

*Documenting the results of
implementing aid effectiveness
principles in the health sector*

Benin case study

Executive summary

Final report, 31 October 2011

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Executive summary

Context and definition of the problem

Benin has a low human development index, with more than one in three people living below subsistence level. Economically, the situation is characterized by low growth in per capita GDP. In 1999 Benin embarked on a series of specific budget reforms including the adoption of a programme budget as a planning and management tool. In recent years the rate of budget execution has been low, including in priority sectors, and public expenditure has been seriously skewed by the considerable size of the total wages bill. The Poverty Reduction Growth Strategy (PRGS) 2011-2015 is divided into five priority areas including one that targets the strengthening of human capital.

Inflowing aid trends have been positive. Over the period 2000-2009, external resources accounted for 22% of State expenditure on average. Nevertheless, the Government still lacks a comprehensive and real-time overview of aid implementation and nationally compiled data often does not match data collected directly from donors.

The epidemiological situation is characterized by a predominance of endemic and epidemic diseases, specifically malaria (44.5% of medical consultations in 2010) and acute respiratory infections (13.2%). Maternal mortality is estimated to be 397 per 100 000 live births over the period 1999-2006; there is no guarantee that MDG 5 will be met. Neonatal, infant and child mortality were 32‰, 67‰ and 125‰ respectively during the period 2001-2006. Falling infant and child mortality are currently on track to meet MDG 4. The progress that has been made in controlling the principal diseases appears to indicate that MDG 6 will be achievable provided appropriate prevention and management policies are effectively implemented.

The health system is pyramid-shaped and comprises three levels (central or national, intermediary or departmental, and peripheral). A number of challenges have been identified in the health system, both on the supply and the demand side; governance is a specific problem in view of the suboptimal organization of the Ministry of Health (MoH). The primary source of financing of the health sector is household expenditure, which accounts for 44% of the total, as against 28% from the State and 24% from the other sources (donors). The National Health Development Plan (PNDS) for 2009-2018 lays down strategic guidelines on health and serves as a reference document for all the stakeholders in the sector. It is embodied in the Triennial Development Plan (PTD) 2010-2012 and its Medium Term Expenditure Framework (MTEF). As regards the breakdown of public expenditure, **the program targeting the control priority diseases attract the bulk of outside funding and almost 30% of the national budget.**

A number of technical and financial partners are active in the health sector. Whereas the proportion of funding for health under the national budget has stagnated and even declined over the past 10 years, appropriations financed by overseas aid in relation to total appropriations for the sector fell between 2001 and 2005 but increased slightly thereafter; they now account for approximately one quarter of all appropriations. This shows the extent to which the sector is dependent on external funding. The technical and financial partners are endeavouring to share information as far as possible and to divide up the support work performed by the MoH having regard to the respective added value of their contributions. However, the partners are unevenly distributed in the various areas of intervention, with the result that some areas are overlooked; and until quite recently, it was not possible to speak of a sectoral approach in the Beninese health

sector. Additionally, there is still a need to improve the coordination and alignment of aid, even though the sectoral coordination framework is increasingly well organized (see box 1, section 1.4 of the French report).

The **health sector coordination framework** forms part of the larger coordination mechanism of the technical and financial partners at national level, culminating in the Joint Annual Review. In the health sector, the Ministry's coordination efforts are handled by its general secretariat, but there are real problems at this level (see section 2.1). A national multisectoral coordinating body was formed in 2004, but it is very cumbersome and does not involve the technical and financial partners. Its recommendations are not sufficiently followed through and thus, to date, it has been unable to carry out its coordination functions. The technical and financial partners in the health sector meet monthly under the direction of a lead agency but until recently the participation of national representatives has been irregular. There are two other formal opportunities for coordination and dialogue between the MoH and all the technical and financial partners at the national level, namely the meeting between Minister of Health and representatives of the partners (in theory, twice a year), and the annual performance review of the sector, which brings together the majority of the stakeholders in the sector (MoH, Ministry of the Economy and Finance (MoEF), other ministries involved in health, technical and financial partners and civil society).

Benin joined the International Health Partnership and related initiatives (IHP+) in 2009.

On 12 November 2010 the Beninese Government (represented by the MoH and the MoEF) signed a country compact with five technical and financial partners, namely WHO, UNICEF, UNFPA, the World Bank and Belgium. The compact seals the signatories' commitment to align themselves with the PNDS for 2009-2018 which has become the shared reference point and sole framework for coordination, guidance, implementation, evaluation and follow-up of all the partners, and more specifically with the PTD for 2010-2012 which is the instrument for translating policy into action. The aid arrangements agreed to by the signatories of the compact were listed as general budget support, sectoral budget support (although such a framework still does not exist) and programme and project financing – without, however, providing more details about the gradual alignment of the technical and financial partners with national procedures. The respective commitments of the Beninese Government and the technical and financial partners are also outlined in the compact, in addition to a number of indicators for monitoring these commitments and performance indicators.

To what extent have aid effectiveness principles been implemented in the health sector?

The principal achievements in terms of specific implementation of aid effectiveness principles in the Beninese health sector are of quite recent date. They involve the strengthening of the sectoral coordination framework, alignment with the PNDS 2009-2018, the 2010 IHP+ Compact and the Joint Platform for Health System Strengthening (HSS) which was inaugurated in 2011 (see box 2, section 2.2.3). The following progress has been made with regard to the five pillars of the Paris Declaration:

Ownership and leadership

There has been some progress with regard to ownership, given that the national plans have been completely assimilated at central level by the MoH; nevertheless, the strategic framework is experiencing some operational difficulties, for example a continuous decline in the rate of budget implementation. **Leadership, on the other hand, is sadly lacking.** This is because, despite the clearly delimited and well elaborated strategic framework for the sector, putting theory into

practice has proved enormously difficult. The leadership role of the MoH in implementing the strategic plan is insufficiently asserted, to the extent that the technical and financial partners sometimes have no qualms about directly launching certain initiatives to help the local population. The problem of introducing a fully-fledged sectoral approach is also partly attributable to the lack of leadership of the MoH in the sector.

Harmonization and alignment with national systems

The IHP+ Compact signed in November 2010 is entirely consistent with moves towards harmonization and alignment because its general objective is to define a single, harmonized framework to boost and enhance aid effectiveness and predictability in the sector with a view to expediting achievement of the health-related MDGs. While it is expected that other technical and financial partners will gradually sign up, at present the Compact has been signed by just five partners, and some of its core elements still need to be defined and put in place. To date the principal achievements in implementing aid effectiveness principles have been:

- **Some alignment with national strategies**, given that all the technical and financial partners active in the health sector profess to adhere to the PNDS 2009-2018, which is therefore the national benchmark and sole framework for coordination, guidance, implementation, monitoring and follow-up for all health system stakeholders. Signing up to the Compact should however reinforce alignment with the PNDS and the PTID.
- **Much less alignment with national public financing and procurement systems**, mainly because national systems are not very reliable and the national authorities still face a considerable challenge to standardize their procedures, specifically with regard to procurement periods and the expenditure cycle. In addition, most financial and administrative decisions by the technical and financial partners are headquarters-centred, which impacts on the level of implementation of activities.
- Considering these financial management problems in Benin in general and the health sector in particular, illustrated by the very low rates of resource execution in the sector, the technical and financial partners are reluctant to align themselves with national public finance systems. In this context, harmonization among the various technical and financial partners could be a satisfactory interim solution. **Very recently some progress has been made with regard to harmonization among the interventions of the technical and financial partners through the launch of the HSS Platform** that brings together WHO, the World Bank, the Global Fund, GAVI and the Belgian Development Agency. The Platform will be managed by a joint management unit (see section 2.2.3); it is undoubtedly a solid basis for strengthening harmonization, alignment, and the rational use of development partner resources and moving towards a joint fiduciary mechanism that will gradually improve national procedures. However, it should be noted that the establishment of the platform has not been enthusiastically welcomed by some technical and financial partners who have felt excluded from it. Additionally, the Decree establishing the Platform coordination mechanism restricts it to HSS activities and to just two development partners. It therefore does not cover the whole PNDS, nor does it include all the technical and financial partners – which risks undermining general coordination and general support for the PNDS in the framework of the Compact unless more comprehensive arrangements are adopted.
- Monitoring and evaluation are based on the statistical yearbook prepared each year by the National Health Information and Management System (SNIGS). The sectoral coordination mechanism is also used for monitoring and evaluation of PNDS implementation; however, despite the existence of sectoral tools and methods, **the lack of effective coordination means that the implementation and monitoring/evaluation arrangements are underperforming**. This mechanism is being reviewed so as to better position monitoring and evaluation as strong components of PNDS and the Compact and to enable the technical and financial partners to play a bigger role in monitoring and evaluation. The PNDS performance monitoring and evaluation plan, which has been assessed using the Joint Assessment of National Strategies (JANS) tool, should in the future constitute the sole plan for monitoring and evaluating the PNDS. The HSS Platform also envisages strengthening the monitoring and evaluation component at all levels.

Managing for results

Nationally, monitoring the results of the PRGS is performed at the Joint Annual Review. Progress is noted every year, but the management of the information produced continues to pose problems and the review process is seen as very cumbersome and insufficiently reflects the realities in the field, sectoral contributions and the critical views of certain technical and financial partners. The finding that there are problems in managing information also holds valid for the health sector performance review. In 2001 Benin introduced reforms to introduce results-based management, for example through the use of programme budgets. However, progress on results-based management in the sector is not obvious because although stakeholders have a good grasp of the challenges involved, putting theory into practice is very difficult given the multiple problems and disorganization in the sector. In the future, the PNDS monitoring plan and its tracking indicators should constitute the framework to evaluate the performance of the sector and the monitoring and implementation of the Compact. Furthermore, in addition to its operational efforts, Benin will soon be launching large-scale implementation of results-based financing, which has already been piloted but will shortly be given more extensive support within the framework of the HSS Platform.

Mutual accountability

Mutual accountability in the health sector is embodied in a number of practices, but to date some observers believe that the political dialogue has not been particularly effective. The IHP+ Compact aims to strengthen mutual accountability, given that the fulfilment of commitments by all signatories will be regularly and jointly evaluated.

Has this yielded better results?

Results 1: Has aid effectiveness actually improved?

Appropriations financed by external resources in the Public Investment Programme (PIP) increased by 87% between 2001 and 2010, but overall the share of the national budget devoted to health has seen a sharp decline in the period 1997-2002, from 15.15% to 8%. It has stabilized at this level since 2010. On the other hand, **the budget for 2011 has contracted by more than 16% compared to the previous year. The situation is even more serious with regard to appropriations actually spent, given that the budget implementation rate in the health sector has been particularly low for a number of years now.** In 2010 the implementation rate (commitment stage) of the operating budget (minus staff costs) was 68.67%, against 27.22% for the PIP (internal resources), and 6.08% for the PIP (external resources), i.e. an overall implementation rate of 30.86%.

The technical and financial partners are encouraged to announce their funding intentions for the next few years so as to improve the predictability of aid. However, promises or indications of funding are not always respected by development partners, and/or funding is delayed for various reasons (cumbersome procedures, etc.), which means that **the predictability of aid is very limited**, not to mention that the Government is still experiencing problems collecting information about aid execution.

Nationally, the establishment of thematic and sectoral working groups has led to a significant reduction the fragmentation of general and sectoral aid. In the health sector, **three initiatives with the potential to reduce transaction costs are to be welcomed:** (i) the transfer of Global Fund funding management from the UNDP to national management units; (ii) the joint management unit of the HSS Platform; and (iii) sharing of experiences among donors regarding implementation of results-based financing.

In addition to the partnership between United Nations agencies driven by the United Nations Development Assistance Framework (UNDAF), **the elaboration of the IHP+ Compact and the search for effective implementation arrangements seem to have given renewed impetus to collaboration between the development partners in the sector.** All the work involved in setting up the HSS Platform was carried out in a spirit of partnership between the five agencies concerned (even though other technical and financial partners initially felt excluded).

The Compact is in some respects an “endorsement” by the signatory partners of the national documents PNDS 2009-2018, PTD 2010-2012 and MTEF, but **there is still no joint financing agreement for the health sector. The first step in this direction is the HSS Platform,** which, although it does not represent a pooling of funds, will at least be overseen by one and the same management unit in accordance with a standard manual of procedures. The intention to harmonize the provision of technical assistance has not yet been translated into reality.

Lastly, while multiple interventions by the technical and financial partners aim to strengthen national capacity at all levels of the health pyramid, the development partners’ coordination efforts in recent years have **made this support more coherent or at least enabled the partners to operate across all health districts.** This approach was used in dividing the various health districts among the members of the HSS Platform.

Results 2: Has the health system been strengthened?

Changes in governance

The PNDS 2009-2018 was prepared following a long process steered by the national authorities with contributions from the technical and financial partners. Thus **consensus was achieved on the strategic guidelines from the outset,** which is definitely an advantage at the implementation stage. Some progress on governance has been noted, specifically as a result of the embedding of the programme budget approach and the sectoral review which enables stakeholders to take stock of progress and pinpoint the cause of any obstacles. Despite this, **sectoral governance is still beset by serious problems;** it was hoped these would have been resolved following the proposed reorganization of the MoH. In addition, operational planning still suffers from multiple shortcomings, but proposals have been made to review the process in order to effect improvements.

Changes in financing

Although the share of funding for health in the national budget has steadily declined over time, **the Government increased allocations for health until 2009. However, allocations to the sector have fallen off again since 2010.** This is probably due to the poor performance of the MoH in implementing its funding. Some characteristics of the fluctuating health budget are:

- Personnel costs have increased in the last 10 years from 12% of the budget in 2000 to 18% in 2010 ;
- Investment expenditure accounts for almost half of the sector’s budget, and are dependent on external aid that makes up about half of the PIP;
- The allocation of resources is not equitable, but the Government has undertaken a series of new initiatives to make health care affordable to the poorest sections of the population;
- Since 2004 health districts have received delegated appropriations, and whereas these used to be fully committed, in 2009 the level of implementation of the delegated appropriations fell sharply, thereby compromising the operation of health facilities and the execution of planned activities;
- In 2009 only 4 health districts were considered financially viable according to their recovery rate; 20 were judged to be in a tenuous financial position and 10 were running a deficit.

The national system for managing public finances and public procurement has been judged to be underperforming. In addition, at national level, the rate of use of public procurement systems by the technical and financial partners was 49% in 2010 compared with

64% in 2005 and 63% in 2007. These financial management problems have also affected the health sector.

Changes in infrastructure

Benin has good public health infrastructure coverage that has not changed much in the last few years.

Changes in human resources

Although the total payroll has increased, **public-sector health workforce coverage has deteriorated in recent years**. Significant regional disparities also continue to exist.

Changes in drugs and medical products

The pharmaceuticals sector has been better organized since the reforms establishing an Essential Medicines Procurement Centre, an autonomously administered wholesaler responsible for supplying public- and private-sector health facilities, and the National Laboratory for Quality Control of Essential Medicines and Medical Consumables, which tests medications prior to product licensing.

Changes in monitoring and review systems

The most recent external assessment of the information system was carried out in 2007 by the Health Metrics Network. The information system was found to be generally sufficient and the most recent demographic and health survey (2006) found few discrepancies between the figures from the national information system and the statistics on immunization coverage rates. However, the quality of the statistics provided by SNIGS is still far from perfect, and these data are insufficiently utilized in planning or decision-making. The MoH has developed a plan to strengthen SNIGS by 2015 in order to overcome these problems. Strengthening the monitoring and evaluation framework should mean that these products can be used more effectively.

Results 3: Have health services improved?

Generally speaking, even though the performance of the health sector is still unsatisfactory when measured against the targets that have been set, some progress has been recorded in recent years, specifically as regards mother and child health indicators which are at relatively high levels. This has resulted in a sharp reduction in maternal mortality (from 224 to 137 per 100 000 live births between 2003 and 2008) and a reduction in HIV/AIDS prevalence among pregnant women (from 2.2% in 2003 to 1.7% in 2007).

The health facility consultation rate fluctuates nationally, but overall has risen slightly from 38% in 2003 to 46.8% in 2010. However, the public-health facility consultation rate is low-to-average among the general population and varies considerably from one facility to the next.

The rate of first-time antenatal consultation was 94% in 2010, which represents a decline in relative terms since 2007. Additional efforts to boost what is already a high rate of coverage have not been very successful. The appropriate rate of coverage (4 antenatal consultations per pregnancy prior to delivery) was 61% in 2006 according to the Benin demographic and health survey-III, a statistic that also seems hard to improve upon. And as is the case for antenatal consultations, it appears that Benin has exhausted its capacity to increase the rate of assisted births, which has remained at the same level (around 80%) since 2001.

On the other hand, there has been a steady increase in the rate of Pentavalent 3 and measles immunization coverage among children under 12 months. Pentavalent coverage for children aged

0-11 months has increased to 96% in 2007 and 98% in 2009 before falling back to 95.9% in 2010 (SNIGS).

With regard to service quality indicators, the serious malaria case fatality fell until 2006 before increasing again in children less than 12 months. The maternal mortality rate per 100 000 live births in a hospital setting fell by just 13% between 2005 and 2009, which confirms that insufficient efforts are being made to achieve MDG5. Neonatal care is also inadequate. Although neonatal mortality is a large component of child mortality, maternity units in Benin suffer from a shortage of proper equipment and skilled personnel.

Overall, evident progress has been made in the area of development outcomes, to the extent that the health MDGs will probably be met in Benin. However, this progress is not systematically linked to public-sector performance, which has been relatively weak in recent years. It may therefore be assumed that the private sector has made an enormous contribution towards achieving the MDGs in Benin.

What factors have been decisive in achieving these results? What constraints have been encountered and how have they been overcome?

Main factors contributing to achievement of results

Until recently, there was no real sectoral approach in the Beninese health sector. Nevertheless, some progress has been made in implementing aid effectiveness principles through coordination mechanisms at the national and sectoral levels. Benin's adherence to IHP+, the elaboration of the country Compact and the HSS Platform have all imparted a new momentum of which great things are expected. Some of the factors that existed before IHP+ or independently of it which have contributed to the achievement of results are:

- **Coordination among technical and financial partners at sectoral level** which, although imperfect and insufficiently steered by the MoH, has nevertheless facilitated progress in reducing inconsistencies and identifying synergies in external interventions;
- **The preparation of the PNDS 2009-2018** which involved a broad spectrum of stakeholders with a view to reaching consensus on strategic directions for the sector;
- **Annual performance reviews** of the sector, which bring together multiple stakeholders;
- **Strengthening of thematic working groups and their coordination at national level** which, together with certain government initiatives, has facilitated better coherence and coordination of public sector actions.

Benin's adherence to the IHP+ Global Compact in 2009 and the elaboration of the country Compact in 2010 have imparted new momentum to the sectoral approach between the Government (MoH and MoEF) and a number of technical and financial partners. It also appears that joining the IHP+ has led to greater awareness of how much Benin needs to catch up to meet the MDGs and hence has triggered reflection on reforms that could be implemented to expedite the achievement of these goals.

Lastly, **the search for ways to implement the Compact in practice has strengthened collaboration among a "core group" of technical and financial partners.** Specifically, the establishment of the HSS Platform has created a harmonized framework to support the MoH, although this has stopped short of full alignment with national procedures. The Platform participants have also endorsed the final version of the plan to monitor and evaluate PNDS performance.

These factors have delivered **progress at process level**, which opens the possibility for progress in health outcomes. However, to date it has not been possible explicitly to attribute improvements in impact indicators to changes in the sector.

Main constraints

The negligible progress that has been made over such a long period of time in the area of aid effectiveness principles is due to certain constraints of which the most important is **the lack of leadership by the MoH** in coordinating the technical and financial partners and steering the sector, coupled with governance problems at the Ministry (organizational challenges, etc.). In addition, **maladjustments in the sectoral coordination framework** and problems with the quality and analysis of statistical data have to date precluded ongoing and priority-focused policy dialogue. **This explains why the technical and financial partners have often had to take the initiative to get projects moving**, for example the organization of their coordination framework (drafting the terms of reference of the lead agencies, etc.); steering the Compact process; making proposals regarding organizational issues affecting the sector (coordination, planning, monitoring and evaluation framework); and harmonization of their procedures (rather than alignment, for example through budget support) in the context of the HSS Platform.

In addition, to be fair to the MoH, it should be noted that in the years immediately after 2000, the initial effect of the transition to general budget support from “big” donors was to deprive the sector of significant technical and financial support. Furthermore, the disparate nature of the technical and financial partners and certain constraints imposed by their respective headquarters mean that they do not always speak with the same voice and that they send contradictory messages to the MoH.

The IHP+ process has given the system fresh momentum, but has itself been constrained by several factors:

- Once again, **leadership and ownership by the MoH (apart from the Office for Planning and Forecasting (DPP)) was so weak** that some observers believed that the process was being steered by UNICEF (the development partner lead agency at the time), which made some technical and financial partners reluctant to join the initiative;
- **The nonexistence of a sectoral approach before the signature of the Compact resulted in a Compact with a number of undefined basic components – in particular its fiduciary, coordination and monitoring and evaluation arrangements**, which has considerably slowed implementation of the Compact’s provisions; moreover, at the present time, the committee that is supposed to monitor and evaluate the implementation of the Compact has still not been established;
- **The establishment of the HSS Platform**, which is seen by its participants as an opportunity to translate the commitments in the Compact into practice, has thus far been bedevilled by communication problems, thereby provoking suspicions on the part of certain technical and financial partners who have felt excluded from the Platform. There is a risk that attention could be diverted away from the Compact unless coordination and monitoring/evaluation frameworks are defined as rapidly as possible.

Lastly, the results of the health sector have been constrained by a number of factors, some external and some internal – specifically recurrent strikes by health workers and the insufficient resources (both human and financial) available at operational level.

Conclusion et prospects

In Benin, IHP+ and the Compact have undeniably acted as a catalyst for a sectoral approach in the health sector and have given substance to the principles of aid

effectiveness which were having difficulty making headway. However, because **certain basic components of the Compact (its fiduciary framework, its coordination framework and its monitoring and evaluation framework) were not defined when the document was signed, it has taken some time before being translated into practice.** Given the immobility of the system and the problems of governance in the sector, some technical and financial partners took the initiative and launched the HSS Platform as a springboard for harmonization (instead of simply aligning themselves on national systems, which does not seem appropriate at the present time). This initiative is seen by its backers as an instrument for implementing the Compact, but some technical and financial partners who were not told about it beforehand have felt excluded and fear that the HSS Platform is overriding the Compact – which could happen unless the Government takes the necessary steps to outline and implement a coherent framework for coordination, policy dialogue and monitoring and evaluation of the PNDS and the Compact. The Platform could then be seen as a “nucleus” that could be extended to embrace all the technical and financial partners and the PNDS in the spirit of the Compact.

To date, the results of putting aid effectiveness principles into practice are noticeable only at the process level. However, if the MoH can reorganize itself, affirm its leadership and relaunch policy dialogue as the new team at the Ministry seems willing to do, the outlook is more promising, especially given the coordinated support for HSS that the technical and financial partners have committed themselves to providing over the next few years. In addition to these questions of governance, the principal challenges facing the health sector are human resources management (redeployment and motivation of technical staff by encouraging a sense of achievement), better operational planning and a higher level of budget implementation.