



STUDY OF THE STATE OF ACCOUNTABILITY FOR UNIVERSAL HEALTH COVERAGE (UHC) IN BENIN

SEPTEMBER 2020



*This report is published in English and French. There may be some slight differences due to the translation
Ce rapport est publié en anglais et en français. Il peut y avoir de légères différences dues à la traduction*

DISCLAIMER

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Results for Development, Duke University Global Health Innovation Center, Amref, Synergos, RESADE, CERRHUD, and Feed the Children and do not necessarily reflect the views of USAID or the United States Government.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS	5
EXECUTIVE SUMMARY	6
CHAPTER 1: METHODOLOGY	8
Introduction	8
About the accountability mapping exercise	8
Study design, scope and limitations	9
CHAPTER 2: ACCOUNTABILITY FOR UHC IN BENIN HEALTH SYSTEM	10
The structure and organization of the health sector in Benin	10
Progress towards Universal Health Coverage (UHC) in Benin	11
History on Accountability efforts in the Health Sector in Benin	12
CHAPTER 3: MAPPING FINDINGS 14	
Actors and their role in accountability	14
Accountability approaches and tools	16
Complementary literature review	17
CHAPTER 4: RECOMMENDATIONS FOR ENHANCING ACCOUNTABILITY	18
Lessons and opportunities for strengthening accountability for UHC in Benin	18
ANNEXES:	20
DATA COLLECTION TOOLS	
KII FOR ACCOUNTABILITY MAPPING EXERCISE CSOs, Youth & Women Groups and Networks etc.	20
KII FOR ACCOUNTABILITY MAPPING EXERCISE Health service providers	21
KII FOR ACCOUNTABILITY MAPPING EXERCISE Media	22
KII FOR ACCOUNTABILITY MAPPING EXERCISE Private sector involvement	23
KII FOR ACCOUNTABILITY MAPPING EXERCISE ANAM	24
KII FOR ACCOUNTABILITY MAPPING EXERCISE Department of Planning and Forecasting	25

LIST OF **ABBREVIATIONS**

ACS	African Collaborative for Health Financing Solutions
AIDS	Acquired Immunodeficiency Syndrome
ALC	Accountability Learning Collaborative
ARCH	Assurance pour le Renforcement du Capital Humain
BTC	Belgian Development Agency (BTC)
COGECS	Comité de Gestion du Centre de Santé
CSO	Civil Society Organizations
DHD	Departmental Health Directorate
FBO	Faith Based Organizations
KII	Key Informant Interview
MoH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-Governmental organizations
NHIA	National Health Insurance Agency
RAMU	Régime d'Assurance Maladie Universelle
RBF	Results-Based Financing
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Accountability is a broad concept and there is no consensus definition among stakeholders working on this topic. The African Collaborative for Health Financing Solutions (ACS) has adopted a World Bank (2004) definition which states that accountability is “the obligation of power-holders to account, or take responsibility, for their actions”. It has been recognized as a core element, not only of democratic governance, but of all aspects of human development since it contributes to ensuring that the interests of the poorest and most marginalized groups in society are taken into account. This document is the output of a mapping conducted on the status of accountability for Universal Health Coverage (UHC) in Benin. The study was conducted by ACS, a five-year (2017-2022), USAID-supported project with the overarching goal of advancing implementation of health financing policies that support countries as they navigate their journeys towards UHC in sub-Saharan Africa (SSA). The study was conducted with the goal of generating evidence on the key accountability actors, the accountability approaches, tools and processes and the opportunities for strengthening accountability in the region. The findings will go towards promoting learning about accountability for informed action towards UHC across the region. The findings and recommendations presented are based on an extensive desk review of relevant documents and primary data collection through key informant interviews with key accountability stakeholders in Benin. Overall, there are various actors involved in accountability efforts in the health sector in Benin. The actors identified through this study include;

1. members of the Comité de Gestion du Centre de Santé (COGECS) who are trusted community members who represent their community
2. providers at the health facility level
3. local government officials such as mayors
4. social workers
5. community members who include the youth and persons living with disability
6. community-based health insurance scheme or mutuelles. These actors have used various accountability approaches such as hotlines, public hearings, suggestion and complaint boxes as well as participatory policy formulation processes.

There is renewed political will in Benin to achieve UHC through roll out of the Insurance for Human Capital Strengthening or Assurance pour le Renforcement du Capital Humain ARCH, a social protection program. Leveraging this commitment to create 'space' for accountability would ensure effectiveness in the roll out of the flagship health financing reform for UHC in Benin. Other recommendations to strengthen accountability based on the study findings include:

1. **Creating awareness** on the role of social accountability in improving health outcomes amongst the health managers at national, zonal and commune levels as well as the health providers since the current UHC push in Benin is targeting the poor and very poor, a unique cohort that requires unique solutions to fully engage in accountability efforts.
2. **Improve functioning of the health committees** at the zonal (health district) and commune levels as well as those at the health facility COGECS which form the link between the communities and formal health system. This would be partly achieved through rolling out the 'Manuel de procédures de mise en place et de fonctionnement des organes de gestion' manual which contains procedures for setting up and operationalizing health management committees. These committees are critical in ensuring performance accountability during health service delivery.
3. **Strengthen capacity of the COGECS** as well as the civil society organizations who are a trusted link between the community and the formal health system in Benin. They present the best opportunity for pushing for accountability as well as for community engagement especially in promoting citizen awareness as well as the community's participation in accountability efforts. Motivating the COGECS members through incentives would keep the members committed to the cause. Currently, the institutional capacity and opportunity offered by COGECS to strengthen accountability is yet to be fully exploited.
4. Leveraging available accountability tools e.g. the hotline service, radio to strengthen accountability. The uptake of the hotline service channel has been very low mainly due to a poor roll out strategy compounded by the lack of capacity to utilize the interface due to the low literacy levels. It is therefore recommended that either the **government provides citizen awareness on the hotline service** or avails public spaces where the citizens can engage their duty bearers directly or through their intermediaries for strong accountability within the health system.
5. **Media engagement:** Community radios are a preferred mass media channel for citizen engagement for accountability given their wide availability and ability to utilize local languages in engaging community members. Journalists working in the community radio stations should be supported to go beyond health education and into promoting transparency and accountability in their programming. For citizens to raise their concerns, they need not only information about their entitlements, but also an accessible 'interface' where they can engage with the duty bearers.
6. It is critical that the ARCH program **builds on the learnings from existing models** that have worked such as the Results-Based Financing RBF as well as the community mutuelle to shorten the learning curve and inject efficiencies in the whole project.
7. Work together through **inclusive stakeholder engagement** in the dialogue platforms while including often left out cohorts of the accountability stakeholders such as youth, women, and people with disability during design and implementation of the ARCH program will accelerate the country's journey to UHC.

CHAPTER 1:

METHODOLOGY

INTRODUCTION

Benin is a geographically small country (114,763 square kilometers), nestled between Nigeria, Niger, Burkina Faso, and Togo on the West Coast of Africa (see “Figure 1: Map of Benin”). The [World Bank](#) estimates the total population of Benin to be at 11,485,098 as at 2018. It achieved independence from France in 1960 and includes a multitude of ethnic and linguistic groups¹.

This document is the output of a mapping exercise conducted on the status of accountability for Universal Health Coverage (UHC) in Benin. It is based on a desk review of relevant documents and field level key informant interviews and a quantitative survey. The report presents a summary of the findings of the mapping exercise with a particular focus on the accountability actors, approaches and tools as well recommendations on how the country can accelerate the journey to UHC through strong accountability mechanisms.

The mapping exercise was conducted by the African Collaborative for Health Financing Solutions (ACS). ACS is a five- year (2017-2022), USAID-supported project with the overarching goal of advancing implementation of health financing policies that support movement towards UHC in sub-Saharan Africa (SSA). Led by Results for Development in partnership with the Duke Global Health Innovation Center, Feed the Children, Amref Health Africa, and Synergos, ACS offers the technical support, facilitation, and coaching that countries need to make progress toward UHC.

ABOUT THE ACCOUNTABILITY MAPPING EXERCISE

One of ACS’ pillars is to strengthen accountability so that UHC health financing solutions are designed, implemented, and tracked through a process that is evidence-based, transparent, and accessible. ACS formed the Accountability Learning Collaborative (ALC) with the goal of generating evidence and promoting learning about accountability for informed action towards UHC in Africa. This accountability mapping exercise was conducted as a first step towards determining the status of accountability in Benin, while identifying learning and accountability challenges that could hamper successful implementation of UHC-related policies and strategies. More specifically, the objectives of the exercise included:

1. Identify the key stakeholders (government, Civil society organizations CSOs, Youth etc.), networks and movements involved in promoting accountability within the health sector in Benin.
2. Identify the processes, strategies, approaches as well as platforms that have and/or can be (successfully) used to promote accountability in Benin.
3. Determine the enablers and obstacles to promoting accountability by the various stakeholders in the health sector.
4. Make recommendations on opportunities for strengthening accountability in Benin.

The study also sought insights into accountability priorities identified during a meeting of accountability actors in the region held in April 2019 in Kenya. The questions identified during this meeting included:

1. How to improve and maintain citizen awareness, empowerment, and engagement around accountability for UHC
2. How to strengthen capacity of different accountability actors to play their role effectively (CSOs, media, parliamentarians, policy makers, providers)?
3. How to communicate and message information for different stakeholders so that they understand their interest and engage?

The body of evidence generated from the mapping exercise seeks to inform documentation to promote learning amongst accountability actors in the region as well as inform accountability capacity development efforts for evidence-based accountability mechanisms in Benin and the region as a whole.

Figure 1: Map of Benin



¹ Adeya, G., A. Bigirimana, K. Cavanaugh, and L. Miller Franco. 2007. *Rapid Assessment of the Health System in Benin, April 2006*. Submitted to the U.S. Agency for International Development

STUDY DESIGN, SCOPE AND LIMITATIONS

The study team employed the following methodology to address the study objectives:

- 1. Document Review:** A systematic document review was conducted, which explored specific themes in accountability efforts in Benin, the SSA region and globally. The aim was to identify published and grey literature on the strategies used in accountability during health service delivery, the contexts in which they have been used, and the attendant health and institutional outcomes. Additionally, citations mentioned in the literature were reviewed, and any other links in the literature explored. To align this assignment with other work conducted within the ACS project, a review of ACS accountability documents such as the ACS Accountability framework were also included in the desk review and findings.
- 2. Primary data collection:** A total of 39 Key Informant Interview (KII) respondents in Benin were identified for the study. The KIIs were conducted and audio recorded after obtaining informed consent. The recordings were subsequently transcribed in French, and then translated into English. An additional 100 youth were identified and provided quantitative data on the perceptions and experiences of young people with health services, their understanding of UHC, and whether they are involved in accountability processes for UHC.

The study respondents were grouped under the following categories:

TABLE 1 : INFORMANTS CATEGORIZATION

<i>Stakeholder</i>	<i>Examples of stakeholders</i>
National level	Policy makers within the Ministry of Health (MoH), parliamentarians who are involved in oversight of the ministry, Heads of public institutions such as AIDS Coordinating councils/bodies, National CSO network representatives and National NGO bodies representatives.
Implementers	National NGOs focused on advocacy, accountability and governance in the health sector, Faith Based Organization (FBO) representatives etc.
Private sector	Private sector health federation representatives
Sub national level	District health managers, CSO network representatives etc.
Community level	Health providers, Health facilities committees, CSOs, local activist and citizen groups e.g. women, youth, people with disabilities, women networks and associations of people living with disabilities.
Media and radio channels	National and local radio station representatives

- 3. Data analysis and report writing:** The quantitative data was then entered into SPSS and analyzed. The qualitative data was arranged thematically and analyzed for recurring trends and patterns. The interview transcripts were reviewed and grouped thematically. Similar themes occurring across interview transcripts were grouped together and analyzed to establish recurrent patterns around indicators of interest. Views that deviated from the dominant patterns within each theme were re-examined by re-reading the original transcripts to ascertain the contexts in which the respondent expressed such views. Judgment was then made on the plausibility of claims made by the respondent, by comparing other responses by the same respondent on other related issues. In most cases, these divergent views have either been treated as based on the unique experiences by a respondent of an issue, or as isolated instances of the same phenomenon that does not fit the usual dominant script but nonetheless exist as realities within the same community. This report summarizes the study findings and makes recommendation on how accountability for UHC can be strengthened in Benin.
- 4. Study limitations:** The study employed a purposive sampling methodology. The respondents to the study were purposefully identified given the need to target only those who had a stake in promoting accountability in the health sector. To remove possible biases due to this methodology, study respondents were identified from the South, Central and North regions of Benin. The second limitation relates to language barriers. The interviews required an English-French and back to French translation, a process that could introduce some degree of nuance due to the translation. Overall, however, the study findings provide a good basis for understanding the status of accountability in Benin.

CHAPTER 2:

ACCOUNTABILITY FOR UHC IN BENIN HEALTH SYSTEM

The following sections explore the current context for the health system in Benin, accountability for UHC as well as an overview of the approaches and tools utilized to promote accountability for UHC in the region.

THE STRUCTURE AND ORGANIZATION OF THE HEALTH SECTOR IN BENIN

The health system in Benin is based on the administrative division of the country into 12 departments and 77 municipal councils. It has a pyramidal shape with three levels: the central level, the intermediate level and the peripheral level. Each of these levels has an administrative body and a health infrastructure. The central or national level, in accordance with Decree 426 of 20 July 2016, is responsible for the design, implementation, monitoring and evaluation of the State's health policy, in accordance with the laws and regulations in force in Benin and the Government's development visions and policy. It is responsible for strategic orientations, policy development and decision-making concerning the development of the health sector and launches health action plans for the sector. It is also responsible for health promotion in Benin.

The intermediate level, composed of 12 Departmental Health Directorates (DHDs), is responsible for programming and supporting the implementation and monitoring of the health policy as defined by the government and for coordinating all health service activities at the departmental level. The DHDs supervise health structures at the intermediate and peripheral levels. The Departmental Hospital Center or Departmental University Hospital Center is the reference structure at the department level. The peripheral level is the base of the health pyramid. The health zone represents the most decentralized operational entity of the health system.

The country has 34 health zones spread over the entire national territory. Each health zone has a network of first contact public health services (Maternity hospitals and dispensaries alone, Health Centers) and private health facilities, all supported by a public or private first referral hospital (zone hospital) designed to serve an area with between 100,000 and 200,000 inhabitants. There is also the private health sector and the pharmaceutical sector. The bulk of health sector funding comes from government allocations, which in recent years have fallen below Abuja declaration requirement of 15% of the total budget.

The state of health in Benin is comparable to that of a low-income country. Overall life expectancy in good health and morbidity and mortality rates are lower than the regional average². For the poor, inaccessibility to health services stems, not from the high user fees, but from total marginalization from the system as a result of poverty. With regard to cultural obstacles to the use of health services, conventional sensitization methods have shown their limits, hardly affecting the utilization rate of health services. Indeed, most people practice self-medication at home or prefer traditional medicine. To encourage utilization of health services, the government introduced the health mutual funds. Health mutual funds are community-managed health insurance systems that enable members to have financial access to healthcare all the year round. The members of the mutual fund pay a premium, to ensure that they are covered for a certain number of medical services determined beforehand, regardless of the amount of contribution paid. However, limited documentation exists on the success of this model.



Figure 2: Map of Communes in Benin

² Health status in the WHO African Region: an analysis of the state of health, health services and health systems in the context of sustainable development goals. WHO Regional Office for Africa 2018.

PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE (UHC) IN BENIN

UHC aims to ensure that every individual and community, irrespective of their circumstances, receives the health services they need without risking financial hardship³. UHC is central to the health-related targets of the Sustainable Development Goals (SDGs). Benin's main development plans are all anchored in the achievement of the SDGs. The national policy frameworks that guide the government's commitment to SDGs include the Programme d'Actions du Gouvernement (PAG, 2016–21) and the Plan National de Développement (PND, 2018–25). The PAG identifies three big levers that could help Benin meet the objectives of the 2030 Agenda for Development: priority projects, 45 flagship projects (projets phares), and structural reforms⁴.

Benin's Constitution enshrines health as a human right. In addition, the right to health for every citizen is highlighted in the Growth and Poverty Reduction Strategy Paper (GPRS). The PNDS, in turn, is operationalized through the Triennial Development Plans (TDPs). Among other things, it aims to guarantee universal access and the provision of quality health care in order to achieve the SDGs, improve health partnerships and strengthen governance and the management of health resources. The PNDS 2018-2022 is subdivided into six (6) strategic orientations which are: (SO1) Development of leadership and governance in the health sector; (SO2) Provision of services and improvement of the quality of care; (SO3) Development of human resources for health; (SO4) Development of infrastructure, equipment and health products; (SO5) Improvement of the health information system and promotion of health research; and (SO6) Improvement of the financing mechanism for better universal health coverage. In its intervention logic, each strategic orientation is broken down into specific objectives, then into lines of intervention and then each line of intervention into priority actions.

The launch of a program called Universal Health Insurance Scheme (Régime d'Assurance Maladie Universelle, RAMU) in 2011⁵ marked a turning point for Benin in its move towards UHC. RAMU was intended to offer insurance coverage to the whole population through a National Health Insurance Agency NHIA (Agence Nationale de l'Assurance Maladie, ANAM) that was established in 2012. However, RAMU became highly politicized and this overshadowed its technical aspects. In December 2015, the national assembly adopted a law establishing RAMU as a compulsory scheme that would gradually cover all Beninese⁶.

The then newly elected President, Patrice Talon, announced his decision to revoke RAMU, after his election in March 2016, in order to implement a new project called Insurance for Human Capital Strengthening (*Assurance pour le Renforcement du Capital Humain, ARCH*⁷). Under its Action Plan 2016-2021, the government of Benin seeks to provide social protection for the poorest and most vulnerable, ultimately aiming to support four million Beninese citizens through a universal health insurance system. This involves providing every community with healthcare equipment and facilities, access to drinking water and electricity, as well as recruiting doctors to widen access to medical care. In addition, the adoption of a new legislative and regulatory framework will enable the introduction of a social protection policy with individual beneficiary contributions supplemented by a government subsidy. A further goal is to establish an insurance fund (ARCH) to reinforce Benin's human capital, providing four different types of social benefits for farmers, traders, artists, and craftspeople in the informal sector. ARCH contains health insurance, occupational training, microloan provision, and pension insurance for people in the formal and informal sectors⁸ at scale.

The legal framework creating ARCH was adopted in May 2017. ARCH is aimed at ensuring effective and affordable health insurance to the Beninese population, especially the poor (40 percent of the total population). The health insurance is the main component of ARCH and its implementation is the most advanced. It replaces exemption policies and also implies a reform of social security schemes for civil service and private sector workers. The scheme intends to exempt extremely poor people from contribution, as well as to partly subsidize the rest of the population living below the poverty line. In 2019, the government started a pilot phase in three health zones; Abomey Calavi/Sô-Ava, Dassa-Glazoué, Djougou-Ouaké-Copargo by identifying and testing the system on the poorest populations. The insurance is expected to be progressively expanded to the rest of the population and become fully operational by 2022.

³ Tracking Universal Health Coverage: 2017 Global Monitoring report <<http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf>>

⁴ Delphine Prady and Mouhamadou Sy, *The Spending Challenge for Reaching the SDGs in Sub-Saharan Africa: Lessons Learned from Benin and Rwanda* IMF Working Paper WP/19/270; December 2019)

⁵ Céline Deville, *Same objective, different paths: An analysis of Universal Health Coverage policies in Benin and Senegal* International Conference on Global Dynamics of Social Policy Social policy dynamics in (West and Central) Africa 25-26 October 2018, University of Bremen

⁶ Ibid

⁷ Ibid

⁸ Delphine Prady and Mouhamadou Sy, *The Spending Challenge for Reaching the SDGs in Sub-Saharan Africa: Lessons Learned from Benin and Rwanda* (IMF Working Paper WP/19/270; December 2019)

HISTORY ON ACCOUNTABILITY EFFORTS IN THE HEALTH SECTOR IN BENIN

To understand how the thinking around accountability in the health sector in Benin has evolved over time, it is important to provide a brief historical background, as follows.

A National Health Forum was convened in Benin in November 2007, bringing together 600 participants. The Forum enabled an in-depth assessment of the health sector context, and was used to formulate a number of recommendations which guided the design, in 2009, of the 10-year health sector development plan. The main issues identified related to governance in the health sector (poor performance, lack of leadership), poor quality of healthcare, inadequate infrastructure and equipment, and the need to incentivize human resources for health⁹.

Prior to this forum, there was hardly any accountability by healthcare workers and at health facilities. According to an internal World Bank Report¹⁰, absenteeism, corruption, dual job holding, drug pilfering, and unresponsiveness to patient needs were widespread, and sanctions were never enforced. Promotions and rewards were rare and had little relation to actual performance. The health facilities received limited resources from the government (about 22 percent of their annual recurrent costs), and these small amounts were mostly determined on a discretionary basis (which was not measured). Budgets, which were not comprehensive, were not clearly linked to evidence-based plans. Several directorates or vertical programs within the MoH prepared and implemented their own plans, without having them go through the national planning process, which had not yet been decentralized.

A related development was the creation of a joint Health System Strengthening (HSS) platform, following the signature, in November 2010, of the first “Compact” between the MoH and five donors within the framework of the International Health Partnership and related initiatives to implement Results-Based Financing (RBF) for the health sector in Benin. The HSS platform gathers the World Bank, the Global Fund GFATM, GAVI and the Belgian Development Agency (BTC) around the MoH, with support from the World Health Organization (WHO).

In order to enhance health system performance, the MoH was engaged in the preparation of three important reforms, notably (i) the implementation of a RBF mechanism to restore the accountability of health facilities and health workers; (ii) the reform of the Health Equity Fund (HEF) along with the implementation of a health care system to better identify the poorest and the development of a Universal Health Coverage scheme (“RAMU”), so as to increase financial accessibility to health services; and (iii) the revision of its planning, budgeting, and management processes, as well as the preparation of a Sector Wide Approach (SWAp) aimed at improving the allocative efficiency of the health budget.

In this context, the four main donors agreed on a geographical distribution of their HSS support so as to cover all the 34 health districts of the country: 8 were already supported by the World Bank and 5 by BTC; GAVI and the GFATM agreed to support respectively the 2 and 19 remaining districts. Other than the BTC model of RBF, all the other donors adopted a RBF model that relies on a project coordination unit for piloting, on an external firm for verification of results, and on community-based organizations for counter-verification¹¹.

An important feature of RBF in general is separation between the various functions of regulation, financing, purchase of services, service provision and data verification, thus creating a clear division of labor between each player and contributing to transparency. The BTC-supported model entrusted RBF coordination to a steering committee organized quarterly at departmental (provincial) level, consisting of representatives from the departmental health office, donors, mayors, civil society organizations (CSOs), health services users' platforms, the mutual health organizations' medical officer, and service providers. This committee was in charge of adapting the overall RBF approach to the local context, deciding on the level of RBF subsidies based on results checked through verification and counter-verification, and managing complaints.

Across both models of RBF implementation, it is reported that the attitude of healthcare workers changed and there were some improvements in service quality. However, what is not clear is whether health outcomes improved as a result. It has been noted that RBF is not a home-grown policy; it is donor-driven in Benin¹². In fact, it faced initial opposition from some former MoH top executives, and it is only after intensive lobbying from the World Bank (including workshops and study tours in Rwanda) that they finally bought the idea. However, ownership of RBF within and outside the MoH remains limited to a few people – and for a long time, only the World Bank approach had some kind of visibility outside the project coordination unit and a few top managers at MoH.

The World Bank report observes that even though the project had been very successful in implementing RBF at the health facility level, RBF had not been discussed as part of a comprehensive health financing strategy with the government. The health facilities in Benin have two parallel sources of funds—through the RBF, subsidies are sent to the health facilities and health workers, and government continues to pay salaries of staff and to send allocated budgets to the health facilities with no links to performance. There was a need to integrate the RBF into the government financial system; **RBF was not sufficiently anchored within a coherent and comprehensive reform approach (authors'**

⁹ Elisabeth Paul, Mohamed Lamine Dramé, Jean-Pierre Kashala, Armand Ekambi Ndema, Marcel Kounnou, Julien Codjovi Aïssan, Karel Gyselinck *Performance-Based Financing to Strengthen the Health System in Benin: Challenging the Mainstream Approach* Int J Health Policy Manage 2018, 7(1), 35–47

¹⁰ Report No: ICR00004222, IMPLEMENTATION, COMPLETION, AND RESULTS REPORT, The World Bank, May 31, 2018

¹¹ Elisabeth Paul, Mohamed Lamine Dramé, Jean-Pierre Kashala, Armand Ekambi Ndema, Marcel Kounnou, Julien Codjovi Aïssan, Karel Gyselinck *Performance-Based Financing to Strengthen the Health System in Benin: Challenging the Mainstream Approach* (Int J Health Policy Manag 2018, 7(1), 35–47

¹² Ibid.

emphasis).¹³

The new government came with a defined health agenda and perceived the RBF approach only as a distribution of bonuses to health staff. The government also had a policy of no “top-ups” to civil servants. Despite strong policy dialogue engagement from the Country Management Unit (CMU) and Health, Nutrition and Population (HNP) Practice Managers, with the Minister of Health and the Head of State, this view about performance payments did not change. The new government has had no financial stake in the RBF, and has made no efforts to put in place structures at the central level to promote and manage RBF. It is still too early to predict how far accountability mechanisms towards UHC will be operationalized under ARCH. The government has put in place mechanisms to operationalize ARCH under the Agence Nationale de l'Assurance Maladie, (ANAM).

Moreover, it is estimated that for Benin to reach its UHC targets it would need to spend about 9.3 percent of its GDP on health (US\$119 per capita) by 2030 compared to a current (2019) total spending on health equivalent to 4.2 percent of GDP (US\$33 per capita). This implies recruiting: (i) 8 times more doctors and (ii) 4 times more support staff than 2019¹⁴. This is based on current weak performance in health and what will be required to deliver the Assurance pour le renforcement du capital humain (ARCH) project's objective of providing universal health insurance scheme. This presents a strong case on the need for strong accountability mechanisms to ensure a gradual increase in health commitments for UHC in Benin.

¹³ Report No: ICR00004222, IMPLEMENTATION, COMPLETION, AND RESULTS REPORT, The World Bank, May 31, 2018

¹⁴ Delphine Prady and Mouhamadou Sy, *The Spending Challenge for Reaching the SDGs in Sub-Saharan Africa: Lessons Learned from Benin and Rwanda (IMF Working Paper WP/19/270; December 2019)*

CHAPTER 3:

MAPPING FINDINGS

This chapter presents the key findings on the status of accountability actors, stakeholders, approaches and tools in Benin. Overall, this discussion on the role of accountability in the health sector is timely given the renewed commitment to improve health service provision in the journey towards UHC in Benin. This follows President Patrice Talon's commitment under the 'Revealing Benin program', a roadmap for government action from 2016 to 2021 to transform the social and economic conditions in Benin. There is therefore a need to leverage this renewed political commitment to create 'space' for accountability which is one of the levers to ensuring success of the ARCH program.

That said, there is temptation to present the beneficiaries of the ARCH program as a whole new separate group of stakeholders. This is because this cohort of the population happens to be 'double marginalized' in terms of health seeking behavior and low literacy levels. This ultimately affects their 'confidence' in engaging other stakeholders such as health providers as well as those in leadership positions in the society. There is need to ensure that they are deliberately included in the UHC conversation by ensuring that they have the right information on the availability of health services as well as the health package under the ARCH program. There is also a need to think outside the box in reaching out to this unique cohort of the population in the way information is packaged as well as the channels and platforms provided to ensure effective participation in social accountability efforts.

ACTORS AND THEIR ROLE IN ACCOUNTABILITY

The presentation of the findings has been anchored on [Bovens'](#) ideology¹⁵ which provides a framework for the empirical study of accountability arrangements in the public domain. Under the framework, Boven's describes accountability as 'responsiveness' and 'a sense of responsibility', a willingness to act in a transparent, fair, and equitable way, 'the obligation to explain and justify conduct'. Boven goes further to explain that a relationship qualifies as a case of accountability when:

1. There is a relationship between an actor and a forum
2. in which the actor is obliged
3. to explain and justify
4. his conduct,
5. the forum can pose questions,
6. pass judgement,
7. and the actor may face consequences.

This study sought to identify these relationships, the obligations and how well these obligations are fulfilled by the actors toward the public.

Policymakers

Policymakers refer to members of parliament, department heads within the MoH, etc. who define vision, provide strategic orientations and guidance for health policies and strategies development, implementation, and assessment. Their role encompasses regulation and equity in resource allocation, promotion of transparency and citizen trust, oversight for effectiveness, actions that ensure government delivers on electoral promises.

- From the data analysis performed with information gathered from various sources, followings were the critical findings that emerged:
- There was a general appreciation of the role accountability could play in strengthening health service delivery in Benin.
- Health policy documents were in place; however, little emphasis was put on the 'how to' ensure accountability.
- Health committees were operating at different levels (primary facility catchment area, district) to promote accountability. However, they had limited capacity to voice vis-a-vis health providers, health zones manager.
- While several non-state actors were present to push for accountability, there were no clear sanctions for misuse or abuse of public resources.

Private sector actors

Private sector includes for profit and not for profit operators. They promote equity in health access, represent private sector interests in the policy dialogue. With regards to private sector contribution to accountability mechanisms, analysis of the data shows that:

- There was a limited inclusion of private sector actors in health policy formulation and implementation.
- Private sector actors reported intermittently but did not render account systematically on their contribution to provision of health services.

¹⁵ <https://www.ihs.ac.at/publications/lib/ep7.pdf>

- There was a limited oversight over private practice by health authorities at the different levels of the health system.

Public providers and health managers

This category is comprised of public personnel who run health facilities and catchment zones, ensure institutional capacity for quality health services, promote equity in access to health, track financial resources. As of providers and health managers engagement for accountability, informants and literature reported that:

- in Benin, health planning and performance review structures and tools were in place at health facility, communal and zonal levels.
- Providers and managers had limited capacity to use the tools and health data for decision making at the different review levels.
- Health providers controlled the information from the health facilities with little transparency to community members.
- Public actors emphasized on vertical accountability to supervisors but little appreciation for accountability to the community.
- Health managers had weak capacity to exercise supervision over health system stakeholders.

Academics and researchers

Academics and researchers constitute the cornerstone in evidence generation; their findings are meant to inform the formulation and implementation of accountability related policies. Key informants reported that academics and researchers were involved occasionally in health reforms, policy formulation and implementation but not systematically despite the fair amount of knowledge they were generating that could be useful for policymakers and implementers.

Civil Society Organisations (CSOs)

These are communities' members and include youth networks as well as women's CSOs. They represent citizen interests to duty bearers, have the purview to ensure provision of quality health services to the community members and look after electoral promises are fulfilled. Key informants and literature shared that:

- Most CSOs with stakes in the health sector were invited to health committees at decentralised levels during health policy formulation. However, there was need for greater involvement in pushing for accountability during these processes.
- CSOs were mainly involved in health education and promotion at the local levels with limited focus on accountability.
- Media especially local radios were a trusted platform for pushing for accountability amongst community members.
- There was little appreciation of the role of CSOs in promoting social accountability to improve the quality of health services and general lack of awareness amongst CSOs on their potential to enhance social accountability.

Recommendations

Informants articulated also recommendations that would support and strengthen their contribution for greater accountability mechanisms being used with the Benin health system.

TABLE 2 : RECOMMENDATIONS FOR ACCOUNTABILITY ACTORS' ENGAGEMENT

Accountability actors	Recommendations
Policy makers	<ul style="list-style-type: none"> • Promote none state actors' inclusion in the policy dialogue • Strengthen capacity of health committees • Promote transparency and citizen trust through feedback and access to information. • Roll out existing policy documents and accountability tools e.g. hotlines • Develop unique approaches for marginalised populations' engagement in accountability activities
Private sector actors	<ul style="list-style-type: none"> • Include the private sector in UHC policy formulation to promote equity and financial protection. • Strengthen oversight for the private sector.
Public providers and health managers	<ul style="list-style-type: none"> • Strengthen data management for informed decision making • Sensitize and train on processes and tools for transparency and equity • Strengthen accountability to community members by activating the health committees COGECES. • Leverage technological innovation to strengthen oversight, reporting and feedback • Detect and sanction malfeasance
Academics and researchers	<ul style="list-style-type: none"> • Promote the inclusion of actors from academia and research in the health policies formulation
Civil Society Organisations (CSOs)	<ul style="list-style-type: none"> • Sensitize CSOs on policy documents for accountability during health policies and strategies' implementation. • Train CSOs in social accountability in order to represent the interests of citizens to duty bearers • Harness the demographic dividend of young people to promote accountability. • Strengthen accountability capacity of youth, women, and people living with disability. • Create 'safe spaces' such as media and community dialogue platforms such as the Comité de Gestion du Centre de Santé (COGECES) for meaningful representation of community interests to duty bearers.

ACCOUNTABILITY APPROACHES AND TOOLS

Accountability-enhancing activities can be regrouped into three general categories¹⁶ : financial, performance and political. Financial accountability deals with compliance with laws, rules, procedures/standards regarding financial resources allocation, disbursement, and utilization. Performance accountability refers to measurement and evaluation, and service delivery improvement in light of agreed-upon performance targets. Political accountability consists in ensuring that government delivers on electoral promises, fulfils the public trust, aggregates, and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns.

From the study, a number of tools and strategies that have been employed in Benin to promote accountability in the health sector were identified. These tools and strategies are outlined in the table below.

TABLE 3 : ACCOUNTABILITY APPROACHES USED IN BENIN

Type of accountability	Accountability approaches
Performance	<ul style="list-style-type: none"> • Toll-free call service • Participatory policy formulation • Suggestion and complaints Boxes • Health committees • Public media channels such as radio • Results Based Financing
Political	<ul style="list-style-type: none"> • Participatory policy formulation • Public hearings
Financial	<ul style="list-style-type: none"> • Health committees • Results Based Financing

Toll-free call service

A toll-free line has been provided by the MOH as a means of collecting feedback from users to improve health service delivery. One of the respondents in the study noted that *"If you enter Glazoué today, you will see that I have put up three posters to be called at each unit that offers paid services. Whether it's the lab, the clinic, the maternity ward. You'll see that I've been posting this all over the place. So far, we've already done more than two months we've never been called up and yet there are bad practices"* (Doctor at the Dassa and Glazoué health zones). At the time of the study, very low uptake of the toll-free service was reported.

Participatory policy formulation

This entails direct inclusive participation of stakeholders, civil society and citizens in the formulation of public policy. At the time of the study, this was mostly achieved through technical working groups under the leadership of the MoH at the National level. While most of the stakeholders reported involvement during policy formulation, some such as the community mutuelle and the private sector representatives had not been involved in the design and implementation of the ARCH program. CSOs also reported limited involvement during policy implementation.

Public hearings

This is a forum intended to promote broader public engagement through citizens' forums and public dialogues. It was noted that public hearings were utilized during the ARCH program beneficiary identification by the social services department as well as in creating citizen awareness on the ARCH program. There has been good utilization of public hearings to create citizen awareness on health priorities in the country.

Health committees

Health committees promote horizontal accountability and exist at the health facility, commune and zonal levels of the health system with membership drawn from health management team at respective levels, CSO representatives, development partners and the private sector. They largely serve as a multi-sectoral review, information-sharing and program coordination platform. While most of the meetings were held on a regular basis, the attendance was irregular, due to staff shortages, data used in these forums was most often delayed or unreliable.

Suggestion and complaints Boxes

These are locked wooden or metal boxes located within health facility into which clients can express sensitive and anonymous complaints. The boxes were mainly located strategically in health facilities with the health facility in charges holding the key to the suggestion boxes. During the study, it was noted that their effectiveness remained low especially because of the low literacy levels as well as the unfortunate mentality of 'the health worker knows it all'.

Public media channels such as radio

Community radios were utilized for health education, creating awareness on health priorities such as the ARCH program, emerging diseases such as well as for issue resolution due to anonymity provided by the radio. Radios provide a voice and platform to individuals and communities who might otherwise be voiceless and in the process, they improve transparency. This tool provides anonymity to the community member and gives flexibility to use local languages especially in regions with low literacy levels.

¹⁶ Brinkerhoff, Derick. January 2003. *Accountability and Health Systems: Overview, Framework, and Strategies*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Results Based Financing

Results-Based or performance-based Financing is an approach that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered¹⁷. In Benin, RBF was launched in 2012 through a World Bank-supported project and later by the BTC through a HSS project. Findings suggest that RBF strengthened various aspects of the health system performance and led to modest progress in utilization of health services and healthcare quality. However, verification procedures & challenges resulted in delays in bonus payment, which delinked effort and reward¹⁸.

Recommendations

Followings are recommendations formulated by the accountability stakeholders. They esteemed that these actions would strengthen accountability approaches being used with the Benin health system.

TABLE 4 : RECOMMENDATIONS FOR ACCOUNTABILITY ENHANCEMENT IN BENIN

Accountability approaches	Recommendations
Toll-free call service	Use of toll-free lines to promote accountability must take into account the implementation context and the activities needed to influence the mechanisms of social responsibility (e.g. information provision, citizen action, and state response). It is therefore critical that adequate citizen awareness is provided on the hotline service for increased uptake.
Participatory policy formulation	There is need for inclusive stakeholder engagement in the dialogue platforms and sufficient citizen awareness during design and implementation of policy.
Public hearings	There is need to ensure deliberate targeted involvement of the most vulnerable such as the differently abled persons as well as the poor and very poor targeted by the ARCH program. Effective communication approaches should also be utilized to ensure an inclusive dialogue for all stakeholders involved.
Health committees	It is recommended to increase the capacity of the health workers for data management to ensure clean and reliable data can inform decision making at each of the health committees.
Suggestion and complaints Boxes	It is recommended that the COGECS get engaged to create awareness on this accountability tool for community members who are able to utilize it.
Public media channels such as radio	This approach is the preferred channel for mass media sensitization given its accessibility and ability to use local languages given the low literacy levels. Radio personalities serving in the community radio stations should be supported to strengthen citizens' capacity in accountability.
Results Based Financing	There is continued investment on this approach by other donors such as the Global Fund, USAID as well as the Belgian cooperation. It is critical to integrate RBF within the normal functioning of local health systems, in line with other reforms. This will ensure that the system is not seen an additional function of the health managers and health providers. It will also ensure that focus remains on provision of quality health services and not so much in the verification procedures.

COMPLEMENTARY LITERATURE REVIEW

A literature review of the policy documents before the data collection exercise revealed that a reimbursement mechanism to health facilities has been put in place which involves verification of the care sheets by an independent structure other than the ARCH Program Monitoring Unit. This is intended to ensure transparency in the management of funds. Failure to adhere to the requirements may result in no reimbursement for the health center. A system has also been put in place to ensure continuous updating of the database of ARCH beneficiaries to ensure that the program continuously reaches the real beneficiaries. However, little emphasis has been put on the need for citizen involvement in promoting accountability for the ARCH program at local and national levels. At the global levels, however, Benin is one of two African countries taking part in a costing exercise on the financing needed to achieve the SDGs in education, water and sanitation and health. In 2017, Benin published its first Voluntary National Review (VNR) of the SDGs in New York. This shows a level of transparency in its commitment to meeting some of the SDG targets, especially those on health.

Findings from the mapping exercise revealed that the government has developed policy documents to guide ARCH implementation and sensitization of the stakeholders including the citizens at the four pilot sites on the ARCH program. Sensitization of stakeholders ensures that the duty bearers are made aware on the expectations and the citizens know their rights and what to expect from the duty bearers. It therefore becomes possible to hold the duty bearers accountable to their obligations. Some of these policy documents for the ARCH program are highlighted in the Figure 4 below.

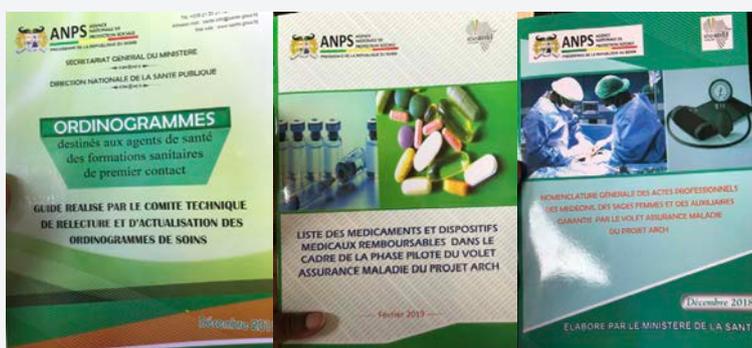


Figure 4: Sample ARCH policy documents

¹⁷ Witter S, Toonen J, Meessen B, Kagubare J, Fritsche G, Vaughan K. Performance-based financing as a health system reform: mapping the key dimensions for monitoring and evaluation. *BMC Health Serv Res.* 2013; 13:367. <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-367>.

¹⁸ Exploring implementation practices in results-based financing: the case of the verification in Benin. Matthieu Antony, Maria Paola Bertone & Olivier Barthes. *BMC Health Services Research* volume 17, Article number: 204 (2017)

CHAPTER 4:

RECOMMENDATIONS FOR ENHANCING ACCOUNTABILITY

This chapter provides a summary of the key recommendations informed by the interactions with the key stakeholders during the study for strengthening accountability in Benin. The obstacles and enablers influencing success of the existing accountability efforts have been taken into consideration in presenting these recommendations.

LESSONS AND OPPORTUNITIES FOR STRENGTHENING ACCOUNTABILITY FOR UHC IN BENIN

From the analysis, a number of issues and trends are discernible. Below, each of these recurrent issues and trends is discussed briefly and opportunities for strengthening accountability for UHC highlighted.

1. President Patrice Talon's has committed, under the 'Revealing Benin program', a roadmap for government action from 2016 to 2021 to transform the social and economic conditions in Benin. There is need to leverage this renewed political commitment to create 'space' for accountability which is one of the ways of ensuring success of the ARCH program.
2. The MoH along with other stakeholders have developed the 'Manuel de procedures de mise en place et de fonctionnement des organes de gestion (comite de gestion des centres de sante et comite de sante de la zone sanitaire'. The manual contains procedures for setting up and operationalizing health management committees (health center management committees and health committees of the health zone). These committees are critical in promoting performance accountability in health service delivery. It is critical that the stakeholders who sit in the different health committees are sensitized and trained on the manual to standardize and improve the operations of the health committees. This will ultimately strengthen performance accountability at every level of the health system.
3. From the study findings, health seeking behavior and citizen awareness on their health entitlements are still very weak in Benin, especially in the rural areas where the bulk of the population designed to benefit from ARCH lives. The key issues are the delayed access to health services, the lack of motivation of the health workforce, and a general poor quality and provision of services. It has been argued that improving accountability for UHC requires transparency in terms of people's understanding of their entitlements (rights) and their obligations with regard to health service use, as well as the extent to which these are realized in practice. Marginalized citizens such as those targeted in the ARCH program rely on intermediaries to access health information and to channel their concerns to service providers. The civil society and the COGECs are a trusted link between the community and the formal health system in Benin and therefore present a good opportunity for community engagement especially in promoting citizen awareness. At the moment, the institutional capacity and opportunity offered by COGECs is yet to be fully exploited. Capacity strengthening of these stakeholders on accountability and supporting them to engage the community members would greatly enhance the community's participation in accountability efforts. This engagement with the community could be done through public gatherings, door to door visitations and accountability sessions with the duty bearers. The government should also provide resources to support the operations of the COGECs because as one member noted; "When people say they want to elect the members of the COGECs, many are interested.' I want to be president, I want to be secretary, I want to be a candidate.' A lot of people are interested. But when we finish the elections, we train them on their roles and responsibilities, sometime later, people start to withdraw simply because they have not found the consequent benefits they expected. So it's a challenge for us" (Zonal Health Center coordinator).
4. In 2018, UNESCO reported that adult literacy rate for Benin was 42.4 % against a global average of 86%¹⁹. Unfortunately, technology design tends to consider the needs of those who are fully literate in all domains and similarly skilled, while those who need additional support to make use of a technology are frequently underserved and excluded²⁰. This implies that reliance on modern channels of technology use may not favor the illiterate population in Benin, the same population that is in dire need for inclusion in access to health services. A study covering twenty countries in Africa found that radio broadcasting dominates the mass media spectrum mainly because it's cheap, easy to use and readily available²¹. This mapping is aligned to this finding given that most respondents reported that the radio is the main source of health information in Benin. The journalists interviewed in the study from the community radio organizations reported the willingness to provide a 'safe space' for the community members to facilitate issue resolution for grievances following visits to the health facility. Providing support to the community radios to go beyond health education and into promoting transparency in their programming would go a long way in creating citizen awareness on their health entitlements and consequently their engagement in accountability efforts at the community level.

¹⁹ Fact Sheet No. 45 September 2017 FS/2017/LIT/45

²⁰ Encyclopedia of Information Science and Technology, Fourth Edition edited by Khosrow-Pour, D.B.A., Mehdi, 2011)

²¹ African Media Development Initiative (AMDI). Research summary report (BBC world service trust 2006)

5. For citizens to raise their concerns, they need not only information about their entitlements, but also an accessible 'interface' where they can engage with the duty bearers. A hotline or messaging service enables citizens to lodge concerns or complaints at a distance and sometimes anonymously. The Benin government introduced a hotline service to serve as an interface through which community members can provide feedback on the quality of health services. However, a key theme in the literature is that poor and vulnerable citizens tend to prefer face-to-face and informal interfaces over more formal ones that depend on written communications or access to technology²². Indeed, one of the respondents in the study noted that *"If you enter Glazoué today, you will see that I have put up three posters to be called at each unit that offers paid services. Whether it's the lab, the clinic, the maternity ward. You'll see that I've been posting this all over the place. So far, we've already done more than two months we've never been called up and yet there are bad practices"* (Doctor). It's therefore recommended that either the government provides citizen awareness on the hotline service or avails public spaces where the citizens can engage their duty bearers directly or through their intermediaries for strong accountability within the health system.
6. Community mutuelles have accumulated institutional learning from the implementation of community insurance schemes in select regions in Benin. This experience could benefit implementation of the ARCH program. It is always difficult and expensive to innovate from scratch, particularly in resource-constrained environments where resources need to be used efficiently. Granted, the community mutual insurance schemes do not target the extremely poor, but they nonetheless have learning that could be useful for the government in the planned scale up of the ARCH program in Benin. ARCH will need to learn from existing models, both those that have worked, but also from those that have not. As noted already, developing new innovations is time consuming and expensive. Learning from RBF as well as the community mutuelle schemes can shorten the learning curve and inject efficiencies in the scale-up.
7. While most of the stakeholders reported involvement during policy formulation, some such as the community mutuelle schemes and private sector representatives were not involved in the design and implementation of the ARCH program. Civil society also reported limited involvement during policy implementation. To advance UHC, there's need for inclusive stakeholder engagement in the dialogue platforms and sufficient citizen awareness during design and implementation of policy. Youth, women, and people with disabilities need to be part of the conversation on UHC accountability, yet from the interviews, this cohort of the population is largely uninvolved. There are promising opportunities of community engagement, which civil society could leverage to anchor community participation in UHC accountability.



Figure 5: Poster depicting the hotline for feedback on health services

CONCLUSION

Benin is currently involved in the roll out of the pilot phase of the ARCH program. It is therefore recommended that these findings are considered in the design of the scale up phase of the ARCH program in Benin. Strengthening and capitalizing on specific accountability tools and approaches such as the hotline and service charters that are already in use could go a long way in ensuring that previous efforts are adapted to improve their effectiveness so they can contribute to advancing UHC. Deliberate focus on accountability in the design of policy documents, guidelines and standards will ensure that accountability is put to the fore front and therefore gains prominence during roll out of policies and strategies aimed at reaching UHC. This would require that accountability stakeholders are brought to the table and are fully involved during design and implementation of the health policy documents and guidelines.

ANNEXES:

DATA COLLECTION TOOLS

KII FOR ACCOUNTABILITY MAPPING EXERCISE CSOS, YOUTH & WOMEN GROUPS AND NETWORKS ETC.

Thank you for agreeing to participate in the study. The interview contains a series of questions on processes that boost local cooperation between national and local governments, health service providers and citizens/users in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Focus areas, membership etc.
 - c. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Have you heard of Universal Health Coverage? Is UHC a priority in your country? Have you been sensitized on UHC?
 - b. Do you contribute to development of policy documents to ensure that your CSO/Group/Network focus areas are included in health policy? If yes, how?
 - c. What platforms do you use to advance your agenda at the different levels?
 - d. Are there any achievements? In your opinion, what's the role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC
 - a. Are there accountability elements to the work that you are doing?
 - b. Could you briefly describe the accountability activities you are involved in? (examples of potential answers - Citizen/CSO/Youth-led anti-corruption campaigns, policy documents, self-policing, codes of conduct, performance contracts, performance audits, parliamentary oversight etc.).
 - c. What do these activities aim to achieve?
 - d. Are these activities supported through any form of funding?
 - e. How long have these activities been going on?
 - f. Is there any documented evidence on these activities' existence? Could you refer us to these?
 - g. If relevant, what engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they?
 - h. Who or what is the focus of these accountability activities? (Probe to determine what category the efforts lie in vertical/horizontal/performance accountability/financial accountability etc.).
 - i. Are there any tools or specific approaches that are being used to promote accountability? Examples of potential answers - Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
 - j. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
 - k. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
 - l. At what levels of the health system or policy arena are these collaborative engagements most predominant? What explains this?
 - m. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health advocacy?
 - b. How credible is the evidence? Please briefly explain the reasons for saying so.
 - c. How easy is it for you to acquire the evidence you use?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. Could you describe the common processes, approaches, strategies and/or platforms being used?
 - b. In your own assessment, how effective are the current processes, approaches and strategies?
 - c. What needs to be done differently to fast track greater accountability towards UHC?
 - d. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - e. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE

HEALTH SERVICE PROVIDERS

Thank you for agreeing to participate in the study. The interview contains a series of questions on processes that boost local cooperation between national and local governments, health service providers and citizens/users in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Focus areas, membership etc.
 - c. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Have you heard of Universal Health Coverage? Is UHC a priority in your zone/commune? Have you been sensitized on UHC?
 - b. Do you contribute to development of policy documents? If yes, how?
 - c. Are you involved in ensuring accountability during policy implementation? E.g are you sensitized on the new policies? Are you allowed to provide feedback on your views during policy implementation? What dialogue platforms are provided for this kind engagement?
 - d. Are there any UHC achievements?
3. Accountability efforts you are involved in for health/UHC
 - a. When you hear the word accountability, what comes to mind?
 - b. Could you briefly describe the common accountability processes, approaches, strategies and/or platforms being used? (examples of potential answers – engagement or participation in COGECS, Local authority platforms, Citizen/CSO/Youth-led anti-corruption campaigns, policy documents, self-policing, codes of conduct, performance contracts, performance audits, parliamentary oversight etc.).
 - c. Are these activities supported through any form of funding?
 - d. Is there any documented evidence on these activities' existence? Could you refer us to these?
 - e. If relevant, what engagement platforms/networks exist to strengthen your accountability efforts at the different levels you engage in?
 - f. Who or what is the focus of these accountability activities? (Probe to determine what category the efforts lie in vertical/horizontal/performance accountability/financial accountability etc.).
 - g. Are there any tools or specific approaches that are being used to promote accountability? Examples of potential answers - Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
 - h. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
 - i. In your opinion, do you think the citizens are aware of their right to quality health care? Please explain your answer.
 - j. In your opinion, do you think that if the citizens could influence the quality of care through accountability?
 - k. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
 - l. At what levels of the health system or policy arena are these collaborative engagements most predominant? What explains this?
 - m. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health advocacy?
 - b. How credible is the evidence? Please briefly explain the reasons for saying so.
 - c. How easy is it for you to acquire the evidence you use?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. In your own assessment, how effective are the current processes, approaches and strategies?
 - b. What needs to be done differently to fast track greater accountability towards UHC?
 - c. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - d. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE

MEDIA

Thank you for agreeing to participate in the study. The interview contains a series of questions on processes that boost local cooperation between national and local governments, health service providers and citizens/users in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Focus areas, membership etc.
 - c. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Have you heard of Universal Health Coverage? Is UHC a priority in your country? Have you been sensitized on UHC?
 - b. Are there any achievements? In your opinion, what's the role of accountability in achieving UHC?
 - c. Under the 'Revealing Benin' programme, health insurance has been identified as one of the key interventions to improve social protection of the poor and vulnerable citizens. In your opinion, is there any role of the media in the programme?
 - d. Have you been sensitised on the programme?
 - e. Do you contribute to development of policy documents to ensure that the role of the media is included in health policy? If yes, how?
3. Accountability efforts you are involved in for health/UHC
 - a. Health has been declared a human right by WHO as well as the constitution in Benin, what does this mean to you?
 - b. In your opinion, is there citizen awareness in on their right to health? Do you see any role for the media in improving citizen awareness on their right to health?
 - c. How does the media gain knowledge on health matters and priorities in the country?
 - d. Are there deliberate efforts to sensitize media practitioners on health strategies and priorities?
 - e. Are there platforms provided where the media contributes to the health agenda in the country?
 - f. In your opinion, is there a role for the media in influencing health priorities in the country?
 - g. In your opinion, how informed is the general population on health matters?
 - h. Is the general population aware of their roles and responsibilities to accessing quality health care?
 - i. In your opinion, what does accountability in health service provision mean?
 - j. Are there any efforts by the media to promote accountability in health? Could you briefly describe the accountability activities you are involved in? (examples of potential answers –radio and TV programmes highlighting health issues, Citizen/CSO/Youth-led anti-corruption campaigns, contribution to policy documents, etc.).
 - k. What do these activities aim to achieve?
 - l. Are these activities supported through any form of funding?
 - m. How long have these activities been going on?
 - n. Is there any documented evidence on these activities' existence? Could you refer us to these?
 - o. If relevant, what engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they?
 - p. Are there any tools or specific approaches that are being used by the media to promote accountability?
 - q. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
 - r. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
 - s. At what levels of the health system or policy arena are these collaborative engagements most predominant? What explains this?
 - t. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health advocacy?
 - b. How credible is the evidence? Please briefly explain the reasons for saying so.
 - c. How easy is it for you to acquire the evidence you use?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. Could you describe the common processes, approaches, strategies and/or platforms being used?
 - b. In your own assessment, how effective are the current processes, approaches and strategies?
 - c. What needs to be done differently to fast track greater accountability towards UHC?
 - d. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - e. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE

PRIVATE SECTOR INVOLVEMENT

Thank you for agreeing to participate in the study. The interview contains a series of questions on processes that boost local cooperation between national and local governments, health service providers and citizens/users in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Focus areas, membership etc.
 - c. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Have you heard of Universal Health Coverage? Is UHC a priority in your country? Have you been sensitized on UHC?
 - b. Do you contribute to development of policy documents to ensure that your CSO/Group/Network focus areas are included in health policy? If yes, how?
 - c. What platforms do you use to advance your agenda at the different levels?
 - d. Are there any achievements? In your opinion, what's the role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC
 - a. Are there accountability elements to the work that you are doing?
 - b. Could you briefly describe the accountability activities you are involved in? (examples of potential answers - Citizen/CSO/Youth-led anti-corruption campaigns, policy documents, self-policing, codes of conduct, performance contracts, performance audits, parliamentary oversight etc.).
 - c. What do these activities aim to achieve?
 - d. Are these activities supported through any form of funding?
 - e. How long have these activities been going on?
 - f. Is there any documented evidence on these activities' existence? Could you refer us to these?
 - g. If relevant, what engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they?
 - h. Who or what is the focus of these accountability activities? (Probe to determine what category the efforts lie in vertical/horizontal/performance accountability/financial accountability etc.).
 - i. Are there any tools or specific approaches that are being used to promote accountability? Examples of potential answers - Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
 - j. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
 - k. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
 - l. At what levels of the health system or policy arena are these collaborative engagements most predominant? What explains this?
 - m. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health advocacy?
 - b. How credible is the evidence? Please briefly explain the reasons for saying so.
 - c. How easy is it for you to acquire the evidence you use?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. Could you describe the common processes, approaches, strategies and/or platforms being used? Have you heard of the PASCom program? How about COLOSS?
 - b. In your own assessment, how effective are the current processes, approaches and strategies?
 - c. What needs to be done differently to fast track greater accountability towards UHC?
 - d. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - e. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE

ANAM

Thank you for agreeing to participate in the study. The interview contains a series of questions on participation in processes aimed at boosting cooperation between national and decentralised government units, health service providers and citizens/users in such a way as to support public service providers to improve their performance. We would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Is UHC a priority in your country? Are there attempts to develop policy documents and sensitization to provide direction in achievement of UHC in your country? Provide examples.
 - b. Are there any achievements so far?
 - c. Under the 'Revealing Benin' programme, health insurance has been identified as one of the key interventions to improve social protection of the poor and vulnerable citizens. What's the role of this department in the programme?
 - d. Are there any accountability mechanisms being put in place to promote success of the programme?
 - e. Do you see any role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC – Health planning and forecasting
 - a. Health has been declared a human right by WHO as well as the constitution in Benin, what does this mean to you? Are the citizens aware of this right?
 - b. Benin builds on existing health insurance initiatives including health mutual to ensure universal health coverage for the population. What accountability mechanisms have been put in place to ensure that those under the programme are able to receive the quality care they deserve and that there are avenues to engage duty bearers to improve quality of service? (probe for service charters, satisfaction surveys, role of VHC, CSO watchdogs, etc.)
 - c. What policy documents have been developed to guide implementation of the ARCH programme? Are you able to share these?
 - d. In your opinion, are there accountability mechanisms built in the policy documents and guidelines to keep the duty bearers (health providers, health managers etc.) accountable to the beneficiaries? Please give examples (Probe for policy documents, performance contracts, performance audits, review sessions, satisfaction surveys etc.)
 - e. Have all stakeholders been sensitized on the policy documents and guidelines?
 - f. What did they aim to achieve? What were some of the successes of these mechanisms?
 - g. In your opinion, do you see the role of accountability in improving success of the ARCH programme?
 - h. What considerations should we make in reviewing the pilot phase to ensure that accountability is built in the scale up phase?
 - i. What stakeholder engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they? Do you see any role for Community Health Support Program (PAScom) which is responsible for health system local component (CoLoSS)? How about CSO networks?
 - j. Do we have a desk within your department in charge of accountability? Would this approach ensure that accountability is brought to the fore front in implementation of health strategies?
 - k.
 - l. Are there any actors (donors, partners, academic institutions etc.) working with your office to promote accountability in financial protection of citizens? If yes, name some of them and highlight areas of intervention
 - m. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health planning?
 - b. How does information flow on the HMIS (SNIGS)? How reliable is the data on the system?
 - c. Is there a feedback mechanism to the peripheral and intermediate levels on the quality of evidence/data being shared?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. What accountability considerations will we need to put in place to ensure successful scale of the ARCH programme?
 - b. What needs to be done differently to fast track greater accountability towards UHC?
 - c. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - d. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE

DEPARTMENT OF PLANNING AND FORECASTING

Thank you for agreeing to participate in the study. The interview contains a series of questions on participation in processes aimed at boosting cooperation between national and decentralised government units, health service providers and citizens/users in such a way as to support public service providers to improve their performance. We would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
 - a. Name and occupation and role in the health sector
 - b. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
 - a. Is UHC a priority in your country? Are there attempts to develop policy documents and sensitization to provide direction in achievement of UHC in your country? Provide examples.
 - b. Are there any achievements so far?
 - c. Do you see any role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC – Health planning and forecasting
 - a. Health has been declared a human right by WHO as well as the constitution in Benin, what does this mean to you? Are the citizens aware of this right?
 - b. How would you describe accountability in the work that you are doing?
 - c. The National Health Development Plan (2009-2018) has just come to an end. How would you rate the impact of the plan?
 - d. What accountability mechanisms had been put in place to ensure that the implementation of the plan is successful? (Probe for policy documents, performance contracts, performance audits, review sessions etc.)
 - e. What did they aim to achieve? What were some of the successes of these mechanisms?
 - f. Are there any tools or specific approaches that are being used to promote accountability? Examples of potential answers - Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
 - g. Accountability was not strongly represented in the just concluded plan; do you think having an emphasis on accountability would have improved the impact of the plan?
 - h. Have we begun working towards the 2019-2028 NHDP? Who are the stakeholders involved in its development? What does the process look like?
 - i. What considerations if any will be made to ensure that accountability is included in policy documents moving forward?
 - j. Are all stakeholders sensitised on their role in implementation of the plan? Do we have a desk within your department in charge of accountability? Would this approach ensure that accountability is brought to the fore front in implementation of health strategies?
 - k. Is there a deliberate plan to include citizen voices in development of the plan? Are there any platforms provided to gather citizen views on the NHDP?
 - l. One of the approaches proposed to promote accountability in the 2009-2018 national health and development plan is Organizing sessions of populations sensitization to the content of policy documents associations of clients of health facilities, one session per district per year. How would you assess the impact of this approach? How active were they? Was it a success? What platforms are available for citizen engagement at the decentralised levels?
 - m. Are there any actors (donors, partners, academic institutions etc.) working with your office to promote accountability in health service provision? If yes, name some of them
 - n. What stakeholder engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they? Do you see any role for Community Health Support Program (PAScom) which is responsible for health system local component (CoLoSS)?
 - o. Who or what is the focus by these activities? (Probe to determine what category the efforts lie in vertical/horizontal/performance accountability/financial accountability etc.).
 - p. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
 - a. How and where do you acquire the evidence you need for health planning?
 - b. How does information flow on the HMIS (SNIGS)? How reliable is the data on the system?
 - c. Is there a feedback mechanism to the peripheral and intermediate levels on the quality of evidence/data being shared?
 - d. How do you process and utilize the evidence?
 - e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?

5. Additional efforts for health/UHC accountability in the spaces where you are active
 - a. Under the 'Revealing Benin' programme, health insurance has been identified as one of the key interventions to improve social protection of the poor and vulnerable citizens. What's the role of this department in the programme? Are there any accountability mechanisms being put in place to promote success of the programme?
 - b. What accountability considerations will we need to put in place to ensure the success of the scale of the ARCH programme?
 - c. What needs to be done differently to fast track greater accountability towards UHC?
 - d. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
 - e. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.