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## REPORT

# ASSESSMENT OF DONOR INVESTMENTS IN HEALTH IN BENIN

*BASICS is an USAID-funded project administered by  
the Partnership for Child Health Care, Inc.*

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**ASSESSMENT OF DONOR  
INVESTMENTS  
IN HEALTH IN BENIN**

February 19-March 4, 1997

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Technical Directive No: 000 BN 01 012  
USAID Contract Number: HRN-6006-C-00-3031-00

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## ACRONYMS

ABPF	Association Beninoise pour la Promotion de la Famille
AIDS	Acquired Immune Deficiency Syndrome
ANSSP	Projet Appuis Néerlandais aux Soins de Santé Primaires
ARI	Acute Respiratory Infections
AVS	Agent Villageois de Santé
AVP	Association des Volontaires du Progrès
BAD	Banque Africaine pour le Développement
BASP	Bureau d'Appui à la Santé Publique
CBD	Community Based Distribution
CCS	Complexe Communale de Santé
CDD	Control of Diarrheal Diseases
CESAG	Centre d'Etudes Supérieures en Administration et Gestion
CCISD	Centre de Coopération Internationale en Santé et Développement
CSSP	Centre de Santé de la Sous-Préfecture
CIDR	Centre International pour le Développement et la Recherche
COGEC	Comité de Gestion de la Commune
COGES	Comité de Gestion de la Sous-Préfecture
COGEZ	Comité de Gestion de la Zone
CREDESA	Centre Régional pour le Développement de la Santé
CREP	Caisse Rurale d'Epargne
CRS	Catholic Relief Services
DDS	Division Départementale de Santé
DHS	Demographic and Health Survey
EPI	Expanded Program on Immunizations
EU	European Union
FHA	Family Health and AIDS Project
FHI	Family Health International
GOB	Government of Benin
GTZ	German Association for Technical Cooperation
HIV	Human Immunodeficiency Virus
IBFAN	International Baby Food Association Network
IPB	Institut de Participation du Benin
IUED	Institut Universitaire d'Etudes du Développement
KAP	Knowledge, Attitudes, and Practice
KIT	Koninklijk Instituut Voor de Tropen
MCH	Maternal and Child Health
MSPSCF	Ministere de la Santé, de la Protection Sociale et de la Condition Feminine
NGO	Nongovernmental Organization
ORDH	Organisation de Recherche pour le Développement Humain
PMSBS	Programme Medico-Sanitaire Benino-Suisse
PNLS	Programme National de Lutte contre le SIDA
PSI	Population Services International
RH	Reproductive Health

<b>SNIGS</b>	<b>Système National d'Information Sanitaire</b>
<b>STD</b>	<b>Sexually Transmitted Diseases</b>
<b>UNDP</b>	<b>United Nations Development Program</b>
<b>UNFPA</b>	<b>United Nations Fund for Population Activities</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>UVS</b>	<b>Unité Villageoise de Santé</b>
<b>WHO</b>	<b>World Health Organization</b>

## EXECUTIVE SUMMARY

An assessment of donor investments in the health sector in Benin was undertaken by a two-person team from BASICS from February 19-March 4, 1997. The team, composed of BASICS Associate Operations Officer for West Africa Caroline J. O'Neill and consultant Claude J. Aguilhaume, interviewed multiple donors and reviewed a wide variety of documents in order to provide USAID with comprehensive information on donor investments. Technical and geographic foci of donor interventions, level of intervention in the health system, and key collaborators were identified during the visit. Concurrent with this assignment, several other assessments were underway or anticipated in the near future, as USAID prepares for the development of its future family health strategy. Assimilating and drawing from this information a focused program which simultaneously builds on USAID's comparative advantage and responds to pressing health needs is an important initial challenge.

The preliminary 1996 DHS report illustrates persistent, serious health problems in Benin. Although infant mortality has declined in the last 20 years, particularly in the last 5 to 10 years, it remains high at 94/1000. Mortality for all children under 5 is 167/1000, with most deaths resulting from malaria, diarrheal diseases, and acute respiratory infections. Moderate malnutrition affects an estimated 20 to 40 percent of children under 5, with 3 to 6 percent among this group severely malnourished (World Bank Evaluation Report, 1995, Annex 2, page 2). Exclusive breastfeeding is 14 percent. According to the Ministère du Plan, maternal mortality is estimated at 473/100,000, although probable under reporting means that this rate is closer to 800/100,000. The population growth rate is 4.55 percent in urban areas, and 2.16 percent in rural areas. Modern contraceptive prevalence is 3.5 percent, although 76 percent of women and 95.7 percent of men were familiar with at least one contraceptive method. Seventy-one percent of women of reproductive age have received no formal education. This group also has the highest number of children—approximately seven. Regional variations exist for these indicators. The 1995 World Bank Staff Appraisal Report for Benin notes that effective health service coverage has increased to 30 percent<sup>1</sup>, but utilization remains low at 20 percent.

The donor community in Benin is faced with uncertainty as well as opportunities as the Ministry of Health's policy and strategy to address these indicators take shape. Recent political changes have resulted in both an expanded portfolio for the Ministry of Health (to include social protection and the feminine condition) and predictable changes in personnel. The national health policy continues to evolve, and a plan of action to which the donor community can make commitments has not yet been developed. Problems confronted most often, according to donors and health professionals interviewed, are limited human and financial resources; geographic, financial, and cultural barriers to access to care; poor quality of care; and weak donor coordination.

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<sup>1</sup>

This is the access rate for public health services.

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Improving coverage and organization of health services based on a decentralized system, improving health planning and management with increased community participation, and reducing the incidence of principal diseases through maximization of human and financial resources represent the priorities for the Ministry (Ministere de la Santé, de la Protection Sociale et de la Condition Feminine, MSPSCF). Benin is divided into six departments. Thirty-six health zones are to be established, each with a functioning referral system, including one hospital per zone and specific criteria for staffing at this and lower service delivery levels. As of November 1996, five zones had been established, according to a UNICEF report. Support to community health management committees continues as a priority, in order to increase coverage and service utilization. The Government of Benin's budget for health has increased in recent years and is supplemented by significant external aid, which it has had difficulty absorbing. User fees have been implemented throughout the public health system as a result of the Bamako Initiative. In addition, the private sector is an important service provider (refer to the recent private sector assessment by INTRAH), which donors are increasingly supporting.

Numerous multilateral and bilateral donors provide support to the Benin health sector. International and indigenous non-governmental organizations (NGOs) often receive support for implementation of health activities. Multiple donors tend to be present in any single geographic area and tend to carry out a wide variety of interventions. Most donors prefer to operate at the department level. The larger bilateral projects (Governments of Switzerland, Germany, Netherlands) often focus on one or two departments only. Collaboration between donors and the MSPSCF over the last two years has taken place through infrequent meetings of the Round Table, led by the European Union. At the central level, the donor community has begun to coordinate, but has been hindered by the lack of a plan of action. Reaching consensus with the MSPSCF on policies and strategies in health has also been a lengthy process. At the department level, donors collaborate informally, yet feel their collaboration is often productive.

Duplication of interventions was not overt, but given extensive donor support throughout the country, examination of specific activities in any single geographic area may yield different results. Donor interventions may address problems in reproductive health, maternal and child health, and AIDS prevention, control, and treatment. Examples of specific support may include training of health personnel, promotion of public health products, implementation of behavior change strategies, and strengthening of the epidemiological surveillance system. Support to administrative and service delivery structures to facilitate decentralization has also been a focus of some donors. This has included the establishment of health zones and construction of hospitals and health centers. Information regarding donor interventions is summarized in tables in this document. More detailed activity descriptions follow, where lessons learned and donor recommendations for future support to the health sector are identified.

Several conclusions and recommendations are offered in Section IV of this report. In summary, USAID can play an active role in stimulating effective donor collaboration, in assuring quality technical assistance, in utilizing formal and informal education systems for improved health

communications to key target audiences, and in identifying best health practices for dissemination in Benin and throughout the West Africa region.

## I. INTRODUCTION

At the request of USAID/Benin, BASICS Associate Operations Officer for West Africa and team leader Caroline J. O'Neill, MA, and consultant Claude J. Aguiillaume, MD, MPH, carried out an assessment of donor investments in the health sector in Benin from February 19-March 4, 1997. The objectives of this assignment were to provide USAID with a description of donor activities, including the distribution of activities by the level and geographic area of intervention, types of partnerships established by donors with public and non-public providers, and range of technical services being provided or supported; a synthesis of lessons learned; and recommendations for future involvement in the Benin health sector. This assessment builds on a November 1996 rapid health sector assessment conducted by BASICS.

Concurrent with this assignment, USAID had commissioned assessments of and recommendations for interventions in support of safe motherhood (carried out by Mothercare), the private sector (INTRAH), and malaria prevention and treatment as part of an overall MCH initiative (USAID/Washington). In early March, BASICS will field a team to review and identify future potential interventions in support of infant/child nutrition and breastfeeding. Similar to the BASICS assignment, USAID will use these products to refine their draft results framework in March 1997. The draft framework, developed in conjunction with the Ministry of Health, Social Protection, and Feminine Condition (MSPSCF), will set forth the strategic basis for a USAID family health project that will integrate maternal and child health, reproductive health, and HIV/AIDS.

The overall goal for USAID activities in population, health, and nutrition, as identified in a draft framework shared with the BASICS consultants upon their arrival, is a stabilized population and sustained protected health. Current interventions are described in Section III. USAID's goal is to increase participation in the economic and social development of Benin. The strategic objective is to make preventive family planning/maternal and child health, and HIV/AIDS and sexually transmitted diseases (STDs) services available and accessible, and to encourage their utilization. Intermediate results include—

- Increased use of quality family planning services by men and women.
- Reduction of infant/child and maternal morbidity and mortality.
- Reduction of HIV/STD transmission.
- Increased participation of civil society in the research for solutions to family health problems.

Trip activities included an extensive literature review (see Appendix A for documents consulted), visits to donors based in Cotonou, a field trip to the Atacora Department, attendance at the private sector debriefing, and multiple conversations with members of the other assessment

teams. A complete list of contacts is provided in Appendix B. The team benefitted greatly from regular meetings with Susan Woolf of USAID/Benin.

Following a discussion of the context in which donors are working, donor investments in the health sector, lessons learned, and conclusions and recommendations are provided.

## **II. CURRENT SITUATION**

### **A. Key Health Indicators**

A preliminary report on the 1996 DHS illustrates persistent, serious health problems in Benin. Although infant mortality has declined in the last 20 years, particularly in the last 5 to 10 years, it remains high at 94/1000. Mortality for all children under 5 years of age is 167/1000, with most deaths resulting from malaria, diarrheal diseases, and acute respiratory infections. Moderate malnutrition affects an estimated 20 to 40 percent of children under 5, with 3 to 6 percent among this group severely malnourished (World Bank Evaluation Report, 1995, Annex 2, page 2). Exclusive breastfeeding is 14 percent. According to the Ministère du Plan, maternal mortality is estimated at 473/100,000, although probable under reporting means that this rate is closer to 800/100,000. The population growth rate is 4.55 percent in urban areas, and 2.16 percent in rural areas. Modern contraceptive prevalence is 3.5 percent, although 76 percent of women and 95.7 percent of men were familiar with at least one contraceptive method. Similar to other Africa countries, there is a large discrepancy between knowledge and practice. The highest fertility rates are found in the two most northern departments, Atacora and Borgou. Seventy-one percent of women of reproductive age have received no formal education. This group also has the highest number of children—approximately seven. Regional variations exist for these indicators.

The 1996 preliminary DHS does not provide information on access to or utilization of formal health services. The 1995 World Bank Staff Appraisal Report for Benin notes that effective coverage has increased to 30 percent<sup>2</sup>, but utilization remains low at 20 percent.

A national surveillance system for AIDS was put into place in 1990. Surveillance is coordinated through the Programme National de Lutte Contre le SIDA (PNLS). Funding has been received from the French, Canadians, UNDP, and WHO. Surveillance of other diseases is managed by the national information system, SNIGS. Donors commented that this system needs to be upgraded.

A complete list of key health indicators is provided in Appendix C.

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<sup>2</sup> This is the access rate for public health services.

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## **B. Ministry of Health Policy/Strategy**

Two changes of government within the last two years have caused predictable shifts within the Ministry of Health (MOH) of Benin. The MOH has become the Ministry of Health, Social Protection, and Feminine Condition (MSPSCF). Most senior professionals within the MSPSCF have changed, with only the director of planning, coordination, and evaluation still in place. A third version of the MSPSCF's National Health Development Strategy was presented to donors in February 1997, and continues to evolve. The MSPSCF has not yet produced a plan of action, making it difficult for donors to know where their assistance should be directed. This is particularly apparent in the area of reproductive health, where the MSPSCF and donors are still struggling to reach consensus on the definition of reproductive health and appropriate avenues to take, despite passage a year ago of a new population policy. The policy represents the GOB's future direction, marking unprecedented openness to child spacing activities by the public sector; yet a 1920 anti-contraception, anti-abortion law<sup>3</sup> is still "on the books." While the MSPSCF organizes internally and contemplates its plan of action, some donors have taken a "wait and see" position, uncertain or hesitant to move forward until the MSPSCF has provided further guidance.

The goals set forth in the GOB 1997-2000 national health policy are to improve the quality of preventive, curative, and promotional health services, and to improve the accessibility of services. Increasing community participation in the planning and delivery of health services through support to community organizations is viewed as a priority component for assuring effective decentralization of the health system which was set in place during the previous government. Five results are expected—

- Improvement in the coverage and organization of health services based on a decentralized health system.
- Improvement in planning and management of the health sector.
- Improvement in the financing of the sector.
- Reduction of the incidence of principal diseases through maximization of human and financial resources.

## **C. Financial and Human Resources**

The percentage of the national budget allocated to health has increased from 3.42 percent in 1993, to 5.9 percent in 1996. The MSPSCF plans to increase this commitment progressively until it reaches 8 percent by the year 2000 (MSPSCF Policy and Strategy, January 1997, page 9). Complementing this budget is a sizable amount of external aid. In 1993, CFA 392,000,000 was

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<sup>3</sup> This law was enacted in France in 1920 to ban abortion and discourage contraception promotion. The law was imposed upon African nations under French rule.

obligated to the health sector in external aid; this amount was expected to increase to CFA 13,718,000,000 by 1996.<sup>4</sup>

Discussions during the two BASICS team visits with public and private health professionals and donors revealed an important lack of human resources at most levels of the public health system. Where the MSPSCF has two new areas of focus—social protection and the feminine condition—human and financial resources have not kept pace with this technical expansion. According to those interviewed, there is a surplus of approximately 365 unemployed doctors who the MSPSCF cannot afford to hire, with approximately 40 doctors graduating from medical school each year. Doctors are reluctant to work far from Cotonou, leaving under served some of the areas in greatest need. In particular, doctors interviewed pointed to insufficient numbers of nurses, particularly female nurses, and midwives. This is particularly problematic for the complexes communale de santé (CCS), the health structure closest to the communities which must be staffed by either a nurse or a midwife. And in more traditional areas in the north of Benin, this situation is compounded by husbands who refuse care for their wives if it is only available from a male health professional.<sup>5</sup>

#### **D. Structure of the Public Health System**

Decentralization of the health system is a priority of the Government of Benin (GOB). The country is divided currently into six health departments (DDS): Atacora, Borgou, Zou, Mono, Ouémé, and Atlantique. Within the health departments, 36 new health zones, known as “zones sanitaires,” are planned. As of September 1996, five zones had been established (UNICEF Mid-term Health and Nutrition Program Report, page 20). Each zone is to cover a population of 100,000-150,000; health zones are roughly equivalent to the former health districts. At present, donors continue to support the establishment of these health zones, each of which must comprise a functioning referral system, including one hospital per zone. In the Zou region, for example, discussions are continuing as to which of three existing hospitals will represent the zone covering Dassa, Save, and Savalou (with support from the Swiss Cooperation and GTZ). In the Atacora region, the Dutch have helped established health zones for Tangueita and Natitingo (ANSSP 1997 Plan of Action, page 3).

Administratively, within the health zones are a number of sub-prefectures. The centres de santé sous-préfecture (CSSP) are the first line of referral for any number of CCS in a given sub-

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<sup>4</sup> World Bank Evaluation Report, Annex 6. The document consulted does not indicate whether both figures are based on the same rate of exchange. Given the devaluation of the CFA in 1994, it is hard to determine whether this increase in funding is an absolute increase. Nevertheless, donor support is significant.

<sup>5</sup> While this information was gained from a limited sample of health professionals, the role of men as key decision-makers (as well as mothers- and sisters-in-law) was consistently identified a cultural barrier to care for both women and children.

prefecture. CSSP are required to have a doctor; CCS require at least a nurse, and ideally, a midwife as well. A committee represents a unité villageoise de santé (UVS), the equivalent of health outposts, and each has a designated agent villageois de santé (AVS), or village health agent, to coordinate local health services with the CCS. See Appendix D for a diagram of the health system and a map of the health departments.

At the central level, the MSPSCF includes seven vertical technical divisions: planning, coordination, and evaluation; finances; national hygiene; family health; pharmacy and laboratories; infrastructure, supplies and maintenance; and water and sanitation.

In 1989, under the first IDA-financed health project, community health management committees were set up by the GOB in order to stimulate community involvement in the planning and delivery of health services, and as coordinating bodies for state, donor, and community inputs into local health activities. As further explained in the 1995 World Bank Staff Appraisal Report (page 7), the COGES, Comité de Gestion de la Sous-Préfecture, and COGEC, Comité de Gestion de la Commune, were created to involve communities more fully in health prevention activities and to provide an institutional guarantee that resources collected through cost recovery activities would be retained and managed by these committees and used for replenishing drug stocks and for financing other non-salary recurrent expenditures. An additional body has been created at the level of the health zones, the COGEZ or Comité de Gestion de la Zone. This same document reports that certain issues still need to be addressed, such as the lack of motivation of committee members due to a lack of understanding of roles and function, lack of skills in community financial management and in group animation techniques, lack of opportunity to exchange information and ideas at the departmental (DDS) and national levels, and finally, lack of remuneration (*ibid*). The BASICS team was not able to secure any documents detailing the relationship between these various committees, or with the UVS, but understands that the Swiss Cooperation is undertaking a study to evaluate the involvement of the COGES and COGEC in health promotion activities in Zou and Borgou.<sup>6</sup>

#### **E. Private Health Sector**

In 1995, the World Bank estimated that the private sector accounted for CFA 12.9 billion (versus 11 billion for the public sector) spent on health services. The MSPSCF estimates that the private sector provides 25 percent of all health services and 60 percent of hospital care (*stratégies santé*). A recent comprehensive assessment by INTRAH of the private sector reviewed private medical practices, NGO activities, private pharmaceutical and medical associations activities, fees for services, health personnel qualifications and roles, and private pre-service training. Details can be found in the forthcoming report. The INTRAH team debriefing drew attention to the overwhelming number of NGOs involved to some degree in the provision of some form of health

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<sup>6</sup> The UVS are regarded as non-functional by the Swiss.

services, often with support of the donor community. A coordinating body for these NGOs does not appear to exist.

#### **F. The Bamako Initiative**

Benin has been viewed as success story for the Bamako Initiative as observed during the November 1996 BASICS mission, with user fees having been implemented in almost all facilities, and cost recovery (revenues versus expenditures) ranging from 10 percent in Atacora to 57.4 percent in Zou (BASICS report, page 4). According to UNICEF, community financing represents 30 percent of health expenditures (UNICEF Mid-term Report, page 1). Apparently, cost recovery has not yet been evaluated in Benin, thus it is difficult to judge which model of cost recovery Benin may represent. Consistency throughout the country in ability to recover costs is not present, and 75 percent of revenue comes from the selling of drugs, which has negative effects on the rationalizing of drug prescription and the containment of overall costs (ibid).

User fees do not apply to routine vaccinations or national immunization days (NIDs), with some exceptions. Yellow fever, polio, and meningitis require fees only as part of routine vaccinations. Substantial subsidization of vaccines has come from USAID, UNICEF, Rotary (for polio NIDs), and the French, with the MSPSCF contributing CFA 30 million of its budget for each of the last two years. According to UNICEF, this comprises approximately 12 percent of the national health budget. The MSPSCF contribution is expected to increase to CFA 145 million in 1997.

### **III. DONOR INVESTMENTS IN THE HEALTH SECTOR**

#### **A. General Observations**

The Benin health sector is supported to some degree by numerous multilateral, bilateral, and international nongovernmental organizations (NGOs) (World Bank Staff Appraisal Report for Benin, May 1995, page 8). Close to 600 indigenous NGOs exist in Benin, with many carrying out health activities.

#### Geographic Distribution and Level of Intervention

Multiple donors tend to be present in any single geographic area or DDS, and most donors prefer to operate no higher than the level of the health zone. Some donors provide assistance, directly or through international or indigenous NGOs, to hospitals, the CCS and UVS, and to related management systems (COGES, COGEC).

#### Intra-Donor Coordination and Collaboration, and with the MSPSCF

Central-level donor coordination with the MSPSCF for the development of the national health policy and strategy has taken place through meetings of the Round Table led by the European

Union (EU), in January 1995 and November 1996. More recently, donors have held informal meetings amongst themselves. USAID has observed the need for an inventory of donor activities supporting both the public and private health sectors, in an effort to create common understanding of support to the health sector, to avoid duplication, and to maximize investments. Donors are awaiting guidance and a plan of action from the MSPSCF as to where their investments should be directed. Nevertheless, at the DDS level and lower, in those health zones where donors are present, donors have assumed significant responsibility for the operationalization of MSPSCF objectives. In comparison with central-level inter-donor coordination, which appears to be accelerating only recently, donors working within the DDS appear to have been coordinating informally, yet more regularly, for a longer period of time.

A central-level coordinating committee for AIDS exists, according to WHO, but the extent of donor participation could not be determined by the team. UNICEF mentioned the formation of an EPI foundation as a type of national savings program and apparently exists on paper (page 58, mid-term report), but it is not certain whether this group is to relate to some existing or planned central-level EPI committee. To the best of the team's knowledge, no other central-level interagency committees have been organized for discussion and coordination of focused health activities.

A main concern of many donors already present in a particular DDS is that duplication and poor coordination may result from new donor involvement in the same geographic area. Also of concern are differing donor priorities which increase the burden of health workers and cause confusion. One difficulty raised by a former MOH employee is that health personnel are often subjected to a variety of reporting forms on health indicators in order to conform to donor information needs.

Most multilateral donors (UNDP, WHO, UNFPA, UNICEF, World Bank) tend to support national programs through the central level, and in some cases operate directly at more peripheral levels. Bilateral donors tend to focus on the DDS and lower levels of the health system. The degree of overlap of services is difficult to judge; most donors did not seem to feel there was duplication at the DDS level, but this may be the result of insufficient sharing of information among donors intervening in any particular geographic and technical area. The team did not observe an obvious high degree of overlap, but deeper investigation into detailed donor activities is likely to yield different observations given the extensive external support to the health sector.

#### Absorptive Capacity of Donor Investments in the Health Sector

The GOB has tremendous difficulty absorbing the external resources which have been made available for the health sector, with only 50 percent of external financing spent in 1993 (May 1995 World Bank Staff Evaluation Report on the PSP, Annex 6, page 3). The MSPSCF national health strategy identifies barriers to absorption such as the rigidity of certain conditions which Benin cannot meet, weighty management structures, slow administration of the health system, and difficulties conforming to donor rules and procedures. This situation was corroborated by

the Canadian Development Agency and by UNFPA, who, for example, has only been able to spend \$1.7 million in two years out of the \$10 million obligated for a four year period.

### Technical Areas of Intervention

As Table A reflects, most donors carry out a variety of health interventions. This may include support to national epidemiological surveillance for AIDS and vaccine-preventable diseases (French, Canadians, WHO); reproductive health (UNFPA, IPPF, USAID, UNDP, WHO); child survival (USAID, UNICEF, WHO, GTZ); STD/HIV prevention, treatment, and epidemiological surveillance (Canadians, UNDP, French, etc); safe motherhood (UNDP); operational research (CREDESA, etc.); and support for primary health care delivery systems as part of the decentralization process (GTZ, Swiss, Dutch). In addition, facility construction and renovation is a focus of some donors (World Bank, FAC, Canadians, Swiss) and some have supported water and sanitation improvements (UNICEF, Denmark, Japan, World Bank). Additional details on technical foci are provided in the section following Table A and are described in the documents of individual donors.

The team sought to determine the degree to which integration of health services is present, that is the degree to which resources are allocated for sustained human development from the national level, down to the community level, including preventive as well as curative services. The challenge for Benin, as in other countries of the region, lies in the ability of a vertically-organized MSPSCF to translate the national health policy and strategy into a plan of action for implementation in a decentralized delivery system.

Health workers with whom the team spoke stated that integration of service delivery occurs by virtue of the presence of only one health worker in a CCS, for example, who is asked to respond to all questions and address all apparent needs. Integration of services and quality of care (widely regarded as a major problem in Benin) will be measured in part by a health facilities survey which WHO plans to carry out.

### **B. Tables Listing Donor Projects**

The following tables present the information obtained during this and the November 1996 BASICS assignment. In Table A, multilateral and bilateral geographic emphasis, level of intervention, technical foci, priority technical focus, collaborators, and NGOs or other organizations funded by donors, are listed. A sample of some of the larger international and national PVOs (Africare, CRS, Rotary, ABPF), which may receive funding from multi- or bilateral donors, have been included. Technical foci may include specific diseases and cross-cutting areas such as IEC/social marketing, delivery systems support, and epidemiological surveillance and information systems. Health facility construction and renovation, water and sanitation, and women and development activities are also mentioned, where this information was available. Table B categorizes donor activity by geographic location.

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Following the tables is a discussion of criteria used for the selection of interventions, results anticipated, results achieved, barriers to program planning, implementation, evaluation, and donor suggestions for USAID intervention. Lessons learned from these experiences, drawn from interviews, documents, and observations of the team, are presented. Comprehensive information was obtained during interviews by using a standardized list of questions developed by Aguiillaume and O'Neill, and provided in Appendix E.

**TABLE A- Map of Donor Investments in the Health Sector, by Donor Name**

<b>Multilateral Donors</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH/NGOs Funded</b>
<b>African Development Bank</b>	Borgou (possibly others)	Central	Women and development, water and sanitation, Bamako Initiative, essential drugs, micro-projects to alleviate poverty	Training MOH personnel in health planning/mgt, TA to SNIGS, renovation of CCS	?
<b>European Union</b>	National	Central, DDS	Hospital construction/renovation, logistics and equipment		At central level, all donors participating in the Round Tables
<b>UNDP</b>	<sup>7</sup> National, Zou (Dassa)	CCS	Safe motherhood (Dassa), STD/AIDS, women and development, community financing, management training for physicians	AIDS, health system support (establishment/strengthening of CCS and UVS), community health development	UN agencies, local NGOs for safe motherhood
<b>UNFPA</b>	National	Central	Reproductive health	Family planning	UN agencies, USAID, ABPF

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National means country-wide coverage, usually through support to the MSPSCF, and includes the central level. A central focus means support to central-level MSPSCF structures and strategy. Atlantique, the department where Cotonou is located, indicates activity within the department, but not necessarily in Cotonou itself.

**Table A - Continued, Map of Donor Investments in the Health Sector, by Donor Name**

<b>Multilateral Donors</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH/NGOs Funded</b>
<b>UNICEF</b>	National (through MSPSCF)	All levels, through MSPSCF	Reproductive health, safe motherhood, CDD, ORS social marketing, ARI, EPI, nutrition, STD/AIDS, water and sanitation, filariasis	Vaccine procurement and NIDs, others?	UN agencies, USAID-FHI-PSI, Family Care International, France, Denmark, World Bank, Japan, 17 NGOS
<b>WHO</b>	National	All levels	Essential drugs, quality of care, AIDS, reproductive health, onchocerciasis, child survival, health systems delivery	Coordination of health care interventions	All UN agencies, USAID
<b>World Bank</b>	National	DDS, CCS, central	Decentralization, construction of CCS and hospitals, quality of care (training of personnel), delivery systems, essential drugs, integration of RH w/nutrition, safe motherhood and child survival, cost recovery	Decentralization of health services	UNFPA, Swiss, others TBD

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**Table A - Continued, Map of Donor Investments in the Health Sector, by Donor Name**

<b>Bilateral Donors and Others</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH/NGO funded</b>
<b>Government of Belgium</b>	TBD-possibly Mono	TBD	Hospital and health outpost construction, ambulance purchase, others TBD	TBD	Currently working at central level
<b>Government of Canada</b>	Atlantique, national (epidemiologic surveillance)	CCS	Cost recovery, AIDS, epidemiological surveillance, systems support to construct/strengthen CCS	Epidemiology surveillance, AIDS	University of Laval, WHO, BASP, FAC, CREDESA (formerly)
<b>People's Republic of China</b>	Atacora, Borgou, Mono	DDS	Construction of health facilities	Construction of health facilities	
<b>Government of Cuba</b>	Atlantique, Borgou	CNHU in Cotonou	Hospital renovation and facilities support		
<b>Government of Denmark</b>	National		Social marketing of ORASEL, drug procurement, water and sanitation	No additional health activities planned	Well construction with Japan, World Bank, UNICEF
<b>Government of Egypt</b>	Ouémé	DDS	Medical teams		

**Table A - Continued, Map of Donor Investments in the Health Sector, by Donor Name**

<b>Bilateral Donors and Others</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH/NGO funded</b>
<b>Government of France</b>	Atlantique, Borgou-Mono-Atacora (for CCS renovation)	Central and DDS levels	STD/AIDS, vaccine procurement, epidemiological surveillance/SNIGS strengthening, IEC, infrastructure	Construction/renovation, establishment of HMOs, CNHU renovation	IPB, UNICEF, USAID, CREP, AVP, Canadians
<b>GTZ/Government of Germany/Bavarian Red Cross</b>	Several departments previously; current focus on Atacora, Borgou and Zou	DDS and lower	Reproductive health, including child health, health zone development/PHC, STD/AIDS	Reproductive health PHC, AIDS	Swiss, Red Cross of Benin
<b>Government of Japan</b>	Cotonou	CNHU	Equipment-medical materials	Curative medicine	
<b>Government of Libya</b>	Ouémé		Hospital construction		
<b>Government of the Netherlands</b>	Atacora (two health zones)	DDS, CCS, UVS	Systems delivery, training, safe motherhood		Hôpital St. Jean de Dieu
<b>Government of Norway</b>					

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**Table A - Continued, Map of Donor Investments in the Health Sector, by Donor Name**

<b>Bilateral Donors and Others</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH</b>
<b>Government of Switzerland</b>	Zou, Borgou	DDS (health zones), COGES, COGEC, (not UVS)	Community-level financial management, infrastructure, medical equipment, systems delivery support, private medical practice establishment and association training, quality of care, generic drugs, STD/AIDS, support to World Bank project	Community financing (mutual funds), development of health zones, support to quality of care	GTZ, World Bank, CIDR
<b>Government of the USA=USAID</b>	Ouémé, central, others TBD	TBD	Family health, reproductive health, health education in primary schools, child survival, STD/AIDS prevention	TBD	Multilaterals, CRS (child survival), PSI, Africare, Futures Group (policy), BASICS (child survival), REDSO/WCA FHA project, ABPF, INTRAH, ORDH
<b>Other Organizations</b>					
<b>ABPF</b>	All departments	RH clinics	reproductive health (FP, contraceptives distribution), IEC program, safe motherhood, HIV/AIDS	Family planning	USAID, IPPF, UNFPA
<b>OXFAM-Québec</b>	Mono (Boichon), Zou (Dassa, Save, Savalou)		PILSA, EPI, nutrition	Same	Local/international NGOs, World Bank

**Table A - Continued, Map of Donor Investments in the Health Sector, by Donor Name**

<b>Bilateral Donors and Others</b>	<b>Geographic Emphasis</b>	<b>Level of Intervention</b>	<b>Technical Foci</b>	<b>Priority Technical Focus</b>	<b>Collaborators in addition to MOH</b>
<b>Catholic Relief Services</b>	Ouémé	NGOs	Child survival, nutrition	Nutrition	USAID, others (?)
<b>Rotary International</b>	National		Polio vaccine procurement, NIDs, psychiatric and tuberculosis facility construction, ambulance purchase		UNICEF, and others collaborating on NIDs
<b>Red Cross of Benin</b>			Catastrophe and emergency situations		
<b>Benin Humanity</b>			Catastrophe and emergency situations		
<b>SOS Benin</b>			Catastrophe and emergency situations		

**Note:** Refer to INTRAH private sector report for comprehensive information on NGO activities. Apparently, a list is available for purchase from GTZ of all NGOs and their areas of intervention.

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**Table B - Department of Emphasis of Donor Investments in the Health Sector**

Department of Emphasis	Donors <sup>8</sup>
Atacora	Belgium, China, EU, Netherlands, World Bank, UNDP, France, GTZ, ABPF
Atlantique	All multilaterals, Canada, EU, France, ABPF, Japan, Cuba
Borgou	BAD, EU, France, China, GTZ, Switzerland, ABPF
Mono	Belgium (potentially), EU, China, France, OXFAM, ABPF
Ouémé	USAID, Africare, CRS, Libya, Egypt, ABPF
Zou	Switzerland, GTZ, OXFAM, ABPF

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<sup>8</sup> Not all donors are involved to the same degree in any given department. Refer to the discussion following the Tables for more detailed information.

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## C. Detailed Description of Donor Activities and Lessons Learned

### Multilateral Donors

#### Banque Africaine de Développement (BAD)

The team could not reach the new BAD representative in Cotonou. BAD is assisting Benin in the following areas:

- Rehabilitation and equipment of health infrastructures outside Cotonou.
- Assistance to the training of the MSPSCF personnel in health planning and management, and technical assistance to the SNIGS.
- Support the Bamako Initiative by providing some essential drugs.

To improve the health status of the Benin population, BAD future interventions may include activities in the following areas:

- Empowerment of women to improve maternal and child health .
- Water and sanitation.
- Micro-projects to increase financial access to primary health care to poor people.

#### European Union (EU)

The European Union has taken the leadership for the Round Table, described earlier. The EU is mainly supporting health infrastructure development in five departments and offers technical assistance, as well as logistics/equipment, for these facilities.

- Ouémé: Centre hospitalier départemental.
- Zou: Centre hospitalier départemental.
- Mono: Several centres de santé at the level of the sub-prefectures.
- Borgou: Centre hospitalier départemental.
- Atlantique: Several centres de santé and the lagune maternité.

#### *Lessons Learned*

Health status will improve, according to the EU, through—

- Closer collaboration between the public and the private sectors to increase coverage.
- Better decentralized management of human and material resources in the health zones.
- Enhanced quality of care in the health sector, especially at the peripheral level.

## United Nations Development Program (UNDP)

UNDP assistance in the health sector is relatively recent. Interventions include the following:

### 1. Safe Motherhood

With the objective of reducing maternal mortality, UNDP is implementing an 18 month pilot project to improve access to health care for pregnant women. Their approach includes creation of village-level mutual funds to cover costs for transport and medicine. Monitoring of this project is currently assumed by UN volunteers (four promoters from the DDS, including one M.D.), who liaise with the MSPSCF (Family Health Division) and local NGOs working in safe motherhood and child survival.

### 2. Cooperative Health Clinics

Implemented by WHO, this project aims to develop 10 private cooperative health clinics in order to improve health care coverage. Simultaneously, this program employs health professionals who have been unable to enter the public health system due to a hiring freeze. Each clinic comprises seven staff members (physicians, paramedics, laboratory technician, and managerial) and each clinic received a loan of CFA 3 million to initiate activities. No loans have been reimbursed yet.

### 3. Integration of AIDS Programs

UNDP is now coordinating all HIV/AIDS programs in Benin funded by UN agencies. A five year national plan has been developed addressing psycho-social, economic, and legislative needs. The plan involves all GOB ministries and NGOs active in AIDS prevention, control, and treatment (CRS, Red Cross, AVP, Clubs SADI et Arc-en-Ciel).

### *Lessons Learned*

UNDP stated that the brief duration of their projects is problematic and that Benin, as well as donors, would benefit from longer projects. UNDP would also like to work in the private sector. In the future, UNDP would like to develop microprojects to help communities care for AIDS victims.

## United Nations Fund for Population Activities (UNFPA)

UNFPA assistance dates from 1979. Currently in their fourth country program in Benin, UNFPA has obligated US\$10 million for 1995-1998. The objective is to support MSPSCF population and development objectives, but only US\$1.7 million has been spent to date.

The proposed 1995 -98 program is based on MSPSCF objectives and strategies as outlined in the Economic Policy Framework 1994-1996; recommendations of the program review and strategy development (PRSD) mission that visited Benin in May/June 1994; lessons learned during the last three previous assistance programs; the program of action of the Cairo International Conference of Population and Development (ICPD); and extensive consultations/discussions with the MSPSCF, the multilateral and bilateral donor community, and NGOs.

### *Lessons Learned*

Despite GOB ratification of the 1994 Plan of Action at the Cairo International Conference of Population and Development (ICPD), UNFPA has had difficulty achieving results. UNFPA has been dependent on GOB vertical programs (different offices, different programs, different budgets), and the new UNFPA representative is fully aware that coordination among major donors, the improvement of the status of women in society, and a consolidated national population/family policy are *sine qua non* to have a notable impact on contraceptive prevalence in the country (Preparatory workshop to the mid-term review of UNFPA Programme, Abomey January 1997). UNFPA is hopeful that GOB will reach a consensus on reproductive health with donors, by June 1997.

UNFPA is more active in donor coordination in the reproductive health sector involving the MSPSCF, but will still have difficulty operating in the absence of a mandate from the Ministry. USAID, which has broad expertise in reproductive health in West Africa, may complement UNFPA and donor efforts assisting MSPSCF through USAID-sponsored NGOs (see recommendations of the POPTECH report, page 192, August 1995).

### UNICEF

The BASICS team, in conjunction with the Mothercare team, had two meetings with Representative M. Malik Sene and with Administrator of the Health and Nutrition Program Dr. Karimou Andele. UNICEF funds three projects in Benin: Support to the Development of the Health System; MCH and Reproductive Health; and Nutrition. Their assistance is provided principally through and in support of MSPSCF goals, in conjunction with a wide range of donors, and with approximately 17 international and national NGOs as of late 1995. A priority for UNICEF is to promote community health, utilizing what they regard as a fairly well-formed community structure in Benin (1994-98 Health and Nutrition Program, Mid-term Report, September 1996, page vi).

UNICEF's 1996-1998 goals include the following items. More specific program goals are provided in their mid-term report:

- Application of a coordinated approach to a variety of interventions at the community level in the Department of Ouémé.

- Expansion of reproductive and sexual health activities in health facilities.
- Promotion of the role of women as a strategy for reinforcing monitoring of the nutritional status of children at the community level.
- Assurance of salt production in Benin.
- Reinforcement of community financial management of health services.

UNICEF has been the largest supplier of vaccines in Benin since 1984. They have received funding from USAID/Washington for the last three years. Through CDC, Rotary International has contributed to the purchase of polio vaccines for national immunization days, yet no longer funds routine polio vaccination. As mentioned earlier, through the Vaccine Independence Initiative, the MSPSCF currently allocates 12 percent of its health budget to vaccine procurement. The government's routine surveillance data is used by UNICEF to monitor vaccine coverage, and a 1994-95 UNICEF validation study corroborated the MSPSCF coverage rate. The 1996 DHS reports that 56 percent of children aged 12-23 months were completely vaccinated against the 6 principal illnesses at the time of the survey, and 14 percent had received no vaccinations. UNICEF/Benin is interested in the testing of sustainability indicators for immunization which is being contemplated by USAID/Washington for grants it provides to UNICEF.

Promotion of exclusive breastfeeding has been carried out through the Baby Friendly Hospital Initiative and with the support of an international NGO, IBFAN (International Baby Food Association Network). UNICEF has purchased ORASEL and funded PSI social marketing activities in Atlantique, Ouémé, and Mono. UNICEF is negotiating with the MSPSCF to secure a line item in the national health budget for ORS purchase. UNICEF has also invested significantly in training of health personnel in appropriate case management of CDD and ARI, with more emphasis traditionally placed on diarrheal diseases. ORT corners have been established in 300 CCS (over what period of time is uncertain). Increased attention has been drawn to ARIs, but as pointed out in the BASICS 1996 report, this program has existed primarily on paper; it is doubtful that correct case management practices have made their way down through the facility levels.

UNICEF's safe motherhood activities include future plans for collaborating with Family Care International on a two-phased program to, first, understand both care giver and health provider barriers to quality of care, and second, to design appropriate interventions. With the International Development Bank (IDB), UNICEF has supported training in maternal health. In Atacora, Borgou, and Mono, no more than 50 percent of births are assisted by a nurse or midwife (1996 DHS).

UNICEF recently collaborated with Family Health International on a KAP study for STDs. A final report is forthcoming. A coordinating body of the UN agencies has been formed for STD/AIDS activities, as mentioned earlier.

Programs for two diseases resulting from polluted water—onchocerciasis and filariasis—are being implemented by WHO and UNICEF, respectively. UNICEF provides technical assistance to a World Bank, Japanese, and Danish water and sanitation program, including well construction.

### *Lessons Learned*

Detailed results on the UNICEF initiative for 1994-1995 can be found on pages 53-63 of their mid-term report. The two biggest problems in the provision of quality health services, according to UNICEF, are geographic, financial, and cultural inaccessibility to health services, and poor quality of care, including poor interpersonal communication. As one example, these barriers to access may influence the fact that, in Mono, 30 percent of women give birth at home, according to a study carried out by UNICEF.

### World Bank

#### 1. Health Services Development Project

The World Bank has been active in Benin since 1985. A first project of US\$17 million titled “Project of Health Services Development (Projet de Développement des Services de Santé)” started in 1990. The project rationale was to strengthen the health national strategy. Project activities have included—

- Construction of health facilities.
- Health personnel training.
- Strengthening of the DDS.
- Building and monitoring of the drug purchase center (CAME: Central d'Achat des Medicaments).

To date, disbursement has been slow (38 percent) according to the project's national coordinator, a Beninese physician and anthropologist. Based on the lessons learned (see next paragraph), the project was slightly modified and its completion date was extended for one year, to 1998. The project was decentralized, and six satellites offices have been developed (one in each department). Each department is earmarked now to receive 10 percent of the budget.

## *Lessons Learned*

A mid-term evaluation points to these lessons learned—

- The project was too centralized and there were not enough field activities.
- Construction costs were not realistic at a time inflation was high in Benin.
- The establishment of norms and standards for the project's construction took more time than planned.
- Management of the project needed to be reviewed.
- Recurrent costs, important in the project, could not be supported by the GOB.
- Project coordinators in Washington DC were not familiar with procedures relevant to the Benin program.

### 2. Health and Population Project

The above lessons learned were taken into consideration for the development of the second project titled "Health and Population." This \$33 million project, signed in 1996 and started in early 1997, focuses on the family planning sector, integrating reproductive health into the three main GOB reforms in the national strategy for 1995-99: decentralization of health activities; upgrading the referral system for primary health care and nutrition; and community participation in health activities.

Activities are as follows—

- Building and renovating CCS and two hospitals.
- Integration of family planning activities with safe motherhood, nutrition, and child survival in every sub-prefecture, that is, 77 CSSP.

Obstacles facing the project include the 1920 law described earlier and lack of GOB consensus on a population policy.

## The World Health Organization (WHO)

The WHO office in Benin serves primarily as a coordinating institution and executes programs funded by other specialized UN specialized agencies. Its technical support is distributed as follows—

- Regular programs, such as development of health human resources, disease control, and management support in the Benin health sector. A budget is approved every two years.
- Regional programs, focusing on West Africa: In Benin, WHO supports the onchocerciasis program and the regional public health institute.
- Specific programs, such as prevention, surveillance, and treatment of leprosy, tuberculosis, and HIV/AIDS.

Among health priorities in Benin, WHO mentions malaria, ARIs, diarrhea, malnutrition, infectious diseases, AIDS, reproductive health, and accidents.

### *Lessons Learned*

The first observation noted by the new representative is the lack of coordination of health activity by the Ministry of Health. This is due largely to the fact that there is no plan of action around which donors can assemble their resources. WHO intends to work with the MSPSCF on the development of the plan.

In the health zones, WHO notes the following problems:

- Physical and financial accessibility of health facilities, especially in remote areas like Atacora and Borgou departments (75 percent of Benin, 25 percent of its population), and recommends outreach mobile health teams as one possible solution.
- Quality of care: WHO will sponsor a health facility survey, and plans to enlist the school of medicine in efforts to improve quality of care throughout the country.
- Supervision: Revision of the job description for supervisors is one urgent action to be undertaken by MSPSCF. Supervision should be decentralized and simple supervision tools should be developed.
- Essential drugs: The national drug delivery system should be reviewed and generic drugs should be encouraged especially in the private sector. Feedback to peripheral levels is inadequate.

- Private practice harmonization, for the purpose of minimizing illegal practices which flourish in the current liberal system. Collaboration between the private and public sectors should improve, as many public health problems are almost exclusively monitored by the private sector (STD/HIV/AIDS).

## **Bilateral Donors**

### Government of Belgium

The Government of Belgium currently has a representative working within the MSPSCF. The representative could not be contacted during this visit, nor were any documents available to the team. Other sources indicated that Belgium is considering investing in the Mono region. Health sector assistance to date has included construction of a pre-fabricated hospital (150 beds) at Natitingou and six satellite dispensaries in six communes of the Atacora department. An ambulance was purchased for each location.

### Government of Canada: Canadian International Development Agency (CIDA)

The Canadian government has undertaken three activities in health since returning to Benin in 1991. Similar to other donors, the Canadians focus on a number of areas in the health sector.

1. Support to Primary/maternal Health Care in Ouidah, Atlantique Department (Completed)
  - Support was provided to the establishment of eight CCS, covering a population of approximately 70,000, including construction/renovation, application of the Bamako Initiative, and training of 22 AVS.
  - Strengthening of the referral system for Ouidah was supported through application of the Bamako Initiative. The Canadians also helped set up a radio communications system in support of the referral system, and purchased an ambulance.
  - Plans were made for construction of a hospital to replace an older hospital, but this did not occur since agreement could not be reached on the definition of a “hôpital de référence.”
2. Epidemiological Surveillance Project (PASE)

With funding and management provided by the Centre de Coopération Internationale en Santé et Développement (CCISD) of the University of Laval, WHO, and FAC (a West Africa regional private public health research group working in Burkina Faso, Benin, Mali, and Niger), the

Bureau d'Appui en Santé Publique (BASP)<sup>9</sup> is executing a 14 month project to improve epidemiological surveillance. This project began in October 1996, and builds on BASP's experiences executing the 1990-95 AIDS surveillance project funded by the Canadians in Burkina Faso, Mali, Niger, and Côte d'Ivoire.

The objectives of the project are to create and operationalize 14 surveillance centers across all 6 departments of Benin, and in the CNHU (national hospital in Cotonou). The first seminar for training of nurses in all aspects of surveillance in Benin began during this assignment.

The national surveillance system, SNIGS (Système National d'Information et de Gestion Sanitaire), was evaluated by WHO in June 1996. Problems identified included, among others, insufficient completion of reporting forms by health workers, weak disease diagnosis capacities of health workers, and minimal understanding as to how to use data for decisionmaking.

### 3. Support to the National Program Against HIV/AIDS

The Canadian government has provided \$2 million (Canadian) for HIV/AIDS prevention and treatment, including promotional campaigns for prevention, monitoring of prostitutes, and treatment of venereal diseases. This program helps fund the activities of three dispensaries in Cotonou.

#### *Lessons Learned*

The Canadians selected Ouidah as the site for their first intervention because they wanted to work with CREDESA. CREDESA, an operations research institution, was initially supported by the Swiss and has received support from a number of donors (World Bank, GTZ, Canadians). Support was provided for operational research for several subjects. Although the research was completed satisfactorily, the Canadians withdrew their funding when their evaluations revealed lower results than anticipated in terms of implementation of relevant interventions. These funds were used to initiate the PASE project.

In terms of the CCS, these centers are recovering their costs, according to a representative of CIDA. Although start-up funds were advanced to the CCS by CIDA for payment of salaries, these funds have not yet been repaid by the MSPSCF. An evaluation conducted in May 1996 showed a doubling in the number of visits to the CCS. In the absence of the written evaluation, the reasons for this increase are not clear.

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<sup>9</sup> BASP is one of few private organizations in Benin, with capacities in a number of areas: information systems, project management and evaluation, public health research, computer training, training in epidemiological surveillance, and operations research. In addition to the partners mentioned above, BASP has carried out activities with funding from GTZ.

The team was able to attain only one document, on the epidemiological surveillance activity. No lessons learned were available as the project was just initiated in Benin in October 1996.

Canadian Representative M. Yves Morneau advises new donors to concentrate their efforts in a limited geographic area. He also recommended that donors work with NGOs. Also noted were weak coordination between donors and frustrating meetings of the Round Table due to the lack of decisions reached.

#### Government of the People's Republic of China

Despite several attempts, the team was unable to make contact with a representative of the People's Republic of China. According to the 1995 WHO Country Profile, China's intervention in the health sector includes—

- Support to medical teams, including drugs and vehicle/equipment, in Natitingou (Atacora) and Kandi (Borgou) since 1994.
- Construction of the centre hospitalier départemental du Mono at Lokossa.

#### Government of Cuba

Two medical teams are present in the Centre National Hospitalier Universitaire and at the Centre Hospitalier Départemental at Parakou (Borgou).

#### Government of Denmark

The Government of Denmark has supported two small activities in health. For a period of one year, they funded some of PSI's promotional activities for ORASEL. In addition, they provided some medicines to the Central d'Achat. No further activities in the health sector are contemplated at this time. The Danish, along with the Japanese, the World Bank, and UNICEF, have also supported the construction of wells.

#### Egypt

An Egyptian medical team (10 physicians) is now present in the Department of Ouémé.

#### Government of France - Fonds d'Aide et de Coopération (FAC) and l'Association des Volontaires du Progrès (AVP)

The French assistance program is provided through FAC and AVP for the areas listed below. FF49 million have been obligated to date. No written documents were available. This information is drawn from an interview with Mme. Françoise Bernard.

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1. The AIDS program (FF4 million), begun in 1995, has three components—
  - Epidemiological surveillance
  - Information, education and, communication
  - Anonymous Testing Center: The GOB has not yet designated a location for this center
2. Rehabilitation of the CNHU-Centre National Hospitalier et Universitaire (national and university hospital)

Since 1991, this project has spent FF35 million on improvements to the CNHU, particularly for the departments of surgery, radiology, pediatrics, and internal medicine. A new project to install computers in the entire hospital is under development.

### 3. SNIGS

The French have supported the development of an early warning system for the SNIGS for malaria, cholera, and yellow fever.

### 4. Vaccine Procurement

FAC, in collaboration with UNICEF and USAID/Washington, has purchased vaccines for the national EPI.

FAC has earmarked FF 10 million for their next program cycle to be distributed as follows—

- Creation of a system similar to the HMOs, focusing on 10 primary health care centers. For this purpose, seven CCS will be renovated in urban zones (with the assistance of Institut de Participation du Benin-IPB), and three in more rural areas (Borgou, Mono, and Atacora). These locations were chosen for the availability of their financial back up by CREP (Caisse Rurale d'Epargne), staffed by French volunteer(s) from AVP.
- The French will continue their assistance to EPI (procurement of vaccines), as well as the SNIGS (staffed with an AVP volunteer).

### *Lessons Learned*

The French assistance notes that projects have a better chance of succeeding when they operate at the peripheral level, and when they are of a smaller scope. FAC suggests the following areas for project development: empowerment of women (promotion of women) and/or projects controlled by women, IEC, and improvements to water and sanitation systems.

## Government of Germany - Project Benino-Allemand des Soins de Santé Primaires/GTZ

The German government has provided aid to the health sector since the 1960s. DM 6.2 million was allocated to primary health care interventions from 1993 to 1996. Germany has also supported the family planning program, as well as the PNLs. The combination of the interventions of three different German institutions in Benin (German Development Service-Service Allemand de Développement or SAD, the Bavarian Red Cross which supports the Beninese Red Cross, and GTZ) has had an important impact in the public health sector in Benin. Principal collaborators, in addition to the MSPSCF, are the Swiss and the World Bank.

Priorities in the health sector, according to GTZ are as follows—

- Improving quality of care, as reflected in the qualifications and the sufficient quantity of the health facility staff in Benin.
- Decentralization of the health system (the concept of the health zone is not well defined).
- Financial planning: Current financing cannot meet the objectives of current health strategies.

GTZ's primary health project, PBA-SSP, is by far the largest of the German-sponsored programs. For the period 1996-1999, DM has earmarked DM 14.2 million (CFA 14.8 billion) for the program. Essentially a maternal and child health project, particular emphasis has been placed on reproductive health. Training has been provided at many levels of the public health system. GTZ has also trained and funded the activities of village health promoters, and found an initial problem in the lack of sufficient promoters for most geographic areas. The project is described in full detail in the Plan Operationnel Phase IV (1996-1999), Projet Benino-Allemand des Soins de Santé Primaires.

### *Lessons Learned/Needs*

- Aid from the German government, geographically, has been provided in many departments. An evaluation conducted of GTZ activities recommended focusing on a more limited geographic area. For this reason and others, GTZ is in the process of slowly withdrawing its support from some departments, with a focus anticipated in Borgou.
- In terms of target audiences for reproductive health activities, GTZ commented that increased targeting of the family as a whole could have beneficial results. In addition, the need for closer collaboration with and increased understanding of communities was highlighted in order to develop appropriate and effective health messages.
- GTZ recommends that the GOB increase the recruitment of personnel by lifting the current hiring freeze.

- Donors should support the private sector, including cooperatives, religious groups, and NGOs.
- MSPSCF should decentralize authority to the DDS for responsibilities such as hiring, promoting, training, and supervision.
- The size of the new health zones should be limited to serve between 80,000 and 300,000 inhabitants, with a better understanding of the socio-economic and epidemiological conditions in order to improve communication with the targeted population and to improve health care organization and management.
- GTZ recommends that MSPSCF activities should not be presented as “shopping list” to donors. All vertical programs should be integrated in horizontal field activities. The GOB has already begun this integration with the PNLs and the prevention of tuberculosis program in various facilities.

#### Government of Japan

The Government of Japan helped finance the purchase of medical equipment and vehicles/ambulances for the Center National Hospitalier Universitaire.

#### Libya

Libya is supporting the construction of a hospital in Ouémé.

#### Government of the Netherlands: Project d'Appuis Néerlandais aux Soins en Santé Primaires (ANSSP)

(See Appendix F for a detailed description of the field trip to the Atacora department.)

The Dutch project ANSSP has been working in two health zones of the Atacora department: Tangueita and Natitingou. Other donors present in the department include UNDP, the World Bank (PILSA), GTZ, and the Belgians, Chinese, and EU, particularly for facility construction.

A team of four persons from ANSSP works directly with the DDS of Atacora. The one expatriate advisor, Dr. Alberto Perra, is housed in the same building as the director of the DDS. The main focus of Dutch activities is to strengthen primary health care services, including support for establishment of two health zones and all levels of service down to the level of the UVS. The team was fortunate to have the opportunity to visit the director of the DDS, a CSSP (physicians, nurse, and midwife on staff), a CCS (nurse and traditional birth attendant on staff), and finally, to meet with a UVS committee. In Tangueita, close and effective coordination between ANSSP and the MSPSCF team (a head physician and three other physicians) was

observed. Two of the physicians hold graduate degrees from the public health school in Cotonou.

A comprehensive plan for 1997 has been developed by the DDS with ANSSP, which includes results to date. In support of the delivery system, activities have focused primarily on quality of care by improving supervision (including on-the-job training), operations research (e.g. factors contributing to high maternal mortality of 1000/100,000 in Atacora (Perra), management information systems support, and a minimum package of activities (immunizations, pre-natal check-ups, tuberculosis and leprosy testing, vitamin A distribution, and nutrition surveillance). Outreach to increase accessibility to elements of the minimum package of services is carried out twice a month to all villages in the Atacora department.

### *Lessons Learned*

In discussions with Dr. Perra and various MSPSCF personnel, communications, geographic, financial, and cultural barriers to access to care persist. Concerns were expressed about meningitis in the area, and the village community expressed concern about the presence of blood in the urine of children and adults. Fourteen UVS are supposed to be present in the health zone, but only six are functioning. The MSPSCF is investigating the reasons for their dysfunction. Dr. Perra mentioned concerns about high maternal mortality in the department, and a study is being completed to examine the reasons for such a high rate.

The UVS of Tankouari covers a population of about 690. This UVS has been organized for the last eight years. Committee leaders seem to feel that their UVS functions positively, having perceived a decrease in childhood morbidity during this period, among other health benefits. The UVS financed the purchase of a scooter for the village health agent. Radio programs reach this village twice a week, and members of the village were able to repeat health messages they had heard most recently (on sugar/salt solution preparation for diarrhea) via this medium. The UVS committee, which included one female (the traditional birth attendant), felt that their biggest needs were the lack of sufficient water pumps, problems reaching the school three kilometers away during the rainy season, and insufficient funds for purchase of medicines.

### Norway

A grant of CFA 980 million has been given by the Norwegians to finance partial renovation of several CCS in Aphlahoue and Klouekanme (Mono), Save (Zou), and Adjohoun and Ketou (Ouémé).

### Government of Switzerland: Programme Medico-Sanitaire Benino-Suisse and Programme de Mutuelles de Santé

The Swiss have been active in Benin since the 1960s. The health sector received more emphasis beginning in the early 1990s and now represents their largest portfolio, with a budget of 2 million

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Swiss Francs per year. Geographically, Swiss activities focus on two departments: Borgou and Zou. The Swiss do not directly support MCH or reproductive health activities per se, but rather support both public and private systems which influence the type, quality, and management/financing of these services. The principal lines of action of the Swiss Cooperation are—

1. Programme Medico-Sanitaire Benino-Suisse (PMSBS)

Managed by the Geneva-based Institut Universitaire d'Etudes du Développement (IUED), the Benin program is carried out in Zou and Borgou, with support from Dr. Dauby (a public health Belgium specialist), who is based in Cotonou. This program has several components:

- Support to health zones: Support has been provided to the establishment of health zones, one each in Zou and Borgou. The main emphasis is to help the MSPSCF to decentralize its primary health care activities, with a focus on quality of care through training of health personnel and operations research. Negotiations and financing of the Swiss intervention in the Dassa health zone are in progress. In the Nikki health zone, the Swiss are helping to develop a self-help organization called SUTIIDERA (Help Yourself).
- Support to the DDS: Support is provided to the DDS in Borgou and Zou for health planning, monitoring, and supervision. The director of the DDS studied at CESAG, a health management program in Dakar, with a fellowship from the Swiss. Support has been provided for in-service training and training overseas for some physicians (public health in Université Libre de Bruxelles/Anwers School of Public Health/Montreal University), for midwives and nurses (PHC in Burkina Faso), nurse-anesthetist and operating room assistant (Ivory Coast), and for ophthalmologists (Bamako, Mali). As of November 1996, the DDS anticipated conducting a participatory evaluation of its 1994-96 action plan.
- Infrastructure development and medical equipment: Through a process of negotiation with the MSPSCF and the COGES and COGEC, the Swiss have constructed and renovated CCS in Zou and Borgou (Hospital Sounon-Sero in Nikki, CCS of Cana, and Dassa).
- Support to the private sector: The Swiss have helped support the creation of an association of private medical practices to create a voice for private health professionals. Grants are provided to physicians to join the association and to help set up private, cooperative clinics. Many private services, according to the Swiss, offer generic drugs, reducing the cost of care to patients. In addition, the Swiss sponsored the first private physician medical symposium in Abomey in November 1996.

- Support to the MSPSCF through the World Bank: The Swiss helped finance a comprehensive package of health policy reforms undertaken by the first World Bank project with the MSPSCF.
- Support to the PNLs: The Swiss have financed 2000 copies of the cartoon strip “Yannick Dombi,” 2000 AIDS tests for the blood transfusion center, and promotion of AIDS prevention messages through theater productions.
- MSPSCF documentation center: More recently, with the help of the Swiss cooperation, the MSPSCF documentation center has been reorganized, and more than 3000 readers are using it every month.

## 2. Programme de Mutuelles de Sante

The Swiss have initiated a pilot activity on mutual funds for health in south Borgou, implemented by the French Centre International pour le Développement et la Recherche (CIDR). A more recent pilot project will be launched in the near future in Zou. The goal of this initiative is to allow the “groupements villageois mutualistes,” or village mutual associations, to manage payment of their health services. To raise awareness for this program, community members were recruited to hold information sessions on this system. Clients can use either public or private health services free of charge upon submission on arrival at the health center of a membership card. The service provider then bills the mutual fund for the charges incurred. As of September 1996, two hospitals and seven CCS in south Borgou were participating in this program.

### *Lessons Learned*

Similar to other donors, the Swiss prefer to work directly at the DDS level. In terms of donor coordination, at the DDS level, the Swiss collaborate with GTZ, who is also involved in support to the DDS, but feel that there is no central-level MSPSCF coordination of donor activities. They view their CCS construction/renovation activities as one of their greatest successes.

Over the years, the Swiss have refined their health sector strategy. Their experiences lead them to recommend that new donors in the health, population, and nutrition sector support the concept of health zones. They suggest a focus for each donor of one or two full health zones, although research should first be done to determine the absorptive capacity of the zone. They also should focus on quality of care (training), and support local NGOs (religious or not) and the private sector.

Quality of care is not high. “Mauvais accueil” or poor welcoming of patients in health facilities is a problem; perceived poor quality of care leads many clients to the private sector for better treatment.

In terms of the pilot project on mutual funds, the Swiss have observed that health providers are accepting this method of payment over the handling of cash within the health center. Coverage rates remain a bit low, with only 10.1 percent of the total target population of 43,993 participating in the mutual funds. Utilization rates tend to be higher by villages located close to one of the two hospitals participating, with low geographic accessibility mentioned as a deterrent to utilization for more distant communities. Other factors may compound low utilization; a poor harvest of cotton during the period reviewed by CIDR means people had less money, and money earned from the cotton is often used by family heads for their own purposes (construction, marriage, purchase of a scooter), at the cost of increased health coverage.

Despite an overall low participation rate in the mutual funds in the second year of the program, of the populations targeted within the total figure of 43,993, re-subscription rates averaged 78 percent (Second Year Activity Report on Mutual Funds, CIDR, October 1995 - September 1996, page 39). The report attributes variance in re-subscription rates in part to the level of organization of different village groups (page 38). The majority of services reimbursed through this system were hospitalizations and deliveries, raising the issue as to how effective this system is for primary health care services. Some abuses have been noted; for example, a member who brings the child of non-member to a health facility for care. The next evaluation is scheduled for April 1997.

Finally, the Swiss recommend that donors maximize their resources by investing in those geographic areas where there is already some community participation in the delivery of health services. They have observed that the Mono department has received comparatively little support from donors, although the Belgians are considering some future involvement in this department.

## USAID

In addition to the assessments (mentioned in Section I of this report) being carried out prior to the development of a broader family health activity, USAID has been funding the following interventions:

- Purchase and social marketing of condoms, with PSI.
- ORS purchase, through PSI's collaboration with REDSO/WCA's regional family health and AIDS project (FHA).
- A workshop to explore legal barriers to reproductive health, with The Futures Group, in conjunction with the Women Lawyers Association and IPPF.
- A grant to the PNLS for capacity building/training in AIDS epidemiological surveillance and the purchase of computers.

- A grant to the NGO, Organisation de Recherche pour le Développement Humain (ORDH), to train village health workers in AIDS prevention.
- A grant to Catholic Relief Services (CRS) for a knowledge, attitudes, and practices (KAP) nutrition study in Ouémé.
- A needs assessment by INTRAH for training in reproductive health. Training will be carried out on a national basis in pre-service institutions for continuing education and for NGOs working in family health.
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- Integration of reproductive health modules into medical and para-professional schools, through the FHA project.

### **Other Actors in the Health Sector**

While the BASICS team focused on donor inputs to the health sector in Benin (rather than on NGOs or other actors in the private sector), to complement their findings the team consulted with a sample of miscellaneous organizations involved in the health sector. Some of these organizations receive funding from the donors described earlier. The following are some brief descriptions of what was found.

#### Association Beninese pour la Promotion de la Famille (ABPF)

IPPF is the principal sponsor of ABPF, which has been providing reproductive health and other services for close to 20 years. Until 1993, ABPF was the main recipient of contraceptives, equipment, and educational materials (from IPPF, UNFPA and USAID) and distributed them to their own clinics and the “integrated government clinics.” Today, under an agreement with and supervision by the MSPSCF, ABPF supplies 80 government clinics with these items.

Presently, ABPF monitors its own six clinics in Cotonou, Porto-Novo, Lokossa, Abomey, Parakou, and Natitingou. These clinics are staffed by trained personnel and provide services using a subsidized fee schedule. ABPF clinics offer a variety of services, including—

- Sterility diagnosis and treatment (both sexes).
- MST diagnosis and treatment for both sexes (except HIV/AIDS).
- Pre-and post-natal visits (safe motherhood program).
- OB/GYN (consultations, Pap smears, etc.).
- Family planning, including combined and progesterone-based oral contraceptives, copper T IUDs, injectables (Noristerat), Norplant subcutaneous implants (to date over 200

insertions and 2 withdrawals), spermicide (creams and jellies), and natural family planning methods.

- Post-abortion counseling.
- Essential drugs.
- IEC program to raise awareness of clinics, including a theater in Lokossa sponsored by Africare.

In addition, ABPF carries out a community-based contraceptives distribution (CBD) program in Cotonou, sponsored by the USAID/SEATS project.

Since the beginning of its operations, ABPF performance has been uneven due to the lack of consensus on reproductive health policy with the MSPSCF. There is no integration with other health services in ABPF clinics. Additional obstacles include the 1920 law described earlier, husbands' resistance to contraception, female illiteracy, and a lack of a coherent and culturally sound IEC program.

#### *Needs and Lessons Learned*

Despite its relatively poor performance and its weak impact on contraceptive prevalence, ABPF appears to be the only functional reproductive health (RH) program in the country. ABPF would like to increase its safe motherhood activities (including breast cancer prevention and prenatal abnormality detection using echography). ABPF's IEC program is weak and an IEC specialist is much needed. Many health professionals have been trained in RH services, but there remains a need for upgrading logistics and management support. ABPF is interested in initiating some child survival activities, beginning with an immunization program, a well baby clinic, and hiring a specialist to focus on linking male contraception and sterilization and STDs/AIDS.

#### Africare

Africare has submitted a child survival project proposal to USAID/Washington for the Ouémé region. No response has been received to date.

Africare's BINGOs project, which works on a number of development issues with local NGOs, was recently extended. The team did not have the opportunity to meet with Africare, but the BASICS nutrition assessment team will seek more information on Africare health activities.

### Catholic Relief Services

CRS has received a grant from USAID to carry out a KPC study in Ouémé, with a focus on childhood nutrition. CRS activities/lessons learned will be explored in more detail by the BASICS nutrition assessment team.

### OXFAM-Québec

OXFAM-Québec executes two health programs in Benin: PILSA and PEV. Financed by the World Bank and carried out in Benin by OXFAM-Québec, in conjunction with international and indigenous NGOs, PILSA is a world-wide nutrition program. In Benin, activities have focused on the Department of Mono. OXFAM-Spain has recently initiated activities in Benin; information on the nature of these activities was not obtained prior to departure of this team.

PEV, a three year vaccination and maternal and child nutrition program in the Zou department, focusing around the towns of Dassa and Savalou, has just been completed. A proposal is currently being prepared for extension of the program.

On a smaller scale, OXFAM-Québec will support an evaluation of the activities of an indigenous NGO which combats female genital mutilation, believed to be a wide-spread practice. Other than OXFAM-Québec, no other donor with whom the team met mentioned any programs to combat the prevalence of this practice, yet most mentioned the health risks associated with it, particularly those encountered during pregnancy and child birth.

One representative of OXFAM-Québec suggested that future donor efforts would best be focused on increasing women's capacity to make decisions. The BASICS nutrition assessment team will meet with OXFAM-Québec to get further details on these activities and lessons learned.

### Rotary International

Rotary has been active in polio vaccine procurement for many years in Benin through its Polio Plus program. Coordination has typically been handled through UNICEF; however, Rotary delivers vaccines directly to the MSPSCF. Rotary is no longer donating routine polio vaccinations, but plans to continue financing NIDs for polio, a series of which were held in December 1996 and January 1997.

In addition, Rotary is financing—

- Construction of a 32 bed-pavilion at the Centre National de la Tuberculose.
- Purchase of an ambulance (but not the operating costs) for the centre de santé near Ganvie.

- Construction of a pavilion for psychiatric patients of Le Centre des Malades Mentaux de Jacquot.

#### Association Raoul Follereau

This NGO has established and is monitoring a national program for leprosy.

#### Lion's Club International

The Lion's Club provides grants in the curative health sector such as the national blood transfusion center; participates in diabetes prevention and activities, including campaigns; and has constructed a pavilion for tuberculosis patients in the national hospital in Cotonou (CNHU).

#### Terre des Hommes

Terre des Hommes sponsors a nutritional center in Bohicon (Zou) and an orphanage in Cotonou.

#### Military Order of Malta

This NGO has been present in Benin for more than 25 years. At present, it finances an orphanage and a full medical and surgical team in the Djougou hospital (Atacora), as well its running costs.

#### Association des Oeuvres Médicales Privées Confessionnelles et Sociales au Benin (AMCES)

The religious (confessional) institutions contribute to the health sector in Benin, primarily through support to hospitals and health centers. AMCES serves as a forum for exchange of information among religious NGOs working in health and education, and tries to coordinate new activities with the MSPSCF.

### **IV. CONCLUSIONS AND RECOMMENDATIONS**

The current health situation in Benin presents donors with an uncertain, yet open future for involvement in the health sector. Donors are operating in a period of uncertainty as to which direction their programs should take, while the GOB attempts to form a cohesive strategy and plan of action for health. Nevertheless, this represents an important opportunity for USAID to gather the information it needs (as it has been doing) to develop a focused program and to consider its comparative advantage in Benin.

By and large, the donors and health professionals interviewed and the documents reviewed pointed to the following barriers to achieving results—

- **Access:** Geographic, financial, and cultural barriers to health care, especially for women and children, are serious.
- **Poor quality of care and limited human resources:** Poor quality of care is, at the least, a widespread perception. Influencing the quality of care are limited human resources, health facilities cannot equip themselves with sufficient staff, especially female staff, to meet the needs of the population they are supposed to serve.
- **Communications:** Communications with the periphery level are difficult and irregular, which, among other reasons, compromises the potential effectiveness of the new referral system being established in health zones.
- **Coordination and collaboration with the MSPSCF:** Stronger leadership from the central level is viewed as an important need by the donor community. DDS directors appear to have participated in the development of the health policy and strategy, yet receive very little feedback from the central level to their input. In addition, health professionals at the periphery are often required to pass through central levels to obtain approvals for personnel assignments and budget allocation, for example, a process which can be lengthy.
- **Coordination and collaboration within the donor community:** Weak coordination between donors has been present, although more attention is being paid to the importance of collaboration. The lack of an MSPSCF plan of action into which donors can plug their efforts leaves them with little focus for coordination meetings. The BASICS team further observed that the bilateral donor focus in the periphery may reinforce weak coordination: donors tend to limit their coordination to those working in the same area, and it appears to be ad hoc in nature. The result is that different agendas and priorities exist among the donor community, priorities may not always be in line with MSPSCF priorities, and opportunities for lessons learned from other regions may be missed.
- **Excessively dispersed interventions:** Most donors have come to the realization that too many activities in too many areas compromises results. Many bilateral and smaller, private donors now seem to focus on a number of interventions across one or two departments, with support sometimes provided to the central-level MSPSCF as well.

The BASICS team offers the following conclusions and recommendations for consideration:<sup>10</sup>

## 1. Donor coordination and collaboration with the MSPSCF

In order to strengthen intra-donor collaboration and with the MSPSCF, USAID may—

- In the short term, offer technical assistance to the development of the MSPSCF plan of action with WHO. The BASICS team supports the recommendation made by Norine Jewell of The Futures Group for analysis of the DHS as a basis for developing a plan of action which responds to the greatest needs, and for a workshop to share this information at both the central and periphery levels. A similar workshop was carried out in Mali by Macro International and was successful in highlighting important malnutrition indicators.
- Support the formation of an interagency coordinating committee and specialized working groups on priority topics such as integrated services, nutrition, EPI, and safe motherhood. The interagency coordinating committee would need to serve as an umbrella to link the inputs of the more specialized groups to avoid excessive verticality.
- In the longer term, consider placement of a public health advisor within the MSPSCF to reinforce attention to priority areas. This type of coordination seems to have benefitted the DDS, where health zones have been established in areas where donors are present (Dutch in Atacora, Swiss and Germans in Zou and Borgou).

## 2. Sector(s) of Involvement, Level, and Location of Interventions

- A combination of support to both the public and private sectors should be considered. Support to the public sector may combine central-level MSPSCF support with a focus in one or two departments, including several health zones. This could help strengthen periphery/central public sector coordination, and allow USAID to carry out an integrated program of technical assistance.

The presence of 600 NGOs in Benin, many of whom work in health, offers USAID the opportunity to have greater access to and influence on the quality and type of services offered at the community level. Since the process of decentralization puts health service management in the hands of those at the community level, USAID should consider working in a geographic location where some community management structure is partially or fully formed.

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It is important to note that a full extensive health sector assessment was not undertaken during this two-week visit, and that USAID will need to consider all of the assessments it is conducting in order to come up with an integrated approach to family health.

- USAID should consider support to a coordinating umbrella group of NGOs, as is present in other West African countries.

### **3. Nature of Technical Support and Integration**

The majority of donors intervene in a number of technical areas. While a full analysis of the budget allocations for each area within a donor's portfolio was not undertaken, it appears that construction/renovation, support to systems delivery (establishment of health zones, CCS); AIDS prevention, control, and treatment; and reproductive health are the major areas of intervention.

During its discussions with the donor community, the team heard very little regarding programs for safe motherhood, female genital mutilation (FGM), and diseases which cause morbidity and mortality in children under 5: malaria, ARIs, and nutrition. Additional assessments being carried out now may provide more details.

Integration, that is, an approach which links comprehensive reproductive health with child survival (ICPD, Cairo 1994), should be incorporated not only into the centrally prepared MSPSCF plan of action, but also in the plans of action at the level of the DDS, in order to encourage integration at the community level, particularly in the CCS, the first-line of referral from the UVS.

- USAID should consider complementing the efforts of donors working in specific departments on health services delivery by offering technical assistance directed at quality of care issues.
- Integration should be considered in the design of any family health project. (To date, there is limited experience with operationalization of the concept of integration, and USAID should continue to seek experiences in this area.)
- In addition to the assessments carried out to date, USAID may wish to investigate the prevalence of FGM, which is believed to be a widespread practice, and consider interventions as appropriate.
- Training activities should have some focus on those health workers closest to the communities: nurses, nurse aides, midwives, and traditional birth attendants.
- Any social marketing activities directed toward generation of demand for public health products should be part of a longer term plan for involving local or regional producers in assuring a sustainable supply of public health products.
- Any IEC interventions should be based on qualitative research on cultural obstacles to care and should seek to utilize traditional means of communication. They should also seek behavior change among the decisionmakers in Beninese society. Donors and health

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professionals pointed to, in families, the predominant role of men in making decisions as to when and what type of health care should be made available to women and children. The team was told that mothers- and sisters-in-law often influence these decisions as well.

#### **4. Linking Health and Education**

- High literacy rates and education for women and girls often lead to improvement of family health and effective utilization use of health facilities. USAID should continue to support formal and informal means for educating girls and women.
- An opportunity exists for USAID to link its efforts to improve pre-service training/education in reproductive health, including medical and nursing schools, with revised curriculum for child survival through the WHO MEDED program, in which BASICS has participated. This was initiated in the September 1996 workshop in Ouagadougou.
- USAID's education project is in the process of revising sixth grade curriculum, which includes health messages. USAID should access technical assistance to assure the appropriateness of those messages, as it is anticipated that curriculum will not be revised again for quite some time.

In addition, technical assistance from a gender specialist, for example, could be provided to ensure that messages in the curriculum support the importance of women and girls in society. This would support the MSPSCF's goal of improving the condition of women in Benin. Given data which suggest the positive correlation between increased education for women with improved health for children and lower fertility, this may be a worthwhile investment.

The team understands that USAID's education program is supporting activities to eliminate school fees for girls in the Atacora department (and possibly other areas), as finances are perceived as a barrier for formal education for girls. While the BASICS team did not investigate any studies on which this approach may be based, there are certain risks which may be present. First, there may be barriers other than financial which are more influential in keeping girls out of schools. Second, fees represent revenue for schools, and the reduction in fees may be a disincentive to schools for providing education to girls. Third, the question should be raised as to whether, in Benin, this will encourage a perception that services (education) paid for (for boys) are worth more than those not paid for, reinforcing society's preferential treatment for boys. Because of the key role education plays in health, USAID's family health team should work closely with the USAID education program to understand the reasons for and results of this approach.

**5. Dissemination of Best Practices and Lessons Learned**

- Forums for discussion of the results of various assessment should be shared with donors and the GOB.
- BASICS is in the process of establishing a health network for West Africa at the request of REDSO/WCA. One of the purposes of this network is to help identify and share best practices and lessons learned within the region. USAID may consider this network an additional venue for disseminating lessons learned in Benin, and a way to learn about successes in other countries in West Africa.

In addition, the team supports the recommendations made in November 1996 for next steps in BASICS support. USAID/Benin and BASICS should also discuss potential links in technical assistance in child survival in the BASICS West Africa program.

**APPENDICES**

**Appendix A: List of Documents Consulted**

## LIST OF DOCUMENTS CONSULTED

- 1) Ministère de la Santé - Benin, Mai 1990: Programme National de Santé Maternelle et Infantile, de Planification Familiale et de Nutrition 1990 - 1994
- 2) Ministère de la Santé - Benin, 1992 Rapport de l'enquête sur les maladies diarrhéiques infantile menée du 05 au 12 Octobre 1992 en République du Bénin
- 3) UNICEF - Bénin, Oct.1993 : Programme de coopération 1994 - 1998
- 4) Elénore Seumo, Ph.d (EDC, Inc), Août 1994 : La situation nutritionnelle au Bénin
- 5) Ministère de la Santé - Ministère du Plan (Bènin), Mars 1995: Rapport de la consultation sur le secteur de la santé (Volume 1: Synthese des travaux)
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- 7) Ministère de la Santé - OMS, Juill. 1995: Profil-Pays
- 8) Ministère de la Santé - (Bènin), 1996 : Programme national de lutte contre le SIDA et les Maladies Sexuellement Transmissibles PMT2 Années 1996 - 2001
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- 10) Africare, Mars 1993: Health sector assessment, Republic of Benin
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- 12) UNICEF - Bénin, Septembre 1996: Programme de coopération 1994 - 1998 Revue à mi parcours - Programme Santé/Nutrition
- 13) Jean Jacques Frère, Maryse Simonet, Nov 11-19, 1996, Rapid Assessment of Health sector in Benin
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- 15) World Bank, May 1995: Staff appraisal report - Republic of Benin Health and Population Project
- 16) Ministère de la Santé (Benin) - Projet Appui Néerlandais aux soins de santé primaire, Janvier 1996 : Ligne d'orientation pour l'exécution du PMA en strategie avancee dans tous les villages du departement.

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- 18) Projet de Développement des Services de Santé (PDSS) et Projet Santé Population, Octobre 1996 : Mission d'évaluation à mi parcours du PDSS et de lancement du PSP.
- 19) Ministère de la Santé - Document de requête Oct. 95 - Revisé le 2/19/96, Appui au developpement d'un projet de santé de la reproduction et planification familiale
- 20) Union Europeenne, 1995, Rapport Annuel : Cooperation entre Union Europeenne et la Republique du Bènin
- 21) Ministère de la Santé - UNICEF - Janvier 1995, Programme Elargi de Vaccination Enquete Nationale de Couverture Vaccinale
- 22) Ministère de la Santé, Service Allemand de Developpement, Office Allemand de la Cooperation Technique; 1996 - 1999, Plan Operationnel Phase VII Projet Benino - Allemand des Soins de Santé Primaires
- 23) POPTECH, August 1995: Population/Family Planning assessment in Benin, POPTECH report 94-010-026

**Appendix B: List of Contacts**

## LIST OF CONTACTS

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## **Appendix C: Key Health Indicators**

## Key Health Indicators

Indicators:<sup>11</sup>

Population (000)		
Total	5,409	
Males	2,674	
Females	2,735	
Sex Ratio	(/100 fem.)	97.8
Urban	1,691	
Rural	3,718	
% Urban	31.3	
Population proj. yr 2000	6,266	
Infant Mortality Rate (/000)	92	
Under 5 Mortality Rate (/000)	140 <sup>12</sup>	
Maternal Mortality Rate	473 <sup>2</sup>	
Life expectancy at birth		
Males	47.2	
Females	50.6	
Both sexes	48.9	
GNP per capita (\$US)	410	
Age Differential (%)		
Young Child: 0-4	19.6	
Child: 5-14	27.8	
Youth: 15-24	18.4	
Elderly: >60	7.1	
% Women 15-49	21.29	
Dependency Ratios: total	101.1	
(/100) Aged 0-14	95.3	
Aged 65>	5.7	
Mean age of marriage	19.2	
Number of living children/wom	6.1	
Agricultural population density (/hectare of arable land)		1.5
Population density (/sq. km.	46	

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<sup>11</sup> Sources: DHS Survey, 1996, World Bank Development Report 1994, UN World Population Prospects: the 1994 Revision, UN World's Women Trend and Statistics, 1970-1990.

<sup>12</sup> Note: MMR varies greatly between 260 per 100,000 live births in hospitals, but the national average is estimated at 800 per 100,000 live births. UNICEF, The Progress of Nations, 1996.

## DEMOGRAPHIC ANNUAL CHANGES (000)

Population increase	171
Birth	267
Death	96
Net migration	0
Annual population total	
(% growth) Urban	4.55
Rural	2.16
Crude birth rate (/000)	45.8
Crude death rate (/000)	16.4
Total fertility rate (/wom.)	6.60
Gross reproduction rate (")	3.25
Net reproduction rate (")	2.35

## CHILD SPACING (Contraceptive Prevalence)

Modern methods/100)	2.69
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## CHILD SURVIVAL<sup>13</sup>

### Immunization

BCG/DTCoq/Polio/Measles	56%
No immunization	14%

Diarrhea incidence (DHS)	26%
ORT use when diarrhea (")	33%

Malnutrition<sup>14</sup> (children <5yrs) 35%

## HEALTH SERVICES<sup>4</sup>

% People access to health serv.	50%
% relying on trad. practitioners	33%
1 MD for 14,768 (39,000 in North) <sup>15</sup>	
1 midwife for 10,530 <sup>5</sup>	
1 nurse for 3,447 <sup>5</sup>	

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<sup>13</sup> DHS: Enquête Démographique et de Santé au Bénin, Rapport Préliminaire, 1996.

<sup>14</sup> UNFPA, Country program, 1995.

<sup>15</sup> 1992, UNFPA.



## EDUCATION

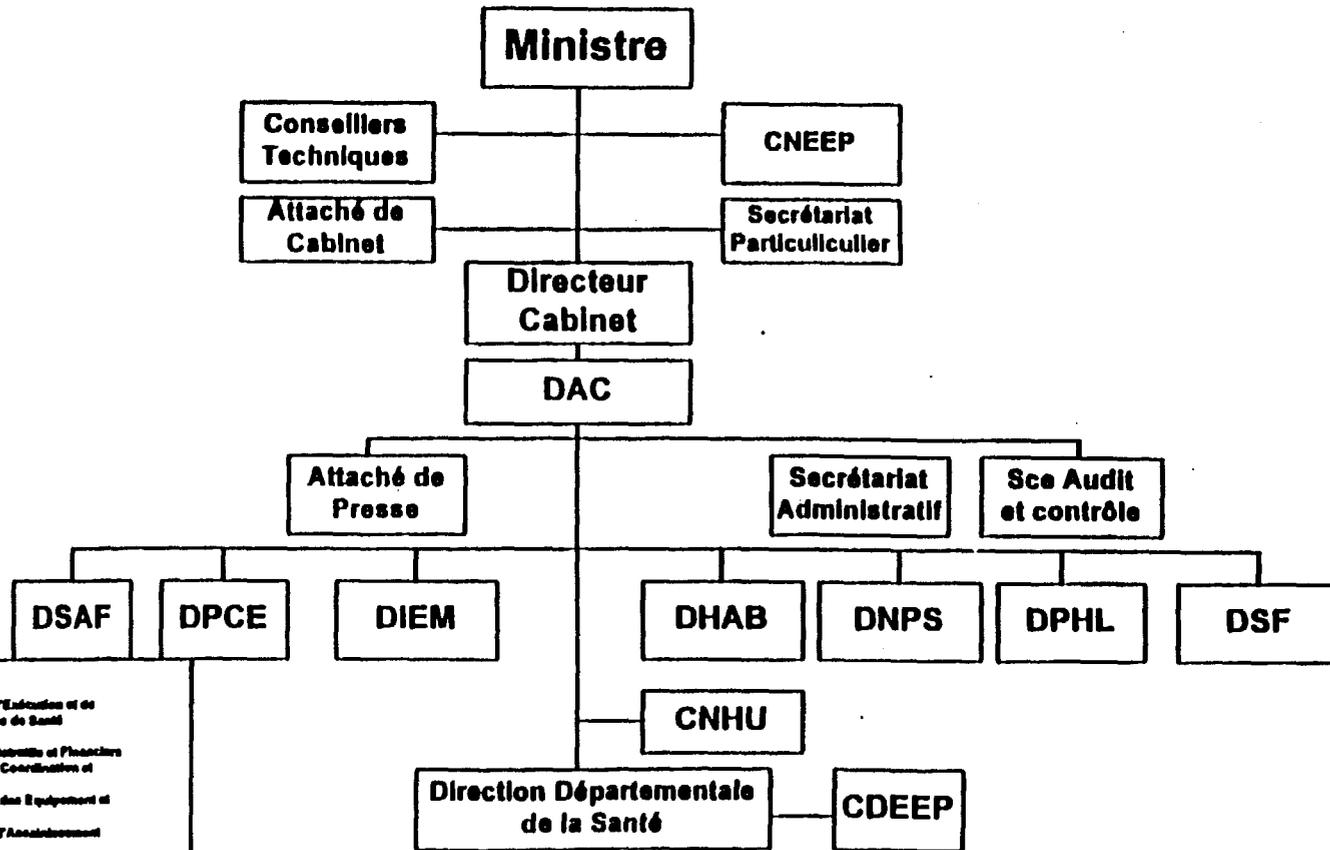
Literacy rate (boys)	70%
Literacy rate (girls)	40%

**Appendix D: Benin Public Health Structure**

# ORGANIGRAMME DU MINISTERE DE LA SANTE

REPUBLIC OF BENIN  
HEALTH AND POPULATION PROJECT  
ORGANIGRAMME OF THE NEWLY REORGANIZED MOH

ANNEX 10  
Page 1 of 1



**CNEEP** : Comité National de Suivi de l'Évaluation et de l'Évaluation des Programmes de Santé  
**DAC** : Directeur Adjoint du Cabinet  
**DSAF** : Direction des Services Administratifs et Financiers  
**DPCE** : Direction de la Planification, Coordonnée et Évaluation  
**DIEM** : Direction de l'Infrastructure, des Équipements et de la Maintenance  
**DHAB** : Direction de l'Hygiène et de l'Assainissement de Santé  
**DNPS** : Direction Nationale de la Prévention Sanitaire  
**DPHL** : Direction des Pharmacies et des Laboratoires  
**DSF** : Direction de la Santé Familiale  
**CNHU** : Centre National Hospitalier Universitaire  
**CDEEP** : Comité Départemental de Suivi et d'Évaluation des Programmes de Santé

**Appendix E: Interview Questions**

## Appendix E: Interview Questions

1. Describe the projects of your organization (in terms of goals, range of technical services, geographic coverage, level of intervention [central versus peripheral], funding commitments).
2. With whom do you collaborate? How effective is this collaboration? Do you know what other donors are doing in the areas in which you work?
3. What are the greatest difficulties/challenges you face in trying to accomplish your goals?
4. What results have you achieved to date?
5. What level of integration characterizes your program?
6. If you were a new donor in the country, where would you invest? How do you see your support in comparison to that of other donors?
7. If you had to restructure your program in any way, what would you do?
8. What do you think the health priorities are in Benin?
9. What other donors/organizations work in the same geographic/technical area as you do?
10. Any recommended field visits?

**Appendix F: Field Trip to the Atacora Department**

## Appendix F: Field Trip to the Atacora Department

February 23-25, 1997

### *Notes from Claude Aguilhouette*

The BASICS team took a three day field trip to the Atacora department in order to learn more about the collaborative efforts between the Dutch program, ANSSP, in support of the health zones of Tangueta and Natitingou.

#### ORDRE SOUVERAIN DE MALTE (Djougou)

On its way to Natitingou, the team discovered this health facility by chance, and experienced the low access to health services which many donors were describing. The team's vehicle was stopped by two policemen, who pleaded with the team to transport an 18 month old boy and his mother to the next hospital facility, approximately 40 miles away. The boy and his mother had been in a bus accident the previous day, and the boy was thrown out the window in an effort to save him. By the time the team saw him 24 hours later, the boy was convulsing, and the parents were trying desperately to get him to a health facility. An expatriate surgeon was on call when the team arrived at the Order of Malta Hospital, which offers curative services only. This is the only intervention in health of the Order of Malta in Benin.

#### DIRECTION DEPARTEMENTALE DE LA SANTE-DDS-A NATITINGOU

The team met with the Director of the Atacora DDS, and the ANSSP program director provided direct support to the DDS. Other donors intervene in this department, including UNDP, the World Bank's PILSA program, GTZ, the Belgian and Chinese governments, and the EU. ANSSP observed that some donor coordination exists, but it does not appear to be extensive. Tangueta and Natitingou are two of the five health zones which had been established as of November 1996 (UNICEF mid-term report), with important support from the ANSSP project.

ANSSP has initiated comprehensive health activities in the two health zones, and has been instrumental in efforts to integrate primary health care activities through all service delivery levels. A comprehensive Plan of Action for the year 1997 was developed by the DDS-ANSSP team (see earlier description). Their strategy is designed to increase the accessibility of medical care in the Atacora Department, maximize the efficacy of the resources, establish regular contact between the Agent de Sante and the community, increase program efficacy demonstrated through the decrease of maternal mortality, improve diagnosis of endemic diseases e.i. onchocerciasis, and rehabilitation of the malnutrition cases; increase the impact of IEC targeting pregnant women, male decision-making, and increased community participation. This strategy also aims to foster the COGEC model of community participation<sup>16</sup>. The main philosophy is to build on and/or reinforce the already existing infrastructures.

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<sup>16</sup>

From Lignes d'orientation pour l'exécution du PMA en stratégie avancée dans tous les villages du département, DDS Natitingou, January 1996 (fifth draft).

The team visited several levels of the service delivery system in Tangueta, including a CSSP for Tangueta, a CCS, and a confessionnal hospital. The team also met with a committee representing a UVS for a village of approximately 690 people.

In the Tangueta health zones, there appeared to be no deficiency in the cold chain, and all the recurrent costs were supported by the community. The midwife was offering family planning services (IUD, condoms, OCs, injectables), however, family planning services are not offered every day. There was no lab in the facilities. The Center is in need of a qualified midwife, and could use solar energy panels. Lack of female staff, high percentage of female illiteracy, and education were referred to as major impediments to improved health indicators.

The CCS of Dassari was visited and is staffed by a traditional birth attendant and a male nurse. The nurse had been trained at the St Jean de Dieu Hospital (a religious health facility) and supervises six UVS (some of them as far as 36 kms away) at least every two months. Accessibility, diarrhea, meningitis and basic hygiene are the greatest difficulties according to the nurse.

The team visited the village of Tankouari (690 habitants) and met with the UVS. This UVS has been in existence for eight years and the nurse (from Dassari) explained that there has been a decrease in certain morbidity and mortality in the village (e.g., only one maternal death three years ago due to placenta retention). Most of the women of the village are illiterate. They described an increase incidence of bilharziosis in both children and adults. Their stock of medicine was adequate, but they needed a better container to store them. The village's greatest needs are for increased water supply and greater proximity to the school, as the road leading to the school is impassable during the rainy season.

The team also visited the Saint Jean de Dieu Hospital, a 200-bed reference (Catholic) hospital staffed with 7 doctors, one RN, 41 other paramedics, and two midwives. Besides offering internal medicine, pediatrics, OBGYN, and general surgery, this hospital supports a nutritional center. Higher fees have been an obstacle to accessibility, although people still travel from Burkina Faso and Niger for care at this facility. Very few preventive activities are offered on the premises.

## **HOSPITAL OF BASSILA**

The team visited the lead hospital for the future health zone covering sub-prefectures such as Bassila and surrounding sub-prefectures. GTZ provides some support to the establishment of the health zone in this area, including renovation of certain infrastructures, provision of medical supplies and equipment, and organization of training activities for its personnel. Family planning methods, almost exclusively, are made available to women only upon presentation of proof of the husband's approval and a marriage certificate. Some women request tubal ligation. Due to the high STD prevalence, the medical staff have observed increasing infertility cases in females as well as males. Early union (16-17 years for a woman) is the norm rather than the exception and abortions, which are illegal, are rampant according to health personnel interviewed. Finally,

female circumcision is regarded as a common practice in the area. According to the chief doctor, high immunization coverage of children has been assured through an outreach program.

Examples of problems cited by the medical team include: illiteracy of women, the lack of female nurses, lack of adequate IEC programmes, parasites such as bilharziosis, and poor water and sanitation.