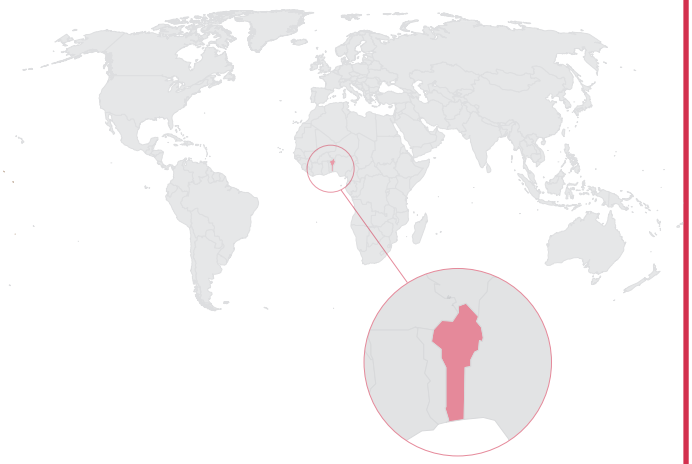
CRC 1342 | No. 38

Social Policy Country Briefs

Benin



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Global Dynamics of Social Policy CRC 1342
DFG Deutsche Forschungsgemeinschaft

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The Health Care System in Benin
CRC 1342 Social Policy Country Briefs, 38
Edited by Mai Mahmoud, Gabriela de Carvalho, and Achim Schmid
Bremen: CRC 1342, 2024

SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term care as a new social risk

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[DOI https://doi.org/10.26092/elib/2835]
[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft
(DFG, German Research Foundation)
Projektnummer 374666841 – SFB 1342

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Content

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/benin/ (Accessed February 28, 2023)

- Sub-Region: Western Africa
- Capital: Porto-Novo
- Official Language: French
- Population size: 13,352,864 (2022)
- Share of rural population: 50 % (2022)
- GDP (current US$): 17.4 billion (2022)
- Income group: Lower-middle-income
- Gini Index: 37.8 (2018)
- Colonial period: Benin was colonised by France, from 1904 to 1959, gaining independence on 1st August 1960

Sources: Encyclopaedia Britannica, 2023; United Nations, 2023; World Bank, 2023a

2. Selected health indicators

Indicator	Benin	Global Average
Male life expectancy at birth (years)	58	61
Female life expectancy at birth (years)	61	74
Under-five mortality rate (per 1,000 live births)	84	38
Maternal mortality rate (per 100,000 live births)	523	223
HIV prevalence (% of population, ages 15-49)	0.8	0.7
Tuberculosis incidence (per 100,000 people)	53	134

Source: The World Bank (2023a)

3. Legal beginning of the system

Before independence, the health care system was created and implemented by colonial institutions, with health care provided for free. The colonial administration was responsible for the procurement of equipment, materials, and medication. Though they were assisted by local staff with limited training, only the colonizers and the local elite had access to this health care. After gaining independence in 1960, the country continued to operate under the inherited colonial health system. As a result, health care remained free but was predominantly accessible only to the local elite. Up until 1975, medical care was mainly provided by health workers with limited qualifications, supplemented by a few doctors who graduated from the medical school in Dakar.

4. Characteristics of the system at introduction

a. Organisational structure

At introduction, the health care system in Benin was decentralized. However, it was highly centralized in terms of implementation and operationalization of the decision and intervention. The main responsibility for health care was assumed by the central government, which took almost all decisions in terms of policy, planning, implementation, monitoring, evaluation, and outlook.

From 1970 to 1990, the health sector was organised in a three-tier pyramid, based on territorial division: (i) a peripheric level, which provided primary health care to the population, (ii) an intermediate or departmental level, which provided technical support to the health zones; and (iii) a central or national level, which provided strategic support to the departments (Republic of Dahomey 1966, 1974; People's Republic of Benin 1984)

In 1975, the Republic of Dahomey became a communist state and was renamed the People's Republic of Benin. With the start of this new era, international donors suspended their financing for health care. Subsequently, the country had to finance the health system with its own resources, a situation similar to most of the developing countries.

In this context, the 1978 Declaration of Alma-Ata, following the conference on primary health care, underlined the importance of primary health care to promote the access to quality health care for everyone. The implementation of this ambitious initiative failed. Although health care services slightly improved, the strong social inequality, inequity, and the choice of some elites to allocate the resources in their home places caused a high disparity in access to health care.

The health system which was financed by taxes faced severe difficulties. The international situation, economic and political crises, and the structural adjustment plan that Benin experienced deteriorated the situation of the public health sector. The inefficiency of the health system caused the concentration of resources in urban areas hospitals and the decline of cost efficiency in terms of the quality of health care services. Overall, this period was characterized by a high inefficiency of the health care system and the increase of the cost of treatments that become paid services.

The initiative of Bamako, launched in 1987, sought to rehabilitate primary health care. Benin was one of the two pilot countries of the initiative. The direct selling of medicines acquired for a low price to the consumers was thought to ensure a margin for the replenishment in medicine and the financing of health centres. Additionally, this was likely to favour creating new services and health care that would encourage community participation. This initiative enabled Benin to ensure certain essential generic medicines' availability and accessibility in rural areas. However, accessibility was chargeable for poor citizens, and sometimes, a very low quality of care was delivered.

The evaluation of this initiative showed that the health human resources (doctors, midwives, nurses, and related) sold the medicines to patients with the progressive development of a parallel market of non-controlled trading of medicines in the informal sector. Moreover, the persistence of social inequalities and inequities and the weak participation of communities has not improved access to health care. The health system stayed mixed and highly dominated by traditional medicine and the increase of private health institutions where illegal medicine was practiced.

The Bamako initiative shaped the HCS in the past. It ended the policy of free access to health care and services. The consequences are the recovery of health care costs. However, it has led to a significant increase in

vaccination coverage and the quality of care. Exemption for the poorest patients is provided for by law under the guise of free care for the indigent, with reallocation of public funds, but on the ground, access to care facilities for this type of patient has not been effective. A decrease in the rate of use of services has been observed overall. The principle of community participation is not effective (Knippenberg et al. 1997).

b. Coverage

Percentage of population covered by government schemes	Around 5% including i) civil servants and army ii) indigents Coverage is limited to eligible services of health care.
Percentage of population covered by social insurance schemes	This includes i) private insurance, ii) mutual health insurance and, iii) elites. They represent a very low percentage.
Percentage of population uncovered	Self-medication and payment out-of-pocket represent the largest percentage.

- Population group(s) entitled to receive services in the system: Indigents profile, civil servants, defence forces, workers/employees of regular companies and organizations
- Eligibility criteria: Civil servants, defence forces and workers/employees of regular companies and organizations have access to health insurance after their probationary period. Meet the criteria for indigence. This means that the person is extremely poor and lacks the basic resources for a normal life. Often the indigent lack not only money but homes. For this category of people, the hospital social services department is involved in their care. Prior to receiving free care, a preliminary assessment was carried out to confirm indigent status (Tizio and Flori 1997).
- Share of population coverage: About 5% of the population for certain services or health care. Around 36% of the population went to health centres and hospitals in 2001.

c. Provision in 2001 (earliest data available)

Physician inhabitant ratio	1:6,883
Nurse inhabitant ratio	1:2,472
Midwife women of childbearing age ratio	1:1,539
Number of hospital beds (total)	3,432

Source: Ministry of Health, Benin (2001: 113)

- Importance of inpatient and outpatient sectors: A total of 155,608 hospitalizations were recorded in 2001 with 851,813 days spent in hospital. The outpatient sector exists but is a very informal activity.
- Service package inclusion: Indigents can have access to a full package (medical consultation, by a physician, a nurse or a midwife, health care and services, medicines, and consumables available) if they meet the eligible criteria. Civil servants or defence forces benefit from 80 % of eligible services which often excludes access to medicines and consumables. For other employees, they benefit from private insurance cover 80-100% of the package according to the agreement. Concerning the private scheme, self-medication by using pharmaceutical medicine or phytotherapy depends on the wealth index of the patient. Around 10% of the needs of the population is covered by national health care or services package.

d. Financing

- In 1990, the budget allocated to the health department was 67,634,000 XOF and represented 3.7 % of the total annual budget. Individuals, families, friends, and diaspora contribution is estimated to 90 % of the health expenditure in 1990. Central government, private insurance, technical and financial partner (PTF) contribution is estimated to 10 % of the health expenditure in 1990 (Ministry of Health, Benin 2001: 113)

e. Regulation

- The Benin Ministry of Health insures the regulation or organization of the health care system. In terms of accreditation, the Benin Ministry of health has given private practice authorization, authorization to open private hospitals or pharmacies. The Orders of physicians and pharmacists accept the nominations for members.
- The Benin Ministry of Health and the insurance companies have decided upon the health services that were included in the benefit package.

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Decree No. 2018-149 of 25th April, 2018 on the creation, composition, powers, organisation and operation of the National Council for the Fight against HIV/AIDS, Tuberculosis, Malaria, Hepatitis, Sexually Transmitted Infections and Epidemics (Republic of Benin, 2018a).
Date the law was passed	2018
Date of *de jure* implementation	2028
Brief summary of content	The purpose of the law is to monitor, guide and coordinate the fight against HIV/AIDS, tuberculosis, malaria, hepatitis, STDs and epidemics in Benin (Republic of Benin, 2018a, CNLS-TP, 2018).
Population coverage	The whole population
Available benefits	The epidemiological system functions better than in the past. And the fight against HIV/AIDS, tuberculosis, malaria, hepatitis, STDs and epidemics has a multisectoral dimension. The emergency response plans are well-harmonised for epidemics. The mobilisation of Global Fund financing in Benin, is well coordinated. The performance of all projects and programmes is also monitored (Republic of Benin, 2018a).

b. Major reform II

Name and type of legal act	Government Law expressly prohibits health service staff from exercising the right to strike (Republic of Benin, 2018b).
Date the law was passed	5th October, 2018
Date of *de jure* implementation	5th October, 2018
Brief summary of content	The total duration of the strike may not exceed ten days in any one year, seven days in any one six-month period and two days in any one month. Whatever the duration of the work stoppage on any one day, it is considered to be a full day's strike (Republic of Benin, 2018b; Republic of Benin, 2022a).
Population coverage	Civil servants of the State and local authorities, as well as by the staff of public, semi-public or private establishments, with the exception of agents to whom the law expressly prohibits the exercise of the right to strike
Type of benefits	A high level of availability and presence of health human resources for all types of service and care, especially in public health facilities. (e.g. hospital care, outpatient services, pharmaceuticals, dental care...) (Republic of Benin, 2018b; Republic of Benin, 2022a).

c. Major reform III

Name and type of legal act	Law No. 2022-17 to 19th October 2022 amending Law No. 2020-37 of 3rd February 2021 on the protection of human health in the Republic of Benin (Republic of Benin, 2022b)
Date the law was passed	2020
Date of *de jure* implementation	2021

Brief summary of content	The purpose of the law is to organise the protection of personal health; - to define the restrictions imposed on citizens in the event of transmissible, non-transmissible, contagious or epidemic diseases; it applies to all persons living in the Republic of Benin or entering Beninese territory (Republic of Benin, 2022b).
Population coverage	Government, public establishments and local authorities should pay, in part or in full, the cost of taking out a health insurance policy covering the basic basket of care for the following target groups: » public sector employees, their spouses and dependent children; » employees of public establishments or non-commercial public bodies, their spouses and dependent children; » Beninese students residing in Benin and receiving a state allowance; » public-sector pensioners, their spouses and dependent children; » low-income private sector pensioners, their spouses and dependent children; » the extreme and non-extreme poor (Republic of Benin, 2022).
Available benefits	The following conditions are included in the basic package of treatments: trauma to the thoracic limbs, trauma to the pelvic limbs, cranial trauma, simple and complex obstetric fistulas, acute upper and lower respiratory infections in children, urinary tract infections in children, sepsis in children under five, bacterial skin infections in children under five, malaria, diarrhoea, infections in adults under medical care. The following services are also covered: general medical consultations, natural or assisted childbirth, caesarean section, haemorrhage during the third trimester of pregnancy and post-partum haemorrhage, hospitalisation for conditions in the basic care basket, laboratory tests for conditions in the basic care package, trauma surgery for conditions in the basic care basket, drainage of a superficial abscess, emergency care, resuscitation care, removal of foreign bodies in children under five years of age, as well as surgery for appendectomy, hernia repair, peritonitis repair, removal of urine retention, intestinal obstruction and burns. The cost of medical transport as part of a referral is also taken into account for benefits and conditions included in the basic package of care. 80% of the cost of consultations, treatment (excluding medication), diagnostic tests and hospitalisation for other conditions not included in the basic health care package is covered by the government for its employees and public sector pensioners, and by public establishments and local authorities for their employees, their spouses, and their dependent children (Republic of Benin, 2022).

6. Description of current health care system

a. Organisational structure

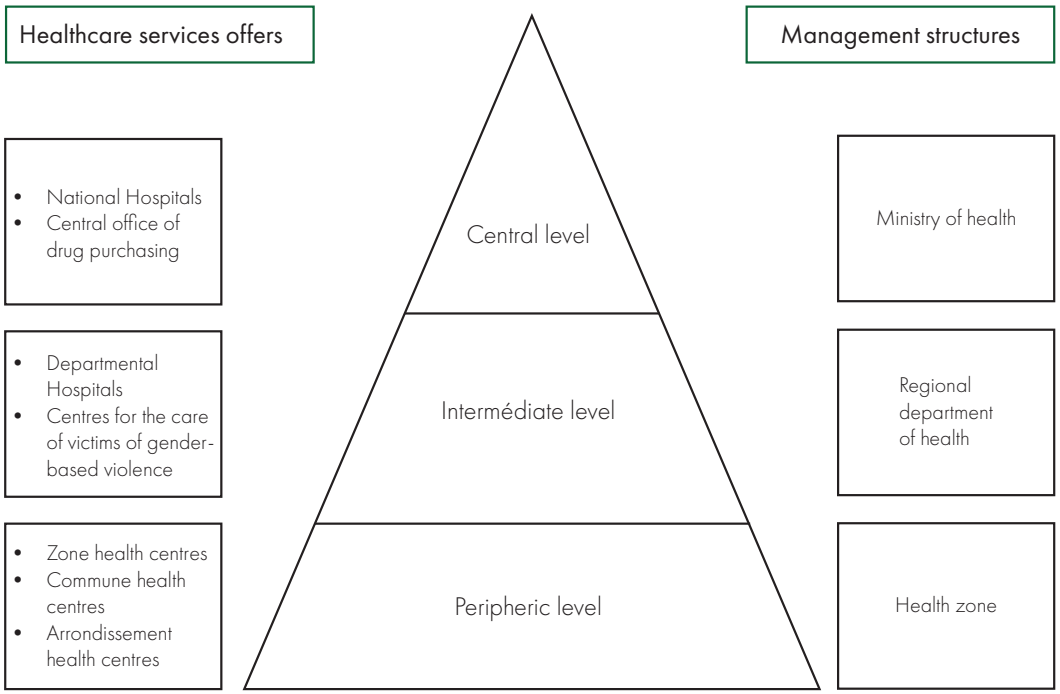
Currently, the Benin health care system is decentralized. However, it is highly centralized in terms of implementation and operationalization of the decision and intervention.

According to the institutional organization described into the Decree No. 2022 - 148 of 2nd March 2022, the health sector is organised in a three-tier pyramid, based on territorial division:

i. a peripheric level, represented by the health zones (ZS), which provide primary health care to the population including (Zone Hospital (HZ), University Zone Hospital (CHUZ), Health Centre (CS), HIV/AIDS care site, Private/church health facility, Tuberculosis screening and treatment centre, Leprosy and Buruli ulcer screening centre, Buruli ulcer, HIV voluntary testing centre (VCT)
ii. an intermediate or departmental level, which provides technical support to the health zones including Departmental University Hospital Centre, Departmental Hospital Centre, Centre for Information, Prospective Studies, Listening and for Advice (CIPEC), Leprosy Treatment Centre, Regional Buruli Ulcer Treatment Centre, Regional Pneumo-Phthisiology, Departmental Blood Transfusion Centre;
iii. a central or national level, which provides strategic support to the departments. This level includes:
   » National Hospital and University Centre (CNHU-HKM)/Armed Forces Training Hospital (HIA)
   » SAMU
   » Mother and Child University Hospital Lagune (CHU-MEL)
   » National Pneumo-Phtisiology Centre
   » National Psychiatry Centre
   » Centre for Integrated Medical Care for

» Infants and pregnant women with Sickle Cell Disease
» National Agency for Primary Health Care (ANSSP)
» National Agency for Quality Control of Health Products and Water
» Benin Pharmaceutical Regulation Agency (ABRP)
» Health Infrastructure, Equipment and Maintenance Agency (AISEM)
» Medical Aid and Emergency Agency
» National Blood Transfusion Agency (ANTS)
» National Agency for Quality Control of Health Products and Water (ANCQ)
» National Council for Primary Health Care
» National Council for Hospital Medicine
» National Ethics Committee for Health Research
» Associations of health professionals
» Beninese Society for the Supply of Health Products

Figure 1. Benin's health pyramid, 2022



Source: Ministry of Health, 2022.

» The main responsibility for health care is assumed by the central government (Ministry of Health), which takes almost all decisions in terms of policy, planning, implementation, monitoring, evaluation and outlook (Republic of Benin, 2021).
» Health care system segmentation: Upper-classes can access to Insurance or civil servant social protection. The poor are enrolled as indigents, most vulnerable people in ARCH project or used self-medication (Présidence de la république, 2023).
» Since 2016, the government of Benin has been successfully rolling out the Insurance for Human Capital Strengthening (ARCH) program, a project with several social components whose implementation will eventually allow vulnerable groups to be protected from poverty. This project consists of an integrated package of four services: health insurance, credit, training and retirement insurance. The first pilot phase of the Health Insurance component of Project ARCH began in July 2019.

b. Coverage

Percentage of population covered by government schemes	Around 20% including i) civil servants; ii) people who benefit from government ARCH programme (the most vulnerable); iii) indigents; iv) free caesarean intervention. Coverage is limited to certain services or health care.
Percentage of population covered by social insurance schemes	This includes i) private insurance, ii) mutual health insurance and, iii) Elites. These groups represent a very low percentage.
Percentage of population uncovered	In 2016 around 43% of the population remain uncovered and rely upon self-medication.

Source: Présidence de la république, 2023.

- Population groups entitled to receive services in the system: Citizens and the most vulnerable groups, civil servants, military, workers/employees of regular private companies and organizations (Présidence de la République, 2023).
- Eligibility criteria: Civil servants and workers/employees of regular private companies and organizations have access to health insurance after their probationary period. The vulnerable groups have access to health care as long as they were registered with the national agency of person identification (Présidence de la République, 2023).

c. Provision

Health Personnel

Benin has 7.8 qualified health personnel per 10,000 inhabitants, instead of the 25 required by international standards (table1).

Table 1. Number and density of human resources

Departments	Population	Physicians per 10,000 inhabitants	Nurses per 5,000 inhabitants	Midwifes per 5,000 women of childbearing age
Alibori	1,088,923	0.3	1.3	1.3
Atacora	969,719	0.5	1.7	1.6
Atlantique	1,755,192	0.7	2.9	2.2
Borgou	1,524,242	0.8	2.5	1.9
Collines	900,646	0.3	1.6	1.4
Couffo	935,607	0.2	1.0	1.2
Donga	681,789	0.4	2.1	1.5
Littoral	852,361	3.1	6.5	5.2
Mono	624,188	0.7	2.3	2.4
Ouémé	1,353,016	0.7	2.9	3.1
Plateau	781,261	0.4	1.1	2.1
Zou	1,068,985	0.5	1.4	1.7
Benin	12,535,929	0.7	1.4	2.2

Source: SGSI/DPAF/Ministry of Health, 2021

Infrastructure

In Benin, a total of 5,011 beds are available in public health centre and 800 in not-for-profit institutions in 2021, with a ratio of 2,151 inhabitants per bed. A total of 397,155 hospitalization recorded in 2021 with 1,498,861 days spent in hospital. The outpatient sector exists but is a very informal activity (Minstry of Health, Benin, 2021: 297).

Service package

At the beginning of the 2000s, Benin experimented community health policy. One of its main objectives was to ensure communities from all socio-economic backgrounds to access essential health care services. Initially, the policy was implemented to localities more than five km from the nearest health centre to fight against malaria (NGO Africare, Global Funds). Later, under the leadership of the national direction for health protection, the policy evolved into a package comprising the promotion of health, prevention, and care for primary childhood diseases (malaria, diarrhoea, acute respiratory infection). The rural areas benefited from the full package, whereas for the urban areas, the package covered only the promotion of health and prevention against diseases. The community health workers (CHWs) were recruited among the community and oversaw the activities related to promoting health, prevention, and taking care of diseases (Adom et al., 2016). The treatment of cases was based on the Integrated Management of Childhood Illness (IMCI) strategy. The U.S. Agency for International Development (USAID), Global Fund, and UNICEF were the main donors to implement this policy. One of the intervention models that was carried out at the community level was the Package for High Impact Intervention (PIHI-C). One of its main objectives was to develop a sustainable community health system and reinforce local institutions' capacity (civil society, municipal and local authorities, Ministry of Health, and establishment of private sanitary) (USAID, n.d).

The community invested and significantly contributed to the success of this policy. Nevertheless, the main challenges were the poor monitoring and evaluation of the activities, the non-operating reference and counter-reference system between the health centres manager and the community level, stock-out in medicines and malaria rapid diagnostic tests, and conflict of interests between health centre and CHWs who delivered the cares almost free of charge. This was in contradiction with the Initiative of Bamako carried out in the health centre. With the support of the WHO, the current government launched a broad reform of community health policy. Benin's new community health policy for the period of 2018-2030 is oriented to achieve universal health coverage through "Insurance for the Reinforcement of the Human Capital" (ARCH) project (CNLSTP, 2020).

At the beginning of the 2010s, with the financing of the World Bank, a new approach of result-based financing (RBF) was tested. The objective was to motivate the health personnel to increase the quantity and improve the quality of the care that they provided. However, its implementation was not adapted to the context because the follow-up and evaluation system and the health information system were inefficient. Consequently, this approach was abandoned.

The service package has evolved considerably over time. The most recent will provide 100 % free care for the extremely poor and 50% free care for the poor for a basic package. Before effective implementation of the new policies, the services package varied according to beneficiaries (vulnerable groups, civil servants or defence forces, supplementary insurance) (Republic of Benin 2023).

For tuberculosis control, all the services with drugs and a part of hospitalization are included.

For HIV, only diagnosis and antiretroviral drugs are included. For the vulnerable groups (government project ARCH), consultation and hospitalization for simple and severe malaria, acute respiratory disease, diarrhoea, and delivery are included in the package. The referral from the health facilities to the hospital are reimbursed for all those diseases. For indigents, 100 % of the available services are delivered if the patient met the criteria. For the civil servants: 80% of all eligible services are included in the package without access to drugs. For insurance and mutual, the package depends on the agreement between 80-100% of the eligible services.

Concerning the private scheme, self-medication by using pharmaceutical medicine or phytotherapy depends on the wealth index of the patient. Currently it seems that around 20% of health care services needs are covered.

d. Financing

In 2020, the current health expenditure (CHE) as a percentage of the Gross Domestic Product (GDP) was 2.6. In terms of shares of health care expenditure, individuals, families, friends, and diaspora contribution is estimated to 80% of total health spending (51.4% domestic out-of-pocket spending, 12.7% of foreign origin distributed by the government, and 17.6% direct foreign spending). Central government (9.1%), private insurance (5.4%), technical and financial partner (PTF) contribution is estimated to almost 20% (WHO, 2023; World Bank, 2023b).

e. Regulation

Only government institutions and agencies are responsible for the regulation and/or organization of the health care system (Republic of Benin, 2019). These are listed below:

The National Agency for Health Regulation (ARS) is linked to the Presidential Office and was officially established on 12th September 2022 by the President of the Republic. It is an autonomous institution. Its mission is to ensure that the right to health for all is realised through continuous improvement in the supply and quality of care.

The Ministry of Health: The role of the Ministry of health is to:

- Define and monitor the national health strategy and ensure its implementation
- Coordinate operational implementation of politics and strategies
- Insure access to quality health
- Design and implement regulatory roles
- Promote the contribution of Benin Diaspora in the health sector
- Facilitate the implementation of the universal coverage
- Coordinate the finance of the health sectors

The National council for the fight against aids, tuberculosis, malaria, hepatitis and epidemics: The CNLS-TP is the national coordinating institution acting as the interface between the ECOWAS Regional Centre for Disease Surveillance and Control and Benin. Then, it is the only institution responsible for coordinating interventions in terms of detection, prevention, surveillance and response to epidemics in Benin. It ensures the national coordination of surveillance, alert and laboratory activities, training, and research activities and those of the "One Health" platform.

The Benin Pharmaceutical Regulatory Agency regulates the acquisition and distribution of pharmaceutical products.

- Regulation of health providers: The Ministry of Health and ARS gives private practice authorization, authorization to open private hospitals or pharmacies and Orders of physicians and pharmacists accept the nominations for members.
- The Ministry of Health, ARS, CNLS-TP and insurance companies are responsible for deciding the services available in the basket of benefits.

7. Role of global actors

Global actors are active in health care in the county, through the supply of medicines, consumables and equipment, deployment of interventions (mosquito nets, vaccinations, etc.), training and skills transfer for health workers, health promotion, rehabilitation of health centres.

Additionally, global actors are involved in health care reform processes and decision making for some aspects.

The most important global actors operating in the country are the World Health Organization (WHO), UNICEF, the Global Fund, the Global alliance for vaccine and immunizations (GAVI), the European Union (EU), the U.S. Agency for International Development (USAID), the President's Malaria Initiative (PMI), the Agence Française de Development (AFD), the Belgian Development Agency (ENABEL), the German Development Agency GIZ, Swiss co-operation and the Bill and Melinda Gates Foundation. The list is not all-inclusive (WHO, 2015; CNLS; 2023).

Churches and other charitable organizations also play a role in providing and financing health care, by building health centres and offering health services, as well as by donating and financing health promotion.

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