STAFF APPRAISAL REPORT

REPUBLIC OF BENIN

HEALTH AND POPULATION PROJECT

MAY 10, 1995
CURRENCY EQUIVALENTS  
(as of November 1994)

1US$ = 600 CFAF  
1FF = 100 CFAF

WEIGHTS AND MEASURES

Metric System

ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABBEF</td>
<td>Association Béninoise de Bien-Etre Familial (Beninese Association of Social Welfare)</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CA</td>
<td>Centrale d'Achat (Central Procurement Agency)</td>
</tr>
<tr>
<td>CCS</td>
<td>Complexe communal de santé (Communal Health Center)</td>
</tr>
<tr>
<td>CDEEP</td>
<td>Comité Départemental de Suivi de l'Exécution et d'Évaluation des Programmes du secteur santé (Departmental Committee for Implementation Monitoring and Health Sector Program Evaluation)</td>
</tr>
<tr>
<td>CFA</td>
<td>Communauté financière africaine (African Financial Community)</td>
</tr>
<tr>
<td>CHD</td>
<td>Centre hospitalier départemental (Departmental Hospital Center)</td>
</tr>
<tr>
<td>CNEEP</td>
<td>Comité National de Suivi de l'Exécution et d'Évaluation des Programmes du secteur santé (National Committee for Implementation Monitoring and Health Sector Program Evaluation)</td>
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<tr>
<td>CNHU</td>
<td>Centre national hospitalier universitaire (National University Hospital Center)</td>
</tr>
<tr>
<td>COGEC</td>
<td>Comité de gestion de la commune (Communal Management Committee)</td>
</tr>
<tr>
<td>COGES</td>
<td>Comité de gestion de la sous-préfecture (Sub-prefecture Management Committee)</td>
</tr>
<tr>
<td>COGEZ</td>
<td>Comité de gestion de la zone sanitaire (District Management Committee)</td>
</tr>
<tr>
<td>CPPR</td>
<td>Country Project Performance Review</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CSSP</td>
<td>Centre de santé de la sous-préfecture (Sub-prefecture Health Center)</td>
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<tr>
<td>DDS</td>
<td>Direction départementale de santé (Departmental Health Directorate)</td>
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<tr>
<td>DPhL</td>
<td>Direction des pharmacies et laboratoires (Pharmacy and Laboratory Directorate)</td>
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<tr>
<td>DPCE</td>
<td>Direction de la Planification, de la Coordination et de l'Évaluation (Planning, Coordination, and Evaluation Directorate)</td>
</tr>
<tr>
<td>DSAF</td>
<td>Direction des services administratifs et financiers (Administrative and Financial Services Directorate)</td>
</tr>
<tr>
<td>DSF</td>
<td>Direction de la santé familiale (Social Welfare Directorate)</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>IAPSO</td>
<td>Inter Agency Procurement Services Office</td>
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<td>ICB</td>
<td>International Competitive Bidding</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MEF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NCB</td>
<td>National Competitive Bidding</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
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<tr>
<td>PFP</td>
<td>Policy Framework Paper</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PTD</td>
<td>Plan Triennal de Développement (Three-year Development Plan)</td>
</tr>
<tr>
<td>SA</td>
<td>Special Account</td>
</tr>
<tr>
<td>SNIGS</td>
<td>Système National d'Information et de Gestion Sanitaire (National Health Management and Information System)</td>
</tr>
<tr>
<td>SOE</td>
<td>Statement of Expenditures</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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FISCAL YEAR

January 1 - December 31
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This report is based on the findings of an appraisal mission, which visited Benin in June/July 1994. Appraisal team members included: Messrs./Mesdames Michael Azefor, Mission Leader (AFIPPH), Denise Vaillancourt, Management Specialist (PHN), Marie-Odile Waty, Health Economist (AF3PH), Robert Leke, Consultant/Professor of Obstetrics and Gynecology (University of Yaounde), Peter Bachrach, Consultant/Planning Specialist, and Abdoulaye Magana, Consultant/Project Management Specialist. It also draws on the findings of a November 1994 post-appraisal mission composed of Messrs./Mesdames Denise Vaillancourt, Mission Leader (PHN), Olusoji Adeyi, Young Professional/Physician (PHN), Michael Azefor, Resident Representative (Resident Mission, Benin), Ousmane Diagana, Economist (Resident Mission, Benin), Peter Bachrach, Consultant/Planning Specialist, Robert Leke, Consultant/Professor of Obstetrics and Gynecology (University of Yaounde), Jean-Pierre Mansmhande, Consultant/Public Health Specialist. Messrs. Hjalte Sederlof (MN3PH) and Aubrey Williams (OPRPG) served as peer reviewers. The Division Chief is Mr. Ian Porter, and the Director is Mr. Olivier Lafourcade.
ANNEXES

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2. Major Causes of Morbidity among the General Population
3. Current Structure of the Ministry of Health
4. Estimates of Additional Personnel by Level and by Category
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6. Evolution of Health Sector Financing in Benin
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18. Technical Assistance
19. Personnel Overseas Training Schedule
20. Disbursement Schedule

DOCUMENTS IN PROJECT FILE

MAP: IBRD 26983
Republic of Benin

HEALTH AND POPULATION PROJECT

CREDIT AND PROJECT SUMMARY

**Borrower:** Republic of Benin

**Implementing Agency:** Ministry of Health

**Beneficiaries:** Population of Benin

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

**Terms:** Standard IDA, with 40 years maturity

**Project Objectives:** The overall objective of the project is to assist the Government in improving the health and well-being of Benin’s population, with particular emphasis on its most vulnerable segments (women, children and the poor). It will do so through the support of national sector policy and strategic objectives. First, in support of Benin’s population policy (expected to be approved by the Council of Ministers before end-November 1995), the project will assist in the further development and expansion of the family planning program. Second, the project will support implementation of the three main reforms included in the national health sector strategy for the period 1995-1999. These reforms, aimed at improving the quality, coverage and efficiency of basic health services and at rendering the health system more accountable to the population, are: (a) decentralization and strengthening of sector management and administration; (b) reconfiguration of the referral system and strengthening of its capacity to provide technical support services to primary health care and nutrition; and (c) expansion of the participation of multiple stakeholders, including beneficiaries, in the planning, implementation and evaluation of national health policy and programs.

**Project Description:** The project’s support to the implementation of national sector policy and strategy will be provided through four components:

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

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

(c) **Strengthening Sector Management and Administration:** This component will support the decentralization of sector management and administration, which
will involve the gradual establishment of health districts, the strengthening and expansion of departmental-level capacity, and the strengthening of key functions of the central MOH. It will also support the development of key management capacities at all levels of the system, including mobilization and management of financial resources, management and training of health personnel, planning, supervision, information collection and analysis, and evaluation. In addition, it will continue to support successful efforts initiated under the first IDA funded health project to improve pharmaceutical policy, legislation and regulation and to fine-tune systems and processes for ensuring the quality, affordability and timely replenishment of essential generic drug stocks throughout the system.

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

**Benefits:**

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

**Risks:**

The main risk of the project is the potential inability of the Government to carry out the comprehensive reforms included in the project. Key stakeholders were involved throughout the process of project preparation, which should mitigate any tendency by central level officials to stall sector reforms or project activities. The coordination mechanisms and supervision arrangements ensure regular consultation among the MOH, beneficiary representatives, other ministries, donors, private sector operators and NGOs to review progress in implementation and provide timely solutions to problems detected. Another risk is that Government budgetary allocations may fall short of resources needed to implement the project. Conditions to be met under the project include a restructuring of the current public budget for health to encourage decentralization and increase absorptive capacity and a gradual increase in the health sector share of the total current budget over the life of the project. In addition, resources generated through cost recovery and managed by communities constitute a guarantee that essential drugs and critical non-wage operating expenses are
protected. To ensure greater sustainability, the project design envisages a
decentralized implementation strategy in which the regions, rather then the
central MOH, are primarily responsible for execution of various project
activities. Periodic reviews and annual programming workshops at the level of
the CNEEP will ensure that all regions are respecting implementation plans,
standards and deadlines. Beneficiary assessments will also be used to monitor
sector performance.
### Project Cost Summary and Financing Plan
(including taxes & duties, in US$ million)

#### Estimated Project Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>Local</th>
<th>Foreign</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Development and Expansion of Family Planning Programs and Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Promotion/Dissemination of Pop. Policy</td>
<td>0.4</td>
<td>0.7</td>
<td>1.1</td>
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<tr>
<td>2. Family Planning Service Delivery</td>
<td>0.3</td>
<td>0.9</td>
<td>1.2</td>
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<tr>
<td><strong>B. Improving Quality and Efficiency of Priority Health Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Strengthening of Priority Health Programs</td>
<td>1.6</td>
<td>2.7</td>
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<tr>
<td>2. Strengthening of Referral System</td>
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<td><strong>C. Strengthening and Streamlining Sector Management and Administration</strong></td>
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<td></td>
<td></td>
</tr>
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<td>1. Decentralization of Management &amp; Administration</td>
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<td>3. Strengthening of Pharmaceutical Sector Management</td>
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<td>1.6</td>
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<tr>
<td><strong>D. Strengthening of Partnerships for Health</strong></td>
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<td>0.1</td>
<td>0.9</td>
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<tr>
<td><strong>E. Project Management Costs</strong></td>
<td>0.3</td>
<td>0.5</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**TOTAL BASE COSTS**

| Total | 9.6  | 17.4  | 27.0  |

**Physical contingencies**

| Total | 0.6  | 1.4   | 2.0   |

**Price contingencies**

| Total | 3.0  | 1.4   | 4.4   |

**TOTAL PROJECT COSTS**

| Total | 13.2 | 20.2  | 33.4  |

#### Financing Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Local</th>
<th>Foreign</th>
<th>Duties</th>
<th>Total</th>
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<td>IDA</td>
<td>8.3</td>
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<td>Government (including taxes &amp; duties)</td>
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<td>2.8</td>
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<td>Beneficiaries</td>
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<td>0.5</td>
<td>0.0</td>
<td>0.5</td>
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</table>

**TOTAL PROJECT COSTS**

| Total | 10.4 | 20.2  | 2.8   | 33.4  |

#### Estimated IDA Disbursements

<table>
<thead>
<tr>
<th>IDA Fiscal Year</th>
<th>FY96</th>
<th>FY97</th>
<th>FY98</th>
<th>FY99</th>
<th>FY2000</th>
<th>FY2001</th>
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<td>Annual</td>
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<td>7.5</td>
<td>6.9</td>
<td>6.1</td>
<td>4.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Cumulative</td>
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<td>9.4</td>
<td>16.3</td>
<td>22.4</td>
<td>26.6</td>
<td>27.8</td>
</tr>
</tbody>
</table>

**Project ID No.:** 118
1.1. Benin is a country of more than five million people with a total GDP of about US$1.5 billion (1994). Its economy is highly open and strongly dependent on primary and tertiary activities. The primary sector, which accounts for 33 percent of total GDP, provides the country's largest export commodity: cotton. A large tertiary sector dominated by commerce accounts for 53 percent of the country's GDP, and its dynamic re-export activities provide about 45 percent of the country's total export revenues. In contrast, the country has a small secondary sector which barely accounts for about 14 percent of GDP.

1.2. The country is a member of the Economic Community of West African States (ECOWAS). As a member of the Union monétaire ouest africaine (UMOA) and of the Banque Centrale des Etats de l'Afrique de l'Ouest (BCEAO), it has a common currency (the CFA franc) with West African francophone countries, which is pegged to the French franc. In January 1994, in conjunction with the other members of the CFA zone, Benin realigned the parity of the CFA franc from 50 to 100 CFA francs to one French franc.

A. COUNTRY ECONOMIC FRAMEWORK

1.3. Benin adopted an adjustment program in 1989 in response to an economic and financial crisis engendered by almost two decades of state domination and mismanagement of the economy. The first phase of this program (1989-90), supported by SAC I and an IMF SAF arrangement, focused on reducing macroeconomic imbalances and initiating market liberalization. Key objectives included reducing the fiscal deficit, initiating a public enterprise divestiture program, and managing the crisis engendered by the collapse of the state-owned banks. Implementation of the program was severely hampered by political disturbances in 1989, which led to a breakdown of the public administration and a dramatic decline in government revenues. The economic crisis was accompanied by a period of sociopolitical turmoil culminating in the naming of a transition government in March 1990. Considerable progress was realized in 1990, particularly with regard to public enterprise divestiture and restoration of a functioning banking system.

1.4. Multiparty elections and the installation of a new President and National Assembly in early 1991 were followed rapidly by a reinforcement of the economic reform program. The second phase of the adjustment program (1991-93), initiated by the newly-elected Government, and supported by SAC II and IMF SAF/ESAF programs, focused on reduction of the current budget deficit, widespread market liberalization, and further public enterprise divestiture. Implementation of the program has culminated in a number of notable achievements. Since the end of the 1980s, the Government has increased its fiscal effort by 70 percent, largely through major reforms in taxation. At the same time it has reduced the size of the civil service by 10 percent and increased budget allocations for non-wage operating costs and actual expenditure for its public investment program. It has dramatically lowered import tariffs and eliminated virtually all restrictions, so that it now has one of the most open trade regimes in sub-Saharan Africa. It has made a clean break with the Marxist-Leninist ideology of the past and made important strides in putting in place a business environment more conducive to private investment. Consistent with a more private-oriented economy, and a leaner public sector, it has cut the number of public enterprises from 120 to 29. Finally, it has begun long-term restructuring of the public administration.

1.5. The main focus of the proposed SAC III operation is to consolidate reforms initiated since 1990. It will support the Government's efforts to: maintain a substantial real depreciation through appropriate
macroeconomic policies, assure a strong supply response to the devaluation, and improve the delivery of essential public services required for higher growth in the medium-term. Policy reforms would be accelerated in two areas. First, the SAC III would support improved incentives for private sector development through further simplification and rationalization of foreign trade taxation, a deeper restructuring of domestic indirect and direct taxation, additional changes in the regulations governing commercial activity and the labor market, and public enterprise divestiture. Second, it would support improved management of public resources and delivery of public services by restructuring current expenditures, improving public investment programming and reforming institutions in key ministries. Given its relatively strong past adjustment performance, the successful devaluation of the CFA franc in 1994, and the reform measures proposed for 1995-96, additional adjustment lending for Benin beyond the proposed credit is not envisaged. Continued economic reforms in key sectors would be pursued primarily through sector investment operations.

B. HUMAN RESOURCES DEVELOPMENT IN THE MACROECONOMIC CONTEXT

1.6. There is increasing recognition on the part of the Government that a skilled, healthy and well-nourished population is a condition *sine qua non* for sustainable development. From the very outset, the Government’s adjustment program has accorded priority to human resource development. It addressed the short-term basic needs of the population through emergency measures to create productive employment and to protect the most vulnerable groups during the adjustment process. The Government has, with donor support, improved the quality and coverage of health and education services in order to meet the needs of the general population. The Government has sought to improve the quality of life of the general population by implementing water and environmental sanitation programs and by supporting women’s economic development activities. Over and above these short-term measures, the Government recognizes the need to develop a long-term strategy for human resources development that would enable Benin to harness its rapidly growing population into an effective, productive force.

1.7. It has therefore embarked on major sector reform and development programs in the areas of poverty reduction, health, education, professional training and enhancement of the role of women in development that are central to sustainable development. It is finalizing a comprehensive population policy that will become an important component of its human resource development program. The findings and recommendations of a participatory poverty assessment carried out by the Bank were recently endorsed by the Government. An important component of the Government’s strategy to reduce poverty is to improve the access of the poor and vulnerable to basic social services. In the area of health, the focus continues to be on: reducing current morbidity and mortality, especially among children and mothers; greater involvement of beneficiaries in health; expanding family planning activities to increase contraceptive practice; and improving the nutritional status of the population. In the education and professional training sector, Government efforts are being directed at the fundamental restructuring of the country’s educational system to accord higher priority to general education, especially for girls. The reforms, which cover all levels of the educational system, will adapt the content of syllabuses and teaching methods to the needs of the economy of Benin. An Education Project approved by the Board on May 17, 1994 will help the Government realize these reforms. An IDA-funded Food Security project, approved by the Board on April 12, 1994, will support efforts to improve the nutrition status of the general population.
II. THE POPULATION, HEALTH AND NUTRITION (PHN) SECTOR

A. SECTOR OVERVIEW

1. PHN Status: Causes and Consequences

2.1. Propelled by persistently high fertility (TFR=7.1) and moderately declining mortality, Benin's population of 5 million is growing at a rapid annual rate of 3.2%. Life expectancy is estimated at 51 years, infant mortality at 80 per 1,000 live births and maternal mortality at about 800 per 100,000 live births. These indicators compare unfavorably with averages for low income countries (life expectancy of 62 years and infant mortality rate of 73 per 1000 live births) and put Benin among countries with the highest mortality in the world. Basic indicators for Benin are presented in Annex 1.

2.2. Benin's poor health status results from the high prevalence of tropical communicable and parasitic diseases, poor nutrition, high fertility, inadequate preventive and curative health services, low access to safe drinking water and sanitation facilities, low levels of literacy and education -- especially among women, and pervasive poverty. The leading causes of morbidity and mortality (discussed in Annex 2) are, in order of prevalence: malaria, diarrheas and gastroenteritis, acute respiratory tract infections, traumas and anemia. Except for measles, vaccine-preventable diseases are not among the main pathologies. A relatively successful vaccination program has, in recent years, shifted the vaccine-preventable disease burden among children into older age groups, who had lower immunization protection and who suffer from serious nutritional problems. Rising HIV infection rates and AIDS cases are of increasing public concern: 218 new cases of AIDS were officially reported for 1992, with a cumulative total of 465 cases; and it is likely that cases are under-reported. The proportion of women among all reported cases is increasing. The principal transmission method is heterosexual intercourse, with an increase in vertical (mother-to-child) transmission. Estimated HIV prevalence in the general population is still 1 percent and no projections of HIV infection have as yet been carried out.

2.3. Malnutrition is very prevalent, but often not diagnosed and generally under-reported. Several nutrition studies show that 25 percent of Benin's population is malnourished and that children and mothers are generally more severely affected. Estimates suggest that between 20 and 40 percent of children under five suffer from some degree of malnutrition and 3 to 6 percent are severely malnourished. These rates are high compared to those of countries with similar socio-economic and geographical features. Signs of vitamin A deficiency are present among the general population in the northern part of the country, but more recently similar deficiencies have been identified among school children in Cotonou. Iodine deficiency is known to be endemic in a number of areas of the country. Although symptoms of iron deficiency are very common among pregnant women and low births weights are frequent, there are no detailed studies analyzing the magnitude and severity of nutritional deficiencies among pregnant women and babies. The major factors adversely affecting nutritional status in Benin are: (a) inadequate allocation of household income; (b) food taboos; (c) unhygienic and inappropriate preparation practices; (d) poor weaning practices; (e) food consumption and distribution patterns within the family; and (f) pervasive poverty.

2.4. Poor PHN status threatens both the quality of life of Benin's population and prospects for achieving development goals. With a per capita income of US$400, Benin is caught in a vicious cycle of poverty and ill health, which has persisted despite national efforts to improve economic and social development in recent years. Constant ill health limits the country's ability to maximize returns on investments in education and training, and to increase its economic productivity. The current population growth rate implies the doubling of the population size in less than 25 years, a rate of increase that will further inhibit national efforts to improve the quality of life. Persistently high fertility, coupled with slowly declining mortality, have culminated in an increasingly youthful age structure: close to half of the
population is under 15 years old. Not only does this impose a severe burden on an under-employed labor force, it also poses greater demands on social services, which already are overextended. This will keep the country’s propensity to save below a level needed for generating adequate capital for economic growth. Furthermore, population growth that outpaces economic growth will contribute to poor nutrition and health status, which will, in turn, inhibit productivity and exacerbate poverty.

2. Structure and Organization of the Health System

2.5. Benin’s public health system has three levels, structured around the administrative subdivisions of the country: central (or national); intermediate (or departmental) and peripheral (composed of two subdivisions: sub-prefectural and communal levels). Annex 3 presents the current structure of the administration, facilities, and management committees that make up the health system, which are described briefly below.

2.6. Administration. At the central level, the Ministry of Health (MOH) coordinates the formulation of sector policy and strategies. It synthesizes requests for inputs from the regions into sector investment programs and prepares corresponding annual investment and recurrent budget proposals for the sector. The MOH prepares medium-term investment plans and collaborates with the Ministry of Plan in mobilizing resources from external sources. It is responsible for setting and enforcing patient care norms and standards. It defines the functions and evaluates the performance of health facilities at all levels. The MOH is responsible for the deployment, supervision and evaluation of all categories of health personnel who work in the health sector. At the regional level, the Departmental Bureau of MOH (DDS) is responsible for managing health programs designed to implement the national health sector policy and strategy as adapted to the particular context of the region. The DDS is responsible for the allocation of resources within the region and for the provision of support to health facilities in the department and to central MOH in planning, management and evaluation of health sector activities. It has primary responsibility for supervision and coordination of health services (curative, preventive and promotional) in the region. It monitors the operation of health facilities in order to assure that they function in line with MOH directives and nationally set standards for patient care. The DDS coordinates the preparation of draft budget requests submitted to the MOH for review and inclusion in the sector budget proposals. At the sub-prefectoral level, the chief medical officer supervises primary health care facilities operating in the sub-prefecture. At the community health center level, a state midwife or nurse manages community-level primary health care and supervises health center staff.

2.7. Health Facilities. The pyramidal structure of Benin’s health care services has at the central level the National University Hospital Center (CNHU), which is responsible for tertiary care and offers specialized medical and surgical care for cases not requiring evacuation. In practice, however, it also functions as a primary health care (PHC) and first referral health center with no patient screening system. It helps train physicians, midwives, nurses and technicians and undertakes medical research. At the regional level, the Departmental Hospital Center (CHD), the second level referral unit, handles complicated cases, requiring medical specialists, which are referred from the sub-prefectoral (or district-level) health centers (CSSP). The CHD is responsible, among other things, for in-service training of regional clinical staff. At sub-prefectoral headquarters, the CSSP provides both PHC and first referral care to patients referred from the Communal Health Center (CCS). A number of CSSPs are sufficiently equipped with technical staff and equipment to serve as the first level of referral for lower-level facilities. At the community level, the CCS provides PHC and serves as the entry point into the health system. It does most of the outreach and promotional activities incorporated in the country’s health strategy. A number of village health posts, established by some villages in Benin have not been sustainable for a number of reasons, including the absence of a fully functional outreach and referral system. As ongoing health sector management reforms improve capacity at the periphery, the role of village health posts and their operational strategies would be defined. However, these must remain demand-driven and community-financed initiatives.
2.8. **Inter-sectoral Coordination and Community Participation.** The coordination, monitoring and evaluation of program implementation is the responsibility of the Comité National de Suivi de l’Exécution et d'Évaluation des Programmes du secteur santé (CNEEP). This inter-ministerial committee, created in 1988 to undertake periodic assessments of the progress of the implementation of objectives set out in the national health policy and strategy, is composed of high-level representatives of key central and line ministries and of key stakeholders, including decentralized MOH authorities and community representatives. At the departmental level, the Comité Départemental de Suivi de l’Exécution et d'Évaluation des Programmes du secteur santé (CDEEP) functions as a regional CNEEP. The sub-prefecture management committee (COGES), made up of representatives elected from the communal management committees (COGEC) (see below) and the chief medical officer is responsible for the planning and management of health activities and resource use for the entire sub-prefecture, including monitoring cost recovery and essential drug stocks. At the level of the commune, the health care program is coordinated by the COGEC, an elected committee, whose membership includes women’s representatives and the head of the health center (CCS), usually a midwife or nurse. This committee is responsible for managing essential drug stocks and proceeds from cost recovery. It participates with the staff of the CCS in the preparation of budget estimates to be reviewed at the sub-prefectoral level prior to submission to the MOH for consolidation. It approves local non-wage expenditures financed under cost recovery. The COGES and COGEC are responsible for health promotion activities and for planning annual activities for the center and for monitoring the use of the center’s finances. They are also active in health information dissemination, especially in the areas of immunization, maternal and child health (MCH) and household sanitation.

B. **PAST SECTOR PERFORMANCE AND KEY ISSUES**

2.9. Since 1972, the Government has periodically updated its health sector strategy, in consultation with IDA, WHO, UNICEF and other bilateral donors. The sectoral strategy for the period 1989-93 established a number of priority programs for improving the quality of health care and for strengthening the organization and management of the health sector. Implementation of this strategy resulted in a number of impressive accomplishments. Numerous aid donors invested in improvements in service access and quality (para. 2.29). In addition, the first ongoing IDA Health Services Development project (Cr. 2031-BEN), approved in 1989, and cofinanced by the Swiss, supported:

(a) the reorganization of the MOH and the creation of three new Directorates (with corresponding services at the departmental level) for, respectively: Planning Coordination and Evaluation (DPCE); Administration and Finance (DSAP); and Family Health (DSP);

(b) the successful extension nationwide of the cost recovery system and the creation of health management committees at the commune level (COGEC) and sub-prefecture level (COGES) through which communities manage cost recovery funds and participate in the planning, implementation and evaluation of sector activities carried out in health facilities;

(c) the establishment of a central procurement agency (Centrale d'Achat), which assures the affordability and constant availability of essential generic drugs at all levels of the health system; and

(d) the establishment of mechanisms for eliciting and facilitating the involvement of various partners in the planning, coordination and evaluation of sector activity (CNEEP and CDEEP).

Despite these notable achievements, a number of issues continue to constrain the performance of the health system. These are briefly described as follows.
1. Quality and Access

2.10. Family planning services. Until recently, the development of family planning services has been hindered by the Government's and communities' traditional pro-natalist position, legislative and regulatory restrictions, and divided responsibilities for actual service delivery. While information concerning the demand for family planning services is incomplete, interviews with field staff and local committees suggest that current demand for family planning services is not being effectively or fully met because both quality and access are inadequate.

2. Health Services. Due to acute underfinancing of the sector for a period of some 30 years, by the late 1980s the existing health infrastructure had reached a serious state of deterioration and no new construction or rehabilitation had been undertaken to improve service quality and access. Since 1989, the Government has made significant efforts both to rehabilitate and re-equip health facilities and to establish norms by level of service delivery, including: facility construction, staffing norms, standard equipment lists, and essential drug lists. Based on existing criteria, 55 percent (206 of 373) of existing health facilities now conform to established norms. While clear progress has been made, several problems remain. The norms emphasize physical rather than programmatic criteria and compliance with them is problematic for virtually all facilities not assisted by a project. In addition, past rehabilitation programs have been funded essentially by donors, and this has resulted in significant imbalances with respect to need and unequal resource and service availability between regions. Finally, because norms have not been strictly adhered to, costly operating inefficiencies have been built into the system through overbuilt and overequipped facilities. As a result, evaluations of utilization rates and health service delivery in Benin indicate that significant investment since 1989 has not substantially improved the level of care. Although effective coverage of the population has increased to an estimated 30 percent, utilization rates remain very low at about 20 percent (as compared with neighboring countries where rates of 60-80 percent are found). This suggests that while geographical (and possibly financial) accessibility may remain a problem, the major problem facing the health sector is the range and quality of services offered. Furthermore, while the establishment of the Centrale d’achat has increased the availability of low-cost, essential drugs in the public health facilities, still lacking are an overall regulatory framework for controlling the import and sale of pharmaceuticals, effective systems for stock management, distribution and accounting and improved prescription practices.

2.12. Nutrition Services. Existing data indicate an adequate production of food, on the one hand, and malnutrition rates of 10-20 percent among children under five, on the other. Such results have contributed to a lack of consensus about the extent and magnitude of the country’s nutritional problems and have hindered development of effective strategies to deal with malnutrition. Furthermore, efforts of numerous ministries and other agencies, such as UNICEF and NGOs, have been fragmented and uncoordinated. In the absence of complete information on the prevalence of malnutrition in Benin, no comprehensive policy or strategy has been adopted. As a consequence, nutrition services and activities are underdeveloped and poorly managed, and their impact unknown.

2.13. Referral system. The pyramid of health services does not function properly as a referral system. Quality of services is low at all levels of the system. There is little, if any, communication between the various levels of service, and virtually no mechanism for managing referral cases. Furthermore, facilities are inefficiently used by the population: the considerably more expensive, higher-level facilities are consulted for the most basic primary care, which is highly cost-ineffective.

2. Sector Management

2.14. The quality and effectiveness of the health system are seriously constrained by weak management capacity. Roles and responsibilities for management and decision making are excessively centralized, particularly with regard to management of infrastructure, management of human resources and planning and budgeting. A decision taken in 1992 to eliminate the directorate of financial and administrative
affairs exacerbated weaknesses in budgeting and investment programming. Those best placed to make informed decisions on the optimal use of resources (i.e., those at the more decentralized levels of the system) have neither the authority, the means, nor the essential skills for carrying out key management functions. In fact, there is a lack of capacity at all levels of the system to carry out functions which are crucial to the efficiency and effectiveness of health sector operations, notably: information collection and analysis; formulation of national health policy and strategy; planning, programming and budgeting; resource mobilization and aid coordination; management of human, physical and financial resources; training and supervision, both of a technical and of an administrative nature; quality control; and monitoring and evaluation. Furthermore, roles and responsibilities at each level of the system for carrying out key management functions are not clearly defined, and management systems and processes are ambiguous, thus further inhibiting the system’s effectiveness.

2.15. Community Participation. The COGES and COGEC were initiated in 1989 under the first IDA-financed health project as a means of stimulating the interest and involvement of Benin’s population, whose confidence in the health system was seriously waning. Through the creation of these committees, the Government aimed to institutionalize participation and to define more clearly the role of the state, communities and donors in the development of the health sector in the medium term. These committees were also created with a view to involving communities more fully in health prevention activities and to providing an institutional guarantee that resources collected through cost recovery activities would be retained and managed by these committees and used for replenishing drug stocks and for financing other non-salary recurrent expenditures. In several years of operation these committees have demonstrated their potential; this experience has also highlighted issues which still need to be addressed. Many COGES/COGEC members lack motivation due to a number of factors, most notably lack of understanding of their roles and functions, lack of skills in community financial management and in group animation techniques, lack of opportunity to exchange information and ideas at the departmental and national levels, and (for some) lack of financial remuneration. While the bylaws state that elections should be held every two years, elections have not been held that frequently or routinely. Some aspects of financial management of these committees are not fully explicit in the bylaws, particularly with regard to modalities for using excess funds aggregated at the sub-prefectoral level and modalities for assisting those CCSs running a deficit. Furthermore, accounting capacity (skills and systems) at the sub-prefectoral level is lacking. Finally, while COGEC bylaws provide for a seat each for one woman and one youth elected by their peers to represent their interests, COGES members are elected from among the COGEC officers (presidents, treasurers and secretaries). There is thus a significant risk that women and youth would not be represented on the COGES.

2.16. Inter-sectoral Coordination. The establishment in October 1988 of the CNEEP and of its departmental bureau, CDEEP, constituted an important step on the part of the government to improve program coordination and to strengthen decision-making capacity in the Ministry. Their creation was meant to correct serious weaknesses in the planning, coordination, monitoring and evaluation of sector investments, which were largely donor-driven. Since their creation, these two organs of intersectoral coordination have not been sufficiently active, particularly at the departmental level; they must be revitalized to enable them to carry out their important functions. Furthermore, while their membership accommodates representatives from other line ministries and some NGOs, there is at present no permanent seat for representatives of the COGES/COGEC, whose perspectives on investment planning and monitoring would be valuable.

2.17. Human Resources. The Ministry has made important progress in inventorying personnel and establishing a computerized system for personnel management at both the central and departmental levels. The results of this work revealed severe shortages of key service staff in Benin, particularly doctors and midwives, whose ratios to the population (1/20,000 and 1/12,000, respectively) are twice those recommended by WHO (1/10,000 and 1/5,000, respectively). Furthermore, these scarce resources are inequitably distributed across the country, the most underserved areas being the rural areas and the North. Benin’s ratio of nurses to population is in line with WHO recommendations and nurses are rather
equitably distributed across the country. However, the range of qualifications of staff included in this category is great, with the more qualified staff concentrated in the South and urban areas. Except for the recruitment of 74 staff in 1994, there have been no new entrants into the health system since 1986. Unfortunately, more than one third of those staff recruited in 1994 were health aids, who were ill equipped to fill acute needs for more qualified staff. There is also a severe shortage of qualified managers and administrators at all levels of MOH administration. Annual departures due to retirement over the next 12 years are projected to increase from 50 to 200. This will further compromise availability of qualified staff, unless vigorous recruitment of essential staff is undertaken, both to fill existing gaps and to replace departing staff. While the adjustment program calls for a freeze in recruitment of civil servants, there is a recognition on the part of central ministries of the acute shortages of key technical and administrative staff in the health sector. And there is a willingness to accommodate an increment of human resources for health within the context of the overall freeze, given the high priority placed on health sector development, reflected both in the PFP and in the SALs. This should be vigorously pursued. Annex 4 provides estimates of needs for additional personnel by level and by category. Finally, MOH capacity to plan, manage, train and supervise human resources for health remains weak. The human resources implications of sector reforms, which the MOH has embarked upon (reorganization and decentralization of management and service delivery) have not been fully worked out, or addressed through a human resources strategy or plan of action to ensure the success of these reforms.

2.18. Health Financing and Financial Management. As shown in Annex 5, MOH’s share of the public current budget declined from 8.8 percent (or CFAF 4 billion) in 1987 to 3.2 percent (or CFAF 2.7 billion) in 1992. Since 1993, however, the MOH share of the public budget has been on the increase, reaching 3.9 percent in 1995 (or CFAF 4.2 billion). It is significant to note that the proportion of the public current budget going to health increases significantly, when other budgets (dépenses communes) are taken into account; total public budget allocated to health amounted to 7.7 percent in 1994 and 8.0 percent in 1995. The salary share of the health budget has declined over the past several years from 79 percent in 1989 to 62 percent in 1995. Again, these levels decrease significantly to 29 and 30 percent, respectively, when taken as a proportion of the total current budget allocated to health. In 1994 the MOH succeeded in spending 97 percent of MOH budget allocations, but only 29 percent of dépenses communes. This translates into an overall execution rate of 65 percent of total public funds allocated for health. Annex 6 shows the evolution of the various sources of health sector financing in Benin, both past and projected. Both donor funding (largely for investments) and cost recovery (for non-salary recurrent costs) have become increasingly important. Despite the real need for investments, capacity to absorb donor assistance is limited. In 1991 and 1992, respectively, 55 and 30 percent of external financing was spent. Reasons for such low absorption of external aid include rigidity of conditionalities, administrative and structural constraints and insufficient familiarity with rules and regulations of the various donors. These are expected to be corrected with the establishment of the DPCE and the revitalization of the CNEEP/CDEEP, both of which will be supported under the proposed project. It is becoming increasingly necessary for the Government to formulate an adequate financing policy, which would establish the principles and regulate the practices for cost sharing among the Government, donors and beneficiary populations. Donor assistance is described in para. 2.29.

2.19. Planning tools have been developed over the past five years to monitor sector resource use, but they have not yet been fully incorporated into the budget formulation and expenditure process. The three-year health sector development plan (PTD), prepared by the MOH with technical assistance provided under the first project, provides a detailed review of donor (and potentially government) funding of sector activities for the past year and for the coming three years. Computerized and updated annually, the PTD permits an analysis of sector funding over time by program, region/level, source of funding,

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1 Dépenses communes is a budget category, which includes funds for, inter alia, maintenance of health centers and administrative buildings, subsidies for health centers, operating costs of the CNHU, training, professional missions, and health care costs for civil servants.
etc. The program budget reviews past activities and expenditures as well as future objectives and resource requirements for each health facility. In light of requirements under the proposed SAC III operation that each line Ministry submit quarterly reports on the budget execution, it is expected that the Ministries of Plan and Finance will gain a better appreciation of these financial management tools and will thus utilize them more effectively during the budget formulation, allocation and authorization phases. Both skills and systems for financial management are currently lacking in MOH.

C. NATIONAL POLICY AND MEDIUM-TERM SECTOR STRATEGY

1. Population

2.20. With support from UNFPA, a draft population policy was developed under the responsibility of the Institut national de la statistique et de l'analyse économique (INSAE) of the Ministry of Plan and Economic Reform. The development of this policy was highly consultative, including the holding of a number of national and regional workshops and seminars to elicit the perspectives of various factions of society, including religious groups, and of bilateral, multilateral and non-governmental partners. In the PFP for 1994-1996 the Government acknowledges the very rapid rate of population growth and its negative impact both on family wellbeing (particularly that of mothers and children) and on prospects for achieving its development goals. It has committed itself to promoting family planning as an instrument of development policy. Furthermore, the PFP specifies that a national population policy will be approved by the Council of Ministers before end-November 1995. Both the recent Cairo Conference and donor requests to include family planning services delivery components in their projects have encouraged the Government to take such positive steps in this critical area of development policy. The approval and dissemination of this policy by the end of 1995 will provide the enabling environment for urgently needed actions to improve the quality and access of family planning information and services.

2. Nutrition

2.21. On December 27-28, 1994 a workshop was held in Cotonou to inaugurate an intersectoral National Committee for Food and Nutrition and to adopt a national plan of action for food and nutrition. Developed through a series of consultative workshops, under the leadership of the Directorate of Applied Nutrition Activities of the Ministry of Rural Development, this plan consists of nine strategies: (a) integration of nutrition concerns and objectives in development policies and programs; (b) improvement of household food security; (c) evaluation, analysis and surveillance of nutrition status; (d) improvement of food quality; (e) prevention and treatment of infectious and parasitic diseases; (f) promotion of breastfeeding; (g) direct support of population groups, which are disadvantaged socio-economically and/or vulnerable to nutritional insecurity; (h) prevention of micronutrient deficiencies; and (i) promotion of nutritious diets and healthy behaviors. The creation of the Committee and development of this plan of action set up a much needed institutional and strategic framework for the coordination and implementation of food and nutrition activities in Benin. More details on these initiatives and their context for Bank interventions (IDA-financed Food Security project, and nutrition component to be financed under this project) are provided in Annex 7.

3. Health

2.22. On the occasion of the Health Sector Round Table, which was held in Cotonou, January 12-13, 1995, the Government and national and international partners discussed and debated a draft sector strategy for the period 1995-99. This draft strategy was prepared by a task force, established by the MOH in 1992, which evaluated existing policy and strategy and sector performance. The work of this task force benefitted from technical and financial assistance from donors active in the sector, including the European Community, which led this effort, and the Bank. And it culminated in the preparation of background
documents for the Round Table. A number of points of consensus were reached at the Round Table for further strengthening the draft strategy, which, it was agreed, would be incorporated into a revised draft. The strategy statement, submitted to IDA, provided the basis for the Government's Letter of Sector Development Strategy (Annex 8), a draft of which was discussed and agreed during negotiations. This Letter specifies that the MOH will finalize and disseminate its national sector strategy by end-December 1995, incorporating revisions suggested by participants to the Round Table, which should ensure its integrity and coherence. It is the intention of the MOH that its sector development strategy should provide the basis for eliciting and coordinating the contributions of all donors active in the sector, who were widely consulted during its preparation. In addition, the draft three-year development plan (PTD) for the period 1995-97 was also discussed and agreed during negotiations with a view to ensuring its reflection of the new sector strategy and priorities therein.

2.23. In support of national health policy goals, and drawing on lessons of experience, the new strategy places great emphasis on consolidating and building on notable achievements of the previous strategy (1989-1993), most particularly: (1) the reorganization of the MOH; (2) the extension nationwide of cost recovery and the creation of health management committees (COGES/COGEC); (3) the establishment of the Centrale D'Achat, which assures affordability and availability of essential drugs at all levels of the health system; and (4) the establishment of mechanisms for fuller participation in the planning, coordination and evaluation of sector activity (CNEEP/CDEEP). Fully cognizant of the constraints caused by an excessively centralized Ministry and by a lack of technical and managerial capacity, the new sector strategy proposes to reform sector organization with a view to achieving improvements in the quality, access and efficiency of services. The general orientation of these reforms include:

- **Strengthening and decentralization of sector organization, management and administration** for greater efficiency and effectiveness, with particular emphasis on: the development of central MOH and DDS capacity in planning and in the mobilization and management of sector resources -- both human and financial, and the gradual establishment of health districts.

- **Streamlining and strengthening of the referral system, strengthening priority programs and services and building on accomplishments already achieved in the supply of essential drugs** to improve the quality, cost-effectiveness, accessibility and affordability of basic health services at all levels of the system.

- **Expansion and strengthening of intersectoral coordination and community participation in health** to ensure optimal contribution of the various contributors and stakeholders in sector management and service delivery, including beneficiaries, private sector (both for-profit and non-profit), academic and research institutions, service delivery staff and decision-makers at all levels of the health system, and decision-makers and implementors working in other relevant sectors at central and peripheral levels.

- **Finalization and dissemination of the national sector strategy by the end of December 1995**, incorporating revisions suggested by participants to the Round Table which should ensure its integrity and coherence.

The proposed structure for the reformed health system is presented in Annex 9 and key elements of each of these reforms are presented below.

2.24. **Sector Organization, Management and Administration.** By Government Decree 145-94 of May 24, 1994, the Ministry of Health was restructured, with a view to streamlining and decentralizing sector management and administration (see Annex 10 for new organigramme). Three new central-level Directorates were created to strengthen capacity in, respectively: planning, coordination and evaluation; administration and management of human and financial resources; and the design and delivery of priority
programmes for family health. The latter would be instrumental in equipping MOH to carry out its responsibilities for implementing the national population policy, expected to be adopted before end-November 1995, and the national plan of action for food and nutrition, adopted on December 28, 1994. During 1995-99, these Directorates and their regional services would be established and strengthened to enable the effective decentralization of each of these key functions.

2.25. Under the Government's revised sector strategy strategic planning functions of the MOH would be strengthened, building on the three-year rolling investment program initiated under the first project. New and decentralized budgetary processes would be put into place to improve resource use and accountability, and to give greater autonomy to local health committees in the management of resources generated through cost recovery. The new strategy envisages the development of a new financing policy, based on the cost recovery and essential drugs programs developed under the first project, which would clearly outline the sharing of costs of administration and of services offered at different levels of the health care system, by, respectively, the Government, the beneficiaries, and external donors. In this light the Government will commit itself to increasing over the medium-term the percentage of the public budget that goes to health.

2.26. The new sector strategy envisages the development of a human resources strategy which would support the successful implementation of sector reforms through improvements in manpower planning, training, supervision, and management. Reforms in the area of human resources development in the sector would be linked with the ongoing program of civil service reform, with Government budget commitments under the health financing policy, and with SAC III -- all of which would enable the recruitment and deployment of needed incremental staff to provide a minimum level of technical and managerial competencies to ensure better health care services to the general population, and successful decentralization of sector management and administration.

2.27. Quality and Effectiveness of Services. The sector strategy will streamline the health pyramid through the progressive consolidation of basic services at the periphery. In this light, improvements in the management and delivery of first referral services at district (zone) hospitals and of second-level referral care in regional hospitals will constitute a key element of the reforms. The definition of patient care norms and standards for the staffing and equipment of these facilities will ensure a minimum level of technical capacity needed to deliver referral services for which they are responsible. The Government will consolidate achievements in the area of essential drugs procurement within the permanent statutes of the Centrale d'Achat and through the strengthening of the Department of Pharmacy in the areas of pharmaceutical legislation and regulatory control of private pharmaceutical operators. As a condition of effectiveness, a legal status for the Centrale d'Achat acceptable to the Borrower and IDA will be adopted.

2.28. Expanded Partnerships for Health. The revitalization and strengthening of COGEC, COGES, CDEEP and CNEEP and the establishment of health management committees (COGEZ) in the new health zones (para. 3.16) will ensure that key stakeholders are regularly involved, in line with their comparative advantages, in the planning, management, implementation and evaluation of health care activities. This reform would render the health system more accountable to the needs of the population through the involvement of elected local health committees, who are held accountable to their own communities. The role of these local health committees in the planning and evaluation of health activities and their autonomy in the collection and management of cost recovery funds is key to ensuring sufficient and meaningful involvement of beneficiaries. The bylaws of these health committees will be revised and appropriate training in management, community outreach and health promotion will be provided to enable these committees to realize their potential. In order to increase the participation of private sector health providers, the Government will expand and institutionalize the involvement of the private sector (for-profit and non-profit) in sector development, coordination and evaluation. The private health facilities
will be incorporated into the concept and development of district (zone) health services in a manner that does not jeopardize their autonomy and independence. The Government will standardize norms for clinical care, qualifications and equipment of private facilities to protect the general public against exploitation by unscrupulous profit seekers.

4. Composition of Donor Assistance to National Policy and Strategy

2.29. Some 20 multilateral, bilateral and non governmental partners are providing assistance to the health sector in Benin; and the volume of this aid has grown significantly in recent years -- from 5.5 billion CFA in 1990 to 12.3 billion in 1992. Based on data from the three-year development plan, which reflects donors’ program commitments, this level of aid will be maintained over the next several years. Annex 11 shows financial commitments of all partners for the period 1994-1998. A considerable portion of aid to the health sector is allocated to construction/rehabilitation and equipment of health facilities to improve access and services. Unlike the situation in many African countries, geographic subregions (departments) benefit from the interventions of multiple donors rather than only one. Improvements in access to services are being supported by the French Cooperation (FAC), the German Cooperation (GTZ), the Swiss Cooperation, the Government of Netherlands, the People’s Republic of China, the Africa Development Bank (AfDB), and the Islamic Development Bank (IDB). In addition, considerable support is also being provided to strengthen priority health programs, such as: STDs/AIDS (FED, WHO, UNDP, Canada, USAID, IDA, FAC, Swiss), and MCH/FP (UNFPA, WHO, IDA, UNICEF, USAID). While some assistance is also provided to strengthen information systems (FAC, IDA), strategic planning (FED, IDA), and community participation (IDA, Swiss, and UNICEF and GTZ), external aid focuses in large part on one or several technical program(s) and/or subregion(s) and is not systemic in its approach. The extent of donor support is a source of both strength and weakness; it has permitted the health sector to develop but at the cost of government acceptance of a project approach, which can fragment efforts, ignore strategy and create inequities. At the recent Health Sector Round Table, donors expressed their willingness to continue their support of the health sector and to channel such support in a more coordinated fashion through the vehicle of the new health sector strategy. The creation of the new MOH Directorate for Planning, Coordination and Evaluation and the strengthening and decentralization of its functions is key to enabling MOH to take advantage and effectively manage this opportunity.

D. THE BANK GROUP’S ROLE AND SECTOR ASSISTANCE STRATEGY

1. The First IDA-Funded Health Project

2.30. In 1989 IDA supplemented the first SAC with a hybrid project (Health Services Development Project, Credit 2031-BEN) co-financed with the Swiss Government at a total cost of US$32.0 million. IDA funding for this ongoing project amounts to US$18.6 million, Swiss Government grant funds total the equivalent of US$11.3 million and Government contribution amounts to US$2.1 million equivalent. The project supports a comprehensive package of national health policy reforms that aim to strengthen the Government’s capacity to respond to basic needs of the population. A combination of quick disbursing funds and program investments are supporting Government efforts to: (a) strengthen the institutional capacity of the Ministry of Health; (b) mobilize additional resources through cost recovery and increased community participation; (c) improve the quality of primary health care through infrastructure rehabilitation and strengthening of priority programs and services; (d) develop small-scale pilot projects; and (e) improve manpower and human resources development.

2.31. While only about 50 percent disbursed, and with a closing date scheduled for 1997, assistance under the first project has already culminated in a number of achievements, which have contributed to improvements in the quality and coverage of basic health services. An independent essential drugs procurement system has been set up and has ensured the regular supply of essential drugs at affordable
prices; mechanisms have been put in place to involve beneficiaries in the management of cost recovery and promoting health; staff have been redeployed to reduce inequities among the regions; supervision and in-service training have improved. Improvements in institutional management processes have included the preparation of a comprehensive sector three-year rolling investment plan, the establishment of computerized personnel management files, the institutionalization of a program management system and the introduction of an inter-sectoral coordination mechanism (CNEEP/CDEEP) for program review and monitoring. The first project also supported an organizational audit of the MOH, which led to the definition and adoption of a much improved organizational structure. The first of three phases of construction of peripheral health facilities has been completed, with the second about to start.

2.32. The launching of the second project is timely. It will consolidate reforms and build on accomplishments initiated under the first and will, in fact, facilitate implementation of the first. It aims to build the capacity of structures for improved sector management, which the first project helped to create, most notably: the three new Directorates within the newly organized MOH at central and decentralized levels, the Centrale d'Achat, and structures for partnerships: CNEEP/CDEEP, and COGES/COGEC. The second project will also complement support programmed under the first: while the first project rehabilitates primary health care services at the bottom of the health pyramid, the second targets the rehabilitation of first- and second-referral services, whose backstopping of primary health care activities is essential to ensuring quality and efficiency of priority services.

2. Key Lessons Learned

2.33. The first project confirmed the relationship between sound sector policy and community participation for sustained mobilization of additional resources for the sector through cost recovery. Its key contribution was to establish the linkages between the supply of low-cost essential drugs, the introduction of cost recovery measures to ensure their continued availability, and the creation of management committees with defined roles and responsibilities to oversee the use of the funds generated by the health centers. Each element contributes to the credibility of the health sector with respect to both its clients (or beneficiaries) and the Central Government authorities. With the development of planning and programming tools (budget program and PTD), the sector managers have the means to plan and monitor sector operations.

2.34. The first project emphasized the promulgation of specific legislative and regulatory texts, which were a necessary but insufficient condition for advancing sectoral reforms. Where reforms went furthest, the texts were accompanied by informed and empowered structures, the most successful example being the Management Committee of the Centrale d'achat and the least the CNEEP. The second project will address more complex changes associated with the reorientation and decentralization of health care delivery. While continuing to focus on the legislative/regulatory framework so as to safeguard advances, it must also concentrate on changing traditional attitudes which have favored centralized decision-making and inhibited the development of local initiatives. In particular, the development of the existing partnerships at the local, departmental, and central levels should provide countervailing pressure against the continuing urge to centralize decision-making.

2.35. Experience under the first project has also highlighted the need to reinforce reforms through the introduction of adequate funding levels, mechanisms and channels. This was best demonstrated by the introduction of cost recovery measures, which were an important means for empowering the local health management structures (COGEC and COGES). Where structures have some control over the generation and use of resources, their relevance is apparent. Where structures have been introduced without the financial means to assure their operations (as was the case with the CNEEP), they eventually become marginalized. The second project will consolidate and streamline mechanisms for cost sharing by (1) defining specific parameters for contributions by the Government through the budget, by donors through
project and other funding, and by beneficiaries through community financing (cost recovery) and (2) defining procedures and accounting systems for ensuring the timely release of appropriated Government budgetary allocations and project funds from donor supported projects. The Government will, in collaboration with beneficiary representatives and donors, establish efficient and transparent accounting and financial control procedures to be used by COGEZ, COGES, and COGEC to account for the collection and efficient use of proceeds generated by cost recovery and allocations provided through the budget.

3. Future Bank Assistance Strategy

2.36. IDA has played a key role in assisting the Government in designing and implementing its Structural Adjustment Program. IDA assistance has been directed to specific investment projects designed to stimulate a supply response in the productive sectors, rebuild the state's institutional management capabilities, rehabilitate infrastructure and road networks in the country and ensure the provision of basic social services to all. As laid out in its Country Assistance Strategy, future IDA assistance will continue in these areas and will provide funding for development projects included in the Government's 1994-96 PFP, which places high priority on social sector development. In the PHN sector, IDA assistance will be directed toward consolidating progress and improvements already made under the first IDA-funded Project. Special attention will be paid to removing current institutional and operational barriers to the provision of better health, family planning and nutrition services to the general population. Sector coordination, financial and personnel management, supervision and evaluation systems will be strengthened.

III. THE PROJECT

A. PROJECT OBJECTIVES

3.1 The overall objective of the project is to assist the Government in improving the health and well-being of Benin's population, with particular emphasis on its most vulnerable segments (women, children and the poor). It will do so through the support of national sector policy and strategic objectives. First, in support of Benin's population policy (expected to be approved by the Council of Ministers before end-November 1995), the project will assist in the further development and expansion of the family planning program. Second, the project will support implementation of the three main reforms included in the national health sector strategy for the period 1995-1999. These reforms, aimed at improving the quality, coverage and efficiency of basic health services and at rendering the health system more accountable to the population, are: (a) decentralization and strengthening of sector management and administration; (b) reconfiguration of the referral system and strengthening of its capacity to provide technical support services to primary health care and nutrition; and (c) expansion of the participation of multiple stakeholders, including beneficiaries, in the planning, implementation and evaluation of national health policy and programs.

B. SUMMARY DESCRIPTION

3.2 The project's support to the implementation of national sector policy and strategy will be provided through four components:

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

2. **Improving the Quality and Efficiency of Priority Health Services.** This component will assist the Government in revitalizing and streamlining the referral system, with a particular emphasis on upgrading and improving the quality of first referral services through the gradual establishment of district hospitals, and on establishing norms and standards for quality services at all levels of the system. To this end, it will support upgrading of selected health infrastructure and strengthening priority health programs and disease interventions, most notably: maternal and child health services (including nutrition), tuberculosis, STDs and AIDS, health education, water and hygiene activities.

3. **Strengthening Sector Management and Administration.** This component will support the decentralization of sector management and administration, which will involve the gradual establishment of health districts, the strengthening and expansion of departmental-level capacity, and the strengthening of key functions of the central MOH. It will also support the development of key management capacities at all levels of MOH administration, including mobilization and management of financial resources, management and training of health personnel, planning, supervision, information collection and analysis, and evaluation. In addition, it will continue IDA support of successful efforts initiated under the first project to improve pharmaceutical policy, legislation and regulation and to fine-tune systems and processes for ensuring the quality, affordability and timely replenishment of essential generic drugs stocks throughout the system.

4. **Strengthening of Partnerships for Health.** Under this component, existing mechanisms and structures for intersectoral coordination and community participation will be revitalized and strengthened. It will also support the operations of these committees through which stakeholders will be more fully and routinely involved in the planning, management and evaluation of sector activity at all levels of the health system.

C. **DETAILED FEATURES (AND BASE COSTS)**

1. **Developing and Expanding Family Planning Programs and Services (US$2.3 million)**
   
   (a) **Dissemination and Promotion of the National Population Policy.**

3.3 The project will support MOH in the dissemination and promotion of the National Population Policy. The project will fund printing and distribution costs and will finance workshops and other publicity activities designed to educate the public about the policy objectives, particularly as they relate to health and family planning. These activities will include radio and drama programs in national languages designed to reach communities in rural areas of all regions of the country. **As a condition of credit effectiveness** the Government will submit to IDA a National Population Policy, acceptable to IDA, as adopted by the Council of Ministers.

(b) **Expansion of Family Planning Services Country-Wide.**

3.4 A major objective of the Government's medium-term sector strategy is to expand contraceptive coverage country-wide through improved family planning services. The project will support improvements in the coverage, quality and availability of FP services in public health facilities, which will complement USAID assistance, aimed at expanding alternative community-based and commercial contraceptive distribution systems. The project will finance equipment, including FP surgical equipment
for district hospitals, and about 337 FP kits for peripheral services. It will also finance contraceptive supplies and incremental operating costs necessary for facility-based service delivery. The project will support the development and implementation of a new staff training program for expanding FP services. Departmental trainers will receive training, pedagogic material and training manuals to enable them to carry out service delivery-related training of service providers in their respective departments. During the life of the project, 1,000 traditional birth attendants will be trained to integrate FP into their services and to improve their ability to ensure higher standards during ante-natal care and improved hygienic practices during delivery. Over 400 service delivery staff (doctors, midwives and nurses) would receive training in new FP delivery techniques and in activities for promoting the adoption of FP by couples and individual adults, who attend health facilities, and by those contacted during outreach activities. Six physicians and nine midwives will receive training in FP in institutes in the Region that have developed a capacity for such training. Skills in FP service delivery will also be monitored and enhanced through the development and implementation of supervision protocols. The project will also support surveys and operational research to determine more precisely: the causes and extent of maternal mortality, infant mortality, determinants of demand for FP, and knowledge, aptitude and practice of various segments of the population with regard to FP services.

2. Improving the Quality and Efficiency of Priority Health Services (US$10.9 million)

3.5 In support of national health sector policy and strategy, this component will support efforts to rationalize and strengthen the referral system, for more effective and efficient delivery and utilization of services. And it will also support efforts to improve the coverage, efficiency and quality of priority health programs and services, which target the main causes of morbidity and mortality in Benin. In accordance with national health policy, a particular emphasis will be placed on the integration of curative services, on the one hand, with preventive and promotional activities, on the other. Specific activities to be supported under the project are as follows.

(a) Strengthening of the Referral System.

3.6 In support of national efforts to reform the referral system, the project will support the establishment of health districts (zones sanitaires), which would provide technical backstopping of primary health care activities carried out by lower level facilities (CSSP, CSS), and which would provide first referral services in surgery, obstetrics/gynecology and pediatrics. The project would also support efforts to strengthen second referral services at departmental hospitals (CHD). Under the new strategy, the roles and responsibilities of the various levels of services have been sketched out, along with input norms and standards, for each level of service, encompassing infrastructure, technical plateau and numbers and qualifications of health personnel. The project will support efforts to render selected facilities capable of fulfilling their new roles. It will rehabilitate and equip 10 CCS, 4 CSSPs and 4 new district hospitals (upgraded CSSP) and provide necessary laboratory materials for diagnostic work. The choice of these facilities was made by respective DDS as a part of the decentralized appraisal process, and in light of projects and activities of other aid donors in the sector. The project will finance the establishment of two of a total of 12 district hospitals to be established in an initial phase of the Government’s program. The financing of two additional district hospitals by the project will be tailored to take into account the results of an evaluation of the first phase, which would determine whether and how nationwide application of the health district (a goal of the national health sector strategy) would be undertaken. The project will also finance equipment for surgical, obstetrical, gynecological and trauma cases and for intensive post surgical care units in one CHD. To ensure a minimum level of staffing of these facilities, the project will finance the salaries of key technical and administrative personnel to be hired on a contractual basis. Technical personnel to be recruited for six new district hospitals include: 8 doctors, 8 laboratory technicians, 8 pharmacists and 6 social assistants. In addition, 8 administrator/accountants and 12 maintenance worker/drivers will be recruited. Nine doctors and 16 drivers will also be recruited to work
in CSSPs to be renovated under the project, whose beneficiary populations have been underserved due to inadequate staffing and infrastructure. The Government has developed procedures for selection and appropriate placement of service delivery staff to be hired on a contractual basis under the project. These procedures are closely linked with civil service reform and cognizant of opportunities and constraints inherent in the adjustment program, particularly those associated with recruitment and the composition of the recurrent budget. Long-term, short-term, refresher and in-service training (described in Section (b) below) will also ensure adherence to norms and standards for every level of service.

3.7 To improve the quality of care provided through the various types of facilities, the project will finance the development of treatment protocols, case management guidelines, and patient care norms and standards that would be applied nationwide. The Government will prepare by December 31, 1996, draft texts, acceptable to IDA, establishing medical treatment guidelines, norms, standards, and protocols for its health facilities and adopt a plan and timetable, satisfactory to IDA, for their application nationwide. To ensure more efficient management of cases and a more rational use of resources, hospital management systems will be evaluated and improved under the project.

(b) Strengthening of Priority Health Programs and Services.

3.8 The project will support selected programs and services targeted at the main causes of morbidity and mortality of Benin’s population. Support will be provided at all levels of the system, in line with the newly defined roles of the various levels of services, and will include: the provision of technical equipment, technical training, supervision, the development of norms, standards and protocols for each program, operational research and evaluation and light technical assistance. Project assistance by program is briefly described below.

3.9 Reproductive Health. Efforts under this component complement those programmed under the first project. This project will finance communications equipment to facilitate effective referral, management and follow-up of high risk cases and complications of pregnancy and childbirth. The provision of eleven sonograms to district and departmental hospitals and the training of 12 doctors and 36 midwives in their use will significantly enhance detection of high risk cases. The project will also support training of service providers in maternal health care. Kits for traditional birth attendants and close supervision of their work should improve the quality of their services, focusing on management of uncomplicated births, and recognition and prompt referral of complicated cases. To the same end, the project will support the costs of supervision by the DDS and by the districts in their respective catchment areas.

3.10 Child Health. Under the project, health facilities will be provided with cold chain equipment to ensure the management and preservation of vaccine supplies. Training will be provided in the maintenance of this equipment and in the various child health activities (in particular, immunization, treatment of acute respiratory infections, and prevention and control of diarrhea). Funds will be provided to each department to finance an evaluation of immunization coverage, and a survey to assess the extent of utilization of oral rehydration therapy by the population, both with a view to fine-tuning program strategies and efforts in light of findings.

3.11 Nutrition. The recent creation of an Intersectoral Committee for Food and Nutrition and the adoption of a National Plan of Action for Food and Nutrition provide a much needed institutional and strategic framework for addressing nutrition problems in Benin. The project will strengthen MOH capacity to carry out its responsibilities within this broader framework. In this regard, efforts under this project will complement those of the IDA-financed Food Security project, designed to support Ministry of Rural Development capacity to implement its own responsibilities within that framework. Specifically, this project will support (a) the proposed national malnutrition prevalence study to strengthen the basis
for program planning, resource allocation and program evaluation, (b) the development of a sentinel surveillance system to monitor trends in the magnitude of deficiencies in priority population groups, (c) strengthening of service provider capacity in the diagnosis, treatment and prevention of malnutrition, and (d) strengthening of promotional activities to increase public awareness of nutrition problems and to encourage behavior change to prevent them.

3.12 The project will finance at the level of each DDS surveys to enable them to track and enhance knowledge of micronutrient deficiencies, particular to their respective regions. Qualitative data will be collected to determine current household practices and to provide a basis for effective IEC activities. Key process indicators for nutrition have also been incorporated into the health information system (SNIGS). Six physicians (one from each of the DDS) responsible for nutrition will receive one month’s training on nutrition techniques, and will, in turn, provide basic and refresher training and follow-up supervision to health service personnel in their respective departments (15 physicians and 15 midwives per department). Equipment and material will also be provided to all public facilities to enable newly trained staff to carry out their responsibilities effectively, including: distribution of micronutrient supplements, growth monitoring and promotion, nutritional counselling activities (including promotion of breastfeeding), and treatment and management of severe cases. Distribution of micronutrient supplements will include the provision of iron supplements to pregnant and lactating women and the provision of other micronutrients to vulnerable target groups identified through the prevalence survey and through ongoing surveillance. The project will also support operational research to be carried out by each DDS on the promotion of locally produced nutritious food. Areas for coordinating and collaborating with ongoing efforts of the Food Security project have been identified and are presented in Annex 7.

3.13 Control of Communicable and Parasitic Diseases and Traumas. The project will support measures to improve the effective treatment and prevention of malaria, tuberculosis, STDs/AIDS. Short-term technical assistance, external training and study visits, and the provision of office equipment will strengthen coordination of the malaria and STDs/AIDS programs. Both of these programs will be strengthened at the service delivery level through the provision of training and essential service and laboratory equipment and material to the DDS and health facilities within their catchment areas. Workshops will be used to prepare service delivery guidelines and define a policy for STDs/AIDS prevention and treatment. To enhance program effectiveness a number of surveys, operational research and evaluation studies will be carried out, at central and departmental levels to better determine: disease prevalence; knowledge, aptitude and practice (KAP) of the population on treatment and prevention; and program performance. To address a growing concern regarding dental and oral health, six nurses will receive a three-month training in Africa, and they will, in turn, provide training to nurses working in CSSP and CCS and to about twenty teachers per department. In addition, annual stocks of drugs and supplies for the treatment of tuberculosis will be furnished to health facilities to enhance their program capacity.

3.14 Promoting Community Health and Education. The project will strengthen capacity for producing and disseminating educational messages for promoting better health and nutrition, safe motherhood, and family planning. To this end, it will cover the costs of equipment, supplies and production activities at central and DDS levels. Training activities will include study tours, and specialized training for one person each in social communications, and in program evaluation. Local training will be given to DDS teams, who will, in turn, train health personnel in their respective regions. Workshops will be held to revise national IEC policy, design and develop locally appropriate messages, and translate messages into local languages. Members of COGES, COGEZ and COGEC will participate both in training and workshop sessions. The results of surveys and operational research, described above, will be used to develop messages and training modules. The project will finance an inventory of KAP surveys already undertaken and will carry out research on the communication channels most used by the public, through
which health, family planning and nutrition education messages can be channeled. Evaluations of the impact of IEC messages will be carried out to ensure their effectiveness.

3.15 Water and Hygiene. The project will finance activities to promote safe water and hygiene, including the reproduction and dissemination of the Code d’Hygiène Publique, Law No. 015 of September 21, 1987, and the provision of guidelines and training for health personnel and hygiene workers. A study will also be carried out to evaluate the environment and its impact on health status, on which improved strategies and IEC activities will be based. MOH’s Directorate in charge of Hygiene and Sanitation will be strengthened through the provision of office equipment, a vehicle, and the salaries of two incremental personnel (sanitation engineer, and sanitation technician). The project will also finance the provision of portable water control laboratories for testing the quality of water at the DDS level, and the construction or renovation and equipping of a small water control laboratory in Cotonou. Water for all health facilities to be constructed and renovated under the project will be at the disposal of all villages in their respective catchment areas.

3. Strengthening and Streamlining Sector Management and Administration (US$12.1 million)

3.16 Implementation of the Government’s new health strategy and programs will require considerable strengthening of departmental and district-level capacity to enable them to effectively assume newly decentralized management functions. And it will also require efforts to improve the performance of key functions of central MOH in light of its newly evolved responsibilities for policy formulation, planning, resource management and regulatory control. The project will support the implementation of the Government Decree No. 94-145 of May 26, 1994, which creates three new Directorates for Planning, Coordination and Evaluation (DPCE), Administration and Finance (DSAF) and Family Health (DSF) and their corresponding services at the DDS level. This Decree also gives the DDS considerably more responsibility and autonomy in the planning, support and oversight of health sector activities and in the management of human, physical and financial resources. The Government has submitted to IDA the final administrative texts outlining the attributions, organization and functions of the MOH, and profiles for key positions. The Government has filled key positions in the three new central level departments and in their corresponding services at the DDS level. The project will also support the establishment of a new, third level of decentralized management: the health district (zone sanitaire). As discussed and agreed during the Round Table, the Government’s health strategy embraces a learning approach to the establishment of health districts, and thus seeks to establish only two districts per department in a first phase. An evaluation of this first phase would determine whether the Government would refine, revise or totally reconsider its strategy to establish health districts nationwide. The project would support the establishment and operation of two health districts, initially, and an additional two districts in a second phase, if experience demonstrates their viability. The establishment and operation of the additional two districts will be decided through the process of annual reviews and planning of project activities.

(a) Decentralization of Management and Administration.

3.17 To enable central, DDS and district levels to effectively implement their newly defined functions, the project would provide necessary infrastructure, equipment, material, training and essential operating costs. At the central level, the project would finance the completion of the new central MOH building, and the supplemental office equipment and supplies needed to permit its occupation by the newly reorganized MOH, which is currently dispersed across several ill-equipped and dilapidated buildings. Each of the six DDS office buildings will be renovated and equipped. In addition, the project will finance training of DDS staff in public health (one physician per DDS), in supervision techniques (ten persons per DDS); and it will support information seminars for health staff on the new role of the DDS and districts. The project will also cover essential operating costs of DDS including those for: training and supervision of districts, and maintenance of infrastructure and technical equipment. The project will
also finance the salaries of contractual staff necessary to ensure a minimum level of staffing of DDS: statistician, epidemiologist, files manager, sanitary engineer, sanitation technician, IEC specialist, pharmacist, two maintenance technicians, maintenance assistant, accountant and administrator.

3.18 Project support for the establishment of 4 health district offices would include technical assistance to help in initiating and coordinating this process. In addition, offices for the district team will be constructed and equipped, and vehicles and other operating costs will be provided to facilitate supervision. Training in Benin will include one-year programs in public health for the district health officers, management and supervision techniques for district teams, and primary health care management for staff of CCS and CSSP. These latter facilities will also be provided with vehicles for supervision, outreach and evacuation activities.

3.19 As a part of the decentralization process, a recasting of roles and responsibilities for a dozen or more administrative (or support) functions must be undertaken. The project will support the streamlining of these support functions, the establishment of systems and procedures for their coordination and execution at the various levels of the health system, and training of responsible staff at these levels, through the preparation and dissemination of operational manuals. These manuals will provide an overview of the rationale and content of key functions, describe the relevant tasks and responsibilities assigned to each level of the health system, and outline how the various levels must coordinate and communicate in carrying out such functions. Manuals will be prepared for the following key functions: supervision; personnel management; health information; in-service training; management of drugs and medical supplies; transportation; communication; facilities and equipment maintenance; financial management; planning, programming, budgeting and evaluation; and patient referral. These manuals would be prepared by experienced MOH staff with technical assistance from local management experts. In order to ensure effective implementation of the decentralization of health sector management and administration, annual reviews of activities in this area will constitute an important component of annual sector performance reports on the key elements of the national sector strategy, which will be carried out by CNEEP.

(b) Strengthening of Key Management Capacities.

3.20 Planning and Coordination of Sector Activities. The recent reorganization of the MOH has established an institutional framework for improved sector planning and coordination. The project will support continued development and utilization, and decentralization of existing sector planning and coordination tools including the rolling three-year planning process (PTD), the management information system (SNIGS), the health mapping exercise, the program budgeting process, and the computerized personnel management system. To this end the project would finance short-term technical assistance (as needed) and local training of central and DDS-level staff. In addition, the project would strengthen capacity of DPCE staff through its support of external training for: one person in health economics, two persons in public health, one person in health planning and one person in document management.

3.21 Planning and Programming of Health Infrastructure. In support of decentralization of this function, the project will provide software and training to the DDS on the use of the health mapping system. Material and training will also be provided to each DDS to enable them to prepare architectural plans and to disseminate within their respective regions norms for each type of health facility. The project will also support biannual evaluations of the state of health infrastructure to be undertaken by each DDS.

3.22 Personnel Management and Training. Implementation of the Government’s new health sector strategy will require significant and long-term commitment to ensuring adequate coverage and quality of staff as well as to improving capabilities for managing staff. The project would thus finance activities
related to: (a) recruitment of additional personnel; (b) supervision and training of staff; and (c) personnel management. Recruitment of incremental personnel, financed under the various components of this project would respond to current acute shortages of clinical staff in rural areas (especially in the north) and of administrative and financial staff for the DDS to carry out tasks, which were previously the responsibility of the central level. Estimates of the kinds and numbers of staff to be hired under the project by category of personnel are presented in Annex 12. In summary, a total of 217 contractual staff will be hired, of which 43 percent will work at the DDS to assume the newly decentralized and critical technical and managerial functions, and 39 percent in the health facilities to fill critical needs for qualified service delivery staff. These costs will be sustainable in light of projected increases in the health salary budget, which are envisaged in the PFP and in SAC III (para. 3.27).

3.23 To improve the performance of its personnel, Government is proposing the establishment of a comprehensive training program comprising pre-service, in-service, and specialized training as well as systematic supervision. The project would support reforms to improve the quality of pre-service training, specifically by financing the preparation of modules on generic drugs, cost recovery, family planning, and other essential topics for inclusion in the basic curriculum. In-service training would be completely restructured and reorganized nationally to address issues of quality and equity. Specifically, the project would finance the design of a new in-service training curriculum, its testing, and implementation at the DDS level. Each DDS would be specialized in a number of areas of the curriculum, thereby justifying project support for curriculum development, refurbishment of appropriate classroom/field facilities and equipment, design of didactic materials, training of trainers, and evaluation.

3.24 The implementation of the new health strategy through decentralized management will require more rigorous supervision. The DDS will assume full responsibility for supervising project activities in the respective regions. At an initial stage, the DDS will be responsible for the establishment of the health district services. As the district teams become operational, management of district-level programs will be shifted to them. The costs of supervision at the departmental and district levels are covered under the various components of this project.

3.25 The first project improved personnel management by introducing methods and tools and by training Ministry personnel. The second project would build on these strengths but would also define more clearly the range of personnel decisions permitted at the departmental level. The project would finance additional training in personnel management at the departmental level enabling DDS staff to: (a) compare present and future staffing needs for implementation of the health strategy, and (b) formulate and carry out a staffing plan (redployment/recruitment) for the period 1995-2000. In addition, two persons would receive external training in human resources management, and periodic workshops, to be attended by managers and service providers, would provide a forum for discussion, debate and resolution of human resource management issues.

3.26 Improved Allocation and Management of Financial Resources. The project will support MOH efforts to refine and implement a health financing policy, which would clearly define the costs of health services and the sharing of these costs by the communities, through cost recovery, and by the government through the public budget. And it will improve MOH capacity in financial management. Specifically the project will finance study trips and workshops to review and discuss options for health financing. It will also finance the training of DDS trainers in budget preparation, who will, in turn, train staff in facilities. One accountant per department will be hired under the project on a contractual basis to render DDS capable of assuming newly decentralized responsibilities for financial management. A few selected staff (one transit agent and four other technical staff) would also be recruited under the project to work in DSAF. The project would continue to strengthen budgeting procedures and accounting arrangements at all levels of the health care delivery system.
3.27 The Government has finalized the draft three-year development plan (PTD) for the period 1995-97, whose descriptions of the various programs and actions have been revised to reflect the new sector strategy. The Government will submit to IDA and to other donors annually by April 30 for its review and comments: (a) the updated three-year rolling development plan for the health sector, and a report on the execution of the sector’s recurrent budget for the past year; and (b) its salary and non-salary recurrent budget allocations to the health sector for the following year. Commitments to increase gradually health’s share of the recurrent public budget over the life of the project are reflected in the Letter of Sector Development Strategy and in the proposed SAC III operation. Coordination of the three-year development plan and of the program budgeting exercises should allow Government to estimate and honor its annual contribution to the health sector with more precision. In light of IDA support to strengthen first and second referral health care, the government will submit to IDA by June 30, 1997 a report on the analysis of cost estimates of hospital care and the Government’s proposal for contribution to these costs by the beneficiaries.

(c) Operational Research.

3.28 The decentralized appraisal process uncovered a strong demand on the part of DDS staff and service providers for support in locally-based research capabilities to gain better understanding of problems and issues and to improve service performance at the local level. The project will build DDS capacity to collect, compile and disseminate relevant findings of research already undertaken through the provision of material, supplies and training for one documentation specialist per DDS. It will also support the training of 30 service providers per department in basic techniques of operational research. The project will also support the costs of small field-based research projects. At the central level (DPCE) the project will finance the costs of office equipment, furniture and vehicles to backstop DDS and facility-based activities. Also under the project two persons will receive short-term (1-month) training in epidemiology; and occasional participation in international seminars will be financed. Short-term local technical assistance will be provided to support the synthesis and dissemination of relevant research findings.

(d) Strengthening of Pharmaceutical Sector Management.

3.29 In 1990, with assistance under the first IDA project, the Government found an effective solution to past shortages in essential generic drugs. It established a financially autonomous agency, the *Centrale d’achat* (CA) responsible for the procurement of medicines and medical supplies for public and private non-profit health facilities. The project will consolidate and build on this achievement. With project assistance the DHPL will prepare legislative and regulatory texts for the pharmaceutical sector, which would facilitate private sector efforts to participate in implementing the national essential drugs program. Short-term external training will be provided in pharmaceutical legislation, policy and control. The Government will submit to IDA by September 30, 1996, a time based action plan, acceptable to IDA, for regulatory reform of the pharmaceutical subsector. Private sector involvement will also be encouraged through occasional meetings for exchange of information and through a feasibility study on the sale of generic drugs. The project will also support the costs of training and information campaigns to inform health personnel and the public at large about pharmaceutical policy and regulations, the dangers of the illicit sale of drugs, and the cost-effectiveness of generic drugs. A study will also be undertaken to provide the basis for setting up a price stabilization mechanism that would ensure continued affordability of essential generic drugs, whose prices were temporarily frozen after the 1994 devaluation, while bringing essential drug prices more in line with their market value. The *Centrale d’Achat* will submit to its Board and to IDA (through MOH) quarterly reports on management of cash and stocks, and annual audit reports on its accounts as a means of monitoring the financial health of this entity. The project will also strengthen DPhL capacity through the financing of the salary of a statistician and technical equipment and software to enhance inspection capacity.
3.30 To support ongoing cost recovery through the sale of drugs, the project will finance on an annual basis throughout the life of the project supplemental drug stocks for all five CHD. It will also finance complementary initial stocks for the four district hospitals to be established under the project; complementary stocks for selected health facilities encountering difficulties in recovering the full costs of drugs, and initial drug stocks for the 5 new CCS to be constructed under the project. Management of these drugs stocks and prescription practices will be improved through the conduct of an evaluation of current practices in public and private health facilities and training and technical supervision of health personnel to improve performance in this regard. Improvements in accounting and financial management will also be supported under the project.

4. Strengthening of Partnerships for Health Program Coordination and Evaluation (US$0.9 million)

3.31 The project will strengthen and further sustain effective participation of stakeholders in the full spectrum of health and family planning activities. It will do so through the strengthening of committees for community participation (COGES, COGEZ and COGEC) and for intersectoral coordination (CNEEP and CDEEP), which, together, are responsible for eliciting and coordinating at all levels of the health system the appropriate inputs of, respectively: clients/communities, NGOs, the public sector (centralized and decentralized), the private commercial sector (including traditional practitioners), national and regional institutions/academia and other relevant line Ministries. This reform is intimately linked with, and is supportive of, the decentralization of sector management and administration.

3.32 CNEEP/CDEEP. The project would support the establishment and operation of a secretariat to CNEEP, located within DPCE, responsible for the animation, facilitation, coordination, training, monitoring and evaluation of the participation of stakeholders represented throughout the system. This will include incremental salaries for contractual staff (one public health management specialist with experience in community participation and one administrator/information specialist). The CNEEP will prepare annual monitoring and evaluation reports on the implementation of the new sector strategy. The project will support the costs of production of these reports and the costs of two annual meetings: one to review progress at the mid-year (end-April), and the other (end-November) to review implementation of annual plans and budget, to evaluate progress achieved and to plan and program the following year’s activities, based on the previous year’s experience and achievements. This annual review will be based on departmental-level reports to be prepared and submitted by CDEEP.

3.33 The DDS Division for Planning, Evaluation and Programming will be strengthened to enable it to serve as secretariat to the CDEEP. Project assistance includes office equipment, training, technical assistance, and support of incremental operating costs for supervision, evaluation and outreach. This assistance will enable CDEEP to prepare reports on their quarterly meetings, whose purpose is to identify and resolve constraints to implementation and provide solutions to these problems before they become serious impediments to timely execution. These reports would also include financial reports on decentralized project accounts and reports on overall progress in the implementation of civil works.

3.34 COGES, COGEZ and COGEC. The MOH has recently carried out a participatory assessment of the experiences of COGES and COGEC thus far and has undertaken to address and resolve key issues identified, most notably: timely delivery of training, autonomy of these entities, improvements to the election process, and motivation of members. The project will support the costs of basic and refresher training of COGES, COGEZ and COGEC members as and when health zones are established. This will be done on a periodic basis, given that members are elected every two years. Training modules for COGES, COGEZ, and COGEC members have already been developed by central MOH on primary health care, community participation, leadership and teamwork, animation techniques, and management of community financing. And training of departmental trainers has already taken place. COGES, COGEZ and COGEC will cover other costs of their networking and outreach operations by retaining
a small portion of funds collected through cost recovery. Technical assistance will also be provided by local NGOs as needed to strengthen management capacity and autonomy of members. Considerable effort will be warranted under the project to ensure that: (a) operations at these levels are realistic in terms of the capacity, availability, interests and comparative advantages of the various partners; (b) health managers and other health personnel work effectively and in cooperation with partners; (c) the need for conflict management is appreciated and effectively met; (d) partners will be given the opportunity occasionally to share experiences and exchange ideas and best practices with their counterparts at the various levels of the system; and (e) information (on the perspectives of the partners and on the quality and extent of participation) flows freely and expeditiously, both up and down the system. As a part of its annual review, CNEEP will evaluate progress made in building and sustaining participation of key stakeholders in health and will revise plans for the coming year accordingly.

3.35 The Government has signed: (a) an Administrative text amending the bylaws of COGEC and COGES (Arrêté No. 0390 of February 14, 1995): (i) to expand membership to other partners working on related issues in the same commune or sub-prefecture; (ii) to clarify aspects of financial management and other operations; (iii) to establish two additional seats on the COGES for, respectively, one woman and one youth, to be elected from women and youth members of COGEC within the sub-prefecture; and (iv) to specify procedures for hiring with their own funds independent auditors to audit their own accounts annually. As a condition of effectiveness, the Government will have adopted a decree, acceptable to IDA, amending the bylaws and internal regulations of CNEEP and CDEEP to replace decree No. 90-236 of August 31, 1990, and Arrêté No. 688 of February 27, 1989, creating the CNEEP and CDEEP: (i) to specify the functions and staff profiles for their respective secretariats; (ii) to provide for the representation of COGEC and COGES and other key partners in these entities; and (iii) to streamline its operations.

5. Project Management, Monitoring and Evaluation (US$0.8 million)

3.36 The project would support project management, monitoring and evaluation activities. Responsibilities for project management and implementation will be undertaken by the appropriate directorates and services of the newly reorganized MOH. The project would also finance the costs of mid-term and final evaluations, two beneficiary assessments to be carried out in the second and fourth years of the project and annual reviews of project experience and consequent revision of plans for the following year based on lessons learned.

D. PROJECT COST AND FINANCING

3.37 The total cost of the project, including contingencies, is estimated at US$33.4 million, with a foreign exchange component of US$20.2 million equivalent or 60 percent of total project costs. Base costs are estimated on the basis of average 1994 post CFAF devaluation values. Physical contingencies of 15 percent have been included for civil works and 10 percent for goods. Price contingencies have been calculated at 2.5 percent per annum for foreign costs during the entire project and for local costs at 14.5 percent (1995), 5.5 percent (1996), and 3.0 percent annually from 1997 onwards. Cost estimates for civil works are based on actual costs from the second phase of rehabilitation of the first IDA-financed project. Cost estimates for other expenditures are based on recent experiences and include changes in prices quoted by suppliers after devaluation. The project financing plan by project component and by disbursement category is summarized in Tables 1 and 2 below. Details are provided in Annex 13.

3.38 The IDA credit will be US$27.8 million equivalent, representing about 83 percent of total project costs (about 91 percent of project costs net of taxes and duties). IDA's financing represents 96.5 percent of foreign cost and 80 percent of local costs. Domestic counterpart financing will be US$5.6 million
equivalent, or 17 percent of total costs, and will be made up of US$5.1 million from Government allocations and US$0.5 million equivalent from beneficiaries through cost recovery.

Table 1: Summary of Financing Plan by Project Component
(in US$ Million, including contingencies)

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>IDA</th>
<th>Govt. &amp; Beneficiaries</th>
<th>Total</th>
<th>IDA as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Development and Expansion of Family Planning Programs and Services</td>
<td>2.4</td>
<td>0.4</td>
<td>2.8</td>
<td>86%</td>
</tr>
<tr>
<td>B. Improving Quality and Efficiency of Priority Health Services</td>
<td>11.6</td>
<td>1.9</td>
<td>13.5</td>
<td>86%</td>
</tr>
<tr>
<td>C. Strengthening and Streamlining Sector Management and Administration</td>
<td>12.8</td>
<td>2.2</td>
<td>15.0</td>
<td>85%</td>
</tr>
<tr>
<td>D. Strengthening of Partnership for Health</td>
<td>0.2</td>
<td>1.0</td>
<td>1.2</td>
<td>17%</td>
</tr>
<tr>
<td>E. Project Management</td>
<td>0.8</td>
<td>0.1</td>
<td>0.9</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27.8</strong></td>
<td><strong>5.6</strong></td>
<td><strong>33.4</strong></td>
<td><strong>83%</strong></td>
</tr>
</tbody>
</table>

Table 2: Summary of Financing Plan by Expenditure Category
(in US$ Million, including contingencies)

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>IDA</th>
<th>Govt. &amp; Beneficiaries</th>
<th>Total</th>
<th>IDA as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Civil Works</td>
<td>2.9</td>
<td>0.7</td>
<td>3.6</td>
<td>81%</td>
</tr>
<tr>
<td>2. Goods</td>
<td>6.9</td>
<td>1.9</td>
<td>8.8</td>
<td>78%</td>
</tr>
<tr>
<td>3. Consulting Services/TA</td>
<td>3.7</td>
<td>0.4</td>
<td>4.1</td>
<td>90%</td>
</tr>
<tr>
<td>4. Training</td>
<td>6.3</td>
<td>1.3</td>
<td>7.6</td>
<td>83%</td>
</tr>
<tr>
<td>5. Incremental Recurrent Costs</td>
<td>8.0</td>
<td>1.3</td>
<td>9.3</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27.8</strong></td>
<td><strong>5.6</strong></td>
<td><strong>33.4</strong></td>
<td><strong>83%</strong></td>
</tr>
</tbody>
</table>

3.39 Recurrent cost implications. This project would generate incremental recurrent costs in the amount of US$9.3 million equivalent, or 28 percent of total project cost. Of this amount, US$3.8 million would finance the salaries of contractual staff who would fill key management and service delivery positions in the health system. The presence of these staff is considered critical to the success of reforms to decentralize and revitalize sector management and service delivery. More than 80 percent of these staff would be working in the DDS and in health facilities, with the balance filling key positions in the newly created directorates in charge of planning and management of resources. These contractual staff would be hired for periods ranging from two to five years and the most efficient performers among them would gradually be absorbed into the civil service as Government allocations to the sector increase. This would be in line with the Policy Framework Paper (PFP) and proposed SAC III operation, both of which advocate the allocation of more human and financial resources to the health sector. At the project's end, their combined annual salaries would amount to the equivalent of US$0.77 million, or about 16 percent of the approved 1995 MOH salary budget. The numbers, types and costs of contractual staff to be hired under the project are shown in Annex 12. These costs are sustainable in light of Government's commitment to increase resource allocations to health (para. 3.27). Incremental recurrent costs would also include expenditures for supervising the setting up of program and financial management and supervision systems envisaged under the project (totalling US$5.5 million).
IV. PROJECT IMPLEMENTATION

A. PROJECT COORDINATION AND MANAGEMENT

4.1 Responsibility for project implementation will rest with the operational units of MOH as part of their functions. Central and departmental level directorates will have direct responsibility for initiating, coordinating, and evaluating the project activities assigned to them. The decentralization of responsibilities should accelerate execution and avoid the slow, centralized procedures which have adversely affected implementation of the first project. These are being addressed in the CPPR and in the mid-term review. Furthermore, in light of the new reorganization of the MOH, the mid-term review of the first project will also seek ways to integrate the work and staff of the project coordination unit more fully into the relevant directorates and decentralized levels. During the course of project development, a draft project implementation manual was prepared in collaboration with key MOH staff, which lays out roles, responsibilities, procedures and processes for the coordination, management, implementation, monitoring and evaluation of project activities --including performance indicators, and which also provides guidance on procurement and disbursement, accounting, auditing and reporting. As a condition of effectiveness, a Project Implementation Manual, satisfactory to IDA, will be adopted. The draft Project Implementation Manual will be finalized during the project launch workshop, scheduled to take place prior to effectiveness. This manual will include the detailed first year implementation plan. Annex 14 shows the project management structure.

4.2 Within MOH, a Project Coordinator has been appointed and located in the DPCE which oversees all sector investments. The Project Coordinator will: (a) facilitate implementation of project activities by the different central level directorates and the DDS; (b) work closely with the Directorate of Administration and Finance to ensure that accounting and audit procedures agreed to with IDA are being respected; (c) work closely with the coordinator of the first project, whose workload is too heavy for him to take on incremental responsibilities for coordinating the second project; and (d) maintain regular contact with the Bank’s Resident Mission and IDA on the technical aspects of project implementation. Funds from the Japanese Grant have been budgeted for the training of accountants, procurement specialists and other project implementation staff. These technical and administrative personnel will provide back-up to the DDS who will be responsible for project management and supervision at the departmental level.

4.3 The CNEEP and its corresponding departmental structure CDEEP will ensure intersectoral communication and coordination concerning this and other health sector projects. CNEEP members would represent: (a) the Ministries of Plan, Finance, Education and Rural Development; (b) the CDEEP; (c) COGES/COGEC; (d) the central teaching hospital; (e) representatives of NGOs; and (f) donors funding projects in the sector. CNEEP will monitor progress and problems affecting project implementation on a semiannual basis based on quarterly reports prepared by CDEEP. During appraisal, IDA and the Government reviewed the statutes of CNEEP and CDEEP and agreed on measures to increase their effectiveness in project monitoring and evaluation. The statutes will be signed by the time of credit effectiveness. Local health management committees (COGES, COGEZ and COGEC) will play an active role in infrastructure rehabilitation, IEC, cost recovery, and community mobilization and education concerning the objectives and activities of the project. They will also participate in periodic reviews at the commune and sub-district levels. Implementation problems will be resolved with assistance from the CDEEP and the DDS.

4.4 Project implementation would be based on annual work programs and corresponding resources identified by the three-year plan (PTD); these annual programs and budgets would be prepared by the central and departmental level directorates, approved by the appropriate local structure (COGES, CDEEP or CNEEP), and submitted to IDA for review and non objection at the beginning of each fiscal year.
Medium-term planning and annual programming tasks have been defined during project preparation for these respective structures, and the project includes funding to carry out this process. Training has been provided to DDS and central staff on the use of the PTD. A project implementation schedule discussed and agreed with MOH staff is attached as Annex 15.

B. MONITORING, EVALUATION AND SUPERVISION

1. Monitoring and Evaluation

4.5 The CNEEP and CDEEP will take a lead role in project monitoring and evaluation and, as such, will provide the mechanism for eliciting the inputs of Government, beneficiaries and donors in this regard. In addition to the regular reporting of physical and financial progress, monitoring and evaluation will cover three other interrelated aspects: health facility performance, beneficiary assessment, and health status impact. During appraisal and post-appraisal a set of performance indicators for use at the level of health facility were discussed. These indicators which represent a mix of inputs, outputs and outcomes would provide the Ministry with (a) a systematic measure of its performing and non performing health facilities; and (b) a means for carefully assessing the critical factors associated with the quality of health service delivery. They are presented in Annex 16 and are also included in the draft Implementation Manual. The Government will submit to IDA a beneficiary assessment report on the impact of services provided under the project in the years 1997 and 1999. These assessments would place a particular focus on the functioning of health districts. With assistance from the FAC, the technical capabilities for conducting health status impact analyses is being strengthened and would be used regularly by the project.

2. Supervision

4.6 MOH. District, departmental and central level personnel will supervise project activities during their regularly scheduled supervision trips. The six CDEEPs will each meet quarterly to review progress and discuss field-level project implementation problems; the CNEEP will meet semiannually to review progress on sectoral issues. The Project Coordinator would prepare semiannual reports based on the results of the CDEEP/CNEEP meetings indicating the project’s physical/financial status as well as its progress on the institutional issues.

4.7 IDA. Because of the sectoral nature of IDA’s support and the decentralization of the proposed activities, IDA supervision will rely on Resident Mission assistance, particularly to attend the CDEEP meetings and to indicate problems needing urgent solution. Supervision from Headquarters would rely on the quarterly and semiannual progress reports to provide the basis for the issues to be discussed during the supervision missions.

4.8 The details of the Bank’s supervision plan are provided in Annex 17. Two supervision missions per year will be required: (a) no later than end of April to, inter alia, evaluate implementation of the three-year sector rolling plan, conduct the annual review of project progress during the previous year, to conduct a mid-year implementation review, to review the proposed annual programs and budgets for the following year, and to examine the annual audit of the project’s accounts; and (b) late in the calendar year (November). At least one of these missions will coincide with a meeting of the CNEEP, so as to demonstrate IDA’s commitment to this institution. Donors will be involved in these reviews to encourage a sector approach.

4.9 In addition, a mid-term review will be carried out not earlier than 34 months and not later than 38 months after credit effectiveness. To be carried out by an independent team of experts selected jointly by the Government and IDA, the review would cover all of the substantive aspects of the project as well as the processes being used and it would be consultative in its design. The results would be reviewed
jointly and the recommendations, once approved by the two parties, would be implemented as soon as possible.

C. PROJECT IMPACT

4.10 Impact on Women. Improvements in access to and the quality of family planning, health and nutrition services will have an immediate positive impact on the life of Beninese women in a number of ways. Raising the CPR will permit women to space births and thus alleviate the burden of maternal depletion and continuous childbirth and the temptation to resort to unsafe abortions. Improved access and outreach will also offer them the opportunity to deal with other obstetric problems and problems of infertility or sub-fecundity which currently disrupt family life. The integration of family planning, maternal and child health, and nutrition services will offer protection to mother and child and lay a solid foundation for healthy growth of newborns and the welfare of their mothers. Effective management of high-risk pregnancies and complications at delivery would save women's lives and offer them a better chance of bringing up healthy children. Systematic monitoring of the nutrition of women will reduce the current high rate of anemia among pregnant women and reduce the incidence of low birth weight. Strengthening of the DSF will enhance MOH capacity to improve quality and access to family planning, MCH and nutrition services. Such improvements will free women's resources and enable them to pursue economic and social activities that fully integrate them into development activities and, as such, complement to the recently approved IDA investment in primary education, which supports national strategy to increase school enrollment for girls.

4.11 Environmental Impact. The project will have a positive environmental impact through activities improving human and household waste disposal and sanitation. The health promotion activities by COGEC and COGES will create greater community awareness of the measures needed to protect the environment and keep public places (health facilities, schools, and markets) clean and provided with toilets. In-service programs under the project will include training of clinical staff in proper procedures for handling and disposing of blood products, needles and other hazardous materials.

D. PROCUREMENT

4.12 Procurement Code. A new procurement code was reviewed by IDA in 1992, approved by the Government and submitted to Parliament, but it has not yet been approved. Under the SAC III operation the Government has assured IDA that the new procurement code will be adopted by Parliament by June 1995. This new code would inter alia facilitate the current cumbersome procurement regulations. Other measures to streamline the procurement process include the establishment of sample bidding documents for national competitive bidding, which was discussed with MOH at appraisal, the existence of experienced PIU staff from the first project, and recent training, in Abidjan and Dakar, of additional staff in procurement methods. The project implementation manual describes in detail the functional relationships associated with the procurement procedures as well as the procurement information to be collected and included in the semiannual progress reports by project management.

4.13 Procurement Methods. Table 3 below summarizes the project expenditures, their estimated costs, and the proposed methods of procurement. All works, goods, and services financed under the IDA credit would be procured in accordance with (a) Bank guidelines and standard bidding documents for International Competitive Bidding (ICB) and for Consultant Services ("Procurement under IBRD Loans and IDA Credits", January 1995, and "Guidelines for the Use of Consultants by World Bank Borrowers and by the World Bank as Executing Agency", August 1981), and (b) with Government documents and procedures reviewed and approved by IDA for National Competitive Bidding (NCB) and other methods of procurement.
Table 3: Summary of Proposed Procurement Arrangements */
(US$ million, including taxes and duties)

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>ICB</th>
<th>NCB</th>
<th>Other</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. WORKS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Construction (5) and Rehabilitation (5) of Health Centers (CCS)</td>
<td>1.0</td>
<td>0.8</td>
<td>0.2</td>
<td>2.0</td>
</tr>
<tr>
<td>(b) Construction of District Hospitals (4 HD)</td>
<td>1.5</td>
<td>1.2</td>
<td>0.3</td>
<td>3.0</td>
</tr>
<tr>
<td>(c) Rehabilitation of Health Centers (4 CSSP)</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>(d) Rehabilitation of Departmental MOH Bureaux (6 DDS)</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>(e) Completion of new Health Ministry building (1 MOH)</td>
<td>0.4</td>
<td>0.1</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>SUBTOTAL WORKS</td>
<td>3.4</td>
<td>0.2</td>
<td>0.3</td>
<td>4.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. GOODS</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Furniture</td>
<td>1.2</td>
<td>0.1</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>(b) Medical Equipment</td>
<td>1.7</td>
<td>1.4</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>(c) Other Equipment</td>
<td>1.9</td>
<td>1.5</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>(d) Vehicles</td>
<td>1.8</td>
<td>1.4</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>(e) Essential Drugs a/</td>
<td>0.5</td>
<td>0.6</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL GOODS</td>
<td>5.9</td>
<td>1.7</td>
<td>8.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. CONSULTING SERVICES b/</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Policy Support</td>
<td>2.1</td>
<td>1.9</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>(b) Project Implementation Support</td>
<td>0.2</td>
<td>0.2</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>(c) Institutional Development b/</td>
<td>1.6</td>
<td>1.5</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>(d) Architectural studies</td>
<td>0.2</td>
<td>0.2</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL CONSULTING SERVICES</td>
<td>4.1</td>
<td>3.7</td>
<td>7.5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. TRAINING c/</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Incremental Contractual Salaries</td>
<td>3.8</td>
<td>3.0</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>(b) Operating Costs d/</td>
<td>5.5</td>
<td>5.5</td>
<td>11.0</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL INCREMENTAL RECURRENT COSTS</td>
<td>9.3</td>
<td>8.0</td>
<td>17.6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. INCREMENTAL RECURRENT COSTS</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Incremental Contractual Salaries</td>
<td>3.8</td>
<td>3.0</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>(b) Operating Costs d/</td>
<td>5.5</td>
<td>5.5</td>
<td>11.0</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL INCREMENTAL RECURRENT COSTS</td>
<td>9.3</td>
<td>8.0</td>
<td>17.6</td>
<td></td>
</tr>
</tbody>
</table>

| TOTAL:                        | 5.9  | 4.8  | 22.7  | 33.4  |
| IDA FINANCING:                | (4.8)| (3.8)| (19.2)| (27.8)|

*/ Figures in parentheses are the amounts financed by IDA, net of taxes and duties. Slight differences may occur as a result of the rounding of figures.
"Other" means LIB, national shopping, IAPSO, and direct contracting, and consultant selection following Bank guidelines.

a/ The total amount of US$0.9 million under "Other" consists of: National Shopping: US$0.2 million; Direct Contracting: US$0.2 million; and Limited International Bidding: US$0.5 million.

b/ The project will finance 85 person-months of external specialist support for implementation (annex 18 provides the details) and 399 person-months of local consulting services. This includes consulting services for project audits. Technical Assistance for Institutional Development includes assistance on: planning and coordination of health services and improvement programs, establishment of health districts, improvement of the cost recovery system, and selected surveys.

c/ Annexes 18 and 19 provide details on, respectively, local training and training abroad.

d/ Operating costs include office supply, field trips, and maintenance of buildings, vehicles and equipment and incremental salaries of local contractual staff.
4.14 **Works** (US$3.6 million). The civil works program includes the completion of the new Ministry of Health building which comprises construction of a laboratory for water quality control, the renovation of six DDS office buildings, four sub-district health centers, as well as the rehabilitation and expansion (construction) of four district hospitals, and 10 local health posts. In view of the nature of works (rehabilitation and construction of small structure, in remote or over dispersed area, the civil works contracts, even if packaged in larger lots, are not likely to attract international competition.

   (a) **NCB**: Civil works contracts estimated to cost US$1.5 million or less per contract and up to an aggregate amount of $3.4 million will be awarded under National Competitive Bidding (NCB) and will be open to foreign bidders who wish to participate. The four district hospitals totalling an aggregate amount of US$1.5 million will be split in four lots and bidders allowed to bid for one, two or all packages.

   (b) **Direct contracting**: Small rehabilitation, renovation or extension works of some rural health posts, sub-district health facilities and DDS below an amount of US$30,000 equivalent and up to an aggregate amount of US$200,000 may be awarded by direct contracting if no local competition is available.

4.15 **Goods** (US$8.8 million). Goods provided under the project include furniture for offices and health centers as well as communication and small medical apparatus, surgical and medical equipment, vehicles, and initial or supplemental drug stocks for departmental, district and the new local hospitals. Drugs (US$1.5 million equivalent) will be purchased by the Centrale d'Achat, the drug procurement agency established under the first project (see para. 4.16).

   (a) Goods other than drugs and medical supplies:

   (i) **ICB**: All contracts for vehicles, medical and other equipment will be procured through ICB. Locally manufactured goods will receive a preference in bid evaluation in accordance with Bank guidelines. Exception to ICB procurement may be made only, if necessary, for vehicles needed for the project start, up to an aggregate amount of US$200,000, and to be purchased either through (a) UNDP's Inter-Agency Procurement Services Office (IAPSO), or (b) national shopping.

   (ii) **NCB**: Furniture and small office equipment, available in the country, will be procured through NCB for contracts estimated to cost US$250,000 million or less and up to an aggregate amount of US$1.3 million.

   (iii) **Other methods**: Goods valued below US$30,000, for rural health facilities, will be procured by national shopping procedures acceptable to IDA (with a minimum of three quotations). Contracts awarded through national shopping would not exceed an aggregate amount of US$400,000.

   (b) **Drugs and Medical Supplies**:

4.16 Drugs and medical supplies would be procured through the already functioning central purchasing agency, the Centrale d'Achat (CA), whose procedures have been approved by its independent management committee and the relevant local ministries as well as reviewed without objection by IDA. The performance of the CA on procurement matters would continue to be subject to review by IDA. In 1992, the CA carried out a prequalification for drug suppliers to be updated every two years. For the purpose of this project, a new prequalification exercise will be conducted for the first order of drugs to be procured under the project (contract value of about US$250,000), using ICB. Consecutive contracts would be procured following these procedures:
(i) **ICB:** All contracts estimated to cost US$250,000 or more would be procured using ICB;

(ii) **LIB:** Replenishment contracts estimated to cost US$250,000 or less per contract and up to an aggregate amount of US$0.5 million would be purchased mostly by LIB from the list of suppliers identified in the prequalification exercise;

(iii) **NCB:** Small contracts for drugs produced locally, estimated to cost US$75,000 or less per contract and up to an aggregate amount of US$0.1 million, would be awarded under NCB procedures;

(iv) Contracts estimated to cost less than US$30,000 per contract up to an aggregate amount of US$0.4 million, may be procured through other methods such as national shopping or direct purchasing, depending on quantities and type of drugs involved and with the purpose of renewing depleted initial stocks and assuring quality standards.

4.17 **Consulting Services/Technical Assistance (US$4.1 million).** The project will finance 85 person-months of external specialist support for implementation and 199 person-months of local consulting services. Details on the external TA are provided in Annex 18. All contracts financed by IDA will be awarded on the basis of Bank guidelines for the use of consultants by Bank borrowers (para. 4.13).

4.18 **Training (US$7.6 million)** includes training abroad (US$4.4 million) and local training (US$3.2 million). External training needs, representing 1014 person-months (of which 930 for long-term training ranging from nine months to four years), are described in Annex 19. Whenever appropriate, external training will take place in the Africa region. Details of local training are provided in Annex 15. Plans for external and local training needs will be reviewed and approved annually by IDA.

4.19 **Incremental Recurrent Costs (US$9.3 million),** including consumables and other administrative costs, incremental contractual salaries, local travel, supervision and training allowances, building and vehicle/equipment operation and maintenance, will be procured and paid for following regular Government procedures, acceptable to IDA.

4.20 **Review by IDA.** Prior IDA review will be required for (a) all contracts above the thresholds of US$100,000 for civil works and goods, including drugs; (b) all consulting services and training contracts estimated to cost more than US$100,000 (for consulting firms), US$50,000 (for individual consultants); and (c) all terms of reference for specialist and training services and all sole source contracts, regardless of contract value, and any amendments of a value above US$100,000. Selective post-review of awarded contracts below the prior review thresholds would apply to about one in five contracts and would be made on the basis of certified Statements of Expenditures (SOE).

E. **DISBURSEMENT**

4.21 The project is expected to be completed by December 31, 2000 and the credit closed by June 30, 2001. The estimated disbursement profile is shown in Annex 20. Full documentation will be requested for disbursements under all categories of the Credit. However, the Borrower may submit withdrawal applications for expenditures under contracts for goods, works and consulting services (for firms) costing less than $100,000 equivalent on the basis of certified statement of expenditures (SOE). SOE would also be used for reimbursements of expenditures against contracts with individual consultants costing less than $50,000 equivalent, and expenditures for training and incremental recurrent costs. Documentation for withdrawals under SOEs will be retained at the DSAF of the MOH for review by IDA supervision missions and for project auditors.
4.22 **Special Account and Project Account.** To facilitate disbursements, the Government will open a Special Account (SA) in a commercial bank in Cotonou to cover IDA’s share of eligible expenditures, and to be managed by MOH with appropriate controls by the Ministry of Finance (MEF). The authorized allocation for the SA will be US$1,500,000. To facilitate payments at the DDS level in accordance with the strategy of decentralizing sector management, advances from the Special Account not exceeding US$40,000 equivalent per Department may be made to each of the six DDS (decentralized) accounts. Documentation pertaining to the DDS accounts would be forwarded every two months to the DSAF of MOH, who will assure regular monitoring of the DDS accounts and replenish the accounts only when satisfied with the documentation submitted (documented expenditures and bank statements). Replenishment to the Special Account would be submitted to IDA every month under normal circumstances but not less frequently than every three months. MEF would exercise its normal review of expenditures through its regional financial comptrollers and in a manner that does not inhibit project implementation. Withdrawal applications for direct payment from the Credit Account may be submitted for expenditures above 20 percent of the initial deposit to the Special Account. All supporting documentation will be retained by the Ministry of Health and will be available for review as requested by IDA supervision missions and project auditors. **As a condition of credit effectiveness,** the Government will (a) open a Project Account and deposit an initial amount of CFAF 216 million; and (b) appoint consultants to assist in the introduction of a decentralized accounting management and monitoring system for the Project accounts and to provide related training. The Government will adopt by December 31, 1995, a budgeting and costing system, acceptable to IDA, for all levels of the health system for the delivery of health services. The Government gave assurances that it will deposit into the Project Account in each year during the implementation of the Project, an amount or amounts equivalent to the following aggregates: (i) CFAF 349 million for the second year after the Effective Date; (ii) CFAF 200 million for the third year after the Effective Date; (iii) CFAF 296 million for the fourth year after the Effective Date; (iv) CFAF 237 million for the fifth year after the Effective Date, or other amount or amounts as IDA may specify during the Annual Review and as being required for the purposes of the Project.

<table>
<thead>
<tr>
<th>Table 4: Withdrawals of the Proceeds of the IDA Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>1. Civil Works</td>
</tr>
<tr>
<td>2. Furniture, Medical &amp; Other Equipment, Vehicles, and Drugs</td>
</tr>
<tr>
<td>3. Consulting Services, and Training</td>
</tr>
<tr>
<td>4. Incremental Recurrent Costs a/</td>
</tr>
<tr>
<td>5. Unallocated</td>
</tr>
<tr>
<td><strong>Total IDA Financing</strong></td>
</tr>
</tbody>
</table>

a/ As defined in para. 4.19 above.
F. ACCOUNTING, AUDITING AND REPORTING

4.23 The DSAF will be responsible for the project's financial management and will maintain consolidated project accounts. Vouchers and checks for payment will be signed by the DSAF and by the Project Coordinator. Project accounts, including the SA, will be audited annually by independent auditors acceptable to IDA; all disbursements under SOEs will be audited semi-annually. The audit reports will be submitted to IDA within six months of the end of each fiscal year. Japanese funds have been budgeted for recruitment of an internationally recognized firm to establish an appropriate computerized accounting system within the DSAF and to adequately train MOH and DDS personnel recruited by the project.

4.24 Audited accounts and reports would be submitted to the MOH and IDA not later than six months after the end of each fiscal year. The auditor would establish a "Long Form Report" as described in the Bank's "Guidelines for Financial Reporting and Auditing of Project Financed by the World Bank", March 1982. Audit on project expenditures would include an examination of the substantiating documentation and a verification that: (a) project accounts permit identification of all receipts and payments; (b) goods had been received or work performed; (c) payments had been made; (d) all expenditures had been legitimate; and (e) the special account has been used appropriately; along with an opinion on the reliability of the SOE procedures and on whether the goods, works, and services acquired under the project were being utilized in accordance with its objectives. The auditors would also include the management report revealing possible shortcomings in staffing and systems, and evaluate the accounting system and efficiency of the internal control procedures.

4.25 In light of the sectoral nature of IDA's support, annual work programs will be based on a review of the previous year's experience in implementing national sector strategy, in which all donors would participate. This will enable support to the sector to remain flexible and responsive to emerging issues, lessons and opportunities. An Annual Review of project performance will take place no later than April 30 of each year. Government will submit to IDA and to other donors, at least four weeks prior to the Annual Review an annual sector performance report to be prepared by CNEEP on the progress made in the implementation of the Project and the national sector strategy. This report would cover, among other things: (a) improvements in the quality of health services (particularly family planning, maternal and child health, immunization, STD/AIDS, and strengthening of the patient referral system); (b) progress in strengthening and decentralizing sector management and administration; (c) increase in participation in various health activities of the private and public sector contributors to, and beneficiaries of, the health services; and (d) in the years 1997 and 1999 an assessment of the impact of services provided under the Project by the beneficiaries. And based on this performance report, submit to IDA not later than four weeks after each Annual Review, an action program and budget acceptable to IDA for the further implementation of the Project, including, if appropriate, consequential amendments to the Project Implementation Manual, and, thereafter, implement such action program. As laid out in the draft Project Implementation Manual, the Government will prepare through CNEEP semiannual project implementation reports that include financial reports on decentralized accounts and on civil works funded under the project, based on quarterly reports to be prepared by CDEEP in each of the departments.
V. BENEFITS AND RISKS

A. BENEFITS

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

B. RISKS

5.2 The main risk of the project is the potential inability of the Government to carry out the comprehensive reforms included in the project. Key stakeholders were involved throughout the process of project preparation, which should mitigate any tendency by central level officials to stall sector reforms or project activities. The coordination mechanisms and supervision arrangements ensure regular consultation among the MOH, beneficiary representatives, other ministries, donors, private sector operators and NGOs to review progress in implementation and provide timely solutions to problems detected. Another risk is that Government budgetary allocations may fall short of resources needed to implement the project. Conditions to be met under the project include a restructuring of the current public budget for health to encourage decentralization and increase absorptive capacity and a gradual increase in the health sector share of the total current budget over the life of the project. In addition, resources generated through cost recovery and managed by communities constitute a guarantee that essential drugs and critical non-wage operating expenses are protected. To ensure greater sustainability, the project design envisages a decentralized implementation strategy in which the regions, rather than the central MOH, are primarily responsible for execution of various project activities. Periodic reviews and annual programming workshops at the level of the CNEEP will ensure that all regions are respecting implementation plans, standards and deadlines. Beneficiary assessments will also be used to monitor sector performance.

VI. AGREEMENTS REACHED AND RECOMMENDATION

6.1 During the negotiations, the Government gave assurances that it will:

(a) submit to IDA not later than April 30 of each year for its review and comments: (i) the updated three-year rolling development plan for its health sector for the succeeding years and a report on the execution of the sector’s recurrent budget for the past year; and (ii) its salary and non-salary recurrent budget allocations to the health sector for the following year (para. 3.27);

(b) submit to IDA and to other donors, at least four weeks prior to the Annual Review of project performance (to occur no later than April 30 of each year), an annual sector performance report, to be prepared by CNEEP, on the progress made in the implementation of the Project and the
national sector strategy. This report would cover, among other things: (i) improvements in the quality of health services (particularly family planning, maternal and child health, immunization, STD/AIDS, and strengthening of the patient referral system); (ii) progress in strengthening and decentralizing sector management and administration; (iii) increase in participation in various health activities of the private and public sector contributors to, and beneficiaries of, the health services; and (iv) in the years 1997 and 1999 an assessment of the impact of services provided under the Project by the beneficiaries. And based on this performance report, submit to IDA not later than four weeks after each Annual Review, an action program and budget, acceptable to IDA, for the further implementation of the Project, including, if appropriate, consequential amendments to the Project Implementation Manual, and, thereafter, implement such action program (paras. 4.5 and 4.25);

(c) submit to IDA, by September 30, 1996, a time based action plan, acceptable to IDA, for regulatory reform of the pharmaceutical subsector (para. 3.29);

(d) submit to IDA, by June 30, 1997, an estimate of costs of hospital care and the Government's proposal for contribution to these costs by the beneficiaries (para. 3.27);

(e) prepare by December 31, 1996, draft texts, acceptable to IDA, establishing medical treatment guidelines, norms, standards and protocols for its health facilities and adopt a plan and timetable, satisfactory to IDA, for their application nationwide (para. 3.7);

(f) carry out jointly with IDA not earlier than 34 months and not later than 38 months after the Effective Date a mid-term review of the progress made in carrying out the Project (para. 4.9);

(g) submit to IDA quarterly reports on management of cash and stocks, and annual audit reports on the Centrale d'Achat accounts as a means of monitoring the financial health of this entity (para. 3.29);

(h) deposit into the Project Account in each year during the implementation of the Project, an amount or amounts equivalent to the following aggregates: (i) CFAF 349 million for the second year after the Effective Date; (ii) CFAF 200 million for the third year after the Effective Date; (iii) CFAF 296 million for the fourth year after the Effective Date; (iv) CFAF 237 million for the fifth year after the Effective Date, or other amount or amounts as IDA may specify during the Annual Review and as being required for the purposes of the Project (para. 4.22); and

(i) adopt by December 31, 1995, a budgeting and costing system, acceptable to IDA, for all levels of the health system for the delivery of health services (para. 4.22).

6.2 As conditions of credit effectiveness, the Government will:

(a) open a Project Account and deposit an initial amount of CFAF 216 million (para. 4.22);

(b) submit to IDA a National Population Policy, acceptable to IDA, as adopted by the Council of Ministers (para. 3.3);

(c) adopt a Project Implementation Manual satisfactory to IDA (para. 4.1);

(d) appoint consultants to assist in the introduction of a decentralized accounting management and monitoring system for the Project accounts and to provide related training (para. 4.22);
(e) amend Decree No. 90-236 of August 31, 1990, and Arrêté No. 688 of February 27, 1989 in manner acceptable to IDA in order to, among other things, modify the composition of the membership of the CNEEP and the CDEEP and to clarify their functions (para. 3.35); and

(f) adopt a legal status for the Centrale d'Achat acceptable to the Borrower and the IDA (para. 2.27).

6.3 Recommendation. Subject to the above terms and conditions, the proposed project would be suitable for an IDA credit of SDR 17.9 million (US$27.8 million equivalent) to the Republic of Benin on standard IDA terms, with 40 years maturity.
### Republic of Benin

**Health and Population Project**

**Basic Indicators**

<table>
<thead>
<tr>
<th>Population</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population a/</td>
<td>5.0</td>
<td>million</td>
</tr>
<tr>
<td>Population Growth Rate b/</td>
<td>3.2%</td>
<td>per annum</td>
</tr>
<tr>
<td>Total Fertility Rate b/</td>
<td>7.1</td>
<td>children per woman</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education a/</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary School Enrollment - Total</td>
<td>66%</td>
<td>of relevant age group</td>
</tr>
<tr>
<td>Primary School Enrollment - Girls</td>
<td>39%</td>
<td>of relevant age group</td>
</tr>
<tr>
<td>Secondary School Enrollment - Total</td>
<td>12%</td>
<td>of relevant age group</td>
</tr>
<tr>
<td>Secondary School Enrollment - Girls</td>
<td>7%</td>
<td>of relevant age group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health c/</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude Birth Rate (CBR)</td>
<td>44</td>
<td>live births per thousand pop.</td>
</tr>
<tr>
<td>Crude Death Rate (CDR)</td>
<td>16.1</td>
<td>deaths per thousand pop.</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>89</td>
<td>per thousand live births</td>
</tr>
<tr>
<td>Life Expectancy at Birth</td>
<td>51</td>
<td>years</td>
</tr>
<tr>
<td>Coverage of deliveries d/</td>
<td>38%</td>
<td>persons</td>
</tr>
<tr>
<td>Population per National Physician</td>
<td>20.685</td>
<td>persons</td>
</tr>
<tr>
<td>Population per Physician (+foreigners)</td>
<td>18.693</td>
<td>persons</td>
</tr>
<tr>
<td>Population per Hospital Bed</td>
<td>2.429</td>
<td>persons per bed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional Status e/</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Malnutrition - Total</td>
<td>25%</td>
<td>of total population</td>
</tr>
<tr>
<td>Incidence of Malnutrition (children)</td>
<td>20 to 40%</td>
<td>of children under 5</td>
</tr>
<tr>
<td>Incidence of Anemia</td>
<td>16 to 75%</td>
<td>of total population</td>
</tr>
<tr>
<td>Incidence of Anemia (children)</td>
<td>54%</td>
<td>of children under 6 to 14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Water Supply f/</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Safe Water</td>
<td>49%</td>
<td>of the population</td>
</tr>
</tbody>
</table>

---

**Sources:**

- a/ World Development Report, 1994
- b/ Divisional Estimate, 1994
- c/ Health Sector Diagnostic Document, Benin, 1994
- d/ Poverty Assessment, 1994
- e/ Study on Malnutrition, Benin, 1984
- f/ Estimate of the Water Works Department, Benin, 1992
The health situation in the Republic of Benin is characterized by a high rate of morbidity and mortality. Average life expectancy at birth was 51 years in 1991. The crude mortality rate was 16.1 per 1,000, infant mortality rate was 89 per 1,000 live births and under-five mortality rate was 149 per 1,000 live births. The major causes of morbidity and mortality are tropical diseases, with a predominance of endemic of epidemic diseases (40% of the total). Malaria is the predominant infection, accounting for 27.1% of notified diseases. Diarrheas and gastroenteritis due to feco-oral transmission and poor hygiene are the second largest group of pathologies, followed by acute respiratory infections (14% of reported cases). Traumas of various types and anemia are the fourth and fifth most important causes of morbidity, respectively.

**Malaria.** The annual incidence rate of malaria in the general population is 57 per 1,000. It is 196 per 1,000 among infants, 89 per 1,000 among children aged between 1 and 4 years, and 45 per 1,000 among those aged 5 years. For cerebral malaria, the average annual incidence rate is 0.9 per 1,000 in the general population, 6 per 1,000 among infants, 2 per 1,000 among children aged between 1 and 4 years and 0.5 per 1,000 among children aged 5 years. There are no major differences in malaria incidence between departments in the northern areas (Borgou and Atacora) and those in the southern areas (Atlantic and Oueme).

**Diarrheal diseases.** These are most common in children under 5 years of age. A national household survey conducted in 1992 showed that 13% of deaths in this age group were related to episodes of diarrhea.

**Acute respiratory infections.** These include broncho-pulmonary and upper respiratory tract infections. They are predominantly seen in young children. Average annual incidence rate is 30.1 per 1,000 population, 154.3 per 1,000 among infants, 56.5% per 1,000 among children aged between 1 and 4 years and 19.2 among children older than 5 years.

**Traumas.** In 1992, traumas accounted for 6.33% of notified morbidities for all ages, including hospitalized and non-hospitalized cases. Average annual incidence rate is 13.7 per 1,000, with little variation among age groups. There were no major differences between departments, apart from Oueme, with 22.66 per 1,000 almost twice the national average.

**Diseases targeted by the Expanded Program on Immunization (EPI).** These are measles, poliomyelitis, tetanus diphtheria, pertussis and tuberculosis, with the addition of meningitis. The number of reported cases declined markedly from 13,413 in 1985 to 3,049 in 1992, despite an improvement in the notification of diseases. This decline was as a result of improved vaccination coverage during the same period, from 10% to almost 70%. While these results are encouraging results, the epidemiological surveillance system requires improvement through the adoption of standardized case definitions within the initiatives to eradicate poliomyelitis and tetanus and to reduce the incidence of measles.
Malnutrition. Several nutrition studies show that 25% of Benin's population is malnourished and that children and mothers are generally more severely affected. Estimates suggest that between 20% and 40% of children under five suffer from some degree of malnutrition and 3 to 6% are severely malnourished. These rates are high compared to those of countries with similar socio-economic and geographical features. Signs of vitamin A deficiency are present among the general population in the northern part of the country, but more recently similar deficiencies have been identified among school children in Cotonou. Iodine deficiency is known to be endemic in a number of areas of the country. Although symptoms of iron deficiency are very common among pregnant women and low birth weights are frequent, there are no reliable national-level data on which to base strategies and programs for nutrition interventions.

Anemia: These constituted 5.07% of notified diseases in 1992, all age groups included. The average annual incidence is 11.1 per 1,000 and highest among infants, 38.66 per 1,000.

Water and sanitation: About 50% of the population have access to potable water. In the rural areas, the sources of potable water are inadequate: 30% of the pumps installed are out of service and people resort to the use of surface water. About half of the population uses water from wells; bacteriological analysis revealed fecal pollution of about 75% of these wells. In general, little has been improved in improving sanitation. The annual national production of solid wastes is about 230,000 tons, about 65% of these from urban centers. While there are collection systems, the proportion of wastes collected is less than 23%. Industrial waste disposal is an urban problem, principally in Cotonou. There is a lack of an effective national program on sanitation.

Acquired Immune-Deficiency Syndrome (AIDS): Since 1986, the number of reported AIDS cases has increased from none to a total of 465. The male:female ratio has declined from about 3:1 between 1985-89 to about 2:1 in 1990-92, indicating a relative increase in the number of reported cases among females. The age group most affected includes young adults (20-39 years), who represent 60% of all cases. The predominant mode of transmission is heterosexual (79%) but there is an increasing number of vertical transmissions from mothers to neonates. A sentinel surveillance system began in 1990, focusing on pregnant women, clients of STD clinics, tuberculosis patients and blood donors, in the departments of Oueme, Atlantic, Borgou and Atacora.

Tuberculosis: Tuberculosis is a public health problem in Benin. It affects the most productive segment of the population, aged 20 to 50 years, and it is the most significant opportunistic infection among AIDS sufferers.
CURRENT STRUCTURE OF THE MINISTRY OF HEALTH

<table>
<thead>
<tr>
<th>Level</th>
<th>Administrative Division/Subdivision</th>
<th>Ministry of Health (MOH)</th>
<th>Intersectoral Coordination</th>
<th>Community Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administration</td>
<td>Health Facilities (pyramid of services)</td>
<td>National Committee for the Monitoring and Evaluation of Program Implementation (CNEEP)</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>National</td>
<td>Central Ministry of Health</td>
<td>National University Hospital Center</td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td>Department</td>
<td>Departmental Bureau of MOH (DDS)</td>
<td>Departmental Hospital Center</td>
<td>Departmental Committee for the Monitoring and Evaluation of Program Implementation (CDEEP)</td>
</tr>
<tr>
<td>Peripheral</td>
<td>Sub-prefecture or Urban Circumscription</td>
<td>Sub-prefectoral Health Centers (CSSP) and Urban Circumscription Health Centers (CSCU)—certified and non certified</td>
<td>Sub-prefecture Management Committee (COGES)</td>
<td></td>
</tr>
<tr>
<td>Commune</td>
<td></td>
<td>Communal Health Centers (CCS)</td>
<td>Communal Management Committee (COGEC)</td>
<td></td>
</tr>
<tr>
<td>Quarter</td>
<td></td>
<td>Village Health Posts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Estimates of Additional Personnel

**By Level and by Category**

#### Simulation des bescins en agents de santé, option basse

<table>
<thead>
<tr>
<th>Corps</th>
<th>ATA</th>
<th>COR</th>
<th>ATL</th>
<th>ANTI</th>
<th>BOR</th>
<th>GOU</th>
<th>MON</th>
<th>QUE</th>
<th>ME</th>
<th>ZOU</th>
<th>PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med. Généralistes</td>
<td>20</td>
<td>17</td>
<td>33</td>
<td>90</td>
<td>22</td>
<td>14</td>
<td>15</td>
<td>18</td>
<td>33</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>Chirurgien</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Gynécologue</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>Pédiatre</td>
<td>4</td>
<td>7</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Infirmier</td>
<td>140</td>
<td>22</td>
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<td>951</td>
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## MOH’S EVOLUTION BUDGET (current prices)

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<th>Years</th>
<th>National Budget of CFA (billions)</th>
<th>MOH’s Budget %</th>
<th>of which Salaries (billions) %</th>
<th>of which recurrent expenses (billions) %</th>
<th>Health Expenses per inhabitant (CFA)</th>
<th>Share of Health Budget/ National Budget (%)</th>
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<td>30</td>
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<td>3.9</td>
<td>62</td>
<td>2.4</td>
<td>38</td>
<td>1.5</td>
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<tr>
<td>1995</td>
<td>108.0</td>
<td>4.2</td>
<td>62</td>
<td>2.6</td>
<td>38</td>
<td>1.6</td>
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</table>

## PUBLIC BUDGET FOR HEALTH: ALLOCATION AND EXPENDITURES 94-95 (in billions of CFA)

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<thead>
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<th></th>
<th>1994 Budget</th>
<th>1995 Budget</th>
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</thead>
<tbody>
<tr>
<td>Total Current Budget</td>
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<td>108.0</td>
</tr>
<tr>
<td>MOH Current Budget</td>
<td>3.9</td>
<td>4.2</td>
</tr>
<tr>
<td>of which for: personnel</td>
<td>(2.4)</td>
<td>(2.6)</td>
</tr>
<tr>
<td>non salary</td>
<td>(1.5)</td>
<td>(1.6)</td>
</tr>
<tr>
<td>As % of total current budget</td>
<td>3.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Other budget allocations for the health (&quot;charges non réparties&quot;)</td>
<td>4.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Total Budget for Health</td>
<td>8.2</td>
<td>8.6</td>
</tr>
<tr>
<td>as % of total current budget</td>
<td>7.7</td>
<td>8.0%</td>
</tr>
<tr>
<td>Salaries as % of MOH current budget</td>
<td>62</td>
<td>62%</td>
</tr>
<tr>
<td>Salaries as % of total current budget allocated for health</td>
<td>29</td>
<td>30%</td>
</tr>
</tbody>
</table>
REPUBLIC OF BENIN
HEALTH AND POPULATION PROJECT

EVOLUTION OF HEALTH SECTOR FINANCING

I. Context for Health Sector Financing

Benin’s health service delivery system is complex and comprises several sub-systems, including the following:

- public sector health services, comprising services offered by the Ministry of Health and those of the armed forces for eligible persons;
- parapublic services, essentially CNPS and certain state enterprises;
- private care, including private enterprises, private physicians (located for the most part in Cotonou), and the not-for-profit/confessional hospitals and health centers, and
- traditional healers.

All of these sub-systems use different methods for financing health services; until recently, only the public sector health services did not require some kind of formal patient payment.

Introduction of cost recovery was made imperative by Benin’s economic crisis during the latter 80’s, but it has occurred without a broader examination of various co-financing strategies.

Economic context

Over the past ten years, Benin’s economy has undergone profound change. From 1984-1989, the economy grew at about 1.25% per year (compared with population growth of about 3% per year); per capita income declined by more than 10% in absolute terms. Since 1990, the economy has grown at about 6% per year.

The Ministry of Health’s budget, like those of other ministries, was cut substantially beginning in 1987, dropping from 8-9% of the national budget to 3-4% in the early nineties. While there have been small increases since, MOH’s budget is far from reaching its former (budgeted) levels.

Sector financing

At the same time that Government’s contribution to public sector health services has declined, cost recovery and external donor assistance have dramatically increased. While there have been attempts to define the roles and responsibilities of the various sources of financing, the discussion has been complicated by a lack of data. While the information available is far from complete, this report indicates the overall picture, focusing on the government’s budget, internal cost-recovery and external donor support.
II. Government Financing

Government financing of public health services in Benin shares a number of characteristics with neighboring countries, including:

- a centralized budget preparation process which ultimately precludes participation and negotiation;
- limited possibilities (given the weight of salary costs) to reallocate resources; and
- delayed and/or reduced authorization to spend which, combined with the usual administrative delays associated with the procurement of goods and services, effectively reduces the actual amounts spent in a given year.

To these problems, Benin has added an additional obstacle to the analysis by establishing two types of investment budgets and three types of operating budgets (for two of which MOH has no information on actual expenditures).

The "loss" of financial resources to the sector from request to authorization to actual expenditure is presented in the table below:

Table 1: Budgeted, Authorized and Expended Resources in Health Sector
(in millions of CFAF)

<table>
<thead>
<tr>
<th></th>
<th>90</th>
<th>91</th>
<th>92</th>
<th>93</th>
<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
<th>98</th>
<th>99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested</td>
<td>5,147</td>
<td>5,836</td>
<td>7,567</td>
<td>6,002</td>
<td>9,228</td>
<td>8,774</td>
<td>9,490</td>
<td>10,269</td>
<td>11,118</td>
<td>12,043</td>
</tr>
<tr>
<td>Authorized</td>
<td>3,652</td>
<td>4,189</td>
<td>5,351</td>
<td>4,530</td>
<td>6,900</td>
<td>7,098</td>
<td>7,676</td>
<td>8,305</td>
<td>8,990</td>
<td>9,736</td>
</tr>
<tr>
<td>Spent</td>
<td>3,023</td>
<td>3,459</td>
<td>4,331</td>
<td>3,757</td>
<td>5,457</td>
<td>5,881</td>
<td>6,448</td>
<td>7,073</td>
<td>7,577</td>
<td>8,246</td>
</tr>
</tbody>
</table>

The last line assumes the proportion of expenditures for the period 1995-99 increasing from 80% to 95% as a means for indicating potential gains simply by spending authorized funds.

III. Community financing

Community financing comprises two principal sources of revenues: taxes which have traditionally been collected and redistributed locally for a number of community works (including health infrastructure and salaries) and cost recovery (introduced in selected health centers beginning in 1988 and generalized since 1990). No systematic evaluation of community financing has been carried out, but partial information from several sources provide the information presented in the following table.
Table 2: Sources and Amounts of Community Financing of Health Services  
(in millions of CFA)

<table>
<thead>
<tr>
<th></th>
<th>90</th>
<th>91</th>
<th>92</th>
<th>93</th>
<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
<th>98</th>
<th>99</th>
</tr>
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<tbody>
<tr>
<td>Local taxes</td>
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<td>136</td>
<td>136</td>
<td>136</td>
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<td>136</td>
<td>136</td>
<td>136</td>
<td>136</td>
<td>136</td>
</tr>
<tr>
<td>Cost rec.</td>
<td>1,912</td>
<td>1,989</td>
<td>2,435</td>
<td>2,795</td>
<td>2,823</td>
<td>3,529</td>
<td>3,882</td>
<td>4,270</td>
<td>4,697</td>
<td>5,167</td>
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<tr>
<td>Total</td>
<td>2,048</td>
<td>2,135</td>
<td>2,571</td>
<td>2,931</td>
<td>2,959</td>
<td>3,665</td>
<td>4,018</td>
<td>4,406</td>
<td>4,833</td>
<td>5,303</td>
</tr>
</tbody>
</table>

The rapid growth projected for 1995 anticipates a 25% increase in drugs, which has been deferred since the devaluation of January 1994 but which will take effect in 1995.

IV. **Donor Financing**

External financing of Benin’s health sector activities comprises the traditional multilateral donors, an increasing range of bilateral assistance, and growing support from (local and international) non governmental organizations. The establishment in 1993 of a three-year rolling plan process for identifying external health sector financing allows for certain precision in estimating the availability of financial resources for the health sector. The following table estimates existing and probable sector financing over the project period:

Table 3: Donor Financing of the Health Sector by Type of Financing  
(in millions of CFA)

<table>
<thead>
<tr>
<th></th>
<th>90</th>
<th>91</th>
<th>92</th>
<th>93</th>
<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
<th>98</th>
<th>99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilat.</td>
<td>4,245</td>
<td>7,142</td>
<td>6,926</td>
<td>6,978</td>
<td>4,927</td>
<td>2,714</td>
<td>582</td>
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<td></td>
<td></td>
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<tr>
<td>Bilateral</td>
<td>1,147</td>
<td>2,904</td>
<td>5,468</td>
<td>6,548</td>
<td>5,930</td>
<td>4,757</td>
<td>2,683</td>
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<tr>
<td>NGO</td>
<td>312</td>
<td>209</td>
<td>186</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,392</td>
<td>10,358</td>
<td>12,603</td>
<td>13,718</td>
<td>10,857</td>
<td>7,451</td>
<td>3,265</td>
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</table>

While the amounts of donor financing are significant, local absorptive capacity remains low (50% in 1993) resulting in underutilization of external assistance. The three-year rolling plan takes this factor into account making a distinction between donor funding in hand (and therefore available) and donor funding actually expended. These results are presented in the following table:

Table 4 Available and Expended Donor Financing (absorptive capacity)

<table>
<thead>
<tr>
<th></th>
<th>90</th>
<th>91</th>
<th>92</th>
<th>93</th>
<th>94</th>
<th>95</th>
<th>96</th>
<th>97</th>
<th>98</th>
<th>99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>6,111</td>
<td>10,352</td>
<td>11,339</td>
<td>10,655</td>
<td>15,230</td>
<td>10,177</td>
<td>4,734</td>
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<tr>
<td>Expended</td>
<td>3,577</td>
<td>5,236</td>
<td>5,499</td>
<td>5,328</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% expended</td>
<td>59</td>
<td>51</td>
<td>48</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

IV. **Conclusions**

The table on the next page summarizes the results presented here so as to indicate the funding gap.
# Estimation des Coûts, Financements et Gap de Financement

**Secteur Santé**

(In Million of CFA)

<table>
<thead>
<tr>
<th>1. Cout estimatif des besoins</th>
<th>11 268</th>
<th>16 188</th>
<th>18 906</th>
<th>16 657</th>
<th>21 458</th>
<th>47 204</th>
<th>30 612</th>
<th>38 754</th>
<th>26 291</th>
<th>35 475</th>
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<td>6 836</td>
<td>7 567</td>
<td>6 002</td>
<td>9 228</td>
<td>8 774</td>
<td>9 490</td>
<td>10 269</td>
<td>11 118</td>
<td>12 043</td>
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<td>183</td>
<td>215</td>
<td>219</td>
<td>274</td>
<td>286</td>
<td>299</td>
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<td>327</td>
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<td>6 602</td>
<td>7 384</td>
<td>5 797</td>
<td>9 009</td>
<td>8 500</td>
<td>9 204</td>
<td>9 970</td>
<td>10 805</td>
<td>11 716</td>
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<td>10 352</td>
<td>11 339</td>
<td>10 655</td>
<td>12 230</td>
<td>38 430</td>
<td>21 122</td>
<td>28 485</td>
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<td>1.2.2. Besoins sollicités, non financés</td>
<td>6 111</td>
<td>10 352</td>
<td>11 339</td>
<td>10 655</td>
<td>12 230</td>
<td>37 707</td>
<td>20 873</td>
<td>28 253</td>
<td>15 061</td>
<td>23 320</td>
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Estimated costs

Line 1.1 estimates needs as expressed by health sector personnel assuming no significant changes in Government policy.

Line 1.2 estimates additional needs which have not been taken into account by health sector personnel. Line 1.2.1 (for which no data exist) represents all of those real costs which are already budgeted, always underestimated, and never financed (such as amortization of buildings and equipment; losses, breakage and theft; etc.). Line 1.2.2 estimates those costs associated with the proposed reforms as well as those linked to program improvement and expansion.

Available financing

Line 2.1.1 calculates the Government’s contribution to sector financing based on actual expenditures for 1990-93 and projected expenditures for the period 1994-99.

Line 2.1.2 estimates the evolution of community financing assuming no growth in local tax contributions but sharp growth in cost recovery resulting from increased utilization of health services and from improved accounting procedures.

Line 2.2 estimates on the basis of the results of the last four three-year rolling plans (for 1991-93 through 1994-96) the evolution of external financing and local absorption of that financing.

Financing Gap

Line 3.1 estimates the theoretical financing gap between estimated needs (Line 1) and available financing (Lines 2.1.1, 2.1.2 and 2.2.1.1).

Line 3.2 estimates the real financing gap between estimated needs (Line 1) and expended financing (Lines 2.1.1, 2.2.2 and 2.2.1.2).

IDA’s contribution to the health sector through the Health and Population Project would reduce the theoretical funding gap substantially.
Background

To improve the efficiency and effectiveness with which the numerous nutrition activities have been carried out, a National Committee for Food and Nutrition (Comité National pour l'Alimentation et la Nutrition -- CNAN) was created by Decree No. 94-103 of April 12, 1994, which sets up a much needed institutional framework for the coordination of food and nutrition activities in Benin. The officers of the CNAN include: the Minister of Rural Development (Chair), the Minister of Health (vice-Chair), the Director of Food and Applied Nutrition (DANA) of the Ministry of Rural Health (Secretary), and the Director of Prevention and Health Promotion, Ministry of Health (Rapporteur). Members include representatives of other (central and line) ministries and other national partners, such as the university, research institutions, chambers of commerce and of agriculture, consumer associations and NGOs. The purpose of this committee is to coordinate and to encourage and manage the complementarities of the interventions of its numerous and varied members in order to achieve Benin's objectives to reduce malnutrition and to increase the food security of its population.

On December 27-28, 1994, a workshop was held in Cotonou to inaugurate the CNAN and to adopt a national plan of action for food and nutrition (Plan d'action national pour l'alimentation et la nutrition -- PANAN). This plan of action had been developed and reviewed by members of the CNAN over a series of work sessions and workshops and thus reflects the spectrum of experiences and perspectives of the group, including the university, NGOs, research institutions, as well as the various planners and implementors in the participating ministries. The inauguration of the CNAN and the development and adoption of a plan of action are very significant and long overdue actions. The Government has now put into place both an organizational and a strategic framework within which all food security and nutrition activities would be coordinated. It is important that the Bank's efforts in this area are fully cognizant and supportive of this framework. This annex presents a brief overview of Benin's PANAN and describes how the IDA-financed Food Security Project and the proposed Health and Population project support its implementation.

National Plan of Action for Food and Nutrition (PANAN)

The three main objectives of the PNAN are: (1) to guarantee to all citizens a constant, reliable diet that is healthy and nutritious; (2) to provide all citizens with the possibility to achieve and maintain good health and nutritional wellbeing; and (3) to strive for a socially sustainable development, which would not threaten the environment, as a means of improving the health and nutritional status of the population. The PANAN sets out a series of indicators to monitor progress in implementing these objectives, grouped into the following categories: food shortages, household food security, malnutrition/infectious disease links, micronutrient deficiencies, chronic disease, food security, population's capacity to combat threats to nutritional health and food security, and living conditions.

Nine strategies (and over 80 activities) are identified in the plan as a means of achieving these objectives. The strategies call for:
integration of nutrition objectives into development policies and programs;

(2) improvement of household food security, including:

(a) development of the rural sector;
(b) improvement of household access to food products;

(3) evaluation, analysis and surveillance of nutritional status;

(4) improvement of the quality and healthy properties of food, including:

(a) legal measures to assure quality;
(b) development of quality control mechanisms;
(c) sensitization of producers, wholesalers and consumers;

(5) prevention and treatment of infectious and parasitic disease;

(6) promotion of breastfeeding;

(7) targeting of groups who are socioeconomically disadvantaged and/or who are vulnerable with regard to their nutrition status;

(8) prevention of micronutrient deficiencies; and

(9) promotion of appropriate diets and healthy life styles.

The Food Security project and the proposed Health and Population project are complementary in that they are building the capacities of different institutions and agencies -- centralized and decentralized -- to enable them to fulfill their respective mandates in carrying out the PANAN. The Food Security project focuses on strengthening the capacities of: the Ministry of Rural Development (particularly DANA), various NGOs and communities. The proposed Health and Population project is strengthening the capacity of the MOH (particularly the Nutrition Service of the newly established Directorate for Family Health) and relevant health services; and it will maximize its contribution by also working through organs within the Ministry for intersectoral coordination (CNEEP/CDEEP) and community participation (COGES/COGEC). Each project intervention is described below, followed by a brief description of areas for collaboration between these two projects.

Food Security Project

This project is assisting the Government to improve the food security and nutrition standards of about 20 sub-prefectures. Covering all nine strategies of the PANAN, it aims at (a) improving the income base of those groups through new income generating opportunities and regular access to food in the more risky areas through simple agricultural, commercial, fisheries, peri-urban and socio-economic activities; (b) reducing malnutrition rates with particular focus on children under five years and pregnant and lactating women; and (c) strengthening the capacity of the Ministry of Rural Development in food security planning, monitoring and evaluation.

Within the limits of identified local implementation capabilities, the proposed project would extend and develop the approach and the activities initiated during the pilot phase. It would support
target groups in preparing, implementing and managing activities aimed at improving their food security and nutrition situation. The approach would build on specific constraints, aiming at their solution through the empowerment of local communities with particular emphasis on women’s groups, who are key actors in the implementation of food security strategies. Activities would comprise: (a) community support for local development initiatives, including (i) income generating activities benefitting rural groups for small agricultural projects and livestock raising techniques, food processing, small trading and marketing; (ii) small constructions and other rural works of a productive nature such as local storage and conservation facilities, bottom-land development, watershed management or tree nurseries; and (iii) improvement of small infrastructure with direct local participation, improvement of village access and feeder roads, anti-erosion works, livestock watering points, and rehabilitation of market infrastructure; (b) nutrition activities for the improvement of the nutritional status of women and children in the target populations, thorough education, growth monitoring, supplementary feeding and referral to health rehabilitation centers when required; and (c) institution building and coordination of field activities, including (i) strengthening of the food security planning and monitoring capacity, updating of the data base on vulnerable populations and information systems; and (ii) implementation and monitoring of field interventions.

**Proposed Health and Population Project**

One objective of this project is to render the MOH capable of effectively contributing to the implementation of selected strategies and the achievement of national nutrition objectives as laid out in the CNAN and the PANAN. An important outcome of the recent reorganization of the MOH has been the creation of a new Directorate of Family Health, within which a new service in charge of nutrition has been established. The project will strengthen the capacity of this nutrition service, both at the central and departmental levels, to enable it to serve effectively as the focal point of MOH’s contribution to the PANAN. And it will strengthen capacity of service providers to play their role in the prevention and treatment of malnutrition and in the promotion of improved nutrition status. Specific project interventions, described in paras. 3.11 and 3.12 of this report, will support: (a) the proposed national malnutrition prevalence study to strengthen the basis for program planning, resource allocation and program evaluation; (b) the development of a sentinel surveillance system to monitor trends in the magnitude of deficiencies in priority population groups; (c) strengthening of service provider capacity in the diagnosis, treatment and prevention of malnutrition; and (d) strengthening of promotional activities to increase public awareness of nutrition problems and to encourage behavior change to prevent them.

**Areas for Collaboration between the Two IDA Interventions**

The following have been identified as opportunities for coordination and collaboration between the two IDA-financed projects. These opportunities will be pursued during the course of implementation of both of these operations.

(a) establishment of mechanisms of coordination and collaboration between the health facilities (to be strengthened under the Health and Population project) and the community nutrition workers (CNW) (to be created under the Food Security project) in the areas of: effective referral and treatment of severely malnourished patients; development and delivery of information, education and communication messages for improving nutritional status.

(b) coordination and sharing of information on nutrition surveillance and monitoring and evaluation of nutrition activities.
(c) Effective use, particularly at the field level, of already established health sector mechanisms for intersectoral coordination (CNEEP/CDEEP) and for community participation (COGES/COGEC), which also accommodate the involvement of other key partners (NGOs, research institutions, other key sectors, the university).
The Minister of Finance
to:

The President of the International Development Association
1818 H Street, NW
Washington, DC 20433
USA


Mr. President,

1. In the context of the implementation of the Health and Population Project, I am pleased to present, on behalf of the Government of Benin, the National Health Strategy Letter.

2. A hot and humid country in West Africa, the Republic of Benin has a total area of 112,622 km². The 1992 population census estimated the population size at 4,915,555 inhabitants in a country in which the health situation is characterized by a varied tropical pathology with a predominance of communicable and parasitic diseases.

3. In the framework of developing its health sector, the Republic of Benin implemented, from 1989-1993, a health strategy which placed priority on:

   (a) preventive activities (vaccinations, maternal and child health, family planning, hygiene and sanitation, information, education, and communication, etc.);

   (b) curative activities with the establishment of a pharmaceutical policy for essential generic drugs;

   (c) rehabilitation/construction of health facilities;

   (d) prevention and control of sexually-transmitted diseases (STDs) and Acquired Immune Deficiency Syndrome (AIDS).

4. The action program, which was developed and implemented during this period, enabled the following to be accomplished:
(a) the restructuring of the Ministry of Health including the creation of three new directorates at the central level (Directorate of Planning, Coordination and Evaluation, Directorate of Administrative and Financial Services, and Directorate of Family Health); and their corresponding services at the Departmental Health Directorate (DDS) level;

(b) the development and implementation of a pharmaceutical policy including a master plan and a priority action plan, marked by the creation and operation of the Central Procurement Agency for essential drugs (*Centrale d’Achat des médicaments essentiels*) through which essential drugs are always available at an affordable price, and at all levels of the health pyramid;

(c) the expansion, nationwide, of the community financing/cost recovery system and the creation of the commune and prefectoral-level management committees (COGEC and COGES), through which the communities manage the funds generated through cost recovery and participate in the planning, execution and evaluation of the activities carried out by the health facilities;

(d) the establishment of important planning and management tools (*Three-year Development Plan, Health Facility Mapping, National Health Information and Management System, Computerized Personnel Management System*);

(e) the establishment of mechanisms to bring about and facilitate the participation of various partners in the planning, coordination and evaluation of sector activities (*Comité National de Suivi de l’Exécution et d’Evaluation des Programmes du secteur santé [CNEEP] and Comité Départemental de Suivi de l’Exécution et d’Evaluation des Programmes du secteur santé [CDEEP]*);

(f) the establishment of programs for maternal and child health/family planning/nutrition and an early warning system for detecting high risk pregnancies for promoting safe motherhood;

(g) the improvement in vaccination coverage (from 10% to more than 70%), which allowed the Republic of Benin to win the WHO Comlan Alfred Quenum Prize in 1992 and brought about the considerable reduction in targeted illnesses of the Expanded Program of Immunization; and

(h) the intensification of the prevention and control of malaria, diarrhea, STDs and AIDS.

5. Despite these notable improvements, there are persisting problems which obstruct the proper functioning of the health system. Some of these are:
(a) the still inadequate reception of patients at health facilities and low accessibility and quality of the services;

(b) insufficient skills and a weak system for management and financial control;

(c) inadequacies in sector organization and management;

(d) the under-financing of the sector by intervening parties;

(e) a mismatch between the demographic growth and the economic growth of the country;

(f) the poor functioning of the referral system;

(g) the still timid nature of community participation;

(h) the low usage in the sector of the tools and mechanisms for planning, monitoring, evaluation, coordination, and sector dialogue; and

(i) the inadequate human resources in light of sector needs.

6. In order to efficiently face such a worrying situation, and to rise to the challenge of Health for All by the year 2000, the Republic of Benin, in compliance with the conclusions of the Health Sector Round Table, which took place in Cotonou on January 12 and 13, 1995, has embarked on a new National Health Strategy for the period 1995-1999. The principal reform measures encapsulated in this strategy are the following:

(a) Improving the quality, efficiency, and coverage of services by: the streamlining and strengthening of the referral system, the strengthening of priority programs and services and the consolidation of successes in the area of essential drugs supply, with a view to improving, at all levels of the system, the quality, cost-effectiveness, accessibility and affordability of basic health services;

(b) Improving the organization, management and administration in the sector by: the consolidation and decentralization of the organization, management and administration with a view to making the sector more efficient and more operational, with particular attention to the strengthening of the planning, coordination, mobilization and management of sector resources, including personnel, materials, and finances, as well as the progressive establishment of health districts (zones sanitaires); and

(c) Strengthening of the partnerships by: the expansion and strengthening of the partnerships in health (intersectoral coordination, community participation, integration of private sector activities) with a view to
achieving an optimal contribution of the different actors in sector management and delivery.

7. These measures will be, for the most part, developed in a document, which will be adopted by the CNEEP before December 31, 1995. The guiding principles which will support these measures are the following:

   (a) take into account the economic and institutional successes in order to reduce the systemic constraints;

   (b) take into account the real needs expressed by the populations in the sector planning and management systems;

   (c) establish monitoring and evaluation indicators in order to assess sector performance regularly in conjunction with the beneficiaries;

   (d) guarantee access to quality services to the entire population;

   (e) make available quality, low cost essential drugs to the population;

   (f) streamline the health system, including the referral services, from the periphery to the central level, by developing health districts, reinforcing decentralization, and improving resource management, and by bringing the private, non-profit health sector together with the public health system;

   (g) integrate progressively the different health services and programs at the health district and CCS levels, based on the primary health care approach;

   (h) harmonize the self-financing procedures at each level of the health pyramid, with a view to ensuring equality and equity;

   (i) strengthen community participation in management and decision making at the health facility level;

   (j) strengthen the intra- and intersectoral collaboration as well as the coordination of the interventions of the various partners active in the sector.

8. The principle actions that the Republic of Benin intends to take in the context of implementing this strategy are the following:

   (a) With regard to improving the quality, efficiency, and coverage of services, the Republic of Benin will:

       (1) strengthen referral services by:
(i) redefining the physical and technical norms and standards for each service level;

(ii) adapting the roles and functions of the different structures of the health pyramid in the context of decentralization and the gradual establishment of the health districts;

(iii) elaborating the norms and care practices at each level of the health pyramid before January 1, 1997;

(iv) establishing a therapeutic referral protocol between the patient care levels;

(v) continuing the rehabilitation program of health facilities;

(vi) establishing two health districts per department during the first phase including: the establishment of the support unit for the development of the districts before September 1995; the evaluation of phase one health districts, the results of which will determine the future actions for establishing other health districts; and inventory of district hospitals with a view to strengthening their technical capacity and their materials;

(vii) undertaking the study on the quality of services and hospital management.

(2) support the priority health programs and services by:

(i) executing the minimum package of services, which encompasses preventive, promotional, and curative activities, including the development of three action plans for implementation of the health components of:

- the national population policy, which will be approved by the Council of Ministers before November 30, 1995;
- the national nutrition action plan; and
- the public hygiene code (Law No. 87-015 of September 21, 1987)

(ii) organizing knowledge, aptitude and practice (KAP) surveys/operational research/
epidemiological studies to better determine and respond to the health problems;

(iii) evaluating the impact of the Information, Education and Communication (IEC) program on the various segments of the population and preparing an action plan to improve the efficiency of the impact of these activities.

(3) strengthen the essential generic drug program by:

(i) adopting, before September 30, 1995, the permanent statutes of the Centrale d'Achat taking into account the following principles:
- the Centrale d'Achat must have sufficient financial and managerial autonomy in order to allow it to carry out its mandate in an efficient and effective manner;
- all partners must be represented in the Centrale d'Achat, most notably, the Government, communities and other partners in health sector development;

(ii) preparing a regulatory reform plan for the pharmaceutical sub-sector before September 30, 1996;

(iii) defining a new price list for essential drugs in the public sector before December 31, 1995.

(b) With regard to sector organization, management, and administration, the Republic of Benin will:

(i) decentralize the health system right to the very lowest level (central, intermediary, and district levels);

(ii) strengthen sector organization and management by supporting the Directorate of Administrative and Financial Services, the Directorate of Planning, Coordination, and Evaluation, and the Directorate of Family Health and their corresponding services at the DDS;

(iii) strengthen community mobilization by updating, before December 31, 1995, the texts regulating these entities, and ensuring training and regular support to the members and by integrating them
more directly into planning, implementation and evaluation of health activities;

(iv) revitalize the entities charged with monitoring and execution of the programs (CNEEP and CDEEP);

(v) develop human resources by:
- revising human resource norms for each level of health services in light of the new institutional reforms (decentralization and streamlining the referral system, etc.);
- preparing the descriptions and profiles for all posts;
- establishing an action plan for the implementation of new standards;
- recruiting contractual staff in accordance with appropriate selection procedures;
- filling key posts in the three new central directorates and in their corresponding services at the DDS level by May 30, 1995 at the latest, taking into account the competencies available;

(vi) decentralize the responsibilities for recruitment and management of human resources;

(vii) assure improved financing of the sector by:
- undertaking a study in 1995 which clarifies the real contributive capacity of the different partners, which will provide the basis for the definition of a new sector financing policy;
- defining in 1996 a budgetary and accounting system appropriate to the various levels of the health system;
- progressively increasing the health sector share of the national current budget;

(viii) assure a better utilization of the planning tools such as the Three-year Development Plan, Health Facility Mapping, the Technical Cooperation Program, the National Health Information and Management System, etc.

(c) With regard to strengthening partnerships in health, the Republic of Benin will:
(i) revise, prior to December 31, 1995, the text regulating the CNEEP, the CDEEP, the COGEZ, the COGES and the COGEC in order to improve their efficiency and performance;

(ii) take into account the services of the private sector in the organization of the referral system and in the organization of training, supervision, and monitoring activities for better health coverage; and

(iii) involve the private sector in the coordination, cooperation and monitoring of sector programs.

9. During the implementation of this strategy, the Government of the Republic of Benin envisages undertaking annual reviews of the periodic evaluations. The lessons learned from this process will allow for constant improvement in performance.

10. In order to correctly implement this strategy and its medium-term action plan, the Government of the Republic of Benin solicits the technical and financial support of the International Development Association in order to implement the Health and Population Project, which was initiated in order to assist the Government to implement its health policy.

11. The above are the general orientations and the strategies defined by the Government for the implementation of the health policy of the Republic of Benin for which I solicit the financial support of the International Development Association in order to implement the Health and Population Project.

Sincerely,
### Proposed Structure for the Reformed Health System

<table>
<thead>
<tr>
<th>Level</th>
<th>Administrative Division/Subdivision</th>
<th>Ministry of Health (MOH)</th>
<th>Organizational Framework for Partnerships (including intersectoral coordination and community participation)</th>
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<td>National</td>
<td>Central Ministry of Health</td>
<td>National University Hospital Center: (3rd level of referral)</td>
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<td>National Committee for the Monitoring and Evaluation of Program Implementation (CNEEP)</td>
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<td>Departmental Bureau of MOH (DDS)</td>
<td>Departmental Hospital Centers: (2nd level of referral)</td>
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<td>Health District <em>(Zone sanitaire)</em></td>
<td>District Hospitals <em>(hopitaux de zone)</em> (1st level of referral)</td>
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<td>Administration</td>
<td>Sub-prefectoral Management Committee (COGES)</td>
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<td>Communal Management Committee (COGEC)</td>
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**NOTES**

- **Pre-Intermediary**: This column should be filled in by the donor agency.
- **Post-Intermediary**: This column should be filled in by the implementing agency.
- **Additional Comments**: Any additional comments or notes should be included here.

**Total**

- **Pre-Intermediary**: 120
- **Post-Intermediary**: 110
- **Additional Comments**: None

---

**Table of Financial Commitments**

**Health and Population Project**

**Republic of Benin**

---

**Page 1 of 1**

**Annex 11**
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of which:

- in center: 38 (18%)
- DDS: 94 (43%)
- facility based: 85 (39%)
### Republic of Benin
#### Health and Population Project

**Project Summary Costs and Financing**

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\* Y compris eau, electricity et telephone

---

*Med May 03 08:18:35 1995*
### A. Développement des Services et Programmes de Planning Familial

1. Promotion et expansion de la politique de population
   - Prog. 11 Planification familiale
   - Prog. 14 Maternité sans risque
   - Prog. 9 Surveillance de l’enfant

2. Services et soins en matière de PF
   - Prog. 17 Tuberculose
   - Prog. 19 MTI/SIDA
   - Prog. 20 Maladie bucco-dentaire

3. Subtotal Services et soins en matière de PF

### B. Amélioration de la qualité et de l’efficacité des services prioritaires

1. Renforcement des programmes prioritaires
   - a. Lutte contre les maladies
     - Prog. 10 Nutrition
     - Prog. 11 Tuberculose
     - Prog. 13 MST/SIDA

   - b. Activités de promotion
     - Prog. 20 Maladie bucco-dentaire

   - c. Subtotal lutte contre les maladies

   - d. Activités de promenade
     - Prog. 20 Maladie bucco-dentaire

   - e. Subtotal Activités de promotion

2. Renforcement du système de finance
   - Prog. 2 Réhabilitation/Développement des infrastructures sanitaires

3. Subtotal amélioration de la qualité et de l’efficacité des services prioritaires

### C. Renforcement de la gestion et de l’administration du secteur

1. Déscentralisation
   - Prog. 26 Renforcement des capacités de planification/programmation des programmes

2. Renforcement des capacités de gestion
   - Prog. 23 Développement des capacités de mobilisation sociale IRC/FRS
   - Prog. 24 Hygiène et environnement
   - Prog. 29 Développement des capacités de recherche
   - Prog. 30 Mobilisation du financement du secteur
   - Prog. 32 Rationalisation de la gestion du personnel

3. Subtotal renforcement des capacités de gestion

4. Renforcement du sous-secteur pharmaceutique
   - Prog. 4 Planification du circuit d’approvisionnement des médicaments
   - Prog. 5 Renforcement du secteur pharmaceutique

5. Subtotal renforcement du sous-secteur pharmaceutique

6. Subtotal renforcement de la gestion et de l’administration du secteur

### D. Renforcement du partenariat dans le secteur de la santé

1. Renforcement du partenariat pour la coordination et l’évaluation des programmes de santé
   - Prog. 36 CHEP/CHEP/CHEP/CHEP/CHEP/CHEP

2. Subtotal renforcement du partenariat dans le secteur de la santé

### E. Gestion du projet

1. Coordonnation du projet
   - Prog. 0 Coordination et gestion du projet

2. Subtotal gestion du projet

### F. Total BASELINE COSTS

- Total BASELINE COSTS
- Physical Contingencies
- Price Contingencies
- Total PROJECT COSTS

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- **% Total Base:**
- **% Local:**
- **% Foreign:**

**Exchange Costs:**

- **Local:**
- **Foreign:**
- **Total:**

**Page 2 of 16**

**ANNEX 3**

**PROJECT COST SUMMARY**

**Wed May 03 08:18:28 1995**
### PROJECT COMPONENTS BY YEAR

#### Project Components by Year

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**Notes:**
- Costs are in USD '000.
- Data as of May 95.

**Source:**
- ANNEX 13
- Page 3 of 6
## PROJECT AREAS BY IMPLEMENTING AGENCIES

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Wed May 03 08:17:42 1995
# EXPENDITURE ACCOUNTS BY FINANCIERS

## EXPENDITURE ACCOUNTS BY FINANCIERS

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### I. Investment Costs

**A. Génie civil**
- **Construction/Rehabilitation CCS:** 762.3 77.3 44.5 4.7 177.5 2.9 986.3 154.8 177.5
- **Construction/Rehabilitation HD:** 1,223.7 82.0 - 269.6 18.0 1,492.3 4.5 1,223.7 154.8
- **Construction/Rehabilitation CSSP:** 200.1 77.3 12.2 4.7 46.6 18.0 258.9 0.8 653.9
- **Construction/Rehabilitation DDS:** 337.0 82.0 - 74.0 18.0 431.0 1.2 337.0 74.0
- **Construction/Rehabilitation Ges:** 137.0 82.0 - 74.0 18.0 431.0 1.2 337.0 74.0
- **Achievement Ministere Sante:** 365.2 82.0 - 74.0 18.0 445.3 1.3 365.2 82.0
- **Façade architecture:** 188.0 94.0 - 12.0 6.0 200.0 0.6 188.0 - 12.0

**Subtotal Génie civil:** 3,076.3 81.1 58.7 154.8 177.5

**B. Biens**
- **Materiel et consommables:** 860.2 82.0 - 188.8 18.0 1,049.0 3.1 860.2
- **Equipements medico-technique:** 1,672.8 82.0 - 367.2 18.0 2,039.9 6.1 1,672.8
- **Equipements:** 1,692.2 82.1 - 368.5 17.9 2,060.7 6.2 1,692.2
- **Mobilier de bureau:** 79.5 82.3 - 17.1 17.7 96.6 0.3 78.4

**Subtotal Biens:** 6,831.0 78.6 436.0 154.8 1,295.9

**C. Etude et recherches**
- **Etude et recherches:** 1,507.8 94.0 - 96.2 6.0 1,604.0 4.8 1,496.3

**Subtotal Services des experts:** 2,073.7 88.9 258.4 11.1 137.2

**D. Formation a l'etranger**
- **Formation a l'etranger:** 4,156.0 93.8 - 273.4 6.2 4,429.4 13.2 4,156.0

**Subtotal Formation:** 6,103.7 82.0 436.0 154.8 1,295.9

**Total Investment Costs:** 19,680.8 82.2 494.6 2.1 1,164.7 1,164.7

### II. Recurrent Costs

**A. Fourniture de Bureau**
- **Fourniture de bureau:** 805.9 91.5 - 74.9 8.5 880.8 2.6 880.8

**B. Agences contractuales**
- **Agences contractuales:** 3,028.4 79.7 - 77.3 10.0 3,801.5 11.4 3,573.4

**C. Maintenance vehicule**
- **Maintenance vehicule:** 2,480.8 90.0 - 20.2 20.2 2,480.8 228.8

**D. Maintenance equipment**
- **Maintenance equipment:** 500.2 90.0 - 10.0 10.0 510.2 0.6 500.2

**Total Recurrent Costs:** 8,153.4 82.0 514.9 1.5 3,120.2 228.8

**Total Disbursements:** 27,834.2 83.2 514.9 1.5 5,085.5 3,120.2 228.8

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*Wed May 03 08:16:12 1995*
### DISBURSEMENT ACCOUNTS BY FINANCIERS

**Disbursement Accounts by Financiers**

(US$ '000)

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**A. Equipment et fourniture**

- Material et consommables
  - 1,058.9 83.9
- Equipeement medico-technique
  - 1,605.5 82.0
- Mobilier de bureau
  - 73.5 82.0

**Subtotal Equipment et fourniture**

- 4,436.2 82.5

**B. Vehicules**

- 1,613.6 82.0

**Subtotal Vehicules**

- 1,613.6 82.0

**C. Medicaments**

- Medicaments
  - 912.7 61.6 436.0 29.4

**Subtotal Medicaments**

- 912.7 61.6 436.0 29.4

**D. Genie Civil**

- Construction/rehabilitation CCS
  - 762.3 77.3 46.5 4.7
- Construction/rehabilitation CSSP
  - 200.1 77.3 12.2 4.7
- Achevement Ministere Sante
  - 365.2 82.0

**Subtotal Genie Civil**

- 3,076.3 81.1 58.7 15.8

**E. Services d'experts**

- Appui aux programmes
  - 1,921.6 94.0
- Preparation et execution projet
  - 84.6 94.0

**Subtotal Services d'experts**

- 2,006.2 88.8

**F. Formation**

- Formation a l'étranger
  - 4,156.0 93.8
- Formation locale
  - 1,013.5 86.4

**Subtotal Formation**

- 6,259.5 92.4

**G. Etudes et recherche**

- 1,507.8 94.0

**Subtotal Etudes et recherche**

- 1,507.8 94.0

**H. Couts de fonctionnement**

- Maintenance vehicules
  - 2,480.8 90.0
- Maintenance batiments
  - 182.1 90.0 20.2 10.0
- Maintenance eqipeement
  - 990.9 90.0
- Salaires
  - 3,058.4 79.7

**Subtotal Couts de fonctionnement**

- 6,031.5 82.8 40.2 10.0

**Total**

- 27,834.2 83.2 514.9 1.5 6,055.5 15.2 33,434.6 100.0 20,251.8 10,400.3 2,782.5

* Wed May 03 08:17:58 1995*
ORGANIGRAMME DU MINISTERE DE LA SANTE
(Structure de gestion du projet)

Ministre

Conseillers Techniques

Attaché de Cabinet

CNEEP

3

Secretariat Particuliculier

Directeur Cabinet

DAC

Attaché Presse

Secretariat Administratif

Sce Audit et contrôle

DSAF 4,2

DPCE 1

DIEM 4

DHAB 4

DNPS 4

DPHL 4

DSF 4

CNHU

DDS 1,2,4

CDEEP 3

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2. Comptabilité
3. Suivi et évaluation
4. Exécution
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## Quality and Sustainability of Health Services

- **Improved patient management**
  - PF/Atelier finalisation normes et standards
  - PF/Atelier finalisation livrets gestes
  - PF/Seminaire sur respect des condi.
  - PF/Seminaire sur respect des condi.
  - MST/SIDA/Atelier elaboration guide prise en charge
  - MST/SIDA/Atelier elaboration schema therapeutique
  - MST/SIDA/Atelier programme de prevention
  - IEC/Atelier trad. en langues nles

- **Pharmaceuticals**
  - DPHL/Seance proclamation politique pharmaceutique
  - DPHL/Information des groupes cibles
  - DPHL/Regle normes prescr.
  - DPHL/Reunion de concertation
  - Seminaires outils de gestion
  - Utilisation formulaire/ordinigramme
  - Gestion des medicaments

## Management of Sector Resources

- **Improved performance of personnel**
  - DDS/TDIEM en informatique
  - PF/Equipe formation/DDS directives
  - Palud./Recyclage formateurs depart.
  - Palud./Recyclage agents sentinnes
  - MST/SIDA/Formations des formateurs
  - MST/SIDA/Tradipraticiens
  - Bucco/CSSP/CCS/Infirmiers
  - Bucco/CSSP/CCS/Enseignants
  - IEC/Formateurs departementaux
  - IEC/Atelier conception messages
  - IEC/DDS/Equipe departementale
  - HYG/ENV/Equipe departementale
  - HYG/ENV/Agents d'hygiene
  - HYG/ENV/CSSP/CCS/Infirmier
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<td>Formation des formateurs en elaboration des budgets</td>
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<td>Atelier sur la capacité de recouvrement des couts</td>
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<td>- Management of sector property</td>
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<td>DDS/Diffusion des normes</td>
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INDICATORS FOR PROJECT MONITORING AND EVALUATION

For each of the main project components, the indicators are classified into one of two categories, monitoring or evaluation, as appropriate. Within each group of indicators, those representing milestones are followed by the letter "M" in parentheses. The indicators will guide project staff in Benin and Bank staff to keep track of project implementation, to make appropriate modifications in implementation and to evaluate the performance of the project on the basis of its specified objectives.

Component: Development and expansion of family planning services.

Indicators for monitoring

For population policy
- Formal adoption of population policy (M)
- % copies of population policy distributed to specified recipients.
- % planned radio and drama programs produced.

For expansion of family planning services
- % planned FP surgical equipment delivered (district level).
- % planned FP kits delivered (CCS/CSSP levels).
- % health facilities with appropriate equipment for FP.
- Staff training program developed (M).
- % planned FP training manuals provided to regions.
- Number of new clients seen per year.
- Number of voluntary surgical contraception procedures performed per year.
- % planned training programs held.
- % eligible staff trained.

Indicators for evaluation
- % of women with access to family planning services.
- % of clients reporting satisfaction with services received.
- Contraceptive prevalence rate.
- Total Fertility Rate (TFR).
Component: Improving the quality and efficiency of priority health services.

Indicators for monitoring

For "Improvement of the health and nutritional status of mothers and children"
- Guidelines and norms developed for antenatal, intrapartum and postnatal care (M).
- Training program developed for staff to use guidelines and norms (M).
- % health facilities with copies of guidelines and norms.
- % planned equipment (for managing high-risk pregnancies, emergency deliveries and post-surgical care) delivered.
- % district hospitals with appropriate surgical units for caesarean sections.
- % district hospitals with appropriate laboratory facilities.
- % CCS with the required number of delivery beds.
- % CSSPs with the required number of delivery beds.
- % planned specialization training started.
- % health facilities delivering ante-natal care according to guidelines and norms.
- % health facilities delivering intra-partum care according to guidelines and norms.
- % health facilities delivering post-natal care according to guidelines and norms.
- % planned cold chain equipment delivered.
- % cold chain equipment in working order.
- % planned ORT supplies delivered.
- % planned weight scales delivered.
- % planned nutrition surveillance records delivered.
- Training program for service delivery staff developed (M).
- % planned micronutrient supplements delivered.
- National malnutrition survey completed (N).
- Evaluation of current EPI strategies completed (M).
- % planned training programs held.
- % eligible staff trained.
- % health facilities implementing appropriate growth monitoring and nutritional counselling activities.

For "Control of communicable and parasitic diseases and traumas".
- Guidelines, norms and standards developed for the control of specified communicable and parasitic diseases (M).
- % eligible health facilities with copies of new guidelines, norms and standards for the control of specified communicable and parasitic diseases.
- Training program developed for the use of new guidelines, norms and standards (M).
- % planned training sessions held.
- % eligible staff covered by training program.
- % eligible health facilities with necessary laboratory materials for diagnostic work.

For "Strengthening of first and second referral health care at the district and regional levels".
- % planned equipment delivered.
- % specified equipment in working condition.
- Guidelines, norms and standards developed for hospital care (M).
- Guidelines, norms and standards delivered to hospitals (M).
- Annual in-service training program formulated.
- % planned specialization training started.
- % planned specialization training completed.
- % eligible staff covered by in-service training program.
- Number of referrals from district hospitals to regional hospitals.
- Number of referrals from regional hospitals to district hospitals.
- Average duration of admission (length of stay) at district hospital level.
- Average duration of admission (length of stay) at regional hospital level.

For "Promoting community health and education":
- KAP-type survey completed on the communication channels most used by the public, through which health, family planning and nutrition education messages can be channeled (M).
- Education materials produced for better health, safe motherhood, family planning, nutrition education, STD/AIDS prevention and environmental sanitation (M).
- % LHMC members trained in health promotion, disease prevention including STD/AIDS and family planning, nutrition and environmental sanitation.

Indicators for evaluation

For "Improvement of the health and nutritional status of mothers and children"
- % of children fully immunized.
- % of women who delivered who had at least one pre-natal consultation with a trained worker.
- % women of reproductive age immunized against tetanus.
- % deliveries assisted by trained personnel per year.
- Mean number of post-partum consultations per expected number of births per year.
- % women delivered in health facilities who returned for post-partum consultation.
- Incidence rate of low birth weight.
- Prevalence rates of:
  - iron-deficiency anemia in women of reproductive age.
  - stunting
  - underweight
  - vitamin A deficiency.

For "Strengthening of first and second referral health care at the district and regional levels"
- % cases managed according to guidelines and norms at district hospital level.
- % cases managed according to guidelines and norms at regional hospital level.
- Bed occupancy rate at district hospital level.
- Bed occupancy rate at regional hospital level.
Component: Strengthening and streamlining of sector management and administration.

Indicators for monitoring
- % planned incremental staff recruited.
- Plans for training formulated (M).
- % planned training activities held, by categories of skills.
- Plans for departmental level supervision formulated (M).
- Pilot district health teams formed (M).
- Operational manual on decentralization prepared (M).
- % planned recipients who received copies of operational manual on decentralization:
  - Planning and budgeting.
  - Supervision.
  - Maintenance.
- % health facilities that received satisfactory supervision in the preceding year.

Component: Strengthening of partnerships for health program coordination and evaluation.

Indicators for monitoring:
- % health facilities in which action plans for the year were made in collaboration with COGEC/COGES.
- % health facilities in which COGEC/COGES meetings were held as scheduled in the preceding year.

Indicators for evaluation:
- % health facilities in which the realization of goals was satisfactory in the preceding year.
- % health facilities maintaining essential drug capital.
- % health facilities implementing the published fee schedule.
Supervision missions will be organized around the two meetings of the national committee in charge of monitoring and evaluating health programs (CNEEP): one to review progress at the mid-year on implementation of the new sector strategy; and the other to review implementation of annual plans and budgets, to evaluate progress achieved and to plan and program the following year’s activities, based on the previous year’s experience.

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<th>Activity</th>
<th>Expected skills required</th>
<th>Staff input (in staff weeks)</th>
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<td>Project launch mission</td>
<td>Procurement, disbursement, health financing, civil works, project management</td>
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<td>4/96</td>
<td>Review implementation of annual plans and budget of previous year and plan/program next year activities</td>
<td>Public health, procurement, project management, planning health financing</td>
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<td>11/96</td>
<td>Strategic plan and mid-year implementation review</td>
<td>Public health, health financing, civil works, management</td>
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<td>Review implementation of annual plans and budget of previous year and plan/program next year activities</td>
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Cycle continues until end of Project.
# Republic du Benin
## Health and Population Project
### Technical Assistance (M/M)

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I: International Consultant
L: Local Consultant
REAUBLIC OF BENIN  
HEALTH AND POPULATION PROJECT  
Personnel Overseas Training Schedule  
(M/M) 

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## Republic of Benin
### Health and Population Project

#### Disbursement Schedule
**(US$ Million)**

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