Overall purpose

The Benin Mission was set up as a direct response to the draft proposal mentioned above. The main objectives were to develop a checklist, a report template guidelines for carrying out detailed reviews of the health sector as preparation for developing TORs for development surveys and development of health master plans. This was undertaken because it has been shown that recent reviews do not appear to provide sufficient information about the development and changes in the health sector, the influence of the various international donors and international and national NGOs on the operations of the MOH and the priorities of the government. This information is critical for setting the stage for the detailed development studies, which are then used to determine the types of technical and other ODA support to be provided to the health sector. It also helps to avoid overlap, duplication, and subsequent misunderstandings.

Thus the overall purpose of the mission was to test the draft template/checklist (see appendix 2) to do a health sector review, developed as a follow up to the proposal submitted to MOHW by JICWELS (See appendix 1). The test would assess the template and checklist in terms of relevance, sequencing, areas included and usefulness to the MOH staff using this template for their own review process. Concurrently, a preliminary review of the current health situation would also be accomplished to some extent to assess the usefulness of the draft template and checklist, eventually identifying the possibility for developing a ToR for a detailed development survey in the near future.

Objectives of the mission:

The specific objectives of the mission were as follows:

1. Field-test the draft health sector review checklist in terms of relevance, sequencing, topics covered and usefulness to host country MOH staff in assessing their own departments and their health sector.
2. Collect information about the health sector as part of testing the checklist.
3. Collect relevant documentation about the government's priorities in health and about the health plan of the MOH.
4. Request through the Director of Planning, MOH, Government of Benin that each director and head of department reviews the checklist and send comments to JICWELS.
5. Draft a report of the mission that would include a plan of action for the development of a revised checklist, sequencing of the areas of the health sector to be covered, a report template and guidelines for carrying out such a health sector review.
6. Make recommendations to MOH and JICA proposing the field-tested systematic approach for preparing for development surveys and health master plans.

Schedule of activities and persons met

Name of person	Position	Date and time of Meeting	Remarks
Mr. ATINDEHOU Christian	Directeur de la Programmation et de la Prospective Ministere de la Sante, de la Protection Sociale et de la Condition Feminine	20, April, 99 10:00	
Dr. Kossou HORTAENSE (Ms)	Direction Natinale de la Protection Sanitaire Service	20, April, 99 16:30	
Mr. John Florentin ZOSSOU	Planificateur-Analyste de Projects Direction de la Programmation et de la Prospective Ministere de la Sante Publique	20, April, 99 16:30	
Mr. Jean-Marie EHOUZOU	Directeur, Direction de la Coordination des Ressources Exterieures Ministere du Plan, de la Restructuration Economique et de la Promotion de L'emploi	21, April, 99 11:45	
Dr. Hamidou SANOUSSI, MPH (Mr)	Conseiller MPN de l'Equipe Pays Representation de L'oms au Benin (WHO)	21, April, 99 14:30	
Dr. S. B. Kouo Epa (Ms)	WHO Representative Benin	21, April, 99 14:30	
Ms Laura	Technical Advisor USAID	21, April, 99 16:30	
Mr.	Result and Resource Specialist USAID	21, April, 99 16:30	
Dr. Emmanuel Carlos A. Gbaguidi	Medicin Coordonnatour Projet Benino-Allemand des Soins de Sante Primaires (GTZ)	22, April, 99 09:35	
Mr. Pierre Codjo-Seijgnm	UNDP, Cotonou	22, April, 99 10:45	
Mr. Agbodge T. HOUENSOU	Chief Section UNDP, Cotonou	22, April, 99 10:45	
Mr. Jocelyn K. DEGBEY	Directeur de l'Administration Ministre de la Sante Publique	22, April, 99 12:30	
Dr. ABDOULAYE Idrissou (Mr)	Pharmacien-Commandant Biologist des Hopitaux Service de Sante des Armees	22, April, 99 12:30	
Mr. Sidi M. BOUBACAR	Representant Resident Banque Mondiale (The World Bank)	22, April, 99 16:20	
Mr. Slaheddine Ben-Halima	Senior Operations Officer Human Development II, Africa Region The World Bank	22, April, 99 16:20	From Washington DC
Dr. Moussa Yaro	Director Department of Environment and Health	22, April, 99 Afternoon	
Mr. Paulin Fassinou	Health Inspector Chief of Public Hyjiene Division	22, April, 99 Afternoon	
Dr. Malick SENE	Representative UNICEF	22, April, 99	
Dr. Fatou	Health Officer UNICEF	22, April, 99	
Dr. Togola	Water and Sanitation Officer UNICEF	22, April, 99	
Dr. MOUSSOU Kuassi Marcel	Directeur de l'Hopital de OUIDAH Minister de la Sante	23, April, 99 10:00	
Marina d'ALMEIDA MASSOUGBODJI (Ms)	Ministre de la Sante Publique Republique du Benin	23, April, 99 12:30	
Dr. Ayite P. Leon MEDJI	Oto-Rhinolaryngologiste Professeur A La Faculte Des Sciences de la Sante (C.H.U)	23, April, 99 14:00	

Name of person	Position	Date and time of Meeting	Remarks
	National Teaching University Hospital		

Preparation for the Mission.

The preparation for the mission consisted of two broad dimensions, **logistics** and **technical**.

The **logistic component** was coordinated by JICWELS and involved with the MOHW and JICA identification of a team leader for the mission, obtaining the necessary permission for travel and contacting the Embassy in Abidjan and through that embassy the JICA staff stationed in Cotonou. Direct contact was also made with the country office of Sumitomo Corporation in Abidjan and Mr. Hirata was assigned to the team. Travel and related logistical arrangements were also made and implemented by JICWELS through the efforts of Mr. S Nozaki and Ms. Y Owaki with support of staff at the JICWELS office.

Preparation for the **technical component** was based on the proposal that had been submitted and approved by the MOH (see Appendix 1) and the draft checklist that had been prepared by Dr Narula. The checklist was expanded and adapted for the mission and the mission objectives as stated below were developed and this checklist was forwarded to the MOH's Director of Planning for translation and forwarding to heads of departments. The list of activities and the person to be met and interviewed was also developed and forwarded to the MOH via Sumitomo Corporation. The team arrived in Abidjan and during the period required to obtain visa for Benin, met with staff from Sumitomo and reviewed the objectives of the mission, the list of persons to be met and the expanded checklist and discussed the assumptions underlying this mission.

There was some debate about the purpose of the mission so this was reviewed and clarified. It was explained that the primary aim of this mission was to examine the usefulness and validity of the proposed checklist for reviewing the health sector as a precursor for the setting up of the terms of reference for a health master plan development exercise. This meant that a detailed review of the health sector would initially be carried out using secondary data and interviews with government and donor staff and staff of local advocacy bodies including NGOs. Based on this review, the TOR for the health development plan would be developed and in this TOR any need for collection of primary data would then be identified. The TOR would lead to the development of a Master Health Plan (a sort of country strategy paper) that would identify gaps and needs that would require to be addressed within the framework or reform and health sector priorities of the government and then propose areas in which projects and programs for ODA support would be proposed.

Activities during the Mission

During the mission, the Director of Planning, Mr. C Atendehou met with the team and reviewed the objectives of the mission. A detailed presentation was made regarding the checklist and what was expected from the visit. This led to the drafting of a plan of action for the duration of the stay. It was agreed that the checklist would be translated into French and these would be distributed to the various directors and heads of the departments for their input. They will comment on the structure of the checklist, the sequencing of the questions, the areas covered, listing those they feel should be included, the usefulness and completeness and how the checklist could be used by them in assessing the role of their department/section in the overall development of the health sector and in identifying health needs that would benefits from ODA inputs.

The plan of action comprising of meetings and interviews was developed. This included meetings with senior staff within the MOH and with other sectoral ministries such as planning, and the sanitation department of Cotonou City office.

The checklist was translated and distributed widely through the MOH including a copy to the Minister of Health. Copies of the checklist were also shared with various donors such as UNICEF, UBDP, WB, WHO, USAID, DFID and NGOs. Feedback was obtained during the interview process where the checklist was used during the interviews. However, in some other situations, where the checklist was forwarded through the MOH or directly given, feedback has not yet been received. The Department of Planning has agreed to collate the feedback from all the recipients of the draft checklist. This is awaited as the Director was away attending a JICA sponsored two month training event on Health Systems Management in Tokyo.

Outcomes of the mission:

Objective 1: Field-Test Checklist
Field-test the draft health sector review checklist in terms of relevance, sequencing, topics covered and usefulness to host country MOH staff in assessing their own departments and their health sector.

The draft checklist is included in Annex 1. This checklist was employed during the various meeting with variable success. The factors that influenced the success in using the checklist were, time allotted for the interview during the which the checklist was used, the experience of the incumbent being interviewed, the respondent's awareness of his/her job description and understanding of the role the department plays in the MOH and knowledge of the overall goals of the MOH and future plans. Other factors intrinsic to the checklist were relevance of the questions to the department's role, the sequencing of the questions and some of the issues that lay outside of the health sector. The financing and management dimensions of the checklist were, as expected, understood by the administration departments, but the technical departments despite their administrative and management task did not address these questions adequately except in one or two situations.

Overall the checklist was considered useful, with many of the staff interviewed expressing how beneficial this checklist appeared to be to review their department's orientation, direction and performance within the overall tasks of the MOH. They also expressed that the checklist could be a useful tool for them to monitor what was happening in their departments and what linkages would need to be further cultivated for enhancing their performance.

Numerous suggestions were offered to make the checklist more effective. Concern was expressed about the depth of the questions asked. Some felt the questions probed too deeply (administration and finance) while others felt that more depth was required. The respondent's understanding of the review process and awareness of sectoral reform issues appeared to condition these responses. However, it was generally agreed that the checklist needed to have sufficient depth to encourage the respondent to rise above the immediate tasks and look at the medium to longer term. Suggestions were also made to adapt the checklist to the logic of the health sector of the country under review. This could be done through a review of the health plan of the government and the priorities of the MOH. Discussion with the planning and monitoring and evaluation divisions could assist in reorganizing the checklist to reflect the logic of the health sector in that country. Transportation as an area was not adequately covered in the draft checklist. UNICEF expressed delight to see the willingness of JICA to engage the government and other donors agencies in such an organized and systematic manner. Other donors were also met and expressed interest in the approach and agreed to provide feedback either directly or through the MOH directorate of planning. Mr. Christian Atendehou would coordinate this feedback. JICWELS through Ms Y Owaki would follow up.

The checklist would be reviewed, re-sequenced and revised. In addition to the revision and enhancement of the checklist, guidelines for the preparation for a health sector review would be developed. These would include steps to be carried out in Japan and those that need to be completed when the team arrives in the country. The guidelines will also include a reporting format and the steps to complete the report of the review following the country visit.

Objective 2: Health Sector Data
Collect information about the health sector as part of testing the checklist.

During the testing of the checklist and meeting with senior MOH officials and those of other ministries a number of documents were obtained. These have been listed in the appendix. The following is a summary of the review of these documents moderated by the notes from the various interviews:

Brief summary of the situation of the Health Sector in Benin

Geography, Climate and Hydrography

The Republic of Benin, formerly Dahomey, is a country in West Africa, located on the Bight of Benin. Benin covers an area of 114,763 sq. km, with unequal population distribution with vast areas of relatively uninhabited desert in the north and rather over-populated areas in the south.

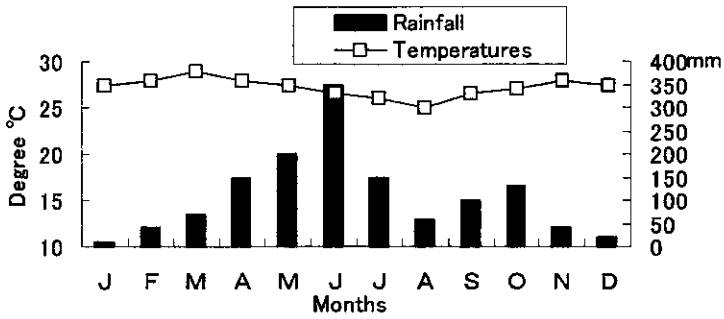
Table 1: Benin's Population Density in 1997

Departments (Administrative Area)	Atacora	Atlantique	Borgou	Mono	Ouémé	Zou	Total
People per sq km	23,2	366,6	18,3	194	219	48	48,8

Benin has a north-south length of 700 km, extending from the Atlantic Ocean to the Niger River. Its width varies from 125 km (along the coastline) to 325 km (in the latitude of Tanquieta town).

The Republic of Benin is mainly divided into three climate zones.

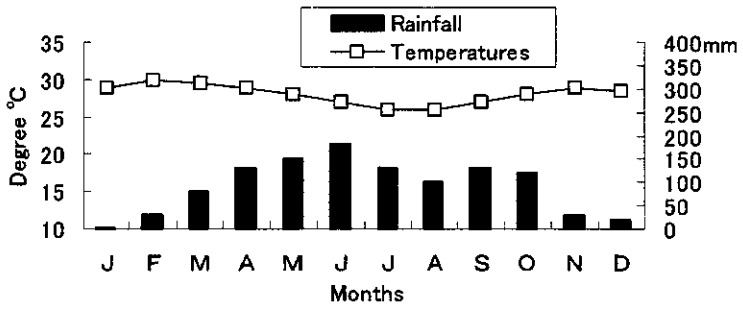
- The south is humid and tropical with two wet seasons (April to June and again between September and October) and two dry seasons (July to August and again between November and March). Temperatures are relatively high, but there is not much variation between 24℃ and 32℃. There, the average annual rainfall is 1,200 mm.



Source: National Meteorological Service

Graph 2: Average Monthly Temperature and Rainfall at Cotonou (1961 - 1990): Southern Zone

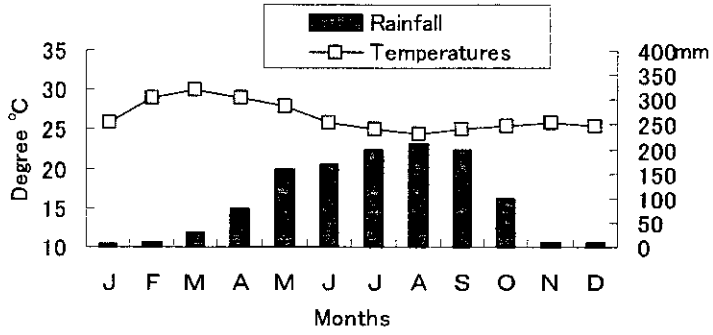
- The area that forms the second climate zone of the Guineo-Sudanian type, is characterized by a semi-humid tropical climate.



Source: National Meteorological Service

Graph 3: Average Monthly Temperature and Rainfall at Bohicon (1961 - 1990): Central Zone

- The north has a humid tropical climate with a dry season and a wet season.



Source: National Meteorological Service

Graph 4: Average Monthly Temperature and Rainfall at Parakou (1961 - 1990): Northern Zone

Many rivers originating from two large basins, the Niger basin and the coast basin water Benin.

Most of these rivers have their source in the Atacora (north-west of the country). The Niger basin includes the Mékrou (410 km), the Alibori (338 km) and the Sota (250 km). The Pendjari (380 km) has its source in the Atacora, and flows to the Volta in Ghana.

The coast basin is further watered by the rivers Ouémé (510 km), the Couffe (190 km) and the Mono (500 km of which 100 km is inside the territory of Benin). The rivers going through the coast basin flow into lakes and lagoons, relaying the streams toward the sea.

Water Supply and Sewerage;

Access to Household Potable Water

Administrative Area	Quality of Drinking Water			
	Potable		Doubtful	
	Number	%	Number	%
Atacora	208	38.3	335	61.7
Atlantique	732	77.1	217	22.9
Borgou	380	52.1	348	47.9
Mono	286	49.8	288	50.2
Ouémé	364	47.3	406	52.7
Zou	414	59.9	278	40.1
Benin	2.384	56.0	1872	44.0

1.2. Administrative Organization

The Republic of Benin, whose administrative capital is Porto-Novo and economic center is Cotonou, is composed of the following six administrative areas:

- Atacora (31,625 sq. km)
- Atlantique (3,312 sq. km)
- Borgou (52,098 sq. km)
- Mono (4,009 sq. km)
- Ouémé (4,545 sq. km)
- Zou (19,174 sq. km)

Each administrative area is divided into urban districts or sub-prefectures. These administrative areas are called prefectures and are administered by a prefectural governor. There are 10 urban districts and 67 sub-prefectures at the present time. Each urban district is administered by a district chief, while each sub-prefecture is administered by a lieutenant governor. Each urban district or sub-prefecture is further divided into communes. Benin has a total of 568 communes.

The village or town wards forms the basic administrative unit around which social life and production activities are organized. The villages or town wards constitute the administrative sub-divisions of communes.

Each village or town ward includes, besides residential areas, other lands that are part of the national heritage of Benin. Thus, Benin has at present a total of 2,367 villages and 1,011 town wards.

Table 2: Benin's Administrative Organization

Administrative Area (prefecture)	Sub-prefectures	Urban districts	Communes
Atacora	11	2	73
Atlantique	7	2	98
Borgou	12	2	86
Mono	11	1	85
Ouémé	13	1	91
Zou	13	2	135
Benin	67	10	568

Source: INSAE

1.3. Decentralization

An administrative land readjustment project is now being examined by the Ministry of the Interior, Safety and Territorial Administration (le Minstère de l'Intérieur, de la Sécurité et de l'Administration Territoriale). The aim of the project is to bring governing bodies closer to the people by increasing the number of administrative areas and promoting decentralization. This decentralization has to be understood as forming the basis of an administration strategy and is expected to result in a real transfer of power and authority commensurate with a clear division of responsibilities. It is to involve multiple sectors.

The decentralization reform proposes the creation of 6 new administrative areas, so that the total number of administrative areas of the country will be raised to 12.

1.4. Demography

Before 1961, the colonial administration had conducted periodic censuses to estimate Benin's total population. During the 1910 census, Benin's population was estimated at 878,000 inhabitants. The first General Census of Population and Habitats (RGPH: Recensement Général de la Population et de l'Habitat) took place in March 1979 and the second in February 1992.

Benin's population shows the characteristics of a developing country, with high rate of growth observed, especially in the younger age groups.

Table 3: Evolution of Benin's Population from 1929 to 1997

Years	1929	1950	1961	1979	1992	1996	1997
Total Pop.	1079 200	1 538 000	2 082 511	3 331 210	4 915 555	5 593 237	5 780 591

Source: INSAE

The analysis of population distributions by sex and age clearly indicates, at both the national and regional levels, the progressive narrowing of the pyramid as ages increase, with an extended base, this having the characteristics of youthful populations with prodigious fecundity.

Annex 1: Population Distributions by Age

Graph 5: Age Pyramid in Benin

(NEED TO SCAN THE TABLE AND CHART FROM THE STATISTICAL REPORT)

Table 4: Benin's Administrative Area Population Distributions: 1997

Administrative Areas	Population in1992	Annual Growth Rate	Population in 1997	Total Population(%)
Atacora	649 308	3.0	755 292	13%
Atlantique	1 066 373	3.2	1 253 943	22%
Borgou	827 925	3.6	990 262	17%
Mono	676 377	3.2	793 204	14%
Ouémé	876 574	3.2	1 027 829	18%
Zou	818 998	3.2	960 069	17%
Benin	4 915 555	3.2	5 780 599	100%

Source: 2nd RGPH, INSAE, March 1994

Major Demographic Indexes

Table 5: Demographic Indexes for the Period 1992 - 1997

Administrative Areas	Infant Mortality Rate(o/oo)	Infant-Juvenile Mortality Rate (o/oo)	Gross Mortality Rate(o/oo)	Gross Birthrate (o/oo)	Integrated Index of Fecundity (o/oo)	Life Expectancy at birth (o/oo)
Atacora	101	149	15.3	45.4	6.4	53.3
Atlantique	98	152	12.8	45.3	5.4	55.5
Borgou	84	121	12.0	47.7	6.7	57.3
Mono	98	153	14.6	46.4	6.4	55.4
Ouémé	101	158	14.6	46.3	6.0	54.7
Zou	117	172	17.8	49.6	6.6	51.1
Benin	99	143	14.3	46.7	6.1	54.3

Source: INSAC's Population Projections (based on the final data of RGPH2)

A higher mortality rate is observed in Zou and Atacora. Accordingly, life expectancy at birth computed in these areas is lower than that of the national average.

Table 6: Evolution of Infant and Juvenile Mortality Rates in Benin

Periods preceding the survey	Infant Mortality	Juvenile Mortality	Infant-Juvenile Mortality
1972-1977	135.6	144.2	260.3
1977-1982	116.6	119.3	222.0
1982-1987	113.5	111.0	211.9
1987-1992	113.6	101.4	203.4
1992-1996	93.9	80.0	166.5

Source: EDSBI 1996/INSAE

Generally, the mortality rate has been decreasing over the past 25 years. In fact, the quotient of infant mortality, which measures the probability of newborns dying before they reach their first birthday, went down from 136/1000 to 94/1000 during that period. Likewise, of 1000 children of age one, 80 did not reach their 5th birthday during the past five-year period, while there were 144, twenty-five years ago.

Table 7: Male-Female Ratio of Benin's Population

Administrative Area	% of men	% of women	Ratio F/M
Atacora	49.11	50.59	103
Atlantique	48.96	51.04	104
Borgou	50.21	49.79	99
Mono	47.70	52.30	110
Ouémé	48.07	51.93	108
Zou	47.49	52.51	111
Benin	48.67	51.33	105

Source: DPP/SSDRO-SNIGS, May 1996

Benin's population is female-dominated (the number of women exceeds that of men) by a percentage of 51 against 49. In other words, this ratio of women to men in the national population is 105 women compared to 100 men . This trend also appears in the administrative areas, except in Borgou, where there is an opposite tendency (99 women against 100 men) exists, as shown in Table 7.

Targeted Populations

In computing and analyzing the various health data, the Ministry of Health, Social Protection and Women's Conditions uses the age category precisely defined to this end. These are additionally oriented towards various programs and care offered by the health or medical centers and in accordance with epidemiological or family health surveillance.

Table 8: Targeted Populations in 1997 for Epidemiological Surveillance

Administrative Area	0-11 months	1-4 years of age	5-14 years of age	15 years of age and more	Total
Atacora	31 722	111 028	237 162	375 380	755 292
	4.2%	15%	31%	50%	100%
Atlantique	51 412	179 314	331 041	692 176	1 253 943
	4.1%	14%	26%	55%	100%
Borgou	44 562	153 490	316 884	475 326	990 262
	4.5%	15%	32%	48%	100%
Mono	35 694	113 428	262 551	381 531	793 204
	4.5%	14%	33%	48%	100%
Ouémé	44 197	151 091	301 154	531 387	1 027 829
	4.3%	15%	29%	52%	100%
Zou	44 163	146 891	282 260	486 755	960 069
	4.6%	15%	29%	51%	100%
Benin % of the general population	251 750	855 242	1 731 052	2 942 555	5 780 599
	4%	15%	30%	51%	100%

Source: DPP/SSDRO-SNIGS, 1997

Table 9: Targeted Populations for Family Health

Administrative Area	FAP	Newborns	Expected Pregnancy	12-36 months of age
Atacora	164 654	34 290	39 434	90 140
Atlantique	310 978	56 929	65 330	120 446
Borgou	209 936	47 235	54 326	127 031
Mono	168 952	36 805	42 325	97 879
Ouémé	240 512	46 663	53 663	111 599
Zou	220 816	44 547	51 229	101 764
Benin	1 315 848	266 469	306 307	648 859

Source: SSDRO-SNIGS, May 1997

FAP (Femme en âge de procréer): Women of childbearing age (15 to 49 years of age)
Living newborns: TBN x Departmental Population
Expected Pregnancy: Living newborns + 15% of living newborns

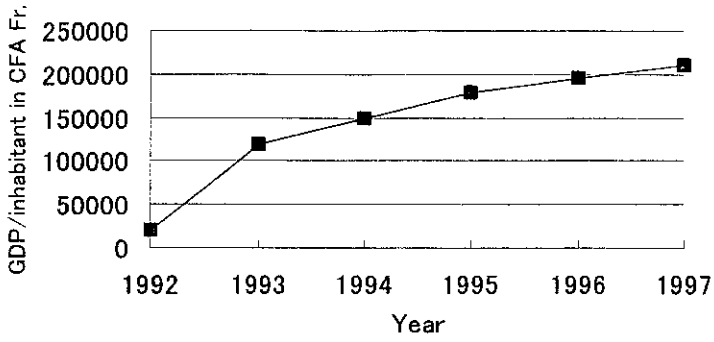
1.5. Evolution of the GDP

The Gross Domestic Product is the major measure of evaluating the riches produced by the whole national economy. For the purpose of more exactly appreciating its evolution, the current market prices of different years have been referenced to the 1985 prices as the standard. The per capita GDP has been seen to be gradually increasing since 1991. During 1997, the GDP increased by 6.6% as compared to 1996. This is almost two-fold compared to its level in 1991. After the growth rate decreased in 1992 - 1993, it has increased again from 1994. Due to the devaluation of the CFA franc that had been pegged to the French franc, there was galloping inflation during 1994. This eroded any gains in GDP per capita. But such inflation has been declining yearly and the deflation of the GDP, which was 33.5% in 1994 dropped to 4.7% in 1997 (cf. Table 10).

Table 10: Evolution of GDP from 1981 to 1997 at constant prices, 1985

Years	GDP (billion FCFA)		Economic growth rate (%)	Current GDP per inhabitant	Deflation of the GDP (%)
	Current market prices	Constant prices, 1985			
1991	529.7	513.4	4.7	109582	1.8
1992	569.5	533.9	4.0	115860	3.4
1993	596.4	552.7	3.5	117289	1.2
1994	831.1	576.9	4.4	158244	33.5
1995	1002.9	603.5	4.6	184904	15.4
1996	1129.5	636.9	5.5	201592	6.7
1997	1249.8	673.4	5.7	215823	4.7

Source: INSAE



Graph 6: Evolution of GDP per Inhabitant at Current Market Prices, 1985

The Ministry of Public Health is in charge of the implementation of the policies defined by the government concerning public health issues. It initiates action relating to health, works out the necessary organization, and coordinates and controls the operation of the relevant activities.

In the national 5-year plan covering the period 1996-2001, the Ministry of Public Health has been assigned 5 main objectives. These are:

- Improve the coverage of the National Health Insurance Scheme
- Encourage traditional medicine and pharmacopoeia
- Establish a national social security system
- Fight illegal trafficking of medicaments and drugs
- Promote behavioral changes that would lead to improved lifestyles

A framework to achieve these objectives has been defined and actions have been taken especially regarding the infrastructure development, upgrading and procurement of medical and technical equipment, training of health personnel, recruiting of additional staff, reinforcement and targeting of bilateral and multilateral cooperation and improved partnership with the private sector.

Situation of the Ministry of Public Health prior to 1996

The health situation was characterized by a variety of tropical diseases with a predominance of endemic and epidemic infections. There was widespread inadequacy in the availability of potable water and sanitary services and facilities were very inadequate, especially in rural areas. This low rate of access to potable water was partially related to the consumption habits, which continued to promote the use of traditional water sources to the detriment of "modern" water sources.
The administration of human resources also presented difficulties because of its decentralization on one hand and the absence of a clear career policy for staff on the other hand. One could observe:

- an insufficiency of generalist doctors in peripheral health training
- an insufficiency of administrative staff, especially in strategic management
- an inequitable distribution of personnel between urban and rural areas
- lack of collaboration between the public and private sectors

The distribution of health infrastructures and organization of the health pyramid followed political and administrative priorities that did not always take into account the distribution and density of population. In 1996, there were 799 public health facilities and 523 private health facilities.

Situation of the Ministry of Public Health since 1996

The examination of the preceding period showed that to address some of the insufficiencies and inadequacies would necessitate the elaboration of policies and strategies. Thus, for better administration of the health sector, the following policies and strategies were formulated:

- Strategies for the development of the health sector (1997-2001)
- National policies on costing of basic health care services and essential drugs (1999-2001)
- Policies regarding blood transfusion
- Policies regarding the reorganization of the basis of the health pyramid
- Norms and standards for the establishment of sanitary zones
- Legal framework of collaboration with NGOs working in the health sector
- Master Plan for Departmental Management of Public Health
- Budget programs
- Triennial plan of Development (2000-2002)

The implementation of various policies and strategies has resulted in the following:

1 - Improvement of the national health coverage

- Health centers have been established and/or rehabilitated
  - 1996 : 53 sanitary facilities costing a total amount of 980,221,545 F CFA
  - 1997 : 45 sanitary facilities costing a total amount of 3,138,929,449 F CFA
  - 1998 : 60 sanitary facilities costing a total amount of 1,907,483,439 F CFA
- Health centers have been equipped with medical and technical equipment amounting to :
  - 2,010,867,096 F CFA in 1996
  - 309,803,625 F CFA in 1997
  - 1,653,483,439 F CFA in 1998
- The number of beds in sanitary facilities has almost doubled. In fact, the situation in Bénin has improved from 1 bed for 2282 inhabitants surveyed at the time of the round table conference on the health sector in 1995 to 1 bed for 1000 inhabitants in 1998.
- Within the framework of the initiative of independence in vaccines, the national budget contributed 30,000,000 F CFA in addition to the intervention of UNICEF. The budget contributed 87 500 000 F CFA.
- Vaccination activities have led to the achievement of the following coverage rates:
  - 1996 : BCG (90%), DTCP (80%), VAR (74%), VAT2 (75%)
  - 1997 : BCG (89%), DTCP (78%), VAR (82%), VAT2 (75%)
  - 1998 : BCG (94%), DTCP (82%), VAR (74%), VAT2 (74%)
- For the eradication of poliomyelitis in our country, vaccination days have been established.
- Vitamin A capsules were administered to infants of ages 1 to 5.

- In 1997, a center of information and of anonymous and free HIV/AIDS tracking was created in Cotonou.
- This action was backed up by a Grand National Awareness Campaign of HIV/AIDS in the armed forces, which are the focal points of PNLS, with the collaboration of military doctors.
- In 1998, grand national AIDS awareness campaigns involving politico-administrative authorities, NGOs and the population, named Operation "Stop AIDS", were carried out all over the country.
- Within the framework of reinforcing the technical capacity of the staff, 41 agents were trained in various fields of specialties in the sub-regions with the back up of partners for development.
- After the establishment of a recruitment scheme in 1986, the tentative recruitment effort started in 1994 has become a reality today; thus, our department has recruited permanent State agents and contractual agents to make up for the insufficiency observed in the sanitary facilities of the country.
    - 123 permanent State agents in 1996
    - 203 permanent State agents and 668 contractual agents in 1997
    - 170 permanent State agents and 578 contractual agents in 1998
- One can see in all parts of the country a continuous decline in the quality of life, as a result of the persistence of waterborne and sanitary diseases aggravated by the risks of recurring natural disasters such as frequent flooding. Proliferation of these diseases is due not only to the ignorance and nonobservance of elementary rules of hygiene but also to the absence of hygiene and sanitation organizations to promote adherence of the public to observe the hygiene codes.
- To remedy this situation and control these diseases, the Ministry of Public Health organized in each sector sanitary brigades and sanitary agents, identified within the community.
- The Ministry of Public Health recruited and trained 250.75 sanitary brigade personnel and 60 hygiene agents to serve in the sectoral sanitary facilities.
- Within this same work scope, more than 1000 familial latrines have been constructed to benefit the population of sectors menaced by a high cholera, potential.
- Besides, actions have been taken for the promotion of hygiene activities and the formation of community relays for potable water treatment.

2 - Encouragement of traditional medicine and pharmacopoeia

- The year 1998 was designated for the census of traditional practitioners. A framework for working with them has been installed. To that effect, a "Promotion of Traditional Medicine and Pharmacopoeia" Project was set up in PIP for a total amount of 580,000,000 F CFA and launched.

3 - Establishing a national social security system

- 10 pilot mutual aid health associations have been installed and are operative; 3 of them are located in urban areas (Parakou, Porto-Novo, Cotonou).

4 - Fight illegal trafficking of medicaments and drugs

- The establishment of a new legislative and financial basis for the development of CAME has engendered a growth of its turnover. This rose from 1,810,822,555 F CFA in 1995 to 2,372,014,074 F CFA in 1998, showing a growth of 31%.

- Intense activities relating to public awareness were conducted through the mass media and consensus meetings.
- To discourage the illegal trafficking of medicaments, operation "Fist" was carried out to seize medicaments of doubtful quality that are in the market.
- A laboratory for quality control and the production of generic medicaments is now in the course of construction.

5 - Promote behavioral changes that would lead to improved lifestyles

- Seminars and workshops have been organized for decision-makers, opinion-leaders, communication professionals and administration staff.

  Constraints:

  The general difficulties shared by all the organizations are:
  - Insufficiency of human resources
  - Insufficiency of vehicles and data processing equipment for periodical supervision and implementation of advanced strategies
  - Insufficient and superannuated medico-technical equipment
  - Information and communication problems

Perspectives

- More than 18 milliards are in the course of investment for improvement of sanitary coverage.
- A financing plan for the acquisition of material resources indispensable for the efficient implementation of vaccination is in the course of elaboration.
- Intensification of activities relating to awareness and promotion of reproductive health
- Fight against endemic and epidemic diseases
- Decentralization of CAME
- Reinforcement of Information & Communication System by installation of INTRANET facilities within the Ministry
- Equip CNHU with scanner

In total, much effort has been made to improve the health situation of the population. New projects/programs that are expected to have an impact on the improvement of the social and sanitary conditions of the population have been set up in PIP and are being implemented.
However, additional efforts still need to be made, especially in the field of Community Health and Development. Consideration must also be given to the care of indigents to address the issue of increasing inequity associated with a changing health delivery structure.

Objective 3: Documents

Collect relevant documentation about the government's priorities in health and about the health plan of the MOH.

The following list of documents was obtained. These are listed below:

-FRENCH-

1. "Benin: Programme de Pays, 1999-2003"
2. "Budget Programme 1999, Direction Departmentale de la Sante Publique ATACORA" Janvier 1999. En Collaboration avec La Direction de l'Administration et la Direction de la Programmation et de la Prospection, Ministere de la Sante Publique, Republique du Benin
3. "Budget Programme 1999, Direction Departmentale de la Sante Publique ATLANTIQUE" Janvier 1999. En Collaboration avec La Direction de l'Administration et la Direction de la Programmation et de la Prospection Ministere de la Sante Publique, Republique du Benin
4. "Budget Programme 1999, Direction Departmentale de la Sante Publique MONO" Janvier 1999. En Collaboration avec La Direction de l'Administration et la Direction de la Programmation et de la Prospection, Ministere de la Sante Publique, Republique du Benin
5. "Budget Programme 1999, Direction Departmentale de la Sante Publique OUEME" Janvier 1999 EnCollaboration Avec La Direction de l'Administration et la Direction de la Programmation et de la Prospection
6. Ministere de la Sante Publique
7. Republique du Benin
8. "Budget Programme 1999, Direction Departmentale de la Sante Publique ZOU" Janvier 1999 En Collaboration avec La Direction de l'Administration et la Direction de la Programmation et de la Prospection, Ministere de la Sante Publique, Republique du Benin
9. "Budget Secteur Sante 1998, Rapport D'Execution" Mars 1999 Direction de l'Administration, Ministere de la Sante Publique
10. "Declaration de Politique de Population de la Republique du Benin"
11. Cotonou, 2, Mai 1996. Minister du Plan de la Restructuration Economique et de la Promotion de L'emploi, Direction Nationale du Plan et de la Prospective Commission, Nationale des Ressources Humanies et de la Population.
12. "Developpement du Secteur de L'Assainissement" Document de Politique Nationale. Juin 1995. Republique du Benin Ministere de la Sante, Ministere de l'Environnment, de l'Habitat et de l'Urbanisme
13. "Enfants et Femmes, Avenir du Benin" Juin 1998, Deuxieme Edition
14. Republique du Benin, UNICEF
15. "Evolution de la Couverture Vaccinale au Benin 1987-1998"
16. "Organigramme de Structure Hierarchique du Ministere de sa Sante Publique"
17. "Plan de Formation Continue et de Perfectionnement 1999" Decembre 1998. Ministere de la Sante Publique, Republique du Benin
18. "Plan Operationnel Phase 1 (1996-1999), Projet Benino-Allemand des Soins de Sante Primaires", Ministere de la Sante, de la Protection Sociale et de la Condition Feminine (MSPSCF), Republique du Benin. Service Allemand de Developpement (DED), Office Allemand de la Cooperation Technique (GTZ)
19. "Politique et Strategies Nationales de Developpement du Secteur Sante 1997-2001". Mars, 1997. Ministere de la Sante, de la Protection Sociale et de la Condition Feminine, Republique du Benin
20. "Politique Nationale de Tarification des Prestations de soins et des Medicaments Essentiels Sous Nom Generique 1999-2001". Juillet 1998. Ministere de la Sante Publique, Republique du Benin
21. "Programme D'action du Gouvernment" Cotonou, Mai 1997. Republique de Benin
22. "Statistiques Sanitaires Annee 1997" Decembre 1998. Service des Statistiques, de la Documentation et de la Recherche Operationnelle, Direction de la Programmation et de la Prospective, Direction du Cabinet, Ministere de la Sante Publique, Republique du Benin

23. "Systeme National D'Information et de Gestion Sanitaires". Guide D'Instructions Pour les Outils du Snigs, Decembre 1996, Republique de Benin, Ministere de la Sante de la Protection Social et de la Condition Feminine, Direction de la Planification de la Coordination et de l'Evaluation, Service des Statistiques de la Documentation et de la Recherche Operationnelle

-ENGLISH-

1. "Master Plan for Socio-Health Sector Development of Atlantique Department, January 1999-December 2001". December 1998. Atlantique Departmental Direcotrate of Public Health, Ministry of Public Health, Republic of Benin
2. "Benin-Second Health and Population Sector Project" March 1994. Government of Benin, Ministry of Health, Cotonou, Benin. (from The World Bank)
3. "Orientation Plan 1998-2002, General Report" July 1998. Ministry of Planning, Economic Restructuring and Job Promotion, Republic of Benin
4. "Orientation Plan 1998-2002, Thematic Reports", July 1998. Ministry of Planning, Economic Restructuring and Job Promotion, Republic of Benin
5. "Results Framework for USAID/Benin's Family Health Strategic Objective" February 25, 1999, USAID, Benin.

Objective 4: MoH Review of Checklist

Request through the Director of Planning, MOH, Government of Benin that each director and head of department review the checklist and send comments to JICWELS.

The following is a summary of the report by the Director of Planning in response to the questionnaires made available in September 1999

I Basic Hygiene and Sanitation

Description of the drinking water supply system, sanitary services and areas covered, financing, and delivery.

Drinking water in Benin is supplied by several different systems. The Société Béninoise d'Electricité et d'Eau (Benin Electricity and Water Utilities) provides running water to the urban populations:

- The Hydraulics Division (Direction de l'Hydraulique) intervenes in rural areas.

- The Department of Basic Hygiene and Sanitation (Direction de l'Hygiène et de l'Assainissement de Base) of the Ministry of Public Health provides drinking water to schools and health centers by construction of impluvia.

The sanitation sub-sector includes: evacuation of excreta, sewage and wastewater, management of solid household, industrial and toxic waste as well as rainwater and flood control. This sub-sector is managed by three different structures:

- The Minister of Public Health via the Department of Basic Hygiene and Sanitation (DHAB) is responsible changing behavior in terms of basic hygiene and sanitation.

- The Ministry of the Environment, Housing and Urbanism constructs gutters and sewers through the Department of Urban Roads (DAVU - Direction de l'Assainissement des Voies Urbaines) and also contributes to solid waste management.
- Many other national and international Agencies and NGOs also contribute to this sub-sector.

The strategy of this sub-sector is based on five fundamental principles:

- Implementation of long-lasting and effective institutional structures for services management;
- Promotion of sanitation programs developed from community requests;
- Participation of communities in financing, operating and maintaining construction projects;
- Skills development for local entrepreneurs and artisans;
- Promotion of appropriate technology adapted to the financial and management capacities of the government, municipalities and beneficiaries.

Evacuation of excreta

Most surveys carried out in Benin indicate that a low percentage of the rural population has an adequate sanitation system for evacuation of excreta available. The most common independent sanitation system is the traditional latrine. The availability of traditional latrines in rural areas is barely 5%, while in urban areas coverage is at 45%.

Rainwater drainage system

This type of drainage is almost completely absent outside certain towns such as Cotonou, Porto-Novo and Parakou that possess a few networks of open sewers. However, AGETUR (Agence des Travaux Urbains - Agency for Urban Construction) has nevertheless completed several pilot projects of urban public works) in the main cities. Most sewers in the towns are regularly blocked by household waste and sand, and consequently are not always operational. Towns such as Cotonou are often flooded as a consequence.

Evacuation of solid household waste

Most towns have no system of garbage collection. In towns with such a system, the collection rate is generally insufficient at around 30% of total waste, which are dumped in uncontrolled sites or in free areas within the town limits.

Management of industrial wastes

Many different kinds of industrial waste are produced in urban areas in the form of liquid or mud. Most of the time, this waste is not treated and is dumped directly into the surrounding environment.

In Cotonou, the cotton industry produces more than 50% of industrial waste. Other establishments produce industrial waste, such as slaughter-houses, hotels, hospitals, markets, restaurants, and paint and textile factories. Given the preceding remarks, it is evident that a great deal remains to be accomplished in the sanitation sub-sector.