BENIN PRIVATE HEALTH SECTOR ASSESSMENT

May 2013

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Strengthening Health Outcomes *through* the Private Sector

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ACRONYMS

ABMS	*Association Béninoise de Planification Familiale et la Communication pour la Santé*
ABPF	*Association Béninoise pour la Planification Familiale*
AMCES	*Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin*
AMM	*Autorisation de Mise sur le Marché*
ANAM	*Agence National d'Assurance Maladie*
ASA-Benin	Association of Insurance Companies in Benin
CAME	*Centrale d'Achat des Médicaments Essentiels et Consommables*
CEBAC STP	*Coalition des Entreprises Béninoises et Associations contre le Sida, la Tuberculose et le Paludisme*
CFR	West African Franc (currency)
CTM	*Commission Technique des Médicaments*
DCA	Development Credit Authority
DHS	Demographic Health Survey
DNSP	*Direction Nationale de Santé Publique*
DPMED	*Direction des Pharmacies et du Médicament*
DPT	*Diphtheria, Pertussis, Tetanus*
EDL	Essential Drugs List
EKG	Electrocardiogram
EPI	Extended Program of Immunization
FCFA	West African Franc (currency)
FNRB	*Fonds National de la Retraite du Bénin*
FP/RH	Family Planning/Reproductive Health
GAPOB	*Groupement d'Achat des Pharmacies d'Officine du Bénin*
GDP	Gross Domestic Product
GHI	Global Health Initiative
GNI	Gross National Income
HIV and AIDS	Human Immunodeficiency Virus Infection and Acquired

	Immunodeficiency Syndrome
HSA	Health Sector Assessment
ICON	International Contraceptive & SRH Marketing Ltd.
ICT	Information and Communication Technology
IMCI	Integrated Management of Childhood Illness
IMPACT	Integrated Project to Promote Family Health and HIV/AIDS Prevention
IPPF	International Planned Parenthood Foundation
ITN	Insecticide-treated Nets
IUD	Intrauterine Device
IV	Intravenous
LARM	Long-acting Reversible Method
LNCQ	*Laboratoire National de Contrôle de la Qualité*
MCDI	Medical Care Development International
MCH	Maternal and Child Health
MFI	Microfinance Institution
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
NGO	Nongovernmental Organization
NHA	National Health Accounts
OC	Oral Contraceptives
PPP	Public-Private Partnership
PSA	Private Sector Assessment
PSI	Population Services International
QA	Quality Assurance
RAMU	*Régime d'Assurance Maladie Universelle*
ROBS	*Réseau des ONG Béninoises de Santé*
SBM-R	Standards Based Management and Recognition
SHOPS	Strengthening Health Outcomes through the Private Sector
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UPEPHAR	*Union Béninoise des Pharmaciens du Benin*

USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

Independent since 1960, Benin is a West African Francophone country with a population of 9.3 million. The bulk of Benin's economy stems from agriculture, with 56 percent of the population either working or involved in this industry. Urbanizing at a rate of 4 percent per year, Benin is currently 42 percent urban and by some estimates is expected to reach a rate of 50 percent by 2017. Benin ranks 166 out of 187 countries on the Human Development Index, with 39 percent of the population living below the poverty line (UNDP 2012.)

The existence of a private health sector is a relatively new development in Benin. At the beginning of the 1980s, few private health care centers existed in Benin's health care system landscape. However, in 1986, a halt in public health care recruiting set the stage for a large expansion of private practice in the country. Private health care centers launched in the 1980s came mostly in the form of faith-based religious institutions and structures located in urban areas. Other private health centers sprang up on an ad hoc basis until 1997 when Law 1997-020 authorized the private practice of medicine in Benin (2006 HSA).

Since 1997, Benin has experienced an explosion of growth in private health practice. According to the 2012 Benin Health Systems 20/20 assessment, health sector human resources in Benin number 18,078 professionals, 25 percent (approximately 4,500 people) of which are located in the private sector. Formal registration of private practice with the Ministry of Health (MOH) remains a major issue, however, as shown by a 2005 survey of 231 private providers that indicated only 12 percent were authorized to practice. Restrictive regulatory and licensing processes, as well as a historically public-oriented health environment, have resulted in both a lack of incentive to register as formal health practices and a rapid growth in the informal private health sector.

USAID/Benin seeks practical strategies to strengthen collaboration between the public and formal private health sectors in Benin. For 2011–2015, USAID/Benin has set forth as a strategic priority the strengthening of private sector involvement to improve health outcomes in Benin. To that end, in mid-2012 USAID/Benin commissioned the Strengthening Health Outcomes through the Private Sector (SHOPS) project to undertake an assessment of the private health sector in Benin to assist USAID and other stakeholders with developing a strategy for further engaging the private sector. The strategy will complement and augment current efforts within the public and private sectors with a focus on family planning, maternal and child health, urban populations (particularly the urban poor), and existing service provider networks.

The assessment focused on five key thematic areas: policy environment, provision of services, pharmaceutical products and supply, access to finance, and health insurance. The scope of the assessment was as follows:

- Determine the size, scope, and scale of private sector providers in Benin.
- Assess the policy and regulatory environment for private provision of health products and services.
- Assess business and financing needs of the private health sector with an emphasis on networked facilities in the *Protection de la Famille* (ProFam) franchise and *the Association of Private Faith-based Medical and Social Providers of Benin (*AMCES).

- Identify synergies with already existing USAID field support activities focused on improving health outcomes in Benin.
- Identify opportunities to increase access to private sector health financing options by examining current initiatives.

In the context of this assessment, the "private health sector" includes a diversity of actors—nongovernmental organizations that include both faith-based organizations and associations, as well as for-profit health care businesses ranging from treatment/prevention and pharmaceutical distribution, to financing and insurance. Traditional healers were determined to fall outside of the scope of work for the present assessment, as specified by USAID/Benin. A separate study on the impact traditional healers have on health care provision, if undertaken by USAID, would likely yield important insights on consumer behavior and out-of-pocket expenditures for health.

FINDINGS

Key **findings** of the team's assessment can be found in Table 1. The findings are organized by the five major health areas analyzed (policy environment, service provision, pharmaceutical supply, access to finance, and health financing), and represent an important overview of the strengths and weaknesses of each health area. Additional details on the points in Table 1 can be found in their respective sections within the body of the report.

Table 1: Key Findings

Finding Area	Strengths	Weaknesses
General	• The private health sector is growing in prominence and there is growing recognition of the private sector as an important player in the Benin health market. • The private sector has significant untapped potential to speed progress toward providing better health care access for Benin's population.	• Benin's post-French colonial and post-socialist heritage have left a public health system reliant on regulation and centralized decision making. This creates an impediment to growth of the private health sector. • Forty-six percent of health sector transactions are occurring through out-of-pocket spending (compared to a regional average of 40 percent), 93 percent of which happens through the private sector (regional average of 62 percent).

Policy environment	• Of the professional orders in Benin, the Order of Pharmacists is strong and has the potential to enact significant change. However, it has a dual role with potential for conflicts of interest. • Advocacy organizations such as *Réseau des ONG Béninoises de Santé* (ROBS), *Coalition des Entreprises Béninoises et Associations contre le Sida, la Tuberculose et le Paludisme* (CEBAC STP), and the Association of Private Clinics are well positioned to take on roles of coordinating and advocating for private sector medical and non-medical practices.	• The private health sector is overregulated**,** which is fueling the growth of the informal sector. • There are restrictive regulations in current health legislation. • The formal private sector is operating on an individual basis, and the policy environment is not favorable for establishing group practices or provider networks. • Most profession medical associations ("Ordres") have limited ability to respond to registration and licensing requirements, mostly due to a lack of time to conduct inspections of prospective member facilities. • There is a potential for conflict of interest between members of professional associations and applicants for registration of health care facilities and/or pharmaceutical products (i.e., for approval of potentially competitive multiple locations serving one catchment area). • Public agencies dominate in initiating and overseeing the implementation of public-private partnerships.
Service provision	• AMCES is a significant actor in the nonprofit health sector with 18 primary health care centers (*centre de santé*) and 10 hospitals that have succeeded in implementing a public-private partnership with the MOH. • ProFam network of 50 members and 100 affiliates is an effective provider of family planning and other priority health services in the private sector, but its growth is dependent on registered providers.	• The business model of the commercial sector is "low-volume, high-unit cost, low-margin." • Most likely, uneven quality exists in service provision as a result of a lack of quality assurance systems in the commercial sector.
Pharmaceutical supply	• Since the restructuring of *Centrale d'Achat des Médicaments Essentiels et Consommables*	• Professional stove piping acts as a barrier to collaboration between pharmacists and other providers.

	(CAME), stock outs are now significantly less frequent than they were earlier; however, challenges still remain in ensuring a regular supply to private sector pharmaceutical dispensary points in locations outside of the main metropolitan center of Cotonou.	The strict segregation of 'professional identities' between pharmacists and the other professions (i.e., service providers) hinders the opportunity for creative engagement across these professional boundaries. • There is an unbalanced pharmaceutical human resources spectrum and a lack of professional cadre preparation. • Limited understanding of market segmentation value among public officials leads to limitations on consumer choice and sector growth.
Access to finance	• One Development Credit Authority (DCA) guarantee with EcoBank is active, and there is interest for additional DCA guarantees among other banks. • There is a strong demand for finance among private health providers.	• The need for financing is high among private providers in Benin, as most facilities are seeking to improve their facilities, upgrade or expand the premises, or acquire new equipment. • At present, there is almost no external financing available for new and early stage private health businesses. • Lack of or weak collateral, as well as weak management skills and lack of business training, severely limits borrowing ability for most private providers. • Bank and MFI lending in the private health sector is sporadic and limited.
Health insurance	• A policy decision has been made to institute a universal health insurance system or *Régime d'Assurance Maladie Universelle* (RAMU). • There is a history and general acceptance of community-based health insurance in Benin that is well understood, is consonant with the local culture, and can be strengthened.	• RAMU faces a number of challenges from a private sector perspective, such as a lengthy and bureaucratic accreditation and quality improvement process and a lack of confidence in timing and transparency of public sector-managed payments. It has a weak legal and institutional basis on which to operate. • An inadequate supply of health service providers undermines the introduction of a universal health insurance. • Lack of actuarial expertise hinders implementation of health

		financing reforms. • Reaching the informal sector is a major challenge. *Mutuelles* are weak: there is no plan to take them to scale, they have weak management and a lack of standardization of services, and they are withering due to lack of support and an inability to ensure access to quality providers.

RECOMMENDATIONS

Key **recommendations** of the assessment are summarized in Table 2. There are five major recommendations, each with its own set of actionable sub recommendations. Many of the recommendations are relevant to multiple stakeholders; the suggested lead agencies best able to move the recommendations forward are listed in the right column. Additional details on most of these recommendations can be found in their respective sections within the body of this report. These recommendations can also be found in Section 8.

Table 2: Key Recommendations

Recommendation Area	Recommendation	Lead Agency
(1) Grow the formal sector by streamlining registration and licensing processes for businesses and supporting provider networks	**Initiate a policy dialogue with the MOH to streamline the registration process and improve compliance with/enforcement of officially set time limitations on the review process.** The creation of a one-stop-shop or "*Guichet unique*" approach, where providers can take care of all aspects of business registration and licensing, could be part of the solution.	USAID
	Provide amnesty for current qualified but unregistered informal providers/ facilities. This would encourage existing facilities to submit an application for registration, especially as it pertains to future growth of the ProFam network.	MOH
	Support a mechanism to identify and support providers in becoming registered. Give technical assistance to an organization, such as *Association Béninoise de Planification Familiale et la Communication pour la Santé* (ABMS) that has a vested interest in the formal health sector, to take on this role. Ensure that formal registration qualifies a provider to participate in RAMU.	USAID/ABMS
	Remove barriers in order to convert private sector clinics into high-volume, high-quality, low-unit cost facilities. Start and maintain a dialogue with MOH and professional orders to relax the constraints	MOH/ Professional Orders

Recommendation Area	Recommendation	Lead Agency
	on marketing and promotion of health services, deregulate prices so that they are more market-based, and develop a package of incentives to **promote group practices** and provider networks.	
	Strengthen the family planning (FP) program in the AMCES network. Link AMCES to ABMS and other FP supply actors in order to increase the volume of FP products at their health centers and hospitals, where such products are allowed, and strengthen FP counseling programs and referrals to emphasize informed choice.	USAID
	Strengthen the financial sustainability of ABPF through targeted assessments. Following on Engender Health's technical assistance to *Association Béninoise pour la Planification Familiale* (ABPF), support development of a strategic plan, an investment plan, and business plans aimed at reducing financial vulnerability of the organization while preserving their social mission.	USAID
(2) Strengthen the role of the private sector at the national policy level and through advocacy groups	**Identify a high profile private sector "champion"** and an MOH counterpart to organize and coordinate regular dialogue meetings between the MOH and private sector stakeholders.	USAID/MOH
	Strengthen the advocacy capacity of the professional orders to participate in the MOH's health systems strengthening efforts. Give technical assistance to professional orders to strengthen strategic plans, improve its role as a secretariat to members, and coordinate training and other benefits for members.	USAID
	Work with thought leaders within the professional associations to separate and clarify regulatory roles from business interests of the members so as to avoid inherent conflicts of interest, especially within the Professional Association of Pharmacists and Professional Association of Physicians.	USAID
	Improve private providers' understanding of government standards and of provider rights surrounding enforcement of time frames for facility/product registration and dossier review. Support an association or NGO to educate providers about these rights and responsibilities.	USAID
	Assess the feasibility of setting up an independent, NGO-led quality standards and quality assurance system in private sector facilities.	USAID

Recommendation Area	Recommendation	Lead Agency
	Strengthen the role of supervision of QA systems and compliance with standards as part of a certification system. Consider support (in the longer term) for the creation of a self-regulating "grading" system for private providers.	
	Provide technical assistance to ROBS to make a thorough sustainability assessment and strategic plan.	USAID
	Support CEBAC STP with targeted technical assistance in order to integrate FP services in the already existing workplace clinics. Make a strategic plan aimed at inclusion of workplace clinics in the ProFam network.	USAID
	Include the Association of Private Clinics in any policy dialogues aimed at streamlining the health facility registration process or establishing quality assurance (QA) systems and PPPs in support of priority programs, especially FP/RH.	USAID
(3) Streamline registration, licensing processes, and business operations for pharmaceutical businesses and products	**Enforce timely and rational review of pharmaceutical product registration dossiers** through technical assistance to MOH**.** Ease restrictive limitations on the level of product competition, which significantly hampers private sector engagement and end-user choice in products.	USAID/MOH
	Advocate with MOH to eliminate conflict of interest associated with the quasi-regulatory role(s) of Orders of Pharmacists, Midwives, and Physicians, by separating regulatory function(s) in product and facility registration dossier review from other (client-oriented) functions.	USAID
	Conduct in-depth study of pharmaceutical product flows to eliminate inefficiencies. Simplify and harmonize pharmaceutical flow through the supply chain.	MOH
	Provide technical assistance to the *Commission Technique des Médicaments* in order to **evaluate current government-set pharmaceutical margins and their effect on private wholesalers**, ensuring that wholesalers are not inadvertently 'squeezed' by changing fixed costs and exchange rate fluctuations. Support the commission to conduct quarterly reviews of pricing throughout the supply chain.	USAID
	Provide technical assistance to ABMS, CAME, and other wholesalers and retailers on market-based pricing and costing.	USAID

Recommendation Area	Recommendation	Lead Agency
	Design and implement targeted training to increase the capabilities of supply chain managers in the labor force. This is a promising arena for promoting PPPs with international industry.	USAID
	Create incentives for private pharmaceutical providers to collaborate with other health professionals to better provide consumer access to pharmaceuticals in remote areas of the country. This could include jointly managed facilities or outreach activities in underserved locations, operating 'branch' dispensaries within faith-based or public health care facilities, or promotion of collaboration between pharmacists and providers on stock estimation in order to avoid stock availability issues.	MOH
(4) Improve access to finance and business capacity of providers	**Design access to finance programs with banks and MFIs to strategically provide an incentive for business formalization.** Stimulate a more rational (desired) mix of health providers by carefully channeling targeted and supervised loans to the types of providers that would advance health outcomes in the priority geographic areas of the country.	USAID
	Provide technical assistance to EcoBank's DCA borrowers receiving funds under the USAID guarantee. This could be structured as pre-borrowing assistance as well as post-borrowing assistance provided on a one-on-one basis to the funded clinics.	USAID
	Arrange two lines of additional credit for private health sector providers with Bank of Africa and FECECAM, in order to provide longer term funding to smaller providers in rural and peri-urban areas.	USAID
	Strengthen business capacity by launching business management trainings and by providing direct technical assistance to increase management capacity of private providers, including developing strategies and business plans, mentoring and coaching senior managers, and facilitating access to finance.	USAID

Recommendation Area	Recommendation	Lead Agency
(5) Foster the growth of private sector health financing mechanisms (health insurance)	**Support the development of RAMU and its mechanisms, and, in particular, ensure that private sector providers are taken into consideration**. Support a private sector working group serving as an advisory body to the government and RAMU, and playing the role of the unified voice of the private sector. Provide technical resources to develop evidence-based arguments to support the terms and conditions of the private sector participation in RAMU.	MOH
	Build the capacity of *mutuelles* through support to national level efforts focused on networking and professionalization. Streamline the process of creation and operation of a local *mutuelle* through development of uniform policies, procedures, and documentation; a centralized operational platform for data processing and management; and assistance to market and promote health insurance among low-income populations. Support the creation of unions of *mutuelles* on a regional basis, which will have the responsibility of both starting new *mutuelles* and supporting existing *mutuelles*.	USAID
	Support the provision of actuarial expertise to ANAM to underwrite evidence based, and appropriately priced, coverage packages for the formal and informal sectors. Facilitate this process by engaging Actuaries without Borders and other similar organizations.	WHO / Swiss

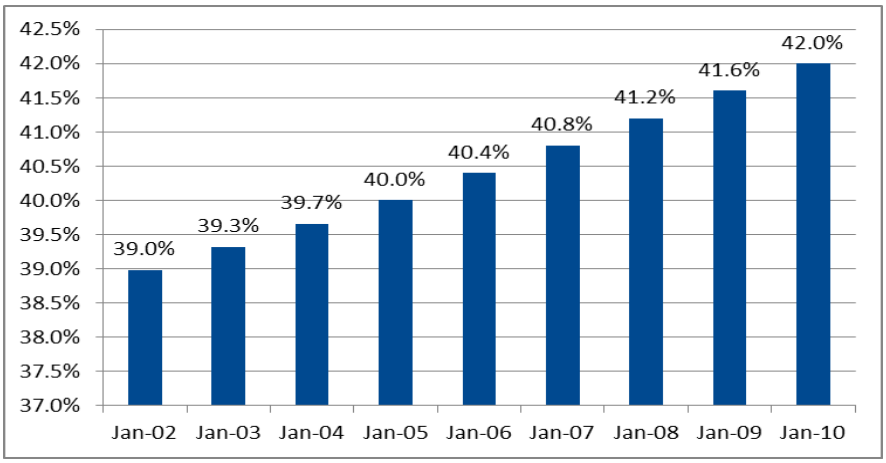
I. BACKGROUND

1.1 INTRODUCTION

Independent since 1960, Benin is a West African Francophone country with a population of 9.3 million. The bulk of Benin's economy stems from agriculture, with 56 percent of the population either working or involved in this industry. Urbanizing at a rate of 4 percent per year, Benin is currently 42 percent urban and by some estimates is expected to reach a rate of 50 percent by 2017 (Figure 1). Benin ranks 163 out of 177 countries on the Human Development Index, with 39 percent of the population living below the poverty line. The average life expectancy at birth is 56 years.

Child health indicators in Benin have been improving over the course of the last decade, yet much work remains to be done. The under-five mortality and infant mortality rates are 106 and 68 per 1,000 live births, respectively, and have been steadily decreasing, from 120 and 76, respectively, in 2006 (World Bank 2011). According to GHI's 2011 strategy paper, malaria is the number one killer of all children under five, constituting 40 percent of outpatient health center visits, and is responsible for 23 percent of all under-five deaths in 2008. As of 2010, 83 percent of children are DPT immunized, with a 69-percent measles vaccination coverage rate. The 2012 Benin Demographic Health Survey (DHS) preliminary report indicates that 28.4 percent of children under five test positive for malaria, and 44.6 percent are severely or moderately stunted due to chronic malnutrition—a rate that has worsened significantly in the past decade.

Figure 1: Trend in Urbanization (% GROWTH)

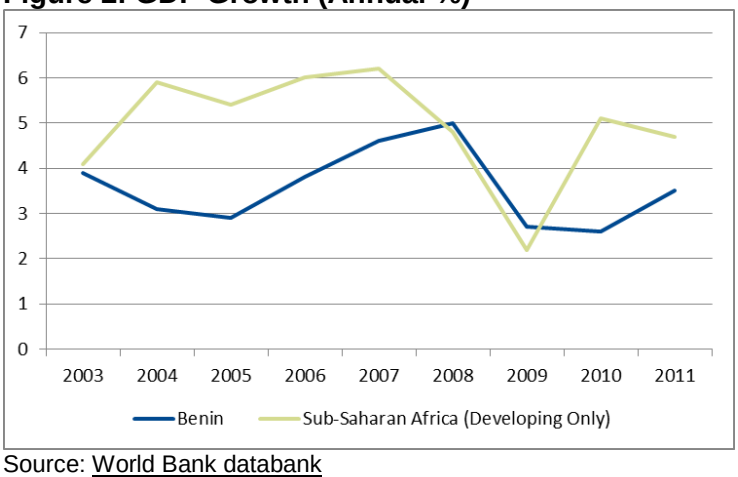


Source: World Bank databank, via Trading Economies

The fertility rate in Benin decreased from 5.6 in 2006 to 4.9 in 2012, while maternal mortality dropped to 350 per 100,000 live births in 2010, down from 770 two decades earlier. A skilled attendant is now present at 84 percent of live births, up from 78 percent in 2006 (DHS 2012). With regard to family planning, Benin hosts a 30-percent unmet need for contraceptives among married women aged 15–49. The recent release of the DHS Benin 2012 preliminary report seems to indicate that a change in contraceptive use among married women aged 15–49 is stagnant at best: the contraceptive prevalence rate among that group fell to 12.9 percent, from 17 percent in 2006; however, the modern contraceptive prevalence rate rose from 6.0 to 7.9 percent. According to 2006 DHS data, 39 percent of males aged 15–24 reported using condoms.

Benin's gross domestic product (GDP) is $7.3 billion, with a GDP per capita of $737 and a GNI per capita of $1,630. Benin has experienced between 3 percent and 5 percent annual GDP growth since 2003 (Figure 2). The country ranks 119 out of 144 economies, according to the World Economic Forum's Global Competitiveness Report 2012–2013. According to this report, the most problematic factors for doing business are (1) corruption (23.8 percent), access to financing (17.2 percent), tax rates (4.0 percent), inadequate supply of infrastructure (11.1 percent), and tax regulations (6.6 percent).

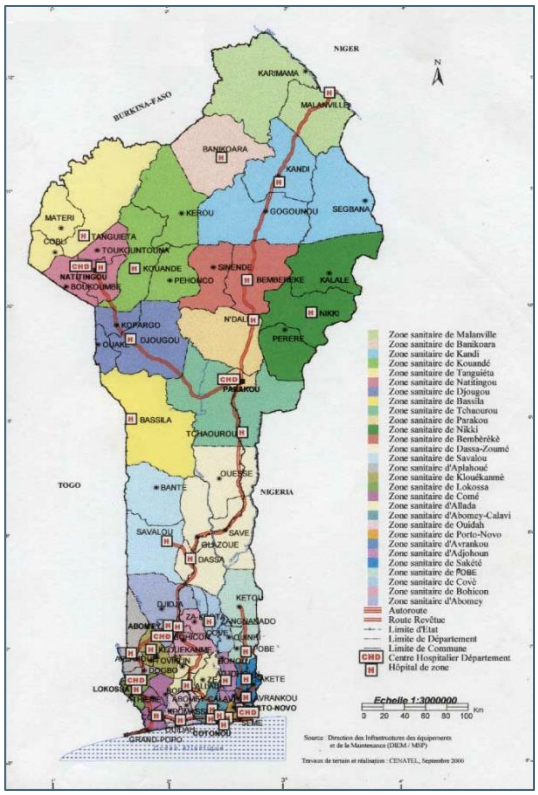
Figure 2: GDP Growth (Annual %)



Source: World Bank databank

Benin has the potential to reach some of the United Nation's Millennium Development Goals (MDG), namely achieve universal primary education, ensure access to sanitation and safe drinking water, develop an open and nondiscriminatory trade and financial system, and reduce its debt in a sustainable manner. Benin is still lagging significantly behind in the goals of eradicating extreme poverty and hunger and reducing biodiversity loss, and has large disparities when compared to other regional countries in the MDG of promoting gender equality, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases (United Nations 2010).

1.2 BENIN'S HEALTH SYSTEM

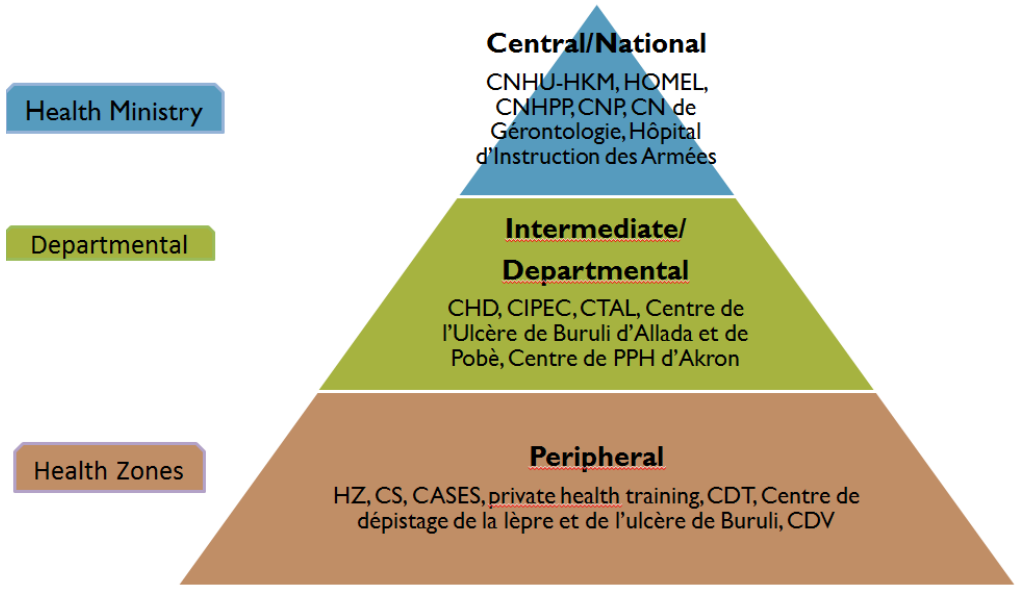


According to Benin's Ministry of Health (MOH), policy and effective strategy around health outcomes and development are indispensable preconditions to the economic development of a nation. Although 77 percent of Benin's population lives within three miles of a health facility, only 45.4 percent utilizes such facilities. Despite having adequate geographic coverage by health facilities, only 79 percent of Benin's zones *sanitaires* (health zones) are functional (Health Systems 20/20 2012). Access to maternal and child health (MCH) care, pharmacies, and private providers is not equitable, with significantly lower access for rural populations.

In the *National Health Policy for Health Sector Development* published in 1999, the MOH lays out a decentralized system of health consisting of central/national, intermediate/departmental, and peripheral levels. The central level includes the MOH and its directorates, as well national reference hospitals. The intermediate level includes departmental directorates for health and departmental referral hospitals. The peripheral level includes health zones, which contain zonal reference hospitals, commune health centers, private health facilities, and village health units (Figure 3).

Source of map: HS20/20 Benin HSA 2006

Figure 3: Health System in Benin



Source: 2012 HS20/20 Benin HSA

The country's 12 departments are split into 34 *zones sanitaires* (or health zones) (see map in section 1.2). These health zones contain anywhere from one to four communes and are managed by health zone committees and health zone management teams. From the smallest to largest facility, each zone has arrondissement health centers, commune health centers, and a zonal hospital. The health zone oversees all public and private health entities within its zone, including private not-for-profit and for-profit hospitals, clinics, and pharmacies.

1.3 THE PRIVATE HEALTH SECTOR IN BENIN

The existence of a private health sector is a relatively new development in Benin. At the beginning of the 1980s, few private health care centers existed within Benin's overall health care system landscape; most health care providers were hired by the state after completion of their studies. In addition, there was a strong Marxist-Leninist orientation in the country during that time period, when the government of Benin was closely allied with USSR, Cuba, and Angola. However, in 1986, a halt in public health care recruiting set the stage for a large expansion of private practice in the country. Private health care centers launched in the 1980s came mostly in the form of faith-based religious institutions and structures located in urban areas. Other private health centers sprang up on an ad hoc basis until 1997 when Law 1997-020 authorized the private practice of medicine in Benin (2006 HSA).

Since 1997, Benin has experienced an explosion of growth in private health practices. The private health sector currently consists of commercial for-profit facilities, nonprofit faith-based and nongovernmental organization (NGO) facilities, and public-private partnerships. According to the 2012 Benin health sector assessment, health sector human resources in Benin number 18,078 people, 25 percent (approximately 4,500 people) of which are located in the private sector. In 2011, the MOH released a list of registered private sector practices indicating the existence of 189 medical practices, 227 midwife practices, 69 nurse practices, and 25 dental practices. As of 2012, the professional association of doctors in Benin had 850 private sector doctors registered as members, the association of midwives listed more than 500 private sector members, and the association of nurses, although without a list, claimed to have an exceedingly large membership as well. There are approximately 15–20 private commercial or NGO-owned hospitals in Benin, and the country hosts approximately 240 registered pharmacies and five major private wholesalers of drugs. Most of the private sector is found in the south of the country, particularly in the communes of Cotonou, Porto-Novo, and Abomey-Calavi. While formal private health sector practices are thought to number over 1,000, it is commonly understood that the informal unregistered sector (determined to be outside the scope of this assessment), made up of traditional healers, unqualified practitioners, and unregistered clinics, is outpacing the formal sector in growth.

Because of its post-colonial and post-communism heritage, the public health architecture in Benin relies heavily on regulation and centralized decision making, as opposed to market forces, to determine pricing, supply, and labor in the health care sector. This over-reliance on regulation creates a strong impediment to growth of private sector health care provision. It is illustrated in numerous challenges currently facing the sector. For example, licensing and registration of private practice is a major issue in Benin. A 2005 survey of 231 private health practitioners by the DNSP in Benin found that only 12 percent were formally registered with the MOH. In order to be licensed and registered in Benin, medical and paramedical professionals must petition their respective Medical Boards. Comprehensive laws governing the licensing of

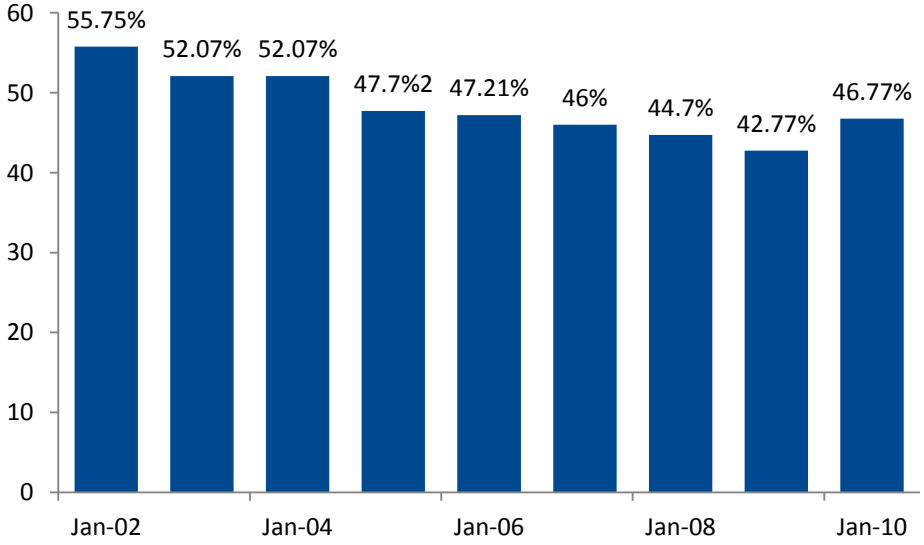
health providers and the establishment of private practices are in place, though such regulations are not sufficiently enforced, making it easier for physicians and other health workers to informally join the private sector. This leads to a handful of issues, such as a low quality of care caused by a lack of rigorous screening, supervision, and recertification of health care providers. Furthermore, biannual MOH inspections of most private health facilities do not occur, due to insufficient human and financial resources. Although it is illegal to practice in both the public and private sectors, dual practice appears to be relatively common among providers (2006 HSA).

1.4 HEALTH EXPENDITURES

Expenditures on health care in Benin have changed dramatically since the country's political independence in 1960. Following the example of other developing countries, Benin's financial access to health care went from being free to becoming a mechanism of cost recovery and subsidies for vulnerable groups, then finally to a system of universal health insurance (*Régime d'Assurance Maladie Universel* [RAMU]) in 2011. It was envisioned that RAMU would greatly enhance access to health services and facilitate the scaling up of health interventions through offering many free health services.

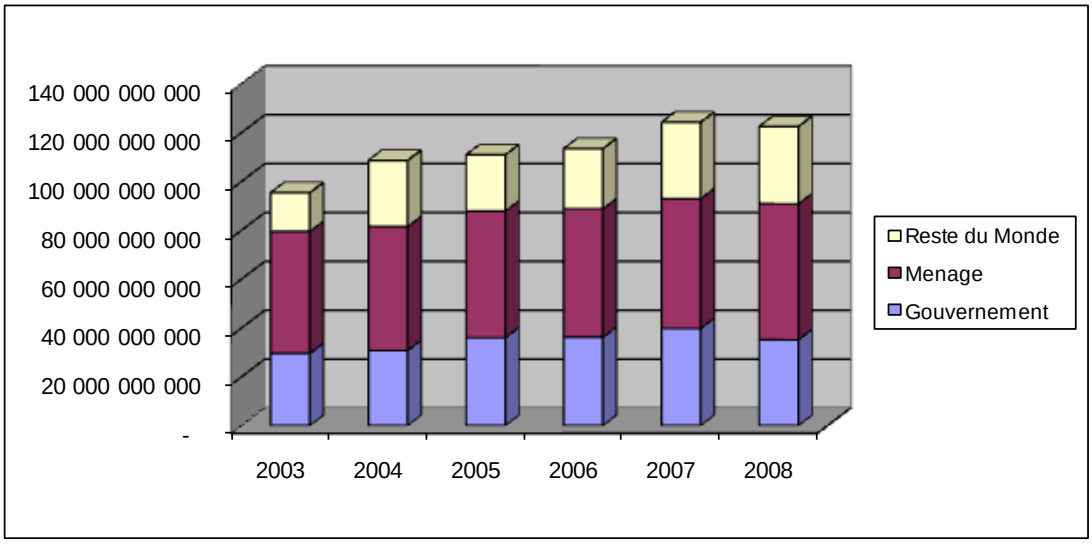
According to the latest National Health Accounts data in Benin, the total expenditure on health, as a percentage of GDP, has been on a downward trend in the last six years. In 2006, expenditures went from 4.8 percent of GDP, to 4.3 percent in 2009 and 4.1 percent in 2010. External resources for health, such as donors, accounted for 35.9 percent of the total health expenditures in 2010, compared to 24.4 percent in 2008 and 16.5 percent in 2003. Total public versus private expenditures on health is nearly even, with private spending at 50.5 percent. Out-of-pocket spending in Benin accounts for 46.8 percent of total health expenditures, 92.7 percent of which are made in the private sector (Figure 4).

Figure 4: Out-of-Pocket Expenditures as a Percentage of Total Health Expenditures in Benin



Source: World Bank Databank, Trading Economies

Figure 5: Evolution of the Structure of Health Financing in Benin from 2003–2008*



Source: National Health Accounts 2008
*Translation: “Reste du monde” (outside donors), “Menage” (households), “Governement” (government)

Figure 5 shows that households are the largest contributors to health spending in Benin, followed by the government and outside donors. The contribution of households to health expenditures went from 52.1 percent (National Health Accounts [NHA] 2003) to 44 percent (NHA 2008); government contribution to health expenditures has fluctuated between 30 percent and 28 percent in the same time period. While the contribution from households between 2003 and 2008 decreased by nearly 16 percent, the percentage of household income spent on health only slightly decreased, from 69.4 percent (in 2003) to 67 percent (in 2008). In a context where 37 percent of the population lives on $1.50 per day, this situation constitutes a heavy burden on households, exposing a large group of the population to catastrophic health spending.

1.5 DONOR ENVIRONMENT

International donors play a significant role in Benin’s health sector. Investment from donor outside sources nearly doubled, from 17 percent of total health funding in 2000 to 35 percent in 2010, a reality that has been accompanied by a relative decline in the national budget allocation to the health sector. The collective investment of U.S. government agencies under the GHI/Benin partnership to improve health in Benin in FY 2010 —the latest year data were available—was nearly $34 million, with USAID managing over 90 percent of this amount. The Benin health sector has existing bilateral partnerships with foreign national governments (Swiss, Dutch, French); multilateral corporations (World Bank, African Development Bank, World Health Organization [WHO], United Nations Development Programme [UNDP]); and NGOs (Association Française des Volontaires de la Paix, Peace Corps, Care International), as well as with U.S. agencies such as the Department of State, the Department of Agriculture, and the Centers for Disease Control.

In the context of MCH, family planning, and community-based health insurance, the Benin health sector is working closely with USAID-funded partners such as Population Services International (PSI), Medical Care Development International (MCDI), Jhpiego Corporation, and

University Research Corporation, LLC. PSI, branded under the name ABMS, works through a network of 50 clinics that provide family planning/reproductive health (FP/RH) and maternal, neonatal, and child health (MNCH) services. This network, *Protection de la Famille* (ProFam), is a clinical franchise that aims to improve FP services in the private sector with respect to quality of care and increase demand for and accessibility of FP. MCDI's Accelerating the Reduction of Malaria-related Morbidity and Mortality (ARM-3) project seeks to implement malaria prevention and treatment interventions as well as strengthen the capacity of Benin's national health system, which complements USAID/Benin's MCH program and other donor-supported malaria programs. Other key donors, such as the Belgian Development Cooperation, partner with the private sector expanding upon public-private partnerships in Benin.

1.6 OVERVIEW OF REPORT

The Private Sector Assessment (PSA) report is divided into nine sections, covering various thematic areas, findings, and recommendations. The following breakdown gives a description of each section as well:

- **Section 2**: "Scope and Methodology of Assessment" presents the scope of the assessment and the methodology used.
- **Section 3**: "Policy Environment" discusses the enabling environment for health in Benin, touching upon aspects of national health policy, business licensing, and registration for both services and products.
- **Section 4**: "Service Provision in the Private Sector" focuses on service provision in the private sector, providing an overview of facilities, providers, and associations in the private sector. This section will include information from literature reviews, DHS analysis, as well as primary data collected via field interviews.
- **Section 5**: "Pharmaceutical Supply and Products" outlines the findings for the private pharmaceutical sector, from product availability and prices to distribution and supply chain management.
- **Section 6**: "Access to Finance" covers an assessment of finance needs and constraints of providers, financial institutions active in the health market, and the business profile of providers in the private health sector.
- **Section 7**: "Health Insurance" focuses on the potential for scaling up health financing options through the private sector.
- **Section 8**: "Recommendations" provides the assessment team's recommendations, which are also found in the Executive Summary.
- **Section 9**: "Conclusion" summarizes the findings, recommendations, and goals of the PSA.

In the context of this report and assessment, the "private health sector" includes a diversity of actors —NGOs that include both faith-based organizations and associations, as well as for-profit health care businesses ranging from treatment/prevention and pharmaceutical distribution, to financing and insurance. Traditional healers are not included in the assessment for at the request of USAID/Benin, but are certainly part of the private health sector.

2. SCOPE AND METHODOLOGY OF ASSESSMENT

2.1 SCOPE OF WORK

USAID/Benin seeks practical strategies to strengthen collaboration between the public and formal private health sectors in Benin. For 2011–2015, USAID/Benin has set forth as a strategic priority the strengthening of private sector involvement to improve health outcomes in Benin. To that end, in mid-2012 USAID/Benin commissioned the SHOPS project to undertake an assessment of the private health sector in Benin to assist USAID and other stakeholders with developing a strategy for further engaging the private sector. The strategy will complement and augment current efforts within the public and private sectors with a focus on FP, MCH, urban populations (particularly the urban poor), and existing service provider networks.

The scope of the assessment was as follows:

1. **Determine the size, scope, and scale of private sector health care providers in Benin.** Identify the location and density of private sector facilities and the services they offer, especially those related to FP and MCH, as well as the supply and demand for private sector provision of health products and services in these key areas. Given budgetary and time constraints, the cadre of traditional healers in Benin was excluded from the scope of the assessment.

2. **Assess the policy and regulatory environment for private provision of health products and services,** particularly looking at how the public sector can steward and supervise the private sector in normalizing and aligning national health strategy and goals.

3. **Assess business and financing needs of the private health sector** in order to better ensure viability of facilities as businesses, with an emphasis on ProFam and AMCES facilities. Examine the extent to which access to credit could improve quality of care or expand service provision, and address training needs in business management.

4. **Identify synergies with existing USAID field support activities** focused on improving health outcomes in Benin.

5. **Identify opportunities to increase access to private sector health financing** options by examining current initiatives.

The complete scope of work can be found in Annex A.

2.2 METHODOLOGY

The private sector health assessment took place in a four-step process: finalize a plan of action, conduct a general background literature review and research, conduct an in-country assessment, and write a report and disseminate information. Step 1 began in August 2012 with initial drafting of the scope of work, and step 4 ended in January 2012 with finalization of the first draft of the assessment report. The team that carried out the assessment consisted of three international private sector specialists, three Beninese specialists with expertise in both the private and public health sector, and two support personnel from the SHOPS team located in Bethesda, Maryland.

Step 1: Finalize plan of action. SHOPS worked with USAID/Benin to finalize the detailed plan of action, including the scope of the assessment, agreement on key survey questions, and schedule and time frame. This was established through email correspondence and several phone teleconferences throughout July and August 2012. The finalized scope of work can be found in Annex A.

Step 2: Conduct general background literature review and research. SHOPS headquarters staff conducted background research using secondary research sources, secondary data analysis of DHS, NHA, and other sources, in order to form a clear picture of the demand for health services in Benin. Interviews conducted later during the in-country visit phase yielded data that were subsequently added to the data collected in step 2. SHOPS used this background research to inform team members of the state of the private health sector in Benin, including, but not limited to, FP coverage and uptake, public and private sector health expenditures, and access to finance for the private health sector.

Step 3: Conduct in-country assessment. SHOPS sent a four-person team to Benin to conduct a three-week assessment. The team worked hand in hand with three local Beninese counterparts, a private health sector expert, a public health sector expert, and a banking sector specialist, while in the field to help facilitate the assessment. The following components were included in the team's assessment methodology:

Stakeholder Meetings: The team held meetings with key decision makers such as the MOH, USAID, and representatives of private sector entities in order to clarify expectations and explain the scope of the assessment; receive guidance and feedback, and reshape the scope of the assessment, as necessary; collect and analyze primary data; assess private sector capacity; and further build support and buy-in to SHOPS work.

Key Informant Interviews: SHOPS team members conducted qualitative, in-depth interviews with key stakeholders and partners. Key informants included the following:

- USAID/Benin staff
- Implementing partners (contractors and cooperating agencies) working on private sector initiatives, specifically PSI and MCDI/ARM-3
- USAID/Washington staff from the Population Office
- More than 40 clinics representing a cross-section of private general practitioners, OB/GYNs, pharmacists, and midwives in Cotonou, Porto Novo, Allada, and Ouidah
- Ten pharmacies and three major wholesalers in Cotonou and Porto Novo
- Professional provider associations, including that of doctors, pharmacists, nurses, midwives, and private clinics

- More than 10 financial institutions, including banks, credit unions, and microfinance institutions (MFIs)
- Key government of Benin MOH staff, including those in the MCH directorate, health business and licensing directorate, pharmaceutical supply and regulation directorate, and the community health directorate
- Multilateral donors, specifically the WHO
- Three business advocacy and NGO umbrella organizations with ties to the health sector
- Six data collection and research firms, to assess research capacity for a potential private sector mapping exercise separate from the health sector assessment.

Field Visits: The assessment team made daily field site visits to urban and peri-urban health facilities ranging from small clinics and pharmacies to hospitals, in order to carry out its initial data collection and assessment activities. Additional visits were made to PSI and wholesaler warehouses, government offices, and the informal marketplace.

Data Analysis: The team conducted analysis of data collected during key informant interviews and field visits in real time, and improvised and adapted their assessment schedule as needed based on findings or new information. Data were analyzed up until the time of report writing and helped to inform the structure and findings of the assessment report.

Step 4: Write report and disseminate information. Upon completion of data analysis and in-country assessment, the team collaborated to write the first draft of the assessment report for USAID/Benin staff review. Upon receipt of comments from USAID/Benin, the team revised and finalized the report accordingly. The final report was subsequently disseminated to interested stakeholders. The process of report writing, receipt of comments, dissemination, and finalization of report took approximately three months, commencing upon return from the field visit.

3. POLICY ENVIRONMENT

3.1 BACKGROUND

The private health sector in Benin is a significant player in the provision of health services and is growing rapidly, as is the case in many developing countries. Also similar to other developing countries, Benin's detailed statistical information on the percentage of services delivered by private providers is not systematically collected. However, the large volume of out-of-pocket spending (46.8 percent, World Bank 2010) suggests that many private transactions are occurring. According to the World Bank, 92.7 percent of out-of-pocket expenditures are happening in the private sector: 56 percent are occurring in pharmacies, 13 percent in private hospitals, 9 percent in zonal hospitals, 7 percent in the traditional sector, 5 percent in specialized practices and other services, and 2 percent in doctor's offices. These data suggest that the poor receive a significant portion of their care from private providers.

Several factors are attributed to the significant growth of the private health sector in Benin. These include accelerated urbanization, poor access/quality of public services, high willingness to pay, and inability of the government of Benin to absorb newly graduated providers. A description of these factors follows:

- Accelerated urbanization. It is estimated that 50 percent of the population in Benin will be urban or peri-urban by the year 2017. This will obviously increase the demand of health products and services of both public and private providers.
- Poor access/quality of public services. It is expected that the public sector will not be able to respond to the growing demand in the urban/peri-urban areas. This vacuum could contribute to the growth of health care facilities operated by modern private providers as well as traditional healers.
- High willingness to pay. High out-of-pocket expenses may reflect a high willingness to pay. The general population, including the poor, is accustomed to making direct payments for certain health care services and products received in both public and private facilities.
- Inability of government of Benin to absorb newly graduated providers. The number of unemployed newly graduated doctors is growing year after year, and markedly so after the MOH froze systematic hiring in 1986. As a result, some are emigrating outside of Benin while the rest are either working in private sector clinics or opening their own practices.

3.2 POLICY ENVIRONMENT FOR SERVICES

The potential contributions of a growing private health sector are compromised by an overregulated policy regime and environment. As noted in the introduction, the combined history of post-colonial and post-communist influences on public oversight practices have had a significant formative influence on the policy environment. This has resulted in a highly regulated

health sector, in the sense of being overly controlled, which is not “friendly” to efficient growth of private enterprise and creates significant hurdles both to entrepreneurs and to potential international investors. The current regulatory practices are fueling the growth of the informal sector, which has consequences in terms of quality of care.

Legal framework

Private sector practice is regulated by Law No. 97, which was enacted on June 17, 1997. This law established the conditions to exercise medical and paramedical professions. The law was complemented by Presidential Decrees that approved the Deontological Codes for the members of professional associations.

Registration and licensing processes

Local legislation has been reformed to provide for specific registration time tables, for both private clinics and pharmaceutical products. On paper, the official timelines for dossier review are not unduly extended. In practice, however, practitioners and manufacturers alike perceive registration and licensing processes to be very bureaucratic and slow. Despite a mandated net maximum of 3–6 months, the general consensus is that the process to practice or to open a private practice can take years. Based on interviews with private practitioners, the average time it takes to complete the registration process is three years; anecdotally, one interviewee reported it took 19 years. The same provider submitted his application four times, citing multiple instances of the government misplacing the application.

Reportedly, one of the main causes for delay in business registration is the limited size and capacity of the technical committee (*Comission Nationale de Deliverance des Autorisations)* fielded by the MOH to review application dossiers. These committees, composed of representatives from the MOH and the relevant professional order (e.g., Order of Physicians, Order of Midwives), conduct physical inspections of applicant facilities as part of the dossier review process. Each committee is scheduled to make a maximum of four rounds of visits in one year. Final approval of a private practice is issued by the MOH and based upon the recommendations of the technical committee. For years, the volume of private clinic applications has far exceeded the respective committees’ capacity to conduct these inspection visits, resulting in a huge backlog of applications pending review. Moreover, a negative recommendation of any first-round inspection visit triggers a requirement for a new inspection visit, further adding to the existing committee workload and timeline.

Restrictions

Crucial restrictions in the current national health legislation include the following:

1. *Property of health facilities:* Each facility can only be run by one doctor, with one specialty. Providers can only own one health facility. Pharmacy or laboratory networks or chains are not allowed.
2. *Location of clinics, hospitals, and maternities:* Physicians and midwives cannot install their private practice next to a pharmacy or a supplier of medical devices. Physicians cannot open their practice in a building in which another physician is already installed unless he or she agrees and the order approves.
3. *Location of pharmacies*: Pharmacies can only be installed in a location that is approved by the respective order and that is not near another pharmacy. The criteria for deciding the location of a new pharmacy that serves a given catchment area are restrictive and ambiguous. This restriction on location impedes the development of

new pharmacies in high demand areas that could potentially sustain more than one pharmacy.

4. *Advertisement of health facilities:* Advertising of services and products by health facilities and pharmacies is forbidden. Size and text of signs displayed at entrances to health facilities and pharmacies is controlled by the respective professional associations.
5. *Honorarium*: Physicians and midwives are not allowed to reduce the price of services as established by their respective professional association. Determination of prices is not based on the market and does not take into account socioeconomic and geographic differences.
6. *Pharmaceutical prices and margins:* These are established by the Order of Pharmacists, wholesale distributors, and the MOH. They are not based on the market.
7. *Dual practice:* Public sector providers are not allowed to establish a private practice nor work in the private sector. There is anecdotal evidence that dual practice is happening, however, as it constitutes a source of additional income for public health providers. In fact, private hospitals use public health providers to cover night shifts and to serve as consultants.

FINDINGS FOR SERVICE POLICY ENVIRONMENT

The private health sector is overregulated, which is fueling the growth of the informal sector. The potential contributions of a growing private health sector are compromised by an overregulated policy regime and environment. The informal sector is growing faster than the formal, yet has no access to finance, FP supplies, equipment, training, and supervision. Major issues are the following:

- Registration and licensing processes are bureaucratic and time consuming.
- Professional associations don't have the resources to respond effectively to the registration and licensing processes.
- Major barriers exist to establishing group practices or provider networks.

There are major restrictive regulations in current health legislation. The following legislation most affects the private sector:

- Providers can only own one facility and networks are not allowed.
- The physical location of clinics, hospitals, maternities, and pharmacies is decided arbitrarily by professional associations.
- Advertisement and marketing of services is forbidden.
- Honorarium of providers is not market based and cannot be changed unless approved by the respective professional associations.
- Pharmaceutical prices and margins are not market based.

The formal private sector is operating on an individual basis, and the policy environment is not favorable for establishing group practices or provider networks. Although no legal restriction exists for setting up group practices, the policy environment is not conducive to doing so. Main reasons include a belief that a medical practice should be set up by an individual, a sense of mistrust among physicians, and a lack of confidence in the judiciary system.

There is a de facto dominance of public agencies in initiating and overseeing the implementation of public-private partnerships. Effective partnerships that add value to delivery of better health outcomes *can and must* be initiated from both the public and the private sectors. Innovative, flexible approaches to problem solving are often a tangible characteristic of private sector entrepreneurs. Bringing the power of a creative dialogue between these two sets of players is of crucial importance in jump starting effective cross-sectoral collaboration in the advancement of better public health outcomes.

RECOMMENDATIONS FOR SERVICE POLICY ENVIRONMENT

- **Initiate a policy dialogue with the MOH to streamline the registration process and improve compliance with and enforcement of officially set time limitations on the review process.** The creation of a one-stop shop or "Guichet unique" approach, where providers can take care of all aspects of business registration and licensing in one place, could be part of the solution.
- **Identify a high profile private sector "champion"** and an MOH counterpart to organize and coordinate regular dialogue meetings between the MOH and private sector stakeholders.
- **Provide amnesty for currently qualified, unregistered informal providers and facilities.** This is necessary to encourage existing facilities to submit an application for registration, especially as it pertains to future growth of the ProFam network.
- **Support a mechanism to identify and support providers in becoming registered.** Give technical assistance to an organization, such as ABMS or another that has a vested interest in the formal health sector, that will take on this role of identifying and supporting providers to become registered.
- **Remove barriers in order to convert private sector clinics into high-volume, high-quality, low-unit cost facilities.** Start and maintain a dialogue with MOH and professional associations to review the rules related to the marketing and promotion of health services, deregulate prices so that they are more market based, and develop a package of incentives to promote group practices and provider networks within the private sector.
- **Improve private providers' understanding of government standards and of provider rights** surrounding enforcement of time frames for facility/product registration and dossier review. Support an association or NGO that will educate providers about these rights and responsibilities.

3.3 POLICY ENVIRONMENT FOR PRODUCTS

As stated in Section 3.2, an overregulated and highly restrictive policy environment also hampers the potential contributions of the private sector regarding registration, price setting, and importation of products. These realities have consequences in terms of quality of care available to the Beninese population.

Product Registration

One of the key barriers to product registration is a highly controlled and centralized decision-making process within the MOH. This limits both the competition for and availability of key pharmaceuticals in the marketplace. Despite a relatively well-defined process and clear time

frames for completion of each phase of review for product registration, during in-field investigations the team observed widespread reports of extended delays in dossier reviews. Additional comments included frequent reports of “document loss” by the MOH during the process of dossier review, necessitating an application be resubmitted and the review process reinitiated.

Government, as opposed to markets, determines whether specific products are “needed” in the market. It is not clear what specific review criteria are used in the clinical trial management review that enables the government to decide whether to include or exclude particular pharmaceutical products in the market authorization process. In addition, an application for market authorization review process denies registration to products similar to those already available on the market, thus limiting consumer choice. When registration is denied to a specific manufacturer or product, inadequate rationale for such denial is given, with the reason given often based on the existence of a similar product already on the market in Benin.

The government places a heavy priority on the procurement of generics, in addition to controlling access and equity-driven prices for non-generics. This leads to the heavy reliance on product donations, mostly generics, and, consequently, to a subsidized pricing structure. The retesting of internationally recognized and prequalified products and production facilities (e.g., WHO prequalified) by the National Laboratory for Quality Control (LNCQ) creates both unnecessary delays in product registration and unnecessary additional costs to both public and private sector partners interested in expanding the private sector role in health care delivery.

Price Controls

Margins for wholesalers are set by central authorities and are limited to a specific percentage spread at the wholesale level. For branded or specialty medications, this margin often is too slim to allow wholesalers to make a reasonable profit (or even in some cases to cover costs of import, duties, and operations). Strict rate controls for markups and margins on the import and distribution of private wholesalers’ nongeneric products, while intended to protect consumers by ensuring that medications remain affordable, trims margins down to a point that revenues frequently do not cover the direct costs of import and distribution. As a result, wholesalers complain that they are unable to identify and import new specialty medicines to meet niche market demand and that they frequently are unable to reliably cover the costs of and supply retail pharmacies with the few specialty medicines that have been approved on Benin’s essential drugs list. This makes it difficult or impossible for private clinics to fully participate in the provision of pharmaceutical supplies in the marketplace. Current regulatory practices therefore dampen the ability of the private sector to sustainably serve the population’s need for specialty medicines and ultimately deny a full range of product choices to consumers, preventing effective market segmentation.

Consumer Choice

Ensuring consumer choice in pharmaceutical product lines and the value of market segmentation are not adequately developed in Benin’s public health policy framework. Private actors are particularly concerned about what constitutes adequate consumer choice in the pharmaceutical sector. Without a shift in the mentality and legal framework governing the pharmaceutical supply environment, there is little optimism among the country’s private proprietors that private actors can play a significant role in achieving public health outcomes.

Public-Private Communications Channels

Based on the extensive interviews the PSA team conducted, it is extremely evident that communication and the flow of information between private sector actors (wholesalers, retail

establishments, manufacturers, various provider associations, individual clinicians) and public sector actors (MOH officials, regulatory bodies and commissions, professional education planners, and enforcement and supervisory bodies) is weak regarding the impact of regulations on the quality of health care. Without improved communication, the development of a more vibrant private health sector is unlikely.

Examples of the information and communication disconnect include the following:

- *Public sector tendency to see private providers as the source of all significant service delivery problems.* The public sector lacks the will to report into national health information system databases, purports predatory pricing and service delivery practices of the private sector, alleges resistance to transparency on health care quality results reporting, and fails to publicly recognize and prioritize the beneficial role of the private sector in effective systemic health care provision for the populace.
- *Private sector distrust of public regulatory authorities*. Private sector practitioners perceive the public regulatory framework (especially provider registrations and mandated pricing for products and services) as a consciously manipulated conundrum intended to control and/or dampen private sector success, are frustrated with the nonresponsive character of public officials to owner/entrepreneur attempts to expose contradictions in the regulatory framework, and have expressed bitterness at perceived 'double dipping' of public sector providers via dual practice in private clinics.

Role Confusion within the Order of Pharmacies

As the leading, most well-organized and effective professional association, the Order of Pharmacies plays a confusing dual role: one role is regulatory (focused on approval/disapproval of applications for new pharmacy entries into the market and involved in the accreditation of Benin's professional training curriculum), and the other is centered on member service provision (a more traditional role for a nonprofit professional association) catered to providing benefits to its membership. Combining these two functions within one organization can be confusing and creates contradictory pressures within the industry, especially when the interaction between the regulatory and nonregulatory functions is not clear. Furthermore, this melding of roles constitutes an inherent conflict of interest. This is especially true given the current source of core membership revenues for the order (and all funds available for service provision to members), which derive solely from the voluntary contributions of eligible/approved member pharmacists.

FINDINGS FOR PRODUCTS POLICY ENVIRONMENT

- Product registration is a highly controlled and centralized decision-making process within the MOH, and this limits both the competition for and availability of key pharmaceuticals in the marketplace for consumers. Widespread extended delays in product registration dossier reviews exist.
- Margins for wholesalers are set by central authorities and are limited to a specific percentage spread, which is often so slim it does not allow wholesalers to make a reasonable profit. Strict rate controls for markups and margins on the import and distribution of private wholesalers' nongeneric products adds to decreased margins.
- Current regulatory practices dampen the ability of the private sector to sustainably serve the population's need for specialty medicines, and ultimately deny a full range of product choices to consumers, preventing effective market segmentation.

- The public sector tends to view private providers as a major source of all significant service delivery problems. Furthermore, the private sector distrusts public regulatory authorities.
- The Order of Pharmacists has a conflicting role. In discharging its regulatory functions, there is no clear separation of powers and personnel, the policy regarding avoidance of conflicts of interests is unclear, and the criteria for approval/disapproval of pharmacy distribution placement are unclear to applicants. The Order of Pharmacists is given too much control over the location and distribution of specific retail locations. This dampens entrepreneurs' abilities to pursue creating new businesses.
- Regulations governing the expansion of pharmacies are very restrictive and create disincentives for opening up new and/or additional pharmaceutical practices.

RECOMMENDATIONS FOR PRODUCTS POLICY ENVIRONMENT

- **Enforce timely and rational review of pharmaceutical product registration dossiers.** Remove restrictive limitations on the level of product competition, which significantly hamper private sector engagement and consumer choice.
- **Advocate with MOH to eliminate conflict of interest associated with the quasi-regulatory role(s) of the professional associations of Pharmacists, Midwives, and physicians**, by separating regulatory function(s) in product and facility registration dossier review from other (client-oriented) functions.
- **Rationalize and clarify criteria** for the process by which new pharmacy outlets are reviewed and approved. Consider providing technical assistance for creation and maintenance of a rotational structure of blind review for applications for new pharmacy registration. Separate financial flows for this quasi-public regulatory function from those that support activities for member-service provision.
- **Work with the MOH and professional associations to reform regulations governing pharmacy and clinic expansion.** This would allow chains of privately owned pharmacies and privately owned clinics that have a history of providing excellent service to expand to other neighborhoods and regions of the country.
- **Adjust regulations governing cross-professional participation in medical establishments** to allow for collaborative ventures and business partnerships among pharmacists, service providers, nurses, midwives, and other providers.
- **Create incentives for private pharmaceutical providers to collaborate with other health professionals** in a variety of ways, for example:
    - Create incentives for private pharmaceutical providers to open and operate collaborative or innovative jointly managed facilities via linkages to social marketing/NGO mobile or outreach activities in underserved locations.
    - Open opportunities for private pharmacies to operate branch dispensaries within faith-based or public health care facilities. This type of partnership will allow each institution to leverage its comparative advantage. Piloting this type of partnership in the harder to reach health zones will provide incentives for private sector-led growth in a risk-sheltered atmosphere.
    - Create incentives to promote joint pharmacist/service provider estimates of demand levels for specific commodities in specific areas, to improve performance on avoiding stock outs or overstock situations.
- **Institute regular forums for constructive dialogue and improved communications** across and among key public sector, private sector, and civil sector actors. To improve collaboration across sectors, breaking down the levels of miscommunication and mutual misconceptions is crucial.

- **Revise practical guidance on creating public-private partnerships**. This can include self-guided step-by-step instructions on high-impact practices, so that professional associations, private wholesalers, retail pharmacies, and government bodies can design and undertake more collaborative programming in the pharmaceutical supply chain that supports the broader public health system.

3.4 CIVIL SOCIETY ORGANIZATIONS

3.4.1 PROFESSIONAL ASSOCIATIONS

The PSA team interviewed three professional associations (Physicians, Midwives, and Pharmacists) and one professional association (Nurses). These associations are legally known as "State supporting technical bodies" (*Organes techniques d'appui à l'Etat*) that have three basic functions: (1) regulate the professional practice (public and private), (2) implement the deontological codes, and (3) support activities that contribute to the public health ("*cadre de solidarité*").

Representatives of the professional associations are part of the *Comission Nationale de Délivrance des Autorisations* headed by the MOH. As stated above, this commission makes a maximum of four rounds of visits to applicants in one year. Currently, the number of applications is much higher than the actual capacity to respond to them. In addition, not all facilities are approved in the first visit and therefore need to be revisited. The members of the *Conseil de l'Ordre* (governing board in charge of inspections) are volunteers and cannot devote the time that is required to conduct the inspection of prospective facilities among other related duties. This has resulted in a considerable delay and backlog in the approval process of health facilities.

Aside from the operational capacity of the professional associations, another potential major issue concerns conflicts of interest. According to most interviewees, the interests of the members of the *Conseil de l'Ordre* could be in conflict with the interests of the applicants. Interviewees indicated the most important areas of potential conflict were the approval of the location of facilities, pricing for low-income segments of the market, interpretation of advertisement/marketing restrictions, and diffusion of technological innovations.

FINDINGS FOR PROFESSIONAL ASSOCIATIONS

- Professional associations have limited ability to respond to registration and licensing requirements. Members of the professional orders are volunteers and cannot devote the time that is required to conduct the inspection of prospective facilities. This has resulted in a considerable delay in the approval process of health facilities.
- There is a high potential for conflict of interest between members of professional associations and applicants. Orders appear to play a dual role of regulating new members and providing service to existing members. Combining these two functions within one organization creates contradictory pressures within the industry, particularly without clarity on the interaction between the regulatory and nonregulatory functions. This is especially true given that the current source of core membership revenues for the

associations (and all funds available for service provision to members) derives solely from the voluntary contributions of eligible/approved members.
- Professional associations are not involved in the development of quality assurance initiatives among their members.
- Despite the large and growing size of the private sector, there is little evidence that the professional associations are fully engaged with the public sector implying that the private sector is not considered to be important actors in the overall health system.

RECOMMENDATIONS FOR PROFESSIONAL ASSOCIATIONS

- Strengthen the advocacy capacity of the provider associations to participate in the MOH's health systems strengthening efforts. Give technical assistance to strengthen provider association strategic plans, their role as a secretariat of its members, and coordination of training and other benefits for members.
- Work with MOH and professional associations to distinguish regulatory roles from service provision roles so as to avoid conflicts of interest, especially within the Association of Pharmacists. Roles of private nonprofits and associations must be clarified as either regulators or professional support organizations. At present many organizations play a mixed role: *Centrale d'Achat des Médicaments Essentiels et Consommables* (CAME) and the professional associations (Pharmacists, Doctors, Nurses, and Midwives) play both a regulatory/approval control-oriented role (in support of the state) and a support-to- members role (in support of the providers themselves). Separating these two functions will increase clarity and efficiency in the sector, and create a more level and supportive playing field for private entrepreneurship.
- Give technical assistance to professional associations in the formation, dissemination, supervision, and enforcement of quality standards and quality assurance systems in private sector facilities. The associations should be part of a certificate system to ensure high-quality care is administered at private facilities.
- Facilitate a regular dialogue activity between public sector stakeholders such as the MOH and professional associations so that private sector interests are kept at the forefront.

3.4.2 ADVOCACY ORGANIZATIONS

3.4.2.1 RESEAU DES ONG BENINOISES DE SANTE

Established in 1997, *Réseau des ONG Béninoises de Santé* (ROBS) is a network of 80 NGOs working in the field of health across Benin. ROBS' objective is to ensure equity, quality, and access to health care for the population through health services and advocacy. The organization's main activities are to coordinate the health activities and capacity building of its members and to advocate for human rights. Areas of intervention include immunization, MNCH, FP/RH, and health systems strengthening. Approximately one-third of the 80 NGOs operate health facilities and 80 percent provide FP services. ROBS receives USAID funding through several projects and recently was part of the "civil society coalition for FP positioning" initiative managed by IntraHealth.

ROBS' governing bodies are a general assembly, six provincial committees, a board of directors, and a coordination office. The coordination office has four full-time employees

(coordinator, accountant, administrative assistant, and monitoring and evaluation officer) and is in charge of providing technical support, coordinating activities, and generating revenue for NGO members in the form of specific projects funded by donors. The funding sources are member fees (FCFA 3,600/year) ($7), donor contributions for specific field activities, and technical assistance to health projects and research activities.

ROBS has played an advocacy role representing its constituency as part of the civil society on MOH-sponsored committees such as the *Comité National d'Evaluation* and on the MCH, Malaria, HIV/AIDS, and Extended Program of Immunization (EPI) committees. ROBS also works in collaboration with the local Global Fund Country Coordinating Mechanism, serving as vice chair on its board, representing the NGO sector.

FINDINGS FOR ROBS

- ROBS seems to play a relatively active coordinating role in support of its 80 NGO members and represents them on key committees and forums.
- ROBS has the potential to become a leading force for NGO capacity building as it continues to play a strong advocacy role. It has the potential to improve access and utilization of FP/RH services to the communities its member NGOs serve.
- The effectiveness of ROBS' work is seriously restricted by its low level of sustainability and organizational capacity.
- ROBS' main constraints are its limited capacity in terms of financial management, operations largely based in small projects, insufficient membership fees to serve as a financial base, and serious cash flow problems between projects.

RECOMMENDATIONS FOR ROBS

ROBS should conduct a thorough sustainability assessment and create a strategic plan. A crucial step would be to determine to what extent the NGO members could benefit from having a strong and lean umbrella organization and what those benefits would be in terms of health gains. A strategic plan exercise could help to determine the resources and sources of funding that ROBS would need to build a stronger NGO network and become sustainable as an organization.

3.4.2.2 COALITION DES ENTREPRISES BENINOISES ET ASSOCIATIONS CONTRE LE SIDA, LA TUBERCULOSE ET LE PALUDISME

Coalition des Entreprises Béninoises et Associations contre le Sida, la Tuberculose et le Paludisme (CEBAC STP) is a nonprofit organization created in 2007 with the objective of establishing a private sector platform to sensitize employers about AIDS, tuberculosis (TB), and malaria, as well as advocate for priority public health problems at a national level. CEBAC STP is part of the Global Fund initiative to encourage the private sector to engage in the health aspects of its work, from mobilizing financial resources to playing an active role in implementing grants and improving governance at the national level. This organization is a full member of the Global Fund's Country Coordinating Mechanism representing the private sector.

CEBAC STP currently has 138 members, which include 66 companies and business associations. Corporate members make up a health committee (*Comité de Santé Enterprise*)

and have implemented workplace programs currently reaching about 35,000 persons (employees and family members). CEBAC STP and its members are working in collaboration with MCDI's ARM-3 project in the distribution of insecticide-treated nets (ITNs), screening and prevention of HIV and AIDS, and malaria treatment. During the PSA team visit to CEBAC STP, the interviewees were clearly FP friendly and expressed their willingness to expand CEBAC STP's focus to a more comprehensive cause, to include FP/RH, rather than address AIDS, TB, and malaria only.

Eleven of the private enterprises that form the coalition have clinics in the workplace. These are typically staffed with one or two nurses and provide a package of services focusing on the three priority programs. In addition, the workplace clinics provide general care and first aid. One of the workplace clinics visited by the PSA assessment team indicated that FP provision is marginal because of lack of contraceptive supplies and training. The nurse in charge expressed a concerted interest in providing FP services, assuming that the employer would be willing to include such an option in a package of services.

FINDINGS FOR CEBAC STP

CEBAC STP is a significant advocate for the improvement of health outcomes among private sector enterprises in Benin. Its board members are young and intelligent and enthusiastic with respect to reforming CEBAC STP's vision in order to be more effective in the future. The organization willingly and openly accepted feedback from the assessment team, and appeared enthusiastic to modify its mission to include a larger focus on FP provision in workplace programs among its member enterprises. Indeed, CEBAC STP constitutes a prime vehicle through which FP can be increased within some of the larger workplace clinics in Benin, and CEBAC STP's status as a grantee of the Global Fund and MCDI ensures its sustainability into the future.

RECOMMENDATIONS FOR CEBAC STP

CEBAC STP should support FP services as part of its focus, through the inclusion of FP services in the already existing workplace clinics and through other promotional activities. Workplace clinics have the infrastructure and the staff to include FP services, provided that they have access to contraceptive commodities and training. It is also recommended to explore the possibility of making these clinics part of the ProFam network.

3.4.2.3 ASSOCIATION DES CLINIQUES PRIVÉES

The Association of Private Clinics was established in 1980 and obtained full legal status as a professional association in 1983. The association gathers physicians officially registered with the *Ordre des Médecins* who own a private hospital or large clinic that has received MOH approval. The objectives of the association are to defend hospital/clinic owners' interests vis-à-vis potential government measures, create opportunities for economies of scale among members, and promote private practice, including advocacy activities to enforce MOH measures against illegal practice. The association is also responsible for "harmonizing" prices among private hospitals, as well as for negotiating prices with health insurance organizations.

The Association of Private Clinics and Public-Private Partnerships

The association has played and can continue to play a major role in advocating and negotiating for the establishment of public-private partnerships with the MOH and others. However, the association expressed that major challenges relating to these activities are still prevalent. The association reported meager to no results on follow-up measures from the MOH after engaging in occasional policy dialogues. While the association has advocated heavily for the establishment of public-private partnerships, success in this category has been limited to implementation of the MOH's EPI, and other critical elements, such as the provision of reagents for HIV tests and Cluster of differentiation 4 (CD4), have been irregular (no reagents since April 2012). The association has advocated for the easing of registration for private clinics but reports significant delays within the *Comission Nationale de Délivrance des Autorisations* and the *Ordre des Médecins* on that front. These delays were cited as the main cause of illegally operated facilities. Although the association seeks to build its membership base, MOH restrictions on dual practice prevent private hospitals from using public health providers to cover shifts as consultants, limiting the availability and cash flow of many providers. The association expressed that it would welcome a more open approach to address this issue—a common practice among private hospitals.

FINDINGS FOR ASSOCIATION OF PRIVATE CLINICS

The Association of Private Clinics has the potential to be a significant, if not the most important, advocate for private sector practices in Benin. The association is keenly positioned to affect change for the private sector and is successful to the extent that it is able to engage in policy dialogues with the MOH, results notwithstanding. The director of the organization is capable, intelligent, and dynamic, and has the right priorities in mind for the private sector. His clinic, which also houses the headquarters of the association, was the best run clinic that the assessment team visited in Benin. As far as financial resources, the association lacks status as a professional order and is registered as an NGO operating almost exclusively from member fees. The association expressed a concerted skepticism of donor-funded assistance to the private sector, citing past projects or monetary commitments by donors that went unfulfilled or whose primary beneficiary was the public sector. Growth of the association is constricted by the lengthy registration process; the director of the association waited 19 years for formal registration of his own practice and understands well that what appears on paper does not always take place in practice. Furthermore, private practices must be formally registered with the MOH as a prerequisite to becoming a member of the association—a fact that may further hinder growth of the association's membership and revenues.

RECOMMENDATIONS FOR ASSOCIATION OF PRIVATE CLINICS

The association should be included in the policy dialogue to streamline the health facility registration process, as well as in any additional dialogues to establish quality assurance systems and public-private partnerships in support of priority programs, including FP/RH. With targeted assistance, the association could act as a major coordinating body of private sector stakeholders in future MOH dialogue activities, with the director of the association specifically taking the lead on this. Upon easing of restrictions for establishing private sector practice, the association should be tapped to play a role akin to a traditional professional association, coordinating and providing benefits for its member units. The association should continue to hold frequent dialogues with the MOH. Specific areas of collaboration between the association and the MOH include the following:

- Establishment of an MOH-sponsored quality assurance system that includes incentives for quality improvement, coverage, and other criteria
- Securing of a continuous provision of electrical power and water in private hospitals
- Access to credit and tax exemptions to procure medical equipment
- Extension of the scope of public-private partnerships to other priority programs, such as malaria, TB, FP/RH, and their incorporation into the RAMU.

4. SERVICE PROVISION IN THE PRIVATE SECTOR

Although MCH indicators in Benin have steadily improved over the course of the last decade, a considerable gap remains in the use of public versus private facilities when obtaining these services. The private sector can and should play a larger role in delivering these services, especially with respect to quality of care, reliability of services, and availability of products. Analyzing secondary data sources such as DHS data gives a clearer picture of the size of the role the private sector plays in health care delivery among the population in Benin. The following section seeks to analyze DHS data for maternal health, child health, and FP indicators, as these were the focus of the assessment.

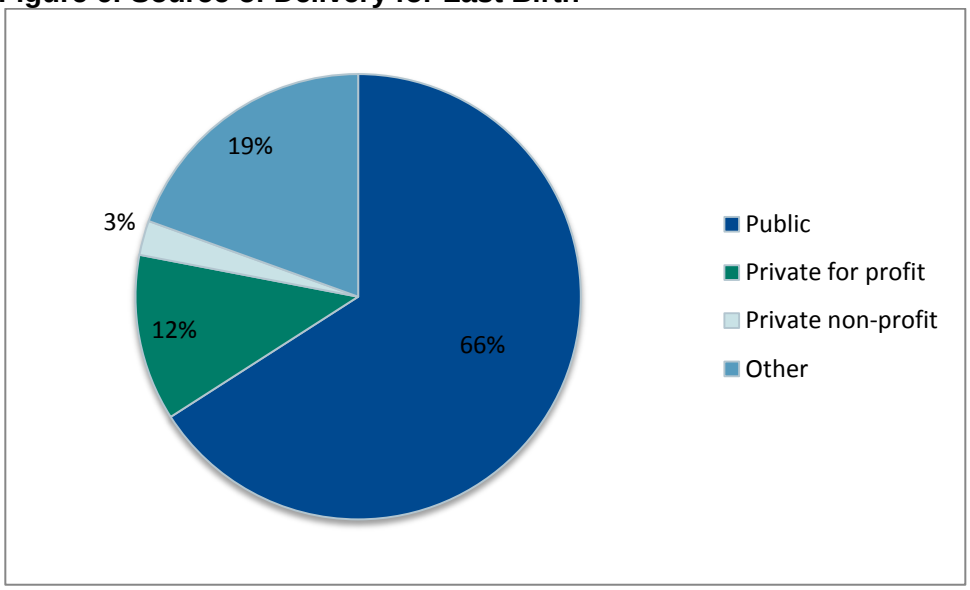
4.1 ANALYSIS OF SERVICES

4.1.1 MATERNAL AND NEWBORN HEALTH

Despite a good coverage of MCH interventions, maternal and child mortality and morbidity rates remain high in Benin. Though 97.2 percent of women receive antenatal care services, 22 percent of births still occur at the household level, mostly in the northern rural part of Benin and among the poorest households (43 percent). The unmet need in obstetrical emergency care, or the percentage of women who do not have access to emergency pregnancy services, is 77.1 percent. For maternal health indicators, the DHS data suggest that the public sector plays a relatively large role, dwarfing private sector use.

Both the impetus and potential for a larger private sector role in maternal health services exist; therefore, reducing the inequality between public and private sector use is vital to ensuring that the private sector plays a larger role in delivering quality maternal health services in Benin. Source of delivery for a woman's last birth is a good indicator of the inequality between public and private sectors as a source for maternal health. Figure 6 shows that 66 percent of women went to a public facility for their last birth, while only 12 percent and 3 percent went to private-for-profit and private nonprofit facilities, respectively. The "other" category, representing households and the informal sector, accounts for 19 percent of sources of last birth, and serves to represent an additional tranche of the health care market in which the private sector can play a larger role.

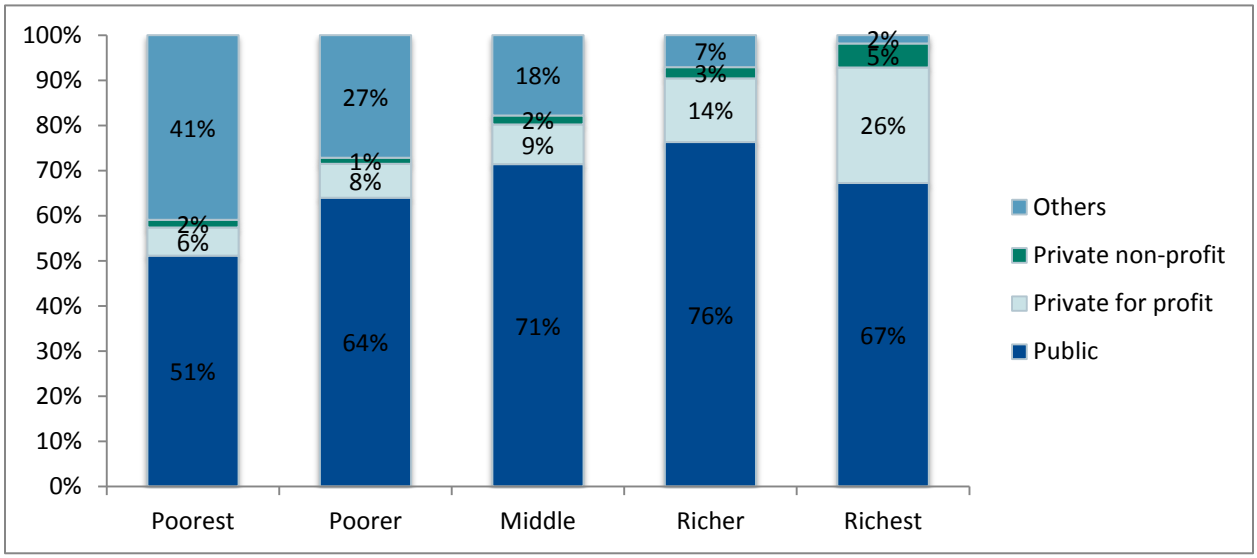
Figure 6: Source of Delivery for Last Birth



Source: DHS 2006

Figure 7 expands upon Figure 6 by clarifying which socioeconomic segments of the population visit the public versus private sector. Although the public sector assumes the vast majority of sources of last birth, "other" sources account for 41 percent of the poorest and 27 percent of the poorer quintiles. In addition to being the target quintile of the SHOPS project, the "other" category represents a major sector into which the private sector can expand. As expected, the largest socioeconomic group of the population visiting the private sector for last birth was the richest quintile at 26 percent of cases. Only 8 percent of the poorest and 9 percent of the poorer quintiles visited a for-profit or nonprofit private facility for their last birth. In general, the private sector is highly underutilized for maternal health, as demonstrated by the source of last delivery indicator.

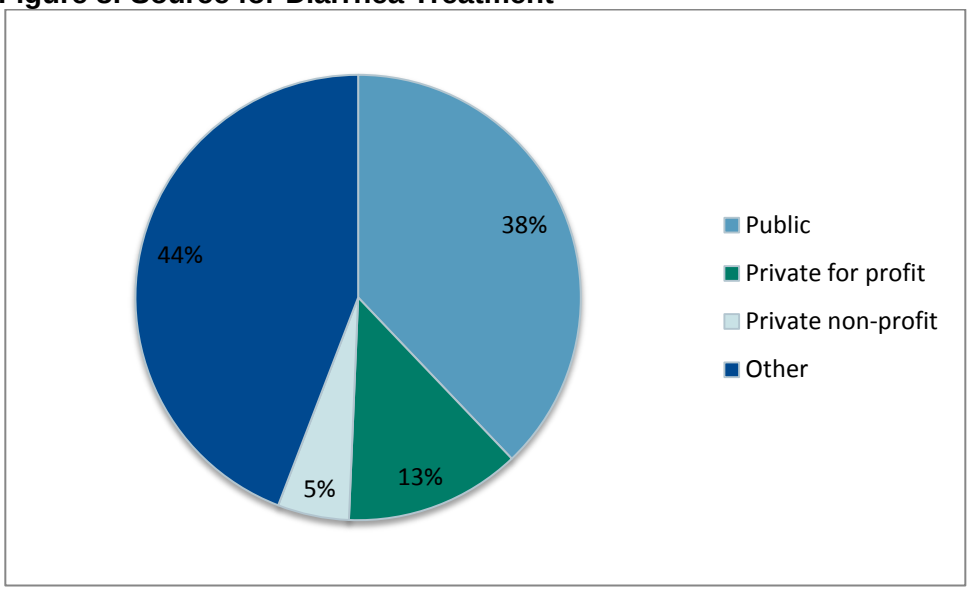
Figure 7: Source of Delivery for Last Birth by Wealth Quintile



Source: DHS 2006

The private sector appears to play a larger role, albeit slightly, in health care delivery when it comes to child health versus maternal health, according to the 2006 DHS data. Figure 8 displays the indicator of source for diarrhea treatment, where the “other” sector accounts for 44 percent of all sources of diarrhea treatment, the public sector is 38 percent, and the combined private sector is 18 percent (5 percent nonprofit, 13 percent for profit). Although the private sector plays a relatively similar role quantitatively, the opportunity to expand into the “other”/informal sector is much larger.

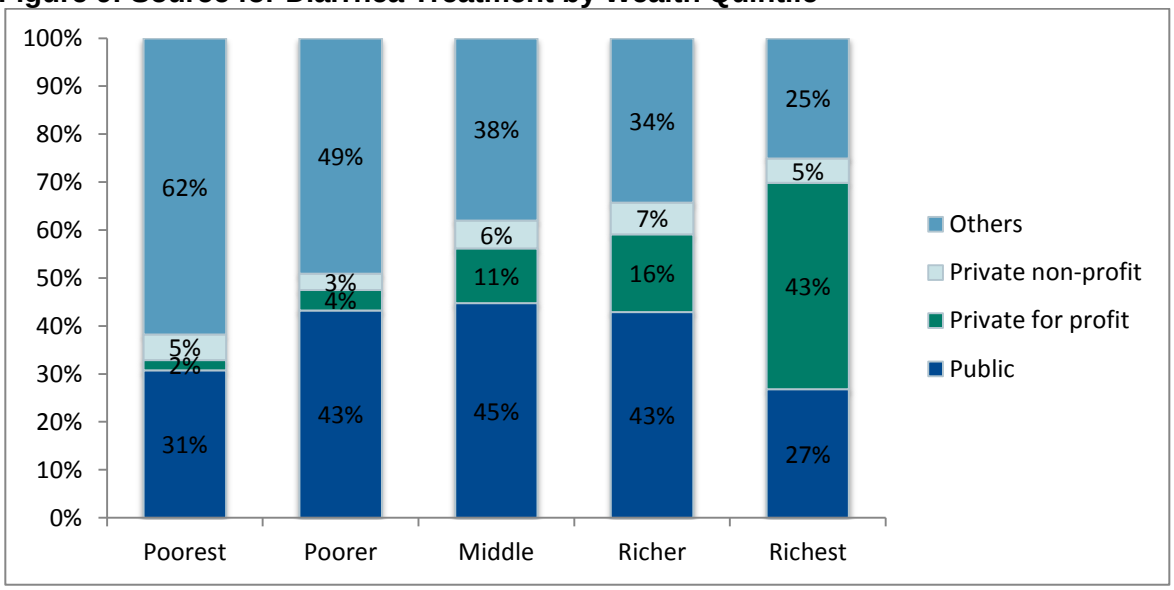
Figure 8: Source for Diarrhea Treatment



Source: DHS 2006

While the richest quintile uses the private sector for nearly half of its diarrhea treatment, use of the private sector remains woefully absent among the two lowest income quintiles. In general, it can be concluded that the private sector is vastly underutilized, especially among the poorest populations, for child health services in Benin, and it has the potential to play a much larger role. Figure 9 shows the breakdown of socioeconomic sections of the population utilizing private and public sources for diarrhea treatment. The proportion of the population using the private sector as a source increases steadily moving up quintiles, starting from poorest (7 percent) to richest (48 percent). Share of the proportion of “other” sector drops significantly along the same spectrum, from 62 percent among the poorest quintile to 25 percent among the richest, while the public sector share fluctuates from 31 percent (poorest) to 45 percent (middle) to 27 percent (richest).

Figure 9: Source for Diarrhea Treatment by Wealth Quintile



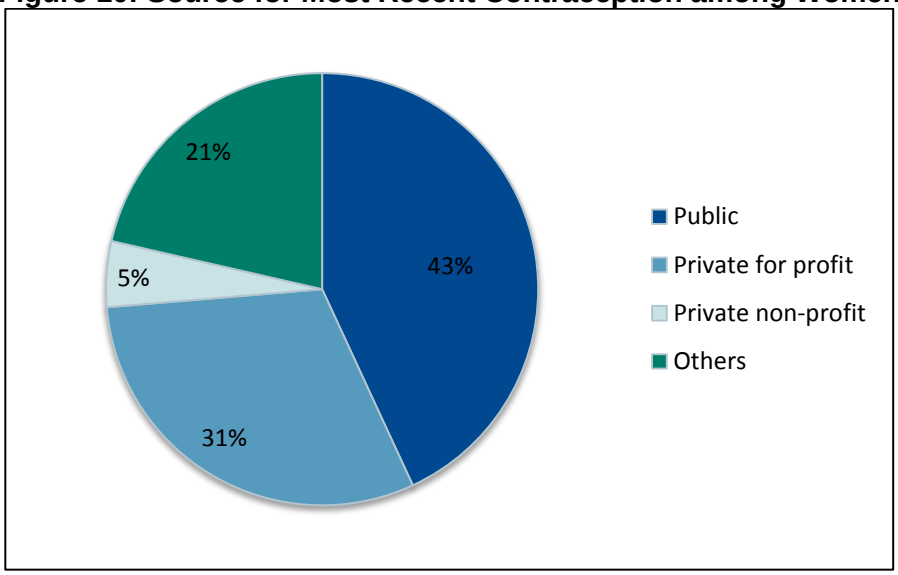
Source: DHS 2006

4.1.2 FAMILY PLANNING

As is the case with MCH, the private sector has an opportunity to expand its share of the market in delivery of quality FP services as well. Benin hosts a 30-percent unmet need for contraceptives among married women aged 15–49. From 2006 to 2012, according to the DHS data, total contraceptive use rate in Benin fell from 17 percent to 13 percent; however, use of modern contraceptives rose from 6.0 percent to 7.9 percent. Thirty-nine percent of males aged 15–24 reported using condoms.

As shown in Figure 10, 43 percent of women went to the public sector to obtain their most recent method of contraception, while 36 percent used the private sector (31 percent for profit, 5 percent nonprofit). The private sector accounts for a significant portion of the FP/RH market, probably due to the fact that the Laafia brand, produced and distributed by PSI/ABMS through their ProFam clinics, dominates the FP market in Benin.

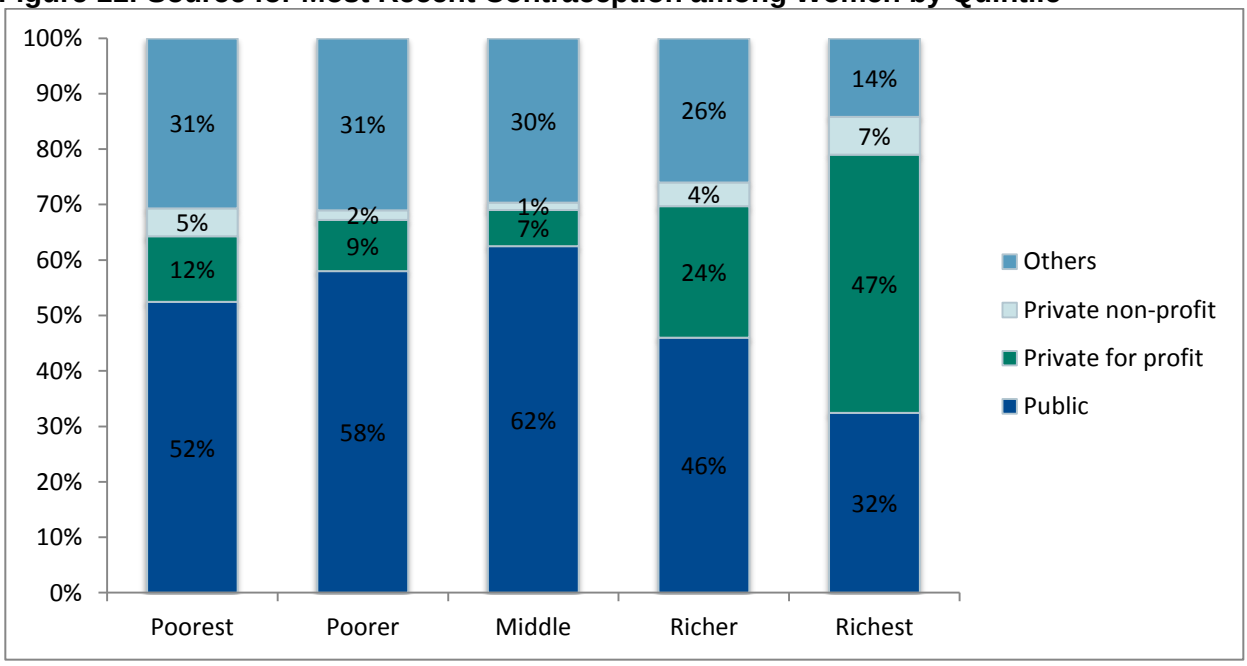
Figure 10: Source for Most Recent Contraception among Women



Source: DHS 2006

Although utilization of the private sector is significantly better for FP services than for MNCH, the private sector can significantly increase its role in all aspects of health care service provision in Benin. Figure 11 presents the habits of where different socioeconomic groups of women accessed their more recent method of contraception. Among the three lower quintiles, utilization of the public sector remains very high at 52 percent (poorest), 58 percent (poorer), and 62 percent (middle). Unsurprisingly, the richest quintile has the largest proportion of use of the private sector at 54 percent, however, the spectrum fluctuates as it moves to lower quintiles—down to 28 percent (richer) and 8 percent (middle), and then up to 11 percent (poorer) and 17 percent (poorest). This trend is interesting, and could suggest that large portions of the poorest segments of the population obtain their FP products in the informal marketplace from semi-wholesalers, as the assessment team witnessed.

Figure 11: Source for Most Recent Contraception among Women by Quintile



Source: DHS 2006

4.2 ORGANIZATION AND SIZE OF THE PRIVATE SECTOR

The private sector in Benin is organized into two main groups: commercial (for-profit) and nonprofit. This division, as shown in the tables below, is in some instances mixed with other private sector actors or the public sector. Table 3 summarizes the way private actors are organized to deliver health care services and pharmaceutical products.

Table 3: Structure of the Private Health Sector in Benin

	Commercial (for profit)		Nonprofit	
	Sole	**Affiliated with a network/chain**	***Associatif* (affiliated with an NGO)**	**Faith-based Organization**
Services	Clinics, hospitals, maternities, nursing practices	ProFaM	Hospitals ABPF ProFAM	AMCES
Products (retail)	Pharmacies dépôts pharmaceutiques semi-wholesalers (non-ethical products)	Not allowed	ABMS	
Products (distribution)	Wholesale distributors i.e.: GAPOB and others	Not allowed		
Products (production)	Not available in the country	N.A.	In-country packing for some products	

While the structure of the private sector in Benin can be laid out in a fairly straightforward manner (Table 3), estimating the size of the private sector is a more difficult task. As stated earlier, a 2005 DNSP survey of 231 private providers in four districts of Benin found that only 12 percent were registered with the MOH. With these statistics in mind, simply counting the list of registered practices does not accurately reflect the true size of the private health sector.

Tables 4 and 5 provide greater depth concerning the types of private health sector practices and providers in Benin, the known quantities (registered) of each type of practice and provider, and the estimated size of the sector. Both tables also give a brief description of the practice type and provider type.

Table 4: Private Health Sector Practices in Benin

Private Health Facility	Quantity	Description
Medical *cabinet*/ private clinic	189 registered; estimated that significantly more are unregistered	Commercial sector or networked, such as ProFam or ABPF. Owned by a practitioner. Usually consisting of a head doctor or midwife and supporting staff.
Maternity (Midwife practice)	227 registered; estimated that significantly more are unregistered	A commercial practice operated and owned by a midwife, potentially with supporting staff.
Nurse *cabinet de soins*	69 registered; estimated that significantly more are unregistered	A commercial practice operated and owned by a nurse, potentially with supporting staff.
Private hospital	Approximately 15-20	Commercial sector and national reference-level hospitals. Majority are faith-based.
Specialized practice	Unknown	Commercial sector practice owned by a qualified specialist practitioner. This may include Radiology, Diagnostic/ Laboratory, Dental, Physiotherapy, etc.
Pharmacy	Approx. 240 registered	Private pharmacies run and owned by qualified pharmacists.
Estimated Total	1,500	Approx. 750 registered; 1,500 estimated.

The private health sector in Benin is broken into six major types of practices: medical *cabinets*, or health centers run by a doctor; midwife maternities, or private midwifery practices; nurse *cabinet de soins*, or private nursing practices; hospitals; specialized practices; and pharmacies. In 2011, the MOH of Benin released a list of all registered private practices numbering approximately 510 registered medical, midwifery, nursing, and dental practices. The list does not include private hospitals, pharmacies, and other specialty practices. If these facilities are added to the registry, the total number reaches approximately 750 known practices. Based on interviews with professional provider associations, research firms, and other knowledgeable health sector specialists in Benin, SHOPS estimates that the unregistered sector is far larger, numbering perhaps close to 1,500 practices, possibly more.

Table 5: Private Health Sector Providers in Benin

Private Health Facility	Quantity	Description
Doctor	Approx. 850 registered with the Order of Doctors; estimated to be well over 1,000	Private sector doctors working at clinics and hospitals. They may or may not have their own practice.
Midwife	Estimated 500-600	Formally and informally trained midwives, working at clinics, hospitals, and cabinets (private practice). May or may not have their own practice.
Nurse	Unknown	Formally and informally trained nurses, working at clinics, hospitals, and cabinets. May or may not have their own practice.
Pharmacy staff	Staff at the approx. 240 registered pharmacies	Qualified pharmacists, pharmacy assistants, and pharmacy technicians.
Specialized practitioner	Unknown	Commercial sector qualified specialists, such as radiologists, lab technicians, dentists, physiotherapists, etc. who have their own practice.
Estimated Total	4,000	Approx. 2,500 known; 4,000 estimated

Table 5 shows the major types of private health sector providers in Benin which include doctors, midwives, nurses, pharmacy staff (including pharmacists, pharmacist assistants, and pharmacy technicians), and specialty practitioners. Data gathered from interviews with professional provider associations for doctors, midwives, nurses, and pharmacists establish the total number of known (enlisted as members of a professional association) providers to be approximately 2,500. SHOPS estimates that this number is closer to 4,000, which is in line with the 4,500 estimate given earlier in the 2012 Health Systems 20/20 Benin health sector assessment.

4.3 FOR-PROFIT SECTOR

The for-profit sector (known in Benin as the “liberal” sector) provides services in clinics, hospitals, maternities, and nursing clinics. These practices may consist of a provider working on his/her own (“sole”) or affiliated with a network. Table 6 provides detail about the characteristics of these for-profit practices. Those in the liberal, commercial sector whose practices are affiliated with a network are more likely to be a part of either the ProFam social franchise or the *Association Béninoise pour la Planification Familiale* (ABPF) network.

Table 6: Main Characteristics of For-Profit Providers

Characteristic	Private Clinics	Private Hospitals	Private Maternities
Management practices	Poor to no accounting systems and financial management	Poor to no accounting systems and financial management	Poor to no accounting systems, financial management
Focus of services	Focused on curative/ specialized care FP services are generally provided	Focused on curative care FP services are generally provided	Focus on maternal/newborn and preventive care More emphasis in FP services
Ownership of business	Owned by a doctor No group practice	Owned by a doctor No group practice	Owned by a nurse midwife No group practice
Ownership of building	Mostly rented	Mostly rented. The most successful ones are owned.	Most are in owned facilities
Capacity	Outpatient; Service during regular office hours: 4-6 hours, 5 days a week	15-25 beds Service 24/7	5-15 beds Service 24/7
Staff pattern	One assistant clerk	Nurses, midwives, and nurse aides Consultants (Vacateurs) on fee-split arrangements	Nurses, midwives, and nurse aides Consultants (Vacateurs) for special cases
Referrals	Mainly to private hospitals	Mainly to public sector hospitals	To public sector and to private hospitals
Laboratory and sonograms	Lab: Outsourcing sonograms: some are owned	Lab: Outsourcing sonograms: some are owned	Lab: Outsourcing sonograms: some are owned
Financing	Fee-for-services	Fee-for-services Informal sliding scale in some cases	Fee-for-services with informal sliding scale More flexible than private hospitals
Marketing	No activities	No activities	No activities

Private Clinics

Private clinics are owned by a doctor that could be either a general practitioner or a specialist. They are normally established in a rented location composed of a consultation room, a waiting area, and a bathroom. Some clinics have diagnostic equipment such as EKG or sonograms, though no clinics were found to have basic laboratories or other ancillary services.

Private Hospitals
Private hospitals are also owned by a single doctor, generally a specialist, and are established in either an owned or rented facility. Most are regular homes that were adapted and expanded to serve as a health facility. Private hospitals have an average of 20 beds and provide outpatient and inpatient services from the four basic specialties (pediatrics, Obstetrics & Gynecology, general surgery, and internal medicine). They tend to have X-Ray, EKG, and sonogram machines. Private hospitals are also allowed to have a basic laboratory and a pharmacy whose use is restricted to patients of the hospital. Nearly all facilities visited provide immunization services, with vaccines and supplies being provided by the MOH's EPI. Hospitals are staffed by salaried nurses and midwives. Doctors are usually paid by shift (general practitioners) or fee-split arrangements (consultants). Anecdotal evidence suggests that most doctors performing night and weekend shifts at private hospitals are public sector physicians that are complementing their salaries with private sector work.

Private Maternities
Private maternities are owned by a single midwife, generally a former MOH employee. The infrastructure is in most cases substandard in terms of layout and equipment. Maternities have an average of 10 beds and provide outpatient and inpatient services focused on deliveries, antenatal and post-partum care, well baby, and Integrated Management of Childhood Illness (IMCI). All facilities visited provide immunization services with vaccines and supplies provided by the MOH's EPI. Some maternities are equipped with a basic laboratory and are allowed to have an area to dispense some pharmaceuticals, including FP products, to their patients only.

Nursing Cabinets (Practices)
Nursing cabinets are owned by a single nurse and operated in a modest two-room facility that has a bathroom and is generally rented. Focus of services is mainly on curative both for adults and children (IMCI). Nursing cabinets tend to provide other services as well, such as injections, IV fluids, and dressings. Some facilities provide FP services. Nurses interviewed expressed strong interest in expanding the FP services if access to training and supplies were to be provided.

Family Planning Services
Private clinics, hospitals, and maternities generally offer both short-term methods, such as oral contraceptives (OCs), injectables, and condoms, and long-term methods, such as intrauterine devices (IUDs) and implants, allowing clients to make informed choices about a preferred method of contraception. Private facilities that are part of the ProFam network are well known for providing FP services and selling FP and other related products such as *OraSel Zinc* and ITNs. ProFam clinics also enjoy other benefits (such as access to training and quality supervision). Although FP services are readily available in many private sector facilities, there are many factors affecting the ability of the private sector to provide these services to low- and middle-income populations (Table 7).

Table 7: Main Factors Affecting the Ability of the Private Sector to Provide FP/RH Services to Middle- and Low-Income Populations

Internal	External
Low managerial ability	Difficult economic situation
Lack of business planning	Demand constrained by ability to pay despite relatively high willingness
Quality of services suffering from coping mechanisms	Intense competition and changes in health care-seeking behavior
Quality of facilities inappropriate; lack of maintenance	Policy environment: barriers to private expansion e.g., advertising policy, price controls
Insufficient staff training	No access to finance
Insufficient equipment	No access to training
Lack of marketing activities	

Uneven Quality of Services

In general, private sector providers are not employing mechanisms for standardizing and ensuring the quality of care that is delivered, a function typically assumed by professional provider associations. Although a full quality assessment was not performed as part of this assessment, biosafety practices were observed as substandard in most facilities. Based on these observations, it is reasonable to expect that the quality of services provided by the private for-profit sector is widely uneven and not based on professional ability or willingness to adhere to clinical guidelines. Private facilities that are affiliated with the ProFam network appear to be the sole practices that display a structured effort to enforce quality. These practices receive regular supervisory visits designed to assess adherence to FP guidelines and reinforce clinical training previously provided.

MOH officials occasionally conduct “inspection visits” of private providers that are registered; however, these visits are not considered part of a comprehensive quality assurance system. In summary, private provision is largely unmonitored, and it is reasonable to expect that this is leading to wide variations in quality.

Low Volume of Users/Patients

Most private providers report that their volume of patients is relatively low due to either inability to pay or intense competition. In fact, most facilities are designed to handle a limited volume of patients, which is expressed in limited office hours (6 hours per day for clinics) and providers’ desire to deliver a “personalized” service. Other elements that contribute to low volume include nonmarket-based price controls and restriction of promotion and marketing of services. Box 1 below goes into detail about potential styles of practice that may help to increase volume of users/patients.

Price Control and Restriction of Promotion and Marketing

As stated above, the price of services is controlled by the MOH and the Order of Doctors, and the promotion and marketing of health services are restricted by the current legislation (Law #97 and Deontology Code). These issues appear to be controversial among providers interviewed. Those who are serving the lower segments of the market think that restrictions on marketing should be lifted and prices should be deregulated so they can increase their volume of patients

and make their business more profitable. Providers who are serving the higher segments of the market prefer to maintain the status quo on these two important matters citing concerns of possible unfair competition and abuse of advertising.

Limited Access to Finance and Training

The formal private sector has limited access to financing opportunities. Priority for financing is given to facility improvement and expansion, equipment acquisition, and working capital. The main barriers to financing include lack of registration and licensing, informality, and customary collateral requirements. In addition to financing barriers, most private providers have limited to no access to training opportunities. The only exceptions are providers that are affiliated with the ProFam network who receive regular training that focuses on FP/RH issues. Section 6: Access to Finance provides additional information on this topic.

Box 1: Group Practice versus the Lone Wolf Model

Group practice in Benin is virtually nonexistent. Barriers to implementing group practices can be overcome with proper support and incentives. The following table shows some of the differences between "lone wolf" traditional private clinics and group practice clinics:

Issue	Individual Practice (the reality in Benin) Limitations	Group Practice Possibilities
Implementation of quality assurance systems	Heavily dependent on individuals	Quality assurance systems that includes peer review of clinical records and case studies
Array of services	Limited to one specialty	Potential of having a wider array of services
Potential volume of users/patients	Low	Higher
Unit costs	Higher	Lower, because of higher volume, cost sharing, and economies of scale
Prices/margin	Lower margin provided standardized prices dictated by the *Ordre*	Higher margins
Access to technology	Limited to the affordability of individual	Higher affordability due to pooling of resources
Cross-subsidization of preventive programs	Usually none	Higher probability of providing some preventive services free of charge
Access to finance	Dependent on individuals	Higher probability
Potential to link with health insurance	Lower because of unit costs/margins	Higher because of unit costs/margins

Business Model

The prevalent business model feature in the commercial private sector is a **low-volume, high-unit cost, low-margin** operation that is less profitable in both financial and social terms. Having a low-volume operation with a significant amount of downtime is a main factor for a relatively high unit cost and, consequently, a low margin in an environment where prices are not market based. Another consideration is the lack of quality assurance systems that could address the

issue of uneven quality. In addition, the entire private sector system is based heavily on direct out-of-pocket payments that are a major contributor to the poor not getting the care they need or being forced to spend an inordinately high portion of their income on health care, leaving them perpetually impoverished.

FINDINGS FOR THE FOR-PROFIT SECTOR

- Private sector providers serving low- to middle-income populations are affected by a restrictive environment (difficult registration process, no market segmentation, no promotion or marketing allowed). The higher income populations do not face these restrictions, as they typically go out of the country to obtain significant health services.
- Volume of users is low and inability to pay is high. In contrast, there is a relatively high willingness to pay for health care.
- Other factors affecting the volume of users in the private sector range from changes in health care-seeking behavior to less expensive alternatives both in the public sector and private sector (pharmacies, traditional medicine), to simply not getting care at all.
- Cost containment is the most important coping mechanism. It most likely affects perceived quality of services (e.g., appearance of clinics) and could affect the user's willingness to pay.
- Private sector providers have very little access to management/marketing training, partly due to low demand for such training
- Private sector providers are not using management and marketing tools to improve their business.
- Providers have none to very limited access to clinical training opportunities. ProFam is the only reliable source of FP/RH training.
- There is limited availability of, and access to, medical equipment (e.g., sonograms). Where medical equipment is available, providers' inability to pay and low client volume, and thus low demand, affect the decision to purchase.
- PSI/ABMS is the main and most reliable source of contraceptive supplies and other health products (ITNs, *OraSel Zinc*)
- Physical facilities are mainly adapted residential buildings and suffer from structural limitations and lack of maintenance.
- Providers experience a lack of government incentives, such as a long registration process and unproductive inspection visits.

Business Model of Commercial Sector

The commercial sector has a low-volume, high-unit cost, low-margin business model. The prevalent business model feature in the commercial private sector is less profitable in both financial and social terms. Having a low-volume operation with a significant amount of downtime is a main factor for a relatively high unit cost and, consequently, a low margin in an environment where prices are not market based.

Uneven Quality in Provision

There is likely uneven quality in service provision as a result of a lack of quality assurance systems in the commercial sector. Biosafety practices are objectively substandard.

RECOMMENDATIONS FOR THE FOR-PROFIT SECTOR

The for-profit sector must create conditions to improve its volume of patients, pricing, and cost structure of health facilities so that its services may be converted into high-volume, high-quality,

and low-unit cost practices. This includes engaging in dialogue with the MOH and the professional associations in order to accomplish the following:

- Advocate for reforming the rules related to the marketing and promotion of health services. Current rules prohibit the marketing and advertisement of a facility's services. Any reformation of the rules must be done concurrently with an upgrading of the quality of services; both are necessary.
- Deregulate price of services in order to allow a market segmentation that takes into account ability to pay and geographic location, among other considerations. Prices are standardized by the MOH and the professional associations and are inflexible to the varying circumstances experienced in different parts of the country.
- Improve the policy environment for group practice and joint practice (doctors/pharmacists/laboratory) through a package of incentives that could include access to credit, equipment, and training. ABMS can play a large role in leading this recommendation, as it could contribute to the expansion of the ProFam network.
- Provide technical assistance to set up an independent, NGO-led quality standards and quality assurance system in private sector facilities. Strengthen the role of supervision of quality assurance systems and compliance with standards as part of a certification system. Consider support (in the longer term) for the creation of a self-regulating "grading" system for private providers. Work with the democracy/governance team within the USAID mission to achieve these objectives.

Further recommendations for the for-profit sector that were mentioned earlier in Section 3.2 include the following:

- Initiate a policy dialogue with the MOH to streamline the registration process and improve compliance with and enforcement of officially set time limitations on the review process. The creation of a one-stop shop or "Guichet unique" approach, where providers can take care of all aspects of business registration and licensing, could be part of the solution.
- Provide amnesty for currently informal providers and facilities. This is necessary to encourage existing facilities to submit an application for registration, especially as it pertains to future growth of the ProFam network.
- Support a mechanism to identify and support providers in becoming registered. Give technical assistance to an organization, such as ABMS or another that has a vested interest in the formal health sector, to take on this role. Ensure that formal registration qualifies a provider to participate in RAMU.

4.4 NOT-FOR-PROFIT SECTOR

4.4.1 FAITH-BASED ORGANIZATIONS

4.4.1.1 ASSOCIATION DES ŒUVRES MEDICALES PRIVEES CONFESSIONNELLES ET SOCIALES DU BENIN

AMCES, founded in 1985, is a Beninese organization that was born out of the aspirations of some health organizations to harmonize their practices and enhance collaboration with the MOH, with whom AMCES currently has an umbrella agreement. The members of AMCES are a dynamic and motivated group of faith-based private health centers, who are open to dialogue and flexible in adopting management techniques and new strategic approaches. The religious groups represented in AMCES are Catholic, Evangelical, Protestant, and Islamic. Their common desire is to implement health measures that would benefit the people of Benin without distinction. Moreover, AMCES is particularly concerned with those segments of the population that are underserved and more vulnerable.

AMCES facilitates dialogue and synergy as much among its member institutions as between private and public health institutions. AMCES desires to function as a catalyst within the national health system and aims to work in collaboration with the MOH to find pragmatic solutions to the diverse challenges facing health care in Benin.

AMCES has the following specific objectives:

- Create a link among the nonprofit health organizations in Benin
- Facilitate a proper functioning of the member organizations
- Strengthen the role of the nonprofit private health sector
- Boost the exchange of experiences and replication of best practices
- Foster the development of public-private partnerships
- Bring contributions to the health system overall.

AMCES is governed through a general assembly, a board of directors, and an executive office. The latter strengthens organizational capacity of the association through the following activities: organizational and technical support, research, exchange meetings and training, lobbying and advocacy, support to health services, and design and management of health promotion projects. The funding of AMCES is based on donations, cost-recovery through user fees, and, at a minor scale, in-kind subsidies from the government of Benin through vaccines, drugs, and supplies for priority programs. Main donors include the European Union, the Belgian cooperation, the French government, and Medicus Mundi.

Health Services

The AMCES network is composed of 28 health facilities: 18 primary health care centers (*Centre de Santé*) and 10 hospitals. All hospitals are designated district hospitals and are part of the MOH delivery system. AMCES claims to provide 40 percent of hospital care coverage to the population and is the most active private actor in the social field. Services provided are both preventive and curative, and are mainly focused on maternal and child care. The volume of curative services is highest in hospitals, with FP counseling and traditional methods provided in all facilities. The availability of modern contraceptive methods is contingent upon the religious

beliefs of the members. The facilities do offer referrals to public and private facilities for modern contraceptive methods, and managers seem to accept such referrals.

Future Plans
AMCES has the intention of pursuing the following strategic activities in the near future:

- Organize a system to procure drugs and supplies in bulk
- Strengthen and modernize the medical equipment in health facilities
- Improve the health information system of the network
- Strengthen the clinic and management training program
- Improve the level of integration into the national health system.

FINDINGS FOR AMCES

- AMCES is a very significant actor in the nonprofit health sector that has succeeded in implementing a public-private partnership with the MOH.
- AMCES services are mainly focused on curative and hospital care.
- AMCES appears to be a reliable source of FP counseling and provision of traditional contraceptive methods. Availability of modern methods is contingent upon the religious beliefs of the members.
- The executive office appears to provide the right type of support to its members and has a clear idea of future strategic actions.

RECOMMENDATIONS FOR AMCES

The assessment team recommends that the FP program in the AMCES network be strengthened. By strengthening FP counseling services and provision of traditional and modern contraceptive methods (in facilities where provision is allowed), AMCES can potentially increase the volume of FP users at its health centers and hospitals.

4.4.2 *ASSOCIATIFS*/NGO-BASED NETWORKS

4.4.2.1 PROTECTION DE LA FAMILLE

Background
ProFam is a provider network franchise that aims “to improve the quality and accessibility of and increase the demand for family planning services in the private sector.” ProFam has a network of 49 privately owned clinics that provide a variety of general primary care, FP/RH, and MNCH services, including the distribution of contraceptives, sexually transmitted infections (STI) testing and treatment, prevention of mother-to-child transmission, HIV counseling and testing, antenatal care, labor and delivery, emergency obstetric care, post-natal care, diarrhea and malaria testing and treatment, and distribution of ITNs. Home visits, education sessions, and referrals for FP or further treatment are conducted by community health workers in the catchment areas. Alongside ProFam is Benin's 'Ligne Verte' (toll-free hotline), which was created by ABMS to offer an anonymous way for clients to receive information on HIV, FP, and referrals to ProFam clinics, and it has experienced great success in terms of volume of calls. ProFam is currently

implementing and enforcing a quality assurance system based on the Standards Based Management and Recognition approach (SBM-R).

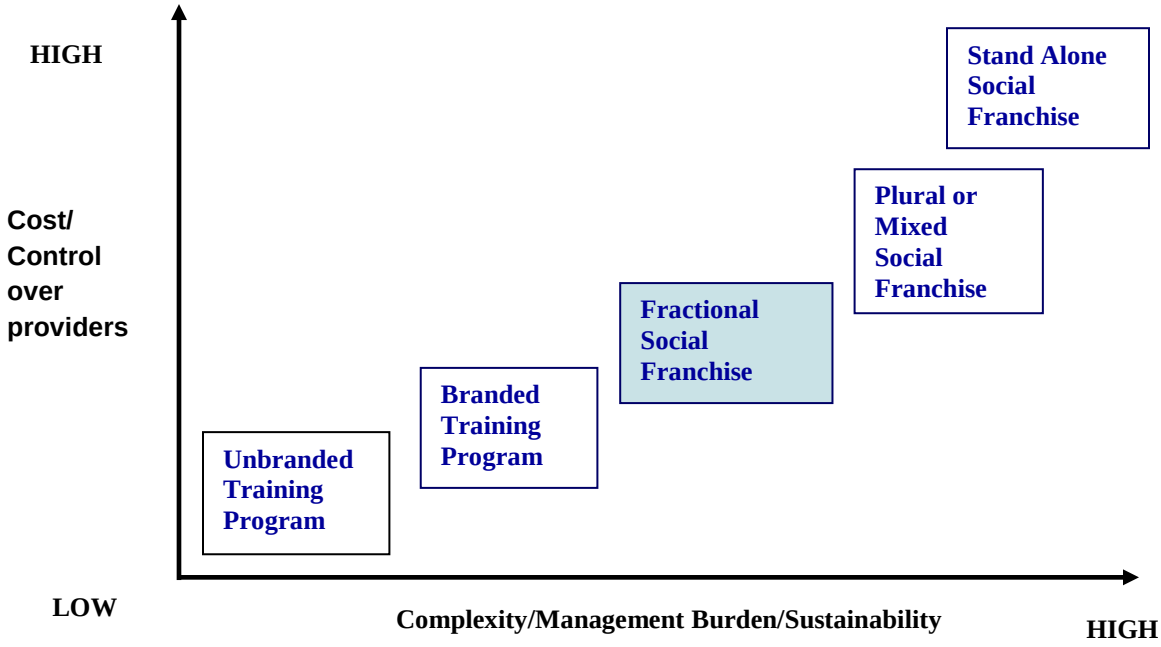
Management
ProFam was developed, and is currently managed by, ABMS, a local affiliate of PSI. The network, launched in 2004, was funded with the support of the German Development Bank, SALIN (The Netherlands), and USAID through the IMPACT Project.

Target Population
The target population of ProFam clinics is young adults (13–24), both men and women. The income level of the target population is the bottom 20 percent, as well as the middle 20–60 percent range (lower to lower middle income). Users provide out-of-pocket payments on a fee-for-service based system. ProFam negotiates prices of target products and services with the owners of affiliated clinics.

Geographic Distribution
ProFam clinics are mainly located in the south and central part of the country (43 clinics), while only six clinics are in the north. Clinics are concentrated in urban areas, predominantly in Cotonou and Porto Novo.

Network Approach
Conceptually, network approaches vary across ProFam clinics according to the following factors: capital and operational cost, management complexity, degree of control over providers, potential for increasing quality and access, and potential for long-term viability. Based on these, ProFam is using a "fractional franchise" approach for its provider network, as explained in Figure 12.

Figure 12: Provider Network Approaches



The ProFam Social Franchise

ProFam is a social franchise[1] network composed of private providers, doctors, and nurse midwives who own their health facilities and accept an agreement to become part of the network. By virtue of this agreement, the franchisees provide a group of services that constitute a "fraction" of their regular practice, under certain conditions dictating quality, pricing, and promotional strategies. Features of the ProFam franchise include the following:

- Selection criteria: Health facilities that are officially registered have a relatively good infrastructure and reputation and are willing to enter in an agreement to provide targeted services and products. They must also agree to abide by the rules in terms of quality control, agreed-upon prices, and promotional activities, including the display of the ProFam sign with a distinctive logo.
- Services and products: ProFam affiliated clinics are providing a wide array of services and products that include:
    - Family planning: counseling and provision of medium and long-term methods
    - FP products: OCs, injectables, DUI, Collier, Norplant, and condoms
    - Other products: *OraSel Zinc* and ITNs
- Supply of products: None of the providers interviewed indicated any significant problems with the product supply chain[2].
- Prices of target products and services: Prices are negotiated by ProFam with the owners of affiliated clinics. Users provide out-of-pocket payments on a fee-for-service based system.
- Quality assurance: Quality assurance is supported through regular supervisory visits. Supervisors are using the Standards-Based Management and Recognition (SBM-R) as a quality assurance approach.
- Network brand and promotion: This agreement specifies putting up the ProFam logo on the gate to the clinic; all visited clinics had complied with this stipulation. In addition, the clinics use a set of printed materials (flyers and posters) as well as community outreach activities aimed to increase demand.
- Training: ProFam has developed a state-of-the-art FP program and other training curriculum for private providers. Training courses offered to ProFam providers include contraceptive technology, medium and long-term contraceptive methods, and SBM-R as a quality assurance tool. Training modules have had the benefit of extensive testing and refinement since their launching. Although private providers interviewed for this assessment consistently expressed appreciation for the training received, their interest

[1] "Social franchise – An adaptation of a commercial franchise in which the developer of a successfully tested social concept (franchisor) enables others (franchisees) to replicate the model using the tested system and brand name to achieve a social benefit. The franchisee, in return, is obligated to comply with quality standards, report sales and service statistics, and, in some cases, pay franchise fees. All service delivery points are typically identified by a recognizable brand name or logo." (Public Policy and Franchising Reproductive Health: Current Evidence and Future Directions © World Health Organization 2007)

[2] ABMS distributes oral, injectables, IUDs, and implants under an umbrella brand *Lafiah* through the private sector in Benin. It's estimated that these products, as well improved training for family planning providers, has helped prevent 174,497 unintended pregnancies since 2010.

to obtain more training was restricted by the high cost of leaving their clinics for a relatively long period of time to attend training.

- Training standards: Minimum training requirements for facilities and providers to be considered part of the network are not clearly stated. The assumption may be that since most clinics have few providers, training for one or two providers may be adequate.

FINDINGS FOR PROFAM

The PSA team met with ABMS staff supporting the ProFam network, visited private providers affiliated with the network, and reviewed available reports. The main findings are as follows:

- The ProFam network operates effectively to support provision of FP and other priority health services in the private sector.
- ABMS is both a trustworthy and reliable source of supplying FP commodities, *OraSel Zinc*, and ITNs to the ProFam affiliates.
- The "fractional franchise" model used seems to be appropriate to balance the need of increasing the uptake of FP and other priority health programs, while preserving the entrepreneurship spirit of private providers.
- The environment for pursuing private provider networks is favorable and the lessons learned from the ProFam network experience can be useful in pursuing new network strategies.
- The growth of the ProFam network is heavily dependent on the number of registered private providers, as only registered providers can become franchisees.

RECOMMENDATIONS FOR PROFAM

ProFam has the capacity to lead a set of strategic interventions to support the development of private providers in general, and through these interventions create the conditions to expand its own network. Specific recommendations are:

- Facilitate policy dialogue to streamline the registration process;
- Identify and assist private providers that are operating illegally to become legal;
- Develop a package of technical assistance and incentives to encourage group practice;
- Mobilize the demand of private providers to access finance and management/marketing training;
- Facilitate the process of linking with health insurance schemes and policy interventions which will inform and facilitate future work with private providers.

4.4.2.2 ASSOCIATION BENINOISE POUR LA PLANIFICATION DE LA FAMILLE

ABPF is a not-for-profit organization that was founded in 1970 and legally established in 1972. ABPF is at its core a network of clinics that provide a wide array of FP/RH services and products as well as targeted promotional activities and advocacy. ABPF is affiliated with and receives funding from the International Planned Parenthood Federation (IPPF). Other donors include DANIDA (Denmark development cooperation), EngenderHealth/USAID, Global Fund (as part of the Country Coordinating Mechanisms), and United Nations Population Fund (UNFPA).

ABPF focuses on the following cross-cutting approaches to health care provision: a community-based approach; information, education, and communication, and *Communication pour le Changement de Comportement*; continuous quality improvement; promotion of gender equity, including male involvement in FP; and governance.

ABPF has defined five strategic lines of action and five cross-cutting strategies. As the first strategy, the organization seeks to improve access to FP services through a comprehensive network. ABPF consists of seven clinics nationwide, one clinic per department. It focuses on community-based distribution that centers on youth and is composed of about 150 community distributors. ABPF is affiliated with approximately 50 private clinics in the form of "*cliniques amies"* and *"cliniques partenaires.*" ABPF's second strategy is the promotion of sexual and reproductive health among adolescents and youth. This is achieved through the maintenance of youth-friendly clinics and eight socioeducational centers throughout the country where youth-specific programming is carried out. The third cross-cutting strategy is the integration of the treatment of STIs and HIV/AIDS prevention, which followed MOH-directed norms and guidelines. ABPF's fourth strategy is the promotion of "low-risk maternity" among the population. This is achieved through comprehensive antenatal care provision, as well as the referral of patients to public facilities for high-risk deliveries or complications. Finally, as the fifth cross-cutting strategy, ABPF advocates for removing legal barriers to FP provision. In order to achieve this, the organization holds policy dialogue activities with a wide range of government entities.

The ABPF Network
The ABPF service network is composed of one central clinic, six regional clinics, and eight "socioeducational centers." Four of the eight socioeducational centers operate in rented facilities while the remaining centers conduct their work out of buildings belonging to the government of Benin. Mobile clinics were discontinued due to budget problems.

Services
ABPF targets low-income populations located in peri-urban areas. The ABPF clinics deliver a wide array of FP services that include FP counseling and provision of medium and long-term methods such as oral contraceptives, injectables, IUDs, cycle beads, Norplant, and condoms. Other services offered include STI treatment, HIV counseling and testing, and antenatal and post-abortion care. According to the ABPF statistics, in 2011 the organization delivered 1,775,000 condoms, 349,000 contraceptive services, 332,000 other sexual and reproductive health services, and 311,000 services to young people under 25 years of age. Quality assurance of services happens via supervisory visits. These visits take place at ABPF clinics, however, the frequency of quality assurance activities has been reduced due to budget constraints.

Source of FP Products
ABPF procures part of its FP supplies from International Contraceptive & SRH Marketing Ltd. (ICON), an IPPF subsidiary company that procures and distributes sexual and reproductive health supplies on a global basis to IPPF member associations. Another source of supplies is CAME, which distributes ABMS/PSI products to ABPF clinics. Additional supply sources include UNFPA and the *Organisation de l'Ouest Africaine pour la Santé*. ABPF last received supplies from USAID in 2009.

Prices
ABPF imposes a fee of FCFA 500 ($1) for all new FP users. Follow-up visits for FP are free of charge. The prices charged are the following: implant (Jadelle), FCFA 800 ($1.60); injectable (Cyclofem), FCFA 600 ($1.20); IUD, FCFA 400 ($0.80); OCs and Progestin only, FCFA 100

($0.20); condom, FCFA 10 ($0.02) (non-branded, provided by IPPF). The price charged for a non-FP visit is FCFA 500 ($1), while a visit for a hemogram is FCFA 2,000 ($4). HIV tests are free of charge.

FINDINGS FOR ABPF

1. ABPF is playing a limited but important role in the provision of FP services and promotional activities in the country. ABPF's potential is mainly constrained by a business model that is narrowly focused on low-price FP services and products.
2. ABPF is operating a heavily subsided network of clinics and socioeducational centers, which provide FP services and a limited range of other related services to low-income populations living in peri-urban areas.
3. ICON and CAME are the main and reliable source of supplies for ABPF and appear to fulfill most of the needs of both ABPF and their users.
4. ABPF linkages with commercial private providers via "*cliniques amies"* and *"cliniques partenaires*" is limited to supplying of FP products and some training. Training provided is minimal and there are no quality control activities.
5. ABPF leadership's main concern is the sustainability of its operations given its high dependency on donor support.
6. Ideas to reduce the financial vulnerability of the organization discussed include the following:
    - Invest in a central clinic/hospital that provides a wide array of services, including maternity, surgery, diagnostics, inpatient, and outpatient
    - Develop a comprehensive laboratory in Cotonou and Porto Novo
    - Equip all clinics with modern sonogram equipment
    - Provide new services: colposcopy and mammography
    - Expand the supply of medical services: general medicine, gynecology, pediatrics, and other specialties
    - Link with private health insurance and *mutuelles* to serve as a provider
    - Partner with both public and private sector facilities and providers with the goal of training providers on FP/RH
7. The future of ABPF in terms of relevance in the health sector is linked with the development and implementation of a thorough strategic and sustainability plan.

RECOMMENDATIONS FOR ABPF

ABPF is an important FP/RH provider for the low-income population and an advocate for key public policies related to ABPF's mission. The PSA team believes that the ABPF significance in the Benin nonprofit health sector can be enhanced through a comprehensive sustainability and strategic plan that includes the development of its network of services. Specific recommendations are the following:

1. Develop a thorough sustainability assessment followed by a strategic planning exercise and an investment plan
2. Develop business plans to determine the feasibility of initiatives aimed to reduce financial vulnerability of the organization while preserving their social mission.

5. PHARMACEUTICAL SUPPLY AND PRODUCTS

5.1 BACKGROUND

Benin's MOH is the primary authority with responsibility and control over all aspects of drug supply. Regulatory groupings and bodies include the following:

- *Direction Nationale de Santé Publique* (DNSP) - sets public health policy and priorities writ large.
- *Direction des Pharmacies et du Médicament* (DPMED) - responsible for all aspects of pharmaceutical regulation, including product registration, testing, and pricing policy. Within DPMED, several key units play important roles in the management of the system of pharmaceutical supply:
    - *Service d'Enregistrement, de Statistiques et de Contrôle de la Qualité* (SESCQ) – division responsible for most regulatory activities of DPMED.
    - *Laboratoire National de Contrôle de la Qualité* (LNCQ) – a national testing lab that carries out the chemical analysis of medications prior to their entry on the public market, as part of the application for market authorization process (*Autorisation de Mise sur le Marché*, or AMM).
    - *Commission Technique des Médicaments* (CTM) – a national review body that reviews the product registration dossiers that pharmaceutical manufacturers submit in application for market authorization (AMM).

Acquisition and distribution of central (public) medical supplies is delegated to CAME, as described in Section 5.3.

5.2 COMMERCIAL SECTOR

Local Manufacturing and Importing
Little significant pharmaceutical manufacturing capacity exists in Benin today, other than informal production of traditional medicinal substances used in the (entirely nonregulated) traditional health care sub economy. Three domestic manufacturers (as cited in the 2012 Evaluation of the Health System of Benin) are Pharmaquick, which produces approximately 72 generic antibiotics and other essential medications in pill form; Bio-Benin, which produces infusion solutes; and *Société des Pansements du Benin,* or SOPAB, which produces wound dressings for domestic consumption and for export.

Thus, virtually all modern FP, MCH, and antimalarial (and other specialty) pharmaceutical products are imported into Benin from other countries. As such, the efficient development of a robust health sector—both private and public—is heavily dependent on effective acquisition and distribution of imported medications and medical consumables and equipment.

Retail Pharmacies
Every retail pharmacy is operated by a single, licensed professional pharmacist who has anywhere from 1 to more than 12 supporting staff. Retail pharmacies are required to carry all of the medicines on the central Essential Drugs List (EDL). Pharmacies located in urban areas tended to be well stocked, and if they experience a stock out, reported that the product would be delivered within 1–2 weeks. Urban pharmacies varied in size and quality from small, store front run by 1–2 staff to supermarket type facilities with computerized cataloging systems.

Facility-based Dispensaries (private)
Many private clinics—both in the private for-profit and private not-for-profit sectors—operate dispensaries on their premises. Depending on the services offered, these facilities provide a broad range of medications, or a specialized subset of the medications authorized on the EDL. Choice of what commodities to stock appears to be determined by the provider/owner or by management of the specific facility. They also appear to be free to choose which wholesale supplier(s) they rely on for their stocks.

Semi-wholesalers and Market Sellers
In distributing its Laafia line of family health products, PSI/ABMS reports working with a network of "semi-wholesale" distributors and a large number of small drug-seller outlets, which are mostly located in the country's many street-market districts. Semi-wholesalers distribute bulk-packaged commodities (most notably a variety of brands of socially marketed male condoms and, to a lesser degree, oral contraceptive pills) to smaller retail establishments. Packaging of condoms in boxes containing one- and two-dozen groupings of product are most common. These semi-wholesalers also sell directly to individual consumers who prefer to purchase in bulk. Team members observed semi-wholesale points adhered strictly to the recommended street price as suggested by PSI/ABMS; no variation from the recommended price points was observed in field visits.

To date, the private sector role in health care provision has been underemphasized in Benin, with most of the focus in international and local reform efforts focusing on public sector facilities and institutions. Recent developments, however, such as the national *Strategie de Croissance et de la Réduction de la Pauvreté* with its focus on opening up markets and the president's efforts to convene a round table on private sector engagement, are hopeful signs that indicate a change in direction to refocus energies on the role of the private sector in health care provision.

5.3 SUBSIDIZED SECTOR

Public Sector Supplies Procurement and Management
Currently in Benin, the central acquisition, warehousing, and distribution of central governmental medical supplies and consumables is carried out (on behalf of the government) by the private not-for-profit agency CAME. USAID financed and managed the restructuring of CAME into a private nonprofit, membership-based organization in 2010, as noted below. CAME is responsible for a wide variety of functions relating to the supply of pharmaceuticals and medical consumables, including the following:

- Operating the central medical stores
- Issuing tenders for state procurements of pharmaceutical commodities
- Managing warehousing and distribution points across the country for the central medical supplies
- Conducting quality assurance activities related to the central stocks warehouse

- Issuing tenders for evaluation of public sector distribution
- Providing services to participating medical distribution points, including public sector health facilities and selected nonprofit facilities that have applied for (and received) membership in CAME.

From its founding in the early 1990s, CAME operated as a public sector organization. In 2010, CAME went through a formal restructuring and became an independent not-for-profit association, controlled by an independent board (COGES) and operating in partnership with the MOH. As such, CAME itself formally belongs to the private (nonprofit) sector, although it is still widely regarded as essentially a public sector organization since it fills a public sector function. The 2010 restructuring provided greater financial autonomy for CAME, among other benefits, and allows the organization greater operational flexibility and better ability to engage in substantial cost recovery in fulfilling its mission.

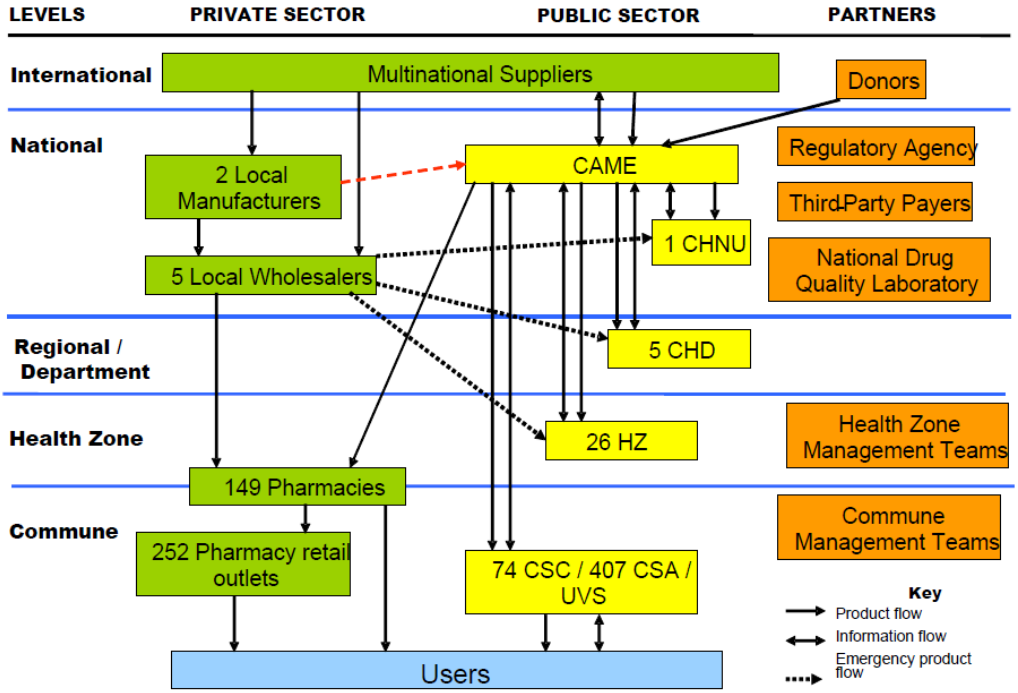
CAME focuses on the acquisition and distribution of generics and also serves as the central product management mechanism for pharmaceutical donations from international donor agencies such as USAID and UNFPA. More than 98 percent of CAME's business, however, is the procurement and distribution of the central medical supplies for the MOH, making it *de facto* a single-client agency serving the needs of the MOH. (Note: Private sector pharmacies are largely supplied by a number of pharmaceutical wholesalers, described below, although they receive some supplies for generic medications via CAME as well.)

Facility-based Dispensaries (public)
Each major public sector health facility operates a dispensary, where basic medications are available to clients and to the public. These dispensaries are stocked exclusively by CAME according to the prescribed monthly quantities of EDL medications, as planned and authorized by the MOH.

5.4 DISTRIBUTION

Centrale d'Achat des Médicaments Essentiels et Consommables
CAME operates three key facilities for distribution of pharmaceuticals: a headquarters facility located in Cotonou and two regional depots. Figure 13 illustrates the distribution system.

Figure 13: Benin's Pharmaceutical Distribution System*



Source: Benin 2006 HSA

CAME distributes generic (and public sector-donated) medications to both public and private sector actors. The major private wholesalers in Benin are *Groupement d'Achat des Pharmaciens d'Officine du Bénin* (GAPOB), *Union Béninoise des Pharmaciens du Bénin* (UBEPHAR), *Groupement Béninois des Pharmaciens* (GB-PHARM), MEDIPHARM, COPHARBIOTEC, and PROMO-PHARMA, who in turn distribute to private pharmacies, public hospitals and clinics, and private clinics/dispensaries.

Central Warehouse/Regional Hubs
The CAME headquarters and central warehouse is found on the premises of the MOH in Cotonou. CAME also stocks and operates two other major regional warehouses in Parakou and Natitingou (North) and Parakou (Central).

Private Sector Wholesale Distributors
Private pharmacies source the majority of their specialty products from a number of wholesale distribution outlets in Benin. They also are able to purchase generic medications from CAME. In all, four private wholesalers operate in the country today: GAPOB (see Box 2), UBEPHAR, GB-PHARM, and MEDIPHARM.

Box 2: Groupement d'Achat des Pharmacie d'Officine du Benin

GAPOB is a private company serving as wholesaler for a very large subset of Benin's pharmacists and pharmacies. More than 180 pharmacists are shareholders in the organization, which represents nearly 76 percent of all pharmacies registered in Benin. GAPOB offers joint/pooled procurement services for members of key pharmaceutical products and supports warehousing and distribution of those products across Benin.

GAPOB operates on the *'societe anonyme'* model, in which participation is determined in accordance with each member's capital contribution levels, and the organization utilizes a common base of pooled capital to finance its product procurement operations. It currently manages a revolving capital pool in excess of CFR13 billion. Minimum capital contribution is CFR 50 million per member. Contributions to the capital pool are opened every two years to incoming members.

On behalf of its members, and in regular consultation with them, GAPOB takes care of product identification, forecasting and ordering, import, customs clearance, central warehousing, and distribution of hundreds of 'specialty' medicines that are marketed by Benin's retail outlets. By law, GAPOB (and other wholesalers in Benin) must stock 90 percent of all medicines listed on the EDL and must maintain a three-month supply of each product, at a minimum, at all times.

5.5 PRICING AND STOCK AVAILABILITY

For purposes of this study, a survey was conducted of stocks on hand for several essential contraceptive and MCH products. The products examined in the team's visits to dispensaries, pharmacies, and wholesale outlets include the following:

FP Commodities:
Condoms (male and female), OC pills (COCs and Progestin only varieties), EC, injectables, implants, IUDs, contraceptive cycle beads.

MCH Commodities
Anti-malarial bednets and oral rehydration salts/zinc supplements.

Availability of Commodities
Following the restructuring of CAME and the opening of two regional CAME distribution hubs, the general availability of basic medicines and essential medical consumables is reported to have improved substantially. Occasional stock outages still occur, particularly in the rural areas, but they were recognized by most study respondents to be less frequent now than in the past.

General Stock Management Trends
Regarding FP, MCH, and malaria commodities examined in the course of this study, several trends were mentioned by respondents:

1. While stock outs still occur regularly, the general stock-out situation has significantly improved (i.e., decline in frequency and duration) since the restructuring of CAME.

2. Regarding FP products in particular, most provider dispensary managers interviewed noted a marked decrease in supply disruptions since the launch of the PSI umbrella brand of "Laafia" products.
3. Bednet stock outs have also declined, but supply usually comes in unpredictable lots of one particular product size only (i.e., one-place, two-place, or three-place bednets). Most of the pharmacies visited had only one given size of bednet in stock at the time of this team's site visits/interviews.

Planned Margins Spanning the Supply Chain

Price-to-consumer levels for every product on the EDL are set in advance by a special pricing commission convened each year by the MOH. In principle, there are set margin rates for each stage of the pharmaceutical procurement and distribution value chain. A rough outline follows:

- CAME routinely adds a 20-percent margin to its purchase price for commodities procured under a general tender.
- Retailers generally multiply by 1.5 the transfer price they pay to CAME to determine the retail price. Within that 50-percent margin both operating costs and various tax obligations must be covered.
- No official text sets a specific margin rate to be added by regional depots onto the product's base transfer price.
- Private wholesalers must adhere to a centrally predetermined maximum transfer price for each product they import and distribute. This price is determined by a working group (consisting of MOH, Ministry of Commerce, and Ministry of Finance representatives) that meets on average once annually. These transfer prices are not regularly adjusted for currency fluctuation, or fluctuation of other major cost factors such as cost of transport/fuel. Theoretically, they should observe at minimum a 36-percent margin to accommodate all costs of goods sold plus import tariffs, but in practice, given the infrequency of adjustment in the centrally set pricing structure, there is no guaranteed minimum margin for private wholesale actors on the specialty products they import.
- Private wholesalers also acquire a certain portion of their commodities direct from CAME and pass them along to certain customer groups. Presumably they must add some margin on moving these products themselves, most likely resulting in a "double bite" of combined profit margins to customers.
- Retail pharmacy owners/managers report that their margins on sales of medications are generally around 30 percent.
- Private and semi-private clinics seem, in practice, to set and apply an established "margin" facility by facility. According to the 2012 Health Systems 20/20 assessment, this rate is determined in consultation with the local health zone officials.

In theory, margins for product markup are set and do not vary—again, policy driven by equity concerns—but in practice, the price to consumer for ***certain*** FP commodities varies significantly, as the team observed during this study. The most noticeable variation exists among the private for-profit and not-for-profit clinic/facility dispensary prices; this variation can be ascribed almost entirely **to divergent sets of costs for service provision** for long-acting contraception methods. The following sections provide details about how pricing and stock issues play out in today's market, broken down by the type of sales/distribution point.

Overall Findings on Pharmaceutical Commodity Pricing Trends

In a *pharmacy context*, by and large, commodity prices were at or close to the government-mandated retail price. Bednets showed the widest variation, both in terms of availability and in terms of price; stock outs were cited most frequently in association with bednets. Several

pharmacists stated that the prior pattern of frequent stock outs on FP commodities has been substantially improved following the introduction of the PSI-managed Laafia brand.

In the *clinic context*, the largest variation in product prices (including service provision costs) was found for contraceptive implants, injectables, and IUDs. Small degrees of price variation were evident among clinics in cost of male condoms and oral contraceptive pills (both COCs and Progestin-only). No price variation whatsoever was found for oral rehydration salts (50-percent markup margin) or cycle beads (consistent 500-percent markup margin). Bednets were not sold or available in any of the clinics surveyed, and neither were female condoms, which are reportedly not available at all in the entire country. Presumably, female condoms are not on the EDL, or are not ordered due to a lack of demand.

Further details on pricing and stock availability trends, outlined and grouped by type of distribution point, follow.

Private Pharmacies and Community Pharmacies
Pricing: During the in-country assessment, the team found essentially no variations from the recommended retail price for any commodity studied. Guidelines on FP product margins were observed to the letter at retail establishments in almost every instance examined. As noted above, bednet prices varied slightly, although still not very significantly.

Pharmacy owners and stock managers seemed satisfied with the margin rates they are able to realize on the sale of pharmaceutical products. One manager of a major Cotonou pharmacy noted that he applies a 30-percent markup on medicinal products, which is a distinctly higher margin than his usual 20 to 25 percent on other consumer products.

Stock Issues: Stock levels for the studied commodities seemed to be fairly regular at private commercial pharmacies. The variety and quantities of available stock for all products was visibly greater for private pharmacies in comparison with clinic-based facilities. This could be caused by any number of possible factors, including better stock management practices at the pharmacies, the scope/focus of clinic operations with a related focus in commodities kept on hand, or focused demand/purchase volumes (and hence more rapid decline of stock on hand) evidenced at the clinic dispensaries. Information and stock management was generally manual in the smaller pharmacies but was computerized in the majority of larger and mid-sized pharmacies.

Both pharmacists and private clinic owners/managers, however, still saw involuntary stock outs (i.e., those that are due to stock deficits at the wholesale level) as being a major barrier to their organizational success and growth, since stock outs have a strong effect on client trust levels, and resolution of such stock outs is entirely exogenous to the practices of the retail establishment itself. Most of those interviewed commented that the rate of involuntary stock outs has improved significantly for FP products following the introduction of the Laafia brand and that while CAME stock outs have not disappeared entirely, their rate has improved noticeably since the 2010 reorganization.

Public and Publicly Contracted Health Facility Dispensaries
Pricing: By and large the recommended commodity price points, as specified by the MOH, were observed in these dispensaries.

Stock Issues: As mentioned above, widespread stock outages were reported for a variety of products, including essential FP, child health, and malaria prevention products, at both public

health care facility dispensaries and, to a lesser degree, at private confessional facilities that serve as contractors in providing public access health care services. Dispensary managers did not seem able to predict or explain the cause or periodicity of their stock outs. No evidence of understanding of (or responsibility for) cost center dynamics or cost recovery considerations was evident in the team's conversations with dispensary managers. Information systems and stock tracking mechanisms were maintained manually.

The assessment team visited three such facilities, stocked exclusively via CAME, during the course of its October site visits in Benin—two private confessional hospitals and one public maternity clinic—located respectively in Cotonou, Porto Novo, and Ganvie. Various levels of stock outages, depending on the location of the facility, were observed for the products in question, as shown in Table 8.

Table 8: Availability of Key Commodities

	Cotonou (faith-based)	Porto Novo (faith-based)	Ganvie (public)
Oral contraceptive pills	In stock	Do not carry	Out of stock – 4+ mos
Injectables	In stock	Do not carry	Out of stock – 4+ mos
Implants	In stock	Do not carry	Do not carry
IUDs	In stock	Do not carry	Do not carry
Condoms	Out of stock, recently	Do not carry	Out of stock – 4+ mos
Contraceptive cycle beads	In stock	Do not carry	Out of stock – 4+ mos
ORS/Zinc	In stock	Out of stock	In Stock
Bednets	In stock	Out of stock	Out of stock – 4+ mos

It is clear that, despite some recent improvements in supply chain practices, challenges still exist in regard to ensuring a regular supply to pharmaceutical dispensary points in locations outside of the main metropolitan center of Cotonou.

Moreover, given that net revenues arising from pharmaceutical sales is often a key portion of the operating funds of major public institutions, a regular and predictable flow of medications and commodities is critical to the efficient functioning of these institutions. Given the rapid decline of the margin of receipts over expenses (as documented in the World Bank study of trends from 2007 to 2010 (Health Systems 20/20 2012 HSA, p.104), an adjustment in the centrally mandated price-to-consumer levels seems long overdue. Further, an improvement in the commodity and supply chain management in these facilities will be mandatory to their fiscal sustainability moving forward. Leveraging the knowhow and capabilities of private sector actors in support of these public and quasi-public facilities can make an important difference in years to

come.

Private Clinic Dispensaries (for-profit and not-for profit)
Pricing: The largest variations from MOH recommended prices were found in this category of dispensary. Price-to-consumer level varied from 1.5 times the transfer price (for products acquired from CAME) to 100 times the transfer price. Similar to the findings of the 2012 Health Sector Assessment conducted by Health Systems 20/20 (p.106), each dispensary seems to set a basic multiplier rate and sticks to that percentage in setting its own price-to-consumer level(s). The largest variation seemed to be in pricing for contraceptive implants, injectables, and IUDs.

Certain NGOs (most notably the IPPF affiliate, ABPF) also apply a needs-based sliding scale to their FP clientele. In cases of extreme financial need, ABPF makes FP products available free of charge to the consumers most in need.

In the case of private nonprofit clinics, owners and managers were generally well aware of both the price-to-consumer level and the approximate monthly sales levels on each type of product. In private for-profit clinics, owner/managers and dispensary managers seemed keenly aware of cost recovery and other commercial principles in their explanations of the dispensary's functioning. Given that this group of providers seems to have the greatest flexibility in setting their actual price-to-consumer levels, it is not surprising that this group also has the strongest success record on financial viability from among the various groupings of provider types.

Stock Issues: By and large, in private clinics—both private for-profit and private not-for-profit—the issue of stock outs seemed less acutely problematic. Staff seemed either better able to manage and predict stock flows, or better at finding alternate sources of supply if stock was running low. Information and stock management is conducted manually in smaller clinics, but is frequently computerized in larger and mid-sized private clinics. Stock outs due to poor projections at the retail level did not seem to present a significant risk level to this category of providers.

5.6 ANALYSIS OF PRICING VARIATIONS AND SALES ESTIMATES FOR FAMILY PLANNING PRODUCTS

The assessment team visited more than 20 pharmacies and clinics in order to gauge price fluctuation and availability of FP products, both long-acting reversible methods (LARMs) and short-term contraceptive products. Despite the small sample size, some clear trends in pricing and product availability emerged from the data.

LARM Products
The largest variation in contraceptive prices was found among LARMs examined, specifically IUDs, implants, and injectables. Most of this variability can be attributed to a range of price bands related to provider services. ProFam clinics (who collaborate in the PSI provider network) have set agreed service provision fees by provider type, and these fees are reflected in the cost-to-consumer fees reported: ProFam clinic midwives charge 2000 CFA for IUD or implant insertions, ProFam clinic doctors charge 5000 CFA for the same insertion services. Although it is not part of a formal pricing structure agreement, well-known clinics run by specialist physicians (OB/GYNs) can choose to charge 10000 CFA for the same services.

For injectable contraceptives, the service fees charged by providers generally range from 1000 to 2000 CFA. This price structure is clearly demonstrated in the survey results and makes up the bulk of the cost to consumers in the case of all long-acting reversible contraceptive methods. A summary of the prices and usage data collected relative to these methods follows.

IUDs (TCu380A)

Clinic Context. IUDs are only available to clients in the clinical context. They are not available for purchase in private pharmacies. Consumer behavior showed very high price elasticity and a greater than anticipated spread in choice of provider, perhaps due to perceptions related to service quality or other factors. The following price and volume variations were observed:

- The reported unit cost at a wholesale level for an IUD is 100 CFA.
- Cost to consumer varied (including insertion service fees) from 1,000 to 10,000 CFA.
- Two clinics with the highest estimated monthly volume (20 units per month each) were observed: one clinic offering services at a median price point (2,000 CFA) and one clinic offering services at an upper end price point (10,000 CFA).
- The next highest monthly volume (12 units per month) was observed at the clinic with the lowest price point (1,000 CFA).
- Estimated monthly volume and percentage breakout by price among the selected clinics shows the following:

Est. Total Monthly Quantity	Percentage	Provider Type	Price
12	14.5	Low-cost clinic	1,000 CFA
39	46.5	Midwives	2,000 CFA
10	11.9	Midwives+product	2,500 CFA
3	3.6	Doctor	5,000 CFA
20	23.8	OB/GYN	10,000 CFA

Implants

Clinic Context. Implants are only available to clients in the clinical context. They are not available for purchase in private pharmacies.

- Reported unit cost at the wholesale level is 50 CFA.
- Jadelle appears to be the only registered brand of implant.
- The pricing structure for cost to consumer for implants (commodity plus service) is identical to that reported for IUDs, however, estimated monthly volumes are much differently distributed.
- The highest single reported monthly volume (30 implant insertions) was reported by one of the median-priced clinics (2000 CFA). No other clinic reported more than eight monthly implant insertions.
- As much as 76.3 percent are at or below the median price point, 23.7 percent are above the median price point.
- Estimated monthly volume/percentage breakout (by price point) among the selected clinics shows the following:

Est. Total Monthly Quantity	Percentage	Provider Type	Price
8	13.6	Low-cost clinic	1,000 CFA
37	62.7	Midwives	2,000 CFA
6	10.2	Midwives+product	2,500 CFA
5	8.5	Doctor	5,000 CFA
3	5.1	OB/GYN	10,000 CFA

Injectables

Pharmacy Context. Ampules of injectable contraceptives are commercially available in pharmacies. They are available in individual ampules and in a bulk package. The pharmacy staff, however, is not authorized to administer the injections. Consumers (and presumably providers for the bulk units) can purchase their commodity in the pharmacy and take it to an authorized service provision point for use.

- There is no variation in price point or margin.
- Most commercial pharmacies have experienced small sales volumes on both products.

Clinic Context. In this context, the consumer price variation was very low overall. In addition, clinics offered the largest choice in brands of injectables (Laafia, Noristerat, Cyclofene, and Depo Provera were all reported as available brands among the reporting clinics), and clients showed the strongest sensitivity to price.

- The reported unit cost at the wholesale level is 100 CFA (for Laafia); other products' wholesale cost is 350 CFA.
- Price variation was very low overall, in comparison with other LARMs. The price to consumer showed variation from 825 CFA to 2,000 CFA.
- Price sensitivity was much more evident among consumers.
- A larger choice in brands was also evident (Laafia, Noristerat, Cyclofene, and Depo Provera were all reported as available brands among the reporting clinics).
- Extrapolated monthly volumes showed that the vast majority of consumer use (fully 98.7 percent of injectable acceptors) demonstrate strong price sensitivity and obtained their services at facilities offering the lowest three price points.
- The two highest volume clinics surveyed (48 and 44 estimated monthly insertions) offered consumer price points of 1,100 CFA and 1,000 CFA respectively.
- Only 1.3 percent of injectable sales were above the median price, at 1,500 CFA, and no reported clients (in this sample) opted for specialist-level providers of their injectable contraceptive.

Details on estimated total monthly quality, percentage, and price by provider type can be found in the table below:

Est. Total Monthly Quantity	Percentage	Provider Type	Price
25	16.1%	Low-cost clinic	825 CFA

80	51.6%	Midwives	1,000 CFA
48	31%	Midwives+product	1,100 CFA
2	1.3%	Doctor	1,500 CFA
0	0	OB/GYN	2,000 CFA

Short-term FP Products
Short-term FP products include oral contraceptive pills and condoms. Below is a summary of the prices and availability of these methods.

Oral Contraceptives.

Pharmacy Context. Pharmacies have a different product range for OCs than what is offered in clinical dispensaries, and they offer a wider choice of brands and largely higher price points. Available brands include Adepal, Microval, Stediril, Minidril, Vikella, Norlevo, and Laafia.

Clinic Context.

- Reported unit cost at wholesale level is 250 CFA for three cycle packs.
- Median price point to consumer is 150 CFA per cycle pack, regardless of the volume purchased.
- Little variation was observed in the sample group; only one pharmacy sold under the median price point (at 100 CFA per cycle pack when purchased in package of three packs), and two pharmacies sold at a slightly higher price point (at 200 per cycle pack).
- No price variation by brand, or between product type (COC or Progestin-only), was observed at any of the clinics.
- A total of only six brands was found in the clinic sample group: Laafia, Microgynon, Microlut, Ovrette, Exluton, and LoFemenal.

Condoms

Pharmacy Context. Pharmacies have a much wider variety of brands available, and a wider range of price points per unit and packaging options, than do the clinics. The average unit cost is 25 CFA, and the top observed unit cost is 200 CFA per condom. Volume packaging was available at some pharmacies, with a maximum size of 12-unit packs.

Clinic Context. In clinics, price variation was only observed among brands:

- Both the “Prudence” brand and unbranded condoms consistently sell at an effective price of 25 CFA per unit, and “Kool” brand is very consistently marketed at an effective price of 50 CFA per unit.
- No variation across clinics was observed relative to the consumer price point for any particular brand.

- Female condoms are entirely absent from the market.

Informal Market, Semi-wholesaler Context. Identical pricing structure was found for small quantity packaging of male condoms, including both Kool and Prudence. Volume purchase packaging (six or more boxes of 12 condoms) allowed for a slight cost discount.

FINDINGS FOR THE PHARMACEUTICAL SECTOR

- **Challenges still exist in ensuring a regular supply to pharmaceutical dispensary points in locations outside of the main metropolitan center of Cotonou.** Following the restructuring of CAME and the opening of two regional CAME distribution hubs, the general availability of basic medicines and essential medical consumables is reported to have improved substantially. Occasional stock outages still occur, particularly in the rural areas, but they were recognized by most respondents to be less frequent now than in the past.
- **Professional stove piping acts as a barrier to collaboration between pharmacists and other providers.** The strict segregation of 'professional identities' between pharmacists and the other professions (e.g., service providers) hinders the opportunity for creative engagement across these professional boundaries. Collaboration of pharmacies and clinics—in prioritization of needs for change in the Essential Medicines List (EML), for example—can help bring about an expansion of private sector-led growth in effective and coordinated health care delivery.
- **There is an unbalanced pharmaceutical human resources spectrum and a lack of professional cadre preparation.** Pharmacist training is soundly established in Benin and curriculum reform is not a major issue leading to an abundance of trained pharmacists available on the Beninese labor market. There are, however, shortages of key specialized skills in the labor market. The most acute shortage of personnel relative to effective management of pharmaceutical supplies is the deficit of appropriately trained supply chain managers. No formal training exists for supply chain management in Benin (Health Systems 20/20 assessment).
- **There is an incomplete comprehension of the value of market segmentation among public officials.**

RECOMMENDATIONS FOR THE PHARMACEUTICAL SECTOR

The assessment team recommends the following changes in policy issues related to product costs, improved service delivery and broadened consumer choice:

- **Increase quantity and variety of contraceptive products available on the market in general, and decrease financial barriers** to greater consumer choice and contraceptive access.
- **Reconsider 'tranched' service delivery costs by provider type**, especially in cases where provider types do not significantly affect product efficacy (such as IUD insertion, implant insertion, and injectable contraceptive administration). Consider instead a pricing structure that reflects cost of goods sold and net value delivered to customer, regardless of provider type.
- **Increase market segmentation, particularly for high demand contraceptive products.** To do this, the pharmaceutical sector could **develop "second tier" products**

in markets where additional consumer choice might be desired by middle-income and upper income citizens.

- **Open channels for provider/pharmacist collaboration to better provide consumer access to pharmaceuticals in remote areas of the country.** By teaming pharmacy and service delivery expertise, and still allowing each stakeholder to do what it does best, the quality and quantity of services offered can be increased while decreasing the overall business risk levels faced by each partner individually.
- **Broaden recommended consumer price points to a wider 'allowable price band' structure**, to allow for the differing cost structures of various facilities along the supply chain, the evolving exigencies of pharmaceutical product procurement cycles, and to help promote progress toward more effective market segmentation.

Supply chain and business enabling environment issues:

- **Evaluate current government-set pharmaceutical margins and their effect on private wholesalers** to ensure that wholesalers are not inadvertently 'squeezed' by changing fixed costs and exchange rate fluctuations.
- **Simplify and harmonize pharmaceutical flow through the supply chain**, eliminating unnecessary addition of middleman activity (and associated marginal cost increases) prior to consumer purchase.
- **Improve access to short-term financing** for private wholesalers and consumer sales points.
- **Design and implement targeted vocational training for supply chain management labor force**. Build international partnership programs to support an in-kind contribution of knowhow on this process from international counterpart organizations.

6. ACCESS TO FINANCE

6.1 BACKGROUND

Access to finance and business management skills is an important aspect of private health sector development in Benin. The October 2012 assessment team administered a survey to providers at more than 40 clinics in Cotonou, Calavi, Porto Novo, Ouidah, and Allada. The results showed that 95 percent of providers have strong interest in obtaining financing and 100 percent are interested in receiving business management training and strengthening their business capacity. Although financing needs are evident, they are not matched by the current supply of credit nor business management training available in the country, most of which does not currently target the private health sector.

As mentioned in Section 4 of this report, Benin has 750 registered and authorized private health practices and many more informal health providers that may or may not be professionally qualified to offer health services. The majority of private providers operating formally are located in the southern part of the country, in particular in the Cotonou and Porto Novo areas, with fewer providers in the rural areas. The number of informal providers is not known but appears to be significantly larger, and increasing faster, than that of the formal sector. The following sections on access to finance cite analyses from the survey the assessment team administered, with an n-value of 40 practices.

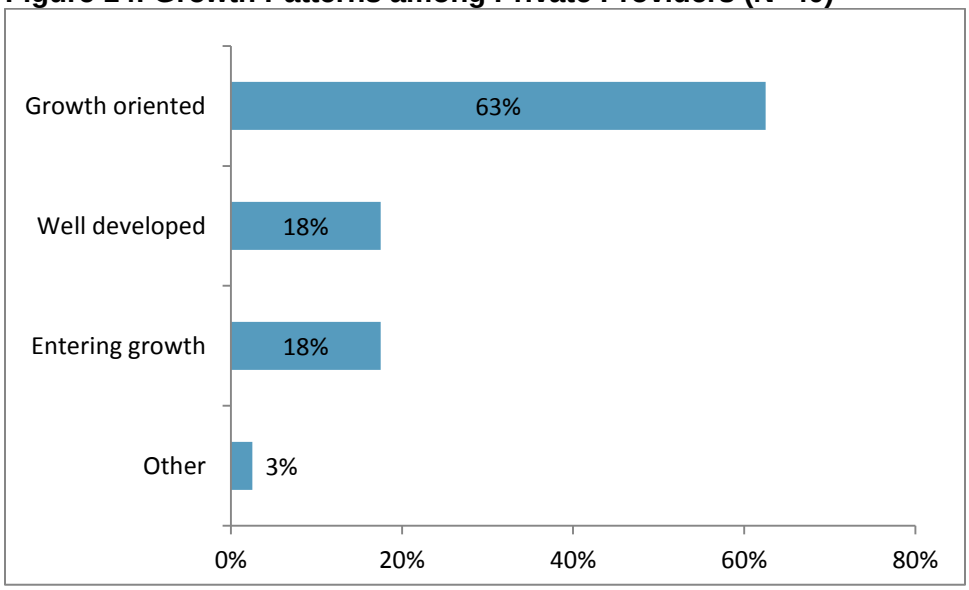
6.2 KEY BUSINESS FEATURES OF PRIVATE PROVIDERS

Overall, the private health sector in Benin can be characterized as an emerging market with many new private businesses entering the market or expanding their operations.

Ownership
The majority of practices (60 percent of the sample) are owned and operated by medical doctors such as general practitioners, dentists, ophthalmologists, surgeons, and gynecologists. A smaller number of practices are run by the midwives (23 percent) and nurses (15 percent), and 3 percent by pharmacists. The current regulation limits the ownership of health facilities to health professionals.

Growth Tendencies of the Private Sector
In general, the private health sector shows positive growth: 63 percent of clinics visited can be classified as “growing,” and 18 percent are well-established, renowned clinics with good capacity to provide services and expand their operations on a continuous basis. Another 18 percent are entering the phase of early growth. Only one facility interviewed (3 percent of the survey sample) can be classified as "fresh start," having lost customers for internal reasons and now struggling to rebuild its clientele. It should be noted that “growth” in the Benin context relates to a practice that is building and/or improving physical infrastructure and obtaining the necessary equipment to provide services. Figure 14 illustrates these growth patterns.

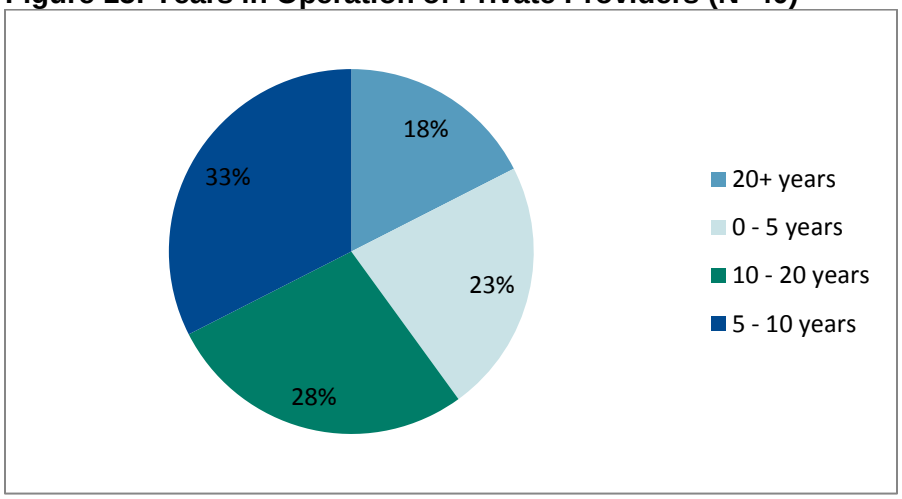
Figure 14: Growth Patterns among Private Providers (N=40)



Years in Operation

More than half of the private providers visited have been in operation for 10 years or less: 23 percent of respondents have been in business between 0 and 5 years, and 33 percent have been in business between 5 and 10 years. Of those surveyed, 28 percent have been operating between 10 and 20 years and 18 percent have more than 20 years in business (see Figure 15).

Figure 15: Years in Operation of Private Providers (N=40)



The assessment team discovered serious delays between the time of opening of a health business and obtaining formal registration and authorization. Among the providers surveyed, the time elapsed until businesses became fully legal and formal is as follows:

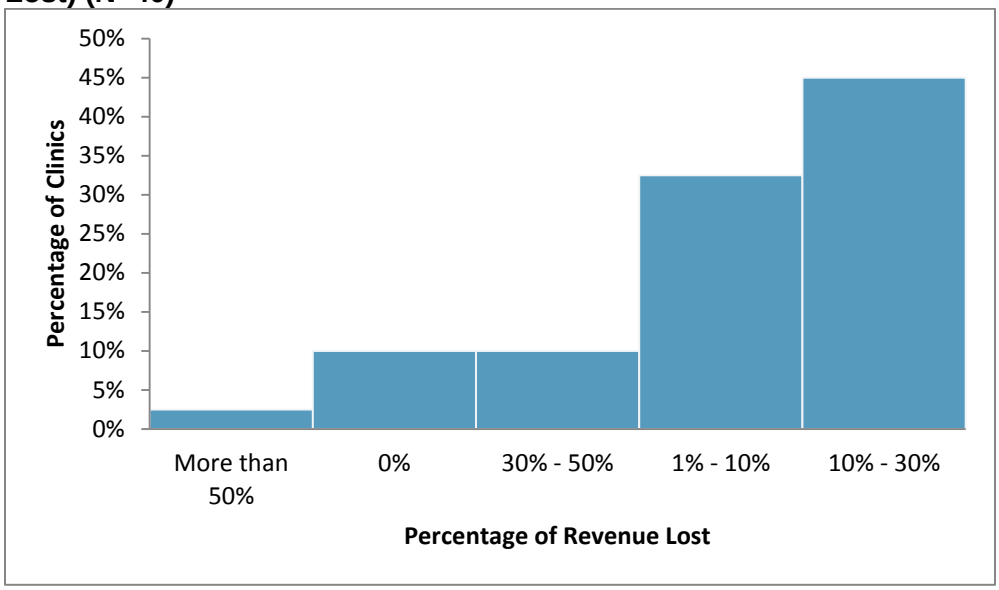
- Between 0 and 5 years: 38 percent
- Between 5 and 10 years: 43 percent
- Between 10 and 20 years: 8 percent
- 20+ years: 13 percent

Older clinics appear to face the largest difficulties in obtaining formal registration, while newer clinics experience a faster process that takes relatively less time but is nevertheless long even by Benin standards of doing business (Doing Business 2013). Because of the lengthy registration process, most clinics obtain permission to operate well after their practice opens.

Payments by Patients

One of the key issues for private providers that affects their financial and operational stability is lack of payments by clients. Figure 16 shows the incidence of nonpayment in terms of revenue lost among the surveyed clinics, which gives some indication of the extent of the problem.

Figure 16: Lack of Payments by Patients of Private Clinic (% of Clinics and % of Revenue Lost) (N=40)



Only 10 percent of the practices visited recorded having no delinquent payments, while 33 percent have a moderate percentage of unpaid bills amounting to between 1 and 10 percent of revenues. Forty-five percent of the sampled clinics recorded unpaid bill rates to be between 10 and 30 percent. The highest delinquency rates of 30 percent and more were found in 13 percent of practices. These high default rates indicate the level of insecurity in which the population lives; widespread poverty deprives a section of the population of the financial means to pay for health services. Private clinics, which are oftentimes more numerous than public, may be the providers of choice or necessity for low-income people, even though these clients may not be able to afford private services. Private providers are not in a financial position to offer free services, at least not on a scale that appears to be currently taking place in Benin.

Insurance Payment Issues

For some health facilities in urban centers, outstanding unpaid bills result from conflicts with insurance companies. Insurance companies commonly do not pay the totality of the invoices presented to them, resulting in clinics absorbing the unreimbursed portions of the bills. On average, insurance companies appear to reimburse 75 to 80 percent of the amount invoiced by clinics, claiming that the bills are either inflated or the services provided were not necessary. The fact that Benin lacks any established methods of calculating costs for services rendered facilitates this cycle of nonpayment between insurance company and provider.

Benin is nearly lacking in professional actuaries, who are essential in calculating appropriate risk-sharing arrangements in order to better estimate costs for services rendered. No insurance companies, nor does the insurance regulation body, employ an actuary certified on an international level. This is a critical issue in view of the introduction of the national health insurance scheme (RAMU), as within this new structure, health insurance will dominate the market. Reimbursement problems are likely to get worse with the growth of the health insurance.
This issue has profound implications for financial stability and profitability of private providers, since any negative effect on the cash flow of businesses may also negatively impact a provider's access to finance.

Sources of Revenue
There are important differences with regard to the sources of revenue for private providers operating in rural versus urban areas. Figures 17 shows that the largest revenue source in rural areas is the sale of drugs (pharmaceuticals, at 38 percent), as patients in these areas generally do not have the means to pay for health care services and resort to obtaining drugs instead, especially generics. In contrast, as shown in Figure 18, urban areas see medical consultation (at 47 percent) as the largest source of revenue.

Figure 17: Sources of Revenue for Private Providers in the Rural Areas (N=40)

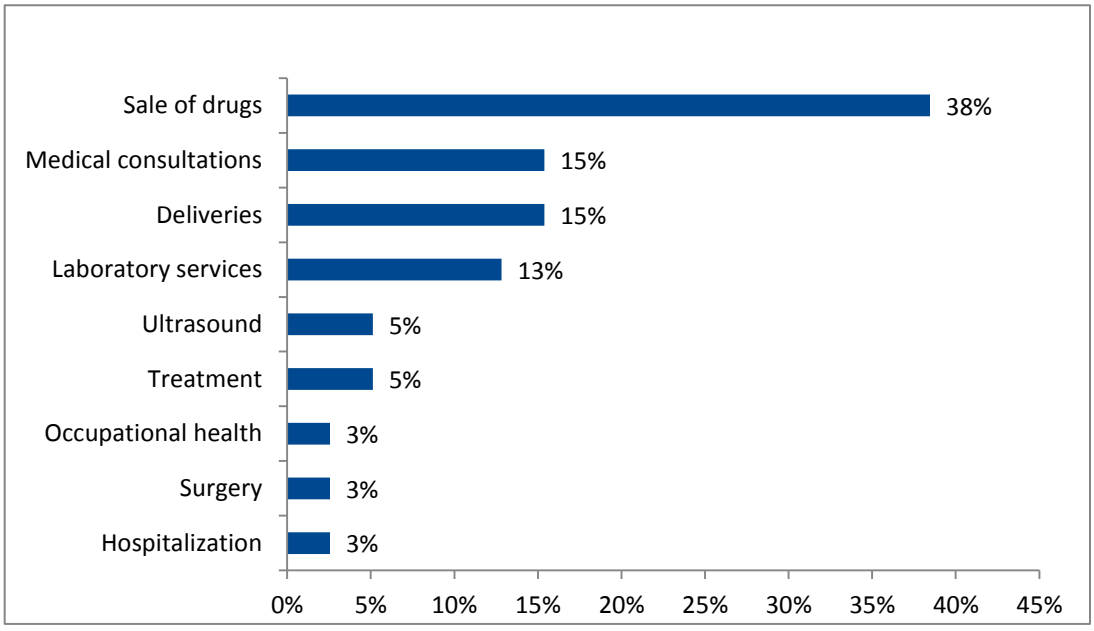
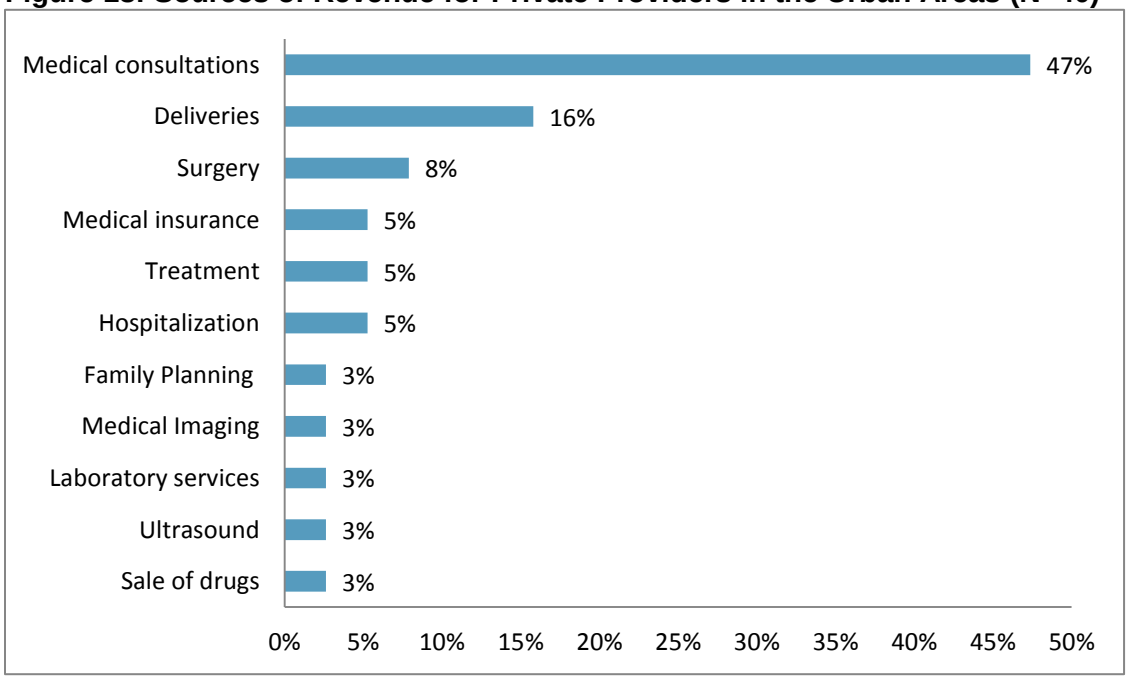


Figure 18: Sources of Revenue for Private Providers in the Urban Areas (N=40)



Generally, in urban centers the sources of revenue are more balanced and diversified across different clinical specialties, with a strong reliance on revenue from medical consultations. Revenue from the sale of drugs accounts for 3 percent of the total proceeds in urban centers. Because urban clinics are also better equipped, they provide surgical services more often than rural clinics, which often lack such facilities or equipment and are limited as to what types of surgeries they can provide.

Rural and urban areas also experience significant differences in the level of pricing for consultations. In rural areas, consultations may cost as little as FCFA 1,000 ($2), whereas similar services in urban areas can run as high as FCFA 5,000–10,000 ($10–$20). This shows that the profitability of clinics can also be strongly affected by physical location.

6.3 BUSINESS SKILLS AND MANAGEMENT CAPACITY OF PRIVATE PROVIDERS

The level of business management competencies among private providers is generally low, as recognized by owners and managers of the facilities, all of whom expressed strong interest in acquiring business skills. Table 9 shows the assessment of business management skills of private providers surveyed by the assessment team in October 2012. The table also displays the stated priorities for learning business competencies and how these priorities relate to the self-assessed level of current business skills.

Table 9: Self-assessed Business Competencies of Private Providers in Benin and Priority Learning Needs (N=40)

Ranking	Business Competencies Current Knowledge	Weak or Less	Average or More	Ranking	Business Competencies Priorities for Learning	Very Important	Less Important
1	Selling	80%	21%	**1**	Selling	61%	40%
2	Access to finance	78%	23%	**2**	Business planning	55%	46%
3	Marketing	75%	25%	**3**	Marketing	51%	51%
4	Business planning	73%	28%	**4**	Financial management	48%	53%
5	Project management	73%	28%	**5**	Project management	45%	55%
6	Financial management	70%	31%	**6**	Leadership	41%	61%
7	Accounting / record-keeping	66%	35%	**7**	Customer service	40%	61%
8	ICT	61%	40%	**8**	Inventory management	38%	63%
9	Leadership	55%	45%	**9**	Access to finance	33%	68%
10	Customer service	51%	50%	**10**	Quality management	33%	68%
11	General management skills	49%	53%	**11**	Accounting / record-keeping	33%	68%
12	Inventory management	48%	53%	**12**	ICT	26%	76%
13	Quality management	46%	56%	**13**	General management skills	15%	86%

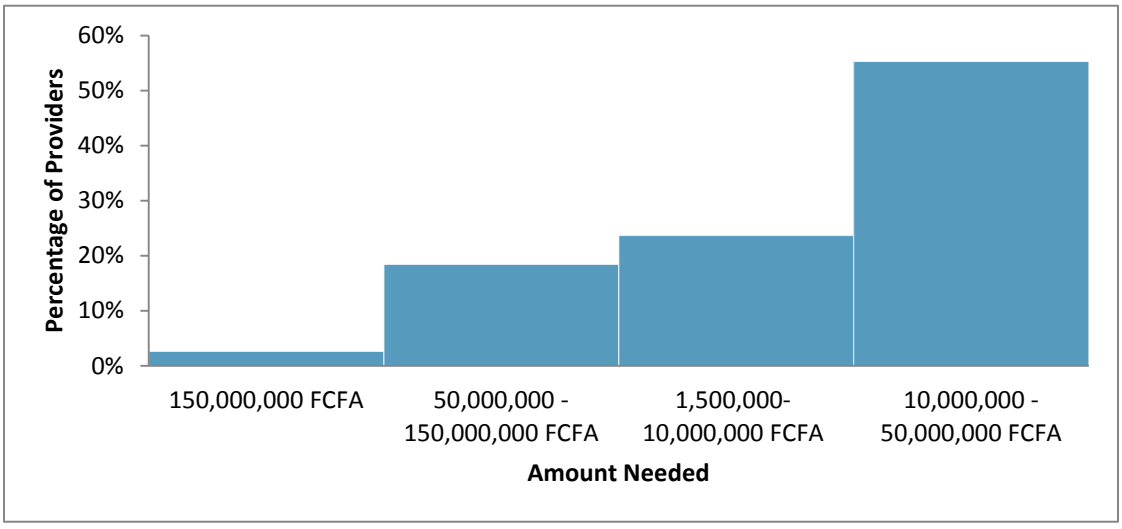
The strongest skills private providers reported having are those related to quality management, with 56 percent of providers reporting they have average and higher levels of competency. Private providers also believe that they have at least average general management (53 percent), customer care (50 percent), and leadership (45 percent) skills. The weakest reported skills are selling[3], access to finance, marketing, business planning, project management, financial management, accounting, and information and communication technologies (ICT), in that order—between 20 and 40 percent of providers reported having average or higher competency in these skills.

In terms of skills that need improvement, the most sought after are selling, business planning, and marketing, followed by financial management, project management, leadership, and customer service—at least 40 percent of survey respondents expressed a willingness to learn these skills. Even though knowledge about securing financing was assessed as low (second to last on the competencies list), only 33 percent of private providers expressed interest in gaining more skills in this area. Similarly, ICT skills, although weak among providers, do not seem to be a priority. The results on the priority list indicate that providers may want to acquire selling and marketing skills in order to bring more clients to their facilities and obtain better financial management and business planning skills to build their business competencies.

6.4 FINANCING NEEDS OF PRIVATE PROVIDERS

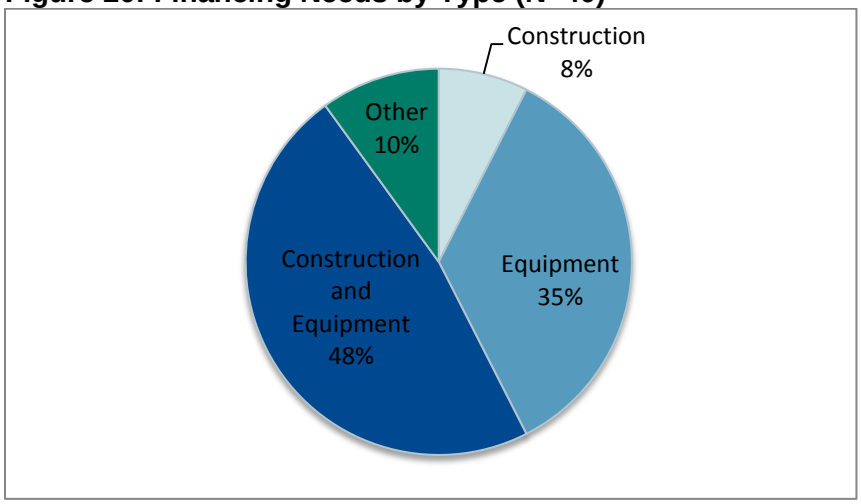
Many private practices the team visited were in the process of improving their facilities, upgrading or expanding the premises, or acquiring new equipment. With limited access to external financing, these practices may not have enough funds to finalize their projects. Most of the expansion and quality improvement projects are financed using a private provider's own funds (retained earnings), although some facilities were able to secure financing from local banks. Figure 19 shows that a majority (55 percent) of clinics interviewed in the survey expressed a need for funding of between FCFA 10 million ($20,000) and FCFA 50 million ($100,000), 24 percent believed their needs to be between FCFA 1.5 million ($3,000) and FCFA 10 million ($20,000), and 18 percent indicated they needed between FCFA 50 million ($100,000) and FCFA 150 million ($300,000). One facility (3 percent of the sample)— Clinique MARINA—expressed a need for FCFA 1 billion ($2 million), as shown in Figure 19.

Figure 19: Financing Amounts Needed by Private Providers (in FCFA) (N=40)



The greatest need for financing (see Figure 20) was for construction and equipment, chosen by nearly 48 percent of respondents, while 35 percent reported needing financing for equipment only, 7 percent for construction only, and 10 percent reported other needs such as purchasing land for the clinic, securing drug supplies, and other working capital.

Figure 20: Financing Needs by Type (N=40)



New enterprises and younger health professionals who want to open a private health practice face severe financial constraints regarding start-up capital. At present, Benin has practically no external financing available for new and early stage private health businesses. Most existing businesses started with financial help from friends and families. In some cases, doctors and nurses worked outside of Benin to gain professional experience and save the start-up capital necessary to open their own private practice within the country. In the 1990s, the government of Benin provided direct financial assistance to a number of health cooperatives to support younger health professionals outside of the public sector. Of the 10 cooperatives created in this period, only three remain and operate successfully to this day, and the government has ceased to provide direct assistance.

6.5 FINANCING CONSTRAINTS

Private providers face a number of constraints to borrowing, with one of the most important being a lack of or weak collateral, which limits borrowing ability and amount. FECECAM, a microfinance institution, for example, lends to private small providers through a network of savings and loan associations, but because providers lack hard collateral, they can typically borrow only up to 5 million CFA (approx. $10,000). Higher amounts require tangible and registered collateral. Collateral constraints are exacerbated by a weak property rights regime; obtaining a clean and valid property title, which could be used as a loan guarantee, takes years, if it can be obtained at all. A related issue is the high cost of registering collateral for bank loans, making borrowing too expensive. Several providers interviewed stated that they decided not to take loans because of the high cost and complicated process of collateral registration.

In addition to the collateral constraint (and the precondition of operating a formal, authorized business), private providers, in general, have weak management skills and lack training in many essential business functions, in particular, record keeping and financial accounting. Of the providers surveyed, 30 percent maintain books and financial records on a permanent basis with a full-time accountant or bookkeeper, and 12 percent have a part-time accountant. Fifty-eight percent of providers have no professional accounting services, and consequently lack reliable financial data, which lenders require. In addition, although a large number of providers would like to expand their businesses, many do not have a strategic plan detailing how to pursue such

growth, often engaging in ad hoc investments without a long-term view for revenue creation. Many facilities the team visited had simultaneous, ongoing construction in various parts of their facilities, most of which was unlikely to be finished in the near term and would not yield revenue.

Those providers who can access funding are somewhat cautious in borrowing funds, either because they are uncomfortable with borrowing or because they are unhappy with the terms and conditions of the banks. Several providers complained about the high interest rates in Benin, citing the 15 percent per annum rate as too high for them to accept. Concerned providers emphasized the absolute levels of interest rates offered by banks, without consideration of the benefits that loan proceeds might bring to a business. In many ways, the providers, who have rarely received any business training, are not ready or prepared to borrow funds and apply them effectively to the expansion of their health facilities.

6.6 DEMAND FOR FINANCING

While the rapid assessment the team conducted does not allow for an in-depth analysis of financing needs of the private health sector, the survey results nevertheless shed light on the amount of financing demanded by the sector (Table 10).

Table 10: Estimated Needs for Financing by Private Health Sector in Benin (in US Dollars) (N=40)

Average Financing Need per Provider	Total Number of Providers	Number of Potential Borrowers (Optimistic Scenario - 60%)	Number of Potential Borrowers (Pessimistic Scenario - 35%)	Financing Needs - Optimistic Scenario	Financing Needs - Pessimistic Scenario	Estimated Financing Needs of the Sector
$20,000	400	240	140	$4,800,000	$2,800,000	$3,800,000
$65,000	275	165	96	$10,725,000	$6,256,250	$8,490,625
$150,000	75	45	26	$4,500,000	$2,625,000	$ 3,562,500
TOTAL	750	450	263	**$21,000,000**	**$12,250,000**	**$16,625,000**

Assuming three groups of borrowers (as suggested by the survey results), with each group borrowing on average a local currency equivalent of $20,000, $65,000, and $150,000, respectively, and taking into account that only 750 facilities are registered and therefore eligible for bank financing, the PSA team estimated the current financing needs to range from $12.2 million to $21.0 million, indicating that current unmet demand is realistically at least $16 million USD (or FCFA 8.3 billion).

6.7 FINANCIAL INSTITUTIONS

Banks Active in the Private Health Sector

The current level of engagement of financial institutions in the private health sector varies among institutions, but in general it is limited both in terms of the types of banks active in the sector and the types of borrowers served by the banks. Some banks, such as EcoBank and Bank of Africa, are either active in the small and medium enterprise (SME) market (EcoBank) or have a large presence in the country (Bank of Africa), and have active portfolios with private

health providers. Other banks provide loans to private providers from time to time but do not make a specific effort to target the private health sector. Not surprisingly, banks tend to serve larger facilities and well-established clinics and hospitals, especially those managed or owned by well-known doctors. All banks to some degree finance pharmacists since risks involved with pharmacies tend to be easier for banks to assess. In addition, three major pharmaceutical wholesalers in Benin often serve as guarantors for loans to pharmacists who have insufficient collateral. High-end, well-established clinics and pharmacists are the two categories that do not generally experience undue credit constraints, although many of the providers who manage or own these practices could improve their business management skills and efficiency.

Within the microfinance segment, the two largest microfinance institutions (FECECAM and PADME) claimed that they have clients in the private health sector (beyond pharmacists) but were unable to provide details as to the number and size of their loans. Lack of portfolio analysis across sectors is characteristic not only of MFIs but banks as well. With the exception of EcoBank, which has a designated staff person assigned to the health sector, no banks were able to provide substantial analysis of their engagement in the heath sector. The inability of banks and MFIs to adequately assess and analyze their levels of lending to the private health sector poses a serious problem for future access to finance work with these institutions.

Finance Gap

Table 11 summarizes the gaps in supply of financing for the private sector, taking into account size of provider, years in operations, location, level of formalization, and type of provider. As this simplified analysis shows, the supply of credit for the sector is limited and only selectively available. The majority of pharmacists and higher end, well-established clinics and hospitals can access bank financing if they desire, while smaller clinics and maternity homes, especially in the peri-urban and rural areas, appear to experience major difficulties accessing finance.

Table 11: Supply of Financing for Private Providers in Benin: Gap Analysis

Characteristics of Providers	Private Health Providers Currently Served by Financial Institutions	Private Health Providers Not Served by Financial Institutions
Size	Larger private facilities, some medium sized and smaller providers	Smaller providers
Years in Business	Older, well established	Early stage and newer providers
Location	Urban areas and to a lesser degree peri-urban areas	Rural peri-urban areas
Formalization	Registered and authorized to operate in the private sector	Informal, including private providers in the process of registration and/or awaiting authorization
Types of Providers	Pharmacists, high end (VIP) clinics, hospitals, larger/stronger members of the ProFam network	Individual medical cabinets, maternity homes,

As far as types of financing available, banks tend to provide loans of short and medium term, although some banks, such as Bank of Africa, have occasionally financed private providers with loans of 10 years duration and more. In the current financial market in Benin, long-term loans are more of an exception than a norm, though EcoBank, one of the more active banks in the private health sector, offers financing for a maximum of five years. For private providers who are in the process of establishing or expanding their businesses, longer term financing is essential.

6.8 POTENTIAL FOR DEVELOPMENT CREDIT AUTHORITY GUARANTEES

USAID has recently engaged with EcoBank to collaborate on a partial credit guarantee to be shared among four sectors, including health. While this is a positive development, it is not likely to address the major financing needs of private providers due to its small size (no more than $2 million in lending) and the restrictive lending terms applied by EcoBank. These terms tend to cater to and attract stronger and more established facilities that would typically have access to financing without the guarantee.

Commercial banks such as Bank of Africa and MFIs such as FECECAM are interested in expanding lending to the private sector. A partial credit guarantee, otherwise known as a Development Credit Authority (DCA), would likely result in additional lending from these two institutions. These guarantees should be of longer duration (10 years and more) to accommodate the investment needs of the emerging health sector.

Total guarantee amount should be close to $7 million, or about 40 percent of the estimated current needs of financing. This percentage would provide a substantial boost to health sector lending while at the same time leave room for other banks to enter the lending market and/or develop new loan products, such as equipment leasing or factoring.

FINDINGS FOR ACCESS TO FINANCE

- **The need for finance is high among private providers in Benin.** Nearly two-thirds of practices are in growth mode, characterized by ongoing construction or expansion, or acquisition of new equipment. A majority of providers expressed a need for between $20,000 and $100,000 in financing. The current unmet demand is realistically at least $16 million USD (or FCFA 8.3 billion).
- **At present, there is practically no external financing available for new and early stage private health businesses.** Most existing businesses started with financial help from friends and families. In some cases, doctors and nurses worked outside of Benin to gain professional experience and save the start-up capital necessary to open their own private practice within the country. Banks tend to loan only to larger facilities and well established clinics and hospitals, especially those managed or owned by well-known doctors. SMEs in the private health sector are rarely considered for loans by banks.
- **A lack of or weak collateral, as well as weak management skills and lack of business training, severely limits borrowing ability for most private providers.** Collateral constraints are exacerbated by a weak property rights regime: obtaining a clean and valid property title, which could be used as a loan guarantee, takes years, if it can be obtained at all. Major wholesalers are unwilling to guarantee loans for small and medium-sized providers. Furthermore, private providers lack important business skills, in particular, record

keeping and financial accounting, and a majority of providers do not track or maintain reliable financial data, which lenders require for loans.

- **Bank and MFI lending in the private health sector is sporadic and limited.** Lending to the health sector happens occasionally, varies by institution, and is usually provided only in the short and medium term, with loans being no more than 5–10 years duration. The inability of banks and MFIs to adequately assess and analyze their levels of lending to the private health sector poses a large problem for future access to finance work with these institutions.
- **There is interest for a DCA guarantee through FECECAM and Bank of Africa.** A guarantee of close to $7 million, or about 40 percent of the estimated current needs of financing, would provide a substantial boost to health sector lending while at the same time leave room for other banks to enter the lending market

RECOMMENDATIONS FOR ACCESS TO FINANCE

Based on the team's rapid assessment, the following recommendations are offered for USAID Benin to consider in accomplishing its goal of strengthening the private health sector in the country:

<u>Access to Finance</u>

1. Use access to finance strategically. Given the early stage of development of the private sector and high demand for financing, access to finance can be used strategically, not only to provide finance to private providers, but also to accomplish at least two very important objectives:
    - Provide an incentive for business formalization as only formal businesses can access bank financing
    - Stimulate a more rational (desired) mix of health providers by carefully channeling funding to types of providers who would advance health outcomes in priority geographic areas of the country.

    To that effect, it is recommended that access to finance interventions be reviewed from the point of view of the overall private health strategy in Benin.

2. Improve access to finance for private providers. This could be done in at least two ways:

    - Provide technical assistance to EcoBank's DCA borrowers receiving funds under the USAID guarantee. This could be structured as pre-borrowing assistance as well as post-borrowing assistance provided on a one-to-one basis to the funded clinics.
    - Develop two additional loan programs using the DCA risk-sharing guarantee to mobilize more local capital for the growing sector.

    It is recommended that two lines of credit be arranged for private providers to address the needs of the sector with the following institutions:

    - Bank of Africa, to provide longer term funding for investments of at least 10-year durations for the amount of at least $5.0–6.0 million USD
    - FECECAM, to provide loans of substantial duration to smaller providers in rural and peri-urban areas for the amount of $1.5–2.0 million USD.

The lines of credit available from these two institutions combined would substantially improve access to financing for the emerging private sector in Benin. It is also recommended that both lines of credit be developed specifically for health and not combined with other sectors.

However, the credit guarantee can be structured on a competitive basis by initially allocating a portion of the funds to each financial institution and leaving some funds for further use by both institutions on a competitive basis.

Business Management Capacity

Expanding business capacity could be supported by strengthening business skills of private providers. Two types of strengthening approaches are recommended:

- Provide business management training that would address the priorities and needs identified through the assessment. The courses could include selling and marketing, financial management, and business planning. In addition, a course on how to start and operate a private medical practice would be very useful for aspiring health care entrepreneurs.
- Provide direct technical assistance to increase the management capacity of private providers, which could include developing strategies and business plans, mentoring and coaching senior managers in good management practices, and facilitating access to finance to support the growth of the facilities.

7. HEALTH INSURANCE

7.1 BACKGROUND

In its vision "Benin Alafia 2025," the government of Benin clearly states its commitment to health: "the country must have a functional, equitable, and accessible health system…." The National Health Development Plan 2009–2018, a policy document to guide health efforts in Benin, includes two subprograms dedicated to the "promotion of health insurance" and "promotion of community-based health insurance." Conscious of existing barriers in terms of accessibility to health care, national government actors and technical and financial partners have, over the past two decades, put in place mechanisms of exemption and subsidy of care in order to ensure that the vision set forth in these various strategic documents can be realized. In 2010, a universal health insurance system (RAMU) became the official government policy for health financing in Benin.

Households finance over 50 percent of total health expenditures, the majority of which goes to drugs and medical supplies. Government is responsible for about one-third, and donors make up the remaining amount of health expenditures. Private health insurance is very limited, covering only 3 percent of the population, and mostly catering to the rich. Although private health insurance covers reproductive health services, family planning is not covered. Most of the *mutuelles* cover the cost of copayments of public sector services. The national regulatory body and the health insurance industry broadly agree that private health insurance is not profitable; this likely is due to a small pool of insured. Similarly, the community health insurance schemes, *mutuelles*, are weak and limited in coverage, offering services to only 5 percent of the population.

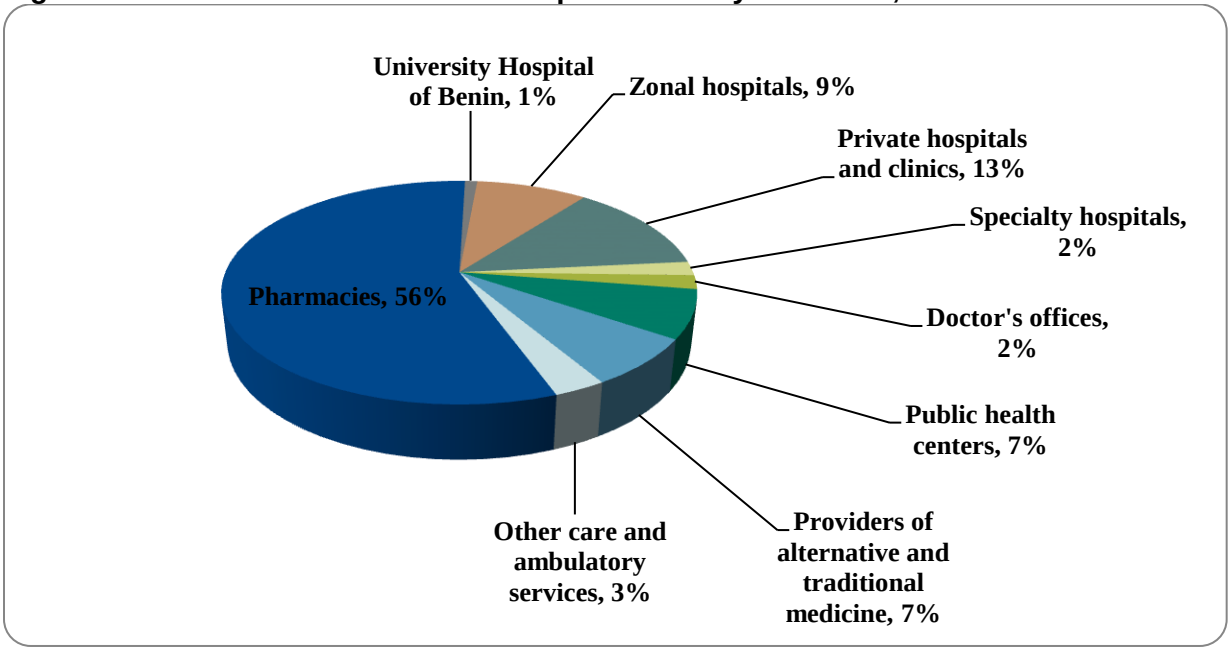
7.1.1 HEALTH EXPENDITURES

The primary source of health system financing in Benin is household funds, which are typically made as direct payments. As noted earlier, 46.8 percent of all health expenditures are made out of pocket, with nearly 93 percent of these payments being made in the private sector. Protection of households against heavy financial burden through a system of risk sharing is also modest but gaining in importance and growing rapidly, most notably across private health insurance, community-based health insurance/*mutuelles de santé*, and the universal health insurance system (RAMU) enacted in 2010.

Pharmacies and other retailers of medicine represent the providers receiving the majority of household resources, around 56 percent, followed by nearly 35 percent for private practices (private hospitals at 13 percent, zonal hospitals at 9 percent, doctor's offices and others at 5 percent, specialized hospitals at 2 percent, and the traditional sector at 7 percent). Figure 21 presents the total breakdown by provider. In sum, the formal private sector mobilizes close to 93 percent of household expenditures (NHA 2008). Traditional medicine, although the first therapeutic resort of the majority of African households, accounts for only 7 percent of household health expenditures.

The high rate of out-of-pocket expenses is partially due to the fact that government health services are fee based; these fees are generally lower than in the private sector, though price differences between facilities in both sectors appears to vary widely. Some of the private clinics visited reported prices up to two times higher than the prices in public health care facilities.

Figure 21: Distribution of Household Expenditures by Providers, 2008



Source: NHA 2008

7.2 TECHNICAL CAPACITY AND MANAGEMENT AT THE NATIONAL LEVEL

Agence National d'Assurance Maladie

Created in May 2012, the ANAM is a public establishment placed under the technical supervision of the MOH. It ensures the implementation of universal health insurance in the Republic of Benin, which is responsible for the following:

- Developing and implementing the practical and efficient plan for application of texts relating to RAMU
- Ensuring the management of RAMU funds
- Driving the deployment process of RAMU
- Providing the technical supervision to ensure the implementation of management tools and the regulation of RAMU
- Providing technical input to providers, organizations of health care/risk management and reimbursement services, consumer associations, and other health sector actors
- Managing the system of information on RAMU
- Organizing and steering medical, pharmaceutical, and other medical supervision.

ANAM was only recently given responsibility for managing the implementation of RAMU, but was assigned this mandate without a clear national plan for executing RAMU and without the necessary

number and quality of staff to implement RAMU. Moreover, the responsibilities assigned include the roles of both insurance regulator and provider—roles that should be separated.

Association of Insurance Companies in Benin

The Association of Insurance Companies in Benin (ASA-Benin) is the umbrella organization of all insurance companies. Created in February 1999, in Cotonou, it is a professional organization made up of the following:

- Six life insurance companies: UBA-Vie; ARGG; COLINA VIE; Avie Assurances; NSIA-Vie Bénin; L'Africaine-Vie
- Five nonlife insurance companies: L'Africaine des Assurances; NSIA-Bénin; GAB; ALLIANZ; SAARB

The association also has the following objectives:

- Represent its member organizations at a national level in all circumstances where joint action is necessary
- Establish relationships and lines of communication between members, study and defend the general interests of the profession, and establish cooperative relations with international sister associations
- Contribute to the respect of the moral code of insurances in Benin
- Build capacity and sustainability of insurance markets, namely through the creation of insurance grants.

ASA-Benin is equipped with four statutory bodies: General Assembly, Executive Bureau, Secretary General, and the Technical Commissions. The 10 Technical Commissions are presided over by the general directors (chief executive officers) of member companies. They assist the Executive Bureau in overseeing the social and training affairs commissions, legal and legislative commission, automobile commission, finance commission, accounting, fire and associated risk commission, maritime and transport commission, life commission, information, statistics, reinsurance commission, and communication and public relations commission.

7.3 CURRENT HEALTH INSURANCE SCHEMES

Benin has several types of health financing schemes, which are summarized in Table 12.

Table 12: Types of Health Insurance Systems in Benin

Type of Insurance	**Caisse Nationale de Sécurité Sociale (CNSS)**	**Fonds National de la Retraite du Bénin (FNRB)**	**RAMU**	**Payment exemption or subsidies mechanisms**	**Private insurance**	**Mutuelles de santé / mutuelle de sécurité sociale**
Beneficiaries	Formal private sector employees and state workers	Civil servants	Benin total population	Vulnerable groups	Formal private sector employees	Rural and urban informal sector population

Coverage	Family benefits for maternity, old age, disability and death benefits, accidents at work, and occupational diseases	Family and maternity allowances, retirement pension, disability pension, pension for beneficiaries, medical evacuation, and hospital care in the country with maternity allowances	N/A	Malaria, HIV/AIDS, Tuberculosis, medical evacuations, health care for hemodialysis, Cesarean, Leprosy and Buruli ulcer, obstetric fistula, etc..	Health insurance	Health insurance. Old age pension (for the MSS)
Coverage rate	7%	6%	ongoing	No information	3%	5%

This analysis of private health sector financing in Benin shows a very heterogeneous sector in which large and profitable clinics and polyclinics coexist among a multitude of small and medium clinics whose results are quite variable. It seems that all large clinics are approved by insurance companies to support the beneficiaries of a health insurance policy. In general, the third-party payer system is used for beneficiaries, with a co-payment varying between 10 and 20 percent. Regarding payment-exemption mechanisms or care subsidy, other than religious private actors partnering with the MOH, there is no mechanism in place to allow for-profit private actors to care for eligible patients through payment exemption measures.

Régime d'Assurance Maladie Universel

Growth of private sector provision of health insurance is constrained by most of the population's lack of purchasing power, especially in rural areas. In addition, the proportion of the population covered by health insurance companies currently remains low (about 3 percent). It is expected that the establishment of universal health coverage under RAMU will greatly increase the financing available to private providers and provide an opportunity to widen the market share of health insurance in the private sector through the development of complementary products; however, RAMU faces significant challenges:

- Lack of planning for the implementation of RAMU
- Lack of coordination between all concerned ministries, especially Ministry of Finance
- Low involvement of the private health sector in the RAMU process
- No prospective actuarial study on health insurance packages and fee amounts
- Weakness of *mutuelles* to implement the RAMU in the informal sector.

From a private sector perspective, the challenges to RAMU are the following:

- A lengthy and bureaucratic accreditation and quality improvement process (especially for single provider clinics)
- Lack of clarity over how participants will be made eligible and how providers will know what coverage they are eligible for
- Cost of insurance mechanism, specifically issues with reimbursement and management of claims

- Lack of confidence in timing and transparency of public sector managed payments

This last factor is the biggest barrier to having private sector providers participate in RAMU, as potential delays in payments would prove fatal to small health providers. General perception of transaction costs (where providers pay a fee to be reimbursed) and outright corruption in public payments will take time to overcome. Because the government has not properly costed the amount of funding needed to provide RAMU and there has been no clarity on how the new funding needed will be mobilized, this further undermines the credibility of RAMU in the eyes of providers.

The MOH should pay close attention to the package of services that will be covered under RAMU. FP, especially LARM, should be part of the package to increase use among the population and lower the unmet demand for FP. Special care should also be given to provider payments on Caesarean sections in order to avoid overuse while at the same time providing coverage for legitimate, lifesaving operations. In all likelihood, however, if the government must prioritize which services are covered under RAMU to make the coverage package affordable, it will likely exclude FP because so many of these services are provided on a subsidized basis by donor-supported programs.

RAMU and *Mutuelles*

Although *mutuelles* offer the best possibility for coverage for the informal sector, considerable investment and capacity building is needed if penetration is to move well above the current level of 3 percent. The challenges are numerous: lack of supply of quality care in rural areas (the public facilities are not providing adequate care), lack of capacity of *mutuelles* (need 'professionalization'), and an urgent need for subsidies (national and external finance). Most *mutuelles* rely entirely on the contribution of members to cover the cost of health claims and administrative costs. Even with the contribution of volunteer administrators, these premiums are rarely enough, mostly because the percentage of members paying all their premiums and paying them on time is so low. The government contributes no funding to their operation, although in some areas, offices are provided for *mutuelle* staff and the district authorities promote them. Adherence to *mutuelles* has been greater in areas where projects funded by the Belgian cooperation have provided some capital or premium subsidies. Although *mutuelles* cover 40 percent of the territory, only 3 percent of the population utilizes these community-based schemes. A substantial effort will be needed to strengthen *mutuelles* so that they can play their part in covering the informal sector.

The current RAMU strategy of using *mutuelles* to cover the informal sector will not be a solution for urban populations since many in the informal sector in urban areas will prefer private providers and can afford to pay more than a typical *mutuelle* coverage package designed for rural consumers. Thus as part of the ongoing design of the RAMU/ANAM package and mechanism, some discussion should be focused on this issue. If the private and nonprofit sector providers are brought into the discussion and design (a current flaw in the process), then other mechanisms could be considered: individual, subsidized, and enrollment through providers or other groups. It is important that the design does not exclude these possibilities. USAID should also work with other donors (Swiss and Belgian Cooperation) that have supported the *mutuelles* over the years to agree on a common strategy. The *Concertation Nationale des Structures d'Appui aux Mutuelles de Santé (*CONSAMUS) group, which brings together all organizations working with *mutuelles,* would be an appropriate forum.

In addition to mobilizing more actuarial expertise to design a feasible coverage package, RAMU should develop a menu of standardized coverage packages and premium options designed for

different consumer segments. Standardized packages that offer four to six different coverage packages and premium payments should allow for some economies of scale in administering claims while giving different population segments packages that suit their needs. In addition, for each package, the government will have to determine its level of premium subsidy, with the highest level of subsidy targeting the rural poor.

To support the development of private sector providers (including nonprofits), the national health insurance initiative (ANAM, RAMU, etc.) is the best long-term bet. But it will be a struggle to find the right design, ensure government commitment, and build capacity of *mutuelles* and other private providers. In addition, if RAMU develops faster in the formal sector than the informal, equity issues will arise: the poor and rural population will be left out.

FINDINGS FOR HEALTH INSURANCE

- **A significant amount of health sector transactions are occurring through out–of-pocket spending.** As of 2008, 44.2 percent of health spending was out of pocket, 92.7 percent of which occurred in the private sector. This is a major contributor to the fact that the poor either do not get the care they need, or are forced to spend an inordinately high portion of their income on health care, leaving them perpetually impoverished.

- **To support the development of private sector providers (including nonprofits) in the health insurance arena, RAMU is the best long-term bet.** While the proportion of the population covered by health insurance companies currently remains low (about 3 percent), RAMU should greatly increase the financing available to private providers and provide an opportunity to widen the market share of health insurance in the private sector.

- **RAMU faces a number of challenges in general and from a private sector perspective in particular.** It will be a struggle to find the right design, ensure government commitment, and build capacity of *mutuelles* and other private providers. The following are some of the challenges RAMU faces:
    - A lengthy and bureaucratic accreditation and quality improvement process (especially for single provider clinics)
    - Cost of insurance mechanism, specifically issues with reimbursement and management of claims
    - Lack of confidence in timing and transparency of public sector managed payments
    - Weakness of *mutuelles*, which are the entryway into the informal market.

  The WHO Providing for Health project's 2012 assessment report (P4H 2012) on the readiness of RAMU concludes that Benin is not ready to launch national health insurance. A number of systems must be strengthened to make RAMU operational and effective, though the idea of a national health system remains valid in the long run.

- **There is little information about the precise set up of the RAMU scheme and private providers do not seem to be included in the design in any significant way.** Currently RAMU remains largely a proposition yet to be developed and operationalized. If any efforts are taking place at the moment, the private sector is not a part of the debates and discussion. Since the private sector plays an important role in the health system of Benin, excluding this sector from the design phase of the national health insurance system is likely to create future challenges in implementing the universal system.

- **The development of community health insurance schemes as an entry point for the informal sector is slow and well below projections**. To date, community health insurance schemes cover only 5 percent of the population with about 200 schemes active in the country, as opposed to the 2,000 schemes that had been projected by year 2012. Thus far, the community health schemes' involvement in the development of the universal health insurance regime has been weak. Moreover, the schemes, often implemented with the support of various international development partners[4], do not appear to be working as a united group and are not recognized as a relevant actor in the conceptualization and the implementation of the national policy on universal health insurance. Mutual type health insurance systems offer an opportunity to reach the vast informal sector, and efforts should be made to expand these schemes even if they may evolve into different structures over time.

- **Weak health providers and, in particular, corrupt and inefficient government health clinics, limit the opportunity to develop the national health system.** Several community health insurance schemes visited by SHOPS said their members had problems obtaining services: the only available services were provided by government centers where quality is low and where employees expect and often outright demand out-of-pocket payments by insured patients beyond their co-payment requirements. This eliminates the incentive to participate in the community health insurance schemes. One community health insurance scheme reported that out of 567 member families in the scheme only 30 percent actually pay their dues, and this number is diminishing because of the extra payments required by the government provider in the area. Such practices severely undermine the otherwise rational effort to replace out-of-pocket payments with pooled funds. Therefore, there is a need to strengthen government-sponsored, community-based health providers in the basics of the universal health insurance in order to ensure the adequate provision of services and pricing. According to the Association of Community Health Insurance Schemes, a pilot project funded by an NGO from Luxemburg is underway in the north that is seeking to remedy this situation, and it has already trained several private providers in conjunction with the local community health insurance schemes.

- **There is a lack of actuaries in general[5] and a complete absence of actuaries trained in health care issues**. None of the insurance companies visited by SHOPS have a qualified actuary that has a degree in actuarial sciences or a certification comparable to international standards. This has been confirmed by the insurance regulator (*Administrateur des Assurance, Ministère de l'Economie et des Finances*), whose department similarly lacks staff knowledgeable in actuarial sciences. This constitutes a major weakness that must be fixed before the RAMU system becomes operational. According to the opinion of the insurance companies interviewed by SHOPS, the tariff packages RAMU recently proposed are not realistic and are not based on actuarial calculations.

  The importance and urgency of this issue should not be understated. In health insurance, including insurance provided directly by employers and social insurance, actuarial science focuses on the analysis of rates of disability, morbidity, mortality, fertility, and other

[4] For details on the various implementing partners and the current challenges to increase membership, see: Turcotte-Tremblay AM, Haddad S, Yacoubou I, Fournier P., Mapping of initiatives to increase membership in mutual health organizations in Benin, International Journal of Equity in Health. 2012 Dec 5;11:74. http://www.ncbi.nlm.nih.gov/pubmed/23217438

[5] There are three actuaries in Benin according to some sources. See: http://www.actuaries.org/FUND/Nairobi_2011/Nairobi2011_Presentation_Oyetunji.pdf

contingencies. Actuarial science also aids in the design of benefit structures, reimbursement standards, and the effects of proposed government standards on the cost of health care. The effects of consumer choice and the geographical distribution of the utilization of medical services and procedures, and the utilization of drugs and therapies, are also of great importance. The inability to provide objective evidence-based actuarial support for the system as a whole, including for RAMU, insurance regulators, and individual insurance providers, puts the idea of a national health insurance scheme in danger from the outset. Even if the Benin insurance market does not support the expansion of the actuarial profession, the government and its partners should mobilize appropriate actuarial expertise to design the RAMU and oversee its implementation during the initial years as it accumulates the necessary data on costs, morbidity, and disability to refine actuarial estimates.

RECOMMENDATIONS FOR HEALTH INSURANCE

- **Support the development of RAMU and its mechanisms to ensure that private sector providers are taken into consideration**, that FP including LARM, is part of the package, and that key high-impact outpatient services are covered. Since a number of donors and agencies are interested in supporting RAMU as the major health insurance vehicle, USAID's involvement should be strategic and add value to the already existing or declared support for the system. USAID's particular contribution could be to ensure that the private sector needs and realities are appropriately taken into account. This could be done through supporting a private sector working group serving as an advisory body to the government and RAMU, and playing the role of the unified voice of the private sector. USAID could also provide technical resources to develop evidence-based arguments to support the terms and conditions of the private sector participation in RAMU.

- **Support the capacity development of *mutuelles* through support to national-level efforts focused on networking and professionalization.** Community based health insurance will remain in the medium term the major avenue to include the informal sector in the national health insurance, even though the role of *mutuelles* is likely to evolve as the system matures. Therefore it is vital to support the development of these entities to engage as many individuals and communities throughout the country. Since the *mutuelle* movement appears to be fragmented, it is necessary to consolidate the efforts to ensure scale and efficiency. To that effect, USAID could offer support to streamline the process of creation and operation of a local *mutuelle* through development of uniform policies, procedures and documentation, launch of a centralized operational platform for data processing and management, and assistance to market and promote the health insurance among low income populations in order to increase enrollment and retention. Since mutuelles are voluntary decentralized entities, RAMU will need an administrative entry point for supervising and supporting mutuelles. The existing number of Unions of mutuelles could be expanded and supported by the government providing the resources for a small staff of professional managers at the commune level to operate the Union, market the standardized packages, and supervise their administration. Unions have not been effective to date because they have relied on the same volunteer leaders from the mutuelles.

- **Support the provision of actuarial expertise for the design of RAMU.** This is critical for the development of the health insurance market and the introduction of RAMU.

USAID could also facilitate the process by engaging Actuaries without Borders and other similar organizations to support the development of actuaries in Benin.

8. RECOMMENDATIONS

This section restates the recommendations given in the Executive Summary.

Recommendation Area	Recommendation	Implementer
(1) Grow the formal sector by streamlining registration and licensing processes for businesses and supporting provider networks	**Initiate a policy dialogue with the MOH to streamline the registration process and improve compliance with/enforcement of officially set time limitations on the review process.** The creation of a one-stop-shop or "*Guichet unique*" approach, where providers can take care of all aspects of business registration and licensing, could be part of the solution.	USAID
	Provide amnesty for current qualified but unregistered informal providers/ facilities. This is necessary to encourage existing facilities to submit an application for registration, especially as it pertains to future growth of the ProFam network.	MOH
	Support a mechanism to identify and support providers in becoming registered. Give technical assistance to an organization, such as ABMS or another that has a vested interest in the formal health sector, to take on this role. Ensure that formal registration qualifies a provider to participate in RAMU.	USAID/ABMS
	Remove barriers in order to convert private sector clinics into high-volume, high-quality, low-unit cost facilities. Start and maintain a dialogue with MOH and professional associations to relax the constraints on marketing and promotion of health services, deregulate prices so that they are more market-based, and develop a package of incentives to **promote group practices** and provider networks.	MOH/ Professional Associations
	Strengthen the family planning program in the AMCES network. Link AMCES to ABMS and other FP supply actors in order to increase the volume of FP products at their health centers and hospitals, where such products are allowed, and strengthen FP counseling programs and referrals to emphasize informed choice.	USAID
	Strengthen the financial sustainability of ABPF through targeted assessments. Following on Engender Health's technical assistance to ABPF, support development of a strategic plan, an investment	USAID

	plan, and business plans aimed at reducing financial vulnerability of the organization while preserving their social mission.	

(2) Strengthen the role of the private sector at the national policy level and through advocacy groups	**Identify a high profile private sector "champion"** and an MOH counterpart to organize and coordinate regular dialogue meetings between the MOH and private sector stakeholders.	USAID/MOH
	Strengthen the advocacy capacity of the professional orders to participate in the MOH's health systems strengthening efforts. Give technical assistance to strengthen strategic plans, role as a secretariat of its members, and coordination of training and other benefits for members.	USAID
	Work with thought leaders within the professional associations to separate and clarify regulatory roles from business interests of the members so as to avoid inherent conflicts of interest, especially within the Professional Association of Pharmacists and Professional Association of Physicians.	USAID
	Improve private providers' understanding of government standards and of provider rights surrounding enforcement of time frames for facility/product registration and dossier review. Support an association or NGO to educate providers about these rights and responsibilities.	USAID
	Assess the feasibility of setting up an independent, NGO-led quality standards and quality assurance system in private sector facilities. Strengthen the role of supervision of QA systems and compliance with standards as part of a certification system. Consider support (in the longer term) for the creation of a self-regulating "grading" system for private providers.	USAID
	Provide technical assistance to ROBS to make a thorough sustainability assessment and strategic plan.	USAID
	Support CEBAC STP with targeted technical assistance in order to integrate FP services in the already existing workplace clinics. Make a strategic plan aimed at inclusion of workplace clinics in the ProFam network.	USAID
	Include the Association of Private Clinics in any policy dialogues aimed at streamlining the health facility registration process or establishing QA systems and PPPs in support of priority programs, especially FP/RH.	USAID

(3) Streamline registration and licensing processes for pharmaceutical businesses and products	**Enforce timely and rational review of pharmaceutical product registration dossiers** through technical assistance to MOH**.** Ease restrictive limitations on the level of product competition, which significantly hampers private sector engagement and end-user choice in products.	USAID/MOH
	Advocate with MOH to eliminate conflict of interest associated with the quasi-regulatory role(s) of Orders of Pharmacists, Midwives, and Physicians, by separating regulatory function(s) in product and facility registration dossier review from other (client-oriented) functions.	USAID
	Conduct in-depth study of pharmaceutical product flows to eliminate inefficiencies. Simplify and harmonize pharmaceutical flow through the supply chain.	MOH
	Provide technical assistance to the *Commission Technique des Médicaments* in order to **evaluate current government-set pharmaceutical margins and their effect on private wholesalers**, assuring that wholesalers are not inadvertently 'squeezed' by changing fixed costs and exchange rate fluctuations. Support the Commission to conduct quarterly reviews of pricing throughout the supply chain.	USAID
	Provide technical assistance to ABMS, CAME and other wholesalers and retailers on market-based pricing and costing.	USAID
	Design and implement targeted training to increase the capabilities of supply chain managers in the labor force. This is a promising arena for promoting PPPs with international industry.	USAID
	Create incentives for private pharmaceutical providers to collaborate with other health professionals to better provide consumer access to pharmaceuticals in remote areas of the country. This could include jointly managed facilities or outreach activities in underserved locations; operating 'branch' dispensaries within faith-based or public health care facilities; or promotion of collaboration between pharmacists and providers on stock estimation in order to avoid stock availability issues.	MOH

(4) Improve access to finance and business capacity of providers	**Design access to finance programs with banks and MFIs to strategically provide an incentive for business formalization.** Stimulate a more rational (desired) mix of health providers by carefully channeling targeted and supervised loans to the types of providers which would advance health outcomes in the priority geographic areas of the country.	USAID
	Provide technical assistance to EcoBank's DCA borrowers receiving funds under the USAID guarantee. This could be structured as pre-borrowing assistance as well as post-borrowing assistance provided on a one-to-one basis to the funded clinics.	USAID
	Arrange two lines of additional credit for private health sector providers with Bank of Africa and FECECAM, in order to provide longer term funding to smaller providers in rural and peri-urban areas.	USAID
	Strengthen business capacity by launching business management trainings and by providing direct technical assistance to increase management capacity of private providers, including developing strategies and business plans, mentoring and coaching senior managers, and facilitating access to finance.	USAID

(5) Foster the growth of private sector health financing mechanisms (health insurance)	**Support the development of RAMU and its mechanisms, and in particular ensure that private sector providers are taken into consideration**. Support a private sector working group serving as an advisory body to the government and RAMU, and playing the role of the unified voice of the private sector. Provide technical resources to develop evidence-based arguments to support the terms and conditions of the private sector participation in RAMU.	MOH
	Build the capacity of *mutuelles* through support to national level efforts focused on networking and professionalization. Streamline the process of creation and operation of a local *mutuelle* through development of uniform policies, procedures and documentation, a centralized operational platform for data processing and management, and assistance to market and promote the health insurance among low-income populations. Support the creation of unions of *mutuelles* on a regional basis, which will have the responsibility of both starting new *mutuelles* and	USAID

	supporting existing *mutuelles*.	
	Support the provision of actuarial expertise to ANAM to underwrite evidence-based, and appropriately priced, coverage packages for the formal and informal sectors. Facilitate this process by engaging Actuaries without Borders and other similar organizations.	WHO/Swiss

9. CONCLUSION

This PSA provides multiple recommendations related to strengthening the private health sector in Benin. These include growing the formal sector by streamlining registration and licensing processes for businesses and by supporting provider networks; strengthening the role of the private sector at the national policy level and through advocacy groups; streamlining registration and licensing processes for pharmaceutical businesses and products; improving access to finance and business capacity of providers; and fostering the growth of private sector health financing mechanisms (health insurance). The government of Benin and its development partners, including USAID, can utilize these recommendations to increase participation of the private sector in health policy and regulation, as well as to strengthen the sector's health service and product provision. Although the private sector is growing rapidly in Benin, the bureaucratic hurdles left over from the pre-1997 era remain, providing disincentives for formal registration of private businesses and fueling the growth of the informal sector. The MOH would benefit from working hand in hand with donors to support the easing of regulations and recognize the importance of the private health sector as a key provider of critical health care services to the people of Benin.

The main overarching recommendations of this PSA focus on establishing dialogue with the MOH in order to reform or scale back onerous health sector regulations for setting up or maintaining a private business. Once private businesses are able to more easily register with the MOH, access finance, join group practices, and advertise their services, they can begin to see real results in terms of higher client volume, lower unit prices, and higher revenues. Likewise, improving the MOH's ability to coordinate with the private sector and effectively create and implement quality assurance standards and systems is essential for the improvement of health outcomes in Benin moving forward.

While the PSA focuses heavily on creating a friendly policy environment for business, strengthening the role of already existing organizations and health mechanisms is equally important. The private sector is enthusiastic to play a larger role in the overall health system of Benin. Supporting professional associations and orders, as well as advocacy groups such as ROBS, CEBAC STP, and the Association of Private Clinics, is essential in establishing mediums through which the private sector can coordinate, advocate, and access services. With the newly established universal health care, RAMU, the private sector has a unique opportunity to play an important role in financing health, especially for the 37 percent of Beninese living below the poverty line.

The PSA outlines many of the steps needed for the private sector to play a larger, strengthened role. These steps include initiating policy dialogues with the MOH; removing barriers in order to convert private sector clinics into high-volume, high-quality, low-unit cost facilities; strengthening faith-based organization and NGO FP programs; building the advocacy capacity of provider associations; clarifying regulatory roles from service provision roles of associations; setting up quality standards and quality assurance systems; and using access to finance as an incentive. These recommendations must be put into context within the current situation of an impoverished country with low demand for private health sector services. Strengthening and growing the

private health sector in Benin needs to happen alongside economic development and reduction in poverty throughout the country.

The goal of this PSA and its recommendations is to build a stronger, more relevant, and less constricted private health sector in Benin. The country's strong history of public sector focus, combined with its current low demand for private sector services, will ultimately determine the interventions to be proposed and implemented so that health indicators in Benin can be improved in the most efficient and appropriate ways. Private providers, health and nonhealth sector businessmen and women, and directors of associations and organizations—all with a stake in the health sector of Benin—have professed their desire and readiness to see a vibrant and well-supported private health sector in their country. The recommendations put forth in this report provide a good starting place on the path to realizing a strong private sector and improved health outcomes in Benin.

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ANNEX A: SCOPE OF WORK

BACKGROUND

Benin is a West African country with a population of 9.3 million people, 58 percent of whom live in rural areas (World Bank, 2010). With a per capita gross national income of $780, Benin ranks 166 out of 187 on the UN's Human Development Index (UNDP 2012).

In the last 15 years, government health expenditures in Benin have hovered between 9 and 12 percent of total health expenditures, while outside resources spent on health have increased from less than 20 percent to over 35 percent of total health expenditures (WHO 2011). **Private expenditures on health represent 50.5 percent of total health expenditures**, the vast majority of which are **out-of-pocket payments (92.7 percent)**. Private health insurance payments account for the remaining 7.3 percent of private health expenditures (WHO 2011).

Health indicators have improved in Benin over the last 50 years with life expectancy increasing from 35 years in 1960 to 56 years as of 2010 (World Bank 2010). Maternal mortality rates have also dropped to 397 deaths per 100,000 live births (DHS 2006) since the 1996 DHS, which reported 498 maternal deaths per 100,000 live births. Over 60 percent of women report receiving antenatal care (four or more visits), and 74 percent report having a delivery with a skilled birth attendant (Countdown, WHO/UNICEF 2012). HIV prevalence in Benin is around 1.2 percent (slightly lower than the seroprevalence estimate of 2 percent), and women are almost 2 times as likely to be infected as men—1.5 percent to 0.8 percent, respectively (DHS 2006). Furthermore, urban women and women who have only received a primary education are more likely to have HIV than rural women or women who have completed secondary school (DHS 2006).

The mortality rate for children under five in Benin has decreased from 178 to 115 deaths per live births in the last 20 years (Countdown, WHO/UNICEF 2012). **Common causes of under-five deaths include pneumonia, malaria, and diarrhea**. Many children do not receive treatment or preventative care for these diseases—36 percent of children with suspected pneumonia are taken to the appropriate health provider, and 23 percent of children are being treated for diarrhea with oral rehydration salts. **Of those receiving treatment, 64% access the private sector** (62.7% went to the private sector for advice for diarrhea treatment and 64.5% sought advice for treatment of fever/cough in the private sector) (Montagu). DHS data from 2006 shows that 64.8% of deliveries took place in public facilities, with 11.2% taking place in private facilities.

Modern contraceptive prevalence, as reported by the 2012 DHS, is 7.9% percent for married women ages 15-49. This is an increase from the 1996 DHS, which reported modern contraceptive prevalence at 3.4 percent; however, there is still a high unmet need for contraception in Benin—27.4 percent (2012 DHS). Many women source their contraceptives in the private sector; however, long-acting methods, such as intrauterine devices (IUDs) and implants, are still mainly sourced in the public sector—82.4 percent and 73.5 percent, respectively (DHS 2006). The **private medical sector is an important source for pills and male condoms,** which women mostly purchase from registered pharmacies— 28.7 percent of

pills and 46.8 percent of male condoms are sourced this way (DHS 2006). The private non-medical sector, dominated by informal shops, is also an important source of pills and condoms—22.7 percent of pill users and 34.2 percent of male condom users source their methods from informal shops (DHS 2006).

According to a June 2012 health sector assessment conducted by the USAID-funded Health Systems 20/20 project, **the private health sector in Benin consists of a commercial private sector based heavily in the south, faith-based organizations found mostly in the interior of the country, and a private pharmaceutical sector with most pharmacies in the Atlantique, Littoral, and Oueme departments.** The commercial private sector consists of clinics, general and specialized medical practices, dental offices, and diagnostic/laboratory and radiology centers, while the faith-based sector comes mostly in the form of hospitals. With a total of around 1,000 beds, **the faith-based sector has 25% of total beds in the country yet accounts for 40% of all daily hospitalizations** in Benin.

The pharmaceutical sector is heavily regulated in Benin; however, in practice the regulations are not always enforced. Since 1994, medicines procured by the government agency CAME, the Centrale d'Achat des Médicaments Essentiels et des consommables médicaux , may be purchased by private sector buyers, with the exclusion of stock that is funded by donors (Distribution Chain for Anti-Malarial Drugs 2009). **As of 2008-2009, there were 180 registered pharmacies in Benin, and 279 pharmaceutical depots (DCAMD 2009).** In 2001, La Direction de la Pharmacie et des Médicaments (DPM) at the Ministry of Health released a new policy allowing for the creation of pharmaceutical depots in places that were more than 10 kilometers from a pharmacy (Evaluation rapide 2007). Depots must sign a memorandum of understanding with a pharmacy and purchase all of their medicines from that pharmacy (DCAMD 2009). A survey of the availability of anti-malarial drugs available in Benin in 2008-2009 found that in practice depots often procure antimalarials from multiple sources, sometimes buying directly from private wholesalers or CAME to take advantage of lower prices (DCAMD 2009). This suggests that they may do so for other drugs as well.

The prices of pharmaceutical products in the private sector are regulated to ensure that the entire population can buy medicines for the same price regardless of where they live, and the price structure set by the government allows for various discounts for pharmaceutical depots and public health facilities (DCAMD 2009). However, while the mark up prices on drugs purchased from private wholesalers are very clear and generally adhered to by commercial pharmacies and pharmaceutical depots, there is ambiguity on how these entities should price products procured from CAME (DCAMD 2009). **The private pharmaceutical sector accounts for 40% of the volume of medications sold**, amounting to FCFA 24 million ($47,500) in price. CAME covers 60% of the market share, yet its total price amounts to only FCFA 2.5 million ($5,000) (HS20/20 HSA).

Some clinical franchises exist, such as the non-profit **Protection de la Famille (ProFam)**, which is a network of fifty clinics managed by **ABMS** (Association Béninoise de Marketing Social et la communication pour la santé), PSI/Benin's local affiliate, and funded by the German Development Bank (KfW), SALIN (Netherlands), and USAID (CHMI 2012). ABMS appears to be a distributor of health products (often through the private sector, including ITNs, condoms, diarrhea prevention and treatment kits, oral and injectable contraceptives) and a social marketing organization. They also do HIV Counseling and Testing at three health centers (and they also have mobile units), organize Family Planning Event days (where they do IUD insertions). The International Planned Parenthood Affiliate in Benin, **Association Béninoise pour la Promotion de la Famille (ABPF)**, is another non-profit entity that operates six

branches and eight clinics throughout the country which provide family planning and reproductive health services (IPPF 2012).

OBJECTIVES

SHOPS will conduct an assessment of the private health sector in Benin to assist USAID and other stakeholders to develop a strategy for further engaging the private sector in Benin. The strategy will complement and augment current efforts within the public and private sectors with a focus on **family planning, maternal and child health, urban populations (particular the urban poor),** and **existing service provider networks.**

The assessment will focus on the following main components:

1) The location and density of private sector facilities and the services they offer, especially those related to family planning and maternal and child health, as well as the supply and demand for private sector provision of health products and services in these key areas. .
2) The policy and regulatory environment for private provision of health products and services; particularly looking at how the public sector can steward and supervise the private sector in normalizing and aligning national health strategy and goals;
3) Assess business and financing needs of the private health sector in order to better assure viability of facilities as businesses, with an emphasis on ProFam and AMCES facilities. Examine the extent to which access to credit could improve quality of care or expand service provision, and training needs in business management.
4) Identify synergies with already existing USAID field support activities focused on improving health outcomes in Benin.
5) Identify opportunities to increase access to private sector health financing options by examining current initiatives.

STATEMENT OF WORK

Determine the size, scope, and scale of private sector providers in Benin.

- **Assess the diversity and distribution of private sector, for-profit providers** and other health sector entities through an initial mapping and surveying exercise:
    - Obtain lists of private health sector facilities through review of MoH registries and interviews with key stakeholders such as private provider associations.
    - Visit a range of facilities, focusing on for-profit and not-for-profit hospitals, networks of clinics such as ProFam and AMCES, and pharmacy and pharmacy depot networks, in order to gain insight into the state of the private health sector in Benin.
    - Hold focus groups and/or interviews with a range of private providers including doctors, nurses, midwives, and pharmacists in order to better understand the kinds of services and commodities they provide, the licensing and regulatory environment for operating a private health facility, issues they face in terms of procuring commodities, obtaining clients, participating in continuing medical education, and accessing finance. These interviews may also provide insight into the barriers to operating in the for-profit sector and the demand for family planning services within this sector.
  - Secondary mapping activity (3-5 months duration, to begin in November 2012):
    - Identify potential data collection firm to carry out large scale private provider mapping and surveying.

    - Data firm to obtain list of all private health facilities in Benin, visit clinics and other facilities on the lists in order to verify their existence and activeness, and search out unlisted facilities.
    - Firm to record GPS points of facilities and collect additional, basic information using a standardized form to be developed for and used on mobile data collection devices. Firm will gather basic information on products and services offered, demographic of clientele, equipment and staffing at the clinic, sales/income and price structure, training and accreditations received, access to finance, and facility needs and wants.
    - All GPS and quantitative/qualitative data found to be input into a database and analyzed in order to produce mapping products demonstrating the diversity and distribution of private health sector facilities and entities.
- **Meet with key provider network associations** such as those of *medecins*, *pharmaciens*, and *sages femmes*, as well as NGO networks, and FBO networks to understand their roles. These interviews will seek to better understand the size and scope of the for-profit private medical sector, the resources available to private providers in terms of access to training and continuing medical education, if there are any commodity distribution systems available to private providers through these associations, and the overall policy environment in which they operate.
- **Understand the private sector role in supply chain**, primarily through interviews with private sector pharmacists and drug distributors. These interviews hope to yield information on the kinds of commodities provided by private pharmacies, especially as it pertains to family planning, maternal and child health , any issues that exist with accessing a constant supply of these commodities, and the regulatory environment both for accessing commodities and for operating a health facility.
- **Identify demand for services and products** through in depth DHS data analysis as well as focus groups with consumers to better understand consumer preferences and health seeking behaviors in regards to the private sector.

Assess the policy and regulatory environment for private provision of health products and services.

- Assess the level of cooperation and exchange between public and private sector providers.
- Examine existing policy and regulatory frameworks and other environmental factors impacting the private sector provision of health products and services. Determine the mechanisms for accrediting, regulating and monitoring private commercial providers of health products and services and their relative effectiveness.
- Analyze health care reform or other government-led initiatives that may impact private providers.
- Assessing the levels of policy dialogue between the public and private sector, existing PPP arrangements in the health sector and opportunities for further engagement and cooperation between the public and private sectors.

Assess financing needs of private health sector businesses.

- Examine access to financing, focusing on ProFam and AMCES facilities, to determine if it is a constraint to the delivery of family planning, MCH and/or HIV/AIDS services and/or products in the private sector.
- Assess financial institutions, such as banks and microfinance institutions, lending to the health sector, to what areas of the health sector, and what type of loan products/terms are available.

- Explore the potential to structure a USAID-funded Development Credit Authority (DCA) guarantee with financial institutions. Also includes feasibility of linking guarantee to reimbursement of private providers participating in National Health Insurance Scheme.
- Through meetings with private provider associations and focus groups with private providers, identify the financial management, business support service, and business management training needs of private health care businesses.

Link up with existing field support mechanisms

- Coordinate with other USAID field support-funded projects to further the work of SHOPS in promoting a larger role for the private sector in improving health outcomes in Benin. Focus especially on other projects working in the private sector and with policy actors such as the Ministry of Health.

Identify opportunities to increase access to private sector health financing options

- Examine current initiatives in health financing, including the role of community-based health insurance schemes as promoted through *mutuelles*.
- Assess current levels of collaboration between existing health financing mechanisms and the private health sector, identifying both barriers and opportunities for scaling up.

Based on the assessment findings, the assessment team will provide a range of options and recommendations for consideration by USAID and other stakeholders (including identifying potential formal public-private partnerships) to further engage the private sector in Benin.

SUGGESTED METHODOLOGY

Step 1 – Finalize Plan of Action: Work with USAID/Benin to finalize the Detailed Plan of Action, including the scope of the assessment, agreement on key survey questions, and schedule and timeframe.

Step 2 – General background literature review and research: Conduct background research using secondary research sources, secondary data analysis of DHS, National Health Accounts, and/or other sources, and interviews conducted prior to the first in-country visit. Use background research to inform team members of the state of the private health sector in Benin, including but not limited to family planning coverage and uptake, public and private sector health expenditures, and access to finance for the private health sector.

Step 3 – Conduct Country Assessment: Send a 3-4 person team to Benin to conduct a 2-3-week assessment. The team will work hand in hand with select local counterparts while in the field to better facilitate the assessment. The following components will be included in the team's assessment methodology.

Stakeholder Meetings: Conduct a stakeholder meeting with key decision makers such as MoH, USAID, and representatives of private sector entities to build support for and buy-in to the assessment, to vet survey questions, determine if stakeholders have additional issues that would like addressed and, if necessary, expand the survey questions and assessment scope. Additionally, there will be discussions on the goal and objectives, design and participants in consultative process. This is designed to increase the likelihood that its findings and recommendations will be used by stakeholders and to ensure greater relevance of the assessment results.

Key Informant Interviews: Conduct qualitative, in-depth interviews with key stakeholders and partners. Key informants should include, but not be limited to:

- USAID/Benin staff
- US Government (USG) counterparts including CDC
- Implementing partners (contractors and cooperating agencies) working on private sector initiatives including other Abt projects, Population Services International (PSI), MCDI/ARM-3, University Research Corporation/PISAF, Wash Plus, and IDEA International-Benin.
- USAID/Washington staff backstopping the Benin Program
- A cross-section of private providers including general practitioners, ob/gyns, pharmacists, and midwives, in rural, peri-urban, and especially urban areas.
- Private and commercial enterprises, including professional associations, pharmaceutical manufacturers, and health insurance companies.
- Private and commercial financial entities such as banks and microfinance institutions, etc.
- Key Government of Benin staff, including staff in maternal and child health, reproductive health and/or family planning divisions, CAME and DPMED within the Ministry of Health.
- Divisional and/or regional health authorities.
- Other multilateral donors supporting the health sector (including UN, DFID, etc.).
- Professional medical, nurses-midwives, pharmacists, bio-laboratory associations, and other private health sector associations.
- Data collection and research firms.

Field Visits: The assessment team will visit field sites where private sector initiatives are underway. The team will visit urban, rural, and peri-urban health facilities ranging from small clinics and pharmacies to hospitals, in order to carry out its initial data collection.

Data Analysis: The team will conduct analysis of data collected during key informant interviews, focus groups, and field visits in real time, and improvise and adapt their assessment schedule as needed based on findings or new information.

Step 4 – Report Writing & Dissemination: The assessment team will write a draft report for USAID/Benin staff review. Upon receipt of comments from USAID/Benin, the team will revise and finalize the report accordingly. The report will then be disseminated through multiple channels including the stakeholder dialogue process. Total time for report writing, receipt of comments, dissemination, and finalization of report will be two months, to commence upon return from the field visit.

DELIVERABLES

Final SOW: Developed in consultation with USAID/Benin in advance of the assessment visit, including:

- Team composition, roles and responsibilities – team will include Abt Associates HQ staff as well as in-country partners
- Assessment budget, including dollar amount of POP core funding
- Relationships and responsibilities (regarding key points of contact, logistical arrangements, scheduling of meetings and appointments, etc.) of assessment team and USAID/Benin
- Timeline and level of effort

Detailed Plan of Action: Developed with input from the pre-assessment briefing with USAID/Benin and the in-country stakeholder meeting. Includes milestones and deliverables with due dates. This plan would include:

- Key research questions, methods, and tools
- Timeline for key activities, including product due dates
- Identified key initiatives for further assessment
- Schedule and itinerary of the assessment trip, including expected interviews
- Schedule of formal debriefing presentations to USAID
- Schedule for dialogue meetings

Debriefing Meeting: The assessment team will hold a debriefing meeting with USAID/Benin and USAID/Washington staff to present the major findings and recommendations of the assessment.

Assessment Report: The assessment team will provide USAID/Benin with a final assessment report including: an executive summary; scope and methodology used; important findings and conclusions; recommendations and opportunities for future investment/support.

ANNEX B: LIST OF CONTACTS

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