family life education. UNFPA has been candid about the weak performance of its past programs and has undertaken course corrections, e.g. substituting school-based educational interventions with targeted education for women's credit groups and expanding the thrust of IEC. Historically the design and orientation of UNFPA programs in Benin have suffered from a lack of synergy; typically they contain a number of

disconnected vertical activities managed by separate ministries or entities. Unfortunately, this tradition has yielded an unfocused program that lacks notable impact.

Meanwhile the office of UNICEF-Benin has yet not applied UNICEF's new family planning policy to its program; however, its emphasis on promotion of breastfeeding would offer a suitable entry point. The current roles of UNDP, the World Food Program (WFP), and WHO in family planning are limited, but potentially important.

Bilateral Agencies

Assistance from most bilateral agencies, except USAID, only indirectly supports family planning and reproductive health. Their projects include health infrastructure support by the European Development Fund (FED); health management information system (MIS) by the French Fund for Aid and Cooperation and the Benin-Swiss Medical Project; support to peripheral health centers by Germany and Switzerland; and HIV/AIDS prevention from the FED, Germany, and USAID.

In the past, USAID has also assisted community-based condom distribution, clinical-based training in reproductive health, and family planning IEC. Presently it supports health NGO strengthening, family health education in schools, population policy development, and foresees additional inputs into the sector in the near term.

Conclusion

The foregoing cursory review of institutional and donor support to population programs in Benin points to the conclusion that neither the key actors (Ministries of Planning and Health) nor the key donors (IPPF, World Bank, UNFPA, USAID) have as yet undertaken concerted efforts to create a strong, high-impact family planning program in Benin. USAID has historically shown a comparative advantage in the field population, family planning, and reproductive health in West Africa and worldwide. USAID has been requested by its potential donor partners in the population sector to bridge this gap in development assistance by assuming a leadership role.

Current Status of Family Planning Services

Family planning services are available every day in almost 80 percent of health centers. Unfortunately, their integration with other MCH activities is rare. Most health centers throughout the country have adequate physical facilities for family planning provision, especially a waiting room; a counseling room; and a clean, well lit, well ventilated room with a safe water supply. Equipment, however, is often outdated or incomplete. Contraceptive supplies are not reliable. Only 60 percent of health centers have a written inventory and procurement system or appropriate storage facilities for contraceptives.

Integration of FP into MCH has made considerable progress at the central level. The essential drugs management model is effective throughout the country. Moreover, central level management has shown a real commitment to installing a decentralized and integrated policy for supervision and coordination. At the intermediary and peripheral levels, this integrated approach to supervision and coordination is already being implemented in certain regions.

Unfortunately, intersectoral coordination in family planning is poorly organized, generating a duplication of resources and activities among donors and other actors. Programming, supervision, and evaluation of FP activities are weak for want of human, material, and financial resources. Staff profiles and management capacities are unsatisfactory at all levels of the health pyramid. In spite of considerable effort on the part of the MSP and donors, the health MIS remains incomplete for family planning data. Finally, prohibitive prices for IUDs and injectables would seem to limit client access to these contraceptive methods.

A number of operational obstacles to family planning service delivery are also evident. Service providers consider FP a secondary duty. Only half of FP providers have received clinical training in FP theory and practice. Moreover, only 25 percent have been trained in IEC for family planning and less than 20 percent in management and logistics. Counseling is rarely oriented to the client's reproductive needs. Only 54 percent of new acceptors hear about injectables, 40 percent about orals and barrier methods, and 18 percent about IUDs. Almost 33 percent of service providers influence client choices, especially in favor of oral contraceptives.

Meanwhile, absence of service protocols and procedures, a referral and counter-referral system, effective IEC, a family planning outreach strategy, and a drop-out tracking system all contribute to the weakness of the Benin FP program. Client follow-up is rare; few clients receive information on how to cope with side effects or on the possibility of switching to another method. Discontinuation rates for short- and medium-term methods are, therefore, unacceptably high. Underutilization of FP services is linked to poorly trained staff; inadequate sensitization of the target population; the absence of activities, training, and materials for FP/IEC; and persistent rumors concerning side effects of contraceptive methods.

Many of these insufficiencies may be traced to the absence of a national population and family planning policy. Current policy for family planning is therefore governed by the strategies and guidelines laid out in the Ministry of Health's MCH/FP/Nutrition Program. With respect to family planning, little consistency exists between the objectives and proposed strategies for the program. The conceptual and institutional frameworks for FP are unclear. Existing needs in family planning are not indicated. Process and impact indicators for evaluating family planning interventions are not defined. Continuous evaluation for each level of service is not addressed.

Not surprisingly, in light of these constraints, the government's policy of decentralization of resources and prerogatives in family planning services is not currently effective.

GOVERNMENT POLICIES AND STRATEGIES

Political Support

In public declarations on population issues and at international conferences on population, Benin's political authorities have always demonstrated an awareness of the relationships between demographic growth and development planning. Thus, Benin adopted the Kilimanjaro Action Program concerning population and autonomous development in Africa, which acknowledges that "demographic problems currently constitute an obstacle to economic development in Africa" (Arusha, 1984).

During the World Conference on Population in Mexico City (1984), the Benin government declared that it is "making considerable efforts to effectively integrate demographic variables as endogenous factors of in development models."

In the preface to the 1994 Benin national report for the International Conference on Population and Development in Cairo, the Minister of Planning remarked that Benin is prepared to adopt a population policy and pointed out that the goal of such a policy would be to specify national priorities and concerns in the area of social development in the face of the population's demographic behaviors and trends and in the face of its ability to satisfy its essential needs.

Finally, in the 1994-96 Economic Policy Framework Document, the government expresses the expectation that it will adopt policies by June 1995 at the latest to contain population growth.

However, despite this often-reiterated political determination, a certain cautiousness, even resistance, is apparent in creating the legal and political environment that enables the development of a family planning program.

The Legislative and Regulatory Context

The weight of tradition, pro-natalist attitudes, and a conservative colonial legal heritage have deeply impregnated the legislative framework. Family subsidies are paid to workers for up to six children, and a father of a family with six children pays less in taxes than other persons.

More significant, the Law of 31 July 1920 outlawing abortion and contraception information is still in force. Article I of the law forbids the sale, preparation for sale, public offering or exhibition, display or distribution, public or not, of all forms of advertising in whatever form they may be—ads, displays, drawings—of contraceptive promotional material. Offenders are liable to receive criminal sanctions.

The 1920 law creates a genuine paradox. The government breached this law by authorizing, as early as 1972, the creation of the precursor of the Beninese Association for Promotion of the Family; it has also created government services charged with MCH and family planning. On the other hand, the 1920 law was reinforced by a 1986 decree regarding traditional medicine practices, stating that they must in no case be used "for destructive purposes, such as homicide, abortion, adultery...."

A revision of the law is now indispensable in order to adapt it to today's context and to the government's population objectives.

Cross-sectoral Impact of Population Growth

Although health indicators have shown improvement over the last 10 years, rapid advance has been stalled by the twofold pressures of demographic growth, which increased the demand for services, and economic constraints.

Similarly, demographic growth has led to high demand for schooling, which Benin has not been able to satisfy due to the deterioration of the economic situation. Thus, the percentage of children in school dropped from 62.21 percent in 1983 to 49.68 percent in 1990, before climbing back to 59.91 percent in 1992. The teacher-student ratio has declined, going from one teacher per 33 students in 1988 to one teacher per 40 students in 1992.

The employment sector is also experiencing strong tensions due to the increasingly rapid growth of the workforce (those age 10 and above) and the weak market that is unable to absorb the supply of labor. Between 1979 and 1992, the workforce experienced an average annual increase of 4.9 percent. The government, the main employer of the modern sector until 1986, was then mandated to cut government employees by 12 percent and foster private initiative. Underemployment is extensive, and the informal sector is predominant. Official unemployment is 1.5 percent; however, the real rate of unemployment is certainly greater than official numbers reveal.

Generally speaking, over the 1970-1990 period, the progress in grain production, with an annual growth rate of 3.7 percent, closely approached the growth rate of the population. The considerable demographic growth, however, especially in urban areas, led to an increase in the demand for food. Nevertheless, the country is confronted with a problem of protein/energy malnutrition. According to a survey carried out in 1986, this type of malnutrition reached an average national level of 21.7 percent, 35 percent in children under five years.

In Benin, demographic growth has consequences for the environment, especially for soil, wildlife, and urban pollution. Cultivation practices (slash-and-burn shifting cultivation), brush fires, wood burning for the production of energy for home cooking, and overgrazing contribute extensively to the environment's deterioration. Demographic pressure (53.5 percent of the population lives on 10 percent of the land) also leads to the extension of arable lands at the expense of forests. The lack of a drainage network, the absence of a functional garbage collection system, the defective condition of the roads, which fosters water stagnation, are causes of pollution in urban areas.

The government has not yet defined an explicit policy for the advancement of women. In the 1994-1996 Economic Policy Framework Document, however, the government is committed to developing a coherent strategy concerning the integration of women in development through the end of June 1995. Therefore, the National Committee for the Integration of Women in Development (CNIFD) was created. It should be noted that there are of several very dynamic

women's nongovernmental organizations in Benin including the Benin Association of Women Jurists (AFJB) and the National Federation of Women's NGOs.

Population and Development Planning

Demographic variables have scarcely been integrated into the different development plans developed and implemented in Benin. Structural adjustment programs, given the economic and financial goals which constitute their prime concerns, do not sufficiently consider demographic effects. In the area of health, the use of demographic variables for the development of programs and projects in the sector is significant. In the area of education, demographic variables are well integrated

The absence of a population policy, however, precludes a reference point to account for these variables in development planning. The low level of integration of demography into planning stems particularly from a lack of human resources trained in demographics or population policy and planning. At the Human Resources and Population Service of the Office of Planning and the Permanent Secretariat of the National Human Resources and Population Commission, not one official has been adequately trained in this area.

The CNRHP, charged with setting up a population and human resource policy and monitoring its implementation, is not open to NGOs or society at large. The SRHP, the Permanent Secretariat of the CNRHP, undertakes most of the technical work. CNRHP displays several weaknesses: (1) the SRHP employs only two full-time persons in upper management; (2) the staff of the SRHP also suffers from a lack of training for integrating demographic variables into planning; and (3) the Commission is not representative of all stakeholders.

Toward a Population Policy

A framework for such a population policy is offered in the objectives and strategies of the document prepared by the CNRHP for the 1994 ICPD:

Overall Objective: Improve mother and child health in Benin through the reduction of morbidity and mortality.

Intermediate Objectives:

- Promote and intensify family planning activities.
- Strengthen existing infrastructures to make them suitable for family health activities.
- Improve the quality of family planning services.

Specific Objectives:

- Increase the number of family planning acceptors by 10,000 a year.

- Increase the national contraceptive prevalence rate (CPR) to four percent overall and to nine percent among women in priority zones (urban and semi-urban areas) by the year 2000.
- Reduce by 75 percent the number of undesired pregnancies.
- Reduce by 50 percent the number of induced abortions.

The strategies proposed for attaining these objectives include IEC, service delivery, training and supervision of personnel, operations research, and coordination of activities in the field. Elements of these strategies include:

- Educate youth about ideas and practices of family life and population.
- Introduce family life education in training programs at all levels.
- Inform and sensitize families, opinion leaders, and decision-makers about family planning and the role of convenient birth spacing.
- Ensure availability of quality FP services.
- Ensure availability of affordable and effective means of contraception.
- Increase in the number of MCH facilities and integration of FP activities within them.
- Train the necessary personnel in the application of the national FP policy.
- Revise the 1920 law and elaboration of legislative texts adapted to the national FP policy.
- Promote and encourage operations research in the area of traditional contraception.

The desired improvements in the population sector will require the following measures:

- Restructuring the organization of health and family planning service
- Gradual decentralization
- Reinforcement of cooperation through sectoral coordination, motivation of community members, and promotion of preventive activities, including family planning, in the private sector

Although development of a family planning policy remains to be undertaken, implementation of the measures above is nevertheless gradually underway owing to public demand and encouragement from development partners.

INFORMATION, EDUCATION, AND COMMUNICATION

For centuries, Beninese culture has granted a privileged place to the role of speech in public and private life. "Saying" is closely bound up with "doing," or at least with a commitment to do. It is not surprising, then, that the world of development has been deeply touched by the communication revolution that has accompanied democratization in Benin. Development as "act" is preceded by development as "speech." Full participation of the population in development action implies a free and open exchange of information and dialogue. This vision of speech and its paramount role has encouraged active attention to information, education, and communication as a part of the development process. It is widely recognized that

communication policy, coordination, and services need to be improved if the political, economic, and social development of Benin is to be sustained.

IEC for Family Planning: The Need for an Overarching Strategy

The near-absence of IEC activities and materials for family planning and reproductive health in Benin has been lamented repeatedly in studies, evaluations, and reports. The government's preparatory document for the 1994 ICPD stresses the urgent need to reinforce IEC for family planning in order to increase demand. A strong consensus has formed in recent years among government staff, NGOs, and development partners that IEC plays a key role in meeting objectives in current and future programs for population and reproductive health. However, field visits undertaken by the Assessment Team in four of the six departments confirmed the observation made recently in the family planning Situation Analysis that—despite IEC efforts made thus far—little IEC activity or impact can be seen in the field. The study also observed that family planning materials, usually posters, were present in only 29 percent of health centers visited and that no materials designed for individual clients were available. The most common props are anatomical models and the contraceptives themselves. Most centers visited had recently received flip charts developed by the PBEF project about health and family planning topics for *causeries*; yet, in most instances they were left to gather dust or remained in their original cartons.

Early morning IEC sessions are a prescribed feature of prenatal service days; however, only three facilities kept records or plans of such activities. Moreover, the records showed that family planning topics constitute no more than five percent of the subjects discussed. Only 21 percent of clients in the clinics visited had received information from any source on family planning; in most instances this information was offered only in the privacy of individual consultations initiated by the client.

Accurate, reliable, and continuous information on family planning and reproductive health is needed in Benin. Anecdotal evidence suggests that women, especially young women, want family planning services that are discreet, private, and unfettered by medical and cultural barriers. Most of all, men and women of all ages need and want information. A future family planning IEC (FP/IEC) strategy, however, should not consist of isolated IEC-specific or IEC-intensive projects as a means of encouraging a rise in demand for family planning services; rather, demand for family planning must be linked to services, well coordinated among all sectors, and fully integrated into the training, work, and evaluation of health workers. A harmonized approach, which stresses the role of IEC development but keeps it in step with other program components, is critically important.

Opportunities and Constraints to IEC for Family Planning and Reproductive Health

Opportunities

Structures. A variety of structures exist in Benin to support IEC for family planning and reproductive health. Progress toward administrative decentralization of powers in health, social

affairs, and communications has expanded available structures by encouraging pragmatic and localized planning. Opportunities have been added by the proliferation of national NGOs and associations for progress and development. To realize their full potential of IEC, however, all structures will need to be better utilized and coordinated.

The IEC Service of the National Directorate of Health Protection is in the MSP. The Service mandate covers IEC planning, conception of IEC materials, coordination, training, research, monitoring and evaluation, and advice to other health units. Currently, the budget (approximately US$20,000 per annum), staff, and office of the Service are relatively small. The offices are woefully inadequate and in disrepair. Owing to lack of funds for program implementation and materials development, practical functions of the Service are limited to technical assistance, training, coordination, and monitoring of health education activities. Greater emphasis on FP/IEC can be expected in future through the new IEC Unit under the Family Planning Service in the Directorate of Family Health, which was mandated by the 1994 reorganization of the health ministry.

About one-quarter of funds for the MSP's Project for Family Well-being are earmarked for IEC training and materials development. As numerous evaluations have observed, the rate of absorption has been low. PBEF does not have a staff member assigned specifically to IEC. Responsibility for IEC training and materials conception has fallen chiefly to the IEC Service in the MSP. Three posters and one flip chart have been developed and very recently distributed to CCSs and CSSPs/CSCUs supported by the PBEF. An individualized flyer for clients is in production and will be the only individualized FP/IEC material available in the country.

Social workers from the Directorate of Social Affairs in the MTEAS have long been associated with IEC for MCH/FP/Nutrition activities in Benin. They are trained in communications at the National Medico-social Institute. Social workers are increasingly assigned tasks in FP/IEC at health and social promotion centers. In addition, experiments in nutritional outreach supported by the DAS have incorporated *mères-animatrices* (mother-promoters) into the communication network.

ABPF, the local IPPF affiliate, has long recognized the paramount importance of demand creation and IEC. Its approaches have been limited by a lack of technical and financial resources but include a wide variety of channels for outreach and interpersonal communication such as volunteers, local development associations, apprentice workshops, markets, health and social centers, private clinics, youth groups, women's groups, churches and mosques, and others. Since 1991 ABPF has also produced a quarterly publication for volunteers and supports radio programming on family health.

Social Marketing. Since 1992, Population Services International, through its local affiliate the ABMS, has pursued an aggressive campaign of HIV/AIDS prevention by marketing condoms under the "Prudence" label. The project may be credited with having been the first to promote a modern contraceptive method through posters, stickers, media, and targeted interpersonal communication. Name recognition has been enhanced by three television spots, one run each evening before and after the evening news. In addition, ORTB (national public) radio runs free of charge three condom promotion radio spots daily in French and in local languages.

"Prudence" is also sold in pharmacies and in the informal market by itinerant sellers, barbers, hairdressers, and in bars and nightclubs, petrol stations, and small corner stands. Wholesalers in the "Prudence" sales network are trained in HIV/AIDS prevention messages. These messages are passed on informally down the marketing chain to end clients.

Family Planning in Formal Education. UNFPA, in its 1994 program, reserved US$625,000 of the proposed US$2.8 million for IEC. Activities include (1) teacher training in population and family life education and (2) support to two documentation centers on population. USAID envisages a Health Education for Schools project for 1995-1998 to develop materials and messages on health, including reproductive health, for primary schools.

Media and channels. A wide range of media and channels are available for IEC in Benin. **Print media** include several stable independent newspapers: *La Nation* (a government-supported daily with a print run of 5,000), a high-quality independent daily, *Le Matin*, and other weeklies. The recent creation of the HAAC, an autonomous nongovernmental regulatory body for communications, is expected to bring about major expansion of media coverage through private channels.

Radio is currently the only communication channel having a nationwide reach. Nearly every Beninese has access to radio broadcasting. "Rural Radio," in local languages, is integrated into the national radio and is conceived as an IEC organ for the rural population.

Television until recently reached only an estimated one-and-a-half million persons, chiefly in the southern and central portions served by broadcast points in Cotonou and Parakou. Television coverage will soon reach the whole of Benin. Health and family planning topics currently occupy only about one percent of weekly broadcast time each for radio and television.

Cinema, video, and tape players are popular media, and the existence of "video clubs" for cassette rental in the major cities indicates a growing market. Tape players and cassette recordings are extremely widespread and affordable for at least half of the population. A small number of ABPF and government clinics have installed videos in waiting rooms, but the selection of videos is very limited.

Impact of broadcast, audiovisual, and print media in rural areas will need reinforcement by interpersonal or more localized channels. Various mechanisms for **IEC outreach** in health and family sector have been attempted by a variety of projects, including volunteer health agents, sanitation agents, literacy training and reading clubs, village health committees (the COGES and COGEC), AIDS social marketing agents, social workers, *mères animatrices*, the CARDER, ABPF outreach to markets and villages, use of traditional music and drama, and so on.

Social mobilization campaigns for health have included oral rehydration therapy, the expanded program of immunization, and more recently AIDS prevention and breastfeeding. Typically, social mobilization relies on a media mix in which oral communication and traditional arts have had a very large share; only one-quarter of the Beninese population is literate. Recent revalorization of traditional cultures and their heritage of social institutions and communication networks has encouraged a revival of traditional arts since 1991.

Materials Development

A key resource for IEC materials development is the **Educational Materials for Health Personnel** (MEPS) center for Francophone Africa, housed within the Regional Institute for Public Health in Cotonou. Capabilities include desktop publishing and printing; black and white photographic developing, processing, enlarging, and printing; video production and editing; and binding, illustration, and design. MEPS continues to serve as a leading source of materials development for the public health, medical, and development community in Benin.

Media houses are developing at a modest pace since the opening of Benin's free, formal sector economy. Local advertising and publicity, which grew quickly to meet the demand of the 1991 electoral campaign, serves the burgeoning commercial sector with the support of high-quality presses and printing services.

Constraints

In January 1990 the Ministry of Health undertook an analysis of its IEC activities. Weaknesses noted included (1) the need for a national IEC policy; (2) the absence of coordination; (3) a didactic, one-way approach to communication; (4) failure to recognize cultural conditions undergirding behavior; (5) the lack of competence in social communication among health workers; and (6) insufficient material and financial resources.

Absence of an Overarching FP/IEC Strategy. A precondition for developing a national population policy is the creation of a consensus environment that would encourage open exchange of information among policy-makers, service providers, and potential clients. This "communication" environment is needed, not only to encourage policy making in the broad sense, but for FP/IEC to prosper within such a policy. IEC draws strength from support at all levels of the decision-making hierarchy—from the highest national figures, through the health and social pyramids, to the household. Without a common vision among the interlocking parts, no part will succeed. A village health worker, for example, cannot aggressively pursue family planning counseling if the village opinion leaders strongly disagree with her message. Similarly, the health ministry will not meet its reproductive health goals if the nation's husbands vehemently object.

Lack of an overarching FP/IEC strategy also results in poor coordination in FP/IEC efforts among various actors in the private, public, and NGO sectors, often with "mixed messages" heard by the public.

Cultural Beliefs Concerning Reproductive Health. A persistent and widespread belief is found among Beninese men and women at all levels that the principal objective of family planning is limitation, and not spacing, of births. Moreover, traditional notions concerning fertility and the regularity of menstruation result in low tolerance for, and some religious prohibitions against, such side effects as spotting and amenorrhea which occur with some family planning methods. At present, cultural beliefs, attitudes, and practices toward family planning are poorly

understood by the public health community. A need for in-depth ethnological studies is evident in order to understand the beliefs undergirding behaviors toward family planning and reproductive health.

Inadequate Training in FP/IEC for Health Workers. Absence of accurate and authoritative information on contraceptives among health professionals leads to application of medical barriers and lack of conviction about the benefits or appropriateness of certain methods. Insufficient FP and FP/IEC training—in quality and quantity—for health and social professionals is evident throughout the health care system in public, private, and NGO sectors. Moreover, lack of personnel and management incentives for conducting FP/IEC activities in the field leads to non-use of the few FP/IEC materials that are currently available. Finally, IEC in all areas of health has often been entrusted to non-professional or volunteer agents, such as members of the COGEC and COGES at village level or petty traders in the condom social marketing network. Quality control of information and communication skills for family planning is critically important.

Limited Reach of IEC Channels. Overall, limited infrastructures for public communication and logistics in Benin confine the reach and speed of information exchange. These constraints are compounded by features of the audience. High illiteracy (75 percent) limits the impact of print materials, and the reach of radio, television, and traditional media is not universal. Women are typically the most difficult audience to reach. Few own radios or televisions. Most women live in a household or compound having a radio, but they rarely select the programs heard. Hours of health broadcasts often conflict with a woman's heavy daily commitments inside or outside the home.

Inadequacy of Financial Resources in FP/IEC. Experience in similar countries suggests that FP/IEC should receive a total population program budget share of around 15-20 percent. Financial resources made available to IEC for family planning so far have not exceeded these levels, but they have not been fully absorbed. For reasons which are unclear, the IEC Service in the MSP has relied on funds from other units and projects to fund IEC training and implementation. Similarly, the incomplete decentralization of IEC budgets, activities, and resources has also contributed to this paradox. One may note the absence of a separate IEC budget for the department level, which requires IEC staff to mobilize funds on a "demand" basis from its colleagues. Finally, because the importance of IEC outreach has not been stressed, the collective community resources managed by the COGEC and COGES have never been mobilized for IEC. Finally, all ministries, including the MSP, have funds budgeted for their "liaison office" and for communications. These resources have not been galvanized in order to promote dissemination of health messages in the public interest.

Toward a Future Strategy for IEC in Family Planning and Reproductive Health

The framework for a future strategy for FP/IEC in Benin should ensure that the strategy be:

- Fully incorporated into an overarching program in family planning and reproductive health, matching demand creation at all points with the supply of quality services.

- Multi-pronged, including (1) advocacy for decision-makers at all levels, (2) demand creation for potential clients and their families, and (3) training for FP workers in counseling, dispelling rumors about such side effects as spotting and amenorrhea, outreach, and group communication.

- Multi-channeled, drawing upon all potential communication networks, whether family-based, institutional, mass media, journalistic, interpersonal, or positioned.

- Multi-media, incorporating all appropriate forms of verbal and visual modes of expression--from training lectures to storytelling; from traditional masquerades to mass media; from a private statement by a satisfied user to an advert; from a whispered direction to a self-proclaiming logo; from a mother's tentative suggestion to a heath worker's counsel.

- Fully researched, including (1) initial knowledge, attitudes, and practice (KAP) and qualitative studies, (2) studies before, during, and after materials production, (3) analyses for impact, and (4) assessments by beneficiaries.

- Conceived within the framework of an overarching national FP/IEC strategy, which includes (1) information for policy making, (2) formal and informal education at all levels, (3) mass media for awareness creation, (4) outreach into rural areas and urban neighborhoods, (5) systematic counseling about FP at prenatal, postpartum, and postnatal visits, (6) clinic-based group communication, and (7) development of appropriate materials, especially for the individual client.

- Approached differently in urban and rural areas, and, where necessary, among different ethnic groups.

- Developed carefully through the stages of (1) building awareness about the benefits of family planning, (2) building approval of contraception, (3) increasing knowledge about specific methods of contraception, and (4) encouraging continued use of family planning methods among women and men who desire to do so.

- Be directed toward both client and decision-making audiences. Client audiences in order of priority would include adult women, young women, adult men, young men; influentials include policy-makers, traditional opinion leaders, health and social workers, teachers, and older female relatives in the household.

- Key promises should turn on the enhancement of personal and family well-being, national development, the status of women, democratic choice, family economies, and the image of contraceptives.

- Sub-strategies may focus on policy, urban areas, service points, rural outreach, adolescent audiences, male responsibility, and the press.

Care should be taken that a FP/IEC strategy does not:

- Proceed in advance of audience readiness to accept the next stage of promotion.
- Be undertaken without ensuring the presence of a consensual environment for the target audience.
- Exclude detractors from discussion, but involve and attempt to persuade them.
- Denigrate relevant cultural traditions or traditional methods.
- Advance the notion that the chief purpose of family planning is the limitation of births.
- Encourage unnecessary medical or religious barriers to contraception.
- Create an impression of pressure or coercion.

TRAINING AND HUMAN RESOURCES DEVELOPMENT

Training for health and social workers in providing quality family planning and reproductive health services is not developed in Benin. An assessment of the sector was approached by interviewing approximately 40 heads of services and representatives of international agencies and assessing the performance of 40 service providers. Among the persons met were the managers of 10 organizations collaborating with the Ministry of Health in the context of the PBEF. They included ABPF, UNICEF, WHO, the Benin-Germany Primary Health Care Project (PBASSP), PSI, MEPS, the Center for Research in Human and Demographic Reproduction (CRRHD), UNFPA, PDSS, and The Population Council. Interviews were also conducted with the managers of three preservice training schools, the faculty of medical sciences, the School of Midwives/State Nurses, and the IRSP. Eighteen FP service delivery sites in five departments were visited and the work conditions surveyed.

Personnel and Human Resources

According to 1992 MSP statistics, the number and distribution of personnel working in the public health sector are as follows:

- 244 physicians
- 1118 nurses
- 413 midwives
- 201 lab technicians
- 614 nurse aids
- 10 pharmacists

Statistics on the number of personnel working in the 162 private sector delivery sites are not available.

According to national MCH/FP officials, approximately 378 service providers have received FP training, including personnel trained by ABPF. Unfortunately, reproductive health service policy and post-training guidelines for FP service providers have not been established, and it is therefore difficult to judge the quality of training in relation to performance expectations.

Results of the Situation Analysis for FP show that:

- The general performance of service providers is insufficient in critical fields such as FP/IEC, administration of contraceptives, and "informed choice" of method.
- 35 percent of FP service providers have not had any formal training in contraceptive technology.
- 43 percent of them have not had any practical training.
- Only 24 percent of them benefit from sufficient supervision.

A pool of resource persons for training in reproductive health does exist at the national level, including central level ministry officials, faculty members from the University Clinic of Gynecology and Obstetrics, CNHU, the Central MCH Clinic in Cotonou, the Lagoon Maternity in Cotonou, and a small cadre of national trainers. The PBEF project has also, over time, formed national and departmental FP training teams.

Infrastructure for FP Services, Training, and Supervision

One hundred five *maternités* in five departments were selected to receive priority UNFPA assistance in the context of the PBEF in order to provide quality services. Training of staff is a first step toward meeting this objective.

The MSP's training policy seems to center on developing training skills within institutions, from which training is decentralized using a "training of trainers" or "cascade" approach. Focus of training is made difficult by the absence of a public health service policy or guidelines.

National institutions strongly involved in FP and reproductive health training are at the Ministry of Health (PBEF, the National Coordination Unit for MCH/FP/Nutrition, and the IEC Unit), the Ministry of Education (the Medical School, INMES in Cotonou, and its equivalent ENIIAB in Parakou), and ABPF. Complementing these structures are smaller NGOs, such as religious clinics or hospitals, and the many private clinics and maternities.

Currently, an integrated supervision system is used for MCH/FP services. Although this approach is economical, technical aspects of FP are often neglected and there is little emphasis on clinical performance. It is not apparent that the personnel charged with supervising family planning service performance are themselves adequately trained.

In-service Training

The average duration of the in-service FP training conducted in-country in the period 1982-1990 was 10 days. This duration may be compared with the 4-6 weeks typically allowed for clinical training in IUD insertion in neighboring countries. Training is chiefly theoretical, without practicum in family planning service provision. Scores on standard measuring tools used in Francophone Africa for knowledge and performance in family planning showed an average

"knowledge" score for trainers at 58.3 percent and for service providers at 61.6 percent; the average "performance" score for both categories was 56.3 percent.

PBEF has developed draft family planning course syllabi and handouts, and there is a preliminary service policy document adapted from the Togo national policy and standards. ABPF has also prepared modules for training in family planning, which could become the basis for a comprehensive in-service training curriculum.

Based on analysis, in-service training needs have been identified as follows:

- Refresher training for clinical FP service providers
- Training of administrative officers in management
- Training in evaluation/supervision
- Training of trainers and preceptors
- Review of the training program
- Provision of technical protocols

Preservice Training

Preservice training institutions—the Faculty of Health Sciences (FSS), INMES, and ENIIAB in Parakou—do not have training curricula; rather they have a list of subject areas to cover and a suggested time frame. The program of the school of state nurses does not include family planning. All institutions lack IEC materials and demonstration equipment such as models or sample contraceptives.

The FSS and INMES managers are interested in assistance in the following areas:

- Development and integration of FP modules
- Training of trainers and preceptors in pedagogy
- Training of trainers and preceptors in evaluation/supervision
- Provision of demonstration and training materials

Proposed Strategy for Family Planning

The following series of activities is proposed as a strategy for beginning the process of building national capacity and capability to plan, implement, and evaluate training in family planning and reproductive health.

- A reproductive health/contraceptive technology update should be conducted for a core of national resource persons. The resource persons should be the current national trainers and members of the MCH/FP Committee set up by the PBEF. An update should also be provided for key service providers selected from those who are motivated and who will be available to work as trainers or preceptors in the future.

- Quality services should be developed in the potential practicum sites through the provision of equipment and supplies and reference materials. IEC efforts should be stepped up in those sites.

- The development of national family planning and reproductive health guides and guidelines should begin immediately.

- A national strategy should be developed and implemented for training and supervision in family planning and reproductive health. The strategy should include the following components at a minimum:

  * Training in performance evaluation and supervision
  * Development of technical supervision protocols
  * Establishment of logistics and finances for supervision activities
  * Training of preceptors in precepting skills and reproductive health technologies
  * Training of provincial trainers in family planning and reproductive health and in training methodologies
  * Training and updating service providers
  * Reinforcement of family planning and reproductive health training in preservice institutions

- Family planning and reproductive health service protocols should be prepared based on the national service policy and standards. These should be widely disseminated to all service providers who should also be trained in their use.

- Clinical family planning training curricula should be prepared based on the service policy and standards and protocols. Curricula and modules currently prepared by the PBEF and ABPF should be used a basis.

BREASTFEEDING

At the 1988 Bellagio Conference in Italy, it was unanimously agreed that women who exclusively breastfeed their babies for the first six months have only a two percent chance of becoming pregnant (Perez, 1992). IPPF acknowledges the important role of breastfeeding in birth spacing. In many developing countries today, breastfeeding prevents more births within a given period than any other method of family planning (Kleinman and Senanayeke, 1984).

Nutritional Status of Children and Women of Childbearing Age

An assessment of the breastfeeding situation at the country level is the first step in developing a comprehensive breastfeeding promotion plan. Poor health status of mothers and children in Benin results from the high prevalence of tropical communicable diseases, poor nutrition, and a high fertility rate.

In Benin, 35-40 percent of children ages 0-3 years suffer from protein-energy malnutrition and 10-17 percent of the babies are born with low birth weight (Hessou, 1994). In some areas, almost 23 percent of women have a low body mass index (Ague, 1993). Iron deficiency is found in 52 percent of the children age six months to two years and in 45 percent of pregnant women. Vitamin A deficiency is a public health problem in the northern part of the country. Iodine deficiency is endemic in certain areas of the north. The prevalence of goiter ranges from 15-61 percent, and it is highest among girls (Hessou, 1994).

The determinants of the poor nutritional status of Beninese children are mothers' ignorance about the nutritional needs of the child, household food insecurity, weaning age, and the child's sex (Batawila, 1990). Poverty and ignorance are the principal determinants of the nutritional status of women in Benin.

Breastfeeding Practices in Benin

It is generally believed that all Beninese children are breastfed; however, there are no representative data to support this belief. The only reliable study on breastfeeding practices in Benin is a thesis conducted at the University of Benin (Ekanmian, 1994). The sample included 500 nursing mothers and 107 health workers randomly selected throughout the country. Based on the study and on some information gathered during field visits, the current breastfeeding practices could be summarized as follows: the prevalence of breastfeeding in Benin averages 77.6 percent; it is higher in rural areas (93.7 percent) than in the cities (53.5 percent). Only seven percent of babies are breastfed exclusively during the first 4-6 months. In urban areas, 45.5 percent of the babies are given breast milk plus infant formula. The duration of breastfeeding ranges from 18 to 24 months. Complementary food is introduced at three months.

The determinants of the prevalence of breastfeeding Benin are the age of the mother, her level of education, civil status, and religious affiliation, and the place of delivery. Approximately 97 percent of Beninese mothers recognize that breastfeeding promotes good health in children; only 58.6 percent, however, initiate breastfeeding soon after delivery. Initiation is usually delayed from 1-3 days after birth. The reasons for delay include lack of breast milk secretion (65.0 percent); mother and baby are separated (13.3 percent); and Cesarean operation (9.8 percent). The introduction of other liquids before breast milk and throughout infancy is almost universal in Benin; 92.4 percent of mothers give other liquids because they think babies are thirsty or mother's milk is not sufficient (49.8 percent). Up to 21.8 percent of the women discard colostrum for the following reasons: it is bad milk (68.8 percent); it is useless (7.3 percent); they are instructed not to use it (11.9 percent); and mother and child separation (13.9 percent).

Only 42.2 percent of health workers do not know that breastfeeding should start within half an hour following delivery. In addition, 72.5 percent recommend liquids, such as plain and sweet water, and solutions of herbs, roots, and spices. However, 85.3 percent of the health workers educate mothers about the importance of breastfeeding.

Breastfeeding Policies and Support

The Beninese Labor Code provides 14 weeks of paid maternity leave and allocates breastfeeding breaks for nursing mothers. A national breastfeeding policy for the protection, encouragement, and promotion of breastfeeding has been adopted by the Benin government (MSP, 1992). A national technical committee has been set up for the follow-up of breastfeeding activities. The policy is being implemented with the assistance of UNICEF through its Baby Friendly Hospital (BFH) initiative. Breastfeeding is a key strategy in the newly formulated National Action Plan for Food and Nutrition (PANAN). Breastfeeding is mentioned in other MSP child survival programs, such as diarrheal disease control and the expanded program of immunization.

UNICEF is the main actor in breastfeeding promotion in Benin. A vast breastfeeding campaign through BHF activities is being undertaken in collaboration with the MSP. So far 33 health establishments in the six regions have been targeted to become BFHs. Their personnel have been trained. Approximately 10 health facilities already fulfill UNICEF's conditions to become BFHs.

A national NGO for the promotion of breastfeeding activities in Benin has been recently formed, IBFAN-Benin, which is the national equivalent of the International Baby Food Action Network.

Breastfeeding as a Family Planning Method in Benin

Generally, breastfeeding is not being proposed to Beninese women as an alternative family planning method. Only one maternity (CHD/Ouémé) has a clear breastfeeding policy for its planning family unit; during family planning counseling, breastfeeding is proposed to women as another method of child spacing. ABPF has developed one rural radio message on breastfeeding as a family planning method, but breastfeeding is not being proposed to women attending ABPF family planning clinics.

Breastfeeding as a birth spacing method has not been integrated into family planning activities. Family planning officials in Benin recognize that IPPF recommends that breastfeeding be proposed to women as an alternative child spacing method. Beninese health and social workers involved in family planning promotional activities also acknowledge that breastfeeding-related abstinence was practiced in the past. After delivery, the women was separated from her husband. It was culturally forbidden to have sex while breastfeeding based on the belief that sperm might contaminate breast milk and cause illness in the child. This practice indirectly contributed to an increase in the interval between births.

Conclusions

Current breastfeeding practices in Benin do not meet the international community's standards for optimum benefits in child survival and family planning: up to 27 percent of mothers delay the initiation of breastfeeding from 24 hours up to three days; exclusive breastfeeding during

the first 4-6 months is rare and other liquids are given to the baby right from birth; colostrum is still considered "bad milk" and is discarded in many cases; the bottle feeding rate is relatively high in urban areas; supplementation starts very early with thin maize porridge; and the weaning age is declining. There are, however, several supportive factors for the promotion of breastfeeding in Benin, despite the constraints.

Supportive Factors for the Promotion of Breastfeeding in Benin

The following are supportive factors for the promotion of breastfeeding in Benin:

- There is widespread acceptance of breastfeeding.
- PANAN includes breastfeeding as one of its strategies.
- A national breastfeeding policy is already operational, and a national code for the marketing of breast milk substitutes has been formulated.
- The Beninese Labor Code provides 14 weeks maternity leave with salary.
- A national technical committee on breastfeeding has been set up and is operational.
- A local NGO for the promotion of breastfeeding activities at the community level, IBFAN-Benin, has been recently created.
- Numerous opportunities exist to reach a large number of women through health centers, social welfare centers, village health centers, food and applied nutrition posts, community-based women's groups, and NGOs.
- The health system is based on the Bamako Initiative with a trend toward integration of MCH/FP/nutrition activities.
- There is strong involvement of donor agencies and NGOs in the promotion of breastfeeding (UNICEF), nutrition, food security, and income-generating activities (United Nations Food and Agriculture Organization, World Food Program, CRS, and Terre des Hommes).

Constraints

The following are constraints to optimal breastfeeding and its promotion in Benin:

- There is a widespread belief that newborn babies are thirsty and they need water and other liquids.
- Women's heavy work load interferes with breastfeeding.
- There is a lack of representative data on breastfeeding practices.
- There is a lack of financial allocations from the state budget for breastfeeding promotion activities.
- Health and social workers are inadequately trained in optimum breastfeeding practices.
- Insufficient emphasis is put on the nutritional status of pregnant and lactating mothers.

FAMILY PLANNING LOGISTICS

The objective of the logistics evaluation was to (1) examine the present system(s) of family planning logistics existing in the country, (2) assess their relative effectiveness in providing for the country's needs, taking into account the stated policy and objectives of the government toward family planning, and (3) suggest or recommend any measures that might strengthen or improve the present system(s) and make them more able to cope with national needs and achieve stated FP targets.

Contraceptive Prevalence

In 1993 there were an estimated 1,095,000 women of reproductive age (WRA) in Benin out of a total population of 5,068,004, of which around 74 percent live in the rural areas. The actual number in 1994 is probably close to 1.23 to 1.3 million. The base data—e.g., actual supplies consumed, established method mix, etc.—appear to confirm that the level of contraceptive acceptance is no more than one percent, despite the fact that approximately 46 percent of married women are said to be aware of modern contraceptive methods (UNFPA, 1992a). Statistics emanating from clinic records appear to place the CPR at a higher level, two to three percent. However, this higher figure appears to be based on the system of counting acceptors every time they appear at a clinic to renew their prescriptions. World Bank figures place it even lower, at 0.5 percent, and the Ministry of Health placed it between 0.7-1.0 percent in 1991.

The lack of adequate planning for supplies to meet the potential demand may have contributed to a less than active promotion of family planning in government health/FP services. Though family planning items may be found in most health units, quantities kept in stock are often quite low.

This situation may be the result of relatively low stocks held in centrally in Cotonou, which reflects upon the estimates of needs and orders placed with UNFPA, the government's main supplier. The estimates have tended to be very modest in recent years and not representative of the country's real needs. Thus the cycle reinforces itself: low stocks in the central store, low stocks in the health units, low level of FP to potential acceptors, low movement of stocks, and thus low level of requests for more supplies to UNFPA.

In 1993 the 59 health units visited had given service to 13,643 old acceptors and 4,718 new acceptors, or an average of 231 old acceptors and 80 new acceptors per health unit. In comparison, in 1993, the numbers of old and new acceptors receiving service in the two clinics of the ABPF, the private FP organization in Benin affiliated with IPPF, were 6,783 and 3,137 respectively, or an average of 3,391/clinic and 1,568/clinic. The comparison serves to show the difference in acceptor level between a clinic with motivated staff and relatively good logistics management (ABPF) and those less well served (public health facilities). The number of family planning acceptors in Benin in 1994 was probably in the region of 15,000-16,000.

It would appear that one of the reasons for the low CPR in the country is the absence of an effective government (MSP) FP logistics system and management thereof, including the following:

- Lack of knowledge about the country's present and future needs for contraceptives
- Unrealistic CPR reporting due to inaccurate data or absence of a data recording system
- Absence of efficient supplies or inventory management at all levels; weak planning, forecasting, or budgeting functions
- Absence of an effective distribution system
- Lack of training in logistics management by headquarters staff and health workers in FP units
- Precarious system of cost recovery and financial management; lack of clear direction to which purposes the funds collected should be used; lack of research into the most effective and acceptable price levels for clients

Situation of Logistics and Supplies

The 1994 Situation Analysis revealed the following facts about the management of supplies and logistics at in government "integrated" (MCH/FP) clinics:

- Only 16 percent of health personnel had received training in FP logistics management.

- Seventy-nine percent of MCH patients were not being informed about FP.

- A relatively high number of contraceptive products were available, particularly the injectable (in stock in 87 percent of health units), the low-dose combined pill (in stock in 74 percent of units), condoms (82 percent of units); however, the progestin-only mini-pill was available in only 27 percent of units. IUDs were available in 55 percent, and foaming tablets in 62 percent of health units.

- Only 60 percent of health units had any basis for a system of contraceptives management or suitable storage capacity. This lack was probably a main cause of stock-outs in 30 percent of the health units over the preceding three months.

- Only 64 percent of the health units had usable FP recorded data. Only 14 percent of units used their data to strengthen their ordering system to prevent stock-outs.

- Seventy-six percent of units had not received sufficient supervisory visits during the preceding three months.

Supplies. The present system of ordering supplies does not appear to be based on a well-planned system. This seems to be the case at all levels—CCS, CSSP/CSCU, CHD, and the center in Cotonou, the PBEF. Units appear to place orders when they start to run out of stock, and this is frequently too late to avoid stock-outs.

Orders passed to UNFPA by the MSP/PBEF are uneconomic; only one large order per annum should be made. This should be based not only on present consumption but on estimated future needs, taking into account CPR targets, training, IEC, and so forth.

UNFPA and IPPF appear to be able to supply most contraceptive needs (orals, injectables, spermicides, IUDs, condoms) without much difficulty and within country budgets (see Appendix D-4, 5, 6). When quantities increase, it is possible that supplies from other sources may be called for; however, for the immediate future, this does not appear to be a requirement.

Distribution. The present system of distribution operated by the PBEF does not appear to be working effectively. It is very much a "pull" system, rather than a "push" system. In fact, there is no effective distribution system at all. The PBEF acts more like a wholesaler, waiting for its clients to call upon it. It has none of its own transport. It carries out little or no management supervision in the field.

The ABPF, on the other hand, appears to have an effective distribution system with its own vehicles and own regional or department stores. However, its distribution functions are greatly reduced, supplying only its three clinics and the 80 integrated clinics of the Ministry of Health.

Cost Recovery

The system of financial management and cost recovery for contraceptive services and supplies appears precarious. Moreover, the system is managed independently by PBEF and is not integrated into the essential drug cost-recovery scheme established through the *Centrale d'Achat*. Department directorates and clinics can draw initial supplies from the PBEF store without payment; clients are supposed to pay for them after usage, according to a set fee schedule: orals 100 FCFA/cycle, injectables 500 FCFA/1, IUDs 400 FCFA/unit, foaming tabs and spermicides 200 FCFA/tube, condoms 25 FCFA/2, etc. However, how much of these client fees is being retained by health units and how much is returned to the PBEF/MSP is not known.

Client payments presently levied for the different types of contraceptives in both government and ABPF clinics do not cover the full costs of the contraceptives (with the possible exception of injectables). Prices appear to be agreeable to most acceptors, particularly in the urban areas; however, they may be an obstacle to contraceptive prevalence in rural areas, particularly to the poorer potential acceptors. Funds received from client charges appear to be banked by the PBEF or held at health units without a clear vision of how such funds should be used (e.g., improvements to storage conditions, training, repurchase of contraceptives, etc.).

Options for Strengthening the FP Logistics and Supply System

Management

The most obvious deficiency in the present system of FP logistics is management at all levels, e.g., supplies planning, assessment of needs, inventory control, distribution, management information, supervision and control, and financial management. There appears to be no system in which the PBEF can accurately forecast needs and therefore arrange to have sufficient stocks. It is also difficult for the departments to arrange to visit Cotonou whenever clinics run down their stocks. Sometimes visits are limited by lack of funds for transport. It is also most uneconomical for each department to have to pick up its own supplies rather than have supplies delivered on one tour by a centrally located vehicle. Furthermore, once supplies reach the department directorate stores, individual health centers are supposed to arrange their own transport to pick up their own supplies, which at times of scarcity of vehicles and fuel can be difficult and lead to stock-outs. It would be appropriate, therefore, to consider whether placing the management of government FP logistics elsewhere than its present location in the MSP/PBEF would be desirable.

Centrale d'Achat. One option to strengthen FP logistics management might be to take this function from the MSP/PBEF and place it with the Centrale d'Achat, which manages the essential drugs program and which appears to have made rapid progress over the past five years, ensuring a wide distribution of essential drugs, dressings, and other medical supplies on a cost recovery basis.

There are obvious attractions in this option: The *Centrale d'Achat* has a spacious and well-organized store, appears to have successfully operated the national essential drugs program, and has a constantly increasing turnover. Approximately 90 percent of health units in the national system (about 360) are said to be customers of the *Centrale d'Achat*. However, the *Centrale d'Achat* does not have the one element that FP logistics needs: a "push" system of distribution. Furthermore, the *Centrale d'Achat* would charge an overhead for its handling and storage. This would have to be negotiated, but would likely be around 15-20 percent of the value of the contraceptives. The required prepayment may not be acceptable to health units which receive contraceptives free at present. The price of contraceptives to the client might increase.

The Beninese Association for the Promotion of the Family. The ABPF delivers/sells contraceptives to its own clinics and to 80 of the 260 government health centers and clinics offering FP services. The government units are provided with contraceptives on a sell and return basis, i.e., they are initially given free and paid for when sold. The ABPF makes these deliveries from stores in its six branch offices or *Antennes*, one in each department. Each *Antenne* has a vehicle, and there are three placed at headquarters in Cotonou. ABPF also appears to have a well-functioning system of data recording, including data emanating from government clinics (ABPF annual reports and Appendix D-9) though there may be multiple counting of acceptors.

The ABPF has long experience in FP and possesses a small, though relatively efficient, distribution system. With considerable injection of monetary resources, personnel, and

equipment, it could, in time, handle the management of a country-wide FP logistics system. However, the activities of the ABPF may best rest in the private sector, offering an alternative to government clinics. Also, its awareness raising and motivation program should perhaps not be diluted by the demands of managing a national logistics system.

Finally, one of the main reasons the PBEF was placed in the Ministry of Health was so that the MSP could directly manage the national FP program and integrate FP into the MCH system. Management of contraceptives logistics should be a key function of a national FP program. Taking the management out of the MSP would defeat this objective and may not be in the best interests of the country.

Due to the relatively low level of staff and logistics training at all levels of the government FP system, one option for raising standards of logistics management in a short (1-2 year) period of time would be to implement a Family Planning Logistics Management (FPLM) program with financial support from USAID. This type of program has been reasonably successful in other countries and is relatively cost effective and targeted.

Supplies Planning

There is an urgent need for a more scientific and rational way of estimating contraceptive needs and ordering them from suppliers. Table X [Morre's Appendix D-1] could be a reasonable starting point for a new system of supplies planning and assessment of needs of contraceptives in Benin. The analysis assumes a CPR in 1994 of 1.2 percent and 1.29 million WRA, which appear from all available data to be reasonably accurate. The table calculates the approximate amounts of different contraceptives needed to cover national needs, based on the current method mix (Column 2). Needs compared with supplies (Column 3) show that:

- Orals were undersupplied by 50 percent of actual needs.
- Injectables were approximately correct.
- IUDs were oversupplied by a factor of three.
- Spermicides and foaming tablets were undersupplied.

Costs of projected contraceptive needs for the year 1994 to 2000 are estimated to increase from CFA 65,282 to CFA 368,668, based upon actual purchase prices factored upward for inflation. Revenues, or financial returns from the sale of contraceptives at current prices plus inflation will increased from CFA 29,363,550 (1994) to CFA 138,527,900. It is further expected that the distribution share of costs will fall from 93% in 1994 to 28% in 2000.

Whatever distribution system is used, however, it can safely be said that unless there is a system of "push" distribution for the contraceptives to ensure that every health unit offering FP services has a regular supply of needed items, the CPR is unlikely to move upward much from its present low level.

Storage and Inventory Control

The present situation regarding storage and inventory control of contraceptives in the government MSP system appears to be grossly inadequate at all levels, central (Cotonou), departmental, and in the health centers themselves. (This observation does not include the ABPF, which appears to have a relatively well-functioning and efficient storage and inventory control system in operation.) At present, the typical storage place of contraceptives in health units are at the bottom of a filing cabinet with little regard for cleanliness, temperature, or security. The central store of PBEF in Cotonou shows several deficiencies in coping with national needs (space, ventilation, and recording). Management forms only indicate amounts in stock and delivered. They do not provide for information on maximum and minimum stock levels or on levels to trigger new orders. The first-in/first-out principle does not appear to be in use.

Government stock control forms for the central MSP store are considerably less informative and useful than those used by ABPF. *Fiches de stock* are not widely used. Indeed, no forms are being used by the majority of health centers or department directorates to place orders, which accounts for irregular ordering and stock-outs. According to a recent survey, only 10 percent of health units make any kind of monthly report.

Management Information Systems

The SNIGS (National Health Information Management System) system as presently organized does not provide for sufficient collection of useful information on FP logistics or usage of contraceptives, nor does it provide a method of stock control/reordering. It also does not provide for feedback to the health units of useful information. Retro-Information Bulletins, published once every three months by SNIGS, as well as the annual report do not yet adequately address FP. The data are often slow to be passed for processing, and this time lag may be an obstacle to using the SNIGS system as a FP logistics management tool. However, there is a plan to extend the SNIGS data to follow more closely developments in FP from 1995.

Supervision

From all observations, one of the main reasons for the general weakness in the FP system and low rate of contraceptive prevalence is the lack of adequate supervision.

According to established MSP procedures, each health unit is supposed to receive a supervisory visit at least once a quarter. The Situation Analysis revealed that there had been an inadequate level of supervisory visits in 76 percent of health units visited; 18 percent of them had not been visited at all; and this lack of supervision played a key role in the absence of enthusiasm and motivation among family planning service personnel.

One of the main functions of the FP management unit should be to ensure an adequate level of field supervision, through its own personnel or through those of the department directorates

of health. The present level of staffing of the PBEF at the Directorate of Family Health hardly seems adequate to ensure a regular program of field visits.

MANAGEMENT INFORMATION SYSTEMS FOR HEALTH AND POPULATION

SNIGS: The National Health Management Information System

The National Health Management Information System receives technical and logistical support from *Coopération française* and WHO. Its goals are the following (MSP, 1994):

- Provide quantitative data indispensable for identifying major health problems and help define and assess Benin's health policy.
- Maintain ongoing dialogue between health statistics producers and users in a sustained effort to target improvement of SNIGS and adapt it to the country's needs.
- Contribute to broader and faster diffusion of information.
- Improve the health sector's management and planning process.

SNIGS is a passive system that relies essentially on health personnel who are the producers and main users of the information that is collected. For it to operate properly, statistical units must be operational at the level of the CSSPs, CHDs, or private organizations, as well as the provincial statistics services for epidemiology and documentation at the Departmental Health Directorate. The statistical units and the provincial statistics services are responsible for various reports: correctly recording them, examining and counting them daily, and sending them out periodically. The requested data pertain to diseases, personnel, infrastructure (essentially beds and health staff), funding (income and expenses, with sources), maternal and child health/family planning, and drugs management.

The types of data records vary, depending on the resources and staff of the health center. Separate records are kept for management, health treatment, and MCH/FP. Within each department there is a DDS where two statisticians from the SNIGS network work. Each DDS has at its disposal at least one personal computer and SNIGS-specific software programs. In addition to the DDSs, the Cotonou CNHU is considered a Department for the SNIGS organization.

Hard-copy records are used at the local level in the CCSs for data collection. These records are transmitted to the CSSPs, where preliminary data are pooled by hand. The records obtained in this way are sent to the DDS, which enters them into the computer using the LOGI-SNIGS software program. The results are sent on diskettes to the MSP, which carries out the national synthesis.

The record-keeping burden of health workers in Benin is considerable. To illustrate, the types of data records kept at the CCS level are the following:

- Approximately 20 types of records are kept in the CCS (index cards, other cards, registers, statements, reports), including record cards for infants, mothers, family planning, and the detailed daily MCH/FP register.
- Data records kept by the patient/consulting physician: treatment record booklet, health record booklet.
- Approximately 10 data records to be sent to the CSSP Health Center, including the maternal activity report and the vaccination activity report.

Each CCS is required to forward its report to the CSS, where information is synthesized, at most five days after the end of the month.

Types of data records kept at the CSSP cover the same information. Each CSSP is required to send its synthesized report to the DDS at most 10 days after the end of each month. At year's end, the CSSP may produce a statistical yearbook (20 pages maximum) containing, among other items, a summary of vaccination, maternity, and MCH/FP activities. A copy of this annual report is sent to each district health unit to inform them of the past year's activities. Two copies are sent to the DDS.

Types of data records kept in the hospitals (CHD, private hospitals, and CNHU) include infant health record cards, maternal health, and family planning, and the detailed daily MCH/FP register; records to be kept by the patient/consulting physician; and records to be sent to the DDS by the CHD or the private hospital to the MSP (sent to the attention of the Statistics and Documentation Service) by the CNHU. These records contain, among other things, the maternity activities report and the vaccination activities report.

Each hospital is required to send its report to the designated agency at most 10 days after the end of the month. At year's end, the hospital may produce a statistical yearbook containing, among other items, a summary of vaccination and maternity activities. A copy of this yearbook is sent to each district health unit to inform them of the past year's activities. Two copies are sent to the DDS.

Types of data records kept at the DDS level include one copy each of the reports produced by the CCS, CSSP, CHD, private hospital, and one copy of each synthesis report received from the DDSs; records to be sent to the MSP for use by the Statistics and Documentation Service, including synthesis reports on vaccination, maternity, and MCH/FP activities carried out within the department.

Each DDS is at most required to ensure these reports arrive at the MSP 15 days after the end of the month. The publication of a statistical yearbook at the level of each department is mandatory. This yearbook must contain, among other things, an up-to-date summary of vaccination, maternity, and MCH/FP activities. It is intended for use by each District Health Center (CSD), CHD, private hospital, and the MSP. The central level will compile data from the departments and the national synthesis will be published in a statistical yearbook intended for various users.

Types of Information Collected

Health Indicators

At the national level, a full range of health indicators is available in the SNIGS health statistical yearbook: geographic, socioeconomic, demographic, and health. Information covers the health system (health-related infrastructures, human and financial resources, the pharmaceutical sector); epidemiological indicators (number of cases and deaths declared for 43 surveillance sites, a summary account of the five most-often used reasons for a medical consultation, summary accounts of the five most-often used reasons for hospital admittance, a detailed analysis of the main pathologies); indicators pertaining to health services activities, treatment-related medical activities in the health units, and MCH activities; maternity-related activities, family planning activities, vaccination activities, and laboratory work.

Epidemiological indicators and certain health service statistics are published quarterly in a bulletin entitled *RETRO-SNIGS*. Because the yearbook for a given year is now published within the following six months, the indicators are available and recent.

Family Planning Statistics

Family planning statistics are not complete or reliable. Information on logistical management of contraceptives are missing from health data publications. Contraceptive prevalence rates published are overstated. What is interpreted as the total number of users is, in fact, merely a monthly compilation of the annual visits of male/female contraception clients. The total number of these first visits effectively corresponds to the number of male/female contraceptive users.

Other MCH indicators are more reliable, where the number of new clients corresponds with reasonable accuracy to the number of first visits. An acceptable rate of prenatal coverage, postnatal coverage, and child consultations would stated the ratio of the number of new clients and the number of expected pregnancies, births, or children.

The daily logbook for family planning clients calls only for total numbers; adding up these totals requires the use of an additional record-keeping medium—notebooks, tear-off calendars—as grids for counting or handling the numbers. In order to limit the risks of counting errors, it is recommended that the layout for the daily recording of numbers be modified so that it may also serve as a counting grid.

Family planning file cards are classified chronologically, without using the system of active tracking batches. Arranged numerically in batches of 100 cards and often by neighborhood, it is impossible, for example, to give a year-end count of those who have abandoned contraception use.

MIS for Planning and Programming

SNIGS has reached a stage at which data collection, processing, and dissemination no longer present any major problems. At the present time, emphasis must be placed on engaging health workers and planners in its use. A computer-based data presentation tool, VISUEL-SNIGS, is being developed for health technical offices, the documentation center, or health sub-prefectures possessing adequate computer equipment. VISUEL-SNIGS may be used to monitor vaccination, maternity, and family planning activities.

The Link Between SNIGS and the National System of Statistics

Whatever the performance of SNIGS, it cannot produce all the information it requires. In most cases, the denominators of the health indicators come from the socioeconomic and demographic data produced by the National System of Statistics (SNS). It is agreed that if the SNS is strengthened, SNIGS will also benefit by a ricochet effect. In general, population censuses make it possible to establish population statistics that are used as denominators of health indicators, and specific surveys and in-depth studies carried out by the SNS make it possible to reliably assess SNIGS and various health programs. Thus, the National Institute for Statistics and Economic Analysis (INSAE), under the auspices of the SNS, will publish in 1994 the volumes of the 1992 census analysis, including regional population prospects into the future. The INSAE has formulated a request, addressed to the participating funding agencies, to carry out a demographic and health survey at the national level and to undertake short in-depth studies on maternal mortality, handicaps, women's activities, and migration. Likewise, INSAE is seeking funding for a seminar to disseminate the results of census analysis.

The Information System of ABPF

ABPF does not have a statistics unit in its clinics, but it produces relatively complete statistics through its own system. Statistics pertaining to project management, cash flow, the analysis of income/expenses by donor, as well as statistics for clinical services, IEC, and contraceptive logistics are published once each year in the activities report. Since 1992, SNIGS has included statistics for services from ABPF in the national data.

Data-recording media, individual record cards, and registers are kept relatively well. The cards are not classified by a system of active research batches. They are classified in batches of 50, by numerical order. The daily count register is done by hand and the record keeping system does not make it possible to count, in the course of the year, the real number of women accepting contraceptive methods because of counting the same individual several times.

The statistics produced are relatively complete and recent but are hardly reliable, especially with respect to statistics on services and logistical management of contraceptives. As in the public sector, it is necessary and useful to clearly define those who have disappeared and those who have dropped out, as well as instructions for counting them. The system for classifying records by active screening batches may be a solution.

OPERATIONS RESEARCH IN POPULATION AND FAMILY PLANNING

Statistical studies and nationwide research on demographic and FP problems have always been a major concern for the Beninese government and administration. Thus, since 1960, apart from the national demographic surveys (1961, 1981-1983) and population and housing censuses (1979, 1992), there have been several population surveys in Benin. For example:

- Multiple round survey (1981)
- Fertility survey (1982)
- Adolescent fertility survey (1986)
- Income and consumption survey (1986-1987)
- Small-scale household survey
- Informal sector surveys and studies program
- Study on male nuptiality and fertility in Southern Benin (1992)
- Study on the impact of migrations on household evolution (1992)

There has been considerable effort in the field of analysis and research on population, especially in specific areas such as marriage, household and family, population dynamics, fertility, internal migration, women's status, and the satisfaction of essential needs. Unfortunately, with regard to the national FP program, operations research (OR) activities, with a view to better assessing the needs of the population, have been very limited. Supporting research institutions for OR activities in family planning is, therefore, necessary to make the FP program more effective.

Institutional Capacities

Several ministries (Planning, Education, and Health) are involved in FP research activities through their technical departments or research institutions.

The institutions are the National Institute for Statistics and Economic Analysis; the Population Training and Research Center (CEFORP); the Regional Center for Health Development (CREDESA); the Center for Research in Human and Demographic Reproduction/Family Health; the Epidemiology and Operations Research Department (SERO); the Beninese Scientific and Technical Research Center (CBRST); the Faculty of Health Sciences; the National Medico-social Institute; and the Regional Institute for Public Health.

The National Institute for Statistics and Economic Analysis

This institution would be the national reference for a demographic and health survey (DHS). INSAE is a technical department of the Ministry of Planning and works in collaboration with the Human Resources and Population Service within the same ministry. This institute is mainly involved in population research activities (demographic, fertility, marriage, income-consumption surveys and censuses); economic analysis and statistics activities; and mid-level training in the fields of demography and economics.

Population Training and Research Center

CEFORP was created in 1987 under the Ministry of Education. So far, CEFORP has trained three classes of 24 senior technicians in demography and sent demographers to Canada, Belgium, and France for doctoral and Diploma for Specialized Scientific Studies (DESS) degrees. The human, material, and computer resources of CEFORP are rather limited. This institution needs logistic and financial support to perform more effectively.

Regional Center for Development and Health

CREDESA, previously known as the Pahou Health Development Project, is involved in research, training, and rationalized health care. It was created in 1983 and is located in Pahou (coastal Benin). CREDESA focuses on participative action research involving service providers, researchers, and communities in the areas of management, health economics, epidemiology, community participation, applied nutrition, and so forth. The CREDESA team includes agronomists, economists, sociologists, social workers, paramedical staff, and specialized doctors in epidemiology, demography, applied nutrition, public health, and community health.

Service-type activities are funded by the government, communities, and partly by research funds. Research activities have been financed by the Royal Tropical Institute and the Regional Center for International Development (IDRC). Training is conducted under specific grants from UNICEF, WHO, PBEF/UNFPA, and CRS. Contraceptive CBD activities are supported by USAID.

The Human Reproduction and Demographic Research Center

CRRHD was created in 1979 and is located within the CNHU in Cotonou. Its activities include research, training, and service provision. In the health sector, CRRHD conducts epidemiological research in gynecological and obstetrical affections, STDs/AIDS, maternal and infant morbidity and mortality, infertility and infecundity, family planning, demography, and MCH services management.

The multidisciplinary team is composed of epidemiologists, demographers, sociologists, bio-statisticians and computer scientists, medical doctor-biologists, gynecologists, and laboratory technicians. Computer and laboratory equipment are of relatively high quality. CRRHD could be one the best Beninese institutions for conducting OR studies in family planning and reproductive health.

The Epidemiology and Operations Research Department

SERO was created in 1990, under the National Directorate of Health Protection (DNPS)/MSP. It is in charge of providing OR training to doctors in the peripheral areas, supervising OR

activities, and developing a regulatory framework for awarding research prizes. SERO's current research activities mainly focus on malaria and communicable diseases with a team of only two epidemiologist/medical doctors and two computers of limited capacity. Under the 1994 reorganization, SERO will be replaced by the Epidemiology and Border Surveillance Department. Research activities will be supervised by a department other than the DNPS.

The Beninese Scientific and Technical Research Center

In 1977, the CBRST was created to coordinate all scientific and technical research activities in Benin. This body includes representatives of all the ministries but is headed by the Ministry of Education. The main responsibility of this center is to coordinate and report yearly on all research activities undertaken in Benin. CBRST has subscribed to the National Essential Research in Health (RNES) scheme.

Health Training Institutions (FSS, INMES, IRSP)

The Faculty of Health Sciences, the National Medico-social Institute, and the Regional Institute for Public Health are all under the Ministry of Education. These institutions are, respectively, in charge of training doctors and social workers; nurses, midwives, and social promotion agents; and public health doctors. Some students of these institutions conduct their thesis or dissertation research in the area of family planning.

Overall, the research capacities of these institutions are limited to human resources with little or no training in research techniques. Material and financial resources for research are almost nonexistent.

FSS and INMES students are entitled to a government grant in the amount of 90,000 FCFA for a thesis and 70,000 FCFA for a dissertation. IRSP trainees receive a research allowance from WHO. Despite the competence of the various thesis directors, these institutions do not seem to present the ideal conditions for OR activities in population/FP due to staff unavailability and students' time constraints.

Weaknesses

- There is no structure within the MSP with adequate human, material, and financial resources that is capable of conducting and coordinating OR activities in family planning.
- There is a lack of a multi-year research program in population/FP and of a socio-demographic and health data collection and analysis system, which can be an obstacle to activities in the sector.
- There is not a human resources policy yet that can help motivate the staff and facilitate long-term interest in research institutions.

- NGOs and associations are not much involved in research activities.

- Activities conducted by existing research institutions are hindered by the lack of coordination mechanisms, which partly affects the quality and dynamics of certain operations research activities in the population/FP sector.

- Operations research is not perceived by MSP officials and service providers as a critical element for the promotion and improvement of health care, in general, and family planning, in particular.

- MSP officials and service providers are not very motivated and involved in OR activities due to the lack of information and training in OR techniques.

- Most of the service providers who received training in public health, epidemiology, and evaluation research do not have sufficient experience in the design and implementation of financially acceptable research protocols.

- The lack of technical, material, and financial resources and documentation and dissemination channels constitutes a major handicap in the promotion of OR in family planning.

Possible FP Operation Research Topics

KAP studies in FP and other studies on contraceptive continuity, introduction to new contraceptive technologies such as NORPLANT®, and the acceptability of IUDs and NORISTERAT would be appropriate for starting FP operations research in Benin. However, conducting research on certain key topics also seems extremely urgent. These topics include the following:

- **Demographic and Health Survey** on a national scale, including husbands and unmarried teenagers. This survey will also study contraceptive prevalence, marriage, fertility, etc., thereby enabling a better understanding of Beninese population behaviors and creating a wealth of baseline data to be used later to evaluate the impact of FP interventions (US$500,000).

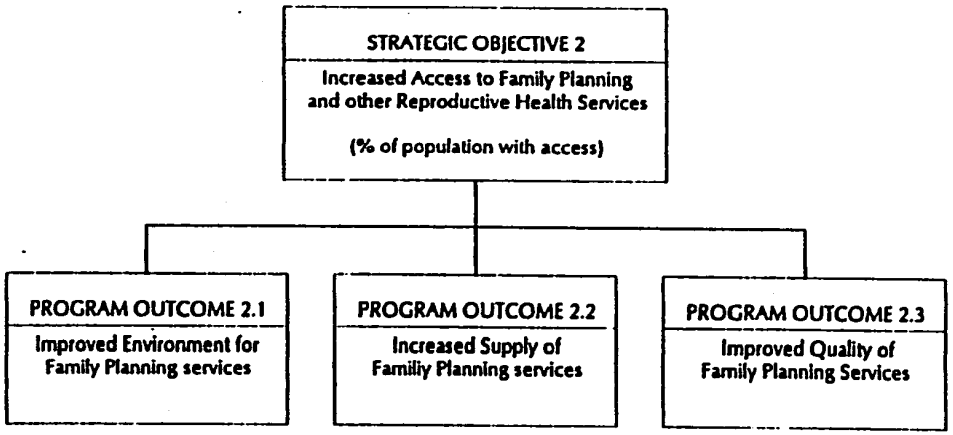
- **Situation Analysis of FP in the private and NGO sectors** in order to assess the extent to which these sectors can contribute to the promotion and expansion of FP services (US$100,000).

- **KAP-type opinion poll among religious, political, administrative, traditional, and legislative leaders and decision-makers and among service providers who** seem to constitute a handicap to FP activities in Benin (US$100,000).

- **Study of the causes of modern contraceptive drop-out and methods for tracking lost acceptors** (US$40,000).

- **Study of the impact of community-based distribution of non-medical contraceptives on KAPs among men and women** (US$60,000).
- **Study of alternative channels for FP/IEC in Benin** (US$40,000).
- **Study to test one or more approaches to the integration of FP with other MCH activities** (US$40,000).

USAID/BENIN


STRATEGIC OBJECTIVE 2
Increased Access to Family Planning and other Reproductive Health Services
(% of population with access)
PROGRAM OUTCOME 2.1
Improved Environment for Family Planning services
PROGRAM OUTCOME 2.2
Increased Supply of Familiy Planning services
PROGRAM OUTCOME 2.3
Improved Quality of Family Planning Services

Benin Population Program (Draft)

GOAL: Increased Participation in Benin's Economic Development

SUB-GOAL: Strengthen Benin's Human Resource Base

Poor family planning and reproductive health indicators:

- Maternal Mortality Rate: 800 per 100,000
- Total Fertility Rate: 7.1
- Contraceptive Prevalence Rate: 1% modern, est.
- Population Growth Rate: 3%

STRATEGIC OBJECTIVE 2.0: (through 1998)

Increased Access to Family Planning and other Reproductive Health Services

- % of the population with access to quality public sector family planning services increased from 5 to 15
- % of the population with access to private sector family planning services increased from 1 to 5

Program Outcome 2.1

Improved Policy Environment for Family Planning

- data for decision-making (DHS, etc.)
- policy change (rescind Law of 1920, national family planning policy in place, etc.)

Program Outcome 2.2

Increased Supply of Family Planning Services

- # of public health centers (CCS, CSSP) with family planning services
- # of NGO (ABPF) centers with family planning services
- # of private and social marketing outlets with contraceptives and family planning information

Program Outcome 2.3

Improved Quality of Family Planning Services

- # of public health centers with quality family planning services (trained staff, IEC, MIS, commodities, equipment, etc.)
- # of NGO health centers with quality services
- # of private and social marketing outlets with quality supplies and information

Benin Population Program

Illustrative Listing of Activities and Key Inputs

INPUTS	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
PO 1: Improved Policy Environment for Family Planning										
- DHS	X	X								
- Legislation	X	X					X			
- Situation Analysis			X			X			X	
PO 2: Increased Supply of Family Planning Services										
- MIS system in place		X	X	X	X	X	etc.			
- Logistics and supply system in place		X	X	X	X	X	etc.			
- Supervision systems in place		X	etc.							
- Social Marketing Program in operation		X	etc.							
PO 3: Improved Quality of Family Planning Services										
- Protocols in place		X	etc.							
- Training of personnel		X	etc.							
- IEC programs		X	etc.							

SUMMARY OF RECOMMENDATIONS

Strategic Objective in Family Planning

The Population Sector Assessment Team was asked to offer a recommendation concerning the creation of an additional Strategic Objective (SO_2) population for the Benin Country Program Strategy for 1994-1998 and beyond. This recommendation would also consider options for managing such an important objective.

The Assessment Team drew several relevant *conclusions* in its deliberations on a possible SO_2. It included the following: (1) Benin has made remarkable progress in promoting sustainable, community-based primary health care initiatives; (2) at the same time, a very low CPR (est. one percent for modern methods) and poor reproductive health indicators suggest that a vast unmet need for family planning exists; (3) current family planning services are feeble overall and reach an estimated 25 percent of the population; (4) donors recognize that support to family planning, which began with UNFPA in 1982, followed by the World Bank and IPPF, has been underfunded, poorly coordinated, fragmentary, and without national development impact; (5) owing to USAID's comparative strength in the population field, donors would welcome its entry into the sector; (6) the policy environment, until recently pronatalist, is undergoing a slow, positive evolution; (7) the Ministry of Health underwent a reorganization in May 1994 which created a new Directorate of Family Health, housing a Family Planning Service—a new structure that could catalyze population programs in both public and private sectors; (8) at the present time, USAID-Benin is willing to commit resources, assuming availability, to a programmatic effort in family planning and reproductive health; however, human resources in USAID-Benin must be increased to meet the additional management burden.

It is *recommended* that USAID:

1. Add improving family planning services in Benin as a Strategic Objective within the USAID Benin Country Plan. This objective may be formulated in terms of the following result: "**Increased access the Family Planning and other Reproductive Health Services.**" A schema and details of a proposed objective tree are shown on pages 55, and 56.

2. Develop a bilateral project which addresses the aims of the Strategic Objective stated above through direct technical and resource assistance in IEC, logistics and management, family planning service delivery, policy development and planning, MIS, and other identified areas.

3. Expand USAID's technical and managerial capacity to include population and family planning by recruiting the following additional staff:

    - A population and reproductive health specialist at mid- or senior-level (preferably PHN officer or alternatively a TAACS Senior Fellow, etc.)

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- One mid- or senior-level FSN or local PSC who will work closely with the Family Planning Service at the Ministry of Health.

Type of Assistance

The foregoing recommendations propose that USAID support the new Strategic Objective through the use of direct "project assistance" (PA). "Non-project assistance" (NPA) in a proportion to be determined was also considered. NPA typically consists of transfers without technical assistance as an inducement to policy reform. It assumes a reasonable national level of technical expertise, infrastructure, and experience in a given sector. Past USAID experience with NPA to induce health reform in West Africa shows that a non-project approach is successful in supporting reforms that have already become approved policy before PA began. However, where local capacity to plan and implement programs in family planning is very limited, NPA is probably not the best format (Foltz, 1994). Moreover, NPA is typically more management-intensive for a USAID field office than PA, owing to the burden of financial accountability.

Given Benin's weak environment for implementing reform and programs in population, family planning, and reproductive health, it is *recommended* that USAID:

4. Support the population, family planning, and reproductive health sector chiefly through technical support and direct project assistance.

Institutional Development

The creation of the Directorate of Family Health—which combines MCH, family planning, and HIV/AIDS prevention—under the 1994 reorganization of the MSP offers an excellent opportunity to reinforce government capacity to implement programs in family planning and reproductive health and to integrate services at the local level.

Therefore, it is *recommended* that the Ministry of Health:

5. Define clearly the structure, attributions, functions, and mechanisms for the Directorate of Family Health, and especially the Family Planning Service within it.

6. Develop a strong partnership with other ministries concerned with population, family planning, and reproductive health and with relevant NGOs and representatives of the private sector. In particular, a tight integration of social workers into MCH/FP activities is strongly recommended. They may be trained to provide practical support to the sector in disseminating general information to communities and clients about MCH/FP, referring potential clients for FP services, and offering FP counseling to clients where appropriate.

7. Integrate, in policy and practice, family planning into existing MCH activities, largely funded by sources other than USAID, to ensure the greatest possible coverage, acceptability, and attention to reproductive health.

Population Policy and Reform

The political environment for population, family planning, and reproductive health reform remains mixed. Paradoxically, the Law of 1920 forbidding contraception has been neither abrogated nor fully enforced. A Family Code reflecting the current legal and socioeconomic environment needs to be developed in Benin. Meanwhile, an excellent ICPD preparatory document has been prepared by the CNRHP, and Benin has committed itself to developing a national Population Policy by mid-1995; however, contributions by the NGO community, the private sector, and even other ministries—especially the Ministry of Health—to this process have so far been negligible. Elsewhere, coordinated program efforts in family planning and population are frequently eroded by a "project mindset," often fostered by donors, which needs to be replaced by the development of a national institutional framework. A general strategy of support to policy reform would therefore consist of strengthening the nation's institutional and technical capabilities in the development, implementation, and monitoring/assessment of a national population policy.

The following government actions are *recommended*:

8. Develop as soon as possible a National Population Policy in concert with the National Committee of Human Resources and Population Commission relevant NGOs, and key donors in population.

9. Create a mechanism for genuinely coordinating activities in population and family planning among all actors. Subcommittees should be established as needed on such support functions as demography, policy, training, IEC, logistics, MIS, and so on.

10. Further advance the status of women by prioritizing the preparation, adoption, and implementation of a Family Code.

11. Revise the 1920 Law forbidding the promotion of contraception in order to provide a clear legal framework to activities fostering family well-being.

12. Revise the decree relating to the composition of the National Human Resources and Population Commission to enable NGOs and society at large to join in the preparation and coordination of population policy.

The following actions are *recommended* for USAID:

13. Support the preparation of a national population plan of action by making available expert international appraisal for the assessment of population programs.

14. Strengthen the Population Documentation Center in the Ministry of Planning to enable the population unit to become a population reference center.

15. Support the department-level Human Resources and Population Commissions whose efficiency is limited by the scarcity of human and material resources. The success of

the population policy will depend, in large measure, on the vitality of these department-level commissions.

Information, Education, and Communication

Donors, NGOs, and government partners agree that IEC must play a key role in meeting development objectives; many take as an imperative the increase in demand for family planning, through multi-channeled and multi-targeted family planning IEC. So far, Benin has seen positive experiences with IEC in EPI and oral rehydration therapy campaigns and in the FP-related areas of HIV/AIDS prevention and breastfeeding. In addition, a major expansion of media coverage has taken place through the creation of local and private radio stations, addition of television and radio relay antennas, and the recent creation of the HAAC. Unfortunately, IEC for FP is hampered by the absence of a national population policy and consequently the lack of a national plan for FP/IEC. Limited infrastructures for public communications and logistics in some rural areas confine the speed and reach of information exchange. More critical, absence of accurate and authoritative information on contraceptives among health professionals lead to application of medical barriers and lack of conviction about the benefits of modern family planning methods. Finally, the limited funds available for FP/IEC are not absorbed, owing to lack of IEC-specific budgeting at national and peripheral levels.

In order to increase demand for family planning services, IEC for FP should be greatly enhanced, adequately funded, and fully integrated into an overarching FP program nationwide.

The following specific actions are *recommended*:

16. Develop a national strategic plan for FP/IEC that includes, but is not necessarily limited to, advocacy and information for formulating population policy, use of mass media, development of clinic-level and individual FP/IEC materials, communication and counseling training for FP staff, grass-roots interpersonal communication, and research.

17. Coordinate fully FP/IEC activities and messages among all partners in government, NGO, and private sectors.

18. Make adequate funds available to the IEC Division within the Family Planning Service and department-level IEC services in order to ensure adequate development and distribution of FP/IEC materials, coordination of the national FP/IEC strategy, and high-quality FP/IEC training for all relevant staff.

Training and Human Resources Development

Preservice and in-service training in family planning and reproductive health must be strengthened at all levels, with special emphasis on the training of midwives, nurses, and social workers. The current MSP policy of decentralization in training should be continued.

The following actions are *recommended* to the government in order to improve training in family planning and reproductive health:

20. Develop a national population and family planning training strategy that is guided by MSP service policy and standards and by the new policy of decentralized training. Representatives of institutions involved in in-service and preservice family planning and reproductive health training should participate in the development of the strategy. The strategy should include options for institutionalizing training capacity and capability. It should also include the following:

    - Development and dissemination of FP service protocols
    - Training of trainers and preceptors from the MSP and MTEAS in training methodologies, evaluation, and supervision
    - Training of FP service heads in management
    - On-site follow-up of trained participants
    - Systematic implementation of a refresher training course for service providers in the field with particular emphasis on IEC, "informed choice" of contraceptive methods, administration of methods, and the health information system
    - Reinforcement of linkages between the in-service training system, preservice training systems, and family planning and reproductive health service systems

21. Supply potential FP training practicum sites in the departments with necessary equipment and materials. Practicum sites in Cotonou should be reinforced as a step toward increasing national family planning and reproductive health training capacity.

22. Provide technical and financial assistance to preservice training sites (e.g., FSS, INMES, ENIIAB) to allow them to integrate the FP modules into their curricula, implement a training course for trainers and preceptors in training methodologies, equip their teaching halls with FP demonstration materials and training materials.

23. Train family planning and reproductive health service managers in the integration of services. Training curricula for in-service and preservice should also reflect the integration of all aspects of reproductive health.

24. Provide assistance to social marketing NGOs (e.g., ABMS) in the training of community-based distributors of contraceptives.

25. Explore opportunities for conducting family planning and reproductive health training-related operations research under the auspices of the CRRHD.

Breastfeeding

There is a widespread acceptance [illegible] breastfeeding in Benin; however, current breastfeeding practices do not ensure optimum [illegible]s for child survival or family planning. Up to 27 percent of mothers delay the initiation of breastfeeding for periods ranging from 24 hours to three days. Exclusive breastfeeding during the first four to six months of life is rare. Other liquids are given to the baby right from birth, and colostrum is still considered "bad milk" and is

discarded. Bottle feeding is relatively high in urban areas; food supplementation starts very early with a thin maize porridge. A major national promotion of breastfeeding is in progress with support from UNICEF; however, so far there has been little effort to educate mothers of the contraceptive benefits of exclusive breastfeeding.

In order to heighten and prolong the impact of breastfeeding promotion, the following actions are *recommended*:

26. Revise curricula for the training of health and social workers to include updated information on breastfeeding. Undertake training activities on optimal breastfeeding for representatives from MPS, MTEAS, MDR, and national NGOs.

27. Improve the quantity and quality of information gathering and research on breastfeeding, especially in the context of routine MIS for health, family planning, and nutrition; a better understanding of attitudes and practices is needed to facilitate the development of communication and counseling messages. Set up a breastfeeding information system for the collection, analysis, and evaluation of breastfeeding interventions.

28. Integrate breastfeeding into family planning, health, and nutrition activities. Promote proper weaning foods and better nutrition during pregnancy and lactation.

Family Planning Logistics and Supplies

At present, commodities for family planning are distributed in three ways: by the government through the Family Well-being Project, by the local IPPF affiliate, and through the private commercial sector. In addition, the social marketing project for HIV/AIDS prevention has opened the market for condom social marketing. Options for future distribution of commodities include the above, with the additional possibility of using the *Centrale d'Achat*, which currently distributes generic drugs to health centers and pharmacies throughout the country. A review of pricing and financing of contraceptives is needed, as funds collected from the government contraceptive distribution program is currently managed separately from the health community financing system. This review should address the wisdom of combining contraceptive distribution with that of the *Centrale d'Achat*. Pending that review, the following tentative suggestions assume the continuation of distribution through the government program.

It is *recommended* that the government with USAID support undertake the following:

29. Reinforce and strengthen the Directorate of Family Health in FP logistics and supplies management. Provide technical support and training in computer-based commodities forecasting.

30. Implement a system of commodities distribution based upon a "push" rather than a "pull" system. The MSP may need to seek logistics support by collaborating with donors or NGOs, although a self-sustaining distribution system is the ultimate goal.

31. Improve stock control, method mix, and supervision by (a) undertaking a survey of stores at central and departmental levels and in health units; (b) instituting strong stock reporting systems; and (c) developing a system for regular supervision.

Management Information Systems for Family Planning

The National Health Management Information System (SNIGS), while useful for many PHC health interventions, does not provide for sufficient collection of useful information on family planning, especially regarding services, utilization, logistics, or stock control. In addition, family planning statistics suffer from the key weakness that each request for contraceptive commodities is counted as a "new acceptor" by most health workers.

The following actions are *recommended*:

32. Change the method used for daily counts and the one used for the monthly reports, making it possible to count the first visits by female contraceptive clients, collect IEC activity data, and manage contraceptive inventory data.

33. Develop a MCH/FP module for the VISUEL-SNIGS database inquiry program.

34. Undertake a DHS near the end of 1995. This survey, which will be nationally representative, will be the basis for assessing all ongoing health-related activities and a basis for planning Benin's health programs.

35. Evaluate the SNIGS system for its appropriateness to family planning information and management.

Operations Research

36. Organize workshops on operations research for population/FP with a view to elaborating a multi-year program of research and setting up an institutional framework for OR activities.

37. Develop sufficient institutional capacity to conceive and execute an operations research protocol, notably in the MSP under the responsibility of the Family Health Directorate. Strengthen the material and technical capacities of existing research centers that are involved in the population/FP sector.

38. In the medium term, set up an effective OR unit for MCH/FP that is able to secure funding for its own research protocols.

40. Provide, as needed, specialized technical assistance to the government, through international research organizations, for conducting these studies.

Financing of Population and Family Planning

41. Owing to the general success—though still uneven—in health services cost recovery by local health committees (Bamako Initiative), a management review of utilization of health committee funds is strongly recommended. Government, relevant NGOs, and donors should jointly consider and establish policies on utilization of health committee funds, pricing and means testing for services, areas of financial support (e.g., additional personnel, outreach, training, maintenance, recurrent costs of consumables, and so on. In addition, the composition and general functioning of the COGEC and COGES needs review, if possible through operations research).

Action Plan

The Assessment Team was asked to develop an Action Plan for planning activities in a future population program. An Action Plan will follow the development of a Family Planning Program Strategy. Meanwhile, an illustrative listing of activities and key inputs into the sector appears in the table on page 57.

1 POPULATION ACTIVITIES AND THEIR INSTITUTIONAL CONTEXT

by Mohammed Zarouf, Aristide Aplogan, and Deirdre LaPin

1.1 Background

1.1.1 Geographical and Historical Setting

The Republic of Benin, a country of 43,484 square miles, is slightly larger in size than the Commonwealth of Virginia. Situated in coastal West Africa, the country shares its western border with Togo, joins Burkina-Faso to the northwest, Niger to the direct north, and Nigeria to the east. Like most countries along Africa's Guinea Coast, it divides roughly into two broad ecological and cultural zones, one being northern savannah and the other southern forest. Over 50 diverse ethnic groups reside in these two regions.

The South is a tropical and humid region characterized by a population of sedentary agriculturalists, traders, and urban dwellers who reside in the fast growing metropolitan areas of Cotonou, Porto Novo, and Abomey-Bohicon. Owing to a traditional surplus economy dating back more than three centuries, southern Benin historically supported a number of centralized states, including the great Fon empire of Dahomey and the smaller Yoruba kingdom at Ketu, which recognized the authority of the central kingdom in Oyo (Nigeria). Smaller, coastal groups include the Adja and Ouatchi. Modern Benin's southern economy is grounded chiefly in agriculture and fishing.

Benin's northern region has a drier climate. Parakou and Natitingou are the principal urban centers. The area is moderately watered and supports a mixed economy of nomadic pastoralists and agriculturalists who were typically grouped into smaller, segmented societies. Key socio-linguistic groups in the North include the Bariba, Dendi, Djougou, Otamari, and both nomadic and sedentary Peuhl (Fulani). For Benin, as for its coastal neighbors, this northern/southern axis continues to mark the social, economic, and political development of the country. Roughly two-thirds of the population currently resides in rural zones. By the year 2000, however, 45 percent of Beninese can be expected to be urban dwellers, increasingly concentrated in the southern part of the country.

Since independence in 1960 Benin has undergone numerous changes of government, most occurring in an early tumultuous period which ended with the installation of a Marxist military regime in 1972. By the mid-1980s, Benin was faced with a severe economic collapse, and the government began to replace its socialist philosophy with a more programmatic approach to the country's economic needs, encouraging Western investment and reorienting Benin's foreign policy. In June 1989 the International Monetary Fund (IMF) approved a three-year structural adjustment program and Benin's US$1.5 billion debt was subsequently rescheduled.

Real democratic process began with the "National Conference of the Active Forces of the Nation" (CNFVN) held in February 1990 that designated a former official of the World Bank, Nicephore Sogio, as Benin's new prime minister. Mr. Sogio was subsequently elected President on March 10, 1991 in a free and fair election. Since that election the country has

continued to make progress toward a pluralistic, democratic government and a liberalized economy.

Today, the Beninese economy is dependent on agriculture (staple foods, cocoa, coffee, cotton, and livestock) and fishing. Some minerals are exploited. The manufacturing and private sectors are being developed, especially in the processing of such raw materials as cotton, palm nuts, sugar cane, and petroleum. A second phase of the structural adjustment program (1992-95) aims at greater involvement of the Beninese population in health and family planning activities. Increasing contraceptive use is viewed as a first step to bringing population growth in step with available resources.

Administrative geography of the country changed little after the National Conference. Today Benin has six departments, formerly known as "provinces." They include the Atacora (1992 pop. 649,308) and Borgou (pop. 827,925) in the north; the Zou (pop. 818,998) in the middle region; and the Mono (pop. 676,104), Atlantique (pop. 1,066,373), and Oueme (pop. 876,574) in the south. The six departments are divided into 77 sub-prefectures and metropolitan areas; these are further divided into 517 communes and finally into 3,378 villages and town quarters.

Benin's total population, according to the 1992 General Census of Population and Housing, was 4,915,555. A population growth rate of 2.9 percent would yield a 1994 population of approximately 5,185,000 persons. Approximately 1,063,000 are women of reproductive age (15-44), including 222,000 young women under the age of 20. The total fertility rate of 6.1 bears witness to a pro-natalist tradition.

Benin has not had the benefit of a fertility or demographic survey. Current sources estimate the contraceptive prevalence rate (CPR) for modern methods at between 0.5 and 2.5 percent. This paper proposes an estimate of one percent (see Chapter 5). The Benin obstetrical community believes that up to 20 percent of all pregnancies are currently terminated by induced abortions and rates of abortion are increasing. Furthermore, unsafe abortion may account for as much as one-third of maternal deaths.

1.1.2 Family Planning in its Socio-cultural Context

Family planning is not a popular notion in Benin; however, health and population indicators suggest that the unmet need for family planning is high. The rapid decline in infant mortality over the past 10 years (falling from about 150 per thousand in 1982 to 105.5 in 1992) has not been matched by improved rates of contraceptive prevalence. The country also manifests excessively high rates of maternal mortality (800 per 100,000 live births), and child mortality (80 per 1,000). (For further indicators, please refer to Table 1).

TABLE 1

BENIN: SOCIOECONOMIC, DEMOGRAPHIC, AND HEALTH INDICATORS

1992

INDICATORS	NUMBER/RATE	REF. YEAR
1. Population	5.185.000 1994	1994
2. Women at reproductive age	21.3%	1992
[15-44 y] [urban: 38%, rural: 62%]		
3. Religion:		1992
Christians	35.4%	
Muslims	20.6%	
4. Ethnic groups	~50	1992
[Fon: 42.0%, Adja: 15.6%, Yorouba: 12.1%, Bariba: 6.6%]		
5. Density	43/sq km	1992
6. Urbanization	36%	1992
7. Literacy : [men=38.7%, women=19.1%]		
French 28.6%	1992	
Dialects	1.5%	1992
8. Education enrollment:		
Primary	59%	1986-90
Secondary	16%	1986-90
9. Annual population growth	2.84% (1985-90)	1992
10. Income per capita	US$380	1991
11. Gross domestic product	2-3%	1991
12. Life expectancy (men & women)	54.2 years	1992
13. Family size (persons)	5.9	1992
14. Polygamy (married men)	30%	1992
15. Age at first marriage:		
Men 26.4 years	1992	
Women	19.2 years	
16. Crude birth rate	47.4/1000	1992
17. Crude death rate	15.5/1000	1992
18. Maternal mortality	800/100,000 (est.)	1992
19. Infant Mortality	105.5/1000	1992
20. Child Mortality Rate	80/1000	1992
21. TFR (Total Fertility Rate)	6.1/woman	1992
[6.9/woman in 1961; 6.1/woman in 1982]		
22. Contraception prevalence rate	1-2.5%	1994

Source: INSAE, RGPH- 1992, February 1994 [and other sources].

As in most West African societies, children in Benin are highly valued and grant status to their mothers. At the same time, traditional methods for child spacing and contraception are known, and many—including breastfeeding and postpartum abstinence—were regularly practiced in the past. The gradual discontinuation of these behaviors has been joined by strong, pro-natalist influences from colonial, Marxist, and religious thought. The Law of 1920 forbidding contraception promotion and services is extant but not enforced; it nevertheless inhibits normative change or policy reform. A confluence of forces, then, has created a challenging policy environment for family planning.

Favorable trends are nevertheless encouraging and growing. Demographic trends may increase acceptance of family planning. Contraceptive use is now estimated to be highest in urban areas, and among the nation's largest ethnic groups, the Fon, Adja, and Yoruba. At 52, life expectancy has now reached the threshold at which a demographic transition is likely to begin.

Meanwhile, women in some quarters are strenuously advocating greater reproductive rights, the revision of the Family Code, and access to contraception and safe abortion. AIDS awareness has increased the mass promotion and availability of condoms. It is also widely recognized that high fertility, combined with a GNP per capita of US$380 will lead to a continuation social misery and poverty, constituting a serious obstacle to national economic development.

1.1.3 The Health Sector: Recent Evolution

In 1972, with the introduction of a socialist government, the Republic of Benin adopted a health policy that emphasized the installation of health infrastructures, especially in the most deprived rural areas. Modern preventive medicine was emphasized over curative or traditional care. These policies were reinforced when Benin subscribed to the Alma Ata Declaration in 1978.

By the mid-1980s, however, it was clear that implementation of the primary health care policy had been only partially successful. The Ministry of Health (MSP) managed approximately five percent of the national budget but devoted more than half of this amount to costly tertiary care. In contrast, a community self-help approach to primary care left most rural areas with health centers that were crumbing or uncompleted. Few had a trained health worker or were supplied with drugs, safe water, or functional basic equipment. For most rural Beninese, the nearest referral centers were situated at the sub-prefecture (formerly "district") capitals, often at too great a distance and with inadequate maternal, preventive, or curative services. Infant mortality rates remained very high, at around 150 per thousand.

Following a diagnostic study carried out in the health sector (1986-1989), Benin defined and adopted a new health policy whose principal objective was to improve health indicators by expanding primary health care coverage throughout the country. Accessible, better quality community health centers were to be established at the "commune" level, midway between the village and the sub-prefecture. These centers offered combined services in both primary health care (PHC) and maternal and child health (MCH). Strategies envisioned for improving health indicators were, first, the development of preventive care, including immunization, family planning, the prevention of sexually transmitted diseases (STDs) including AIDS, and information, education, and communication (IEC); and second, the reinforcement of curative

services, including establishing a program of essential generic drugs (Bamako Initiative), the rehabilitation of existing infrastructures, service for the sick child, and reproductive health care.

Substantial progress has been made over the last ten years in Benin's public health sector with regard to selected health strategies and interventions. Oral rehydration therapy (ORT) is currently widely understood and practiced throughout the country; cases of severe dehydration due to diarrhea are reportedly rare. Benin's essential drug program, with a revolving fund financed by the community at commune and sub-prefecture level, has provided one model that inspired the 1987 "Bamako Initiative." The increased community participation and financing resulting from the system helped to maintain full immunization coverage rates nationwide at nearly 70 percent each year since 1990. By 1992 infant mortality rates (IMR) had dropped to 105.5 per thousand, a significant improvement over one decade earlier, though still unacceptably high.

High IMRs persist, in part, because progress in child health has not been matched by comparable advances in maternal and reproductive health, including family planning. Today Benin suffers from the absence of a global MCH policy, low quality and use of services, and the need for a population and official family planning policy. Family planning is therefore evolving in Benin without a clear definition of target populations, objectives, or program strategies.

1.2 Background to Family Planning and Reproductive Health Services

The concept of modern family planning has existed in Benin for about 20 years. In 1971, family planning activities began under a nongovernmental organization (NGO), the National Committee of Benin for the Promotion of the Family (CNBPF). In 1992, the CNBPF became the Beninese Association for the Promotion of the Family (ABPF); the International Planned Parenthood Federation (IPPF) provides a portion of its funding.

In subscribing in 1978 to the Alma Ata Declaration, the Republic of Benin also opted for the provision of family planning (FP) services. Today, however, the political and cultural environment is still very confused regarding FP activities. The Benin government has pursued a "laissez-faire" attitude toward family planning services: they are quietly accepted, without being publicly promoted. The absence of clear guidelines for family planning providers creates major insufficiencies in the delivery of FP services, in the coordination, follow-up, and evaluation of activities, and in the performance of service delivery sites.

There has been effort on the part of the government to correct this situation. In 1983 Benin officially integrated family planning services into MCH. Public services for family planning were established with UNFPA funding through the Project for Family Well-being (Projet Bien-être Familial, PBEF). In principle the program ensures availability—in all government hospitals, health centers, and other health posts—of methods of family planning which will give couples and individuals freedom of choice in the spacing of births and/or limitation of family size. In practice, however, public services are not adequate in terms of access or quality.

Other government efforts include establishment of the National MCH/FP Coordination Committee (CNEEP, 1989) and its counterparts at the department level (CDEEP); the National MCH/FP/Nutrition Program with the "Alert" System for high-risk pregnancies (1991-1995); and

additional UNFPA-supported programs in policy, analysis, population education, and family life education. Additionally, in 1993 the Ministry of Planning created a Department of Human Resources and Population (SRHP) and the National Human Resources and Population Commission (CNRHP).

Meanwhile, public and NGO services were complemented in 1992 by the onset private commercial sector activities. Condom promotion and distribution for HIV/AIDS prevention began through the Benin Association for Social Marketing (ABMS). ABMS, which receives technical and financial support from Population Services International (PSI), focuses on condom sales for HIV/AIDS prevention, with corollary benefits to family planning.

Through these public, nongovernmental, and private commercial initiatives, the accessibility of family planning services has grown substantially over the last decade; still, the quality and utilization of these and other reproductive health services are generally disappointing. Low modern contraceptive prevalence rates of about one percent, combined with poor pre-natal and post-natal care, continue to bring about pregnancies that are too early, too frequent, too many, and too late. Other consequences include rising levels of unsafe abortion, postpartum and post-abortion complications, a high maternal mortality rate, and such social outcomes as abandoned children and infanticide, couple infertility, and other deficiencies stemming from early and sudden weaning practices as a result of multiparity.

1.3 The Public Sector

The Ministry of Health is mandated to develop and carry out national health and family planning policies and programs; however, its activities are coordinated intersectorally with other ministries. They include the Ministry of Planning and Economic Restructuring (MPRE), the Ministry of Labor, Employment, and Social Affairs (MTEAS), the Ministry of Education and Scientific Research (MERS), and the Ministry of Culture and Communications (MCC). Other ministries contribute indirectly to these activities: the Ministry of Rural Development (MDR), the Ministry of Youth and Sport (MJS), the Ministry of the Interior (MISAT), the Ministry of Justice and Legislation (MJL), the Ministry of Defense (MDN), and the Ministry of the Environment, Housing, and the Ministry of Environment, Housing, and Urban Development (MEHU).

1.3.1 Ministry of Health

Preventive and clinical activities in family planning are undertaken chiefly in public health facilities throughout Benin, although the IPPF affiliate ABPF, cooperative clinics, and the private sector also provide some services. Until May, 1994, these activities were managed by the Preventive Services Unit (SAP), under the National Directorate of Health Protection (DNPS). (See Table 2). In the current MSP organizational scheme (See Table 3), family planning activities are given greater prominence as a separate service under the Directorate of Family Health (DSF). This directorate will also include under its integrated umbrella MCH activities and HIV/AIDS prevention.

TABLE 2

SYSTÈME NATIONAL DE SANTÉ - BÉNIN, 1993.

NIVEAUX		INSTITUTIONS	STRUCTURES HOSPITALIERES ET SANITAIRES	SPECIALITES
CENTRAL		Ministère de la Santé (MS)	Centre National Hospitalier et Universitaire (CNHU)	- Médecine - Pédiatrie - Chirurgie - Gynéco-obs - Radiologie - Laboratoire - O.R.L, OPH - Autres spécialités
INTERMEDIAIRE ou DEPARTEMENTAL		Direction départementale de la Santé (DDS)	Centre hospitalier départemental (CHD)	- Médecine - Pédiatrie - Chirurgie - Gynéco-obs - Radiologie - Laboratoire - Autres spécialités
PERIPHERIQUE	Chef lieu de sous-préfecture ou de circonscription urbaine	Centre de santé de sous-préfecture ou de circonscription urbaine (CSSP/CSCU)	Centre de santé de sous-préfecture ou de Circonscription urbaine (CSSP/CSCU)	- Médecine - Chirurgie - Maternité - Radiologie - Laboratoire - Pharmacie
	Chef lieu de commune	Complexe Communal de santé (C.C.S.)	Complexe Communal de Santé (C.C.S.)	- Dispensaire - Maternité - Pharmacie
	Village ou quartier de ville	Unité villageoise de santé (U.V.S.)	Unité villageoise de santé (U.V.S.)	- Soins - Accouchements - Caisse de pharmacie

Source : MS-SESP

ORGANIGRAMME DU MINISTERE DE LA SANTE

Avril 1994

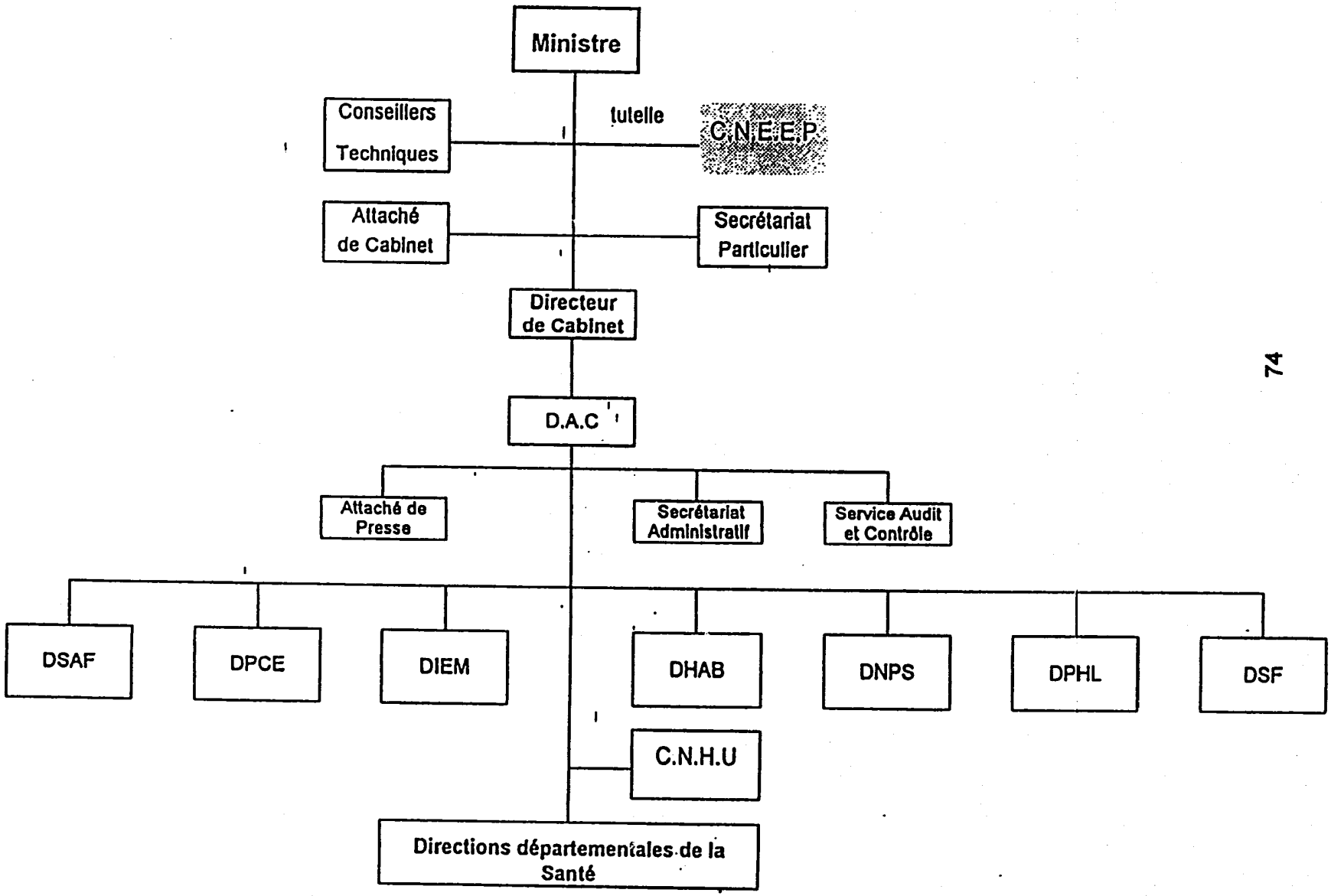

TABLE 3

Overall, the structure of family planning and reproductive health services in Benin is organized through the health ministry to match the country's administrative divisions. This decentralized system has a pyramid structure. (See Table 3.) At the national level is the Central Teaching Hospital in Cotonou (CNHU), responsible for tertiary care and specialized medical and surgical cases. The CNHU trains physicians, midwives, nurses, and technicians and undertakes medical research.

At the regional level is the Departmental Hospital Center (CHD, in four out of six departments). The CHD provides specialized care for complex cases referred from the peripheral clinics. Management of the CHD falls to the Departmental Health Directorate (DDS), which is responsible for implementing national health policies, allocating resources, and coordinating health services throughout the department.

At the peripheral level are 84 referral centers known either as the Sub-prefecture Health Centers (CSSP) or Metropolitan Area Health Centers (CSCU). A number of CSSP/CSCU are adequately equipped and staffed to offer first referral care in PHC, MCH, and FP for the Communal Health Centers (CCS, 90 in 517 communes) and individual dispensaries and maternities (an additional 62). The sub-prefecture facilities are managed by the *Médecin Chef* or district medical officer. Typically, a nurse or midwife is assigned to the commune level to manage the CCS, which constitutes the primary care entry point into the public health system. In addition, some 313 Village Health Units (UVSs), which pre-date the revised health structure of 1986, continue to serve small communities, although their services are rudimentary, and they are typically not staffed by medically trained personnel.

An important feature of Benin's decentralized health structure is the community management committee at the CSSP/CSCU and the CCS levels. These are known respectively as the Sub-prefecture Health Management Committee (COGES) and the Commune Level Health Management Committee (COGEC). Among other tasks, these committees are responsible for health promotion in the commune and maintain the health centers' local policies and accounts from paid curative services. Fees are set by the national revolving drug fund scheme. The sense of ownership and autonomy that has been generated through this community management system has accounted in large measure for the revival of primary health care in Benin. The community-managed health care system and its revolving fund offers an ideal setting for integrating family planning counseling and services into an auto-financing scheme that could be extended to include contraceptives.

1.3.2 Ministry of Planning and Economic Restructuring

The Human Resources and Population Department of the Ministry of Planning is in charge of coordinating activities with the aim of developing a draft National Population Policy. In order to accelerate this process, the National Human Resources and Population Commission was established on July 9, 1993. One of the tasks assigned to the CNRHP is to propose a draft population policy to the government. To this end, the CNRHP commissioned the drafting of the pre-International Conference on Population and Development (ICPD) Conference report "The Demographic and Political Situation and Population Programs in Benin." It has requested ongoing data collection and analysis by the National Institute for Statistics and Economic Analysis (INSAE). It organized two regional conferences and one national conference in

August 1994 with the task of making recommendations on orientations for population policy in Benin at the ICPD in Cairo.

The Cabinet of the CNRHP is composed of the Minister of Planning (President), the Minister of Labor and Social Development (1st Vice-president), and the Minister of Environment, Housing, and Urban Development (2nd Vice-president). Members include the Ministry of Rural Development, the Ministry of Justice and Legislation, the Ministry of the Interior, the Ministry of the Environment, the Ministry of Finance, the Ministry of Youth, and the Ministry of Health.

Given the central place of the MSP in the formulation of policies for family planning and reproductive health, it would seem appropriate that the MSP be granted CNRHP Cabinet status; rather, it is ranked as a member of the full Commission and its Technical Coordination Group. In addition, NGOs, which spearheaded family planning programs in Benin, have not been included in the CNRHP deliberations. One may conclude that the perspective of the CNRHP is therefore more demographic than programmatic, with passing attention given to reproductive health, family responsibility, and the better health of women and children.

1.3.3 Other Ministries

IEC sensitization activities for family planning and population offer a positive example of the interdepartmental and interministerial cooperation necessary to making a complete and successful national family planning program. IEC efforts are carried out in health facilities by service providers with technical assistance from the IEC unit in the DSF, in cooperation with the IEC service of the DNPS. Social Promotion Centers, managed by the Social Affairs Directorate in the Ministry of Labor and Social Affairs, are among the most effective sources of family planning IEC in department capital towns. These activities are carried out by social workers and social promotion agents, who are based in Social Promotion Centers in key towns and cities. Meanwhile, in schools and colleges, FP/IEC is carried out through population education and family education programs managed by the Ministry of Education. The mass media at the Ministry of Culture and Communications especially the radio, are beginning to sensitize people to population issues through special programs on health.

A brief list of current and potential public sector partners in a Benin population program follows.

Ministry of Labor, Employment, and Social Affairs. MTEAS is an important partner in family planning education though its Social Affairs Directorate (DAS). The DAS has a permanent presence in metropolitan areas throughout the country through its social promotion centers and social worker staff. In addition, DAS collaborates actively with other ministries and international institutions. Its child nutrition program offers nutrition and family health education to mothers who come to social promotion centers to receive food supplements for their children. More important, DAS social workers frequently team up with health center staff to provide health education. The DAS program includes other initiatives which may serve as entry points to family planning. Among them are community-based readaptation, nutrition, MCH, prevention of STD/HIV/AIDS, and skills training for women.

The DAS has currently 71 social promotion centers, 17 specialized social offices, and eight MCH Medical Action Centers. They serve schools, soldiers, hospitals, and communities. Two

hundred social workers undertake health and population educational activities with the help of community committees, women's "groupements," and women's leaders at the level of districts and villages. They also visit homes and provide counseling on health issues, including oral rehydration therapy. These structures and activities find close parallels in family planning education activities

Ministry of Education and Scientific Research. MERS is a privileged partner in conducting demographic and medical research and providing accurate, reliable information about population and family planning to students and health professionals and social workers in training. USAID and UNFPA, in addition to some NGOs and bilateral institutions, collaborate with MERS in supporting the development of curricula in health and family life education in schools. Sixty percent of out-of-school children in Benin are girls, and only four out of five women are literate. In view of the statistical association between female education and fertility decline, these data present a special challenge to MERS and population policy-makers.

Institutions for research and training in health and population under the aegis of MERS include the National Medico-social Institute (INMES), which trains nurses, midwives, and social workers; the Faculty of Medicine at the National University of Benin, which includes training in reproductive health with limited emphasis on family planning methods and counseling; research through the Center for Reproductive Health Research and the Regional Center for Health Development (CREDESA); and the WHO Regional Institute for Public Health (IRSP) housed in the Faculty of Medicine and which serves Francophone West Africa.

Ministry of Rural Development and Cooperative Action. MDRAC has activities integrated with rural development through the Regional Center for Action in Rural Development (CARDER). Over the past 15 years, CARDER has played a part in disseminating information to rural farming communities on such topics as sanitation, safe water supply, prevention of Guinea Worm disease, and so on. Such committees could be engaged in promoting other health-seeking behaviors and in disseminating reliable information on family planning.

Ministry of Culture and Communications. Historically, broadcast media in Benin have been the responsibility of the MCC. Radio and television are key sources of public information about health in the country. Three transmitting stations assure radio a nationwide reach, with the exception of small unreached pockets in the north. The range of television has been limited until recently to about one quarter of the population. Expanded broadcast services are expected under the newly created autonomous High Authority for Audiovisual Services and Communication (HAAC), which will permit private broadcast ventures in the country.

Ministry of Defense. This ministry has participated in immunization and HIV/AIDS prevention efforts and remains a potential partner in wider family planning information program.

Ministry of Justice and Legislation. The MJL represents an obvious ally owing to the great number of prisoners who depend on its welfare. Information on HIV/AIDS prevention and family planning information are currently being disseminated in prisons, although in a limited manner. In addition, this Ministry will become a collaborator in processing any future repeal of the Law of 1920.

Ministry of Youth and Sport. Considering the importance of youth to this Ministry, its role may be reviewed to integrate HIV/AIDS and FP activities and messages into its programs.

1.4 NGOs and the Associative Movement

1.4.1 Background

Self-help for health and development has long been a national policy in Benin. The dismantling of the single party structure in 1991 resulted in a dissolution of official party-based associations among local youth, women, agricultural cooperatives, and other groups. Action favoring the social mobilization of Beninese men and women for public causes has increasingly fallen to the independent associative movement. Such organizations range from legally registered *associations sans but lucratif* (ASBLs, non-profit organizations), the Scouts, traditional and modern religious organizations, professional groups, *associations de développement rural* (ADRs, rural development associations), public and private interest groups, traditional marketing associations, and so on. In many instances the objectives of NGOs, ADRs, and other voluntary associations mix politics, profit, and public interest.

The NGO sector of the civil society has grown markedly, from an estimated 32 organizations in the early 1980s to 72 by 1989 to perhaps 500 non-traditional associations in 1994. The uncertainty of the total number bears witness to the considerable momentum underlying the associative movement and the government's slowness in accrediting and monitoring them.

In Benin an NGO, ADR, or ASBL is registered by the Ministry of Internal Affairs following receipt of a constitution, minutes of the constituent general assembly, personal histories of the four principals, and a fee of 3,000 FCFA. For NGOs wishing to undertake technical projects in health or family planning, written agreement from the DNPS is requested.

Several factors have encouraged the associative movement. First is the model provided by the successful expansion of community-based health and development committees, the COGEC and the COGES. Second the reduction of the civil service staff, stipulated by the nation's structural adjustment program, has encouraged former government employees to undertake individual initiatives in the NGO sector. A third factor is the creation of associations tightly entwined with selected political parties, currently estimated around 100. A fourth reason is the growing number of international NGOs or associations which seek to create local affiliates (Rotary, Lions Club, Soroptimists, Scouts) or which aim to form partnerships or networks with local NGOs. Currently, over three dozen international non-profit organizations are present in Benin.

A final and important reason for the growth of Benin's associative movement is the promise of donor financing and support. First, beginning in the 1980s, the United Nations Development Program (UNDP) pursued a program to encourage community-based initiatives called *Fonds d'appui aux initiatives de base* (FAIB, Fund for Community-based Initiatives). Reinforcement of local NGOs has been the principal objective of the FAIB. Second, the effort to mitigate the immediate negative effects of the structural adjustment program led in 1992 to the creation of the *Agence pour la dimension sociale de développement* (AGDSD, Agency for Social Development) in the MPRS. In principle, this agency was charged with the double task of carrying out two components of the government's Social Action Program. First, an "Emergency Program" for infrastructure development in the social sector was mounted. Second, the

AGDSD was charged with channeling funds for small-scale social development projects through local NGOs. This second component has not been executed.

A reorganization of these two initiatives was proposed in a Round Table on the Social Dimensions of Adjustment held in mid-1994. It was suggested that the FAIB and the AGDSD be combined under a single independent unit within the Planning Ministry. This unit, to be called *Agence pour la gestion des projets aux initiatives de base* (AGEPIB, Agency for the Management of Community-based Projects), will serve as a regulatory channel through which donor assistance passes to the NGO sector. The proposal remains controversial because of its potential for centralizing and stifling grass-roots initiatives. Proponents of the proposal, however, point out the need for vigilant monitoring of the sector owing to common weaknesses of NGOs in technical capacity, project preparation skills, monitoring and evaluation, transparent financial management, democratic management, and sustainability.

USAID has recently funded BINGOS (Benin Indigenous NGO Strengthening Project), executed by AFRICARE, to pursue activities in health, family planning, and democratic governance by supporting local NGOs and associations. The project will select 20 to 30 organizations having competence in these fields. On the basis of an initial institutional needs analysis, AFRICARE will make available, among other assistance, training in administration and finance; project design, management, and evaluation; long-term planning; identification of funding; and funding for micro-projects. Meanwhile, other bilateral donors such as the Netherlands and Germany continue to support the NGO sector. A key purpose of the BINGOS project is to identify, strengthen, and orient these organizations toward meeting specific health and family planning objectives.

Project implementation is only one of the multiple roles which Beninese associations and NGOs may play to support reproductive health and family planning. Equally important are their contributions to policy development through advocacy and the political process and their function as channels of communication about family planning to their members, friends, and neighbors.

1.4.2 NGOs and Family Planning

Historically, local and national NGOs have played a unique role worldwide in advocating, initiating, and sustaining family planning programs. Their contributions and strengths include their advocacy for sexual and reproductive health rights; their catalytic role in policy dialogue; their civic representation at grass-roots level; their flexibility and responsiveness; their innovative approaches to service delivery; their testing and reinforcing of cross-sectoral linkages; and, often, their self-sustainability.

Regional or local development associations have indirectly supported family planning by establishing and staffing private health centers and hospitals, complementing the efforts of public health center management committees, or seeking the assistance of external NGOs in the health field.

Several studies of the sector have flowed from the new emphasis on building the capacities of NGOs and local organizations and harnessing their resources for development. These studies suggest that, at present, only a small number of viable associations are active in the health

sector. Local groups which might currently assist in implementing family planning programs—either through project implementation or advocacy support—include the following: (1) ABPF (Beninese Association for the Promotion of the Family) (an IPPF affiliate); (2) Association of Benin Midwives; (3) Inter-African Committee on Traditional Practices Affecting the Health of Women and Children; (4) *Survie* (Child and Mother Survival); (5) The Beninese Red Cross; (6) Association of Private, Religious, and Social Medical Action in Benin); (7) Association for Training, Health, and Development; (8) Mother and Child Survival Association; (9) International Center for Social Development and Community Health in Benin; (10) Benin Association for Social Marketing; and of special importance (11) Regional Center for Health and Development (CREDESA).

1.4.3 Benin Association for Family Planning

Precursor of the present ABPF was the National Committee of Benin for the Promotion of the Family. Created in 1972, CNBPF started its activities in 1973 and joined IPPF in 1975. Its headquarters is in Cotonou with branches in the six departments. It has three clinics in Cotonou, Porto-Novo, and Parakou; two additional clinics are planned to be established in the Atacora and the Mono departments.

ABPF has 53 staff members and 1,200 volunteers. Through the efforts of this staff, the NGO addresses a range of family planning activities. Among them are sensitization, IEC, family planning services, and social marketing for contraceptives. These services include pre- and post-natal consultations in its own clinics; they also include family planning supplies and equipment in 80 public sector clinics of the health ministry, which it supports as "integrated" FP/MCH clinics. In 1991-1993 ABPF undertook an experiment in community-based distribution of non-medical contraceptives in Cotonou, but discontinued the activity for lack of funds.

Several constraints currently face ABPF. Funding to support new initiatives to supplement its clinic-based cost recovery is limited. Currently, ABPF funding comes mainly from IPPF and UNFPA, which contributes some contraceptives and clinical training activities. In addition, ABPF is struggling to identify a clear role for itself in relation to government services. Coordination with the government-based Family Well-being Project—which supports an additional number of "integrated" clinics—has been limited.

1.4.4 NGOs in Related Sectors

In addition, approximately two dozen associations and an equal number of NGOs target the development, promotion, and rights of women. The National Federation of Beninese Women's Associations, the Beninese Women's Association for Development, the Association of Beninese Businesswomen and Company Heads, and the Benin Association of Women Jurists (AFJB) are broad structures which have also emerged as potential forces in promoting the rights and welfare of women. Women's associations and NGOs offer important channels of communication and support to family planning programs in Benin.

Finally, several associations and NGOs may be noted in the communication field. Their expertise may be harnessed for activities in advocacy, publicity, reporting, and social

mobilization. Figuring among them are the following: (1) Association of African Professional Women in Communication; (2) Media and Peace; (3) African Association of Journalists for Health and the Environment); (4) Beninese Association of Writers in National Languages (ABEL); (5) Group for Studies and Research in Communication - Media South); (6) Society of Editors in the Private Press; and (7) Beninese Association of Promoters of Private Radio and Television.

1.4.5 International NGOs

Complementing the local NGO movement is a wide variety of international NGO partners.

Among them, **AFRICARE** has received US$4.6 million from USAID to implement a private voluntary organization (PVO) umbrella project entitled BINGOS. The project intends to select 20 to 30 NGOs in order to strengthen their management and implementation capacity through training in democratization and health; it expects to fund small-scale projects in three departments where FP activities are already underway.

Population Services International (PSI) has been working with its counterpart ABMS in Benin since 1990 in the field of social marketing for contraceptives. Owing to an extremely aggressive media promotion and distribution program, it sold 1.5 million units of "Prudence" condoms in 1993 alone and expects to double that number in 1994.

IPPF assists ABPF by supplying contraceptives and making advance payments available for planned activities. Its average annual assistance package is approximately US$400,000.

Other groups include the following:

- **The French Association of Volunteers for Progress** (AFVP) supports PHC and AIDS control activities in Benin. Provision has been made for incorporating family planning in the AFVP program once a national policy has been established.

- **The German Volunteer Service** provides health technical assistance to government clinics (CSSP) in 10 sub-prefectures.

- **The U.S. Peace Corps** undertakes health activities in urban areas and could become a valuable partner in community-based family planning education activities.

- **"Terre des Hommes"** participates in PHC and MCH activities, with an emphasis on nutritional rehabilitation.

- Cathwell (**Catholic Relief Services**, CRS) has for many years managed a food distribution program for young children through the social promotion centers of the DAS.

- **CSDO** (Canadian Solidarity and Development Organization) collaborates with the Ministry of Labor and Social Affairs in activities that promote women and women's

status and with Ministry of Health in the Expanded Program of Immunization (EPI) and PHC. It discreetly promotes modern and traditional family planning activities.

The nongovernmental sector also includes the multiple religious orders and confessional institutions that have established health care facilities in Benin. These clinics and hospitals typically offer services of high quality. The four visited by the assessment team offered family planning services and a range of methods, but usually excluded injectables and surgical techniques. Strong support for HIV/AIDS prevention and breastfeeding are in evidence. Such facilities are generally well staffed and equipped, and staff members are trained under an apprenticeship approach to standards set by the supporting institution. They also enjoy a large clientele, despite prices for services which frequently exceed those of government hospitals and clinics.

1.5 Private and Commercial Family Planning Services

In reality, a strict demarcation between voluntary nongovernmental and the for-profit commercial structures is difficult to draw. As NGOs are being increasingly urged to recover costs, their non-profit relationship to the consumer differs little in practice from that of profit-making ventures. For the sake of discussion, however, the private health sector in Benin may be said to be comprised of private for-profit and not-for-profit hospitals, cooperative clinics, social marketing activities, private health centers and maternities, private medical practitioners, traditional medicine, and pharmacies.

1.5.1 Private Health Sector

Ministry of Health statistics for 1993 note the following known elements in the private health sector infrastructure: 15 hospitals or polyclinics, 46 private surgeries, 56 maternity clinics, 59 private paramedical centers, four pharmaceutical companies, 86 registered pharmacies, and 231 local drug "depots" maintained by drug sellers. The number a traditional practitioners, who are generally part-time specialists, is not known, but it is assumed to be quite large. Traditional practitioners typically continue to be a favored point of contact for treatment among rural Beninese.

1.5.2 Social Marketing of Contraceptives

The Benin Association for Social marketing (ABMS) is a fledgling NGO created to support the USAID-funded HIV/AIDS condom social marketing project. This activity is executed through a grant to the Washington-based contraceptive social marketing firm Population Services International. Originally a component of The National AIDS Prevention Project, the social marketing scheme underwent a course correction in 1992 by changing its "brand" of condoms and becoming independent under ABMS. Between December 1992 and June 1994, two million condoms have been sold and a sophisticated mass media marketing campaign undertaken. Special IEC activities are undertaken among such target groups as students, lorry drivers, commercial sex workers, and military men. Donated condoms are packaged by ABMS and distributed at 20 FCFA for a package of four condoms. A marketing network of wholesalers and petty traders sell the product for a retail price of 50 FCFA per pack. In the

future ABMS would be willing to add oral contraceptives to is product range, expanding its venture more directly into family planning.

1.5.3 The Pharmaceutical Central Purchasing Office, the "Centrale d'Achat"

Benin's scheme of community health center management through the COGEC and COGES is financed through paid treatments and other services that rely on a revolving fund for essential drugs at each center. Generic pharmaceuticals for the scheme are supplied through a central purchasing office for essential drugs, the *Centrale d'Achat.* Effective coverage of the population by this scheme is estimated to be around 30 percent. Utilization rates have been a rather low 20 percent; however, the 1994 devaluation of the FCFA increased drug prices in private pharmacies to non-competitive levels, thereby making the CSSP/CSCU and the CCS more attractive to the population.

By presidential decree, the *Centrale d'Achat* is a non-profit, independent entity, having a Management Committee and Administrative Board separate from government. Members of the Board represent government, NGO, private commercial, and donor interests. Impetus for the *Centrale* arose from the community-based revolving drug scheme, but sales may extend to any authorized drug outlet—public, NGO, or private commercial. About 40 percent of drugs are purchased from local suppliers and 60 percent from overseas imports. The Management Committee sets the wholesale and retail prices of the drugs; in periods of price shock, as in 1994, the Committee may propose to regulate prices through subsidies in order to ensure that drugs remain accessible to the population.

1.5.4 Cooperative Clinics

An innovative quasi-private sector health scheme funded by UNDP and managed in cooperation with the government, has encouraged the establishment of cooperative clinics by qualified medical personnel. The cooperative receives a loan in lump sum at the outset, which it repays with interest over six years. By mid-1994, 10 such clinics had been created in localities selected by the MSP.

1.6 Multilateral and Bilateral Support to Population Activities

1.6.1 Multilateral Agencies

Benin's steady advances in the health sector over the last 10 years may be attributed in no small measure to its active collaboration with donors. Many donors currently support an integrated approach to public health services that includes family planning and reproductive health.

The World Bank, in its first Project for Health Services Development (PDSS I), supported family planning activities chiefly through an emphasis on training and infrastructure development. PDSS II (1995-2000, US$31 million in International Development Agency [IDA] funds, plus other donor contributions) will make a more concerted contribution to family planning within an integrated PHC/MCH/FP approach. Project components will include (1)

developing and expanding family planning program and services; (2) improving the quality and efficiency of priority health services; (3) strengthening and streamlining sector management and administration; (4) strengthening partnerships for health, including intersectoral coordination and community participation.

Activities specific to family planning (about US$2 million) are expected to include (1) supporting the expansion of FP services and their integration into the minimum package of service at all levels of the health system; (2) developing the first- and second-level referral centers for family planning in three departments; (3) supporting central and peripheral restructuring, including the creation of the Family Health Department in the MSP which embraces MCH, STD/HIV/AIDS prevention, and family planning; (4) adding health staff at the peripheral levels through a special fund for use by local management committees; (5) providing equipment and a limited supply of contraceptives, possibly through the Central Purchasing Office for essential drugs.

UNFPA, in its current program (1995-1998, approximately US$10 million), will continue its efforts in the following areas: (1) improving capacity of the CNRHP to conceptualize, implement, and manage population policies and coordinate donor activities at the department level; (2) supporting development of a system for data collection and analysis on safe motherhood, and research into population and demographic issues by INSAE in the Ministry of Planning; (3) continuing general support to PBEF, especially in the areas of IEC, training, counseling, contraceptive supply, and rehabilitation of 120 health centers; (4) launching a community-focused family life (FL) and population education project for empowering women through women's craft associations, replacing an earlier school-based FLE approach; (5) strengthening the capacity of ABPF to provide outreach services in rural areas; (6) reviewing the national MCH/FP program in light of the restructuring efforts of PDSS II.

UNICEF supports child survival, with an emphasis on EPI and the Bamako Initiative. The relevant areas of the 1994-98 program include (1) PHC and health system strengthening; (2) safe motherhood; (3) HIV/AIDS prevention; (4) health and family planning communications; and (5) child nutrition and a breastfeeding campaign. A family planning policy paper issued in 1993 expressed UNICEF's renewed interest in providing limited support to family planning as part of a reproductive health and child survival strategy. UNICEF-Benin has not applied this new policy to its program; however, promotion of breastfeeding would offer a suitable entry point.

While UNDP has in the past funded a number of health activities executed chiefly by WHO, it currently does not contribute to the health and population sectors, apart from supporting the Round Table on Health scheduled for January 1995. Past activities have included (1) support to primary health care by improving the community-based management of resources, availability of essential drugs, and improvement of health coverage; (2) supply of teaching materials to the Faculty of Health Sciences through the Educational Materials for Health Personnel (MEPS) project; (3) establishing 10 cooperative health clinics (1987-92) intended to give loans to qualified, young, jobless health graduates. UNDP will continue support to the health sector through the cooperative clinics project and the rehabilitation of some health training centers.

World Food Program (WFP) has provided food incentives for the training of village health workers. Five hundred women have been trained to mobilize other women in rural areas with a view to adopting a method of family planning.

WHO provides ongoing technical advice as requested to the UNFPA program in Benin. It participates in the training of midwives in human reproduction together with the National University Teaching Hospital. It also participates in primary health care activities, training and equipment, and in the National AIDS Program (PNLS).

1.6.2 Bilateral Agencies

The European Development Fund (FED) provides assistance to the health and population sectors chiefly through infrastructure development, rehabilitation of health centers and facilities, and the provision of equipment. Its current program focuses on integrated rural development, which includes construction and rehabilitation of health clinics.

USAID, which did not have a country presence in Benin between 1982 and 1991, continued to provide assistance to health and family planning through its USAID Affairs Office in Lomé. A major effort in community-based water supply, sanitation, and health education was undertaken in cooperation with UNICEF (1986-1994). During the same period limited assistance to family planning activities included support to ABPF for (1) a pilot project in Cotonou for community-based distribution of condoms, (2) family planning IEC, and (3) clinical training of primary health providers in family planning and reproductive health.

Proposals were also advanced concerning development of RAPID modules to sensitize decision-makers about population and family planning issues; these discussions continue at the present time. Similarly, a social marking scheme for contraceptives was suggested. Currently, the USAID program includes indirect assistance to population and family planning through the HIV/AIDS social marketing program conducted by the local NGO ABMS with technical and financial assistance from PSI. In addition, the BINGOS umbrella NGO project executed by AFRICARE and a new health education project for schools provide additional structures for future family planning and IEC services.

The Fund for Aid and Cooperation (FAC), supported by the French government, provides funding, equipment, and technical assistance to a number of selected projects. They include SNIGS, the National Health Management Information System; epidemiological surveillance and IEC for HIV/AIDS prevention; EPI through UNICEF; and donations of essential drugs to the Central Purchasing Office and the National University Teaching Hospital since the 50 percent devaluation of the FCFA currency in early 1994. An amount of 15 million FF is budgeted for FAC assistance in the next three-year-period, 1995-1998.

The Benin-Swiss Health Project (PMSBS) began assistance to the Benin health sector in 1983. Activities have included support through the World Bank PDSS I project to departmental health directorates in the Ouémé, Zou, and Borgou departments for construction, equipment, rehabilitation, training, and improved management. The Swiss were among the early donors to support the community financing system based on a revolving drug fund.

Currently, three projects supported by the Swiss are worthy of note: an experimental health information system that is being piloted in three departmental health directorates; establishment of a health information documentation center for the MSP; and the publication of a bulletin entitled "Retro-SNIGS," which provides feedback to health centers on the quarterly data collected by the central health information system (SNIGS).

A **Benin-German Project**, currently in its fourth phase (1994-96, 1.02 billion FCFA), began in 1980 by establishing cooperative links between the German Association for Technical Cooperation (GTZ) and the German Development Service (SAD). The project works in close collaboration with other projects and donors and targets technical assistance to local rural community health centers and their management committees (COGES/COGEC) in order to enhance their institutional capacity. Ten sub-prefecture health centers are currently receiving assistance, grouped into six geographical zones. Two are at a pilot stage. Project components include support to the following areas: PHC and quality of care; decentralized management structures; IEC; STD/HIV/AIDS; and promotion of women's status. A family planning component is also planned but as yet has not begun.

Special interests of the Benin-German Project include: operations research into PHC with CREDESA at Pahou, construction of CCSs (community health complexes), and training and supervision of village health workers.

1.7 Current Status of Service Delivery for Family Planning

1.7.1 Infrastructure, Equipment, and Supplies

Family planning services are available every day in almost 80 percent of health centers. Unfortunately, their integration with other MCH activities is rare. Most health centers throughout the country have adequate physical facilities for family planning provision, especially a waiting room, and a counseling room, a clean, well-lit, well-ventilated room with a safe water supply. The major problem is the lack of visual and auditory privacy.

Equipment available for adequate service provision is outdated in most health centers, and in centers with highest attendance rates it is insufficient. Sterile conditions are poor in most centers; more than half of the health centers do not have sterilizers.

Insufficiencies can also be observed in the logistics and supply of contraceptives. Since 1982, when the PBEF began, only oral contraceptives, injectables (Noristerat), intrauterine devices (IUDs), condoms, and spermicides have been offered in all the regions of the country. Availability of methods, however, is not consistent from one health center to another. Indeed, there is a high predominance of injectables followed by combined orals. On the other hand, progesterone-only pills, IUDs, and spermicides are available in only a few health centers. Surgical methods and NORPLANT® are not available to clients. Tubal ligation is very rare and is performed only in exceptional cases.

Commodities management is still precarious. Only 60 percent of health centers have a written inventory and procurement system or appropriate storage facilities for contraceptives. Contraceptives are currently not supplied through the Central Purchasing Office for essential

drugs, therefore requiring a parallel system of supply. These shortcomings often result in stock-outs at the health centers.

1.7.2 Staff and Training

FP service providers are mostly health professionals (90 percent) mainly paramedicals, of which 75 percent are midwives and nurses. Most consider FP as a secondary activity. Only half of FP providers have received clinical training in the theory and practice of FP. Moreover, only 25 percent have been trained in IEC for family planning and less than 20 percent in management and logistics.

Given staff shortages, more than 10 percent of the health centers are obliged to use nurse's aids for FP activities, following a brief training "on the job." Because FP personnel are often those with least professional training, contraceptive choice is often compromised. According to national standards, contraceptives can be prescribed by the following categories of personnel (and at the following health centers, in parentheses):

- Non-medical methods only: traditional midwife, first aid worker, social worker (UVS)
- Non-medical and oral contraceptives: educated nurse's aid (CSSP-CSCU,CCS)
- Non-surgical: physician, nurse, midwife (CSSP, CSCU, CCS)
- All methods: specialist physician (CNHU, CHD)

FP training needs remain very critical in Benin. Half of the service providers have no training and almost half of the trained personnel received their last training more than three years ago. As a result, training in clinical FP and IEC is needed at all levels.

Training of health workers in FP service delivery is in principle a prerequisite to the implementation of any FP program. Unfortunately, no national training program in integrated MCH/FP is offered in Benin. Since 1982, the UNFPA-sponsored PBEF has helped train some of the MCH/FP staff abroad (in Belgium, Mauritius, Rwanda, Tunisia, Morocco) and in Benin through regional and interregional seminars. At the national level, training focuses almost exclusively on MCH with very little emphasis on practical FP. From 1982 to 1990, about 360 health workers were trained in Benin; however, this training was mostly clinical, and the practical phase was usually too short.

1.7.3 IEC and Outreach Activities

In the absence of a national family planning IEC program (FP/IEC), objectives, strategies, and educational materials, IEC outreach activities are insufficient or even nonexistent in most health centers offering MCH and FP services. Apart from a few posters in some health centers, FP/IEC materials are severely lacking. Brochures and pamphlets to assist clients in their decision making simply do not exist.

Faced with such a complete absence of IEC materials, service providers are obliged to use anatomic models and contraceptive samples during their counseling and educational talks. This is obviously not the best approach to winning new clients and ensuring long-term

acceptance of modern FP methods. In addition, very few service providers have been trained in FP/IEC. In order to increase people's awareness of the benefits of FP, an IEC program must be developed by the technical personnel of the health ministry in collaboration with the other actors in the FP sector. IEC materials, especially those designed to inform the individual user, must be developed and distributed in all communities and health centers.

1.7.4 Quality of Care

FP service delivery currently poses serious obstacles to method choice. During counseling, service providers do not present all the methods available. Thus, only 54 percent of new acceptors hear about injectables, 40 percent about pills and barrier methods, and 18 percent about IUDs. Almost 33 percent of service providers influence client choices, especially in favor of pills. Information given to acceptors on each method is therefore insufficient and essentially relates to the use of the method. More than 80 percent of clients do not receive information on side effects or the advantages of each method.

More needs to be done to improve service providers' overall performance, especially by increasing their knowledge of FP methods, (utilization, management of side effects), clinical examination procedures, and sterile safeguards.

Provider-client interaction is generally satisfactory in terms of time allowed; however, during counseling, service providers are rarely concerned with their clients' own objectives regarding reproduction. All health centers also have a reception system (first in, first served basis) and the waiting time seems reasonable, except in health centers with a high attendance rate.

Unfortunately, client follow-up is rare; very few health centers keep a precise record of their clients for possible home visits or reminders in case of missed appointments. Consequently, few clients receive information on how to cope with side effects or on the possibility of switching to another method. Discontinuation rates for short- and medium-term methods are, therefore, unacceptably high.

1.7.5 Management

The management of equipment, personnel, and activities is still poor. For example, personnel job descriptions are available in only 40 percent of health centers; descriptions of FP program activities are kept in only 29 percent; and FP objectives are spelled out in only 50 percent. This situation creates a number of insufficiencies for the planning and organization of personnel duties and workload.

The intermediate and peripheral levels are scarcely involved in the planning of FP activities. Most health centers do not keep written records of their daily FP activities. Records and statistics management is not satisfactory, especially with respect to the filing of client data for medical follow-up, the home tracking of drop-outs, activity records keeping, and the design and utilization of activity reports.

The MSP has set up a decentralized system for follow-up and supervision of MCH/FP activities, but it is not yet effective in all the regions of the country. In most cases, supervision is carried out without any supervision tools. A supervision document for MCH/FP activities has

been developed at the central and intermediary levels, but it is unsound in many respects. Currently supervision of FP activities is carried out as part of supervision for MCH, but in practice it is often neglected and is reduced to the mere count of FP service cards. In truth, FP supervision is left to regional officers according to their convictions.

Current practice does not match the standards set for health supervision, which call for the central level to carry out biannual supervision of regional health centers, the intermediary level (department) to carry out a quarterly supervision, and the peripheral level (sub-prefecture), monthly supervision. Budgetary, logistical, and organizational constraints result in very weak supervision as compared with these national standards. In addition, at the qualitative level, the lack of indicators, specific objectives, and immediate feedback do not allow this supervision to improve the quality of services, ensure in-service training, or motivate the FP service providers. Supervision should focus more on technical support.

1.7.6 Policy and Practice

In 1989, with a view to improving the coordination of MCH/FP/Nutrition activities, the Ministry of Health set up a National Coordination Committee. Unfortunately, this committee has not led to an effective coordination of these activities owing to structural, functional, and resource constraints. Moreover, the attributes and activities of the committee are not clearly defined. As a consequence, integration and coordination in the field among the different actors in FP is inadequate.

In the absence of a definitive government population and family planning policy, current policy for family planning is governed by the strategies and guidelines laid out in the Ministry of Health's MCH/FP/Nutrition Program. With respect to family planning, however, weaknesses in the program—in addition to those of integration and coordination—are also apparent. Little consistency exists between the objectives and proposed strategies for family planning. The conceptual and institutional frameworks for FP are unclear. Existing needs in family planning are not indicated. Process and impact indicators for evaluating family planning interventions are not defined. Continuous evaluation for each level of service is not addressed.

Not surprisingly, in light of these constraints, the decentralization of resources and prerogatives in family planning is not effective. As regards the organization of services, the integration of FP with other MCH activities is at best geographical in most health centers. Mechanisms for the real and operational integration of FP into other MCH activities are not proposed.

Clearly, it is time for Benin to develop a firm policy for planning, implementation, and evaluation of population, family planning, and reproductive health activities.

1.8 Toward a Family Planning Policy for Benin

So far, responsibility for development of a national family planning policy in Benin has fallen chiefly to the public sector. The NGO and private commercial sectors have been marginally included in this process, but most often in the role of private citizens rather than institutional voices.

Because overall social well-being is closely intertwined with population, it is important that Benin elaborate in the very near future a national population policy. The policy should include a framework for action and guidance to all family planning providers. Movement in this direction has been made in several recent preliminary reflections on the population sector by Beninese governmental institutions and their cooperating agencies (MSP 1991, Aplogan 1994c, UNFPA 1994, CNRHP/MPRE 1994).

The decree 93-159 of July 9, 1993, establishing the CNRHP offers an institutional setting for the elaboration of population policies. This body is charged with overseeing and coordinating the policy planning process. So far, it has commissioned elaboration of a national report on the demographic situation of population programs in Benin for the International Conference on Population and Development. Subsequently, it will organize two regional conferences in the country and follow them by a National Conference on Population. It is expected that the outcome of these events will facilitate the elaboration of a national population policy.

A framework for such a policy is offered in the objectives and strategies of a proposed population and family planning program developed for the ICPD and were elaborated as follows:

Overall Objective: Improve mother and child health in Benin through the reduction of morbidity and mortality.

Intermediate Objectives:

- Promote and intensify family planning activities.
- So strengthen existing infrastructures to make them suitable for family health activities.
- Improve the quality of family planning services.

Specific Objectives:

- Increase the number of family planning acceptors by 10,000 a year.
- Increase the national contraceptive prevalence rate to four percent overall and to nine percent among women in priority zones (urban and semi-urban areas) by the year 2000.
- Reduce by 75 percent the number of undesired pregnancies.
- Reduce by 50 percent the number of induced abortions.

The strategies proposed for attaining these objectives include IEC, service delivery, training and supervision of personnel, operations research, and coordination of activities in the field. Elements of these strategies include:

- Educate youth to ideas and practices of family life and population.
- Introduce family life education in training programs at all levels.
- Inform and sensitize families, opinion leaders, and decision-makers about family planning and the role of convenient birth spacing.
- Ensure availability of quality FP services.

- Ensure availability of affordable and effective means of contraception.
- Increase in the number of MCH facilities and integration of FP activities within them.
- Train the necessary personnel in the application of the national FP policy.
- Revise the 1920 law and elaboration of legislative texts adapted to the national FP policy.
- Promote and encourage operations research in the area of traditional contraception.

The desired improvements in the population sector will require the following measures:

- Restructuring the organization of health and family planning service
- Gradual decentralization
- Reinforcement of cooperation through sectoral coordination, motivation of community members, and promotion of preventive activities, including family planning, in the private sector

Although development of a family planning policy remains to be undertaken, implementation of the above measures is already underway.

1.9 Conclusions

1.9.1 Political and Institutional Levels

Positive Aspects. The government of Benin has demonstrated a strong commitment to improving health conditions for Beninese families by setting up various structures to deal with population issues, including a Family Health Service within the MSP. FP activities have been carried out in Benin for over 20 years and throughout the country for more than 12 years. A wide range of actors are involved in FP in Benin, including Ministries (Health, Labor and Social Affairs, Rural Development, etc.); NGOs (ABPF, women's groups, etc.); donors (UNFPA, World Bank, UNICEF, UNDP, USAID, etc.); and the private sector. Health structures and institutions are found at all levels (central, intermediary, and peripheral) throughout the country.

Negative Aspects. The political and cultural environment is confused and characterized by an absence of a population policy and the persistence of the Law of 1920 prohibiting the sale of contraceptives in Benin. Currently, several decision-making centers exist as regards FP (DNPS, SAP, PBEF, MCH/FP Coordination Committee, ABPF). Programming and planning of FP activities is very weak, which constitutes a handicap to program performance. The heavy involvement of the Ministry of Planning in population activities, given its slow administrative procedures, is an obstacle to the rapid promotion of family planning in the country.

1.9.2 Management of Services

Positive Aspects. Integration of FP into MCH has made considerable progress at the central level. Meanwhile, the essential drugs management model (Bamako Initiative), as part of community financing, is effective throughout the country. This model could serve as an ideal framework for the purchase and distribution of contraceptives. Moreover, central level

management has shown a real commitment to installing a decentralized and integrated policy for supervision and coordination. At the intermediary and peripheral levels, this integrated approach to supervision and coordination is already being implemented in certain regions.

Negative Aspects. Intersectoral coordination is poorly organized and almost nonexistent, generating a duplication of resources and activities. The verticality of programs, especially at the intermediary and peripheral levels, does not foster effective integration of FP and MCH activities. Programming, supervision, and evaluation of FP activities are weak for want of human, material, and financial resources. The inconsistency between program objectives and strategies and the lack of performance indicators constitute major handicaps for the development and harmonious management of FP activities. Staff profiles and management capacities are unsatisfactory at all levels of the health pyramid. In spite of considerable effort on the part of the MSP and donors, the health Management Information System (MIS) remains incomplete and poorly used. Finally, prohibitive prices for IUD and injectables limit client access to these contraceptive methods.

1.9.3 Service Delivery

Positive Aspects. Infrastructure, human resources, and FP services are available at many service points throughout the country. Women appear to favor FP, with hormonal methods most often adopted by new FP acceptors.

Negative Aspects. A number of obstacles to family planning service delivery are evident in Benin. Many men and certain political and religious leaders often regard FP negatively and discourage women from using family planning methods. Service providers consider FP a secondary duty, thereby adopting a passive attitude toward that activity. Absence of service protocols and procedures, a referral and counter-referral system, an outreach strategy, and a drop-out tracking system all contribute to the weakness of the Benin FP program. Contraceptive method mix is incomplete, and poor management of contraceptives leads to frequent shortages in some health centers. The quality of services is hardly acceptable due to the insufficiency and outdatedness of the equipment, inappropriate work conditions, and the lack of qualified staff. Under-utilization of FP services is linked to inadequate sensitization of the target population (women, men, adolescents, opinion leaders); the absence of activities, training, and materials for FP/IEC; and persistent rumors concerning side effects of contraceptive methods.

1.10 Recommendations

1.10.1 General Recommendations

At the political and institutional levels:

- Accelerate processes for developing a national population policy, revising the Law of 1920, and revising the family code.

- Develop and disseminate a RAPID model with special attention to political and religious leaders to encourage their commitment to FP.

- Make the new MSP organigram operational, especially the Family Health Directorate (DSF).

- Define clearly the structuring, attributions, functioning, and the coordination and collaboration mechanisms of the DSF with the other sectors involved in Population/FP.

- Refocus MSP attributions in the population/FP sector and strengthen the leadership of the intersectoral coordination at the central, intermediary, and peripheral levels.

- Develop a real partnership between the MSP and the other Ministries (Labor, Education, Planning, Communication, and Rural Development), NGOs, and the private sector.

For management and service delivery:

- Reformulate the national MCH/FP program by (1) better specifying quantifiable objectives for FP and at each level; (2) defining clearly the reference framework for the technical assistance financed by donors and NGOs; (3) specifying modalities for intervention by private implementing agencies and associations.

- Develop and disseminate policy standards and procedures for MCH/FP as well as for FP service quality, which will permit harmonization of service protocols, development of instruments for supervision and performance evaluation, and the preparation of training curricula.

- Develop a national MCH/FP training policy based on a training needs assessment, an identification of the types and contents of training, the development of training modules, the selection and technical and pedagogical training of a group of trainers, and the development of instructional materials.

- Ensure that service providers are trained in contraceptive technology, IEC, and contraceptive management and logistics.

- Improve supervision, monitoring, and evaluation of activities by reinforcing the cascade and integrated supervision strategy, developing technical supervision instruments based on program process and impact indicators, planning supervision activities, and providing supervisors with appropriate logistics.

- Improve information available to populations on FP services by developing FP/IEC activities targeting women of reproductive age, adolescents, men, and opinion leaders, promoting IEC in health centers through interpersonal communication and educational small group discussions in the waiting rooms, and through IEC on family planning during advanced strategy sessions for vaccination.

- Develop and test integration guidelines for total and effective integration of MCH and FP services.

- Make FP services available in all CSSP, CSCU, and CSS facilities and promote community-based distribution of non medical contraceptives.

1.10.2 Support to the Program

Future USAID support should suit the country's national MCH/FP program in coordination with other donors. USAID could, therefore, assist Benin with the following initiatives:

- Development and quick adoption of a national population policy and revised family code

- Revision of the 1920 law

- Reformulation of the MCH/FP program, including setting objectives and developing appropriate process and impact indicators for evaluation

- Development and implementation of an affective FP IEC program

- Setting up and implementing a national MCH/FP training policy including the revision of the training modules and the development and dissemination of standards and procedures and instructional materials

- Reorganization of services and provision of equipment and contraceptives

- Training service providers in FP/IEC, FP activities and contraceptives management, and contraceptive logistics

2 GOVERNMENT POLICIES AND STRATEGIES

by Mamadou Dicko

In 1990 Benin became the first African country to establish a National Conference as an instrument to foster the establishment of democracy.

Adopting the constitution on December 11, 1990, and organizing free elections made the formation of Democratic Renewal possible. This Renewal, created new areas of freedom and enabled the development of associations and nongovernmental organizations, some of which are actively involved in solving Benin's demographic problems.

Although the country's population remains of modest size in terms of numbers, Benin is experiencing significant demographic problems due, in part, to very rapid population growth and a persistent economic crisis.

The demographic and economic situation that is analyzed in the first part of this chapter reveals a peculiar overall context; a diagnosis of that context is the subject of the second part of this chapter.

In the third part, a program is proposed and recommendations are made. These are followed by proposals relative to a draft plan of action for a possible intervention on the part of USAID and a table giving the main details of the plan of action. The draft is meant to be merely a tool for fostering thought and action.

2.1 The Demographic and Economic Situation in Benin

2.1.1 The Demographic Situation

Benin's population is estimated to be 5,200,000 inhabitants in an area of 114,763 square kilometers, yielding a mean density of 45 inhabitants per square kilometer. This population, 51 percent female and 49 percent male, is experiencing rapid growth. The intercensal growth rate (1979-1994) was 2.84 percent, whereas the natural growth rate resulting from the natural increase of the population was 3.15 percent.

The population is distributed on a very unequal geographic basis. Thus, 53.4 percent of the population is concentrated on 10 percent of the land, especially in the South.

A breakdown by age shows that 48.5 percent of Beninese were under age 15 in 1992 and only 5.5 percent were 60 or more years old. The sex ratio, which differs between urban and rural settings, was 94 males per 100 females in 1992, but for the 15-29 age group, the ratio was 84 males per 100 females.

Urbanization underwent significant development, increasing from 27 percent in 1979 to 36 percent in 1994. The Atlantic department (capital: Cotonou), 58 percent of whose population is made up of city dwellers, is the most urbanized region in the country.

Fertility. With an average 6.8 children per woman (compared to 6.4 for Africa as a whole), Benin has one of the continent's highest birthrates. This near-natural fertility rate is closely linked to a marriage rate that is marked by its intensity (almost all women marry at least once) and its precociousness (at age 20, 60 percent of women are already married). Polygamy, which affects one out of three men, is also characteristic of the marriage rate in Benin.

Since 1960, fertility has scarcely dropped in Benin.

Mortality. Mortality dropped considerably, from 26 per 1,000 in 1961 to 20.6 per 1,000 in 1980 and 17 per 1,000 in 1990. Although dropping, infant and child mortality remain high: in 1992, 105.5 children out of 1,000 live births died before their first birthday, while an additional 70.5 children out of 1,000 were to die before the age of five (MRI, 1993a). In 1961, infant mortality was 210 per 1,000 and in 1982, 137 per 1,000.

Maternal mortality remains a subject of concern, being 800 deaths per 100,000 live births. Non-spontaneous abortions account for 33 percent of maternal mortality.

Life expectancy increased from 37 years in 1961 to 54.2 years in 1992 (General Census, 1992).

Migration. Migration is an area in which very few studies have been undertaken.

Within the country, the cities of Cotonou and Parakou are important arrival points, while the regions of Mono and Atacora (in the North) are settling points.

Little is known about international migration. However, the low sex ratio for the 15-59 age group (84 males per 100 females) could be explained by heavy male out-migration.

Perspective on Population Growth. Given its high growth potential, Benin's population will continue to grow during the coming years and may reach 10.7 million by the year 2015. Should a slow decline in fertility take place and should lower mortality be pursued, Benin's total population may pass the 14 million mark in the year 2025 and reach 14.4 million (CFRP and UPP, 1991)—nearly three times the 1992 population.

This demographic vitality will exert very great pressure on resources and will generate huge needs in the areas of health, education, employment, and the environment.

2.1.2 The Economic Situation

During the 1980s, Benin entered a period of severe economic and financial difficulty that was a consequence of the failure of the Marxist regime that governed the country from 1972. Economic growth was slower than demographic growth. This economic crisis was characterized by a "large drop in per capita income, by a rapid deterioration of the economic and social infrastructures, by an acute liquidity crisis, and by a worsening of internal and external imbalances" (Ministère des Finances, Février 1994). In 1989, Benin implemented, with the support of the Bretton Woods institutions (the World Bank and the International Monetary Fund), a structural adjustment program (SAP) to create the conditions for sustained economic growth and reestablish a viable internal and external financial situation.

In 1989-90, the country's socio-political instability, which led to the National Conference of the Nation, made it impossible for the SAP to reach its expected performance. Between 1991 and 1993, a slight upturn resumed economic growth: gross domestic product (GDP) increased 4.7 percent in 1991 and 4.3 percent in 1992 and 1993 (Ministère des Finances, Février 1994).

Nonetheless, despite some progress, Benin's economy remains fragile: agriculture, dominated by cotton, is scarcely diversified; the secondary sector remains very limited and dominated by small-scale businesses (96 percent of the 8,905 industrial concerns that were counted in 1992 employed fewer than 10 persons [MPRE, 1993a]). In addition, domestic savings and investment remain low in a country belonging to the group of the least developed countries (LDCs) with a per capita income less than US$400 in 1992.

This context is worsened by external adjustment (the devaluation of the CFA franc) to which Benin, along with other countries in the African Financial Community (CFA) zone, signed in January 1994.

Benin again agreed to strengthened structural adjustment by signing, with the World Bank and the IMF, a 1994-1996 structural adjustment program, the main goal of which is to raise the GDP growth rate to an average level of 5-5.5 percent per annum beginning in 1995.

The new SAP will pursue the following three objectives:

- Reduction of domestic and foreign imbalances
- Reduction of poverty and better protection of vulnerable groups in the population
- Reparation of social and material infrastructures and promotion of human resources development

Since 1989, as a requirement of the structural adjustment program, Benin entered into medium- and short-term programming. This could explain, in part, the country's delay in developing a population policy as a long-term solution for demographic problems.

2.2 General Diagnosis of Population Policies and Programs

2.2.1 Political Determination

Political determination makes the development of population programs possible. In public declarations relative to population issues and at international conferences devoted to population, Benin's political authorities have always demonstrated an awareness of the relationships between demographic growth and development planning. Thus, Benin adopted the Kilimanjaro Action Program concerning population and autonomous development in Africa, which acknowledges that "demographic problems currently constitute an obstacle to economic development in Africa" (ARUSHA, 1984).

During the World Conference on Population in Mexico City (1984), the Benin government declared "that it is making considerable efforts to effectively integrate demographic variables as endogenous factors in development models" (UNFPA, 1984).

In the preface to the Benin national report for the International Conference on Population and Development in Cairo, Egypt, September 1994, the Minister of Planning and Economic Restructuring, after remarking that Benin is prepared to adopt a population policy, pointed out that the goal of such a policy would be to specify national priorities and concerns in the area of social development in the face of the population's demographic behaviors and trends and in the face of Benin's ability to satisfy its essential needs.

Finally, in the 1994-96 Economic Policy Framework Document, the government expects to adopt policies by June 1995 at the latest to contain population growth.

However, despite this often-reiterated political determination, there is a certain cautiousness, or even resistance, to preparing or creating the legal conditions for the development of the planning program.

2.2.2 The Legislative and Regulatory Context in the Area of Population

The weight of traditions, very pro-birth attitudes, and a repressive colonial legal heritage with respect to contraception have deeply impregnated the current legislative framework in Benin in the area of population. Thus, in the area of social policy, family subsidies are paid to workers for up to six children, and a father of a family with six children pays less in taxes than a father with fewer children or a unmarried person.

The July 31, 1920 French law outlawing abortion and information on contraception is still in force. This brings about a genuine paradox: the government was the first to break this law by authorizing, as early as 1972, the creation of the Beninese Association for Promotion of the Family, creating services charged with maternal and child health and family planning, and implementing a "National Program for MCH/FP/Nutrition and System of Alert."

On the other hand, the 1920 law was reinforced by decree number 86-685 of April 13, 1986, concerning traditional medicine practices in Benin. By the provisions of this decree, traditional medicine must in no case be used "for destructive purposes, such as homicide, abortion, adultery...." Article I of the 1920 law forbids the sale, preparation for sale, public offering or

exhibition, display or distribution, public or not, of all forms of advertising in whatever form they may be—ads, displays, drawings—of contraceptive propaganda. Offenders are liable to receive criminal sanctions.

The most immediate consequence of this law's existence is that public participants (the government) and private participants (the ABPF), as well as bi- and multi-lateral organizations that carry out activities in the areas of family planning, do so completely illegally.

A revision of the 1920 law is now indispensable in order to adapt it to today's context and to the government's population objectives.

2.2.3 The Health Sector

The overall health situation has severely deteriorated due to the twofold pressures of demographic growth, which increased the demand for services, and the economic crisis, which put the cost of health care, in general, and medication, in particular, out of the reach of a large portion of the population. Thus, only one out of two Beninese has access to health services and about one out of five Beninese uses health services (ICPD, 1994).

The rate of health coverage in Benin is below WHO's recommended standards: one medical doctor for 14,768 inhabitants (versus the WHO recommendation of one per 10,000); one midwife for 10,530 (versus the WHO standard of one per 5,000 inhabitants); but one nurse for 3,447 inhabitants (versus the WHO standard of one per 5,000 inhabitants).

The government has implemented a health development policy that favors prevention activities and the rehabilitation of existing health infrastructures, among other goals. The government has also implemented a program for maternal and child health and family planning (MCH/FP/Nutrition/System of Alert) and has created a national coordinating committee for MCH/FP.

These efforts, however, are impeded by a low level of coordination of activities, an insufficient integration of family planning into maternal and child health, and the modest nature of IEC activities. These circumstances lead to a low prevalence of contraception. Estimates, which need to be fine-tuned, place the national contraceptive prevalence rate for modern methods at 1.5-2.5 percent.

2.2.4 The Education Secto

Demographic growth has led to high demand for schooling, which Benin has not been able to satisfy due to the deterioration of the economic situation. Thus, the percentage of children in school dropped from 62.21 percent in 1983 to 49.68 percent in 1990, before climbing back to 59.91 percent in 1992. The teacher-student ratio has deteriorated, going from one teacher per 33 students in 1988 to one teacher per 40 students in 1992.

The ratio of girls to boys in school, although low, did nonetheless advance, increasing from 35 girls per 100 boys in 1960 to 47 per 100 in 1980 and to 50 per 100 in 1992.

The returning student percentage remains low at the primary school level (the pass rate from one class to the next is 25 percent; the drop-out rate is 15 percent) and the secondary level (retention rate, about 30 percent; drop-out rate, 25 percent).

With an annual average school population growth rate estimated at five percent for the period 1992-2027, Benin will need 76,435 teachers to ensure the teacher-student ratio that was reached in 1992 (with 13,422 teachers).

In 1991, the government, which devotes more than 30 percent of its budget to education, adopted a policy framework document for education that states among its goals the consolidation and broadening of primary education and the improvement of education quality.

2.2.5 *The Employment Sector*

The employment sector is also experiencing strong tensions due to the increasingly rapid growth of the workforce (those age 10 and above) and the weak market that is unable to absorb the supply of labor. Between 1979 and 1992, the workforce experienced an average annual increase of 4.9 percent.

The government, the main employer of the modern sector until 1986, was then mandated to cut government employees by 12 percent and foster private initiative.

Underemployment is extensive, and the informal sector is predominant. Official unemployment is 1.5 percent, however, the real rate of unemployment is certainly greater than official numbers reveal.

The government has implemented programs for unemployed graduates who are entering the workforce or who have not yet entered the workforce, particularly by setting up the Small Business Development Center (CEPEPE) and the National Fund for the Promotion of Employment. It should, however, be noted that the CEPEPE's performance was modest. It has no funding to help graduates who have not yet entered the workforce find jobs, and 80 percent of the graduates were finally recruited by the government. As for the National Fund for the Promotion of Employment, it has not yet been effectively implemented.

2.2.6 *Food Security*

The total production of produce (grains, tubers, legumes) between 1978 and 1993 underwent an irregular evolution. Produce production rose until 1982 when it approached 1.5 million tons and dropped appreciably in 1983 and 1985. From 1986 on, food production has been constantly above 1.5 million tons; it even surpassed 2 million tons in 1989, 1991, and 1993, but with periods of sizeable drops. Generally speaking, over the 1970-1990 period, the progress in grain production, with an annual growth rate of 3.7 percent, closely approached the growth rate of the population. The considerable demographic growth, however, especially in urban areas, led to an increase in the demand for food.

From the point of view of food production, Benin's situation is better than that of many other African countries, but it must nevertheless import food, particularly rice and wheat. Rice

imports went from 161,000 tons in 1990 to 273,000 tons in 1992, before dropping to 198,000 tons in 1993.

The country is confronted with a problem of protein/energy malnutrition. According to a survey carried out in 1986, this type of malnutrition reached an average national level of 21.7 percent.

Benin does have a political instrument to combat these food problems: the Rural Development Policy Declaration Letter (May 1991) and a national strategy of Food Insecurity Prevention. The implementation of this strategy, however, is dependent upon partners in development: the World Bank; the GTZ; and the FAO. It is possible for food production to cover the nation's needs, but the most significant problem remains market balance.

2.2.7 The Environment

In Benin, demographic growth has noteworthy consequences on the environment: soil and wildlife deterioration and urban pollution. Cultivation practices (slash-and-burn shifting cultivation), brush fires, wood burning for the production of energy for home cooking, and overgrazing contribute extensively to the environment's deterioration.

Demographic pressure (53.5 percent of the population lives on 10 percent of the land) also leads to the extension of arable lands. This extension is undertaken at the expense of forests. The lack of a drainage network, the absence of a functional garbage collection system, the defective condition of the roads, which fosters water stagnation, are causes of pollution in urban areas.

It is estimated that less than 35 percent of refuse and household garbage is collected in urban areas, out of an annual production of 226,000 tons. The capital city of Cotonou produces 143,000 tons annually, of which only 20 percent is collected.

In 1990, the supply of wood-based fuels (firewood and charcoal) represented 44.70 percent of the demand for energy; in the year 2005, only 21.76 percent of the demand will be covered by this supply, without additional deforestation. Unless there is vigorous promotion of the use of other sources of energy (such as natural gas), there is great risk of extensive deforestation.

Since 1993, Benin has had an Environmental Plan of Action (PAE) whose major goals are the following:

- Promote a change in attitudes relative to the environment.
- Gain control of the development of natural resources and foster better management of biodiversity.
- Improve the standard of living for all Beninese.

The PAE, which is made up of several major programs, aims at emphasizing environmental education among its other activities. By working with the Ministry of Education, the PAE hopes to introduce programs on the environment into the school curriculum.

The PAE is currently seeking financial supporters. Its cost is estimated at US$80-100 million over a 15-year period.

2.2.8 Woman's Status and Advancemen

Women make up more than 51 percent of Benin's total population. The 1990 constitution acknowledges the same rights for men and women. In reality, however, the advancement of women in development has yet to be completed.

The schooling of girls is constantly increasing; however, despite government efforts (free schooling for girls in rural areas), the percentage of girls in school remains low; the schooling of boys was twice that of girls in 1992.

The extent of polygamy, the very heavy weight of tradition, and a high rate of illiteracy are among the factors that contribute to the current situation of women in Benin. The absence of a family legal code also constitutes a handicap for the advancement of women.

The government has not yet defined an explicit policy for the advancement of women. In the 1994-1996 Economic Policy Framework Document, however, the government states its commitment to developing a coherent strategy concerning the integration of women in development. Therefore, the National Committee for the Integration of Women in Development (CNIFD) was created.

It should be noted that there are of several very dynamic women's NGOs in Benin including the Benin Association of Women Lawyers and the National Federation of Women's NGOs.

2.2.9 The Contributions of Nongovernmental Organizations

NGOs have been present in the area of population activities in Benin for some time. Democratic Renewal has made it possible for new organizations to flourish, e.g., the Benin Association of Women Lawyers, the National Federation of Women's NGOs, and the Association for Nature Conservation (Benin-Nature). Some NGOs have joined together to created the NGO Coalition for Development.

A few NGOs carry out very significant activities in the areas of family planning and the women's advancement. Following are two examples:

The Benin Association for the Promotion of the Family. Since its recognition by the government in 1972, the ABPF has increasingly extended its activities to field offices in each of the country's six departments, three of which have health care clinics.

The ABPF has 1,200 volunteers throughout the country and a staff of 53 persons; the medical activities of its clinic in Cotonou are run by one doctor and two midwives. The ABPF is involved in family planning IEC, as well as in providing family planning services. The ABPF has also helped the government train doctors and midwives in contraceptive techniques.

The problems encountered by this NGO are found at several levels: scarcity of human resources, especially in the area of research and in-depth analysis, and a difficult legal climate with the existence of the 1920 law. In addition, ABPF has not been integrated into population coordination structures, especially into the the National Human Resources and Population Commission.

With USAID's indirect support (by means of The SEATS Project/Lome), ABPF has successfully completed an experiment in community-based distribution (CBD) of contraceptives. The ABPF's program could be supported in the following areas:

- ABFP's permanent staff, as well as its volunteers, need appropriate training, especially in IEC.
- The establishment and operational support of an organization for operations research. Program development could also be included in this phase.
- Contraceptive products could be supplied.
- Intervention capability could be strengthened by building new clinics and youth centers.
- Support for extending the CBD experience into rural areas is needed.
- A statistic unit for data management could be created and supported.

The Benin Association of Women Lawyers. Created in 1990, the AFJB has fought for the advancement of Beninese women by defending women's and children's rights and making the public, especially women, knowledgeable of the law.

AFJB's activities include the following:

- Involvement in developing a draft Family Code, submitted to the government in 1992.
- The development of a Legal Guide for Beninese Women in 1992. This Guide has been translated into the country's two national languages.
- Opening and running a Legal Aid Center with two women on staff.
- Running mobile legal aid centers.

Thoughtful proposals concerning revision of the 1920 law were made by one of the Association's officials.

AFJB, which believes the government has not involved the association sufficiently in the work leading to the development of a national population policy nor in setting up the CNIFD, needs multi-faceted support in order to pursue its actions. This support could involve training paralegals and strengthening institutions.

Generally speaking, the Beninese NGOs need support in the form of stronger institutions in order to carry out their missions more effectively. The NGO Coalition for Development is particularly destitute, and its activities are worthy of support.

2.2.10 The Partners' Role in Development

Many partners in development are involved in the Beninese population activities, but only the United Nations Population Fund supports the Ministry of Planning and Economic Restructuring in its efforts to develop a national population policy. The other partners have special areas of concentration. In addition to USAID, the most important participants are the UNDP, UNICEF, UNFPA, and the World Bank.

The United Nations Development Program. UNDP's activities in the program completed in 1994 are the following:

- The Health Education Project with support for the production of educational materials and investigation into attitudes concerning AIDS
- Support for the development of a plan of action concerning women and development and for the International Conference on Women (Beijing, 1995)
- The project for "Cooperative Health Clinics." This five-year project made it possible to set up 10 cooperative health clinics with a funding of US$400,000. About eight of the clinics are currently operational
- Support for the "General Census of Population and Housing" (RGPH, 1992)

UNDP's new program in Benin begins in 1995. In the course of the next program, emphasis will be placed, among other things, on the following activities:

- Support for Economic Management: The Social Dimensions of Development. The Agency for the Social Dimension of Development is to be set up during this program.
- NGO support to better meet the needs of the population
- Support for the government to help it prepare for, and participate in, the Copenhagen Conference on Social Development and the Beijing Conference on Women in 1995

The United Nations Children's Fund. In the course of its 1990-1993 program, emphasis was placed, among other things, on the following aspects:

- Strengthening the vaccination program
- Strengthening outlying health services with support for the communities' organization for the management of health training
- Food security: support for soybean production in the Zou department

In its next program (1994-1998), UNICEF will assist the government in certain areas, including the following:

- Support for a health program with three main components:

- Development of a health program with strengthening of services and support for a health information system
- A broadened vaccination program, diarrheal disease and malaria prevention, prenatal care, family planning, and risk-free childbearing
- Nutrition: food deficiency prevention, nutritional supervision, and food security

The cost of the program is estimated at US$9 million.

The United Nations Population Fund. This is the only development partner currently supporting the Human Resources and Population Service (SRHP), which, at the Ministry of Planning, is responsible for carrying out activities relating to the formulation of the Declaration of Population Policy.

In addition to this support, the UNFPA has intervened in the following areas:

- The MCH/FP Project. UNFPA support supplied equipment for 120 maternity clinics involved in the project.
- Data collection and analysis, with funding participation for the second General Cencus of Population and Housing (RGPH 1992).
- The Family Life and Population Education Project (FL/PopEd) in schools. This project is currently active.
- Academic training: scholarships for doctoral training in the areas of demography and population and development.
- Support for the Population Training and Research Center and for the National Committee charged with integrating women into development.

All these activities were included in the 1992-1994 program.

UNFPA's new program is currently being developed. The areas of emphasis will include the following:

- MCH/FP
- Strengthening IEC activities
- Strengthening the FP/PopEd Project to increase its coverage
- Support for the Population Training and Research Center in order to integrate it into the university
- Support for formulating population policy

The World Bank. The assessment team did not meet with officials of this institution to take stock of programs currently supported or to be supported in the future. Nonetheless, World Bank support for the development and implementation of the Envirommental Action Program is considerable.

The World Bank will also be supporting a Health and Population Project which is in preparation (Economic Policy Framework Document, 1994-1996).

In the area of education, the World Bank is funding an Education Sector Development Project expected to begin in 1994.

The World Bank also supports the development of activities generating income (for women) in the context of a Food Security and Nutrition Project targeting rural communities, expected to be implemented in 1994.

2.2.11 Taking Demographic Variables into Account for Development Planning

Benin went through several development planning experiences depending on the political regimes in power: 1960-1972 was the period of classical planning; 1972-1989 was the revolutionary period but lacked rigor in carrying out the planning. Thus, the 1983-1987 Plan was carried out without being adopted, and the 1980-1993 Plan was neither adopted nor carried out. Since 1990, however, Benin has been undergoing a new political experience with Democratic Renewal.

Long-term planning gave way to structural adjustment programs that have short-term and medium-term perspectives. It should be noted, however, that demographic variables were scarcely integrated into the different development plans that were developed and implemented. The SAPs, given their limited perspective in time and macroeconomic and macro-financial goals, which constitute their prime concerns, do not sufficiently integrate demographic variables into the programs.

Health and education are the sectors in which demographic variables are best integrated. In the area of health, the use of demographic variables for the development of programs and projects in the sector is significant. In the area of education, demographic variables are well integrated, in particular in the Population Education Project. The absence of a population policy, however, does not provide a reference point in order to account for those variables in development planning.

The low level of integration of demographic variables into planning stems particularly from a lack of human resources trained in this area. Thus, at the Human Resources and Population Service and the Permanent Secretariat of the National Human Resources and Population Commission, not one official has been adequately trained in this area.

2.2.12 The Institutional Framework

In order to coordinate preparation for the national policy on population, the government created the National Human Resources and Population Commission by Decree 93-159 on July 9, 1993. This CNRHP is charged with setting up the agencies involved with population issues, a population and human resource policy, and monitoring the policy's implementation (Article 3, Paragraph 2 of Decree 93-159).

At the department level, a Human Resources and Population Commission was also created. A technical coordination group was also created to serve as the technical organ of the CNRHP.

The CNRHP and the technical group are interministerial agencies not open to NGOs or society at large. The Human Resources and Population Service (the Permanent Secretariat of the National Human Resources and Population Commission) undertakes most of the technical work.

The current institutional framework presents a few weaknesses:

- The SRHP does not have a sufficient number of managers, and the agency set up by the National Human Resources and Population Commission employs only two full-time persons in upper management.

- The staff of the SRHP also suffers from a lack of training for integrating demographic variables into planning.

- The Human Resourcess and Population Commission is not adequately representative of all those involved in the area of population (e.g., NGOs are excluded from it).

At the present time, intersectorial coordination is not very operational, except in specific cases such as preparation for the ICPD in Cairo. In fact, no institutional framework exists for coordinating the current program; the one that was created targets, instead, the preparation of a declaration of population policy. In addition, a formal system for permanent coordination and dialogue on the side of the partners for development does not exist.

Adopting the population policy ought to make it possible for the country to have an institutional framework for coordination and operational monitoring/assessment.

2.3 Proposals for a Plan of Action

2.3.1 Justifications

The maintenance of a high fertility rate has negative consequences on the supply side in the areas of education, health, employment, and the conservation of a healthy environment. Benin is a developing country that is also experiencing economic difficulties.

The deterioration of the general health situation (less than 25 percent of the population has access to health services), the deterioration of the educational system (with a school attendance rate less than 60 percent), and the increase of unhealthy living conditions, particularly in cities (where less than 35 percent of household waste is collected), are subjects of concern. The slow progress made in the area of contraceptive prevalence (prevalence rate under 2.5 percent for modern methods) justifies the doubt concerning a medium-term shift in fertility.

The current dissipation of development efforts through insufficiently integrated sectors and the "project mindset" that drives some participants beg the creation of an institutional framework for the coordination of monitoring and assessment of population activities.

All these reasons explain the need to develop a national population policy as an overall frame of reference. To undertake this effort, Benin needs the support of all its partners, and USAID, along with UNFPA and others, should find a niche in order to support efforts that have been undertaken.

2.3.2 The Proposed Program

USAID's support should target the following objective: **Find an appropriate relationship between demographic growth and economic growth by progressively gaining control of fertility.** The general strategy would consist of strengthening the nation's institutional and technical capabilities in the development, implementation, and monitoring/assessment of a national population policy.

The specific strategies of this plan could include the following:

1. Strengthen institutions. This support ought to benefit both governmental agencies (Ministries of Planning and Health) and NGOs (the ABPF, the AFJB, the NGO Coalition for Development, etc.).

2. Support the creation of a definition of a national IEC strategy in the area of population. In Benin, the awareness of decision-makers and opinion leaders about population issues is not satisfactory. The development and dissemination of a model for creating awareness and helping decision making, of the RAPID model variety, is desirable.

3. Strengthen training activities. Training would be for government technicians in the areas of microcomputer use (the use of software relating to population studies) and integrating demographic variables into development planning (by organizing a national workshop with the support of international African expert appraisal of variable integration). In addition, NGO volunteers and leaders need improved IEC population training.

4. Support the preparation of a national population plan of action. Assistance in this area could be provided to the government by making expert international appraisal for the assessment of population programs available. This activity could take place in 1995.

5. Strengthen the Population Documentation Center. This will enable the unit to become a population reference center.

6. Support the regionalization of population policy. There are department-level Human Resources and Population Commissions whose efficiency is limited by the scarcity, or even nonexistence, of human and material resources. The success of the population policy depends, in part, on the vitality of the department-level commissions. This activity could span the years 1995-1998.

2.3.3 General Recommendations

For the Government. The many important efforts that have been made are worthy of being pursued, amplified, and consolidated. The political determination that has been expressed must be translated into concrete acts. NGO activities must continue to be taken into account in order to turn them into genuine partners.

The following activities should be undertaken by the government:

- Development and implementation of a national population policy with the involvement of NGOs, in particular
- Further advancement of the status of women by prioritizing the preparation, adoption, and implementation of a Family Code
- Revision of the 1920 law in order to give a legal framework to activities fostering family well-being
- Revision of the decree relating to the composition of the National Human Resources and Population Commission to enable NGOs and society at large to join in the preparation and coordination of population policy

For Partners in Development. Given the economic situation, and especially the acuteness of population problems, the partners in development must become keenly interested in Benin in order to bring the government suitable support in finding the best solutions for an appropriate relationship between demographic growth and economic growth. In this context, particular support should be granted to the formulation and implementation of a national population policy.

2.4 Conclusion

Benin's population problems run the risk of hindering the country's development if appropriate solutions are not implemented reasonably soon. In light of the country's economic situation, the demographic growth rate presents a challenge and an obstacle for any attempt to significantly improve the population's quality of life. Indeed, it can be observed that, in recent memory, no country has been able to trigger sustained economic growth and durable development with such a high rate of demographic growth.

The existing political determination must be supported by Benin's partners. Moreover, the present appears to be a suitable time for better coordination of the country's partners' population activities, as the principle partners are in the process of preparing their assistance programs for the next five years.

An increase in and a better coordination of the partners' support for development will enable the government to create legal and consensual bases for effective action to solve Benin's population problems.

TABLE 4

A PLAN OF ACTION			
OBJECTIVE	**STRATEGIES**	**PERIOD**	**EXPECTED RESULTS**
Help reach a more appropriate relationship between demographic growth and economic growth	General strategy: Strengthen institutional and technical capabilities through the development, implementation, and monitoring/assessment of the national population policy.	1994-98	Improvement of coordination and management capabilities of population policies and programs
	SPECIFIC STRATEGIES		
	1) Help strengthen the institutions of governmental and nongovernmental agencies that are involved.	1995-98	
	2) Support the definition of a national IEC strategy in the area of population	1995-96	Coordination of IEC activities in the field
	3) Help strengthen training activities in the areas of population	1995-98	Improvement of national capabilities in research studies and population problem analysis
	4) Help regionalize population policy		Foster improved accounting of the local needs and problems in implementing the population policy

3 INFORMATION, EDUCATION, AND COMMUNICATION

by Deirdre LaPin

3.1 Introduction

The Republic of Benin is currently at the threshold of a communication revolution. Liberalization of the press followed the National Conference on democratic elections in 1990. In July 1994 the High Authority for Audiovisual and Communication (HAAC) was created, an autonomous regulatory body independent of the state. Privately owned newspapers now exist, and under the new policy private transmitting and broadcasting stations will likely follow.

For centuries, Beninese culture has granted a privileged place to the role of speech in public and private life. "Saying" is closely bound with "doing," or at least with a commitment to do. It is not surprising, then, that the world of development has been deeply touched by the communication revolution. Development as "act" is preceded by development as "speech." Full participation of the population in development action implies a free and open exchange of information and dialogue.

This vision of speech and its paramount role has encouraged active attention to IEC as a part of the development process. It is widely recognized that communication policy, coordination, and services need to be improved if the economic development of Benin is to be sustained.

The purpose of this chapter is to situate the future of IEC within the context of family planning and reproductive health. It will first summarize the strengths and weaknesses of the sector. It will then review the socio-cultural environment undergirding behavior in family planning and reproductive health. Subsequently, it will discuss current interventions in the sector by government, NGOs, and private partners. It will proceed to a review of available communication channels. The chapter will offer proposals for a future IEC strategy which may figure within a bilateral family planning project. Finally, the chapter will conclude with general recommendations concerning family planning IEC in order to raise current levels of knowledge about modern methods from under 5 percent of men and women of reproductive age to around 50 percent.

3.2 A Summary of Opportunities and Constraints

3.2.1 Opportunities

1. Strong consensus and project support among donors, NGOs, and government partners in the social sector concerning the key role that must be played by IEC in meeting objectives in development, particularly in population and reproductive health.

2. Decision by the Ministry of Planning to develop a national population policy before the close of 1994.

3. Reorganization of the Ministry of Health, leading to the creation of the Directorate of Family Health and, underneath, a separate service for IEC.

4. Positive past experience with social mobilization in the Expanded Program of Immunization and more recently with the impact of IEC in FP-related areas of AIDS prevention and breastfeeding.

5. Liberalization of all public and private channels of communication within the democratization process, permitting the use of media to promote condoms for HIV/AIDS.

6. Progress toward administrative decentralization of powers in health, social affairs, and communications which encourages pragmatic and localized planning.

7. Revalorization of traditional cultures and their heritage of social institutions and communication networks.

8. Proliferation of national NGOs and associations for progress and development.

9. Major expansion of media coverage through the creation of local and private radio stations, addition of television and radio relay antennas, and the recent creation of the autonomous nongovernmental regulatory body for communications, the HAAC.

10. Existence of IEC support structures in the governmental, NGO, and private sectors which complement Health Ministry IEC and which demonstrate willingness to collaborate in FP/IEC.

11. Positive experience in the formal and informal private sector with a small, high-impact condom social marketing program for HIV/AIDS prevention; intention to expand the program to include contraceptive pills.

12. An expressed desire by many women and men for high-quality, discrete, and affordable services without cultural and medical barriers.

13. A major national campaign to increase awareness of the advantages of exclusive breastfeeding as a nutritional method, opening the way to its use as an entry point for family planning among postpartum women.

14. Successful experience in the use of television and radio for condom promotion to prevent HIV/AIDS, an opportunity which may be built upon for mass media information and promotion of family planning.

3.2.2 Constraints

1. A persistent and widespread belief among Beninese men and women at all levels that the principal objective of family planning is limitation—and not spacing—of births.

2. The absence of a national population policy, which reflects the larger, underlying problem of a missing consensus environment that would encourage open exchange of information among policy-makers, service providers, and potential clients.

3. Lack of an overarching FP/IEC strategy, resulting in poor coordination in FP/IEC efforts among various actors in the private, public, and NGO sectors.

4. Absence of accurate and authoritative information on contraceptives among health professionals leading to application of medical barriers and lack of conviction about the benefits or appropriateness of certain methods.

5. Insufficient FP and FP/IEC training—in quality and quantity—for health and social professionals.

6. A high illiteracy rate of 75 percent.

7. Limited infrastructures for public communication and logistics, confining the reach and speed of information exchange.

8. Need for in-depth ethnological studies in order to understand the beliefs undergirding behaviors toward family planning and reproductive health.

9. Recent tendency to create projects that adopt a vertical approach to FP/IEC without ensuring its integration into an overarching FP strategy for improving the quality of services.

10. Inadequate financing of FP/IEC—and absorption of available funds—by government and external Cooperating Agencies; absence of a separate IEC budget for the department level; rare mobilization for IEC activities of collective community health accounts managed by the COGEC and COGES.

11. Lack of personnel and management incentives for conducting FP/IEC activities in the field, leading to non-use of the few FP/IEC materials available.

12. Traditional notions concerning fertility and menstruation which encourage pro-natalist behavior and low tolerance for—and some religious prohibitions against—such side effects as spotting and amenorrhea.

3.3 The Socio-Cultural Context of Family Planning and Reproductive Health

3.3.1 A Socio-cultural Overview

Family planning is not a popular collective notion in Benin. Nevertheless, personal comments and behaviors suggest that the unmet need for family planning is high. A rapid decline in infant mortality has been seen in the past 10 years (falling from about 150 to less than 100 per 1000). This positive outcome of child survival programs has not gone unnoticed by married women. At the same time, maternal mortality rates remain unacceptably high at an estimated level of 800 per 100,000.

Youth have their own needs for contraception. A 1988 study shows that 69 percent of urban youth surveyed were favorable toward contraception. A 1990 INSAE study estimated that between 14 percent and 18 percent of adolescent girls had ended an unwanted pregnancy by induced abortion. Physicians and midwives at maternities and referral hospitals often report cases of complications following attempts to induce abortion. Some note that—owing perhaps to current economic stress—the number of cases seems to be increasing.

Such statistics are closely bound with the status of women. Resistance by husbands is consistently given as the key reason for low contraceptive use among women. The high popularity of the injectable Noristerat, a discrete method, would seem to confirm this observation. Under Beninese law a man may divorce his wife for adultery and sterility, but a woman may make the same demand only if her husband has had relations with her sister. Polygyny, practiced in about one-third of households, encourages reproductive competition among wives, especially for male children.

As in most West African societies, traditional methods for child spacing and contraception are known, and many—including breastfeeding and postpartum abstinence—were regularly practiced. The gradual discontinuation of these behaviors has been joined by strong, pro-natalist influences from colonial, Marxist, and religious thought. The law of 1920 forbidding the promotion of contraception is still in force. Marxist teaching under the Kerekou government viewed family planning as an externally conceived plan to limit the size of Benin's population. The Beninese Roman Catholic Church is conservative. While the majority of Beninese practice traditional religions (35 percent), Roman Catholics (26 percent) figure most prominently among Beninese of influence. Islamic leaders tend to teach their followers (21 percent) the incorrect view that contraception is disallowed by the Koran.

A confluence of forces, then, has created a challenging policy environment for family planning. The absence of a general consensus—or strong sectoral support from medical practitioners—has meant that most midwives or nurses are reluctant to include family planning in their pre- or post-natal counseling or to follow up contraceptive defaulters. Practitioners need to liberalize existing policies that limit the use of injectables to high parous women or to women who have had at least one pregnancy. Appropriate training for counseling is needed to dispel rumors and increase tolerance of such side effects and spotting or amenorrhea. Most of all, public and medical opinions need to hear the view that, in a modern democracy and free economy, family planning is in the best national interest and in the interest of family health.

Favorable trends are encouraging and growing. Women in some quarters are strenuously advocating greater rights, the revision of the Family Code, and access to contraception and safe abortion. AIDS awareness has increased the mass media promotion and availability of condoms. Training of health workers in family planning communication and methods has won genuine converts in the medical community. A midwife in Abomey, for example, attributed the success of her family planning program to her technical skills, conviction, and willingness to counsel reluctant husbands. Demographers and intellectuals charged with preparing the country's policy for the ICPD undertook their task with intelligence, precision, and care. The policy advocates an increase of contraceptive prevalence to 10 percent by the year 2000.

Demographic trends may also increase acceptance of family planning. At present, levels of modern contraceptive use are estimated to be highest among the nation's largest ethnic groups, the Fon (42 percent), the Adja (16 percent), and the Yoruba (12 percent). Sixty percent of the population now lives in the southern coastal region. By 2000, the urban population, now 37 percent, will reach 45 percent, and the three main towns are growing at a rate of eight percent. Such concentration of the population will increase the need for access to information, services, and awareness the benefits family planning may offer.

3.3.2 Accurate Information on Family Planning: A Need Felt Among Women

A notebook of IEC field visits made by *animatrices* of the ABPF in the Porto Novo area bears witness to the importance ABPF places on understanding the socio-cultural environment in which it works and on monitoring the social appropriateness of its IEC activities.

In general, the notebook also offers insights into the preoccupations of men and women concerning family planning services. The most recurrent questions recorded in the notebook include the following: "Can women come to your center alone [without their husbands or parents]?" "Can minors come to your center?" "Can teenage mothers come to your center?" "Is it true that the IUD [or pills] causes cancer?" "Can you get AIDS from *coitus interruptus*?" "Are there pills for men?" "Where is your center?" "Does it provide general health services?" "Why is Noristerat not given to young women?" "Why is it necessary to have the husband's agreement before receiving a contraceptive method?"

Porto Novo women, the notebook suggests, want family planning services that are discreet, private, and unfettered by medical and cultural barriers. Young women are especially interested in having access to services. Most of all, women of all ages need and want accurate and credible information about family planning and reproductive health.

3.4 FP/IEC Activities, Planning, and Coordination

3.4.1 Overview

The near-absence of IEC activities and materials for family planning and reproductive health in Benin has been lamented repeatedly in studies, evaluations, and reports. A beneficiary assessment of health programs in Benin undertaken by the World Bank noted, "The results of the survey revealed inadequacies in the social communication program that was designed to sensitize the population about specific aspects of health care." In its evaluation of the Benin health sector, AFRICARE observed: "*Un programme de planification familiale devrait comprendre un volet information avec des hommes et des femmes.*" In a recent Aide-Memoire, UNFPA once again deplored the absence of an IEC strategy for population. A Situation Analysis of the family planning sector undertaken by The Population Council noted, "*Le matériel IEC/PF manque cruellement dans les 59 FS visitées.*" Finally, the government's preparatory document for the 1994 ICPD stresses the urgent need to reinforce IEC for family planning in order to increase demand.

In the face of this consensus, the response has been to create IEC-specific or IEC-intensive projects in order to encourage a rise in demand for family planning services. The government target is to increase contraceptive prevalence to 10 percent by the year 2000.

Recognition of the key role of IEC in behavior change is welcome, appropriate, and necessary. At the same time, the low absorption of IEC funding thus far suggests that weaknesses in communication are bound to programmatic weaknesses elsewhere. Success in FP/IEC will require a coordinated effort that touches upon all aspects of population programming, most notably on policy and planning, training, management, contraceptive supply, and monitoring. A harmonized approach, which stresses the role of IEC development but keeps it in step with other program components, is critically important. The support functions discussed in this chapter are only of value when they are viewed as integral moving parts of a programmatic whole.

3.4.2 Past and Ongoing IEC in Health and Family Planning

In January 1990 the Ministry of Health undertook an analysis of its IEC activities. Weaknesses noted included (1) the need for a national IEC policy; (2) the absence of coordination; (3) a didactic, one-way approach to communication; (4) failure to recognize cultural conditions undergirding behavior; (5) the lack of competence in social communication among health workers; and (6) insufficient material and financial resources.

<u>The IEC Service, Ministry of Health.</u> This reflection led to the creation of an IEC Service under the National Directorate of Health Protection (DNPS) in the Ministry of Health. The Service was charged with IEC planning, materials conception, coordination, training, research, monitoring and evaluation, and advice to other units. So far, the Service has undertaken a knowledge, attitudes, and practice (KAP) study in the health sector, formulated a well-conceived national health IEC policy, and launched a cascading program in health/IEC training, beginning with 10 master trainers selected from health and social service staff in each department. These in turn train 30 persons from health, social affairs, rural development,

education, and literacy programs. Competent training modules have been developed, a series of five for the master trainers and one for IEC at the field level.

Currently, the budget, staff, and office of the Service are relatively small. The staff is headed by one medical doctor currently pursuing a Masters in Public Health with IEC emphasis at Tulane University; other staff members include a second medical doctor trained briefly at the Regional Institute for Public Health in IEC, two midwives, a nurse, and a graphic artist. Total estimated annual government budget for the Service is approximately US$20,000; modest support has been provided in the past through the PDSS I Project, UNICEF, the Swiss government, WHO/UNDP (until 1992), UNFPA, and indirectly through the MEPS project (see below). The offices of the Service are woefully inadequate and in disrepair.

Because the IEC Service has limited program funds, it is chiefly a point of technical referral, coordinating its IEC activities and training with other health and family planning projects. It also monitors activities with the IEC Service staff (usually one person) at the department level, which—like the central Service—typically relies on other project funds for its IEC activities.

One positive example of collaboration is in the development of materials for the National AIDS Program. This project has its own small, but capable, IEC Unit and has produced by far the best IEC health materials in range and quality. A second example is assistance in training and materials development to the MCH/FP project (The Project for Family Well-being). A cascading training program for FP, following the model described above, is currently in its first stage and is integrated into an overarching FP training program. One module for this training activity is devoted to IEC.

Various mechanisms for IEC outreach in the health sector have been attempted by a variety of projects, including the AVS (volunteer health agent for Guinea Worm eradication), the sanitation agents, village health committees, the COGES and COGEC as health promoters, and so on. Success of these efforts is variable. Few have been sustained through local resources.

The Directorate of Social Affairs. The DAS, under the Ministry of Labor, Employment, and Social Affairs, has long been associated with health activities in Benin. *Assistants sociaux* (social workers) are trained at the National Medico-social Institute, the institution which also trains nurses and midwives. Following the recent strengthening of the health system and the increased workload of health workers, social workers are increasingly assigned tasks of health and FP/IEC in health centers and the DAS's Centers for Social Promotion (CPSs) in the departments and sub-prefectures. Their training at INMES stresses communication.

The *raison d'être* of most CPS activities continues to be nutritional support to under-fives through nutrition IEC and distribution of food aid. In addition, experiments in nutritional outreach supported by the DAS have incorporated *mères-animatrices* (mother-promoters) into the communication network. Similar outreach experiments are being attempted elsewhere. Some CPSs successfully draw upon community volunteers for IEC.

Strengths of the DAS include its close contact with marginal groups, e.g., prostitutes, school drop-outs, teenage mothers, street children, orphans, delinquent children, and so on. The DAS sets social targets for health activities, e.g., to eliminate practices harmful to women's

health, including early marriage, excision, nutritional taboos, etc. It also promotes women through self-help and skills training (e.g., soap, cereals, baby food, sewing workshops, fish smoking, and credit groups). These contacts offer important opportunities for IEC and have on occasion been utilized for this purpose.

As a result of the recent reduction in government staff, the DAS now has only 59 social workers, 41 *animateurs,* and 55 health and management staff persons throughout the country. Department level staffing ranges from 13 in Atacora to 31 in Ouémé. Observation suggests that the DAS could provide important services in FP/IEC through a well-designed scheme.

Rural Development Agents. These agents, attached to the Regional Center for Action in Rural Development, generally promote agricultural innovations and techniques. They have been used successfully in agricultural and nutritional IEC, but their role in health promotion is occasional.

Literacy Training and Reading Clubs. Under the Literacy Directorate in the Communication Ministry, these groups have been targeted, often at considerable expense, for health education. For example, booklets on "seven health preoccupations" were developed with UNICEF assistance and translated into nine national languages. Given that one percent of the Beninese population is literate in a national language, the impact of this effort is likely to be very small. UNFPA has also supported literacy modules counseling against rural out-migration.

Project of Family Well-being. Supported by UNFPA under the MCH/FP Service of the DNPS, about one-quarter of total funds in this small FP project were earmarked for IEC training and materials development. As numerous evaluations have observed, the rate of absorption has been low. Unlike the national AIDS project (PNLS), PBEF does not have a staff member assigned specifically to IEC, although one member has attended the "Advances in Family Health Communication" workshop at Johns Hopkins University. Responsibility for IEC training and materials conception has fallen chiefly to the IEC Service in the Health Ministry. A redoubled IEC effort began in early 1994, and since that time the project has trained 40 master trainers in FP/IEC (three days) and other program components in four of the six departments and expects to train 20 in the remaining two departments. In addition, three posters and one flip chart have been developed and very recently distributed to the Communal Health Complex and the Sub-prefecture Health Center supported by the PBEF. An individualized flyer for clients is in production and will be the only individualized FP/IEC material available in the country.

Family Planning in Formal Education. In its current 1994 program UNFPA has reserved US$625,000 of the proposed US$2.8 million for IEC. This support does not include the PBEF. Activities include (1) training in population and family life education of teachers in the teacher training schools, a program fully integrated into the department of the Ministry of Education in charge of curriculum revision and (2) documentation centers in the Population Planning Unit in the Planning Ministry and a research center in demography at the Université du Bénin.

Program for Health Services Development (PDSS I). This integrated health, nutrition, and family planning project financed principally by the World Bank has supported overseas training

for the IEC Service chief and the development of IEC materials. FP/IEC has not received specific support.

ABPF. ABPF, the local IPPF affiliate, has long recognized the paramount importance of demand creation and IEC, but its approaches have been limited by a lack of technical and financial resources. Since its inception in 1972, ABPF has explored a wide variety of channels for outreach and interpersonal communication (IPC). They include such diverse groups as its own volunteers, local development associations, apprentice workshops, markets, health and social centers, private clinics, youth groups, women's groups, churches and mosques, and others. Since 1991 ABPF has also produced a quarterly publication for its volunteers and supporters entitled *Bien-Naître* (a French language pun combining the notions "to be born well" and "well-being"). ABPF has supported radio programming on family health for a number of years.

With assistance from the USAID-funded SEATS Project in Togo, in 1992 the ABPF began to produce family planning posters for health centers (five at 1,000 copies each) and print T-shirts for community-based distributors of condoms and creams in Cotonou. APBF puts considerable emphasis on promotional outreach. For example, the Porto Novo office has two *animatrices* who work within a 20-kilometer radius of the city. Male or mixed teams undertake long-distance or evening outreach. The office records that between January and June 1994, 529 men (202 young men) and 2700 women (398 young women) were grouped in markets, nutritional centers, health centers, garment workshops, and peri-urban communes for presentations on child spacing and contraception. In some instances a Yoruba-language film, "My Brother's Children" (1960), made in Nigeria was shown.

APBF's FP/IEC materials warrant detailed description, as they are well conceived and of high material quality. At the same time, they illustrate the need for further technical support in materials development.

Logo: APBF has developed a disk-shaped logo depicting rounded and stylized images of a man, a woman, and an infant in a nesting motif. The name of the Association is written out in full around a rim surrounding the central image. At the bottom of the logo the abbreviation "ABPF" appears in large letters. The logo may appear in four colors (yellow, black, red, green) or in a more easily reproduced version in shades of black on white. The difference between the two versions of the logo may have an impact on logo recognition.

Posters: Five posters produced recently by ABPF were designed and illustrated by a local artist. The images are simple, uncluttered, and clear. The messages are brief and straightforward ("Before becoming a father, be a mature and responsible man" "I am a student and pregnant; what future do I have?" "Planned family, happy family" "Spaced births, a happy and healthy family" "Harmonize burdens with income; this will contribute happiness to his family"). Two posters, meant to be used together, may be understood principally through their images. One midwife in Ndali described a "typical" (and appropriate) interpretation of these posters by her clients. Two other posters, targeting students, assume a literate audience. Each poster carries the ABPF logo.

Finally, ABPF uses video monitors in its clinic waiting rooms. Two video cassettes were available.

Private Religious Hospitals. Hospitals supported by the Catholic Church in Benin generally provide a range of contraceptives. The two private hospitals visited by the team prominently displayed posters for HIV/AIDS prevention and breastfeeding. Contraceptive services are offered when requested or when they are medically indicated; family planning and contraceptives are not promoted and FP/IEC is not pursued.

Current Government IEC Campaigns: HIV/AIDS Prevention and Breastfeeding. Two integrated IEC strategies are underway in Benin. Their apparent impact bears witness to the success of well-planned health promotion and social mobilization in Benin. The national HIV/AIDS project, which benefits indirectly from a related social marketing effort (see below), has developed an excellent strategy that includes a variety of posters, a quarterly bulletin, educational materials for primary and secondary schools, programs on the "Rural Radio," a flip chart for group IEC, videos, a modern play, and tape recorded songs. In large measure the campaign owes its success to the adoption of an unequivocal national HIV/AIDS policy, a coordinated strategy among over a half dozen donors, and a social environment of consensus. In addition, the program has harnessed promotion directly to condom supply.

A second integrated campaign on the nutritional benefits of exclusive breastfeeding has been no less aggressive. The strategy relies heavily on counseling and IEC training for health workers; creation of "Baby Friendly" service points; creation of a large and attractive poster displaying a local personality breastfeeding twins; creation of songs for entertainment in health center waiting rooms; and posters with specific instructions to health workers for postpartum counseling in breastfeeding. By targeting its efforts specifically to pregnant and postpartum women, the campaign benefits once again from the dual strategy of promotion and voluntary supply of the desired product.

Social Marketing. Since 1992, Population Services International through its local affiliate the Benin Association for Social Marketing, has pursued an aggressive campaign of HIV/AIDS prevention by marketing condoms under the "Prudence" label. In the past 18 months, ABMS has sold over 2 million condoms at a retail price of 50 FCFA (US$0.10) for a package of four.

The project may be credited with having been the first to promote a modern contraceptive method through posters, stickers, media, and targeted interpersonal communication. Name recognition has been enhanced by three television spots, one run each evening before and after the evening news. For this televised service a social price of US$4,000 was negotiated with the national broadcasting entity (ORTB) for one year. In addition, ORTB-radio runs free of charge three condom promotion radio spots daily in French and in local languages.

"Prudence" posters, developed in Benin or nearby countries, are evident throughout the countryside. They carry such slogans as "*Confiance d'accord, mais Prudence d'abord*"; "*Abstinence, Fidelité, et Prudence*"; and "*Aimez avec Prudence.*" Many are displayed in health centers where staff persons may participate in the Prudence marketing network and gain a small profit from sales. Otherwise, Prudence is sold in pharmacies and in the informal market by itinerant sellers, barbers, hairdressers, and in bars and nightclubs, petrol stations, and small corner stands.

ABMS also pursues interactive IPC with the help of local NGOs. Teams visit selected audiences (military camps, truck drivers, sub-prefecture health centers, schools, youth organizations). In addition, the wholesalers in the Prudence sales network are trained in HIV/AIDS prevention messages. These messages are passed on informally down the marketing chain to end clients.

This first experiment in social marketing in Benin would suggest that the use of private sector approaches yields a positive synergy with a national health program (PNLS). The experiment merits evaluation. Meanwhile, ABMS plans to add contraceptive pills and oral rehydration salts (ORS) to its product mix in the near future.

Bilateral Assistance to IEC. Nearly all actors working in the Benin health sector include IEC and social mobilization as a component of their interventions. Often, these efforts are highly localized, but some serve as interesting experiments for future FP/IEC planning. For example, the *Programme Medico-Sanitaire Benino-Swisse* supports a planning process for certain departmental health centers; social mobilization is encouraged. A German-assisted health center (CSSP) in Cové (Zou department) undertook two IEC initiatives: (1) a youth training program in AIDS and reproductive health which would lead to youth-to-youth *sensibilisation* in local schools and (2) a locally produced video on AIDS. The Cové CSSP has a VCR and monitor and an array of IEC materials from Benin and nearby countries.

3.4.3 New Structures and Projects for FP/IEC

Reorganization of the Ministry of Health. Family planning will assume greater prominence and more likely integration into MCH services following the reorganization of the Health Ministry, approved in May 1994. The new structure foresees a Family Health Directorate, having three Services: Mother and Child Health, Nutrition, and Family Planning. The Family Planning Service will comprise two divisions: Family Planning IEC and Family Planning Services. Following the example already set by the IEC Unit of the HIV/AIDS Prevention Project, the FP/IEC division chief will work in close collaboration with the IEC Service in the DNPS.

Reinforcement of the DNPS IEC Service: Support to IEC Activities in Population and Health (1993-1996). UNFPA seeks to reinforce the IEC service in the Ministry of Health and at the department level by improving IEC planning capability, offering operations research training to senior IEC staff, and offering counseling training to 120 health workers and 30 social workers. The project also seeks to improve coordination in FP/IEC by creating a structure for this purpose in the IEC Service.

Owing to delays in meeting preconditions, the project has not begun. Because the project was conceived chiefly to reinforce an existing government structure, the restructuring of the MSP may require a revised design.

Family Life and PopEd for Craft Associations (1994-1996, 18 months). UNFPA proposes to replace its earlier school-based family life education activities with a small pilot project in the informal sector. The project is grafted onto two ongoing artisan group support projects funded by UNDP. One hundred fifty women and 90 men will benefit from the development of research-based materials (to be produced by MEPS), training of in-group *animatrices*, and

monthly group discussions meant to encourage household dialogue. Distribution of contraceptives during these discussions is not envisaged.

PDSS II (1995-2000). The World Bank is proposing, for International Development Agency and complementary bilateral funding, a follow-on to the current PDSS I project. The project will fund the cost of producing educational materials for better health, safe motherhood, family planning, nutrition education, STD and AIDS prevention, and household and environmental sanitation. A KAP survey will be undertaken, together with training of COGEC and COGES members in health promotion. Beneficiary assessments will monitor the impact of the effort.

A corollary activity of the project will strengthen the management and technical capacity of the IEC staff within a newly created IEC division under the Family Planning Service of the Health Ministry's Family Health Directorate. In addition, it is expected that similar support will be given to selected IEC personnel at the department level.

Health Education in Schools (1995-1998). USAID envisages a project, possibly to be managed by a U.S.-based NGO, that will develop materials and messages on health for primary schools. The project offers an important opportunity for introducing notions of family planning and reproductive health to school-going youth.

3.4.4 A Proposal for an Autonomous Center for Development Communication: National Program of Communication for Development

With democratization, the opening of communication channels brought about a relaxation of government control but also raised new concerns about what kind of information would pass to the public and in what form. A communication policy was needed, some said. For the donor community a liberalized press expanded the possibilities for IEC, and indeed "*l'IEC*" is widely viewed as essential to all development interventions.

Because Benin has had little experience in IEC, apart from two major health campaigns, external Cooperating Agencies, under the leadership of UNDP, met in early 1992 to discuss three issues: (1) the usefulness of a national policy for development communication that would encourage access to communication channels; (2) the need for stronger sectoral and intersectoral coordination in message development; and (3) the need to expand access to communication services at a reasonable and fair price. Concern was raised about the apparent proliferation of development messages and IEC activities in pursuit of aims that are duplicative or contradictory. In addition, the independent pricing policies of the ORTB tended to cede media expression to projects or initiatives having generous budgets for communication.

A national policy for development communication was suggested and the establishment of an autonomous, subsidized Center for Development Communication proposed in order to harmonize government development policies with information provided to the population, especially those persons in rural areas targeted by the programs of Rural Radio.

No practical action followed, but discussion and debate continued through 1993. The "need" for the communication center continued to be expressed by some donor agencies, but without

precision. At the same time a spirit of caution took root among government specialists directly engaged in health communication. A centralized and heavily regulatory approach, it was felt, may little advance positive harmonization of development objectives. Rather, it could do harm to development by curbing the free flow of information and participation in the social sectors by dampening IEC initiatives of technical ministries, diverting financial resources toward structures and studies and away from development action, and opening the way to potential censorship. Some donors interested in supporting the communication sector viewed the center concept as a source of delay to operationalizing their support.

Mid-1994 saw a revival of the concept—no longer a "center" but reformulated as a national "program" in development communication governed by an overarching "policy." Meanwhile, in May 1994 the Ministry of Culture and Communication (MCC) officially nominated a "coordinator" for the "center," whose future existence still remained uncertain. In addition the recent creation of the HAAC (an autonomous communications regulatory body), the imminent approval of private radio channels and the important future for media in the 1995 elections have introduced further unknowns into the future of development communications.

An effort to gain clear understanding of communication needs for development is currently envisaged over a six-month period. During that time a team of international and local consultants is expected to sound out the major actors in the communication and development fields. On a needs basis, the team will develop a concrete proposal for a development communication program. The proposal merits careful elaboration and study by all partners, given the risks of regulation policies in a newly democratic environment where development communication needs are very great. Thought must also be given to the interests that undergird the development communication "center" initiative and whether the new scheme might not in fact duplicate—at unnecessary cost to donors—existing communication structures (e.g., MEPS, ORTB) or dampen the development of local, private sector communication initiatives.

3.4.5 Financing and Sustainability of IEC for Family Planning and Reproductive Health

Funding for FP/IEC is infrequently isolated in government, donor, or NGO budgets. An accurate account of the resources available to the sector is difficult to obtain. An informed impression suggests that, while financial resources made available have not been generous, they have not been fully absorbed. Training programs and studies have mobilized funds most successfully; materials development has been less aggressive; outreach has received and absorbed a very low proportion of funds. Finally, radio is occasionally used for FP/IEC and, more recently, television for social marketing and programming preceding the ICPD. Unfortunately, the cost of media programming is often an obstacle.

A tradition of small-scale, vertical IEC projects, unlinked to service objectives, should be replaced by a coordinated, adequately funded, and sustainable demand and supply effort that targets the public, private, and NGO sectors simultaneously. A broad mix of communication channels, including multi-media and village-level outreach, is needed. At the outset, funding for this effort must be provided by donors. Experience in similar countries suggests that FP/IEC should receive a total population program budget share of around 15-20 percent.

Meanwhile, Benin's health services cost recovery program, through the *Centrale d'Achat* for distributing generic essential drugs and its local management by health center committees (COGEC and COGES), offers one potential source of local health funds that may be used for financially sustainable strategies in IEC. The recent experience of social pricing for televised spots on HIV/AIDS prevention further suggests that media channels are available at affordable cost. As all ministries, the MSP has a media liaison office and a budget for communications, but this opportunity is underutilized. Benin, through its membership in the French international television network, also has opportunities to sell its television productions.

Finally, family planning services must appear to health personnel as a good business for their cost recovery program. Promotion, combined with high-quality services, will help to realize this objective and create incentives for better and sustainable FP/IEC.

3.4.6 IEC for Family Planning: The Need for an Overarching Strategy

The plethora of new and ongoing activities in health and family planning IEC, reassuring at first blush, is deceptive. Field visits undertaken by the Assessment Team in four of the six departments confirmed the observation made recently in the family planning Situation Analysis that—despite IEC efforts made thus far—little IEC activity or impact can be seen in the field. The study also observed that family planning materials—usually posters—were present in only 29 percent of health centers visited and that no individualized materials were available. The most common props are anatomical models and the contraceptives themselves.

This observation parallels the health IEC situation generally, which the team noted to be weak overall. Apart from a wide variety of posters, often framed and carefully displayed on walls, few materials (flip charts, training guides) are being utilized in health and social promotion centers. While most centers have received recently distributed government materials, they are commonly left to gather dust on bookshelves or remain in their original crates or cartons shoved under cabinets or tables.

The placement of IEC materials out of reach suggests that visual props are rarely used. Nearly every health and social worker questioned by the team replied that early morning IEC sessions were a standard feature of prenatal service days; only three facilities (CSSP-Tchaourou, Center for Maternal and Infant Protection [PMI]-Cotonou, and ABPF-Porto Novo) kept records or plans of *animation* activities. While breastfeeding figured prominently—owing to the current campaign—family planning topics constituted no more than five percent of the subjects discussed in non-ABPF clinics. The Situation Analysis also noted that only 21 percent of clients in the clinics visited had received information on family planning and that in most instances this information was offered only during individual consultations.

Clearly, a well-conceived, muscular FP/IEC strategy is needed in the spirit of past Benin health campaigns (ORT, EPI) or current efforts (HIV/AIDS prevention and breastfeeding). Such a strategy must be well coordinated among all sectors and fully integrated into a service delivery scheme.

3.5 Material for the Future: Media and Channels for IEC

3.5.1 Social Mobilization

Benin has enjoyed considerable success in social mobilization for health, beginning with the national campaign to promote oral rehydration therapy of 1986 and the more recent Expanded Program on Immunization (1990). Before 1991, social mobilization was officially realized through the Party structure, having representatives at all administrative levels. Health campaigns and the 1991 election prized open additional channels, including such nongovernmental structures as NGOs, associations, cooperatives, religious organizations, market and trade groups, and others. Certain traditional religious groups based on worship of the *voudoun* or *orisha*, together with some apostolic sects, have lent promotional support to health campaigns.

In government, structures for IEC outside the MSP include the social assistants and medical personnel of the Social Affairs Directorate, the ABPF/IPPF, the program in school health, the CARDER, and possibly political parties.

Common social meeting points have been successfully targeted for social mobilization, including markets, water points, and health and social centers.

No less important to social mobilization is the extended structure of the Beninese family in which the considerable authority of elder male and female members is exercised over a group which is large, diversified, and often widespread. Families often serve as important links between rural and urban centers. In many localities, entire villages or town quarters have a common historical lineage which encourages a high level of social exchange.

Successful social mobilization campaigns in Benin have relied on a media mix in which oral communication and traditional arts have had a very large share. Only one-quarter of the population is literate. It is widely observed that radio and group meetings are the most successful mobilizing vehicles, especially in rural areas.

Two government structures are directly concerned with inter-sectoral social mobilization. The Ministry of Parliament Relations houses a Service for Social Mobilization; the Communications Ministry has a social mobilization committee.

3.5.2 Print Media

An initial flowering of independent newspapers following democratization yielded several stable titles: *La Nation* (a government-supported daily with a print run of 5,000) and a high-quality independent daily, *Le Matin*. *La Croix*, a Catholic bi-weekly, has been joined by several other weeklies or dailies in French. Nearly all independent newspapers receive some external subsidies.

The new Beninese constitution guarantees free expression (Article 23) and a free press (Article 24). These freedoms are vigorously exercised and protected.

Local language newspapers attract intense interest and curiosity, but they are generally irregular and usually promoted by local literacy committees and the government agents who organize them. The only offset title is *Kparo*, published in Batounou language. Because only about one percent of the Beninese population is literate in any of the 50 or so local languages (compared to 23 percent in French), their impact and reach is extremely limited.

3.5.3 Radio and Television

Until the initiation of the HAAC in July 1994, the ORTB under the Communications Ministry was the sole broadcast organ in Benin. The HAAC, an autonomous body, now replaces the state as the regulatory agency for communication. HAAC has received a large number of applications for rights to broadcast on private FM radio channels that are expected to be established in near future. Four local FM radio stations have been started in rural areas of Mono, Zou, Borgou, and Ouémé departments and are expected in Atlantique and Atacora.

Radio. National radio is currently the only communication channel having a nationwide reach. In theory nearly every Beninese has access to radio broadcasting. Reception at certain times of day is faint in hilly areas and along the western border. Two of Benin's three major transmitting stations broadcast in Cotonou, one in AM (*Radio Diffusion du Bénin* [RDB]) and a second retransmits *Radio France Internationale* (RFI). A smaller FM station alternates its schedule with RDB to cover the broadcast day. In Parakou the AM station *Radio Diffusion Parakou* (RDP) has erected new relays to improve coverage in the North.

Two-thirds of RDB's 105 weekly hours of programming are produced in French and the remainder in 18 local languages. A microwave connection to Parakou provides news and other program feeds. Otherwise, the two stations produce their radio programs independently.

"Rural Radio," in local languages, is integrated into the national radio. Programmed by a national committee, it is conceived as an IEC organ for the rural population. Impact is limited because of the didactic tone of programs; producers have few opportunities or means to report on development initiatives or to create human interest stories where they occur.

Television. Until recently it was estimated that only 1.5 million persons had access to television in Benin, chiefly in the southern and central portions served by broadcast points in Cotonou and Parakou. With the addition of a relay station in Natitingou in July 1994 and others in Dassa and Kandi in 1995, television coverage will soon reach the whole of Benin.

Benin's one television station broadcasts for 7.5 hours daily except for Mondays and Thursdays when broadcast time is one hour less. The broadcasts are complemented for some viewers by access to broadcasts from Togo, Nigeria, and by satellite from France and other global channels. Young urban audiences generally prefer the French programs. Benin television relies on CFI-France for about 70 percent of its broadcast material, but it wishes to have the means to undertake more local production. In general, Benin television can be expected to remain attractive to local audiences, especially those desiring programs in local languages.

Health and family planning topics currently occupy only about one percent of weekly broadcast time for radio and television each. Rural Radio in Cotonou and Parakou each assigns a specific producer to health issues. Recent topics include the ICPD summit. Current radio broadcasts of interest to health and family planning include weekly programs on health (totaling one hour) and selected women's programs. A bi-monthly television program "*Dites-moi Docteur*" has recently touched on the country's high rates of induced abortion, causes of sterility, and the importance of population in development planning.

The use of radio or television for mass information about family planning should figure as part of any FP/IEC strategy in Benin. At present this opportunity has not been explored for family planning and has been little used for health promotion. Editorial freedom on all government-owned stations is respected. Despite the law of 1920 inhibiting promotion of contraception, a discussion of modern methods for family planning was aired recently on Benin television.

Impact by broadcast media on individual men and women in rural areas will need reinforcement by interpersonal or more localized channels. Typically, women have less access to media than do men. Few women own radios or televisions. Although most women live in a household or compound in which at least one member owns a radio, their choice of programming is limited. In addition, it has long been observed that broadcast hours often conflict with a woman's heavy daily commitments outside the home.

3.5.4 Cinema, Video, and Tape Player

The number of video cassette players in Benin is difficult to estimate, but the existence of "video clubs" for cassette rental in the major cities of Cotonou, Porto-Novo, Abomey-Bohicon, and Parakou indicates a growing market. Video cassettes, locally copied, are sold in every urban and some rural markets. Itinerant or independent video cameramen are found throughout the country and have, in many instances, replaced local photographers where affordable. Typically, they are hired to record marriages, funerals, training seminars, and similar group events.

Tape players and cassette recordings are extremely widespread and affordable for at least half of the population. Increasingly they are purchased in combination with radios.

Cinema has a diminishing importance. Cotonou has two functioning cinema houses and Parakou one.

Some ABPF and government clinics have installed videos in waiting rooms. The choice of video cassettes is often limited to one on family planning and a second on AIDS.

A consensus view of health professionals is that video monitors would be an excellent addition to waiting rooms in electrified portions of the country. This communication point, combined with personally owned video and tape players, offer an important opportunity for transmitting messages on family planning and reproductive health.

3.5.5 Communication Arts: Modern and Traditional

For many centuries Benin has been recognized for the diversity and quality of its communication arts. "We," observed one local IEC specialist, "are *oralistes* above all." Traditional narratives, songs, poems, and masquerade dance performances continue to enthrall a population which, since 1991, has participated in the active revival of its cultural heritage. Songs on health themes are sung on occasion in Social Promotion or Health Centers to enliven health talks or to lighten the boredom of waiting.

Health campaigns have also mobilized traditional and modern theater troupes. A recent example is the play, *SIDA* (AIDS), conceived by the local writer Hippolyte da Silva. Recent liberalization of expression has encouraged a flowering of modern artists, writers, and musicians. A motion picture industry has not developed. Associations of writers and musicians exist, including the Beninese Association for Writers in National Languages.

3.5.6 IEC Materials Development

Educational Materials for Health Personnel. Intended as an African regional program, MEPS was established in 1981. By 1987 Benin became the center of the Francophone African regional MEPS network, and it is now housed within the Regional Institute for Public Health in Cotonou. Until very recently, UNDP and WHO supported The MEPS Project, the first providing equipment for desktop publishing and printing; black and white photographic developing, processing, enlarging, and printing; video production and editing; and binding, illustration, and design. In 1994 external financial assistance to MEPS ended.

MEPS continues to serve as a leading source of materials development for the public health, medical, and development community in Benin. MEPS is a recurrent and salient feature in health centers in the field. The unit offers services at competitive prices in conceptualization, illustration, desktop publishing design, pretesting, duplication and serigraphy, medical and illustrative photography, binding, and—minimally—VHS video production. MEPS products are also of competitive quality and include booklets for literacy training in French and local languages, posters, flyers, stickers, T-shirts, one film in video, training manuals, calendars, and periodicals.

Technologically, MEPS is not highly advanced but makes good use of its available skills and equipment. It contracts out color photography and printing jobs to local, good-quality firms. Its capabilities in color separation and video production are limited. Affiliated with the Benin University Faculty of Health Sciences, MEPS is housed at no cost in a spacious facility; its director is a salaried university professor, and its medical photographer is also university staff. Currently, MEPS's volume is small (about US$2,000 per month in receipts) but covers recurrent costs of consumables, equipment repairs, and 11 full-time local contract employees. A modest, well-organized, documentation center relies on free publications and materials that it shares throughout the regional network. A WHO-funded technical assistant ended her contract in July 1994. Additional technical assistance is provided from Canada through World Universities Welfare and Aid-Canada (EUMC), a university exchange network. A sustainable future for MEPS will in large measure depend on its ability to meet an increased demand for

materials development by enhancing the technical and production capacities of locally recruited staff.

Media Houses. Benin's free, formal sector economy opened in 1991. Local advertising and publicity, which grew quickly to meet the demand of the 1991 electoral campaign, continues to develop at a modest pace. So far, most name brand advertising in print and on television is produced in France or Côte d'Ivoire. At present, Cotonou has one privately owned media house that is equipped to produce modern print and video materials. In general, local businesses rely on a growing number of independent artists and producers. Some have opened small agencies of two or three persons. For video production, nearly all independents or small agencies rent or subcontract equipment or services from ORTB. ORTB television, with two-dimensional computer-based production facilities, sells services locally and to neighboring countries for advertising or promotional and electoral campaigns.

Demand for advertising is still very low. Pricing for illustrations, spots, or video films and promotions is highly variable but is in large measure guided by ORTB as the predominant market force. In general, ORTB television prices are high for the local market: 250,000 FCFA (US$500) to develop a one-minute spot and equivalent amount for each broadcast. Radio spots are much less expensive at 7,500 FCFA (US$12.50) for a one-minute announcement. ORTB pursues an informal policy of social pricing, applied on a case-by-case basis. Competition from within the communication sector will likely increase over time, both within Benin and from bordering countries. Meanwhile, most advertising and media production is pursued within what is called *l'informelle* (the informal economy).

Presses. Cotonou has over a dozen presses, four of which are considered to be diverse and of high quality. A press in Porto Novo, launched with German assistance, provides good services, and Parakou has one strong, quality press. An expanding market for newspapers, magazines, trade or professional journals, and publicity undergirds the relative high quality of printed materials in Benin.

3.6 Toward a Future Strategy for IEC in Family Planning and Reproductive Health

3.6.1 Do's and Don'ts for FP/IEC in Benin

Earlier sections of this review concluded that a future strategy in FP/IEC should be:

- Fully incorporated into an overarching program in family planning and reproductive health, matching demand creation at all points with the supply of quality services.

- Multi-pronged, including (1) advocacy for decision-makers at all levels, (2) demand creation for potential clients and their families, and (3) training for FP workers in counseling, dispelling rumors about such side effects as spotting and amenorrhea, outreach, and group communication.

- Multi-channeled, drawing upon all potential communication networks, whether family-based, institutional, mass media, journalistic, interpersonal, or positioned.

- Multi-media, incorporating all appropriate forms of verbal and visual modes of expression—from training lectures to storytelling; from traditional masquerades to mass media; from a private statement by a satisfied user to an advert; from a whispered direction to a self-proclaiming logo; from a mother's tentative suggestion to a heath worker's counsel.

- Integrated, wherever possible, into reproductive health and MCH activities.

- Fully researched, including (1) initial KAP and qualitative studies, (2) studies before, during, and after materials production, (3) analyses for impact, and (4) assessments by beneficiaries.

- Conceived within the framework of an overarching national FP/IEC strategy that includes (1) information for policy making, (2) formal and informal education at all levels, (3) mass media for awareness creation, (4) outreach into rural areas and urban neighborhoods, (5) systematic counseling about FP at prenatal, postpartum, and postnatal visits, (6) clinic-based group communication, and (7) development of appropriate materials, especially for the individual client.

- Approached differently in urban and rural areas, and, where necessary, among different ethnic groups.

- Developed carefully through the stages of (1) building awareness about the benefits of family planning, (2) building approval of contraception, (3) increasing knowledge about specific methods of contraception, and (4) encouraging continued used of family planning methods among women and men who desire to do so.

A FP/IEC strategy should NOT:

- Proceed in advance of audience readiness to accept the next stage of promotion.
- Be undertaken without ensuring the presence of a consensual environment for the target audience.
- Exclude detractors from discussion, but involve and attempt to persuade them.
- Denigrate traditional methods.
- Advance the notion that the chief purpose of family planning is the limitation of births.
- Encourage unnecessary medical or religious barriers to contraception.
- Create an impression of state pressure or coercion.

3.6.2 Target Audiences

Client audiences for a FP/IEC strategy should include both young and adult clients, in many contexts, addressed separately according to gender. In order of priority these groups may be: adult women, young women, adult men, young men.

Audiences of influentials include policy-makers, traditional opinion leaders, health and social workers, teachers, and older female relatives in the household. At initial stages of the strategy, approval from this group will be critically important.

3.6.3 Key Promises: A Basis for Message Development

The "key promises" of the message development strategy will vary according to target audiences. In the Beninese context, they may include the following:

- Family planning enhances national social and economic development.
- Family planning improves the status of women.
- Family planning is another form of democratic choice (an "election").
- Birth spacing improves family health, especially for women and young children.
- Family planning enhances family resources and well-being.
- Contraception prevents unwanted pregnancy and induced abortion in young women.
- Contraceptives are safe, effective, and reversible; such side effects as ammenorhea and spotting are normal and will not affect fertility or purity for religious worship.

3.6.4 Sub-strategies

Specific sub-strategies will figure within an overall FP/IEC plan. Important sub-strategies may include the following:

- Policy strategy. Advocacy and information for policy-makers, using the RAPID IV model among other communication tools. Family planning may be included in political party platforms.

- Urban strategy. Cotonou, Abomey-Bohicon, and Porto Novo should be the focus of a southern urban strategy relying on mass media, posters, personalized client materials, neighborhood outreach, and counseling. A separate northern strategy in Parakou and Natitingou may also be considered.

- Clinic and service-point strategy. Intensive communication and counseling training for health and social workers may be supported by the production of counseling guides and consulting room posters, videos in waiting rooms, additional waiting room posters and entertainment, and regular clinic-based group counseling. In time, a strategy to promote the trained provider and improved service point may be considered.

- Rural outreach strategy. By far the most convincing and important communication channel for men and women in Benin is the recommendation of family, friends, and neighbors. Outreach teams based at nearby service points and APBF volunteers may be used to launch a village-based information program. Ideally, this effort will

be combined with village-based distribution of contraceptives. Consideration should be given to grafting this effort into vaccination outreach.

The rural outreach strategy may be supported by (1) the creation of local family planning committees of advocates or satisfied users (ideally composed of a young woman, an adult married woman, a young man, and an adult married man), (2) local radio broadcasts in local languages, (3) personal visual and possibly sound tape materials, and (4) visits by local personalities.

- Youth strategy. Materials and channels targeting youth should be considered, especially school-based efforts, mass media, and materials designed for display or distribution at common youth meeting points.

- Male strategy. Materials and discussion groups for men should be considered in urban and rural areas. Male personalities in sports, politics, and religion should be solicited for this effort.

- Social mobilization. This strategy will incorporate all of the above and target the entire population through every available communication channel.

- Evaluation strategy. The entire FP/IEC effort should be closely monitored and evaluated for impact. Materials and strategies that do not work (currently flip charts and booklets in local languages) should be discarded and resources redirected.

- Journalist strategy. Support groups of journalists should be created and furnished with appropriate information and materials.

- Study tours. Selected key actors in FP and policy making should visit countries having developed successful FP/IEC programs in similar socio-cultural environments.

3.7 Recommendations for the Future of FP/IEC

3.7.1 General Recommendations

In order to increase demand for family planning services, IEC for FP should be greatly enhanced, adequately funded, and fully integrated into an overarching FP program nationwide. The following specific actions are recommended:

- Full coordination of FP/IEC activities and messages among all partners in government, NGOs, and private sectors

- Development of a national strategic plan for FP/IEC which includes, but is not necessarily limited to, advocacy and information for formulating population policy, use of mass media, development of clinic-level and individual FP/IEC materials,

communication and counseling training for FP staff, grass-roots interpersonal communication, and research

- Conception and implementation of innovative and socio-culturally appropriate strategies for FP/IEC outreach

- Creation of an IEC division within the Family Planning Service whose task is to ensure the development and distribution of FP/IEC materials, coordinate the national FP/IEC strategy, and ensure FP/IEC training for all relevant staff

- Continuation of the department IEC service and its reinforcement in FP/IEC to ensure implementation at its level the tasks described in the preceding point

3.7.2 Specific Recommendations

The "strategy" section that precedes contains a number of implicit recommendations for the future. Additional proposals follow:

1. Intensive technical assistance should be foreseen for the early stage of the FP/IEC program, possibly with the support of a resident technical advisor. The purpose of the support should be to build local capacity to conceive, design, produce, distribute, monitor, and evaluate the program.

2. Funding levels should reflect the broad consensus on need for strong reinforcement of FP/IEC; 20 percent of total program budget is suggested, or approximately US$400,000 to US$500,000 per year.

3. Private sector materials production should be encouraged.

4. Special attention should be paid to building local FP/IEC capacity at the district and sub-prefecture level. Improved management, communications training, planning, and evaluation and correct and consistent use of print and audio-visual material should be encouraged.

5. The government should be encouraged to increase its share of funding of FP/IEC and health IEC in general. Broadcast time at no or social cost should be made available. Communications budgets in ministries should be exploited for their original purpose. Local resources to support IEC efforts, especially outreach, should be mobilized. A policy on the use of the COGEC and COGES funds for IEC is strongly suggested.

6. An operations research plan should be developed in concert with other donors, especially the World Bank and UNFPA. Topics may include (1) a full literature search, (2) analysis of modern and traditional beliefs or attitudes toward reproductive health and contraception, (3) appraisal of past FP/IEC efforts, (4) a full technical analysis of mass communications capabilities and reach, and (5)

identification of natural institutional communication networks among women and men in representative areas, including traditional marketing and product associations.

7. Local NGOs should be closely associated in strategies for rural outreach and specific target audiences.

8. Indicators for FP/IEC (and health IEC generally) should be developed and included in management information systems. An incentive mechanism for health and social workers who reach FP/IEC targets should be considered.

Practical and updated curricula for IEC training should be developed for INMES, IRSP, and in-service training conducted by the MSP. All midwives, nurses, and physicians should be trained in IEC and communication techniques.

4 TRAINING AND HUMAN RESOURCES DEVELOPMENT

by Pape Gaye

4.1 Background

In early April 1994, assistance was requested from the Program for International Training in Health (INTRAH) to plan and conduct a family planning training needs assessment. It was expected that the needs assessment would yield data to be used in formulating options for USAID assistance in the area of population and family planning. The Regional Economic Development Services Office/West and Central Africa (REDSO/WCA) and USAID/Benin asked that INTRAH participate in a sector assessment scheduled for late June/early July 1994. INTRAH suggested that the assessment be conducted in two phases prior to the sector assessment team's arrival in order to collect as much data as possible.

A preliminary assessment was thus conducted April 15-26, 1994, by INTRAH consultant Joanny Kabore. This first visit aimed at updating and collecting available data on general health statistics, the national policy for population and MCH/FP, the national MCH/FP program, the national capacity to provide and manage national MCH/FP services, the status and conditions of MCH/FP services delivery, the MCH/FP projects and Cooperating Agencies, and MCH/FP training capacity. The assessment also solicited expectations of health center managers and other partners' suggestions for USAID's possible interventions in family planning and reproductive health training. The INTRAH consultant worked closely with a Population Council consultant and used data available from the recently completed Situation Analysis.

A second assessment was conducted June 2-17, 1994, by an INTRAH team of Mr. Kabore and Emilie Mensah, INTRAH clinical consultant. The purpose of the second visit was to conduct an inventory of FP clinics in the country to assess provider performance to collect data on potential family planning clinical practicum sites and on the existing family planning and reproductive health guides and guidelines.

The present report is a synthesis of the two assessment reports and summarizes major findings, conclusions, and recommendations. Its was prepared based on guidelines provided by the sector assessment team.

4.2 Methodology

During preparation in Lomé, information on the national program for MCH, family planning, safe motherhood, and nutrition (1991–1995) was reviewed. Sources of information in Cotonou were identified and supplemented with a briefing with USAID/Benin. Data collection instruments were drafted in Lomé and finalized in-country with national counterparts. For the clinic inventory, instruments for Togo (for FP and knowledge assessment) were adapted and the same standards used.

Data collection consisted of interviews, document review, and discussions on the preliminary results of the Population Council Situation Analysis recently completed.

The document review focused on the statistics from the Ministry of Health, the preliminary results of the second population census conducted in Benin (1992), the preliminary results of the Situation Analysis on FP in Benin, and the national health strategy project (1994-1999).

The interviews were conducted with a guide reflecting the objectives of the activity and INTRAH's data collection approach. Approximately 40 heads of services and representatives of international agencies were interviewed during the two visits and the performance of 40 service providers assessed. Among the persons met were the managers of 10 organizations collaborating with the MSP in the context of the Project for Family Well-being (PBEF). They included ABPF, UNICEF, WHO, the Benin-Germany Primary Health Care Project (PBASSP), PSI, MEPS, the Center for Research in Human and Demographic Reproduction (CRRHD), UNFPA, PDSS, and the Population Council. Interviews were also conducted with the managers of three preservice training schools, the faculty of Medical Sciences, the School of Midwives/State Nurses, and the IRSP. Eighteen FP service delivery sites in five departments were visited and the work conditions assessed.

INTRAH participated in work sessions to discuss the preliminary results of the Situation Analysis and in the formal dissemination meeting held in May 1994. Meetings organized by UNFPA were also attended, and briefing and debriefing meetings regularly held with USAID and the Ministry of Health to discuss accomplishments and preliminary results.

4.3 Major Findings and Conclusions

4.3.1 Institutional Level

National family planning and reproductive health service policy or standards do not exist in Benin. This is partly due to the lack of a population policy and the existence of the 1920 contraceptive law which, contrary to other African countries, seems to constitute a major obstacle.

An integrated supervision system is used for MCH/FP services. Although it is more economical, technical aspects are often neglected. There does not seem to be any emphasis on the clinical tasks of service providers, and the absence of any service delivery guidelines makes it difficult. It is not apparent that the personnel in charge of supervising family planning are adequately trained.

The Ministry of Health's training policy seems to be based on the institutionalization of training skills, decentralization of training using the "cascade approach." The Ministry of Health and officials of the PBEF would like to see all of their partners respect this policy.

There are a large number of private practices and health delivery centers. These need to be taken into account when designing a new FP/reproductive health program. The private sector can play a key role in expanding FP services and access.

National institutions strongly involved in FP and reproductive health training are at the Ministry of Health (the PBEF, the National Coordination Unit for MCH/FP, and the IEC Unit), the Ministry of Education (the Medical School, the INMES in Cotonou, and the Benin National School of Nurses and Auxiliary Nurses [ENIIAB] in Parakou), and among the NGOs, the ABPF.

The IRSP staff believes that there is no clear health policy in Benin. As a result, there is no coordination between interventions and FP services integration.

There does not seem to be any clear policy about FP and reproductive health services for adolescents.

4.3.2 Health Infrastructure, Personnel, and Human Resources

Infrastructure. In Benin, there is one National University Hospital Center (CNHU), three Departmental Hospital Centers (CHDs), 19 Sub-prefecture Health Centers (CSSPs) and Health Centers of the Urban Communes (CSCUs), and over 208 Communal Health Complexes (CCSs) that include communal health centers and *maternités*. There are also 293 village health units (UVSs). According to MSP officials, family planning services should be available at the CNHU and in all CHDs and CSSPs/CSCUs. One hundred five *maternités* in five departments were selected to receive priority UNFPA assistance in the context of the PBEF. There are an additional 162 private health service delivery sites and 85 pharmacies in the country.

The CRRHD, the IRSP, and the ABPF are institutions involved in family planning and reproductive health. Prof. Eusebe Alihonou, Dean of the medical school at the National University of Benin and a renown West African reproductive health resource person, is the head of the CRRHD. Prof. Alihonou has a wide network in the country, and his center has initiated most of the family planning and reproductive health research efforts in the country.

Preservice training and education institutions are the Faculty of Health Sciences (FSS) and the National Medico-social Institute.

Personnel and Human Resources. According to 1992 MSP statistics, the number and distribution of personnel working in the public sector are as follows:

- 244 physicians
- 1118 nurses
- 413 midwives
- 201 lab technicians
- 614 nurse aids
- 10 pharmacists

Viable statistics on the personnel working in the private sector are not available.

Data on personnel trained in family planning are sketchy. According to national MCH/FP officials, approximately 378 service providers received FP training. The figure includes

personnel trained by ABPF. According to the same source there should be approximately three service providers trained oversees and 60 in-country in each department. Clearly stated, post-training functions and tasks for service providers have not been established.

There is a pool of resource persons at the national level, including central level ministry officials, faculty members from the University Clinic of Gynecology and Obstetrics (CUGO) and CNHU, the CSMI and maternity in Cotonou, and national trainers. There are also national and departmental teams formed in conjunction with the national PBEF program.

4.3.3 In-service Training

There has been no training of trainers in andragogy and training methodologies. Personnel in service delivery sites used as practicum sites have not been trained in precepting skills, and national trainers have not been trained in training evaluation.

The average duration of the FP training conducted in-country from 1982 to 1990 is 10 days, whereas comprehensive clinical training with intrauterine device insertion in neighboring countries has lasted 4-6 weeks. Furthermore, there has not been any practical training for family planning, and the courses have been mostly theoretical.

Using an acceptable level of FP knowledge and performance of 70 percent (as in Togo), the average score for trainers for FP knowledge was 58.3 percent and for service providers 61.6 percent and 56.3 percent for performance of providers and preceptors.

The preliminary results of the Situation Analysis for the FP sector published in May 1994 show that:

- The general performance of the service providers is insufficient in critical fields such as FP/IEC, administration of contraceptives, and "informed choice" of method.
- 35 percent of FP service providers have not had any formal training in contraceptive technology.
- 43 percent of them have not had any practical training.
- Only 24 percent of them benefit from sufficient supervision.

Although the Situation Analysis recommended that the training curricula be revised, additional training and update are scheduled. The Situation Analysis data also show that the supervisors rarely use supervision instruments. The existing supervision instruments do not allow for the analysis of the service provider performance.

The Ministry of Health has adequate training rooms and furniture at central and departmental levels. However, capacity for duplicating training materials is very limited.

Work conditions in clinics inventoried were not satisfactory, as the majority of the clinics did not meet the criteria for becoming practicum sites. Two sites did meet the criteria: the ABPF clinic in Cotonou and CUGO in Cotonou.

The PBEF has developed family planning course syllabi and handouts, and there is a preliminary service policy document adapted from the Togo national policy and standards. These documents are in draft. It is not clear who has been involved in the process of developing the draft service policy or what sanction was given by the Ministry of Health.

The ABPF has prepared modules for training in family planning. The modules outline the sessions but do not provide many details. They could become the basis for a comprehensive in-service training curriculum.

Outside technical assistance to the PBEF has been provided by Prof. Leke from Cameroon.

The PBEF has set some short-term objectives which include working toward repealing the 1920 law and preparing national FP service policy and standards, service delivery guidelines, and training guides. It also intends to train trainers in the use of the guidelines and plans to resume training and refresher training of service providers which were temporarily suspended. Funding for these activities could come from UNFPA.

The ABPF expressed the following training needs:

- Refresher training for clinical FP service providers
- Training of administrative officers in management
- Training in evaluation/supervision

Other non-expressed needs are the following:

- Training of trainers and preceptors
- Review of the training program
- Provision of technical protocols

UNICEF is interested in assisting with the improvement of the draft protocols and the training in evaluation and supervision in order to revitalize the quality of services.
PSI is interested in the training of community-based distributors in contraceptive technology and the development of guidelines for these distributors.

PDSS hopes that USAID will provide financial and technical support for the following:

- Training
- Transportation for supervision
- IEC materials

4.3.4 Preservice Training

At FSS and INMES, where midwives and state-certified nurses are trained, there are some courses and a practicum in contraceptive technology. Four practicum sites are used in Cotonou (CUGO, ABPF, Lagoon Maternity Hospital, and the PMI).

The preservice training institutions—FSS, INMES, and ENIIAB in Parakou—do not have training curricula; rather they have a list of subject areas to cover and a suggested time frame. The program of the school of state nurses does not include family planning. The preservice schools lack IEC materials and demonstration equipment such as models or sample contraceptives.

The FSS and INMES managers are interested in assistance in the following areas:

- Development and integration of FP modules
- Training of trainers and preceptors in pedagogy
- Training of trainers and preceptors in evaluation/supervision
- Provision of demonstration and training materials

Prof. Alihonou at FSS is working on modules on family planning and reproductive health; his current project is funded by UNFPA in the context of the PBEF.

The INMES managers highlighted the lack of contact between their institution and the system of continuing education at the Ministry of Health.

There is a need for a national strategy to integrate family planning and reproductive health teaching and training in preservice education. This should be taken into account when developing a national training strategy.

4.4 Recommendations

The following recommendations are made to the Ministry of Health and USAID based on the findings of the two needs assessments conducted:

1. There should be coordinated efforts to abolish the 1920 contraceptive law. While this is being undertaken, family planning and reproductive health service policy and standards should be prepared under the guidance of the Ministry of Health. The process of developing the policy and standards should involve NGOs and the private sector. The policy should clearly spell out which services are available for adolescents.

2. A partnership approach between the MSP, NGOs, and the private sector should be developed and implemented for the promotion of family planning and reproductive health services. In order to increase access to services, primary health care should be promoted and the MSP should complete information on the minimum package of services according to level and types of infrastructure. Training of service providers should reflect this partnership.

3. A coordination and consultation mechanism should be established among all partners involved in family planning and reproductive health.

4. The linkages between the in-service training system, preservice training system, and family planning and reproductive health service systems should be reinforced. The process of this reinforcement could begin with the preparation of a national training strategy.

5. A national training strategy should be prepared that is guided by the service policy and standards and based on the current MSP training policy of decentralization. The strategy should include options for institutionalizing training capacity and capability. It should also include the following:

   - Development and dissemination of FP service protocols
   - Training of trainers and preceptors in training methodologies
   - Training of FP service heads in management
   - Training of trainers, supervisors, and administrative officers of MCH/FP services in evaluation/supervision
   - On-site follow-up of trained participants
   - Systematic implementation of a refresher training course for service providers in the field with particular emphasis on IEC, "informed choice" of contraceptive methods, administration of methods, and the health information system

   Until the strategy is prepared, the MSP should de-emphasize current FP training efforts. The emphasis should instead be placed on defining the post-training functions of service providers.

   Representatives of institutions involved in in-service and preservice family planning and reproductive health training should participate in the development of the strategy.

6. Potential FP training practicum sites in the departments should be supplied with necessary equipment and materials. Practicum sites in Cotonou should be reinforced as a step toward increasing national family planning and reproductive health training capacity. This reinforcement could be achieved through the following:

   - Providing supplies and equipment to the practicum sites
   - Developing and/or providing IEC materials and FP record keeping forms
   - Reinforcing the existing contraceptive supply systems
   - Instituting an appropriate supervision system

7. Technical and financial assistance should be provided to preservice training sites (e.g., FSS, INMES) to allow them to

   - Integrate the FP modules into their curricula.
   - Implement a training course for trainers and preceptors in training methodologies.
   - Equip their teaching halls with FP demonstration materials (models) and training materials (i.e., formatheques).

8. Training of family planning and reproductive health service managers in the integration of services should be promoted. Training curricula for in-service and preservice should also reflect the integration of all aspects of reproductive health.

9. Assistance may be provided to PSI in the training of community-based distributors of contraceptives.

10. Opportunities should be explored for conducting family planning and reproductive health training-related operations research under the auspices of the CRRHD. For example, the national strategy to be developed could include implementing new training approaches, such as distance learning, on-site training, and studying the impact of the different approaches on the quality of services.

4.5 Proposed Strategy for Family Planning Training

The following series of activities is proposed as a strategy for beginning the process of building national capacity and capability to plan, implement, and evaluate training in family planning and reproductive health. Implementation of these activities could begin during the bridge period from the present to the development of a USAID-funded population project.

1. A reproductive health/contraceptive technology update should be conducted for a core of national resource persons. The resource persons should be the current national trainers and members of the MCH/FP Committee set up by the PBEF. An update should also be provided for key service providers selected from those who are motivated and who will be available to work as trainers or preceptors in the future. This activity should be conducted before the end of 1994.

2. Quality services should be developed in the potential practicum sites through the provision of equipment and supplies and reference materials. IEC efforts should be stepped up in those sites.

3. The development of national family planning and reproductive health guides and guidelines should begin immediately. The action plan prepared by Dr. Zomahoun and Mme Gbaguidi during the regional conference on guides and guidelines in Lomé, July 18-22, 1994, should be implemented.

4. A national strategy should be developed and implemented for training and supervision in family planning and reproductive health. The strategy should include the following components at least:

    - Training in performance evaluation and supervision
    - Development of technical supervision protocols
    - Establishment of logistics and finances for supervision activities
    - Training of preceptors in precepting skills and reproductive health technologies
    - Training of provincial trainers in family planning and reproductive health and in training methodologies
    - Training and updating service providers
    - Reinforcement of family planning and reproductive health training in preservice institutions

5. Family planning and reproductive health service protocols should be prepared based on the national service policy and standards. These should be widely disseminated to all service providers who should also be trained in their use.

6. Clinical family planning training curricula should be prepared based on the service policy and standards and protocols. Curricula and modules currently prepared by the PBEF and ABPF should be used as a basis.

5 BREASTFEEDING: THE SITUATION IN BENIN

by Julienne Ngo Som

5.1 Introduction

Two of the key objectives of USAID for population and health over this decade include the reduction of child and maternal mortality by one-third and one-half, respectively. USAID's Center for Population, Health, and Nutrition (PHN) has identified the following priority program components to achieve these objectives: (1) family planning and related services; (2) safe pregnancy services, improvement of women's nutritional status, and the promotion of breastfeeding; and (3) the prevention and management of HIV/STDs. One of the elements in family planning programs to be addressed includes the availability of a wide range of contraceptive methods, including breastfeeding.

At the 1988 Bellagio Conference in Italy, it was unanimously agreed that women who exclusively breastfeed their babies for the first six months have only a two percent chance of becoming pregnant (Perez, 1992). IPPF acknowledges the important role of breastfeeding in birth spacing. In many developing countries today, breastfeeding prevents more births within a given period than any other method of family planning (Kleinman and Senanayeke, 1984).

Contraceptive effects and maximum nutritional benefits are best achieved when breastfeeding is practiced according to certain standards established by the international community. WHO/UNICEF (1989) have issued "Ten Steps to Successful Breastfeeding." The Institute for International Studies in Natural Family Planning (1990) has also issued recommended behavior for successful breastfeeding. USAID has developed a "Breastfeeding for Child Survival Strategy" (USAID, 1990). The assessment of the breastfeeding situation at the country level is the first step in developing a comprehensive breastfeeding promotion plan.

5.2 Scope of Work and Methodology

This assessment has been requested by REDSO/WCA and USAID/Benin. Specific objectives were to (1) review the current breastfeeding practices in Benin; (2) assess the policies and programs in support of breastfeeding; (3) assess the extent to which breastfeeding is proposed to the Beninese as an alternative method of family planning; (4) identify supportive factors and constraints to optimal breastfeeding in the country; and (5) make recommendations for the promotion of breastfeeding in Benin as a strategy for birth spacing and, therefore, for maternal and child survival.

Activities to accomplish this work included (1) a review of literature; (2) interviews with government, NGOs, and donor agency officials; health, social, and community workers; and women's groups; and (3) site visits to maternities and social welfare, health, and rural development centers.

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5.3 Country Background

5.3.1 Maternal and Child Mortality and Morbidity

The poor health status of mothers and children in Benin results from the high prevalence of tropical communicable diseases, poor nutrition, and a high fertility rate. The leading causes of morbidity and mortality in children are malaria, acute respiratory infections, diarrhea, measles, and malnutrition. According to the World Bank's 1993 World Development Report, infant and under-five mortality rates are estimated at 111 and 172 per 1000, respectively; maternal mortality is 800 per 100,000 live births.

5.3.2 Nutritional Status of Children and Women of Childbearing Age

In Benin, 35-40 percent of children ages 0-3 years suffer from protein-energy malnutrition and 10-17 percent of the babies are born with low birth weight (Hessou, 1994). In some areas, almost 23 percent of women have a low body mass index. Iron deficiency is found in 52 percent of the children age six months to two years and in 45 percent of pregnant women. Vitamin A deficiency is a public health problem in the northern part of the country. Iodine deficiency is endemic in certain areas of the north. The prevalence of goiter ranges from 15-61 percent, and it is highest among girls (Hessou, 1994).

The determinants of the poor nutritional status of Beninese children are mothers' ignorance about the nutritional needs of the child, household food insecurity, weaning age, and the child's sex (Batawila, 1990). Poverty and ignorance are the principal determinants of the nutritional status of women in Benin.

5.4 Breastfeeding Practices in Benin

5.4.1 Current Breastfeeding Practices

It is generally believed that all Beninese children are breastfed; however, there are no representative data to support this belief. The only reliable study on breastfeeding practices in Benin is a thesis conducted at the University of Benin (Ekanmian, 1994). The sample included 500 nursing mothers and 107 health workers randomly selected throughout the country. Based on the study and on some information gathered during field visits, the current breastfeeding practices could be summarized as follows: the prevalence of breastfeeding in Benin averages 77.6 percent; it is higher in rural areas (93.7 percent) than in the cities (53.5 percent). Only seven percent of babies are breastfed exclusively during the first 4-6 months. In urban areas, 45.5 percent of the babies are given breast milk plus infant formula. The duration of breastfeeding ranges from 18-24 months. Complementary food is introduced at three months.

The determinants of the prevalence of breastfeeding Benin are the age of the mother, her level of education, civil status, and religious affiliation, and the place of delivery. See Table 5.

TABLE 5

COMPARISON OF BREASTFEEDING PREVALENCES			
AGE (years)		RELIGION	
<20	89%	Christians	68.2%
20-30	75%	Muslims	86.7%
>30	76%	Animists	93.0%
LEVEL OF EDUCATION		OCCUPATION	
None	91.5%	Office workers	26.7%
Primary	72.5%	Small traders	80.9%
Secondary	53.8%	Housewives	91.6%
University	35.3%	Laborers	55.6%
CIVIL STATUS		PLACE OF DELIVERY	
Married	78.6%	CNHU	42.2%
Single	60.0%	CHD	66.6%
Widow	66.7%	CSSP	92.3%
Monogamic	73.5%	CCS	94.4%
Polygamic	84.6%	Home	93.9%

5.4.2 Knowledge, Attitudes, and Practices of Mothers and Health Personnel

Approximately 97 percent of Beninese mothers recognize that breastfeeding promotes good health in children; only 58.6 percent, however, initiate breastfeeding soon after delivery. Initiation is usually delayed 1-3 days after birth. The reasons for delay include lack of breast milk secretion (65.0 percent); mother and baby are separated (13.3 percent); and Cesarean operation (9.8 percent). The introduction of other liquids before breast milk and throughout infancy is almost universal in Benin; 92.4 percent of mothers give other liquids because they think babies are thirsty or mother's milk is not sufficient (49.8 percent). Up to 21.8 percent of the women discard colostrum for the following reasons: it is bad milk (68.8 percent); it is useless (7.3 percent); they are instructed not to use it (11.9 percent); and mother and child separation (13.9 percent).

In Benin, 42.2 percent of health workers do not know that breastfeeding should start within half an hour following delivery. In addition, 72.5 percent recommend liquids, such as plain and sweet water, and solutions of herbs, roots, and spices. However, 85.3 percent of the health workers educate mothers about the importance of breastfeeding.

5.5 Breastfeeding Policies and Support

5.5.1 National Policy and Legislation Affecting Breastfeeding in Benin

A national breastfeeding policy for the protection, encouragement, and promotion of breastfeeding has been adopted by the Benin government (MSP, 1992). A national technical committee has been set up for the follow-up of breastfeeding activities. The policy is being implemented with the assistance of UNICEF through its Baby Friendly Hospital (BFH) initiative. Breastfeeding is a key strategy in the newly formulated National Action Plan for Food and Nutrition (PANAN). Breastfeeding is mentioned in other MSP child survival programs, such as diarrheal disease control (CDD) and EPI.

A national code for the marketing of breast milk substitutes in Benin has been drafted. Meanwhile, the MSP has issued instructions forbidding the sale and advertisement of infant formulas in health establishments.

The Beninese Labor Code provides 14 weeks of paid maternity leave and allocates breastfeeding breaks for nursing mothers.

5.5.2 Breastfeeding Promotion Efforts

UNICEF is the main actor in breastfeeding promotion in Benin. A vast breastfeeding campaign through BHF activities is being undertaken in collaboration with the MSP. So far 33 health establishments in the six regions have been targeted to become BFHs. Their personnel have been trained. Approximately 10 health facilities already fulfill UNICEF's conditions to become BFHs.

A national NGO for the promotion of breastfeeding activities in Benin has been formed recently, IBFAN-Benin, which is the national equivalent of the International Baby Food Action Network. ABPF has chosen breastfeeding as a topic for its IEC activities in July 1994. Information on breastfeeding has been broadcast in local languages through rural radio.

Breastfeeding is a nutrition education theme that is carried throughout the country by social welfare centers (CPSs), food and applied nutrition posts (PANAN), maternities, health centers, and local communities. These activities are jointly carried out by the Ministries of Labor, Employment , and Social Affairs, Rural Development, and Health.

5.5.3 Women's Work and Support Groups

Women make up approximately 35 percent of the Beninese labor force. They spend long hours in domestic work. Many of them are engaged in agricultural production, small trading, and street sales. A small percentage are employed in government or private offices. They are engaged for a large proportion of the day, and this may interfere with optimum breastfeeding.

There is a limited effort to support child care. No facilities are available in government or private work places to allow nursing mothers to breastfeed at work. However, there are many

women's groups throughout the country. The Regional Center for Action for Rural Development has created women's groups throughout the six national departments. One of them has a opened a rural day care center at Detepka village in the Zou region where approximately 50 children ages 0-4 years are taken care of while their mothers are busy in the farms. There are also several women's NGOs in Benin that could form breastfeeding support groups.

Within the framework of the BFH initiative, breastfeeding support groups are being created both at the health facility and community levels. So far six community-based breastfeeding support groups have been formed and are operational.

5.5.4 Training and Research Programs Related to Breastfeeding

The preservice training of health personnel is carried out in the following schools: the National Medico-social Institute, the Faculty of Health Sciences, the School of Nurses and Assistant Nurses, and the WHO regional Institute for Health. Nutrition topics with chapters on breastfeeding are included in the training programs. The curricula, however, have not yet been revised to include updated information on optimum breastfeeding and its relation to child spacing. Health workers learn more about nutrition and breastfeeding during in-service training through workshops and seminars. Under the framework of the MCH/FP/Nutrition program of the MSP, a series of three-week training workshops are under way with the support of the World Bank. Breastfeeding is included in the various nutrition topics.

Training and research activities related to breastfeeding are still very limited. One research project in this area is a student's thesis (Ekanmian, 1994) from the Faculty of Health Sciences at the National University of Benin. Some aspects of breastfeeding practices are also examined during community nutrition surveys carried out by the Regional Center for Health Development (CREDESA).

5.5.5 Financial Support for Breastfeeding Promotion

There is no provision in the government budget to support breastfeeding activities. UNICEF has been the main donor for the promotion of breastfeeding through the BFH initiative. The newly created IBFAN-Benin is planning to engage in fund-raising operations to support its breastfeeding promotion activities.

5.5.6 Information, Education, and Communication Efforts

On many occasions, breastfeeding has been the main theme of communication efforts that are part of nutrition education campaigns. Breastfeeding messages are transmitted to women through several channels.

Communication in Local Languages. Breastfeeding is selected as a theme during specific nutrition education sessions carried out in CPSs, maternities, health centers, village health

units, or community-based women's groups. The aspects of breastfeeding developed during these sessions deal mainly with its nutritional value and advantages as compared to formula.

Songs and Slogans. Breastfeeding messages have been developed into songs and slogans in local languages. One example of a slogan is "Breast milk is very important because it contains the four food groups." A song goes, "Breast milk is very nutritious for the baby. It allows him to grow and develop well."

Posters. Posters targeting health and social workers are found in many maternities and pediatric units. They have been developed within the BFH framework and convey messages on the "Ten Conditions for Successful Breastfeeding" and policies to be implemented within the health facility. The CHD of Ouémé in Porto Novo, for instance, has developed posters with written messages on the breastfeeding policies of the Ouémé Regional Hospital. Clearly defined breastfeeding protocols are found in the following MCH/FP sectors: prenatal consultation, family planning, Cesarean operations, delivery rooms, and pediatrics.

Pictures. Pictures of breastfeeding mothers are found on the walls of some maternities.

Rural Radio Messages in Local Languages. ABPF has recently chosen breastfeeding as a theme for its family planning IEC. The messages were translated into local languages and broadcast through the rural radio.

Films. At the launching of BFH activities in Benin, a film was made about the advantages of breastfeeding and projected at various maternities. Another film is currently being made on the activities of six community-based breastfeeding support groups.

5.6 Breastfeeding as a Family Planning Method in Benin

Generally, breastfeeding is not being proposed to Beninese women as an alternative family planning method. Only one maternity (CHD/Ouémé) has a clear breastfeeding policy for its planning family unit; during family planning counseling, breastfeeding is proposed to women as another method of child spacing. ABPF has developed one rural radio message on breastfeeding as a family planning method, but breastfeeding is not being proposed to women attending ABPF family planning clinics.

Breastfeeding as a birth spacing method has not been integrated into family planning activities. Family planning officials in Benin recognize that IPPF recommends that breastfeeding be proposed to women as an alternative child spacing method. Beninese health and social workers involved in family planning promotional activities also acknowledge that breastfeeding-related abstinence was practiced in the past. After delivery, the woman was separated from her husband. It was culturally forbidden to have sex while breastfeeding based on the belief that sperm might contaminate breast milk and cause illness in the child. This practice indirectly contributed to an increase in the interval between births.

5.7 Conclusions

Current breastfeeding practices in Benin do not meet the international community's standards for optimum benefits in child survival and family planning: up to 27 percent of mothers delay the initiation of breastfeeding from 24 hours up to three days; exclusive breastfeeding during the first 4-6 months is rare and other liquids are given to the baby from birth; colostrum is still considered "bad milk" and is discarded in many cases; the bottle feeding rate is relatively high in urban areas; supplementation starts very early with thin maize porridge; and the weaning age is declining. There are, however, several supportive factors for the promotion of breastfeeding in Benin, despite the constraints.

5.7.1 Supportive Factors for the Promotion of Breastfeeding in Benin

The following are supportive factors for the promotion of breastfeeding in Benin:

- There is widespread acceptance of breastfeeding.
- PANAN includes breastfeeding as one of its strategies.
- A national breastfeeding policy is already operational, and a national code for the marketing of breast milk substitutes has been formulated.
- The Beninese labor code provides 14 weeks maternity leave with salary.
- A national technical committee on breastfeeding has been set up and is operational.
- A local NGO for the promotion of breastfeeding activities at the community level, IBFAN-Benin, has been recently created.
- Numerous opportunities exist to reach a large number of women through health centers, social welfare centers, village health centers, food and applied nutrition posts, community-based women's groups, and NGOs.
- The health system is based on the Bamako Initiative with a trend toward integration MCH/FP/nutrition activities.
- There is strong involvement of donor agencies and NGOs in the promotion of breastfeeding (UNICEF), nutrition, food security, and income-generating activities (FAO, the World Food Programme, CRS, and Terre des Hommes).

5.7.2 Constraints

The following are constraints to optimal breastfeeding and its promotion in Benin:

- There is a widespread belief that newborn babies are thirsty and they need water and other liquids.
- Women's heavy work load interferes with breastfeeding.
- There is a lack of representative data on breastfeeding practices.
- There is a lack of financial allocations from the state budget for breastfeeding promotion activities.

- Health and social workers are inadequately trained in optimum breastfeeding practices.
- Insufficient emphasis is put on the nutritional status of pregnant and lactating mothers.

5.8 Recommendations

5.8.1 General Recommendations to Support Breastfeeding in Benin

Training.

1. Curricula for the training of health and social workers should be revised to include updated information on breastfeeding.

2. A series of training activities on optimal breastfeeding involving representatives from MTEAS, MDRAC, MSP, and national NGOs (ABPF, IBFAN-Benin) engaged in MCH/FP/nutrition promotion activities at regional, district, and community levels should be organized. Ignorance about breastfeeding (based on current international standards) is still widespread.

Research, Monitoring, and Evaluation.

3. Nationally representative breastfeeding data should be collected along with information on breastfeeding-related abstinence and other traditional family planning methods; a better understanding of attitudes and practices is needed to facilitate the development of communication and counseling messages.

4. Health/family planning/nutrition information should include breastfeeding indicators; breastfeeding information should be analyzed and interpreted in order to determine the impact of intervention programs.

Integration of MCH Activities.

5. Program managers of family planning, EPI, acute respiratory illness (ARI), and CDD/ORT should place emphasis on effective breastfeeding integration and promotion into their respective activities through training, IEC, and social mobilization of women's groups.

6. Proper weaning foods and better nutrition during pregnancy and lactation should be promoted through training, IEC, and income-generation activities.

5.8.2 Recommendations for USAID/Benin

7. USAID/Benin should include a breastfeeding/maternal nutrition component in its population/family planning program. In close collaboration with MTEAS, MDRAC, MSP, ABPF, and IBFAN-Benin, USAID/Benin should undertake the following:

    - Provide its leadership in the organization and conduct of a survey on breastfeeding practices in Benin as part of a demographic and health survey (DHS).
    - Provide assistance and guidance for the training of trainers at regional, district, and community levels.
    - Help promote breastfeeding, weaning food, and maternal nutrition activities through IEC.
    - Set up a breastfeeding information system for the collection, analysis, and evaluation of breastfeeding interventions.

6 FAMILY PLANNING LOGISTICS

by Gerald Moore

6.1 Objective

The objective of the logistics evaluation was, as part of a POPTECH consultancy team to USAID/Benin, to (1) examine the present system(s) of family planning logistics existing in the country, (2) assess their relative effectiveness in providing for the country's needs, taking into account the stated policy and objectives of the government toward family planning, and (3) suggest or recommend any measures that might strengthen or improve the present system(s) and make them more likely to be able to cope with national needs and achieve stated FP targets.

6.2 Toward a National Family Planning Policy

6.2.1 Consequences of Unrestrained Population Growth

It is recognized that the present total fertility rate (TFR) of 6.8 and an annual population increase of around three percent, combined with a stagnating or even declining GNP/capita of US$ 380/annum will only lead to a continuation and even increase of social misery and poverty, an unacceptably high maternal and child morbidity and mortality, and a serious obstacle to national economic development.

By the year 2000, without a more effective family planning intervention, it is estimated that the population of Benin will increase by another million, and by the year 2023, it is expected that the present population of five million will double.

During this period, the majority of the population will be young (more than 50 percent below the age of 15), and consequently there will be a heavy burden on the productively active population and a limitation on the capacity for savings and investment necessary for sound economic and social development (République du Bénin, 1993).

Furthermore, with a continuing high population increase, there is little likelihood of a reduction in the excessively high rate of maternal mortality (800 per 100,000 live births), the infant mortality (89 per 1000), and the mortality of children under age five (149 per 1000), as well as the numbers of induced abortions, said to be up to 20 percent of all pregnancies and contributing to approximately 33 percent of all maternal deaths (MPRE, 1993b and Republic of Benin, 1994b).

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6.2.2 Population and Family Health Targets

Recognizing the demographic, health, social, and economic problems resulting from unrestrained population growth, the Government of Benin proposes to undertake a series of measures designed to strengthen the national family planning program, including (1) awareness raising of the population to family planning, (2) assurance of access and availability, at affordable prices, of methods of family planning in health centers and clinics to couples and individuals wishing to make choices concerning child spacing, (3) improving and extending family planning services throughout the country, and (4) setting population growth targets (République du Bénin, 1993 and Republic of Benin, 1994b).

6.2.3 Maternal and Child Mortality

The Government of Benin also intends to reduce the mortality rate of children under five from 150 per 1000 in 1990 to 100 per 1000 by the year 2000 and the maternal mortality rate from eight per 1000 to four per 1000 over the same period (Republic of Benin, 1994b).

6.2.4 Family Planning Targets

Though there appears to be no clear government policy on the subject, various family planning- and health-related targets for Benin have been put forward at different times and by different proponents as follows:

- Increase the number of family planning acceptors by 10,000 a year (MSP/Cabinet, 1991 and Aplogan, 1994c).
- Increase the contraceptive prevalence rate to 5-10 percent of women of reproductive age (WRA) by the year 2000. (UNFPA, 1992–1994).
- Increase the overall contraceptive prevalence rate to four percent and that of women in priority zones (urban and semi-urban areas) to nine percent by the year 2000 (CNRHP/MPRE, 1994).
- Reduce by 75 percent the number of undesired pregnancies (Aplogan, 1994c).
- Reduce by 50 percent the number of induced abortions (Aplogan, 1994c).

6.3 Contraceptive Usage

6.3.1 Women of Reproductive Age

In 1993 there were an estimated 1,095,000 WRA in 1993 in Benin out of a total population of 5,068,004, of which around 74 percent live in the rural areas. At an expected average annual increase rate of three percent, this will be 1.12 million or 21.5 percent WRA out of a population of 5.22 million in 1994 (MSP, 1994).

However, other reports (UNICEF, UNFPA, and the National Program on Maternal and Child Health, MSP, 1991) have estimated that the numbers of women of reproductive age represent 24-25 percent of the total population, which would give a figure of 1.25 to 1.3 million WRA. The difference is important when it comes to planning for FP supplies and services.

6.3.2 Supplies Planning

The lack of adequate planning for supplies to meet the potential demand (see Appendix D-1) may have contributed to a less than active promotion of family planning in government health/FP services. Though family planning items may be found in most health units, quantities kept in stock are often quite low.

This situation may be the result of relatively low stocks held in Cotonou, which reflects upon the estimates of needs and orders placed with UNFPA, the government's main supplier. The estimates have tended to be very modest in recent years and not representative of the country's real needs. Thus the cycle reinforces itself: Low stocks in the central store, low stocks in the health units, low level of FP supplies to potential acceptors, low movement of stocks, and thus low level of requests for more supplies to UNFPA.

In some health units, family planning in Benin may not receive the attention and emphasis it does in other countries of the region, e.g., Mali, where there is active management and promotion of FP down to the lowest level of the health care system.

For all these reasons, it is likely that the CPR in Benin among WRA was more likely one percent than two percent in 1994. An analysis of acceptors compared with population target groups in two health centers in July 1994 (field visits Ouémé and Mono departments), while not attempting to arrive at national figures, tended to show that the lower figure was probably more accurate. The figure one percent also seems to be borne out by the supplies currently ordered by the Ministry of Health from UNFPA and by ABPF from IPPF (see Appendix D-1).

6.3.3 Contraceptive Prevalence Rate

The base data—e.g., actual supplies consumed, established method mix, etc.—appear to confirm that the level of contraceptive acceptance is relatively low in Benin, at only one percent, despite the fact that approximately 46 percent of married women are said to be aware of modern contraceptive methods (UNFPA, 1992a). (UNFPA figures for 1992 give a prevalence rate of three percent; however, in light of all recent data, this is believed to be excessively high.)

Other statistics emanating from clinic records appear to place the CPR at a higher level, 2-3 percent. However, this higher figure appears to be based on the system of counting acceptors every time they appear at a clinic to renew their prescriptions for pills (four times a year) or injectables (six times a year). It is therefore likely to be overstated, and the acceptance rate is more likely to be around one percent. World Bank figures place it even lower, at 0.5 percent, and the MSP placed it between 0.7-1.0 percent in 1991.

Before measures can be suggested to improve or increase the low contraceptive prevalence rate, the reasons for the low level of acceptance must first be ascertained. Some reasons given for this comparatively low CPR have been given:

- Absence of a clear national population policy, in particular, one focusing on the possibility of limiting the number of births rather just child spacing

- Relatively low levels of FP service, which has tended to be reactive rather than proactive

- The fact that access to public health facilities is limited to about 50 percent of the total population (UNFPA estimates)

- Socio-cultural obstacles, in particular the dominant role of the man/husband in deciding the number of children, which tends to be unrestrained, the effect of polygamy, etc. It is reported (ABPF interviews) that many women are still apprehensive about the use of contraceptives, fearing sterility, cancers, and other health hazards.

- Absence of effective IEC activities (Aplogan, 1994c)

In its 1992–1994 Country Assistance Report, UNFPA describes the reasons for the relatively low impact of its previous population assistance program as follows: "contraceptive prevalence remains low....the implementation of the project was affected by the lack of management resulting in irregular supply of contraceptives, the insufficient commitment of the staff, the lack of regular technical backstopping, the absence of IEC strategies, and the weakness of relationships with other national bodies involved in FP, especially NGOs."

These obstacles can be overcome by relevant IEC programs, as well as a more determined national will to reach sound population goals through modern FP methods. However, the questions to be addressed in this assignment are the following: (1) To what extent are logistics, or lack thereof, the reason for the poor level of contraceptive prevalence? (2) Can strengthening logistics play a role in improving the low CPR? (3) If so, how?

6.4 Situation Analysis

6.4.1 Findings

A recent Situation Analysis (May 1994) of maternal and child health clinics in Benin revealed some interesting facts and seemed to confirm earlier assessments of the family planning situation by UNFPA, the World Bank, and others:

- Only 16 percent of health personnel had received training in FP logistics management.

- Very little IEC material was available, and what little was available was not widely used (79 percent of MCH patients were not being informed about FP).

- A relatively high number of contraceptive products were available, particularly the injectable (in stock in 87 percent of health units); the low-dose combined pill (in stock in 74 percent of units), condoms (82 percent of units), however, the progestin-only mini-pill was available in only 27 percent of units. IUDs were available in 55 percent, and foaming tablets in 62 percent of health units.

- Only 60 percent of health units had any basis for a system of contraceptive management or suitable storage capacity. This lack was probably a main cause of stock-outs in 30 percent of the health units over the preceding three months.

- In the majority of health units there was no written documentation giving guidelines for the management of FP activities.

- Only 64 percent of the health units had usable FP recorded data. Only 14 percent used their data to strengthen their ordering system to prevent stock-outs.

- Seventy-six percent of the health units had not received sufficient supervisory visits during the preceding three months.

According to the Situation Analysis, in 1993 the 59 health units visited had given service to 13,643 old acceptors and 4,718 new acceptors, or an average of 231 old acceptors and 80 new acceptors per health unit.

In comparison, in 1993, the numbers of old and new acceptors receiving service in the two clinics of the ABPF, the private FP organization in Benin affiliated with IPPF, were 6,783 and 3,137 respectively, or an average of 3,391/clinic and 1,568/clinic.

The ABFP estimates that there were a total of 7800 new and 24,000 existing acceptors nationwide in 1993 (from ABPF clinics and Cliniques Intégrées [CIs], government health center family planning units) (ABPF 1993). (As mentioned above, this figure is believed to be considerably overstated due to the practice of counting acceptors every time they enter a FP clinic for further supplies, which is normally four to six times a year). However, the above comparison serves to show the difference in acceptor level between a clinic with motivated staff and relatively good logistics management (ABPF) and those less well served (CI).

The actual figure in 1994 of women contraceptive acceptors is probably in the region of 15-16,000 (see Appendix D-1).

6.4.2 Conclusions

These figures, and the findings of the Situation Analysis above, tend to reinforce the conclusion that, although some stocks of contraceptives are to be found in most Cliniques Intégrées, they are not being used to any large extent, certainly far less than they are being used in the ABPF's clinics, and that this is the main reason for the low CPR in the country.

This leads to the conclusion that the difference in contraceptives usage probably is due to the degree that FP is actively promoted in the Cliniques Intégrées, for FP client charges are the same in both types of clinic. There appears to be only a passive type of FP service in many CIs, with a low level of acceptors and virtually no system of management or data recording.

The low CPR in government clinics could also be due to a generally low level of supplies and stocks. FP service providers are apprehensive about promoting FP to many clients for fear the stocks will quickly run out and FP would have to be discontinued. The low usage would reflect a low level of orders to Cotonou; this would then lead to a low level of orders to suppliers, and thus the low supply-usage level would continue.

The system of recording and reporting acceptors in CIs, both new and existing, appears to be inaccurate and may not reflect the actual situation in department and community health centers. There is a lack of stock control and inventory management which leads to frequent stock-outs and does not give adequate management information to the MSP headquarters in Cotonou for supplies planning.

There is, therefore, no sound basis for calculating supply needs from the present recorded usage figures of CIs, and in this situation, over- and under-ordering would be a common occurrence, as can be seen in Appendix D-1.

The recording system of the ABPF appears to be more realistic. However, even with this system, new acceptors may be counted more than once a year. Furthermore, it appears likely that a considerable number of acceptors stop using contraceptives after a time, which again might account for some of the discrepancy between the numbers of acceptors recorded and the low actual usage of contraceptives. This factor may be more important in Benin than in other countries. ABPF service providers report drop-outs as being a common occurrence in the ABPF clinics (interview with midwife providers at the ABPF clinic in Cotonou).

6.5 FP Service Infrastructure

6.5.1 ABPF

The government Cliniques Intégrées are staffed with trained personnel and provided with equipment and contraceptives through an ongoing UNFPA support program (see Appendix D-2,3). In addition to the CIs, there are now three (two in 1993) urban clinics operated by the ABPF that also provide FP counseling and information services to the public through ABPF's six branches, one in each department.

Until 1993, ABPF was the main distributor of contraceptives and related materials to the CIs. Since then, under an agreement with the Ministry of Health, all but 80 of the CIs have been supplied by the MSP FP unit, the PBEF, which is presently situated under the National Directorate of Health Protection but which will soon be relocated to a new directorate that has been created, the Directorate of Family Health.

The ABPF has its own three clinics plus the 80 CIs to supply, which it does from its depots in Cotonou and its five other branches on a sale and refund basis. In addition, the ABPF carried out a CBD program in Cotonou using condoms and spermicides (mousse and foaming tablets) under a SEATS project. ABPF is mainly supplied with contraceptives by IPPF in London, USAID under the SEATS program, and PBEF for the CIs.

6.5.2 PBEF and UNFPA

The PBEF, which is still a "project" rather than a full-scale department or operating unit, is supported technically and materially by UNFPA, which supplies contraceptives and other FP materials, training, and operations research under a comprehensive population program (1992–94). The goals of the US$2.7 million PBEF/UNFPA program include increasing the CPR to 7.5 percent by 1994. For the reasons mentioned above, this rate has not likely been achieved. This conclusion is also deduced by the amount of contraceptives imported by UNFPA (and the ABPF), which indicate a CPR of one percent in 1994.

The PBEF program appears to have trained considerable numbers of health personnel in FP services; however, so far it does not appear to have touched the subject of logistics management. The PBEF is itself seriously understaffed. The system of distribution is non-existent. Relatively small stocks are kept at a central store in Cotonou, and department officials are expected to come to Cotonou and draw supplies whenever their stocks run down. In some cases, the CI staff members may also come in and pick up supplies directly.

There appears to be, however, no system in which the PBEF can accurately forecast needs and therefore arrange to have sufficient stocks. It is also difficult for the departments to arrange to visit Cotonou whenever the CIs run down their stocks. Sometimes visits are limited by lack of funds for transport. It is also most uneconomical for each department to have to pick up its own supplies rather than have supplies delivered on one tour by a centrally located vehicle. Furthermore, once supplies reach the department directorate stores, individual health centers are supposed to arrange their own transport to pick up their own supplies, which at times of scarcity of vehicles and fuel can be difficult and lead to stock-outs.

In many cases still, the ABPF is called upon to replenish stocks at CIs from its branches, which it does so on a supply now/pay later when sold basis.

Very little feedback on usage or future needs is received by the PBEF main store; orders are placed with UNFPA as stocks dwindle, on a sporadic basis. Not only does this risk stock-outs, but it presents UNFPA with an inefficient ordering pattern, having to deal with several small orders instead of a large annual one.

6.5.3 Conclusions

Supplies. The present system of ordering supplies appears to be haphazard, ad hoc, and not based on a well-planned system. This seems to be the case at all levels—CI, department, and the center in Cotonou, the PBEF. Units appear to place orders when they start to run out of stock, and this is frequently too late to avoid stock-outs.

Orders passed to UNFPA by the PBEF are uneconomic; only one large order per annum should be made. This should be based not only on present consumption but on estimated future needs, taking into account CPR targets, training, IEC, and so forth.

UNFPA and IPPF appear to be able to supply most contraceptive needs (orals, injectables, spermicides, IUDs, condoms) without much difficulty and within country budgets (see Appendix D-4, 5, 6). When quantities increase, it is possible that supplies from other sources may be called for; however, for the immediate future, this does not appear to be a requirement.

Distribution. The present system of distribution operated by the PBEF does not appear to be working effectively. It is very much a "pull" system, rather than a "push" system. In fact, there is no effective distribution system at all. The PBEF acts more like a wholesaler, waiting for its clients to call upon it. It has none of its own transport. It carries out little or no management supervision in the field.

The ABPF, on the other hand, appears to have an effective distribution system with its own vehicles and own regional or department stores. However, its distribution functions are greatly reduced, supplying only its three clinics and the 80 CIs of the Ministry of Health.

6.6 Cost Recovery

6.6.1 Findings

The system of financial management and cost recovery for contraceptive services appears precarious. Department directorates and clinics can draw initial supplies from the PBEF store without payment. They are supposed to pay for them after usage, according to a set fee schedule: orals 100 FCFA/cycle, injectables 500 FCFA/1, IUDs 400 FCFA/unit, foaming tabs and spermicides 200 FCFA/tube, condoms 25 FCFA/2, etc. However, how much of these client fees is being retained by health units and how much is returned to the PBEF is not known.

The PBEF reports 12 million FCFA in the bank so far, approximately US$23,000, so the system must be working to some extent, although in a national health policy document, it is reported that some 25 percent of health units are not recovering their costs. The objective is to reduce this figure to 10 percent by 1998.

6.6.2 Conclusions

The client payments presently being levied for the different types of contraceptives in both CI and ABPF clinics do not cover the full costs of the contraceptives (with the possible exception of injectables). Payments appear to be set at a level acceptable to most acceptors, particularly in the urban areas, however, they may be an obstacle to contraceptive prevalence in rural areas, particularly to the poorer potential acceptors.

Funds received from client charges appear to be banked by the PBEF or held at health units without a clear vision of how such funds should be used (e.g., improvements to storage conditions, training, repurchase of contraceptives, etc.).

There would appear to be a need for financial management guidelines and appropriate training at all levels in the health/FP system. It must be clarified the proportion of client fees to be held by the health units, directorates of departments, etc., and how much returned to the MSP. It should also be clarified how such funds should be utilized.

6.7 Logistics: Overall Conclusions

It would appear that one of the reasons for the low CPR in the country is the absence of an effective government (MSP) FP logistics system and management thereof, including the following:

- Lack of knowledge about the country's present and future needs for contraceptives
- Unrealistic CPR reporting due to inaccurate data or absence of a data recording system
- Absence of efficient supplies or inventory management at all levels; weak planning, forecasting, or budgeting functions
- Absence of an effective distribution system
- Lack of training in logistics management by headquarters staff and health workers in FP units
- Precarious system of cost recovery and financial management; lack of clear direction to which purposes the funds collected should be used; lack of research into the most effective and acceptable price levels for clients

In effect, the MSP, through the PBEF, has taken over most of the FP supplies and the logistics function for the country (from ABPF) without having the necessary systems, personnel, or training in place. This has led [illegible] present chaotic, inefficient, and insufficient situation. Unless this vital function is im[illegible]d, there is little chance, even with the best IEC campaign, that the levels of FP usage will increase significantly.

6.8 Options to Strengthen the FP Logistics System

In the following discussions, options are considered that would have the effect, short-term and long-term, of strengthening the national system of contraceptive logistics and management.

6.8.1 Management

The most obvious deficiency in the present system of FP logistics is that of management at all levels and in all aspects of logistics, e.g., supplies planning, assessment of needs, inventory control, distribution, management information, supervision and control, and financial management.

It would be appropriate, therefore, to consider whether placing the management of FP logistics elsewhere than its present location in the MSP/PBEF would be desirable.

Centrale d'Achat. One option to strengthen FP logistics management might be to take this function from the MSP/PBEF and place it with the Centrale d'Achat, which manages the essential drugs program and which appears to have made rapid progress over the past five years, ensuring a wide distribution of essential drugs, dressings, and other medical supplies on a cost recovery basis.

There are obvious attractions in this option: The Centrale d'Achat has a spacious and well-organized store in Cotonou under the management of pharmacists. It appears to have successfully operated the national essential drugs program and achieved wide distribution. Its turnover continues to increase (735 million FCFA or up 63 percent from 1992 to 1993 and up 66 percent in the first quarter 1994 versus the same period 1993, at constant, i.e., pre-devaluation, rates of exchange). Its client base hovers around the 200/month mark. Approximately 90 percent of health units in the national system (about 360) are said to be customers of the Centrale d'Achat (see Appendix D-7).

However, the Centrale d'Achat does not have the one element that FP logistics needs: a "push" system of distribution. In fact, it has no system of its own distribution at all. Clients must come to Cotonou to pick up their supplies. Therefore, placing contraceptives with the Centrale d'Achat would not solve the present problem of distribution.

Furthermore, the Centrale d'Achat would charge an overhead for its handling and storage. This would have to be negotiated, but would likely be at least 15-20 percent of the value of the contraceptives (as for essential drugs). This would either have to be paid by health units on collection from the stores in Cotonou, which may not be acceptable to health units which receive them free at present and pay back later, or amounts would have to be claimed back from the health units after sales, a somewhat complicated procedure.

In either case, the price of contraceptives to the client would immediately increase by the amount of the Centrale d'Achat's charges, and health/FP units would be likely to increase their charges by a similar amount. This might lead to a reduction in the level of acceptors, particularly in the rural areas.

The Centrale d'Achat has been instructed by the government not to increase its prices of essential drugs after the 50 percent devaluation of the FCFA for at least a year. In order to keep its old prices and still carry on business, the Centrale d'Achat has requested compensation for its loss of profit, its devalued monetary assets, its stocks, as well as its new orders, at a value of approximately 1,600 million FCFA (approximately US$3 million). This support is apparently being guaranteed by France, Denmark, and Switzerland, as well as by a credit from the World Bank (see Appendix D-8).

However, this support is unlikely to be provided indefinitely. Once it ceases, the viability of the Centrale d'Achat depends on it being able to sell its products at the new, increased prices. It may take some time for the Centrale d'Achat to implement these, and during this period, its level of operations may suffer.

Placing the six or seven FP products with the Centrale d'Achat might also risk their being neglected among the 250-300 pharmaceutical and medical products that the Centrale d'Achat handles. Furthermore, it is not certain if UNFPA would deliver its contraceptives to a commercial, privately-run company. In addition, the decision by the MSP to allow contraceptives to be handled by the Centrale d'Achat is not yet certain.

For the above reasons, it may not be the best option to place the management (storage/handling/sale) of FP contraceptives with an organization such as the Centrale d'Achat.

The Beninese Association for the Promotion of the Family. The ABPF has been in the FP business in Benin since 1971. It has been the prime mover in promoting FP and providing FP services in the country up to and through the formation of the Ministry of Health's FP unit, the PBEF, in 1982.

Today, the ABPF possesses its own clinics, one in Cotonou, one in Ouémé, and a third in Parakou. It would eventually like to have a FP clinic in all six departments.

The ABPF delivers/sells contraceptives to its own clinics and to 80 of the 260 government health centers and clinics offering FP services. The government units are provided with contraceptives on a sell and return basis, i.e., they are initially given free and paid for when sold. The ABPF makes these deliveries from stores in its six branch offices or *Antennes*, one in each department. Each *Antenne* has a vehicle, and there are three placed at headquarters in Cotonou.

ABPF appears to have a well-functioning system of data recording, including data emanating from government clinics (ABPF annual reports and Appendix D-9) though there may be multiple counting of acceptors.

ABPF's assigned role, however, is to support the governmental FP system, not replace it. It should focus on awareness raising of the population, i.e., motivation, education, and information, referring potential users to government clinics when visits to ABPF clinics may not be feasible.

Therefore, the efforts of the ABPF concentrate on projects such as the following:

- Awareness raising and motivation of women of reproductive age
- Participation of men in FP
- Preparation of the young for family life
- Media and FP

In addition, the ABPF has been involved in a test CBD project in the Cotonou area using non-medicinal methods such as condoms, spermicides, and foaming tabs. This has been carried out in conjunction with The SEATS Project. Current funding runs out in April 1995.

The ABPF has long experience in FP and possesses a small, though relatively efficient, distribution system. With considerable injection of monetary resources, personnel, and equipment, it could, in time, handle the management of a country-wide FP logistics system. However, the activities of the ABPF may best rest in the private sector, offering an alternative to government clinics. Also, its awareness raising and motivation program should perhaps not be diluted by the demands of managing a national logistics system.

Finally, one of the main reasons the PBEF was placed in the Ministry of Health was so that the MSP could directly manage the national FP program and integrate FP into the MSP MCH system. Management of contraceptives logistics should be a key function of a national FP program. Taking the management out of the MSP would defeat this objective and may not be in the best interests of the country.

Recommendations. For the above reasons, it is recommended that the management of FP logistics in Benin be maintained, though reinforced and strengthened, at the level of the Ministry of Health, Directorate of Family Health. Functions of this management would be the following:

- Planning and assessment of needs
- Supervision
- Effective storage and distribution (the distribution function possibly through a third party for the next 3-5 years)
- Financial management, including the level of acceptor charges, cost recovery, and the use of funds
- Training in logistics management, headquarters and field workers (midwives, storekeepers)
- Development of an adequate management information system
- Coordination with donor, supply, and technical assistance agencies

Due to the relatively low level of staff and logistics training at all levels of the FP system, one option for raising standards of logistics management in a short (1-2 year) period of time would be to implement a Family Planning Logistics Management (FPLM) program with financial support from USAID. This type of program has been reasonably successful in other countries and is relatively cost effective and targeted. Approximate costs for a 1-2 year program: US$250,000.

FPLM focuses on management of FP logistics at the central, regional, and health unit levels, usually with a resident adviser placed within the central Ministry of Health MCH/FP unit; setting up appropriate management systems, including assessment of needs; carrying out training programs at all levels; and developing appropriate management information systems.

6.8.2 Supplies Planning/Assessment of Needs

Contraceptive Supplies. There is an urgent need for a more scientific and rational way of estimating contraceptive needs and ordering them from suppliers. Appendix D-1 could be a reasonable starting point for a new system of supplies planning and assessment of needs of contraceptives in Benin.

The analysis and projections assume a CPR in 1994 of 1.2 percent and 1.29 million WRA, which appear from all available data to be reasonably accurate.

According to the method mix presently in use in the country (Aplogan, 1994c and other data, e.g., ABFP) the approximate amounts of different contraceptives needed to cover the national needs can be calculated (see Appendix D-1, column 2).

The comparison of needs so calculated with supplies actually made for 1994 by UNFPA and ABPF (Column 3) show that:

- Orals were undersupplied (by 50 percent) of actual needs.
- Injectables were approximately correct.
- IUDs were oversupplied by a factor of three.
- Spermicides and foaming tabs were undersupplied.

The projections of annual needs on the basis of 1994 until the year 2000 (columns 4-9 of Appendix D-1) take into account a steady increase in the numbers of WRA in line with expected population growth, as well as a CPR increasing to meet the national target of four percent by the year 2000.

These can be said to be reasonable assumptions; however, the increase in CPR will also depend upon the success of other measures, such as IEC and training of FP providers, as well as the general acceptance of the current contraceptive charges.

It is important that orders for annual needs are passed to UNFPA in a rational manner, i.e., one order per annum containing full quantities and not in several small orders as from a wholesaler (see Appendix D-10). It is also important that sufficient lead time is given to UNFPA to deliver. At present, UNFPA needs at least 6-9 months after the supply order is placed for delivery to the destination.

Recommendations: Supply Sources. According to present and future levels of needs, assuming continued availability of contraceptives from the two main sources, UNFPA and IPPF, and given more rational supply planning, it does not appear necessary for other contraceptives (except for condoms, spermicides, and foaming tabs, etc. for social marketing

and CBD programs) to be supplied by other donor or aid agencies, at least not until the year 2000.

UNFPA and IPPF would appear to have the budget and the commitment to the national program to cover needs of orals, injectables, IUDs, and spermicides, at least for the next five years. However, clear planning of supply needs according to established criteria must be undertaken by FP logistics managers and such needs communicated to main supply sources in a rational manner with adequate lead time.

Cost of Supplies. The costs section of Appendix D-1 informs management what the projected needs for the years to 2000 will cost for purchasers, e.g., UNFPA, IPPF, or others. These costs are based upon actual purchase prices of the above agencies in 1993/94, factored upward in line with expected inflation over the years to 2000. This information may be useful to MSP, ABPF, and UNFPA planners in preparing budgets.

Expected Revenues/Cost Recovery. The revenues section of Appendix D-1 shows what financial returns can be expected by the sale of the total amounts of contraceptives provided at the present level of client charges for 1994/95, then factored upward by 2.5 percent a year to the year 2000. Thus, by the year 2000, revenues of approximately 138 million FCFA from the sale of contraceptives might be expected by the MSP and the ABPF combined, at a CPR of four percent, more if it is higher.

It is not known if the present level of charges for contraceptives is an obstacle or not to the uptake of contraceptive usage. It has been postulated that a price of 100/cycle, which means a constant outlay of 100 FCFA/month, might be a barrier to some women, particularly the poorer ones in the rural areas, and might be leading to a high rate of FP abandonment. The cost for an injection, 500 FCFA, giving two months of protection, is even higher per month, though this does not appear to be an obstacle for those who insist on this method, particularly in the urban areas.

There appears to be a need to carry out a study into the levels of charges and their acceptability to determine both the upside potential as well as the downside. The present levels do not cover even the base purchase price of the items, even at lowest world market levels. It might be possible to have higher charges in the urban areas, possibly according to a means test, and subsidized charges in the poorer, rural areas. This should be established by the study.

Distribution Costs. Distribution costs have been worked out to cover the costs of moving the total amounts of contraceptives estimated per annum from a central store in Cotonou to the end users throughout the country, i.e., department directorate stores, district and community health centers, and maternity units. (Note: These figures have been provided by the condom social marketing project, ABMS, supported by PSI. Other possible distribution agencies, e.g., ABPF, may have different figures.)

Appendix D-1, bottom line, shows that, as contraceptive supplies and revenues increase in line with expected usage, the costs of distributing these supplies to the nation's health units go down as a percentage, and projecting onward into the next century, it could be expected that

distribution costs would be reduced to 15–20 percent of sales, approaching a normal percentage for any commercial operation.

Whatever distribution system is used, however, it can safely be said that unless there is a system of "push" distribution for the contraceptives to ensure that every health unit offering FP services has a regular supply of needed items, the CPR is unlikely to move upward much from its present low level.

It may also be appropriate, with a more effective distribution system, to move from the present method of "supply first/pay later" under which the health unit appears to gain little or no revenue, to one where the distribution agency pays a certain price to the MSP on collection of the items and sells them on with an agreed mark-up to the health units. The health units would then sell them to the clients. Under this system, each player in line would make a certain profit, and each would have a motivation to ensure an efficient distribution/sale to clients. This system could be studied by a small task force of representatives of the MSP, UNFPA, and USAID.

Recommendations: Supply Planning. A new system of needs assessment should be adopted, based on current levels of WRA and method mix, and not on what is presently being supplied by the UNFPA and ABPF, and sound projections should be made for future needs based on these assessments. Such assessments will provide the basis for orders to supply agencies from 1995.

To calculate future needs more precisely, a computer-operated program, such as Cocoplan or NewCPT, as developed by The FPLM Project, might be used.

Recommendations: Distribution. It is recommended that a new system of distribution of contraceptives be implemented in the country, particularly for MSP/UNFPA supplies, based on a "push" rather than a "pull" system and on a regular delivery schedule to all major users. If adequate transport facilities do not exist in the MSP, a distribution contract should be made with another agency, e.g., ABMS or ABPF. Both of these agencies have the basics for a distribution system in the country; both are experienced in carrying contraceptives; both could also use the distribution function to carry out promotion and awareness-raising activities.

According to estimates from ABMS/PSI, which presently distributes and promotes the use of the Prudence condom in the country, distribution of the MSP's contraceptives nationwide would cost about 30 million FCFA (approximately US$57,000) in the first year of operation, 1995, rising to 39 million FCFA (US$74,000) by the year 2000.

These costs are primarily based on fuel needs, vehicles and maintenance, and personnel. Because some of the costs would be already covered under the regular distribution program, the costs to the MSP would only be a part of the true costs; in other words, distribution of the MSP's contraceptives would be subsidized by using either of these two agencies.

Because of the MSP's financial constraints and the urgent need to improve the present distribution system, it is recommended that USAID finance the majority of costs of distribution at least between 1995 and 1999. Costs are estimated at US$323,000 (ABMS/PSI figures). The MSP could possibly be asked to co-finance the distribution at 20 percent beginning in

1998 and increase 20 percent per annum to take over the full costs of distribution by the year 2003.

Another option would have a distribution agency purchase the contraceptives from the MSP for an agreed price and sell/distribute them to health units for an agreed mark-up. Health units would then sell the contraceptives to clients with a reasonable mark-up. This would mean that the MSP's revenues would be less, but distribution costs would be at least partially covered, and the health units would gain some profit (ABMS/PSI condom social marketing system, Appendix D-11). This option should be studied by a small MSP/UNFPA/USAID task force with the assistance of a distribution agency such as ABMS/PSI or ABPF.

Recommendations: Cost-Recovery and Client Charges. It is recommended that a study be carried out by the MSP with the assistance of external consultants of the level and acceptability of current FP client charges; whether these are now or will be an obstacle to FP prevalence; whether possibilities exist to adjust charges more in line with actual contraceptive costs and/or the ability of clients to pay and/or adapt charges to the levels of purchasing power of poorer groups, particularly in the rural areas; and to study the CPR and financial revenue consequences of making any changes thought appropriate.

It is recommended that this study be financed by USAID. Approximate cost: US$20,000 (2-3 weeks of a 2-3 person team, 1-2 local consultants, one external).

6.8.3 Storage and Inventory Control

The present situation regarding storage and inventory control of contraceptives in the MSP system appears to be grossly inadequate at all levels, central (Cotonou), department, and in the health centers themselves (Aplogan, 1993c, UNFPA reports, observations on field visits, July 1994). This observation does not include the ABPF, which appears to have a relatively well-functioning and efficient storage and inventory control system in operation.

Storage. To store the quantities of contraceptives needed according to the supply plan 1995–2000, space will have to be expanded at the central level in Cotonou, in the department stores, as well as in the individual health units (for health infrastructure and chain of supply please refer to Appendix D-9). At present, the typical storage place of contraceptives in health units is at the bottom of a filing cabinet with little regard for cleanliness, temperature, or security (field visits, July 1994, UNFPA reports). The central store of the PBEF in Cotonou shows several deficiencies in coping with national needs (space, ventilation, and recording).

Management forms only indicate amounts in stock and delivered. They do not provide for information on maximum and minimum stock levels or on levels to trigger new orders. The first-in/first-out principle does not appear to be in use.

Regarding storage space needs, 0.5 million cycles of oral contraceptives would need approximately 17 cubic meters of space; therefore, for FP needs of a client population of 45,000 a year (by 1998), storage space needs of oral contraceptives and condoms alone would be some 32 cubic meters. However, this represents the storage area for the two types of contraceptives alone. Approximately 50 percent must be added for aisles, handling, and

ventilation, which totals 48 cubic meters, and additional space will be needed for injectables, IUDs, and spermicides.

Stores should have good ventilation, with temperatures ranging 15-25 degrees centigrade, and must be protected from high humidity, insects, and rodents. Inventory management must operate on the first-in/first-out basis, or better, first expiring/first out, to avoid exceeding shelflives. This implies good principles of store management and record keeping.

Recommendations. It is recommended that the PBEF make a survey of stores at the central and department level and in the FP health units to determine their adequacy for contraceptive storage and to make improvements and/or extensions, if necessary, in line with expected storage needs as indicated in Appendix D-1. Costs of this survey and the improvements to be carried out should be borne by the PBEF, using some of the funds gained through the cost recovery system, running at approximately 20 million FCFA.

Stock Control. Appendices D-12 and D-13 show the stock control form in the central MSP store and the main MCH/FP clinic in Cotonou, respectively. These may be compared with the form used by the ABPF (Appendix D-14) that is considerably more informative and useful.

Appendices D-15 and D-16 show the two forms that should be completed by health centers (C6 and A3). C6 goes to the department directorates where the information is collated with others completed at the department level (Appendices D-17 and D-18) and finally sent to the headquarters of SNIGS in Cotonou on diskette where it is included in the annual report on health information. As the report for 1993 was only published in July 1994, it is doubtful if the FP information, which only reveals the numbers of acceptors and methods, will be of much use to the central level of FP, the PBEF.

The *Fiche de Stock*, (Appendix D-16), is not widely used and is, in fact, out of stock in most units, which is the main reason for its non-use. This form is sent to the department level, but transmission seems to stop there. The information on stocks at the health center level is therefore not reaching the central store in Cotonou.

As was confirmed by the Situation Analysis carried out in May 1994, there are no forms being used by the majority of health centers or department directorates to place orders, which accounts for irregular ordering and stock-outs. According to the above survey, only 10 percent of health units made any kind of monthly report.

Recommendations: Stock Control and Inventory Management. It is recommended that the method of stock control and reporting be strengthened throughout the MSP FP service system. This should be the subject of a special study, taking into account the special needs of Benin, available resources, and experiences of other, neighboring countries, e.g., Mali, that have developed a relatively efficient, manual stock control and ordering system and forms. This study, which should be assisted by an international consultant, should be carried out by the MSP/PBEF. Estimated cost: US$20,000 (2-3 weeks). Possible funding might be forthcoming from USAID and/or UNFPA.

It is not recommended at this time that the SNIGS system of health data recording and collection be adapted or expanded to include FP stock control data. First, the needs of the FP

program (information, forms, etc.) should be closely defined, including the methods of recording, transmission, utilization, feedback, and so forth.

Subsequently, SNIGS may be evaluated as a suitable method of collecting and transmitting such information promptly or whether a separate channel should be established for FP as part of the improved management information system. (See section on MIS below, as well as the chapter on MIS).

6.8.4 Management Information System

The SNIGS system as presently organized does not provide for sufficient collection of useful information on FP logistics or usage of contraceptives, nor does it provide a method of stock control/reordering. It also does not provide for feedback of useful information to the health units.

The Retro-Information Bulletins, published once every three months by SNIGS, as well as the annual report, contain interesting and valuable data on epidemiology and morbidity but do not yet adequately address FP. The data are often slow to be passed for processing, and this time lag may be an obstacle to using the SNIGS system as a FP logistics management tool. However, there is a plan to extend the SNIGS data to follow more closely developments in FP from 1995. The health centers should be computerized between 1996 and 1997, and data will be passed to the department directorates every month.

The SNIGS system, with some adaptation and with a more precise form of reporting from the health units, could well be used to give a clearer picture of the CPR on a quarterly and annual basis. Clear guidelines, however, have to be given on how to register new and old acceptors to avoid multiple counting.

Recommendations: MIS. It is recommended that the system of reporting contraceptive prevalence, stock movements, maximum and minimum stock levels, and levels for reordering be strengthened by the design and implementation of new forms, training of health workers and storekeepers on how to use them, and their rapid transmission through department directorates to the central level in the MSP.

It is recommended that a central FP logistics unit in the MSP be organized, computerized, and trained in the collection and analysis of such data, including adequate field supervision, and in the feedback of relevant information to department directorates and health/FP units. This could be achieved in the framework of an FPLM project.

It is NOT recommended (contrary to the MIS chapter's recommendations) that a database be established at USAID offices in Cotonou. The appropriate place for this would be at the Ministry of Health, family planning logistics management.

It is recommended that support be given to the ABPF to establish a strengthened and computerized MIS at its offices in Cotonou and in its *Antennes* which would provide valuable complementary information to the MSP's system.

6.8.5 Supervision

From all observations, one of the main reasons for the general weakness in the FP system and low rate of contraceptive prevalence is the lack of adequate supervision.

According to established MSP procedures, each health unit is supposed to receive a supervisory visit at least once a quarter. The Situation Analysis revealed that there had been an inadequate level of supervisory visits in 76 percent of health units visited; 18 percent of them had not been visited at all; and this lack of supervision played a key role in the absence of enthusiasm and motivation among family planning service personnel.

One of the main functions of the MSP's FP management unit should be to ensure an adequate level of field supervision, through its own personnel or through those of the department directorates of health. The present level of staffing of the PBEF at the Directorate of Family Health hardly seems adequate to ensure a regular program of field visits.

Recommendations: Supervision. It is recommended that a regular system of supervision and field visits be drawn up at the central and department levels. If present levels of staff are insufficient for this purpose, additional personnel should be recruited or responsibilities reallocated to allow sufficient time for supervisory duties. Regular reports should be made and their conclusions acted on by department directorates and the central unit at the MSP. Feedback should be provided to health units and remedial actions taken.

6.9 Summary

The above sections assess the present system of logistics of FP in Benin, analyze its strengths and weaknesses, and offer solutions to reinforce the strengths and overcome the weaknesses. In conclusion, the present system of FP logistics at a national level is generally weak and obviously contributes to a continuing low CPR, around one percent of WRA. This is also a major reason for the continuing high level of maternal and child mortality in the country.

Unless the FP logistics system is strengthened, little improvement or increase in the CPR can be expected, and the national target of four percent CPR by the end of the century is unlikely to be reached. The high rates of maternal and child mortality will not show much improvement. In addition, socioeconomic conditions will continue to suffer under the heavy burden of unrestrained population growth on a stagnating or even declining GNP/capita.

Several recommendations are made which should help strengthen FP logistics and, together with other measures such as an effective IEC program, increase the national CPR. These recommendations focus on the management of logistics from rational supplies planning and assessment of needs down through effective distribution, cost recovery, and financial management, backed by appropriate management information systems. Training of personnel in FP logistics management at all levels will be a crucial element of this program. A supply/revenues plan has been drafted which may be used as the basis for stronger FP logistics management (see Appendix D-1).

Cost estimates for the strengthening of these functions have been made and are presented as a basis for possible external funding support (see Appendix D-19).

7 MANAGEMENT INFORMATION SYSTEM

by Baba Traore

In Benin, maternal and child health activities that are combined with family planning activities are essentially preventive and promotional; they represent a large number of activities, especially for health care training in outlying areas. They are worthy of special attention due to their share of health care activities, the importance given to women and children in the process of sustainable socioeconomic development, and finally because most disease and health problems for which the population continues to pay heavily can be avoided by simple preventive measures if they are carried out in time. The management of health care activities in general, and of MCH/FP in particular, is based on a well-developed, operational information system at all levels of the health pyramid.

7.1 Diagnostic Report of SNIGS in the Ministry of Health

7.1.1 Organization of the Health System

The health system is divided like government agencies; it has the structure of a three-level pyramid:

- The central/national level, where the National University Hospital Center is located and where the following activities are undertaken: [general] medicine, pediatrics, surgery, gynecology/obstetrics, radiology, laboratory, otorhinolaryngology, ophthalmology, and other specializations.

- The intermediate/department level, where the Departmental Hospital Center is located and where the following activities are undertaken: [general] medicine, pediatrics, surgery, gynecology/obstetrics, radiology, laboratory, and other specializations.

- The outlying level is made up of three sublevels:

  * The sub-prefecture where the Sub-prefecture Health Center or Sub-district Health Center carries out the activities of [general] medicine, surgery, maternal care, radiology, laboratory, and pharmacy.

  * The commune where the Communal Health Complex is located and where the following activities are carried out: clinic, maternal care, and pharmacy.

  * The village or city neighborhood where the Village Health Unit undertakes the activities of general care, childbirth, and prescription payments.

7.1.2 *Goals of SNIGS*

The MSP's National Health Management Information System (SNIGS) receives technical and logistic support from *Coopération française* and WHO. Its goals are the following (MSP, 1994):

- Provide quantitative data indispensable for identifying major health problems and help define and assess Benin's health policy.
- Maintain ongoing dialogue between health statistics producers and users in a sustained effort to target improvement of SNIGS and adapt it to the country's needs.
- Contribute to broader and faster diffusion of information.
- Improve the health sector's management and planning process.

7.1.3 Description of SNIGS

SNIGS relies essentially on health organizations that are the producers and main users of the information that is collected. For it to operate properly, statistical units must be operational at the level of the CSSPs, CHDs, or private organizations, as well as the provincial statistics services for epidemiology and documentation at the Departmental Health Directorate. The statistical units and the provincial statistics services are responsible for various reports: correctly recording them, examining and counting them daily, and sending them out periodically. The requested data pertain to diseases, personnel, infrastructure (essentially beds and health agencies), funding (income and expenses, with sources), maternal and child health/family planning, and medication management.

The types of data records vary, depending on the resources and staff of the health organizations. These data records are numbered by type:

"A" followed by a number is a management document.
"B" followed by a number is a health treatment document.
"C" followed by a number is a MCH/FP document.

<u>Data Records at the Communal Complex Level</u>. Types of data records kept at the CCS level are the following:

- Approximately 20 types of records to be kept in the CCS (index cards, other cards, registers, statements, reports), including record cards for infants (C2), mothers (C3), family planning (C4), and the detailed daily MCH/FP register (C5)

- Data records to be kept by the patient/consulting physician: treatment record booklet (B2), health record booklet (C1)

- Approximately 10 data records to be sent to the CSSP and CSD, including the maternal activity report (C6) and the vaccination activity report (C7). Reports pertaining to family planning are not affected in this case because the CCSs are not involved in family planning.

Each CCS is required to forward its report to the CSSP at most five days after the end of the month.

Data Records at the Sub-prefecture Health Center. Types of data records kept at the CSSP for districts that include several city health precincts or sub-prefectures are the following:

- Approximately 10 types of records to be kept at the CSSP level, not counting copies of reports received from the CCSs and sent to the DDS. Included among these types of records are infant care, maternal care, and family planning record cards, and the detailed daily MCH/FP register

- Records to be kept the by patient/consulting physician

- Records to be sent to the DDS, including vaccination activity synthesis reports (C8), maternal care activity synthesis reports (C9), family planning activity synthesis reports (C10), and MCH care activity synthesis reports (C11)

Each CSSP is required to send its report to the DDS at most 10 days after the end of each month. At year's end, the CSSP may produce a statistical yearbook (20 pages maximum) containing, among other items, a summary of vaccination, maternity, and MCH/FP activities. A copy of this annual report is sent to each district health unit to inform them of the past year's activities. Two copies are sent to the DDS.

Data Records in the Hospitals. Types of data records kept in the hospitals (CHD, private hospitals, and CNHU) are the following:

- Records to be kept at the hospitals, including infant health record cards, maternal health, and family planning, and the detailed daily MCH/FP register

- Records to be kept the patient/consulting physician

- Records to be sent to the DDS by the CHD or the private hospital to the MSP (sent to the attention of the Statistics and Documentation Service) by the CNHU. These records contain, among other things, the maternity activities report and the vaccination activities report.

Each hospital is required to send its report to the designated agency at most 10 days after the end of the month. At year's end, the hospital may produce a statistical yearbook containing, among other items, a summary of vaccination and maternity activities. A copy of this yearbook is sent to each district health unit to inform them of the past year's activities. Two copies are sent to the DDS.

Data Records in the Department Office. Types of data records kept at the DDS level are the following:

- The records to be kept at the DDS level (one copy of the reports produced by the CCS, CSP, CHD, private hospital, and one copy of each synthesis report received from the DDSs)

- The records to be sent to the MSP for use by the Statistics and Documentation Service, including synthesis reports on vaccination, maternity, and MCH/FP activities carried out within the department

Each DDS is at most required to ensure these reports arrive at the MSP 15 days after the end of the month. The publication of a statistical yearbook at the level of each department is mandatory. This yearbook must contain, among other things, an up-to-date summary of vaccination, maternity, and MCH/FP activities. It is intended for use by each CSD, CHD, private hospital, and the MSP. The central level will compile data from the departments and the national synthesis will be published in a statistical yearbook intended for various users.

Data Processing Organization of SNIGS. Within each department there is a DDS where two statisticians from the SNIGS network work. Each DDS has at its disposal at least one personal computer and SNIGS-specific software programs. In addition to the DDSs, the Cotonou CNHU is considered a "Department" for the SNIGS organization (Tchabo, 1994).

As mentioned earlier, hard-copy records are used at the local level in the CCSs for data collection. These records are transmitted to the CSSPs, where preliminary data are pooled by hand. The records[1] obtained in this way are sent to the DDS, which enters them into the computer using the LOGI-SNIGS software program. The results are sent on diskettes to the MSP, which carries out the national synthesis.

7.2 Diagnostic Factors for SNIGS

7.2.1 Health Indicators

At the national level, a full range of health indicators is available in the health statistic yearbook: geographic, socioeconomic, and demographic indicators; indicators pertaining to the health system (health-related infrastructures, human and financial resources, the pharmaceutical sector); epidemiological indicators (number of cases and deaths declared for 43 surveillance sites, a summary account of the five most-often used reasons for a medical consultation, summary accounts of the five most-often used reasons for hospital admittance, a detailed analysis of the main pathologies); indicators pertaining to health services activities, treatment-related medical activities in the health units, and MCH activities; maternity-related activities, family planning activities, vaccination activities, and laboratory work.

[1]There are seven types of computerized records: the monthly disease report (B5), the monthly medical activity report (B7), the monthly medical consultation report (B11), the monthly vaccination activity report (C8), the monthly maternity activity report (C9), the monthly family planning activity report (C10), and the monthly MCH activity report (C11).

Once each year, the entire range of indicators is updated at the national and department level. For the purposes of epidemiological surveillance, epidemiological indicators and certain health service statistics are published quarterly in a bulletin entitled *RETRO-SNIGS*. Because the yearbook for a given year is now published within the following six months, the **indicators are available and recent**. The 1993 yearbook went to press in July 1994.

The published health services statistics are relatively complete, except for family planning data, which are supposed to pertain to the total number of male and female contraceptive users, but which, in reality, are probably statistics of female user visits. **Statistics relating to the logistical management of contraceptives are missing from health data publications.**

Regarding the reliability of available indicators, more attention should be paid to the CPR published in the yearbooks. This indicator seems neither correct nor reliable. Such as it appears in the yearbooks, it is the year's number of male/female contraceptive users divided by the total number of women in their childbearing years (15 to 49). But by examining the periodical reports and the way in which they are filled out, one realizes that what is interpreted as the total number of users is, in fact, merely a monthly compilation of the annual visits of male/female contraception clients. This number is not converted to the number of visits in terms of female users referred to in the yearbooks. If the number of visits is considered as the total number of female users of contraception, then the CPR published in the yearbooks is overstated. **SNIGS will have to modify the daily detailed record-keeping method for family planning in order to count the year's first visits of both new and previous (female) contraception clients.** The total number of these first visits effectively corresponds to the number of male/female contraceptive users. As for the other MCH indicators, they can be considered to be correctly estimated and reliable for the simple reason that, with the prenatal count as an example, the number of new clients corresponds to the number of first visits as well as the number of women counted, one time each, in the course of the year. It is, thus, acceptable for the rate of prenatal coverage to be stated as the ratio of the number of new clients and the number of expected pregnancies. It is the same situation for the rate of postnatal coverage and child consultations.

7.2.2 Concepts and Definitions

Although the concepts of new and previous clients makes it easy to count the number of persons involved in prenatal and postnatal visits, such is not the case with family planning visits. Since a new family planning client is defined as a client who accepts a contraceptive method for the first time, it is not always easy to count the total number of users of contraceptive methods using the number of visits by new and previous clients. Thus, at the Cotonou MCH/FP Center, all visits of new contraception clients are recorded in comparison with new clients during the year, and all visits by previous ones are also recorded on behalf of the previous ones. The definitions do not differ at the Lagoon Maternity Care Center or at the MCH/FP Center. On the other hand, statistical statements at the two centers do not make reference to those who have disappeared or who have dropped contraceptive use. **These two concepts should be clearly defined so that the monthly statistical reports of services account for the number of women who abandon contraceptive use during the year.**

7.2.3 Management of MCH/FP Cards and Client Counts

Pursuant to the evaluation team's visit to the MCH/FP Center of PBEF and to the Lagoon Maternity Care Center, it can be said that the different types of data records pertaining to various MCH/FP services are regularly filled out. Given the fact that the daily logbook must be filled out using only numbers, the counting operation requires the use of an additional record-keeping medium, the nature of which varies from one service to another and within the same center. Some use notebooks; others, tear-off calendars. These additional media are grids for counting or handling the numbers. **In order to limit the risks of counting errors, it is recommended that the layout for the daily recording of numbers be modified so that it may also serve as a counting grid.**

SNIGS describes the billbook or active research batches as being a set of 14 batches corresponding to the 12 months of the year; the thirteenth and fourteenth are reserved, respectively, for classifying women who have disappeared and women who have completely dropped out or correctly completed the expected services. The file cards are to be classified by appointment month during which a specific action is to take place. Infants' file cards should be classified in the same way in order to facilitate monitoring vaccinations, height, and weight; likewise for MCH file cards for prenatal monitoring and family planning file cards for monitoring visits for supplies or inspections. **At the MCH/FP Center, as well as at the Lagoon Maternity Care Center in Cotonou, the file cards are not classified using the system of active tracking batches.** They are classified numerically in batches of 100 cards and often by neighborhood, which makes it impossible, for example, to give a year-end count of those who have abandoned contraceptive use.

7.2.4 Analysis and Utilization

With the exception of certain family planning indicators, such as the CPR and indicators for contraceptives logistics management, the other indicators are evaluated relatively well by specific data analysis software programs produced by SNIGS. As for the CPR, it is a problem involving improvement of the data collection tools at the level of the health units and clear definitions of the concepts of disappearance and drop-out. Thus, it will be possible to assess two contraceptive prevalence indicators: **prevalence over a period of time**, for example, the civil year in which all women who have used contraception during that period constitute the numerator of the rate and the total number of women of childbearing age (15-49 years or 15-44 years) constitute the denominator and **prevalence at a point in time**, calculated, for example, on December 31 of the current year by subtracting the number of women who dropped out from the number of women using a contraceptive method in the course of the year.

An accurate, rigorous monitoring of the instructions for filling out and classifying the SNIGS data records by service providers makes it possible to facilitate the daily management of health services. Regular supervision is needed to be sure the instructions given are followed. **One of the main causes of failure for most health programs and projects is the near total**

absence of regular supervision (MSP, Notions préliminaires sur le système national d'information et de gestion sanitaires).

The coordination of SNIGS activities is satisfactorily carried out at the central level by the Programming and Coordination Unit at the MSP. At the department level, it is done by the Department Health Office. These two levels of coordination are evident in the semiannual meetings of the various Department Health Offices.

Past activity information is carried out from the central level to the level of the departments through the regular annual publication of national statistical yearbooks and quarterly epidemiological and statistical bulletins (*RETRO-SNIGS*) and by supplying monthly (on the 30th of the month) two national databases on magnetic recording media: the LOGI-SNIGS and VISUEL-SNIGS databases. Likewise, the past activity information is ensured by DDS for health sub-prefectures by the publication of department yearbooks.

7.2.5 Planning and Programming

SNIGS has reached a stage in which data collection, processing, and dissemination no longer present any major problems. At the present time, emphasis must be placed on the appropriation of various participants at the MSP and satellite institutions.

Consideration is being given, in the short term, to installing the VISUEL-SNIGS software and databases in the various MSP health technical offices that are equipped with a computer able to use them. Likewise, consideration will be given to installing those tools at the documentation center for access by visitors to the MSP and partners in development who might request to do so, such as the European Development Fund. Consideration is also being given to having the DDSs disseminate the VISUEL-SNIGS tools among the health sub-prefectures possessing adequate computer equipment.

Medium-term perspectives include considering extending VISUEL-SNIGS to monitor vaccination, maternity, and family planning activities.

Consideration is being given, in the long term (1996-1997), to decentralizing data entry at the sub-prefecture level. Each health sub-prefecture will have to possess adequate computer equipment and software for data entry and processing. Data from the sub-prefecture will have to be exported to the DDSs each month. The DDSs will need to reconstitute the departmental database before exporting it to the central level.

7.2.6 The Link Between SNIGS and the National System of Statistics

Whatever the performance of SNIGS, it cannot produce all the information it requires. In most cases, the denominators of the health indicators come from the socioeconomic and demographic data produced by the National System of Statistics (SNS). It is agreed that if the SNS is strengthened, SNIGS will also benefit by a ricochet effect. In general, population censuses make it possible to establish population statistics that are used as denominators of health indicators, and specific surveys and in-depth studies carried out by the SNS make it possible to reliably assess SNIGS and various health programs. Thus, the National Institute for Statistics and Economic Analysis, under the auspices of the SNS, will publish in 1994 the volumes of the 1992 census analysis, including regional population prospects into the future. The INSAE has formulated a request, addressed to the participating funding agencies, to carry out a demographic and health survey at the national level and to undertake short in-depth studies on maternal mortality, handicaps, women's activities, and migration. Likewise, INSAE is seeking funding for a seminar to disseminate the results of census analysis.

7.2.7 Constraints

The decentralization of the computerization of SNIGS at the level of the health sub-prefectures and districts is linked with the institutional plan for internal restructuring within the MSP. It will require many material, human, and financial resources; it will probably be necessary for the MSP to broaden the number of development partners interested in strengthening SNIGS.

In addition, a heavy decentralization of the computerization of SNIGS requires that the SNIGS network be closely directed, that maintenance of computer equipment and software be regularly ensured at all levels, and that effective supervision be regularly ensured in order to comply with SNIGS procedures, including complying with due dates for sending reports and magnetic media.

7.3 The Information System of the ABPF

The ABPF does not have a statistics unit in its clinics, but it produces relatively complete statistics through its own system. Statistics pertaining to project management, cash flow, the analysis of income/expenses by donor, as well as statistics for clinical services, IEC, and contraceptive logistics are published once each year in the activities report. Since 1992, SNIGS includes statistics for services from ABPF in the national data.

Data-recording media, individual record cards, and registers are kept relatively well. The cards are not classified by a system of active research batches. They are classified in batches of 50, by numerical order. The daily count register is done by hand and the record keeping system does not make it possible to count, in the course of the year, the real number of women accepting contraceptive methods because of counting the same individual several times.

The statistics produced are relatively complete and recent but are hardly reliable, especially with respect to statistics on services and logistical management of contraceptives. The former relate to the number of visits by female clients without counting the real number of men/women

accepting contraception during the year, which makes any calculation of prevalence impossible. The latter contain inconsistencies in the totals of quantities of contraceptives distributed by method, and non-standardized norms are used to convert them into the number of couple years of protection.

As for the definitions of the concepts of new and previous contraception clients, there are no differences with SNIGS. Nonetheless, documentation of women who leave government services for ABPF clinics is important. As in the public sector, it is necessary and useful to clearly define those who have disappeared and those who have dropped out, as well as instructions for counting them. The system for classifying records by active screening batches may be a solution.

In terms of future prospects, the ABPF's president is very interested in setting up a research department at the Cotonou clinic to improve the quality and quantity of family planning services in Benin.

7.4 Recommendations

1. So that family planning statistics might be complete, the evaluation team recommends that short-term activity be undertaken by the MSP in order to change the method used for daily counts and the one used for the monthly reports, making it possible to count the first visits by female contraceptive clients, collect IEC activity data, and manage contraceptive inventory data .

2. In the medium term, USAID could support the MSP to develop a MCH/FP module for the VISUEL-SNIGS database inquiry program. In this way, the database could be set up in USAID's office in order to daily monitor health programs in general and MCH/FP programs in particular.

3. The team encourages the MSP to proceed, as was expected, with the internal assessment of SNIGS. It recommends that USAID fund a demographic and health survey to be carried out near the end of 1995. This survey, which will be nationally representative, will be the basis for assessing all ongoing health-related activities and a basis for planning Benin's health programs.

4. In the long term (1996-1998) and through co-funding with other partners in development in Benin, USAID could support the computerization of health districts and health sub-prefectures, depending on how extensively the government will decentralize.

In order to promote family planning rapidly in Benin, a reliable information system will have to be developed in the clinics run by the ABPF. To this end, it is recommended that USAID help develop a statistical unit in the clinics and strengthen the one in Cotonou in order to carry out research on the extent and quality of family planning services.

8 OPERATIONS RESEARCH IN POPULATION AND FAMILY PLANNING

by Aristide Aplogan

8.1 Background Elements

The definition of an effective population program requires an accurate knowledge of the problems and behaviors of the target population. Statistical studies and nationwide research on demographic and FP problems have always been a major concern for the Beninese government and administration. Thus, since 1960, apart from the national demographic surveys (1961, 1981-1983) and population and housing censuses (1979, 1992), there have been several population surveys in Benin. For example:

- Repeated survey (1981)
- Fertility survey (1982)
- Adolescent fertility survey (1986)
- Income and consumption survey (1986-1987)
- Small-scale household survey
- Informal sector surveys and studies program
- Study on male nuptiality and fertility in Southern Benin (1992)
- Study on the impact of migrations on household evolution (1992)

There has been considerable effort in the field of analysis and research on population, especially in specific areas such as marriage, household and family, population dynamics, fertility, internal migration, women's status, and the satisfaction of essential needs. Unfortunately, with regard to the national FP program, operations research (OR) activities, with a view to better assessing the needs of the population, have been very limited. Supporting research institutions for OR activities in family planning is, therefore, necessary to make the FP program more effective.

8.2 Institutional Capacities

Several ministries (Planning, Education, and Health) are involved in FP research activities through their technical departments or research institutions. The institutions are the National Institute for Statistics and Economic Analysis; the Population Training and Research Center (CEFORP); the Regional Center for Health Development; the Center for Research in Human and Demographic Reproduction/Family Health; the Epidemiology and Operations Research Department (SERO); the Beninese Scientific and Technical Research Center (CBRST); the Faculty of Health Sciences; the National Medico-social Institute; and the Regional Institute for Public Health).

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8.2.1 The National Institute for Statistics and Economic Analysis

The INSAE is a technical department of the Ministry of Planning and works in collaboration with the Human Resources and Population service within the same ministry. This institute is mainly involved in population research activities (demographic, fertility, marriage, income-consumption surveys and censuses); economic analysis and statistics activities; and mid-level training in the fields of demography and economics.

This institute has important human resources including statistical engineers and economists, sociologists, and computer scientists, as well considerable computer resources. Given the capacities and experience of the staff and the computer resources available at INSAE, this institution remains the national reference for a demographic and health survey. Staff salaries and operational costs are supported by the government. INSAE also receives grants from donors such as UNFPA and UNDP to implement specific population activities.

8.2.2 Population Training and Research Center

CEFORP was created in 1987 under the Ministry of Education but started research activities in 1989. So far, CEFORP has trained three classes of 24 senior technicians in demography and sent demographers to Canada, Belgium, and France for doctoral and Diploma for Specialized Scientific Studies (DESS) degrees.

As far as research is concerned, CEFORP has conducted a study of Cotonou women and the decision-making process (1991); the current and future status of the Beninese population (1991-1993); men's fertility and marriage (1992); and the impact of migration on households (1992).

The human, material, and computer resources of CEFORP are rather limited. CEFORP receives funding mainly from the government for salaries and operational costs from UNFPA for training and research activities. This institution needs logistic and financial support to perform more effectively.

8.2.3 Regional Center for Development and Health

CREDESA, previously known as the Pahou Health Development Project, is involved in research, training, and rationalized health care. It was created in 1983 and is located in Pahou (coastal Benin). CREDESA focuses on participative action research involving service providers, researchers, and communities in the areas of management, health economics, epidemiology, community participation, applied nutrition, and so forth.

An in-house computer unit enables data processing and analysis. The CREDESA team includes agronomists, economists, sociologists, social workers, paramedical staff, and specialized doctors in epidemiology, demography, applied nutrition, public health, and community health.

Various funding sources are available to CREDESA depending on the type of activity. Service-type activities are funded by the government, communities, and partly by research funds. Research activities have been financed by the Royal Tropical Institute in The Netherlands from 1986 to 1989 and, since 1990, by Canada through the Regional Center for International Development (IDRC). With regard to training, CREDESA has received specific grants from UNICEF, WHO, PBEF/UNFPA, and CRS. Service rationalization and grassroots development activities have been financed by the Canadian International Development Agency (CIDA), IDRC, and CRS, while contraceptive CBD activities are supported by USAID.

8.2.4 The Human Reproduction and Demographic Research Center

The CRRHD was created in 1979 and is located within the CNHU in Cotonou. Its activities include research, training, and service provision. In the health sector, CRRHD conducts epidemiological research in gynecological and obstetrical affections, STDs/AIDS, maternal and infant morbidity and mortality, infertility and infecundity, family planning, demography, and MCH services management.

The multidisciplinary team is composed of epidemiologists, demographers, sociologists, bio-statisticians and computer scientists, MD-biologists, gynecologists, and laboratory technicians. Computer and laboratory equipment are performing relatively well.

Staff training, computer and laboratory equipment, and documentation have been provided by WHO. Financial resources are provided by the Long Term Institutional Development Grant under the WHO-Geneva special program; WHO, UNICEF, the International Children's Center (CIE), INSERM, The Rockefeller Foundation, USAID, and UNFPA through financing of research protocols; and service charges (for research expertise, training, and laboratory analyses). CRRHD could be one the best Beninese institutions for conducting OR studies in family planning and reproductive health.

8.2.5 The Epidemiology and Operations Research Department

SERO was created in 1990, under the DNPS/MSP. It is in charge of providing OR training to doctors in the peripheral areas, supervising OR activities, and developing a regulatory framework for awarding research prizes.

SERO's current research activities mainly focus on malaria and communicable diseases with a team of only two epidemiologist/MDs and two computers of limited capacity.

Working conditions are rather poor, and SERO has no financial resources to support its activities. The very few activities conducted by SERO were supported by WHO. SERO's functional capacities are very weak due to the lack of human, material, and financial resources. In addition, in the new MSP organogram, SERO will be replaced by the Epidemiology and Border Surveillance Department. Research activities will be supervised by a department other than the DNPS.

8.2.6 The Beninese Scientific and Technical Research Center

In 1977, the CBRST was created to coordinate all scientific and technical research activities in Benin. It is located in Cotonou and includes representatives of all the ministries but is headed by the Ministry of Education. The main responsibility of this center is to coordinate and report yearly on all research activities undertaken in Benin. CBRST has subscribed to the National Essential Research in Health (RNES) scheme.

8.2.7 Health Training Institutions (FSS, INMES, IRSP)

The Faculty of Health Sciences, the National Medico-social Institute, and the Regional Institute for Public Health are all under the Ministry of Education. These institutions are, respectively, in charge of training doctors and social workers; nurses, midwives, and social promotion agents; and public health doctors. Some students of these institutions conduct their thesis or dissertation research in the area of family planning.

Overall, the research capacities of these institutions are limited to human resources with little or no training in research techniques. Material and financial resources for research are almost nonexistent.

FSS and INMES students are entitled to a government grant in the amount of 90,000 FCFA for a thesis and 70,000 FCFA for a dissertation. IRSP trainees receive a research allowance from WHO. Despite the competence of the various thesis directors, these institutions do not seem to present the ideal conditions for OR activities in population/FP due to staff unavailability and students' time constraints.

8.3 Studies in Family Planning

Various studies have been conducted in the area of family planning in Benin by CRRHD, the University Clinic of Gynecology and Obstetrics, IRSP, and FSS, as follows:

- Family Planning in Developing Countries: Its Role and Place in the Development of a Nation (MEGNIGBETO Antoinette; 1977)
- The Future of Pregnancies, Knowledge, Attitudes, and Practice (KAP) in School and University Environment in Benin (AVODAGBE Valentin; 1988)
- Contraception in Gakpé Rural Area: Analysis of KAPs and Contraceptive Needs Among 280 Men and 264 Women (HOUETO Colette; 1988)
- Contraception in Rural Environment in the Pahou and Avlékété Communes: Analysis of KAPs in Contraception Among 724 Men and 767 Women, and of Reasons for Rejecting Contraception (TOSSOU Yélognissè; 1988)

- Summary Review of Family Planning by Artificial Contraceptive Methods in Benin: Preliminary Study (EKANMIAN Gatien; 1989)

- Contraception in Cotonou Based on Needs, KAPs Among 635 Women Surveyed in a Hospital Environment (HOUNDJREBO Armand; 1989)

- Contraception at the Postpartum Consultation Section of CNHU: 1,038 Patients Surveyed from 3/1/87 to 2/29/88 (DOVONOU Marie-Anne; 1988)

- KAP in STDs, Contraception and Sexual Education Among 234 Secondary School Teachers in Cotonou (AUGOU Thomas)

- IUD and Its Acceptance in three FP Centers in Cotonou: Among 1,020 Users and 223 Non-users (ABLEY Pascal)

- Noristerat and Its Acceptability and Effectiveness in Three FP Centers in Cotonou: on 1,137 Users, 32 Endometer Biopsies and 81 Biochemical Analysis (MITOHADE Aimé; 1989)

- Adolescent Contraception Based on a Study Among 513 Students and Seamstress Apprentices in the Ouidah I Urban Area (SANTOS Paul)

- Changing Contraceptive Knowledge, Attitudes and Practices in Rural Benin: Elements of Success in a Community-based Family Planning Intervention (GANDAHO Timothée; 1993)

- Home-based Monitoring of Acceptors and Contraceptive Continuity Rate in Benin: Excluding Natural Methods (GOUFODJI Sourou and ALIHONOU Eusèbe; 1994)

- Integration of FP in Mother and Child Health Care Activities in Benin (SANOUSSI Lamatou; 1982)

- Contraceptive KAP in Two Secondary Schools in Bohicon (ZOMAHOUN Suzanne; 1991)

- Study of the Characteristics and Continuity of Contraceptive Methods Acceptors in Benin (Ministry of Health, Project BEN/88/PO3; 1991)

- Situation Analysis of the FP Program in Benin (Ministry of Health, USAID/Benin, The Population Council; 1994)

- The Effect of the Community-based Distribution on Artificial Contraceptive Acceptance in Ouidah (CRRHD; in process)

- Sexuality and Contraceptive KAP of Adolescents in School Environment in Cotonou (FSS; in process)

- Voluntary Abortion in Three Maternities in Cotonou (CRRHD/WHO; in process)
- Family Planning KAP of Health Personnel in Cotonou (FSS; in process)

8.4 Global Diagnosis of OR Activities in Population/Family Planning

8.4.1 Positive Aspects

- There are various research centers with adequate functional capacities and which could be used for future population/family planning OR activities.
- There are a considerable number of researchers in socio-demography, biostatistics, and reproductive health in Benin.
- Baseline data exists, and although they are insufficient, they are also very useful for the population/FP sector.
- Recent data on population and housing surveys are available (RGPH, 1992).
- A nationwide Situation Analysis of family planning in the public sector has recently been undertaken (1994).
- Several donors are very committed to supporting OR activities in population/FP.

8.4.2 Negative Aspects

- There is no structure within the MSP with adequate human, material, and financial resources that is capable of conducting and coordinating OR activities in family planning.
- There is a lack of a multi-year research program in population/FP and of a socio-demographic and health data collection and analysis system, which can be an obstacle to activities in the sector.
- There is not yet a human resources policy that can help motivate the staff and facilitate long-term interest in research institutions.
- NGOs and associations are not much involved in research activities.
- Activities conducted by existing research institutions are hindered by the lack of coordination mechanisms, which partly affects the quality and dynamics of certain operations research activities in the population/FP sector.

- Operations research is not perceived by MSP officials and service providers as a critical element for the promotion and improvement of health care, in general, and family planning, in particular.

- MSP officials and service providers are not very motivated and involved in OR activities due to the lack of information and training in OR techniques.

- Most of the service providers who received training in public health, epidemiology, and evaluation research do not have sufficient experience in the design and implementation of financially acceptable research protocols.

- The lack of technical, material, and financial resources and documentation and dissemination channels constitutes a major handicap in the promotion of OR in family planning.

8.5 Possible FP Operation Research Topics

KAP studies in FP and other studies on contraceptive continuity, introduction to new contraceptive technologies such as NORPLANT®, and the acceptability of IUDs and NORISTERAT would be appropriate for starting FP operations research in Benin. However, conducting research on certain key topics also seems extremely urgent. These topics include the following:

- **Demographic and Health Survey** on a national scale, including husbands and unmarried teenagers. This survey will also study contraceptive prevalence, marriage, fertility, etc., thereby enabling a better understanding of Beninese population behaviors and creating a wealth of baseline data to be used later to evaluate the impact of FP interventions (US$500,000).

- **Situation Analysis of FP in the private and NGO sectors** in order to assess the extent to which these sectors can contribute to the promotion and expansion of FP services (US$100,000).

- **KAP-type opinion poll among religious, political, administrative, traditional, and legislative leaders and decision-makers and among service providers** who seem to constitute a handicap to FP activities in Benin (US$100,000).

- **Study of the causes of modern contraceptive drop-out and methods for tracking lost acceptors** (US$40,000).

- **Study of the impact of community-based distribution of non-medical contraceptives on KAPs among men and women** (US$60,000).

- **Study of alternative channels for FP/IEC in Benin** (US$40,000).

- **Study to test one or more approaches to the integration of FP with other MCH activities** (US$40,000).

8.6 General Recommendations

1. Train a pool of staff in the public, private, and NGO sectors in OR techniques and methodology and assist them in the design and implementation of at least one OR activity in population/FP.

2. Organize workshops on OR in population/FP with a view to developing a multi-year sectoral research program and setting up an institutional framework for OR activities as well as effective coordination mechanisms.

3. Sensitize and involve NGOs and associations in OR activities regarding population/FP.

4. Set up a system for sharing results among all the actors in the sector and a mechanism for large-scale dissemination of OR results.

5. Develop capacities for the design and implementation of OR protocols, especially within the MSP.

6. Strengthen existing research centers with technical, material, and human resources.

7. In the medium term, set up within the MSP a performing and effective OR unit for MCH/FP that is able to secure funding for its own research protocols.

8.7 Recommendations for USAID

After this diagnosis, USAID could support OR activities in FP/Population by:

1. Assisting the MSP in setting up, in the medium term, an OR unit for MCH/FP activities.

2. Funding, partially or totally, the studies identified above as priorities.

3. Assisting the government of Benin in seeking additional funding, if necessary, for these priorities.

4. Providing specialized technical assistance to the government, through international research organizations, for conducting these studies.

5. Strengthening the material and technical capacities of existing research centers which are involved in the population/FP sector.

APPENDICES

APPENDIX A

STATEMENT OF WORK

ARTICLE I - TITLE: Population/Family Planning Assessment in Benin

ARTICLE II - BACKGROUND:

As a direct result of Benin's high population growth rate, the average Beninese today is poorer than elders were at Independence. Real gross domestic product (GDP) growth projections is estimated at 3 percent which means that the 3.1 percent population growth rate threatens to deflate any gains to be realized from reform. This growth rate will lead to a doubling of the current population within 25 years, which in turn will put undue pressure on the country's already insufficient public institutions.

Per capita income in Benin has been estimated at $380 and real economic growth has not surpassed the population growth rate. The population of over 5 million inhabitants is unevenly distributed with nearly 66 percent of the total occupying 12 percent of the land area in the south where the country's two largest cities are located. The overall unemployment rate was nearly 31 percent in 1990. The situation is not expected to improve in the near future.

- Population: > 5 million inhabitants (1992).
- Life expectancy: 51 years; infant mortality: 115/1000 live births and U5MR: 150/1000; population per physician: 1:14,768 (cf. OMS standard 1:10,000).
- Primary education: 59% net enrollment (girls 42%, boys 74%); secondary: 16% enrolled; adult literacy: 23%.
- Contraceptive prevalence rate (CPR): c. 1%; Total Fertility Rate (TFR): 7 children/woman.
- Average annual population growth rate: 3.1% (1985-90)
- Population Density: 42 inhabitants per square kilometer (national average, masks density imbalances between regions); 27% urban, 73% rural.

Data on Benin

Equally striking is the undesirable impact that population pressures are exerting on the fragile land and ecological systems. Studies done in the 1970s argued that an average family

needed 5 hectares to produce an adequate food supply. In Southern Benin, the average family farm plot is about 1 hectare today. Annual forest loss is 1.7% and it has been estimated that by the year 2000, Benin will be able to produce enough to feed only 95 percent of its people.

Benin's experience in promoting family planning (family planning) has been weak and fragmented. There is no national population strategy or policy, and the 1920 colonial anti-contraceptive law is still on the books (even if it is not systematically enforced). Despite support for FP at the highest level of the Ministry of Health, acceptance of the concept of FP is mixed among other elements of the leadership class. Nonetheless, the impact of unchecked population growth and a high fertility rate can no longer be ignored in Benin -- at a minimum, in regard to their nefast influence on maternal and child health.
It is evident from the above that Benin needs a strong and forward-looking population/family planning program. Although family planning services were integrated into the public health system 10 years ago, services could be improved, are not available everywhere, and have not resulted in any significant increase in contraceptive prevalence in the country.

ARTICLE III - OBJECTIVE:

USAID/Benin wishes to undertake a population/family planning sector assessment to determine whether it is feasible to upgrade Mission emphasis on population to a Strategic Objective, or whether it is more sound to continue addressing the sector as a Target of Opportunity. For this reason, the assessment will analyze the national family planning situation and population policy and related issues in other sectors in order to identify unmet needs and recommend potential areas of focus for future USAID assistance.

ARTICLE IV - SCOPE OF WORK:

1. Description and Analysis of Family Planning Services:

- Describe the current status of public sector family planning services in Benin commenting upon strengths and weaknesses of the different essential components of a FP program. Analysis of strengths and weaknesses should culminate in concrete recommendations for reinforcing strengths and/or addressing shortcomings noted in each of these components:
  - Management, supervision, evaluation -- at central,

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regional and local levels;

- Facility-based service delivery sites and alternative contraceptive distribution systems;
- Contraceptive procurement: Logistics system, distribution, recordkeeping, ordering, supplies, equipment, etc;
- Staffing -- current and projected levels;
- Information, Education and Communication (IEC): counseling, mass media;
- Training -- magnitude of needs for clinical training, IEC, logistics, management, supervision, evaluation, etc.;
- Management Information System; record keeping for service statistics;
- Quality of Services (access, method mix, new acceptor and continuation rates, information given to clients, etc.);
- Operations Research (past, current, planned, needed, capacity);
- Contraceptive pricing, cost effectiveness, and sustainability.

- Assess the viability of current and/or potential involvement of indigenous nongovernmental organizations (NGOs) and other private sector entities and community groups in providing family planning information and services; discuss the experience and potential for both clinic-based and nonclinic-based activities (e.g., social marketing, community-based distribution, community health education programs).

- Describe the pharmaceutical sector in Benin and actual and potential roles played by pharmacies in providing FP information and methods to the population.

2. Description and Analysis of Population and Sectoral Issues:

- Study and comment on existing and planned official declarations, policies and/or legislation which address the question of population growth and its impact on general health services, national employment, food requirements, land distribution, the education sector, public works and utilities, etc.

- Assess the extent to which demographic variables have been/are taken into account in the development planning process and comment on the existing institutional capacities for doing so.

- Assess the extent to which the general political environment

is currently conducive to the undertaking of a strong population program.

- Assess the current and/or potential involvement and needs of governmental and nongovernmental organizations (NGOs) and private sector community groups in promoting population policy initiatives.

- Prescribe a plan of action for the next five years that would address shortcomings and otherwise strengthen the development planning process in Benin at a macro level.

3. Description and Analysis of Other Donors' Programs:

- Describe the present and future-planned interventions and activities of other donors which support family planning activities and population initiatives in Benin, assess their relevance in regard to GOB needs and their effectiveness in achieving stated objectives.

- Comment on the complementarity of other donors' efforts and the recommendations made by the assessment team concerning future USAID interventions in the population/family planning sector. To what extent are the team's recommendations contingent upon assumptions concerning other donors' future levels of support to the sector?

ARTICLE V - SCHEDULE AND REPORTS:

1. **Schedule:** The consultancy shall be conducted in Benin over a 5-week period. The contractor shall brief with the USAID Representive and his designees upon arrival in country to clarify scope of work and timetable for submission of required reports. The USAID Representative will appoint a USAID/Benin employee to act as the principal contact person for this consultancy.

2. **Reports:** All reports shall be in English, using WordPerfect 5.1., unless otherwise agreed upon by the USAID Representative. At the end of week 2 of the consultancy, the contractor will provide, to USAID for review and comments, an **detailed outline** of the assessment report. A **draft written report** of the contractor's findings and recommendations should be presented to USAID/Benin, for review and comments, at the end of Week 4 of the consultancy. The **final written report** ("hard" paper copy plus computer diskette copy) must be submitted to USAID within 20 calendar days of team leader's departure from Benin.

The following apply to the content and recommendations of the final report:

- The report shall clearly recommend to USAID/Benin whether,

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given findings on constraints, opportunities and USAID management capabilities, population/family planning should remain a Target of Opportunity or should become a Strategic Objective in the Mission's overall development program. The strategic analysis which led to the team's recommendation must be clearly articulated in the report.

- Each recommendation concerning potential activities must include a discussion of local USAID and GOB management requirements as well as an illustrative timetable, and approximate budget (where relevant) for proposed activities. Underlying assumptions, possible risks, potential executing agencies (both off and on-shore) and anticipated outcomes should be delineated.

- The report should demonstrate, by providing a succinct description of each component, that the essential elements of a FP program (see Article IV.1. above) were studied to ascertain strengths and weaknesses. Private sector and NGO programs shall be considered in addition to the public sector program. Recommendations to satisfy unmet needs should specify not only actions which need to be taken (by sector) but also should suggest appropriate sources (G/POP contractors, grantees, local resources, etc.) for implementing recommendations.

- The report shall outline options (e.g., working with private sector, public sector, or both) for increasing contraceptive prevalence (e.g., promotion of long-term methods, initiating postpartum programs, community based distribution, contraceptive social marketing) and for ensuring quality FP services in Benin. The report shall propose specific steps/measures (for each option recommended) to achieve these objectives under either the Target of Opportunity or Strategic Objective scenario.

- In addition to addressing the points listed in Article IV.2 on population policy, the report should include a discussion of policy initiatives that have been successfully undertaken in other African countries and which might be appropriate for Benin.

- The report should discuss the relationship and overlap between population/family planning issues and the critical concerns in the education sector which receive major attention under USAID/Benin's overall development portfolio; suggest ways in which USAID activities and management efforts in the education sector might reinforce or be used as leverage to maximize efforts in the pop/FP sector, and vice versa.

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ARTICLE VI - PERFORMANCE PERIOD:

Services are to start on/about June 27, 1994. Field work, including the complete Draft Report, is to be completed by July 29, 1994. The Final Report must be submitted to USAID/Benin no later than August 19, 1994.

ARTICLE VII - DAYS ORDERED: 89

Position

1. Family Planning Program Management Expert (Team Leader...30 work days, 35 total days)

Graduate degree required and at least 12 years experience in design, management, strategic analysis and planning, supervision and evaluation of population/ family planning programs in Sub-Saharan Africa, including at least two francophone countries. Preference will be given to candidates who have managed indigenous FP programs (as opposed to donor-designed projects). Very good knowledge of management information systems (MIS) is required. Must be very familiar with requirements of USAID assistance programs, and USAID Global Bureau population/family planning resources. Must be a team player and be able to collaborate with and orchestrate work efforts of other assessment team members, including those who may not be fielded by Poptech (team may comprise as many as 7 members). African national preferred.

In regard to final report, the Program Manager Expert will have primary responsibility for writing section on FP MIS, private sector FP, sustainability issues, and alternative service delivery systems (CBD, CSM, etc.). In addition, will be expected to discuss and analyze written contributions of other team members and incorporate their contributions into the final "synthesis" report which clearly states whether (and why) population should remain a Target of Opportunity or become a Strategic Objective for the USAID/Benin.

The Program Manager Expert (Team leader) will be responsible for administrative and logistical requirements of the consultancy (car rentals, room rentals, hiring secretarial services, faxes, etc.) and for providing the draft final report prior to leaving Benin.

2. IEC Specialist...15 work days, total 19 days

Graduate degree required in public health, communications or related discipline, with expertise in family planning IEC programs. A minimum of 10 years experience in FP health

education and IEC programs including a minimum of 5 years experience working in Sub-Saharan African countries.

The IEC Specialist will produce a report (for incorporation into the final assessment report) which describes and analyzes FP IEC activities (current and planned) in Benin, and makes recommendations for strengthening FP/IEC in the country.

3. FP Logistics System Expert...15 work days, total 19 days

Minimum 7 years experience working in commodity logistics systems, including 3 years evaluating and trouble-shooting for contraceptive logistics systems. Must have good knowledge of public health drug and medical supplies distribution systems in Sub-Saharan Africa and be able to make recommendations concerning Push/Pull distribution systems, inventory systems and controls, recordkeeping, ordering procedures, contraceptive requirements of recommended activities, etc.

The Logistics Expert will be responsible for producing a report which describes and analyzes the contraceptive distribution system in Benin especially in regard to its efficiency, effectiveness and sustainability. S/he will make specific recommendations, complete with plan of action, implementation schedule and approximate budget, designed to improve the system.

4. Family Planning Training Expert...12 days, total 16 days

M.D., registered nurse, or certified nurse-midwife with minimum 5 years experience in FP training, including minimum 3 years experience in the development and implementation of service standards and protocols for FP service providers in Sub-Saharan Africa.

The FP Training Expert will produce a report which describes FP curricula content and duration of FP training in Benin (both pre-service and in-service); the number, type and skills of service providers trained to date; existence and quality of local training capacity; training plans for new and old service providers; area and magnitude of perceived needs; and, specific recommendations, including a plan of action and approximate budget, for future USAID interventions in the FP training area.

<u>Illustrative Breakdown of Writing Responsibilities for Information Which will be Incorporated into the Final Report</u>

- Management and Supervision - Public Sector (*Local resource person to be contracted directly by USAID/Benin*
- Management and Supervision - Private Sector (*FP Management Expert*)

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- Facilities and alternative contraceptive distribution systems - (*Public Sector - Local resource person; private sector - FP Management Expert*)
- Logistics/Supplies/Equipment - (*Logistics Expert*)
- Staffing - (*Public Sector - Local resource person; private sector - FP Management Expert*)
- Training - (*FP Training Expert*)
- Information, Education and Communication (IEC) - (*IEC Expert*)
- Record Keeping - (*FP Management Expert*)
- Quality of Services (dropout rates, new acceptor rates over time, etc.) - (*Local Resource Person and FP Management Expert*)
- Operations Research (past, current, planned, needed) - (*Local Resource Person*)
- Cost effectiveness and sustainability issues - (*FP Management Expert*)
- Population Policy - (*Policy Expert from CERPOD*).
- Family Planning and Breastfeeding - (*G/N Regional Nutrition Advisor*)

ARTICLE VIII - SPECIAL PROVISIONS:

a. Duty Post: Benin.

b. Language Requirements: Fluency in English and French (3+ level). Reports must be prepared in English in WP5.1 unless otherwise authorized by the USAID/Benin Representative.

c. Background Information on Benin will be provided by USAID/Benin in Cotonou.

d. Office Space, computer rental, secretarial, photocopy, fax, phone services. To be provided by the contractor.

e. In-Country Travel/Transportation Shall be the responsibility of the contractor. Approximately 2 weeks shall be spent visiting service delivery sites and meeting officials in the interior of the country.

f. Hotel Reservations will be made by USAID/Benin when itinerary is received from the contractor.

g. Work Week: A six-day work week is authorized.

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APPENDIX B

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APPENDIX C

LIST OF CONTACTS

MINISTERY OF HEALTH CENTRAL ADMINISTRATION

Veronique LAWSON, Minister of Health
Geogette DOSSOU, Cabinet Director
P. Doussou TOGBE, Adjoint Cabinet Director

DNPS

SAP

Cyriaque GNITOUNGBÉ, Office Head

SIEC

Emile AKOWANOU, Office Head
Mme DASSI, Nurse
Mme DOSSOU, Midwife
Mme KOFFI, Midwife

SSCSH (Hospital and Community Care Office)

Victor HOUNKONNOU, Office Head

SERO

Comlan COMLANVI, Head Manager
Leon KOHOSSi, Cadre

CNHU MATERNITY

Lucie CAPO-CHICHI, Midwife

Central Maternity of Cotonou

Sikiratou GOUTON, FP Manager
Mme BOUSSOU, Social Assistant

CUGO Maternity Hospital of Cotonou

Thimotée GANDAHO, Deputy Medical Director of CRRHD
Lydie KANHNOUNOU, CRRHD Sociologist

"Lagune" Maternity of Cotonou

Alfred C. KOUSSEMOU, Director
Beatrice AGUESSY, Medical Director and President of the Beninese Reproductive Health Research Unit
Alphonse GBANGUIDI

PBEF

Jonathan BALLEY, Program Manager
Suzanne ZOMAHOUN, Program Manager

PNLS

Nicaise DAVO, Coordinator
Céline SEIGNON, IEC Coodinator

SNIGS

Brigitte HELYNCK, Tehnical Assistant and French Technical Health Assistance Coordinator
Mathias FINOUDE, Assistant

Centrale D'Achat des Medicaments (Bamako Initiative Central Store)

Kokou AFOGBE, Deputy Director
Marie Paule FARGIER, Tehnical Assistant

DDSs

DDS of Borgou

Laurent ASSOGBA, Deputy Director
Sylvie AMADOU, FP-MCH Manager
Saloumou ALEUKOUTOU, IEC Manager

DDS of Ouémé in Porto Novo

Danielle ACHIRON, Departmental MCH-FP Manager

DDS of Zou

Lucien KOUNIHANDE, Director
Solange OGOUBIYI, MCH-FP Manager
Dominique DO-REGO, Chief Statistician of SSED
Charles da SILVA, Adjoint Director

CHDs

CHD/Borgou Maternity Hospital

Jean KOUASSI, Medical Director

CHD/Quémé Maternity Hospital

Urbain KOFFI, Medical Director
Lucien AKOCHON, Departmental ABEF Project Manager
Jeanne TOPANOU, MCH-FP Manager

CHD/Zou

Louis AHOKPOSSI, Director
Adisso VICENTIA, Social Worker

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CSSP/CSCU

CSCU in Abomey

Etienne DOUSSANOU, Chief of Medicine
Josette Johnson, Midwife

CSSP of Bohicon

Hilaire DOSSOU, Medical Director

CSSP of Cové

Oscar DJIGBENOUDE, Medical Director
Raoul EDEMESSI, Deputy Medical Director
Clarisse SOZONLIN, MCH-FP Manager

CSSP of Glazoué

Anatole B. AKOYI, Medical Director
Thérèse FAKAMBI, MCH-FP Manager

CSSP of N'Dali

Théophile HOUNOU, Senior-level Nurse
Mme ALYAROU, Midwife
Mme YACOUBOU, Nurse

CSSP of Nikki

Salamatou YOUSSOUFOU, Midwife

CCSP of Parakou (including members of the COGES

Ali ALAMOU, President
Chabi BOUKOU, Treasurer
Ibrahim COULIBALY, Secretary
Yacoubi BABONI, Member
Bernard GNAHOUI DAVID, CHD Medical Director

CCS

CCS of Birou (Nikki)

Florence DABA, Nurse
Florence SEGDO, Nurse

CCS of Kpébié (Parakou)

Félicien AZONHATIN, Senior-level Nurse
Mme MAMOUDOU, Midwife
Mme ZOUDÉHOUGAN, Midwife

CCS of Tchaourou

Salifou KABIBOU, Medical Director

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Fidele AGOSSOU, MCH-FP Manager

CCS of Zébou (Porto Novo)
Laetitia DOVONOU, FP Manager
Aimée DEGNOU, Deputy FP Manager
Antoinette MEDO, Nurse

UVS

UVS OF TAMOUROU (Subprefecture of N'Dali)
Mr OUROUGAIN, First Aid Worker
Mme GANDI, Traditional Midwife

MINISTRY OF LABOR, EMPLOYMENT, AND SOCIAL AFFAIRS

Social Affairs Directorate
Victorine HOUNSINOU, Director of the D.A.S
Louise TAUZIET, Interim Head of the SFPF (Family & Woman Promotion Office)
Pierre C. AYEBOA
Z. Barnabé

CPSs

CPS of Contou
Valente TOUSSOU, Departmental Social Assistant

CPS of Parakou
Sidika CHALA
Pauline KOURIKOU GNEN

CPS of Bohicon
Catherine AGOSOUVO, CPS Manager

CPS of Abomey/Zou
Benoite HOUNDIGANDE, Social Action Technician

DANA
Falilou AKADIRI, Director
Makina SEPHOU, Nutritionist
Joseph D. HESSOU, Nutritionist
Yessoufou ALAMON, Head, Quality Control Laboratory
Boniface B. YEHOUENOU, Microbiologist, Food Quality Control
Gilbert C. DAGBA

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MINISTRY OF PLANNING AND ECONOMIC RESTRUCTURING

Human Resources and Population Office

Julien GUINGNIDO GAYE, Head
and Permanent Secretary of the CNRHP
Françoise ALODJOGBE, Statistician Demographer
Marc AGONSANOU, Adjoint Cabinet Director
Nicaise KODJOGBE, National Institute of Statistics and Economic Analysis (INSAE)

MINISTRY OF ENVIRONMENT, HOUSING, AND URBANIZATION

Jean-Roger AHOYO, Minister
Damien HOUETO, Environment Director
Marcel BAGLO AYITE, PAE Coordinator

MINISTRY OF EDUCATION AND SCIENTIFIC RESEARCH

Center for Development and Research in Population
Akouma KOUNI, Research Manager
Appolinaire TOSSOU, Demographic Economist
Moustaou AMADOU-SANNI, Demographer
Denis AMOUSSOU-YEYE, Psycho-sociologist

MEPS
Raphael DARBOUX, Corrdinator
Ina BOSCH, WHO Associate Expert
Madeleine Anne DECKER, Documentarian

INFRE
Irenée B.D. ZEVOUNOU, Education/Planning
Euphrasie SALAKO, Primary Education Inspector

MINISTRY OF CULTURE AND COMMUNICATION

ORTB
Constant AGBIDINOUKOUN, TV news chief editor
~~Martial L. GOSSY, Regional Director~~
Noellie Patience LALUPO, Audiovisual Documentarian
Cyrille S. OGNIN, Chief of English Service

UNITED NATIONS AGENCIES

FAO
Jean J. SAHOU, Project Director
Lode DELBARE, Program Officer

UNDP
Babacar CISSE, Deputy Representative
Anne Birgitte HANSEN, Principal Professional Manager

UNFPA
Adeleki Isai EBO, Regional Representative (Bamako)
Micheline ZINSOU, Program Officer in Cotonou
Florentin DONADJE, Program Officer

UNICEF
Alegria R. MENDOZA, Representative
Odile AKPAKA, Education Program Assistant
Andree COSSI, Planning, Follow-up, and Evaluation Assistant
Maria Thérèsa GONCALVES, Social Mobilization Officer
Aboudou Karimou ANDÉLÉ, Program Officer, Health and Nutrition
Michéle Akan BADAROU, IEC Officer
Mohamed CISSE, Project Officer, Health

WFP
Emmanuel T. DANHOUNSI, Program Officer

WHO
B. KAMBIRE, WHO Representative, Cotonou

The World Bank
Michael AZEFOR, Principal Health and Population Specialist
Robert LEKE, MCH-FP Consultant Specialist
Aboubacar MAGASSOUBA, Project Management Specialist
Christian LOUPADA, Program Officer

BILATERAL/COOPERATING AGENCIES

The Benin-Switzerland Health Project
Jean Pierre EPAILLARD, Medical Advisor and Programs Manager

FAC
Jean François LANTERI, French Health Technical Assistance Coordinator

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USAID/Benin
Thomas CORNELL, USAID Bureau Representative in Cotonou
Sherry SUGGS, Program Officer
Jean-Claude CRINOT, Program Assistant-Health, Program Assistant-Education

U.S. Embassy in Benin
Ambassador Ruth DAVIS

NGOS

ABPF

Central Office
Francis AVODAGBE, President
Guy KPAKPO, Interim General Secretary and IEC Manager
Hortense AHOUANDJINOU, Health Promotion
Julien AYIVI , Program Coordinator for the Atlantique Department
Innocent DEGBOEVI, Equipment Manager
Ludovic SAEDLER, Deputy General Secretary of the Executive Bureau

ABPF Clinic of Cotonou
Rébecca GBAGUIDI, Clinical Manager and Midwife
Boniface YEHOUENOU, Administrator
Prudencia TOKPLO, Midwife

ABPF Regional Representation of Parakou
Ibrahim BANIGORO, Regional Coordinator
Diomama LAHANATOU, Clinical Manager and Clinic Midwife
Lahanatou DIOMAMA, Animator

ABPF Regional Representation of Porto Novo
Flavien B.M APLOGAN, Regional Coordinator

ABPF/Zou
Akiyo J. ADEWALE, Family Planning Agent

AFJB
Grâce d'ALMEIDA ADAMON, President

AFRICARE
Daniel Eric GERBER, Representative
Brownie LEE, Program Coordinator

APFEM
Innocentia GUEDEGBE, President

Mr DJiVOH, Member
Djeffa Village
Ekpé Village

Coalition des ONG pour les Developpement
Toussaint HINVI, President
Noël DOSSOU-YOVO, Technical Counselor
Valentin HOUNSA HOUNSOU, President, GSEC Promotions

CREN
Marie Bottineau, "Terre des Hommes", Bohicon/Zou
Martine D'ALMEIDA, Head MCH/CREN, Ouando/Oueme

CRS
Ange TINGBO, Director
Rigobert K. HOUNNOUVI, Head, CRS/MTEAS Food and Nutrition Project

GTZ
Emmanuel GBAGUIDI, Project Manager

IBFAN
Mr MOUDASHIROU, President, IBFAN/Benin

ONASA
Benjamin K. SOUDE, PILSA Project Manager

PSI/ABMS
Auguste J.M. KPOGNON, Representative
Paige HOLT, Assitant Coordinator

PANA
Therese KPATINDE, Head, PANA Dasa Village
Genevieve ETEKA, Head, PANA Soclogbo Village
Hounhowedo J. ZOKPEME, Head, PANA Zakpota

CREDESA of Pahou
Eusèbe ALIHONOU, Director
Thimotée GANDAHO, Deputy Medical Director
Gbangbade SOUROU
Seraphin VISSOH
Marguerite VIGNIGBE, Midwife, Nutrition Education

PRIVATE COMMERCIAL ENTITIES

Pharmacies

Pharma-Quick
Monique SOMDA-CEAUX, Commercial Manager

GAPOB
Jalilou ADEBO, General Director

Pharmacie Tranza in Parakou
Natougou Benoît DAKOU, Pharmacist and Biologist

Private Hospitals/Clinics

"Clinique Coopérative" of Parakou
Yessoufou SAFIOU , Deputy Medical Director

Hospital Saint Jean de Dieu of Boko
Edith BIAOU, Nurse

Hospital of SANOU-SEROU in Nikki
Dr DIJKRSTK, Medical Director

Hospital Saint Martin
Guy LAURENT, Medical Director
Alain SANTOS, Surgeon

ORDH
Hospice SECLONDE COMLAN, Director

Food Processing

SUPER FARINE BEBE PROCESSING PLANT (Weaning Food)
Rocco CONTE, Director
Robert Z. METOHOUE, Head of Production

OTHER

Muslim Community of Djeffa
Ali Karim BEDOUNOU, Imam

APPENDIX D

BENIN
FAMILY PLANNING
Contraceptive Supplies/Revenue Projections 1994-2000

7/94

Target Population	1993	1994		1995	1996	1997	1998	1999	2000
WRA	1,250,000	1,290,000		1,330,000	1,370,000	1,410,000	1,450,000	1,490,000	1,530,000
CPR (%)	1	1.2		1.5	2	2.5	3	3.5	4
acceptors	12,500	15,500		20,000	27,500	35,000	43,500	52,000	61,000
			Amount supplied by UNFPA/ IPPF (1994)						
Contraceptive Needed									
55% Pills	81,250	110,825	65,088	143,000	190,625	250,250	311,025	371,800	436,150
35% Injectables	26,250	32,550	36,800	42,000	57,750	73,500	91,350	109,200	128,100
5% IUDS	1,250	1,550	6,350	2,000	2,750	3,500	4,350	5,200	6,100
2.5% Spermicides	3,125	3,875	1,900	5,000	6,875	8,750	10,875	13,000	15,250
2.5% VFTs	3,750	4,650	3,000	6,000	8,250	10,500	13,050	15,600	18,300
Condoms	100,000	110,000	73,500	121,000	133,000	146,000	161,000	177,000	195,000
Costs ($)									
Pills (28/cycle)	21,125	29,590	17,378	38,610	55,055	72,573	93,308	115,258	139,568
Injectables(1.00 ea.)	26,250	32,550	36,800	42,000	63,525	80,850	109,620	131,040	166,530
IUDS (.50 ea.)	625	775	3,175	1,000	1,375	1,750	2,610	3,120	3,660
Spermicides (3.00/tube)	9,375	11,625	5,940	15,000	20,625	27,125	34,800	42,900	50,325
VFTs (2.85/12 tubes)	891	1,104	713	1,425	1,894	2,025	3,371	4,030	4,880
Condoms (0.0175 ea.)	1,750	1,925	1,286	2,118	2,398	2,628	2,898	3,363	3,705
TOTAL (US$)	60,016	77,570	65,292	100,153	144,968	187,551	246,607	299,711	368,668
Revenues (CFA)									
Pills (100 CFA)	8125000	11082500	6508800	14657500	20645625	26778750	34212750	42013400	50593400
Inject. (500 CFA)	13125000	16275000	18400000	21504000	30318750	39543000	50425200	60715200	74298000
IUDs (400 CFA)	500000	620000	2540000	820000	1155000	1508500	1922700	2355800	2830400
Spermicides(200 CFA)	625000	775000	396000	1025000	1443750	1881250	2403375	2938000	3538000
VFTs (200 CFA/tube)	750000	930000	600000	1230000	1732500	2257500	2884050	3525800	4245800
Condoms (12.5 CFA)	1250000	1375000	918750	1573000	1729000	2044000	2334500	2865000	3022500
TOTAL (CFA)	24,375,000	31,057,500	29,363,550	40,809,500	57,024,625	74,011,000	94,182,575	114,202,800	138,527,900
Distribution Costs (in CFA)		29,000,000		30,450,000	31,972,500	33,571,125	35,249,681	37,012,165	38,862,774
Dist. costs as % of revenues		93%		75%	56%	45%	37%	32%	28%

Assumptions:

1) Women of Reproductive Age (WRA) would increase 3%/year between 1994 and 2000, in line with the expected population increase.
2) Contraceptive Prevalence Rate (CPR) will rise from 1% in 1993 to 4% in 2000 to meet Govt. of Benin's population targets.
3) The method mix as in 1993-4 will remain constant throughout the period 1994-2000.
4) Quantities calculated on basis of following usage rates per client: OCs-13 cycles/yr, injectables- 6 ampoules/yr, IUDs 2/yr, spermicides- 10 tubes/yr, foaming tablets 12 tubes/yr, condoms -- figure based upon 1993-4 supplies to public health and ABPF clinics.
5) Costs of supplies (based on UNFPA/IPPF 1993-4 prices) would increase an average of 2.5% a year 1995-2000.
6) Revenues: 1993-4 client charges would increase 2.5%/year from 1995 to 2000.
7) Figures assume that all supplies will be sold and at a 100% collection rate of revenues.
8) Distribution of all contraceptives (UNFPA/ABPF/others) would be centralized and carried out by one distribution management organization (eg. ABMS/PSI).
9) Distribution costs include one vehicle depreciated over 5 years.
10) Constant exchange rate $1US = 525CFA
11) Majority of contraceptives will be continued to be supplied by UNFPA/ABPF

GDM/PH

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2. SYSTEME DE SANTE

Annex 3

2.1. Organisation du système national de santé

Le système de santé est calqué sur le découpage administratif. Il a une structure pyramidale à trois niveaux :

- le niveau central ou national;
- le niveau intermédiaire;
- et le niveau périphérique.

Ce système est résumé par le tableau n°7.

TABLEAU N°7 : SYSTÈME NATIONAL DE SANTÉ - BÉNIN, 1993.

NIVEAUX		INSTITUTIONS	STRUCTURES HOSPITALIERES ET SANITAIRES	SPECIALITES
CENTRAL		Ministère de la Santé (MS)	Centre National Hospitalier et Universitaire (CNHU)	- Médecine - Pédiatrie - Chirurgie - Gynéco-obs - Radiologie - Laboratoire - O.R.L., OPH - Autres spécialités
INTERMEDIAIRE ou DEPARTEMENTAL		Direction départementale de la Santé (DDS)	Centre hospitalier départemental (CHD)	- Médecine - Pédiatrie - Chirurgie - Gynéco-obs - Radiologie - Laboratoire - Autres spécialités
PERIPHERIQUE	Chef lieu de sous-préfecture ou de circonscription urbaine	Centre de santé de sous-préfecture ou de circonscription urbaine (CSSP/CSCU)	Centre de santé de sous-préfecture ou de Circonscription urbaine (CSSP/CSCU)	- Médecine - Chirurgie - Maternité - Radiologie - Laboratoire - Pharmacie
	Chef lieu de commune	Complexe Communal de santé (C.C.S.)	Complexe Communal de Santé (C.C.S.)	- Dispensaire - Maternité - Pharmacie
	Village ou quartier de ville	Unité villageoise de santé (U.V.S.)	Unité villageoise de santé (U.V.S.)	- Soins - Accouchements - Caisse de pharmacie

Source : MS-SESP

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TABLEAU N°9 : INFRASTRUCTURES SANITAIRES PUBLICUES PAR DÉPARTEMENT AU 31/12/93.

		Atacora	Atlantique	Borgou	Mono	Oueme	Zou	Bénin
CNHU		0	1	0	0	0	0	1
CHD	Conformes	1	0	1	0	1	1	4
	Non Conformes	0	0	0	0	0	0	0
CS-SP ou CS-CU	Conformes	3	1	3	2	3	6	18
	Non Conformes	10	13	11	10	13	9	66
CCS	Conformes	33	42	40	32	34	37	218
	Dispensaire seul	13	8	16	2	10	22	71
	Maternité seule	0	4	2	1	1	11	19
Dispensaires Isolés		13	11	13	2	6	6	51
Maternités Isolées		0	1	1	5	2	2	11
Centre Psychiatrique		0	1	0	0	0	0	1
Centre de pneumo-phtisiologie		0	1	0	0	1	0	2
Centre de traitement anti-lèpre		2	1	2	1	1	2	9
Infirmeries Scolaires		0	12	4	1	10	0	27
UVS		122	11	76	25	17	62	313
Lits d'hospitalisation		310	606	145	108	432	311	1912
Lits de Maternité		345	494	230	235	569	414	2287

Source : SESP/MS

Le secteur privé peut se subdiviser en 2 catégories : le secteur privé à but non lucratif (hôpitaux confessionnels ou associatifs) et le secteur privé à but lucratif (cabinets privés).

La situation de ce secteur privé à but lucratif est difficile à cerner avec exactitude. En effet nous assistons à une prolifération des cabinets médicaux, cabinets de soins et cliniques d'accouchement depuis 1987, date à laquelle le recrutement du personnel dans la fonction publique Béninoise a été gelé. L'installation de ces cabinets et cliniques étant souvent anarchique et sans autorisation du Ministère de la Santé, il n'est pas possible, surtout dans les départements du sud où le phénomène est très important, de donner une situation exacte sans un recensement des formations sanitaires privées. Les chiffres que nous présentons sous estiment donc très probablement la réalité.

UNFPA

PRODUITS CONTRACEPTIFS COMMANDES EN 1993

Date de Réception	N° Bon de Commande	Nature du Produit	Qté	Coût
Juillet 1993	P.O. TC-F93-95 00559 du 12 Novembre 1993	500 Colis de 147 condoms	73500	1,290 $
Mai 1993	P.O. LB-F93-95 00025	. Microgynon 30 ED FE TAB 3 x 28 . Eugynon 30 ED FE TAB 3 x 28 . Noristerat Ampoules 100 x 1 ml . Microlut Tablettes 100 x 35	7000 7000 300 111	41,922.56 $
Octobre 1993	P.O. LG-F93-95 00023 du 07 Mars 1993	Intrauterine Contraceptive device . CUT 380 A . CUT 200 B	3000 3000	1,926 $ 1,320 $
Février 1993	P.O. TC-F93-95 00558 of 12/11/93	Speton Packages of 12 vaginal tablets	3000	8,550 $
TOTAL				55,008.56 $

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STATUTS DE LA CENTRALE D'ACHAT DES MEDICAMENTS ESSENTIELS ET CONSOMMABLES MEDICAUX

CHAPITRE PREMIER DE LA DEFINITION, DU SIEGE SOCIAL, DE L'OBJET ET DU CAPITAL SOCIAL

ARTICLE 1ER: Il est créé en République Populaire du Bénin une Centrale d'Achat des Médicaments essentiels et Consommables médicaux dans le cadre du Programme de Développement des Services de Santé.

ARTICLE 2: La Centrale d'Achat est dotée de la personnalité civile et de l'autonomie financière.

ARTICLE 3: Le siège social de la Centrale est fixé à Cotonou. Il peut être transféré en tout autre lieu du territoire national.

ARTICLE 4: La Centrale d'Achat a pour objet:

- l'approvisionnement en médicaments essentiels et consommables médicaux des formations sanitaires publiques et privées à but non lucratif.
- la passation à l'intérieur et à l'étranger des commandes auprès des fournisseurs
- la cession à un prix social mais rémunérateur pour la Centrale aux formations sanitaires publiques et privées à but non lucratif des objets susmentionnés.

ARTICLE 5: Le règlement intérieur de la Centrale sera établi par la Direction et soumis au Comité de Gestion pour fixer les conditions dans lesquelles la Centrale effectuera les opérations correspondant à son objet.

ARTICLE 6: Les ressources de la Centrale sont constituées par:

- une dotation initiale: en numéraires ou médicaments mis à la disposition de la Centrale par les bailleurs de fonds
- la valeur des immeubles mis à la disposition de la Centrale d'Achat par l'Etat
- les recettes issues des cessions de médicaments
- des produits des placements de fonds
- des subventions

et toutes autres ressources attribuées à la Centrale par un acte international ou un texte législatif ou réglementaire.

CHAPITRE II DU COMITE DE GESTION

ARTICLE 7: La Centrale d'Achat est administrée par un Comité de Gestion investi des pouvoirs les plus étendus pour agir en toute circonstance au nom de la Centrale. Il les exerce dans la limite de son objet.

ARTICLE 8: Le Comité de Gestion a notamment les pouvoirs suivants dont l'énumération n'est pas limitative:

- il élabore la politique générale de la Centrale;
- il reçoit directement communication des rapports trimestriels annuels et délibère à leur sujet;
- sur proposition le Comité de Gestion examine et approuve chaque année:
  * l'étude prévisionnelle sur les perspectives d'activités de la Centrale pour l'exercice suivant;
  * les comptes de l'exercice écoulé;
- il propose par un rapport motivé toutes modifications aux statuts qui lui paraissent utiles ou indispensables pour assurer le bon fonctionnement ou le développement de la Centrale.
- il procède au contrôle et donne son avis sur les procédures d'achats y compris la régularité de celles-ci, les choix des clients et il approuve les prix, assure la gestion matérielle et financière des médicaments et ordonnance de la manière et aux conditions qu'il juge convenable les contrôles, audits et inspections appropriés.
- Il exerce toutes actions judiciaires, tant en demande qu'en défense.

ARTICLE 9: Le Comité de gestion se réunit chaque fois que nécessaire en tout une fois par trimestre 15 jours avant les sessions du Comité de revue. En tout état de cause il est tenu de se réunir:

- une fois dans les trois mois précédant la fin de l'exercice pour examiner le programme et le budget de l'exercice à venir;

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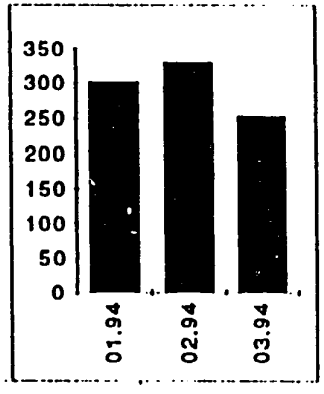
3' ANNEE 1994 jusqu'au 24 mars 1994

Mois	Nbre Clients	Chiffre d'Affaires FCFA	Chiffre d'Affaires médicaments	Chiffre d'Affaires consommables
01.94	302	83123270	60047975	23075295
02.94	329	88607908	65558018	23049890
03.94	253	88852425	70733370	18119055
TOTAL :	884	260583603	196339363	64244240
Pourcentage :		100%	75,35%	24,65%



Nombre de clients

ANNEE 1994 / PERIODE 1er JANVIER au 24 MARS par rapport à la même période en 93 :

EVOLUTION	45%	66%	73%	46%

Ce chiffre d'affaires est exprimé en prix bloqués à l'ancien taux du FCFA .

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Rétro-snigs

Bulletin trimestriel d'informations épidémiologiques et statistiques du ministère de la santé du Bénin

Avril 1994 Volume 3, numéro 2

ACTUALITE

Dévaluation du FCFA et approvisionnement du Bénin en médicaments

Au lendemain de l'annonce de la dévaluation du franc CFA, le Gouvernement béninois en accord avec les bailleurs de fonds, a pris la décision de bloquer, pour l'année 1994 les prix de cession des médicaments essentiels au niveau de la Centrale d'Achat et des formations sanitaires publiques au tarif de 1993: Cette mesure salutaire devrait permettre de retarder les effets douloureux de la dévaluation sur cette gamme de produits et de garantir aux populations les plus défavorisées l'accessibilité financière de ces médicaments essentiels.

Cette décision revient à subventionner le prix des médicaments génériques pour un montant égal à leur valeur nominale en FCFA, puisque la dévaluation devait conduire grossièrement à un doublement du prix d'achat des produits. Pour permettre à la Centrale d'Achat des Médicaments Essentiels de faire face aux conséquences de cette décision et de pouvoir satisfaire l'augmentation de la demande pour ces produits, qui doit en résulter, la Centrale d'Achat aura besoin d'un apport financier supplémentaire estimé pour l'année 1994 à 1,6 milliard FCFA. Cette somme lui permettra de revaloriser son stock, revaloriser sa trésorerie et compenser la perte en chiffre d'affaires sur ses achats qui seront vendus en 1994.

Conformément aux résolutions de la réunion de concertation des bailleurs de fonds, tenue à Paris le 4 février 1994, certains partenaires au développement du secteur de la santé ont déjà annoncé des intentions de contributions financières à la recapitalisation de la Centrale d'Achat.

A ce jour, la Centrale d'Achat a déjà obtenu plusieurs subventions pour faire face à ses commandes urgentes, rendues nécessaires par la forte augmentation des ventes depuis la dévaluation :

- 150 millions de FCFA de la France déjà décaissés et utilisés pour acheter les médicaments à Pharmaquick,
- 250 millions de FCFA, promis par le Danemark, en cours de décaissement, seront utilisés pour l'achat des solutions de perfusion à Bio-Bénin.
- 200 millions FCFA, promis par la Suisse et qui seront décaissés sous peu, seront utilisés pour l'achat des consommables médicaux. Le reste des besoins financiers sera fourni par la Banque Mondiale sous forme de crédit.

En outre le Gouvernement a obtenu de la France une subvention de 200 millions de FCFA pour la création, au niveau de la Pharmacie du CNHU, d'une unité de cession de médicaments essentiels génériques et ce dans le souci d'accroître la couverture pharmaceutique de la ville de Cotonou.

Par ailleurs, le Gouvernement a prévu une enveloppe de 200 millions de FCFA pour l'approvisionnement par la Centrale d'Achat des officines privées en médicaments essentiels génériques.

La mise en oeuvre de l'ensemble de ces mesures par la Centrale d'Achat a permis jusqu'à présent d'assurer la disponibilité sur l'ensemble du territoire national des médicaments de bonne qualité à un prix abordable à la majorité des populations.

Ceci a été facile au Bénin, contrairement aux autres pays de la zone, grâce à un atout majeur : l'existence d'une structure unique d'approvisionnement du pays en médicaments essentiels : la Centrale d'Achat.

Toutefois, pour assurer que l'impact de ces subventions atteignent effectivement les populations bénéficiaires, il est urgent que les autorités sanitaires renforcent les actions de sensibilisation du public, de contrôle systématique des centres de santé et éventuellement des mesures de sanctions des agents de santé en cas de déviations qui rendraient nuls les efforts entrepris pour garantir à tous des soins de qualité à un coût abordable.

Enfin, il est opportun de convier chacun à oeuvrer dans le sens de la préservation de ce joyau qu'est pour le Bénin, la Centrale d'Achat des Médicaments Essentiels. Ceci ne sera possible qu'à un prix : l'engagement de tous pour le renforcement de l'autonomie financière et de gestion de la Centrale d'Achat, conformément aux résolutions des Ministres de la Santé de la Zone Franc à Abidjan le 18 mars 1994.

Kokou Afogbé (CAMEE)

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ANNEXE

APF: A.B.P.F. BP. 1486 COTONOU
(REP. DU BENIN)

SITUATION DES SORTIES DES CONTRACEPTIFS

RAPPORT ANNUEL: 1 9 9 3

CONTRACEPTIFS.	STOCKS DEBUT PERIODE	RECUS PENDANT LA PERIODE	TOTAL DISPONIBLE	SORTIES: AUTRES AGENCES	SORTIES: ACCEP/APF GRATUITS	SORTIES: PEREMPT. PERTES	SORTIES: DONS/ ECHANTIL.	SORTIES: VENTES CLIENTS	PRIX UNIT CONTRAC.	MONTANT VENTES	TOTAL SORTIES	STOCK FIN PERIODE
MICROGYNON 3c ED Fe	9348	6843	16191	392	296	-	-	9990	111,37	1112625	10678	5513
NEOGYNON ED Fe	4689	2400	7089	-	147	-	-	3878	106,10	411490	4025	3064
EUGYNON 3c ED Fe	1896	6675	8571	39	163	-	-	4514	108,11	488040	4716	3855
OVRAL 28	863	1200	2063	-	79	-	-	1446	115,28	166700	1525	538
OVRETTE	1258	1000	2258	13	22	-	-	1191	120,23	143200	1226	1032
EXLUTON	1200	1800	3000	-	14	-	-	2445	105,70	258450	2459	541
LO FEMENAL	289	-	289	-	23	-	-	267	153,74	41050	289	-
NORDETTE 21	2001	1800	3801	-	16	-	-	1844	108,92	200850	1260	1941
DIU Copper Tcu 380 A	3006	-	3006	197	29	-	-	936	484,85	425740	1162	1844
NORISTERAT	4097	3000	7097	696	60	96	-	3097	613,73	1900750	3949	3148
DELFEN + APPLICAT.	3019	-	3019	2042	70	337	-	570	239,85	136720	3019	-
KOROMEX	2439	-	2439	1219	47	-	-	680	211,76	144000	1946	493
CONCEPTROL COMP.	53445	201200	254645	56200	4822	-	-	44951	14,26	641075	105973	148672
CONDOMS	114000	266303	380303	103742	19432	-	-	58586	10,02	587392	181760	198543

TOTAL VENTES CONTRACEPTIFS PERIODE 6658082

COMMENTAIRES : Suite à l'harmonisation des prix des produits contraceptifs, l'Association a connu deux périodes de vente au cours de l'année. Ainsi les prix unitaires de vente n'ont pas été identiques dans toutes les Antennes. Par ailleurs chaque Antenne a accordé une commission sur vente de 10 % à ses clients. C'est ce qui justifie les présents prix unitaires moyens.-

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UNFPA

1994

BON DE COMMANDE au 21/07/94

LIGNE BUDGETAIRE 44

$ US 50 000 -

-:-:-:-:-:-:-:-

DESIGNATION	QUANTITE	CONDITIONNEMENT	PROVENANCE
Microgynon Eugynon	5 000 2 000	Boîte de 3 plaquettes " " "	Schering AG Post Fach 650311 D 106 Berlin 65 w
Speton	1 500	Boîte de 12 comprimés	Tember WEKE P.O BOX 2269 Narburg Fed Rep of Germany
Latexprophy Latex Condoms	2 778	Boîte 144 unités	SEOHUNG Industrial CO, LTD KPO BOX 721 Seoul KOREA

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PSI/Benin
Condom Social Marketing Project
Distribution System

PSI/Benin's distribution system is key to the project's success, and has systematically disseminated nearly 4.5 million condoms throughout Benin in only three and a half years. Although the project relies heavily on educational and promotional activities to create demand for the product, it is the distribution system that meets this demand efficiently.

The sale of Prudence condoms starts with a pricing policy that gives incentives at every level of the sale. The price breakdown is as follows:

Distributor's price:	20 F CFA/packet (of 4 condoms)
Wholesaler's price:	30 F CFA/packet
Retailer's price:	40 F CFA/packet
Consumer's Price:	50 F CFA/packet

At each level, the vendor is receiving a commission, while still leaving the consumer price affordable to the entire population.

PSI has its own distributors and wholesalers who are largely responsible for product distribution, and for whom a system of quotas and bonuses is in place. The distributor for the North (based in Parakou) has a warehouse where he stores a two months' supply of product, and comes to Cotonou to restock every other month. He is responsible for the Borgou, Atacora, and Northern Zou departments, and has two salesmen with mopeds who follow the distribution system, restocking in small supply and alerting the distributor when a larger amount of stock is needed for a client. A Southern distributor is responsible for the Ouèmè (outside Porto Novo), Mono, Atlantique (outside Cotonou), and Southern Zou areas. Both distributors make sales tours each month, focusing on one department or region at a time, reaching both major cities as well as villages. Two other salesmen, equipped with mopeds, are responsible for all of Cotonou and Porto Novo.

Additionally, PSI works with outside distributors such as private pharmaceutical wholesalers like SOPHABE and GAPOB, and a major consumer product distributor, the CFAO (who supplies the COOP, Benin's only chain supermarket with outlets nationwide).

Non-governmental organizations have also become an integral part of the project's distribution system. Several NGOs in Benin provide assistance in some way or another to the public health sector, and have collaborated with PSI in disseminating condoms and AIDS information. These NGOs include ABPF, OCSD, GTZ, UNHCR, Survie de la Mère et l'Enfant, and the Red Cross

REPUBLIQUE POPULAIRE DU BENIN

MINISTÈRE DE LA SANTÉ PUBLIQUE

PROJET BIEN - ÊTRE FAMILIAL
BEN/80/PO 2

FICHE DE GESTION DE CONTRACEPTIF

Formation : _____

Province _____

Type (a) MICROGYNON

Présentation (b) Boites de 3 plaquettes

DATES 1	QUANTITÉ Reçue 2	Sortie ou utilisée 3	en Stock 4	ORIGINE DESTINATION OBSERVATIONS 5
1993	7000		7000	
10/8/93		100	6900	DDS OUERE
27/8/93		100	6800	DDS Atlantique
21/9/93		200	6600	DDS Zou
6/10/93		350	6250	DDS OUERE
21/10/93		500	5750	DDS ATACORA
23/10/93		630	5120	DDS Mono
30/9/93		100	5020	DDS Atlantique
3/11/93		100	4920	DDS Atlantique
11/11/93		40	4880	DDS ATACORA
17/11/93		890	3990	ABPF
14/12/94		100	3890	DDS Atlantique
09/02/94		350	3540	DDS OUERE
14/1/94		100	3440	Atlantique
9/2/94		350	3190	OUERE
19/4/94		700	2490	BOLGOU
22/4/94		200	2290	Atlantique
27/4/94		200	2090	Zou

(a) Exemple : Condom, ou Pilule _____ , ou Stérilet _____

Une Fiche est réservée pour un type de contraceptif donné.

(b) Exemple : plaquette de 10, ou boîte de 20.

Point sur la gestion des produits contraceptifs du PBEF
Maternité Lagune Cotonou

Stock / Produits	Stock Initial	quantité Vendue	quantité Restante	Recette	Observations
Noristerat	100				500.-
Sterilet T380	61				400
Eugynon	10 boîtes 30 plaquettes				100.-
Microgynon	20 bles 60 plaquettes				100.-
Microlut	10 bles 30 plaquettes				100.-
Spelon	12 boîtes				200.-
Neo-Sampoon	1 ble 20 tubes				200.-
Condom	1 ble 144 unités				2/25

A.P. /

STOCK / RESUME FINANCIER

ANTENNE DE Porto-Novo ABPF

ANNEE : 1984 MOIS DE : Janvier à Juin

DESIGNATION	STOCK INITIAL	STOCK RECU	STOCK DISPONIBLE	SORTIES VENDU	SORTIES DON	SORTIES TOTAL	PRIX UNITAIRE	RECETTES	STOCK FINAL CLINI. INTEGR.	STOCK FINAL SIEGE	STOCK FINAL TOTAL
MICROGYNON	34	351	385	335		335	100	33.500			50
EUGYNON	17	171	188	152		152	100	15.200			36
NEOGYNON	16	203	219	197	1	197	100	19.700			21
LO FEMENAL	0	30	30	10		10	100	1000			20
NORDETTE	32	90	122	105		105	100	10.500			17
OVRETTE	35	72	107	96	1	96	100	9.600	10		0
OVRAL 28	35	98	133	125		125	100	12.500			8
EXLUTON	31	80	111	87		87	100	8.700			24
Seringues	0	248	248	232	2	232	100	23.200			14
NORISTERAT	82	260	342	324	3	324	500	162.000			15
T AU CUIVRE	12	90	102	88	7	88	400	35.200			7
CONCEPTROL	108	3.200	3.308	3.108		3.108	15	46.620			200
DELFEN	8		8	2		2	200	400			6
KOROMEX	22	24	46	40	1	40	100	4.000			5
APPLICATEURS	20	24	44	35	1	35	100	3.500			8
Carnets	12	260	272	264		264	50	13.200			
CONDOMS	98	5.164	5.262	5.016	4	5016	6,25	31.350			242
Planosec	17	20	37	22	2	22	1000	22.000			13
Controle						250	200	50.000			

TOTAL = 502.170F

STATISTIQUES

ACCEPTEURS METHODES	NOUVEAUX	NON RECIDIVISTES	TOTAL VI
CONTRACEPTIFS ORAUX	86	404	
INJECTABLES	52	266	
D.I.U.	87	10	
PRESERVATIFS	197	48	
COMPRIMES MOUSSANTS	136	25	
MOUSSE (FLACONS)	15	-	
CREMES GELEES (TUBES)	17	-	
TOTAL DES METHODES	590	753	
AUTRES (PRECISER)			

REPUBLIQUE DU BENIN

MINISTERE DE LA SANTE PUBLIQUE

DEPARTEMENT DE : .....

C.C.S./CS / SP - CS / CU / C.H.D. Hôpital privé/CNHU

(C 6)

RAPPORT SUR LES ACTIVITES DE MATERNITE

Nom de la formation sanitaire : ..... Mois de .....19 .....

TOTAL D'ACCOUCHEMENTS	
ACCOUCHEMENTS EUTOCIQUES	
ACCOUCHEMENTS DYSTOCIQUES	
dont :	
. CESARIENNES	
. FORCEPS	
VENTOUSE	
AUTRES	
TOTAL DE NAISSANCES VIVANTES	
MORTS - NES	
ENFANTS NES VIVANTS DE POIDS<2500 g	
AVORTEMENTS	
DECES MATERNELS	
DECES D'ENFANTS<07 JOURS	
PARTURIENTES EVACUEES	
HOSPITALISEES	
JOURS D'HOSPITALISATION	

RAPPORT SUR LA SANTE MATERNELLE ET INFANTILE

	CONSULTATIONS				
	DES MERES		CONSULTATION DE PLANNING FAMILIAL	DES ENFANTS SAINS	
	CONSULTATION PRENATALE	CONSULTATION POST - NATALE		0 - 11 MOIS	12 - 35 MOIS
NOUVEAUX (ELLES) CONSULTANTS (ES)					
ANCIENS (NES) CONSULTANTS (ES)					
TOTAL DES CONSULTATIONS					
NOMBRE DE GROSSESSES A RISQUE DETECTEES					
NOMBRE DE CAS REFERES					

RAPPORT SUR L'ACCEPTATION DES METHODES CONTRACEPTIVES

ACCEPTANTES	METHODES			
	DISPOSITIF INTRA - UTERIN (D. U.)	CONTRACEPTIF ORAL (C. O.)	CONTRACEPTIF INJECTABLE (C. INJ.)	" DITE BARRIERE"
NOUVELLES ACCEPTANTES (1)				
ANCIENNES ACCEPTANTES (2)				
ACCEPTANTES TOTALES (3)				

ARRETS POUR : **NOMBRE** :

- DESIR DE GROSSESSE .....
- GROSSESSES ACCIDENTELLES .....
- PERDUES DE VUE .....
- ABANDON .....

Signature

Date ..... Nom .....

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FICHE DE STOCK N-

(A 3)

CSD _____ CCS _____

Article _____

Forme _____ Dosage _____

Stock de Sécurité _____ Point de Commande _____

Date	Prov · Dest · Avaries	Entrées	Sorties	Stock	Date de Péremption	Observations	Signature

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REPUBLIQUE DU BENIN

MINISTERE DE LA SANTE PUBLIQUE

DEPARTEMENT DE : .....

RAPPORT DE SYNTHESE SUR L'ACCEPTATION DE METHODE CONTRACEPTIVE DE : .....

(C 10)

MOIS DE : ..... 19 .....

RUBRIQUES / FORMATIONS SANITAIRES	DISPOSITIF INTRA UTERIN (D. I. U.)			CONTRACEPTIF ORAL (C. O.)			CONTRACEPTIF INJECTABLE (C. INJ.)			ARRETS POUR			
	Nouvelles acceptantes	Anciennes acceptantes	Acceptantes totales	Nouvelles acceptantes	Anciennes acceptantes	Acceptantes totales	Nouvelles acceptantes	Anciennes acceptantes	Acceptantes totales	Désir de Grossesse	Grossesse Accidentelle	Perdu de Vue	Abandon
Ensemble Sous-Préfecture ou du Département :													

* Rayer la mention inutile

Signature

Date : .....

Nom : .....

REPUBLIQUE DU BENIN

MINISTERE DE LA SANTE PUBLIQUE

DEPARTEMENT DE : .....

(C 9)

RAPPORT DE SYNTHESE DES ACTIVITES DE MATERNITE DES FORMATIONS SANITAIRES DE :

_____

Mois de : ..... 19 .....

RUBRIQUES / FORMATIONS SANITAIRES	ACCOUCHEMENTS							NAISSANCES VIVANTES		MORTS NES	AVORTEMENTS	DECES		Parturientes évacuées	hospitalisées	Jours d'hospitalisation	Lits de Maternités
	EUTOCIQUES	DYSTOCIQUES DONT :					TOTAL DES ACCOUCHEMENTS	Enfants nés vivants poids inf.-2500 g	Total des naissances vivantes			Maternels	Enfant < 7 jours				
		Césariennes	Forceps	Ventouse	Autres	TOTAL											
Ensemble de																	

Signature

Date : .....

Nom : .....

BENIN
STRENGTHENING OF FP LOGISTICS

US$ 000's

COMPONENT	1995	1996	1997	1998	1999	TOTAL
I. Management (MOH/DSF)	100	100	50			250
e.g., FPLM, including:						
-- Resident Adviser						
-- Training						
-- MIS						
-- Technical Assistance						
II. Consultancies						
1. Cost Recovery/Client fees	20		20			40
2. MIS	20	10				30
3. Storage Facilities & Stock Control	20		20			40
4. Distribution study	15					15
III. Distribution	57	61	64	67	70	319
IV. Data Collection/Analysis (ABPF)	10	10	10	5	5	40
TOTAL US$	242	181	164	72	75	734

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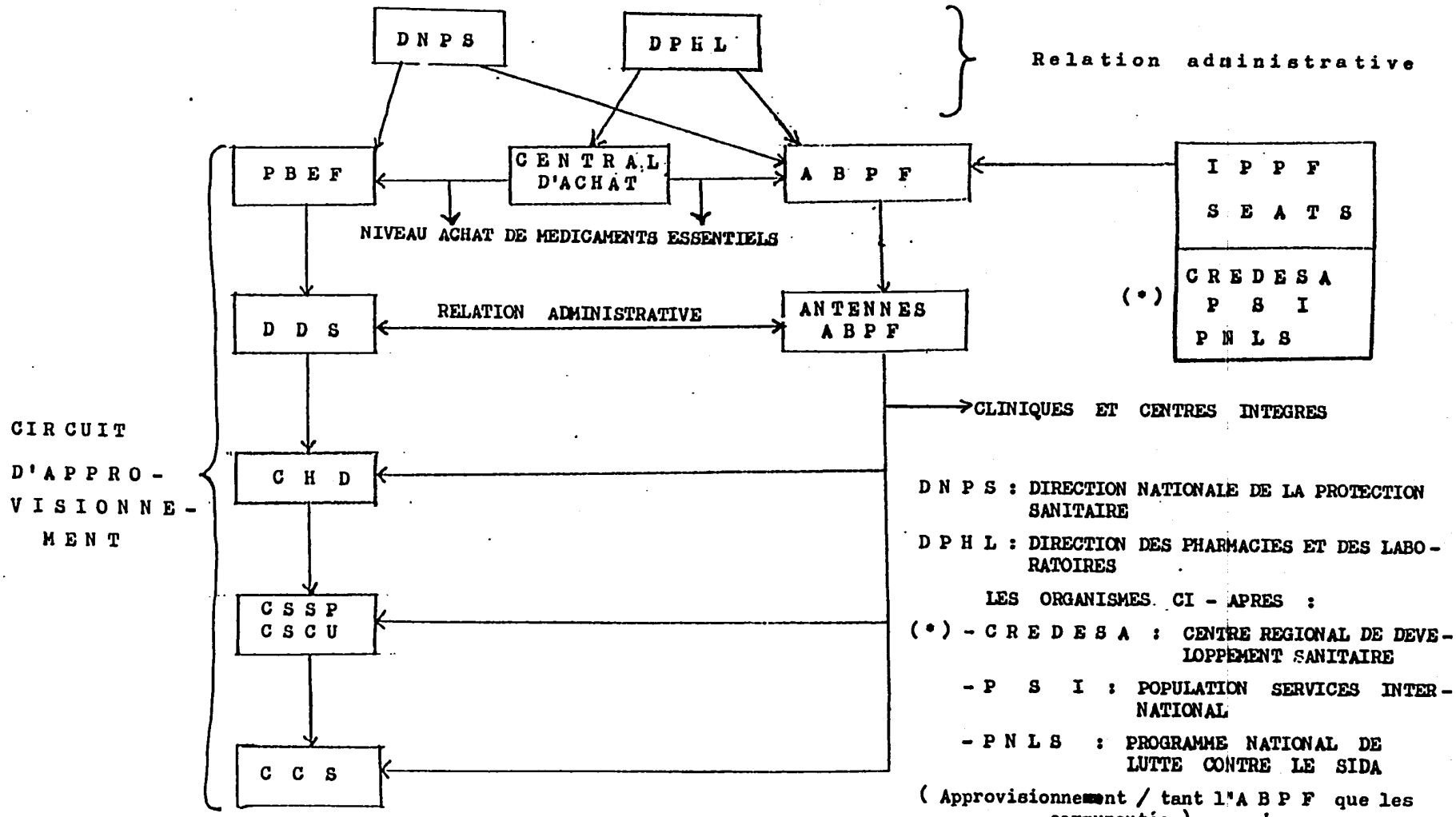


DNPS : DIRECTION NATIONALE DE LA PROTECTION SANITAIRE

DPHL : DIRECTION DES PHARMACIES ET DES LABORATOIRES

LES ORGANISMES CI - APRES :

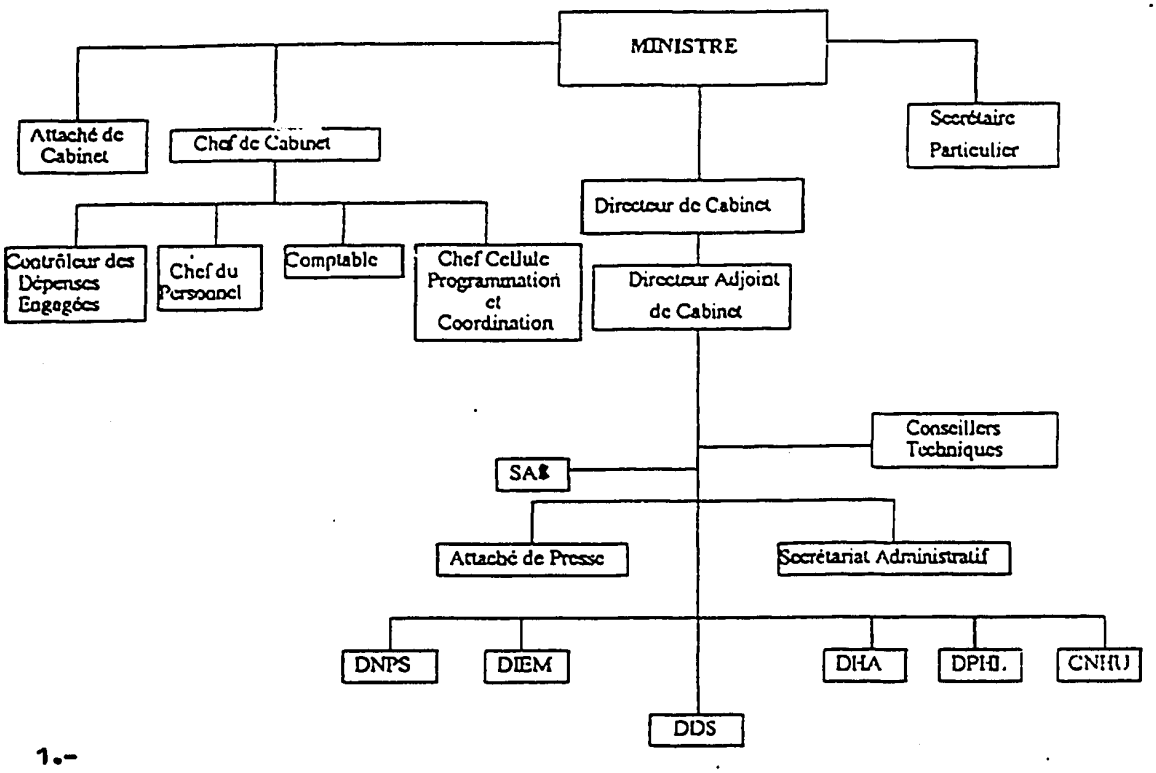
(*) - CREDESA : CENTRE REGIONAL DE DEVELOPPEMENT SANITAIRE

- PSI : POPULATION SERVICES INTERNATIONAL

- PNLS : PROGRAMME NATIONAL DE LUTTE CONTRE LE SIDA

(Approvisionnement / tant l'ABPF que les communautés) .-

1.- ORGANIGRAMME DU MINISTERE DE LA SANTE



1.-

D N P S : DIRECTION NATIONALE DE LA PROTECTION SANITAIRE

D I E M : DIRECTION DE L'INFRASTRUCTURE, DE L'EQUIPEMENT ET DE LA MAINTENANCE

D H A : DIRECTION DE L'HYGIENE ET DE L'ASSAINISSEMENT

D P H L : DIRECTION DES PHARMACIES ET DES LABORATOIRES .-

2.-

P B E F : PROJET DE BIEN - ETRE FAMILIAL (PROJET GOUVERNEMENTAL)

A B P F : ASSOCIATION BENINOISE POUR LA PROMOTION DE LA FAMILLE ET SES CLINIQUES

I P P F : FEDERATION INTERNATIONALE POUR LA PLANIFICATION FAMILIALE

S E A T S : PROJET D'EXPANSION ET DE SOUTIEN TECHNIQUE AUX SERVICES DE PLANIFICATION FAMILIALE

D D S : DIRECTION DEPARTEMENTALE DE LA SANTE

C H D : CENTRE HOSPITALIER DEPARTEMENTAL

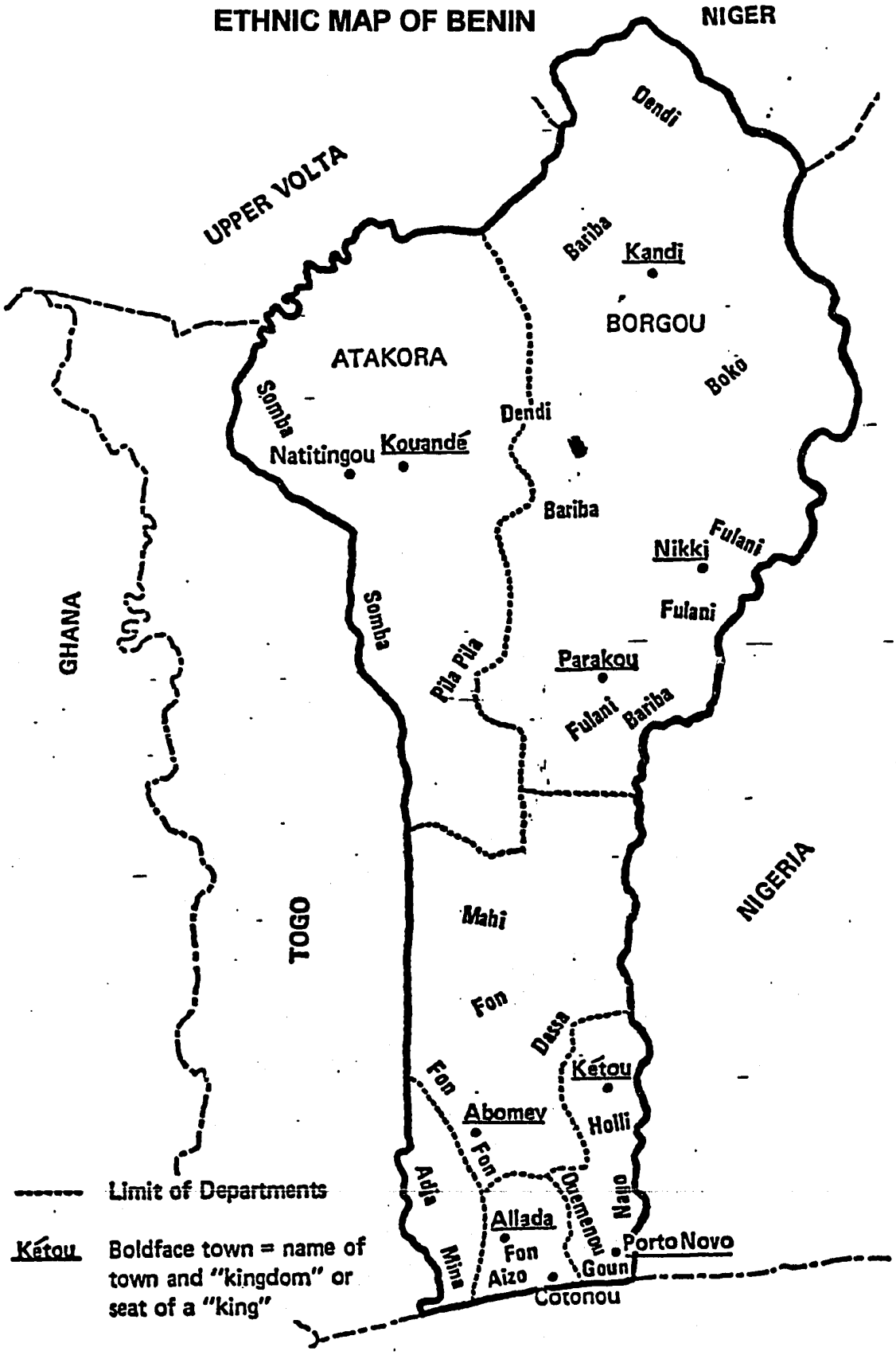
C S S P : CENTRE DE SANTE DES SOUS - PREFECTURES

C S C U : CENTRE DE SANTE DES CIRCONSCRIPTIONS URBAINES

C C S : CENTRE COMMUNAL DE SANTE .-

APPENDIX E

ETHNIC MAP OF BENIN



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