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BENIN

Program for Results (PforR)

Benin Health System Enhancement (P172940)

Technical Assessment
April 6, 2022

Benin

Health System Enhancement -- Program for Results (PforR) (P172940)

Table of Contents

Contents

I. Introduction and Scope of the Technical Assessment 3

II. Program Strategic Relevance 3

A. Country and Sector Context 3

B. The Government's Program 8

C. Rationale for World Bank Involvement 10

III. Technical Soundness 12

A. World Bank Supported PforR Program 12

B. Technical Soundness 13

IV. Program Expenditure Framework 19

A. Program Budget Structure and Classification 19

B. Adherence of Budgeted Program Expenditure and Execution to Government Priorities 23

C. Efficiency of Program Expenditures 24

V. Program Results Framework and M&E Capacity 24

A. Description and Assessment of Program Results Framework and M&E Capacity 24

B. Capacity Building 25

C. Results Chain 26

VI. Program Economic Evaluation 27

A. Rationale for Public Provision/Financing 27

B. Economic Impact 27

VII. Program Action Plan 28

VIII. Technical Risk Rating 28

I. Introduction and Scope of the Technical Assessment

1. This technical assessment has been carried out as part of the preparation of the Benin Health System Enhancement Program for Results (PforR). The assessment and design of the Program are underpinned by extensive analytical work on service delivery, governance and health systems reforms, organization and management of resources, and health financing. The assessments and analytical work from which this assessment pulls include, the Human capital diagnostic in Benin: Investing in Education and Health today; the Investing in Human Capital Tomorrow, 2020; Health Budget Note 2019; Benin Gender assessment report 2019; Improving the quality of care in the private health sector in Benin: Lessons Learned and Perspectives, 2018; the report of the National Health Sector Reform Committee (NHSC), 2016; the report of the self-assessment of the implementation of the International Health Regulation (IHR) (2005) in Benin, 2020; and the Joint External Evaluation (JEE) of key IHR capacities in Benin, 2017. In addition, key inputs for the technical assessment were obtained from key surveys such as the World Health Organization (WHO) Service Availability and Readiness Assessment (SARA) 2018, the Health sector statistical yearbook 2019, the Multiple Indicator Cluster Surveys 2014, and General Population and Housing Census.

II. Program Strategic Relevance

A. Country and Sector Context

2. **Real GDP growth slowed to two percent in 2020, as the COVID-19 crisis affected global demand, containment measures hindered services, and recession hit Benin's main trading partner, Nigeria.** Benin entered the COVID-19 pandemic with real GDP growth averaging 6.4 percent in the period 2017-2019 (3.5 percent in per capita terms), driven by cotton exports, and the construction and transport sectors. The 16-month border closure with Nigeria has, however, brought to light some of the vulnerabilities of its growth model. Despite some domestic manufacturing in cement and textile, the economy is hampered by its reliance on re-exporting imported goods and commodities (e.g. used cars, rice) to Nigeria through its land border, and the concentration of formal exports in agricultural products (mainly cotton and cashew). Eighty-five percent of the labor force is working in the informal economy, which is costly for firms and workers and has hampered productivity growth. Domestic revenue mobilization is low and has remained among the lowest in the West Africa Economic Monetary Union (WAEMU) despite ambitious tax policy and administration reforms since 2016. While economic gains at the macro level have started to translate into better living standards and improved human development indicators, the effects of COVID-19 on informal businesses and households, could reverse recent trends. The duration of the COVID-19 pandemic, both regionally and globally, constitute substantial downside risks. A prolonged outbreak would compromise the economic recovery, with new containment measures undermining poverty reduction by threatening the livelihoods of the large informal sector and increasing food insecurity, while raising fiscal and external financing requirements and debt pressures. Diversifying the economy and reducing the fiscal

dependence on trade with Nigeria remain medium-term challenges to economic transformation that raises productivity and reduces poverty. Increased security threats spilling over from the Sahel region could also threaten growth.

3. **Benin was among the first countries hit by the COVID-19 pandemic in Sub-Saharan Africa, but the number of cases remains controlled.** The first known Coronavirus disease (COVID-19) case was reported on March 16, 2020. By the end of March, the country had recorded fewer than 100 cases, but a State of Emergency was declared at the beginning of April 2020 and swift containment measures were immediately put in place to contain and mitigate the spread of the virus. First, a sanitary cordon (*Cordon sanitaire)* was established, thus separating and quarantining only people in the fifteen most affected southern communes including Cotonou and Porto-Novo, from the other northern part of the country; and a monitoring system tracked passengers at the port, airport and land borders. In addition, the following mitigation measures were imposed: (i) mandatory use of masks; (ii) social distancing measures including restrictions on the number of people allowed at bars, restaurants and eateries and restrictions on the number of passengers on public transport; (iii) mandatory hand washing measures outdoor and (iv) temporary closure of schools, universities, and religious institutions. Strict containment measures were eased on June 2, 2020, while some barrier measures are still in place. After a slow recorded spread, the number of reported cases grew rapidly in June and July, before plateauing in August. As of March 3, 2021, Benin has reported 5,434 COVID19 cases and 70 deaths. To reduce the economic and social impact of the pandemic, the authorities adopted first a Health Preparedness and Response Plan (in early March 2020) and then a National Response Plan to protect livelihoods, strengthen the health sector and ensure the recovery of the economy.

4. **Prior to the COVID-19 pandemic, Benin was showing progress towards improving its Human Capital, yet continued to face challenges in key areas.** While Benin's HCI score of 0.41 ranks it slightly above the average for its region and income group, the country has one of the lowest rates of survival to age five (ranking the country 153 out of 157 countries). Infant and maternal mortality rates, though decreasing slowly, remain high at 60.5 infant deaths per 1,000 live births and 391 maternal deaths per 100,000 live births. These high mortality rates are related to communicable diseases and non-communicable diseases, as well as related to a high prevalence of chronic malnutrition and anemia in background. Indeed, malaria continues to be the leading cause of medical consultation (44.3 percent of cases), hospitalization (29.9 percent)[1], morbidity (15,2%) and mortality (36,7%) among children under-five years of age, with a 37% prevalence among pregnant women[2]. The two current levels of stunting in Benin have slowly come down from a high of 45 percent in 2006 to 32 percent in 2018[4] but remain high compared to other West African countries[3] and pose considerable risk of delayed socio-economic growth. Figures also pointed out high prevalence of anemia among both children (6-59 months old) and pregnant women although with a slight decrease from 82% to 72% and from 64 to 58%, respectively, over the 2001-2017 period.

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[1] National Health yearbook. 2019

[2] Benin. Demographic and Health Survey. 2017-2018

[3]World Bank Group. World Development Indicators. 2019

Table 1: Key demographic and health indicators in Benin

Indicator	Value
Life expectancy at birth, 2019	61,5 years
Mortality rate, 2019	9.0/1000 population
Maternal mortality rate, 2017	397/100 000 live births
Under-five mortality rate, 2018	96/1000 live births
Neonatal (<1 month) mortality rate, 2018	30/1000 live births
Early initiation of breastfeeding, 2018	47
Children <6 months exclusively breastfed, 2018	42%
Children 12-23 months fully immunized, 2018	51%
Children <5 years who are stunted, 2018	32%
Children <5 years with acute malnutrition, 2018	5%
Antenatal care, 4+ visits, 2018	52%
Skilled attendance at delivery, 2018	78%
Contraception prevalence rate (all women), 2018	13,2%
Unmet need for family planning	35,3
Total fertility rate (15-49 years)	4.87 children per woman

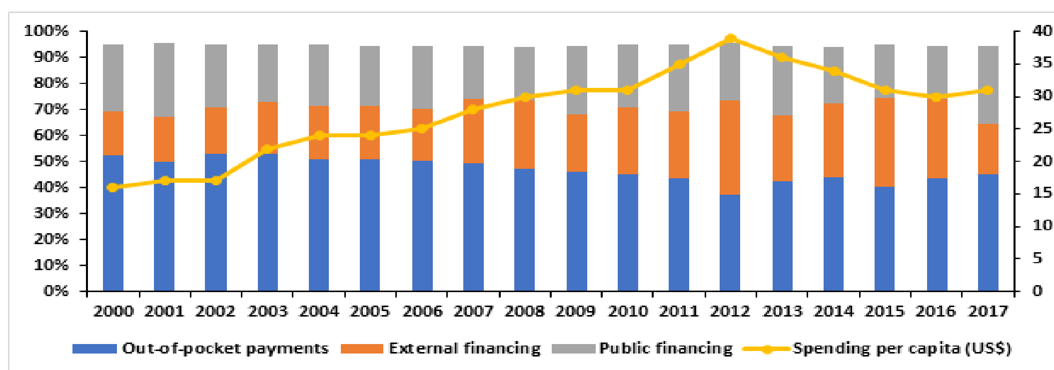
[a]Children who received vaccines - BCG, pentavalent, polio, pneumococcal, measles, yellow fever - according to recommended schedule
Source: United Nations Population Division, 2019.[2,3] Demographic and Health Survey, 2018

5. **These challenges have resulted in low health outcomes which reflect the weak performance of the health system in Benin**. The country suffers from: (i) insufficient health infrastructure, equipment, and materials; (ii) financial hurdles to access care; (iii) relative absence of normative protocols in medical practice; (iv) insufficient, and insufficiently qualified, human resources for health, including medical staff; and (vi) scarcity of health workers in rural and hard-to-reach areas. Infection prevention and control as well as hygiene and sanitation in health facilities also remain challenges. As a result, the health system encountered hurdles to deliver quality service to most disadvantaged people including women, children and adolescents; thus

reproductive maternal and neonatal, children and adolescents health and nutrition outcomes are lagging behind: (a) Antenatal care: about half (52%) of women (15-49 years aged) have received at least 4 antenatal care in 2017 while they were 61% in 2001 and 58 in 2011, revealing a substantial fall out; (b) Assisted delivery: only 78% of women have delivered assisted by a qualified health personnel in 2017, showing a slight improvement compared to 66% in 2001; (c) Postnatal care: in Benin, most of maternal mortality occurs before the 48 first hours following delivery. Between 2012 and 2018, the percentage of women who have benefited from postnatal care during the first 48 hours rose from 51% to 66% while 35% did not received any postnatal care. (d) Family Planning outcome: there was a 50% increase of modern contraceptive prevalence with 8% recorded in 2011 against 12% in 2020, with a subsequent drop of the total fertility rate from 6 to 5,7 children; (e) Immunization: over the past decade, immunization program has reached and fully immunized 57% of the 12-23 months aged Children while 11% of this age group has received no vaccine, but this remains better than the figures of 39% in 2001. Overall, none of these results met Government's 2018 goals and health targets. In addition to apparent clients' reluctance to use health services, this poor performance could outline physical and financial hardship, the healthcare users particularly women and children as well as people in rural and underserved areas, may encountered in the quest of quality health service.

6. Benin's health system also remains inadequately financed. Benin is far from meeting the Abuja declaration commitment of allocating 15 percent of the general budget to Health, Benin's health allocation fell from 9 percent in 2009 to 5.53 percent in 2017 and 5 percent in 2019. This low health budget tends to lag Benin behind compared to other WAEMU countries in their state expenditure priorities[4] Subsequently, households' contribution to covering health expenditure increased from 42 percent in 2012 to 52 percent in 2015 while the State's contribution decreased from 24 percent in 2012 to 20 percent in 2015 along with the share of Technical and Financial Partners which lowered from 29 percent in 2012 to 20 percent in 2015.

Figure 1. Sources of health financing and spending per capita in Benin between 2000 and 2017



Source: The World Health Organization, 2020.

[4] World Bank. World Bank Indicators 2019.

7. **Benin's health challenges are further aggravated due to a lack of a robust surveillance system capable of monitoring common diseases.** The lack of a proper surveillance system limits the country being able to trigger alarms in a timely manner to contain disease outbreaks or to rapidly detect and investigate any abnormal clustering of cases or deaths. The 2017 Joint External Evaluation (JEE) and country-led self-assessment in February 2020, revealed key weaknesses: (i) lack of a qualified and motivated health workforce for disease surveillance, preparedness and response at each level of the health pyramid; (ii) absence of functional community level surveillance and response structures; (iii) insufficient laboratory infrastructure for timely and quality diagnosis including of influenza and Covid-19; (iv) monitoring and evaluation (M&E) system performance hampered by the absence of interoperability of different information systems; (v) inadequate infection prevention and control standards, infrastructure and practices; (vi) low availability of medical equipment, essential goods and adequate supply chain system management; and (vii) poor national surge capacity for outbreak response, information sharing and collaboration (viii) non-formalization of the concept of "One Health" with epidemiological surveillance networks for animal and human health operating separately.

8. **To respond to these challenges, the Government has rolled out its five-year plan called Government Action Program 2016-2021 (*Programme d'Action du Gouvernement*).** The Program is built on three pillars, seven strategic axis and twenty-six large actions. One of the key Program actions aims to reorganize the health system for more effective health coverage. In support of this reorganization, a set of reforms have been identified and are being implemented. These reforms have led to the development of a new five-year National Health Plan 2018-2022 (*Plan National de Développement Sanitaire*) that was validated on June 13, 2018. In line with this document, the Ministry of Health (MOH), in collaboration with the National Council for fight against HIV/AIDS, sexually transmitted infections, tuberculosis, malaria, hepatitis and epidemics diseases (*Conseil national de lutte contre le VIH/SIDA, la tuberculose, le paludisme, les hépatites, les infections sexuellement transmissibles et les épidémies* -CNLS-TP) has drafted a five-year plan called "Integrated national strategic plan for the elimination of priority diseases following a *OneHealth*[5] approach, in order to implement an integrated approach to end HIV/AIDS, sexually transmitted infections, tuberculosis, malaria, hepatitis and epidemics diseases. In addition, a National Action Plan for health security 2019-2021 and a new National Community Health Policy 2019-2021 have been prepared and validated during 2019. All these health policies set out the vision, goals, objectives and strategic directions for the related health areas.

9. **The Government has also started the roll out of one of its flagship social programs called "Assurance pour le Renforcement du Capital Humain (ARCH)"**. The ARCH program includes insurance for the poor at its initial stage with at end being mandatory for all people living in Benin, pension for the informal sector, micro finance and professional training. The health insurance

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[5] OneHealth is a collaborative approach for strengthening systems to prevent, prepare, detect, respond to, and recover from primarily infectious diseases and related issues such as antimicrobial resistance that threatens human health, animal health, and environmental health collectively, using tools such as surveillance and reporting with an endpoint of improving global health security and achieving gains in development.

component aims to ensure financial protection against health risk to overall Benin population. The pilot stage was launched in July 2019 and is being effectively implemented in the three health districts as planned. The World Health Organization (WHO) is supporting the pilot stage independent evaluation that started in late November 2020. Approximately 88,948 extreme poor have been enrolled as of October 31, 2020 and 2309 people have received health service free of charge. The scale-up of the intervention to fourteen communes is planned for the end of December 2020.

B. The Government's Program

10. **In the aftermath of the health sector roundtable in 1995, the Ministry of Health (MOH) embarked on the preparation of five-year health development plans.** After two generations of five-year plans, the Ministry of Health adopted in 2009 its first National Health Development Plan (PNDS) covering the period 2009-2018. After five years of its implementation, it was the subject of a mid-term evaluation which revealed remarkable progress and major challenges to be met in relation to the objectives set. The end of this study coincided with the expiry of the Millennium Development Goals (MDGs), the advent of the Sustainable Development Goals (SDGs) and a new regime with a Government Action Program (PAG 2016- 2021).

11. **At the end of the provisions of Article 3 of Decree No. 426 of July 20, 2016 relating to the Attributions, Organization and Operation (AOF) of the MOH,** "the Ministry of Health is responsible for the design, implementation and monitoring and evaluation of the State health policy, in accordance with the principles and values of governance, the laws and regulations in force in Benin and the visions and development policy of the Government… ". With this in mind and to comply with the new vision and development policy of the Government, the health actors and the Technical and Financial Partners (PTF) agreed to draw up the PNDS covering the period 2018-2022. This updated version takes into account the conclusions and recommendations of the mid-term evaluation reports of the PNDS 2009-2018, the Technical Commission for Health Sector Reforms (CTRS), the Sustainable Development Goals and the Government's Action Program. It is therefore the translation of national and international policy and wants to be the programmatic compass of the activities of the sector in order to provide urgent and effective responses to the health problems of the populations.

12. **The National Health Development Plan (PNDS) is the translation of the National Health Policy.** This 2018-2022 PNDS is based, among other things, on the National Development Plan (PND), the Growth Plan for Sustainable Development (PC2D), the Health Sector policy, the Sustainable Development Goals, the conclusions and recommendations of the evaluation. mid-term of the PNDS 2009-2018, the PAG 2016-2021 and the report of the Technical Commission in charge of Health Sector Reforms (CTRSS).

13. **Following the analysis of the health situation carried out in a consensual manner, the following priority problems were identified**: (i) insufficient governance and leadership; (ii) low quality of health care and service delivery; (iii) insufficient human resources; (iv) insufficient

management of human resources; (v) insufficient health information and health research; (vi) insufficient health financing; (vii) poor management of drugs, vaccines and blood products; (viii) poor management of infrastructure, equipment and maintenance.

14. **The PNDS 2018-2022 structured in six strategic orientations contributes to the vision of the sector worded as follows:** "In 2030, Benin will have a regulated, efficient and resilient health system based on the permanent availability of preventive, curative, re-adaptive and palliative promotional care of quality, equitable and accessible according to the life cycle, at all levels. of the health pyramid with the active participation of the population."

15. **The strategic orientations are broken down into specific objectives and axes of intervention** which contribute to ensuring to each and all a good state of health according to the life cycle by 2022 with their participation.

(i) Strategic Orientation (SO1): Development of leadership and governance in the health sector. (i) Strengthening of the internal coordination of interventions at all levels, (ii) Strengthening leadership and governance at all levels, (iii) Strengthening of intersectoral collaboration and partnership in the health sector, (iv) Strengthening of regulation, promotion of ethics and medical responsibility, (v) Improving the integration of cross-cutting aspects (gender, environment and climate change) in the structures and programs of the Ministry of Health.

(ii) Strategic Orientation (OS2): Service provision and improvement of the quality of care: (i) Strengthening the supply of quality services for the health of mothers, newborns, children, adolescents and young people, (ii) Intensification of Family Planning services, (iii) Strengthening the supply of quality nutrition services, (iv) Strengthening of the strategic organization of the community health component, (v) Reinforcement of the financing of the community health component, (vi) Strengthening of the monitoring and evaluation mechanism of the community health component, (vii) Strengthening the supply of quality health services, (viii) Strengthening emergency preparedness and health security, (ix) Promotion of hygiene and basic sanitation, (x) Rehabilitation of the health system to fight against communicable diseases; (xi) Rehabilitation of the health system to fight against non-communicable diseases, (xii) Rehabilitation of the health system to fight against Neglected Tropical diseases, (xiii) Strengthening the fight against vaccine-preventable diseases.

(iii) Strategic Orientation (SO3): Development of human resources in health: (i) Strengthening of health human resources planning, (ii) Rationalization of the management of human resources for health, (iii) Production and development of health human resources skills, (iv) Establishment of a motivation mechanism for human resources in health.

(iv) Strategic Orientation (OS4): Development of infrastructure, equipment, maintenance and health products: (i) Reinforcement in adapted infrastructures, (ii) Reinforcement of equipment, (iii) Strengthening of the upkeep and maintenance mechanism of health infrastructure, materials and equipment, (iv) Improving the availability of quality health products (drugs, vaccines, medical products and technologies).

(v) Strategic Orientation (SO5): Improvement of the health information system and promotion of health research: (i) Production, conservation and use of quality health information, (ii) Management and conservation of archives and knowledge, (iii) Institutional and operational capacity building in the field of research, and (iv) Use of e-health at all levels including the community level.

(vi) Strategic Orientation (SO6): Improvement of the financing mechanism for better universal health coverage: (i) Mobilization of financial resources for health, (ii) Rational use of the sector's resources, (iii) Strengthening of pooling, (iv) Strengthening of the service purchasing mechanism

16. The operationalization of the PNDS 2018-2022 will be done through the development of the Multi-Year Expenditure Programming Documents (DPPD), Annual Performance Projects (PAP), Integrated Annual Work Plans (PITA) of the MOH, Three-Year Plans Development at intermediate and peripheral levels. Its implementation will be based on three main bodies with branches at the intermediate and peripheral levels. These are: Board of Directors, Budget Steering Committee, Single Operational Planning Framework, Framework for consultation between the PTF and the Ministry of Health and the Joint Annual Performance Review of the Health Sector. It is based on the Beninese Constitution of December 11, 1990 amended by Law 2019-40 of November 7, 2019, the National Development Plan (PND) 2018-2025, the PAG 2016-2021, the third pillar of which aims to improve conditions of life, in particular by reorganizing the health system for more effective coverage. It is also aligned with the Growth Program for Sustainable Development (PC2D) 2018-2021, with the results of the Technical Commission in charge of Reforms in the Health Sector (CTRSS) and the National Health Policy (PNS 2018- 2030) whose vision is: "by 2030, Benin will have an efficient and resilient health system based on a sustained availability of promotional, preventive, curative, rehabilitative, palliative care of quality which is equitable and accessible to all. life, at all levels of the health pyramid and the active participation of the population". It is also linked to other important documents in the sector, namely: the National Health Development Plan (PNDS) 2018-2022, the Decentralization and Deconcentration Plan (P2D) 2020-2024, the Integrated Strategic Plan of Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health (SRMNEAJ) 2017-2021.

C. Rationale for World Bank Involvement

17. **The proposed project will complement existing World Bank-financed health sector operations in Benin which collectively align under the Government National Health Plan 2018-**

2022 overarching framework. This proposed PforR represents a next phase of the World Bank engagement that is currently supporting separate health projects responding to specific challenge areas of the health sector. These projects include the Regional Disease Surveillance Systems Enhancement Project (REDISSE) (P161163), Regional Sahel Women Empowerment and Demographic Dividend Project (SWEDD) (P150080), the Early Years Nutrition and Child Development Project (P166211), Benin COVID-19 Preparedness and Response Project (P173839), and Additional Financing (P175441). The P4R will build on the experience of these projects and provide a program approach instead of a project approach by identifying key results areas to be achieved and aligning financing to these areas. The proposed project will be the first P4R for Benin's health sector and has been identified as the proper financing instrument to support the institutionalization of key program actions based on results as opposed to project specific activities. The P4R has been designed to reflect the priorities of the Government in terms of improving health outcomes through quality service delivery and reinforcing the accessibility to these services. Accordingly, all project activities will be aligned with the Government's reform agenda in these areas.

18. **In addition to the existing operations, the proposed Program will also work in harmony with forthcoming operations which will support the continued country response to COVID-19.** An Additional Financing of US$30 million (P176562) to the Benin COVID Emergency Response Project (P173839) will finance the purchase of COVID19 vaccines and the immediate supporting deployment actions. The PforR will finance complementary activities more focused on the structural reinforcement and support to strengthening systemic structures and functioning of the overall Government program, but no vaccine purchase.

19. **The proposed operation is core to meeting Focus Area 2 of the Country Partnership Framework[6] (CPF)**. The CPF, covering the FY19–FY23 time horizon, identifies three focus areas for reducing extreme poverty and boosting shared prosperity: i) achieving the structural transformation for competitiveness and productivity; ii) investing in human capital, and iii) increasing resilience and reducing climate-related vulnerability. The proposed operation strongly supports the second CPF focus area which has as one of its objectives to improve social protection systems. Under objective 6, key priority areas for support include actions for improved administration of pensions and health insurance, improved child nutrition and family services, and improved disease surveillance. The proposed P4R operation is a key instrument for improving health insurance through strengthening the ARCH program, providing results focus to maternal and child health services, and improving disease surveillance through support to COVID-19 response efforts.

20. **The proposed Program-for-Results (PforR) is the first time this financing instrument will be used by the World Bank in support of Benin's health sector.** The Ministry of State, Planning and Development has explicitly expressed interest in the use of a results-based operation using

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[6] Benin - Country partnership framework for the period of FY19-FY23 (English). Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/643931531020663012/Benin-Country-partnership-framework-for-the-period-of-FY19-FY23.

the PforR instrument to support the design and implementation of its national program with a set of measurable results. This is the direct result of the broad engagement the WB has established with the Benin health authorities over the past thirty (30) years through lending operations and analytical work. Through this operational and analytical work, the planning, budgeting, and monitoring functions within the MOH have been strengthened over the seven years of project implementation. In addition, lessons learned from across these years of Bank engagement in the Benin health sector help inform the design of the proposed PforR. These include the importance of providing autonomy to health facilities to make local decisions related to staffing and inputs, ensuring Government commitment of resources as a reflection of ownership, importance of demand-side interventions for activities requiring active participation of household and community members, linking project activities to emphasize building institutions, and incorporating verification of results based on risk factors that should be identified by the Government.

III. Technical Soundness

A. World Bank Supported PforR Program

21. The proposed PforR will be structured around two results areas aligned to the Government program six strategic orientation areas. These results areas are aligned with the analysis and conclusions of the work conducted by the Technical Commission in Charge of Reforms in the Health Sector (CTRSS). The CTRSS was set up in 2016, during the Government transition, when a new dynamic of public service and action was initiated and at a time when key national strategy documents were developed (PAG) or updated (PND and PNDS). The conclusions of the work carried out by the CTRSS provided the new directions for improving the performance of the health system. This new direction resulted in a focus across two results areas. The results areas that will be supported by the proposed PforR are:

(i) **Result area 1**: Access and Quality. This result area seeks to improve access to and strengthen the delivery of quality Reproductive, Maternal, Newborn, Child, and Adolescent Health + Nutrition (SRMNCAH + N) health services. This result area would support activities related to ensuring that high impact interventions are developed and implemented in 90 percent of health facilities through a minimum package of health services that aims to improve SRMNCAH+N results by the end of the project, the quality assurance system is strengthened in the sector, the infrastructure and the technical training platforms are modernized, medicines and essential health products are available at the last mile, and qualified human resources for health (HRH) in sufficient numbers and equitably distributed are available. The list of activities to be supported by the proposed PforR and that are mainly related to access, and quality is presented below. These activities include responsibilities that correspond to community health workers (CHWs), front-line clinicians, and health system managers. However, it should be noted that, as

discussed above, the intrinsic relationship that exists between the result areas imply that some activities are related to more than one result area.

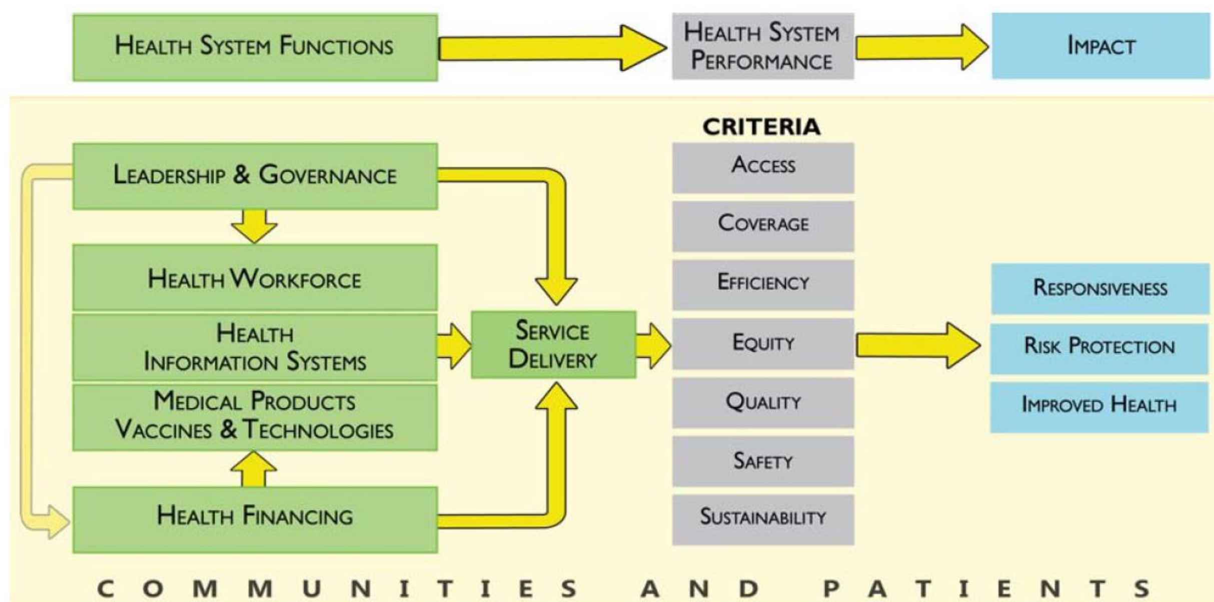
(ii) **Result area 2:** Health System Capacity and Emergency Preparedness and Response. This Result Area is aligned with the government program's Strategic Orientation 4: "Development of infrastructure, equipment and health products." This Results Area will support investments in key components of primary health care service delivery, notably infrastructure, equipment and supply of medicines and consumables. The Results Area will also support investments in emergency preparedness and response. DLIs will reflect the establishment of functional health facilities, improvements in medicine supply, and improved capacity for public health emergencies and response. The PforR will support the necessary activities to achieve these results, including key infrastructure of the Government's infrastructure development plan. Activities to improve supply chain management will include support for budgeting and planning processes and strengthening warehouse and distribution capacity to ensure the risks of stock-out of maternal and child health drugs are health facilities are reduced. Under these Results Areas, the PforR will also support emergency response capacity building. Activities will include: (i) hiring and training a sufficient number of competent community health workers; (ii) development of an integrated strategic communication strategy and plan on preventive measures to be rolled out at the point of health service delivery focused at the community-level; (iii) development of tools to strengthen programs for the prevention of gender-based violence (GBV) and mental health support that will be provided through the public health department; (iv) further development and roll-out of a national and regional communicable and non-communicable disease surveillance system and early warning systems; (v) development of protocols to ensure the routine delivery of health services at community health centers. Support from the PforR in this area will complement the existing COVID project.

22. **Developed through the analysis of the strengths, weaknesses and challenges of the Benin health system, the NHDP shows a sound strategic rationale**. The mid-term evaluation of the previous PNDS (2009-2018), the conclusions of the technical commission in charge of health sector reforms and the analyses of the integration of climate change adaptation have highlighted the priority areas that hampers the Beninese' welfare and to which the current health sector program aims to cope with and for which it defines the six strategic orientations. The NHDP is fully aligned with international commitments for which Benin has subscribed**.** The NHDP is consistent with the country's partnership strategy for the period 2018-20203.

B. Technical Soundness

23. The lacking performance of the Benin health system, particularly on maternal and child health can be attributed to shortcomings in the six health system core components: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance. The World Health Organization (WHO) (2007) has defined health system strengthening, as: "…improving [the] six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. There is growing recognition of the importance of Health System Strengthening (HSS) and Universal Health Coverage (UHC) as critical strategies for improving global health outcomes. In a 2005 World Health Assembly resolution, WHO member states committed to develop their health systems with the goal of ensuring that all people have access to health services, without being subject to financial hardship for paying for them (WHO 2010). As part of the HSS framework, WHO (2000) organized the health system into six functions, or building blocks: (i) Leadership and governance, (ii) Health financing, (3) Service delivery, (4) Human resources for health (HRH), (5) Medical products, vaccines and technologies, (6) Health information systems (HIS). A functioning health system is constituted by the multiple relationships and interactions among the blocks. Further, not all functions are equal – some, such as leadership, pull the health system, while others, such as information systems, support the system in the delivery of services.

Figure 2. Building blocks interactions



24. The National Health Development Plan (PNDS) is defined based on two overarching and inter-related areas required for a program that can improve health outcomes. These include

- Technically sound and costed strategic plans (Maternal, infant, child, adolescent health operational plan, National food and nutrition action plan and National Health Security

Action Plan (NHSSAP)), consistent with the PAG, the PC2D, the National Development Plan and the SDGs

- High-level political commitment. The ongoing administration has committed to implement ambitious institutional, political and economic reforms outlined in policies and operational plans. The social component namely, improved social well-being remains one of three development's pillars. Thus, a series of well-defined Health policy and strategies have been defined to enable the achievement of international (SGDs) and national commitment. Significant achievements have been made so far thanks to strong government leadership and several major reforms have begun to have an impact.
- An effective project institutional and governance arrangement including the MoH, the executing body, which will have an oversight for policy and strategic guidance; the Program implementing bodies lead by the Agence Nationale des Soins de Santé Primaires (ANSSP) with the other implementing stakeholders including the line ministries, governmental entities, other MoH departments; a well-defined decentralized Program delivery arrangement and a sound coordination mechanisms and strong donor coordination and aid harmonization leaded by the MoH.

25. The two results areas supported by the PfoR and that derived from both the PNDS and the current Benin Health system analysis are intrinsically related. Access and quality problems are not only challenges in and of themselves, but they are also most felt at the point of service delivery, particularly at the primary health care level, accentuated in emergency contexts and situations. Quality primary health care is the cornerstone of universal health coverage. Evidence suggests that Inherent in universal health coverage is the need to think beyond improving access to services to also ensuring that those services are of good enough quality to be effective. Thus, it is important to acknowledge that quality and access are not competing agendas but are mutually reliant. In addition, Primary health care services account for a large and growing proportion of a country's health care provision, thus high-quality universal health coverage cannot be achieved without systematically addressing the quality of primary health care. Indeed, the original Declaration of Alma-Ata and the 2018 Declaration of Astana are grounded in the core principle of quality: the need for strong public health and high-quality primary care throughout people's lives, and the ability to provide effective, scientifically sound care, engage people and communities and address inequities. In addition, quality in primary health care is critical to achieve the broad public health goals within universal health coverage. It makes the case for quality improvement as a core function of primary health care and provides the perspectives of different levels of the health system.

26. The quality of primary health care can be greatly affected by the prevailing culture and environment of the health system. There are a number of interventions to improve quality of care at the system level that create an enabling environment, including: national workforce strategies; registration and licensing mechanisms; external evaluation or accreditation; public reporting and benchmarking mechanisms; and national regulatory bodies for medicines, medical devices and other health products. Health information systems to measure and drive quality of

care, and financing methods to support provision of high-quality care are also essential. While recognizing these linkages between quality and primary health care, it is widely acknowledged that quality does not occur spontaneously. Several key features of a culture of quality are foundational and are very much aligned with the principles of primary health care.

27. Proper emergency response requires interaction across the results areas as at the height of an emergency, it is critical to ensure quality services are being deployed, that these services reach the community level, and that governance of the health sector enables and supports the roll-out of an emergency campaign which requires cross-sectoral engagement and timely actions.

C. Institutional Arrangements for Implementation

Institutional Structures

28. **The proposed PforR operation will no add new structure and will use existing institutional and implementation arrangements.** The implementation of the Program like the NHDP will rely on three main bodies with dismemberments at central or national, the intermediate or regional (Regional Health Directorate) and peripheral or operational levels (health districts) of the health pyramid. The central or national level represented by the MoH has the responsibility to: (i) design the national health policy; (ii) define the strategies and main actions to be carried out to reduce morbidity and mortality, improve the quality of life of the population, reduce social inequalities and geographical disparities (iii) define norms, standards and protocols for services and care; (iv) mobilize the resources necessary for the implementation of the NDHP; (v) Coordinate the implementation of the various interventions; (vi) Monitoring and evaluating the implementation of the policy and strategies. It also promotes intra and intersectoral collaboration to achieve the programs development objectives and enables the transfer of resources according to decentralizing and deconcentrating processes. The coordination of all the st GOs and other civil society organizations working in the health sector, lead technical analysis on health Care financing agenda, managing the overall monitoring and evaluation and mainstreaming cross-cutting issues (gender, environment and climate change) into structures and programs Three entities under the MoH with specific mandates will be in charge for coordinating and supporting their respective programs in all regions. They will collaborate in a synergistic and complementary manner to achieve the Program's objectives as follows:

29. **The ANSSP will be responsible for planning, budgeting and reporting funds disbursed under the Program in line with the PHC intervention**. Established in October 2019 by presidential decree following reforms to revamp the health sector, the ANSSP is a state agency with a social mission and has legal personality and financial autonomy under the aegis of the MoH. It is responsible for the implementation of the National Health Policy health policy with a focus on primary health care. In this regard, it is in charge of: (i) ensuring the implementation of policies, strategies, standards and regulations in the different the different areas of primary health care in accordance with the NHDP; (ii) planning and coordinating the implementation of policies and strategies related to primary health care Planning and coordinating the implementation of

policies and strategies related to primary health care; (iii) ensuring the provision of quality health care; (iv) integrating the socio-cultural component in the implementation of PHC policies and strategies ; (v) advocating for the mobilization and pooling of the necessary financial resources resource; (vi) Ensure the financial sustainability of PHC structures; (vii) contributing to the production and management of health information related to PHC.

30. The structural and functional architecture is close to be completed, the Board of Directors and management is established while the management body is being set up. The General Directorate who was appointed one year ago has been recently discharged and the position has been taken over by an interim Director. The following technical departments existing under the previous MoH organizational chart have been moved under the ANSSP: (i) strategic orientations and the area of intervention is the responsibility of the programs' coordination entity which under the authority of the Minister of Health. The coordination, monitoring and evaluation of all strategic areas are the responsibility of the National Implementation and Monitoring Committee of Health Sector Projects and Programs (*Comité National de suivi de l'Exécution et d'Evaluation des Projets/Programmes du secteur santé CNEEP*) with includes the sector's partners, and civil society. The Forecasting and Planning Department is in charge of strategic and annual planning, improvement of the health management information system (HMIS) mobilizing domestic and external resources, coordinate Department of Epidemiological Surveillance and Monitoring-Evaluation, (ii) Directorate of protection of mothers and children (iii) Department of Immunization and Logistics (iv) Department of Nursing and Obstetric Care, (v) Directorate for the Promotion and Protection, (vi) Directorate for the Promotion of Hygiene and Basic Sanitation and (vii) Public Health Emergency Operations Center.

31. The fiduciary departments of the ANSSP has been recently appointed and will therefore be supported by the Fiduciary departments of the MoH at the early stage of implementation in the management the PforR's fiduciary aspects. Close intra-sectoral collaboration within the MoH will apply to help ANSSP achieve the Program's goals including: National Directorate of Hospital Medicine (DNMH), the Beninese Agency for Pharmaceutical Regulation (ABRP), the National Agency for Quality Control of Health Products and Water (ANCQ), the Agency for Health Infrastructure, Equipment and Maintenance (AISEM), the directorate of Health Information Systems the Beninese Society for the Supply of Health Products (SoBAPS) and the blood transfusion agency (Agence nationale de la transfusion sanguine ANTS)..., as well as inter-sectoral partnership with the health sector regulatory authority (ARS), the Health Care Delivery Control Commission, the Ministry of Finances and Economy, the Ministry of Infrastructures.

32. **The Government of Benin has established the Food and Nutrition Council (FNC), the multisectoral body for effective coordination of the food and nutrition sector in Benin.** Chaired by the President of the Republic, the FNC is composed of Seventeen (17) members representing public and para-public actors including seven (07) line Ministries, civil society organizations, private sector actors. It is assigned three main functions: (i) To define the National Food and Nutrition Policy; (ii) Toensure the elaboration, implementation, monitoring and evaluation of the National Action Plan for Food and Nutrition; (iii) To ensure the coordination of actions related to food and nutrition. The FNC has been institutionalized administratively with the establishment

of Regional Coordinating Bodies (RC), Departmental Consultation Bodies (DCB), Communal Consultation Bodies (CCB) and community-based nutrition organizations. Its Executive Body called the 'Permanent Secretariat', manage technical issues, coordination and monitoring. It comprised of representatives from all seven-line ministries including the Directorate of mother and child Protection from ANSSP (MoH) and nutrition partner and nutrition partner.

33. The Permanent Secretariat of the National Committee for the Fight against HIV (Comité National de Lutte contre le VIH-Sida, les IST, la Tuberculose, le Paludisme, les Epidémies et les Hépatites SP-CNLS-TP), ithe implementing body of the CNLS-TP, will collaborate with the ANSSP to ensure a coordinated and effective implementation of activities related to improve the country preparedness and ensure rapid response to any diseases with epidemic potential. While the SP-CNLS-TP will ensure the strategic orientation and coordinate the overall country preparedness day-to day implementation, the PHEOC will be preparing the emergency axis of the implementationand response to any outbreak.

34. **Program financing management.** Considering institutional responsibilities and the ongoing budgetary reform, the Program will be operationalized through the multi-annual Expenditure programming Documents, the Annual Performance Plan (PAP) and the three-Year Development Plans of the Regional Health Directorate and Health districts. In accordance with the provisions of the new organic law governing finance, the Program operational budgets will be carried out within the framework of the directives of the UEMOA harmonized framework of public finances of 2009, based on a results-based management (RBM) logic. Consequently, the Program budget will be prepared according to the following existing three budget Plans: (i) Steering and support to the departments of the MoH for Program Result Area 2 interventions, (ii) Prevention and health security Health for Program Result Area 3 interventions, (iii) Care delivery and access for Program Result Area 1 interventions. The Program will be provided with funding from the state budget, local authorities, the private sector, national and international NGOs and bilateral and multilateral partners. External funding is estimated from the data recorded in the self-evaluation reports of the structures benefiting from this support. The hypothesis of maintaining the average level observed over the last ten years with an annual increase of 2% over the implementation period is assumed.

The Governance structure and Institutional Capacity

35. **Benin Government has been implementing a governance and institutional reforms in the MoH since the report of the CTRSS to upgrade the health sector.** On September 2017, the CTRSS report recommended substantial reforms both on the institutional, the organizational and functioning component to reorganize the health sector and thus increase the level of governance, leadership and improve the overall sector performance. From quarter 3 of Year 2018 to quarter 4 of year 2020, the government have adopted by cabinet decree several main reforms as follows: (a) nine (09) main institutional reforms including: (i) National Council for Primary Health Care, (ii) National Council of Hospital Medicine (iii) National Directorate of Hospital Medicine (DNMH), (iv) National Agency for Pharmaceutical Regulation (v) the Health Sector Regulatory Authority, (vi) the Beninese Agency for Pharmaceutical Regulation (ABRP), (vii) the National Agency for Quality

Control of Health Products and Water (ANCQ), (viii) the Agency for Health Infrastructure, Equipment and Maintenance (AISEM), (ix) Beninese Society for the Supply of Health Products (SoBAPS); (b) four (4) reforms related to the health sector functioning including (i) the Health Care Delivery Control Commission, (ii) the Ministerial Internal Audit Committee, (iii) the Ministerial Risk Management Committee, (iv) the Ministerial Commission on Information Systems and Connectivity (CMSIC); and (c) four (4) reforms on the sector overall governance including (i) Law on the protection of human health in the Republic of Benin, (ii) the revision of the law on private practice, (iii) the regulation of the collective work suspension related to the exercise of the right to strike in the Republic of Benin (iv) the prohibition of private practice for public officials and (iv) the reorganization of the private health sector by reviewing all authorizations for private practice and authorizations for the opening and operation of private health facilities. All these reforms are in early stages of implementation and do require technical and financial support to achieve the objective in order to meet the assigned objectives.

36. **Despite the health sector has demonstrated a certain capacity to define, and implement the NHDP, the need to improve the sector overall capacity remains.** Thus, to achieve the objective that are assigned, while adapting to the new paradigm of the various reforms, a capacity-building is required to improve the sector institutional, organizational and operational capacity at national and local through technical assistance and training in various areas including: the Health sector reforms in implementation; evidence-based decision making, quality assurance system development, certification an accreditation process development; maternal, child and adolescent; IT for health development research in health; quality health workforce at all levels; climate change and environmental health.

IV. Program Expenditure Framework

A. Program Budget Structure and Classification

37. The proposed PforR would finance part of the total Government program. The general budget of the PNDS 2018-2022 is estimated at CFAF 1913.974 billion (about US$3.5 billion equivalent). This funding will be mobilized through the contribution of the State, technical and financial partners, local authorities, households, insurance companies, NGOs, the private sector, the diaspora, etc. The PforR would provide US$100 million to support the activities in three of the six strategic orientation areas.

The Beninese Health Sector remains adherent to the provisions of the Organic Law 2013-14 of finance in managing economic resources across its authorized expenditures. The sector has migrated from the resource-based budget management approach to a performance-base one which helps control public expenditure, reduce variations between forecasted and actual expenditures, and minimize disparities between sector's expected and realised outcomes.

The Ministry of health, in recent times, has amended its medium-term expenditure frameworks and budgeting process to enhance their practicality and restrain unjustified budget growth. Yet, further enrichment would be quintessential as substantial deviations between approved and revised budget persist. Budgetary gaps of -2.3 percent, -1.05 percent and +35.76 percent are recorded by the sector in 2018, 2019 and 2020 accordingly, partly due to increased subsidies.

The integral role of the health sector in maintaining and improving the well-being of residents of Benin, predisposes it to continue receiving increased governmental attention amidst surging economic and social challenges. The sector, though financed by resources pooled from diverse sources, requires more innovative financing instruments for quality healthcare to be accessible to the most deprived communities.

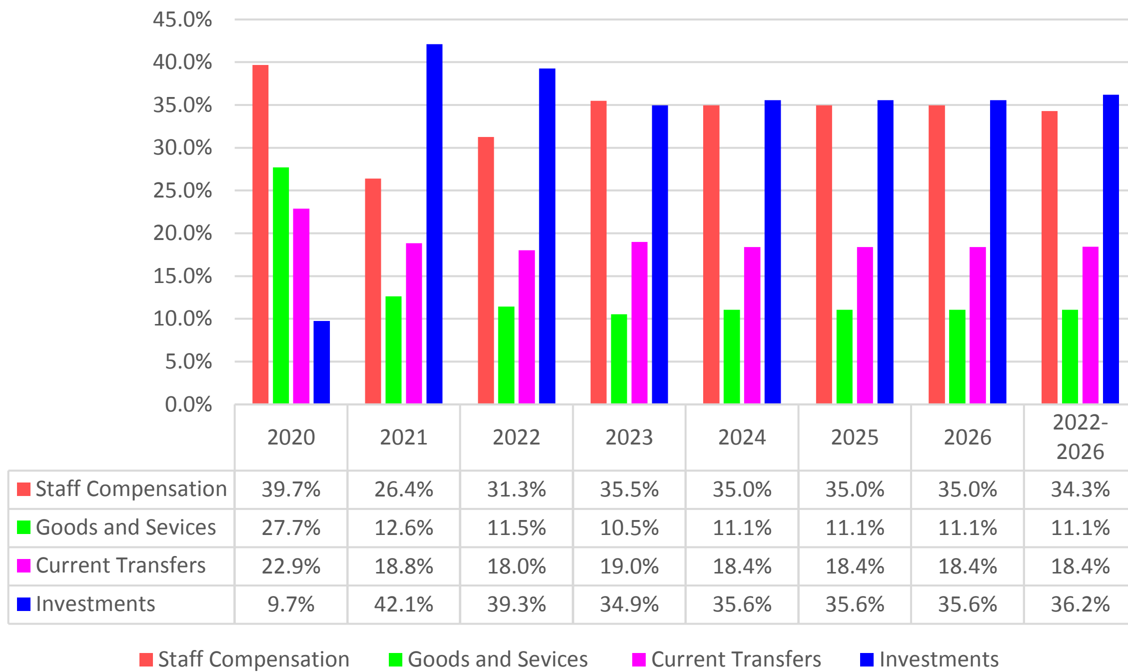
Over the five-year period spanning 2022-2026, the Ministry of Health is programmed to execute a budget of about US$1.23 billion. With the increased consideration the sector receives from the government, it is usually assigned annual expenditure limits that are accommodative of the sector's expenditure. In 2020 and 2021 for instance, the sector's indicative spending ceiling were roughly US$128.2million and US$167 million respectively whereas it ran on budgets of US$21.2 million and US$109 million, accordingly. Again in 2020, nearly US$6.2 million budgetary surplus was realized by the sector; the performance-based budgeting approach employed for budgeting played a crucial role to this effect.

Though the ministry's budgeted expenditure for the 2022-2026 period exceeds the projected indicative spending limit of US$862 million for the sector for the same period, it is notable that the indicative spending limit exceeds the expected financial commitment from the government for the PforR program. Additionally, the ministry has in the past made heavy investments, and as such, during the program period, could cut back on its non-essential investments to permit the indicative spending limit projected for the ministry over the period to encompass the US$740.4 million expected from the government for the financing of the project. Though the authorized budget may exceed the projected financial resources for a period, the latter is more than adequate to allow the execution of the program.

The comparative composition of expenditures on the health sector's budgets has significantly varied over the years. Nevertheless, between 2022-2026, Health Ministry's expenditure is estimated to mainly favour investments (36.2 percent). Almost 34.3 percent is slated for compensation of the sector's personnel whereas 18.4 percent and 11.1 percent are intended for current transfers and the purchasing of goods and services, accordingly (see figure 1). While as much as 63.8 percent of the sector's expenditure is recurrent spending, it is laudable that a substantial fraction of the ministry's spending (36.2 percent) is geared toward the sector's growth.

On the revenue side, less than a fourth (see figure 2) of the funds is predicted to be externally sourced which immensely reduces the precariousness that may be associated with canvassing financial resources to cover expenditure.

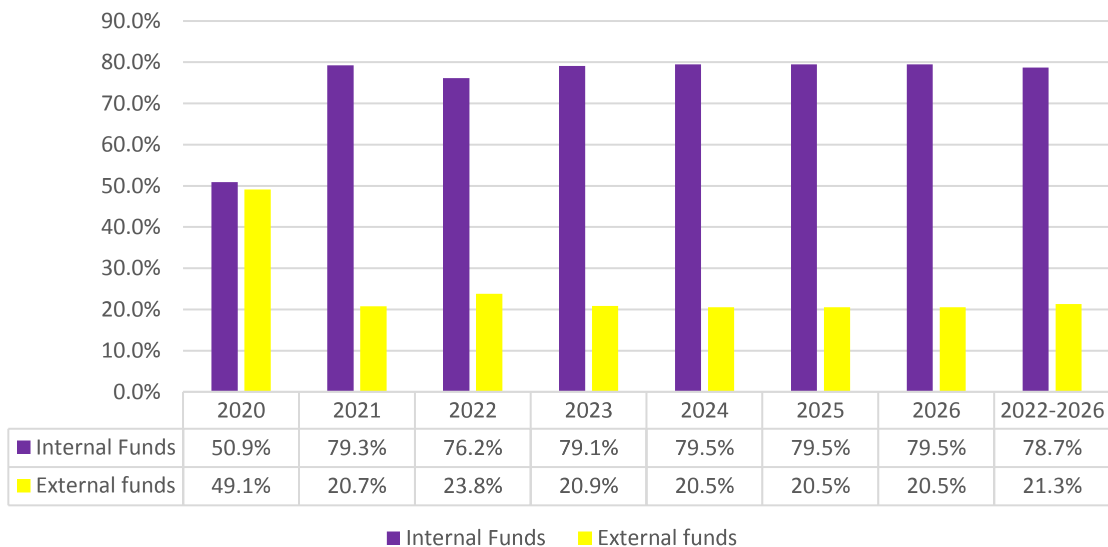
Figure 1: Ministry of Health's Expenditure by Spending Categories, 2020-2026 (Actual and Projected)



	2020	2021	2022	2023	2024	2025	2026	2022-2026
Staff Compensation	39.7%	26.4%	31.3%	35.5%	35.0%	35.0%	35.0%	34.3%
Goods and Sevices	27.7%	12.6%	11.5%	10.5%	11.1%	11.1%	11.1%	11.1%
Current Transfers	22.9%	18.8%	18.0%	19.0%	18.4%	18.4%	18.4%	18.4%
Investments	9.7%	42.1%	39.3%	34.9%	35.6%	35.6%	35.6%	36.2%

Source: *Team's Computation from Ministry's Estimates*

Figure 2: Funding Sources for Ministry of Health's Expenditure, 2020-2026 (Actual and Projected)



	2020	2021	2022	2023	2024	2025	2026	2022-2026
Internal Funds	50.9%	79.3%	76.2%	79.1%	79.5%	79.5%	79.5%	78.7%
External funds	49.1%	20.7%	23.8%	20.9%	20.5%	20.5%	20.5%	21.3%

Source: *Team's Computation from Ministry's Estimates*

The Benin Health System Enhancement PforR program is envisaged to cost approximately US$940.4 million with US$200 million (21 percent) being from IDA sources and the remaining US$740 million (79 percent) funding from the Government of Benin. Both the period's budget and payment limit projections of over US$1.2 billion and US$862 million are adequate to absorb the government's share of funding for the period and still create ample fiscal space for other ministerial and sectoral spending.

The earmarked US$940.4 million is envisioned to be allocated to ameliorate human and financial resource management; upgrade healthcare information systems; fight various diseases at the primary healthcare level; enhance health security and preventive systems; improve the quality of health service delivery as well as access to quality healthcare across the country. The funds are intended to be apportioned as depicted in table 1. Tables 2 to 7 summarize constituents of revenues and expenditure for the ministry from 2020 to 2026

Table 1: Program Budget Breakdown

Budget Line Item	Total 2022-2026 (CFA)	Total 2022-2026 (USD)	Total (USD)
045: Steering and Support to services	***169,747,865,187***	***308,632,482***	***331,988,846***
045001: Steering and coordination	13,038,605,000	23,706,555	25,161,100
045002: Program Planning and M&E	3,002,500,000	5,459,091	7,277,273
045003: Human Resources Management	41,025,015,000	74,590,936	90,285,300
045006: Information System	880,000,000	1,600,000	5,989,273
046: Prevention and Health Security	***75,914,575,000***	***138,026,500***	***174,979,227***
046003: Fight Against Disease	36,012,500,000	65,477,273	88,084,545
046004: Primary Health Care Promotion	39,902,075,000	72,549,227	86,894,682
047: Access and Health Service Delivery	***161,581,027,000***	***293,783,685***	***433,474,594***
047001: Hospital Development	74,754,002,000	135,916,367	251,370,912
047002: Health Zones Development	72,227,025,000	131,321,864	147,685,500
047004: Health Products Availability	13,100,000,000	23,818,182	31,009,091
047005: Health Infrastructures Development	1,500,000,000	2,727,273	3,409,091
Total		**740,442,668**	**940,442,667**

Source: *Team's Computation from IDA and Health Ministry's Estimate*

Table 2. Health Sector Budget Summary (in US Dollars)

MOH	**2022-2026**	
Budget Item	**Authorized Budget (US$)**	**Credit of Payments (US$)**
Total Expenditure	**1,225,281,764**	**862,039,046**
Staff Compensation	0	295,640,307
Goods and Services	0	95,349,463
Current Transfers	0	158,815,100
Investments	1,225,281,764	312,234,176
Government Investment	422,179,946	247,933,103
Capital Transfers	803,101,818	64,301,073
Total Funds	**1,225,281,764**	**862,039,046**
Internal Funds	899,663,273	678,547,779
Budgetary allocation	899,663,273	678,547,779
Domestic loans	0	0
External funds	325,618,492	183,491,267
Foreign Loans	150,761,025	152,970,263
Donations/Grants	174,857,466	30,521,004

Source: *World Bank computation from Ministry Estimates.*

B. Adherence of Budgeted Program Expenditure and Execution to Government Priorities

38. The Program will be mostly financed by the World Bank loan. The Disbursement-Linked Indicators (DLIs) have been designed in such a way to eliminate cash flow constraints for the Agency, which should always have enough cash available in order to finance investments. The overall cost of the supported Program including the portion financed by the Bank are included in the multi-year expenditure programming documents as well as the program for priority investment (PIP). The annual budgets are prepared based on the PIP. Importantly, the government has recently adopted a policy of only including projects from the government action plan (GAP) in the PIP, as well as projects which are mature and ready for implementation (e.g., feasibility studies and technical evaluation already conducted to project readiness).

39. The component to be contributed by the GoB will come mostly through the GoB budget allocation to the Ministry of Health, for its running costs and for some investments in new health facilities infrastructure. The GoB has made an initial budgetary allocation to the MOH. The budget allocation is sufficient to cover its initial projections of costs for the first year. It is assumed that this budget will be supplemented as and when it is needed, given that the Ministry of Health, which is directly accountable to the President of the Republic of Benin, is clearly aligned with the GoB's top priorities of addressing health sector challenges resulting from the impact of the COVID impact.

C. Efficiency of Program Expenditures

40. The funding for the Program is adequate, sustainable and aligned with the intended results under the Program's Result Framework. The activities and expenditures under the Program will be funded from the budget assigned to the Ministry of Health. This budget has been analyzed and has been found to be fully budgeted and executed over the years.

V. Program Results Framework and M&E Capacity

A. Description and Assessment of Program Results Framework and M&E Capacity

41. **Assessment of the Monitoring and Evaluation (M&E) Arrangements.** An assessment of the quality and capacity of the M&E arrangements found that Benin has several data and M&E systems that can be used to monitor and evaluate results. As much as possible the proposed program will draw upon the existing M&E and data systems from previous and ongoing projects which include the Regional Disease Surveillance Systems Enhancement Project (REDISSE) (P161163), Regional Sahel Women Empowerment and Demographic Dividend Project (SWEDD) (P150080), the Early Years Nutrition and Child Development Project (P166211), Benin COVID-19 Preparedness and Response Project (P173839), and Additional Financing (P175441). These systems will need to be complemented with additional collection and independent verification, as needed.

42. **Results-based financing approaches, such as the one implemented in Benin from 2012 to 2017, are typically designed and implemented around a rigorous M&E system.** Under the Health System Performance Project (P113202), a performance-based financing (PBF) scheme was implemented which substantially improved the coverage of maternal, neonatal, and child health services, and the quality of care in the eight health zones of the project as well as the institutional capacity of the MOH. Under this project, the M&E qualitative and quantitative data were very important for the effective functioning of the RBF. The project supported improvements of the monitoring and evaluation system by (i) removing redundant processes, (ii) developing new indicators, and (iii) reinforcing national capacity to carry out impact evaluations. One of the components supported under the project was technical assistance for institutional strengthening which focused on the stewardship of the health sector by improving several management functions at the MoH: planning, budgeting and supporting improvements for the monitoring and evaluation (M&E) system, including (i) the merger of overlapping M&E processes, (ii) the development of additional indicators (e.g., referral rate for pregnant women), and (iii) the strengthening of national capacities in impact evaluation. Through this operational and analytical work, the planning, budgeting, and monitoring functions within the MOH were strengthened over the five years of project implementation. The proposed program will build on these lessons learned as well as lessons from other operations across the years of Bank engagement in the

Benin health sector, and will support the continuous improvements of the M&E systems through capacity building and training of project staff. Other needs for technical capacity building will be further assessed and support will be provided during implementation, through the World Bank as well as partner organizations.

43. **Results Monitoring and Evaluation.** The proposed Program will use the government system for the M&E, and reporting arrangements. The Institut Regional de Sante Publique (IRSP) will be the independent verification agency for the Program DLIs. Data for quantitative indicators will be provided by national and sector-specific databases. Qualitative indicators will be monitored according to the verification of milestones and processes described in the verification protocol. The MOH will oversee program implementation progress. The MOH will be responsible for collecting the information required to ensure DLI compliance and for submitting it to the IRSP. Similarly, the MOH will ensure that technical and analytical areas of the Program report timely progress of program indicators (DLIs and PDOs).

44. **Monitoring and Evaluation and Review Plan (PSER 2009-2018).** To continuously monitor the progress of its National Health Development Plan, the Government of Benin developed a Monitoring and Evaluation and Review Plan (PSER 2009-2018) to support the implementation of the objectives of the National Health Development Plan. The PSER is closely monitored by the Ministry of Health. The monitoring plan and tracking indicators of the PSER constitute the framework to monitor progress and measure the performance of the health sector. The Ministry of Health oversees the implementation of the PSER with further participation from technical and financial partners providing resource mobilization, financing and technical support. The PDO will be measured by four PDO indicators, which are present in the PNDS. The PSER will be a critical tool for the regular monitoring of the proposed program results during implementation to help redirect certain actions where needed, to improve the performance of the project.

B. Capacity Building

45. **The proposed project will build on the experience of previous projects** - the Regional Disease Surveillance Systems Enhancement Project (REDISSE) (P161163), Regional Sahel Women Empowerment and Demographic Dividend Project (SWEDD) (P150080), the Early Years Nutrition and Child Development Project (P166211), Benin COVID-19 Preparedness and Response Project (P173839), and Additional Financing (P175441), however given that the PforR instrument is new to the Ministry of Health, both project staff and implementing partners will benefit from capacity building activities on the PforR lending instrument, as well as other technical capacity building activities during preparation and implementation.

46. **Institutional Capacity for Implementation**. The Institute for Public Health research (*Institut de Recherche en Santé Public Comlan Alfred Auguste QUENUM (IRSP - CAQ*) is a regional and international institution created on the initiative of the Beninese Government and WHO, that provides public health training, health research, expertise and services. This Institute which benefits from the autonomy of management within the University of Abomey- Calavi will serve

as the Verification Agency for the achievement of all the DLIs. IRSP was created in 1977 and is well experienced in research, implementations of surveys and use of verification arrangements. While the need for capacity building within the IRSP will be minimal, other needs for support and technical capacity building will be further assessed and provided during implementation, through the other implementing agencies.

47. **The following topics have been identified for capacity building and institutional strengthening, under each of the two results areas**.

- Quality: Technical Assistance (TA) to update the facilities providing Emergency obstetric and newborn care (EmONC) and Basic emergency obstetric and newborn care (BEmONC) services, TA for increasing the capacity of health sector workers in continuous quality improvement, TA in conducting an in-depth assessment of the performance of its PHC system focused on RMNCAH+N;

- Efficiency: TA for supply chain management and logistics; capacity building for developing interoperability standards and health data analysis;

- DLI reporting and verification: Capacity building in the process of collecting the data for reporting the DLIs, and for the MOH to strengthen the verification process of compliance with the DLIs, among others to be included in the Program Action Plan (PAP).

48. **Result Area 1: Access and Quality: Strengthening the supply of quality health services in health facilities and improving demand for care.** Capacity support will include activities aimed at building local government capacity by developing and implementing capacity building workshops to support public sector management functions for planning, budgeting and management of health services.

49. **Result Area 2: Health System Capacity and Emergency Preparedness and Response**. Training activities will be targeted to outbreak preparedness and response teams at regional and district levels to increase regional and district level capacity to promptly detect cases and follow-up all suspected cases and contacts, enhance coordinated planning and monitoring of response interventions. Capacity support will also be needed to support risk communication and community engagement by developing training modules and brochures to facilitate health promotion activities with/by communities. Capacity building will also be required to support and improve the handling of complaints.

C. Results Chain

50. The results chain which includes the Disbursement Linked Indicators DLIs, Disbursement Arrangements and Verification Protocols (included in Annex 2 of the PAD), show the linkages between the activities, outputs, intermediate outcomes, and the final outcomes from the proposed PforR program. This also articulates the PDO indicators (in bold), DLIs (in italics).

VI. Program Economic Evaluation

A. Rationale for Public Provision/Financing

51. Public provisioning/Financing is appropriate for the proposed operation since it will support a broader Government program. In addition: (a) Benin has sound institutions and procedures; (b) by linking disbursements to achievement of results that are tangible, transparent, and verifiable, the shift of public funds can be made to focus towards the achievement of results, rather than concentrating on issues related to the financing of inputs; (c) the use of public financing will ensure that priority is given to key goals of the Government, based on the national strategy developed under national consensus, thus shielding them from political uncertainties; (d) the use of public funds will also allow for improvements, as necessary, in the implementation of governments' own technical, fiduciary and safeguard systems through the technical assistance and monitoring support provided by the World Bank technical experts; and (e) because the Government's program is also being supported by sector-specific health projects financed by the Bank and other key partners, the use of public funds will ensure complementarity across the projects and thus maximize the value added of external financing.

52. The flow of funds under the PforR will be carried out using country systems while providing assurance that funds will reach the health sector. Under the World Bank financing portfolio to Benin, there is an existing PforR under implementation in support of the water sector. Using the experience of the water sector PforR, the flow of funds for the health sector PforR will include steps involving the Central Bank, Ministry of Economy and Finance, and the Ministry of Health. The first step in the disbursement flow would be for an initial advance of up to 20 percent of the PforR amount as well as the amounts corresponding to the DLIs achieved to be transferred to a project Designated Account (DA) to be opened at the Central Bank to provide up-front initial financing for needed inputs. The second step would involve having the Ministry of Finance authorize the transfer of these funds from the DA to a Treasury account. The third step would involve the transfer of funds from the Treasury account to a commercial bank account opened by the MOH for the project. This third step ensures the funds reach the health sector in line with the disbursement schedule corresponding to the achievement of the DLIs.

B. Economic Impact

53. The proposed PforR is economically justified based on the positive macroeconomic impact it will bring to the country. First and foremost, an enhanced health system is huge step towards augmenting the Human Capital Index (HCI) score of Benin which presently just about 40 percent of its potential[7]. An improved HCI signals a more productive population and attracts foreign direct investments which in turn boosts economic growth and development.

[7] World Bank. 2020. *Human Capital Index.* World Bank, Washington, D.C.

Furthermore, most recent data estimates show that Benin loses a minimum of 3 million years of life of its nationals and residents to diseases and death[8] from communicable, maternal, neonatal, and nutritional diseases, alone. This translates into an annual loss of about US$15.6 billion at an estimated Disability-Adjusted Life Year (DALYs) value of US$5,000.[9] Similarly, years of life lost to disability and death as a result of non-communicable and other diseases (excluding Injuries) is estimated at 2.8 million which also implies an approximated US$14.1 billion yearly loss to the Beninese economy. This evolves into a direct financial loss of roughly US$29.7 billion yearly, to the economy. Regrettably, where the loss of DALYs is heavily inclined towards the most productive human resources of Benin, these economic losses could be larger and further dragging on the country's macroeconomic targets. To this end, the proposed program is would work towards averting as many DALYs as are possible.

VII. Program Action Plan

54. **The Program Action Plan includes a total of 17 actions.** These actions are organized across three sections which include technical actions, fiduciary systems actions, and environmental and social actions. These actions have been identified by the Government and Bank team based on the findings of the technical assessments conducted as part of the project preparation process. These actions include those that are regular and ongoing which are monitored as part of regular and routine supervision. In addition, there are actions that will be monitored as dated covenants as they are specific time-bound actions. Annex 1 presents the actions organized under the three sections.

VIII. Technical Risk Rating

55. Over the past decades, analysis has shown that Benin did not make significant progress in health outcomes in general and particularly in improving maternal and child health outcomes. The ongoing Government program based on the results of assessment of the previous National health plan, benefits from the commitment at the high-level of the power to carry out far-reaching reforms and then achieve the objective of ensuring good health for all in order to promote the wellbeing of populations throughout the life cycle. The proposed PforR is fully aligned the Government National Health program.

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[8]Roser, Max, and Hannah Ritchie. 2016. "Burden of Disease". *Published online at OurWorldInData.org*

[9]Jamison Dean T., Prabhat Jha, Ramanan Laxminarayan, and Toby Ord. 2012. "Infectious Disease". Copenhagen Consensus. Though Jamison et al. (2012) estimated the value of a DALY to be US$5,000 for Low Income Countries about ten years ago, the Beninese GNI per capita between 2012 and 2020 augmented by only US$160 from US$1,120 US$1,280 over the period and as such, will not impact the present value of the DALY. Hence, though since 2019, Benin has been classified by the World Bank as a lower middle income country, using a DALY value for lower middle income countries in this estimation would amount to overvaluation of its economic losses.

56. Sector Strategies and Policies Risk is Moderate. In their development policy, the various governments of the Republic of Benin have always prioritized the health of the population. This effort is visible through various national policy documents. This includes the Constitution of December 11, 1990 where the right to health, in its articles 8 and 26, is a major priority area for the development of Benin's society. The Benin 2025 National Long Term Perspectives Studies focuses on social well-being which is based, among other things, on quality health care. In addition, the adoption of the Sustainable Development Goals in September 2015 prioritizes health through SDG3 to "Enable everyone to live in good health and promote the well-being of all at all ages". The National Population Policy (PNP) aims to promote health through several of its specific objectives, including specific objectives 2 and 3 which respectively aim to reduce early and late fertility rates and to contribute to the reduction of maternal and child mortality. The Government's Action Program (PAG 2016-2021) aims to "relaunch in a sustainable manner the economic and social development of Benin". To this end, three pillars have been defined. The third entitled: "Improving the living conditions of the populations" takes into account the interventions of the health sector through axis 6 relating to the strengthening of basic social services and social protection. Furthermore, the National Health Policy (PNS) articulates the Government's policy in the health sector ensuring the improvement of the quality of life of the populations.

57. Technical Design of Project or Program Risk is Moderate. The operation will support the Government's national program and does not contemplate radical design changes to the system. In order to comply with the indicators, regulatory changes together with practical implementation are expected to be discussed and implemented by the MOH, which has shown technical proficiency to conduct these tasks, and also benefits from the political legitimacy resulting from their inclusion in the PNDS. In addition, the PforR will finance the COVID-19 vaccines deployment and operational support for which the Government is already leading a technical assessment and coordination effort of technical and financing partners to define the technical and financial need and the role and contribution of the Government and key partners. In addition, the MOH has proven experience in collaboration with its partners in carrying out large immunization campaign countrywide trough the Expanded Program for Immunization (EPI) such as measles, rubella, meningitis, poliomyelitis's immunization campaign and well-planned national immunization strategy.

Program Implementation Support Plan

58. The ambitious nature of the reforms supported by the Program will require carefully tailored and intensive implementation support. The challenges are not just addressing capacity deficits, but managing across levels of government, and coordinating among central government agencies. This will require working within the political economy of possible reforms. The Bank has calibrated implementation support to address the capacity issues identified in the technical, fiduciary, and environmental and social assessments.

59. **The World Bank team will provide continuous Program support and conduct official implementation support missions at least twice a year to ensure that appropriate technical**

support is provided for the achievement of Program results. The task team will be led by the co-task team leaders and will consist of experts/specialists on relevant technical areas, fiduciary management, social and environmental aspects, and general operations management. The World Bank team will emphasize that MoH (in conjunction with MoF) prepares progress reports and work plans as a basis for Program implementation review. Technical missions will be organized between the regular implementation support missions, as needed. In addition to missions, document review, and routine communications, the task team will maintain regular communication with MoH's PCU via staff and consultants based in the country office.

60. **The PforR will also have complementary technical assistance from the World Bank though the responsibility of implementation will lie with the Government of Benin.** Table 2 below clarifies the different roles of the World Bank and the implementing agencies of the Government of Benin.

Table 2. Responsibility of Implementation

Results Area	**Government of Benin**	**World Bank**
M&E Framework	Finalize indicators Develop feedback mechanisms	Bring relevant international experience on different models of performance monitoring systems and choice of indicators
Health Information Systems for timely quality data reporting	Develop Health Information Systems (HIS) application, field test and roll out	Bring relevant international and local experience on HIS application and its uses for primary care
Quality measures in implementing programs to support Emergency obstetric and newborn care (EmONC) and Basic emergency obstetric and newborn care (BEmONC) services	Expand capacity, complete processes to become fully independent and improve quality assurance processes	Bring relevant international and local experience to help inform processes
Local government capacity for health sector planning and budgeting	Develop training modules and continuous hand-holding methods and roll out to health zones	Bring relevant international experience to help inform development of methodology
Review how Benin's earlier experience implementing performance based was designed and developed to	Review how the capitation was defined	Bring relevant international experience on different models

help inform PforR results monitoring and disbursement.	Review the results achieved under the performance-based financing experience	of performance-based financing systems and choice of indicators