Global Health Initiative: Benin Country Strategy

Photos by Charlie Darr, US Peace Corps

DOS, USAID, CDC, Peace Corps, USDA, USADF, DOD

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Figure 1. Map of Benin

List of Acronyms

ABMS	*Association Béninoise de Marketing Social* (Beninese Social Marketing Association)
ABPF	*Association Béninoise de Planning Familial* (Beninese Family Planning Association)
ACT	Artemisinin-based Combination Therapy
ADF	African Development Foundation
AMCES	*Association des Oeuvres Médicales Privées Confessionnelles et Sociales* (Association of Faith-based Medical and Social Work)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Consultation
AOTR/COTR	Agreement/Contracting Officer's Technical Representative
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCC/IEC	Behavior Change Communication
CAME	*Centrale d'Achats des Médicaments Essentiels* (Central Medical Stores)
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community Health Workers
COGECS	*Comité de Gestion des Centres de Santé* (Health Center Management Committee)
CPR	Contraceptive Prevalence Rate
CREC	*Centre de Recherche Entomologique de Cotonou* (Entomology Research Center)
DHS	Demographic and Health Survey
DNSP	*Direction Nationale de la Santé Publique* (Public Health Directorate)
DOD	Department of Defense
DOS	Department of State
DSME	*Direction de la Santé de la Mère et de l'Enfant* (Mother and Child Health Directorate)
DTP3	Diphtheria, Tetanus, Pertussis (3 doses)
EONC/EmONC	Essential/Emergency Obstetric and Neonatal Care
EPI	Expanded Program on Immunization
FBO	Faith-based Organization
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
GFATM	Global Fund to fight AIDS, TB and Malaria
GHI	Global Health Initiative
GOB	Government of Benin
HIV	Human Immune-deficiency Virus
HSS	Health Systems Strengthening
IEC	Information, Education, Communication
IMCI/iCCM	Integrated Management of Childhood Illness/Integrated Community Case Management
IMR	Infant Mortality Rate
INSAE	*Institut National de la Statistique et Analyse Economique* (National Statistics and Economic Analysis Institute)
IPTp	Intermittent Preventive Treatment in Pregnancy
IR	Intermediate Result
IRS	Indoor Residual Spraying
IRSP	*Institut Régional de Santé Publique* (Regional Public Health Institute)
JSI	John Snow, Inc.
LLIN	Long-Lasting Insecticide-Treated Nets
LMIS	Logistics Management Information System
MCC	Millennium Challenge Corporation
MCH	Mother and Child Health
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSH	Management Sciences for Health
MSRP	Mission Strategy and Resource Plan

NGO	Non-governmental organization
NMCP	National Malaria Control Program
OGAC	Office of the Global AIDS Coordinator
OP/MOP	Operational Plan/Malaria Operational Plan
ORS/ORT	Oral Rehydration Salts/Oral Rehydration Therapy
PC/PCV	Peace Corps/Peace Corps Volunteer
PEPFAR	President's Emergency Plan for AIDS Relief
PEV	*Programme Elargi de Vaccination* (EPI)
PHC	Primary Health Care
PIHI	*Paquet d'Interventions à Haut Impact* (High Impact Interventions Package)
PITA	*Plan Intégré du Travail Annuel* (Annual Integrated Work Plan)
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PNDS	*Plan National de Développement Sanitaire* (National Health Plan)
PPR	Performance Plan and Report
PSI	Population Services International
PTD	*Plan Triennal de Développement Sanitaire* (Triennial Health Plan)
PTF	Technical and Financial Partners
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Tests
RED	Reaching Every District
RH	Reproductive Health
ROBS	*Réseau des ONGs Béninoises de Santé* (Beninese Health NGO Network)
RTI	Research Triangle Institute
SP	Sulfadoxine-Pyrimethamine
SPS	Strengthening Pharmaceutical Systems
TB	Tuberculosis
TETU	Triage, Evaluation and Treatment with Urgency
U5MR	Under-five Mortality Rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Co.
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
USG	United States Government
WGGE	Women, Girls and Gender Equality
WHO	World Health Organization

Note on Data Sources: Unless otherwise indicated, all data quoted in this country strategy were taken from the Benin Demographic and Health Survey (DHS) III in 2006. The DHS was implemented by the National Institute of Statistics and Economic Analysis of Benin and the National AIDS Control Program, with funding from the Government of Benin, USAID, UNICEF and UNFPA. Data dated 2006 are presumed to be quoted from the DHS III. The DHS IV will be completed in 2012.

GHI Vision for Benin

In an effort to increase inter-agency coordination, efficiency in implementing activities, and program sustainability, a whole-of-US Government approach to conduct health programs has been developed – the Global Health Initiative (GHI). For Benin, the GHI Country Strategy will focus on achieving specific and measurable goals, while placing particular emphasis on two of the GHI's seven core principles: *focusing on women, girls and gender equality*; and *building sustainability through health systems strengthening.* Women's health is a priority concern in health service planning and delivery in Benin; women also play a critical role as caregivers, professionals and advocates towards health improvement. The GHI Country Strategy will support health system strengthening at different levels to provide decentralized quality services and commodities in both public and private sectors.

GHI/Benin will concentrate health investments in three program areas: malaria prevention and control, child health, and maternal health, including family planning. Malaria remains the top killer of children in Benin and afflicts many pregnant mothers. The numbers of newborns, infants, young children and mothers dying in Benin each year are unacceptably high. Hence, GHI efforts will focus on mortality reduction, and will help energize the achievement of the Millennium Development Goals (MDGs). Three MDGs directly relate to health, and are central to the GHI vision in Benin. Both the GOB and the GHI Country Strategy share the below targets to be achieved by 2015[1]:

- MDG 4: Reduce the under-five mortality rate to 62/1,000 live births (from the 1990 MDG baseline level of 184/1,000 live births and the estimated 2006 Demographic and Health Survey [DHS] level of 125/1,000).
- MDG 5: Improve maternal health – by reducing the maternal mortality ratio to 125/100,000 live births (from the 1990 MDG baseline of 790/100,000 live births and the estimated 2006 DHS level of 397/100,000 live births).
- MDG 6: Combat HIV/AIDS, malaria, and other diseases – by reducing by half the estimated annual malaria deaths using the 2006 baseline.

The GHI Country Strategy has the Objective of *"Improved health status of Beninese families"* to be achieved through Intermediate Results (IRs) organized to improve the supply of quality services and products in both the public and private sectors. It also seeks to increase appropriate prevention and care-seeking behavior in the population. Benin's Ministry of Health (MOH) recently chose the interventions included in an integrated package of low-cost, high impact services that will be delivered at community and household levels: the PIHI *(Paquet d'Interventions à Haut Impact)*. The PIHI concentrates on health promotion, disease prevention and treatment-seeking behaviors. It has major overlaps with the GHI Country Strategy, and will be promoted through public and private sector facilities, and for some items in the package, at the household and community levels. The strengthening of a dual-track health system – public and private – will ensure that the supply of quality services and goods is able to match household and community demand for health services and products at all times.

Currently, seven different USG agencies, led by the US Agency for International Development (USAID), are members of the GHI/Benin Team. The others are the Department of State (DOS), the Department of Agriculture (USDA), Peace Corps, Department of Defense (DOD), the Centers for Disease Control and Prevention (CDC) and the African Development Foundation (ADF). The collective investment of these USG agencies to improve health in Benin in FY 2010 was nearly $34 million, with USAID managing over 90 percent of it.

This Country Strategy was completed with inputs from the Benin Country Team in Washington and Atlanta, and has benefited from a series of consultations with the MOH; bilateral and multilateral health

[1] The MDG 4 target is from the UNDP database. The MDG 5 target is from the Ministry of Health, which is more ambitious than UNDP's Maternal Mortality Rate target of 197/100,000 live births. There is no target for malaria in the UNDP database. The target for malaria is taken from the MOH's National Malaria Strategic Plan.

partners in-country; civil society, including nongovernmental organizations and faith-based organizations; the private sector and associations of health professionals.

Benin Health Context and Priorities

Health context: Benin, a West African country with a population of nine million people, has a gross national income (GNI) per capita of US$1,510 (based on Purchasing Power Parity methodology, World Bank, July 1, 2011) which is above average for sub-Saharan Africa. Nevertheless, poverty is widespread: 37 percent of the population lives on less than $1.50 per day. The global literacy rate is 41 percent (28% for women, 55% for men) and the mean number of years of schooling for adults is 3.5 years. Six in ten adult women and four in ten adult men have never attended school.

Current status of GHI health outcome goals: Malaria's contribution to Benin's disease burden is significant, affecting both the health and finances of many households. It is the number one killer of children under-five and is a common condition afflicting many mothers and pregnancies each year. It constitutes 40 percent of all out-patient consultations in health facilities, and 22 percent of all hospital admissions. In 2010, **Lancet** (375:9730, pp.1969 – 1987) estimated that 9,165 children under-five died of malaria in 2008, representing 23% of all under-five deaths.

For the period 2001–2006, Benin's under-five mortality rate (U5MR) according to the DHS was 125/1,000 live births and the infant mortality rate (IMR) was 67/1,000 live births. Benin's 2015 targets for child mortality are: U5MR to 62/1,000 live births, and the IMR to 40 per 1,000 live births. These targets are achievable, but will require a closer alignment of efforts among stakeholders. Child deaths in Benin are due to preventable childhood illnesses, mainly malaria, pneumonia and diarrhea. Special attention will be required to reduce the neonatal mortality rate (NMR), which was estimated at 32/1,000 live births in 2006, and has hardly declined from the 1996 level of 40/1,000 live births. Half of the IMR is neonatal, occurring during the first four weeks after birth. Approximately 80 percent of neonatal deaths occur during the first seven days after birth. The most significant direct causes of neonatal deaths are infections, prematurity and asphyxia.

The number of children 12-23 months who were fully vaccinated as indicated by DTP3 coverage has been below 70% since 2004. This is below the eligibility threshold required by GAVI to introduce new vaccines against pneumococcus and rotavirus; however, GAVI has given Benin's MOH the go-ahead to introduce pneumococcal vaccine in 2011. Meanwhile, only a quarter of mothers of young children reported taking appropriate measures for the evacuation of child stools or followed good hygiene practices and hand-washing with soap. Malnutrition, a factor in child survival, is common: 43 percent of children measured in the 2006 DHS were stunted – a sign of chronic malnutrition. Breastfeeding is almost universally practiced but just half of newborns are breastfed within an hour after birth and only 43 percent of infants less than six months old are exclusively breastfed, and only one-third of children and infants are breastfed and weaned properly.

Benin's Maternal Mortality Ratio (MMR) estimate for 1990 in UNDP's database was 790/100,000 live births. In the 2006 DHS, it was 397/100,000 live births, a 20 percent decline from the 1996 level of 498 per 100,000 live births. The current MMR figure translates to 1,400 maternal deaths per year, and a 1:43 lifetime risk of maternal death. Based on 2010 MOH service records, roughly 90 percent of pregnant mothers consult pre-natal clinics, and 78 percent of deliveries are assisted by trained personnel – among the highest in West Africa. However, quality of care varies, and high maternal mortality persists. The main direct causes of maternal deaths are hemorrhage, severe infection, eclampsia and obstructed labor, and complications from abortions. The MDG 5 target of 125/100,000 live births by 2015 is roughly a 70% reduction from the 2006 level.

The total fertility rate for Beninese women is 5.6 children born per woman. Rural women have more children than urban women (6.3 vs. 4.9), and women in the lowest economic quintile or who have never attended school have more children than those in the highest economic quintile or who finished elementary school. Early childbearing is the norm and 24 percent of women have their first baby by age 19. Modern contraceptive prevalence is just above six percent, and 30 percent of women in union have unmet needs for family Planning (FP). The HIV/AIDS epidemic in Benin has been stable at 1.2 percent adult prevalence over the last five years.

Benin's National Health Strategies and Priorities: The GOB's health sector strategy is described in the ten-year National Health Development Plan (*Plan National de Développement Sanitaire,* PNDS), a policy document to guide health efforts during 2009-2018. The GOB's priorities are to achieve universal access to and improve quality and coverage of services leading to significant and lasting reductions in infant, child and maternal mortality. Benin's three-year operating plan for 2010-12, the *Plan Triennal de Développement Sanitaire*, focuses on the delivery of a package of low-cost, high impact interventions called *Paquet d'Interventions à Haut Impact (PIHI).* In 2010, the GOB issued the *Cadre de Dépenses à Moyen-Terme, 2010-2012*, an attempt to assign costs needed to achieve different scenarios to the achievement of the MDGs. This was followed in early 2011 by a five-year plan (*Plan Opérationnel de la Mise à l'Echelle Nationale des Interventions à Haut Impact sur la Mortalité Maternelle, Néonatale et Infanto-juvenile, 2011-2015)* to bring to scale the PIHI interventions to accelerate reductions in maternal, neonatal and child mortality in time for the deadline on the MDGs. The first phase of PIHI implementation will cover 16 of the 34 health zones in the country by 2012, with the other 18 to be covered by 2015. Elements of the PIHI are in Table 1 below and are compared with the priorities of the GHI Country Strategy.

Preceding the PIHI were several GOB policy initiatives that were designed to increase access to health services to all Beninese. These include: 1) free or heavily subsidized caesarean sections, 2) a waiver of user fees for children under-five who consult public sector facilities, 3) reinforcement of health financing schemes, 4) creation of an Indigent Fund to provide free health services to the extremely poor, and (5) revitalizing primary health care (PHC) by increasing the number of community health workers (CHWs) and improving their capacity to promote PHC and treat common diseases at household and community levels. The role of CHWs is being enhanced by piloting contract arrangements between local government and CHWs in the delivery of health services and by expanding the range of services and FP commodities they offer. In addition to the above, major reviews of these four important documents are currently being conducted to generate recommendations to accelerate achievement of health targets: the National Malaria Control Program and Strategy (NMCP/NMCS), the MCH National Action Plan, the Road Map to Maternal and Neonatal Mortality Reductions, and the Neonatal Survival Strategic Plan. As these documents are finalized, sections of this Country Strategy will be updated.

Overlaps between the National Health Plan and GHI Country Strategy: The interventions under PIHI overlap with both the MDGs and GHI as shown in the table below. GOB priorities such as free caesarian sections, nutrition rehabilitation, food supplementation, neglected tropical diseases, non-infectious diseases, and nosocomial infections are outside of GHI's focus in Benin. The delivery of PMTCT services is not a GHI focus, although prior support on PMTCT was provided for training and promotion. USG-funded agencies will implement the GHI Country Strategy, with close integration of activities with existing national health programs, most notably health systems strengthening components for the NMCP, as well as the MCH, EPI and FP/RH programs. Under USAID Forward, increased channeling of USG resources through host government systems will be piloted in FY 2012 after the completion of appropriate risk assessments of in-country partners to track funds. GHI will provide support to capacity building in financial management and organizational leadership.

Table 1: Overlap between GOB Priorities and GHI Country Strategy Priorities

MDG	PIHI Package	GHI Country Strategy
MDG 4: Reduce child mortality rates	• Case management of low birth weight newborns • Integrated Management of Childhood Illness (IMCI) • Expanded Program on Immunization (EPI), by Reaching Every District (RED) • Free malaria treatment with artemisinin-based combination therapy for under-5s • Improving infant and young child nutrition and combating malnutrition • Addressing maternal attitudes toward breastfeeding • Nutrition Rehabilitation for children • Hand washing with soap at critical times (before eating, after using latrines) • Prevention of Mother-to-Child Transmission (PMTCT) of HIV	• Case management of low birth weight newborns • Community IMCI through Community Health Workers (CHWs) • EPI revitalization, including the Reaching Every District (RED) strategy • Artemisinin-based combination therapy for malaria in children • Nutrition promotion in mothers and young children under-five • Breastfeeding promotion • Social marketing/ BCC for diarrhea prevention and treatment, other healthy behaviors • Hand washing with soap at appropriate times • Antibiotics for pneumonia
MDG 5: Improve maternal health	**Family Planning** • Contraceptive Security • Participation of men in FP • Introduction of implants **Refocusing Antenatal care** • Iron & folic acid supplementation, long-lasting insecticide-treated nets (LLINs), Tetanus Toxoid Immunizations, • Management of essential and emergency obstetrical and neonatal care (EONC and EmONC) • Active Management of the Third Stage of Labor (AMTSL) • PMTCT, IPTp • Diabetes and nutrition counseling	**Family Planning** • Contraceptive Security • Increased men's participation in FP • Access to long-term methods through social marketing • IEC/BCC for a broader range of methods, including long-term modern methods • Healthy timing and spacing of pregnancies **Focused Antenatal Care** • EONC and EmONC • Assisted deliveries with AMTSL • IPTp and bednet distribution • Maternal nutrition **Fistula Repair**, including surgery and social re-integration
MDG 6: Combat HIV/AIDS, malaria, and other diseases	• Free malaria treatment with artemisinin-based combination therapy for under-5s • Testing and treatment of infectious and non-infectious diseases, including HIV/AIDS • Prevention of nosocomial infections • HIV/AIDS prevention among priority vulnerable groups	**Malaria** • Artemisinin-based combination therapy for malaria in children • Indoor Residual Spraying • LLINs • Case Management • IPTp • IEC/BCC

Barriers to achieving country priorities and GHI goals and implementing principles: The GOB is working with donor partners to address gaps in service delivery and financing of essential health programs. Some donors have renovated or built hospital buildings, clinics and offices, but many others need upgrading. Regular maintenance is not yet in place for equipment. Reports of stock-outs of essential drugs and supplies still occur, especially at peripheral locations. The health information system is in place, but some reports do not get submitted on time for timely decision-making. Health workers in the public sector cover large populations, are concentrated in the South, and are not motivated due to low salaries. A decline in the national budget's allocation to health over the last three years has been offset by external donor support from bilateral and multilateral partners to the health sector.

Strengths and opportunities in the health system: In spite of its weaknesses, the health system has its strengths. National policies favor the poor: the PIHI, an indigent fund, and free caesarians have been instituted to make services affordable to them. The structure of the health system ensures access to health services in all sub-districts of the country. The focus on malaria has galvanized both the MOH and donors into a collaborative network driven to eliminate malaria as a killer in Benin. With the current emphasis on decentralization and performance-based management, communities and health zones have the chance to shape, manage and monitor health services that they need. USAID has also worked with CHWs to enhance their skills and competencies in treating childhood illnesses, promoting malaria prevention and increasing FP coverage. USAID/PMI-funded reforms at the Central Medical Stores (CAME) have improved transparency and availability of drugs and commodities.

Existing systems and service delivery platforms: The decentralized public sector health system has generated an opportunity for many actors to collaborate below the MOH central level. At the health zone and department levels, agencies have formal and informal collaborative arrangements around local health issues giving communities a voice.

Combatting malaria is essential to improving child health in Benin. Over the last five years, the campaign for the elimination of malaria as a public health problem in Benin has contributed to a reduction in child mortality. The Roll Back Malaria network and the Country Coordinating Mechanism (CCM) of the Global Fund to fight AIDS, TB and Malaria (GFATM) are coordinating the complementary use of resources among partners. An annual workshop of malaria partners prepares the *Plan Intégré du Travail Annuel (PITA)* or the joint work plan for the year on malaria control. USAID is a permanent member of the CCM and is the only USG agency currently involved in Roll Back Malaria. Peace Corps Health Volunteers focusing on malaria will be invited to these meetings when appropriate.

The GHI Team will continue to apprise and coordinate with Benin's Technical and Financial Partners in Health (PTF). The PTF is a loose grouping of donors that meets monthly and coordinates donor response to broad areas of health problems that arise. The World Bank also conducts an annual Health Sector Review, the results of which are included as a health sector chapter of Benin's report on its Growth and Poverty Reduction Strategy. Other existing platforms are the Technical Working Groups for maternal and neonatal mortality, which is conducting a midterm evaluation of Benin's roadmap to maternal and neonatal mortality reduction. Benin is also participating in pan-African efforts at maternal mortality reduction through the Campaign on Accelerated Reduction of Maternal Mortality in Africa which is supported by all African governments.

GHI Objectives, Program Structure and Implementation

(See **Results Framework, Annex 1**)

Results Framework: The Objective of the GHI Country Strategy for 2011-2015 is **"improved health of Beninese families."** This will be achieved through three Intermediate Results (IRs): **IR 1. Improved public health sector performance in delivering integrated family health services; IR 2. Improved private health sector performance in delivering integrated family health services**; and **IR 3. Improved preventive and care-seeking behaviors of an empowered population.** Supporting the above are the two cross-cutting GHI principles prioritized by the GHI Team for immediate focus beginning 2011: *building sustainability through health systems strengthening* (HSS); and *focusing on women, girls and gender equality* (WGGE). Progress on the Objective and IRs will be achieved through activities that will focus on reducing deaths from malaria (MDG 6), lowering maternal mortality (MDG 5) and reducing under-five mortality (MDG 4).

Both IR 1 and IR 2 directly target HSS: IR 1 focuses on the public health system, while IR 2 focuses on the private sector. Under the GHI Country Strategy, USG agencies will continue to work closely with the MOH to improve basic health services nationwide, but will also invest in engaging private health providers as a significant and growing sub-sector that can help accelerate achievement of health

improvement targets. For example, the private sector needs to align clinical practices with national policies on national health goals and assure the same quality standards across private providers across the country – especially as the demand for private health services grows with each instance of health service interruptions in the public sector.

The IRs and sub-IRs of the GHI Results Framework are designed to address the key barriers to achieving the GHI Objective. The following barriers will be given specific attention in the next five years:

- an incomplete process of decentralization, with weak (or at least not uniformly strong) planning and management at the decentralized levels;
- poor quality of services in the public and private sectors;
- weak planning to maintain stocks of essential drugs and commodities;
- a growing use of private sector services and products, which are poorly organized and supervised; and
- the lack of awareness of, and/or willingness to use key preventive and care-seeking behaviors that are directly tied to health outcomes.

IR 1. Improved public health sector performance in delivering integrated family health services. Benin's decentralized public health system has services organized around 34 health zones. Each health zone covers a population of 100,000-200,000 people, and consists of a network of public and private health facilities, all backstopped by a first referral hospital. A total of 855 health facilities are recognized by the MOH: 669 public and 186 private. Physical access to health facilities is good: 76% of Benin's population lives within five kilometers of a health facility (70% in rural areas and 86% in urban ones), providing access to nearly all Beninese. However, poor infrastructure, shortages of medicines and supplies, and a lack of emergency transport limit utilization. A snapshot of health facilities includes:

- Only one quarter offer focused antenatal care; 63% provide basic emergency obstetrical and neonatal care (with only 6% offering the entire package of emergency obstetrical and neonatal care);
- Nine out of ten provide postnatal care (but only 4% provide the entire postnatal care package);
- 29% provide vaccination services seven days a week;
- 81% provide FP services (but only 7.5% offer all the standard modern methods; most centers cannot offer intra-uterine devices or implants); and
- Only 17% had all essential medicines as mandated by the MOH.

Benin's health workforce crisis is acute. There are 1,088 doctors, 999 midwives and 3,563 nurses in Benin, split between the public and private sectors. This workforce density of 6-7 health workers per 10,000 people is far below the World Health Organization (WHO) recommendation of 23 per 10,000. Several donors, including French Cooperation, Belgian Cooperation, UNFPA, and USAID/Benin have begun discussions on accelerating training of midwives, updating knowledge and skills of professional and other staff in maternities and dispensaries through refresher courses. PMI also is focusing on building the capacity of the NMCP as a team capable of managing a complex national program well.

Strengthening the public health system is at the core of this IR. WGGE will be addressed by ensuring health services give equal access to both males and females. Activities under the sub-results may include:

1.1 Improved planning and management of health systems and services especially at decentralized level. GHI will support training and technical assistance to improve leadership capacity at the MOH central level with an emphasis on the phased delivery of PIHI to all districts by the *Direction de la Santé de la Mère et de l'Enfant (DSME)* and the National Malaria Control Program. Under this sub-result, support for rationalizing and strengthening the network of community health workers will play an important role in strengthening service delivery, including prevention and health promotion, for those services that may be appropriately delivered at community level. At the department level, the quality improvement collaboratives that were introduced by USAID in four departments will receive further training and support in organizing health services at health centers. At the central level, the focus will be on improving the leadership, planning and supervision skills of MOH staff to enable them to manage national programs effectively. Services to be addressed include focused antenatal services,

with the use of Active Management of the Third stage of Labor (AMTSL) to prevent postpartum hemorrhage as a core element in reducing maternal deaths. Support to the EPI will focus on the revitalization of routine immunization services, through information, education and communication campaigns, increasing maintenance efforts for the supply chain, polio surveillance and the full achievement of the Reaching Every District (RED) Strategy. Progress will be measured through the vaccination rates in each department and case detection of non-polio acute flaccid paralysis confirmed through surveillance activities. For malaria, the Department of Atacora will be helped in the planning and supervision of additional rounds of Indoor Residual Spraying (IRS) in selected communes. Other activities include supporting the Health Management Information System focused on malaria indicators for the PNLP and the Demographic and Health Survey (DHS). The support for the expansion of reforms towards transparency and efficiency at the Central Medical Stores (CAME) will include regional CAME offices, and peripheral health units outside Cotonou at the health zone level. Support for equipment and supplies, as well as technical assistance to implement the Demographic and Health Survey (DHS) IV in 2011 will be provided. CDC and USAID are also supporting the forthcoming DHS IV financially, along with UNICEF, UNFPA, WHO, the Millennium Challenge Corporation, and the GOB. Planning of activities will seriously consider WGGE to ensure equal access to boys and girls.

1.2 Improved quality service delivery, especially for women and young children, at health facilities. GHI will support quality improvements in service delivery, with an emphasis on the elements of PIHI, by providing quality improvement support through training and mentoring to nurses, midwives and other clinic or maternity staff who are at the frontlines of serving mothers and children. The elements of the PIHI cut across malaria, maternal health/FP and child health, and are intended to be applied to the different levels of the health system, including the community and the household. As a national policy, PIHI needs to be adopted by both the public and private health service providers to ensure maximum impact on health. This sub-result will be implemented through the initiation of quality improvements in health services provided at health centers as well as referral facilities like the *Centre Hospitalier Départemental*, where children with severe malaria will be treated with the TETU (Triage, Evaluation and Treat with Urgency) approach. Checklists, supervision visits, case studies will all be used to upgrade the clinical knowledge and competence of health staff. Special attention will be given to staff's awareness and attitudes towards pregnant mothers during labor and delivery, preserving their dignity at a time of vulnerability. Service delivery data will be collected and disaggregated by sex.

1.3 Essential commodities more available at service and product delivery points. The quality and timeliness of care and treatment will not be possible without the essential medicines and supplies needed for the case management of malaria, pregnant mothers and sick children. A vaccination program will lose credibility if vaccines are not available to maintain child health, and a family planning program will not be effective if commodity stock-outs are frequent. The aim of this sub-result is to enable the supply chain for both the public and private health sub-sectors to effectively manage the procurement and flow of essential drugs, vaccines and supplies. For malaria, the prevention of stock-outs of ACT and Sulfadoxine-Pyrimethamine (SP) will be emphasized; for child health, vaccines and antibiotics for pneumonia; and for FP, injectable contraceptives, implants and condoms, within the context of a broad method mix. GHI has supported and will continue support the training of staff at the Central Medical Stores (CAME) in the management of the supply chain, from the planning and quantification of orders to the point of reporting back to the MOH and donors on the use of products. Training and technical assistance will support the MOH's FP program in the introduction of implants as an available option for long-term FP use, and the EPI to fully implement RED and prepare for the addition of vaccines against pneumococcus and rotavirus for children. PMI will continue to support the NMCP's procurement of kits and drugs for malaria, to diagnose and treat children testing positive for malaria. PMI will also supply sulfadoxine-pyrimethamine to prevent malaria in pregnant women.

IR 2. Improved private health sector performance in delivering integrated family health services. The private health care sub-sector is an increasingly important source of health care for the Beninese. Its potential to improve the health status of Beninese families is enormous, and its coverage of services rises to 60-70 percent of care provided nationally when the public health sector is on strike. The size of the target group of private sector and NGO health providers in Benin is currently unknown, as it is a mix of large private hospitals run by faith-based organizations, private clinics run by licensed health practitioners, pharmacies and dispensaries, unlicensed traditional practitioners, and itinerant service providers and drug vendors (mostly unlicensed). The long-term goal of the GHI Country Strategy is to enable private and NGO health providers to deliver quality services that are aligned with USAID's focus in the public sector for years. The first step will be to map and quantify the sub-sector, and provide training and technical assistance to motivate unlicensed providers to conform to GOB protocols and standards. Gender considerations will be applied in the mapping of personnel and services, training and technical assistance processes. Because the MOH is authorized by law to work only with the 189 licensed facilities and practitioners, a GHI target will be to double that number of licensed facilities by 2015. Hence, in the next three years, GHI will provide support and technical assistance to gradually enable and equip the MOH to enforce comprehensive regulations, including government accreditation and enforcement of biennial inspections of private health facilities. USG support will help assist in strengthening networks of health professionals and other provider networks.

2.1 Improved public sector policies, oversight and supervision of private sector service delivery. GHI will engage private health sector providers to follow national policies on licensing, staff skills and service standards, while building the capacity of the GOB/MOH to assume a supervisory role over private health providers. This will help align clinical practices and standards of the private with the public sector, and along the lines of best practices recommended by WHO or UNICEF. Information on the diagnosis, management and follow-up of killer diseases or conditions in Benin will be disseminated, and seminars or short courses will be held. Mentoring, technical assistance and exchange visits will be organized in collaboration with other donors and Beninese health professional associations to upgrade the capacity of Benin's private health sector. The focus will be on malaria prevention and control, maternal health and FP, and child health – and interventions will closely follow the MOH protocols and plans. On FP services, the socially franchised private network of ProFam clinics is more experienced than the MOH in the insertion of implants, and their experience can be used to help the public sector adopt the use of implants for FP, further expanding the method mix available in the public sector.

2.2 Improved quality service delivery, especially for women and young children, at private health facilities. GHI activities will mirror those provided to the public sector to improve the quality of service delivery with a particular emphasis on PIHI. As in the public sector, the focus for quality improvement will be on the prevention and case management of malaria, the use of AMTSL for preventing hemorrhage during delivery, and IMCI for sick children. GHI will be attentive to gender equality issues in human resources as it supports training and mentoring to nurses, midwives and other clinic or maternity staff who are at the frontlines of serving mothers and children. Checklists, supervision visits, case studies will all be used to upgrade the clinical knowledge and competence of staff. Special attention will be given to staff awareness and attitudes towards pregnant delivering mothers, protecting their dignity at a time of vulnerability. A second element that GHI will support under this sub-result includes the access of private clinics to supplies available through CAME.

2.3 Strengthened private health sector providers, as both for-profit and not-for-profit businesses. To improve sustainability of services, private providers must be able to manage their costs and revenues effectively. GHI will support activities to enhance the viability and sustainability of private for-profit and not-for-profit health service providers. The ProFam[2] franchises will be showcased as a private

[2] The ProFam clinics are a socially franchised network of medical clinics run by Population Services International.

not-for-profit model, alongside for-profit private clinics. Joint training with public health sector providers will be organized around the subjects of leadership training, project development, financing, personnel management, and clinic or pharmacy management. GHI will initiate discussions with the Government of Benin, World Bank and the European Union on how a privatized health insurance system could be set up in the country, and offer linkages to training on the creation of business plans and the development of competencies in priority service delivery areas.

IR 3. Improved preventive and care-seeking behavior of an empowered population. This IR will focus on activities that will positively influence decisions and actions taken by individuals, households and communities to improve or maintain health. Empowerment is defined as being able to make informed decisions to act on choices and follow-through on measures to ensure health is achieved or maintained. Interpersonal communication and social marketing campaigns using a diverse mix of media will be used, with community radio as an information channel for those outside the urban areas. It also includes the strengthening of the role of communities in the financing of and advocacy for health care at the community level. This is based on the fact that community financing for health care has outpaced central government financing as a percentage of total resources available to health zones. An analysis of financing sources for health needs done in 2008 by the MOH indicate that households are now the largest source of health spending, with consumer payments accounting for 42 percent of total health spending in the public sector and nearly 99 percent of private care spending.

3.1 Increased appropriate health-promoting behaviors made by households, and especially women. This sub-result includes the promotion of personal and household behaviors that lead to disease prevention and health maintenance. This sub-result also recognizes the central role women play in maintaining family health in the home and in the community. For malaria prevention, children and young mothers sleeping under a mosquito net will be an ongoing theme for behavior change communication, as it was in the recent universal distribution campaign of long-lasting impregnated mosquito nets. Motivating mothers to take SP during pregnancy is another theme. For child health, the use of Orasel with zinc to treat diarrhea in young children will continue to be emphasized, together with hand-washing at appropriate times and point-of-use disinfection of drinking water to prevent it. Mothers will be encouraged to practice exclusive breastfeeding of infants beginning at birth and until six months to promote good infant nutrition. For FP, the use of condoms (female and male) for dual protection (HIV and unintended pregnancy prevention), as well as other modern contraceptive methods to avoid unintended pregnancy will be promoted. Women with fistulas will be counseled to undergo surgical repair. Many of the above behaviors are focused on women; hence, messages will be appropriately targeted to women in their local languages.

3.2 Informed families make appropriate choices on accessing public and private health services and commodities. This sub-result focuses on educating families to use health facilities and services in appropriate ways. Families and households will be targeted to utilize health information and services that are only available from a good understanding of the interface that must exist between them and the health system, public or private. This includes the ability of women to make voluntary and informed FP choices, including about long-term methods such as implants and injectables which are available at a clinic or health facility. In line with their roles in maintaining family health, mothers will be strongly encouraged to bring their children for vaccinations at the appropriate intervals to maintain health, and women who have fistulas will have the knowledge and ability to seek surgical repair of their condition. Families will be informed of the need for and demand that their children with fever to be tested with Rapid Diagnostic Tests (RDTs) and treating them with artemisinin-based combination therapy (ACTs). Prompt decision-making to seek treatment after the recognition of the signs of and symptoms of malaria and pneumonia in children will be emphasized.

3.3 *Strengthened community-level contribution to health sector decisions and financing.* This sub-result promotes the education of local community clients to advocate, organize and manage aspects of their health care to the extent possible, including assuring health care financing for health services. GHI will support activities to enhance the ability of community members, especially women, to shape and

actively participate in the financing and management of their *mutuelles*, Village Health Committees, and mobilize immunization campaigns, bednet distribution campaigns; and potentially, managing the work of CHWs. This will also include information campaigns to organize support for emergency transport of obstetric emergency cases, assist the very poor to access a free caesarian section funded by the government, or apply for health services with support from the Indigent Fund.

Consideration of GHI principles: WGGE and HSS are Benin's priority GHI principles. Maternal health will improve as the appreciation of health problems specific to women and girls in Benin also improves. To cite a few of the health risks many girls and women face: female genital cutting and its complications, early marriage and childbearing resulting in increased maternal deaths, increased vulnerability to malaria in pregnancy, frequent teenage pregnancies associated with obstructed labor, the stigma in women who suffer from fistulas, and the frequent abuse and violence committed against women. These risks, coupled with poor access to health information due to low literacy levels and social barriers that inhibit many women from seeking care on their own, must be better taken into account by the health system. Their mitigation will be pursued with compassion in the design of responsive health services at the community and health facility levels. Women also play a critical role as caregivers, professionals and advocates towards health improvement. The GHI Country Strategy will champion WGGE and give women and girls a voice by ensuring every project has a well-executed gender analysis. A gender analysis is planned as a key process to be documented in the upcoming project design of the follow-on integrated family health project; there has been no gender analysis completed in Benin in the last two years. GHI will also encourage advocacy to ensure that women's health needs are addressed by the health system. In the implementation of the BEST Action Plan[3], male and female champions for WGGE will be identified. USAID/Benin has designated the Program Officer as the Mission's new focal point on gender issues.

GHI will support HSS at various levels to provide decentralized quality services and commodities in both public and private sectors. GHI will explore the creation of a coordinated public-private partnership network of health service providers committed to quality of health care. GHI support will facilitate the harmonization of health services provided by the private sector with that of GOB policy by facilitating the formulation of policies for accreditation and supervision, and joint training on health information systems.

The two priority GHI principles above will be applied immediately and emphasized throughout the next five years. However, emphasis will also be placed on these other GHI principles as opportunities arise:

The use of country systems: This will be explored and piloted under GHI in 2012, with the application of USAID Forward and the new guidelines for project design and procurement reform. Possible areas through which USG resources could be channeled will be performance-based initiatives at the departmental level to develop local public and private sector capacity for improved quality of services and sustainability. This principle will be monitored and its application expanded depending on the results of the experience.

Leveraging other partners' efforts: This is another principle that has been and will be an ongoing task. Joint consultations and information-sharing leading to program planning have been initiated with UNICEF, the World Bank, UNFPA, the French Cooperation, and the Belgian Cooperation. The national health sector review has been a good platform to discuss how donors and partners could focus collective efforts on strengthening the health system. Other platforms used have been the Malaria Operational Planning exercise in June of each year. GHI priorities and concerns, such as fistula repair and maternal mortality reductions are actively shared by UNFPA, WHO, and UNICEF.

[3]Best Practices at Scale in the Home Communities and Facilities (BEST) is USAID's mechanism to integrate Mother and Child Health, Family Planning and Nutrition activities. The Benin BEST Action Plan was developed in 2011.

Strategic coordination and integration: In Benin, successful integration of health services will depend on availability of supplies, the quality of training of staff, and the level of coordination between these different stakeholders: the MOH, Benin's donor partners, the community and the private sector. Integration of services at the community level will also depend on the success of decentralization and the deployment of CHWs at the village and commune levels. Integrated services of high quality are key to increased coverage, greater efficiency and improved outcomes. The attention to CHWs is shared with the Belgian Cooperation, UNICEF, and WHO. Manuals for training and the development of policies and procedures regarding the work of CHWs have been developed. As experience with decentralization continues to grow, and more and more services are decentralized, local government units will become more comfortable in their roles of planning, supervision and evaluation of health services provided in the community. UNICEF and WHO have worked side by side with the USG on creating policies that favor decentralization and the role of CHWs.

GHI Team Members: Seven USG agencies will be involved in health-related activities in Benin and will be included in the Benin GHI Team: the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Department of State, the Peace Corps, the United States Department of Agriculture (USDA), the African Development Foundation (ADF), and the Department of Defense.

USAID/Benin has 20 years' experience serving Benin. Its current health portfolio consists of malaria, Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH) and HIV/AIDS control and prevention. Malaria activities are funded through the President's Malaria Initiative (PMI) Principal PMI activities are: distribution of insecticide treated bed-nets, indoor residual spraying, malaria prevention in pregnancy, case management of uncomplicated and severe malaria in children under-five, and behavior change communication. Health systems strengthening under PMI funding focuses on building the capacity of the National Malaria Control Program to manage all aspects of malaria control in Benin, procurement of commodities and pharmaceuticals, supply chain management and logistics, commodity monitoring and evaluation.

USAID's MCH and FP/RH future plans are articulated in the BEST Action Plan. Current activities include: 1) the Integrated Family Health Program which supports the MOH in Zou and Collines departments; 2) Integrated Project to Promote Family Heath and HIV/AIDS Prevention which promotes health behavior changes and provides subsidized health commodities such as condoms, contraceptives, water purification, oral rehydration salts, zinc treatment for diarrhea and bednets for malaria; and 3) Community Case Management for Integrated Management of Childhood Illness (CCM/IMCI) which emphasizes community systems strengthening for improving the quality of family health services. USAID/Benin has funded and will continue to fund Peace Corps' small grants program for small-scale health promotion, malaria, HIV prevention and family planning.

In addition to the above, USAID/Washington's centrally and regionally funded activities include a Child Survival grant to the Center for Health Services, a salt iodization grant to UNICEF, and a surveillance grant to WHO's polio eradication program. USAID/Benin's President's Emergency Plan for AIDS Relief (PEPFAR) funding is administered through the Department of State Office of the Global AIDS Coordinator (OGAC) to support HIV prevention activities. Additional funding for PEPFAR assistance to Benin is currently anticipated to end after FY 2011.

In Benin, the Department of State provides diplomatic, commercial, political and economic support for USG and US private sector health activities in Benin. The Ambassador's Self-Help Fund supports small projects in Benin, and in FY 2011, 12 out of 14 Self-Help programs with a total value of $87,000 for the year had health, nutrition or sanitation elements. Peace Corps/Benin has over 40 years' experience working to improve the health and well-being of Benin's rural communities. There are now 100 Peace Corps Volunteers (PCVs) working across the country; a quarter of them serve as Rural Community Health volunteers. The program supports malaria, MCH, nutrition, and HIV/AIDS prevention activities

and assigns health volunteers to work with rural health clinics, social work centers and local NGOs throughout Benin. PCVs implement small-grant projects funded by USAID, focusing on MCH, nutrition, water and sanitation and HIV prevention.

CDC has seconded a malaria advisor to USAID to help with PMI implementation, and provides PMI support from CDC headquarters. The CDC and Health and Human Services staffs are also available for emergency support of disease threats such as Ebola or Avian Influenza. The DOD works with the Benin military to support health programs for the military, and also implements humanitarian assistance activities and excess property projects for use in the health sector. The ADF funds local projects including several related to food and nutrition security, many of which are managed by women or have primarily women beneficiaries. In FY 2012, ADF will have an additional $1 million available to fund similar projects to benefit more women beneficiaries. USDA will partner with two civil society partners to manage a cash grant to distribute locally purchased food in a food-deficit area in northern Benin.

These interagency collaborative arrangements will now be better coordinated through the GHI Country Strategy under the leadership of the Ambassador in a whole-of-government approach. For example, with increased collaboration between USAID and Peace Corps, PCVs will have improved access to behavior change communication materials and socially marketed products to use in their community programs throughout Benin, as their needs will be included in the quantification of commodity orders. The PCVs will complement, wherever possible, community-level social marketing work related to USAID programs to ensure better acceptance of health interventions. Peace Corps and USAID are now formalizing and broadening their partnership to expand their collaboration under GHI via the placement of Peace Corps Response Volunteers directly with USAID, at the National Malaria Control Program, or with PMI implementing partners. The Ambassador has designated USAID as the lead planning agency for GHI and the MOH is the primary GOB partner for GHI in Benin.

GHI Program Focus Areas: The USG will use GHI principles in individual agency activities to support three major programs:

Malaria – The most significant health threat in Benin under MDG 6 is addressed by programs run by USAID through the PMI and by the Peace Corps. Malaria control also directly contributes to reductions in child mortality (MDG 4) and improvement of maternal health (MDG 5). USAID, CDC and the Peace Corps are currently coordinating more closely on this focus area. PMI activities closely collaborate with different interventions coordinated by the MOH's National Malaria Control Program. IRS, HSS, LLIN distribution and IPTp activities are integrated within the Mother and Child Health activities of the *Direction de la Santé de la Mère et de l'Enfant (DSME).*

WGGE will be emphasized in malaria activities by ensuring that every mother with a child under-five will have access to a mosquito net for prevention, every pregnant woman will access SP for malaria prevention in pregnancy, and both mother and child will have access to ACTs for treatment of malaria episodes year-round. The PMI program will support the GOB in ensuring that free care for malaria is given to both pregnant mothers and children under-five. This will be a commitment shared with the GFATM, UNICEF and other donors.

Maternal Health and FP – This focus area includes antenatal care, essential and emergency obstetric and neonatal care (EONC/EmONC), including AMTSL to prevent maternal mortality due to hemorrhage, and family planning. Most activities in this focus area are managed by USAID, with additional contributions from the Peace Corps. Maternal and neonatal mortality constitute major bottlenecks in achieving health improvements. Under the BEST Action Plan, the GHI focus will be on health zones that are lagging in the achievement of their maternal and child health indicators: urban slums whose unprecedented growth is already stretching the local capacity of the health system and the six newly weaned off departments that do not yet have a full complement of services and staff.

Maternal Health and FP activities under GHI link closely with most priority MOH activities targeting mothers and children at the household, community and peripheral health unit levels (maternities and

health centers) under the MOH's *Direction de la Santé de la Mère et de l'Enfant (DSME).* The most relevant programs are MCH, EPI and FP/RH. Nutrition promotion activities under the DSME's Nutrition program will also be supported, as integrated with the PIHI package. Quality improvement collaboratives at the departmental level will be supported to ensure smooth functioning of home- and community-level interventions.

Most activities under this program focus area benefit women and girls, and gender issues will be emphasized throughout the implementation of the GHI Country Strategy. Saving mothers' lives during pregnancy and delivery has been and will continue to be a major focus of USAID investment; training and re-training of midwives in the use of EONC and EmONC, especially AMTSL, will also be a major investment area. For FP, communities and families will be strongly encouraged to delay sexual debut, marriage and pregnancy for adolescent girls. This will be added as priority themes during FP counseling and will be repeated in IEC/BCC campaigns. This will contribute to the reduction of teenage pregnancies and their life-threatening complications such as obstructed labor and illegal abortions. FP will also emphasize the shared roles of women and men in determining their desired family size.

Child Health – This focus area includes collaboration with the MOH in the implementation of essential newborn care, integrated management of childhood illness at the facility and community levels; prevention and treatment of malaria, diarrhea and pneumonia; promotion of immunizations, and nutrition promotion. GHI will also invest to revitalize the MOH's national immunization program to achieve the Reaching Every District (RED)[4] strategy, and to eradicate polio once and for all in Benin. Most activities in this focus area are programs led by the MOH and supported by USAID, with additional contributions from the Peace Corps. Portions of the USDA and ADF portfolios will include nutrition support activities.

Child health activities will closely link with GOB program priorities such as the EPI to raise immunization coverage; IMCI to reduce child morbidity and mortality due to child killer diseases; and point-of-use water treatment and personal hygiene to prevent diarrhea; and correct and consistent mosquito net to prevent malaria.

Integrating WGGE with child health will take two directions: first, an emphasis on child survival by maintaining the health of mothers and improving their skills in infant and child care, and second, the insistence that young girls receive equal preference to boys in the utilization of health services. Counseling on these two points will be delivered during post-natal consultations, an important component of maternal health. During such encounters, it will be essential to the mother who has recently delivered a baby, that she receive advice on self-care, nutrition counseling for her and her baby, and family planning options.

The perception that genders are unequal, with boys being of more value, is the one social barrier that will be pursued with great intensity. This is rooted in the cultural assumption among most Beninese families that a daughter eventually leaves home anyway for the benefit of her husband's family. This attitude drives the lower school-enrolment rates for girls, the early marriages and teenage pregnancies, and even gender violence. Evidence of this attitude, in fact, shows early in life: health service utilization rates for girls are not at the same level as that for boys. Achieving gender equality will be a constant theme in everything implemented under the GHI Country Strategy. These will be tracked through sex-disaggregated data for children under-five in health units, public or private, that will receive USG assistance. The data on this will be examined annually, and if evidence of discrimination against girls exists, those communities concerned will be targeted for greater IEC on the equal value of girls and boys in the home, the community and in the economy. These efforts will be linked to the mothers' groups created by USAID's education program that have been effective in working with schoolteachers to maintain young girls in school until they graduate from elementary school.

[4] The Reaching Every District (RED) strategy is intended to extend the national immunization program to every commune in Benin, expanding access of children to routine immunizations nationwide.

Innovations for sustainable scale-up of interventions and new reforms optimizing local partners:
Examples of innovations and reforms that will be scaled-up by GHI in Benin:

- *Wireless technology for reporting:* PMI will track usage of supplies by wireless technology. USAID is funding a project that will use wireless technology in reporting services delivered. This will lessen the time it normally takes hard copies to be processed by at least three weeks. Routine forms on paper were previously submitted monthly.
- *Formalizing CHWs' engagement:* USAID is working alongside Africare, UNICEF and UNFPA in enabling local NGOs and local governments to mobilize and train CHWs for community-based services. This has allowed USAID and other donors to recruit and train close to five thousand CHWs across the country.
- *Expanding the role of CHWs:* With USAID support and advocacy, the GOB now allows CHWs to administer antibiotics for pneumonia. This is a change in policy that has the potential to save lives by increasing access to prompt treatment in many isolated rural communities nationwide.
- *Enhancing the role of midwives for maternal and infant survival:* The role that midwives play in maternity clinics and outpatient consultations will be given appropriate recognition, by providing additional training, awards or added incentives to do an even better job in reducing maternal and infant deaths. Respectful care by midwives to women during the delivery will be an important theme.
- *TETU or Triage, Evaluation and Treatment with Urgency:* This is a PMI/Benin-supported innovation that saves lives of young children with malaria by cutting waiting times for treatment and application of urgent care. It will be scaled up to 55 hospitals this year, after experience in the pilot 13 hospitals has shown mortality reductions by up to 53%.
- *Responding to women with fistula:* After a year of collaboration, a loose coalition of partners will attempt to double the number of women undergoing fistula repair in 2012. USAID will fund several grassroots NGOs to identify and encourage women with fistulas to undergo surgery at two faith-based hospitals in the North of Benin. The women's travel and other non-hospital expenses are paid by USAID/Benin, while UNFPA pays for the cost of the surgical intervention. The surgeons in the faith-based hospitals do not charge professional fees.

Accelerating research and innovation: Examples of specific research and innovation that are ongoing or will be completed in the next five years include:

- *Malaria research:* PMI has supported over the past three years the training of researchers at the Entomology Research Center of Cotonou (CREC) to build Benin's capacity to pursue research on malaria vectors. This activity has the potential of increasing new knowledge and approaches to vector control.
- *Injectable contraceptives:* USAID/Benin will support a pilot of the delivery of injectable contraceptives to women at the community level. This will eventually assist the government in scaling-up the availability of injectable contraceptives. A parallel study will also be funded to verify claims that Depo-Provera, a common injectable contraceptive supported by USAID, delays the return of fertility to women for a longer period than Noristerat, another injectable contraceptive.
- *Supply Chain Assessment Tool:* USAID/Benin recently hosted a supply chain assessment team from Deloitte, the accounting firm. Benin was the first country where a Supply Chain Assessment Tool developed by Deloitte was tested. This tool has the potential of identifying weaknesses in the supply chain and in resolving them during the course of the implementation of the GHI Strategy.

Monitoring and Evaluation and Learning

USAID/Benin is in the process of revising its Benin performance management plan, including new performance indicators, to be in line with the GHI Results Framework. The Results Framework will allow individual agencies to better monitor the achievements of program operations, collect and analyze performance information to track progress toward planned results, and influence decision-making and resource allocation. Child health indicators will be disaggregated by sex to monitor progress on WGGE.

The main sources for monitoring performance information will be quarterly and annual partner progress reports, site visits, and periodic evaluations. Information gathered through these sources will be disaggregated by gender and analyzed regularly during activity implementation reviews. The information will also feed into the annual performance report shared with the Office of the Executive Director of the Global Health Initiative through the Performance Plan and Report. Major impact and outcome indicators will be tracked through the Demographic and Health Surveys (DHS) and EMICOV, a survey which will be implemented jointly with the DHS, focuses on economic indicators, and is funded by the Millennium Challenge Corporation (MCC).[5] This report will be issued in 2012, and will be used to establish baselines for the GHI indicators and mid-terms for PMI. The addition of gender disaggregated economic data will also provide a rich source of accurate information to inform a national gender analysis. Another DHS will be done in 2016 to provide a basis for evaluating the impact of GHI in Benin, and the achievement of the health MDGs. The UNICEF-sponsored Multiple Indicator Cluster Surveys (MICS) and other stakeholders' documents will help the Benin GHI team measure progress on the impact indicators between the DHS surveys.

Whenever feasible and beneficial, the GHI Team will assist individual agencies to set up annual portfolio reviews to determine whether health programming is "on track" or if new actions are needed to better achieve results. These portfolio reviews will review performance information from the annual performance report, examine strategic and operational issues, and determine whether GHI-supported activities are leading to the results outlined in the Results Framework. Analysis during the portfolio review will influence management decisions about implementation and feedback into planning and achieving processes.

Periodic evaluations will be undertaken during the implementation of the GHI (see Table 2 below) over the next five years. Mid-term evaluations will be conducted on the health activities to document progress or lack thereof and the types of actions needed to improve performance of the project or portfolio. Health facility surveys and behavioral surveillance surveys will be conducted by the implementing partners targeting key services and behaviors. A health facility survey for malaria case management and IPTp is already planned for 2012. End-Use Verification Surveys are conducted under PMI on a quarterly basis to assess the availability of malaria products and other essential medicines on a sample of 20 service delivery sites. The GHI Team will explore the possibilities of integrating additional information required by different agencies into these surveys. For example, PCVs may assist USAID on field surveys and data quality assessments and channel lessons learned into the database of USAID's other larger projects.

Table 2. GHI Evaluation Schedule

NAME OF EVALUATIONS	WHEN	KEY RESEARCH QUESTIONS
Demographic and Health Surveys (DHS)	2011, 2016	-What is the health status of the population of Benin? -What is the impact of interventions on malaria and family health in our target population?
Health Facility Survey	2013	-How have Benin's health services in public and private sector facilities improved since the start of GHI implementation?
UNICEF MICS	2013	-What is the health status of the population of Benin?

[5] EMICOV is Benin's national household living standards measurement survey, *L'Enquête Modulaire Integrée sur les Conditions de Vie des Ménages.*

		-What is the impact of interventions on malaria and family health in our target population?
Behavioral Surveillance Survey	2014	-How has behavior changed in the target population since the start of GHI implementation?
Midterm Evaluation of Projects	Various	-Are programs being implemented as planned, reaching the target population, documenting lessons learned, etc.?
End-Use Verification Surveys	Quarterly	-Are essential services and products available at the service delivery sites?

In addition to monitoring and evaluation activities, GHI research activities will contribute to country and agency learning in service delivery and implementation of integrated programming. A USAID centrally-funded four-year child survival project will focus operations research to test mobile telephone technologies for improving referrals and communication between CHWs and health facilities. Given the successful advocacy vis-à-vis the GOB to revise policy to allow treatment of ARI with antibiotics by CHWs at the community level, USAID will continue to work with the MOH to pilot-test other services at the community level for eventual policy revision and scale-up. The potential list includes: community-based approaches for antibiotics for newborns, injectable contraceptives, and immunization services. Other potential areas for research include community-based financing options and integration of health promotion and BCC activities into micro-credit services. Resources will be sought for a general Benin gender analysis based on the integrated DHS survey, which includes modules on female genital cutting and obstetric fistulas.

Communications and Management Plan

The first step to harmonizing health programs under one country strategy will be the use of the same baseline data on population, literacy rates, mortality rates and other health indicators relevant to the GHI Country Strategy. In April 2012, the DHS IV will have issued preliminary data that can be used for planning. The members of the GHI Team also commit to share with each other their planning documents, planned procurement activities, and any major changes in their budgets and key personnel. They will also share with each other plans and resources in celebrating World Health Day, World Malaria Day and World AIDS Day, tapping into each other's staff or partners as speakers or resource persons for the event being celebrated. In all instances, procurement sensitivities will be strictly observed.

The approved Benin GHI strategy will be posted on the USAID/Benin website and those of other agencies, as appropriate, to promote transparency. Whenever possible, GHI principles will be considered in all partner agreements and future amendments, and the Agreement Officer's Technical Representative/ Contracting Officer's Technical Representative (AOTR/COTR) will discuss the GHI program with the relevant activity management teams. A map will be created to show the locations in Benin of current projects of USG agency members. The GHI Team, in collaboration with the MOH, will publish a short newsletter every six months. It will focus on plans, project progress and partnering opportunities.

Each agency with a health portfolio in Benin will be represented on the GHI Team in Benin. The lead agency will be USAID/Benin, as it funds approximately 90 percent of the USG health portfolio in the country. USAID/Benin will provide technical direction and leadership to the process with the Ambassador providing overall policy leadership. There will be an annual planning meeting co-chaired by the Ambassador and the Minister of Health or her representative to coordinate annual operating plans and planned project designs around the GHI Country Strategy. This will occur during the first quarter of the year as a preparation for the Mission Strategic and Resource Plan (MSRP), the Operational Plan (OP), the Malaria Operational Plan (MOP), and other planning documents. This will enable member USG agencies

to identify common issues, and to share resources, such as training, visitors, consultants and celebrations of health events during the year. During that period, consultations with the GOB will also be conducted, and indicators shared between the GHI Country Strategy and the GOB will be identified for any new projects. Consultations with multilateral and other bilateral partners, civil society and the private sector may also be organized.

For the rest of the year, quarterly meetings will be convened to review progress against planned GHI processes and milestones and discuss other matters necessary to promote successful GHI implementation. USAID/Benin, being the lead agency in Benin's health sector, will act as the Secretariat, and will organize meetings and contacts with the MOH. Two MOH focal points will be identified for ongoing USG contact with key MOH programs: the National Malaria Control Program (NMCP) of the *Direction Nationale de Santé Publique (DNSP)* for malaria activities, and one from the *Direction de la Santé de la Mère et de l'Enfant (DSME)* for MCH, and FP/RH activities. Additional meetings outside of the scheduled quarterly meetings may be called to resolve problems or to welcome visiting teams, visitors or technical consultants. Short summaries of regular meetings that USAID/Benin attends with the GOB and other donors will be circulated to members of the GHI Team to ensure they are apprised of Benin's bigger health sector picture.

Linking high-level goals to programs: Illustrative actions and milestones

Below, listed by IR, are illustrative activities that will go into the OP, the MOP and the MSRP, and some selected milestones. Malaria activities within GHI will closely link with the NMCP and will involve all sub-results across the three intermediate results, with the exception of IR 2.3. Some malaria interventions, such as IPTp, TETU and behavior change related to the use of mosquito nets will be closely linked with Maternal and Child Health activities. Other MCH and FP activities will also have elements spread almost evenly across all three IRs in the Framework, again with the possible exception of IR 2.3.

IR 1. Improved public health sector performance in delivering integrated family health services.
Current activities in this area include USAID's PMI, MCH and FP/RH activities. All these activities have a health systems strengthening component that support this IR. Peace Corps health volunteers may assist in delivering services at maternity clinics and health units at the periphery of the health system.

Milestones:

- At the end of March 2012, the first yearly planning exercise between the GHI Team and the MOH and multilateral and bilateral partners will be conducted. Subsequent annual exercises between 2013 and 2015 will include an evaluation of the first year's achievements.
- By end-2012, all GHI member agencies in Benin will have adopted the GHI Strategic Framework as the common game plan facilitated by all to accelerate child and maternal mortality reductions by 2015. Each USG agency will list items of GOB priorities they are adopting and describe where in Benin's health system their support will be focused on.
- By September 2012, USAID/Benin will have facilitated the preparation of a capacity building and leadership plan for the NMCP and the DSME, with co-funding from other donors.
- By January 2013, DHS IV results will have been used to adjust baselines of all health service indicators, with a comparative analysis of differentials between genders, and recommendations on increasing coverage for women and girls.

IR 2. Improved private health sector performance in delivering integrated family health services.
USAID is currently the only USG agency promoting this IR. The expansion of socially franchised ProFam clinics will be supported. In collaboration with the World Bank and UNICEF, USAID will fund a study to create a road map to engaging the private health sector around national health priorities. USG technical assistance will be tapped to enable this sector to get organized to deliver quality health services in line with national policies and protocols.

Milestones:

- At the end of March 2012, planning exercises to align priorities will be conducted between the GHI Team, private sector and civil society health providers, with the participation of the MOH.
- During the next 12 months, USAID/Benin will work with Benin's Financial and Technical Partners to include private health sector governance as a broad issue to examine during annual health sector reviews.
- By June 2012, a registry and map of active private health care providers in Benin will be completed.
- By September 2012, a strategy for the registration and ongoing supervision of the services provided by civil society and private health providers will be presented to the MOH for approval.
- By September 2015, the number of registered private health providers will have doubled over the 2011 baseline.

IR 3. Improved preventive and care-seeking behavior of an empowered population.

This IR, with a major social marketing and behavior change component, is a principal focus of activities of USAID and the Peace Corps. These USG agencies will be actively involved at the community level, promoting new healthy behaviors and products to maintain or improve health. Major preventive behaviors promoted will be antenatal consultations and postpartum care for mothers, immunizations for children and hand-washing with soap at appropriate times. Point-of-use water treatment, FP use to prevent unintended pregnancy, use of bednets, and correct condom use for HIV prevention are some of the product-related behaviors that will be promoted.

Milestones:

- By the end of February 2012, GHI Team members will participate in a national consultation on advancing PIHI coverage at the household and community levels, and will list their agencies' specific inputs to expanding coverage, especially on those items targeting women and adolescent girls.
- By June 2012, all GHI member agencies active in behavior change communication in Benin will participate in planning a behavior change and social marketing strategy for 2012-2016 focused on ORS point-of-use water treatment, bednet use, FP, HIV prevention and ANC visits.
- By January 2013, the ten to twelve health zones targeted by the BEST Action Plan will be chosen on the basis of health system performance, service coverage levels and mortality indicators.

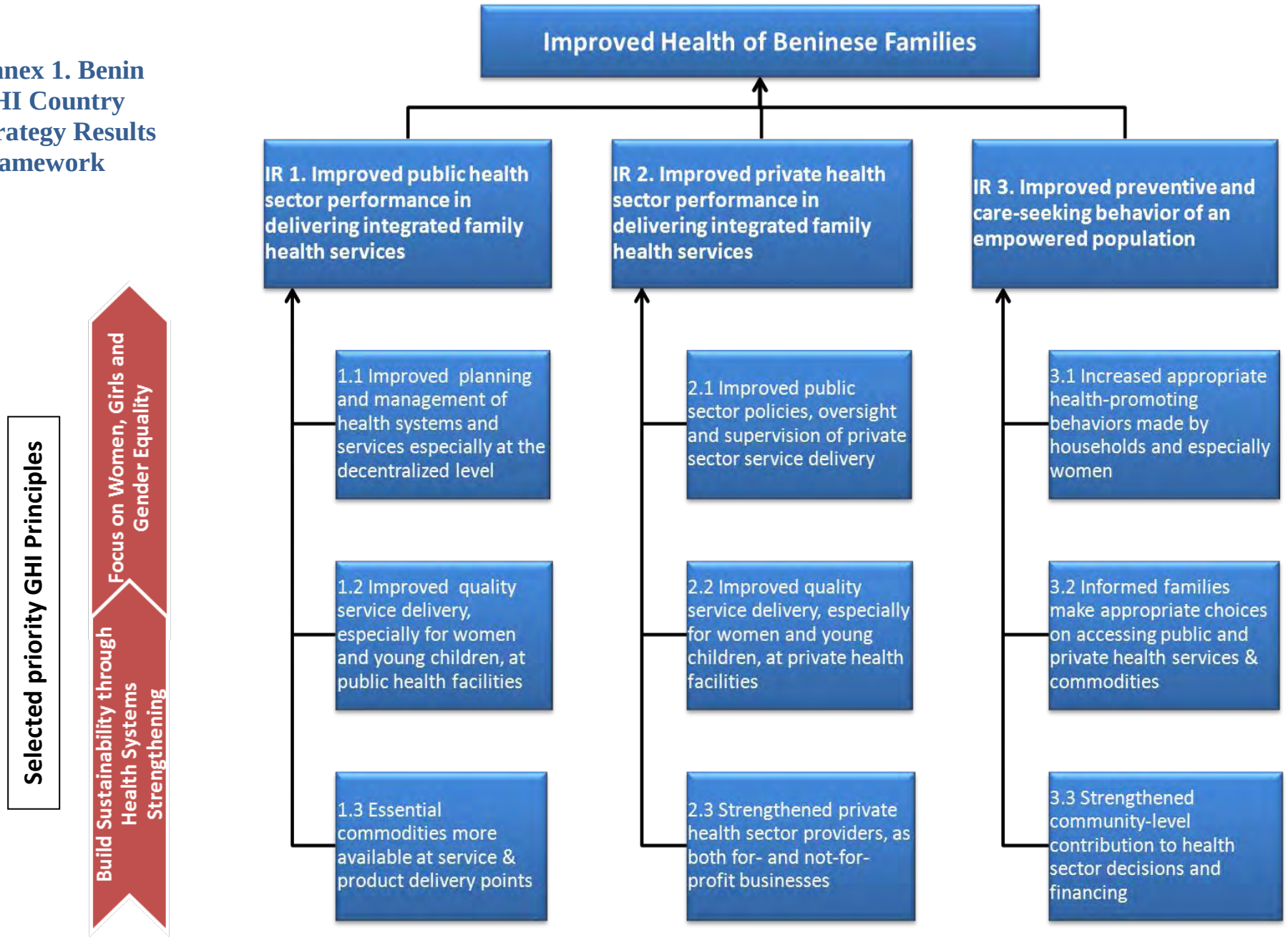
What's new: The collaboration that began with USAID and the Peace Corps on health activities in Benin several years ago will now include all USG agencies involved in Benin's health sector. The availability of a common country strategy that describes a shared results framework, programmatic focus and common targets and indicators of progress will facilitate the process. The joint reviews co-chaired by both the Minister of Health and the US Ambassador are also new. Joint program planning and evaluation among the Benin GHI Team members is the logical next step.

Programmatically, the expanded focus on the private sector is new, and will be broader than USAID/Benin's prior limited experience with socially-franchised private health service providers. It will include support to private clinics and health providers, helping them achieve financial sustainability. The inclusion of the private sector in the strategy has some known risks that will need to be managed. These include the amorphous character of the sub-sector, the difficulty of monitoring and evaluation of private sector activities, and the lack of experience of the MOH to supervise and harness the sector's potential for health and development. There is also the necessity to work with another government ministry, the Ministry of Small and Medium-Sized Enterprises, requiring another layer of coordination and supervision.

The higher level of collaboration with other donors and the leveraging of resources from government and other partners are also new. This is both an emerging necessity within the current financial environment and a potential source of strength in program design, as it builds commitment from a variety of stakeholders.

The GHI target population has also expanded southward, and will include the urban and peri-urban populations of Cotonou and Porto-Novo. Recent service maps have shown that vulnerable groups from these populations now have less access to many basic health services than the rural populations of departments in northern and central Benin.

Annex 1. Benin GHI Country Strategy Results Framework



Annex 2 GHI Benin Strategy Matrix

Relevant National Priorities/ Initiatives: All GHI activities support the Benin ten-year National Health Development Plan (*Plan National de Développement Sanitaire 2009-2018*, PNDS) and the three-year health operating plan (*Plan Triennal de Développement Sanitaire 2010-2012)*
Overall GHI Principles: All activities implemented through GHI support to these GHI Principles as priorities:

- Focus on Women, Girls and Gender Equality
- Build Sustainability through Health Systems Strengthening

GHI Benin Health Priorities to Improve the Health of Beninese Families by 2015:

1. **Malaria –** ***Reduce malaria mortality by 50% from the 2006 level of 9,165 deaths***
2. **Child Health –** ***Reduce the U5MR to 62/1,000 live births (2011 baseline TBD)***
   Reduce the neonatal mortality 20/1,000 live births (2011 baseline TBD)
3. **Maternal Health and FP –** ***Reduce the MMR from 790/100,000 live births to 197/100,000 live births***
   Increase the modern contraceptive prevalence rate from 6.1% to 15%

(N.B.: All child health indicators will be disaggregated by sex. Baselines will be reset when the 2011 DHS results are available. MDG-related figures are from UNDP MDG database. CPR is from 2006 DHS.)

Priority Actions with Largest Impact	GHI targets/Baseline Information	Potential current Partners
Intermediate Result 1: Improved public health sector performance in delivering integrated family health services		
IR 1.1 Improved planning and management of health systems and services especially at the decentralized level		
-Scale up EONC services in targeted departments.	-80% of health zones staffed and equipped to provide EONC and Basic EmONC (Baseline: 6%, 2010/MOH) -100% of district hospitals (*Centre Hospitalier Départemental*) staffed and equipped to provide Complete EmONC (Baseline: 50%, 2010/MOH)	-MOH, UNICEF, UNFPA, WHO, Local Government Units, URC/CHS, Peace Corps
-Develop health facility capacity in target districts to provide routine vaccinations per EPI protocols.	-100% of districts reached by PEV under RED (Baseline: 50%, 2010/MOH) -90% of children 12-23 months fully vaccinated (Baseline: 47%, 2006)	-MOH, UNICEF, local NGOs, Peace Corps
-Scale up Quality Improvement Collaboratives in southern Benin.	-Quality Improvement Collaboratives are expanded to two new departments (Littoral and Atlantique). -All NMCP and DSME staff undergo Leadership Skills Training (Baseline: 0) -80% of health facilities reporting no stock-outs of ACTs and other essential medicines during the quarter (Baseline: 50%, EUVS/2010)	-MOH, URC/CHS, Abt Associates, Belgian Cooperation, URC, CAME, Deloitte, JSI/Deliver
-Contribute to Benin's Health Information System including strengthening of monitoring and evaluation functions.	-Benin's DHS 2011 completed and data available by September 2012. -Quarterly polio surveillance and DTP3 reports maintained (Baseline: 80%, 2011/WHO) -80% of health zones sending complete and accurate LMIS reports on a quarterly basis (Baseline: 40%, 2011/CAME)	-INSAE, ICF Macro, UNFPA UNICEF, WHO
-Conduct indoor residual spraying of houses in Northern Benin with an appropriate insecticide.	-Maintain current IRS coverage level at > 95% (Source: 2011/RTI)	-RTI, CREC, IRSP

IR 1.2 Improved quality service delivery, especially for women and young children, at health facilities		
-Scale up training, implementation and supervision of EONC (focused ANC, EmONC-B and post-natal care) and *PIHI* implementation. -Expand FP services provided to women post-partum. -Promote timely vaccination of eligible children.	-Increase to 65% assisted deliveries using AMTSL (Baseline: 13%, MOH) -Increase to 70% women receiving ANC with four visits during pregnancy (Baseline: 42%, 2006) -Increase to 90% of women followed up for post-partum care and FP counseling (Baseline: 68%, 2006) -Increase to 80% full immunization coverage of children by 12 months of age (Baseline: 47%, 2010/UNICEF)	-MOH, UNICEF, WHO, UNFPA, Peace Corps, USDA -MOH, UNICEF, UNFPA, WHO, Peace Corps -MOH, UNICEF Peace Corps
IR 1.3 Essential commodities more available at service & product delivery points		
-Ensure supply of essential drugs and FP commodities by training, supervision and mentoring of supply chain staff at all levels.	-80% of public health facilities reporting no stock-out of essential medicines and FP commodities (Baseline: 24%, 2010/EUVS)	-MOH, CAME, Peace Corps
Intermediate Result 2: Improved private health sector performance in delivering integrated family health services		
IR 2.1 Improved public sector policies, oversight and supervision of private sector service delivery		
-Facilitate private sector provider licensing and accreditation. -Disseminate information on FP/MCH/Malaria protocols of the MOH.	-Number of licensed private facilities licensed doubled from 189 (2011) to 378. -80% of private/NGO health care providers follow malaria diagnosis using RDTs (Baseline: TBD)	-MOH, FBO Network AMCES, Professional Associations -AMCES, ROBS, PSI, URC, ABPF
IR 2.2 Improved quality service delivery, especially for women and young children, at private health facilities		
-Scale up EONC (focused ANC, EmONC-B and post-natal care) and FP coverage by expanding *PIHI* implementation in private facilities.	-Proportion of deliveries with skilled attendants using AMTSL in private facilities increased to 65% (Baseline: 20%, 2010/MOH) -100% increase in the number of women receiving FP services in ProFam and other licensed private clinics (Baseline: 7,000, 2010/PSI)	-MOH, AMCES, ROBS, Professional Associations -MOH, PSI, URC, ABPF, ProFam, Peace Corps
IR 2.3 Strengthened private health sector providers, as both for- and not-for-profit businesses		
-Support the development of social franchise networks. -Conduct joint training with public health sector. -Include private health care providers in network of ACT recipients.	-70% of licensed private/NGO health care providers have a five-year business development plan (Baseline: 0) -At least 200 private clinics have one staff member trained to insert FP implants (Baseline: 50, 2011/PSI) -100% of private hospitals with 50 beds or more are included in the network of ACT recipients (Baseline: TBD)	-Abt Associates, Benin Management Association -MOH, Professional Associations, ROBS, AMCES -AMCES, ROBS
Intermediate Result 3: Improved prevention and care-seeking behavior of an empowered population		
IR 3.1 Increased appropriate FP/MCH/Nutrition behaviors made by households and especially women		

-Implement state-of-the-art BCC/Social Marketing activities.	-90% of households with a pregnant woman and/or children under-five will own at least one ITN (Baseline: 25%, 2006) -85% of children under-five will have slept under an ITN the previous night (Baseline: 20%, 2006) -85% of pregnant women will have slept under an ITN the previous night (Baseline: 20%, 2006) -85% of children under-five with diarrhea treated with Oral Rehydration Therapy (ORT) (Baseline: 23%, 2006) -80% exclusive breastfeeding rate at six months (Baseline: 43%, 2006) -70% of households in target areas practice hand washing with soap at appropriate times at a point used by family members (Baseline: 25%, 2006) -50% of households in target areas practicing correct use of recommended household water treatment technologies (Baseline: 6%, 2006)	-MOH, Africare, UNICEF, MCDI, BASICS, MSH, PSI, URC, ABPF
IR 3.2 Informed families make appropriate choices on accessing public and private health services & commodities		
-Implement state-of- the-art communication to promote private health facility selection based on quality and cost.	-By the end of 2014, 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy (Baseline: <1%, 2006) -85% of children under five with suspected malaria will have received treatment with ACTs within 24 hours of onset of their symptoms (Baseline: <1%, 2006)	-MOH, PSI, URC, UNICEF
-Conduct social marketing of ORS/Zinc for diarrhea treatment.	-80% of children receive ORS/Zinc for diarrhea (Baseline: 23%, 2006)	-PSI, MOH, URC, UNICEF, Peace Corps
-Enhance care-seeking behaviors for diarrheal disease and pneumonia.	-80% of children referred to a health facility for pneumonia (Baseline: 36%, 2006)	-MOH, BASICS/MSH, Peace Corps
-Support women with obstetric fistula to undergo surgical repair.	-100% increase in number of women accessing surgery for repair of obstetric fistula (Baseline: 38 in 2010/URC)	-MOH, UNFPA, Faith-based hospitals, Mercy Ships, NGOs
-Promote universal use of iodized salt.	-85% of households using iodized salt (Baseline: 25%, 2009/UNICEF)	-UNICEF, local salt producers
-Promote voluntary use of a broad range of modern FP methods.	-CPR (modern methods) increased to 15% (Baseline: 6.1%, 2006)	-MOH, UNFPA, PSI, URC, UNICEF, Peace Corps
IR 3.3 Strengthened community-level contribution to health sector decisions and financing		
-Create more effective community support systems: • Women's participation in *COGECS* • Financial support of *mutuelles.*	-70% of village health committees have at least 40% women in their decision-making body (Baseline: 35%, 2010/MOH) -70% of households who are *mutuelles* members pay their premiums regularly. (Baseline: 25%, 2011/URC)	-URC, BASICS/MSH, local NGOs -URC, Abt Associates, BASICS/MSH