National Health Development Plan
(2009-2018)
PREFACE

One of the fundamental rights of every human being is the right to health. The Constitution of Benin of December 11, 1990 establishes that right in Article 26 on Rights and Duties.

Our country occupies a highly strategic position marking a transition between the French- and English-speaking countries. A peaceful and stable land, Benin enjoys a pacified democracy that gives it a platform in the subregion where security and calm prevail.

In addition, in the context of implementing its overall development policy, Benin’s commitment to achieving the Millennium Development Goals reflects our country’s desire to make health one of the important levers of economic and social development through three (3) of the eight (8) goals.

To achieve these objectives, government must increase its initiatives in all sectors of national life. It is within this context that the choice has been made to provide the health sector with a National Health Development Plan (NHDP) for the next ten years so that all strata of society can benefit from excellent quality health care and services.

This desire on the part of government will take shape with the construction of a subregional or regional reference hospital, a hub of excellence providing leading edge care and high-quality training for health personnel. This action will allow our country to save foreign exchange used to evacuate patients and to strengthen the technical capabilities of qualified medical and health care personnel.

This ambition requires that the sector make optimum use of its resources and available potential. To do this, medical and paramedical staff, hospital chiefs, health facility administrative staff, and volunteers as well as everyone dedicated to health as a profession in our country are called upon to have a better understanding of the spiritual and moral aspects of disease and a well-developed work ethic and to pay better attention to both the sick and those who attend them.
Thus, by responding to the fundamental questions of human existence, adopting the spiritual sense of suffering and health, and ensuring better governance within the sector, we will strengthen the capabilities and management of the human resources who are the driving force of our health facilities.

This is why this third generation of the strategic plan, in which all health care personnel as well as the health sector’s technical and financial partners have participated, has made it possible to put the emphasis on human resources, ethics, and medical responsibility for better management of the clients/users of our health facilities.

The Operational Plans to be developed will find the appropriate framework for guiding action.

I take this opportunity to congratulate all those who have invested their energies in the production chain for this strategic plan, from the situational analysis document to the policy statement.

On this occasion, I would like to express my sincere appreciation and satisfaction to all our technical and financial partners for all their efforts toward the success of this plan. I should particularly like to thank the European Union (EU) and, the World Health Organization (WHO) for their technical and financial support.

Finally, I urge all national and international stakeholders to become actively involved in the implementation of the plan.

Professor Issifou TAKPARA
Minister of Health
**ACRONYMS AND ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACN</td>
<td>Aerial Communication Network</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>BHS</td>
<td>Basic Hygiene and Sanitation</td>
</tr>
<tr>
<td>BI</td>
<td>Bamako Initiative</td>
</tr>
<tr>
<td>CAME</td>
<td>Essential Drugs Purchasing Center</td>
</tr>
<tr>
<td>CASES</td>
<td>Solidarity Action Center for Health Development</td>
</tr>
<tr>
<td>CDEEP</td>
<td>Departmental Project/Program Performance and Evaluation Monitoring Committee</td>
</tr>
<tr>
<td>CDT</td>
<td>Screening and Treatment Center</td>
</tr>
<tr>
<td>CGE</td>
<td>Contract Government Employee</td>
</tr>
<tr>
<td>CHD</td>
<td>Departmental Hospital Center</td>
</tr>
<tr>
<td>CHU</td>
<td>University Hospital Center</td>
</tr>
<tr>
<td>CNEEP</td>
<td>National Project/Program Performance and Evaluation Monitoring Committee</td>
</tr>
<tr>
<td>CNERS</td>
<td>National Health Research Ethics Committee</td>
</tr>
<tr>
<td>CNH</td>
<td>National Hospital Centers</td>
</tr>
<tr>
<td>CNHU</td>
<td>National University Hospital Center</td>
</tr>
<tr>
<td>CNTS</td>
<td>National Blood Transfusion Center</td>
</tr>
<tr>
<td>COGES</td>
<td>Management Committee</td>
</tr>
<tr>
<td>CS</td>
<td>Health Center</td>
</tr>
<tr>
<td>CSA</td>
<td>District Health Center</td>
</tr>
<tr>
<td>CSC</td>
<td>Commune Health Center</td>
</tr>
<tr>
<td>CSE</td>
<td>Epidemiological Surveillance Center</td>
</tr>
<tr>
<td>CWIQ</td>
<td>Core Welfare Indicators Questionnaire</td>
</tr>
<tr>
<td>DDS</td>
<td>Departmental Health Directorate</td>
</tr>
<tr>
<td>DDZS</td>
<td>Health Area Development Directorate</td>
</tr>
<tr>
<td>DEPOLIPO</td>
<td>Population Policy Statement</td>
</tr>
<tr>
<td>DH</td>
<td>Directorate of Hospitals</td>
</tr>
<tr>
<td>DHAB</td>
<td>Basic Hygiene and Sanitation Directorate</td>
</tr>
<tr>
<td>DHS-B</td>
<td>Demographic and Health Survey of Benin</td>
</tr>
<tr>
<td>DIEM</td>
<td>Directorate of Infrastructure, Equipment, and Material</td>
</tr>
<tr>
<td>DIVI</td>
<td>Directorate of Internal Inspection and Verification</td>
</tr>
<tr>
<td>DNPEV-SSP</td>
<td>National Directorate for the Expanded Program on Immunization and Primary Health Care</td>
</tr>
<tr>
<td>DNPS</td>
<td>National Directorate for Health Protection</td>
</tr>
<tr>
<td>DPP</td>
<td>Directorate for Planning and Forecasting</td>
</tr>
<tr>
<td>DRFM</td>
<td>Directorate of Financial and Material Resources</td>
</tr>
<tr>
<td>DRH</td>
<td>Human Resources Directorate</td>
</tr>
<tr>
<td>DRS</td>
<td>Directorate of Health Research</td>
</tr>
<tr>
<td>DSF</td>
<td>Directorate of Family Health</td>
</tr>
<tr>
<td>DSIO</td>
<td>Directorate of Nursing and Obstetrical Care</td>
</tr>
<tr>
<td>EDA</td>
<td>Each District Approach</td>
</tr>
<tr>
<td>EEZS</td>
<td>Health Area Training Team</td>
</tr>
<tr>
<td>EMAS</td>
<td>Emergency Medical Assistance Service</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

PREFACE .......................................................................................................................... II
ACRONYMS AND ABBREVIATIONS ................................................................................ IV

SUMMARY ....................................................................................................................... 1

I- CONTEXT ..................................................................................................................... 6

II- METHODOLOGY ....................................................................................................... 8

  2.1- SITUATION ANALYSIS.......................................................................................... 8
    2.1.1- Agencies responsible for developing the NHDP ........................................... 8
    2.1.2- Gathering the information .......................................................................... 9
    2.1.3- Analysis and dissemination of data .............................................................. 9
  2.2- BUILDING THE SCENARIOS ............................................................................. 10
    2.2.1- Multi-criteria analysis of problems and consideration of the results from the Etats Généraux (General Meeting) ................................................................. 10
    2.2.2- Analysis of the sector’s performance .......................................................... 11
    2.2.3- Choice of the scenario .............................................................................. 11
  2.3- DEVELOPING THE POLICY DOCUMENT .................................................. 11
    2.3.1- Defining broad outlines ............................................................................ 11
    2.3.2- Validation .................................................................................................. 11
  2.4- PREPARING THE NHDP .................................................................................. 13

III- CHARACTERISTICS ................................................................................................. 13

  3.1- GEOGRAPHIC SITUATION ............................................................................... 13
  3.2- SOCIO-ECONOMIC AND ADMINISTRATIVE SITUATION ............................. 14
  3.3- DEMOGRAPHIC SITUATION ............................................................................ 15
  3.4- SOCIAL AND HEALTH SITUATION ................................................................. 17

IV – ANALYSIS OF THE SITUATION ............................................................................. 18

  4.1- HEALTH PROFILE OF BENIN ......................................................................... 18
    4.1.1- Course of the main diseases ....................................................................... 18
    4.1.2- Utilization of health services ...................................................................... 18
    4.1.3- Reproductive health .................................................................................. 19
    4.1.4- Nutritional status of mothers and children ............................................... 21
    4.1.5- Health of adolescents and youth ............................................................... 22
    4.1.6- Family planning ......................................................................................... 22
  4.2- SECTOR RESOURCES ...................................................................................... 22
    4.2.1- Financial resources ................................................................................... 22
    4.2.2- Human resources ....................................................................................... 24
  4.3- MATERIAL RESOURCES ............................................................................... 27
    4.3.1- Health infrastructure situation ................................................................... 27
    4.3.2- Equipment situation .................................................................................. 28
  4.4- ORGANIZATION OF THE HEALTHCARE SYSTEM ..................................... 29
    4.4.1- Health pyramid ........................................................................................ 29
    4.4.2- Public sector .............................................................................................. 30
    4.4.3- Private sector ............................................................................................ 30
    4.4.4- Traditional medicine ............................................................................... 32
    4.4.5- Blood transfusion ...................................................................................... 32
    4.4.6- Health research ......................................................................................... 33
    4.4.7- Health information ................................................................................... 33

V- ANALYSIS OF SECTOR PERFORMANCE ............................................................. 34

  5.1- SECTOR PROBLEMS ......................................................................................... 34

National Health Development Plan: Benin 2009 - 2018
VI- PRIORITY AREAS, PROGRAMS AND SUB-PROGRAMS OF THE SECTOR. .................................................. 39

6.1- PRIORITY AREA: PREVENTING AND COMBATING DISEASE AND IMPROVING HEALTH CARE QUALITY .................................................. 39
  6.1.1- Program: Promoting hygiene and basic sanitation. .................................................. 39
  6.1.2- Program: Reproductive health .................................................................................. 42
  6.1.3- Program: Combating disease .................................................................................. 48
  6.1.4- Program: Hospital development ............................................................................. 67

6.2- PRIORITY AREA: ADVANCING HUMAN RESOURCES .................................................. 75
  6.2.1- Program: Strengthening human resources planning ............................................. 75
  6.2.2- Programme: Improving the production and development of skills ....................... 78
  6.2.3- Programme: Improving the human resources management system ................... 81

6.3- PRIORITY AREA: STRENGTHENING PARTNERSHIP IN THE SECTOR AND PROMOTING MEDICAL ETHICS AND RESPONSIBILITY .................................................. 88
  6.3.1- Program: STRENGTHENING PARTNERSHIP AMONG THE STAKEHOLDERS .......... 88
  6.3.2- Program: Promoting medical ethics and responsibility ......................................... 94

6.4- PRIORITY AREA: FINANCING MECHANISM FOR THE SECTOR .................................................. 96
  6.4.1- Program: FINANCING ....................................................................................... 96
  6.4.2- Program: STRENGTHENING MEDICAL ASSISTANCE TO THE POOR, THE INDIGENT AND VULNERABLE STRATA ................................................. 99

6.5- PRIORITY AREA: STRENGTHENING MANAGEMENT OF THE SECTOR .................................................. 101
  6.5.1- Program: Institutional strengthening .................................................................... 101
  6.5.2 Program: Development of health areas .................................................................. 105

VII – FINANCING THE NHDP .................................................. 107

7.1- POTENTIAL INDICATION OF NHDP FINANCING .................................................. 107
7.2- INDICATIONS OF FINANCING BY PROGRAM OVER 5 YEARS .................................................. 108
7.3- ALLOCATION OF RESOURCES BY EXPENDITURE CATEGORY .................................................. 110
7.4- DIRECT ALLOCATION OF RESOURCES BY HEALTH SYSTEM LEVEL .................................................. 111

VIII. IMPLEMENTATION, MONITORING AND EVALUATION... 112

8.1- IMPLEMENTATION AND MONITORING MECHANISMS .................................................. 112
  8.1.1- Managing the NHDP ...................................................................................... 112
  8.1.2- Organizing the monitoring of NHDP implementation ........................................... 114

8.2- MONITORING & EVALUATION .................................................. 116
  8.2.1- Monitoring the NHDP ................................................................................... 116
  8.2.2- Midpoint evaluation ...................................................................................... 117
SUMMARY

The National Health Development Plan (NHDP) reflects the desire of Ministry of Health stakeholders and the Technical and Financial Partners to provide rapid and effective responses to the population’s health problems. This plan is the embodiment of consensus-based work targeting the major health problems of Benin’s population and the result of many workshops on the health sector’s priorities for the next ten years (2009-2018).

The National Health Development Plan is broken down into five (5) priority areas contributing to the achievement of the following vision: “In 2025 Benin has an effective health system based on public and private, individual and collective, initiatives to ensure the continuous supply and availability of quality, equitable, and accessible care to all segments of the population, founded on the values of solidarity and risk-sharing in response to the health needs of Benin’s people.”

Priority areas

In light of the problems identified, the following five (5) priority areas were defined:

- Preventing and combating major diseases and improving the quality of care;
- Developing human resources;
- Strengthening partnership in the sector, promoting medical ethics and responsibility;
- The financing mechanism for the sector;
- Strengthening the management of the sector.

The priority areas were broken down into programs and sub-programs whose efficient implementation would allow the sector to address the challenges.

NHDP programs and subprograms

The programs broken down into subprograms are as follows:
1. Promoting hygiene and basic sanitation
   - Environmental services and sanitation
   - Behavior change communication

2. Reproductive health
   - Combating maternal and neonatal mortality
   - Combating under-five mortality

3. Combating disease
   - Combating priority diseases, STI/HIV/AIDS, malaria, and tuberculosis
   - Combating other communicable diseases
   - Combating non-communicable diseases
   - Improving the availability of good quality medications at reduced cost
   - Promoting diagnostic explorations and transfusion safety
   - Promoting traditional medicine and pharmacopoeia
   - Promoting health in the school, university, and professional environment
   - Promoting mental health
   - Promoting health research

4. Hospital development
   - Developing a quality health care management system in the hospital setting
   - Strengthening technical platforms
   - Hospital reform
   - Organizing and reinforcing the supply of care

5. Strengthening human resources planning
   - Strengthening human resources personnel in the field of health
   - Strengthening the partnership between domestic and foreign stakeholders in the area of human resources planning in health
   - Developing research on human resources

6. Improving the production and development of skills
   - Developing a consensual plan for initial training of health sector personnel
   - Developing the skills of the sector’s personnel

7. Improving the human resources management system
Improving management of staff careers
Improving incentive mechanisms for staff retention and performance
Prevention and management of professional risks
Deconcentration/decentralization of human resources management

8. Strengthening the partnership between the stakeholders

- Partnership between the public sector and the private sector
- Partnership between the Ministry of Health, local elected officials, and local communities
- Partnership between the Ministry of Health and other ministries

9. Promoting medical ethics and responsibility

- Strengthening medical ethics and responsibility
- Developing and promoting quality assurance

10. Financing

- Promoting health insurance
- Promoting mutual health insurance schemes

11. Strengthening medical assistance to the poor, the indigent, and vulnerable sectors

- Strengthening medical assistance
- Mobilizing national savings and the savings of the diaspora

12. Institutional strengthening

- Strengthening coordination, planning, and evaluation capabilities
- Strengthening the health infrastructure maintenance mechanism

13. Developing health areas

- Strengthening the base of the health pyramid
- Developing community-based services

The strategies will be used as the basis for determining and implementing the lines of action for achieving the objectives of the NHDP. These objectives essentially seek to reduce the diseases of poverty, to really improve the health of mothers and children, to significantly check the priority diseases, and to strengthen the institutional capacities of the health sector with a view to making it more suited to the reforms and the implementation of the necessary strategies.
Making the NHDP operational

Following this ten-year plan, Three-Year Development Plans (3YDP) will be developed and will provide the precise and detailed framework for the monitoring and implementation of the NHDP. Thus, at the departmental level, the technical coordination of the NHDP will go through the mechanisms for implementing the departmental three-year plans. At the health area level, which is the operational level for the implementation of health programs and activities, the Departmental Health Directorate will see to the preparation of the three-year plans through the health areas, plans that will manage the achievement of the NHDP objectives.
 Roles of sectoral stakeholders

The central level consists of the office of the Ministry of Health and the central and technical directorates and is the primary agency responsible for the design and implementation of actions based on policies defined by the government in the area of health. Thus, it plays a normative, design, coordination, planning, regulatory, and implementation monitoring role with respect to those activities. The intermediate level, bringing together the Departmental Health Directorates, is responsible for the implementation of health policy as defined by the government and for the planning and coordination of all health services activities. It also provides epidemiological surveillance in the departments. As for the peripheral level represented by the health area, it is the most decentralized entity in the health system. The health area is the level for operational implementation of health programs and activities seeking to achieve conclusive results. In this context, it plans and provides for the planning and implementation of these programs throughout the entire health area.

Financing of the NHDP

The total budget for the NHDP amounts to 2,255 billion CFAF. The various sources of financing are the government, the community, and the technical and financial partners.

The budget will be progressively allocated to the health areas, with 60% going to the communities, 25% to the departments, and 15% to the central level.

NHDP monitoring mechanism

The successful implementation of this frame of reference document will essentially depend on the support provided by political authorities and the restructuring of the Directorate of Planning and Forecasting, which is the agency responsible for coordinating and monitoring the programs defined in the plan. In this context, the availability and ongoing desire of health stakeholders to adapt to the new principles based on the effective decentralization of health actions will have to be noted with a view to achieving the objectives sought.
I- CONTEXT

The National Health Development Plan is developed within a specific context characterized by a fairly widespread stagnation of the principal performance indicators of the health sector despite the efforts made by the government, the communities, and the technical and financial partners.

The government of the Republic of Benin is not indifferent to this situation and sees it as the conjunction of exogenous and endogenous factors.

Exogenous factors include:

- Deterioration in the terms of exchange;
- Inadequate aid given the needs felt by the beneficiaries;
- The increased cost of medical equipment, medications, vaccines, reagents, and other medical goods; and
- The cross-border spread of some ailments.

Endogenous factors include:

- The growing poverty of the population;
- The uneven distribution of national income;
- The uneven distribution of nursing staff;
- Inadequate coverage given the needs of the population; and
- Pressing and sustained environmental degradation.

This perception led the country’s political and social authorities to exercise options reflected in concrete actions, most of which necessitated structural actions.

These options involve:

- Health for all based on the Primary Health Care (PHC) strategy in 1978. The overriding principles of this option address equity, community participation, and
intersectoral collaboration. The context for the application of this strategy is the health area;

- The 1987 Bamako Initiative (BI) emphasizing community participation and cost recovery in health care;
- The 1987 Risk-Free Maternity initiative, a PHC component seeking the reduction of maternal and child mortality following the Nairobi Conference in 1987 and the Niamey Conference in 1989;
- The right to health: in effect, Article 2 of the Constitution of December 11, 1990 on rights and duties stipulates that “…the State protects the family, particularly mothers and children. It cares for the handicapped and the elderly”;
- Continuous improvement of the population’s living conditions through adoption of the Population Policy Statement (DEPOLIPO) on May 2, 1996;
- Decisions made in 2000 committing the government to make a significant contribution to combating STIs/AIDS. At the end of this commitment, a budget line reserved for combating HIV/AIDS is created within each ministry.

These options were reflected in reforms, particularly: (i) territorial reform based on decentralization and community participation; (ii) economic reform with its corollary budgetary reform, the objective of which is performance in the management of financial resources with the effective delegation of credits to health areas and the establishment of a fund for the indigent.

The various policy and strategies documents adopted rely on the willingness of health authorities to adhere to the government’s plan, the basic objective of which is to improve the social and health conditions of the population.

Thus, the Ministry of Health has undertaken the mission to: “improve the social and health conditions of families based on a system that includes poor and indigent populations.”

The 2002-2006 policy and strategies document has reached its conclusion. A midpoint review was performed and underscores the persistence of some problems, particularly disturbing
rates of maternal and child mortality, the marginalization of a sizeable portion of the population with respect to health care, and the inadequacy of human, material, and financial resources. There is thus an urgent need to overcome these deficiencies on a permanent basis.

To do this, a study was conducted on possible development scenarios for the sector over ten years, following the Alafia scenario of national studies on the long-term prospects for Benin 2025. The 2003 National Health Accounts were prepared. On the basis of these actions, the sector was viewed from a prospective approach. The resulting strategic guidelines, programs, and subprograms are codified in a consistent and integrated series of actions that the government of the Republic of Benin intends to take over the period 2009-2018.

II- METHODOLOGY

The National Health Development Plan of Benin was developed in four stages as follows:

- Analysis of the situation;
- Identification of priorities and choice of development scenarios;
- Development of policy;
- Development of the strategic plan.

2.1- Situation analysis

The analysis included four basic phases, namely: (i) establishing the agencies responsible for preparation, (ii) information gathering, (iii) data analysis and dissemination, and (iv) writing of the report.

2.1.1- Agencies responsible for developing the NHDP

By Order No. 2327/MSP/DC/SGM/DPP/SA of March 17, 2006, the Minister of Health established a Steering Committee and a Technical Team responsible for developing the NHDP.
The Steering Committee consists of representatives from the sectoral ministries, the Technical and Financial Partners, civil society, and health sector stakeholders. It defines broad outlines and validates the work of the Technical Team.

The Technical Team is a multidisciplinary team and is the mainstay of the NHDP. It has ten (10) members and is responsible for technical tasks, namely data collection, analysis, and preparation of various reports that are submitted to the steering committee for validation.

2.1.2- Gathering the information

The data collection techniques used are documentary review and interviews.

For the documentary review, a series of documents was consulted to reveal the real health situation for purposes of in-depth analysis. Thus, project and program evaluations, the evaluation of the 1997-2001 policy and strategy document, the midpoint review of the 2002-2006 policy and strategies document, studies on possible scenarios for development of the health sector, the Millennium Development Goals (MDG), the Poverty Reduction Strategy Paper (PRSP), health statistics yearbooks, and other planning documents were consulted. These documents made it possible to outline Benin’s health situation and its development over an extended period. Interviews of stakeholders in the field made it possible to complete some information drawn from the documentary review.

2.1.3- Analysis and dissemination of data.

These included dissemination workshops in the health areas and the Departmental Health Directorates where health stakeholders, the population, and partners at various levels of the health pyramid contributed their changes and observations to enrich the work of the team.
2.2- Building the scenarios

This involved a multi-criteria analysis of problems uncovered in the analysis of the situation, an analysis of the sector’s performance based on its strengths, weaknesses, assets, and potential threats and the choice of the key scenario.

2.2.1- Multi-criteria analysis of problems and consideration of the results from the Etats Généraux (General Meeting)

Analysis of the situation revealed twenty-six (26) major problems. An order of priority was set up at each level of the health pyramid by the stakeholders in the sector based on four (4) criteria for assessing the importance of the perception of these problems by the community. These criteria are:

- The relevance of the problem
- The scope of the problem
- The acceptability of the problem to the stakeholders involved
- Availability for resolution of the problem

A summary was prepared to determine the priority problems in the sector, which were then converted into priority areas of intervention.

As result of the consideration of conclusions and recommendations from the Etats Généraux on health, the weakness associated with the management of human resources was retained as a priority problem.
2.2.2- Analysis of the sector’s performance

This analysis made it possible to assess the possible development of the health sector through its strengths, weaknesses, and above all threats and advantages. Value ranges including potential growth, added value, and competitive intensity as limitations and basic resources, infrastructure, and know-how as advantages made it possible to determine the key subsectors.

2.2.3- Choice of the scenario

Based on multi-criteria analyses of the problems, the performance of the sector, and national priorities, a choice was made from among the four possible development scenarios for the health sector.

2.3- Developing the policy document

The policy document was developed in two phases: definition of broad outlines and validation.

2.3.1- Defining broad outlines

Based on the analysis of health sector problems and performance, priority areas were defined and broken down into strategic guidelines.

These guidelines take into account the major challenges to government policy.

2.3.2- Validation

Validation was done in two stages:
- A technical study of the guidelines by the steering committee with a view to their adoption;
- Validation of these guidelines at a workshop held by the steering committee and expanded to include all technical and financial partners of the sector.
2.4- Preparing the NHDP

This phase included three stages; (i) breakdown of the strategic guidelines into programs and sub-programs, (ii) economic and budgetary framing, (iii) the monitoring mechanism.

III- CHARACTERISTICS

3.1- Geographic situation

Located in western Africa on the Gulf of Guinea, the Republic of Benin extends 700 kilometers from the Atlantic Ocean to the Niger River and 125 kilometers along the coast. It covers a surface area of 114,763 km².

The Republic of Benin borders Niger to the north, Burkina Faso to the northwest, Togo to the west, Nigeria to the east, and the Atlantic Ocean to the south.

There are:

- Three climate zones:
  - In the south, the climate is typical of the humid tropics with two rainy seasons and two dry seasons. The temperature is high and ranges between 24° and 32° C. Precipitation varies from 900 mm to 1480 mm/year with an average of 1200 mm per year;
  - In the center, the climate is semi-humid (Guineo-Soudanien) with average annual rainfall of 1000 to 1200 mm/year;
  - In the north, the climate is typical of the semi-arid tropics with rainfall varying from 900 mm to 1300 mm per year.

- Two types of vegetation fundamentally influenced by the characteristics of the climate, soil capabilities, and human impact.
The northern and central area has savannah with gallery forests increasingly giving way to shrub savannah.

The south has dense forest that is at risk of disappearing due to deforestation.

3.2- Socio-economic and administrative situation

In economic terms, growth is stable at 3.9%, a rate that is slightly higher than the rate of population growth. Nonetheless, this growth is fragile because it is highly dependant on fluctuations in world cotton prices.

However, based on the studies conducted on poverty in Benin, it should be noted that this rate of growth is too weak to trigger a rapid and sustainable reduction in poverty. Achieving such a reduction would instead require a more sustained growth rate of between 7% and 10%. Poverty is entrenched among a large percentage of households in both rural and urban areas. Only a small percentage of the population has effective access to basic services such as health, education, water, electricity, etc.

Considering the poverty thresholds calculated on the basis of data gathered by the 2003 CWIQ survey, 22% of the population (or 1.5 million people) is considered extremely poor in monetary terms and 39% (or 2.6 million people) is considered poor. Poverty holds greater sway in rural and marginal urban areas in terms of both percentages and absolute numbers. However, note must be made of the exacerbation of the depth and severity of poverty in urban areas.

This situation has not escaped Benin’s political authorities who have implemented a poverty reduction strategy, the first generation of which has reached its conclusion.

The second generation strategy was prepared and emphasizes the following development priorities:

- Strengthening good governance and democracy as well as decentralization;
- Increasing the rate of growth by increasing private investment;
- Land use planning;
- Strengthening the ability to manage and absorb public resources;
- Strengthening the ability of the poor to generate income;
- Strengthening basic social services;
- Strengthening efforts to combat HIV/AIDS, malaria, and tuberculosis.

In administrative terms, the local elections of December 2002 and the effective installation of municipal councils marked the launch of the decentralization process.

The health system is thus strengthened with the reorganization of the base of the health pyramid. The effective impact of elected local and community officials will allow the health sector to take better advantage of the system.

### 3.3- Demographic situation

According to various sources (surveys and censuses), the population of Benin has grown as follows: in 1910, Benin had 878,000 inhabitants. It grew to 1,528,000 inhabitants in 1950; 2,106,000 inhabitants in 1961; 3,331,210 inhabitants in 1979; 4,915,555 inhabitants in 1992, and finally 6,769,914\(^1\) in 2002. Based on this information, it can be said that Benin has experienced an acceleration in its population growth rate: 1.8% between 1910 and 1950, 2.8% between 1979 and 1992, and then 3.2% between 1992 and 2002. The inter-census growth rate between 1979 and 1992 corresponds to a rate of duplication on the order of 25 years.\(^2\) According to INSAES demographic projections, the population of Benin was 7,839,915 inhabitants in 2006.

### Table 1- Change in the population of Benin from 1961 to 2006

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>2,082,511</td>
<td>3,331,210</td>
<td>4,915,555</td>
<td>5,780,591</td>
<td>6,169,084</td>
<td>6,769,954</td>
<td>7,839,915</td>
</tr>
</tbody>
</table>

---

\(^1\) GPHC 2002

\(^2\) Total population is estimated at about 6.2 million inhabitants in 2000.
In general demographic terms, Benin is characterized by:

- An essentially young and predominantly female population. In effect, in 2002 Benin’s population continued to be young with a median age of about 16 (15.6 in 1979 and 1992, then 16.3 in 2002). The population under the age of 15 represents 47%. Children under the age of 5 represent 17% of the total population and 37% of the young population (under the age of 15).

  From 1979 to 2002, 52% of the population was female with a masculinity ratio of 94.2 men for every 100 women. This predominance of females in the population of Benin is more marked in rural areas than in the city: 61.1% lives in rural areas. In 2002, the percentage of women of child-bearing age was 46% of the female population and 24% of the total population.

- A population unevenly distributed over the country in 2002, with the eight southern and central departments representing 25% of the surface area and containing 71% of the population while the four other departments contain only 29% of the population.

- A population subject to rural exodus; in the 1961 census, the rural population represented 90% of the total population. It represented only 73% in 1979, 64% in 1992, and 60% in 2002.

With an inter-census growth rate of 3.25% per year (GPHC 2002), Benin is classified as one of the world’s countries with a high population growth rate. This high level of growth is the result of a fertility rate that remains high while the mortality rate is declining gradually even if the current level continues to be a cause for concern.
This population growth has a very significant impact on the development of social demand on the one hand and puts great pressure on available resources on the other. Thus, it follows that:

- Strong urbanization leads to increased demand for basic social services (education, health, housing, transportation, etc.)
- Increases in the number of births lead to continuous growth in the need to protect mothers and children;
- The population’s increased requirements in terms of health and protection is reflected in a resulting demand for health personnel, health infrastructures, health care materials, and appropriate medications.

3.4- Social and health situation

The social and health situation is far from impressive. It is characterized by an unacceptable standard of living – a factor that favors the emergence of communicable and parasitic diseases. Essential components of this standard of living that merit particular attention are pollution and inadequate drinking water and waste management.
IV – ANALYSIS OF THE SITUATION

4.1- Health profile of Benin

Benin’s health profile is characterized by high morbidity despite all the programs and reforms implemented in past years to improve the state of health of the population. The following paragraphs will discuss the course of the main diseases, the use of healthcare services, reproductive health, the state of mother and child nutrition, the health of youth and adolescents, and family planning.

4.1.1- Course of the main diseases

In Benin, transmissible diseases are still the main causes of morbidity and mortality. They are followed by anemia, which can be of infectious or nutritional origin. The predominant reasons for visits are malaria and acute respiratory infections (ARI). There has been a gradual decrease in their proportion of general visits from 2000 to 2006. This trend could be explained by the effect of programs for awareness and community management of these diseases at home.

The leading reason for hospitalization is severe malaria replaced by anemia in 2003. After a decrease from 2000 to 2001, the hospitalization rates for the main diseases tended to stabilize from 2002 to 2006.

In 2006, malaria caused 25% of hospitalizations in health facilities versus 36% in 2000. It was followed by anemia at 11% in 2006.

4.1.2- Utilization of health services

The utilization of health services basically measures actual accessibility of health services and healthcare to the population. The measures show:

a- Geographic accessibility

Geographic accessibility to healthcare and health services is defined as the percentage of the
population that lives less than 5 kilometers from a health center. In Benin overall, 66% of households\(^3\) have access to a health facility in their location within a 5-km radius.

Because this is accessibility to first-referral health facilities, note that more than 50% of the population has access to a referral hospital if needed; 13% of the people still live more than 30 km from a referral hospital. Most rural communities do not have a hospital less than 5 km away (34% versus 77% for urban environments).

b- Frequency of use of health services

In 2006 according to the Health Statistics Yearbook, the rate of use of health centers for curative care (public and semi-public) was 44%.

This situation is in contrast to health coverage that is close to 86%, and it could be explained by financial constraints and unsatisfactory reception and quality of care. The highest level is observed in children under five years (79%) versus 17% in children ages 5 to 14 years.

In the departments, the highest rate of use of curative services (for children under five years) was observed in the Littoral department (163%) versus 53% in the Donga department.

4.1.3- Reproductive health

a- Maternal mortality

According to DHS III data, the maternal mortality rate was 397 women per 100,000 live births in 2006.

According to the 2002 General Population and Housing Census (GPHC), the maternal mortality ratio was 474.4 per 100,000 live births in 2002; it was 397.7 per 100,000 births in urban environments and 505.4 in rural environments. The risks in rural environments are therefore higher than in urban environments. The factors promoting this situation and the causes of death are:

**Promoting factors:** The current social and cultural environment, home deliveries, accessibility of maternity services, insufficient screening for high-risk pregnancies, insufficient monitoring of labor, and insufficient financial resources.

**Direct medical causes:** Hemorrhage 25%, dystocia 10%, pregnancy complicated by

---

\(^3\) DHS-B II 2001
hypertension 13%, complication of abortion 13%, anemia, and severe infection 14%.

**Indirect medical causes:** 25% (diabetes, sickle cell anemia, heart disease, etc.)

**b- Child health**

According to the 2006 Health Statistics Yearbook, visits recorded for children under five years were 38.4% of visits provided to the entire population; 97% of these cases were treated as outpatients and 3% as inpatients.

In this age bracket, malaria is 44.3% of cases followed by acute upper and lower respiratory infection (20.4%). It remains the main cause of morbidity and mortality, and the incidence has not decreased. On the contrary, it seems to be increasing over time. This calls into question the efficacy of strategies for fighting it up to now.

**Stillbirths**

The number of pregnancies resulting in a stillbirth was estimated at 2.95% of live births in 2006. This rate can be explained by the fact that women do not comply with the number of prenatal visits recommended by WHO.

**Infant mortality**

Overall, infant mortality remained high in 2006 at 67% (DHS III) and was more marked in rural areas and in the poorest environments. Children under one year living in rural environments (81%) were at higher risk for death than those living in urban environments (59%) and at Cotonou (67%).

Note that the infant mortality rate in the quintile of the wealthiest families was half that of other families.

All else being equal, the wealthiest families had better financial accessibility (purchasing of care and drugs) and could more easily than others have potable water, a more balanced diet, and a healthier living environment.

**Under-five mortality**

On the national level, the adjusted under-five mortality rate was 146.4% in the 2002 GPHC. This indicator had also been declining since 1982 (Benin Fertility Survey) when it was 243% and then declined to 167% in 1992.

According to the 2006 Demographic and Health Survey (DHS III), the under-five mortality rate was 125%.

Note that in general, the mother’s educational level affects the health and education of the
children. It is a reflection of the level of hygiene and knowledge of the causes of disease. It affects the frequency of use of health services, the frequency of monitoring of pregnancy, autonomy, and the decision-making power of the woman in the home.

According to the 2006 DHS, the under-five mortality rate was 143% for uneducated women versus 61% for women with at least a high school education.

The interval between successive births is another variable influencing the mortality level of children. The risk of childhood death increases as the interval between successive births decreases. In 2006, the mortality rate of children under five years was 121% for births that were close together (less than two years apart) versus 51% for births that were years apart and 52% for births four years apart.

Deliveries that are too close together cause malnutrition, which affects almost one-third of children under three years.

Poor water quality is also a cause of many diseases in children. This problem is acute in rural areas.

4.1.4- Nutritional status of mothers and children

Malnourished children are at high risk for morbidity and mortality, and in addition, malnutrition compromises the physical and mental development of children. The levels of failure to thrive increase rapidly with age and peak at 18-23 months (24%) (DHS III). After this age, it is difficult to catch up. The children who most often have failure to thrive are male, come from rural environments, and have uneducated mothers. Children are particularly affected in Alibori with 60% having this form of malnutrition (43% with the severe form).

The same results note that:

- 95% of children are breastfed;
- 54% of children are breastfed within one hour after birth;
- Fewer than half (43%) are breastfed exclusively in the first six months;
- More than two of five children under five years (43%) show failure to thrive, and the rate has increased since 2001;
- 78% of children under five years are anemic;
- 9% of women are too thin, and 61% are anemic.

---

4DHS-B II
4.1.5- Health of adolescents and youth
The estimated fertility rate is 5.7 children per woman. Fertility is very high in women in rural environments (6.3) and in uneducated women (6.4). Fertility is high in adolescents – at 19 years, more than 4 of 10 women (44%) already have at least one child or are pregnant. Half of women give birth to their first child before the age of 19.9 years. Half of women have already married before 18.6 years. Half of men are married by the age of 24.7 years. At 17.8 years, half of women have already had sexual relations.

4.1.6- Family planning
The results of the 2006 DHS for family planning show that 17% of married women currently use some method of contraception. Only 6% of married women use a modern method. Almost half (46%) of married women who do not currently use a method of contraception intend to use one in the future. Half of them (49%) want to use injections. Half of women (48%) have not recently heard or seen a message about family planning in the media.

4.2- Sector resources
The health sector is confronted with insufficient resources and poor management of existing resources. There are three categories of resources – financial, human, and material resources.

4.2.1- Financial resources
Global health expenditures in 2003 were about 96 billion CFA francs. They were mainly financed at 52.1% by households, 30.8% by the State, 16.5% by the rest of the world, and 0.6% by local communities, health insurance and mutuals, and private and public companies.

a- Financing of expenditures by the Ministry of Health
Results of the national accounts for health show changes in the budget indices for the State and for health. The State budget index is increasing more rapidly. This emphasizes the fact that the health sector still does not have all the attention required of the State.

Use of health credits allocated to the Ministry of Health
The overall rate of use of credits allocated to the Ministry of Health was 86.2% in 2003. This rate is low for the part of the Public Investment program (PIP) financed by partners, 66.0%. Analysis of the results of the national health accounts shows that:
The purchase of goods and services that are essentially designated credits to operate community health facilities shows a percentage of 43.7%, while personnel consumes 30.2% and investments 26.1%.

All hospitals together consume 29.5% of this budget, while community health centers consume 54.5% and general administration 13.8%. The Ministry of Health therefore gives priority to mass medicine by allocating almost 55% of its resources to community health. Hospital medicine is not neglected even so.

b- Financing of expenditures by the international community

The overall amount of health financing though international cooperation was almost 11,318,371,202.5 CFA francs, which is US$ 21,203,790.3 or US$3.04 per capita in 2003. The portion of external financing devoted to health fluctuated between 15% and 23% from 1999 to 2003. The average portion of external financing devoted to health was 18.82%, while other sectors divided up more than 80% of this financing. Functional analysis of the credits allocated by the international community shows the priority on outpatient care at 68% of financing followed by prevention (17%), de administration (11%), and inpatient care (4%).

c- Health financing by local communities in Benin.

Historically, the health missions of local communities (LC) through hygiene activities and health inspections were mainly related to group health prevention in terms of hygiene and public health. With today’s decentralization and the autonomy given to communes, they participate just like the Ministry of Health (MS) in all functions, even though the participation still remains very marginal (0.1% of total health expenditures in Benin).

d- Health financing by households

Households make direct payments to both pubic and private healthcare facilities, which constituted 52.1% of total health expenditures in Benin in 2003. Distribution of direct payments by households by function shows that 76% of the expenditures are devoted to pharmaceutical products, 8% to inpatient care, 5% to outpatient care, 5% to laboratory ancillary services, 5% to medical imaging, and 6% to other health expenditures.
These results show that households constitute the main source of healthcare financing despite the low income level. The lack of a mechanism to manage third-party payers makes the situation more cumbersome and complicated.

Graph: Distribution of total health expenditures by function in Benin, 2003

4.2.2- Human resources

a- Availability of personnel

In 2006, there were 6,275 health workers in the public and private health facilities in the country. With this staff, the number of inhabitants per physician was 7,006 for all of Benin. The ratio is relatively satisfactory in light of WHO standards.

In reality, there are great disparities among departments (one physician per 25,829 inhabitants in Alibori versus one physician per 1,690 inhabitants in the Littoral). Only the Littoral, Ouémé, and Atlantique departments have standards higher than the WHO standards\(^5\). All other departments are below this standard. The distribution of medical personnel is therefore inequitable. The unequal distribution is even more marked from one commune to another.

The ratio of the number of women of child-bearing age (FAP, Femme en Age de Procréer) per

---

\(^5\) One physician per 10,000 inhabitants; one nurse per 5,000 inhabitants; one midwife per 5,000 inhabitants
midwife in Littoral is three times higher than the national level, while the level of the Couffo department is one-seventh of the national level.

A clear improvement was observed in the availability of personnel particularly starting in 1999 when the ratios for all categories of personnel showed positive change even in comparison with WHO standards. Disparities still exist, however, between the private sector and the public sector and between urban and rural environments. As the level of health worker training rises, the disparities become even greater.

Table 22- Distribution of health personnel on December 31, 2006

<table>
<thead>
<tr>
<th>Department</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Midwives</th>
<th>Laboratory Technicians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nb</td>
<td>Nb of</td>
<td>Nb</td>
<td>FAP/ MW</td>
</tr>
<tr>
<td></td>
<td>Nb</td>
<td>inhab/phys</td>
<td>of</td>
<td>MW/ 10,000 inhab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>phys</td>
<td>nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alibori</td>
<td>24</td>
<td>25,829</td>
<td>0.39</td>
<td>182</td>
</tr>
<tr>
<td>Atacora</td>
<td>44</td>
<td>14,422</td>
<td>0.69</td>
<td>230</td>
</tr>
<tr>
<td>Atlantique</td>
<td>217</td>
<td>4,522</td>
<td>2.21</td>
<td>620</td>
</tr>
<tr>
<td>Borgou</td>
<td>58</td>
<td>14,860</td>
<td>0.67</td>
<td>459</td>
</tr>
<tr>
<td>Collines</td>
<td>33</td>
<td>18,959</td>
<td>0.53</td>
<td>231</td>
</tr>
<tr>
<td>Couffo</td>
<td>27</td>
<td>23,031</td>
<td>0.43</td>
<td>197</td>
</tr>
<tr>
<td>Donga</td>
<td>21</td>
<td>19,055</td>
<td>0.52</td>
<td>99</td>
</tr>
<tr>
<td>Littoral</td>
<td>426</td>
<td>1,690</td>
<td>5.92</td>
<td>862</td>
</tr>
<tr>
<td>Mono</td>
<td>44</td>
<td>9,160</td>
<td>1.09</td>
<td>219</td>
</tr>
<tr>
<td>Ouémé</td>
<td>145</td>
<td>5,768</td>
<td>1.73</td>
<td>467</td>
</tr>
<tr>
<td>Plateau</td>
<td>26</td>
<td>15,768</td>
<td>0.56</td>
<td>184</td>
</tr>
<tr>
<td>Zou</td>
<td>54</td>
<td>12,473</td>
<td>0.8</td>
<td>334</td>
</tr>
<tr>
<td>Benin</td>
<td>1,119</td>
<td>7,006</td>
<td>1.43</td>
<td>4,084</td>
</tr>
</tbody>
</table>

Source: National Health Information and Management System (SNIGS, Système National d'Information et de Gestion Sanitaires), SSD; Directorate for Planning and Forecasting (DPP, Direction de la Programmation et de la Prospective), Ministry of Health (MS, Ministère de la Santé); Directorate of Internal Inspection and Verification (DIVI, Direction de l'Inspection et de la Vérification Interne), MS; 2006

b- Personnel management

Personnel management in the public sector encounters obstacles because the status of health workers varies:

- Permanent government employee (PGE);
- Contract government employee;
- Contractual workers recruited on community financing; and
- Contractual workers recruited through social measures.

PEGs are governed by the particular statutes of their bodies, and productivity can be evaluated only according to the standards and procedures of the Beninese civil service.
Those, there are the teachers of the College of Health Sciences who provide both teaching and care but fall under only the Ministry for Higher Education. Reporting to two bodies poses the problem of the authority of the Ministry of Health over their care activity.

Contract government workers are recruited by the Ministry for Civil Service on two-year renewable contracts managed by the Ministry for Civil Service.

Contractual workers on community financing are recruited by Management Committees (COGES, Comité de Gestion) on resources from the cost recovery policy to fill the shortage of government workers. Contractually, they fall under the direct authority of the Management Committee of the Health Center or the Physician Chief.

There are contractual workers recruited through social measures. It is a job recruitment financed by the State on resources allocated by the State as part of social measures taken by the government in 2000. Their administrative situation is precarious, because renewal of their contracts in the next year depends on the availability of credits allocated for this purpose.

The coexistence of more than one status in the operation of a health facility can make personnel management complex and can affect team cohesion and the social climate of the health center.

For career management, the practice of assignments and promotions considered absurd is often lamented when considering the career development of workers who are the victims of these failings. Personnel transfers do not always take into account the forecasting or needs established in the periphery, which adds to lack of worker motivation. Of course, poor control of the consistency of assignments also makes future control of the development of the health system difficult.

Insufficient and poorly distributed human resources seriously limit the implementation of health system reform in Health Areas. The personnel necessary for the development of Health Areas is blatantly lacking.

There is a crucial shortage of surgeons and anesthesiologists in several Health Areas. The very few specialists available are forced to travel to work periodically in the Commune Health Centers (CSC).

The personnel shortage is quite marked in the northern part of the country where the caregivers assigned to the health facilities of this region of the country do not stay and prefer to work in the south.
Generally, the challenges in the field of human resources for healthcare are numerous. Like most African countries, Benin is facing a crisis in human resources characterized by insufficient care personnel and inadequate productivity of healthcare professionals with the sector’s need for skills especially for allied health personnel.

The strategic and operational management of human resources brings deficiencies to light particularly in the planning for development of human resources, consideration of the private sector, the management and monitoring of worker careers, personnel motivation, performance incentives and establishing worker loyalty to jobs in disadvantaged areas, the protection of personnel from occupational hazards, research on the problems related to human resources, etc.

4.3- Material resources

4.3.1- Health infrastructure situation

Benin has a pyramid health structure modeled on the division of the territory.

It includes:

- In the periphery, the district health center (for districts), the commune health centers (for communes), and Area Hospitals (for Areas). To this infrastructure are added isolated community clinics and maternity units, the Village Health Units (UVS), and the Solidarity Actions Centers for Health Development (CASES, Centre d’Action de Solidarité pour l’Évolution de la Santé);
- At the intermediate level, the departmental hospital centers and related health facilities; and
- At the central level, the National University Hospital Center, the Essential Generic Drugs Purchasing Center, and other specialized facilities, which are the Pulmonary Tuberculosis Center and the Psychiatric Center.

The situation of the infrastructure at each of these levels is shown below.

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Atacora/ Donga</th>
<th>Atlantique/ Littoral</th>
<th>Borgou/ Alibori</th>
<th>Mono/ Couffo</th>
<th>Ouémé/ Plateau</th>
<th>Zou/ Colline</th>
<th>All of Benin</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Center (CSA, CSA)</td>
<td>59</td>
<td>72</td>
<td>71</td>
<td>62</td>
<td>67</td>
<td>95</td>
<td>425</td>
</tr>
</tbody>
</table>
Health infrastructure coverage has improved. Disparities exist, however, particularly in the departments of Zou/Collines and Atlantique/Littoral, where the CSA coverage rate is below the national average. Within the departments, the disparity is even greater. Although the average CSA coverage level in Atacora/Dongais 87%, the CSA coverage level in the Djougou Health Area surprisingly scarcely exceeds 45%. The same is true for the Health Areas of Bohicon and Covè where the levels are 48% and 56% respectively with a departmental average of 61%.

Aside from these disparities, there is also the dilapidated condition of 40% of the infrastructure, most of which does not comply with standards. There is a similar problem with equipment.

### 4.3.2- Equipment situation

Problems with lack of equipment are a hindrance or even a hazard to the quality of diagnosis and treatment for patients, for example, during surgical procedures in an under-equipped environment (non-functional ventilator, no sterilizer, etc.). We have not been able to get a lot of information on equipment levels in public health facilities. As for buildings, the State has also made a lot of effort in the area of equipment to make the public health facilities more functional.
Much remains to be done, however, concerning the means of transportation that are useful for moving patients, supervisors, and vaccinations. The means of communication are inadequate to establish regular liaisons among health centers.

Maintenance difficulties are costly because of the sometimes-permanent shutdown of unamortized equipment that was often expensive to acquire. Longevity of infrastructure and equipment that often was acquired at very high cost is not ensured, seeing as it very quickly is out of service with no means to replace it.

The acuteness of the problems of servicing and maintenance in health facilities leads to the assumption of very limited maintenance capacity in the sector (insufficient qualification and/or specialists).

Maintenance problems have direct repercussions on the operation of the entire healthcare system – evacuation, supervision, drug and vaccine procurement, etc.

4.4- Organization of the healthcare system

4.4.1- Health pyramid

The healthcare system in Benin has a pyramid structure taken from the divisions of the territory. It has three different levels:

- **The central or national level** is administered by the Ministry of Health, which implements the health policy defined by the government. From this perspective, it initiates health action, plans the organization, and coordinates and monitors the implementation of health projects and programs. At this level are found healthcare facilities such as the Hubert Koutoukou Maga National University Hospital Center (CNHU, Centre National Hospitalier et Universitaire), the National Pulmonary Tuberculosis Center, the National Psychiatry Center, and the Lagune Maternal Child Hospital (formerly Lagune Maternity Unit).

- **The intermediate or departmental level** is administered by the Departmental Health Directors. Health activities at this level take place in departmental hospitals. The departmental administrations (there are currently six) are responsible for implementing the health policy defined by the government, the planning and coordination of all health services activities, and epidemiologic surveillance in the departments. The departmental hospital centers are the referral center for cases
referred by Area Hospitals (for those that are operational) or by the health centers.

➢ The peripheral level is the most decentralized operational entity of the health system. The country is divided into 34 areas. Each area is called a Health Area and brings together a number of first-line of contact public health services (UVS and CS, Centre de Santé) and private health facilities supported by a referral hospital (public or private) called the Area Hospital. The Health Area is a legal entity and has management autonomy. It is supervised by the Ministry of Health. Its management bodies are the Health Committee of the Health Area (CS/ZS, Comité de Santé/Zone Sanitaire) and the Health Area Training Team (EEZS, Équipe d’Encadrement de la Zone Sanitaire).

4.4.2- Public sector

Aside from the Ministry of Health, the public sector designates the other government facilities involved in the provision of care.

The Ministry of Defense is the most important of these. It manages the Armed Forces Training Hospital, 10 medical-social centers, and five medical posts inside the country.

The Armed Forces Health Service (SSA, Service de Santé des Armées) provides care to Benin’s armed forces personnel and to the police departments and their families, which is a group of several tens of thousands of patients. It has services available including specialties such as cardiology, radiology, gynecology, oral medicine, etc.

It also sees private patients other than those listed above, but they must pay for the care they are given.

4.4.3- Private sector

Principal components of the private sector

With the advent of economic liberalism, private medical units are flourishing. As an example, in 1997, there were 580 private health facilities in all categories combined for the entire country⁶. This increased to 660 in 1998. Statistics showed that almost 60% of the private

⁶ Annual Health Statistics, Ministry of Public Health (MSP) 1997
facilities were concentrated in the city of Cotonou, which has only 9.75% of the population\(^7\).

There are:

- The non-affiliated private sector, which consists of two categories of health facilities, medical-technical facilities (clinics, multispecialty clinics, generalist and specialist physician offices, dental offices, and diagnostic centers/laboratory and radiology), and health facilities run by nurse ancillaries and midwives (nursing care offices and normal-delivery clinics). The presence of the non-affiliated private sector is reported chiefly in the southern part of the country particularly in urban environments.

- The sectarian and association private sector whose presence has been reported for about 30 years. It fills the deficit of health coverage in the country. Other than a few small community clinics run since time immemorial by people belonging to religious orders, the sectarian facilities inside the country are mainly hospitals. With about 1,000 beds (25% of the national beds), they account for almost 40% of the hospital days produced by Benin’s healthcare system\(^8\).

- The private pharmaceutical sector consists of a small pharmaceutical industry that packages medications, four wholesalers-distributors authorized only to import medications for income-producing private facilities, a network of 125 pharmacies including 97 in the departments of Atlantique and Ouémé, and about 250 authorized pharmaceutical warehouses that contribute to extending pharmaceutical coverage. The private pharmaceutical sector processes 40% of the medication volume with estimated annual sales of about 24 billion CFA francs\(^9\) at list prices. In comparison, the Essential Drugs Purchasing Center (CAME, Centrale d’Achat des Médicaments Essentiels) manages 60% of the volume with sales of only 2.5 billion CFA francs.

There is nevertheless a network of illicit sales of medications and a propensity for self-medication. In Benin, the extent of illegal drug sales is increasingly disturbing. The activity takes place openly, seeing as it uses the traditional distribution channels of the markets,

\(^7\) National Institute of Statistics and Economic Analysis (INSAE, Institut National de la Statistique et de l’Analyse Économique), General Population and Housing census (GPHC) preliminary results

\(^8\) MSP, Statistics Yearbook, 1998

\(^9\) Sales of wholesalers-distributors: 12 billion CFA francs including 5% of business with countries of the sub-region. Benin portion: 95% or 11.4 billion CFA francs. List price value: x 1.27 or 14.5 billion CFA francs.
shops, roadsides, and door-to-door. In the markets, drug sellers are not distinguished from other merchants and likewise pay the taxes required by official institutions. The development of the parallel market poses a real public health problem if only because of the continuously increasing risks.

4.4.4- Traditional medicine

Despite high usage, there is very little information on the resources and activities of traditional medicine. It is not truly incorporated into the concerns of the health sector. Trusting relationships do not exist between health workers and traditional healers despite numerous initiatives (inclusion of matrons in the health centers, approval of traditional practitioners in hospitals, etc.) in recent years to promote them. Traditional practitioners have been encouraged by the public powers to form a national association. There were internal coordination difficulties, which reduced the cooperative efforts undertaken by the authorities with the association.

In March 2002, the Ministry of Health adopted by policy of the promotion and incorporation of the pharmacopeia and traditional medicine into the national healthcare system. It aimed to codify the practice of traditional medicine and ensure the availability, accessibility, and rational usage of effective traditional medications in the national healthcare system. Among the activities carried out in this framework, there was the census of traditional medicine practitioners whose number was estimated at 7,500 in 1999, the development of the list of rare medicinal plants by commune, and the training of 800 traditional practitioners on malaria.

4.4.5- Blood transfusion

The national blood transfusion network consists of the National Blood Transfusion Service, the Departmental Blood Transfusion Services, the blood banks, and Blood Transfusion Posts in health facilities. Promotion activities for blood donation are not actually effective in the departments for lack of material, financial, and logistics means.

The sub-sector is still far from meeting the demand. The rate of meeting the demand for blood products is 86.5%, but this number does not take into account the requests for which no blood products are available.

The cost to produce one bag of verified blood was calculated and estimated in 2002 at 20,000
CFA francs. Based on technological changes and new tests that have been done since on donated blood, the cost is only increasing. One unit of verified blood is currently sold for 1,500 CFA francs, which demonstrates a significant margin to be subsidized. The sale price of a unit of blood is not adhered to everywhere.

4.4.6- Health research
In Benin, research is the major mainstay of development of the health sector and is not yet fully playing its part. In 1991, the Republic of Benin identified with the assistance of the United Nations Special Commission on Health Research for Development the priority problems in health and development that could be the subject of research activity useful for effective decision making by the country’s leaders.

The sources of financing on its own and external funds are the most important. The national budget financed only 3 of the 33 research subjects cited. It therefore appears that the national budget plays a very small part in research activities.

4.4.7- Health information
The importance of health information in the planning and decision making for improvement of living conditions of the people no longer has to be demonstrated.

In Benin, the health information system is mainly organized by the National Health Information and Management System (SNIGS, Système National d’Information et de Gestion Sanitaires) along with the alert system (for integrated surveillance of disease and response) and the system for specific programs (AIDS, malaria, tuberculosis, leprosy, etc).

Although the system is active and regularly produces the main indicators for performance evaluation of the sector, it is severely disrupted by a woeful lack of resources (financial, material, and human) and appropriate mechanisms for coordination between the SNIGS and the sub-systems that supplement it. These all seriously affect the quality and reliability of data.

Furthermore, the private sector, which is very active in the field, is poorly integrated with the health information system. Fewer than 10% of private health facilities are integrated into the SNIGS database. Most of the private health facilities are sectarian private health facilities.
V- ANALYSIS OF SECTOR PERFORMANCE

5.1- Sector problems
The following 25 sector problems have been compiled:

- Low accessibility of the population to basic social services – health, education, water, electricity, etc.
- Pollution of the atmosphere
- Uncontrolled urbanization
- Low coverage in potable water
- Poor waste management
- The outbreak of infectious and parasitic diseases
- Strong demographic pressure
- High mortality rate
- Lack of clarification of relationships among Health Areas and decentralized administrative structures
- Precarious financing mechanism of Health Areas
- Lack of adherence to good governance practices
- High proportion of public and private health centers non-compliant with norms and standards
- Weak partnership between the public sector and the private sector
- Poor integration of traditional medicine in the healthcare system
- Difficult access to healthcare for households
- Inequity in the distribution of the sector’s resources
- Low use of resources
- Poor financial viability of hospital facilities
- Poor career management
- Poor performance healthcare providers
- Lack of equipment in health facilities
- Low use of public health facilities
- High morbidity rate
- High rate of malnutrition in mothers and children
- High maternal mortality rate

Grouping of the priorities established by the stakeholders at various levels of the health pyramid and consideration of the recommendations of the États Généraux (general meeting) brought out the following seven priority problems:

1- Poor access of the population to basic social services (education, health, water, etc.),
2- Poor planning for the acquisition, construction, and maintenance of infrastructure and equipment,
3- Precarious financing mechanism for healthcare expenditures,
4- High morbidity and mortality,
5- Insufficient inter- and intra-sector cooperation,
6- Non-compliance with good governance practices, and
7- Poor human resources management.

These seven priority problems underline the following concerns for the sector.

5.2- Sector concerns
There are five (05) sector concerns:
   a) The fight against disease,
   b) Development of the sector’s human resources,
   c) Physician partnership and responsibility,
   d) Financing of the sector, and
   e) Management of the sector.

5.3- Ministry of Health vision
The global vision of Benin contained in the National Studies of Long-Term Perspectives: Benin 2025 stresses social well-being based among others on the following elements:

- an efficient and effective education system;
- quality healthcare;
- potable water, electricity, and healthy housing for everyone; and
- a healthy living environment.
The vision will gradually be made practical through implementation of the Millennium Development Goals (MDG), decennial plans, the Growth and Poverty Reduction Strategy (GPRS), and various governmental action programs. Action targeting the improvement of social-health conditions of the population is a priority. The Ministry of Health (MS) is responsible for the development and implementation of the health part.

Following the work of the États Généraux (general meeting) on health of November 2007, a vision capable of contributing to strengthening the performance of Benin’s national healthcare system was defined and is stated below.

“In 2025, Benin will have an effective health system based on public and private and individual and group initiatives for the ongoing provision and availability of quality, equitable, accessible care to the populations of all categories founded on the values of solidarity and risk-sharing to meet all the health needs of the Beninese people.”

The mission of the Ministry of Health thus is to “improve the social-health conditions of families based on a system that incorporates poor and indigent populations.”

To do this, the following global objectives have been defined:

• Ensure universal access to healthcare services and better quality of care to achieve the Millennium Development Goals (MDG).
• Strengthen the partnership for health.
• Improve the governance and management of resources in the health sector.

In view of achieving these objectives, the National Health Development Plan has the following five (05) main strategic areas:

• The prevention of and fight against the main diseases and improvement of the quality of care;
• Development of human resources;
• Strengthening of the partnership in the sector and the promotion of ethics and physician responsibility;
• Improvement of the sector’s financing mechanism; and
• Strengthening of the sector’s management.

These priority areas have been broken out into programs and sub-programs whose efficient
implementation will allow the healthcare sector to rise to the multiple challenges.

To achieve that, the following priority action must be taken.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Area</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure universal access to healthcare services and better quality of care to achieve the Millennium Development Goals (MDG).</td>
<td>• The prevention of and fight against the main diseases and improvement of the quality of care.</td>
<td>- Make all Health Areas functional so they can be the mainspring of operational implementation of this plan. – Promote the culture of the continuum of care, namely, health promotion and preventive, curative, rehabilitation, and palliative care. - Raise to the level of a national priority the assurance of quality of care and services at all levels, which necessarily leads to meeting certain prior conditions (100% availability of services 24/24, cultural and financial accessibility, and the establishment of norms, standards, and procedures).</td>
</tr>
<tr>
<td>• Strengthen the partnership for health.</td>
<td>• Strengthening of the partnership in the sector, the promotion of ethics, and physician responsibility. • Improvement of the sector’s financing mechanism.</td>
<td>- Implement the incorporation of various types of medicine (western, alternative, and also traditional medicine) and the incorporation of the activities within each of the types of medicine. - Establish an environment that promotes modernization of the Beninese healthcare system. - Promote visionary leadership based on a systemic, participative, non-bureaucratic approach that seeks better consistency of the management process. - Set up a creative, transparent, effective arrangement for financing the sector involving all sectors and all involved parties (health insurance and health mutuals).</td>
</tr>
</tbody>
</table>
| • Improve the governance and management of resources in the health sector. | • Development of human resources. • Strengthening of the sector’s management. | - Set up a national body responsible for conceptualization of the vision and sector policies. - Promote a patient-focused managerial culture that encourages placing the needs and rights and the interests and problems of patients receiving services above all other considerations. - Establish a management system based on a culture of performance, a sense of responsibility, and centered on results. - Transform healthcare administration into an administration obligated to achieve results, obligated to provide reports, and subject to public evaluation. - Review the provisions of the Agreement on Government Procurement to simplify and involve users in the...
The State will now be the regulator of the system and responsible for the design of policy and standards and for their monitoring and evaluation.

This vision requires that the sector optimize available resources and potential. Making following areas priorities therefore seems urgent.

5.4- Priority areas
There are five (05) priority areas:

- The prevention of and fight against the main diseases and improvement of the quality of care.
- Development of human resources.
- Strengthening of the partnership in the sector and the promotion of ethics and physician responsibility.
- Improvement of the sector’s financing mechanism.
- Strengthening of the sector’s management.

These priority areas have been broken out into programs and sub-programs based on the strategic directions defined in the policy.
VI- PRIORITY AREAS, PROGRAMS AND SUB-PROGRAMS OF THE SECTOR.

6.1- Priority Area: Preventing and combating disease and improving health care quality

6.1.1- Program: Promoting hygiene and basic sanitation
For several decades, throughout the world and particularly in the poor nations, hygiene and sanitation have often been neglected as having no immediate effect in terms of results.

Like other African countries, Benin underwent the International Drinking Water Supply and Sanitation Decade (IDWSSD); but despite efforts made by the government and development partners, 39% of the population of Benin does not have access to drinkable water and 67% does not have adequate sanitation service (EDSB 2).

In Benin, several ministries operate in the sanitation sector. These are the Ministry of Health, which defines policy in matters of hygiene, sanitation and prevention, and the Ministries of the Environment and of Public Works, which develop environmental policy, major sanitation projects and highway safety policy. The Ministry of the Interior has administrative oversight of local authorities responsible for implementing various policies.

The question of environmental quality is an important component of prevention, accentuated for better or for worse by the behavior of individuals and communities in matters of hygiene and sanitation. Government services have been set up to heighten awareness and assist individuals and communities in acquiring a healthy quality of life; these were mainly the Department of Hygiene and Basic Sanitation and especially the agents of the Department of Sanitation. Various legal texts and framework papers have been developed (cf. Annex 1).

Two (2) sub-programs have been indicated to take charge of the country’s significant priorities in the area of health care promotion and preventive health care. These are:

   a) Provision of basic services and cleaning of the environment

   b) Information influencing practices.

a- Sub-program: a) Provision of basic services and cleaning of the environment
**General goals**: To contribute to improving the surroundings and living conditions of the public.

**Specific goals**
- Promoting hygiene and basic sanitation in rural settings;
- Promoting hygiene and basic sanitation in the urban and outlying-urban areas;
- Improving operating capabilities of the DHAB and its decentralized facilities.

**Expected outcomes**: Hygiene and basic sanitation will be improved by integrated action of various participants between now and 2016.

**Strategies**
- Operational integration of waste-management activities;
- Improving operating capabilities of decentralized facilities;
- Involvement of local authorities and NGOs in hygiene and sanitation activities;
- Effective implementation of the compulsory measures provided for in existing laws and regulations;
- Information influencing practices.

**Lines of action**
The key points regarding the main activities of basic services and cleaning of the environment are indicated in the document, National Program of hygiene and basic sanitation and the five-year operationalization plan.

It includes the following:
- Construction of additional units of BHS divisions in the administrative districts (départements) without them and furnishing them with office fixtures and equipment;
- Allocation to the BHS divisions of rolling stock and enough qualified personnel (sociologists, health and sanitation police personnel);
- Training and recycling of the personnel operating in health and sanitation activities through short-term training or workshops and seminars;
- Outreach and social mobilization toward technical and financial partners of the sector, local authorities, the private sector and especially end-user populations;
- Implementation of resources functionally necessary to make services available;
- Providing institutional support to the DHAB and its decentralized facilities (supply sanitation agent facilities with uniforms and office fixtures and equipment)
- Ensuring monitoring and evaluation of the national program of hygiene and basic sanitation through oversight, studies and monitoring.

**b- Sub-program: - Information influencing practices**

**General goals:**
- Improving individual and group practices in matters of health.

**Specific goals:**
- Promoting health information campaigns at the community level (community cooperation, community-based services, coordination structures at the community level);
- Developing/improving the capabilities of providers in providing quality services as regards information influencing practices;
- Promoting information to develop health care through professionals’ practices;
- Promoting information for young people to motivate desirable practices.

**Expected outcomes:**
- Health information campaigns promoted at the community level;
- Quality services provided as regards information influencing practices;
- The capabilities of health care providers improved;

**Strategies:**
- Involvement of the end-user community,
- Improving intra- and inter-sectoral collaboration,
- Improving partnerships/alliances/networks,
- Improving skills and capabilities of providers,
- Promoting research/action,
- Promoting audiovisual production for the levels of society at risk,
- Improving social marketing.

**Lines of action:**
The key points regarding the main activities of social information are indicated in the document, Policy and national information strategies for health care development. These are:
- Developing and implementing an information and awareness plan toward aseptic practices and prevention of hospital-acquired infections at all levels of the health care system,
- Implementing a decentralized information structure at the level of each department;
- Training local agents and participants in the new techniques of health care development information;
- Coordinating the production activities of support and strategic information plans of the sector;
- Performing monitoring and evaluation of the activities of the IEC through oversight, studies and monitoring.

6.1.2- Program: Reproductive health

Reproductive health, according to the Benin family health norms and standards policy document, aims at general well-being, physical and mental as well as social, of the individual human being, for everything concerning the genitalia, their functions and their functioning and not only the absence of disease or disability relative to functioning and the functions of their genitalia and not only disease or disability concerning them.

In Benin, the adoption of the population policy statement in 1996 marked an initial acceleration of the creation of multiple institutional measures promoting reproductive health care. Indicative in this respect is the implementation of essential laws and documents listed in Annex 1.

Two (2) sub-programs have been indicated to take charge of the country’s significant priorities in the area of reproductive health care, underscoring the place of MDGs in national policy:

a) Combating maternal and newborn mortality,

b) Combating under-age-five mortality.

a- Sub-program: Combating maternal and newborn mortality

General goals:

Reducing the ratio of maternal mortality from 474 per one hundred thousand live births in 2002 to 125 per one hundred thousand live births by 2016 and reducing the rate of newborn mortality from 38.2 per thousand live births to 10 per thousand live births by 2016.

Specific goals:

- Increasing fulfillment of EmONC service needs from 22.9% in 2003 to 100% by 2010,
- Increasing the coverage rate for caesareans from 2.6% in 2003 to a norm of 5% by 2010,
- Increasing the rate of use of family planning services from 7% to 15% between now and 2016
- Improving the rate of PNC from 80% to over 90% during the period 2009-2018.
- Ensuring the full range of maternal and newborn health care at all levels of the health care system by 2018.
- Reducing from 60% to 20% the percentage of pregnant women suffering iron deficiency anemia, by 2018.
- Reducing maternal mortality by 50% by 2010.

**Expected outcomes:**

- Fulfillment of EmONC service needs increased from 22.9% in 2003 to 100% by 2010.
- The coverage rate for caesareans gone from 2.6% in 2003 to a norm of 5% by 2010.
- The usage rate of family planning services 15% by 2016.
- The PNC rate above 90% by 2018.
- Newborn and maternal health care ensured at all levels of the health care system by 2018.
- The percentage of pregnant women with iron deficiency anemia reduced from 60% to 20% by 2018.
- The maternal mortality rate reduced from 50% by 2010.

**Strategies:**

- Twenty-four-hour-a-day availability of the optimum set of highly effective obstetric and newborn procedures in all national and administrative districts (départements) hospitals, as well as in all health care units of the Health Areas.
- Financial and geographic accessibility of the optimum set of highly effective obstetric and newborn procedures in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving the quality of obstetric and newborn services in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving the usage rate of obstetric and newborn services in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving the usage rate of deliveries assisted by qualified health care personnel in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving education of the family and pregnant women to improve the nutritional practices of pregnant women.
- Improving the capabilities of individuals, families and the community to improve the health of the mother and the newborn.
- Improving the reorganization of maternal and newborn health care provision services.
- Improving family planning services.
- Improving the partnership with the private sector to ensure availability, accessibility and quality of the optimum set of highly effective obstetric and newborn procedures.

**Expected outcomes:**

- Twenty-four-hour-a-day availability of the optimum set of highly effective obstetric and newborn procedures in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Establishment of financial and geographic accessibility of the optimum set of highly effective obstetric and newborn procedures in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Establishment of quality obstetric and newborn services in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving the usage rate of obstetric and newborn services in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving the usage rate of deliveries assisted by qualified health care personnel in all national and departmental hospitals, as well as in all health care units of the Health Areas.
- Improving education of the family and pregnant women to improve the nutritional practices of pregnant women.
- Improving the capabilities of individuals, families and the community to improve the health of the mother and the newborn.
- Improving the reorganization of maternal and newborn health care provision services.
- Improving family planning services.
- Improving the partnership with the private sector to ensure availability, accessibility and quality of the optimum set of highly effective obstetric and newborn procedures.

**Lines of action:**
The key points regarding the main activities of maternal and newborn mortality are indicated in the national strategy documents and the five-year implementation plan for combating maternal and newborn mortality. Included are:

As part of the optimal set of immediate procedures:

- supplying emergency obstetric kits to private and public health care units (about 6000 kits per year) and ensuring wide geographic and financial availability at all times of the set of immediate procedures.

- Reaching an iron fortification rate corresponding to the PNC coverage rate by 2018.

- Developing a permanent strategy to make the iron fortification level correspond to the level of PNC coverage.

Regarding health care system procedures:

- Installing qualified, competent human resources in various administrative functions (for example, the departmental reproductive health teams), provision of services functions (at least 24 medical specialists and registered midwives) and supervision and monitoring functions.

- Supplying equipment (ambulances), supplies and products to satisfy the needs of transportation and communication.

- Continuing development and distribution of framework papers.

- Improving regulation and financing of health care in order to take better care of reproductive health.

- Outreach and social mobilization toward partners, local authorities, the private sector and above all the public.

- Conducting operational research at all levels of the health care sector.
b- Sub-program: Combating under-age-five mortality

**General goal:**

Reducing under-five morbidity and mortality

**Specific goals**

*In connection with immunization*

- Maintaining availability of immunization at 100%;
- Achieving immunization coverage at or above 80% for all antigens in 100% of communes between now and 2011;
- Increasing the usage rate from 80% to 90% between now and 2016;
- Reducing the withdrawal rate between Pentavalent1 and Pentavalent3 to 10% between now and 2011
- Eradicating polio between now and 2011;
- Eliminating neo-natal tetanus between now and 2011;
- Measles under control;
- Yellow fever, hepatitis B and Hemophilus Influenza B infections under control;

*In connection with IMCI*

- Putting the IMCI strategy into general use, going from 22 Health Areas to 30 Health Areas by 2010;
- Establishing provision targets, in the public and private sectors and in the community setting, for the Minimum Package of Activities/nutrition (MPA/nut.);
- Increasing the rate of exclusively maternal nursing from 0 to 6 months from 38% to at least 60%;
- Ensuring vitamin A fortification for children ages 6 to 59 months each year;

**Expected outcomes**

*In connection with immunization*

- Immunization available and kept at 100%;
- Accessibility of immunization services 100% by 2016;
- The usage rate gone from 80% to 90% by 2016;
- Immunization coverage kept at 90% in all countries;
- Polio eradicated by 2018;
- Neo-natal tetanus gone by 2018;
- Measles under control;
- Yellow fever, hepatitis B and Hemophilus Influenza B infections under control;

  *In connection with IMCI*

- The IMCI strategy applied in 30 Health Areas by 2010;
- The provision targets, in the public and private sectors and in the community setting, for the Minimum Package of Activities/nutrition (MPA/nut.) established;
- The rate of exclusively maternal nursing from 0 to 6 months increased from 38% to at least 60%;
- Ensured vitamin A fortification for children ages 6 to 59 months each year;

**Strategies**

- Implementation of the EDA, with particular emphasis on improving the advanced strategies and active search for those with whom contact has been lost.
- Mobilization of additional resources in the context of immunization independence.
- Improving intra- and inter-sectoral collaboration and collaboration with international cooperation.
- Rehabilitation and renovation of cold-chain equipment.
- Improving capabilities of personnel at all levels and integration of EPI management and the IMCI in the curricula of health care schools and training institutions.
- Development of communication with the public to influence behavior.
- Implementation of the IDSR at all levels of execution of the program.

**Lines of action**

Immunization coverage is much improved, with a coverage rate for fully immunized children that has gone from 59% in 2001 to 83% in 2004. It will therefore be necessary to:

- Accentuating efforts in 5 departments with rates below the national average, Atacora (81%), Atlantique (75%), Littoral (82%), Oueme (72%) and Plateau (65%).
- Collaborating with other sub-programs, such as the health promotion program, the program to combating disease, etc.
- Putting the IMCI into general use by swiftly extending activities to the poorly covered departments of Atacora / Donga.
- Applying jointly the community IMCI with the clinical IMCI,
- Putting the IMCI into general use by going from 5 active Health Areas in 2005 to the full 30 Health Areas by 2010.
- Improving the training of IMCI providers by going from the 807 trained in 2005 to
  the full 2100 public and private sector providers indicated for 2010. Train all public
  and private sector providers, as well as those at the community level in
  MPA/nutrition.

6.1.3- Program: Combating disease

In 1978 in Alma Ata, the international community set as goal “health for everyone by the
year 2000.” Today, that goal is far from being reached, because in most of the poor countries
like Benin, morbidity and mortality levels remain very high. So, in order to carry out its
mission “of improving families’ socio-sanitary conditions on the basis of a system integrating poor
and destitute populations,” the Ministry of Health of Benin is making combating disease one of
the priorities of the sector. From the institutional point of view, various laws and framework
papers were developed (cf. Annex 1).

Nine (09) sub-programs have been indicated to take charge of the country’s significant
priorities in the area of combating disease.

   a) Combating priority diseases (STD/HIV/AIDS, malaria and tuberculosis).
   b) Combating other communicable diseases
   c) Combating the main noncommunicable diseases.
   d) Improving the availability and quality of generic medication at low cost
   e) Promoting diagnostic research and transfusion safety and diagnostic tests.
   f) Promoting traditional medicine and pharmacopoeia
   g) Promoting health in the school, university and occupational settings;
   h) Promoting mental health
   i) Promoting health research

a- Sub-program: a) Combating priority diseases

Priority diseases include HIV/AIDS, malaria and tuberculosis

General goal

Reduce by at least 50% the prevalence of HIV/AIDS, malaria and tuberculosis between now
and 2018.

Specific goals
- Extending the medical scope of PLHIV, including children, particularly access to antiretrovirals by going from 3500 persons at the end of 2005 to 8500 by 2010.

- Ensuring the correct treatment of every patient for opportunistic infections, including co-infected persons diagnosed with TB/HIV.

- Increasing from 10,000 to 20,000 between now and 2010 the number of orphans and infants at risk receiving treatment services in all the communes of Benin.

- Reducing the incidence of STDs from 44.4 per 10,000 in 2003 to 25 per 10,000 in 2010 by expanding quality treatment procedures for cases of groups at risk in the 34 Health Areas and in 145 private institutions.

- Reducing by 10% between now and 2010 the risk of HIV transmission from mother to child by expanding PMTCT services.

- Increasing the number of individuals voluntarily screened for HIV from 85,000 to 300,000 by the year 2010.

- Increasing prevention among the young and specific groups.

- Improving strategic information, particularly epidemiologic monitoring of HIV and STDs, by increasing sentinel sites from 45 to 65 by 2010.

- Improving diagnosis and biological monitoring of HIV by training/recycling of laboratory personnel and by improving laboratory technical equipment.

- Taking part in improving the capabilities of the permanent secretariat, the departmental secretariats and 77 communal committees to make coordination of the national response better.

- Reducing by 50% morbidity and mortality due to malaria between now and the end of 2010.

- Ensuring between now and the end of 2010 the correct treatment of 80% of children under 5 years of age infected with malaria.

- Increasing to at least 80% the proportion of pregnant women and children under the age of 5 years using the impregnated mosquito net and other ITM, between now and 2010.

- Increasing to 80% the proportion of pregnant women generally and primiparous women in particular practicing intermittent preventive treatment, between now and 2010.

- Curing 85% of the cases of contagious tuberculosis (with a positive smear) detected each year by 2010.
- Detecting at least 90% of the cases of contagious tuberculosis (with a positive smear) arising each year among the public, by 2016.

**Expected outcomes**
- Medical treatment of PLHIV, including children, particularly with access to antiretrovirals, by going from 3500 persons at the end of 2005 to 8500 by 2010 realized.
- Correct treatment of every patient for opportunistic infections, including co-infected persons diagnosed with TB/HIV, ensured.
- The number of orphans and infants at risk receiving treatment services in all the communes of Benin increased to 20,000 by 2010.
- The incidence of STDs reduced from 44.4 per 10,000 in 2003 to 25 per 10,000 in 2010 by expanding quality treatment procedures for cases of groups at risk in the 34 Health Areas and in 145 private institutions.
- The number of individuals voluntarily screened for HIV increased from 85,000 to 300,000 by the year 2010.
- Prevention among the young and specific groups increased.
- Strategic information, particularly epidemiologic monitoring of HIV and STDs, improved by increasing sentinel sites from 45 to 65 by 2010.
- Diagnosis and biological monitoring of HIV improved by training/recycling of laboratory personnel and by improving laboratory technical equipment.
- The capabilities of the permanent secretariat, the departmental secretariats and 77 communal committees improved to make coordination of the national response better.
- Morbidity and mortality due to malaria reduced by 50% at the end of 2010 compared to 2001.
- The correct treatment of 80% of children under 5 years of age infected with malaria ensured between now and the end of 2010.
- The proportion of pregnant women and children under the age of 5 years using the impregnated mosquito net and other ITM increased to at least 80% by 2010.
- The proportion of pregnant women generally and primiparous women in particular practicing intermittent preventive treatment increased to at least 80% by 2010.
- 85% of the cases of contagious tuberculosis (with a positive smear) detected yearly cured by 2010.
- At least 90% of the cases of contagious tuberculosis (with a positive smear) arising yearly among the public detected by 2016.

**Strategies**

*Specific STD/HIV/AIDS Strategies*
- Increasing voluntary screening and medical treatment of PLHIV/AIDS
- Developing operational research on STD/HIV/AIDS
- Developing psychosocial treatment of persons infected and affected
- Improving STD treatment through the syndrome approach and improving health care personnel capabilities
- Sizing the program to reduce mother-to-child transmission (PMTCT) of HIV
- Expanding prevention of sexual transmission of HIV with increase of the awareness/information procedures and promotion of condoms
- Increasing transfusion safety and nationwide precautions for prevention of blood transmission
- Developing second-generation epidemiologic monitoring

*Specific malaria strategies*
- Improving malarial prevention through the integrated antivector fight and environmental sanitation
- Improving the quality of treatment of cases at the health care unit level and in the community
- Promoting IPT among pregnant women
- Developing community-based initiatives in combating malaria
- Improving epidemiologic and entomologic monitoring and the effectiveness of monitoring-evaluation and antimalarials in combating malaria
- Developing services networks for parasitological diagnosis of disease,
- Decentralizing and integrating primary health care activities.

*Transverse Strategies*
- Introducing new treatment strategies for priority diseases in the training curricula of schools for health care professionals
- Improving sub-systems of monitoring-evaluation
- Improving implementation of quality measures in laboratories.

**Lines of action**
- Installing a voluntary screening and treatment unit in every Benin commune
- Regular stocking of ARV medications to cover needs gradually increasing from 3500 to 8500 patients.
- Training/recycling all public and private service providers in treatment of STDs by the syndrome approach
- Installing a PMTCT unit in each maternity hospital in Benin
- Increasing IEC activities among the public
- Improving all laboratory equipment and RDT supplies for all patients
- Training/recycling all laboratory personnel
- Training/recycling all health care centers personnel in treatment of malaria
- Increasing integrated vector-combating activities by sanitation of living conditions in all towns in Benin and by household fumigating
- Promoting intersectoral collaboration
- Promoting research by increasing the funds allocated
- Training/recycling personnel in treatment of the ill
- Increasing screening campaigns supported by community work teams.

**b- Sub-program b) Combating other communicable diseases**

Other communicable diseases include:
- Diseases constituting major public health problems such as African human trypanosomiasis;
- Potentially epidemic diseases such as meningitis, cholera, measles;
- Diseases to be eradicated/eliminated: Polio, dracunculosis, maternal and newborn tetanus.

**General goal:**
Reducing by at least 50% the morbidity and mortality due to communicable diseases between now and 2016.

**Specific goals:**

- Establishing an effective integrated epidemiological monitoring system between now and the end of the year 2009,

- Improving capabilities of stakeholders in prompt and effective treatment of cases/epidemics between now and the end of the year 2009.

**Expected outcomes:**

- Existence of an effective integrated epidemiological monitoring system by the end of the year 2009.

- Capabilities of stakeholders in prompt and effective treatment of cases/epidemics improved before the end of the year 2009.

**Strategies:**

- Improving the institutional framework.

- Improving treatment quality of cases in health care facilities and at home.

- Integration of the program into various health care structures to allow decentralization of activities nearer to the needs of the public.

- Improving research capabilities.

- Improving human resources capabilities.

- Promoting partnership to ensure sustainable adequate financing of all sections of the program.

- Regular periodic evaluation of the program in order to correct possible malfunctions.

- Improving capabilities of health care agents and community work teams (training, supervision, monitoring, motivation, equipment) as concerns epidemiological monitoring and preparedness for and responsiveness to epidemics.

- Improving community participation in epidemiological monitoring and management of epidemics.

- Improving procedural capabilities of the national network of laboratories (training, supervision, equipment).
**Lines of action:**

- Increasing IEC activities among the public
- Training/recycling all laboratory personnel
- Promoting intersectoral collaboration
- Promoting research by increasing the funds allocated
- Training/recycling personnel in treatment of the ill
- Increasing screening campaigns supported by community work teams
- Equipping monitoring cells at various levels with adequate equipment.
- Involving elected local officials in the financing and implementing of the departmental fight against epidemics
- Training/recycling socio-sanitary agents and community work teams in epidemiological monitoring
- Training/recycling network laboratory personnel
- Furnishing laboratories with equipment, medico-technical paraphernalia and reagents
- Expanding epidemiological surveillance centers (CSE) in all health care areas
- Equipping monitoring cells at various levels with computer and calculating equipment
- Invigorate the national epidemic management committee and its decentralized facilities
- Creating and supplying a special epidemic management fund in order to ensure the availability of vaccines, reagents and emergency medications at the central level
- Supervising and assessing monitoring activities
- Institutionalizing the training of paramedics in epidemiological monitoring.
- Training/recycling socio-sanitary agents in treatment of cases/epidemics.

c- **Sub-program: Combating noncommunicable diseases**

**General goal:**

Improving combating noncommunicable diseases.

**Specific goals:**

- Promoting the best preventive practices against noncommunicable diseases as of 2009
- Continuing systematic implementation of the best preventive practices against noncommunicable diseases as of 2009;
- Improving the system’s capacity for treatment of noncommunicable diseases;
- Reducing by 50% mortality due to traffic accidents;
- Reducing by 50% morbidity due to water quality.

**Expected outcomes:**
- The best preventive practices against noncommunicable diseases promoted as of 2009;
- The best preventive practices against noncommunicable diseases systematically implemented as of 2009;
- Treatment of noncommunicable diseases improved thanks to improving the system’s capacity;
- Mortality due to traffic accidents reduced by 50%;
- Morbidity due to water quality reduced by 50%.

**Strategies**
- Carrying out at least two studies to determine the morbidity connected with risk factors for noncommunicable diseases
- Improving capabilities of health care institutions for treating noncommunicable diseases;
- Improving programs for screening and fighting against noncommunicable diseases;
- Improving mechanisms for handling expenses connected with noncommunicable diseases;
- Improving activities in nutrition and in occupational hygiene and hygienic living.

**Lines of action**
- Carrying out two national studies of the level of morbidity due the quality of the environment (air quality on the one hand and water quality on the other);
- Improving the capabilities of health care institutions for treating disease
  - Improving the equipment of health care institutions for treatment of noncommunicable diseases;
  - Improving the skills of current personnel for treatment of noncommunicable diseases;
- Recruiting specialized personnel.
- Improving programs for screening and combating noncommunicable diseases
  - Setting up a system of monitoring noncommunicable diseases;
  - Developing the policy and strategies of combating noncommunicable diseases;
  - Developing mapping of emerging epidemics of noncommunicable diseases;
  - Reducing the level of exposure of individuals and populations to risk factors for noncommunicable diseases (bucco-dental ailments, blindness, sickle-cell anemia, diabetes, etc.).
- Improving the mechanisms for handling expenses connected with noncommunicable diseases;
- Determining the costs and methods of treatment of emerging degenerative pathologies (diabetes in particular) and emerging life-style pathologies (HT)
  - Improving methods of treating the pathologies involved.
- Improving activities in nutrition and in occupational hygiene and hygienic living.
  - Developing a national strategy to promote nutrition and hygienic living among workers.
- Improving intersectoral collaboration

d- Sub-program: Improving the availability of good-quality medications at reduced cost.

General goal:
Ensuring the availability of low-cost, quality medications in quantity, used reasonably.

Specific goals:
- Ensuring full accessibility of medications to hospitalized patients;
- Ensuring full availability of and access by populations to medication;
- Ensuring safety, effectiveness and quality of medication.

Expected outcomes:
- Accessibility of medications to hospitalized patients ensured 100%;
- Availability of and access by populations to medication ensured 100%;
- Safety, effectiveness and quality of medication ensured.

Strategies:
- Improving decentralization in the sub-sector;
- Improving quality control;
- Improving the legal and regulatory framework;
- Promoting activities encouraging rational use of medications;
- Improving the financial and management capabilities of the pharmaceutical sub-sector;

**Lines of action:**
- Improving the technical and operational capability of the Laboratoire National de Contrôle de Qualité [national quality-control laboratory] for medication.
- Improving combating the alternative market and improving blisterpack unit deblistering.
- Encouraging operational research and coordination research activities.
- Developing a system of coordination, information and publication of results.
- Supporting pharmaceutical industry initiatives (traditional, essential generics).
- Applying the WHO system of certification of medication quality.
- Establishing a simplified registration system for generic medication.
- Improving the department of registration with qualified personnel and equipment.
- Applying laws in effect in collaboration with the ONPB.
- Drafting additional necessary regulations.
- Developing a regulatory framework for donations of medication in accord with WHO guidelines.
- Equipping the authority responsible for regulation with the necessary human resources.
- Producing simplified versions of laws and regulations.
- Registering, monitoring, and selecting medications in compliance with sub-regional standards.
- Encouraging and participating in shared-experience and information dialogues at the sub-regional, regional and international levels.
- Organizing IEC sessions about the dangers of the alternative market and self-medication.
- Monitoring promotional activities of pharmaceutical products.
- Establishing a pharmaceutical information system by radio, TV, bulletins and documentation.
- Reviewing the distributional flow of medications through wholesalers, NGOs, denominational health care centers, etc.
- Establishing a pharmacovigilance system, including a pharmacovigilance center.
- Training/informing the public in rational use of medications and in pharmacovigilance programs.
- Regular recycling of personnel, particularly pharmacists and their assistants.
- Creating a training path for assistant pharmacists.
- Creating a pricing code mechanism in the outlying health care units and conforming transfer prices of essential medications.
- Establishing a sectoral, multidisciplinary committee to review national pharmaceutical policy;
- Creating a data base for the national pharmaceutical situation.
- Develop a three-year plan for development and yearly budget programs.
- Assessing the implementation of national pharmaceutical policy.
- Improving intersectoral collaboration with the NRA.

e- Sub-program: Promoting diagnostic examinations and transfusion safety

**General goal**
Sustained contributing to improvement of health care benefit quality

**Specific goals**

- Ensuring legal and regulatory provisions for diagnostic examinations and blood transfusion
- Improving and standardizing of infrastructure and equipment of the diagnostic examination and blood transfusion sub-sectors
- Ensuring administrative and financial independence of the blood transfusion sub-sector
- Ensuring training of management in the fields of blood transfusion and diagnostic examination, as well as recycling of management
- Improving implementation of quality measures in the blood transfusion and diagnostic examination sub-sectors
- Controlling import of reagents and supplies used in the diagnostic examination and blood transfusion sub-sectors
- Ensuring continual availability of quality blood products
- Making statistical data concerning the fields of diagnostic examination and blood transfusion available and utilizable

**Expected outcomes**

- Legal and regulatory provisions for diagnostic examinations and blood transfusion ensured.
- Infrastructure and equipment of the diagnostic examination and blood transfusion sub-sectors improved and standardized.
- Administrative and financial independence of the blood transfusion sub-sector established.
- Management in the fields of blood transfusion and diagnostic examination trained and recycled.
- Implementation of quality measures in the blood transfusion and diagnostic examination sub-sectors improved.
- Import of reagents and supplies used in the diagnostic examination and blood transfusion sub-sectors controlled.
- Continual availability of quality blood products ensured.
- Statistical data concerning the fields of diagnostic examination and blood transfusion available and utilizable.

**Strategies**

**For the blood transfusion sub-sector**

- Developing the transfusion system’s financing capabilities
- Improving the sub-sector’s organization
- Improving management of resources
- Improving blood management

**For diagnostic examinations (biomedical analyses and medical imaging sub-sectors)**

- Legal and regulatory provisions for diagnostic examination work.
- Improving technical capabilities of diagnostic examination facilities.
- Improving human resources.
- Improving the financing of diagnostic examinations.
- Systematizing quality measures.
- Controlling provisioning of reagents and supplies

**Lines of action**

**For the blood transfusion sub-sector**

- Developing a five-year financing plan
- Improving the decentralization transfusion facilities
- Developing partnerships between blood transfusion support structures and the private sector
- Improving the document system by computerizing it
- Improving the national system of blood transfusion monitoring-evaluation
- Improving planning and activities coordination capabilities
- Improving management of material resources
- Improving management of human resources
- Improving financial management
- Increasing the number of blood donor units
- Improving rational utilization of labile blood products
- Improving hemovigilance
- Energizing the Association des Donneurs de sang Bénévoles du Benin [Bénin benevolent blood donors association]
- Promoting autotransfusion
- Constructing/rehabilitating and equipping departmental transfusion centers
- Creating a National Blood Transfusion Center (CNTS) with local departmental sections and making it administratively and financially independent
- Making the CNTS a public institution scientific in nature and a center of sub-sector management training.

**For diagnostic examinations (biomedical analyses and medical imaging sub-sectors)**

- Developing laws and regulations
- Constructing infrastructures regarding sub-sector functional standards
- Equipping diagnostic examination facilities according to the minimum package of activities corresponding to the health care pyramid level
- Ensuring provision of quality reagents and supplies to facilities conducting diagnostic examination activities
- Designing and implementing a strategy of equipment maintenance
- Training/recycling management in the area of diagnostic examinations as well as recycling them
- Improving the Laboratoire Central [Main Laboratory] of the Service National des Laboratoires de Santé Publique [National public health laboratories service] in its role of referral laboratory
- Computerizing management of sub-sector diagnostic examinations data
- Controlling costs of biomedical analyses
- Adapting and coordinating diverse support for the national Laboratoires de Santé Publique network by various programs and projects in order to rationalize use of available funding;

**f- sub-program: Promoting traditional medicine and pharmacopoeia**

**General goal:** Making the most of local therapeutic resources.

**Specific goals:**
- Inventorizing traditional formulas existing in 2009.
- Establishing a quality-control mechanism in 2009.
- Promoting use of local products.

**Expected outcomes:**
- Inventory of traditional formulas available in 2009.
- A quality-control mechanism established by 2009.
- Use of local products promoted.

**Strategies:**
- Reorganizing practitioners of traditional medicine;
- Protecting and promoting of the most-used medicinal plants
- Developing of medicinal plants on the basis of established research.

**Lines of action:**
- Developing laws and regulations;
- Training/recycling of practitioners of traditional medicine (in the diagnosis and prevention of malaria and HIV/AIDS);
- Organizing consultation meetings between practitioners of traditional medicine and practitioners of modern medicine;
- Setting up gardens of medicinal plants in each commune;
- Organizing community awareness sessions to promote health through practitioners of traditional medicine;
- Developing and disseminating medicinal plant user manuals;
- Constructing health care centers in all the departmental administrative centers;
- Adapting existing botanical gardens and creating them in communes currently without them;
- Creating a traditional medicine institute, in collaboration with pharmacists.

g- Sub-program: Promoting health care in school, university and occupational settings

**General goal:**
Promoting the safety and health of Benin primary, secondary and university students and Benin workers in order to improve productivity.

**Specific goals:**
- Making available at a manageable cost up-to-date health care in primary and secondary schools, universities and occupational settings by 2018.
- Ensuring observance of the immunization schedule for 100% of school-age children by 2011.
- Ensuring twice-yearly removal of parasites from school-age children between now and 2011.
- Ensuring dietary supplementing with proteins, iodine and vitamins for school-age children of the disadvantaged areas by 2011.
- Producing simplified versions of texts creating the framework of collaboration of school nurses and the administration of educational institutions by 2009
- Ensuring continuous training of school and company nurses for all the Health Areas between now and the end of 2009.

**Expected outcomes:**
- Up-to-date health care at a manageable cost in primary and secondary schools, universities and occupational settings available by 2018.

- Observance of the immunization schedule for 100% of school-age children ensured by 2011.

- Twice-yearly removal of parasites from school-age children between now and 2011 ensured.

- Dietary supplementing with proteins, iodine and vitamins for school-age children of the disadvantaged areas by 2011 ensured.

- Texts creating the framework of collaboration of school nurses and the administration of educational institutions simplified by 2009.

- Continuous training of school and company nurses ensured for all the Health Areas.

**Strategies:**

- Improving capabilities of school and university nurses

- Improving programs of screening and combating disease in school and university settings

- Promoting education for health, prevention of priority diseases in the school environment and nutrition.

- Promoting full, quality health care in school infirmaries

- Calling for promotion of Mutuelles de santé [Mutual health insurance companies] at the university.

**Lines of action:**

- Furnishing all school and university infirmaries with equipment and medications

- Rehabilitating/constructing school infirmaries in every department

- Promoting hygiene and sanitation in the school environment

- Organizing immunization fairs in every school

- Organizing disease-specific treatment fairs in every school

- Organizing fortification fairs in every school

- Developing a description of the tasks performed by school infirmary personnel, taking into account the individuality of each school.

- Improving the school infirmary staff

- Organizing IEC/CCC [Communication pour un Changement de Comportement: information to influence behavior] sessions about health problems in the school and university setting
h- Sub-program: Promoting mental health

**General goal:**
Ensuring for individuals and communities the best mental health condition possible.

**Specific goals:**
- Revising existing law regarding mental health between now and the end of 2009.
- Developing between now and the end of 2009 new strategies allowing establishment of a real policy of decentralization and relocation in mental health.
- Between now and the end of 2009, integrating mental health activities into existing primary health care approaches, particularly to ensure basic care to the entire population.
- Making available adequate tools for raising awareness and IEC/CCC in mental health.
- Reducing the disabilities associated with neurological, mental and psychosocial problems.
- Creating and/or making operational at least three public and/or private centers for treatment of the mentally ill, drug-users, the mentally impaired and the senile (including 1 in the center of the country and 1 in the north) between now and 2018.
- Promoting mental health training and research activities as of 2009.

**Expected outcomes:**
- New laws regarding mental health available by the end of 2009.
- New strategies allowing establishment of a real policy of decentralization and relocation in mental health developed by the end of 2009.
- Mental health activities integrated into existing primary health care approaches, particularly to ensure basic care to the entire population, by the end of 2009.
- Adequate tools for raising awareness and IEC/CCC in mental health available.
- Disabilities associated with neurological, mental and psychosocial problems reduced.
- At least three public and/or private centers for treatment of the mentally ill, drug-users, the mentally impaired and the senile (including 1 in the center of the country and 1 in the north) operational before 2018.
- Mental health training and research activities promoted as of 2009.

**Strategies:**
- Creating an adequate institutional framework,
- Improving programs for screening and combating mental illness
- Improving capabilities
- Developing competence at the staff level
- Epidemiological monitoring

**Lines of action:**
- Integrating mental health into PHC
- Creating facilities adapted to treating children and adolescents for mental health
- Constructing, equipping and staffing psychiatric centers in the center and the north of Benin
- Developing and carrying out CCC programs for drug-users and young people and adults at risk,
- Increasing support activities (particularly social support) for persons afflicted with mental illnesses.

i- sub-program: Promoting health research

**General goal:**
Through research, supporting the decision-making process at all levels of the health care system.

**Specific goals:**
- Training management personnel of the DRS, as well as members of the intermediate and outlying areas teams, in health care research methodology and planning between now and 2012;
- Improving material capabilities of the DRS and material capabilities of facilities conducting research activities at all levels of the health care pyramid between now and 2016;
- Achieving before 2018 an 80% level of secured financing of the research protocols accepted by the Ministry of Health.
- Ensuring collaboration between the DRS and all institutions committed to health care research in Benin, particularly with universities.
- Producing yearly simplified versions of results of health care research conducted in Benin.
- Ensuring observance of ethical standards by researchers when implementing health care research protocols in Benin.
- Carrying out official monitoring and evaluation of health care research in Benin.

**Expected outcomes:**

- Management personnel of the DRS, as well as members of the intermediate and outlying areas teams, trained in health care research methodology and planning between now and 2012
- Material capabilities of the DRS and material capabilities of facilities conducting research activities improved at all levels of the health care pyramid before 2016;
- By 2018, 80% of health care research protocols financed.
- Collaboration established between the DRS and all institutions committed to health care research.
- Simplified versions of results of health care research conducted in Benin produced yearly.
- Ethical standards observed by researchers when implementing health care research protocols in Benin.
- Official monitoring and evaluation of health care research in Benin carried out by the DRS.

**Strategies:**

- Training/recycling of personnel
- Calling upon the government and partners for mobilization of investment resources (renovation/expansion of infrastructure, furnishing with equipment),
- Interinstitutional collaboration with research facilities,
- Disseminating health care research results
- Implementing the regulatory framework of health care research in Benin,
- Rewarding the best research.
**Lines of action**

- Increasing the training of agents in research methodology (operational research or health care systems research), in ethics and additionally, for some managers, in planning and administration of research.
- Expanding and renovating the offices, computer equipment, communication equipment (telephone and internet) and wheeled vehicles of the DRS;
- Improving monitoring-evaluation, starting with inventory of the researchers and the research carried out
- Annually updating the list of researchers and health care research carried out in Benin;
- Supervising research activities organized by coordinations of projects and programs, the DDSs and the HAs
- Monitoring observance of ethical standards by the National Health Research Ethics Committee (CNERS).
- Organizing scientific workshops around the results of health care research conducted in Benin to share knowledge from these studies and to reward the best researchers.

**6.1.4- Program: Hospital development**

The health care system has a pyramid structure patterned on the territorial division. It includes three different levels, namely:

- The central or national level
- The intermediate or departmental level
- The outlying level, made up of the health areas.

For each level of the health care pyramid, there is a corresponding hospital category. They are distinguished thusly:

- For the public sector, the National Hospital Centers (CNH), the Departmental Hospital Centers (CHD), the Area Hospitals (HA), the Screening and Treatment Centers (CDT) of Buruli Ulcers and the leprosy Screening and Treatment Centers;
- In the private sector, the Denominational Hospitals, the Polyclinics and the Clinics, some private hospital centers have been designated “Area Hospitals”
- Public hospitals and some private sector hospitals take part in:
- undergraduate and graduate teaching and medical, odontalgic and pharmaceutical research;
- The initial training of paramedical personnel and in research in their areas of competence.

For several years, hospital services have all too often been universally deplored, and patients risk going to them only in extreme need, i.e., when disease is in an advanced phase, or even incurable. From the PNDS analysis of the situation, it emerges that, despite all the means implemented to improve the public’s state of health, the health care situation in Benin remains characterized by high levels of morbidity and mortality.

In the light of this social and health care situation and to support this pyramidal organization, Benin envisions creating a large, quality sub-regional referral hospital around which other health care units will develop into a network. This American- and European-style hospital will answer the most difficult health care needs and allow evacuations that are painful in human and financial terms to be avoided.

Thus, to achieve the general goal of this hospital development program during the next ten years will be a matter of permitting all strata of the public to receive excellent quality health care and hospital services when needed.

Four (04) sub-programs have, consequently, been indicated for the development of the hospital sector, which plays a referral role at all levels of the health care pyramid. These are:

a) Quality management in the hospital setting;

b) Improving technical capacity

c) Organizing and improving health care provision

d) Hospital reform.

a- Sub-program: Developing a health care quality management system in the hospital setting

General goal:
Improving health care quality in the hospital setting

Specific goals:
- Putting into general use, between now and 2012, hospital health care and services quality-control measures
- Organizing hospital emergencies for immediate high-quality treatment
- Performing at least once yearly a client-satisfaction evaluation study in 100% of the hospitals before the end of 2009
- Establishing, before the end of 2009, a process for monitoring continuity, safety and efficiency of hospital health care.

**Expected outcomes:**

- Hospital health care and services quality-control measures in general use before the end of 2009.
- Hospital emergencies better organized.
- A once-yearly client-satisfaction evaluation study established as of the present in all hospitals.
- A process for monitoring continuity, safety and efficiency of hospital health care set up before the end of 2009.

**Strategies:**

- Developing among all hospital staff the culture of striving to furnish quality services to users
- Improving staff skills
- Creating specialized centers necessary for the effectiveness of the system
- Implementing an effective system of hospital information management
- Developing hospital communication;
- Developing a partnership between the hospital and outside collaborators;
- Implementing a client satisfaction monitoring-evaluation system
- Efficient managing of resources;
- Efficient managing of obstetrical emergencies

**Lines of action**

- Ensuring availability of 24-hour-a-day services
- Creating and operating a national facility for accreditation of health care institutions and certification of services;
- Producing simplified versions of and promoting standards and existing procedures;
- Improving risk management and hospital hygiene, particularly promoting aseptic practices and prevention of hospital-acquired infections;
- Making personnel with standard qualifications available to the hospital;
- Instituting quality measures in all hospital;
- Acquiring new means of communication such as the Internet and telemedicine;
- Out-managing some support services
- Implementing effective decentralization of resources among all hospitals;
- Developing descriptions of staff positions and tasks;
- Developing a hospital information management system;
- Improving medical centers management coordination;
- Improving capabilities of national medical analysis and quality-control laboratories;
- Improving capabilities of medical analysis laboratories in CHDs and health care areas;
- Applying rewards or penalties, with an annual report indicating the sanctions issued and the reasons.
- Drafting for emergency services an operations document of emergency treatment standards, procedures and protocols;
- Creating high-quality medical centers;
- Creating a regional referral center.

b- Sub-program: Improving technical capacity

General goal
Improving the hospital sub-sector through infrastructure and quality equipment.

Specific goals:
- Preparing an inventory of infrastructure and medico-technical equipment before the end of 2009;
- Developing a strategic development plan in every hospital before the end of 2009;
- Improving and modernizing medico-technical equipment between now and 2016;
- Implementing by appropriate channels an equipment maintenance and monitoring system before the end of 2009.

Expected outcomes:
- An inventory of infrastructure and medico-technical equipment available before the end of 2009.
- 100% of hospitals equipped with and performing their activities according to a strategic development plan before the end of 2009.
- Medico-technical equipment improved and modernized before 2016.
- An equipment maintenance and monitoring system established before the end of 2009.

**Strategies:**

- Developing and implementing a national development plan of hospital technical capacity;
- Reviewing and enhancing equipment management tools, including inventory tools;
- Developing maintenance strategies adapted to each health care training category, especially to hospitals.
- Developing and implementing a national hospitals development plan;
- Establishing a system of hospital equipment redeployment;
- Developing a national hospitals development plan;
- Establishing a preventive maintenance program in hospitals;
- Developing, applying and assessing new standards and norms for public and private health care units infrastructure and equipment

**Lines of action:**

- Preparing an exhaustive inventory of infrastructure and equipment of all health care units;
- Developing a national hospital equipment development plan (public and private together) taking into account progress in medical technologies and the morbidity and mortality table;
- Developing a set-up plan adopted by the Board of Directors for each hospital under an independent management plan before MS approval;
- Establishing quality human resources (maintenance engineers and technicians), properly equipped, to ensure maintenance of hospital equipment;
- Developing and producing simplified versions of a list of donations of supplies, equipment and infrastructure;
- Developing and implementing a national biomedical waste management plan taking the private and public sectors into account;
- Creating and equipping departmental maintenance units;
- Instituting computerized monitoring of equipment (inventorying, preventive maintenance)
- Making widely known and monitoring the functions of the RAC (Réseaux Aériens de Communication: *Aerial Communication Networks*)
- Conforming laboratories, imaging services and hospital surgical wards at all levels of the health care pyramid;
- Constructing new CHUs in collaboration with the ministry of higher education.

c- Sub-program: Hospital reform

**General goal**: Contributing to improving health care quality and treatment of patients through proper administration of the hospital sub-sector

**Specific goals:**
- Developing, adopting and producing simplified versions of hospital laws before the end of 2009;
- Developing and producing simplified versions of 100% of hospital norms and standards before the end of 2009;
- Updating 100% of existing regulatory texts in compliance with decentralization before the end of 2009;
- Developing all hospital reform support texts before the end of 2009.
- Establishing administrative and management bodies complying with hospital reform guidelines in 100% of hospitals before the end of 2009;
- Developing between now and 2016 at least three referral centers in the hospital sub-sector;
- Developing and making available nomenclature

**Expected outcomes:**
- Hospital laws developed, adopted and popularly simplified before the end of 2009;
- 100% of hospital norms and standards developed and popularly simplified before the end of 2009;
- Between now and the end of 2009, 100% of existing regulatory texts updated in compliance with decentralization;
- All hospital reform support texts developed between now and the end of 2009;
- Between now and the end of 2009, 100% of hospitals having administrative and management bodies that comply with hospital reform guidelines;
- At least three referral centers developed between now and 2016 in the hospital sub-sector,

**Strategies**

Committed hospital reform will proceed according to the following strategies:
- Establishing a system of vertical and horizontal complementarity between public and private health care units at all levels;
- Promoting partnership with other internal or external stakeholders in the health care sector,
- Support for development of a set-up plan for each hospital;

**Lines of action**

- Updating existing texts in compliance with hospital policy
- Developing new texts
- Developing Benin hospital standards (hospital standards, protocols, procedures and hospital collective agreements)
- Developing hospital laws
- Developing the hospital map;
- Promoting delivery of user-satisfying quality health care

**Sub-program: Organizing and improving health care provision**

**General goal:**
Organizing the hospital system so that the main roles of the hospital are effectively carried out

**Specific goals:**
- Establishing a national strategy to improve the referral and counter-referral system at all levels of the health care system;
- Creating or expanding hospitals, particularly offering new services;
- Improving the dimensions of health care quality that are not specifically medical;
- Developing, before the end of 2009, specifications of various hospital categories in their role supporting the rest of the health care system;
- Defining the rights and duties of the various hospitals regarding training (continuous training or basic training application ground);
- Between now and 2016, bringing 100% of hospitals to initiate, and even support, the least expensive operational research.

**Expected outcomes:**
- The operating rules of the referral and counter-referral system among the various institutional categories of the health care system defined before the end of 2009;
- New services in hospitals;
- Nonmedical health care quality improved;
- Specifications of various hospital categories in their role supporting the rest of the health care system developed before the end of 2009;
- The rights and duties of the various hospitals regarding training (continuous training or basic training application ground) defined;
- 100% of hospitals initiating and supporting the least expensive operational research between now and 2016.

**Strategies:**

- Developing Guides,
- Developing specifications and agreements,
- Continuous training of hospital personnel,
- Partnership between public and private hospitals.

**Lines of action:**

- Establishing institutional connections between Health Area Management Teams, area hospitals and public and private health care units located in the same geographic area; promoting set-up of Emergency Medical Assistance Services (EMAS) throughout the country by furnishing them with adequate equipment;
- Establishing a public/private partnership in the context of emergency treatment (establishing operational teams);
- Organizing medico-surgical missions as needed;
- Organizing regular technical supervision of hospitals;
- Creating a state-of-the-art diagnostic center at the national level;
- Defining the operating rules of the referral and counter-referral system among the various institutional categories by setting up mechanisms to implement, manage and monitor at all levels of the system between now and the end of 2009.
6.2- Priority Area: Advancing human resources

Improvement of healthcare and health indicators depends in large part on Human Resources that are at the center of health services delivery. This is why Human Resources mobilization around health development projects and programs constitutes today a major priority in the health sector. The development of human resources will increase both the quality and quantity of personnel able to implement, at all levels of the system, the national health policy.

Three (03) programs are identified to address the country’s major priorities in the area of human resources development. These are:

a) strengthening human resources planning;
b) improving the production and development of skills;
c) improving the human resources management system.

6.2.1- Program: Strengthening human resources planning

a) Sub-Program: Strengthening health human resources in size

General objective:
To make a sufficient number of qualified personnel available to health sector facilities.

Specific objective:
- To determine workforce size and the needs in personnel
- To substantially reduce personnel shortage
- To institute a data repository of positions and profiles

Expected results:
- Workforce size and personnel needs are determined
- Personnel shortage is substantially reduced
- A data repository of positions and profiles is instituted

Strategies:
- Strengthening HRH data collection and processing system
- Describing positions and profiles
- Recruiting new agents on a need basis
- Developing national and foreign medical missions (with national specialist physicians in country and from abroad)

**Lines of action:**

Most activities to strengthen planning of health human resources are included in the human resources development document. Among these, we find:

- Regularly measuring performance indicators as a tool to facilitate planning;
- Creating an observatory for human resources in health
- Compiling an index of jobs, positions and duties in the sector;
- Defining and validating the profiles of various positions and duties;
- Developing staffing size standards for each health facility based on workloads and ergonomic principles;
- Redeploying health personnel;
- Developing a workforce increase plan based on needs;
- Implementing the workforce increase plan
- Advocating an increase of financial resources devoted to recruitment;

b) Sub-Program: Strengthening the partnership between internal and external partners in health human resources planning

**General objective:**

To improve partnership between internal and external stakeholders in the sector

**Specific objectives:**

- To develop consultation mechanisms among all stakeholders in HRH.
- To render effective the collaboration among private and public sectors and social partners.

**Expected results:**

- Consultation mechanisms among all stakeholders in HRH are developed
- Collaboration among private and public sectors and social partners is effective
Strategies:

- Strengthening collaboration between internal and external stakeholders
- Developing a consultation framework between private and public sectors
- Advancing social dialog

Lines of action:

- Creating an inter-ministerial consultation committee on health human resources
- Setting up a framework of communication, exchange and decision making on HRH between deconcentrated facilities and local collectivities
- Allowing participation of private sector health professionals to trainings organized by the Ministry of Health
- Formalizing partnership agreements between the public sector and other stakeholders
- Supervising HR management in private sector facilities
- Supporting private structures in the implementation of their health human resources development and incentive strategies
- Including traditional therapists in health human resources development programs
- Creating a national framework in charge of private sector and traditional medicine
- Instituting regular meetings with social partners
- Outsourcing some services in health facilities (catering, linen services, maintenance, laundry, etc.)

c) Sub-Program: Developing research on human resources

General objective:

To promote research on HRH

Specific objectives:

- To develop an index of priority research subjects on Human Resources in Health;
- To set up a collaboration mechanism with internal and external research institutions

Expected results:

- The index of priority research subjects on Human Resources in Health is developed;
- A collaboration mechanism with internal and external research institutions is set up
Strategies:

- Compiling a data bank on priority subjects by domains of HRHM
- Creating an exchange framework for the promotion of research on human resources in health.
- Creating an environment favorable to research development

Lines of action:

The main activities to develop research on human resources are:

- Performing a document review on human resources management problems;
- Making an inventory of existing research work on HRM;
- Conducting additional surveys in workplaces on human resources management problems;
- Advocating HRH research promotion to partners and training institutions;
- Proposing dissertation and thesis subjects to training schools;
- Sponsoring research on priority subjects
- Awarding prizes to best research works

6.2.2-Programme: Improving the production and development of skills

a) Sub-program: Development of a consensus plan for primary training of sector personnel

General objective:

To provide the health sector with a primary training consensus plan

Specific objectives:

- To determine training needs on the basis of HRH norms and standards
- To adapt training institutions’ curricula to the training needs of the sector

Expected results:

- Training needs are determined
- Training institutions’ curricula are adapted to the training needs of the sector

Strategies:

- Compiling a databank on training needs and costs
- Strengthening relationships with training facilities and other institutions involved in training
- Strengthening training institutions’ output capacity
Improving students’ supervision in practical training locations
Monitoring and evaluation of training plan

**Lines of action**

The major activities to undertake for the development of a consensus plan for primary training of sector personnel are as follows:

- Using qualitative and quantitative standards to define training needs
- Developing collection instruments for data on HRH training needs and costs
- Developing an updating guide for the database of training needs
- Setting up an accreditation mechanism for health professionals training schools
- Developing partnership agreements with accredited schools;
- Organizing regular reviews of the inter-ministerial committee on trainees recruitment, training curricula development and definition of trainers’ profiles
- Organizing training monitoring visits in schools
- Advocating to Ministries in charge of training:
  - the control of schools creation
  - the training/retraining of a sufficient number of trainers
  - the set-up of appropriate infrastructures and equipments
  - the control of the size of the workforce to train
  - a regular audit of technical management and resources of training schools
- Setting-up a mechanism to certify the quality of training provided in schools
- Creating training schools and institutions for the various categories of health human resources (orderlies, health officers, medical specialties);
- Making an inventory of locations that could accept practical trainees
- Improving the environment of practical training locations (didactic material, capacity, trainer’s skill, number of trainers, equipment)
- Motivating the trainers
- Strengthening trainees’ support mechanisms in practical training locations
- Developing monitoring and evaluation tools
- Implementing midpoint and final evaluations of training plan

**b) Sub-Program: Developing skills of sector personnel**
**General objective:**
To improve skills of health sector personnel

**Specific objectives:**
- To enable agents’ specialization and advanced training
- To develop a network of trainers in priority areas of the sector

**Expected results:**
- Agents’ specialization and advanced training are enabled
- A network of trainers in priority areas of the sector has been developed

**Strategies:**
- Promoting agents specialization and advanced training
- Developing on-the-job training
- Promoting new fields of training

**Lines of action:**
The main activities to develop skills of sector personnel are:

- Identifying health professionals’ needs in new skills
- Developing plans for advanced training in health facilities
- Signing partnership agreements between hospitals for advanced training of personnel
- Organizing training seminars and workshops for all agents
- Inserting into curricula the new skills that have been inventoried
- Organizing specialization and short-term practical trainings for agents
- Developing a text promoting the development of health professionals’ skills
- Setting up a training system using ICT
- Setting up a database on training activities of the sector
- Creating a paramedical specialists training institute
- Raising the recruitment and training level in training schools for non-medical personnel
- Improving practical training environment (didactic material, capacity, trainer’s skill, equipment, etc.)
- Creating medical specialty fields that do not exist yet at the School of Health Sciences
- Identifying priority areas requiring additional training
• Creating structures to conduct trainings at the departmental level

6.2.3-Programme: Improving the human resources management system.

a) Sub-program: Improving personnel career management

General objective:
To improve practices in the management of agents’ career

Specific objectives:
• To develop a career plan for each category of health personnel
• To set up an efficient personnel distribution system

Expected results:
• A career plan is developed for each category of health personnel
• An efficient personnel distribution system is set up

Strategies
• Strengthening career evolution mechanisms in the health corps
• Strengthening mechanisms of production of administrative acts
• Advancing professional skills and experiences
• Strengthening the capacity of structures in charge of career production and monitoring
  Improving mechanisms of agents career monitoring
  Setting-up an agent performance evaluation system facilitating a rational career management
• Improving mechanism of personnel distribution

Lines of action

Major activities to undertake to improve personnel career management are as follows:

• Developing career plans
• Updating existing career management texts;
• Popularizing and disseminating career management texts
• Regularly organizing professional competitive exams
Informing agents on the evolution and monitoring of their career and on the construction of files (nomination, advancement, tenure, promotion…)

Correcting disparities between categories in health human resources by reviewing various statutes and texts

Develop a special statute for the health sector

Develop and adopt the special statute of hospital physicians

Harmonizing the modes of recruitment and management of contractual agents (self-financing, community financing)

Recruiting personnel for specific positions

Determining objective criteria for holding positions of responsibility;

Rewarding deserving agents

Creating an appropriate setting to reward experience and people having held positions of responsibility

Strengthening skills of personnel in charge of producing and following up career documents

Ensuring documents follow-up in administrative circuit (Civil Service, Finance, agents posting locations)

Strengthening skills of personnel in charge of producing career documents

Automatic production of documents

Developing and popularizing the career management procedure guide

Ensuring an internal control of careers management

Computerizing career documents production

Modernizing the processing and storage of individual files

Conducting an audit of the current performance evaluation system

Developing and popularizing new grids of agents performance evaluation based on the job profiles in the health sector

Training the personnel to use the new agents performance grids

Signing a performance contract with each agent called to hold or holding a position of responsibility

Evaluating the performance of agents

Evaluating the current mechanism of personnel distribution

Updating the list of areas that are underprivileged or difficult of access

Proposing new mechanisms to control staffing unbalances
- Effectively implementing the new personnel transfer regulation
- Defining new assignment criteria for agents posted in underprivileged areas (agents involvement in assignment or job retention)
- Assigning agents in underprivileged areas for a period of three years minimum
- Setting up a mentoring system of newly assigned agents by older ones in underprivileged areas
- Promoting position-specific recruitments
- Defining and implementing mechanisms of retention in underprivileged jobs
- Setting up a monitoring mechanism for retired personnel

a) Sub-program: Improving incentive mechanisms for personnel retention and performance

**General objective:**
To develop efficient work incentive mechanisms in the health sector

**Specific objectives:**
- Setting up a suitable system of motivation of the performance of agents
- Setting up incentive measures for personnel retention in their positions

**Expected results**
- A suitable system of motivation of the performance of agents is in place
- Incentive measures for personnel retention in their positions are adopted

**Strategies**
- Adopting measures to motivate the performance of agents
- Adopting measures to retain agents in their positions
- Strengthening measures to reduce health personnel migration

**Lines of action**
- Identifying factors of personnel attrition
- Identifying sources of personnel motivation
- Defining and analyzing the feasibility of incentive measures (congratulations letters, medals, training travels)
- Instituting and making effective quality assurance committees in public and private health facilities…
- Implementing measures to motivate agents performance
- Extending the provision of free care: Visits; Hospital admissions; Exploration; Diagnostics; Drugs; Surgical acts; Devices etc. to all agents, active or retired
- Increasing significantly salary and benefit grids for health personnel
- Enforcing current provisions regarding indemnities and bonuses due to personnel
- Enforcing sanctions (positive and negative)
- Conferring a special status to health personnel
- Developing and adopting the hospital bill
- Integrating the Gender Approach in appointments to positions of responsibility
- Regulating private practice in teaching hospitals for senior faculty
- Provide each health facility with a pleasant work environment (buildings and equipment, particularly in remote, difficult of access and/or underprivileged areas)
- Providing adequate housing to personnel serving in underprivileged areas
- Granting personnel with cash advantages (substantial remoteness bonus, moving bonus…) based on hardships of the living environment
- Developing internal communication at the ministry of health
- Creating a network of communication and experience exchange between hospital practitioners (telemedicine, teleconference, ACN, ICT)
- Increasing salaries of health professionals
- Creating rewarding and attractive working conditions (remuneration, buildings, working materials, equipment, working atmosphere, housing…)
- Conferring a special status to health professionals
- Defining and providing special bonuses to health agents practicing in health facilities and hospitals
- Granting bonuses for being on call and other rewards to trainees
- Organizing a forum on strategies to improve the quality of care delivery

a) Sub-program: Preventing and managing professional risks

General objective:

To promote health and safety at work in the health sector

Specific objectives:
• To strengthen the institutional framework that regulates prevention and management of occupational risks in the sector
• To set up mechanisms of prevention and management of occupational accidents and illnesses

**Expected results**

• The institutional framework that regulates the prevention and management of occupational risks in the health sector is strengthened
• Mechanisms of prevention and management of occupational accidents and illnesses are in place

**Strategies**

• Strengthening the institutional framework
• Creating/energizing structures of prevention and management of occupational risks
• Setting up an information system and a mechanism of qualification of occupational risks
• Developing mechanisms for evaluating, monitoring of health status and addressing needs of workers in the sector
• Strengthening skills of health professionals in ergonomics and occupational risks prevention
• Developing mechanisms of stress and work overload reduction

**Lines of action**

• Updating existing legal texts
• Developing complementary texts
• Popularizing various texts about prevention and management of occupational risks
• Compiling an index of occupational risks
• Extending occupational medicine activities to public health facilities
• Setting up systematic hygiene and safety committees in health facilities and health services (public and private)
• Making operational the hygiene and safety workplace committees and the committee against nosocomial infections
- Updating and enforcing norms and standards of construction of health facilities and administrative buildings
- Updating every 5 years the index of occupational risks in the health sector
- Making an inventory of new illnesses to qualify as occupational risk
- Submitting this list to competent authorities for ratification
- Setting up a system of data collection, processing and analysis
- Disseminating information on occupational risks
- Making health check-ups systematic in all health facilities and services
- Undertaking actions for addressing the needs, compensating or for the professional reconversion of health agents affected or handicapped.
- Ensuring a permanent watch on the health status of agents
- Promoting health cooperatives: health insurance for workers in the sector
- Defining the modalities for addressing occupational accidents and illnesses
- Introducing modules on ergonomics and occupational risks prevention in training curricula of health professionals
- Training health professionals in ergonomics and occupational risks prevention
- Sensitizing agents to risk behaviors (occupational risks, risks related to the profession, blood exposure accidents, respect of norms…)
- Putting agents in systematic administrative leave
- Creating leisure and recreation settings (outings, vacation camps…)
- Improving physical environment at work (noise, lighting, aeration, sanitary conditions…)
- Reducing health impairment due to physical and mental pressures of work (respect of staffing standard, elimination of political pressures and sexual harassment)
- Improving workplace atmosphere
- Fighting discrimination and stigmatization

a) Sub-program: Deconcentrating/decentralizing human resources management

General objective:
To promote proximity management of HRH

Specific objectives:
- To increase HRM decision powers at central, intermediary and peripheral tiers of the health sector
To develop HR management capabilities at central, intermediary and peripheral tiers

**Expected results**

- HRM decision powers are increased at central, intermediary and peripheral tiers of the health sector
- HR management capabilities are developed at central, intermediary and peripheral tiers

**Strategies**

- Consolidating HRM governance and institutional framework
- Strengthening power delegation at all tiers of the health system pyramid
- Supporting the operation of management structures at intermediary and peripheral tiers

**Lines of action**

- Creating a consultation framework (boards, associations, unions) on professional conduct and ethics in the sector
- Creating a consultation framework on skills transfer between MS and other stakeholders involved in HRM
- Defining roles and responsibilities that could be transferred (MTFP, MDEF, MISPCL)
- Defining the new roles of HRM bodies at the decentralized level
- Implementing the process of uncoupling the management of health personnel careers
- Updating and developing appropriate legal texts
- Popularizing the various texts
- Strengthening the technical capacity of stakeholders
- Strengthening the mechanism of information exchange and communication between MS and other ministries involved in HRM
- Defining roles and responsibilities that could be delegated
- Enacting the appropriate acts
- Training the stakeholders (HR managers, local elected officials and others) on their new roles
- Setting up a HRM conformity audit system
- Providing structures with necessary resources (qualified personnel, material resources...
- Developing a procedure manual for HR management at intermediary and peripheral tiers
- Supervising HR management structures at intermediary and peripheral tiers
- Linking management structures in a computerized network to facilitate decisions

6.3- Priority Area: Strengthening partnership in the sector and promoting medical ethics and responsibility

6.3.1- Program: STRENGTHENING PARTNERSHIP AMONG THE STAKEHOLDERS
Today, many private and public stakeholders, but also external partners and the community, whose role increased considerably in the last few years, deliver health care and services. The mission of the Ministry of Health being to improve sanitary conditions of families based on a system integrating poor and indigent populations, it is necessary to develop and nurture a partnership between the various stakeholders in the health sector by defining interactions and interrelations that need to exist among them and the roles, duties and obligations of each of them to guarantee equity in availability of care and quality health services.

In the context of strengthening the partnership among stakeholders in Benin, institutional systems have been set up. Thus, legal texts and strategic documents have been developed (see annex 1):

In the context of the development of the National Health Development Plan (NHDP), three (3) sub-programs have been identified to strengthen partnership among stakeholders in the health sector. These are:

- a) Partnership between Ministry of Health and other ministries;
- b) Partnership between Ministry of Health and local governments;
- c) Partnership between public and private sectors.

a) Sub-program: Partnership between Ministry of Health and other Ministries

Maintaining the good health status of populations must be a central concern of other ministries whose activities have a direct or indirect impact on the health of individuals or communities. It is therefore necessary that they be more involved in the health policy.
**General objective**

- To improve dialog and collaboration between MS and other Ministries to ensure an adequate level of health care quality

**Specific objectives**

- To set up a collaboration agreement, before the end of 2009, between MS and the armed forces (Armed Forces Health Service) indicating clearly the partnership mechanisms by which the armed forces will contribute to national health objectives.

- To set up a collaboration agreement, before the end of 2009, between MS and the Ministry in charge of National Education indicating clearly the school and university health development mechanisms by which they will contribute to national health objectives.

- To set up a collaboration agreement, before the end of 2009, between MS and the Ministry of Labor indicating clearly the occupational health development mechanisms by which they will contribute to national health objectives.

- To set up a collaboration agreement, before the end of 2009, between MS and others Ministries (Interior, Environment, Justice, Public Works, Finance, Mines, Energy and Water, Foreign Affairs, Communication, etc.) indicating clearly the partnership mechanisms by which these institutions will contribute to national health objectives.

- To study national and international legal texts, before the end of 2009, to recommend to the government all modifications likely to ensure an optimal coverage of health care needs of State and Companies employees.

- To implement health prevention and promotion activities programs in all workplaces by 2011.

- To impulse as early as 2009, the creation of a special health program in prisons.

**Expected results**

- A collaboration agreement between MS and the armed forces (Armed Forces Health Service) clearly indicating partnership mechanisms by which the armed forces will contribute to national health objectives is set up before the end of 2009.

- A collaboration agreement between MS and the Ministry in charge of National Education clearly indicating mechanisms of development of school and university
health by which they will contribute to national health objectives is set up before the end of 2009.

- A collaboration agreement between MS and the Ministry of Labor indicating clearly the occupational health development mechanisms by which they will contribute to national health objectives is set up before the end of 2009.

- A collaboration agreement between MS and others Ministries (Interior, Environment, Justice, Public Works, Finance, Mines, Energy and Water, Foreign Affairs, Communication, etc.) indicating clearly the partnership mechanisms by which these institutions will contribute to national health objectives is set up before the end of 2009.

- National and international legal texts are studied to recommend, before the end of 2009, to the government all modifications likely to ensure an optimal coverage of health care needs of State and Companies employees.

- Health prevention and promotion activities programs are implemented in all workplaces by 2011.

- A special health program in prisons is created as early as 2009.

**Strategies**

- Advocating a deeper collaboration among sectors,

- Developing a standard partnership agreement,

- Holding regular evaluation meetings,

- Strengthening MS in health communication

**Lines of action**

- Training coordinating physicians and commune chief medical officers in evaluation of activities in school and university health, occupational health and health in prisons,

- Involving socio-medical agents working in other sectors in training, supervision and other activities,

- Training teachers to understand child, adolescent and youth priority problems and how they are dealt with by health professionals so that they become appropriate health relays,

- Contributing to develop training modules to integrate health promotion in Training Schools programs,
- Developing a standard partnership agreement with other Ministries or activity sectors,

**a) Sub-program: Partnership between the Ministry of Health, the local Elected Officials and the recipient communities**

**General objective**
- To strengthen the partnership with local Elected Officials and the recipient communities in the decision making process of organization and management of health care and services

**Specific objectives**
- To create, by the end of 2009, a consistent legal framework between the health areas and the primary local governments for the development and the management of health actions.
- To bring about the communes to include credit lines in their budgets for health services in their geographic areas.
- Provide communes with funds intended for health coverage of their populations.

**Expected results**
- A consistent legal framework is created, by the end of 2009, between the health areas and the primary local governments for the development and the management of health actions.
- The communes have included credit lines in their budgets for health services in their geographic areas.
- Funds intended for health coverage of their populations are provided to communes.

**Strategies**
- Creating a consultation framework between the Ministry of health and local governments
- Advocating to local elected officials for support to provide to health facilities.

**Lines of action**
- Developing a partnership agreement between MS and local elected officials
- Organizing the dissemination of policy documents, the national health development plan and the three year development plan in all communes of Benin,
- Organizing biannual meetings of assessment of these plans implementation in each commune,

c) Sub-program: Partnership between public and private sectors

General objective

- To strengthen the partnership between public and private sectors

Specific objectives

- To improve the quality of health care and services delivery;
- To achieve an operational integration of private sector activities into national strategies of development of the health sector;
- To update the law regulating the private practice of medical and paramedical professions;
- To strengthen the capability of regulatory bodies and representative structures in the sector (boards, unions, associations).

Expected results

- Quality of health care and services delivery is improved;
- An operational integration of private sector activities into national strategies of development of the health sector is achieved;
- The law regulating the private practice of medical and paramedical professions is updated;
- The capability of regulatory bodies and representative structures in the sector (boards, unions, associations) is strengthened.

Strategies

- Integrating private sector activities into national strategies of development of the health sector;
- Strengthening institutional capabilities of representative structures of the private sector;
- Enforcement of the current legal and regulatory framework in Benin;
- Strengthening intervention capabilities of the private sector
Lines of action

For integrating private sector activities into the national strategies of development of the health sector, the following actions will be undertaken:

- Integrating private sector activities into the priority health programs;
- Setting up a plan of action to improve the quality of services delivered by private health facilities;
- Promoting the set-up of private medical and paramedical facilities in the interior of the country;
- Promoting outsourcing the management of public health facilities to the private sector;
- Promoting the establishment of private hospitals and their designation as reference facilities in the health areas;
- Promoting the establishment of pharmacies and pharmaceutical outlets in the interior of the country;
- Promoting the availability and quality of drugs in the pharmaceutical outlets.

For strengthening institutional capabilities of representative structures of the private sector, it is necessary to undertake the following actions:

- Creating a consultation and coordination framework between private and public sectors in the area of health;
- Implementing a program of institutional strengthening of representative bodies of the private sector through support provided to representative structures of the sector that are:
  - professional boards,
  - private professionals unions,
  - health professionals associations,
  - other associations acting in the area of health.

Interventions aimed at strengthening the enforcement of the current legal and regulatory framework will require:

- Regulating the private practice of health personnel of the public sector;
- Regulating the curative practices conducted by NGOs;
- Regularizing the situation of existing private health facilities in particular unauthorized health facilities;
- Developing medical, paramedical and pharmaceutical inspections;
Strengthening intervention capabilities of the private sector will require:

- Strengthening human capital in the private sector by advancing paramedical professionals and by promoting the access of private sector agents to continuing education.

6.3.2- Program: Promoting medical ethics and responsibility

This program aims to establish good governance rules in the sector in particular transparency, accountability and a better quality service for users.

a) Sub-program: Strengthening medical ethics and responsibility

**General objective**

To normalize the practice framework of medical and paramedical professions

**Specific objectives**

- To implement measures of the framework regulating the practice of medical and paramedical professions in Benin with a particular accent on professional responsibility;
- To define, relative to texts, the rights and obligations of providers and users;
- To ensure consistency between existing texts by 2010;
- To popularize the texts related to rights and obligations of providers and users;
- To strengthen skills in defense of individual and collective health interests of at least 50 individuals from associations of clients of health facilities by 2010.

**Expected results**

- The measures of the framework regulating the practice of medical and paramedical professions in Benin are implemented with a particular accent on professional responsibility;
- The rights and obligations of providers and users are defined, relative to texts;
- The consistency between existing texts is ensured before the end of 2010;
- Texts related to rights and obligations of providers and users are popularized;
- Skills in defense of individual and collective health interests of at least 50 individuals from associations of clients of health facilities have been strengthened before the end of 2010.

**Strategies**

- Developing/Updating texts on the practice of medical and paramedical professions
- Revising the code of professional conduct of medical and paramedical professions
- Setting up a mechanism to monitor the implementation of measures of different texts
- Training associations of clients of health facilities in the new texts measures

**Lines of action**
- Developing, adopting and implementing a Public Health Code
- Developing, adopting and implementing a National Charter on Governance in the health sector
- Creating and rendering operational a national body of accreditation of healthcare facilities and certification of services;
- Sponsoring studies to update and revise texts
- Organizing sessions of populations sensitization to the content of new texts by associations of clients of health facilities, one session per district per year
- Organizing, once a year, the evaluation of the implementation of the texts measures.

**b) Sub-program: Developing and promoting Quality Assurance**

**General objective:**
To guarantee the quality and safety of provision of services and care to the satisfaction of patients in all facilities at all tiers of the health system pyramid.

**Specific objectives:**
- To inform health stakeholders of and sensitize them to the concept of quality assurance for a full adherence to the process
- To define the national policy of quality assurance in the health sector
- To define a quality improvement program by facility or intervention area
- To inventory or define normative texts by facility
- To create and set up a body to enhance quality in the system (support, control, monitoring, evaluation and quality assurance)
- To improve intervention capabilities of health stakeholders in the area of quality

**Expected results:**
- A wide information and sensitization effort is accomplished for the commitment in quality assurance of all system stakeholders
- The national policy of quality assurance is defined, validated and disseminated
• Each system facility possesses and implements its quality improvement program
• An index of all existing normative texts is created an/or an update by specific area is completed
• A mechanism of accreditation and certification is created and set up
• A plan to strengthen capabilities of stakeholders in quality assurance is in place

Strategies:
• Mobilizing resources for the implementation of the quality approach in all facilities of the system
• Setting up quality improvement focal points in all facilities
• Strengthening capabilities of all stakeholders involved in implementation of quality assurance
• Developing and promoting quality improvement networks
• Strengthening the legal and regulatory framework
• Setting up a quality assessment program

Lines of action:
• Developing and implementing a quality assurance policy of the health sector
• Developing a legal and regulatory framework for quality assurance
• Setting up methods and tools for care delivery accreditation and services certification
• Popularizing best practices and results in quality improvement of care
• Rewarding the best facilities in managing to improve quality
• Warning and penalizing facilities not following quality improvement measures

6.4- Priority Area: Financing mechanism for the sector

6.4.1- Program: FINANCING
Health is priceless but has a cost. Financing of the sector is a crucial problem. The 2003 national health account results show that 52.1% of health expenses are directly borne by households. To lighten the financial burden on households, it is important to find other financing mechanisms for the sector, outside of existing traditional ones.

In addition, a particular attention must be directed toward the poorer strata who live in total poverty and who will be excluded from the health system if nothing is done.
The present policy document provides approaches of solutions through three (3) sub-programs:

a) Promoting health insurance;
b) Promoting health cooperatives;
c) Strengthening medical assistance to the poor and the indigent.

a) Sub-program: Promoting health insurance

**General objective:** To improve financial accessibility of households to health services

**Specific objectives:**
- To set up a viable health insurance system by the end of 2010;
- To reduce by 30% direct payments of households in health facilities by 2018;
- To create conditions enabling 50% of target households to subscribe to health insurance by 2018.

**Expected results**
- A viable health insurance system is effectively set up by the end of 2010;
- Direct payments of households in health facilities are reduced by 30% in 2018;
- At least 50% of target households have subscribed to health insurance in 2018.

**Strategies:**
- Setting up a mechanism to generalize health insurance by 2010;
- Making health insurance mandatory in public and private companies by 2014;
- Sensitizing and encouraging households to subscribe to health insurance.

**Lines of action**
The major actions to conduct for the promotion of health insurance are:
- Setting up a legal framework to institutionalize health insurance.
- Contributing (discussion with health insurance companies) to the improvement of access to health insurance;
- Institutionalizing mandatory health insurance for State employees;
- Forcing private companies to institute health insurance for their employees;
- Setting up a mechanism to facilitate the access of households to health insurance.
a) Sub-program: Promoting health cooperatives

General objective: To improve financial accessibility of households to health services

Specific objectives:
- To accelerate the effective set up of a viable health cooperative system;
- To strengthen membership of populations to health cooperatives in areas where they already exist.
- To promote the creation of at least one health cooperative in each commune by 2016.

Expected results
- The rate of membership of populations to health cooperatives has increased by 2016;
- Each commune has at least one health cooperative.

Strategies
- Creating an environment conducive to an accelerated development of health cooperative before 2010;
- Strengthening technical and institutional capabilities of health cooperatives;
- Promoting new cooperative initiatives;
- Strengthening communication in the context of the promotion of health cooperatives
- Strengthening the capabilities of stakeholders in development of health cooperatives (training, research and information and management system)

Lines of action
The main actions to conduct for the creation of an environment conducive to cooperatives development are defined in the health cooperatives strategic plan. The focus is put on:

For the creation of an environment conducive to an accelerated development of health cooperatives:
- Setting up a legal framework favorable to the creation of health cooperatives;
- Creating a network of coordination of and support to the development of health cooperatives;

For health cooperatives already existing:
- Developing strategies of acceptance of cooperatives by the health personnel
- Implementing mechanisms ensuring the financial viability of cooperatives

**For strengthening capabilities of health cooperatives:**
- Strengthening capabilities of human resources involved in the management of health cooperatives
- Strengthening institutional capabilities by an organizational assistance
- Strengthening capabilities to mobilize financial resources

**For promoting new cooperative initiatives:**
- Setting up strategies that inform widely on the necessity to create health cooperatives
- Improving the offer of care in health facilities in Benin

**For strengthening capabilities of stakeholders in the development of health cooperatives:**
- Driving a system of information, monitoring and research
- Training stakeholders in the development of health cooperatives

### 6.4.2- Program: STRENGTHENING MEDICAL ASSISTANCE TO THE POOR, THE INDIGENT AND VULNERABLE STRATA

The desire to restore equity in the delivery of health care is permanent. But as far as curative care is concerned, the lack of equity remains patent and public health protection is exclusively reserved to civil servants and political officials in the country. The larger mass, more than 90% of the country’s population, is not covered.

Therefore, in the context of poverty reduction, the initiative was taken to redistribute a part of public resources to the health of poor and indigent populations. The proportion of indigents identified among attendees in care facilities does not exceed 5%, irrespective of the category of care - outpatient care, medical or surgical care. Resources currently available can readily support their needs for care, if the same modalities and level of recruitment of indigents are maintained and a rigorous management of the fund is ensured.

**a) Sub-program: Strengthening of medical assistance**

To promote a better accessibility of the neediest populations to health care, the government has, in inter-ministerial order 743/MFE/MSP/SGM/CAB/SP of June 13, 2005, established the modalities of use of the indigents’ health fund.

**General objective:** To facilitate health services access to the poor, the indigent and vulnerable strata.

**Specific objectives:**

- To make health care completely free for children aged 0 to 5 years in public health facilities by 2016.
- To improve the mechanism of management and usage of the indigents’ health funds for an improved access to care of beneficiaries.

**Expected results**

- Health care is completely free for children aged 0 to 5 years in public health facilities in 2018.
- The mechanism of management and usage of the indigents’ health funds is improved.

**Strategies**

- Strengthening of institutional capabilities of system stakeholders in accounting for the neediest and the indigent;
- Strengthening the dialog between commune and socio-medical authorities;
- Informing more widely the populations on the said funds;
- Decentralizing indigents’ health funds to all communes as was done with social measures funds;
- Generalizing indigents’ health funds to all health areas;
- Strengthening medical assistance to vulnerable strata (0 to 5 years old).

**Lines of action**

Setting up a legal framework institutionalizing a scheme of medical assistance to the poor and the indigent.

Revising conditions of access and usage of the indigents’ health funds

Setting up a monitoring mechanism;

Simplify disbursement procedures of the funds;

Setting up a fund to support health cooperatives.

Conducting studies to identify the causes of the high percentage of resources used by households for drugs purchase.

a) Sub-program: Mobilization of national savings and savings from citizens abroad (gifts and bequests)

**General objective:**

To improve accessibility of the poor and the indigent to health care and services

**Specific objectives:**

- To set up a support fund for health needs of the poor and the indigent
- To promote mechanisms of health guardians for the poor and the indigent

**Expected results**

- A support fund for health needs of the poor and the indigent is set up
- Mechanisms of health guardians are created and are operational.

**Strategies**

- Strengthening the capacity of collection of funds from people of good will
- Social mobilizing in favor of health solidarity

**Lines of action**

- Organizing the Telethon
- Sensitizing people on health solidarity
- Organizing advocacy in favor of health solidarity
- Establishing groups of friends of health solidarity using communication tools (internet), development associations and organized groups (self-financing groups)
- Developing the mechanism of health guardian (advice, material and financial support)
- Promoting the assistance of citizens of Benin from abroad to raising the solidarity fund

**6.5- Priority Area: Strengthening management of the sector**

**6.5.1- Program: Institutional strengthening**

**a- sub-program: Strengthening capabilities in planning, coordination and evaluation**

**General objective**

To ensure at all tiers of the health system pyramid the optimal conditions to implement the national health development plan

**Specific objectives**

- To adapt by the end of 2009 the norms and standards to new realities of the health sector (quality approach, health communication, health research etc.)
- To ensure by the end of 2009 the consistency of the organizational framework to requirements of the health policy
- To strengthen NHDP implementation capabilities at each tier of the health system pyramid

**Expected results**
- The norms and standards are adapted to new realities of the health sector (quality approach, health communication, health research etc.) before the end of 2009

- The consistency of the organizational framework to requirements of the health policy is ensured, by the end of 2009.

- NHDP implementation capabilities are strengthened at each tier of the health system pyramid

**Strategies**

- Developing and regularly updating management and decision analysis tools;
- Developing three year development plans and annual work plans taking into account the vision of the sector;
- Developing and implementing a training plan of agents in charge of the coordination of the planning and management of activities at each tier of the health system pyramid;
- Developing, implementing and monitoring the annual work plan at each tier of the health system pyramid;
- Strengthening and/or setting up sufficient logistical means at each tier of the health system pyramid;
- Ensuring the consistency of norms, standards and legal texts to the new policy;
- Strengthening capabilities of the sector in planning, statistics production, programming, supervision and coordination;
- Strengthening quality approach, health communication and health research.

**Lines of action**

- Setting up a High Council on Health
- Conducting an institutional and organizational audit of the ministry to adapt structures of the health sector to the vision
- Ensuring the training of trainers (at all tiers of the health system pyramid) in project management, leadership, quality approach, health communication, health research and contractualization
- Training of stakeholders of health areas in project management, result-oriented management, quality approach, health communication, health research and contractualization.
- Allocating supervision means (motorcycles, vehicles, motorized boats, etc.) to each tier of the health system pyramid (central, intermediary and peripheral)
- Allocating adequate ambulances and Aerial Communication Networks (ACN) to each tier of the health system pyramid
- Developing 3YDPs at central, intermediary and peripheral tiers taking into account the vision of the sector.
- Developing National Health Accounts for budgetary years 2006, 2010 and 2015
- Developing a regular statistics yearbook of the sector
- Developing the annual performance report of the sector
- Developing annuals work plans of all health facilities
- Improving the statistics production system through the National Health Information and Management System (SNIGS)
- Training and re-training DPP managers in techniques of development, monitoring and evaluation of projects and programs
- Training and re-training managers in result-oriented management process
- Strengthening support (technical, financial, logistical) to health areas not supported by a partner
- Strengthening advice, control and inspection capabilities (institutional, technical and logistical support) of the Directorate in charge of inspection;
- Strengthening intervention, coordination and technical support capabilities of the Directorate in charge of planning;
- Strengthening intervention, coordination and technical support capabilities of the Directorate in charge of development of health areas.

b- Sub-program: Strengthening of the mechanism of maintenance of health facilities

To reach one of the major objectives of the health policy, “to improve the health status and the quality of life of populations”, the Ministry of Health implemented several intervention strategies and orientations that led to the construction and equipment of suitable health facilities and the set-up of a significant fleet of vehicles. But one must acknowledge that these efforts were very soon negated by the lack of upkeep and maintenance. To remedy this situation detrimental to the sector, different experiences of organization of a system of hospital maintenance have been conducted with partners. Unfortunately, none of these experiences provided long-term positive results. Learning from
the shortcomings in personnel and taking into account the lack of financial and material resources, the government has developed and implemented in 2002 a policy of maintenance of infrastructures, medical and technical equipment and the vehicles fleet. This policy aim at ensuring the permanent availability of adequate infrastructures, medical and technical equipment and vehicles in health facilities at each tier of the health system pyramid.

This program has the following objectives:

**General objective:**
- To ensure a long usable life to equipment, infrastructures and vehicles at all tiers of the health system pyramid in Benin.

**Specific objectives:**
- To ensure preventive maintenance of infrastructures, medical and technical equipment and vehicles;
- To reduce maintenance costs of infrastructures, medical and technical equipment and vehicles;
- To set up and monitor performance indicators of the maintenance of infrastructures, medical and technical equipment and vehicles.

**Expected results:**
- the preventive maintenance of infrastructures, medical and technical equipment and vehicles is ensured;
- maintenance costs of infrastructures, medical and technical equipment and vehicles are reduced;
- performance indicators of the maintenance of infrastructures, medical and technical equipment and vehicles are set up and monitored.

**Strategies:**
- Efficiently reorganizing the maintenance services;
- Strengthening intervention capabilities at each tier of the health system pyramid;
- Providing adequate equipment to maintenance services;
- Setting up an effective depreciation mechanism of infrastructures, medical and technical equipment and vehicles;
- Implementing a mechanism of motivation of maintenance personnel.

**Lines of action**
- Ensuring adequate training or re-training of maintenance personnel currently employed;
- Recruiting additional personnel;
- Allocating adequate means of intervention to maintenance services;
- Defining maintenance indicators by tier of the pyramid
- Ensuring monitoring of the implementation of these indicators

6.5.2 Program: Development of health areas

**a- sub-program: Strengthening the lower tier of the health system pyramid**

In the context of improving the quality of health care to populations, the Ministry of Health has chosen to reorganize the lower tier of the health system pyramid in Areas since the round-table of the health sector of January 1995. To date, 34 health areas have been created. Some are not functional yet.

**General objective:** To strengthen capabilities of implementation of the NHDP at the peripheral tier

**Specific objective:** To ensure the functionality of all health areas

**Expected results:** All health areas are functional.

**Strategies**
- Strengthening health services using the health area approach;
- Supporting the reform of the sector and the decentralization of the entire health system;
- Strengthening management capabilities at all levels (planning, organization, implementation, evaluation);

**Lines of action**
- Making first tier care accessible to populations (geographical and financial accessibility);
- Improving the quality of health care and services delivery at the first tier;
- Improving the system of referral and counter-referral at all tiers;
- Strengthening integration of activities at all tiers;
- Making existing health facilities conform to standards relating to infrastructure and equipment;
- Providing qualified personnel to first tier health facilities.
- Strengthening coordination and advice capabilities of DDS and health areas management bodies;
- Defining roles and responsibilities of each tier of the health system pyramid and the links between the different tiers;

b- sub-program: Development of services at the community level

**General objective:** To strengthen community services

**Specific objective:** To promote community activities

**Expected results:** Community activities are strengthened

**Strategies**
- Strengthening social mobilization;
- Providing technical and financial support to community initiatives;
- Strengthening capabilities of community stakeholders;

**Lines of action**
- Strengthening management bodies of health areas;
- Training and re-training members of management bodies;
- Training community stakeholders
- Sensitizing the population to decentralized and participative management principles.
- Promoting contractualization in health facilities;
- Supporting the development of action plans of community stakeholders;
- Supervising activities of community stakeholders.
VII – FINANCING THE NHDP

The estimate of desired financing for the NHDP has been based, on the one hand, on resource projections and, on the other hand, on resource requirements. The potential resources are determined based on population projections, a national effort to allocate a growing share of GDP to health expenditure and the Government’s intention to harness more resources in the public health sector through better quality provision of public health services. As regards the resource requirements, they are determined depending on the realities of the time and the challenges of the ten-year plan, the Millennium Development Goals, the Growth and Poverty Reduction Strategy (GPRS) and the strategic orientations contained in the health sector policy statement.

7.1- Potential indication of NHDP financing

The National Health Expenditure (NHE) per inhabitant, according to the 2003 National Health Accounts (NHA), was estimated at 13,742 FCFA per year. This expenditure will show a slight increase in the coming years to take account of the rising costs of medical and technical equipment, the complexity of the morbidity pattern and the sector’s requirements in qualified human resources for the next ten years. This increase could be of the order of 5% from 2008.

Considering the share of health expenditure per source in comparison with the nation’s entire health expenditure, the overall amount of the resources committed by various sources is determined. The sector financing program seeks to promote other private sources, in particular compulsory health insurance, community-based health insurance schemes and the assistance funds for the poor, vulnerable groups and the indigent. Taking this financing mechanism into account must, at the end of ten years, reduce the household share of financing health expenditure and in turn increase the shares of insurance, local authorities and private businesses.

The State’s intention to actually devote 15% of budget resources to health, the strengthening of the Heavily Indebted Poor Countries (HIPC) initiative, community financing and the creation of specific taxes for health will enable the sector to have the resources essential for implementing the sector’s programs and sub-programs. Thus, the estimated resources are as follows:
Estimated resources per source

<table>
<thead>
<tr>
<th>Sources</th>
<th>2003</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>29,571,781,539</td>
<td>179,465,594,716</td>
<td>179,029,072,881</td>
<td>358,494,667,597</td>
</tr>
<tr>
<td>%</td>
<td>30,8</td>
<td>30</td>
<td>25</td>
<td>27,28</td>
</tr>
<tr>
<td>Household</td>
<td>49,962,277,132</td>
<td>179,465,594,716</td>
<td>179,029,072,881</td>
<td>358,494,667,597</td>
</tr>
<tr>
<td>%</td>
<td>52,1</td>
<td>30</td>
<td>25</td>
<td>27,28</td>
</tr>
<tr>
<td>Partner</td>
<td>15,840,371,203</td>
<td>95,714,983,849</td>
<td>114,578,606,643</td>
<td>210,293,590,492</td>
</tr>
<tr>
<td>%</td>
<td>16,51</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>LCs</td>
<td>133,810,238</td>
<td>17,946,559,472</td>
<td>35,805,814,576</td>
<td>53,752,374,048</td>
</tr>
<tr>
<td>%</td>
<td>0,14</td>
<td>3</td>
<td>5</td>
<td>4,09</td>
</tr>
<tr>
<td>Private</td>
<td>324,380,608</td>
<td>107,679,356,829</td>
<td>179,029,072,881</td>
<td>286,708,429,710</td>
</tr>
<tr>
<td>%</td>
<td>0,34</td>
<td>18</td>
<td>25</td>
<td>21,81</td>
</tr>
<tr>
<td>Other</td>
<td>124,241,727</td>
<td>17,946,559,472</td>
<td>28,644,651,660</td>
<td>46,591,211,132</td>
</tr>
<tr>
<td>%</td>
<td>0,13</td>
<td>3</td>
<td>4</td>
<td>3,54</td>
</tr>
<tr>
<td>Total</td>
<td>95,956,862,447</td>
<td>598,218,649,054</td>
<td>716,116,291,522</td>
<td>1,314,334,940,582</td>
</tr>
</tbody>
</table>

As provided in the policy document, the share of health expenditure that households will bear will gradually drop, going from 52.1% to 25% by the end of the Plan, while the private share will go from 0.34% to 25%. As for the State share, it will fall from 30.8% to 25%.

The share of overall financing expected from technical and financial partners would be kept practically at the same proportion throughout the period of the plan.

Local authorities will see their share go from 0.14% to 5%. As for “other sources” including community-based health insurance schemes, their share will increase considerably, going from 0.13% to 4% over the period.

7.2- Indications of financing by program over 5 years

In moving from five to eight principal programs, the new plan aims first to achieve the health policy’s general goals, but it also provides clarification in terms of the major action fields for determining the activities and management processes enabling the expected results to be achieved, following the strategic orientations.

The estimate of the resources needed for each program is based on analysis of the information mentioned in the 2004 and 2005 performance reports, the report of the 2005
Health Sector Public Expenditure Review, as well as analysis of the 2007-2009 Medium-Term Expenditure Framework (MTEF).

Table 2: Estimated requirements per program and sub-program.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SUB-PROGRAM</th>
<th>Cost in billions of FCFA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2009-2013</td>
</tr>
<tr>
<td>Health Promotion and Prevention</td>
<td>Environmental services and sanitation</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>Increasing Prevention Capacities</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Social Communication</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1,1</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>Control of maternal and neonatal mortality</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Control of infant and child mortality</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>129</td>
</tr>
<tr>
<td>Disease control</td>
<td>Communicable disease control</td>
<td>90,3</td>
</tr>
<tr>
<td></td>
<td>Non-communicable disease control</td>
<td>0,4</td>
</tr>
<tr>
<td></td>
<td>Improving availability of low-cost good-quality drugs</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Promoting blood transfusions and diagnostic tests</td>
<td>7,5</td>
</tr>
<tr>
<td></td>
<td>Promoting traditional drugs and medicine</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Promoting health in schools, universities and the workplace</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>Promoting mental health</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Promoting health research</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>249,6</td>
</tr>
<tr>
<td>Hospital development</td>
<td>Management of the quality of care in health</td>
<td>0,4</td>
</tr>
<tr>
<td></td>
<td>Strengthening the technical support centre</td>
<td>275</td>
</tr>
<tr>
<td></td>
<td>Organizing and increasing the supply of treatment</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>Hospital reform</td>
<td>0,3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>276,4</td>
</tr>
<tr>
<td>Increased planning of human resources</td>
<td>Increasing the human resources workforce in health</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Strengthening the partnership between internal and external stakeholders as regards human resources planning in health</td>
<td>0,5</td>
</tr>
<tr>
<td></td>
<td>Development of research into human resources</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>151,5</td>
</tr>
<tr>
<td>Improving production and development of skills</td>
<td>Developing a consensus plan for initial training of personnel in the sector</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Developing skills in personnel in the sector</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>31</td>
</tr>
<tr>
<td>Improving the management system for human resources</td>
<td>Improving career management for the personnel</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Improving incentive mechanisms for personnel retention and performance</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Preventing and managing occupational risks</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Deconcentration/decentralization of human resources management</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

National Health Development Plan - Benin 2007-2016
### Strengthening the Partnership with the Stakeholders

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership between the Health Ministry and other ministries</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Partnership between the Health Ministry and the local authorities</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Partnership between the private sector and the public sector</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3.6</td>
<td>1.4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Promoting Ethics and Medical Responsibility

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting ethics and medical responsibility</td>
<td>0.3</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Promoting and developing quality assurance</td>
<td>0.2</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.5</td>
<td>0.5</td>
<td>1</td>
</tr>
</tbody>
</table>

### Financing

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting health insurance</td>
<td>0.6</td>
<td>0.4</td>
<td>1</td>
</tr>
<tr>
<td>Promoting community-based health insurance schemes</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.9</td>
<td>0.6</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### Increasing Medical Assistance to the Poor, the Indigent and Vulnerable Groups

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing medical assistance</td>
<td>20</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Mobilizing national savings and the savings of the diaspora</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>36</td>
<td>61</td>
</tr>
</tbody>
</table>

### Strengthening Institutions

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing capacities for coordinating planning and evaluation</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Strengthening the mechanism for maintenance of health infrastructure</td>
<td>0.5</td>
<td>0.3</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.8</td>
<td>0.5</td>
<td>1.3</td>
</tr>
</tbody>
</table>

### Developing Health Areas

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening the base of the health pyramid</td>
<td>21</td>
<td>6</td>
<td>27</td>
</tr>
<tr>
<td>Developing community-based services</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>10</td>
<td>35</td>
</tr>
</tbody>
</table>

### Grand Total

<table>
<thead>
<tr>
<th>Category</th>
<th>2009-2013</th>
<th>2014-2018</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Total</strong></td>
<td>912.4</td>
<td>1078.6</td>
<td>1991</td>
</tr>
</tbody>
</table>

Between financing requirements and potential financing for the sector, there emerges a gap of 677 billion francs, divided as follows: 316.4 for the 2009-2013 period and 362.6 for the 2014-2018 period.

### 7.3- Allocation of Resources by Expenditure Category

The structure of the budget as it appears in 2005 has been considered, as was the 2007-2009 MTEF. However, this structure was progressively modified to take account of the major efforts already made as regards investment. The construction of the referral hospital for the sub-region is not counted in this financial forecast, as its financing is exceptional. Notwithstanding some heavy investments contemplated, such as the Parakou CHU, the sector’s new priorities concern making the health services operational and effective operation of the entire health system, in particular putting in place qualified and competent human resources. In terms of the annual structure of resource allocation, the “personnel” heading will go from 16.12% of annual resources in 2007 to 25% in 2011 (recruitment and improvement of working conditions, payment of bonuses and incentives) before reaching...
30% by the end of the plan. On average, this share will be 22% on average for the first five years and 28% for the second. On the other hand, investment resources will be brought down to 35% in 2011 instead of 45.16% in 2007. Operating resources will progressively take a greater share of annual appropriations, moving from 38.72% in 2007 to a stabilized rate of 40% in 2009. The following table shows the allocation of resources by categories.

### ALLOCATION OF RESOURCES BY EXPENDITURE CATEGORIES

<table>
<thead>
<tr>
<th>EXPENDITURE CATEGORY</th>
<th>Amount in billions of FCFA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009-2013</td>
</tr>
<tr>
<td>Personnel</td>
<td>200,7</td>
</tr>
<tr>
<td>%</td>
<td>22%</td>
</tr>
<tr>
<td>Operation</td>
<td>310,2</td>
</tr>
<tr>
<td>%</td>
<td>34%</td>
</tr>
<tr>
<td>Investment</td>
<td>401,5</td>
</tr>
<tr>
<td>%</td>
<td>44%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>912,4</td>
</tr>
</tbody>
</table>

7.4- Direct allocation of resources by health system level

The NHDP provides support for institutional reforms including those concerning decentralized resource management, and the trend of various headings has been shown in relation to this.

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>Amount in billions of FCFA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009-2013</td>
</tr>
<tr>
<td>Central</td>
<td>274</td>
</tr>
<tr>
<td>%</td>
<td>30%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>274</td>
</tr>
<tr>
<td>%</td>
<td>30%</td>
</tr>
<tr>
<td>Peripheral</td>
<td>364,4</td>
</tr>
<tr>
<td>%</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>912,4</td>
</tr>
</tbody>
</table>

The weight of the central and intermediate levels in the direct allocation of NHDP annual resources will gradually drop until it reaches respectively 15% and 25% of resources. Resources for the peripheral level will show an increase and reach 60% by the end of the Plan.

The strategic choice to change the allocation of resources as shown above fits with the policy directions of the Government and the health authorities, to increase decentralization
and growing management by the communities and local authorities of the problems of economic development and population well-being.

VIII. IMPLEMENTATION, MONITORING AND EVALUATION

8.1- Implementation and monitoring mechanisms

8.1.1- Managing the NHDP

Management of the NHDP involves the three levels of the health pyramid, namely the peripheral, intermediate and central levels, and relies on a choice of building cooperation between directorates or services to achieve the development program goals.

The role of monitoring and evaluation falls on the Direction de la Programmation et de la Prospective (DPP, Directorate of Programming and Forecasting) which must be strengthened to effectively meet the NHDP requirements. The ministry agencies responsible for monitoring and assessing the NHDP must consolidate their skills and resources. Coordination of all programs and sub-programs comes under the authority of the Health Ministry which delegates this responsibility as follows:

- Coordination of programs coming under a single directorate is done by the person in charge of the directorate;
- Coordination of programs involving several central and/or technical directors is done by the director identified among those concerned;
- Coordination of programs in the same priority field is done by a leader identified for this purpose;
- Coordination, monitoring and evaluation of all priority fields under the health sector’s Comité National de suivi de l’Exécution et d’Evaluation des Projets/Programmes (CNEEP, national committee for monitoring project/program performance and evaluation). The DPP provides secretarial services.
Taking institutional responsibilities into account, the list of priority field leaders selected is as follows:

<table>
<thead>
<tr>
<th>Fields</th>
<th>Leader</th>
<th>Program and agency in charge</th>
<th>Sub-program</th>
<th>Other Health Ministry stakeholders involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventing and controlling the principal diseases and improving the quality of care</td>
<td>NHDP</td>
<td>11. Preventing and controlling the principal diseases and improving the quality of care (DHAB)</td>
<td>111. Environmental services and sanitation</td>
<td>DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>112. Communication for behavioral change</td>
<td>ALL DIRECTORATES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Reproductive Health (DSF)</td>
<td>121. Controlling maternal and neonatal mortality</td>
<td>DH, DNPEV, DEDTS, DIEM, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>122. Controlling infant and child mortality</td>
<td>DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Disease control (NHDP)</td>
<td>131. Controlling the priority diseases: STDs/HIV/AIDS, malaria and tuberculosis</td>
<td>DHAB, DISO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>132. Communicable disease control</td>
<td>DHAB, DISO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>133. Non-communicable disease control</td>
<td>DHAB, DISO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>134. Improving availability of low-cost good-quality drugs</td>
<td>DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>135. Promoting diagnostic tests and transfusion safety</td>
<td>DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>136. Promoting traditional drugs and medicine</td>
<td>DNPS, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>137. Promoting health in schools, universities and the workplace</td>
<td>DSF, DRS, DRH, DRFM, DPP, DIVI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>138. Promoting mental health</td>
<td>DPM, DRS, DPP, DIVI, DRH, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>139. Promoting health research</td>
<td>ALL DIRECTORATES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14. Hospital development (DH)</td>
<td>141. Developing a system for managing the quality of care in the hospital environment</td>
<td>DNPS, DISO, DPP, DIVI, DRS, DRH, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>142. Strengthening the technical support centers</td>
<td>DPP, DIVI, DRS, DRH, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>143. Hospital reform</td>
<td>DNPS, DISO, DSF, DIEM, DPP, DIVI, DRS, DRH, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>144. Organizing and increasing the supply of treatment</td>
<td>DNPS, DISO, DPP, DIVI, DRS, DRH, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Development of human resources</td>
<td>DRH</td>
<td>211. Increasing the human resources workforce in health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>212. Strengthening the partnership between internal and external stakeholders as regards human resources planning in health</td>
<td>DIVI, DPP, DRS, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>213. Development of research into human resources</td>
<td>DIVI, DPP, DRS, DRFM</td>
</tr>
</tbody>
</table>
## National Health Development Plan - Benin 2007-2016

### 22. Improving production and development of skills (DRH)
- Developing a consensus plan for initial training of personnel in the sector
- Developing skills in the personnel in the sector

### 23. Improving the management system for human resources
- Improving career management for the personnel (DIVI, DPP, DRS, DRFM)
- Improving incentive mechanisms for personnel retention and performance (DIVI, DPP, DRS, DRFM)
- Preventing and managing occupational risks (DIVI, DPP, DRS, DRFM)
- Deconcentration/decentralization of human resource management (DIVI, DPP, DRS, DRFM)

### 3. Strengthening the partnership in the sector, promoting ethics and medical responsibility (DRS)
- Partnership between the public sector and the private sector (All directorates)
- Partnership between the Health Ministry, local elected representatives and local authorities (All directorates)
- Partnership between the Health Ministry and the other ministries (All directorates)

### 4. Financing mechanism for the sector (DRFM)
- Promoting health insurance (DIVI, DPP, DRS, DRFM, DRH)
- Promoting community-based health insurance schemes (DIVI, DPP, DRS, DRFM, DRH)

### 5. Strengthening management of the sector (DDZS)
- Increasing capacities for coordinating planning and evaluation (All directorates)
- Strengthening the mechanism for maintenance of health infrastructure (All directorates)

### 8.1.2 Organizing the monitoring of NHDP implementation

#### a) At the central level
The central level, made up of the Health Minister's staff and the Central and Technical Directorates, is in charge of the design and monitoring of the implementation of actions under policies defined by the government as regards health. Thus, it plays a standard-setting role in design, coordination, planning and regulation of the implementation of activities. Twice a year, the CNEEP, which brings together, along with the Technical and Central Directors, the Departmental Directors, unions and management in the Health Ministry and...
representatives of ministries related to health, meets to assess progress and difficulties in carrying out the Plan. Furthermore, a half-yearly review of the Financial and Technical Partners, chaired by the Health Minister surrounded by his Health Ministry Technical and Central Directors, is also a test for monitoring the NHDP. The DPP is also secretary of this. In addition, a joint performance review of the sector is organized annually.

b) At the intermediate level

The intermediate level, which brings together the DDSs, is responsible for implementing the health policy defined by the government, and for programming and coordinating all health service activities in the departments. It also provides epidemiological surveillance in the departments. At this level, the Comité Départemental de suivi de l’Exécution et d’Évaluation des Projets et Programmes (CDEEP, Departmental committee for monitoring project/program performance and evaluation), the departmental branch of the CNEEP, is the decentralized monitoring agency. It brings together senior managers from the DDS and representatives of ministries that are members of the CNEEP. CDEEP meetings are quarterly.

c) At the peripheral level

The peripheral level, made up of the health areas, represents the most decentralized entity in the health system. It is the operational level where programs and health activities are carried out to achieve conclusive results. In this context, it plans and ensures that these programs are scheduled and carried out throughout the health area. In the health area, the three-year plan will be responsible for realizing the NHDP goals. The Équipes d’Encadrement de Zone sanitaire (EEZ, health area supervision teams) must work in an integrated way to achieve the goals of the health area development plan and thus of the NHDP.

The area coordinating doctor organizes a monthly coordination meeting with managers of the health facilities in his area to assess how the annual work plan is being carried out. He prepares a quarterly report that he sends to the DDS.

Furthermore, monitoring is organized twice a year at the peripheral level.
8.2- Monitoring & Evaluation

8.2.1- Monitoring the NHDP

Monitoring the NHDP is the responsibility of the DPP. Three tools or aids are to be designed for this activity:

- Progress card for physical constructions
- Half-yearly accounting report
- Management chart for priority sub-programs.

**Progress card for physical constructions**

This is for the central, technical and department directorates and for the health areas. When construction/renovation/extension works start, the card is filled in half-yearly by the National Director, the DDS or the area coordinating doctor, respectively for the central, departmental and health area services. The card contains information on the kind of operation (construction, renovation, extension), notes the planned cost and construction period, indicates progress, specifies any problems and makes recommendations. The cards, duly filled in, are sent twice a year to the reorganized and restructured DPP, with a copy to the DIEM, for data entry and processing.

**Half-yearly accounting report**

This record gives the financial situation in one page, according to the selected standards and procedures. The card is filled in twice yearly with copies appended of supporting documentation for the expenditure carried out, including the most recent account statements. The half-yearly accounting report is also sent twice yearly to the DIVI, with a copy to the DPP for data entry and processing.

The progress card for physical constructions and the half-yearly accounting report allow calculation of results indicators: completion rates for inputs and outputs.

**Priority program management chart**

Progress in achieving the three Millennium Development Goals concerning health will be an essential element in a midpoint evaluation of the NHDP: this involves two reproductive health sub-programs, the priority diseases being in particular malaria, HIV/AIDS and tuberculosis. However, the indicators selected for this midpoint evaluation are coverage
indicators. The priority program management chart is filled in twice a year and sent to the DPP for data entry and analysis of the following indicators:

**Reproductive Health**
- PNC coverage
- EPI use
- EPI coverage
- High-risk pregnancy (HRP) detection %
- Proportion of home births
- Assisted delivery %
- Contraceptive prevalence
- % of diarrhea cases treated with ORS
- % of diarrhea cases treated with antibiotic treatment
- % of malnourished children receiving nutritional rehabilitation

**Control of priority diseases:**
- Correct rate of use of algorithms for simple and serious cases of malaria in pregnant women according to age groups
- Proportion of area laboratories in which quality control of thick/thin blood smears shows a match of 80% or more.

The midpoint evaluation will be done based on the half-yearly reports by the Internal Monitoring Committee and also analysis of aids such as the progress card for physical constructions, the half-yearly accounting report and the priority program management chart.

**8.2.2- Midpoint evaluation**

This will be conducted at the end of the second three-year plan and will be done based on two surveys, one qualitative and one quantitative.

The quantitative survey will be done with the participation of the development partners. It will be a national survey. Three groups of indicators are selected for this survey: results indicators, coverage indicators and impact indicators. The list of results indicators is shown in
the part dealing with the ten-year action plan. The coverage indicators are the same as those selected for monitoring. The impact indicators are related to mortality and morbidity.

**Impact indicators**

**Mortality**
- Infant mortality rates
- Under-five mortality rates
- Maternal mortality rates
- Malaria lethality rates

**Morbidity**
- AIDS prevalence rates
- Proportional malaria morbidity rates
- Meningitis incidence rates (*or cholera prevalence rates*)
- Tuberculosis incidence rates

The qualitative survey will examine areas of participation by the communities in the health effort (impact of decentralization, health committees, civil society), the level of satisfaction in users of health services (in relation to service, quality of care, cost of drugs and treatment), and the solidarity systems set up to resolve problems posed by social cases (the indigent, vulnerable groups).

The quantitative survey and the qualitative survey will be conducted towards the end of the second year of the three-year plan and will constitute the substance of the report. For the quantitative part, progress will be measured based on the level of health described through the health statistics yearbooks and the various surveys conducted before the start of the NHDP.
ANNEXES
APPENDIX 1

BASIC DOCUMENTS AND LEGAL PROVISIONS

Program promoting basic hygiene and sanitation

As legal provisions, we have:

- Law No 87-015 of 21 September 1987 relating to the Public Hygiene Code
- Decree No 2002-484 of 15 November 2002 providing for rational management of biomedical waste in the Republic of Benin.
- Decree No 2006-087 of 8 March 2006 approving the national policy on hospital hygiene in the Republic of Benin.

As framework documents, we have:

- National Program of Basic Hygiene and Sanitation (PNHAB)

Policy documents on information, education and communication.

Reproductive Health Program

Legal provisions

- Laws No 2003-03 and No 2003-04 of March 2003 relating respectively to elimination of female genital mutilation and to sexual health and reproduction.
- The law protecting adolescents in the school environment

Framework documents

- The 1998 family health policy, norms and standards
- The 2002-2006 policy and development strategies for the health sector
- The National Health and Reproduction Program
- The national strategy for reducing maternal and neonatal mortality (Route map for the African Union and Vision Initiative 2010)
- The 2006-2010 five-year operationalization plan
- The 2007-2011 full Benin EPI multi-year plan
- The protocols for family health services
- The training guide for emergency obstetrical and neonatal care
- The trainer’s manual on the nutrition Minimum Package of Activities
- The national strategy for prevention and management of fistulas
- The national strategy for securing reproductive health products
- The national strategy for survival of mothers, newborns and children, currently being developed.
- The integrated PF malaria/STD/HIV protocols

Program: Disease control

Legal provisions:
- Decree No 85-112 of 5 April 1985 creating the National Committee for Emergency Preparedness.
- Decree No 2006-396 of 31 July 2006 containing the responsibilities, organization and operation of the Health Ministry.
- Order No 3898/MSP/DC/SA of 31 July 2006 containing the responsibilities, organization and operation of the National Directorate of Health Protection.

Framework documents:
- The policy and national strategies for the nursing and obstetrical care sub-sector.
- The national pharmaceutical policy and strategies.
- The national policy for control of malaria and the strategic implementation framework.
- The 2006-2010 strategic malaria control plan.
- The national policy on school and university health, developed in 2006.
- The 2003-2007 policy and national strategies for developing the biomedical analytical laboratories sub-sector.

Hospital development program

Legal provisions:
- Decree No 91-77 of 12 May 1991 approving the Articles of Association of Cotonou CNHU.
- Decree No 98-330 of 3 August 1988 creating and organizing the Benin CHU space.
- Decree No 2002-0113 of 21 May 2002 approving the Articles of Association of the area hospitals.
- Decree No 98-77 of 6 March 1988 providing for the special status of the Public Health Personnel Corps.
- Decree No 2005-611 of 28 September 2005 reorganizing the base of the Republic of Benin health pyramid into health areas;
- Decree No 2006-386 of 31 July 2006 containing the responsibilities, organization and operation of the Health Ministry.

Framework documents:
- The emergency plan for revitalizing the health sector and improving hospital management.

Strengthening the Partnership with Stakeholders Program

Legal provisions
- Law No 97-020 of 17 June 1997 setting the conditions for private practice of medical and paramedical professions.
- Order No 73-14 of 8 February 1973 instituting the Code of Medical Ethics.
- Order No 73-38 of 21 April 1973 creating and organizing the national registration boards for doctors, pharmacists, dental surgeons and midwives.
- Decree No 2000-410 of 17 August 2000 applying Law No 97-020 of 17 June 1997 determining the conditions for the private practice of medical and paramedical professions and relating to the opening of pharmaceutical warehouses in the Republic of Benin.
- Decree No 2000-411 of 17 August 2000 applying Law No 97-020 of 17 June 1997 determining the conditions for the private practice of medical and paramedical professions and operating a pharmaceutical plant in the Republic of Benin.
- Decree No 2000-449 of 11 September 2000 applying Law No 97-020 of 17 June 1997 determining the conditions for the private practice of medical and paramedical professions and relating to the conditions for being in private practice and opening private health care facilities.
- Decree No 2000-450 of 11 September 2000 applying Law No 97-020 of 17 June 1997 determining the conditions for the private practice of medical and paramedical professions and relating to the opening of wholesale distribution companies in the Republic of Benin.
- Order No 5658/MSP/DC/SGM/DPHL/SPM authorizing the import and sale of medical equipment.
- Order No 2723/MSP/DC/SGM/DNPS creating and appointing members to the technical commission responsible for examining applications authorizing private practice and opening health care facilities for the medical and paramedical professions.
- Order providing for the creation, responsibilities, composition and operation of a consultation framework for the partnership between the public and private sectors.

Framework document
- The policy and development strategies for the partnership between the public and private sectors in the field of health (2002-2006).