MPH/BENIN **IPFH** **USAID/BENIN**

PUBLIC HEALTH STUDY, PROSPECTION
AND
ASSISTANCE OFFICE
(PHS-OFFICE)

BENIN INTEGRATED FAMILY HEALTH PROGRAM (PROSAF) SUSTAINABILITY ASSESSMENT

FINAL REPORT

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ACCRONYMS

QI	Quality Insurance
BAFP	Benin Association for Family Promotion
CBHW	Community Based Health Worker
TA	Technical Assistance
KAP	Survey on Knowledges, Attitudes and Practices
SSHZD	Support Section of Health Zones Development
CRS	Catholic Relief Services
CBC	Change of Behavior and Communication
CLUSA	Cooperative League of USA
MMC	Municipality Management Committee
PMC	Prefecture Management Committee
PNC	Prenatal Consultation
DHC	District Health Center
MHC	Municipality Health Center
PPD	Population Polity Declaration
DH	Departmental Hospital
DDPH	Departmental Direction of Public Health
DFH	Direction of Family Health
NUTH	National University Teaching Hospital
DHR	Direction of Human Resources
NDPHR	National Direction of Human Resources and Population
DFH	Direction of Family Health
DSPR	Document on Strategy for Poverty Reduction
DPP	Direction of Planning and Prospect
ZH	Zone Hospital
MCLH	Mother Child Lagune Hospital
HZMT	Health Zone Monitoring Team

MQAHS	Management Quality Assessment of the Health System
QAHP	Quick Assessment of the Health Workers' Performance
SRI	Severe Respiratory Infection
HZCD	Health Zone Coordinating Doctor
MCCAG-PD	Minister in Charge of Coordination, Government Action, of Prospect and Development
MPH	Ministry of Public Health
NGO	Non-Governmental Organizations
CP	Community Participation
PATH	Program for Appropriate Technology in Health
NPRH	National Program for Reproduction Health
IPFH	Integrated Promotion of Family Health in B/A
ICTCD	Integrated Care and Treatment of Childhood Diseases
CBS	Community Based Services
SSPD	Service of Studies, Planning and Documentation
EONC	Emergency Obstetrical and Neonatal Cares
SHPP	Service for Health Protection and Promotion
FHS	Family Health Services
SNOC	Services of Nursing and Obstetrical Cares
URC	University Research Co, LLC
USAID	United States Agency for International Development
VHU	Village Health Unit
CZ	Concentration Zone
HZ	Health Zone

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To all the readers of this document, we wish a pleasant reading and expect very openly their Constructive criticism and suggestions for improvement.

SUMMARY

The integrated Promotion of Family Health Program, implemented in 1999, primarily aims at increasing the use of the Family health services and preventive measures in a policy-improved environment.

It includes five Stages : I/ Improvement of family health planning and Coordination; ii/ Increase of the access to family health services; iii/ Improvement of the Capacity of the service providers for quality services; iv/ Reinforcement of knowledges and behaviors favorable to the use of family health services, Products and preventive measures; v/ Involvement of the Community in the services provision planning process and the use of preventive measures.

Despite its experiences, the IPFH intervention appeared to be too vertical and likely not to guarantee the continuation of the activities at the end of the program. At the end of a midterm assessment in 2002, the principle of the extension of the USAID support was granted for two years for the following purposes: i/ To design the conditions to reinforce the experiences of the program; ii/ To achieve a larger involvement of the departmental health officials in the implementation of the activities with a view to perpetuating the experiences; iii/ To achieve the appropriation of the program by the government of Benin for a better management of the experiences.

A consultation mission designed a perpetuation planning in January 2004, following the consultation between the Ministry of Public Health (MPH) and USAID. This planning is used as the basis for the orientation of the activities of the IPFH the term of which is extended to two years (2004 to 2006).

Considering the interest shown by the participant in the continuation of the program, USAID initiated this survey to better appreciate and reinforce the contours of the ongoing perpetuation.

After analyzing the IPFH activities, it is easy to notice that its action meanly consisted in reinforcing the managerial capacities of the actors of the health system as regards its activities in the Borgou and Alibori.

This action lead to the increase in family health services in the Borgou / Alibori departments, the development of the health coverage, the autonomy in the training of health professionals, the capacity of planning and management in the health zones, the reinforcement and motivation of the communities to participate in to the management of the municipality management committees (MMC/DMC), change of the communities behaviors regarding health practices.

Therefore it is worth keeping in mind that the IPFH succeeded in setting in the Borgou, the example of the systemic set-to-work of a health zone which proved its capacities to favorably influence the peripheral health indicators notably with regards FH. This assessment shows that the perpetuation process initiated is likely to lead to the transfer of all the good manners which can perpetuate the IPFH experiences. The question which remains unanswered is that of autonomization of the perpetuation process.

The perpetuation of the experiences requires the assimilation of the good manners used by IPFH during the implementation of the program and the establishment of a system designed to replicate the results chain. This concerns the perpetuatable experiences.

The good manners are related to competences and the capacity to use them:

Areas :

The mastery of the concept and the problematic of FH in Benin and in the Borgou / Alibori problems analysis, priority problems diagnosis, definition of the needs, definition of the determinants, definition of the indicators and operational strategies),

- FH planning and programming,
- Elaboration of a specific and adapted health information system,
- The correct execution of an FH program (integration of activities, stocks and logistics management, continued quality insurance, IEC/CBC management and social mobilization)
- Horizontal and descending supervision,
- Assessment of an FH program,
- Management

APTITUDE: Leadership.

The Experiences are made up of the first-level results : Relevant activities :

1ST LEVEL-RESULTS : ACTIVITIES i/ The field of training in witch the IPFH not only found the opportunity to improve the quality of the healthcares, but also it was planned, adapted to the needs made lasting because of its autonomization. Obviously, the constitution of the training and monitoring teams of competences at various several levels starting from the personnel in service are undoubtedly cheap, ii/ The implementation of a supply system which reduces the shortages reinforced the availability of the services, iii/ The designing of the technical norms and protocols facilitated the quality of the services. It is also worth noting that the constitution of the minimum package of family health services (norm) benefited from the supply of useful equipments.

In the zone Monitoring teams, we notes a sufficient capitalization of competences to secure the continuation of the activities at the end of the period of transfer. The opportunities of the program and the perpetuation lie in several potential assets:

Opportunities :

- The IPFH gave the new proof of the efficient setting-to-work of the health system.
- The integration of efficient strategies implemented by PROLIPO and INTRAM PRIME II favors full perpetuation.
- The partnership with BAFP and PSI resulting from the research of a synergy of actions.
- The partnership which requires several advantages : i/ Integration of efficient strategies, ii/ the research of synergy, iii/ valorization of the opportunity, iv/ social mobilization, v/consultation for concept harmonization with the partners, vi/complementarity.
- The actual decentralization of the health system and the community partnership in the planned management which privileges the local community needs.
- Community based services and the social intermediation (CBHW) formula.

The involved officials are : the DDPH and its competent services (FHS and SNOC etc.), the MPH and its technical services (DPP, DFH, DHR), the ZCD (ZMT), the NGOs chairmen and communities.

However, there are some difficulties which are likely to curb the replication of the IPFH performances:

Constraints:

- This primarily concerns the mobility of the trained health personnel and the problematic of motivation and management of the careers of the Community Based Services Health-workers.
- Apart from these critical points, the huge hypothesis which darkens the possibilities of perpetuation is the difficulty to mobilize the local resources to secure a lasting continuation of the experiences.
- The mastery of the good manners and leadership.
- The mutual acceptance (DPP, HZ) of the principle of ascending planning and its functioning.

The relevant activities concentration axes are the following :

Axes of relevant activities concentration:

- It is important to make dynamic the budgeting mechanism in order to secure the mobilization of local resources to finance the continuation of IPFH experiences.
- A plan of actions which aims at mobilizing the necessary local resources is suggested to facilitate the implementation of the process of consolidation of the ongoing perpetuation.
- More over, it would be use full to envisage following the Borgou/Alibori example, the extension of the IPFH to other departments as a response to the mobility of the trained officials.
- Finally, the professionalization of the community based services could be a key response to the issue of the CBHW and to the performance of the community health system.

It is necessary to make the organs of HZ management and the monitoring framework of the implementation of the interventions in the framework of the IPFH perpetuation operational :

The management process of the consolidation stage of the experiences lies in :

- the dynamization of the fonctionality of the peripheral health system as regards the ascending planning (DDPH, ZMT, Health Zone Committee). A good management of the peripheral partnership will be a second avenue of a gradual securization to keep the experiences.

The National monitoring framework of the implementation of the interventions could be :

- the monitoring committee of the cooperation with USAID (IPFH team, USAID, PROLIPO, INTRAH PRIME II, DFH, DPP, DRFM, SG, DDPH Concerned, DNPS, SSHZD).

- It is interesting that the DFH is the first person in charge of this committee. It must be equipped, among other instruments, with monitoring instruments (plan, strategy, frameworks, ….etc.)

It is finally to be wished with that afterward, the IPFH be able to intervene in other zones concurrently to the deployment of a similar national team set up, deployed at the same time by the MPH with the USAID eventual support. This team can meet the overall goals of SSHZD and the specific goals of the DFH.

CONTENT

INTRODUCTION

INTRODUCTION AND JUSTIFICATION

The integrated Promotion of Family Health Program, implemented in 1999, primarily aims at increasing the use of the Family health services and preventive measures in a policy-improved environment.
It includes five Stages : i/ Improvement of family health planning and Coordination; ii/ Increase of the access to family health services; iii/ Improvement of the Capacity of the service providers for quality services; iv/ Reinforcement of knowledges and behaviors favorable to the use of family health services, Products and preventive measures; v/ Involvement of the Community in the services provision planning process and the use of preventive measures.

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OBJECTIVES OF THE SURVEY

The objectives of the survey are expressed in seven specific points which are in line with the framework of the mastery of the perpetuation of IPFH experiences.

1. Sum up the experiences and the experiences that the IPFH can perpetuate;

2. Assess the opportunities and constraints related to the perpetuation of IPFH experiences;
3. Identify the IPFH synergy axes with the other projects or activities financed by the USAID implemented by its Integrated Family Health Program with a view to reaching its strategic objective;
4. Analyse the axes of actions concentration for the stage of IPFH experiences consolidation and set out the most relevant ones;
5. Suggest a management process of the stage of the experiences consolidation which can facilitate the perpetuation of IPFH experiences;
6. Design a joint plan for the implementation of the stage of IPFH consolidation;
7. Design a monitoring plan for the implementation of the joint plan of IPFH consolidation.

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CHAPTER I : GENERALITIES

1.1. FH in BENIN : POLITICAL CONTEXT
1.2. IMPACT OF THE PROGRAMS ON FH
1.3. FH SYSTEM AND SERVICES
1.4. HEALTH SYSTEM & PROBLEMS
1.5. IPFH INTERVENTION

CHAPITRE I : GENERALITIES

1.1. FAMILY HEALTH IN BENIN: POLITICAL AND REGULATORY CONTEXT

The Population Policy Declaration (PPD) of May 2nd 1996 appears as the consensus document for the resolution of Population problems in Benin. One of the Objectives which result- from the Population Policy is to promote family well being.

The Document on Strategy for Poverty Reduction in Benin (DSPR) of the period 2002 – 2004 is considered as the only national referential to focus the national policies and the interventions of all the development partners of Benin on the Objective of poverty reduction and the improvement of basic Social Services.

In fact, the government had implemented since 1992 a project named Maternal and Infantile Health / Family Planning (MIH / FP). This project, since 1995 has become Reproductive health and Family planning. It aims at promoting Family Health (FH) through the availability of Family Planning (FP) Services in the governmental health centers.

More over, the Ministry of Public Health (MPH), in its document on <<National policies and Strategies for the development of the health Sector 1997-2001>> declared that it was vital to promote family development through a group of coherent actions which integrate the improvement of the performance of and the accessibility to FH services.

The document on National Policy and Strategies for the Development of the Health Sector 2002-2006 is the only sectorial referential to focus the interventions of all the development partners on the Health sector, interventions which contribute to the improvement of the health conditions of the families. The vision of Benin in 2025 lays emphasis on social well-fair which relies, among other things on the following items: i/ an efficient and effective educational system, ii/ quality health cares, iii/ drinkable water, electricity and a healthy habitat; iv/ a health living environment.

The mission of the MPH has evolved with the taking into account, in its programs, the contribution to the fight against poverty. It is worded as follows: “Improve the health conditions of the families through a system

which integrates the poor populations[1]. In so doing new overall objectives have been defined: i/ to improve the quality of and the accessibility to the healthcares services, ii/ to improve community participation and the use of health services, iii/ to improve the care and treatment of the poor populations.

In this framework, the expected results are: i/ improvement of the health coverage and the organization of the health pyramid; ii/ improvement of the management of the resources of the sector; iii/ improvement of the healthcares quality and treatment of the main diseases.

At present, Benin is carrying out various reforms the main of which are: i/ territorial reform based on decentralization and community participation; ii/ economical reform the corollary of which is the budgetary reform the objective of which is efficiency in the resources management; iii/ the implementation of the health zones which contributes to the concretization of decentralization in health sector.

Finally, the government made in August 2000 some decisions which devote Benin commitment to contribute in a significantly way to the fight against STI / AIDS.

The Document on Policy, Norms and Standards as regards FH in Benin is the specific reference framework for the development of FH services and is used as a guideline to the decision-makers for the elaboration of the programs, to the supervisors and service providers to better understand their duties and responsibilities. It includes: i/ the main features of the national policy as regards FH. Ii/ the norms and standards of FH services in four stages : woman's health stage ; man's health stage, teenagers and young people health stage, children health stage.
The National Program for Reproductive Health (NPRH) 2003-2007 is the logical continuation of the document on policy, norms and standards regarding FH and that on national policy and strategies for the development of health sector 2002-2006. In Benin, the notion of Reproductive Health (RH) is assimilated with that of Family Health[2].

[1] National Policies and strategies for the development of health sector 2002-2506.

[2] From the policy, norms and standards as regards family health in Benin results in fact the national program for reproduction health managed by the Office of Family Health of the Minister of Public Health.

1.2. IMPACT OF NATIONAL PROGRAMS ON FAMILY HEALTH.

The full integration of the component of RH or the FH (including the STI / HIV prevention, the IEC/CBC and vaccination) is not a reality a cross the nation. It remains incomplete in general and in particular for the development of Emergency Obstetrical Neonatal Cares (EONC) and the integrated care and treatment of childhood diseases (ICTCD) .
The use of the FH services varies according to the components. Although 87% of women benefit from a Natal Prenatal Consultation (NPC) and 73% give birth with the help of a qualified personnel, the contraceptive prevalence has increased a little, from 3% IN 1996 to 7% for the modern methods in 2001 against only 0.3% in 1990 (HDS I&II).
Actions have been envisaged to reinforcement the implementation of the FH programs, notably:

- The elaboration of the protocols of the FH SERVICES IN Benin with the technical support of INTRAH PRIME in the framework of the project of training and support to the RH primary service providers. These protocols make the policies, norms and standards of FH services operational. They contribute to the reinforcement of the services integration and will be used as the basis to the actualization of the training curricula in order to standardize the training of the service providers at all levels;
- The elaboration of a national strategy as regards supervision, along with supervision forms for the supervision team at the peripheral, intermediary and national level;
- The elaboration of a manual of procedures on the management of the contraceptive logistics;.
- The elaboration of an instructions guideline for the tools of the national system of health formation and management with the support of the French Cooperation;
- The implementation of an integrated program of the EONC.

These actions aim at reinforcement the FH services integration into the activities of the health centers in order to optimise the impact in the local communities.

1.3. THE INSTITUTIONAL FRAMEWORK, FH HEALTH SYSTEM AND SERVICES

1.3.1. THE INSTITUTIONAL FRAMEWORK AND THE HEALTH SYSTEM

In order to meet the new needs of the RH, the institutional framework has favorably evolved with the creation of the Direction of Family Health (DFH) by the decree of May 26, 1994. Its main mission is the designing, planning, coordination, monitoring and assessment of the FH activities.
It includes the service of MIH and the FP service.
In order to better make effective its new health policy, the Republic of Benin has started a reform of the health system modelled on the administrative cutting out presenting three-level pyramidal structure: Central, intermediary and peripheral :

THE CENTRAL OR NATIONAL LEVEL whose mission is the implementation of the government policy as regards health, the elaboration of the strategic orientations by the management organs (the cabinet of the MPH, the board of directors, the national committee for the execution and assessment of the health programs, the technical Directions which are the execution organs) and the functioning of the National University Teaching Hospital (NUTH) where the second level of tertiary healthcares is being applied. The creation of a family health direction aims at favoring the implementation of the programs of RH in Benin. This direction is presented at all the levels of the health pyramid.

With its attributions which are stated again in the decree of March 29, 2000, the DFH has the power to monitor and coordinate the different programs as regards RH. Its attributions concern notably the following points:

- To elaborate and monitor the application of the policies, Norms and Standards as regards FH;
- To elaborate, monitor and coordinate the different programs : less-risk maternity strategies of ICTCD programs related to teenagers and young people RH (RH/TY), Program of FP including the fight against infertility, sterility as well as screening, care and treatment of genital pathologies and the STI / HIV / AIDS and the programs as regards nutrition;
- To ensure the training of the trainers in FH.
- To coordinate the activities of the non Governmental Organizations and of the other participants' in FH.

THE INTERMEDIARY OR DEPARTMENTAL LEVEL is assigned the mission to implement the policy defined by the government by providing a strategic and technical support to the health zones (planning, coordination, epidemiological monitoring, supervision) and to the departmental hospitals where the first level of tertiary healthcares is applied through management organs (departmental committee for the execution and assessment of the health programs, departmental administrative conference, departmental directions of health, boards of directors, consultative medical commissions)

THE PERIPHERAL LEVEL divided into health zones is organized in centralized operational entities made up of a network of first contact services (VHU, DHC, MHC, CSSP, CSCU and private organs) of which the zone hospital is the first public or private reference. This restructuring into health zones aims at improving the quality of the public health services and the living standards of the populations located in defined geographical areas in order to secure the viability of the health services. It should reinforce decentralization, community participation, partnership between the public and private sectors and ensure the quality of the services.

The reform aims at researching an efficient and effective health system for the improvement of social health conditions. This process is in line with the territorial reform which must contribute to the rooting of the peripheral management and to the reinforcement of community power in every field. The zone committee, the technical committee to carry out the health programs, is chaired by the zone coordinating doctor. The following management organs, the zone health committee (decision making organ) and the zone monitoring team (execution organ) are based on the principles of planning, coordination, supervision and monitoring in order to manage the healthcare service and related initiatives. The operationalization of the objectives by the healthcares services is under the direct responsibility of the decision making organs (board of managers, municipality management committee, district management committee, village assembly), technical organs and officials (management committee, consultative medical commission, managers, doctors, nurses, midwives, village health workers) who are in charge of primary and secondary healthcares.

This arrangement still remains non-operational while it is the very weft national programs concretisation process in terms of health.

1.3.2. THE REPRODUCTIVE HEALTH SERVICES OR FAMILY HEALTH SERVICES

The services which follow from the political orientations of the MPH in terms of RH are health services meant for women, men, children, teenagers and young people, to which are added the FP programs, the programs for the fight against the STI/HIV/AIDS, the practices that rare harmful to RH, infertility and sterility, the iatrogenous infections; the social mobilization programs for RH/FP and the promotion of less-risk behaviors through advocacy and the IEC. All these components are integrated in accordance with the levels of competences into the services of the VHU, DHC, MHC, ZH, DH, and the NUTH/MCLH.
It in therefore worth noting that the functioning of the FH services depends on the functioning of the health system in general.

1.4. ANALYSIS OF THE HEALTH SYSTEM PROBLEMS

1.4.1. A LOW VALORIZATION OF THE FH SERVICES WITHIN THE BENEFICIARIES

A large number of the beneficiaries do not ask for FH services. It is true that the majority of Benin population is illiterate (71.4% in 1993)[1] and this does not facilitate the interventions related to IEC as well as the advocacy with a view to adopting favorable behaviors to health. However, several tools and approaches help to go round this difficulty but the problem lies in the designing of the IEC in terms of program which clearly identified the desired changes and the activities to set up in order to achieve it. Several communication channels are available[2] and their choice easy in accordance with the target.

1.4.2. LESS EFFICIENT INSTITUTIONAL FRAMEWORK AND HEALTH SYSTEM

The national framework for the management of population programs is the Ministry in charge of Coordination, of Governmental Action, Prospect and Development (MCCAG-PD). The National Direction of Human Resources and Population (NDHRP) coordinates the strategy section in terms of population and the DFH the implementation of the RH sub-program. This framework shows some weak points, one of which seems important to us : the non-involvement of the direction of planning and

[1] RGPG2, 1992
[2] Community Radio, proximity actions etc.

prospect (DPP) which contributes to the low appropriation of the programs/projects and account for some implementation difficulties[1].

The health system is being restructured. All the health zones are not functional. The reorganization of the basis the health pyramid still being ongoing in Benin, the health system therefore is not generally functional. Unfortunately the FH services will be integrated into this structure and the implementation of the FH program lies on this very structure. This hybrid state of the health system, which is partially reformed, puts a heavy prejudice on the efficiency of the coordination at the DFH level and the results expected from the periphery. The RH services were only partially integrated and moreover they involve managerial dimensions (IEC, Quality Insurance, Health information system, targeted intervention) which the personnel is not necessarily familiar with.

1.4.3. IN INSUFFICIENT, INADEQUATE AND DIFFICULT ACCESS TO FH SERVICES

The provision of services is certainly insufficient in quantity and quality. It remains to ensure a provision of complete services in tune with the needs : this will require an accurate assessment of the quantity of the needs in terms of RH services in order to ensure the coverage of the goal : and all the targets including teenagers and old people as regards RH. There is a need improvement of the quality through the coverage of the beneficiaries with normative services of care and treatment. An important stage is the full integration of the activities of the RH programs into the existing health services.
The inexistence of a referential base which defines the exhaustive needs of the programs as regards the services and their possible assessment is currently a weakness which does not help quantify the degree of their satisfaction in terms of :

- IEC, services, reforms (minimum package, norm and standard, reorganization of the services, reforms in the context of care and treatment of gynaecological and obstetrical complications);
- Family Planning;
- Low-risk maternity, sterility, abortion;
- Satisfaction of the sexual needs (women, men, teenagers) without risks (STI/HIV/AIDS);
- Organization of adequate health services which meet the needs of the population.

[1] for exemple the fact that the government doesn't plan their contribution to the funding of the RH project and to the care and treatment of the ressourceful persons who intrevene in health development projects.

The programs allow for services which can qualitatively cover the whole object of RH but at this present implementation stage the needs of the services as regards RH/FP of the teenagers and young people as well as old people are not satisfied. It also remains to check the actual integration of all the RH services whose quality must be ensured at all levels of the health system and everywhere in Benin.
The corollary of this full coverage in quality RH services would be the necessity to ensure the access to health services (and RH) knowing that 66% of Benin populations do not go to health centers[1]. The accessibility to the services is all the more easy that the demand, the supply and need coincide. Apart from the physical and functional accessibility, the financial accessibility appears as the most difficult problem to solve.
In fact, as far as economy is concerned, the poverty of the populations and the precarity of their contributive capacity also restrict their access to services and in so doing create a low use of the services already available. This major limitating factor remains pernicious. It is the less vulnerable but significantly restricts the efficiency and effectiveness in the implementation of the RH programs.

1.4. 4 - A LOW CAPACITY OF THE MANAGEMENT OF FH PROGRAMS AND PROJECTS

We have noticed a validity of the designing of the programs, because in general, they are relevant and designed with inputs, products, objects, clearly stated and coherent purposes and appropriate strategies.
The available health information system is not specific to the management of the RH programs. The management of the RH programs relies on the community knowledge and its main problems. The statistical, epidemiological and sociological approaches should help to definie the reliable and mesurable indicators which are used as the basis to planning, execution and assessment of all the actions undertaken as well as to the requirement of the result which would correspond to the satisfaction of the RH rights.
A lack of harmonization, continuation and reliability of some information makes some supposedly existing data not usable. The lack of this information expecially at the peripheral level is a weakness in the planning process.
In the prospects of a result centered management, the impact of the implementation of the programs on the beneficiaries is very low. In fact we notice a low appropriation of the programs and projects at the national level. The consequence is the difficulty of performance and

[1] national system of information and health management, year 2000

perpetuation. We notice a total inexistence of national assessment of the needs in RH services by locality even though these services have been largely valorized within the beneficiaries by means of a strong advocacy activity carried out with a lot of efficiency.
There has not been an objective measure of the possible progress according to the means in order to establish the implicit refentials (indicators) which must be used as the basis of a monitoring assessment, and an efficient intra program coordination. In other words the exists a weakness of the cause-effect link forces between the interventions, the means and the result chain. The ultimate consequence is the inexistence of quantitative measures, in accordance with the specific problems by locality, does not allow the adequation between the availability of the services, the needs and demand on the one hand, the input and outputs on the other.
As these conditions of management are not fulfilled, quite obviously, it is difficult to master the quality of the services, monitoring, coordination and the results. These incoherences of the process of national planning resulted in the insufficient use of the RH services by the beneficiaries.
As the problematic of RH is beyond the limits of the sectorial health framework, the performance of the interventions is necessarily conditioned by the mastrery of the synergy of the actions as regards the intersectorial, intra sectorial levels and at the very level of the development parteners.
The mobilization of the sources and the channelling of development aid to is the manifestation of the taking into account of the synergy in the cooperation for development.
On the other hand, the non-mastery of the needs in terms of RH services and the inexistence of an efficient synergical management framework of the programs of population at the national level does not allow a good visibility on the types of priority interventions, their measures, the emergency zones, the channelling of the aid of the government significant and efficient results.
The national RH program shows the major weakness of the inexitence of a macro-economical framing which helps to know the evaluation of the cost of the program and the projection of the funding sources.
Another weak point is the inexistence of a distribution map of the avariables funds over health zones, in accordance with the objectively stated needs, the expected results, the logically elaborated indicators and the progress assessment referential. The advantage will have been the achievement of the performance conditions and the efficient orientation of the development partners to the zones where their interventions would find the favorable ground for their fulfilment.

1.5. IPFH INTERVENTION

Since1998 the USAID strategic options have helped to establish a link between possible efficiency of the programs and the funtionning of the health system.This observation will appear in the elaboration of the IPFH.

1.5.1 CONTEXT

The IPFH intervention is in line with the framework of the "Country Strategic Plan 1998-2005" of the United States Agency for International Development (USAID) in Benin, which is centered on the following four axes :

- The improvement of the political environnement;
- The increase in the health services and products;
- The improvement of the management and the quality of the services;
- The improvement of the demand and practices which reinforce the use of the services, product and FH prevention measures.

The IPFH carried out in the Borgou and Alibori departements is scheduled to cover the period 1999-2004.
The program is carried out by a consortium of execution agencies (URC, CLUSA, PATH, BAFP).
Fives axes have been the subject of IPFH intervention :

- The improvement of planning and coodination at all levels;
- The improvement of the access to the FH services and products, of MIH and the fight against STI / HIV / AIDS;
- The improvement of the capacities of the health workers to provide quality healthcares and services;
- The increase in the demand, the use of the services and preventive measures;
- Community participation.

From 1999 to 2002 the program carried out several activities which are summarized as follows:

- Training of health officials (Health organization, ZMT, DDPH) in " quality Insurance" approach;
- Setting up of mechanisms of planning, coodination wich the DDPH, the partners and the ZMT;

- Review and adaptation of the logistical system of the FH products to the real needs both at the peripheral and departemental levels ;
- Training of the health workers in logistical management;
- Training and equipment of the community health workers ;
- Training of the Trainers of the CBS health workers;
- Integration of the EONC protocol ;
- Training of the village committees in problems solving;
- Introduction of the community ICTCD;
- Establishment of a departmental nucleus of IEC and CBC with the initiation of the members to the techniques and strategies of communication;
- Training of the members of PMC, DMC, in planning, IEC/ CBC.

From these interventions, some strong points are recognized to the IPFH, viz :

- The setting up of a coordination at the departmental level, which favors the synergy of the expected action;
- The reinforcement of the competences of the local, departmental human resources as regards planning;
- The development of the quality insurance approaches;
- The reinforcement of the capacities of the actors on problems solving approach.

The implementation of the program lies in a technical and financial support to the reinforcement of the capacities of the service providers, the local institutions, the communities and the promotion of solutions in a view of the continued performance of the FH services in the Borgou and Alibori.
However, important issues are raised in relation to the continuation of these experiences.

1.5.2 PROBLEMATIC OF CONTINUITY:IPFH in transtory stage : 2004-2006

A the end of the year 2003, on the initiative of USAID and the IPFH team, an exhaustive survey of the members of the Integrated Promotion of Family Health Program in the Borgou / Alibori, helped after a long consultation, to work out a plan of action for the transitory stage of IPFH which covers the period 2004-2006. This plan integrates several activities for the perpetuation of the program.

In fact, the MPH authorities recognized the impact of the project, as regards decentralized management of the health programs, the management of the information system as efficient monitoring and Quality Improvement tools. Also the ministry wished that the IPFH ensures during this period " the technical leadership " of the activities and spreads them to the non-concentration zones.

All these expectations have been integrated into the perpetuation plan of the transitory stage of the IPFH which matches with a monitoring and assessment plan at real time with objectively verifiable indicators.

However some restrictive factors were high lighted, viz :
The resources and the available time. The transitory stage of the IPFH comprises three challenges : i/ the consolidation of the experiences as regards the availability of the services, the technical and management competences, ii/ the extension of the community participation activities to the non-concentration zones, iii/ the institutionalization of the principles of Quality Insurance.

CHAPTER II : METHODOLOGY

2.1.Framework, Nature & Duration of the Survey

2.4.Techniques and Data Collection

2.7.Data processing

CHAPTER II : METHODOLOGY

2 .1 - FRAMEWORK AND NATURE OF THE SURVEY

The areas of this survey is the Borgou/Alibori Department which have benefited from the USAID support since January 1999. In these departments seven health zones are the main intervention zones of the IPFH. They are Bembèrèkè / Sinendé, Nikki / Pèrèrè /Kalalé, Parakou / Ndali, Tchaourou in the Borgou and Banikoara, Kandi / Gogounou / Ségbana, Malanville / Karimama in the Alibori.

It is a qualitative, descriptive and analytical survey which was about an assessment of the strategies of the experiences perpetuation.

2.2 - DURATION OF THE SURVEY

The survey was completed in six working weeks. The first week was devoted to documentation review, taking of appointments, meetings with resourceful persons and the elaboration of the data collection tools.
The 2nd and 3rd weeks were devoted to the inquiry on the sites of the survey. The 4th and 5th weeks were devoted to data reduction, to the analysis and interpretation of the collected data. Finally the sixth weeks was devoted to the writting of the preliminary report on the survey.

2.3 - POPULATION OF THE SURVEY

The survey targetted :

- The resourceful persons of USAID,
- The members of the IPFH team,
- The technical directors of the MPH or their representatives (DFH, DPP)
- The technical directors of the DDPH, the concerned health zone or their representatives,
- The members of the Health committees,
- The members of the Zone Monitoring Team,
- The local, political and administrative authorities,
- The service providers,
- The local beneficiaries
- Some key–informers from other projects of technical assistance of USAID (INTRAH PRIME II, PROLIPO, PSI).
- Some key informers for NGO and other institutions (BAFP, Swiss Project Parakou, PBA).

2.4 -DATA COLLECTION TECHNIQUES

Several techniques were used to collect the data : Techniques of quick opinion pool, informal interview, detailed interview, constructive observation and data reduction. The technique of data reduction was used for the review of the existing secondary data. The quick opinion pool, the informal interviews, the detailed interviews and the constructive observation were used for the actual investigation.

2.5 - DATA COLLECTION PROCESS

2.5 -1 MASTERING OF THE REFERENCE TERMS

This stage helped to tell in clear operational terms, the expectations of the assesment sponsor. It required exchanges of ideas with some resourceful persons of the office of USAID on some points with a view to consolidating the understanding of the reference terms.

2.5-2 DOCUMENTATION REVIEW

A required documentation was provided essentially by the competent services of USAID and the IPFH. This basic documentation was supplemented at the Ministry of Public Heath by the documents on the policies, norms and standards with regards to health, and FH and the national RH program. Equally, the documentation on INTRAH PRIMEII, PROLIPI and PSI was of paramount importance. It helped to draw from the basic documentation (program, project documents, monitoring and assessment plan, reference terms, reports and other documents…) two vital data :

- The objects of the perpetuation in terms of objectives, activities, process and products.

- The definition of the norms of assessment and the designing of a logical framework matrix which includes the objectively verifiable indicators (OVI) which are devised or perceived from both quantitative and qualitative view point.

In this context, the survey examined : through the activities, the effort made; through the products, the results achieved and through the process, the quality of the approaches and or strategies.

2.5-3 PRELIMINARY MEETINGS

With a view to obtaining further possible information and integrating useful reports into the documentation information, a number of indispensable meetings were held. These were meetings held with the recommemded resourceful persons of USAID bureau, the MPH espacially the DFH and the service of studies, planning and documentation, some key NGO (BAFP) informers, the development partners (PSS, PBA, UNFPA) and other technical assistance project of USAID (INTRAH PRIME II, PROLIPO, PSI).

2.5-4 HOW WAS THE DATA COLLECTION CONDUCTED ?

Concurrently with the formal appointments taken informal meetings were held with a view to collecting ''on the spot'' within the communities and from some resourceful persons, some information related to the IPFH activities. This approach helped us to make the devised data collection tools more accurate.

Different techniques were used according to the opportunities that we had. Formal interviews were conducted either by both consultants together or by one consultant depending on the availability of the interviews and some given points of interest. Some interviews required the interviewers to visit the same interviewees several times whenever the topics required it.
On the whole, 34 detailed interview were conducted out of which 10 with some community members.
Before each interview, the interviewees were informed about the object of the survey and they gave their consent before the interview was conducted. It is worth noting that no refusal was ever registered.
The constructive observation was used during the visits to the concentration zones, to directly appreciate some experiences of the IPFH in the field.
That is for example the consultation of the planning maps of the activities of the MHC, DHC etc., The maps which show the organigram of the health zones, the posters, leaflets, health notebooks, etc.

2.6 - DATA COLLECTION TOOLS

Three data collection were designed viz : i / A guideline for secondary data collection, ii / A guideline for quick opinion pool, iii / Two detailed-interview guidelines (local actors and community).

2.7 - DATA PROCESSING

The collected data were subjected to a mannal reduction and processing. They were afterward classified and categorized by theme and objective then submitted to a content analysis.

2.8 - PLEASANT AND HARD TIMES GONE THROUGH

The preparatory arrangements (telephone calls, written messages, cover letter etc…) by the USAID family health team of considerably cut down the differenties which could hinder the successful conduct of the survey. Apart from the mobility and the unavailability of some resourceful persons, no major difficulty was met during the actual survey.

CHAPTER III : OUTCOME OF THE SURVEY

CHAPTER III : OUTCOME OF THE SURVEY

3.1 DESCRIPTION OF THE ONGOING PERPETUATION PROCESS

3.1.1. DESCRIPTION OF THE SUGGESTED CHANNEL OF ANALYSIS

According to the mission report of January, 30th 2004, the plan would be based on an analysis framework for the perpetuation of the IPFH activities defined into seven factors: i/ The appopriation of the beneficiaries, ii/ the support policy, iii/ the human resources and competence, iv/ integration, v/ efficiency, vi/ organizational and management capacity, vii/ funding and partnership.
From this analysis framework, it is expected that, from the scheduled activities, the program gets the following result :
At the close of the year 2004, the Zone Monotoring Teams should appropriate the IPFH activities, conveniently use the “ascending planning principles”, get the required competences in the management of health services, have the capacity to integrate the FH activities into the strategic and operational plans and implemente the so called plan completed with an appropriate assessment process, make sure that the MMC / DMC and the partners contribute to the funding of some activities initiated in the framework of FH. The significant improvement of the FH indicators would prove the efficiency of this first stage of the perpetuation.

At the close of the year 2005, the perpatuation program expects that, the DDPH appropriates the established strategies, effectively supports the ZMT and extends the ascending planning to all the health zones; the DDPH has within its team, management and planning competences and fully integrates the IPFH activities; the State Budget and new international partners finance the activities of the central plan; the plans of actions the DDPH and the ZMT. The improvement of the FH indicators is considered as the assessment instrument of the efficiency of the second stage of perpetuation.

However, several critical hypotheses are added to these expected results, which hypothese slip out of the direct control of the IPFH. They are related to the motivation of the DDPH and the olvious commitment of the MPH more particularly of its competent services to actually encourage and play their monitoring and control role.

3.1.2.- PLANNED ACTIVITIES OR INTERVENTIONS

The IPFH experiences perpetuation plan indicates several activities on the appropriation of the principles of planning, regular meeting (DDPH

team, monitoring committee), training visits (monotoring, supervision, ICTCD, EONC, resources management), coaching, the use of the procedures and norms of management, training, review worshops, integration, the funding of the plans of CBC and community participation. The assessment of the efficiency of the plan which must be co-management, the integrated provision of quality health cares, monitoring, supervision of trainings and monitoring of activities.
The officials involved are : the DDPH and its competent services (SFH and SNOC etc.), the MPH and its technical services (DPP, DFH, DHR), the ZCD (ZMT), NGOs presidents and communities.

3.1.1 DESCRIPTION OF THE PLAN OF ASSISTANCE OF THE DDPH AS REGARDS THE REINFORCEMENT OF ITS ROLE OF FACILITATOR IN THE FRAMEWORK OF DECENTRALIZATION

This plan is based on the observation that the zone monitoring teams have assimilated sufficient competences for the perpetuation which require that the DDPH team be equiped with required competences in order to be able to play its role of coordination and monitoring of the health zones. For the decentralized management which falls to the DDPH be efficient it is scheduled in the framework of the perpetuation that the DDPH be made to play the role which is played by the IPFH team as regards the ascending operational and strategie planning, human resources, the organization of the services and governance.

The implicit activities are grafted with heavy hypotheses :
The necessity of technical support, the changes of the regulatory texts as regards the management of the public administration personnel for more flexibility, as regards motivating bonus, the use of additional funding for equity in the improvements mutual health promotion, the adoption of the pilot experience of income generating activities implemented by the MMC in the areas of concentration, as regards close technical support based on actual supervision.

At the end of this review, it appears the will of the IPFH to pass the lead to the DDPH despite the constraints which result from it. The ZMT being considered as equiped enough to take over from the DDPH. Ginven these several hypotheses which are grafted on the whole process of perpetuation about to be carried out and noticed in the plan of perpetuation in general and in particular in the DDPH plan of assistance to the reinforcement of its role of facilitator, serious questions arise about its achievement.

The data collected and the observation made during the meetings tell us that there is a lack of consensus on the perpetuation concept although several activities which are part of this framework are of a great importance. This situation, may be prejudicial to a methodical appreciation of efficiency, the efficiency of the implementation and the sustainability of the results. That is why we suggest an analysis framework which takes into account the opinion of the resouceful persons we have met.

3.2. DEFINITION OF AN ANALYSIS FRAMEWORK OF THE PROCESS OF IPFH PERPETUATION

3.2.1- DEFINITION OF THE CONCEPT

Perpetuation is defined as the capacity to preserve and continue the good manners of a program without receiving out side support. To do so the efforts that have been made to favor this perpetuation should take into account the political will and the financial policies.

3.2.2- THE PERPETUATION CYCLE

The perpetuation process includesfive successive stages : validation, appropriation, transfer, autonomization or consolidation and assessment.

VALIDATION OF THE PRINCIPLE

This stage consists in validating of the principle of continuation which should be planned in the program or the project. Three data need important to be integrated at the approach of the project. They are :

- The anticipation of the perpetuation in the agreements while taking into account the appropriateness with the sectorial policy and the priorities of the participants,
- The relevance of the choices (existences of the arrangement to apply or to replicate specific activities,
- The preliminary definition of five useful parameters (the mechanism of perpetuation, the plan, the actors, the funding, the assessment instruments).

This first stage helps to achieve the condition of the manifestation of the participants interest in the program and its perpetuation.

APPROPRIATION

Identification is an important stage of appropriation. This stage includes three phases : identification of the good manners, identification of the strategies and identification of the targets.

- The identification of the good manners likely to replicate the experiences is carried out according to an approach which consists in:

    - Extracting significant results which must be continued. It results from the implementation of the program.

    - Analyzing the results and identifying the experiences. This analysis in carried out following the criteria which are based on the establishment of relevant relations between the policies, norms and strategies and the results as well as the appreciation of the correlation of how the indicators evolve with the national objectives. A result is considered as achieved when it fulfills these two conditions.

    - Deduction the good manners to preserve and continue (or factors of perpetuation) which uses the criteria of search of cause-effect relations between the determining actions and experiences (efficiency). This is about the indicators of efficiencies certified by the indicators which evolve in the director of the desired progress.
      These are the good manners which have a replication effect on the experiences and which are therefore capable of preserving them.

    - Analyzing the satisfaction of the beneficiaries of the program. It helps to appreciate how the actors of the system and the community are satisfied in order to diagnose the critical points related to the experiences.

    - Analyzing and lifting the critical points or bottlenecks. They concern the experiences which bear serious hypotheses. These experiences must be analyzed in order to favor the lifting of the bottlenecks.

- Identifying the strategies of the preservation and continuation of the good manners which lies in the determination of the means through

which it will be possible to introduce in the system the capacity of the replication of the experiences.

- Identifying the targets which consists in drawing the nomenclature of the good manners which the targets must have and in finding the level of the “grafting” in the health systems. To do so, the assimilation capacity of the receivers and the transfer capacity of the transmitters must be taken into account. The assimilation capacity depends on the induvidual aptitude, the background and the appropriateness of the specifications to the object to be assimilated.

TRANSFER

This is about the transfer of competences. The competences to transmit being in terms of good manners it is useful to be methodical by defining the objectives, the activities, the resources, the chronology of the transfer and the monitoring indicators. A perpetuation plan must therefore be elaboreted and budgeted. This plan must distinguish the budget of transfer from the budget of consolidation. In fact, the budget of trasfer is secured by the external resources and that of consolidation by local resources.

AUTONOMIZATION OR CONSOLIDATION

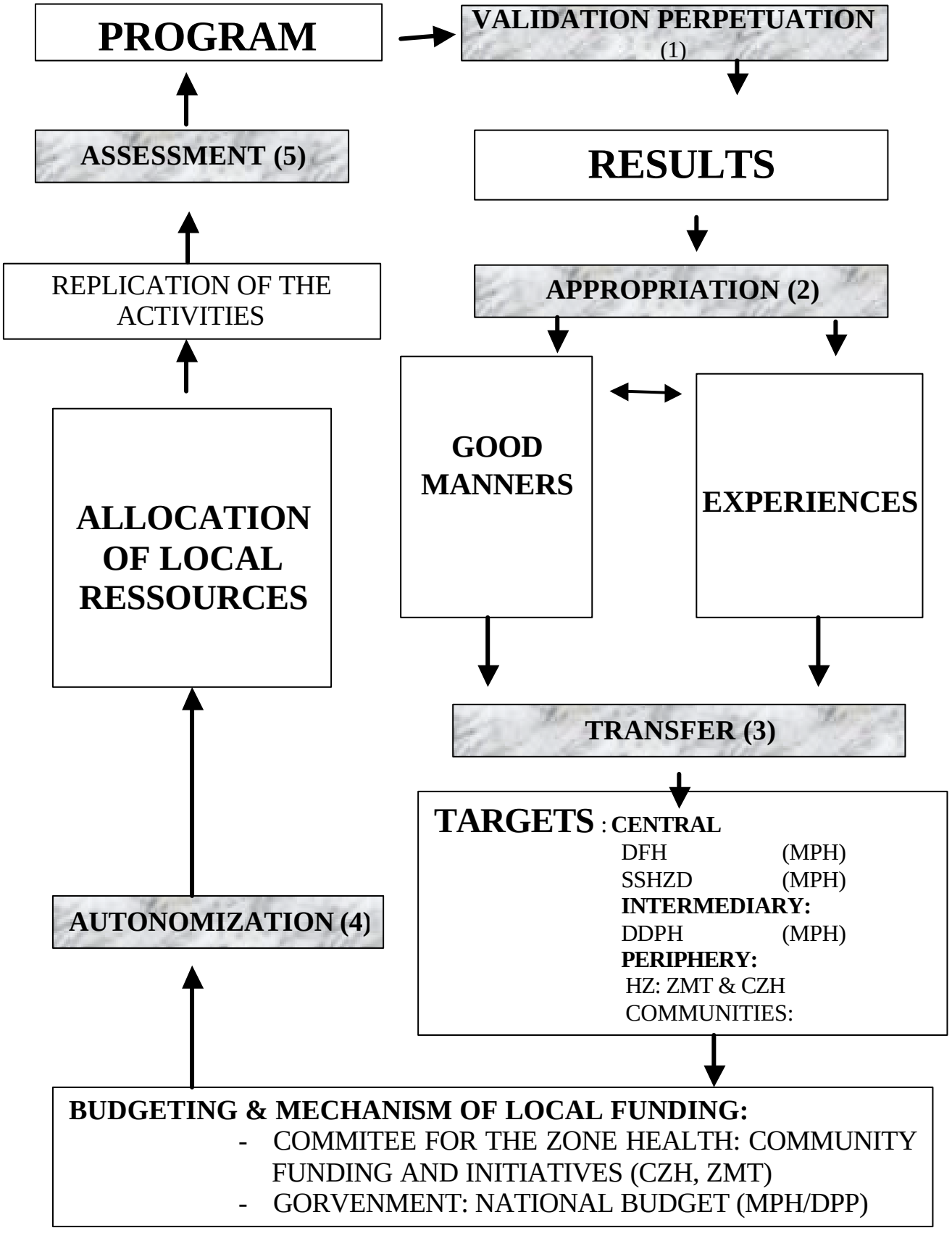
This is carried out in case of sovereignty that is in case of external ressources withdrawal. It aims at a sustainable allocation of local resources in order to replicate and maintain the good manners and results. These resources which can come from the national budget or from the health zones will be devoted to the needs of staff, equipment of and funding of the activities. Three activities are essential during a variable period :

- The analysis of the budget of consolidation and its adoption,
- The implementation of the consolidation process,
- The elaboration of the mechanisms of allocation of the financial resources, technical support and monitoring.

ASSESSMENT OF THE NEW PERFORMANCES AND VALIDATION OF THE CONTINUITY

To be sure that assimilation of the results is mastered, it is useful to access at the end of a determined time and after the withdrawal of the external support, the perfomances of the system through the results indicators. Once the assessment is satisfactory, perpetuation is considered as achieved.

3.2.3. OPERATIONAL AND CONCEPTUAL FRAMEWORK



3.3- SYSTEMATIC ANALYSIS OF THE PROCESS OF THE IPFH PERPETUATION

3.3.1 VALIDATION STAGE

From the study of the ongoing process and the interviews carried out in the framework of this assessment, it results that the perpetuation as such was not seriously analyzed in the beginning of the program. Therefore it was difficult to draw a clear, precise and unanimously accepted concept which is a common framework of reflection for the IPFH participants. This first observation is certainly the consequence or cause of the conditions in which it is necessary to finally plan a perpetuation for which the actors are not convinced of its achievement, although they are all unanimous on the performances of the program. First there is obviously a lack of validation at the right time of the principle of prejudicial perpetuation, the quality of the results to expect.

All in all: we notice that the project approach didn't certainly tackle the definition of a mechanism of implementation, of an institutional framework, of a plan or a mechanism of funding the continuity. Some data obtained from resourceful persons tells us for example that the DPP committed itself to the process of perpetuation although the financial contribution of the government for the long–term keeping of the results in not clearly defined. It is the same for the DDPH, the Zone Health Committees and the zone Coordinators. Some technical services of the MPH which are directly concerned such as the Support Section of Health Zones Development (SSHZD) were involved in the process of perpetuation only during the last workshop of ascending planning[1]. however no particular role was given to it. In addition, there lacked a mechanism of the management of the budgetary implications of the perpetuation, which influences the transfer and consolidation of the experiences.

3.3.2 THE APPROPRATION STAGE

A - ANALYSIS OF THE RESULTS OF THE IPFH

This systematic analysis is based on the principles of appropriation which form the second stage of the cycle continuation. In general it is worth noting that the activities of the IPFH lead to a chain of results obtained at different levels.

As regards the input, the IPFH provided technical assistance, the assistance to the trainers and the funding of the team according to the needs.
The activities which have been carried out can be classified into four fields: equipment of the health services and the support services, training of the personnel, the establishment of a supply system, establishment of norms and procedures .
The first level of results was based on the effective availability of the complete range of the minimum packed of FH services in the health zones of the Borgou and the Alibori.
The second level of results concerned the increase in the use of the FH services.
The third level of results concerned the effects on the factors listed as determinants of RH quality (Cf. table N°1 in annex).

From reports, documents and interviews conducted, we can conclude that the implementation of the IPFH helped to carry out a new and considerable progress in the Borgou and the Alibori.

Among these progresses we can stress on those which appeared to us the most spectacular.

- The increase in the FH services was acquired through several achievements. The integration of the minimum package load of family health (FP, PNC, Children health, IEC / CBC, STI/HIV/ AIDS prevention) into the health services in constant progression. In fact, the availability of the minimum package of the quality FH services (Five days out of seven) increased from 12% in 1999 to 50% in 2002 (MQAHS) and could reach 85% in 2005 according to the projections. This achievement is followed by a reinforcement of the competence of the health workers, their technical equipment and the implementation of the principles of Quality Insurance (Q I).

- The extension of health coverage and the improvement of the access to FH services were remarkable because not only did the minimum package of FH services become accessible in the health services but also the community based services covered 96% (routine data collection of 2003) of the populations notably in the concentration zones of the IPFH activities.

- Autonomy in the training of the health professionals is a significant result because the implementation of the minimum package and the research of quality requires permanent refreshers courses, trainings imposed by the new concepts and strategic choices (ICTCD, EONC, … CBHW). With the trainers of the trainers of the Health Zones, the Tutors (cf. principle of ‘’Tutorship’’) and the departmental training team, the IPFH helped zone of the Borgou and the Alibori to acquire not only the autonomy but the efficiency in the field.
- The valorization and the reinforcement of the capacities of planning and management in the health zones are one of the assets which the IPFH equipped itself with and which helped the actors to channel their efforts towards the achievement of the objectives. These objectives were quantified from the Management quality assessment of the health system (MQAHS). The corollary is the introduction of the required norms and indicators which help to assess at the right time the quality of the services and the progresses. It favors through the supervisions, quick diagnosis of the gaps, their correction, the mastering of the systematic functioning and of the departmental health indicators.
- The reinforcement of the communities motivations to participate in the management of the municipality management committees was felt through the improvement of the coverage in efficient MMC and DMC.
- The change of behavior of the communities towards health practices was tackled and constantly progresses as it is proved by the present degree of the contraceptive prevalence which increased from 3% according to the HDS (1996) to 12% in 2003.

B - STUDY OF THE VALIDITY OF THE RESULTS

To sort out the experiences, we submitted the results to some criteria of relevance which are related to the national policies, norms and strategies. Then the results which fulfilled these criteria were selected according to their correlation with the national FH objectives (Table N°2 in annexe). We realize then a perfect correlation between the

results of the IPFH and the objectives of the national health policy. This observation devotes the validity of the results of the IPFH which roughly concern: the increase in the family health services, the extension of the health coverage and the improvement of the access to the FH services, the autonomy in the training of the health professionals, the valorization and reinforcement of the capacities of planning and management in the health zone, the reinforcement of the communities motivations to participate in the management, and the change of behavior of the communities towards some health practices. In fact, Benin health policy aims at the improvement of the quality of and the accessibility to the healthcares, the improvement of community participation and the use of the services, the improvement of the care and treatment of the poor populations.

C- DEFINITION OF THE SIGNIFICANT RESULTS

Before we defined the significant results, we checked the relevance of the valid results with respond to the objectives of USAID and the national health strategy as regards FH; which helped to sort out some experiences. (Tables N°3 in annex).

1st LEVEL OF RESULTS: ACTIVITIES; i/ the training constituted a field in which the IPFH not only found the opportunity to improve the quality of the healthcares but also it was planned, adapted of the needs made sustainable because of its autonomization. Obviously, the constitution of the training teams and the monitoring of the competences at several levels, starting from the personnel in service are necessarily less expensive, ii/ the implementation of a supply system which reduces the shortages reinforced the availability of the services, iii/ the designing of technical norms and protocols facilitated the quality of the services. It is worth noting that the constitution of the minimum package of Family Health services (norm) benefited from the provision of necessary equipment.

2nd LEVEL OF RESULTS: AVAILABILITY

The IPFH secured the availability of the services through their increase, their coverage, their completion and their accessibility. The fact of making the FH services close to the communities is carried out through the establishment of community based services and the innovating development of the CBHW were very useful in the framework of the extension of services provision. The development of the IEC / CBC helped to influence the access to the services.

3rd LEVEL OF RESULTS: USE OF THE SERVICES

The IPFH ensured a significant improvement of the access to and the use of the services by reinforcing the motivation of the communities and by reinforcing the populations knowledge in terms of preventives measures and change of behaviour.

It is the first level of results which actually conditions the second and the third levels.

D - CORRELATION BETWEEN THE IPFH PERFORMANCES AND THE FH OBJECTIVES AND **DEFITION OF T HE EXPERIENCES: 4th LEVEL OF THE RESULTS CHAIN**

The correlation assesses the cause-effect relation between the IPFH performances and the operational objectives. The most significant results are those which have a significant positive and direct effect on the performance indicators. These significant results which induce the desired and predetermined change of behaviour are at various levels of the experiences. The evolution of the performances of the IPFH is towards the referential of a good family health, that is the level of the desired progress through national policy.

Therefore we notice a perfect appropriateness between the IPFH performances and the national objectives in terms of FH as it is proved in table N°4 in annex.

The intervention of the IPFH lead to a chain of results the most relevant of which fulfill all the criteria. If the intervention of the IPFH enabled for example the implementation of mobilization actions these actions would lead to community involvement, which eventually helped achieve an increase in the demand and the knowledge improvement of the preventive measures.

This result appropriately fits in the framework of the objectives which are targeted at the national level. In other words, the experiences are the results which can bend the operational indicators in the good direction. In this particular case, all the IPFH results which were identified were proved to be achievements.

However, it is worth noting that the obtaining of the results in series is made up of a coherent dynamics of channelling and concentration of values which are the corner stone of the performances. This dynamics was made up of a certain way to apply the principles of planning, budgeting, coordination and management which were centered on the results (information system, QI, Coaching). It more specifically concerns the manifestation of some capacity of choice and coherent arrangement of tools, the appropriate use of the resources in order to

achieve the objectives of consensus. In other words, it is the capacity of setting up an efficient process which can perpetuate the experiences.

E- THE RESULTS AND GOOD MANNERS TO PRESERVE AND PERPETUATE.

By correctly looking into it, to perpetuate the experiences of the IPFH, it won't be a matter of a blind re-edition of activities, whether they were efficient elsewhere or before. Instead it would be a matter of giving to the actors of health development some abilities which they will use to focus their management on the results and show innovation and adaptation in time, space and taking into account the peculiarities of the social, cultural and economical environment. These abilities are appropriate to the good manners to preserve and perpetuate.
In the case of the IPFH, the analysis of the results through a backward method of step-by-step deduction helps understand that the necessary fields of knowledge to acquire the sufficient arrangement for the replication of the IPFH results are the following:

- The mastery of the concept and problematic of FH in Benin and in the Borgou/Alibori (analysis of the problems, diagnosis of the priority problems, definition of the needs, the determinants, the indicators and the operational strategies),
- FH planning and programming,
- The designing of a specific and adapted health information system,
- The execution of a FH program (activities integration, stocks and logistics management, continued quality insurance, IEC/CBC management and social mobilization),
- Horizontal and descending supervision,
- The assessment of a FH program,
- Management.

In fact the IPFH approach was based on the combination of all its assets through a powerful managerial capacity. Otherwise, in the Borgou / Alibori framework it was not a matter of lack of competences but certainly the lack of capacity to use together all the acquired knowledges, the available resources and the voluntary collaboration of health development in order to reach the desired and predetermined objectives.

F- RESULTS AND TARGETS

The good manners which appear as factors to perpetuate the results should be assimilated and used by the local actors of health development at various levels of the health pyramid, once they assimilate them.

The targets which should acquire these knowledges or fundamental approaches (Good manners) and which should know how to use them, are made up of the articulations of the health system; they are: i/ The MPH (DFH, HSDHZ, DPP, DRFM), the DDPH and its technical services, iii/ the zone offices, ZMT and the officials of health centers, iv/ the zone health committees, v/ the community organizations. On the other side, the target of the experiences is made up of the practitioners at various levels: Doctors, midwives, nurses, Doctors Assistants, CBHW and other technical services.

Now, it seems that the IPFH activities were integrated in to the practices of the ZMT, the health centers, the MMC : DMC and into the practices of the populations. At the periphery, we can think that the IPFH displayed a good performance in the five sections of intervention.
The consultations of the IPFH with the SSDHZ, the DPP and the DRFM resulted into training activities of the ZMT teams, the officials of the DDPH the DH under budgeting. However, the mutual introduction of a procedure of a budgetary management which grants the duties of the DPP and the needs of the health zones of reckoning the activities which condition their performance is not concretely shown. Moreover, it seems that the IPFH ignored the zone health committees which are the institutions of the system which should play an important role in the management policy at the peripheral level. It is worth noting that the program did not allude to private structures.

All in all: Either the appropriation principle defined in the ongoing perpetuation plan as a vital factor was not sufficiently clarified in order to be the basis of a methodical approach which takes into account all the steps of a well carried out appropriation. Or all the partners of the IPFH implementation did not understand these principles in the same way. Anyway, some of the aspects of the lacks of collaboration or communication reported in the interviews can be explained by this observation. There was a lack of a clear documentation or definition of the identification criteria of the good manners which result from the analysis of the appropriate experiences and an approach of identifying

the targets which bear the required conditions and capacities of assimilation. However, the process implemented by the IPFH, identified without clear distinction some interventions likely to lead to a perpetuation whose conceptual and methodological contours are not clear to some local partners or non consensual partners and which will necessarily lead the actors towards prejudicial misunderstandings. The use of a methodological approach to the analysis of the IPFH results, logically lead to distinguish:

- **the raw results** of the IPFH which resulted from the interventions,
- **the valid results** which fulfilled the criteria of relevance with the policies; norms, national strategies and the national FH objectives,
- **the significant results** which resulted from the assessment of the relevance of the valid results with the USAID objectives and the operational objectives. At this level, in the case of the Borgou and the Alibori three links in the results chains were drawn.
- **the experiences** are therefore all the activities, which, while inducing the availability and the use of the services, have an important influence on the health indicators. So they have a specific character. The impressive experiences at these three levels of results which were made by the IPFH are not magic formula to manipulate, everywhere and all the time. The defined activities and the expected results cannot be systematically replicated elsewhere (outside of the Borgou / Alibori for example) It is all the more true that to define its activities, the IPFH resorted to the QMAHS. The definition of specific activities depends on a continuous approach which is the situational analysis. In this situation where the experiences are relevant activities, the obtaining of performances from them calls on a know-how whose acquisition strongly depends on a certain number of personal, environmental and cultural knowledges and arrangements. The experiences (relevant activities of potential performances) are therefore a group of tools which are selected among others and which can be reproduced only in the specific conditions of their genesis. This are integrated into the institutional or ordinary practices. Their execution is a matter of specifications and too much more calls on praxis.

- **the good manners** come under knowledge and abilities which generate the capacity to lead a unit or system towards the desired results. The expression of these good manners depends on the capacity of assimilation, adaptation and innovation. It requires a spirit of designing and a more important resort to the cognitive. The targets of the good manners transfer are therefore decision levels. In the ongoing process, it seems that two values shall be transferred at various levels, the good manners and the experiences. Many targets were identified and the appropriate objects transferred. However some targets were not touched or perceived at the right time. This concerns the DFH, the SSHZD, the zone health committees.

Obviously, the process of appropriation helps to identify the values and establish in advance the most attractive chronological order for their transfer. In the case of the IPFH, it should have been more profitable to transfer first the knowledges of the good manners at the decisions levels before transferring the experiences. This is all the more necessary that the exercise is done in an environment where the managerial capacity is not enough. We easily understand the historical difficulties encountered in the DDPH.

3.3.3. THE STAGE OF TRANSFER IN THE PROCES OF THE ONGOING PERPETUATION

The stage of transfer requires training of the appropriate actors the acquisition of the good manners which give them the capacities, the ability (which will be improved through the transmission of the experiences) to use the available resources in order to achieve the predetermined objectives. We can consider that the IPFH is at this stage of perpetuation. It was facilitated through the existence of a perfect appropriateness between the concept of health zone as a decentralized unit which has a large working autonomy and the needs of autonomy in planning and management with a view to developing local initiatives.
The experiences which result from the results of a first implementation of the program imply, in order to ensure their continuation, a supplementary injection of resources which shall be autonomously budgeted. Once the good manners are transferred for a long time, they automatically determine a perpetuation competence. The fact these peculiarities were not differentiated constituted the origin of some confusion and omissions such as the lack of budgetary revision in order to maintain the experiences.

Never the less we realize that in this process the IPFH on the good way for an appropriate transfer of the required knowledges to the appropriate targets. The only problem will be how to cover the non-identified targets.
The regional extension to the non concentration zones is done in a situation of reducing the IPFH budget. Considering that the two zones have similar realities, it seems that it is necessary to know the necessary local supplementary needs to ensure the continuity at the right time.
The national extension of the IPFH could be envisaged by training at the DFH a national team which will be in charge of the perpetuation.

3.3.4. THE STAGE OF AUTONOMIZATION IN THE PROCESS OF PERPETUATION

Nothing makes it possible to imagine the possibility of the accomplishment of the autonomy because of the total lack of procedures, provident mechanisms and mechanisms of local resources allocation so as to ensure the sustainability of the experiences after the stage of the stage of transfer which ends in 2006. In fact, we realize the existence of a formalized peripheral budgetary procedure and a procedure of a balanced budgetary distribution or a distribution which privileges the local needs.
It is necessary to equip the MPH with the tools which will help it to plan the consolidation of the IPFH perpetuation by involving its technical services and its local partners in the designing of favorable conditions.
It is necessary to formulate the administrative stage of the budgetary management in the zones. Because of the requirements of the health system decentralization, the budgetary allocation is open to other funding sources. Other new budgetary in puts must be taken into account in the health zones in the funding of the activities. This supposes a necessary clarification of the process of budget allocation so that the elaboration of an estimated budget largely takes into account the various sources of funding. Well, obviously there is a shift of the context of financing health cares whose motive is based on equity, efficiency and perpetuation. So, apart from the Government budget, the funding of the national NGO, foreign assistance (institutional organs, cooperation and assistance agencies), the contribution of the populations (community funding of the type IB) the contribution of local initiatives and the municipalities contribution which have the right to work together with the government for social health development[1] must be considered.
The ministerial letter N°7556 of 9/22/2003 on regulation of the contribution of the community funding for the running of the DDPH and

[1] (Chap 3 art 82, Law N°97-029 of January 15th , 1999 on municipalities organization in RB)

the organs of peripheral management open a systematic approach for the funding of the health zones whose contours are unknown. In terms of budget planning the IPFH hit a real obstacle which the trainings which were organized did not tackle.
Obviously the attempt of systemic harmonization of the plans of action which were budget in 2002 could not succeed because the imperative of submitting Government budget to the National Assembly comes before the local preoccupations. It does not seem that the difficulty is primarily due to management competence. There is a problem of how the resources, the systemic harmonization of the procedure of budget allocation which takes into account the peripheral priorities (ascending budgeting) are mastered. Moreover, the IPFH when trying to solve this problem omitted an important and target which is the zone health committee which is considered as an entity.
The resolution of this problem of "budget management which is centered on the results" concerns the SSHZD, the DPP, the DRFM, the DDPH and the zone heath committee.
In the framework of perpetuation some hypotheses remain and therefore must be mastered: the financial means (local), the means in terms of material and human resources in order to ensure the maintenance of the results over a long term through the replication of the relevant activities and the leadership of the actors.

3.4. THE FACTORS WHICH CONDITION THE ACHIEVEMENT OF THE EXPERIENCES

The analysis of the factors which lead the experiences helps to find out that the IPFH achieved its objectives in the Borgou / Alibori through:

- **the use of a knowledge and more than a knowledge**, a know-how in terms of the capacity to improve the output of a health system by privileging the achievement of the results. The ways which here prove their efficiency are based on the observation, adaptability, innovation, coherence, relevance and the achievement of the free participation of the populations.
- **The setting up of a system in the intervention zone in order to carry out the specific and relevant activities** in the concentration zones and to replicate them in the non concentration zones.
- **The injection of supplementary resources (IPFH)** in order to maintain the results over a short term (personnel, equipment).

3. 5. THE EXPERIENCES AND ANALYSIS OF THE CRITICAL POINTS

3.5.1. ANALYSIS OF THE BENEFICIARIES SATISFACTION

The appreciation of the beneficiaries satisfaction helps to get at all levels the opinions about the results which were obtained in order to facilitate their replication. Here, the beneficiaries satisfaction is ordered into five decreasing levels. The appreciation is quantified through a score which varies from one to five in decreasing order. It is :

- Very good, when the score is one or two;
- Good, when the score is three or four;
- Enough, when it is five.

The interviews carried out with the DFH, the DDPH, the ZCD, some community members and partners helped us appreciate their satisfaction by taking into account the above described scale and the Table N°6 in annex.
Their strongly mutual appreciations of each component indicates the good knowledge they have of the program and the interest they have over the results.
In fact, they agree to give a very good appreciation of the IPFH as regards planning, coordination, increase of the access to quality family health services (minimum package, logistics, QI), improvement of the capacity to provide quality family health services (training, tutorship), reinforcement of knowledge and favorable behaviors in order to use the Family Health services and products.
The health development actors agree to give a good appreciation of the IPFH in terms of reinforcement of favorable knowledge and behaviors towards the preventive measures and the involvement of the community in the planning of services provision.
In terms of community involvement in the planning of preventive measures, the action of the IPFH is considered as a good one.

In general the beneficiaries at various levels are satisfied with the experiences of the IPFH. However, as regards some experiences, our interlocutors are unanimously convinced that their perpetuation will not be easy. Some critical points result from this situation.

3.5.2. THE ANALYSIS OF THE CRITICAL POINTS.

This concerns the aspects which are related to the experiences which can bump into some obstacles.

A) THE ISSUE OF COLLABORATION OR DIFFICULTY OF TRANSFER IN THE DDPH

The data collected from the interviews and the documentation review seem to show a difficulty of collaboration between the DDPH and the IPFH team in spite of the activities which are however carried out together, according to the content of the activities report (IPFH 2000).
Given that the IPFH transfers to the DDPH the mechanisms for the continuation of the activities which were undertaken, this situation could be prejudicial to the quality of the appreciation, the good manners to be preserved and continued. According to the decree N°2000-164 of March 29, 2000 on the attribution, organization and running of the MPH, in its article 49 and 50, it is not a mistake to think that the DDPH could play this role.

However, considering the importance of its attributions and the present requirements of the health zones management, it seems that the DDPH could not play this role if it is not supported, in spite of the present involvement of similar services in the process. There lies a difficulty the origin of which can be found at various levels:

- The DDPH actors lack a consensus on the very concept of perpetuation which was not clarified anywhere,
- the DDPH did not assimilate at the right time the principles which it should have in order to ensure the IPFH perpetuation. But, we know that during the last epidemy of cholera, the Ministry of Public Health made some rigorous recommendations by firmly stating that nobody should die from the disease and the DDPH tried with all its effort to abide by the recommendations. We can think that it could play the role which was given to it in the context of the IPFH. Now, the setting up of similar services during the transitory stage helps expect that the transfer will be carried out.
- Moreover, we must not neglect the objective difficulty of the DDPH to meet other requirements especially in terms of personnel management and the provision of financial and material means in order to secure the maintenance of the IPFH significant results. It seems that the government personnel administration follows some norms and procedures

which would not facilitate decision making. The needs in the program equipment for the coming years are not likely to be financed by the local resources. At least the issue is not clarified. It is also worth noting that the DPP and the IPFH / DDPH shall get a consensus on the notion of ascending planning and therefore gather their efforts so that there exists an amalgamation of the central approach of budget planning and the peripheral ascending approach. Otherwise, the DDPH could be the victim of many misunderstandings.

In actual fact, in the perpetuation context, the DDPH encountered two imperatives:

- The assimilation of the competences in order to keep promoting the IPFH via the health zones which now display a good capacity of reception. We suggest that the technical service of the DDPH such as the SSPD, SHPP, SFH, the IEC /CBC service and the SNOC quickly appropriate competences in order to play their normative role. It is worth noting that since the strategy of the similar services, chances are that at the end of the process this transfer of technical competences is done as it should. The similar services which were selected have the will to which they can join the capacity.
- The consolidation or autonomization of the perpetuation raises some financial problems whose resolution is beyond the competence of the DDPH and requires a more serious involvement of the Ministry of Public Health (especially the DPP). A serious problem of training and systemic harmonization of the budgetary procedures which privileges the local needs and takes into account the validity of the budget management of the health zones is raised.

At the moment, it is very necessary to try to know from now the needs of the Borgou and the Alibori in terms of equipment, personnel in order to continue carrying out the relevant results generating activities.
It is also worth mentioning that in terms of transfer, the IPFH always displays an effort in the research of the most appropriate working term in order to achieve the objectives. It is the case of similar services transfer.

B) PARTNERSHIP

The partnership with some institutions (BAFP, PROLIPO, PSI, INTRAH PRIME II) was very useful in the process of the IPFH implementation. However some misunderstandings were raised and seemed to come

from the fact that the collaboration agreements were not clear. For the continuation of the activities, it would be important to improve the collaboration. Apart from that, the interest of the collaboration lies in the integration of efficient strategies which constitute short circuits which help to quickly achieve the objectives which are usually hard to achieve. This is about infantile mortality (ICTCD for PROLIPO and PSI), maternal and neonatal mortality (EONC for INTRAH PRIME II), the reduction in HIV / AIDS transmission and the contraceptive prevalence (PSI).

PROLIPO and INTRAH PRIME II: The strategies implemented by PROLIPO and INTRAH PRIME II right away favor the perpetuation. The two programs will be at every time necessary in the stage of appropriation and the transfer of competences. The experience is the integration of efficient strategies. The collaboration with the BASICS is part of the same framework and brought a minimum package of Nutrition activity which is integrated into the services.

BAFP and PSI: The partnership with the BAFP and the PSI lies in the research of a synergy of actions in which the IPFH looked for the consolidation of a continuation of logistical services which favors the extension of the others activities. We can keep in mind that it is the principle of synergy which is highlighted in this partnership.

WORLD EDUCATION: The collaboration with World Education was part of the activities integration of HIV / AIDS prevention in the field of an institution expertise. In the present case, it helped the IPFH promote the activities of HIV / AIDS prevention for teenagers and their parents. This is the principle of opportunity valorization. This principle seems to have guided the collaboration with the CRS, WHO, UNICEF and MCDI.

CARE / ROB: The collaboration with CARE / ROBS, a network of NGO_S, helped the IPFH start the promotion of social mobilization.

PSS / PBA: The collaboration with the PSS and the PBA is centered on consultation and concepts harmonization in the context of the functioning of the health system.

UNFPA: The collaboration with the UNFPA is based on complementarity. It will be very useful in the whole context of perpetuation and in particular in the context of the maintenance of the relevant activities and efficient results of the IPFH. Given that Malanville and Bembèrèkè are the UNFPA concentration zones in its sixth program, a collaboration which is based on complementarity would make easy and efficient the

continuity of the family health activities. Provided the specific needs of the continuity are well identified. Because the UNFPA has planned its intervention on accurate knowledge of RH services provision and demand, the chance that there exists a budgetary availability likely to reduce the budgeting of the continuity is very high for Malanville and Bembèrèkè.

ALL IN ALL: From the partnership we keep in mind many principles which will be preserved. This is the principle of: i/ efficient strategies integration ii/ search of synergy, iii/ opportunity valorization, iv/ social mobilization, v/ consultation for concept harmonization with the partners, vi/ complementarity.

C) THE ISSUE OF THE MOBILITY OF THE TRAINED HEALTH WORKERS

At the present state of the perpetuation, the mobility of the health workers seriously prejudices the capitalization of the competences in favor of the experiences preservation and continuation.

To do so, the extension of the same experience to all the departments becomes necessary as a mid-term solution. In fact, it is difficult to block the mobility of the civil servants and the competences which are sensitive to the signals of well-being.

It does not seem certain that the promotion of local authorities favors stabilization. It would be more efficient to promote at the level at the national authorities who have position or who must be promoted to positions, responsibilities in the field of family health , the mastery of good manners. This presupposes the relevance of the IPFH extension all over the county for national performances and the maintenance of the departmental experiences beyond the competences mobility reasons. It is worth underlying that mobility also affects the MMC / DMC since most of those who acquired the competences became local leaders in the IPFH concentration zones. At this level, the principle of training the new comers must be maintained. That is why the local training and refresher courses teams are of a vital relevance and vital in terms of perpetuation.

D) THE PROBLEMATIC OF COMMUNITY INVOLVEMENT

The strategy of the CBS is a success for the IPFH since it helped significantly increase the access to FH services for the local population. However this strategy shows a thorny problem of its perpetuation because of the motivation of the CBHW (wage and career management) and the perception that the populations have their normative limits.

In the field, we notice the loss of the CBHW for various reasons (their services contract is not honored by the population, going away for a training, abandonment due to embezzlement of services funds … etc). This situation is of great concern because few VHU work while this strategy is the only one which now shows evidence of efficiency. In order to avoid loosing this experience in a near future it would probably be better to take the risk of hiring nurses so that they cumulatively play with their capacity the role of the CBHW.

Moreover, the IPFH involved the MMC / DMC in its implementation process, but we realize the total inexistence of the relationship with the health committee which is the guarantee of the health policy in the areas. If it is true that the IPFH did not extend its action to the health committee which is an important organ for the health system articulation in the local population, on the other hand it paid a particular attention to the acquisition of good manners, the performance of MMC / DMC and the VHC.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION ET RECOMMANDATIONS

I - CONCLUSION

The notion of perpetuation therefore requires the assimilation of some principles and the capacity of production and autonomous re-edition of values which result from their implementation.

From this survey we keep in mind some important points.

1. The perpetuation process does not seem to have been taken into account from the very beginning of the program. As a consequence, the perpetuation faces difficulties at several levels; i/ achievement of a consensus on the concept, ii/ budgeting and autonomous funding for the maintenance of the results, iii/ institutional mechanism for the concerted management of the perpetuation.

2. The analysis of the appropriation mechanism which is implemented shows the following points:

   a - After analyzing the IPFH activities, it is easy to realize that its action essentially consisted in reinforcing the action essentially consisted in reinforcing the managerial capacities of the actors of the health system in terms of its activities in the Borgou / Alibori. We can keep in mind that the field of Knowledge and the Know-how which we had to get the participants to acquire is that of the capacity of using the required competences in planning / FH program management, social communication / mobilization / IEC / CBC, partnership management. (integration, synergy, opportunity, social mobilization, consultation, concept harmonization with the partners, complementary); as well as the health system management. In this regards it would be hard to draw an exhaustive list of the interventions that the management would involve. They are dictated by the specificity of the problems stated by the surveys progressively carried out, on a large or small scale (MQAHS, KAP, routine assessment).

   b- The partnership appears as a major opportunity in the context of the progressive autonomization, in the acceleration of the improvement of the indicators, in FH services coverage and the involvement of the cal population. In the framework of partnership management, the IPFH in collaboration with the DDPH initiated a consultation framework which will be very useful for the performance of the zone.

c- The action of the IPFH resulted in the increase in the family health services in the Borgou / Alibori departments, the extension of the health coverage, the autonomy in the training of the health professionals, the capacity of planning and management in the health zones, the reinforcement and motivation of the communities for their participation in the management of the municipal management committee (MMC/DMC, the change of behaviors of the communities with regard to health practices.

d-The results have been achieved thanks to the identification of relevant and efficient activities. These activities are: i/ training, ii/ the implementation of a supply system which minimizes the shortages, iii/ designing of technical norms and protocols, iv/ integration of the minimum package of family health services (FP, PNC), v/ child health, vi/ IEC / CBC, STI / HIV / AIDS prevention.

3- The perpetuation lies in the assimilation of the good manners which were used by the IPFH during the implementation of the program and the preservation of the experiences. As regards the ZMT, we notice a sufficient capitalization of the competences to secure the continuity of the activities at the end of the transfer period.

4-Nevertheless, there are some difficulties which are likely to hinder the replication of the IPFH performances. These difficulties are essentially the mobility of the trained health personnel and the problem of motivation and the career management of the CBHW.

5-Apart from these critical points, the heavy hypothesis which darkens the possibilities of perpetuation is the difficulty to mobilize the local resources in order to secure the sustainable continuity of the experiences.

It is then worth remembering that the IPFH has therefore succeeded in giving in the Borgou, the example of the systemic setting to work of a health zone which has shown its capacities to favorably influence the peripheral health indicators essentially in terms of FH. Therefore this assessment shows that the perpetuation process started is likely to result in the transfer of all the good manners which can perpetuate the IPFH experiences. The question which remains an unanswered is that of the autonomization of the process of perpetuation.

II - RECOMMENDATIONS

The critical points give the opportunity to highlight the aspects of the process of perpetuation which require a particular attention at the present stage and to suggest some solution or valorization points.

1-The transfer of managerial competences (good manners) to the DDPH is vital to the devolution of the program.

2-The advantages of the partnership deserve to be privileged, in relation to the difficulties of collaboration which sometimes set themselves on relations whose motive has always been related to communication and therefore vulnerable.

3-The consequences of the mobility of the competences could only be lessened through the regional and national extension of the IPFH and the preservation of an endogenous training capacity and the monitoring of new competences.

4-The professionalization of the job of CBHW could be a valid means to perpetuate this efficient strategy in order to reach the beneficiaries. This is an advanced strategy that can be improved and introduced in the training curriculum of the, assistant nurses. These nurses during their training could benefit from a transfer of competence in terms of community ICTCD and EONC with a view to integrating them into the practices of the populations.
These nurses who have preliminary technical competences in terms of preliminary efficient assistances technical competences as regards nursing or obstretical will make effective, at the peripheral level, the valorization and use of the FH services, the products, the involvement of the community in the preventive measures. In this context, this body will have the competence to conduct if need be, cumulatively, the functioning VHU and the health system will be made efficient on the periphery, regardless of the existence or not of infrastructures (VHU). This will be the body of competent community based health workers.

From the ongoing process of perpetuation we keep in mind that it successful end essentially depends on:

1-The transfer of the good manners and the preservation of the current experiences of the IPFH in the regions of its experimentation.

2- the extension of the transfer of the good manners and the promotion of the relevant and efficient results in terms of FH to the non concentration zones of the IPFH and to the other departments.

3- the consolidation or autonomization of the perpetuation lies in:

- The securization of funding especially the budgeting of the resources necessary for the preservation of the experiences. This requires a clarification of the procedures of allocation and budgets adoption.

- The reinforcement of the DFH capacities to perpetuate the IPFH in the other departments and ensure the monitoring, assessment and the requirement of the results in the DDPH and its technical services and indirectly in the ZMT.

4-The dynamization of the peripheral partnership the a view to alleviating the funding weight of the expenses immediately incurred because of the perpetuation in order to promote a progressive consolidation. That is a national autonomy of gradual funding and a continuity of the preservation of the experiences.

5–The efficient running of the management bodies of the health zones especially the ZMT and the zone health committee. It is worth recommending that the principles of ascending priority planning be institutionalized because these are the bodies which secure the experiences consolidation.

6- Stabilization of community mediation to ensure in the local populations the advantage of community based services (CBS)

To successfully carry out the ongoing perpetuation, each partner or group of partners can contribute.

1- The MPH

a. The DPP is invited to actively contribute to the clarification of the allocated mode of the share of the national budget to the health zones. What would be important to defend would be the spirit of equity which would allow a supplementary budgetary allocation after the inputs of community funding, local initiatives, NGOs and foreign partners have been defined. The DPP, in collaboration with the DRFM and the SSHZD will have to set up a procedure for the elaboration of the budget which meets the ZH priority needs.

b- The DFH shall play its role of supporter for the implementation of the FH programs and its results requirement prerogatives. It has been agreed upon during the restitution workshop that the DFH will be in charge of the analysis of the recommendations which are related to the issue of the CBS and to provide the most appropriate solutions to this issues. The third goal of the plan of action is submitted to the technical appreciation of the DFH and the SSHZD for decision making and approaches which can help solve this problem.

c- The DDPH shall set up one consultation framework for external partners and another one for the local partners. It shall update a repertoire of the intervention and funding needs from the budgeted plans of action. It shall also make dynamic the running of the ZMT and the zone health committees running in which are the representative of the financial backers and the representative of the local NGOs.

2- **The USAID** is invited to finance the series of surveys necessary for decision makings in favor of a good perpetuation (assessment of the need in terms of the experiences preservation) and the capacities reinforcement in the DFH.

3- The IPFH team is invited to finalize the good manners transfer in the Borgou and the Alibori and to contribute to the national competences reinforcement which must make up an autonomous team for the IPFH perpetuation.

As a national framework for the monitoring of the implementation of the scheduled interventions we propose the monitoring committee of collaboration with the USAID (the IPFH team, USAID, INTRAM PRIME II, DFH, DPP, DRFM, SG the concerned DDPH, NDHP, SSHZD). It is necessary that the DFH be the first chairperson of the committee.

Finally we which that in the future, the IPFH could intervene in other zones independently from the deployment of a similar national team set up, deployed at the some time by the MPH with a possible support of the USAID. This team can serve the SSHZD overall objectives and the DFH specific objectives.

PLAN OF ACTIONS

PLAN OF ACTIONS

Considering the results of the survey, it is to be recommended that the IPFH takes there imperatives into account in the ongoing perpetuation process: i/ the funding of the experiences maintenance in the concentration zones and their replication in the non-concentration zones, ii/ the IPFH perpetuation in order to extend it to the other departments, iii/ the issue of the career of the CBHW.

I- THE CONCENTRATION AXIS OF THE CONSOLIDATION ACTIONS

The must difficult axis on which all the uncertainties of the IPFH perpetuation are concentrated is that of consolidation. The most immediate actions must aim at the identification of the needs in terms of consolidation and the setting up of a mechanism for local resources mobilization. A plan of action would facilitate the management of such a mechanism.

AIM :
Achieve the conditions of a complete perpetuation of the IPFH in the Borgou / Alibori up to December 31st, 2006.

ACTIVITIES
1- Assessment and budgeting of the needs in terms of necessary resources (equipment, financial and human) in order to secure an effective consolidation of the IPFH. It is important to mention that this assessment must take into account other partners's programs which are already being carried out. It will be financed and carried out by the IPFH. (August – September 2004).

2 – Analysis of the budget for the consolidation of the IPFH perpetuation by the MPH and its technical services (DPP, DHR, SSHZD). This analysis aims at determining the amount of money the national budget must allocate for the funding and the period of allocation. The IPFH / DDPH will submit this project document to the MPH in October 2004. the possible expenses will be covered by the MPH.

3- Analysis of the budget for the consolidation of the IPFH perpetuation by the health zones committees. This analysis aims at determining the amount of money the community must consolidation. The project document will be submitted by the IPFH /DDPH in October 2004.

4 - Study and compilation of the zone committees suggestions by the DDPH and the zone coordinators. This final document will be submitted to the MPH by the IPFH/DDPH in November 2004.

5- Holding of a national workshop on the planning of the IPFH perpetuation (Plan, budget, funding, activities chronogram). This workshop will be held by the MPH in December 2004 and will gather the USAID, the IPFH, the DDPH, the zones committees, the zone coordinators, development partners who are already operating in the Borgou / Alibori (PSS, PBA, UNFPA etc.)

6- From January 2005, the implementation of the consolidation of the IPFH perpetuation by the DDPH. The monitoring of the execution will be secured by the DFH, the DPP and the SSHZD.

II - THE AXIS OF REINFORCEMENT OF THE DFH CAPACITIES IN TERMS OF FAMILY HEALTH PROGRAMS MANAGEMENT

AIM : Set up a national team at the DFH in order to reinforce the DFH capacities with a view to extending the IPFH perpetuation all over the country.

ACTIVITES:

1 - Census taking of the existing competences and training of the national team for the IPFH perpetuation (IPFH / January 2005).

2 - Assessment of the needs in terms of competences and FH supply and demand in the other departments of Benin (USAID/ February – June 2005).

3 - Definition of the institutional mechanism for the implementation of the IPFH national extension program (IPFH / DFH / February 2005).

4 - Elaboration of the training modules and the national extension plan of the IPFH perpetuation (IPFH / DFH / April 2005).

5 - Elaboration of the budget for the implementation of the national extension of the IPFH perpetuation (IPFH / DFH / April 2005)

6- Elaboration of the implementation schedule (IPFH/DFH/April 2005)

III- THE AXIS RELATED TO THE PROFESSIONALIZATION OF THE CBS IN TERMS OF FH.

AIM : Analysis of the conditions of integration and validation of a professionalization process for the implementation of the CBS.

ACTIVITIES

1 - Analysis of the terms and conditions of integration and the content the training modules in terms of community based services in the health nurses training centers for the emergence of a body of competent nurses working in the local communities (DFH / USAID / May – June 2005).

2 - Drafting of a training program for competent health nurses who working in the local communities (DFH / USAID / July – August 2005).

3 - Implementation of the program (DFH / USAID / October 2005).

REFLECTION WORKSHOP ON THE RESULTS OF THE ASSESSMENT AND THE STRATEGIES FOR THE IPFH

THE EXPERIENCES WHICH MUST BE PERPETUATES : WITHIN THE IPFH EXPERIENCES

PERPETUATION PLAN OF ACTIONS, ROLES AND RESPONSIBILITIES OF THE DIFFERENT PARTICIPANTS

HOW TO SECURE THE FUNDING OF THE CONTINUATION OF EFFICIENT ACTIVITIES.

REFLECTION WORKSHOP ON THE RESULTS OF THE ASSESSMENT AND THE STRATEGIES FOR THE IPFH PERPETUATION (July 9, 2004).

After the results of the assessment have been presented at the workshop, some clarification questions were asked to the consultants which they answered. There were also some contributions to the understanding of the different aspects of the notion of perpetuation. In order to set up a strategy to perpetuation the IPFH experiences and seek a consensus, an outline, which describes about ten centers of interest, was suggested and made available to the participant in order to facilitate the reflections on the perpetuation strategies.
After the release of the results, three work groups were set up to discuss the four most important centers of interest selected out of the ten suggested in the outline.
The plenary session review of the consensus findings from the different work groups and their validation helped achieve the following important conclusions: The list of the IPFH experiences to be perpetuated was accepted and approved. A plan of actions for the perpetuation was adopted clear cut interventions, and the roles and responsibilities of the different participants were determined. Finally the list of the secured funding sources of the activities of perpetuation was adopted. From the heated debates of the plenary session on the results which were presented by each of the three work groups, the following consensual points emerge:

The experiences to be perpetuated: what is to be perpetuated as far as the IPFH experiences are concerned.

GOOD MANNERS AND EXPERIENCES	**CONCERNED LEVELS**
GOOD MANNERS	
MQAHS /QAAP	DDH / HZ
Data use for decision making	HZ / HC
Quarterly review of the plans of action	HZ / DDPH / HC
Quarterly review of the performance indicators	HZ / HC
Definition of the priority performance indicators (list of indicators)	HZ
Weekly meeting	DDH
Systematization of the approach of formative supervision ant its frequency	HZ
Daily integrated provision of FH services	HC
Introduction and use of the QI approach	HC / ZH / DHC
Systematization of the post training monitoring	HZ / DDH
Dissemination and monitoring of the norms application	HC
Reinforcement of the community structures capacities	HC/ COM
Community partnership: involvement in decisions making and management	HC / COM
EXPERIENCES	
Training of the pool of trainers	DDH / HZ
Methods of supervision	DDH / HZ
Tutorship: training through practice and on the site	HC / HZ
Setting up of the CBHW network	HC / COM
Availability of pocket – looks	HC
Availability of training curricula	DDH / HZ
Availability of IEC / CBC and computer science equipment	HC /HZ /DDH
Harmonization and use of the procedures of order and supply	HC / HZ
Setting up of medical and technical equipment in the HC	HC
Harmonization and use of the procedures of ascending management and planning	COM / HC / HZ / DDH
Favorable knowledges and attitudes for the promotion of FH	COM

DDH = Departmental Direction of Health ; DHC = Departmental Hospital; COM = Community;
HC = Health Center;
HZ = Health Zone; ZH = Zone Hospital.

PERPETUATION PLAN OF ACTION, ROLES AND RESPONSABILITIES OF THE DIFFERENT PARTICIPANTS

CONSENSUAL PLAN OF ACTIONS

AIM	INTERVENTIONS	INDICATORS	Responsibilities, roles and period	CHRONOLOGY																	FUNDING
				A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
Achieve the conditions for a complete perpetuation of the IPFH in the Borgou/Alibori up to December 31,2006	1 – Assessment and budgeting of the needs in terms of equipment, financial and human resources necessary for the perpetuation	REPORT	MPH : achievement/USAID : financial and technical assistance October-November 04			X	X														MPH
	2 – Analysis of the consolidation budget for the IPFH perpetuation by the central services of the MPH and its technical services (DPP, DHR, SSHZD	REPORT	MPH December 04					X													MPH
	3 – Analysis of the consolidation of the IPFH perpetuation (Plan, budget, funding, IPFH activities chrono-gram) by the health zones committees	REPORT	DDPH December 04					X													MPH

	4 – Study and compilation of the zone committees suggestions by the DDPH and the zone coordinators	REPORT	DDPH February 05							X											MPH
	5 –Holding of a national workshop on the planning of the consolidation of the IPFH perpetuation (plan, budget, funding, activities chronogram	REPORT	MPH April 05									X									MPH and partners
	6 - Implementation of the consolidation of the IPFH by the DDPH from June 2005	REPORT	DDPH-DFH/SSHZD											X							MPH
Set up a national team at the DFH in order to reinforce the DFH capacities with a view to extending the IPFH perpetuation all over the country	1 – Definition of the institutional mechanism for the implementation of the IPEH national extension program (January 2005)	REPORT	MPH						X												MPH and partners
	2 – Census taking of the existing competences and training of the national team for the IPFH perpetuation (February 2005)	REPORT	MPH							X											MPH and partners

	3 – Assessment of the needs in terms of competences and FH supply and demand in the other departments of Benin (March 2005)	REPORT	MPH								X										MPH and partners
	4 – Documentation of the good manners and elaboration of the training modules and the national extension plan of the IPFH perpetuation (April-Sept 2005)	Module	DFH									X	X	X	X	X	X				MPH and partners
	5 – Elaboration of the budget for the implementation of the national extension of the IPFH perpetuation (April-May 2005)	REPORT	DFH/DDPP									X	X								MPH and partners
	6 – Elaboration of the implementation schedule (October-November 2005)	schedule	DFH															X	X		MPH and partners
	7 – Implementation (January 2006)	REPORT	DFH																		MPH and partners
Analysis of the conditions of integration and validation of a professionalization process for the implementation of the CBS	Analysis of the terms and conditions of integration and the content of the training modules in terms of community based services in the health nurses training centers for the	REPORT	DFH/SSHZD										X	X							MPH and partners

	emergence of a body of competent nurses working in the local communities (DFH/USAID/May-June 2005)																				
	Drafting of a training program for the competent health nurses who are working in the local communities (DFH/USAID/July-August 2005)	REPORT	DFH/SSHZD												X	X					MPH and partners
	Implementation of the program (DFH/USAID/October 2005)	REPORT	DFH/SSHZD															X			MPH and partners

HOW TO SECURE THE FUNDING OF THE CONTINUATION OF THE EFFICIENT ACTIVITIES

Before releasing the secured funding sources of the activities of the IPFH experiences perpetuation, the group highlighted some preconditions deemed indispensable for the achievement of conditions that will help to take into account the financial partners and their commitment in order to appropriately carry out the Ascending Process of Planning (APP), viz :

- Respect of the deadlines
- A clearly expressed political will,
- The appointment of the a manager (in order to facilitate mobilization and outlay of public funds),
- The organization in the department of a fair/an arbitration to attract and commit the financial partners at a yearly rate.

The secured consensual funding sources agreed upon and validated in the plenary session by all the participants are :

At the central level

- The National Budget (NB), which can be obtained through :
    - the projects and programs,
    - the delegated credits,
- Bilateral partnership and
- Multilateral partnership

At the intermediary level

- The National Budget (NB) which can be obtained through :
    - Projects and programs,
    - Delegated credits,
- Bilateral partnership and
- Multilateral partnership
- Community funding in the health Zones
- NGOs financial contributions

At the operational level

- The National Budget (NB) which can be obtained through :
    - Projects and programs,
    - Delegated credits,
- Local communities financial contributions (Municipality Budget),
- Towns Twinning resources,
- The financial contributions of the partners and NGOs,
- The financial contributions of the development associations,
- The financial contribution of good will people.

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CONTENT	

TABLE 1 : IPFH'S RESULTS

FIELD OF THE IPFH'S INTERVENTIONS	SUB-COMPONENTS	RESULTS	
		LEVELS	NATURE OF THE RESULT
Improvement of planning and coordination	Planning	DDPH	- Performance in term of planning (plan of actions, assessment, Monitoring, training, IEC/CBC) [=competences reinforcement in terms of planning]
		HZ	- Performance in terms of ascending planning
		Community	- Performance in terms of elaboration of Community plan of actions
	Coordination / management	DDPH	- Performance in terms of FH products order management - Reinforcement of the capacities in coordination and management (budgeting, equipment, infrastructure, logistics…) - Equipment reinforcement = reinforcement competences in coordination and management

		HZ	- Performance of the ZMT in the health centers supervision - Performance of the ZMT in the execution of the planned activities - Reinforcement of the main capacities in management - Training of the teams of trainers and tutors by health zone. - Equipment reinforcement - Reinforcement of the community-health services partnership
		Community	- Participation in setting to work of the CBHW - Participation in setting up QI teams - Improvement of Communication with the Community through teaching how to read and writes in local language - Reinforcement of the Community-health services partnership.
Increase in the access to FH services	Improvement of the quality of the services	DDPH	- Performance in coordination, monitoring and control. - Performance of the technical services in results

			supervision and analysis (FHS, SNOC…) - Performance in the management of health information system
		HZ	- Reinforcement of the capacities in ZMT, ZH, MHC, DHC, VHS, CBHW management (training, planning, PMA integration, Health Information System, Supervision, list of indicators) - Reinforcement of the health workers competences tutorship, ICTCD, EONC, Contraceptive technology, Supervision of the healthcares management) - Setting up of the teams of trainers and tutors in each zone - Elaboration of training curricula - Training of the health workers and community actors (MMC, DMC, CBHW) in local languages - Reinforcement of the equipment (vehicule, computer equipment, medical and technical

			material and training material) and repairs of infrastructure - Efficiency of the partnership between health centers and MMC/DMC - Coverage in CBS - Improvement of families and community's knowledge in FH - Availability of the minimum package of FH services and products - Implementation of the process of QI (Team problems solving).
		Community	- Efficiency of the partnership between health centers and MMC/DMC - Coverage in CBS - Improvement of families and community's knowledges in FH - Improvement of communication through teaching of how to read and write in local languages

Improvement of the capacity to provide quality services	Training	DDPH	- Definition of the minimum package of FH services - Elaboration of the plans of curricula and training instruments - Training of the teams of trainers - Orientation of the HZ in QI - Reinforcement of the training equipment
		HZ	- Reinforcement of the capacities in ZMT, ZH, MHC, DHC, VHU, CBHW management (training, planning, PMA integration, Health Information System, supervision, list of indicators). - Reinforcement of the health workers competences (tutorship, ICTCD, EONC, contraceptive technology, supervision of the healthcares management) - Setting up of the teams of trainers and tutors in each zone. - Elaboration of the training curricula - Training of the health workers and community actors (MMC, DMC, CBHW)

			in local languages. - Reinforcement of the equipment (computer and training equipment)
		Community	- Efficiency of the partnership between health centers and MMC/DMC - Coverage in CBS - Improvement of families and Community's knowledges in FH - Improvement of communication through teaching how to read and write in local languages - Training of the community actors (MMC, DMC, CBHW) in local languages - Reinforcement of the communities' aptitudes (Community ICTCD and EONC).
Reinforcement of the knowledge and behaviors favorable to : Use FH services, Products, preventive measures	Information, Education, Communication Communication for change of Behaviour Social mobilization	DDPH	- Reinforcement of the capacities in IEC/CBC and social mobilization technique
		HZ	- Reinforcement of the capacities of the ZMT in IEC/CBC and social mobilization techniques

			- Development of communication strategies in FH (IEC/CBC) by the ZMT (local radios, popular and traditional media, IEC supports to the CBHW, health notebooks, leaflets, hoardings…) - Coverage in CBS - Reinforcement of the communities' aptitudes in FH (Community EONC/ICTCD…)
		Community	- Coverage in CBS - Reinforcement of the communities' aptitudes in FH (community EONC/ICTCD…)
Involvement of the community in the services provision planning, and preventive measures	Social mobilization Information, Education, Communication Communication for change of Behaviors	DDPH	- Reinforcement of the capacities in IEC/CBC and social mobilization techniques.
		HZ	- Reinforcement of the capacities of the ZMT in social mobilization techniques. - Development of communication strategies in FH (IEC/CBC) by the ZMT (local radios, popular and traditional media, IEC

			supports to the CBHW, health notebooks, leaflets) - Coverage in CBC, Reinforcement of communities' aptitudes in FH (Community EONC/ICTCD).
		Community	- Development of communication strategies in FH (IEC/CBC) by the ZMT (local radios, popular and traditional media, IEC supports to the CBHW, health notebooks, leaflets) - Training of the community actors (MMC, DMC, CBHW) in local languages - Involvement of the MMC, DMC in health development - Coverage in CBS - Reinforcement of the communities' aptitudes in FH (Community EONC/ICTCD) - Development of income generating activities - Involvement of village associations and NGOs

TABLE 2 : RELEVANCE REPORT BETWEEN THE HEALTH POLICY AND IPFH'S RESULTS

COMPONENTS	SUB-COMPONENTS	RESULTS	OBJECTIVES OF THE HEALTH POLICY	CORRELATIONS
Improvement of planning and coordination	Planning	- Reinforcement of the competences in planning and management of health programs (DDPH, ZMT, MHC, DHC, VHU, MMC/DMC, Community). - Reinforcement of the partnership (Financial Backers, Health development actors, Community, Government). - Reinforcement of the logistics	Improve community participation and the use of the health services : reinforcement of the capacities in planning and management.	Perfect
	Coordination			
Increase in the access to FH services	Improvement of the quality of the services	- Reinforcement of the competences in QI - Availability of the FH services according to the norms at various levels of the health system. - Reinforcement of the capacities of providing services valorization of the RH services with the beneficiaries	Improve the quality of and accessibility to health services	Perfect
Improvement of the capacity to provide quality services	Tanning	- Reinforcement of the capacities of planning and execution of	Improve the quality of and the accessibility to health services	Perfect

		trainings - Reinforcement of the competences in FH services. - Reinforcement of the capacities of the population to change their behaviors		
Reinforcement of knowledges and behaviors favorable to : use the FH services, products, preventive measures	Information, Education, Communication Communication for changing behaviors. Social mobilization	- Development of the performances in FH IEC/CBC, social mobilization	Improve the quality of and the accessibility to health services	Perfect
Involvement of the community in the planning of services and preventive measures provision	Social mobilization Information, Education, Communication Communication for changing behaviors	Involvement of the populations	Improve community participation and the use of the health services Improve the care and treatment of the poor populations	Perfect

TABLE 3 : RELEVANCE BETWEEN THE USAID MOST SIGNIFICANT RESULTS, ITS OBJECTIVES AND THE NATIONAL HEALTH STRATEGY IN FH

COMPONENTS	SUB-COMPONENTS	RESULTS	USAID OBJECTIVES	OBJECTIVES OF THE NATIONAL HEALTH POLICY
Improvement of planning and coordination	Planning	- Reinforcement of the competences in planning and management of health programs (DDPH, ZMT, MHC, DHC, VHU, MMC/DMC, Community). - Reinforcement of the partnership (Financial Backers, Health development actors, Community, Government). - Reinforcement of the logistics	Improve of the political environment : health policy, support system : reinforcement of the capacities in planning and management in health.	Improve community participation and the use of the health services : Reinforcement of the capacities in planning and management.
	Coordination / management	Idem	Improve of the quality of management and services : reinforcement of the capacities in management and improvement of the health workers performances	Idem
Increase in the access to FH services	Quality improvement	- Reinforcement of the competences in QI - Availability of the FH services according to the various norms of the health system. - Reinforcement of the capacities of services. - Valorization of the RH services in the beneficiaries	Increase in the access to services and products : Integration of the FH services into the health centers	Improve the quality of and the accessibility to health services.

Improvement of the capacities provide to quality services.	Training	- Reinforcement of the capacities of planning and carrying out trainings - Reinforcement of the competences in FH services.	Improvement of the quality of management and services : reinforcement of the capacities in management and improvement of the performances of the health workers. Reinforcement of the capacities of the populations to change their behaviors	Improve the quality of and the accessibility to health services
Reinforcement of knowledges and behaviors favorable to : use the FH services, products, preventive measures	Information, Education, Communication -Communication for changing behaviors. - Social mobilization	Development of the performances in FH IEC/CBC, social mobilization	Increase in the demand and the support practices to use the services products and preventive measures : improvement of the knowledge of the preventive measures and appropriate practices.	Improve community participation and the use of the health services
Involvement of the community in the planning of services and preventive measures provision	Social mobilization Information, Education, Communication Communication for changing behaviors	Involvement of the population	Increase in the demand and the support practices to use the services products and preventive measures : improvement of the knowledge of the preventive measures and appropriate practices.	Improve community participation and the use of the health services Improve the care and treatment of the poor populations.

TABLE 4 : RELEVANCE BETWEEN THE BORGOU/ALIBORI FH INDICATORS AND THE NATIONAL FH OBJECTIVES

COMPONENTS	SUB-COMPONENTS	MOST SIGNIFICANT RESULTS	IMPACT OF IPFH ON THE PERFORMANCE INDICATORS	OPERATIONAL FH OBJECTIVES
Improvement of planning and coordination	Planning	- Reinforcement of the competences in planning and management of health programs (DDPH, ZMT, MHC, DHC, VHU, MMC/DMC, Community). - Reinforcement of the partnership (Financial Backers, Health development actors, Community, Government). - Reinforcement of the logistics	- Reinforcement according to the needs of capacities in planning, management, budgeting, computer science, in the DDPH, ZMT, health centers (SSHZD, DRFM). - Definition of the indicators of performance of the ZMT, MMC, VHU, HZ in collaboration with the SSHZD, the DDPH. - Definition of the norms and protocols of care and treatment of the patients. Collaboration with the DDPH in terms of norms and protocols of the patients. - Reinforcement and implementation of the integrated health information system MQAHS - Coaching of the MPH, DPP for the decentralization of the management of the allocated credits by the national budget to HZ.	

			- Workshop on indicators, team work, Analysis of the situation (KAP, MQAHS). NB : Significant progress in : the performance of the MMC, the ZMT in the execution of the planned tasks and supervision (90%).	
	Coordination / management / budgeting	Idem	- Promotion of the partnership : DDPH and USAID/BENIN, BASICS (PMA Nutrition), PRIME II (EONC) PROLIPO (ICTCD), PSI (Products) CRS (Community activities), Word Education (HIV/AIDS prevention), CARE/ROBS, MCDI (Community ICTCD), PBA (Budgeting and perpetuation, PSS (planning with regards to the partners and ICTCD), UNICEF (ICTCD), UNFPA (Complementarity of actions), WHO (CBS, ICTCD, Comm, malaria)	

Increase in the access to FH services	Quality improvement	- Reinforcement of the competences in QI - Availability of the FH services according to the various norms of the health system. - Reinforcement of the capacities of services provision. - Valorization of the RH services in the beneficiaries	- Reinforced departmental system for logistics management and distribution (training, coaching and ZMT logistics performance indicators) - Evolution in the good direction of the shortage index. - Evolution of the index of orders management in the good direction. - Contribution to the availability of a departmental store for FH products. - Extension of Norplant supply in the B/A - Availability of the integrated FH services. - Prevalence + 50% Polyvalence training and definition of training norms and standards. - Reinforcement in FH technical equipment and repair of the infrastructures - Dynamization of the EVP : Full vaccination between 60 and 65% - Evolution of gradual PNC Community based distribution : Index of CB products distribution performance (73 to	Objective for year 2016 : PNC : 67 to 90% Rate of assisted delivery : 50 to 80% Rate of full vaccination for children : 56 to 80% reduce infantile and-juvenile mortality rate (malaria, IRA, diarrhea, malnutrition) by 50% Rate of the use of ORT : from 33 to 80% Rate of maternal breast-feeding 50% Contraceptive Prevalence from 3% to 40% Strategies : PM/FH/STD/HIV ICTCD EONC IEC/CBC Reduction of maternal mortality the rate by 3/5

			99%) in the BA by 404 CBHW who were trained, equiped, retrained and apt to assess and conduct workshops. CG : 1306, VAD 1724, R&CR 364. - Soaring sales of products (condom, spermicids, pills, mosquito nets and others).	
Improvement of the capacity to provide quality services	Training	- Reinforcement of the capacities of trainings planning and execution. Reinforcement of the competences in FH services. - Reinforcement of the capacities of the population to change their behaviors.	- Diagnostics of the needs in training (Assessment). -Trainings in QI, ICTCD, supervision, integration of activities - Training of the trainers (departmental training team). -Tutorship -Availability of protocols, norms (ICTCD, EONC…) -Collaboration with schools which train technicians in nursing cares (BNSAN). -Aptitude of the health workers in problems solving process. -Optimistic Index of the performance of the health teams.	Training, advocacy IEC/CBC administration, management and FH information system, Researches (KAP,…)
Reinforcement of knowledges and favorable behaviors to : use the FH services, products, preventive	- Information, Education, Communication - Communication for changing behaviors	Development of the performances in FH, IEC/CBC, social mobilization	-Strategic diagnosis of the messages (KAP) on Radios, popular and traditional media (singers, griots, dancers public informer : Indicators state in	FP, IEC in FH/STD/HIV, Prevention, vacc, hygiene, environment, nutrition, teaching how

measures	- Social mobilization		2002 : contract. Prev. : 11%; PAM : 61%; Rate of ORT : 61%, Home ttt : 55%; knowledge of the methods, modes of FP : 25% (three), Knowledge of the signs of severe IRA seriousness : 72%, children diarrhea prevention : 76%; knowledge of STD prevention 32 to 40%, knowledge of HIV, malaria prevention : 59 to 76%; Access to health messages : 47 to 53%	to write and read in local languages. Improvement of the communities knowledge in FH and prevention.
Involvement of the community in planning of services and preventive measures provision	- Social mobilization Information, education, communication - Communication for changing behaviors	Involvement of the of the populations : IEC/CBC, CBHW, ROBS, NGOs. Involvement of the community in planning, budgeting and CBS/CBC and MP supply : MMC/DMC, CVA. Training of the MMC, CVA in QI and how to teach and write in local language : MHC, DHC. Elaboration of plan of actions and budget : MHC, DHC participation in funding : VA, SPA, MMC, MCDI, IPFH, FAMILIES, Gradual Index of the performance of VHC, MMC,	Increase in the demand and the support practices to use the services, products and preventive measures : Improvement of the knowledge of the preventive measures and appropriate practices.	idem

TABLE 5 : IDENTIFICATION OF THE ‘’GOOD MANNERS TO BE PRESERVED AND CONTINUED’’

INTERVENTION FIELDS	EXPERIENCES	FACTORS WHICH INDUCE THE EXPERIENCES OR GOOD MANNERS TO BE PRESERVED AND CONTINUED		
		PRINCIPLES/INSTRUMENTS	PARAMETERS OR FIELDS OF KNOWLEDGE	LEVELS TO BE MADE RESPONSIBLE
Improvement of planning and coordination	Planning/budgeting	“Ascending” operational and strategic planning	1 – Situational analyses (diagnosis of health indicators level and health system management) 2-Interventions orientations : Performance objectives, tasks/works, resources, schedule, assessment	MPH DDP/PSIF DFH DDPH HZ
	Coordination/management	Management Centered on results : management	Organization/Activities/Integration/Team work/Supervision/control Health information system Midway review Training	DDPH HZ Partners
Increase in access to FH services	1 – Networks : FH CBS including ICTCD and EONC 2 – Minimum package of integrated services (equipment, interventions, procedures, protocols) 3 – Appropriate competence : training/coaching of the HW to the service	1 – setting up of communication networks with the community 2 – setting up services and logistics 3 - Improvement of the competences	Continuous improvement of the quality	DDPH HZ
Improvement of the capacities to provide quality	1 – Trainings : FHS protocols, ICTCD, EONC, quick assessment of the	Training to and promotion of the use of competences in assessment, supervision,	Training and reinforcement in management competence	DDPH HZ

services	health workers' performance, supervision, monitoring, coaching, quick problems solving 2-Techniques for training supervision 3-Techniques for performances assessment 4-Techniques for quick problems solving : FP, PNC, AA 5-Techniques to use monitoring data	problems solving, coaching		
Reinforcement of knowledges and behaviors favorable to :	Use the FH services	1 – Multimedia campaign 2 – Endogenous capacities to promote change of behaviors 3 – Assessment of the CBC and KAP survey	IEC/CBC Social mobilization	DDPH HZ
	Products	Idem	ii	DDPH HZ
	Preventive measures	Idem	ii	DDPH HZ
Involvement of the community in the planning of :	Services provision	1 – Development of community structures 2 – Involvement of the MMC/PMC in the elaboration and implementation of the plans. 3 – Development of the capacity to solve MMC/DMC/VHC problems	Social mobilization	DDPH HZ
	In preventive measures	Reinforcement of the aptitudes in prevention	Social mobilization	DDPH HZ

TABLE 6 : BENEFICIARIES SATISFACTION ORDER IN RELATION TO THE IPFH EXPERIENCES

COMPONENTS	SUB-COMPONENTS	EXPERIENCES & GOOD MANNERS Order of satisfaction																								
	LEVEL	DFH					DDPH					ZCD					COM					PART				
	SCORE	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Improvement of planning and coordination	Planning	X					X					X					X					X				
	Coordination	X					X					X					X					X				
Increase in the access to FH services	QI, logistics	X					X					X					X					X				
Improvement of the capacity to provide quality services	Training tutorship	X					X					X					X									
Reinforcement of Knowledges and behaviors favorable to	Use FH services		X					X					X					X					X			
	Products		X					X					X					X					X			
	Preventive measures			X					X					X					X					X			
Involvement of the community in planning :	Services provision				X					X					X					X					X	
	Preventive measures					X					X					X					X					X

TABLE 7 : PLAN OF ACTIONS

AIM	INTERVENTIONS	INDICATORS	RESPONSOBLES	CHRONOLOGY																	FUNDING
				A	S	O	N	D	J	F	M	A	M	j	J	A	S	O	N	D	
Achieve the conditions for a complete perpetuation of the IPFH in the Borgou/Alibori up to December 31st, 2006	Assessment and budgeting of the needs in equipment, financial and human resources necessary for the perpetuation	REPORT	IPFH/USAID	X	X																USAID
	Analysis of the consolidation budget for the IPFH perpetuation by the MPH and its technical services (DPP, DHR, SSHZD)	REPORT	IPFH/DDPH			X															MPH
	Analysis of the consolidation budget of the perpetuation. Holding of a national workshop for the consolidation planning of the IPFH perpetuation (plan, budget, funding, IPFH activities chronogram) by the health zones committees	REPORT	IPFH/DDPH			X															MPH

	Study and compilation of the zone committees suggestions by the DDPH and the zone coordinators	REPORT	IPFH/DDPH					X													DDPH
	Holding of a national workshop for the planning of the consolidation of the IPFH perpetuation (plan, budget, funding, activities chronogram)	REPORT	IPFH/DDPH					X													MPH
	Implementation of the consolidation of the IPFH perpetuation by the DDPH from January 2005	REPORT	DDPH						X												MPH
Set up a national team at the DFH in order to	Census taking of the existing competences and training of the national team for the IPFH perpetuation (January 2005/IPFH)	REPORT	IPFH						X												IPFH

reinforce the DFH capacities with a view to extending the IPFH perpetuation all over the country	Assessment of the needs in competences and FH provision and demand in the other departments of Benin (February-June 2005/USAID)	REPORT	USAID										X							USAID
	Establishment of the institutional mechanism for the implementation of the IPFH national extension program (IPFH/DFH/February 2005)	REPORT	IPFH/DFH/f							X										IPFH
	Elaboration of the training modules and the IPFH perpetuation national extension plan (IPFH/DFH/April 2005)	MODULE	IPFH/DFH/f									X								IPFH
	Elaboration of the budget for the implementation of the national extension of the IPFH perpetuation (IPFH/DFH/April 2005)	REPORT	IPFH/DFH/f									X								IPFH

	Elaboration of the schedule of implementation (IPFH/DFH/April 2005)	schedule	IPFH/DFH/f									X									IPFH
Analysis of the conditions of integration and validation of a professionalization process of the CBS	Analysis of the terms and conditions of integration and the training modules content in community based services in the health workers training centers for the emergence of a body of competence nurses (who work in the local communities (DFH/USAID/May-June 2005)	REPORT	DFH/USAID										X	X							USAID
	Drafting a program for the training of the competent health workers who work in the local communities (DFH/USAID/July-August 2005)	REPORT	DFH/USAID												X	X					USAID
	Implementation of the program (DFH/USAID/October 2005)																	X			USAID

Work schedule

From March 25 - 31, 2004: Preparatory stage

- Analyse of the TDR
- Documentation review
- Elaboration of the data collection instruments
- Meetings with resourceful persons

From April 1st - 21, 2004: Data Collection

- Cotonou: Porto-Novo: From April 1st - 6, 2004
- Borgou: from April 13 -16, 2004
- Alibori: From April 19 - 22, 2004

From April 22 - May 05, 2004 : Data analysis
Drafting of the preliminary report

May 7, 2004 : Submission of the preliminary report

N.B : Departure for the Borgou / Alibori on 4 / 13 / 04
Trip Back to Cotonou on 4 / 23 / 05

June 20 : Release of the results of the assessment in Parakou.

July : Submission of the final report of the assessment

DATA COLLECTION PROCESS : PROGRAM

Institutions / data sources	Resourceful Persons		Dates	Observations
MPH				
DFH (33 20 21) Cotonou	Director		4 / 2 / 2004 and 4 / 5 / 2005 at 4 p.m	
DPP Cotonou	PISF Leader		4 / 2004	
DDPH	Director		04/19/2004	
DDPH / BA: Service of studies of planning and documentation (SSPD) (Responsible for DDPH/BA documentation) Parakou	Head of service		4/2004	
DDPH / BA: Service of Health service (SHPP) Parakou	DDPH FH Head of Service		4/20/2004	
DDPH: SONC			04/20/2004	
Health zone Monitoring Team and or Health Zone Committee	**Borgou** ZMT (4) of the health zones of:	HZ Bembèrèkè / Sinendé	Bembèrèkè	04/21/2004
	Alibori ZMT (3) of the health zones of:	HZ NIKKI / Pèrèkè / kalalé	NIKKI	04/21/2004
		HZ Parakou / Ndali	Parakou	04 /16/ 2004
		HZ Tchaourou	Tchaourou	04 /19/ 2004
		HZ Banikoara	Banikoara	04/21/2004
		HZ Kandi / Gogounou / Sègbana	Kandi	04/20/2004
		Malanville	Malanville	04/20/2004

Prolipo 21 34 91 Porto-Novo (See Dr. Onikpo; Vigno Josette; Mr. Paul KPLE FAGET…)	Coordinator	4/5/2004 at 3 pm.	
USAID			
USAID/ Family health team	USAID / Benin Director of mission	3/6/2004 at 3pm	
	(Family health team): Health team leader: Pascal ZINZINDOHOUÉ		3/29/2004: Team Leader + FH program Leader
	FH program Leader: Francine NICOUÉ: Development Assistance Specialist	3/29/2004 3/31/2004	3/31/2004: FH program Leader
	Technical Adrisor: KONDÉ Nicoderme		4/5 /2004: FH Program Leader
	Charles OGOUCHI		
	Administrative Assistant: Blaise ANTONIO		
IPFH Parakou	Coordinator 61 12 07 / 61 29 90 and his team	April /15, 19, 22 /2004	
	Assistant Coordinator and the technical team	Idem	
INTRAH Prime II	Resident Representative	April /1st and 2nd / 2004	
NGOs			
BAFP / 95 69 10	Coordinator	4 / 2 / 2004	
ROBS 30 63 16	Coordinator	4 / 6 / 2004	
OTHER INSTITUTIONS / RESOURCE FUL PERSONS			
Swiss Project Parakou	Dr. DOSSOUVI	4 / 19 / 2004	
Resourceful person Cotonou	Dr. KESSOU	4 / 22 / 2004 in Parakou	
TERRITORIAL COLLECTIVITIES + SANITARY ZONES			
BA Prefect 61 04 70		4 / 19 /2004	
Local authorities	Community advisors	April / 2004	
Users of the services	Community members	April/ 2004	

Assessment of the perpetuation process of the Integrated Promotion of Family Health Program (IPFH) Borgou / Alibori.

INTERVIEW GUIDELINE

THEME I : The activities carried out by the IPFH

(Targets to survey: IPFH , USAID, DFH, DDPH, BAFP, ROBS, Prime II, Municipality Health Center, District Health Center, Health Zone Monitoring Team, Services Beneficiaries, HZ Committees..)

SUB – THEMES	KEY QUESTIONS
1.1. Justification for the IPFH existence	1.1.1. what justified the creation of IPFH?
1.2. IPFH 's Orientations and Objectives	1.2.1. In the beginning, what were the IPFH ' s Orientations and Objectives?
1.3. The IPFH ' s actual activities	1.3.1. What types of activities does IPFH do? 1.3.2. Which areas are covered by IPFH? 1.3.3. What were the targets / Beneficiaries of IPFH?
1.4. Partners to implement the IPFH' s action	1.4.1. With which partners does IPFH collaborate to implement its activities? 1.4.2. What is the nature of the collaboration between IPFH and its partners? 1.4.3. What are the first collaboration criteria does it require from the partners? 1.4.4. What does IPFH require from its partners when the programs is being carried out?
1.5. Resources available for the implement of the activities	1.5.1. Which resources (human, Material, Financial) does IPFH have to implement its activities?
1.6. Methods to implement the Program	1.6.1. What methodological approaches have been used by IPFH to implement its activities? 1.6.2. What are the mechanisms to implement the IPFH activities?
1.7. The Results achieved by IPFH	1.7.1. What are the most important results which have been achieved by IPFH since the beginning of the Program?

	Quantitative and qualitative results 1.7.2. Do you think the Objectives of IPFH have been achieved? To what extent ? 1.7.3. What did the implementation of the program improve in terms of IPFH ' s activities planning, Coordination and management 1.7.4 What did the implementation of the program improve in terms of partnership with IPFH? 1.7.5. What did the implementation of the program improve in the community in terms of reinforcement of knowledges and behaviors favorable to the use of the services / Products and preventive measures? 1.7.6 What did the implementation of the program improve in terms of access to family health services and products? 1.7.7. What did the implementation of the program improve in terms of capacity reinforcement as regards management and services provision? 1.7.8. What are therefore the IPFH experiences according to you?
1.8 Difficulties in the implementation of the program	1.8.1 What are the difficulties encountered by IPFH in the implementation of its activities? 1.8.2. What are the difficulties encountered in the community as regards the reinforcement of knowledges and behaviors favorable to the use of the services / products and preventive measures? 1.8.3 What are the difficulties encountered in relation to the improvement of the access to the family health services and products? 1.8.4. What are the difficulties encountered in relation to capacities reinforcement as regards management

	and services provision? 1.8.5 What are the difficulties encountered in relation to IPFH ' s activities planning, coordination and management? 1.8.6. What are the difficulties encountered as regards the partnership which is established with the IPFH?
<u>THEME II</u> : The beneficiaries' satisfaction of the activities which have been carried out by IPFH. (Targets to survey: IPFH, USAID, DFH, DDPH, BAFP, ROBS, Prime II Municipality Health Center District Health Center Health Zone Monitoring Team Services Beneficiaries HZ Committees…)	
2.1. DFH satisfaction	2.1.1. What judgement does the DFH pass on the experiences of IPFH? 2.1.2. What link of relevance do you make between the experiences of IPFH and the national polity in terms of health and the strategic FH objectives?
2.2. DDPH ' s satisfaction	2.2.1. What judgement does the DDPH / BA pass on the experiences of IPFH? 2.2.2. What link of relevance do you make between the experiences of IPFH the plans of development and their implementation in the Borgou / Alibori departments? 2.2.3. What link of relevance do you make between the experiences of IPFH and the national polity in terms of health and the strategic FH objectives?
2.3. Satisfaction of the HZ committees (coordinator, HZ personnel MMC, PMC), Zone monitoring team	2.3.1. What judgement does the HZ committee (coordinator, HZ personnel, MMC, PMC) the Zone monitoring team) pass on the experiences of IPFH in the health Zone ? 2.3.2 What link of relevance do you make between the experiences of IPFH, the plans of development and their implementation in the Borgou / Alibori departments? 2.3.3. What link of relevance do you make between the experiences of IPFH and the national policy in terms of health and the strategic FH objectives?

2.4. Satisfaction of the population	2.4.1. What judgement does the population pass on the experiences of IPFH in the community? 2.4.2. Justify your answer.
2. 5 Access to family health services and products	2.5.1. What must be perpetuated as regards the access to family health services and products? 2.5.2. Why ?
2.6. Capacity reinforcement in terms of management and services provision	2.6.1. What must be perpetuated in terms of management and services provision? 2.6.2. Why ?
2.7. Reinforcement knowledges and behaviors favorable to the use of the services / products and the preventive measures.	2.7.1 What must be perpetuated in teams of reinforcement of knowledges and behaviors favorable to the use of the services / products and the preventive measures? 2.7.2. Why?
2.8. The IPFH ' s activities planning coordination and management	2.8.1. What must be perpetuated in terms of the IPFH ' s activities planning coordination and management? 2.8.2. Why?
2.8. Partnership with IPFH	2.9.1. What must be perpetuated in terms of partnership with IPFH ? 2.9.1. Why ?

THEME III. Opportunities of the activities which must be perpetuated.
(Targets to survey: IPFH, USAIS, DFH, DDPH, BAFP, ROBS, Prime II, municipality Health Center, District Health Center, Health zone monitoring team, Services beneficiaries, HZ Committees, Local authorities…)

3.1 Political level	3.1.1. What are the opportunities which are exploitable in order to perpetuate the IPFH activities in the political field?
3.2.Economical level	3.2.1. What are the opportunities which are exploitable in order to perpetuate the IPFH activities in the economical field?
3.3. Social and cultural level	3.3.1. What are the opportunities which are exploitable in order to perpetuate the IPFH activities in the social and cultural field?
3.4. Institutional level	3.4.1. What are the opportunities which are exploitable in order to perpetuate the IPFH activities in Institutional level?

THEME IV: Constraints related to the process of perpetuation (Targets to survey: IPFH, Prime II, BAFP, ROBS, Health zone monitoring Team, HZ Committees…)

4.1 Requirements of the perpetuation of the IPFH activities	4.1.1.What are the requirements related to the perpetuation of the IPFH experiences?
4.2. Pragmatic constraints : In relation to the involvement of the DDPH / BA, the Health zone team, the CBHW the PMC, the populations / Communities	4.2.1. What are the pragmatic constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the DDPH / BA? 4.2.2. Why? 4.2.3. What are the pragmatic constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the health zone team? 4.2.5. What are the pragmatic constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the CBHW, the MMC and the PMC? 4.2.6. Why? 4.2.7. What are the pragmatic constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the populations / communication? 4.2.8 Why?
4.3. Financial constraints: In relation to the involvement of the DDPH / BA, the health zone term, the CBHW, the MMC, the PMC, the Populations / Communities.	4.3.1. What are the financial constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the DDPH / BA? 4.3.2 Why? 4.3.3. What are the financial constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the health zone team? 4.3.4. Why? 4.3.5. What are the financial constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the CBHW, the MMC, the PMC? 4.3.6. Why?
	4.3.7. What are the financial constraints of the perpetuation of the activities carried out by IPFH in relation to the involvement of the population / Communities? 4.3.8 Why?
4.4 Constraints which are related to the functioning of the system (organization, number of skilled the personnel…)	4.4.1. What are the constraints which are related to the functioning of the system (organization, number of skilled personnel, …)?
4.5. Constraints which are related to the mobilization of the necessary resources for the perpetuation.	4.5.1. What are the constraints. Which are related to the mobilization of the necessary resources for the perpetuation?

THEME V Suggestion as regards the types of potential partners and their role in the monitoring of the process of perpetuation.
(Targets to survey: IPFH, BAFP, ROBS, Health Zone Monitoring Team, HZ Committees, PSI, DFH, USAID, Local authorities, Prime II, DPP…)

5.1. Types of partners and the role of each partner	5.1.1. What are the types f potential partners for the consolidation of the IPFH experiences? 5.1.2. What could be the role of each partner?
5.2. Nature of the partnership	5.2.1. What is the nature of the partnership to privilege for the consolidation of the IPFH experiences? 5.2.2. Why?
5.3. Duration of the partnership according to the types of partner.	5.3.1. What would be the duration of the partnership (according to the types of partner) for the consideration of the IPFH experiences? 5.3.2 Why?
5.4. Types of partnership to reinforce	5.4. What is the types of partnership to reinforce for the perpetuation of the IPFH activities? 5.4.2. Why?

THEME VI: Suggestions of the results which must be diffused throughout the country during the perpetuation process.
(Targets to survey: DPP, DFH, DDPH / BA, IPFH, USAID, BAFP, RBS, Prime II, Health Zone Monitoring Team, HZ Committees…)

6.1 Reinforcement of knowledges and behavior favorable to the use of the services / products and the preventive measures.	6.1.1. What are the mechanism and actions which were used to reinforce the knowledges and behavior favorable to the use of the services / products and the preventive measures? 6.1.2. Which ones could be replicated throughout the country?
6.2. Access to the family health services and products	6.2.1. How (means, strategies) has the access to the family heath services and products been improved? 6.2.2. What must be diffused all over the country?
6.3. Reinforcement of the capacities in management and services provisions..	6.3.1. What are the mechanism and actions which were used to reinforce the capacities in management and services provision? 6.3.2. Which ones could be replicated throughout the country?

6.4. The IPFH activities planning, coordination and management.	6.4.1 What was the approach f the IPFH activities planning, Coordination and management? 6.5.2. What could be perpetuated in this approach?
6.5. Partnership will the IPFH.	6.5.1. What could be perpetuated in the partnership which the IPFH? 6.5.2 Why?

<u>THEME</u> VII: Suggestions of the consultation frameworks / mechanisms in the community, the department and in the country in which the potential partners will be able to participate in the process of the IPFH perpetuation.
(Targets to survey IPFH, USAID, BAFP, ROBS, Prime II, Health Zone Monitoring Team, HZ Committees,…)

7.1. National level	7.1.1. What could be the consultation framework / mechanism in the country in which the potential partners will be able to participate in the process of the IPFH perpetuation?
7.2. Departmental level	7.1.1. What could be the consultation framework could be the consultation framework / mechanism in the department in which the potential partners will be able to participate in the process of IPFH the perpetuation?
7.3. Local level	7.3.1. What could be the consultation framework / mechanism in the community in which the potential partners will be able to process of the IPFH perpetuation?

GUIDELINE FOR A QUICK OPINION POOL

AIM :See how the populations are infirmed about the existence of the IPFH and its activities in the Borgou and Alibori.

TARGETS: Beneficiaries of the services.

11. Knowledge of the IPFH	1.1.1. Do you know the IPFH? 1.1.2. What is the profile of the people who work with the IPFH?
1.2. Knowledge of the IPFH activities.	1.2.1. What kind of activities does the IPFH do? 1.2.2. What are the areas covered by the IPFH? 1.2.3. Who are the targets / beneficiaries of the IPFH activities?
1.3. What do you like in what the IPFH in doing?	
1.4. What do you like in what the IPFH is doing?	
1.5. What would you like the IPFH keeps on doing?	

GUIDELINE OF INTERVIEW WITH THE LOCAL COMMUNITY

THEME I : Activities which have been carried out by the IPFH.

Targets to Survey:

SUB- THEMES	KEY QUESTIONS
1.1 . knowledge of the CBHW	1.1.1- What are they according to you? 1.1.2- What do they do? 1.1.3- Who do they work with? 1.1.4- What are the products that the CBHW give?
1.2. Appreciation of their work.	1.2.1. What do you like in what they do? 1.2.2. What don't you like in what they do? 1.2.3. What benefits do you get from their activity? 1.2.4. What would you have wished to change in what they are doing?
1.3. Continuity	1.3.1. Would you like to continue with the CBHW?
1.4. Accessibility to the FH services	1.4.1. How hard do you find it to get at any time the product that the CBHW give? 1.4.2. How hard do you find it to get treatment in the health centers of your community?
	1.4.3. How do you get the information which is related to the FH services? 1.4.4. What do you suggest in order to improve what is being done?

LIST OF THE PEOPLE WHO HAVE BEEN MET WITH

N°	First Name/Family name	Title / Occupations / Structures / Addresses
1	Mr. Pascal ZINZINDOHOUÉ	Team Leader Family Health Team USAID Tel: 00229 30 05 00 Cotonou
2	Mrs. Francine NICOUÉ	CTO USAID / BENIN Tel : 00229 30 05 00 Cotonou
3	Dr. Valère GOHITO	Director of Family Health MPH / DFH Tel : 229 33 21 82 02 33 20 21 Cotonou
4	Mr. Médard AHOUANSOU	Statistician and Economist DDP/ MPH Integrated Family Health Program. Cotonou
5	Dr. ONIKPO	Prolipo coordinator tel. +229 21 34 91 or 21 24 06 Porto-Novo
6	Dr Paul KPE FAGET	Prolipo Technical Advisor. Tel +229 21 34 91 or 21 24 06 Porto-Novo
7	Dr. Ange MÈGNIZOUN	Prolipo Tel. + 229 21 34 91 or 21 24 06 Porto-Novo
8	Mr John JUSTINO	Resident Representative Population Service International (PSI). te. 30 77 00 / 01 / 02 Cotonou
9	Dr. KITIHUN	Social Program and services BAFP Cotonou
10	Mr BONIGORA Ibrahim	Technical Assistant BAFP Parakou tel. 61 23 04 and 85 41 83
11	Mr. ZOURKARNÉYNI Tungouh	Prefect of the Borgou and Alibori Departments
12	Dr. Soulé Abdoulaye	DDPH Borgou / Alibori
13	Dr. Aguima F. Tankoano	Integrated Family Health Program Coordinator in Borgou. Tel. 229 61 29 90 Parakou. Aguima @prsaf.org
14	Dr. SAGBOHAN Marcel	Integrated Family Health Program assistant Coordinator in Borgou (IPFH). Monitoring and Assessment Specialist Tel. 229 61 29 90 Parakou
15	Mrs Susan B. Aradeon	Integrated Family Health Program in Borgou (IPFH). Specialist in IEC / Communication for Changing Behavior. PhD. Tel 229 61 29 90 Parakou
16	Mr. Télesphore KABORÉ	Integrated Family Health program in Borgou (IPFH). Specialist in Community Mobilization. Tel. 229 61 29 90 Parakou
17	Mr. Valentin TOSSÈ	Information System Leader. Integrated Family Health Program in Borgou (IPFH). Tel. 229 61 29 90 Parakou
18	Dr Jodi Hadda	Health Zone coordinator Parakou N'Dali (ZMT)
19	Dr. Jean Pierre HOUNGet	Director of the Zone Hospital "St Jean de Dieu de Boko": Health Zone Parakou / N'Dali Tel. 229 61 33 32

20	Dr. Alin Santos	Director of the zone Hospital “St Martin de PAPANE”. Health zone Tchaourou Tel. 61 33 32
21	Dr. Yves MONGBO	Health Zone Coordinator Tchaourou tel. 61 90 06 / 05 mayesmong@yahoo.fr
22	Dr. Christophe Dossouvi	Social and Health program Coordinator (Swiss) SSP Tel. 61 40.24 and 93.14.27 Parakou.cdoddouvi@borgou.net
23	Dr. Karim Salami	DDFH Leader. DDPH Borgou / Alibori
24	Mrs Sylvie Amadu	SONC Chief of Service DDPH Borgou / Alibori
25	Dr. Justin Atadé	Geneacologist. Ex Zone Coordinator Malanville / Karimama in assessment Mission of the EONC.
26	Dr. Kouassi Jean	Malanville / Karimama Zone Hospital Director (ZMT).
27	Dr. Amédée de Souza	Malanville / Karimama Health Zone Coordinator
28	Dr. Yébadkpo André Sourou	Kandi / Gogounou / Segbana Health Zone Coordinator (ZMT).
29	BIAOU Emmanuel	Social Mobilization Technical assistant in the Kandi / Gogounou / Segbana Health Zone (ZMT).
30	Dr. Kèkin Gaston	Zone Coordinator and Director of Banikoara zone Hospital.
31	GBADAMASSI Limatha	Health nurse interim of the Senior Nurse Doctor of Gounparou / Banikoara DHC.
32	OROU- SOULEY Osséni	Gonparou / Banikoara CBHW
33	OUANSOU Wilfrid	Senior Nurse (ZMT) Bembèrèkè / Sinendé Health Zone
34	SOUKPON Monique	Accountant Bembèrèkè / Sinendé Health Zone
35	Mr. OROU Yorou Méré	Administrator / Hospital Manager/ Bembèrèkè / Sinendé Zone Hospital
36	Dr. MAMA AMADOU Bouraïma	Doctor / Surgeon, Coordinator/ interim Nikki/ Pèrérè/ Kalalé Health Zone.
37	Mr FICO Raphaël	Nikki / Pèrérè/ kalalé Health Zone Manager.
38	Mrs. ADJIBI Véronique	Midwife, IEC group Leader at the DDPH – B/A Parakou
39	Dr. KESSOU Léon	Doctor, Health Economist, Public Health Consultant
40	Dr. DJIVO Célestin	SSHZD Coordinator / MPH
41	Dr. Ali Maroufou	Support Doctor / UNFPA Concentration Zone / Borgou - Alibori
42	Dr. Edwige ADÉKAMBI	UNFPA Program Leader
43	Mr. Onanga Bongwele	Resident Advisor PRIME II