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The World Bank

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Report No.P-6498-BEN

MEMORANDUM AND RECOMMENDATION

OF THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

TO THE

EXECUTIVE DIRECTORS

ON A

PROPOSED CREDIT

IN THE AMOUNT EQUIVALENT TO SDR 17.9 MILLION

TO THE

REPUBLIC OF BENIN

FOR A

HEALTH AND POPULATION PROJECT

MAY 10, 1995

CURRENCY EQUIVALENT

(as of November 1994)
Currency Unit: CFA Franc (CFA) [a/]
US$ = 600 CFAF

WEIGHTS AND MEASURES

Metric System

ABBREVIATIONS AND ACRONYMS

ABBEF	*Association Béninoise de Bien-Etre Familial* (Beninese Association of Social Welfare)
AIDS	Acquired Immune Deficiency Syndrome
CA	*Centrale d'Achat* (Central Procurement Agency)
CAA	*Caisse autonome d'amortissement* (Government Debt Management Agency)
CAS	Country Assistance Strategy
CDEEP	*Comité Départemental de Suivi de l'Exécution et d'Evaluation des Programmes du secteur santé* (Departmental Committee for Implementation Monitoring and Health Sector Program Evaluation)
CFA	*Communauté financière africaine* (African Financial Community)
CNEEP	*Comité National de Suivi de l'Exécution et d'Evaluation des Programmes du secteur santé* (National Committee for Implementation Monitoring and Health Sector Program Evaluation)
COGEC	*Comité de gestion de la commune* (Communal Management Committee)
COGES	*Comité de gestion de la sous-préfecture* (Sub-prefecture Management Committee)
COGEZ	*Comité de gestion de la zone sanitaire* (District Management Committee)
CPR	Contraceptive Prevalence Rate
DDS	*Direction départementale de santé* (Departmental Health Directorate)
DPCE	*Direction de la Planification, de Coordination et de l'Evaluation* (Planning, Coordination, and Evaluation Directorate)
FP	Family Planning
GDP	Gross Domestic Product
NCB	National Competitive Bidding
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PFP	Policy Framework Paper
PTD	*Plan Triennal de Développement* (Three-year Development Plan)
SNIGS	*Système national d'Information de Gestion Sanitaire* (National Health Management and Information System)
STD	Sexually Transmitted Disease
WHO	World Health Organization

GOVERNMENT FISCAL YEAR

January 1 - December 31

[a/] The CFA Franc exchange rate is fixed at a rate of 100:1 with the French Franc. The latter is a floating currency.

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REPUBLIC OF BENIN
HEALTH AND POPULATION PROJECT

CREDIT AND PROJECT SUMMARY

Borrower: Republic of Benin

Implementing Agency: Ministry of Health (MOH)

Beneficiaries: Population of Benin

Amount: SDR 17.9 million (US$27.8 million equivalent)

Terms: Standard IDA with 40 years maturity

Financing Plan:

	Local	Foreign	Taxes & Duties	Total
	----------US$ million----------			
IDA	8.3	19.5	0.0	27.8
Government (including taxes & duties)	2.1	0.2	2.8	5.1
Beneficiaries	0.0	0.5	0.0	0.5
Total Project Cost	**10.4**	**20.2**	**2.8**	**33.4**

Economic Rate of Return: Not applicable

Program Objectives Category: Poverty Reduction and Human Resources

Poverty Category: Program of Targeted Interventions

Staff Appraisal Report: Report No. 13098-BEN

Map: IBRD No. 26983

Project ID No.: 118

MEMORANDUM AND RECOMMENDATION OF THE PRESIDENT OF THE INTERNATIONAL DEVELOPMENT ASSOCIATION TO THE EXECUTIVE DIRECTORS ON A PROPOSED CREDIT TO THE REPUBLIC OF BENIN FOR A HEALTH AND POPULATION PROJECT

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1. I submit for your approval the following report and recommendation on a proposed development credit to the Republic of Benin for SDR 17.9 million (US$27.8 million equivalent), on standard IDA terms with a maturity of 40 years. This credit would help finance a project for assisting the Government to improve the health and well-being of Benin's population with special emphasis on its vulnerable segments (women, children and the poor). It will do so through the support of national sector policy and strategic objectives. The Government and beneficiaries will contribute US$5.6 million equivalent.

2. **Country Economic Background.** Benin is a country of more than five million people with a total GDP of about US$1.5 billion (1994). Its economy is highly open and strongly dependent on primary and tertiary activities. The primary sector, which accounts for 33 percent of total GDP, provides the country's largest export commodity: cotton. A large tertiary sector dominated by commerce accounts for 53 percent of the country's GDP, and its dynamic re-export activities provide about 45 percent of the country's total export revenues. In contrast, the country has a small secondary sector which barely accounts for about 14 percent of GDP. A new Constitution was approved by referendum in December 1990 and multi-party legislative and presidential elections were held in February/March 1991. The President, Mr. Nicéphore Soglo, a former Bank Executive Director, was elected with an overwhelming majority of the votes and took office on April 4, 1991. Legislative elections took place on March 28, 1995, and presidential elections are scheduled for March 28, 1996.

3. After nearly two decades of state-led development, Benin embarked, in 1989, on an ambitious economic reform program, supported by an IDA SAL I, and by an IMF Structural Adjustment Facility (SAF), approved in May and June 1989, respectively. A second phase of this program adopted by the newly elected Government in 1991, was supported by an IDA SAL II and an IMF three-year Enhanced Structural Adjustment Facility (ESAF). Together with its partners in the CFAF zone, Benin decided to modify the parity of the CFA franc from CFAF50 to CFAF100 to the French franc in January 1994. By increasing Benin's external competitiveness this measure helped strengthen the ongoing adjustment program, the results of which had been encouraging during 1990-93. A proposed third SAL will support measures to strengthen the supply response to the devaluation and consolidate reforms initiated under previous operations. The third annual arrangement of the IMF three-year ESAF is expected to be approved in May 1995.

4. Benin's medium-and long-term economic prospects have improved. Although GDP increased by 4.3 percent in 1992 and 1993, several major constraints to development remain to be addressed, including a high fertility rate of 7.1, a still heavy and ineffective public sector, a strong dependence on cotton, an inadequate administrative and human resource capacity, and limited employment opportunities in the private sector.

5. The Bank's country assistance strategy aims to promote a private sector supply response and to strengthen the market orientation of the economy by supporting policy measures which are critical for the country's long-term prospects: public finance management, human resource development, and the public sector's administrative capacity to implement the reforms.

6. **Sector Background**. The rehabilitation and reform of social service delivery is a key area of concern in Benin's adjustment program and in the Government's overall development strategy as stated in the Policy Framework Paper distributed to the Executive Directors on March 14, 1994.

7. Benin's population growth rate of 3.2 percent will result in a doubling of its current 5.1 million population size in less than 25 years. A persistently high fertility rate will burden the labor force with an increasingly large proportion of young persons needing education, health care, nutrition and other services, and will keep the country's propensity to save below a level needed for generating adequate capital for economic growth. High fertility alongside low economic growth will contribute to poor nutrition and health status which will, in turn, inhibit productivity and exacerbate poverty. Contraceptive prevalence is well below 5 percent despite availability of funding for family planning and safe motherhood activities under the first IDA funded health project. Both the recent Cairo conference and the sector dialogue have encouraged the Government to acknowledge and address population issues and it proposes in its PFP to adopt a population policy by November 1995.

8. Despite recent improvements in health care reflected in higher immunization rates and increased attendance at health facilities, morbidity and mortality rates are still very high. The prevalence of tropical communicable and parasitic diseases as well as poor nutrition remain the major causes of morbidity and mortality. Efforts initiated since 1989 with IDA and other donor funding have been limited by inefficient organization and resistance to reforms that would improve management within the Ministry of Health (MOH). The causes of morbidity and mortality are dominated by malaria, acute respiratory tract infections, diarrhea and water borne diseases, which could be drastically reduced if the MOH improved its management capacity. Rising HIV infection rates and AIDS cases are matters of public concern. The crude death rate and infant mortality rates are 16.1 and 80 per thousand, respectively, and the maternal mortality rate (800 per 100,000 live births) is high even by African standards. Between 20 and 40 percent of children under five are malnourished and three to six percent are severely malnourished.

9. Reforms initiated since 1989 with the support of IDA (Health Services Development Project, Credit 2031-BEN, cofinanced with the Swiss) and other donors have begun to tackle basic curative and preventive health care needs of the population. Essential generic drugs and basic supplies are now available on a regular basis in all health facilities and a cost recovery program initiated under the first IDA-financed project currently guarantees replenishment of such supplies. A major facility rehabilitation program is underway and new management tools have been developed in an effort to improve sector performance. Current budgetary constraints have limited the proportion of the Government recurrent budget allocated to health. However, donor funding and community financing through cost recovery and investments have compensated for the low level of public resources for health. Over-dependence on external funding in the sector poses a problem for future sustainability. The shift of financial responsibility to beneficiaries through cost recovery has become relatively substantial amounting to over 1.5 billion CFA in 1993. The Government with Bank assistance is continuing efforts to improve donor coordination and to articulate a clear health financing policy.

10. At the recent Health Sector Round Table (January 12-13, 1995), the Government and its partners discussed and debated a draft sector strategy for the period 1995-99. The new strategy places great emphasis on consolidating and building on notable achievements of the previous strategy (1989-1993), most particularly: (a) the reorganization of the MOH; (b) the extension nationwide of cost recovery and the creation of health management committees (COGES/COGEC); (c) the establishment of the *Centrale d'Achat*, which assures affordability and availability of essential generic drugs; and (d) the establishment of mechanisms for fuller participation in the planning, coordination and evaluation of sector activity (CNEEP/CDEEP). In addition, the new

sector strategy proposes to reform sector organization with a view to achieving improvements in the quality, access and efficiency of services. It is the intention of the MOH that this strategy would provide the basis for eliciting and coordinating the contributions of all donors active in the sector.

11. **Project Objectives**. This project will assist the Government to improve the health and well-being of its people, particularly the most vulnerable groups: women, children, and the poor. First, in support of Benin's population policy (expected to be approved by the Council of Ministers before end-November 1995), the project will assist in the development of the nascent family planning program. Second, it will support the implementation of the main reforms included in the national health sector strategy for 1995-1999: (a) the decentralization and strengthening of sector management and administration; (b) the reformulation of the referral system and strengthening of its technical support capacity; and (c) expansion of the participation of major stakeholders, including beneficiaries, in the planning, implementation and evaluation of national health policy and strategy.

12. **Project Description**. The project's support to the implementation of national sector policy and strategy will be provided through four components. A breakdown of the costs and the financing plan is shown in Schedule A.

(a) **Development and Expansion of Family Planning Program and Services**: To ensure nationwide availability of quality services and information, this component will assist the Government in disseminating and promoting its population policy and in establishing a viable, nationwide family planning program. It will also support expansion of family planning (FP) services and their integration into the minimum package of services at all levels of the public health system.

(b) **Improving the Quality and Efficiency of Priority Health Services**: This component will assist the Government in revitalizing and streamlining the referral system, with a particular emphasis on upgrading and improving the quality of first referral services through the gradual establishment of district hospitals (*hôpitaux de zone*), and on establishing norms and standards for quality services at all levels of the system. To this end it will support upgrading of the health infrastructure and focus on strengthening priority health programs and disease interventions.

(c) **Strengthening and Streamlining Sector Management and Administration**: This component will support the decentralization of sector management and administration, which will involve the gradual establishment of health districts (*zones sanitaires*), the strengthening and expansion of departmental-level capacity, and the strengthening of key functions of the central MOH. It will also support the development of key management capacities at all levels of the system. In addition, it will improve pharmaceutical policy, legislation and regulation and fine-tune systems and processes for ensuring the quality, affordability and timely replenishment of essential generic drug stocks throughout the system.

(d) **Strengthening of Partnerships for Health**: Under this component, existing mechanisms and structures for intersectoral coordination and community participation will be revitalized and strengthened, and integrated into an organizational framework for partnerships. It will support the operations of these committees through which stakeholders will be more fully and routinely involved in the planning, management and evaluation of sector activity at all levels of the health system.

13. **Project Implementation**. Responsibility for project implementation will rest with the operational units of MOH--both central and decentralized--as part of their functions. Furthermore, in light of the new reorganization of the MOH, the upcoming mid-term review of the

first project will also seek ways to integrate the work and staff of the project coordination unit more fully into the relevant directorates and decentralized levels of administration. A project coordinator, working out of the MOH's *Direction de la Planification, de la Coordination et de l'Evaluation* (DPCE), will coordinate programming and supervision activities, including works scheduling, budgeting and procurement requests. Funds from the Japanese Grant have been budgeted for the training of accountants, procurement specialists and other project implementation staff.

14. **Project Sustainability**. Recurrent costs generated by the project include the salaries of contractual staff who would fill key management and service delivery positions at decentralized levels of the health system. The most efficient performers among them would eventually be absorbed into the civil service, as Government allocations to the sector increase. At the project's end, their combined annual salaries would amount to the equivalent of US$0.77 million or about 16 percent of the approved 1995 MOH salary budget. These costs are sustainable in light of Government's commitment to increase resource allocations to health, reflected in the PFP, in the SAL III and in the Government's Letter of Sector Development Strategy. Already successful cost recovery activities initiated under the ongoing project will ensure adequate coverage of drugs and other non salary operating costs in health facilities. The participatory process used in the design and development of this project, and project components to strengthen decentralization and participation will ensure local ownership and continued stakeholder involvement in project implementation.

15. **Lessons Learned from Previous IDA Involvement.** While only about 50 percent disbursed and with a closing date scheduled for September 30, 1997, the first project has already revealed important lessons. Its key contribution was to establish the linkages between the supply of low-cost essential drugs, the introduction of cost recovery measures to ensure their replenishment, and the creation of management committees to manage funds generated by the health centers. The second project will strengthen existing partnerships at the local, departmental, and central levels, which should provide countervailing pressure against the continuing urge to centralize decision-making. Experience under the first project has also shown that structures with sufficient control over the generation and use of resources (such as COGES/COGEC) are much more likely to be viable than those without the financial means to assure their operations (CNEEP/CDEEP). The second project will consolidate and streamline mechanisms for cost sharing by: (a) defining specific parameters for contributions by, respectively, the Government, donors and beneficiaries; and (b) defining procedures and accounting systems for ensuring the timely release and management of appropriated Government budgetary allocations and project funds from donor supported projects.

16. **Rationale for IDA Involvement**. This project is consistent with IDA's Country Assistance Strategy (CAS) for Benin, which was discussed by the Board on June 7, 1994. Its main objectives are to encourage and support the private sector supply response and to ensure adequate provision of basic social services. The proposed health and population project will enhance quality and coverage of health services and thus contribute to improving the quality of life and well-being of Benin's population. The improved nutritional and health status of the population is a condition *sine qua non* for sustainable development. Furthermore, the project supports a number of objectives laid out in the CAS. It will contribute to strengthening public sector capacity through: (a) improved management of public resources and delivery of public services; (b) improved public investment programming; and (c) the reform of institutions. In addition, the improved access and quality of family planning, health and nutrition services will enhance women's opportunities to participate in economic activities. Finally, the project is designed to complement donor interventions and to encourage donor coordination.

17. **Agreed Actions**. The Government has: (a) submitted to IDA a signed Letter of Sector Development Strategy; (b) completed the staffing of key positions in the three new central-level departments (Planning, Coordination and Evaluation; Financing and Administration; and Family Health) and in their corresponding services at the DDS level; and (c) presented to IDA a signed administrative text amending the bylaws of COGES and COGEC (*Arrêté* No. 0390 of February 14, 1995). During negotiations, the Government agreed to: (a) submit to IDA not later than April 30 of each year for its review and comments: (i) the updated three-year rolling development plan for its health sector for the succeeding years and a report on the execution of the sector's recurrent budget for the past year; and (ii) its salary and non-salary recurrent budget allocations to the health sector for the following year; (b) submit to IDA and to other donors, at least four weeks prior to the Annual Review of project performance (to occur no later than April 30 of each year), an annual sector performance report, to be prepared by CNEEP, on the progress made in the implementation of the Project and the national sector strategy. This report would cover, among other things: (i) improvements in the quality of health services (particularly family planning, maternal and child health, immunization, STD/AIDS, and strengthening of the patient referral system); (ii) progress in strengthening and decentralizing sector management and administration; (iii) increase in participation in various health activities of the private and public sector contributors to, and beneficiaries of, the health services; and (iv) in the years 1997 and 1999 an assessment of the impact of services provided under the Project by the beneficiaries. And based on this performance report, submit to IDA not later than four weeks after each Annual Review, an action program and budget, acceptable to IDA, for the further implementation of the Project, including, if appropriate, consequential amendments to the Project Implementation Manual, and, thereafter, implement such action program; (c) submit to IDA, by September 30, 1996, a time based action plan, acceptable to IDA, for regulatory reform of the pharmaceutical subsector; (d) submit to IDA, by June 30, 1997, an estimate of costs of hospital care and the Government's proposal for contribution to these costs by the beneficiaries; (e) prepare by December 31, 1996, draft texts, acceptable to IDA, establishing medical treatment guidelines, norms, standards and protocols for its health facilities and adopt a plan and timetable, satisfactory to IDA, for their application nationwide; (f) carry out jointly with IDA not earlier than 34 months and not later than 38 months after the Effective Date a mid-term review of the progress made in carrying out the Project; (g) submit to IDA quarterly reports on management of cash and stocks, and annual audit reports on the *Centrale d'Achat* accounts as a means of monitoring the financial health of this entity; (h) deposit into the Project Account in each year during the implementation of the Project, an amount or amounts equivalent to the following aggregates: (i) CFAF 349 million for the second year after the Effective Date; (ii) CFAF 200 million for the third year after the Effective Date; (iii) CFAF 296 million for the fourth year after the Effective Date; (iv) CFAF 237 million for the fifth year after the Effective Date, or other amount or amounts as IDA may specify during the Annual Review and as being required for the purposes of the Project; and (i) adopt by December 31, 1995, a budgeting and costing system, acceptable to IDA, for all levels of the health system for the delivery of health services. As conditions for credit effectiveness, the Government will: (a) open a Project Account and deposit an initial amount of CFAF 216 million; (b) submit to IDA a National Population Policy as adopted by the Council of Ministers; (c) adopt a Project Implementation Manual satisfactory to IDA; (d) appoint consultants to assist in the introduction of a decentralized accounting management and monitoring system for the Project accounts and to provide related training; (e) amend Decree No. 90-236 and *Arrêté* No. 688 of February 27, 1989 in manner acceptable to IDA in order to, among other things, modify the composition of the membership of the CNEEP and the CDEEP and to clarify their functions; and (f) adopt a legal status for the *Centrale d'Achat* satisfactory to the Borrower and the IDA.

18. **Poverty Category**. The findings and recommendations of a participatory poverty assessment carried out by the Bank in 1994 have been endorsed by the Government. An important component of the Government's strategy to reduce poverty is to improve the access of the poor and vulnerable to basic social services. In support of this strategy, the project will strengthen priority

programs aimed at the most vulnerable target groups (women and children) and it will improve access in currently underserved areas.

19. **Environmental Aspects.** The project is rated C for its negligible environmental impact. The implementation of this project, however, will lead to the adoption by households and communities of better sanitation practices. In the long term, reduction of fertility achieved through the implementation of appropriate family planning services will reduce the burden on land and contribute to enhancing its productivity.

20. **Program Objective Categories**. The project is consistent with the Bank's strategy on poverty alleviation, public sector institution building and management of human resources development. It is also consistent with Bank strategy to increase ownership of programs funded through credits, consolidating progress achieved under the first Bank-funded health and population project.

21. **Participatory Approach.** Continuing the approach adopted under the first operation, the design and development of this project were highly participatory. All operational missions were carried out through a series of workshops, many of which occured outside of Cotonou, in which departmental and health facility managers, service providers and community members actively participated. These workshops also served as the vehicle for eliciting opinions of the various stakeholders on the new draft health sector strategy (1995-99).

22. **Project Benefits**. The main benefit of the project will be improved welfare for the general population, especially women and children, resulting from greater spacing of births and improved health and nutrition status. Time spent by women attending to patients in the household and on continuous childbirth will be channeled into more productive endeavors. The general population will benefit as family planning services are made available in all districts of the country. Improved curative and preventive health services will motivate a growing number of Beninese to use the health services and thereby reduce the high cost of medical complications. The institutional reforms carried out under the project will enhance the Government's responsiveness to the basic family planning, health and nutrition needs of the population and will lead to better resource use and greater equity in service delivery. Greater involvement of beneficiaries in sector operations will strengthen the decentralization process, lead to greater transparency and mobilize the population to prevent rather than cope with disease. The project will contribute to building a solid human resource base for future development and will progressively reduce the high dependency burden and limited opportunities for women that result from high fertility, morbidity and mortality.

23. **Risks**. The main risk of the project is the potential inability of the Government to carry out the comprehensive reforms included in the project. The extensive participatory strategy used for preparing the project will mitigate any tendency by central level officials to stall sector reforms or project activities. The coordination mechanisms and supervision arrangements will ensure full stakeholder involvement in the monitoring and evaluation of project implementation. Another risk is that Government budgetary allocations may fall short of resources needed to implement the project. Conditions to be met under the project include a restructuring of the current public budget for health to encourage decentralization and increase absorptive capacity, and a gradual increase in the health sector share of the total current budget over the life of the project. In addition, resources generated through cost recovery and managed by communities constitute a guarantee that essential drugs and critical non-wage operating expenses are protected. To ensure greater sustainability, the project design envisages a decentralized implementation strategy in which the regions, rather than the central MOH, are primarily responsible for execution of various project activities. Periodic reviews and annual programming workshops at the level of the CNEEP will ensure that all regions are respecting the implementation plans, standards and deadlines. A mid-term review and two

beneficiary assessments to be carried out in years two and four of the project will be used as a monitoring mechanism to tackle any problems of implementation that are detected.

24. **Recommendation**. I am satisfied that the proposed credit would comply with the Articles of Agreement of the Association and recommend that the Executive Directors approve it.

Richard Frank
President *ad interim*

Washington, D.C.
May 10, 1995

Attachments

Schedule A

REPUBLIC OF BENIN
HEALTH AND POPULATION PROJECT

Project Costs and Financing Plan
(US$ million, including taxes and duties)

ESTIMATED PROJECT COST

	Local	Foreign	Total
A. DEVELOPMENT AND EXPANSION OF FAMILY PLANNING PROGRAMS AND SERVICES			
1. Promotion/Dissemination of Pop. Policy	0.4	0.7	1.1
2. Family Planning Service Delivery	0.3	0.9	1.2
B. IMPROVING QUALITY AND EFFICIENCY OF PRIORITY HEALTH SERVICES			
1. Strengthening of Priority Health Programs	1.6	2.7	4.3
2. Strengthening of Referral System	1.8	4.8	6.6
C. STRENGTHENING AND STREAMLINING SECTOR MANAGEMENT & ADMINISTRATION			
1. Decentralization of Management & Administration	3.9	4.4	8.3
2. Strengthening of Key Management Capacities	0.4	1.8	2.2
3. Strengthening of Pharmaceutical Subsector	0.1	1.5	1.6
D. STRENGTHENING OF PARTNERSHIPS FOR HEALTH	0.8	0.1	0.9
E. PROJECT MANAGEMENT COSTS	0.3	0.5	0.8
TOTAL BASE COSTS	9.6	17.4	27.0
Physical contingencies	0.6	1.4	2.0
Price contingencies	3.0	1.4	4.4
TOTAL	**13.2**	**20.2**	**33.4**

FINANCING PLAN

FINANCING PLAN	Local	Foreign	Taxes & Duties	Total
IDA	8.3	19.5	0.0	27.8
Government	2.1	0.2	2.8	5.1
Beneficiaries	0.0	0.5	0.0	0.5
TOTAL	**10.4**	**20.2**	**2.8**	**33.4**

Schedule B
Page 1 of 2

REPUBLIC OF BENIN
HEALTH AND POPULATION PROJECT
Proposed Procurement Arrangements
(US$ million equivalent, including taxes and duties, and contingencies)

Expenditure Category	Procurement Method			Total Cost
	ICB	NCB	Other	
1. WORKS				
(a) Construction (5) and Rehabilitation (5) of Health Centers (CCS)		1.0		1.0
		(0.8)		(0.8)
(b) Construction of District Hospitals (4 HD)		1.5		1.5
		(1.2)		(1.2)
(c) Rehabilitation of Health Centers (4 CSSP)		0.2	0.1	0.3
		(0.1)	(0.1)	(0.2)
(d) Rehabilitation of Departmental MOH Bureaux (6 DDS)		0.3	0.1	0.4
		(0.2)	(0.1)	(0.3)
(e) Completion of new Health Ministry building (1 MOH)		0.4		0.4
		(0.4)		(0.4)
SUBTOTAL WORKS		**3.4**	**0.2**	**3.6**
		(2.7)	**(0.2)**	**(2.9)**
2. GOODS				
(a) Furniture		1.2	0.1	1.3
		(1.0)	(0.1)	(1.1)
(b) Medical Equipment	1.7		0.2	1.9
	(1.4)		(0.2)	(1.6)
(c) Other Equipment	1.9	0.1	0.1	2.1
	(1.5)	(0.1)	(0.1)	(1.7)
(d) Vehicles	1.8		0.2	2.0
	(1.4)		(0.2)	(1.6)
(e) Essential Drugs a/	0.5	0.1	0.9	1.5
	(0.5)	(0.0)	(0.4)	(0.9)
SUBTOTAL GOODS	**5.9**	**1.4**	**1.5**	**8.8**
	(4.8)	**(1.1)**	**(1.0)**	**(6.9)**
3. CONSULTING SERVICES/TA b/				
(a) Policy Support			2.1	2.1
			(1.9)	(1.9)
(b) Project Implementation Support			0.2	0.2
			(0.1)	(0.1)
(c) Institutional Development b/			1.6	1.6
			(1.5)	(1.5)
(d) Architectural studies			0.2	0.2
			(0.2)	(0.2)
SUBTOTAL CONSLT. SERVICES/TA			**4.1**	**4.1**
			(3.7)	**(3.7)**
4. TRAINING c/			**7.6**	**7.6**
			(6.3)	**(6.3)**
5. INCREMENTAL RECURRENT COSTS				
(a) Incremental Contractual Salaries			3.8	3.8
			(3.0)	(3.0)
(b) Operating Costs d/			5.5	5.5
			(5.0)	(5.0)
SUBTOTAL INCREMENTAL RECURRENT COSTS			**9.3**	**9.3**
			(8.0)	**(8.0)**
TOTAL:	**5.9**	**4.8**	**22.7**	**33.4**
IDA FINANCING:	**(4.8)**	**(3.8)**	**(19.2)**	**(27.8)**

*/ Figures in parentheses are the amounts financed by IDA, net of taxes and duties. Slight differences may occur as a result of the rounding of figures.
"Other" means LIB, local shopping, IAPSO, and, direct contracting, and consultant selection following Bank guidelines.
a/ The total amount of US$0.9 million under "Other" consists of: National Shopping: US$0.2 million; Direct Constracting: US$0.2 million; and Limited International Bidding: US$0.5 million. b/ The project will finance 85 person-months of external specialist support for implementation and 199 person-months of local consulting services, this includes consulting services for project audits. Technical Assistance for Institutional Development includes assistance on: planning and coordination of health services and improvement programs, establishment of health districts, improvement of the cost recovery system, and selected surveys. c/ Annexes 15 and 19 of the SAR provide details on, respectively, local training and training abroad. d/ Operating costs include office supply, field trips, maintenance of buildings, vehicles and equipment, incremental salaries of local contractual staff.

Summary Disbursement Schedule

Category	Amount of the Credit Allocated (in US$ million)	% of Expenditures to be financed
1. Civil Works	3.0	100% foreign, 80% local
2. Furniture, medical & other equipment, vehicles, and drugs	6.5	100%, foreign, 100% local (ex-factory cost), and 80% local
3. Consulting Services and Training	8.8	100%
4. Incremental Recurrent Costs	8.0	90% up to December 31, 1998, thereafter 80%
5. Unallocated	1.5	
Total IDA Financing	**27.8**	

Estimated IDA Disbursements

	IDA FISCAL YEAR					
	FY96	FY97	FY98	FY99	FY2000	FY2001
Annual	1.9	7.5	6.9	6.1	4.2	1.2
Cumulative	1.9	9.4	16.3	22.4	26.6	27.8

Schedule C

REPUBLIC OF BENIN

HEALTH AND POPULATION PROJECT

Timetable of Key Processing Events

(a)	Time taken to prepare the project:	13 months
(b)	Prepared by:	Government, with IDA assistance [1]
(c)	First IDA mission:	October 1993
(d)	Appraisal mission:	June 1994
(e)	Post-Appraisal mission:	November 1994
(f)	Negotiations:	April 18, 1995
(g)	Planned date of effectiveness:	September 30, 1995
(h)	Relevant PCRs and PPARs:	None

[1] This report is based on the findings of an appraisal mission, which visited Benin in June/July 1994. Appraisal team members included: Messrs./Mesdames Michael Azefor, Mission Leader (AF1PH), Denise Vaillancourt, Management Specialist (PHN), Marie-Odile Waty, Health Economist (AF3PH), Robert Leke, Consultant/Professor of Obstetrics and Gynecology (University of Yaounde), Peter Bachrach, Consultant/Planning Specialist, and Aboubacar Magassouba, Consultant/Project Management Specialist. It also draws on the findings of a November 1994 post-appraisal mission composed of Messrs./Mesdames Denise Vaillancourt, Mission Leader (PHN), Olusoji Adeyi, Young Professional/Physician (PHN), Michael Azefor, Resident Representative (Resident Mission, Benin), Ousmane Diagana, Economist (Resident Mission, Benin), Peter Bachrach, Consultant/Planning Specialist, Robert Leke, Consultant/Professor of Obstetrics and Gynecology (University of Yaounde), Jean-Pierre Manshande, Consultant/Public Health Specialist. Messrs. Hjalte Sederlof (MN2PH) and Aubrey Williams (OPRPG) served as peer reviewers. The Division Chief is Mr. Ian Porter, and the Director is Mr. Olivier Lafourcade.

Schedule D
Page 1 of 3

REPUBLIC OF BENIN
THE STATUS OF BANK GROUP OPERATIONS IN BENIN
Statement of IBRD Loan and IDA Credits
(as of March 31, 1995)

	Loan or Credit No.	Fiscal Year	Borrower	Purpose	Amount in US$ million (less cancellations) Bank	IDA	Undis-bursed	Closing Date
	Credits							
	32 Credits(s) closed					358.24		
	C17480-BJ	1987	BENIN	PUBLIC ENTERPRISES		15.00	10.20	06/30/95
	C19600-BJ	1989	BENIN	TELECOMMUNICATIONS		16.00	1.02	06/30/95(R)
	C20310-BJ	1989	BENIN	HEALTH SERVICES DEV		18.60	9.35	09/30/97
	C20860-BJ	1990	BENIN	RURAL CREDIT		2.50	.10	12/31/95
	C22840-BJ	1991	BENIN	POWER REHAB		15.00	13.98	12/31/97
	C22850-BJ	1991	BENIN	AGRIC. SERVICES		12.30	9.66	06/30/95
	C22860-BJ	1991	BENIN	PRE-INVESTMENT		5.40	4.53	06/30/95
	C23380-BJ	1992	BENIN	URBAN REHAB & MGT		22.84	21.59	12/31/97
	C23440-BJ	1992	BENIN	MGT OF NAT RESOURCES		14.10	10.28	12/31/97
	C25290-BJ	1993	BENIN	RURAL CREDIT II		3.80	4.15	06/30/99
	C25520-BJ	1994	BENIN	ECON. MGMT.		5.20	5.32	12/31/98
	C26010-BJ	1994	BENIN	FOOD SECURITY		9.70	9.30	12/31/99
*	C26130-BJ	1994	BENIN	EDUCATION DEVELOPMEN		18.10	20.54	02/29/00
*	C26220-BJ	1994	BENIN	RURAL WATER SUPPLY &		9.80	10.89	12/31/97
	TOTAL number Credits =	14				168.34	130.91	
			TOTAL***			526.58		
			of which repaid			23.33		
			TOTAL held by Bank & IDA		---------	503.25		
			Amount sold					
			of which repaid					
			TOTAL undisbursed				131.77	

Notes:

* Not yet effective
** Not yet signed
*** Total Approved, Repayments, and Outstanding balance represent both active and inactive Loans and Credits.
(R) indicates formally revised Closing Date.
(S) indicates SAL/SECAL Loans and Credits.

The Net Approved and Bank Repayments are historical value, all others are market value.

The Signing, Effective, and Closing dates are based upon the Loan Department offical data and are not taken from the Task Budget file.

Disbursements

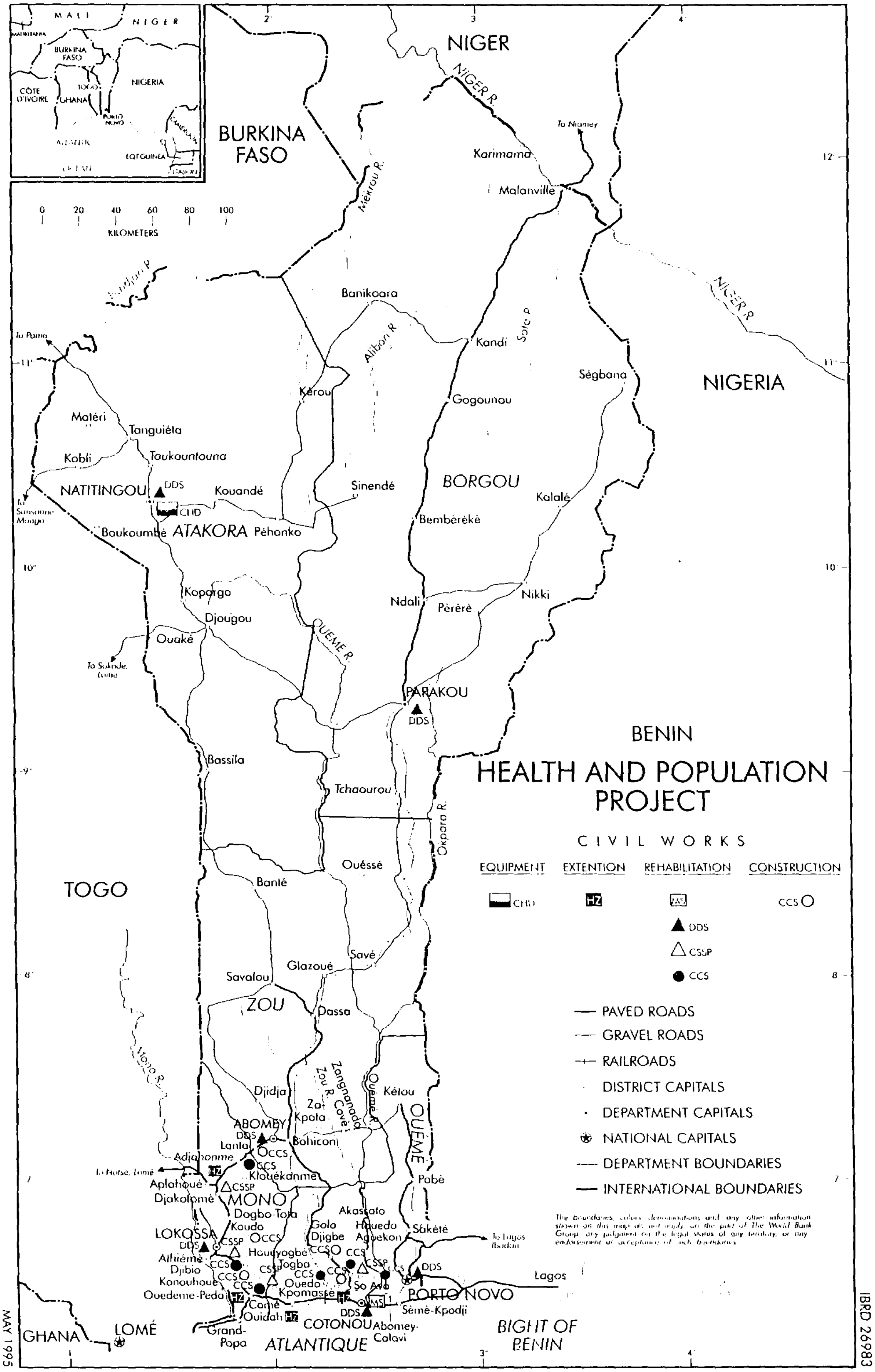
The bulk of the portfolio has been put in place since Benin's move to a democratic government and a market-oriented economy in 1991. Credit effectiveness and, for that matter, project implementation of some operations have been delayed because of the insistence of the newly elected Parliament, in which the Government only holds a small majority, to review in detail the related legal documents. Moreover, project implementation issues, such as poor administration of special accounts and non-compliance with the Bank's procurement procedures have slowed down disbursements. A country implementation review in June 1992 addressed these and other issues and agreed upon specific corrective actions, such as carrying out an audit of the government debt (CAA) management agency, restructuring of some projects and organization of a disbursement seminar for project coordinators which took place in February 1993. In September 1993, the Government agreed to improve management of special accounts, formerly administered by the CAA. Special accounts are now opened and maintained in a commercial bank, in line with the Bank's Loan Department's recommendations. A Country Project Performance Review (CPPR) was conducted in November 1994. It concluded with a series of recommendations to facilitate project implementation and disbursement of funds including the harmonization of Government and cofinanciers procedures for procurement, disbursement and taxation issues and the provision of clear descriptions be included in project implementation manuals. In order to facilitate and accelerate procurement steps, it was asked that the signature of procurement contracts be delegated from ministers to cabinet directors, that project units be equipped with electronic mail in order to speed up response time of non-objection requests, and that the Bank's resident missions be available to provide advice and guidance on procurement issues. It was suggested that problems concerning counterpart funds be examined. A committee was established to follow up on the implementation of these and other recommendations made at the review. The next CPPR, tentatively scheduled for October 1995, will follow up on these reforms.

Statement of IFC Operations
(As of March 31,1995)

BENIN
STATEMENT OF IFC INVESTMENTS
As of March 31, 1995
(In Millions US Dollars)

Fiscal Years Committed	Obligor	Type of Business	- Original Gross Commitments - IFC Loan	IFC Equity	Partic	Totals	Held by IFC	Held by Partic	Undisb incl. Partic
1992	Société Béninoise de Pêch	Food and agribusiness	.25	.06	-	.31	.20	-	-
1993	Société Fruitex Industrie	Food and agribusiness	.43	-	-	.43	.43	-	-
1993/94	Bank of Africa Benin (BOA	Capital markets	-	.29	-	.29	.29	-	-
	Total gross commitments b/		.68	.35	-	1.03			
	Less cancellations, terminations, repayment & sales		.09	-	-	.09			
	Total commitments now held c/		.59	.35	-	.94	.94	-	-
	Pending commitments								
	AEF-UNION BENIN.		-	.08	-	.08			
	EQUIPBAIL		.74	.17	-	.90			
	Total pending commitments		.74	.24	-	.98			
	Total commitments held and pending commitments		1.33	.59	-	1.92			
	Total undisbursed commitments		-	-	-	0.00			

a/ Investments which have been fully cancelled, terminated, written-off, sold, redeemed, or repaid.
b/ Gross commitments consist of approved and signed projects.
c/ Held commitments consist of disbursed and undisbursed investments.


BENIN
HEALTH AND POPULATION PROJECT
CIVIL WORKS
EQUIPMENT
EXTENTION
REHABILITATION
CONSTRUCTION
CHD
CCS
DDS
CSSP
CCS
PAVED ROADS
GRAVEL ROADS
RAILROADS
DISTRICT CAPITALS
DEPARTMENT CAPITALS
NATIONAL CAPITALS
DEPARTMENT BOUNDARIES
INTERNATIONAL BOUNDARIES
NIGER
BURKINA FASO
NIGERIA
TOGO
GHANA
BORGOU
ATAKORA
ZOU
MONO
OUEME
ATLANTIQUE
BIGHT OF BENIN
NATITINGOU
PARAKOU
ABOMEY
LOKOSSA
COTONOU
PORTO NOVO
LOMÉ
Lagos
Karimama
Malanville
Banikoara
Kandi
Ségbana
Gogounou
Kérou
Matéri
Tanguiéta
Kobli
Toukountouna
Kouandé
Sinendé
Bembèrèkè
Kalalé
Boukoumbé
Péhonko
Kopargo
Djougou
Ouaké
Ndali
Pèrèrè
Nikki
Bassila
Tchaourou
Ouèssè
Banté
Savè
Glazoué
Savalou
Dassa
Djidja
Kétou
Bohicon
Pobè
Sakété
Sèmè-Kpodji
Abomey-Calavi
Ouidah
Grand-Popo
Comè
Kpomassè
So Ava
Akassato
Aplahoué
Djakotomè
Dogbo-Tota
Athiémè
Adjohonme
Klouékanme
Houéyogbé
Lalo
Ouedo
0 20 40 60 80 100
KILOMETERS
MAY 1995
IBRD 26983