Program Information Document (PID)

Concept Stage | Date Prepared/Updated: 15-Dec-2020 | Report No:

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Parent Project ID (if any)	Program Name
Benin	P172940		Benin Health System Enhancement
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Does this operation have an IPF component?**
AFRICA WEST	15-Mar-2021	18-Mar-2021	No
Financing Instrument	**Borrower(s)**	**Implementing Agency**	**Practice Area (Lead)**
Program-for-Results Financing	Ministry of Economy and Finance	Ministry of Health	Health, Nutrition & Population

Proposed Program Development Objective(s)

To improve the access to quality health services with a focus on reproductive, maternal, neonatal, child, adolescent and nutrition (RMNCAH+N) in selected areas

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	150.00
Total Operation Cost	90.00
Total Program Cost	90.00
Total Financing	100.00
Financing Gap	-10.00

FINANCING (USD Millions)

Total World Bank Group Financing	100.00
World Bank Lending	100.00

Concept Review Decision

The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **Benin is a low-income economy which has made significant progress economically and politically over the last 25 years.** With a population of 11.49 million, Benin's Gross National Income per capita (World Bank 2018) was US$800 in 2017, well below the Sub-Saharan Africa (SSA) regional average (US$1,454). Fifty two percent of its people lives in urban areas, and the population and the economy are mostly concentrated in the southern parts of the country, close to the sea and the biggest cities of Cotonou, the economic capital, and Porto-Novo, the political capital. The economy of Benin remains dependent on subsistence agriculture, cotton production, and regional trade**.** The country's recent enhanced growth performance has been supported by the Port of Cotonou, a vital regional trade hub with access to the interior of West Africa.

2. **Despite significant economic growth, poverty levels are high**. Real gross domestic product (GDP) growth rate recently edged up from 5.7 percent in 2017 to 6.7 percent in 2018 and remained high in 2019 at 6.9 percent, supported by the strong performance of cotton production and port activity, and a renewed increase in construction. Benin has recently been upgraded from low-income to a lower middle-income country (LMIC) as its Gross National Income (GNI) per capita reached US$1,250 in 2019. Despite this, poverty levels remain substantial. According to the National Institute for Statistics and Economic Analysis (*Institut National de Statistique et de l'Analyse Economique,* INSAE), Harmonized Survey of Household Living Conditions (*Enquête Harmonisée sur les Conditions de Vie des Ménages,* EHCVM, 2018-2019), 38.5 percent of households have incomes below the poverty line. World Bank estimates based on official consumption aggregates suggest that US$1.9 a day (2011 purchasing power parity, PPP) poverty declined from 49.6 percent in 2015 to 45.4 percent in 2019[1].

3. **The widening differences between urban and rural development hinders the achievement of shared prosperity and poverty elimination.** Significant disparities in poverty rates exist between urban areas (36 percent) and rural areas (44 percent)[2]. Approximately 65 percent of all poor reside in rural areas. Rural populations suffer from inadequate infrastructure: only 15 percent of the rural population has access to electricity compared to 68 percent of the urban population; while 72 percent of the rural population has access to potable water compared to 85 percent for the urban population. Rural communities are also more vulnerable to climate and environmental disasters. For example, the floods in 2010 affected the poverty rates in four departments (Couffo, Collines, Mono and Zou) where the poverty rates between 2009 and 2011 increased to alarming levels, at least 5 percent above the national average of 36 percent.

4. **The COVID-19 crisis could result in driving poverty back to pre-2016 levels.** As a result of the COVID-19 crisis, growth is currently estimated to decline from 6.9 percent in 2019 to 2 percent in 2020 and real GDP per capita growth is expected to contract by 1 percent in 2020, reversing the gains achieved over the two preceding years. Overall, poverty reduction should pick up in 2021 as the economy recovers, with per capita income growth reaching pre-crisis levels by 2023[3].

[1] The World Bank, Benin/Macro poverty outlook (MPO), Feb. 2020 and post-COVID-19 estimates by the IMF, the World Bank and Beninese authorities as of April 2020.
[2] INSAE, *Evaluation de la pauvreté au Benin,* 2014. Nb. Official poverty lines in Benin are commune-specific and are divided between urban and rural areas, which limits the comparability of data
[3] The World Bank, Benin/Macro poverty outlook (MPO), Feb. 2020 and post-COVID-19 estimates by the IMF, the World Bank and Beninese authorities as of April 2020.

5. **The Government of Benin (GoB) outlined its objectives for inclusive growth and poverty reduction in its Government Action Plan 2016-2021 (*Programme d'Actions du Gouvernement, or PAG*).** The current Government, in office since April 2016, has shown strong commitment to economic reforms and developed a new and more inclusive growth model. The PAG is premised on the 2030 Agenda and 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.[4] 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. However, financial constraints, a fragmented legislature and weak underlying administration capacities mean that progress on reforms and controversial restructurings may continue to be sluggish.

Sectoral (or multi-sectoral) and Institutional Context of the Program

6. **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 in March 16, 2020. As of end-March, the country recorded fewer than 100 cases, but State of Emergency was declared at the beginning of April and swift containment measures were immediately put in place to contain and mitigate the spread of the virus. First, a sanitary cordon (*Cordon sanitaire)* were 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 in 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. There were 3055confirmed cases and 44 COVID-19 deaths as of November 30, 2020. The number of cases per million people remains low (273), less than one fourth of the sub regional average. 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.

7. **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 against 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)[5], morbidity (15,2%) and mortality (36,7%) among children under-five years of age, with a 37% prevalence among pregnant women[6]. 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[7] and pose considerable risk of delayed socio-economic growth. Figures also pointed out high prevalence of anemia among both

[4] Economist Intelligence Unit, Benin Country Report, 2017.
[5] National Health yearbook. 2019
[6] Benin. Demographic and Health Survey. 2017-2018
[7] World Bank Group. World Development Indicators. 2019

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[4].

8. **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 2011 and 2017, 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.

9. **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[8] 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.

10. **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] World Bank. World Bank Indicators 2019.

11. **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*[9] 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.

12. **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 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.

13. **Benin's climate change and disaster risk screening suggests a high risk**. Based on the climate change and disaster risk screening conducted for other Bank-financed projects in Benin, the screening suggests the risks are high, due to the potential for extreme temperatures, extreme precipitation and flooding, drought, and sea level rise. In the last published poverty analysis[10], 29 percent of rural households and 16 percent of urban households declared being impacted by biophysics shocks. While serious 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.

14. **Benin is only partially equipped to respond to climate shocks**. The country scores 35.7 (ranks 156th) in the Notre Dame Global Adaptation Initiative (ND-GAIN), which measures two dimensions of adaptation: (i) the vulnerability of six life-supporting sectors (food, water, health, ecosystem services, human habitat, and infrastructure); and (ii) countries' economic, governance, and social readiness to respond to these vulnerabilities. In 2015, the Government adopted a National Program to manage Climate Change[11].

15. **Climate change and disasters disproportionally affect the most vulnerable**. [1]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

[9] 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.
[10] Ministry of the Environment. 2015.
[11] INSAE. EMICoV 2015 Report. March 2016. (Poverty analysis for the 2018 Survey is not yet available).

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 common 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 is relying on agriculture as the basis of its food security as well as economic development since about seventy percent of the population are engaged in the sector that generates 30 per cent of GDP. Therefore, the country is highly vulnerable to natural disasters, like flooding and drought, which exacerbates nutritional instability and malnutrition. According to World Food Program, 9.6 percent of the population was food insecure while chronic malnutrition, which prevents body growth and cognitive development with irreversible consequences after the age of 2, affects 32 percent of young children. In this context, ensuring access to health services is especially relevant for mitigating climate shocks.

Relationship to CAS/CPF

16. **The proposed project is aligned with the World Bank Group (WBG) strategic priorities, particularly the WBG's mission to end extreme poverty and boost shared prosperity.** It is also aligned with the Human Capital Project (HCP): it is a first line of defense to protect people from the impact of the pandemic and invests in mitigating future shocks and building resilience in order to help ensure the continued development of Benin's human capital. Furthermore, the project is focused on improving access to health services which is critical to achieving Universal Health Coverage (UHC). The economic rationale for investing in the project's interventions is strong, given that success can reduce the economic burden suffered both by individuals and the country. The project complements both WBG and development partner investments in health systems strengthening, disease control and surveillance, attention to changing individual and institutional behavior, and citizen engagement.

17. **The Government National Health Plan 2018-2022 provides the overarching framework under which the proposed project is being designed and will be implemented.** This proposed P4R 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. **The proposed operation is core to meeting Focus Area 2 of the Country Partnership Framework[12] (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

[12] 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.

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.

Rationale for Bank Engagement and Choice of Financing Instrument

19. **The proposed Program directly contributes to the health sector goals of Benin's PND and to the strategic vision of the MOH.** The goal of the proposed operation of strengthening the health system through improvements in quality and access is directly aligned with the health sector goals of the PND 2018-2025. The PND states that the main health sector objective is to reorganize the health system for more effective health coverage. The consistency between the goals of the proposed Program and the strategic vision of the MOH is also evident when it is observed that the areas of reform being prioritized focus on addressing the challenges faced in quality and access to health services.

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 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.

21. **Benin has experience with the implementation of results-based approaches in the health sector.** 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 the PBF scheme, from 2012 to 2017, the coverage for deliveries increased from 16 percent to 53.2 percent; antenatal care (four visits) and postnatal visit grew respectively from 14 to 32 and from 10 to 30 percent; children under-five fully immunized rose from 25 percent to 65 percent; general health services utilization increased from 6.7 percent to 23.4 percent; and growth monitoring trend for children 11–59 months grew from almost 0 to 25 percent. Regarding quality of care, there was noticeable increased structural and process quality in health facilities with improved availability of drugs and equipment as well as improved history taking and physical examination for both ANCs and curative consultations. In addition, the PBF scheme supported the process that identified the poor households and established a database that was aimed to be used by the government for the roll out of the insurance for strengthening of human capital (ARCH) program and developed guidelines for treatment of the poor. Even though universal health insurance was not in place yet, the project was able to provide free treatment to a few poorest people and free malaria treatment to children under-five and pregnant women. The PBF scheme was halted by the newly appointed Government at the completion of donor-funded pilot testing in 2017 due to lack of Benin Government ownership[13]. With the new administration now well in place and having defined its national and sectoral strategies, the Government is keen to re-visit a results approach which is already being implemented in the water sector and now being proposed through this PforR for the health sector.

[13] The PFF scheme was implemented in all country 34 health zones at the end of 2017 and supported by a set of partners including the Word Bank in 8 health zones, Gavi and Global Fund in 21 health zones and the Belgian Technical Cooperation in the remaining 5 health zones

22. **The PforR instrument 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 PforR can be an effective instrument to shift focus towards the achievement of results, rather than concentrating on issues related to the financing of inputs; (c) the use of the PforR instrument 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 PforR instrument 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 PforR instrument will ensure complementarity across the projects and thus maximize the value added of external financing.

23. **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.

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

Program Development Objective(s)

24. To improve the access to quality health services with a focus on reproductive, maternal, neonatal, child, adolescent and nutrition (RMNCAH+N) in selected areas

PDO Level Results Indicators

25. **The four results areas – (1) quality and access, (2) community engagement, (3) leadership and governance, and (4) emergency, including COVID, preparedness and response - will be measured through six PDO indicators, five of which are present in the PNDS and one which is directly related to COVID vaccination readiness. All six PDO indicators are directly associated with the Program's development objectives:**

(i) For *quality*– Percentage of pregnant women who receive four ante-natal care (ANC) consultations
(ii) *For access* - Percentage of extreme poor[14] who received free health care as per the Health insurance approach. (can be disaggregated on gender aspect).
(iii) For *community engagement* – Percentage of households who received at least one visit by a community health agent in the last three months as per the government community health guidelines.

[14] An extreme poor refers to a person who cannot meet its food needs, especially cannot afford a hot meal a day on its own. Typically, such a person also has difficulty meeting its housing, health, childcare, and clothing needs.

(iv) For *leadership and governance* – Percentage of health facilities (public and private) accredited as per the Government established strategy/protocol.
(v) *For Emergency Preparedness and Response* - Country has activated their Public Health Emergency Operations Centre or a Coordination Mechanism for COVID-19
(vi) *For COVID Vaccine Readiness.* Legislation for COVID-19 vaccine importation completed and presented for approval.

D. Program Description

PforR Program Boundary

26. **The program to be supported by this PforR is based on lessons learned from Benin's earlier experience advancing its national strategies and is responsive to the dynamic national and international context.** Since 2009, Benin has been guided by its National Health Policy (Politique Nationale de Santé, PNS, 2018-2030) and a National Health Development Plan (PNDS) 2009-2018 adopted by the Council of Ministers on September 1, 2010. This document is accompanied by a Monitoring and Evaluation and Review Plan (PSER 2009-2018). The PNDS has been implemented through two Triennial Development Plans (PTD) respectively from 2010 to 2012 and from 2013 to 2015. The latter coincided with the deadline for the Millennium Development Goals (MDGs). The evaluation of the PNDS at the 2016 mid-point made it possible to measure the performance in the sector, learn lessons, and reorient strategies. In view of the significant changes that have taken place on the national and international level, particularly the commitment to the Sustainable Development Goals (SDGs), the development of the National Development Plan (PND) 2018-2030, the Growth Plan for the Sustainable Development (PC2D) (2018-2021), the Government Action Program (PAG 2016-2021), and the reforms in the health sector, a new plan was developed to deal with development issues of the health sector. This PNDS (2018-2022) is based on, among other things, the sector health policy as well as the major concerns identified in the analysis and results from the mid-term evaluation of the PNDS (2009-2018) which highlighted the major challenges of the health sector for the years to come.

27. **The program to be supported by this PforR is part of the Government's 2018-2022 National Health Development Plan (PNDS).** This PNDS (2018-2022) is based on the PNS 2018-2030 and aims to respond to the key challenges identified in the analysis and results of the mid-term evaluation of the PNDS (2009-2018). The PNDS 2018-2022 is organized around six pillars for strengthening the health system. These pillars are: (1) leadership and governance development, (2) service delivery, (3) development of human resources for health, (4) development of infrastructure, equipment, maintenance and health products, (5) improvement of the health information system and promotion of health research, and (6) improvement of the financing mechanism for better universal health coverage. These pillars, referred to as Strategic Orientations in the PNDS, are broken down into specific objectives under which interventions and priority actions are defined. The proposed PforR will support a part of this program as show in Table 1 below.

Table 1: Government program and PforR Results Areas

Strategic Orientation 1: Development of Leadership and Governance in the Health Sector	PforR	PforR Results Area
• Ensure effective and efficient coordination in the sector	X	
• Ensure the implementation of the mechanism for strengthening the partnership between stakeholders	X	
✓ Ensure transparency in the management of resources, the promotion of ethics, equity, medical responsibility and accountability	✓	**Leadership and Governance**
Strategic Orientation 2: Service Delivery and Improving the Quality of Care		

✓ Reduce morbidity and mortality among mothers, newborns, children, adolescents and young people	✓	**Quality**
✓ Promote community health	✓	**Community Engagement**
✓ Improve the Quality of Care	✓	**Quality**
✓ Prevent and fight against Diseases	✓	**Emergency Preparedness and Response**
Strategic Orientation 3: Development of Human Resources for Health		
✓ Ensure the availability of qualified human resources in accordance with standards at the level of all health facilities	✓	**Quality**
• Improve the quality and motivation of human resources for health	**X**	
Strategic Orientation 4: Development of infrastructure, equipment and health products		
• Ensure the availability of infrastructure and equipment according to standards in health structures	**X**	
✓ Ensure the maintenance of health infrastructure and equipment	✓	**Quality**
✓ Make quality health products (drugs, vaccines, medical products and technologies) available at all levels	✓	**Quality**
Strategic Orientation 5: Improvement of the health information system and promotion of health research		
✓ Ensure the availability and use of quality health information at all levels including the private sector	✓	**Leadership and Governance**
• Promote research and the use of health research results	**X**	
• Ensure the digital transformation of the health system	**X**	
Strategic Orientation 6: Improvement of the financing mechanism for better universal health coverage		
✓ Ensure health financing on an equitable, sustainable and predictable basis	✓	**Leadership and Governance**
• Strengthen the pooling of resources and the mechanism for purchasing services	**X**	

28. **The proposed PforR will be structured around four results 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 action was initiated and at which time, 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 four results areas. The results areas are:

- **Result area 1:** Access and Quality. Improve demand for health services by improving access and strengthening the delivery of quality Sexual, Reproductive, Maternal, Newborn, and Adolescent Health + Nutrition (SRMNAH + N) health services;
- **Result area 2:** Community Engagement. Strengthen the community health system with the effective participation of grassroots populations;
- **Result area 3:** Leadership and Governance. Strengthen leadership and governance to improve the health of the population in general with a focus on mothers and children.
- **Result area 4:** Emergency, including COVID, Preparedness and Response. Strengthen the health system emergency preparedness and response capacity and specifically respond to the COVID-19 pandemic emergency

29. **The four results areas 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 at the community level. In this sense, improving (i) the points of care (health care centers and hospitals) where beneficiaries can access health services and (ii) the quality in the provision of health services, are necessary conditions for ensuring quality health services are available to, and reach those most in need at the community level. This involves clearly delineating the services provided by the formal health workers and those of community health workers given the geographical imbalance of human resources for health in Benin. Leadership and Governance is a result

area that cuts across all results areas. Leadership is needed to guide policy implementation to ensure an appropriately widespread service delivery network with needed and capable human resources. Moreover, governance of the sector provides the regulatory framework for the delivery of quality services, and provides the guiding structure under which action in support of the country needs in crisis and emergency situations, such as the current COVID pandemic and the vaccination urgency which involves the mobilization of multi-sectoral actors, are implemented. Moreover, the governance of the health system is critical to ensure the different aspects of a health system work in an integrated manner under a guiding framework and in line with shared objectives. Lastly, a proper emergency response requires interaction across all 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 the leadership and governance of the health sector enable and support the roll-out of an emergency campaign which requires cross-sectoral engagement and timely actions. The four results areas are described below with an initial set of activities to be potentially support as outlined in the PNDS.

30. **Result area 1: Access and Quality.** This result area seeks to improve access to and strengthen the delivery of quality Sexual, Reproductive, Maternal, Newborn, and Adolescent Health + Nutrition (SRMNAH + N) health services. This result area would support activities related to ensuring that high impact interventions are developed and implemented in health facilities through a minimum package of health services that aim to improve SRMNAH + N, the quality assurance system is strengthened in the sector, the operational capacity of health facilities is strengthened, medicines and essential health products are available at the last mile, qualified health human resources in sufficient number and equitably distributed are available, and the demand for quality health services is improved. The list of potential activities that could be supported by the proposed PforR and that are mainly related to 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 four result areas imply that some activities are related to more than one result area. These activities will be reviewed and developed further during preparation, in consultation with the client.

i. Strengthening the implementation of Basic Emergency Obstetric and Newborn Care (BEmONC), Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) in all maternity hospitals in the health zones "*zone sanitaire (ZS)*";
ii. Continuation of the implementation of Integrated Management of Child Illness (IMCI) in all health facilities and the triage, assessment and emergency treatment of children (TAET) *(Triage, Evaluation, Traitement en urgence, TETU)* approach in all reference structures;
iii. Strengthening of antenatal care; promotion of appropriate feeding practices and good nutrition for pregnant and lactating women, mothers, newborns and infants;
iv. Promotion of exclusive breastfeeding from 0 to 6 months and complementary feeding from 6 to 24 months;
v. Scaling up the management of acute malnutrition;
vi. Strengthening the functionality of the health system regulatory authority;
vii. Strengthening of referral and counter-referral systems;
viii. Institutionalization of the certification and accreditation of healthcare structures;
ix. Provision of health facilities with bio-medical equipment, protection devices (protection and stability of electrical energy) and consumables;
x. Rehabilitation of existing infrastructure meeting standards (solar panels in primary health centers, boreholes, etc.);
xi. Establishment of an optimized logistics management system (essential drugs, vaccines and consumables);
xii. Human Resources, production and development, recruitment, and deployment.

31. **Result area 2: Community Engagement.** This result area aims to support the Government of Benin in the implementation of measures aimed at strengthening the community health system with the effective participation of grassroots populations. This result area would aim to ensure there is a sufficient numbers of competent community health workers available and to ensure an integrated strategic communication on preventive measures are developed in support of health services delivered at the community-level. Resources will also be developed to strengthen programs for the prevention of gender-based violence (GBV) and mental health support provided through the public health department, national and regional communicable and non-communicable disease surveillance system, and routine health service at community health centers. The activities that are mainly related to this result area and that could potentially be supported by the Proposed Program include:

i. Increasing the number and strengthening the capacity of community health workers;
ii. Development and implementation of a training plan for community health workers;
iii. Supervision and coaching of community health workers;
iv. Establishment of community information and feedback mechanism, social media monitoring, practice surveys, direct dialogues and consultations for motivation of community health workers;
v. Updating and implementation of the integrated risk communication, outreach and citizen engagement plan for the survival of the mother, newborn and child;
vi. Establishment of a citizen watch and reporting mechanism to enable communities to help monitor the COVID response at the local level.

32. **Result area 3: Leadership and Governance.** This result area would focus on the development of activities that are directly related to strengthening leadership and governance to improve the health of the population in general with a focus on mothers and children. This result area would support activities to strengthen leadership and governance in the health sector, promote research and the use of health research, and strengthen the health management and information system. The potential activities directly related to leadership and governance that could be supported by the proposed PforR include:

i. Development / review / updating of policy documents and sector strategies
ii. Support for the functioning of the National Council for Primary Health Care (CNSSP), the National Council for hospital medicine;
iii. Implementation of the partnership agreement between the MOH and the private health sector platform;
iv. Organization of performance reviews and SDMPR (mother, perinatal, response) in the intervention areas;
v. Strengthening of the operational capacities of actors in health, environmental health and climate change research at all levels of the health pyramid;
vi. Strengthening of multisectoral consultation frameworks (researchers and decision-makers) and between health research institutions to support strategic orientations in the field of SRMNAH +N;
vii. Updating and implementation of the SNIGS strengthening strategic plan;
viii. Development and updating of the dynamic health map;
ix. Strengthening of the hospital health information system (computerization, digitization, archiving) and use of ICT (mobile-health, e-learning, etc.);
x. Recruitment and establishment of members of the project coordination unit and operation of the coordination unit (audit and management control, monitoring-evaluation, etc.);
xi. Development and implementation of the project risk management plan;
xii. Capacity building of project staff.

33. **Result area 4: Emergency, including COVID, Preparedness and Response.** This result area would focus on actions to strengthen the health system emergency preparedness and response capacity and direct support to COVID-19 preparedness and response actions, including financing the COVID-19 vaccine. This result area would support

strengthening the health system capacity for monitoring of public health and prevention events and ensure that the needed operational capacities for integrated and timely surveillance are in place. The potential activities that could be supported by the proposed PforR include:

i. Capacity building for the detection of epidemics or other health events;
ii. Identification and promotion of measures to prevent health emergencies and crises;
iii. Development of health research (clinical trials, therapeutics, etc.);
iv. Computerization of the management of epidemiological surveillance data;
v. Capacity building of HR specialists in epidemic management including laboratory and community level.
vi. Preparation for the management of emergency situations;
vii. Strengthening of diagnostic and emergency management structures in terms of equipment, qualified human resources and inputs;
viii. Purchase of vaccines to include, but not be limited to COVID-19 vaccines;
ix. Development and implementation of national deployment and vaccination plan targeted to COVID-19;
x. Procurement of ancillary supply kits that may include needles, syringes, alcohol prep pads, COVID-19 vaccination record cards for each vaccine recipient, and PPEs for vaccinators;
xi. Recruitment and training of health personnel for vaccine roll-out;
xii. Supply chain system, including cold chains adapted for COVID19-vaccine (includes improvements and/or procurement).
xiii. Indemnity/ compensation to individuals for COVID vaccine side-effects.

34. The four results areas will be measured by several intermediate indicators as listed in the table below. Intermediate indicators were chosen based on activities that are supported under each results area and closely reflect the DLIs being proposed under each results area

Table 2: Intermediate and PDO indicators, by results area

Results Areas	**PDO Indicators**	**Intermediate Indicators**
Access and Quality	• For *quality*– Percentage of pregnant women who receive four ante-natal care (ANC) consultations • *For access* - Percentage of extreme poor[15] who received free health care as per the Health insurance approach. (can be disaggregated on gender aspect).	• For quality - Basic Emergency Obstetric and Newborn Care (BEmONC) and/or Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) being implemented in all maternity hospitals in the health zones "*zone sanitaire (ZS)"* • *For access* – Number of health facilities providing nutrition monitoring and counseling to pregnant women
Community Engagement	• Percentage of households who received at least one visit by a community health agent in the last three months as per the government community health guidelines	• Development and implementation of a training plan for community health workers • *GBV* – Number of community-level primary health care centers providing gender-based violence counseling

[15] The Definition of extreme poor retained by Benin Government

		• *Citizen Engagement* - Establishment of a citizen watch and reporting mechanism to enable communities to help monitor the COVID response at the local level
Leadership and Governance	• Percentage of health facilities (public and private) accredited as per the Government established strategy/protocol	• partnership agreement approved between the MOH and the private health sector
Emergency, including COVID, Preparedness and Response	• Country has activated their Public Health Emergency Operations Centre or a Coordination Mechanism for COVID-19	• Percentage of diagnosed cases treated per approved protocol

Table 3: Summary of DLIs for the PforR

35. **In line with the Results Areas, the following potential DLIs have been identified:**

DLI Indicator	Disbursement Amount (US$ million)	DLI Baseline	Year 1 (US$)	2 (US$)	3 (US$)	4 (US$)	5 (US$)
DLI1. Contraceptive prevalence (modern method)		12 (2017)	15.5	15.8	17.3	18.8	20.3
Disbursement Amount	10.0		2.0	3.0	2.5	2.0	0.5
DLI2. Full immunization coverage (children 12 to 23 months)		52% (2017)	NA	NA	57%	NA	NA
Disbursement Amount	10.0		2.0	3.0	2.5	2.0	0.5
DLI3. Degree of functionality of the reference and counter-reference system		NA (2018)	20%	30%	40%	50%	60%
Disbursement Amount	10.0		2.0	3.0	2.5	2.0	0.5
DLI4. Proportion of health facilities that have not experienced a shortage in the last three months in products of vital importance for maternal and child health		NA (2018)	30%	40%	60%	70%	80%

Disbursement Amount	10.0		2.0	3.0	2.5	2.0	0.5
DLI5. Percentage of households who received at least one visit by a community health agent in the last three months as per the government community health guidelines		NA (2018)	60%	65%	70%	75%	80%
Disbursement Amount	10.0		3.0	3.0	2.5	1.5	0.0
DLI6. Proportion of private health facilities whose data are included in the SNIGS		NA (2018)	30%	50%	80%	90%	95%
Disbursement Amount	10.0		2.5	3.0	2.0	2.0	0.5
DLI7. Existence of an up-to-date public health crisis/outbreak preparedness and response plan		(2018)	Up-to-date public health event preparedness and response Plan				
Disbursement Amount	15.0		3.0	3.0	3.0	3.0	3.0
DLI8. National deployment and COVID vaccination plan and associated budget finalized		(2020)	Yes	NA	NA	NA	NA
Disbursement Amount	20.0		20.0	0.0	0.0	0.0	0.0
DLI9. Degree of implementation and compliance with the environmental and social requirements of the program		N/A (2018)	50%	60%	70%	80%	90%
			Satisfaction with ESSA performance indicators (timely production and submission of reports, tracking and processing of acceptable non-conformities, correct management of accidents and waste, PMM in place and functional, etc.)				
Disbursement Amount	5.0		1.0	1.0	1.0	1.0	1.0
Total Financing Allocated	**100.0**		**37.5**	**22.0**	**18.5**	**15.5**	**6.5**

36. **The choice of Disbursement Linked Indicators (DLIs) is based on the Government program and the verification protocols use existing systems.** A set of nine DLIs have been selected in line with the project's four results areas. The first four DLIs correspond to Results Area 1 which aims to improve access to and strengthen the delivery of quality Sexual, Reproductive, Maternal, Newborn, and Adolescent Health + Nutrition (SRMNAH + N) health services. DLI #5 is directly related to result area #2 which will support the strengthening of the community health system with the effective participation of grassroots populations by measuring and disbursing for results achieved related households receiving defined number of visits by a community health agent. DLI#6 is related to the project result area #3 which supports activities to strengthen leadership and governance will measure the capacity of the national health system to manage the full health network through evidence and data, to include the private sector. DLI#7 and 8 are directly related to results area #4 which focuses on actions to strengthen the health system emergency preparedness and response capacity and direct support to COVID-19 preparedness and response actions, including financing the COVID-19 vaccine. Lastly, DLI#9 is aligned with environmental and social safeguards responsibilities which cut across the project results areas and will measure and disburse against results in line with the degree of implementation and compliance with the environmental and social requirements of the program. The MOH has an established unit that will collect data and monitor the progress towards fulfillment of the DLIs.

E. Initial Environmental and Social Screening

37. **The environmental and social risk areas of the Program are: (i) risks related to rehabilitation of existing healthcare facilities; (ii) risks related to management of solid waste from safety equipment to be procured for health workers, medical waste management and disposal as well as potential electronic waste from ICT; (iii) risks related to spread of the infections among health care workers and among the community at large.** Within the community at large, those who are at risk of infection are women and girls who generally tend to be the caregivers within families and the frontline health care workers and social workers. Increased risk also exists for vulnerable groups such as the elderly, poor, and people with disabilities not benefiting equally from public awareness campaigns, quality services in hospitals, quarantine facilities. There are also increased risks for GBV and child abuse when women and children are under quarantine and self-isolation.

38. **The risk screening at PCN suggests that the overall social impact of the operation is likely to be positive.** Perceived social risks and adverse impacts of the Program are expected to be minimal. However, the deep social risk assessment to be undertaken through the ESSA will set up a clear list of excluded activities. Through previous projects financed by the Bank such as REDISSE and some ongoing projects such Covid 19, the MoH has gained experience and institutional capacity to manage expected social risks and impacts. The Program is not expected to have impacts on physical and cultural resources or natural habitats as the focus will be on existing health care facilities and community health workers. The project will support minor civil works for small scale rehabilitation and equipping health centers with better quality of the facilities, bio-medical equipment, and protection devices. These interventions are expected to take place on the property of existing facilities; therefore, environmental issues (and impacts thereof) are expected to be temporary, predictable, and easily mitigated.

39. An Environmental and Social Systems Assessment (ESSA) will be prepared to assist the Program in mitigating environmental, social, health and safety issues associated with activities. The ESSA will provide a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. The ESSA will describe the extent to which the applicable government environmental and social policies, legislations, program procedures and institutional systems are consistent with the World Bank's Operational core principles of OP/BP 9.00. Finally, the ESSA will include recommendations and Program Action Plans (PAPs) to address

the gaps and to enhance performance during Program implementation. For the assessment, the team will review the environment and social systems that are relevant to the Program, among potential aspects to be assessed would be energy efficiency standards or/and certification schemes for hospitals, medical waste management, genders gaps, if any, and access to health care by vulnerable groups (e.g. people with disabilities, minor ethnic and communities living far from heath centers, etc.). Public consultations with key stakeholders or representatives will be carried out in preparation of ESSA. A draft of the ESSA will also be available at the MOH website for public comments and review as well. The final version of the ESSA will be disclosed at the InfoShop after it is published in the MOH website.

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