Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 24-Feb-2022 | Report No: PIDA244180

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Benin	P172940	Benin Program for Results (P4R) Health System Enhancement	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA WEST	11-Feb-2022	31-Mar-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Ministry of Economy and Finance	Ministry of Health	

Proposed Program Development Objective(s)

To improve the quality and access to primary health care services, with a focus on reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH+N) and strengthen public health emergency preparedness and response capacity.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	3,500.00
Total Operation Cost	187.00
Total Program Cost	187.00
Total Financing	187.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	187.00
World Bank Lending	187.00

Decision

The review did not authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Benin, a country with a small open economy, has experienced robust growth over the past decade, albeit volatile and with limited income per capita gains.** Due to greater macroeconomic stability and a relatively favorable external environment, economic growth has increased over the past decade. Real gross domestic product (GDP) growth averaged 5.1 percent from 2011-19, one percentage point (ppt) above the average for sub-Saharan Africa (SSA).[1] Most recently, after the commodity price shock in 2014-15, real GDP growth averaged 6.4 percent over the 2017-19 period (3.5 percent in per capita terms), driven by agriculture (cotton) and services (transportation, commerce). However, sustaining the economic performance and stabilizing the growth volatility remain key challenges due to limited economic diversity, high levels of informality, including in trade with Nigeria,[2] and slow structural change (CEM 2021). Labor productivity growth only marginally increased and – coupled with high population growth – has resulted in limited income per capita gains over the same period. In 2019, 38.5 percent of the population lived below the poverty line. Laying the foundation for a solid step up along the middle-income economy ladder is Benin's next great challenge

2. **The global recession and border restrictions induced by the COVID-19 pandemic resulted in an economic deceleration in 2020, but the short-term impact on poverty has been temporary.** Albeit moderate compared to other countries in the region, real GDP growth decelerated from 6.9 percent in 2019 to 3.8 percent in 2020 (1 percent in per capita terms). Labor shortages due to border restrictions with neighboring countries affected the primary sector, which accounts for 28 percent of the GDP, while supply-chain disruptions impacted manufacturing on the supply-side. Services gradually picked up as mobility restriction eased in June 2020. Supported by a rapid and large countercyclical fiscal response, the COVID-19 crisis has had only a moderate impact on Benin's short-term growth and the impact on the poor is expected to be temporary. Economic activity is projected to recover in the short and medium term. Real GDP growth is estimated at 6.0 percent in 2021 (2.9 percent in per capita terms) driven by a gradual recovery in agriculture and the secondary sector, due to increased construction and the easing of global supply-chain disruptions. The gradual re-opening of the border with Nigeria since December 2020 has increased exports, with port activity significantly improving in most recent months. In the medium-term, growth will revert to its pre-COVID level and is expected to grow at potential as reforms to the business environment and investments in infrastructure pay out.

3. **COVID-19 has reduced the fiscal space and enhanced the need for efficient fiscal policy supportive of long-term growth.** As a result of the COVID-19 crisis, the fiscal deficit (including grants) increased to 4.7 percent of

[1] Excluding high and upper-middle income countries.

[2] Nigeria is Benin's main trading partner, although majority of the trade is unrecorded. Benin imports – for re-exporting to Nigeria through its land border – a large quantity of consumer goods subject to import protection (such as second-hand cars, cloth, rice, and frozen poultry) in this country. On the other hand, Benin illegally imports a large proportion of fuel from Nigeria, where consumer prices have historically been highly subsidized.

the GDP in 2020 and an estimated 4.5 percent of the GDP in 2021. Public and Publicly Guaranteed (PPG) debt is expected to reach 52.3 percent of the GDP in 2021, up from 46.2 percent of the GDP in 2020, while remaining at moderate risk of debt distress with liquidity indicators improving in the medium term due to a liability management operation in early 2021. Converging towards the West African Economic and Monetary Union (WAEMU) fiscal deficit ceiling of 3 percent of the GDP in the next two years will support fiscal and debt sustainability. Increasing revenue and reigning in spending while still ensuring fiscal policy can meet long-term inclusive growth goals will remain the key medium-term challenge.

4. **The Government of Benin (GoB) outlined its objectives for inclusive growth and poverty reduction in its Government Action Program 2016-2021 (Programme d'Actions du Gouvernement, or PAG).** The current government has shown strong commitment to economic reforms and developed a new and more inclusive growth model. The PAG outlines a three-pronged approach: (i) consolidation of democracy, the rule of law, and good governance; (ii) structural transformation of the economy; and (iii) improved social well-being. The government launched several new investment initiatives to boost growth.[3] These aim to improve human capital, increase the efficiency of public investment and state-owned enterprises, improve production capacity in the agriculture sector, develop the tourism sector, and ensure access to water and electricity.

C. Sectoral and Institutional Context

5. **The most binding constraints to Benin's health sector center on quality of care that erodes maternal, infant, and child health along with public health emergencies which hinder an already strained health system.** The current COVID-19 crisis will bring further rollbacks on both agendas.

6. **Increasing evidence shows that ensuring the quality of care could prevent an estimated half of all maternal and newborn deaths alone according to the Lancet Commission on High Quality Health Systems (2018).** High impact and good quality interventions in maternal and neonatal care have progressed, but at a too slow pace. For maternal and neonatal outcomes, the slow progress can be related to issues related to utilization of prenatal, assisted deliveries and postnatal consultations. According to the 2018 DHS, 83.2 percent of pregnant women have had some prenatal consultations, which is an indirect indicator that there is appropriate acceptability and accessibility for these services, which in turn would result in positive progress in maternal health indicators.

7. **Public health emergencies like the current pandemic, result in the already stretched resources of the health sector being diverted from system-wide priorities, in order to address the imminent needs of the COVID-19 response.** This section outlines the challenges that both of these agendas face, along with a description of how those limitations will be further intensified due to the COVID-19 pandemic. Table 1 contains a sample of national-level indicators for Benin's health sector which provides a snapshot of the country's maternal and child health statistics for the past few years, which highlights the need to focus on maternal and child health interventions in order to protect recent gains in health outcomes of recent years, from being fully lost due to a shift in focus on the emergent COVID-19 response.

[3] Economist Intelligence Unit, Benin Country Report, 2017.

Table 1. Binding Constraints and Challenges to Benin's Health Sector

Binding Constraint 1. Maternal and Child Health	Binding Constraint 2. Maternal and Child Health
Challenge 1. Poor maternal and child health outcomes	*Challenge 6. COVID-19 continues to strain the Benin health system and negatively impact any progress that had been made in overall health outcomes*
Challenge 2. Low child immunization coverage contributing to poor child health	*Challenge 7. Lacking number and equipped health facilities to respond to the current crisis*
Challenge 3. Need to improve reproductive health	
Challenge 4. Inadequate supply of medications and medical supplies at all levels of care, is detrimental to maternal, child and adolescent health as it hinders the system's ability to provide quality of care	
Challenge 5. Continued challenges in maternal and child health outcomes suggest that access to and knowledge of health personnel needs to be improved	

Binding Constraint 1. Maternal and Child Health

Table 2. Benin Health Outcomes 2018-2021

Indicator	2018	2019	2020	2021
Life expectancy at birth	61.5 years	61.8 years		
Mortality rate		9.0/1000		
Maternal mortality rate	397/100,000 live births			
Under-five mortality rate	90.9 1000 live births	88.4/1000 live births	85.9/1000 live births	
Neonatal (<1 month) mortality rate	30.64 /1000 live births	30.2/1000 live births	29.73/1000 live births	
Children 12-23 months fully immunized	51%			
Children <5 years who are stunted	32%	31.9%	31.3%	
Children <5 years with acute malnutrition	5%	-	-	-

Antenatal care, 4+ visits	52%	-	-	-
Skilled attendance at delivery	78%	-	-	-
Contraception prevalence rate (all women)	13,2%	-	-	-
Unmet need for family planning	35,3	-	-	-
Total fertility rate (15-49 years)	4.836	4.767	4.7	-

Challenge 1. Poor maternal and child health outcomes

8. **Benin's health system encounters hurdles in delivering quality services at all levels including maternal and child health services.** About half (52 percent) of pregnant women received at least four antenatal care consultations in 2017, compared to 58 percent in 2011. Between 2011 and 2017, the percentage of mothers who benefited from postnatal care during the first 48 hours after delivery increased from 51 to 66 percent, although 35 percent did not receive any postnatal care. As mentioned before, this is evidence of the availability of maternal care as well as the fact that women of reproductive age are aware of the need for it, yet they don't demand these services and this is reflected in the lack of improvement on the maternal and child morbidity and mortality indicators; with a maternal mortality rate of 397 per 100,0000 live births in 2018 and an estimated neonatal mortality rate of 29.7 per 1000 live births in 2020. Interventions aiming to identify and eliminate access barriers in order to make these antenatal and postnatal services more easily accessible, will drive performance indicators and therefore healthcare outcomes associated with these services to improve.

9. **Incorporating Basic Emergency Obstetric and Newborn care (BEmONC) is considered the basic standard of care in maternal and neonatal care to the maternal and neonatal care in Benin's health care facilities would contribute to the improvement of health outcomes.** This includes services such as the administration of antibiotics, uterotonic drugs, and anticonvulsants; manual extraction of a retained placenta; removal of retained products following delivery or abortion; assisted vaginal delivery; and basic neonatal resuscitation procedures. Adequately training personnel and equipping facilities to provide standardized basic quality services, should bridge the gap that currently exists in the country between adequate access to services and a high prevalence of positive outcomes in maternal, neonatal and child health.

Challenge 2. Low child immunization coverage contributing to poor child health

10. **Child immunization coverage in Benin remains low, with data reported showing that only 57 percent of children aged 12-23 months were fully immunized, while 11 percent of children in this age group had received no vaccine at all**. Immunization has proven to be a global success story that saves millions of lives every year. It is a cost-effective intervention that uses the body's own natural defenses, and helps prevent diseases and infections like diphtheria, polio, pertussis, polio, yellow fever and rotavirus, as well as prevent and control infectious disease outbreaks. These diseases have the most impact on infants and children, who's immune system isn't ready to fight disease, which leads to a higher morbidity, mortality and complications in that age group. The higher morbidity in

children leads to hindrance of their growth and development adding to the burden of disease of the country, along with putting an additional strain on health resources that are already limited.

11. **Benin's current prevalence of complete vaccination remains low compared to the global prevalence and that of most Sub Saharan Africa countries**. However, some cross sectional studies show a significant positive correlation showing a higher immunization prevalence among children of mothers who had received 4 or more antenatal visits (93.8 percent), children of mothers who were assisted by a skilled professional during delivery (92.4 percent), and those who had postnatal check-up visits less than 24 hours after birth (93.3 percent).[4] This data once again reflects the relevance of convergent basic health care services that provide high impact services such as immunization, antenatal, and postnatal care.

Challenge 3. Need to improve reproductive health

12. **With a fertility rate of 4.7 births per woman in 2020, Benin needs interventions that have a significant impact on women's reproductive health outcomes, interventions such as modern contraception**. Use of contraception has shown to prevent pregnancy-related health risks for women, especially for adolescent girls, and when births spaced out within less than two years, the infant mortality rate is 45 percent higher than in births which are 2-3 years apart and 60 percent higher than it is when births occur 4 or more years apart. Contraception also offers a range of potential tangential, non-health benefits that encompass expanded education opportunities and empowerment for women, sustainable population growth, and economic development for the country.

13. **The country's proportion of married women who use modern contraception was 12 percent in 2020, contributing to high fertility, although an improvement from 8 percent in 2017.** Pregnancy among adolescents is decreasing, from 26 percent in 1996 to 22 in 2001, 21 percent in 2006 and 20 percent in 2018. However, the utilization rate of modern contraception remains very low, at 7 percent in 2001, 6 percent in 2006, 8 percent in 2012 and 12 percent in 2018. Yet there remains 32.3 percent of unmet needs for contraception in 2018. This reflects a relevant gap in care practices that provides an opportunity to intervene multiple health outcomes.

Challenge 4. Inadequate supply of medications and medical supplies at all levels of care, is detrimental to maternal, child and adolescent health as it hinders the system's ability to provide quality of care

14. **Quality of care encounters additional challenges when facing infrastructure deficiencies.** The country's care units are particularly scarce in rural areas and/or urban tenement areas or slums. Urban areas are not exempt from care infrastructure issues. These infrastructure barriers encompass both the physical facilities, it's human resource, as well as the medical supplies that support it. It is important to recognize that there are also socioeconomic and cultural factors which have an impact on how regularly a patient can seek health care services. An example of this are the patients coming from remote areas to visit a healthcare facility in order to access services

[4] Budu, E., Seidu, AA., Agbaglo, E. et al. Maternal healthcare utilization and full immunization coverage among 12–23 months children in Benin: a cross sectional study using population-based data. Arch Public Health 79, 34 (2021). https://doi.org/10.1186/s13690-021-00554-y

or therapies, and often require to be hospitalized instead of being treated as ambulatory or remotely. Facilitating access to health facilities that may provide easier access to medicine, medical supplies, and services will better allocate financial expenditures within the healthcare system such as unnecessary hospital stays.

15. **A USAID report on the state of Benin's supply chain for medical supplies[5], found that 58 percent of re-supply orders placed by *Dépôts Répartiteurs de Zone* (DRZs; zone distribution warehouses) at the *Centrale d'Achat des Médicaments Essentials* (CAME, the central medicines store) needed modification because of stock-outs or inadequate stocks reasons.** This situation negatively impacts the availability of medications both at health facility level and the general population's access to them, given that DRZs serve as an intermediate supply source between CAME and the health facilities. This stock out rate was found to include some basic malaria products. The report overall states that the supply chain capabilities for management of warehousing, inventory, transportation, and pharmaceutical waste are below 50 percent. The unreliability of the supply chain and subsequently the inadequate supply of medications and medical supplies at all levels of care, is detrimental to maternal, child and adolescent health as it hinders the system's ability to provide proper quality of care.

Table 2. Overall Findings of the National Supply Chain Assessment[6]

[5] USAIDS SIAPS. For, E., Maxim, L., Gbaguidi, A., Levenger, M., Consa. S. Benin National Supply Chain Assessment 2016 https://pdf.usaid.gov/pdf_docs/PA00SVZ6.pdf

[6] USAIDS SIAPS. For, E., Maxim, L., Gbaguidi, A., Levenger, M., Consa. S. Benin National Supply Chain Assessment 2016 https://pdf.usaid.gov/pdf_docs/PA00SVZ6.pdf

Functional areas	Capability	KPI	
Overall	Not applicable	Stock card availability	79%
		Stock card up to date	82%
		Stock-out (6-month average)	21%
		Stock-out (day of visit)	14%
		Stock accuracy	83%
Product selection	85%	% of facilities with National Essential Medicine List	80%
Quantification	71%		
Procurement	83%	% deliveries that were urgent orders	19%
		Supplier fill rate (top 10 suppliers)	88%
		Average order lead time (order to first delivery) (top 10 suppliers)	192 days
Warehousing and inventory management	43%	Stock accuracy (CAME)	79%
		Stock-out rate (CAME)	3%
		Stocked according to plan (CAME)	8%
		Percentage of orders placed as unplanned or emergency (CAME–DRZ)	15%
		Percentage of orders placed as unplanned or emergency (DRZ–Health Facilities)	35%
		Order fill rate (CAME–DRZ)	73%
		Order fill rate (DRZ–Health Facilities)	66%
Transportation	48%	Percentage of orders delivered by established transport system (CAME–DRZ)	49%
		Percentage of orders delivered by established transport system (DRZ–Health Facilities)	5%
Waste management	43%	Percentage of facilities with incinerators	66%
Laboratory	84% (LNCQ only)	Not assessed	n/a
LMIS	Not assessed	On-time reporting rates (DSME, PNLP, PNLS)	32%
	Not assessed	Complete reporting rates (DSME, PNLP, PNLS)	79%

Challenge 5. Continued challenges in maternal and child health outcomes suggest that access to and knowledge of health personnel needs to be improved.

16. **Traditional birth attendants continue to operate on the margins of the health system providing important and necessary services to women and children.** However, traditional birth attendants also reportedly have higher rates of adverse maternal events compared to national statistics. In contrast, in 2017, 78 percent of deliveries were performed by qualified health personnel, an improvement from 66 percent in 2001. It is estimated that about two thirds of neonatal mortality could be prevented through maternal and child health programmes, such as antenatal care, skilled birth delivery, and postnatal care.

17. **The rate of health facility delivery in Benin is relatively high (87.0 percent), yet high maternal mortality rates suggest that access barriers aside, problems exist with the quality of care.** A 2006 article in The Lancet[7] refers to multiple studies including one in Benin which suggest that health professionals' knowledge and skills in maternal healthcare are inadequate, ranging from 40 to 65 percent of pre-specified norms. The human resource who is part of the health system's infrastructure, just like any other part of it, needs to be adequately prepared to provide the best available quality of care in order to have a positive impact on the health outcomes of its patients, in this case maternal, newborn and child mortality and morbidity rates.

Binding Constraint 2. Public Health Emergencies

Challenge 6. COVID-19 continues to strain the Benin health system and negatively impact any progress that had been made in overall health outcomes.

18. **Benin's health challenges are further aggravated due to insufficient capacity to respond to public health emergencies.** Prior to the outbreak of the COVID-19 pandemic in January 2020, the World Bank assessments of Benin's health system revealed that the country did not have a disease surveillance system. Subsequently, the country also lacked the capacity to trigger alerts in a timely manner in order to contain outbreaks when necessary or investigate cluster 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.

19. **Thus, regarding the COVID-19 pandemic, Benin's health care system required support in rapidly strengthen its epidemiological surveillance system, and build its infrastructure to effectively respond to the screening of the population as well as caring for the affected**. An example of this occurred at the onset of the pandemic, when COVID-19 test results were confirmed in Senegal, and patients had to wait several days for the results. The World Bank has accompanied the country's efforts in the COVID-19 crisis, providing among other things support in the commissioning of 13 laboratories (equipped with 12 COVID-19 test machines, extraction kits, diagnostic reaction kits, 40 biosafety cabinets and cold chain equipment); eighty-nine screening centers created and equipped, and providing protective equipment that was made available to over 6,000 workers in laboratories and treatment centers.

[7] Koblinsky, M; Matthews, Z; et al The Lancet, Vol368 October14,2006 Maternal Survival 3. Going to scale up with professional skilled care

20. **Benin was one of the first countries in Sub-Saharan Africa to be affected by the Coronavirus disease (COVID-19) pandemic; however, as of December 6, 2021, the number of cases was low.** The first known COVID-19 case was reported on March 16, 2020. A State of Emergency was declared in April 2020, and swift measures were put in place to contain and mitigate the spread of the virus. Subsequently, the country faced three waves of the pandemic with the last and worst one ending in September 2021. As of December 6, 2021, the country has reported 24,897 cumulative cases, with a death toll of 161 people and 36 active cases (with no COVID-19 patient in the urgent care unit). Overall, compared to neighboring countries and with regard to mortality, Benin has been less impacted by COVID-19. As of December 6, 2021, the country's mortality rate stands at 0.65 percent while the average mortality in West Africa is at 2.48 percent.[8] The adoption of a Health Preparedness and Response Plan, including strong yet carefully measured public health strategies, and its timely implementation has improved the country's outbreak surveillance system and response capacity, helped to contain the spread of the pandemic, and limited the loss of human life.

21. **The country is ramping up its national vaccination campaign, after a slow initial start.** On March 29, 2021, the Government launched the COVID-19 national vaccination campaign aiming to vaccinate priority groups, which represents 40 percent of the population. However, misinformation on vaccine safety and effectiveness conveyed by social media fueled widespread vaccine rejection and hampered the pace of vaccine deployment. As a consequence, the country had vaccinated 1.9 percent of the population as at the end of October 2021. To cope with these challenges and attain the new objective to cover 60 percent of the population set by the African Union, the GoB adopted several measures including (i) mandating vaccination for people who work in the health sector and requiring that people show a health pass in order to access public areas; (ii) intensifying awareness and community engagement campaigns coupled with (iii) organizing a mass vaccination campaign by increasing the number of vaccination sites (the number of vaccination sites has been quadrupled). As a result, vaccination coverage increased from 1.9 to 7.3 percent of the population on December 6, 2021. Moreover, 9.5 percent of the population has received at least one dose of the vaccine, after three weeks of an intensified campaign. In addition to the Health Preparedness and Response Plan (March 2020), the authorities adopted a National integrated Response Plan against COVID-19 for the 2021-2025 period to protect livelihoods, strengthen the health sector, and ensure the recovery of the economy.

22. **Benin continues to need support in expanding the reach of its emergency intervention efforts as well as solidifying a disease monitoring and surveillance system.** The current COVID-19 epidemic continues to hurt Benin, which reinforces the need to strengthen the COVID response, but we also need to strengthen the Country's overall disease surveillance capacity. The aim should be to support the Country Preparedness through activities such as the appointment and training of members of rapid response teams at the national, regional and district levels in order to develop, establish and implement sustainable surveillance, monitoring and evaluation policies and strategies across the country.

[8] https://www.worldometers.info/coronavirus/

Challenge 7. Lacking number and equipped health facilities to respond to the current crisis.

23. **Benin's health system comprises of three tiers.** These are the central/national, intermediate/regional, and peripheral levels. The central level is responsible for designing, implementing, and monitoring health policy. The 12 Regional Health Directorates (RHD) and the secondary level referral hospitals constitute the intermediate/regional level of the health pyramid. The RHD are responsible for planning, coordinating, and implementing health policies in their respective geographical areas. They oversee the provision of and provide stewardship for primary and secondary levels of care within their respective regions. The peripheral level forms the backbone of the health system and includes 34 health zones organized into a network of first contact public services (maternity wards and dispensaries, village health unit and commune, and arrondissement health centers) and private health facilities, all supported by a first reference public or private hospital called the zone hospital. To strengthen service delivery at the local level, the health zones are given the responsibility to oversee all providers (public and private) operating in the zone and plan for the best use of resources within the zone to achieve health objectives. Starting in 2004, the health zones were given the responsibility of directly managing their state allocated budgets (*credits délégués*).

24. **COVID-19 is expected to continue to place a substantial burden on inpatient and outpatient health care services**. As such, continued support is necessary in order to adequately equip primary health care facilities and hospitals for the delivery of critical medical services and to cope with increased demand of services posed by the outbreak, as well as develop intra-hospital infection control measures. Additional support should be included for intensive care facilities within hospitals through provision of medical equipment and training of health teams. Training could comprise solutions for supply chain coordination for essential goods to be developed in order to guarantee the ability to maintain facilities adequately supplied over time.

25. **Although Benin appears to be well-positioned to have a functional health system that provides appropriate health care, for reasons including the existence of necessary laws and policies in the country, the health system has been unable to achieve the desired performance.** Weaknesses that persist in the health system are interrelated and revolve around three main areas: human resource incentives and insufficient infrastructure that affect quality and access; leadership and governance challenges that compromise the management and regulation of the sector; and health financing challenges affecting the magnitude and efficiency of public spending in the health sector. The global COVID-19 pandemic has also prioritized the need to strengthen the country's emergency response and preparedness capacity. Improving health system performance in Benin requires the reinforcement of interventions to address these challenges.

26. **The government's five-year plan aims to respond to these challenges.** One of the key goals of the PAG is to reorganize the health system for more effective health coverage. The necessary reforms are reflected in the five-year National Health Plan 2018-2022. In line with this Plan, the Ministry of Health (MOH), in collaboration with the National Council for the fight against HIV/AIDS, sexually transmitted infections, tuberculosis, malaria, hepatitis, and epidemic diseases, has adopted a five-year national strategic plan to combat infectious diseases and improve epidemic preparedness. At the same time, a National Action Plan for Health Security 2019-2021 and a National Community Health Policy 2019-2021 were adopted in 2019. These policies set out the vision, goals, objectives, and strategic directions for the various aspects of the health sector. The Government has also started the rollout of a flagship social program called "Assurance pour le Renforcement du Capital Humain (ARCH)," that includes health insurance for the poor.

D. PforR Program Scope

27. **The proposed PforR will support part of the government program.** The PforR will be implemented over five years and support the 2018-2030 National Health Policy (NHP). The PforR will span two Government plans for the health sector 2018-22 and 2023-27 which will encompass part of the current national health sector program (National Health Development Plan, PNDS 2018-2022) and its successor plan for the period of 2023-2027. With regard to scope, the PforR will focus on two key Result Areas which address key areas of the six Strategic Orientations of the 2018-2022 National Health Development Plan. In terms of geographic coverage, the PforR will have a national focus while ensuring health zones are prioritized as needed. The health zones will be prioritized from a double perspective: geographic areas with the highest health disparities and the most concerning health outcomes. There are no activities or contracts that should be excluded from the PforR program in accordance with the Bank's Policy and Directive on Program-for-Results Financing. During appraisal, the team will determine if any of the infrastructure support to be included in the PforR program will involve high environmental and social risk or high-value contracts (contracts that are deemed to be important to the integrity of the PforR program). The PforR program beneficiaries are the target groups for reproductive, maternal, newborn, child, and adolescent health services.

Table 2. Program Boundaries

	Government program	Program supported by the PforR	Alignment
Objective	Contribute to improving the health of the population in Benin in general and that of the SRMNEA + N targets in particular	To improve the quality and access to primary health care services, with a focus on reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH+N) and to strengthen public health emergency preparedness and response capacity.	The Government program and PforR objectives are aligned.
Duration	2018-2022 National Health Development Plan (PNDS) and 2023-2027 (new) PNDS under 2018-2030 National Health Policy	2022-2026	Under the overall National Health Policy timeframe, the PforR will support part of the current 2018-2022 PNDS and part of the successor PNDS for the period of 2023-2027.
Geographic coverage	National	National	PforR in line with national program
Result Areas	Strategic Orientations 1-6	Result Areas 1 and 2	Result Area 1 supports Strategic Orientation 2 Result Area 2 supports Strategic Orientation 4. Strategic Orientation 2 includes key interventions related to service delivery and improving the quality of care. Strategic Orientation 4 includes key interventions related to purchase of infrastructure,

			equipment and health products in support of the emergency preparedness and response.
Overall Financing	US$4.2 billion This amount is a projection of total government spending during the period of PforR implementation (2023-2027). US$3.5 billion will be allocated to PNDS 2018-2022.	US$940,442,667 This amount is the IDA (US$187 million) plus the amount of government funding (US$740,442,668) needed to achieve the DLIs. This is detailed below in Table 4. Program Expenditure Framework.	The PforR encompasses part of the government health sector program.

28. **The goal of the government program is supported by the PforR framed under a result focus.** The goal of the government program is to contribute to improving the health of the population in Benin in general and in particular to improve Sexual, Reproductive, Maternal, Newborn, Adolescent, and Nutrition (SRMNEA+N) outcomes. The objective of the PforR is aligned with the goal of the government's overall program and with two of its six Strategic Orientations.

29. **The two Result Areas are intrinsically related.** Access and quality problems are not only challenges, but are also most felt at service delivery points, particularly at the primary health care level, accentuated in emergency contexts and situations. Proper emergency response requires interaction among the Result Areas since 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. The two Result Areas are described below with an initial set of activities to be potentially supported as outlined in the PNDS.

30. **Result Area 1: Access and Quality.** This Result Area is aligned with the government program's Strategic Orientation 2: "Service Delivery and Improving the Quality of Care." This Result Area seeks to improve access to and strengthen the delivery of quality primary health care services focusing on Reproductive, Maternal, Newborn, Child, and Adolescent Health + Nutrition (RMNCAH + N) services. This Result Area would support activities related to ensuring that high impact interventions are developed and implemented through a minimum package of health services. In line with ensuring the quality of these high impact interventions, this Result Area would support activities to strengthen the governance system of the health sector and support actions to improve the availability of qualified human resources for health and their equitable distribution. DLIs under this Result Area will reflect improvements in maternal and neonatal health care, reproductive health care, family planning, and child immunization. To achieve these results, the PforR will support improvements in emergency obstetric care and child health care services, development of health human resources, and strengthening of referral systems. Activities will include the implementation of quality-of-care approaches such as BEmONC and EmONC in all maternity hospitals, Integrated Management of Childhood Illness (IMCI), and Emergency triage assessment and treatment (ETAT) (Triage, Evaluation et Traitement d'Urgence) and innovative capacity building program for health care providers including e-learning, mentoring coupled with on the job short training. In addition to these approaches, activities

to support the delivery of quality of care will be supported such as purchase of products/consumable and traditional medicines being made available. Activities will also support systemic investments in support of improving quality of care management such as the development of a hospital referral network, pre-integration of a cadre of specialized doctors and paramedics and pre-integration of young health professionals; and availability and use of quality health information. Annex 11 provides a list of specific activities that will be supported through the PforR.

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 Result Area will support investments in key components of primary health care service delivery, notably infrastructure, equipment, and supply of medicines and consumables. This Result 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 at health facilities are reduced. Under this Result Area, the PforR will also support emergency response capacity building. Activities will include: (i) training specialists in epidemic management, laboratory surveillance, and rapid response to include a sufficient number of competent community health workers, (ii) strengthening operational capacities in place (logistics, quantification, community coordination, communication) to include the development of an integrated communication strategy and plan on preventive measures to be rolled out at the point of health service delivery focused at the community-level and development of protocols to ensure the routine delivery of health services at community health centers., (iii) digitized surveillance system capable of managing epidemiological data collection and reporting to support the roll-out of a national and regional communicable and non-communicable disease surveillance system and early warning systems; (iv) 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; and (v) investments in infrastructure and equipment (adapted to climate change).

31. **Gender Analysis**. The design of the Program involved conducting a gender analysis of the sector context and challenges. As part of the gender analysis, key gaps and bottlenecks of service delivery focused on maternal and child health and more broadly on RMNCAH were identified. In line with the challenges, the operational response of the Program was framed to ensure the Result Areas and key actions supported under the Program can make a positive impact in addressing the challenges. Furthermore, the gender analysis reviewed the Program's results framework (RF) to ensure a balance of program development objective (PDO)-level, intermediate-level, and Disbursement-level indicators that will be monitored and verified over the project implementation period.

E. Program Development Objective(s) (PDO) and PDO Level Results Indicators

32. **To improve the quality of and access to primary health care services, with a focus on reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH+N) and strengthen public health emergency preparedness and response capacity.** The various elements of the PDO will be reflected by the following PDO indicators. The DLIs of the Program are the PDO indicators.

Table 5. PDO Indicators

PDO Elements	PDO Indicators
Quality	1. Proportion of potential Basic Emergency Obstetric and Newborn Care (BEmONC) health facilities offering BEmONC in line with the MOH protocols (DLI 1)
Access	2. Contraceptive Prevalence Rate (DLI 2) 3. Full immunization coverage of children 12-23 months old (DLI 3) 4. Percentage of pregnant women of reproductive age accessing health facilities for reproductive health consultation (DLI 6)
Emergency Preparedness and Response	5. Health facilities with no stock-outs of maternal and child health drugs in past 3 months (DLI 4). The following are potential replacement DLIs and will be reviewed with the counterpart during appraisal. a. Number of beneficiaries utilizing integrated public health laboratory services (disaggregated by gender) b. Percent of district public health laboratories participating in quality assurance mechanism established by the MOH 6. Level of preparedness and response in the event of a public health emergency according to IHR2005 (index made up of 7 key activities: risk mapping, resources mapping, preparedness plan, response plan, simulation exercise, COUSP constructed, and COUSP functional (percentage)) (DLI 5). The following are potential replacement DLIs and will be reviewed with the counterpart during appraisal. c. Percent of integrated disease surveillance teams detecting and responding to outbreak threats within nationally stipulated standards d. Operationalization of a nation-wide strategy for networking of public health laboratories at district, regional, and national levels to provide timely and high-quality diagnostic support during disease outbreaks 7. Percentage of new health establishments constructed and equipped (DLI 7)

F. Disbursement Linked Indicators and Verification Protocols

33. **Result Area 1. Access and Quality**. This Result Area supports improvements to the quality of and access to primary health care services with a focus on RMNCAH+N services. Four DLIs measure improvements to the delivery, quality, and coverage of selected services which reflect investments in the various health system components required for effective service delivery. DLI 1 reflects improvements in maternal and neonatal care, particularly Basic Emergency Obstetric Care (BEMonC). This is necessary to achieve further reductions in maternal mortality, which is still high. Currently, 71 percent of relevant health facilities have the capacity to manage obstetric emergencies, and the PforR will support the government in achieving a target of 80 percent by the end of the implemenation period. This DLI will evaluate both service delivery capacity and elements of quality of care. DLI 2 assesses the delivery and coverage of family planning services, notably access to modern contraceptives. Currently, 12 percent of women of reproductive age use modern contraceptives, while 32 percent express the desire to use them (unmet need). This provides an opportunity to improve family planning services to contribute to reducing Benin's still high fertility rate. The PforR will support an increase in modern contraceptive coverage to 16 percent. DLI 3 addresses immunization coverage. Only 57 percent of children aged 12 to 23 months are fully vaccinated, and the PforR will support an increase to 65 percent by the end of the implementation period. This indicator measures the percentage of one-year-olds who have received one dose of the Bacille Calmette-Guérin (BCG) vaccine, three doses of the polio vaccine, three doses of the combined diphtheria, tetanus toxoid, and pertussis (DTP3) vaccine, and one dose of the measles vaccine. Lastly, DLI 6 will help monitor access to health services by women of reproductive age.

34. **Result Area 2. Health System Capacity and Emergency Preparedness and Response**. Under this Result Area, the PforR will support improvements in service delivery capacity, with DLIs evaluating the supply of medicines, preparedness and response level for emergencies, and the numbers and functionality of health facilites. Adequate service delivery capacity is required to improve the coverage and quality of primary heatlh care services. DLI 4 will determine the proportion of health facilities that are adequately equiped to provide maternal and child health services according to national protocol. Currently, 70 percent of health facilities do not experience stock-outs of essential medicines for maternal and child health care services, and the PforR will support the government in achieving a proportion of 80 percent by the end of the implementation period. DLI 5 will measure the level of preparedness and response in the event of a public health emergency through an index made up of seven key activities of the preparedness and response plan in the event of a public health crisis/epidemic according to the International Health Regulations (IHR) 2005. The index will be used to assess the first three years of implementation while the construction and functioning of the Public Health Emergency Operations Center (PHEOC) will be assessed in years four and five. The annual targets of DLI 5 will be confirmed during appraisal, which will include sequenced aspects such as risk and resource mapping conducted, adoption of risk and resource mapping, a constructed and equipped PHEOC, and an operational PHEOC. DLI 7 will measure the percentage of new health establishments constructed and equipped to focus on the functionality of health establishments.

35. **Verification arrangements.** The Institute for Public Health research (*Institut de Recherche en Santé Publique Comlan Alfred Auguste QUENUM (IRSP - CAQ)*) will be the verification agency for the PforR. The IRSP is a renowned and credible West African regional institution established under The West African Health Organisation in 2001 with the technical guidance and support of the World Health Organization (WHO). The objective of the IRSP is to provide training, research, and technical assistance to strengthen the capacity of health system institutions

and providers in West African countries. IRSP operates out of the University D'Abomey-Calavi and was formally established as a technical institution under the legal framework of the Ministry of Superior Education and Scientific Research. The IRSP in Benin, through its dedicated team with expertise in public health, epidemiology, and biostatistics, will evaluate the PforR DLIs. This will be done by integrating the verification process of the DLIs into their monitoring of data across the Benin health program and by designing and conducting field data collection as required. The Benin MOH has formally integrated the IRSP into its institutional structure, with the responsibility of verifying health data reported across the health system. Although the IRSP is an integrated institution of the MOH, it maintains its autonomy and independence by being formally established under the Ministry of Superior Education and Scientific Research.

36. **A DLI verification manual will guide the IRSP in the data collection and verification processes.** Prior to project implementation, the IRSP team will develop a DLI verification manual which will describe the detailed processes to be followed for monitoring and verifying each DLI. This manual will identify the existing sources of information that can be used to inform DLI reporting and verification. The manual will also outline additional tools that will have to be developed to support the DLI verification process. The processes will also indicate the periodicity of data collection to align with the disbursement calendar of the PforR. The verification manual will be developed with inputs and feedback from the MOH, key technical partners, and the World Bank team. The verification manual will be a living document to ensure it is responsive and continually updated and adapted to the needs of the PforR needs and dynamics.

PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

37. **The BHSE Program will use the government system for implementation, oversight, financial management (FM), procurement, safeguards, M&E, and reporting arrangements**. The MOH, the Executing Agency (EA), will be responsible for high-level coordination with other stakeholders involved in the Program's implementation. The MOH formulates and plans public health policies for the government, ensures its implementation, and monitors its execution throughout all the decentralized levels of the health care pyramid.

38. **The National Agency for Primary Health Care (*Agence Nationale des Soins de Santé Primaires; ANSSP*), established under the Ministry of Health and headed by the General Director, will serve as the Program Coordination Unit (PCU).** It will be responsible for (i) the overall implementation and coordination of the Benin Health System Enhancement (BHSE) activities between the MOH's entities. The Agency is composed of 6 technical departments, each headed by a Director: Directorate of Epidemiological Surveillance and Monitoring-Evaluation, Directorate of Mother and Child Protection, Department of Immunization and Logistics, Directorate of Nursing and Obstetric Care, Directorate of Health Promotion and Protection, Directorate for the Promotion of Hygiene and Basic Sanitation, and the Public Health Emergency Operations Center (PHEOC). Each of these technical entities will be responsible for the implementation of the Program's intervention areas in line with their respective mandate. These entities are supported by the 12 Regional Health Directorates at the intermediate level and the 34 Health District Zones at the operational level, which is key to ensuring implementation of the day-to-day health activities in the field. Full details of implementation arrangements are provided in the technical assessment.

B. Monitoring and Evaluation

39. **The monitoring and evaluation data provided by internal and public sources are largely reliable.** The progress of indicators related to regulatory changes will be verified by the IRSP. 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 and be responsible for collecting the information required to ensure DLI compliance, and for submitting it to the independent verification agency, the IRSP. The MOH will also be responsible for submitting the disbursement requests based on DLI achievement. Additionally, the MOH will ensure that technical and analytical areas of the Program report timely progress of program indicators (DLIs and PDOs). The MOH will serve as the focal point to the WBG for the purposes of program supervision and will submit progress reports as required. The WBG will provide analytical, administrative, and technical support to the MOH.

C. Disbursement Arrangements

40. **The Program's funding will be based on the achievement of DLI targets as certified in accordance with the independent verification protocol**. The Association will disburse US$187 million through 7 DLIs under the Program. Payments will be disbursed as targets are achieved. The release of DLI amounts will be done after a verification of DLI evidence by the verification agency as per the agreed verification protocols.

41. **The Government can request advances up to 25% of the Financing allocated to DLIs that have not yet been achieved by following the relevant procedures**. This will ensure that the government has the funds required to fulfill the intermediate operational requirements of the Program, leading to achievement of the Disbursement Linked Results (DLRs). When the DLI against which an advance has been disbursed is achieved, the amount of the advance will be deducted from the total amount due to be disbursed under that DLI. The Bank will record the amount disbursed to achieve a Disbursement Linked Result ("recovered") after it has notified the Borrower of its acceptance of the evidence of achievement of the result.

42. **The Program will use the flow of funds arrangements used for the execution of the National Budget**. The funds of the World Bank will be transferred to the Treasury account at the Central Bank BCEAO (*Banque Centrale des Etats de l'Afrique de l'Ouest*), managed by the National Treasury Directorate (*Direction Generale du Trésor et de la Comptabilité Publiqu*e DGTCP).

D. Capacity Building

43. The following topics have been identified for capacity building and institutional strengthening under each of the Result Areas:

- Quality: Technical Assistance (TA) to update facilities providing EmONC and 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 Primary Health Care (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 data collection for DLI reports, 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).

E. Financing

Program Financing

Source	Amount (USD Million)	% of Total
International Development Association (IDA)	**187.00**	**20.17%**
IDA Credit	**87.00**	**9.39%**
IDA Grant	**100.00**	**10.79%**
Government	**740.00**	**79.83%**
Total Program Financing	**927.00**	**100%**

44. The budget lines to be financed were identified based on how they will contribute to the achievement of the DLIs. By providing financing to budget line items 045 and 047, this additional investment will help achieve the four DLIs under Result Area 1, which focuses on access to and quality of care. The PforR Result Area 2 aligns with budget line item 046 regarding prevention and health security and will support the achievement of the three DLIs captured under Result Area 2. Moreover, budget line item 046 presents a breakdown of capital expenditures of which a larger share will go to the health zone and health infrastructure development in primary care level health facilities.

F. Environmental and Social

45. **The Environmental and Social Systems Assessment (ESSA) for this Program** was undertaken to: 1) assess Benin's systems for managing environmental and social effects that are associated with the proposed set of investments related to this Program; and 2) strengthen the GoB's institutional capacity to plan, monitor, and

report on environmental and social management measures as part of the Program's implementation. The ESSA took into consideration the requirements of the Program-for-Results Financing Policy and Directive. Its findings will help ensure that this Program is implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes, or mitigates adverse environmental and social impacts and risks. The combined risk assessed at entry is substantial; the ESSA confirms that the current system for managing the environmental and social aspects of the Program are covered by the regulations. Institutional capacity of the entities involved is deemed sufficient even though additional measures were recommended following the ESSA assessment. This will contribute to the preparation of the Program Action Plan (PAP) that the GoB is expected to use to bridge any significant gaps in existing environmental and social management systems in line with the six core sustainability principles of the PforR.

46. **The Program itself does not have explicit environmental management objectives.** The ESSA found that Benin has an important legal arsenal in environmental and social management. The country's existing legal and regulatory frameworks for environmental management are relevant to the activities supported under the Program and consistent with the World Bank's PforR Policy and Directive. Despite the existence of the regulatory framework, the institutions in charge do not have the human resources or sufficient financial means to enable them to fully enforce the laws. In addition, certain legal provisions are obsolete and should be reviewed. In general, awareness of environmental and social management issues at the level of state and non-state actors is low. The Result Areas identified under the Program and the corresponding DLIs do not recommend activities and/or actions that will have significant adverse effects on the environment.

47. **During the various phases of program implementation (construction, repair, rehabilitation, and operation of the various structures), hazardous solid wastes will be produced** (in particular, glassware, rubble, packaging (paper and plastic) and waste materials, remaining building materials and cements, chemicals (paint, thinner, etc.)). Likewise, liquid waste management is also a fundamental problem in most of the health facilities. They are drained in pits sometimes near water points or homes, causing a considerable risk of contamination of underground water and rivers. As the Program will support new investments in construction or major rehabilitation works, this assessment does include other environmental and social issues such as the potential impact of civil works that will generate solid waste (bags of cement and other types of packaging, material residues, workers' household waste, etc.) and issues associated with the use of vehicles and machinery (dust, noise, emissions, and accidental spills of hydrocarbons and used oils).

48. **Constructions envisioned to be realized thanks to the Program will be done in existing health facilities such as district hospitals or on land owned by the MOH with moderate impact on vegetation**. These are medium to small-scale structures, not much larger than typical Beninese district hospitals. Potential environmental and social impacts associated with the construction and operation of these facilities include dust, noise, waste management, and waste water produced during operation. These impacts are expected to be substantial and can be readily mitigated by adopting good recognized practices.

49. **Environmental and Social Management Action Plan (ESMAP).** The program will support specific measures aimed at improving the performance conditions of the environmental management system in the implementation and monitoring of program activities. These measures are proposed within the framework of an Environmental and Social Management Action Plan (ESMAP), which is part of the overall Program Action Plan (PAP). Strengthening of the environmental and social management systems will be the core part of the PAP,

as well as the management of biomedical, solid, and liquid waste through the continuous implementation of mandatory legal regulations for medical waste management to avoid potential risks of inappropriate disposal in non-authorized landfills.

50. **Reinforcement of the adequacy and capacity of the existing systems.** At the institutional level, there is a need to reinforce the adequacy and capacity of the existing systems to manage risks and impacts of the Program. An interinstitutional agreement between the PIU and the ABE will be drawn up and implemented to strengthen the functioning of the national environmental and social management system. The content of this agreement will establish the conditions for collaboration for the rapid examination and certification of Program subproject reports and the environmental and social monitoring of the implementation of safeguard documents.

51. Key issues identified following the Environmental System Assessment will be addressed through the continuous enforcement of the specific regulatory framework.

52. The Program is expected to generate substantial social benefits through efforts to improve health care coverage in general and for vulnerable groups (people with low incomes, including people with disabilities, women, youth, children, people living in communities with no health centers, etc.). The Program will achieve this by expanding community health care and strengthening the government's capacity to address barriers hindering poor households from accessing essential services in urban and rural areas. The targeted communities will receive support from health staff through a communication strategy to identify specific social barriers and address them adequately.

53. **The following core ESSA principles are relevant to this Program**: (i) Core Principle 1: General Principle of Environmental and Social Management; (ii) Core Principle 3: Health and safety of the population; and (iii) Core Principle 5: Due consideration to be given to the needs or concerns of vulnerable groups. The ESSA findings confirm that the GoB's current system for managing the environmental and social aspects of the Benin Health Program-for-Results has several strengths, such as an acceptable legal framework for improving equitable and inclusive access to health care services; institutional mechanisms for stakeholders to relay their perspectives on the Program's design, including national and local level complaint procedures. However, there are potential bottlenecks that could hinder the target population's access to the project's benefits: (i) Key institutions in charge of E&S assessment do not have enough human and financial resources and adequate materials to enable them to enforce the texts. Additionally, awareness of E&S issues at the institutional actors' level is low as well as their management of social risks and cross-cutting issues; (ii) the national ESIA system does not include all aspects of public and worker safety. There is a lack of awareness of public health and safety issues, particularly with regard to exposure to hazardous materials; (iii) the functioning of the complaints mechanism at the local level is uneven in the different health zones of the country. These actions have been recommended as part of the mitigation measures in the Program's action plan to (i) strengthen the E&S management system through the preparation of an E&S risk management manual in the hospital environment and the development and functioning of a complaints mechanism within the framework of the Program; (ii) update or develop a hospital waste-management plan (HWMP) for each health facility of the Program by rationalizing the waste-management practices within health-care facilities, developing specific mechanisms to replace critical equipment and install appropriate treatment facilities, launching capacity building and training measures, setting up a monitoring plan, and reducing pollution; (iii) strengthen the technical and institutional capacities of the Program's implementation team through the

appointment of E&S management experts, and information and awareness campaigns mainly for the potentially affected stakeholders on E&S risks and impacts management and trainings of key institutional actors involved in the Program's E&S management.

54. **The Core Principle 4 describing land Acquisition is not relevant.** In this case, since there is no land acquisition, no impact on private assets or livelihoods is expected, while all new constructions will be located on existing sites or on land owned by the MOH. However, for any planned investment in the context of the Program, an E&S screening will be performed, subsequent social studies will be carried out including the development of appropriate resettlement action plans (RAP), if required, and mitigation measures will be fully implemented in a manner satisfactory to the Bank before the commencement of civil works.

55. **Consultation and disclosure of the ESSA Report**. Public consultations on the risks and potential effects of investment sub-projects should be conducted within a reasonable time, in an accessible place, and in a form and in terms understandable to the parties affected by the sub-projects. These consultations must make a valid contribution to the development of the design and mitigation measures envisaged under the Program. All E&S risk management tools prepared as part of the sub-projects should be formally published. Key stakeholders, mainly people likely to be affected, should be informed of the commitments contained in the E&S instruments and should have easy and transparent access to the complaint's mechanism. The ESSA report is prepared in consultation with several stakeholders including the implementing agencies and other public institutions, NGOs, municipal authorities, health sector practitioners, etc. The World Bank team participated in several meetings with the health ministry of Benin on the ESSA process. During the ESSA process, several consultations with key stakeholders from the public sector (such as the MOH, ABE, etc.), the private sector (such as owners of private health centers), and the civil society (such as chiefs of some communities in the Program implementation areas), have been held. The final draft of the ESSA report has been presented in a workshop which involved Benin's health ministry and key stakeholders, and their concerns and suggestions have been included in the final version of the report. The English and French versions of the ESSA report will be published on the World Bank's website.

Climate change risks and co-benefits

56. **Climate change risks and vulnerabilities.** This project has been screened for climate change and disaster risks. The overall potential risks in Benin were assessed as 'moderate' in the Summary Climate and Disaster Risk Screening Report. The exposure rating was assessed as 'high' due to the potential for extreme temperatures, extreme precipitation and flooding, drought, and sea level rise. In the last published poverty analysis,[9] 29 percent of rural households and 16 percent of urban households reported being impacted by biophysical shocks. While severe floods date back to 2010, when half of Benin's communes were affected, seasonal floods impact large numbers of communities and their residents every year. These floods can lead to higher prevalence of water- and vector-borne diseases, injuries, and drowning. The poor are particularly vulnerable to climate-related shocks, as they are net purchasers of food, live in low-quality housing in exposed areas, and have limited access to social services. Among poor households, food consumption accounts for over 70 percent of total expenditures on average, and three of the most commonly reported coping mechanisms to climate shocks are reducing food consumption, selling assets, and pulling children out of school (to save the fees and have the children work). Benin relies on rain-fed agriculture as the basis of its food security as well as economic development since about 70 percent of the population is engaged in the sector that generates 30 percent of GDP. Agriculture is highly vulnerable

[9] Ministry of the Environment. 2015.

to natural disasters, such as severe flooding and drought, which exacerbates nutritional instability and malnutrition among the population. According to the World Food Program, 9.6 percent of the population is food insecure while chronic malnutrition, which prevents body growth and cognitive development with irreversible consequences after the age of 2 years, affects 32 percent of young children. Although Benin is partially equipped to respond to climate shocks, the country was ranked 150th in vulnerability to climate disruptions and readiness for adaptive actions in the 2018 Notre Dame Global Adaptation Initiative (ND-GAIN). In this context, climate adaptation and mitigation strategies are critical to reduce population vulnerability and to ensure access to health services.

Corporate Requirements

57. **Key corporate requirements in the areas of gender and citizen engagement are addressed in the Program.** Specific to gender, the Program includes a focus on interventions to support maternal health and will monitor such support through key indicators across the Results Framework. The Program's DLIs include monitoring service delivery related to obstetric care and contraceptive prevalence. At the PDO-level, the quality of care related to ante-natal care and reproductive health is monitored, and at the intermediate level, skilled birth and post-natal care attendance are monitored. Actions in support of citizen engagement are outlined in the PAP, including the establishment of a Grievance Redress Mechanism (GRM) and the development of a Citizen Engagement Plan and mechanism within six months of effectiveness.

Grievance Redress Mechanism

58. Communities and individuals who believe that they are adversely affected as a result of a Bank-supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the Program's existing grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel, which will determine whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit http://www.inspectionpanel.org.

.

CONTACT POINT

World Bank

Name :	Carmen Carpio		
Designation :	Senior Health Specialist	Role :	Team Leader(ADM Responsible)
Telephone No :	5340+3028 /	Email :	ccarpio@worldbank.org
Name :	Zenab Konkobo Kouanda		

Designation :	Public Health Specialist	Role :	Team Leader
Telephone No :	5390+3925 /	Email :	zkonkobokouanda@worldbank.org

Borrower/Client/Recipient

Borrower :	Ministry of Economy and Finance		
Contact :	Romuald Wadagni	Title :	Minister of Economy and Finance
Telephone No :	0022921314781	Email :	hermann_ourou@yahoo.fr

Implementing Agencies

Implementing Agency :	Ministry of Health		
Contact :	Benjamin Hounkpatin	Title :	Minister of Health
Telephone No :	0022921332163	Email :	sante.infos@gouv.bj

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects