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### ***Fostering Health Service Delivery via Public Financial Management: The Case of Participatory Budgeting in Benin's Local Governments***

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## Abstract

The principle of participatory budgeting (PB), as a mechanism to foster the involvement of local communities in sub-national public financial management (PFM) systems, rarely generates strong opposition given its inherent ability to embed ‘pro-poor’, equitable, and/or inclusive approaches to the allocation of public resources. Yet, and somewhat paradoxically, the depth and/or extent of its implementation and efficacy in many countries are seen to be limited in scope or lacking in dynamism. Drawing from a fieldwork of PB practices in selected municipalities in Benin and insights from different actors in the field (elected representatives, government officials, community groups, civil society organisations, donors), we add to existing expositions on PB’s emancipatory features, in terms of the space and voice it can offer for local engagement. At the same time, we see the need for a step change at the PFM supra-national policy and national/sub-national levels to ensure PB can be developed in a more strategic, sustainable and inclusive way - while minimizing the risks of ‘PB capture’. Our key recommendations are (i) the incorporation of PB within broader PFM frameworks and PEFA assessments at national level, and improving PEFA’s proposed subnational government indicator on public consultation, (ii) the promotion of a community of practice, by PEFA partners and the development agencies, to share good experiences and mechanisms, with the involvement of international PB networks, (iii) the need to embed a PB feedback process at national/sub-national levels to foster a cycle of learning, sustainability and inclusion within the community.

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# **Fostering Health Service Delivery via Public Financial Management: The Case of Participatory Budgeting in Benin's Local Governments**

**(August 2021)**

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## Abbreviations and Acronyms

CPC	Citizen Participation Unit ( <i>Cellule de Participation Citoyenne</i> )
CSO	Civil Society Organization
HNPS	Health Nutrition and Population Statistics
MTEF	Medium-term Expenditure Framework
NGO	Non-governmental Organization
PB	Participatory Budgeting
PBB	Performance Based Budgeting
PDC	Municipal Development Plan ( <i>Plan de Développement Communal</i> )
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PI	Performance Indicator
QCA	Qualitative Content Analysis
SSA	Sub-Saharan Africa
WAEMU	West African Economic and Monetary Union
WDI	World Development Indicators

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## Executive summary

Public Financial Management (PFM) systems play a central role in the formulation and prioritization of social and development policies and in the delivery of public goods and services at the national and subnational levels. A key issue is the ability of subnational PFM systems in Sub-Saharan African (SSA) to foster wider engagement of community members and marginalized constituencies in a sustained manner and address grassroots challenges (such as health, sanitation, education, safe water, power, or infrastructure). The study therefore examines how the use of participatory budgeting (PB) as a PFM mechanism can contribute to achieving social and development goals through better public service delivery, focusing on the case of subnational health services in Benin, a Francophone least-developed SSA country. Three basic research questions are presented: (1) From a broader perspective, what is the association between the quality of PFM systems and health indicators in SSA countries? (2) How is PB deployed in local government in the context of health service delivery in Benin? (3) What is the nature and extent of stakeholder involvement and engagement in the Benin PB process, with a particular emphasis on service delivery in healthcare provision at the grassroots level?

In response to our first question, and based on existing PEFA assessment reports for SSA countries over the past 15 years, we analyze trends in comparable core dimensions from PEFA 2011 and pillars from PEFA 2016 frameworks relating to *Budget Reliability/Credibility, Transparency & Comprehensiveness, Policy-based Budgeting, Predictability and Control in Budget Execution, Accounting and Reporting, and External Scrutiny and Audit*. These evaluations are associated with key measures in SSA of health service delivery, resources and outcomes. Our evaluation of PFM performance in SSA countries, including Benin, reveals mixed results, with very limited improvements, and in some cases deterioration. On average, the comparatively best performing indicators are the so-called ‘upstream ones’ (for example, the *Policy-based Budgeting and Comprehensiveness and Transparency* pillars), whereas the ‘downstream’ indicators have performed poorly (*External Scrutiny and Audit*). Using correlation analysis, health expenditures are in the main significantly and positively associated with many of the PFM systems or processes. Although we do not claim causality, one implication is the alignment between increased health expenditure and transparency, adequate documentation (which enables monitoring and provides an audit trail for external scrutiny at a later stage), improved control over spending, and proper accounting for its execution, for enhanced oversight (with a view to lessons learned, in the interests of appropriate rectification and future planning). In terms of health outcomes, particular metrics, such as the maternal mortality ratio, are significantly associated with all of the six PEFA pillars used in the analysis. Similar results are observed across immunization outcomes, albeit to varying degrees. At the same time, a finding worthy of further investigation is that capital health expenditure (as a percentage of GDP) is negatively and significantly associated with two PEFA 2011 core dimensions/2016 pillars (*Comprehensiveness and Transparency, and Predictability and*



*Control in Budget Execution*). As a result, we examine the broader implications of PB, namely in relation to budget execution, reporting, accountability and governance at both the central and local levels in Benin.

In response to our second and third research questions, we explore the implementation of PB in selected municipalities in Benin, with an emphasis on approaches advocated by donor-inspired civil society organizations (CSOs) and their execution in local communities. Our fieldwork initially outlines the normative expectations and aspirations of the Beninese authorities, donor agencies and CSOs. These were compared and contrasted to the realities on the ground, firstly in terms of the enabling actors (community participation, the role of elected representatives and the influence of donor-funded CSOs and other NGOs) and secondly in terms of context-specific factors relevant to Benin's experience. We highlight how PB has contributed to addressing various local needs and expectations, particularly with respect to gendered demands and community health service provision, mainly in terms of infrastructure. We also document some innovative approaches to PB locally, reflected in its mobilization, for instance, as a mechanism for fostering people's responsibility for paying local taxes and encouraging financial or in-kind community contributions. Particularly, within the specific analysis of PB in the context of health delivery, we bring to the fore attempts by the community and local groups to leverage PB as a means by which to address their local health needs, even when this may not have been the stated objective at the higher political level or even a component of government priorities. Unlike other contexts where PB appears to be imposed by donors and other actors, local communities and actors in Benin have adopted it 'voluntarily', and in general remain enthusiastic participants. Hence, our study adds to the cumulative evidence on the emancipatory role of PB in creating an opportunity for local constituencies to engage with PFM systems and improve sustainable livelihood opportunities for community members. We do highlight unintended, contextual and political economy challenges such as the sustainability of PB initiatives, and contradictions between them and the bureaucratic rules associated with traditional top-down budgeting systems. The analysis also reveals a rather unidimensional approach to the practical realization of 'participation' in the public budgeting processes as captured in PEFA subnational and national assessment indicators. We conclude with a number of recommendations aimed at the government and at PEFA with a view to improve PB and consequent public services outcomes (not least health), inclusive of the need for developing context-specific adjustments to mitigate unintended consequences.

## Synthèse

Les systèmes de gestion des finances publiques (GFP) jouent un rôle central dans la formulation des politiques sociales et de développement, ainsi que dans la fourniture de biens et services publics aux niveaux national et infranational. Toutefois, une préoccupation majeure concerne la capacité des systèmes de GFP des collectivités décentralisées en Afrique subsaharienne à favoriser un engagement plus large des membres des communautés locales et des groupes marginalisés de manière durable, et à relever les défis qui se posent au niveau local (par exemple, sur le plan de la santé, l'assainissement, l'éducation, l'eau potable, l'électricité, ou des infrastructures). Pour cela, la présente étude a examiné comment l'utilisation du budget participatif (en tant que mécanisme du système de GFP) peut contribuer à la réalisation des objectifs sociaux et de développement grâce à une meilleure fourniture de services publics. Ce faisant, l'étude se concentre sur le cas des services de santé infranationaux au Bénin, un pays francophone d'Afrique subsaharienne. Pour atteindre cet objectif, trois questions de recherche sont posées : (1) Dans une perspective plus large, quelle est l'association entre la qualité des systèmes de GFP et les indicateurs de santé dans les pays d'Afrique subsaharienne ? (2) Comment le budget participatif est-il déployé dans les collectivités locales dans le contexte de la prestation des services de santé au Bénin ? (3) Quelle est la nature et l'étendue de l'implication et de l'engagement des parties prenantes dans le processus du budget participatif au Bénin (avec un accent particulier sur la prestation des services de santé au niveau local) ?

En réponse à notre première question, et sur la base des rapports PEFA dans les pays d'Afrique subsaharienne au cours des 15 dernières années, nous avons analysé les tendances des dimensions essentielles du cadre PEFA 2011/ piliers du cadre PEFA 2016 comparables liées à la Fiabilité/Crédibilité du Budget, la Transparence & Exhaustivité du Budget, la Budgétisation Fondée sur les Politiques Publiques, la Prévisibilité et le Contrôle de l'Exécution du Budget, et la Comptabilité, l'Enregistrement de l'Information et Rapports Financiers, et le Contrôle Externe et l'Audit. Ces évaluations sont associées aux mesures clés relatives à la prestation des services de santé, aux ressources et résultats du secteur de la santé des pays concernés. Notre évaluation de la performance du système de GFP dans les pays d'Afrique subsaharienne révèle des résultats mitigés et met en évidence des améliorations très limitées, et dans certains cas, une détérioration pour les pays couverts par l'étude (y compris le Bénin). En moyenne, les indicateurs les plus performants sont ceux dits « en amont » (tels que ceux des dimensions essentielles de PEFA 2011/ piliers de PEFA 2016 Budgétisation Fondée sur les Politiques Publiques et Transparence & Exhaustivité du Budget), tandis que les indicateurs dits « en aval » représentent les indicateurs les moins performants.

Sur la base de l'analyse de corrélation, les dépenses de santé sont pour l'essentiel associées de manière significative et positive à de nombreux indicateurs des systèmes/processus de GFP. Une telle association ne signifie pas nécessairement un lien de causalité. Néanmoins, une implication importante qui en découle est l'alignement entre l'accroissement des dépenses de santé et l'amélioration de la transparence et documentation adéquate (qui permet un suivi et fournit une piste d'audit pour un examen externe à un stade ultérieur), un meilleur contrôle des dépenses et une comptabilité adéquate de leur exécution pour une surveillance renforcée et des leçons apprises pour d'éventuelles mesures correctives et la planification. En termes de résultats de santé, les indicateurs particuliers, tels que le taux de mortalité maternelle, sont significativement associés à l'ensemble des six piliers de PEFA utilisés dans l'analyse. Des résultats similaires sont observés pour les indicateurs de vaccination, quoique à des degrés divers. Dans le même temps, nous relevons une observation qui peut être examinée en profondeur ultérieurement. Il s'agit de l'association entre les dépenses en capital de santé (en pourcentage du PIB) et deux piliers du PEFA (Transparence & Exhaustivité, et Prévisibilité et Contrôle de l'Exécution du Budget) : les premiers (c'est-à-dire les dépenses en capital) sont négativement et significativement associées aux deux piliers de PEFA mentionnés. Nous avons exploré ensuite les implications plus larges du budget participatif, notamment en ce qui concerne l'exécution du budget, le reporting, la responsabilité et la gouvernance à la fois aux niveaux central et local avec un accent particulier sur le contexte béninois.

En réponse à nos deuxième et troisième questions de recherche, nous avons examiné la mise en œuvre du budget participatif dans certaines municipalités du Bénin, les approches préconisées par les organisations de la société civile (OSC) inspirées des bailleurs de fonds, et l'exécution de ces approches dans les communautés locales. Notre travail de terrain décrit dans un premier temps les attentes et aspirations normatives des autorités béninoises, des bailleurs de fonds et des OSC. Ces attentes et aspirations ont été comparées et contrastées avec les réalités du terrain, d'une part en termes d'acteurs facilitant le processus (participation communautaire, rôle des élus et influence des OSC financées par des bailleurs) et d'autre part en termes de facteurs contextuels propres à l'expérience du Bénin. Nous avons noté comment le budget participatif a contribué à répondre aux divers besoins et attentes des locaux, en particulier en ce qui concerne les demandes basées sur le genre et la fourniture de services de santé communautaire. Nous avons également documenté certaines approches innovantes du budget participatif qui se reflètent dans sa mobilisation, par exemple, comme mécanisme pour inciter la responsabilité des citoyens à payer les impôts locaux et encourager les contributions financières ou en nature de la part de la communauté. En particulier, dans le cadre de l'analyse spécifique du budget participatif dans le contexte de la prestation des services de santé, nous avons mis en évidence les tentatives des communautés et groupes locaux pour tirer parti du budget participatif comme un moyen pour répondre à leurs besoins en santé communautaire, même lorsque cela n'a pas été l'objectif déclaré au niveau de politique publique et/ou faisant partie des priorités des acteurs publics. Contrairement à d'autres contextes où le budget participatif semble être imposé par les bailleurs de fonds et d'autres acteurs, les communautés locales et les acteurs au Bénin l'ont adopté (et continuent de l'adopter) sur une base

« volontaire » et sont généralement enthousiastes dans son opérationnalisation. Par conséquent, notre étude ajoute aux travaux cumulatifs sur le rôle émancipateur du budget participatif dans la création d'opportunité offerte aux communautés locales pour s'engager dans les systèmes de GFP aux fins d'améliorer leurs conditions de vie. Nous avons également souligné les défis non anticipés relatifs à la soutenabilité des initiatives de budget participatif et les contradictions relatives aux règles bureaucratiques associées aux systèmes traditionnels de budgétisation. L'analyse révèle également une approche plutôt unidimensionnelle concernant la manière dont la « participation » est opérationnalisée dans les processus de budgétisation publique et ensuite capturée dans les indicateurs d'évaluation PEFA aux niveaux national et infranational. Nous avons conclu l'étude avec un certain nombre de recommandations destinées au gouvernement (et organisations locales) et au PEFA en vue d'améliorer les résultats et l'efficacité du budget participatif, y compris la nécessité de développer des ajustements spécifiques relatifs aux contextes pour atténuer les conséquences (négatives) non anticipées.

## 1. Introduction

Public Financial Management (PFM) systems provide a fiscal framework for the design of development plans and policies to deliver a high standard of public goods and services. This is particularly crucial for Sub-Saharan African (SSA) countries that are constantly struggling to design or implement PFM systems that meet their development needs, especially public services in poor and marginalized constituencies. In this connection, the initiation of the Public Expenditure and Financial Accountability (PEFA) framework, as a diagnostic tool for PFM systems, has enabled a more harmonized assessment of a country's progress with PFM reforms and serves as a basis for facilitating dialogue between governments, the donor community and a wider constituency of development partners.

PEFA has already contributed significantly to assess PFM systems at the central level. Meanwhile, the need to improve PFM systems at the subnational level has attracted increasing attention, especially in developing countries. In this regard, participatory budgeting (PB) has emerged as a 'pro-poor' mechanism with the potential to facilitate a more equitable and inclusive (including gender-balanced) allocation and distribution of scarce resources (Shah 2007; Fritz et al. 2017). Currently, PB is limited to a few isolated experiences, mostly outside of Africa<sup>1</sup> even though that continent is home to the world's poorest populations.<sup>2</sup> This study addresses that imbalance, discussing how PB experiences can inform PFM systems (and PEFA assessments) and, more fundamentally, how PB can engender improved public service delivery. This is of the utmost importance given ongoing global efforts to achieve sustainable health services, as embedded in the Sustainable Development Goals, in developing countries.

For the purpose of this study, Benin (and its health service delivery in local communities) has been selected as a case study given the country's democratic credentials (until recently), and its governance, notably including the recent implementation of PB in a number of its municipalities. For Benin, PB is an approach that has only been adopted in earnest at the subnational level since 2016.<sup>3</sup> The following research questions are addressed:

- (1) From a broader perspective, what is the association between the quality of PFM systems and health indicators in SSA countries?
- (2) How is PB deployed in local government in the context of health service delivery in Benin?
- (3) What is the nature and extent of stakeholder involvement and engagement in the Benin PB process, with a particular emphasis on service delivery in healthcare provision at the grassroots level?

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<sup>1</sup> Notable exceptions being Tanzania and South Africa (e.g. Shall, 2007; Fritz et al., 2017).

<sup>2</sup> See, Lassou et al., (2018) and: <https://www.worldbank.org/en/news/immersive-story/2018/10/17/going-above-and-beyond-to-end-poverty-new-ways-of-measuring-poverty-shednew-light-on-the-challenges-ahead> [Accessed 10/05/2019].

<sup>3</sup> There was an early and very limited attempt in the 2000s.

This study is conducted in two phases. The first phase targets the first of the above research questions, and focuses on a macro-level analysis of PFM systems across Sub-Saharan Africa (including Benin), using PEFA indicators and selected health statistics (covering both expenditures and outcomes) from publicly available health documents. The second phase, addressing the other two questions, involves micro-level fieldwork analysis in Benin, undertaken from late May to July 2020, investigating the country's experiences of PB, with an emphasis on the health sector.

## **2. Conceptual background and context**

### **2.1. Conceptual framing of participatory budgeting**

Participatory Budgeting (PB) has emerged as an important mechanism for effective implementation of public financial management (PFM) due to its focus on fostering political emancipation, public deliberation and civic participation at the grassroots levels (Grillos 2017). This budgeting practice originated in Porto Alegre (Brazil) and achieved recognition in terms of being pro-poor and potentially facilitating a more equitable (including gender-balanced) allocation and distribution of scarce resources (Wampler 2007; Rocke 2014). Over the past two decades, PB has become one of the most widespread reforms undertaken in local government (Baiocchi and Ganuza 2014). As part of the PFM agenda, PB seeks to enable the engagement of multiple actors in resource allocation and promotes operational efficiency by selecting projects and programs that deliver outputs and outcomes relevant to grassroots needs: recognizing the crucial role of local citizens and communities (Grillos 2017). PB contributes to a sense of community, fostering the feeling of being a good citizen and delivering on civic responsibilities (Hong and Cho 2018; Brun-Martos and Lapsley 2017). In addition, the democratic values, knowledge, skills and responsibilities of major stakeholders—politicians, bureaucrats and citizens—are expected to be enhanced in the process of implementing PB (Rocke 2014). Current evidence on PB practices within a PFM umbrella derives mostly from experience in the following regions: Asia, especially in Korea, Indonesia and Sri Lanka (Im et al. 2014; Jayasinghe et al. 2017; Nurmandi et al. 2015; Uddin et al, 2017; Jayasinghe et al. 2020), Latin America, mainly in Brazil (C  l  rier and Botey 2015) and Europe (Brun-Martos and Lapsley 2017). Very little research (such as UN-HABITAT 2008) has been reported on PB in Sub-Saharan Africa generally, let alone in those less prominent countries that have experienced atypical colonial and post-colonial development paths in terms of institutional and cultural settings, regional coalitions, progress (or lack thereof) in terms of socioeconomic outcomes, and geopolitical relationships, such as Francophone<sup>4</sup> African countries (Lassou et al. 2018). Moreover, little is known, if any, about the extent to which the indicator-

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<sup>4</sup> The terms 'Francophone' or 'Anglophone' are often used to classify African countries in the academic literature. As we set out above, we are more concerned about the different development models SSA countries have taken post-independence, that is, after British or French rule (for example), and the way that formal institutions, laws and regulations have developed over time. While it is noted that former French African countries have often remained 'tethered' to France's geopolitical, economic and military interests (Lassou et al., 2018), we do not seek to use the Francophone/Anglophone label as an analytical framework for our findings. Lastly, we acknowledge that very little work on Francophone African experiences has appeared in English-language publications, owing primarily to the language barrier; hence this study.

based assessment tool developed by PEFA (de Renzio 2009) reflects the extent of PB practices in the public sector, or reliance on them, particularly at subnational level in the delivery of public services. It is also worth noting that most donor-led PFM interventions and evaluations in the region concentrate on central government, with a limited focus on decentralized, subnational, settings (Lassou et al. 2018).

Earlier research has identified a number of enabling factors and a common set of actors conducive to the effective adoption of PB. Wampler (2007) identifies four factors relevant to the subnational context, namely: (1) a willing (and participating) civil society, (2) strong mayoral (political) support, (3) a supportive political environment, serving as a shield against political attacks, and (4) the availability of sufficient financial resources to fund the projects generated by the participatory process. A vibrant civil society (such as community groups, social movements, women's groups, NGOs) is seen as a source of countervailing power (Lassou et al. 2020b) that provides voice to the voiceless. This voice is expressed in particular through the capacity of these groups to mobilize the participation of different segments of the community; it enables them to analyze "their own situations" and formulate workable and sustainable 'solutions' (Cornwall and Jewkes 1995, p.1670). Mayoral support is seen as essential for the initiation of the process and lobbying for PB resources during budget deliberations. Similarly, a supportive political environment helps to prevent some politicians from thwarting the process in order to protect narrow interests and existing channels of patronage (Lassou et al. 2020a). Wampler (2007) highlights the importance of discretionary funding to support financial flexibility that is responsive to citizens' project choices during the PB process; without such funding, further participation is likely to be compromised. Shall (2007) concurs with these arguments, and adds the existence of local government-enabling legislation and explicit support for decentralization, and in some cases the influence of PB on traditional community gatherings (e.g. *Barazas & Harambee* meetings in Kenya). One implicit but important factor in current PB research concerns the financing of the PB process. Unlike the pattern in richer developed countries, where the financing of the process more or less automatically ensues from the decision to carry out PB (Burn-Martos and Lapsley, 2017; Michels and de Graaf, 2017), in developing countries finding such resources to fund the process is often problematic (not only during the initial phase, but persistently) and hence a varying degree of donor support is sought (e.g. Fritz et al. 2017). The preceding review thus leads to a conceptual framework by which to analyze PB practices in the field. This is organized into three thematic areas of relevance to the field study: (1) regulatory and normative aspirations; (2) enabling 'actors' on the ground (community participation; role of elected representatives; role of donors, as in the provision of funding to CSOs and NGOs for community mobilization); and (3) context-specific factors.

## **2.2. Context – Sub-Saharan Africa, Subnational Governance and Benin**

Since the early 2000s PFM reforms to improve service delivery have resulted in further complications in Sub-Saharan Africa. Countries have intensified the decentralization of their PFM arrangements without due regard to specific local contexts and community engagement (Lassou et

al. 2018). This has led to internal tensions, resistance and fragmented accountability (Andrews 2013; Fritz et al. 2017). In Africa, efforts to sustain PFM reforms at the subnational level in key sectors, including health and education, have posed even more substantial challenges both for policy makers and development partners. These potentially entail further adverse effects, particularly on the lives and livelihoods of the most vulnerable and poorest elements of communities (World Bank 2013; Andrews 2009). The improvement of PFM requires the meaningful involvement of local governance actors and local people (see 2005 Paris Declaration and 2008 Accra Agenda for Action),<sup>5</sup> including officials at all levels, communities and citizens. PB appears to be a relevant and appropriate PFM mechanism to address this issue within the context of pro-poor and inclusive development initiatives, alongside traditional or grassroots initiatives.

With a total population of approximately 12 million people, Benin provides an important setting in this regard. It is classified as a ‘Least Developed Country’ by the 2018 Development Assistance Committee (DAC). Its 2015 poverty headcount ratio was 40.1 percent, and according to the World Development Indicators, life expectancy in Benin in 2018 was 63 years for males and 59.9 years for females. The most recent calculation of per capita gross national income (in 2018) was roughly US\$ 1,200. It ranks 163rd out of 189 countries on the 2019 human development index. It shows relatively poor health service outcomes. According to 2017 WHO data, Benin’s IHR<sup>6</sup> capacity index is 46 (out of 100) for response capability, 27 for preparedness (for major health outbreaks), and 29 for risk communication. Benin had only five hospital beds for every 10,000 people in 2010 (the latest statistic available, and one of the lowest rates in Africa) and its infant mortality (between birth and 12 months) was 66.3 per 1,000 live births on average from 2009 to 2018, one of the highest rates in the Francophone African region. In response to these pressures, it has attempted to decentralize its health service delivery with the involvement of local communities, under the aegis of its health coordination committee, known by its French acronym COGEC.<sup>7</sup>

More generally, Benin started setting its development agenda (and budgeting and PFM implications) focusing on the grassroots level in the late 1990s. A range of subnational governance reforms passed into law, and the first local government elections were held in 2002, providing further impetus towards localizing development efforts. A key concern at the beginning of the new century was to increase grassroots participation in identifying development needs, allocating municipal resources with improved accountability and delivery of services, not least in the health sector (Lassou et al. 2018), with the ability to channel resources to traditionally marginalized or excluded areas (Cabannes 2004). To this end, donors, particularly GIZ (a German development agency) and very recently, *Coopération Suisse*, prioritized and promoted the voluntary adoption of PB in several local governments. Overall, about 25 out of 77 municipalities chose to take part.

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<sup>5</sup> See, <https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm> [Accessed 19/03/2020]

<sup>6</sup> International Health Regulation. IHR capacity index is “the proportion/percentage of attribute (a set of specific elements or functions which reflect the level of performance or achievement of Core Capacity 1: National legislation, policy and financing) that has been attained” (<http://apps.who.int/gho/data/node.main.HS11?lang=en>)

<sup>7</sup> *Comité de Gestion de la Commune* [or Management Committee of Municipal (Health) Affairs]. The committee is made of representatives of local communities, health professionals, and elected borough officials.



### 3. Methodology

The study was conducted in two phases. The preliminary phase was conducted at the macro-level to examine how the quality of PFM systems as measured by PEFA assessments across Sub-Saharan Africa was statistically associated with health expenditure and outcomes. A focus on health expenditure sought to reveal the influence of health considerations on government financial planning and priorities. Meanwhile, health outcomes measure the extent to which the quality of PFM has brought about improved health service delivery. This analysis helps to provide an overview of the influence of PFM (direct or indirect) on public service delivery with respect to health, and how this applies to Africa. It should be noted that any use of subnational PEFA assessments would have been constrained or vitiated by the current problem of coverage (reach). In Benin, for example, only the municipality of Cotonou underwent two PEFA assessments, in 2012 and 2017 (and this municipality has not yet experienced any PB). Moreover, health data tend not to be reported at the municipal or subnational level, which makes it difficult to conduct any meaningful analysis between PEFA assessments (reflected in indicators or scores) and health statistics at the subnational administrative level. Nonetheless, the analysis at the national level provides a glimpse of the quality of PFM and its connection with health at the macro-level (with a view to further micro-level analysis in subnational settings). There are some links between PEFA assessments at the national level and subnational PFM systems that support this. For example, PI-8 (Performance Indicator 8) *Transparency of Inter-governmental Fiscal Relations* (2011 Framework) and PI-7 *Transfers to Subnational Governments* (2016 Framework) measure the financial relations between the central government and local governments. Additionally, both PI-11 *Orderliness and Participation in the Annual Budget Process* (2011 Framework) and PI-17 *Budget Preparation Process* (2016 Framework) feature ‘participation’ which applies to both levels of governments, and particularly to PB at the subnational level.

The macro-level analysis was conducted between February and May 2020. The work carried out at this stage involved:

- The collection of available PEFA assessment reports for all Sub-Saharan African (SSA) countries that underwent the assessment over the period from 2001 to 2019 (2011 and 2016 Frameworks). During this collection, it was noted that the first assessment was conducted in 2005 for Zambia. Overall, 38 countries underwent this assessment exercise, yielding 103 assessment reports in total over the period. The list of countries and the year of PEFA assessment is provided in Appendix A.

Here it was noted that two different PEFA assessment frameworks were used in the assessment exercise. To enable a comparable longer-term analysis of the PEFA scores by using all the available data, we selected common indicators across six of the initial pillars from the 2011 framework and the corresponding indicators from the 2016 framework. We acknowledge that a full transposition of the indicators across both frameworks is not always desirable or indeed possible. The list of relevant indicators used is provided in Appendix B.

We repeated the analysis using a subsample of data relating to each framework (2011 and 2016). Unfortunately, we noted that the number of observations available for the 2016 framework is very limited and, as a result, the statistical analysis did not yield any meaningful insight; thus, the 2016 framework-based assessments could not be used in isolation. In the main, the results of the quantitative analysis are driven by the 2011 Framework-based assessments, and in Appendix E we provide the correlation analysis between the PEFA indicators and health expenditures and outcomes using only the 2011 Framework-based assessments. With few exceptions, the results compare well with the results of the combined sample. Consequently, we decided to rely on the results from the two frameworks to support our conclusions and implications.

- The conversion of the assessment ratings in the PEFA reports into numerical scores in order to carry out some quantitative analysis. To this end, the PEFA ratings D, D+, C, C+, B, B+ and A are assigned the values 0, 0.5, 1, 1.5, 2, 2.5, and 3 respectively.
- The collection of health statistics, namely: health expenditure and health outcomes data from the World Development Indicators (WDI) and Health Nutrition and Population Statistics (HNPS) of the World Bank. Health data from the WHO were also considered, but not chosen because these were less amenable to analysis than the WDI and HNPS data (in terms of structure). The data was collected for all SSA countries with a PEFA assessment between 2005 (the year of first PEFA assessment) and 2016 (the year of the most recent data available; except for the immunization data, collected in 2018).

The analysis at this stage was performed at two levels. First, descriptive statistics (such as means, standards deviation, minimum and maximum values) were calculated for each indicator and for each pillar to explore the performance of PFM systems in SSA countries over the study period (inclusive of Benin). This gave rise to potential questions for further investigation and analysis in the next phase of the study. Second, the indicator scores were used in conjunction with the health statistics to explore possible correlations between the assessed performance of PFM systems (via the PEFA scores) and health expenditures and outcomes. This in turn gave rise to questions and areas deserving of further investigation in terms of implications for PB. Two important notes of caution are: (i) we do not claim causality between these variables, and (ii) it has not been possible to assess the quality of financial data (used to determine the PEFA ratings and subsequently to assign PEFA scores) or the health statistics upon which the analysis is based. The results reached and implications drawn are influenced by the quality of the underlying financial data and health statistics, which are reflective of the quality and integrity of financial and non-financial reporting systems in place in the respective countries.

The second phase of the study started in May 2020 with fieldwork conducted between May and July 2020. The fieldwork was carried out by the lead investigator (who is a native of Benin) and

involved six municipalities, namely: Adjarra, Comè, Cotonou, Covè, Ouinhi and Toffo. Initially, four municipalities were scheduled—two large (Cotonou and Porto-Novo) and two small or medium-sized (Covè and Ouinhi)—but during the field visit it became apparent that none of the large municipalities has experience of PB, largely for lack of political will. Consequently, Porto-Novo was replaced by Comè and Adjarra. Furthermore, as the fieldwork was progressing, Toffo was cited by many in Benin as an example of fairly consistent success as a PB model. We therefore decided to investigate that perception. Semi-structured interviews were conducted with municipal officials (both elected and administrative) and key stakeholders including community members (citizens), civil society organization leaders, central government officials, representative of donor agencies, and health professionals (medical doctors, regional health service civil servants). Most of the interviews (except three conducted on WhatsApp and Skype) were carried out on a face-to-face basis at the respondent's office, while adhering to COVID-19 social distancing measures.

Despite a range of challenges (restrictions on travel, adherence to quarantine procedures and difficulties in securing interviews with key officials), 55 officials and actors were interviewed (see Table 1 for a summary of research participants and their organizations). In particular, 12 of the respondents were female and 13 were citizens (five drawn from the concerned communities and eight from Citizen Participation Units,<sup>8</sup> that is, direct representatives of citizens). Admittedly, 12 female respondents out of 55 may appear small; this is reflective of a context where most of the leadership and representative roles tend to be ascribed to men. The 12 women we interviewed was the result of our efforts to hear from the perspective of female experiences in an attempt to counter the dominant gender imbalances at play. Some of the interviews also helped to inform our investigation of the macro-level research question and subsequent findings. In addition to the interviews, documents and reports were sought on health policy formulation, health budget and spending at both central and municipal government levels, PB exercise reports, public hearing reports, and fund transfers to municipal governments. While some of these documents were obtained, others were not readily available, especially those involving statistical or financial data. In a few cases, access was subtly denied. The translation of relevant parts of the data from French into English was performed by two members of the research team who are bilingual.

Interviews and documentary data (in the main evaluation reports) were analyzed following a qualitative content analysis (QCA) approach. QCA is “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh and Shannon, 2005 p. 1278). The QCA process was applied to each transcribed interview and report to derive categories based on a “thematic criterion” driven not only by the picture emerging from the data but also from the theoretical constructs identified from the literature (that is, normative expectations versus observed reality; positive versus problematic circumstances and phenomena). More specifically, the themes used to code the data draw on the conceptual framing (see Section 2.1), namely: (1) regulatory and normative aspirations; (2) enabling actors on the ground (community participation; role of elected

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<sup>8</sup> In French: *Cellule de Participation Citoyenne (CPC)*.

representatives; role of donors (for example, providing funding to CSOs and NGOs for community mobilization); and (3) context-specific (Beninese) factors.

**Table 1: Research participants and their organizations**

<b>Organizations / Individuals<sup>9</sup></b>	<b>Number of respondents</b>
Municipalities: Adjarra, Comè, Cotonou, Covè, Ouinhi & Toffo	17 (elected and administrative officials)
Ministry of Finance, Ministry of Health & Ministry of Decentralization	8 administrative officials
Representatives of Municipality Advocacy Group	2 representatives
Civil Society Organizations (NGOs)	3 senior leaders
Donor representatives: Two donor agencies	6 representatives working with CSOs, Ministries or Municipalities.
Health professionals and civil servants	6 (4 health professionals and 2 civil servants)
Members of local communities (citizens) and CPC members	5 Citizens and 8 Community representatives
<b>Total</b>	<b>55 Participants (43 males, 12 females)</b>

The project team repeatedly reflected on and discussed the initial codes and themes from the interview and reports, identifying any commonalities or contradictions in relation to previous interview or documentary evidence, seeking to find confirmatory insights where possible, but also leaving room to reflect on emerging themes from the data (that is, a bottom-up analysis).

The main results and recommendations of the study were presented to key stakeholders involved with PFM and PB in Benin at a round table event held on 22 December 2020 for 19 participants, including officials from three relevant ministries (responsible for finance, health and decentralization, respectively), representatives from the municipalities studied, from donor offices (GIZ), and from CSOs. Discussion with the participants following the presentations allowed the research team to explain further the insights gained from the study, and policy implications for both central and local government as well as community-level mobilization. The discussion also generated feedback subsequently incorporated into the final report.

## **4. Findings from SSA PEFA and selected health data**

### **4.1. Average PEFA Scores**

As shown in Table 2, the average scores for each performance indicator range from 0.78 (PI-28, *Legislator Scrutiny of Audit Reports*) to 1.94 (PI-11, *Orderliness and Participation in the Annual Budget Process*). All are below 2.0, meaning that they fall short of a ‘B’ rating. The notably poor

<sup>9</sup> In the interest of maintaining anonymity and assurances of confidentiality, we do not provide a more detailed breakdown of our informants.

score for legislative scrutiny suggests either a complete absence of the administrative machinery of parliamentary due process—in terms of holding the executive accountable—or a limited capacity on the part of the parliament to put such due process into effect. Instances of such issues are noted in PEFA reports for a number of countries, including Benin, where legislative scrutiny of audit reports is virtually absent (with a rating D in 2007 and D+ in 2014). The relatively high score for PI-11 indicates that the general framework for the preparation of the budget is in place (recurrent and capital development budgets) with a reasonable level of adherence in most of the African countries, at least in principle (note: PI-17 is the 2016 framework equivalent). However, despite the mention of ‘participation’ in this indicator, the concept is quite narrow and typically involves technical guidance, timelines and formal consultations for ministries and budgetary units; hence limited to a fairly bureaucratic and closed process. In the main, participation is conceived by central government actors (albeit occasionally by local government too) with the (often nominal) involvement of different organizational units in the budgeting process. The relative low average score for PI-10 (*Public Access to Key Fiscal Information*) also suggests that a key ingredient for greater public participation is limited or absent in SSA countries.

**Table 2: Average score of PEFA SSA indicators from 2005 to 2019**

	N	Minimum	Maximum	Mean	Std. Deviation
PI-01 (Credibility) Aggregate Expenditure out-turn compared to original approved budget	103	0.00	3.00	<b>1.54</b>	1.10
PI-02 (Credibility) Composition of expenditure out-turn compared to original approved budget	99	0.00	3.00	<b>0.99</b>	0.91
PI-03 (Credibility) Aggregate revenue out-turn compared to original approved budget	105	0.00	3.00	<b>1.67</b>	1.12
PI-05 (C&T) Classification of the budget	106	0.00	3.00	<b>1.71</b>	0.88
PI-06 (C&T) Comprehensiveness of information in budget documentation	106	0.00	3.00	<b>1.75</b>	0.94
PI-07 (C&T) Extent of unreported government operations	93	0.00	3.00	<b>1.11</b>	1.04
PI-08 (C&T) Transparency of inter-governmental fiscal relations	91	0.00	3.00	<b>1.49</b>	0.94
PI-10 (C&T) Public access to key fiscal information	106	0.00	3.00	<b>1.24</b>	0.93
PI-11 (PBB) Orderliness and participation in the annual budget process	106	0.00	3.00	<b>1.94</b>	0.79
PI-12 (PBB) Multi-year perspective in fiscal planning, expenditure policy and budgeting	106	0.00	3.00	<b>1.22</b>	0.75
PI-16 (Predictability) Predictability in the availability of funds for commitment of expenditures	106	0.00	3.00	<b>1.28</b>	0.80
PI-18 (Predictability) Effectiveness of payroll controls	102	0.00	3.00	<b>1.27</b>	0.86
PI-19 (Predictability) Competition, value for money and controls in procurement	101	0.00	3.00	<b>1.25</b>	0.82
PI-20 (Predictability) Effectiveness of internal controls for non-salary expenditure	106	0.00	3.00	<b>1.27</b>	0.71
PI-21 (Predictability) Effectiveness of internal audit	106	0.00	3.00	<b>1.09</b>	0.72
PI-24 (Accounting) Quality and timeliness of in-year budget reports	106	0.00	3.00	<b>1.26</b>	0.80
PI-25 (Accounting) Quality and timeliness of annual financial statements	105	0.00	3.00	<b>1.20</b>	0.84
PI-26 (Audit) Scope, nature and follow up of external audit	103	0.00	2.50	<b>0.92</b>	0.77
PI-27 (Audit) Legislative scrutiny of the annual budget law	104	0.00	3.00	<b>1.46</b>	0.80
PI-28 (Audit) Legislative scrutiny of external audit reports	98	0.00	3.00	<b>0.78</b>	0.77

Note: The **BLUE** figure is the highest mean PI score and the **RED** figure the lowest mean PI score

By contrast, insights from the fieldwork in Benin revealed varying notions of ‘participation’ (and access to relevant information) in the budgeting process, particularly at the grassroots level—since the latter represents a key constituency affected by health service delivery. For civil society actors and citizens (as well as donors), participation is seen as a critical means by which they engage in public policy from the perspectives of their needs and contextual knowledge and experience. To engage effectively in the process, the various actors, particularly grassroots community members, require appropriate information, not least regarding the extent of their participation envisaged, budget amounts available, the negotiation process, access to in-year budget execution reports, enacted budgets and feedback on prior decisions and implementation results. Findings from the fieldwork show that local governments already have some of these important ingredients in place, while others are absent. For instance, the value of the municipal investment budget is available, and the proportion allocated to participatory budgeting (PB) projects is usually communicated to civil society and community members involved in the PB process. However, in the municipalities we investigated, the extent of participation by community members varies according to the number of years of PB experience, ‘political interests and timeframe available’ (Faladé, 2019). In-year budget reports were not available in most municipalities; and oral feedback on executed budget was provided through one or two municipal public hearing forums. The public can and do voice their concerns, and ask questions accordingly, but they lack the means to follow up any unsatisfactory replies. There is therefore ample scope for improvement of current practices, to capitalize on the evident potential for much deeper participation, to engender greater societal benefits.

At the central government level, participation entails the traditional bureaucratic involvement of government structures and institutions in the budgeting process. It is only recently that some NGOs were invited to the process, which resulted in a specific budget allocation for health in decentralized territorial units:

*‘...it was in 2016 that we were invited for the first time to the annual reviews of public finances. When the draft government budget is sent to the National Assembly [i.e., the Parliament], it usually sends us an invitation. So, every year in November we go to it to pose the problems of society... But we found that our involvement did not change anything... It just became a simple formality! And we told them [i.e. MPs]: ‘you listen to us attentively, but you do not take any of the measures that we propose’. It was officials from the Ministry of Finance who told us informally that when the budget reaches the National Assembly, it is already too late to change anything... Then, we agreed that we can participate earlier in the process... As a result, we succeeded in agreeing with the government to have a specific investment budget allocation for health in municipalities [called FADEC Health] from 2019...’ [SCO02; SCO07]*

Returning to the PEFA data, between the two extreme indicators (PI-28 and PI-11) discussed above, there are a few indicators that stand out, in particular PI-5 *Classification of the Budget* and PI-6 *Comprehensiveness of Information included in Budget Documentation* which are part of the

*Comprehensiveness and Transparency* pillar. Even though these indicators do not generally reach expected standards, they do appear in relative terms to be among the strongest links. The structure of revenue and expenditure items and accounts, and their classification within the budget, tend to more or less inform budget execution and related financial reporting. Coupled with adequate supporting documentation at the budgeting level, this should facilitate accounting, auditing and parliamentary scrutiny at the downstream level. Among the remaining indicators of the *Comprehensiveness and Transparency* pillar, PI-8 *Transparency of Inter-governmental Fiscal Relations* appears to emerge as moderate. This denotes the extent to which rules and processes for budgeting and transfers or allocations between central and local governments are timely, objective and transparent. It suggests that *Comprehensiveness and Transparency* is in relative terms one of the strongest pillars, possibly only somewhat less robust than the *Policy-based Budgeting* pillar (PI-11 discussed above). More specifically, the framework and processes of central and local government budgeting and transfers arguably provide the foundation for PB to cascade down to the grassroots level. Public access to information as measured by PI-10 *Public Access to Key Fiscal Information* is virtually lacking across the countries studied. For example, in Benin “none of the six dimensions of information required by PEFA is made available to the public” (ACE International Consultants, 2014, p.58). With regard to the health service as an illustrative example from Benin, some publicly available policy documents<sup>10</sup> as well as discussions with key stakeholders during the fieldwork revealed that the health service in Benin has been sufficiently decentralized across the various levels of governments and territorial areas. But, as discussed in Section 5 below, even though health service provision is considered to be part of the decentralization policy and municipal development, it has not featured highly in PB in many municipalities owing to regulatory, financial and political constraints. Consequently, meaningful progress has been difficult.

The next indicators that stand out are PI-1 *Aggregate Expenditure Out-turn Compared to Original Approved Budget* and PI-3 *Aggregate Revenue Out-turn Compared to Original Approved Budget* (within the *Budget Credibility* pillar). These two indicators assess the consistency between budget forecasts and realized expenditures and revenues respectively. Large discrepancies are indicative of flaws in the budgeting process that undermine its credibility. The average scores of both indicators are not significantly different (slightly above the mid-point) suggesting moderate credibility of the budgeting process in the countries covered. There are some isolated extreme cases, however. For example, in 2014, Benin’s budget credibility with respect to expenditure is rather weak (equivalent to a D rating) while it is very strong regarding revenues (rating: A). According to the assessment report, “the current situation [with respect to expenditure in Benin] is characterized by a worsening of the discrepancies between the expenditure forecasts and the

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<sup>10</sup> Examples: World Bank (2013) Restructuring Paper on a Proposed Project Restructuring of Health System Performance Project Grant. Washington, DC: World Bank; Organisation Mondiale de la Santé (2016) Stratégie de Coopération de l’OMS avec le Bénin 2016–2019. Cotonou: WHO; Ministère de la Santé (2015) Politique Nationale de la Santé Communautaire. Cotonou: Ministère de la Santé.

amounts accounted for by the Treasury” (ACE International Consultants, 2014, p.38); whereas domestic revenue collection rates range from 97 to 106 percent of budgeted amounts.

Another noteworthy item is PI-27 *Legislative Scrutiny of the Annual Budget Law* of the *External Scrutiny and Audit* pillar. Despite this pillar being the weakest one, PI-27 stands out somewhat, indicating some effort, albeit modest, in reviewing the annual budgets and in-year amendments within established procedures: possibly as a result of pressure from development partners in this regard.

The average score per pillar is presented in Table 3 (and Figure 1) and shows that except for one pillar (*Policy-based Budgeting*) which exceeds the mid-point, all the pillars fare below 1.50 (i.e. rating C+) on average. This reflects, with few exceptions, persisting weaknesses in the PFM system across Sub-Saharan African countries. Consistent with the insights from the analysis of indicators, *External Scrutiny and Audit* emerges as the weakest pillar. Overall, the ‘downstream’ pillars appear to be weaker than the upstream indicators, suggesting a disproportionate attention to the budget formulation phase compared to oversight of its execution. Similar findings were reported by de Renzio (2009).<sup>11</sup> Without adequate control over the use of public resources and proper accounting for them, service delivery and accountability are likely to be compromised. Nonetheless, in spite of the observed PFM system weaknesses, it would be helpful to see whether there has been a shift in the degree of attention accorded to upstream and downstream PFM, respectively, since the earlier assessment by de Renzio (2009).

Nevertheless, in absolute terms, these (albeit significant) results provide limited insight into progress or improvements achieved over time, particular as further reforms and capacity building programs come into play. To gain such insights, the next section therefore considers the evolution of scores across periods.

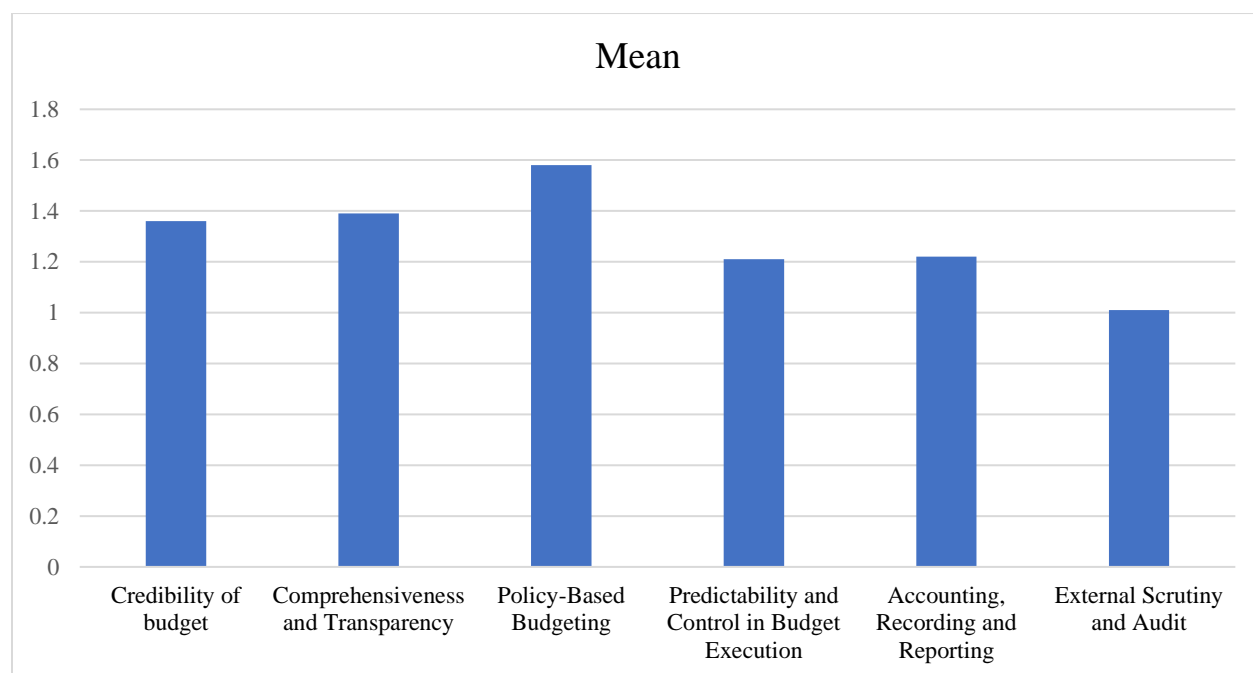
**Table 3: Average SSA score per PEFA pillar**

	N	Minimum	Maximum	Mean	Std deviation
Credibility of Budget	106	0.00	3.00	<b>1.36</b>	0.74
Comprehensiveness and Transparency	106	0.20	3.00	<b>1.39</b>	0.61
Policy-based Budgeting	106	0.00	2.75	<b>1.58</b>	0.66
Predictability and Control in Budget Execution	106	0.00	2.70	<b>1.21</b>	0.58
Accounting, Recording and Reporting	106	0.00	3.00	<b>1.22</b>	0.70
External Scrutiny and Audit	106	0.00	2.67	<b>1.01</b>	0.58

<sup>11</sup> de Renzio, P. (2009) Taking Stock: What do PEFA Assessments tell us about PFM systems across countries [Online], Overseas Development Institute Working Paper 302, Available from: <http://www.odi.org.uk/resources/download/3333.pdf> [Accessed 17 April 2020]



**Figure 1: Average score per PEFA pillar (SSA)**



#### **4.2. Progress achieved**

In an attempt to assess progress in PFM systems in the countries covered, the PEFA assessment scores have been divided on the basis of two periods: (1) up to 2010 and (2) after 2010. The rationale for choosing that particular year is twofold. First, it offers a chance to see how the PEFA assessments compare after roughly a decade of experience since launch in 2001. Second, given the 2008 financial crisis and consequent impact on government finances, thus PFM, especially in poor African countries, it would be reasonable to follow up on changes that it might have brought about, and likely persistent effects on the PFM system and processes after 2010.

With this in mind, the average score is calculated for each indicator up to 2010 and after 2010. The result is presented in Table 4. In most of the upstream aspects of the PFM system, the average scores appear to have deteriorated, with few exceptions. For example, the *Budget Credibility* pillar records a decline in all its indicators, more notably in *PI-3 Aggregate Revenue Out-turn Compared to Original Approved Budget*. This may be explained by some unpredictability in domestic revenues that are highly connected to overseas transactions (such as custom levies) including export revenues (and related domestic income tax), arising from the financial crisis and its aftermath. Given the limited capacity of many governments, a considerable period of time may well be needed to adjust to these challenges. Such adjustment is now likely to take even more time, as the COVID-19 crisis introduces additional and possibly far-reaching challenges that have taken all these countries by surprise. In some cases, the quality of the input data and the underlying methodology were called into question. For example, inquiries at the Ministry of Finance revealed

that: ‘the lack of sincerity in the budgeting process, particularly the lack of quality data, compromised the integrity of the forecasts, which had become less and less relevant for decision-making... But since 2014, efforts have been made with the use of modern tools to improve the process’ [MEF02; MEF03]. Similarly, scores fell for three of the five indicators of the *Comprehensiveness and Transparency* pillar (including *Public Access to Key Fiscal Information*), and the remaining two only improved very marginally after 2010.

**Table 4: Average SSA indicator scores for the period up to 2010 and after 2010**

	Up to 2010		After 2010	
	N	Mean	N	Mean
PI-01 (Credibility) Aggregate Expenditure out-turn compared to original approved budget	45	1.69	58	<b>1.43</b>
PI-02 (Credibility) Composition of expenditure out-turn compared to original approved budget	44	1.07	55	<b>0.94</b>
PI-03 (Credibility) Aggregate revenue out-turn compared to original approved budget	45	2.09	60	<b>1.35</b>
PI-05 (C&T) Classification of the budget	46	1.74	60	<b>1.68</b>
PI-06 (C&T) Comprehensiveness of information in budget documentation	46	1.74	60	<b>1.77</b>
PI-07 (C&T) Extent of unreported government operations	41	1.32	52	<b>0.94</b>
PI-08 (C&T) Transparency of inter-governmental fiscal relations	39	1.47	52	<b>1.50</b>
PI-10 (C&T) Public access to key fiscal information	46	1.30	60	<b>1.18</b>
PI-11 (PBB) Orderliness and participation in the annual budget process	46	1.86	60	<b>2.01</b>
PI-12 (PBB) Multi-year perspective in fiscal planning, expenditure policy and budgeting	46	1.13	60	<b>1.29</b>
PI-16 (Predictability) Predictability in the availability of funds for commitment of expenditures	46	1.24	60	<b>1.31</b>
PI-18 (Predictability) Effectiveness of payroll controls	43	1.10	59	<b>1.39</b>
PI-19 (Predictability) Competition, value for money and controls in procurement	42	1.25	59	<b>1.25</b>
PI-20 (Predictability) Effectiveness of internal controls for non-salary expenditure	46	1.11	60	<b>1.40</b>
PI-21 (Predictability) Effectiveness of internal audit	46	1.04	60	<b>1.13</b>
PI-24 (Accounting) Quality and timeliness of in-year budget reports	46	1.24	60	<b>1.28</b>
PI-25 (Accounting) Quality and timeliness of annual financial statements	46	1.15	59	<b>1.23</b>
PI-26 (Audit) Scope, nature and follow up of external audit	44	0.89	59	<b>0.94</b>
PI-27 (Audit) Legislative scrutiny of the annual budget law	45	1.33	59	<b>1.56</b>
PI-28 (Audit) Legislative scrutiny of external audit reports	42	0.76	56	<b>0.79</b>

The most notable improvements shown in Table 4 are in downstream indicators, particularly within the *Predictability and Control in Budget Execution* and *External Scrutiny and Audit* pillars. On average, all the indicators within these pillars have seen an increase in score (except one, which remains static). Payroll controls (PI-18) and non-salary expenditure controls (PI-20) show the highest improvements, followed by legislative scrutiny of the budget (PI-27). Greater expenditure (salary and non-salary) controls may reflect efforts to reduce ‘leakages’ in response to unpredictability in revenues, and possibly the increased use of technology to underpin controls (Lassou et al. 2020a). Progress in parliamentary control of the budget could be motivated by the same factor, and potentially, increased pressures from donors. To some extent, and as revealed from the fieldwork, the increasing donor pressures are thought to be the result of learning from

earlier assessments, which provided empirical evidence for the need to balance efforts across the budget cycle.

Notably for Benin, the average scores for all the pillars (Table 5), except two (*External Scrutiny and Audit* and *Accounting, Recording and Reporting*), have deteriorated over time from the initial assessment in 2007 to the recent one in 2014. This is quite intriguing, given the elapse of seven years which might arguably have provided sufficient learning experience and time to improve initial weaknesses. A recurrent explanation to emerge from the fieldwork was a general lack of political will to undertake (and resource) prompt and relevant remedial action. As a result, there was insufficient allocation of ‘resources to elaborate and implement needed reforms to address the weaknesses identified by the PEFA assessment’ [DON04].

**Table 5: Average score per pillar in 2007 and 2014**

	2007	2014
Credibility of Budget	1.67	1.00
Comprehensiveness and Transparency	0.80	0.50
Policy-based Budgeting	2.00	1.75
Predictability and Control in Budget Execution	1.10	1.00
Accounting, Recording and Reporting	0.75	1.00
External Scrutiny and Audit	0.50	0.83

Additionally, there is a general observation that another assessment is overdue in order to evaluate improvements achieved and challenges remaining since 2014; especially given the realization that the 2007 assessment did not yield significant improvements or progress. Some stakeholders involved in central government PFM commented that discussions were initiated by donors, but to no avail:

*‘We [donors] said, after 2014, 2015, and 2016, that we need another PEFA assessment, but people slowed down the process... At some point, they [i.e. the government] suggested that they would first conduct an auto-evaluation [a PEFA self-assessment] to see where they stand by themselves. We accepted the idea and offered to fund it. We made the fund available... Even the UNDP wanted to fund it in coordination with the other donors... We received two Terms of Reference, but as of today no-one knows why it didn’t happen.’*

*‘The Ministry of Economy and Finance stated that ‘if we carry out an auto-assessment, we will find out the weaknesses, and correct them before we carry out the formal assessment to show that things are on track’.*

Although the idea that a self-assessment be conducted in advance of the formal one could be regarded as some sort of image remediation exercise, it could also be commended for its ultimate objective to improve PFM systems for better economic and social outcomes. However, there is no

evidence to date that the political impetus was ever translated into action likely to attain the intended results. More recently,

*‘... the DGB [Budget Department] accepted to perform a PEFA-like diagnostic assessment but only confined to the DGB, only the budget part, which means that we should not look at all the PEFA indicator sets. Here also we agreed to support them; but in the end it didn’t take place...’*

The lack of political will and limited interest within civil service circles to engage (even partially) with the PEFA agenda may suggest a reluctance to engage in ‘difficult conversations’ expected to ensue if indicators and assessments reveal a predictable lack of improvement or worsening performance. This reluctance carries a telling resonance in the context of the persisting COVID-19 crisis and calls upon governments to implement substantial economic support policies and increase public health expenditure.

#### **4.3. Analysis of potential associations (correlations) between PEFA indicators/pillars and selected health expenditures and outcomes**

To explore the likely relationships between PFM systems or processes and health service delivery in Africa, we estimate bivariate correlations between PEFA pillars and selected health expenditures and outcomes extracted from the World Development Indicators (produced by the World Bank). The results are presented in Table 6. As mentioned previously, we do not presume there is a direct relationship between PFM systems or processes (via PEFA scores) and health outcomes in the sense that having better PFM processes might automatically result in improved health outcomes. Such a relationship is likely to be indirect and mediated by a number of factors, which can be explored further as part of qualitative analysis. For example, a solid PFM system or process is likely to lead to better planning and improved allocation of resources to key sectors (such as health or education), improved controls and monitoring of resource use for public goods and services (such as health service delivery), thus leading to better access for citizens and thereby better health treatment and outcomes.

Hence, as shown in Table 6, we find most of the correlations between PEFA pillars and health expenditures/outcomes are as expected, that is, improved PEFA scores are significantly and positively associated with improved health expenditure and outcomes. Domestic health expenditure per capita is significantly associated with four PEFA pillars, namely: *Comprehensiveness and Transparency, Predictability and Control in Budget Execution, Accounting Recording and Reporting, and External Scrutiny and Audit*. This indicates that there is an alignment between health expenditure and transparency, adequate documentation (which enables monitoring and provides an audit trail for external scrutiny at a later stage), improved control over spending, and proper accounting for its execution, leading to enhanced oversight and lessons learned for potential corrective measures and future planning.

**Table 6: Correlations between PEFA pillars and selected SSA health expenditures and outcomes**

		Credibility of the Budget	Comprehensiveness & Transparency	Policy-Based Budgeting	Predictability and Control in Budget Execution	Accounting, Recording and Reporting	External Scrutiny and Audit
Capital health expenditure (% of GDP)	Pearson Correlation	-0.108	<b>-0.320*</b>	-0.098	<b>-0.378*</b>	-0.291	-0.238
	Sig. (2-tailed)	0.486	0.034	0.526	0.011	0.056	0.119
Domestic general government health expenditure (% of GDP)	Pearson Correlation	0.123	<b>0.304**</b>	0.198	0.026	0.030	0.217
	Sig. (2-tailed)	0.270	0.005	0.074	0.818	0.791	0.052
Domestic general government health expenditure per capita (current US\$)	Pearson Correlation	0.172	<b>0.352**</b>	0.089	<b>0.324**</b>	<b>0.309**</b>	<b>0.381**</b>
	Sig. (2-tailed)	0.122	0.001	0.428	0.003	0.005	0.000
External health expenditure (% of current health expenditure)	Pearson Correlation	-0.051	0.165	0.123	0.022	0.070	0.009
	Sig. (2-tailed)	0.647	0.137	0.271	0.846	0.530	0.938
External health expenditure per capita (current US\$)	Pearson Correlation	-0.160	<b>0.314**</b>	0.014	0.085	0.053	<b>0.262*</b>
	Sig. (2-tailed)	0.150	0.004	0.902	0.449	0.634	0.018
Immunization, BCG (% of one-year-old children)	Pearson Correlation	0.173	<b>0.257**</b>	0.146	0.115	<b>0.208*</b>	0.176
	Sig. (2-tailed)	0.084	0.009	0.145	0.250	0.037	0.080
Immunization, HepB3 (% of one-year-old children)	Pearson Correlation	0.042	<b>0.287**</b>	0.176	0.193	<b>0.225*</b>	0.194
	Sig. (2-tailed)	0.687	0.005	0.086	0.060	0.027	0.060
Immunization, measles (% of children ages 12–23 months)	Pearson Correlation	0.087	<b>0.359**</b>	<b>0.232*</b>	<b>0.314**</b>	<b>0.349**</b>	<b>0.365**</b>
	Sig. (2-tailed)	0.387	0.000	0.020	0.001	0.000	0.000
Immunization, Pol3 (% of one-year-old children)	Pearson Correlation	0.049	<b>0.279**</b>	<b>0.198*</b>	<b>0.223*</b>	<b>0.212*</b>	0.193
	Sig. (2-tailed)	0.625	0.005	0.047	0.025	0.033	0.054
Maternal mortality ratio (modeled estimate, per 100,000 live births)	Pearson Correlation	<b>-0.219*</b>	<b>-0.308**</b>	<b>-0.257*</b>	<b>-0.368**</b>	<b>-0.298**</b>	<b>-0.366**</b>
	Sig. (2-tailed)	0.034	0.003	0.012	0.000	0.004	0.000
Newborns protected against tetanus (%)	Pearson Correlation	0.113	0.176	0.032	0.142	0.120	-0.002
	Sig. (2-tailed)	0.260	0.078	0.747	0.157	0.232	0.985
Tuberculosis case detection rate (% , all forms)	Pearson Correlation	0.153	0.176	0.118	<b>0.313**</b>	<b>0.215*</b>	<b>0.295**</b>
	Sig. (2-tailed)	0.129	0.079	0.241	0.002	0.032	0.003
Tuberculosis treatment success rate (% of new cases)	Pearson Correlation	0.185	0.079	0.075	<b>0.242*</b>	0.185	0.191
	Sig. (2-tailed)	0.081	0.459	0.484	0.022	0.080	0.073

The **GREEN** color stands for significance at 1%; **LIGHT GREEN** for significance at 5%; and **RED** for odd correlations

Similarly, External Health Expenditure per capita (which represents all financial inflows into the national health system from outside the country),<sup>12</sup> including donor funding, is significantly associated with *Comprehensiveness and Transparency* and *External Scrutiny and Audit* pillars.

<sup>12</sup> World Bank's World Development Indicators: <https://databank.worldbank.org/source/world-development-indicators>

This is revealing of donors' increasing push for transparency in PFM (particularly in the budgeting process) in aid recipient countries, and the associated pressure for greater external scrutiny (with an emphasis on the legislative processes) of the budget execution cycle. For example, in 2014 the pillar that in Benin improved significantly was *External Scrutiny and Audit*. In that year, and the next, Benin faced mounting pressures from donors who made their budget support conditional on the passage into law of the *Lois de Règlement* (budget out-turn) from 2009 to 2013.<sup>13</sup> Compliance meant improved parliamentary oversight of the budget execution process. The strong correlation between external health expenditure and external scrutiny could be attributed to that effort on the part of donors.

Eight health outcomes have been selected for the correlation analysis. Among these, Maternal Mortality Ratio, one of the major health outcomes, stands out as the one with significant correlations with all six PEFA pillars used in the analysis. Improvements in any of the pillars translate, albeit indirectly, into reduced 'number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination' (a key indicator of health performance). Better planning and budgeting, tighter monitoring, and improved accounting and stronger legislative oversight can be seen to have lifesaving implications.

The rate of immunization (vaccination) of children aged 12–23 months against measles is another health outcome with similar results, except for the *Budget Credibility* pillar, with which it is positively, but not significantly, associated. Unvaccinated young children, particularly in Africa and Asia, are at the highest risk—sometimes fatal—of contracting measles.<sup>14</sup> The association between this vaccination rate and PFM processes (through PEFA scores) offers an important insight. For the same reasons affecting maternal health, improvements in PFM reflected in PEFA scores appear to foster positive outcomes for young children.

Other childhood immunization rates—against polio; hepatitis B; and BCG against tuberculosis—are also positively related to PEFA pillars, but the significance of the relationships varies across the pillars. While immunization against polio is significantly correlated with four pillars (*Comprehensiveness and Transparency, Policy-based Budgeting, Predictability and Control in Budget Execution, and Accounting, Recording and Reporting*), immunization against hepatitis B and tuberculosis (BCG) are only correlated with two pillars (*Comprehensiveness and Transparency, and Accounting, Recording and Reporting*). In any case, the importance of transparency and accounting and reporting comes to the fore when considering any of the health outcomes that flow from immunization. This highlights the significance of transparency and accountability in PFM for improved public service delivery.

Two tuberculosis related health outcomes have been considered: Tuberculosis Detection Rate and Tuberculosis Treatment Success Rate. The first—Tuberculosis Detection Rate—is significantly and positively associated with downstream PFM reflected in three PEFA pillars, namely:

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<sup>13</sup> Damiba, L., & Badet, G. (2016). *Évaluation du Système National d'Intégrité du Bénin*. Cotonou, Benin: Transparency International.

<sup>14</sup> World Health Organization: <https://www.who.int/news-room/fact-sheets/detail/measles>

*Predictability and Control in Budget Execution, Accounting, Recording and Reporting, and External Scrutiny and Audit.* This adds to the points raised above regarding the importance of effective monitoring of budget execution and related reporting and oversight without downplaying the upstream pillars (which are positively, but not significantly, related to the tuberculosis detection rate). The second health outcome—Tuberculosis Treatment Success Rate—is significantly related only to the *Predictability and Control in Budget Execution* pillar.

Nevertheless, one correlation appears odd. Capital health expenditure (as a percentage of GDP) is negatively and significantly associated with two PEFA pillars (*Comprehensiveness and Transparency*, and *Predictability and Control in Budget Execution*). It is also negatively related to the other pillars, but in this case, the relationship is not statistically significant. The indicator level correlation analysis reveals the same results (see Appendix C). This raised questions regarding the integrity of recording and reporting processes with respect to capital expenditure data, as well as the extent to which the disclosed capital health expenditure is reflective of actual investment in health infrastructure. The issue was explored during the fieldwork phase. Inquiries were formulated at key institutions, and senior officials across the health sector offered some insights that can be summarized as follows:

*‘For example, equipment that is energy-intensive is placed in a health center with erratic power, and sometimes the main user has not been properly trained to operate it... Then the equipment breaks down, following a power outage, and the service is stopped even though the equipment is still brand new... Most of the time, the incident is not reported because no one wants to take responsibility for it...’*

*‘There is also the issue of weak technical monitoring of some health building construction. It's built, and it's all beautiful, but, once the rain falls, you see that water is flowing through cracks. This is the case for the new building for the Research Division within the Ministry of Health ... at the very heart of the Ministry, next to the Division in charge of infrastructure that is supposed to oversee the work. Can you imagine what things are like for the peripheral units?’*

The implication of the above is that capital health spending indicators focus on the investment in infrastructure and equipment, without much monitoring of subsequent performance or functionality (or even whether a given item of equipment is still physically located on site). Furthermore, this lack of information, or covering up of deficiencies in equipment and facilities, impinges on actual health investment needs and undermines the accuracy of health investment data. This is exacerbated by some tactical ‘gaming’ during the reporting process, as explained by a senior health official: *‘Obviously, when you go for the reporting, you see that the criteria are met. To understand what is going on, to know, you have to have lived in the area maybe a week before the assessment. There are even tools, materials, that people move from one center to another, just because it is the reporting period.’* This behavior is understood to be mostly motivated by a fear of sanctions (such as a job transfer or change in role). Another critical factor

is the way data is sometimes collected: *‘There are forms that are put in place in health centers. The health official gives the form to the caregiver who fills it in as they see fit... When you go to verify these data in the field, they don’t always tally. To give an example, the 2013 EDS survey [Demographic and Health Survey] was challenged by a mixed survey that revealed the truer face of the health indicators. It’s true that when it [the indicator] came out, it made people believe that everything was fine, while the reality was different.’* It also emerged that capital expenditure on health has significant political and financial implications, which represent influential political economy factors that interact with the quality of reported health investment data. As remarked by many informants within the health sector and administrative structures, the desire to appeal to citizens (in effect the electorate) means that politicians tend to report these expenditures *‘more favorably than they actually are’*. Similarly, we understood that the urge to maintain donors’ interest in the sector (as reflected in the relatively high external health expenditure per capita; see Table D.4, in Appendix D) amounts to an incentive to *‘produce health investment data as expected’* and thereby secure recurring financial support from donors.

Due to the limited number of PEFA assessments in Benin (there are only two), it is not possible to conduct correlation analysis between PEFA scores and health expenditure and outcomes specifically for the country. Instead, we explore the trend of selected health statistics and how they compare with the WAEMU<sup>15</sup> regional member countries (except Guinea-Bissau). As shown in Table D.2, on average, Benin’s general health expenditure stood at 0.9% of GDP over the period from 2004 to 2016 (the latest data available), which is the lowest of the region (together with Cote d’Ivoire). In current dollars, it is the third lowest (Table D.4). Data on expenditure or budget allocations obtained during the fieldwork show that less than 5% of the government budget/expenditure is allocated to the health sector. For example, the 2017 WHO statistics show that health expenditure represents only 3.4% of total government expenditure in 2015; in 2016, the budget allocation was 6.1%, subsequently dropping to 2.7% in 2018, before a slight increase in 2019 (see Table 7). This is indicative of the limited priority of the sector relative to neighboring countries. The limited government resource allocation to the health sector may also explain why we see an increasing trend in external health expenditure from overseas averaging US\$ 8.20 per capita, the third highest in the WAEMU region (see Table D.4).

With regard to health outcomes, as revealed by immunization, Benin performs worse than most countries in the WAEMU region (Tables D.5–D.8), except for immunization against tuberculosis (Table D.5). However, the country fares well on newborns protected against tetanus (Table D.10) and successful tuberculosis treatment (Table D.11), and has one of the lowest maternal mortality rates (Table D.9); this could be attributable to the renewed focus on improving the quality of maternal and neonatal health services, particularly for the poorest segments of the population.<sup>16</sup> In relation to the PEFA assessment scores, even though it is difficult to draw definite connections

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<sup>15</sup> West African Economic and Monetary Union: Benin, Burkina Faso, Cote d’Ivoire, Guinea-Bissau, Mali, Niger, Senegal, and Togo.

<sup>16</sup> World Bank (2013) Restructuring Paper on a Proposed Project Restructuring of Health System Performance Project Grant. Washington, DC: World Bank.



with health outcomes from two observations, it appears that, on average, the drop in PEFA scores from the 2007 assessment to the 2014 assessment is concurrent with a deterioration in a number of health outcomes in these years, especially immunization. Only two outcomes improved: maternal mortality rate (moderately) and tetanus treatment rate (marginally). In effect, these results support the findings from the correlation analysis.

Interestingly, however, despite the increasing efforts, including from development partners, to strengthen health service provision at a subnational government level to improve access to vulnerable communities (see for example, World Bank 2013), there is little evidence from health policy documents that communities are involved in defining health-related priorities or delivery in their areas. Relatedly, a review of the existing PEFA indicators shows that they have little ability to capture such participation, assuming that it is taking place. The examination of Benin's experience of participatory budgeting (PB) provided insights into the extent of community involvement in health service delivery (but not in health policy) at a local level.

Malaria is a major health issue, with 93% and 94% of related cases and deaths respectively occurring in Sub-Saharan Africa.<sup>17</sup> As a result, we sought to examine malaria health outcomes as part of the analysis. However, no such data could be located during this initial analysis phase. Instead, we accessed reported cases of malaria, but a further search did not yield any statistics on treatment (whether actual or availability of access) that could serve as a proxy for health outcomes. Inquiries among health officials revealed that: *'successful treatment cases and death cases related to malaria are not recorded... What is recorded is the consultation and treatment given in terms of prescription and those such as pregnant women and children under five who receive free treatment, but when they leave the health center there is no follow-up, unless they return to the center again'* [MED03; MED04]. The reporting policy underpinning this situation could have been further examined, given the importance of indicators relating to tangible health outcomes. Unfortunately, the request to meet the relevant officials at the Ministry was not successful. Nevertheless, according to the WHO,<sup>18</sup> there were some encouraging results between 2013 and 2014 in Benin, with only a minor increase in cases of malaria, and a slight decrease in the death rate. As learned during the fieldwork, the death rate, however, only covers those who died at a hospital or health center.

This phase of the study has focused on using quantitative analysis to examine the performance of a PFM system (via PEFA assessment ratings/scores) and potential links with selected health expenditures and outcomes (including related policies), while relying on some insights from the field study to offer possible explanations. Overall, PFM systems remain weak across Sub-Saharan Africa, with downstream PFM pillars appearing the weakest. However, our analysis reveals a slight shift in the relative efforts by both domestic and donor actors towards this phase of the budgeting cycle, which resulted in greater improvements of downstream pillars compared with the upstream ones. In conjunction with health service delivery, the results show statistically significant

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<sup>17</sup> World Health Organization: <https://www.who.int/news-room/fact-sheets/detail/malaria>

<sup>18</sup> Organisation Mondiale de la Santé (2016) Stratégie de Coopération de l'OMS avec le Bénin 2016–2019. Cotonou: WHO

associations between PEFA scores and health resources and outcomes; thus, bringing out the lifesaving implications of effective PFM systems. While the analysis provides interesting findings in terms of both progress achieved and remaining challenges at the macro-level, it has also raised significant questions, especially with regard to the translation of PFM systems into the delivery of public services at the micro-level of grassroots communities. In particular, there are significant gaps in the understanding of how PB, as an integrated component of PFM, is deployed in local government in the context of health service delivery in individual countries, and the nature and extent of stakeholder involvement and engagement in these locally adopted PB process, with an emphasis on service delivery in healthcare provision. These particular questions, which originated during phase one of this study, are answered by insights from the second phase in Benin in the context of health service delivery to local communities at the subnational level.

## **5. Participatory Budgeting in Benin and its ramifications for health service provision to local communities**

The second phase of our analysis is conducted at the micro-level of subnational government (municipalities and local government).<sup>19</sup> This examines the extent of adoption of PB as a PFM submechanism for public service delivery, how it is deployed in local communities, and how it contributes to addressing community needs, with an emphasis on community health service provision.

Participatory budgeting in Benin has been, for the most part, a donor-driven initiative, except in one case (Adjarra), which in more recent years also received donor support. The involvement of donors is both direct and indirect. The bulk of their support to PB in Benin is through civil society organizations (CSOs), and we refer to this as a form of indirect intervention. Additionally, donors such as GIZ have technical assistants seconded to some municipalities and employed in an advisory role, also providing some financial support, at times, which we refer to as direct intervention. By the time our fieldwork was completed in July 2020, of the 77 municipalities, approximately 30 had undertaken a PB exercise at least once—whether officially recognized or not (such as by the International Observatory on Participatory Democracy, IOPD). It also came to our attention during the fieldwork that none of the largest municipalities—Cotonou, Parakou or Porto-Novo, (known as municipalities with special status, in view of their size and geographical position)—has undergone a PB experience to date.

The experience of five municipalities that had undertaken PB exercises (Adjarra, Comè, Covè, Ouinhi and Toffo) was investigated, alongside that of one that did not adopt PB (Cotonou). These municipalities represent a range of sizes, in terms of population, and different geographical locations: one in the South (Cotonou), one in the South-West (Comè), one in the South-East (Adjarra), one in the South-Centre (Toffo), and two within the central region (Covè and Ouinhi). The population of these municipalities ranges from about 40,000 (Covè) to over 100,000 (Adjarra),

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<sup>19</sup> Municipalities or local governments are used interchangeably in the report to designate subnational governments in Benin.

other than Cotonou, which is home to roughly one million. With respect to gender, one of the six municipalities selected is led by a woman Mayor, while the other five are led by men. It needs to be emphasized that at the time of the fieldwork, there were only three female Mayors out of 77 across the country. Although the five selected municipalities with PB experience reflected some similarities in terms of the involvement of various stakeholders in the process (ranging from local community groups to village chiefs, CSOs and elected and administrative municipal officials), they also displayed significant differences in terms of approach, the extent of citizen engagement in the process, the degree of flexibility to modify the approach as necessary, and the consequences (enhancing citizen influence, fostering public accountability and improving financial and social/health outcomes).

As we outlined earlier, Benin's PB systems, particularly in relation to health service delivery, face critical challenges, particularly in local and sometimes fairly remote communities. This is reflected in key health data analyzed in phase one of the study, such as high maternal and neonatal mortality rates and the steady number of malaria cases, with important consequences for social and economic activities. It is in this context that we examined the extent to which health service provision flows from local PB systems. We observed that health service was to some extent considered in four out of the five selected municipalities that exercised PB, but the scope of this consideration and progress achieved vary substantially among these municipalities. We structure our findings in terms of (i) what is *expected* or *ought* to be happening from a regulatory and/or normative perspective of PB in these municipalities, and (ii) what is *actually* happening on the ground, both in terms of addressing expectations of PFM through PB systems, engendering contextually-specific benefits and mitigating challenges.

### 5.1. Regulatory and Normative Aspirations

A PB-related PFM mechanism was set up in Benin (including within the health sector) in 2016 to embed and facilitate dialogue and negotiation between local authorities, NGOs and community-level civil society organizations. The objective behind this initiative has been to promote citizen participation when addressing their needs and in doing so instigate a culture of accountability, which has manifested in post-audit and public hearings across municipal governments. This initiative, facilitated jointly by two main NGOs – Social Watch Benin and ALCRER – has resulted in the establishment in 76 (out of 77) municipalities of a Citizen Participation Unit (*Cellule de Participation Citoyenne*, CPC). Each CPC comprises 13 to 15 members, bringing together local citizens and civil society organizations to serve as an interface between the elected officials and local population. This ensures their collective participation in the public decision-making process and in holding the authority to account for its activities (Loko 2017, p. 4).

An initial 'arena for such participation' was enacted through the formulation of the municipal development plan (PDC)<sup>20</sup> and provided for by Law No. 97-029 enacted in 2008. All *communes* highlighted the involvement of the population and civil society groups in the drafting of planning

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<sup>20</sup> In French, *Plan de Développement Communal* (PDC).

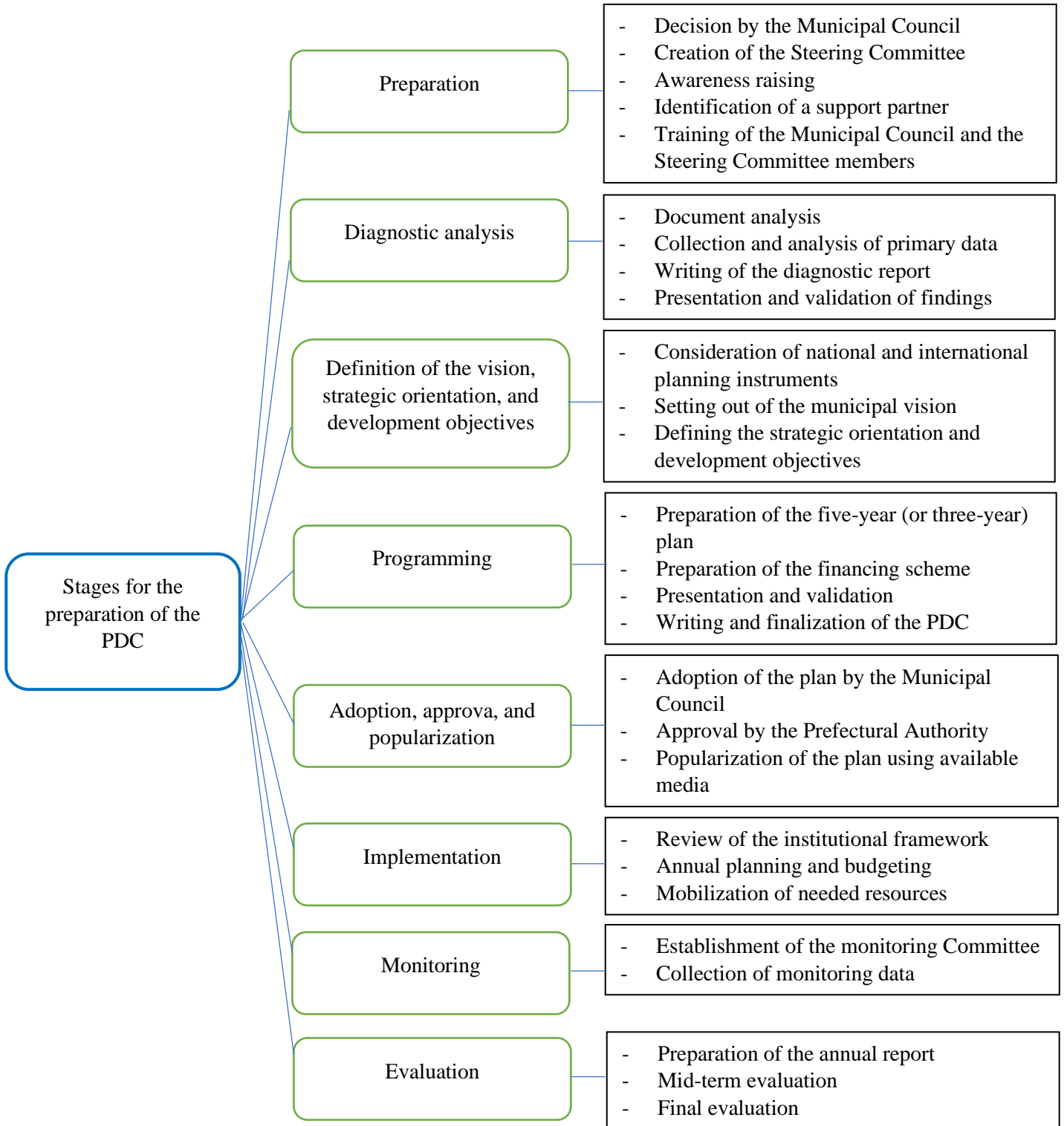
documents, primarily the PDC, such that beneficiary populations are recognized as key integral stakeholders. The PDC is akin to the medium-term expenditure framework (MTEF) at the municipal government level, covering a period of three years (for the largest municipalities), or five years (for small and medium-sized municipalities). The plan is designed and developed in eight essential stages, as set out by the Ministry in Charge of Decentralization: preparation; diagnostic analysis; definition of the vision; programing; adoption, approval and popularization; implementation; monitoring; and evaluation. Figure 2 below portrays the eight steps embedded in the PDC framework.

The adoption of this framework by all municipalities was attributed to the preparation of their medium-term plan (Law No. 97-029), which serves as the basis for the annual budget, and must ultimately be approved by the Prefect. The involvement in the plan of the population and civil society, including local community groups, is highlighted in three out of the eight stages, namely: (1) the preparation stage, with an awareness-raising campaign to enable community members and relevant groups to make informed contributions at the subsequent stages; (2) the diagnostic analysis stage, when they provide critical information about local and community conditions, needs and priorities; and (3) the monitoring stage through their oversight of community projects and works. However, despite the importance of such an engagement of the citizens and other local stakeholders in defining the local or municipal development plan, setting priorities, and related resource allocations, ‘participation’ as conceived within the PDC framework does not appear to be aligned with the expectations of PB. The reasons for this are three-fold.

First, the PDC participation is conducted once for a five-year or three-year plan and the municipal annual budgeting process does not provide any further space for input from the community and other local stakeholders. Second, once the initial consultation to gather community needs for the PDC is completed, actual prioritization of these needs is decided in the presence of elected municipal officers in the Town Hall, with no further involvement of community members or representatives. It is thus frequently unclear why a given project is selected in preference to a rival option. Third, while the entirety of the municipal investment plan and budget are in principle subject to the participation exercise, in practice often only a portion is made available for discussion or scrutiny within the PB process, as if that were tantamount to full *participation*. Finally, given that the PDC requirement is formally set out in the law, many stakeholders claimed that this often leads to various forms of instrumentalization (that is, a box-ticking approach that subordinates ends to means) and scant realization of the broader aims of accountability and citizen engagement.

In view of these problems with the PDC, donors and the two above-mentioned NGOs joined forces to seek ways to incentivize elected municipal officials (especially the Mayors) to adopt PB principles. This was presented to them as ‘*an innovative device for local governments to foster inclusive management of local resources for better outcomes and to promote ‘good governance’ at the level of decentralized units*’ [SCO02].

**Figure 2: Local Development Planning in Benin – The PDC framework**



Source: Ministère de la Décentralisation, de la Gouvernance Locale, de l'Administration et de l'Aménagement du Territoire, p.23

As a result of this, and in the cases we studied, a tripartite steering committee, involving the municipal council and office, civil society, and the community, was set up by the *commune* and assigned the task of leading each stage of PB. The implementation of PB is not just a matter for the municipal administration and council.

An underlying concern is for the whole participatory process to be transparent and for the rules to be observed. The committee which works closely with the Mayor consists of a group of representatives incorporating various other stakeholders, such as community groups, and local civil society organizations. The steering committee facilitates awareness-raising activities, with a view to encouraging citizens to express their interests, and their representatives are fully involved in the prioritization of these interests.

The *commune* forum generally approves the budget presented by the steering committee. At the next stage, the steering committee is replaced by a follow-up monitoring committee to evaluate the execution of the budget and to ensure that the projects selected by the citizens are carried out.

The *commune* steering committee develops a participation guide and distributes it to citizens. Close collaboration is sought with NGOs and civil society to make citizens aware of ongoing activities in their town or village and apprise them of the importance of their involvement in the decision-making process. Citizens are also involved in the implementation and monitoring of certain communal projects. All these are initiatives that were adopted only recently to make PB a reality. Previously, the communal budget had been a confidential document. The gradual push for citizen mobilization and involvement in public management (including the budget process) contributed to the liberalization represented by PB in Benin. The following statement by MID04 serves as an example:

*'We felt that the communal budget becomes a secret document. So beyond the budget itself as a document to be made public, there is the participatory budget approach that we have embedded in our PTF [Annual Work Plan] as a process that must be led and promoted by the DGCL [i.e. Division in charge of Municipalities at the Ministry of Local Governments]'.*

At the central government level, PB is yet to be recognized as an official approach to budgeting for municipalities. The legal dimension provides an insight into the extent to which legal and other regulatory provisions are applied in facilitating program budgeting. For example, the decentralization Law No. 97-029 has provided some actors with the opportunity to take advantage of regulatory provisions. These actors have influenced the deliberations of communal councils including those during budget debates (e.g. Ségbana and Pèrèrè). They have obtained access to administrative documents, and in some cases even the communal budget, using articles 30 and 34 of Law No. 97-029. This shows that the normative framework set up to enable PB in Benin facilitates 'citizen engagement' and in many cases this is supported by political will. It is possible to observe this very early on, from the advocacy stage to the vote on the budget, and on several forms (see for example the 2017 evaluation report for Ségbana and Pèrèrè). Examples of political involvement and influence include:

- the large and ubiquitous presence of elected officials at all of the advocacy, training and so-called restitution (accountability) phases,
- the unanimous vote of the elected officials to start the process in the municipal council,
- the mobilization of the communal team during forums at the sub-communal level,
- the decision to allocate a relatively significant part of the investment budget (e.g., 10%) for works arising from the PB process,
- the integration of primary needs, as expressed by the populations, within a rather satisfactory range for some municipalities (e.g. between 57% and 88%),
- the manifest will to continue the process, and
- the promise to take ownership of the approach in the long term.

Overall, we highlight how an existing framework (PDC) at the subnational level provided a sufficiently ‘formal’ structure to accommodate PB across a number of municipalities. We now consider in greater detail the contributory factors and local challenges, from the perspective of various PB evaluation reports and the experiences of various stakeholders, such as politicians (in local or central government), civil servants, civil society, NGOs and community members.

## **5.2. PFM implementation through PB at local government level: actual practices**

### **5.2.1. Enabling actors on the ground**

#### **5.2.1.1. Community participation**

The village forum is the first level of participation in the PB process, and that forum is frequently the main setting for the identification and assessment of community needs and related community projects. A village forum also monitors the implementation of the municipal projects as budgeted and is responsible for facilitating the mid-term evaluation and reporting of the projects. This evaluation is very important, in terms of establishing the extent to which the objectives set out in the PB projects are achieved. The literature (Faladé 2019; Loko 2017) states that such evaluations have helped authorities elucidate the objectives of a budget even when achievements fell short of what was expected. Other benefits of the monitoring undertaken by the forum are highlighted in the reports, for instance, authorities were able to understand and share the difficulties encountered by the population.

The level of participation by citizens in the budget seems to vary across local *communes* in Benin. In Toffo and Adjarra, for instance—two relatively successful examples of PB often cited by stakeholders—village forums are carried out in an open and accessible space where citizens can freely join in, express concerns and provide input. The approach has resulted in high rates of participation, sometimes exceeding 2,000 people (2017 evaluation report for Toffo, MT015; MAD01; SCO01). An official from Toffo explained: *‘we divided the commune into zones... [otherwise], some people would need a 30 to 80 km journey to get here, which may be prohibitive... Once we did that, the number of citizens who come to the forum exceeded 3,000’* [MT017] or 2,047

(2019 Evaluation report) and these include ‘women, young people, disabled people, farmers, village development group representatives, and the elderly’ (2019 Evaluation report for Toffo).

Conversely, various stakeholders in Covè and Ounhi conceded that, for political and logistical reasons, direct citizen participation is somewhat limited, often at arm’s length, via representatives or organized groups. Participation in these municipalities was 488 and 304 citizens respectively according to a 2019 evaluation report. The following statement by a community member summarizes the issue: ‘Few people come... It is often between 15 and 30’ [SCO11] at district level. In Ounhi, the forum tends to be organized at district level instead of village level, which also explains the low participation numbers. The mayoral office acknowledged: ‘We stayed at the district level. Normally, we should go from village to village, but we had limited time and we couldn’t go to the 40 villages of the municipality’ [MOU11]. Nonetheless, when carefully identified, citizens’ representatives can provide valuable insights about their community needs and priorities from their contextual knowledge and experience. A Village Chief from Ounhi, who is reported to have contributed vocally to improve his village’s access to essential needs (water and health facilities), stated:

*‘We observe the difficulties faced by the community, whether it is about water, electricity, roads that are impracticable or even schools lacking classrooms. If there is a locality where the health center or the maternity ward is having difficulties, we know it. In these health centers, equipment is sometimes lacking... If there is a lack of teachers in a school, [we know]... The citizens talk to us and report these things. And then we ourselves make inquiries to this effect’ [VIL01].*

We noted concerted action by donors and civil society in a few villages. There was much more of a sense of responsibility on the part of citizens and more citizens were eager to understand events and processes at municipal councils. There is now a feeling among community members that *commune*-level budgeting is less secretive than in the past.

Another positive observation was the keen interest of the community with regard to the PB accountability process. People were actively participating in mid-term oral reporting (public hearings) on the implementation of municipal budgets. As cited in Rapport in a 2017 evaluation for Ségbana and Pèrèrè:

*‘Even when the level of achievement is low, the exercise has the merit of sharing the difficulties encountered with the population, which has the advantage of arousing their sense of understanding and even their commitment to participate in resolving the difficulties’ (p. 47).*

The PB process provided an opportunity to empower not only the poor neighborhoods and villages but also vulnerable groups, particularly women. For instance, the PB process in Segbana and Pèrèrè has included as many women in the village PB committee as possible (25% and 22% respectively). Thus, once PB has increased women’s participation at village forums, the statistical



representation could have been increased to 51.20% (Loko 2017). Among the municipalities studied, Toffo stood out with nearly 62% of women participants in village forums (2017 Evaluation report for Toffo), followed by Cove with about 51% (Falade, 2019), then Adjarra with a rate between 40% and 50%, according local civil society accounts. Women's participation rates tend to be lower in Ouinhi (17.7%, according to a 2019 report), but overall, stakeholders noted that the trend has been upward (improving).

The presence of women in the budget process is hailed as a significant achievement considering the Benin context “*where women remain the weakest link in society and continue to bear the brunt of sociological burdens*” (Loko 2017, p. 48). The low level of women's participation in decision-making bodies is perhaps not a surprise in Benin. The representation of women is virtually absent in most of the communal councils of the country. Apart from Pèrèrè, which is represented by the elected female Mayor (and two other municipalities), not a single woman has been elected as village chief in the remaining 61 villages of the *commune*.

In some *communes*, local NGO representatives (via the CPC) are sent to the communities to talk with local people and elicit their needs and requirements. This is a form of indirect participation where the CPC plays an intermediary role between the citizen and the municipal official. Local needs and requirements are noted and then submitted to higher authorities able to initiate spending decisions. On some occasions, a session is also held at the borough level to record and prioritize these local needs. At the next stage, the prioritized needs are forwarded to the *commune* level. An interviewee remarked:

*‘In 2018, they [the commune] asked me [a CPC member] to go and look for the needs of each community. We went to collect these needs, as the CPC.’*

*‘And we do several sessions with the populations, to ask for their needs and prioritize them. During these sessions, there are also the coordinating doctors and chief doctors from [local/zonal] health centers as part of the decentralized services of the State. Doctors came with their own roadmap. And there, with the exchanges, the population asks for this or that work, for example. They look at their roadmap to see if this is possible. And together, we decide what is going to be done. So it's all the actors at the municipal level who are brought together, sometimes by district, sometimes by village.’ (OVA01)*

The role of the local health professionals seems to be crucial. For example, it is reported that “before leaving the participants for questions of understanding and clarification, the Coordinating Doctor of the Covè Zagnanado and Ouinhi Health Zone, through his communication, gave details of what there is and what can be achieved in the health centers of the municipality” (2019 Evaluation report for Ouinhi). Similarly, the medical officer at a local dispensary and maternity unit in Covè was invited by community members to a PB community forum to help articulate the significance of their need for a vaccination hall at the dispensary and maternity unit. The medical officer recounted that upon explaining the issue at the forum, he concluded by inviting municipal councilors:

*‘...to come and see the location where the vaccination takes place. It is not well located, the benches are not enough and the number [of children to vaccinate] is increasing day by day... Now it is in the [dispensary] corridor that the women gather for the vaccination [of the children], the patient has to go through them which can also pose other health problems. Then, they [the councilors] asked me what to do and I replied that a separate small hall is needed’ [MED02].*

Nevertheless, other municipalities we investigated did not appear to have benefited from a similar involvement of health officials with first-hand experience of community health conditions and needs in their PB process. Enquiries made as to why this has not happened led to responses ranging from increasing duties in health units (owing to insufficient health personnel) to an absence of communication by community members or municipal officials regarding participation in the PB process. A senior health officer at another municipality<sup>21</sup> said that:

*‘I didn’t know about the participatory budgeting here... I found myself at a workshop with the health focal point of the municipality. This is where I learned about this budget and tried without success to meet with the Town Hall. I tried several times to meet with the Mayor with no success. Then I learned that the allocated budget had been taken away, yet we have been experiencing major health problems in the municipality’ [MED03].*

Local needs are severe, and the selection process can be an arduous task, hence the significance of grassroots involvement in solution seeking. Such needs range from health problems to water supply, to solar electrification, sanitation, school facilities, and so forth. There is a general tendency to accord priority to those needs relating to basic sanitation, water supply and electricity. Whatever the solutions, they appeared to address specific needs perceived as important by the citizens and community groups.

In conclusion to this section, it is noted that community participation in the *communes* has been enhanced during the PB process, alongside the caveat that this does require time and continuing financial resources to further mobilize local involvement. Without such resources, participation numbers drop sharply. Arguably, the question of resources impinges on the extent to which CSOs and local municipal officials are able to engage with people in different (and sometimes isolated) areas. However, what seems to be more challenging from a PB perspective is for the public to make its emphasis on health projects and spending felt. Despite amicable and well-informed discussions, it was not always possible for community members to impress on appropriate individuals (such as local health officers) the urgency of intervention on health needs amid what is largely a political process involving elected Mayors.

#### **5.2.1.2. The role of elected representatives**

Following initial advocacy campaigns and training by NGOs (supported by donors) targeted at Mayors and elected municipal officials (GIZ 2019), some elected representatives of the *communes*

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<sup>21</sup> The name of the municipality is not revealed to protect the anonymity of the official quoted.

have become advocates of PB (for example, a powerful and vocal advocate was the Mayor of Toffo, an elected woman representative). They offered examples of France and some European countries and discussed what the population has to look for in the elaboration of a municipal budget. This has created a sort of consensus and expectations about the engagement of the population in the municipal budget process. The underlying assumption is that if the population could be involved in the elaboration of the budget and its execution, they would develop better ideas about the everyday affairs of the *commune*. Interviewees (DONO1 and DONO2) mentioned:

*'... So when we started to talk about it (PB), it is the elected representatives who [...put it into effect, as...] you do in France, in Europe or elsewhere... what the population has to look for in the elaboration of the municipal budget. So little by little, we started by saying that if the population is interested in the budget, its elaboration and execution, they will be able to be better involved in the affairs of the commune... And they will be able to know why their involvement is important to ensure adequate services.'*

One of the enabling aspects that can be drawn from our interviews is the evidently increasing political will of elected representatives in selected municipalities. As cited in a 2017 evaluation report for Ségbana and Pèrèrè:

*'The normative PB framework is not a sufficient guarantee in the Beninese context; this is why the project was right to rely on political will. This was evident very early on, from the advocacy stage to the vote on the budget: it took several forms: the massive presence of elected officials at all the advocacy, training and restitution phases devoted to them; the unanimous vote of the elected officials to start the process in the communal council; the mobilization of the communal team during forums at the sub-communal level; the decision to allocate a significant part of the investment budget (10%) for the PB works; the integration of the primary needs expressed by the populations within a rather satisfactory range (between 57% and 88%); the manifest will to continue the process and above all the promise to take ownership of the approach in the long term... are all elements that reveal the political will that characterized the process in the two communes [Ségbana and Pèrèrè]' (p. 51).*

In Toffo and Adjarra, *'high political will ... [coupled with] the high personal involvement of the Mayor... and her/his team'* [MT015, MT017, SCO01] have often surfaced during discussions with local stakeholders as the most significant factors in the take-off of the PB experience and its gradual embedding in those municipalities. Where the political decision maker was seen to be hesitant or reluctant (as in Comè, Covè and Ouinhi), the take-off has been relatively slow and participation rates have also been somewhat limited, and in some cases such as Cotonou, efforts to introduce the PB experience have stalled altogether.

The participation of elected representatives in village forums and communal forums has been envisaged as positive factors by some villagers. A villager commented:

*'Because I come from the place, I see many things that are needed to develop it. But we couldn't jump on that to start by mentioning what it takes. There is the Village council, the village leaders who formed a group to identify what is needed for our village' (CIT04).*

Broader societal benefits and outcomes could flow from efforts to entice politicians and elected representatives to engage in thoughtful and collaborative resource allocation (via the budgeting process) and in managing community level projects and facilities. This is illustrated by an experience in health service management in many municipalities across the country. Although the arrangement did not address the deeper substantive issues in the sector, it did help improve access to health service facilities and led to somewhat better services for community members.

*'...In principle, each of Benin's 546 arrondissements should have at least one health center. And a management body called the Management Committee (COGEC),<sup>22</sup> led by the population, is set up. The president of COGEC is someone who is elected by the population. Here again, the texts [i.e. regulatory provisions] define the groups of actors that can be found in this COGEC to help the head doctor, nurses and others to better manage the health center. Today the coverage rate is good—when it started we didn't have enough health centers. We used to travel for kilometers... 20 to 50 kilometers to find a health center' (OVA01)*

*'...The doctor collects [information on community needs] in conjunction with the COGEC to be able to really support the health service in terms of improving the indicators [e.g. access]. Today, it's true, there's a community health policy that was drawn up a fortnight ago and which makes it possible to put in place what are called community relays with well-defined specifications, who do health promotion, who can even administer minor care, detect fevers, refer cases to the nurse in charge of the district... We used to say that there should be one health center per district. But given these difficulties and these realities brought about by Mayors, today the policy allows for satellite health centers, an isolated dispensary, an isolated maternity clinic to be set up in addition to the central health center, offering care under the supervision of the district health center.' (OVA02)*

Overall, and in line with prior experiences, the role of the elected official at different levels of local government and in the *commune* is seen as crucial for an effective rolling out of PFM through PB processes. Training and advocacy are seen as important initiatives to address the perennial issue of entrenched patterns of local political behavior, and the power dynamics associated with elected office. To some extent, PB does provide a way to mitigate the hitherto inherent opacity of financial decisions and planning in the local context, while offering some perceived reputational benefits to Mayors and politicians who actively engage with local communities via PB. At the same time, it is noted that current efforts on local healthcare management dovetail with PB's intentions, albeit that the experience is as yet too embryonic in some municipalities to have achieved a broader

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<sup>22</sup> In French, *Comité de Gestion de la Commune (COGEC)*.

impact on health outcomes. The establishment of the COGEC mechanism is interesting in that it is an existing locally-driven health institution with formal links to every area (ward).

### **5.2.1.3. Role of donors: funding of NGOs and CSOs for community mobilization**

The donors' support to NGOs and Civil Society Organizations (CSOs) in fostering public participation in Benin is documented. As a result of their efforts, in some *communes*, the whole town effectively became a training course for PB involving wider stakeholder groups, including the whole town council, NGOs, CSOs and town administrators. All these actors are offered training on capacity building, showing them the different stages of PB. The effort has been welcomed by many elected officials and other stakeholders (such as community groups, NGOs) in the *communes*. This has helped many of these officials and members to revisit the PB process although they are not in a position to instigate any major changes or influence the prioritization of projects. Given the financial constraints at the municipal level, not all PB projects selected would be able to secure financial support from the municipal budget. However, donors' financial support has ensured the PB process can run smoothly, because officials are made aware of the merits of the process during the capacity building training. For instance, interviewees [DONO1 + DONO2] explained:

*'It is a training course where the whole town council is present—civil society organizations, town administration etc. We bring them together and we build capacity in the system. The elected officials or the communes agree that they lack sufficient resources to support every project, but they are willing to financially support the implementation of the process.'*

Civil society has in recent years emerged as an important organizing structure of Beninese society, functioning as a bridge between the population and communal councils. CSOs are active in allowing the marginalized voices of village populations to be heard and in ensuring that their civil rights are protected. Initially, the engagement of these organizations in the PB process was limited, because they were perceived primarily as a monitoring agency, and they were not readily accepted within local communities. However, this perception has altered more recently, and these organizations are appreciated for their advocacy of basic rights to the population, as well as their attempts to bring the younger generation and women to the forefront of community development. The following comment exemplifies the appreciation of CSOs in the local government context in Benin:

*'At the beginning, the communal councils thought CSOs are reticent and behaving as policemen. It's true that we denounce them. It is [also] true that within CSOs, there are people who are CSOs by day and then politicians by night, which is precisely what makes the authorities timid at a given moment. Now CSO members have understood this attitude of a few selfish individuals and try to isolate them. Civil society is more and more accepted by the communal councils. For youth groups and groups of young people it is rather*

*difficult to come forward and play a role in society all the time. That is why it is interesting that this civil society exists to accompany its young people and women of the community'* [MIDO1].

CSOs have been mobilized by donors (and other actors) to address a range of social and community problems in municipalities. They have recently been called upon to assist on community health issues across municipalities.

*'We can sometimes act in the health sector for capacity building. Currently, we are working on family planning to see how they [CSOs] can better collaborate in helping health centers, because they generally don't feel able to address these issues. So we are trying to strengthen them so that they feel involved with women in the health centers. Because there is no specific service dedicated to health in the municipalities. There is no service called 'women's health promotion service'. (OVA01)*

CSOs have also offered political solutions to *communes*, in particular to Mayors, in many important aspects of local decision-making. In some cases, CSOs are referred to whenever a crisis is experienced by the *commune* and the Mayor. This has enabled the *communes* and the Mayor to address problems, the laborious resolution of which would otherwise have sapped local goodwill (or political capital). The interviews revealed many instances when the Mayor had transferred a problem to civil society, or when civil society had then searched for solutions collectively with the Mayor. For example, [MID 02] explained:

*'When I take the case of the Mayor of Toffo as an example, she properly uses civil society actors to really get a certain number of things across. CSOs help identify the flow of resources across districts, mobilize resources in various projects and ensure efficiency in using resources in the districts. I think the engagement of CSOs in participatory budgeting is really interesting.'*

In conclusion, CSOs appear to be essential cogs in the PB machinery. While there may be a view that their intervention in the PB process can be time-limited, perfunctory or constrained to (somewhat abstract) training and preparedness events, the reality on the (primarily rural or peripheral) ground is that a sustainable CSO involvement is crucial for the successful delivery of PB processes and outcomes on a longer-term basis. This would have significant implications for funding schemes and resource needed for their operations.

### **5.2.2. Emerging context-specific factors that interact with Benin's experience of PB implementation**

Our findings also bring insights to factors driving Benin's experience of PB (some positive, others problematic). We present these below under the following thematic headings: pragmatic use of PB for resource mobilization; enabling factors specific to Benin's experience of PB; gender conflicts and patriarchal social relations; and resource constraints and budget delays.

### 5.2.2.1. Pragmatic use of PB for resource mobilization

In Benin, the PB has generated a discourse of positive reactions at the community level. There was a promise from the municipality that the community has the power to make budget decisions depending on needs and expectations. This policy appears to have inspired villagers and local people to enter into a dialogue with local council members (in effect, the Mayor) and motivated them to pay their taxes. The villagers have felt that their tax money would help to fund their village level projects. This emerging reality is epitomized by the following observation:

*'The participatory budget also contributes to the mobilization of resources. It is a powerful means of mobilizing resources because a population that has been given the latitude to make choices about the infrastructure to be built for them feels concerned. When we come back to them to say, well, here we are, we need the money, so paying for your [market place] tickets and taxes, that normally follows and then this population feels associated, considered as a member of the society. And then there are other times when the population is well integrated, they form groups to make pleas to this or that economic operator to give a little money to our commune because they feel considered, they feel concerned by the development of the commune' (MID01).*

Other stakeholders added:

*'So it allows the commune to mobilize a lot of resources because no mayor would go to the communities to tell them I already have 30 million reserved for you, in fact he doesn't have it; the 30 million will only be 30 million when the populations pay the taxes. But if the populations don't understand that 30 million we're talking about here it's us who must mobilize them. Previously, for the population, as soon as we've said that there will be a module or a health center, the State only has to manage to make the health center for us; as such, they don't feel concerned about the resources involved. So, with the participatory budget, we have seen that it can help to put the communities and their mayor in dialogue' (DON01+DON02).*

Some town councils have pragmatically exploited this belief, to encourage the local community to make tax payments. We found that since the introduction of PB, the rate of collection of taxes and revenues in Benin town councils has been improving. Early evidence was provided by Adjarra, the first municipality to try PB in Benin: between 2002 and 2005, the municipality nearly quadrupled its revenue collection from less than CFAF 53 million to more than CFAF 209 million (GIZ, 2019). When asked whether the continuing PB experience still drives revenue mobilization across the municipality, the Mayor's office commented that PB remains a major instrument in building consensus, and collecting taxes and other contributions from the community. More recently, Ségbana and Pèrèrè, two Northern municipalities, reported similar achievements albeit at relatively lower rates:

*'In the case of Ségbana, where the communities made a pledge of around CFAF 44.2 million, this is more than double the commune's total non-tax revenue in 2016 (CFAF 21,682,044) and more than half the commune's total tax revenue in 2016 (84,123,025). The non-evaluation of the contributions of the communities of Pèrèrè did not make it possible here to assess the impact of the process on communal revenues.'* (Loko 2017, pp.50–51).

Confirming the above findings, some stakeholders commented:

*'If elected officials now leave the choice of projects to the communities, the communities can better participate in the mobilization of resources...that is also the parallel with the PB: if the communities say that is what we want and the Mayor says that is what you want, I can only put that into effect with taxes. We have arrived at a system where people participate better; you also talk about it because they are the ones who have experienced it. The people said, "Ah, if it should depend on us, then we'll pay for it", and everyone in that village paid. [Before that,] people didn't often pay their taxes. People started by saying I will go to the tax office and pay my tax.'* (DON01 + DON02)

The PB's positive effect on revenue mobilization is not only confined to fiscal revenue generation. The study found that it has become a common practice across municipalities to use the PB to collect revenue beyond taxes. For example, a PB consultant explained how in Ségbana, non-fiscal contributions far outweighed revenue collections in the past:

*'What did we observe when the municipality started the participatory budgeting? The first year, 2016, when they experienced the participatory budget, the municipal communities in the process promised CFAF 40 million as an extra contribution, which was twice the non-fiscal annual revenue of the municipality'* [SCO02].

Faced with serious legal impediments to functional community and village health centers, some municipal officials and community members, with the technical support of health professionals, have leveraged the PB mechanism to devise ways to address community health issues. The following account from a former municipal Secretary General is reflective of this experience:

*'The law does not allow the commune to inject money to recruit health workers. But there are mechanisms by which people get around this [through the PB process] so that they can help the head doctor to have perhaps a part-time nurse dedicated to preventive needs at the local level. It is these kinds of participation that the doctor gets'* (OVA02).

Despite the considerable potential this represents, a number of municipalities have so far not been able to rely on PB to collect more contributions from the public for the sake of extending community services. For example, a 2019 evaluation report for Ounhi, noted that: *"village forums should be used to collect the needs of the populations but also to collect their promises [financial contributions]. This is why the PB is seen as a resource mobilization tool. In the case of Ounhi, the forums only served to collect needs. The people manage to stay within the envelope of the town hall."*



Other than paying taxes and additional financial contributions, the communities were also motivated to provide free labor to bring down PB project costs and complete the work. According to the PB process, this free labor percentage that was agreed at village forums had to be approved by the members of borough forums at the higher level. In other words, the PB budget of local projects included government allocations plus extra financial contributions and free labor from the local community.

In conclusion, a key outcome from the PB process in Benin was the impact on local government revenues (taxes and non-fiscal contributions). The PB effectively enabled a conduit for public discussions on the relevance of tax and other non-fiscal contributions to achieve expectations in terms of PFM.

### 5.2.2.2. Flexibility and empowerment

The study has uncovered these aspects in relation to Toffo and Adjarra, which are reckoned to be the most successful cases of PB in Benin. In the case of Toffo, there was flexibility to adjust its PB approach. This is a factor which was also identified as having contributed to the positive experiences at Adjarra. For example, Toffo started with a PB voting approach in which the choice of the majority (in terms of the number of villages) took precedence, leaving behind several ‘*unhappy communities*’. As a result,

*‘We changed to a “no one left behind” approach, and this had the most impact. It was an innovation in Toffo following the first PB experience. [In this approach], we respect the choice of each community. In a district of 12 villages, if there are 10 villages that choose one type of infrastructure and two villages choose another type, we act on that. We don’t require these villages to go for the choice of the other ten villages [i.e., the majority]’ [MTO15; MTO17].*

Similarly, Adjarra has also adjusted its approach, from a village-focus to a district community-focus with a flexibility to blend the two where relevant, which accounted for its achievements in its community health sector.

Another successful factor identified in Toffo is the empowerment of the community with respect to the implementation of the PB projects. The following account epitomizes this:

*‘The other thing, it is to do everything so that the communities take charge of the infrastructure building... To that end, we transfer the PB funds directly into the CLCAM<sup>23</sup> accounts of each community... It is the community that organizes itself for the construction of the infrastructure, with our assistance of course. Our belief is that it would impact people better if the community was in charge’ [MTO16].*

These aspects are virtually absent in the other municipalities studied—Comè, Covè and Ouinhi—which appear less successful compared with Adjarra and Toffo. For example, Comè did not involve the CPC in raising community awareness before the village forum, and was, thus, managed

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<sup>23</sup> CLCAM is a traditional microfinance institution, especially in villages and rural communities.

only at the local political level. An Executive CPC member of the municipality reflected that *‘if we had been involved at that level of the process, we would have adequately informed the population... and community members would have come to the forum well prepared’* [SCO03]. However, those municipalities are at the stage of their first PB exercise and have therefore had too few opportunities to ‘learn from experience’ (Lassou et al. 2020a) as did Adjarra and Toffo. But common to all the municipalities studied is the involvement, to a varying degree, of a variety of local actors. Given the central government budget following a ‘top down approach’, the PB exercise has gradually been instilling in the communities we investigated a sense of engagement and responsibility over matters that concern them, not least health service provision. This provides a bottom-up feeling in the local budgeting and broader PFM process which resulted in greater social and political accountability at the communal and grassroots level. Notwithstanding, we identified a few challenges, which we discuss in Sections 5.2.2.3 and 5.2.2.4.

### **5.2.2.3. Gendered demands and challenges**

Similar to many other African countries, the marginalization of women is not an uncommon factor in local communities of Benin despite the progress being achieved. This was reflected in resource allocation through PB. For instance, when the communities were asked to choose one project from two available proposals (streetlamps versus water supply), the male and female groups were divided in their opinions and made gendered demands. As two interviewees (DON01 + DON02) comment:

*‘I looked at Sèhouè once, the communities were divided on two projects: streetlamps and water, but they were going to have to choose one, and it was too hard. At this level of meeting you can clearly see that it's the women who want water and it's the men who want streetlamps. We said that we are not going to proceed by election, you have to agree to come up with a project. When we said it like that, the steering committee said: “OK, the women get three people out, the men get three; will you agree to come up with a project?” But when they left for the conclave, they came back with the water project and the men started by telling the other men that they are letting themselves be dominated by the women.’*

Moreover, the relative marginalization of women in the PB process was seen as a common factor in Benin’s villages (though this appears to be somewhat improving in the face of a growing push for gender equality). In view of a largely patriarchal social system, Beninese men hold the primary power and predominate in roles of political leadership and control over the decision-making bodies, including the PB process. Thus, the women still remain the weakest link in Benin society and continue to bear the brunt of sociological burdens (Loko 2017).

More recently, a 2019 evaluation report for Ouinhi corroborated this marginalization of women’s experience in the PB process, including when dealing with issues such as certain health matters, which are of greater concern to them:

*Low representation of women: during the village assemblies, women were not very active. The highest number of women in these village forums is four, and some villages have no women in their representatives. They [only] represent 17.76 percent of the total population in the village forums, even though they are the most concerned by health issues.'*

Even when women are given a participatory role, it sometimes transpires that this is an instrumental strategy in response to expectations. One woman offered us similar accounts to those provided by the Village Chief. Upon further enquiry, she acknowledged that she was 'told' by the Village Chief what to say during the interview, and added that they are similarly 'coached' when selected for the PB exercise in order to ensure consistency between the accounts provided. We learned that a similar experience exists across PB processes and across municipalities, and it is indicative of the patronizing treatment women face in their political and social life within the Beninese cultural context. Indeed, there are other historical and cultural factors (for example, the role and responsibility of women within the family setting) in the marginalization of women, but the predominant factor that surfaced during the study was the patriarchal nature of Beninese society and the place of women therein.

Nevertheless, the PB experience is providing some emancipatory space for women to challenge widely held beliefs regarding their status in society. This is evidenced in a number of cases where women defy established tradition to advance their collective needs through the PB process. One consultant commented:

*'I remember in a village for example, the women said if you don't give us water, we will boycott the session: "we are ready to go". It seems that for two years there had been no water in the village... As a result, this [water] issue was addressed.'* [SCO02].

In conclusion, the various evaluation reports we accessed all emphasized the need for an inclusive approach (to women and other marginalized members of the community) and the PB experience is gradually providing such an approach. The marginalization of women is of particular concern in health service delivery, given the poor outcomes (malaria, maternal mortality) and facilities (such as for women's health, or vaccination). While there are some efforts from the different officials (CSO and local municipalities) to focus on the gendered implications of PB practices, the risk remains that local representatives and politicians will engage in instrumentalized practices (with token or managed attendance or representation by women) mainly as a box-ticking exercise with no substantial benefits for the women and marginalized members of the community. Further adaptation may help to address this, involving efforts to meaningfully embed the concerns of women and other marginalized members of the community.

#### **5.2.2.4. Bureaucracy and top-down, program-based budget allocations: resource constraints and budget delays**

Another challenge identified by the study is financial constraint, with budget delays that at times hampered the implementation of PB projects. Ideally, PB is predicated on the intention of the

national governments to use the process as one form of wealth redistribution. However, in order to achieve this end, implementing municipalities should have reasonably sufficient resources to fund the proposed PB projects. Meanwhile, the situation in African countries including Benin reflects a diametrically opposite PB context, due to limited financial resources (Loko 2017). In these countries, it seems PB was transformed into a mode of resource allocation and mobilization, particularly on the basis of a hypothetical promise of resources conditional on central government allocations and transfers, and contributions from within the community. Because of this structural weakness in the government's budgetary mechanism, PB has evidently failed, in some cases, to deliver on its promise. This situation has created significant unrest among the local communities concerned.

Because of the lack of resources to fund all PB projects and cumbersome public procurement rules, the rate of execution or progress in the implementation of selected projects has sometimes remained low. For example, in Ségbana council, out of 14 works needed and agreed by the population, the town council included only eight in the 2017 municipal budget (2017 evaluation report for Ségbana and Pèrèrè ). Similarly, in Comè, community projects selected from the 2019 PB process were yet to be implemented at the time of completion of this fieldwork. Exceptions are the cases of Adjarra and Toffo, with relatively few instances of a lack of implementation, primarily due to strong political support. Notably, all these difficulties mostly arose not because of any deeper problems intrinsically linked to the PB process, but simply due to delays in government funding allocations. An interviewee commented on his frustration over the delayed projects:

*'We have a common need in all the villages in our district, i.e., the health center... If you want to do anything for us here, it needs to be about the health center since it is there that we treat ourselves; it is where we go for all our health needs. And currently, the center is dilapidated; you can't say I want to go and get treatment in a health center where there is not at least the minimum...[But unfortunately], the renovation project has not commenced... In April [2020], I wrote to the Mayor, saying that we are already in April, the budget has already been approved, you have already received the approval, so what happened with the delivery of the PB projects?' [SCO03].*

A consultant on PB warned that if such an important issue is not adequately addressed, it runs the risk of jeopardizing the prospects of the PB experiment in other contexts:

*'There is a lot of uncertainty about the funds pledged by the municipalities [for PB projects]. And that weighs on the process, and the threat that one day the population will perceive the participatory budget exactly like a traditional budget; and this compromises their participation afterwards... This situation takes a toll on health-related projects in municipalities too' [SCO02].*

Additionally, some senior health professionals with past and present oversight responsibility over many municipalities cautioned against the recurrent approach to resource allocation which tends to be rather broad or general in nature instead of being specific and narrowed down to

organizational, communal and zonal levels. This is also relevant for PB health projects that go beyond the village or community level, and are thus decided by people with limited knowledge of actual needs and challenges. This again underscores the importance of health professionals in the field in the PB process.

*‘It is not all about increasing resources. You have to know how to direct them and see the needs of everyone in these areas. The top tends to buy us tables, computers... We don't need that. But when you add it up, they say how much they've had put into health, you'll say it's gone from 10 billion to 20 billion. But these 20 billion, is this [money] well used? When resources are misdirected, the [health] indicators fall. My ‘cold chain’ [refrigeration chain for maintaining safe vaccine products] is failing. But instead of providing for the cold chain, you give me a motorbike. My vaccines are miles away. I have to go and get them so I can vaccinate the children. Does the agent have time to go? In public health, when you identify problems, you look for resources, you organize them. I have to have a plan to find out who needs this or who needs that.’ (MED01).*

Insights drawn from above statements lead to an argument that PB systems as an integrated part of PFM are implemented as an add-on to existing public budgeting, procurement, and particularly resource allocation systems from a top-down perspective (from the central government to municipalities). To this extent, and particularly in relation to health-related spending, the PB process is found constrained to act as a catalyst for the efficient and rapid implementation of projects selected by local communities in a context where PFM initiatives (that is, public procurement and spending priorities) remain heavily centralized and bureaucratically determined. Consequently, we recognize several challenges as well as progress achieved, which we discuss in Section 5.2.3.

### 5.2.3. PFM through PB systems in relation to community health

Benin, like most Sub-Saharan African countries, struggles to provide adequate resources to support its health sector. As shown in Table 7, Benin allocates only a very modest fraction of its budget to health, mostly below five percent (except 2016). These proportions are likely to be even lower when looking at spending, because actual executed budgets tend to be lower than allocated budgets. For example, in 2019, actual spending was 88.9 percent of budgeted spending (Ministère de l’Economie et des Finances, 2019). Health spending below five percent, on average, is indicative of the limited focus on the health sector, and falls far short of the Abuja Declaration of April 2001 in which Heads of States of African Union countries pledged to spend at least 15 percent of their annual budget on the health sector (WHO 2011).

**Table 7: Health budget as percentage of total government budget (Benin)**

	2016	2017	2018	2019
Government (Million CFAF)	1,143,167	1,697,986	1,406,318	1,373,413
Health (Million CFAF)	69,616	81,814	38,307	59,990
Percentage	6.1%	4.8%	2.7%	4.4%

However, Benin has made some progress in allocations to community health in recent years. Between 2017 and 2018 one billion CFA francs (US\$ 2 million) has been allocated to investments each year in community health as shown in Table 7; however, in real terms, these investments approximate to those in 2010 and 2011. These capital expenditures halved in 2019 before an increase in 2020, but still remained below levels in earlier years (except 2012). The lower amount in 2020 appears problematic given the ongoing COVID-19 pandemic, with potentially devastating effects in rural and peripheral areas affected by highly challenging socioeconomic circumstances. Most of the investments are in the form of community health center construction, which translate *‘the government’s will to bring basic health services close to the communities’* [MIS07]. The bulk of funding in the community health sector, however, is in operating (recurrent) expenditure (including maintenance of peripheral and community health facilities). As shown in Table 8, operating (recurrent) expenditure has followed a steady increase, especially more recently from 2016 to 2019, and represents more than double the funds allocated for capital expenditure in those years. This trend, attributed to donors and central government efforts, has been welcomed by key community representatives and elected municipal officials who claimed that *‘community health services [in most areas] would have been worse without the increasing efforts through FADEC’*<sup>24</sup> [OVC05; SCO05]. The FADEC is a mechanism whereby donors and the government use criteria, *‘most of which remain under the responsibility of the central government’* [DON03], to grant and transfer resources to municipal governments.

**Table 8: Capital and operating expenditures on community and peripheral health in Benin**

Year	Capital expenditure (CFAF)	Operating expenditure (CFAF)
2007		730,204,000
2008		730,000,000
2009		730,000,000
2010	840,000,000	730,000,000
2011	840,000,000	885,000,000
2012	650,000,000	960,000,000
2013	-	990,000,000
2014	-	1,020,000,000
2015	-	1,080,000,000
2016	-	2,029,000,000
2017	1,000,000,000	2,029,200,000
2018	1,000,000,000	2,100,000,000
2019	500,000,000	2,600,000,000
2020	800,000,000	2,500,000,000

<sup>24</sup> FADEC means Municipal Development Support Fund (*Fonds d'Appui au Développement Communal*).

Despite the efforts to bring health services close to the public through investment in building community health centers, expected improvements are constrained:

*'We built [community] health centers... but they turned into white elephants. Because there are no human resources—nurses, doctors—to run them for the community. I don't have the means to recruit these personnel... The consequences are straightforward: you have people who are kilometers away from the main health center, and when there is a serious case of malaria, for example, their transportation to the main center is problematic; [consider] a pregnant woman who is in difficulty, has begun to give birth, then her transportation to the main center, far away, while those complications worsen, rapidly... and when they get to the center...it is too late' [MED04].*

Even though the lack of resources appears to account for this state of affairs, the situation is complicated by constraints posed by the decentralization law (No. 97-029 of January 1999) which thwarts elected municipal officials' ability to recruit health personnel. According to the law, municipalities may build and equip community health centers but they cannot recruit the personnel required to run them. Municipal officials explained that any failure on the part of elected municipal representatives to adhere to those strictures can result in dire personal consequences, including reimbursement of the monies paid to the personnel recruited, fines, and even imprisonment.

To circumvent such constraints, to a certain extent, some community members organized themselves through the PB mechanism to assist local health professionals in their efforts to provide a basic health service:

*'in some locations, the communities have devised mechanisms<sup>25</sup>... to help the health professionals in charge to get, for example, a nurse who works sometimes part-time to deal with preventive treatments at the locality. This is an example of the kind of the participation that local doctors get from the population [in those communities]' [OVA01].*

It also emerged that other communities pool funds to support the salary payments of health assistants. This in turn encourages certain health professionals to devise innovative ways to alleviate the financial burden on poor community members. In Covè, for instance, a senior health official explained how he managed to make up some of the shortfall in personnel to support his community:

*'The health assistants we have are not enough. So, we employ two more as voluntary trainees and we pay them in relation to the activities that come, such as the distribution of mosquito nets and other activities... This is how we go about it... There are months when the revenue is very short of expectations, and you start to think about how to pay them... and you find a way. It is challenging' [MED02].*

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<sup>25</sup> These mechanisms are not specified in order to avoid exposing these communities (which would risk compromising the community health solution mentioned).

In other instances, communities and CPCs insistently called on elected municipal officials to seek solutions to acute community health problems. This resulted in reallocation of resources from other ends to health projects through skillful reframing of the issues. For example, in Adjarra:

*‘a community health center is often flooded during the rainy season, and we need to build a bridge along the shore to allow the water to drain away [and facilitate access] ... If you knew Adjarra, you would know where I am talking about... It is the road that passes in front of the Town Hall. The road is a double track road but is regularly blocked for months by floodwater [next to the health center]. So, in the 2020 PB we decided that part of the investment budget be used to construct the bridge...’ [SCO05].*

The framing of the problem was around ‘access to the health center’ and this enabled consensus around this project. The budget reallocation to the bridge construction project received the approval of community members and elected officials alike.

Another challenge revealed by the study relates to the allocation of resources for operating (recurrent) expenditure per zone. Benin comprises 34 health zones, each containing a number of municipalities. A senior health official from one of these zones revealed the amount of their annual operating budget, roughly US\$ 100,000<sup>26</sup> (in equivalent terms), and the 2021 budget is reduced by a significant proportion. As a result, many community health centers are in a dilapidated state. To remedy this situation, to some extent, a few communities organized themselves during PB sessions to force the hands of their elected municipal officials to allocate parts of the investment budget to renovate existing community health centers. The outcome in Adjarra during the 2020 PB was successful:

*‘The community requested the renovation of the maternity unit of Malanwi. It was the population of Mèdédjonnou, Aglogbè and Malanwi who collectively made this happen. They acted in solidarity with each other and they succeeded’ [MAD01, SCO01].*

A similar experience was observed in one of the districts of Ouinhi. A mayoral spokesperson explained: *‘As a result of the 2019 PB forum, the district of Sagon elected to build the fence of their health center which was beyond the five million [CFAF] allocated... But the municipality was planning to build a partial fence. So, we had to do our best to build the fence completely once and for good’ [MOU11, MOU12].* A CPC representative from the area acknowledged: *‘I recognize that the participatory budgeting has impacted our community [with regard to health outcomes]’ [SCO10].*

Surprisingly, Toffo, constantly cited as one of the few successful PB cases in Benin, has not yielded a direct investment in the area of community health. When asked the reason for this, the mayoral spokesperson said: *‘it is because health infrastructures cost more than the amount set aside for the participatory budgeting’ [MTO16].* In spite of this, however, Toffo made progress in other areas that serve to improve community health, such as safe water, or rural road construction, which facilitates access to health units.

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<sup>26</sup> This is an indicative amount because further details could serve to reveal the zone and consequently the identity of the respondent.



#### **5.2.4. Summary of findings: PB as an integrated system of PFM in Benin**

As a summary of findings, we note that PB was essentially a voluntary venture and donors' support was for the most part indirectly channeled through NGOs and local civil society organizations. The voluntary character of the PB exercise in Benin made it appealing, and parties involved showed interest in the process and commitment to the delivery of expected outcomes. Although most municipalities in Benin are still at the stage of their first experience of PB, several tangible achievements have already been made. In many municipalities, PB has been leveraged to mobilize needed resources to provide various public goods and services (such as community markets, community health infrastructure and services, rural roads, basic sanitation, safe water). The Benin case also reveals the importance of flexibility and context-specific understanding of PB. The approaches used by elected municipal officials in the selection of PB projects should be aligned with the local context to better address community issues and ensure the sustainability of solutions formulated. The empowerment of local community members to manage the PB-related financial allocation (with the support of the municipal administrative service) has also emerged as a crucial factor that is specific to Benin's experience. Additionally, despite the patriarchal nature of Benin's society, the PB experience has provided an emancipatory space for women and other marginalized constituencies to gradually voice their concerns and actively participate in deliberations on issues that affect them, not least health ones.

In health service delivery specifically, despite the prevalence of several structural and centralized bureaucratic constraints (such as legal or regulatory impediments), communities were able to think innovatively and pragmatically to formulate solutions that alleviate the negative consequences of such barriers (for example, lack of health personnel; poorly maintained health infrastructure; absence of health facilities such as vaccination centers). This has contributed to offering citizens local and indigenous solutions to address some basic health issues. In addition, an astute or pragmatic reframing of community problems in some cases has enabled communities to force the hands of elected officials to reallocate resources towards addressing urgent health needs, such as access to community health centers.

### **6. Overall discussion**

Participation in budgeting is premised on its ability to improve the performance and accountability of the bureaucracy (whether at the central or local government level), which is seen as unrepresentative and underperforming, a situation commonly observed in developing countries (Moynihan 2007, p.55). Hence, PB as a form of participation provides a forum for citizens to engage in the decision-making process (for example, budget allocation and feedback on implementation) and offers both democratic participation in and a check on the activities of the bureaucracy. It goes beyond the notions of 'community' or 'public' participation that are often touted in government and international development policy documents, but which are quite amorphous in the context of providing genuine accountability to the people and fostering

grassroots ‘bottom-up’ communication and influence over the delivery of key public services (Fritz et al. 2017).

PB was initially implemented in Porto Alegre Council of Brazil during the 1980s and it proved to be a useful PFM tool in the redistribution of economic resources and service provision (Grillos 2017). Different reasons are provided for its proliferation across countries. For instance, in Western countries it is linked to an ongoing transition towards pluralistic democracy, which revolves around the central ideas of citizen engagement and deliberation (Burn-Martos and Lapsley 2017). This PFM tool has been implemented in many European local governments in the expectation that several benefits will accrue, such as developing a sense of community, fostering democratic skills, and delivering civic responsibilities (Michels and de Graaf, 2017). In developing countries, including Benin, by contrast, PB as an integrated system of PFM is presented by international organizations as the means to promote grassroots democracy, pro-poor allocation of resources to deliver public service that meet fundamental community needs, and social and public accountability. Shall (2007) reviews the extent of PB-related practices in African local government and finds some positive developments in the case of South Africa, Tanzania, Kenya and Mozambique. These are, in the main, associated with the existence of local government-enabling legislation, a decentralization process, and the use of PB through traditional community gatherings. In their recent study of PB in Indonesia, Jayasinghe et al. (2020) demonstrate how this budgeting mechanism has increasingly become part of the evolving social and civic logic of the World Bank and bilateral donor agencies such as USAID and DANIDA while they execute their development agenda in emerging economies. The World Bank has alone invested nearly US\$ 85 billion over the past decade on development activities embedding an element of public participation (Fung et al. 2015). It is believed that PB would help lessen political, racial, ethnic and gender-based discrimination, patronage politics and corruption, all of which have eroded democracy and emancipation at local levels in developing countries (Kuruppu et al. 2016).

A number of World Bank reports (jointly with other institutions) have also highlighted the use of PB. Among the key conditions conducive to the adoption of PB, Wampler (2007) identifies four, namely: a receptive civil society, strong mayoral support, a supportive political environment, and the availability of sufficient financial resources. Shall (2007) concurs with these points but also highlights the need for legislative backing, an inclusive approach to citizenry participation and a need to give the community sufficient time to reach a conclusion. Our study has evidenced the critical influence of mayoral (political) support on the relative success of PB experiences at Adjarra and Toffo municipalities in Benin and the crucial role played by NGOs and local civil society groups such as grassroots community groups (such as women’s groups, artisan groups). Fritz et al. (2017) mention the important role of CSOs and community groups in the case of Tanzania, and separately how a well-organized, active, and ‘technically proficient’ civil society in the Philippines (coupled with strong political commitment) led to the development of a form of ‘Bottom-Up Budgeting’ (for the national budget). The latter ensured that people became meaningfully involved in public policy and programs, and that political leaders and citizenry alike see the benefits of

genuine dialogue and a good relationship between leadership and public. A more recent report by Arizti et al. (2020) focuses on the East European and Central Asian regions. It also highlights that these factors are important ingredients to enable public participation in public financial management and that more efforts are needed in contexts traditionally accustomed to opacity and government by fiat.

The normative expectations of PB held by international organizations and policy makers—alongside the promotion work undertaken by Western NGOs—have to some extent yielded tangible benefits in Benin in terms of providing the rationale to facilitate public service delivery in spite of the observed challenges. One distinct benefit which can be drawn from Benin’s experience is how some municipal actors and communities appear to make use of PB to raise needed revenue (above and beyond tax revenue) and to address community basic needs (including health) in a manner which otherwise would not have materialized. In the literature, PB is often considered as a resource (re)allocation tool (Fritz et al. 2017; Jayasinghe et al. 2020; Shall 2007; Uddin et al. 2019), and sometimes a response to austerity measures (Williams et al. 2017). However, as our cases show, those municipalities that tried to follow such an approach did not fare well in the Beninese context compared to those that complemented it with an explicit strategy to communicate the need for additional financial or in-kind resources from the community (that is, as a form of resource mobilization). Additionally, our cases demonstrate an innovative approach to PB when faced with structural and centralized bureaucratic constraints (such as legal or regulatory impediments) in the context of health service provision. This approach has encouraged community members and health professionals to innovate by reframing the immediate issues, devise appropriate mechanisms to secure consensus and find space to interpret and address constraints. Therefore, our Beninese cases show the ability of community groups and local officials to adapt to contextual and sectoral differences (for example, health) when formulating solutions to cater to community needs. This highlights the emancipatory potential of PB in terms of giving the local community a space (sometimes indirectly) for developing creative approaches, as demanded by specific circumstances.

In terms of challenges, there are gender-related issues which are further exacerbated by the centrally-defined bureaucratic structures. These findings do partly support previous academic work on PB, as they have revealed challenges in implementing PB in different settings (Uddin et al. 2011; Kuruppu et al. 2016). Despite such challenges, a growing body of research has documented the success of PB in many countries and regions, including Porto Alegre (Santos 1998), Ichikawa (Sintomer et al. 2012), Sub-Saharan and West Africa (Krawczyk and Sweet-Cushman 2017; Shall 2007) and some Canadian local authorities (Baiocchi and Lerner 2007). In contrast to Benin’s experience, where marginalization of women is found to be gradually improving in the PB process, Alegretti and Falanga (2016) mention that women and other marginalized groups are often excluded from the PB process, and this has caused reduced levels of attendance (participation), the retrograde prioritization of projects on a gendered basis and difficulties in ensuring a more inclusive process. Important mitigating factors (as reported in the

case of Benin) are strong political will demonstrated by the Mayor and a supportive overall political environment (Wampler 2007). In contrast to other PB experiences in African countries, as in Kenya (Shall 2007), there has been limited reliance on existing traditional community gatherings (which could serve as a relatively straightforward way to foster deeper engagement with PB processes by more people). There is therefore a risk that sustaining the process will become problematic when donors' support terminates.

The findings from Benin regarding financial challenges at the municipal level and delays in implementing PB projects also tally with the insights in the literature. For instance, the influence of PB was de-emphasized in many countries because of the absence of discretionary budgets and budget cuts. Rossmann and Shaahan (2011) illustrate how PB has turned out to be a ceremonial event at US universities due to limited flexibility for adjusting budget allocations, whereas Cepiku et al. (2016), Ahrens and Ferry (2015) and Williams et al. (2017) show how PB was used by local governments to mitigate the wrath of the citizenry and shift the blame for budget cuts to central government. Thus, the Benin PB context exposes the unintended consequence that for lack of sufficient resources (Loko, 2017) PB in some municipalities appears to be changing into a tool for resource allocation; predominantly on the basis of a hypothetical assurance of resources to be mobilized within the municipality. This reflected a structural weakness in the government budgetary mechanism, hindering the successful delivery of PB promises. It should however be borne in mind that most PB experiences in Benin are in their infancy, with stakeholders still endeavoring to assimilate lessons learned and translate them into modified approaches better suited to the local context.

Additionally, some cultures and contexts have appeared to be unprepared for the idea of participation (Flynn, 1998). It is therefore not surprising that the process and outcomes of PB could vary from some contexts to others. For instance, Uddin et al. (2019) provide examples of PB in the local governments of Japan, where the existing culture of verticality has made individual participation in the budget process virtually nonexistent. Jayasinghe et al. (2020) show how the predominance of indigenous culture has led to some remote and indigenous communities in Indonesia pragmatically resisting the normative use of the PB model by steadfast adherence to their existing traditions and social practices. In general, PB experience in Benin can be seen as an emancipatory device employed to gradually redress extant cultural constraints, such as gender imbalances. Our findings also showed that local stakeholders use an astute reframing of public service issues affecting disadvantaged communities to reallocate resources from other ends to health projects. In another example, the study revealed the pragmatic use of PB by town councils that seem to be exploiting the local community's belief that tax is a contribution to community development (to set up or improve vital public services).

Lastly, our study reveals some PB challenges specific to the local health portfolio, namely in terms of the limited or perfunctory input of health professionals, despite the fact that Benin does not lack a dedicated community health system and structure. In many of the PB cases we investigated, 'health issues' become inherently associated with spending on 'infrastructure assets', with

insufficient regard to the substantial need for corresponding investment on ‘human assets’. This appears to be more of a bureaucratic issue rather than a problem with PB per se. There is however an understanding among many decision makers of this limitation and the need to address crucial structural barriers (legal restrictions, ministerial boundaries, competence and expertise) to the effective implementation of PB. From the PEFA assessment perspective, while significant attention is placed on budget ‘participation’ (PI-17 in the 2016 Framework), the emphasis of this assessment is on the formal administrative process within central and local governments. It is explicitly stated that the “wider scope of participation of the legislature and citizens in the budgeting process is not covered here” (PEFA, 2019, p. 60), while PI-18 considers oversight by the legislature. These findings therefore demonstrate the importance of a renewed focus on these less prioritized elements of the budgeting process.

## **7. Conclusions and recommendations**

Our study has sought to explore the implementation of PB as an integrated system of PFM in an African developing country setting, Benin, with an emphasis on the health delivery sector. We started from a ‘macro’ and largely quantitative perspective, analyzing the association between the state of PFM systems in Africa (by mainly relying on PEFA assessments) and health indicators, and linking these insights to the specific case of Benin in terms of its current PFM and health infrastructure. Informed by these broader considerations, we proceeded to in-depth fieldwork to explore the micro-level in selected municipalities.

In response to our first research question, our macro-level analysis shows that PFM systems remain relatively weak across Sub-Saharan Africa with the so-called downstream PFM pillars being the less performing ones, notwithstanding apparent efforts by both domestic and donor actors to improve the situation. Statistically significant associations between PEFA scores and health resources and outcomes do exist, highlighting the key relevance of effective PFM systems. In considering some of the counter-intuitive results (that is, capital health spending) and the absence of some health indicators, our fieldwork has pinpointed particular issues with the reporting system and the possible incentive for governments to manage indicators.

In response to our second and third research questions, our fieldwork initially sets out the normative expectations and aspirations of the Benin authorities, donor agencies and CSOs. These were compared and contrasted to the realities on the ground, and the role of enabling actors (community participation, the role of elected representatives and the influence of donor-funded CSOs and other NGOs). We also highlight the context-specific factors that we observed, namely gendered demands, challenges in gathering genuine participation (which seems conditional on significant investment of time and resources), clashes with bureaucratic rules associated with traditional top-down budgeting systems and, distinctively, the mobilization of PB as a mechanism for raising taxes and encouraging in-kind community contributions. Within the analysis of PB in the context of health delivery, we also bring forward attempts by the community and local groups to leverage PB as a means to meet their local health needs, even when this may not have been the stated objectives of higher level political or government priorities. These context-specific factors

can be resolved through an awareness and understanding of the unintended consequences of democratic-led consultation exercises, and through careful management and planning of the ‘rules of the game’ and fostering participatory events.

Our quantitative analysis at the macro-level was exploratory in nature. With a view to examine the contribution of PFM systems in developing countries (including SSA countries), further research could investigate the impact of PFM systems on public service delivery (including at subnational level) using more detailed statistical models. Our project highlights the importance of institutional settings, legal systems, development paths and political economy in the implementation (and success) of PFM mechanisms, not only in relation to PB but potentially in relation to mechanisms concerned with accountability and transparency to the wider public. We therefore suggest further quantitative and qualitative research to examine the links (or interplay) between these antecedents and the extent or success of PFM mechanisms. Furthermore, the case of Benin also revealed some idiosyncrasies at the local level in terms of revenue mobilization, community and governance. We suggest that additional field studies about PFM mechanisms could be extended to other countries in the West African Economic and Monetary Union (WAEMU) and in the Economic and Monetary Community of Central Africa.

There is a large concurrence of insights from our empirical work with prior research and policy documents, including recommendations on the practice of PB worldwide. Our evidence in the SSA context reveals a fair amount of enthusiasm and interest in embedding PB, notwithstanding that implementation challenges at the local level will persist. We put forward the following recommendations, the execution of which may help foster the PB philosophy in the context of PFM and PEFA assessments and so improve public service (including health) delivery in Benin and beyond. The first three recommendations are addressed to PEFA, its partners and the wider constituency of development agencies.

The inclusion of PB within the PFM framework and PEFA assessment would reduce political interference in the PB process and result in greater citizens’ engagement in policy making and service delivery at national and subnational levels alike. Our findings, as well as the findings of prior work on PB in developing countries, show that PB remains an effective democratic and ‘bottom-up’ mechanism which can contribute to the legitimacy of PFM systems and the processes that shape social and development policies. Given the prominence of PEFA evaluations for governments, the inclusion of PB systems within the PFM national and sub-national frameworks would provide developing countries with a strong impetus to promote greater citizen engagement and social accountability in policy making and service delivery at national and subnational levels alike. Therefore:

### **Recommendation 1:**

**We recommend a greater consideration of participatory budgeting (PB) and other similar ‘public engagement’ processes in the proposed PI9bis sub-national government (SNG) public consultation assessment as well as an evaluation of PB in national assessments.**

We commend the proposed PI9bis SNG indicators, which seek to capture the extent of public consultation in preparing the budget, designing service delivery programs, and planning investments (anchored around principles of public access, timeliness and inclusiveness). However, existing policies, processes and practices around the notion of ‘public consultation’ are very eclectic and may lead to difficulties in comparability across SNGs and national settings. Furthermore, our research and prior studies highlight the existing and credible challenges of symbolic compliance with public consultation, often as a result of the unwarranted influence of political elites in the SNG context. This suggests a need to tighten the notion of public consultation to emphasise ‘public engagement’ along with an assessment of the processes thereof. In addition, while our research findings fully support the incorporation of inclusiveness to enable the involvement of marginalised constituencies, the guidance could further tease out how inclusiveness will be assessed and on the basis of which measures and data sources.

### **Recommendation 2:**

At the national level, we propose that PEFA considers an evaluation of participatory budgeting by relying on the following data sources (i) a percentage of subnational units engaged in PB mechanisms, (ii) the proportion (in value terms) of the operational and investment budget subject to participatory processes, (iii) the percentage of the population represented by those individuals who are involved in the PB processes, (iv) the extent to which the participation of vulnerable or marginalized groups of society has been achieved (for example, women; people with disabilities, people in remote areas), and (v) the level of citizens’ participation in the monitoring and evaluation of approved projects. Such data sources will contribute to a comparative analysis of national level policies and processes with regards to PB, and in turn help improve outcomes at the SNG level.

### **Recommendation 3:**

**PEFA partners and development agencies should use their best endeavours to foster the establishment of an international ‘community of practice’ on the use of PB in subnational and national PFM systems.**

There are many cases of successful PB approaches in SSA and in other developing countries which already provide a strong evidence base for developing appropriate practice. For example, the World Bank’s efforts in supporting PB in Makueni County Kenya are well established. The community of practice’s key roles should be to develop and refine a code of practice for the organization of PB processes at the subnational level, taking into account sectoral differences (for example, health-related spending). This principles-based code of practice could elaborate on guidelines such as minimum periods for the involvement of local communities, a communication strategy to convey the process and outcomes of meetings, an arbitration mechanism to deal with conflicts and disagreements, the monitoring and evaluation of approved projects by the citizenry, how to incorporate participation from women and marginalized communities and how PB

processes would be funded. Adherence to a code of practice could be evaluated and used as the basis for resource allocation to subnational governments. The different development partners could thus rely on existing agencies and non-governmental organisations, such as the International Observatory on Participatory Democracy to develop this community of practice.

#### **Recommendation 4:**

**Building on some of the successful implementation of PB in different municipalities, a national organization could be set up to bring together individuals and other organizations such as CONAFIL<sup>27</sup> and Local Government Departments that have been involved in the delivery of PB projects and in various areas of interventions (CSOs, village leaders, mayors, ANCB,<sup>28</sup> donors, health centers).**

This proposed organization would set the scene for the development of a common set of guidelines which would be given statutory backing and ensure that municipalities devote the appropriate resources and time to implementing PB. Adherence to these guidelines could also be evaluated and form an aspect of the allocation of local budgets. At the same time, it is important to acknowledge that a one-size-fits-all approach would not be effective. Hence some flexibility should be offered to municipalities and community groups in addressing the demands raised by citizens, and enabling local communities to align it with their local culture, values and everyday lives. This would address the contextually specific challenges, namely the local cultures reported in the previous literature and also our study on successful PB implementation.

At the same time, with a view to fostering a sense of local community and long-term responsibility for the investments selected through the PB process, a policy on a form of future ‘in-kind’ contribution could be agreed to incentivize local villages, forums and people to maintain the infrastructure (such as maintenance, cleaning) in tandem with local officials and municipalities

#### **Recommendation 5:**

**An evaluation of the outcomes of PB-selected projects needs to be carried out and communicated to the local people and decision makers.**

A medium-term evaluation of the outcomes arising from the PB-related investments and how they have actually addressed community demands, needs and expectations is crucial. In this way, and rather than envisaging each PB process separately and relying on limited insights derived from each village forum or *commune*, a regular appraisal and communication of what has worked (or not) in a wider local context can help local inhabitants and decision makers become more effective and informed during the PB processes. This will engender community confidence and sustainability when replicating the PB process in future. While we have accessed a host of

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<sup>27</sup> National Commission of Local Finances.

<sup>28</sup> National Association of Municipalities of Benin.



evaluation reports for the different PB experiments, they are not geared towards encouraging learning and improvement.

These outcomes must be based on a range of measures relating to both financial and social metrics.

### **Recommendation 6:**

**Community participation must swiftly put down local roots and not rely on continued external support.**

The continued reliance on donors' funding to finance PB advocacy and processes has become problematic in that it does not appear to generate sustainable commitment among local community members or the political elites. Given that democratic local structures prevail in many developing countries, including Benin, (traditional village gatherings, COGEC for local health care), it would be a more cost-effective exercise to train and empower local people. This may help community members to embed such structures and become motivated to participate at village and community forums. Furthermore, the representatives who emerge from this process would certainly be more credible and accountable, when conveying the needs of the local community at borough- and commune-level meetings and deliberations. The democratic mandate at the local level will be reinforced, especially when relying on less substantial recurrent investment in the PB process.

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## Appendixes

### Appendix A: Sub-Saharan African countries' PEFA assessment reports used

Country	Year	Country	Year	Country	Year	
Benin	2014	Lesotho	2017	Senegal	2011	
	2007		2012	Seychelles	2017	
Botswana	2013		2007		2011	
	2009	Liberia	2016	2009		
Burkina Faso	2017		2012	Sierra Leone	2018	
	2014		2009		2014	
	2010	Madagascar	2010			
	2007		2018		2007	
Burundi	2012	2014	South Africa	2014		
	2009	2008		2008		
Cabo Verde	2016	Malawi	2018	South Sudan	2012	
	2008		2011	Sudan	2010	
Cameroon	2017		2008	Tanzania	2017	
Central African Republic	2010	Mali	2013			
Chad	2018		2018		2010	
Cote d'Ivoire	2019		2016		2006	
	2013		2011	The Gambia	2015	
	2008	2008	2016			
Democratic Republic of Congo	2008	Mauritania	2014	Togo	2009	
Ethiopia	2015		2008		2008	2006
		2010	Mauritius		2015	Uganda
		2007		2011	2012	
Gabon	2017	2007	2009			
	2014	Mozambique	2008	2008		
	2006		2015	Zambia	2017	
Ghana	2018		2011		2013	
	2013	2008	2005			
	2010	Niger	2017	Zimbabwe	2018	
	2006		2013		2012	
Guinea-Bissau	2018	2008	Republic of Congo	2014		
	2014	2014		2006		
	2009	Rwanda	2017	2010		
	2006		2010	2008		
Kenya	2019	Sao Tome and Principe	2013	2007		
	2012		2010			
	2009		2007			
	2006					

## Appendix B: PEFA Indicators used

Pillars	Indicators
Credibility of the budget	PI-01: Aggregate Expenditure out-turn compared to original approved budget
	PI-02: Composition of expenditure out-turn compared to original approved budget
	PI-03: Aggregate revenue out-turn compared to original approved budget
Comprehensiveness and Transparency	PI-05: Classification of the budget
	PI-06: Comprehensiveness of information in budget documentation
	PI-07: Extent of unreported government operations
	PI-08: Transparency of inter-governmental fiscal relations
	PI-10: Public access to key fiscal information
Policy-Based Budgeting	PI-11: Orderliness and participation in the annual budget process
	PI-12: Multi-year perspective in fiscal planning, expenditure policy and budgeting
Predictability and Control in Budget Execution	PI-16: Predictability in the availability of funds for commitment of expenditures
	PI-18: Effectiveness of payroll controls
	PI-19: Competition, value for money and controls in procurement
	PI-20: Effectiveness of internal controls for non-salary expenditure
	PI-21: Effectiveness of internal audit
Accounting, Recording and Reporting	PI-24: Quality and timeliness of in-year budget reports
	PI-25: Quality and timeliness of annual financial statements
External Scrutiny and Audit	PI-26: Scope, nature and follow up of external audit
	PI-27: Legislative scrutiny of the annual budget law
	PI-28: Legislative scrutiny of external audit reports

## Appendix C: Correlation between PEFA indicators and health expenditure and outcomes

		PI-01	PI-02	PI-03	PI-05	PI-06	PI-07	PI-08	PI-10	PI-11	PI-12	PI-16	PI-18	PI-19	PI-20	PI-21	PI-24	PI-25	PI-26	PI-27	PI-28
Capital health expenditure (% of GDP)	Corr	-0.152	-0.177	0.028	<b>-0.226</b>	<b>-0.257*</b>	-0.168	-0.030	<b>-0.428**</b>	-0.046	-0.124	<b>-0.339*</b>	<b>-0.340*</b>	-0.176	-0.229	<b>-0.257*</b>	<b>-0.246</b>	<b>-0.274*</b>	-0.223	-0.146	-0.152
	Sig.	0.169	0.138	0.429	0.070	0.046	0.156	0.429	0.002	0.384	0.212	0.012	0.013	0.132	0.068	0.046	0.054	0.036	0.075	0.172	0.174
Domestic general government health expenditure (% of GDP)	Corr	0.041	<b>0.214*</b>	0.065	0.072	<b>0.214*</b>	<b>0.353**</b>	0.180	<b>0.223*</b>	0.135	<b>0.214*</b>	0.134	0.131	-0.086	-0.114	0.020	-0.035	0.087	0.155	0.131	<b>0.197*</b>
	Sig.	0.358	0.031	0.283	0.261	0.027	0.001	0.070	0.022	0.113	0.027	0.115	0.125	0.230	0.153	0.428	0.378	0.221	0.085	0.124	0.044
Domestic general government health expenditure per capita (current US\$)	Corr	0.068	<b>0.277**</b>	0.067	0.019	<b>0.258**</b>	<b>0.377**</b>	<b>0.126</b>	<b>0.368**</b>	0.094	0.058	<b>0.273**</b>	<b>0.462**</b>	-0.050	<b>0.218*</b>	<b>0.257**</b>	<b>0.206*</b>	<b>0.324**</b>	<b>0.404**</b>	0.150	<b>0.267**</b>
	Sig.	0.273	0.008	0.277	0.434	0.010	0.001	0.152	0.000	0.201	0.302	0.007	0.000	0.332	0.025	0.010	0.032	0.002	0.000	0.092	0.010
External health expenditure (% of current health expenditure)	Corr	0.129	<b>-0.356**</b>	0.058	<b>0.239*</b>	0.115	-0.104	<b>0.240*</b>	0.029	0.084	0.132	0.025	-0.032	0.002	0.005	0.078	0.021	0.102	-0.070	0.048	0.053
	Sig.	0.128	0.001	0.304	0.015	0.151	0.193	0.023	0.397	0.226	0.118	0.410	0.389	0.493	0.482	0.243	0.424	0.181	0.267	0.337	0.324
External health expenditure per capita (current US\$)	Corr	-0.069	<b>-0.259*</b>	-0.036	0.071	<b>0.315**</b>	0.012	<b>0.277*</b>	<b>0.322**</b>	-0.059	0.092	0.114	0.108	0.005	0.010	0.078	0.064	0.031	<b>0.235*</b>	<b>0.159</b>	0.167
	Sig.	0.272	0.012	0.373	0.264	0.002	0.459	0.011	0.002	0.299	0.205	0.155	0.171	0.482	0.464	0.244	0.284	0.393	0.018	0.079	0.074
Immunization, BCG (% of one-year-old children)	Corr	<b>0.251**</b>	-0.052	0.152	0.035	<b>0.199*</b>	0.109	<b>0.221*</b>	<b>0.274**</b>	0.104	0.147	0.063	0.133	0.034	0.066	0.143	0.143	<b>0.212*</b>	<b>0.202*</b>	0.058	0.146
	Sig.	0.006	0.310	0.065	0.363	0.023	0.153	0.020	0.003	0.151	0.072	0.264	0.097	0.373	0.256	0.076	0.077	0.017	0.022	0.283	0.081
Immunization, HepB3 (% of one-year-old children)	Corr	0.098	0.030	0.015	0.048	<b>0.174*</b>	<b>0.205*</b>	<b>0.237*</b>	<b>0.268**</b>	0.127	<b>0.177*</b>	<b>0.180*</b>	<b>0.190*</b>	0.093	0.137	0.093	<b>0.195*</b>	<b>0.192*</b>	0.162	0.125	0.133
	Sig.	0.174	0.390	0.443	0.320	0.045	0.030	0.015	0.004	0.108	0.042	0.039	0.034	0.189	0.092	0.184	0.029	0.031	0.060	0.114	0.105



Immunization, measles (% of children ages 12-23 months)	Corr	0.184*	-0.007	0.069	0.054	0.234**	0.259**	0.256**	0.368**	0.179*	0.217*	0.230*	0.299**	0.163	0.239**	0.209*	0.288**	0.309**	0.287**	0.240**	0.258**
	Sig.	0.035	0.472	0.246	0.297	0.009	0.007	0.008	0.000	0.037	0.015	0.010	0.001	0.057	0.008	0.018	0.002	0.001	0.002	0.008	0.006
Immunization, Pol3 (% of one-year-old children)	Corr	0.116	-0.017	0.072	0.055	0.182*	0.131	0.286**	0.271**	0.186*	0.150	0.164	0.206*	0.133	0.169*	0.157	0.188*	0.178*	0.186*	0.099	0.137
	Sig.	0.128	0.435	0.239	0.293	0.034	0.109	0.004	0.003	0.032	0.067	0.051	0.021	0.099	0.045	0.058	0.030	0.038	0.033	0.165	0.095
Maternal mortality ratio (modeled estimate, per 100,000 live births)	Corr	-0.115	-0.167	-0.183*	-0.190*	-0.183*	-0.369**	-0.131	-0.242**	-0.249**	-0.188*	-0.274**	-0.390**	-0.065	-0.306**	-0.338**	-0.112	-0.385**	-0.362**	-0.238*	-0.182*
	Sig.	0.137	0.060	0.040	0.033	0.039	0.000	0.123	0.009	0.008	0.035	0.004	0.000	0.273	0.001	0.000	0.141	0.000	0.000	0.011	0.046
Newborns protected against tetanus (%)	Corr	0.069	-0.089	0.151	0.038	0.135	0.129	0.048	0.174*	-0.035	0.095	0.114	0.086	0.077	0.166*	0.103	0.022	0.175*	0.004	0.063	-0.091
	Sig.	0.251	0.194	0.067	0.351	0.090	0.112	0.330	0.041	0.364	0.172	0.129	0.201	0.227	0.048	0.152	0.415	0.041	0.483	0.269	0.194
Tuberculosis case detection rate (% of all forms)	Corr	0.049	0.205*	0.099	0.113	0.102	0.103	0.101	0.118	0.113	0.087	0.248**	0.324**	0.060	0.338**	0.174*	0.182*	0.175*	0.285**	0.197*	0.133
	Sig.	0.315	0.024	0.166	0.133	0.157	0.167	0.179	0.122	0.132	0.193	0.006	0.001	0.282	0.000	0.042	0.035	0.042	0.002	0.026	0.103
Tuberculosis treatment success rate (% of new cases)	Corr	0.137	0.084	0.127	0.088	-0.069	-0.088	0.241*	0.163	0.022	0.111	0.094	0.088	0.212*	0.237*	0.250**	0.153	0.164	0.116	0.178*	0.136
	Sig.	0.102	0.223	0.118	0.205	0.259	0.218	0.017	0.062	0.420	0.148	0.188	0.208	0.026	0.012	0.009	0.074	0.063	0.142	0.049	0.110

## Appendix D: Selected health expenditure and outcomes for Benin

**Table D.1: Capital health expenditure as percentage of GDP**

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Average
Benin	<b>0.27</b>	<b>0.27</b>	<b>0.24</b>	<b>0.21</b>	<b>0.28</b>	<b>0.55</b>	<b>0.76</b>	<b>0.43</b>	<b>0.26</b>	<b>0.69</b>	<b>0.25</b>	<b>0.38</b>
Burkina Faso	2.43	1.50	0.74	1.54	1.69	1.28	0.32	0.61	0.40	0.42	0.23	<b>1.02</b>
Cote d'Ivoire	0.60	0.59	0.59	0.69	0.90	0.93	0.25	0.24	0.55	0.42	0.55	<b>0.57</b>
Mali	0.52	0.19	0.19	0.20	0.20	0.20	0.18	0.21	0.30	0.03	0.00	<b>0.20</b>
Niger	..	..	..	..	..	..	0.14	0.04	0.18	0.95	0.54	<b>0.39</b>
Senegal	0.75	0.80	0.61	0.65	0.65	0.19	0.49	0.43	0.25	0.76	..	<b>0.56</b>
Togo	2.05	2.20	2.01	0.49	2.19	0.48	..	..	0.11	0.11	0.12	<b>1.09</b>

**Table D.2: Domestic general government health expenditure as percentage of GDP**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average
Benin	<b>1.0</b>	<b>0.9</b>	<b>1.0</b>	<b>0.8</b>	<b>0.8</b>	<b>1.0</b>	<b>1.0</b>	<b>1.1</b>	<b>1.0</b>	<b>1.0</b>	<b>0.8</b>	<b>0.8</b>	<b>0.8</b>	<b>0.9</b>
Burkina Faso	1.9	1.4	1.6	1.6	1.5	1.8	1.5	1.5	1.2	1.8	1.8	1.7	2.7	<b>1.7</b>
Cote d'Ivoire	0.8	0.7	0.8	0.8	0.8	0.9	0.8	0.8	1.1	1.1	0.9	1.1	1.1	<b>0.9</b>
Mali	2.0	1.8	1.9	1.5	1.1	0.9	0.6	0.7	0.5	0.7	0.9	1.0	1.2	<b>1.1</b>
Niger	1.5	2.5	2.7	2.0	2.1	2.1	1.6	1.8	1.5	1.8	1.7	1.5	1.5	<b>1.9</b>
Senegal	2.0	1.9	2.1	1.5	1.7	1.7	1.5	1.6	1.5	1.5	1.8	1.7	1.9	<b>1.7</b>
Togo	0.6	0.7	0.8	0.8	0.8	1.0	1.6	1.4	1.6	1.3	1.4	1.3	1.3	<b>1.1</b>

**Table D.3: Domestic general government health expenditure per capita in current US\$**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average
Benin	<b>5.8</b>	<b>5.6</b>	<b>6.2</b>	<b>5.8</b>	<b>6.3</b>	<b>8.1</b>	<b>7.5</b>	<b>9.0</b>	<b>8.6</b>	<b>9.6</b>	<b>7.4</b>	<b>6.3</b>	<b>6.2</b>	<b>7.1</b>
Burkina Faso	7.1	5.6	6.8	7.7	8.7	10.2	8.5	10.2	8.1	12.7	12.9	9.5	16.4	<b>9.6</b>
Cote d'Ivoire	7.1	6.8	7.3	8.6	10.3	11.2	9.9	10.3	13.3	15.8	13.7	16.5	17.4	<b>11.4</b>
Mali	8.7	8.8	9.7	9.0	7.3	6.2	4.6	5.8	3.6	5.8	7.5	7.3	9.4	<b>7.2</b>
Niger	3.4	6.2	6.9	5.9	7.6	7.2	5.7	6.8	6.0	7.5	7.2	5.4	5.5	<b>6.2</b>
Senegal	14.8	14.8	17.0	14.2	18.7	16.9	14.5	17.2	15.6	15.7	18.9	15.8	18.2	<b>16.3</b>
Togo	2.4	2.7	3.1	3.7	4.4	5.1	8.2	8.4	9.2	8.2	8.8	7.2	7.8	<b>6.1</b>

**Table D.4: External health expenditure per capita in current US\$**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average
Benin	<b>4.9</b>	<b>4.9</b>	<b>5.1</b>	<b>7.0</b>	<b>7.8</b>	<b>6.7</b>	<b>8.0</b>	<b>9.0</b>	<b>14.2</b>	<b>9.1</b>	<b>9.8</b>	<b>10.7</b>	<b>9.3</b>	<b>8.2</b>
Burkina Faso	4.7	6.4	7.6	12.0	10.9	9.8	14.0	11.6	12.2	13.7	10.6	9.9	9.6	<b>10.2</b>
Cote d'Ivoire	6.4	4.9	5.3	5.9	8.1	9.0	10.6	9.1	12.0	6.4	14.7	19.9	10.1	<b>9.4</b>
Mali	1.3	1.3	1.9	3.3	3.5	3.7	4.8	5.1	8.8	12.2	17.2	12.6	9.6	<b>6.6</b>
Niger	1.3	1.8	1.9	2.5	2.8	2.7	2.6	2.5	2.6	2.9	2.9	3.7	2.9	<b>2.6</b>
Senegal	0.9	2.5	2.1	2.4	2.2	3.2	4.9	3.7	3.9	5.5	3.8	3.9	3.3	<b>3.3</b>
Togo	1.2	1.4	1.7	2.3	3.0	3.1	1.9	3.0	3.7	6.7	6.5	5.9	8.0	<b>3.7</b>

**Table D.5: Immunization against TB (BCG) as percentage of one-year-old children**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>89</b>	<b>88</b>	<b>93</b>	<b>97</b>	<b>96</b>	<b>93</b>	<b>90</b>	<b>88</b>	<b>96</b>	<b>95</b>	<b>91</b>	<b>86</b>	<b>88</b>	<b>89</b>	<b>89</b>	<b>91</b>
Burkina Faso	99	99	99	99	99	99	99	99	96	96	98	98	98	98	98	<b>98</b>
Cote d'Ivoire	71	85	77	94	91	95	91	74	93	90	84	79	95	93	98	<b>87</b>
Mali	76	83	86	86	86	84	82	84	77	70	73	76	77	81	83	<b>80</b>
Niger	61	64	69	73	78	86	81	53	85	43	87	94	91	92	87	<b>76</b>
Senegal	95	92	94	96	98	97	97	97	97	97	95	95	97	99	83	<b>95</b>
Togo	91	96	96	91	92	91	97	97	97	97	79	86	79	75	83	<b>90</b>

**Table D.6: Immunization against Hepatitis B as percentage of one-year-old children**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>75</b>	<b>70</b>	<b>74</b>	<b>82</b>	<b>75</b>	<b>79</b>	<b>76</b>	<b>75</b>	<b>80</b>	<b>77</b>	<b>74</b>	<b>74</b>	<b>76</b>	<b>76</b>	<b>76</b>	<b>75.9</b>
Burkina Faso	..	..	76	89	93	92	91	91	90	88	91	91	91	91	91	<b>89.6</b>
Cote d'Ivoire	67	76	77	76	74	81	85	62	82	75	73	77	85	83	82	<b>77</b>
Mali	73	83	90	74	74	71	72	66	65	64	66	67	69	70	71	<b>71.7</b>
Niger	..	..	..	..	..	71	70	75	71	73	81	84	80	85	79	<b>76.9</b>
Senegal	54	84	89	94	88	86	89	92	91	92	89	89	93	91	82	<b>86.9</b>
Togo	..	..	..	..	24	78	83	85	84	84	87	88	89	90	88	<b>80</b>

**Table D.7: Immunization against measles as percentage of children aged 12–23 months**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>63</b>	<b>61</b>	<b>66</b>	<b>70</b>	<b>66</b>	<b>71</b>	<b>68</b>	<b>70</b>	<b>74</b>	<b>68</b>	<b>65</b>	<b>67</b>	<b>68</b>	<b>70</b>	<b>71</b>	<b>67.9</b>
Burkina Faso	78	84	88	94	94	94	92	89	87	82	88	88	88	88	88	<b>88.1</b>
Cote d'Ivoire	78	84	73	67	63	67	70	49	74	69	59	65	71	70	71	<b>68.7</b>
Mali	63	73	68	66	71	73	78	72	67	62	61	62	66	67	70	<b>67.9</b>
Niger	45	47	53	60	66	69	67	69	75	80	80	85	76	82	77	<b>68.7</b>
Senegal	57	74	80	84	77	79	81	84	83	84	80	80	93	90	82	<b>80.5</b>
Togo	70	70	78	71	63	66	68	72	72	72	82	85	87	91	85	<b>75.5</b>

**Table D.8: Immunization against polio as percentage of one-year-old children**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>74</b>	<b>73</b>	<b>76</b>	<b>82</b>	<b>77</b>	<b>80</b>	<b>77</b>	<b>77</b>	<b>80</b>	<b>73</b>	<b>71</b>	<b>72</b>	<b>75</b>	<b>75</b>	<b>75</b>	<b>75.8</b>
Burkina Faso	83	94	94	93	92	91	90	90	90	89	91	91	91	91	91	<b>90.7</b>
Cote d'Ivoire	76	87	76	75	58	77	81	58	83	74	71	74	71	82	82	<b>75.0</b>
Guinea-Bissau	69	73	74	76	77	78	82	85	87	88	88	89	89	89	89	<b>82.2</b>
Mali	70	78	79	76	74	77	77	72	65	57	62	65	67	70	73	<b>70.8</b>
Niger	45	46	52	57	68	71	75	40	71	62	79	83	82	85	79	<b>66.3</b>
Senegal	87	84	89	93	87	83	76	89	83	89	85	85	92	91	81	<b>86.3</b>
Togo	71	80	85	72	80	78	83	85	84	84	85	88	89	84	66	<b>80.9</b>

**Table D.9: Maternal mortality ratio per 100,000 live births**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Average
Benin	<b>505</b>	<b>500</b>	<b>493</b>	<b>486</b>	<b>480</b>	<b>471</b>	<b>464</b>	<b>458</b>	<b>450</b>	<b>441</b>	<b>432</b>	<b>421</b>	<b>408</b>	<b>397</b>	<b>458</b>
Burkina Faso	454	437	422	410	401	393	385	377	369	362	353	343	331	320	<b>383</b>
Cote d'Ivoire	709	704	699	698	694	700	701	703	702	691	676	658	636	617	<b>685</b>
Mali	715	691	675	663	661	661	660	663	663	663	642	620	590	562	<b>652</b>
Niger	770	755	739	725	709	688	663	639	616	594	573	555	530	509	<b>648</b>
Senegal	526	519	514	504	492	472	447	423	400	381	364	346	330	315	<b>431</b>
Togo	488	492	482	480	473	458	440	422	410	404	401	398	395	396	<b>439</b>

**Table D.10: Newborns protected against tetanus (percent)**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>93</b>	<b>95</b>	<b>95</b>	<b>93</b>	<b>92</b>	<b>92</b>	<b>92</b>	<b>92</b>	<b>93</b>	<b>93</b>	<b>93</b>	<b>85</b>	<b>85</b>	<b>85</b>	<b>85</b>	<b>91</b>
Burkina Faso	69	72	76	80	79	85	85	88	88	88	89	92	92	92	92	<b>84</b>
Cote d'Ivoire	76	75	75	74	92	92	82	82	82	82	82	85	85	85	85	<b>82</b>
Mali	86	86	89	90	92	92	85	89	89	85	85	85	85	85	85	<b>87</b>
Niger	66	69	73	79	84	84	84	84	84	81	81	81	81	81	81	<b>80</b>
Senegal	78	80	86	85	88	88	88	88	91	91	91	91	91	95	95	<b>88</b>
Togo	79	81	81	82	81	81	81	81	81	77	81	81	81	83	83	<b>81</b>

**Table D.11: Tuberculosis case detection rate (as percentage of all forms)**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average
Benin	<b>54</b>	<b>56</b>	<b>62</b>	<b>61</b>	<b>64</b>	<b>63</b>	<b>60</b>	<b>66</b>	<b>62</b>	<b>60</b>	<b>61</b>	<b>63</b>	<b>61</b>	<b>55</b>	<b>62</b>	<b>60.7</b>
Burkina Faso	34	41	45	45	47	52	53	58	57	58	59	60	60	59	63	<b>52.7</b>
Cote d'Ivoire	39	40	44	52	55	54	56	57	62	66	62	61	59	58	59	<b>54.9</b>
Mali	52	53	56	57	65	71	56	57	56	59	60	68	68	63	68	<b>60.6</b>
Niger	35	40	44	49	49	54	54	56	59	60	57	54	52	54	55	<b>51.5</b>
Senegal	58	62	64	64	68	67	66	65	71	75	75	74	71	72	71	<b>68.2</b>
Togo	61	64	66	54	63	62	57	60	61	58	61	68	80	81	85	<b>65.4</b>

**Table D.12: Tuberculosis treatment success rate (as percentage of new cases)**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Average
Benin	<b>83</b>	<b>87</b>	<b>86</b>	<b>86</b>	<b>87</b>	<b>88</b>	<b>90</b>	<b>89</b>	<b>90</b>	<b>89</b>	<b>89</b>	<b>88</b>	<b>88</b>	<b>87</b>	<b>87.6</b>
Burkina Faso	67	71	72	73	76	77	78	77	80	80	81	78	80	80	<b>76.4</b>
Cote d'Ivoire	69	74	73	71	75	77	75	76	79	80	79	80	82	83	<b>76.6</b>
Mali	71	75	76	77	81	79	77	69	93	74	73	77	77	78	<b>76.9</b>
Niger	61	74	77	79	79	79	81	80	77	79	79	80	81	82	<b>77.7</b>
Senegal	74	76	76	68	79	81	82	83	84	87	87	86	86	87	<b>81.1</b>
Togo	66	71	67	77	82	83	85	85	86	88	88	86	85	82	<b>80.8</b>

## Appendix E: Correlation between PEFA indicators and health expenditure and outcomes using only 2011 Framework-based assessments

		PI-01	PI-02	PI-03	PI-05	PI-06	PI-07	PI-08	PI-10	PI-11	PI-12	PI-16	PI-18	PI-19	PI-20	PI-21	PI-24	PI-25	PI-26	PI-27	PI-28
Capital health expenditure (% of GDP)	Corr	-0.162	-0.190	0.009	-0.240	-0.274	-0.193	-0.057	<b>-0.461**</b>	-0.072	-0.154	<b>-0.355*</b>	<b>-0.359*</b>	-0.169	-0.225	-0.273	-0.276	-0.272	-0.222	-0.145	-0.152
	Sig.	0.313	0.246	0.953	0.122	0.075	0.253	0.741	0.002	0.645	0.323	0.019	0.020	0.292	0.147	0.076	0.073	0.078	0.158	0.352	0.348
Domestic general government health expenditure (% of GDP)	Corr	0.038	0.211	0.056	0.067	0.210	<b>0.348**</b>	0.172	0.217	0.127	0.208	0.129	0.126	-0.081	-0.112	0.015	-0.046	0.089	0.155	0.132	0.197
	Sig.	0.741	0.069	0.624	0.555	0.060	0.003	0.160	0.052	0.259	0.063	0.250	0.270	0.489	0.318	0.896	0.680	0.434	0.172	0.247	0.088
Domestic general government health expenditure per capita (current US\$)	Corr	0.065	<b>0.275*</b>	0.059	0.014	<b>0.254*</b>	<b>0.374**</b>	0.117	<b>0.365**</b>	0.085	0.049	<b>0.269*</b>	<b>0.460**</b>	-0.045	<b>0.220*</b>	<b>0.254*</b>	0.200	<b>0.326**</b>	<b>0.405**</b>	0.151	<b>0.267*</b>
	Sig.	0.568	0.017	0.606	0.904	0.022	0.001	0.342	0.001	0.448	0.665	0.015	0.000	0.697	0.048	0.022	0.074	0.003	0.000	0.184	0.020
External health expenditure (% of current health expenditure)	Corr	0.127	<b>-0.360**</b>	0.053	<b>0.237*</b>	0.113	-0.110	0.238	0.024	0.080	0.129	0.023	-0.035	0.005	0.006	0.075	0.016	0.104	-0.070	0.048	0.053
	Sig.	0.265	0.002	0.639	0.033	0.316	0.366	0.051	0.831	0.479	0.251	0.842	0.758	0.966	0.955	0.503	0.888	0.360	0.538	0.674	0.648
External health expenditure per capita (current US\$)	Corr	-0.073	<b>-0.264*</b>	-0.047	0.066	<b>0.311**</b>	0.005	<b>0.272*</b>	<b>0.318**</b>	-0.071	0.083	0.109	0.104	0.011	0.012	0.073	0.055	0.033	<b>0.236*</b>	0.160	0.167
	Sig.	0.524	0.022	0.680	0.559	0.005	0.969	0.025	0.004	0.531	0.459	0.332	0.367	0.926	0.912	0.518	0.627	0.774	0.036	0.159	0.149
Immunization, BCG (% of one-year-old children)	Corr	0.210	-0.082	0.096	-0.021	0.191	0.026	0.221	<b>0.295**</b>	0.028	0.065	0.023	0.134	0.041	0.005	0.106	0.137	0.191	0.203	-0.066	0.035
	Sig.	0.061	0.480	0.395	0.854	0.086	0.833	0.068	0.007	0.803	0.561	0.838	0.241	0.722	0.963	0.345	0.221	0.088	0.070	0.561	0.765

Immunization, HepB3 (% of one-year-old children)	Corr	0.022	0.047	-0.017	0.010	0.189	0.168	0.234	<b>0.314**</b>	0.079	0.191	0.159	0.219	0.102	0.052	0.048	<b>0.258*</b>	0.154	0.144	0.014	-0.010
	Sig.	0.853	0.698	0.884	0.933	0.100	0.178	0.061	0.005	0.497	0.096	0.168	0.060	0.388	0.655	0.680	0.024	0.184	0.217	0.908	0.930
Immunization, measles (% of children ages 12-23 months)	Corr	0.128	-0.037	0.038	0.052	<b>0.276*</b>	0.207	<b>0.251*</b>	<b>0.441**</b>	0.161	<b>0.222*</b>	<b>0.220*</b>	<b>0.319**</b>	0.156	0.187	0.186	<b>0.340**</b>	<b>0.304**</b>	<b>0.296**</b>	0.119	0.135
	Sig.	0.257	0.752	0.738	0.640	0.012	0.083	0.037	0.000	0.149	0.045	0.047	0.004	0.175	0.092	0.094	0.002	0.006	0.008	0.295	0.246
Immunization, Pol3 (% of one-year-old children)	Corr	0.056	-0.017	0.060	0.026	0.195	0.072	<b>0.286*</b>	<b>0.302**</b>	0.162	0.148	0.137	<b>0.230*</b>	0.138	0.092	0.130	<b>0.235*</b>	0.146	0.164	-0.023	0.008
	Sig.	0.624	0.887	0.596	0.820	0.079	0.552	0.017	0.006	0.145	0.186	0.221	0.041	0.230	0.410	0.244	0.034	0.194	0.146	0.839	0.943
Maternal mortality ratio (modeled estimate, per 100,000 live births)	Corr	-0.136	-0.176	-0.205	-0.161	-0.174	<b>-0.361**</b>	-0.096	<b>-0.274*</b>	<b>-0.270*</b>	-0.191	<b>-0.247*</b>	<b>0.434**</b>	-0.062	<b>-0.263*</b>	<b>0.392**</b>	-0.131	<b>0.330**</b>	<b>0.414**</b>	<b>-0.233*</b>	-0.186
	Sig.	0.229	0.127	0.066	0.147	0.118	0.002	0.430	0.013	0.014	0.085	0.025	0.000	0.593	0.017	0.000	0.239	0.003	0.000	0.038	0.107
Newborns protected against tetanus (%)	Corr	0.031	-0.096	0.164	0.001	0.134	0.084	0.009	0.198	-0.068	0.067	0.078	0.062	0.139	0.126	0.101	-0.001	0.145	-0.005	-0.012	-0.191
	Sig.	0.788	0.411	0.143	0.990	0.231	0.486	0.939	0.074	0.541	0.550	0.484	0.589	0.229	0.261	0.365	0.991	0.196	0.963	0.914	0.099
Tuberculosis case detection rate (%; all forms)	Corr	0.038	<b>0.243*</b>	0.129	0.137	0.130	0.061	0.132	0.215	0.175	0.127	<b>0.245*</b>	<b>0.353**</b>	0.091	<b>0.325**</b>	0.214	<b>0.253*</b>	0.154	<b>0.359**</b>	0.179	0.102
	Sig.	0.737	0.036	0.255	0.223	0.246	0.613	0.284	0.054	0.118	0.257	0.028	0.002	0.434	0.003	0.055	0.023	0.173	0.001	0.115	0.384
Tuberculosis treatment success rate (% of new cases)	Corr	0.141	0.067	0.109	0.200	-0.031	-0.155	0.208	<b>0.238*</b>	0.075	0.172	0.142	0.039	0.154	<b>0.229*</b>	<b>0.255*</b>	<b>0.228*</b>	<b>0.261*</b>	0.099	0.112	0.024
	Sig.	0.221	0.574	0.343	0.077	0.783	0.202	0.091	0.035	0.509	0.130	0.210	0.735	0.192	0.042	0.024	0.043	0.021	0.389	0.331	0.842