

PJ-ABZ-949

**RAPID ASSESSMENT OF
HEALTH SECTOR IN BENIN**

November 11, 10, 1006

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ACRONYMS

ADB	Asian Development Bank
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCG	Bacillus Calmette Guerin (tuberculosis vaccine)
CEDA	Centre pour l'Environnement et le Développement en Afrique
CFA	Central Franc African
CNHU	Centre National Hospitalo-Universitaire
COGEC	Comité de Gestion de Circonscription
COGES	Comité de Gestion des Souprefectures
CRS	Catholic Relief Services
DHS	Demographic Health Survey
DNPS	Direction National de Planification Sanitaire
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
EPI	Expanded Program on Immunization
FAC	Cooperative Assitance Fund
GOB	Government of Benin
GTZ	German Technical Cooperation Agency
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HQ	Headquarters
IDB	Inter-American Development Bank
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
ISS	Institut de Science de Santé
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
OCCGE	Organisation de Coordination de Contrôle des Grandes Endémies
ORS	Oral Rehydration Solution
PSI	Population Services International
PVO	Private Voluntary Organization
SNIGS	Système National d'Information et de Gestion de la Santé
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

PURPOSE AND ACTIVITIES

BASICS Technical Officer Jean-Jacques Frère and consultant Maryse Simonet visited Benin from November 11 - 19, 1996. The purpose of this mission was twofold: 1) to identify key areas for future child survival interventions, and 2) to assist USAID/Benin in defining a strategic basis to prepare for a broader family health project that will integrate maternal and child health, family planning and HIV/AIDS.

Despite the short-term character of this assignment, it was both pleasant and productive due to the support provided by USAID Representative Thomas Park and Health Technical Assistant Susan Woolf, who greatly helped the BASICS team by giving logistical support as well as technical guidance. Mr. Park and Ms. Woolf accompanied the team members during almost all visits made to governmental institutions, bilateral and multilateral donors and members of the PVO/NGO community. This made it possible for the team, despite the time constraints, to collect a significant amount of useful information pertaining to the health sector in Benin from several governmental and non governmental sources. Dr. Simonet benefitted from the presence of a Futures Group team, which was carrying out a field visit in Abomey, by using the opportunity to gather additional information at the facility level as well as from the Departmental Direction for Health. An abundance of literature about the health sector exists in Benin that contains the findings of several sector assessments, studies and evaluations. The team devoted a significant amount of time in reviewing these various documents that include, in particular, the recent DHS draft report, a strategy document prepared by the GOB, the UNICEF mid-term review paper, and several World Bank reports.

This report presents the main findings of this rapid assessment of the health sector in Benin as well as recommendations that are designed to help USAID/Benin in defining and targeting its interventions for child survival within the broader framework of an integrated family health project. Additional notes prepared by Dr. Simonet, as well as a list of the main documents reviewed by the team, are presented as appendices.

BACKGROUND

Democratic rule was established in Benin in 1991 and a democratically elected President, Nicéphore Soglo, ruled the country until the elections of 1996. These elections resulted in the re-election of former ruler Dr. Kerekou, former head of the Marxist-Leninist regime that prevailed in Benin between 1972 and 1990. As a result of this somewhat unexpected change in the political arena, most senior posts in the Ministry of Health (among others) were shifted to newcomers and out of the five Directorates in the MOH, only one director, the Director of Planning, Coordination and Evaluation, has kept his post. The Ministry of Health has become the Ministry of Health and Social Protection and of the Feminine Condition and has to face additional challenges, in addition to those of the health sector itself. Central institutions were always described as weak in terms of management and planning capacities but the current situation in

the MOH renders the task of most donors, including USAID, more complex. The Minister herself has already been severely criticized in the local press for a supposedly poor handling of cholera and yellow fever outbreaks in the north, and in the Parliament when she had to defend an administrative reform that will result in the progressive creation of 36 health zones.

However, while the MOH appears rather feeble, it seems that the main health sector reforms instituted during the previous period are not at stake. On the contrary, at least in terms of population issues, the current regime has a much more open attitude towards birth spacing. Major components of the reform such as decentralization, community participation and an improvement of the quality of care and of the referral system have been endorsed by the government. The recent expansion of the Ministry's portfolio with the inclusion of feminine condition and social protection may, however, result in a certain lack of focus on what should remain priorities within the health sector. Decentralization is incomplete and stagnates despite support provided by some donors to some departmental direction. Thirty-six new health zones, equivalent to health districts, should be progressively established and be substituted for the current 77 *sous prefectures* in order to facilitate decentralized management and planning as well as increase the efficiency of resource allocations and the rehabilitation of referral units. The *sous prefectures* will continue to serve as administrative regions.

Benin has been praised for three major achievements in the recent past: the Bamako Initiative, the Centrale d'Achat, and its expanded program of immunization. However, severe health problems still persist in Benin. Although infant mortality has significantly declined during the past 20 years (from 135/1000 to 93/1000), it remains high. The DHS suggests that very little gain was obtained between 1970 and 1985 (116/1000-113/1000) but that progress did take place in the recent five to 10 years. Mortality for children under five years of age is also very high; out of 1000 births, 166 children will die before their fifth birthday. Maternal mortality is reported as 473 maternal deaths per 100,000 births; however, given the high level of under-reporting, it is probably around 800 deaths per 100,000 births. The main causes of infant and child mortality are malaria, diarrheal diseases, and respiratory infections.

Malnutrition

Malnutrition is highly prevalent. Although no results from a national study are currently available, estimates suggest that between 20 and 40 percent of children under five years of age are malnourished with 3 percent to 6 percent being severely malnourished. Iodine deficiency is endemic in certain areas but is being addressed by a successful UNICEF program of production of iodized salt. Vitamin A deficiencies have also been documented but little information is available about the effectiveness of vitamin A capsule distributions. While 97 percent of infants are breastfed in Benin, exclusive breastfeeding under four months of age remains low at 14 percent; 69 percent of infants receive solid or liquid food before they reach four months of age. The DHS suggests, however, that this proportion represents progress compared to baseline data collected by UNICEF two years ago when less than 1 percent of infants were exclusively breastfed.

Diarrheal Diseases

The incidence of diarrhea varies, depending on the region, between 3.5 and 6 episodes per year (in the department of Mono). Overall, little difference exists between urban and rural children (DHS 1996) which suggests that the roots of the problem may be found more in inappropriate behaviors than in the availability of better water and sanitation. However, no information was offered about the type of water and sanitation facilities available in the urban strata.

Social marketing of ORS (distributed under the brand name ORACEL by PSI) has been very successful. However, UNICEF is the current supplier of ORS sachets (re-conditioned into ORACEL) and this source seems to be in jeopardy because USAID funds have to be used to buy the product from an American manufacturer. The proportion of children receiving ORS or a home made solution of sugar and salt is approximately 33 percent. Additional information about knowledge and utilization of ORS has been collected by the SNIGS and suggests that a higher proportion of mothers (compared to the DHS statistics) uses rehydration salts; however, the same source indicates that correct case management of diarrhea, including continued feeding and an increase in the quantity of fluids, is only 20 percent (UNICEF).

Expanded Program on Immunization

The Expanded Program on Immunization (EPI) in Benin is generally considered as a success story. The coverage rate is 85 percent for BCG, 70 percent for DTP3, and 64 percent for measles. The proportion of infants fully immunized is lower at 55.6 percent (DHS). In terms of sustainability, an encouraging step has been taken by the GOB which has allocated a small share of its own budget to the purchase of vaccines (10 percent of the cost). However, concerns exist about the aging cold chain and the costs of outreach services, which have been heavily subsidized by UNICEF and which provide 38 percent of the vaccination coverage. An acute respiratory infection program exists on paper but is coordinated by a professor of pneumology who works at the CNHU and it is doubtful that correct case management practices have made their way down to facility level.

Malaria

The malaria control program is attached to the DNPS and the team was not able to gather evidence of the effectiveness of the program. An OCCGE center for malaria studies has been established in Benin and good data about the time and space distribution of malaria as well as on chemoresistance to chloroquine should be available. Both PSI and the DNPS have expressed a strong interest in distributing impregnated bednets. Two local NGOs have been involved in the production of impregnated bednets but apparently on a very limited basis. Important issues such as the availability and cost of insecticides for primary impregnation and re-impregnation, the local production capacity, and the overall affordability of bednets have to be carefully studied, even if acceptability is thought to be high, before social marketing is undertaken on a significant scale.

Drug Availability

User fees have been implemented in almost all facilities under the Bamako Initiative approach and generic drugs are widely available through the Centrale d'Achat, which is now capable of supplying all public health facilities with essential drugs. Unfortunately, the quality of care in most public health facilities is considered as low. People refer to "bad practices" in government facilities, which may imply poor motivation, insufficient training, and a lack of supervision. Utilization remains insufficient and consists of .2 -.3 visits per person and per year. Alternative sources of health care include private providers, traditional healers and self-medication. Self-medication is apparently very common due to a huge parallel market of imported or smuggled drugs of uncertain quality.

As the budget allocated by the state to the health sector remains under 5 percent (approximately 10 percent if development assistance is included), community participation has been able to absorb a growing share of health expenditures. At the health facility level, revenues generated by the imposition of user fees for drugs and consultations exceed the cost of providing services by 27 percent. This recovery rate (revenues versus expenditures) varies from 10 percent in the department of Atacora to 57.4 percent in Zou. This success in generating revenues may only be relative; some health facilities are quite prosperous but others experience difficulties in recovering the cost of drugs and recurrent expenditures. Moreover, as 75 percent of revenues come from the selling of drugs, this obviously has negative effects on the rationalizing of drug prescription and the containment of overall costs. Also, in terms of equity, the current payment scheme does not seem to include any defined mechanism to protect the poor, since current prices are thought to be a major deterrent to utilization of public facilities by the poor. The poorest segment of the population is likely to be more sensitive to prices than the better off, and there may be a dangerous delay in the seeking of health care. For the truly indigent the situation may be intolerable.

Donors

A number of donors support the health sector in Benin. In addition to WHO, UNICEF, UNFPA and the European Union, ADB, IDB and the World Bank, bilateral donors are also very active. These include the Swiss Cooperation, German GTZ, the Dutch Cooperation, People's Republic of China bilateral aid and the French FAC. Little coordination exists between these donors. The government is unable or unwilling to provide effective coordination and the donors themselves are well entrenched in their own priorities and experiences. Recently, though, the European Union has been proactive in getting donors together and a donors/government meeting is to be held next week to follow-up on the January 1995 "round table" and to present the updated strategies for the health sector.

Although only fragmentary information was collected by the BASICS team, it seems that, in general, donors have 1) lost faith in the capacity of the central level, and 2) preferred to target their interventions at the departmental or even at more peripheral levels in selected regions of the

country. Criteria for this kind of geographic targeting is uncertain; however, given the sometimes vertical nature of interventions, USAID should probably identify geographic areas where its activities those of other donors would be complementary and achievable. Another option might be to select future areas to receive USAID's assistance on the basis of need, as disparities exist between regions with an unequal distribution of economic and human resources available from donors and government.

NGOs

Since the establishment of democracy in 1991, and not unlike what happened in other West African countries, local NGOs have started to proliferate. Many are involved in the provision of some form of health services and are emerging as one of the most important sources of innovative models of community services. The CEDA carried out an assessment of NGOs operating in Benin and identified more than 600 groups in addition to 28 federations and networks. These NGOs vary widely in terms of size, capacity and aims but some are viewed as effective partners in the delivery of health and family planning services, IEC and the promotion of better health and nutrition practices at community and household level. The large number of independent NGOs is in itself a major operational problem both in identifying them and in communicating with so many separate organizations. Furthermore, the local solutions generated by NGOs are typically not disseminated effectively. A collective organizational structure is necessary for organizations such as USAID to communicate and work effectively with small scattered NGOs.

PVOs

In order to address the problems mentioned in the above paragraph in terms of PVOs, USAID may rely on several major PVOs that operate in Benin. United States-based PVOs include Catholic Relief Services (CATHWELL) and Africare. CRS is especially active in the area of nutrition and Africare has launched an interesting initiative of capacity building with a group of local NGOs under the BINGO project. In addition, Africare is completing the design of a child survival project for the development and testing of interventions appropriate to the Benin environment. This project may offer the possibility of some form of partnership with BASICS. PSI has been very successful in the marketing of condoms (PRUDENCE) and ORS (ORACEL), using 1,500 distribution points. PSI complements its marketing activities with IEC and is now interested in exploring the possibility of marketing impregnated bednets for malaria control.

Private Sector

For 1995, the World Bank estimates that the private sector accounted for 12.9 billion CFA (versus 11 billion for the public sector) spent on health services. Of this amount, 73 percent was spent on drugs. Limited information is available about the number of private providers, the range and quality of services they provide and their distribution throughout the country. The Ministry mentions (in *Strategies Sante*) that the private sector provides 25 percent of all health services and 60 percent of hospital care. In 1992, 13 private hospitals, 56 maternities, 46 private clinics

and 47 private nurses were registered. In addition, 72 private pharmacies and more than 2,000 depots were licensed. Although 40 new doctors continue to graduate from the medical school (ISS) each year, the current number of non-publically employed practitioners is probably higher due to a freeze in government hiring between 1986 and 1994. Ten “cooperative health clinics” have been subsidized to allow unemployed doctors, midwives and nurses to deliver medical services on a private basis. These clinics seem to function in a satisfactory way but additional information about this interesting initiative would be desirable. In addition to freeing up resources much needed by the public sector by providing services to those who can afford to pay more, private providers could also be used effectively to deliver public health services such as family planning, prenatal care, vaccination services, and health education. Mechanisms to ensure a true partnership between the two sectors should be designed and tested, preferably at a decentralized level.

RECOMMENDATIONS

The BASICS team is fully aware of the limits of this preliminary assessment of potential interventions. Additional information is needed about the distribution and the role of other donors, the quality of child survival services in both the public and the private sectors, the effectiveness of IEC interventions, and the non-public sector in general. Given the variety of external support provided to the health sector and the absence of a real coordination mechanism established by the government, it would be essential for USAID to select carefully its areas of intervention from the geographic, administrative, and technical points of view. A more thorough analysis is necessary to identify imbalances in the current allocation of foreign aid and the specific role and magnitude of multi/bilateral donors interventions in each region.

Engaging in a capacity building effort at the central level would probably not be very effective. However, the provision of technical support to one or two departments (intermediate level) would be legitimate in as much as they represent the Ministry in the region and can be instrumental in improving planning, management and the quality of care. However, a further degree of decentralization may be even more appropriate as the responsibility of delivering services is in the hands of doctors in the districts, or, in the future, of the supervisory doctors in the region.

Existing information strongly suggests that an impact on children’s lives would be obtained by 1) focusing on better case management (and prevention, if the marketing of bednets proved to be a feasible intervention) of malaria, diarrhea, and respiratory infections; and 2) the promotion of best practices in nutrition and breastfeeding.

A number of tools exist or are under development to address the first objective. The IMCI training approach bears the potential to improve the quality of care in both public and private facilities while rationalizing drug prescription and containing the cost of health care. The Ministry, the USAID Mission and Africare have expressed interest in adopting IMCI as an

innovative and cost effective way to address childhood illnesses in Benin. Despite all the weaknesses of the current system, physical accessibility to health centers is better than in neighboring countries and essential drugs are, by and large, available. But a number of steps are necessary for a successful implementation of IMCI. For example, the identification of key actors within the MOH, the assignment of clear responsibilities and the reaching of a consensus between the various training institutions are crucial for success.

In addition, the current treatment algorithms need to be reviewed to determine if they are in harmony with WHO recommendations and to assess their compatibility with IMCI. Then, the IMCI modules will have to be adapted to the Beninois context and a core of West Africa trainers will have to be trained to organize the first training of trainers in Benin itself (this is due to happen during the first quarter of 1997). In summary, while introducing IMCI in Benin is a worthwhile effort, caution must be paid to the timing of this activity and the need to meet some preliminary conditions. WHO support is essential and active discussions will have to be initiated as soon as a WHO representative is posted in Benin.

The assessment of nutritional status and nutritional counseling are part of IMCI but additional work will be needed to develop the nutrition content and counseling approach of the IMCI course. Collaboration between BASICS and the new centrally funded breastfeeding and nutrition project in Washington seems desirable to identify a limited number of key nutrition (including breastfeeding) behaviors and associated interventions for achieving them.

Finally, USAID could support activities to inform and persuade decision makers of the importance and feasibility of reducing malnutrition. Specific tools such as PROFILES have been developed and used in other West African countries for data-based policy analysis and advocacy. Dakar-based BASICS Regional Advisor Dr. Serigne Diene would be available for such an activity should the Ministry and other donors be interested and supportive.

An integrated approach to reproductive health, HIV/AIDS and MCH services should support interventions beyond the traditional public health facility venue. As only a small proportion of sick children are brought to modern health centers, additional vehicles must be identified to reach the caretaker at the community and household level. The private sector offers an untapped potential for the delivery of quality family planning and MCH services. Neither the doctors nor the midwives seem to be very well organized; three entities (Order, Union, and Association) coexist without very clear mandates and, probably, with some degree of rivalry. Once a given region (or *sous prefecture* or zone) has been selected, a first step will be to identify all private, for profit and non-profit providers. Under the coordination of the local DDS or head doctor of the zone, interventions that are needed to achieve a satisfactory degree of partnership at the local level must be defined. This may take the form of joint training and planning, reporting, or even regional planning.

The type of support (training, equipment, or even small grants) required to achieve this goal will have to be discussed further, preferably at the decentralized level. Similarly, the capacity of carefully selected local NGOs can be improved (as with the Africare BINGO project) to increase

their effectiveness in delivering health and family planning services or in influencing caretakers' behavior, which has the greatest impact on child survival and reproductive health. The COGES and COGEC are other important, yet insufficiently explored ways, to facilitate the use of curative and preventive services. This would be done through education and promotion activities as well as through social mobilization to accomplish the goals, and would include collaboration with other community organizations and local and traditional leaders. Community participation has been widely encouraged but is apparently restricted to the management of cost recovery funds at the health center level. The COGES/COGEC are also, in principle, involved in health promotion activities but whether this is actually taking place is unclear (the Swiss cooperation agency is carrying out an evaluation).

FOLLOW-UP ACTIONS (to be discussed with the Mission)

As soon as USAID/Benin has completed its own strategic planning/result-package exercise (January 1997), it may be appropriate to plan a follow-up visit by an other BASICS team to fill the information gap and to assist the Mission in defining operational strategies which would be useful in the preparation of a family health project. Possibilities of follow-up interventions to be carried out in the next six to 12 months include:

- 1) Capitalize on other donors' experiences and review existing projects to present lessons learned (what worked and what did not) in a systematic manner in order to select technical and geographic areas of interventions. This should include a mapping of the different projects and would require sufficient time in the field. (Three weeks in February or March; two BASICS consultants.)
- 2) Carry out an assessment of private providers' behavior and identify areas of intervention as well as flaws in the current policy environment that should be corrected.
- 3) Work with local NGOs that have established a partnership with Africare or CRS and assess their current capacity for IEC and community outreach activities. (Regional Advisor Yaya Drabo or consultant identified with the help of BASICS HQ.)
- 4) Carefully assess the current case management situation and the potential for IMCI with all parties involved (MOH, WHO, UNICEF, training institutions and the private sector). This could be coordinated by the BASICS regional office with support from BASICS HQ.
- 5) Use the new breastfeeding and nutrition project to identify interventions with public and private providers, including NGOs. Collaboration with BASICS, using Dr. Serigne Diene's presence in Dakar, would be a possibility. (Two-week joint mission with BASICS and the nutrition project; first semester of 1997.)

- 6) Carry out a marketing study with PSI (possibly with BASICS' help) to assess the availability of bednets (locally manufactured or imported) and impregnation products and to prepare preliminary costs estimates. This would require a social marketing specialist from BASICS (at least two weeks) and malariologist (five days) to assess the expected effectiveness of impregnated nets in reducing morbidity/mortality due to malaria in the population aged under five years in Benin.

APPENDICES

APPENDIX A

APPENDIX A
FIELD NOTES FROM MARYSE SIMONET

1. PUBLIC HEALTH SYSTEM

1.1. CENTRAL LEVEL

- The organization chart has no specific PHC division, this may lead to a lack of coordination in the support of the successful PHC program.
- There is no General Secretary in the MSPSCF, according to WB, the position will be created.
- The rotating three year plan has not been updated since 94.
- A document on the health sector strategy for 1995-99 has just been drafted and circulated (see summary at the end of the notes).
- the CNEEP is not working well but the MSPSCF strategy is to strengthen it.
- round tables have six sub committees:
 - health areas
 - decentralization
 - financing
 - collaboration with private sector
 - hospitals policy
 - essential drugs

The round tables were held in early 1995. the consultants did not hear about any other meetings except at the level of the sub committees.

A round table is scheduled for November 21, 1996. An informal donors meeting, initiated by the E.U. will take place before.

- The Division de la Protection Sanitaire is interested in impregnated bednets and tries to identify suppliers. Two or three NGOs already distribute those bednets.

1.2. PERIPHERY

1.2.1. DECENTRALIZATION

There is six "Direction Departementale de la Santé". those offices have been created more than ten years ago. Until the early 1990s, the DDS role has been limited to a representation of the MSPSCF in one unique person: the Director. Recently, the organization chart of the DDS has been filled and some activities are supported by donors such as the Swiss (Zou and Borgou Departments) and E.U (Southern part of the country). Donors pay for some of the recurrent costs and training activities which focus on developing planning and budgeting capacities.

We visited the DDS of Abomey, it is staffed with several physicians and its activities are supported by the Swiss Cooperation. The Director studied public health at the CESAG in Dakar with a fellowship from the Swiss Cooperation.

The DDS is about to conduct a participatory evaluation of its three year action plan (1994-1996). This evaluation may be linked with central level plans or with the Swiss project program. The Director reported that his office provides technical support to the Sub-Prefecture level for the design of annual operation plans. Other sectors, community representatives and some NGOs participate to this design. The DDS is about to receive training for this activity and for the design and budgeting of a three year departmental plan. The training will be supported by numerous donors.

The DDS of Abomey has no bank account. It receives supplies directly from the MSPSCF. At the Sub-Prefecture level (equivalent of the WHO health district), supervision and drugs transportation costs are funded by the cost recovery system. A percentage of user fees collected at the health centers supports the activities of the district team (one physician, one midwife and one person in charge of EPI). Therefore, the head of the Sub-Prefecture has some decentralized resources for his functioning. The director of Abomey DDS mentioned that his office, by times, receives some funds from the sub-Prefectural level to finance the activities of the DDS, he pointed out that such practices are not officially recognized.

The picture is likely to differ in other Departments. For example, E.U piloted decentralized financing of DDS activities. E.U have provided technical assistance to the DDS, the responsibility of the funds, initially shared with expatriate technical assistants is now devoted to the DDS. Those decentralized funds support mainly training activities annually planned. Disbursements are ordered by the Prefet and controlled by the "receveur général des finances" at the departmental level. In the Northern Departments, GTZ operates mainly at the Sub-Prefecture level and appeared skeptical with respect to the potential role of the DDS.

According to the Director in the DDS of Abomey, human resources management has somewhat been decentralized. At the central level, decisions to redeploy staff across regions are discussed with DDS Directors, representatives of midwives, doctors, nurses and other actors. Within the Department, the Director decides of personnel movements across Sub-Prefectures and sometimes within Sub-Prefecture. The Director complained about the lack of personnel, in seven out of seventy primary health care units, either the nurse or the midwife is lacking. Thirty two out of the four hundred and thirty four employees of the MSPSCF in the Department are paid by the "Fond National de solidarité pour l'emploi". This staff is recruited at the National level for one year and health officials are reluctant to train and use at best those temporary employees. When interviewed, other donors suggested that there were some controversies over the recruitment practices for 1996 and that a new competitive examination was scheduled for January 1997.

1.2.2. COORDINATION WITH PRIVATE SECTOR

The DDS is neither empowered nor encouraged to coordinate private sector activities. The Director mentioned that some NGOs searched for technical advice and support from the DDS. Other private organizations start their program with an authorization of the Central level and bypass the DDS. The Central level does not inform the DDS. When private service providers such as religious organizations do not comply to existing norms, The DDS informs them and tries to reach a consensus. The Director is interested in making an inventory of private organizations and plans to involve them in the planning process.

1.2.3. EPI

The Director shares UNICEF concerns with respect to the replacement of the refrigerators. He has no particular problem with the cold chain, except the need to train several new nurses and to reinforce the monitoring of the temperature in the health centers. He mentioned having one week stock out last year but given his recent nomination as Director he ignores the causes of the problem.

1.2.4. HEALTH DISTRICTS

The strategy of the MSPSCF is to redesign health areas using technical rather than politico-administrative criteria. At present, the six Departments are divided in 77 Sub-Prefectures. The Sub-Prefecture is according to the norms defined in 1982, an equivalent of health district since there is to be basic surgery and health centers supervision capacities. Fifty three out of the seventy seven Sub-Prefectures do not have the appropriate resources. In rural areas, the average Sub-Prefectures has a population of fifty to sixty thousand inhabitants .

Given its limited resources, the MSPSCF proposes to revise the boundaries of the health district. The new health areas should cover approximately hundred to hundred fifty thousand inhabitants and the country would have 36 health districts. each district being made of two or three Sub-Prefectures. This courageous proposition is politically very sensitive, therefore, its implementation is at the level of a pilot experience in two districts. If replicated, those district would provide a convenient entry point for institutional development at the periphery and for coordination of health sector activities.

1.3. PROVISION OF SERVICES

The low utilization of public services has conflicting explanations depending on the organizations:

- the quality of services, particularly patients reception is criticized. There is no structured intervention of donors that emphasize modern approaches to quality of services. There is no standards of quality defined at the National level beyond availability of infrastructures, personnel and supplies.

Treatment algorithms utilization is low (57 percent in the health centers). New algorithms have just been developed and a training is scheduled for January 1996, the quality of this tool and of the training may be worth being studied.

There is tremendous problem of personnel motivation and availability in the public sector. Some NGOs (such as AFVP: French volunteers financed by E.U) pilot projects where part of the staff is recruited and paid by the community.

- affordability of services is another issue.

There is two pilot experiences on mutual funds for health. One is led by the CIDR (Dr Galland) under the Swiss project, the other is led by a local NGO; "Institut de participation du Benin" under the French Cooperation project. It would be interesting to verify that the sub-commissions of the table ronde provide an appropriate environment to share lessons learnt.

The price structure of public services may also be studied and improved as needed.

Cash availability is said to be low, especially for women, most community based projects have an income generating component. Other people believe that cultural practices prevent from spending on health. Each donor has probably done its own investigations, in addition to the Nationwide surveys on household health expenditures (UNDP) and the health and education sectors expenditure review. It may be worth collecting documents available at donors and NGO level to identify gaps in information and build upon experiences.

2. DONORS

Among the main donors, the team met E.U, GTZ, Swiss Cooperation, French Cooperation, UNICEF, WHO and World Bank. Other important organizations are: BAD, BID, UNDP, FNUAP, Danish, Dutch, Chinese and Canadian Cooperations. Bilateral donors tend to develop a wide range of activities within a limited geographical area. Approaches vary among those organization: the E.U supports Sub-Prefectural, central and departmental levels (primary and secondary care), the Swiss Cooperation project has a similar approach with less emphasis on the central level (the Swiss financing of the PDSS project is managed by the WB) and GTZ focus is the Sub-Prefecture or district level. As donors range of activities vary, they may overlap on geographical areas.

There is a general trend among donors to avoid funding central activities. The most involved there may be the E.U and it may be worth reading their forthcoming mid-term evaluation report.

3. PRIVATE SECTOR

3.1. FIELD VISITS

The mission did not visit private profit organizations and religious organizations. Contact were made with three International NGOs (Africare, PSI and Terre Des Hommes) and one local NGO (Survie de la mère et de l'enfant).

Terre des hommes is working in the ZOU Department. It is a Swiss NGO financed by the Swiss Cooperation. They are running the pediatric departments of the hospitals of Bohicon and Abomey (120 beds). These clinics are managed separately from the rest of the hospitals. The NGO has recruited its own local personnel who should be hired by the MSPSCF later on. Patients pay a bulk sum of 8000 FCFA, for any pathology and any length of stay. Quantitative data on clinics activities were not available. Malnutrition cases are housed for two weeks at the nutrition center in Bohicon after hospitalization. This service is free of charge and food is provided for cooking demonstrations. Back to the village, a physician is regularly visiting the children during several month. Although the nutrition center may be viewed as a model, the sustainability of this program is to be demonstrated.

Survie de la mère et de l'enfant is located in Dassa. This NGO is born following the death of a women during birth-giving. A group of young people initiated a dialogue with villagers on the subject and, later on, the head of the district and International Organizations encouraged the group to create an NGO. From 1990 to 1995, NGO members trained by the Doctor of the Sub-Prefecture conducted IEC sessions in villages located within walking distance.

Since 1995, the NGO receives financial support and training from different projects and donors (Africare, National water and Sanitation service, DANIDA..). The NGO employs a total of 16 persons: 11 at technical posts and 5 for support activities. They have recently received mobylettes to visit their audience: 22 groups of 25 women.

Increasingly donors turn to the private sector for the implementation of their projects. The multiplication of projects may overburden these small NGOs thereby reducing the quality of the services and duplicating resources for the same activities. Africare trained the staff of Survie de la mère et de l'enfant in management, and, provided a small grant. When interviewed, Africare mentioned a lack of transparency in the use of financial resources given to this NGO by different projects.

Survie de la mère et de l'enfant has developed a strong collaboration with the public health system, the head of the district trained the staff of the NGO and IEC sessions are conducted concomitantly with outreach EPI strategies. However, there is no formal mechanism of collaboration with the public sector such as exchanges of plans and reports or regular meetings. Projects evaluation sessions gather several similar NGOs, this creates some coordination mechanisms for a limited number of NGOs involved in the same project. Survie de la mère et de l'enfant is skeptical about Nationwide umbrella organizations, this NGO pulled out of the CONGAB (Conseil des ONG en Activité au Bénin) because of the lack of transparency, the lack of true participation, and, conflicts of interests among members.

Africare is currently working with NGOs, the project BINGO has trained them in human and financial resources management. Africare provided small grants for NGOs as the basis of a practical exercise. Africare expressed the need for training NGOs in their technical field and, at the National level, the need for some criteria to identify reliable NGOs.

AGEPIP is an agency supported by the World Bank Division of Structural Adjustment, it is aimed at managing a social fund against poverty involving numerous donors. NGOs implement micro-programs and are supervised by this agency (the GOB was considered as unable to carry this supervision activity). AGEPIP will have some NGOs selection criteria that may be useful either for other projects or to establish regulations for the private sector.

3.2. GENERAL FINDINGS

The private sector is rapidly expanding and offers opportunities to implement projects. There is a wide variety of organizations:

- some are funded by donors such as GTZ to carry training activities for health centers management committees (Africa Obota).
- ten cooperative clinics have been created to absorb unemployed health staff. The physicians, nurses and midwife create an association and receive grants to establish a clinic. Some of these clinics behave as profit organizations and others as non-profit organizations. A workshop is scheduled in December 1996 to evaluate this initiative.
- National NGOs and some donors such as the Swiss Cooperation provide grants to physicians who are requested to join an association of physicians. They receive training, grants or loans, and, equipment to set up small private clinics.
- At the village level, many NGOs run IEC projects with income generating activities.
- The ABPF has a nationwide coverage in family planning. Although the team did not visit the NGO, it may be of interest for later activities. The NGO is the main supplier of contraceptives in the country. Today, the drugs central supply system (CAME) is reliable, the MSPSCF plans to add contraceptives to the list of essential drugs and to integrate contraceptive supplies to the National public system. Therefore, ABPF may consider further developing other existing activities or initiating new ones. Informal sources revealed some skepticism about the efficiency of this NGO.

There is a lack of policies and coordination, particularly at the National level. The draft document describing the National health strategy for 1995-99 reflects this situation with its limited description of the private sector where only confessionnal hospitals are considered. There is no tool to classify private service providers, no regulations and no pricing policy. Tools to assess and officially recognize different types of NGOs are lacking, a code for appropriate NGOs behavior may also be useful.

4. INTERVENTIONS - APPROACHES TO THE HEALTH SECTOR

4.1. Geographical area of intervention

USAID supports specific interventions who need to be implemented in a convenient environment (i.e: availability of infrastructures, staff, equipment, supplies..). There are numerous players in Benin whose interventions are not guided by a structured national health development program: the complexity of the picture may lead to duplications.

To precisely identify other donors input, a mapping of donors geographical coverage and activities is necessary. The first step is to define a framework to collect information on donors activities in a standardized way. This framework should analyze, along time, donors support at each level of the health system, in each type of health sector related activities and in each geographical area of the country.

4.2. Health financing and financial accessibility

There is a need to study existing sources of information to define people ability to pay for health services. Prices in the public sector were not studied during this mission and there is no pricing policy for the private sector. There may be gaps in information which need to be filled, otherwise, a project aimed at developing or improving services (private or public) may have no impact because of financial obstacles. In addition, financial accessibility is on the agenda of the MSPSCF (see the health sector strategy document), the MSPSCF may appreciate technical support to solve the question.

4.3. Lessons to be learned

As numerous donors and NGOs are active in the country, there are a lot of reports and pilot experiences. Coordination has been rather weak until the E.U took the lead. To avoid duplication and to select truly innovative interventions, USAID should collect as much documents and information as possible and draw lessons from it.

4.4. Private sector

The MSPSCF has a very low absorptive capacity (tremendous problems of personnel availability and motivation). Unemployment of medical staff is a significant problem in the country, and, the rapidly expanding private sector offers an opportunity.

Local NGOs may be more indicated to reach rural populations, private for profit sector may be considered to answer part of the demand in urban settings. However, this question is to be studied.

When working with private sector, special attention should be paid to equity and coordination. Coordination on technical issues need a national approach whereas coordination in operations can be done at the district level, using the MSPSCF structures.

There is a need to define the rules for the private sector at the national level. External support to the policy making process may be useful, at the mean time, pilot implementation of a set of rules within a project may provide some insights and tangible results.

4.5. Public sector

The moving situation at the central level does not appear to be very attractive for most donors. The central level should be involved in technical decisions and could benefit from technical support in policy related interventions. Some policy areas relevant to potential USAID interventions at the operations level can be: private sector, health financing, HIV/AIDS.

Within a project, resources devoted to institutional development could target the operation level to develop capacities for an improved coordination of public and private organizations involved in health.

The new health areas would be the ideal beneficiaries of capacity building activities: the likelihood to see tangible results is rather high since those district teams are pillars of the PHC system. Close to health centers and management committees, they are rather responsive to community needs. The new health areas are also covering an appropriate population to justify investments in terms of cost-effectiveness. In addition, their limited number (36) makes them more reachable. However, this reform is not yet implemented and the absorptive capacity of the new districts will have to be studied.

The new areas may not be implemented. Then, the choice is between the Sub-Prefecture (77 units) and the Department (6 units). The Sub-Prefectures have the same strength as the new districts except that each has a smaller target population and many are not properly staffed and equipped. It may appear more simple to collaborate with the Departmental level, however, the

structure may be more bureaucratic and less responsive to community needs than the Sub-Prefecture.

4.6. Africare

Africare has already some experience with NGOs and is developing a project proposal for child survival. The presence of this NGO in the field is an opportunity for the USAID mission to test several approaches. Africare is interested in collaborating with BASICS in Benin, this kind of collaboration should be encouraged whenever possible.

ADDITIONAL DOCUMENTS OF POTENTIAL INTEREST (suggestions)

- PIP (Programme d'Investissements Publics) at the MP or WB
- list of NGOs of the WB
- forthcoming mid-term evaluation report AEDES/FED
- Benin cold chain assessment by WHO/Ghana (contact: UNICEF)
- Policy document for breast-feeding (DSF/UNICEF) and for IEC
- Aide mémoire des activités des différents donneurs élaboré lors des ateliers de financement du PSP
- WB nutrition study protocol (since the report may not be completed)
- Household expenditures studies: ELAM (PNUD)
- reports from Swiss and French Cooperation initiatives on mutuelles

ADDITIONAL CONTACTS OF POTENTIAL INTEREST (suggestions)

- Associations and National order of physicians, midwives and nurses
- CRESESA
- Department of public health of the University of Benin, teaching hospital
- NGOs umbrella organizations and NGOs involved in relevant projects (community participation, IEC, mother and child health, healthcare financing)
- AGEPIP (coordinator: Mrs Gnimadi)
- religious organizations involved in health

SUMMARY OF THE NATIONAL HEALTH STRATEGY

The draft document is drawn from the round tables held in January 1995, it is circulated among actors in the health sector since November 12, 1996. It is therefore subject to changes.

To improve health and quality of life of the population in Benin, the strategy is:

- to improve quality, efficiency and access to health services
- to improve management and organization of the health sector
- to improve partnership between public health sector, private health sector, other sectors and communities.

Nine programs are defined as priorities:

- 1 - reorganization of the health districts: create 36 districts instead of the existing 77 Sub-Prefectures.
- 2 - decentralization: define roles and responsibilities at all levels, provide adequate resources, define norms of care and Strengthen the referral system.
- 3 - strengthening of planning and coordination capacities: strengthen the management information system, revitalize the CNEEP and the CDEEP (Departmental level), increase participation of MSPSCF partners.
- 4 - collaboration with private sector: integrate and increase participation of the private sector in planning health sector activities.
- 5 - pharmaceutical: the national drugs supply system is an outstanding achievement in the region, the program is now to improve prescriptions practices, reinforce regulations against the parallel market and revise drugs prices in the public sector.
- 6 - health financing: design a policy for health sector financing, study households contributive capacity, revise the pricing policy, increase GOB expenditures on health.
- 7 - human resources management: define norms according to institutional reform, revise and implement personnel management policy (training and career plan).
- 8 - supervision and research: develop supervision tools and train especially at decentralized levels, develop capacities and material resources for fundamental and operational research (quality of services).
- 9 - diseases control:
 - prevention: implement minimum health package, increase EPI coverage and sustain it, improve hygiene and sanitation, develop IEC capacities and integrate IEC programs, launch an inter-sectoral program against HIV/AIDS
 - treatment: implement minimum health package, malaria control, diarrheal diseases, onchocerciasis, schistosomiasis.

APPENDIX B

**APPENDIX B
LIST OF CONTACTS**

USAID/COTONOU

- Mr. Thomas Park : AID Representative
- Ms. Susan Woolf: Family Health Team

MOH

- Irénée Stanislas Kotchofa, Directeur Departemental de la Santé, Zou region
- Dr Antonin Jacques Hassan, Directeur National de la Protection Sanitaire

NGOs

- Christophe Courtin, Terre des Hommes, Country Representative
- Steven Lutterbeck, PSI, Country Representative
- Dan Gerber, Africare, Country Representative
- Laura Hoemeke, Africare, Child Survival Specialist
- Mariam Olodo, Survie de la mère et de l'enfant, Présidente
- Guillaume Zanou, Survie de la mère et de l'enfant, Program Officer
- Agathe Houndonougbo, Survie de la mère et de l'enfant, IEC Project coordinator
- CRS
- Futures Group, Mr. John May
- DSMI, Dr. Azandegbe

DONORS

- Jean M.Dricot, UNICEF, Program Coordinator
- Dr Cisse Mohamed, UNICEF, Program Administrator
- Mr Ousmane Diagana, World Bank, economist
- Ms. Denise Vaillancourt, World Bank (Washington)
- Bruno Massit, French Cooperation, technical assistant
- Dr Gbaguidi, GTZ, health project Coordinator
- Mr Vielen, U.E, economist
- WHO