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December 15, 1995

M. David GUILKEY
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Re: Final report of the case study on "Program Structure and Performance: comparison of vertical and integrated approaches to Family Planning deliveries in Benin."

Dear M. Guilkey,

Thank you for memorandum of December 5, 1995 regarding my first draft report on the study on Program Structure and Performance: Comparison of Vertical and Integrated Approaches to Family Planning Deliveries in Benin. I very much appreciated your specific comments which have already been incorporated in my final report. However, some additional informations are not available that could have been very useful for this study. Most donor agencies seem rather reluctant to provide financial informations. You will receive my final report with a US \$ 1,000 invoice which is still due by the "Evaluation Project".

Thank you again for your very fruitful collaboration on this study. I look forward to contribute to any future activities you may have in french speaking Africa, either as a consultant or as Operations Research study coordinator. Enclosed is a copy of my resume for your files. Let me seize this opportunity to wish you and your family and collaborators, a Merry Christmas and happy New Year.

Yours, sincerely



Dr Aristide APLOGAN

A

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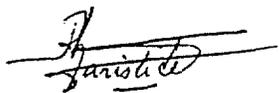
Service: EVALUATION

INVOICE ITEMS

| Phase # | Description | Amount (US \$) |
|---------|--------------------------------|----------------|
| 3 | Final of the evaluation report | 1,000 |

TOTAL

US \$ 1,000



Dr Aristide APLOGAN
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THANK YOU FOR YOUR BUSINESS !!!

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1991: Field Epidemiology Certificate.
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1990: Operations Research Certificate. Centers for Diseases Control and
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1989: PhD Degree in Medicine.
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THE POPULATION COUNCIL

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- Jun-Dec 94: (60 days) Technical Assistance for Situation Analysis of Family Planning Services in SENEGAL
- Feb 95: (10 days) Technical Assistance for Situation Analysis of Family Planning Services in MALI

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

- Jun 94: (10 days) Technical Assistance to the Benin's Family Planning Situation Analysis Follow up Committee, for the development of strategies and program budget
- July-Aug 94: (30 days) Assessment of public sector, operations research capacities in the Population/Family Planning sector in BENIN

THE EVALUATION PROJECT

- Mar-Aug 95: (15 jours) Family Planning Program Structure and Performance: Comparison of vertical and integrated approaches in BENIN (Multicentric Study)

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- July 95: (5 days) Technical evaluation of ABPF's Family Planning activities in BENIN

CFDIE EXPERTISE FIRM

- May 94: (5 days) Writing of a proposal to USAID for an Impact Assessment of the Catholics Relief Services Health Nutrition program in BENIN

REGIONAL PUBLIC HEALTH INSTITUTE (IRSP/WHO/UNB)

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- Feb-May 95: (100 days) Preparation and coordination of the Epidemiology component of the first Inter-african Epidemiology, Applied Computer Sciences, and Management of Health Programs (BENIN, COTE D'IVOIRE, FRANCE, MAURITANIE, TOGO)
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TRAINING AND FIELD SUPERVISION

Training in Operations Research for the central and regional Directors of the Ministry of Health in Togo (1990)

Training of research teams for various Operations Research in Togo, Benin and Senegal (1992, 1994)

Training in Applied Epidemiology of the IDEA's, IRSP's, EPIGEPS's groups (1992, 1993, 1994, 1995)

RESEARCH: COORDINATION AND TECHNICAL ASSISTANCE

1. Prévalence de l'hypertension artérielle au Nord Togo (1988)
2. Carence martiale, immunité à médiation cellulaire et infection chez les enfants de 6 mois à 3 ans au Sud Togo (1989)

E

3. **Prévalence des affections neurologiques au sein de la communauté de la région des plateaux au Togo (1989)**
4. **Risque d'exposition à l'hépatite B des professionnels de la santé dans les hospices civiles de Lyon en France (1991)**
5. **Enquête nationale de couverture vaccinale et de CAP des mères en matière de lutte contre la diarrhée et le paludisme au Togo (1991)**
6. **Etude des occasions manquées de vaccination chez les enfants de 0 à 23 mois et les femmes en âge de procréer au Togo (1991)**
7. **Impact de la vaccination à tout contact sur la couverture vaccinale des enfants et des femmes en âge de procréer au Togo (1991)**
8. **Etude de l'intégration de la planification familiale au programme élargi de vaccination au Togo (1992)**
9. **Lutte contre le paludisme et les maladies diarrhéiques dans la région des plateaux au Togo: Connaissances et Pratiques des mères et du personnel de santé (1992)**
10. **Attitudes, Opinions et Pratiques des populations rurales de la Kozah au Togo vis-à-vis des modes d'approvisionnement en médicaments (1992)**
11. **Connaissances Attitudes et Pratiques des populations de la Kozah au Togo en matière de lutte contre les diarrhées et le paludisme selon leurs sources d'information (1992).**
12. **Morbidité palustre chez les enfants de 0 à 5 ans à Sotouboua au Togo: Fiabilité de l'examen clinique (1992)**
13. **Impact de l'Education Pour la Santé sur les connaissances et pratiques des mères dans la réhydratation par voie orale à domicile dans le Moyen-Mono au Togo (1992)**
14. **Risques d'exposition aux maladies sexuellement transmissibles et le SIDA chez les jeunes de la rue de Lomé au Togo (1992)**
15. **Apports sodés et risque d'hyponatrémie et d'hypokaliémie chez les enfants diarrhéiques avec déshydratation de type B ou C à Kara au Togo (1992)**
16. **Anémie et état nutritionnel chez les enfants de 3 mois à 4 ans au Centre Hospitalier Régional de Kara au Togo (1992)**
17. **Paludisme et anémie chez les enfants âgés de 0 à 12 ans de la préfecture d'Afagnan au Togo (1992)**
18. **Déficit en Glucose 6 Phosphate Deshydrogénase: fiabilité du dosage qualitatif et impact dans les anémies hémolytiques chez les enfants au Centre Hospitalier et Universitaire de Lomé-Tokoin au Togo (1992)**
19. **Pratiques d'achat des médicaments dans les communautés rurales du Zio au Togo (1992)**

F

20. Recours aux soins des habitants de St-Jean de Maurienne en France (1992)
21. Accès aux soins des populations défavorisées de Vienne en France (1993)
22. Analyse situationnelle de la planification familiale du Bénin (1994)
23. Acuité visuelle chez les soudeurs à l'arc de Cotonou au Bénin (1994)
24. Alcool au volant et sur les lieux de travail à Annecy en France (1994)
25. Analyse situationnelle de la planification familiale du Sénégal (1994)
26. Analyse situationnelle de la planification familiale du Mali (1995)
27. Enquête de couverture vaccinale et des facteurs de non vaccination dans le district de Yamoussoukro en Côte d'Ivoire (1995)
28. Enquête de couverture vaccinale et connaissance des élèves de 5ème en matière de prévention de l'hépatite B à Annecy en France (1995)

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MEMBERSHIP OF SCIENTIFIC ASSOCIATIONS

International Association of Field Epidemiologists (EPITER, since 1991)

African Network for Research in Reproductive Health (Togo Chapter, since 1991)

Republic of Benin

PROGRAM STRUCTURE & PERFORMANCE

**Comparison of vertical and
integrated approaches to Family
Planning deliveries in Benin**

Final Report

By

Dr Aristide APLOGAN

**Medical Epidemiologist
Operations Research Consultant**

For

The EVALUATION Project

December 1995

Abbreviations

| | | |
|----------------|---|---|
| ABMS | : | Benin Association for Social Marketing |
| ABPF | : | Beninese Association for Promotion of the Family |
| ACDI | : | Canadian International Development Agency |
| AIDS | : | Acquired Immunodeficiency Syndrom |
| AFVP | : | French Association of Volunteers for Progress |
| CBD | : | Community-Based Distribution |
| CCS | : | Communal Health Complex |
| CDEEP | : | Departmental Committee for Project Implementation and Evaluation |
| CHD | : | Departemental Hospital Center |
| CNHU | : | National University Hospital Center |
| CNBPF | : | National Committee of Benin for the Promotion of the Family |
| CNRHP | : | Nationale Human Resources and Population Commission |
| CNEEP | : | National Committee for Evaluation and Support of Health Sector Program |
| COGEC | : | Commune Level Health Management Committee |
| COGES | : | Sub-prefecture Level Health Management Committee |
| CPR | : | Contraceptive Prevalence Rate |
| CPS | : | Center for Social Promotion |
| CRDI | : | Regional Center for International Development |
| CREDESA | : | Regional Center for Health Development |
| CRS | : | Catholic Relief Services |
| CSDO | : | Canadian Solidarity and Development Organization |
| CSSP | : | Sub-Prefecture Health Center |
| CSCU | : | Metropolitan Area Health Center |
| CUGO | : | University Clinic of Gynecology and obstetrics |
| DAC | : | Cabinet Deputy Director |
| DDS | : | Departmental Health Directorate |
| DHAB | : | Directorate of Basic Hygiene and Health |
| DIEM | : | Directorate of Infrastructure, Equipement and Maintenance |
| DNPS | : | National Directorate of Health Protection |
| DPCE | : | Directorate of Planning, Coordination and Evaluation |
| DPHL | : | Directorate of Pharmacies and Laboratories |
| DSAF | : | Directorate of Administration and Finance |

| | | |
|---------------|---|--|
| DSF | : | Directorate of Family Health |
| EPI | : | Expanded Program of Immunization |
| FAC | : | Fund for Aid and Cooperation |
| FCFA | : | African Financial Community Franc |
| FED | : | European Development Fund |
| FF | : | French Franc |
| FP | : | Family Planning |
| FL | : | Family Life |
| FSP | : | Public Health Centers |
| GTZ | : | German Association for Technical Cooperation |
| HIV | : | Human Immunodeficiency Virus |
| IEC | : | Information Education and Communication |
| IMR | : | Infant Mortality Rate |
| IPPF | : | International Planned Parenthood Federation |
| INSAE | : | National Institute for Statistic and Economic Analysis |
| IUD | : | Intrauterine Device |
| MOH | : | Ministry of health |
| MPRE | : | Ministry of Planning and Economic Restructuring |
| MTEAS | : | Ministry of Labor, Employment, and Social Affairs |
| MERS | : | Ministry of Education and Scientific Research |
| MCC | : | Ministry of Culture and Communication |
| MDR | : | Ministry of Rural Development |
| MJS | : | Ministry of Youth and Sport |
| MISAT | : | Ministry of Domestic Affairs, Security Territory Administration |
| | | MJL : Ministry of Justice and Legislation |
| MEHU | : | Ministry of Environment, Housing and Urban Development |
| MCH | : | Maternal and Child Health |
| NGO | : | Nongovernmental Organization |
| PBEF | : | Project for Family Well-Being |
| PBASSP | : | Benin-Germany Primary Health Care Project |
| PDSS | : | Project for Health Services Development |
| PHC | : | Primary Health Care |
| PMSBS | : | Benin-Swiss Health Project |
| PSI | : | Population Services International |
| PVO | : | Private Voluntary Organization |
| REDSO | : | Regional Economic Development Services Office |

| | | |
|---------------|---|--|
| RGPH | : | General Census of Population and housing |
| SAP | : | Service of Preventive Activities |
| SNV | : | Dutch Association for Development Assistance |
| SRHP | : | Human Resources and Population Service |
| SAD | : | German Development Service |
| SNIGS | : | National Health Management Information System |
| SSDRO | : | Operations Research, Documentation and Statistics Service |
| STD | : | Sexually Transmitted Disease |
| UNICEF | : | United Nations Children's Fund |
| UNDP | : | United Nations Development Program |
| UNFPA | : | United Nations Fund for Population Activities |
| US | : | United State |
| USAID | : | United States Agency for International development |
| UVS | : | Health Village Unit |
| WB | : | World Bank |
| WCA | : | West and Central Africa |
| WFP | : | World Food Program |
| WHO | : | World Health Organization |
| WRA | : | Women of Reproductive Age |

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Foreword

The purpose of this study is to obtain detailed information on the organizational structure of the family planning (FP) system in Benin.

The characteristic of the delivery system that is of central importance is the degree of integration of the FP delivery system with the health care delivery system. At the extremes are a vertical system that operates independently of others types of services and a fully integrated system. The relative efficiencies of these systems will ultimately be compared across a large set of African countries.

1. Background informations

1.1 Geographical setting

Located in West Africa, the Republic of Benin, has a total land area of 112,622 km². The country is bounded by Nigeria in the East (750 km); Niger in the direct North (120 km); Burkina Faso in the Northwest (270 km); Togo in the west (620 Km) and the Atlantic Ocean in the South (125 km).

Benin is divided into two broad ecological and cultural zones, one being southern forest and the other northern savannah.

The South is a tropical and humid region characterized by a population of sedentary agriculturalists, traders, and urban dwellers who reside in the fast growing metropolitan areas of Cotonou, Porto-Novo, Abomey and Bohicon. Modern Benin's economy is grounded chiefly in agriculture and fishing.

Benin's northern region has a drier climate. Parakou and Natitingou are the principal urban centers. The area is moderately watered and supports a mixed economy of nomadic pastoralists and agriculturalists who were typically grouped into smaller, segmented societies.

Administrative geography of the country changed little after the National Conference (1990). Today Benin has six departments, formerly known as "provinces".

They include the Atacora (1992 population 649,308) and Borgou (population 827,925) in the north; the Zou (population 818,998) in the middle region; and the Mono (population 676,104), Atlantique (population 1,066,373), and Oueme (population 876,574) in the south. The six departments are divided into 77 sub-prefectures and metropolitan areas; these are further divided into 517 communes and finally into 3,378 villages and town quarters.

1.2 Demographic data

Benin's total population, according to the 1992 General Census of Population and Housing, was 4,915,555. A population growth rate of 2.9 percent would yield a 1994 population of 5,185,000 persons. Approximately 1,063,000 are woman of reproductive age (15-44), including 222,000 young women under the age of 20. Two-thirds of the population currently resides in rural zones. By the year 2,000, however, 45 percent of Beninese can be expected to be urban dwellers, increasingly concentrated in the southern part of the country. The average population density is 43 dwellers per km².

Benin has over 50 ethnic groups, the most important being the Fon (42.0 percent), Adja (15.6 percent), Yoruba (12.1 percent) and Bariba (6.6 percent).

Life expectancy at birth is 54.2 years; the gross mortality rate is 16.0 per 1000, the infant mortality rate is 105.5 per 1000 live births. The country manifests excessively high rates of maternal mortality (800 per 100,000 live births) and child mortality (80 per 1000). The total fertility rate of 6.1 bears witness to a pro-natalist tradition. Current sources estimate the contraceptive prevalence rate (CPR) for modern methods at between 1.0 and 2.5 percent. The Benin obstetrical community believes that up to 20 percent of all pregnancies are currently terminated by induced abortions and rate of abortion are increasing. Furthermore, unsafe abortion may account for as much as one-third of maternal deaths. (For further indicators, please refer to Table 1)

Table 1: Socio-economic, demographic and health indicators

| INDICATORS | NUMBER/RATE | REFERENCE YEAR |
|----------------------------------|--------------------|-----------------------|
| Population | 5,185,000 | 1994 |
| Annual population growth | 02.9% | 1985-1990 |
| Religion | | 1992 |
| Christians | 35.4% | |
| Muslims | 20.6% | |
| Women at reproductive age | | 1992 |
| Urban | 38.0% | |
| Rural | 62.0% | |
| Urbanization | 36.0% | 1992 |
| Literacy | | 1992 |
| Men | 38.7% | |
| Women | 19.1% | |
| French | 28.6% | |
| Dialects | 01.5% | |
| Education enrollment | | 1986-1990 |
| Primary | 59.0% | |
| Secondary | 16.0% | |
| Polygamy (married men) | 30.0% | 1992 |
| Age at first marriage | | 1992 |
| Men | 26.4 years | |
| Women | 19.2 years | |
| Family size | 5.9 persons | 1992 |
| Crude birth rate | 47.4/1000 | 1992 |
| Crude death rate | 15.5/1000 | 1992 |
| Maternal mortality | 800/100,000 | 1992 |
| Infant mortality | 105.5/1000 | 1992 |
| Child mortality rate | 80/1000 | 1992 |
| Total fertility rate | 6.1/woman | 1992 |

Source: INSAE, RGPH 1992 and other sources

1.3 Evolution of health sector

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

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

Following a diagnostic study carried out in the health sector (1986-1989), Benin defined and adopted a new health policy whose principal objective was to improve health indicators by expanding primary health care coverage throughout the country. Strategies envisioned for improving health indicators were, first, the development of preventive care, including immunization, family planning, the prevention of Sexually transmitted diseases (STDs) including AIDS, and Information, education and communication; and second, the reinforcement of curative services, including establishing a program of essential generic drugs (Bamako Initiative), the rehabilitation of existing infrastructures, service for the sick child, and reproductive health care.

Substantial progress has been made over the last years in Benin's public health sector with regard to select health strategies and interventions. Oral rehydration is currently widely understood and practiced throughout the country; cases of severe dehydration due to diarrhea are reportedly rare. Benin's essential drug program, with a revolving fund financed by the community at

commune and sub-prefecture level, has provided one model that inspired the 1987 "Bamako Initiative". The increased community participation and financing resulting from the system helped to maintain full immunization coverage rates nationwide at nearly 70 percent each year since 1990. By 1992, infant mortality rate (IMR) had dropped to 105.5 per thousand, a significant improvement over one decade earlier, though still unacceptably high.

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

In 1994, the MOH managed 3,738,734,305 f CFA (2.46 percent of the national budget) but devoted 64 percent of this amount to pay personnel costs (2,376,841,324 fCFA).

1.4 FP in its socio-cultural context

Family planning is not a popular notion in Benin; however, health and population indicators suggest that the unmet need for FP is high.

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

Favorable trends are nevertheless encouraging and growing. Demographic trends may increase acceptance of FP. Contraceptive use is now estimated to be highest in urban areas, and among the nation's largest ethnic groups, the Fon,

Adja and Yoruba. Meanwhile, women in some quarters are strenuously advocating greater reproductive rights, the revision of the family code, and access to contraception.

In the Beninese society, where great emphasis is placed on fertility and where the Catholic Church is opposed to modern contraception, the desire to limit the number of children has not yet made itself felt. Such is the context in which family planning is evolving in Benin. It is, therefore, not surprising that the contraceptive prevalence rate of women aged between 15 and 44 is low.

1.5 FP in its political and institutional environment

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

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

In spite of the family planning activities numerous social and health problems still exist: unwanted pregnancies, a source of social problems; early pregnancies; late pregnancies; clandestine voluntary abortions; deaths and complications linked to abortion; high maternal mortality rate; abandoned children and infanticide; marital sterility; malnutrition and other deficiencies caused by the brutal and premature separation of children from their mothers due to too many and/or too closely spaced pregnancies.

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

Other government efforts include establishment of the National MCH/FP Coordination Committee (CNEEP, 1989) and its counterparts at the department level (CDEEP); the national MCH/FP/Nutrition Program with the "Alert" System for high-risk pregnancies (1991-1995); and additional UNFPA-supported programs in policy, analysis, population education, and family life education. Additionally, in 1993 the Ministry of Planning created a Department of Human Resources and Population (SRHP) and the National Human Resources and Population Commission (CNRHP).

2. Evolution of Family Planning program

2.1 Objectives and strategies of the FP Program

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

Intermediate objectives: Promote and intensify FP activities; strengthen existing infrastructures to make them suitable for FP activities and improve the quality of FP services.

Specific objectives: Increase the number of FP acceptors by 10,000 a year; increase the national contraceptive prevalence rate to 4 percent and to 9 percent among women in priority zones (urban and semi-urban areas) by the year 2000; reduce by 75 percent the number of undesired pregnancies and reduce by 50 percent the number of induced abortions.

Strategies of the FP program

The strategies proposed for attaining these objectives include IEC, service delivery, training and supervision of personnel, operations research and coordination of activities in the field. Elements of these strategies include: educate youth to ideas and practices of family life and population; introduce family life education in training programs at all levels; inform and sensitize families, opinion leaders and decision-makers about FP and the role of convenient birth spacing; ensure availability of quality FP services; ensure availability of affordable and effective means of contraception; increase in the number of MCH facilities and integration of FP activities within them; train the necessary personnel in the application to the national FP policy; revise the 1920 law and elaborate the legislative texts adapted to the national FP policy; and promote and encourage operations research in the area of traditional contraception.

As regards the MCH/FP/Nutrition program document, there is a lack of consistency between the objectives and proposed strategies, especially with respect to FP. The conceptual and institutional frameworks for FP are unclear. There are no clearly defined process and impact indicators, nor is there any indication of existing needs in these areas. There is no continuous evaluation for each level of service and, in addition, the decentralization of resources and prerogatives is not effective in practice. In 1989, with a view to improving the coordination of MCH/FP/Nutrition activities, the MOH set up a National Committee of Coordination. Unfortunately, this committee has not led to an effective coordination of these activities because of its unwieldy structure and functioning. In fact, this committee has no resources (human, material and financial) and its functional and conceptual capacities are weak. In addition, the attributes and activities of this committee are not clearly defined. As a consequence, there is insufficient coordination of activities in the field and between the different actors in FP.

2.2 FP and public sector

The Ministry of Health (MOH) is mandated to develop and carry out national health and FP policies and programs; however, its activities are coordinated intersectorally with other ministries. They include the Ministry of Planning and

Economic Restructuring (MPRE), the Ministry of Labor, Employment and Social Affairs (MTEAS), the Ministry of Education and Scientific Research (MERS), and the Ministry of Communications and Culture (MCC). Other ministries contribute indirectly to these activities: the Ministry of Rural Development (MDR), the Ministry of Youth and Sport (MJS), the Ministry of the Interior (MISPAT), the Ministry of Justice and Legislation (MJL), the Ministry of Defense and the Ministry of Environment, Housing and Urban Development (MEHU).

Preventive and clinical activities in FP are undertaken chiefly in public health facilities throughout Benin, although the IPPF affiliate ABPF, cooperative clinics and the private sector also provide some services. Until May, 1994, these activities were managed by the Preventive Services Unit (SAP), under the National Directorate of Health Protection (DNPS). In the current MOH organizational scheme (Table 2), FP activities are given greater prominence as a separate service under the Directorate of Family Health (DSF).

IEC/FP sensitization activities are carried out in health facilities by service providers with technical assistance from the IEC department of the MOH. At the Social Promotion Centers, they are carried out by social workers and social promotion agents from the MTEAS. In schools and colleges, it is carried out through Population Education and Family Education programs by the MERS. The mass media at the MCC, especially the radio, are beginning to sensitize people to the FP issues through special programs on health.

The Human Resources and Population Department of the MPRE is in charge of coordinating activities with the aim of developing a draft National Population Policy. In order to speed up this process, a CNRHP was set up on July 9, 1993. Apart from the above-mentioned ministries, the other members of the CNRHP are the MDR, the MJL, the MISAT, the MEHU and the Ministry of Finance.

2.3 FP and private sector

In reality, a strict demarcation between voluntary nongovernment and the for-profit commercial structure is difficult to draw. As NGOs are being increasingly urged to recover costs, their non-profit relationships to the consumer differs little in practice from that of profit-making ventures. For the

sake of discussion, however, the private health sector in Benin may be said to be comprised of private for-profit and non-profit hospitals, cooperative clinics, social marketing activities, private health centers and maternities, private medical practitioners, traditional medicine, and pharmacies.

MOH statistics for 1994 note the following known elements in the private health sector infrastructure: 22 hospitals or polyclinics, 52 private surgeries, 87 maternity clinics, 141 private paramedical centers, for pharmaceutical companies, 100 registered pharmacies and 225 local drug "depots" maintained by drug sellers. The number a traditional practitioners, who are generally part-time specialists, is not known, but it is assumed to be quite large.

2.4 FP and local NGOs

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

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

Several studies of the sector have flowed from the new emphasis on building the capacities of NGOs and local organizations and harnessing their resources for development. These studies suggest that, at present, only a small number of viable associations are active in the health sector. Local groups which might currently assist in implementation or advocating support include the following: Beninese Association for the Promotion of the Family (ABPF); Association of Benin Midwives; Inter-African Committee on Traditional Practices Affecting the health of Women and Child; Survie (Child and Mother Survival); The Beninese Red Cross; Association of Private Religious and Social Medical

Action in Benin; Association for Training, Health and Development; Mother and Child Survival Association; International Center for Social Development and Community Health in Benin; Benin Association Social Marketing (ABMS); and Regional Center for Health and Development (CREDESA). The nongovernment sector also includes the multiple religious orders and confessional institutions that have established health care facilities in Benin. Several of these institutions offered FP services and a range of methods, but usually excluded injectables and surgical techniques.

Beninese Association for the Promotion of the Family (ABPF) was the CNBPF created in 1972. CNBPF started its activities in 1973 and joined IPPF in 1975. Its headquarters is in Cotonou with branches in the six departments. It has three clinics in Cotonou, Porto-Novo and Parakou; two additional clinics are planned to be established in the Atacora and the Mono departments. ABPF has 53 staff members and 1,200 volunteers. Through the efforts of this staff, the NGO addresses a range of FP activities. Among them are sensitization, IEC, FP services, and social marketing for contraceptives. These services include pre and post-natal consultation in its own clinics; They also include FP supplies and equipment in 80 public sector clinics of the MOH, which it supports as "integrated" FP/MCH clinics. In 1991-1993, ABPF undertook an experiment in community-based distribution of non-medical contraceptives in Cotonou, but discontinued the activity for lack of funds. Several constraints currently face ABPF. Funding to support new initiatives to supplement its clinic-based cost recovery is limited. Currently, ABPF funding comes mainly from IPPF and UNFPA, which contributes some contraceptives and clinical training activities. In addition, ABPF is struggling to identify a clear role for itself in relation to government services. Coordination with the government-based Family Well-being Project which supports an additional number of "integrated" clinics has been limited.

2.5 FP and International Agencies

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

The World Bank, in its first Project for Health Services Development (PDSS) supported FP activities chiefly through an emphasis on training and infrastructure development. PDSS II (1995-2000, US\$ 31 million in International Development Agency funds, plus other donor contributions) will make a more concerted contribution to FP within an integrated PHC/MCH/FP approach. Project components will include: developing and expanding FP program and services; improving the quality and efficiency of priority health services; strengthening and streamlining sector management and administration; strengthening partnerships for health, including intersectoral coordination and community participation. Activities specific to FP (about US\$ 2 million) are expected to include: supporting the expansion of FP services and their integration into the minimum package of service at all levels of the health system; developing the first- and second-level referral centers for FP in three departments; supporting central and peripheral restructuring, including the creation of the Family Health Department which embraces MCH, STD/HIV/AIDS prevention and FP; adding health staff at the peripheral levels through a special fund for use by local management committees; providing equipment and a limited supply of contraceptives, possibly through the Central Purchasing Office for essentials drugs.

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

United Nations Fund for Children (UNICEF) supports child survival, with an emphasis on EPI and the "Bamako Initiative". The relevant areas of 1994-1998

program include: PHC and health system strengthening; safe motherhood; HIV/AIDS prevention; health and FP communications; child nutrition and breastfeeding campaigning. A FP policy paper issued in 1993 expressed UNICEF's renewed interest in providing limited support to FP as part of a reproductive health and child survival strategy. UNICEF-Benin has not applied this new policy to its program; promotion of breastfeeding would offer a suitable entry point.

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

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

United States Agency for International Development (USAID), which did not have a country presence in Benin 1982 and 1991, continued to provide assistance to health and FP through its USAID affairs Office in Lome. A major effort in community-based water supply, sanitation and health education was undertaken in cooperation with UNICEF (1986-1994). During the same period limited assistance to FP activities included support to ABPF for a pilot project in Cotonou for community-based distribution of condoms, FP IEC and clinical training of primary health providers in FP and reproduction health.

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

The Fund for Aid and Cooperation (FAC), supported by the French government, provides funding, equipment, and technical assistance to a number of selected projects. They include the National Health Management Information System (SNIGS); epidemiological surveillance and IEC for HIV/AIDS prevention;

EPI through UNICEF; dotation of essential drugs to the Central Purchasing Office and the National University Teaching Hospital. An amount of 15 millions FF is budgeted for FAC assistance in the next three-years-period, 1995-1998.

The Benin-Swiss Health Project (PMSBS) began assistance to the Benin health sector in 1983. Activities have included support through the World Bank PDSS I to department health directorates in the Oueme, Zou and Borgou. The Swiss were among the early donors to support the community financing system based on a revolving drug fund. Currently, three projects supported by the Swiss are worthy of note: an experimental health information system that is being piloted in three departmental health directorates; establishment of a health information documentation center for MOH, and the publication of a bulletin entitled "Retro-SNIGS", which provides feedback to health centers on the quarterly data collected by the central health information system (SNIGS).

A Benin-German Project, currently in its fourth phase (1994-1996, 1.02 billion fCFA), began in 1980 by establishing cooperative links between the German Association for Technical Cooperation (GTZ) and the German Development Service. Ten sub-prefecture health centers are currently receiving assistance, grouped into six geographical zones. Two are at a pilot stage. Project components include support to the following areas: PHC and quality of care; decentralized management structures; IEC; STD/HIV/AIDS; and promotion of women's status. A FP component is also planned but as yet has not begun.

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

AFRICARE has received US\$ 4.6 million from USAID to implement a Private Voluntary Organization (PVO). It expects to fund small-scale projects in three departments where FP activities are already underway.

Population Services International (PSI) has been working with its counterpart ABMS in Benin since 1990 in the field of social marketing for contraceptives. Owing to an extremely aggressive media promotion and distribution program, it sold 3.0 million units of "Prudence" condom in 1994.

International Planned Parenthood Federation (IPPF) assist ABPF by supplying contraceptives and making advance payments available for planned activities. Its average annual assistance package is approximately US\$ 400,000.

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

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

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

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

Catholic Relief Services (CRS) has for many years managed a food distribution program for young children through the social promotion centers.

Canadian Solidarity and Development Organization (CSDO) collaborates with the MTEAS in activities that promote women and women's status and the MOH in the Expanded Program of Immunization (EPI) and PHC. It discreetly promotes modern and traditional FP activities.

3. Organizational structure of FP

3.1 Structure of FP program

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

Table 3: National Health System, Benin, 1994

| Levels | | Institutions | Hospital and Health structures | Specialties |
|------------------------------|--|--|--|--|
| Central | | Ministry of health (MS) | National University Hospital Center (CNHU) | Medicine Paediatrics Surgery Gynaeco-Obstetric Radiology Laboratory ORL/Ophthalmology Others specialities |
| Intermediary or Departmental | | Departmental Health Directorate (DDS) | Departmental Hospital Center (CHD) | Medicine Paediatrics Surgery Gynaeco-Obstetric Radiology Laboratory Others specialities |
| Peripheral | Chief town of Sub Prefecture or of Metropolitan Area | Sub Prefecture Health Center or Metropolitan Area Health Center (CSSP or CSCU) | Sub Prefecture Health Center or Metropolitan Area Health Center (CSSP or CSCU) | Medicine Paediatrics Surgery Maternity Radiology Laboratory Drugstore |
| | Chief town of Commune | Communal Health Complex (CCS) | Communal Health Complex (CCS) | Dispensary Maternity Drugstore |
| | Village or Neighbourhood | Health Village Unit (UVS) | Health Village Unit (UVS) | Health care Delivery Drugstore box |

Source: SSDRO, Statistiques Sanitaires, Année 1994, p 5

At the regional level is the Department Hospital Centers (CHD, in 4 out of 6 departments). The CHD provides specialized care for complex cases referred from the peripheral clinics. Management of the CHD falls to the Departmental Health Directorate (DDS), which is responsible for implementing national health policies, allocating resources and coordinating health services throughout the department.

At the peripheral level are 84 referral centers known either as the sub-Prefecture Health Centers (CSSP) or Metropolitan Area Health Centers (CSCU). A number of CSSP/CSCU are adequately equipped and staffed to offer first referral care in PHC, MCH and FP for the Communal Health Centers (CCS, 220 in 517 communes), 126 individual dispensaries and 30 individual maternities. The CSSP/CSCU are managed by the district medical officer. Typically, a nurse or midwife is assigned to the commune level to manage the CCS, which constitutes the primary care entry point into the public health system. In addition, some 362 Village Health Units (UVS), which pre-date the revised health structure of 1986, continue to serve small communities, although their services are rudimentary, and they are typically not staffed by medical trained personnel.

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

According to national standards, contraceptives can be prescribed by the following categories of personnel and health centers: all methods (specialist physician; CNHU, CHD); Non-surgical (physician, nurse, midwife; CSSP, CSCU, CCS); Non medical and oral contraceptives (educated nurse's aid; CSSP,

Table 4: Health Centers (public sector) by department in 1994

| | Atacora | Atlantique | Borgou | Mono | Ouémé | Zou |
|-------------------|---------|------------|--------|------|-------|-----|
| CNHU | - | 1 | - | - | - | - |
| CHD | 1 | - | 1 | - | 1 | 1 |
| CSSP/CSCU | 13 | 14 | 14 | 12 | 16 | 15 |
| CCS | 33 | 42 | 44 | 34 | 29 | 38 |
| Dispensary | 26 | 19 | 26 | 5 | 22 | 28 |
| Maternity | - | 5 | 2 | 5 | 4 | 14 |
| UVS | 122 | 11 | 96 | 32 | 17 | 84 |

Source: SSDRO, Statistiques Sanitaires, Année 1994, p 8

Table 5: Health staff (public sector) by department in 1994

| | Atacora | Atlantique | Borgou | Mono | Ouémé | Zou |
|--------------------|---------|------------|--------|--------|--------|--------|
| Physician | 21 | 117 | 29 | 25 | 47 | 29 |
| Nurse | 138 | 397 | 194 | 125 | 194 | 164 |
| Midwife | 29 | 137 | 39 | 43 | 88 | 48 |
| Technician | 21 | 64 | 34 | 20 | 39 | 26 |
| Nurse's aid | 73 | 248 | 195 | 170 | 277 | 73 |
| Population | 649308 | 1066373 | 827925 | 676104 | 876574 | 818998 |

Source: SSDRO, Statistiques Sanitaires, Année 1994, p 10

CSCU, CCS); Non medical methods only (traditional midwife, first aid worker, social worker; UVS).

Since 1983, FP is officially integrated with MCH services (immunization, ante and post-natal consultations, childbirth, nutrition, IEC) in all public health centers; but few health centers can't provide FP services. In practice, in all FP public centers, FP activities are integrated with MCH services (integrated structure). But the three clinics of ABPF provide FP only (vertical structure).

As for the organization, FP services are available every day in almost 80 percent of FP public centers. Unfortunately, their integration with other MCH activities is not yet effective. As regards the organization of the services in public sector, the integration of FP with the other MCH activities is only geographical in most health centers. There is no innovation regarding real and operational integration of FP into the other MCH activities.

In the CNHU, CHDs and Lagoon Maternity, FP and other MCH activities are delivered every workdays (5 days/week), with a separate staff and dedicated resources for different services.

At the peripheral level (CSSP, CSCU, CCS), FP services are offered at specific days (means = 4 days/week). In these health centers FP and other MCH services are delivered with the same staff and dedicated resources.

In ABPF's clinics, the staff and resources are mainly dedicated for FP services.

3.2 Management of FP activities and statistics

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

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

The MOH has set up a decentralized system for follow up and supervision of MCH/FP activities, but it is not yet effective in all the regions of the country. In most cases, supervision is carried out without any supervision tools. A supervision document for MCH/FP activities has been developed at the central and intermediary levels. This document has many insufficiencies as regards technical aspects. There are no dynamics for supervision of FP activities with clear and precise program strategies and objectives. Currently, supervision of FP activities is carried out as part of the supervision of the MCH, but in practice it is often neglected and is reduced to the mere control of FP service cards. In truth, FP supervision is left to regional officers according to their convictions.

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

3.3 Current status of service delivery for FP

Infrastructure, equipment and supplies

Most health centers throughout the country, have adequate physical facilities for FP provision, especially a waiting room, a counseling room, and a

clean, well-lit, well-ventilated room with a safe water supply. The major problem here is the lack visual and auditory privacy.

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

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

Commodities management is still precarious. Only 60 percent of health centers have a written inventory, and procurement system or appropriate storage facilities for contraceptives. Contraceptives are currently not supplied through the Central Purchasing Office for essential drugs, therefore requiring a parallel system of supply. These shortcomings often result in stock-outs at the health centers. The management of the facility is not responsible for making equipment purchases or for supply ordering. It receive a set of inventories from a higher level of decision makers as PBEF or ABPF. The management of the facility have not got its own budget for making equipment purchases or for supply ordering.

The lack of adequate planning for supplies to meet the potential demand may have contributed to a less than active promotion of FP in government health/FP service. Though FP items may be found in most units, quantities kept in stock are often quite low. This situation may be result of relatively low stocks held in Cotonou. Thus the cycle reinforces itself: low stocks in the central store, low stocks in the health units, low level of FP supplies to potential acceptors, low movement of stocks, and thus low level of request for more supplies to UNFPA.

Until 1993, ABPF was the main distributor of contraceptives and related materials to the government clinics. Since then, under an agreement with the MOH, all but 80 of these clinics have been supplied by the PBEF. The PBEF, which is still a "project" rather than a full-scale department or operating unit, is supported technically and materially by UNFPA, which supplies contraceptives and other FP materials, training and operations research under a comprehensive population program (1992-1994).

The system of distribution is non-existent. Relatively small stocks are kept at a central store in Cotonou, and department officials are expected to come to Cotonou and draw supplies whenever their stocks run down. In some cases, the clinics staff members may also come in and pick up supplies directly. It is also difficult for the department to arrange to visit Cotonou whenever the clinics run down their stocks. Sometimes visits are limited by lack of funds for transport.

Staff and training

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

Given staff shortages, more than 10 percent of the health centers are obliged to use nurse's aids for FP activities, following a brief training "on the job". FP training needs remain very important in Benin. Half of the service providers have no training and almost half of the trained personnel received their last training more than three years ago. As a result, training in clinical FP and IEC is needed at all levels. Training of health workers in FP service delivery is in principle a prerequisite to the implementation of any FP program. Unfortunately, no national training program in integrated MCH/FP is offered in Benin. Since 1982, the UNFPA-sponsored Family Well-Being Project (PBEF) has helped train some of the MCH/FP staff abroad (Belgium, Mauritius, Rwanda, Tunisia, Morocco) and in Benin through regional and interregional seminars. At the national level, training focuses almost exclusively on MCH with very little emphasis on practical FP. Data on personnel trained in FP are sketchy. According

to national MCH/FP officials, approximately 378 service providers received FP training. The figure includes personnel trained by ABPF. This training was mostly clinical and the practical phase was usually too short.

Quality of care

FP service delivery currently poses serious obstacles to method choice. During counseling, service providers do not present all the methods available. Thus, only 54 percent of new acceptors hear about injectables, 40 percent about pills and barrier methods, and 18 percent about IUDs. Almost 33 percent of service providers influence client choices, especially in favor of pills. Information given to acceptors on each method is therefore insufficient and essentially relates to the use of the method. More than 80 percent of clients do not receive information on side effects or the advantages of each method. More needs to be done to improve service providers' overall performance, especially by increasing their knowledge of FP methods (utilization, management of side effects); clinical examination procedures and sterile safeguards.

Provider-Client interaction is generally satisfactory in terms of time allowed; during counseling, service providers are rarely concerned with their clients' own objectives regarding reproduction. All health centers also have a reception system (first in, first served basis) and the waiting time seems reasonable, except in health centers with a high attendance rate. Unfortunately, client follow-up is rare; very few health centers keep a precise record of their clients for possible home visits or reminders in case of missed appointments. Consequently, few clients receive information on how to cope with side effects and on the possibility of switching to another method.

IEC outreach activities

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

Faced with such a complete absence of IEC materials, service providers are obliged to use anatomic models and contraceptive samples during their counseling and educational talks. This is obviously not the best approach to winning new clients and ensuring long term acceptance of modern FP methods. In addition, very few service providers have been trained in FP/IEC. In order to increase people's awareness of the benefits of FP, an IEC program must be developed by technical personnel of the MHO in collaboration with the other actors in the FP sector. IEC materials, especially those designed to inform the individual user, must be developed and distributed in all the communities and health centers.

4. Data analysis

In Benin, all the international cooperation agencies are located in Cotonou, the economic capital city. Most of these agencies provide their assistance to the Family Planning (FP) sector through bilateral or multilateral agreements with the Government of Benin. All contributions go through the Government of Benin - for the World Bank, US \$ 2 millions through the Health Services Development Project (PDSS, 1995-2000); and for the UNFPA, US \$ 5 millions (1995-1998) through the Family Health Division (DSF). No public health unit receives direct funding from donor agencies for FP service delivery. The World Bank's contribution represents 6.45% of the PDSS's overall budget and that of UNFPA, 50% of all its fundings in Benin.

Except the World Bank and the UNFPA which have specific funds for FP, the other agencies provide their support through the global health care assistance. Currently, it is virtually impossible to specify the amount that each agency contribute to the FP sector. The International Planned Parenthood Federation (IPPF) provides US \$ 400,000/p.a. which benefits certain public sector entities through the technical and material support provided by ABPF, the IPPF local affiliate.

4.1 Performance by type of facilities in 1994 at Benin

According to the Ministry of Health (MOH) norms, The National University Hospital Center (CNHU), the four Departmental Hospital Centers (CHD), the 84 Sub Prefecture Health Centers/Metropolitan Area Health Centers (CSSP/CSCU),

Table 6: Utilization of contraceptives methods: numbers of FF' clients, Benin, 1994

| Department | Type of structure | FAP (1) | DIU (2) | CO (3) | CI (4) | Other (5) | All methods (6)=2+3+4+5 | Utilization Prevalence (6)/(1) |
|------------|-------------------|---------|---------|--------|--------|-----------|-------------------------|--------------------------------|
| Atacora | FSP | | 1335 | 202 | 851 | ND | 2338 | 2.41% |
| | ABPF | | 0 | 431 | 198 | 334 | 963 | |
| | Total | 139188 | 1335 | 633 | 1049 | 334 | 3351 | |
| Atlantique | FSP | | 2344 | 1288 | 2910 | ND | 6542 | 6.21% |
| | ABPF | | 928 | 3572 | 2048 | 3412 | 9960 | |
| | Total | 265739 | 3272 | 4860 | 4958 | 3412 | 16502 | |
| Borgou | FSP | | 1872 | 359 | 1352 | ND | 3583 | 2.71% |
| | ABPF | | 29 | 254 | 218 | 721 | 1222 | |
| | Total | 177523 | 1901 | 613 | 1570 | 721 | 4805 | |
| Mono | FSP | | 1451 | 193 | 1036 | ND | 2680 | 3.12% |
| | ABPF | | 0 | 352 | 105 | 1389 | 1846 | |
| | Total | 145037 | 1451 | 545 | 1141 | 1389 | 4526 | |
| Oueme | FSP | | 1845 | 862 | 1466 | ND | 4173 | 3.55% |
| | ABPF | | 473 | 1037 | 704 | 855 | 3069 | |
| | Total | 204076 | 2318 | 1899 | 2170 | 855 | 7242 | |
| Zou | FSP | | 850 | 1093 | 893 | ND | 2836 | 2.00% |
| | ABPF | | 162 | 151 | 23 | 556 | 892 | |
| | Total | 186440 | 1012 | 1244 | 916 | 556 | 3728 | |
| Total | FSP | | 9724 | 4002 | 8535 | ND | 22261 | 3.60% |
| | ABPF | | 1592 | 5797 | 3296 | 7267 | 17952 | |
| | Total | 1118003 | 11316 | 9799 | 11831 | 7267 | 40213 | |

FSP: Public Health Centers
CO: Pills

ABPF: ABPF's Clinics
CI: Injectables

FAP: Women 15-45 years
ND: Not available

DIU: Intrauterine Device

Source: SSDRO, Statistiques Sanitaires Année 1994, p 89

the 220 Communal Complex Centers (CCS) and the 30 isolated maternities should provide FP services. However, there are currently no accurate statistics available at the MOH on which of these health units actually provide regular FP services. The only certainty is that the CNHU, the CHDs and all the CSSPs and CSCUs provide FP services.

In 1994, activity reports submitted by the 113 health units -- 110 from the public sector and 3 from the ABPF -- provided the basic data for the FP service statistics (see table 6). A list of the concerned health units is in the attachment. An analysis of this table reveals the following:

- the public health centers do not record non-medical methods (i.e., condoms and spermicides); which leads to under estimation of the "other methods" category and thus, to a reduction in the overall number of FP users;
- ABPF contributes largely to increasing the contraceptive prevalence rate in Benin;
- the highest contraceptive prevalence rates are observed in the Atlantique and Oueme regions where the two major cities are located (Cotonou, the economic capital and Porto-Novo, the political capital).

4.2 Comparison of Vertical and Integrated approaches

In Benin, the CUGO and the Lagoon Maternity -- both located in Cotonou -- are the only two reference centers for MCH/FP. They both provide FP services in integration with the other MCH activities. This integrated approach is also used in all public hospitals and health centers in Benin. ABPF's clinics in Cotonou and Porto-Novo are the two reference centers for this organization. FP activities are performed with a vertical approach. It must be noted that Porto-Novo is only 30 km away from Cotonou.

The comparison of "integrated" versus "vertical" performances will be based on data from these four health centers. These comparative data are presented in table 7. Since public health centers do not record systematically

Table 7: Patients served by type of services in 1994 in two Integrated Clinics and two Vertical clinics

| | Two Integrated clinics: CUGO and Lagoon Maternity at Cotonou | Two Vertical clinics: ABPF at Cotonou and Porto Novo |
|---|---|---|
| Total number of patients | 28 384* | 28 211** |
| Total number of FP clients | 4 142 | 13 029 |
| Number of clients using medical methods# | 4 142 | 8 762 |
| Pills | 1 274 | 4 609 |
| Injectables | 1 904 | 2 752 |
| Intrauterine Devices | 964 | 1 401 |
| Condoms and Spermicides | ND | 4 267 |

Medical methods: Pills, Injectables, Intrauterine Devices

* Prenatal, Postnatal, FP and Delivery clients,

** FP and Medical Counseling clients

ND Not available

condom and spermicid users, only medical methods (pills, injectables, IUDs) will be considered in this comparative analysis.

Table 7 reveals that in 1994:

- CUGO and Lagoon Maternity on the one hand, and the ABPF clinics in Cotonou and Porto-Novo on the other hand, received approximately the same number of Women of Reproductive Age (WRA): 28,384 and 28,211. It must be noted that CUGO and Lagoon Maternity clients came mostly for pre-natal and post-natal consultations, child delivery and FP, whereas ABPF clients came mostly for FP and medical counselling.
- the total number of FP clients is three times as high in ABPF clinics as in CUGO and Lagoon Maternity (13,029 versus 41,142). It must be noted however that the latter two do not record condoms and spermicides users;
- "medical" contraceptive method users (pills, injectables, IUDs) are twice as many in ABPF clinics as in CUGO and Lagoon Maternity (8,762 versus 4,142);
- the data relating to the type of contraceptive method used are also consistent with the trends mentioned above.

The analysis of these quantitative results suggests that clinics using the vertical approach perform better than those using an integrated approach. It is, however, necessary to be cautious in interpreting and extrapolating these results since they may have been influenced by other factors. Indeed, the "integrated approach" clinics are both from the public sector whereas those using a "vertical approach" are all private. And it is common place that management styles and incentive measures are different from one sector to the other.

On the other hand, public sector clinics receive their funding through government channels -- characterized by lengthy and inefficient procedures -- whereas ABPF clinics are directly funded and managed by IPPF.

It is also necessary to realize that some methodological differences exist between private and public clinics, in relation to FP user recording, accounting and notification systems, which may have caused certain bias in the results.

In conclusion, the data currently available in Benin suggest that a vertical approach to FP services with direct funding and management yields better performances than an integrated approach with indirect funding and management. However, it is not possible to draw any definite conclusions from these data since the vertical approach is used only in private clinics and the integrated approach, only in public clinics. Moreover, FP user recording and notification systems are not exactly the same in both sectors, these data may be biased. Only a multicentric study or a quasi experimental study will enable any pertinent conclusions in that respect.

4.3 Volume of supplies/contraceptives distributed to SDP's by source

The volume of supplies/contraceptives distributed to SDP's by source is presented in table 8.

4.4 Support of health staff (public sector) position by type

The support of health staff (public sector) position by type is presented in table 9.

Table 8: Volume of supplies/contraceptives distributed to SDP's by source in 1994

| | Available | | | Distributed | | |
|-------------------|-----------|--------|--------|-------------|-------|--------|
| | ABPF | PBEF | Total | ABPF | PBEF | Total |
| Pill | 64550 | 110825 | 175575 | 31811 | 26300 | 58111 |
| Injectable | 13075 | 32550 | 45625 | 7000 | 5000 | 12000 |
| IUD | 2572 | 1550 | 4122 | 1067 | 1450 | 2517 |
| Spermicid | 242664 | 46500 | 289164 | 78999 | 3400 | 82399 |
| Condom | 312699 | 110000 | 422699 | 275468 | 8820 | 284288 |

Table 9: Support of health staff (public sector) positions by type in 1994

| | Total number | Government's budget | Other's budget |
|---------------------|--------------|---------------------|----------------|
| Physician | 318 | 279 | 39 |
| Nurse | 1247 | 994 | 253 |
| Midwife | 409 | 360 | 49 |
| Technician | 251 | 215 | 36 |
| Nurse's aid | 1048 | 445 | 603 |
| Others | 1078 | 595 | 483 |
| Total number | 4351 | 2888 | 1463 |

5. Conclusions

5.1 Political and institutional levels

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

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

5.2 Management of Services

Positive aspects: Integration of FP into MCH has made considerable progress at the central level. Meanwhile, the essential drugs management model (Bamako Initiative), as part of community financing, is effective throughout the country. This model could serve as an ideal framework for the purchase and distribution of contraceptives. Moreover, central level management has shown a real commitment to installing a decentralized and integrated policy for supervision and coordination. At the intermediary and peripheral levels, this integrated approach to supervision and coordination is already being implemented in certain regions.

Negative aspects:

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

5.3 Service delivery**Positive aspects:**

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

Negative aspects:

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

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Appendix

List of Health Centers (SDPs) which are provided FP statistics in 1994

Department ATACORA (16 SDPs)

Materi
Kerou
Tanguieta
Toukountouna
Kobli
Boukoube
Natitingou
Kouande
Pehonko
Kopargo
Ouake
Djougou
Bassila
CHD de Natitingou
St Jean de Dieu
Ordre de Malte

Department ATLANTIQUE (18 SDPs)

Abomey-Calavi
Allada
Cotonou I
Cotonou II
Cotonou III
Cotonou IV
Cotonou V
Cotonou VI
ABPF Cotonou
Kpomasse

Ouidah
So-Ava
Toffo
Tori-Bossito
Ze
Zinvie
CUGO
Lagoon Maternity

Department BORGOU (20 SDPs)

Karimama
Malanville
Kandi
Banikoara
Segbana
Gogounou
Sinende
Bembereke
Kalale
Nikki
Ndali
Perere
Parakou
ABPF Parakou
CHD Parakou
Tchaourou
Boko
Papane
Guere
Sounon Sero

Department MONO (14 SDPs)

Aplahoue
Athieme
Bopa
Djakotome
Dogbo-Tota
Grand-popo
Houeyogbe
Klouekanme
Lalo
Toviklin
Lokossa
"CHD" Lokossa
St Camille
Come

Department OUEME (19 SDPs)

Adjara-Ouere
Adjara
Adjohoun
Aguague
Akpro-Misserete
Avrankou
Bonou
Dangbo
Ifangni
Ketou
Pobe
Porto-novo I
Porto-Novo II
Porto-Novo III
CHD Porto-Novo
ABPF Porto-Novo

Sakete
Seme-podji
Akron

Department ZOU (26 SDPs)

Ouesse
Bante
Save
Savalou
Glazoue
Dassa-Zoume
Soeur de Dassa
Djidja
Zagnanado
Cove
Za-Kpota
Abomey
Abomey Cooperative
CHD Abomey
Bohicon
Deo Bohicon
Ouinhi
Zogbodome
Agbangnizoun
Adandokpodji
St Camille
Sedovikon I
Sedovikon II
Sagon
St Joseph Zag
Agbangni