FOREWORD

The need to provide an orientation in order to guide the development process is a major concern for the government as well as for our development partners. Due to this need, the government has adopted the Strategic Development Guidelines which determine the major points of reference for public action. It is expected that each development sector will translate these guidelines into sectoral strategy broken down in operational terms. Together, these strategies must constitute the priority foundations for actions at the sector level. The preparation of the National Health Development Plan falls within this framework.

The work on preparation of the National Health Development Plan have been driven by the Ministry of Health with the technical support of the Minister responsible for Forecasting, Development, Evaluation of Public Policy and the Coordination of Government Action.

The National Health Development Plan is, for example, for the health sector, the medium-term programmatic basis for the allocation of resources at the macro budgeting level and at the intra-sectoral level.

In reference to the Paris Declaration, the Technical and Financial Partners of the Ministry of Health must agree with the choices made therein.

I would like to take this opportunity to express my congratulations to all who have invested themselves in the preparation of this document. I would also like to express my sincere gratitude to all the Technical and Financial Partners for their ongoing support.

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

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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AH</td>
<td>Area Hospital</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ARI</td>
<td>Permanent State Agent</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>Came</td>
<td>Essential Medicines Procurement Agency</td>
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<tr>
<td>Came</td>
<td>Health Improvement Solidarity Action Center</td>
</tr>
<tr>
<td>CCC</td>
<td>Communication for behaviour change</td>
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<tr>
<td>CDEEP</td>
<td>Comité Départemental de suivi de l’Exécution et d’Evaluation des Projets/Programmes</td>
</tr>
<tr>
<td>CGE</td>
<td>Contract Government Employee</td>
</tr>
<tr>
<td>CNEEP</td>
<td>Comité National de suivi de l’Exécution et d’Evaluation des Projets/Programmes</td>
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<tr>
<td>CNH</td>
<td>National Hospital Centers</td>
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<tr>
<td>CNHU</td>
<td>University Hospital Center</td>
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<tr>
<td>CNTS</td>
<td>National Blood Transfusion Center</td>
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<td>CSC</td>
<td>Health Centre</td>
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<tr>
<td>DH</td>
<td>Directorate of Hospitals</td>
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<td>DHBS</td>
<td>Directorate of Health and Basic Sanitation</td>
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<tr>
<td>DHC</td>
<td>District Health Center</td>
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<tr>
<td>DHC</td>
<td>Departmental Hospital Centre</td>
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<tr>
<td>DHD</td>
<td>Departmental Health Directorate</td>
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<tr>
<td>DIEM</td>
<td>Directorate of Infrastructure, Equipment and Maintenance</td>
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<tr>
<td>DNOC</td>
<td>Directorate of Nursing and Obstetrical Care</td>
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<tr>
<td>DSF</td>
<td>Directorate of Family Health</td>
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<tr>
<td>EMCS</td>
<td>Emergency Medical Care Service</td>
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<tr>
<td>ENOC</td>
<td>Emergency Neonatal and Obstetric Care</td>
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<tr>
<td>FAC</td>
<td>Fund for Aid and Cooperation</td>
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<tr>
<td>FAP</td>
<td>Women of Child-Bearing Age</td>
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<td>FMRD</td>
<td>Directorate of Financial and Material Resources</td>
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<td>FSS</td>
<td>Department of Health Sciences</td>
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<tr>
<td>GCPH</td>
<td>General Census of Population and Housing</td>
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<td>GDP</td>
<td>Human Resource Management</td>
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<tr>
<td>GPHC</td>
<td>General Population and Housing Census</td>
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<tr>
<td>GPRS</td>
<td>Growth and Poverty Reduction Strategy</td>
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<tr>
<td>HHR</td>
<td>Health Human Resources</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>HRD</td>
<td>Human Resources Directorate</td>
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<td>HZ</td>
<td>Health Zone</td>
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<td>HZDD</td>
<td>Health Area Development Directorate</td>
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<td>HZMT</td>
<td>Health Zone Management Team</td>
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<tr>
<td>IDSR</td>
<td>Integrated Disease Surveillance and Response</td>
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<tr>
<td>IEC</td>
<td>Information Education et Communication</td>
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<tr>
<td>IGM</td>
<td>IG (General Ministry Inspectorate)</td>
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<tr>
<td>INSAE**</td>
<td>National Institute of Statistics and Economic Analysis</td>
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<tr>
<td>ITM</td>
<td>Insecticide-Treated Materials</td>
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<tr>
<td>LCs</td>
<td>Gross Domestic Product</td>
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<tr>
<td>MDGs</td>
<td>Minimum Package of Activities for Nutrition</td>
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<td>MPA/nut</td>
<td>National Program for Health and Basic Sanitation</td>
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<td>MS</td>
<td>Ministry of Health</td>
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<tr>
<td>MTEF</td>
<td>Medium Term Expense Framework</td>
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<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<tr>
<td>NDEPI/PHC</td>
<td>National Expanded Immunisation and Primary Healthcare Programme Directorate (NEPID-PHC)</td>
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<td>NHDP</td>
<td>National Health Protection Directorate</td>
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<tr>
<td>NHE</td>
<td>National Health Expenditures</td>
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<td>NHIMS</td>
<td>National Health Information and Management System</td>
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<tr>
<td>OMD</td>
<td>Objectifs du Millénaire pour le de Développement [Millenium Development Objectives]</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ONG</td>
<td>Nongovernmental Organization</td>
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<tr>
<td>PCIME</td>
<td>Integrated Care for Childhood Diseases</td>
</tr>
<tr>
<td>PEV</td>
<td>Programme Elargi de Vaccination [Expanded Program for Immunisation]</td>
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<tr>
<td>PFD</td>
<td>Programming and Forecasting Directorate</td>
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<tr>
<td>PHC</td>
<td>Reproductive Health</td>
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<td>PIP</td>
<td>Public Investment Program</td>
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<tr>
<td>PMCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PNC</td>
<td>Prenatal Consultation</td>
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<td>PNDS</td>
<td>National Plan of Health Development</td>
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<td>PPTE</td>
<td>Ministry of Health</td>
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<tr>
<td>PRSP:</td>
<td>Poverty Reduction Strategy Document</td>
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<tr>
<td>RED</td>
<td>Reach Every District</td>
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<tr>
<td>RHD</td>
<td>Directorate of Health Research</td>
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<tr>
<td>SFE</td>
<td>Primary Health Care</td>
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<tr>
<td>SM</td>
<td>State Midwife</td>
</tr>
<tr>
<td>SNIGS</td>
<td>National Health Information and Management System</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis*</td>
</tr>
<tr>
<td>TFP</td>
<td>Ministry of Labor and Civil Service</td>
</tr>
<tr>
<td>VHU</td>
<td>Village Health Unit</td>
</tr>
<tr>
<td>WCBA</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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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:

- Reducing maternal and infant mortality; prevention; fighting disease and improving the quality of care;
- Developing human resources;
- Strengthening the partnership in the sector and the promotion of ethics and physician ethics;
- Improvement of the sector's financing mechanism;
- and Strengthening of the sector's management.

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;
   - a) Provision of basic services and cleaning of the environment
   - Communication for behaviour change

2. Improving reproductive health
   - Combating maternal and newborn mortality
   - Combating under-age-five mortality

3. Disease control
   - Combating priority diseases, STI/HIV/AIDS, malaria, and tuberculosis
   - Combating other communicable diseases
   - Combating non-communicable diseases
   - Improving availability of low-cost good-quality drugs
   - Promoting diagnostic examinations and transfusion safety
Promoting traditional medicine and pharmacopoeia
Promoting health care in school, university and occupational settings
Promoting mental health
Promoting health research

4. Hospital development
   - Developing a health care quality management system in the hospital setting
   - Improving technical capacity
   - Hospital reform
   - Organizing and improving health care provision

5. Increased planning of human resources
   - Increasing the human resources workforce in health
   - Strengthening the partnership between internal and external partners in health human resources planning
   - Development of research into human resources

6. Improving production and development of skills
   - Developing a consensus plan for initial training of personnel in the sector
   - Developing skills in personnel in the sector

7. Improving the management system for human resources
   - Improving career management for the personnel
   - Improving incentive mechanisms for personnel retention and performance
   - Preventing and managing occupational risks
   - Deconcentrating/decentralizing human resources management

8. Strengthening the partnership between the stakeholders
   - Partnership between public and private sectors
   - Partnership between the Ministry of Health, local elected officials, and local communities
   - Partnership between Ministry of Health and other ministries;

9. Promoting ethics and medical responsibility
   - Strengthening medical ethics and responsibility
   - Developing and promoting Quality Assurance

10. Improvement of sector financing
    - Promoting health insurance
    - Promoting community-based health insurance schemes

11. Increasing medical assistance to the poor, the indigent and at-risk groups
    - Increasing medical assistance
    - Mobilizing national savings and the savings of the diaspora
12. **Institutional strengthening**
   - Strengthening coordination, planning, and evaluation capabilities
   - Strengthening of the mechanism of maintenance of health facilities

13. **Development of health areas**
   - Strengthening the lower tier of the health system pyramid
   - Development of services at the community level

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 related to 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 the policy 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, including the Departmental Directorates of Health, is responsible for the implementation of health policy at the department level, as defined by the government. 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 activities throughout the entire health area.

**Financing of the NHDP**

The total budget for the NHDP amounts to 2,850,889 million CFA Francs. The various financing sources are the State, Local Municipalities, households, Technical and Financial Partners, insurance companies and companies from the private sector.

**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.
INTRODUCTION

The National Health Development Plan (NHDP) reflects the desire 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 period of 2009-2018.

The NHDP is based on Strategic Development Positions, the Statement of Health Sector Policy as well as the major concerns identified in the current diagnostic analysis. Furthermore, it includes the Millennium Development Objectives (MDO) in order to allow Benin to respond to the commitment made to all the countries of the United Nations System through 2015.

In its structure, in light of the problems that have been identified, the National Health Development Plan is broken down into five (5) sections that contribute to the attainment of the development vision selected for the sector: (1) prevention and combating the primary diseases and improvement of the quality of care; (2) development of human resources; (3) strengthening of the partnership with the sector, promotion of ethics and medical responsibility; (4) financing mechanism of the sector; and (5) strengthening of the management of the sector. These areas have been broken out into programs and sub-programs whose efficient implementation will allow the identified challenges to be overcome.
I—CONTEXT FOR DEVELOPMENT OF THE NHDP

Analysis of 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 increased to 1,528,000 residents in 1950; 2,082,511 residents in 1961; 3,331,210 residents in 1979; 4,915,555 residents in 1992 and 6,769,914 in 2002. INSAE projections yield a population of 7,839,915 in 2006 and 8,224,644 in 2008. Based on these data, it can be stated that Benin experienced an increase in the pace of growth of its population: 1.8% between 1910 and 1950; 2.8% between 1979 and 1992, then 3.2% between 1992 and 2002. The rates of growth between censuses from 1979 through 1992 corresponds to a doubling time of approximately 25 years.

In general demographic terms, Benin is characterized by:

- An essentially young and predominantly female population. In 2008, the population of Benin remained young, with a median age of approximately 16 years. Youth less than 15 years represent 47% Children age 0 to 5 represent 17% of the total population. In 2008, it had 51% women and 49% men. The ratio of males yields a national proportion of 96 men to 100 women. The age pyramid of the population has a large base with rapid constriction as of 10 years. This is the result of a high birth rate and an infant-juvenile mortality that notwithstanding the decrease remains high. Beyond 20 years, it is noted that the constriction is regular and more accentuated for men than for women. The migration could be a plausible explanation for these types of observations. The phenomenon seems more intense among men than among women. Similarly, overall mortality is still high in Benin in a context of poverty, because the increasing constriction observed as one moves towards the older age groups is also an explanation for the same.

This predominance of females in the population of Benin is more marked in rural areas than in the city: In 2008, the percentage of women of child-bearing age was 46% of the female population and 23% of the total population.

---

1 RGPH 2002
2 L’effectif de la population est estimé à environ 6,2 millions d’habitants en l’an 2000.
Population fully distributed across national territory in 2002: the eight departments in the south and central areas represent 25% of surface area and house 71% of the population, while the four other areas account for 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, 60% in 2002 and 57.4% in 2008.

In Benin, males run a greater risk of death than females. In contrast, a male child that is born can expect to live 57.18 years on average before dying, if health conditions are maintained similar to those of 2002, compared to an age of 61.25 for a female child.

This demographic growth exerts a great influence on the evolution of social demand, in particular in regards to health services.

Thus, it follows that:

- Strong urbanization leads to increased demand for basic social services (education, health, housing, transportation, etc.)
- An increase in the number of births leads 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.

Demographic trends in Benin, as presented, must, more than in the past, draw the attention of planners and other deciding factors for economic and social development. The use of demographic variables in the programs of the health sector must be actively recommended for the most effective management of the system because the regular increase in all these target populations necessarily involves actions, resources, infrastructures of all types and political orientations for the future years.

**Graphic 2: Age pyramid for Benin, 2008**

Source: INSÆ, RGPH3, 2002

**Analysis of poverty in Benin**

Poverty in Benin is more rural and has multiple facets. According to the EMICoV survey, and taking into consideration both dimensions of poverty studied (monetary poverty and non-monetary poverty broken down into poverty of living conditions and poverty based...
on assets), at least 3 out of 10 people in Benin are poor. According to the monetary approach, the proportion of the population that was poor in 2007 was estimated at 33% (compared to 37% in 2006). On the non-monetary level, poverty affects 40% of the population. When non-monetary poverty is broken down according to living conditions and assets, the proportion of the population that is poor in terms of living conditions is estimated at 37% (compared to 40% in 2006). In contrast, in terms of assets, this proportion is estimated at 44% (compared to 48% in 2006). Therefore an important portion of the population of Benin is deprived in terms of living conditions and assets.

The analysis of these various forms of poverty according to the living environment confirms that poverty is a phenomenon that is especially harsh in rural environments. Regardless of the form of poverty in question, more than 36% of people living in a rural environment are poor. From the perspective of living conditions, it affects more than 37% (in 2007) of the rural population and approximately 41% of those living in an urban environment. The relative discrepancy seems more accentuated when we consider poverty in terms of assets: 54% in rural environments compared to 27% in urban environments.

Furthermore, more than one person out of 10 is subject to the various forms of poverty at the same time. To appreciate the scope of this poverty, we evaluated the proportion of the population that suffers from monetary poverty, poverty of living conditions and poverty in terms of assets. Households fulfilling this criterion were identified and classified as “hard core.” The cumulation of the three forms of poverty allowed a hard core of poverty to be identified, which is estimated at 7.8% in 2007. Thus, households in this class represented more than one-tenth of the population of poor households in 2007. This involves households that are clearly poor, since they simultaneously have low consumer expenses, poor living conditions and are lacking in assets.

Education level, household size and the sector of activity of the head of household significantly effect the status of well-being of the household. This observation is noted in all forms of poverty.

In relation to the dynamic of poverty, and according to the results of the EMIcoV survey, poverty in Benin has moved backwards during the 2006-2007 period, regardless of the index in question. The incidence of monetary poverty decreased from 37.2% in 2006 to 33.3% in 2007, i.e. a decline of 3.9 points. The poverty gap, which in 2006 represented 30.9% of the poverty threshold was only 28.5% in 2007; the severity index measuring inequality among the poor is down, decreasing from 0.053 in 2006 to 0.040 in 2007. The results based on residence environment indicate that poverty has declined, regardless of the index considered and independent of the poverty threshold. The incidence of monetary poverty decreased from 34.79% in 2006 to 28.31% in 2007, i.e. a decline of 6 points. In rural environments, the decline was around 2 points (38.55 in 2007 compared to 36.08 in 2006).

Thus, the decline in poverty occurred in conjunction with the decline in inequalities. During the same period, the inequality index in Benin declined, from 0.53 in 2006 to 0.47 in 2007. This translates into a change in the distribution of consumer expenses and income of households over this same period. Nevertheless, a distinction in dynamics has been observed, depending on the municipality. The comparative analysis of poverty indices for the two periods at the municipality level shows situations that contrast with the reduction in poverty observed at the national level.
However, an analysis according to entry into and exit from poverty shows that urban households are more involved in business. Out of 100 households classified as not poor in 2006, 15 became poor in 2007. In contrast, out of 100 poor households, 43 remained poor and 57 came out of poverty. The rate of exiting poverty for urban households was 59.5%; this is greater than the figure for rural households (55.1%). As a result, the rate of entry into poverty for non-poor households is greater in rural environments than in urban environments: 16.3% compared to 11.9%.

**Economic and financial condition of Benin**

Since 2006, the Benin economy has entered a new growth phase. The rate of growth increased from 3.8% in 2006 to 5.0% in 2008, in conjunction with: (i) the reestablishment of trust at the level of economic operators; (ii) the resurgence of agricultural production; (iii) improvement in economic cooperation relations with Nigeria; (iii) [sic] cleaning up of public finances; (vi) [sic] the major construction relations sites opened up by the State throughout national territory, etc. This expansion of the economy did not continue in 2009 due to the effects of the second round of the international financial crisis and the measures taken by Nigeria to confront the food crisis.

An analysis of performance by sector of activity shows that the primary sector recorded an average growth rate during the 2007-2009 period of 3.9%, with a contribution to growth estimated at 1.5%. These performance figures relate to the levels of growth recorded in sub-sectors, i.e. agriculture (4.1%), livestock (3.5%), fish and forestry (3.5%). In regards to the secondary sector, the rate of growth increased on average to 4.4% over the period of 2007-2009, with an average contribution to growth of 0.6% in relation to the resurgence of activity experienced among extractive industries, manufacturing and Building and Public Works.

In regards to the tertiary sector, it recorded an increase in value added of 4.5% during the period of 2007-2009, with an average contribution of 1.4%, attributable to the improvement in the competitiveness of the Port of Cotonou thanks to the various reforms undertaken there, the arrival of the operator Global Com in 2008, and the improvement in cooperation relationships with Nigeria.

Since 2008, the Harmonized Index of Consumer Prices (HICP) has shown an upward trend in connection with tensions on food supplies. This increase in prices caused an inflation rate of 7.9% in 2008, significantly above the community standard of 3%, compared to 1.3% in 2007. The inflation rate should be within the community norms for 2009.
II - PROCESS FOR PREPARATION OF THE NHDP

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.

In 2009, based on the recommendations of the Council of Ministers in its meeting on Wednesday, April 22, 2009, and in accordance with the summary of administrative rulings No. 16/PR/SGG/REL dated April 23, 2009, the Council of Ministers recommended that the NHDP be submitted to the Minister of State responsible for Forecasting, Development and Evaluation of Public Policies and the Coordination of Government Action for a review.

Thus, following the comments made by the Minister of State responsible for Forecasting, Development and Evaluation of Public Policies and the Coordination of Government Action, a select team of twelve executives from the Ministry of Health, supported by a representative of the Minister of State responsible for Forecasting, Development and Evaluation of Public Activities re-read the National Health Development Plan. The NHDP was then presented to the various stakeholders in the health sector for appropriation of the document and to facilitate its implementation.

2.1.2- Information gathering

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 Objectives (MDO), the Poverty Reduction Strategy Paper (PRSP), health statistics yearbooks, and other planning documents were consulted. These documents made it allowed the health situation in Benin to be plotted as well as its evolution over a long period of time.

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 de la Santé (General Health Meetings)

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.
The health sector increasingly mobilizes a significant share of public action, and therefore, it remains a sector with a concentration of public expenditures. Although the investments made in the sector are up sharply, the issues to be resolved are worrisome and require particular attention.

Benin's health profile is characterized by a high morbidity rate despite all the programs and reforms implemented in past years to improve the state of health of the population.

Thirty-eight (38) conditions are under epidemiological monitoring throughout the country. The leading two (2) conditions that have frequently been the subject of consultation in 2008 represent more than 50% of consultations. These conditions are: (i) Malaria (39.6%) and (ii) Acute Respiratory Infections (15.9%).

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 have access to a health facility in their location within a 5-km radius.

In 2008 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 facilities coverage that is close to 86%, and it could be explained by financial constraints and unsatisfactory reception and quality of care.

The level of maternal mortality remains high. According to data from the Demographic and Health Survey (EDS III), the rate of maternal mortality is 397 women per 100,000 live births in 2006. Overall, infant mortality remains high (67‰ in 2006). It is more pronounced in rural areas and in the poorest areas. Children under one year living in rural environments (81%) were at higher risk for death than those living in urban environments (59%).

According to the 2006 Demographic and Health Survey (DHS III), the under-five mortality rate was 125‰ and it varied based on the level of education of the mothers.

The nutritional condition of mothers and children improved but is still worrisome. The children who most often have failure to thrive are male, come from rural environments, and have uneducated mothers.

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). Adolescents have a high birth rate: at 19 years of age, more than 4 women out of 10 (44%) already have at least one child or are pregnant.

Much work remains to be done to attain the MDOs for the health sector if current trends continue. This health situation in the country is overall explained by:

- **inadequate supply of health services**: although the proportion of districts in 2008 having Health Centers was 89%, it must be noted that most were not compliant with standards. Thus, many existing Health Centers require rehabilitation, in addition to construction to be carried out in districts without sanitation infrastructure.

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3 Health Statistics Yearbook, 2008
Furthermore, in spite of the efforts made, several Health Areas are without an area hospital and the personnel available are insufficient, in particular the specialist physicians called upon to serve in area hospitals. Similarly, the communications system is relatively undeveloped. In 2008, most Health Areas had difficulties implementing an adequate referral and counter-referral system.

- **limited human capabilities:** Health personnel are insufficient in terms of quantity and quality. The sector includes many personnel who are not qualified, such as assistants and attendants. The distribution of personnel is highly imbalanced, to the detriment of the peripheral and rural levels. Lastly, the insufficiency of training, supervision and encouragement measures, as well as technical weaknesses in places persist, contributing to the discouragement of care personnel at the administrative and technical levels.

Table 1: Progression of the number of health care personnel by socio-professional categories from 2000 to 2008

<table>
<thead>
<tr>
<th>Socio-professional categories</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>909</td>
<td>923</td>
<td>939</td>
<td>975</td>
<td>1013</td>
<td>1025</td>
<td>1088</td>
<td>1087</td>
<td>1095</td>
</tr>
<tr>
<td>Nurses</td>
<td>2336</td>
<td>2570</td>
<td>2774</td>
<td>2140</td>
<td>2730</td>
<td>3091</td>
<td>3563</td>
<td>3971</td>
<td>3663</td>
</tr>
<tr>
<td>Midwives</td>
<td>885</td>
<td>977</td>
<td>1029</td>
<td>1036</td>
<td>993</td>
<td>1230</td>
<td>999</td>
<td>1270</td>
<td>1392</td>
</tr>
<tr>
<td>Laboratory Technicians</td>
<td>336</td>
<td>345</td>
<td>387</td>
<td>421</td>
<td>451</td>
<td>435</td>
<td>317</td>
<td>473</td>
<td>528</td>
</tr>
<tr>
<td>Radiology Technicians</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>71</td>
<td>63</td>
<td>87</td>
<td>77</td>
<td>76</td>
</tr>
</tbody>
</table>

Source: Statistics Yearbook - 2000-2008/SNIGS/DPP/MS

- **low use of health services offered:** In 2008, the rate of use of health services was still low (45.1%) compared to 46% in 2007.

From the point of view of **governance of the health system,** several issues must be corrected, in particular high costs and inefficient and insufficiently transparent management of public expenditures, allowing trust vis-à-vis the administration of public health services to be reestablished among the 35% of the population that believe that they do not work well or not at all (EMICoV 2006). The governance of the health system must allow the overall management of the system to be improved and transparency of public expenditures to be established.

In regard to the low levels of Government technical and financial capabilities to confront the needs expressed in regards to health, the support of other non-governmental partners (PTFs, social partners, private sector, etc.) is insufficient and is one of the issues to be resolved in the sector.
IV - DIAGNOSTICS

4.1. Health profile of Benin

The health profile of Benin is characterized by a predominance of communicable diseases and the emergence of non-communicable diseases over the past several years.

4.1.1- Course of the main diseases

In Benin, transmissible diseases are still the main causes of morbidity and mortality. Thirty-six (36) conditions are under epidemiological monitoring throughout the country. Malaria and acute respiratory infections are the leading two (2) causes of consultations, accounting for 39.6% and 14.9% of cases in 2008, respectively. These are followed by other gastro-intestinal disorders (6.8%); trauma (5.8%) and diarrheic diseases (3.5%).

In terms of hospitalization, malaria is still in the lead (20.1%), followed by anemias (7.9%), traumatic injuries (5.0%), diarrhea (4.0%) and Acute Respiratory Infections (3.4%) for 2008.

The predominance of these diseases is explained, among other reasons, by the following: (i) environmental conditions; (ii) consumption of non-potable water and at-risk hygienic practices; (iii) poor knowledge of risk factors and prevention methods on the part of the community; (iv) weakness of actions to improve the environment; (v) weakness of preventive and promotional health activities; (vi) the very low level of community education intervention activities.

4.1.1.1. Communicable Diseases

4.1.1.1.1. Malaria with Epidemic Potential (MEP)

Benin was on the road to certification of eradication of poliomyelitis between 2006 and 2007, when no cases were reported, but the wild polio virus reappeared with 6 cases in 2008 and 20 cases in 2009. These new cases were due to the proximity to Nigeria. In regards to other diseases targeted by the EPI, 1185 suspected cases of measles, of which 201 were confirmed in the laboratory were recorded in 2008, with 5 deaths (mortality rate of 0.42%); 7 cases of Neonatal Tetanus with 2 deaths (mortality rate: 28.57%), 106 suspected cases. No yellow fever case has been confirmed by the laboratory.

Regarding other potentially epidemic diseases, cholera continues to evolve in an endemic-epidemic manner in the country. In 2008, 1009 cases were reported, with 6 deaths (mortality rate: 0.6%).

Additionally, Benin is located in the meningitis strip. In 2008, 461 cases of meningitis were reported, with 63 deaths (mortality rate: 13.7%). Lastly, for febrile diarrhea, 168 deaths were reported out of 76,731 cases reported (mortality rate: 0.2%).

These epidemiological data show the need to improve interventions falling within the battle against these diseases to increase the performance of Integrated Epidemiological Monitoring of diseases and Response.

In spite of the interventions that were implemented in the context of eradication, control and elimination of certain diseases with a high morbidity and mortality rate, it is necessary to note that these diseases are still public health problems.
Sustained efforts must still be taken in coming years so that the eradication and elimination of potentially epidemic diseases may become a reality.

4.1.1.1.2 Priority diseases (Malaria, Tuberculosis and HIV infections/AIDS)

Malaria

In Benin, the cumulative incidence of simple and serious malaria was 14.3% in 2008. Malaria was the leading cause of hospitalization (20.1%) and of death (15.7%) during the same year. Mortality related to malaria in 2008 was on average 5.0%, a slight decline over prior years. The treatment of malaria continues to involve significant health expenses for at-risk populations, plunging them further into extreme poverty. According to the Communicable Diseases bulletin for the African Region published in 2004 by WHO-Africa, the cost of malaria has represented a significant burden for the poorest households since they spend a large portion of their income on malaria prevention and treatment. The situation becomes worse when the household has several and/or repeated access during the same period. For example, the average cost of 15.79 $EU per malaria episode for a household and the average monthly cost of 1.26 $EU for a household represent 13.7% and 1.1% of total household expenses, respectively.

The continued existence of this situation is due in particular to the existence of an environment favorable to the proliferation of the vector agent of the disease.

The fight against malaria is among the Millennium Development Objectives (MDO) as one of the global targets for 2015 and the period of 2001 – 2010 was declared by the United Nations as the “Decade to make malaria retreat in developing countries, particularly in Africa.”

Malaria in Benin is endemic and stable, with seasonal resurgence therefore the entire population of Benin is considered to be at risk. Malaria is the most significant vectoral transmission disease for public health in the country, with 1,147,006 cases and 918 deaths recorded by the SNIGS in 2008. The National Program to Fight Malaria (PNLP) in its 2006-2010 Strategic Plan defined several strategies in relation to the intensification of the fight to reduce morbidity and mortality linked to malaria, following the reduction of its transmission. Malaria is the most significant vectoral transmission disease for public health in the country, with 1,147,006 cases and 918 deaths recorded by the SNIGS in 2008. The National Program to Fight Malaria (PNLP) in its 2006-2010 Strategic Plan defined several strategies in relation to the intensification of the fight to reduce morbidity and mortality linked to malaria, following the reduction of its transmission.

The levels of use of MILDs increased from less than 5% in 2001 to 56% and 54% respectively among children 0 to 59 months and pregnant women, and this witnesses the good progress towards the objectives targeted by Benin for 2010. Regarding Intermittent Preventive Treatment (IPT) in pregnant women, the percentage of pregnant women who received at least two doses of IPT during their pregnancy increased from 3% to 35%. An improvement in the use of MILDs has been noted, as well as compliance with IPT, although there is a remaining significant gap in terms of universal access.

However, there are many challenges which the PNLP is confronting today, and that involve the lack of a systematic parasitologic diagnostic tool for each case of malaria, the weakness of the information and logistics management system (SIGL) for CTAs, MILDAs, TDRs. Mosquito resistance to insecticides represents a major threat to the success of this battle in Benin, which will probably require the systematic development of operational research.

In order to reach universal coverage, Benin must organize the national campaign to distribute MILD by household (1 MILD per 2 people) by the end of 2010.

**Tuberculosis***

During the past decade, changes in the rates of incidence for all forms of tuberculosis have been observed. These rates are between 41 and 44 [cases] per 100,000 residents. In contrast, the incidence of cases of TPM+ over the past decade varied between 34 and 38 per 100,000 residents. In 2008, this rate was 35 cases per 100,000 residents for the entire country. The number of tuberculosis cases (all types as a whole) recorded and treated this same year is equal to 3,977, of which 2,966 were new cases of TPM+, compared to 3,673 cases in 2007.

The treatment success rate achieved in 2008 was 89% and persons with whom contact was lost totaled 3%. These numbers, compared to those from prior years, allow us to see the improvement that was attained thanks to the joint commitment of the government and the development partners. Monitoring activities for TB-HIV co-infection are conducted at all CDTs in the program and 96% of tuberculosis patients (all forms) agreed to have the screening test. The seroprevalence among tuberculosis patients was 17% in 2008; 94% were placed on CTM and 44% ARV. Even though these numbers seem satisfactory, there are insufficiencies. In regards to these figures, we note:

- the low operational implementation of the intermediate level in the management of the program, which nevertheless has improved substantially thanks to funding from the Global Fund, in particular in regard to supervision of CDTs.
- the insufficiency of decentralization and integration of tuberculosis care into the health enters, in particular non-CDT public health facilities, private sector health facilities, companies and military stations.
- the insufficiency of community participation in the fight against tuberculosis.

These weaknesses must be transcribed into strategies and will be gradually put into place.

**HIV Infections / AIDS**

This prevalence in 2008 was 1.8%, with regional disparities.\(^5\) The rate was almost double in women (1.5%) versus in men (0.8%)\(^6\). Projections show that the number of adults living with HIV by 2015 will be 58,657 as controlled epidemic cases, with 27,577 persons requiring treatment with ARVs. The number of deaths yearly due to AIDS will total 2,402, and the number of children orphaned by the loss of both parents will total 11,028. National

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\(^5\) Sero-monitoring report, 2008
\(^6\) Demographic and Health Census (EDS), 2006
coverage in terms of persons being treated with ARVS and seropositive pregnant mothers on the protocol to prevent mother-to-child transmission, will be 67% and 38%, respectively.

The immediate causes of the spread of the infection are high-risk sexual relations and multiple partners. The subjacent causes are (i) the level of knowledge and insufficient awareness of the people; (ii) erroneous perception of risks; (iii) the significant percentage of HIV-positive persons who are unaware of their status; (iv) migration and very mobile prostitution; (v) the low level of education, low economic autonomy and subordination of women, reducing their capability to negotiate the use of condoms during sexual relations; (vi) the financial and psychological vulnerability of youth and young workers., (vii) low accessibility and insufficient coverage of care, in particular treatment with ARVs.

The primary difficulties in relation to the fight against STDs/HIV/AIDS are:

- weakness of the supply chain for these medications, reagents and supplies. It is due to the multiple sources of financing and the burden of procedures, causing interruptions in inventory;
- the malfunction of the medical-technical equipment maintenance plan related to the wide variety of equipment, based on financing sources;
- the instability of qualified personnel at treatment and PMCT sites;
- the insufficient decentralization and integration of care for HIV patients at the operational level;
- insufficient coordination by the various national structures responsible for combating HIV/AIDS.

In general, the fight against these priority disease may attain objective six (6) of the Millennium Development Objectives (MDO) by: (i) strengthening community participation; (ii) improving decentralization of services; (iii) ensuring the effective implementation of communication plans; (iv) reorganizing the medication, reagents and consumables supply system.

In summary, Objective 6 of the MDOs may be attained if the various programs fighting these three priority diseases are put into place.

4.1.1.1.3. Other communicable diseases (UB, leprosy, etc.)

Among the other communicable diseases, we note the group of tropical diseases that are neglected, including onchocerciasis, lymphatic filariasis, Human African Trypanosomiasis, dracunculosis and schistosomoses, just to name a few.

Although dracunculosis and Human African Trypanosomiasis are in the process of eradication, with nevertheless the need for more acute epidemiological monitoring, onchocerciasis may today be considered to be under control, however there are some incomplete areas and particular a real threat of reinfection from Nigeria.

As for lymphatic filariasis, which is present in 50 villages out of the 77 comprising the country, as well as schistosomiasis, the prevalence of which hovers at around 26% at the national level, these diseases are still true public health problems in Benin.

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7 Sero-monitoring report, 2008
**Buruli Ulcers**

From 1995 to 2007, the number of new cases detected increased from 199 to 1203. Nevertheless, a slight decline was recorded in 2008, when the number of new cases fell to 892 at treatment centers (CDTUB). During this year, 31 cases (3.5%) of relapses and 861 (96.5%) of new cases were reported. Children less than 15 years of age continue to be significant targets of this disease. They represent 40% of patients. A little more than one patient out of four (27.13%) already has invalidating signs upon screening. One-half of the patients recorded present Category 2 lesions. Among 892 patients in 2008, 446 (53%) were observed to have the ulcerous form, 92 (11%) the patch form and 153 (18%) the hybrid form. UB is still a public health problem. Benin is among the most endemic countries in the West African sub-region. The immediate causes of the spread of the infection are as follows:

- Poor perception of the disease by populations that consider it to be curable;
- Low patient attendance at CDTUB in spite of awareness;
- Late screening and consultation at CDTUB;
- Insufficient food for hospitalized patients.

These immediate causes are founded on determining factors such as the general context of poverty; absence of mobilization of the international community around “Neglected Tropical Diseases,” and the insufficient accessibility of populations to basic social-health structures.

In regards to the implementation of interventions to fight UB, the primary problems observed are:

- the weakness of the institutional structure to treat UB in Benin in regards to the health system;
- insufficient quality of UB diagnosis in spite of progress that has been made;
- low accessibility to care on geographical, economic and cultural levels;
- insufficient quality in the supply of treatment which is not uniform across the CDTUBs;
- insufficient decentralization of treatment;
- insufficient initial training of socio-health personnel;
- the near total absence of primary prevention.

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8 PNLLUB, 2008
**Leprosy**

The detection rate of leprosy per 10,000 Benin residents decreased from 0.52 to 0.36 from 2005 to 2008. The total number of cases reported in 2008 was 598, of which 417 were cases of multibacillary leprosy and 181 were cases of paucibacillary leprosy. The country in 2008 had 8 leprosy screening and treatment centers. The departments of Alibori, Ouémé, Mono and Littoral do not have any.

In the fight against leprosy in Benin, the persistent prevalence at more than one case per 10,000 residents in certain villages has been noted, in particular those with CTALs.

The primary immediate causes are summarized as:
- Insufficient qualified and motivated personnel;
- Delay in screening for new cases;
- Lack of knowledge of the early signs of leprosy;
- Fear of stigmatization;
- The influence of traditional healers;
- Ineffective integration of activities to fight leprosy into all health facilities.
- Weakness in the implementation of the communication plan.

The distant causes of the current situation with leprosy are in particular related to:
- A context of general poverty;
- Insufficient accessibility by the population to basic socio-health structures;
- The absence of good bodily and clothing hygiene practices;
- A life framework in an unhealthy and unclean environment.

Among the other communicable diseases, we note the group of tropical diseases that are neglected, including onchocerciasis, lymphatic filariasis, Human African Trypanosomiasis, dracunculosis and schistosomoses, just to name a few.

Although dracunculosis and Human African Trypanosomiasis are being eradicated, with increased vigilance through epidemiological monitoring, onchocerciasis may at its present stage be considered to be controlled with occasional unsatisfactory results, but in particular with the presence of the threat of reinfestation from Nigeria.

As for lymphatic filariasis, which is present in 50 villages out of the 77 comprising the country, as well as schistosomiasis, the prevalence of which hovers at around 26% at the national level, these diseases are still true public health problems.

### 4.1.1.2. Non-communicable diseases

Benin has paid a high price in terms of morbidity and mortality related to Non-communicable Diseases (NCDs). NCDs have the same risk factors, treatment of a single risk factor allows the incidence of several NCDs to be reduced. An evaluation of these FDRs (STEPS Survey) conducted in 2008 in the 12 departments of Benin revealed very alarming results: 27.5% of the population aged 25 to 64 years in Benin suffer from arterial hypertension, i.e. about 1,500,000 Benin residents. The situation is just as alarming for the 7 other risk factors, i.e.: diabetes, hypercholesterolemia, obesity, unbalanced nutrition, physical inactivity, tobacco use and alcohol abuse. One-half of the population has at least
two risk factors for NCDs. In order to remedy this situation, it is important to implement integrated approaches and simultaneous interventions. From this perspective, the national programs to combat NCDs in December 2008 prepared a National Policy Document to Combat NCDs, the foundations of which are based on national and international provisions, i.e. the sectoral plans and policies of the Ministry of Health, the General Health Condition in Benin, the WHO resolutions on strategies for fighting non-communicable diseases, and the declarations of Libreville, Algiers and Ouagadougou regarding the improvement of health in Africa. The fight against NCDs is based on the following guiding principles: global, integrated health intervention, intersectoral action, an approach that considers the entire span of life, gradual implementation based on local needs and parameters. The determining factors of NCDs are multiple. The immediate causes are poor eating habits and physical inactivity.

The implementation of interventions has come up against the insufficiency of personnel trained in treating NCDs, low financial resource, inadequacy of treatment facilities for NCDs and low involvement of OSCs in the fight against NCDs.

In total, the risk factors for non-communicable diseases are to a large extent unknown by the people. Similarly, the level of knowledge on the part of health agents is insufficient, which does not allow them to provide good awareness to the people. In order to promote best prevention practices for non-communicable diseases, emphasis must be placed on the capabilities of the system to treat these diseases. This reveals the importance of studies to determine morbidity related to risk factors and measures intended to promote early screening and improvement of workplace and life health.

Aside from traditional non-communicable diseases, we must emphasize in particular drepanocytosis, which is not an infectious disease, but rather one that is genetically transmitted.

**Drepanocytosis**

Drepanocytosis (sickle cell anemia) is a hereditary blood disease affecting about 5% of the global population, and 300,000 newborns each year. Benin is located at the epicenter of the zone of maximum frequency of drepanocytosis, which poses a worrisome public health problem. Nearly 1 out of three Benin citizens can transmit the disease to their children.

The serious consequences of this disease on one’s health are an economic and social burden for the families affected, for society and for the country as a whole.

Benin, through its Drepanocytosis program, has made great strides in adopting WHO resolutions WHA59.20 and EB 118, in May 2006 and Resolution A/63/237 of the United Nations General Assembly in December 2008, recognizing Drepanocytosis as a Public Health issue in Africa. The current major problem with the program is the insufficient financial and human resources available, given the size of the challenges being faced.

As a genetic disease, drepanocytosis cannot be recognized and treated unless populations are screened, in particular during prenuptial exams that are required in order to avoid transmission to their children. The disease is spread due to:

- poor knowledge on the part of the people regarding the mode of transmission of the disease;
• the insufficiency of the communication plan for this disease;
• the fact that the majority of the population foregoes the prenuptial exams;
• the absence of decentralization of the program’s interventions.

**In summary,** the institutional framework of the fight against these diseases still requires improvement. It may also be seen that there is a need to establish an effective, comprehensive epidemiological monitoring system, capable of generating relevant information. Lastly, the improvement of community participation and the enhancement of the skills of health agents will allow the correct, prompt and effective treatment to be improved for cases in order to avoid the consequences.

### 4.1.2. Reproductive Health

The study of reproductive health allows concerns related to the significant demographic thrust and their impact on sector performance values to be examined more closely. Reproductive health means the physical, mental and social well-being of the human being in all that relates to the genital tract, its functions and operation, and not the absence of disease or infirmity.

**Determining factors for fertility**

Benin women have one of the relatively high levels of fertility (measured using the synthetic fertility index) - 5.6 children per woman). Socio-cultural factors explain this situation. Children benefit from the solidarity of a large family, which reduces education and maintenance costs for the parents. The child thus is more a part of society, rather than belonging to the parents alone. The child in general plays a role of social security and old age insurance. In addition, considering the limited life expectancy, the belief is strong that a high number of children will allow this constraint to be overcome. Aside from the cultural context, natalist behavior of women is determined by the existence of a relationship between the level of education, place of residence and ethnicity. These factors are intermediate variables that have an impact on the level of fertility. Furthermore, early marriage age and procreation age have been observed: the average marriage age is 19 years; 50% of women have had children before reaching 20 years of age.

**Mother’s health**

According to data from EDS III, the maternal mortality rate was 397 women per 100,000 live births in 2006. According to the 2002 RGPH census, the ratio for maternal mortality was 474.4 per 100,000 live births in 2002; it was 397.7 per 100,000 births in urban areas and 505.4 for rural areas; risks are therefore much more considerable in rural areas than in urban areas. The factors promoting this situation and the causes of death are:

- **Promoting factors:** The current social or cultural environment, home births, low accessibility to maternity services, insufficient screening for at risk pregnancies, insufficient follow-up after labor due to not controlling delays (decision making, removal and treatment) and insufficient financial resources.

- **Direct medical causes:** Hemorrhage 25%, dystocia 10%, pregnancy complicated by hypertension 13%, complication of abortion 13%, anemia, and severe infection 14%.

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

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9 Demographic and Health Census (EDS), 2006
In order to attain Objective 5 of the MDOs, Benin must strengthen monitoring of the nutritional state of mothers, the development of Emergency Neonatal and Obstetrics Care and Essential Neonatal and Obstetrics Care, IEC sessions related to reproductive health. These targeted interventions must be supported by an improvement in the CPN coverage rate, that is refocused and the implementation of a continuum of maternal and neonatal care at all levels of the health pyramid. Similarly, measures must be taken to significantly reduce the percentage of anemic pregnant women due to the lack of iron and increasing the Caesarean coverage rate in order to reach the norm in the short term.

**Children’s Health**

According to the 2008 Health Statistics Yearbook, for all consultations recorded at health facilities, children less than 5 years of age represent 37.9% of consultations, 97% of these cases were treated on an outpatient basis and 3% through hospitalization. In this age bracket, malaria is 43.5% of cases followed by acute upper and lower respiratory infection (21.1%). It remains the primary cause of morbidity and mortality. Among children, malaria and anemia representing in themselves more than one-half (50.3%) of hospitalized cases.

4.1.2.3.1 Stillbirths

The rate of pregnancies resulting in a stillbirth was estimated at 2.5% of live births in 2008. This rate can be explained by the fact that women do not comply with the number of prenatal visits recommended by WHO.

4.1.2.3.2 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.

4.1.2.3.3 Infant-juvenile mortality

The quotient of infant-juvenile mortality at the national level is 146.4‰ according to the RGPH in 2002. The progression of this indicator has also trended downward since 1982 (Benin Fertility Survey) when it was at 243‰, decreasing to 167‰ in 1992. According to the Demographic and Health Survey released in 2006 (EDS III), the infant-juvenile 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.

Benin is on the correct path to reaching MDO 4 if its efforts are continued to improve interventions to reduce infant mortality.

In order to do this, it will be necessary to maintain the availability of immunization activities at a maximum level in order to achieve vaccine coverage in greater than or equal to 80% for all diseases. In addition, it is important to extend the PCIME to all health areas, in particular community PCIME, and to maintain good dissemination of the Minimum Package of nutrition Activities, taking into consideration breastfeeding and micronutrient supplements.

**Youth and adolescent health**

The estimated fertility rate is 5.6 children per woman. Fertility is very high in women in rural environments (6.3) and in uneducated women (6.4). Adolescents have a high birth rate: at 19 years of age, more than 4 women out of 10 (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. Furthermore, a vulnerability to STDs/HIV/AIDS has been observed based on frequent risky sexual behavior in this age range.

**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.

It is noted that the more the educational level increases, the more knowledge increases, with ratios exceeding 89% for uneducated women and 97% for women with primary education; knowledge is almost universal for women who completed secondary education or greater. The level of education therefore plays an important role in the level of knowledge about and use of contraceptive methods: the higher one’s educational level, the greater their knowledge and use of contraceptive methods. In general, knowledge of contraception has a limited effect on its effective use; the level of education and attitude regarding fertility are decisive aspects to be integrated into the strategies that are intended to improve the effectiveness of family planning.

**Nutritional state of the mother and child**

In Benin, the nutritional situation is still worrisome, and progress is slow. Nearly 4 children out of 10 in Benin suffer from failure to thrive (38% in 2006, compared to 21% in 2001, NCHS/WHO). In addition, 7% suffer from acute malnutrition. A national food safety and nutrition survey conducted in late 2008 confirms that the nutritional status is serious, according to the thresholds established by the WHO. The prevalence of insufficient weight, an indicator of MDO 1, has been stagnant from 2001 through 2006 (23%). As in failure to thrive, insufficient weight is present from the youngest age and its prevalence is greater
among rural populations. The nutritional status of women of childbearing age is also of concern, since 9% of them suffer from thinness and 61% are anemic.

Benin is one of the 13 countries in the world that has succeeded in increasing breastfeeding rates among children less than 6 months of age by more than 20 percentage points in 10 years. The percentage of women exclusively breastfeeding their children increased from 10% in 1996 to 43% in 2006. This is still insufficient in relation to coverage standards (80%). The experience of Benin shows therefore that significant progress in the area of breastfeeding and more broadly in feeding infants and young children may be attained. However, progress has a tendency to slow and efforts must therefore be maintained because exclusive breastfeeding as well as feeding an appropriate supplement are necessary interventions for the survival and development of a young child (The Lancet, 2003 and 2008).

Furthermore, malnutrition due to insufficient micronutrients is also widespread and catastrophic. In Benin, nearly eight out of ten children 6 to 59 months of age (78%) are afflicted with anemia: 25% with a slight form; 46% with a moderate form and 8% have severe anemia. Consumption of iodized salt has decreased during the past several years, to the point that nearly one-half of Benin households did not adequately use iodized salt in 2006.

Malnutrition has a negative impact on survival, but not only this. It also causes a decrease in capacity of the immune system, sub-optimal cognitive and physical development, and a decrease in performance at adult age.

According to the results of the EDS III in 2006, malnutrition reportedly causes enormous economic losses (913 billion CFA francs in economic losses are attributable as of the end of 2013, according to the results of the Profiles Analysis), if nothing is done at a fundamental level to reverse this trend. The integration of nutrition into the package of essential interventions for children's survival and development is therefore a priority for interventions targeting the "window of opportunity" from pregnancy to the age of 24 months.¹⁰

The causes of malnutrition are multifaceted (food, health, practices). Other related causes that have led to needs not being met include: (i) low grain productivity; (ii) the sale of livestock to neighboring countries and for uncontrolled export (ONASA, 2004-2006); (iii) insufficient wheat acreage; (iv) significant post-harvest losses (domestic storage/conservation systems and collection systems that are ineffective) and low transformation rates; (v) the modification of consumption habits favoring corn and manioc which have low nutritional value. However, although food safety of households is essential for nutritional safety, it is far from being sufficient. Nutritional safety implies much more than access to an adequate quantity of food that varies in terms of quantity and quality (including micronutrients). Nutritional security requires: a) access to potable water, hygiene and sanitation; b) access to quality health care services; c) adequate practices in households in relation to care for infants, food hygiene and food preparation; d) a clean environment. Nutritional security is even more important for the most at-risk groups of society, i.e. infants and young children under two years of age, pregnant and breastfeeding women, children under five years of age who suffer from acute malnutrition or diseases including HIV/AIDS.

¹⁰ The Lancet series on maternal and child malnutrition, January 2008.
4.1.3. General Population and Housing Census

Access to safe drinking water

In spite of the efforts made, the situation in the potable water sub-sector is hardly noteworthy. It has been characterized by insufficient access to potable water. The use of water from unprotected wells is still widespread. Households continue to get drinking water from rivers, seas and/or backwater areas. Contamination often occurs during collection, transport, storage and consumption. This contamination is also related to defects in works, poor layout of discharge equipment, fecal contamination and poor handling of the water. Beyond the technical issues, a behavioral problem is present, which will be minimized in the long term by dynamic awareness activities involving multiple sectors.

The primary immediate causes of difficulty accessing potable water for poor populations are: (i) insufficient number of water supply points available; (ii) difficulties mobilizing water resources in certain areas; (iii) low number of connections to the network in urban areas; (iv) the lack of water hygiene; (v) the relatively high cost of water.

There are multiple underlying causes: (i) low monitoring of water quality in rural areas; (ii) low management capability, in particular for maintenance of wells, water supply points and mini-networks; (iii) difficulties mobilizing the community contribution in certain areas; (iv) the cost of connection in urban areas; (v) the low level of health education and water hygiene.

The structural causes are: (i) the poverty of households; (ii) the weakness of education programs regarding potable water and hygiene; (iii) the low capacity of competent services to absorb funding; (iv) long terms for setting up water supply points (administrative and financial red tape).

Domestic and industrial solid waste management

Solid waste is generated in large quantities in urban centers due to the growth of the population and economic development. According to a study conducted in 1997 by DESSAU Soprin and by PGDSM in 2002, each citizen of Cotonou generated approximately 210 kg of solid household waste per year, i.e. (0.58 kg/resident/day). In 2001, the quantity of solid household waste produced in Cotonou was on average 400 tons per day, while the precollection coverage rate was determined to be 70%, and the collection rate 55%. The portion not removed was left in the street, in random dumps, on empty property, buried or incinerated at home. More than one hundred organizations or grass-roots associations and at times micro-companies in Cotonou conduct pre-collection, collection and processing of solid waste. These organizations are brought together under the Non-governmental Solid Waste Management and Sanitation Organizations Coordination Office (COGEDA). The environmental problems posed by recycling and the elimination of waste are in the process of being diminished by the gradual implementation of permanent dumps, in particular at Cotonou.

Management of human waste, domestic and industrial waste water

Individual sewer works used are traditional toilets, improved traditional toilets, San Plat platform toilets, Mozambique-type toilets, ventilated pit toilets, manual flush toilets and even water flush toilets. These are hygienic works, except for the traditional latrines. Very few households use septic tanks, manual flush toilets and ventilated pit toilets. Nearly 8% of houses in urban areas do not have sanitation facilities. In rural areas, in certain
departments, whole villages reject sewerage structures for cultural reasons. Pesticides used in agriculture, domestic and industrial waste water dumped into the environment are the primary sources of soil pollution, water flows and planes and the phreatic layer.

**Healthiness of food**

Food establishments, in particular markets in large cities in the country are, overall, subject to unhealthy conditions, due to the insufficient sanitation and potable water supply measures, as well as the behavior of users, whose practices do not ensure the safety of foodstuffs. Food vendors on the street do not observe basic food hygiene practices. These foods are sold on major arteries, along access routes to markets, schools, near garbage, major storage areas and in other public locations without basic hygiene measures.

**Vectors for disease**

The unhealthy conditions that prevail in towns and in the country are a factor that encourages the multiplication of insects and rodents, vectors of disease and sources of nuisances, in particular mosquitoes (anopheles and culexes), flies, rats and mice. Combatting these vectors is carried out piecemeal.

Food hygiene is characterized, among other conditions, by poor storage and conservation conditions, exposure of foodstuffs to dust, vehicle exhaust gases and flies, non-hygenic handling of food and the use of unclean containers or utensils.

In addition, only 4% of households wash their hands with soap and water at critical junctures.

The status of hospital hygiene is not spectacular, and waste management from health facilities has not yet been brought under control by personnel from health facilities, whether they are public or private.

The garbage disposal rate is 17% for Benin as a whole, with 39% in urban areas and 3% in rural areas.

Management of domestic waste water is an issue in urban areas and particularly in major concentrated areas; only 2 households out of 1000 correctly dispose of their waste water.

This situation has contributed to the emergence and the reemergence of certain diseases, in spite of the existence of an institutional and regulatory arsenal.

In this context, the Ministry of Health, in partnership with the Technical and Financial Partners, has initiated two projects / programs: The Multi-year Water and Sanitation Program (PPEA) with financing from the Netherlands and the Kingdom of Denmark, and the National Hygiene and Sanitation Program (PHA) financed by the National Budget.

The absence of basic sanitation and at-risk hygiene behavior is at the root of the causes that encourage the spread of diarrheic diseases and intestinal worms. In 2001, 7 households out of 10 did not have toilets (9 out of 10 in rural areas) and 8 households out of 10 discharged household waste into the environment.
The immediate causes of inadequate sanitation which is harmful to health, in particular in rural areas, are: (i) poor family and community management of waste and waste water; (ii) defecation in nature; (iii) insufficient control of atmospheric and noise pollution; (iv) low level of knowledge of the harmful effects of at-risk behavior. In relation to underlying causes, these include, in particular: (i) low household income; (ii) low educational, information and awareness levels regarding at-risk behavior; (iii) weakness of community initiatives. The structural causes are: (i) the weakness of available resources for the National Basic Sanitation and Hygiene Program (PNHAB); (ii) low level of commitment by health officials and opinion leaders; (iii) the absence of provisions for the harmful effects brought about by the expansion of cities; (iv) the inability of the administration (central or local) to enforce public hygiene codes and the regulations regarding atmospheric and noise pollution. The lack of access to sewers is closely linked to the degree of poverty of households.

Management of waste from health facilities and hospital hygiene

These past few years, health facilities have multiplied quickly, making the situation of waste management from health facilities in Benin worrisome. Due to a lack of organization of the chain, these institutions that generate various types of waste find makeshift means to handle the waste, which often is mixed with household waste to be discarded in primitive dumps within large cities. Risks related to contact with contaminated material and other sharp objects and blades and toxic materials from medical care are enormous, given the transmission of diseases from these objects to the population, particularly among health care personnel. Officials from institutions that generate the various waste give little importance to the safe elimination of this waste, and are not likely to pay for disposal services.

The primary causes of this situation are:

- the absence of a plan for management of the various wastes in the various health care facilities;
- the insufficiency of incinerators at health care facilities;
- the defective nature of existing incinerators;
- the insufficiency of maintenance of biomedical waste management equipment;
- the lack of information for health care agents regarding the management of biomedical waste;
- the insufficiency of hygiene agents to manage hygiene and sanitation at health care facilities.

The implementation of a good policy in terms of basic hygiene and sanitation comes up against the problem of the operational integration of waste management activities.

Furthermore, intervention capacities of decentralized facilities must be strengthened, with the involvement of the towns in hygiene and sanitation activities. Lastly, the effective implementation of encouraging measures provided for in the existing regulations and legislation, reinforced by good communications policy to change behavior, are the best guarantee of intervention in this regard.

4.1.4 Immunization
The EPI review in 2008 allowed the actual impact of vaccine coverage rates for various diseases to be determined. According to the 2009 DNPEV self-evaluation report, coverage rates for certain diseases were: 114% for BCG, 98% for the third dose of the pentavalent vaccine, 95% for VAR1 and 68% for VAT2+. This level of performance, even though it may seem to be satisfactory overall, conceals disparities. The primary problems that arise relate to:

- insufficient communication towards the communities;
- insufficient cold chain equipment at the operational and intermediate levels, in spite of the current refresher effort that is underway;
- failure to control the estimate of vaccine and injection material requirements at the operational level;
- less than full availability of vaccines and supplies at all Health Centers.
- the absence of a maintenance plan for cold chain and transport equipment at the operational level, which causes 24% of the cold chain equipment used in peripheral locations to be broken down or out of service, which reduces the storage capacity at the intermediate and peripheral levels, in relation to the introduction of new vaccines;
- 56% of the towns do not have a supervision vehicle in good condition and 48% of the motorbikes used for advanced strategy are out of service;
- 61% of health care facilities do not have an operational Monfort-type incinerator.

4.1.5 Utilization of health services

Access by the people to health care is one of the priorities of the health authorities. In Benin overall, 66% of households have access to a health facility in their location within a 5-km radius. Regarding accessibility to first-referral health care facilities, more than 50% of the population has access to a reference hospital if necessary; 13% live more than 30 km from a reference hospital. Most rural communities do not have a hospital less than 5 km away (34% versus 77% for urban environments). On average, the ratio of basic emergency neonatal obstetrics care (SONUB) is 1.4 per 500,000 residents, compared to the target of 4 per 500,000 (2003 data).

According to the 2008 Health Statistics Yearbook, the rate of consultation at heath centers for curative care (public and para-public) is 45.1% for the entire population and 73.1% for children under 5 years of age. This situation contrasts with the health coverage, which is at 89%. It could be explained by financial constraints, the quality of the reception and care.

Economic reasons are one of the primary problems in terms of accessibility to care. According to the EDS III, "obtaining money to go" and the "excessively high cost" were cited by 74% and 57% of women, respectively. The lack of money affects women in rural areas even more (83%) than those in urban areas (62%). Similarly, women from the departments of Alibori (90%), Atacora (88%), Collines (89%), Couffo (85%) and Zou (86%) were more frequently faced with this problem, than those from Littoral (40%). In addition, this problem often concerned uneducated women (82%) and women from the poorest households (89%). The "high cost of care" was also frequently mentioned by all categories of women, in particular those from Atacora (89%) and Collines (84%).

Furthermore, the distance from home to the health center is a problem for nearly two out of five women. This proportion is higher in Atacora (66%), followed by Borgou (51%) and
Collines (50%). Additionally, for 37% of women, taking a means of transport is an obstacle that limits their access to health care. The significant proportions of women who cited problems related to the operation of health services must also be noted, in particular: “too long of a wait” (30%); “missing or late personnel” (29%); “ineffective treatment” (24%), “poor reception” (24%) and “the lack of female personnel” (16%).

In general, in order to improve the rate of utilization of services, it will be necessary to use community diagnostics as a more precise basis and to improve the quality of care. This will involve concerted management of the system by maintaining and strengthening procurements. Additionally, the importance of ensuring access to essential, integrated and quality care may be seen, particularly for the most destitute populations, and in particular women and children 0 to 5 years of age. More explicitly, this involves considering the poverty level and ensuring access to care at these targets, with the support of other related sectors and the technical and financial partners of the health sector, having as a focus the Millennium Development Objectives.

4.2- Sector resources

The health sector is confronted with insufficient resources and difficulties managing and using existing resources. There are three categories of resources, specifically financial, human, and material resources.

4.2.1- Financial resources

Financing for health services covers the strategy for resource mobilization and payment of expenses in order to attain the health objectives. In Benin, this financing is rather unfavorable to the demand for care, because the income level of the population is low and the workforce works primarily in the under-the-table sector. The literacy rate among adults is high, and approximately 20% of the population lives below the poverty line. In order to remedy this situation, Benin dedicates 4.6% of its GDP to health and approximately 8.34% of public expenditures to health, compared to 9.24% on average for countries of Sub-Saharan Africa. So, the commitment made by the Chiefs of State in the Abuja Declaration in 2001 is to dedicate 15% of public expenditures to health in order to attain the Millennium Development Objectives.

However, the resources currently available are not the first to be assigned to high-impact (priority and efficiency) and the organizational and institutional capacity of the health and finance sectors do not encourage the consumption of these available resources. This translates most often into a delay in the startup of activities, and slows the public contract approval process. This situation is aggravated by mechanisms for financing the demand for services and rather inadequate care.

Four primary sources contribute to the financing of health in Benin:
- financing by households: according to national health summaries prepared in 2006, households cover 52% of health expenses;
- financing by the State: the State finances nearly 31% of expenses;
- financing by local municipalities accounts for less than 1%;
- financing by the Technical and Financial Partners is 16%.
4.2.1.1 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.

The overall budget allocated to the health sector during the period of 2003-2008 totals up to 76.33% (basic commitment) i.e. 251,699 214,063 CFA Francs out of 329,751,724,000 CFA Francs.

This level of budget expense is relatively low. This is due to factors such as the economic contingency that disrupts the budget framework, the hypothetical nature of the projections of expenses onto external financing, the delay in the availability of credits, which causes late startups of activities at all levels of the health pyramid, and other malfunctions related to governance, which compromise the strengthening of the health system.

Analysis of the results of the national health accounts shows that:

- the assigned credits cover 43.7% of the purchases of goods and services, 30.2% of personnel and 26.1% of investments;
- community financing is one of the important aspects of the financing of the Ministry of Health;
- All hospitals together consume 29.5% of the resources of this sector, while community health centers consume 54.5% and general administration 13.8%.

4.2.1.2 Financing of expenditures by the international community

The overall amount of health financing though international cooperation was almost 23,256,572,000 CFA francs in 2008, which is US$ 46,513,144 or US$ 5.655 per capita in 2008.

Excluding budget support, the share of external financing dedicated to health has varied from 18.84% to 24.99% from 2003 to 2008 with an average of 20.86%. Other sectors split the remaining 80% of this financing.

Functional analysis of the credits allocated by the international community shows the priority given to outpatient care (68% of financing), followed by prevention (17%), administration (11%), and inpatient care (4%).

External resources are directed with priority to fighting disease, strengthening institutions, promoting hygiene and basic sanitation, hospital development and reproductive health.

4.2.1.3 Health financing by local communities in Benin.

Historically, health missions of local communities has primarily dealt with collective sanitary 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) due to the low level of transfer of skills and resources.
With the establishment of the Towns Development Support Fund (FADEC) and its extension to the Public Investments Program, the portion of municipal expenses will improve.

4.2.1.4 Health financing by households

Households make direct payments to both public 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 ancillary services (laboratories, medical imaging) and 6% to other health expenditures.

Households thus are the primary source of financing of health, in spite of their low income level. This state of affairs limits the accessibility of households to health care and services. The lack of a mechanism to manage third-party payers makes the situation more cumbersome and complicated. The lack of an institutional legal framework, the fact that no viable health insurance exists are factors that encourage the low financial accessibility by households to services and care.

In regards to the contribution of each financing stakeholder, the national health financing policy provides for the reduction in charges for households through the implementation process of the Universal Health Insurance Plan (RAMU) which will take into consideration the various strategies for caring for at-risk or impoverished populations.

The resolution of these problems includes the promotion of health insurance, the promotion of health mutual funds, improvement of medical assistance for the poor, indigent and at-risk groups.

4.2.2- Human resources

The problems that characterize the situation of the human resources in the health sector are:

- insufficient planning and recruitment of medical and paramedical personnel;
- the insufficiency of specialized personnel;
• the inequitable distribution of personnel which translates into the concentration of personnel in urban centers, to the detriment of rural centers;
• low motivation of the agents;
• production by health professionals that is not in line with the needs of the sector.

4.2.2.1 Availability of personnel

In 2009, there were 13,982 agents in the health sector. However we can see a shortfall in personnel estimated at 7,334 agents, i.e. 53.2% of personnel currently available.

With this staff, the number of inhabitants per physician was 7,511 for the entire country, therefore this ratio is relatively satisfactory in light of WHO standards.

In spite of this gleaming situation, there are great disparities among departments (one physician per 35,170 inhabitants in Alibori versus one physician per 1,456 inhabitants in the Littoral). Only the departments of Littoral, Ouémé and Atlantique are within the standards set forth by the WHO\textsuperscript{11}. The distribution of medical personnel is therefore not equitable; this integral distribution is even more accentuated from one town to the next.

\textsuperscript{11} 1 physician per 10,000 inhabitants, 1 nurse per 5,000 inhabitants, and 1 midwife per 5,000 inhabitants.
The ratio of the number of women of child-bearing age (FAP, Femme en Age de Procréer) per midwife in Littoral is three times higher than the national level, while the level of Alibori is 3 times less than 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.

The high concentration of personnel in urban centers in the South of the country is the fact of the absence of the maintenance mechanisms of agents working in unfavorable zones. To this, we add the lack of a personnel recruitment policy that explains the insufficiency of personnel in the health sector. The following statistics take into consideration all personnel in the sector, including contracted employees in all categories.

### Table 2 : Key ratios for healthcare staff in 2008

<table>
<thead>
<tr>
<th>Department</th>
<th>Population</th>
<th>WCBA</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Midwives</th>
<th>Laboratory Technicians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td></td>
<td>No. people per doctor</td>
<td>Phys per 10,000 res.</td>
<td>No.</td>
<td>Phys per 10,000 res.</td>
</tr>
<tr>
<td>Alibori</td>
<td>633 067</td>
<td>132 786</td>
<td>18</td>
<td>35 170</td>
<td>0,28</td>
<td>179</td>
</tr>
<tr>
<td>Atacora</td>
<td>667 475</td>
<td>145 577</td>
<td>36</td>
<td>18 541</td>
<td>0,54</td>
<td>192</td>
</tr>
<tr>
<td>Atlantique</td>
<td>973 950</td>
<td>233 261</td>
<td>109</td>
<td>8 935</td>
<td>1,12</td>
<td>415</td>
</tr>
<tr>
<td>Borgou</td>
<td>879 782</td>
<td>188 713</td>
<td>69</td>
<td>12 750</td>
<td>0,78</td>
<td>499</td>
</tr>
<tr>
<td>Collines</td>
<td>651 085</td>
<td>146 038</td>
<td>20</td>
<td>32 554</td>
<td>0,31</td>
<td>244</td>
</tr>
<tr>
<td>Couffo</td>
<td>637 309</td>
<td>148 812</td>
<td>29</td>
<td>21 976</td>
<td>0,46</td>
<td>172</td>
</tr>
<tr>
<td>Donga</td>
<td>425 284</td>
<td>92 293</td>
<td>21</td>
<td>20 252</td>
<td>0,49</td>
<td>112</td>
</tr>
<tr>
<td>Littoral</td>
<td>808 018</td>
<td>232 305</td>
<td>555</td>
<td>1 456</td>
<td>6,87</td>
<td>803</td>
</tr>
<tr>
<td>Mono</td>
<td>437 403</td>
<td>99 509</td>
<td>35</td>
<td>12 497</td>
<td>0,8</td>
<td>193</td>
</tr>
<tr>
<td>Ouémé</td>
<td>877 800</td>
<td>224 525</td>
<td>119</td>
<td>7 461</td>
<td>1,34</td>
<td>383</td>
</tr>
<tr>
<td>Plateau</td>
<td>494 598</td>
<td>120 014</td>
<td>31</td>
<td>15 955</td>
<td>0,63</td>
<td>126</td>
</tr>
<tr>
<td>Zou</td>
<td>728 873</td>
<td>108 881</td>
<td>53</td>
<td>13 752</td>
<td>0,73</td>
<td>345</td>
</tr>
</tbody>
</table>

| Benin      | 8 224 644  | 1 872 713 | 1005 | 7 511 | 1,33 | 3663 | 2 245 | 2,23 | 1392 | 1 345 | 1,69 | 528 | 15 577 |

Source: SNIGS/OPPM, DRH/MS, 2008

### 4.2.2.2 Personnel Management

The management of personnel in the public sector encountered obstacles due to the relevance of health agents for various types of statuses, i.e.:

- Permanent State Agents;
- Contracted State Agents;
- Contract Agents recruited with community financing;
- Contract Agents recruited through social measures.

The coexistence of more than one status in the operation of a health facility can make personnel management complex and can affect team cohesion as well as the social climate of the health center. Of 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.
The Ministry of Health must contribute to their training to develop a certain expertise in various specialties in order to significantly reduce the needs for disposal of sanitation outside the country.

In terms of agents recruited on social measures funds, their administrative status is precarious, because the renewal of their contracts depends on the availability of credits allocated to that purpose.

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.

Generally, the challenges in the field of human resources for healthcare are numerous. The inadequacy of the production of health professionals in relation to needs in terms of competence of the sector, in particular in terms of paramedical personnel, affects the quality of care offered in the sector.

These various difficulties are the result of insufficient strategic and operational management of Human Resources, in particular in regards to the planning of Human Resources development, management and monitoring of agent careers.

In the end, poor management of human resources has been observed, due to the weakness of the sector's human resources development policy.

4.2.3 Material resources

4.2.3.1 Health infrastructure situation

In 2008, the status of infrastructures at each of the levels of the health pyramid is presented as follows:
Table 3: Health infrastructure situation

<table>
<thead>
<tr>
<th>Department</th>
<th>Atacora/Donga</th>
<th>Atlantique/Littoral</th>
<th>Borgou/Alibori</th>
<th>Mono/Couffo</th>
<th>Ouémé/Plateau</th>
<th>Zou/Collines</th>
<th>Benin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of districts</td>
<td>73</td>
<td>87</td>
<td>84</td>
<td>86</td>
<td>81</td>
<td>136</td>
<td>547</td>
</tr>
<tr>
<td>Number of districts covered with Health Centers</td>
<td>69</td>
<td>78</td>
<td>81</td>
<td>78</td>
<td>78</td>
<td>103</td>
<td>487</td>
</tr>
<tr>
<td>Health coverage rate in %</td>
<td>95</td>
<td>90</td>
<td>96</td>
<td>91</td>
<td>96</td>
<td>76</td>
<td>89.03</td>
</tr>
<tr>
<td>Number of communes</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td>14</td>
<td>15</td>
<td>77</td>
</tr>
<tr>
<td>Number of towns covered with a Health Center</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td>14</td>
<td>15</td>
<td>77</td>
</tr>
<tr>
<td>Health coverage rate in %</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of Health Areas</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Number of Health Areas with an Area Hospital</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Health coverage rate in %</td>
<td>80</td>
<td>71</td>
<td>100</td>
<td>100</td>
<td>60</td>
<td>67</td>
<td>79</td>
</tr>
<tr>
<td>DHC</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Number of departments</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Coverage rate in %</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>83</td>
</tr>
</tbody>
</table>

Source: SNIGS/DPP/MS, 2008

Health infrastructure coverage has improved in the past several years. Disparities exist, however, particularly in the departments of Zou/Collines, where the CSA coverage rate (76%) is below the national average (89.03%). Although the District Hospital Center is overall satisfactory, the one in the zone hospital is not outstanding. It is 60% in Ouémé-Plateau, 67% at Zou-Collines and 71% in Atlantique-Littoral which are all below the national average (79%). Only the departments of Borgou Alibori and Mono Couffo are fully covered with a Area Hospital.

Aside from these disparities, there is also the dilapidated condition of 40% of the infrastructure, most of which does not comply with standards. The insufficient monitoring of the performance of works is one of the reasons that explains this state of affairs. The absence of an appropriate policy for distribution of infrastructure is the primary cause of the unequal distribution that has been observed.

4.2.3.2 Status of equipment

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.). The irregularity of inventories of the fleet of equipment, slowness in procurement procedures for spare parts, are among the primary weaknesses of the sector. The result is early degradation of the equipment.

The same problem is present, 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. This situation is favored by the absence of an appropriate policy for the procurement and management of medical-technical techniques and the absence of a national infrastructures development plan.
4.2.3.3 Maintenance

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 intensity of maintenance and repair problems (preventive and curative) at health facilities leads one to assume that maintenance capabilities in the sector are very limited.

These various problems are due primarily to:

- The multiplicity of brands of equipment with no training, or refresher training for maintenance personnel;
- The insufficiency of specialists providing maintenance;
- The absence of a mechanism for maintenance and monitoring of equipment;
- The lack of a maintenance procedures manual for medical devices.

In total, one must note poor planning in regards to infrastructure and equipment (construction/procurement, maintenance).

4.3 Organization of the healthcare system

4.3.1 Health care 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 point of view, it initiates the health action, plans its organization, coordinates and controls its implementation. At this level there are 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 (CNP), the National Gerontology Center (CNG), which is relatively non-operational, and the Lagune Maternal Children’s Hospital.

- The intermediate or departmental level is administered by the Departmental Health Directors. Health activities at this level take place in departmental hospitals. The departmental managers are responsible for the implementation of health policy defined by the minister of planning and coordination of all activities of the peripheral health services. They are also responsible for epidemiological monitoring in the departments. The departmental hospital centers are the referral center for cases referred by Area Hospitals or by the health centers.

- The Peripheral or Operational Level: comprises health areas that number 34, and are distributed throughout national territory. The health area represents the most decentralized operational entity of the health system. It is comprised of a network of public first contact services (UVS, maternity centers and dispensaries, Health Centers) and private health facilities, all supported by a public or private first referral hospital called the area hospital, intended to serve an area comprising between 100,000 and 200,000 residents. A health area covers one to four towns.

The reorganization in health areas is intended to improve the socio-health conditions of the population residing in well-defined geographic spaces. It targets the following objectives:

- improving the quality of basic and first referral health services;
• improving the viability of socio-health services;
• encouraging decentralization and community participation;
• developing the partnership with the private sector, NGOs, local municipalities, other ministries, the Technical and Financial Partners, etc.

The health area 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).

Today, 26 Health Areas are operating, out of the 34 planned, i.e. 76%. However, there is not yet a legal framework between the health areas and the primary local governments for the development and the management of health actions. It therefore seems necessary and very important to improve the capabilities of management structures to plan, coordinate and evaluate, in order to ensure the optimal conditions at all levels of the health pyramid to execute the sector development plan.

It must be noted as well that for several years, hospital services have 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. This situation is due, among other factors, to the fact that:

- the quality assurance process for hospital services and care is relatively unsatisfactory;
- hospital emergency departments do not systematically provide immediate and good quality treatment;
- the mechanism for monitoring continuity, harmlessness and efficiency of hospital care is non-existent.

From the foregoing, the development of a care quality management system in a hospital environment is a necessity. This requires hospital reform that calls, among other things, for the improvement of good governance in a hospital environment.
### Table 4: National health system in Benin in 2009

<table>
<thead>
<tr>
<th>Levels</th>
<th>Structures</th>
<th>Hospital and Socio-health Institutions</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CENTRAL or NATIONAL</strong></td>
<td>Ministry of Health (CNHU-HKM)</td>
<td>- National and University Hospital Center</td>
<td>- Medicine</td>
</tr>
<tr>
<td></td>
<td>- National Pneumo-Phthisiology Center</td>
<td>- Pediatrics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- National Psychiatry Center</td>
<td>- Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- National Gerontology Center</td>
<td>- Obstetrics-Gynecology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Maternal and Children’s Hospital – Lagune (HOMEL)</td>
<td>- Radiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Laboratory</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- O.R.L.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ophthalmology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Other specialties</td>
<td></td>
</tr>
<tr>
<td><strong>INTERMEDIATE or DEPARTMENTAL</strong></td>
<td>Direction départementale de la Santé (Departmental Health Directorate)</td>
<td>- Departmental Hospital Center (CHD)</td>
<td>- Medicine</td>
</tr>
<tr>
<td></td>
<td>- Information, Forecasting, Listening and Advice Center (CIFEC)</td>
<td>- Pediatrics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Leprosy Treatment Center (CTAL)</td>
<td>- Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Screening and Treatment Centers for Buruli Ulcers located in Allada and Pobé</td>
<td>- Obstetrics-Gynecology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Akron Pneumo-Phthisiology Center</td>
<td>- O.R.L.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ophthalmology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Radiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Laboratory</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Other specialties</td>
<td></td>
</tr>
<tr>
<td><strong>PERIPHERAL</strong></td>
<td>Area Hospital (HZ)</td>
<td>- General medicine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Health Centre (CS)</td>
<td>- Emergency chemistry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Solidary and Health Evolution Action Center (CASES)</td>
<td>- Obstetrics-Gynecology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Private health facilities</td>
<td>- Dispensary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Tuberculosis Detection Center (CDT)</td>
<td>- Maternity ward</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- dispensary or maternity areas alone</td>
<td>- Literacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Village Health Unit (UVS)</td>
<td>- Recreation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Area Office)</td>
<td>- Radiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Laboratory</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pharmacy or Pharmacy warehouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Births</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pharmacy cashier window</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** DPP.MS

#### 4.3.2 Public Sector

Aside from the Ministry of Health, there are other government facilities involved in the provision of care. They include the Ministry of Defense, which is one of the largest; it manages the Hopital d’Instruction des Armées, ten medical-social centers and five medical stations in the interior of 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.

It must be noted, however, that the partnership between the ministry of health and the other ministries is still in some ways insufficient. Today, there is still no collaboration agreement between the Ministry of Health and the army in order to clearly determine the mechanisms for partnership with the army in order to attain the national health objectives. Similarly, between the Ministry of Health and the Ministries responsible for education, this agreement does not exist, which causes any school and university health development mechanism is not defined in this context in order to attain the national health objectives which require, among other items, the promotion of safety and health of school students, university students and Benin workers in order to improve performance. The same problem...
is observed at the level of the other ministries, in particular the ministries responsible for labor, the interior, the environment, justice, public works, foreign affairs, etc.

Thus the need to improve dialog and collaboration between the Ministry of Health and other Ministries to ensure an adequate level of health care quality has arisen. Similarly, the partnership with local Elected Officials and the recipient communities in the decision making process of organization and management of health care and services.

4.3.3 Private sector

At the start of the 1990s, marked by freezing recruitment of care personnel, and the international situation, there was an abnormal resurgence of private medical units. By way of example, in 1997 there were 580 private health care facilities of all categories combined, throughout the country\textsuperscript{12}. This number increased to 660 in 1998. Statistics have shown that nearly 60% of these private health facilities are focused on the town of Cotonou, which only has 9.75% of the population of Benin.\textsuperscript{13}

The measures show:

- The private liberal sector: comprises two categories of health facilities: the medical-technical structures (clinics, poly-clinics, general or specialized medical office, dental office, diagnostic center / laboratory and radiology) and health facilities kept open by paramedical personnel; nurses and midwives (nursing care office, eutocic birth clinics). The presence of the non-affiliated private sector is reported chiefly in the southern part of the country particularly in urban environments.

We have noted that the operational integration of the activities of the private sector into national health sector development strategies is not yet effective and the law regulating the exercise with private customers of medical and paramedical professions seems to be ill-suited.

The partnership between the public and private sectors warrants strengthening in order to clean up the framework for the exercise of the medical and paramedical professions for development and promotion of Quality Assurance.

- The religious and non-profit private sector: has existed for nearly thirty 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 of the country are mainly hospitals. With approximately 800 beds (i.e. 19% of the national total), they account for an average of 35% of the hospital admission days recorded by the Benin health system\textsuperscript{14}. Il existe quelques expériences de prise en charge des besoins de la population sur une base associative résultant de l’initiative des associations de développement ou des cadres des localités concernées et l’administration sanitaire décentralisée avec le soutien des ONG internationales (ou de bailleurs de fonds).

It is in this same context that we must point out the emergence of community health centers in several villages that also contribute to improving health care coverage of rural individuals.

- Private cooperative sector: The cooperative health centers, launched by joint action between the Ministry of Health and the United Nations Development

\textsuperscript{12} Annual Health Statistics Yearbook, Ministry of Public Health (MSP) 1997
\textsuperscript{13} INSAE, GPHC 3
\textsuperscript{14} Moyenne calculée à partir des données de l’Annuaire des statistiques Sanitaires de 2007 et 2008.
Programme (UNDP) have not had the expected impact. Ten cooperative centers were opened of the 15 that were initially planned. Of these cooperative centers, only two (2) (ne in Cotonou and the other at Porto Novo) are operating today in a satisfactory financial manner. The other centers are experiencing more or less significant difficulties, in particular when they are located in a rural environment (For example Kissamey).

- **Private company sector:** Certain companies have their own care treatments. This is the case for the Autonomous Port of Cotonou and SOBEMAP. The infirmary of SOBEMAP covers more than 4000 employees and their families, i.e. approximately 25,000 persons. It employs physicians and nurses and provides treatment to approximately 60 customers per day.

- **Non-Governmental Organisations:** Since the start of the 1990s, many NGOs were established in Benin in the health domain. This primarily involves structures serving in an associated mode on the basis of Article 23 of the constitution of Benin in 1991. In 2000 the health domain already had 65 officially recognized NGOs. This number increases from year to year. Most of these NGOs participate in rather diversified areas such as health, hygiene, nutrition and insurance. This significant dispersion of their efforts does not facilitate the evaluation of their role and their actual contribution in the domain of health.

- **Informal Sector:** The provisions of Law 97,020 dated June 17, 1997 that established the conditions for the exercise for private customers that form the legal framework for the medical and paramedical professions are not respected. Most health facilities in the private sector are located haphazardly without respecting current standards. This phenomenon develops in particular in major cities and poses the problem of quality of the care offered to the population.

- **Private pharmaceutical sector:** it includes a small pharmaceutical industry that packages medications, four wholesalers-distributors are the only ones authorized to import medications for private for-profit operations. Today, the pharmaceutical sub-sector is confronting a variety of problems related to the various functions of medication, in particular geographical availability, financial accessibility of pharmaceutical products, their quality and their rational use. In Benin, there are 185 pharmacy shops unequally distributed throughout national territory and nearly half of them are found in the Department of Littoral

- **Public pharmaceutical sector:** The Central Exchange for Purchasing Essential Medications (CAME), the medication supply structure, seems to effectively provide for the storage and distribution of medications throughout national territory. It fulfills the needs of public health institutions as well as those of private wholesalers-distributors for filling orders. Approximately 279 private pharmaceutical warehouses whether authorized or not participate in extending pharmaceutical coverage beyond the two CAME regional warehouses located at Parakou and Natitingou. **It must be noted that** the private pharmaceutical sector processes 40% of the volume of medication, with annual revenue estimated at approximately 24 million CFA francs at retail prices. By 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.

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15 Chiffre d’affaires réalisé par les grossistes-répartiteurs : 12 milliards FCFA dont 5% d’affaires avec des pays de la sous-région. Part Bénin : 95% soit 11,4 milliards FCFA. Valeur px public : x 1,27 soit 14,5 milliards FCFA.
There is nevertheless an informal network of illegal 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, shops, roadsides, and door-to-door sales. In the markets, drug sellers are not distinguished from other merchants and likewise pay the taxes required by official institutions. In health care facilities one also observes the phenomenon of the illegal sale of medications, which causes problems with their rational use, as well as the quality of these products.

The development of the parallel market poses a real public health problem if only because of the continuously increasing risks.

In regards to the foregoing, the State has the duty to ensure the availability of the appropriate quality and quantity of medications at the lowest cost. It must also ensure their rational use.

- **Vaccines sub-sector:** The Ministry has a budget line item secured to purchase vaccines with the support of various partners. **Vaccines are considered** in the national list of essential medications, in accordance with the epidemiological profile observed in Benin, and their supply is assured by the approved structures, i.e. DNPEV/SSP, DNPS, CAME, and private Wholesalers-Distributors.

At the level of health facilities, the cold chain is available based on level of care (central, intermediate, peripheral), with regular distribution of vaccines from the central level to the intermediate level, where the towns come to get supplies. There is also a plan to refresh the cold chain equipment and vehicles.

Immunization activities are carried out at all public health care facilities and several private ones thanks to the ongoing availability of vaccines and supplies. This vaccine coverage of the population is assured at permanent stations in the health centers, by catch-up sessions, advanced strategies and by immunization campaigns. There is, however, some slackening in the implementation of these strategies.

In addition, there are opportunities for the training of EPI managers in Benin, such as the EPIVAC program from AMP at IRSP, the Regional MLM program from WHO. There is also an integrated disease and response surveillance system with the creation of epidemiological monitoring centers at the level of all health zones.

In regards to the cold chain, there is limited storage capacity for vaccines for major immunization campaigns and it has been seen that equipment and vehicles at all levels of the health care pyramid are aging, for example a large number of motor bikes (63%) and vehicles (48.5%) are broken.

Maintenance contracts at the local level are not yet signed, and spare parts for the cold chain equipment are not being refreshed at certain facilities, which causes disruptions in vaccination activities.

### 4.3.4 Traditional Medicine

Despite high usage, there is very little information on the resources and activities of traditional medicine. It is difficult to assess the state of traditional medicine in Benin,
because no accurate statistics exist. The existing data are patchy and are based on a project to evaluate natural substances initiated in 1970.

Therefore, it has not truly been incorporated into the concerns of the health sector. There are no trusted relationships between health care agents and traditional healers. In 1995, the government fostered collaboration with traditional medicine and the integration of the primary stakeholders in primary health care. The first attempts at collaboration were launched in 1999, with the survey of traditional medicine practitioners, therapeutic practices, pathologies and medicinal plants in Benin.

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 urban areas, there is total anarchy in the practice of this medicine. In order to offset this situation, several associations were created.

In rural areas, the cost of the services of traditional medicine practitioners is symbolic. The flexibility of payment terms is appreciated by all. This is one of the primary reasons that the population seeks out traditional medicine options. The remuneration of the traditional medicine practitioner is made at times in kind, after healing occurs. Within the community, the traditional medicine practitioner is a modest citizen. In contrast, in urban areas, the path to wealth entails inflation of the price for service and anarchy in the profession.

In general, support by the traditional medicine practitioner for treating the people’s health contributes to the economic development of the country, by improving the health of the people.

However, scientific piracy in the area puts the brakes on the development of traditional medicine. Aside from the plant-based medication harmonization referenced from OAPI, no regulatory text mentions the protection of intellectual properties and traditional recipes.

Furthermore, at the level of medications, the preparation, packaging and conservation of medication products is often accomplished under unhealthy conditions (equipment and devices not sterilized, soaking and disorganized with no expiration date are kept too long, no control of the existence of micro-organisms in the preparations, etc.).

However the high demand for medicinal plants and the increasing number of traditional medicine practitioners who collect plant species in the forest, may cause the extinction of the species if no provision is made to protect the forest.

Therefore, in view of these observations, it is necessary to promote local therapeutic resources.

4.3.5. Blood Transfusions

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 are now carried out on donated blood, the cost is only increasing. One unit of verified blood is currently sold for 1,500 CFA francs, which entails a significant margin to be subsidized. However, the price of a unit of blood is not adhered to everywhere. Currently, the transfusion system is being completely overhauled with the creation of the National Blood Transfusion Center (Centre National de Transfusion Sanguine – CNTS) which is a public scientific, technical and social institution with financial autonomy.

4.3.6 Diagnostic examinations: Medical imaging and analysis laboratory

Activities of the subsector of diagnostic examinations are unavoidable in any treatment process, whether for individual or community-based diseases. It is also encountered upstream during diagnosis and follow-up and downstream to confirm healing or the end of an epidemic. At the institutional and organizational levels, this sub-sector does not benefit from the support necessary for its correct operation. At the level of diagnostic examinations we see the failure to control the supply and management of reagents and consumables and the absence of a corresponding regulatory and legislative framework. Lastly, we note that the quality system at the level of biomedical analyses and medical imaging is relatively unsatisfactory.

It is therefore urged that the State contribute on an ongoing basis to improving the quality of care services by promoting diagnostic examinations and transfusion safety.

4.3.7 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. However, research has not yet managed to contribute effectively to improving the health state of the Benin people due to the insufficient research work, the low degree of use of results for decision-making and low coordination of research activities. The low use of research results could be explained by the failure of stakeholders and decision-makers to see the use of research results, a corollary to misinformation on the research work carried out in the country and the low degree of popular dissemination of the results of this work.

Furthermore, many avenues of health research have not been explored due to the fact of a low budget policy commitment in favor of research and poor living and working conditions of the researchers.

The State therefore has the duty to support, through research, the decision-making process at all levels of the health system.

4.3.8 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.

The health sector has a National Information and Health Management System (SNIGS). This system has been put in place since 1990 based on the consensus of all stakeholders in the sector (producers, users). Since then, it has taken into consideration the objectives established by health policy and undergone several evaluations, the fourth of which took place in 2006.

The SNIGS is comprised of several sub-systems. The primary sub-system is the information sub-system for ongoing trends monitoring. It produces routine data on the activities of health facilities at all levels of the health care pyramid, which are supplemented by the other sub-systems of the health sector, i.e.:

- the epidemiological monitoring and epidemic detection sub-system;
- the information system for program management;
- the information system for administrative and financial management;
- the periodic survey sub-system; and
- the community-based information sub-system.

The data produced are intended to be used to calculate the primary indicators necessary for planning, monitoring and evaluation of the actions implemented within the sector.

Most of the information produced is set out in the health statistics yearbook which has been released each year since 1984. The system currently has two major advantages, notably the standardization of media for data collection throughout the entire territory, and computerization of the information system.

Today, the SNIGS has databases from various levels of the health pyramid covering at least ten (10) years, broken down by health care facility and by month. The information contained in the database covers all activities of the sector: epidemiological data and non-epidemiological data (human and financial resources, infrastructure, equipment and material).

In spite of the accomplishments of the system listed above, there are insufficiencies that adversely affect its correct operation. These insufficiencies notably include:

- the lack of availability of real-time data;
- low coordination in the collection and production of data;
- insufficient quality of data generated; and
- insufficient resources.

One of the causes of the insufficient quality of data generated is the lack of integration of data from the private sector. The data on health care facilities in the private sector are still poorly integrated into the SNIGS database. Less than 10% of their statistics are incorporated into the SNIGS database, while they alone total approximately 40% of the treatment activities, especially in large cities. To this we must add the insufficient coordination of the health information subsystems and insufficient standardization of data of the early warning system with the system for diseases with monthly or delayed reporting. Lastly, we note insufficient decentralization of computerized entry of the data collected, which takes place only at the health area level. The summary at the level of the towns
which is the first summary level is still done manually. All of these aspects have an effect on the quality and reliability of data.

4.3.9 Mental Health

Mental health is increasingly perceived as a factor of well-being, at the home as well as the community level. In Benin, the analysis of the mental health situation reveals insufficient specialists in this domain, the concentration of specialists in Cotonou, treatment of mental diseases by traditional practitioners and religious officials, the absence of mental health research activities and the failure to take mental health activities into consideration in existing primary health care approaches. To all this we must add the abdication of authorities and stakeholders in modern medicine, the upsurge in the mental disease epidemic, the lack of a mental health prevention policy, the ineffectiveness of existing legislation regarding mental health, the near absence of treatment centers (mental disease, drug addiction, mental deficiencies and senile dementia) and the absence of training of paramedical personnel.

As a result, the State must pay more attention to this sub-sector.

4.3.10 Gender and health

In Benin, sociocultural principles focus all decision-making authority in the hands of the man. This dominant status\(^{17}\) of the man over the woman covers nearly all dimensions of social life, primarily health and family planning. Although the health of family members is the shared responsibility of the father and the mother, the decision as to the type of recourse generally falls to the father. In particular, aside from caring for infants, which is the woman’s responsibility, accessing any type of treatment requires the approval or the support of the man, with whom the final decision rests. Thus, even if the woman has financial resources that are able to cover the medical expenses, she often cannot take responsibility for having the child treated without her husband’s consent. However, these practices are increasingly less restrictive, particularly in urban or polygamous homes where women tend to make their own decisions in terms of accessing care for their health or that of their children.

Family planning and use of contraceptives are two dimensions of the male domination. In several traditional cultural contexts, women are not authorized to discuss their sexuality and their reproductive health with their spouse, in particular planning for births (contraception). Many women who practice it [contraception], do so without the knowledge of their husband, who is still reticent in rural areas. This difficulty for women to use contraception for family planning explains the frequency of undesired pregnancies, large families and the poverty of households.

These inequalities have harmful consequences for women and on those around them (children and their home). They lead, among other outcomes, to the progression of STDs/HIV/AIDS and to high rates of maternal and infant mortality.

Cultural practices also lead women to behaviors such as absolute discretion during the first trimester of pregnancy, preventing them from accessing Prenatal Visits (CPN). In rural areas, nearly 30% of women seeking a prenatal visit only had one, and fewer than 10% comply with the 4 prenatal visits before giving birth. These various situations often lead to

\(^{17}\) This dominant status of the man over the woman covers nearly all dimensions of social life, primarily health and family planning.
serious health problems, in particular to obstetric complications, and they compromise the attainment of development objectives in regards to reproductive health.

In spite of the gender inequalities set forth above and the health problems that they create, insufficient financial resources are allocated in the national budget to gender promotion. In addition, human resources who are qualified in regards to gender are insufficient and hinder gender promotion.

Lastly, in spite of the adoption of conventions and laws, for the most part enabling legislation does not exist, which explains the low extent to which they are respected in legal arenas.
V – HEALTH DEVELOPMENT STRATEGIES

5.1- Sector problems

From a diagnostic of health development we see that a significant portion of the population of Benin is faced with a lack of health care services and an unviable life environment, which translates into a lack of potable water, electricity and basic sanitation facilities. In addition, this situation is aggravated by unfamiliarity with the health issues related to waste management and the environment in general, one of the consequences of which is the spread of infectious and parasitic diseases. These health problems have increased considerably under demographic pressure.

Confronted with this situation, the ability to provide treatment or to cover health needs are not up to the level of the requirements of the current health development context. The current level of the mortality rate is one illustration of this situation.

At the institutional level, analyses have shown a weakness in the organization of sector stakeholders, leading to the low degree of effective care and adaptation to change. The vulnerability of health sector stakeholders is also justified by the needs in terms of limited technical, material and financial capabilities.

The 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 meetings) brought out the following seven priority problems:

1- Low accessibility of the population to basic social services, including health care;
2- Poor planning for the acquisition, construction, and maintenance of infrastructure and equipment,
3- The precarious nature financing mechanism for health care expenditures,
4- High morbidity and mortality rates,
5- Insufficient inter- and intra-sector cooperation,
6- Non-compliance with good governance practices.
7- Poor human resources management.

These seven priority problems underline the concerns for the sector.

5.2- Sector concerns

There are five (05) sector concerns:

a) maternal and infant mortality, prevention, combating disease and quality of care;
b) The sector’s human resources;
c) Partnership and medical ethics;
d) Financing of the sector;
e) Management of the sector.

These five concerns of the sector have allowed the determination of strategic areas, broken down into programs and sub-programs based on guidelines defined in the policy.
5.3 Foundations of the strategic plan

5.3.1 Foundations of the policy

✓ Strategic Development Guidelines (OSD)

By adopting the strategic development guidelines, the Government produced a guiding document for its actions. The Strategic Development Guidelines are a point of reference for promoting and effective conducting the development process of the country. In reality these are fundamental, structural choices, that fall within the medium-term prospects. The objective is to offer all development sectors the reference necessary for action.

It is expected that the Strategic Development Guidelines will initially be transformed into sector-based strategies and then made operational through the Strategy for Growth to Reduce Poverty, which is the programmatic platform for implementation of national policies, in accordance with the development management process of the country. In this regard, basing the NHDP on the Strategic Development Guidelines, the health sector aims to translate national development policy in this sector.

The eradication of poverty and improvement of quality of life of the people is one of the challenges of the Strategic Development Guidelines assumed by the NHDP. So, the development strategies of the health sector will contribute to overcoming this national challenge.

In terms of commitment for the health sector in the Strategic Development Guidelines, a health reference is offered through the preparation and implementation of a suitable legislative and regulatory framework, strengthening capacities and skills of stakeholders in the sector, and the implementation of special budget items.

✓ Millennium Development Objectives (MDOs)

A party to the Millennium Declaration, the Government of Benin is committed to preparing and implementing the public policies necessary to improve living conditions for the people through 2015. In this regard, and since the early 2000s, the MDOs have been a major foundation for national policies and sector-based strategies, which are the reference points for public action for the economic and social development of the country. The health sector is responsible for three of the eight objectives targeted at the global level, i.e.:

- Reducing mortality in children under 5 (MDO 4);
- Improving maternal health (MDO 5);
- Fighting HIV/AIDS, malaria and other diseases (MDO 6).

This conveys the significance to be granted to the health sector among the development sectors.

Since its independence Benin has been a preferred land for grassroots development experiments. With the adoption of Primary Health Care in 1978, these experiments have been expanded and gone more in depth, making the country, on many levels, an example for grassroots health development efforts. The changes that have occurred on the political level since the global economic crisis of 1989 have not canceled out the promotion of health of the most disadvantaged, in particular the populations of rural areas and semi-urban areas.
5.3.2 Values and principles of the health system

For several decades the successive governments of Benin have always made their own the values and principles conveyed by Primary Health Care. The approach of the health officials through institutions and various health programs emphasizes accessibility and quality of care, integration of intervention, applicability and efficacy, decentralization, inter-sector coordination and sustainability.

So, to make its vision reality, the health sector focuses on:
- dispensing appropriate care to the people;
- promoting good governance;
- equitable financing and good management of health expenses;
- solidarity and sharing of risk;
- decentralization, partnership and results-driven management.

5.3.3 The Vision of the Sector

The global vision of Benin contained in the National Studies of Long-Term Perspectives: Benin Alafia 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 Objectives (MDOs), ten-year plans, the Growth and Poverty Reduction Strategy (GPRS), and various government action programs. Actions 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 aspect.

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 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."

5.3.4 Objectives of the NHDP

In general, the objective of the NHDP is "to improve the health condition of the population of Benin based on a system comprising the poor and indigent populations."

This specifically involves:
- ensuring universal access to healthcare services and better quality of care to achieve the Millennium Development Objectives (MDO);
- strengthening the partnership for health;
- improving the governance and management of resources in the health sector.
5.4 Strategies

The development objectives chosen for the health sector were broken down and will be made operational in the following five (5) primary strategic areas:

- Reduction of maternal and infant mortality; preventing and fighting disease and improving the quality of care;
- Developing human resources;
- Strengthening the partnership in the sector and the promotion of ethics and physician ethics;
- Improvement of the sector’s financing mechanism; and
- Strengthening the management of the sector.

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.

*The State will now be the regulator of the system and will be 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 priorities of the following areas therefore seems urgent.
STRATEGIC AREA 1

REDUCTION OF MATERNAL AND INFANT MORTALITY, PREVENTION OF AND COMBATING DISEASE AND IMPROVEMENT IN THE QUALITY OF CARE
Strategy area 1: Reducing maternal and infant mortality; prevention and combating disease and improving the quality of care;

The strategic diagnosis on which the NHDP is based, in particular in regard to primary complaints, has determined that the prevalence of diseases is explained primarily by the non-regulatory environmental conditions, and quality conditions that are not appropriate for consumption. These factors of vulnerability were fostered by the ignorance of risk factors and prevention methods. In response to this situation, it was decided to anticipate and control the health risk factors based on interventions that provide an improvement in the framework and the living conditions of the people, as well as the promotion of individual and collective behavior that ensures good health. Furthermore, the improvement of the health environment of the people will be accompanied by ongoing oversight of priority diseases, i.e. HIV/AIDS, Malaria and Tuberculosis, followed by effective care based on the availability of medication in a quantity and quality, at a lower cost, and their rational use, as well as the improvement of hospital equipment and infrastructure. The axes of intervention decided upon to this end are:

Program No. 1: Promotion of hygiene and basic sanitation.

This program will be implemented through the viabilization and cleanup of the environment and communication for behavior change. This involves contributing to the improvement of individual and collective behavior in regards to health and cleaning up the framework and the living conditions of the people. These axes of intervention will be implemented by:

- 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;
- Strengthening of communication to promote behavior change (CCC);
- Improvement of intra- and inter-sectoral collaboration;
- Improving partnerships/alliances/networks;
- Improving skills and capabilities of providers;
- Promoting research/action;
- Promoting audiovisual production directed at the levels of society at risk;
- Promoting hygiene at water supply points;
- Promotion of the collection, transport, storage and hygienic use of drinking water in homes;
- Improvement of the capacities of towns for participatory, shared management of solid and household waste;
- Popular dissemination of the guide for preparing a communal hygiene and sanitation plan;
- Acceleration of the transfer of hygiene and sanitation activities to towns;
- Popular dissemination of the Promotion of Hygiene and Sanitation (PHS) approach.

**Program No. 2: Improving reproductive health**

This program will be implemented through the *fight against maternal and infant mortality and the fight against infant and youth mortality*. This involves reducing the maternal mortality rate, the newborn mortality rate, mortality and morbidity of children-youth.

In order to respond to issues related to maternal health, it was decided to provide:

- Twenty-four hour-a-day availability of the optimum set of highly effective obstetric and newborn procedures in all national and administrative district (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 facilities 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 facilities 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 facilities 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 facilities 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 package of high-impact obstetric and newborn procedures;
- Improvement of the EPI by:
  - Implementation of the ACD approach with particular emphasis on the strengthening of advanced strategies and active search for dropouts;
  - Mobilization of additional resources in the context of immunization independence;
  - Improving intra- and inter-sectoral collaboration and collaboration with international cooperation;
  - Rehabilitation and updating 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 change behavior;
• Implementation of the IDSR at all levels of execution of the program;

- Prevention and treatment of maternal and infant malnutrition by:
  • scaling up the package of high-impact nutrition interventions for women of child-bearing age;
  • promoting good eating practices for infants and young children in health care facilities and in the community (IEC);
  • fighting micronutrient deficiencies (supplementation, fortification, nutritional counseling);
  • comprehensive care for acute malnutrition;
  • strengthening the nutritional information system;
  • improving management of supplies for treating acute malnutrition (therapeutic foods);
  • integration of nutrition into training curricula.

Program No. 3: Fighting disease.

This program will be implemented via the fight against priority diseases, other communicable diseases and non-communicable diseases, improvement in the availability and quality of generic medications at reduced cost, promotion of diagnostic research and transfusion safety and diagnostic exams, traditional medicine and pharmacopeia, health in school, university and work environments, mental health and health research. This involves:

- reducing the prevalence of HIV/AIDS, Malaria and Tuberculosis, morbidity and mortality attributable to communicable diseases, and strengthening the fight against non-communicable diseases;
- ensuring the availability of medications in a sufficient quantity and quality, at low cost, and their rational use, and improving local treatment resources;
- sustained contribution to the improvement of the quality of health care;
- promoting the safety and health of Benin primary, secondary and university students and Benin workers in order to improve productivity;
- ensuring for individuals and communities the best mental health condition possible;
- through research, supporting the decision-making process at all levels of the health care system.

In the context of the fight against priority diseases, the axes of intervention will be implemented through:

- reduction in the incidence of STDs by extending quality treatment intervention of at-risk groups to all health areas;
- reduction of the transmission risk of HIV from mother to child by extension of PTME services;
- increasing the number of persons who are voluntarily screened and that received the test results;
- intensification of prevention efforts directed at at-risk groups and high-risk groups, such as youth, sex workers and their customers and mobile populations;
- increasing transfusion safety and universal precautions for prevention of blood transmission of HIV;
- extension of medical treatment of PLWHIV, including children, in particular, access to antiretrovirals;
- ensuring the correct treatment of every patient for opportunistic infections, including persons diagnosed with TB/HIV co-infection;
- improving diagnosis and biological monitoring of HIV by training/refresher training of laboratory personnel and by improving the technical level of laboratories;
- increasing coverage of comprehensive care for Orphans and At-risk Children;
- improving implementation of quality measures in laboratories;
- improving strategic information, in particular epidemiological monitoring of HIV and STDs;
- improving the capabilities of the permanent secretariat, the departmental secretariats and the 77 communal committees to improve coordination of the national response;
- development of operational research on STDs/HIV/AIDS;
- correct treatment of children under 5 years of age suffering from malaria;
- increase in the proportion of pregnant women and children under 5 years of age using treated mosquito nets and other insecticide treated mosquito nets;
- improving the prevention of malaria by comprehensively combating vectors and cleaning up environments;
- improving the quality of treatment of cases at the health care unit level and in the community;
- developing community-based initiatives for combating malaria;
- improving epidemiological and entomological monitoring, and monitoring of the effectiveness of anti-malarials;
- monitoring/evaluation of the fight against malaria;
- development services networks for parasitological diagnosis of disease;
- decentralizing and integrating primary health care activities;
- promotion of research by increasing the credits granted;
- improving sub-systems of monitoring-evaluation;
- promoting IPT among pregnant women;
- community participation in the fight against tuberculosis;
- introduction of new treatment strategies for priority diseases in the training curricula of schools for health care professionals;
- extension of the integration and decentralization of the National Program to Combat Tuberculosis to non-Tuberculosis Detection Centers;
- treatment of tuberculosis diseases;
- improvement of the Global Reference Laboratories and the microscopy network.

In order to effectively combat other communicable diseases, we must rely on:
- active and passive monitoring;
- comprehensive mass treatment with ivermectin, albendazol and praziquantel;
- treatment of cases;
- strengthening of institutions;
- training;
- treatment of the soil with larvicide;
- IEC/CBC;
- monitoring and evaluation;
- completion of work to expand the National Reference Center;
- promoting research;
- improving technical capabilities of the National Reference Center;
- improving the institutional framework and decentralization of activities;
- improving research capabilities;
- receiving doctoral candidates.

In order to effectively combat non-communicable diseases, the axes of intervention will be implemented through:
- a reduction of morbidity due to Non-communicable Diseases (NCDs);
- conducting at least two studies to determine the morbidity related with risk factors for non-communicable diseases
- improving activities in nutrition and in occupational hygiene and hygienic living;
- reduction in mortality due to traffic accidents;
- improving capabilities of health care institutions for treating non-communicable diseases;
- improving programs for screening and fighting against non-communicable diseases;
- documenting the prevalence of abnormal hemoglobin in Benin;
- improving the knowledge of communities regarding sickle cell anemia;
- improving the knowledge of health care personnel regarding sickle cell anemia.

The operational implementation of the axes of intervention for improvement of availability and the quality of generic medications at a reduced cost will be carried out by:
- improving accessibility to and the availability of medications;
- promotion of activities encouraging the rational use of medications;
- improvement of the management of medications and control of the pharmaceutical sub-sector;
- improving quality control;
- improving the legal and regulatory framework.

In regards to the promotion of diagnostic exploration, transfusion safety and diagnostic exams, the thrusts of intervention will be based on:
- improving capacities of the central public health laboratory;
- improving the system for importing reagents and supplies used in the biomedical analysis laboratories sub-sector;
- improving the organization of the sub-sector;
- the regulatory and legislative framing of the activities of biomedical analysis laboratories;
- improving technical capabilities of the structures of biomedical analysis laboratories;
- improvement of the system for equipment maintenance;
- improvement of the quality of services;
- development of the financial capabilities of the structures of biomedical analysis laboratories;
- improving the skills of human resources;
- systematizing the quality process;
- controlling the supply of reagents and consumables;
- management of laboratory data;
- analysis of data from biomedical analysis laboratories;
- improving the hygiene profile of water and food from the central laboratory;
- extension of the transfusion network to cover all national territory;
- preparation of a rate sheet for labile blood products and other services, as well as a financing plan;
- creation of new transfusion structure sites;
- improvement of the operation of the transfusion network;
- improving the capabilities of the sub-sector;
- improving the documentation system;
- improving planning and activities coordination capabilities;
- improving the management of physical and human resources;
- increasing the number of units of blood collected;
- improving rational utilization of labile blood products;
- improving blood products monitoring;
- availability of statistical data on Blood Transfusions;
- organization of Research;
- improving the organization of the sub-sector;
- establishing the regulatory and legislative framework for medical imaging activities;
- improving technical capabilities of Medical Imaging facilities;
- development of financing capabilities for the medical imaging sub-sector;
- development of administrative management capabilities and resources;
- improvement of the financing of diagnostic examinations;
organization of active gathering of statistical data generated by medical imaging services;
improvement of the capabilities of medical imaging personnel in regard to radiation protection.

In relation to the promotion of traditional medicine and pharmacopeia, intervention will be based on:
- the existing inventory of traditional prescriptions;
- reorganizing practitioners of traditional medicine;
- protecting and promoting of the most-used medicinal plants;
- developing medicinal plants based on established research.

In order to promote health in schools, universities and the workplace, we will rely on:
- improving the promotion of school, university and workplace health;
- developing the offering of school, university and workplace health services;
- improving the promotion of school, university and workplace health;
- development of school, university and workplace environments that are healthy and safe;
- improvement of community participation and solidarity.

Strategies for intervention related to the promotion of mental health will be implemented via:
- the creation of an adequate institutional framework;
- integration of mental health activities into existing primary health care approaches, particularly to ensure basic care to the entire population;
- the creation and/or operational implementation of 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);
- the improvement of programs for screening and combating mental illness;
- the promotion of mental health training and research activities;
- the development of skills at the staff level;
- strengthening Epidemiological Surveillance.

In the context of the promotion of health research, the intervention strategies will be based on:
- the creation of an environment that favors health research;
- improving the involvement of decision-makers, partners, expatriates and communities in health research;
- improvement of the coordination of research activities;
- improvement of the skills of stakeholders in health research;
- improvement of the sharing of experiences among researchers;
- establishing a mechanism for encouraging researchers;
- assessment of the results of research work;
- the development, coordination and revitalization of the partnership.
Program No. 4: Hospital development.

This program will be implemented via quality management in hospital environments, the improvement of technical levels, hospital reform, organization and improvement of the care provided. This involves improving the quality of care in hospital environments; improving the hospital sub-sector in terms of quality equipment and infrastructure; contributing to the improvement of the quality of care and treatment of patients through good governance of the hospital sub-sector and organizing the hospital system so that the hospital will effectively perform its primary roles.

For quality management in hospital environments, the axes of intervention will be implemented via:
- the development at the level of all hospital stakeholders, the culture of striving to furnish quality services to users;
- improving staff skills;
- creating specialized centers necessary for the system to be effective;
- development of hospital communications;
- development of a partnership between the hospital and outside staff;
- implementation of an effective hospital information management system, and an effective system for monitoring-evaluation of customer satisfaction;
- efficient management of resources;
- efficient management of obstetrics emergencies.

In regards to improving technical levels, the axes of intervention will be based on:
- the development and implementation of a national development plan for hospital technical capacity;
- the review and supplementation of equipment management tools, including inventory tools;
- the establishment of a system for the redeployment of hospital equipment;
- the preparation, application and evaluation of new norms and standards for public and private hospital infrastructure and equipment;
- the development of maintenance strategies adapted to each category of health care institution, especially to hospitals.
- the establishment of a preventive maintenance program in hospitals.

In regards to hospital reform, the axes of intervention will be based on:
- the preparation and updating of the texts necessary for hospital reform;
- the establishment of a system of vertical and horizontal complementarity between public and private health care institutions at all levels;
- the construction of centers of excellence in the hospital sub-sector.

In regards to the organization and improvement of care offered, the intervention will be based on:
- the preparation and updating of treatment guidelines for patients;
- the creation and expansion of hospitals; in particular the opening of new departments;
- the preparation of a plan adopted by the Board of Directors of each hospital under an independent management plan before approval by the Ministry of Health;
- the strengthening of laws governing the quality of care provided at health care facilities.
STRATEGIC AREA 2

DEVELOPMENT OF HUMAN RESOURCES
Strategy area 2: Development of Human Resources

From an analysis of the situation, we can see the inadequacy of the Human Resources produced for Health Care in terms of the qualitative and quantitative requirements of the sector, which affects the quality of care and services. This situation results from insufficient strategic and operational management of health care personnel, in particular in regards to the planning of Human Resources development, management and monitoring of the careers of personnel.

It calls for the implementation of a mutually agreed upon plan for initial training intended to provide the facilities of the health care system with a sufficient number of qualified personnel, while developing effective mechanisms to encourage performance. Furthermore, there are plans to improve the partnership between the internal and external participants in the sector, in regards to the promotion of proximal management of HR. Lastly, the promotion of research regarding HR and health care and safety in the workplace in this sector are also priorities for the sector.

The interventions that fall within these priorities are broken down via:

**Program No. 5: Improving human resources planning:**

This program will be implemented by strengthening HR personnel in health fields, improving the partnership between internal and external members in regards to health care HR planning and the development of research regarding human resources. This involves making a sufficient number of qualified personnel available to structures in the health sector, improving the partnership between internal and external sector participants, and the sector committing to promoting HR research.

In order to improve health care HR personnel, the axes of intervention will be operationally implemented via:

- improvement of the health care HR data collection and processing system;
- describing positions and profiles;
- recruiting new agents on an as-needed basis;
- the development of domestic and foreign medical missions (with national specialist physicians in country and from abroad);

The axes of intervention in regards to the partnership between internal and external participants in regards to health care HR planning will be based on:

- strengthening collaboration between internal and external stakeholders;
- developing a consultation framework between the private and public sectors;
- advancing social dialog.

The axes for intervention regarding the development of human resources research will be based on:

- compiling a data bank on priority subjects by domains of Health Care HR management;
- creating an exchange framework for the promotion of research on human resources in health care;
- creating an environment favorable to research development.

**Program No. 6: Improving production and the development of skills;**

This program will be implemented via the development of a mutually agreed upon initial training program for personnel in the sector and the development of skills of these personnel. This involves providing the health care sector with a mutually agreed upon plan for initial training of health care personnel, ensuring specialization and the development of agents and developing a network of trainers in the strategic domains of the sector.

In regards to the development of a mutually agreed upon initial training program for sector personnel, the axes of intervention will be implemented via:

- compiling a databank on training needs and costs;
- strengthening relationships with training facilities and other institutions involved in training;
- strengthening training institutions' output capacity;
- support for improving students' supervision in practical training locations;
- monitoring and evaluation of the training plan.

For the development of skills of sector personnel, the axes of intervention will be implemented via:

- promoting the specialization and advanced training of agents;
- developing on-the-job training;
- promoting new fields of training;
- implementation of a network of trainers in the strategic areas of the sector.

**Program No. 7: Improvement of the human resources management system.**

This program will be implemented via the improvement of personnel career management; mechanisms for encouraging holding positions and the performance of personnel, prevention and management of occupational risks and the decentralization/deconcentration of human resources management. This involves improving practices in terms of the career management of agents, implementing an appropriate system for motivating performance of agents and incentives for agents keeping their jobs, promoting workplace health and safety in the health care sector and proximal management of health care HR.

The axes of intervention to improve personnel career management will be implemented via:

- improvement of governance in the domain of health care HR;
- strengthening career evolution mechanisms in the health corps;
- improving mechanisms for carrying out and monitoring career activities;
- improving the mechanisms for distribution of personnel.

In terms of the improvement of mechanisms to encourage personnel to stay in their position and to encourage performance, the axes of intervention will be based on:
- improving working conditions;
- developing performance;
- the adoption of measures to keep agents in their positions.

In order to prevent and manage occupational risks, the axes of intervention will be based on:
- Creating/empowering structures for prevention and management 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.

Regarding the deconcentration/decentralization of human resources management, the axes of intervention will be implemented via:
- consolidation of the institutional framework of the General Reference Hospital;
- strengthening the delegation of authority at all tiers of the health system pyramid;
- supporting the operation of management structures at intermediate and peripheral levels.
STRATEGIC AREA 3

STRENGTHENING PARTNERSHIPS IN THE SECTOR AND PROMOTION OF RESPONSIBILITY AND MEDICAL ETHICS
Strategic area 3: Strengthening partnership within the health sector and promoting medical ethics and responsibility

The unsatisfactory level of the quality of care is due to the low level of dialogue and collaboration between the Ministry of Health and the other ministries that are directly involved in health care in terms of health care services for the armed forces, school and university health care, occupational health and indirectly in terms of the environment, public works, water and energy, communications, etc. This context is also encouraged by the low level of organization and management of health care and services that relates to the competence of local elected officials and beneficiary communities, the partnership between the public and the private sector.

In order to remedy this situation, it is planned to implement formal collaboration agreements, to clean up, strengthen the regulatory frameworks for implementation and to strengthen partnerships. These strategic choices will be implemented via:

Program No. 8: Strengthening the partnership among the stakeholders

The partnership among the stakeholders will be strengthened through the partnership between the Ministry of Health and other ministries, the Ministry of Health and local municipalities and between the public and the private sectors. This will involve improving the dialogue and collaboration between the Ministry of Health and the other Ministries in order to ensure a satisfactory level of quality of care and to implement collaboration agreements, to improve the partnership with local elected officials and the beneficiary communities in the decision-making process relative to organization and management of health care and services, to make the legal framework for management and development of health care actions consistent between the health areas and local grassroots communities and to strengthen the partnership between the public and the private sectors.

The axes for intervention relative to the partnership between the Ministry of Health and the other ministries will be based on:

- the implementation of a lobbying mechanism for more concerted inter-sectoral collaboration;
- the development of a standard partnership agreement,
- the improvement of national laws and regulations;
- the adaptation of international laws to the national realities for optimal coverage of employee health care needs.

For the partnership between the Ministry of Health and local communities, the axes of intervention will be implemented via:

- creation of a consultation framework between the Ministry of health and local governments;
- advocacy to local elected officials for support to provide to health facilities;
- implementation of the decentralization laws in regards to the transfer of skills;
- support of towns in the context of the attainment of national health objectives that are entrusted to them.

In regards to the partnership between the public and the private sectors, strengthening will take place based on:
- establishment of a plan of action to improve the quality of services delivered by private health facilities;
- development of medical, paramedical and pharmaceutical inspections;
- integration of private sector activities into national strategies of development of the health sector;
- strengthening of the intervention capabilities of the private sector
- enforcement of the current legal and regulatory framework in Benin;
- strengthening of institutional capabilities of representative structures of the private sector;
- strengthening of the capability of regulatory bodies and representative structures in the sector (boards, unions, associations).

**Program No. 9: Promotion of ethics and medical responsibility**

This will be accomplished by the development and promotion of Quality Assurance. This involves cleaning up the context in which the medical and paramedical professions are carried out, and guaranteeing the quality and safety of services and care provided for the satisfaction of patients at all facilities at all levels of the health care pyramid.

The axes of intervention to improve medical ethics and responsibility will be based on:
- the development / updating of texts on the practice of medical and paramedical professions;
- the definition, relative to texts, of the rights and obligations of providers and users;
- training associations of clients of health facilities in the provisions of the new regulatory texts.

Regarding the development and promotion of Quality Assurance, the axes of intervention will be implemented via:
- mobilization of resources for the implementation of the quality process at all facilities of the system;
- preparation of the program to implement the quality process;
- development and promotion of quality improvement networks;
- establishment of a quality assessment program;
- coordination of the hospital structures involved in the quality process;
- improvement of the intervention capabilities in the domain of quality for health stakeholders;
STRATEGIC AREA 4

IMPROVEMENT OF THE SECTOR FUNDING MECHANISM
Strategic area 4: Improvement of the sector funding mechanism

Financial barriers are still high for most of the population, which does not provide for equitable access to health care services. It is urgent, therefore, to take action to provide better health for the people. In order to reach this goal, it will be necessary to improve the funding mechanism which must be based on a decrease in the direct contribution by households to their health care expenses, while paying particular attention to the poor, indigent and at-risk classes. This will allow an improvement of financial accessibility to health care services by households. In addition in a context of budget constraints, it is necessary to improve strategies to mobilize additional resources. The interventions chosen to this end are:

Program No. 10: Improvement of sector funding.

This program will be implemented via the promotion of health insurance and the promotion of health cooperatives. This will allow an improvement of financial accessibility to health care services by households.

Intervention in the context of the promotion of health insurance will be implemented via:
- implementation of a mechanism for widespread availability of health insurance;
- the establishment of mandatory health insurance at the level of public and private companies;
- promoting awareness and encouraging households to subscribe to health insurance.

The promotion of health cooperatives will be based on:
- the creation of an environment that is conducive to the accelerated development of health cooperatives;
- development of strategies for the acceptance of cooperatives by the health personnel;
- strengthening the capabilities of stakeholders in the development of health cooperatives (training, research and information and management system);
- strengthening technical and institutional capabilities of health cooperatives;
- promoting new cooperative initiatives;
- strengthening communication in the context of the promotion of health cooperatives.

Program No. 11: improving medical assistance for the poor, indigent and at-risk groups.

This intervention will be implemented via the strengthening of medical assistance and the mobilization of national savings and that of expatriates (donations and bequests). This involves providing access to health services to the poor, the indigent and at-risk groups.

Interventions falling within the sphere of improving medical assistance will be based on:
- the improvement of institutional capabilities of system stakeholders in accounting for the neediest and the indigent;
- improving medical assistance to at-risk groups (0 to 5 years old);
- improving the dialog between town and socio-medical authorities;
- providing broader information to the people regarding these funds;
- decentralizing indigents' health funds to all communes as was done with social measures funds;
- expanding health funds for indigents to all health areas;

Interventions related to the mobilization of national savings and funds from expatriates (donations and bequests) will be implemented via:
- strengthening the capacity to collect funds from people of good will;
- social mobilization in favor of health solidarity.
STRATEGIC AREA 5

STRENGTHENING SECTOR MANAGEMENT
Strategic area 5: Strengthening sector management

The diagnostic analysis of the sector management mechanism shows that the insufficient management of the sector is facilitated by the absence of an adequate legal framework for management and development of health actions at all levels of the health care pyramid, in particular within the health areas and local grassroots communities. This situation in particular is fostered, on the one hand, by the weak capabilities of management structures in planning, coordinating and evaluating in order to ensure at all levels of the health care pyramid the optimal conditions for implementation of the sector development plan, and on the other hand, by poor planning in terms of infrastructure and equipment.

In order to find a solution to these insufficiencies, it is planned to ensure that the optimal conditions are present at all levels of the health care pyramid for implementation of the national health development plan, on the one hand, and a long service life for equipment, infrastructure and vehicles, on the other hand. The interventions chosen in this regard are:

- **Program No. 12: Institutional strengthening.**

This axis will be implemented via the strengthening of capabilities for planning, coordination and evaluation and the strengthening of the mechanism for maintenance of health care infrastructures. This involves ensuring at all levels of the health care pyramid the optimal conditions for implementation of the NHDP and to ensure a long service life for equipment, infrastructure and vehicles at all levels of the health pyramid.

Interventions in regards to improving planning, coordination and evaluation capabilities will be implemented via:

- Ensuring the consistency of norms, standards and legal texts with the new policy;
- improving the quality process, health communications and health research;
- periodic development and updating of management and decision analysis tools;
- development of 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;
- the preparation, implementation and monitoring of the annual work plan at each level of the health system pyramid;
- improving and/or setting up sufficient logistical means at each level of the health system pyramid;
- improving capabilities for planning, programming, supervision and coordination of the sector;
- creation and coordination of the institutional framework of the health information system;
- on-time production of complete and quality information;
- improvement of the operation and use of data;
- improvement of health information system resources;
- promotion of the gender approach and other transverse measures such as the environment in the implementation of the NHDP;
- breaking down of statistics by gender at all levels of data generation for sectors;
- the development of a monitoring-evaluation device for the implementation of transverse measures (gender, environment, etc.).

Strengthening of the mechanism for maintenance of health structures will be based on:
- the effective reorganization of maintenance services;
- strengthening intervention capabilities at each level of the health system pyramid;
- providing adequate equipment to maintenance services;
- implementing a mechanism of motivation for maintenance personnel;
- establishment of an effective depreciation mechanism for infrastructures, medical and technical equipment and vehicles;
- establishment of a maintenance policy.

**Program No. 13: Development of health areas.**

This program will be implemented by strengthening the base of the health care pyramid and the development of grass-roots services. This involves improving the capabilities to implement the NHDP at the peripheral level and community services, while focusing on the promotion of their activities.

Interventions that fall within the framework of improving the base of the health care pyramid will be operationally implemented via:
- 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).

**The development of grassroots services will be based on:**
- strengthening social mobilization;
- providing technical and financial support to community initiatives;
- strengthening the capabilities of community stakeholders;
- promotion of community health in all health areas.

**VI – NHDP PLAN OF ACTION**

The plan of action of the NHDP is the budgeted breakdown of the strategic domains into thirteen (13) programs, which themselves are broken down into programs, objectives and measures that are necessary to attain the objectives established in the plan.

This plan of action is the subject of a document attached to the NHDP.
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 were determined based on: (i) population projections; (ii) health care expenses of households; (iii) the national effort to allocate a growing share of the GDP to health care expenses; (iv) the desire of the Government to capture more resources in the public health care sector through better quality of public health care services; and (v) the commitment of the Technical and Financial Partners to comply with the priorities of the sector.

As regards the resource requirements, they are determined depending on the realities of the time and the challenges of the Millennium Development Objectives, the Growth and Poverty Reduction Strategy (GPRS) and the strategic orientations contained in the health sector policy statement.

7.1 Potential indication of NHDP funding

The National Health Expenditures (NHE) per resident, according to the 2003 National Health Accounts (NHA), was estimated at 13,742 CFA francs per year. These expenses will increase slightly, perhaps on the order of 5%, as of 2008, in order to take into consideration the increase in the cost of medical-technical equipment, the complexity of the morbidity table (emergence of neglected diseases, appearance of new diseases, epidemiological transition, etc.) and the need for qualified human resources in the sector for the next ten years.

The resources that can be mobilized were estimated based on per capita health care expenses and the population for each year. Considering the share of health expenditure per source in comparison with the nation's entire health expenditure, the amount of potential 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. Consideration of this financing mechanism must, after a period of ten years, reduce the household share of financing of health expenditures and in turn increase the share covered by the State, the Technical and Financial Partners, local communities, insurance and private companies.

The State's intention to actually devote 15% of budget resources to health, the strengthening of the Heavily Indebted Poor Countries (HIPC) initiative and community financing will enable the sector to have the resources necessary for implementing the sector's programs and sub-programs.

Thus, the estimated resources are as follows:

Table 5: Estimated resources per source

<table>
<thead>
<tr>
<th>Sources</th>
<th>Amount in Millions of CFA Francs</th>
<th>Total</th>
</tr>
</thead>
</table>

National Health Development Plan – Benin, 2009 - 2018
7-2. Indications of financing by program and sub-program per year.

The estimate of the resources necessary for each program is based on the analysis of the information mentioned in the performance reports, the requirements set forth in the sub-sector policies and the cost estimates for attaining the MDOs.

The following table presents the requirements for attaining the objectives established in the NHDP.

<table>
<thead>
<tr>
<th></th>
<th>2008 (Baseline year)</th>
<th>2009-2013</th>
<th>2014-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt.</td>
<td>44 454</td>
<td>281 171</td>
<td>447 068</td>
</tr>
<tr>
<td>%</td>
<td>30,8%</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>Households</td>
<td>414 435</td>
<td>356 393</td>
<td>770 828</td>
</tr>
<tr>
<td>%</td>
<td>52,1%</td>
<td>47%</td>
<td>28%</td>
</tr>
<tr>
<td>TFP</td>
<td>162 714</td>
<td>308 460</td>
<td>471 175</td>
</tr>
<tr>
<td>%</td>
<td>16,5%</td>
<td>18%</td>
<td>23%</td>
</tr>
<tr>
<td>Local communities</td>
<td>11 467</td>
<td>56 068</td>
<td>67 535</td>
</tr>
<tr>
<td>%</td>
<td>0,1%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Private sector (companies) via insurance</td>
<td>19 088</td>
<td>107 482</td>
<td>126 570</td>
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<tr>
<td>%</td>
<td>0,3%</td>
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<td>8%</td>
</tr>
<tr>
<td>Other (NGO)</td>
<td>6 137</td>
<td>35 915</td>
<td>42 052</td>
</tr>
<tr>
<td>%</td>
<td>0,1%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total resources available</strong></td>
<td><strong>895 012</strong></td>
<td><strong>1 311 386</strong></td>
<td><strong>2 206 398</strong></td>
</tr>
</tbody>
</table>
Table 6: Estimated requirements per program and sub-program

<table>
<thead>
<tr>
<th>STRATEGIC AREAS – PROGRAMS – SUB-PROGRAMS</th>
<th>COSTS (IN MILLIONS OF CFA FRANCS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIC AREA 1 REDUCTION OF MATERNAL AND INFANT MORTALITY, PREVENTION OF AND COMBATING DISEASE AND IMPROVEMENT IN THE QUALITY OF CARE</td>
<td>137 254</td>
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<tr>
<td>PROGRAM 1 Promotion of Basic Sanitation and Hygiene</td>
<td>258</td>
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<tr>
<td>a) Provision of basic services and cleaning of the environment</td>
<td>236</td>
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<tr>
<td>Communication for behaviour change</td>
<td>21</td>
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<tr>
<td>PROGRAM 2 Improving reproductive health</td>
<td>36 362</td>
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<tr>
<td>Combating maternal and newborn mortality</td>
<td>4 948</td>
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<tr>
<td>Combating under-age-five mortality</td>
<td>31 414</td>
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<tr>
<td>PROGRAM 3 Disease control</td>
<td>54 285</td>
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<tr>
<td>a) Combating priority diseases</td>
<td>52 942</td>
</tr>
<tr>
<td>Combating other communicable diseases</td>
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<tr>
<td>Combating non-communicable diseases</td>
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<tr>
<td>Improving the availability of good-quality medications at reduced cost.</td>
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<tr>
<td>Promoting diagnostic examinations and transfusion safety</td>
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<tr>
<td>Promoting traditional medicine and pharmacopoeia</td>
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<tr>
<td>Promoting health care in school, university and occupational settings</td>
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<tr>
<td>Promoting mental health</td>
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<tr>
<td>Promoting health research</td>
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<tr>
<td>PROGRAM 4 Hospital development</td>
<td>46 349</td>
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<tr>
<td>Developing a health care quality management system in the hospital setting</td>
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</table>
### National Health Development Plan – Benin, 2009 - 2018

#### STRATEGIC AREA 1 IMPROVING TECHNICAL CAPACITY

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<tbody>
<tr>
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<td>361</td>
<td>396</td>
<td>156</td>
<td>91</td>
<td>5113</td>
<td>17263</td>
<td>18698</td>
<td>0</td>
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<tr>
<td>Organizing and improving health care provision</td>
<td>0</td>
<td>3549</td>
<td>3538</td>
<td>1565</td>
<td>1566</td>
<td>613</td>
<td>1968</td>
<td>2001</td>
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#### STRATEGIC AREA 2 DEVELOPMENT OF HUMAN RESOURCES

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#### STRATEGIC AREA 3 STRENGTHENING OF THE PARTNERSHIP IN THE SECTOR AND PROMOTION OF MEDICAL ETHICS AND RESPONSIBILITY

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#### STRATEGIC AREA 4 REFORM OF HOSPITALS

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<td>0</td>
<td>3549</td>
<td>3538</td>
<td>1565</td>
<td>1566</td>
<td>613</td>
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#### STRATEGIC AREA 5 ORGANIZING AND IMPROVING HEALTH CARE PROVIDATION

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<td>613</td>
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#### STRATEGIC AREA 6 MANAGEMENT OF HUMAN RESOURCES

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<td>613</td>
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#### STRATEGIC AREA 7 MANAGEMENT OF HUMAN RESOURCES

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<td>613</td>
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<td>2001</td>
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#### STRATEGIC AREA 8 STRENGTHENING THE PARTNERSHIP BETWEEN THE STAKEHOLDERS

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<td>613</td>
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<td>2001</td>
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#### STRATEGIC AREA 9 PROMOTING ETHICS AND MEDICAL RESPONSIBILITY

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<td>1566</td>
<td>613</td>
<td>1968</td>
<td>2001</td>
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**Note:** The numbers represent budget allocations for each strategic area and program within the National Health Development Plan for Benin, 2009 - 2018.
### National Health Development Plan – Benin, 2009 - 2018

#### STRATEGIC AREA 4 IMPROVEMENT OF THE SECTOR

<table>
<thead>
<tr>
<th>STRATEGIC AREA</th>
<th>IMPROVEMENT OF THE SECTOR</th>
<th>ANNUAL TOTAL</th>
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<tbody>
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<td>229 976</td>
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<td>248 257</td>
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<td></td>
<td></td>
<td>267 977</td>
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<td>289 253</td>
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<td>392 440</td>
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#### PROGRAM 10 Improvement of sector financing

<table>
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<tr>
<th>PROGRAM 10</th>
<th>IMPROVEMENT OF SECTOR</th>
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<td></td>
<td>1 214 8</td>
</tr>
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<td></td>
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<td>2 148</td>
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#### PROGRAM 11 Increasing medical assistance to the poor, the indigent and at-risk groups

<table>
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<tr>
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<th>IMPROVEMENT OF SECTOR</th>
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</thead>
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<td></td>
<td></td>
<td>6 214 8</td>
</tr>
<tr>
<td></td>
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<td>8 734 5</td>
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#### STRATEGIC AREA 5 STRENGTHENING SECTOR MANAGEMENT

<table>
<thead>
<tr>
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<th>STRENGTHENING SECTOR MANAGEMENT</th>
<th>ANNUAL TOTAL</th>
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</thead>
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<td>51 978</td>
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<td></td>
<td></td>
<td>1 861</td>
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</table>

#### PROGRAM 12 Institutional strengthening

<table>
<thead>
<tr>
<th>PROGRAM 12</th>
<th>STRENGTHENING SECTOR MANAGEMENT</th>
<th>ANNUAL TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>1 206</td>
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</table>

#### PROGRAM 13 Development of health areas

<table>
<thead>
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<th>PROGRAM 13</th>
<th>STRENGTHENING SECTOR MANAGEMENT</th>
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<td></td>
<td></td>
<td>31 759</td>
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#### ANNUAL TOTAL

<table>
<thead>
<tr>
<th>ANNUAL TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 850 889</td>
</tr>
</tbody>
</table>

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**Note:** The data includes the following strategic areas:

- Strengthening medical ethics and responsibility
- Developing and promoting Quality Assurance
- Strengthening the lower tier of the health system pyramid
- Development of services at the community level
- Mobilization of national savings and savings from expatriates (gifts and bequests)
- Strengthening the mechanism for maintenance of medical and technical equipment of health facilities and vehicles.
- Strengthening capabilities in planning, coordination, and evaluation
- Strengthening medical assistance to the poor, the indigent and at-risk groups
- Increasing medical assistance
Between financing requirements and potential financing for the sector, there emerges a gap of 644 billion francs, divided as indicated in the following table:

### Table 7: Estimate of additional five-year costs of the NHDP

<table>
<thead>
<tr>
<th>Sources</th>
<th>Amount in Millions of CFA Francs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008 (Baseline year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009-2013</td>
<td>2014-2018</td>
</tr>
<tr>
<td>Total resources available</td>
<td>895 012</td>
<td>1 311 386</td>
</tr>
<tr>
<td>Total actual expenses</td>
<td>186 385</td>
<td>1 156 446</td>
</tr>
<tr>
<td>Gap to be collected (Additional costs)</td>
<td>261 434</td>
<td>383 057</td>
</tr>
</tbody>
</table>

Source: DPP.MS

#### 7.3 Allocation of resources by expenditure category

The structure of the budget as it appeared in 2008 was considered. 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" category will increase from 12.6% on average for 2007 and 2008 to 28% in 2013 (recruitment and improvement of working conditions, payment of bonuses and incentives) before reaching 35% by the end of the plan. On average, this share will be 23% on average for the first five years and 35% for the second. In contrast, the investment resources will be decreased to 40% in 2013, from an average of 51.6% for 2007 and 2008. Operating funds will gradually account for a relatively large share of annual contributions, increasing from 35.7% on average for 2007 and 2008 to 40% by the end of the plan.

The following table shows the allocation of resources by categories.

### Table 8: Actual NHDP expenses per five-year period and by expense category

<table>
<thead>
<tr>
<th>Actual expenses</th>
<th>Amount in Millions of CFA Francs</th>
<th>Total 2009 - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td></td>
<td>275 331</td>
</tr>
<tr>
<td>%</td>
<td>12.6%</td>
<td>23%</td>
</tr>
<tr>
<td>Operating</td>
<td></td>
<td>456 503</td>
</tr>
<tr>
<td>%</td>
<td>35.7%</td>
<td>39%</td>
</tr>
<tr>
<td>Investment</td>
<td></td>
<td>424 612</td>
</tr>
<tr>
<td>%</td>
<td>51.6%</td>
<td>37%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1 156 446</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.

The current burden of the central level in terms of operation is 42%, excluding personnel expenses. The intermediate and local levels account for 32% and 26% of operations, respectively, excluding personnel expenses. This trend will gradually improve, bringing the share of non-personnel operating expenses allocated to the central, intermediate and local levels down to 30%, 30% and 40% on average by the end of the 1st five year plan, then to 15%, 25% and 60% on average 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 wellbeing.

Table 9: Non-personnel operating expenses of the NHDP per five-year period and per level of the health care pyramid

<table>
<thead>
<tr>
<th>Level</th>
<th>2008</th>
<th>2009-2013</th>
<th>2014-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>136 951</td>
<td>101 667</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>42%</td>
<td>30%</td>
<td>15%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>136 951</td>
<td>169 444</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>32%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Peripheral</td>
<td>182 601</td>
<td>406 666</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>26%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Total</td>
<td>456 503</td>
<td>677 777</td>
<td></td>
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VIII. IMPLEMENTATION, MONITORING AND EVALUATION

8.1- Implementation and monitoring mechanisms

8.1.1 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 to the Directorate of Programming and Forecasting (DPP) which must be strengthened to effectively meet the NHDP requirements. 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 strategic area is provided 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).

Taking institutional responsibilities into account, the list of the leaders of the strategic areas are selected as follows:

<table>
<thead>
<tr>
<th>Area</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. Reducing maternal and infant mortality; prevention and combating disease and improving the quality of care;</td>
<td>NHDP</td>
<td>11. Promoting hygiene and basic sanitation (DHAB)</td>
<td>111. a) Provision of basic services and cleaning of the environment</td>
<td>DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>112. Communication for behaviour change</td>
<td>ALL DIRECTORATES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Improving reproductive health (DSF)</td>
<td>121. Combating maternal and newborn mortality</td>
<td>D, DNPEV, SSP, DEDTS, DIEM, DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>122. Combating under-age-five mortality</td>
<td>D, DSF, DEDTS, DIEM, DRS, DRH, DRFM, DPP, IGM, DNPEV, SSP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Disease control (NHDP)</td>
<td>131. Combating priority diseases, STI/HIV/AIDS, malaria, and tuberculosis</td>
<td>DHAB, DSIO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>132. Combating other communicable diseases</td>
<td>DHAB, DSIO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>133. Combating non-communicable diseases</td>
<td>DHAB, DSIO, DH, DEDTS, DNPEV, DRS, DRH, DRFM, DPP, IGM</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, IGM</td>
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<td></td>
<td></td>
<td></td>
<td>135. Promoting diagnostic examinations and transfusion safety</td>
<td>DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>136. Promoting traditional medicine and pharmacopoeia</td>
<td>DNPS, DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>137. Promoting health care in school, university and occupational settings</td>
<td>DSF, DRS, DRH, DRFM, DPP, IGM</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>138. Promoting mental health</td>
<td>DPM, DRS, DPP, IGM, DRH, DRFM</td>
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<td></td>
<td></td>
<td>139. Promoting health research</td>
<td>ALL DIRECTORATES</td>
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<td></td>
<td></td>
<td>14. Hospital development (DH)</td>
<td>141. Developing a health care quality management system in the hospital setting</td>
<td>DNPS, DSIO, DPP, IGM, DRS, DRH, DRFM</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>142. Improving technical capacity</td>
<td>DPP, IGM, DRS, DRH, DRFM</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>143. Hospital reform</td>
<td>DNPS, DSIO, DSF, DIEM, DPP, IGM, DRS, DRH, DRFM</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>144. Organizing and improving health care provision</td>
<td>DNPS, DSIO, DPP, DRS, DRH, DRFM</td>
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<tr>
<td>2. Developing its human resources</td>
<td>HRD</td>
<td>21. Increased planning of human resources (DRH)</td>
<td>211. Increasing the human resources workforce in health</td>
<td>IGM, DPP, DRS, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>212. Strengthening the partnership between internal and external partners in health human resources planning</td>
<td>IGM, DPP, DRS, DRFM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>213. Development of research into human resources</td>
<td>IGM, DPP, DRS, DRFM</td>
</tr>
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</table>
### 2. Promoting ethics and medical responsibility (Reg. Health Directorates)

<table>
<thead>
<tr>
<th>Area</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>2. Promoting ethics and medical responsibility</td>
<td>RHD</td>
<td>31. Strengthening the partnership among the stakeholders (NHDP)</td>
<td>311. Partnership between public and private sectors</td>
<td>All directorates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>312. Partnership among the Ministry of Health, local elected officials, and local communities</td>
<td>All directorates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>313. Partnership between Ministry of Health and other ministries;</td>
<td>All directorates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Promoting ethics and medical responsibility</td>
<td></td>
<td>All directorates</td>
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</table>

### 4. Improvement of the sector funding mechanism

<table>
<thead>
<tr>
<th>Area</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>41. Improvement of sector financing (DRFM)</td>
<td>FMRD</td>
<td>411. Promoting health insurance</td>
<td>IGM, DPP, DRS, DRFM, DRH</td>
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<td>412. Promoting community-based health insurance schemes</td>
<td>IGM, DPP, DRS, DRFM, DRH</td>
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<tr>
<td></td>
<td></td>
<td>42. Increasing medical assistance to the poor, the indigent and at-risk groups (DRFM)</td>
<td>DNPS, IGM, DPP, DRS, DRH</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>421. Increasing medical assistance</td>
<td>DNPS, IGM, DPP, DRS, DRH</td>
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<td></td>
<td></td>
<td>422. Mobilizing national savings and the savings of the diaspora</td>
<td>DNPS, IGM, DPP, DRS, DRH</td>
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### 5. Strengthening management of the sector

<table>
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<tr>
<th>Area</th>
<th>Leader</th>
<th>Program and agency in charge</th>
<th>Sub-program</th>
<th>Other Health Ministry stakeholders involved</th>
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<td>51. Institutional strengthening (DPP)</td>
<td>HZDD</td>
<td>511. Strengthening coordination, planning, and evaluation capabilities</td>
<td>All directorates</td>
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<td>512. Strengthening of the mechanism of maintenance of health facilities</td>
<td>All directorates</td>
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<td>52. Developing health areas (DOZS)</td>
<td>DNPS, DSIO, DNPEV, DSF, DIEM</td>
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<td>521. Strengthening the lower tier of the health system pyramid</td>
<td>DNPS, DSIO, DNPEV, DSF, DIEM</td>
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<td>522. Development of services at the community level</td>
<td>DNPS, DSIO, DNPEV, DSF, DRH</td>
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</table>

#### 8.1.2 Organizing the monitoring of NHDP implementation

The NHDP will be the subject of monitoring and evaluation of the implementation of the various three-year plans resulting from it, on the one hand, and on the other hand through the cooperation agreements which are:

**a) 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 resulting from the policy 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 semi-annual review of the
Financial and Technical Partners, chaired by the Health Minister surrounded by his Health Ministry Technical and Central Directors and the Public/Private Sector partnership supervisor are also tests for monitoring the NHDP.

To this, we must add control entities, such as: The Financial Auditing Unit, the General State Inspectorate which has the authority, as well as the General Inspectorate of the Ministry, to intervene at all levels of the health care pyramid, the anti-corruption entities.

b) 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. 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 attaining 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.

At the direction of the central and intermediate levels, the local level shall have monitoring and evaluation bodies, i.e. the Health Committee, the Management Committees, the Health Area Supervision Teams (EEZS) and the executive from the Public/Private Sector partnership.

In addition, the National Health Management and Information System (SNIGS), the studies and surveys, are other links in the monitoring-evaluation chain.
8.2 Strengthening of Monitoring and Evaluation

8.2.1 8.2.1- Monitoring the NHDP

Three tools or aids are to be designed for monitoring:

- Progress card for physical constructions
- Semi-annual accounting report
- Management chart for sub-programs.

**Progress card for physical constructions**

This is for the central, technical and department directorates and for the health areas. Upon the start of operations, the card is filled out periodically (quarterly, semi-annually or annually, as applicable) by the supervisor from the facility in question at various levels of the health care pyramid. The card contains information on the kind of operation, notes the planned cost and construction period, indicates progress, specifies any problems and makes recommendations. The card, duly filled out, is sent to the DPP for data entry and processing.

**Semi-annual 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 expenditures made, including the most recent account statements. The semi-annual accounting report is also sent twice yearly to the Inspectorate General of the Ministry, with a copy to the DPP for data entry and processing.

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

**Management chart for sub-programs.**

Progress in achieving the three Millennium Development Objectives 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 selected indicators:
The midpoint evaluation will be carried out based on the periodic reports and the analysis of the supporting documents, i.e. the progress card for physical constructions, the semi-annual accounting report and the sub-program management chart.

8.2.2 Evaluations

The NHDP will be the subject of two evaluations: one at the mid-point which will be conducted at the end of the second three-year plan and the other at the end of the plan. These two evaluations will cover the selected impact indicators. Among other things they involve:

For mortality:
* the infant mortality rate
* the under-five mortality rates
* the maternal mortality rate
* the malaria death rate.

For morbidity
* the AIDS prevalence rate
* the malaria incidence rate
* the tuberculosis incidence rates
ATTACHMENTS

BASIC DOCUMENTS AND LEGAL PROVISIONS

Legal provisions

- Law No. 97-020 of 17 June 1997 setting the conditions for private practice of medical and paramedical professions.
- Order No. 73-38 of 21 April 1973 creating and organizing the national registration boards for doctors, pharmacists, dental surgeons and midwives.
- Order No. 73-14 of 8 February 1973 instituting the Code of Medical Ethics.
- Code of persons and the family in Benin, Decree No. 2009-245 of 9 June 2009 regarding the creation, allocation, organization and operation of the Food and Nutrition Council (CAN) repealing Decree No. 94-103 of 12 April 1994 regarding the creation and operation of the National Committee for Food and Nutrition (CNAN).
- Decree No. 2006-396 of 31 July 2006 regarding the responsibilities, organization and operation of the Health Ministry.
- Decree No 2006-386 of 31 July 2006 containing the responsibilities, organization and operation of the Health Ministry.
- Decree No. 2006-087 of 8 March 2006 approving the national policy on hospital hygiene in the Republic of Benin.
- Decree No. 2005-611 of 28 September 2005 reorganizing the base of the Republic of Benin health pyramid into health areas;
- Decree No. 2002-484 of 15 November 2002 providing for rational management of biomedical waste in the Republic of Benin.
- Decree No. 2002-0113 of 21 May 2002 approving the Articles of Association of the area hospitals.
- Decree No. 2000-450 of 11 September 2000 regarding the application of 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.
- Decree No. 2000-449 of 11 September 2000 regarding the application of 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. 2000-441 of 17 August 2000 regarding the application of 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. 2000-410 of 11 September 2000 regarding the application of 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.
- Decree No. 2000-409 of 17 August 2000 regarding the application of Law No. 97-020 of 17 June 1997 determining the conditions for the private practice of nursing.
- Decree No. 98-77 of 6 March 1988 providing for the special status of the Public Health Personnel Corps.
- Decree No. 97-643 dated 31 December 1997 regarding the Regulation of the Sale of Breast Milk Substitutes and Baby Food.
- 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. 85-112 of 5 April 1985 creating the National Committee for Civil Protection.
- The Decree providing for the creation, responsibilities, composition and operation of a consultation framework for the partnership between the public and private sectors.
- Decree No. 3898/MSP/DC/SA of 31 July 2006 regarding the responsibilities, organization and operation of the National Directorate of Health Protection.
- Inter-ministerial Decree No. 2000/MSP/DC/SGM/DSF/SA dated 07 April 1999 regarding the creation and appointment of members of the National Committee for the Coordination of Activities for the Amis de Bébés Hospital Initiative (IHAB).
- Decree No. 3667/MSP/DC/SGM/DNPS/SSHCC determining the conditions and standards for health care facilities covered by Law No. 97-020 of 17 June 1997.
- Decree No. 2723/MSP/DC/SGM/DNPS regarding the creation and appointment of members to the technical commission responsible for examining applications authorizing private practice and opening health care facilities for the medical and paramedical professions.

**Framework documents**
- Declaration of the national policy for protection, encouragement and promotion of breastfeeding adopted on 21 December 1992 and revised on 28 December 2009;
- The policy and development strategies document for the nursing and obstetrics care sub-sector.
- The 2002-2006 policy and development strategies document for the health sector.
- The policy and development strategies document for the partnership between the public and private sectors in the field of health (2002-2006).
- The 2003-2007 national development policy and strategies document for the biomedical analysis laboratories sub-sector.
- National pharmaceuticals policy document, 2008-2012;
- The national policy document for control of malaria and the strategic implementation framework, 2005;
- The national policy on school and university health, developed in 2006.
- The emergency plan for revitalizing the health sector and improving hospital management, 2006.
- The 2007-2011 Benin EPI complete multi-year plan.
- The 2009-2013 Benin EPI complete multi-year plan.
- The 2006-2010 strategic malaria control plan.
- Protocols for family health services, revised in February 2006.
- The national strategy to reduce maternal and neonatal mortality (Road map of the African Union and the Vision 2010 Initiative), March 2006.
- Five-year plan for operational implementation of the national strategy to reduce maternal and neonatal mortality, 2006 - 2010.
- The national strategy for securing reproductive health products, August 2006.